West Africa Regional Program
Regional Operational Plan (ROP) 2022
Strategic Direction Summary

May 23, 2022

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1.0 Vision and Goal Statement

The FY 2023 Regional Operational Plan (ROP22) is the fourth year of implementation for six of the eight countries in the West Africa Regional (WAR) program, which comprises Benin, Burkina Faso, Togo, Ghana, Liberia, Mali, Senegal, Sierra Leone. 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 ROP22 proposed activities are aligned with the 2021 Political Declaration on AIDS to ending inequalities and getting on track to end AIDS as a public health threat by 2030 and Sustainable Development Goals (SDGs) based on continued ambitious targets and transformative shifts at all levels. Achievement of the 95-95-95 and 10-10-10 targets by 2025, 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 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. In Togo, PEPFAR aims to increase the population viral load suppression (popVLS) rate in the 4 PEPFAR supported regions (Grand Lome, Maritime, Plateaux, and Central Regions) from 71% in FY22 (projected Spectrum 2021 data) to 78% in FY 23, and to increase the PLHIV ART coverage from 83% to 90%. In Burkina Faso, it plans to increase the popVLS from the targeted 78% to 80% and the PLHIV ART coverage the percent of PLHIV on ART from 85% to 95% in the 5 PEPFAR supported regions (Centre, Centre Ouest, Hauts Bassins, Centre-Nord, and Boucle du Mouhoun Regions).
2. In **Benin,** a newly added country to the West Africa Regional platform in ROP21, PEPFAR aims to a popVLS rate of 77% % in FY23 and the percent of PLHIV on ART from 82% to 89% in the PEPFAR supported regions (Atlantique, Littoral, Mono, and Couffo) the national ART coverage from 68% in FY21 (projected Spectrum 2020 data) to 80% by continuing to optimize 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 **Ghana,** PEPFAR aims to achieve 95-95-95 in the Western, Western North, and Ahafo Regions of Ghana, strengthen Viral Load diagnostics networks and support national scale up of HIVST and PrEP.

3. In **Liberia**, PEPFAR will maintain ROP21 strategies and innovations as well as its current geographic footprint. Particularly, PEPFAR ROP22 counties will include the current ROP21 four

supported counties as well as twenty-one supported health facilities. PEPFAR will collaborate with the National AIDS Control Program (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), improve VL interventions, as well as Pre-Exposure Prophylaxis (PrEP) initiation and scale-up.

4. In **Senegal** and **Mali,** the PEPFAR program will maintain ROP21 strategies, implementing activities in 13 districts (through 25 health facilities) 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 continue to be scaled up and offered in all PEPFAR sites in Senegal. In Mali, PrEP was initiated to HSH and will be extended to FSW in ROP22.

5. In **Sierra Leone**, PEPFAR will maintain its existing geographic coverage involving thirty sites across four of the seven highest burden districts as well as eight Drop-in Centers where KP services including PrEP continue to be successfully administered. This geographic coverage represents a doubling from FY21 to FY22, with unmet need compatible with a continued scale up aggressive strategy which includes improving coverage for men across all age ranges. Intensive technical assistance to strengthen laboratory and the strategic information system will be provided to support high quality viral load testing and data generation and usage.

In 2020, in the West and Central African region, 81% of adult PLHIV knew their status, 77% of adult [1]62% of adult PLHIV were virally suppressed.[2] Similarly, children (<15) cascade is 35-35-24.

During ROP22, in **Burkina Faso** and **Togo,** PEPFAR will enroll 4,457 and 4,532 PLHIV respectively on (ART), retain 43,499 and 52,382 PLHIV on ART at PEPFAR sites, and ensure 95% viral load suppression (VLS) among the 90% of PLHIV on treatment at PEPFAR supported facilities. 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 2,520 PLHIV, retain 25,787 on treatment and ensure 95% viral load suppression among 88% of those on treatment at PEPFAR supported facilities in four health regions of the country.

In **Ghana**, 6,615 new PLHIV will be added to the treatment cascade to reach and retain 40,749 PLHIV active on treatment and ensure 95% VLS in the Western, Western North, and Ahafo Regions; best practices will be shared and amplified across the rest of Ghana's national system.

For **Liberia, Mali, Senegal, and Sierra Leone** 4,052 PLHIV, 6,832 PLHIV, 686 PLHIV and 4,087 PLHIV will be newly identified; 3,858, 6,611, 2,233, and 3,895 newly enrolled and 22,319, 45,363, 16,299 and 14,124 retained on ART, respectively.

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

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 ROP22, 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 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 and self-testing scale up will continue in the eight countries of the West Africa Regional platform with an increase of >100% of the PrEP New targets in 6 out of the 8 recipients countries; Senegal has oral PrEP, a new prevention modality for West Africa, and HIV self-testing (HIVST) will be implemented in all countries, with continuation of scale-up efforts in Ghana following successful implementation of a jump-start strategy implemented under the Key Populations Investments Fund (KPIF) and also under the JSI's Strengthening the Care Continuum project. Scale up of both interventions will also continue in Sierra Leone following a highly successful program initiation in FY21 and a FY22 target of 4,000.

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 Response Team meetings, relevant regional training meetings and newly created PEPFAR WA Technical Working Groups. Regional mechanisms Epic (community and clinical), Data.fi (strategic information), and GHSC-TA Francophone Task Order (supply chain) will continue to be leveraged for capacity building and health system strengthening across the region. 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/West Africa 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 ROP22, **Senegal and Liberia** will use funds to improve case finding and linkage targets with a focus on diagnosing men and children and ensure continuity of treatment and address stigma and discrimination. The program will bolster activities at existing sites. The **Senegal** program will work toward limiting interruption in treatment among clients and ensure those who have stopped their treatment are brought back to care. These funds will also be used to continue 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 third 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 2,743 PLHIV to treatment. PEPFAR will continue working with the Ministry of Health to procure viral load reagents and ensure viral load machines are functional. In addition, PEPFAR will advocate for viral load sample collection at the community level. 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 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 continue to expand these interventions and innovations across all supported sites. The program will expand index testing in the general population with focused outreach 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 expansion of the program's social media strategy called Going Online, to find more men.

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 95. 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)**. Mali will also support strategic information.**

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.

In **Sierra Leone**, the same geographic footprint will be maintained across 4 districts. Prevention initiatives will continue to be scaled up though at a slower pace consistent with a reduction in funding. Above site interventions will include reductions in stigma and discrimination, supply chain strengthening, expansion and enhancement of Patient Tracker and development of better KP data, support for a reliable sample transport system, in collaboration with CDC GHS and Global Fund. Funds will also be needed to support several categories of commodities to secure PEPFAR's ability to achieve targets. Though it is anticipated that VL coverage will be optimized prior to FY23, any remaining gaps with VL will be addressed through ROP22 funding. It is anticipated that a SID will be required in FY23. Efforts to identify and cultivate local partner candidates will continue in FY23, with possible partial interim transitions of components through IP sub-contracting.

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 **347,370** in Ghana (Spectrum 2021), followed by **107,238 in** Togo (UNAIDS Spectrum 2021), **94,484** in Mali (Spectrum 2020), **87,686** in Burkina Faso (UNAIDS Spectrum 2021), **74,178** in Benin (UNAIDS Spectrum 2021)**, 73,870** in Sierra Leone, **37,222** in Senegal (Spectrum 2021), and **34,358** in Liberia (Spectrum 2021). 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 87,686 PLHIV with an adult and a prevalence rate of 0.40% (UNAIDS Spectrum 2021), HIV prevalence is 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 58%, 36%, and 17% 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 57% of the country's total PLHIV.

In **Togo**, the number of PLHIV is estimated at 107,238 with an adult prevalence rate of 1.27%. Estimates among MSM are 22% and 13 % among FSWs (IBBSS 2017). Adult women, adult men, and children represent 60%, 32%, and 8% 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 74,178 with an adult overall prevalence rate of 0.59%. HIV prevalence among MSM is 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 50% of the country total PLHIV.

Ghana is estimated to have a total population of 31,188,329, and an estimated 347,370 PLHIV (SPECTRUM 2021). 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 1.67% among adults (Spectrum 2021), 18.1% among MSM (GMS II, 2017), and 4.6% among FSW (IBBSS, 2019).

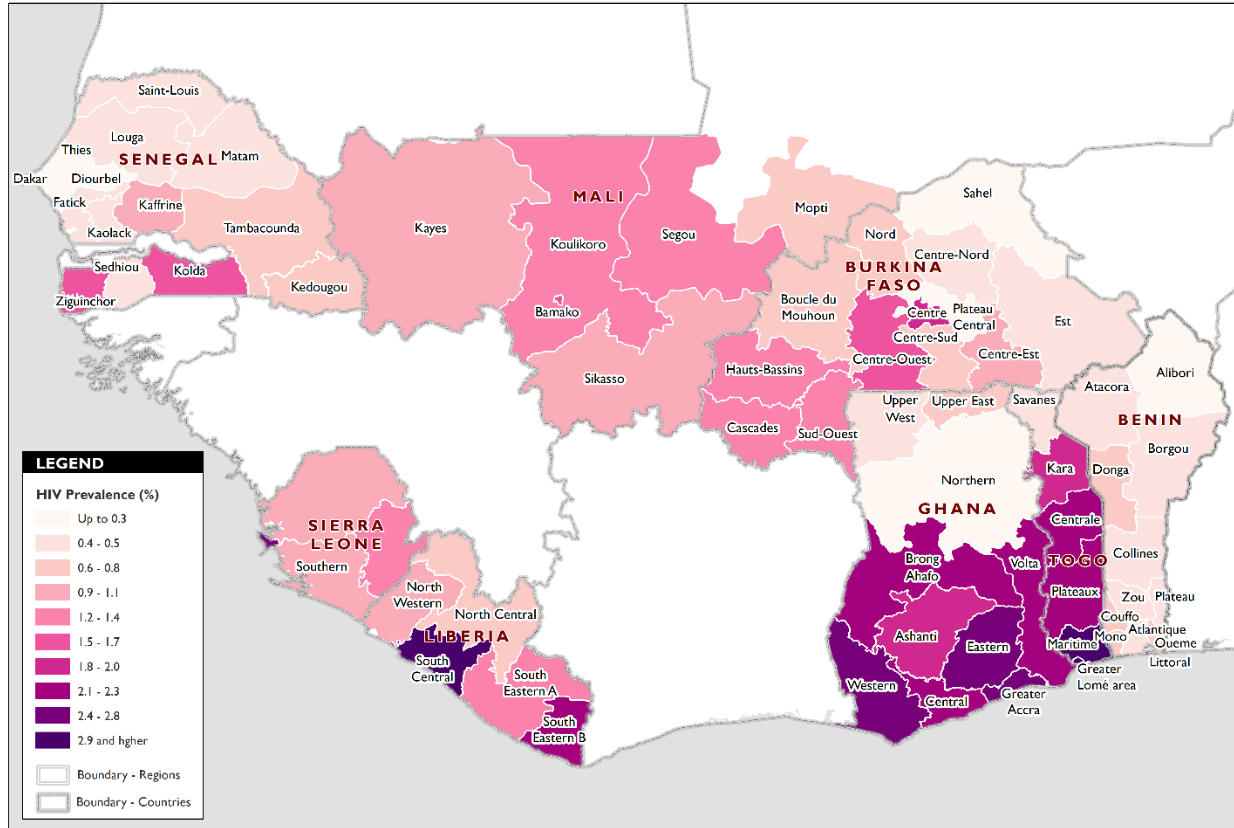
In **Liberia**, HIV prevalence is estimated at 1.05% (Spectrum 2021), with an estimated 34,358 PLHIV. Prevalence is 16.7% among FSW (Liberia, 2018 IBBS) and 37.9% among MSM (2018 IBBS).

Mali has a total population of about 19.1 million (World Bank, 2018). The number of PLHIV is estimated at 89,619, with HIV prevalence of 0.46% among the general population and 0.77% among adults aged 15-49, in 20121 (Spectrum 2020). Prevalence is 12.7% among MSM and 8.6% among FSW (IBBS 2018).

HIV prevalence in **Senegal** is estimated at 0.3% (2020), though prevalence among FSW is 5.8 and 27.6% among MSM.

There are an estimated 75,795 PLHIV in **Sierra Leone**, which has an estimated population of 8 million, with an adult prevalence of 1.7% and prevalence of 11.8% among sex workers (20.9% in Freetown), 3.4% among MSM, and 4.2% among persons who inject drugs (PWID) (SPECTRUM 2021/KP data from 12/21 IBBSS). A December 2021 IBBSS Report suggests an FSW size estimate of 27,990, down from 240,000 in a 2013 IBBSS. MSM and PWID size estimates remained relatively constant, but prevalence fell sharply across all three KP groups.

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																
	Country	Total		<15				15-24				25+				*Source, Year*
				Female		Male		Female		Male		Female		Male		
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	Burkina Faso	21,651,595		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	8,067,851		1,514,183	18.8%	1,523,794	18.9%	836,180	10.4%	867,7668	10.8%	1,776,078	22.0%	1,549,850	19.2%	**Projections INSEED 1st Janvier 2022**
	Benin	12,079,455		2,490,917	20.6%	2,562,940	21.2%	1,187,464	9.8%	1,214,126	10.0%	2,366,026	19.6%	2,257,982	18.7%	Projections SPECTRUM 2020
HIV Prevalence (%)	Burkina Faso		0.4%		0.16%		0.16%		0.44%		0.35%		0.82%		0.56%	UNAIDS SPECTRUM 2021
	Togo		1.27%		0.25%		0.25%		0.98%		0.48%		3.23%		1.95%	UNAIDS SPECTRUM 2021 (V6.16)
	Benin		1.02%						0.5%		0.21%					UNAIDS SPECTRUM 2020
AIDS Deaths (Per year)	Burkina Faso	3,300														UNAIDS data 2020 report
	Togo	2,556		337		342		107		111		707		953		SPECTRUM 5.86, 2019

	Benin	1,684	100	136	8.08	141	8.37	68	4.04	55	3.27	557	33.08	727	43.17	UNAIDS SPECTRUM 2021
# PLHIV	Burkina Faso	95,736		7,380		7,687		9,071		7,592		39,455		24,551		UNAIDS SPECTRUM2020
	Togo	107 087		4,331		4,395		7,480		4,168		56,765		29,948		UNAIDS SPECTRUM 2021
	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		0.05%						0.08		0.02					UNAIDS SPECTRUM 2021
	Benin		0.03%													
New Infections (Yr)	Burkina Faso	2,100						211		103		702		693		UNAIDS SPECTRUM 2020 report
	Togo	3,097		500		508		609		154		766		560		UNAIDS SPECTRUM 2021
	Benin	2,863	100	182	6.36	189	6.60	786	27.45	283	9.88	902	31.51	525	18.34	UNAIDS SPECTRUM 2020
Annual births	Burkina Faso	761 766														MoH Statistic Report 2019

	Togo	184944														DIHS2
	Benin	N/A														
% of Pregnant Women with at least one ANC visit	Burkina Faso		75.1													MoH statistic report 2019
	Togo	N/A	86% (227 463 /277 480)													Numerator: Program data (DIHS2) Denominator: Spectrum
	Benin															
Pregnant women needing ARVs	Burkina Faso															
	Togo	5,245														SPECTRUM 6.13, 2021
	Benin	6,000														
Orphans (maternal, paternal, double)	Burkina Faso	100,000														UNAIDS data 2020 report
	Togo	81,172														Spectrum 2021
	Benin	N/A														
Notified TB cases (Yr)	Burkina Faso	5906	28.3/100000													MoH statistic report 2019

	Togo	2490														Program Data, TB Program 2021
	Benin	4,002														Program Data, TB Program 2020
% of TB cases that are HIV infected	Burkina Faso	424	7.8%													MoH Endos data December 2020
	Togo		13% (328/ 2490)													TB Program Data
	Benin	561	14													
% of Males Circumcised	Burkina Faso															
	Togo															
	Benin		95													DHS 2017-2018
Estimated Population Size of MSM*	Burkina Faso	8,361														JHU SAE 2020
	Togo	16,133														JHU SAE 2020
	Benin	5,846														IBBSS with size estimation 2015
MSM HIV Prevalence	Burkina Faso		1.9%													UNAIDS data 2020 report
	Togo		21.98 %													IBBSS MSM 2017
	Benin		7%						10.02%				4.20%			IIBBSS MSM 2017

Estimated Population Size of FSW	Burkina Faso	21,464														JHU SAE 2020
	Togo	29,382														JHU SAE 2020
	Benin	28,790														FSW hotspots mapping 2017
FSW HIV Prevalence	Burkina Faso		5.4%													UNAIDS data 2020 reportI
	Togo		13.2%													IBBSS FSW and Clients 2017
	Benin		8.5%						2.9%				10.7%			IBBSS FSW 2017
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%										2.80%			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	31,188,329		5,843,500	50.0%	5,846,663	50.0%	3,015,641	50.0%	3,022,555	50.1%	6,900,978	51.3%	6,558,992	48.7%	SPECTRUM 2021
HIV Prevalence (%) 15 – 49 yrs		1.67%													SPECTRUM 2021
AIDS Deaths (per year 2020)	9,859		3,960	54.2%	3,334	47.7%	475	57.7%	347	42.2%	3,487	53.8%	2,988	46.1%	SPECTRUM 2021
# PLHIV	347,311		12,773	49.9%	12,842	50.1%	30,522	74.4%	10,516	25.6%	192,201	68.5%	88,458	31.5%	SPECTRUM 2021
Incidence Rate (Yr)		0.57%													SPECTRUM 2021

New Infections (Yr)	15,225		1,173	49.8%	1,175	50.2%	3,668	83.3%	734	16.7%	5,443	64.3%	3,024	35.7%	SPECTRUM 2021
Annual births	888,031														SPECTRUM 2021
% of Pregnant Women with at least one ANC visit	962,301						320,231	33.3%			642,070	66.7%			SPECTRUM (NAOMI2021)
Pregnant women needing ARVs	1,474														NACP Status Update, 2021
Orphans (maternal, paternal, double)	234,960														SPECTRUM 2021
Notified TB cases (Yr)	13,278	41.7%													
% of TB cases that are HIV infected	2,602	19.5%													NACP Status Update, 2021

% 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	21,651,595	0.4%	87 686	76,838	72,886	83,12%	62%	1 637 705	15 296	8,7837 780
	Togo	8,067,851	1.27%	107,238	86,345	80,998	76%	68%	590,431	5,000	*7,338*
	Benin	12,528,838	0.50%	74,178	59,342	57,667	78%	65%	852,255	10,072	*9,962*
	Ghana	31,188,329	1.67%	347,311	319,021	233,715	73%	79%	1,976,134	50,187	*27,786*
	Liberia	5,125,691	1.05%	34,358	22,637	21,067	61%	47%	326,758	9,631	6,315
	Mali	19,307,552	0.46%	89,619	61,981	57,257	92%	83.7%	276,778	18,854	15,418
	Senegal	16,705,608	0.3%	37,222	30,755	27,973	75%	64%	1,356,024	**30,479**	5,164

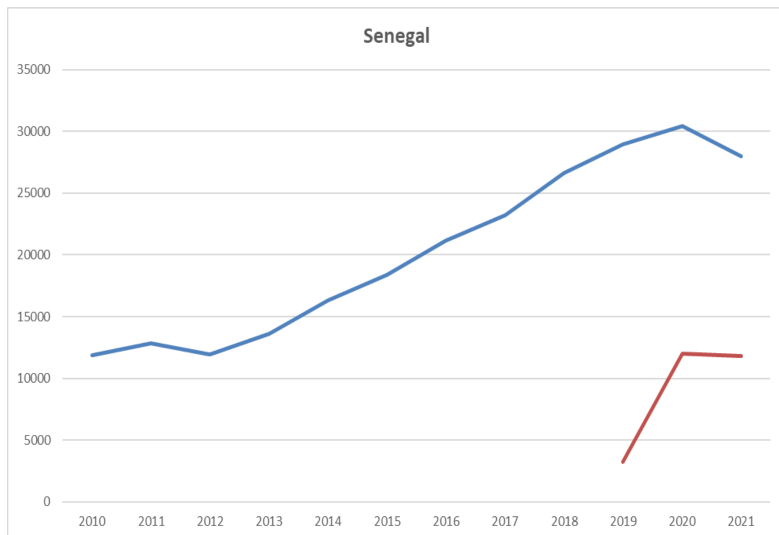
				,400	,250	30,431	%				
	Sierra Leone	8,150,934	0.22%	76,063	49,151	46,445	62%			3,122	
Population <15 years	Burkina Faso	9,491,357	006%	5822	5752	2531	43.37%	37%	N/A	<1,000	
	Togo	3,384,750	0.25%	8,361	4,543	4,271	51%	32%	N/A	1,200	535
	Benin	5,143,694	0.07%	3,442	2,392	2,392	69%	40%			
	Ghana	11,690,163	0.22%	25,615	N/A	11,508	43%	79%	153,055	2.173	*1,619*
	Liberia	2,050,618	0.19%	2,549	808	808	32%	N/A	12,662	428	*220*
	Mali	8,957,285	0.08%	7,416	3,915	4,536	N/A	N/A	N/A	740	625
	Senegal	8,676,596	0.003%	34,438 ,479	29,275	26,527	77% %	70%	2,380	562	*474*
	Sierra Leone	3,237,070	0.07%	10,272	1387	1387	23%			1,053	
Men 15-24 years	Burkina Faso	2,242,925	0.18%	4138	2705	2536	61.29%		N/A	<500	
	Togo	851,079	0.48%	4121	3,163	2,418	50%		N/A	<500	
	Benin	1,273,446	0.20	2,527	2,526	1,095	43%				
	Ghana	3,022,555	0.35%	10,516	5,270	5,134	97.4%		N/A	1,480	
	Liberia	524,893	0.40%	1,670	N/A	214	11%		N/A	<500	
	Mali	2,024,631	0.19%	3,775	2,288	1,601	70%		N/A	.	
	Senegal	1,654,126 1,578,036	0.00% %	1,373 3,024	870	658	48% %		N/A		
	Sierra Leone	837,400	0.29%	2,504		1,127	47%			266	
Men 25+ years	Burkina Faso	3, 761,121	0.34%	26,970	20,880	17,210	82%		N/A		
	Togo	851079	0.48%	4,121	22,091	16,886	48%		N/A		
	Benin	3,653,324	0.96%	23,582	14,416	14,416	61%				
	Ghana	6,558,992	2.70%	88,458	54,817	53,834	98%		N/A		
	Liberia	1,007,013	1.25%	9,740	N/A	2,600	22%		N/A		
	Mali	3,083,194	0104%	31,965	20,2797	14,534	72%		N/A		
	Senegal	1,654,126	0.00 %	3,826	1,926	1,436	37%		N/A		

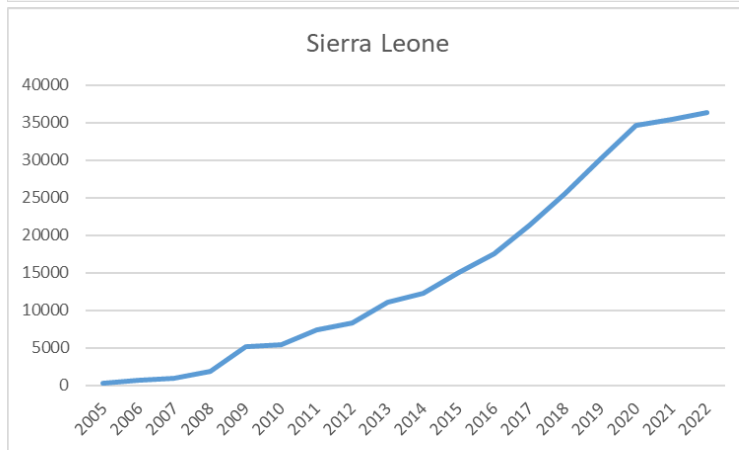
				11,166		6,207	56%				
	Sierra Leone	1,609,511	1.36%	21,974		10,686	65%			517	
Women 15-24 years	Burkina Faso	2162998	0.27%	5784	5777	5777	99.88%		N/A	<500	
	Togo	844,108	0.98%	8,143	5,374	5,347	66%		N/A	<1,000	
	Benin	1,245,033	0.43%	5305	3755	3755	71%				
	Ghana	3,015,641	1.01%	30,522	19,067	19,067	100%		N/A	3,924	
	Liberia	510,817	0.75%	3,129	N/A	827	23%		N/A	<500	
	Mali	1,966,481	0.24%	4,670	3,108	3,405	N/A		N/A		
	Senegal	1,588,695 1,564,167	0.00 %	1,360	1,360 N/A	1,360	99%		N/A	<500	
	Sierra Leone	831,386	0.17%	5,777		4,039	82%			750	
Women 25+ years	Burkina Faso	3 993 193	1.18%	44,971	44,850	44,831	99.98%		N/A		
	Togo	1,719,761	3.29%	56533	50,817	49,444	87%		N/A		
	Benin	2,486,786	1.68	41,849	37104	37104	90%				
	Ghana	6,900,978	5.25%	192,201	160,398	155,680	97%		N/A		
	Liberia	1,032,351	1.91%	17,270	N/A	8,465	46%		N/A		
	Mali	3,275,961	1.28%	41,793	32,390	33,181	N/A		N/A		
	Senegal	3,387,292	0.00 %	3,294	3,294	3,294	99%		N/A		
	Sierra Leone	1,635,567	2.17%	35,536		29,497	91.5%			535	
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		

