United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 19th, 2022

INFORMATION MEMO FOR CHARGÉ D' AFFAIRS KENNETH H. MERTEN, HAITI

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

THROUGH: William S. Paul and Tiana Jaramillo

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

Dear Chargé Merten,

First and foremost, I sincerely hope that you and your team are safe and healthy. I am extremely grateful for the U.S. Embassy's support of the PEPFAR program and additional COVID-19 response efforts during this extraordinarily difficult year for Haiti.

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, 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:

- The continued growth of the number of people receiving life-saving HIV treatment, approaching the UNAIDS 95/95/95 goals for HIV epidemic control.
- Simplifying HIV treatment for people by advancing multi-month dispensing (MMD) and community drug distribution (CDD).
- Accelerated Pre-Exposure Prophylaxis (PrEP) scale-up.
- Improved coordination and collaboration with stakeholders, and a strong start to community-led monitoring (CLM).

Working with the Government of Haiti and civil society leadership, we have made tremendous progress together. Haiti should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing close 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 Haiti:

- Low viral load testing coverage (VLC) and low viral load suppression (VLS) across age/sex categories and populations.
- Gaps in the HIV prevention, diagnosis, and treatment cascade for children.
- Sustained focus on tailoring services, systems, and partnerships to differentiate service delivery to optimize care and reduce interruptions in treatment. Community-led monitoring should be emphasized as a crucial source of information to improve service delivery.
- Optimizing services for members of key populations and vulnerable populations, including apparent gaps in testing, linkage, and prevention.

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 Haiti is **$106,800,000** 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 Haiti and civil society of Haiti, 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 – William S. Paul, PEPFAR Chair; Tiana Jaramillo, PEPFAR Program Manager; Hamfrey Sanhokwe, 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. Steady growth of the treatment cohort (125,438 at the end of Q4 in FY 2021) compared to FY 2020 (116,829) while keeping the quarterly reported interruptions in treatment (IIT) to $\leq$ 2.7% of the total people on treatment (TX_CURR), having consistently positive numbers of people newly initiated on treatment (TX_NEW), and successfully tracking and tracing interruptions in treatment (IIT) and bringing clients back to care.
2. Being a leader in simplifying ART treatment by advancing multi-month dispensing (MMD) and community drug dispensing. The PEPFAR Haiti program has one of the highest MMD3+ (97%) and MMD6+ (72%) coverage rates among PEPFAR-supported countries. It continues to maintain the high rates of coverage among adults (15+ years old) and increase MMD uptake among pediatric clients (<15 years old).
3. Accelerated Pre-Exposure Prophylaxis (PrEP) scale-up, surpassing 100% of targets for all age groups and female sex workers (FSW) in FY 2021, and policy efforts to introduce PrEP on demand for selected individuals.
4. Progress on community-led monitoring (CLM), and coordination and collaboration with stakeholders to advance PEPFAR goals.

Challenges

1. Low viral load testing coverage (VLC) and low viral load suppression (VLS) across age/sex categories and populations. VLC rates decreased from 86% in FY 2020 to 81% in FY 2021. VLC among adults of all ages reported significant gaps, particularly young adults (20-34 years old). VLC remained suboptimal for key populations, except transgender clients (TG, 94%), and for pregnant women (44%). While the number of patients virally suppressed increased from 80,801 in FY 2020 to 85,555 in FY 2021, VLS among children/adolescents <15 years old, pregnant women, and breastfeeding women remained quite low at 78%, 81%, and 83% respectively. VLS among key populations also remained suboptimal.
2. There are gaps in pediatric ART coverage and gaps in testing and linkage among key populations. Except for female sex workers (FSW), all other key population groups reported low ART initiation rates in FY 2021.
3. While the rate of interruption in treatment (IIT) was comparable to other PEPFAR countries in FY 2021, there were high rates of IIT among certain age and sex bands (e.g., 4.8% IIT among young adults 25-29 years old and 3.4% IIT among adults 45-49 years old in treatment for less than three months). A high proportion of TX_ML included patients who died, particularly among children <9 years old. According to program data in MESI, the MoH information system, deaths represented 30% of the total loss of clients in FY 2021. This appears high relative to other PEPFAR countries.
4. Nearly 40% of pregnant women living with HIV were newly initiated ART at the first ANC visit. Initiating ART prior to conception and having a suppressed VL throughout the pregnancy and breastfeeding periods reduce the risk of vertical transmission. The proxy early infant diagnosis (EID) positivity rate for FY 2021 was high at 4.8% and 28.7% of HIV exposed infants (HEI) have an unknown final outcome status.

