



BOTSWANA

Country Operational Plan

COP20

Strategic Direction Summary

7 April 2020

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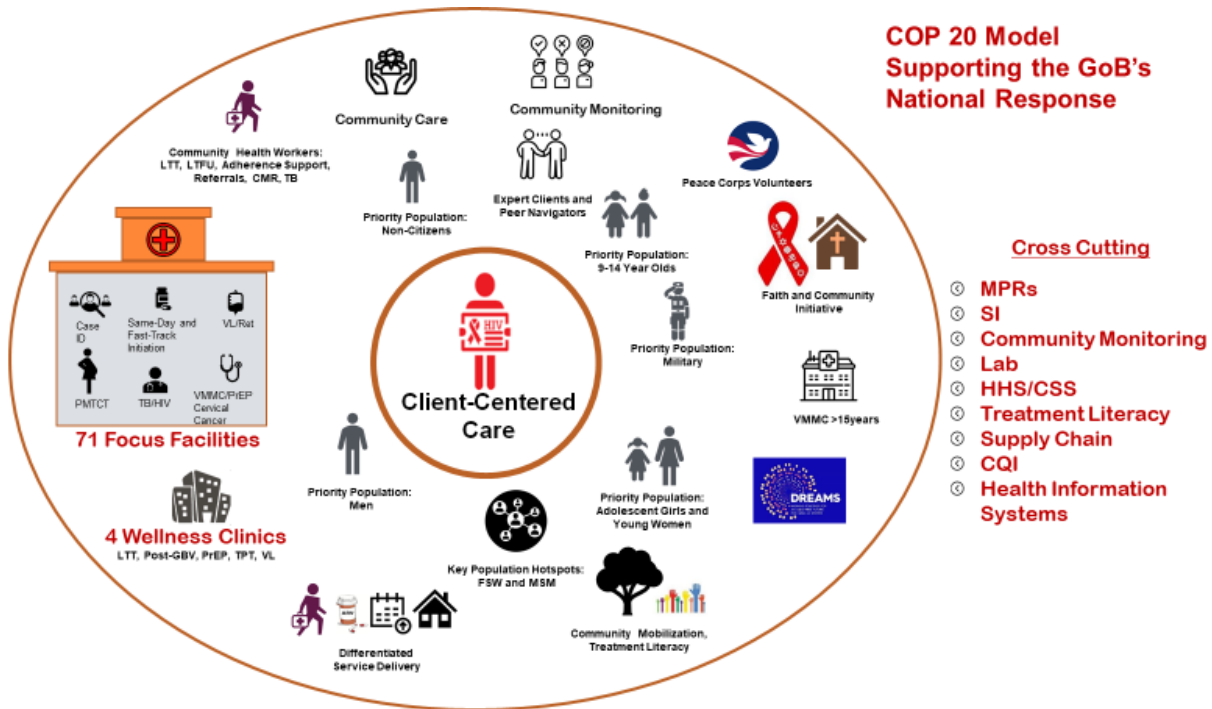
1.0 Goal Statement

The goal of COP20 is to build upon the work of COP19 as “One Botswana” with all stakeholders to eliminate policy barriers and re-focus strategies on delivering innovative, client-centered programs in order to reach the 95-95-95 goals across all populations, sex and age bands. The Government of Botswana (GoB) made the decision to do things differently and has adopted all of the recommended Minimum Program Requirements (MPRs) – the most significant of these for Botswana is the provision of free ART treatment to all people living with HIV (PLHIV), including non-citizens. Among the MPRs that will help revitalize the response to HIV at the ground level are the offer of same-day and fast track ART initiation to all newly diagnosed patients; adoption of differentiated service delivery models, including three months of ART delivery for stable patients; better screening and more effective case identification strategies, including scale-up of self-testing and index testing with active partner notification; the re-introduction of TB Preventive Therapy (TPT) across the country; the transition to TLD and removal of Nevirapine-based drug regimens; and improvement of patient-level data collection and integration of data systems.

In COP20, PEPFAR/B will support the GoB to ensure implementation of the MPRs with fidelity at all districts and sites while building on new data available to adjust approaches and address key barriers. COP20 programming will continue to focus the program on the 71 high volume facilities across 17 districts, several key population hotspots as well as four Wellness Centres. The focus is to maintain the progress made in linkage, retention and adherence for the general population and improve programming to reach key populations with data from the second Botswana Behavioral and Biological Surveillance Survey (BBSS 2017). When the results of the fifth Botswana AIDS Impact Survey (BAIS V) are released, PEPFAR/B will work with the Ministry of Health and Wellness (MoHW) and the National AIDS and Health Promotion Agency (NAHPA) on an appropriate course correction of the national direct support program to achieve policy implementation and ensure quality HIV service delivery to move quickly towards 95-95-95 goals.

PEPFAR/B is committed to supporting the GoB in the implementation of the third National Strategic Framework for HIV (2018-2023). In partnership with the Global Fund, we are focused on capitalizing on the lessons learned from the COP18 reboot and we will intensify our client centered approach around efficient case finding, retention in care and prevention. We are well poised to pivot our program once the BAIS results are known.

Our program supports the integration of facility and community activities around the client and their family so that quality services are provided at all stages of their care. The community is central to the prevention and care and treatment programs and we will scale up our partnerships with Civil Society Organizations so that they are able to monitor the services provided. The model below shows the community-facility integration and features the comprehensive cross-cutting aspects of the program as well as the new aspects of COP20, specifically community monitoring of service delivery, treatment literacy and Continuous Quality Improvement (CQI) across the programmatic spectrum.



PEPFAR/B will continue prevention efforts through the VMMC, OVC, Cervical Cancer and an expanded DREAMS programs. The VMMC program will strive to close the unmet need following the gap analysis conducted in COP18 with the MoHW. The OVC program will increase its focus on the 9-14 year old girls and boys working through schools to provide primary prevention of sexual violence and HIV and other socio-economic interventions. Through DREAMS, PEPFAR/B is offering a package of evidence-based combination prevention interventions that target vulnerable adolescent girls and young women (AGYW), their families, communities and sex partners with the ultimate goal of protecting the AGYW from HIV infection. The program will expand from two districts to eight districts with a high HIV incidence rate among AGYW and are currently not covered by the Global Fund or UNICEF programs. In COP20, PEPFAR/B will continue to build on the existing platform and strategies to increase cervical cancer screening among Women Living with HIV (WLHIV) aged 25-49 on ART, including female sex workers.

COP20 will require a coordinated effort from all stakeholders. Community-based organizations will serve as monitors of program activities; District Health Management Teams (DHMTs) will monitor the implementation of the MPRs across the country; GoB facilities will standardize data reporting across the cascade; Community Health Workers (CHWs) will engage clients at the household level to ensure that all PLHIV are linking to treatment; and the BAIS V investigative teams will gather data to fully understand the current state of the epidemic. This is the year for One Botswana to move closer to achieving the 95-95-95 goals and epidemic control.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Botswana is a sparsely populated land-locked country with a population of approximately 2.36 million (2018 Projection). HIV infection in Botswana, one of the hardest hit countries in the world, is largely concentrated in the urban and peri-urban areas of the country with the highest disease burdens in Greater Gaborone and Greater Francistown. The burden in absolute numbers is highest among older populations (age 25+), and strikingly so among women. Botswana's 2017 GNI per capita, according to the World Bank, was \$6,730. While classified as an upper middle-income country, Botswana's Gini index of 53.3 (World Bank, 2015), reflects one of the starkest income disparities globally.

The most recent Botswana prevalence survey was conducted in 2013. All stakeholders look forward to receiving preliminary results from the Botswana AIDS Impact Survey (BAIS V) during 2020. Until the preliminary results are shared, PEPFAR/B will continue to use program data and UNAIDS Spectrum estimates to guide program decisions. The most recent UNAIDS Spectrum (2019) estimates suggest a lower burden of HIV compared to the previous year, although modifications to the model may account for the apparent differences. The PLHIV estimate is now 360,183 (HIV prevalence of 15%) and incidence rate estimated at 0.31 (6,405 new infections).

The second Botswana Behavioral and Biological Surveillance Survey (BBSS 2017), the first in five years, has provided data related to key populations (KP). Botswana conducted the BBSS among KP in five districts (Chobe, Francistown, Gaborone, Ngamiland South and Palapye). The data analysis shows significant progress in reaching KP, especially female sex workers (FSWs). Among Female Sex Workers, 92.9% had ever been tested for HIV, compared to 88.1% in 2012 BBSS. The results show a decrease in prevalence for FSW from 61.9% to 42.8% (2012, BBSS; 2017 BBSS). Among FSW, 96% had been tested for HIV at some point in the past, and about half were tested in the last year. Access to treatment for those who knew their status improved drastically from 2012 BBSS from 25% to 88% in 2017 BBSS II and 99% report taking their ARVs every day. Knowing one's HIV status was an entry point to treatment. Among FSWs, HIV prevalence steadily increases by age group. Declines between 2012 and 2017 were seen most noticeably in the younger age groups.

In contrast, for men who have sex with men (MSM) the trend was upward, with prevalence increasing from 13.1% in 2012 to 14.8% in 2017. The report is important to understand the epidemic in KP and allows us to further focus our KP activities. The proportion of MSM who have ever tested has increased significantly since 2012 (76% vs. 92%) and this trend is seen across districts. Testing rates are highest in Gaborone and Chobe and similar in Francistown, Palapye and Maun. About 76% tested in the last 12 months compared to 80% in 2012. Most of them tested HIV negative.

Table 2.1.1 and 2.1.2 reflect a national ART coverage estimate of 90%. Women age 25+ have the highest coverage at 96%; the lowest ART coverage is among males younger than 15 and males 15-24 years, 56% and 74%, respectively. Botswana's viral suppression rate overall is high at 85%, however younger people have much lower rates, with those < 15 years old at 38%.

“Based on 2019 Spectrum estimates, approximately 281,241 people were tested, about 11,249 were identified as HIV positive and approximately 10,100 initiated ART. The overall testing yield was 4%, while the overall ART initiation rate was 94%. These data are invaluable for assisting the national and PEPFAR programs in developing population specific programming approaches.

The Botswana PMTCT program continues to achieve high coverage of HIV testing and enrollment of HIV-infected pregnant women on life-long ART. The national HIV testing uptake of 97% and treatment uptake of 96.2% have resulted in a perinatal transmission rate of 0.64% in 2018 (national PMTCT program data). PEPFAR/B's overall FY19 achievement for the percentage of pregnant women with known HIV status at antenatal care was 99.8% (23,545/23,600) and the overall achievement for PMTCT_ART was 99.9% (5215/5220). Despite high coverage of HIV testing and enrolling HIV-infected pregnant women on life-long ART, coverage for early infant diagnosis (EID) at 4-6 weeks remained low at 56% according to 2018 national program data. This trend had never surpassed 50% since the inception of the EID program until FY17 data showed 60% EID coverage at two months and 88% at 12 months. EID continues to be a major area of focus for PEPFAR/B in FY20 and FY21.

Since inception of the national safe male circumcision (SMC) program, 246,360 voluntary medical male circumcision (VMMC) procedures were performed in Botswana, representing approximately 27% coverage in the male populations aged 15 years and older. VMMC will continue to be a major area of focus for PEPFAR/B during COP20 implementation, as the program strives to close the unmet need following the gap analysis conducted with the MoHW in COP18.

Table 2.1.1 Host Country Government Results

| Host Country Government Results | | | | | | | | | | | | | | | |
|---|-----------|------|---------|------|---------|------|---------|------|---------|------|---------|------|---------|------|--------------------------------------|
| | Total | | <15 | | | | 15-24 | | | | 25+ | | | | Source, Year |
| | | | Female | | Male | | Female | | Male | | Female | | Male | | |
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | |
| Total Population | 2,435,498 | 100 | 365,477 | 15.0 | 372,317 | 15.3 | 211,496 | 8.7 | 214,441 | 8.8 | 633,613 | 26.0 | 638,154 | 26.2 | Census 2019 Projections |
| HIV Prevalence (%) | | 14.8 | | 1.4 | | 1.4 | | 7.5 | | 4.4 | | 29.2 | | 21.9 | UNAIDS, 2019 |
| AIDS Deaths (per year) | 4,791 | | 126 | | 130 | | 261 | | 259 | | 2357 | | 1658 | | UNAIDS, 2019 |
| # PLHIV | 360,183 | | 5,036 | | 5,150 | | 15,840 | | 9,534 | | 184,928 | | 139,695 | | UNAIDS, 2019 |
| Incidence Rate (Yr) | | 0.31 | | 0.02 | | 0.02 | | 0.75 | | 0.31 | | 0.44 | | 0.44 | UNAIDS, 2019 |
| New Infections (Yr) | 6,405 | | | | | | | | | | | | | | UNAIDS, 2019 |
| Annual births | 53,201 | 95 | | | | | | | | | | | | | PMTCT, FY2019 |
| % of Pregnant Women with at least one ANC visit | 56,109 | 95 | 2,801 | 5 | | | 24,088 | 43 | | | 29,130 | 56 | | | PMTCT, FY2019 |
| Pregnant women needing ARVs | 12,451 | 22 | | | | | | | | | | | | | PMTCT, FY2019 |
| Orphans (maternal, paternal, double) | 123,459 | | 51,284 | | 52,226 | | 10,044 | | 9,906 | | NA | | NA | | BAIS IV 2013, Census Proj 2019 |
| Notified TB cases (Yr) | 3,650 | | 108 | | 101 | | 271 | | 238 | | 1,192 | | 1,740 | | Global TB report, 2018 |
| % of TB cases that are HIV infected | 1,617 | 59 | 12 | 0.7 | 16 | 1 | 74 | 4.6 | 40 | 2.5 | 672 | 41.6 | 803 | 49.7 | Global TB Report, 2018 |

| | | | | | | | | | | | | | | | |
|---|---|------|---------|------|---------|----|---------|------|---------|----|--|--|--------|----|---|
| % of Males Circumcised | 246,360 | 23 | | | 110,862 | 45 | | | 90,784 | 37 | | | 44,714 | 18 | BAIS IV 2013, Census Proj 2019 |
| Estimated Population Size of MSM* | 15,759 | | | | | | | | | | | | | | Mapping and Size Estimation on Select KP in Botswana (MoHW/ ACHAP 2017) |
| MSM HIV Prevalence | | 14.8 | | | | | | | | | | | | | MoHW Botswana BBSS (2017) |
| Estimated Population Size of FSW | 25,772 | | | | | | | | | | | | | | Mapping and Size Estimation on Select KP in Botswana (MoHW/ ACHAP 2017) |
| FSW HIV Prevalence* | | 42.8 | | 14.7 | | | | 34.8 | | | | | 79.2 | | MoHW Botswana BBSS (2017) |
| Estimated Size of Priority Populations (AGYW) | 658,167 | | 115,168 | | 117,062 | | 211,496 | | 214,441 | | | | | | Census 2019 Proj |
| Estimated Size of Priority Populations Prevalence (specify) | 31,087 | | 2,827 | | 2,886 | | 15,840 | | 9,534 | | | | | | Census 2019 Proj |
| | *Age groups for FSW prevalence is as follows: <20, 20-29, and 40-49 | | | | | | | | | | | | | | |

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*

| 95-95-95 cascade: HIV diagnosis, treatment and viral suppression* | | | | | | | | | | |
|---|------------------------------------|---------------------|---------------------------|---------------------|-------------------------------------|--------------------|-----------------------|---|----------------------------|----------------------|
| Epidemiologic Data | | | | | HIV Treatment and Viral Suppression | | | HIV Testing and Linkage to ART Within the Last Year | | |
| | Total Population Size Estimate (#) | HIV Prevalence (%) | Estimated Total PLHIV (#) | PLHIV diagnosed (#) | On ART (#) | ART Coverage (%) | Viral Suppression (%) | Tested for HIV (#) | Diagnosed HIV Positive (#) | Initiated on ART (#) |
| Total population | 2,435,498 | 14.8 | 360,183 | 335,121 | 323,573 | 90% | 85% | 281,241 | 11,249 | 10,601 |
| Population <15 years | 737,794 | 1.4 | 10,186 | 5,719 | 5,677 | 56% | 38% | 12,111 | 68 | 107 |
| Men 15-24 years | 214,441 | 4.4 | 9,534 | 5,606 | 7,010 | 74% | 72% | 29,895 | 421 | 312 |
| Men 25+ years | 638,154 | 21.9 | 139,695 | 127,584 | 121,397 | 87% | 72% | 94,088 | 4,218 | 3,949 |
| Women 15-24 years | 211,496 | 7.5 | 15,840 | 14,402 | 12,553 | 79% | 95% | 45,430 | 1,366 | 1,235 |
| Women 25+ years | 633,613 | 29.2 | 184,928 | 181,810 | 176,936 | 96% | 95% | 94,780 | 5,102 | 4,564 |
| | | | | | | | | | | |
| MSM | 15,759 ² | 14.80% ¹ | 2,332 ⁴ | 222 ⁴ | 193 ³ | 73.5% ³ | 100% ³ | 1,699 ³ | 131 ³ | 114 ³ |
| FSW | 25,772 ² | 42.80% ¹ | 11,030 ⁴ | 1,985 ³ | 1,517 ³ | 87.6% ³ | 95% ³ | 2,455 ³ | 305 ³ | 318 ³ |
| PWID | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Priority Pop (specify) | | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |

