



**United States Department of State**

*Washington, D.C. 20520*

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January 16, 2020

COP 2020 Planning Level Letter | PART 2

**INFORMATION MEMO FOR AMBASSADOR STEPHANIE SULLIVAN, WEST AFRICA REGION**

**SUBJECT: Fiscal Year (FY) 2020 PEPFAR Planned Allocation and Strategic Direction**

With input from the field teams through the quarterly POART calls and from the Headquarters Country Accountability and Support Team (CAST), we have thoroughly reviewed progress of the program in your region over time and specifically the end-of-year results of the Country Operational Plan (COP) 2018 and current ROP 2019 implementation as we plan for ROP 2020. We have noted the following key successes and specific areas of concern:

In the West Africa Regional Program, the sharing of expertise and experience by the USG agencies operating in the former PEPFAR STAR and F-Op countries of West Africa – as envisioned by the regional realignment that began in late 2018 – has largely been very successful, as evidenced by the programmatic pivots and improvements in efficiency and effectiveness that have occurred over the past year. Further interagency collaboration should continue to improve PEPFAR program performance in the West Africa Region. In this regard, beginning with ROP20, we are pleased that the U.S. Health Resources and Services Administration (HRSA) will join the West Africa ROP; HRSA currently conducts HIV/AIDS activities in Liberia and Sierra Leone under PEPFAR central funds.

As noted on numerous occasions, adoption and implementation with fidelity of PEPFAR's minimum program requirements (MPRs) are essential to the success of any program to combat HIV/AIDS at the national, sub-national, community, and/or service-delivery levels. Evidence continues to demonstrate that deficiencies in any of the MPRs significantly undermines efforts to reach epidemic control and results in inefficient and ineffective programs. We note and applaud the significant improvements achieved on adoption and implementation of the MPRs in the West Africa Region over the past year, notably in the areas of index testing, unique identifier codes (UICs), transition to TLD, and multi-month ARV dispensing (MMD). However, implementation of the MPRs beyond PEPFAR sites generally lags behind the high level of implementation at PEPFAR sites, and PEPFAR teams must continue to encourage and ensure adoption and implementation with fidelity of the MPRs across each country.

Region-wide, while there has generally been mixed improvement over the past year in the national clinical cascades and the number of PLHIV on treatment has risen, the overall cascades remain highly concerning, especially in the first and third 90s. Burkina Faso, Senegal, and Togo

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are making progress toward epidemic control, while Ghana's progress on reducing new infections and deaths of PLHIV has stalled and new infections in Mali are rapidly increasing (AIDS Info 2018). Testing yields and linkage to treatment, while improved, generally have room for significant enhancement. In ROP20, closing the gaps at all levels of the clinical cascade must be a priority. All countries must continue scaling client-centered approaches, such as the use of peer navigators and case managers, to improve testing, linkage to treatment, and retention. Continued improvements in index testing is key, and loss-to-follow-up (LTFU) must be minimized. VL/EID optimization, supply chain management, and national monitoring and evaluation systems must be intensified, and increased domestic investments in these and other areas must be encouraged.

## SECTION 1: COP/ROP 2020 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total ROP 2020 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by the implementing agencies.

**Table 1. West Africa Region ROP 2020 Total Budget including Applied Pipeline**

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
<b>Total New Funding</b>	\$ 31,302,500	\$ 7,063,568	\$ -			\$ 38,366,068
GHP-State	\$ 30,799,449	\$ 7,063,568	\$ -			\$ 37,863,017
GHP-USAID	\$ -	\$ -	\$ -			\$ -
GAP	\$ 503,051	\$ -	\$ -			\$ 503,051
<b>Total Applied Pipeline</b>				\$ 6,660,932	\$ 3,309,389	\$ 9,970,321
DOD				\$ 1,189,478	\$ -	\$ 1,189,478
HHS/CDC				\$ 1,676,969	\$ -	\$ 1,676,969
HHS/HRSA				\$ -	\$ -	\$ -
PC				\$ -	\$ -	\$ -
State				\$ -	\$ -	\$ -
USAID				\$ 3,794,485	\$ 3,309,389	\$ 7,103,874
<b>TOTAL FUNDING</b>	\$ 31,302,500	\$ 7,063,568	\$ -	\$ 6,660,932	\$ 3,309,389	\$ 48,336,389

*\*Based on agency reported available pipeline from EOFY 2019, including KPIF Year 2 and Game-Changer Year 2.*

