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INFORMATION MEMO FOR AMBASSADOR CRAIG CLOUD, U.S. Ambassador to Botswana

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

THROUGH: S/GAC Chair, Sara Klucking
S/GAC PEPFAR Program Manager, Kayla Zhang

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

Dear Ambassador Cloud,

First and foremost, I sincerely hope that you and your team are safe and healthy. I am extremely grateful for your leadership of the PEPFAR program and additional COVID-19 response efforts during this difficult year.

While countries around the world continue to manage the effects of the COVID-19 pandemic, and the U.S. government acts on its commitment of support, it is encouraging to see vaccines making their way around the globe. The COVID response efforts – and continued use of the PEPFAR platform to support testing and vaccine delivery and uptake at point of care settings - are essential to our ability to provide ongoing care and life saving support for people living with HIV. The PEPFAR program has faced many challenges as a program during this period. Nevertheless, members of the PEPFAR family have carried the mission forward while enduring significant personal impacts of COVID-19. Despite these challenges, what remains true is the strength and resilience of PEPFAR in partnership with countries and communities – through our teams, and our programs in the midst of dueling pandemics.

Tremendous effort has been made by PEPFAR over the year to protect and accelerate the HIV gains, while leveraging the platform to respond to COVID-19 as well.

PEPFAR Country/Regional Operational Plan (COP/ROP 22) (for implementation in FY2023) represents a pivotal year in PEPFAR, as several countries are reaching or approaching the agreed upon UNAIDS 95/95/95 benchmarks for attaining epidemic control. As countries approach these benchmarks, while pivoting from "scaling to close gaps" to "sustaining" epidemic control, we must ensure HIV program and population equity, address outstanding barriers that threaten to derail progress made in reducing new HIV infections and associated mortality, and tailor our programs to serve all populations.

This year it is particularly important to plan COP/ROP 22 together with the country government and civil society. The strategic goals of PEPFAR to build enduring capabilities and build lasting collaborations should be an integral part of the planning regardless of how near the country is to treatment saturation. Across PEPFAR, the focus on equity requires vigilant attention to program data demonstrating results and gaps. A focus on equity also means a focus on population groups where our efforts to date have not closed gaps, and specific planning, resource allocation, and program tailoring are needed – depending on what the data reveal for each country – focusing on: children, adolescent girls and young women, and key populations.

While implementation continues, or in many cases, has started to scale up, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach COP/ROP 22 planning and implementation:

1. Completing the Mission (95/95/95) - achieve and sustain epidemic control using evidence-based, equitable, people-centered HIV prevention and treatment services.
2. Building Enduring Capabilities - resilient and capacitated country health systems, communities, enabling environments, and local partners.
3. Building Lasting Collaborations - strengthen cooperation and coordination for greater impact, burden sharing, and sustainability.
4. Equity, with a persistent focus on reducing persistent inequalities experienced by children, key populations, and adolescent girls and young women.

I want to applaud your PEPFAR Botswana team for:

- The successful completion, during the COVID-19 epidemic, of the fifth Botswana AIDS Impact Survey (BAIS V) revealing a remarkable preliminary result of 93/98/98!
- The achievement, recognized by the WHO Global Validation Advisory Committee, of Botswana being the first country with a high-burden HIV epidemic to meet the global standards for the silver tier on the path to elimination of maternal to child transmission of HIV.
- Scaling access to oral pre-exposure prophylaxis (PrEP). PEPFAR Botswana continues to expand PrEP services year-over-year serving both key population groups and adolescent girls and young women, expanding to ensure that all eligible clients are educated about and offered PrEP.

Together with the Government of Botswana and civil society leadership we have made tremendous progress on the HIV response. Botswana should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing and deep coordination with the Global Fund and UNAIDS. Botswana has been especially successful and is one of a number of countries to have achieved and exceeded the UNAIDS 90-90-90 goals and effective control of the HIV epidemic. We now must work to sustain the HIV impact and begin the long-term, gradual transformation of the program including the merging, management, and oversight of HIV services in more intentional alignment and integration with domestic systems. COP/ROP 22 will represent the first step in this journey.

Despite the achievement of the UNAIDS high level goals, our work is not done. In COP 22 guidance, changes in program direction will vary depending on where countries are in reaching epidemic control and the continued COVID-19 mitigations efforts each program is facing.

