United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 19th, 2022

INFORMATION MEMO FOR CHARGE D'AFFAIRES DALE, ZAMBIA

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

THROUGH: S/GAC Chair, Mamadi Yilla and PPM Neha Safaya

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

Dear Chargé d'Affaires Dale,

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 – 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 Zambia team for:

- The strong HIV program through PEPFAR utilizing its health system strengthening platform to support Zambia in testing, treating and deployment of vaccines to combat COVID-19 and for leveraging trusted in-country relationships and a collaborative whole-of government team effort to combat a new and ongoing health threat. The team should continue to institutionalize best practices of COVID-derived adaptations.
- Achieving and exceeding results, despite devasting pandemic impacts, and transitioning clients to the more efficacious TLD regimen (*In FY20Q4 29% of TX_CURR where on TLD compared to 93% in FY21Q4*) and providing up to 92% of TX-CURR clients on 3+ months of supply of antiretroviral medication which helped suppress the HIV virus and reduce transmission.
- Prioritizing client and health worker safety and expanding community health delivery systems to maintain testing goals for key populations and offering PrEP, VMMC and GBV prevention interventions despite COVID-19.

Together with the Government of Zambia and civil society leadership we have made tremendous progress together. Zambia 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 Zambia:

- We acknowledge that by the conclusion of the COP 22 process, PEPFAR Zambia in partnership with MOH and UNAIDS would have utilized ZAMPHIA 2 results and program ART and ANC data to improve PLHIV estimates for the country and confidently plan for COP 22. Nonetheless, we stress the importance of correcting the UNAIDS data that is utilized globally to track progress of the AIDS epidemic in Zambia.
- While we commend the transition of Children Living with HIV (CLHIV) to optimal regimens which resulted in improved VLS (89%), persistent gaps in treatment coverage of pediatrics and adolescents remain. Treatment interruptions continue to be found in 1-4yo, and those receiving less than 3+ MMD have been identified as vulnerabilities by the team.
- In COP 22, and for the next two years, PEPFAR Zambia will need to be strategic, so we endorse the efforts proposed by the team as a country on the cusp of epidemic control and needing to sustain impact to 1) Continue to strengthen the country's ability to implement HIV programs at the local level including KP work and expanding successful community models like KPIF and CSO/community based models 2) Work with provincial and district health offices and local NGOs across the board to run, manage, monitor and report on the HIV service delivery programs,

3) Incorporate community led monitoring into the health delivery architecture and address the vulnerabilities in the supply chain for life-saving commodities that COVID-19 disruptions exacerbated, particularly for viral load, early infant diagnosis and TB services.

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 Zambia is **$401,600,000**, inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Zambia and civil society of Zambia, 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 – Chair and PPM, Mamadi Yilla and Neha Safaya, PEPFAR Country Coordinator, Daphyne Williams**

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

With input from both the field teams through the quarterly monitoring POARTs, as well as Headquarters Country Accountability and Support Teams (CAST), 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

- We commend PEPFAR Zambia for proving that despite the grueling effect of a relentless pandemic that shows no sign of waning, they could take 18 years of partnership combating HIV and use that understanding and engage MOH at both the national, provincial and district level when COVID-19 cases first appeared; addressing low vaccine uptake among HCWs when doses slowly became available and creating an environment to tackle hesitancy; anticipating training needs for ART HCWs so clinics could join the vaccination effort; developing a specific demand creation strategy for ART clinics; integrating data capture into the national vaccination data system; piloting early and rapid scale-up using a CQI approach; performing site-level monitoring of vaccinations, including adopting vaccination targets in each province, and ultimately achieving close to 2 million vaccinations, using the opportunity presented by World AIDS day 2021.

- For prioritizing additional prevention efforts and achieving results in PrEP and VMMC despite COVID-19 and supporting GBV survivors at heightened risk during the pandemic. PEPFAR Zambia continues to be a leader in PrEP expansion and implementation, exceeding targets and scaling up exponentially every year in recent COPs. In COP20 131,260 individuals were initiated on PrEP, allowing the country to achieve 151% of its PrEP_NEW target, with the highest uptake among ages 25+ and a significant increase along KPs and AGYW. COVID interrupted the community mobilized VMMC program, yet the resilient Zambia HIV program reached 522,589 males, achieving 139% of its target and focused in prioritizing the target age group of 15–29-year-old, by performing 89% of VMMC in this group.