**Table 1a. West Africa Region ROP 2020 Country Allocations**

WEST AFRICA REGION					
TOTAL ROP 2020 PLANNING LEVEL: \$48,336,389					
Total Base Budget for ROP 2019 Implementation:		\$25,980,000			
Total ROP20 Base Funds	\$	37,963,432	Game-Changer Year 2	KPIF Year 2*	Total ROP20 Funds
<i>of which, Burkina Faso</i>	\$	2,203,767	\$ 4,296,233	\$ 477,841	\$ 6,977,841
<i>of which, Ghana</i>	\$	9,000,000		\$ 496,215	\$ 9,496,215
<i>of which, Liberia</i>	\$	6,500,000		\$ 349,620	\$ 6,849,620
<i>of which, Mali</i>	\$	5,750,000		\$ 399,266	\$ 6,149,266
<i>of which, Senegal</i>	\$	6,000,000		\$ 498,957	\$ 6,498,957
<i>of which, Sierra Leone</i>	\$	5,000,000			\$ 5,000,000
<i>of which, Togo</i>	\$	2,759,665	\$ 2,767,335	\$ 477,333	\$ 6,004,333
<i>of which, West Africa Region M&amp;O</i>	\$	750,000		\$ 610,157	\$ 1,360,157
<b>Totals:</b>	<b>\$</b>	<b>37,963,432</b>	<b>\$ 7,063,568</b>	<b>\$ 3,309,389</b>	<b>\$ 48,336,389</b>

\*KPIF Year 2 excess pipeline breakdown by country from FY19 EOFY Tool

## SECTION 2: ROP 2020 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS\*\*

Countries should plan for the full Care and Treatment (C&T) level of \$5,000,000, at a minimum, across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

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

**Table 2. ROP 2020 Earmarks**

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	\$ 5,000,000	\$ -	\$ -	\$ 5,000,000
OVC	\$ -	\$ -	\$ -	\$ -
GBV	\$ 343,400	\$ -	\$ -	\$ 343,400
Water	\$ -	\$ -	\$ -	\$ -

**Table 3. Total ROP 20 Initiative Funding**

	COP 20 Total
<b>Total Funding</b>	<b>\$ 7,063,568</b>
VMMC	\$ -
Cervical Cancer	\$ -
DREAMS	\$ -
HBCU Tx	\$ -
COP 19 Performance	\$ -
HKID Requirement	\$ -
Game Changer Year 2	\$ 7,063,568

**Ambition Funds:** \$15,000,000 has been set aside as one-year ROP20 Ambition Funds for the PEPFAR Regional Programs (Asia, Western Hemisphere, and West Africa). Within the West Africa Regional Program, Liberia, Mali, and Senegal shall be eligible for these Ambition Funds. Country teams, including agencies independently, can request a portion of these Ambition Funds, additive to the ROP20 notational budget, by submitting a request to OGAC by February 4, 2020. More details on eligibility and how to apply for Ambition Funds is forthcoming from OGAC. Approved projects will be included in the draft FAST(s) to be submitted prior to the Johannesburg ROP20 meeting, based on their stated increased ambition in Treatment/Prevention, with commensurate increased partner-level targets. Eligibility will apply only to partners with the highest performance with evidence that they are addressing the one of the critical gaps outlined above. Budget requests must be consistent with the cost of expanded targets and address one of the programmatic gaps noted in this memo. These requests should be discussed with the Chair and PPM during the January Regional Strategic Retreat and tentatively approved and be submitted with the DataPack(s) and FAST(s). The final budget and associated country-level targets will be discussed and approved during the Johannesburg meeting.

### SECTION 3: PAST PERFORMANCE – COP 2018 Review

**Table 4. OU-Level FY19 Program Results (COP18) and FY20 Targets (ROP19)**

Indicator	FY19 result (COP18)	FY20 target (ROP19)
<b>TX Current Adults</b>	<b>14,298 (Ghana only)</b>	<b>83,485 (all 6 countries)</b>
<i>of which, Burkina Faso</i>		<b>21,319</b>
<i>of which, Ghana</i>		<b>16,648</b>
<i>of which, Liberia</i>		<b>3,581</b>
<i>of which, Mali</i>		<b>3,753</b>
<i>of which, Senegal</i>		<b>3,101</b>
<i>of which, Togo</i>		<b>35,083</b>
<b>TX Current Pediatrics</b>	<b>3,241 (Ghana only)</b>	<b>7,194 (all 6 countries)</b>
<i>of which, Burkina Faso</i>		<b>1,480</b>
<i>of which, Ghana</i>		<b>3,307</b>
<i>of which, Liberia</i>		<b>0</b>
<i>of which, Mali</i>		<b>0</b>
<i>of which, Senegal</i>		<b>0</b>
<i>of which, Togo</i>		<b>2,407</b>
<b>VMMC among males 15 years or older</b>	<b>n/a</b>	<b>n/a</b>
<b>DREAMS</b>	<b>n/a</b>	<b>n/a</b>
<b>Cervical Cancer</b>	<b>n/a</b>	<b>n/a</b>

TB Preventive Therapy	n/a	n/a
TB Treatment of HIV Positive (TX TB)	n/a	n/a

**Table 5. Ghana COP 2018 | FY 2019 Agency-level Outlays versus Approved Budget**

OU/Agency	Sum of Approved COP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
<b>Ghana</b>			
DOD	375,000	352,649	22,351 (under)
HHS/CDC	2,833,504	2,532,782	300,722 (under)
HHS/HRSA	n/a	n/a	n/a
PC	n/a	n/a	n/a
State	75,000	33,164	41,836 (under)
State/AF	40,000	30,000	10,000 (under)
State/SGAC	n/a	n/a	n/a
USAID	8,610,214	7,085,001	1,525,213 (under)
<b>Grand Total</b>	<b>11,933,718</b>	<b>10,033,596</b>	<b>1,900,122 (under)</b>

\*Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.

