INFORMATION MEMO FOR CHARGE d’ AFFAIRES GREG SEGAS, ANGOLA

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

THROUGH: S/GAC Chair, Samuel Kalibala and PPM, Michelle Zavila

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

Dear Chargé Segas,

First and foremost, I sincerely hope that you and your team are safe and healthy. I am extremely grateful for your leadership of the PEPFAR program and additional COVID-19 response efforts during this difficult year.

While countries around the world continue to manage the effects of the COVID-19 pandemic, and the U.S. government acts on its commitment of support, it is encouraging to see vaccines making their way around the globe. The COVID response efforts – and continued use of the PEPFAR platform to support testing and vaccine delivery and uptake at point of care settings - are essential to our ability to provide ongoing care and life saving support for people living with HIV. The PEPFAR program has faced many challenges as a program during this period. Nevertheless, the PEPFAR family and partners have carried the mission forward while enduring significant personal impacts of COVID-19. Despite these challenges, what remains true is the strength and resilience of PEPFAR in partnership with countries and communities – through our teams, and our programs in the midst of dueling pandemics. Tremendous effort has been made by PEPFAR over the year to protect and accelerate the HIV gains, while leveraging the platform to respond to COVID-19 as well.

PEPFAR Country/Regional Operational Plan (COP/ROP 2022) (for implementation in FY2023) represents a pivotal year in PEPFAR, as several countries are reaching or approaching the agreed upon UNAIDS 95/95/95 benchmarks for attaining epidemic control. As countries approach these benchmarks, while pivoting from “scaling to close gaps” to “sustaining” epidemic control, we must ensure HIV program and population equity, address outstanding barriers that threaten to derail progress made in reducing new HIV infections and associated mortality, and tailor our programs to serve all populations.

This year it is particularly important to plan COP/ROP22 together with the country government, civil society, and multilateral partners. Across PEPFAR, the focus on equity requires vigilant attention to program data demonstrating results and gaps. A focus on equity also means a focus on population groups where our efforts to date have not closed gaps, and specific planning, resource allocation, and program tailoring are needed – depending on what the data reveal for each country – focusing on: children, adolescent girls and young women, and key populations.

While implementation continues, or in many cases, has started to scale up, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach COP/ROP 22 planning and implementation:
1. Achieve and sustain epidemic control using evidence-based, equitable, people-centered HIV prevention and treatment services.
2. Support resilient and capacitated country health systems, communities, enabling environments, and local partners to build enduring capabilities.
3. Strengthen cooperation and coordination for greater impact, burden sharing, and sustainability.
4. Employ an equity lens with a persistent focus on reducing persistent inequalities experienced by children, key populations, and adolescent girls and young women.

I want to applaud the PEPFAR team for:

- Successful TLD transition for adolescent & adult populations and scaling up three multi-month dispensing (MMD),
- Strong PMTCT performance across indicators, and
- Expanding EID sample collection and viral load testing coverage.

Together with the Government of Angola and civil society leadership we have made tremendous progress together. Angola should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

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

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

- Improving the clinical cascade for the pediatric population and improving efficiency of case-finding approaches by scaling safe and ethical index testing for adults and children,
- Expanding measures to improve continuity of treatment, such as expanding 3-6MMD, community ART delivery, and continued policy efforts to ensure ARV stock coverage, and
- Continue to strengthen the national laboratory network to increase viral load coverage and working to improve viral load suppression, especially in children and adolescents by completing national transition to pediatric DTG +10.

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 22 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from years past, PEPFAR teams will once again be responsible for setting their own targets across PEPFAR program areas (with the treatment current target no less than the result that was to be achieved in COP 2021) in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR’s but flow directly from the partner country government’s commitment to the UNAIDS and SDG 3 goals.

The PEPFAR COP/ROP 22 notional budget for Angola is **$12,901,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in
collaboration with the Government of Angola and civil society of Angola, believes is critical for the country’s progress towards controlling the pandemic and maintaining control.

Finally, in alignment with efforts by the U.S. government to support diversity, equity, inclusion, and accessibility as well as to advance equity for underserved communities and prevent and combat discrimination or exploitation on the basis of race, religion, gender identity or sexual orientation, PEPFAR will work to ensure that these principles are upheld, promoted, and advanced in all PEPFAR programs and in how we do business.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will review this planning letter and details contained, herein, with your wider PEPFAR country team. Stakeholder engagement is essential for a productive and impactful planning process, and civil society engagement will continue to be an integral part of this planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual COP/ROP22 planning and approval process.

Once again, thank you for your continued leadership and engagement during the COP/ROP22 process.

Sincerely,

Angeli Achrekar

Attachment: COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction Summary.

