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INFORMATION MEMO FOR AMBASSADOR WRIGHT, TANZANIA

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

THROUGH: **SGAC/Chair, Michelle Chevalier and PPM, Elyssa Finkel**

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

Dear Ambassador Wright,

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:

- Sustained growth of population on treatment and viral suppression despite impacts of COVID-19
- Scaling differentiated service delivery models, including multi-month dispensing
- Approval of the national PrEP framework and initiation of new PrEP clients in FY22 Q1

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

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

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

- Population-specific case identification and treatment continuity for priority populations, including key populations
- Laboratory network optimization to improve the efficiency of HIV detection and viral load monitoring
- Reducing vertical transmission of HIV disease from mother to infant and enhancing pediatric case identification, case management and treatment continuity.

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 Tanzania is **$449,000,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. Additionally, this level assumes that DoD AFRICOS will be funded at the same level as in COP21 and that a PHIA will be funded for COP22 from within this envelope. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Tanzania and civil society of Tanzania, 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 – Michelle Chevalier, Chair;
S/GAC - Elyssa Finkel, PPM;
PEPFAR Tanzania – Jessica Greene, 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. **Sustained growth of population on treatment and viral suppression despite impacts of COVID-19.** Tx_CURR has incrementally increased across quarters from FY20 Q1 to FY21 Q4. In FY21 the program added 117,119 new individuals to treatment for a TX-CURR total of 1,474,460. Viral Load suppression rates also experienced a steady increase between FY20 Q1 and FY21 Q4 rising from 92% to 97%, respectively.
2. **Scaling differentiated service delivery models, including multi-month dispensing.** Tanzania has successfully scaled up MMD over the past year with 60-65% of ART patients on 3MMD in each quarter of FY21**.** Following the approval of 6MMD nationwide in August 2021, 90% of eligible clients were receiving 6MMD in Dar Es Salaam by October 2021, 26 SNUs experienced increases in clients receiving 6MMD and over 200,000 clients received 6MMD in FY21Q4.
3. **Approval of the national PrEP framework and initiation of new PrEP clients in FY22 Q1**. The Government of Tanzania officially approved the national PrEP framework in September 2021 accelerating the enrollment of individuals at high-risk for HIV acquisition on this prevention method. Between October 1st and December 15th, 2021, 8,180 new clients have initiated PrEP with the weekly enrollment averaging between 1000-2000 clients over the last 4 weeks of FY22 Q1. In addition, during FY22 Q1 Tanzania experience an 860% increase in the number of sites prepared to enroll/offer PrEP to new clients, rising from 210 sites on October 1st, 2021, to 2,019 sites by December 15th, 2021.

Challenges

1. **Population-specific case identification and treatment continuity for priority populations, including key populations.** Case identification has steadily improved in Tanzania with the scale-up of index testing, which contributed to 56% of positives from all testing modalities in FY21. However, despite these improvements, gaps in TX_NEW persist among children and adolescents, with the largest gap in 15-19yrs (5,369) in FY21 Q4. Waterfall analyses show that the largest volume of clients with treatment interruptions are those who were on ART >3+ (28,405) and TX-ML transfer out (21,551). At the end of FY21, interruption of treatment was highest among older adolescents and young adults aged 15-39yrs at less than 3 months, with 12% of 15-19yrs experiencing a treatment interruption (highest of all age bands). Last, treatment continuity in key populations ranges as low as 41% in MSM to 73% in PWID in FY 21.
2. **Laboratory network optimization to improve the efficiency of HIV detection and viral load monitoring.** Viral load testing coverage in Tanzania has steadily increased from 77% to 86% (FY19 Q4 baseline coverage) between FY20Q3 and FY21Q4, respectively. Failure to exceed VLC performance of years past largely stems from a confluence of national policy issues, which led to reagent stockouts and equipment failures as labs reduced a VL sample backlog of over 155,000 in FY20Q4 to 36,500+ by the end of FY21Q4. Reagent stock outs also contributed to a backlog of over 16,000 and 12,000+ DBS samples in April 2021 and October 2021, respectively, and a reduction in 2-month EID coverage from 110% in FY20 Q4 to 80% in FY21 Q4.

