United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 19th, 2022

INFORMATION MEMO FOR AMBASSADOR LEONARD, NIGERIA

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

THROUGH: William Paul M.D. and Lorin Letcher M.P.H.

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

Dear Ambassador Leonard,

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:

1. Dramatic increases in the number of people on antiretroviral treatment in FY21, with net growth of over 500,000 people despite the impact of COVID-19. This has moved Nigeria significantly closer to the UNAIDS 2025 benchmarks of 95/95/95.
2. Consistent efforts to make HIV treatment simpler and easier and to support continuity of treatment. This includes dramatic scale-up of 6-month multi-month dispensing
3. Expansion of services for key populations, with significant growth in the number of people on treatment and pre-exposure prophylaxis, while addressing human rights concerns with the Patient Education Empowerment Project (PEEP).
4. Launching the National Alignment to improve coordination, planning, and capacity building between the National HIV Program, Global Fund, and PEPFAR efforts.

Working with the Government of Nigeria and civil society leadership, we have made tremendous progress together. Nigeria 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, focus and attention should be given to the following key challenges in PEPFAR Nigeria:

1. Completing the mission to reach 95/95/95: ART Coverage in 16 PEPFAR states remains below 81%.
2. Addressing the gaps for children: **38%** of estimated children living with HIV are on treatment.
3. Continuing to develop and advance the National Alignment in pursuit of a longer-range vision, as you accomplish ART treatment goals in a context of COVID-19. Note that this is both a strength and a challenge which requires sustained coordination of work on systems (e.g., NDR, supply chain) as well as building plans and partnerships in support a shared vision.

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 Nigeria is **$400,000,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. This level also assumes that the DoD AFRICOS program will be funded at the same level in COP22 as it was in COP21. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Nigeria and civil society of Nigeria, 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 Paul, Lorin Letcher, and Murphy Akpu**

Overview: COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction

With input from the country 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. The PEPFAR team worked with partners and stakeholders to successfully grow the treatment cohort by 502,533 in fiscal year 2021.
2. The viral load coverage was brought up to 90% and viral load suppression to 95% in fiscal year 2021 for all states supported by PEPFAR.
3. Multi-month dispensing for 6 months expanded from 11% in fiscal year 2020 to 66% by the end of fiscal year 2021.
4. The TB preventive therapy completion rate was at 94% by the end of fiscal year 2021.
5. The Key Population program has seen tremendous growth over fiscal year 2021 both with the uptake of services and growth of the cohort.
6. The roll-out of the Patient Education Empowerment Project (PEEP) program was met with success this year and will help to support an enabling environment for HIV prevention and control.

Challenges

1. There are still some treatment gaps including ART coverage being below 81% in 16 PEPFAR states to be prioritized for focus in COP22.
2. Of the children living with HIV in Nigeria, only an estimated 38% are on treatment.
3. The PMTCT (prevention of mother to child transmission) program continues to have reporting and data issues that obscure clear assessment of the program issues and viral load coverage gaps for this population.
4. The viral load coverage programming is impacted by supply disruptions, equipment breakdown and issues with coordinating clinic-laboratory interface.

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

1. **Maintain forward movement with stakeholders in the national alignment.** PEPFAR Nigeria has achieved success with the national alignment to date, reducing duplication of effort and playing to the strengths of the government, PEPFAR, and Global Fund. During COP22 planning, PEPFAR Nigeria should articulate the medium-term vision for the Nigeria HIV program, and plan COP22 as a step toward this vision. Include stakeholders under National Alignment in plans to scale and optimize services and standardize the service package for key populations, including prevention services such as PrEP.
2. **Aim to close the treatment gaps in states with ART Coverage less than 81%.** To support this, an interim assessment of ART surge impact should assess current estimates of people living with HIV in 12 PEPFAR states with greater than 100% treatment coverage, and refine our understanding of the remaining gaps.
3. **Plan a specific effort to close the treatment gaps for children & adolescents.** This plan should include increased support of the OVC program, aligned with pediatric Care & Treatment services to maximize the impact of both. PEPFAR Nigeria should address improving the pediatric cascade by:

- Setting ambitious pediatric case finding targets and ensuring the HIV case identification strategies for children and adolescents are appropriately aligned, with an increased focus on scaling index testing in facility and community platforms;
- Targeted interventions to address interruptions in treatment for CLHIV and mortality in children < 5years (strengthen advanced disease package); and
- Targeted interventions to improve VLC for CLHIV <5 years of age (80% in Q4). Efforts should be intensified to ensure all C/ALHIV are transitioned to DTG/TLD based regimens as one strategy to improve VLS rates among C/ALHIV (<90% in Q4).

