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INFORMATION MEMO FOR AMBASSADOR WILLIAM POPP, GUATEMALA, AND CHARGE D'AFFAIRES LINNISA WAHID, JAMAICA

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

THROUGH: S/GAC Chairs, Kristin Kelling and Alexander Cumana, and PPMs, Erin Riley and Paola Chanes-Mora

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

Dear Ambassador Popp and Chargé d'Affaires Wahid:

First and foremost, I sincerely hope that you and your teams 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 during 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/ROP22 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 teams for:

- In ROP21, there was a 150% increase in new HIV positives identified in Central America, and improved achievement amongst Caribbean implementing partners (IPs) providing direct service.
- The Caribbean Regional Program's viral load suppression (VLS) increased from 81% to 87%. Jamaica's national VLS percentage reached 74%, up from 52% five years ago, though Jamaica needs to continue addressing viral suppression in females (particularly in the younger age bands). Panama's VLS increased from 34% in ROP19 (lowest in the region) to 65% in ROP21, in large part due to a concentrated surge in VL testing, VL strengthening, and the creation of a national VL network starting in ROP20.
- Resolution of long-standing laboratory viral load backlog in the Caribbean.
- Minimum Program Requirements (MPRs) continued toward full implementation throughout the region even though there were legal roadblocks from moving from 3-month multi-month dispensing (MMD) to more than 3-month MMD policies. During ROP21, MMD launched in Panama in ROP21 and was increasing rapidly by the end of Q4. All of the other countries in Central America experienced increases in MMD during ROP21.

<u>Central America and Brazil</u>

- While new positives were difficult to find or services were paused due to COVID-19-related disruptions, there were increases in active case finding through a diversified strategy in the portfolio focused on high-yield testing modalities in high-burden areas, specifically in the Northern Triangle and Panama. Central America continued to provide client-centered antiretroviral treatment (ART) services to all patients at current sites and expanded direct service delivery (DSD) implementation strategy at the 81 sites throughout Central America and Brazil (e.g., MMD, home delivery, online Pre-Exposure Prophylaxis (PrEP) services in Brazil). The team needs to urgently address issues related to continuity of treatment regardless of net gain.
- Panama showed vast improvement in Viral Load Coverage (VLC) and VLS in the past year. In ROP19, Panama reported the lowest VLS percentage in the region at 34% with a growing epidemic and the largest prevalence rate in the region between ages 18-49. Panama reached 65% in VLS and 69% in VLC in FY21Q4. Multiple best practices were shared from the Santo Tomas Hospital in Panama.

- Before the launch of PrEP in Central America, the PEPFAR regional team worked to set the stage for PrEP roll-out. This engagement promoted a sense of ownership within regional ministries of health, resulting in the launch of PrEP delivery in FY21 in Panama, El Salvador, and Honduras, as well as site expansion and introduction of PrEP in Guatemala.

Caribbean

- Despite challenges across the sub-region associated with COVID-19, Jamaica met its key population targets in ROP21 and showed promising gains in VLC and VLS, along with lab strengthening which should continue into ROP22. Trinidad and Tobago continued to excel in VLC and VLS, and we look forward to seeing results as they bolster index testing as a primary case-finding strategy across the sub-region.
- Fifty percent of all PEPFAR supported sites in Jamaica have achieved 90% VLS and are moving toward reaching the 95% target. This is a significant improvement from FY20 Q4 when none of the PEPFAR supported sites in Jamaica had reached 90% VLS. The implementing partner Jamaica AIDS Support for Life (JASL) has surpassed all its key population (KP) targets for ROP21, reaching 150% KP prevention services, 174% of KP testing targets, and 123% of testing new positives. Furthermore, there were 480 patients who identified, and were registered, as men who have sex with men (MSM) in JASL sites. Of the 480 MSM, 374 (89%) remained on treatment and 306 (82%) were virally suppressed. JASL is known as a KP-friendly, and stigma-free, space and has been working with the LGBTQIA+ community in Jamaica for over 30 years, which attributes to their success. Another successful partner has been the Centre for HIV/AIDS Research and Education Services (CHARES) which was the first facility in Jamaica to achieve 90% VLS and is closely moving to 95% VLS of its patients in care. This facility focuses on a comprehensive client-centered clinical service model that works to meet the clients where they are to support their continuity of treatment and viral load suppression. One hundred percent of individuals who identified as transgender (n=6) in CHARES are on treatment and virally suppressed.
- In Jamaica, a new cooperative agreement was signed on October 1, 2020, between the CDC and the Ministry of Health and Wellness that supports PEPFAR's efforts to strengthen prevention, strategic information, and laboratory system care. Jamaica's Viral Load Lab, National Public Health Laboratory has been accredited in ISO 15189 and has scored 100% the first-round Viral Load Proficiency Testing in 2021. Additionally, the lab backlog from ROP20 has been resolved. We look forward to seeing this cooperative agreement drive higher results and move Jamaica closer toward epidemic control.

Region At Large

- Even in a mostly virtual setting and without the benefits of frequent in-person site visits from HQ staff and country teams, the two sub-regional teams continued making progress. Country teams are encouraged to continue to share and review data, as well as exchange best practices and arrange joint technical sessions during this critical juncture in our regional program, including among agencies and sites within and across each sub-region.

