PEPFAR
U.S. President's Emergency Plan for AIDS Relief

West Africa Regional Program
Regional Operational Plan (ROP) 2021
Strategic Direction Summary

May 7, 2021

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1.0 Goal Statement

The FY2021 Regional Operational Plan (ROP21) is the third year of implementation for the West Africa Regional (WAR) program, which comprises Burkina Faso, Togo, Ghana, Liberia, Mali, Senegal, Sierra Leone, and, newly added in ROP21, Benin. As evidenced by programmatic pivots and improvements in efficiency and effectiveness that have occurred over the past year, the West Africa Regional platform continues to consolidate its vision **to catalyze sustained epidemic control in eight countries in West Africa by leveraging national and donor investments to implement adaptive, client-centered and evidence-based interventions to reach, test, treat, and retain on HIV treatment Key Populations (KP) and People Living with HIV (PLHIV) in settings with the greatest HIV burden.**

West Africa Region will continue to align proposed activities with Fast-Track and Sustainable Development Goals (SDGs) based on continued ambitious targets and transformative shifts at all levels. To date, Ghana and Togo have specific Fast-Track action plans to accelerate the HIV response in high burden cities, however, each of the countries in West Africa Region have adopted the Fast-Track targets of 95-95-95. Achievement of the 95-95-95 Fast-Track targets will put countries on course towards achieving the SDG goal of ending the AIDS epidemic by 2030. In alignment with the SDG goal to end the AIDS epidemic and to leave no one behind in West Africa, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is working with national stakeholders to provide high quality, client-centered care and reduce barriers to accessing treatment for all PLHIV.

Working in close collaboration with the various Host Country Governments, Civil Society Organizations (CSOs), the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), and other partners, the PEPFAR program in the West Africa Region aims to support progress towards epidemic control. By 2022:

1. **In Burkina Faso and Togo,** PEPFAR will continue to accelerate progress toward the achievement of the 95-95-95 targets with a focus on closing disparities among children, men, women and key populations across the HIV clinical cascade. PEPFAR aims to increase the national ART coverage from 78% in both Burkina Faso and Togo in FY21 (projected Spectrum 2020 data) to respectively 87% and 89% in FY22 and improve viral load suppression.
2. In **Benin,** a newly added country to the West Africa Regional platform in ROP21, PEPFAR aims to increase the national ART coverage from 68% in FY21 (projected Spectrum 2020 data) to 80% by optimizing HIV case finding among key and general populations, ensuring continuity of treatment and viral load (VL) suppression, and providing HIV prevention services and interventions against stigma and discrimination in four high burden departments (Atlantique, Littoral, Couffo, and Mono).
3. In **Ghana,** PEPFAR aims to achieve 95-95-95 in the Western, Western North, and Ahafo Regions of Ghana.
4. In **Liberia**, with increased funding, PEPFAR will maintain ROP20 strategies and innovations while expanding to one additional county and four additional high burden sites. PEPFAR will collaborate with the National AIDS Control Programme (NACP), GFATM, UNAIDS and other national stakeholders to scale up best practices and learning at PEPFAR-supported sites. In accordance with the Planning Level Letter, PEPFAR will support

Tenofovir/Lamivudine/Dolutegravir (TLD) transition, scale up of 6-Multi-Month Dispensing (6MMD), VL interventions, and Pre-Exposure Prophylaxis (PrEP) initiation.

5. In **Senegal** and **Mali,** the PEPFAR program will maintain ROP20 strategies, implementing activities in 13 sites in seven regions in Senegal and three regions and 23 Health Districts in Mali, to reach epidemic control in KP groups, namely men who have sex with men (MSM) and female sex workers (FSW). PEPFAR will also target priority populations and children/partners of KP. PrEP will be introduced in all sites in Senegal.
6. In **Sierra Leone**, PEPFAR aims to dramatically improve coverage through expansion to additional districts with high unmet need and significant opportunities to engage successfully with KP. With a substantial increase in funding for ROP21, PEPFAR will grow from supporting 15 high burden sites in four districts to supporting approximately 30 sites and drop-in centers in the four districts, while also saturating existing PEPFAR supported districts with significant additional unmet need.

In 2019, in the West Africa Region, 68% of PLHIV knew their status, 58% of PLHIV were on antiretroviral therapy (ART), and 45% of PLHIV were virally suppressed.[1]

During ROP21, in **Burkina Faso** and **Togo,** PEPFAR will enroll 4,551 and 6,876 PLHIV respectively on (ART), retain 39,370 and 48,923 PLHIV on ART at PEPFAR sites, and ensure 95% viral load suppression (VLS). Burkina Faso's increasingly tenuous security situation and rise in internally displaced persons (IDPs) may limit the ability to meet these enrollment goals in the Centre Nord area of the country. In **Benin**, PEPFAR will enroll onto ART 3,738 PLHIV, retain in 23,732 on treatment and ensure 95% viral load suppression at PEPFAR supported facilities in four health regions of the country.

In **Ghana**, 6,397new PLHIV will be added to the treatment cascade to reach and retain 34,422 PLHIV active on treatment and ensure 95% VLS in the Western, Western North, and Ahafo Regions; best practices will be amplified across the rest of Ghana's national system.

For **Liberia, Mali, Senegal, and Sierra Leone** 6,262 PLHIV, 3,504 PLHIV, 2,233 PLHIV and 3,364 PLHIV will be newly identified; 6,262, 3,504, 2,233, and 3,364 newly enrolled and 22,319, 38,078, 16,299 and 10,519 retained on ART respectively.

At the site level across all countries, emphasis will be placed on continuing to implement client-centered approaches with effective case finding, linkage to care, retention strategies, and scale-up of VL access. Continuous quality improvement (CQI) approaches and community-led monitoring will also be a focus to improve the quality of site-level services and client outcomes.

At the national level across all countries, PEPFAR/West Africa will work in partnership with host-country governments, various National AIDS Control Programs (NACP), Ministries of Health (MoH), the GFATM, and other key stakeholders to address barriers that limit the ability to reach targets throughout the region. PEPFAR will coordinate with donors and CSOs to support the governments' implementation of client-centered services and approaches to reach, treat, and retain PLHIV on treatment.

In ROP21, PEPFAR/West Africa will continue scaling client-centered policies and approaches, such as the use of peer navigators and case managers, to improve testing, linkage to treatment, and retention. This will continue to include adaptive strategies to mitigate the challenges and

[1] Estimated using data from UNAIDS. http://aidsinfo.unaids.org. Data accessed May 28, 2021.

restrictions associated with the COVID-19 pandemic. PEPFAR/West Africa will support implementation with fidelity of effective policies, namely test and start, index testing and partner notification, and differentiated service delivery (DSD) with multi-month prescribing and dispensing (MMD). Stigma and discrimination reduction activities for KP and PLHIV and the elimination of informal user fees will also be implemented to remove barriers to services. Addressing systems weaknesses in supply chain (including completion of TLD transition and MMD), laboratory management, and monitoring and evaluation, will remain a critical focus. Oral PrEP, a new prevention modality for West Africa, and HIV self-testing (HIVST) will be implemented in all countries, with scale-up in Ghana following successful implementation of a jump start strategy implemented under the Key Populations Investments Fund (KPIF).

National consultations are regularly held with stakeholders through PEPFAR steering committees, GFATM Country Coordination Mechanisms (CCMs), and other existing forums of cooperation to analyze barriers in programming, review achievements, and to ensure synergy in the implementation of best practices. PEPFAR teams are working closely to build synergy with GFATM programming in the development of the country funding requests due this year.

At the regional level, PEPFAR/West Africa will continue to share expertise, resources, and cross-country best practices. This information sharing will be done during the quarterly PEPFAR Oversight and Accountability Reporting Tool calls, relevant regional training meetings and newly created PEPFAR WA Technical Working Groups. Multilateral entities such as West African Health Organization (WAHO), UNAIDS, and the GFATM will continue to be engaged to support countries in scaling-up effective policies and to eliminate system barriers. Civil Society will be engaged both at site and above-site levels as implementing partners, carrying out community-led monitoring and oversight. PEPFAR WA will provide support to a regional CSO to build KP-led Civil Society Organizations' (CSO) and groups' advocacy skills to create a stronger enabling regional, national and local environment for more accessible and available KP-friendly HIV and health services.

In ROP21, **Senegal and Liberia** will use increased funds to improve case finding and linkage targets with a focus on diagnosing men and children, and ensuring continuity of treatment. The program will expand successful interventions to new sites and regions, as well as bolster activities at existing sites. These funds will also be used to test, treat, and retain internally displaced persons (IDP) living with HIV in **Burkina Faso**.

In **Senegal**, funds will be used to expand high-quality, client-focused KP programs in seven regions (Dakar, Thies, Ziguinchor, Saint-Louis, Kolda, Kaolack and Sehdiou) to accelerate strategic case finding across targeted KP and close the gap in the first and second 95s. Activities will include KP testing and reinforcing testing using high-yield modalities, as well as testing of partners and children of Key Populations Living with HIV (KPLHIV). PEPFAR will also expand its case worker and peer navigator network to ensure adherence. PEPFAR aims to identify and link an additional 2,138 PLHIV to treatment. PEPFAR will also use funds to increase support to military facilities and the services they provide to servicemen, their dependents, and the surrounding population by expanding index testing and targeted testing at military sites using risk assessment tools.

In **Liberia**, PEPFAR will use increased funds to maintain the surge in Montserrado County, which has an estimated 60% of the national HIV burden, as well as in four new high-burden sites in Grand Bassa County and Margibi County, with the aim of closing the gap in the first two 90s. Additionally, PEPFAR will expand to four new sites in Nimba County using increased funds. This surge will expand index testing in the general population with focused outreach to priority populations

(women and men over 25, TB patients, inpatients, high-risk men, and caregivers of exposed infants) through targeted strategies that include information on Undetectable = Untransmittable (U=U) messaging to promote testing, linkage, and retention and to provide index testing to existing ART clients. Technical assistance (TA) for Early Infant Diagnosis (EID) at 21 focus facilities will ensure that exposed infants receive testing and follow-up, which is currently a significant gap in Liberia. Funds will also create demand for testing among men through male-only clinics and flexible hours, as well as the introduction of HIVST kits in priority community locations. Through these interventions, Liberia aims to link an additional 5,665 PLHIV to treatment.

In **Mali**, funding will be used to maintain the footprint in the 23 sites in the current regions of Bamako, Segou, and Sikasso implementing targeted case finding and index testing strategies to improve gaps in the first 90. PEPFAR will expand index testing and other high-yield modalities, as well as expand the reach of peer navigators and case managers to strengthen retention and VL suppression. In collaboration with GFATM and NACP, PEPFAR will expand the integration of the e-Tracker into the national Health Information Management System (HMIS). Unique Identifier Codes (UICs) and electronic medical records in the District Health Information Software (DHIS2) will be extended to all HIV counseling and treatment sites. Currently UICs are used for all KP populations, and only PEPFAR supported sites benefit from the UICs for both KP and priority populations and the use of e-Tracker (Kolochi)**.**

Pervasive insecurity continues to threaten case-finding and retention in **Mali** and **Burkina Faso**. With the displacement of PLHIV due to conflict in both countries, funding will also be directed towards retaining IDP PLHIV on treatment. PEPFAR will support the Governments of Burkina Faso and Mali to mitigate attrition caused by insecurity, prevent new infections, and provide patients with a pathway to stay on treatment. In **Burkina Faso**, this support will include funding to support community-based organizations and health facilities to deliver prevention, care and treatment services to IDP PLHIV; MMD; and the provision of tools for Gender-Based Violence (GBV) prevention including Post Exposure Prophylaxis for IDPs experiencing sexual violence. In **Mali**, PEPFAR will continue to provide support to areas with health facilities that have been overwhelmed by an influx of IDPs to ensure IDP PLHIV have access to care and can be retained on treatment.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

With a combined population of 120 **million** inhabitants (World Bank Data, 2019, the West Africa PEPFAR Region has an estimated **850,000** total PLHIV (Spectrum; UNAIDS) in 2019. The number of PLHIV was estimated at 346,120 in Ghana (Spectrum 2020), followed by **94,484** in Mali (Spectrum 2020), **111,320** in Togo (UNAIDS Spectrum 2020), **95,736** in Burkina Faso (UNAIDS Spectrum 2020), **75,399** in Benin (UNAIDS Spectrum 2020)**, 73,870** in Sierra Leone, **40,153** in Senegal (Spectrum 2020), and **35,009** in Liberia (Spectrum 2020). The HIV prevalence is higher in urban areas than rural areas, higher among women than men, and higher among KP, such as MSM and FSW. The HIV epidemic is defined as concentrated in KP in Mali, Senegal, and Sierra Leone, while Burkina Faso, Togo, Ghana, and Liberia have a mixed HIV epidemic.

HIV prevalence in the region varies in the general population between countries and in KP groups. In **Burkina Faso,** with an estimated 95,736 PLHIV and a prevalence rate of 0.46% (UNAIDS

Spectrum 2020), HIV prevalence 1.9% among MSM and 5.4% among FSW (HIV integrated biological and behavioral surveillance survey (IBBSS) 2017). Adult women, adult men, and children represent 50%, 34%, and 16% of the PLHIV in Burkina Faso, respectively. The PEPFAR prioritized regions of Centre, Centre Ouest, Hauts Bassins, Centre Nord, and Boucle du Mouhoun are home to about 74% of the country's total PLHIV.

In **Togo**, the number of PLHIV is estimated at 111,320 with an adult prevalence rate of 1.35%. Estimates among MSM are 22% and 13 % among FSWs (IBBSS 2017). Adult women, adult men, and children represent 59%, 32%, and 9% in Togo, respectively (UNAIDS Spectrum 2020). The PEPFAR-prioritized regions in Togo of Lomé commune, Maritime, Plateaux, and Centrale are home to about 88% of the country total PLHIV.

In **Benin**, the number of PLHIV is estimated at 75,399 with an adult overall prevalence rate of 0.6%. Estimates among MSM are 9% and 7% among FSWs (IBBSS 2017). Adult women, adult men, and children represent 63%, 32%, and 5% in Benin, respectively (UNAIDS Spectrum 2020). The PEPFAR-prioritized regions in Benin of Littoral, Atlantique, Mono, and Couffo are home to about 54% of the country total PLHIV.

Ghana is estimated to have a total population of 31,785,763, and an estimated 346,120 PLHIV (SPECTRUM 2020). The HIV epidemic is defined as a mixed epidemic, and HIV prevalence is higher in urban areas than rural areas, higher among women than men, and higher among KP such as MSM and FSW. Ghana has an estimated HIV prevalence of 1.68% among adults (Spectrum 2020), 18.1% among MSM (GMS II, 2017), and 4.6% among FSW (IBBSS, 2016).

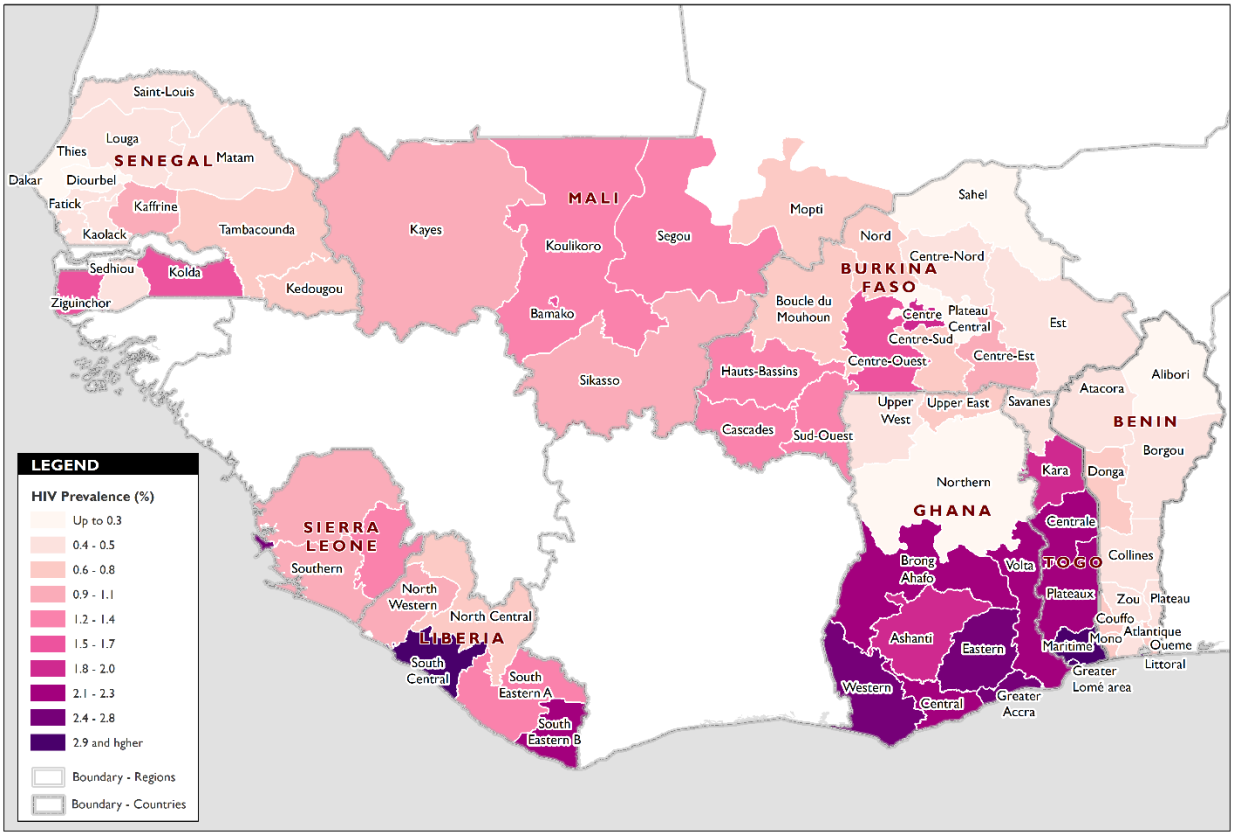
In **Liberia**, HIV prevalence is estimated at 1% (Spectrum 2020), with an estimated 35,009 PLHIV. Prevalence is 16.7% among FSW (Liberia, 2018 IBBS) and 37.9% among MSM (2018 IBBS).

Mali has a total population of about 19.1 million (World Bank, 2018). The number of PLHIV is estimated at 94,484, with HIV prevalence of 0.8% among the general population and 1.4% among adults aged 15-49, in 2018 (Spectrum 2018). Prevalence is 13.7% among MSM and 8.7% among FSW (IBBS 2018).

HIV prevalence in **Senegal** is estimated at 0.3% (2020), though prevalence among FSW is 6.6% and 27.6% among MSM.

There are an estimated 80,158 PLHIV in **Sierra Leone**, which has an estimated population of 7.6 million, with an adult prevalence of 1.54% and prevalence of 8.5% among sex workers, 14% among MSM, and 8.5% among persons who inject drugs (PWID) (SPECTRUM 2020/KP data from 2013 with IBBSS currently underway).

WEST AFRICA: HIV PREVALENCE AMONG GENERAL POPULATION



Standard Table 2.1.1

Table 2.1.1 Host Country Government Results: Burkina Faso, Togo, and Benin																
		Total		<15				15-24				25+				*Source, Year*
	Country			Female		Male		Female		Male		Female		Male		
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	Burkina Faso	20,809,664		4,760,034	8.5%	4,928,775	23.7%	2,138,844	10.3%	1,870,343	*9.0%*	3,840,718	18.5%	3,270,947	15.7%	Projections INSD 2020
	Togo	8,244,097		1,658,763	19.2%	1,668,492	19.3%	817,124	10.1%	823,664	10.7%	1,664,046	21.9%	1,612,008	18.8%	Projections INSEED 2020
	Benin	12,247,810		2,518,362	20.6%	2,592,064	21.1%	1,203,432	9.8%	1,230,571	10.0%	2,379,142	19.4%	2,297,239	18.8%	Projections SPECTRUM 2020
HIV Prevalence (%)	Burkina Faso		0.46%		0.16%		0.16%		0.44%		0.35%		0.82%		0.56%	UNAIDS SPECTRUM 2020t
	Togo		1.35%													UNAIDS SPECTRUM 2020
	Benin		0.62%													UNAIDS SPECTRUM 2020
AIDS Deaths (per year)	Burkina Faso	3100														UNAIDS data 2020 report
	Togo	2,998		542		546		124		154		1,314		1,645		SPECTRUM 5.86, 2019
	Benin	2000		292		398										

# PLHIV	Burkina Faso	95,736		7,380		7,687		9,071		7,592		39,455		24,551		UNAIDS SPECTRUM2020
	Togo	111,320		4,576		4,633		8,143		5,769		57,691		30,119		UNAIDS SPECTRUM 2020
	Benin	75,399		1,862		1,926		5,018		2,461		42,652		21,790		UNAIDS SPECTRUM2020
Incidence Rate (Yr)	Burkina Faso		0.01%													UNAIDS SPECTRUM 2020
	Togo		0.04%													UNAIDS SPECTRUM 2020
	Benin		0.03%													
New Infections (Yr)	Burkina Faso	1709						211		103		702		693		UNAIDS SPECTRUM 2020 report
	Togo	3,058														UNAIDS SPECTRUM 2020
	Benin	2300														
Annual births	Burkina Faso	761 766														MoH Statistic Report 2019
	Togo	171,228														Preliminary Program Data, DSMNI 2019
	Benin	N/A														
	Burkina Faso		75.1													

% of Pregnant Women with at least one ANC visit																MoH statistic report 2019
	Togo	N/A														
	Benin															
Pregnant women needing ARVs	Burkina Faso															
	Togo	5,558														SPECTRUM 5.86, 2019
	Benin	6,000														
Orphans (maternal, paternal, double)	Burkina Faso	100,000														UNAIDS data 2020 report
	Togo	83,221														
	Benin	N/A														
Notified TB cases (Yr)	Burkina Faso	5906	28.3/100000													MoH statistic report 2019
	Togo	2,664														Preliminary Program Data, TB Program 2019
	Benin	N/A														
% of TB cases that are HIV infected	Burkina Faso	424	7.8%													MoH Endos data December 2020
	Togo		16%													Preliminary Program Data, TB Program 2019
	Benin															

% of Males Circumcised	Burkina Faso															
	Togo															
	Benin															
Estimated Population Size of MSM*	Burkina Faso	8,361														JHU SAE 2020
	Togo	16,133														JHU SAE 2020
	Benin	5,800														UNAIDS 2019
MSM HIV Prevalence	Burkina Faso		1.9%													UNAIDS data 2020 report
	Togo		21.98 %													IBBSS MSM 2017
	Benin		7%													UNAIDS 2019
Estimated Population Size of FSW	Burkina Faso	21,464														JHU SAE 2020
	Togo	29,382														JHU SAE 2020
	Benin	28,800														UNAIDS 2019
FSW HIV Prevalence	Burkina Faso		5.4%													UNAIDS data 2020 reportI
	Togo		13.2%													IBBSS FSW and Clients 2017
	Benin		8.5%													
Estimated Population Size of PWID	Burkina Faso	87														IBBSS 2017
	Togo	2,698														Mapping and size estimation

																study (MSM, FSW, PID, and Prisoners), 2017
	Benin	N/A														
PWID HIV Prevalence	Burkina Faso															
	Togo		3.9%													IBBSS PID 2017
	Benin		2.2%													UNAIDS 2019
Estimated Size of Priority Populations (specify)	Burkina Faso	9,429														RNM, 2018
	Togo	5,154														Prisons Administration Data 2018
	Benin															
Estimated Size of Priority Populations Prevalence (specify)	Burkina Faso		2.15%													IBBSS, 2017
	Togo		4.30%													IBBSS Prisoners 2011
	Benin		N/A													
		**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table. Cite sources*														

Table 2.1.1 Host Country Government Results: Ghana															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	

Total Population	31,359,530		5,909,004	50.0%	5,911,743	50.0%	3,041,902	49.9%	3,049,721	50.1%	6,901,963	51.3%	6,545,197	48.7%	SPECTRUM 2020
HIV Prevalence (%) 15 – 49 yrs		1.68%													SPECTRUM 2020
AIDS Deaths (per year 2020)	12,758		1,475	49.8%	1,486	50.2%	500	54.2	423	45.8%	5,9492	51.8%	4,280	48.2%	SPECTRUM 2020
# PLHIV	346.120		14,317	49.9%	14,393	50.1%	31,054	73.9%	10,963	26.1%	184,385	67.0%	91,011	33.0%	SPECTRUM 2020
Incidence Rate (Yr)		0.63%													SPECTRUM 2020
New Infections (Yr)	18,928		1,834	49.8%	1,850	50.2%	4,348	83.4%	863	16.6%	6,260	62.4%	3,773	37.6%	SPECTRUM 2020
Annual births	89374														SPECTRUM 2020
% of Pregnant Women with at least one ANC visit	962,301						320,231	33.3%			642,070	66.7%			SPECTRUM (NAOMI2020)

Pregnant women needing ARVs	17,694														SPECTRUM 2020
Orphans (maternal, paternal, double)	154,967														SPECTRUM 2020
Notified TB cases (Yr)															
% of TB cases that are HIV infected	2,602	19.5%													NACP Status Update, 2018
% of Males Circumcised	NA	96.0%													DHS, 2014
Estimated Population Size of MSM*	54,759	0.72%													GMS II, 2017
MSM HIV Prevalence	9,856	18.1%													GMS II, 2017

Estimated Population Size of FSW	60,049	0.76%													IBBSS, 2020
FSW HIV Prevalence		4.6%													IBBSS, 2020
Estimated Population Size of PWID															
PWID HIV Prevalence															
Estimated Size of Priority Populations (specify)															
Estimated Size of Priority Populations Prevalence (specify)															
	If presenting size estimate data would compromise the safety of this population, please do not enter it in this table. Cite sources														

