West Africa Regional Program

Regional Operational Plan

ROP 2019

Strategic Direction Summary

April 21, 2019

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1.0 Goal Statement

This Regional Operation Plan (ROP 19) is the first for the West Africa Region (Burkina Faso, Togo, Ghana, Liberia, Mali, and Senegal), and represents a major pivot from previous HIV programming in each of the countries.

The West Africa PEPFAR Vision is to **catalyze sustained epidemic control in West Africa by leveraging national and donor investments to implement adaptive, evidence-based interventions to reach, test, treat and retain Key Populations (KP) and People Living with HIV (PLHIV) in settings with the greatest HIV burden.**

Working in close collaboration with the various Host Country Governments, Civil Society Organizations (CSOs), the Global Fund for HIV/AIDS, TB and Malaria (GF), UNAIDS, the World Health Organization (WHO) and other partners, the US President's Emergency Plan for AIDS Relief (PEPFAR) program in the West Africa Region aims to support the achievement of epidemic control at three different levels by 2021:

1. In **Burkina Faso and Togo**, with additional "Game Changer" funds, PEPFAR aims to reach the first and second 90 nationally in ROP19, and achieve the third 90 in ROP20 through direct service delivery, with a targeted focus on the highest burden sites for KP and PLHIV (Centre, Hauts Bassins, and Centre Ouest Regions in Burkina Faso; Lome Commune, Maritime, and Plateaux Regions in Togo), and with technical assistance to other sites;
2. In **Ghana**, PEPFAR aims to achieve saturation and reach epidemic control in the Western Region, and;
3. In **Liberia, Mali and Senegal**, PEPFAR aims to reach epidemic control in KP groups, namely Men who Have Sex with Men (MSM) and Female Sex Workers (FSW), in targeted local, administrative areas.

In 2017, in the region, only 56% of PLHIV knew their status, only 47% of PLHIV were on ART, and only 28% of PLHIV were virally suppressed.[1]

In ROP19, it is expected for **Burkina Faso and Togo,** with the support of the Game Changer Funds, to achieve 95% and 90% respectively of PLHIV knowing their status, 85% and 81% of PLHIV on ART (8,500 and 20,240 PLHIV newly enrolled on ART) respectively, and 67% of PLHIV who are virally suppressed in both countries.

For **Ghana,** ROP19 investments will increase ART coverage in the new Western Region from 34% to 83% by identifying, linking and retaining 12,810 PLHIV in the treatment cascade.

For **Liberia, Mali and Senegal**, 2,045 PLHIV, 3,450, PLHIV, and 1,105 PLHIV will be identified, linked and retained on ART respectively.

At site level across all countries, emphasis will be placed on rapid scale-up of effective case finding strategies (namely index testing, enhanced peer outreach approach, social network testing, and targeted Provider Initiated Testing and Counselling (PITC)), prompt linkage to ART, and retention on treatment interventions.

[1] Estimated using data from UNAIDS. http://aidsinfo.unaids.org. Data accessed April 11, 2019.

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At national level, in partnership with host Governments, through the various National AIDS Control Programs (NACP) and Ministries of Health (MOH) and with GF, common barriers which are preventing achievement of 90-90-90 targets will be addressed in ROP19 in order to enable countries to accelerate their progress. PEPFAR will support implementation with fidelity of effective policies (including Test and Start, Index testing and Partner Notification, Differentiated Service Delivery (DSD) - with multi-month scripting and dispensing (MMS/D), TLD transition and removal of Nevirapine-based regimens), reduction of stigma and discrimination against KP and PLHIV, elimination of informal user fees, improvement of supply chain and lab system management, and improvement of the monitoring and evaluation system.

At regional level, cross-country best practices sharing will be done during the quarterly PEPFAR Oversight and Accountability Reporting Tool calls. Multilateral entities such as West African Health Organization (WAHO), UNAIDS West Africa and Country Offices, and the GF will continue to be engaged to support countries in scaling-up effective policies and to eliminate system barriers. Civil Society will be engaged both at site and above site levels as sub-implementing partners, and oversight and advocacy committee members.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

With a combined population of 93.1 million inhabitants, the West Africa PEPFAR Region is home to an estimated 730,000 total PLHIV in 2018. The number of PLHIV was estimated at 325,681 in Ghana, followed by 134,123 in Mali, 114,534 in Togo, 94,000 in Burkina Faso, 42,422 in Senegal, and 40,265 in Liberia.[2]

The HIV epidemic is defined as concentrated in KP in two countries (Senegal, Mali), and other countries (Burkina Faso, Liberia, Togo, and Ghana) have a mixed HIV epidemic. In 2018, HIV prevalence ranges from 0.3% in Senegal to 3.1% in Liberia.[3] It is higher in urban areas than rural areas, higher among women than men, and higher among KP such as Men who Have Sex with Men (MSM) and Female Sex Workers (FSW). HIV prevalence among FSW ranges from 5.6% in Burkina Faso to 24.2% in Mali and among MSM ranges from 1.9% in Burkina Faso to 27.6% in Senegal.[4]

Figure 2.1 Western Africa: HIV Prevalence among the General Population

[2] Spectrum 2019 preliminary data.
[3] Spectrum 2019 preliminary data.
[4] IBBSS FSW (Burkina Faso : 2017, Mali : 2009, Ghana: 2017, Liberia: 2013, Togo : 2017 and Senegal : Spectrum 2017)

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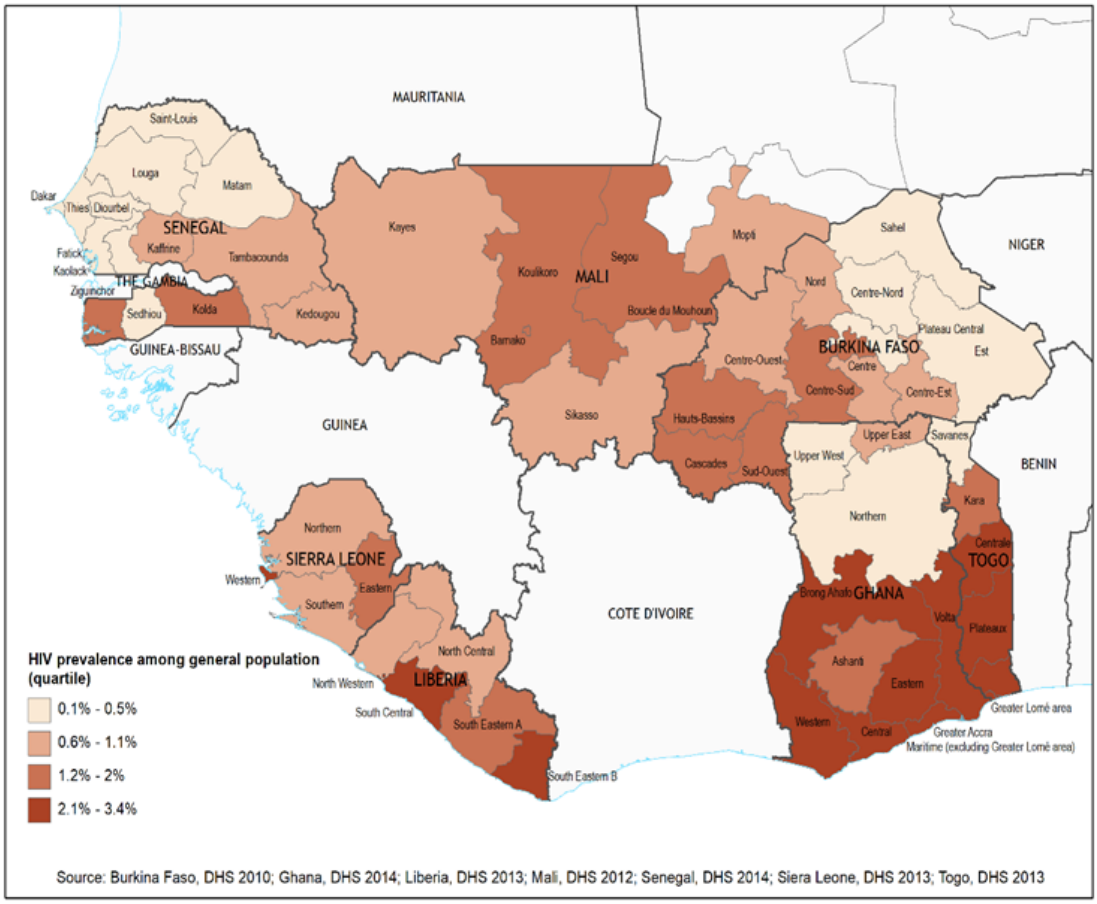

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Standard Table 2.1.1

Table 2.1.1 Host Country Government Results: Ghana															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	29,614,005		5,444,368	49.3%	5592801	50.7%	2,826,747	49.9%	2,835,838	50.1%	6792623	52.6%	6,121,628	47.4%	GSS
HIV Prevalence (%)		1.8%		0.3%		0.3%		1.1%		0.4		3.1%		1.7%	NACP Status Update, 2018
AIDS Deaths (per year)	15,681.29		1,605		1,671		521		523		5,686		5676		NACP Status Update, 2018
# PLHIV	325,681		13,145		13,882		26,405		9,942		172,565		89,741		Spectrum 2018 (April 19, 2019 version)
Incidence Rate (Yr)		0.81%		N/A		N/A		N/A		N/A		N/A		N/A	NACP Status Update, 2018
New Infections (Yr)	23,231														NACP Status Update, 2018
Annual births	1,184,560.2	4%													DHMS 2, 2018
% of Pregnant Women with at least one ANC visit	939,074	79.2%	2,710	0.3%			331,750	35.3%			604,614	64.4%			DHMS 2, 2018

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	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Pregnant women needing ARVs	18,441	5.2%													NACP Status Update, 2018
Orphans (maternal, paternal, double)	237,004		N/A		N/A		N/A		N/A		N/A		N/A		NACP Status Update, 2018
Notified TB cases (Yr)															NACP Status Update, 2018
% of TB cases that are HIV infected	2,602	19.5%													NACP Status Update, 2018
% of Males Circumcised	NA	96.0%			N/A	N/A			N/A	N/A			N/A	N/A	DHS, 2014
Estimated Population Size of MSM*	54,759	0.72%													GMS II, 2017
MSM HIV Prevalence	9,856	18.1%													GMS II, 2017
Estimated Population Size of FSW	65,053	0.9%													IBBSS, 2016
FSW HIV Prevalence	4,488	6.9%													IBBSS, 2016
Estimated Population Size of PWID	N/A	N/A													
PWID HIV Prevalence	N/A	N/A													

Note: Cells left blank indicate the prompt is not applicable (N/A) or there is not sufficient data gathered

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Table 2.1.1 Host Country Government Results: Liberia, Mali, and Senegal

		Total		<15				15-24				25+				*Source, Year*
	Country			**Female**		**Male**		**Female**		**Male**		**Female**		**Male**		
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	Liberia	4,809,768		1,040,211	21.6%	1,062,766	22%	478,999	10%	478,041	9.9%	887,025	18.4%	863,666	17.9%	https://www.cia.gov/library/publications/the-world-factbook/geos/print_li.html July 2018
	Mali	19,979,227					49.59%									
	Senegal	15,200,000		3,300,000	22%	3.1%	20%	1,500,000	10%	1,500,000	10%	2,800,000	18%	3,000,000	20%	CNLS
HIV Prevalence (%)	Liberia		3.1%		0.2%		0.7%		0.4%		0.13%		0.2%		N/A	Spectrum data 2018
	Mali		1.1%													
	Senegal	.3%														UNAIDS
AIDS Deaths (per year)	Liberia	1,805		147		152		589		916						Spectrum data 2018
	Mali															
	Senegal															
# PLHIV	Liberia	438,54						1,979		1,935		18,368		11,768		Spectrum data 2018
	Mali	134,123														
	Senegal	42,422														UNAIDS, 2017
Incidence Rate (Yr)	Liberia		3%		0.7%		0.7%		0.9%		0.4%		0.9%		0.4%	Spectrum data 2018
	Mali															
	Senegal		.14%													CNLS
New Infections (Yr)	Liberia	1,859														Spectrum data 2018
	Mali															
	Senegal	1,600														UNAIDS, 2017

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Annual births	Liberia	4,810	37.9%													Spectrum Data 2018
	Mali															
	Senegal	992														UNAIDS, 2017
% of Pregnant Women with at least one ANC visit	Liberia	44,292	100%	N/A	N/A			N/A	N/A			N/A	N/A			NACP 2018
	Mali	671 025														
	Senegal															
Pregnant women needing ARVs	Liberia	672	7%													NACP 2018
	Mali	7,058														
	Senegal	2300														UNAIDS 2017
% of TB cases that are HIV infected	Liberia															
	Mali															
	Senegal		6.4%													CNLS
Estimated Population Size of MSM*	Liberia	74,631	5.56%													Liberia, 2013 IBBS National AIDS Control Program size estimation study 2017
	Mali	11,319														
	Senegal	9,265														UNAIDS 2017
MSM HIV Prevalence	Liberia	14,766	19.8%													Liberia, 2013 IBBS National AIDS Control Program size estimation study 2017
	Mali		13.7%													
	Senegal		27.6%													UNAIDS 2017
Estimated Population Size of FSW	Liberia	163,031	11%													Liberia, 2013 IBBS National AIDS Control Program size estimation study 2017
	Mali	37,626														

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	Mali	37,626														
	Senegal	20,763														UNAIDS, 2017
FSW HIV Prevalence	Liberia	15,977	9.8%													Liberia, 2013 IBBS National AIDS Control Program size estimation study 2017
	Mali		24.2%													
	Senegal		6.6%													UNAIDS, 2017
Estimated Population Size of PWID	Liberia	4,088	1.7%													Liberia, 2013 IBBS National AIDS Control Program size estimation study 2017
	Mali	833														
	Senegal															
PWID HIV Prevalence	Liberia	204	5%													Liberia, 2013 IBBS National AIDS Control Program

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																size estimation study 2017
	Mali															
	Senegal		1.6%													UNAIDS, 2017

Note: Cells left blank indicate the prompt is not applicable (N/A) or there is not sufficient data gathered.

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Table 2.1.1 Host Country Government Results: Burkina Faso and Togo																
	Country	**Total**		**<15**				**15-24**				**25+**				***Source, Year***
				Female		**Male**		**Female**		**Male**		**Female**		**Male**		
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	Burkina Faso	19,200,000	100%	4,260,000	22.19%	4,410,000	22.97%	1,890,000	9.84%	1,950,000	10.16%	3,510,000	18.28%	3,135,000	16,33%	INSD 2017
	Togo	7,440,365	100%	1,463,104	19.66%	1,474,460	19.82%	7,28,699	9.79%	776,407	10.43%	1,620,217	21.77%	1,377,479	18.51%	INSEED 2018
HIV Prevalence (%)	Burkina Faso		0.8%						0.5%		0.3%					AIDS info 2017, UNAIDS database
	Togo		2.27%													EPP Estimations/Spectrum 2019. Version 5.755
AIDS Deaths (per year)	Burkina Faso	2,900														UNAIDS data 2018 report
	Togo	4,327		542		546		124		154		1,314		1,645		EPP Estimations/Spectrum 2019. Version 5.755
# PLHIV	Burkina Faso	94,000														UNAIDS data 2018 report
	Togo	114,000		5,900		6,500		7,500		4,090		56,620		33,840		EPP Estimations/Spectrum 2019. Version 5.755
Incidence Rate (Yr)	Burkina Faso		0.23%													UNAIDS data 2018 report

Unclassified

	Togo		0.10 %		1.02 %		1.02%						0.12 %		0.08 %	EPP Estimations/Spectrum 2019. Version 5-755
New Infections (Yr)	Burkina Faso	4,300														UNAIDS data 2019 report
	Togo	5,302														EPP Estimations/Spectrum 2019. Version 5-755
Annual births	Burkina Faso	741,830														MoH Statistic Report 2017
	Togo	169,738														Monthly Activity Reports Mother and Children Health (SMI)
% of Pregnant Women with at least one ANC visit	Burkina Faso	77.53% (213439/275294)														Monthly Activity Reports Mother and Children Health (SMI)
	Togo	77.53% (213439/275294)														Monthly Activity Reports Mother and Children Health (SMI)
Pregnant women needing ARVs	Burkina Faso															
	Togo	6,017														Spectrum, 2019, Version 5.755
Orphans (maternal,	Burkina Faso	71,000														Rapport ONUSIDA 2018

Unclassified

paternal, double)	Togo	95,745														Estimations EPP/Spectrum 2019. Version 5.7
Notified TB cases (Yr)	Burkina Faso	4,473														
	Togo	2,501 (H=1622 F=879 Inf 15 ans=85 Sup15 ans 2416														
% of TB cases that are HIV infected	Burkina Faso	476	8.63%													
	Togo	17,2% (424/2458)														
% of Males Circumcised	Burkina Faso															
	Togo															
Estimated Population Size of MSM*	Burkina Faso	3,458 *26,821														IBBSS 2018 *R2P study in 2014
	Togo	6,100														Mapping and size estimation study (MSM, FSW, PID, and Prisoners), 2017

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MSM HIV Prevalence	Burkina Faso		1.9%													IBBSS 2017
	Togo	21.98%														IBBSS MSM 2017
Estimated Population Size of FSW	Burkina Faso	21858														IBBSS 2017
	Togo	11746														Mapping and size estimation study (MSM, FSW, PID, and Prisoners), 2017
FSW HIV Prevalence	Burkina Faso		5.4%													IBBSS 2017
	Togo	13.2%														IBBSS FSW and Clients 2017
Estimated Population Size of PWID	Burkina Faso	87														IBBSS 2017
	Togo	2,698														Mapping and size estimation study (MSM, FSW, PID, and Prisoners), 2017
PWID HIV Prevalence	Burkina Faso	ND	ND													
	Togo	3.9%														IBBSS PID 2017
Estimated Size of	Burkina Faso	9,429														RNM, 2018

Unclassified

Priority Populations (Prisoners)	Togo	5,154														Prisons Administration Data 2018
Estimated Size of Priority Populations Prevalence (Prisoners)	Burkina Faso		2.15%													IBBSS, 2017
	Togo		4.30%													IBBSS Prisoners 2011

Unclassified

Standard Table 2.1.2

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*											
		Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Country	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	Ghana	29,614,005	1.1%	325,681	193,831	113,171	34.7%	21.0%	1,702,543	72,291	30,410
	Liberia	4,809,768	3.1%	40,090	26,018	13,880	32%	71%	74,051	4,725	1,884
	Mali	19,528,865	1.1%	134,123		46,598	34.7%				
	Senegal	15,200,000	0.3%	42,222	30,393	23,202	54.7%	19%	550,386	9,005	5,355
	Burkina Faso	19,200, 000	0.8%	94,000	77,113	66,983	71%	49%	1,897,665	20,607	ND
	Togo	7,440,360	2%	114,000	72,745	64,842	56.9%	45%	491,263	15,833	7,338
Population <15 years	Ghana	11,073,169	0.3%	33,083	5,878	5,876	17.8%	11.8%	112,703	4,818	1,619
	Liberia	2,102,977	2%*	4,488	296	680	15%	0	N/A	N/A	N/A
	Mali			11,439							
	Senegal	6,400,000									
	Burkina Faso	8,670 000	ND	9,400	3,034	2,684	28.5%	ND	ND	ND	ND
	Togo	2,937,564		14,133	4,649	4,194	29.68%	64.77%	28,638	ND	535
Men 15-24 years	Ghana	2,835,838	0.4%	11,132	44,496	25,580	23.5%	15.6%	278,799	17,701	7,909
	Liberia	478,041	0.4%*	1,935	224	3,383	24%	0	N/A	N/A	N/A
	Mali			3,329							
	Senegal	1,500,000	0.1%								