¹ BBSS II 2017

² KP 2017 Size estimation and Census Projections 2019

³ Peer Network Surge and APR 19

⁴ BBSS 2017 and Census Projections 2019

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

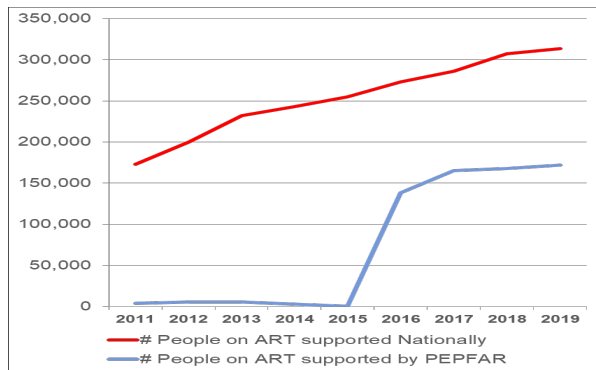


Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV

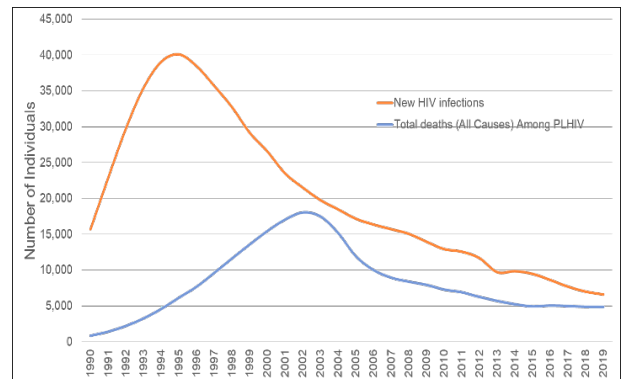


Figure 2.1.5 Progress retaining individuals in lifelong ART in FY19

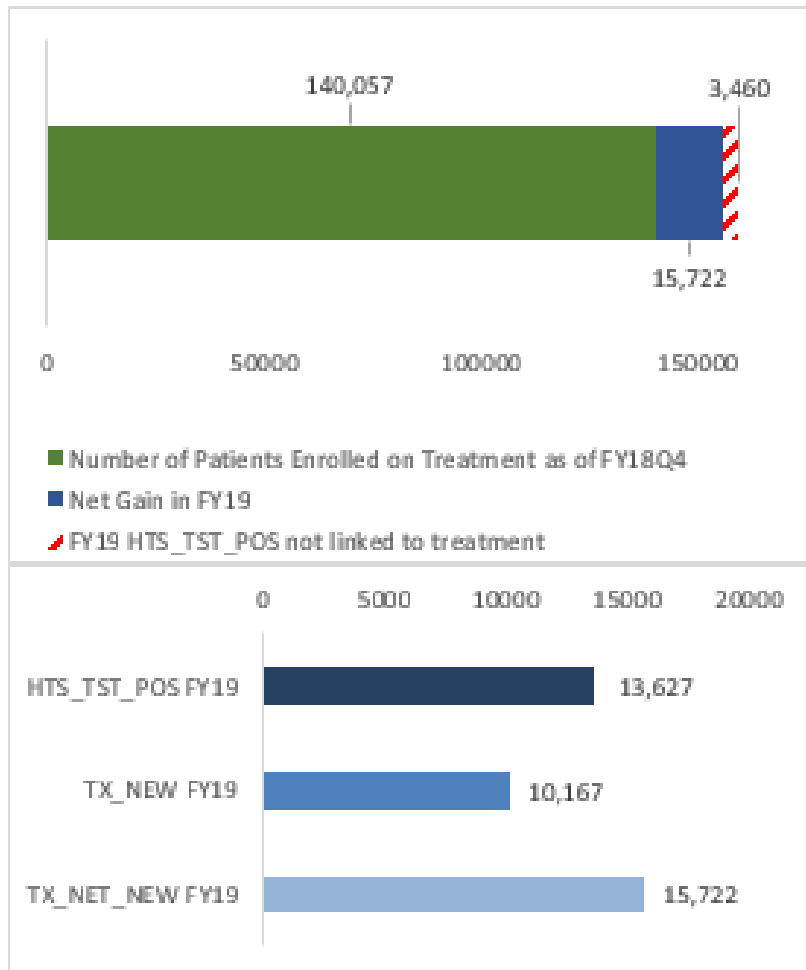


Figure 2.1.7 Epidemiologic Trends and Program Response for Botswana

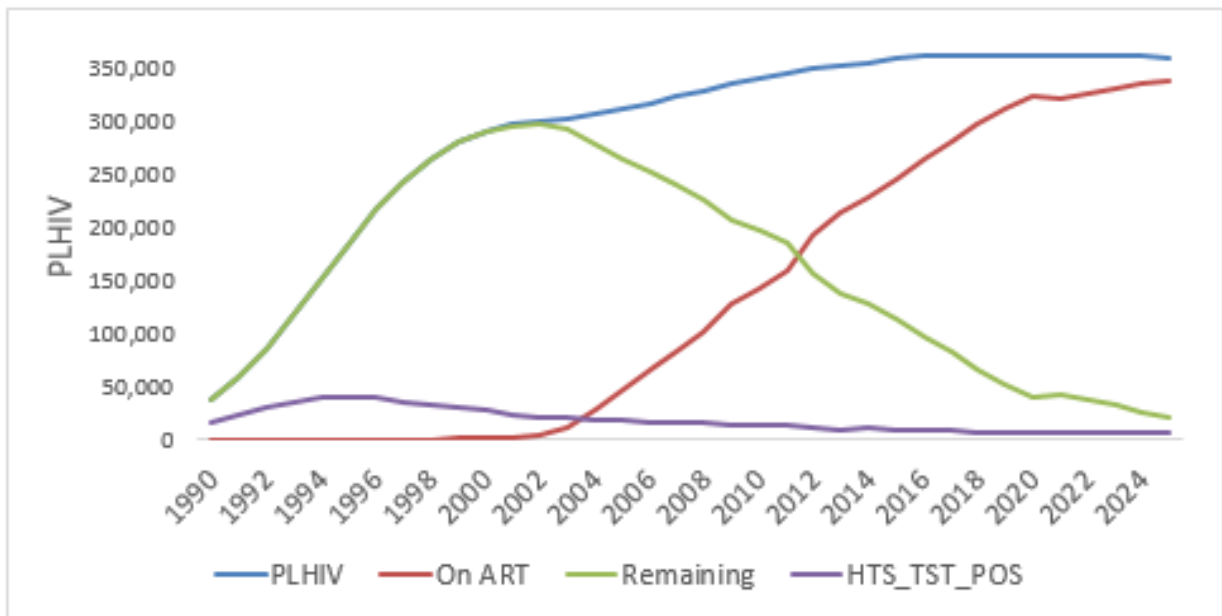
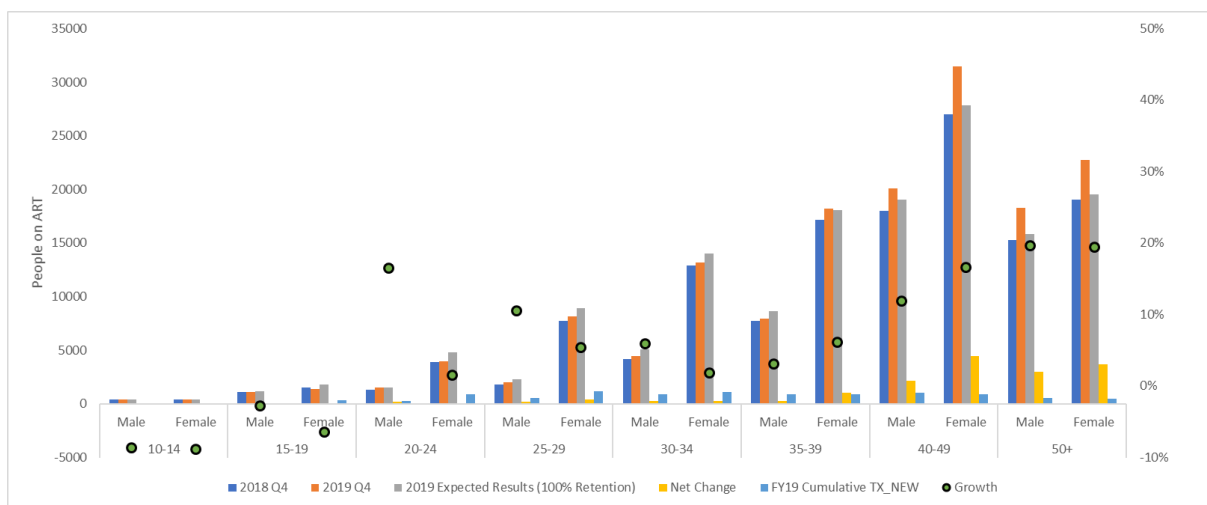


Figure 2.1.8 shows the HIV treatment growth by age/sex in order to pinpoint where there are specific areas of intervention needed to maintain and grow the HIV treatment population.

Figure 2.1.8 Net change in HIV treatment by sex and age bands 2018 Q4 to 2019 Q4



2.2 New Activities and Areas of Focus for COP20

| New | Focus |
|---|--|
| Case finding (General population) | |
| Voluntary Recency testing for newly diagnosed positives to optimize case-based surveillance | Community-Facility Interface for effective APN implementation |
| Index testing among OVC beneficiaries and clients with unsuppressed VL | Offer of voluntary APN for all newly diagnosed HIV positive clients (including elicitation for biological children <19 years) & informed consent for index testing in social networking Case Identification in TB and ANC clinics |
| Case finding (Key population) | |
| Combine index testing with HIV self-testing | Task shifting of new roles to peer navigators |
| Reach transgenders | Expansion of PrEP |
| Through DREAMS, reach HIV+ young girls selling sex | Implement interventions to reduce stigma & violence |
| Linkage & Retention Strategies (General Population) | |
| Promote U=U (Undetectable=Untransmittable) and increase treatment literacy | ART initiation on weekends & extended opening hours |
| | Provide clinical services for non-citizens |
| | Expand treatment literacy |
| | Differentiated service delivery, including Community-initiated ART and community Refill models |
| Linkage & Retention Strategies (Key Population) | |
| Promote U=U and increase treatment literacy for MSM | Clinical services for non-citizens |
| Promote online platforms to identify & link HIV positive MSM | |
| TB/HIV | |
| HIV testing at TB clinic | Expansion of TPT |
| PMTCT | |
| Introduction of PrEP for HIV-negative PBFW | Strengthen re-testing of pregnant & breastfeeding women |
| Introduce POC EID platforms for hard-to-reach areas (based on findings from lab optimization exercise) | |
| Viral load coverage | |
| SMS technology for EID and viral load test appointments, results and to send reminders on clinical activities | Completion of lab optimization and equipment placement rationalization |
| Line list for VL follow up in the community | Support for laboratory commodities management |
| CQI | |

| | |
|---|--|
| Develop the health provider's charter to help advance a culture of CQI in the health system | Review of patient's charter to include client centered approach Timely identification of implementation challenges and introduction of course correction measures to sustain treatment net gains. |
| Supply chain | |
| Rollout of e-LMIS from district warehouses to last mile facilities and data visualization dashboard | Completion of TLD transition & 3-6 months multi-month dispensing (MMD) implementation |
| Develop and operationalize e-procurement platform for contract management | Decentralized drug distribution approaches implemented |
| MSM key activities | |
| Preventive, clinical services and stigma reduction while maintaining their safety, dignity and confidentiality. | Personalized services meeting the needs and situation of each MSM |
| Expand KP competence training and stigma free services at MOHW facilities | Expand access points through a differentiated service delivery model |
| Scale up PrEP for case-finding and combine index testing with HIV self-testing | Integrate prevention with clinical ensuring that linkage to treatment is provided at all Drop-in-centers. |
| Introduce a total market approach (TMA) that all three sectors — public, social marketing, and commercial — can deliver health choices for MSM. This will work for condoms, HIVST, PrEP and ART. | Partner with private practitioners for MSM who have insurance schemes or those that can afford to pay for services. |
| Community-Led Monitoring | |
| Treatment and viral load literacy | Quality of Service delivery |
| Use client feedback to inform the design and implementation of DSD services | |

2.2.1 Task Shifting for Key Populations Peer navigators

At the community level there are three cadres that provide services to key population, Peer Outreach Workers (POW), Peer Navigators (PN) and Case Managers. The POW are at community level mobilizing KP, the Case Manager links KP to service points and ensures that they receive the service. The Peer Navigators are the link between the POW and CM.

Table 2.2.1 Monitoring the Expanded Role of the Peer Navigators in KP program

| | Link KPLIV to treatment (SDART) | Support retention | | | Support viral load suppression |
|---------------------|---|--|---|---|--|
| | | Improve adherence | Improve attendance at clinic appointments | Trace LTFU | |
| PN Responsibilities | Accompany KPHIV to treatment following HIV positive diagnosis | <ul style="list-style-type: none"> Assist with adherence techniques Refer KPLIV with side effects to clinic provider Generate demand for MMD and TLD Counsel on medication adherence Serve as role models Facilitate support group participation | <ul style="list-style-type: none"> Appointment reminders Facilitate communication with clinic providers Help KPHIV interpret lab results | <ul style="list-style-type: none"> Communicate regularly with clinic providers on missed appointments and trace defaulters Determine reasons for LTFU | <ul style="list-style-type: none"> Generate demand for VL testing Support attendance for regular VL testing Communicate with health providers to ensure results reported back to KPHIV Help KPHIV interpret VL testing results |
| MER Indicators | TX_NEW | TX_ML TX_CURR TLD MMD | TX_ML TX_CURR | TX_ML TX_NET_NEW | TX_PVLS |
| Custom Indicators | TX_LINK_NEW TX_LINK_RETURN | COMM_SUPP_RET | COMM_SUPP_RET | TX_LINK_RETURN | VL_ELIGIBLE |

2.3 Investment Profile

A major constraint of the Botswana public health system is efficiency and effectiveness of spending, not the availability of funding. Botswana's fiscal space is relatively unconstrained in absolute terms, in the short-term, due to high fiscal revenues from diamond exports and a history of prudent public financial management. Revenues are predicted to fall in 2020 due to the impact of COVID-19 travel restrictions on Botswana's two major revenue sources, tourism and the diamond sector.

Economic growth is still somewhat volatile and is subject to the performance of the diamond sector, which is in long-term decline. During the presentation of the GoB's budget to Parliament in February 2020, the GoB projected revenues in 2020 of \$5.78 bill or which 32% comes from the diamond industry. The average real GDP growth rates in the first 25 years after independence were consistently in double figures, as diamond mining expanded. But over the past 25 years, real GDP growth rates have been modest, averaging 4% a year, which has been inadequate to create enough jobs for the growing labor force¹. Botswana therefore faces major long-term challenges of generating new sources of export-led growth, to supplement and eventually replace diamonds, beyond customs revenues and tourism receipts.

Botswana consistently conducted National AIDS Spending Assessments (NASA) every three years, from 2003-2012, to track and report on HIV/AIDS spending. However, Botswana's last NASA was done in 2012 and National Health Accounts in 2013/14. In NASA reports for the years 2006-2012, an estimated 66% of the national response was financed by the GoB, 32% by international partners and 2% by domestic private sources. Botswana MoHW completed data collection for 2014/2015, 2015/16, 2016/2017 and 2017/18 National Health Accounts in 2019. Data cleaning and analysis is ongoing; a final report is expected before the end of 2020. However, the National Health Accounts process does not adequately capture the amounts spent on different program areas of HIV treatment and prevention making it difficult to direct resources appropriately in the National HIV and AIDS Response and to sustain domestic funding for HIV treatment and prevention. It has therefore become important to conduct a National AIDS Spending Assessment (NASA) covering recent financial years to be able to plan for HIV programming in the coming years.

The GoB, the World Bank and UNAIDS jointly commissioned the HIV/AIDS Investment Analysis for a rapid tracking and analysis of HIV/AIDS investment in Botswana from 2012/13 to 2017/18. The investment tracking and analysis focused on three main sources of HIV/AIDS financing in Botswana: Government of Botswana, PEPFAR and The Global Fund. In USD terms, an estimated \$964 million was spent on HIV/AIDS over the six year period from 2012 to 2018. Annual spending data however shows increased funding in 2013/14 (\$168 million) and 2017/18 (\$168 million); see Figure 2.3.1.

¹ Government of Botswana (ISBN:978-99968-465-2-6): Botswana Development Plan II, Volume 1; April 2017 – March 2023; Page 29-30)

Figure 2.3.1 Botswana Annual HIV/AIDS Spending in USD 2012/13-2017/18

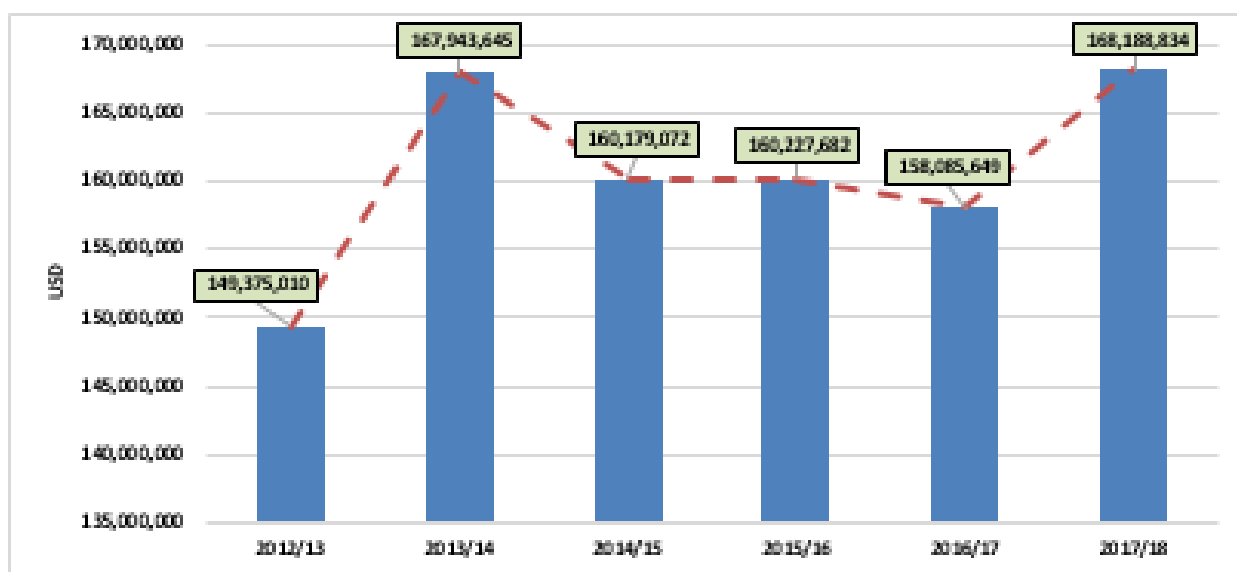


Table 2.3.1 Spending by Financing Sources (USD)

| Program Area | Total Expenditure (USD) | GoB (%) | PEPFAR (%) | GF (%) | Merck Company Foundation (%) |
|--|-------------------------|-------------|-------------|------------|------------------------------|
| Treatment, care and support | 497,037,589 | 62.7 | 32.8 | 0.2 | 4.3 |
| Prevention of vertical transmission of HIV | 33,246,788 | 71.3 | 28.7 | - | - |
| Prevention | 100,572,781 | 31.7 | 57.1 | 6.3 | 4.9 |
| Gender programs | 776,823 | 100.0 | - | - | - |
| Programs for children and adolescents | 2,249,987 | 14.4 | - | 85.6 | - |
| Social protection | 220,478,305 | 89.4 | 10.6 | - | 0.0 |
| Community mobilization | 974,718 | 100.0 | - | - | - |
| Governance and sustainability | 91,42,450 | 40.8 | 46.2 | 5.0 | 8.1 |
| Critical enablers (sub-total) | 1,295,737 | 5.2 | - | 94.8 | - |
| TB / HIV co-infection, diagnosis and treatment | 318,397 | - | - | 100.0 | - |
| Other essential programs outside the suggested framework of core HIV & AIDS programs | 5,906,411 | 100.0 | - | - | - |
| Total | 963,999,986 | 63.5 | 31.3 | 1.6 | 3.5 |

Table 2.3.1 shows the spending on HIV/AIDS by financing sources from 2012/13 to 2017/18. Botswana's spending on HIV/AIDS has remained constant over the 6-year period of 2012/13 to 2017/18. Over the six-year period, the government of Botswana contributed 64%, PEPFAR 31%, Merck Company Foundation 3% and The Global Fund 2% of all spending on HIV/AIDS. The Merck Company Foundation ceased its funding of the national response during the 2015/16 financial year with The Global Fund resuming its funding of the national response in the following four years of 2016/17, after years of absence. From 2012/13 to 2017/18, \$428,595,860 (52%) was spent on treatment, care and support, \$190,107,470 (23%) was spent on social protection, \$95,376,890 (11%) was spent on prevention, excluding PMTCT which consumed 3% of financial resources, and \$78,572,830 (9%) was spent on governance and sustainability. The rest of the remaining programs make up 1% of the overall budget.

Spending by GoB and PEPFAR has remained consistent over the six-year period, in line with the overall spending on HIV/AIDS. GoB spending peaked at about \$111 million in 2015/16. This was due to increased procurement of ART related pharmaceutical products in preparation for the launch of the Treat All program, which commenced in June 2016. The consistent year on year spending by PEPFAR, which averages about \$50.4 million (P470 million) per year, masks the fact that funding allocations to Botswana were decreasing over this period from \$54 million in 2012/13 to \$48 million in 2015/16. The consistency of the spending is due to prior periods of COP allocations being carried over from year to year. There seems to be an inverse relationship between spending by GoB and PEPFAR (See figure 2.3.2). GoB spending increases in the years of decreasing PEPFAR spending and decreases when PEPFAR spending increases.