Specifically, more focus and attention should be given to the following key challenges in PEPFAR Botswana:

- Data availability, quality, and use: high quality data and analyses to inform decision making are core to PEPFAR achievements and will be core to sustaining impact. PEPFAR Botswana must institutionalize a focus on data availability, quality, and use to support decision-making.
- Lagging performance in the context of the COVID-19 pandemic for TB Preventive Therapy (TPT) service delivery and cervical cancer screening services for people living with HIV as well as VMMC and DREAMS prevention services.
- Persistent gaps in case-finding, linkage, treatment, and viral load coverage/suppression for pediatric and adolescent people living with HIV.

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 22 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from years past, PEPFAR teams will once again be responsible for setting their own targets in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals.

S/GAC will not assign targets to countries, but only provide notional budget levels sufficient to achieve the full SDG goal and sustain gains made. Teams will develop their own targets across PEPFAR program areas, with the treatment current target no less than the result that was to be achieved in COP 2021.

The PEPFAR COP/ROP 22 notional budget for Botswana is **$60,000,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Botswana and civil society of Botswana, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

Finally, in alignment with efforts by the U.S. government to support diversity, equity, inclusion, and accessibility as well as to advance equity for underserved communities and prevent and combat discrimination or exploitation on the basis of race, religion, gender identity or sexual orientation, PEPFAR will work to ensure that these principles are upheld, promoted, and advanced in all PEPFAR programs and in how we do business.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will plan to review this planning letter and details contained herein, with your wider PEPFAR country team. Stakeholder engagement is essential for a productive and impactful planning process, and civil society engagement will continue to be an integral part of this planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual COP/ROP 22 planning and approval process.

Once again, thank you for your continued leadership and engagement during the COP/ROP 22 process.

Sincerely,

Angeli Achrekar

Attachment: **COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction Summary**

CC: **S/GAC – Chair, Sara Klucking and PEPFAR Program Manager, Kayla Zhang, and PEPFAR Botswana Country Coordinator, Lindsay Little.**

Overview: COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction Summary

With input from the field teams through the quarterly monitoring POARTs, as well as headquarters Country Accountability and Support Teams (CAST) input, a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2020 and current COP 21 implementation as we plan for COP 22. We have noted the following key successes and challenges:

We applaud PEPFAR Botswana on both the achievement of completing the fifth Botswana AIDS Impact Survey (BAIS V) during the COVID-19 epidemic and the remarkable preliminary result of 93/98/98 coming out of the survey. Botswana was the first country to begin implementation of an incidence survey of this scale during the COVID-19 pandemic and its successful completion is a triumph. Field survey implementation teams worked tirelessly on the frontlines of COVID-19 to collect this data that will be foundational to decision-making for national programing and sustaining impact in the years ahead. In addition, the preliminary result of 93/98/98 shows tremendous progress as measured by UNAIDS target commitments and Botswana's community viral load suppression preliminary result of 89% places it as the leader of all PEPFAR countries with recent survey data available.

A second impressive and well-earned success is the achievement of silver tier status on the path to elimination of maternal to child transmission of HIV. Botswana has the distinction of being the first country with a high-burden HIV epidemic to be recognized by the WHO to meet this critical milestone of reducing mother-to-child HIV transmission rate to under 5%. Since the inception of PMTCT programs, Botswana's program has been one of the most successful in the region.

We also note PEPFAR Botswana's success with provision of and continued scale up of oral pre-exposure prophylaxis (PrEP). Here, the team rose to the challenges presented by COVID-19 and embraced and deployed online platforms that enabled the expansion of PrEP services among both key population groups and young women. PEPFAR Botswana achieved several PrEP milestones including expansion of new PrEP delivery sites and an enhanced online outreach. In addition, as an adaptation during COVID-19, PrEP multiple month dispensing was introduced.