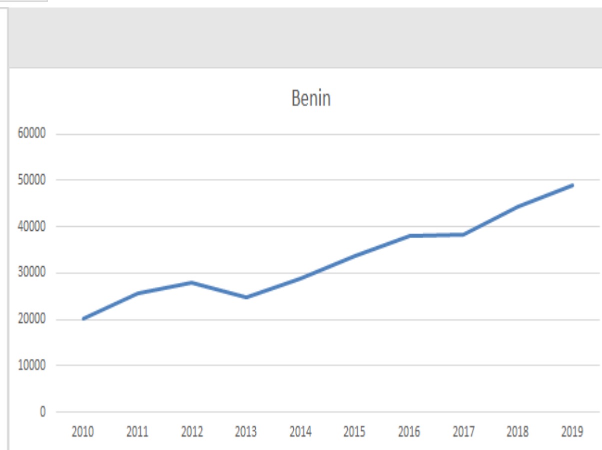
	Liberia	74,600	37.9%	28,273	N/A				N/A		
	Mali	13,998	12.6%	1,763	N/A	849			N/A		
	Senegal	54,775	27,6	2,531	N/A				N/A		
	Sierra Leone	31,773	14%	4,448							
	Burkina Faso	13,500	6%	810	N/A				N/A		
	Togo	8,000	14%	1,080	N/A	256	24%		N/A		
	Benin	28,800	8.5%						18,954	271	
	Ghana	51,900	7%	2581	N/A				N/A		
	Liberia	163,100	16.7%	27,221	N/A				N/A		
	Mali	39,944	8.7%	3,475	N/A				N/A		
FSW	Senegal	27,012	5,8	484	N/A	95	20%		N/A		
	Sierra Leone	27,900	6.7%	1869							

*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 2021, AIDS INFO, UNAIDS Key Populations Atlas)

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

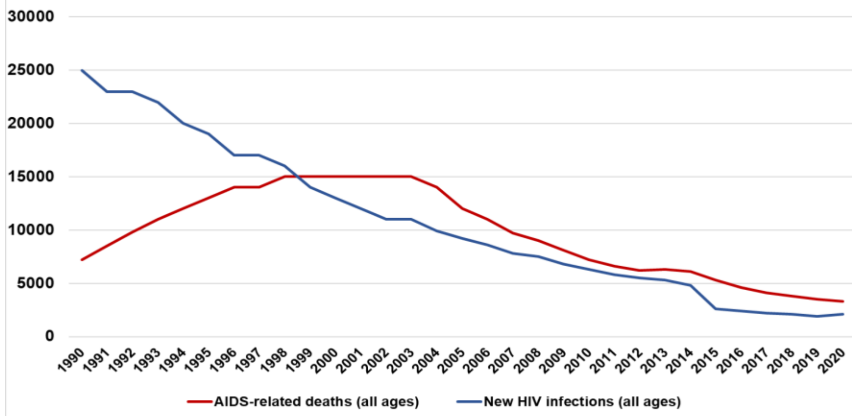


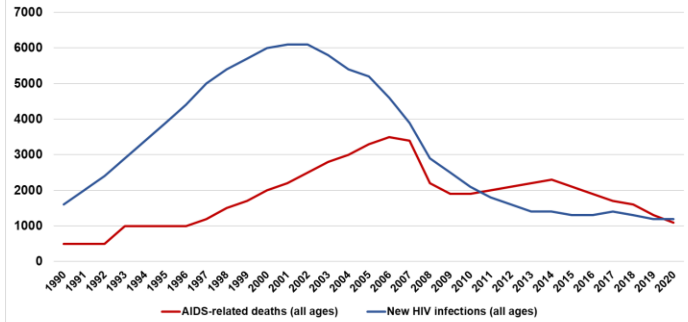


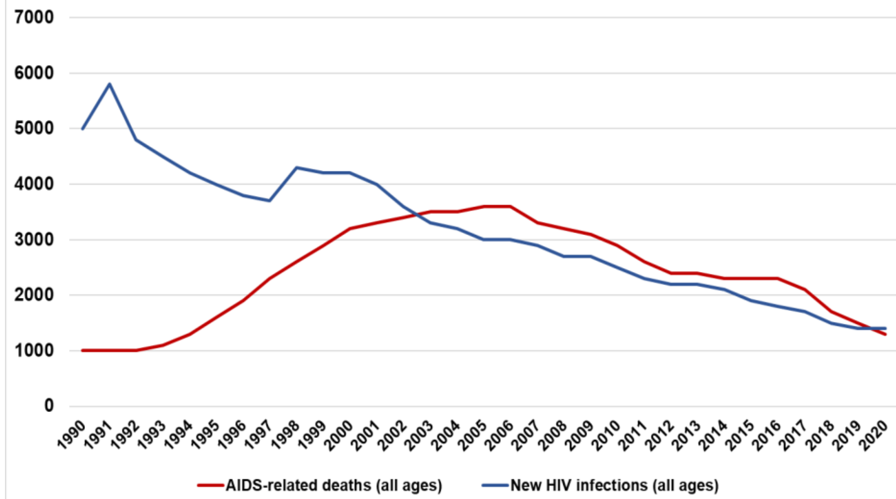


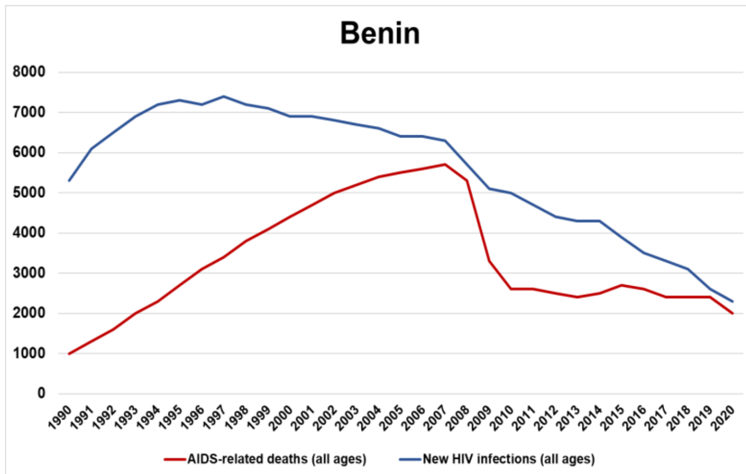
*These graphs show UNAIDS data.

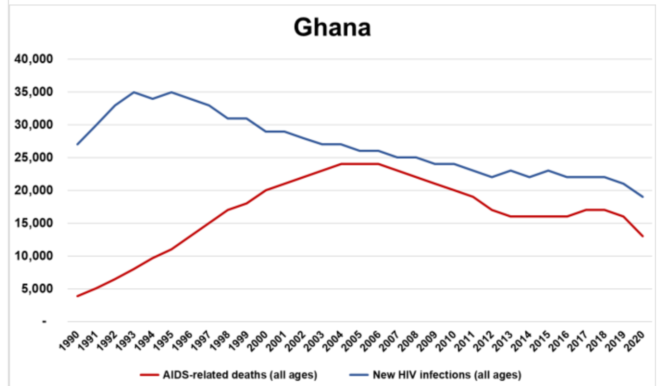
Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV

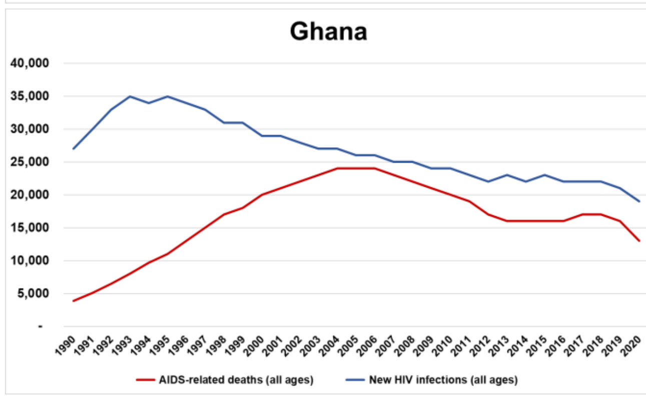

Burkina Faso
30000
25000
20000
15000
10000
5000
0
1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020
AIDS-related deaths (all ages)
New HIV infections (all ages)

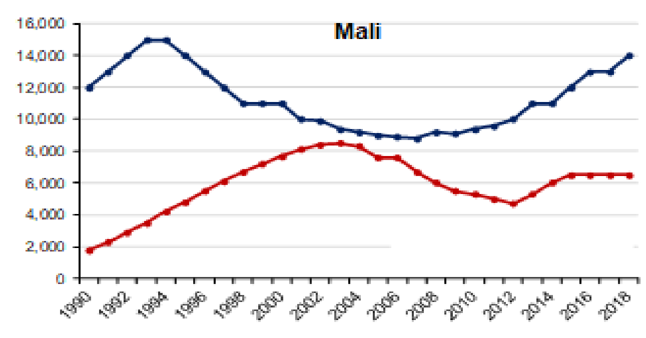

Senegal
7000
6000
5000
4000
3000
2000
1000
0
1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020
AIDS-related deaths (all ages)
New HIV infections (all ages)

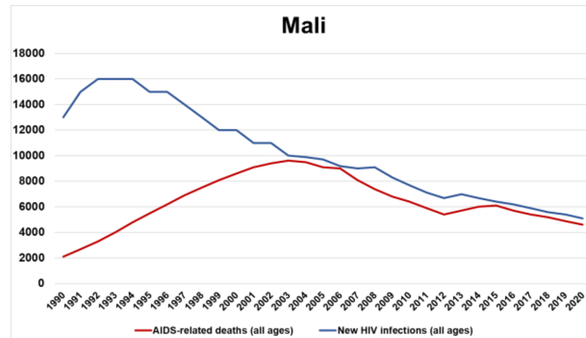

Liberia
7000
6000
5000
4000
3000
2000
1000
0
1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020
AIDS-related deaths (all ages)
New HIV infections (all ages)











AIDS-related deaths (all ages)

New HIV infections (all ages)

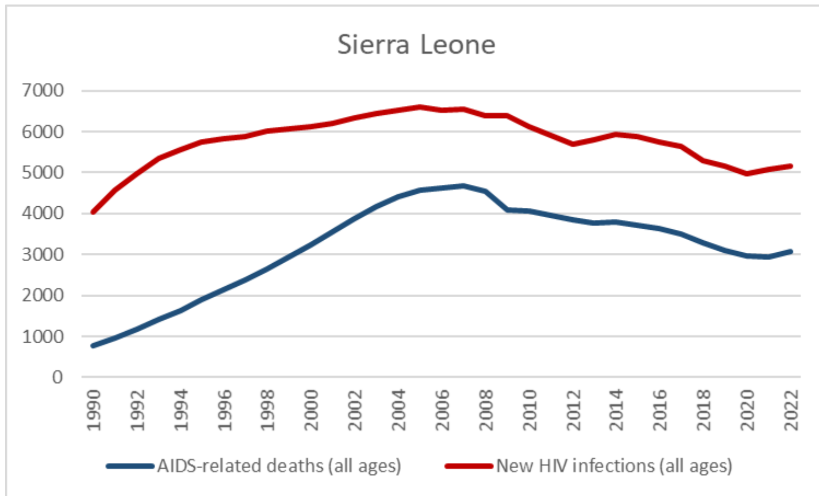
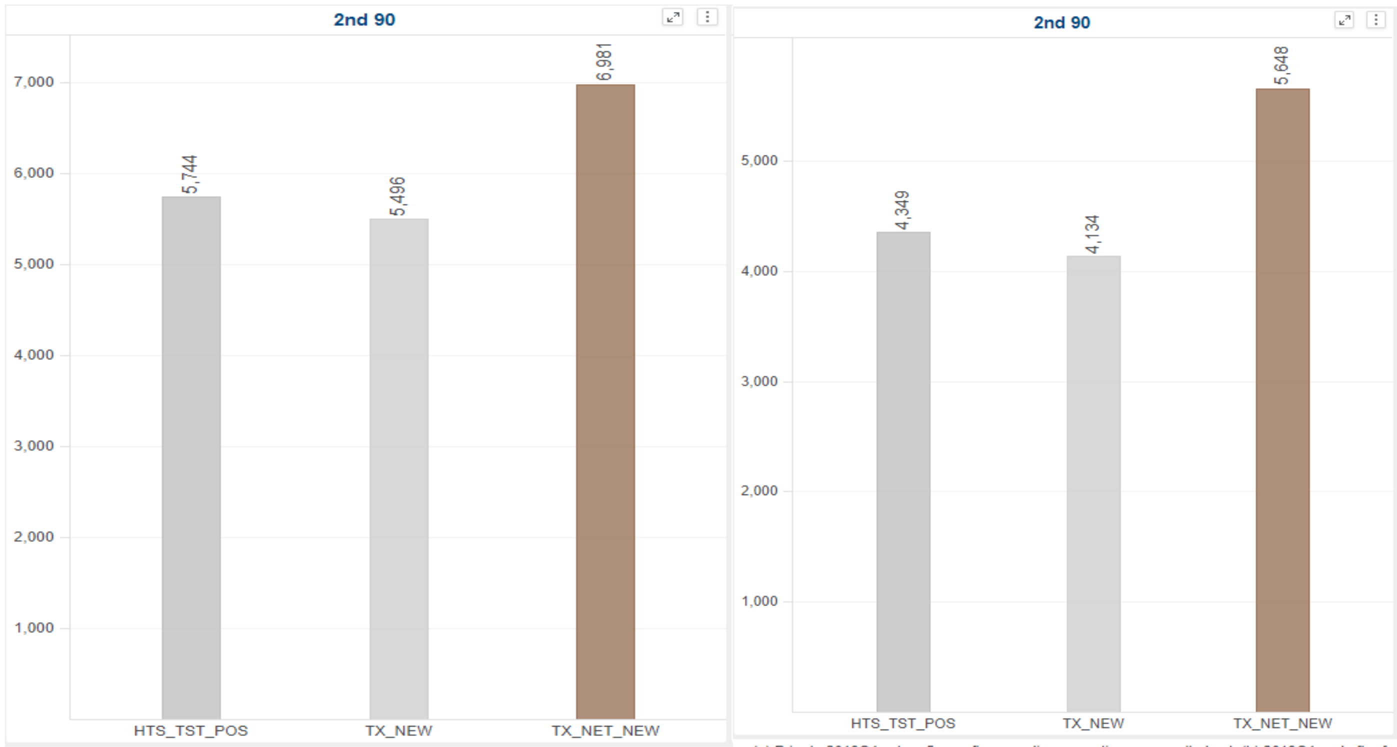
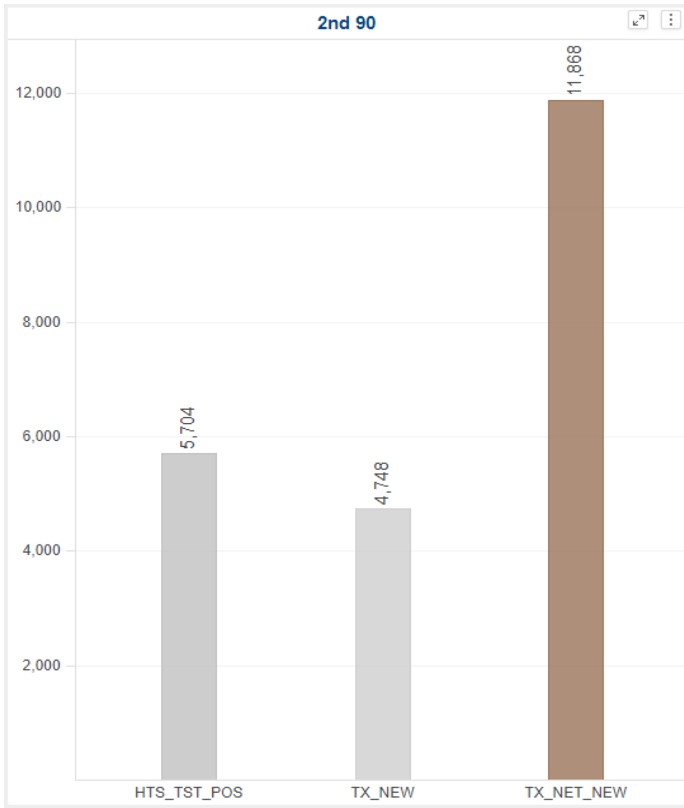
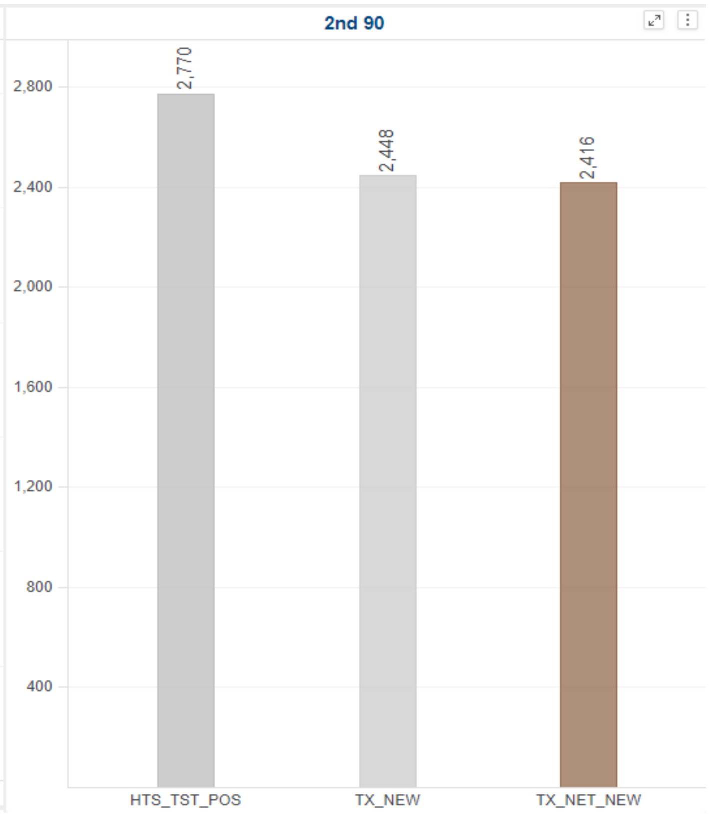

Sierra Leone
7000
6000
5000
4000
3000
2000
1000
0
1990
1992
1994
1996
1998
2000
2002
2004
2006
2008
2010
2012
2014
2016
2018
2020
2022
AIDS-related deaths (all ages)
New HIV infections (all ages)