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	Burkina Faso	1,950,000	0.3%	ND	1,309	ND		ND	ND	ND	ND
	Togo	776,407			ND	ND		56.20% (195/347)	ND	ND	ND
Men 25+ years	Ghana	6,121,628	1.7%	97,715	44,496	25,580	23.5%	15.6%	278,799	17,701	7,909
	Liberia	863,666	0.13%*	11,767	645			0	N/A	N/A	N/A
	Mali										
	Senegal	2,800,000	0.7%*								
	Burkina Faso	3,135,000			18,727			ND	ND	ND	ND
	Togo	1,377,479			ND	ND		79.46% (3625/4562)	ND	ND	ND
Women 15-24 years	Ghana	2,826,747	1.1%	29,950	143,457	81,715	37.8%	25.1%	1,311,041	49,772	20,882
	Liberia	478,999	0.7%*	3,532	426	9,817	45%	0	N/A	N/A	N/A
	Mali			6,335							
	Senegal	1,500,000	0.2%								
	Burkina Faso	1,890,000	0.5%	ND	4,488	ND		ND	ND	ND	ND
	Togo	728,699			ND	ND		70.94% (415/585)	ND	ND	ND
Women 25+ years	Ghana	6,792,623	3.1%	186,109	143,457	81,715	37.8%	25.1%	1,311,041	49,772	20,882
	Liberia	887,025	0.2%*	18,368							
	Mali										
	Senegal	3,000,000	0.7%								
	Burkina Faso	3,510,000	ND	ND	49,555	ND		ND	ND	ND	ND
	Togo	1,620,217			ND	ND		81.89% (10865/13252)	ND	ND	ND
MSM	Ghana	54,759	18.1%	9,856					16,189	2,051	1,908
	Liberia	74,631	19.8%	14,777	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Unclassified

	Mali	11,319	13.7%								
	Senegal	9,900	27.6%	1712	334	316	21%		813	32	17
	Burkina Faso	3,458	1.9%	66	ND	ND		ND	465	53	48
	Togo	6,100	21.98%	1342		179	13.5%	75%	466*	42*	33*
FSW	Ghana	65,053	6.9%	4,488					36,555	2,969	2,363
	Liberia	163.031	9.8%	15,977	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Mali	37,626	24.2%								
	Senegal	22,033	6.6%	1346	622	406	34%		1488	14	12
	Burkina Faso	21,858	5.4%	1,180	ND	ND	ND	ND	1,583	97	ND
	Togo	11,746	13.2%	1526		326	23.9%	82%*	749**	123**	106**
PWID	Ghana										
	Liberia	4,088	5%	204	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Mali										
	Senegal	3,067	9.4%								
	Burkina Faso	87		ND	ND	ND	ND	ND	ND	ND	ND
	Togo	2,608	3.9%	104		1	.9%	ND	ND	ND	ND

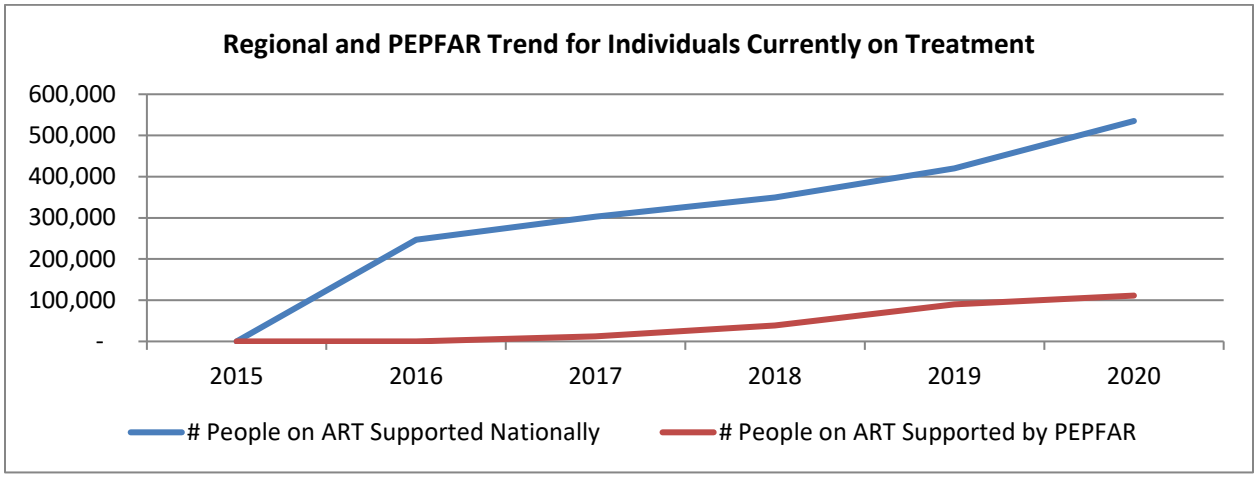
PEPFAR Program data; ** PEPFAR FY19 Q1 data

Note: Cells left blank indicate the prompt is not applicable (N/A) or there is not sufficient data gathered.

ND = No Data available

Unclassified

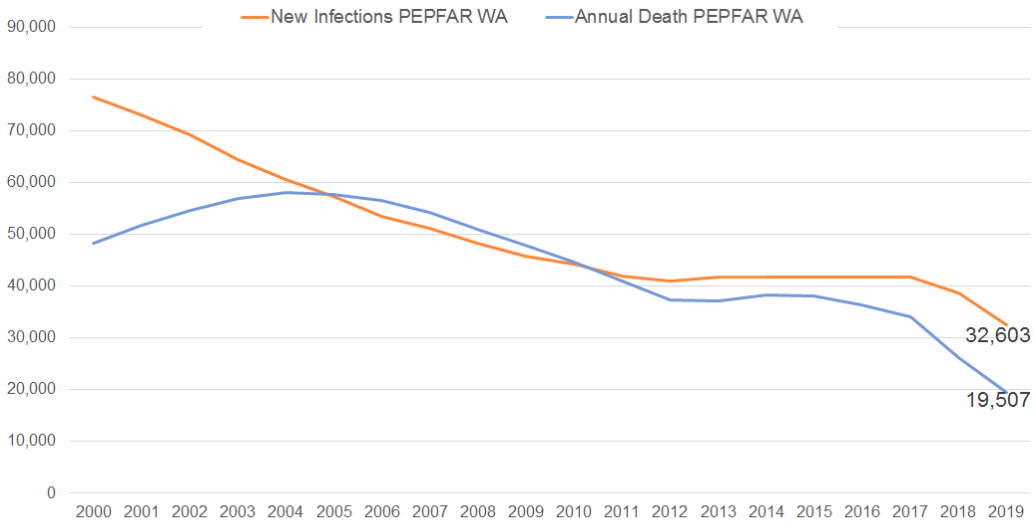
Figure 2.1.3 Regional and PEPFAR Trend for Individuals Currently on Treatment



New Infections and All-Cause Mortality among PLHIV

Although there has been a progressive decrease of the number of new infections and the number of AIDS-related deaths from 2010 to 2018, the number of new infections is still higher than the number of AIDS-related deaths. In 2018, the number of AIDS-related deaths was estimated at 26,193 in the region (11,908 in Ghana, 3,997 in Togo, 2,565 in Burkina Faso, 4,571 in Mali, 1,658 in Liberia, and 1,494 in Senegal) against 38,669 new HIV infections (17,649 in Ghana, 5,126 in Togo, 3,212 in Burkina Faso, 9,279 in Mali, 2,115 in Liberia, and 1,288 in Senegal).[5]

Figure 2.1.4 Trend of New Infections and All-Cause Mortality among PLHIV



[5] Spectrum 2018 preliminary data

Unclassified

PLHIV and ART Coverage Estimates by Country

In the West Africa PEPFAR Region, though average prevalence rates are relatively low compared to other countries in East and Southern Africa, the low ART coverage, high levels of stigma and discrimination, and weak health systems mean that HIV/AIDS morbidity and mortality remains very high. In 2018, the percentage of PLHIV on ART was estimated at 71% in Burkina Faso, followed by 56% in Togo, 54% in Senegal, 34% in Mali, 32% in Liberia, and 35% in Ghana[6]. This coverage is lower among children and men compared to women. For example in Togo, the ART coverage was 28.5% among children against 72% among women.[7] In Ghana, the ART coverage was 23.5% among men 25+ years against 37.8% among women 25+years[8]. There is a lack of data on ART coverage among key populations mainly due to stigma and discrimination. However existing data show low coverage (21% among MSM in Senegal and 23.9% among FSW in Togo[9]).

Table 2.1.2

	Liberia	Mali	Senegal	Togo	Burkina	Ghana
Estimated PLHIV	40,265	134,123	42,422	114,534	88,669	325,681
Estimated PLHIV Prevalence (%)	3.1%	0.8%	0.3%	1.9%	0.6%	1.1%
Estimated individuals receiving ART**	13,114	46,598	23,202	64,842	66,991	113,171
Estimated PLHIV not receiving ART	27,151	87,525	19,220	49,692	21,678	212,510
Est. ART Coverage (%)***	32.7%	29.8%	43.3%	50.2%	67.0%	34.8%
Est ART Coverage (%)****	32.58%	34.74%	54.69%	56.61%	75.55%	36.9%

***PEPFAR data pack ****Calculated

All six countries in the West Africa PEPFAR region have extremely high burden of HIV disease among KP, namely among MSM and FSW. This is a result of high levels of stigma and discrimination, structural, legal and socio-cultural barriers to services. As such, PEPFAR will place major emphasis on these population groups who have often been marginalized and lack access to targeted services. In Togo, Burkina Faso, and Ghana, which target the general population in addition to KP, emphasis will also be placed on reaching men, and children, providing them ART, retaining them on ART, and getting them virally suppressed.

[6] NACP program data 2018
[7] UNAIDS. Togo factsheet 2018.
[8] Spectrum 2018
[9] NACP Togo and Senegal data 2018

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Implementation of key policies to address minimum program requirements

Policy implementation: Across the region, there is political will to adopt policies that are required to implement ROP19 minimum program requirements. PEPFAR will support finalization of essential policy development, and focus specifically on the most significant challenges of adoption and implementation with fidelity. Specific objectives throughout West Africa include the implementation with fidelity of Test and Start, intensifying case finding by scaling-up index testing, utilizing enhanced KP HIV case finding, and development and implementation of DSD policies, including MMS/D for ARV. Many of the associated policies are in different stages of development and are therefore not yet implemented down to the site level in the West Africa region. For example, while Test and Start is being implemented across all population groups in Burkina Faso, Ghana, Senegal, Liberia and Mali, implementation with fidelity remains a challenge. By May 2019, with mostly GF support, Togo will have expanded its policy to cover all population groups and commenced implementation.

TLD Transition: Apart from Ghana, which already has TLD incorporated as a first line option in their Treatment Guidelines, PEPFAR is working with the GF to accelerate transition to TLD and the elimination of Nevirapine-based regimens in the other West African countries.

Unique Identifier Code (UIC) systems: Given the weakness of data systems throughout the region, PEPFAR West Africa will invest in improving national HIV data quality and use for decision making. Ghana, Togo and Burkina Faso have national UIC systems in operation; Liberia has a UIC system and is in the process of implementing and scaling-up a unique KP code; and Mali and Senegal will implement and scale-up UIC systems to improve data visibility, while ensuring confidentiality. Ghana's e-UIC was launched in April 2019 and will provide linkage of KP into the e-patient tracker systems used to track PLHIV on treatment in all 448 ART sites. The e-UIC system still has challenges with backlog of data entry and connectivity. Using UIC systems provides enhanced individual-level and system-level tracking, and is in line with PEPFAR's increased emphasis on using data to make decisions about programming and to track KP cascades as well as new infections among negative KP.

Elimination of Informal User Fees: While many of the countries in the region have explicit policies against formal user fees for HIV/AIDS related services, minimal formal user fees exist for services such as registration at private clinics and related services such as STI treatment. Informal user fees are exacerbated by various governments' inability to pay salaries to many healthcare workers (as in the case of Liberia), lack of timely reimbursement of health insurance claims to facilities (as in the case of Ghana), and overall insufficient domestic resources invested in HIV. PEPFAR West Africa will work with Civil Society Organizations (CSOs) including various PLHIV associations and MOH, to eliminate informal user fees.

Please see West Africa Policy Dashboard in Appendix C for further information.

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Major Programmatic and Systems gaps:

Weak data systems: There is a paucity of data regarding HIV, particularly for KP. Size estimations are irregularly conducted due to limited resources across the region, and often due to security issues which are pervasive in Mali, and increasingly in Burkina Faso, where carrying out comprehensive surveys is fraught with challenges.

Supply chain weaknesses: Limited capacity and resources for public health supply chain systems and commodities cause West African governments to be heavily dependent on external donors for support. Site-level stockouts are frequent and thus major supply chain reforms are underway in Ghana, Liberia, and Mali to improve public health supply chain systems, targeting reforms to areas including commodity planning and distribution.

Laboratory Strengthening and Viral Load Optimization: Major improvements are necessary in the national viral load system to improve national lab policies and lab capacity to reach targets for VL testing for patients currently on treatment. While extensive work on laboratory optimization has been undertaken in Ghana, all the other countries in West Africa will adopt appropriate policies to ensure access to viral load testing and timely receipt of results to improve adherence and increase early detection of treatment failure. Major improvements are necessary in the national viral load system to improve national lab policies and lab capacity building to reach targets for viral load testing.

Stigma and discrimination (S&D) is a major barrier to all aspects of HIV care and treatment. It prevents access, isolates those who need services, and even impacts the power of civil society organizations to demand better services and develop as advocates against discrimination of PLHIV. Quality of care is often variable due to limited staff capacity and lack of supervision and mentoring of clinical staff. S&D in health care provision further compromises the quality of care. A recent study conducted in Ghana in 2017 showed that the percentage of senior clinical providers who worry about HIV transmission while providing care to HIV patients ranges from 43% in Western Region to 85% in Eastern Region, and the percentage of those who practice stigmatizing avoidance behaviors, (e.g. wearing double gloves when treating PLHIV) ranges from 57% in Western Region to 68% in Ashanti Region. PEPFAR will be working to reduce S&D against KP and PLHIV through above site activities, like working with the Police and other relevant agencies, and ensuring that PEPFAR-supported facilities are safe and KP-friendly.

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2.2 Investment Profile:

The GNI per capita in the six focus countries in West Africa range from $383 in Liberia to $1,493 in

Ghana. Among this group of countries Ghana is the only one classified in the lower middle income category, often indicating limited fiscal space. Other five countries are classified by the World Bank as low income country (Senegal: $ 1,000 GNI per Capita; Mali: $753; Burkina Faso: $670; Togo: $553; and Liberia: $383).The HIV response in West Africa is largely funded through external development partners (donors), households, and from the public revenue.

Country	GNI per Capita[10]
Ghana	1,493
Liberia	383
Senegal	1,000
Mali	753
Togo	553
Burkina	670

Across West Africa, GF remains the major donor to the HIV response.

Among the six countries, **Burkina Faso** is the only country that funds a significant portion of its HIV/AIDS response estimated at 52 percent.[10] GF contributed 29% of the total expenditure in 2017 ($33,788,155) in Burkina Faso. The contribution of the PEPFAR program represented 4% of the total expenditure. The majority of the domestic resources were used to purchase drugs and pay human resources salaries. Forty eight percent of the expenditures related to ARVs came from domestic resources. Some gaps still remain to cover all the needs to reach 90-90-90 targets. Some of the Game Changer Funds will be used to fill these gaps.

In **Togo**, despite a 26% increase in domestic AIDS funding from 2016 ($5,024,176) to 2017 ($ 6,331,314), the country remains dependent on external funding, which provides 81% of the funding, for its HIV/AIDS national response. In 2017, $32,839,729 was spent on HIV according to the NASA report. GF was the main contributor with 69% of funding, while PEPFAR funding represented 5% of the expenditures. In general, 47% of expenditures are related to care and treatment. Domestic resources are mainly used to finance ARVs and the health system strengthening. Twenty-seven percent of ARVs are purchased with domestic resources. However, there are some commodity gaps, and the current level of funding does not fully cover the quantity of ARVs needed to reach the second 90 in 2020, so Game Changer resources will contribute towards filling these gaps.

In **Ghana**, the Government of Ghana (GoG) allocated $1.17 billion in 2019 for health, more than double what was allocated in 2018. However, budget allocations remain vulnerable to overarching budgetary and economic challenges including high fiscal deficit and unstable national currency.

The GF is the largest external source of funding for the HIV/AIDS response in Ghana. Ghana has received five GF grants, with a cumulative total of $834 million to address HIV/AIDS, TB and malaria. Of that, $323 million (40%) has been used to address HIV/AIDS. Ghana's National Strategic Plan (NSP) 2016-2020, which is in its fourth year of implementation, is projected to cost $494 million with treatment making up the largest share of the NSP budget (61%, $302.8 million). Prevention of new infections (behavior change communication and condoms and lubricants) will account for 13% ($65.5 million), while critical enablers (policy environment, stigma and discrimination, coordination and management of the HIV/AIDS response) represent 17.5% ($86.5 million).

[10] Burkina Faso NASA report 2018

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Synergies with development sectors (health and community systems strengthening, social protection programs, etc.) constitute 8.1% ($39.8 million). The direct cost of the prevention and treatment programs is US$368 million forming 74.5% of the total cost while indirect cost constitutes the remaining 25.5%.[11]

In **Liberia,** in 2017/18, 81.8% of the total Liberia HIV response was funded primarily through GF,[12] which contributed US $18 million over three years in its current funding cycle, 2017-20. In 2019/20, PEPFAR will be the second largest source of funds, contributing USD $3.5 million. The 2013-2015 National AIDS Spending Assessment reported other external sources (bilateral and multilaterals) accounting for about 5% of HIV response funding.

The GF will allocate most of its 2019/20 resources towards purchase of ARVs, rapid test kits, lab reagents, other drugs and viral load commodities as the only purchaser of HIV and STI commodities in Liberia. USAID FP has allocated US $722,047 to condoms and lubricants procurement for the period of 2018 to 2020, and US $158,659 has been spent on condoms and lubricants so far in 2018 and the 2nd quarter of 2019.

An additional $2.25 million in PEPFAR Headquarters Operational Plan (HOP) funding was allocated through Health Resources and Services Administration (HRSA).

In **Mali,** the GF is the main contributor to the HIV response, funding the majority of HIV testing and treatment services in the country. For services targeting key populations, GF supports the Kouloikoro and Kayes regions while PEPFAR provides KP-focused prevention, testing, treatment, and adherence support in Sikasso, Segou and Bamako regions. PEPFAR also supports data quality improvement, and technical assistance to laboratories and viral load testing. UNAIDS and WHO provide technical assistance to reinforce implementation of the three 90s. UNICEF works specifically on children's' issues which include prevention of HIV mother-to-child transmission. UNITAID supports some HIV self-testing research.

In **Senegal,** after the GF, the Government of Senegal contributes the second largest investment towards the HIV response, followed by PEPFAR. The GF has recently negotiated a catalytic funding request for 2019-2020 of an additional $2 million EUR to focus on KP interventions. Given the GF's significant, long-term investment in the HIV response in Senegal, PEPFAR is focusing its limited resources on four KP hot-spots to maximize the impact of its funding. PEPFAR and GF investments are both focused on supporting key and vulnerable populations, and PEPFAR is coordinating closely with the GF to ensure complementarity of programming at the site where both donors are funding activities in order to best leverage each other's' investments. The GF also purchases the majority of the commodities for the response, including ARVs and PrEP. As of yet, the private sector in Senegal has not played a large role in financing the response or providing HIV/AIDS services.

The GoS investment in HIV/AIDS remained consistent, but expenditure data from 2015 indicate that GoS expenditures accounted for only 15% of the response.[13] There is some evidence of increased resource commitments by the GoS, and Senegal has made a public commitment to financing HIV

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[11] Ghana's National HIV & AIDS Strategic Plan 2016- 2020

[12] "Liberia - Country Overview - The Global Fund to Fight AIDS ...." https://www.theglobalfund.org/en/portfolio/country/?loc=LBR&k=2ebb6460-e75b-422d-8f75-2ed9f241f5d5. Accessed 9 Apr. 2019.

[13] IHME Financing Global Health Data, https://vizhub.healthdata.org/fgh/

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commodities. During the last New Funding Model (NFM3) negotiation, the GoS committed to increasing its allocation gradually over the next three years.

