United States Department of State

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ACTION MEMO FOR:
Chargé d'Affaires Michael F. Kleine, Indonesia
Chargé d'Affaires Katherine E. Monahan, Papua New Guinea
Acting Deputy Chief of Mission Matthew K. Bunt, Papua New Guinea
Ambassador MaryKay L. Carlson, Philippines

FROM: GHSD – U.S. Global AIDS Coordinator,
Ambassador Dr. John Nkengasong

THROUGH: Erin Eckstein, Chair
Nicole Espy, PEPFAR Program Manager

SUBJECT: Fiscal Year (FY) 2025 PEPFAR Planned Allocation

Dear Ambassador, DCM, and Chargés,

To reach the global HIV/AIDS 2030 goals, it is critical that PEPFAR investments and activities are aligned with the unique situation of the partner countries we are supporting. This requires that we continue to work together to operationalize the PEPFAR Five-year Strategy, helping partner countries achieve or exceed the 95/95/95 HIV treatment targets by 2025, as well as provide a strong and sustainable public health infrastructure that can be leveraged to tackle current and emerging disease threats.

In response to stakeholder input and to make the ROP process more fit-for-purpose, there are many improvements to this year's process: a) transitioning from an annual planning process to 2-year operational planning to facilitate longer-term thinking. The shift to a 2-year cycle began in fiscal year 2024 (FY24) for COP and in fiscal year (FY25) for ROP; b) a redesigned COP/ROP Guidance Document that is a shorter, more strategic, and more useful resource to support country teams as they work with stakeholders to develop regional operating plans; c) Technical Considerations, formerly a section within the Guidance, has been moved to an

annex document and has only been revised where necessary; and d) Minimum Program Requirements have been reframed as Core Standards to better reflect PEPFAR's role as a respectful partner helping to enable the goals of national HIV efforts. This year we included OU Chair recommendations for programmatic improvement for ROP23 implementation (Table 4).

The function and purpose of the COP/ROP process remains unchanged. We must maintain an inclusive process, use data for decision making, maximize partnership and interagency collaboration, and pursue program and policy priorities efficiently for maximum impact. All ROP changes are intended to preserve accountability, impact, and transparency, and to redesign or eliminate things that are no longer fit-for-purpose.

As our teams engage in the ROP process, these six priority considerations should be top of mind: (1) Assess new data and adjust implementation accordingly; (2) address performance gaps through policy actions and policy implementation; (3) lean into systems strengthening to sustain the response; (4) prioritize impact for the 1st 95 and for youth; (5) promote innovation and modernization; and (6) enhance interagency coordination and consistency across partners. I shared details on these priorities in our recent COM call and the COP/ROP All Hands Launch call and all PCOs have these presentations.

Consistent with the approach from years past, PEPFAR teams will be responsible for setting their own targets across PEPFAR program areas in consultation with stakeholders and in consideration of any updated epidemiologic data including surveys and surveillance, PLHIV estimates, program results that require significant adjustment, and any new macro dynamics (e.g., social, political, economic, GF GC7) at the country level. PEPFAR targets are not PEPFAR's but flow directly from Indonesia, Papua New Guinea, and Philippines commitments to the U.N. Sustainable Development Goal (SDG) 3 target of ending the global AIDS epidemic as a public health threat by 2030 while also advancing interdependent SDGs. System gaps that inhibit achieving impact should be identified and addressed with a view to the systems improvements needed to sustain impact in the future.

Convening with our partners to review country programs is our most important collaborative act. I have full confidence in our highly skilled teams and their ability to guide the process for ROP24, with governments, communities, civil society, faith-

based organizations, and other partners continuing to assume a more active role. Our shared goal to end HIV/AIDS as a public health threat by 2030 should be the overarching motivation for all participants in the ROP process. As we proceed with regional operational planning, we must all strive to uphold the PEPFAR Guiding Principles: respect/humility, equity, accountability/transparency, impact, and sustained engagement. We ask that teams carefully consider which discussants from each country are invited to join the co-planning meeting, ensuring that both the technical needs (health, finance) and political needs (foreign affairs, private sector) are well represented. Stakeholder engagement is essential for a productive and impactful planning process, and civil society engagement will continue to be a priority in this planning process.

Creating a safe and healthy space for community/civil society engagement will continue to be an integral part of this process. 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, age, gender identity, or sexual orientation, PEPFAR will work to ensure that these principles are upheld, promoted, and advanced in all PEPFAR programs and in the way we conduct business.

The PEPFAR ROP24 notional budget for **the Pacific Region is Year 1 $30,960,000 and Year 2 $30,960,000** inclusive of all new funding accounts and applied pipeline.

Table 1: Total Pacific Region Funding

Op Div	Bilateral GHP-State	Central GHP-State	Bilateral GHP-USAID	Central GHP-USAID	GAP	Total New	Applied Pipeline	Year 1 TOTAL	Year 2 NOTIONAL
DOD	$857,061	$-				**$857,061**	$-	**$857,061**	$857,061
HHS/CDC	$4,080,370	$-			$400,000	**$4,480,370**	$1,290,550	**$5,770,920**	$5,770,920
HHS/HRSA	$823,728	$-				**$823,728**	$33,333	**$857,061**	$857,061
USAID	$19,503,675	$-	$-	$-		**$19,503,675**	$3,821,283	**$23,324,958**	$23,324,958
USAID/WCF	$50,000	$-		$-		**$50,000**	$-	**$50,000**	$50,000
State/EAP	$100,000	$-				**$100,000**	$-	**$100,000**	$100,000
TOTAL FUNDING	**$25,414,834**	**$-**	**$-**	**$-**	**$400,000**	**$25,814,834**	**$5,145,166**	**$30,960,000**	**$30,960,000**