Figure 2.3.2 Inverse relationship between GoB and PEPFAR funding

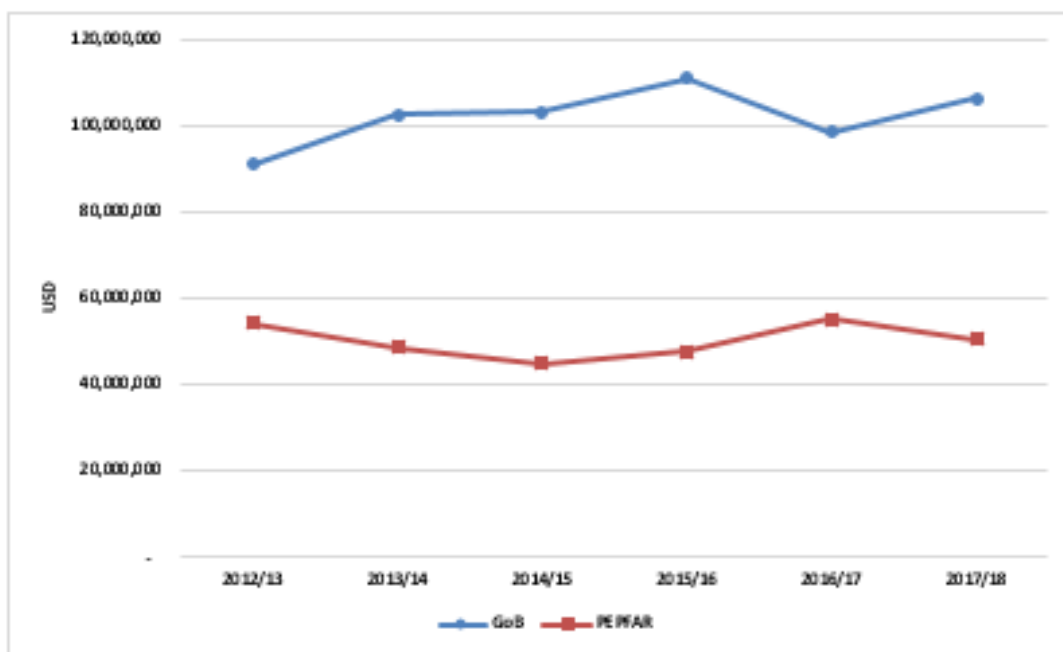


Table 2.3.2 shows analyses of total HIV/AIDS expenditure in Botswana for 2012/13 to 2017/18 using the program areas or spending categories of the Global AIDS Monitoring (GAM) matrix.

Figure 2.3.3 shows HIV/AIDS spending by program area source (2012/13 – 2017/18). Prevention spending seems to be decreasing over the years. With increased new infections, opportunities must be sought to fund more evidence-based and context relevant prevention interventions. PEPFAR was responsible for majority of the funding for prevention, governance and sustainability, while the GoB was major source of funding for the remaining interventions. Of note is that the data show that GoB has funded 100% of Gender programs and Community mobilization. PEPFAR has expended a considerable amount of funding in these two areas, however the data analyzed do not show this. This is an area to investigate further in future analysis of HIV financing.

Table 2.3.2 Analyses of total HIV/AIDS expenditure by program area for 2012/13-2017/18

| Program Area | Total Expenditure (USD) | CoB (%) | PEPFAR (%) | GF (%) | Merck Company Foundation (%) |
|--|-------------------------|-------------|-------------|------------|------------------------------|
| Treatment, care and support | 497,037,589 | 62.7 | 32.8 | 0.2 | 4.3 |
| Prevention of vertical transmission of HIV | 33,246,788 | 71.3 | 28.7 | - | - |
| Prevention | 110,572,781 | 34.7 | 57.1 | 6.3 | 4.9 |
| Gender programs | 776,823 | 100.0 | - | - | - |
| Programs for children and adolescents | 2,249,987 | 14.4 | - | 85.6 | - |
| Social protection | 220,478,305 | 89.4 | 10.6 | - | 0.0 |
| Community mobilization | 974,718 | 100.0 | - | - | - |
| Governance and sustainability | 91,142,450 | 40.8 | 46.2 | 5.0 | 8.1 |
| Critical enablers (sub-total) | 4,295,737 | 5.2 | - | 94.8 | - |
| TB / HIV co-infection, diagnosis and treatment | 318,397 | - | - | 100.0 | - |
| Other essential programs outside the suggested framework of core HIV & AIDS programs | 5,906,411 | 100.0 | - | - | - |
| Total | 963,999,986 | 63.5 | 31.3 | 1.6 | 3.5 |

Figure 2.3.3 HIV/AIDS Spending by program area source 2012/13 – 2017/18

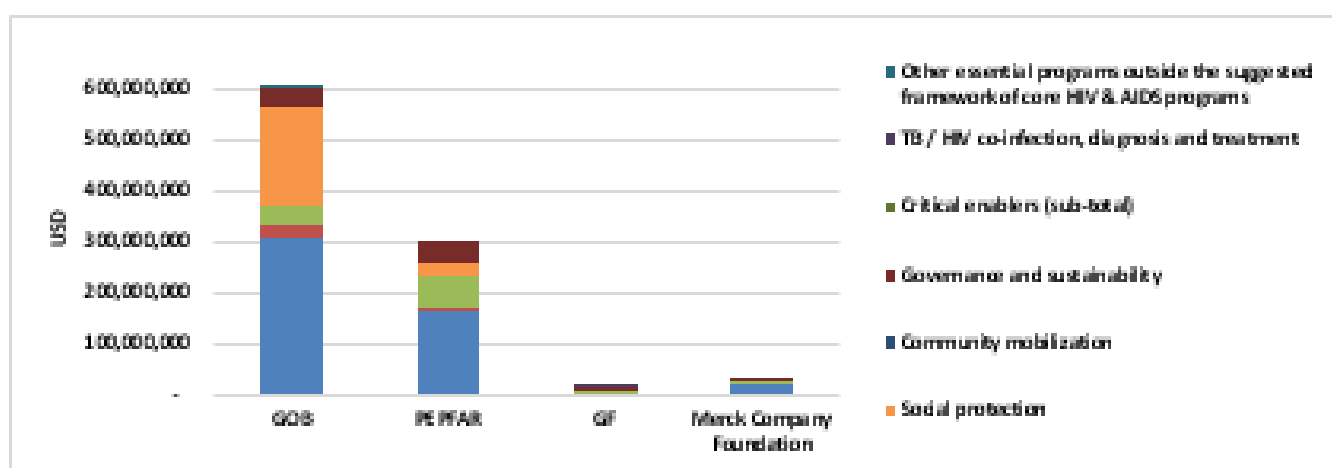


Table 2.3.3 Annual Procurement Profile for Key Commodities

| Commodity Category | Total Expenditure (USD) | % PEPFAR | % GF | % Host Country | % Other |
|------------------------|-------------------------|----------|-------|----------------|---------|
| ARVs | 32,506,127 | | 0.020 | | 99.98 |
| Rapid test kits | 519,318 | | | 100 | |
| Other drugs | 44,138,226 | | | 100 | |
| Lab reagents | 20,444,164 | | | 100 | |
| Condoms | 465,500 | | | 100 | |
| Viral Load commodities | 6,564,204 | | | 100 | |
| VMMC kits | 370,700 | | | 100 | |
| MAT | 0 | | | 0 | |
| Other commodities | 7,289,312 | | | 100 | |
| Total | 111,647,550 | | | 100 | |

There were no procurements of key commodities by PEPFAR and other donors for the reporting period (April 2019 -March 2020). GoB procured all HIV related commodities during the reporting period.

Table 2.3.4 Annual USG Non-PEPFAR Funded Investments and Integration

| Funding Source | Total USG Non-PEPFAR Resources | Non-PEPFAR Resources Co-Funding PEPFAR IMs | # Co-Funded IMs | PEPFAR COP Co-Funding Contribution | Objectives |
|----------------|--------------------------------|--|-----------------|------------------------------------|--|
| Peace Corps | 1,982,200 | - | - | - | Appropriated funds that support allowances, transportation, medical, and training for Peace Corps Volunteers |
| Total | 1,982,200 | - | - | - | |

2.4 National Sustainability Profile Update

The Sustainability Index Dashboard (SID) is a tool completed every two years by PEPFAR/Botswana and local stakeholders to sharpen the understanding of the sustainability landscape of the country's national HIV/AIDS response and to assist all key stakeholders, and particularly the GoB, PEPFAR, and the Global Fund to make informed investment decisions. A transparent, participatory, collaborative and consultative process is used to assess the current state of sustainability of Botswana's national response across 17 critical elements distributed across four domains. Stakeholders are required to respond to 110 questions across the domains and elements.

Botswana completed the fourth iteration of the SID in September 2019 at a multi-stakeholder consultative workshop co-convened by PEPFAR and UNAIDS. Participants included representatives from several host government ministries and departments, multilateral organizations, local NGOs and CSOs, USG IPs and academia. Table 2.4.1 below shows the results from the current and previous SID exercises.

Table 2.4.1 Botswana SID Dashboard – Domains and Elements (2015-2019)

| | 2015 (SID 2.0) | 2017 (SID 3.0) | 2019 (SID 4.0) |
|--|----------------|----------------|----------------|
| Governance, Leadership, and Accountability | | | |
| 1. Planning and Coordination | 7.70 | 7.50 | 8.29 |
| 2. Policies and Governance | 6.58 | 7.06 | 8.40 |
| 3. Civil Society Engagement | 5.60 | 6.88 | 5.50 |
| 4. Private Sector Engagement | 3.08 | 5.78 | 6.90 |
| 5. Public Access to Information | 8.00 | 6.00 | 7.00 |
| National Health System and Service Delivery | | | |
| 6. Service Delivery | 6.11 | 6.90 | 6.69 |
| 7. Human Resources for Health | 6.33 | 6.23 | 7.50 |
| 8. Commodity Security and Supply Chain | 6.27 | 6.79 | 6.58 |
| 9. Quality Management | 4.76 | 6.14 | 5.48 |
| 10. Laboratory | 5.69 | 5.58 | 6.58 |
| Strategic Financing and Market Openness | | | |
| 11. Domestic Resource Mobilization | 5.56 | 7.10 | 8.13 |
| 12. Technical and Allocative Efficiencies | 5.75 | 6.89 | 5.33 |
| 13. Market Openness | N/A | N/A | 7.59 |
| Strategic Information | | | |
| 14. Epidemiological and Health Data | 5.48 | 4.76 | 5.86 |
| 15. Financial/Expenditure Data | 8.33 | 5.83 | 5.83 |
| 16. Performance Data | 5.77 | 6.66 | 7.67 |
| 17. Data for Decision-Making Ecosystem | N/A | N/A | 7.50 |

From the previous two SIDs (2015 and 2017), Botswana has shown an overall improvement. In the 2019 SID 4.0 assessment, 53% (9) of the elements scored yellow and 47% (8) scored light green. There were no elements that scored red. The most positive trends are seen with Policies and Governance, Planning and Coordination and Domestic Resource Mobilization. Although Public Access to Information decreased from 2015, it did increase from the last SID and is still approaching sustainability.

Sustainability strengths:

Several sustainability strengths were identified by stakeholders; three of them are presented below:

- i. **Policy and Governance:** Botswana has laws and policies in place that follow the most recent WHO guidelines for initiation of ART and protect key populations against discrimination. Furthermore, there are no user fees for HIV and other health services that can create a barrier to accessing health care generally and HIV care specifically. Botswana has recently adopted very progressive policies to accelerate its path to epidemic control. For example, the 14 minimum program requirements (MPRs) adopted in 2019 include commitments to provide free ART to non-citizens and to strengthen the health sector's Health Management Information Systems (HMIS) – both identified as

vulnerabilities in the 2017 SID. The MPRs also include plans for same-day initiation of ART and multi-month dispensing of ART for stable HIV-infected patients.

- ii. **Planning and Coordination:** The MoHW and NAHPA provide strong leadership in planning and coordinating the national HIV response. A costed National Strategic Framework (NSF) is developed, implemented and supervised every five years with midterm reviews. The third iteration of the document (NSF III – 2019/2023) has been approved and launched. The development of the NSF III as well as its implementation is generally well-coordinated across all sectors and levels of government as well as between government, multilateral and donor agencies, and local civil society organizations.
- iii. **Domestic Resource Mobilization:** GoB funds more than 60% of the cost of the national HIV response, PEPFAR covers approximately 30% and the Global Fund covers the remainder. Recent commitments to providing free ART to non-citizens and improving the country's HMIS will require additional resource commitments down the road unless the country improves its procurement processes and other technical and allocative efficiencies. For example, a recent efficiency analysis (Musau et al. 2018²) has demonstrated that Botswana could save more than US\$ 14 million in three years by using a pooled procurement mechanism to purchase ARVs. The government is working with donors and multilaterals on several initiatives to further strengthen the financial sustainability of the HIV response.

Sustainability vulnerabilities:

The 2019 SID analysis revealed vulnerabilities in five sustainability elements: civil society engagement, quality management, technical and allocative efficiencies, epidemiological and health data, and financial/expenditure data. As a result, in COP20, the OU will seek to strengthen the sustainability of the national HIV response with funding and technical assistance through the following programmatic objectives.

- i. **Improve the linkages between facility and community based HIV services to ensure high quality client-centered services:** this objective will be supported through targeted investments in the MPRs seeking to improve immediate and direct linkage to treatment and retention across the cascade, clients' treatment and viral load literacy as well as through the coordination of PEPFAR partners to improve linkage to treatment, active partner notification and differentiated service delivery models.
- ii. **Further strengthen the laboratory capacity to meet the service needs of current and future PLHIV:** This objective will be supported specifically through

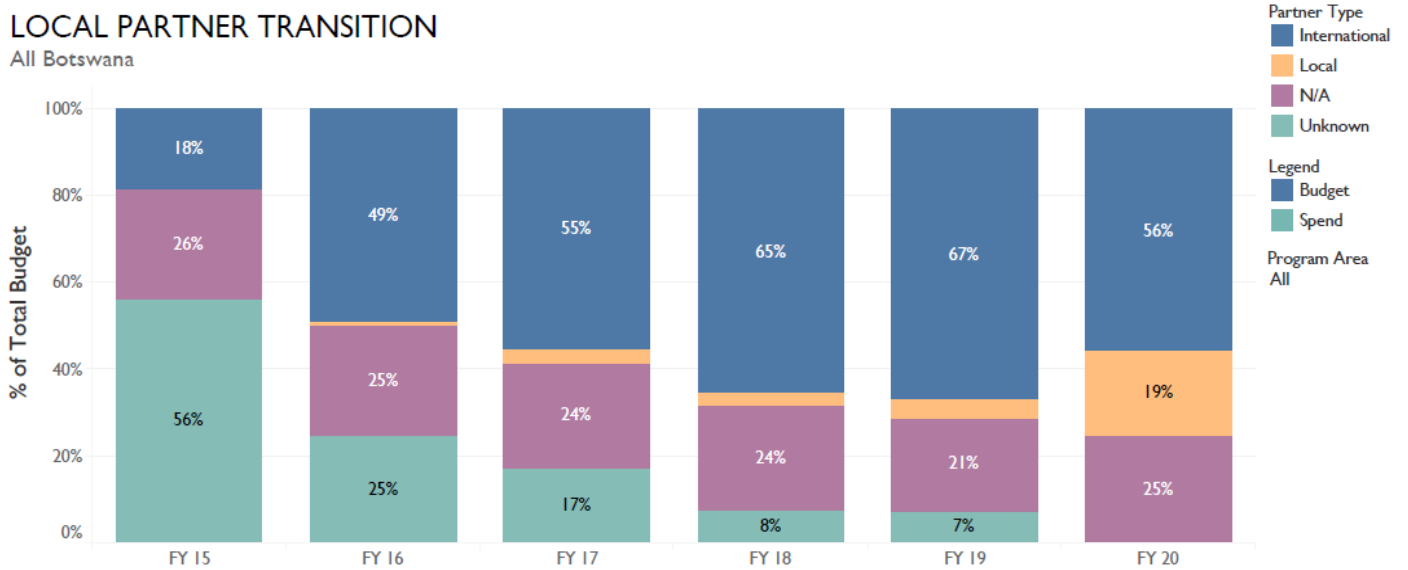
² Musau, Stephen, Qinani Dube, Heather Cogswell, Batsile Peloewetse, Marjan Inak, and Claire Jones. September 2018. Opportunities to improve the efficiency of HIV/ AIDS services in Botswana. Rockville, MD: Health Finance and Governance Project, Abt Associates Inc.

the planned Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections as well activities addressing CQI across the cascade.

- iii. **Continue to fine-tune the timely supply, distribution, and quality of key commodities:** Specific investments will be made in COP20 to address gaps in the supply chain in collaboration with the Global Fund. Key among them are activities supporting ART optimization to scale up the implementation of the 3-6 month ART dispensing, the rollout of an e-LMIS from district warehouses to the last mile facility, and the creation and use of an e-procurement platform to improve contract management within the central medical store.
- iv. **Improve the technical and allocative efficiencies in the national response, which is dependent on a stronger capacity for gathering and analyzing epidemiological, health, financial, and expenditure data for decision-making:** Botswana's NSF III mandates the institutionalization of resource tracking and efficiency analyses to advance Botswana's ownership of the national HIV response and strengthen the country's leadership of the program. In support of this effort, the PEPFAR/B will commit additional resources to strengthen the health sector's Health Management Information Systems (HMIS), provide technical assistance to GoB and advocate for additional resources for a future NASA in COP20.

The 2019 PEPFAR/B Expenditure Report (ER) in Figure 2.4.1, shows that the portion of the PEPFAR program managed by local partners increased from 5% in FY19 to 19% in FY20. While the international partner proportion reduced from 67% to 56%. The increase in local partner expenditure was because of increased prime funding of local partners by CDC (11% to 35%) and USAID (0% to 3%). In COP20, planned changes to funding arrangements across agencies will see the country approach the target of 70% prime funding allocation to local partners by the end of the COP20 implementation period.

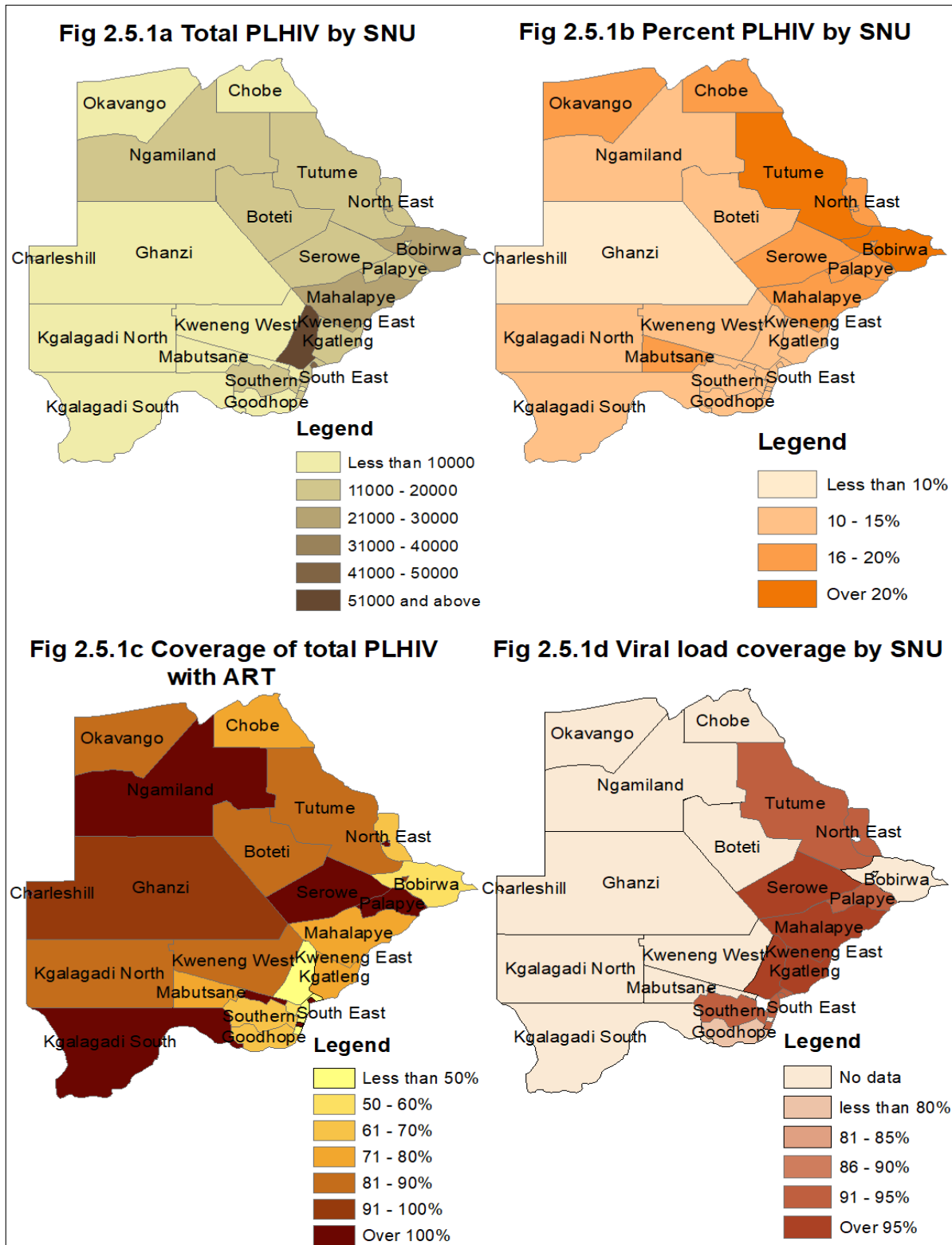
Figure 2.4.1: ER Integrated Analytics Dashboard (Local Partner Transition)



In COP20, CDC/Botswana anticipates meeting the 70% OGAC requirement of prime funding to local partners. However, with three of five cooperative agreements being TBDs (partners yet to be identified), an exact calculation is not possible at this time. The awardees will have to be selected before the actual percentage of prime funding to local partners can be determined. The remaining two known implementing partners in COP20 are the GoB and the African Comprehensive HIV/AIDS Partnerships (ACHAP) and make up about 1/3 of the total CDC program funding.