Figure 2.1.5 Assessment of ART program growth in FY21



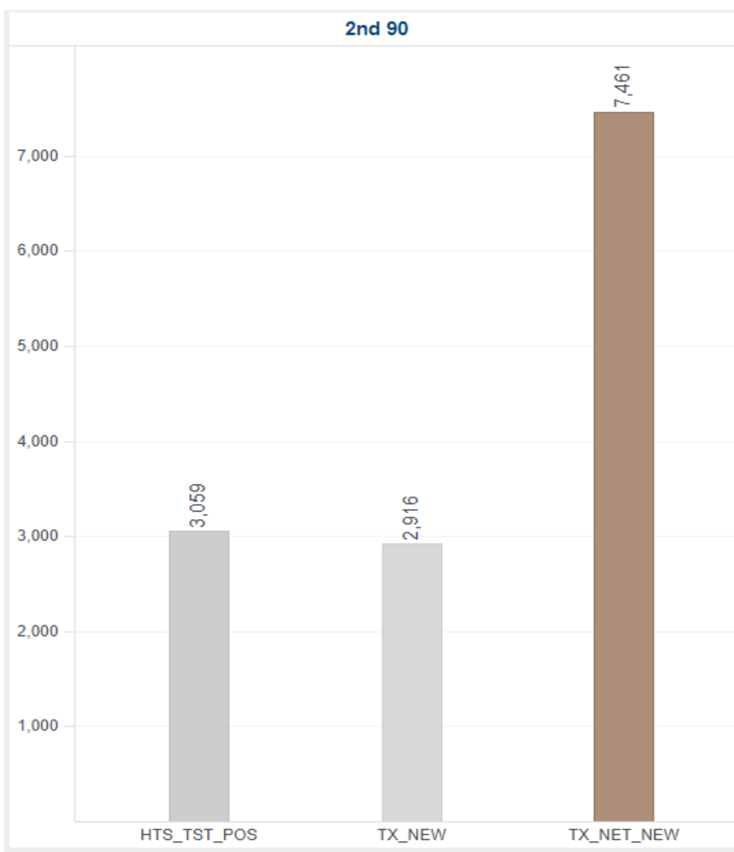
Burkina Faso Ghana



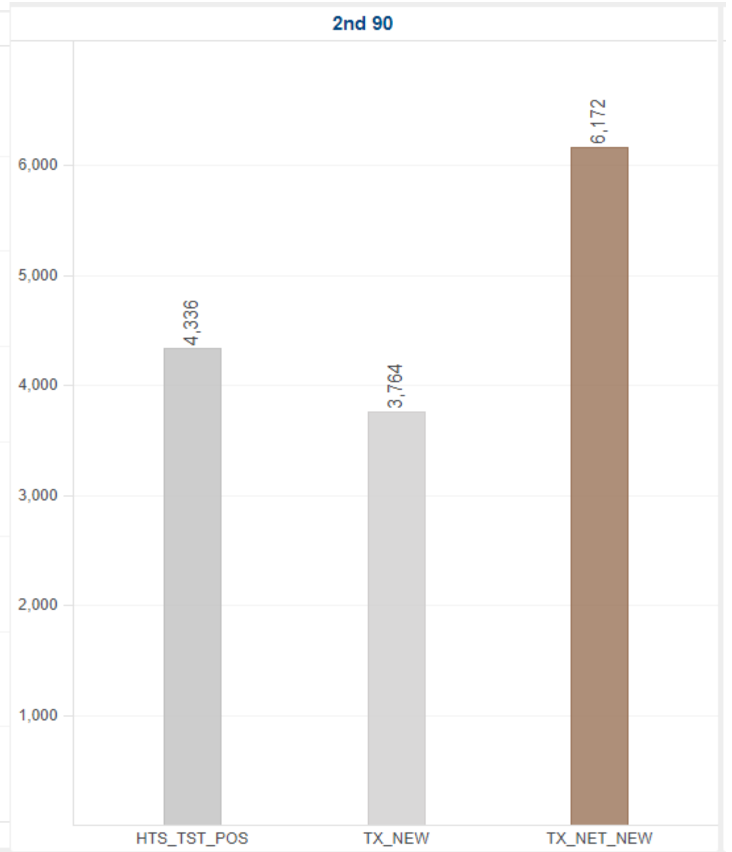


Liberia

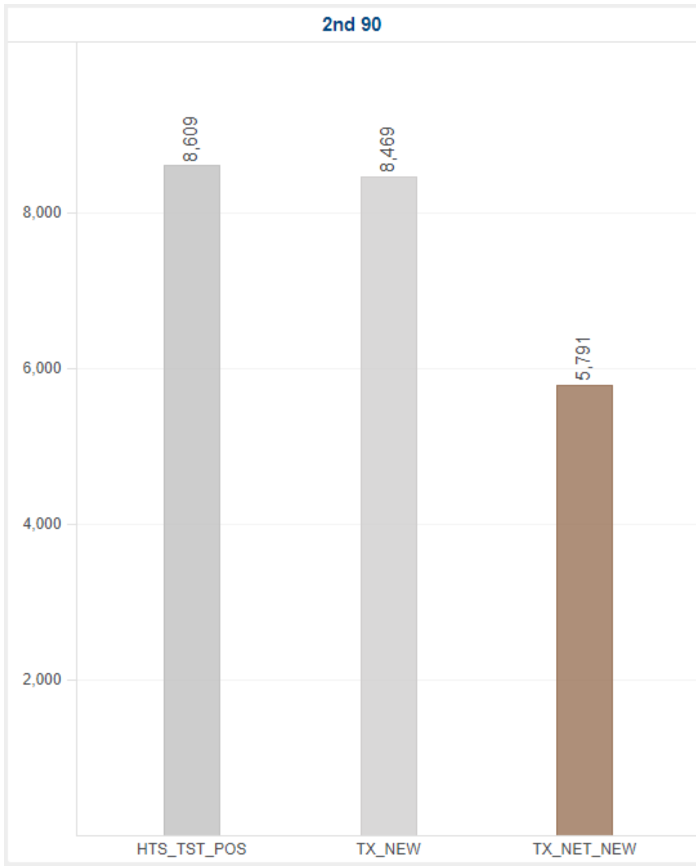
Mali



Senegal

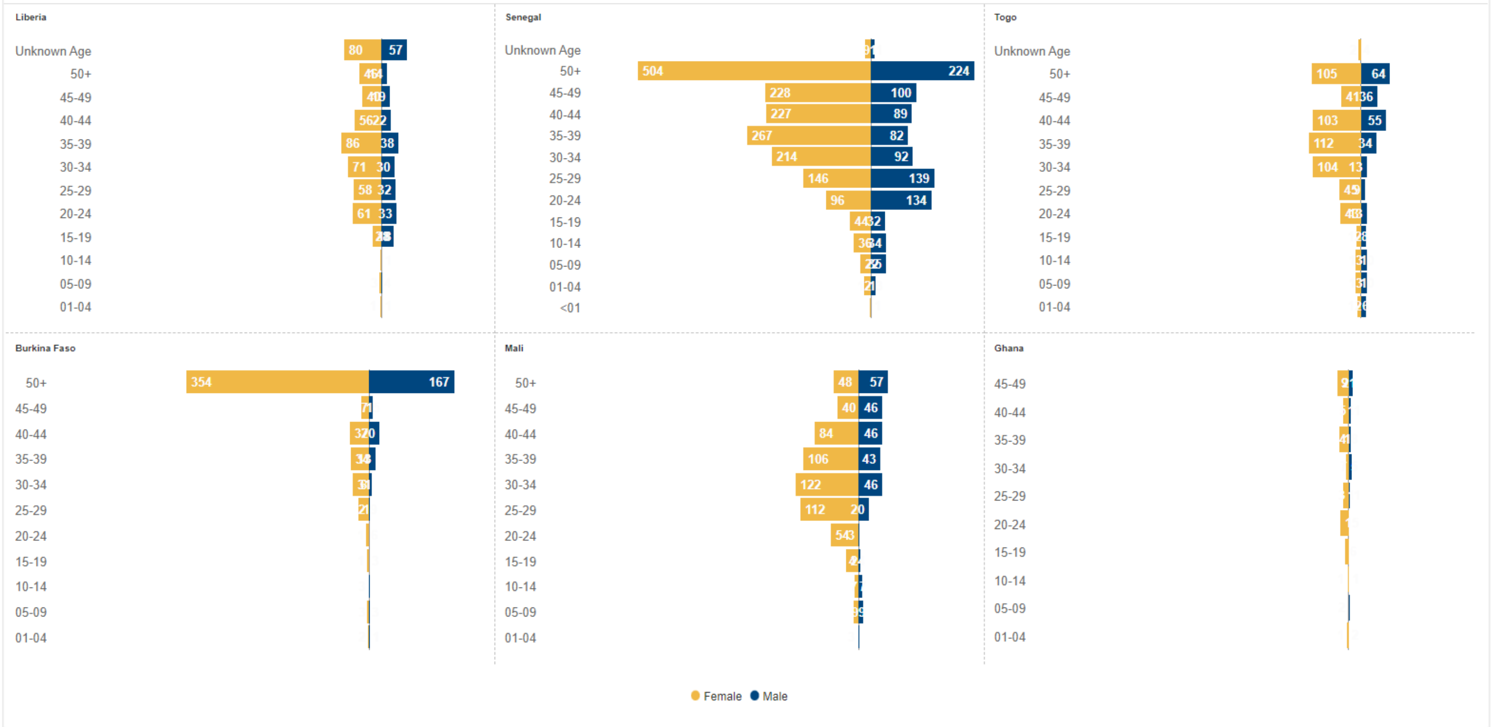


Sierra Leone



Togo

Figure 2.1.6 Clients Gained/Lost from ART by Age/Sex, FY21 Q4


Number of Interruptions in Treatment (TX_ML_IIT)
Liberia
Senegal
Togo
Burkina Faso
Mali
Ghana
Unknown Age
50+
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
05-09
01-04
<01
Female
Male

Percent of Interruptions in Treatment (TX_ML_IIT)
Burkina Faso
Liberia
Mali
Senegal
Togo
Ghana
50+
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
05-09
01-04
Female
Male

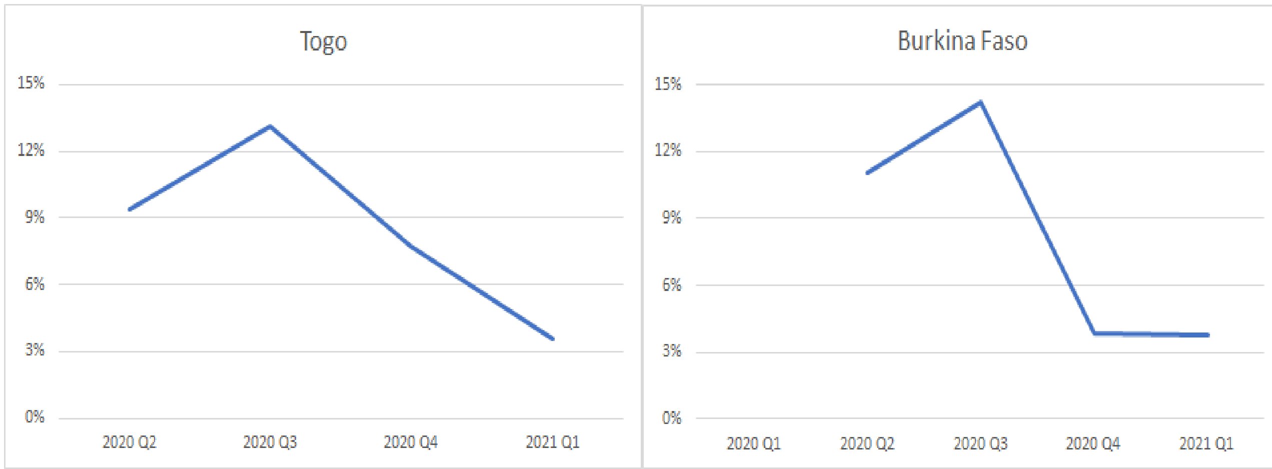
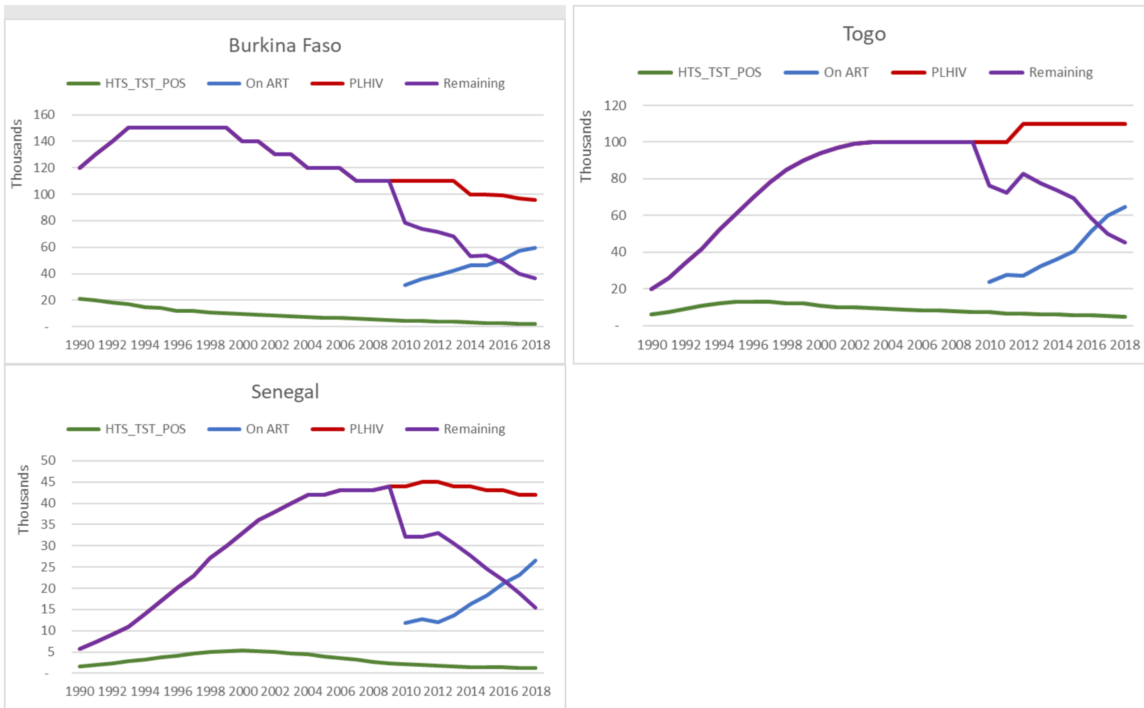
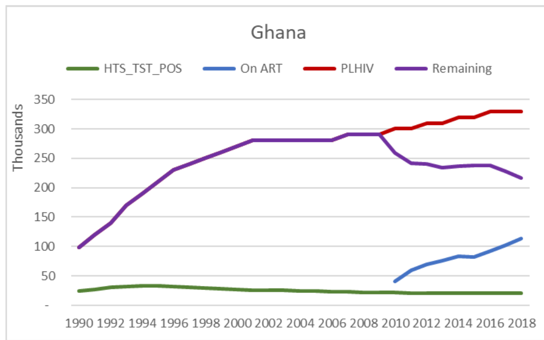


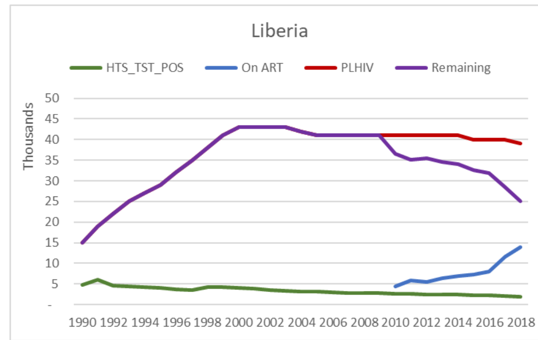
Figure 2.1.7 Epidemiologic Trends and Program Response for your Country (Figure 2.1.1.3 in COP20 Guidance)

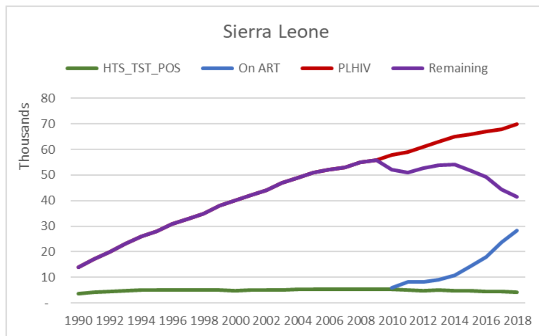
<u>Fewer positives to find than are currently on treatment</u>



Slow progress and a long way to go







Behind with a growing epidemic

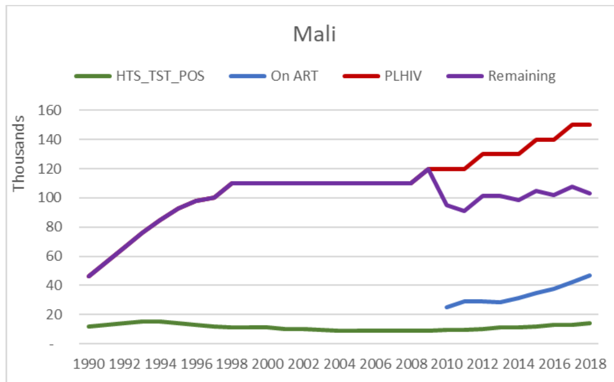
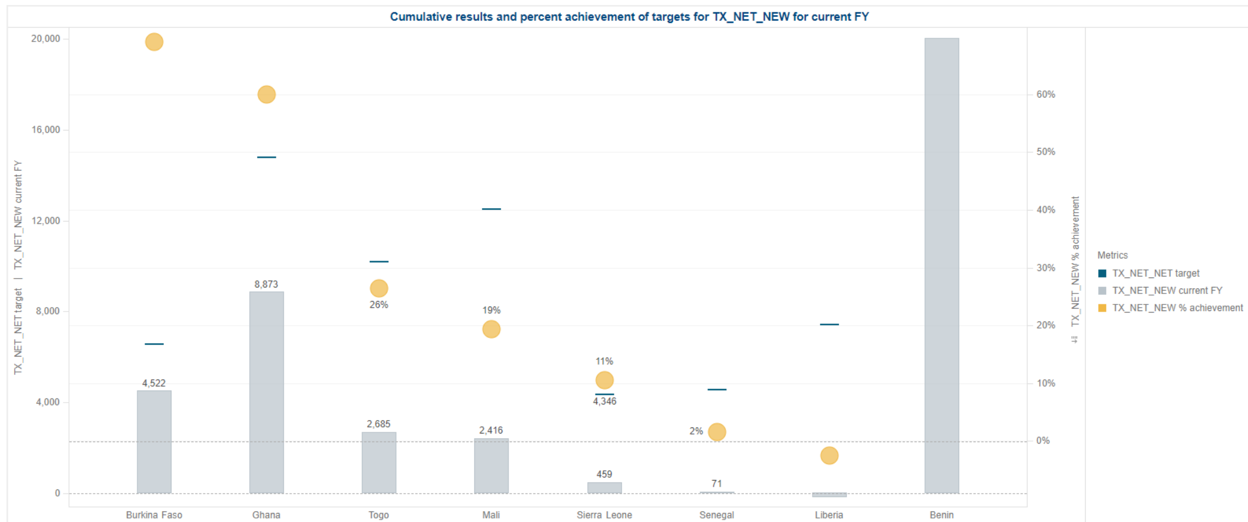


Figure 2.1.8 Net change in HIV treatment by sex and age bands 2020 Q4 to 2021 Q4



2.2 New Activities and Areas of Focus for ROP22, 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 ROP22. 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 donors' support from ROP19-21 in **Burkina Faso and Togo** achieved respectively 84% and 81% ART coverage and 76% and 68% population viral load suppression in December 2021 (Spectrum 2021 data). In ROP22, no geographic extension is planned, and PEPFAR will maintain gains made and strengthen progress in the regions the program is supporting currently in both. Emphasis will be made on: (i) providing person-centered approaches to close disparities among children, adolescents and youth, men (15-39), 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 be scaled up for MSM and FSW who test HIV-negative.

In **Benin**, a newly added country to the West Africa Regional Platform, in FY22, PEPFAR will continue optimizing HIV case finding 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. The e-Tracker will be used to track clients who miss appointments and identify eligible patients for viral load test and collect and analyze granular to early identify issues 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 Burkina and Benin, PEPFAR will support the development and implementation of a national action plan against stigma and discrimination based on finding from 2021 stigma index 2.0 results and other studies in collaboration with national stakeholders. In Togo, PEPFAR will support the implementation of the gender and human rights action plan that is already developed by the NAC in collaboration with CSOs, UNAIDS, MoH, and PEPFAR.

In ROP22, PEPFAR/**Ghana** will work towards achieving 95-95-95 targets in the Western, Western North and Ahafo regions. Activities will build on lessons learned from ongoing interventions to provide person-centered quality services across the HIV continuum of care. PEPFAR/**Ghana** will prioritize targeted 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 ROP21 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 (in the three PEPFAR regions and the Ga East district in the Greater Accra region), 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 distribution 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 ROP22, PEPFAR/**Liberia** will scale up 6-MMD, support TLD transition to ensure and maintain full transition for all eligible clients on ART at PEPFAR-supported sites, support scale-up of PrEP enrollment while strengthening 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 ROP21 strategies and cutting-edge innovations in a total of twenty-one (21) health facility sites spread across four counties of Montserrado, Margibi, Grand Bassa and Nimba, with 2 health facilities in Margibi, 2 health facilities in Grand Bassa, 4 facilities in Nimba, and 13 health facility sites in Montserrado County. PEPFAR also supports community outreach interventions in 9 community sites in Montserrado County. ROP21 shifts which will continue to be supported in ROP22, including VL specimen transportation 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 at all 21 PEPFAR-supported health facility sites. In ROP22, as a continuation from ROP21, 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.

PEPFAR/**Liberia** will oversee implementation of a significant component of the PEPFAR above-site activities during ROP22, including the following:

- Support resolution of any remaining gaps with MPRs following FY22 assessment.
- Provide limited salary support for the Liberia Coordinating Mechanism (Global Fund) to support the collaboration required for PEPFAR to succeed.
- Build the capacity of the existing PEPFAR CLM partner.
- Support progress with a reliable sample transport system for HIV specimens, considering existing systems and also leveraging Global Fund commitments for sample transport.

In ROP22, 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 ROP22 to cover FSW. 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 ROP22 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 ROP22, PEPFAR/**Senegal** will scale up client-centered approaches such as targeted community testing, HIV self-testing, and MMD scale up. 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 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.

In **Sierra Leone**, coverage for case finding and ART continue to rise, but commodities, equipment and power have led to low viral load coverage. These issues are being confronted in FY22 including with Global Fund and other stakeholders and increasing coverage will remain a PEPFAR priority in FY23 as needed. Support for improved sample transport will also be pursued with Global Fund and in collaboration with CDC Sierra Leone (Global Health Security). In **Sierra Leone**, PEPFAR will create a limited platform to spread PEPFAR practices to non-PEPFAR supported sites, a priority request from the Ministry of Health. PEPFAR will also initiate limited AGYW interventions in one district, also a priority request from the Ministry of Health and UNAIDS. Patient Tracker will be restored, enhanced and expanded across PEPFAR sites, and SIMS coverage is expected to exceed 90% in FY23. PEPFAR will procure limited commodities to offset recurring supply chain challenges while also supporting supply chain strengthening. And PEPFAR will build on existing highly

productive collaboration with Global Fund and UNAIDS. PEPFAR will build on the success of its CLM partner and possibly triangulate CLM and SIMS data.

In ROP22, 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 ROP22. 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. Through the ARPA funds, Senegal will continue supporting the Ministry of Health by contributing to the reduction of the impact of COVID-19 at the national level. **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 support Ghana Health Service's COVID-19 Vaccination program to rapidly accelerate widespread and equitable access to and delivery of safe and effective COVID-19 vaccinations to eligible populations per national standards, and further offer targeted assistance to overcome barriers for populations who, as a result of social determinants or vaccine acceptance, are less likely to become fully vaccinated. In **Liberia**, ARPA funds will go toward supporting increased COVID-19 vaccine uptake, as well as the coordination and logistics around vaccine delivery and storage. 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[3]						
Program Area	**Country**	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment, and support	Burkina Faso*	$16,136,315	20%	58%	23%	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	$8,891,702	29%	71%	0%	0%
	Sierra Leone	GF budget details are not currently available across individual categories, only total. Total GF HIV grant is $16.06 million annually. PEPFAR estimated to represent about 45% of the National response.			0%	0%
Community-based care, treatment, and support	Burkina Faso*	$4,344,135	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					
PMTCT	Burkina Faso*	$3,798,153	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%

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

	Mali	$2,032,263		27%	24%	49%
	Senegal	$348,008		100%		
	Sierra Leone					
HTS	Burkina Faso*	$4,209,232	15%	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	$2,158,549	70%	30%		
	Sierra Leone					
VMMC	Burkina Faso*	Not applicable to West Africa Regional				
	Togo					
	Benin					
	Ghana					
	Liberia					
	Mali					
	Senegal					
	Sierra Leone					
Priority population prevention	Burkina Faso*	$3,727,386		10%	62%	28%
	Togo	$1,398,694	1%	7%	19%	73%
	Benin	N/A				
	Ghana					
	Liberia					
	Mali	$330,598		100%		
	Senegal					
	Sierra Leone					
AGYW Prevention	Burkina Faso*					
	Togo	$11,031	4%	0%	96%	0%
	Benin	N/A				
	Ghana					

	Liberia	$236,105	100%			
	Mali					
	Senegal	$348,008		100%		
	Sierra Leone					
Key population prevention	Burkina Faso*	$321,429	35%	65%	0%	0%
	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	$ 1,702,366	17%	83%		
	Sierra Leone					
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*	$6,809,758		50%	50%	
	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			100%		
SI, Surveys and Surveillance	Burkina Faso*	$418,919	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			100%		
HSS	Burkina Faso*	$4,713,537	0%	30%	68%	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					

*Burkina Faso data is from COP22 Resource alignment verification table, 2022 data
**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[4]
Burkina Faso	$770
Togo	$820
Ghana	$2,340
Benin	$1,280
Liberia	$570
Mali	$870
Senegal	$1,450

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

Sierra Leone	$540

The Gross National Income (GNI) per capita in the eight countries in PEPFAR/West Africa range from US$540 in Sierra Leone to $2,340 in Ghana. Only Ghana ($2,340 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 ROP22, 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 2021 ($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. ROP22 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. ROP22 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 regard 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 $492million from PEPFAR and GFATM to address HIV/AIDS. The GoG allocated $1.81 billion for health in 2022, slightly higher than the allocation of $1.50 billion in 2021. 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 HIV care and treatment for key and vulnerable populations, as well as for the general population. These investments also focus on 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, and this remains the case. A March 2022 report from the Office of the Inspector General (OIG) highlights fraud and abuse on use of GF financing from the NACP. Significant staff are expected to be removed from their positions. New leadership will likely be appointed. 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. ROP22 funding will be used to bolster services, purchase PrEP commodities to target FSW, 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 ROP22, PEPFAR will continue purchasing 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 and GFATM to ensure the optimal allocation of these commodities.

In **Sierra Leone,** PEPFAR is the second largest contributor to the National HIV response behind the GFATM. The Government of Sierra Leone has not met its Global Fund financing target and is not co-funding any of the PEPFAR supported response. PEPFAR, UNAIDS and Global Fund will jointly pursue this in the coming months, with the expectation that the GoSL will be initiating and scaling up investments no later than FY23.

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	$23,844,252.85	0%	65%	35%	0%
	Liberia*	$1,950,700	0%	98%		
	Mali	$5,807542	1%	99%	0%	0%
	Senegal	$1,614,346		100%		
	Sierra Leone			99%	0%	
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	$12,019,551.53	1%	46%	53%	0%
	Liberia*	$745,914	0%	100%		
	Mali	$2,663,928	9%	91%	0%	
	Senegal	$767,397		100%		
	Sierra Leone			99%	0%	1%
Other drugs	Burkina Faso*	$3,399,287	0%	52%	48%	
	Togo					
	Benin	142,998	0%	60%	40%	
	Ghana	-	-	-	-	-
	Liberia*	$292,721	0%	30%	0%	0%
	Mali	$789,136.88	0%	100%		
	Senegal	$43,478		100%		
	Sierra Leone			100%	Unknown	
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	$1,984,022.93	0%	100%	0%	0%
	Liberia*	$66,929	0%	100%		
	Mali	$2,763,023	8%	61%	29%	3%

	Senegal	$$536,973		53	47%	
	Sierra Leone			100%	0%	
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	$745,977.60	0%	0%	0%	100% (UNFPA)
	Liberia*	106,884	93%	7%		
	Mali					
	Senegal	$236,497		91%	9%	
	Sierra Leone				0%	
Viral Load commodities	Burkina Faso*	Included in lab reagents				
	Togo	$943,765.94	0	56	44	
	Benin	1,861,336	0%	60%	40%	
	Ghana	$1,984,022.93	0%	100%	0%	
	Liberia*	$286,817		100%		
	Mali	$3,641,278.26		48%	52%	
	Senegal	Included in lab reagents			53%	47%
	Sierra Leone				0%	
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					
	Liberia					
	Mali	$5,397,271.28		80%	20%	
	Senegal					
	Sierra Leone				Unknown	
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	$8,000,000	0	0	0	Improvement of mother and child health
	Togo	0	0	0	0	
	Benin	$6,000,000	$700,000	1		Reduce maternal, newborn, child, and adolescent mortality and morbidity
	Ghana	$11,000,000	$1,091,303	One (1)	$1,959,286	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	$27,500,000	0	0	N/A	Prevention and treatment of malaria
	Togo	0	0	0	N/A	
	Benin	$16,000,000	$850,000	1		Reduce malaria mortality and morbidity
	Ghana	$28,000,000	$12,091,928	One (1)	$1,959,286	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	$8,000,000	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	$6,000,000	$800,000	1		Increase access, availability of FP commodities and uptake of FP services.