Standard Table 2.2.1

Table 2.2.1 Annual Investment Profile by Program Area[14]						
Program Area	**Country**	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	Ghana	37,251,641	11%	40%	0%*	49%
	Liberia	3,887,099	20.5%	79.5	0	0
	Mali	18,094,157		83%	17%	
	Senegal	6,933,643	49%[15]		33%	
	Burkina Faso	12,634,025	0%	30%	47%	23%
	Togo	8,279,178		71%	27%	2%
Community-based care, treatment, and support	Ghana	1,220,275	0%	100%	0%*	0%
	Liberia	428,000	100%	0	0	0
	Mali	694,600	71%	29%		
	Senegal					
	Burkina Faso	3,398,506	7%	23%	39%	31%
	Togo	7,211,903	3%	71%	11%	12%
PMTCT	Ghana	968,739	0%	100%	0%*	0%
	Liberia	225,158	0%	95	0	5
	Mali	1,848,017	0%	30%	16%	54%
	Senegal	245,289	100%			
	Burkina Faso	2,788,090	0%	46%	52%	2%
	Togo	1,983,033		84%	0.94%	15%
HTS	Ghana	1,800,689	61%	39%	0%*	0%
	Liberia	970,531	36.3%	63.7%	0	0
	Mali	5,180,539	13%	87%		
	Senegal	326,066	100%			
	Burkina Faso	2,652,445	14%	43%	28%	14%
	Togo	2,486,867	29%	7%	58%	6%
VMMC	**Not Applicable**					
Priority population prevention	Ghana	1,443,107	7%	0%	84%*	9%*
	Liberia	0	0	0	0	0
	Mali	472,283	30%	70%		
	Senegal	1,328,283	100%			
	Burkina Faso	2,103,044		10%	63%	28%
	Togo	102,760		15%	27%	58%
AGYW Prevention	Ghana	n/a				
	Liberia	218,814	0	100	0	0
	Mali	n/a				
	Senegal	236,105	100%			
	Burkina Faso					
	Togo	68,641			16%	84%
Key population prevention	Ghana	4,364,451	37%	63%	0%*	0%*
	Liberia	445,010	97%	3%	0	0
	Mali	811,667	32%	68%		
	Senegal	510,854	100%			
	Burkina Faso	489,718	98%	2%		
	Togo	1,123,949	45%	84%	9%	3%

[14] (GRP, National AIDS Spending Assessment , 2012), all amounts in 2012 USD
[15] Senegal NASA 2015 combined GF and PEPFAR investments

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OVC	Ghana	134,982	0%	0%	91%*	9%*
	Liberia	n/a				
	Mali	n/a				
	Senegal	n/a				
	Burkina Faso	368,676			100%	
	Togo	59,379			50%	50%
Laboratory	Ghana	623,020	100%	0%	0%*	0%*
	Liberia	128,580	7.7%	92.3%	0	0
	Mali	3,572,213	17%	83%		
	Senegal	24,010			100%	
	Burkina Faso	4,424,047		50%	50%	4,424,047
	Togo	253,803		99%		1%
SI, Surveys and Surveillance	Ghana	3,389,993	10%	90%	0%*	0%*
	Liberia	582,143	55.6%	44.4%	0	0
	Mali	495,476	50%	50%		
	Senegal	392,052	100%			
	Burkina Faso	339,194	28%	7%	65%	0%
	Togo	9,780,198		84%	1%	15%
HSS	Ghana	6,406,917	25%	74%	1%*	0%*
	Liberia	754,113	22%	78%	0	0
	Mali	784,928	36%	64%		
	Senegal	2,436,344	88%		12%	
	Burkina Faso	4,590,410	0%		8%	2%
	Togo	1,490,018		20%	108%	82%
Total		176,257,672				

Note: Cells left blank indicate the prompt is not applicable (N/A) or there is not sufficient data gathered.
* NASA, 2016; GoG expenditures mainly in HR
** Out-of-Pocket expenditure. (NASA, 2016).

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Standard Table 2.2.2 *FY19's expenditures

Commodity Category	Country	Total Expenditure	% PEPFAR*	% GF**	% Host Country**	% Other
ARVs	Ghana	11,804,122.30	15%	84%	1%	0%
	Liberia	1,454,362.62	0%	98%	0%	0%
	Mali	5,397,271.28	0%	80%	20%	0%
	Senegal		0%			
	Burkina Faso	12,009,837	0%	50.82%	48.70%	0.48%
	Togo	7,430,167	0%	64.94%	27.28%	7.78%
Rapid test kits	Ghana	751,007.19	0%	32%	68%	0%
	Liberia	293,936.65	0%	100%	0%	0%
	Mali	1,158,916.05	14%	72.14%		13.86%
	Senegal					
	Burkina Faso	1,946,003		35%	65%	
	Togo	Included in lab reagents	0%	36.00%	55.0%	9.0%
Other drugs	Ghana	748,939.92	0%	100%	0%	0%
	Liberia	275,069.24	0%	30%	0%	0%
	Mali	789,136.88	0%	100%		
	Senegal					
	Burkina Faso	3,399,287	0%	52%	48%	
	Togo	129,435	0%		94.29%	5.71%
Lab reagents	Ghana	227,194.98	0%	100%	0%	0%
	Liberia	106,664.82	0%	100%	0%	0%
	Mali	1,790,395.20		100%		
	Senegal					
	Burkina Faso	4,424,047	0%	40%	60.00%	
	Togo	699,293	2%	65.64%	4.70%	27.66%
Condoms	Ghana	471,190.81	16%	0%	0%	84%
	Liberia					
	Mali					
	Senegal					
	Burkina Faso	1,165,933	0%	20.00%		80.00%
	Togo	1,665,081	2%	65.64%	4.70%	27.66%
Viral Load commodities	Ghana	1,442,255.93	0%	100%	0%	0%
	Liberia	346,176.00	0%	100%	0%	0%
	Mali	3,641,278.26		48%	52%	
	Senegal					
	Burkina Faso	Included in lab reagents				
	Togo	Included in lab reagents				
Other commodities	Ghana					
	Liberia					
	Mali	5,397,271.28		80%	20%	
	Senegal					
	Burkina Faso					
	Togo					
Total		$34,249,059.91				

Note: Cells left blank indicate the prompt is not applicable (N/A) or there is not sufficient data gathered.

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Standard Table 2.2.2B-- FY20's Planned Commodity Purchases

Commodity Category	Country	Total Expenditure (USD)
ARVs	Burkina Faso	1,584,411
	Togo	1,331,705
Viral Load reagents	Burkina Faso	89,189
	Togo	252,422
Condoms	Ghana	15,733
	Liberia	0
	Mali	73,300
	Senegal	25,172
	Burkina Faso	89,214
	Togo	85,736
Lubricants	Ghana	4,267
	Liberia	0
	Mali	21,700
	Senegal	2,828
	Burkina Faso	11,780
	Togo	13,946
Total		3,458,024

Unclassified

Standard Table 2.2.3

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration						
Funding Source	**Country**	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	Ghana	12,300,000	225,000	One (1)	N/A	Reduce maternal and child mortality
	Liberia	10,000,000	0	0	N/A	Reduce maternal and child mortality
	Mali	18,000,000	0	0	N/A	Prevent maternal and child deaths
	Senegal	10,000,000	2,737,600	Two (2)	N/A	Prevent maternal and child deaths
	Burkina Faso	2,500,000	0	0	N/A	Prevent maternal and child deaths
	Togo	0	0	0	N/A	
USAID TB	Ghana	0	0	0	N/A	
	Liberia	0	0	0	N/A	
	Mali	0	0	0	N/A	
	Senegal	0	0	0	N/A	
	Burkina Faso	0	0	0	N/A	
	Togo	0	0	0	N/A	
USAID NTDs	Ghana	0	0	0	N/A	
	Liberia	0	0	0	N/A	
	Mali	0	0	0	N/A	
	Senegal	0	0	0	N/A	
	Burkina Faso	3,500,000	0	0	N/A	Control and Elimination of Neglected Tropical diseases including Trachoma, Lymphatic filariasis, schistosomiasis, soil transmitted helminths.
	Togo	0	0	0	N/A	
USAID Malaria	Ghana	28,000,000	12,416,000	One (1)	654,656	Reduce mortality and morbidity from malaria.
	Liberia	14,000,000	0	0	N/A	Reduce mortality and morbidity from malaria.
	Mali	25,000,000	0	0	N/A	Reduce malaria morbidity and mortality
	Senegal	24,000,000	1,442,400 for 2018	Two (2)	N/A	Reduce malaria morbidity and mortality
	Burkina Faso	25,000,000	0	0	N/A	Reduce the morbidity and mortality due to malaria
	Togo	0		$334,760 for 2018	N/A	TA to support the USG's Global Fund
Family Planning	Ghana	11,000,000	1,375,000	One (1)	N/A	Increase access and availability to a full range of contraceptive methods.

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	Liberia	7,000,000	N/A	100	N/A	Increase access and availability to a full range of contraceptive methods.
	Mali	13,000,000	0	0	N/A	Increase healthy timing and spacing of pregnancy
	Senegal	15,000,000	0	0	N/A	
	Burkina Faso	2,500,000 + 2,000,000	0	0	N/A	Support family planning services
	Togo	1,660,000	0	0	N/A	Support family planning services.
NIH	Ghana	0	0	0	N/A	
	Liberia	15,000,000	0	0	N/A	U.S. Liberia Joint Clinical Research Partnership (PREVAIL) on infectious disease
	Mali	0	0	0	N/A	
	Senegal	0	0	0	N/A	
	Burkina Faso	0	0	0	N/A	
	Togo	0	0	0	N/A	
USAID (Global Health Security)	Ghana	0	0	0	N/A	
	Liberia	0	0	0	N/A	
	Mali	0	0	0	N/A	
	Senegal	0	0	0	N/A	
	Burkina Faso	Average of 3,000,000	0	0	N/A	Enhance the prevention, detection and response capacities to public health threats.
	Togo	0	0	0	N/A	
CDC (Global Health Security)	Ghana	2,300,000	0	0	N/A	
	Liberia	4,150,000	0	0	N/A	Strengthen Liberia's capacities to prevent, detect, and respond to disease outbreaks and other public health emergencies and events.
	Mali	400,000	0	0	N/A	GHSA support staff towards SI and lab capacity (IBBS, VL)
	Senegal		0	0	N/A	
	Burkina Faso	Average of 3,000,000	0	0	N/A	Enhance the prevention, detection and response capacities to public health threats.
	Togo	0	0	0	N/A	
USAID Nutrition	Ghana	6,000,000	0	0	N/A	Improved nutrition
	Liberia	0	0	0	N/A	
	Mali	0	0	0	N/A	
	Senegal	5,500,000		One (1)	N/A	Improved nutrition
	Burkina Faso	3,400,000	0	0	N/A	Technical assistance and food assistance.
	Togo	0	0	0	N/A	
Peace Corps	Ghana	3,600,000	0	0	N/A	2019 CBJ
	Liberia	4,800,000	0	0	N/A	2019 CBJ
	Mali	0	0	0	N/A	2019 CBJ
	Senegal	8,500,000	0	0	N/A	2019 CBJ
	Burkina Faso	3,000,000	0	0	N/A	2019 CBJ

Unclassified

	Togo	851,657.11	0	0	N/A	Community Health and Malaria Prevention, 2017
DOD	Ghana	60,000	0	0	N/A	Infectious disease staff from Naval Medical Center San Diego support clinical training in HIV medicine at the partner military's main hospital.
	Liberia		0	0	N/A	
	Mali	615,000	0	0	N/A	$265,000 to support partner military in prevention, care and treatment, and retention activities and $350,000 to provide local logistical support in the planning and implementation of a Seroprevalence and Behavioral Epidemiology Risk Survey (SABERS) among partner military.
	Senegal	0	0	0	N/A	
	Burkina Faso	320,000	0	0	N/A	$320,000 to support partner military in case identification, treatment quality, and laboratory QA/QI.
	Togo	378,000	0	0	N/A	$378,000 to support partner military in prevention, targeted testing, linkage to treatment, and lab QA/QI activities.
MCC	Ghana	498,200,000	0	0	N/A	
	Liberia	256,726,000	0	0	N/A	
	Mali	0	0	0	N/A	
	Senegal	550,000,000	0	0	N/A	
	Burkina Faso	0	0	0	N/A	
	Togo	35,000,000	0	0	N/A	
WASH	Ghana	6,325,000	0	0	N/A	
	Liberia	0	0	0	N/A	
	Mali	0	0	0	N/A	
	Senegal	0	0	0	N/A	
	Burkina Faso	0	0	0	N/A	
	Togo	0	0	0	N/A	
Total		**1,634,785,657**	**18,196,000**			

Note: Cells left blank indicate the prompt is not applicable (N/A) or there is not sufficient data gathered.

Unclassified

Standard Table 2.2.4

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP						
Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
DREAMS Innovation	N/A	N/A	N/A	N/A	N/A	
VMMC – Central Funds	N/A	N/A	N/A	N/A	N/A	
Other PEPFAR Central Initiatives--HRSA	Liberia-only 2.250,000	Liberia-only 2.250,000	N/A	N/A	N/A	HRSA's focus in Liberia is to improve medical, nursing and midwifery cadres HIV competency through clinical rotations to HIV clinical sites, including rural, and conduct CPD for existing HCWs; support quality improvement activities at JFK and Redemption Hospitals, which account for approximately 50% of total TX_CURR, and supply chain improvements.
Other Public Private Partnership	N/A	N/A	N/A	N/A	N/A	
Total	Liberia-only: 2,250,000	Liberia-only: 2,250,000	N/A	N/A	N/A	

2.3 National Sustainability Profile Update:
*Note: This section only applies to Ghana

Ghana's last Sustainability Index Dashboard (SID) process identified three main sustainability vulnerabilities: laboratory, service delivery, and commodity security and supply chain. Although progress has been made in addressing some of these sustainability vulnerabilities, gaps remain. Therefore, in ROP19 Ghana will continue to prioritize and address the same elements in support of

Unclassified

GoG efforts to achieve epidemic control in the Western Region and accelerate the overall national response.

Commodity security and supply chain: PEPFAR Ghana has improved forecasting and supply planning with timely supply plans to meet the challenges of the 90-90-90. PEPFAR is currently spearheading Ghana's transition to TLD with its support for forecasts and supply planning. Moving forward, PEPFAR will continue working with the GF to align technical assistance in support of achieving sustainable outcomes in this area. In ROP19, PEPFAR will build on its ongoing collaboration with the GF to roll out an integrated Logistics Management Information System (GhiLMIS) to facilitate accurate data entry, timely generation of suitable reports, data analysis and information use to optimize stock distribution, particularly in the context of multi month dispensing. PEPFAR will also prioritize the Western Region to strengthen last mile distribution of health commodities from regional level to service delivery points. PEPFAR will also support the timely completion of TLD transition.

Laboratory: Ghana has made progress with the development of policies and guidelines to regulate testing in the laboratories. However, challenges remain with their effective implementation. PEPFAR has provided technical assistance to the government of Ghana to implement viral load scale up activities. Support has also been provided to improve the diagnostic capacities of national and regional laboratories. In ROP19 PEPFAR will implement VL scale up activities through a strengthened sample referral and results transmission system, improved VL data management system, and continuous quality improvement initiatives.

Service delivery: While Ghana adopted a number of policies to improve access to quality HIV/AIDS service provision (e.g. Treat all, Task Shifting, DSD), implementation of those policies with fidelity remains a significant barrier. In ROP19, PEPFAR will support the implementation of client-centered HIV/AIDS service delivery that facilitates the implementation of effective modalities for case finding, initiation and retention.

Since COP18, PEPFAR has shifted the Game Changer Funds to Burkina Faso and Togo, and decreased Ghana's annual budget by $3 million.

SIDs will be carried out in Burkina Faso, Togo, Liberia, Mali, and Senegal in ROP19.

2.4 Alignment of PEPFAR investments geographically to disease burden

In the six focus countries in West Africa, PEPFAR has analyzed the available data to ensure that our investments are geographically oriented to the areas of highest disease burden.

In **Burkina Faso**, as illustrated in the maps below, the HIV burden is concentrated in Centre (2.1% HIV prevalence), Hauts Bassins (1.5% HIV prevalence), and Centre Ouest Regions (1.4% HIV prevalence). These three regions are home to 66% of PLHIV in Burkina Faso,[14] and have a higher HIV prevalence than the national average of 0.8%.[15] They also account for 65% of PLHIV among

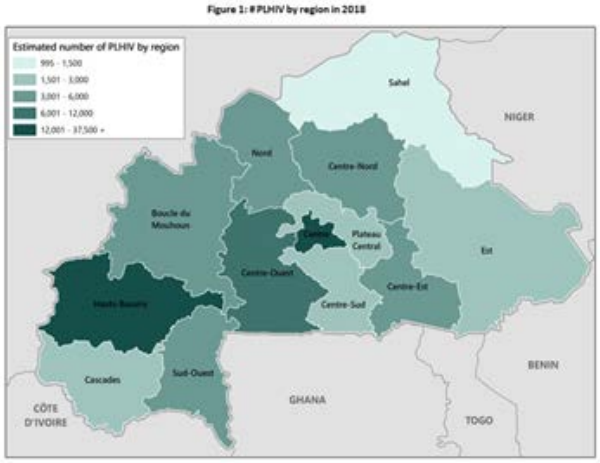
[14] NACP data 2018
[15] UNAIDS data report 2018

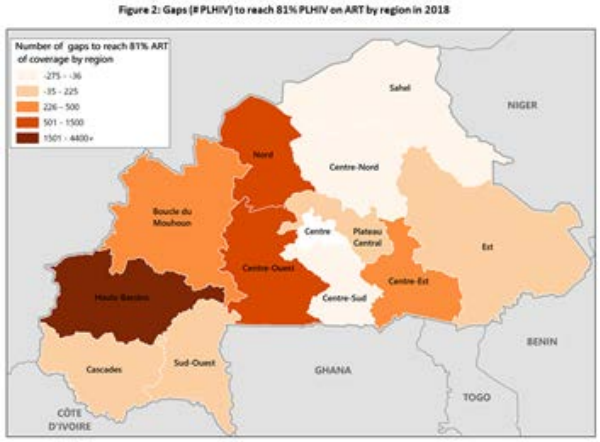
Unclassified

FSW, and 86% of PLHIV among MSM.[16] Accordingly to the gap analysis done in collaboration with the host country, these regions have the largest gap to reach the 90-90-90 targets.

The current PEPFAR supported program implements targeted KP-focused activities in Centre and Hauts Bassins Regions. With the support of the Game Changer Funds, the program will shift beyond KP to target the general population as well. In alignment with this strategy and the geographic distribution of the burden, the PEPFAR program will be expanded to Centre Ouest Region.

Figure 2.4.1A Burkina Faso: People Living with HIV by Region, Gaps in ART Coverage and Viral Suppression

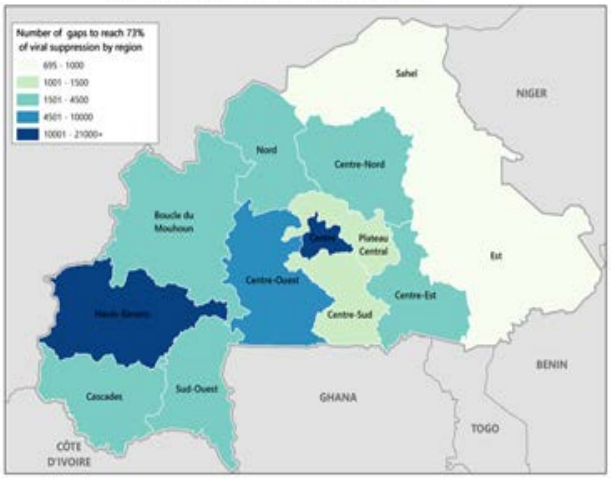




[16] IBBSS and Size estimation MSM and FSW 2017 Burkina Faso

Unclassified

Figure 3: Gaps (# PLHIV) to reach 73% PLHIV virally suppressed by region in 2018



In **Togo**, as illustrated in the maps below, the HIV burden is concentrated in the Southern regions. Lome Commune, Maritime and Plateaux regions are three southern regions home to 78% of PLHIV in Togo, and the current PEPFAR supported program implements targeted KP-focused activities in these three regions.[17] With the support of the Game Changer Funds, a pivot will be made to go beyond KP and to target general population as well. In alignment with this strategy and the geographic distribution of the burden, the PEPFAR program will be expanded to Maritime and Plateaux Region to support GoT to close the gaps towards the 90-90-90. According to the gap analysis of each region, carried out in collaboration with the host country, the Maritime and Plateaux Regions have the largest gaps to cover. The figures below show the distribution of the gaps towards achieving the 90-90-90 targets.

[17] NACP data 2018.