**Table 6. Ghana COP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget**

Mech ID	Prime Partner	Funding Agency	COP/ROP18/FY19 Budget (New funding + Pipeline + Central)	Actual FY19 Outlays (\$)	Over/Under FY19 Outlays (Actual \$ - Total COP/ROP18 Budget \$)
17326	Palladium Group	USAID	\$181,874	\$309,781	(\$127,907)

\*Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.

**Table 7. Ghana COP 2018 | FY 2019 Results & Expenditures**

Agency	Indicator	FY19 Target	FY19 Result	% Achievement	Program Classification	FY19 Expenditure	% Service Delivery
HHS/CDC	HTS_TST				HTS Program Area		
	HTS_TST_POS						
	TX_NEW				C&T Program Area		
	TX_CURR					437,968	0%
	VMMC_CIRC				VMMC		
OVC_SERV				OVC			
DOD	HTS_TST				HTS Program Area		
	HTS_TST_POS						



gap toward achieving epidemic control. In FY19, quarterly yield averaged 8.3% and linkage was approximately 93.8%. However, given that UNAIDS estimates that MSM prevalence is 27.6% and FSW prevalence is 6.6%, yields had room for improvement. Early ROP19 performance from the eight sites in Senegal has witnessed a remarkable increase in testing, and the yield of 14.4% is much better compared to FY19. A 97% linkage rate in early ROP19 is encouraging and must be maintained.

In **Liberia**, the pivot to KP-focused sites in Monrovia has been especially successful, with FY19 targets being achieved in only two quarters and linkage of over 100% due to enrollment of pre-ART patients. The index testing cascade was particularly notable, with more than three contacts elicited per index patient and 13% yield. While it is currently very early in ROP19 implementation, the yield of 6.1% and a linkage rate of 86% at the 18 sites in Liberia have room for improvement. Significant gaps exist across the clinical cascade, and yield and linkage goals must be at least 20% and 95% respectively. The very substantial gap in viral load testing and suppression is a particularly serious concern. We note that at HRSA-supported sites in Maryland County in FY19, of an estimated 3,100 PLHIV enrolled, only 700 were on ART.

In **Mali**, the pivot initiated in late 2018 to focus on three regions in the southern half of the country has largely proven successful, with index testing, EPOA, and escorted referral being implemented. While a majority of PLHIV who know their status are on treatment, Mali's largest gap is in the first 90, as only a third of PLHIV know their status – further accelerating the rate of new infections. The third 90 is also a gap of particular concern. In FY19, there were notable quarter-on-quarter improvements in yield and linkage, averaging 5.2% and 78.8% respectively, as index testing and DSD were introduced – index testing produced a yield of 28.8% and EPOA produced a yield of 8.1%. With a yield of only 4.1%, mobile clinic testing should be examined for discontinuation. As ROP19 has been implemented at the 13 sites in Mali, early results indicate a yield of 10.3% and a linkage rate of 82%, indicating a need for additional effort.

Continued outstanding program performance in **Burkina Faso** and **Togo**, particularly in the areas of testing yield and linkage to treatment, provides further confidence in achieving the 90-90-90 targets at PEPFAR sites in ROP19. In Burkina Faso, where PEPFAR only operated at 2 sites in FY19, the program implemented test and start while adopting index testing/EPOA, risk assessment, and escorted referral strategies. Yield averaged 10.5% and linkage averaged 91%, with consistent TX\_CURR growth throughout the year. Index testing produced a yield of 26.7% in Q4, but at less than 1:1, the rate of HTS\_INDEX reach per HTS\_POS needed improvement. With the launch of ROP19 and expansion to 17 sites, early results indicated a yield of 16.6% and a linkage rate of 97%. We note that the current TX\_CURR of over 24,000 is one quarter of the estimated 96,000 PLHIV in all of Burkina Faso (at just 17 sites). In Togo, where PEPFAR operated at only 2 KP-focused sites in FY19, the program concentrated on implementing test and start while launching index testing, risk assessment, and escorted referral approaches for KPs. The program grew from 292 to 1,323 patients in FY19 (1,031 new patients, an over 4-fold increase at just those two sites). Yield had a quarterly average of 17%, but a slight Q4 drop is of some concern. Linkage improved from 84% in Q1 to 100% in Q4. Index testing yield was 24.7% in Q4, but at 0.6, the rate of at least 1 HTS\_INDEX per HTS\_POS was not reached. With the launch of ROP19 and expansion to 25 sites, early testing yields are approximately 18% and linkage is approximately 98%. The current TX\_CURR of 29,420 is over one quarter of the

estimated 110,000 PLHIV in all of Togo at just the 25 PEPFAR sites.

In **Sierra Leone**, the clinical cascade largely mirrors that of the rest of the region, with gaps in all three 90s, particularly the first and third 90. Of note are the estimated 240,000 sex workers in Sierra Leone – far more than any other country in the region. HRSA’s efforts over the past year have evolved to emphasize differentiated testing strategies, linkage to care, and supply chain strengthening. Index testing, launched in September 2019 at five pilot facilities, resulted in an impressive 2.3 contacts/case, 29% yield, and a 96% linkage rate.