- For your situational awareness, S/GAC is continuing the special PEPFAR assistance supporting HIV activities in countries impacted by the Venezuela Regional Crisis, including Colombia and Peru. This will build on the progress made in treatment and monitoring over the last three years to assist this vulnerable migrant and refugee population.
- COVID-19 continues to impact the region and has disrupted testing sites and treatment services, which has resulted in challenges for ART coverage. The region continues to build upon innovative strategies scaled up in ROP21, including direct drug delivery, telemedicine, virtual training, and other methods in effort to maintain gains and make progress toward 95-95-95 targets.
- Based on data shared during Q4 POART, S/GAC recommends continued focus on optimized case finding, particularly on high-yield testing modalities in high-burden areas, throughout the region. An expansion of differentiated service delivery, including the accessibility of prevention services, may be necessary as the region increases PrEP.
- The region made more investments in human resources for health (HRH), including site-level staff with a contribution to increased treatment performance in several countries including El Salvador (65% in 2020 to 88% in 2021) and Honduras (78% in 2020 to 80% in 2021). All countries in the region completed and successfully submitted their first HRH inventory template. Over 37% ($13.7 million) of HRH expenditures was allotted to the Caribbean and Central America.

Together with the governments in the Western Hemisphere and civil society leadership, we have made progress together. Countries in the region 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 ROP22 guidance this year, changes in program direction will vary depending on where countries are in reaching epidemic control and the continued COVID-19 mitigation 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 Western Hemisphere:

Central America:

- The FY21 HIV clinical cascade is concerning and programmatic gaps need to be addressed in order to reach epidemic control. There is a need to review granular program and financial data to understand what is working at each site and each community in order to allocate resources effectively as we proactively adapt programs to for maximum impact in ROP22. Active program and partner management is to be continued, with a focus on continuous quality improvement and people-centered design. Fostering partnerships and collaboration will be key to ensuring the sub-region is well-positioned to protect and sustain collective gains as the COVID-19 pandemic enters its third year.
- The Northern Triangle area (El Salvador, Honduras, and Guatemala) shows gaps across the cascade and lags in the first 95 in all three countries. Now that the site expansion has moved forward, it is important to accelerate scale-up and rapidly adopt innovations and policies in

Northern Triangle countries to improve case finding and identify new positives (e.g., provider-initiated testing and counseling (PITC) and PrEP).

- Central America reached 78% in overall testing, 17% achievement of finding new positives, and 28% achievement in index testing in FY21. To close the first 95 gap in Central America in ROP22, there is a need to implement a strategic mix of case finding approaches including optimizing safe and ethical index testing at the community and facility levels, targeted PITC, expanding social networking strategies for KPs, continue to scale up self-testing, and to explore a mix of testing modalities to reach other priority populations.
- The number of new patients on treatment reached 24% achievement. While the percent achievement appears low, this percentage has increased by 50% as compared to last year. In general, there was a steady upward trend in treatment initiation through Q3 and a slight drop in Q4 partially due to COVID-19. The percentages ranged from 17% in Brazil to 69% in Panama. Nicaragua achieved 86%, but the results were lowest in the region with 320 as compared to Panama with 1,709 new patients on treatment. The trend in Brazil was a constant increase in treatment initiation across all four quarters.
- The percentage of patients currently on treatment was 75% overall. Target achievement appeared slightly lower; the cohort increased by 22% by prioritizing continuity of treatment during the pandemic. Percent achievement of patients on treatment across the region was high with 63% in Brazil, 71% in Guatemala, 75% in Nicaragua, 80% in Honduras, 88% in El Salvador, and 89% in Panama.
- PEPFAR activities in Nicaragua are limited due to socio-political crisis that has been ongoing since April 2018. With only 38% reporting viral suppression among PLHIV who know their status and are on treatment, it is imperative to find innovative ways to address low VLC and VLS. The U.S. Embassy in Managua is supportive of the work the Center for Disease Control and Prevention (CDC) is implementing through the implementing partner, Universidad del Valle de Guatemala (UVG).
- As PEPFAR Brazil's targets in ROP21 may have been unrealistic, team is encouraged to realign the targets to be appropriate given funding level and achievable in the context of the HIV epidemic in Brazil.
- Panama experienced a high rate of patient interruptions in treatment. In Q4 of FY21, a total of 2,050 patients had interruptions in treatment with cumulative results for the entire year of 2,129.

Caribbean:

- The FY21 HIV clinical cascade is concerning, and programmatic gaps need to be addressed to reach epidemic control. There is a need to review granular program and financial data to understand what is working at each site and each community in order to allocate resources effectively as we proactively adapt programs for maximum impact in ROP22. Active program and partner management is to be continued, with a focus on continuous quality improvement and people-centered design. Fostering partnerships and collaboration will be key to ensuring the sub-region is well-positioned to protect and sustain collective gains as the COVID-19 pandemic enters its third year.
- Looking at current progress, Jamaica continues working toward 90-90-90 in their National Strategic Plan on HIV and we see the greatest gap here, particularly in the 2nd pillar with only 51% on treatment according in Ministry of Health data. As S/GAC has discussed with the team

and partners several times, PEPFAR strongly encourages achievement of the 90-90-90 targets prior to 2030, the target date per the country's National Strategic Plan on HIV. The team has been working with others in-country to intensify efforts and strengthen the commitment to execute global recommendations and adopt policies that will result in stronger patient outcomes sooner than projected. We know it was important that ROP 2021 targets were aligned with the National Strategic Plan, but now we need to focus on getting Jamaica on track to achieve the UNAIDS 95-95-95 by 2030.