Standard Table 2.1.2

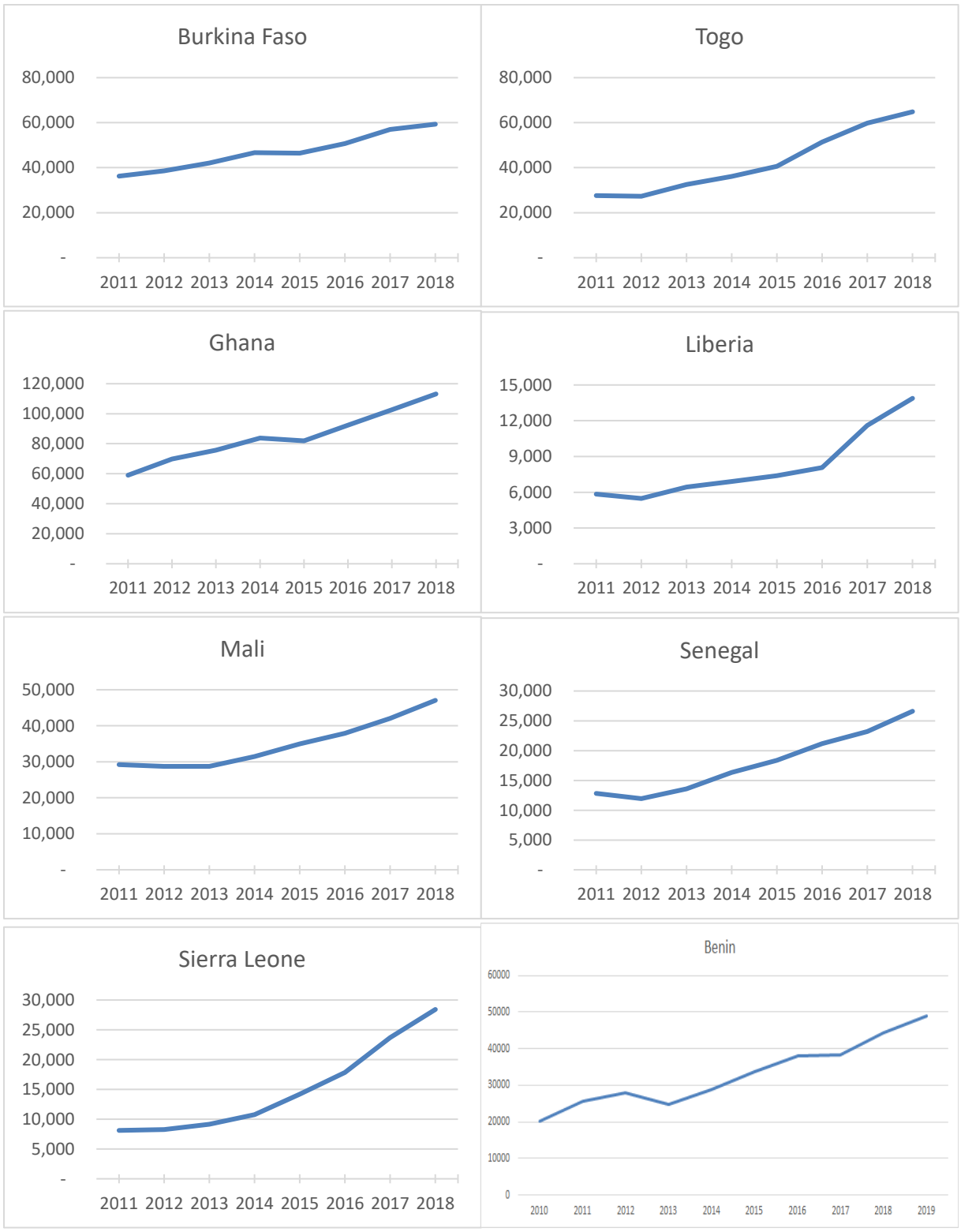
Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*											
		Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
		Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	Burkina Faso	20,809,664	0.46%	95,736	73,816	70,602	74%	64%	1,200,000	2,400	*8,783*
	Togo	7,706,446	1.35%	111,320	85,580	80,869	73%	61%	590,431	5,000	*7,338*
	Benin	12,247,810	0.90%	75,399	53,750	52,497	70%	57%	852,255	10,072	*9,962*
	Ghana	31,359,530	1.68%	346,120	218,741	208,811	60.3%	44.2%	1,837,149	58,746	*31,035*
	Liberia	4,883,469	0.81%	35,009	22,763	18,515	53%	35%	293,039	7,664	6,519
	Mali	18,821,770	0.80%	94,484	60,898	59,927	98%	42%	1,076,923	9,902	8,546
	Senegal	16,705,608	0.24%	40,153	34,311	30,453	76%	64%	1,300,000	7,148	5,164
	Sierra Leone	7,684,737	0.91%	69,631	34,119	26,042	37%	26%	455,556	4,100	
Population <15 years	Burkina Faso	9,246,768	0.16%	15,067	4,291	3,767	25%	18%	N/A	<1,000	
	Togo	3,327,255	0.28%	9,209	4,762	4,762	35%	32%	N/A	1,200	535
	Benin	5,109,426	0.07%	3,891	2,142	2,142	55%	40%			
	Ghana	10,455,002	0.30%	31,340	N/A	6,403	20%		N/A	3,300	*1,628*
	Liberia	2,018,658	0.19%	3,808	N/A	627	16%		N/A	<500	*244*
	Mali	8,760,32	0.2%	13,562	N/A	4,453	33%		N/A	740	625
	Senegal	6,955,469	0.04%	3,470	1,613	1,447	42%	24%	N/A	<500	*304*
	Sierra Leone	2,975,909	0.29%	8,627	N/A	1,486	17%	17%	N/A	<1,000	
Men 15-24 years	Burkina Faso	2,158,983	0.35%	7,592	4,743	4,241	56%		N/A	<500	
	Togo	823,664	0.70%	5,769	3,163	2,949	51%		N/A	<500	
	Benin	1,230,571	0.18	2,220	932	860	92%				
	Ghana	2,592,143	0.64%	16,590	N/A	2,459	15%		N/A	1,200	
	Liberia	487,838	0.40%	1,936	N/A	214	11%		N/A	<500	
	Mali	1,953,175	0.29%	5,468	2,606	2,498	46%		N/A	1,400	
	Senegal	1,578,036	0.08%	1,300	N/A	527	40%		N/A	<200	
	Sierra Leone	652,583	1.00%	6,517	N/A	916	14%	17%	N/A	<1,000	
Men 25+ years	Burkina Faso	3,617,916	0.87%	24,551	19,240	15,901	65%		N/A		
	Togo	1,612,008	0.19%	30,119	22,091	16,886	53%		N/A		

	Benin	2,298,239	0.96%	22,053			93%				
	Ghana	6,844,808	1.28%	87,653	N/A	34,441	39%		N/A		
	Liberia	942,357	1.25%	11,769	N/A	2,600	22%		N/A		
	Mali	3,028,419	0.84%	23,502	15,347	14,495	62%		N/A		
	Senegal	2,876,180	0.39%	11,166	N/A	6,207	56%		N/A		
	Sierra Leone	1,670,041	1.07%	17,815	N/A	5,454	31%	17%	N/A		
Women 15-24 years	Burkina Faso	2,083,1634	0.44%	9,071	8632	8,616	95%		N/A	<500	
	Togo	817,124	1.00%	8,143	5,374	5,347	66%		N/A	<1,000	
	Benin	1,203,432	0.38%	4,684	2,799	2,616	93%				
	Ghana	2,513,233	1.81%	45,529	N/A	12,359	27%		N/A	4,300	
	Liberia	471,648	0.75%	3,533	N/A	827	23%		N/A	<500	
	Mali	1,898,399	0.42%	7,766	4,336	4,336	100%		N/A		
	Senegal	1,564,167	0.15%	2,328	N/A	984	42%		N/A	<500	
	Sierra Leone	670,483	1.85%	12,388	N/A	4,322	35%	17%	N/A	1,200	
Women 25+ years	Burkina Faso	3,858,457	1.02%	39,455	38,273	38,202	97%		N/A		
	Togo	1,664,046	3.47%	57,691	50,434	49,222	85%		N/A		
	Benin	2,406,142	1.81	43,586	34,142	32,477	95%				
	Ghana	7,167,078	2.18%	156,099	N/A	98,239	63%		N/A		
	Liberia	962,968	1.91%	18,368	N/A	8,465	46%		N/A		
	Mali	3,181,475	1.64%	44,186	N/A	33,571	76%		N/A		
	Senegal	3,254,591	0.70%	22,776	N/A	15,883	70%		N/A		
	Sierra Leone	1,715,722	1.42%	24,284	N/A	13,863	57%	17%	N/A		
MSM	Burkina Faso	16,600	5%	869	N/A				N/A		
	Togo	6,356	28%	1,761	N/A	24,834	14%		N/A		
	Benin	5,800	7%						1,394	106	
	Ghana	54,800	18%	9,864	N/A	365	4%		N/A		
	Liberia	74,600	20%	14,771	N/A				N/A		
	Mali	26,690	14%	3,657	N/A				N/A		
	Senegal	4,228	27%	2,531	N/A				N/A		
	Sierra Leone	20,000	14%	2,800	N/A			17%	N/A		
FSW	Burkina Faso	13,500	6%	810	N/A				N/A		
	Togo	8,000	14%	1,080	N/A	256	24%		N/A		
	Benin	28,800	8.5%						18,954	271	
	Ghana	51,900	7%	2,581	N/A				N/A		
	Liberia	163,100	10%	15,984	N/A				N/A		
	Mali	74,040	9%	6,441	N/A				N/A		

	Senegal	9,348	7%	484	N/A	95	20%		N/A		
	Sierra Leone	240,000	8.5%	16,080	N/A			17%	N/A		

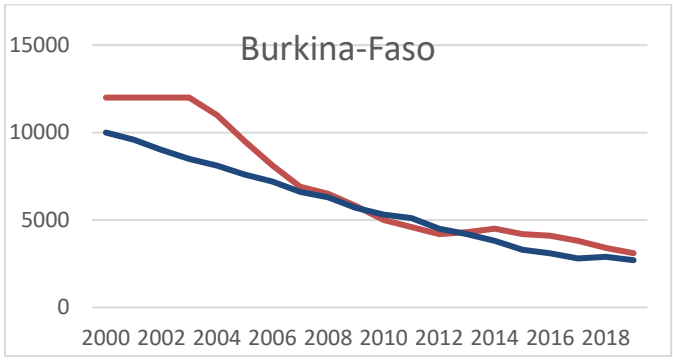
*These should be national data; if the data do not exist, PEPFAR data may be used if relevant. Estimates for testing, treatment, retention, and suppression for key and priority population groups (below grey line) should only be included if reliable data exists.
(Spectrum 2020, AIDS INFO, UNAIDS Key Populations Atlas)

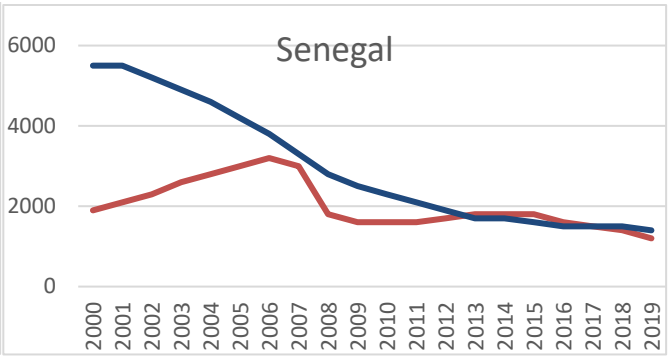
Figure 2.1.3 Updated National and PEPFAR Trend for Individuals currently on Treatment *

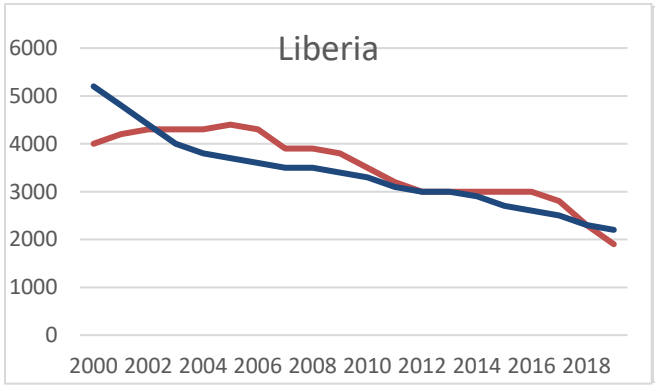


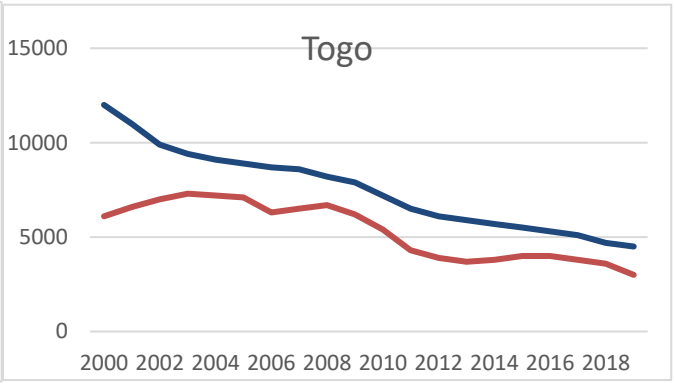
*These graphs show UNAIDS data, as PEPFAR data is unavailable.

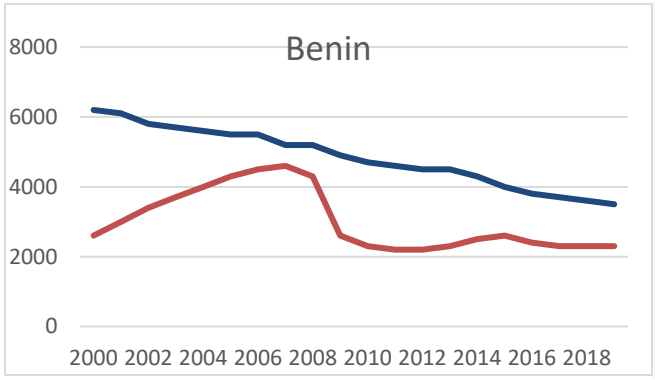
Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV

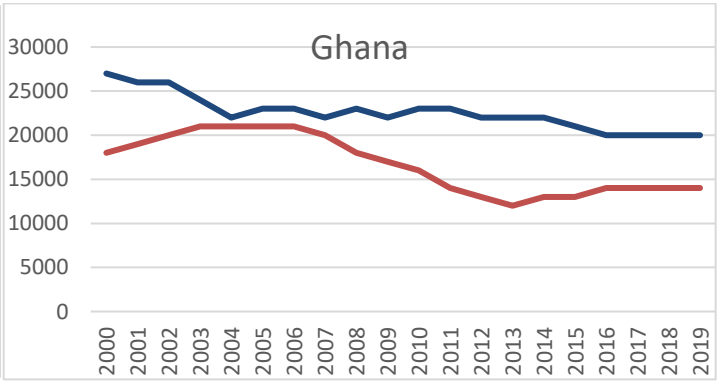


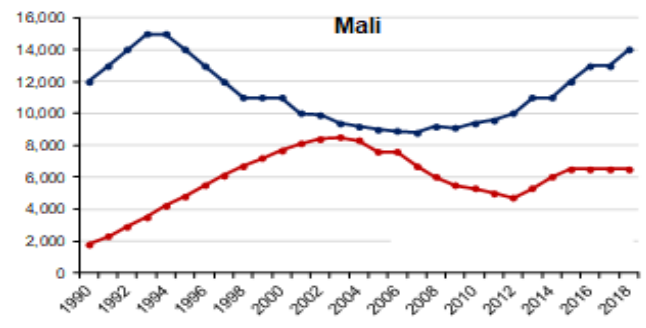


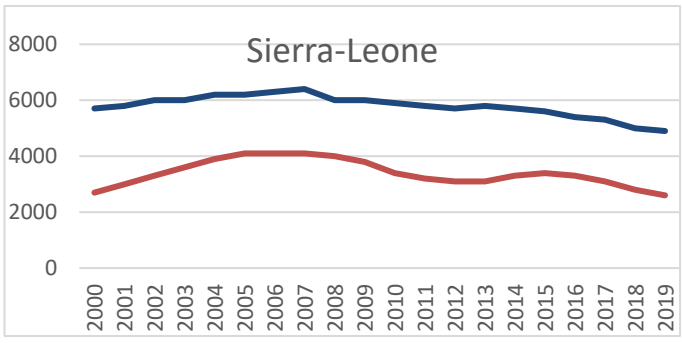












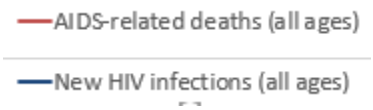

AIDS-related deaths (all ages)
New HIV infections (all ages)

Figure 2.1.5 Progress retaining individuals in life long ART in FY19

As FY20 is the first year of new PEPFAR programming, PEPFAR/West Africa does not have data available.

Figure 2.1.6 Proportion of clients lost from ART 2018 Q4 to 2019 Q4

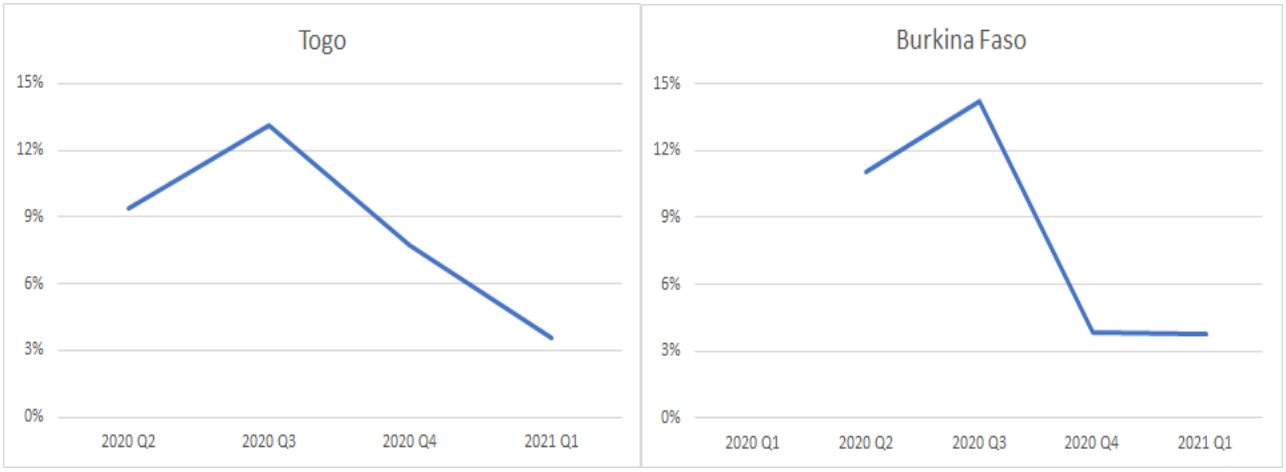
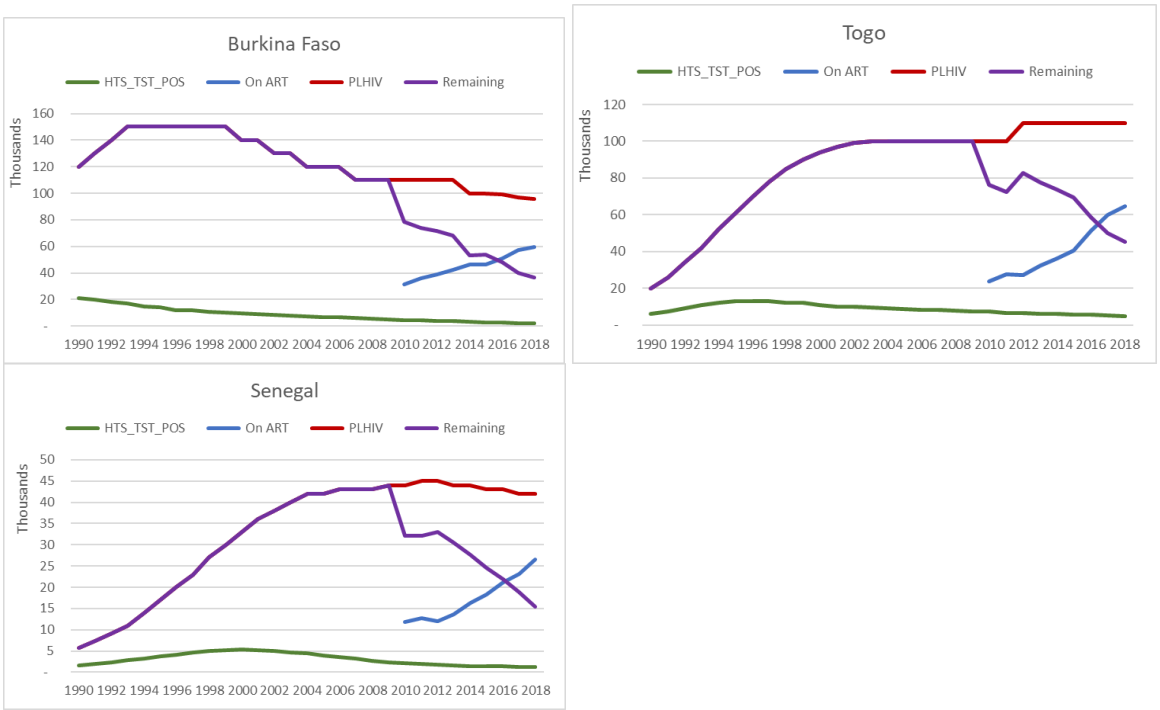
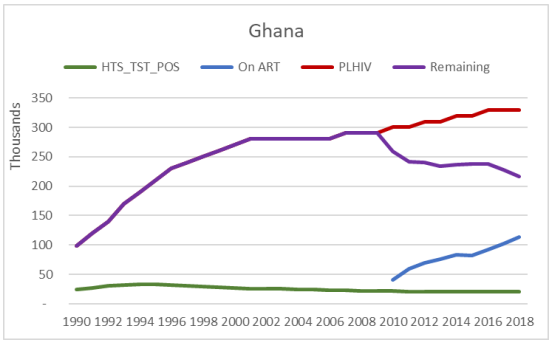


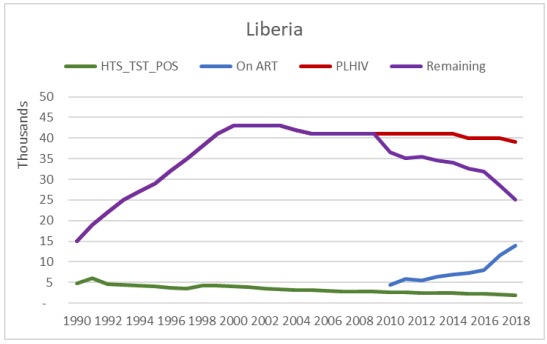
Figure 2.1.7 Epidemiologic Trends and Program Response for your Country (Figure 2.1.1.3 in COP20 Guidance)

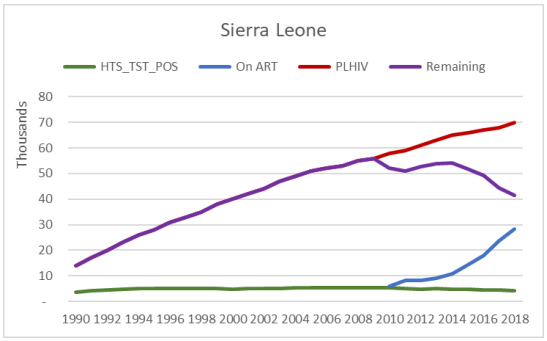
Fewer positives to find than are currently on treatment



Slow progress and a long way to go







Behind with a growing epidemic

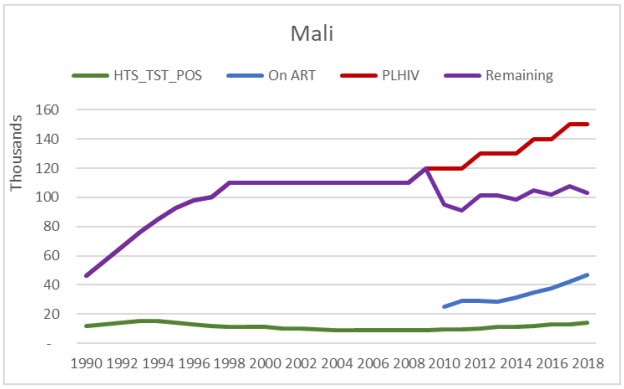


Figure 2.1.8 Net change in HIV treatment by sex and age bands 2019 Q4 to 2020 Q4

Given, geographical shifts across the health regions of some countries in the West Africa PEPFAR program, the net change across quarters in the HIV treatment cohort is not representative, hence not presented.

2.2 New Activities and Areas of Focus for ROP21, Including Focus on Client Retention

PEPFAR/West Africa will implement client-centered, client-friendly approaches across the clinical cascade to improve client linkage and retention in ROP21. Programs will continue to develop and expand improved service delivery, including evidence-based interventions such as expanded days and hours of service (extended hours/Saturday clinics), male-friendly clinics (men's corners,

alternative locations for service delivery where men usually congregate), and family-centered care and treatment approaches.

All eight countries will implement community-led monitoring as part of Continuous Quality Improvement (CQI). Led and implemented by CSOs, community-led monitoring will include: (i) monitoring of policy implementation (Index Testing, Test and Start, MMD, TLD transition, elimination of informal user fees); (ii) Mystery Client surveys; (iii) routine data collection regarding quality of HIV services; (iv) collection and monitoring of discrimination/stigmatization; (v) advocacy for removal of barriers to access to care and treatment services; (vi) monitoring of corrective actions implementation; and (vii) monitoring of government financial commitments.

With PEPFAR and other donor support in FY20 (ROP19) and FY21 (ROP20), **Burkina Faso and Togo** will both achieve 78% ART coverage by September 2021 based on projected Spectrum 2020 data. In ROP21, PEPFAR will maintain these gains and strengthen progress by adding one additional high burden region in each country (Boucle du Mouhoun in Burkina Faso and Centrale region in Togo). Emphasis will be made on: (i) providing client-centered approaches to close disparities among children, adolescents and youth, men (20-34), MSM and FSW, (ii) ensuring continuity of treatment in all ages, sex, and population type, (iii) ensuring VL suppression with U=U messaging and full transition to TLD and DTG-based regimens among adults and children, (iv) strengthening the lab system, and (v) strengthening supply chain management. PrEP service delivery, including demand creation, will also start for MSM and FSW who test HIV-negative.

In **Benin**, a newly added country to the West Africa Regional Platform, optimized HIV case finding will be implemented among MSM, FSW, their sexual partners, and the general population (safe and ethical index testing, social network testing, self-testing, community-led testing, targeted PITC, social media outreach) in four high burden regions (Atlantique, Littoral, Couffo, and Mono). HIV-positive clients will benefit from a strategy of enhanced enrollment on ART (accompanied referral, peer navigation, and case management). Same day ARV initiation and differentiated care and treatment services including MMD to stable patients will be implemented. An e-tracker will be developed and used to track clients who miss appointments and to allow for granular program data collection, analysis and use to identify issues rapidly and provide corrective actions across the clinical cascade. VL load testing demand and VL suppression will be improved through patient education including U=U messaging, ART optimization with transition to TLD and DTG-based regimens, coaching and supportive supervision to service providers and enhanced adherence services to patients who are non-virally suppressed.