5. The rate of TB screening among ART patients (74.4%) and the low overall TB screening rate (2.7%), especially among clients already on ART (2.2%), are below standards.

Given your country's status of near achieving epidemic control, the following priority strategic and integrated changes are recommended:

1. **Continue to simplify and strengthen continuous, person-centered treatment** among all age and sex bands and population groups. Continue to build community-led monitoring (CLM) as a useful source of information for program improvements.
2. **Improve diagnostics for VL, EID and TB** by creating more demand for testing, conducting diagnostic network optimization, and accelerating multiplex use of POC platforms for 2 months EID and VL among infants, children, PBFW and non-suppressed population. Increase use of POC for TB testing.
3. **Address gaps for children and for prevention of vertical HIV transmission with specific, measurable, resourced plans** (see technical directives).
4. **Align and optimize services for key populations.** Conduct a biobehavioral survey, address apparent gaps in testing and linkage for MSM, and complete assessment for trans-friendly services.
5. **Scale existing and introduce new effective high-impact prevention interventions**, including but not limited to shifting from user-initiated service to provider-initiated service PrEP, increasing GBV services and support, and scaling the provision of PrEP for higher incidence populations and prioritized populations such as adolescent girls and young women (AGYW).
6. **Accelerate progress of and optimize above-site investments**, including but not limited to the implementation of a government-led, person-centered, private-sector operated, resilient, and adaptive supply chain model, enhancing data quality, data accessibility, and health management information systems, and accelerating the transition to local partners.

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

	Bilateral				Central				Total
	FY22	FY21	FY20	Unspecified	FY22	FY21	FY20	Unspecified	TOTAL
Total New Funding	**$ 103,648,902**	**$ -**	**$ -**	**$ -**	**$ 800,000**	**$ -**	**$ -**	**$ -**	**$ 104,448,902**
GHP-State	$ 102,661,402	$ -	$ -		$ -	$ -	$ -		$ 102,661,402
GHP-USAID	$ -				$ 800,000				$ 800,000
GAP	$ 987,500				$ -				$ 987,500
Total Applied Pipeline	**$ -**	**$ -**	**$ -**	**$ 2,351,098**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 2,351,098**
HHS/CDC				$ 903,144				$ -	$ 903,144
USAID				$ 828,963				$ -	$ 828,963
State/WHA				$ 618,991				$ -	$ 618,991
TOTAL FUNDING	**$ 103,648,902**	**$ -**	**$ -**	**$ 2,351,098**	**$ 800,000**	**$ -**	**$ -**	**$ -**	**$ 106,800,000**

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

Countries should plan for the full Care and Treatment (C&T) level of $66,366,800 and the full Orphans and Vulnerable Children (OVC) level of $8,714,900 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*

	Appropriation Year			
	FY22	FY21	FY20	TOTAL
C&T	$ 66,366,800	$ -	$ -	$ 66,366,800
OVC	$ 8,714,900	$ -	$ -	$ 8,714,900
GBV	$ 2,198,700	$ -	$ -	$ 2,198,700
Water	$ 813,000	$ -	$ -	$ 813,000

*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.

	Bilateral	Central	TOTAL
Total Funding	**$ 106,000,000**	**$ 800,000**	**$ 106,800,000**
Core Program	$ 95,582,633	$ -	$ 95,582,633
Condoms (GHP-USAID Central Funding)	$ -	$ 800,000	$ 800,000
DREAMS	$ 3,810,967	$ -	$ 3,810,967
OVC (Non-DREAMS)	$ 6,606,400	$ -	$ 6,606,400

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.

