United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 13th, 2021

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

FROM: S/GAC Chair, Sara Klucking and PPM, Ronald Carter

THROUGH: Ambassador Deborah L. Birx, MD

SUBJECT: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador Cloud,

I sincerely hope that this note finds you and your team well, safe, and healthy. We are grateful for your leadership protecting staff through this difficult time.

This year has brought unprecedented challenges with the COVID-19 pandemic impacting the entire global community. Despite obstacles faced, what has remained unwavering is the tireless commitment and incredible resiliency of our PEPFAR program, partners, and team across the over 50 countries in which we work. This includes rapid program adaptations, emerging innovations, and client-centered solutions to ensure continuity of HIV services. As the threat of COVID-19 has impacted PEPFAR countries, PEPFAR country teams and programs have proven to be focused and resilient in the face of dual pandemics of HIV and COVID-19.

PEPFAR implementation over the past year has shown tremendous effort to maintain clients on treatment, initiating and accelerating client centered service delivery adaptations, while doing what was possible in HIV prevention programs deeply affected by COVID-19 shutdowns. The following themes have emerged across all of PEPFAR-supported countries; As the economic impact of COVID-19 continues to be seen at both national and community levels, it is more important than ever to use granular data and expand what is working in specific SNUs for viral load coverage and suppression. We saw differential progress in this area independent of the impact of COVID-19. Focus groups and deep analytics of client returning to care to ensure we are addressing the critical persistent and new structural barriers. Focus on areas of recent treatment interruption to understand how COVID-19 may have created or exacerbated barriers to access and treatment continuity. Across all countries we see persistent gaps in pediatric diagnosis, treatment and viral suppression. Particular attention should be paid to the pediatric cascade and identifying challenges by district and country for clear and actionable plans. In addition, leverage OVC, DREAMS and other resources for clear accountability to work with mothers and improve early infant diagnosis by two months of age and strengthen resiliency among at-risk women and girls. Community-led monitoring must raise visibility and appropriate response to the needs of populations already vulnerable before COVID-19. The assessment of needs, and strategies to reinforce OVC caregivers and HIV-affected families in crisis should contribute to budget and activity planning for care and treatment, DREAMS, OVC and wraparound resources. Furthermore, analyzing expenditures at mechanism and program areas level, along with the work teams have done, to build relationships and co-planning with your partner government, the Global Fund, UN organizations and other donors. These relationships and planning efforts are critical to supply chain stability for key commodities as well as understanding COVID-19 relief and other potential funding available in country to ensure most effective and efficient use of PEPFAR's contributions to the national HIV response in COP21.

We understand that specific programs will have carryover and others may not and these funds will be critical to ensure stabilization and expansion of critical prevention programming.

The COVID-19 pandemic also laid bare the depth and breadth of inequities still across the globe and clear evidence that when constrained, Ministries of Health and governments make choices that differentially impact specific programming areas and specific populations. The pandemic revealed vulnerabilities in our non-public sector community efforts that we knew were present, and are now fully exposed, as these specific activities were the first to be dropped. Communities of women and children, and key populations including men who have sex with men, transgender individuals, sex workers, people who inject drugs, and people in prisons and other closed settings are not being adequately and sustainably supported by public-sector mechanisms. We have lost ground in all of our prevention services for all populations and for our most vulnerable and marginalized populations and must make every effort to recover.

Despite the disruptions caused by the COVID-19 pandemic, a number of countries have shown a level of resiliency were achieving epidemic control of HIV, and others are on the brink of epidemic control. With continued implementation, 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 Country Operational Plan 2021 planning and implementation: advancing client-centered services; engaging with communities; implementing resilient and adaptive approaches; and supporting capacities for sustainable epidemic control.

We commend you and your team for your attention to the adoption and implementation of the public health policies that have the greatest impact on HIV, particularly as these very policies are critical to ensuring sustained HIV services during COVID-19. Also, we appreciate your role in supporting PEPFAR teams through this challenging period, and continuing to hold implementing partners accountable for their performance.

We are grateful to your incredible PEPFAR team in country, working together across agencies to ensure the most effective and efficient use of U.S. taxpayer dollars. We know there are strengths and weaknesses across the board and across the implementing agencies; and we look forward to working together to support those strengths and address those challenges.

We are excited about your progress in:

- Maintaining adult treatment continuity – PEPFAR Botswana's performance in linkage, retention, and viral load suppression demonstrates that Botswana continues to excel at starting and maintaining clients on effective HIV treatment regimens.
- Combatting gender-based violence (GBV) – Amid COVID-19 and increased reports of GBV, PEPFAR Botswana worked closely with the Government of Botswana (GoB) to amplify the issue, support vulnerable populations and leverage PEPFAR programs including the DREAMS platform to increase support for survivors of sexual violence.
- Scaling-up oral pre-exposure prophylaxis (PrEP) – PEPFAR Botswana continues to expand PrEP services year-over-year to both key populations and adolescent girls and young women, pushing 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 together. Botswana should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

As you will see in COP guidance this year, there are no substantial changes in program direction. While assessing possible deficits in programming arising from COVID-19 our fundamental challenges continue and we again highlight 5 overarching issues we see across PEPFAR.