In COP20, USAID/Botswana will have five local prime partners that will receive approximately 30% of USAID/Botswana total program funds. USAID/Botswana had expected to reach more than the 70% target for local partners in COP20 but decided to continue with EpiC/FHI360 in COP19 to get the KP program through a scale-up phase; COP21 will begin a maintenance phase, which will be managed by a local partner. In addition, USAID/Botswana overall program budget increased by about 45% between COP19 and COP20 because of the increase in DREAMS funding. Two local prime partners will receive significant funding, increasing their funding from \$400,000 total in COP19 to \$4.2 million in COP20. However, most of the DREAMS/OVC funds will be programmed through PCI, an international prime partner in COP20 to ensure the integrity of the program. USAID/Botswana expects to increase local prime partner funding to reach 60-70% in COP21.

2.5 Alignment of PEPFAR investments geographically to disease burden



2.6 Stakeholder Engagement

PEPFAR/B has continuously improved its stakeholder engagement process through investments in existing and new communications, coordination, and collaborative platforms over the past year. Throughout the past year, PEPFAR/B has focused its stakeholder engagement on strengthening national and district-level coordination around awareness, ownership, and implementation of the Minimum Program Requirements. PEPFAR/B built on the success of the Treat All communications campaign by designing new, targeted communications activities, including radio and social media programming, addressing specific gaps in knowledge and attitudes that stakeholders identified through our engagement process and human-centered design workshops.

Another new platform for stakeholder engagement was created through the Faith and Community Initiative (FCI) and has since brought in key voices from several FBOs and CSOs which are giving valuable feedback on current implementation and have increased faith leaders' participation in the COP20 process (including new representation at the Johannesburg meeting). The FCI was launched by the Vice President and the US Ambassador and was front page news.

PEPFAR/B also intensified our collaboration with GoB and multilateral organizations in shared platforms for stakeholder engagement, most notably during the First Lady Neo Masisi's series of community dialogues with groups of youth and men in different parts of Botswana.

Our COP20 stakeholder engagement process began with circulating the draft and final COP20 guidance for comments from more than 140 partner and stakeholder organizations (see Appendix E Stakeholder and Partner List). This was followed by two rounds of stakeholder meetings in January through which we engaged with more than 100 representatives from GoB, implementing partners, donors/multilaterals, civil society, and the private sector. In early February, three special consultative meetings were held, first with strategic information experts to review the Data Pack and the COP20 target setting process and find consensus on key assumptions, and secondly at a breakfast dialogue with the Minister of Health Lemogang Kwapo and eight of Botswana's HIV Response Legends, recognized by PEPFAR/B in a 2020 calendar (seated next to First Lady Neo Masisi in picture below). During the dialogue, PEPFAR/B's leadership and partners gleaned their insights on finding undiagnosed men through traditional leaders and cultural resources, and strategies to increase treatment initiation and viral suppression in young people living with HIV.

The third consultation was held with 40 key CSOs to conduct a joint planning session devoted to the community-led monitoring initiative, building on an initial discussion and planning session held during the first meeting in January. Following a review of the core elements and



our January meeting’s priority ranking of key elements to include in the monitoring scheme, the CSO representatives worked in small groups to create and present draft monitoring plans, including existing CSO/NGO resources and strategies that could be adapted. These plans were further reviewed and consolidated into a refined plan that was presented at the Johannesburg meeting.



Embassy Gaborone Photo: Breakfast dialogue with Ambassador Craig Cloud (standing center), First Lady Neo Masisi (seated center), Health Minister Lemogang Kwape (standing center left), and eight of the Botswana HIV Response Legends (seated).

3.0 Geographic and Population Prioritization

3.1 General Population

Pending results from BAIS V, PEPFAR/B will continue to implement in the current COP19 facilities and surrounding communities. The 71 sites were selected for COP19 implementation based on their high volume of patients receiving ART treatment and the four TWC were selected to offer DSD based on accreditation status as shown in Table 3.1. The map in Figure 3.2 shows HIV services for the general population.

Figure 3.1 Map showing the Community-Facility activities, KP program and locations of 75 sites.

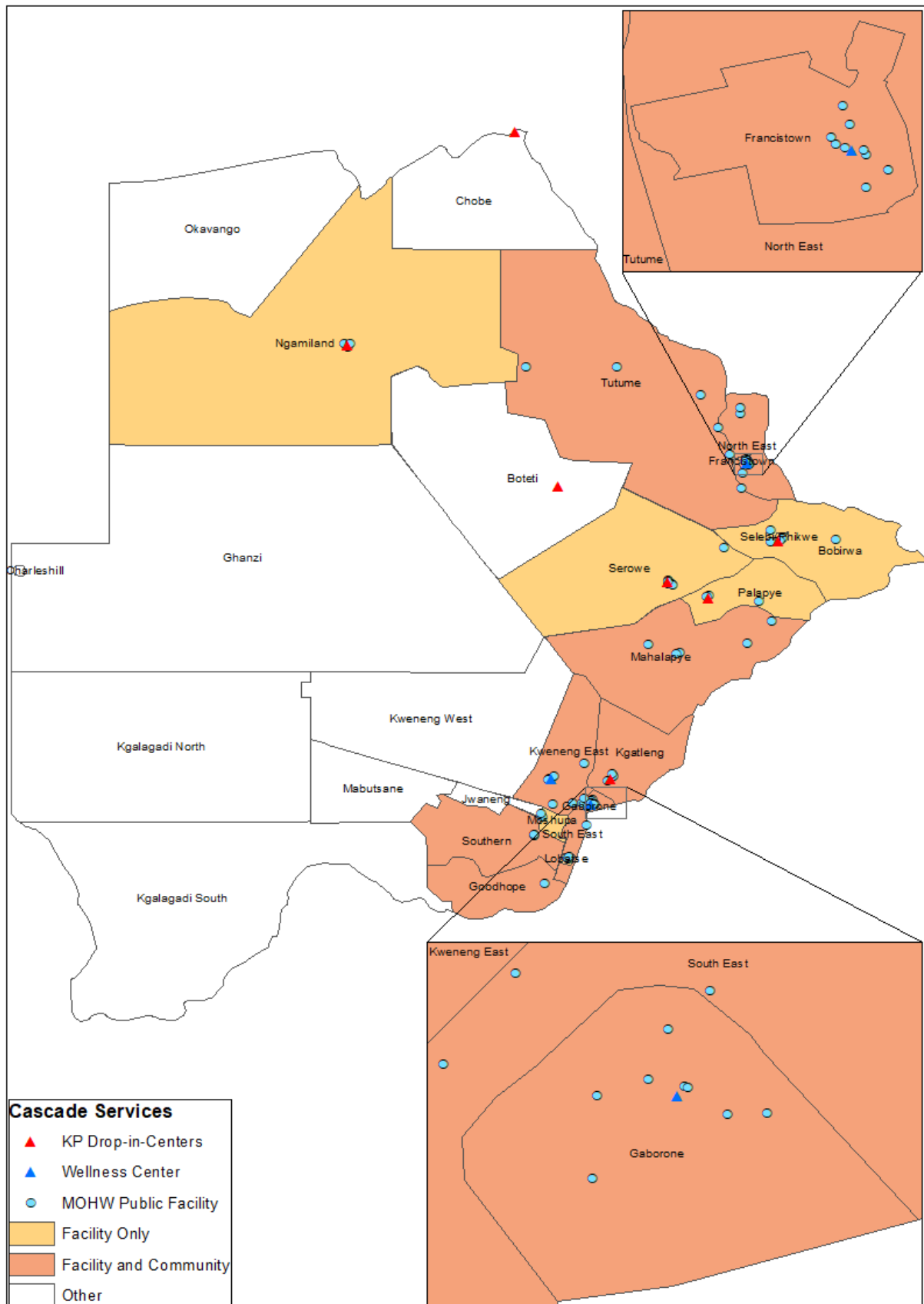


Table 3.1 Current Status of ART saturation

| Prioritization Area | Total PLHIV/% of all PLHIV for COP20 | # Current on ART (FY19) | # of SNU COP19 (FY20) | # of SNU COP20 (FY21) |
|------------------------|--------------------------------------|-------------------------|-----------------------|-----------------------|
| Sustained | 308,298 (86%) | 155,544 | 17 | 17 |
| Central Support | 51,885 (14%) | 235 | 10 | 10 |

3.2 OVC and AGYW

In COP20, the OVC program will pivot to increase reach of the following OVC sub-populations: i) children and adolescent living with HIV (C/ALHIV), ii) children of HIV positive mothers/caregivers, iii) children of female sex workers, iv) HIV Exposed Infants (HEI) and iv) survivors of sexual violence while also continuing to focus on orphans. All these sub-populations will be enrolled in the comprehensive program where each beneficiary or family will have a case plan and be case managed and monitored against graduation benchmarks. The program will continue to increase reach for 9-14-year-old boys and girls through the preventive program, reaching this population group with primary prevention of violence and HIV, using an evidence-based curriculum and working through the school platform. Learning from the current implementation of DREAMS in the 2 SNUs, the OVC program will continue assessing AGYW 10-17 years old for DREAMS eligibility and linking those eligible to DREAMS mentors for enrolment into DREAMS as appropriate. These lessons will be used to implement DREAMS in the new 6 SNUs.

3.3 Key Populations

The key population program will target female sex workers (FSW), men who have sex with men (MSM), and transgender (TG) individuals with prevention, care and treatment interventions. The program will also focus on other high-risk groups associated with KPs, such as sexual partners, clients, and/or children of and/or living with sex workers, among others.

PEPFAR/B, Global Fund and Government of Botswana are the key players in HIV prevention, treatment and care for key populations. The Government through the MoHW provides commodities that include ARV's, test kits and lab reagents. In public health facilities, MoHW offers ART initiation as well as STI treatment for key populations. The Global Fund mainly provides prevention services and refers KP to either government or PEPFAR-supported sites for clinical services. PEPFAR and Global Fund only cover 40% of FSW with comprehensive services leaving a service gap of 60%. Out of the estimated 18,000 FSW nationally in 2019, PEPFAR reached 28.5% (5145/18,000) and Global fund reached 11.5% (2067/18,000) leaving a gap of 60% 7,221/18,000. Both organizations only cover 42% of MSM leaving a service gap of 58%. From an estimated 10,000 MSM in 2019, PEPFAR reached 24.3% (2431/10,000) and Global fund reached 17.4% (1736/10,000) leaving a gap of 58.3% 5,831/10,000. (calculation based on Botswana Mapping and Size Estimation of 2017 by ACHAP-Global fund and BBSS II 2017).

Key populations, especially MSM and transgender, still face high level of stigma at MOHW facilities where providers have not been trained. A 2014 study by the Botswana Network of People Living with HIV and their partners explained the impact of stigma to this group. They avoided either being tested or seeking health care services. The study stated that 21% experienced verbal insults and 10% had experienced physical harassment.

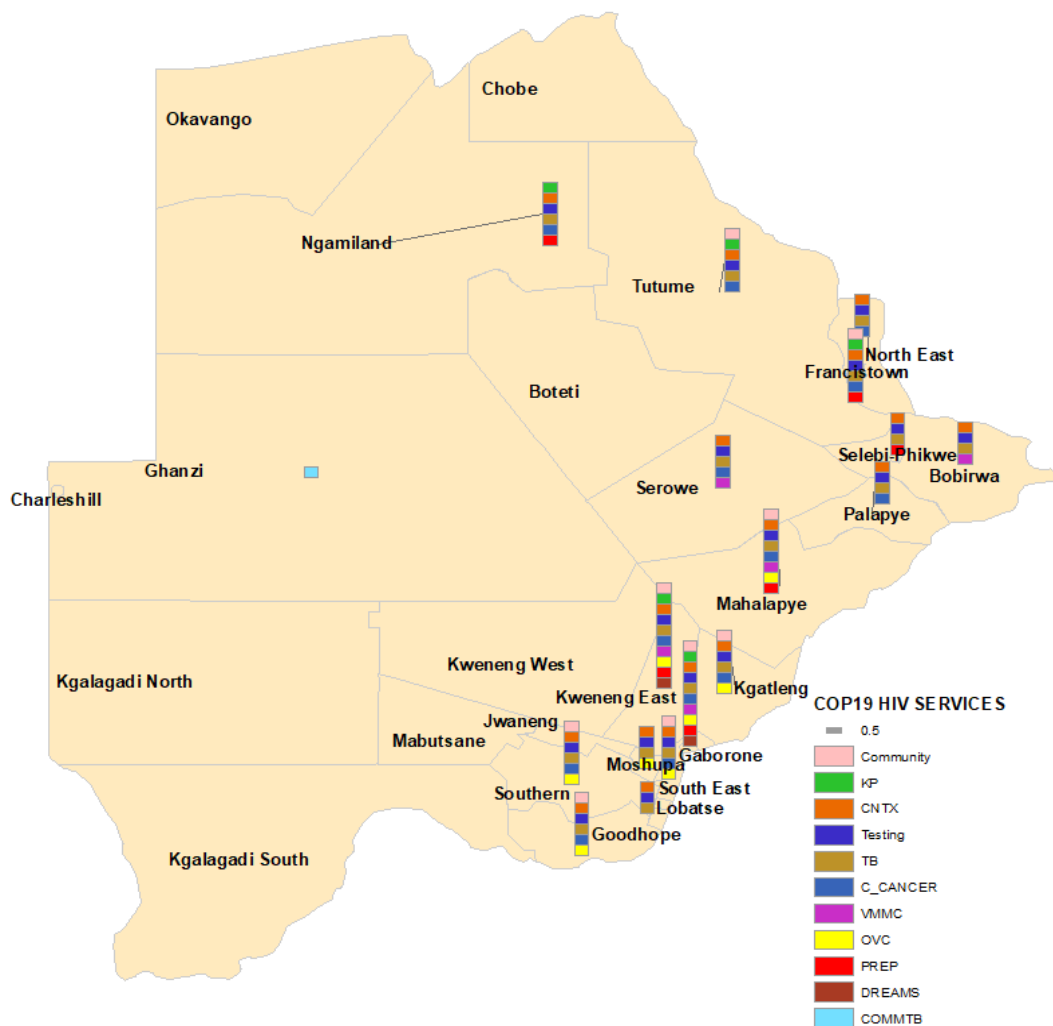
The Botswana 2017 BBSS II study found that the transgender people were the KP group that reported the highest level of stigma and discrimination at health facilities, which was 27% in the year preceding the study.

As a response to this, PEPFAR/B IP trained several service providers in facilities popular with KP on providing stigma free services. In COP20 through a partnership with MOHW STI unit, the KP competence training will be cascaded to all MOHW facilities. In addition, the following activities will be undertaken:

- Developing of a training curriculum to accompany existing guidelines
- Scaling up training to all STI TOTs through MOHW in 24 GoB districts including those we operate in, so that there is a KP focal person in all public facilities for increased access of services for KPs
- Supporting the Global Fund programs to strengthen referral mechanisms to public facilities and ensure GoB facilities have the capacity to provide KP competent services in non-EpiC sites

The KP program targets resources to the geographic areas with the highest numbers of key populations and insufficient intervention/service coverage for key populations. The interventions address low coverage in prevention, treatment and care. PEPFAR/B KP intervention will be implemented in the following districts: Boteti, Chobe, Francistown, Gaborone, Kweneng East, Ngamiland, and South East.

Figure 3.2 Map showing HIV services provided in PEPFAR/B supported districts



4.0 Client Centered Program Activities for Epidemic Control

4.1 Finding the Missing

Since the COP18 reboot, PEPFAR/B's overall HIV testing has shifted to a highly targeted case finding approach through assisted partner notification services to reach all exposed contacts (sexual partners and biological children) of all newly diagnosed PLHIV. In FY20, Botswana started conducting index testing with clients currently on treatment. Moving forward, adults and children identified as unsuppressed through viral load chart reviews, will be considered as index clients and offered partner notification services.

HIV self-testing (HIVST) will be used to reach populations with the greatest gaps (i.e. men, adolescents, and KP). Partner notification approaches will be offered to newly diagnosed positives with the understanding that this is a voluntary process, meaning they can decline or refuse at any time without any impact on the services they receive. Clients will be told that providers can anonymously notify partner(s) about their need to test (i.e., the index client does not have to be the one to tell their partner(s), but that they also have the option to notify their partner(s) and children”. Most importantly, implementation will take into account the WHO’s 5C minimum standards, including Consent, Counseling, Confidentiality, Correct test results, and Connection to HIV prevention (for both HIV-positive and HIV-negative individuals), and HIV care and treatment (for HIV-positive individuals).

With a key focus on the 75% benchmark for index testing in COP20, PITC in general/universal OPD will be transitioned to GoB by the end of the current fiscal year. Technical assistance is being provided to ensure adaption and implementation of screening tools across GoB facilities.

COP20 funds are limited to only supporting testing at ANC and TB clinics in addition to ensuring integrated case finding for prevention programming including Voluntary Medical Male Circumcision (VMMC). Social network and index testing will also be supported to optimize key populations services.

Case-based surveillance including recency, are new interventions supported to monitor and characterize newly identified positives to further optimize case finding. Leveraging on COP19 Faith and Community Initiative, there will be increased engagement of local and faith leaders to promote HIVST among men and youth using COP20 resources.