	Bilateral	Central	TOTAL
Total Funding	**$ -**	**$ -**	**$ -**
PrEP (AGYW)	$ -	$ -	$ -
PrEP (KPs)	$ -	$ -	$ -

TABLE 5: State ICASS Funding

	Appropriation Year
	FY22
ICASS	$ 51,428

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)

Indicator	FY21 result (COP20)	FY22 target (COP21)
TX Current <15	3,632	5,087
TX Current >15	121,801	128,893
DREAMS (AGYW PREV)	32,958	26,596
TB Preventive Therapy	16,244	22,597

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

OU/Agency	Approved COP/ROP 2020 Planning Level	Total FY 2021 Outlays	Over/Under Outlays
Haiti	**$101,463,224**	**$96,068,600**	**$5,394,624**
HHS/CDC	$50,847,536	$47,163,782	$3,683,754
State	$359,364	$79,951	$279,413
USAID	$27,298,943	$27,299,809	-$866
USAID/WCF	$22,957,381	$21,525,058	$1,432,323
Grand Total	**$101,463,224**	**$96,068,600**	**$5,394,624**

TABLE 8. COP/ROP 2020 | FY 2021 Results & Expenditures

Agency	Indicator	FY21 Target	FY21 Result	% Achievement	Program Classification	FY21 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	213,702	278,497	130.3%	HTS Program Area	$1,235,665	100%
	HTS_TST_POS	6,077	9,566	157.4%			
	TX_NEW	5,484	9,732	177.5%	C&T Program Area	$23,518,926	73%
	TX_CURR	102,923	97,603	94.8%			
	OVC_SERV	35,332	34,471	97.6%	OVC Beneficiary	$2,541,309	100%
USAID	HTS_TST	73,326	155,212	211.7%	HTS Program Area	$2,001,574	93%
	HTS_TST_POS	1,494	5,417	362.6%			
	TX_NEW	1,972	5,202	263.8%	C&T Program Area	$25,596,795	86%
	TX_CURR	27,940	27,835	99.6%			
	OVC_SERV	77,537	98,787	127.4%	OVC Beneficiary	$4,853,206	97%
				Above Site Programs		$4,855,014	
				Program Management		11,796,763	

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 and practices significantly undermines HIV impact and results in inefficient and ineffective programs.

All PEPFAR programs are expected to meet all 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

Care and Treatment
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: Completed. Fully implemented at all PEPFAR-supported sites. Issues or Barriers: N/A.
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: Completed. 87% of all ART clients (20+ kg) on TLD-based regimen. NVP-based regimen removed. Pediatric DTG introduced in FY 2021. ~74% of the eligible children have been transitioned. Issues or Barriers: Supply chain issues. Eligible children were initially transitioned to DTG 5mg. Haiti received DTG 10mg. to complement the transition.
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 (target date: September 2022). In FY 2021, 97% of all patients were on MMD3+, including 72% who were on MMD6+. Issues or Barriers: The MoH authorized MMD3+ for newly enrolled and unstable clients. Advocacy is needed to ensure that new patients transition smoothly from MMD3+ to MMD6+.
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 (target date: September 2023). TPT and cotrimoxazole implemented at all supported sites as part of the HIV clinical care package. Issues or Barriers: Policies are in place; performance needs to improve. The program should work with relevant stakeholders to assess TB screening practices among PLHIV and consider updates based on WHO guidance. Tracking and completion of TPT should be improved as well.
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 (target date: September 2023). Activities and mapping completed. Partial readiness assessment (done at 50%) for sites/hubs selected to integrate EID in TB POC GeneXpert. The regional lab in the North department is fully functional for EID/VL testing. There are three (3) EID/VL hubs in country. Issues or Barriers: VL backlogs and increased turn-around time (TAT). Service interruptions were reported due to multiple equipment failures, delays in repairs due to lack of spare parts in country,