Noting that epidemic control, as demonstrated through successful BAIS V execution, EMTCT success, and PrEP scale up are significant achievements, there remains room for improvement in several areas. One cross-cutting challenge for PEPFAR Botswana is institutionalizing the availability, quality, and routine use of data to inform program improvement and decision making. Data is core to PEPFAR achievements to date and will be core to sustaining program impact. PEPFAR Botswana must commit increased attention to data availability, quality, and use to support decision-making and should prioritize data quality assessments, data systems, decision-analytics, and collection and use of survey data to advance and sustain HIV epidemic control. The GoB/MOH leadership has previously identified data analytics for decision making as a high priority. PEPFAR Botswana should strengthen internal capacity for data use and analysis and support this line of effort in Botswana, working closely with the Government of Botswana on all things data including the improvement of electronic medical records and ongoing work on HMIS interoperability.

A second challenge this year was seen in multiple program areas where COVID-19 has had a large impact and where innovations and adaptations to mitigate COVID-19 impact have not yet shown promise. Of particular concern is performance in TB preventive therapy (TPT) services, cervical cancer screenings, and prevention interventions such as VMMC and DREAMS. These services all continue to suffer under COVID-19 pandemic impacts. For example, TB screening in FY 21 was an excellent 100% among PLHIV however only a small fraction of those testing negative for TB were provided with TPT services and of those, the TPT completion rate was less than 63%. Similarly, cervical cancer screening has

achieved less than 60% of the expected target two years running, achieving only 42% in FY 21. Prevention services, most specifically VMMC and DREAMS interventions, have likewise suffered and only moderately recovered from COVID-19 impacts. PEPFAR Botswana has proven to be focused and resilient in the face of the dual pandemics of HIV and COVID-19 and has demonstrated significant progress with operating in the COVID-19 environment with several proven strategies that were adapted from lessons learned during the pandemic. However, TPT services, cervical cancer screening, VMMC services, and DREAMs are specific areas where performance challenges persist and where urgent action to address underperformance is required.

Finally, pediatric and adolescent HIV services continue pose a challenge for PEPFAR Botswana and continue to lag behind adult services across the full treatment cascade -- from case finding to linkage to ART treatment with optimized regimens to viral load coverage and viral load suppression challenges. The underperformance in this population requires that new strategies and a shift in focus be adopted.

COP 22 Directives for all PEPFAR programs and specifically PEPFAR Botswana can be found in Section 4, tables 9 and 10 of this summary. Given Botswana's status of having achieved epidemic control, the following high-level priority strategic and integrated changes are recommended:

- Focus on the *One Botswana* strategic objective and the strengthening of communication, collaboration, and cooperation across stakeholders. Efforts should extend to strengthening both internal and external relations, the community/facility interface, and the taking of a *One Botswana* approach to problem solving across the program ensuring that all voices are heard and contributing to solutions and progress towards sustained epidemic control.
- Advance the ongoing COP 21 portfolio review process to develop a knowledgebase and strategy that aligns with the needs and vision of the Government of Botswana to sustain epidemic control, leveraging all available data and clarifying stakeholder responsibility and contribution to the *One Botswana* approach.
- Develop a plan with the GoB, multilaterals, and local partners that establishes milestones and a path for a staged shift in responsibilities. Botswana is a leader in addressing and managing their HIV epidemic and should now consider the long-term, gradual transformation of the program including the merging, management, and oversight of HIV services in more intentional alignment and integration with domestic systems.

SECTION 1: COP/ROP 2022 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2021 (EOFY) tool, and performance data, the total COP/ROP 2022 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by the Agencies identified.

TABLE 1: All COP 2022 Funding by Appropriation Year

	Bilateral				Central				Total
	FY22	FY21	FY20	Unspecified	FY22	FY21	FY20	Unspecified	TOTAL
Total New Funding	$ 42,648,333	$ -	$ 7,500,000	$ -	$ 517,000	$ -	$ -	$ -	$ 50,665,333
GHP-State	$ 40,452,083	$ -	$ 7,500,000		$ 517,000	$ -	$ -		$ 48,469,083
GAP	$ 2,196,250				$ -				$ 2,196,250
Total Applied Pipeline	$ -	$ -	$ -	$ 9,334,667	$ -	$ -	$ -	$ -	$ 9,334,667
DOD				$ 256,679				$ -	$ 256,679
HHS/CDC				$ 1,782,996				$ -	$ 1,782,996
HHS/HRSA				$ 4,039,405				$ -	$ 4,039,405
PC				$ 2,964,944				$ -	$ 2,964,944
USAID/WCF				$ 203,464				$ -	$ 203,464
State/AF				$ 87,179				$ -	$ 87,179
TOTAL FUNDING	$ 42,648,333	$ -	$ 7,500,000	$ 9,334,667	$ 517,000	$ -	$ -	$ -	$ 60,000,000