4. **Optimize viral load diagnostic network**. This would include improving equipment and reagent supply chain management at national and sub-national level. Similar client level systems (EMR-LIMS) should be assessed for improved viral load coverage, turn-around-time, and for timely decision-making.

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	$ 395,074,982	$ -	$ -	$ -	$ 1,000,000	$ -	$ -	$ -	$ 396,074,982
GHP-State	$ 347,112,482	$ -	$ -		$ -	$ -	$ -		$ 347,112,482
GHP-USAID	$ 46,000,000				$ 1,000,000				$ 47,000,000
GAP	$ 1,962,500				$ -				$ 1,962,500
Total Applied Pipeline	$ -	$ -	$ -	$ 3,925,018	$ -	$ -	$ -	$ -	$ 3,925,018
DOD				$ 2,651,326				$ -	$ 2,651,326
USAID/WCF				$ 922,834				$ -	$ 922,834
State/AF				$ 350,858				$ -	$ 350,858
TOTAL FUNDING	$ 395,074,982	$ -	$ -	$ 3,925,018	$ 1,000,000	$ -	$ -	$ -	$ 400,000,000

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

Countries should plan for the full Care and Treatment (C&T) level of $277,419,600 and the full Orphans and Vulnerable Children (OVC) level of $29,315,200 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	$ 257,419,600	$ -	$ -	$ 257,419,600
OVC	$ 29,315,200	$ -	$ -	$ 29,315,200
GBV	$ 4,690,000	$ -	$ -	$ 4,690,000
Water	$ 437,000	$ -	$ -	$ 437,000

*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	**$ 399,000,000**	**$ 1,000,000**	**$ 400,000,000**
Core Program	$ 370,684,700	$ -	**$ 370,684,700**
Cervical Cancer	$ -	$ -	**$ -**
Community-Led Monitoring	$ -	$ -	**$ -**
Condoms (GHP-USAID Central Funding)	$ -	$ 1,000,000	**$ 1,000,000**
DREAMS	$ -	$ -	**$ -**
HBCU Tx	$ -	$ -	**$ -**
One-time Conditional Funding	$ -	$ -	**$ -**
OVC (Non-DREAMS)	$ 28,315,300	$ -	**$ 28,315,300**
Surveillance and Public Health Response	$ -	$ -	**$ -**
VMMC	$ -	$ -	**$ -**

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	**$ 5,533,000**	**$ -**	**$ 5,533,000**
PrEP (AGYW)	$ -	$ -	**$ -**
PrEP (KPs)	$ 5,533,000	$ -	**$ 5,533,000**

TABLE 5: State ICASS Funding

	Appropriation Year
	FY22
ICASS	$ 144,509

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	**53,735**	**84,146**
TX Current >15	**1, 597,487**	**1,612,328**
Cervical Cancer Screening	**68,621**	**75,695**
TB Preventive Therapy (N)	**574,859**	**366,616**

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

OU/Agency	Sum of Approved COP/ROP 2020 Planning Level	Sum of Total FY 2021 Outlays	Sum of Over/Under Outlays
OU	$375,016,542	$353,075,129	$21,941,413
DOD	$13,491,612	$10,341,853	$3,149,759
HHS/CDC	$128,314,137	$126,221,830	$2,092,307
State	$1,081,192	$664,320	$416,872
USAID	$142,314,107	$129,911,473	$12,402,634
USAID/WCF	$89,815,494	$85,935,653	$3,879,841
Grand Total	$375,016,542	$353,075,129	$21,941,413