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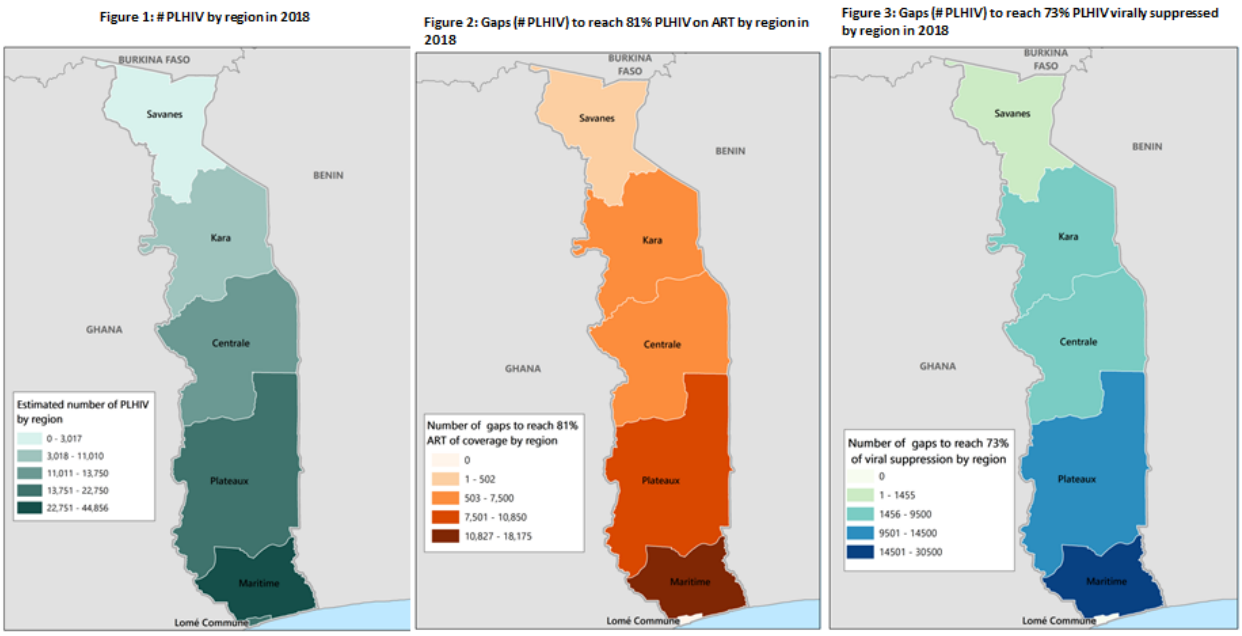
Figure 2.4.1B Togo: People Living with HIV by Region, Gaps in ART Coverage and Viral Suppression



In **Ghana**, PEPFAR tracks HIV/AIDS expenditures annually by both geography and disease burden in order to consistently align resources to need. While HIV-infected FSW and MSM make up less than 0.5% of the total Ghanaian population, they may be associated with as much as 28% of new infections among adults aged 15-49 years of age (MOT 2014). In ROP19, PEPFAR Ghana will realign its programs based on strategic direction from OGAC to collaborate with the Government of Ghana, civil society, and other partners to achieve epidemic control in a single region for all populations (Key Populations and General Populations) by September 2020. This will involve transitioning out of current site-level technical assistance and KP programming in all other regions, and focusing above-site activities to support regional saturation. Based on epidemiological data and other implementation considerations PEPFAR/Ghana selected the new Western Region. Although prevalence is on the lower end, the total number of KPLHIV is the highest. The new Western region is experiencing tourism and mining boom, which will lead to increased KP.

PEPFAR Ghana's strategy and funding alignment demonstrates program funds and activities are channeled to areas with the highest HIV burden. As a result, planned ROP19 spending matches the new strategic shifts in program focus and priorities.

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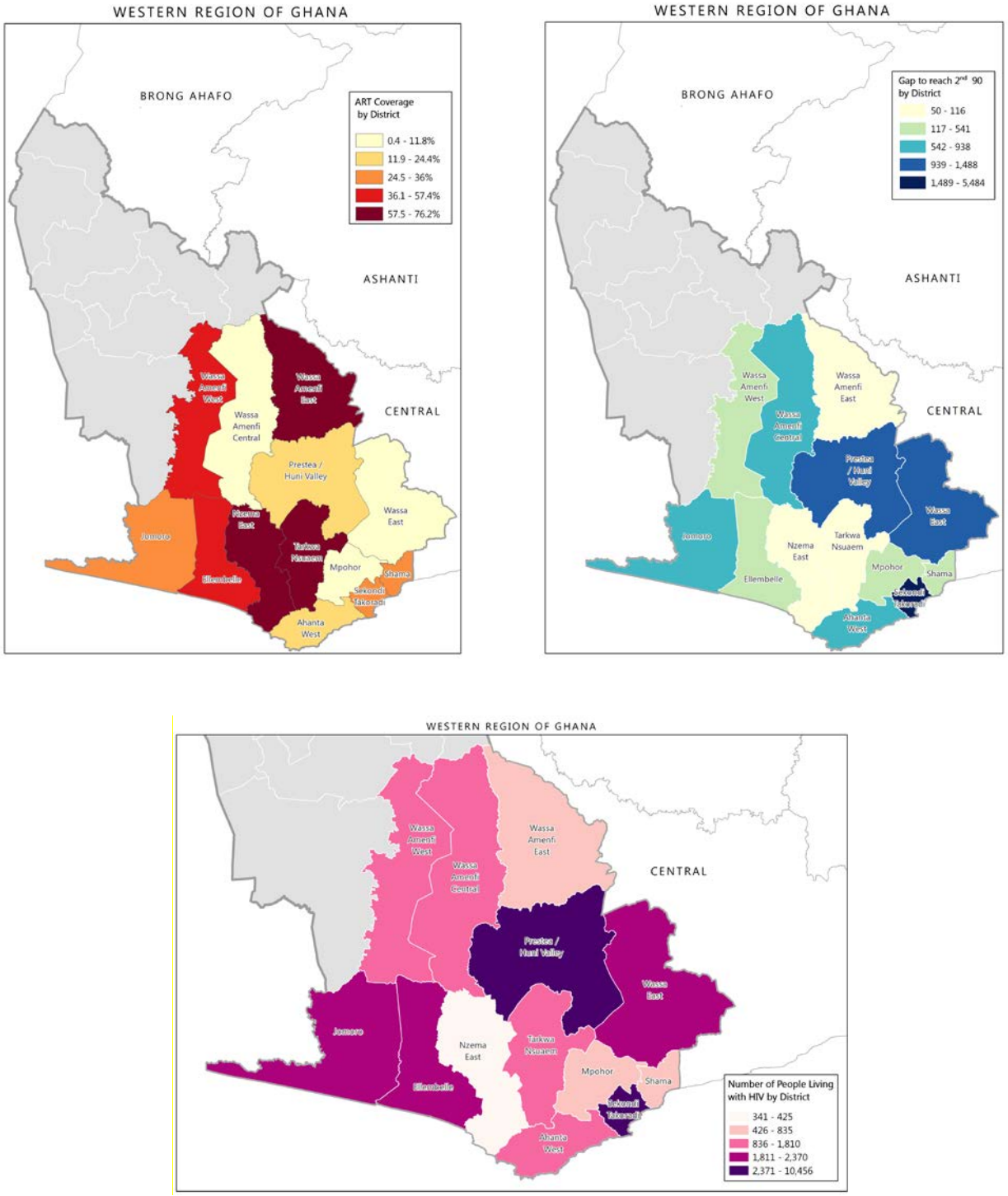
Figure 2.4.1C Western Region, Ghana: People Living with HIV by District, Gaps in ART Coverage and Viral Suppression (PEPFAR districts in color)



In **Liberia,** PEPFAR will focus on ten facilities in Montserrado County which, when combined with one high burden site supported by GF, currently serve about 95% of people on ART. At the community level, PEPFAR will target resources in five community sites, also in Montserrado

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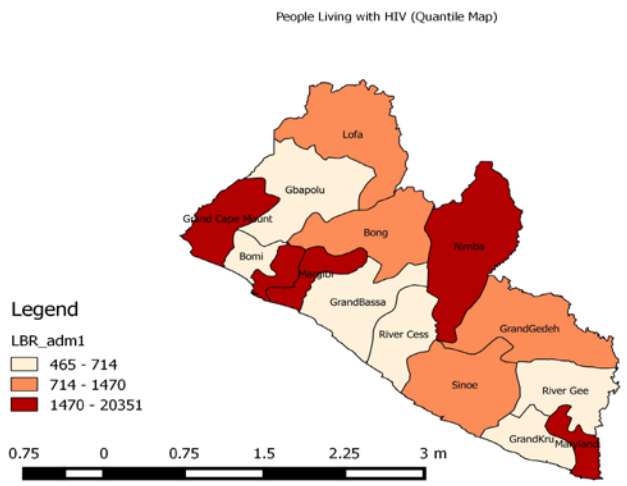
County. GF will complement PEPFAR activities at the community level and will provide more comprehensive support to Margibi and Grand Bassa Counties.

Figure 2.4.1D



In **Mali,** to avoid duplication of efforts regarding KP services, PEPFAR and GF entered into a rationalization agreement in 2017 that specified that PEPFAR would cover KP services in three high-prevalence regions for KP (according to a 2015 mapping study): Bamako, Sikasso, and Segou. In the past, PEPFAR also covered KP services in a fourth region, Gao; however, because the results from that region were so low, it was decided to concentrate resources on the three higher-yield regions in the coming implementation year. Within the three focus regions, the 14 highest-yield districts have been selected as the focus of PEPFAR's KP interventions in the upcoming year.

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Figure 2.4.1E ART Coverage by Region

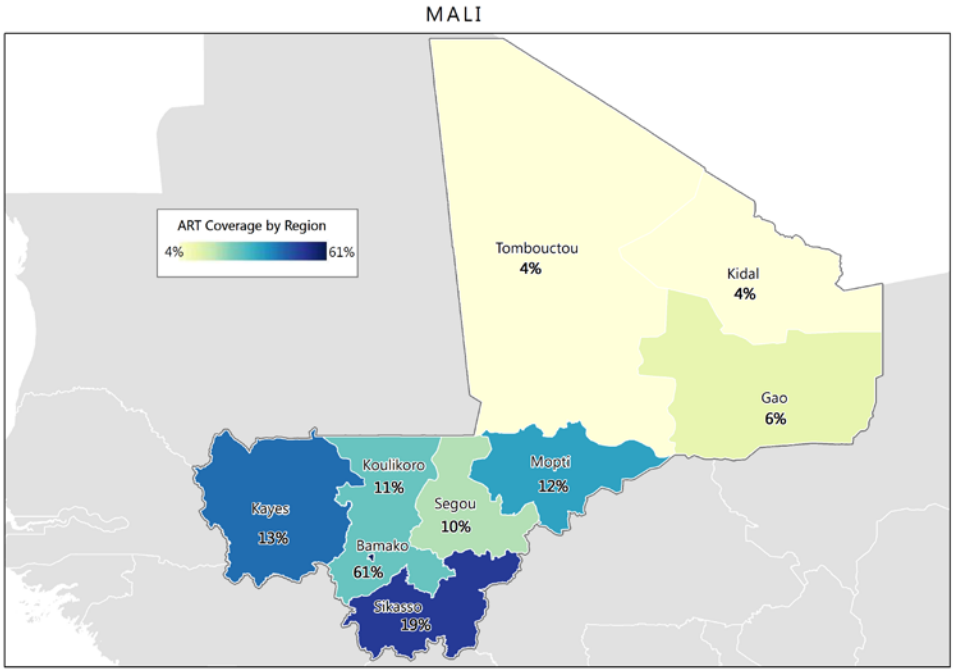
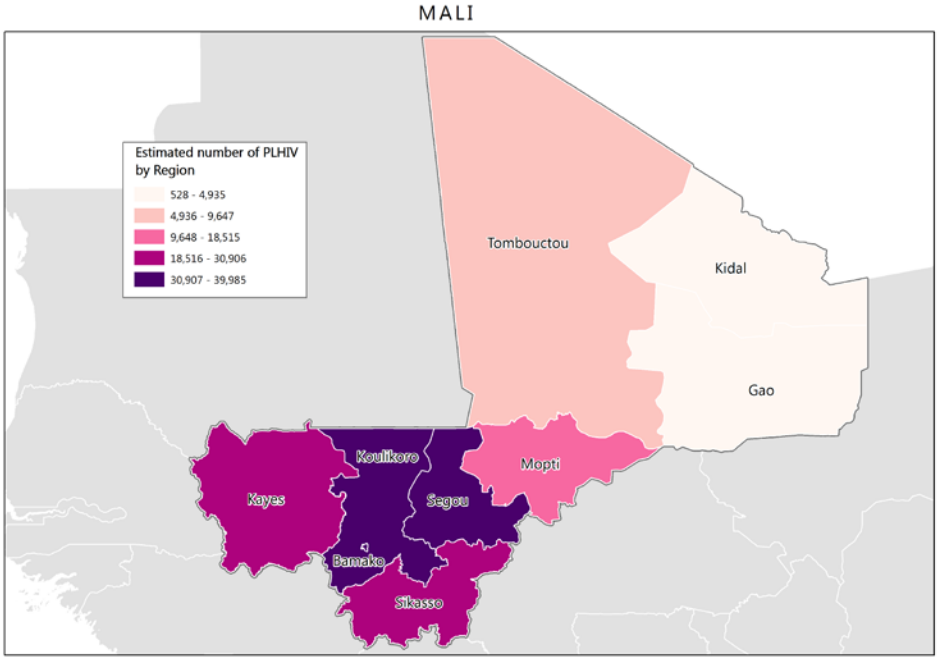


Figure 2.4.1 F Total PLHIV by Region



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Viral Load: In Mali, the USG through CDC is working with the government entities to set a baseline for Viral Load coverage by region, sex, and age. However, there is data available, which is not well compiled and documented. ROP19 will focus on this activity to ensure quality VL coverage and suppression data are available.

In **Senegal,** PEPFAR previously focused its HIV/AIDS program in five high HIV prevalence regions-- in Sedhiou, Kolda, Ziguinchor, Mbour, and Dakar. Although the prevalence is high in these regions, the population and KP size estimates were very small and testing yields were consistently low; in FY18, yield was only 1.9%, a slight decrease from the 2.0% yield in Fy17. Given these low yields, PEPFAR shifted in the third year of implementation to focus on KP hot-spot sites in the higher burden areas of Dakar (two sites), Mbour, Ziguinchor, and engaged in a more targeted testing strategy focused on KP. As a result of this shift, FY19 Q1 yields increased to 9.5%, a considerable increase from the 1.9% yield demonstrated in FY18. The increased yield had a dramatic impact on the total number of HTS_POS found - the program found almost as many HTS_POS in one quarter as they did in the entire previous year. Given these encouraging results, PEPFAR/Senegal is transitioning out of low-burden, low-yield sites in the South in cooperation with GF to ensure that HIV services for clients at these sites are not interrupted.

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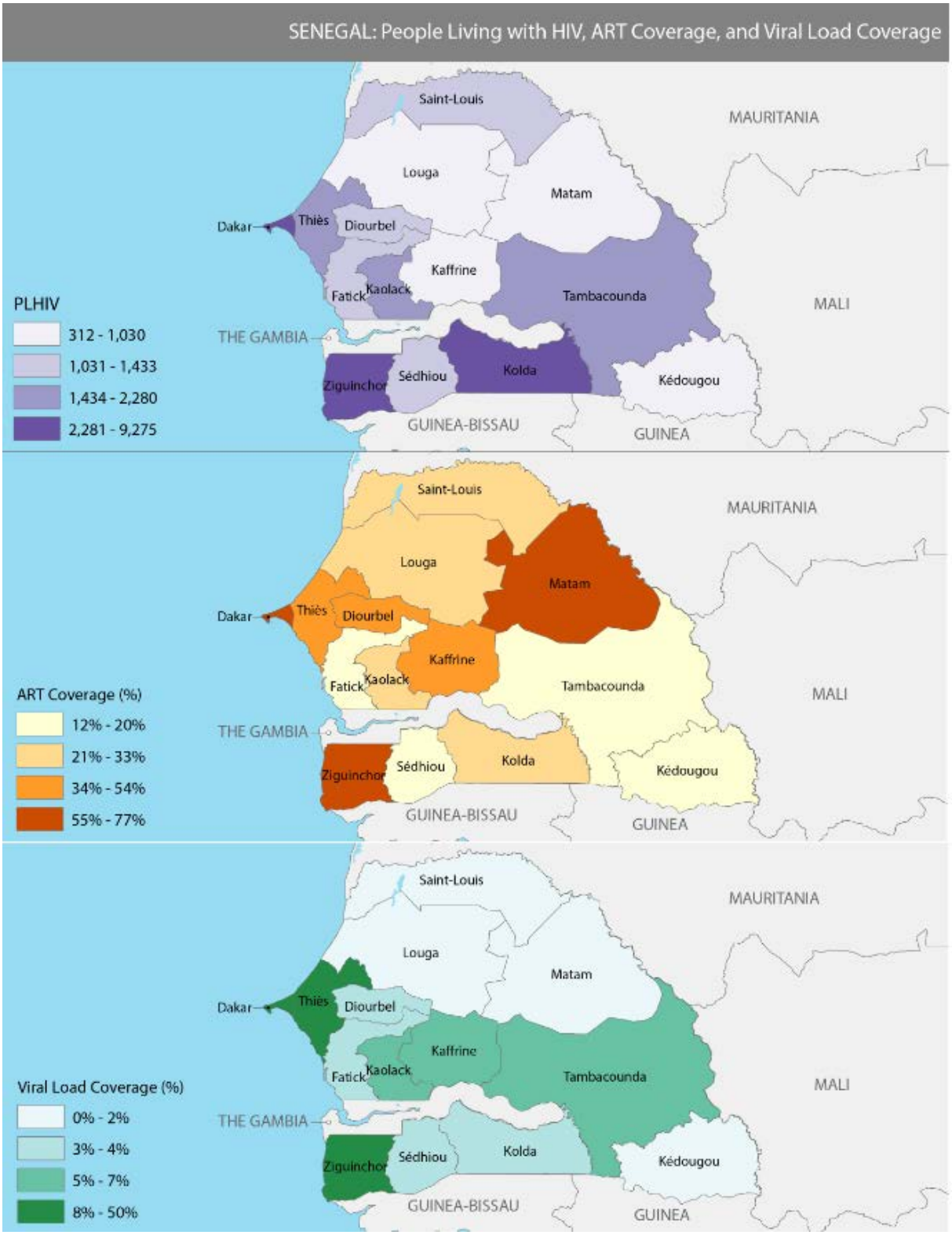
Figure 2.4.1 G Total PLHIV, ART Coverage, and Viral Load Coverage, by Region



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Source: CNLS, 2017

Headquarters-Level Funded Activities

In addition to PEPFAR country-level funding, additional Headquarters' Operational (HOP) funds for HIV activities are made available to support the Health Resources and Services Administration (HRSA) and Department of Defense (DoD).

Health Resource and Services Administration (HRSA)

In Liberia, HRSA contributes to the overall implementation of the Health Workforce Program (HWP). In Sierra Leone, which has the highest maternal mortality in the world (1,360/100,000 live births), the Government asked that HRSA support be focused on midwifery and nursing. In both Liberia and Sierra Leone, HIV was emphasized in pre-service and in-service across the supported cadres.

With the formation of the West Africa Regional Program in October 2018, HRSA was asked to significantly increase the impact of these investments on the National HIV response.

In Liberia, two hospitals in Greater Montserrado comprise approximately 50% of all PLHIV on ART. USAID and HRSA are providing complementary support to JFK Hospital, the main tertiary hospital, and HRSA is supporting Redemption Hospital, the second of the two hospitals with high numbers of patients in ART. HRSA is also providing some support to the National AIDS Control Program (NACP) including achieving policy reforms required by PEPFAR. Quality improvement projects will be undertaken at the two hospitals to optimize performance across the clinical cascade. Stigma and discrimination reduction activities will be pursued, and support will be provided to optimize supply chain performance for HIV commodities, in collaboration with Global Fund and USAID who are mainly responsible for the supply chain for HIV commodities.