3. **Reducing vertical transmission of HIV disease from mother to infant and enhancing pediatric case identification, case management and treatment continuity.** The number of new HIV infections for children 0-14 yrs in Tanzania has steadily decreased since 2015, however, in 2020 10,000 new HIV infections still occurred in the pediatric population. ANC 1 testing coverage as indicated by the PMTCT_STAT MER indicator has consistently remained between 99- 100% over the last 8 program quarters, however Post ANC1 and VLC testing data for breastfeeding women is insufficient. Pediatric case finding ranges between 1500-2500 per quarter since FY20Q1 and the index testing elicitation ratio remains at less than one child per index case since FY19Q4. Last in FY21Q4 there was a negative NET_NEW of 1,283 children, which is in large part due to treatment interruptions in children on ART for greater than 3 months.

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

1. Continue to build on strong population-specific case identification efforts, with an enhanced focus on safe and ethical index testing services as a primary priority for the program in COP22. Tanzania should also validate and align risk screening tools to ensure the highest risk individuals receive HIV testing, diagnosis and treatment.
2. Ensure the implementation of tailored linkage and treatment continuity interventions by client/population through real-time data analysis, targeted case management approaches, and population-specific health education/literacy.
3. Ensure the implementation of short and long-term strategies to eliminate HVL and DBS sample backlogs, including completion of lab diagnostic network optimization by the start of COP22.
4. Validate revised maternal retesting tools and include maternal re-testing as part of a comprehensive prevention package including PrEP and family planning for high risk pregnant and breastfeeding women to reduce new child infections. Improve mother-baby cohort monitoring, EID 2-month testing coverage through the use of novel EID assays and scale the roll-out of DTG 10mg (3kg infants) across all service delivery sites.
5. Ensure PrEP is reaching priority subpopulations, including KP (FSW, MSM, PWID), AGYW, sero-discordant couples and pregnant/breastfeeding women and that uptake / coverage by sub-populations is being tracked and monitored.
6. Conduct a new PHIA (THIS 2.0) for Tanzania in COP 22 and utilize data to assess progress towards epidemic control and inform testing, treatment and prevention strategies.

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	$ 378,206,094	$ -	$ -	$ -	$ 500,000	$ -	$ -	$ -	$ 378,706,094
GHP-State	$ 343,087,344	$ -	$ -		$ -	$ -	$ -		$ 343,087,344
GHP-USAID	$ 32,500,000				$ 500,000				$ 33,000,000
GAP	$ 2,618,750				$ -				$ 2,618,750
Total Applied Pipeline	$ -	$ -	$ -	$ 70,293,906	$ -	$ -	$ -	$ -	$ 70,293,906
DOD				$ 929,550				$ -	$ 929,550
HHS/CDC				$ 8,229,950				$ -	$ 8,229,950
PC				$ 1,432,563				$ -	$ 1,432,563
USAID/WCF				$ 59,403,792				$ -	$ 59,403,792
State/AF				$ 298,051				$ -	$ 298,051
TOTAL FUNDING	$ 378,206,094	$ -	$ -	$ 70,293,906	$ 500,000	$ -	$ -	$ -	$ 449,000,000