CQI approaches, particularly the Plan-Do-Study-Act (PDSA) cycle and collaborative model, will be used to address gaps identified by routine performance reviews and community-led monitoring to increase continuity of treatment and quality of service. Each facility will apply the PDSA cycle, an iterative four-step problem-solving process to identify, test, and implement changes that can result in best practices. Systematic application of PDSA cycles will help to ensure that all service changes/activities related to providing men-friendly services, self-testing, MMD, and continuity of treatment are planned and tested, and that feedback is incorporated before scale-up. It will address systems issues affecting the performance of providers and service quality.

Violence, including physical, sexual, emotional, and economic violence, increases HIV risk, decreases HIV testing uptake and disclosure, and decreases enrollment and adherence to ART. For the prevention of gender-based violence (GBV), PEPFAR will support **Burkina Faso**, **Togo, and**

Benin to offer information on rights and will develop a network of KP-friendly violence-response service providers to make services more responsive. Talking to KP members explicitly about the impact of violence on HIV vulnerability also encourages testing among those who may not recognize that they are at risk. **Burkina Faso, Togo, and Benin** will also work diplomatically to educate and mediate with the police (common perpetrators of violence against KPs) in order to improve the environment for KP to congregate and to access condoms and lubricant without fear of arrest. The PEPFAR program will work closely with the human rights observatories in each country to document and address GBV. For GBV response care and treatment, **Burkina Faso**, **Togo, and Benin** will provide violence response services in the context of KP HIV programming to make services more responsive.

In ROP21, PEPFAR/**Ghana** will work towards achieving 95-95-95 targets in the Western region and expanding its current portfolio to the Western North and Ahafo regions. Activities will build on lessons learned from ongoing interventions to provide client-centered quality services across the HIV continuum of care. PEPFAR/**Ghana** will prioritize case finding, continuity of care and optimization of ARV among children, adolescents, youth, and men. Activities will strengthen the implementation of safe and ethical index testing across clinics and communities according to WHO and PEPFAR standards. PEPFAR/**Ghana** will build on sustained achievement of its ROP20 targets to continue to identify and link PLHIV to ART through active referral and linkage, use of linkage registers and operationalization of Ghana's policies for task shifting and DSD. Activities will also focus on active and timely follow-up to minimize treatment interruption. Emphasis will be placed on U=U messaging in the community and at the site level, as well as in training of media personnel to help promote awareness of the benefits of adhering to treatment and being virally suppressed. KP-accessible HIV prevention activities including PrEP will be closely linked to HTS and ART. PEPFAR/**Ghana** will continue to build the capacity of data officers to ensure quality data collection and reporting, which will enable effective and timely monitoring of treatment growth indicators. PEPFAR/**Ghana** will support the continued scale-up of PrEP and HIVST, as well as community-led monitoring activities to ensure adherence to PEPFAR Minimum Program Requirements (MPRs). PEPFAR/**Ghana** will continue to provide targeted above-site TA to strengthen supply chain security and to optimize pediatric ART regimens, MMD, and decentralized drug distributions models. Based on feedback from stakeholders, this area needs continued support to develop a national forum from a broad range of stakeholders to monitor commodity security and advocate for greater financial commitment by the Government of Ghana.

In ROP21, PEPFAR/**Liberia** will scale up 6MMD, support TLD transition to ensure full transition for all eligible clients on ART at PEPFAR-supported sites, support PrEP policy and SOP roll-out, provider training and demand creation, and initiate service delivery to enroll eligible clients on PrEP services. PEPFAR will also support strengthening VL systems and interventions by improving coverage and suppression, and support stigma and discrimination reduction interventions.

PEPFAR/**Liberia** will also maintain ROP20 strategies and cutting-edge innovations in four health facilities in Margibi and Grand Bassa counties, nine community and 13 health facility sites in Montserrado County. PEPFAR will also expand to one additional county (Nimba) and four new health facility sites. This will bring the total number to nine community and 21 health facility sites in ROP21. ROP20 shifts which will continue to be supported in ROP21, including VL specimen transfer for all PEPFAR-supported facilities, with tracking of VL test results for all patients at facilities and community-led monitoring activities. In addition, PEPFAR will support provision of PrEP services in up to six out of 21 health facility sites. In ROP21, as a continuation from ROP20,

PEPFAR/**Liberia** will provide continuity of treatment support and tracking of interruption of treatment for all patients at its 21 supported facilities, with links to CSOs for community-based follow up. Meanwhile, PEPFAR will transition out of Maryland County and shift the investment to Nimba County, and funds have been allocated in ROP21 to support activities around sustainability and close out in Q1 of FY22, after which PEPFAR support in Maryland County will end. The PEPFAR Inter-agency Team also concluded that there should not be targets for Maryland County for a single quarter of DSD in FY22.

PEPFAR/**Liberia** through HRSA will oversee implementation of a significant component of the PEPFAR above-site activities during ROP21, including the following:

1. Address remaining gaps with MPRs, including unique identifier integration into MOH's DHIS2 system; accelerate TLD transition by assisting NACP with supply chain aspects of accelerated transition to also include new pediatric formulation (DTG10);
2. Accelerate MMD uptake, including in partnership with the HIV Coverage, Quality and Impact Network which is also supporting differentiated service delivery in Liberia through the Gates Foundation, by assisting NACP with supply chains aspects of 6MMD
3. Improve VL testing coverage by rationalizing existing capacity; enhancing program management to assure VL optimization at the site level, monitoring sample transport and results reporting, and strengthening laboratory systems;
4. Support rollout of endorsed PrEP policies;
5. Support existing M&E systems for optimized national supply chain data collection, review and use.

In ROP21, PEPFAR/**Mali** will maintain existing KP activities in the 23 health districts with high-burden urban sites in the current regions of Bamako, Sikasso, and Segou. The national PLHIV network will be contracted to increase client-centered approaches at health facilities and in the community. In addition, USAID will support strengthening the capacity of key stakeholders, including training of the GFATM Principal Recipients on high-impact strategies. PEPFAR will also fund supportive supervision and data quality with the NACP - specifically on quality and timely data collection. The national PLHIV network will be contracted to increase client-centered approaches at health facilities and in the community. PEPFAR will support satellite sites for aggressive, highly targeted case-finding, linkage and retention to care. To accelerate case-finding, PEPFAR/Mali will expand successful strategies implemented in ROP19, including the Enhanced Peer Outreach Approach (EPOA) and peer navigator outreach, while continuing to hone strategies to ensure that they are client-centered for key and priority populations, such as targeted community-based services for DSD and adapting clinic services to be more user friendly. PEPFAR will strengthen continuity of treatment by supporting task shifting to nurses, expanding and strengthening patient tracking both at the site and community level, and accelerating the implementation of the e-Tracker and the UIC. To advance progress of the third 95, PEPFAR will support the optimization of the national lab network and ensure proper sample transportation, while enhancing demand creation activities at the site and community level. PEPFAR/Mali will also procure PrEP commodities in ROP21 to address the rising rate of new infections. Mali is facing rising instability and conflict, resulting in over 200,000 IDPs, many of whom gravitate towards major urban areas in Bamako, Segou, and Sikasso. To ensure that PLHIV among IDPs can continually access HIV services, in ROP21 PEPFAR/Mali will implement activities to support and retain IDPs PLHIV on treatment. PEPFAR/**Mali** will leverage the knowledge and expertise of existing U.S. Government (USG) and international humanitarian actors in Mali (Office of U.S. Foreign Disaster

Assistance, Food For Peace, United Nations Office for the Coordination for Humanitarian Affairs, World Food Program) to strategically design and implement interventions aimed at finding known and unknown positives among IDPs in PEPFAR regions and ensuring they access quality clinical services by targeting PEPFAR sites with "surge" support for direct service delivery. Programming targeting IDPs will also ensure an adequate patient referral and tracking system to ensure retention on treatment in a fluid and unpredictable population movement context.

In ROP21, PEPFAR/**Senegal** will expand to nine additional sites and scale up client-centered approaches that are being used in the four existing sites. PEPFAR/Senegal will also further optimize case-finding to focus on finding men and asymptomatic clients. To ensure continuity of treatment, PEPFAR will expand peer navigator and case manager networks, and ensure that flexible services are available to link and retain men and KP on treatment (modified hours, KP-friendly services, etc.). Critical VL testing commodities, including VL testing reagents and cartridges, will be procured for PEPFAR sites, and will be accompanied by the creation of SOPs to optimize VL commodity distribution, and interventions to ensure timely communication of results to patients and to increase demand for VL testing. Interventions will be undertaken to optimize the national lab and sample transportation network to drive achievement towards the third 95.

The PEPFAR program in **Sierra Leone** will retain its KP and priority population strategy, with plans to saturate districts with highest unmet need and proximity to KP. IBBS results due in the summer of 2021 will sharpen the focus of interventions. PrEP enrollment will be significantly expanded and self-testing will be introduced. CDC will join the response with support for lab and SI. Development of KP data will be prioritized. Continuity in care has been high, and this will be maintained at existing sites and monitored closely at new sites. Newly released national data points to the need to reach men, and the PEPFAR/**Sierra Leone** will consult with others across the West Africa Region platform to develop a set of strategies for increasing coverage for men. PEPFAR/**Sierra Leone** also plans to initiate a process to identify and strengthen potential local partners for future transition, building upon successful expertise from PEPFAR Track 1.0 transition. PEPFAR will maintain and strengthen collaboration with Global Fund.

In ROP21, all countries will continue implementing adaptive measures to protect clients and service providers and mitigate impact of COVID-19 on their HIV programs. In order to ensure continuity of PEPFAR services in the context of COVID-19 restrictions and disruptions, all the countries in PEPFAR West Africa instituted program adaptations in ROP20 which will continue into ROP21. These include increased community testing, virtual meeting platforms, Decentralized Drug Distribution, and MMD. In-person trainings have occurred in **Liberia** but are limited to critical topics with fewer participants. **Ghana** is also placing more pressure for domestic resources, due to concerns about supply chain security. **Mali** is reinforcing the use of self-testing to maintain HIV testing access. COVID-19 has impacted the scheduling of mobile clinic outings and mediator activities in hotspots. **Senegal** has been responding to the impact of COVID-19 on services by providing PPE and adapting work schedules around the 9PM curfew. **Sierra Leone** has not experienced significant impact on service delivery, nor any immediate consequences on domestic resource mobilization. The program is, in fact, going through advances in DSD and MMD due to the COVID-19 restrictions. Most sites are adhering to safety guidelines.

PEPFAR/West Africa countries will use supplemental American Rescue Plan Act (ARPA) funds to accelerate some of the adaptations referenced above to prevent, prepare for, and respond to coronavirus in the context of PEPFAR programs, and to mitigate COVID-19 impact on PEPFAR

programs and beneficiaries and support PEPFAR program recovery from the impacts of coronavirus. ARPA funds in all West Africa Region countries will fund the provision PPE and/or hygiene supplies, as well as IPC training, education, and management. **Benin, Burkina Faso,** and **Togo** will additionally support ARV buffer stock to accelerate MMD, logistics for the supply chain, and return to care campaigns. Togo and Benin will also use ARPA funds to procure VL reagents and develop a VL optimization plan. **Ghana** will invest ARPA funds for HIV testing commodities, lab strengthening, and surge teams to expand HIVST, gap filling on ICT, rapid ART initiation and re-engagement of ART patients. In **Liberia**, ARPA funds will go toward supporting appropriate triage and screening, as well as lab commodities for case management. The ARPA-funded activities in **Mali** runs from multi-faceted staff support (including training and vaccination access), to transportation for PLHIV to COVID-19 care centers to tracking of COVID-19 and GBV. **Senegal** will use ARPA funds for vaccine advocacy and communication, return to care campaigns, lab reagents and supplies, and HR support. In **Sierra Leone,** supported activities cover health care worker vaccinations, VL optimization, and teleconference support.

2.3 Investment Profile

Table 2.3.1 Annual Investment Profile by Program Area[2]

Program Area	Country	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	Burkina Faso*	12,015,220	0%	57%	43%	0%
	Togo	$12,487,797	19%	59%	1%	7%
	Benin	$8,766,257	0%	60%	40%	0%
	Ghana	$38,924,743	14.94	78.82	6.24	
	Liberia	$3,887,099	20.5%	79.5	0	0
	Mali	$19,991,962		75%	25%	
	Senegal	$3,895,597	16%	41%	42%	
	Sierra Leone	$7,147,600	0%	92.5%	7.5%	0%
Community-based care, treatment, and support	Burkina Faso*	$3,398,506	7%	23%	39%	31%
	Togo	$25,499	0%	7%	88%	5%
	Benin	NA				
	Ghana	$2,951,713	22.95	52.60	24.45	
	Liberia	$428,000	100%	0	0	0
	Mali	$1,433,080	86%	14%		
	Senegal	$3,895,596	16%	41%	42%	
	Sierra Leone	$291,200	0%	100%		

[2] (GRP, National AIDS Spending Assessment , 2012), all amounts in 2012 USD

PMTCT	Burkina Faso*	2,788,090	0%	46%	52%	2%
	Togo	$1,188,622	2%	78%	11%	9%
	Benin	$1,734,086	0%	60%	40%	0%
	Ghana					
	Liberia	$225,158	0	95%	0	5%
	Mali	$2,032,263		27%	24%	49%
	Senegal	$348,008		100%		
	Sierra Leone	$784,000				
HTS	Burkina Faso*	2,652,445	14%	43%	28%	14%
	Togo	$727,928	4%	58%	6%	32%
	Benin	N/A				
	Ghana					
	Liberia	$970,531	36.3%	63.7%		
	Mali	$5,470,943	18%	82%		
	Senegal	$1,383,762	67%	32%		
	Sierra Leone	$4,210,000	13.3%	86.7%		
VMMC	Burkina Faso*	Not applicable to West Africa Regional				
	Togo					
	Benin					
	Ghana					
	Liberia					
	Mali					
	Senegal					
	Sierra Leone					
Priority population prevention	Burkina Faso*	2,103,044		10%	63%	28%
	Togo	$1,398,694	1%	7%	19%	73%
	Benin	N/A				
	Ghana					
	Liberia					
	Mali	$330,598		100%		
	Senegal					
	Sierra Leone	$201,200				
	Burkina Faso*					
	Togo	$11,031	4%	0%	96%	0%

AGYW Prevention	Benin	N/A				
	Ghana					
	Liberia	$236,105	100%			
	Mali					
	Senegal	$348,008		100%		
	Sierra Leone					
Key population prevention	Burkina Faso*	489,718	98%	2%		
	Togo	$535,206	7	78	15	0
	Benin	$433,522		100%		
	Ghana**	$4,364,451	37%	63%	0%***	0%***
	Liberia	$445,010	97%	3%		
	Mali	$1,356,182	59%	41%		
	Senegal	$629,996	44.76%	55.24%		
	Sierra Leone	$106,000				
OVC	Burkina Faso*	$368,676			100%	
	Togo	$134,563	0	0	64%	36%
	Benin	N/A				
	Ghana	$1,080,849		100%		
	Liberia					
	Mali					
	Senegal	$358,527		100		
	Sierra Leone					
Laboratory	Burkina Faso*	$4,424,047		50%	50%	4,424,047
	Togo					
	Benin	$783,466	0%	40%	60%	
	Ghana	$623,020	100%	0%	0%***	0%***
	Liberia	$128,580	7.7%	92.3%		
	Mali	$3,845,187	23%	77%		
	Senegal	$453,665		100%		
	Sierra Leone	$570,000		100%		
SI, Surveys and Surveillance	Burkina Faso*	$339,194	28%	7%	65%	0%
	Togo	$3,246,234	12%	37%	28%	24%

	Benin	N/A				
	Ghana	$3,882,258		100		
	Liberia	$582,143	55.6%	44.4%		
	Mali	$651,186	62%	38%		
	Senegal	$655,313		100%		
	Sierra Leone	$140,000		100%		
HSS	Burkina Faso*	$4,590,410	0%		8%	2%
	Togo	$1,435,329	55%	9%	14%	23%
	Benin	N/A				
	Ghana	$2,644,666	100			
	Liberia	$754,113	22%	78%		
	Mali	$968,887	48%	52%		
	Senegal	$4,997,514	42%	29%	28%	
	Sierra Leone	NA - separate GF cross-cutting grant		100%		

*Burkina Faso data is COP19 Table 2.3.1 table, updated data not available
**Ghana data is from COP19 Table 2.3.1 table, updated data not available
*** NASA, 2016; GoG expenditures mainly in HR

Country	GNI per Capita in USD[3]
Burkina Faso	$780
Togo	$690
Ghana	$2,220
Benin	$1,250
Liberia	$580

[3] GNI per capita, Atlas method (current US$) - https://data.worldbank.org/indicator/NY.GNP.PCAP.CD. Consulted on May 7, 2021.

Mali	$870
Senegal	$1,460
Sierra Leone	$500

The Gross National Income (GNI) per capita in the eight countries in PEPFAR/West Africa range from US$490 in Sierra Leone to $2,220 in Ghana. Only Ghana ($2,130 GNI per Capita), Senegal ($1,460 GNI per Capita), and Benin ($1,250 GNI per Capita) are classified in the lower-middle-income category. The other countries are classified by the World Bank as low-income countries (Mali: $870; Burkina Faso: $780; Togo: $690; Liberia: $580; Sierra Leone: $540). The HIV response in West Africa is largely funded through external development partners (donors), households, and public revenue. Across West Africa, the GFATM is the largest external source of funding for the HIV/AIDS response. For ROP21, PEPFAR core funding will increase by 42% for the West Africa Regional Platform.

Among the eight countries, **Burkina Faso** is the only country that funds a significant portion of its HIV/AIDS response through domestic funding, estimated at 41%. The GFATM contributed 28% of the total expenditure in 2018 ($9,450,802) in Burkina Faso. The contribution of the PEPFAR program represented 4% of the total expenditure. The majority of the domestic resources were used to purchase antiretrovirals (ARVs) and pay staff salaries. 48% of the expenditures related to antiretrovirals (ARVs) came from domestic resources. ROP21 will contribute to filling some of the remaining gaps to reach 95-95-95 goals. These national funding levels may drop given the prioritization of budget expenditures to the security sector in response to a precipitous decline in security.

In **Togo**, despite a 26% increase in domestic HIV/AIDS funding from 2016 to 2018, the country remains dependent on external resources, while providing 28% of the HIV response funding. According to the National AIDS Spending Assessment report in 2018, $18.7 million was spent on HIV services. The GFATM contributes 41% of funding, while PEPFAR funding represents 10% of the expenditures. In general, 54% of expenditures are related to care and treatment. Domestic resources are mainly used to finance ARVs and health system strengthening. 30% of ARVs are purchased with domestic resources. ROP21 resources will contribute towards filling commodity gaps.

In **Benin,** the total expenditure for the HIV response is $11,717,331. The country also depends largely on external funding, with the GFATM contributing up to 60% of the national response. Overall, 75% of expenditures are spent on clinical care, treatment and support. In regards to the procurement of key commodities, the GFATM contributes in a similar manner, with the host country supporting 40%.

Ghana has received a cumulative total of $342 million from PEPFAR and GFATM to address HIV/AIDS. The GoG allocated $1.50 billion for health in 2021, slightly higher than the allocation of $1.22 billion in 2020. Ghana's National Strategic Plan (NSP) 2021-2025[4], which is in its first year of

implementation, is estimated to cost $661,562,182, increasing from $113.0 million in 2021 to $145.3 million in 2025. HIV Treatment, Care and Support makes up the largest share of the estimated cost over the 5-year period, representing 55.4%. This is mainly driven by ART which is about 98% of the cost. Prevention of new infections (HIV Testing Service, Elimination of Mother-to-Child Transmission of HIV, Sexually Transmitted Infections, Blood Safety, Condom programming, and Pre-Exposure Prophylaxis and Post-Exposure Prophylaxis) will account for 17.9%. The direct cost of the prevention and treatment programs form 73.3% of the total resources to execute the NSP, while indirect cost constitutes 26.7%. Under NFM3, the GF committed $108 million for HIV covering the period 2021 through 2023. This is an increase of approximately $20 million over the NFM2 allocation.

In **Liberia**, the GFATM is the primary funder of the HIV response, including all related testing, ARV, and laboratory commodities. PEPFAR contributes the second largest investment towards the HIV response, followed by the Government of Liberia and UNAIDS. PEPFAR and GFATM investments are both focused on supporting key and vulnerable populations but include additional high-risk populations. PEPFAR, GFATM, UNAIDS, and NACP have routine meetings and interact and collaborate closely through the CCM. The Government of Liberia pledged to purchase sexually transmitted infection (STI) medications as part of their contribution and cost share for the HIV response. That pledge was partially met in 2019, but it was insufficient for the country's needs.

In **Mali,** the GFATM is the primary funder of HIV testing and treatment services. For services targeting KP, the GFATM supports the Kayes, Koulikoro, and Mopti regions while PEPFAR provides key and priority populations prevention, testing, treatment, and adherence support in Sikasso, Segou, and Bamako regions. ROP21 funding will be used to bolster services, purchase PrEP commodities to further minimize new infections, and provide free STI treatment as part of a comprehensive care and treatment package. PEPFAR also supports data quality improvement and TA to laboratories and VL testing. UNAIDS and WHO provide TA to reinforce implementation across the treatment cascade. UNICEF specifically supports pediatric services, including prevention of mother-to-child transmission. Unitaid supports some HIV self-testing research.

In **Senegal**, the GFATM is the primary funder of the HIV response, followed by PEPFAR, and then the Government of Senegal. PEPFAR and GFATM investments are both focused on supporting key and vulnerable populations, and PEPFAR coordinates closely with the GFATM to ensure that clients receive a full package of services. The Government of Senegal has advocated to use PEPFAR's target setting methods for GFATM KP programming. The GFATM also purchases the majority of the commodities for the response, including ARVs, VL reagents, and PrEP. In ROP21, PEPFAR will purchase VL testing reagents and point-of-care cartridges for PEPFAR sites to create VL 'centers of excellence' among PEPFAR sites, and is coordinating with the Government of Senegal, GFATM, and the Clinton Health Access Initiative (CHAI) to ensure the optimal allocation of these commodities.

In **Sierra Leone,** PEPFAR is the second largest contributor behind the GFATM, with the Government of Sierra Leone meeting its GFATM co-funding obligation. Given that a large portion of the GFATM NFM3 is for commodities, PEPFAR covers more direct service delivery. PEPFAR and GFATM investments are both focused on supporting key and vulnerable populations, though PEPFAR support is far more targeted. PEPFAR coordinates closely with the GFATM to ensure complementarity of programming. The GFATM also purchases all HIV commodities, including rapid test kits (RTKs), ARVs, PrEP, and VL testing commodities.