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	2,935,506	**5,880,785**	200.3%	HTS	$21,758,214	76%
	HTS_TST_POS	72,943	**283,809**	389.1%			
	TX_NEW	69,841	**285,171**	408.3%	C&T	$52,420,254	68%
	TX_CURR	883,395	**1,040,026**	117.7%			
	OVC_SERV	613,758	**636,629**	103.7%	OVC	$15,219,995	97%
DOD	HTS_TST	86,042	**73,085**	84.9%	HTS	$620,461	83%
	HTS_TST_POS	2,560	**4,411**	172.3%			
	TX_NEW	2,436	**4,004**	164.4%	C&T	$3,807,637	81%
	TX_CURR	35,229	**37,023**	105.1%			
USAID	HTS_TST	3,176,640	**4,054,305**	127.6%	HTS	$23,137,948	79%
	HTS_TST_POS	58,141	**138,561**	238.3%			
	TX_NEW	51,288	**138,044**	269.2%	C&T	$124,748,820	87%
	TX_CURR	509,973	**574,173**	112.6%			
	OVC_SERV	544,466	**530,223**	97.4%	OVC	$9,827,306	84%
					Above Site Programs	$7,950,327	
					Program Management	$35,165,062	

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

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 Issues or Barriers: Minimal to none
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 Issues or Barriers: Minimal to none
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: Close to completion. Issues or Barriers: Minimal to none with progressive progress made each quarter.
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 with target date of Q4 FY23 Issues or Barriers: Currently scale-up of TPT is only optimal in surge states. Additional progress still needs to be made in red, yellow, and green states. Documentation of TPT completion particularly for adolescents should be addressed.
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 with target date of Q4 FY23 Issues or Barriers: While saturation is above 80% for all state categorization, there is still work needed to be done in this MPR as evident by the drop in VL for EID and other beneficiaries in Q4 FY20. Work is being done to identify the bottlenecks contributing to the drop, and implement solutions.
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 with target date post FY23 Issues or Barriers: Scale-up of index testing continues to be a challenge across states particularly in the red states. Contributing issues include lack of proper documentation of testing of children of PLHIV that compounds the ability to understand the scope of the program issue.
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 with a target date post FY23 Issues or Barriers: Need to build sustainability into the model as PrEP programming is brought to scale.
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 with a target date post FY23 Issues or Barriers: limitations in red, yellow, and green states have prevented completion of this MPR.
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 to be completed post FY23 Issues or Barriers: legal barriers for the rights of KPs and societal stigmas continue to present challenges with addressing this MPR.

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: In-process with a target completion date of post FY23 Issues or Barriers: Success in surge, red, and green states has been curved by delays of removal of user fees across all yellow states. With a renewed focus on improved programming to accelerate saturation in these states, removal of user fees in these states should be a top priority for FY23.
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 with a target completion of post FY23 Issues or Barriers: Team should specifically articulate approach/es to QA in addition to CQI, and assess implementation of infection prevention and control and index testing quality standards.
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 to be completed post FY23 Issues or Barriers: U=U campaigns continue to scale up with success but have been met with issues in areas with high security risks.
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 to be completed post FY23 Issues or Barriers: there continues to be an increase in the budget allocation to local partners each year.
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 to be completed post FY23 Issues or Barriers: there are opportunities to make large gains in this MPR due to lack of progress during previous years.
15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. Status: Close to completion Issues or Barriers: Minimal to none.
16. Scale-up of case surveillance and unique identifiers for patients across all sites. Status: In-process with a target completion of post FY23 Issues or Barriers: scale-up of the biometric screening through the Nigeria MRS EMR system continues to be scaled up each quarter with 70% of sites supporting the system. Work continues to reach 100% of sites and patients recorded with a unique identifier. Barriers include infrastructure and security issues in select states.

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

Nigeria –Specific Directives
HIV Clinical Services
1. Ensure that safe and ethical index testing is offered to all eligible people living with HIV (universal offer), including those who are newly diagnosed and those with unsuppressed viral load. Report quarterly on this standard. De-emphasize use of risk stratification tool in prioritized PITC settings to increase absolute case finding.
2. Treatment coverage for some age bands and PSNUs is over 100%. Re-evaluate estimates for people living with HIV and the distribution by age and sex to ensure best possible population estimates.
3. Ensure optimal utilization of NDR and biometric data. Site staff routinely access NDR to investigate new clients to determine their treatment status at time of presentation: Treatment Naive counted under TX_NEW, Non-Naive counted as returned or transferred, and tracking transfers to ensure completed and trace patients with interruptions in treatment (IIT) across facilities; routine use of biometrics to de-duplicate the count of clients reported on treatment (TX_CURR)
4. Investigate sites (> 500 clients) that are reporting zero IIT or less than 0.2% IIT for completeness of reporting. Use findings from investigation of large sites to work with partners to correct TX_ML_IIT reporting errors in all sites to ensure most accurate information on IIT is available for program planning and monitoring.
5.To address supply chain constraints on viral load coverage, consider vendor-managed inventory approaches. Fully utilize LIMS for visibility into laboratory related supply chain, and optimize EHR-LIMS integration. Ensure all data systems and solutions meet interagency information needs and establish clear expectations around data visibility and use for supply chain management. ,
6. Despite the global gains in VLC/VLS for the 15+, there are gaps in testing across age bands with varying numbers of unsuppressed PLHIV. Along with optimizing lab systems, consider a strategy that will leverage clinical, community and case-based management approaches to expand VL testing equitably across age bands
7. Address PMTCT data challenge and work with NMoH in context of National Alignment to advance PMTCT design and implementation. Strengthen integration of MCH and HIV services and support provision of RTKs for MTCT.
HIV Prevention Services
1. In COP 2022, 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 including pregnant and breastfeeding AGYW, and other identified higher-incidence populations. Strengthen the capacity of and fund KP-led organizations to serve as promoters of PrEP. Ensure demand creation, entry points, accessibility and barriers to PrEP are addressed.