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

Countries should plan for the full Care and Treatment (C&T) level of $260,508,100 and the full Orphans and Vulnerable Children (OVC) level of $33,212,200 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	$ 260,508,100	$ -	$ -	$ 260,508,100
OVC	$ 33,212,200	$ -	$ -	$ 33,212,200
GBV	$ 7,238,600	$ -	$ -	$ 7,238,600
Water	$ 2,160,000	$ -	$ -	$ 2,160,000
*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	**$ 448,500,000**	**$ 500,000**	**$ 449,000,000**
Core Program	$ 378,469,000	$ -	$ 378,469,000
Cervical Cancer	$ 3,531,000	$ -	$ 3,531,000
Condoms (GHP-USAID Central Funding)	$ -	$ 500,000	$ 500,000
DREAMS	$ 25,000,000	$ -	$ 25,000,000
OVC (Non-DREAMS)	$ 21,000,000	$ -	$ 21,000,000
VMMC	$ 20,500,000	$ -	$ 20,500,000

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	**$ 12,999,700**	**$ -**	**$ 12,999,700**
PrEP (AGYW)	$ 2,657,100	$ -	$ 2,657,100
PrEP (KPs)	$ 10,342,600	$ -	$ 10,342,600

TABLE 5: State ICASS Funding

	Appropriation Year
	FY22
ICASS	$ 197,957

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	**58,405**	**87,972**
TX Current >15	**1,417,044**	**1,477,886**
VMMC >15	**594,192**	**432,612**
DREAMS (AGYW PREV)	**196,015**	**115,800**
Cervical Cancer Screening	**314,695**	**329,654**
TB Preventive Therapy	**307,475**	**380,241**

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

Agency	Approved COP/ROP 2020 Planning Level	Total FY 2021 Outlays	Over/Under Outlays
DOD	$49,659,525	$48,004,350	$1,655,175
HHS/CDC	$167,304,445	$151,860,997	$15,443,448
PC	$2,823,746	$981,545	$1,842,201
State	$1,129,756	$696,140	$433,616
USAID	$194,112,297	$178,936,843	$15,175,454
USAID/WCF	$82,355,102	$81,071,653	$1,283,449
Grand Total	**$497,384,871**	**$461,551,528**	**$35,833,343**

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	1,527,311	1,598,734	104.68%	HTS Program Area	$14,605,982	47%
	HTS_TST_POS	116,301	118,800	102.15%			
	TX_NEW	114,805	114,178	99.45%	C&T Program Area	$66,509,076	30%
	TX_CURR	812,650	804,725	99.02%			
	VMMC_CIRC	352,457	337,989	95.90%	VMMC Sub-Program Area	$12,139,058	80%
	OVC_SERV	17,605	15,332	87.09%	OVC Beneficiary	-	-
DOD	HTS_TST	520,341	491,001	94.36%	HTS Program Area	$298,366	100%
	HTS_TST_POS	35,388	27,662	78.17%			
	TX_NEW	33,433	26,392	78.94%	C&T Program Area	$20,274,030	100%
	TX_CURR	235,251	213,238	90.64%			
	VMMC_CIRC	203,254	189,309	93.14%	VMMC Sub-Program Area	$9,625,493	96%
	OVC_SERV	15,719	1,325	8.43%	OVC Beneficiary	$85,793	100%
USAID	HTS_TST	1,150,776	1,195,453	103.88%	HTS Program Area	$18,521,292	51%
	HTS_TST_POS	80,546	65,453	81.26%			
	TX_NEW	72,962	62,424	85.56%	C&T Program Area	$139,577,224	90%
	TX_CURR	509,982	457,497	89.71%			
	VMMC_CIRC	152,271	66,894	43.93%	VMMC Sub-Program Area	$5,045,982	73%
	OVC_SERV	829,863	851,520	102.61%	OVC Beneficiary	$28,111,427	83%
				Above Site Programs		$33,820,518	
				Program Management		$53,294,799	