	reagent stock-outs, power shortage, shutdown, and staff infected with COVID-19 at the three labs. Inter-agency collaboration needed to mitigate challenges.
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: In process (target date: September 2022). Scale-up of index testing and self-testing underway. Issues or Barriers: Issues were identified in the implementation of pediatric index testing, with case finding below the target of 45% in FY 2021.
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: In process (target date: September 2023). Prevention services offered to high-risk clients, including PrEP. Ongoing implementation of PrEP in 13 arrondissements (districts) across 9-geographic departments. Outstanding results on PrEP in FY 2021. Issues or Barriers: There is need to improve performance and coverage of PrEP among MSM.
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: In process (target date: September 2023). Issues or Barriers: 82% achievement of the OVC_SERV target for <18 yr. old reported in FY21 but over 250% achievement for age 18+. Program implementation review (including looking at potential reporting inaccuracies) required to ensure partners are targeting appropriately and reporting accurately.
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 (target date: Ongoing). Issues or Barriers: No explicit laws or policies to include the control of HIV and ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS exist. Legal protection for key populations is limited. Limited efforts in place to educate and ensure the rights of PLHIV, all epidemiologically significant key populations, and adolescents (SID 2021). CLM results from 41 supported sites show that at least 22% of the establishments have at least one-patient's confidentiality or/and privacy problem.
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: Completed. Issues or Barriers: User fees for other health services exist (SID 2021).
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: In Process (Target date: Ongoing). Intensification of IP performance monitoring and virtual site visits. Web-based electronic platform for CQI (HealthQual) activities monitoring used at all PEPFAR –supported sites. PLHIV associations engaged in clients monitoring and adherence. Issues or Barriers: Communication and collaboration challenges between PEPFAR/Haiti and the MoH and CLM implementer should be addressed to ensure complementarity of data collection and continuous quality improvement efforts. Approach to QA (site standards including infection prevention and control, safe/ethical index testing) needs to be clarified and implemented.
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 (target date: Ongoing). U = U messages ongoing for general population. VL Class ongoing at all PEPFAR-supported sites. Education sessions ongoing for PLHIV beneficiaries. Engagement of PLHIV at selected sites initiated in some districts. ART Treatment literacy with messages including messages of hope translated into Creole and disseminated via mass media. CLM results from 41 supported sites found that 71% of those interviewed agreed with the statement 'having an undetectable viral load means that HIV is untransmissible. Issues or Barriers: CLM results also found that only 59% of PLHIV interviewed knew their viral load test result.
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 (target date: September 2023). Issues or Barriers: Need to recruit more local implementing partners.
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 (target date: Ongoing). MSPP has a stewardship role for the national HIV response, in terms of policies and guidelines. Issues or Barriers: Budget for FY 2021 by Haiti's Ministry of Economy and Finance had a total government revenue shortfall of ~$617 million. Budget for nearly all programs and ministries decreased, including the Ministry of Public Health and Population. Monitoring actual disbursements is critical going forward.
15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. Status: In-process (target date: Ongoing) Issues or Barriers: High proportion of treatment interruptions with an outcome of "died". Improvement in verbal autopsy roll-out and COD field completion in EMR needed. Need to refresh to ICD11.
16. Scale-up of case surveillance and unique identifiers for patients across all sites. Status: Completed. Up and running fully since 2018. Issues or Barriers: Need for enhanced data quality, data accessibility and health management information systems, including a TB patient tracking system integrated with MESI.

In addition to meeting the minimum requirements outlined above, it is expected that Haiti 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