- Overall, the Caribbean continues to underperform in terms of case finding and placing new patients on treatment. Jamaica only met 25% of its new positive test target in FY21 and the Caribbean met 37% of its new treatment target. In Q4, both Jamaica and Trinidad and Tobago had a negative net new of 78 and 17, respectively - a major concern for S/GAC despite the ongoing COVID-19 challenges. Case finding as an extension of treatment initiation remains particularly challenging given the context. The current case finding strategy should be re-evaluated, focusing on index testing and possibly a scale up of HIVST. Index testing needs to be expanded, and cascade drop-off at finding partners of clients' needs to be addressed. Treatment initiation and continuity need to be based on client-centered clinical service models. Barriers need to be urgently addressed to ensure immediate linkage and improve continuity of treatment. While both males and females are being lost in the Caribbean, females in the reproductive age group contribute a larger proportion of patients with interruptions in treatment, a trend that needs to be analyzed and addressed. As these clients return, the team should consider a "welcome back to care" approach to understand and address the reason for disengagement.
- Jamaica needs to continue improving VLC, particularly among younger males and females, as well as males overall. Jamaica also needs to continue addressing viral suppression in females (particularly in the younger age bands). While the progress Trinidad and Tobago has made in VLS is commendable, the under 30 age group – particularly the females – needs to be addressed.
- The prevalence of HIV in Jamaica is 1.8% overall and approximately 0.81% among 15–24-year-olds. Among adolescent MSM, HIV prevalence is 14%. Targeted programs that meet the unique challenges, such as barriers to accessing HIV prevention and treatment services, stigma and discrimination, unemployment, and food insecurity of this population must continue. The expansion of best practice treatment services for the MSM and the trans community across all PEPFAR supported sites must occur in ROP22. A prioritization of PEPFAR funding for decriminalization and/or for promoting anti-discrimination policies and legal strategies/legal services is needed. Sustainability of KP-led organizations, supporting social contracting schemes to integrate these organizations into government funding mechanisms, such as health insurance schemes is also necessary. Furthermore, the commencement of the Violence Against Children and Youth Survey will begin to collect programmatically actionable data to prevent and respond to violence against children and youth in Jamaica as part of the HIV prevention portfolio.
- HR-related barriers in Jamaica continue to limit the success of index testing, which is the highest yield case-finding approach. Rather than contact tracing being the responsibility of only contact investigators (CI), we suggest task sharing to other cadres. We also note that we have dedicated funding to support CIs, but it has not been fully utilized. One barrier to overcome in Jamaica is the need to eliminate the requirement for lab technicians to confirm HIV diagnosis. This is unusual by global standards and results in failure to link individuals to treatment, as some do not go to the facility for the second test. Confirmation of HIV should be possible in an outreach

setting based on the two-test algorithm, including by lay testers/counselors, allowing individuals to be linked to treatment services right away. This has been a topic of discussion for years and it may benefit from high-level engagement. Supporting the scale-up of HIV self-testing and task-shifting from lab techs to lay/counselor testers for HIV confirmatory diagnosis will likely improve case finding.

- In FY21, the Caribbean invested considerable resources in testing that did not lead to a yield or new positives that aligns with the associated funding. Agency partner spending must better track to the results expected and optimized case finding strategies to continue the reduction of excessive HST spending is necessary. Partner management efforts need to be intensified to prevent major over-outlays and unauthorized spending, particularly in Jamaica. Implementing partners continue to expend funds on programs without sufficient, or in some cases any budget amounts in each ROP cycle. Furthermore, an increase in targets for the Caribbean to align with the budget is necessary along with a commitment from the region to achieve 95-95-95 by 2030.
- in Trinidad and Tobago, participation in the Strengthening Laboratory Management Toward Accreditation (SLMTA) program and full participation in the CDC Proficiency Testing Program is necessary.
- Trinidad and Tobago is making swift progress towards achieving 95-95-95 in the second and third pillars, while their first pillar continues to make incremental progress. More focus is necessary on the first pillar.

Region At Large:

- Throughout the entire region with a particular focus on the Northern Triangle, Jamaica, and Trinidad and Tobago, there needs an alignment to awareness on barriers to treatment faced by Key Populations and Central American migration. A human-rights approach is needed to address structural barriers that KPs and other groups, including indigenous and migrant communities, experience to better prevent HIV and expand access to treatment services for all PLHIV at the policy, above-site, and site levels.
- The entire region needs to focus on antiretroviral (ARV) optimization, as it is urgently needed to improve viral load suppression and continuity of treatment, as well as the continuation of expanding PrEP and DSD.
- Poor linkage continues to be a concern in the Caribbean, and continuity of clients is an issue throughout the region. It is critical to expand case finding, ART coverage, and embrace client-centered services to improve linkage and continuity of treatment. Although we are hopeful that the redesign in Jamaica has alleviated some of this issue as seen by an improved return to treatment, Central America saw increases in patients lost to follow-up. Countries need to address ongoing continuity of treatment challenges by enhancing client-centered approaches and services. Over-testing needs to be addressed, as shown in the Caribbean that over-tests and has a low testing yield.
- Laboratory issues are prevalent throughout the region. While some countries experienced issues with viral load backlog pre-COVID-19, the pandemic has had a substantial impact on laboratory services across the treatment and care cascade. Issues that impact patient monitoring urgently need to be resolved. Reductions and delays of viral load testing have been reported and the results are not being returned due to COVID-19. To strengthen laboratory systems, key strategies going

into ROP22 to apply lessons from regional lab mapping exercises, build on laboratory continuous quality improvement to resolve deficiencies and ensure timely, accurate and reliable results for patient care, and build on training platforms to develop human resources through training, certification, and recruitment of officers to assist in the implementation of HIV rapid testing continuous quality improvement (RTCQI). If the national lab cannot meet demand, then we must fast-track decentralization.

- Across the region, there is a need to continue to increase PrEP roll-out. Only 39% of eligible patients are enrolled in PrEP and only 23% are newly enrolled, illustrating major gaps in coverage and demand creation. Regionwide, there is a need to expand the accessibility of prevention services to better engage with high-risk populations. Policy barriers need to be addressed that are preventing full implementation/scale-up and teams may want to consider expanding PrEP in FY23 as an essential prevention service.
- Regionwide, most countries are underperforming in case finding and locating new positives partially due to COVID-19 interruptions. All countries need to continue focusing on active case finding and increasing the scale-up of innovative case finding. We expect to continue to see progress toward 95-95-95 goals despite the presence and dedication to COVID-19 mitigation strategies.

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying ROP22 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 ROP21) 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 the three Sustainable Development Goals (SDG).