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

Countries should plan for the full Care and Treatment (C&T) level of $18,446,400 and the full Orphans and Vulnerable Children (OVC) level of $13,906,200 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2: COP 2022 Earmarks by Appropriation Year*

	Appropriation Year			
	FY22	FY21	FY20	TOTAL
C&T	$ 18,446,400	$ -	$ -	$ 18,446,400
OVC	$ 13,906,200	$ -	$ -	$ 13,906,200
GBV	$ 1,660,000	$ -	$ -	$ 1,660,000
Water	$ 50,000	$ -	$ -	$ 50,000

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

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

TABLE 3: COP 2022 Initiative Controls

Each dollar planned in COP can belong to only one initiative. Most COP funding will be budgeted as Core Program. In general, initiatives other than Core Program are used to track activities/programs that cannot be tracked by the combination of program area and beneficiary alone. See Appendix 1 for more detailed information on initiatives.

	Bilateral	Central	TOTAL
Total Funding	$ 59,483,000	$ 517,000	$ 60,000,000
Core Program	$ 36,682,528	$ -	$ 36,682,528
Cervical Cancer	$ 1,000,000	$ -	$ 1,000,000
Community-Led Monitoring	$ -	$ -	$ -
Condoms (GHP-USAID Central Funding)	$ -	$ -	$ -
DREAMS	$ 19,000,000	$ -	$ 19,000,000
HBCU Tx	$ -	$ -	$ -
One-time Conditional Funding	$ -	$ -	$ -
OVC (Non-DREAMS)	$ 1,000,472	$ -	$ 1,000,472
Surveillance and Public Health Response	$ -	$ -	$ -
USAID Southern Africa Regional Platform	$ -	$ 517,000	$ 517,000
VMMC	$ 1,800,000	$ -	$ 1,800,000

TABLE 4: Programmatic Controls

Programmatic controls are used to track programmatic directives that can be tracked by a combination of program area and/or beneficiary. Programmatic controls may overlap with Initiatives, for example PrEP for Adolescent Girls and Young Women may count towards both the DREAMS Initiative and the PrEP (AGYW) programmatic control. See Appendix 1 for detailed information on programmatic controls.

	Bilateral	Central	TOTAL
Total Funding	**$ 244,800**	**$ -**	**$ 244,800**
PrEP (AGYW)	$ 200,000	$ -	$ 200,000
PrEP (KPs)	$ 44,800	$ -	$ 44,800

TABLE 5: State ICASS Funding

	Appropriation Year
	FY22
ICASS	$ 136,844

See Appendix 1 for detailed budgetary requirements and other budgetary considerations.

SECTION 3: PAST PERFORMANCE – COP/ROP 2020 Review

Table 6. COP/ROP OU Level FY21 Program Results (COP20) against FY22 Targets (COP21)

Indicator	FY21 result (COP20)	FY22 target (COP21)
TX Current <15	**1,154**	**1,760**
TX Current >15	**156,809**	**172,607**
VMMC >15	**3,733**	**10,010**
DREAMS (AGYW PREV)	**30,113**	**33,308**
Cervical Cancer Screening	**13,518**	**32,394**
TB Preventive Therapy	**1,348**	**147,519**

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

OU/Agency	Sum of Approved COP/ROP 2020 Planning Level	Sum of Total FY 2021 Outlays	Sum of Over/Under Outlays
Botswana	**$66,028,758**	**$58,223,036**	**$7,805,722**
DOD	$809,355	$727,951	$81,404
HHS/CDC	$34,137,760	$32,596,377	$1,541,383
HHS/HRSA	$700,000	$544,358	$155,642
PC	$3,894,908	$679,000	$3,215,908
State	$629,431	$665,366	-$35,935
USAID	$24,392,893	$21,912,530	$2,480,363
USAID/WCF	$1,464,411	$1,097,454	$366,957
Grand Total	**$66,028,758**	**$58,223,036**	**$7,805,722**