CC: S/GAC – Samuel Kalibala, Chair; Michelle Zavila, PPM; Amaka Nwankwo-Igmu, PEPFAR Country Coordinator
Overview: COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly monitoring POARTs, as well as Headquarters Country Accountability and Support Teams (CAST) input, a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2020 and current COP 2021 implementation as we plan for COP 2022. We have noted the following key successes and challenges:

Successes
1. TLD transition for civilian adolescents, adults, and pregnant and breastfeeding women, and PEPFAR-supported sites’ military population was completed by FY 2021 Q4. The transition was successfully implemented across all 18 provinces in Angola as well. Additionally, the majority of both adult and pediatric PEPFAR patients from all SNU received at least 3-6+ months of MMD by FY 2021 Q4, with the majority of these clients on 3MMD.
2. PEPFAR Angola maintained a 100% stock availability rate for first line ARVs both at the site level and provincial warehouse levels throughout the second half of FY 2021.
3. Sustained success in linkage and continuity of treatment for PEPFAR-supported military sites. The Military population achieved 94% linkage and had less than 0.5% interruption in treatment (IIT) across quarters in FY 2021. Over 93% of the client population received 3 or 6+ MMD quarterly.
4. Continued PMTCT program success, achieving 98.6% PMTCT_STAT coverage and 94.8% PMTCT_ART coverage in FY 2021. Indicators improved from FY 2020 which had 94% PMTCT_STAT and 91% PMTCT_ART coverage.
5. 380% increase in annual EID sample collection between FY 2020 and FY 2021. EID coverage progressed throughout FY 2021 with proxy EID 2-month coverage starting at 7% in Q1 growing to 63% coverage by Q4. Proxy EID 12-month coverage was 25% in Q1, and 84% by Q4.
6. Viral load coverage improved both in terms of the number of VL samples referred and the number of health facilities referring samples between FY 2020 and FY 2021, as well as throughout the year. In FY 2021 Q1, VL coverage was 14%, and more than doubled by Q4 with 33% VL coverage and 1,972 VL samples referred, the largest increase of VL testing between quarters, and following 6 months of TLD.

Challenges
1. PEPFAR Angola’s pediatric population had a high positivity yield at 7% and a low linkage rate of 54% in FY 2021. While 30% of HTS_POS <15 were identified through index testing modalities in Q4, there is a continued need to intentionally scale up safe and ethical index testing services and strengthened linkage efforts for children across PEPFAR sites. Shortages and stock outs of pediatric regimens during FY 2021 Q2 and Q3, as well as delayed ART optimization for children, posed as barriers to CLHIV linkage, continuity of treatment, and viral load suppression.
2. After suffering 30% interruption in treatment during Q1, where over 6,500 people experienced an interruption in treatment, PEPFAR Angola saw vast improvements in TX_ML and a decreased IIT rate of 6% in Q4. While IIT improved significantly throughout the year following PEPFAR Emergency Commodities Fund approval, and host government and donor response to ARV stockouts in Q1, IIT varied across civilian SNU. Lunda Sul and Cunene have twice the IIT rate compared to other provinces. Aside from ARV shortages, other factors that continued to contribute to civilian IIT include patients’ financial limitations and challenges with travel.
3. While there was much improvement in viral load coverage in FY 2021, more work is needed. Viral load suppression also remains too low across all age bands and was under 75% across quarters. Ages 20-29 tend to have the highest viral load suppression rate yet is still sub-optimal and ranged from 77-85% across quarters. VL suppression is particularly concerning for pediatric age bands and adolescents (46% VL suppression rate for 01-04 age band, 55% for 05-09 age
band, 43% for 10-14 age band, and 60% VL suppression rate for 15-19-year-olds in FY 2021 Q4). ART Optimization is still pending for CLHIV and a small amount of NVP use still exists in Cunene and Lunda Sul. Both are contributing factors to low viral load suppression among CLHIV.

As Angola has not yet reached the UNAIDS 90-90-90 goals, the following strategic priorities are recommended to optimize PEPFAR resources in supporting Angola to reach these goals:

1. To ensure nationwide benefit of PEPFAR’s technical assistance (TA) and best practices developed at the sites, PEPFAR Angola will, in COP22, strengthen its engagement at the national level in policy and guidelines development in PMTCT clinical and community programs as well as laboratory and supply chain activities.

2. Continuation and scaling down of the current PMTCT TA model in Phase-1 provinces (Benguela, Cunene, Lunda Sul, and Huambo) while preparing to move to Phase-2 for COP23. This process will effectively entail closing out PEPFAR TA activities in Phase-1 provinces by the end of COP22 and handing over to the Government of Angola to oversee. PEPFAR Angola will transition to Phase-2 provinces (Huila and Moxico) in COP23. Investing time to scout new sites, shift program geography, and understand epidemiological data, while reducing the intensity of work and identifying clinical and community mentorship for the transition is crucial. Even while scaling back TA during COP 22, effort should be made to further improve the pediatric cascade in Phase-1 provinces.