#### SECTION 4: COP/ROP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements in place no later than the beginning of COP 2019 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs.

For ROP 2020, the failure to meet any of these requirements will result in reductions to the West Africa Regional budget (see Section 2.2. of COP Guidance).

**Table 8. ROP 2020 (FY 2021) Minimum Program Requirements**

	<b>Minimum Program Requirement</b>	<b>Status</b>	<b>Outstanding Issues Hindering Implementation</b>
<b>Care and Treatment</b>	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. <sup>1</sup>	By the start of ROP19, Test and Start had been adopted and implemented in the 6 West Africa Region countries (Burkina Faso, Ghana, Liberia, Mali, Senegal, and Togo). Sierra Leone, which will be added to the Region in ROP20, has adopted Test and Start, but implementation with	For all 7 countries in the West Africa Regional Program in ROP20, implementation with fidelity of Test and Start beyond PEPFAR-supported sides needs to improve. Linkage rates have generally been improving, but countries need to ensure the needs of all groups are being met,

<sup>1</sup> Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

		fidelity lags due to gaps in supply chain. All countries in the region are making progress toward >95% linkage for all groups.	including KPs who face strong stigma and discrimination in the region.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing $\geq 20$ kg, and removal of all nevirapine-based regimens. <sup>2</sup>	The transition to TLD has begun in all 7 countries, with varying degrees of implementation based on availability of TLD and existing previous regimens. Nevirapine-based regimens for adults have generally been eliminated. DTG-based regimens for children are slower in being rolled out.	Complete transition to TLD will require supply chain interventions to better forecast, order, and finance ARV purchases. Some countries are still in the process of adopting TLD for women of childbearing potential. Pediatric regimens generally lag behind those for adults.
	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents. <sup>3</sup>	All 7 countries in the region have adopted policies for multi-month dispensing and are routinely available at most PEPFAR-supported sites (3 or 6 months). The use of differentiated and client-centered delivery models, including community-based peer mentors, is being rolled out across the region.	Lack of ARV availability is the primary hindrance to full implementation of 6-month MMD. Training down the clinician level on clinical criteria which need to be met for eligibility for MMD is also needed, as some policies still require a VL test, which is not always available presently.
	4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20; cotrimoxazole, where	n/a – no TPT activities in the West Africa Regional Program	n/a – no TPT activities in the West Africa Regional Program

<sup>2</sup> Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

<sup>3</sup> Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

	indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. <sup>4</sup>		
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	Across the countries in the West Africa Regional Program, VL/EID availability remains one of the largest gaps. Optimization activities have begun in all countries, starting with a survey of resources, machines, reagents, and HRH currently available, challenges to scaling up VL testing, and data systems needed to return results to patients.	Reagent availability, reliability of VL machines in each country, and efficient systems to transport samples from clinics to lab and transmit results back to clinicians are all serious gaps to improving VL testing in the West Africa Regional Program. As ROP19 focused on the first and second 90s, VL should be emphasized more starting in ROP20.
Case Finding	6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV. <sup>5</sup>	Policies for index testing have been adopted in all 7 countries. Implementation and scaling up of index testing beyond PEPFAR-supported sites in each country continues to lag. Adoption of self-testing policies is not complete in the region, although host-country governments are generally favorable to piloting it in PEPFAR sites. All countries have policies in place to test	Improvements in index testing, including offering index testing to every newly identified positive, improving acceptance of index testing, tracing of contacts, and acceptance of testing by contacts identified must continue. Self-testing policies must be pushed for at the national level in all 7 countries.

<sup>4</sup> Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

<sup>5</sup> Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 <https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/>

		all children with an HIV-positive biological parent.	
Prevention and OVC	7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) <sup>6</sup>	Policies for PrEP are not yet adopted in every country the West Africa Region. Ghana's PEPFAR program is currently supporting operationalization of PrEP in the Western Region and supporting implementation for KPs in Ashanti and Accra through KPIF. Pilot studies have been conducted by another donor (France) in Burkina Faso, Mali, and Togo as part of a research study. The government of Sierra Leone is open to adopting and implementing PrEP.	Policies for PrEP need to be adopted in Liberia and Sierra Leone and implemented widely in all 7 countries. The availability of PrEP medication is a significant barrier to wider implementation in the West Africa Region.
	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for	n/a – no OVC activities in the West Africa Regional Program	n/a – no OVC activities in the West Africa Regional Program

<sup>6</sup> Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (<http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en>).

	vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.		
Policy & Public Health Systems Support	9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention. <sup>7</sup>	The elimination of both formal and informal user fees in the public sector for direct HIV services and medications has been one of the biggest improvements across the 7 countries in the West Africa Regional Program in the past 12 months. Policies to eliminate these fees have been adopted in all 7 countries, and community groups are monitoring in-country implementation.	Most countries in West Africa charge nominal fees to all citizens for basic health services, and these fees are not always waived. Surveys are underway to identify these costs (typically \$1-2 dollars/year) and ensure they are not a barrier to clients receiving HIV-related services.
	10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work	As 6 of the 7 countries (all except Ghana) are new to being full PEPFAR programs, the integration of CQI activities is just beginning with ROP19 implementation. Teams will use SIMS to monitor and improve the quality of service provision. In	CQI activities are not yet consistently incorporated in all USAID work plans. HRSA is scaling up activities to reach 20 sites by the end of ROP19 and will include QI approaches as sites are added. Moving forward, HQ agencies and field teams