Table 8. COP/ROP 2020 | FY 2021 Results & Expenditures

Agency	Indicator	FY21 Target	FY21 Result	% Achievement	Program Classification	FY21 Expenditure	% Service Delivery
HHS/ CDC	HTS_TST	56,480	33,701	167.59	HTS Program Area	$1,730,711	91
	HTS_TST_POS	2,506	4,262	170.07			
	TX_NEW	3,480	6,556	188.39	C&T Program Area	$11,278,236	68
	TX_CURR	170,027	157,139	92.42			
	VMMC_CIRC	9,010	2,748	30.50	VMMC Sub-Program Area	$1,338,525	100
	OVC_SERV	3,720	-	-	OVC Beneficiary	N/A	
DOD	HTS_TST	937	736	78.55	HTS Program Area	N/A	
	HTS_TST_POS	-	2	-			
	TX_NEW	-	-	-	C&T Program Area	N/A	
	TX_CURR	-	-	-			
	VMMC_CIRC	1000	997	99.70	VMMC Sub-Program Area	$124,162	100
	OVC_SERV	-	-	-	OVC Beneficiary	N/A	
PC	HTS_TST	-	-	-	HTS Program Area		
	HTS_TST_POS	-	-	-			
	TX_NEW	-	-	-	C&T Program Area	N/A	
	TX_CURR	-	-	-			
	VMMC_CIRC	-	-	-	VMMC Sub-Program Area	N/A	
	OVC_SERV	7,295	-	-	OVC Beneficiary	N/A	
USAID	HTS_TST	10,164	10,473	103.04	HTS Program Area	$726,004	71
	HTS_TST_POS	2,071	1,715	82.81			
	TX_NEW	980	1,625	165.82	C&T Program Area	$3,574,853	76
	TX_CURR	2,928	3,588	122.54			
	VMMC_CIRC	-	-	-	VMMC Sub-Program Area	N/A	
	OVC_SERV	30,698	40,165	130.84	OVC Beneficiary	$1,127,974	95
					Above Site Programs	$2,363,530	
					Program Management	$11, 867, 153	

SECTION 4: COP/ROP 2022 DIRECTIVES

The following section has specific directives for COP 2022 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

Minimum Program Requirements (MPR)
All PEPFAR programs – bilateral and regional– must ensure the following minimum program requirements are in place. Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g., facility, school, community). Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs.

All PEPFAR programs are expected to meet all of the requirements below, and the COP22 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP22 Planning Meeting, the PEPFAR OU team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2023. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2023 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table below.

Table 9. COP/ROP 2022 (FY 2023) Minimum Program Requirements

Care and Treatment	
1.	Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups. Status: Completed
2.	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens. Status: In-process Issues or Barriers: Persistent challenges with pediatric ART regimen optimization
3.	Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups. Status: In-process Issues or Barriers: Persistent policy and supply chain management barriers to MMD implementation.
4.	All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.

	Status: In-process Issues or Barriers: TPT implementation severely stalled in COP20 due to COVID-19 and policy barriers.
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. Status: In-process Issues or Barriers: Uneven district and site-level viral load coverage. Persistent challenges with EID at 2 mo. Persistently high number of new HIV diagnoses presenting with late-stage disease.
	Case Finding
6.	Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV. Status: Completed
	Prevention and OVC
7.	Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices). Status: Completed
8.	Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV. Status: Completed
	Policy & Public Health Systems Support
9.	In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups. Status: In-process Issues or Barriers: Limited ability to measure progress.
10.	Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention. Status: Completed
11.	OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous

Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy. Status: In-Process Issues or Barriers: Implementation monitoring limited to facilities directly supported by PEPFAR.
12. Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other partner country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention. Status: In-process Issues or Barriers: Limited ability to measure.
13. Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses. Status: Completed
14. Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended. Status: In-process Issues or Barriers: Limited ability to assess this year.
15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. Status: Completed
16. Scale-up of case surveillance and unique identifiers for patients across all sites. Status: In-process Issues or Barriers: Persistent challenges with interoperability and consistent reporting and data use.

In addition to meeting the minimum requirements outlined above, it is expected that Botswana will consider all the following technical directives and priorities. A full list of COP/ROP 2022 Technical Priorities and Considerations are listed in COP guidance and can be referenced in Section 6.