Standard Table 2.3.2

Table 2.3.2 Annual Procurement Profile for Key Commodities						
Commodity Category	**Country**	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	Burkina Faso*	$12,009,837	1%	50.82%	48.70%	0.48%
	Togo	$4,680,183.50	23%	70%	7%	
	Benin	$5,290,707	0%	60%	40%	
	Ghana	$15,510,117	0%	100%	0%	0%
	Liberia*	$1,454,362.62	0%	98%		
	Mali	$1,911,153	0%	80%	20%	0%
	Senegal					
	Sierra Leone			99%	1%	
Rapid test kits	Burkina Faso*	$1,946,003	10%	35%	55%	
	Togo	$779,367.51	59%	53%	47%	
	Benin	$2,167,608	0%	60%	40%	
	Ghana	$3,319,445	0%	89%	11%	0%
	Liberia*	$293,936.65	0%	100%		
	Mali	$1,527,331	14%	72.14%	13.86%	
	Senegal	$55,244.0		100%		
	Sierra Leone			99%		1%
Other drugs	Burkina Faso*	$3,399,287	0%	52%	48%	
	Togo					
	Benin	142,998	0%	60%	40%	
	Ghana					
	Liberia*	$275,069.24	0%	30%	0%	0%
	Mali	$789,136.88	0%	100%		
	Senegal					
	Sierra Leone			100%		
Lab reagents	Burkina Faso*	$4,424,047	0%	40%	60.00%	
	Togo	$390,244.06	30%	5%	95%	
	Benin	1,614,215	0%	60%	40%	
	Ghana	$2,414,408	0%	100%	0%	0%
	Liberia*	$106,664.82	0%	100%		

	Mali	$1,790,395.20		100%		
	Senegal	$662,639.0			64%	36%
	Sierra Leone			100%		
Condoms	Burkina Faso*	$1,165,933	0%	20.00%		80.00%
	Togo	$911,108.61	0	100%		
	Benin	$1,584,876	0%	0%	0%	100%
	Ghana	$817,440	0%	0%	46%	54% (WAHO))
	Liberia*					
	Mali					
	Senegal					
	Sierra Leone			100%		
Viral Load commodities	Burkina Faso*	Included in lab reagents				
	Togo	$943,765.94	0	56	44	
	Benin	1,861,336	0%	60%	40%	
	Ghana					
	Liberia*	$346,176.00		100%		
	Mali	$3,641,278.26		48%	52%	
	Senegal	$1,154,193.0			53%	47%
	Sierra Leone			100%		
VMMC kits	Burkina Faso*	Not applicable to West Africa Regional				
	Togo					
	Benin					
	Ghana					
	Liberia*					
	Mali					
	Senegal					
	Sierra Leone					
MAT	Burkina Faso	Not applicable to West Africa Regional				
	Togo					
	Benin					
	Ghana					
	Liberia					
	Mali					
	Senegal					

	Sierra Leone					
Other commodities	Burkina Faso					
	Togo					
	Benin	$783,466	0%	40%	60%	
	Ghana	$21,935 (lubricants)	100%			
	Liberia					
	Mali	$5,397,271.28		80%	20%	
	Senegal					
	Sierra Leone			100%		
Total						

*Data is from FY2019, FY20 data was not available

Standard Table 2.3.3

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Country	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	Burkina Faso	$4,458,721	0	0	0	Improvement of mother and child health
	Togo	0	0	0	0	
	Benin	$4,000,000	$700,000	1		Reduce maternal, newborn, child, and adolescent mortality and morbidity
	Ghana	$13,000,000	$1,090,303	One (1)	$1,926,956	Reduce maternal and child mortality; Activities relate to GHSM-PSM
	Liberia	$10,000,000	0	0	N/A	Reduce maternal and child mortality
	Mali	$18,000,000	0	0	N/A	Prevent maternal and child deaths
	Senegal	$10,000,000	3,425,824	Two (2)	N/A	Prevent maternal and child deaths
	Sierra Leone	$2,000,000				

USAID TB	Burkina Faso	0	0	0	N/A	
	Togo	0	0	0	N/A	
	Benin	0	0	0	N/A	
	Ghana	0	0	0	N/A	
	Liberia	0	0	0	N/A	
	Mali	0	0	0	N/A	
	Senegal	0	0	0	N/A	
	Sierra Leone					
USAID Malaria	Burkina Faso	$27,000,000	0	0	N/A	Prevention and treatment of malaria
	Togo	0	0	0	N/A	
	Benin	$16,000,000	$1,065,000	1		Reduce malaria mortality and morbidity
	Ghana	$28,000,000	$11,086,928	One (1)	$1,926,956	Reduce malaria morbidity and mortality; Activities relate to GHSM-PSM
	Liberia	$13,500,000				Reduce mortality and morbidity from malaria.
	Mali	$25,000,000	0	0	N/A	Reduce malaria morbidity and mortality
	Senegal	$24,000,000	4,514,681 for 2019	Two (2)	N/A	Reduce malaria and mortality
	Sierra Leone	$15,000,000				
Family Planning	Burkina Faso	$7,133,954	0	One (1)		Healthy timing and spacing of pregnancies
	Togo	$1, 525, 000	0	One (1)	N/A	Support family planning (FP) activity to implement and catalyze pathways to scaling up FP High Impact Practices (HIPs)

	Benin	$4,000,000	$800,000	1		Increase access, availability of FP commodities and uptake of FP services.
	Ghana	$131,140	$1,258,955	One (1)	$654,656	Support family planning (FP); Activities relate to GHSM-PSM
	Liberia	$6,000,000		100		Increase access and availability to a full range of contraceptive methods.
	Mali	$13,000,000	0	0	N/A	Increase healthy timing and spacing of pregnancy
	Senegal	$15,000,000	3,645,265	0	N/A	Increase access and availability to a full range of contraceptive methods
	Sierra Leone	$2,000,000				
NIH	Burkina Faso	0	0	0	N/A	
	Togo	0	0	0	N/A	
	Benin	0	0	0	N/A	
	Ghana	0	0	0	N/A	
	Liberia	$15,000,000				U.S. Liberia Joint Clinical Research Partnership (PREVAIL) on infectious disease
	Mali	0	0	0	N/A	
	Senegal	0	0	0	N/A	
	Sierra Leone					
CDC (Global Health Security)	Burkina Faso	$5,000,000	0	0		Prevention, detection, and response to global public health threats

	Togo	0	0	0	N/A	
	Benin	0	0	0	N/A	
	Ghana	$5,000,000				Support prevention, detection, and response to disease outbreaks, including polio, yellow fever, and COVID-19; training of healthcare workers through Field Epidemiology Laboratory and Training Program (FELTP)
	Liberia	$4,150,000				Strengthen Liberia's capacities to prevent, detect, and respond to disease outbreaks and other public health emergencies and events
	Mali	$400,000	0	0	N/A	GHSA support staff towards SI and lab capacity (IBBS, VL)
	Senegal	0	0	0	N/A	
	Sierra Leone	$2,699,318		1	0	ICAP funded by HRSA and CDC
	Sierra Leone	$44,400,000 (for health				
Other (specify) [Nutrition]	Burkina Faso	3,566,977				
	Togo	0	0	0	N/A	
	Benin	0	0	0	N/A	
	Ghana	$5,500,000	$200,000	One (1)	$654,656	Improve Nutrition activities relate to GHSM-PSM
	Liberia					
	Mali					
	Senegal	5,500,000	2,163,322	One (1)	NA	Improve nutrition
	Sierra Leone					
Other (specify)	Burkina Faso	0	0	0	N/A	

	Togo	0	0	0	N/A	
	Benin	0	0	0	N/A	
	Ghana	$9,000,000 [WASH]	0	0	0	WASH activities
	Liberia					
	Mali	$615,000 0 0	0	0	N/A	$265,000 to support partner military in prevention, care and treatment, and retention activities and $350,000 to provide local logistical support in the planning and implementation of a Seroprevalence and Behavioral Epidemiology Risk Survey (SABERS) among partner military.
	Senegal					
	Sierra Leone					
Other (specify) [Health Systems strengthening, Neglected Tropical Diseases [NTDs]]	Burkina Faso	$5,884,000	0	0	0	Elimination of trachoma and other NTDs
	Togo	$1,400,000				Support disease-endemic countries to control and eliminate NTDs with proven, cost-effective public health interventions to treat and measure treatment impact against 7 NTDs: lymphatic filariasis, blinding trachoma, onchocerciasis, schistosomiasis, and three intestinal worms, known as soil-transmitted helminths
	Benin					
	Ghana					
	Liberia					
	Mali					
	Senegal					
	Sierra Leone					
Total						

2.4 National Sustainability Profile Update

Ghana was the only country to carry out a Sustainability Index Dashboard (SID) in 2019. While Ghana's policies, laws, and regulations enable a permissive environment for HIV services, there are still opportunities to improve linkage to ART services, increase continuity on treatment, and reduce stigma and discrimination. Ghana continues to face sustainability challenges, which threaten to slow gains in the HIV response. Several critical Sustainability Elements have either continued to worsen or fluctuated since first completing the SID in 2015, including data for decision-making, domestic resource mobilization, laboratory, service delivery and supply chain, and civil society engagement.

PEPFAR/**Ghana** will prioritize activities to address some of those gaps, such as supporting data quality to improve data-driven decision making and providing TA to optimize supply chain and VL testing systems. Other gaps, such as increased domestic resource mobilization, will be addressed through continuing advocacy in coordination with the GFATM and the Embassy Accra Front Office.

The GFATM has prioritized the procurement of HIV commodities including ARVs, VL reagents, and other essential commodities in the next funding request, so **Ghana** can provide ART to 90% of PLHIV by 2023. In addition, GFATM has increased allocation for CSO interventions to improve KP programming and expand community interventions to sustain HIV programs, expand the DHIS2 e-Tracker, reinforce and sustain the supply chain reform, and promote performance-based financing through decentralization of funds and robust financial management systems. PEPFAR has reduced its investments in KP programming since FY2020 and is strategically focusing on a combination of site level and above-site level support to reach epidemic control in Western, Western North and Ahafo regions, thereby setting a path that other regions can follow towards achieving epidemic control in Ghana.

While the West Africa Region has not been mandated to transition to indigenous partners in ROP21, PEPFAR/West Africa is committed to building the capacity of the many local partners that currently serve as sub-recipients of PEPFAR funding throughout the region. In addition, local partners will be directly contracted to carry out community-led monitoring (see Section 4). These sub-recipients will be selected based on demonstrated strong performance. The West Africa Region will continue to build management and technical capacity among them.

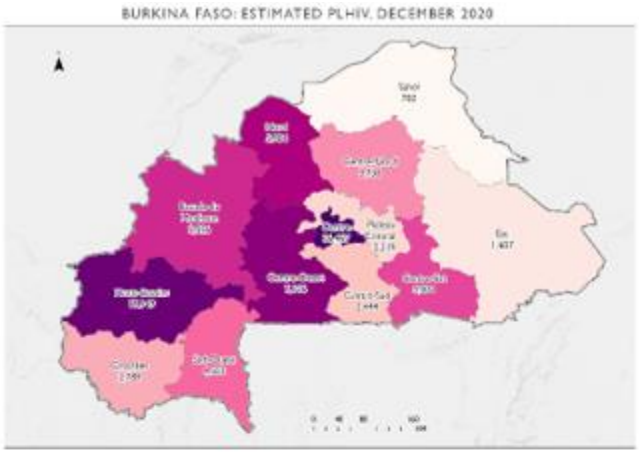
2.5 Alignment of PEPFAR investments geographically to disease burden

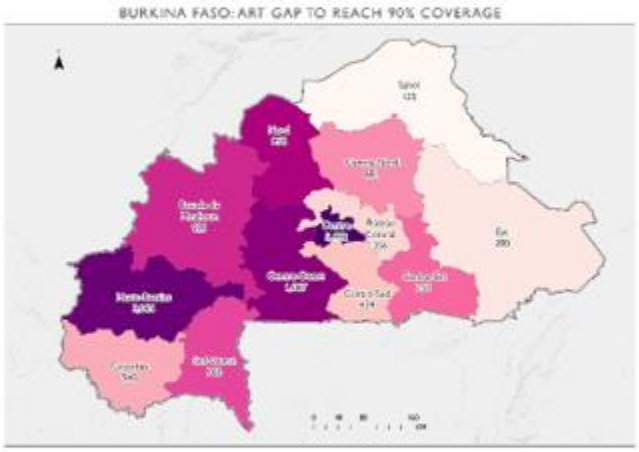
PEPFAR/West Africa has analyzed the available data to ensure that our investments are geographically oriented to the areas of highest disease burden.

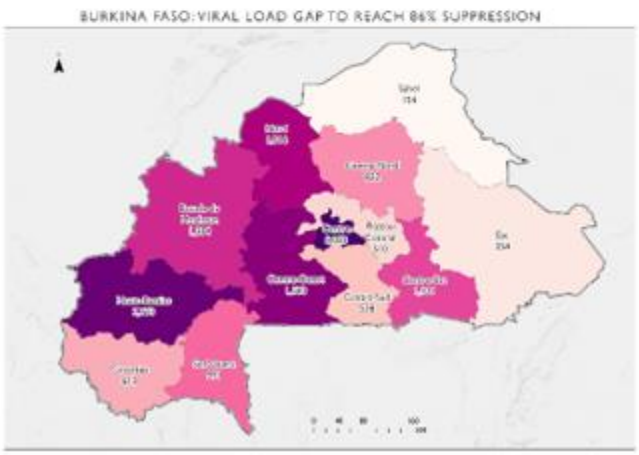
To ensure continuous alignment of PEPFAR investment to the HIV burden areas in **Burkina Faso,** an updated gaps analysis was done in collaboration with national stakeholders. According to Spectrum 2020 data, the four regions currently supported by PEPFAR in ROP20 (Centre, Centre-Ouest, Hauts Bassins and Centre-Nord) will reach 77% ART coverage in September 2021. To maintain high PEPFAR contribution to accelerate the national growth of people currently on treatment, Boucle du Mouhoun was selected in collaboration with the National AIDS Commission and the National AIDS Control Program, to be added to the PEPFAR-supported regions for ROP21. This region is the fifth with the highest ART coverage gaps, after the four regions currently supported by PEPFAR. Therefore, in ROP21, PEPFAR program will be implemented in five high burden regions (Centre, Centre-Ouest, Hauts Bassins, Centre-Nord, and Boucle du Mouhoun).

Those regions are also home to 89% of the MSM and 67% of the FSW (MSM and FSW size estimation and IBBSS 2017).

Figure 2.5.1A Burkina Faso: People Living with HIV by Region, Gaps in ART Coverage and Viral Suppression

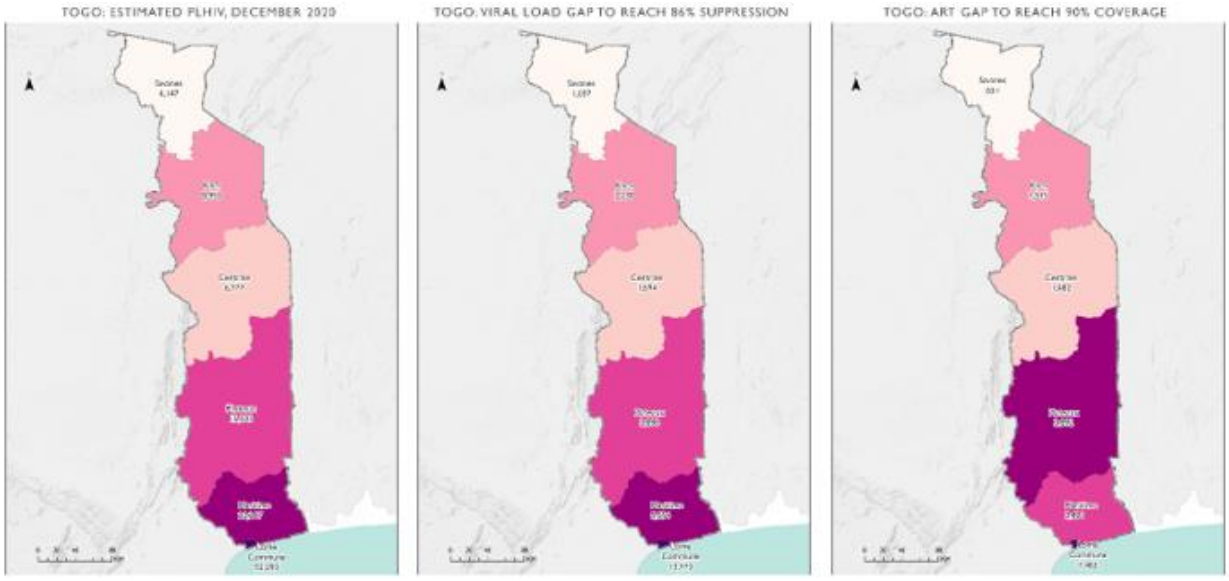






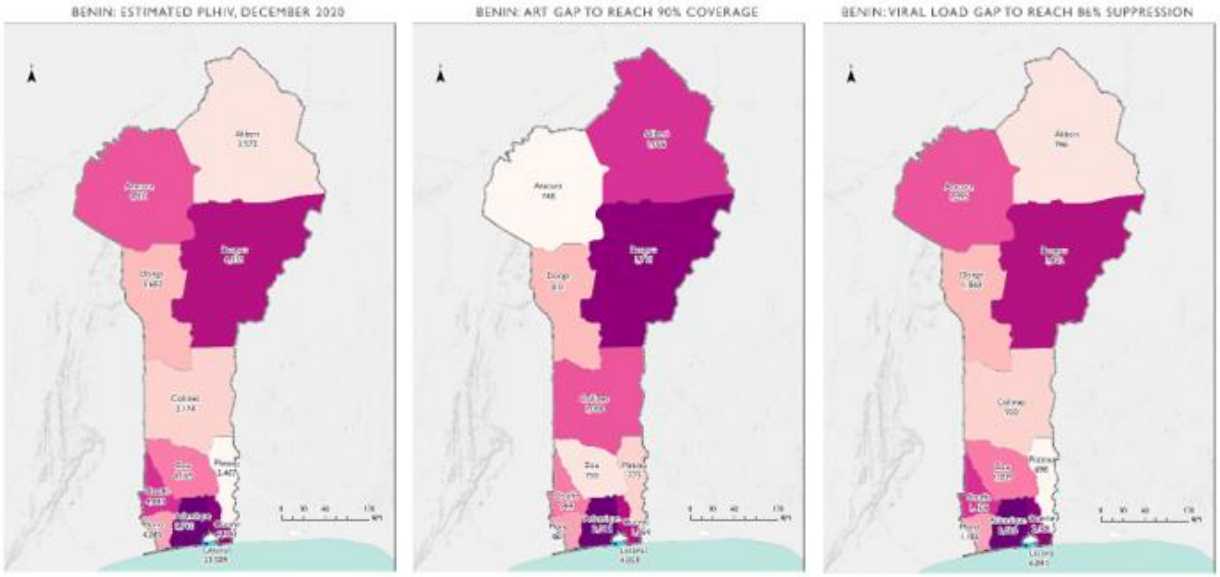
In **Togo,** as illustrated in the maps below, the HIV burden is concentrated in the Southern regions. In ROP20, PEPFAR focused its interventions on Lomé Commune, Maritime, and Plateaux regions which have the highest ART coverage gaps. According to Spectrum 2020 data, those three regions will achieve 78% ART coverage in September 2021. In ROP21, to continue to accelerate the national number of people currently on treatment, PEPFAR/**Togo** will expand its support to the fourth region with the highest ARV coverage gaps (Centrale region) to reach the second 95. The four selected regions for ROP21 (Lomé Commune, Maritime, Plateaux, and Centrale regions) cover 88% of the national ART gap and are home to 89% of the MSM, and 85% of the FSW (MSM and FSW size estimation 2017).

Figure 2.5.1B Togo: People Living with HIV by Region, Gaps in ART Coverage and Viral Suppression



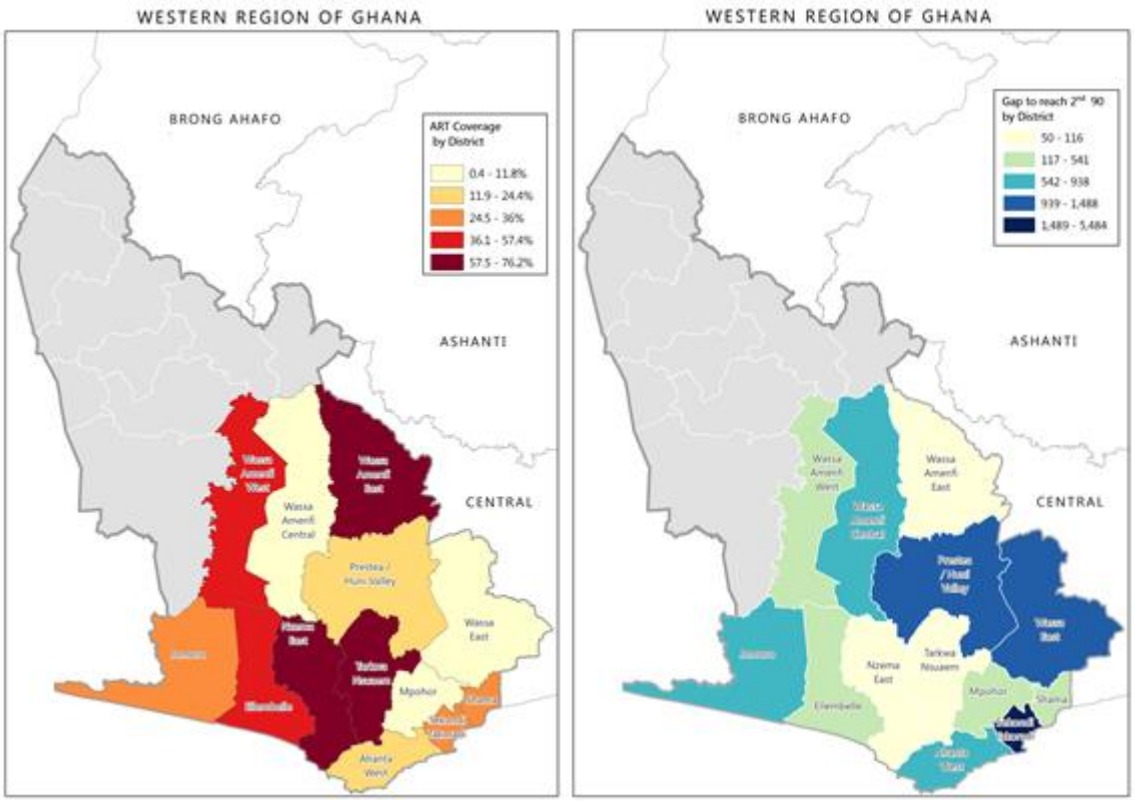
In **Benin**, in collaboration with the National Commission against AIDS, Malaria, Tuberculosis, Hepatitis and Epidemic, the Ministry of Health and other key stakeholders, PEPFAR analyzed the HIV burden and ART coverage gap using Spectrum 2020 data. Based on that analysis and the level of funding allocated to Benin for the first year of PEPFAR support, four high burden regions were selected as PEPFAR-supported regions in ROP21 (Atlantique, Littoral, Couffo, and Mono). Those four regions are home to 52% of the national ART coverage gap.

Figure 2.5.1C. Benin: People Living with HIV by Region, Gaps in ART Coverage and Viral Suppression



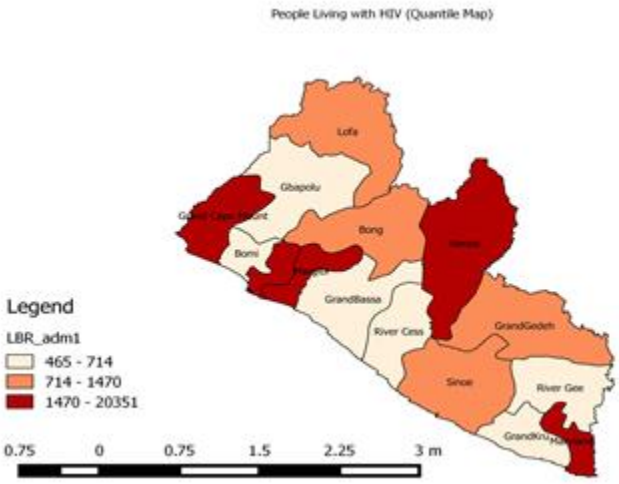
PEPFAR/**Ghana** will continue its support to the Western region to achieve 95-95-95 targets and will expand activities to the remaining eight districts in the Western North (WN) region and the entire Ahafo region (six districts). Per 2020 Spectrum estimates, both Western North and Ahafo regions have relatively higher prevalence (1.5% and 1.9%, respectively) and lower treatment coverage (65% and 58%, respectively) compared to the other 10 priority regions. In addition, the proportions of PLHIV who know their status are at 73% for Western North and 74% for Ahafo, which indicates a high unmet need for HIV case identification in these regions. This expansion is in full alignment with NFM3 and has received strong support during the stakeholder engagement consultations. PEPFAR/**Ghana** will continue to work closely with the GoG and the GFATM to scale up successful interventions in the remaining regions.

Figure 2.5.1C Ghana: People Living with HIV by Region, Gaps in ART Coverage and Viral Suppression



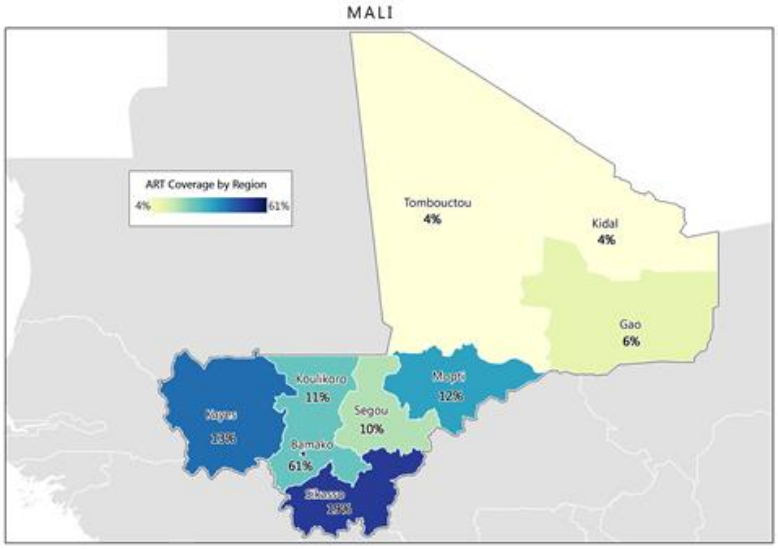
In ROP21, PEPFAR/**Liberia** will maintain support towards provision of quality HIV services in the counties of Montserrado, Margibi and Grand Bassa Counties, with a total of 17 health facility sites and nine community sites. PEPFAR will also expand to Nimba County, where it will provide support to four additional health facility sites. In total, PEPFAR will support 21 health facility sites and nine community sites across four counties in ROP21. Building on the gains under ROP20, this will ensure scale-up of evidence-based guidelines, policies, and strategies to the majority of clients while maintaining a relatively tight geographic focus in the county. At the community level, PEPFAR will target resources in nine community sites in Montserrado County and will use the facilities in Grand Bassa and Margibi as a springboard for index testing and retention strategies. GFATM will purchase all commodities, provide strategic TA for VL testing, and support additional facilities and communities in Margibi and Grand Bassa Counties. The 2017 KP size estimation confirmed that Montserrado County has the highest numbers of MSM and FSW and provides information on hot spots which continues to be refined by PEPFAR to inform strategies. Grand Bassa and Margibi have the third and fourth highest estimates with Nimba County second.

Figure 2.5.1D Liberia: People Living with HIV by Region, Gaps in ART Coverage and Viral Suppression



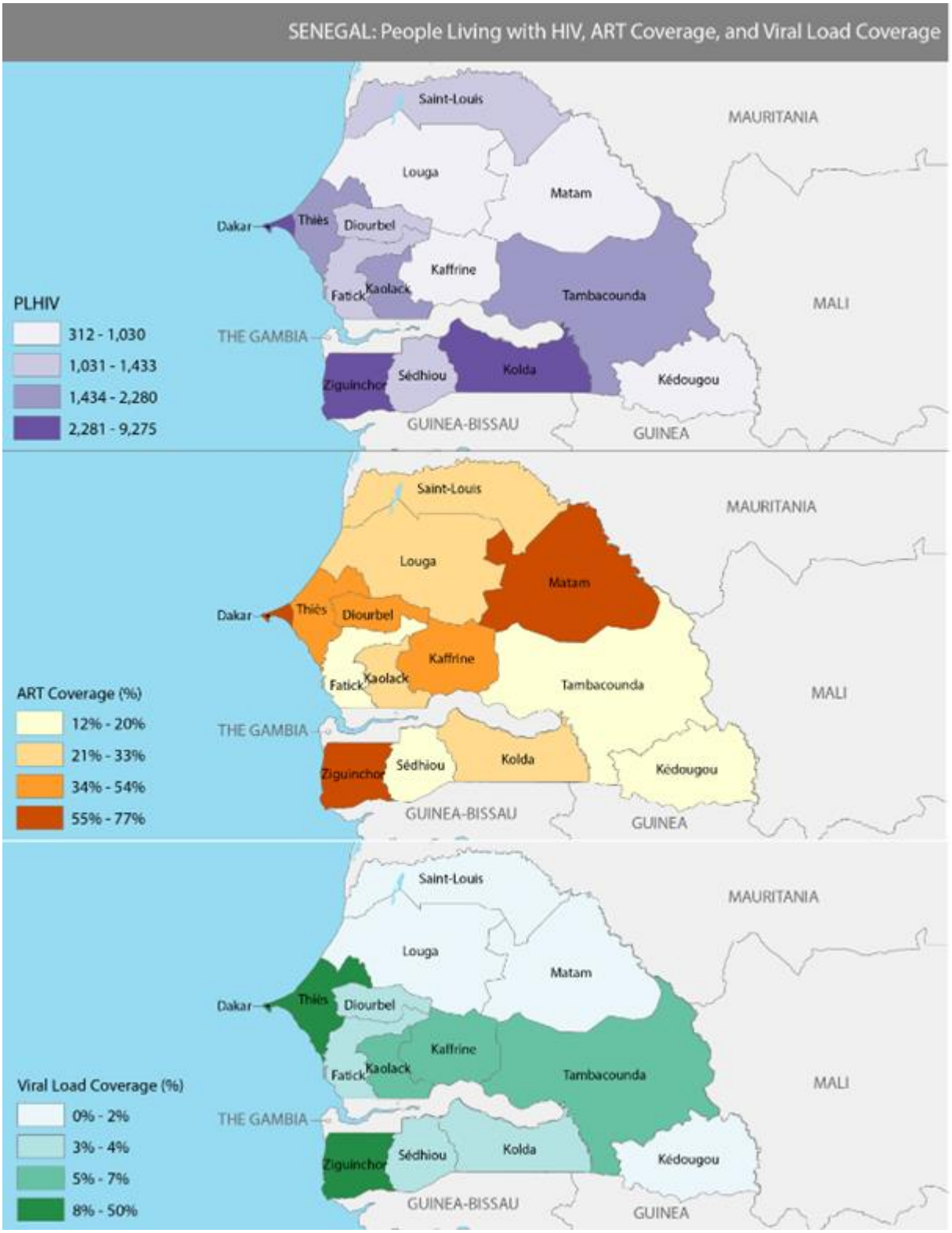
In **Mali**, to avoid duplication of efforts regarding KP services, PEPFAR and GFATM entered into a rationalization agreement in 2017 that specified that PEPFAR would cover KP services in three high-prevalence regions for KP (according to a 2015 mapping study): Bamako, Sikasso, and Segou. In the past, PEPFAR also covered KP services in a fourth region, Gao; however, because the yield results from Gao were so low, it was decided to concentrate resources on the three higher-yield regions in ROP20. In ROP21, PEPFAR will maintain its footprint in the three regions of Bamako, Sikasso and Segou, supporting the continuity of PLHIV on treatment.