1. Continued new HIV infections in adolescents and young women
2. Supporting key populations with prevention and treatment services
3. Ensuring men are diagnosed and treated early (testing positive and new on treatment (linkage surrogate))
4. Ensuring 15-35-year-old asymptomatic clients are maintained on treatment and virally suppressed [net new on treatment and treatment current growth, (retention surrogate)]
5. Ensuing all children are diagnosed and are on the best treatment regimens and virally suppressed

Moreover, we note the following specific key challenges in PEPFAR Botswana:

- Data quality, availability, and use – Multiple challenges in documenting and measuring progress made toward nationwide epidemic control persist. PEPFAR Botswana must institutionalize a focus on data to support decision-making and to prioritize data quality assessments, data systems, decision-analytics, and the collection and use of the Botswana AIDS Impact Survey (BAIS) V and other survey data.
- Pediatric and adolescent HIV services – Case identification, treatment continuity, and viral load suppression in C/ALHIV continues to lag behind adults.
- Viral load coverage – PEPFAR Botswana's excellent viral load suppression is undermined by low coverage that is highly variable across sites, age-bands, and sexes.

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 21 PEPFAR Planned Allocation and Strategic Direction Summary

Consistent with the approach from last year, PEPFAR teams will once again be responsible for setting their 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. Since 2016, PEPFAR and the Global Fund resources have been focused on achieving these global goals that have been translated to each country by UNAIDS and subsequently supported financially and technically by the PEPFAR family. Since 2016, PEPFAR has utilized these global commitment targets as PEPFAR targets with the commensurate increased funding to countries to achieve the goals set out by the Heads of State. Many countries have made tremendous progress towards these targets and others need to accelerate. Botswana is understood to have achieved the 2020 goals however the trajectory toward achieving the 2030 goals is highly uncertain. Sustaining the amazing gains will need to be our constant focus as we strive to build the evidence base needed to realize the 2030 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 2020.** After the PEPFAR country team submits their COP 21 targets, the notional budget will then be adjusted to the presented level of ambition.

The PEPFAR Country/Regional Operational Plan (COP/ROP 2021) notional budget for Botswana is **$60,000,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program direction 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.

We are hoping this approach to target-setting and budget will establish an open dialogue on target-setting and empower teams to work with all stakeholders to plan a strategic and impactful COP. The expectation is for country teams and agencies to propose to S/GAC the targets they believe are achievable and feasible and hold their partner's accountable to that achievement.

PEPFAR, with partner governments, multilateral partners, and communities, continues to move rapidly toward control of the HIV pandemic and plan for sustainability of programs. Achieving epidemic control for HIV will be a remarkable accomplishment, saving millions of lives, significantly lowering the burden of HIV/AIDS in countries and communities, reducing the future costs required to sustain the HIV response, and building sustainable public health systems capacity in host countries.

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. Where PEPFAR successfully navigated disruption due to COVID-19 during 2020, it was a result of strong teams, local partners, communities, dedicated health and community workers, leveraging longstanding capacities and platforms established by PEPFAR. Our teams, partners, and communities worked together to adapt and further innovate program implementation and models of service delivery so that the adverse impacts of a dual pandemic threat on essential HIV services were mitigated. Stakeholder engagement is essential for a productive and impactful 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 2021 COP planning and approval process.

I am so grateful to you and your entire team for your leadership and engagement in the planning, review and implementation of the President's Emergency Plan for AIDS Relief (PEPFAR) program, along with the community and Government to enhance PEPFAR's program impact.

Sincerely,

Deborah Birx

Attachment: **Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction Summary.**

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

Overview: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction Summary

With input from the field teams through the quarterly POARTs, the agency self-assessments and from Headquarters Country Accountability and Support Teams (CAST), 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) 2019 and current COP 2020 implementation as we plan for COP 2021. We have noted the following key successes and challenges:

PEPFAR Botswana has been very successful in adopting and operationalizing many of the minimum program requirements as well as the lessons learned through addressing past performance challenges and continuous quality improvement processes. This is apparent from the strong COP19 overall performance in linkage, retention, and viral load suppression. Botswana continues to excel at getting and maintaining clients on highly effective treatment regimens. The laser focus on treatment continuity and establishing durable improvements across the treatment cascade with same-day treatment initiation, adherence support, viral load testing, and on bringing non-citizens with HIV and those lost to follow up into care is notable and undoubtedly better positioning Botswana toward national HIV epidemic control.