3. In COP22, PEPFAR Angola should engage GRA and other stakeholders to develop a joint strategy for weaning-off Phase-1 provinces from PEPFAR TA support and for transferring PEPFAR TA support to Phase-2 provinces. To ensure a smooth handover and limit loss of the gains made in the PMTCT cascade in Phase-1 provinces, implementing partners will, in collaboration with GRA, identify and strengthen the capacity of appropriate personnel and systems in the best practices developed by PEPFAR Angola. Handover should support both clinical and community components of the PMTCT cascade including robust and timely service delivery statistics to be fed into the national HMIS.

4. In COP22, each implementing agency will undertake scoping visits to Phase-2 sites to begin local stakeholder engagement as well as generate sufficient data (including a DQA exercise where necessary) for setting targets to ensure smooth initiation of PMTCT TA support in COP23.

5. Further, in COP23 a geographical rationalization approach of PMTCT TA for clinical and community programming should be considered for the two provinces in Phase-2.

6. Continuation of the current DOD support to military sites in COP22 and COP23.

In summary, in COP22, PEPFAR Team will pursue a strategic approach of supporting epidemic control in Angola through continued site-level support at military sites; generating PMTCT site-level best practices at Phase-1 sites—transitioning to Phase-2 sites in COP23; and engaging in PMTCT and other national-level technical working groups to share best practices.

SECTION 1: COP/ROP 2022 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2021 (EOFY) tool, and performance data, the total COP/ROP 2022 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.
TABLE 1: All COP 2022 Funding by Appropriation Year

<table>
<thead>
<tr>
<th></th>
<th>Bilateral FY22</th>
<th>FY21</th>
<th>FY20</th>
<th>Unspecified</th>
<th>Central FY22</th>
<th>FY21</th>
<th>FY20</th>
<th>Unspecified</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total New Funding</td>
<td>$10,336,728</td>
<td>-</td>
<td>$-</td>
<td>$-</td>
<td>$901,000</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$11,237,728</td>
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<tr>
<td>GHP-State</td>
<td>$9,935,478</td>
<td>-</td>
<td>$-</td>
<td>$-</td>
<td>$501,000</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$10,436,478</td>
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<td>GHP-USAID</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$400,000</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$400,000</td>
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<tr>
<td>GAP</td>
<td>$401,250</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$401,250</td>
</tr>
<tr>
<td>Total Applied Pipeline</td>
<td>$1,663,272</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$901,000</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$1,663,272</td>
</tr>
<tr>
<td>DOD</td>
<td>$335,752</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$335,752</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$335,752</td>
</tr>
<tr>
<td>HHS/CDC</td>
<td>$1,327,520</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$1,327,520</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$1,327,520</td>
</tr>
<tr>
<td>TOTAL FUNDING</td>
<td>$10,336,728</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$901,000</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$12,901,000</td>
</tr>
</tbody>
</table>

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

Countries should plan for the full Care and Treatment (C&T) level of $6,210,900 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2: COP 2022 Earmarks by Appropriation Year*

<table>
<thead>
<tr>
<th></th>
<th>Appropriation Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FY22</td>
</tr>
<tr>
<td>C&amp;T</td>
<td>$6,210,900</td>
</tr>
</tbody>
</table>

*Only GHP-State and GHP-USAID will count towards the earmarks (Care and Treatment, OVC, GBV, and Water).

**Only GHP-State will count towards the GBV and Water earmarks.

TABLE 3: COP 2022 Initiative Controls: Each dollar planned in COP can belong to only one initiative. Most COP funding will be budgeted as Core Program. In general, initiatives other than Core Program are used to track activities/programs that cannot be tracked by the combination of program area and beneficiary alone. See Appendix 1 for more detailed information on initiatives.
TABLE 4: Programmatic Controls: Programmatic controls are used to track programmatic directives that can be tracked by a combination of program area and/or beneficiary. Programmatic controls may overlap with Initiatives, for example PrEP for Adolescent Girls and Young Women may count towards both the DREAMS Initiative and the PrEP (AGYW) programmatic control. See Appendix 1 for more detailed information on programmatic controls.

<table>
<thead>
<tr>
<th></th>
<th>Bilateral</th>
<th>Central</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Funding</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
<tr>
<td>PrEP (AGYW)</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
<tr>
<td>PrEP (KPs)</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
</tbody>
</table>

TABLE 5: State ICASS Funding

<table>
<thead>
<tr>
<th>Appropriation Year</th>
<th>FY22</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICASS</td>
<td>$</td>
</tr>
</tbody>
</table>

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

SECTION 3: PAST PERFORMANCE – COP/ROP 2020 Review

TABLE 6. COP/ROP OU Level FY21 Program Results (COP20) against FY22 Targets (COP21)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>FY21 Result (COP20)</th>
<th>FY22 Target (COP21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX Current &lt;15</td>
<td>754</td>
<td>1,660</td>
</tr>
<tr>
<td>TX Current 15+</td>
<td>23,592</td>
<td>25,440</td>
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<tr>
<td>VMMC 15+</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>DREAMS (AGYW PREV)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>TB Preventive Therapy</td>
<td>1,152</td>
<td>15,477</td>
</tr>
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</table>