<sup>7</sup> The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

	plans, Agency agreements, and national policy. <sup>8</sup>	Ghana, Care Continuum conducts joint CQI sessions at the facility level on a monthly basis. In Mali, quality improvement activities began in Q2 of FY19.	will ensure CQI practices are rolled out throughout PEPFAR sites, that supportive supervision visits are conducted, and that CQI is included in all work plans and policies.
	11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Recent evidence of these activities include a rollout of the new strategy in Ghana's Western Region, which included treatment literacy for TLD and U=U; a billboard campaign for VL testing in Liberia; and the recent launch of an I=I (U=U in French) in Mali.	Viral load availability could hinder the success of U=U messaging if patients are unable to reliably access VL testing and receive their results. Stigma continues to be pervasive throughout the region.
	12. Clear evidence of agency progress toward local, indigenous partner prime funding.	Many local, indigenous partners currently serve as sub-recipients on PEPFAR grants in the West Africa Region. Capacity-building programs for these groups should be ensured.	Capacity of local organizations to be able to serve as prime partners needs to be further developed, but the performance of many of these organizations as sub-recipients is promising.
	13. Evidence of host government assuming greater responsibility of the HIV response including	Among the 7 countries in the region, Liberia, Burkina Faso, and Togo provide the highest relative proportion of funding toward their	Political will, in the form of increased funding for HIV, continues to lag in Ghana. Political stability and security concerns in both Mali and Burkina

<sup>8</sup> Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

	demonstrable evidence of year after year increased resources expended.	HIV responses, followed by Ghana, Mali, and Senegal. There is room for improvement in these last 3 countries. While Ghana's budget line for HIV has increased for the past 3 years, expenditures have not matched the budget increase. Sierra Leone is meeting its Global Fund co-financing requirement.	Faso pose a threat to these countries' abilities to increase health investments in the near future. PEPFAR will work with the governments of all 7 countries in the West Africa Region to advocate for increased domestic funding of the HIV response.
	14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Monitoring and reporting of morbidity and mortality outcomes of PLHIV has begun in all 6 ROP19 countries. HRSA is currently rolling out an electronic Case-Based Disease Surveillance system which will link data and focus on outcomes.	The ability of clinicians and case managers to track those LTFU patients, primarily due to incorrect contact information, is a threat to complete monitoring and reporting of morbidity and mortality outcomes.
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	The scale-up of unique identifiers has progressed in Burkina Faso, Ghana, Liberia, Senegal, and Togo. Implementation is still underway in Mali and Sierra Leone.	Use of unique identifiers for all patients still needs to be scaled up beyond PEPFAR-supported sites in some countries.

In addition to meeting the minimum requirements outlined above, it is expected that the West Africa Region will implement the following:

**Table 9. ROP 2020 (FY 2021) Technical Directives**

<b>West Africa Region – Specific Directives</b>
HIV Treatment:
1. Continue to scale index testing and community-based approaches, including peer mentoring and outreach
2. Continue to improve linkage to attain >95% linkage for all HTS_POS

3. Improve VL availability and efficiency, to include demand creation through U=U and similar campaigns
HIV Prevention:
1. Continue activities to counter stigma and discrimination, through KPIF and other mechanisms
2. For clients testing negative, conduct a risk assessment and consider offering PrEP where available
3. For Mali, new approaches to tackle the rising rate of new infections is needed
Other Government Policy or Programming Changes Needed:
1. Complete TLD transition and adopt policies for PrEP and self-testing in all countries

### **ROP20 Strategic Direction**

**Region-wide**, in ROP20, closing the gaps in the clinical cascades must be a priority. All countries must continue scaling client-centered approaches, such as peer navigators and case managers, to improve testing, linkage to treatment, and retention. VL/EID optimization, supply chain management, and national monitoring and evaluation systems must be increased. Self-testing to increase case finding among hard-to-reach populations should be implemented and/or expanded. Community-level interventions to enhance linkage should be improved. Efforts to combat stigma and discrimination, including at facilities and in communities, should be scaled up; year two KPIF activities will be essential to addressing the stigma and discrimination challenges that are pervasive in the region. Faith-based and other community groups should be engaged to encourage testing, linkage to treatment, and retention. PEPFAR teams should coordinate with the Global Fund to update policies and implement HIV self-testing and PrEP, and a situation room approach to improve data analysis and the use of data for decision-making should be implemented.

In **Ghana**, index testing, active case-finding, and prevention methods, including PrEP, should be scaled up. Linkage registers should be used to allow for follow-up by case managers and Models of Hope. eTracker data entry and use trainings should be supported as well as monitoring and support visits. Technical assistance to optimize supply chain at the national and regional levels should be provided. A strong emphasis should be placed on strengthening the viral load referral system. PEPFAR efforts in the Western Region should serve as a model to be replicated by others elsewhere in the country.

