United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 19, 2024

ACTION MEMO FOR:
Ambassador Virginia Palmer, Ghana
Chargé d'Affaires Catherine Rodriguez, Liberia
Ambassador Rachna Korhonen, Mali
Ambassador Bryan David Hunt, Sierra Leone

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

THROUGH: Elizabeth Sharp, PEPFAR Chair
Nuha Naqvi, PEPFAR Program Manager

SUBJECT: Fiscal Year (FY) 2025 PEPFAR Planned Allocation

Dear Ambassadors and Chargé,

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 Ghana, Liberia, Mali, and Sierra Leone's commitment 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 West Africa Region 2 is Year 1 $44,293,444 and Year 2 $44,293,444** inclusive of all new funding accounts and applied pipeline. The $2,263,000 allocated to State/GHSD/PEPFAR should be programmed during ROP development through interagency discussion and collaboration with the Chair and PPM.

Table 1: Total West Africa Region 2 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	$1,211,487	$-				**$1,211,487**	$183,326	**$1,394,813**	$1,394,813
HHS/CDC	$9,746,158	$-			$453,051	**$10,199,209**	$279,893	**$10,479,102**	$10,479,102
HHS/HRSA	$1,493,258	$-				**$1,493,258**	$213,625	**$1,706,883**	$1,706,883
USAID	$21,513,674	$-	$-	$-		**$21,513,674**	$1,662,300	**$23,175,974**	$23,175,974
USAID/WCF	$2,997,382	$-		$670,000		**$3,667,382**	$-	**$3,667,382**	$3,667,382
State	$161,520	$-				**$161,520**	$-	**$161,520**	$161,520
State/AF	$1,431,911	$-				**$1,431,911**	$12,859	**$1,444,770**	$1,444,770
State/GHSD/PEPFAR	$2,263,000	$-				**$2,263,000**	$-	**$2,263,000**	$2,263,000
TOTAL FUNDING	**$40,818,390**	**$-**	**$-**	**$670,000**	**$453,051**	**$41,941,441**	**$2,352,003**	**$44,293,444**	**$44,293,444**

Table 1A: ROP24 Planning Level Allocation by Country

West Africa Regional 2

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
HHS/CDC	$-	$-			$-	$-	$105,563	$105,563	$105,563
USAID	$-	$-	$-	$-		$-	$909,881	$909,881	$909,881
State/AF	$1,218,000	$-				$1,218,000	$-	$1,218,000	$1,218,000
TOTAL FUNDING	$1,218,000	$-	$-	$-	$-	$1,218,000	$1,015,444	$2,233,444	$2,233,444

Ghana

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	$845,971	$-				$845,971	$21,259	$867,230	$867,230
HHS/CDC	$1,396,158	$-			$453,051	$1,849,209	$174,330	$2,023,539	$2,023,539
USAID	$7,596,901	$-	$-	$-		$7,596,901	$-	$7,596,901	$7,596,901
USAID/WCF	$1,451,040	$-		$410,000		$1,861,040	$-	$1,861,040	$1,861,040
State	$161,520	$-				$161,520	$-	$161,520	$161,520
State/AF	$213,911	$-				$213,911	$12,859	$226,770	$226,770
State/GHSD/ PEPFAR	$2,263,000	$-				$2,263,000	$-	$2,263,000	$2,263,000
TOTAL FUNDING	$13,928,501	$-	$-	$410,000	$453,051	$14,791,552	$208,448	$15,000,000	$15,000,000

Liberia

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	$365,516	$-				$365,516	$162,067	$527,583	$527,583
HHS/HRSA	$1,493,258	$-				$1,493,258	$213,625	$1,706,883	$1,706,883
USAID	$6,767,534	$-	$-	$-		$6,767,534	$-	$6,767,534	$6,767,534
USAID/WCF	$448,000	$-		$100,000		$548,000	$-	$548,000	$548,000
TOTAL FUNDING	$9,074,308	$-	$-	$100,000	$-	$9,174,308	$375,692	$9,550,000	$9,550,000

Mali

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	$7,149,239	$-	$-	$-		$7,149,239	$752,419	$7,901,658	$7,901,658
USAID/WCF	$1,098,342	$-		$60,000		$1,158,342	$-	$1,158,342	$1,158,342
TOTAL FUNDING	$8,247,581	$-	$-	$60,000	$-	$8,307,581	$752,419	$9,060,000	$9,060,000

Sierra Leone

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
HHS/CDC	$8,350,000	$-			$-	$8,350,000	$-	$8,350,000	$8,350,000
USAID/WCF	$-	$-		$100,000		$100,000	$-	$100,000	$100,000
TOTAL FUNDING	$8,350,000	$-	$-	$100,000	$-	$8,450,000	$-	$8,450,000	$8,450,000

Table 2: Congressional Directive Controls

	FY24	TOTAL
C&T	$18,910,366	$18,910,366

**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	$43,623,444	$670,000	$44,293,444
Core Program	$43,623,444	$-	$43,623,444
Condoms (GHP-USAID Central Funding)	$-	$670,000	$670,000

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

Ghana

- Focus on specific prevention approaches, including continuing scale up of PrEP and ensuring continuity of KP services in current legal setting
- Implement DSD approaches to strengthen clinical cascade for underserved populations such as pediatrics and adolescent girls and young women; optimize treatment options for all populations; increase VL coverage; strengthen integration of CQI into HIV service delivery activities; and focus on structural interventions, including stigma & discrimination and human resources

- Prioritize systems strengthening activities, such as implementation of diagnostic network optimization (DNO) recommendations; instituting lab dashboard systems and bar coding for VL sample testing; improving supply chain management; strengthening data systems; enhance PEPFAR-GF coordination; collaborate with government and other stakeholders on sustainability plan/roadmap; and using networks of practice to implement clinical service integration.

Mali

- Focus on programming to increase index testing and PrEP among key and priority populations, as well as closely monitoring activities and using lessons learned for improvement.
- Improve viral load (VL) coverage and suppression through strengthening partnerships with all stakeholders, including working closely with Global Fund to ensure there are no gaps in VL reagents; closely monitoring the VL testing cascade via dedicated laboratory staff recruitment; as well as support efficient sample transportation and rapid return of results.
- Reduce stigma and discrimination by continuing to encourage advocacy and involvement of stakeholders at all levels; and further incorporating community-led monitoring (CLM) and implementing resulting recommendations.

Liberia

- Address stigma and discrimination at all levels as a key barrier to HIV service uptake across the clinical cascade to achieve 95-95-95
- Strengthen viral load and EID services to improve viral load coverage and suppression, including by supporting NACP in pursuing possible all-inclusive reagent rental agreement for replacement or additional instrument
- Accelerate HIV combination prevention services, including scale-up of PrEP services.

Sierra Leone

- Improve clinical cascade for all populations – including pediatrics by focusing on case-finding, efficient linkage to treatment, treatment retention, and

increasing VL coverage by strengthening laboratory systems to reduce turn-around-time and expand national VL capabilities.

- Collaborate across all partners to improve quality and availability of epidemiologic data for evidence-informed programmatic and policies.
- Improve advanced HIV disease (AHD) and treatment continuity by expanding screening coverage, treatment and prophylaxis for major opportunistic infections, and intensified adherence support interventions. Target case finding based on AHD to prevent late stage presentation.

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 – Elizabeth Sharp, Chair
GHSD – Nuha Naqvi, PEPFAR Program Manager
West Africa Region II – Daniel Craun-Selka, PEPFAR Coordinator