Figure 2.5.1E Mali: People Living with HIV by Region, Gaps in ART Coverage and Viral Suppression



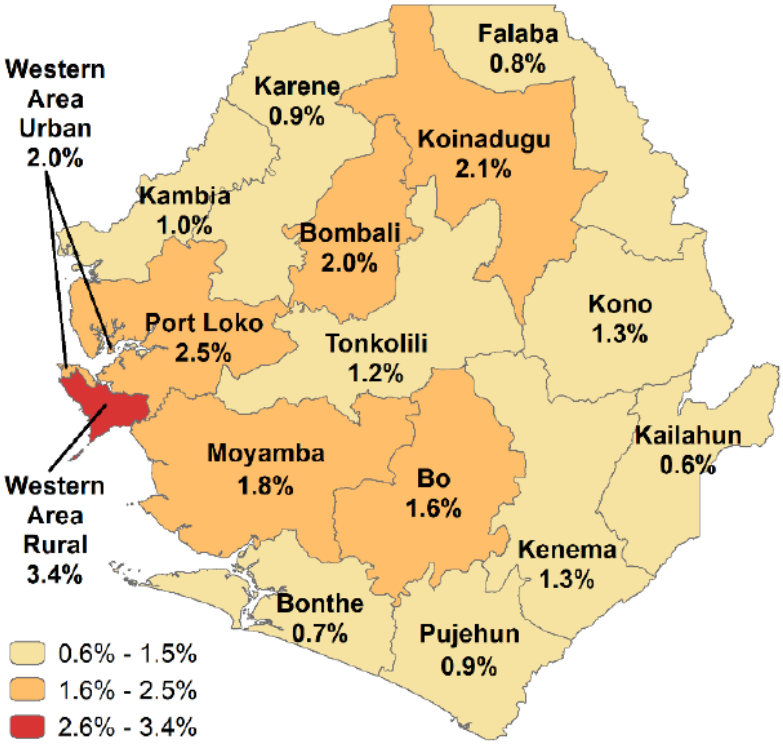
With the shift in ROP19 to a KP-focused program, the PEPFAR/**Senegal** program is focused in four regions with high incidence among KP. In ROP 19, PEPFAR will implement KP hot-spot sites in the high burden areas of Dakar (two sites), Mbour, and Ziguinchor, and is engaged in a KP-focused targeted testing strategy. Senegal's shift from a general population program in FY18 to a KP-focused program in FY19 resulted in an increase in yield to 8.2%, a considerable increase from the 1.9% yield demonstrated in FY18. The increased yield has had a dramatic impact on the total number of PLHIV identified; in ROP19 Q1, yield for the program was 17%, and more PLHIV were identified in Q1 of ROP19 than in all of FY19. Given these encouraging results, PEPFAR/Senegal is adding nine additional sites to the four existing sites. The PEPFAR/Senegal will be implemented in thirteen health districts in seven regions: Dakar (five sites), Ziguinchor (two sites), Thies (two sites), St Louis (one site), Kaolack (one site), Kolda (one site), and Sedhiou (one site). The expansion to additional sites in the North (St Louis) and the South (Ziguinchor, Kolda, Sedhiou) is due to the changing dynamic of the epidemic (KP mobility) and transborder activities. PEPFAR/Senegal provides TA to the National AIDS Council (NAC) and MoH to implement cross-border activities with Gambia, Guinea Bissau, and Guinea Conakry in order to reduce cross-border infections among MSM and FSW along the southern border. In ROP21, the PEPFAR Program will be implemented in the same thirteen sites.

Figure 2.5.1F Senegal: People Living with HIV by Region, Gaps in ART Coverage and Viral Suppression



In **Sierra Leone**, PEPFAR's extensive TA to 30 high burden sites will continue to produce evidence and a roadmap for broader impact across the national response, in which new data will inform the strategy. PEPFAR activities will focus on the highest-prevalence Western Area, particularly Western Rural, and Port Loko District, and sustain coverage at several high burden sites in Kambia District. These districts account for approximately 65% of the HIV burden in Sierra Leone and also represent the greatest opportunities to reach KP.

Figure 2.5.1G Sierra Leone: People Living with HIV by Region



2.6 Stakeholder Engagement

Across all the countries in the West Africa Regional program, the PEPFAR/West Africa teams work in collaboration with key stakeholders, including host country governments, the GFATM, CSOs, MoHs, and Non-governmental organizations (NGOs) in the fight against HIV/AIDS. The development of ROP21 was a participatory process that included consultation with key stakeholders in the HIV response and reflects a high level of collaboration. In all countries, regular coordination meetings are held to ensure alignment of strategy and review results and progress.

In each of the countries, regular forums to review progress are in place, which include analyses of MPRs and development of proposed corrective actions. Given the tremendous need to ensure synergy and complementarity, all the country teams have engaged continuously with GFATM and in each country, PEPFAR indicators and progress will also be reviewed in the Quarterly CCM meeting. Each of the NACs, NACPs, CSOs and Fund Portfolio Managers of the GFATM have been

involved in the gap analysis, the definition of the priorities, strategies, and the selection of the sites. Discussions were done also to ensure synergy with upcoming HIV NSP and GFATM Grants.

Within the U.S. Missions, each of the Ambassadors have been briefed on the major pivots in the programs. The PEPFAR teams will continue to rely on Ambassadors in each country to be very involved in any discussions with Ministries of Finance about domestic resource mobilization for HIV. P EPFAR teams have also presented ROP21 plans to their Interagency Health groups, where these exist.

Most importantly, CSOs, including MSM and FSW associations and networks across the region, have been foundational players in PEPFAR discussions. They remain essential throughout the process to ensure transparency, accountability, and synergy. They have actively contributed during the national in-country consultations, and in each country will be sub-recipients of funding to strengthen their ability to demand quality services for those they represent and hold PEPFAR and the Host Country Governments accountable. A CSO representative from each country actively participated at the ROP21 virtual meeting. CSOs will continue to play a key role in the implementation and monitoring of the PEPFAR programming.

In each of the countries, consultations were held with the statutory Presidential entities overseeing the HIV/AIDS response.

In **Burkina Faso**, **Togo**, **and Benin,** in-country consultations were led by the National AIDS Commission. They involved, as recommended, key stakeholders of the national HIV response (NAC, MoH, GFATM, CSO, associations and networks of key populations and PLHIV, UNAIDS, WHO, and other UN Agencies participating in the HIV response). During those consultations, updated country gaps to reach 95-95-95 targets in all groups and country priorities were analyzed. Discussions were held on the ROP21 PEPFAR Planned Allocation and Strategic Direction Letter, current PEPFAR program performances, policies and socio-cultural barriers, and corrections needed to be done. They were opportunities to get feedback from CSOs and design, together with national stakeholders and other donors, the ROP21 proposal. This dialogue will continue during the implementation to ensure continuous synergy.

The PEPFAR/**Ghana** team works very closely with the GoG, the GF, and UNAIDS, through routine meetings and ad hoc interactions. Following the USG planning meeting, a stakeholder meeting was convened on January 21, 2021, to discuss the PEPFAR Planned Allocation and Strategic Direction Letter and proposed activities, challenges, and solutions with the GoG, civil society, the GF country coordinating mechanism, the private sector, UNAIDS, and WHO. Stakeholders subsequently agreed with PEPFAR's proposals to expand to Western and Ahafo regions. The stakeholders also expressed support for PEPFAR's proposed priority interventions to: accelerate TLD transition, expand PrEP, HIVST, 6MMD, and improve VL coverage as outlined in the PEPFAR Planned Allocation and Strategic Direction Letter. The stakeholders also shared their support for prioritizing TA in the supply chain area to institutionalize best practices at national and regional levels and to support coordination and advocacy forums to advance HIV commodities security. The group provided suggestions and felt the overall direction and activities addressed the gaps and needs in Western Region and the proposed new regions. The stakeholders also highlighted the importance to continue scaling up PEPFAR's interventions in regions outside PEPFAR focused regions. The team worked closely with civil society to identify the critical elements that would make up the proposal for community-led monitoring.

In **Senegal**, PEPFAR will continue to work with the NAC on coordination and cooperation with other donors and partners in the HIV/AIDS space. NAC has an existing quarterly coordination meeting, which the PEPFAR/Senegal team uses to guide implementation of PEPFAR MPRs nationwide, tackle service delivery bottlenecks - including supply chain issues, and share PEPFAR data and best practices with a wide audience. PEPFAR/Senegal is also building off existing GFATM-initiated community monitoring efforts. In ROP20, PEPFAR will provide resources to existing KP advocacy networks in Senegal to ensure that the PEPFAR team gets consistent feedback on what clients are seeing, needing and asking for in terms of HIV/AIDS services. PEPFAR/Senegal will strive to focus down on client-centered services by listening consistently to the clients themselves.

In anticipation of ROP21, the NAC hosted the PEPFAR/Senegal stakeholders' meetings where the Government of Senegal, civil society, KP advocacy groups, NGOs, and others collectively reviewed PEPFAR MPRs and technical priorities.

In **Liberia**, two separate national consultations were held with CSO partners and MoH on February 2 and 10, 2020 respectively. During these consultations, emphasis was placed on ROP21 MPRs and policy barriers, which need to be addressed to enhance access to services. Consultations also focused on the ROP21 process in general, overall recommendations for improvement, and various critical next steps. To further strengthen ongoing consultations, PEPFAR/Liberia will host bi-annual CSO and KP consultations and is kick-starting PEPFAR IP meetings now that HRSA is also part of the regional program. There are various technical working groups (TWGs) on M&E, supply chain, HIV prevention, TB/HIV, etc., and PEPFAR will ensure its participation in these TWG meetings as a means of remaining actively engaged with stakeholders. To further strengthen coordination, collaboration and performance on the Global Fund-supported grants, PEPFAR has allocated up to $150,000 to support maintaining critical staff on the CCM Secretariat. The support will go towards Secretariat staff salaries and increasing oversight capacity which will ultimately increase performance across the HIV, malaria and TB grants supported by the Global Fund.

In **Mali**, as PEPFAR increases support in the 23 sites of Bamako, Sikasso and Segou and supports PLHIV IDP, PEPFAR will continue to liaise closely with GFATM to ensure there is no duplication of services. Each of the NACs, NACPs, CSOs, and GFATM have been involved in the gap analysis, the definition of the priorities, strategies, and the selection of the sites. During the implementation of ROP20, PEPFAR Mali program agreed to transfer the management of existing KP activities in selected geographic areas of Bamako to a national NGO which is currently a PEPFAR and GFTAM sub-recipient in accordance with an agreement with NACP. For ROP21, USAID also conducted similar country stakeholder consultations before the meeting to eliminate duplication and improve collaboration and increase collective impact.

In **Sierra Leone**, PEPFAR will continue to work with the National HIV/AIDS Secretariat (NAS), NACP, UNAIDS, and the GFATM CCM to coordinate the National response and optimize the contributions of the various donors. Sierra Leone will continue to take advantage of the capacity of the other countries in the Regional Program for best practices and other insights.

Private sector involvement in HIV is limited in West Africa. While private sector actors are to be members of the quarterly CCM meetings and in some countries provide HIV services in urban areas, participation in most countries can be improved. PEPFAR will, where appropriate, actively seek opportunities to engage private sector players and faith-based organizations in PEPFAR programming.

3.0 Geographic and Population Prioritization

Burkina Faso does not yet have granular data at the district level. Thus, the geographic prioritization was determined at region level considering Spectrum 2020 data and gaps to reach 90% ART coverage by region. In addition to the four regions prioritized in ROP20 (Centre, Centre-Ouest, Hauts Bassins, and Centre-Nord), one additional region (Boucle du Mouhoun) was prioritized to allow PEPFAR to continue to accelerate the national growth of people currently on treatment and viral load suppression among PLHIV. This additional region has the highest ART coverage gaps after the four regions prioritized in ROP20. In total, the fifth region prioritized represents 73% of the national gaps to reach 90% ART coverage.

While close, none of the five prioritized regions are expected to reach 81% ART coverage by April 2021. Rapid scale-up towards saturation will be done in these prioritized regions in order to reach 87% ART national coverage by Sept 2022. Above-site activities will also contribute towards improving the overall national cascade.

The disaggregation by age and sex revealed low coverage among children and adult men. The ART coverage among children and adult men were respectively 25% and 63% versus 96% among adult females in 2020 (Spectrum 2020). There is also a lack of information regarding the ART national coverage among KP; however, it is assumed that coverage is low, due to the high level of stigma and discrimination. The ROP21 program will maximize opportunities to reach KP, children, and men and to address barriers that have limited their access to ART. ROP21 targets were set accordingly in order to fill gaps by sex and across all age.

Togo also does not have well-disaggregated data at the district level, so the gap analysis occurred at the regional level. Four regions were prioritized: the three regions prioritized in ROP20 (Lomé Commune, Maritime and Plateaux regions) and one additional region in ROP21 (Central region). These four prioritized regions have the highest gaps to reach 90% ART coverage and represent 88% of the national gap. Except for Lomé Commune, none of the other prioritized regions is expected to reach 81% ART coverage by April 2021. PEPFAR's programmatic objective will be to support the Government of Togo to reach 89% national ART coverage by September 2022, with a focus on reducing disparities among children, men, and KP.

Disaggregation of the gaps by sex and age revealed that **Togo's** national program faces challenges in reaching children (49% ART coverage in 2020) and adult men (61% ART coverage in 2020). There is limited national data in terms of ART coverage for KP due to stigma and discrimination. However, it assumed that it is low, also due to stigma and discrimination that KP face in Togo. In ROP21, PEPFAR program will continue to emphasize reaching these population sub-groups and address barriers that have limited their access to ART.

Benin is prioritizing implementation in four regions for the first year of PEPFAR support, based on their HIV burden and ART coverage gaps to reach 90% ART coverage. They are Atlantique, Littoral, Couffo, and Mono departments. Those four prioritized regions are home to 52% of the national ART coverage gaps. None of those regions is expected to reach 81% ART coverage by April 2021. In ROP21, PEPFAR aims to implement an aggressive scale-up to support the Benin government to reach by September 2022, 80% ART national coverage.

The disaggregation of the ART coverage by sex and age in **Benin** shows low ART coverage among children (55%), and adult men (56%) compared to women (78%) in 2020. The available data does not allow the identification of gaps disaggregated by 5- year age bands. Corrective actions will be taken during the implementation of ROP21 to strengthen the monitoring and evaluation system to collect data by five-year age bands and by sex for better decision making. The ROP21 program will maximize opportunities to reach KP, children, and men and to address barriers that have limited their access to ART.

In ROP20, PEPFAR/**Ghana** shifted its strategy from supporting KP programming in five high-burden regions to supporting direct service delivery models to achieve epidemic control in the Western region. The overall objective was to demonstrate that achieving epidemic control in Ghana was possible, and to work with the Government and the GFATM to scale up successful interventions in other regions. In ROP20, PEPFAR/Ghana made significant progress in Western region to achieve the 95-95-95 cascade. ROP21 activities will expand to cover two adjacent regions, Western North and Ahafo. Activities in ROP21 will prioritize case finding, linkage, and continuity of treatment for men, youth, and adolescent girls and young women. PEPFAR/Ghana will work with Regional Health Directorates and facility managers to offer male-friendly clinic services, including trained/sensitized staff, male-only clinics, expedited services (fast-tracking) for working men, and after-hours and community-based ART distribution. Activities will improve continuity of treatment and adherence counseling among men and youth. CSOs will also mobilize men and young people in communities for age- and sex-appropriate prevention and services.

PEPFAR/**Liberia** is targeting KP (MSM and FSW) and priority populations in the two highest-burden districts in Margibi County, one in Grand Bassa County (with two health facilities), and seven highest-burden districts (Commonwealth, Central Monrovia, Bushrod, Somalia Drive, St Paul River, Todee, and Careysburg) within Montserrado County, where the capital city of Monrovia is located. These seven districts comprise 32% of the population of Liberia, and approximately 60% of the HIV burden. An acceleration plan undertaken by the Government of Liberia in 2016 sought to triple the country's testing and treatment results within a short window to fast-track progress towards 90-90-90. The plan targeted counties with the highest unmet need (Grand Bassa, Margibi, and Montserrado), and specifically focused on urban areas and hotspots within these counties.

There are significant gaps along the cascade for KP (MSM and FSW) which have been identified under the GFATM program. In Montserrado County, it is estimated that 10,000 KP do not know their status; 18,557 will need to be initiated on treatment; and 28,870 VL tests need to be done to achieve viral suppression. PEPFAR will target KP to ensure they receive appropriate counselling and support to link to and be retained on treatment. Through the combined efforts of the Government of Liberia, PEPFAR, and GFATM, 95% of PLHIV will continue on treatment in Montserrado County by 2021.

The PEPFAR/Mali program will focus on KPs, including scaling up index testing. Mali will prioritize MSM, FSW, clients of FSW, sexual partners of all people testing positive for HIV, and children under 15 of an HIV-positive parents. PEPFAR will strengthen the KP activities in the 23 health districts across the three high-burden regions in Mali to reach epidemic control:

- Strengthen index testing and other highly targeted testing strategies in all 23 sites.
- Expand the reach of peer navigators to strengthen retention and VL suppression among old and new patients.

- Extend the integration of the e-Tracker into the national HMIS with the introduction of UICs and computerized medical records on DHIS2 in all HIV counseling and treatment sites in Mali in collaboration with NACP and GFTAM.

In addition, USAID will support strengthening the capacity of key stakeholders, including training of the GFATM Principal Recipients on high-impact strategies. PEPFAR will also fund supportive supervision and data quality with the NACP - specifically on quality and timely data collection.

Given promising results focusing on KP in Dakar, Ziguinchor, and Thies in ROP19 and ROP20, PEPFAR/**Senegal** is expanding to other high-burden, high-prevalence regions in ROP21 to increase KP case finding and linkage to treatment and close the gap to 95-95-95. PEPFAR/Senegal will support 13 health districts in seven regions: Dakar (five sites), Ziguinchor (two sites), Thies (two sites), St Louis (one site), Kaolack (one site), Kolda (one site), and Sedhiou (one site). Additional districts were selected based on KP size estimations, prevalence, and disease burden. Additionally, new sites in Ziguinchor and St. Louis were chosen due to their proximity to Senegal's northern and southern borders, respectively, and the frequent movement of KP between these borders. St. Louis was also chosen following strong advocacy from the MoH and data that showed increasing prevalence among MSM specifically. By re-focusing support on sites that have greater access to KP, and by doubling efforts to provide client-centered, KP-friendly care, PEPFAR/Senegal can sustain the momentum on case finding for KP.

PEPFAR/**Sierra Leone** will expand support in Western Area, comprising the two districts with the highest prevalence, as well as neighboring Port Loco and Kambia Districts. Site selection is influenced by proximity to KP hot spots and drop-in centers (DICs), in which MSM and FSW are target populations for PEPFAR.

Table 3.1

Table 3.1 Current Status of ART saturation					
Prioritization Area	**Country**	**Total PLHIV/% of all PLHIV for COP20**	**# Current on ART (FY19)**	**# of SNU COP19 (FY20)**	**# of SNU COP20 (FY21)**
Attained	Togo*	54,955/50%	42,145	1 region	1 region
Scale-up Saturation	Burkina Faso	69,290/ 74%	52,120	69,290/ 74%	52,120
	Togo	42,450 / 38%	29484	2 regions	3 regions
	Benin	41,462/54%	28,827	N/A	4 regions
	Ghana	29,685 (8.8%)	12,003	1 region (Western)	1 region (Western) and 1 adjacent district in 1 region (Western North)
	Liberia	24,100 (56%)	13,117	N/A	9 districts

Scale-up Aggressive	Mali	7,520 (71%)	N/A	23 districts in 3 regions (23 sites)	23 districts in 3 regions (23 sites)
	Senegal	12,135 (52%)	26464	3 regions (4 sites)	7 regions (13 sites)
	Sierra Leone	HTS_POS target is 2,511, and PLHIV is 73,870.	7,044	NA	2 districts

*NACP data as of June 2019. Some PLHIV from other regions are on treatment in Lome (Togo Capital)

4.0 Client Centered Program Activities for Epidemic Control

4.1 – **4.4 COP21 Programmatic Priorities for Epidemic Control**

4.1 Finding the missing and getting them on treatment

Across the region, efforts will be made to intensify client-centered approaches, in particular MMD, which is still being expanded in most countries. Due to the challenges in ARV supply and perennial stock-outs of commodities, additional emphasis on working with GFATM and host country governments to ensure adequate stock will enable MMD to be implemented with fidelity. In addition, all countries show that men in particular those under 40, continue to be missed for treatment. All countries will deploy various strategies including male-friendly clinics and extended hours for services to access these men. In the same way, children under 15 also remain a group that require special effort to access.

Stigma and discrimination against KP across West Africa remain extremely high. To reduce its impact on access to HIV services, PEPFAR will implement activities to make health facilities a KP-friendly environment. Service providers, policemen, and judges will be trained, and advocacy will also be done. GBV prevention and clinical care will also be provided.

Community-led programming will be implemented in close collaboration with KP associations and networks in order to ensure a client-centered focus. Using a multi-pronged strategy to find KPLHIV, programs will use hot-spot outreach, index testing and EPOA, social network strategies, as well as social media and Information and Communications Technology platforms to carry out targeted testing. KP peer educators will be trained on social and behavior change messaging including U=U messaging for VL suppression, distributing condoms and lubricants, and referring people for HIV counseling and testing services.

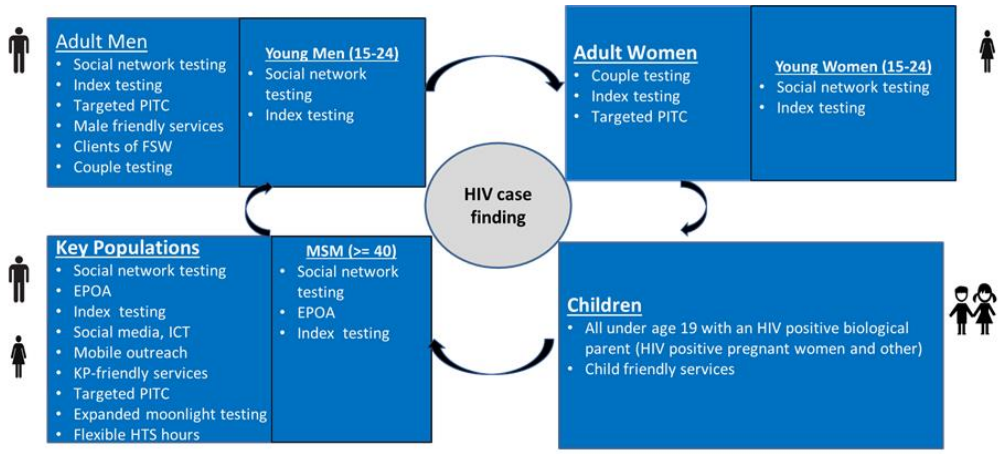
Index testing and partner notification throughout the region was found to be the most efficient case finding strategy at PEPFAR sites. It will be implemented with compliance to WHO's 5 C's (counseling, including consent procedures, correct test results, linkage to care and treatment of positive clients, and protecting confidentiality). Site assessments and certification, supportive supervision and coaching of service providers, as well as monitoring of index testing will continue to be an emphasis in West Africa in compliance with the MPRs.

In Burkina Faso, Togo, and Benin, for the general population, rapid saturation of the prioritized regions with differentiated HIV case-finding methods and client-centered approach will be carried out. In addition to the KP-specific methods, hard-to-reach adult men, mainly those who are asymptomatic and aged 20 to 34, will be reached through safe and ethical index testing via their sexual partners, social network testing, and targeted and risk-based Provider-Initiated Testing and Counseling (PITC). Appropriate messaging (U=U), self-testing, and male-friendly services (night hours, male case managers), and risk network referral testing, will be provided to increase HIV service demand among men. Periodic focus groups will be organized at site level to understand men's needs and tailor services accordingly. Special emphasis will also be placed on identifying MSM aged over 40, as they have higher prevalence and are hard to reach. HIV self-testing, introduced in ROP19, will continue to be expanded. Once clients are navigated to PEPFAR-supported KP friendly facilities, a peer navigation and case management approach will ensure immediate initiation of ART and support for retention on ART.

To increase HIV case finding among children, optimized HIV testing strategies will be implemented: (i) safe and ethical index testing at facility and community level to encourage women living with HIV to elicit all their children including those aged 10 to 19, (ii) targeted PITC for children with malnutrition and suspected TB, (iii) use of existing Point of Care Machine to increase access to EID. HIV-related services will also continue for adolescent girls and young women through social network testing, self-testing, safe and ethical index testing, and prevention and care of GBV violence.