TABLE 7. COP/ROP 2020 | FY 2021 Agency-level Outlays versus Approved Budget

<table>
<thead>
<tr>
<th>OU/Agency</th>
<th>Sum of Approved COP/ROP 2020 Planning Level</th>
<th>Sum of Total FY 2021 Outlays</th>
<th>Sum of Over/Under Outlays</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOD</td>
<td>$2,395,000</td>
<td>$671,708</td>
<td>$1,723,292</td>
</tr>
<tr>
<td>HHS/CDC</td>
<td>$7,647,799</td>
<td>$6,516,446</td>
<td>$1,131,353</td>
</tr>
<tr>
<td>State</td>
<td>$160,000</td>
<td>$160,000</td>
<td>$0</td>
</tr>
<tr>
<td>USAID</td>
<td>$3,768,137</td>
<td>$2,947,003</td>
<td>$821,134</td>
</tr>
<tr>
<td>USAID/WCF</td>
<td>$1,854,018</td>
<td>$1,531,873</td>
<td>$322,145</td>
</tr>
<tr>
<td>Grand Total</td>
<td>$15,824,954</td>
<td>$11,827,030</td>
<td>$3,997,924</td>
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</table>
## TABLE 8. COP/ROP 2020 | FY 2021 Results & Expenditures

<table>
<thead>
<tr>
<th>Agency</th>
<th>Indicator</th>
<th>FY21 Target</th>
<th>FY21 Result</th>
<th>% Achievement</th>
<th>Program Classification</th>
<th>FY21 Expenditure</th>
<th>% Service Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHS/CDC</td>
<td>HTS_TST</td>
<td>100,570</td>
<td>144,513</td>
<td>143.69%</td>
<td>HTS Program Area</td>
<td>$414,431</td>
<td>0%</td>
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<tr>
<td></td>
<td>HTS_TST_POS</td>
<td>2,969</td>
<td>6,411</td>
<td>215.93%</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>TX_NEW</td>
<td>3,286</td>
<td>5,075</td>
<td>154.43%</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>TX_CURR</td>
<td>17,738</td>
<td>15,163</td>
<td>85.48%</td>
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<tr>
<td>DOD</td>
<td>HTS_TST</td>
<td>24,121</td>
<td>16,908</td>
<td>70.10%</td>
<td>HTS Program Area</td>
<td>N/A</td>
<td>0%</td>
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<tr>
<td></td>
<td>HTS_TST_POS</td>
<td>2,106</td>
<td>2,079</td>
<td>98.72%</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>TX_NEW</td>
<td>2,046</td>
<td>1,948</td>
<td>95.21%</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>TX_CURR</td>
<td>10,279</td>
<td>9,183</td>
<td>89.34%</td>
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<tr>
<td>USAID</td>
<td>HTS_TST</td>
<td>2,305</td>
<td>4,728</td>
<td>205.12%</td>
<td>HTS Program Area</td>
<td>$1,563,517</td>
<td>100%</td>
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<td>HTS_TST_POS</td>
<td>512</td>
<td>561</td>
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<td>TX_NEW</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td></td>
<td>TX_CURR</td>
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<td>N/A</td>
<td>N/A</td>
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<td></td>
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<td>Above Site Programs</td>
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<td>Program Management</td>
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<td></td>
<td>C&amp;T Program Area</td>
<td>$919,123</td>
<td>0%</td>
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## SECTION 4: COP/ROP 2022 DIRECTIVES

The following section has specific directives for COP 2022 based on program performance noted above. Please review each section carefully including the minimum program requirements.

**Minimum Program Requirements (MPR)**

All PEPFAR programs – bilateral and regional– must ensure the following minimum program requirements are in place. Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g., facility, school, community). Evidence demonstrates that lack of any one of these policies/practices significantly undermines HIV impact and results in inefficient and ineffective programs.

All PEPFAR programs are expected to meet all of the requirements below, and the COP22 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP22 Planning Meeting, the PEPFAR OU team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the
requirement(s) prior to the beginning of FY2023. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2023 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table below.