	Ghana	$13,140,000	$1,258,955	One (1)	$1,959,286	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	$3,948,815	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	$4,000,000	$200,000	One (1)	$1,959,286	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	$615,000,000	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	$2,028,655	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 and Senegal were the only countries to carry out a Sustainability Index Dashboard (SID) in 2021. 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 ROP22, 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.

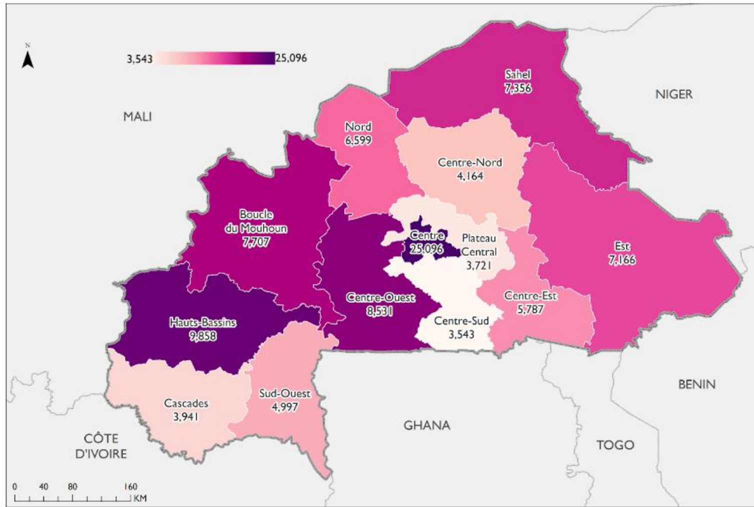
2.5 Alignment of PEPFAR investments geographically to disease burden

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

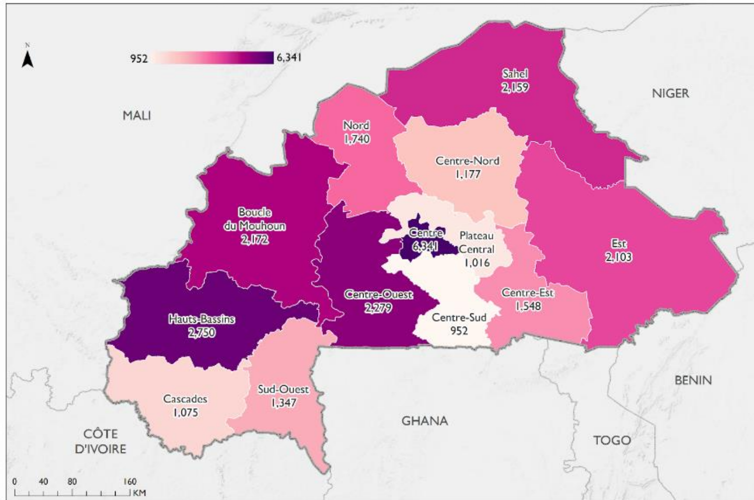
To ensure continuous alignment of PEPFAR investment to the HIV burden areas in **Burkina Faso,** an updated gaps analysis was done in collaboration with national stakeholders. According to Spectrum 2020 data, the five regions currently supported by PEPFAR in ROP21 (Boucle Du Mouhoun, Centre, Centre-Ouest, Hauts Bassins and Centre-Nord) will reach 85% ART coverage in September 2022. For ROP22, PEFPAR will remain in the five supported regions listed above. Those regions are home to 58% of the country's total PLHIV as well as PLHIV on ART and 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

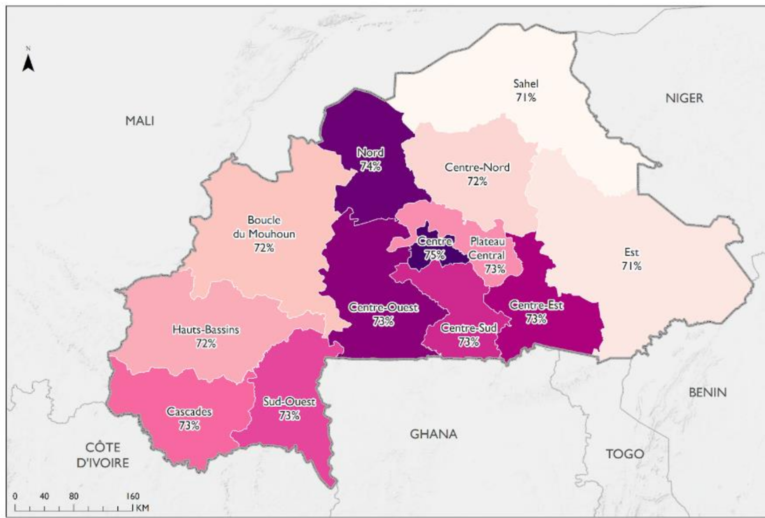
BURKINA FASO: PEOPLE LIVING WITH HIV

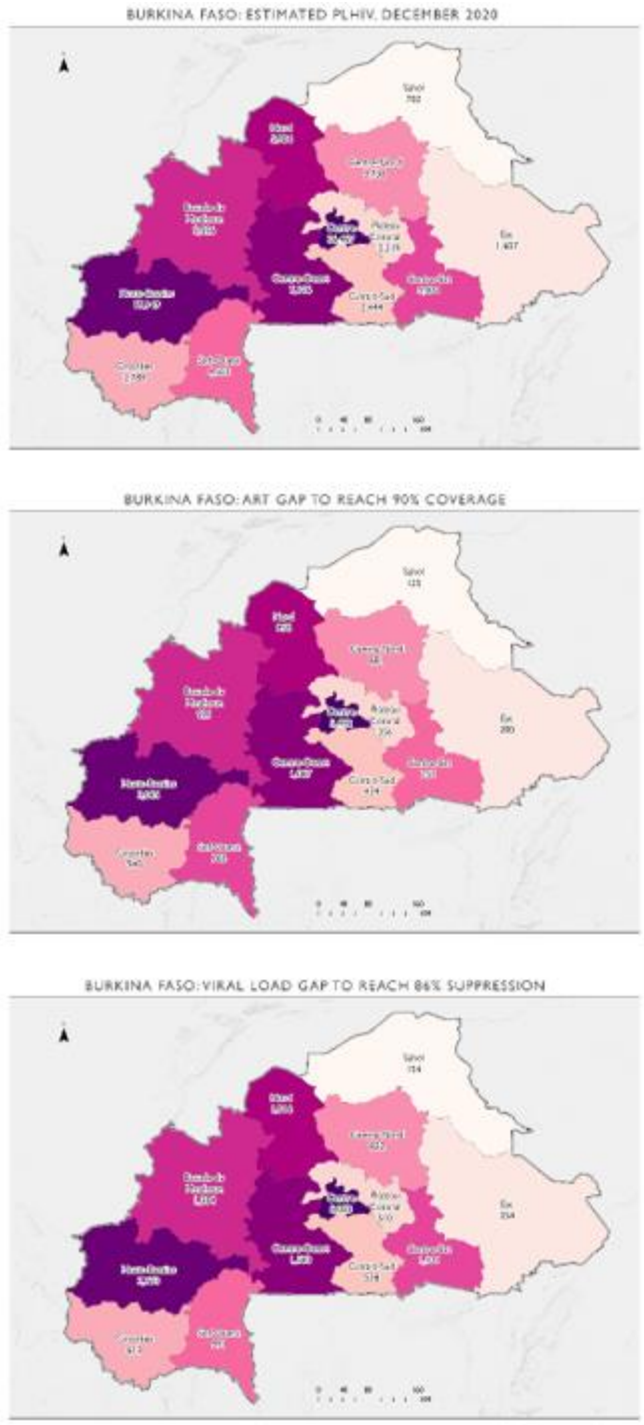


BURKINA FASO: PEOPLE LIVING WITH HIV NOT ON ART



BURKINA FASO: ART COVERAGE

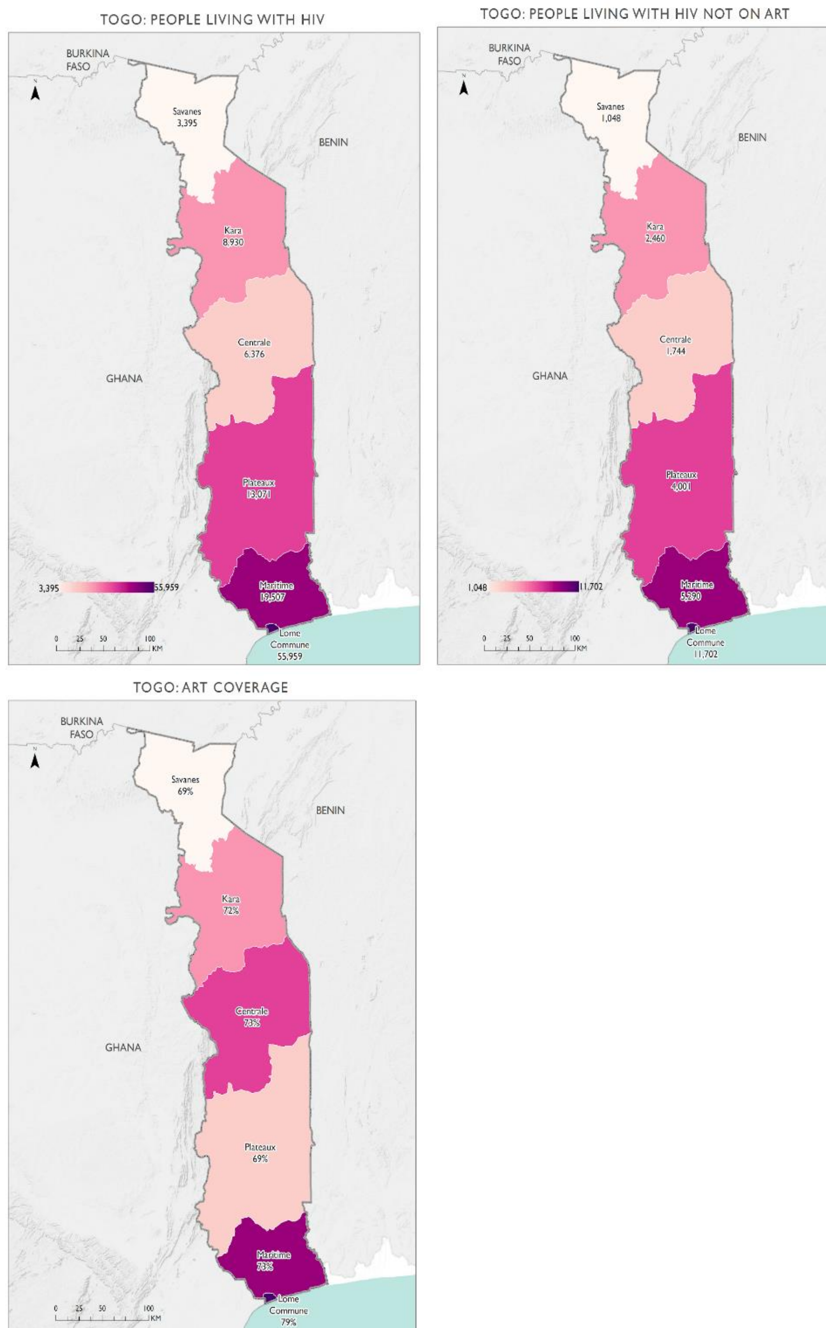


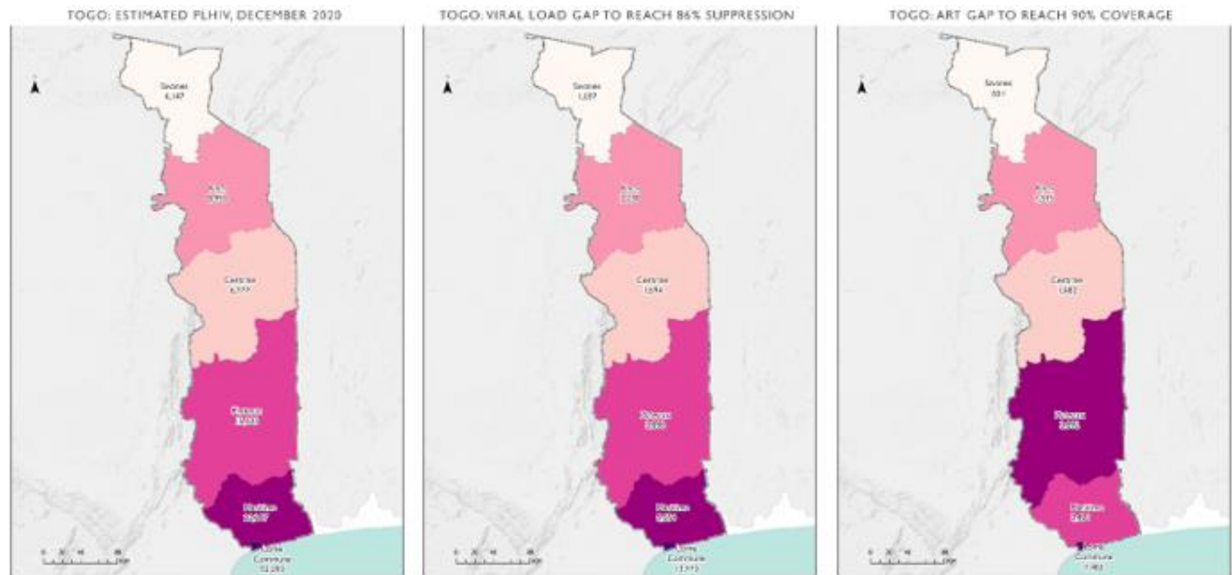


In **Togo,** as illustrated in the maps below, the HIV burden is concentrated in the Southern regions. In ROP21, PEPFAR focused its interventions on Lomé Commune, Maritime, Plateaux and Centrale regions which have the highest ART coverage gaps. According to Spectrum 2020 data, these four regions will achieve 80% ART coverage in September 2022. ROP22's focus is to continue to accelerate the national number of people currently on treatment in these 4 regions with an additional focus on the Viral Load suppression among PLHIV. The four selected regions for ROP22

(Lomé Commune, Maritime, Plateaux, and Centrale regions) cover 81% of the national ART gap and are home to 89% of the MSM, and 85% of the FSW (MSM and FSW size estimation 2017).

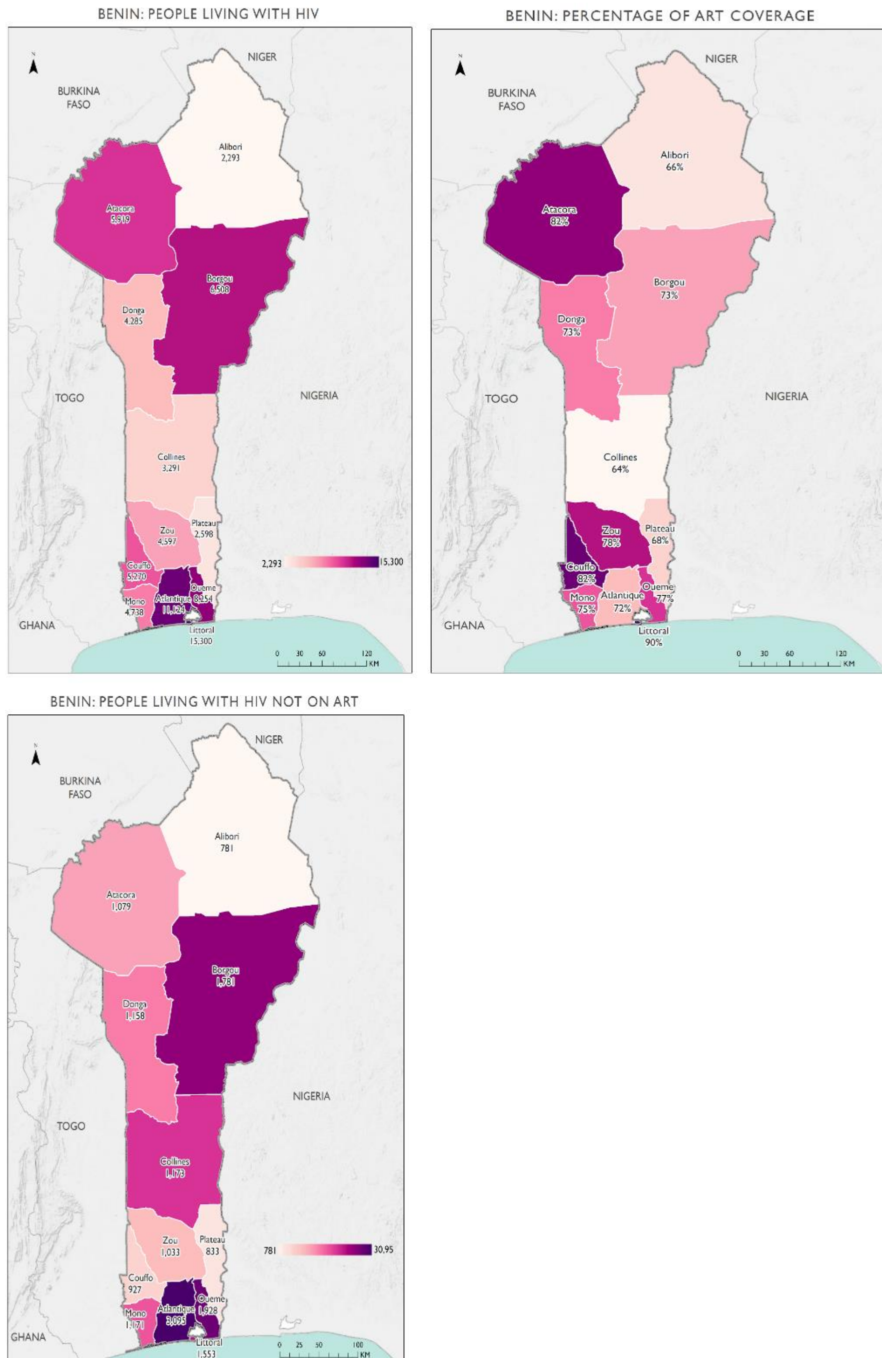
Figure 2.5.1B Togo: People Living with HIV by Region, Gaps in ART Coverage and Viral Suppression

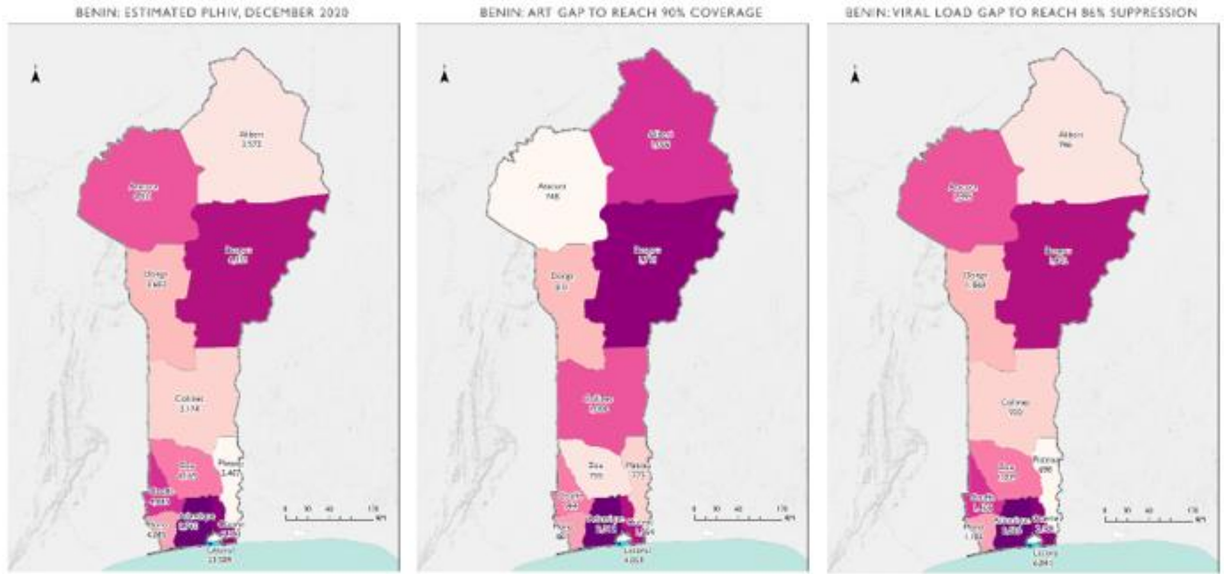




In **Benin**, in collaboration with the National Commission against AIDS, Malaria, Tuberculosis, Hepatitis and Epidemic, the Ministry of Health and other key stakeholders, PEPFAR analyzed the HIV burden and ART coverage gap using Spectrum 2021 data. Based on that analysis and the level of funding allocated to Benin the four high burden regions supported during ROP21 (Atlantique, Littoral, Couffo, and Mono) remain for ROP22. The Littoral region was over-saturated at over 100% based on the country context and the fact that it hosts many large service delivery facilities. These four regions are home to 41% of the national ART coverage gap.

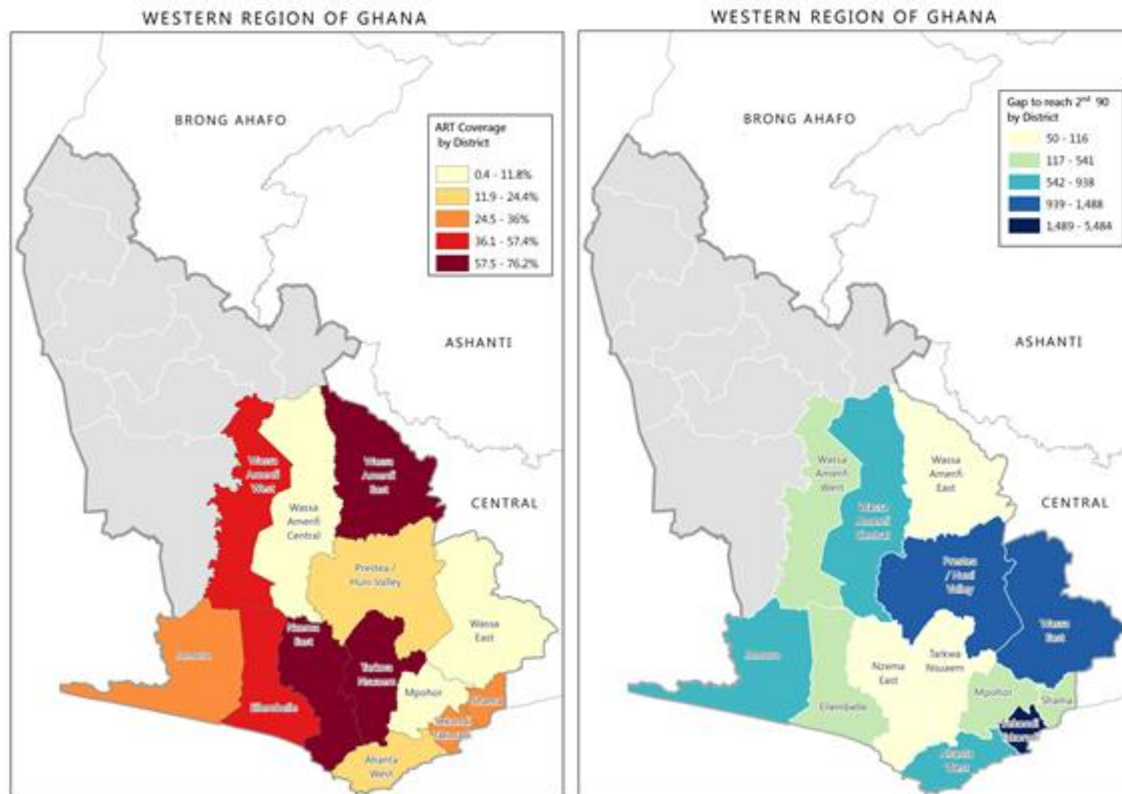
Figure 2.5.1C. Benin: People Living with HIV by Region, Gaps in ART Coverage and Viral Suppression





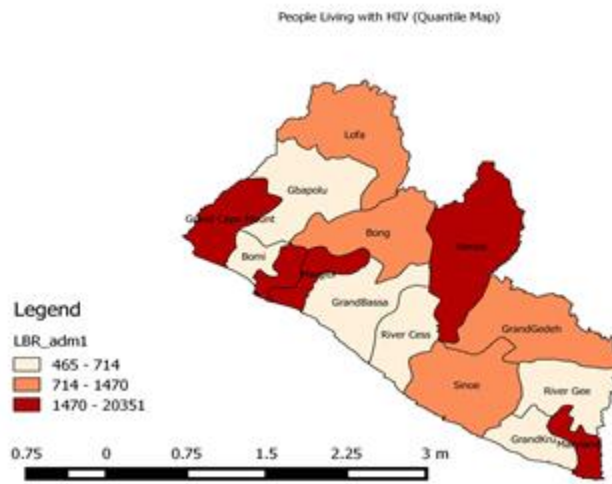
PEPFAR/**Ghana** will continue its support to the Western, Western North and Ahafo regions to achieve 95-95-95 targets. Per 2020 Spectrum estimates, both Western North and Ahafo regions had relatively higher prevalence (1.5% and 1.9%, respectively) and lower treatment coverage (65% and 58%, respectively) compared to the other 10 priority regions. In addition, the proportions of PLHIV who knew their status was at 73% for Western North and 74% for Ahafo, which indicated a high unmet need for HIV case identification in these regions. The expansion to the two regions was in full alignment with NFM3 and received strong support during the stakeholder engagement consultations. PEPFAR/Ghana will continue to scale up successful interventions in the two new regions and work closely with the GoG and the GFATM to do same in the remaining regions.