Ghana will implement an optimal mix of testing strategies to maximize case identification, focusing on targeted testing to improve yield. Activities will ensure targeted and effective screening to increase yield at PITC and other entry points, and to scale up index testing for the general population. Ghana will improve EID by ensuring timely diagnosis and follow up at antenatal wards. Infants of women with HIV will be tested periodically during breastfeeding and after end of breastfeeding to establish final status. To reach missed children, strategies will include index testing to identify eligible children of women living with HIV, and targeted PITC for children with malnutrition and suspected TB signs. Ghana will focus on providing youth-friendly services to improve services for adolescents and youth (15-24). Activities will adapt and use certain case finding strategies for adolescents and youth, such as index testing, social network testing, PITC of youth presenting for sexual and reproductive services, and HIV self-testing. Case finding strategies for men will include index testing, male-friendly facility-based testing (flexible hours, weekend), targeted community-based testing, and self-testing.

Ghana will continue to implement proven case-finding strategies for KP, including EPOA, hotspot mapping, social media outreach, and social networks. Index testing will also be one of the main case-finding strategies. Ghana will ensure that facilities are certified to provide index testing according to WHO and PEPFAR standards for safety, confidentiality, and volunteerism. HIV self-testing will be one of the case-finding strategies among KP. Ghana will strengthen peer navigation as part of a comprehensive community case-management system to help resolve leakages between community and facility and ensure fast track services for clients.



In **Liberia,** only 65% of PLHIV know their status and only 53% are on treatment (2020 Spectrum and routine program data). To address this, in ROP21, PEPFAR/Liberia will continue providing adherence and retention support to all patients at PEPFAR-supported facilities, not just patients who entered treatment through PEPFAR-supported testing. PEPFAR will continue ROP20 KP activities by directly supporting HIV testing for KP (MSM and sex workers) and newly in ROP21 will support comprehensive, multi-modal screening and testing among other high-risk populations at PEPFAR-supported health facilities such as TB, STI, and emergency ward patients. PEPFAR will continue support towards offering index testing to all patients on treatment at PEPFAR-supported facilities by supporting the dedicated index testing counselors strategy, deploying dedicated index testing counselors at new sites, and linking them with CSO groups to track index testing contacts in communities. Because treatment initiation rates are half as high among men as they are among women, PEPFAR will support activities to better target men, such as men-only and weekend community clinics, and self-tests kits in priority community locations such as urban and peri-urban slums. PEPFAR will also provide outreach in targeted communities and churches with U=U messaging, treatment options, and information to improve HIV health literacy, de-stigmatize HIV, and de-link it from a "KP only" epidemic to improve case finding and linkage to treatment. Finally, PEPFAR will support a VL specimen transport system to ensure that all patients at PEPFAR-supported facilities have access to VL testing and receive their results.

PEPFAR/**Senegal** will make several key programming adaptations to better serve male clients and fit within men's existing health care access patterns. Spectrum estimates indicate that ART coverage is especially low among men and children. The program will support longer clinic hours to better cater to working men's schedules, mobile outreach to find men where they are, and providing peer navigators or case managers to follow-up and provide consistent contact with men. For children of KP, who are at a significantly higher risk of being infected, PEPFAR will work with case managers (as well as peer navigators for their parents) to implement index testing safely and anonymously for HIV+ clients and their families. Case managers will particularly follow-up to ensure continuity of treatment of children on ARVs.

The first 95 is a major gap for **Mali**, with only about a half of PLHIV knowing their status. To find missing PLHIV, Mali will scale up EPOA and self-testing, as well as scaling up community-level index testing in collaboration with the national network of PLHIV. Index testing and EPOA were both successful strategies in FY19, with yields of 49% for index testing and 8.1% for EPOA. Mali will support task-shifting to nurses, who are more mobile, and will continue working with peer

navigators. To reach missing male PLHIV, Mali will support longer clinic hours to better cater to working men's schedules and mobile outreach to find men where they are as well. Peer navigator/case manager programming will be expanded to additional sites to follow-up and provide consistent contact with men. Only 18% of children know their status in Mali, so Mali will also be targeting children of KP and ensuring that children of all PLHIV have been tested. For children of KP, PEPFAR will work with case managers (as well as peer navigators for their parents) to implement index testing safely and anonymously for HIV+ clients and their families.

Sierra Leone's performance is weak across the cascade, with a viral suppression rate of 26% being the weakest of the three 95s. The Government of Sierra Leone has been engaged in low-yield testing modalities but has embraced PEPFAR's introduction of index testing, which has consistently maintained high yields. In addition to high-yield testing modalities at high-burden sites, linkage and continuation in care, emphasizing client centered care, community monitoring, and supply chain strengthening will take place along with actions to improve VL/EID coverage, in collaboration with the GFATM. Within this strategy, MSM and FSW will be prioritized and be reinvigorated by IBBSS results expected this summer. PrEP was successfully introduced and will be expanded in ROP21 along with introduction of self-testing. PEPFAR/West Africa is partnering with KP subject matter experts and other individuals to begin to develop KP data for **Sierra Leone**. CDC will become a new PEPFAR implementing agency in ROP21 and support SI and Lab. PEPFAR/Sierra Leone will award a new cooperative agreement for CLM in **Sierra Leone** to a local CSO**,** building on the work performed in ROP20 through UNAIDS.

4.2 Retaining clients on treatment and ensuring viral suppression

In **Burkina Faso** and **Togo,** a scale-up of strategies to support, client-centered ART in all sites providing HIV testing, care, and treatment services will continue. This will ensure: (i) immediate and easy access to ARVs, (ii) immediate implementation of four existing MPRs related to linkage and retention at all sites, and (iii) implementation of quality management policies and practices to support and maintain site standards. To increase retention, PEPFAR-supported sites will implement intensive follow-up counseling in the first month after ART initiation, including adherence risk assessment, treatment readiness preparation strategies (ART readiness checklist, intensive adherence support calendar), disclosure support, side-effect management, retention strategies (escort services, transport vouchers), and referrals to other clinical or support services. Existing case management interventions will be strengthened.

This will include intensifying the case management approach through: (i) immediate assignment of a long-term case manager to every client testing HIV-positive, who will facilitate progress throughout the HIV care cascade; (ii) utilizing a mobile platform to track referral completion with alerts to health workers, case managers, and clients; (iii) ensuring complete, timely, and accurate use of recording tools for linkage, pre-ART, and ART registers; (iv) developing or updating tools (referral forms, appointment diaries, defaulter tracking registers) and (v) conducting weekly reviews of client information to ensure they are still in the system, with immediate follow-up in the event of missed appointments. The patient e-Tracker system will be used to identify defaulters rapidly and follow-up on them with the support of the case managers.

Viral load testing demand creation and receipt of viral load results will be strengthened through: (i) patient education including U=U messaging, (ii) training and coaching of service providers, (iii)

generation of weekly lists of clients eligible for viral load testing using the e-Tracker; (iv) enhanced adherence support to patients who are not virally suppressed, and (v) ART optimization with full transition to TLD for PLHIV weighing ≥ 30 kg and DTG-based regimens for children.

In **Benin,** to ensure high continuity of treatment proxy (>=98%), PEPFAR-supported sites will : (i) implement same-day ART initiation; (ii) have appropriate messaging and services to encourage men, in particular asymptomatic men aged 20-34 and MSM over 40 to early seek HIV services; (iii) scale-up DSD including 6MMD, community ARV dispensing, fast track appointments, and flexible working hours; (iv) send pre-appointment reminders to clients (via SMS messages and phone calls); (v) complete daily monitoring of defaulters with active tracing through phone calls, home visits, and social networks and (vi) use the e-Tracker to weekly monitor site performance, to easily identify gaps across sex and age, and implement corrective actions. Particular attention will also be paid to patients with advanced HIV disease, TB patients, and patients who are not virally suppressed.

Ghana will continue training healthcare providers to achieve a sustained shift in CQI approaches across all facilities. The focus is on providing client-centered services to address important aspects of continuity of treatment, such as assessing adherence risk, ensuring patient readiness, emotional support, management of side effects, and other retention strategies, such as transport vouchers. Healthcare providers will also be trained and sensitized on how to provide respectful and friendly care to patients, including awareness of needs for each subpopulation (e.g., males, adolescents, etc.). DSD approaches will be implemented with fidelity across all facilities, to provide tailored services that meet the individual patient needs. Activities will focus on ensuring complete scale-up of the fixed dose combination for TLD and ensuring access to 6MMD for all stable clients. A model for refills and for fast-track refills will be implemented as part of this approach. Ghana will use case managers and Models of Hope to actively link clients and track those LTFU. Continued support to train data officers and to improve the functionality of the e-Tracker will be essential for generating reports for patient follow-up and tracking. Recognizing the importance of U=U messaging in the HIV continuum of care, Ghana will support the integration and institutionalization of U=U messages to increase demand for VL, improve treatment adherence, and reduce stigma and discrimination toward PLHIV.

Liberia continues to improve in the area of treatment continuity, though there are still challenges that need to be addressed. Ensuring VL suppression continues to be an area of challenge, and PEPFAR will strengthen support in this area during ROP21. Currently, only 53% of PLHIV who know their status are on treatment and of those on treatment, only 35% are virally suppressed (2020 Spectrum and routine program data DHIS-2). PEPFAR/Liberia will support efforts to reach the second and third 95s by continuing its KP-focused peer navigation and case management approach introduced in ROP19 to ensure immediate initiation of ART and support for retention and VL suppression. PEPFAR will continue ROP19 retention activities around Test and Start, health messaging, DSD, LTFU tracing, and pre-appointment reminders as well as VL testing support. PEPFAR will provide U=U messaging, robust adherence counseling for those not virally suppressed, advocacy to ensure access to VL testing and monitoring for all PLHIV at PEPFAR-supported sites and strengthening the sample referral system developed in ROP19. Furthermore, PEPFAR will support the ongoing TLD transition to ensure PLHIV have access to more effective ARVs with decreased side effects and increase their likelihood of reaching adherence and VL suppression. Supply chain TA, including quantification, forecasting, inventory management, and last-mile delivery support will also continue in order to address stock challenges which limit the adoption

and implementation of six-month dispensing at sites nationally. Newly in ROP21, PEPFAR/Liberia will expand its focus on other high-priority populations and will support facility retention counselors for all PLHIV at PEPFAR-supported facilities.

To ensure the retention of clients on treatment and VL suppression, **Mali** will continue to expand its successful strategy of case managers and clinicians conducting patient-by-patient tracking. The program will also expand the reach of critical TA to sustain outcomes in Health districts and expand the integration of the e-Tracker into the national HMIS with the extension of UICs and electronic medical records on DHIS2 to both KP and priority populations in all HIV counseling and treatment sites. Currently only PEPFAR supported sites benefit from the UICs for both KP and priority populations and the use of the e-Tracker (Kolochi). The program will intensify community-based monitoring and client feedback, establishing a solid foundation for sustaining improved retention outcomes. To rapidly accelerate access and uptake, PEPFAR will support VL testing demand creation and VL testing network optimization activities to ensure timely analysis and communication of results.

PEPFAR/**Senegal** has learned from Mali and Ghana that detailed and focused client tracking, patient by patient, from case managers and clinicians, is the key to both understanding retention issues and ensuring that clients remain on treatment. Community-led monitoring and reporting will also help PEPFAR/Senegal better understand retention pitfalls and modify approaches in real time. While TLD commodity security remains an issue, PEPFAR will work to increase the length of multi-month dispensing (now at three months) to ensure that clients have consistent access to treatment.

PEPFAR in **Sierra Leone** overcame significant obstacles with VL testing capacity in ROP20, including through an innovative agreement with a Gates Foundation-funded research program. These are bridge strategies while waiting for the GoSL to restore and expand testing capacity and coverage. CDC will begin providing lab technical support to further bolster coverage under PEPFAR. Sierra Leone will also fully capitalize on its association with seven other operating units in the West Africa Region to gain insights from their successful interventions.

Sierra Leone has a unique identifier for HIV clients but it is not functioning in any productive way, and PEPFAR will continue exploring solutions for a reliable UIC as well as improvements to existing poor documentation systems. Site Improvement Through Monitoring System (SIMS) helped illuminate the documentation problems early, and PEPFAR/Sierra Leone is consulting across the West Africa Region for best practices with UIC and client level documentation.

4.3 Prevention, specifically detailing programs for priority programming:

Children under 15: As mentioned above, across West Africa, children under the age 15 remain a group that is continually missed in HIV services. The data suggests routine testing of children of mothers who are HIV-positive is inadequate. To reach these missing children, all HIV-positive mothers will be offered HIV testing of their biological children. Special attention will be given to index testing with fidelity to identify eligible children of all women living with HIV, as well targeted PITC for children with malnutrition and suspected TB. For children of KP, who are at a significantly higher risk of being infected, PEPFAR will work with case managers (as well as peer navigators for their parents) to implement index testing safely and anonymously for HIV positive clients and their families.

KP: Stigma and discrimination against KP is very high across the West Africa Region, so prevention interventions throughout the region will aim to improve KP' access to HIV services through making health facilities KP-friendly and eliminating stigma and discrimination at the site level, thus increasing the number of KP that are reached by prevention services. Service providers, law enforcement officials, and judges will be trained, and advocacy activities will be modeled after more established KP programs in the region, such as **Ghana**. Other prevention activities for KP across the region include: STI screening and treatment, condoms and lubricants promotion and distribution programming that focuses on addressing barriers to condom use, social norms change messaging, gender-based and intimate partner violence screening and support, and referral to other psychosocial services as needed where available.

In **Burkina Faso, Togo, and Benin,** peer educators will continue to be trained and coached on prevention strategies, U=U literacy, and KP prevention Social and Behavior Change Communication tools. Helpline counselors and outreach workers engage online with clients and use information and communications technology. Correct and consistent condom use is a priority prevention strategy, and PEPFAR has worked closely with authorities (including the NACP, the police, peer educators, and Local Councils) and some brothels and clubs to ensure that condoms are accessible.

Responding to GBV and violence against KP is another priority for the West Africa Region. **Burkina Faso, Togo, and Benin** are working to develop a stronger violence prevention and response program for KP, through offering information to KP clients on rights, and developing a network of KP-friendly violence response service providers that can be shared with clients during outreach and testing. PEPFAR/West Africa will also work with the police to improve KP's ability to move freely and access condoms or to seek out information on HIV prevention without fear of arrest.

PrEP will be introduced and scaled up where applicable in the West Africa Region in ROP21. **Ghana** will prioritize PrEP for KP using proxy measures to assess substantial HIV risk, including early sexual debut, history of STIs, adolescent pregnancy, transactional sex, history of or current report of experiencing violence, and engagement in sex work. **Senegal** will leverage GFATM procurement and TA to provide PrEP for clients who are identified as high-risk through screening and will work closely with the Government of Senegal to ensure PrEP is available in PEPFAR sites. PEPFAR in **Sierra Leone** participated fully in GFATM NFM3 negotiations and obtained complete coverage for all commodities consistent with ROP21 targets, including PrEP and self-testing. **Mali** will continue PrEP for KP as well as sero-discordant couples. VL coverage will be improved to reduce transmission. Mali will support PrEP with the procurement of drugs, and support at the systems and site level for the development and dissemination of SOPs, training of providers, and monitoring of implementation. In **Burkina Faso, Togo**, **Benin** and **Liberia,** PEPFAR will support PrEP service delivery including demand creation for MSM, FSW, sero-discordant couples as well as tools and SOPs for national roll-out strategies.

Ghana will implement tailored prevention programs for adolescents and young adults, including AGYW. This will include evidence-based prevention interventions to reduce risks, and provision of condoms (external and internal) and lubricant. PEPFAR/Ghana will continue to support the provision of Opt-out HIV testing to all pregnant women at first antenatal clinic visit (ANC1). Retesting is considered and prioritized where there is a high risk of HIV infection. Those who test positive receive active referral for treatment initiation. They receive high-quality counseling services to ensure treatment readiness, which includes counseling on HIV infection during postpartum and breastfeeding periods.

4.4 Additional country-specific priorities listed in the PEPFAR Planned Allocation and Strategic Direction letter

While all countries in the West Africa Regional program are implementing Test and Start, ensuring fidelity beyond PEPFAR sites is critical. All countries are expected to complete TLD transition and support countries to fully implement 6MMD. This will require significant support of supply chain management and procurement. In the same way, availability of VL testing reagents has been a considerable challenge, and countries across West Africa will be investing significant resources into VL testing optimization and, in some countries, reagent procurement. Given the limited resources in the region, countries will need to work in close collaboration with host-country governments and the GFATM to ensure availability. West Africa was also mandated to advance the roll-out of PrEP and self-testing in all countries. Self-testing policies are now complete in the region, and will be part of ROP21 implementation in all eight countries. All countries use peer navigator and case manager approaches, and these methods and other community-based interventions (including community-led monitoring) will be scaled up, to increase the use of client-centered strategies to improve linkage and retention. CQI activities and implementation of UIC are expected to be consistently implemented across all countries.

Under partner management, all countries will manage implementing partners through site-level monitoring of monitoring, evaluation and reporting (MER) target achievement, including through the use of high frequency reporting to identify gaps and ensure course correction needs in real time. Systematic assessment and monitoring to ensure service quality will be carried out through PEPFAR SIMS assessments.

Index testing, which has been shown to be a most efficient testing strategy, will be implemented with fidelity and with compliance to WHO's 5 C's (counselling, consent procedures, correct test results, linkage to care and treatment of positive clients, and protecting confidentiality). To find KP who are in need of services, the West Africa Regional program will ensure index testing, through STI and other clinics, to encourage index contacts to come to facility, ensure contacts of all PLHIV are tracked to get previously diagnosed cases on treatment, and implement client-centered testing services to target men, KP, children, and other priority populations.

Burkina Faso and Togo will continue to accelerate progress toward the achievement of the 95-95-95 targets. Supply chain gaps, stockouts, and management system weaknesses throughout the region in ROP20, have highlighted the need for Burkina Faso to provide support for key commodity acquisition (RTKs, ARVs, and VL reagents). Poor VL testing coverage in the region led to Burkina Faso being directed to improve the VL lab system through VL testing optimization plans, data management and quality assurance. In line with that, PEPFAR teams increased the budget allocated to the supply chain in ROP21, by 146% and 97% in Togo and Burkina Faso respectively, against an overall 97% and 44% increase of those countries' budgets in ROP21. Lab system strengthening budgets also increased by 116% in Togo and 74% Burkina Faso. PEPFAR/Burkina Faso and Togo will continue to manage implementing partners through PEPFAR site visits and targeted TA to underperforming sites. Additional efforts will also include deep dive site level data analysis to identify low performing sites and prioritize those for TA as needed.

Benin already adopted all the MPRs policies and in ROP21, the focus will be on ensuring implementation with fidelity of those policies. PEPFAR/Benin will work hand in hand with the GFATM to address supply chain issues hindering achievements of HIV programs. ROP21

investments will complement the on-going efforts outlined in the GFATM NFM3 proposal covering the period from 2021 thru 2023. In addition to the procurement of some commodities (see section 4.5 below), PEPFAR investments will be geared towards strengthening specific supply chain functions including end-to-end visibility of logistics data; implementation of an adaptive last mile logistics; coordination among supply chain stakeholders on monitoring joint commodities supply plans.

In 2020, with support from PEPFAR, **Ghana** developed and piloted national PrEP and HIV self-testing policies in high burden sites in Accra and Ashanti regions using KP platforms supported by the GFATM. The policies are now being scaled up by the GoG and GFATM in all regions. In ROP21 PEPFAR/Ghana will continue to provide PrEP and HIV self-testing in Western, Western North and Ahafo regions. PEPFAR will continue to provide limited above-site TA to the National PrEP and HIV Self-testing Committee. The Committee was organized with support from PEPFAR to develop the policies and to ensure effective implementation. PEPFAR will also support a private clinic in the Accra region operated by the West Africa AIDS Foundation (WAAF) to expand differentiated service delivery options for KP. This is very important given the recent public outcry against the LGBTQI community in Ghana. Lesson and innovations learned through working with WAAF and from the three PEPFAR-supported regions will be incorporated to the national program by the PrEP and HIV Self-testing Committee.

Ghana will strengthen implementation of index testing and adapt successful KP case finding approaches to rapidly improve case finding among the general population, including targeted social networks testing and social media campaigns that have proved effective in reaching and identifying older MSMs. Ghana will also adopt some of the best practices from the MenStar program to engage men in new and innovative ways to break the cycle of HIV transmission. This will include multiple approaches around data analytics and human-centered design to better adapt services to men, nuanced demand creation, and other innovations such as self-testing and PrEP. Ghana's implementing partners will be managed through routine site level granular data reviews, site-level monitoring of target achievement, SIMS, periodic PEPFAR site-level monitoring of quality improvement (QI)/quality assurance (QA) plans, weekly partner reporting, targeted TA to underperforming sites, and identifying and sharing best practices from high-performing sites with other sites.

In **Liberia**, remarkable progress has been made towards meeting the MPRs in ROP20. Test and Start implementation is ongoing at site level. 6MMD has been endorsed and is now being implemented. There are currently no recorded formal or informal user fees being charged at public facilities for access to all direct HIV and related services, among others. National testing guidelines have been revised, validated and approved to include index testing and self-testing as testing modalities. Areas for improvement include TLD transition and VL/EID optimization. In ROP21, efforts will be applied to ensure that progress already made in achieving the MPRs is sustained, monitored and strengthened. More emphasis will be placed on VL optimization, TLD transition, and strengthening data and national commodity/supply chain systems.

In coordination with the NAC, **Senegal** has made significant progress towards meeting the MPRs (see Policy and Implementation Status of Minimum Requirements). Senegal will also expand the case finding and UIC system pilot. PEPFAR will be working with GFATM to ensure that there is one streamlined UIC system in Senegal.

During ROP19 and 20, **Mali** made significant progress in implementation of the MPRs. At the policy level, Test and Start, index testing, DSD and MMD, and transition to TLD are being implemented, marking an important step toward greater impact of PEPFAR investments. In ROP19, implementation of these minimum requirements was not widespread outside of PEPFAR-supported sites. ROP21 will be focused on the implementation nationally at scale of MPRs, to ensure that all Malians have access to high-quality and client-centered health services. While Mali eliminated formal user fees for all HIV services, PEPFAR continues to receive reports of informal user fees. Additionally, clients may revert to the private sector when public facilities are unable to provide services due to stock-outs. In ROP21, the PEPFAR program will continue to work with CSOs, GFATM, and UNAIDS to sustainably address the elimination of user fees, advocating at all levels to disincentivize this practice, as well as ensuring more effective stock monitoring so that clients may access services in the public sector for free. At the above-site level, Mali continues its progress in implementing the use of UICs for patient tracking in PEPFAR sites, with national expansion planned for ROP21. For the laboratory optimization minimum requirement, the assessment was completed in the first half of ROP19, and an action plan ready for implementation is expected by ROP21.

In **Sierra Leone**, PEPFAR will work with other stakeholders to strengthen the supply chain. PEPFAR will continue to collaborate with GFATM as part of a shared National response. TLD transition, DTG 10, and 6MMD will all be accelerated and expanded under PEPFAR. The Gates Foundation-funded CQUIN initiative is placing a full-time technical focal person in Sierra Leone to spearhead differentiated service delivery progress, and PEPFAR will collaborate with and leverage this resource. The need for physical distancing caused by COVID-19 gave a boost to many of these differentiated service delivery options.

4.5 Commodities

Limited capacity and resources for public health supply chain systems and commodities cause West African governments to be heavily dependent on external donors for support. Site-level stockouts are frequent and major supply chain reforms are underway to improve public health supply chain systems, targeting reforms to areas including commodity planning and distribution. Across all countries in the West Africa Regional program, improvement in supply chain management and information systems is critical to completing the TLD transition and rolling out MMD and ensuring consistent availability of ARVs and other HIV commodities. Supply chain strengthening (forecasting, quantification, management of supply chain information systems, and early warning systems) will continue to be an area of emphasis in all countries in ROP21. PEPFAR will work closely with the GFATM to advocate for increased domestic investment by host country governments, particularly into commodity purchases.

In **Burkina Faso,** the national commodity security and supply chain management systems (financing, quantification, forecasting, and distribution) must be strengthened to ensure complete transition to TLD and 6MMD, and to ensure access for PLHIV to appropriate ART (TLD for all PLHIV > 30kg, complete removal of all Nevirapine). Currently, the national warehouse does not have data on ARV consumption, so the PEPFAR program will provide support and supervision to the MoH on the use of a Logistics Management Information System (LMIS) to inform accurate reporting of commodity consumption. During ROP20, the TLD transition policy was adopted, which led to a TLD transition rate of 49 % as of end of FY21 Q2. The program has achieved full

elimination of suboptimal ART regimen, such as nevirapine-based regimen. Building on the successes from ROP20, the PEPFAR Team in Burkina Faso will continue to support health facilities to maintain high TLD transition rate in PEPFAR-supported sites. As of the end of FY21 Q2, the number of patients on MMD refill schedule accounted for 96% of patients on ART, of which 51% were on 3MMD and 44% on 6MMD. With ROP21 resources, the efforts will also be geared towards ensuring continuous availability of sufficient stock of commodities at facility levels to support expansion of 6MMD to a larger number of patients.

In order to address the ROP21 priorities highlighted for **Burkina Faso**, the country team will adopt a two-pronged approach as the strategy to strengthen supply chain functions: (i) at central level, this will include a stronger coordination with GF for improved quantification, supply plan monitoring; (ii) at health facilities/Services Delivery points, this will consist of improving last mile logistics and increased support for production of routine logistics data, ensuring data visibility to drive program performance with data triangulation; monthly supply chain performance review monitoring (TLD uptake; MMD implementation, Stock-level). Deep-dive analysis at site level will be conducted to identify specific supply chain issues and fix them. PEPFAR/Burkina Faso will also work with implementing partners to implement a coaching and mentoring supply chain workforce program on preventing stock-out of HIV commodities (inventory management; LMIS). A rigorous virtual site-visit plan focusing on problem-solving approach will be developed and implemented. PEPFAR/Burkina Faso also works with the other stakeholders to address the additional logistics challenges associated with COVID-19.