Through HRSA's support for medical, nursing and midwifery education, broad Continuous Professional Development (CPD) offerings will be developed and implemented for nurses and midwives, and internal medicine and family medicine residents, and these same cadres will have clinical rotations in HIV clinics and inpatient units treating HIV patients including co-infection with TB, including in a rural setting. Technical assistance will be provided to increase effective index testing. Actions will also be taken to address any informal user fees. HRSA is also providing some support to NACP including on improving its capacity to execute national guidelines and policies.

In Sierra Leone HRSA has identified ten high volume HIV clinics for which support will be provided to improve performance across the clinical cascade. Stigma and discrimination reduction activities will be pursued, and support will be provided to optimize supply chain performance for HIV commodities, in collaboration with Global Fund and USAID who are mainly responsible for the supply chain for HIV commodities.

Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP)

In Mali, Burkina Faso, Togo, and Sierra Leone, DoD supports HIV prevention, care and treatment, and retention activities among the partner military, their dependents, and the surrounding communities. High yield testing strategies such as index testing and partner notification will be employed in order to ensure that HIV+ individuals are identified and quickly linked to treatment

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services. DoD will support active follow up of patients to improve treatment retention rates. DoD programs will also improve military lab capacity through various activities including, but not limited to, conducting proficiency testing, carrying out internal audits, and developing and adhering to standard operation procedures. Support for regular viral load testing will inform and improve patient care and management. Partner militaries that have not yet fully adopted Test and Start will receive DoD support to implement the policy with fidelity. Military personnel, their dependents, and the communities surrounding military installations will continue to receive a comprehensive package of HIV prevention services.

2.5 **Stakeholder Engagement:**

Across the six countries in the West Africa region, the development of ROP19 was a participatory process which included consultation with all the key stakeholders of the HIV national response.

In each of the countries, consultations were held with the statutory Presidential entities overseeing the HIV/AIDS response. In **Burkina Faso, Togo**, **Mali, and Senegal**, this national consultation was led by the National AIDS Council (NAC). In **Ghana**, meetings with the Ghana AIDS Commission were held prior to the Johannesburg meeting and after, where PEPFAR presented the major shift in strategic direction at the Annual HIV Partnership Forum attended by MOH, CSOs, GF, UN Agencies and WHO. In **Liberia**, the National AIDS Control Program at the Ministry of Health led these national consultations. All these consultations involved the major actors of the national HIV response (MoH, CSOs including associations and networks of KP, UNAIDS, GF, UN Agencies, Implementing partners). Particular attention was paid to describing the ROP19 process and ensuring understanding of the minimum program requirements of PEPFAR and the various policy barriers that would have to have to be addressed.

In each of the countries, regular review mechanisms have been put in place to review progress. In the case of **Burkina Faso and Togo**, the NAC put together a technical committee to review the concept note of the Game Changer program, analyze the country status regarding the minimum program requirements, and to propose corrective actions. In **Ghana**, the HIV Prevention, Care and Treatment Technical Working group will be another forum for regular review and in **Senegal** the NAC will institute quarterly meetings. Given the tremendous need to ensure synergy and complementarity, all the country teams have engaged continuously with GF and in each country, PEPFAR indicators and progress will also be reviewed in the Quarterly Country Coordination Mechanism meeting. Each of the NACs, NACPs, CSOs and Fund Portfolio Managers of the GF have been involved in the gap analysis, the definition of the priorities, strategies, and the selection of the sites.

Within the US Missions, each of the Ambassadors have been briefed on the major pivots in the programs. The US Ambassador to Ghana has engaged with key stakeholders in HIV and has convened a virtual "West Africa Ambassadors' Group" to engage regularly on PEPFAR. The PEPFAR teams will rely on Ambassadors in each country to be very involved in any discussions with Ministries of Finance about domestic resource mobilization for HIV and, in the case of **Burkina Faso** and **Togo,** in any Memorandum of Understanding that will be developed with regard to Game Changer funding. PEPFAR teams have also presented ROP plans to their Interagency Health groups, where they exist.

Most importantly, civil society organizations, including MSM and FSW associations and networks across the region, have been foundational players in PEPFAR discussions. They remain essential

Unclassified

throughout the process to ensure transparency, accountability, and synergy. They have actively contributed during the national in-country consultations, and in each country will be sub-recipients of funding to strengthen their ability to demand quality services for those they represent and hold PEPFAR and the Host Country Governments accountable. The PEPFAR team in **Liberia** has already introduced a best practice in CSO engagement, working with 15 CSOs organizations, who provided insight into the barriers, stigma, and user fees present in most facilities. The organizations provided technical advice on gender identity, stigmatization in the Liberian context and other critical information toward appropriate site selection. A CSO representative from each country actively participated at the COP19 meeting in Johannesburg, and these representatives will continue to play a key role in the implementation and monitoring of the PEPFAR programming throughout West Africa.

Private sector involvement in HIV is limited in West Africa. While Private Sector actors are to be members of the Quarterly CCM meetings and often provide HIV services in urban areas (as in the case of **Ghana and Liberia**), participation in most countries can be improved. PEPFAR will need to actively seek opportunities to engage private sector players and faith based organizations in PEPFAR programming.

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3.0 Geographic and Population Prioritization

Table 3.1 Current Status of ART Saturation

Table 3.1 Current Status of ART saturation					
Prioritization Area	**OU**	**Total PLHIV/% of all PLHIV for COP19**	**# Current on ART (FY18)**	**# of SNU COP18 (FY19)**	**# of SNU COP19 (FY20)**
Attained		N/A	N/A	N/A	N/A
Scale-up Saturation	Ghana	23,909 (83%)	6,563	5 regions	1 region (Western)
	Burkina Faso	61,703 (83%)	42,194	2 communes	3 regions
	Togo	90,042 (81%)	53,872	1 commune	3 regions
Scale-up Aggressive	Senegal	12,135 (52%)	23,202	7 regions	3 regions (4 sites)
	Mali	3,753 (71%)	N/A	23 districts in 4 regions	14 districts in 3 regions
	Liberia	24,100 (56%)	13,117	N/A	5 districts
Sustained		N/A	N/A	N/A	N/A

Note: Cells left blank indicate the prompt is not applicable (N/A) or there is not sufficient data gathered.

Scale-up Saturation

Burkina Faso does not yet have granular data at the district level. Thus, three regions were considered to be priority SNUs. Three regions, Centre (49% of the national gap to 81% ART coverage), Hauts Bassins (21% of the national gap to 81% ART coverage), and Centre Ouest Regions (15% of the national gap to 81% ART coverage), have the highest gaps and were therefore prioritized, accounting for 66% of all PLHIV nationally.

The disaggregation by age and sex revealed low coverage among children and adult men. The ART coverage among children and adult men were respectively 28% and 52% in 2017 versus 90% among adult females in 2017.[18] The available data does not allow identifying the gaps disaggregated by 5-year age bands. Corrective actions will be undertaken during the implementation of COP19 to strengthen the monitoring and evaluation system to collect data by 5-year age bands, and by sex for better decision making. There is also a lack of information regarding the ART coverage among KPs, however it is assumed coverage is low, due to the high level of stigma and discrimination

[18] Burkina Faso Factsheet. UNAIDS 2017

Unclassified

against KPs. The ROP19 Program will maximize opportunities to reach KP, men, and children, and to address barriers that have limited their access to ART.

While close, none of the 3 prioritized regions (Centre, Hauts Bassins, and Centre Ouest Regions) are expected to reach 81% ART coverage by 2019. Rapid scale-up towards saturation will be done in these three prioritized regions in order to reach 85% of ART coverage by 2020. Above-site activities will also contribute towards improving the overall national cascade. It is expected by 2020 at national level, that 95% of PLHIV know their status, 85% of PLHIV are on ART, and 67% of PLHIV are virally suppressed.

Like Burkina Faso, **Togo** also does not have well disaggregated data at the district level, so the gap analysis occurred at the regional level. In addition, the current PEPFAR program in Togo is focused on KPs and implemented in only one commune, Lome Commune. With the support of the Game Changer Funds, the COP19 program will go beyond KPs and support GoT to close the gaps toward the second 90.

For the Game Changer Program, Maritime, Plateaux Regions, and Lome Commune will be prioritized for saturation scale-up. Maritime and Plateaux Regions are home to 59% of PLHIV in Togo and have the highest gaps to cover in terms of ART coverage.

The gap analysis indicated that Lome Commune reached 100% ART coverage. This can be explained by the movement of PLHIV from other regions to Lome, given better access to services and due to stigma and discrimination. PLHIV often travel each quarter to Lome to pick-up their ARVs.

The disaggregation of the gaps by sex and age revealed the national program faced challenges in reaching adult men and children. There is limited data in terms of ART coverage for KP due to stigma and discrimination. However, existing data shows low ART coverage among MSM (13.5%) and FSW (23.9%) in Togo.[19] In COP19, the Game Changer Program will maximize opportunities for reaching these population sub-groups and address barriers that have limited their access to ART.

Ghana's overall performance across the 90-90-90 cascade is weak, with only 61% of people living with HIV knowing their status, 33% on ART and 6% virally suppressed.[20] While the KP program continues to show high linkage, retention, and VL suppression across the KP cascade, it will not advance the national cascade given the small estimates of KPLHIV. Ghana currently has no region/district that has experienced saturation. Using a mix of both facility-based and community-level interventions, PEPFAR Ghana's new strategy is to concentrate efforts in ten out of the 13 districts in the new Western Region of Ghana to rapidly achieve the second 90 by September 2020. PEPFAR will prioritize all PLHIV in Western region; however, PEPFAR/Ghana will use granular, site level, data to design specific interventions to target different populations, e.g. men, priority populations, etc. by age bands. The decision to focus on all PLHIV and achieve saturation in one region is aligned with PEPFAR's overall strategic direction to focus and leverage resources for greater impact and to advance the national program towards achieving epidemic control. By prioritizing the new Western Region, the PEPFAR program will be able to demonstrate the achievement of epidemic control is possible in Ghana.

[19] NACP Togo Program data 2018.

[20] FY 2019 PEPFAR Planned Allocation and Strategic Direction

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Scale-up Aggressive

LIBERIA

PEPFAR in **Liberia** is targeting key populations (MSM and FSW), in the five highest burden districts (Commonwealth district, Central Monrovia district, Bushrod district, Somalia Drive district, St Paul River district) within Montserrado County, which contains the capital city of Monrovia. These five districts comprise 32% of the population of Liberia, and approximately 60% of the PLHIV burden.

An acceleration plan undertaken by the Government of Liberia (GoL) in 2016 sought to triple the country's testing and treatment results within a short window to fast-track progress towards 90-90-90. The plan targeted counties with the highest unmet need (Grand Bassa, Margibi and Montserrado), and specifically focused on urban areas and hotspots within these counties.

Estimates for Montserrado County			
KP Type	**Size estimation**	**HIV prevalence**	**Est. # PLHIV based on est.**
FSW	71,012	9.8%	6,959
MSM	32,694	19.8%	6,473
PWID	4,088	5%	204
Military (DHAPP)	2,300	1.8%	41

Source: NACP Size Estimation 2018; IBBS 2018; Department of Defense Size Estimation 2018

Outside of Montserrado County, Margibi and Grand Bassa have the highest estimated number of PLHIV. HRSA is also implementing workforce activities in several districts within Maryland County, centered on two HIV clinical sites within the County using PEPFAR HOP funds. HRSA will emphasize index testing and DSD and will assure strategies are in place for achieving high retention and viral suppression. HRSA is working to obtain baseline data to be used to assess the impact of these interventions and make changes as necessary.

In Montserrado County it is estimated that 10,000 KP don't know their status; 18,557 will need to be initiated on treatment; and 28,870 viral load testing needs to be done to achieve viral suppression.[21]

There are significant gaps along the cascade for KP which have been identified under the GF program. For example, from April 1 – December 31, 2018, 2,779 KP received unique identifier numbers, with 2,736 tested for HIV. Of those tested, 237 (8.6%) tested positive. However, only 19 reported for confirmatory testing, of which 15 (79%) were confirmed positive. Only five (33%) were initiated on treatment. PEPFAR will target KP to ensure they receive appropriate counselling and support to link to and be retained on treatment.

[21] "Liberia Demographic and Health Survey 2013 - The DHS Program." https://dhsprogram.com/pubs/pdf/fr291/fr291.pdf. Accessed 10 Apr. 2019.

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Through the combined efforts of the GOL, PEPFAR, and GF, 90% of PLHIV will be retained on treatment in Montserrado County by 2021.

MALI

PEPFAR Mali's program will focus on KP including scaling up index testing. The following populations are prioritized:

- MSM
- FSW
- Clients of FSW
- Sexual partners of all people testing positive for HIV
- Children under 15 of HIV-positive mothers or of HIV-positive fathers when the mother's status is unknown

PEPFAR originally implemented KP activities in 23 districts across 4 regions in Mali. These regions were selected based on a rationalization agreement with GF and the Government of Mali (GoM); three of the four regions were among the highest burden. To improve the utilization of limited resources and to better focus KP activities, an analysis was conducted of the total yield over the past fiscal year in each district, the total number of PLHIV diagnosed in each district, and the total number of PLHIV on treatment. Results varied widely from district to district, and those with the largest results were selected. This analysis resulted in a planned shift from four to three regions, and from 23 to 14 districts.

These prioritizations will enable PEPFAR to target high-yield sub-populations to find, test, treat, and retain the greatest number of people possible on a limited budget.

SENEGAL

PEPFAR/Senegal is focusing on targeted case finding in military installations and four KP hot-spot sites: two sites in Dakar (IHS and Pikine), Mbour, and Ziguinchor. In order to target PEPFAR's focused investment in Senegal and maximize its impact on the epidemic, PEPFAR is shifting away from general population testing and PMTCT and shifting towards patient-centered care for MSM and FSWs. This decision was informed by an examination of FY19 Q1 results, which indicated that PEPFAR could dramatically increase testing yields by shifting its focus away from the Southern regions and general population testing and towards the four KP hot-spots, and towards higher yield modalities. These sites have high KPLHIV burdens. PEPFAR will conduct a population mapping of these four sites to identify satellite sites and additional hot spots to micro-target these key populations.

This strategy will help Senegal move towards achieving epidemic control by targeting the most difficult to reach and highest risk populations with testing, treatment, and prevention activities. By re-focusing support on sites that have greater access to KPs, and by doubling efforts to provide patient-centered, KP-friendly care, PEPFAR/Senegal can dramatically increase case finding for KPs.

As PEPFAR transitions away from the southern regions and general population testing, PEPFAR/Senegal is also working closely with GF and GoS to ensure coverage is maintained for the PLHIV in these regions. Both PEPFAR and GF investments focus on services for KPs. PEPFAR is coordinating closely with the GF to ensure a full, non-duplicative package of services for KPs at the four PEPFAR sites.

Unclassified

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

4.1 – 4.3 COP19 Programmatic Priorities for Epidemic Control

By 2021, in line with the overall objectives of the West Africa region:

1. In **Burkina Faso and Togo**, with additional "Game Changer" funds, with additional "Game Changer" funds, PEPFAR aims to reach the first and second 90 nationally in ROP19, and achieve the third 90 in ROP20 through direct service delivery, with a targeted focus on the highest burden sites for PLHIV and KP (Centre, Hauts Bassins, and Centre Ouest Regions in Burkina Faso; Lome Commune, Maritime, and Plateaux Regions in Togo), and with technical assistance to other sites;
2. In **Ghana**, PEPFAR aims to achieve saturation and reach epidemic control in the Western Region and;[22]
3. In **Liberia, Mali and Senegal**, PEPFAR aims to reach epidemic control in Key Population (KP) groups, namely Men who Have Sex with Men (MSM) and Female Sex Workers (FSW), in targeted local, administrative areas.

PEPFAR will work in the West Africa region to address policy and structural barriers that slow progress towards reaching epidemic control at the various levels described above. Developing specific strategies to find the missing, get them on treatment, and retain them to ensure viral suppression requires detailed data analysis of who is accessing treatment, weekly monitoring of data, improved counselling to ensure adherence, and robust referral and follow-up to ensure retention.

4.1 Finding the missing, getting them on treatment and retaining them ensuring viral suppression

All six countries will focus on KP programming, given the high burden of HIV in these population groups. Specific **differentiated case finding strategies for KPs** to be implemented in all countries are listed below:

Community-led programming will be implemented in close collaboration with KP associations and networks. Using a multi-pronged strategy to find HIV positive KP, programs will use peer-driven and hot-spots outreach, index testing and enhanced peer outreach approach (EPOA), social network strategies, as well as social media and ICT platforms to carry out targeted testing. KP peer educators will be trained on providing behavior change messages including U=U messaging for viral load suppression, giving condoms and lubricants to their peers, and referring people for HIV counseling and testing services. Community-led testing implemented by trained peer-educators or

[22] By Legislative Instrument, Western Region has been divided into "new" Western Region and Western North Region. Western Region in this document refers to the "new" Western Region where PEPFAR will be working to achieve saturation and epidemic control.

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lay counselors will be strengthened or expanded where currently utilized (Burkina Faso, Togo, Ghana) and introduced in other countries where permitted (Liberia, Senegal and Mali). KP-friendly drop-in centers that also provide STI treatment and HIV testing and linkages to treatment will be supported where they already exist (Togo, Ghana, and Mali). Special emphasis will be placed on identifying MSM aged over 40, and providing targeted services since evidence shows that they are the most hidden MSM sub-groups and are difficult to find with conventional strategies, and often have higher HIV prevalence than other MSM age bands. Peer educators will continue to escort HIV+ clients to health facilities. At health facilities, PEPFAR will support programs where KPs are welcomed by peer navigators who will facilitate their access to ART.

In **Senegal**, an innovative case finding strategy will also be expanded. Two mobile clinics will be used to provide KP-friendly services, including ART initiation and distribution and linkage of positive clients to public sector health facilities. This direct service delivery model will allow the program to reach more effectively into high-burden KP communities, including identifying hidden KP for effective linkage and initiation on treatment. The mobile clinics (one in Dakar, one in Mbour/Ziguinchor) will each be staffed with one trained case manager, a driver, and a health worker trained in KP-friendly care to offer services across the clinical cascade (screening, testing, treatment initiation, counselling for retention) to KP in hot spots. Mobile clinics will make ten trips each month to KP hot spots at night or on weekends to accommodate KP schedules. Mobile clinics are currently used in Senegal to test KP, but in ROP19, PEPFAR will expand mobile services to include HIV testing with confirmation, initiation of ARV treatment or ARV refills, collection of blood and referral for viral load, and other services as deemed feasible and necessary. Mobile clinics will report their results to PEPFAR on a bi-weekly basis.

Unique Identifier Code (UIC) systems will be strengthened and expanded in **Burkina Faso, Togo, Liberia, Mali**, and **Senegal** and also be monitored to ensure implementation with fidelity in order to avoid double counting. **Ghana**'s KP Unique Identification Systems (GKPUIS) has been launched with unique capabilities for generating identification codes for KP offered services and minimizes issues of double counting, thereby enhancing the quality of data for effective planning and decision making. The unique codes entered into e-tracker will enable the country to track KPs linked to treatment.

Stigma and discrimination against KP across West Africa is extremely high. To reduce its impact on the access of KP to HIV services, enabling environment activities to make health facilities KP-friendly will be implemented. Service providers, policemen, and judges will be trained and advocacy will also be done, using lessons from more mature KP programs in the region such as Ghana's. Gender based violence prevention and clinical care will be also provided.

For other general population groups in **Burkina Faso, Togo, and Ghana**, rapid saturation of the prioritized regions with **differentiated HIV case-finding methods** will be carried out. In addition to the KP specific methods described above, missed **adult men** will be reached through index testing via their sexual partners, social network testing, and targeted and risk-based Provider Initiated Testing and Counselling (PITC). Appropriate messaging (U=U message, benefit from early ART initiation) will be provided to men to increase HIV service demand. Particular attention will be paid to patients who are diagnosed with TB, orpatients with suspected TB. Specific focus groups will be organized at site level to deeply understand men's needs and tailor the sites' services to these needs. Index testing and partner notification will be implemented with compliance to WHO's 5 C's (counselling, including consent procedures, correct test results, linkage to care and treatment of positive clients and protecting confidentiality).