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



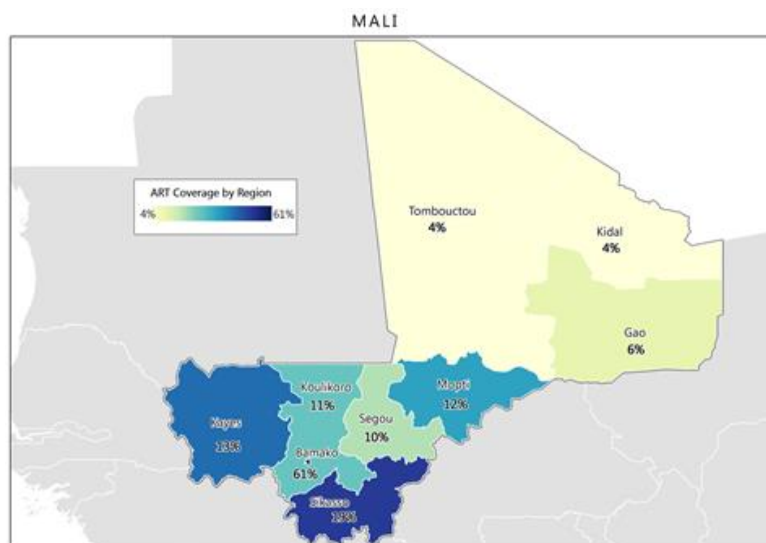
In ROP22, PEPFAR/**Liberia** will maintain support towards provision of quality HIV services in the counties of Montserrado, Margibi, Grand Bassa and Nimba Counties, with a total of 21 health facility sites and nine community sites. Building on the gains under ROP21, this will ensure scale-up of evidence-based guidelines, policies, and strategies to the majority of clients while maintaining a relatively tight geographic focus in the county. PEPFAR/Liberia will continue to scale-up index testing for case finding, which has proved to be the most effective testing modality with over 15% case finding. Through index testing, the program will aim to identify and put on treatment more children and men who current record low ART coverage. Additionally, PEPFAR/Liberia will expand its going online strategy to find more men, as current data show the program is missing men. At the community level, PEPFAR will target resources in nine community sites in Montserrado County and will use the facilities in Grand Bassa, Margibi and Nimba 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, Grand Bassa and Nimba 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



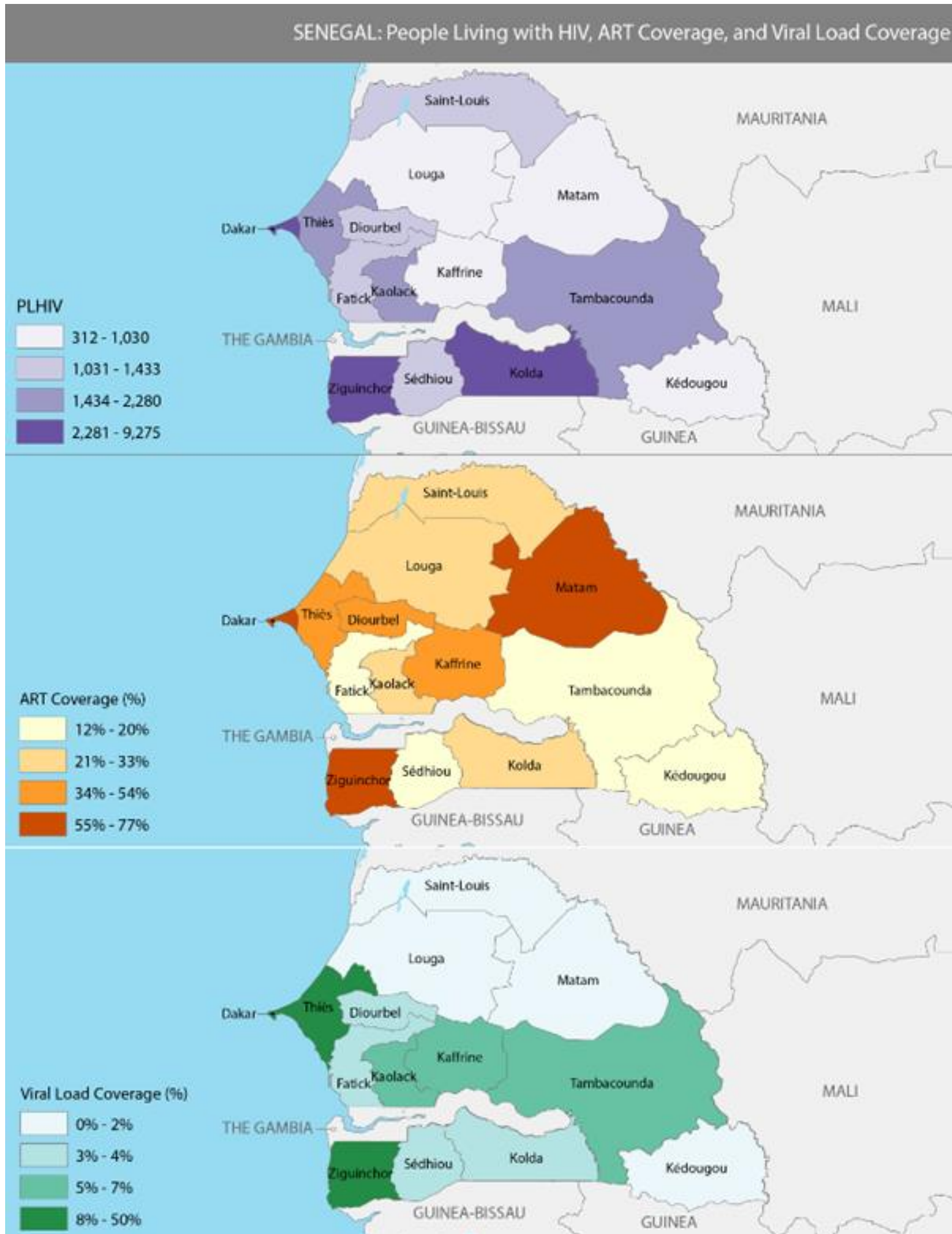
In **Mali**, to avoid duplication of efforts regarding KP services, PEPFAR and GFATM entered into a rationalization agreement in 2017 that specified that PEPFAR would cover KP services in three high-prevalence regions for KP (according to a 2015 mapping study): Bamako, Sikasso, and Segou. In the past, 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 ROP22, 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



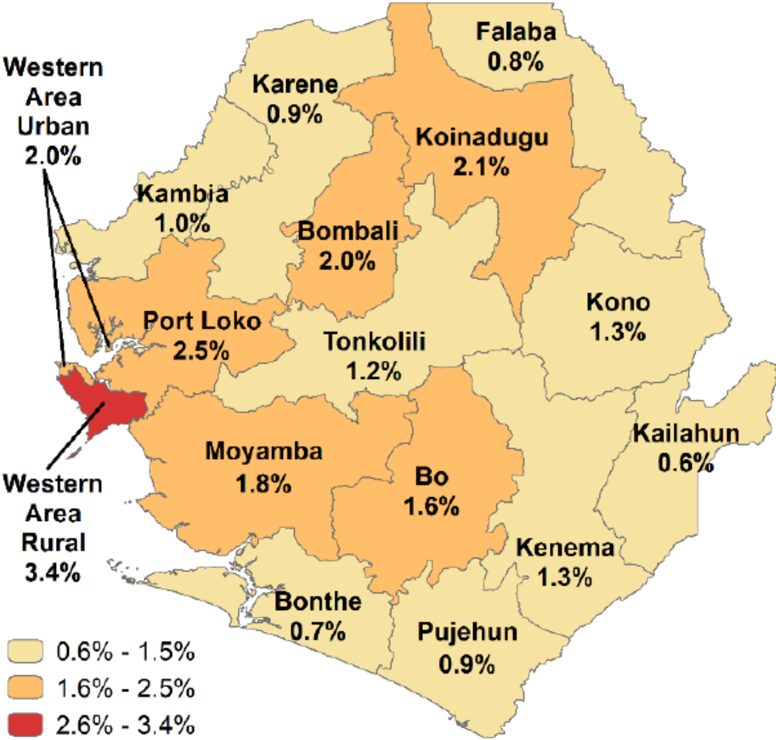
With the shift in ROP19 to a KP-focused program, the PEPFAR/**Senegal** program is focused in seven regions with high incidence among KP. In ROP 22, PEPFAR will continue implementing in KP hot-spot sites in high burden areas of Dakar, Mbour, and Ziguinchor, and is engaged in a KP-focused targeted testing strategy which includes testing for partners and children. 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 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 FY19. In FY21, the yield increased to 20%. Given these encouraging results, PEPFAR/Senegal expanded the program by adding new sites and regions. The PEPFAR/Senegal program will continue implementing in thirteen health districts in seven regions (twenty-six health facilities in total): Dakar (five districts), Ziguinchor (two districts), Thies (two district), St Louis (one district), Kaolack (one district), Kolda (one district), and Sedhiou (one district). 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 ROP22, the PEPFAR Program will be implemented in the same thirteen districts.

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



In **Sierra Leone**, PEPFAR will maintain a scale up aggressive posture in four high burden districts, having doubled the number of sites in FY22 and with substantial unmet need remaining. Above site investments will focus on supply chain and stigma and discrimination. It is hoped that PEPFAR will not need to support commodities after FY23. Technical support for Lab and SI will continue to build on gains in FY22 including expansion and enhancement of Patient Tracker across the PEPFAR sites and possibly beyond. KP data and use of a UIN are within FY23 plans. PrEP and other prevention interventions will continue through eight drop-in centers, with FY23 targets putting the program on a glide path to almost 7,500 enrolled on PrEP across the three years. Cultivation and capacity building of local partner candidates will continue in FY23, with prospects for sub-contracting program components through existing IPs. PEPFAR will support a limited AGYW program in one district based on a strong request from the GoSL and UNAIDS. A productive CLM partner will balance new data collection with advocating for solutions. Strong collaboration with Global Fund, UNAIDS, GoSL and civil society will be maintained and strengthened.

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 ROP22 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 ROP22 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 ROP22 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 ROP22 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 ROP22 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 in January 2022, 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 continue to work in Western, Western North and Ahafo regions. The stakeholders also expressed support for PEPFAR's proposed priority interventions to: optimize case finding strategies, complete 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, Western North and Ahafo 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 monthly 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 ROP22, PEPFAR will continue providing 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 ROP22, 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**, one national stakeholder consultative meeting was held with major stakeholders, including the National AIDS Commission, the Ministry of Health/National HIV & STI Control Program (NACP), CSO partners, UNAIDS, the GFATM Liberia Country Coordinating Mechanism (LCM) and other national stakeholders on February 24, 2022. Additional consultations were held with the GFATM Country Team. During these consultations, emphasis was placed on ROP22 MPRs and policy barriers, which need to be addressed to enhance access to services. Consultations also focused on the ROP22 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 will continue to hold quarterly PEPFAR IP meetings. There are also 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 strengthening grant oversight capacity which will ultimately improve performance across the HIV, malaria and TB grants supported by the Global Fund.

In **Mali**, as PEPFAR is 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 ROP22, 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.

NACP is now the principal recipient of the Global Fund HIV grant in Sierra Leone (was NAS previously). NACP has a new program manager who is showing the kind of leadership required. The leadership of NAS, NACP and NETHIPS, the CLM IP under PEPFAR, comprise the team for development of ROP22. These stakeholders have made two requests to PEPFAR for ROP22. First, to develop a plan to transfer PEPFAR best practices to sites not supported by PEPFAR. The PEPFAR team plans to support this on a limited basis, including assisting stakeholders to develop a plan to spread these best practices further on their own. Second, stakeholders are very concerned about the lack of support for AGYW. PEPFAR will support this population on a limited basis in one of four districts, to show what can be accomplished, and to pursue expansion in ROP23, if possible, as well as through Global Fund and National Response.

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.

2.7 Stigma and Discrimination

Ghana's national HIV response recognizes that the presence of stigma and discrimination in both health facilities and communities is a serious problem and that addressing it is crucial to ensure equitable access to care, improve service delivery, and foster health facility environments that promote non-stigmatizing and non-discriminatory care. Ghana is wrapping up its PLHIV Stigma Index study 2.0, which for the first time also included TB stigma index study. This will inform the roll-out of a refined and all-inclusive anti-stigma and discrimination effort by PEPFAR and other stakeholders. Within the region, Ghana has been selected to participate in the focal countries' collaboration, an effort among the Global Fund, UNAIDS and PEPFAR to measurably reduce stigma and discrimination through increased coordination, collaboration and planning with communities, governments and national partners, in a set of focal countries over a 3–5-year period. This will help implement comprehensive programmatic strategies to reduce stigma and discrimination at scale, promote partner government and community leadership at the country level, and advance efforts toward meeting the 10-10-10 societal enabler targets and PEPFAR's minimum program requirement. The Ghana Armed Forces is also benefiting from stigma and discrimination reduction interventions focusing on health workers, military officers/men, their family members and civilian employees in Accra and health facilities in the Western Region.

Senegal is one of the West African countries where homosexuality can lead to punishment. While homosexuality is not illegal, someone who is found committing an "improper or unnatural act" with a person of the same sex could be sentenced to up to five years in prison and be fined up to $2,715 under article 319 of Senegal's penal code. Although there is no centralized gender-based violence documentation and reporting mechanism at the national level, the National AIDS Program (Division de Lutte contre le Sida et les IST [DLSI]) and multisectoral council (Conseil National de Lutte contre le Sida [CNLS]) understand the impact that homophobia has on HIV program implementation and epidemic control amongst KP groups. In recent years, CNLS has held several workshops to take human rights into account in HIV programming and engage

religious leaders in preventing stigma and discrimination against people living with HIV (PLHIV). However, stigma, discrimination, and violence against LGBTQI individuals have been much less addressed. In ROP22, Senegal will support training for clinical providers, community leaders, local/national authorities, and police on stigma, discrimination, and human rights as well as provide support for national KP networks, civil society and GOS to harmonize prevention and care activities.

In **Mali**, Lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) people face stigma, discrimination, violence, and criminalization. While no laws explicitly criminalize LGBTQI+ people, Article 179 of the penal code regulates acts that "offend public decency" and has been used to punish them. According to a December 2019 global report on State-sponsored homophobia by the International Lesbian, Gay, Bisexual, Transgender and Intersex Association, Mali has no formal protections in the Constitution, no laws against hate crimes or incitement, and no broader protections against stigma and discrimination. In short, no protections for LGBTQI+ people exist in Mali. For these reasons, LGBTQI+ people must navigate a precarious environment in Mali, which includes anti-LGBTQI+ violence by state and nonstate actors, high risk of persecution, and limited legal protections. This --creates an environment where LGBTQI+ people are unsafe and their human rights can be and are disrespected and abused.

The ongoing country conflict in Mali compounded by the COVID-19 pandemic has all but eliminated previous safe spaces for LGBTQI+ people. Staff from three leading LGBTQI+ associations have documented increased anti-LGBTQI+ violence since 2020. In January 2020, 12 gay/bisexual men were arrested and incarcerated for 10 to 15 months. In October 2021, the office of an LGBTQI+ organization was attacked and ransacked during a routine HIV/health promotion talk, and four Malian lesbians were incarcerated following a police sting operation that infiltrated a private WhatsApp virtual safe space. The case is currently in court and the women are still being held without access to visitors. In the face of all this adversity, the LGBTQI+ organizations continue to plan and organize efforts to create an enabling environment that is safe, secure, and allows for freedom of expression and assembly. However, resources for such initiatives remain extremely limited.

The Government of Mali's 2021-2025 Integrated National Strategic plan (INSP) to fight HIV/AIDS acknowledges the complex health needs of men who have sex with men (MSM) and transgender people (TG) and recognizes them as priority populations for achieving HIV epidemic control. It is the only government document in the country that refers to gender and sexual minorities, with the aim of increasing access to health services for MSM and TG and reducing stigma and discrimination associated with accessing HIV services in Mali. This document has created an enabling environment to address the human rights of LGBTQI+ people through the lens of health. While the Government of Mali is not supportive of LGBTQI+ people, it appears to be supportive of their health needs. LGBTQI+ stakeholders in Mali increasingly understand the connection and importance of addressing human rights considerations in health programs.

Under separate cover, USAID/Mali is also engaging with DDI/GenDev to pursue supplemental and complementary funding to address gender-based violence (GBV) faced by LGBTQI+ people in Mali.

Togo Stigma Index Survey 2.0 Report was released in June 2021 and shows that despite a protective political and legal context, significant proportions of PLHIV continue to face stigma. In the last 12 months, respondents have experienced several cases of stigmatization and discrimination because

of their HIV status. 14.7% of the respondents were subjected to discriminatory remarks or gossip by family members, and 15.5% by others (beyond their family); 12.0% were verbally harassed; 7.2% were blackmailed; 4.8% were physically harassed or injured; 5.5% were refused a job or ever lost a source of income or a job. Some mitigation actions have started. For the first time, Togo has a specific focus in its National Strategic Plan against HIV/AIDS that addresses gender and human rights barriers in the national response. In 2022, a specific national plan for gender and human rights in HIV/AIDS was developed for 2022-2025. In ROP22, PEPFAR will support the implementation of that action plan. PEPFAR will strengthen its collaboration with the human right observatory and increase the awareness of KP and PLHIV on their rights and availability of supportive services (educational talk, online awareness with go online, development of self-esteem, GBV prevention and care, referral to legal services). Partnership with law enforcement officers, religious and customary authorities will also be improved for an improvement of the social environment in favor of KP and PLHIV. Health workers including Community Health Worker will be sensitized on promotion of free stigma and discrimination services. Community-led monitoring interventions will be leveraged to routinely monitor stigma, discrimination, and GBV at facility and community levels and provide corrective actions.

In **Burkina**, there is still a need to promote Stigma and Discrimination-free environment for Key Populations and PLHIVs. The Stigma index 2.0 report was released in June 2021 showing that a significant proportion of PLHIVs or KPs are still facing either stigmatization or auto-stigmatization related to their HIV positive status and/or their gender. In ROP22, the focus will be on activities to reduce stigma and discrimination through continued site-level interventions to make facilities KP-friendly. The country will continue to address stigma and discrimination as part of community-led monitoring efforts, including quarterly mystery clients' surveys, client's satisfaction surveys, and routine data collection conducted by CSOs and PLHIV associations. PEPFAR will support monitoring of subsequent corrective actions implementation and will provide resources as needed for human rights response in the context of potential KP criminalization and anti-LGBTI incidents affecting service delivery.

An emphasis will also be put on the empowerment of KP and PLHIV led associations, as well as strengthening the offer of services for the prevention and management of gender-based violence.

Additionally, in collaboration with all the stakeholders PEPFAR will support the development and implementation of a national joint action plan to reduce stigma and discrimination through the leadership of the community led monitoring project.

In **Benin**, despite enabling legal environment to limit the cases of stigmatization and discrimination, the PLHIVs and Key populations continue to face a hostile environment. In ROP 22, the focus will be to reduce stigma and discrimination through National advocacy in collaboration with the Global Fund and other donors to promote relevant actions, and combat stigma, discrimination, violence against PLHIV and key populations. Our approach will consist in supporting CSOs, PLHIV associations, PS/HSH associations and faith-based organizations to develop breakthrough activities to promote PLHIVs and Key populations' rights. Additionally, we will strengthen collaboration with local authorities and other Govt bodies such as police, judicial, human rights observatory for the defense of the rights of key Pop and PLHIV. Moreover, our assistance will help sensitize key Pop, adolescents and youth on their rights and harmful social norms, and use the CLM activity to monitor stigma, discrimination cases and provide corrective actions.

In **Liberia**, members of the LGBTQI community experience high levels of stigma, discrimination, criminalization, and violence. These members include lesbians, gays, bisexual, transgender, queer, and intersex persons. Additionally, same-sex sexual activity is illegal and is punishable by up to one year in prison. Chapter 14 of the Penal Law of Liberia criminalizes voluntary sodomy. Meanwhile, the National Strategic Plan (NSP) of Liberia acknowledges the huge health gaps and disparities as well as the health needs for men. It identifies men who have sex with men, transgender persons, among others as key populations and prioritizes interventions for these populations as key for achieving HIV epidemic control. Currently, UNAIDS, GFATM, PEPFAR, MOH and the PLHIV network are collaborating to conduct Stigma Index 2.0. This will be completed during the early parts of ROP22 and will inform some of the specific interventions on the ground in terms of reducing stigma and discrimination. In ROP22, PEPFAR/Liberia will continue to invest resources in sensitization on KP rights, sensitization on stigma and discrimination for health workers to ensure friendly environment at health facilities for KPs, monitoring incidences of violence, putting in place measures to prevent issues around safety and security. Additionally, PEPFAR will continue to implement community-led monitoring and building capacity for KP and PLHIV civil society organizations. Through UNAIDS's leadership and a national consultative process, Liberia selected 3 areas to focus its stigma and discrimination work, including addressing stigma and discrimination in the health, household & community, and legal & justice settings. These have been outlined in a national Stigma and Discrimination Action Plan which is now validated. In ROP22, PEPFAR will prioritize working with the UNAIDS, the PLHIV network and NAC to address existing gaps in the national S&D Action Plan.

In **Sierra Leone**, The Stigma Index 2.0 was conducted in 2020, under the direction of the PEPFAR CLM partner, and the report contains a clear roadmap for confronting stigma and discrimination. This roadmap will be prioritized, in consultation with recipients of care, providers and others, and a work plan will be created. Plans will also be guided by PEPFAR's minimum program requirement. Sierra Leone has diverse and high functioning civil society organizations, along with a permissive and supportive Government. Work in this area is well timed with efforts for aggressive scale up, with stigma and discrimination representing a key barrier to case finding, continuation in care and uptake of prevention initiatives. The CLM partner will play a central role in this work.

3.0 Geographic and Population Prioritization

Burkina Faso's geographic prioritization was determined at region level considering Spectrum 2021 data and gaps to reach 95% ART coverage and 80% PopVLS overall. Based on the latest SPECTRUM 2021, while Burkina Faso has reached 83% nationwide and in all 5 PEPFAR supported regions, a focus is placed on viral load access for a rapid increase of these patients to viral load. Above-site activities will also contribute towards improving the overall national cascade.

The disaggregation by age and sex revealed low coverage among children (<50%) and adult men (60%). The ART coverage among children and adult men were respectively 43% and 63% versus 99% among adult females in 2021 (Spectrum 2021). 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 ROP22 program will maximize opportunities to reach KP, children, and men and to address barriers that have limited their access to ART. ROP22 targets were set accordingly in order to fill gaps by sex and across all age.

Togo's gap analysis occurred at the regional level. Four regions were prioritized: the three regions prioritized in ROP20 (Lomé, Maritime, and Plateaux regions) and an additional region in ROP21 (Centrale region). These four prioritized regions have the highest gaps to reach 90% ART coverage and represent 88% of the national gap. Except for Lomé, none of the other prioritized regions is expected to reach 81% ART coverage by September 2022. PEPFAR's programmatic objective will be to support the Government of Togo to reach 90% 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 (51% ART coverage in 2021) and adult men (63% ART coverage in 2021). 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 ROP22, 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 departments, as in ROP21, based on their HIV burden and the department context. They are Atlantique, Littoral, Couffo, and Mono departments. Those four prioritized regions are home to 52% of the national ART coverage gaps. Mono is expected to reach 80% ART coverage but given its proximity to Couffo (60% ART coverage) and patient movements between both departments, they will remain at scale-up to saturation prioritization. Littoral is expected to surpass 100% coverage; however, this department hosts the largest and highest number of public facilities to which converges patients across the country. This department is strategically prioritized at scale-up to saturation to continue the efforts around positives identification and enrollment on ART In ROP22, PEPFAR aims to implement a scale-up to saturation approach to support the Benin government to reach by September 2023, 90% ART national coverage.