**TABLE 9. COP/ROP 2022 (FY 2023) Minimum Program Requirements**

<table>
<thead>
<tr>
<th>Care and Treatment</th>
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</table>
| **1.** Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.  
**Status:** Test and Start - Completed; >95% Linkage - In-process  
**Summary:** Adopted Test and Start as national policy in September 2017. Ongoing monitoring of SOPs and policy fidelity by health care workers and PEPFAR implementing partners (IP) is required. PEPFAR Angola continues to provide technical support including standard operating procedures and tools to improve ART initiation. Linkage remains a challenge (between 75-79% throughout COP20) with variation among age bands (Linkage rates below 65% for pediatric age bands and males 15-24). |
| **2.** Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are >4 weeks of age and weigh >3 kg, and removal of all NVP- and EFV-based ART regimens.  
**Status:** In-process  
**Summary:** The TLD transition for adults, adolescents, and pregnant and breastfeeding women was successfully rolled out in all 18 provinces (including PEPFAR provinces) by FY 2021 Q4. ART optimization is still pending for the pediatric population, and unfortunately small amounts of NVP are still in use. However, implementation is set to be achieved in COP21. |
| **3.** Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.  
**Status:** In-process  
**Summary:** In COP20, the majority of PEPFAR Angola patients received 3-6 MMD marking progress in key policy implementation. A Nota Tecnica released in March 2020 called for 3MMD if service drug stock allows, and as this barrier continues to be addressed so has the expansion of MMD. INLS has established an MMD technical working group which PEPFAR continues to contribute to and monitor for fidelity. |
| **4.** All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.  
**Status:** In-process  
**Summary:** PEPFAR Angola continues to provide TA for expansion of TPT to all appropriate PLHIV in all PEPFAR-supported facilities. In COP20 and COP21, compliance with the national |
policy is dependent on the availability of isoniazid, an issue that has been an important barrier for the TA approach. The GRA has provided a LOC to GF to increase their commitment to TB drugs (1st line & 2nd line) which would improve outcomes towards TPT.

5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.

   Status: In-process

   Summary: Diagnostic Network Optimization exercise is underway and to be completed in COP21. Angola does not currently have laboratory capacity for 100% coverage but PEPFAR Angola continues to work with INLS to optimize VL and EID testing and appropriate patient level use of testing results in priority provinces. VL testing and EID capacity was scaled considerably over COP20.

Case Finding

6. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.

   Status: Completed

   Summary: PEPFAR Angola continues to scale up facility and community index testing however safe and ethical practices should be emphasized and remain a priority. Policy environment is permissive for index testing of older children above 15. PEPFAR Angola should work with MOH to clarify testing guidelines for children of HIV+ parents up to the age of 19 is recommended.

Prevention and OVC

7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)

   Status: Not applicable at this time

8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.

   Status: Not applicable at this time

Policy & Public Health Systems Support

9. In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.
**Status:** In-process  
**Summary:** Stigma continues to be a major barrier to access to health services in Angola. During COP21 PEPFAR Angola will implement and use the findings of the Stigma Index 2.0 to combat stigma and discrimination in planned activities which are key barriers to treatment, retention, and adherence.

10. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.  
**Status:** Not started  
**Summary:** No formal policy established, PEPFAR Angola to prioritize and readdress in COP22 per COP19 agreement.

11. OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.  
**Status:** Completed  
**Summary:** PEPFAR Angola continues to implement continuous quality improvement (CQI) approaches from the national to site level. PEPFAR Angola should continue to implement targeted CQI activities (gap analyses, etc.) to better identify, report, and respond to on-site challenges.

12. Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other partner country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.  
**Status:** In-process  
**Summary:** PEPFAR Angola supports the INLS in literacy activities where possible however, specific funding for marketing and widespread messaging has been limited.

13. Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses.  
**Status:** In-process  
**Summary:** In FY 2021, 23% of PEPFAR Angola’s budget transitioned to local partners (a 7% increase compared to FY 2020). The majority of PEPFAR funding is still programmed through international partners and agencies should continue to look for opportunities to transition to local entities when possible. Additionally, due to delays in CLM implementation during COP20, programming is set to begin during COP21.

14. Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.  
**Status:** In-process  
**Summary:** The Government of Angola (GRA) and PEPFAR Angola signed an MOU in June 2021 to address ARV commodity coverage. GRA has since delivered on the agreement procuring 1,200,000 TLD 30-tab bottles, exceeding the agreed upon amount by 40%. Additionally, GRA
increased the national health budget over the past two years by 7% (sub-program budget for HIV remains unclear, however).

15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.
   Status: In-process
   Summary: Monitoring and reporting of morbidity and mortality outcomes is currently provided within PEPFAR health facilities but not address at national level.

16. Scale-up of case surveillance and unique identifiers for patients across all sites.
   Status: Not started
   Summary: Discussions started in December 2019 and have continued with INLS for unique identifiers (especially for PMTCT, EID and Pregnant Women) however implementation proves challenging and time intensive.

In addition to meeting the minimum requirements outlined above, it is expected that Angola will consider all the following technical directives and priorities. A full list of COP/ROP 2022 Technical Priorities and Considerations are listed in COP guidance and can be referenced in Section 6.