The PEPFAR ROP22 notional budget for the Western Hemisphere region, including special assistance to the Venezuela Regional Crisis, is **$80,000,000** 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 Governments in the Region and civil society, believes is critical for the country's progress toward controlling the pandemic and maintaining control.

The ROP22 notional budget is allocated by sub-region, Brazil, and programs related to the Venezuela Regional Crisis as noted below. Please note that of the Caribbean Regional Program's $18 million initial budget, $4 million may be shifted to other regional programmatic needs if S/GAC believes the funding will produce higher achievement elsewhere. To maintain its full initial budget level, we expect the Caribbean to work toward the following goals, as explained elsewhere in this letter: optimized case finding strategies, a focus on linkage and return to treatment, an implementation of best practices implemented across all sites, and efforts toward breaking down barriers and stigma associated with KPs seeking treatment services. Further, we expect to see targets commensurate with the funding provided and ambitious enough to drive meaningful progress toward epidemic control. Finally, S/GAC will work with the country team to continue to emphasize the adoption of UNAIDS 95-95-95 goals by the Government of Jamaica. PEPFAR programs must continue to drive OUs toward epidemic control despite the

challenges posed by COVID-19. Finally, S/GAC expects that funding will continue at the same ROP21 budget, at a minimum, for programs shown to have had the highest achievement in ROP20.

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 based on 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 ROP22 planning and approval process.

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

Sincerely,

Angeli Achrekar

Attachment: **ROP 2022 PEPFAR Planned Allocation and Strategic Direction**

CC: **S/GAC – Kristin Kelling and Alexander Cumana, Co-Chairs and Erin Riley and Paola Chanes-Mora, PPMs, Simone Jackson, Caribbean Regional Program Coordinator and Tisa Barrios-Wilson, Central America and Brazil Regional Coordinator**

Overview: 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/Regional Operational Plan (COP/ROP) 2020 and current ROP 2021 implementation as we plan for ROP22. We have noted the following key successes and challenges:

Successes

1. 150% increase in HIV positives identified in Central America and improved achievement amongst Caribbean IPs providing direct service.
2. Caribbean Regional Program viral load suppression (VLS) increased from 81% to 87%; Panama VLS increased from 34% to 65%.
3. Gains and improvements in the number of ART patients with no clinical contact for ARV drug pick-up across the region and an increase in new patients on treatment throughout Central America.
4. Increases in MMD throughout Central America and MMD launched in Panama in Q4.

Challenges

1. Return to treatment and linkage gaps remain.
2. Only 39% of eligible patients are enrolled in PrEP and only 23% are newly enrolled, illustrating major gaps in coverage and demand creation for the region. Expand accessibility of prevention services to better engage high-risk populations.
3. Finding new positives (some current challenges relate to COVID-19).
4. VLS has been consistently low quarter over quarter in both sub-regions, with a vast improvement in Panama.

<u>Central America:</u>
Central America and Brazil Regional Program's overall performance improved, as compared to ROP20, and is on track to continue making substantial progress into ROP22. The HIV prevalence rate is highest in Brazil for men who have sex with men (MSM) at 18.3% and transgender women at 30%. In terms of progress toward the 95-95-95 goals, considerable gaps remain and vary by country. The overall progress toward the 95-95-95 goals is 91-76-86, of which 76% of PLHIV are on treatment, and 86% of PLHIV are virally suppressed for the six countries in the sub-region. There was high target achievement for KP treatment at 199% and 142% of patients currently on treatment. Target achievement for new HIV positives and new patients on treatment appear low, but the number of positives found increased by 154% and new patients increased by 50% as compared to FY20. PEPFAR Central America and Brazil will continue to work with the ministries of health and partners to expand to different testing modalities including PITC, index, and KP testing to improve the performance.

Yield for the sub-region is concerning with a decrease from FY20 at 5% to 4% in FY21 with 6,281 new positives found. Testing achievement ranged from 44% in Panama to 671% in Nicaragua and new positives ranged from 2.48% in Brazil to 318% in Nicaragua. Nicaragua's results show high percent achievements with a 9% yield, but the cumulative targets were low for 698 for testing and 130 new positives (as compared to 4,684 for testing and 414 for new positives in FY20). S/GAC would like to see an upward trajectory of yield, testing, and new positive achievements in ROP22 with corrective targets. Among HIV testing clients, KP yield increased from 3.24% in Q1 to 6.47% in Q4 mainly due to index testing and PITC, which contributed to preventing over-testing and potential stockouts. New positives across both sexes were greatest among males between the ages of 20-24 and 25-29 with 1,165 and 1,486 respectively.

Treatment coverage was high across the region, ranging from 71-89% in El Salvador, Guatemala, Honduras, Nicaragua, and Panama. Brazil had a 63% target achievement due to a larger number of interruptions in treatment and reported a lower number of individuals in treatment due to access issues and COVID-19. Treatment interruption after 3 months and the number of ART patients with no clinical contact were key challenges in the region. The number of treatment interruptions after 3 months ranged from 5,869 in Q1 to 7,292 in Q4. Patients with no clinical contact were greatest at the end of the year with 6,092. Common themes included work and schedule conflict, economic conditions, and COVID-19. The region should focus on decreasing treatment interruption (especially after 3 or more months) to find the root causes and tailor interventions to keep patients on treatment. Teams are to continue to create concentrated interventions to reach high-burden populations like MSM, young LGBTQ+, and transgender-identifying individuals.