4.1.1 Case Finding strategies relevant to adult men and women and adolescent <19 years

In COP20, PEPFAR/B’s case-finding strategies for the general population are limited to: a) testing at TB and ANC clinics; b) implementing index and voluntary assisted partner notification that conforms to PEPFAR guidance; c) utilizing HIVST where partner notification is not an option and leveraging the Faith and Community Initiative (FCI) platform to reach men and youth; and d) conducting recency testing for all newly identified PLHIV. Below is a detailed description of the case finding strategies approved in the COP20 PLL letter for Botswana across genders and age groups including for adolescent children under 19 years. Of note is that index testing should be offered to all appropriate clients regardless of gender. The descriptions below show how this can be used to reach men or women, but index testing will not be limited to reach a specific gender:

Reaching Adult men 19 years and above

- *Utilizing Antenatal Care (ANC) HIV testing to generate index clients:* In Botswana, facility-based testing generally reaches more females than males due to poor health seeking behavior among men. In contrast, more than 95 percent of pregnant women receive ANC services with 98 percent of them tested for HIV through the PMTCT program. PEPFAR/B plans to offer partner notification and HIVST kits to all HIV positive pregnant women to in order to reach their male counterparts for testing. Partner notification approaches will be offered to all newly diagnosed positives with the

understanding that this is a voluntary process, meaning they can decline or refuse at any time without any impact on the services they receive. Hence, HIV positive pregnant women will be told that providers can anonymously notify their partner(s) about their need to test (i.e., they do not have to be the one to tell their partner(s), but that they also have the option to notify their partner(s) and children. Program will offer clients a 'menu' of services. This menu would include:

- Counseling on the importance of partner testing
 - Assessing barriers/concerns
 - Providing on-site testing
 - Offering provider assisted notification or 'unassisted HIVST for individuals who do not accept on-site testing
 - Providing 30-day starter packs (same day) for active linkage to treatment.
- *Utilization of HIVST as an option based on client preference:* HIVST kits will be offered to ANC women as one way of encouraging the testing of their partner(s). HIVST kits may also be given to HIV+ pregnant or post-partum women not on treatment presenting at post-partum or ante natal care who have a male partner with unknown HIV status. Women presenting at health facilities for TB treatment will also be leveraged to reach their male sex partners through HIVST.
 - *Review of Viral Load data to identify unsuppressed women to generate index clients:* Botswana recently started conducting index testing with clients currently on treatment. Moving forward, adults and children identified as unsuppressed through viral load review, will be considered as index clients and offered partner notification services.
 - *Reaching men through testing for PrEP:* Pregnant and breastfeeding women (PBFW) have been shown to be at 3-4 times at higher risk of acquiring HIV infections when compared to their non-pregnant counterparts³. PEPFAR/B will continue to support index elicitation and testing of men whose HIV positive female partners who are pregnant, or breast feeding given the heightened risk of seroconversion. Pregnant women will be encouraged to bring their partners in for testing or given an HIVST to mobilize their partners for testing.
 - *Testing of patients with TB symptoms as a strategy for reaching men:* Presumptive TB identification is significantly higher in men than women aged 25+ (54% versus 37%)⁴ reinforcing the value of this strategy for identifying men. All patients presenting at TB clinics will be tested for TB and offered HIV testing with a voluntary assisted partner notification as a strategy to reach men.

Reaching Adult women 19 years and above

- *Utilizing TB clinics, all newly diagnosed and virologically unsuppressed men to generate index clients:* HIV testing at TB clinics identifies a higher proportion of men compared

³ PEPFAR COP20 Country Operational Plan: Guidance for all PEPFAR countries

⁴ PEPFAR supported PITC Program data FY19APR

to their female counterparts. COP20 strategic approach involves conducting partner elicitation among all HIV positive men in order to access their female counterparts for *Adult women* will be reached through all newly identified men from other entry points. Men enrolled in treatment in the last 24 months will also be prioritized for partner elicitation. Index client ART files in the facility's Infectious Disease Control Centers (IDCC)/ANC will use color coded flags for "needs elicitation," "in progress," and "complete." Index cases will also be sourced from new cases identified among HIV positive men seeking and receiving treatment for TB and VMMC.

- *Registers* documenting unsuppressed viral load will be used as starting point for index testing of partners of men who are long-term HIV clinic clients but found to have unsuppressed viral load during routine testing. Adult men, who do not volunteer to bring their partners for index testing, will be offered self-testing kits.
- *Utilization of HIVST to complement voluntary Active Partner Notification services:* to optimize case finding among adult women HIVST kits will be distributed to adult men who choose to bring HIVST kit home to screen their partners. Men presenting at health facilities for TB treatment will also be leveraged to reach their female sex partners through HIVST.
- *Testing at ANC clinics:* in Botswana, 95 percent of pregnant women receive ANC services with 98 percent of them tested for HIV through the PMTCT program. In COP20 PEPFAR will continue to ensure all pregnant women are tested at their antenatal clinic visit. Maternal re-testing will also be supported especially for high risk postpartum mothers who previously tested HIV negative.

Reaching Pediatrics and Adolescents - < 19 years

An optimal mix of interventions will be implemented to maximize case finding among pediatrics and adolescent <19 years

- With limited case finding modalities supported in COP20, index testing is still the most effective and efficient way for reaching undiagnosed children and adolescents with HIV. With attention to family testing, COP20 support will include
 - Review of care and treatment patient records to identify biological children < 19 years of age of PLHIV who have not been tested. Given the low treatment coverage of children (39%), COP20 support will include ensuring that any known positives currently not in treatment are also linked to treatment for rapid initiation.
 - Based on index testing principles (mother with HIV; father with HIV and mother's status not known to be negative; sibling with HIV; mother deceased) index services will also be facilitated among OVC beneficiaries. Through collaboration with clinical partners and the OVC program, OVC case workers will assess all HIV-infected women whose children are registered in the OVC program to ensure all their biological children are tested.

4.1.2 Additional general populations case finding interventions

Promotion of HIVST among men and youth in the community using the FCI platform

- Through the FCI, there will be increased engagement of local and faith leaders to promote HIVST among men and youth. Expert clients, Treat All champions and health workers will engage with faith and community leaders to promote HIV testing through HIVST to finding men and youth and linking them to treatment. Leveraging relationships and social networks within communities, faith leaders will identify those at risk for HIV, offer them HIVST kits and refer to facilities those with reactive results for testing according to the national algorithm. Those confirmed as HIV positive will be actively linked and initiated on treatment and provided ongoing support for adherence.
- While PEPFAR support is being transitioned from all other testing modalities outside ANC and TB clinics, index elicitation and testing will be conducted on all newly identified positives regardless of who identified the clients.

PEPFAR/B in collaboration with GoB will support the development of a Memorandum of Understanding (MOU) and associated standard operating procedures on confidential data sharing between facility and community IPs. This will facilitate follow-up of index partners not reaching facilities. Through the MOU it is expected that Community and Facility IPs will connect on a weekly basis to share information about partners that need tracking and tracing. Partner information will only be shared if the index client consents to information being shared with another organization. Further, the time frame in which partner information will be shared with the community IP will be dependent upon the notification approach selected by the index client. Lastly, the community IP will provide information to the Facility IP about the outcome of any tracking and tracing efforts so that records can be updated.

Recency Testing

- In COP20, countries near epidemic control, such as Botswana, are required to have recency testing at scale across all PEPFAR-supported sites. This is for all newly diagnosed HIV individuals aged 15 years and older, who consent to the test. For Botswana, recency testing will be used in conjunction with the case-based surveillance system to monitor trends in the proportion testing positive on the Recent Infection Testing Algorithm (RITA) among newly diagnosed PLHIV of the specified populations. Recency testing will also be used to compare HIV positive contacts from index patient testing recent versus non-recent to inform prioritization and targeting of interventions. This activity will include agreeing on a recency testing algorithm and the site roll-out plan. Refer to section 4.4 for detailed description on recency implementation and roll-out plan.

4.1.3 Case Finding among Key Populations

The BBSS II (2017) revealed that among FSWs, HIV prevalence steadily increases by age group. Declines between 2012 and 2017 were seen most noticeably in the younger age groups. Among MSM, HIV prevalence steadily increases by age group and doubles in the 40-49 age group. PEPFAR/B's case finding strategy therefore focuses on an improved HIV screening tool that can identify the FSWs at the highest risk.

To enhance case finding for FSW and MSM PEPFAR/B has revised the mobilization and recruitment strategy for individuals to be offered HIV testing Services. The program will prioritize high-yielding case finding strategies from the community and the facility. These strategies include:

- The expansion of Enhanced Peer Outreach Approach (EPOA) that engages individuals at high risk or those living with HIV to recruit members of their social and risk network for HTC. EPOA includes performance-based incentives that provide peers with increasing benefits in return for achieving measurable service benchmarks and coupons to track referrals, testing and linkage to treatment.
- Using recency test results, the program will engage key population members that are newly diagnosed with HIV to identify their sexual partners and members of their networks.
- The program will use HIVST for KPs and their clients. This will overcome stigma and discrimination and fear of loss of confidentiality. The program will engage the KP community on HTS and introduce testing for triage using self-test kits. Key populations in high risk setting, for example, those selling sex in a brothel are at elevated HIV risk and will be provided HIVST. They also do not have the opportunity to leave their places of work which also serves as their homes. In addition, PEPFAR/B will also target MSM, who occasionally congregate at a site/home where there is a cookout and high- risk sex can follow. HIVST in this setting is indicated.
- KP community providers will conduct a single rapid diagnostic test. KPs with a reactive test will be linked immediately to a facility for further HIV testing and treatment. Those with non-reactive results will be recommended for enrolment into PrEP and other prevention services. The program will enhance the use of ICT to engage and recruit the online population of KP, especially those visiting matchmaking and dating sites. Online outreach makes the program relevant to young and urban populations.

In terms of HTS modalities, the PEPFAR/B KP program will use HIV testing strategies that have been documented to be KP relevant and high yielding. Index testing and mobile testing modalities will be used as outreach at community level. This will be complemented by online platforms where mostly MSM wishing to remain anonymous will book an appointment with a choice of services either at a Tebelopele Wellness Centre (TWC) or at a private practitioner. The choice of private practitioners is based on discussions that informed PEPFAR/B that MSM preferred private practitioners to public facilities, for confidentiality and privacy offered. Public facilities currently do not have the infrastructure to host online-platform (internet, dedicated person to receive clients from online to physical space, availability of services with flexi-hours/extended hours). In COP20 PEPFAR/B has planned to build the capacity of KP model

clinics to add to the differentiated models of service delivery for virtual outreach. Virtual outreach is a modality used to reach KPs who would otherwise not present to the facilities. These are classified as smart sellers (high-end sex workers) and older MSM who are professional.

In COP20, priority will be given to targeted mobile outreach strategies at hot spots. Index testing among regular partners of MSM will be rolled out after completion of certification process that ensure safety and non-coercion of index cases. The use of HIV self-testing will enhance the reach of index testing to KP partners who still wish to remain anonymous. Partners and children of FSWs will be referred for HIV testing/self-testing and those who test positive will be fast tracked into treatment. Biological children of KPs will be elicited and referred to OVC partner for continued support.

The hidden KPs in remote safari hotels and camps in the Delta and Chobe areas will be reached through outreach services. The KP program in Maun also covers the hotels in the Okavango Delta. Services in these areas are provided each quarter. At every visit about 20 FSW and MSM are provided with services. To minimize costs, the site visits are conducted in collaboration with DHMT through the District Multisectoral team. The program leverages on existing structures such as saving on transport costs by sharing vehicles. In addition, the team does not stay at the expensive lodges but instead stays in camps and facilities within US Government per diem rates.

In Gaborone where many MSM are engaged with either work or school, HIV self-testing will be enhanced. The use of social media will also be promoted so that non-citizen KP, not on treatment, will be identified through reboot-like activities and linked into treatment.

4.1.4 Using HIVST Kits to Advance Index and Social Network Testing and Targeted Case Finding Activities

In support of its limited case finding activities in COP20, PEPFAR/B plans to distribute approximately 16,000 HIVST kits to expand reach to unnamed sexual partners or contacts of index clients. The program will use two HIVST distribution models: community based through FCI networks and secondary distribution with the support of HCWs. In secondary distributions, HIVST kits are given to women attending ANC (see PMTCT-related indicators in table 4.2.2) and to FSWs at drop-in centers to take home for their male sex partner(s) as well as other at-risk individuals within their social network.

The estimated number of HIVST kits to be distributed is primarily based on the OU's target of HTS_POS among the general population and among KPs in COP20. Taking into account the average 1.5 sex partners per HIV positive client (based on previous index testing elicitation estimates), the estimation assumes 4 contacts per index client and plans to provide up to 3 kits to each client for his/her sexual partners or contacts. The HIVST kits will be distributed to KPs as well as the general population, which includes index clients, pregnant and breastfeeding women, infected mothers in the OVC program, and other individuals at high risk of contracting HIV (mostly men) identified through social networks.

PEPFAR/B will leverage its current FCI-related network of 320 Faith Leaders and Traditional Healers in priority project areas to distribute about 2,300 HIVST kits to hard-to-reach men and

youth among their congregants. These religious and traditional leaders have been trained on “Messages of Hope” and the importance of HIV testing for these populations. They have already demonstrated their readiness and ability by using the “one-on-one” pastor counseling and referral method to provide HTS to their congregants with an impressive 13.6% testing yield. Building on this success, they will use their relationships and social networks to identify those at risk for HIV, have them screened, tested, and immediately linked to treatment. Table 4.2.2 below provides further details on the estimation process.

Table 4.1.1: HIV Self-Test Kits Estimates

| Modality | Index Client | No. HIVST Kits (3 times # of index clients) |
|----------------------|--------------|---|
| INDEX Facility | 2097 | 6291 |
| TB_STAT | 178 | 534 |
| PMTCT_STAT_POS (ANC) | 193 | 579 |
| PMTCT_POST_ANC (ANC) | 18 | 54 |
| VMMC | 13 | 39 |
| INDEX Comm | 1116 | 3348 |
| INDEX Comm (KP) | 325 | 975 |
| INDEX Mob (KP) | 626 | 1878 |
| FCI Networks | | 2300 |
| TOTAL | 4566 | 15008 |

4.2 Immediate ART initiation

The MoHW has adopted rapid ART initiation as part of the MPRs in COP19, and PEPFAR/B is fully supporting the implementation of same-day and fast track initiation of ART to all newly diagnosed HIV patients who have no contraindications in all the 75 sites. Ensuring effective Linkage to Treatment (LTT) services is essential for achieving the second and third 95 goals.

Immediate ART initiation and overall LTT has been steadily increasing since FY19 and FY 20 due to the commencement of non-citizen treatment as well as the consistent implementation of the reboot strategies initially implemented in 41 sites. In FY20 Q1, the overall LTT stood at 89% while the Same Day (SD) initiation rate improved from 54% in FY19 Q4 to 57% in FY20 Q1, and Fast Track (FT) initiation rate improved from 70% in FY19 Q4 to 73% in FY20 Q1. In COP20, PEPFAR/B will maintain the replication of the reboot model in the 75 supported sites including supporting the provision of additional nurse practitioners (NP) for extended hours and weekend ART services in facilities to ensure that patients who have a positive HIV test result have access to immediate ART initiation. PEPFAR/B will also build GoB capacity to optimize linkage to treatment through integration of ART services at Out-Patient Departments (OPD), building the capacity of GoB NPs to serve as “Fast Track Champions,” ART initiation on non-ART clinic days, and use of 30-day starter packs as a means to operationalize the Same-Day, and Fast-Track minimum requirement already adopted by GoB. A GoB/PEPFAR/B MPR TWG will continue to actively engage in implementation and monitoring of the MPR related to ART initiation. PEPFAR/B will also continue to strengthen facility-community linkages to ensure clients are provided services where and when they want them and to continue to improve overall linkage rates.

PEPFAR/B will continue to promote the Wellness clinics as a complementary alternative to government health facilities, to enable reaching patients who will not access traditional health facilities. Through the Wellness clinics, client-centered comprehensive services will be offered integrating HIV testing, treatment, Viral Load testing, TB screening, diagnosis and treatment, STI management, Family planning, PrEP and post GBV services to enable clients to receive as many services as they need within the same visit. These services will continue to be accessible through weekend and extended hours of operation to attract men, non-citizens, and AGYW. The wellness clinics recently introduced men's and adolescent-friendly corners, an innovation that offers a great opportunity to serve hard to reach populations and ensure adherence. PEPFAR/B will continue promotions for client-centered wellness center services including radio and television exposure and use of social media to create demand for HIV linkage and retention services. To expand services to the hard to reach populations, especially men, PEPFAR/B will implement community ART initiation through mobile outreaches.

PEPFAR/B IPs will continue to utilize standard operating procedures (SOPs) and job aids for active referrals of clients who do not link at the facilities to the community for follow-up. Community IPs will support facility IPs to track and link to treatment both *Prospective clients*: (these are clients who tested positive at the facilities but do not link to treatment within 3 days) and *Defaulters/Lost to Follow Up* (these are clients who had been on treatment, but have stopped for different reasons). PEPFAR/B will continue to track reasons for defaulting to be able to minimize these numbers.

PEPFAR/B will strengthen the facility-community interface to ensure timely hand over of clients for tracking, through employing CQI methodologies to identify and ease bottlenecks that hinder this process to take place by Day 3. The following good practices will be implemented to optimize LTT:

- Integrated services, where HIV testing and treatment is packaged with other services such as sexually transmitted infections and TB at a single site
- Intensified post-test counselling and education
- Assistance with transport, client accompaniment, and warm handover of clients.
- Treatment navigation
- Decentralized ART provision and community-based ART provision through mobile outreach
- Telephone follow-up, reminder calls, or text messaging and contact tracing if treatment is not initiated
- Psychosocial support

- Strengthening client-centered approach to ensure services are available where and when clients need and want them
- Robust outreach program to create demand for treatment services among men, AGYW, and non-citizens

4.2.1 Retaining clients on treatment and ensuring viral suppression

| Population | Proposed Interventions |
|---------------|---|
| Children | <ul style="list-style-type: none"> Pediatric and adolescent friendly clinicians Convenient appointment times in consideration of school hours Structured support to caregivers by community health workers Use of appropriate pediatric formulations |
| AGYW and ABYM | <ul style="list-style-type: none"> Adolescent and youth friendly services Psychosocial support Peer support models Targeting adolescents and caregivers with family interventions |
| Men | <ul style="list-style-type: none"> After hours men's clinic Weekend drug pick-up or initiation Male-friendly services with male providers Enhanced focus on confidentiality Provision of clinical services closer to workplace or in community Multi-disease or 'wellness' clinics Availability of choice for male adherence treatment clubs Promoting male patients' input in design and package of service delivery |

Program data from an FY18 treatment cohort was analyzed to determine 12-month retention rates. The analysis identified groups most at risk of being lost to follow up. These included children aged 0-4, young women and men aged 15-19 and 20-24, and men aged 25-29. FY20 Q1 data also confirms observations made with retention analysis. The Q1 data shows that among those LFTU after more than 3 months on medication, 37% (80/218) were male, 7% (16/218) were AGYW, and 2% (5/218) were Adolescent Boys and Young Men (ABYM). This trend is consistent across quarters and at the national level, and points to the need to have targeted interventions and additional services beyond the core package focusing on these subpopulations' needs. Table 4.2.1 shows the specific COP20 additional interventions for the priority populations.

Table 4.2.1. Priority populations and specific PEPFAR /B COP20 retention interventions

Based on PEPFAR's number one treatment priority of facilitating continuous ART, the existing reboot and COP19 interventions will be continued in COP20 to ensure maintenance of the improved retention. In COP19, a case management approach using expert clients, Community Health Workers (CHW), Health Education Assistants (HEA), case managers and social workers supported retention on treatment through provision of psycho-social support, tracking and tracing, and continuous adherence support. Compliance with the use of the MoHW follow up registers for missed appointments and LTFU, and peer support groups for adherence to treatment for all age and sex bands, was enhanced. The use of differentiated service delivery

such as MMD and community ART refills in COP19 helped to improve retention. However, there were challenges during FY19 Q1 reporting period such as the lack of a pharmacy refill appointment system creating a challenge to account for all patients who refilled, and the number of months ARV medication was dispensed. The incomplete refill data poses challenges to sufficiently account for MMD. In COP20, mentoring of pharmacy staff on utilizing the pharmacy appointment modules on PIMS and IPMS will be optimized. In order to ensure a client-centered approach to retention, PEPFAR/B will further intensify TA to dispensing units to better measure the uptake of MMD.

Sustaining of improved retention rates will also be realized through continued engagement of expert clients at national, facility and community for provision of peer support and stigma reduction messaging. Peer support will be critical to establishing the specific needs of ART beneficiaries at the different sites and the required shifts necessary to make services more friendly and convenient. Continuous quality improvement teams will be supported to assess sites for client centeredness as well as whether they are men- and youth -friendly. Working with the DHMTs and the community led monitoring agencies, sites will be supported to implement the necessary improvements and corrective measures.

Additional strategies to facilitate continuous ART will include the continuation of health care worker managed groups for more intensive monitoring and adherence support especially targeting the newly initiated men and youth and patients with advanced HIV disease. The implementation of MMD has contributed to decongestion of health facilities giving health care workers more time to monitor client retention. Clients requiring more support will be referred to HEAs, community health workers, and expert clients for tracing at household level with provision of feedback to clinicians for coordinated proactive monitoring and support.