The disaggregation of the ART coverage by sex and age in **Benin** shows lower ART coverage among children (70%), and adult men (61%) compared to women (86%) in 2021. When analyzing 5 years age bands, 10-14, 15-19, and 20-24 have the lowest coverages at 55%, 60% and 63% respectively. The ROP22 program will maximize opportunities to reach KP, children, and men and to address barriers that have limited their access to ART.

In ROP19, 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 towards achieving the 95-95-95 target in Western region, with stakeholders proposing an expansion to cover two adjacent regions, Western North and Ahafo in ROP21. ROP22 activities will sustain, and in some cases scale up implementation of strategies that have proven successful since ROP21 in the three regions. Activities in ROP22 will prioritize optimized case finding, linkage, and continuity of treatment for men, children, 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, while HIV continuum of services for KP and other priority populations will continue to be prioritized.

PEPFAR/**Liberia** shifted its strategy from supporting KP (MSM and FSW) and priority populations to supporting a care and treatment model for both KPs and the general population. The objective was to improve case finding and treatment initiation. With significant progress made in case finding and treatment initiation, the program shifted in ROP21 to support retention on treatment and viral load interventions. In ROP22, PEPFAR/Liberia will continue to focus highly on adherence, retention and viral load coverage and suppression. To achieve this, PEPFAR will strengthen individual patient tracking and follow-up through operationalizing DHIS2 e-Tracker.

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 treatment in Montserrado, Grand Bassa, Margibi, and Nimba Counties in ROP22.

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** expanded 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. The PEPFAR/Senegal program will continue implementing in thirteen health districts in seven regions in ROP22 (twenty-six health facilities in total): Dakar (five districts), Ziguinchor (two districts), Thies (two district), St Louis (one district), Kaolack (one district), Kolda (one district), and Sedhiou (one district). PEPFAR/Senegal will continue providing TA to the National AIDS Council (NAC) and MoH to implement cross-border activities with Gambia, Guinea Bissau, and Guinea Conakry to reduce cross-border infections among MSM and FSW along the southern border. In ROP22, the PEPFAR Program will be implemented in the same thirteen districts The number of sites supported in **Sierra Leone** through PEPFAR doubled in size in FY22. This expansion occurred across each of the original four districts (16 districts in Sierra Leone), and these four districts will remain scale up aggressive for ROP22. National coverage remains low across the cascade. Prevention activities are bolstering case finding. Serious gaps remain in reaching men across nearly all age groups, and

coverage with children is poor. There is abundant unmet need in these four districts to support continued aggressive scale up. There are additional high burden districts, but geographic expansion is not possible currently.

Table 3.1

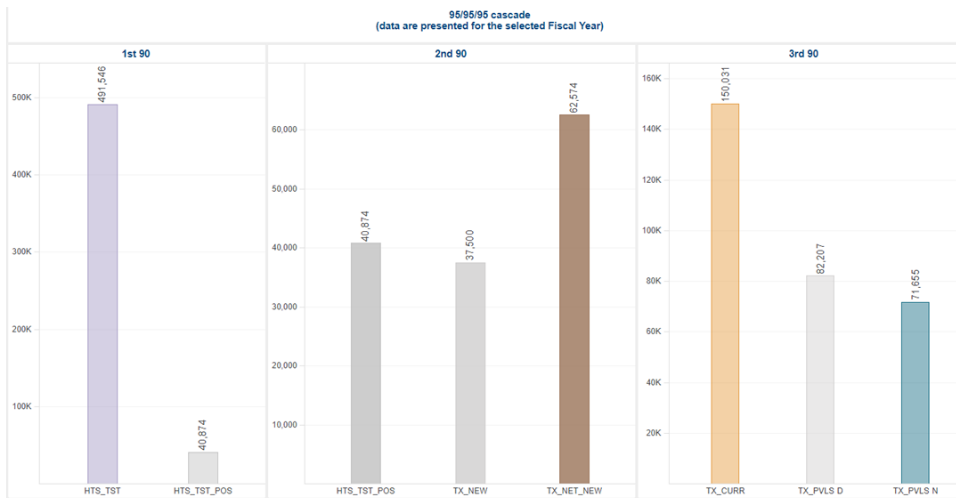
Table 3.1 Current Status of ART saturation					
Prioritization Area	**Country**	**Total PLHIV/% of all PLHIV for COP21**	**# Current on ART (FY21)**	**# of SNU COP21 (FY22)**	**# of SNU COP22 (FY23)**
Attained	Togo*	55,673/50%	45,137	1 region 1 region (Grand Lome)	1 region
Scale-up Saturation	Burkina Faso	50,294/ 74%	41,680	4 regions	5 regions
	Togo	38,700 / 38%	27,303	3 regions	3 regions
	Benin	37,475/52%	30,842	4 regions	4 regions
	Ghana	41,337 (11.9%)	29,426	1 region (Western)	3 regions (Western, Western North and Ahafo regions)
Scale-up Aggressive	Liberia	25,000 (73%)	17,000	N/A	9 districts
	Mali	89,619 (69%)	57,257	23 districts in 3 regions (23 sites)	23 districts in 3 regions (23 sites)
	Senegal	23,886	18,023	7 regions (13 districts) sites)	7 regions (13 districts, 26 sites)
	Sierra Leone	21,237 in 4 districts NAOMI 22	11,568 NAOMI 22	4/16 Districts	4/16 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 COP22 Programmatic Priorities for Epidemic Control

Figure 4.0.1 Overview of 95/95/95 Cascade, FY21



4.1 1 Finding people with undiagnosed HIV and getting them started 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 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.

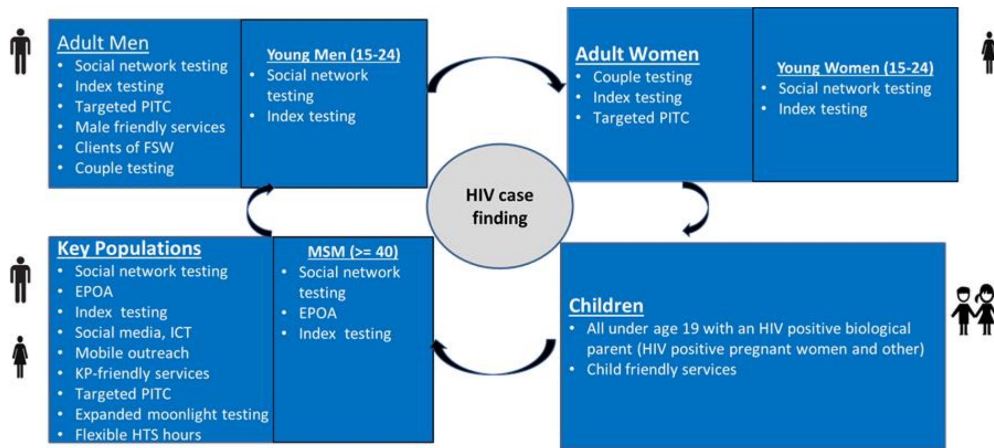
Index testing and partner notification throughout the region was found to be the most efficient case finding strategy at PEPFAR sites. It will be implemented with compliance to WHO's 5 C's (counseling, including consent procedures, correct test results, linkage to care and treatment of positive clients, 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 person-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 15 to 39, 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 and PrEP services, introduced respectively in ROP20 and ROP21, 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 and person-centered approaches. Activities will ensure targeted and effective screening to increase positivity 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. Safe and ethical 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 66% of PLHIV know their status and only 61% are on treatment (2021 Spectrum and routine program data). To address this, in ROP22, 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 ROP21 KP activities by directly supporting HIV testing for KP (MSM and sex workers) and newly in ROP22 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.

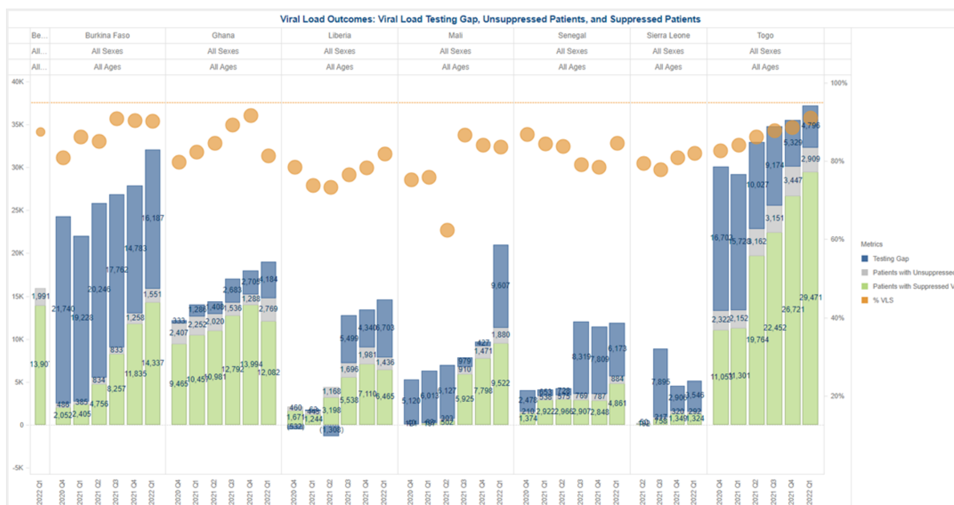
The first 95 is a major gap for **Mali**, with only about a half of PLHIV knowing their status. To find missing PLHIV, Mali will scale up EPOA and self-testing, as well as scaling up community-level index testing in collaboration with the national network of PLHIV. Index testing and EPOA were both successful 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.

Index testing has been a very successful strategy in **Sierra Leone** under PEPFAR. The doubling of the program in FY22, and abundant unmet need in the four PEPFAR supported districts, will support significant gains in case finding for which National coverage remains around 50%. ART coverage showed strong growth Nationally, but Global Fund recently initiated an ART audit to confirm ART coverage. PEPFAR sites continue to perform well against targets. National TLD coverage is high, but myriad supply chain issues have delayed DTG10 roll out and has caused MMD3 to be temporarily curtailed. MMD6 has not been widely supported, and PEPFAR will work with NACP and Global Fund to align health products in support of MMD6. Men are being missed across all age bands, and this represents an important opportunity to increase caser finding and treatment coverage. VL testing has been plagued by equipment, power and commodity failures. PEPFAR has leveraged GeneXpert platforms but still fell far short of VL targets. Sustainable solutions are being aggressively pursued in FY22, and FY23 is expected to build on rapidly improving coverage. Trends in transmission and AIDS-related deaths are both upward for Sierra Leone, and this needs to be interrogated and acted upon.

4.2 Ensuring viral suppression and ART continuity

Figure 4.2.2 Viral Load Outcomes, FY21



4.3

In **Burkina Faso** and **Togo,** a scale-up of strategies to support, person-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 five existing MPRs related to care and treatment at all sites, and (iii) implementation of quality management policies and practices to support and maintain site standards. To increase continuity of treatment, 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 15-30 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 person 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 persons who have discontinued treatment. 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 ROP22. Currently, only 61% of PLHIV who know their status are on treatment and of those on treatment, only 47% are virally suppressed (2021 Spectrum and routine program data DHIS-2). PEPFAR/Liberia will support efforts to reach the second and third 95s by continuing its 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 ROP21 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 strengthen the sample referral system. 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 ROP22, 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.

4.4 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, PrEP, promotion of condoms and lubricants use, diagnosis and treatment of STI, 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 and PrEP services provision are priority prevention strategies, 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 and lubricants and PrEP services 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.

In **Sierra Leone**, FY23 represents the third year of PrEP under PEPFAR, with nearly 7,500 targeted across three years. A newly released IBBSS contains substantial reductions in estimates, particularly with FSWs. Technical support for strategic information through CDC will assist with better KP data, which is largely absent in Sierra Leone except for data developed through PEPFAR prevention activities. An existing DHIS2 patient tracker is being reinvigorated and expanded, including a reliable unique identification number, and with a substantial Global Fund allocation to expand Patient Tracker.

PrEP will continue to be scaled up in all 8 countries of the West Africa Region in ROP22.

Ghana will scale up PrEP for KP and other high risk groups 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. **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,** PrEP enrollment will continue and expand in Liberia, with USAID supporting a community-based model with final enrollment occurring at health facilities and HRSA supporting an entirely community-based model, building on a successful model in Sierra Leone, while also accounting for a number of sensitivities in Liberia.

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.

4.5 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 ROP22 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 (counseling, consent procedures, correct test results, linkage to care and treatment of positive clients, and protecting confidentiality). To find KP who need 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 ROP201, 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, and the use of VL results at site level to improve viral load suppression. In line with that, PEPFAR teams increased the budget allocated to viral load intervention in ROP 22, by 35% both in Togo ($1.9 million) and Burkina Faso ($1.56 million). Particular attention was made to ensure availability of VL reagents and commodities in collaboration with GFTAM and the MoH. Budget allocated in ROP 22 to viral load reagents and commodities was increased by 128% in Togo ($1.1 million allocated in ROP22) and 214% in Burkina Faso ($700.000 allocated in ROP22. 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.

In addition, PEPFAR Burkina Faso plans to provide technical assistance to the Ministry of Health to coordinate, consolidate, and improve laboratory capacity to advance HIV testing, treatment, retention, and viral suppression. Specific areas of support will include: 1) External Quality Assurance/Proficiency Testing (PT) to improve testing accuracy with increased percentage of laboratories scoring 100% at each PT cycles as well as impact on the quality of laboratory system for accreditation toward international standards; 2) HIV Viral Load Laboratory Network Optimization to ensure efficiency and accuracy of HIV viral testing as well as specimen referral networks for timely production of results and program monitoring; 3) HIV VL Laboratory Continuous Quality Improvement and Laboratory Management by building the capacity and enable Viral Load laboratories and partner with options to improve the management, quality, and efficiency of the Viral Load performance; 4) Laboratory Information Management Systems (LIMS) to ensure all laboratories transmit VL and EID data to a national Viral Load dashboard that serve as platforms for analyzing and visualizing lab data from all laboratories and facilities in real-time. This process will help monitor VL and EID coverage, testing network efficiency and viral load suppression, as well as Improved turnaround time for VL and EID results delivery and minimize errors associated with manual data entry.

Benin already adopted all the MPRs policies and in ROP22, 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. ROP22 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. Budget allocated to viral load was increased by 93% in ROP 22 ($953,00) compared to ROP 21 ($495,000) to strengthen each viral load chain component (demand creation and samples transportation, supply chain, lab system strengthening, use of viral load results, coordination). Budget allocated to PrEP also increased by 64% to accelerate its scale-up through strengthening training/refresher, demand creation, service delivery with appropriate monitoring system.

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 high disease burden regions. In ROP22 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 Greater 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. Lessons and innovations learned through working with WAAF and from the three PEPFAR-supported regions will be incorporated into the national program by the PrEP and HIV Self-testing Committee, including supporting a framework for supportive supervision and monitoring to ensure quality implementation.

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 ROP21. 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, and over 95% of PLHIV on ART have been transitioned to TLD. Areas for improvement include individual patient tracking, preventing treatment interruption and focusing TLD transition and on VL/EID optimization to increase coverage and suppression. In ROP22, 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, scaling up 6 MMD, maintaining 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. ROP22 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 ROP22, 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 ROP22. 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 ROP22.

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 ROP22. 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) should continue to be strengthened to ensure complete transition to TLD and 6MMD, to ensure access for PLHIV to appropriate ART (TLD for all PLHIV > 30kg, complete removal of all Nevirapine). The national warehouse does not track ARV consumption data from services delivery point. 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 ROP21, the PEPFAR continued to monitor implementation of TLD transition policy adopted in ROP20. As of FY22Q2, the program achieved a TLD transition rate of 49 % in PEPFAR-supported sites. 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 FY22 Q1, 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 ROP22 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 ROP22 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). The PEPFAR Team will support. end-to-end supply chain data visibility to support programmatic goals in general, with a focus on logistics data for viral load commodities and other lab consumables. 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 ROP21, PERFAR team has continued to provide TA to MoH to better manage the supply chain stock to prevent stockouts at services delivery points. This support included training of supply chain workforce across the health systems (central level, regional levels, and health facilities) on forecasting, quantification, and inventory management tools. The TLD transition reached the impressive coverage of 98 % in PEPFAR-supported sites (compared to 97% in other facilities) as of end FY21 Q1. This This performance is the result of combined actions from multiple technical areas including supply planning, meticulous inventory management, and greater visibility of TLD stock across the health system. Availability of monthly consumption data has improved significantly. PEPFAR support aims to work with the government and GFATM to address remaining issues, such as unavailability of routine logistics data at facility level to inform decisions making. At the end of FY22 Q1, patients on MMD refill schedule accounted for 97% of patients on ART (of which 27% on 3MMD and 67% on 6MMD) in PEPFAR-supported sites. At national level, the overall MMD coverage is 78% (58% on 3MMD and 20% on 6MMD). This data suggests the need to increase the proportion of patients on 6MMD in the non-PEPFAR supported sites. ROP22 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); r; 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) Continue systems interoperability: EDT and DHIS2; iii) continue systematic and periodic review meetings to update supply plan and anticipate shipments delays, and improve tracking of HIV commodities orders from all fundings; 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 the second, year of PEPFAR support, the investments in supply chain strengthening will continue to complement the ongoing efforts provided by the GFATM and Government of Benin. Similar to Burkina Faso and Togo, the PEPFAR team in Benin will collaborate with other stakeholders to address ROP22 supply chain-related priorities highlighted for Benin namely: strengthening the overall supply chain (Data visibility and data use for decision making; advocate for adoption of 6MMD policy adoption;, full transition to TLD (adults) and DTG 10 transition for

children;, improve viral-load access including continuous commodity availability) 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 stock management with LIMS implementation, production of routine logistics data, data visibility to drive program performance with data triangulation; and monthly supply chain performance review monitoring to boost TLD uptake (50.3% in PEPFAR-supported sites end FY22Q1; and accelerate; MMD implementation (approx. 30% in PEPFAR supported sites at the end of FY22Q1). 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 (improve storage, inventory management). A rigorous site-visit plan focusing on problem-solving approaches will be developed and implemented. PEPFAR also works with the other stakeholders to provide technical assistance to the subnational level of the health systems, to implement client-centered supply chain activities geared towards support to the three 95 goals.

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 ROP22, 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. In ROP22, through GHSC-PSM, 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. PEPFAR has allocated $100,000 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 **Sierra Leone**, PEPFAR will continue to work with other stakeholders to strengthen the supply chain, support which only began in FY22. Continued poor site level quantification and other factors have led to shortages and stock outs. These factors create risk for the PEPFAR program. For these reasons, modest procurement of several commodities is recommended under PEPFAR for FY23. Aggressive efforts to strengthen supply chain will continue, with the goal of having a better functioning system which does not require additional commodity support through PEPFAR.

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.

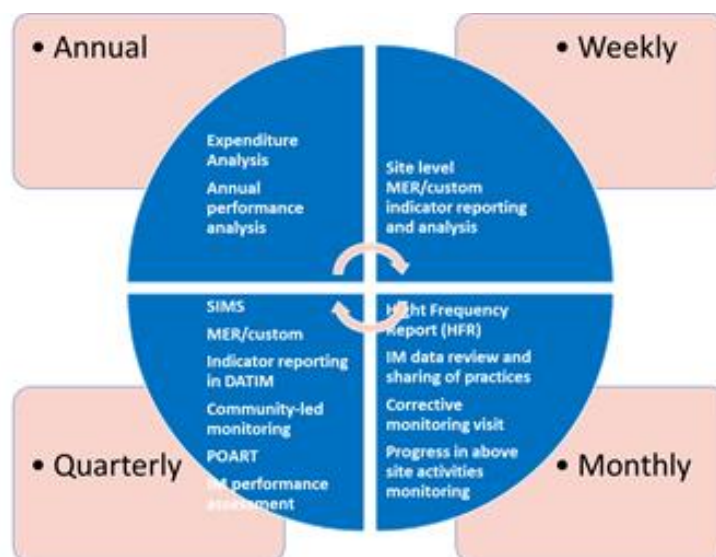
In ROP22, PEPFAR/**Mali** will purchase PrEP commodities and RTKs. The inclusion of PrEP in the prevention package for KP has been limited in Mali, with procurement limited to pilot programs. PEPFAR will purchase PrEP commodities to ensure availability at PEPFAR-supported sites for at-risk KP and sero-discordant 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.

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. In addition, Ghana has been selected to participate in the focal countries' collaboration, the Global Fund, UNAIDS and other stakeholders to measurably reduce stigma and discrimination through increased coordination, collaboration and planning with communities, governments, and national partners.

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 ROP22, 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.

Benin, Burkina Faso and Togo will continue implementation of community-led monitoring in ROP22 through routine data collection and quarterly mystery client surveys conducted by CSO and PLHIV associations. Data will be collected data on availability of services, client satisfaction, user fees, waiting times, implementation with fidelity of Test and Start, and TLD transition, and barriers to service. Findings will continue to be disseminated, bottlenecks identified, and corrective actions implemented to improve the quality of services to PLHIV and remove structural barriers to access to services.

Sierra Leone has an effective CLM IP which continues to achieve important results. The IP has found balance between data collection and driving for results and has a central position with leaders in the National response. The IP has taken dramatic actions to bring about solutions. For example, seven containers of commodities procured by Global Fund were stranded at the port for many months. NETHIPS, HRSA's CLM IP, recently threatened to hold a press conference to describe the various failures that led to this crisis. Within a few days of the announcement the containers were released from the port and the press conference was called off.

Ghana is currently implementing a rigorous system to monitor the quality-of-service provision across all facilities in the Western, Western North and Ahafo regions. 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. Community-led monitoring will be coordinated through USAID with a planned award to a local organization. Starting in ROP22, Ghana will 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.

Liberia will ensure continued support to the implementation of community-led monitoring interventions through CSOs and will continue capacity building for the CLM CSO partner in ROP22. This level of monitoring through CLM 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-led monitoring through CSOs will cover all PEPFAR-supported sites in ROP22 and results will be used to improve treatment outcomes for HIV clients and will be 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 ROP22, the e-Tracker will be scaled up nationally in collaboration with the GFATM. Similar to Burkina Faso and Togo, **Benin** will continue to use 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. In **Sierra Leone**, a patient tracker and UIN were established previously but not widely in use. In FY22, PEPFAR is reinvigorating the existing patient tracker and UIN. There is strong leadership and technical support for this within NACP, and Global Fund planned a significant expansion of patient tracker in NFM3.

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 (Grand Lomé)	55,673	46,710	-	27,822	2,585	>100%
Scale-Up Saturation	Burkina Faso	49,808	53,890		43,499	4,457	95%
	Togo	38,700	28,583		24,560	1,947	88%
	Benin	37,475	32,249		25,687	2,520	94%
	Ghana	41,657	30,707	2,618	32,000	6,615	73.7%
Scale-Up Aggressive	Liberia	34,358	30,922	6,419	15,690	4,737	55%
	Mali	89,619	62,407	9,288	57,257	8,474	73%
	Senegal	23,886	18,023	1,023	16,299	2,139	>100%

	Sierra Leone	80,000 Total 21,237 in 4 districts NAOMI 22	95% coverage = 20,175	18% left to go for 80% of 21,237 = 3,822	14,124 (FY23 Target)	3,895 (FY23 Target)	- 62% NAOMI FY 22
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	4,575	75%	3,433
	FSW	12,859	75%	9,645
	Total	**17,434**	**75%**	9,645
	MSM	8,920	66%	5,882

Togo	FSW	20,231	70%	14,137
	Total	**29,151**	**69%**	**20,019**
Benin	MSM	**2,756**	**75%**	2,066
	FSW	**7,646**	**75%**	**5,735**
	Total	**10,40**	**75%**	**7,802**
Ghana	MSM	6,699	88.8%	5,949 (KP_PREV)
	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	**13,998**	60%	8,400 (TX_NEW)
	FSW	**39,944**	60%	23,966 (TX_NEW)
	Total	**53,942**	**60%**	**32,366**
Senegal	MSM	1,857	95%	8,307
	FSW	656	95 %	4,114
	Total	**12,421**	**63.5%**	**8,820**

Sierra Leone	MSM	31,773 Datapack 22	**20%**	395(KP_PREV) Datapack 22
	FSW	27,900 Spectrum 22	**80%**	2,457 (KP_PREV) Datapack 22
	Total	**59,673**		**2,852 of total KP PREV Target 3205**

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, despite progress made, results are not yet at the expected level (viral load coverage and suppression superior to 95%). In Togo, the viral load testing coverage proxy increased at PEPFAR supported sites, from 46% in FY21 Q1 (DATIM data) to 78% in F21 Q2, and the viral load suppression increased in the same period from 84% to 91%. In Burkina, overall, the viral load testing coverage proxy remains under 50% (44% at the end of FY21, and 50% at the end of Fy22Q1) and viral load suppression proxy was 90% in FY22Q1. The country faced recurring challenges with viral load commodities availability at the country as well as at the site's level, impacting optimization of viral load demand creation and the performance of the viral load labs. Additionally, a fire incident that occurred at the central level medical warehouse in FY22Q1 impacted the viral load system performance in the country due to limited availability of viral load commodities in the country. PEPFAR has worked in collaboration with the Government of Burkina and the Global Fund to cover the viral load commodities gap, through initiation of early delivery of FY22 orders and coordination between the stakeholders. In addition, PEPFAR allocated an Emergency Commodities fund of $1,400,000 to optimize the availability of viral load testing commodities and improve VL system performance by the end of FY22. In Burkina and Togo, the common 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 ROP22, PEPFAR will increase its support on: (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, $1,56 million (including $700,000 for VL commodities) was

budgeted for viral load and EID in Burkina Faso and $1,92 million (including $1,1 million for VL commodities) in Togo.