In addition, we wish to recognize the continued commitment of the GoB in funding, particularly in the challenging context of the COVID-19 pandemic, the majority of the country's HIV prevention, care and treatment costs. COVID-19 introduced a myriad of obstacles and yet the data show that that PEPFAR/Botswana, in partnership with the GoB, responded and adapted during COP 2019 in ways that strengthened the program and program partnerships. We applaud the team for innovations and adaptations in their communications, case-management, and prevention interventions that protected the vulnerable and ensured continued access to essential HIV services. Of particular note is the cooperation and leveraging of the DREAMS platform to combat gender-based violence in the context of increased GBV incidence during COVID-19 movement restrictions.

The provision of oral pre-exposure prophylaxis (PrEP) is an additional program area where the team rose to the challenges of COVID-19 and embraced and deployed online platforms that enabled and resulted in the expansion of PrEP services to both key populations and adolescent girls and young women. In this area and others, PEPFAR Botswana has proven to be focused and resilient in the face of the dual pandemics of HIV and COVID-19.

While COVID-19 adaptations and the trends on linkage, retention, and viral load testing are encouraging, evidence shows that across the treatment and prevention cascades there is room for improvement. Pediatric and adolescent HIV services, viral load coverage, and case-finding are three specific areas where challenges must be addressed and performance improved. Moreover, there are two crosscutting areas that will benefit from attention in COP 2021. The first is a renewed focus on data quality, data availably, and data use. The second is in performing a comprehensive review/assessment of the PEPFAR Botswana portfolio to ensure the footprint and posture are optimal for achieving and sustaining epidemic control in Botswana under the "One Botswana" strategy adopted in 2019.

Pediatric and adolescent HIV services lags behind in case identification, treatment continuity, and viral load suppression in C/ALHIV relative to adults. National ARV Quantification Report in June 2020 estimates that only 4,195 out of an estimated 10000 C/ALHIV are on treatment. In COP 2019, PEPFAR Botswana struggled to find positives of all ages, but particularly within the pediatric groups. This suggests that new strategies and shift in focus is needed. Moreover, per the minimum program requirements, all children of HIV positive mothers should be assessed for HIV and all at-risk families enrolled in the OVC program.

PEPFAR Botswana's impressive viral load suppression and strong adult continuity of treatment is undermined by low viral load coverage (VLC) rates. VLC performance is uneven and variable across sub-national units, sites, age-bands, and sexes. Performance challenges in VLC rates preceded and were amplified by COVID-19 interventions and persisted throughout COP 2019. Improving coverage must be prioritized, particularly for children, adolescents, and young adults, and in low performing districts and sites.

Data quality, data availability, and data use for decision-making will be critical for attaining and sustaining the 95/95/95 commitment and goal. New GoB/MOH leadership has identified data analytics for decision-making as a priority. PEPFAR should support this effort with a commitment to improving data quality, availability, and use. This commitment should include, but may not be limited to, data quality assessments, analytics that support measuring progress toward goals, health information systems, supply chain support, and prioritizing the collection and use of the fifth Botswana AIDS Impact Survey (BAIS) and other survey data. In doing so, interoperability and coordination with the GoB to support the national program and decision-making must be primary.

Data challenges aside, achieving and sustaining epidemic control in Botswana will additionally require execution of the right programs in the right places at the right times. PEPFAR Botswana should review and evaluate its current portfolio to determine if and how to better unify and harmonize programs across the HIV response under the "One Botswana" strategy adopted in 2019. The review should consider the current programmatic footprint, the donor environment, and the needs of the GoB, to ensure an optimal program for achieving and sustaining epidemic control in Botswana. The review should address issues of sustainability, resource levels, and the balance between technical assistance and direct service delivery, prevention and treatment, and HRH capacities and staffing patterns.

Finally, PEPFAR Botswana sharply underperformed in case finding and, as a consequence, ART treatment growth, in COP 2019. Spectrum modeling estimates that 92% of people living with HIV in Botswana are aware of their HIV-positive status. Under that assumption, a strategy of highly targeted index-testing based approach has been recommended, combined with recency testing and robust case-based surveillance. Resources for active case finding are likely to be restricted while we await updated epidemiological data from the BAIS V. However, the team should consider and anticipate the need for robust and highly targeted case-finding capabilities in anticipation of BAIS data becoming available.

SECTION 1: COP/ROP 2021 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2020 (EOFY) tool, and performance data, the total COP/ROP 2021 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency. Due to increased costs in FY 2020, including those due to COVID-19, and correspondingly lower applied pipeline going into COP 2021, COP envelopes have been decreased in some OUs so that S/GAC has funds reserved to address program gaps identified by PHIAs that have yet to be completed and to address other potential future requirements as the impacts of COVID-19 on the program are better known. These funds will be allocated to OUs at a later date as appropriate.