PEPFAR/B will continue to scale up technical assistance and direct service delivery to ensure consistent adherence to treatment, support LTFU and defaulter management SOPs which form part of the mentorship program for HCWs. The scale-up of client literacy programs will be continued at both the facility and community levels to emphasize adherence. Technical assistance will include support for integration of services, especially in outpatient areas will be optimized to achieve a patient- and family -centered approach. Integration however requires an increased number of HCW able to provide HIV services at any service point within the facility. More nurse prescribers and dispensers will be trained to ensure wider patient access to services. Districts that have received training on the Integrated Health Services will be supported to optimize results through targeted district mentorship support. The MoHW emphasizes integration for the routine mobile stops scheduled across all facilities for the hard to reach areas.

PEPFAR/B, through facility and community-based implementing partners, will continue to work across the cascade to ensure that clients that have been linked to lifelong HIV treatment are retained in treatment and are virally suppressed in order to achieve epidemic control. PLHIV that are not retained in care pose a risk of continued HIV transmission. PEPFAR/B will ensure demonstrated implementation with fidelity by enrolling clients in community HIV care according to the recommended eligibility criteria focusing on unstable clients including newly diagnosed, treatment interrupters, clients with a detectable viral load, pregnant women,

TB/HIV co-infected, and those with other opportunistic infections. These clients are supported with PHDP minimal package which entails adherence assessment and counselling, risk reduction counselling focusing on consistent and proper condom use, safer pregnancy counselling, sexually transmitted infections (STIs) education and referrals, TB screening and referral of presumptive clients for further TB evaluation, NCD screening, nutritional assessments and counselling, including Mid Upper Arm Circumference (MUAC) assessment and linkage to nutrition services, psychosocial support services, as well as partner notification counselling including mediated disclosure support. Ongoing partner notification and elicitation of index testing will be done among clients in community HIV care who do not know their partner's HIV status, and those eligible referred for HTS services. CQI activities including timely identification of implementation challenges, and introduction of course correction measures to sustain treatment net gains will be an ongoing process.

4.2.2 Retention Strategies for Non-Citizens

In December 2019, the GoB approved the policy of free ART for non-citizens as one of the MPRs and began offering treatment services for this population. The retention challenges with non-citizens are substantial in that they are highly mobile as they are constantly looking for livelihood and job opportunities in different parts of the country or are travelling between their native country and Botswana. Many of the non-citizens lack official documentation and hence are sometimes deported to their countries, hindering their ability to do regular refills and prevent full access to treatment services. Strong retention strategies will be put in place to ensure retention and medication adherence for this population. During client registration the client unique identifier will be issued, and the patient's full contact including their physical address and contacts of next of kin documented to enable tracing of the client when they miss their appointments. The client will be strongly encouraged to notify the health care provider upon migration to enable smooth transfer out and linkage to the next facility for continued care. For those eligible and stable on treatment, transition to TLD, as well as MMS and MMD as per the Government of Botswana guidance will be prioritized. Other differentiated service delivery models such as the Community ART Groups (CAGS) fast track refills, community medication refills, and family member refill will also be prioritized to promote retention for non-citizens. Non-citizens will be offered an opportunity to enroll in a program where a CHW will offer them support to address any barriers to adherence in order to achieve viral suppression. PEPFAR/B will promote stigma-free, client-centered, and friendly services for non-citizens regardless of their immigration status to enable retention for this community across the cascade. Non-citizen patients who have missed appointments, defaulted, or are LTFU will be traced in the community, linked back to care, and supported to retain in treatment through community care services.

4.2.3 Differentiated Service Delivery Models for All Populations

As part of the MPRs, PEPFAR/B will continue to implement differentiated service delivery models and client-centered approaches tailoring clients' services to their needs.

1. MMD and fast track refills

MMD brings an opportunity for improved retention in care and reduces the burden at clinical sites. Stable and eligible clients will receive multi-month scripting (MMS) of six months and MMD of three to six months according to the government of Botswana's set guidance, and a fast track refill model will be adopted that entails introducing drug pick up points and strengthened appointment systems for refills. Clients on MMD will also receive periodic community health worker support to ensure adherence to medications.

2. Community ART Groups (CAGS) and Community Medication Refills (CMR)

As a requirement for the MPRs, PEPFAR/B will continue to collaborate with DHMTs on the implementation of community based differentiated service delivery models which include CAGS and CMR. Clients in the CAGS will receive ART refills as a group, i.e., a CHW or a single member of the group will pick up medications for the entire group and distribute; if the picking of the drugs is done by a member of the group the role is rotated among group members. The CAGs will also offer opportunities to act as support groups enabling members to meet in community locations and receive adherence and psychosocial support as needed. The CMR approach entails providing medication refills through CHWs to more stable clients at their homes or workplaces to address client's concerns of frequent visits to the health facilities.

3. Community ART initiation

This differentiated service delivery will continue to be implemented in COP20 as an option to clients who reject linkage to treatment. Clients that opt for community ART are mapped to ensure a manageable number of clients in an area. A clinical team will proceed to the area and initiate the clients on treatment. CHWs continue to follow up the clients to ensure that they are linked to a facility of their choice to continue receiving HIV care. Community ART initiation enables reach to populations who do not want to lose income by visiting facilities during normal working hours e.g. construction workers whose pay is prorated according to number of hours worked. It also facilitates reach to clients who fear being stigmatized by receiving services at conventional clinics. Once these clients have initiated on treatment, they are supported to remain on treatment through the afterhours and weekend clinics, community medication refill/Community adherence groups, or fast track refills.

4. Engagement with the faith community

Botswana data shows that compared to women, men and children living with HIV are less likely to know their status and to have viral load suppression. Thus, engagement with faith communities and traditional leaders, including traditional healers, represents a pivotal opportunity to accelerate uptake of treatment services and therefore address the gap in HIV epidemic control. Faith-based structures are an integral part of the communities in which PEPFAR/B IPs work, and have durable relationships built on trust which act as leverage and an entry point to offer services to the missing populations. Through the FCI PEPFAR/B community IPs have engaged Treat All Ambassadors and expert clients to advance FCI implementation by promoting treatment literacy, retention, and VL suppression. Treat All Ambassadors and expert

clients will also be assigned “difficult clients” for community tracking and linkage to treatment and offer one-on-one support to encourage adherence. Treat All Ambassadors will mentor the expert clients, so they are confident to speak to clients about their journey with HIV.

Table 4.2.2 Retaining adult men and women on ART and keeping them virologically suppressed

| Retention Strategies by Population and age bands | | |
|--|--|---|
| Age | Adult Male | Adult Female |
| 25-34 35-45 | <ul style="list-style-type: none"> • MMD • CMR • Men’s friendly corners • Expert Client • PHDP minimum package • Use of faith-based leaders to target men in churches and the mothers of adult men to persuade them to link and stay on treatment • Engagement with traditional healers to target men who do not visit health clinics | <ul style="list-style-type: none"> • MMD • CAGS • Support Groups • Integrating ART with Family planning services • Peer support and Expert Clients • Case Manager • PHDP minimum package • Use of faith-based leaders to target women in churches |
| 50+ | <ul style="list-style-type: none"> • Integrate ART services with other health services e.g. Hypertension and Diabetes Mellitus • Use of Faith f-based leaders to target men in churches • Engagement with traditional healers to target men who do not visit health clinics | <ul style="list-style-type: none"> • Track LTFU after Option A and B, motivate to keep in care through integrated services • Use of faith-based leaders to target women in churches |

4.2.4 Retention Strategies for KPs

The KP program improved linkage to ART from 60% in FY18 to 104% in FY19 to 120% in FY20Q1 for FSW, due to expanding services to non-nationals and increasing number of DSD sites from 1 to 5 sites. There was improved linkage to ART for MSM from 59% in FY18 to 88% in FY19 to 123% in FY20Q1.

The reason for these improvements included the use of differentiated service delivery models. The use of Drop-in centers made it easy for KPs to be initiated at places that were most convenient and accessible to them. In addition, the clinical service provider increased ART and PrEP sites from 1 to 5 sites.

In COP20, the program will strengthen Peer Navigators through training and task shifting as to improve their linkage to care activities. The Implementing partner will also promote and create demand for clinical services for non-citizen members of the key population.

To meet the needs of MSM, the program will establish partnerships with private practitioners for MSM reached through an Online platform. The promotion of U=U will increase treatment literacy for MSM and encourage them to remain on treatment.

4.2.5 Viral load Suppression and coverage

Botswana continues to have high viral load-coverage and high viral load suppression. In COP20 focus will be on continued reboot interventions to maintain and further improve VL coverage. Strategies to be continued for maintenance will include use of appointment systems for patient bleeding and targeted site staff mentorship to ensure site staff proactively update client results in EMRs before clinic visits. Clinic lab interphase activities such as monitoring clinic turnaround times and roll out of specimen and results management register utilization. Targeted quality improvement initiatives to optimize VL access will be provided to sites with VL coverage below 95%. Reboot interventions will be introduced at the new GOB reporting sites to improve coverage. The use of a tracking log for systematic follow up of clients with detectable VL will be supported in all sites by community workers including the roll out of the viremia registers to enhance management of clients with detectable VL for timely and targeted referral interventions.

Clients with detectable viral load, those expressing some difficulties with their treatment, as well as new and defaulting clients will be followed-up monthly until they stabilize. Follow-up visits will include an evaluation of the client's adherence patterns and an individual assessment aiming to identify any health issues that may have arisen. All pediatric clients will be followed-up at home monthly due to the complexities of pediatric ART care and the fact that children and adolescents are less likely to achieve virologic suppression.

4.2.6 Monitoring Community Work through Custom Indicators

The community service delivery program is designed to link and keep people on lifelong ARVs. The majority of the work will be at community level, providing client-centered care services so we can meet the clients where they are with what they need, and ensuring strengthened community/facility linkage across the different areas of the HIV spectrum. Most of this critical work falls outside the "normal" PEPFAR clinical work that is monitored through the PEPFAR MER indicators. Because of this, targets associated with community health work are monitored using custom indicators which do not appear in the data-pack.

Custom indicator reference sheets on 12 of the indicators have been cleared by the inter-agency and finalized. During COP19, PEPFAR/B is working with IPs so that all mechanisms will collect the same information in the same way for congruent activities. They will be reviewed and modified as needed, going through an iterative and collaborative process with all agencies, as with standard MER indicators. Custom indicators are documented in the partner's PMP to ensure accountability and standardization. All indicator results, both MER and custom, will be subjected to routine data quality assessments (RDQA) which will be done internally by IPs and externally by agency representatives. Community partners are currently using DHIS to collect program data which will be used for custom indicators as well as for standard MER indicators. Results will be reported on and analyzed quarterly together with MER indicators, and will be

done on an agreed upon platform such as excel or tableau. This will enable PEPFAR/B to track the complex and interconnected activities that move patients through the clinical cascade and achieve better results at the OU level; demonstrate collaboration between facilities and the community; help the interagency better understand the program and course correct as needed; and most importantly, serve our clients with “what they need, where they are.” These indicators are captured in Table 4.2.3.

Table 4.2.3 Custom Indicators for Community Work

| Custom Indicator Code | Indicator Group | Indicator Description | Reporting Frequency |
|-------------------------|-------------------|---|---------------------|
| HTS_TST_POS_AFTERTHOURS | Testing | Number of persons newly diagnosed HIV positive (New positive) after hours (weekdays) and weekend hours within the reporting period | Quarterly |
| TX_NEW SAME DAY | Treatment | Number of persons newly diagnosed HIV positive (new positive) initiated on treatment on the same day as being diagnosed | Quarterly |
| TX_NEW FAST TRACK | Treatment | Number of individuals newly diagnosed HIV positive (New positive) initiated on treatment within seven days of being diagnosed within the reporting period | Quarterly |
| TX_NEW AFTERTHOURS | Treatment | Number of individuals newly diagnosed HIV positive after hours (New positive) who were initiated on treatment within the reporting period | Quarterly |
| TX_NEW_PROS_TRACED | Treatment | Number of persons newly diagnosed HIV positive (New Positive) who did not initiate on ART within three days referred by the facility to the community traced in the community and linked to treatment | Quarterly |
| TX_NEW_LEG | Treatment | Number of persons previously diagnosed with HIV (Known/legacy positive) who did not initiate on treatment within 28 days of diagnosis and were referred to community, traced and initiated on treatment | Quarterly |
| TX_PVLS_COMM | Viral suppression | Number of ART clients who are eligible for VL test (missed and reminders) and those with unsuppressed VL tracked by community health workers | Quarterly |

| | | | |
|---------------------|-----------|--|-----------|
| TX_ML_COMM | Treatment | Number of ART clients who are eligible for VL test (missed and reminders) and those with unsuppressed VL tracked by community health workers | Quarterly |
| TX_CURR_COMM REFILL | Treatment | Number of ART clients receiving their drugs through community home delivery | Quarterly |
| TX_CURR_TLD | Treatment | Number of ART clients switched to TLD from a different regimen | Quarterly |
| TB_CARE_COMM | Treatment | Number of PLHIV who received community TB screening and/or community TB DOT through community health workers | Quarterly |
| PMTCT_EID_COMM | Testing | Viralogic HIV test by 2 months of age traced by community health workers and linked to testing | Quarterly |

4.2.7 TB/HIV services

In Botswana, the average rate of decline in the tuberculosis incidence rate was 8% per year in the period of 2013-2017, way above the global decline of 2% (Ref: WHO global TB report 2014, 2018 and 2019). In 2018, TB incidence was estimated to be 275 per 100,000 population. This significant reduction in TB incidence may partly be attributable to high ART coverage. However, despite a decline in tuberculosis notification, TB/HIV comorbidity remains high (49%) (Ref: WHO global TB report 2019). For more than eight years of tuberculosis preventive treatment (TPT) was a missed opportunity. In 2019, through outstanding leadership and a collaborative effort, policy on TPT for HIV-positive persons was reintroduced and implemented.

In the past year (FY19) among 2,762 TB patients identified, 2,742 (99%) knew their HIV status and 1,369/1436 (95%) co-infected patients were initiated on ART in PEPFAR/B supported districts. Though high ART coverage is being achieved among identified TB/HIV patients, the following major gaps remain in Botswana hence the need for increased effort to control the HIV and TB epidemic:

1. Both TB and TB/HIV co-infection rates are unacceptably high.
2. TPT greatly reduces development of TB and mortality. All eligible people living with HIV need TPT. The TPT policy issue has now been resolved, and implementation started in COP19 and by quarter one report 11, 606 patients were initiated on TPT out of a target of 72,272. TPT needs to be scaled up in the remaining COP19 and COP20.
3. Develop the capacity to conduct routine contact investigations for all PLHIV who are found to have TB disease.
4. Design facility/community-based, patient-centered approaches in TB/HIV service deliveries including MMD and community drug distribution for the patients who are coinfectd.
5. There is a loss of patients between TB diagnosis and registration to TB treatment; in FY19 the loss of patients has remarkably reduced, and this effort will continue.

6. TB screening and HIV testing among presumptive TB is not optimized yet; this is especially evident among male age group 25 and above.
7. Since mid-FY19, non-citizens TB patients are eligible for ART. Initiating ART to non-citizens with TB and HIV need to be maximized towards achieving a 100% coverage.
8. Strengthening of M&E for TB/HIV activities
9. Continuous quality improvement on the barriers and gaps identified in the use of standardized tools, complete documentations, availability of commodities and reporting of achievements.

PEPFAR/B through strengthened Facility-Community linkages will implement the activities and interventions below in COP20 to expand and sustain the coverage of TPT in Botswana:

- i. In-service training of health care workers on initiating TPT eligible HIV patients
- ii. Technical assistance through mentorship and supervision to health care workers on initiating TPT eligible HIV patients
- iii. Adequate follow-up of patients for adherence and completion of TPT
- iv. Technical assistance to operationalize the national tuberculosis preventive therapy guideline and appropriate utilization of registers and monitoring tools
- v. Support the procurement and availability of TPT commodities

PEPFAR/B will implement the activities and interventions below in COP20 to maintain TB case finding and ART uptake:

- i. Technical assistance to strengthen mentoring and supervision to health care workers on TB/HIV services, including initiating ART to TB patients
- ii. Support TB diagnostics for case finding by introducing TB_LAM tests, ensuring Xpert MTB/RIF testing is used as initial diagnostic test and ensure that laboratory quality standards are met
- iii. Provide the necessary support to ensure HIV testing is done where TB diagnosis is made
- iv. Provide the necessary support to ensure that screening and HIV testing of all presumptive TB patients are done
- v. Facility and community stakeholders will collaborate to conduct contact tracing of index TB case, TB screening, evaluation, diagnosis and treatment

4.3 Prevention, specifically detailing programs for priority programming

4.3.1.a Prevention: OVC

The availability of both the PMTCT and ARV programs have dramatically reduced the number of children born HIV positive and those who are orphaned due to HIV and AIDS. While the focus on AIDS orphans has markedly reduced, there remains an increased need to focus on specific sub-populations of the vulnerable children that are directly affected by the epidemic and ensuring that they receive the services they need to enable them to thrive, grow up healthy and become resilient. COP20 is guiding OVC programs to intentionally target these children and offer and provide them the relevant OVC services using differentiated service delivery

models that include the comprehensive, preventive and OVC/DREAMS programming. The specific OVC sub-populations that COP20 will focus on include: i) children and adolescents living with HIV, ii) children of HIV+ caregivers (especially mothers), iii) children of female sex workers, iv) survivors of sexual violence, v) HIV Exposed Infants, vi) Orphans, vii) 9-14 year boys and girls and viii) vulnerable AGYW 10-17 years old.

Table 4.3.1 OVC sub-populations and the applicable DSD model.

| Prioritized sub-populations | Applicable Differentiated Service Delivery Model |
|---|---|
| <ul style="list-style-type: none"> • Adolescents and children living with HIV • Children of HIV+ mothers/caregivers • Children of female sex workers • Survivors of sexual violence • HIV Exposed Infants • Orphans | <p><i>Comprehensive Programming</i></p> <ul style="list-style-type: none"> • Every client has a case plan • Every client/family gets assessed for OVC services followed by provision of the needed services (client-centered programming). The services provided are aligned to the 4 OVC domains of healthy, schooled, safe and stable • Every client/family is monitored against graduation benchmarks approved by OGAC |
| <ul style="list-style-type: none"> • 9-14-year-old boys and girls | <p><i>Preventive Programming</i></p> <ul style="list-style-type: none"> • Primary prevention of sexual violence and HIV <ul style="list-style-type: none"> • Delivered in groups through school platforms; Single intervention using evidence-based curriculum • There are no case plans, therefore no case management for every client • Beneficiaries are not monitored against benchmarks • Either towards the end of the curricula or at mid-point, all 9-14 years old boys and girls in one classroom are assessed for OVC services and only girls are assessed for DREAMS eligibility. The facilitator doing the assessments initiates referrals as necessary to the relevant programs and makes follow up to ensure referrals are completed. |
| <ul style="list-style-type: none"> • Vulnerable AGYW 10-17 years old | <p><i>OVC/DREAMS Programming</i></p> <p>Layered interventions are provided by both platforms</p> <ul style="list-style-type: none"> • The AGYW is linked to a DREAMS mentor who places them into a safe space so they receive applicable services via the safe space platform • The AGYW also receives applicable OVC services that are otherwise not available through the DREAMS program |

Below are details of how these sub-groups will be identified including some of the critical approaches and interventions.