In **Benin**, a new added country in West Africa Regional platform in ROP21, the viral load coverage at PEPFAR supported sites was 79% and the viral load suppression was 87%. The MoH has already identified some equipment and VL commodity gaps. In addition to improving supply chain component, PEPFAR plans to strengthen demand-creation and use of VL test results, sample transportation and results return, as well as lab system strengthening. Existing points of care will also be solicited to facilitate access to EID. For ROP22, PEPFAR has budgeted $ 953,000 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 2020 Ghana moved from a single vendor centralized sample referral system to a region/district based decentralized system. Ghana has also successfully implemented an integrated viral load data management system (VLDMS) that interphases the PCR analyzer and the e-Tracker. In ROP22, PEPFAR will enhance the functionalities to include a laboratory dashboard and use bar coding for unique identification. The Enhanced VLDMS/E-Tracker will be expanded to cover all sites in Western, Western North and Ahafo regions. PEPFAR will work with the 3 regional health administrations to strengthen the decentralized sample referral systems. GIS mapping will be created to reflect the decentralized sample referral system, Viral Load Testing Capacity Scale Up, sample tracking systems from spoke to hub and to testing sites to support real time monitoring. Komfo Anokye Teaching Hospital (KATH)and Bono Regional Hospital laboratories will be brought on board as alternate testing laboratories to augment testing during equipment downtimes and service interruptions in the PEPFAR priority regions. KATH and Bono Regional Hospital will benefit from QMS trainings and eventually guided to attain accreditation to strengthen VL testing laboratory systems. Refresher trainings, monitoring and corrective action visits to VL testing sites will be undertaken and both testing labs in KATH and Sunyani will support VL and EID needs of the 3 PEPFAR priority regions, 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 ROP22, PEPFAR in collaboration with GFATM 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 $450,337,00.

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 ROP22, 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 budgeted $1,493,998 for laboratory systems strengthening, lab commodity procurement, and lab services. In ROP22, PEPFAR has budgeted $1,395,301 for laboratory systems strengthening, lab commodity procurement, and lab services.

In **Sierra Leone**, FY21 and FY22, viral load and EID coverage have remained horrendously low for myriad reasons and has reached a crisis point. PEPFAR has leveraged GeneXpert platforms and limited PCR testing capacity to conduct as much testing as possible, but coverage remains low.

For 12 months ending in May 2021, the two Roche PCR platforms were down because a renewal maintenance agreement had never been executed and both machines needed repairs. In May of 2021 a new contract was executed and both platforms were restored, but a failing generator quickly brought testing to a very slow pace. PEPFAR supported repairs to the generator, but those repairs were short lived, and in late February 2022, testing again collapsed. A large capacity solar installation, funded through COVID funds (non-PEPFAR) has been installed at the central public health reference lab but is not yet operational. Meanwhile Roche has announced that after this year these two machines will no longer be supported due to obsolescence. Commodities for the Roche platforms expired, and GeneXpert commodities were limited since PCR testing was expected to achieve the necessary coverage.

Global Fund included a new PCR machine in NFM3, and PEPFAR is providing decision support, relying on PEPFAR SMEs, to reach an effective solution and place an order. Also, CDC started providing technical support for Lab in FY22, and this support is driving progress in VL and EID. VL and EID is a priority of the new NACP program manager. Finally, the Global Fund Portfolio Manager raised this issue with the Minister of Health, and he requested a few weeks to find a solution. PEPFAR staff are tracking this issue and remain in contact with the Global Fund Portfolio Manager and UNAIDS Country Director on this issue. There is initial evidence that the Minister initiated actions to solve the power problem.

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, Mali, Burkina Faso, Togo, Benin and policy development in the other three 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 ROP22. 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 ROP22. VL/EID policies have been adopted across the countries, but many challenges remain. In **Liberia**, the national policy approving 6MMD was adopted in January 2020 and is gradually being scaled-up. PEPFAR will continue to support the implementation of 6MMD within PEPFAR sites and outside of Montserrado County 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. In **Burkina,** while national policies exist for TLD transition and MMD there is a need to strengthen, scale up TLD and optimize the MMD6 at the country level. ROP22 will support the intensification of DTG 10 for CLHIVs and full TLD transition. ROP22 will also support the country to scale up PrEP through sustained availability of PrEP commodities and PrEP demand creation. In **Togo**, national policies exist for Test and Start, TLD transition, DTG10, MMD, with a good implementation; TLD Transition is completed and MMD is on Going; ROP22 will support the intensification of DTG 10 for CLHIVs and to scale up PrEP through sustained availability of PrEP commodities and PrEP demand creation. Also ROP22 will provide targeted TA to the Government of Togo for the optimization of VL diagnostics and VL literacy. In **Benin**, national policies exist for Test and Start, TLD transition is underway, ROP22 will continue to work closely with Government counterparts and other donors to secure the procurement process and ensure availability at site level.

Health systems challenges: In ROP22, Ghana's above-site activities will focus on supply chain strengthening to ensure adequate stocks are available at the site level, data management, Diagnostic Network Optimization, 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

Enhanced E-Tracker-Viral Load 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 PrEP initiation for 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. CDC will work with relevant partners 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.

Sierra Leone has a permissive and progressive Government when it comes to HIV and health system initiatives and innovations. In general, policies are adopted quickly, and guidelines revised efficiently when necessary. Collaboration between PEPFAR and its implementing partners, and GoSL, is seamless. System issues sometimes interfere with program implementation, and sustainable solutions are being pursued, in collaboration with Global Fund and other stakeholders, in supply chain, lab and strategic information. PEPFAR supported sites have strong and reliable M&E systems, which are mostly manual, but broad use of electronic solutions is being pursued with Global Fund. KP data is being developed.

The Stigma Index 2.0 was completed in 2020 under the guidance of NETHIPS, the PEPFAR CLM IP. Clear recommendations were made available to stakeholders to confront stigma and discrimination, with new energy arising from a new PEPFAR mandate.

In FY22, initial actions were undertaken to identify qualified local partner candidates to be developed for transition. Those activities will continue in FY23 and include possible sub-contracting by PEPFAR IPs. In FY22 and continuing in FY23, PEPFR, Global Fund and UNAIDS will engage more forcefully with the GoSL regarding sustainable financing of the National HIV Response. The outcome of elections in the spring of 2023 may impact any commitments.

Prevention activities including PrEP and self-testing continue to be successfully implemented and expanded unimpeded.

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 ROP22. 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. Since ROP19, Burkina-Faso and **Togo are** implementing e-Tracker providing robust capacity to monitor site level performance. In **Benin,** PEPFAR introduced the e-Tracker in ROP21 and will continue in ROP22 to 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.

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 ROP22 to strengthen interventions against stigma and discrimination. In ROP22, 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 ROP22.

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**, the new CDC country Director onboarded FY22Q1 and serves as an HIV Clinical Advisor, focusing on Burkina Faso, but also available to provide support across the West Africa Region. He is one of the co-chairs of the PEPFAR West Africa Testing Care and Treatment Technical Working Group. A USAID HIV/AIDS Project Management Specialist (LES) has been recruited during FY21. In **Togo,** the recruitment of a USAID HIV/AIDS Project Management Specialist (LES) is ongoing and will be finalized by the end of this fiscal year.

In **Benin**, the recruitment of the USAID LES Project Management Specialist (HIV/AIDS) is done. The Specialist started working in December 2021 and will provide programmatic and technical guidance and assisting in the development and management of HIV-related programs. For ROP22, a USAID Local Partner Specialist position was approved to facilitate the transition to local partners. The recruitment process will be carried out in this fiscal year.

In **Ghana**, USAID recruited and has fully onboarded 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 in ROP22 will on-board two LES positions from an interagency transfer. One will function as an interagency SI advisor and the second one as technical advisor LES role which is yet to be determined. USAID has also allocated additional funding to cover both positions. A HRSA Sierra Leone based USDH will support Liberia.

In **Mali**, USAID onboarded a full-time LES SI Advisor in FY19. USAID has allocated additional funding to CODB for ROP22 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. The USDH will also support HRSA's PEPFAR portfolio in Liberia, with approximately 35% on the ground coverage. Meanwhile HRSA turned over two LES FTEs to USAID in FY22, and these eventual staff will support the entire PEPFAR Inter-Agency response. HRSA will continue TDY support including following hiring of staff in the Region. In Sierra Leone and Liberia, HRSA M&O budgets were lowered substantially, with the resulting amounts being added to program budgets.

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**	3%	3%	49%	49%	45%	45%	43%	43%	100 %	62%	100 %	61%	100 %	61%	100 %	61%	100 %	63%	100 %	65%	100%	66%	99%	67%	83%
Benin	**Scale-Up: Saturation**	61%	61%	90%	90%	60%	60%	53%	53%	74%	64%	80%	55%	87%	65%	91%	74%	92%	79%	79%	67%	81%	70%	81%	71%	85%
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**	37%	37%	37%	37%	31%	31%	33%	33%	38%	28%	46%	25%	53%	27%	58%	29%	65%	35%	68%	42%	70%	50%	68%	54%	61%
Mali	**Scale Up: Aggressive**	15%	16%	17%	17%	41%	41%	60%	60%	26%	51%	20%	54%	18%	57%	20%	57%	16%	54%	14%	50%	12%	44%	13%	36%	34%
Senegal	**Scale Up: Aggressive**	33 %	11 %	34 %	28 %	19 %	24 %	28 %	29 %	34 %	34 %	81 %	89 %	65 %	50 %	70 %	29 %	80 %	26 %	64 %	32 %	53 %	23 %	84 1%	29 %	49 %
Sierra Leone	**Scale Up: Aggressive**	10%	10%	14%	14%	18%	18%	18%	18%	58%	54%	72%	58%	78%	61%	83%	64%	86%	68%	87%	71%	87%	73%	84%	74%	62%
Togo	**Attained**	18%	18%	41%	41%	69%	69%	55%	55%	72%	57%	77%	56%	81%	52%	87%	55%	91%	62%	93%	71%	93%	76%	92%	80%	79%
	Scale-Up: Saturation	16%	16%	38%	38%	66%	66%	53%	53%	60%	44%	67%	44%	72%	41%	80%	43%	86%	50%	89%	60%	88%	66%	86%	71%	72%

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

B1. ROP22 Planned Spending in alignment with planning level letter guidance

Table B.1.2 COP22 Budget by Program Area

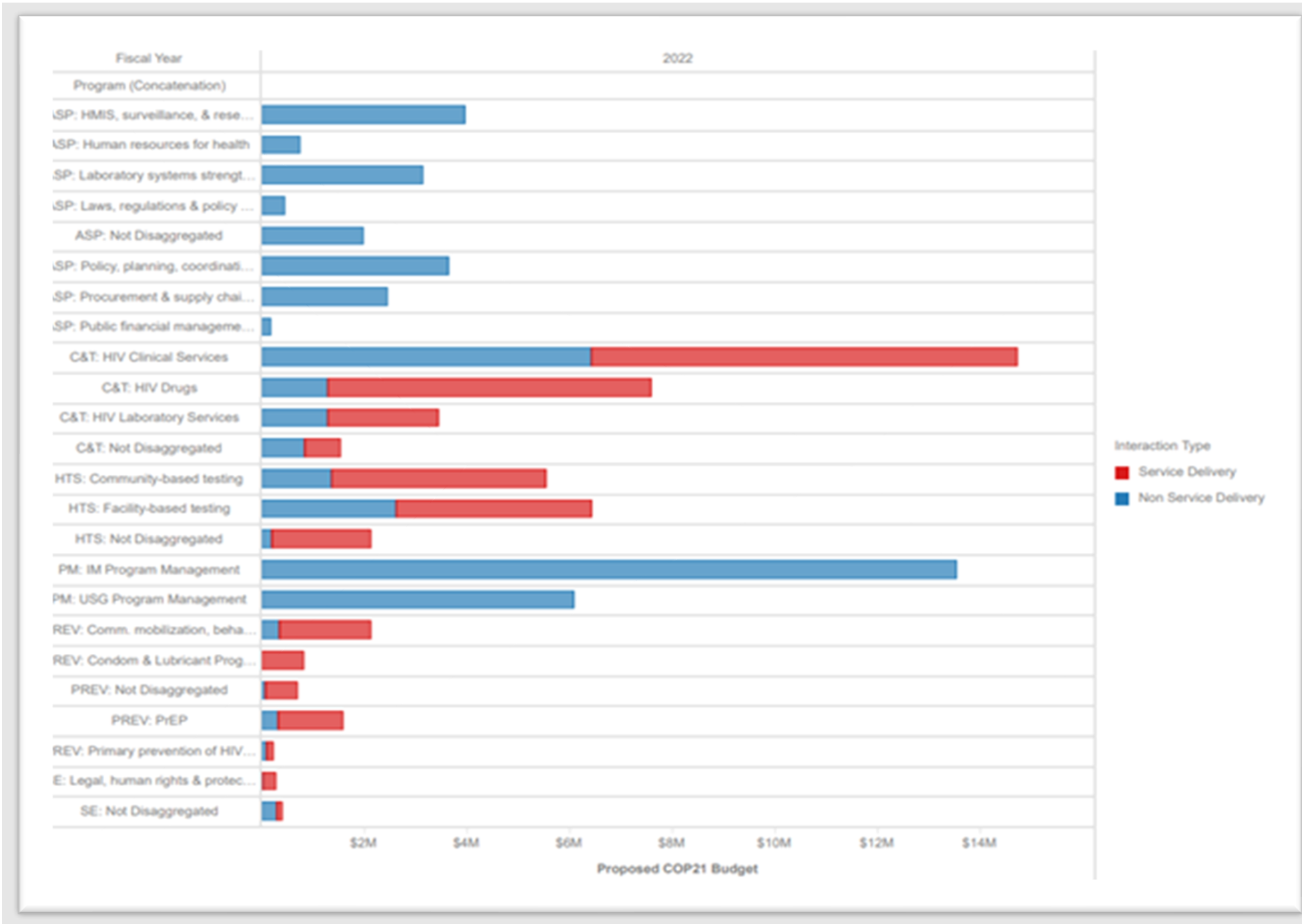


Table B.1.2 ROP22 Budget by Program Area

	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 ROP22 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	**$2,270,191,704**	**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 ROP22. 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)

Benin

Table 6-E (Entry of Above Site Programs Activities)							
Activity Budget	**COP22 Program Area**	**COP22 Beneficiary**	**COP22 Activity Category**	**Expected Outcome**	**COP22 Activity Description**	**Intervention Start**	**Intervention End**
$180,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Infrastructure and tools in place to collect, analyze, and use data for program monitoring and reporting. 100% of site staff implementing PEPFAR supported programs use data for decision making	Support e-Tracker implementation at all PEPFAR supported sites Support the indicators and data alignment efforts between MoH, UNAIDS, PEPFAR and other stakeholders Provide technical Assistance to MoH/GF for e-Tracker scale up to non PEPFAR	COP21	COP25

					supported sites, Support data collection, monitoring, and reporting at PEPFAR supported sites and alignment of site reported data into the national DHIS2 to improve data quality and estimates accuracy		

$70,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Index testing, and care and treatment Differentiated Service Delivery to KP, children, adolescents, adults scaled up nationally PrEP service scaled up	1. Conduct MoH-GF-PEPFAR joint quarterly supervisions at non PEPFAR and PEPFAR sites 2. Organize semesterly best practices sharing meetings between PEPFAR and non PEPFAR sites 3. Train/refresh/coach service providers on (i) PrEP services and demand creation, (ii) index testing, and (iii) care treatment Differentiated Service Delivery to KPs, children, adolescents and youth, and adult men 4. Strengthen capacity of	COP21	COP25

					KP-led Associations /CSOs on Index testing EPOA, RNR, peer navigation, escorted referral and other targeted HIV case finding and linkage to care strategies 5. Use CLM findings to improve access and quality of services to KP and PLHIV		

$21,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Transition to local partner/CSO and qualified indigenous local partners/CSOs facilitated for potential direct funding post COP 22	Strengthen at least 02 local KP/PLHIV-led Associations/Networks capacity (governance, financial management, technical, and advocacy) to be USG funded projects Prime Recipient (Baseline assessment, capacity building plan development and implementation)	COP22	COP24

$200,233	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Optimized supply chain system to sustain TLD and DTG10 transition, MMD6 scale up, PrEP scale up, VL testing performance support monitoring and reporting to ensure availability of ART drugs and other key HIV commodities	1. Strengthen supply chain system to improve coordination of procurement through forecasting, periodic review of supply plan and order tracking; advancing the schedule of quantification exercises; accelerating the design of eLMIS to improve data visibility and completeness. 2. Provide support to the MoH to improve inventory management at services delivery points) 3. Strengthen routine logistics management information system in order to improve data visibility and data use for decision	COP21	COP25

					making; 6-MMD, full TLD transition, PrEP 4. Provide support to improve availability of HIV commodities at services delivery points to enable rapid TLD uptake, 6 MMD expansion, and PrEP		

$40,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	Reduced stigma and discrimination against all PLHIV, including KPs through KPIF, SID, and community monitoring efforts	1. Develop and disseminate communication materials on stigma and discrimination against PLHIV and KPs 2. Refresh/sensitize health workers including CHW on stigma and discrimination free services and prevention and care of GBV 3. Sensitize/Refresh law enforcement officers, religious and customary authorities for an improvement of the social environment in favor of the KP and PLHIV 4. Strengthen routine data collection	COP21	COP25

					channel to facilitate stigma, discrimination, and GBV reporting and immediate response 5. Engage community actors and CSOs, service providers in monitoring user fees, index testing, VL access scale-up, and continuity of treatment		

$200,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Laboratory infrastructure and technical capacity strengthened to facilitate optimization of VL and EID diagnostics and VL literacy	1. Strengthen the sample referral network of IED and VL samples and reduce turnaround time (TAT) 2. Support External Quality Assurance (EQA) for VL and EID results 3. Weekly monitor VL cascade from sites to labs including commodities data 4. Strengthen Community collection of VL samples coupled with ARV community dispensing if patients consent 5. Organize a monthly coordination meeting with MoH, GF, PEPFAR IPs, labs, sites, CSO including representative of PLHIV to analyze VL cascade data and provide corrective actions	COP21	COP22

$10,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization	Government financial commitment in HIV response tracked and advocacy made for increase	Carry out country budget reviews and health budget tracking Advocate for increasing domestic resource mobilization	COP21	COP22

Burkina Faso

Table 6-E (Entry of Above Site Programs Activities)							
Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	Expected Outcome	COP22 Activity Description	Intervention Start	Intervention End
$250,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Increased national capacity in routine data management, validation, and use, to perform timely, granular and impactful program monitoring to improve program performance	1. Technical Assistance to the MOH for the e-Tracker nationwide scale up and utilization, data quality improvement, and data use for decision making at all PEPFAR and non PEPFAR supported sites. 2. Support MoH in bi-annual reporting and alignment of national and	COP19	COP25

					PEPFAR data 3. Support the NACP in periodical cleaning and analyzing national annual program data to be used in Spectrum modeling		
$160,000	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Sustained availability of HIV products for prevention (including PrEP products), testing (including self-tests), treatment (TLD and DTG10), and VL. Enhanced MMD-6 and full TLD and DTG10 transition	1. Coordination and collaboration with HIV Supply Chain stakeholders for effective supply planning 2. Technical assistance to the MoH to support end-to-end logistics data visibility	COP19	COP25

					and analysis to drive program performance 3. Support a sustained transition to TLD, shift to DTG10 for children and adolescents		
$110,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Index testing, and Differentiated Service Delivery to KP, children, adolescents, adults scaled up nationally in PEPFAR supported sites and non PEPFAR supported sites PrEP services scaled up to strengthen HIV	1. Organize a joint MoH-GF-PEPFAR quarterly supervision at non PEPFAR and PEPFAR sites 2. Organize semesterly best practices sharing meetings between PEPFAR and non PEPFAR sites	COP19	COP25

				prevention outcomes	3. Train/refresh/coach service providers on **(i)** PrEP services and demand creation, **(ii)** index testing, and **(iii)** care treatment Differentiated Service Delivery to KPs, children, adolescents and youth, and adult men 4. Use CLM findings to improve access and quality of services to KP and PLHIV		

$40,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Civil society engagement	Transition to local partner/CSO and qualified indigenous local partners/CSOs facilitated for potential direct funding post COP 22	Strengthen at least 03 local KP/PLHIV-led Associations/Networks capacity (governance, financial management, technical, and advocacy) to be USG funded projects Prime Recipient (Baseline assessment, capacity building plan development and implementation)	COP22	COP25

$50,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Civil society engagement	Stigma, discrimination and GBV against KP and PLHIV reduced at health facility and community settings Community led monitoring strengthened to help PEPFAR program and MoH pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level.	1. Develop a national action plan against stigma and discrimination with the national stakeholders, through the Community Led Monitoring project implemented by a local CSO network 2. Refresh/sensitize health workers including CHW on stigma and discrimination free services and prevention and care of GBV using 2021 stigma index 2.0 results, host country laws and policies	COP22	COP25

					3. Sensitize/ Refresh law enforcement officers, religious and customary authorities for an improvement of the social environment in favor of the KP and PLHIV 4. Strengthen routine data collection channel to facilitate stigma, discrimination, and GBV reporting and immediate response 5. Strengthen awareness of KP and PLHIV (educational talk,		

					online awareness with go online, developme nt of self-esteem ...) on their rights and availability of services		

$10,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization	Increased domestic resources mobilization towards HIV programming and commodities Community led monitoring strengthened to help PEPFAR program and MoH pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level.	Carry out country budget reviews and budget tracking Advocate for increasing domestic resource mobilization	COP19	COP25

$150,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Lab system technical capacity is strengthened to facilitate optimization of VL/EID diagnostics and viral load literacy	1. Support VL samples transportation in collaboration with host country and GF 2. Support VL commodities data visibility and use for decision making at sites and labs 3. Support Community collection of VL samples coupled with ARV community dispensing if patients consent 4. Enhanced communication between labs and sites with designated PoC at each side 5. Organize a quarterly coordinati	COP19	COP25

					on meeting with MoH, GF, PEPFAR IPs, labs, sites, CSO including representative of PLHIV to analyze VL cascade data and provide corrective actions		

$450,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Improved quality system and operations of laboratories for accreditation and Increase quality and coverage of VL testing among HIV Exposed Infants (HEI) and PLHIV receiving antiretroviral therapy	1. QMS document and record reviews, inventory management, internal audits, Competency assessments and training 2. Panel preparation, distribution, testing, CAPA and RCA 3. Continuous Quality Improvement	COP21	COP23

Mali

Table 6-E (Entry of Above Site Programs Activities)							
Activity Budget	**COP22 Program Area**	**COP22 Beneficiary**	**COP22 Activity Category**	**Expected Outcome**	**COP22 Activity Description**	**Intervention Start**	**Intervention End**
$279,000	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Well monitored and organised nationwide supply chain system that sustain TLD transition and constant availability of drugs and other key HIV commodities	Monitor and organise nationwide supply chain system that sustain TLD transition and constant availability of drugs and other key HIV commodities	COP19	COP22

$336,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Increased access to high quality viral load testing to reach at least 95% coverage and improved patient understanding of the impact of suppressed viral load	Increase access to high quality viral load testing to reach at least 95% coverage and Improve patient understanding of the impact of suppressed viral load	COP19	COP22
$350,000	ASP: HMIS, surveillance, & research-NSD	Key Pops: Men having sex with men	Surveillance	Support IBBSS and programatic mapping activities among KPs	Support IBBSS and programatic mapping activities among KPs	COP22	COP22

$184,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	National HIV/AIDS program budget assessment (Resource Alignment,..) Support HMIS activities (Spectrum,...)	Assess National HIV/AIDS program budget (Resource Alignment,..) Support HMIS activities (Spectrum,...)	COP22	COP22

$300,000	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Tools in place to collect, analyze, and use data for program monitoring and reporting.(support for national e-Tracker implementation) Supportive supervision visits are conducted and CQI is included in all work plans and policies	Support for national e-Tracker implementation (have tools to collect, analyze, and use data for program monitoring and reporting.(support for national e-Tracker implementation) Conduct supportive supervision visits and include CQI in all work plans	COP22	COP22

$600,000	ASP: Policy, planning, coordination & management of disease control programs -NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Full implementation (direct and immediate linkage) of Test and Start with >95% linkage across all age, sex, and risk groups (including KPs) Improved implementation of quality differentiated care services, including MMP/D for six months and DDD National testing policies that include index-testing and self-testing are in place, disseminated to all levels of the health system and is practice nationwide PrEP policies adopted and implemented	Full implementation (direct and immediate linkage) of Test and Start with >95% linkage across all age, sex, and risk groups (including KPs) Improve implementation of quality differentiated care services, including MMP/D for six months and DDD Disseminate national testing policies	COP20	COP22

					(that include index-testing and self-testing) to all levels of the health system and advocate policies implementation nationwide Scale up PrEP implementation to all eligible populations		

$200,000	ASP: Policy, planning, coordination & management of disease control programs -NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization	Regional team to proactively collaborate with multilateral stakeholders and encourage governments to commit more resources towards HIV programming and commodities	Regional team to proactively collaborate with multilateral stakeholders and encourage governments to commit more resources towards HIV programming and commodities	COP22	COP22

$200,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Civil society engagement	Policies and laws exist against persistent stigma and discrimination against PLHIV and KPs	Support CLM activities to assess policies and laws against persistent stigma and discrimination against PLHIV and KPs	COP20	COP22

Sierra Leone

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	Expected Outcome	COP22 Activity Description	Intervention Start	Intervention End
$300,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Improved quality system and operations of laboratories for accreditation and Increase quality and coverage of VL testing among HIV Exposed Infants (HEI) and PLHIV receiving antiretroviral therapy	1. QMS document and record reviews, inventory management, internal audits, Competency assessments and training 2. Panel preparation, distribution, testing, CAPA and RCA	COP21	COP25
$200,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Strengthened use and management of HIV Health information systems for strategic decision making and tracking progress towards epidemic control	1.Patient Tracker and DHIS2 Refresher Training 2. Supportive supervisory monitoring 3. Link Laboratory Information System to Patient Tracker 4. Link KP unique ID system to	COP21	COP25

					Patient Tracker 5.HIV Testing Module linked to Patient tracker for Clinical cascade		
$150,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Strengthen Strategic Information capacity and HIV data quality assurance and control systems	1.Develop a Strategic Information Strategic Plan 2. Undertake Data Quality Assessment 3.Organize an Annual performance Review 4.Build Capacity Building for NACP to manage Patient Tracker and DHIS2 5.Organize a Quarterly Situation Room Meeting and SI Technical Working Group	COP21	COP25

$555,914	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Consistent and reliable district level quantification and distribution	Work through Government structures to build accountability, and reliability for supply chain activities at the district level as well as to strengthen national distribution and other systems.	COP21	COP25
$115,000	ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pop: Not disaggregated	Civil society engagement	Reliable collection of information on the quality of HIV services, and effective advocacy for solutions to challenges facerd by PHLIV.	Continuation and expansion of CLM activities, emphasizing monitoring for key issues such as user fees as well as prioritizing effective collaboration with stakeholders to drive improvements. PEPFAR, UNAIDS and GLobal Fund are all supporting the progress of a high	COP20	Post COP25

					functioning CLM IP.		