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. Tanzania has adopted and implemented a test and start policy, which is aligned with WHO guidance.
2.	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens. **Status:** In process (target date: end of COP21). Adult TLD transition has moved quickly to overall coverage of 96% of eligible clients (including 97% of all eligible women of child-bearing age) as of July 2021. Orders for pediatric DTG10 placed on June 23, 2021. Next steps include monitoring DTG10 arrival and outlining details of roll-out plan (expected arrival date of first order of DTG10 is March 2022).
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 (6MMD scale-up expected to reach 60% of TX_CURR in March 2022). 90% of eligible clients receiving 3MMD. 6MMD started in Dar es Salaam in March 2020 and 90% of eligible clients were receiving 6MMD by October 2021. Sufficient stock was received in August and national 6MMD roll out is ongoing. **Issues or Barriers:** Potential risks include transitioning of IPs and TLD stockout.
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: 100% by end of COP21). By FY21 Q4, an estimated 82% of PEPFAR FY21 Q4 TX_CURR had completed TPT of the total currently on ART for PEPFAR. Efforts have continued to reach all existing and new clients. **Issues or Barriers:** Gaps remain in specific geographic areas and among children.

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 (DNO to be completed March 2022). PEPFAR Tanzania has prioritized utilization of high-throughput platforms within the existing laboratory diagnostic network for COP21 with a focus on an updated DNO exercise to support lab optimization and supply chain strategies to ensure efficiencies and uninterrupted HVL testing. Plans for Tanzania Posts Corporation (TPC) sample transportation have shifted and discussions between PEPFAR, GOT, TPC and PEPFAR IPs are ongoing.
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: end of COP21). Self-test kits have arrived in Dar es Salaam, and distribution will begin in mid -December. Thereafter self-test kit support will continue to be provided by the Global Fund. HIVST scale-up ongoing. **Issues or Barriers:** National self-testing shortages were expected to be gap filled by PEPFAR through a consignment scheduled for August 2021 arrival. Unfortunately, delays in the consignment resulted in the order being fulfilled in late November 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 (scaling up of PrEP services throughout COP21). PrEP scale-up started in October 2021. Weekly data is being collected for monitoring purposes. More than 8100 PrEP-NEW clients since October 1. Next Steps: Monitor scale-up progress weekly and work with IPs to address challenges. **Issues or Barriers:** Closely monitoring scale-up implementation to identify any barriers.
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:** Completed. OVC packages have been aligned.
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:** Not started.
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. The GOT prohibits user fees for HIV, TB, and MCH services in public and private settings. There is no evidence of user fees.
11.	OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI)

	practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy. **Status:** Completed. CQI integrated into all facilities and in line with national policies. CQI incorporated into work plans. Currently most quality assurance assessments and subsequent mentoring and supportive supervision being managed virtually.
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: end of COP21). Treatment and VL literacy integrated into facility and community-level counseling and communication activities. Stigma reduction messaging is also ongoing. UNAIDS stigma index draft report will be circulated for comments. **Issues or Barriers:** The stigma index did not include MSM. This is an area of continued advocacy for inclusion.
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:** Completed. Tanzania is on track towards its contribution to local, indigenous prime partner funding.
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: COP22). GOT has established an AIDS Trust fund and is exploring an HIV levy and partnerships with private sector entities to channel funds. Activity-based costing (ABC), National AIDS Spending Assessment (NASA), and test case costing studies conducted to inform longer term plans. GOT is ready to have further discussions on sustainability. Next steps include disseminating ABC results and looking for opportunities to increase dialogue.
15.	Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. **Status:** In process (target date TBD pending COP22 discussion with GOT stakeholders). PEPFAR utilizes the CTC2 system from HIV clinics to track outcomes among clients in care, in morbidity (e.g., TB) and death. **Issues or Barriers:** Clear timeline for strengthening monitoring and reporting of morbidity and mortality outcomes for PLHIV needed. CTC2 system does not track causes of death. Capacity building needed to address following GOT/PEPFAR priorities: i) support integration of ICD-10 coding into client-level systems, ii) support the inclusion of more specific ICD-10 codes in HIV within available systems, and iii) support training of health care workers on improvements in the use of ICD-10 codes.
16.	Scale-up of case surveillance and unique identifiers for patients across all sites. **Status:** In process (target date TBD pending COP22 discussion with GOT stakeholders). Unique ID is provided to all new clients for use within CTC2 system at HIV clinics, which facilitates patient level monitoring. Biometrics were integrated into CTC2 system during Zanzibar pilot in 2017 and into mainland CTC2 system in 2019. **Issues or Barriers:** Although unique IDs were integrated into CTC2, the system does not allow for tracking clients who move between facilities or are registered with multiple CTC IDs. GOT also has not yet approved activation of biometrics use.