Comprehensive Service Delivery Programming Model

The Botswana OVC program has traditionally had a pediatric clinical provider as a sub-partner under the one large OVC program that PEPFAR/B is implementing. Additionally, other OVC sub-partners in the various districts have developed relationships with health clinics in their villages/communities including health facilities that are not receiving PEPFAR support. Some of the Peace Corps Volunteers (PCVs) doing OVC work are placed in MoHW health facilities and with social workers to support OVC including ALHIV and their families. All these relationships have made it possible for the OVC program to reach the number of adolescents and children living with HIV. For example, at FY19Q4, 9% of OVC reached were HIV positive while by FY20Q1 it was 10%. With the call from OGAC to offer OVC services to 90% of children and adolescents living with HIV, the PEPFAR/B OVC program needs to intensify its strategy for reaching this population group as well as reaching others such as HEI and children of HIV positive mothers. The below strategies are being implemented now in COP19 and into COP20 to significantly increase these numbers and track progress towards this goal:

- *Strengthen and expand partnership with the Baylor pediatric clinical providers:* The Baylor Children's Centre of Excellence has been a sub-partner to the OVC program for several years now. Baylor has a very strong relationship with the MoHW in terms of pediatric HIV care and treatment. They provide specialized teams that visit different health facilities to attend to pediatrics on HIV care and treatment, focusing especially on difficult cases. These include treatment defaulters, those with poor viral load results etc. Continuing to strengthen the partnership with Baylor will ensure OVC partners reach all adolescents and children living with HIV (A/CLHIV) being served by Baylor especially reaching those that need the services the most. The OVC program will therefore continue partnering with Baylor and ensuring Baylor's role includes:
 - Training OVC community health workers (case managers) in areas such as HIV treatment, adherence, viral load and others. This technical assistance ensures OVC case managers are well informed on the clinical aspects of HIV and that they are providing relevant services. Baylor will also do quality assurance, monitoring to ensure services are provided as per the training provided to the OVC case managers. Baylor will also train its staff on OVC services to enable referrals to come from Baylor.
 - Case conferencing on all HIV cases that Baylor manages for Baylor to appreciate the services that the OVC service providers are providing, challenges and successes. Baylor on the other hand provide updates to the OVC service providers on the clinical aspects of the clients being managed by the OVC program in terms of adherence, viral load etc. These meetings offer each party an opportunity to understand the role of the other service provider and ensures coordination of service provision.
 - Referring existing and new HIV cases to the OVC services so that OVC service providers can assess the cases and offer OVC services.

- Strengthening the Teen-club Model to reach more adolescents. These are clubs where HIV positive adolescents meet in a safe space to address issues of adherence as peers. Word of mouth publicity on the teen clubs has created a “snowball” effect and increased participation and brought more adolescents to be part of the teen clubs. This will continue in COP20. Additionally, Baylor will work with the OVC program to make the model more exciting for adolescents through integrating social enterprising & social asset building in the teen club model as a way of building the adolescent’s resilience, confidence and promote general well-being.
- The OVC program is currently finalizing a study in partnership with Baylor to better understand why mothers of HIV exposed infants are not coming back for confirmatory testing and for not taking their children back to access treatment. The results of this study will be shared widely with the PEPFAR team and used to inform how best to program for this population from an OVC point of view.
- *Strengthen partnership with other implementing partners working in the clinical space:* PEPFAR/B provides support to the MoHW via several implementing partners who already have a presence in the 75 health facilities. A preliminary review based on a mapping exercise that PEPFAR/B conducted in 2019 showed that almost all these health facilities have a case manager who is based in the health facility either via a CDC or USAID implementing partner. The exercise also showed how OVC partners are working closely with all these health facilities. Peace Corps also has between 30 and 40 PCVs supporting in health facilities, guidance and counseling teachers, social workers and implementing partners working with C/ALHIV and their families across the country at any one given time. To ensure these partnerships yield the results expected, the OVC program will reach out to other implementing partners, even before COP20 starts, to negotiate signing of memorandum of understanding (MOUs) and develop SOPs of how to do bi-directional referrals from the facility to the community and vice-versa, so that each partner contributes to the success of the other.
- *Strengthen partnership with other civil society organizations (CSOs) working with adolescents and children living with HIV:* Several CSOs that work with adolescents and children living with HIV exist in the country. These include organizations such as Botswana Network of People Living with HIV (BONEPWA) and Sentebale Youth Group. The OVC program will reach out to these organizations through signing memorandum of understandings (MOUs) to be able to offer OVC services to the clients being served by these organizations.

The partnerships between facility and CSOs will also allow OVC programs to reach parents/mothers of HIV positive children where the OVC service providers can educate, encourage and refer these mothers to take their children for HIV testing services. Additionally, the OVC program will partner with the HTS program to engage on how the OVC program can benefit from the HTS self-test kits distribution program especially targeting the mothers living with HIV to test their children.

For children of female sex workers, the OVC program will employ some of the following strategies:

- *Strengthen partnership with PEPFAR implementing partners and other civil society organizations working with the key populations:* This partnership will include setting up MOUs with IPs currently implementing the KP program. The MOU will speak to how referrals will be done to ensure the OVC program reaches children of female sex workers as well as how the OVC program can refer female sex workers identified in the community to the KP program. In SNUs where the KP program does not have a presence, the OVC IP will identify and work with other existing CSOs. There will be challenges where no CSO working with female sex workers exist.

Increasing reach for children who survived sexual violence is also a priority for COP20. The Botswana Violence Against Children Survey (VACS) released in 2019 showed among other things that 1 in 4 females (22.8%) age 18-24 years who experienced childhood sexual violence had their first incident at or before the age of 13 (VACS 2019). At FYQ4, the Botswana OVC program had identified and served 93 survivors of sexual violence. There is a need to prioritize this OVC sub-population and ensure relevant service provision. Some of the strategies to be employed in COP20 to increase reach for this population group include:

- *Training Districts Child Protection Committees on sexual violence against children:* This is a multi-disciplinary (social workers, police, teachers, nurses and traditional leadership) platform that can help identify cases. The Child Protection Training Manual developed in 2017 by a PEPFAR supported IP through the support of the European Union and adopted by GoB has been successful in capacitating committees to identify and respond to cases at district level. The content of the manual includes how to identify sexual violence cases and link them to the relevant services. The manual/curriculum will be used to train these committees to ensure they are well equipped to identify cases and make referrals. There might be a need to review the manual and update with current data as well as ensure there is service directory attached to the manual to make service referrals easier.
- *In some select SNUs, OVC providers have developed a program called “Grannies Group”.* The role of the group is to protect girls against sexual violence. The grannies were trained on gender-based violence (GBV) and the Children’s Act of 2009. Baylor trained the grannies on basic aspects of HIV including the relationship between HIV and GBV. They are active in raising awareness about sexual violence and identifying cases of sexual violence and making the necessary referrals for services. They have also been trained in economic empowerment. The program will cascade this model into other SNUs in order to have more groups that are acting as eyes and ears of their communities.
- *Using the FCI platform to identify cases of sexual violence.* The OVC program is currently using the SVAC 101 toolkit provided by OGAC for COP19 implementation of the justice for children section of FCI. This work will continue in COP20 where different faith community leaders are trained on violence against children to raise their awareness and they are also provided the necessary technical assistance and support to identify

cases and refer them for services. The FCI platform will also be used to identify children of HIV positive mothers who need to be referred for HIV testing services.

- *Close collaboration with DREAMS Post-GBV clinical providers:* The post GBV clinical providers are another source for identifying cases of sexual violence against children. Close partnerships with these providers will be established.

To accommodate the new emphasis on reaching these prioritized sub-populations, the PEPFAR/B OVC program has started engaging with the IPs to do a thorough analysis of the current beneficiary list, determine the number of those who meet the prioritized sub-populations and develop and implement a proper, responsible and sensitive transition process for all the beneficiaries that do not meet the current focus sub-populations. This will be done in order to create room to enroll new beneficiaries. Enrollment of new beneficiaries will align with the maintenance phase of the program so that the program enrolls only numbers that we can adequately maintain and support with the available resources. This process will be conducted in close collaboration with the GoB relevant ministries.

Preventive Service Delivery Programming Model

Over the past three years, the PEPFAR/B OVC program continued to shift focus to the 9-14-year-old group for both boys and girls, targeting them with primary prevention of sexual violence and HIV. The focus started during COP17 implementation in the two DREAMS SNUs where PEPFAR/B was implementing both DREAMS and OVC. The program has since been extended to non-DREAMS SNUs and this will continue in COP20. These services specifically target adolescents who are deemed to have not started engaging in risky behavior and the program equips them with the necessary skills to prevent sexual violence (either as perpetrators or victims), prevention acquisition of HIV for those that are HIV negative and prevent spreading of HIV for those already infected. Implementation is done through schools as most of the 9-14-year old are in school. This therefore requires close coordination and collaboration with the Ministry of Basic Education (MoBE).

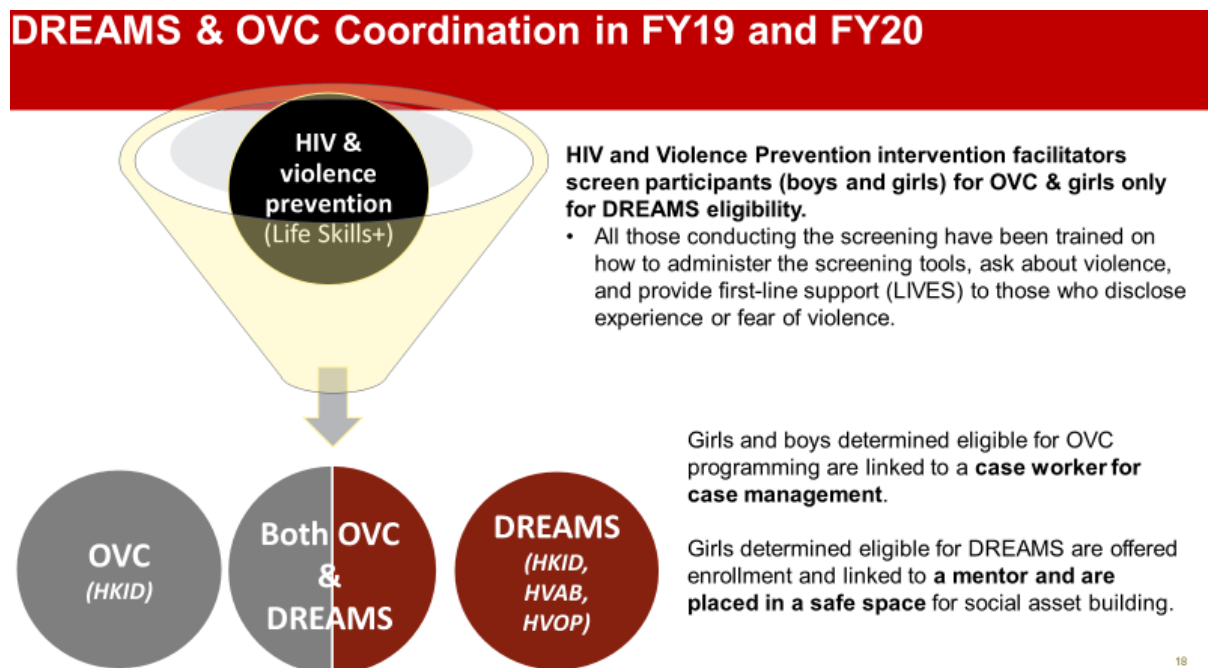
Implementing partners work in partnership with the guidance and counseling teachers to deliver the lessons or modules in the agreed upon curriculum following a pre-determined schedule with some lessons/modules delivered by the IPs while others are delivered by the teachers. The schedule is heavily dependent on the school calendar and as a result, there are times when the IPs may go for extended periods without delivering any lessons if schools are closed or learners are taking examinations. Currently there are two curricula that are being used and will continue in COP20: LIFESKILLS+ by USAID IPs and Grassroots Soccer by Peace Corps Volunteers. These curricula are used in both the DREAMS and non-DREAMS SNUs.

Through OVC and DREAMS platforms, parents of 9-14-year olds are also being reached through parenting programs in order to help parents develop the necessary skills to engage in healthy relationships that promote honest and open conversations. In COP20, the OVC platform will continue to leverage the FCI platform built in COP19 to expand work with this targeted age group. The work will involve expanding evidence based primary prevention of sexual violence and HIV targeting faith and traditional leaders with SASA! faith, Coaching Boys into Men, Faith

Matters (from Families Matters Program) in all the SNUs where OVC and DREAMS programs are implemented. The work with FCI will also include providing faith communities with technical assistance to implement child safe-guarding policies for their own organizations.

OVC/DREAMS Service Delivery Model

During the past two years, the OVC and DREAMS programs have established close operational relationships. The below table summarizes this relationship well using the HIV & violence prevention platform as an example, showing the importance of having a strong coordination between the two programs.



Current joint implementation between OVC and DREAMS is less complex as we have the same IP doing both work in the 2 DREAMS SNUs. However, with the COP20 expansion of DREAMS into six more SNUs and new IPs doing DREAMS work, it will become very important to set up coordination mechanisms between the different players to streamline implementation and tighten on coordination. This will include:

- Systematic referral processes to ensure there are bi-directional referrals taking place from both platforms
- SOPs defining warm hand-over processes for when a client is referred from one IP to another
- Formalized coordination meetings to discuss referrals, M&E issues and service provision

COP20 implementation will also see the OVC program continuing to work on the FCI platform to advance interventions/activities started under the Justice for Children program. Some of the activities envisaged for implementation in COP20 include:

- Modifying the safe space guide for DREAMS to include issues of faith as appropriate
- Revising the Comprehensive Sexuality Education (CSE) aspects of the program in partnership with UNESCO to ensure the context is faith sensitive
- Rolling out Coaching Boys into Men program
- Rolling out IMPower program with school going pupils
- SASA! Faith to mobilize communities of faith
- SVAC 101 tool developed by OGAC to continue being used in COP20 in different SNUs. The tool has been excellent in raising awareness and increasing buy in for the OVC work within the faith sector.

In doing all this work, the OVC program will ensure that critical partnerships with the relevant GoB ministries and departments are maintained and are continually updated on work being done at district level.

4.3.1. b Prevention: DREAMS programming with AGYW

PEPFAR/B has been implementing the DREAMS program for the past three years in two SNU's in partnership with the GoB. DREAMS Botswana is coordinated through a National DREAMS Coordination Unit based at the NAHPA. This is a unit of three people: a DREAMS Coordinator and two DREAMS M&E Specialists. The unit provides oversight and coordination for the national DREAMS program with regular district coordination meetings and quarterly national coordination meetings. Additionally, the M&E Specialists engage frequently with the DREAMS implementing partners on data-related matters to ensure timely collection, cleaning and reporting of DREAMS data. The GoB's coordination role will continue in COP20, ensuring there are district consultations with the relevant GoB ministries and departments, CSOs, Global Fund, UNICEF, and other partners ahead of COP20 implementation. AGYW-focused programming is currently a political priority for Botswana. The First Lady of the country has been appointed the UNAIDS Special Ambassador for Youth Empowerment, and DREAMS' objectives and activities are aligned with her initiatives. This provides PEPFAR/B with a unique opportunity for collaboration. Existing SOPs outlining partnerships, coordination, and collaboration will be revised with implementing partners, PEPFAR/B, and the GoB DREAMS National Coordination Office to take advantage of this opportunity as well facilitate the expansion to the six new SNUs in COP20.

DREAMS Botswana implements an OGAC approved standardized package of interventions which are categorized into primary, secondary and contextual services as well as different age groups (refer to Table 4.3.2 -DREAMS Package of Interventions). The different interventions within the package contribute to the following PEPFAR MER Indicators: OVC_SERV, PP_PREV, PrEP_NEW, PrEP_CURR etc., and ultimately AGYW_PREV, the indicator that tracks layering of services for all AGYW enrolled in the DREAMS program with specific focus on completion of the primary package (+secondary) of interventions. Furthermore, the team has committed to ensuring that all partners collaborate and coordinate efforts to report their performance, share

key lessons, and accurately track activities to document appropriate layering. The core focus of the DREAMS program has been to recruit, enroll and retain AGYW at risk and ensure that beneficiaries receive all the relevant services specific to their age cohort as per PEPFAR/B DREAMS layering table. Recruitment and enrollment in DREAMS has been largely guided by the eligibility screening criteria that the DREAMS Botswana program has developed in partnership with the GoB. Since in COP20 OGAC has prescribed eligibility criteria, following COP submission, the PEPFAR/B team will engage with the GoB DREAMS Coordination Unit and Implementing Partners to review and adapt the current eligibility criteria based on the COP20 Guidance.

Table 4.3.2 DREAMS Package of Interventions (COP20 Updated Layering Table)

| | | 9-14 | 15-19 | 20-24 |
|--------------------|---|--|---|---|
| INDIVIDUAL | Primary Individual Interventions | <ul style="list-style-type: none"> HIV & violence prevention Social asset building Screening for HTS eligibility | <ul style="list-style-type: none"> HIV & violence prevention Social asset building Condom promotion & Distribution Screening for HTS eligibility | <ul style="list-style-type: none"> HIV & violence prevention Social asset building Condom promotion & Distribution Combination socio-economic approaches Screening for HTS eligibility |
| | Secondary Individual Interventions | <ul style="list-style-type: none"> Risk-based HTS Condom Education Post-violence care Contraceptive mix | <ul style="list-style-type: none"> Risk-based HTS Post-violence care Contraceptive mix PrEP (age 18 and above) Combination socio-economic approaches | <ul style="list-style-type: none"> Risk-based HTS Post-violence care Contraceptive mix PrEP |
| | Services Referred for | | | |
| | Educational support, National registration, Legal protection and services, Child protection, Substance abuse rehabilitation | | | |
| | Range Individual Level Interventions including services referred for | 3-12 | 4-14 | 5-12 |
| DREAMS SNUs | | | | |
| CONTEXTUAL | Contextual Level Interventions | <ul style="list-style-type: none"> Parenting/caregiver programming Household economic strengthening Community mobilization and norms change Reducing risk of sex partners (link to HTS, VMMC, Treatment) | | |
| | Total Contextual Level Interventions | 4 | | |

In line with the COP19 MPR to develop a national DREAMS M&E system, PEPFAR/B hosted a Health Information Systems TDY from USAID HQ to do an initial assessment of the current situation. The TDY team found that i) current IPs implementing DREAMS had different DHIS2 systems that were not communicating with each other and ii) the program needed an M&E system at the national DREAMS Coordination Unit. The TDY team recommended that as a first step of developing a national DREAMS M&E system, all IPs upgrade their respective systems to ensure interface capability before embarking on the national system. This initial step is almost complete as DREAMS IPs have harmonized and aligned their digital systems to track layering across partners through regular system development check-ins, shared system documentation, shared data mapping and historic data import. All IPs will report using the DHIS2 database starting in FY20 Q2. The next phase involves the setup of the national DREAMS M&E system, which is underway and will be completed by COP19 APR. PEPFAR/B will continue to support the maintenance and provide technical support to GoB to ensure successful transfer of the system as well as the integration of the 6 new SNU in COP20.

PEPFAR/B's COP20 DREAMS program has been approved to expand to six more SNUs as indicated in the PLL: Bobirwa, Kgatleng, Mahalapye, North East, Serowe and Southern (Table 4.3.3). It is important to note that these districts are different from the ones that were listed in the PLL. The PLL included Boteti, Francistown, Palapye, and Selibe-Phikwe. PEPFAR/B could not expand to these districts as either Global Fund or UNICEF already have a presence in these districts doing similar work. The selected DREAMS districts have the highest risk of incidence (1-1.36%) in Botswana according to 2019 UNAIDS Spectrum model estimates, with an estimated average of 1,000 new infections per year (districts ranged from 150 to 530 new infections). The DREAMS districts also rank among the highest pregnancy rates among 15-24-year old, ranging from 14-17 percent in FY 2018.