In **Senegal**, PEPFAR should consider expanding to additional sites to achieve 90-90-90 nationally across the treatment cascade. The roll-out of case-based surveillance systems to all sites, based on geographic priority and patient load, should be continued; the key population challenge in testing and linkage to treatment should be addressed through increased numbers of peer navigators and case managers and efforts to reduce stigma and discrimination; supply chain information systems should be improved and viral load optimization supported with a focus on demand-creation and capacity building; and a LIS needs assessment should be conducted and a linkage between LIS and SENCAS should be established.

In **Liberia**, KP activities should be expanded to additional sites; testing yields should be improved by conducting risk assessments, tracking, and outreach to new KP hotspots, and intensifying index testing; and quality-of-care monitoring should be continued to achieve client-friendly services. Viral load technical assistance should be provided to optimize specimen referral, efficient utilization of existing lab equipment, and the timely return of results to clinicians and patients. Additional support for supply chain and data management/systems should be also provided.

In **Mali**, the number of sites should be expanded to focus on high-burden facilities in urban areas, including optimizing and increasing testing to narrow the first 90 gap. TLD transition and roll-out should be accelerated, including building supply chain capacity. Key population activities should be expanded to additional sites, including the provision of technical assistance to public sites serving KPs. PrEP should be introduced in the prevention package, and peer-navigation activities should be reinforced to improve linkage, adherence, and VL access. Support for lab optimization should be increased as well as support for access to VL testing, including sample transportation. The e-tracker should be expanded and integrated into the national DHIS2. Mobile clinic testing should be reduced due to its low yields and replaced with an increased emphasis on index testing.

In **Burkina Faso** and **Togo**, with Year 2 Game Changer funds and other resources, Burkina Faso and Togo will focus on closing the gaps to achieve 90-90-90 targets across the national cascade for all PLHIV, in collaboration with government, civil society, and other partners. In order for both countries to achieve these targets, the rate of HTS\_INDEX reach per HTS\_POS must be improved, support for key commodity acquisition (RTKs, ARVs, and VL reagents) must be provided, and the VL lab system must be improved through VL optimization plans, data management, and quality assurance. In Togo, support for the national implementation of the patient e-tracker developed at PEPFAR sites should be provided.

In **Sierra Leone**, HRSA should continue its activities to improve human resources for health (HRH) and clinical quality, with a particular focus on strengthening peer supervision of community health workers (CHW) to improve retention and adherence and harmonize CHW policy across agencies and disease areas. Supply chain support and support/coordination of Global Fund programming are also critical activities for Sierra Leone to be undertaken by HRSA.

## **ROP 2020 Technical Priorities**

### Client- and Family-Centered Treatment Services

ROP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and asymptomatic – and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients and make it easy for patients on ART to continue treatment. PEPFAR requires

development and full implementation of key client-centered policies and practices at the site-level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services. The West Africa Regional Program must ensure 100% “known HIV status” for biological children of TX\_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

#### Community-Led Monitoring

In COP20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador’s small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

#### Pre-Exposure Prophylaxis (PrEP)

Groups to be prioritized for PrEP include those testing negative in index testing but remaining at increased risk of HIV acquisition by virtue of unprotected exposure to a PLHIV with unsuppressed viral load, key populations including sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls and young women, including pregnant and breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified serodiscordant couples (groups will be tailored to country context).

#### PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0 or complement Global Fund or other donors financing implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma and can inform future HIV program planning. If the revised Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 20, whether supported by PEPFAR or other resources.

#### **ROP 2020 Stakeholder Engagement** (see Section 2.5.3 of COP20 Guidance)

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of ROP 2020 remains a requirement for all PEPFAR programs, and as such the ROP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all ROP 2020 tools,

guidance, results and targets as well as the proposed trajectory and strategy for ROP 2020. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa; Bangkok, Thailand; and Atlanta, GA where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Specific guidance for the 2020 meeting delegations have been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the ROP 2020 development and finalization process. As in ROP 2019, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP/ROP 2020 Guidance for a full list of requirements and engagement timelines.

## APPENDIX 1: Detailed Budgetary Requirements

**Table 10. ROP 2020 New Funding Detailed Controls by Initiative**

	COP 2020 Planning Level									COP 20 Total
	FY20			FY19			FY17			
	GHP-State	GHP-USAID	GAP	GHP-State	GHP-USAID	GAP	GHP-State	GHP-USAID	GAP	
Total New Funding	\$ 30,799,449	\$ -	\$ 903,051	\$ 7,063,568	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 38,366,068
Core Program	\$ 30,799,449	\$ -	\$ 903,051							\$ 31,302,500
COP19 Performance	\$ -									\$ -
HKID Requirement ++	\$ -									\$ -
Game Changer Year 2				\$ 7,063,568						\$ 7,063,568
										\$ -
										\$ -
										\$ -

*Care and Treatment: If there is no adjustment to the ROP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part I of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.*