Table 1A: ROP24 Planning Level Allocation by Country

Pacific Regional

Op Div	Bilateral GHP-State	Central GHP-State	Bilateral GHP-USAID	Central GHP-USAID	GAP	Total New	Applied Pipeline	Year 1 TOTAL	Year 2 NOTIONAL
State/EAP	$100,000	$-				$100,000	$-	$100,000	$100,000
TOTAL FUNDING	$100,000	$-	$-	$-	$-	$100,000	$-	$100,000	$100,000

Indonesia

Op Div	Bilateral GHP-State	Central GHP-State	Bilateral GHP-USAID	Central GHP-USAID	GAP	Total New	Applied Pipeline	Year 1 TOTAL	Year 2 NOTIONAL
USAID	$9,023,440	$-	$-	$-		$9,023,440	$1,741,560	$10,765,000	$10,765,000
USAID/WCF	$50,000	$-		$-		$50,000	$-	$50,000	$50,000
TOTAL FUNDING	$9,073,440	$-	$-	$-	$-	$9,073,440	$1,741,560	$10,815,000	$10,815,000

Papua New Guinea

Op Div	Bilateral GHP-State	Central GHP-State	Bilateral GHP-USAID	Central GHP-USAID	GAP	Total New	Applied Pipeline	Year 1 TOTAL	Year 2 NOTIONAL
USAID	$4,390,227	$-	$-	$-		$4,390,227	$204,773	$4,595,000	$4,595,000
TOTAL FUNDING	$4,390,227	$-	$-	$-	$-	$4,390,227	$204,773	$4,595,000	$4,595,000

Philippines

Op Div	Bilateral GHP-State	Central GHP-State	Bilateral GHP-USAID	Central GHP-USAID	GAP	Total New	Applied Pipeline	Year 1 TOTAL	Year 2 NOTIONAL
DOD	$857,061	$-				$857,061	$-	$857,061	$857,061
HHS/CDC	$4,080,370	$-			$400,000	$4,480,370	$1,290,550	$5,770,920	$5,770,920
HHS/HRSA	$823,728	$-				$823,728	$33,333	$857,061	$857,061
USAID	$6,090,008	$-	$-	$-		$6,090,008	$1,874,950	$7,964,958	$7,964,958
TOTAL FUNDING	$11,851,167	$-	$-	$-	$400,000	$12,251,167	$3,198,833	$15,450,000	$15,450,000

Table 2: Congressional Directive Controls

	FY24	TOTAL
C&T	$17,172,211	$17,172,211
GBV	$203,000	$203,000

**Only GHP-State and GHP-USAID will count towards the Care and Treatment and OVC earmarks*
***Only GHP-State will count towards the GBV and Water earmarks*

Table 3: Programmatic/Initiative Controls

	Bilateral	Central	TOTAL
Total Funding	$30,960,000	$-	$30,960,000
Core Program	$30,960,000	$-	$30,960,000

As in previous years, OUs may request limited changes to these controls working with their Chair/PPM and Management and Budget Liaison, who will work with GHSD leadership. Details of the control change request parameters and process will be distributed prior to the co-planning meetings. GHSD does not set a formal control for Community Led Monitoring (CLM); however, OUs must continue to program appropriately for CLM and discuss shifts in CLM-funded levels during the co-planning meeting.

Table 4: Chair Recommendations for ROP23 Programmatic Improvement

Cross-Cutting	• Work collaboratively with partners to accelerate the adoption of modern HIV policies, guidelines and strategies • Address, where data indicate, the significant or growing proportion of new infections among MSM
Indonesia	• Continue to address gaps in the first 95 through innovative strategies, including those which focus on MSM. • Build upon policy changes and national and subnational levels to accelerate multi-month dispensing of ARVs, accelerate VL testing, accelerate rapid treatment initiation and reduce PLHIV treatment interruption.
Papua New Guinea	• Continue to identify challenges and opportunities to better characterize client movements and engagement with HIV care and improve interruption in treatment • Build upon the DNO and other efforts to support a sustainable VL testing strategy • Identify opportunities to promote innovations and successful strategies (e.g. PrEP, index testing) at scale.

Philippines	• Given that new infections outpace current achievements on the 95s, work collaboratively with partners to disrupt this dynamic and advance policies and reduce barriers to accelerated HIV case finding and new treatment initiation. Address high rates of advanced HIV disease in PLHIV by intensifying focus on targeted case finding modalities among young key populations by furthering high impact HIV testing programs and promoting HIV self-testing. • Expand differentiated ART delivery to address challenges in continuity of care for PLHIV. • Overall continue to work to modernize HIV strategies, guidelines and policies.

Please note that within the next few days our GHSD Chairs and PEPFAR Program Managers (PPMs), working closely with our headquarters support teams, will review this planning letter and details contained herein, with your wider PEPFAR regional team.

Thank you for your continued leadership and engagement during the ROP24 co-planning process.

Sincerely,

John Nkengasong

CC: GHSD – Rebecca Bunnell, Principal Deputy Coordinator (A)
GHSD – Irum Zaidi, Deputy Coordinator
GHSD – Erin Eckstein, Chair
GHSD – Nicole Espy, PEPFAR Program Manager
Pacific – Sara Klucking, PEPFAR Coordinator