In **Togo**, PEPFAR adjusted its supply plan to purchase HIV test kits, TLD and VL reagents in ROP20 to address concerns about gaps in RTK stock and other HIV commodities. Since ROP20, PERFAR team has provided TA to MoH to better manage the supply chain stock to prevent stockouts. This support includes training on forecasting and quantification tools. The first TLD shipment arrived in January 2020 and the program was able to achieve a satisfactory TLD coverage of 84% as of end FY21Q2. This achievement is the result of improved supply planning and greater visibility of TLD stock. Availability of monthly consumption data has improved significantly. PEPFAR support aims to work with the government and GFATM to address these issues. At the end of FY21 Q1, the number of patients on MMD refill schedule accounted for 90% patients (of which 78% on 3MMD and 12% on 6MMD) in PEPFAR-supported sites. This data suggests the need to increase the proportion of patients on 6MMD. ROP21 investments in supply chain strengthening will help tackle the following challenges: sub-optimal last mile logistics management; limited availability of logistics data (electronic dispensing tool (EDT) not optimally used on non-PEPFAR sites); recurrent shortage of critical HIV commodities in health facilities, thus hindering program performance; insufficient coordination of procurement across funding sources. To address those challenges, the following interventions will be carried out: i) provide support for re-design and implement an adaptive last mile logistics system to suit program needs; ii) work on systems interoperability: EDT and DHIS2; iii) continue systematic and periodic review meetings to update supply plan and anticipate shipments delays; iv) conduct site-level supply chain dashboard review and data triangulation (logistic vs. clinical data); v) reinforce collaboration/communication with GFATM Procurement and Stock Management (GAS) team to proactively tackle procurement and supply planning issues.

Benin: For this first year of PEPFAR support, the investments in supply chain strengthening will complement the ongoing efforts provided by the GFATM. Similar to Burkina Faso and Togo, the PEPFAR team in Benin will collaborate with other stakeholders to address ROP21 supply chain-related priorities highlighted for Benin namely: strengthening the overall supply chain (Data

visibility and data use for decision making; 6MMD, full TLD transition) and contributing to procurement of HIV commodities (HIV RTKs, HIV self-tests, TLD, DTG, ARVs for PrEP, and VL reagents). More specifically, the interventions will consist of the following: (i) at central level - stronger coordination with GFATM for improved quantification, supply plan monitoring; (ii) at PEPFAR-supported health facilities/service delivery points: improvement in last mile logistics and increased support for production of routine logistics data, data visibility to drive program performance with data triangulation; and monthly supply chain performance review monitoring (TLD uptake; MMD implementation, Stock-level). A site-level deep-dive analysis will be conducted to identify specific supply chain issues to be addressed. The country team will also work with partners to implement a coaching and mentoring supply chain workforce program to prevent stock-out of HIV commodities (inventory management and LMIS). A rigorous site-visit plan focusing on problem-solving approaches will be developed and implemented. PEPFAR also works with the other stakeholders to address the additional logistics challenges associated with COVID-19.

Ghana has already improved forecasting and supply planning to meet the challenges of the 95-95-95. Ghana will continue to support system improvements for forecasting and supply planning for Ghana's TLD transition. In ROP21, PEPFAR will provide TA to optimize supply chain activities at the national and regional level. Activities will improve data visibility, coordination, last mile distribution, and forecasting and supply planning. Activities will also build the capacity of the supply chain workforce at the site level in the Western, Western North and Ahafo regions. The GFATM capped its commitment to fund the cost of commodities to a maximum of 125,000 PLHIV on treatment. As the number of PLHIV on treatment continues to increase, the cost of commodities supply will increase, which means the GoG will need to increase financial resources to pay for the additional supply needs. The PEPFAR/Ghana team will continue to coordinate with the GFATM to advocate for a firm commitment by the GoG to avoid any vulnerabilities in this area.

Similar to other West African countries, **Liberia** faces periodic stockouts of HIV commodities at site level which are a major concern. Liberia is highly dependent on the GFATM which funds 100% of HIV commodities. Supply chain strengthening (forecasting, quantification, management of supply chain information system, logistics, and early warning system) will continue to be an area of emphasis with close coordination and collaboration between the GFATM, Government of Liberia, and USG. In ROP21, PEPFAR has increased support to supply chain strengthening due to program expansion and because of existing critical gaps in the country. Additionally, PEPFAR has also allocated $71,000 for condom procurement, which will increase in-country supply of condoms and help address the existing need. PEPFAR aims to support national efforts that will enhance domestic resource mobilization for future Government of Liberia HIV contributions.

In **Senegal,** VL tests are not conducted for all eligible patients, and results are not communicated in a timely fashion. PEPFAR/Senegal aims to create "centers of excellence" among PEPFAR sites by ensuring that VL commodities are available, both for standard VL testing machines for high-turnover sites and for point-of-care equipment at low-turnover sites and for EID for those children of KP referred through index testing. Purchase of commodities will be informed by the implementation of a sample transport network system and lab optimization efforts. Supply chain strengthening (forecasting, quantification, management of supply chain information system, and early warning system) will continue to be an area of emphasis with close coordination and collaboration between the GFATM, Government of Senegal, and USG.

In ROP21, PEPFAR/**Mali** will purchase PrEP commodities and RTKs. The inclusion of PrEP in the prevention package for KP has been limited in Mali, with procurement limited to pilot programs. PEPFAR will purchase PrEP commodities to ensure availability at PEPFAR-supported sites for at-risk KP and sero-discordant couples. In ROP19, Mali experienced RTK stockouts, which affected program performance, especially at PEPFAR sites. Therefore, the program has planned to purchase RTKs to address concerns about gaps. For STI drugs, PEPFAR will closely coordinate with the GFATM to ensure the drugs availability at site. PEPFAR will also support TA for supply chain strengthening (forecasting, quantification, management of supply chain information and logistics, and early warning systems), in close coordination with the GFATM and the MoH.

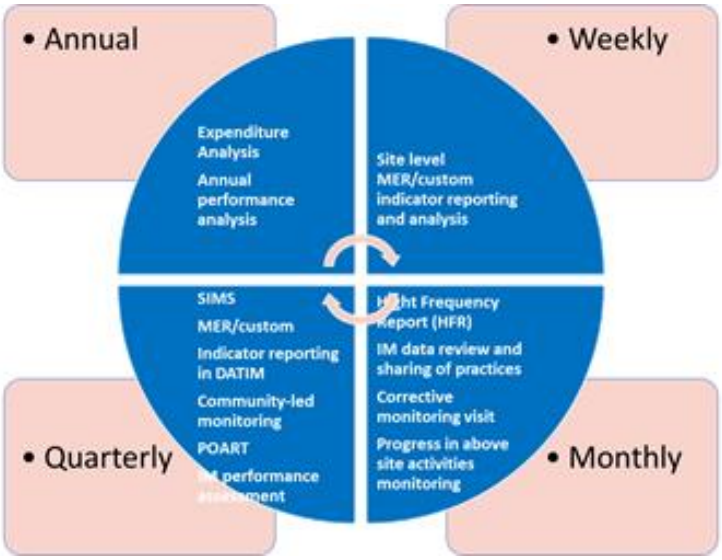
In **Sierra Leone**, commodities, funded entirely by GFATM, are routinely available, and improvements have been seen with quantification. PEPFAR will continue efforts to assure reliable availability of all commodities

At the **Regional level,** PEPFAR investments will support WAHO to improve regional visibility on HIV commodities, building on other initiatives in the region. This will lead to increased end-to-end supply chain visibility by transforming dispersed data across multiple systems into a single, flexible platform. In addition, PEPFAR will work with WAHO to conduct deep dive analyses across PEPFAR countries to map supply chain challenges due to COVID-19, in order to prioritize effective supply chain interventions and approaches as part of a regional supply chain strategy.

4.6 Collaboration, Integration. and Monitoring

Cross Technical Collaboration with external stakeholders: PEPFAR is closely collaborating with the MoH as well as GFATM and UNAIDS on all aspects of programming in the eight PEPFAR-supported countries in the West Africa Region. With a relatively small HIV national response in all the countries in West Africa, all resources must be closely coordinated and targeted. UNAIDS plays an important role of coordination and support for CSO engagement, while GFATM contributes most of the commodities and critical implementation support to all aspects of the response. Through the various forums at country level, (including PEPFAR Steering Committees, CCMs, and regularly held PEPFAR review meetings), technical collaboration with stakeholders will continue to play an essential aspect of cooperation.

Implementing Partner Management: Implementing partners will be managed through routine site-level monitoring of target achievement, monthly PEPFAR site visits (virtual and in-person - where COVID-19 restrictions allow), weekly partner reporting, targeted TA to underperforming sites, and identifying and sharing best practices and innovative strategies from high-performing sites with other sites across the region. High Frequency Reporting, a monthly reporting of country datasets requested by USAID's Office of HIV/AIDS, will be used to track results in real time, using the data as an early identifier of gaps and concerns to allow for course correction.



Health Systems Interventions: Significant health system weaknesses exist across West Africa. With the limited resources, PEPFAR will support the strengthening of the following areas:

1. Adoption and implementation with fidelity of critical policies that will support best practice implementation, such as Index Testing and MMD
2. HIV service delivery with a specific emphasis on treatment and laboratory optimization and increasing efficiency and quality of service delivery through DSD
3. Supply chain and information management system strengthening and supply chain training to host governments to ensure reliable access to life-saving HIV commodities
4. HRH capacity-building through training, corrective supervision and recruitment of staff for PEPFAR-supported health facilities
5. Health information reinforcement through support to DHIS2
6. Expansion of UIC systems to improve individual-level and system-level data tracking for better decision making, and ensure patients are accurately tracked and resources are effectively managed
7. Targeted above service delivery activities to ensure they address key barriers to reaching epidemic control
8. Advocacy to host country governments to increase domestic resources for HIV services and, where relevant with non-PEPFAR funding (namely in Ghana and Senegal), support for the expansion of social health insurance to help defray healthcare costs for the most vulnerable

Community-Led Monitoring: CSOs are foundational partners to PEPFAR's HIV response and are critical to PEPFAR achieving its ambitious goals. In ROP21, all countries will make direct awards for community-led monitoring to local CSOs, with established reporting systems to both host country governments and PEPFAR.

Community-led monitoring is built on the existing observatory of human rights by the community and CSOs. It will include: (i) monitoring of policy implementation (index testing, Test and Start, MMD, TLD Transition, elimination of informal user fees); (ii) Mystery Client surveys; (iii) routine

data collection regarding quality of HIV services; (iv) monitoring of discrimination/stigmatization cases; and (v) monitoring of corrective action implementation. The findings will be used for advocacy with national and regional stakeholders and to improve the PEPFAR program in the West Africa Region.

Burkina Faso and Togo will continue implementation of community-led monitoring in ROP21 through quarterly mystery client surveys and routine data collection conducted by CSO and PLHIV associations. The surveys will collect data on availability of services, client satisfaction, user fees, waiting times, implementation with fidelity of Test and Start, and TLD transition. Findings will continue to be disseminated, bottlenecks identified and corrective actions implemented to improve the quality of services to PLHIV. **Benin** will develop its community-led monitoring platform at PEPFAR-supported sites in ROP21, building on existing platforms managed by the PLHIV network and CSO.

Ghana is currently implementing a rigorous system to monitor the quality of service provision across all facilities in the Western region. The core component of the system is a CQI approach called Monitoring for Impact. The approach uses monthly results across the three 90s to monitor yield from different entry points, linkage, index testing quality, continuity of treatment, VL, etc. Key staff from the health facility meet every month to discuss the results, identify issues, and recommend actions to address them. Starting in ROP21, **Ghana** will continue to utilize local CSOs to conduct community-led monitoring in areas of operation to provide additional data to improve the effectiveness and quality of service delivery. Local organizations will use a mix of approaches, such as mystery clients and community score cards. PEPFAR will work with the leadership of the Ghana Health Service and the Commission on Human Rights and Administrative Justice to address issues related to human rights abuses at the facility level as necessary. Community-led monitoring will be coordinated through USAID with a planned award to a local organization.

Liberia will ensure continued support to the implementation of community-led monitoring interventions through CSOs. Liberia increased the allocation for community-led monitoring to accommodate new geographic areas in ROP21. This level of monitoring will focus on client satisfaction, establishing communication channels for clients to take advantage of, and ensure there is a feedback/mitigation mechanism which addresses issues raised by clients from an access-to-service standpoint. Community monitoring through CSOs will cover all PEPFAR-supported sites in ROP21 and results will be used to improve treatment outcomes for HIV clients and shared regularly with major stakeholders.

Senegal and **Mali** will continue to ensure rapid-roll out of required small grants for community-led monitoring. In Mali, CLM will be awarded to the local CSO. PEPFAR staff will meet regularly with CSOs to identify any emerging issues and implement a follow-up or remediation plan.

Unique Identifier Codes and **e-Tracker:** All countries in West Africa have adopted UICs. In some countries, national scale-up is underway. In **Burkina Faso** and **Togo**, a patient e-Tracker system that covers services from prevention to treatment and VL suppression data has been established at PEPFAR sites and provides better quality program data. In ROP21, the e-Tracker will be scaled up nationally in collaboration with the GFATM. Similar to Burkina Faso and Togo, **Benin** will deploy the e-Tracker system at PEPFAR-supported sites to track individual client interventions and effectively report quality data. Through the use of e-Tracker, **Ghana** adopted a unique identifier system effective August 2019 for all ART clients. In FY21, Ghana Health Service, with support from GFATM and PEPFAR, will implement a testing module in the -Tracker that will assign a unique

identifier starting at testing, helping to deduplicate repeat tests. Discussions are ongoing regarding a unique identifier that works across the entire healthcare system, regardless of disease type. In **Senegal,** PEPFAR will support the continued roll-out of the case-based surveillance system, SENCAS, to all sites, with integration of a laboratory information system. **Sierra Leone** has a unique identifier for HIV clients but is not functioning in any productive way, and PEPFAR will continue exploring solutions for a reliable UID as well as improvements to existing poor documentation systems. SIMS helped illuminate the documentation problems early, and PEPFAR/Sierra Leone is consulting across the West Africa Region for best practices with UIC and client level documentation.

4.7 Targets by population

The targets for the following three tables should be generated from DATIM, a "COP20 Target Table Favorites" will be available:

Standard Table 4.7.1

Table 4.7.1 ART Targets by Prioritization for Epidemic Control							
Prioritization Area	**Country**	**Total PLHIV**	**Expected current on ART (APR FY21)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY21) *TX_CURR***	**Newly initiated (APR FY21) *TX_NEW***	**ART Coverage (APR 21)**
Attained	Togo (Lomé)	54,955	46,084	-	25,805	2,833	>100%
Scale-Up Saturation	Burkina Faso	69,290	53,890	1542	39,370	4,551	32%
	Togo	42,377	29,293	4609	23,118	4,043	73%
	Benin	41,462	20,480	12,690	23,732	3,738	
	Ghana	29,685	19,995	3,753	24,096	4,574	81%
Scale-Up Aggressive	Liberia	Liberia	39,414	10,953	4,737	15,690	55%
	Mali	Mali	94,484 (a)	56,071(a)	19,516	38,078 (b)	45%
	Senegal	Senegal	12,448 (b)	1,362	392	2,330	>100%
	Sierra Leone	73,870	14,840	14,117	7,044	2,384	47.6%
Total		**236,012**	**188,442**	**42969**	**127,554**	**29,609**	**54%**

Standard Table 4.7.2 - N/A to West Africa

Standard Table 4.7.3

Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control				
Country	**Target Populations** [Specify target populations for focus, e.g. AGYW] *Indicator Codes include PP_PREV and KP_PREV*	**Population Size Estimate** **(SNUs) and disease burden**	**Coverage Goal** **(in FY22)**	**FY21 Target**
Burkina Faso	MSM	4,602	82%	2,650
	FSW	12,850	100%	11,475
	Total	**17,452**	**%**	**14,125**
Togo	MSM	8,920	83%	5,403
	FSW	19,379	66%	6,800
	Total	**14,356**	**85%**	**12,203**
Benin	MSM	**6342**	**39%**	
	FSW	**17,594**	**40%**	
	Total	**23,936**	**40%**	
	MSM	6,699	88.8%	5,949 (KP_PREV)

Ghana	FSW	20,243	43.3%	8,769 (KP_PREV)
	Total	**26,942**	**54.6%**	**14,718 (KP_PREV)**
Liberia	KPLHIV	9,000	81%	6,300
	Total	**9,000**	**70%**	**6,300**
Mali	MSM	**6,732** (849 PLHIV)	95%	419 (TX_NEW)
	FSW	**26,932** (2,345 PLHIV)	95%	1,184 (TX_NEW)
	Total	**33,664 (3,194 PLHIV)**	**27.8%**	**1,698**
Senegal	MSM	8,325	59%	4,900
	FSW	5,754	68%	3,920
	Total	**14,079**	**63.5%**	**8,820**
Sierra Leone	MSM	20,000	**3%**	1,076 (KP_PREV)
	FSW	240,000	**0.8%**	4,500 (KP_PREV
	Total	**260,000**	**1%**	**5,576**

Standard Table 4.7.4

N/A to West Africa

4.8 Cervical Cancer Program Plans

N/A to West Africa

4.9 Viral Load and Early Infant Diagnosis Optimization

Major improvements are necessary in the national VL and EID systems across the West Africa Region to improve national lab policies and lab capacity to reach targets for VL testing for patients currently on treatment and EID testing is conducted in a timely manner. Extensive work on laboratory optimization has been undertaken in **Burkina Faso, Togo, Ghana, and Mali**, and other countries in the West Africa Region have begun adopting appropriate policies to ensure access to VL testing and timely receipt of results to improve adherence and increase early detection of treatment failure. Plans for optimization activities have already begun throughout the region to survey what resources and VL commodities currently exist, and to identify challenges and solutions. TA, HRH training on VL test results usage, monitoring of VL testing access at the site level, and lab data management will all be scaled up to address the challenges with VL testing coverage in the region.

PEPFAR/Burkina Faso and Togo have been supporting viral load testing scale up in ROP20. However, results are not yet at the expected level. In Togo, the viral load testing coverage proxy increased at PEPFAR supported sites, from 35% in FY20 Q1 (DATIM data) to 58% in F21 Q2 (preliminary program results). The main challenges are related to: (i) deficiencies in supply chain management, (ii) insufficient human resources, (iii) inadequate national coordination and monitoring of stakeholders' commitments, and (iv) competing involvement of some HIV labs in COVID-19 testing (mainly in Burkina Faso). In ROP21, PEPFAR will support : (i) implementation of the national viral load plan, (ii) intensification of VL demand creation and results use (patient education with CSO support, U=U messaging, coaching and supportive supervision to health care workers, enhanced adherence support), (iii) VL commodities supply chain management (quantification, procurement, and stock management), (iv) lab information system management with better interface labs-sites, (v) sample referral and results use, and (vi) better national coordination and monitoring of key stakeholders commitments. To implement those interventions, $622,471 (including $222,471 for VL commodities) was budgeted for viral load and EID in Burkina Faso and $983,160 (including $483,160 for VL commodities) in Togo.

In **Benin**, the MoH has already identified some equipment and VL commodity gaps. PEPFAR plans to do a deep dive analysis of the VL testing situation and identify gaps for funding at clinical sites and labs. Emphasis will also be made on demand creation and use of VL test results, sample transportation and results return, as well as lab capacity strengthening. Existing points of care will also be solicited to facilitate access to EID. For ROP21, PEPFAR has budgeted $ 255,000 for viral load and EID activities including $150,000 for VL reagents and consumables procurement.

Ghana has sustained integrity of the VL system since ROP18 with consistent use of the VL sample referral and transportation system, but VL coverage continues to lag. In ROP21, PEPFAR will support expansion of the VL data management system following a successful pilot in ROP19. The Viral Load Data Management which allows for electronic transmission of results from PCR

Analyzer to the e-Tracker will be expanded to cover all sites in Western, Western North and Ahafo regions. Additionally, hub and spoke sites will be created for the Western North and Ahafo Regions and mapped to the new Testing Lab at the Bono Regional Hospital in Sunyani, Refresher trainings, and monitoring and corrective action visits to VL testing sites will be undertaken and both testing labs in Takoradi and Sunyani will support all VL and EID needs of Western Region, with the laboratory at Korle-Bu serving as a backup.

In **Liberia**, rates of VL testing coverage and suppression are low. GFATM currently supports the majority of VL activities in-country through a comprehensive VL/EID improvement plan. This includes: updates to SOPs and registers, costing studies for sample transport, improved forecasting and quantification of reagents, improved laboratory information systems and quality management through NACP capacity building, equipment maintenance, and M&E frameworks. In ROP21, PEPFAR will support the VL sample transportation system, results turnaround time, supply chain TA, improved monitoring and analysis of VL data at all levels, and site-level follow up to ensure all eligible patients at PEPFAR-supported facilities receive EID and VL results. The total PEPFAR budget plans for supporting VL/EID access is $337,000.

In **Mali,** the PEPFAR team will provide TA to the Government of Mali for lab infrastructure and technical capacity strengthening to facilitate optimization of VL diagnostics, VL sample referral and logistics, dried-blood-spot training for clinical and lab personnel, and development of VL policy. Based on the current available point-of-care (POC) instruments across the country (30), the program will support better utilization of POC for VL testing/EID at PEPFAR-supported sites. For TB and HIV integration and optimization, existing GeneXpert machines will be used. Advocacy will be done to GFATM and the Government of Mali to provide reagents. A PEPFAR budget of $600,000 is planned to support the access to VL/EID.

In **Senegal**, VL testing and suppression remain a challenge to reaching epidemic control, due to stockouts and misallocation of commodities, high HRH turnover, malfunctioning equipment, and lack of training. These issues reduce demand for VL testing, so in ROP21, PEPFAR interventions aim to routinize VL testing and increase testing demand. PEPFAR/Senegal will procure VL reagents and cartridges and support the creation and dissemination of VL commodity distribution SOPs. Distribution of VL reagents will focus on two high-turnover labs in Dakar and Ziguinchor. The POC cartridges will be focused on sites with low VL testing turnover in rural Ziguinchor, Sedhiou, Kolda, Mbour, and St. Louis. Commodity investments will be coupled with above-site activities for lab optimization, sample network transport systems started by CHAI, and lab information systems. PEPFAR will focus its TA on reinforcing national military labs in Ziguinchor and Ouakam, as other national labs have been plagued by strikes and HRH issues. These military labs have the equipment and consistent personnel to become high-quality VL testing centers. For ROP20, PEPFAR has budgeted $1,493,998 for laboratory systems strengthening, lab commodity procurement, and lab services. In ROP21, PEPFAR has budgeted $1,395,301 for laboratory systems strengthening, lab commodity procurement, and lab services.

PEPFAR in **Sierra Leone** overcame significant obstacles with VL testing capacity in ROP20, including an innovative agreement with a Gates Foundation-funded research program. These are bridge strategies while waiting for the GoSL to restore and expand testing capacity and coverage. CDC will begin providing lab technical support to further bolster coverage under PEPFAR. Sierra Leone will also fully capitalize on its association with seven other operating units in the West Africa Region to gain insights from their successful interventions.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

West Africa Regional countries face several systems barriers challenges that have the potential to hinder the region's progress towards sustained HIV epidemic control. These challenges can be categorized into six main categories:

1. Policy adoption and implementation barriers: implementation with fidelity of Test and Start; DSD models, including 6MMD; index testing; and elimination of informal user fees
2. Health systems challenges: systemic supply chain management and national commodity security issues, resulting in frequent stock-outs, and weak VL systems (laboratory capacity and transportation networks), resulting in long delays in test results and limited VL testing coverage
3. Weak strategic information and surveillance capacity
4. Stigma and discrimination toward PLHIV and KP
5. Lack of sustainable financing of the national HIV response
6. Slow adoption and implementation of prevention activities, through direct PrEP delivery in Ghana and Mali, and policy development in the other six countries.

Policy adoption and implementation barriers: The West Africa Region has made significant progress towards the adoption and implementation of policies with fidelity across all countries, though there are still some gaps that need to be addressed in ROP21. All countries have adopted Test and Start, and continued improvements should be informed through close monitoring. UICs have been adopted across the region, but sites need to be monitored for fidelity. While index testing was adopted in all countries, implementation needs to continue to be strengthened in ROP21. VL/EID policies have been adopted across the countries, but many challenges remain. In **Liberia**, the national policy approving 6MMD was recently adopted in January 2020 but has not yet been implemented. PEPFAR will provide TA to support the implementation of 6MMD within PEPFAR sites and outside of Montserrado County in order to free up over-crowded health facilities, increase retention, and minimize LTFU. In **Mali**, PEPFAR will provide targeted TA to the Government of Mali to monitor a newly implemented VL policy that will ultimately enable the optimization of VL diagnostics and VL literacy. In **Senegal**, while national policies exist for TLD transition, Test and Start, MMD, and support for supply chain systems, national level execution with fidelity is limited. PEPFAR will continue work with the Government of Senegal and GFATM to address key system barriers and strengthen site level, client-centered services.

Health systems challenges: In ROP21, **Ghana's** above-site activities will focus on supply chain strengthening to ensure adequate stocks are available at the site level, data management, quality, training and use. Ghana has a revised three-test HIV testing algorithm; proficiency testing will be undertaken to enhance its reliability and validity, VL testing capacity and systems strengthening including Viral Load Accreditation, creating systems for easy request, test and transmission of VL test results, and sample transport will be supported. The VL data management system will allow for easier and more accurate ordering of tests and electronic transferring of results to ensure there

are no errors and results are available immediately. The sample referral system, with support from GFATM, will provide for timely transport of VL samples to the most appropriate lab.

In **Liberia**, PEPFAR will support the weak national supply chain system to strengthen commodity availability at site-level and will support the roll-out of PrEP to HIV-negative clients found through testing in populations at elevated risk of HIV-acquisition. In **Senegal**, PEPFAR will support the Government of **Senegal** and GFATM to reinforce the supply chain to better manage commodities that are made available by the Government of Senegal and the GFATM. PEPFAR/Senegal will address VL challenges through supporting the availability of reagents and cartridges for POC machines in sites and will work with CHAI to update the lab optimization tool and conduct a comprehensive mapping of VL capabilities. The transition to TLD has started in Senegal, but insufficient TLD procurements have limited MMD. PEPFAR will support more precise quantifications so that six-month MMD can be implemented in all PEPFAR sites. In **Mali**, PEPFAR will invest in LMIS to improve commodity visibility. In **Sierra Leone**, GFATM investments in VL/EID commodities, including to support PrEP, will extend the reach of PEPFAR above-site investments.

Weak strategic information and surveillance capacity: Availability of strategic information is a challenge across all countries in the West Africa Region. Through direct PEPFAR support and close collaboration with GFATM, routine program monitoring and surveillance capacity will be increased through ROP21. In **Burkina Faso and Togo**, PEPFAR will work to improve the quality of granular data to monitor performance and for decision making and improving the quality of services. In ROP19, **Togo** implemented e-Tracker providing robust capacity to monitor site level performance. In **Benin,** PEPFAR will deploy its e-Tracker system based on Togo's best practice and build capacity across supported sites for its optimal use for reporting and decision making. In **Ghana**, GFATM is supporting the implementation of the testing module of e-Tracker, allowing for surveillance opportunities and deduplication of repeat testing. PEPFAR will support training on data entry, analysis, and use to improve programming. In **Senegal**, PEPFAR will support the continued roll-out of the case-based surveillance system, SENCAS, to all sites, with integration of a laboratory information system. In **Sierra Leone**, new national population data and HIV estimates were collected in 2019. GFATM, with TA support from PEPFAR, is funding an IBBSS and population size estimates for FSW, MSM, PWID, and disabled PLHIV, with results expected this summer. CDC will begin providing technical support for SI in FY22.