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

Botswana – Specific Directives
Data Availability, Quality, and Use
Work closely with the Government of Botswana on issues of data quality, data for decision making, and improvement of electronic medical records, including ongoing work on HMIS interoperability.
Strengthen local capacity for data analysis and use of strategic information by implementing the SI TDY recommendations.
Leverage the new BAIS V data to orient and scope prevention and treatment services toward closing gaps and maintaining gains.
Conduct an IBBS and PLHIV Stigma Index 2.0.
HIV Clinical Services
Ensure that strategies to reduce HIV-related mortality are available and integrated into clinical services.

Take measures to improve linkage to care and continuity of care including VLC and VLS for children and adolescents.
Address the TPT coverage issues including the barriers to commodity availability and the sites in implementing/reporting TPT services.
Work with the GoB to expand policy on and access to multi-month dispensing.
HIV Prevention Services
PrEP should continue to be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP should be tailored to the OU's epidemic context with a focus on Key Populations, adolescent girls and young women including pregnant and breastfeeding AGYW, and other identified higher-incidence populations.
Expand support for decentralized and differentiated service delivery models for PrEP with a focus on KP groups and AGYW, including ED-PrEP for men.
Work to adapt the VMMC, CXCA Screening, and TPT programs to minimize impact of COVID-19 barriers.
HIV Testing Services
Continue with expansion and implementation of recent infection surveillance activities.
Other Government Policy, Systems, or Programming Changes Needed
Advance the portfolio review process to develop a strategy that aligns with the needs and vision of the Government of Botswana to sustain epidemic control, leveraging all available data and clarifying stakeholder contributions to the One Botswana approach.
Develop a "Transformation" plan with GoB and local partners that establishes milestones and markers for a staged shift in responsibilities. Any transformation plan needs to fully incorporate elements of risk to ensure a responsible transition that sustains the gains already achieved.
Capitalize on the development of CLM activities to further engage and implicate communities in local planning, implementation, and M&E of HIV, health and social services

COP22 plans should prioritize and take specific steps to address the structural barriers that impede scale up of KP-led and KP-competent differentiated HIV services, as well as the lack of robust data to guide key populations programming. To strengthen strategic information to guide KP responses, plans may include efforts to strengthen individual level data systems and analyses and address gaps in subnational data. Addressing structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and strengthening the KP competency of HIV service providers. PEPFAR teams should ensure they are coordinating strategically with relevant State and U.S. government units (e.g., DRL), partner government, multilateral, and other donor funding streams and institutions.

As part of the new COP 22 MPR (#9), PEPFAR teams will be expected to describe and present their approach to improving KP data and addressing barriers to accelerated KP-centered HIV services during COP22 planning meetings.

COP/ROP 2022 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring as appropriate and consistent with applicable law, regulations

and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional, and international civil society and community stakeholders, multilateral partners and the partner country government.

As in years past, civil society organizations are considered essential and invited to participate both in the virtual COP22 strategic virtual planning meetings, as well as virtual approval meetings. In particular, engagement with local CSOs at the country-level is required and should begin early and continue during the entirety of the COP planning and implementation process.

This engagement of civil society, including faith-based organizations/faith communities, specifically includes the sharing of FY 2021 Q4 and FY 2021 APR results and analyses and the convening of an in-country planning retreat with local stakeholders, no later than the week of February 7, 2022, in order to introduce and discuss all COP/ROP 2022 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2022. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund, with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In March 2022, PEPFAR will convene virtual meetings where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations, faith-based organizations/faith communities, and multilateral partners. Specific guidance for the 2022 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2022 development, finalization, and implementation. As in COP/ROP 2021, the draft Strategic Direction Summary (SDS) is required to be shared with both CSO and FBO stakeholders for their input and comments at least 7 days prior to submission to S/GAC. Please refer to the COP/ROP 2022 Guidance for a full list of requirements and engagement timelines. In addition, a more detailed timeline for sharing key data visualizations and other information with stakeholders is forthcoming.