Togo

Table 6-E (Entry of Above Site Programs Activities)							
Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	Expected Outcome	COP22 Activity Description	Intervention Start	Intervention End

$100,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Index testing, and care and treatment Differentiated Service Delivery to KP, children, adolescents, adults scaled up nationally PrEP service scaled up	1. Conduct MoH-GF-PEPFAR joint quarterly supervisions at non PEPFAR and PEPFAR sites 2. Organize semesterly best practices sharing meetings between PEPFAR and non PEPFAR sites 3. Train/refresh/coach service providers on (i) PrEP services and demand creation, (ii) index testing, and (iii) care treatment Differentiated Service Delivery to KPs, children,	COP19	COP25

					adolescents and youth, and adult men 4. Use CLM findings to improve access and quality of services to KP and PLHIV		
$50,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Civil society engagement	Transition to local partner/CSO and qualified indigenous local partners/CSOs facilitated for potential direct funding post COP 22	Strengthen at least 03 local KP/PLHIV-led Associations/Networks capacity (governance, financial management, technical, and advocacy) to be USG funded projects Prime Recipient	COP22	COP25

					(Update capacity assessment, capacity building plan development and implementation)		
$250,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Increased national capacity in routine data management, validation, and use, to perform timely, granular, and impactful program monitoring to improve program performance	1. Provide Technical Assistance to the MoH to scale up the e-Tracker nationwide and improve data quality and data use for decision making at national, regional, district, and site level 2. Support the MoH in bi-annually reporting and alignment of national and	COP21	COP25

					PEPFAR data 3. Support the NACP in cleaning and analyzing national annual program data to be used in Spectrum modeling 4. Support interconnectivity between E-Tracker-Lab Information System-Logistic Management Information System to enhance data sharing, analysis and use for decision making		

$200,000	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	National commodity security and supply chain management systems (financing, quantification, forecasting, and distribution) strengthened to ensure complete transition to TLD, DTG10 and PLHIV have access to appropriate ART (TLD for all PLHIV >30kg or Dolutegravir for all the first line? complete removal of all NVP)	1. Strengthen supply chain data visibility and data use for decision making. 2. Support MMD6, TLD transition, DTG10 and PrEP full implementation; Provide Coaching and supervision to the health Providers for DTG10, TLD, 6MMD/P. 3. Provide support for re-design and implement an adaptive last mile logistics system to feed the program needs 4. Hold systematic and	COP19	COP25

					periodic Supply Plan Review meetings to update delivery dates, and anticipate on procurement delays 5. Advocacy efforts and support for health supply chain integration 6. Continue the adaptive measures and align with the situation status (i.e. COVID-19) Supply chain coordination with other commodities funding sources (Host country		

					Government and GF) Provide support and supervision to the MoH for the usage of LMIS to inform accurate reporting of commodity consumption		

$40,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Civil society engagement	Reduced stigma, discrimination and GBV against KP and PLHIV at health facility and community settings Community led monitoring strengthened to help PEPFAR program and MoH pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level.	1- Support the National AIDS Commission in the develop and implementation of a national plan against stigma and discrimination and GBV addressing structural barriers 2. Refresh/sensitize health workers including CHW on stigma and discrimination free services and prevention and care of GBV using 2021 stigma index 2.0 results, host country laws and policies	COP20	Post COP25

					3. Sensitize/ Refresh law enforcement officers, religious and customary authorities for an improvement of the social environment in favor of the KP and PLHIV 4. Strengthen routine data collection channel to facilitate stigma, discrimination, and GBV reporting and immediate response 5. Strengthen awareness of KP and PLHIV (educational talk, online awareness with go		

					online, developme nt of self-esteem ...) on their rigths and availability of services		

$10,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization	Government financial commitment in HIV response tracked and advocacy made for increase	Carry out country budget reviews and budget tracking Advocate for increasing domestic resource mobilization	COP21	Post COP25
$80,000	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization	Government financial commitment in HIV response tracked and advocacy made for increase	1.Support development of policy document to promote sustainable financing of HIV services delivery. 2. Develop case scenario to inform advocacy efforts, and target setting for increased domestic resources for HIV response. 3. Support development of tracking systems to monitor contributi	COP21	Post COP25

					on of domestic financing to the overall national financing of HIV response.		
$220,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Laboratory infrastructure and technical capacity strengthened to facilitate optimization of VL and EID diagnostics and VL literacy	1. Support the MoH to develop and implement a national e-Laboratory Information System interconnected with the E-Tracker to enhance lab performance monitoring and real time VL results return 2. Develop a VL lab dashboard	COP22	COP23

					and provide technical assistance to the MoH and labs staff on its interpretation and use for decisions making		
$200,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Laboratory infrastructure and technical capacity strengthened to facilitate optimization of VL and EID diagnostics and VL literacy	1. Strengthen the sample referral network of IED and VL samples and reduce turnaround time (TAT) 2. Support External Quality Assurance (EQA) for VL and EID results 3. Weekly monitor VL cascade from sites to labs including commodities data 4. Strengthen Communit	COP19	COP25

					y collection of VL samples coupled with ARV community dispensing if patients consent 5. Organize a monthly coordination meeting with MoH, GF, PEPFAR IPs, labs, sites, CSO including representative of PLHIV to analyze VL cascade data and provide corrective actions		

WAR

Table 6-E (Entry of Above Site Programs Activities)							
Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	Expected Outcome	COP22 Activity Description	Intervention Start	Intervention End
$80,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	WHO recommendations and PEPFAR MPR related to HIV services delivery are implemented with fidelity	Provide regional technical assistance to strengthen and scale WHO guidance and PEPFAR MPR with a focus in ROP 22 on care and treatment differentiated Service Delivery for KPs, Children, and Adult men, and Going Online Service	COP21	COP23

$240,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Civil society engagement	WAR CSOs capacity in advocacy, Community-Led Monitoring, and USG grant management are strengthened to influence health policy and HIV services and facilitate transition to local partners	1- Organize quarterly best practices sharing meetings among CLM organizations in WAR 2- Strengthen local CSO capacity to receive direct funding from donors (rapid baseline technical and organizational capacity assessment of at least 04 local CSOs, development of capacity building plan, organization of webinars to explain and go over the USG requirements)	COP21	COP24

					3- Engage parliamentarians, media, religious leaders, and other key stakeholders to improve the environment for KP service delivery 4- Strengthen local CSOs' knowledge in ROP/COP development and facilitate their engagement in ROP 23 development		

$136,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	WAR national M&E systems are aligned with global standard; produce and report on high quality data including well designed surveys informing decision	1- Support the alignment of key HIV indicators with MOH, UNAIDS and PEPFAR (incl. age/sex, KP disaggregates) 2- Support national DQA exercises, IBBSS, SPECTRUM and other surveys (elaboration of protocols and tools) 3- Provide capacity building activities to MOH staff and IPs at centralized and decentralized levels on data quality, data demand and use (including dashboard and data	COP21	COP24

					visualization tools)		
$85,000	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Increased and centralized supply chain visibility led by WAHO	Provide technical support to WAHO to conduct supply chain optimization activities for all HIV commodities (testing, treatment, prevention, and viral load). Assist in establishing a centralized supply chain visibility approaches for the	COP21	COP24

					region as a whole.		
$70,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	WHO recommendations related to HIV programming are adopted by ECOWAS members States and enabler social strengthened	Support the annual regional coordination meeting organized by WAHO to take stock of the implementation of West Africa KP strategy 2020-2025 and progress toward the achievement of the 95-95-95 targets and 10-10-10 societal enabler targets in	COP21	COP25

					the 15 ECOWAS Member States		

APPENDIX D– ROP 2022 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. Burkina Faso: Test and Start policy adopted and implemented. This is monitored during site visits and SIMS. Benin: Test and Start policy adopted and implemented. This implemented and monitored during One-site coaching and monitoring visits Togo: Test and Start policy adopted and implemented. This is monitored during site visits and SIMS. Liberia: Test and start policy has been adopted. This is being monitored through SIMS and site visits. Mali: Test and Start policy adopted and implemented.
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	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.

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. Burkina Faso: TLD transition is underway (73% at the end of FY22Q1). PEPFAR will continue supportive supervision visits to supported sites, ensure site level availability of TLD, and conduct deep dive site level analysis to identify low performing sites to prioritize. Benin: TLD transition is underway (50.37% at PEPFAR sites). Ensure availability of TLD. Work closely with Government counterparts and other donors to secure the procurement process and ensure availability at site level. Togo: TLD transition is completed (98% at PEPFAR sitesFY22Q1 and 97% at national level). PEPFAR will continue to improve stock availability and continue distribution of TLD 90 and TLD180. For DTG10, Arrival of 20 060 DTG10 on FY22 Q2; with the beginning of distribution for April. PEPFAR will continue sensitization of the Health Providers for prescription, and supportive Supply chain activities at facilities to maintain good stock availability. Liberia: TLD transition is completed at 98% for PEPFAR sites and 96% for non-PEPFAR sites. DTG10 has recently being rolled out at very few facilities. Regular site mentoring is ongoing for TLD and DTG10 prescription while at the same time monitoring facility stock levels.

	Mali: The TLD transition is underway:55% at PEPFAR supported sites compared to 50% nationally. DTG10mg status: 13,235 bottles delivered by GF in December 2021. ART policy adaptation ongoing to include DTG10mg.
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. Burkina Faso: MMD transition is completed on PEPFAR supported- sites with 93% coverage at the end of FY22Q1. PEPFAR supports distribution of TLD90 and TLD180 bottles, community ARV dispensing, and continues to ensure continuous availability of adequate amounts of ARVs to support expansion of 6MMD. Benin: MMD3 adopted and implemented. PEPFAR will encourage a patient- centered approach and continue advocacy on the HIV policies and programs especially on the MMD6 policy to be adopted by the country. Togo: MMD transition is completed on PEPFAR supported- sites with 94% coverage at the end of FY22Q1. PEPFAR will continue the sensitization of the health providers for the MMD prescription; also supports distribution of TLD90 and TLD180 bottles, community ARV dispensing, and continues to ensure continuous availability of adequate amounts of ARVs to support expansion of 6MMD.

	Liberia: 3-5MMD has been adopted and implemented. 6-MMD+ has also been adopted and is gradually being scaled-up, while at the same time PEPFAR is supporting facilities to address stock issues and provider mentoring. At the end of FY21, 3-5MMD coverage was 48% while 6-MMD+ coverage was 34%. MMD scale-up and expansion is an area for ongoing work. Mali: the MMD has been adopted and implemented. At PEPFAR supported sites the overall MMD is at 72%. Much effort is needed for 6MMD
4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	N/A – no TPT services in the West Africa Regional Program
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. Burkina Faso: the country is facing some challenges for VL and EID optimization. But the situation is improving thanks to weekly monitoring of the VL process at sites and at labs level, enhanced demand creation, coaching on VL results use, reinforcement of adherence through peer group support, use of the E-Tracker to early identify patients in need of a VL test. PEPFAR is supporting efforts to ensure VL commodity security.

	Benin: VLC adopted: 79% at PEPFAR supported sites. The improvement will continue through close monitoring of sites and laboratories and the provision of commodities. Togo: with a VLC : 87%, VLS : 91% at PEPFAR-supported sites in FY22 Q1, the country is facing some challenges for VL and EID optimization. The situation is improving via the weekly monitoring of the VL process at sites and at labs level, enhanced demand creation, coaching on VL results use, reinforcement of adherence through peer group support, use of the E-Tracker to early identify patients in need of a VL test. PEPFAR is supporting efforts to ensure VL commodity security. Liberia: VL/EID optimization policies adopted, but with challenges in implementation. VLC and VLS at PEPFAR-supported sites are 68% and 78% respectively, and this is an area for ongoing work. PEPFAR is supporting strengthening demand creation, deployment of viral load counselors at high volume sites, increasing messaging on U=U and treatment literacy, and expanding community VL sample collection. DHIS2 e-Tracker is also currently being rolled-out to improve individual patient tracking, while at the same time strengthening VL commodity monitoring and weekly performance monitoring. Mali : VLC is increasing and will improve by addressing stockout of DBS and lab reagents, improve identification of eligible people using Kolochi(e-Tracker). Ongoing improvement on TLD transition and MMD will increase the VLS.
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	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

established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	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. Burkina Faso: Index Testing policy is adopted and implemented. This is monitored during site visits and SIMS. Benin: Index testing policy adopted and implemented. This is monitored during one-site coaching and monitoring visits, as well as sharing best practices between PEPFAR sites and close monitoring of data. Togo: Index Testing policy is adopted and implemented. This is monitored during site visits and SIMS. Liberia: Index testing policy is adopted and implemented, and this is being expanded and monitored during SIMS visits. The index testing is fully implemented in Mali and is monitored during IPs site visits and supervisions.
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. Burkina Faso: PrEP policy is adopted, and the country is starting the implementation. PEPFAR will continue to support continuous

	availability of PrEP drugs and enhancement of PrEP demand creation Benin: PrEP policy is adopted, and the implementation begins in April 2022. To improve the implementation, PEPFAR will continue service providers training and enhance PrEP demand creation. Togo: PrEP policy is adopted, and the country has started the implementation. PEPFAR will continue to support continuous availability of PrEP drugs and enhancement of PrEP demand creation Liberia: PrEP policy has been adopted; guidelines and SOPs have also been developed and validated. PrEP providers have been trained and site-level orientation held. Focus is now on commodity management, demand creation and PrEP enrollment. As of FY22 Q3, Liberia has initiated clients on PrEP, and this is an area for continuous learning and expansion. Mali: The policy has been adopted and the implementation is ongoing MSM and couple Serodiscordant. Like FY22, Mali is planning to procure a quantity of PrEP commodity to expand the target to FSW as the policy has been updated
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	N/A – No OVC activities in the West Africa Regional Program DOD Liberia doing OVC

9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV	
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. Burkina Faso: Policies to eliminate formal and informal user fees are adopted and implemented. This is monitored during site visits and SIMS. Benin: Policies to eliminate formal and informal user fees are adopted and implemented. This is monitored during site visits and during implementation of CLM activities. Togo: Policies to eliminate formal and informal user fees are adopted and implemented. This is monitored with CLM activities, during site visits and SIMS. Liberia: Policies that eliminate formal and informal use fees have been adopted and implemented. This is an area for ongoing monitoring through CLM and SIMS visits. Mali: The policy has been adopted and it is implemented. However, close monitoring is ongoing through SIMS visits, Community Led Monitoring, supersessions to keep the implementation effective.

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 reduce stigma and encourage HIV treatment and prevention.	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.
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 ROP22, 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.

	Burkina Faso: PEPFAR will continue to develop advocacy efforts and monitor government financial commitments through the CLM project, despite a challenging security and political context. Benin: PEPFAR will continue to develop advocacy efforts and monitor government financial commitments through the CLM activity. Togo: in 2019, the country mobilized 2.113731 060 CFA (increase of 0.8%); in 2020 with 2 413 879 157 CFA (increase of 12.4%) budget including all the ministries activities for HIV . PEPFAR will continue to develop advocacy efforts and monitor government financial commitments through the CLM project. Mali: With the political and socio security situation ongoing, there is a pression on the national budget leading the government to review its priorities than on HIV /AIDS. Advocacy should continue to with the Government to allocate more funding to HIV/AIDS which is a development issue
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. Burkina Faso: the Unique Identifier policy is adopted and fully implemented on PEPFAR-supported sites.

	Benin: The Unique Identifier policy is adopted and fully implemented on PEPFAR-supported sites. Togo: The Unique Identifier policy is adopted and fully implemented on PEPFAR-supported sites and national level. Liberia: Unique identifiers have been adopted and implemented and is being monitored. M&E tools have been updated, printed and rolled-out across all PEPFAR sites, and DHIS2 system also updated with UICs. Mali: UIC fully used at PEPFAR supported sites. PEPFAR to continue support of GF and NACP to use the UIC in nationwide with adoption of national e-Tracker which is under development.

ROP 2022 (FY 2023) 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– Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

Ghana

The sustainability of the Ghana national HIV response relies on many factors, including government ownership, durable multilateral partnership, and integration of the HIV response into the national public health system. Currently there are national funding gaps to scale up case finding, initiation, and viral load testing in all other non-PEPFAR supported regions. Host country government could further facilitate clearance of commodities and supplies to support the HIV program when procured by other non-governmental entities to ensure continuity of services. Government leadership in coordinating and optimizing the national laboratory network to integrate HIV and viral load testing into routine health services will increase access to these essential services. As in previous years, PEPFAR Ghana continued to engage with host country government, multilateral partners, and CSOs to ensure that sustainability and country ownership is the ultimate goal in ROP22. Mentoring and supporting hospital laboratories to prepare for accreditation is one example of a sustainable approach to technical assistance. Good practices such as high-level meetings between NACP and the regional health directorates where PEPFAR Ghana works should expand to other regions to solidify and affirm both regional and national ownership of the HIV response. The NACP and Policy, Planning, Monitoring & Evaluation (PPME) also hold stakeholders' consultation to improve the E-Tracker system, which further demonstrate government ownership. Clinic staff at PEPFAR-supported sites have been trained and can potentially serve as trainers to other regions as the national program expands and improves case finding, initiation, and viral load coverage to reach 95-95-95 nationally.

Benin, Burkina Faso, and Togo were not requested to develop a Sustainability Index and Dashboard in FY22. In the West Africa Regional platform, only Ghana and Senegal were requested. However, there are some opportunities that Benin, Burkina Faso, and Togo will use in ROP23.

Development of the next Global Fund Grants

Current Global Fund grants in **Benin, Burkina Faso, and Togo** will end in FY23. The development of the next grant will be an opportunity to strengthen sustainability efforts in various domains: (i) supply chain, (ii) health management information system, (iii) lab system, and (iv) capacity building of health workers including community health workers and scale-up of PEPFAR best practices. As a member of the CCM in all those three countries, USAID on behalf of the PEPFAR team, will ensure that those discussions are made during the development of the country's proposal. For example, regarding the supply chain, the upcoming Global Fund grant could be an opportunity to reduce PEPFAR footprint in commodities purchasing, to strengthen the national supply chain management including logistic data visibility and data use for decisions making. Liberia's current Global Fund grants will close in by the beginning of FY24. Collaboration with the Global Fund Country Team and the Liberia CCM continues to be great. As USAID plays an active role in the CCM, it will ensure discussions are held on sustainable HIV epidemic control, and that the next

grant cycle is regarded as an opportunity to harness these conversations and also leverage existing resources to achieve some of the goals related to sustainable HIV epidemic control. Meanwhile, it is critical for conversations around sustainability to take into account supply chain, monitoring & evaluation, data visibility, DHIS2 e-Tracker rollout, laboratory systems strengthening, health care provider training and supportive supervision, among others. **Increase of domestic resources allocated to HIV response**

In ROP 22, PEPFAR will continue to advocate with **Benin, Burkina Faso, and Togo** governments for increasing domestic resources allocated to HIV response as part of PEPFAR Minimum Program Requirements. In November 2021, during the high-level regional summit for HIV/AIDS in West and Central Africa held in Dakar, West and Central Africa countries renewed their commitment to increase national resources allocated to HIV response. However, their ability to honor these commitments may be undermined by the negative impacts of the COVID 19 pandemic on the global economy, the rising cost of living with increased oil prices, and the insecurity situation in the Sahel affecting Burkina Faso and Benin.

Transition to local partners

In ROP 22, **Benin, Burkina Faso, and Togo** will continue their efforts to transition to local partners. The three countries are implementing the community-led activities through direct awards to local CSOs. It envisions to extend progressively this transition to other program areas like key populations programming and lab system strengthening. A rapid risk assessment was conducted and several scenarios including government-to-government agreements and awards to CSOs were considered. A capacity building plan will be developed and implemented in ROP 22, to build local CSOs capacity on governance, financial and technical management, and compliance with US government grant requirements.

In addition, USAID Benin and USAID West Africa got approval for 03 additional staff in ROP 22 (02 local partner Specialists and 01 finance specialist) to facilitate the transition to local partners in the region.

In **Mali** the current GF grant will end by end of FY23. With the strong partnership with GF, the development of its future GF grant will be used to reinforce PEPFAR and GF collaboration and to maximize our commune intervention.

Since ROP21, Mali is working with about 12 CSO/COB including KP-led organizations. In ROP22, in addition to continue working with CSO/COB, Mali will reinforce its effort to transition to local partner by through Community Led-Monitoring activity.

In ROP22, Liberia will continue to build capacity of ten (10) local civil society organization partners who are currently involved with program implementation as sub-grantees. Among these CSOs are KP-led and PLHIV-led organizations, who are involved with various aspects of program implementation at the community and health facility levels. Additionally, capacity building initiatives will be supported for the CLM partner, which is a local civil society organization as well.

Together, the ongoing capacity strengthening interventions for these local CSOs will provide excellent opportunities for Liberia to enhance its work with and progress towards local partner transition.

Cleared:	S/GAC – Chair, Fatuma Sanneh	OK
	S/GAC – PPM, Diana Huestis	OK
	CDC – Clement Zeh	OK
	DOD – Daniel Tessou	OK
	HRSA – George Tidwell	OK
	USAID – Shimon Prohow	OK