VLC and VLS varied by site across countries, demonstrating the importance of strengthening viral load networks and supply chain efforts in the region. Overall, there was an impressive improvement in VLC and VLS. VLC rose from 86% in FY20 Q4 to 95% at the end of FY21. VLS increased from 82% to 91%. In Panama, VLC was 31% in FY20 Q3 and VLS was 78%. These rates increased to 80% and 88% in FY21 Q4 respectively. Best practices in Panama that contributed to the vast increase in VLC and VLS were increased local lab hours for processing viral load, hired additional medical technicians for extended hours, after hours sample collection, and enhanced adherence counseling. Ministries of health, KP community-based organizations (CBOs), and civil society collaborated to increase VLC and VLS among MSM and transgender women by identifying challenges of treatment at sites with a high volume of KP clients by hiring peer-based counselors and supporting local CBOs for community-based follow-up. Among MSM, coverage increased from 37% in Q3 of FY20 to 96% in Q4 of FY21 and from 41% to 70% among transgender women in the same period. VLS increased for 89% of MSM and 87% for transgender women. PEPFAR Central America and Brazil focused on young PLHIV between 15-29 years old and saw VLS increase quarter after quarter standing at 86% at the end of the year. Their best practices included involving targeting younger PLHIV in the broader VL support strategies, expansion of sampling sites for viral load to community-based and convenience sites for sampling, home delivery of ART, and tailored adherence counseling.

Caribbean:
Overall, the Caribbean Regional Program did not reach their FY21 HIV-positive and new treatment targets (25% of new positives and 43% in Jamaica, and 29% in Trinidad and Tobago). This achievement represents a decrease compared to FY20. Linkage to treatment remains a challenge among 15–24-year-olds in Jamaica. Jamaica's PLHIV estimate is 32,617; of these, 40% who know their status are on ARV treatment.

When reviewing agreements with Jamaica's Ministry of Health and Wellness related to DSD, keep agencies and S/GAC informed. It is our understanding that Jamaica is exploring how PEPFAR activities fit within the health system as they consider restructuring. This issue might need higher-level engagement (e.g., U.S. Jamaica Strategic Dialogue).

Given each countries achievement of 95-95-95 in the region, the following priority strategic and integrated changes are recommended:

1. Person-Centered Prevention to continue to scale up PrEP in ROP22. All countries will apply lessons learned from project start-up to other countries that are rolling out PrEP. They will continue to implement to scale-up the program and create sustainable demand and effectively advocate for government policy. Additionally, the creation of person-centered prevention is

essential by expanding community-based distribution as an option for clients, demand creation through social medial, MMD of PrEP, text message reminders to clients and event-driven PrEP.

2. Sustain and improve patient service along the treatment cascade including in the first 95 via case finding to increase active case finding through a diversified strategy portfolio focused on yield testing modalities in high-burden areas. In the second 95, the focus is to continue the initiation and continuity of patients on treatment by continuing to provide client-centered ART services to all patients at current sites. For the third 95, there is a need to provide adherence and viral load comprehensive package of all services to all patients at current sites. Importantly, a focus on addressing the high levels of stigma and discrimination and barriers put in place by providers by ensuring barriers around starting treatment or accessing testing are lowered and to focus on client-centered clinical service models to ensure immediate linkage and improve continuity of treatment.
3. Differentiated Service Delivery: A focus on person-centered care by improving differentiated service delivery models for testing, treatment, viral load sample collection and PrEP. Key strategies include the expansion of 3-6 MMD, providing tailored adherence and VL packages by population, including peer/case managers, text messages, treatment literacy, ensuring full access to Tenofovir/Lamivudine/Dolutegravir (TLD), and the expansion of community-level ARV/PrEP delivery, testing services, and viral load sample collection strategies.
4. Focus on return to treatment campaigns in the Caribbean and Central America.
5. Improve linkage to treatment across the region by implementing best practices across sites.
6. Utilize cross-cutting approaches to align with the U.S. Strategy to Address the Root Causes of Migration in Central America by using a humans-rights approach to address structural barriers that KP and other groups, including indigenous and migrant communities to expand access to treatment services for all.
7. Above-site program for regional impact: including accountability of all above-site activities and MPRs, strengthening national laboratory capacity and systems, strengthening HIV based-case surveillance systems, data quality, capacity in epidemiology and data analysis, and investing in local partnerships for sustainability and integration of services into the national response across the region.

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 ROP 2022 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

TABLE 1: All COP/ROP 2022 Funding by Appropriation Year

	Bilateral				Central				Total
	FY22	FY21	FY20	Unspecified	FY22	FY21	FY20	Unspecified	TOTAL
Total New Funding	$ 68,233,283	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 68,233,283
GHP-State	$ 65,017,033	$ -	$ -		$ -	$ -	$ -		$ 65,017,033
GHP-USAID	$ -				$ -				$ -
GAP	$ 3,216,250				$ -				$ 3,216,250
Total Applied Pipeline	$ -	$ -	$ -	$ 11,766,717	$ -	$ -	$ -	$ -	$ 11,766,717
DOD				$ 212,378				$ -	$ 212,378
HHS/CDC				$ 8,720,552				$ -	$ 8,720,552
HHS/HRSA				$ 402,000				$ -	$ 402,000
PC				$ -				$ -	$ -
USAID				$ 2,218,361				$ -	$ 2,218,361
USAID/WCF				$ -				$ -	$ -
State				$ -				$ -	$ -
State/AF				$ -				$ -	$ -
State/EAP				$ -				$ -	$ -
State/EUR				$ -				$ -	$ -
State/PRM				$ -				$ -	$ -
State/SCA				$ -				$ -	$ -
State/SGAC				$ -				$ -	$ -
State/WHA				$ 213,426				$ -	$ 213,426
TOTAL FUNDING	$ 68,233,283	$ -	$ -	$ 11,766,717	$ -	$ -	$ -	$ -	$ 80,000,000

TABLE 1: All COP 2022 Funding by Appropriation Year

TABLE 1a: Western Hemisphere COP/ROP 2022 Notional Allocations

Total ROP22 Planning Level: $80,000,000	
Caribbean	$17,900,000
Central America	$51,100,000
Brazil	$3,000,000
Venezuela Regional Crisis	$8,000,000
Total	**$80,000,000.00**

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

Countries should plan for the full Care and Treatment (C&T) level of $43,932,200 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/ROP 2022 Earmarks by Appropriation Year