Table 10. COP/ROP 2022 (FY 2023) Technical Directives

<table>
<thead>
<tr>
<th>Angola –Specific Directives</th>
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</thead>
<tbody>
<tr>
<td>HIV Clinical Services</td>
</tr>
<tr>
<td>1. HIV Testing</td>
</tr>
<tr>
<td>• Continue to intentionally scale up of safe and ethical index testing and proactive optimization of pediatric HIV case finding as funding allows.</td>
</tr>
<tr>
<td>2. Continuity of Treatment Services</td>
</tr>
<tr>
<td>• Prioritize full cooperation and two-way data sharing between partners to better serve clients, people testing for HIV, and clients with interruptions in treatment for seamless linkage and return to treatment.</td>
</tr>
<tr>
<td>• Ensure that PEPFAR sites remain appropriately stocked with ARVs and allow patients to receive an initial supply of ART at time of diagnosis irrespective of where the patient chooses to receive care.</td>
</tr>
<tr>
<td>• Continue to build off of COP20 progress and expand 3 to 6MMD policy to ensure client-centered continuity of care, including pregnant women, children, and those newly enrolled on treatment.</td>
</tr>
<tr>
<td>3. Viral Load Coverage and Suppression</td>
</tr>
<tr>
<td>• Complete the Laboratory Diagnostic Network Optimization (DNO) to meet MPR.</td>
</tr>
<tr>
<td>• Given the success with increased VL coverage and expansion of the sample transport system and use of centralized testing, continue COP20 and COP21 efforts to provide TA to Central, Benguela and Military labs, and continue supporting current POC and EID testing in Lunda Sul, Cunene and Huambo.</td>
</tr>
<tr>
<td>• Increase visibility of product use in Benguela and Central labs.</td>
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</tbody>
</table>
|   • At a policy level, PEPFAR Angola should advocate for the adoption of GeneXpert technology and continued use of both POC and conventional platforms complementarily in an
integrated/multiplex manner based on outcomes of DNO to support testing for HIV (VL, EID), TB, COVID-19 and other relevant infections.

4. Pediatric Cascade
   - If feasible, increase case identification and family index testing in communities and facilities and improve tracking of pediatric cases.
   - Work with Provincial community health members to improve pediatric linkage.
   - PEPFAR Angola should ensure that all infants (at least 4 weeks old and 3 kg), children, and adolescents are transitioned to a DTG-based regimen (in COP21), whilst ensuring a consistent supply of optimal pediatric ART by working with the GRA and multilateral partners. Furthermore, prioritize training and monitoring of pDTG rollout.
   - Implement CLM activity to track pediatric outcomes.

5. PMTCT
   - As funding allows, increase community and facility-based support targeted directly toward PBFW and EID.

**Other Government Policy, Systems, or Programming Changes Needed**

1. Government Policy
   - Continue advocacy through technical working groups for key policies such as:
     - GRA commitment to prioritize national commodities coverage (TLD & pDTG); Continue discussions with Global Fund, World Bank and other key stakeholders to better track and understand national commodities coverage.
     - Scale up of 3 to 6MMD for pregnant women, adolescents and children, community ART delivery and other DSD models.
     - Contribute to national PMTCT efforts through national technical working group.
     - Advocate for implementation of DHS in order to gain better understanding of HIV epidemic in Angola.
     - Encourage GRA to prioritize the improvement of national data quality in order to have a better understanding of the response to the HIV epidemic (DQA and MOH data alignment activity).
   - Continue engaging GRA to ensure their commitment to key policy movement and meaningful procurement of TLD and DTG-based regimens to cover national population and PEPFAR sites moving forward. None the less, if necessary (and as funding permits), consider renewing MOU with GRA to procure a reduced amount of TLD buffer stock for PEPFAR program patient populations.

2. Stigma & Discrimination
   - COP22 plans should prioritize and take specific steps to address the structural barriers that impede scale up of differentiated HIV services, as well as the lack of robust data to guide focus clients and PMTCT programming. Addressing structural barriers should entail improving the enabling environment for HIV service delivery, mitigating harmful policy and social norms that fuel stigma, and mitigating discrimination and violence; PEPFAR team should ensure they are coordinating strategically with relevant State and U.S. government units (e.g., DRL), partner
COP/ROP 2022 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring, as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional, and international civil society and community stakeholders, multilateral partners and the partner country government.

Civil society organizations are essential and to be invited to participate in the virtual COP22 strategic retreats, planning meetings, as well as approval meetings. In particular, engagement with local CSOs at the country-level is required and should begin early and continue during the entirety of the COP planning, monitoring, and implementation process.

This engagement of civil society, including faith-based organizations/faith communities, specifically includes the sharing of FY 2021 Q4 and FY 2021 Annual Program Results (APR), analyses, and the convening of an in-country planning retreat with local stakeholders, no later than the week of February 7, 2022, in order to introduce and discuss all COP/ROP 2022 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2022. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund, with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In March 2022, PEPFAR will convene virtual meetings where outstanding decisions will be discussed and finalized. In addition to partner country representatives, the meetings will also include representatives from local and international civil society and community organizations, faith-based organizations/faith communities, private sector, and multilateral partners. Specific guidance for the 2022 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2022 development, finalization, and implementation. As in COP/ROP 2021, the draft Strategic Direction Summary (SDS) is required to be shared with both CSO and FBO stakeholders for their input and comments at least 7 days prior to submission to S/GAC. Please refer to the COP/ROP 2022 Guidance for a full list of requirements and engagement timelines. In addition, a more detailed timeline for sharing key data visualizations and other information with stakeholders is forthcoming.