Stigma and discrimination toward PLHIV and KP: Stigma and discrimination of PLHIV and KP across all countries in the West Africa Region is a known problem. All countries in West Africa will focus on activities to reduce stigma and discrimination through site-level trainings to make facilities KP-friendly. All countries will also address stigma and discrimination as part of community-led monitoring efforts. In ROP 20, PEPFAR supported Stigma Index 2.0 surveys in Togo, Burkina Faso and Senegal with ROP19 funds. Results of this study will be used in ROP21 to strengthen interventions against stigma and discrimination. In ROP21, PEPFAR, along with GFATM, will support implementation of the Stigma Index 2.0 surveys in Mali and Liberia.

Sustainable financing of the national HIV response: While West Africa is not mandated to transition to indigenous partners in ROP20, PEPFAR/West Africa is committed to building the capacity of the many high-performing indigenous partners that currently serve as sub-recipients of PEPFAR funding throughout the region. In addition, local CSOs will be directly contracted to carry out community-led monitoring in all eight countries. The West Africa Regional program will also

proactively collaborate with multilateral stakeholders and encourage host country governments to commit and execute more domestic resources towards HIV programming and commodities.

Adoption and implementation of prevention activities: Direct PrEP delivery will be implemented in all eight West Africa Region countries.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

The following positions for the West Africa Regional program are still under recruitment:

1. **Regional PEPFAR Coordinator** (Resident Hire U.S. Personal Services Contractor [USPSC]): This position was originally the vacant Ghana PEPFAR Coordinator position that has been redefined to play the role for the West Africa Region based in Accra, Ghana.
2. **Regional Laboratory Advisor** (CDC - Locally Employed Staff [LES] or Third Country National): To support VL testing scale up and provide essential laboratory TA throughout the region based in Accra, Ghana. In ROP19, this position was proposed to be based in Senegal, pending the establishment of a CDC regional office.

While these positions are still under recruitment, there are no other long-term vacancies greater than six months. PEPFAR/West Africa has no major changes to the Cost of Doing Business (CODB) in ROP21.

For USAID/West Africa, the Senior HIV Advisor (Third Country National based in Accra) and the Senior Strategic Information Advisor (USPSC based in Accra) are the only two full-time equivalents (FTE) for USAID/West Africa. Existing staff providing partial FTE support to West Africa, based in Accra and Togo, are the Senior Health Systems Strengthening Advisor, the Senior Health Advisor (USAID/West Africa staff based in Togo) and the Project Management Specialist for HIV. Other non-PEPFAR funded staff providing support and oversight are the USDH Regional Health Office Director, the Regional Finance and Budget Specialist, and the CDC/Ghana staff who will provide TA to PEPFAR implementing agencies and partners across all countries in the Region for lab and SI activities.

The following positions are country-specific positions in PEPFAR/West Africa countries:

In **Burkina Faso**, CDC is recruiting a US physician to serve as an HIV Clinical Advisor, focusing on Burkina Faso, but also available to provide support across the West Africa Region. A USAID HIV/AIDS Project Management Specialist (LES) has been newly recruited. In **Togo,** a USAID HIV/AIDS Project Management Specialist (LES) will be recruited in ROP21. The recruitment process will be carried out in this fiscal year.

In **Benin**, USAID received approval to recruit a LES Project Management Specialist (HIV/AIDS). The Specialist will provide programmatic and technical guidance and assist in the development and

management of HIV-related programs. S/he will serve as an in-house subject matter expert on HIV/AIDS and will work in close collaboration with Government stakeholders and other development partners to support a coordinated and strategic approach to various HIV/AIDS-related programming. The recruitment process is underway.

In **Ghana**, USAID received approval to recruit an LES Clinical Care and Treatment Advisor to provide comprehensive expertise in clinical HIV/AIDS services and support, program design, implementation, and monitoring. In FY20, a successful candidate was selected. USAID Ghana is currently recruiting an LES M&E Advisor at 65% FTE, a position which has been vacant since June 2019. USAID is also recruiting a new incumbent for the program management specialist position, which became vacant in June 2020.

In **Liberia,** USAID has on-boarded a full-time HIV Specialist. USAID has also allocated additional funding to accommodate one new technical expert position in ROP21 to support the expansion of the program. HRSA has been approved to hire a USDH and two LES, with one LES potentially in the role of an interagency SI advisor.

In **Mali**, USAID onboarded a full-time LES SI Advisor in FY19. USAID has allocated additional funding to CODB for ROP21 to accommodate additional staff time to the PEPFAR program which is increasing dramatically in size from ROP19 to ROP20. CDC will no longer support staff in the country to work on PEPFAR activities as of March 31 ,2020.

In Senegal, the HIV Specialist has been recruited and on board since January 2021. Non-PEPFAR funded staff providing support and oversight are the USDH Health Office Director and one USAID USDH.

In **Sierra Leone,** HRSA has been approved to hire a USDH and 2-3 LES.

Community-Led Monitoring oversight: Across West Africa, USAID programs will work closely with the Financial Management and Acquisition and Assistance offices to appropriately contract local CSOs to carry out community-led monitoring activities. Existing staff will be assigned as cognizant officers responsible for monitoring development of work plans and implementation of activities in line with USAID oversight regulations. HRSA is pursuing various options for contracting, in consultation with PEPFAR HQ, and will perform monitoring activities consistent with work plans and targets, in addition to close monitoring of expenditures and other activities to ensure compliance with relevant regulations. Site visits will also be conducted to assess the quality of the community monitoring. HRSA will also support the CSOs to help them achieve optimal results.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

		ART Coverage																						Overall ART Coverage
		<01		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
Country	Prioritization	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Burkina Faso	Scale-Up: Saturation	0%	0%	62%	63%	40%	40%	28%	29%	93%	58%	94%	65%	95%	67%	95%	67%	96%	68%	96%	70%	96%	72%	96%	75%	78%
	Non Supported	0%	0%	64%	64%	40%	40%	29%	30%	93%	56%	94%	64%	95%	65%	95%	65%	95%	66%	96%	68%	96%	70%	96%	73%	77%
Benin	Nationally	0%	0%	95%	95%	50%	50%	53%	53%	47%	47%	52%	34%	64%	45%	73%	56%	77%	64%	79%	67%	81%	70%	81%	71%	69%
Ghana	Not PEPFAR Supported	20%	21%	22%	22%	20%	21%	23%	15%	24%	20%	30%	12%	42%	12%	57%	23%	71%	36%	80%	49%	89%	65%	37%	39%	47%
	Scale Up: Aggressive	22%	20%	24%	23%	20%	24%	24%	15%	25%	20%	32%	13%	44%	12%	59%	22%	66%	33%	79%	52%	75%	68%	40%	41%	47%

	Scale-Up: Saturation	18%	20%	21%	21%	18%	19%	23%	18%	25%	18%	29%	13%	40%	13%	50%	21%	57%	33%	56%	31%	63%	56%	24%	26%	40%
Liberia	**Scale Up: Aggressive**	12%	13%	12%	13%	20%	21%	15%	16%	23%	12%	24%	11%	28%	9%	35%	10%	44%	16%	52%	24%	57%	33%	61%	42%	32%
Mali	**Scale Up: Aggressive**	15%	16%	15%	16%	19%	20%	17%	17%	13%	18%	15%	13%	20%	14%	26%	15%	37%	22%	47%	33%	53%	43%	57%	52%	29%
Senegal	**Scale Up: Aggressive**	20%	21%	20%	21%	36%	36%	35%	35%	44%	46%	41%	35%	48%	31%	60%	39%	69%	50%	74%	58%	78%	65%	81%	71%	59%
Sierra Leone	**Scale Up: Aggressive**	17%	18%	17%	18%	11%	12%	22%	15%	30%	13%	39%	15%	49%	19%	58%	27%	64%	34%	67%	40%	67%	46%	17%	18%	37%
Togo	**Attained**	39%	39%	53%	53%	63%	63%	59%	58%	76%	69%	80%	66%	85%	63%	90%	64%	93%	69%	96%	76%	97%	82%	99%	87%	84%
	Not PEPFAR Supported	38%	42%	50%	49%	60%	59%	57%	56%	68%	62%	72%	59%	77%	56%	83%	57%	88%	63%	92%	71%	94%	78%	95%	84%	79%
	Scale-Up: Saturation	31%	32%	42%	41%	53%	52%	48%	48%	54%	52%	59%	49%	64%	46%	71%	48%	77%	53%	82%	61%	85%	68%	86%	75%	69%

APPENDIX B – Budget Profile and Resource Projections (Update from PAW Dossier)

B1. ROP21 Planned Spending in alignment with planning level letter guidance

Table B.1.2 COP21 Budget by Program Area

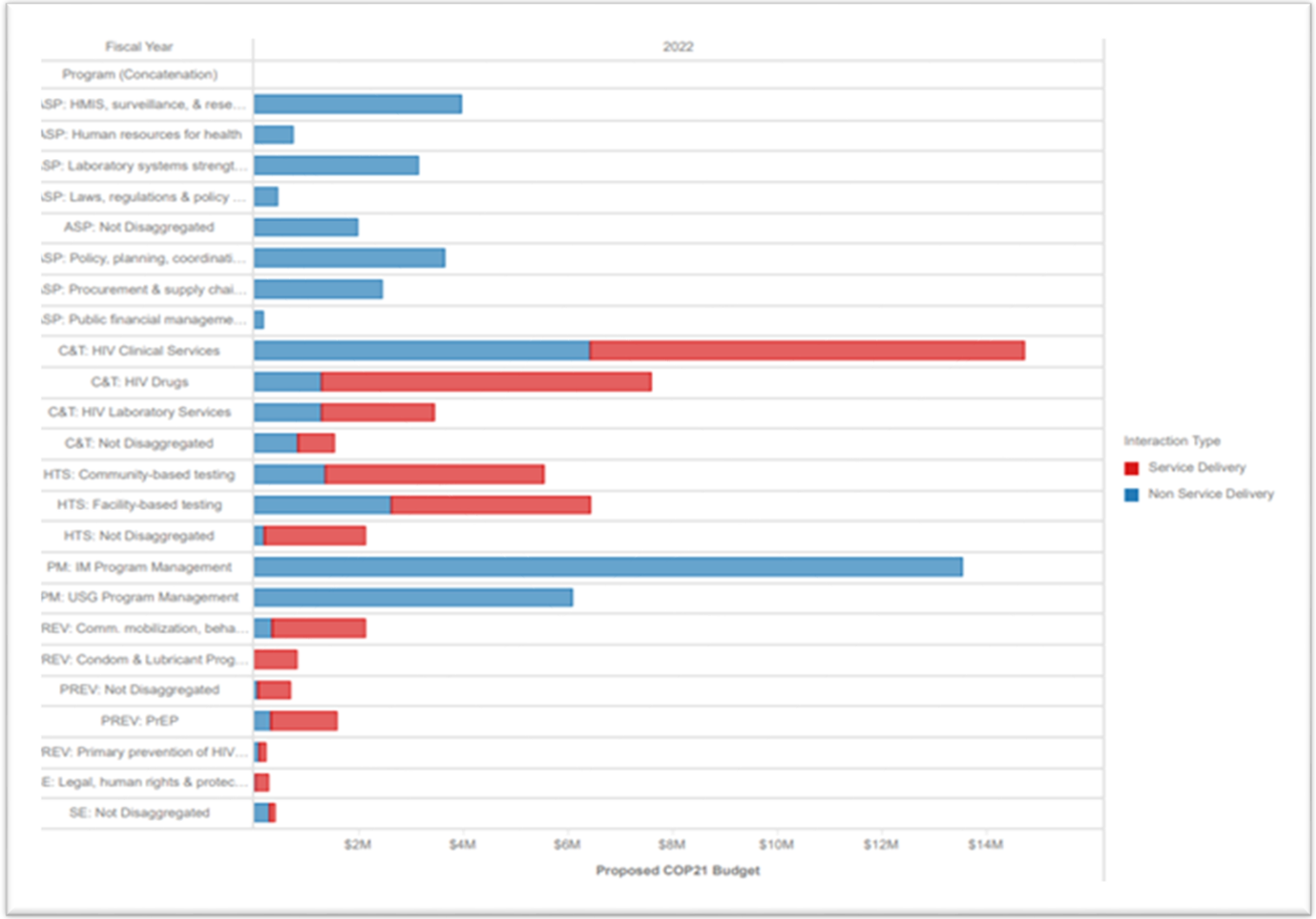


Table B.1.2 ROP21 Budget by Program Area

	Metrics	Proposed COP21 Budget			Percent of COP 21 Proposed Budget		
	Subprogram	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$51,245,936**	**$32,333,976**	**$83,579,912**	**61.31%**	**38.69%**	**100.00%**
C&T	**Total**	**$9,824,275**	**$17,441,120**	**$27,265,395**	**36.03%**	**63.97%**	**100.00%**
	HIV Clinical Services	$6,420,003	$8,301,912	**$14,721,915**	43.61%	56.39%	**100.00%**
	HIV Drugs	$1,279,750	$6,310,555	**$7,590,305**	16.86%	83.14%	**100.00%**
	HIV Laboratory Services	$1,278,522	$2,151,881	**$3,430,403**	37.27%	62.73%	**100.00%**
	Not Disaggregated	$846,000	$676,772	**$1,522,772**	55.56%	44.44%	**100.00%**
HTS	**Total**	**$4,174,158**	**$9,908,866**	**$14,083,024**	**29.64%**	**70.36%**	**100.00%**
	Community-based testing	$1,368,609	$4,158,018	**$5,526,627**	24.76%	75.24%	**100.00%**
	Facility-based testing	$2,608,608	$3,817,152	**$6,425,760**	40.60%	59.40%	**100.00%**
	Not Disaggregated	$196,941	$1,933,696	**$2,130,637**	9.24%	90.76%	**100.00%**
PREV	**Total**	**$820,053**	**$4,614,098**	**$5,434,151**	**15.09%**	**84.91%**	**100.00%**
	Comm. mobilization, behavior & norms change	$334,982	$1,798,988	**$2,133,970**	15.70%	84.30%	**100.00%**
	Condom & Lubricant Programming		$817,168	**$817,168**		100.00%	**100.00%**
	Not Disaggregated	$79,750	$611,048	**$690,798**	11.54%	88.46%	**100.00%**
	PrEP	$314,321	$1,266,894	**$1,581,215**	19.88%	80.12%	**100.00%**
	Primary prevention of HIV and sexual violence	$91,000	$120,000	**$211,000**	43.13%	56.87%	**100.00%**
SE	**Total**	**$301,638**	**$369,892**	**$671,530**	**44.92%**	**55.08%**	**100.00%**
	Legal, human rights & protection	$6,415	$270,002	**$276,417**	2.32%	97.68%	**100.00%**
	Not Disaggregated	$295,223	$99,890	**$395,113**	74.72%	25.28%	**100.00%**
ASP	**Total**	**$16,512,207**		**$16,512,207**	**100.00%**		**100.00%**
	HMIS, surveillance, & research	$3,961,953		**$3,961,953**	100.00%		**100.00%**
	Human resources for health	$743,000		**$743,000**	100.00%		**100.00%**
	Laboratory systems strengthening	$3,131,208		**$3,131,208**	100.00%		**100.00%**
	Laws, regulations & policy environment	$442,000		**$442,000**	100.00%		**100.00%**
	Not Disaggregated	$1,974,320		**$1,974,320**	100.00%		**100.00%**
	Policy, planning, coordination & management of disease control programs	$3,625,867		**$3,625,867**	100.00%		**100.00%**
	Procurement & supply chain management	$2,453,859		**$2,453,859**	100.00%		**100.00%**
	Public financial management strengthening	$180,000		**$180,000**	100.00%		**100.00%**
PM	**Total**	**$19,613,605**		**$19,613,605**	**100.00%**		**100.00%**
	IM Program Management	$13,535,334		**$13,535,334**	100.00%		**100.00%**
	USG Program Management	$6,078,271		**$6,078,271**	100.00%		**100.00%**

Table B.1.3 COP21 Total Planning Level

Metrics	Proposed COP21 Budget		
Operating Unit	Applied Pipeline	New	Total
Total	**$4,450,615**	**$79,129,297**	**$83,579,912**
West Africa Region	$4,450,615	$79,129,297	**$83,579,912**

Table B.1.4 ROP21 Resource Allocation by Program and Beneficiary

Fiscal Year	2022													
Program	C&T		HTS		PREV		SE		ASP		PM		Total	
Beneficiary	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total
Total	**$2,278,191,704**	**100%**	**$311,565,054**	**100%**	**$596,449,699**	**100%**	**$296,471,913**	**100%**	**$358,438,638**	**100%**	**$906,643,441**	**100%**	**$4,739,760,449**	**100%**
Females	$70,523,797	3%	$2,175,591	1%	$177,658,863	30%	$92,577,645	31%	$5,990,225	2%	$9,785,250	1%	**$358,711,371**	**8%**
Key Pops	$76,493,163	3%	$59,049,439	19%	$90,732,083	15%	$3,549,750	1%	$18,872,454	5%	$2,432,120	0%	**$251,129,009**	**5%**
Males	$60,976,835	3%	$9,536,018	3%	$157,090,947	26%	$1,500,000	1%	$453,347	0%	$14,000	0%	**$229,571,147**	**5%**
Non-Targeted Pop	$1,959,347,538	86%	$207,491,652	67%	$100,833,722	17%	$13,470,396	5%	$321,577,984	90%	$869,748,839	96%	**$3,472,470,131**	**73%**
OVC	$8,514,260	0%	$5,045,119	2%	$15,971,997	3%	$180,468,828	61%	$2,998,470	1%	$11,904,410	1%	**$224,903,084**	**5%**
Pregnant & Breastfeeding Women	$61,567,600	3%	$14,715,993	5%	$11,989,849	2%			$1,555,385	0%			**$89,828,827**	**2%**
Priority Pops	$32,768,511	1%	$13,551,242	4%	$42,172,238	7%	$4,905,294	2%	$6,990,773	2%	$12,758,822	1%	**$113,146,880**	**2%**

B.2 Resource Projections

To achieve the specific goals laid out for each of the countries in the West Africa Region, the PEPFAR teams reviewed the current epidemiology, ROP20 performance, and the current funding availability across donors and host-country governments. All countries, except **Benin**, carried out expenditure reporting in FY20 and worked closely with implementing partners to review expenditures for the first few months of FY21. For each country, the team analyzed what resources would be required to achieve the specific objectives and targets outlined in the ROP21. Where there is robust GFATM and host-country government support, PEPFAR will focus on specific target populations and catalytic points.

APPENDIX C – Tables and Systems Investments for Section 6.0 (Not Required)

APPENDIX D– ROP 2021 Minimum Program Requirements

Minimum Program Requirement	Status and issues hindering Implementation
Care and Treatment	
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Test and Start has been adopted across all 7 ROP20 West Africa Region countries, and countries are making progress toward >95% linkage for all groups. Progress in full implementation of Test and Start and higher linkage beyond PEPFAR sites, particularly for KPs, are more challenging due to stigma and discrimination in the region.
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.	The TLD transition made rapid progress in FY20, with improvements forecasted in FY21 as new ARV orders are filled with TLD instead of legacy regimens. NVP-based regimens have generally been eliminated, and teams will focus on adoption of DTG-based regimens for pediatrics in ROP20.
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.	In FY20, the West Africa Region significantly accelerated the roll out of MMD, particularly in the final 2 quarters. In FY21 and beyond, dispensing must increase from 3-month to 6-month for most patients. Decentralized drug distribution also increased throughout the year, and peer-led services to improve services for KPs scaled up.
4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated	n/a – no TPT services in the West Africa Regional Program

into the HIV clinical care package at no cost to the patient.	
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.	VL/EID optimization remains a challenge across the West Africa Region; ROP20 activities are focused on improving reagent availability, sample transportation systems, and data systems needed to return results within 4 weeks. Significant progress still needs to be made to make viral load and EID access universally available across the region.
Testing	
1. 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.	Index testing has been rolled out across the region, and sites have undergone the required evaluations and remediations for safe and ethical index testing. Now that improvements have been made and training has been conducted, countries should rapidly scale up index testing to increase the proportion of new positives identified via index testing. Self-testing pilots have started in several countries, but policies need to be further pushed for at the national level. All countries have policies in place to test all children with an HIV-positive biological parent.
Prevention and OVC	
1. 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*)*	PrEP policies have now been adopted in each country, an improvement since the start of ROP19. Most countries started PrEP programs during ROP19, some supported by PEPFAR and others supported by the Global Fund or other donors. Sierra Leone will be rolling out PrEP for the first time in CY21.

2. 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 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV	n/a – no OVC activities in the West Africa Regional Program
Policy & Systems	
1. 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.	Policies to eliminate formal and informal user fees are now in place in all 7 countries, and community groups are monitoring in-country implementation. Most countries in West Africa charge nominal fees to all citizens for basic health services ($1-2/year), and surveys are underway to monitor these costs and ensure they are not a barrier to clients receiving HIV-related services.
2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.	CQI practices began with the formalization of the West Africa Region in ROP19, and are now included in ROP20 IP work plans. SIMS visits are used to monitor quality of service delivery.
3. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to	Viral load and treatment literacy activities are now being undertaken in most countries in the region, including messaging around the TLD transition and U=U. Sierra Leone, being new to PEPFAR, has the most room for improvement. Stigma continues to be pervasive throughout the region.

reduce stigma and encourage HIV treatment and prevention.	
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Many local, indigenous partners are sub-recipients to PEPFAR IPs, but capacity of local organizations to serve as prime partners needs to be further developed. The roll out of community-led monitoring activities in ROP20 will allow direct local funding for the first time in many countries in the region. In ROP21, countries should aim to add local partners where possible and increase the overall percentage of funds going to local vs. international partners.
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	Within the region, Liberia, Burkina Faso, and Togo provide the highest relative proportion of funding toward their HIV responses. Political will, in the form of increased funding for HIV, continues to lag in Ghana. Political instability and security concerns in both Mali and Burkina Faso pose a threat to these countries' abilities to increase health investments in the near future. The impacts of the COVID-19 pandemic threaten the ability of host-country governments to increase or even meet their budgets for the HIV response.
6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Morbidity and mortality outcomes were monitored and reported for the first time in ROP19, and reporting improved throughout ROP19 implementation. The difficulty for some clinicians and case managers to track interruption in treatment (LTFU), primarily due to incorrect contact information, is a threat to complete monitoring and reporting of morbidity and mortality outcomes.
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	The scale-up of unique identifiers has progressed in all countries, but still needs to be implemented beyond PEPFAR-supported sites in some countries.

ROP 2021 (FY 2022) Technical Directives

HIV Treatment
1. Accelerate the roll out of MMD for all patients, and increase the relative proportion of 6-month MMD
2. Continue to accelerate the TLD transition in all countries in the region, including for women of childbearing potential, and the adoption of DTG-based regimens for pediatrics alongside the removal of any remaining NVP- and EVF-based regimens
3. Improve viral-load access, including commodity availability, lab capacity, and data systems, to ensure at least 95% viral load coverage for all eligible patients in the region
4. Strengthen patient-centered approaches, including at the peer-navigator, community, and clinical levels, to improve linkage, continuity of treatment (retention), and VLS for all PLHIV, including children
HIV Prevention
1. Continue, expand, and initiate PrEP programs for patients testing negative and at-risk populations
2. Continue and expand activities to counter stigma and discrimination against PLHIV and KPs, including working alongside faith-based and civil society organizations
Other Government Policy or Programming Changes Needed
1. Ensure self-testing policies are in place in each country in the region and that self-testing is available
2. Supply chain optimization for all HIV commodities (testing, treatment, and viral load), potentially to include starting centralized supply chain visibility approaches for the region
3. In Burkina Faso and Mali, continue support for PLHIV in IDP situations and other approaches to optimize case-finding and treatment under challenging security situations

APPENDIX E– Acronym List and Definitions

Acronym	Definition
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretrovirals
CCM	Country Coordination Mechanisms
CDC	Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CODB	Cost of doing business
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
DHIS2	District Health Information Software
DIC	Drop-In Center
DoD	U.S. Department of Defense
DoS	U.S. Department of State
EID	Early Infant Diagnosis of HIV
EPOA	Enhanced Peer Outreach Approach

FSW	Female sex workers
FTE	Full-time equivalent
FY	Fiscal year
GBV	Gender-based violence
GFATM	Global Fund for HIV/AIDS, TB, and Malaria
GNI	Gross National Income
HMIS	Health Information Management System
HRH	Human Resources for Health
HRSA	Health Resources and Services Administration
HSS	Health Systems Strengthening
IDP	Internally Displaced Persons
KP	Key Populations
KPLHIV	Key Populations Living with HIV
LES	Locally employed staff
LOE	Level of effort
LTFU	Lost to Follow-Up
MCH	Maternal and Child Health

MMD	Multi-Month Dispensing
MoH	Ministry of Health
MPR	Minimum Program Requirements
MSM	Men who have Sex with Men
MTCT	Mother-To-Child Transmission
NAC	National AIDS Commission/Council
NACP	National AIDS Control Program
NAS	National HIV/AIDS Secretariat
NASA	National AIDS Spending Assessment
NGO	Non-governmental organizations
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PICT	Provider-Initiated Counseling and Testing
PLHIV	People Living with HIV/AIDS
PLL	Planning Level Letter
PMI	President's Malaria Initiative

PMTCT	Prevention of Mother-To-Child Transmission
POC	Point-of-care
PrEP	Pre-Exposure Prophylaxis
PWID	Persons Who Inject Drugs
QA	Quality Assurance
QI	Quality Improvement
ROP	Regional Operational Plan
RTK	Rapid test kit
SI	Strategic Information
SIMS	Site Improvement through Monitoring System
SOPs	Standard Operating Procedures
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TLD	Tenofovir, Lamivudine, and Dolutegravir
TWG	Technical Working Group
U=U	Undetectable=Untransmittable (messaging)

UICs	Unique Identifier Codes
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USDH	U.S. direct hire
USG	U.S. government
USPSC	U.S. Personal Services Contractor
VL	Viral load
WAR	West Africa Regional
WHO	World Health Organization

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