TABLE 1: All COP 2021 Funding by Appropriation Year

	Bilateral				Central				Total
	FY21	FY20	FY19	Unspecified	FY21	FY20	FY19	Unspecified	TOTAL
Total New Funding	$ 51,426,542	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 51,426,542
GHP-State	$ 49,230,292	$ -	$ -		$ -	$ -	$ -		$ 49,230,292
GHP-USAID	$ -				$ -				$ -
GAP	$ 2,196,250				$ -				$ 2,196,250
Total Applied Pipeline	$ -	$ -	$ -	$ 8,573,458	$ -	$ -	$ -	$ -	$ 8,573,458
DOD				$ 866,839				$ -	$ 866,839
HHS/CDC				$ 4,906,546				$ -	$ 4,906,546
HHS/HRSA				$ 203,577				$ -	$ 203,577
PC				$ 2,524,840				$ -	$ 2,524,840
USAID				$ 71,656				$ -	$ 71,656
USAID/WCF				$ -				$ -	$ -
State				$ -				$ -	$ -
State/AF				$ -				$ -	$ -
State/EAP				$ -				$ -	$ -
State/EUR				$ -				$ -	$ -
State/PRM				$ -				$ -	$ -
State/SCA				$ -				$ -	$ -
State/SGAC				$ -				$ -	$ -
State/WHA				$ -				$ -	$ -
TOTAL FUNDING	$ 51,426,542	$ -	$ -	$ 8,573,458	$ -	$ -	$ -	$ -	$ 60,000,000

SECTION 2: COP 2021 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $28,000,000 and the full Orphans and Vulnerable Children (OVC) level of $11,600,000 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 2021 Earmarks by Appropriation Year*

	Appropriation Year			
	FY21	FY20	FY19	TOTAL
C&T	$ 28,000,000	$ -	$ -	$ 28,000,000
OVC	$ 11,600,000	$ -	$ -	$ 11,600,000
GBV	$ 1,000,000	$ -	$ -	$ 1,000,000
Water	$ 50,000	$ -	$ -	$ 50,000

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

TABLE 3: COP 2021 Initiative Controls

	Bilateral	Central	TOTAL	Comments/Notes
Total Funding	**$ 60,000,000**	**$ -**	**$ 60,000,000**	
Core Program	$ 38,200,000	$ -	**$ 38,200,000**	
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	$ -	$ -	**$ -**	
Surveillance and Public Health Response	$ -	$ -	**$ -**	
VMMC	$ 1,800,000	$ -	**$ 1,800,000**	

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

TABLE 4: State ICASS Funding

	Appropriation Year			
	FY21	**FY20**	**FY19**	**Unspecified**
ICASS	$109,635	$-	$-	

SECTION 3: PAST PERFORMANCE – COP/ROP 2019 Review

Table 5. COP/ROP OU Level FY20 Program Results (COP19) against FY21 Targets (COP20)

Indicator	FY20 target (COP19)	FY20 result (COP19)	FY21 target (COP20)
TX Current <15	1,810	1,375	1,844
TX Current >15	170,156	152,193	171,111
VMMC >15	22,006	4,147	10,010
DREAMS (AGYW PREV)	(n/a)	11,317	n/a
Cervical Cancer Screening	32,396	17,957	32,393
TB Preventive Therapy	72,305	42,664	142,363

Table 6. COP/ROP 2019 | FY 2020 Agency-level Outlays versus Approved Budget

Agency	Sum of Approved COP/ROP 2019 Planning Level	Sum of Total FY 2020 Outlays	Sum of Over/Under Outlays
Planned			
DOD	1,137,843	1,091,435	46,408
HHS/CDC	25,206,016	18,868,825	6,337,191
HHS/HRSA	4,550,000	4,453,297	96,703
PC	2,415,868	1,279,759	1,136,109
State	252,547	256,839	-4,292
USAID	14,085,369	15,625,394	-1,540,025
Grand Total	**47,647,643**	**41,575,549**	**6,072,094**

Table 7. COP/ROP 2019 | FY 2020 Implementing Partner-level Significant Over-Outlays versus Approved Budget

The following IMs outlayed at least 110 percent in excess of their COP/ROP19 approved level.

Mechanism ID	Partner Name	Funding Agency	Total Planning Level	Total Outlays	Outlay Delta Check
17862	FHI Development 360 LLC	USAID	$0	$1,207,990	($1,207,990)
102018		USAID	$2,844,303	$3,505,065	($660,762)