*Orphans and Vulnerable Children (OVC): Countries must program to the full OVC amount from Part I of the planning across all funding sources. Your OVC requirement is made up of the*

*HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.*

*HKID Requirement: West Africa's ROP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your ROP 2020 HKID requirement is derived based upon the approved ROP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The ROP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.*

*Gender Based Violence (GBV): West Africa's ROP 2020 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2020** funding programmed to the GBV cross-cutting code. Your ROP 2020 earmark is derived by using the final ROP 2019 GBV earmark allocation as a baseline. The ROP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.*

*Water: West Africa's ROP 2020 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2020 funding** programmed to the water cross-cutting code. Your ROP 2020 earmark is derived by using the final ROP 2019 water earmark allocation as a baseline. The ROP 2020 planned level of new FY 2020 funds for water can be above this amount; however, it cannot fall below it.*

*Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal **by agency** by the end of FY20 and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP/ROP 2019 submission.*

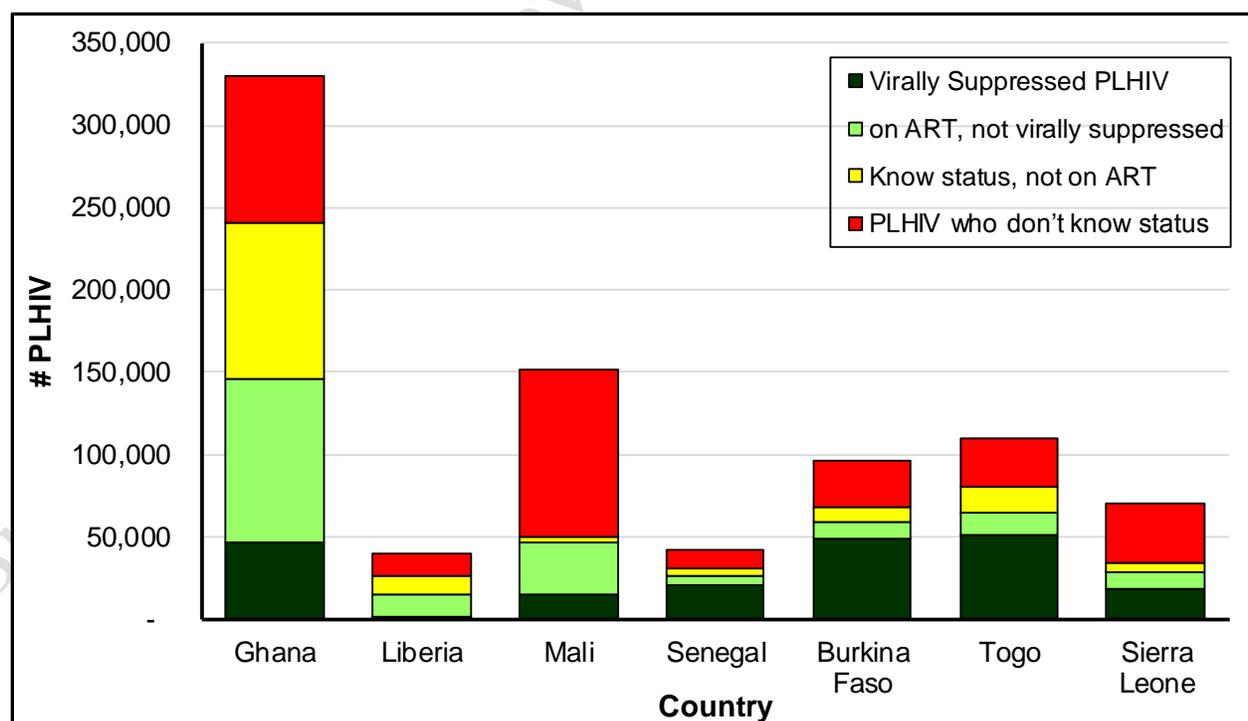
#### **ROP 2020 Applied Pipeline** (See Section 9.1.2 Applied Pipeline of COP20 Guidance)

*All agencies in the West Africa Region should hold a 3-month pipeline at the end of ROP 2020 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending ROP 2019 implementation (end of FY 2020) with a pipeline in excess of 3 months is required to apply this excessive pipeline to ROP 2020, decreasing the new funding amount to stay within the planning level.*