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

Tanzania –Specific Directives
HIV Clinical Services
1. 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 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.
2. Leverage best practices from initiatives such as FCI and FASTER, and peer-to-peer support programs/coaches, such as MENSTAR, to increase case-identification, linkage and treatment continuity for hard-to-reach populations (i.e., men and children), young adults (20-39yrs), and newly diagnosed mothers.
3. Expand HIVST beyond key populations to reach individuals missed with traditional testing approaches and address supply chain root causes for HIVST underperformance in FY21.
4. Improve EID 2-month coverage through the use and integration of novel EID assays, renewed focus on quality, and turn-around-time.
5. Increase treatment continuity through increased availability of the 6-month linkage case management model for newly diagnosed and returning clients on ART. Optimize the tracking of transfer out clients and intensify efforts in SNUs with the highest volume of treatment interruptions.
6. Ensure that national 6MMD scale-up reach at least 75% of established targets. Failure to achieve benchmarks could result in the reassessment of PEPFAR funding.
7. Ensure implementation of short and long-term strategies to eliminate HVL and DBS sample backlogs, including completion of lab diagnostic network optimization.
8. The 7 regions with <80% VLC should be supported to optimize VL testing networks and demand creation activities to improve access and eliminate geographic VLC gaps.
9. Scale-up recency testing to provide epidemic surveillance and target HIV prevention measures.
10. Increase use and optimize WHO recommended molecular testing for TB diagnosis.
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. Failure to achieve at least 75% of quarterly targets may result in a reassessment of PEPFAR funding.
2. Ensure the quality and safety of VMMCs through the continuation of COVID risk mitigation measures and essential tetanus prevention, diagnosis, and management activities.
3. Building off FY21 analyses, in COP 22, continue to conduct internal reviews of the OVC program to ensure that the program is geographically aligned with clinical programs/sites, particularly considering shifts in geographic placement of OVC and A/CLHIV population

	dispersion. Enhance focus to strengthen the linkage of children of FSW into OVC service delivery platforms. Continue to strengthen PSNU-level program alignment with TX_CURR <15 and <20 y/o volume as well with HIV+ pregnant women accessing ANC burden. Reallocation of targets for OVC partners is recommended in COP22 depending on results of these on-going analyses.
4.	Begin phased integration of HPV DNA testing by SNU to increase cervical cancer screening rates, and scale-up routine quality assurance and improvement activities to ensure adequate treatment of precancerous lesions.
5.	Utilize BBS to fill gaps in population-level surveillance data for key populations, especially MSM and transgender populations and use data for targeted program implementation.
6.	Strengthen linkages between facility and community DREAMS partners to ensure effective linkages of AGYW to community safe spaces and continue to strengthen economic strengthening and entrepreneurship models for AGYW 15-24 yrs.
Other Government Policy, Systems, or Programming Changes Needed	
1.	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
2.	Enhance collaboration and engagement with the Government of Tanzania in supply chain forecasting, monitoring and bottom-up quantification from sites. Align shelf-life requirements with the WHO and ensure that all public health commodities are imported tax-free.
3.	Collaborate with the government of Tanzania to strengthen health information systems and increase availability and access to client level data for enhanced site-level monitoring and program improvement.
4.	Align HRH with regions of highest incidence rates and advance local partner portfolios to build local system capacity for HRH to support and guide sustainability investments.
5.	Establish a formal working group comprised of national and international stakeholders to develop a sustainability strategy to gradually begin implementation 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.

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.