2. In order to plan for sustainability of PrEP programming, PEPFAR Nigeria should develop a plan for differentiated service delivery models, including private sector engagement and solutions, exploring options such as pharmacy delivery models.
3. PWIDs continue to be reached, tested and placed on ART. Implementation of a harm reduction strategy for PWID based on medically assisted therapy (MAT) is needed to ensure they are retained in care in achieve viral suppression. Also, MAT is important as prevention strategy for PWID who are HIV negative.
4. Continue improved wraparound services to enroll children and adolescents living with HIV and improve HIV-Exposed Infant enrollment. Strengthen PSNU-level OVC program alignment with TX_CURR<15 and <20y/o volume (proxy coverage of 75%) as well as with HIV+ pregnant women accessing ANC and other sites. Work closely with PMTCT to align OVC_SERV <1y/o targets with PSNU-level PMTCT_ART results, prioritizing high coverage of PMTCT_ART<20y/o, to accelerate HEI/MBP enrollment in the OVC program. Currently, <1 enrollment for OVC_SERV reached only 24% achievement.
5.In the Nigeria PMTCT program, 2-mo and 12-mo HEI linkage remains low (73% and 79% respectively in FY21 Q4). In COP22, Nigeria could optimize client tracking of positive infants and implement case management support. Another effective strategy to consider supporting HEI linkage is point of care testing (POCT) for early infant diagnosis (EID), which has been shown to significantly reduce turnaround times and increase rates of ART initiation.
6. Close gaps in PEPFAR-supported countries with highest Pediatric/PMTCT needs. Despite our successes, significant challenges remain to eliminate vertical transmission of HIV and close the treatment gap for children and adolescents. Seven PEPFAR-supported countries have the largest gaps per UNAIDS 2020 estimates triangulated with PEPFAR data/footprint: Nigeria, Mozambique, Zambia, South Africa, Tanzania, Uganda, and DRC. COP 22 submissions for these focus countries must clearly describe existing gaps (including those related to service delivery and socioeconomic needs) and how their respective OU will program to achieve specific goals/targets that will address these gaps. Budgetary specificity for each of these beneficiary groups should be provided in the FAST. Pediatric and PMTCT human resources should be allocated, as needed, to reach goals/targets. Throughout the year these countries will be expected to have dedicated, regular, review meetings to monitor and evaluate progress and take corrective action, if necessary, through the POART process. Reviews should also include detailed expenditure analysis to ensure appropriate resources are directed to closing PMTCT/Pediatric gaps.
7.Ensure gender-based violence services include services for sexual violence and post-exposure prophylaxis, as well as linkage to PrEP.
Other Government Policy, Systems, or Programming Changes Needed
1. Strengthen Government of Nigeria capacity to oversee the public health supply chain as stewards for commodity availability and security through assistance to NAFDAC and Logistics Management Coordination Units (LMCU), including advocacy for National Traceability Strategy implementation, support for data-driven supply chain decision-making, and accelerated utilization of private sector capabilities. Strengthen Government of Nigeria's capacity to address structural barriers for KP. Continue to segment supply chains to meet unique patient/population needs by developing and implementing coordinated strategies to increase commodity and laboratory supply chain responsiveness and resilience, including expansion of differentiated service delivery modalities such as MMD and DDD.
2. 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.

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:

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 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.