Haiti – Specific Directives
HIV Clinical Services
1. **Universal offer of safe and ethical index testing is required for all eligible clients.** Ensure case finding optimization to reduce over testing and optimize rates of positivity across all partners. Continue to accelerate implementation of self-testing to serve key and vulnerable populations. Design and implement strategies targeting men who have sex with men (MSM). Optimize contributions of communities of faith within overall testing strategy.
2. Accelerate expansion of mobile outreach, men's clinics and men-friendly services, and client-friendly services for hard-to-reach populations. Intensify use of data on clients who experience high mobility and are at high risk of IIT to design and implement appropriate strategies. Collaborate as appropriate with PEPFAR DR.
3. **Focus on improving the pediatric cascade** by 1. Intensifying case finding efforts for unidentified children and adolescents living with HIV (C/ALHIV) with a special focus on scaling family index testing; 2. Target interventions to address interruptions in treatment for CLHIV, i.e. ensure age-appropriate disclosure, strengthen OVC/community enrollments, scale up family-centered DSD services and peer support; 3. Complete the transition to DTG10mg for all eligible children, including monitoring of outcomes; and 4. Improve TB screening of CLHIV and TB testing of those who screen positive.
4. **Improve PMTCT so that HIV Exposed Infants are HIV free**. Some areas of focus are: A) Expand efforts to test and treat adolescent girls and young women (AGYW) prior to antenatal care (ANC) attendance; B) Increase focus on pregnant and breastfeeding women (PBFW). Sustain high performance in PMTCT_STAT and PMTCT_ART. Improve continuity of treatment, multi-month dispensing (MMD). Update guidelines to include VL testing during pregnancy and advance viral load testing coverage (VLC) and viral load suppression (VLS) for pregnant women and improve EID coverage through demand creation, community testing, and use of point of care platforms; and C) Improve final outcome reporting through enhanced mother-baby-pair monitoring (e.g., mentor mothers), utilization of OVC enrollment, and enhanced case monitoring. To decrease HEI positivity rate, PEPFAR Haiti should also consider the implementation of a robust maternal re-testing strategy for high risk PBFW and a focus on PrEP for HIV-negative mothers throughout the pregnancy and breastfeeding period. Consider an HEI/EID audit if feasible given overall country context.
5. Continue to focus on a proactive approach to preventing interruptions in treatment (IIT), successfully tracing IIT clients and bringing them back to care. Provide a re-engagement package of care that addresses clients' reasons for IIT in a person-centered way to prevent and minimize the constant cycle of disengagement and re-engagement. Scale differentiated service delivery (DSD) services such as early initiation of multi-month dispensing (MMD) for clients with high risk of IIT in the first three months on treatment (e.g., 25-29 age band) to promote continuity of treatment from the point of treatment initiation. Use pharmacy cards and biometrics to better track clients and ensure treatment continuity, provision of a package of support services for the young adult age bands who are too old for OVC support and at high risk of IIT, and virtual models for engagement/case management.
6. Assess causes of high proportion of TX_ML clients reported as having died, particularly among pediatric clients. Increase use and review of surveillance data to capture treatment interruptions and improve monitoring of all-cause mortality among HIV cohorts vs. HIV-related mortality.