	Appropriation Year			
	FY22	FY21	FY20	TOTAL
C&T	$ 43,932,200	$ -	$ -	**$ 43,932,200**
OVC	$ -	$ -	$ -	**$ -**
GBV	$ -	$ -	$ -	**$ -**
Water	$ -	$ -	$ -	**$ -**

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

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

TABLE 3: COP/ROP 2022 Initiative Controls: Each dollar planned in ROP can belong to only one initiative. Most ROP 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	**$ 80,000,000**	**$ -**	**$ 80,000,000**
Core Program	$ 80,000,000	$ -	**$ 80,000,000**
Cervical Cancer	$ -	$ -	$ -
Community-Led Monitoring	$ -	$ -	$ -
Condoms (GHP-USAID Central Funding)	$ -	$ -	$ -
DREAMS	$ -	$ -	$ -
HBCU Tx	$ -	$ -	$ -
One-time Conditional Funding	$ -	$ -	$ -
OVC (Non-DREAMS)	$ -	$ -	$ -
Surveillance and Public Health Response	$ -	$ -	$ -
VMMC	$ -	$ -	$ -

TABLE 4: Programmatic Controls: Programmatic controls are used to track programmatic directives that can be tracked by a combination of program area and/or beneficiary. Programmatic controls may overlap with Initiatives, for example PrEP for Adolescent Girls and Young Women may count toward 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	**$1,291,800**	**$-**	**$1,291,800**
PrEP (AGYW)	$-	$-	**$-**
PrEP (KPs)	$1,291,800	$-	**$1,291,800**

TABLE 5: State ICASS and LNA Funding

	ICASS
Central America/Brazil	$21,623
Caribbean	$131,060
TOTAL	**$152,683**

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 (ROP20) against FY22 Targets (ROP21)

Western Hemisphere		
Indicator	**FY21 result (ROP20)**	**FY22 target (ROP21)**
TX Current <15	**677**	**303**
TX Current >15	**98,846**	**130,592**
VMMC >15	**N/A**	**N/A**
DREAMS (AGYW PREV)	**N/A**	**N/A**
Cervical Cancer Screening	**N/A**	**N/A**
TB Preventive Therapy	**7,095**	**1,158**

Brazil		
Indicator	**FY21 result (ROP20)**	**FY22 target (ROP21)**
TX Current <15	**N/A**	**105**
TX Current >15	**22,302**	**18,300**
VMMC >15	**N/A**	**N/A**
DREAMS (AGYW PREV)	**N/A**	**N/A**
Cervical Cancer Screening	**N/A**	**N/A**
TB Preventive Therapy	**57**	**1,158**

El Salvador		
Indicator	**FY21 result (ROP20)**	**FY22 target (ROP21)**
TX Current <15	**113**	**N/A**
TX Current >15	**13,148**	**15,257**
VMMC >15	**N/A**	**N/A**
DREAMS (AGYW PREV)	**N/A**	**N/A**
Cervical Cancer Screening	**N/A**	**N/A**
TB Preventive Therapy	**2,123**	**N/A**

Guatemala		
Indicator	**FY21 result (ROP20)**	**FY22 target (ROP21)**
TX Current <15	**278**	**64**
TX Current >15	**21,011**	**32,127**
VMMC >15	**N/A**	**N/A**

DREAMS (AGYW PREV)	**N/A**	**N/A**
Cervical Cancer Screening	**N/A**	**N/A**
TB Preventive Therapy	**1,629**	**N/A**

Honduras		
Indicator	**FY21 result (ROP20)**	**FY22 target (ROP21)**
TX Current <15	**236**	**N/A**
TX Current >15	**10,093**	**13,619**
VMMC >15	**N/A**	**N/A**
DREAMS (AGYW PREV)	**N/A**	**N/A**
Cervical Cancer Screening	**N/A**	**N/A**
TB Preventive Therapy	**910**	**N/A**

Jamaica		
Indicator	**FY21 result (ROP20)**	**FY22 target (ROP21)**
TX Current <15	**17**	**61**
TX Current >15	**11,563**	**17,815**
VMMC >15	**N/A**	**N/A**
DREAMS (AGYW PREV)	**N/A**	**N/A**
Cervical Cancer Screening	**N/A**	**N/A**
TB Preventive Therapy	**N/A**	**N/A**

Nicaragua		
Indicator	**FY21 result (ROP20)**	**FY22 target (ROP21)**
TX Current <15	**N/A**	**N/A**
TX Current >15	**1,485**	**2,430**
VMMC >15	**N/A**	**N/A**
DREAMS (AGYW PREV)	**N/A**	**N/A**
Cervical Cancer Screening	**N/A**	**N/A**
TB Preventive Therapy	**2,359**	**N/A**

Panama		
Indicator	**FY21 result (ROP20)**	**FY22 target (ROP21)**
TX Current <15	**24**	**56**
TX Current >15	**12,822**	**22,444**

VMMC >15	**N/A**	**N/A**
DREAMS (AGYW PREV)	**N/A**	**N/A**
Cervical Cancer Screening	**N/A**	**N/A**
TB Preventive Therapy	**17**	**N/A**

Trinidad and Tobago		
Indicator	**FY21 result (ROP20)**	**FY22 target (ROP21)**
TX Current <15	**9**	**17**
TX Current >15	**6,422**	**8,600**
VMMC >15	**N/A**	**N/A**
DREAMS (AGYW PREV)	**N/A**	**N/A**
Cervical Cancer Screening	**N/A**	**N/A**
TB Preventive Therapy	**N/A**	**N/A**