Community-led Monitoring (CLM)

In addition to prescribed and routine engagement during PEPAR's annual business cycle, including around COP/ROP planning and quarterly POART processes, all PEPFAR programs are required to develop, support, and fund community-led monitoring (CLM) in close collaboration with independent, local civil society organizations and host country governments. Community-led monitoring in COP22 should build on prior activities in COP21 and be designed to help PEPFAR programs and health institutions pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. In addition to being data-driven and action-oriented, CLM should continue to ensure indicators are defined by communities and health service users, and data should be additive and not a duplicate collection of routine data already available to PEPFAR through MER or SIMS. New in COP22, PEPFAR-supported community-led monitoring programs must include an explicit focus on key populations. CLM should be utilized to advance equity and to support improvement in programs, especially for populations who have not yet fully experienced the benefits of HIV epidemic control. For example, OUs with pediatric care and treatment programs should consider utilizing CLM to track and ensure accountability for child, adolescent, and family-centered care.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment: Each OU's COP/ROP 2022 minimum requirement for the care and treatment earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2022 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): Each OU's COP/ROP 2022 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. Generalized epidemic countries which do not meet the 50 percent threshold must provide a brief written justification in FACTS Info, explaining the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors.

Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)
+
Prevention: **community mobilization, behavior, and norms change** (all populations)
+
50 % Prevention: **Not disaggregated** (all populations)

Gender Based Violence (GBV): Each OU's COP/ROP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2022** funding programmed to the GBV cross-cutting code. Your COP/ROP 2022 earmark is derived by using the final COP/ROP 2021 GBV earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Each OU's COP/ROP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2022 funding** programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2021 water earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for water can be above this amount; however, it cannot fall below it.

Initiative Controls: Table 3 shows initiative controls where S/GAC has directed funding for a set of activities that cannot be accounted for through program areas and/or beneficiaries alone. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned.

The four initiative controls below (**Cervical Cancer**, **DREAMS**, **OVC (non-DREAMS)**, and **VMMC**) have been assigned to the appropriate OUs. For OUs where these controls are designated in the PLL, the amounts reflect the minimum required. These initiative controls can be exceeded without a control change, but a control change request would be required before a lower level for these activities can be planned.

Cervical Cancer - This initiative provides funding for all activities related to cervical cancer screening and diagnosis and treatment of precancerous cervical lesions for women living with HIV as outlined in the COP Guidance.

DREAMS - The DREAMS initiative should capture all funding specifically allocated as DREAMS in the OU's planning level and must be used for the goal of HIV and sexual violence prevention among adolescent girls and young women (AGYW) ages 10-24 years (unless otherwise approved) in approved DREAMS SNUs in accordance with the DREAMS and COP Guidance. The DREAMS initiative can also include prevention interventions in DREAMS geographic areas for girls and boys aged 10-14 which may be cost shared with the OVC (non-DREAMS) initiative as noted in the COP guidance.

OVC (non-DREAMS) - OVC (non-DREAMS) is a new initiative in COP/ROP 2022. OUs should use the initiative to budget for OVC (non-DREAMS) programming, including all OVC comprehensive activities as outlined in the COP Guidance. The OVC (non-DREAMS) initiative should include ASP, SE, and PREV costs (except PrEP and VMMC) linked to any OVC beneficiary (including sub-beneficiaries such as OVC caregivers). As the initiative is new for COP/ROP 2022, OUs should pay particular attention to funds programmed under OVC (non-DREAMS) to ensure that the current cohort of children enrolled in the comprehensive program receive continuity of care for FY 2023. The OVC (non-DREAMS) initiative can also include prevention interventions for girls and boys aged 10-14 which may be cost-shared with the DREAMS initiative as noted in the COP guidance. The OVC (non-DREAMS) initiative cannot be met with any HTS, C&T, PM or commodities costs.

VMMC - All services and equipment related to providing surgical and ShangRing VMMC for boys/men ages 15 and above, and ShangRing circumcision only for boys age 13 and 14 years, should be budgeted using the VMMC initiative.

While the CLM initiative does not appear in PLL budget tables, as CLM remains a requirement in COP/ROP 2022 for all OUs, each OU is responsible for programming a portion of funds under the **Community-Led Monitoring** initiative.

Community-Led Monitoring - During COP/ROP 2020, PEPFAR invested in expansion of community-led monitoring, making it a requirement of all OUs, as a critical way to listen to community voices in assessment of program quality and design of client-centered services. Community-led monitoring remains a requirement in FY 2023.