Table 8. COP/ROP 2019 | FY 2020 Results & Expenditures

Agency	Indicator	FY20 Target	FY20 Result	% Achievement	Program Classification	FY20 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	66830	**22107**	33	HTS	$658,540	83
	HTS_TST_POS	5153	**1020**	20	HTS		
	TX_NEW	17999	**7951**	44	C&T	$8,683,831	43
	TX_CURR	170198	**153938**	90	C&T		
	VMMC_CIRC	20891	**5845**	-	VMMC	$2,588,808	87
	OVC_SERV	-	-	-	OVC	N/A	N/A
HHS/HRSA	HTS_TST	98966	**69447**	70	HTS	$2,333,425	34
	HTS_TST_POS	11469	**4903**	43	HTS		
	TX_NEW	-	-	-	C&T	$286,936	46
	TX_CURR	-	-	-	C&T		
	VMMC_CIRC	-	-	-	VMMC	N/A	N/A
	OVC_SERV	-	-	-	OVC	N/A	N/A
DOD	HTS_TST	-	**812**	-	HTS	$19,385	100
	HTS_TST_POS	-	**7**	-	HTS		
	TX_NEW	-	-	-	C&T	$138,535	0
	TX_CURR	-	-	-	C&T		
	VMMC_CIRC	4985	**1604**	32	VMMC	$608,231	100
	OVC_SERV	-	-	-	OVC	N/A	N/A
PC	HTS_TST	-	-	-	HTS	N/A	N/A
	HTS_TST_POS	-	-	-	HTS		
	TX_NEW	-	-	-	C&T	N/A	N/A
	TX_CURR	-	-	-	C&T		
	VMMC_CIRC	-	-	-	VMMC	N/A	N/A
	OVC_SERV	895	**1592**	178	OVC	N/A	N/A
USAID	HTS_TST	2747	**2734**	100	HTS	$158,132	100
	HTS_TST_POS	401	**618**	154	HTS		
	TX_NEW	1058	**1465**	138	C&T	$2,589,285	71
	TX_CURR	1768	**2448**	138	C&T		
	VMMC_CIRC	-	-	-	VMMC	$79	0
	OVC_SERV	14105	**24886**	176	OVC	$2,281,426	40
					Above Site Programs	$1,378,964	
					Program Management	$7,286,580	

COP/ROP 2019 | FY 2020 Analysis of Performance

Case-Finding and Linkage: PEPFAR Botswana reduced the number of tests performed and increased testing efficiency. Improvement in overall testing yield was observed across male and female sex groups (<15 and 15+ age band), as compared to FY19 achievements. The team also decreased distribution of HTS_TST_POS from lower yield modalities such as other PITC (46% in FY19 vs. 41% in Fy20), and increased efforts in targeted case finding strategies. Additionally, between FY18 Q4 and FY20 Q3, the percentage of adult males (15+ years) on treatment increased by 11%. Thus, efforts demonstrate a shift in the right direction in terms of progress away from non-targeted testing approaches and towards more targeted approaches and closing gaps. Linkage to treatment for newly diagnosed PLHIV (male, female) have increased over time from about ~50% in FY19Q1 to >117% in FY20Q4, and an overall OU linkage of 94% as compared to 86% in FY19.

The COP 2019 distribution of HTS_TST_POS remains inconsistent with a strong, targeted, case-finding strategy characteristic of Botswana's stage in epidemic control. To maximize impact, increase targeted testing; Utilize a combination of case finding strategies like index testing, HIVST, and validated risk screening tools to ensure case-finding efforts are identifying and testing individuals and populations that are at high risk of HIV infection. Additionally, increasing training and capacity for index testing to all PEPFAR supported clinics and IPs can help ensure that safe and ethical index testing services are implemented with fidelity and that services are offered to all persons newly diagnosed with HIV as well as to persons returning to care and PLHIV who are not virally suppressed. Continue moving forward with recency testing implementation and targeting known gaps in the treatment cascade.

DREAMS: In FY20, enrollment dramatically increased, reaching 11,317 AGYW with DREAMS interventions and services, with 7,193 (64%) completing at least the primary package of DREAMS interventions and services. This is an increase from FY19, where the just 3,949 AGYW were reached with only 1,724 (42%) completing at least the primary package. Additionally, PEPFAR Botswana achieved 146% of its GEND_GBV targets, up from an achievement of just 41% in FY19. This is an important achievement given the rise of GBV as a result of COVID-19-related restrictions on mobility and gatherings. Finally, PEPFAR Botswana built upon its successes in FY19 to strengthen demand creation efforts for PrEP among AGYW and increase the accessibility of PrEP services for this population, achieving 130% of its FY20 PrEP_NEW and 120% of its PrEP_CURR target with AGYW contributing to much of the results.

Cervical Cancer Screening: With only 55% of the screening target met in FY20, demand creation is needed. Successful strategies include interpersonal communications and materials targeting WLHIV at key service delivery points, support groups, and in the community; and interventions targeting staff such as supervision and mentoring, IEC materials, and sensitization at the facility and district level. The follow-up and linkage to treatment for screen-positive women also needs to be improved. The percent of screen-positive women treated has been consistently below 90% since FY19 Q2, although linkage to treatment has improved to 83% in the most recent quarter (FY20 Q4).

OVC: Excellent target achievement (163% for OVC <18) and sustained improvement in Known Status Proxy (97%) in COP19. The OVC program should consider capitalizing on strong clinical linkages to support index testing of biological children of all HIV+ mothers, and continue to monitor viral load coverage and suppression for enrolled C/ALHIV.