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

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
Barbados	**$389,548**	**$204,506**	**$185,042**
HHS/CDC	$389,548	$204,506	$185,042
Brazil	**$5,293,276**	**$1,508,080**	**$3,785,196**
HHS/CDC	$5,293,276	$1,508,080	$3,785,196
Colombia	**$1,547,295**	**$588,404**	**$958,891**
DOD	$400,000	$0	$400,000
HHS/CDC	$1,147,295	$588,404	$558,891
El Salvador	**$6,231,303**	**$8,235,440**	**-$2,004,137**
DOD	$125,600	$107,011	$129,000
HHS/CDC	$2,273,834	$2,325,818	-$51,984
USAID	$3,828,469	$5,909,622	-$2,081,153
Guatemala	**$17,834,528**	**$15,545,664**	**$2,288,864**
DOD	$200,700	$128,556	$210,684
HHS/CDC	$8,972,445	$6,061,647	$2,910,798
State	$154,854	$92,974	$61,880
USAID	$8,424,729	$9,319,227	-$894,498
Honduras	**$9,414,570**	**$8,844,680**	**$569,890**
DOD	$117,700	$85,202	$88,000
HHS/CDC	$2,602,820	$2,631,341	-$28,521
USAID	$6,723,750	$6,213,339	$510,411
Jamaica	**$13,264,832**	**$10,847,381**	**$2,417,451**

HHS/CDC	$6,552,083	$5,140,336	$1,411,747
HHS/HRSA	$2,572,720	$2,215,082	$357,638
State	$770,215	$539,527	$230,688
USAID	$3,369,814	$2,952,436	$417,378
Nicaragua	**$1,322,904**	**$1,078,676**	**$244,228**
HHS/CDC	$458,230	$310,067	$148,163
USAID	$864,674	$768,609	$96,065
Panama	**$5,061,032**	**$4,466,032**	**$595,000**
HHS/CDC	$1,703,423	$1,328,109	$375,314
USAID	$3,357,609	$3,137,923	$219,686
Trinidad and Tobago	**$1,764,432**	**$2,078,639**	**-$314,207**
HHS/CDC	$1,614,432	$1,962,056	-$347,624
HHS/HRSA	$150,000	$116,583	$33,417
State	$0	$0	$0
Venezuela	**$3,452,294**	**$3,452,294**	**$0**
USAID	$3,452,294	$3,452,294	$0
Western Hemisphere Region	**$269,454**	**$201,343**	**$68,111**
HHS/CDC	$0	$0	$0
USAID	$269,454	$201,343	$68,111
Grand Total	**$65,845,468**	**$57,051,139**	**$8,794,329**

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	115,850	**93,094**	80.36%	HTS	$2,587,564	97%
	HTS_TST_POS	29,015	**3,510**	12.10%			
	TX_NEW	32,244	**6,564**	20.36%	C&T	$5,863,168	79%
	TX_CURR	84,787	**56,024**	66.08%			
	VMMC_CIRC	-	-	-	-	-	-
	OVC_SERV	-	-	-	-	-	-
DOD	HTS_TST	286	**1,551**	542%	HTS	$71,184	100%
	HTS_TST_POS	26	**6**	23.08%			
	TX_NEW	26	**9**	34.62%	C&T	$25,046	100%
	TX_CURR	131	**117**	89.31%			
	VMMC_CIRC	-	-	-	-	-	-
	OVC_SERV	-	-	-	-	-	-
HHS/ HRSA	HTS_TST	1,556	**116**	7.46%	HTS	$270,007	100%
	HTS_TST_POS	281	**18**	6.41%			

	TX_NEW	775	**300**	38.71%	C&T	$1,740,506	100%
	TX_CURR	5,607	**4,239**	75.60%			
	VMMC_CIRC	-	-	-	-	-	-
	OVC_SERV	-	-	-	-	-	-
USAID	HTS_TST	78,961	**59,169**	74.93%	C&T	$6,850,863	100%
	HTS_TST_POS	8,166	**2,964**	36.30%			
	TX_NEW	9,865	**3,911**	39.65%	HTS	$1,542,214	100%
	TX_CURR	48,731	**39,151**	80.34%			
	VMMC_CIRC	-	-	-	-	-	
	OVC_SERV	-	-	-	-	-	-
				Above Site Programs		$7,348,967	
				Program Management		$9,445,543	

SECTION 4: COP/ROP 2022 DIRECTIVES

The following section has specific directives for ROP22 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

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 the requirements below, and the ROP22 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 ROP22 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: In-process; End of fiscal year 2025 Issues or Barriers: All countries have adopted Test and Start policies at the national level, but implementation has varied by country.

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; End of fiscal year 2024 Issues or Barriers: Adopted in the Caribbean and Central America but there is need for technical assistance, harmonization of TLD procurement plans with TLD transition trends, and strengthening of pharmacy registering information and data visibility to avoid stockouts. Continued engagement on this issue is needed in Jamaica and Trinidad and Tobago. TLD transition has not begun in Nicaragua due to continuing political instability.
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; End of fiscal year 2024 Issues or Barriers: Adopted in both sub-regions. The main gap to MMD expansion is low stock levels resulting from COVID led to decline in 3+ MMD in the Caribbean. In Central America, there was high-level political advocacy, policy updates, clinical staff training, promoting awareness, identifying eligible PLHIV, updating data collection tools to capture MMD, forecasting and supply planning. The number of patients receiving ART under MMD 3+ months ranges from 17% in Panama to 69% in Guatemala, with an increase in all countries.
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. N/A
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. N/A
	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; End of fiscal year 2023 Issues or Barriers: The region continues to struggle with active case finding, finding new positives, and ensuring new patients on treatment. Both sub-regions will continue to ensure innovative and inclusive case finding and high-burden populations and key populations. Additionally, they will emphasize safe and ethical index testing. Scale up on self-testing is needed in both sub-regions; Jamaica should continue to build upon their successful pilot program.
	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: End of fiscal year 2024 Issues or Barriers: PrEP is available in all countries, except for Nicaragua. Jamaica and Trinidad and Tobago should continue to engage to expand PrEP availability for KPs and high-risk-negative individuals.
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.