In addition to the five initiatives above, S/GAC may also allocate funding to OUs under two additional initiative controls: **Condoms (GHP-USAID Central Funding)** and **One-Time Conditional Funding**. If the OU was designated to receive funding under either one or both these initiatives in COP/ROP 2022, Table 3 will reflect these amounts. Unless otherwise noted, country teams should meet these funding controls when programming in their FAST.

Condoms (GHP-USAID Central Funding) - This initiative control denotes the amount of GHP-USAID central funding the country team may use to procure male and female condoms, lubricants, and to ship these commodities to the OU. Any additional condoms and lubricants to be procured with PEPFAR funding should be budgeted in the FAST with bilateral funding. Botswana has not been allocated central funds for condoms.

USAID Southern Africa Regional Platform - This initiative is for the country's share of the costs to operate the USAID Southern Africa Regional Platform, which provides administrative and technical support for Angola, Botswana, Eswatini, Lesotho, and Namibia. These funds were previously planned as part of the bilateral COP funding, but are now budgeted and notified centrally, with country amounts included as central funding in the overall COP levels for Angola, Botswana, Eswatini, Lesotho, and Namibia. Only these 5 countries may use this initiative, and this initiative can only be used with central funding specifically provided as part of the PLL controls.

One-Time Conditional Funding - The release of any funding made available under this initiative is contingent upon the OU's ability to meet all requirements outlined in their final COP/ROP approval memo. OUs that fail to meet these minimum standards may be ineligible to receive these funds for programmatic implementation in FY 2023.

No control is set in the PLL for the **HBCU Tx** and **Surveillance and Public Health Response** initiatives, but OUs may include relevant funds under these initiatives instead of Core Program as appropriate.

All funding not attributed to one of the nine COP/ROP 2022 initiatives above should be attributed to the **Core Program** initiative.

For additional details on initiatives, see the PEPFAR Financial Classifications Reference Guide.

Programmatic Controls: Table 4 shows programmatic controls where S/GAC has directed funding for certain programmatic activities. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned. Since every dollar programmed in COP must belong to one initiative, programmatic controls will be a subset of one or more initiative controls, even if the standard Core Program initiative.

PrEP (AGYW) – The PrEP (AGYW) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for the Females – Adolescent Girls and Young Women sub-beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of AGYW on PrEP wherever possible. Countries with a PrEP (AGYW) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

PrEP (KPs) – The PrEP (KPs) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for all sub-beneficiaries under the KP beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of KPs on PrEP wherever possible. Countries with a PrEP (KPs) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

State ICASS: Table 5 shows the amount that the OU must program under State for ICASS Costs.

Funds Programmed under State/SGAC (S/GAC TBDs)

No funding may be programmed under State/SGAC without prior approval from S/GAC M&B. In general State/SGAC TBDs are only used in extraordinary and or unusual circumstances. To the degree that funding is approved, the rationale and any conditions attached to the funding will be documented by M&B. Any S/GAC TBDs approved during COP/ROP 2022 planning will require supplemental language in the OU's COP/ROP 2022 approval memo, clearly outlining the process for how these funds can be accessed. Any funds that have not been distributed to agencies before the end of FY 2023 may be subject to reprogramming in future planning cycles towards the same OU or another OU.

COP/ROP 2022 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

Whenever possible, all agencies within an OU should hold several months of pipeline at the end of COP/ROP 2022 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain this buffer. With the exception of Dominican Republic, Ethiopia, Haiti, South Sudan, Zimbabwe, Asia Regional Program, and Western Hemisphere Regional Program, which should hold up to four months of pipeline, all other OUs are permitted to hold no more than three months of buffer pipeline.

Any agency that anticipates ending COP/ROP 2021 implementation (end of FY 2022) with a pipeline in excess of three or four months is required to apply this excessive pipeline to COP/ROP 2022, decreasing the new funding amount to stay within the planning level.

Transitioning HIV Services to Local Partners

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. In COP19 Guidance, PEPFAR set a goal that 40% of partners must be local by the end of FY19, and 70% by the end of FY20.While considerable progress was made in this effort, the 70% mark was not achieved by all agencies in all OUs, and thus in FY22 and FY23, teams must continue to prioritize this so that the 70% goal can be realized. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY23 as appropriate through their COP/ROP 2022 submission.