Challenges

- Zambia can close the gaps in treatment coverage for pediatrics and adolescents. Scale up of family index testing has only contributed to 61% of all pediatric positives. With an estimate of 77,631 Children Living with HIV (CLHIV), the program is falling short in finding enough children, despite surpassing case finding targets. The treatment coverage for children is 82% and the viral load coverage is only at 61%, so attention must be given to innovate to shorten the gaps across the country, particularly in Lusaka, Copperbelt, Southern and Central Provinces.

- Commodity challenges for VL, EID & TB reagents were reported, resulting in reduced viral load coverage. Viral Load Suppression (VLC) has continued to rise to 96%, but Viral Load Coverage (VLC) declined to 75% of targets during the COP 20 implementation period. The team has identified COVID-19, insufficient Diagnostic Network Optimization (DNO), aging machines and supply chain challenges as reasons, so the team should leverage private sector capabilities where possible, particularly for last mile delivery, and continue to proactively monitor and mitigate risks to optimize VLC.

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

- PEPFAR Zambia should focus on improving the pediatric cascade by 1). Setting ambitious pediatric case finding targets to close the treatment gap and ensuring the HIV case identification strategies for children and adolescents are appropriately aligned with such targets, i.e., addressing pediatric undertesting in outpatients setting; 2). Target interventions to address interruptions in treatment for CLHIV, especially children 1-9 years; and 3). Targeted interventions to improve low VLC rates in children <5 yo.

- Work with the Government of Zambia to ensure alignment in the vision to jointly sustain impact on the HIV epidemic and support Zambia's public health approach and platform to strengthen primary care. PEPFAR Zambia should continue to adapt the program to ensure retention of patients on ART during COVID-19 waves, but also to leverage the moment for clients' preferences to be anchored into the service delivery platform. We encourage continued integrated efforts including minimizing clinic visits, maintaining patients on 3-6 MMD and shoring up commodity vulnerabilities, ensuring adequate supply of PPEs, covid testing and vaccination, strengthening community systems to follow up on patients, and to ascertain outcomes of those missing appointments. The team should continue to ensure strong prevention programming is in place to reduce the number of Zambians infected.

- Continue to work closely with the Global Fund to address commodity challenges and ensure alignment on key priorities, including mitigating COVID-19 impact on supply of COVID-19 and HIV commodities.

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	**$ 349,761,617**	**$ -**	**$ -**	**$ -**	**$ 1,440,000**	**$ -**	**$ -**	**$ -**	**$ 351,201,617**
GHP-State	$ 324,049,086	$ -	$ -		$ -	$ -	$ -		$ 324,049,086
GHP-USAID	$ 23,300,000				$ 1,440,000				$ 24,740,000
GAP	$ 2,412,531				$ -				$ 2,412,531
Total Applied Pipeline	**$ -**	**$ -**	**$ -**	**$ 50,398,383**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 50,398,383**
DOD				$ 3,049,285				$ -	$ 3,049,285
HHS/CDC				$ 17,686,019				$ -	$ 17,686,019
HHS/HRSA				$ -				$ -	$ -
PC				$ 4,742,273				$ -	$ 4,742,273
USAID				$ 22,347,473				$ -	$ 22,347,473
USAID/WCF				$ 2,573,333				$ -	$ 2,573,333
TOTAL FUNDING	**$ 349,761,617**	**$ -**	**$ -**	**$ 50,398,383**	**$ 1,440,000**	**$ -**	**$ -**	**$ -**	**$ 401,600,000**

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

Countries should plan for the full Care and Treatment (C&T) level of $249,579,300 and the full Orphans and Vulnerable Children (OVC) level of $35,137,600 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	$ 249,579,300	$ -	$ -	$ 249,579,300
OVC	$ 35,137,600	$ -	$ -	$ 35,137,600
GBV	$ 5,376,000	$ -	$ -	$ 5,376,000
Water	$ 614,000	$ -	$ -	$ 614,000

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	**$ 400,160,000**	**$ 1,440,000**	**$ 401,600,000**
Core Program	$ 335,537,577	$ -	$ 335,537,577
Cervical Cancer	$ 5,363,700	$ -	$ 5,363,700
Community-Led Monitoring	$ -	$ -	$ -
Condoms (GHP-USAID Central Funding)	$ -	$ 1,440,000	$ 1,440,000
DREAMS	$ 30,720,723	$ -	$ 30,720,723
HBCU Tx	$ 6,000,000	$ -	$ 6,000,000
One-time Conditional Funding	$ -	$ -	$ -
OVC (Non-DREAMS)	$ 10,766,200	$ -	$ 10,766,200
Surveillance and Public Health Response	$ -	$ -	$ -
VMMC	$ 11,771,800	$ -	$ 11,771,800