	N/A
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; End of fiscal year 2025 Issues or Barriers: The Caribbean and Central America are extremely complex environments, and all countries are committed to provide stigma-free, life-saving treatment to improve health outcomes for key populations, adolescent girls, young women, and others. Teams are committed to continuing to make strides toward equality and the reduction of stigma and discrimination in HIV services.
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. N/A
11.	OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy. Status: In process; End of fiscal year 2024 Issues or Barriers: QA and CQI practices have been introduced across the region, but countries should continue to support CQI practices consistently and use SIMS data to identify areas for continuous improvement.
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; End of fiscal year 2025 Issues or Barriers: U=U and viral load literacy messaging are currently being implemented across the region.
13.	Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses. Status: In process; End of fiscal year 2024 Issues or Barriers: Countries should continue making progress toward local 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; End of fiscal year 2024 Issues or Barriers: All countries should demonstrate evidence of year on year increases of host government expenditures for the HIV response.
15.	Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. N/A
16.	Scale-up of case surveillance and unique identifiers for patients across all sites. Status: In process; End of the fiscal year 2025 Issues or Barriers: All countries should continue making investments in systems and patient-level tracking.

In addition to meeting the minimum requirements outlined above, it is expected that the Western Hemisphere Region will consider all the following technical directives and priorities. A full list of ROP22 Technical Priorities and Considerations are listed in ROP22 guidance and can be referenced in Section 6.

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

Central America/Brazil–Specific Directives
HIV Treatment
1.Ensure treatment continuity for all current and new clients, and identifying the profile of those with treatment interruptions and barriers to treatment
2.Improve and scale client-centered services to initiate ART when 7 days of diagnosis and retain patient throughout the region
3. Expediate transition to TLD for all PLHIV in El Salvador, Guatemala, Honduras, and Panama
HIV Prevention
1. Optimize and find the right balance between social network testing and index testing
2. Expand and promote the implementation of PrEP and self-testing activities throughout the entire region
Other Government Policy, Systems, or Programming Changes Needed
1. Increase MMD to >4 months 2. Expand differentiated service delivery throughout the entire region 3. Identify and break down barriers to treatment for specific communities in the Northern Triangle, such as KPs, indigenous communities and migrants

Caribbean–Specific Directives
HIV Treatment
1. Identify profile of return to treatment patients and barriers to retention in Jamaica and Trinidad and Tobago
2. Improve linkage to treatment services after HIV diagnosis with a particular focus on 15-24 years old in Jamaica; identify and break down barriers to treatment and stigma associated with KPs
3. Improve client-centered services to retain PLHIV, especially adolescent and young men
HIV Prevention
1. Optimized testing with appropriate quality assurance and CQI monitoring activities throughout the region, as well as identifying the right balance between social network testing and index testing
2. Expand and promote PrEP and self-testing activities throughout the region
Other Government Policy, Systems, or Programming Changes Needed
1. Better monitor partner expenditures and increase fidelity in outlays to budgets

PrEP

In COP/ROP22, 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.

Addressing Structural Barriers to KP service delivery

COP/ROP22 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/ROP22 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/ROP22 planning meetings.

Other Government Policy, Systems, or Programming Changes Needed: HIV-related stigma and discrimination: Within the region, Jamaica has been selected to participate in the focal countries collaboration, an effort among the Global Fund, UNAIDS and PEPFAR to measurably reduce stigma and discrimination through increased coordination, collaboration and planning with communities, governments, and national partners, in a set of focal countries over a 3–5-year period. The focal countries collaboration will help advance efforts toward meeting the 10-10-10 societal enabler targets and PEPFAR's minimum program requirement #9, and will build upon existing initiatives, activities and coordinating mechanisms. As an initial step, PEPFAR teams are requested to work with partners to convene a meeting during the strategic planning meeting window (January 24th - February 11) to take stock of key opportunities to advance national efforts to address HIV-related stigma and discrimination, such as, as applicable, national strategic plans, settings prioritized under the Global Partnership For Action to Eliminate All Forms of HIV-Related Stigma and Discrimination, new evidence provided by the PLHIV Stigma Index 2.0 and GF Breaking Down Barriers mid-term assessments. It is expected that such stock taking will inform coordinated action in funding and implementing comprehensive programmatic strategies to reduce stigma and discrimination at scale and promote partner government and community leadership at the country level.

COP/ROP 2022 Active Engagement with Community and Civil Society (see section 2.5.3 of COP/ROP 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 ROP22 strategic retreats, planning meetings, as well as approval meetings. Engagement with local CSOs at the country-level is required and should begin early and continue during the entirety of the ROP 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, to introduce and discuss all ROP 2022 tools, guidance, results, and targets as well as the proposed trajectory and strategy for 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 ROP 2022 development, finalization, and implementation. As in 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 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 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 ROP22 should build on prior activities in ROP21 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 ROP22, 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/ROP22 minimum requirement for the care and treatment earmark is reflected in Table 2. If there is no adjustment to the COP/ROP22 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)

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/ROP22 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/ROP22 earmark is derived by using the final COP/ROP21 GBV earmark allocation as a baseline. The COP/ROP22 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/ROP21 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/ROP21 earmark is derived by using the final COP/ROP21 water earmark allocation as a baseline. The COP/ROP22 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.

While the CLM initiative does not appear in PLL budget tables, as CLM remains a requirement in COP/ROP22 for all OUs, each OU is responsible for programming a portion of funds under the **Community-Led Monitoring** initiative.

Community-Led Monitoring - During COP/ROP20, 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/ROP22, 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/ROP22 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/ROP22 planning will require supplemental language in the OU's COP/ROP22 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 toward 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/ROP22 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/ROP21 implementation (end of FY 2022) with a pipeline in excess of three or four months is required to apply this excessive pipeline to COP/ROP22, 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.