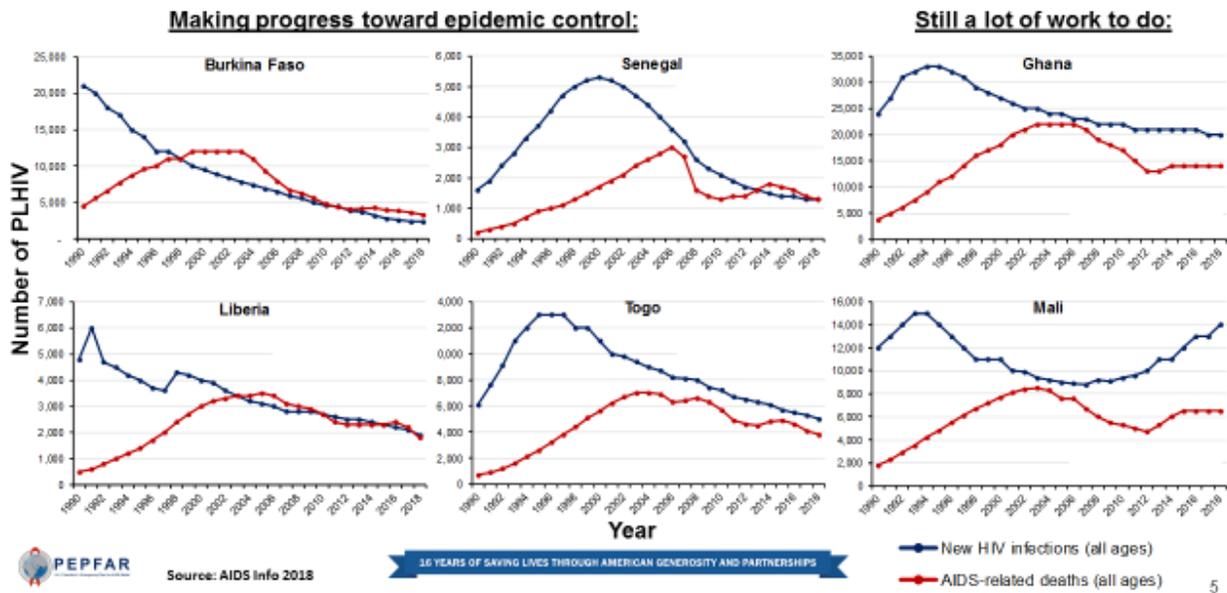
APPENDIX 2: Detailed epidemiological estimates and MPR progress for each country

Clinical cascades – progress to 90-90-90 goals

Status of 90-90-90 targets				
	Estimated # PLHIV	% Who Know Status	% of Known Status who are on ART	% on ART who are Virally Suppressed
<b>Ghana</b>	330,000	73%	60%	32%
<b>Liberia</b>	39,500	68%	55%	8%
<b>Mali</b>	151,900	33%	93%	32%
<b>Senegal</b>	42,400	65%	87%	79%
<b>Burkina Faso</b>	96,100	70%	87%	82%
<b>Togo</b>	110,000	73%	80%	79%
<b>Sierra Leone</b>	70,000	49%	83%	64%



## Progress Toward Epi Control in PEPFAR West Africa Regional Countries



Subject to COP Developer

## Status of PEPFAR's COP19 Minimum Program Requirements (MPRs) in West Africa

Status of ROP19 Minimum Program Requirements								
	Ghana			Liberia			Mali	
Policy	Pre-ROP19 Finalization	Current Status		Pre-ROP19 Finalization	Current Status		Pre-ROP19 Finalization	Current Status
Test and Start	adopted and implemented	adopted and implemented		adopted	implemented and IPs are intensifying		adopted	adopted and implemented
Index Testing	no policy in place	adopted and scaling up		no policy in place	adopted; still underway (PEPFAR)		no policy in place	adopted; still underway (PEPFAR)
Eliminating User Fees	no specific policy; HIV services free	HIV services are free; monitoring		policy in place	adopted and implemented		policy in place	policy being monitored
Unique Identifiers	adopted and implemented	adopted and implemented		adopted and implemented	adopted and implemented; KPs added		no policy in place	adopted; still underway (PEPFAR)
TLD Transition	policy in development	adopted; transition underway		no policy in place	adopted; transition underway		no policy in place	adopted; transition underway
DSD models and MMD	policy in place	adopted; transition underway		policy in place	adopted; transition underway		no policy in place	adopted; still underway (PEPFAR)
Viral Load / EID Optimization	policy in place	improving and scaling up		no policy in place	adopted; challenges but improving		policy in place; not implemented	adopted; challenges but improving

Status of ROP19 Minimum Program Requirements						
	Senegal		Burkina Faso		Togo	
Policy	Pre-ROP19 Finalization	Current Status	Pre-ROP19 Finalization	Current Status	Pre-ROP19 Finalization	Current Status
Test and Start	adopted and implemented	adopted and implemented, still scaling	adopted and implemented	adopted and implemented	adopted	adopted and implemented
Index Testing	no policy in place	adopted; still underway (PEPFAR)	no policy in place	adopted; still underway (PEPFAR)	no policy in place	adopted; still underway (PEPFAR)
Eliminating User Fees	policy in place	adopted and implemented; monitoring	adopted and implemented	adopted and implemented; monitoring	policy in place	adopted and implemented; monitoring
Unique Identifiers	no policy in place	adopted and implemented	adopted and implemented	adopted and implemented	adopted and implemented	adopted and implemented
TLD Transition	no policy in place	adopted; transition underway	no policy in place	adopted; transition underway	no policy in place	adopted; transition underway
DSD models and MMD	policy in place	adopted; transition underway	policy in place	adopted; transition underway	policy in place	adopted; transition underway
Viral Load / EID Optimization	policy in place; not implemented	adopted; challenges but improving	policy in place; not implemented	adopted; challenges but improving	policy in place; not implemented	adopted; challenges but improving