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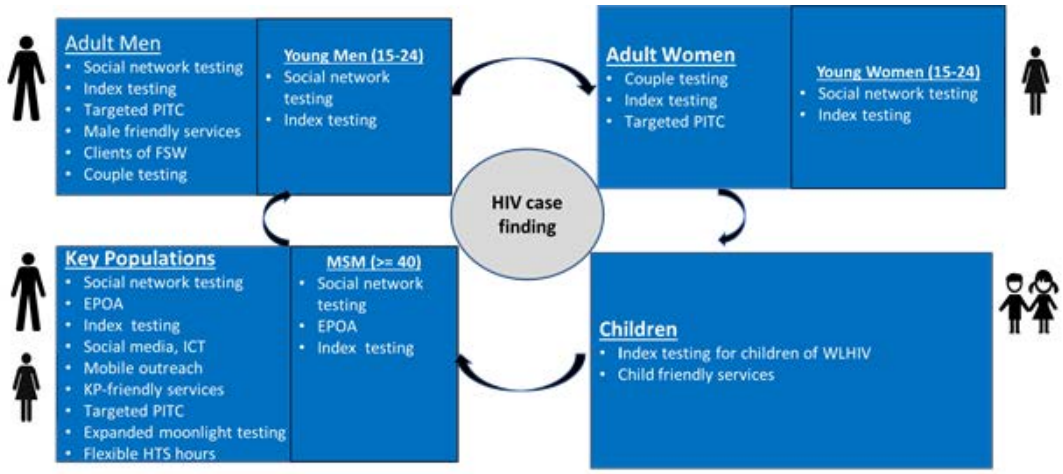
To reach missed **children**, strategies will include index testing to identify eligible children of women living with HIV, and targeted PITC for children with malnutrition and suspected TB signs. HIV related services to **women** and young girls will continue.



In all six countries, once clients are navigated to PEPFAR-supported KP friendly health facilities, a peer navigation and case management approach will be used **to** ensur**e immediate initiation of ART and support for retention on ART.** To increase the retention rate, each of the six countries will: (i) implement same-day ART initiation (ii) have appropriate messaging and services to encourage men, in particular MSM over 40, to seek early HIV services; (iii) scale-up DSD MMS/D, (iv) send pre-appointment reminders to clients (via SMS messages and phone calls), and (v) do daily monitoring of defaulters with active tracing through phone calls, home visits, and social networks.

To ensure ART **adherence, retention in care, and timely viral load testing**, peer educators, navigators, and psychosocial counsellors will continue to play a critical role in regular follow-up, making sure that clients are supported and are retained in care through pre-visit appointment reminders through calls, SMS messages, and home visits as appropriate. For viral load testing, navigation through the health facility and timely receipt of results will be emphasized through U=U messaging. For those who are not virally suppressed, robust adherence counselling and enhanced support strategies will be provided according to the WHO and national guidelines. To ensure access to viral load testing, demand creation, improved provider and laboratory training is required. PEPFAR will ensure access to VL testing and monitoring for all PLHIV on ART in all PEPFAR-supported sites, and functional sample referral system and VL reminders will be put in place in each of the countries modelled after Ghana's program. Policy documents and guidelines will be developed to support these activities. . In addition, policies for TLD transition will be finalized in countries where they do not exist to ensure PLHIV in PEPFAR supported regions have access to effective ARVs with better side effects profiles to promote adherence and retention.

In Ghana, Community Health Nurses will be assigned Clinic-Community Liaison Officer (CCLO) roles to support efficient and effective flow of patients across the cascade at site level. This will include ensuring the fidelity of implementing effective case finding modalities, same day ART initiation, quality adherence counseling, VL testing and tracking of lost to follow up. USG will collaborate with GF and the various country Governments regarding availability of VL reagents to ensure appropriate amounts are procured and the functionality of the machines provided.

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Across the region, 39,127 new HIV positive clients are to be found in ROP19 (4,679 in Burkina Faso, 13,569 in Togo, 13,789 in Ghana, 2,193 in Liberia, 3,703 in Mali and 1,119 in Senegal). Thirty-two percent (32%) of the new HIV positive clients will come from index testing and 53 percent of these will be found at the community level. The average yield ranges from 14 percent in Senegal to 16 percent in Liberia for the three KP programming focus countries. For the three KP and General Population focus countries (Ghana, Togo, and Burkina Faso), the average yield will range from 9 percent in Ghana to 12 percent in Togo.

4.2 Prevention programming for KPs

HIV negative clients will benefit from STI screening and treatment as needed, condoms and lubricants promotion and distribution programming that focuses on addressing barriers to condom use, social norms change messaging, gender-based and intimate partner violence screening and support, and referral to other psychosocial services as needed where available.

4.3 Additional country specific priorities listed in the planning level letter

Given the major **policy barriers** that exist throughout the region, **Burkina Faso, Togo, Liberia, Mali, and Senegal** will emphasize the development and implementation of key national policies including for TLD transition, Index Testing, DSD (including community-based testing and multimonth scripting) and lab strengthening and viral-load scale-up. Implementation with fidelity remains a key challenge and will be a focus for all countries.

Countries are also encouraged to invest in above-site **supply chain strengthening** to address stock-out issues. Some of the activities to be supported include quantification (forecasting, supply planning); quarterly data validation for commodities (regional to central level) as well as training service providers and supply chain managers on logistics management; quarterly Monitoring and Supervision and, in the case of Burkina Faso and Togo, operationalizing electronic commodity data tools at site level.

For Burkina Faso and Togo, additional country specific priorities listed in the planning level letter included ensuring that 1) User fees do not prohibit access to HIV services and 2) Adequate data systems are in place to monitor performance and use of these funds.

While formal policies for free HIV testing, ART, and VL testing are in place in all six of the countries in West Africa, informal user fees may exist. As such, all six countries will work with Civil Society groups in particular PLHIV networks on a comprehensive activity to educate service providers and clients, post patient rights in health facilities, and support the monitoring and reporting of user fees for action as illustrated in the figure below. In addition, countries like **Ghana and Senegal** will continue to use social health insurance schemes to help defray the costs of healthcare for the most vulnerable.

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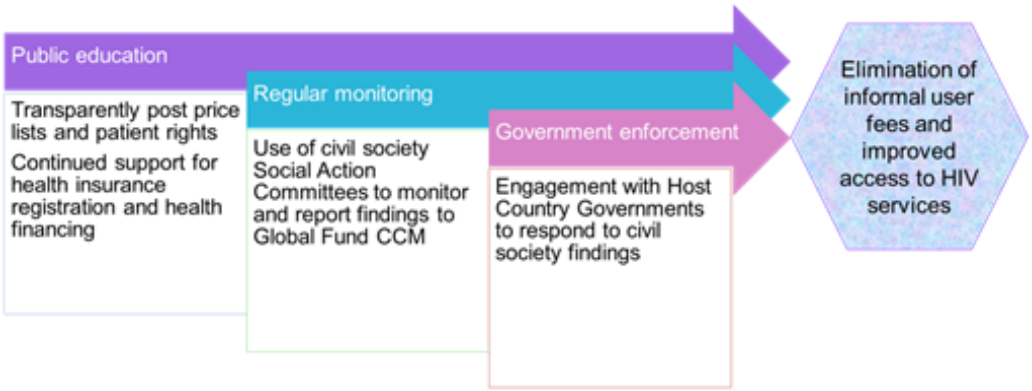
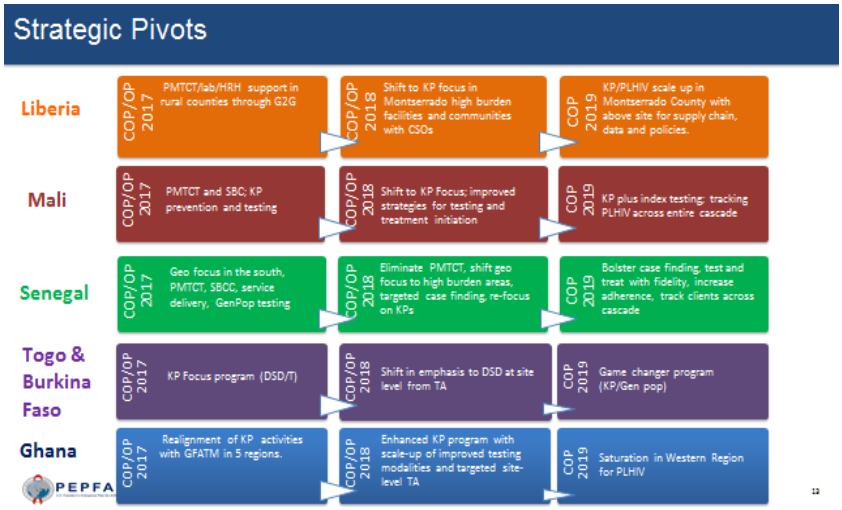


Adequate data systems - Strengthening data collection and analysis will be a focus throughout the region to respond to PEPFAR requirements and also to enable corrective action to improve patient outcomes. To address the lack of quality data for better monitoring of performance, in **Burkina Faso and Togo** (where adequate data systems were cited as a requirement in the PLL to monitor performance and use of funds), strengthening of DHIS2, expansion of a patient eTracker system, and the revision of data collection tools to comply with PEPFAR Monitoring, Evaluation and Reporting indicator disaggregation will be undertaken. Across all countries, weekly data monitoring and analysis will be done at site level for early corrective action. Quarterly health district level monitoring will be also supported to identify gaps in implementation of the key policies at site level and provide corrective action.

Decisions made on the program direction in COP19 based on Q4 POART findings and the PEPFAR Regionalization meeting: Major pivots in programming have been made subsequent to the PEPFAR regionalization meeting in all countries. Countries have worked to harmonize programming to focus on KP in all countries, and expand to overall PLHIV programming in **Burkina Faso, Togo, and Ghana**; share best practices across the region; and increase coordination and technical support. The major changes made are illustrated in the figure below:



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4.4 Commodities

A major concern throughout the region is the supply chain management of commodities. Stock-outs of HIV commodities at site level in the various countries do occur on a periodic basis, and the dependence of countries on the GF's procurement of HIV commodity and lab procurement is a reality. In ROP19, PEPFAR will procure TLD and VL reagents in **Burkina Faso and Togo**. PEPFAR will purchase condoms and lubricants will be purchased in Burkina Faso, Togo, and Mali. Supply chain strengthening (forecasting, quantification, management of supply chain information system, and early warning system) will be an area of emphasis in all countries. PEPFAR will work closely with the GF to advocate for increased domestic investment by host country governments, particularly into commodity purchases.

TLD Transition: Accelerating the transition to TLD and phasing out the use of Nevirapine will be a focus for all the countries in the region. In Ghana, PEPFAR will support the updating and finalization of ART guidelines to include TLD as adult first-line regimen and to phase out Nevirapine-based regimens to be in line with WHO recommendations by December 2019: Using a phased approach, all clients on Nevirapine-based regimen are expected to be transitioned to TLD by December 2019. All the other countries are working to develop their policies and put in place transition plans, with GF and PEPFAR support. PEPFAR is also exploring with GF the possibility of accelerating shipments of TLD to the region to further accelerate the transition. PEPFAR will work with the West Africa Health Organization (WAHO) to bring together countries in the region to encourage a rapid transition.

4.5 Collaboration, Integration, and Monitoring

Cross Technical Collaboration with external stakeholders: As described in previous sections, PEPFAR is closely collaborating with the MOH as well as GF and UNAIDS on all aspects of programming in the six PEPFAR-supported countries. With a relatively small HIV national response in all the countries in West Africa, all resources must be closely coordinated and targeted. UNAIDS plays an important role of coordination and support for CSO engagement, while GF contributes most of the commodities and critical implementation support to all aspects of the response. CSOs remain foundational partners to PEPFAR's HIV response and, as has been described in sections 2.5 and 4.3, CSOs will be critical to PEPFAR achieving its ambitious goals.

Implementing Partner Management: The implementing partners will be managed through routine site-level monitoring of target achievement, monthly PEPFAR site visits, weekly partner reporting, targeted TA to underperforming sites, and identifying and sharing best practices from high-performing sites with other sites across the region.

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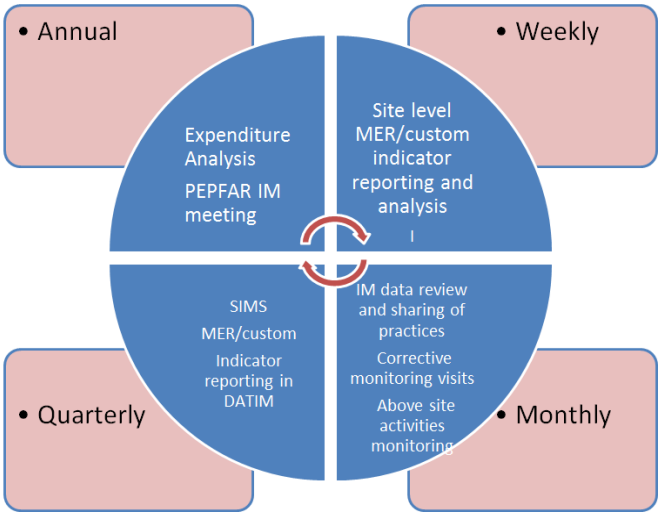

Health Systems Interventions: Significant health system weaknesses exist across West Africa. With our limited resources, PEPFAR will support the strengthening of the following areas:

1. Adoption and implementation of critical policies that will support best practice implementation, such as Index Testing and DSD including MMS/D;
2. HIV service delivery with a specific emphasis on treatment and laboratory optimization;
3. Supply chain strengthening to ensure access to life-saving HIV commodities;
4. Building human resources for health capacity through training, corrective supervision and recruitment of staff for PEPFAR-supported health facilities;
5. Strengthening health information through support to DHIS2, expansion of UIC systems to improve data analysis for better decision making; and
6. Advocacy to host country governments to increase domestic resources to HIV and where relevant with non-PEPFAR funding (namely in Ghana and Senegal), support to the expansion of social health insurance to help defray healthcare costs for the most vulnerable.

4.6 Targets for scale-up locations and populations

Given that this is the first ROP for the region, DATIM-generated tables are not yet available. With West Africa's almost universal coverage of traditional circumcision, no investments are made in VMMC. Lastly, no investments will be made in West Africa in OVC, Cervical Cancer, or Early Infant Diagnosis. Viral Load is discussed in sections 4.8.

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Standard Table 4.6.1

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts				
Entry Streams for ART Enrollment	**Country**	**Tested for HIV (APR FY20) *HTS_TST***	**Newly Identified Positive (APR FY20) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 20) *TX_NEW***
Total Men	Ghana	24,982	3,173	2,886
	Mali	5,413	882	820
	Senegal	6611	989	1002
	Liberia	5,135	1,027	925
	Burkina Faso	12340	1,321	1,489
	Togo	31607	3,831	4,292
Total Women	Ghana	155,373	9,521	8,569
	Mali	21,064	2,878	2,620
	Senegal	866	130	135
	Liberia	8,735	1,166	1,050
	Burkina Faso	31788	3,366	3,790
	Togo	80466	9,740	10,973
Total Children (<15)	Ghana	21,587	2,268	2,041
	Mali	TBD*	TBD*	TBD*
	Senegal	0	0	0
	Liberia	0	0	0
	Burkina Faso	2,555	300	339
	Togo	5,864	710	979
Total from Index Testing	Ghana	12,514	4,143	3,729
	Mali	3,781	1,110	1,055
	Senegal	1685	337	432
	Liberia	5,500	1,100	991
	Burkina Faso	7,025	1,405	1,265
	Togo	17,103	4,072	3,665
Adults				
TB Patients	N/A			
Pregnant Women	Ghana	55,538	676	648
VMMC clients	N/A			
Key populations	Ghana	10,589	1,230	1,108
	Mali	22,696	2,650	2,385
	Senegal	5792	782	705
	Liberia	13,870	2,193	1,966
	Burkina Faso	3540	382	281
	Togo	6172	933	839
Priority Populations	N/A			

Unclassified

Other Testing	Ghana	N/A	N/A	N/A
	Mali	3,781	1,110	1,055
	Senegal	N/A	N/A	N/A
	Liberia	N/A	N/A	N/A
	Burkina Faso	38,033	4,005	3,598
	Togo	100,037	11,928	10,396
Previously diagnosed and/or in care	Ghana	0	0	0
	Mali	N/A	N/A	119
	Senegal	N/A	N/A	142
	Liberia	N/A	N/A	N/A
	Burkina Faso	N/A	N/A	1,061
	Togo	N/A	N/A	2,856
Pediatrics (<15)				
HIV Exposed Infants	Ghana	6,914	N/A	N/A
Other pediatric testing	Ghana	N/A	N/A	N/A
	Mali	N/A	N/A	N/A
	Senegal	N/A	N/A	N/A
	Liberia	N/A	N/A	N/A
	Burkina Faso	2,555	300	339
	Togo	5,864	710	979
Previously diagnosed and/or in care	Ghana	N/A	N/A	N/A
	Mali	N/A	N/A	N/A
	Senegal	N/A	N/A	N/A
	Liberia	N/A	N/A	N/A
	Togo	N/A	N/A	195
	Burkina Faso	N/A	N/A	69

*Since the program for Mali is KP-focused, and the population data informing target setting for KP and index-testing was minimal, we established it would be better to target for KP 15+. During implementation, we will be able to report results for children (<15). We can use those results to inform our target setting for the next fiscal year.

Note: Cells left blank indicate the prompt is not applicable (N/A) or there is not sufficient data gathered.

Standard Table 4.6.2 VMMC: N/A to West Africa Region

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Standard Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control				
Country	**Target Populations**	**Population Size Estimate (scale-up SNUs)**	**Coverage Goal (in FY20)**	**FY20 Target**
Ghana	FSW	20,243	31.4%	7,061 (KP_PREV)
	MSM	6,699	63.2%	4,703 (KP_PREV)
	TOTAL	26,942	39.3%	10,589 (KP_PREV)
Liberia	KPLHIV	9,000	70.0%	6,300
Mali	MSM	5,516 (751 PLHIV)	35.8%	269 (TX_NEW)*
	FSW	18,082 (5,367 PLHIV)	25.4%	1,429 (TX_NEW)*
	TOTAL	**23,598 (6,118 PLHIV)**	27.8%	1,698
Senegal	MSM	8,325	59%	4,900
	FSW	5,754	68%	3,920
	TOTAL	**14,079**		**8,820**
Burkina Faso	MSM *Indicator Codes include PP_PREV and KP_PREV*	8,806	80%	7,045
	FSW	10,653	80%	8,522
	TOTAL	**19459**	**80%**	**15,567**
Togo	MSM	5,903	80%	4,,722
	FSW	6,943	80%	5,554
	TOTAL	**12,846**	**80%**	**10276**

***KP only in 3 PEPFAR-supported regions. Does not include index testing.**

Note: Cells left blank indicate the prompt is not applicable (N/A) or there is not sufficient data gathered.

Standard Table 4.6.4 OVC investments and targets —N/A to West Africa

4.7 Cervical Cancer Program Plans— N/A to West Africa

4.8 Viral Load

Access to viral load is low in the region. It was for example 20% in Togo in 2018. In ROP19, access to viral load will be increased to reach at least 60% coverage across the region with technical assistance of CDC.

In **Burkina Faso and Togo**, the viral load system will be optimized in collaboration with CDC through technical assistance, development and implementation of viral load scale-up plan including optimization viral load labs network, support to samples transportation, lab data management, and training of health service providers on viral load results use. Weekly monitoring of the viral load access will be done at site level with corrective actions. $ 100,000 is planned to support the lab system optimization in both Togo and Burkina Faso. PEPFAR program will also contribute to fill the gaps on viral load reagents up to $ 252,422 in Togo and $ 79,143 in Burkina Faso.

Unclassified

Among the six countries, **Ghana** has shown the most progress with the viral load system including implementation of the VL sample referral and transportation system. In ROP19, this lab system will be further strengthened and three Centers of Excellence will be established through training and accreditation by both PEPFAR and Global Fund. PEPFAR will support final developments of the VL load data management system, accreditation for the Center of Excellence which supports Western Region, mapping expansion of the sample referral and results transmission system to cover all ART sites in Western Region, refresher trainings, and monitoring and corrective action visits to viral load testing sites. The total budget plans for supporting viral load/EID access is $265,000.

PEPFAR **Senegal and Liberia** will support the access to viral load testing at site level. In Senegal, two PEPFAR supported sites have viral load testing equipment. The program will support the transportation of the samples from PEPFAR supported sites without viral load equipment to health facilities with viral load platforms. PEPFAR Senegal plans to invest $20,000 to improve the access to viral load testing at its supported sites.