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	**$ 8,229,400**	**$ -**	**$ 8,229,400**
PrEP (AGYW)	$ 4,229,400	$ -	$ 4,229,400
PrEP (KPs)	$ 4,000,000	$ -	$ 4,000,000

TABLE 5: State ICASS Funding

	Appropriation Year
	FY22
ICASS	$ 252,971

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	43,861	62,315
TX Current 15+	1,119,947	1,206,090
VMMC 15+	522,598	228,001
DREAMS (AGYW PREV)	260,480	291,726
Cervical Cancer Screening	239,619	280,272
TB Preventive Therapy	375,939	426,299

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

OU/Agency	Approved COP/ROP 2020 Planning Level	Total FY 2021 Outlays	Over/Under Outlays
OU	**$444,696,348**	**$386,068,679**	**$58,627,668**
DOD	$12,757,709	$6,987,246	$5,770,463
HHS/CDC	$149,530,766	$139,658,692	$9,872,074
HHS/HRSA	$11,351,564	$9,722,974	$1,628,590
PC	$5,320,621	$1,079,487	$4,241,134
State	$2,982,160	$2,135,694	$846,466
USAID	$172,661,205	$160,328,724	$12,332,480
USAID/WCF	$90,092,323	$66,155,862	$23,936,461
Grand Total	**$444,696,348**	**$386,068,679**	**$58,627,668**

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**	531,928	**1,501,119**	282.20%	HTS Program Area	**$6,048,794**	94%
	HTS_TST_POS	29,115	**96,978**	333.09%			
	TX_NEW	28,823	**90,204**	312.96%	C&T Program Area	**$72,491,938**	75%
	TX_CURR	629,966	**668,347**	106.09%			
	VMMC_CIRC	203,133	**282,259**	138.95%	VMMC Sub-Program Area	**$7,818,351**	98%
	OVC_SERV	28,732	**30,294**	105.44%	OVC Beneficiary	**$262,753**	100%
DOD	**HTS_TST**	42,060	**60,941**	144.89%	HTS Program Area	**$583,405**	85%
	HTS_TST_POS	3,621	**4,816**	133.00%			
	TX_NEW	3,418	**3,919**	114.66%	C&T Program Area	**$2,225,443**	97%
	TX_CURR	48,401	**33,201**	68.60%			
	VMMC_CIRC	33,332	**19,898**	59.70%	VMMC Sub-Program Area	**$1,032,540**	81%
	OVC_SERV	12,714	**12,610**	99.18%	OVC Beneficiary	**$702,461**	65%
USAID	**HTS_TST**	624,962	**861,572**	137.86%	HTS Program Area	**$10,168,904**	83%
	HTS_TST_POS	70,489	**80,277**	113.89%			
	TX_NEW	65,895	**70,835**	107.50%	C&T Program Area	**$130,025,459**	88%
	TX_CURR	484,895	**504,846**	104.11%			
	VMMC_CIRC	139,143	**222,233**	159.72%	VMMC Sub-Program Area	**$7,097,789**	81%
	OVC_SERV	468,639	**441,201**	94.15%	OVC Beneficiary	**$5,607,182**	61%
				Above Site Programs		**$21,726,589**	N/A
				Program Management		**$49,710,660**	N/A

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

Minimum Program Requirement	Status for COP21 Implementation (and issues hindering implementation)
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 treatment across age, sex, and risk groups.	**Status: Complete** The "Test and Start" protocol is part of the Zambia Consolidated HIV Treatment Guidelines. Unless there is an immediate contraindication, all newly identified HIV-infected people are offered treatment immediately.
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: Complete.** The preferred first line HIV treatments in both adults and children in Zambia should contain DTG • TLD: Uptake is now at more than 90 percent for all TLD-eligible HIV-infected individuals • DTG 10 Mg: The transition of the approximately 12,000 children from Lopinavir to DTG 10 mg only started in August 2021 (and as of November 2021, 2111, children were already on DTG 10 Mg) • EFV is being phased out rapidly • NVP regimens for treatment have been phased out completely
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: Complete** • MMD: About 93 percent of clients on HIV treatment are on MMDTLD: Uptake is now at more than 90 percent for all TLD-eligible HIV-infected individuals • 6MMD: Over 60 percent of clints are on 6MMD
4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV	**Status: In process** 74% of adults and children completed a course of TPT between FY 19 and FY 21 **Issues or Barriers**