7. Implement U=U messaging and user-friendly U=U materials, including age-appropriate disclosure and client-centered psychosocial services for children and adolescents living with HIV (C/ALHIV). Ensure community engagement in these efforts.
8. Improve viral load (VL) testing coverage among all ages, sex and populations and two months early infant diagnosis (EID) by creating demand for more testing, conducting diagnostic network optimization (DNO) to address issues around supply chain, all-inclusive pricing, and ensuring integrated diagnostics and multiplex use of conventional and point of care (POC) platforms to support testing for HIV (VL, EID), TB and COVID-19 as needed. Support decentralized and community viral load sample collection and testing, particularly in the context of MMD3+ and MMD6+. Specifically consider the use of POC platforms for EID and VL testing among infants and children, pregnant and breastfeeding women (PBFW) and non-suppressed populations.
9. Conduct cohort assessments to track actual outcomes for defined groups where relevant, e.g., infants <1 year old, to inform related programming. Review current assessment and response (as available) or develop an assessment of needs and resources addressing advanced HIV disease and for comorbidities among people aging with HIV comorbidities.
HIV Prevention Services
10. Improve TB screening levels and TB screening yield. Review with relevant stakeholders the new WHO TB screening guidelines and assess current algorithm and feasible improvements. Assess and monitor quality of TB symptom screening for PLHIV. Ensure TB data quality and reporting into the HIV system.
11. Sustain or improve TPT completion rates across all partners. Improve tracking of PLHIV initiating TPT.
12. Ensure all AGYW complete the primary package and receive necessary secondary components. Review performance of all IPs for delivery and monitoring of the DREAMS Core Package and make course corrections and/or realignment of DREAMS portfolio to ensure implementation of complete package. Ensure all IPs utilize the same reporting system to ensure data quality.
13. In COP 22, PrEP should continue to be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP should be tailored to the OU's epidemic context with a focus on key populations (including sex workers, men who have sex with men, transgender people, people in prisons and other closed settings, people who inject drugs), adolescent girls and young women (AGYW) including pregnant and breastfeeding (PBFW), and other identified higher-incidence populations. Ensure PrEP access for anyone who requests PrEP and include Event-Driven PrEP for gay, bisexual and men and other men who have sex with other men in national guidelines. Continue to expand PrEP, especially among AGYW and key populations, increasing the corresponding targets and budget. Adopt a decentralized approach to delivering of services and consider using virtual platforms to reach and retain clients. Leverage the scale-up of index testing to offer PrEP to partners who test negative.
14. 98% or more of children and adolescents on ART in OVC SNUs must be offered enrollment in comprehensive OVC program.
Other Government Policy, Systems, or Programming Changes Needed
15. Report quarterly on work and results with mobile populations, including ART clients who migrate or visit to the DR or other countries. Collaborate as appropriate with PEPFAR DR.
16. COP/ROP 22 plans should prioritize and take specific steps to address the structural barriers that impede scale up of KP-led and KP-competent differentiated HIV services, as well as the lack of robust data to guide key populations programming. To strengthen strategic information to guide KP responses, plans may include efforts to strengthen individual level data systems and analyses and address gaps in subnational data. Addressing structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that

fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and strengthening the KP competency of HIV service providers. PEPFAR teams should ensure they are coordinating strategically with relevant State and U.S. government units (e.g., DRL), partner government, multilateral, and other donor funding streams and institutions. As part of the new COP 22 MPR, PEPFAR teams will be expected to describe and present their approach to improving KP data and addressing barriers to accelerated KP-centered HIV services during COP/ROP 22 planning meetings.
17. Ensure partners and sites have contingency plans for continuity of care during events that may disrupt normal services. Contingency plans must be addressed in work plans and program implementation (including education for ART clients).
18. Accelerate implementation of a modernized, sustainable, government-led, client-centered, resilient, and adaptive supply chain model. Work with unit at the MoH level to manage 3PL contracts towards achieving a Mixed Model Supply Chain. Develop a regional supply chain management model to be replicated by the MOH at other regions of the country with other key partners; emphasize a client-centered approach to achieve epidemic control, site level data visibility, product availability, and quality while proactively monitoring and mitigating the related risks. Transition to a system with increasing responsibility by government counterparts for oversight and management.
19. Build practices for inter-agency collaboration to mitigate supply chain challenges caused by security issues, fuel shortage, COVID-19, and others.
20. Increase integration of effective predictive analytics for targeted program improvements while sustaining the investments in monitoring and evaluation and data use capacity. Complete the roll-out of iSantePlus (based on opensource OpenMRS version) and ensure the implementation of guidelines on personal identifiable information (PII) protection, data open standards, and data sharing, as well as a transition and sustainability plan.
21. Intensify the correct use of patient-level data based on biometric code to close gaps in clinical and prevention cascades.
22. For COP21/FY22 benchmarks for above-site investments that were not achieved or completed, review the activities to ensure that they are still addressing gaps or barriers towards sustainability, if so, accelerate progress towards their completion, particularly the ones that reported delays. Ensure that adaptations moving toward sustainability are incorporated into COP22 planning.
23. Continue to ensure MSPP[1] participation and leadership in national quantification exercises to plan for anticipated needs of HIV commodities. Quantification for commodities for advanced disease should include children and adolescents, and pediatric formulations of cotrimoxazole and TPT should be procured.
24. Set aside sufficient funding for commodities in COP 22.

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.

[1] Ministry of Public Health and Population.

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:

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)
+
Prevention: **community mobilization, behavior, and norms change** (all populations)
+
50 % Prevention: **Not disaggregated** (all populations)

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 aged 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 person-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.