In **Mali,** the PEPFAR team will provide technical assistance to GOM for lab infrastructure and technical capacity strengthening to facilitate optimization viral load (VL) diagnostic, VL sample referral and logistic, DBS training for clinical and lab personnel, development of VL policy. Based on the current available point of care (30) instrument across the country, the program will support the better utilization of POC for VL testing/EID at PEPFAR-supported sites. For TB and HIV integration and optimization, existing GenXpert machines will be used. Advocacy will be done to GF and GOM to provide reagents. A budget of $ 600,000 is planned to support the access to viral load/EID.

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

This section does not apply to PEPFAR West Africa

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6.0 Program Support Necessary to Achieve Sustained Epidemic Control

West Africa Regional countries face several above site challenges that have the potential to hinder the region's progress towards sustained HIV epidemic control. These challenges can be categorized into five main categories:

a) Policy adoption and implementation barriers: Adoption and implementation with fidelity of Test and Start; DSD models, including MMS/D; index testing, and elimination of informal user fees
b) Health systems challenges: Systemic supply chain issues resulting in frequent stock outs and weak viral load systems (laboratory capacity and transportation networks) resulting in long delays in test results and limited viral load testing coverage
c) Weak strategic information and surveillance capacity
d) Stigma and discrimination towards PLHIV and KP
e) Sustainable financing of the national HIV response

Policy Adoption and Implementation barriers: Significant policy adoption remains to be done in many of the countries in West Africa. For example, while all of the countries have adopted Test and Start, fidelity in implementation remains a challenge. Policies for Index Testing, DSD, including MMS/D in some countries need to be developed and implemented to scale.

PEPFAR has identified the elimination of user fees as a major priority for West Africa. While Mali, Liberia, Senegal, Burkina Faso, and Togo have policies in place directly eliminating formal user fees, and Ghana provides free services and drugs for PLHIV, informal user fees may exist throughout the region for uninsured PLHIV or for other health services, such as STI treatment.

PEPFAR will support implementation with fidelity of DSD, including MMS/D, through scaling-up interventions and investing in corrective supervision in **Burkina Faso, Togo and Ghana**. Across the six countries in the region, new interventions to enhance case finding, including index testing, and EPOA will be scaled up.

PEPFAR will engage in above-site activities to improve the quality of care for KP and PLHIV. These include: optimization of ART through in-service training on treatment literacy and strengthening adherence support; initiating a database for the management of KP cohorts in target areas; and development and/or strengthening of M&E and patient tracking systems for retention and loss-to-follow-up. PEPFAR is committed to confront stigma and discrimination, and both formal and informal user fees by working with CSO networks and KP-led organizations to optimize the national HIV responses. The ultimate goal of these systems-level investments is to have a data-driven response, which leverages evidence-based interventions and removes barriers to access for all populations.

Health Systems Challenges: Due to limited government capacity and resources, public health supply chain systems across the six countries are weak and are heavily reliant on donor support. PEPFAR will invest in supply chain technical assistance in a number of different areas. In **Burkina Faso, Togo, Ghana and Mali,** PEPFAR will invest in logistics management information systems to improve commodity visibility. In Burkina Faso and Togo, PEPFAR will be purchasing HIV

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commodities. In **Ghana,** PEPFAR will support the Western Region to strengthen last mile distribution of health commodities from regional level to service delivery points. Commodity forecasting and procurement planning will be supported in all the six countries across West Africa.

PEPFAR activities aim to further support all of the six countries' government and GF investment in the national HIV supply chain program by fostering improvements in site level reporting to inform optimal commodity distribution. Working in concert with GF, PEPFAR will ensure that transition to TLD and the elimination of Nevirapine-based regimens is achieved as quickly as possible.

Major improvements are also necessary in the national VL system to reach targets for patients currently on treatment and to improve national lab policies and capacity. While extensive work on laboratory optimization has been undertaken in **Ghana**, all of the other countries in West Africa will need to ensure that appropriate policies are in place to ensure improved access to routine VL testing and timely receipt of results for patients to reinforce improve adherence and increase early detection of treatment failure. In **Ghana,** PEPFAR will continue to support the training of laboratory staff in drawing and handling samples, proficiency testing for viral load, accreditation of the center of excellence supporting laboratory analyses for Western Region, and demand creation for viral load testing. Also, a laboratory data management system will be implemented to improve data accuracy and access.

Weak Strategic Information and Surveillance Capacity: PEPFAR will support improvements and address weaknesses in strategic information systems across the West Africa Region. The **Ghana** program continues to suffer from data incompleteness and availability at a granular level. In COP19, PEPFAR will train staff in eTracker use for programmatic decisions, particularly staff in the Western Region. PEPFAR will also support the development of sub-national estimates to inform better programming. PEPFAR will provide training for the implementation of the Ghana KP Unique Identifier System (GKPUIS) and use of data for KP in the Western Region.

In **Liberia**, surveillance and monitoring at the target facilities is variable and generally weak, so PEPFAR/Liberia will conduct a detailed review of current reporting systems, data and trends. PEPFAR will also support the harmonization of the MOH UIC and GF-supported UIC.

In **Senegal**, PEPFAR will scale up a UIC system (SENECAS) that will help ensure KP positives are immediately linked to and retained in care, and will also help PEPFAR facilities and mobile clinics track negatives to ensure they remain negative.

In **Mali**, PEPFAR will collaborate with GF and GoM through appropriate technical assistance (TA) for a populations size estimate and IBBS for FSW and population size estimate for MSM. PEPFAR TA will focus on protocol development, development of SOPs, training, data analysis and report writing. Similarly, in **Togo** and **Burkina Faso**, PEPFAR will work to improve the quality of granular data to monitor performance and for decision making and improving the quality of services.

S&D towards PLHIV and KP: S&D against KPs and PLHIV continues to be a critical barrier to care for PLHIV across all six countries. To overcome this discrimination, PEPFAR is coordinating with the GF and civil society to eliminate stigma and discrimination. PEPFAR's efforts will include policy development and advocacy at the site level through conducting studies and forming committees to better understand the level and nature of stigma experienced, and then to work with health

Unclassified

facilities, and train civilian and military health workers to provide KP-friendly services and overcome myths and misconceptions of PLHIV.

Working with CSOs and KP-led organizations will be critical in this effort. PEPFAR will support the media in **Ghana** to improve accurate reporting of HIV statistics and information to help reduce stigmatization of PLHIV. Across **Ghana, Liberia and Senegal**, PEPFAR will address high levels of S&D within the military against PLHIV by clinical staff and leadership. As a special population with distinct concerns, improved data management will be supported to inform program decisions. PEPFAR will work with UNAIDS in **Burkina Faso and Togo,** to conduct a stigma index to further guide the development of effective interventions against stigma. PEPFAR will train service providers, health workers, and regional and district-level public health leadership, as well as members of the judiciary, local authorities, security forces, and religious leaders on issues of gender identification, sexual diversity, gender-based violence, and other issues pertaining to KPs.

Sustainable Financing of the HIV response: Domestic resource mobilization for HIV remains a critical challenge. According to the most recent National AIDS Spending Assessments, only Burkina Faso has been able to fund 52% of its HIV response with domestic government resources. Other countries struggle to invest adequately. In **Ghana,** actuarial analyses are underway to ascertain the country's ability to include HIV services into their national health insurance benefits package. In **Senegal,** PEPFAR is also working to support the enrollment of PLHIV in national health insurance to reduce out of pocket costs. There are currently around 300 PLHIV enrolled on health insurance, and the target is 1,000 PLHIV by 2020. In the other countries, working with CSOs, PEPFAR will track and advocate with National Governments for increased domestic resources for HIV.

Benchmarks and outcomes across the above-site activities are appropriate to the scope of the activities, and SMART, to ensure the ability to measure and track over time.

Unclassified

7.0 Staffing Plan

The PEPFAR Regionalization meeting held in October 2018 in Washington DC set the stage for the development of the PEPFAR West Africa platform. At that meeting, an analysis was conducted of existing PEPFAR-funded staff across the region, and some slight adjustments were made based on factors, including the burden of disease in each country. One of the main purposes of regionalization was to "**increase efficiency through the consolidation** of functions and the numbers of U.S. Direct Hires across countries and share technical expertise across the region."

It was decided at this meeting to create three new positions for the region:

1. **Regional PEPFAR Coordinator** (Resident Hire USPSC) - This position was originally the vacant Ghana PEPFAR Coordinator position that has been re-defined to play the role for the West Africa region based in Accra, Ghana. It is currently under recruitment.
2. **Regional Strategic Information Advisor** (USAID - Third Country National/USPSC)- To provide SI support throughout the region based in Accra, Ghana
3. **Regional Laboratory Advisor** (CDC- Locally Employed Staff) - To support viral load scale up and provide essential laboratory technical assistance across the region, to be based in Dakar, Senegal.

With the addition of Game Changer funding to accelerate achievement of epidemic control in Burkina Faso and Togo, 2.5 additional FTE (full-time equivalent staff) have been added to three positions agreed at the Regionalization meeting, to provide the requisite oversight, technical expertise and in-country support. The positions include:

1. **Medical Officer/Physician** (CDC - USDH) - To be based in Burkina Faso
2. **Program Management Specialist, HIV** (USAID - FSN) - To be based in Burkina Faso

The Senior HIV Advisor (Third Country National based in Accra) is the only FTE for USAID/West Africa. Existing staff providing partial FTE support to West Africa, based in Accra and Togo, are Senior Health Advisor (USAID/West Africa staff based in Togo), the Project Management Specialist for HIV, and the Health Systems Strengthening Specialist. Other non-PEPFAR funded staff providing support and oversight are the Regional Finance and Budget Specialists and the USDH Regional Health Office Director.

DOD Regional Staff

For DoD programming, the level of PEPFAR-supported DoD staff will be maintained in Ghana, Liberia, and Senegal. Non-PEPFAR funded DoD staff also provide oversight in Togo and Sierra Leone.

The USG staffing structure aligns efficiently with the requisite management and oversight of PEPFAR activities, including the carrying out of SIMS requirements, effective partner management, and technical expertise.

Unclassified

CDC Regional Staff

Due to the reorganization of the PEPFAR Ghana office into the West Africa Regional Hub, the scope of the duties and responsibilities of all CDC/Ghana PEPFAR staff has expanded to support regional activities. To meet new COP 19 requirements, CDC HQ reassigned a 100% HQ-supported FTE to fulfill Deputy Director responsibilities for the new region and expanded responsibilities for the Country Director and all other CDC Ghana staff to support the regional hub across agencies for lab and epidemiology. Additionally, CDC determined the need for a USDH medical office/physician position in Burkina Faso and repurposed a vacant Ghana SI advisor position to provide regional laboratory support.

Regional CDC PEPFAR staff are two USDH staff, Country Director (100%) and Deputy Director (HQ-based) (100%), and 6 Locally Employed Staff, (two SI advisors (100% each, one is currently vacant), laboratory advisor (100%), finance specialist (100%), administrative/cooperative agreement management specialist (60%) and chauffeur (100%)). The vacant SI position in Ghana will be repurposed as a term-limited LES laboratory advisor who can also provide some SI support, while waiting for the Regional Laboratory Advisor position based in Senegal to be filled.

Ghana has maintained its overall levels of FTE working on PEPFAR. However, in FY18 & 19, owing to a strong focus on clinical services, USAID received approval to recruit a Clinical Care and Treatment Specialist to provide comprehensive expertise in clinical HIV/AIDS services and support, program design, implementation, and monitoring. The position however could not be filled due to Mission's inability to find a suitable candidate. With PEPFAR Ghana's new direction in COP 19, focusing on one region to achieve saturation and reach epidemic control in the Western Region, there is an even greater need for a dedicated Clinical Care and Treatment Specialist. The position has been readvertised and Recruitment will be completed by the end of FY19.

Liberia, Mali, and Senegal have maintained their overall levels of FTE working on PEPFAR. Each USAID office will be recruiting full time technical experts in KP programming to secure the technical expertise necessary to effectively oversee and manage the new KP focus in these countries. CDC Mali currently cost-shares all staff with the Division of Global Health Protection (DGHP). Any changes in funding from DGHP will require a staffing review. CDC Senegal is considering options for recruiting a senior laboratory advisor to support viral load scale-up and provide essential laboratory technical assistance across the region. Options under consideration include either hiring a LES staff in Senegal or reassigning the vacant position from Ghana to meet this need.

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APPENDIX A – PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1 is Not Applicable

Table A.2 ART Targets by Prioritization for Epidemic Control

Table A.2 ART Targets by Prioritization for Epidemic Control							
Country	**Prioritization area**	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Burkina Faso	Scale-up saturation	46,000	3,362	50,279	5,279	46,000	83%
Ghana	Scale-up saturation	23,909	8,863	10,503	19,955	12,810	83%
Liberia*	Scale-up aggressive	24,100	8,043	12,846	2,042	2,708	55%
Mali*	Scale-up aggressive	5,272	682	3,588	3,753	3,450	45%
Senegal*	Scale-up aggressive	2,193	1,362	392	2,330	1,137	
Togo	Scale-up saturation	90,042	57,000	15,000	72,625	15,265	80%
Total		191,516	79,312	92,608	105,984	81,370	80%

* KP Total PLHIV

Unclassified

APPENDIX B – Budget Profile and Resource Projections

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

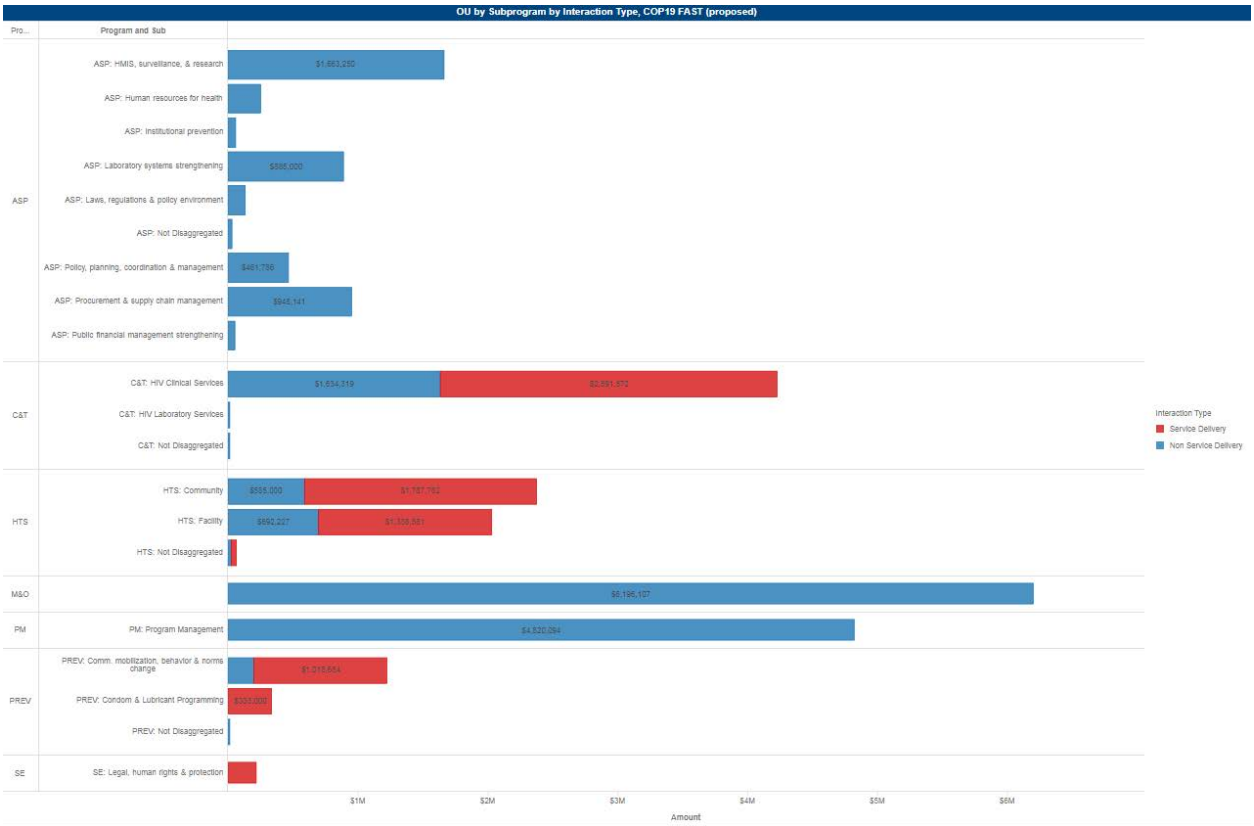

Table B.1.2 COP19 Total Planning Level

Applied Pipeline	Gamechanger Funding	New Funding	Total Spend
$2,635,504	$ 12,515,986	$ 35,860,482	$ 38,495,986

Data included in Table B.1.2 should match FACTS Info records, and can be double-checked by running the "Summary of Planned Funding by Agency" report.

Unclassified

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)

PEPFAR Budget Code	Amount Allocated
HBHC	$481,993
HLAB	$1,234,530
HTXD	$60,737
HTXS	$4,939,302
HVAB	$603,285
HVCT	$6,957,185
HVMS	$2,710,395
HVOP	$1,795,584
HVSI	$2,025,513
MTCT	$625
OHSS	$2,529,292
PDCS	$3,027
PDTX	$3,027
HBHC	$481,993
HLAB	$1,234,530
HTXD	$60,737
HTXS	$4,939,302
HVAB	$603,285
HVCT	$6,957,185

*Data included in Table B.2.2 should match FACTS Info records, and can be double-checked by running the "Summary of Planned Funding by Budget Code" report

B.2 Resource Projections

To achieve the specific goals laid out for each of the countries in West Africa Regional, the PEPFAR teams looked at the current epidemiology in each country (burden of disease, the state of the treatment cascade, epidemiology for specific key populations, etc.) along with the current funding availability across donors and host country governments. For each country, the team analyzed what resources would be required to achieve the specific objective outlined in the COP19 and what funding PEPFAR could contribute to a national disease response. In these countries with robust GF and host-country government support, PEPFAR will focus on specific target populations and catalytic points. In countries such as Burkina Faso and Togo, where the national response has made progress without PEPFAR support, the West Africa team has sought to calculate the costs necessary to achieve 90-90-90 epidemic control and the timeline for achieving this, using game-changer funds.

Unclassified

APPENDIX D– Minimum Program Requirements

Policy	Ghana	Mali	Liberia	Senegal	Togo	Burkina Faso
Test and Start for all PLHIV	Completed and implemented with fidelity	A test and start policy is in place but not implemented with fidelity. A working group is developing SOPs to improve implementation	Policy adopted. PEPFAR will roll out with fidelity	Policy adopted. Implemented in some sites, but not consistently implemented with fidelity	For KP, Pregnant Women and Children. Currently updating their Test & Start policy to expand to all populations and will disseminate the policy and commence implementation by May/June 2019.	Policy in place, PEPFAR supported intensification to reach fidelity
Differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models	Completed and implemented with fidelity	A DSD policy has been adopted and a roll-out plan developed. A training for providers on DSD is being prepared. Goal is for 3 month prescribing/dispensing to be in place by the time the TLD transition is finished.	Guidelines in place. PEPFAR support will roll-out including MMP/D.	Limited multi-month scripting (3 months only), tied to systemic supply chain issues	Government directive for 3 months for 3 months MMS/D for stable patients is in place and is being implemented. An official policy will be developed by the end of 2019	MMS/D currently at 3 months for stable patients due to resource constraints for ARVs. Policy will be developed to extend to 6 months, by the end of 2019
TLD transition	Guidelines are finalized. Implementing transition July-December 2010	Transition plan under development. First order is expected to arrive in September 2019.	Government agreement on TLD transition. Updated guidelines pending Minister's signature. Detailed transition plan to be developed before the end of 2019	Transition plan under development with the support of WHO. First order is expected to arrive in September 2019	Government agreement for TLD transition. Detailed plan to be developed before the end of 2019	A TLD transition plan will be developed by May 2019.