clinical care package at no cost to the patient.	• Clinicians' hesitancy to initiate TPT due to limited diagnostics to rule out active TB brought about by the limited global availability of GeneXpert cartridges in the wake of COVID-19 pandemic • The push for ART 6MMD as a COVID mitigation measure led to less clients visiting the facilities, hence initiations reduced • A pause on community activities led to reduced community follow ups and ultimately affected completion
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: Complete** To improve labs outcomes in general, the deployment of all lab inputs and/or capabilities in Zambia (machines, human resources, transport, etc.) will be informed by DNO. Machines: Viral work will be done on the COBAS 6800 and 4800, Hologic Panther, and Gene Xpert Machines (TB work will be performed on the Gene Xpert) • All the other capabilities (Transport, Human resources, lab information systems, etc.) will be positioned to support the machine arrangement under a) • End-point: The aspiration is to achieve a 24 hour turnaround time for EID and priority viral loads and two weeks for all the viral loads. **Issues or Barriers** • Reagents commodity security has been a problem for all the platforms • Machine down time, especially for the legacy equipment such as the CAP CTMs. • Competition for resources with COVID-19
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: Complete** **Issues or Barriers** • Attritions/dropouts of the Community Based Volunteers (CBV), which has been compounded by the COVID-19 impact on community follow-ups. • Stock-out of HIV ST. • Partners have challenges tracking completion coverage rates of family index testing (i.e., what proportion of HIV+ women with children have their children tested) and in facilities without PEPFAR support (centrally supported facilities), we have received feedback from MoH that they're not familiar with KYCHS and are not routinely offering testing.
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-	**Status: In process** **Issues or Barriers** • Restricted movement during COVID waves impacting populations at elevated risk of HIV acquisition to access prevention services, resulting in poor continuation rates

burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices*)*	• Limited community-based activities due to COVID waves affecting reach among populations who shun health facilities • Cultural barriers resulting in lower PrEP initiation rates among pregnant and breastfeeding women
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: Complete** The Zambia OVC portfolio includes the three models of Comprehensive, Preventive, and DREAMS programming to vulnerable children, adolescents and AGYW in Zambia across the interagency. The comprehensive OVC package of services offered provides comprehensive prevention and treatment services to OVC ages 0-17 and includes specific components of facilitating testing for all children at risk of HIV infection and facilitating linkage to treatment and care for C/ALHIV. In addition to the risk reduction activities included in the comprehensive model, the package of services under the Preventive DREAMS models also reduce 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 **Issues or Barriers:** • The provision of mentorship and monitoring activities which require physical presence have been conducted virtually or have been pushed to windows when COVID-19 numbers are low. • The closure of schools due to COVID-19 has limited provision of school-based activities, such as the Comprehensive Sexuality Education curriculum administered by the Peace Corps. • The gap in linkage between facility and community partners to support HIV cascade, this issue is being addressed through MOUs and training of both facility and community staff to ensure clear understanding, collaboration, and data sharing. • Delays in viral load turnaround time, which poses challenges in providing quality case management. 5) Experiences of sporadic stock out of Dry Blood Spot test kits.
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** The progress towards 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 is in process. Activities include training of health care workers in the provision of key population friendly health services which addresses stigma and discrimination, and improves the treatment outcomes for key populations, increased knowledge of rights of KP, and more KP organizations running safety and security interventions. **Issues or Barriers:** • The prohibitive legal environment which criminalizes same sex relations and sex work. • Closure of hotspots resulting in limited HIV activities in the community during COVID. • The limited knowledge of KP human rights, exacerbated by religious beliefs, making key populations more vulnerable to abuse.
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** Zambia does not have a formal user fees policy which would include a combination of any of the following: drug costs, supplies and medical material costs, entrance fees or consultation fees paid at each visit. However, select services attract a subsidy from patients: a) registration fee to facilitate/procure a registration card and/or a book for recording (one off); b) initial radiographs, c) self-referral (patients who avoid to navigate the primary health care system by self-referring themselves to a designated higher level of care). These out of pocket costs can potentially reduce access to HIV care, especially among the indigent populations (though there is no formal evidence of this)
11. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.	**Status: Completed** Quality assurance is an integral part of HIV programming in Zambia and focuses on data and contents of the program such as: a) laboratory (where the hallmark is maintenance of minimum standards and patient care (where the hall marks are patients' clinical and surrogate outcomes). These are monitored in a structured manner using internal and external quality improvement and assessment.
12. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	**Status: In process** There is enough evidence of this effort at policy, implementation, and community levels. At policy level, the U=U was officially launched publicly by the Zambian Republican President. At implementation level, the Ministry of Health continues to promote awareness amongst service providers and the community on the need for all HIV-infected clients to achieve HIV viral suppression. At community level, civil society organizations and political and traditional leaders continue to engage stakeholders on the same subject. As a result, the following have improved: 6MMD, retention in treatment, and viral load coverage and viral suppression.