Community-led Monitoring (CLM)
In addition to prescribed and routine engagement during PEPFAR's annual business cycle, including around COP/ROP planning and quarterly POART processes, all PEPFAR programs are required to develop, support, and fund community-led monitoring (CLM) in close collaboration with independent, local civil society organizations and host country governments. Community-led monitoring in COP22 should build on prior activities in COP21 and be designed to help PEPFAR programs and health institutions pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. In addition to being data-driven and action-oriented, CLM should continue to ensure indicators are defined by communities and health service users, and data should be additive and not a
duplicate collection of routine data already available to PEPFAR through MER or SIMS. New in COP22, PEPFAR-supported community-led monitoring programs must include an explicit focus on key populations. CLM should be utilized to advance equity and to support improvement in programs, especially for populations who have not yet fully experienced the benefits of HIV epidemic control. For example, OUs with pediatric care and treatment programs should consider utilizing CLM to track and ensure accountability for child, adolescent, and family-centered care.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment: Each OU’s COP/ROP 2022 minimum requirement for the care and treatment earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2022 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): Each OU’s COP/ROP 2022 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. Generalized epidemic countries which do not meet the 50 percent threshold must provide a brief written justification in FACTS Info, explaining the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors.
Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

<table>
<thead>
<tr>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention:</strong> primary prevention of HIV and sexual violence</td>
</tr>
<tr>
<td>(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)</td>
</tr>
<tr>
<td>+</td>
</tr>
<tr>
<td><strong>Prevention:</strong> community mobilization, behavior, and norms change</td>
</tr>
<tr>
<td>(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention:</strong> primary prevention of HIV and sexual violence (all populations)</td>
</tr>
<tr>
<td>+</td>
</tr>
<tr>
<td><strong>Prevention:</strong> community mobilization, behavior, and norms change (all populations)</td>
</tr>
<tr>
<td>+</td>
</tr>
<tr>
<td>50 % Prevention: Not disaggregated (all populations)</td>
</tr>
</tbody>
</table>

Gender Based Violence (GBV): Each OU’s COP/ROP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total new FY 2022 funding programmed to the GBV cross-cutting code. Your COP/ROP 2022 earmark is derived by using the final COP/ROP 2021 GBV earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Each OU’s COP/ROP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total new FY 2022 funding programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2021 water earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for water can be above this amount; however, it cannot fall below it.

Initiative Controls: Table 3 shows initiative controls where S/GAC has directed funding for a set of activities that cannot be accounted for through program areas and/or beneficiaries alone. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned.

The four initiative controls below (Cervical Cancer, DREAMS, OVC (non-DREAMS), and VMMC) have been assigned to the appropriate OUs. For OUs where these controls are designated in the PLL, the amounts reflect the minimum required. These initiative controls can be exceeded without a control change, but a control change request would be required before a lower level for these activities can be planned.

*Cervical Cancer* - This initiative provides funding for all activities related to cervical cancer screening and diagnosis and treatment of precancerous cervical lesions for women living with HIV as outlined in the COP Guidance.
**DREAMS** - The DREAMS initiative should capture all funding specifically allocated as DREAMS in the OU's planning level and must be used for the goal of HIV and sexual violence prevention among adolescent girls and young women (AGYW) ages 10-24 years (unless otherwise approved) in approved DREAMS SNUs in accordance with the DREAMS and COP Guidance. The DREAMS initiative can also include prevention interventions in DREAMS geographic areas for girls and boys aged 10-14 which may be cost shared with the OVC (non-DREAMS) initiative as noted in the COP guidance.

**OVC (non-DREAMS)** - OVC (non-DREAMS) is a new initiative in COP/ROP 2022. OUs should use the initiative to budget for OVC (non-DREAMS) programming, including all OVC comprehensive activities as outlined in the COP Guidance. The OVC (non-DREAMS) initiative should include ASP, SE, and PREV costs (except PrEP and VMMC) linked to any OVC beneficiary (including sub-beneficiaries such as OVC caregivers). As the initiative is new for COP/ROP 2022, OUs should pay particular attention to funds programmed under OVC (non-DREAMS) to ensure that the current cohort of children enrolled in the comprehensive program receive continuity of care for FY 2023. The OVC (non-DREAMS) initiative can also include prevention interventions for girls and boys aged 10-14 which may be cost-shared with the DREAMS initiative as noted in the COP guidance. The OVC (non-DREAMS) initiative cannot be met with any HTS, C&T, PM or commodities costs.