Unclassified

Index testing	Implemented by PEPFAR. Partner notification included in policy. PEPFAR to support roll-out in Western Region	A national-level policy is being revised to include index testing. Index testing expansion estimated to take place by September 2019	Policy in place. PEPFAR will support roll-out.	In national strategic 2019-2022. Started index testing in Dakar (1 site) and will be conducting in all PEPFAR sites	Implemented by PEPFAR supported sites. Not systematic in other sites. PEPFAR will roll out	Implemented by PEPFAR supported sites. Not systematic in other sites. PEPFAR will support roll out.
Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Policy in place. PEPFAR to support implementation with fidelity	Direct and immediate linkages of care not yet implemented with fidelity. Strategies to increase immediate linkage to treatment include expansion of treatment services to the community level. National policy to be revised to include direct and immediate (>95%) linkage of clients.	Political will and policy are present but not implemented with fidelity. PEPFAR to support roll out	Senegal has good linkage results, need to track anomalies closely. Senegal's PEPFAR strategy includes increasing linkages to treatment at facility, mobile and community levels	Data only available at PEPFAR sites 84% at Q1. Additional refinements to be made	Data only available at PEPFAR sites 91% at Q1. Additional refinements to be made.
Elimination of formal and informal user fees	Services and drugs for PLHIV are free. Informal fees apply for those uninsured	A policy is in place forbidding user fees for HIV services. Fees not charged for HIV testing or treatment. Informal user fees have been found in some facilities; actions are taking place to monitor and address them.	Policy eliminating user fees for treatment initiation exists. Free HIV testing, ARVs, TB drugs. Informal user fees exist, particularly for STI treatment. Private sector charges registration fees while drugs and services are free	Policy eliminating fees for HIV testing and ART initiation exists. However, informal user fees exist while on treatment, such as lab testing and STI treatment. Efforts to incorporate HIV/AIDS services into community health insurance efforts are underway.	Policy eliminating user fees for treatment initiation exists. Free HIV, CTM, CD4, CV, TB drugs. However, informal user fees may exists	Policy eliminating user fees for treatment initiation exists. Free HIV, CTM, CD4, CV, TB drugs. However, informal user fees may exists

Unclassified

VL/EID optimization	Above site VL scale up	Currently little VL testing capacity across the country. FY20 solution: sample referral transport system to bring VL samples to regional and national lab for testing, including PEPFAR supported sites. FY21 and beyond: TA to improve VL and EID optimization	Major VL challenges. Advocate for Viral Load Management policy to be adopted and implemented with fidelity, Monitor Scale-Up	CHAI and UNICEF supports Senegal in implementing point of care for testing and viral load suppression -- active in 3 out of 4 PEPFAR sites.	Significant challenges in VL. PEPFAR to invest in lab strengthening and VL scale up	
Unique Identifier Code for all PLHIV	UIC for KP in PEPFAR-supported sites	PEPFAR and GF have piloted the UIC for their respective key population programs. A national policy is being considered by GoM to expand UICs nationally	MOH UIC in place, KP code being added	CDC supported a UIC system (SENECAS) that will be implemented in all PEPFAR sites and will be harmonized with DHSI2.	UIC exists for both KP and all PLHIV	UIC exists for both KP and all PLHIV
Scale-up of TPT for all PLHIV	A policy exists but has not been implemented with fidelity.	N/A	N/A	N/A	A policy exists but has not been implemented with fidelity,	A policy exists but has not been implemented with fidelity.
Evidence of resource commitments by host governments with year after year increases	Increased contribution to health; USG program advocates for DRM	Ministry of Health and the National HIV/AIDS Council advocate for additional funds but the overall health budget has been steadily decreasing (along with other social sectors) due to the costs associated with the country's security challenges. GOM has committed to funding HR for health after GF pulls out of human resources funding at the end of CY2019.	High-level advocacy for more targeted resources for health	GF agreement includes a scale up of GOS financing for commodities	Increase up to 26% the domestics resources in 2017 (compare to 2016). Advocacy will continue by CSO and partners	60% of HIV/AIDS program is domestically resourced. This could potentially be decreased given GOBF investments in security

Unclassified

APPENDIX E – Addressing Gaps to Epidemic Control including through Communities of Faith receiving central funds

Appendix E is Not Applicable to the West Africa Regional program

Unclassified

Tables and Systems Investments for Section 6.0

Unclassified

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	GHANA AIDS COMMISSION	13475	ASP: HMIS, surveillance, & research	$ 50,000.00	Support generation of annual national and sub-national estimates, down to the district level, for data on PLHIV estimates, incidence, deaths, and ART coverage, through training, TA, generation of estimates, and dissemination of results.	HMIS systems	Surveillance and survey capacity to collect and analyze data to monitor the HIV epidemic is strenthened	COP19	2018 national and sub-national (regional and district) estimates published by May 2019
HHS/CDC	GHANA AIDS COMMISSION	13475	ASP: HMIS, surveillance, & research	$ 15,000.00	Ongoing training and monitoring for Ghana's key population data management and unique identifier system (GKPUIS) for use and reporting by CSOs working with key Populations, through data entry and use to support a KP cascade.	Training in HMIS systems or processes	Good data system in place and data used for decision making and improving quality of services	COP19	1) 2 Stakeholder meeting held on GKPUIS 2) 30 CSO Data base administrators and supervisors staff trained on Use of GKPUIS 3) 50 CSO front line peer educators, navigators and care givers staff trainined in the use of GKPUIS 4) GKPUIS Go Live Launch
HHS/CDC	Ghana Health Service/National AIDS Control Programme	11951	ASP: HMIS, surveillance, & research	$ 40,000.00	Support the deployment, data quality assessments, and monitoring of the viral load data management system (VLDMS) and eTracker.	HMIS systems	Good data system in place and data used for decision making and improving quality of services	COP17	1) Reporting of key Indicators; TX_CURR, TX_NEW, and VL from eTracker 2)
HHS/CDC	Ghana Health Service/National AIDS Control Programme	11951	ASP: HMIS, surveillance, & research	$ 25,000.00	Support eTracker annual refresher training for data officers and maintain subscription of eTracker server	Training in HMIS systems or processes	Surveillance and survey capacity to collect and analyze data to monitor the HIV epidemic is strenthened	COP18	1) Four trainings on data entry and analysisusing off line version of etracker conducted 2) Server subscription purchased

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
DOD	HEALTH CRESCENDOS FOUNDATION	18424	ASP: Laws, regulations & policy environment	$ 92,000.00	Assessing the impact of policies and regulations on HIV.	Assessing impact of policies and regulations on HIV	Reduced stigma and discrimination against all PLHIV, including KPs	COP17	GAF members demonstrate a 25% decrease in perceived discrimination scores as measured by the Genberg Stigma scale from baseline data observed in 2016 SABERS
DOD	HEALTH CRESCENDOS FOUNDATION	18424	ASP: Human resources for health	$ 100,000.00	Training health care workers to effectively counsel positives in prevention, adherence, and finding positives. Prevention: participants will understand why it is important to use protection while having intercourse in order to protect their loved ones and sexual partners. Adherence: participants will understand the importance of taking ARVs regularly and showing up to medical appointments; they will understand the importance of achieving a suppressed viral load and U=U (also part of prevention). Finding Positives: participants will understand the importance of partner notification and index case testing and will bring their sexual partners in for testing.	Institutionalization of in-service training	Scale up of Index Testing and HIV Self-testing (HIVST), and enhanced KP positive case finding.	COP19	20 health care workers trained in PHDP implementation, including active tracking of LTFU patients and proactive partner notification strategy

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	Ghana Health Service/National AIDS Control Programme	11951	ASP: Laboratory systems strengthening	$ 20,000.00	1) Enroll VL testing sites into an external EQA program provided by IRESSEF/CADU in Senegal. 2) Conduct routine monitoring and supervision using the viral load score card 3) Support non-performing sites with corrective action TA.	Lab quality improvement and assurance	Lab infrastructure and technical capacity strengthened to facilitate optimization of VL/EID diagnostics	COP19	1) Revise specimen referral network in western region (sample transport and results reporting) based on COP16 pilots 2) Expand specimen referral network to 3 other regionsthat support Vl testing for the western region 3) Western Regional training for all ART sites on proper sample collection and packaging. 4) PHASE 1 of accreditation process completed in 3 labs 5) Monitor efficacy of sample referral network (VL Scorecard)
HHS/CDC	Association of Public Health Laboratories, Inc. (THE)	18428	ASP: Laboratory systems strengthening	$ 80,000.00	1) Mapping expansion of the sample referral and results transmission system to cover all ART sites in western region. 2) Revision of sample referral system quality indicators 3) Conduct refresher training for courier staff on sample transportation and hazard management 4) Train ART center staff on sample management (sample collection, processing, and packaging) 5) Conduct monitoring and corrective action visits to viral load testing sites	Lab quality improvement and assurance	Lab infrastructure and technical capacity strengthened to facilitate optimization of VL/EID diagnostics	COP17	Revise specimen referral network (sample transport and results reporting) based on COP16 pilots 2) Expand specimen referral network to 3 other regions (total of 5). GF will manage the other 5 regions. 3) National training for all ART sites (in collaboration with GF) on proper sample collection and packaging. 4) PHASE 1 of accreditation process completed in 7 labs 5) Monitor efficacy of sample referral network (VL Scorecard)

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	Association of Public Health Laboratories, Inc. (THE)	18428	ASP: Laboratory systems strengthening	$ 100,000.00	1) Provide onsite mentorship and training for SPHL and one center of excellence at Korle-Bu using the SLMTA module 2) Enroll one of the CoE into an international accreditation program for VL testing	Lab accreditation	Lab infrastructure and technical capacity strengthened to facilitate optimization of VL/EID diagnostics	COP19	VL Baseline Assessment Conducted Sites receiving mentorship Two LQMS training completed
HHS/CDC	Association of Public Health Laboratories, Inc. (THE)	18428	ASP: Laboratory systems strengthening	$ 65,000.00	Support final developments of the VL load Data management system and complete installation and configuration of the VL Data management system with Interphase of the VL data managementwit DHIMS II and Etracker.	Training in laboratory systems strengthening	Good data system in place and data used for decision making and improving quality of services	COP19	1) Revise specimen referral network in western region (sample transport and results reporting) based on COP16 pilots 2) Expand specimen referral network to 3 other regionsthat support Vl testing for the western region 3) Western Regional training for all ART sites on proper sample collection and packaging. 4) PHASE 1 of accreditation process completed in 3 labs 5) Monitor efficacy of sample referral network (VL Scorecard)
HHS/CDC	Ghana Health Service/National AIDS Control Programme	11951	ASP: HMIS, surveillance, & research	$ 10,000.00	Training of Regional-level health Information officers in data use and management	Program and data quality management	Good data system in place and data used for decision making and improving quality of services	COP17	1) eTracker updated with required fields in data entry screens. 2) Report content and style drafted for eTracker development team. 3) 2 trainings delivered on data use and management 4) 30 GHS staff trained on data use and management

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	Chemonics International, Inc.	18415	ASP: Procurement & supply chain management	$ 480,141.00	- Forecasting and Procurement Planning to ensure sufficient stock to reach test and start targets and eliminate/minimize wastage; - Last Mile Distribution to timely position ARVs (and other HIV related commodities) at SDPs to ensure uninterrupted HIV treatment, better retention and viral load suppression; - TLD transition to meet minimal PEPFAR requirement, to ensure better retention and VL suppression; - LMIS to provide timely and accurate data for improved patient management; - Support GoG MMD efforts to improve retention and viral load suppression; and - Improve Supply Chain oversight at regional level	Forecasting, supply chain plan, budget, and implementation	National commodity security and supply chain management systems (quantification, forecasting and distribution), strengthened to ensure PLHIV have access to appropriate ART	COP16	- Manage coordinated private sector storage, warehouse and distribution system for USG and GF donated commodities; - Operationalize integrated LMIS for improved data visibility; - Quantification and forecasting of HIV and lab commodities using actual and realistic consumption data from facilities; - Regional and central monthly stock status reports available; - Site monitoring visits to 20 ART facilities; and - Strengthen regional and central warehouse management
HHS/CDC	Institut National De Recherche En Santé Publique	81287	ASP: HMIS, surveillance, & research	$ 150,000.00	Provide technical assistance to GOM and GF to improve data quality, analysis and data use for better programming for KP (size estimation, surveillance data, cascade analysis)	Surveillance	Surveillance and survey capacity to collect and analyze data to monitor the HIV epidemic is strenthened	COP18	Stakeholders including GF, MOH, HNLS, INRSP, UNAIDS discussions on TOR and approved protocols by June 2019.
HHS/CDC	COMITE SECTORIEL DE LUTTE CON TRE LE SIDA DU MINISTE	81286	ASP: Laboratory systems strengthening	$ 75,000.00	Provide technical assistance to GOM to develop and implement viral load policy	Lab policy, budgets, and strategic plans	Lab infrastructure and technical capacity strengthened to facilitate optimization of VL/EID diagnostics	COP19	Consttute a national task force to develop the viral load scale up policy

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	COMITE SECTORIEL DE LUTTE CON TRE LE SIDA DU MINISTE	81286	ASP: Laboratory systems strengthening	$ 100,000.00	Provide technical assistance to GOM to train 200 laboratory and clinical personnel on DBS training across 7 regions and 67 districts	Lab quality improvement and assurance	Lab infrastructure and technical capacity strengthened to facilitate optimization of VL/EID diagnostics	COP19	1. DBS training materials updated 2. Lab technicians identified for the training
HHS/CDC	COMITE SECTORIEL DE LUTTE CON TRE LE SIDA DU MINISTE	81286	ASP: Laboratory systems strengthening	$ 225,000.00	Provide technical support to improve sample referral system, sample referral logistic and documentation	Laboratory infrastructure	Lab infrastructure and technical capacity strengthened to facilitate optimization of VL/EID diagnostics	COP19	1. Expand specimen referral network to 3 regions by end of Q4. GF will manage the other 5 regions 2. Complete national training for all ART sites (in collaboration with GF) on proper sample collection and packaging by Q4. 3. Conduct 4 monitor visits to assess the efficacy of sample referral network (VL Scorecard)
HHS/CDC	COMITE SECTORIEL DE LUTTE CON TRE LE SIDA DU MINISTE	81286	ASP: Laboratory systems strengthening	$ 150,000.00	Provide technical assistance to GOM for lab infrastructure and technical capacity strengthen to facilitate optimization Viral load diagnostic	Laboratory infrastructure	Lab infrastructure and technical capacity strengthened to facilitate optimization of VL/EID diagnostics	COP19	Lack of quality control on viral load
HHS/CDC	Institut National De Recherche En Santé Publique	81287	ASP: Policy, planning, coordination & management	$ 100,000.00	Provide technical assistance to GOM for supportive supervision to monitor the implementation of the testing strategies, Viral load, care and treatement and case based surveillance provide feedback for better improvement	National strategic plans, operational plans and budgets	Good data system in place and data used for decision making and improving quality of services	COP19	Technical group established at MOH/ HCNLS to analyse and improve data quality for decision making

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	FHI Development 360 LLC	81294	ASP: HMIS, surveillance, & research	$ 125,000.00	Project strategic information	Program and data quality management	Good data system in place and data used for decision making and improving quality of services	COP19	100% of Data on MERS and customs indicators available
USAID	FHI Development 360 LLC	81294	ASP: Policy, planning, coordination & management	$ 100,000.00	Support evidence based strategies implementation	Clinical guidelines, policies for service delivery	Scale up of Index Testing and HIV Self-testing (HIVST), and enhanced KP positive case finding.	COP19	4 Local NGO under LINKAGES trained on index testing
USAID	Chemonics International, Inc.	81295	ASP: Procurement & supply chain management	$ 118,000.00	Provide support for technical assistance in procurement and supply chain management	Forecasting, supply chain plan, budget, and implementation	Good data system in place and data used for decision making and improving quality of services	COP19	Reagent stock out less that 30 days
USAID	FHI Development 360 LLC	81280	ASP: HMIS, surveillance, & research	$ 107,250.00	Linkages will work with MOH and NACP to review HMIS and LMIS reporting at target facilities and to ensure/update the current systems for compatability with PEPFAR and DATIM reporting requirements. This will include a detailed review of current data and trends as well as reporting systems. This will also include scale-up of a harmonized UIC between the MOH unique identifier and the Global Fund supported unique identifier. This excercise will be conducted on a quarterly basis starting in COP18. By the start of COP19 the harmonized UIC will be in place so Q1 will include final scale-up activities.	HMIS systems	Good data system in place and data used for decision making and improving quality of services	COP19	Harmonized UIC agreed on; HMIS reporting systems aligned to PEPFAR requirements.

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	FHI Development 360 LLC	81280	ASP: Policy, planning, coordination & management	$ 136,786.00	Building on recently (Q1 2018) finalized differentiated service delivery guidelines which were developed by the MOH with support from Global Fund, Linkages will support implementation and roll out to decentralized levels. This will include roll out of index testing, currently being piloted. This activity will start in ROP18 and reach full scale-up in Q1 of ROP19.	Oversight, technical assistance, and supervision to subnational levels	Adoption and implementation of differentiated service delivery (DSD) models, including multi-month prescribing/dispensing (MMP/D) and delivery models to improve identification and ARV coverage of PLHIV, including KPs.	COP19	Differientiated models rolled out at target facilities in Greater Monrovia and index testing in place.
USAID	Chemonics International, Inc.	81281	ASP: Procurement & supply chain management	$200,000	The supply chain in Liberia is extremely weak and HIV has recieved little to no support to date. PSM will provide TA to develop a transition plan for TLD in coordination with Global Fund and will support inventory and commodity managment at focus PEPFAR facilities. This will include VL requirements. PSM will support staff training and mentorship on LMIS reporting and use. These activities will start in COP18 and reduce in intensity through ROP19.	Forecasting, supply chain plan, budget, and implementation	National commodity security and supply chain management systems (quantification, forecasting and distribution), strengthened to ensure PLHIV have access to appropriate ART	COP19	HIV quantification completed and forecast planning conducted. TLD transition plan in place.
USAID	Palladium International, LLC	81437	ASP: Laws, regulations & policy environment	25,000	Reduce stigma and discrimination against PLHIV and KPs through training, education and supervision of health staff on the provision of KP friendly services.	Information and sensitization for public and government officials	Reduced stigma and discrimination against all PLHIV, including KPs	COP18	Stigma and discrimination reduction activities are implemented in all PEPFAR supported sites

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	Chemonics International, Inc.	81438	ASP: Procurement & supply chain management	300,000	Provide technical assistance to Host Government on supply chain management (forecasting, management of supply chain information system, EDT, and early warning system OPSIDA) Provide Technical assistance on development and implementation of TLD transition plan	Forecasting, supply chain plan, budget, and implementation	Good data system in place and data used for decision making and improving quality of services	COP19	TLD transition and removal of Nevirapine-based regimens plan are in place by FY19 Q4
USAID	WEST AFRICAN HEALTH ORGANISAT ION	81058	ASP: Laws, regulations & policy environment	50,000	Reduce stigma and discrimination against PLHIV and KPs through training, education and supervision of health staff on the provision of KP friendly services.	Information and sensitization for public and government officials	Reduced stigma and discrimination against all PLHIV, including KPs	COP18	Stigma and discrimination reduction activities are implemented in all PEPFAR supported sites
USAID	Chemonics International, Inc.	81059	ASP: Procurement & supply chain management	$ 200,000.00	Provide technical assistance to Host Government on supply chain management (forecasting, management of supply chain information system, EDT, and early warning system OPSIDA) Provide Technical assistance on development and implementation of TLD transition plan	Forecasting, supply chain plan, budget, and implementation	Good data system in place and data used for decision making and improving quality of services	COP19	Discussion began with Host Government for TLD transition and removal of Nevirapine-based regimens
USAID	INTRAHEALTH INTERNATIONA L, INC.	81364	ASP: Laws, regulations & policy environment	$ 15,000.00	Training for medical officers, providers, police and providers on stigma, discrimation, human rights	Information and sensitization for public and government officials	Reduced stigma and discrimination against all PLHIV, including KPs	COP19	Country continue to implement the Dakar Declaration on KP

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	COMITE SECTORIEL DE LUTTE CON TRE LE SIDA DU MINISTE	81286	ASP: Laboratory systems strengthening	$ 50,000.00	Viral load demand creation campaign	Lab quality improvement and assurance	Lab infrastructure and technical capacity strengthened to facilitate optimization of VL/EID diagnostics	COP19	1. Commence viral load demand creation activities by Q2 2. 40% increase in viral load requisitions