PMTCT: HIV testing and linkage of HIV-positive women to ART at first ANC is very high, with 98% or greater HIV testing coverage and linkage across all quarters and in all SNUs. However, close partner

management and focused interventions are needed to address persistently low 2 month EID coverage in Botswana, particularly in the three districts reporting <80% 2 month EID coverage in FY20 (South East, North West, and North East).

TB and TPT: The rate of positive screens is lower than expected. The quality of TB screening should be reviewed to improve TB case identification, especially in children. TPT completion rates are high although absolute numbers initiating and completing TPT are low relative to TX_CURR and the number of negative TB screens. To increase TPT initiations, address clinical and supply chain barriers to adult and pediatric TPT at all sites. While the percentage of TB screening for patients on ART has increased from 70% to 95% over the last fiscal year, the percentage of TB specimens sent to the laboratory for diagnostic testing has remained consistently <65% which is lower than expected (MER TX_TB, FY19 Q4, FY20 Q2 and FY20 Q4). All PLHIV patients screened positive for TB should have a sample sent to the lab for diagnostic testing and treatment, if necessary.

Key Populations: High target achievement on HTS_TST_POS and TX_NEW, with a proxy linkage of 111% and positive TX_NET_NEW maintained through FY20. The increase in peer navigation and the utilization of virtual means (applying lessons learnt from COVID-19 pandemic) to support adherence and stay in touch with clients is excellent. PrEP uptake is greatly improved in COP19. Strengthen PrEP literacy among lay counselors to ensure all who test negative are sensitized about PrEP services.

VMMC: PEPFAR Botswana's chronic underperformance in VMMC calls out for active partner management for performance improvement.

SECTION 4: COP/ROP 2021 DIRECTIVES

The following section has specific directives for COP 2021 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– were expected to have the following minimum program requirements in place by the beginning of COP 2020 implementation (FY2021). 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 COP 2021 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 COP 2021 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 FY2021. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2022 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table on the following page.

Table 9. COP/ROP 2021 (FY 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.	Adopted. Uneven district and site level implementation. Implementation monitoring limited to facilities directly supported by PEPFAR
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.	Adopted, partially implemented. Challenges with supply chain management and forecasting capacity. Challenges with pediatric regimens persist.
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.	Adopted, partially implemented. Challenges with scale-up of DSD to reach all clients who could benefit. Supply chain management hinders full implementation of MMD. Persistent low ART coverage in men.
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.	Adopted. Challenges with scale-up.
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.	Adopted, in process. Persistently high number of new HIV diagnoses presenting with late stage disease. Uneven district and site-level viral load coverage history. Persistent challenges with EID at 2 mo.
Testing	
1. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	Adopted, in process. Index testing and active case finding for the diverse range of clients in Botswana us unevenly implemented and may require the development of new capacities, HRH cadres, and networks.
Prevention and OVC	
1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis	Adopted.

(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*)*	Expansion to all populations who may benefit including PBFW, partners of index cases, and more.
2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV	Adopted. OVC services must be more focused on caring for vulnerable children and families dealing with HIV. Barrier to identifying and enrolling all at risk families.
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.	Adopted.
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.	Adopted. Challenges with implementation in non-SIMS facilities.
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.	Adopted, partially implemented. Legacy communication on timing for ART initiation
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Adopted.
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	Adopted.
6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Adopted.
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	Adopted, partially implemented. Interoperability and systems and data usage remains a challenge.

In addition to meeting the minimum requirements outlined above, it is expected that Botswana will consider all the following technical directives and technical priorities:

Table 10. COP/ROP 2021 (FY 2022) Technical Directives

PEPFAR Botswana –Specific Directives
Data Use and Data Quality
Data collection, use, and analysis and improved data quality are essential for better understanding of the HIV epidemic and reaching epidemic control in Botswana. PEPFAR Botswana should: • Work closely with the GoB on completion of the BAIS V, and be prepared to adapt and/or realign the program as needed once data is available • Work closely with the GoB to ensure quality data is collected through the performance of DQAs, and improvement of electronic medical records, including ongoing work on PIMS interoperability and IPMS • Consistently and continuously use and analyze data with the aim of continuous program improvement and informing decision-making. • Triangulate available data, including (but not limited to) the GoB-led MPR monitoring tools, MER results, custom community program indicators, SIMS results, site mapping, and other available survey and surveillance results
HIV Treatment
PEPFAR Botswana should ensure that their improved performance on linkage and continuity of treatment translates to regions and sites nationwide, particularly for men and adolescents. Continue to improve quality and scale up the linkage to treatment, retention, and differentiated service delivery models that contributed to a successful "reboot" and or success during COVID-19 mitigation. Implement granular site-level management to understand reasons for LTFU and take steps to prevent LTFU, with special focus on age groups (15-39) and site locations with highest proportion of loss to follow-up. Scale up MMD among all age groups.
Case-Finding
PEPFAR Botswana should continue to implement and refine a case-finding strategy consistent with a high level of epidemiological control, focusing on men and adolescents and children. This includes: • Scale-up and optimization of safe and ethical index testing • Strengthening of facility and community collaboration to ensure effective implementation of active partner notification • Scale-up and optimization of self-testing to enhance active partner notification • Introduction/continuation of recency testing to guide surveillance and case finding • Testing all children of HIV positive mothers • Refinement of case-based surveillance
Supply Chain and Commodities
PEPFAR Botswana should work closely with the GoB to: • Support host government ownership of commodity procurement and supply chain by strengthening procurement and contract management systems, advancing pooled procurement approaches to achieve cost savings, and redistribution of commodities among facilities at the last mile • Expand and accelerate implementation of multi-month dispensing and decentralized distribution models of ARVs to further improve treatment continuity and viral suppression
Other Government Policy or Programming Changes Needed