**VMMC** - All services and equipment related to providing surgical and ShangRing VMMC for boys/men ages 15 and above, and ShangRing circumcision only for boys age 13 and 14 years, should be budgeted using the VMMC initiative.

While the CLM initiative does not appear in PLL budget tables, as CLM remains a requirement in COP/ROP 2022 for all OUs, each OU is responsible for programming a portion of funds under the **Community-Led Monitoring** initiative.

**Community-Led Monitoring** - During COP/ROP 2020, PEPFAR invested in expansion of community-led monitoring, making it a requirement of all OUs, as a critical way to listen to community voices in assessment of program quality and design of client-centered services. Community-led monitoring remains a requirement in FY 2023.

In addition to the five initiatives above, S/GAC may also allocate funding to OUs under two additional initiative controls: **Condoms (GHP-USAID Central Funding)** and **One-Time Conditional Funding**. If the OU was designated to receive funding under either one or both these initiatives in COP/ROP 2022, Table 3 will reflect these amounts. Unless otherwise noted, country teams should meet these funding controls when programming in their FAST.

**Condoms (GHP-USAID Central Funding)** - This initiative control denotes the amount of GHP-USAID central funding the country team may use to procure male and female condoms, lubricants, and to ship these commodities to the OU. Any additional condoms and lubricants to be procured with PEPFAR funding should be budgeted in the FAST with bilateral funding.

**USAID Southern Africa Regional Platform** - This initiative is for the country’s share of the costs to operate the USAID Southern Africa Regional Platform, which provides administrative and technical support for Angola, Botswana, Eswatini, Lesotho, and Namibia. These funds were previously planned as part of the bilateral COP funding, but are now budgeted and notified centrally, with country amounts included as central funding in the overall COP levels for Angola, Botswana, Eswatini, Lesotho, and Namibia. Only these 5 countries may use this initiative, and this initiative can only be used with central funding specifically provided as part of the PLL controls.

**One-Time Conditional Funding** - The release of any funding made available under this initiative is contingent upon the OU’s ability to meet all requirements outlined in their final COP/ROP approval
memo. OUs that fail to meet these minimum standards may be ineligible to receive these funds for programmatic implementation in FY 2023.

No control is set in the PLL for the HBCU Tx and Surveillance and Public Health Response initiatives, but OUs may include relevant funds under these initiatives instead of Core Program as appropriate.

All funding not attributed to one of the nine COP/ROP 2022 initiatives above should be attributed to the Core Program initiative.

For additional details on initiatives, see the PEPFAR Financial Classifications Reference Guide.

Programmatic Controls: Table 4 shows programmatic controls where S/GAC has directed funding for certain programmatic activities. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned. Since every dollar programmed in COP must belong to one initiative, programmatic controls will be a subset of one or more initiative controls, even if the standard Core Program initiative.

PrEP (AGYW) – The PrEP (AGYW) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for the Females – Adolescent Girls and Young Women sub-beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of AGYW on PrEP wherever possible. Countries with a PrEP (AGYW) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

PrEP (KPs) – The PrEP (KPs) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for all sub-beneficiaries under the KP beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of KPs on PrEP wherever possible. Countries with a PrEP (KPs) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

State ICASS: Table 5 shows the amount that the OU must program under State for ICASS Costs.

Funds Programmed under State/SGAC (S/GAC TBDs)

No funding may be programmed under State/SGAC without prior approval from S/GAC M&B. In general State/SGAC TBDs are only used in extraordinary and or unusual circumstances. To the degree that funding is approved, the rationale and any conditions attached to the funding will be documented by M&B. Any S/GAC TBDs approved during COP/ROP 2022 planning will require supplemental language in the OU’s COP/ROP 2022 approval memo, clearly outlining the process for how these funds can be accessed. Any funds that have not been distributed to agencies before the end of FY 2023 may be subject to reprogramming in future planning cycles towards the same OU or another OU.

COP/ROP 2022 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

Whenever possible, all agencies within an OU should hold several months of pipeline at the end of COP/ROP 2022 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in
cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain this buffer. With the exception of Dominican Republic, Ethiopia, Haiti, South Sudan, Zimbabwe, Asia Regional Program, and Western Hemisphere Regional Program, which should hold up to four months of pipeline, all other OUs are permitted to hold no more than three months of buffer pipeline.

Any agency that anticipates ending COP/ROP 2021 implementation (end of FY 2022) with a pipeline in excess of three or four months is required to apply this excessive pipeline to COP/ROP 2022, decreasing the new funding amount to stay within the planning level.

**Transitioning HIV Services to Local Partners**

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. In COP19 Guidance, PEPFAR set a goal that 40% of partners must be local by the end of FY19, and 70% by the end of FY20. While considerable progress was made in this effort, the 70% mark was not achieved by all agencies in all OUs, and thus in FY22 and FY23, teams must continue to prioritize this so that the 70% goal can be realized. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY23 as appropriate through their COP/ROP 2022 submission.