13. Clear evidence of agency progress toward local, indigenous partner direct funding.	**Status: In process** USAID and CDC provide direct funding to the Zambian government through G2G and cooperative agreements. USG is making progress towards more direct funding to local partners for key population-led responses. USG has not yet started directly funding women-led responses. **Issues or Barriers:** • The lack of capacity of local KP led organizations to manage and implement activities. • Complicated application processes and challenges with registration of KP organizations.
14. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	**Status: In process** Although the Zambian government (GRZ) has been increasing its budgetary allocation for health (2020 ZMW9.3bn; 2021 ZMW9.6bn; 2022 ZMW13.9bn), the sector budget as a proportion of the national budget has been reducing (2020 8.8%; 2021 8.1%; 2022 8.0%). With the rapid depreciation of the local currency in 2020 - 2021, the dollar equivalence of the 2021 health budget was $480m compared to $548m in 2020 (-11%).
15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	**Status: Complete** **Issues or Barriers:** • Forty facilities in 7 provinces are conducting Verbal Autopsies and transmitting data to the mortality surveillance database. Data analysis and dissemination is occurring • Verbal autopsy coverage of community deaths at each facility varies. Some sites have low volume of community deaths being brought into their mortuaries. With CDC support, MOH is proactively addressing system gaps to improve this program
16. Scale-up of case surveillance and unique identifiers for patients across all sites.	**Status: Complete (all sites with SmartCare)** **Issues or Barriers:** • CBS analysis and data collection transitioned to use of routine country data systems; therefore, all facilities using SmartCare in all ten provinces are now included in CBS. • Routinizing use of data for surveillance and program improvement has been a challenge, but data analysis and use workshops and increased data dissemination planned for Q2-Q4 COP21. • Reconceiving system to utilize routine data systems required substantial effort by CDC, MOH, and CIDRZ but will result in greater coverage and enhanced sustainability.

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

Zambia – Specific Directives

HIV Clinical Services
1. **Closing the 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.
2. **Resolve PLHIV Estimates –** The team does have a well-articulated plan to address this, and we expect by COP approval, there will be a resolution with UNAIDS.
3. **Continuity of Treatment** - Zambia has a declining NET NEW Growth from 3% in Q1 2020 to -1% in 2021 Q4. Lusaka Province has the highest TX_ML IIT. PEPFAR Zambia needs to intensify strategies for tracing and tracking patients and bringing them back to care that include SMS reminders for appointments, physical tracing of patients who are late for appointments or have interrupted treatment especially in regions like Lusaka Province that have high TX_ML IIT. With regards to reporting completeness of TX_ML_IIT, only 44% of Zambia's TX_CURR sites reported at least one IIT event at Q4, which may reflect an underreporting of actual IIT events. Further interrogation of IIT reporting at site-level may be warranted to improve reliability of IIT data, especially at higher volume sites that may be reporting lower than expected IIT.
HIV Prevention Services
1. **PrEP for KP and AGYW** - 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
2. Ensure alignment of OVC programs and high-volume pediatric treatment sites - Based on FY21Q4 data, the proxy coverage of existing PEPFAR OVC programs in Zambia is 70% for TX_CURR <15 and 42% for TX_CURR <20 in OVC PSNUs. True coverage falls somewhere in between these two estimates since the OVC program enrolls C/ALHIV 17 years of age and younger. While crude, the "proxy coverage" provides an estimate of how well OVC partners are doing at reaching C/ALHIV current on treatment in the same geographic areas where they are providing OVC program services. Also, consider the total estimated coverage of OVC programs compared to the number of C/ALHIV current on treatment across the OU and supported by PEPFAR. For Zambia this is estimated at 48% for TX_CURR <15 and 29% for TX_CURR <20. As part of COP22 planning, all Zambia should conduct an analysis to understand how well the OVC program is geographically aligned with clinical programs/sites. If Zambia doesn't already have a consensus definition for high-volume pediatric sites the OU should reach out to their SI and PEDS, OVC liaisons for further guidance and support. Pending the results of these analyses, and key factors such as A/CLHIV population dispersion, shifts in geographic placement and target allocation for OVC partners may be necessary.
Other Government Policy, Systems, or Programming Changes Needed
1. **Structural barriers for KP** - 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. State/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 **Surveillance and Public Health Response** initiative, but OUs may include relevant funds under this initiative 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.