PEPFAR Botswana should perform a program review to ensure that they are implementing the right programs in the right places at the right times with the goal of achieving and sustaining HIV epidemic control in Botswana. The review should consider the current programmatic footprint, donor environment, and the needs of the GoB, and determine if and how to better unify and harmonize programs across the HIV response under the "One Botswana" strategy adopted in 2019. The review should address, at a minimum, issues of sustainability and the balance between technical assistance and direct service delivery, prevention and treatment, HRH capacities and staffing patterns, and available resources. Moreover, investments should be aligned with activities from planning through execution. Misaligned resources will lead to an inefficient program and reduce the expected impact of programmatic investments.

COP/ROP 2021 Technical Priorities

Client Centered Treatment Services

COP 2021 planning must ensure treatment continuity for all current and new clients. To do this, programs must specifically and thoroughly address the challenge of interrupted antiretroviral treatment, especially after initiating ARVs and through young adulthood. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous adherence to ART for an adult population that is asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are free, fit the lives of the clients, and empower clients to on ART to stay the course. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including client education on the benefits of lifelong treatment, optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient and safe ARV access arrangements, and community and client participation in design and evaluation of services.

Pediatric- and Adolescent-Centered Services

In COP 2021, PEPFAR programs are required to demonstrate improvement in pediatric case finding, including safe and ethical index testing, to close HIV treatment gaps across age and sex bands. Programs must move forward with the introduction and broad use of pediatric DTG formulations in FY21 (COP20), with full implementation expected to occur during the first quarters of FY22 (COP21). Programs need to further advance pediatric- and adolescent-specific continuity of treatment programming, including age-appropriate differentiated models of care and leveraging bidirectional synergies with clinical and OVC implementing partners. OUs must develop a comprehensive plan to achieve ≥ 90% viral load coverage and viral load suppression across all age and sex bands. To further reduce morbidity and mortality, clinical programs should include an evidence-based advanced HIV disease package of care for children and adolescents.

Community-led Monitoring

In COP 2021, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)

In COP 2021, PrEP should continue to be made widely available with a focus on getting PrEP, (including

possible new PrEP options) to the people that need it. Groups to be prioritized for PrEP include HIV negative partners of index cases key populations including sex workers, men who have sex with men, transgender persons, people in prisons and other closed settings, people who inject drugs, adolescent girls and young women and, pregnant and breastfeeding women, in areas with high HIV incidence or with higher risk partners, and other identified serodifferent couples. Groups should be tailored to the OU's epidemic context.

TB/HIV

TB/HIV services must be integrated, including DSD and MMD models for both TB and TB preventive treatment (TPT). All PLHIV must be routinely screened for TB and have access to molecular diagnostic testing and/or point of care tests such as LF-LAM. TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP21; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

Advanced HIV disease

The advanced disease package of care should be fully integrated into clinical care and includes diagnostics and therapeutics for tuberculosis and cryptoccal meningitis as well as cotrimoxazole. Countries should budget adequately for commodities including urinary LAM, CrAg, amphotericin B and flucytosine. Please see section 6.5.2 of the COP guidance.

DREAMS

DREAMS funding is allocated within your COP 2021 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2021 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP21 DREAMS implementation include systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition; particularly pregnant AGYW and those who are mothers; improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR); ensuring evidence-based curricula are implemented with quality and fidelity; enhancing mentoring selection, training, compensation and supportive supervision processes; and accelerating PrEP uptake for AGYW in DREAMS SNUs.

OVC

To support the Minimum Program Requirement described above, in COP 21 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, pediatric case finding, case conferencing, shared confidentiality, joint case identification, and data sharing. In high volume clinics within high burden SNUs, at least 90% of children (<age 19) in PEPFAR-supported treatment sites should be offered enrollment in OVC programs. OVC staff placed in clinics (e.g., as linkage coordinators, case managers, etc.) should have the capacity to assess child and family needs (including food and economic security) and to offer appropriate referrals. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

VMMC

Funds have been provided to conduct VMMC for males 15 years or older. The team is reminded of the revised guidance which allows surgical VMMC for those 15 or older. While Shang ring may be considered for those below age 15 with headquarters approval, it should be limited to those age 13 or above who are able to understand the procedure and provide informed consent, along with parental

consent as dictated by local laws. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

Cervical Cancer Screening and Treatment:
Funding for cervical cancer screening and treatment of pre-invasive lesions. The target for screening must be equal to half of the TX_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance and report into the cervical cancer MER indicators. Basic treatment should be available for pre-cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results.

PLHIV Stigma Index 2.0
PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised PLHIV Stigma Index 2.0 utilizing the standard methodology, or complement Global Fund or other donors financing implementation of the PLHIV Stigma Index 2.0, if it has not already been implemented in the OU. If the revised PLHIV Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 21, whether supported by PEPFAR or other resources. Completion of the PLHIV Stigma Index 2.0 should be accompanied by a response and action plan discussed and agreed upon by all stakeholders that will address findings. Where the PLHIV Stigma Index 2.0 has already been conducted, COP/ROP 21 focus should be on concerted action to address findings.

Human Resources for Health (HRH) and Sustainability
Using data from the HRH Inventory completed in COP20 Q4, OUs are expected to complete a comprehensive HRH analysis to optimize staffing at the site- and above-site-levels. PEPFAR programs in countries that will be near to or reach 95/95/95 in the COP20 implementation cycle are required to develop and implement plans to sustain their progress and effectively retain clients in quality HIV treatment programs. Results from the Sustainability Index and Dashboard (SID) 2019 should inform the OUs on their progress and gaps related to the policies and technical areas for inclusion in the sustainability plans. Resource alignment data should be used to understand the HIV funding landscape--especially with a more granular understanding of PEPFAR and GFATM investments-- who is paying for what services in order to enhance strategic collaboration and coordination and avoid duplication during the program planning cycle.

Cross-HIS Data interoperability - Use and Analysis
Improved data visibility, and analysis are essential for better understanding the HIV epidemic and reaching epidemic control. PEPFAR Botswana should 1) consistently and continuously use and analyze data at the individual patient level with aim of program improvement (e.g. use patient level data to understand retention differences across patient cohorts and create more tailored risk models and intervention). 2) utilize available data interoperability solutions to harmonize and triangulate data across EMRs, commodities, pharmacy dispensation, laboratory data, HRH and other data.

Systems Investments
PEPFAR teams are expected to align systems investments with key systems barriers to achieving epidemic control. System investments should also be aligned to achieving and maintaining minimum program requirements for COP including adoption and use of unique identifiers, building country capacity in disease surveillance and other core competencies to achieve and maintain epidemic control including country ability to perform continuous quality improvement. Systems investments that have

achieved their goals should be candidates for countries to assume responsibility to achieve the minimum program requirement for increased responsibility and increased government expenditures.

Innovative solutions and adaptive practices
There are extraordinary examples of innovation by our field teams and partners during COVID-19. These include adaptations and lessons learned that span across many of our technical and program areas as well as all countries we work in. Teams should look at ways to strengthen and improve our capacity to innovate, design, and create within the communities we serve. This includes systematically looking at the evidence base and how to learn from these examples as well as strengthen our methods to help scale proven strategies and interventions.

COP/ROP 2021 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 host country government.

As in years past, civil society organizations are considered essential and invited to participate both in the virtual COP21 strategic planning meetings, as well as virtual approval meetings. .

This engagement, of both civil society, and of faith-based organizations/faith communities, specifically includes the sharing of FY 2020 Q4 and FY 2020 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2021 in order to introduce and discuss all COP/ROP 2021 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2021. 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 February and March 2021, 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 2021 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2021 development, finalization, and implementation. As in COP/ROP 2020, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with both CSO and FBO stakeholders for their input and comments at least 48 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP/ROP 2021 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment C&T: OU's COP/ROP 2021 minimum requirement for the C&T earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2021 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY

2021 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): OU's COP/ROP 2021 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2021 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. In such cases, teams should provide brief justifications and explain the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors. The written justifications should be uploaded as 'Budgetary Requirements Justification' to the document library of FACTS Info.

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): 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 2021** funding programmed to the GBV cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2020 GBV earmark allocation as a baseline. The COP/ROP 2021 planned level of new FY 2021 funds for GBV can be above this amount; however, it cannot fall below it.

Water: 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 2021 funding** programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 2021 planned level of new FY 2021 funds for water can be above this amount; however, it cannot fall below it.

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. PEPFAR has set a 70% goal **by agency** by the end of FY21, and must meet 40% by FY20. 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 FY21 as appropriate through their COP/ROP 2020 submission.

State ICASS: Table 3 shows the amount that the OU must program under State for ICASS Costs.

COP/ROP 2021 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in Botswana should hold a 3 month pipeline at the end of COP/ROP 2021 implementation whenever possible 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 a 3 month buffer. Any agency that anticipates ending COP/ROP 2020 implementation (end of FY 2021)

with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP/ROP 2021, decreasing the new funding amount to stay within the planning level.