Table 4.3.3: DREAMS COP20 SNUs

| DREAMS SNU | AGYW Incidence | Total PLHIV |
|-----------------------|----------------|-------------|
| Bobirwa District | 1.30 | 20,713 |
| Gaborone District | 0.72 | 45,362 |
| Kgatlung District | 0.86 | 15,804 |
| Kweneng East District | 0.93 | 54,521 |
| Mahalapye District | 1.19 | 29,638 |
| North East District | 1.18 | 12,088 |
| Serowe District | 1.16 | 11,218 |
| Southern District | 0.61 | 12,825 |

Figure 4.3.1 DREAMS EXPANSION

COP20 DREAMS Interagency Collaboration for Geographic Expansion

Cross-cutting: GOB National DREAMS Coordination Office & PEPFAR DREAMS Coordinator

| | | |
|--|---|--|
|  <p>2 ORIGINAL Districts</p> <ul style="list-style-type: none"> Will continue to provide primary community-based Interventions (<i>Life Skills+ and Safe Space Guide</i>); <i>ReadyToWork, Aflateen etc.</i> Will continue to provide secondary clinical services Will continue to provide contextual community-based interventions (<i>SASA! and Sinovuyo</i>) <p>6 NEW Districts</p> <ul style="list-style-type: none"> Will provide contextual community-based interventions (<i>SASA!, SASA! Faith, and Sinovuyo</i>) <p>3 NEW Districts (Kgatleng, Mahalapye, Southern)</p> <ul style="list-style-type: none"> Will provide primary community-based Interventions (<i>Life Skills+ and Safe Space Guide</i>) Will hire 4 DREAMS Ambassadors to work at the district level |  <p>2 ORIGINAL Districts</p> <ul style="list-style-type: none"> Will continue to provide secondary clinical services. <p>6 NEW Districts</p> <ul style="list-style-type: none"> Will provide secondary clinical services. <p>3 NEW Districts (Bobirwa, Serowe, North East)</p> <ul style="list-style-type: none"> Will provide primary community-based interventions (<i>i.e. Lifeskills+, IMPower, Aflateen</i>) Will hire 4 DREAMS Ambassadors to work at the district level |  <p>6 NEW Districts</p> <ul style="list-style-type: none"> Engage 46 Volunteers strategically placed to : <ul style="list-style-type: none"> Support implementation by partnering with USAID, CDC, and other district stakeholders. Support DREAMS referral, linkage, and tracing clinical services. provide primary community-based interventions in some of the expansion SNU's (<i>Grassroots Soccer, Aflateen</i>). Provide the contextual community-based intervention; Community Mobilization and Norms Change at some of the expansion SNU's (<i>SASA!</i>) Support the DREAMS Ambassadors at the district level |
|--|---|--|

Partnership with schools, communities, community leaders, and faith-based groups will provide additional opportunities to expand DREAMS services to rural areas with limited resources but high HIV disease burden. A key component in COP20 will be strengthening multi-stakeholder partnerships to ensure active linkage of DREAMS beneficiaries to appropriate services and ensure services are delivered with quality and fidelity. Evidence-based curricula and comprehensive approaches will be utilized for the primary and contextual interventions to ensure services are client and family focused (refer to Table 4.3.4).

- Primary Individual Interventions:** PEPFAR/B's DREAMS program is designed as an interagency collaboration, building on COP 19 lessons to reach the most vulnerable AGYW. S/GAC approved curricula will be used to ensure provision of HIV and violence prevention to all age-groups as per the layering table. OU will use the following curricula for these interventions; LIFESKILLS+, IMPower and Grassroots Soccer. Social asset building sessions will be provided through safe spaces for in-and-out of school AGYW. All this is done to empower recipients/beneficiaries to reduce their risk of acquiring HIV. Economic strengthening interventions will be implemented to provide necessary skills to promote self-sufficiency and resilience to overcome economic disparity. All these services are provided by trained personnel (facilitators and mentors) who receive continuous training and mentoring to ensure provision of high-quality services. Mentors continue to play a pivotal role in linkage and retention of AGYW in the program; making sure they receive the primary, secondary and contextual services they need.
- Secondary Clinical Interventions:** In COP20 PEPFAR/B will continue to implement DREAMS clinical services with fidelity as part of secondary package to promote prevention among the AGYW at risk of acquiring HIV. The clinical package entails Pre-Exposure Prophylaxis (PrEP), Post Gender Based Violence (GBV) clinical care services

that include Post Exposure Prophylaxis (PEP), STI screening and treatment, risk screening HTS, and contraceptive methods mix which will be provided at the community-level through clinical platforms that include Tebelopele Wellness Centers (Gaborone and Kweneng East) and youth friendly public health facilities and community platforms (through the CSOs implementing DREAMS) in all eight districts. Clinical sites will be capacitated to deliver youth friendly services and sites that have dedicated youth friendly centers will be strengthened to increase opportunities to identify the most vulnerable AGYW as potential DREAMS beneficiaries.

- ***Contextual community-based interventions:*** PEPFAR/B will implement the community mobilization and norms change in all the eight SNU. SASA! will be used for reaching communities and ensuring that GBV and HIV issues are discussed. Furthermore, parents and caregivers of DREAMS beneficiaries will be reached to discuss issues surrounding HIV, child-parent communication as well as building their skills to support AGYW through the *Sinovuyo* curriculum. Household economic strengthening interventions will also be implemented as part of the contextual interventions. PEPFAR/B is reviewing approved curriculum and receiving guidance from S/GAC ISMEs on the appropriate curriculum for older age cohorts.

Completion of the DREAMS primary interventions and secondary interventions is critical if we are to make an impact in the lives of DREAMS beneficiaries. We need to reach an increased number of AGYW in COP20 in order to work towards 75% saturation in the DREAMS implementation SNU. See Table 4.3.5 for the estimated number to achieve saturation across age bands and SNU.

Table 4.3.5 DREAMS Saturation Estimates Across Age Bands and SNUs

| PSNU | Age | Sex | Estimated Population 10-24 females | Estimated PLHIV 10-24 females | Est. PLHIV who know their status 10-24 Females | Estimated HIV Prevalence (%) | Estimated individuals receiving ART 10-24 females | Est. PLHIV on ART & virally suppressed | Estimated Population 10-24 females | Estimated HIV NEGATIVES 10-24 females | AGYW AT RISK (Vulnerability with the highest risk to the nearest 10) | SATURATION (75%) |
|--|-------|--------|------------------------------------|-------------------------------|--|------------------------------|---|--|------------------------------------|---------------------------------------|--|------------------|
| | | | 175,362 | 10,157 | 8,697 | | 6,960 | 6,195 | 175,362 | 165,205 | 75,419 | 56,564 |
| Bobirwa District [#SNU] [gGqaAXuUGpb] | 10-14 | Female | 4,722 | 158 | 88 | 3.34% | 70 | 27 | 4,722 | 4,564 | 1,417 | 1062 |
| Bobirwa District [#SNU] [gGqaAXuUGpb] | 15-19 | Female | 4,297 | 292 | 265 | 6.79% | 122 | 116 | 4,297 | 4,005 | 1,719 | 1289 |
| Bobirwa District [#SNU] [gGqaAXuUGpb] | 20-24 | Female | 4,375 | 591 | 537 | 13.51% | 295 | 280 | 4,375 | 3,784 | 2,625 | 1969 |
| Gaborone District [#SNU] [VB7am4futjm] | 10-14 | Female | 17,620 | 345 | 193 | 1.96% | 228 | 87 | 17,620 | 17,275 | 5,286 | 3965 |
| Gaborone District [#SNU] [VB7am4futjm] | 15-19 | Female | 16,033 | 639 | 581 | 3.99% | 711 | 675 | 16,033 | 15,394 | 6,413 | 4810 |
| Gaborone District [#SNU] [VB7am4futjm] | 20-24 | Female | 16,325 | 1,295 | 1,177 | 7.93% | 1,720 | 1,634 | 16,325 | 15,030 | 9,795 | 7346 |
| Kgatleng District [#SNU] [yNcvm7JYBfi] | 10-14 | Female | 5,201 | 120 | 67 | 2.31% | 46 | 17 | 5,201 | 5,081 | 1,560 | 1170 |
| Kgatleng District [#SNU] [yNcvm7JYBfi] | 15-19 | Female | 4,733 | 223 | 203 | 4.70% | 138 | 131 | 4,733 | 4,510 | 1,893 | 1420 |
| Kgatleng District [#SNU] [yNcvm7JYBfi] | 20-24 | Female | 4,819 | 451 | 410 | 9.36% | 334 | 317 | 4,819 | 4,368 | 2,891 | 2169 |
| Kweneng East District [#SNU] [Uz8LWtCovYF] | 10-14 | Female | 16,736 | 415 | 232 | 2.48% | 92 | 35 | 16,736 | 16,321 | 5,021 | 3766 |
| Kweneng East District [#SNU] [Uz8LWtCovYF] | 15-19 | Female | 15,228 | 768 | 698 | 5.04% | 247 | 235 | 15,228 | 14,460 | 6,091 | 4568 |
| Kweneng East District [#SNU] [Uz8LWtCovYF] | 20-24 | Female | 15,506 | 1,556 | 1,414 | 10.04% | 598 | 568 | 15,506 | 13,950 | 9,304 | 6978 |
| Mahalapye District [#SNU] [iY69BUSqcnC] | 10-14 | Female | 7,282 | 226 | 127 | 3.10% | 105 | 40 | 7,282 | 7,056 | 2,185 | 1638 |
| Mahalapye District [#SNU] [iY69BUSqcnC] | 15-19 | Female | 6,626 | 417 | 379 | 6.30% | 251 | 238 | 6,626 | 6,209 | 2,650 | 1988 |
| Mahalapye District [#SNU] [iY69BUSqcnC] | 20-24 | Female | 6,747 | 846 | 769 | 12.54% | 609 | 579 | 6,747 | 5,901 | 4,048 | 3036 |
| North East District [#SNU] [nszh0FzynaQ] | 10-14 | Female | 3,004 | 92 | 52 | 3.06% | 36 | 14 | 3,004 | 2,912 | 901 | 676 |
| North East District [#SNU] [nszh0FzynaQ] | 15-19 | Female | 2,733 | 170 | 155 | 6.23% | 80 | 76 | 2,733 | 2,563 | 1,093 | 820 |
| North East District [#SNU] [nszh0FzynaQ] | 20-24 | Female | 2,783 | 345 | 314 | 12.40% | 194 | 184 | 2,783 | 2,438 | 1,670 | 1252 |
| Serowe District [#SNU] [YmeyoDakwFX] | 10-14 | Female | 2,833 | 85 | 48 | 3.01% | 103 | 39 | 2,833 | 2,748 | 850 | 637 |
| Serowe District [#SNU] [YmeyoDakwFX] | 15-19 | Female | 2,578 | 158 | 144 | 6.13% | 177 | 168 | 2,578 | 2,420 | 1,031 | 773 |
| Serowe District [#SNU] [YmeyoDakwFX] | 20-24 | Female | 2,625 | 320 | 291 | 12.20% | 428 | 407 | 2,625 | 2,305 | 1,575 | 1181 |
| Southern District [#SNU] [LEUjALXInGD] | 10-14 | Female | 4,427 | 98 | 55 | 2.20% | 51 | 19 | 4,427 | 4,329 | 1,328 | 996 |
| Southern District [#SNU] [LEUjALXInGD] | 15-19 | Female | 4,028 | 181 | 165 | 4.49% | 95 | 90 | 4,028 | 3,847 | 1,611 | 1208 |
| Southern District [#SNU] [LEUjALXInGD] | 20-24 | Female | 4,101 | 366 | 333 | 8.93% | 230 | 219 | 4,101 | 3,735 | 2,461 | 1845 |

Assumptions: 1) Population estimates based on UNAIDS Spectrum Estimates Datapack COP 20; 2) Populations at elevated risk of HIV infections by age group: 10-14 yrs = 24%; 15-19 yrs = 37%; 20-24 yrs = 53%. Data source BYRBSS (2016) and BVACs (2019). These are the risk estimates used for COP 20; 3) Saturation rate set at 75% of AGYW at risk.

To achieve saturation, PEPFAR/B will build on lessons learned from COPs 18 and 19 and expand best practices. For example:

- *Strengthen and increase bi-directional referrals between the DREAMS community and clinical partners:* Effective and successful bi-directional referrals continue to be a challenge between DREAMS community and clinical partners. PEPFAR/B is working with IPs to ensure there is a clear system in place to initiate and follow up on referrals between community and clinical partners. The current system is a DREAMS referral system (paper-based) where a client takes the referral form to the next DREAMS service provider. The initiating service provider remains with a copy to enable a follow up to ensure the referral has been completed. Follow ups are made with the partners and places the clients were referred to, as well as following up directly with the clients to ensure they received the service. Additionally, to ensure that bi-directional referrals are being made and completed, M&E teams meet bi-weekly to review data, including referrals for services and determine corrective actions if necessary. One weakness from previous implementation that contributed to poor bi-directional referrals was that the referring organization did not correctly capture the contact details of the person being referred. PEPFAR/B is working with IPs to ensure this is addressed now in COP19 and in COP20.
- *Convene service days whereby clinical services will be brought to safe spaces:* Service days are important in bringing service providers closer to the beneficiaries. Since safe spaces are a place that brings AGYW together, the idea is to have the clinical partner coming to venues where safe spaces are held and providing the needed clinical services on-site. This model ensures that beneficiaries are not always moving from one service provider to another, something that can negatively affect retention in the program. This initiative was introduced in COP18 and will be expanded in COP20. Service days are also a strategy to increase bi-directional referrals between the clinical and community service providers.
- *Identify PrEP champions who will visit safe spaces and speak to AGYW about the benefits of PrEP, what taking PrEP is like, how to access PrEP, etc.:* PrEP is a new intervention in the Botswana HIV prevention landscape. Some AGYW have refused to take the pill after realizing that it is also an anti-retroviral drug demonstrating a lack of understanding of what it is and how it works. Identifying PrEP champions and bringing them to safe spaces to educate and share experiences on the benefits of PrEP is helping to increase uptake of and even adherence to PrEP. This will be expanded in COP20. Safe spaces will also serve as a PrEP adherence platform for AGYW, providing group-based support to DREAMS participants on PrEP.
- *Identify AGYW GBV survivors who are willing to share their experiences with DREAMS participants in safe spaces:* The Botswana National Relationship study conducted by Ministry of Nationality, Immigration, and Gender Affairs in 2018 indicated that 37% of women reported experiencing some form of GBV in their lifetime including intimate

partner violence (IPV). These figures illustrate the need to educate individuals, families, and communities on GBV, human rights, and GBV response services, as well as use innovative means to identify GBV survivors and assist them in accessing both clinical and non-clinical GBV response services. Finding GBV survivors who are open about their situations and willing to share their experiences in safe spaces is one method of encouraging AGYW to disclose experience and/or fear of violence and seek help. Current activities such as training safe space mentors and facilitators to appropriately respond to disclosure of violence, supporting clinical post-violence care services, and working with the GoB to develop SOPs for GBV case management will help position service providers to respond better to GBV cases.

- *Increase reach of out of school AGYW with combination socio-economic approaches:* One of the challenges facing PEPFAR/B is retaining women between the ages of 20-24 in the program. In working towards understanding their issues especially on what is holding them back from completing the program, we learned that the AGYW's most immediate need includes finding jobs, doing something meaningful or engaging in an income generating activity. During COP19 implementation, PEPFAR responded by revising how safe spaces and economic strengthening platforms are run for this age group. Initially, the AGYW were taken via a weeklong course on *ReadyToWork* followed by placements for job shadowing etc. It became clear that once this aspect was completed, the AGYW were not returning to the program to complete the social asset building part, which is also a critical component of their lives. The program has since re-packaged these two components such that implementation is done in a parallel manner so that completion of one result in completion of the other. The program continues to monitor this new development. If there are positive results yielded, the model will be expanded to COP20 implementation. The program will also continue linking the AGYW to other existing platforms and opportunities in the GoB and other parastatals such as the Citizen Entrepreneurial Development Agency (CEDA) and the Local Enterprise Authority (LEA). These organizations offer opportunities for young people to start small businesses and can also offer the AGYW technical assistance to develop business proposals. Additionally, PEPFAR/B will also expand the current *WE GROW* methodology to reach more AGYW. *WE GROW* is a savings and loans program that also covers basic business skills to assist beneficiaries to start and improve income generating programs. The *WE GROW* has traditionally targeted parents and caregivers in the OVC program, however, it is gradually being introduced in the DREAMS program as well targeting older AGYW. PEPFAR/B will continue engagement with the Botswana AGYW ISME team on how to strengthen this part of the program, especially considering new COP20 guidance.
- *Intensify DREAMS partner management through bi-weekly DREAMS M&E check-ins:* M&E is a critical piece in DREAMS. Having a strong DREAMS M&E system to track completion of primary services & number of secondary services accessed, layering, and progress against targets is important to monitor the successes and challenges as DREAMS implementation expands. In addition, a robust M&E system will give

stakeholders an opportunity to review data, identify gaps and collaborate on identifying and implementing solutions. The M&E system currently under development in COP 19 will be expanded in COP20 to facilitate and strengthen partner collaboration based on access to reliable data.

The key strategies that will be used to recruit and retain AGYW:

- *Optimize entry points:* Existing service delivery platforms (i.e. ANC, FP, HTS, STI, etc.) will be prioritized to recruit AGYW into DREAMS programs. Furthermore, community mobilization activities by PrEP ambassadors, AGYW volunteers, community health workers (CHWs) and the screening of AGYW accessing other clinical services at the facility will also be leveraged in recruiting more AGYW into the program. Inter-IP referrals will be strengthened to ensure beneficiaries within safe spaces receive appropriate layering services. Other strategies currently used that will be expanded include hotspot mapping and social network tracing of AGYW on PrEP, especially for the FSW. Additionally, DREAMS platforms will leverage the FCI to reach out to more vulnerable AGYW.
- *Development of DREAMS Villages (girl-only spaces exclusive for DREAMS participants):* The AGYW Village will have dedicated computers to be used by AGYW offering an opportunity to print out business plans and go online to research professional opportunities. The room will have cellphone charging bays where AGYW can utilize the resources allowing them to join virtual safe spaces. Within the same structure, space will be reserved for facilitating safe spaces by mentors. The IPs will manage an information desk to screen and link AGYW to mentors running safe spaces and to health care providers for clinical services.
- *Use of Social Media and Radio:* Facebook and WhatsApp are very popular among AGYW in Botswana. There is an opportunity to leverage the 80% social media penetration in Gaborone and the 48% penetration in Kweneng East to reach at-risk AGYW. WhatsApp will also be used for virtual safe spaces to reach and retain highly mobile 20-24-year olds. Radio is one of the most popular ways to reach AGYW, their peers, their parents/caregivers, and their communities in Botswana hence it will be fully utilized through the already available slots where AGYW discuss topics of importance and share experiences of being part of the DREAMS movement in Botswana.
- *Demand Creation:* In COP20 PEPFAR/B will intensify communications efforts targeted at AGYW through engagement of multi-media platforms such as Television, print media, social media and radio to raise awareness about DREAMS. Furthermore, IPs will continue to promote the national DREAMS Botswana Facebook page as well as the “Cookie Jar” which is a Facebook page managed by AGYW where they share experiences and support each other to stay safe from HIV as well as creating demand for the DREAMS program. AGYW identified through the Cookie Jar and eligible to be enrolled into DREAMS will be linked to the appropriate services. Other social media platforms

like WhatsApp will be explored to reach out-of-school AGYW who will be linked to a mentor for social asset building, and other primary DREAMS services as per the layering table.

- *Strengthening the socio-economic approach:* IP's will utilize the socio-economic component of DREAMS as an entry point for older girls and continue to incorporate the social asset building component. These two will take place simultaneously to ensure that both skills are built at the same time. The interventions will expand to reach young Female Sex Workers and ensure that they remain in the program to reduce their risk of HIV infection. PEPFAR/B will strengthen collaboration with the government and the private sector as the potential employers and business funders of DREAMS beneficiaries. Qualified and older DREAMS beneficiaries will be given an opportunity to work as DREAMS Ambassadors at District level.

PEPFAR/B will continue to ensure provision of comprehensive and age-appropriate clinical post-GBV care that meet the expressed needs of survivors. These will include: 1) basic counseling that comprises elements of first line support, 2) treatment of injuries; 3) STI screening and treatment; 4) rapid HIV testing and counseling services and referrals to care and treatment as needed; 5) post exposure prophylaxis (PEP) for sexual exposures within 72 hours; 6) emergency contraceptives within 120 hours; and 7) provision of or active linkage to services, including the Botswana Police Service, legal support, shelter, community leaders, Social and Community Development Officers, child protection and MoBE officials. In ensuring that the OU responds to reports of violence amongst the DREAMS beneficiaries, all personnel interacting with AGYW at community or facility will be trained to offer First Line Support and link survivors to GBV response services at both community and facility. Bi-directional referrals in this regard will be emphasized to ensure that any IP inquiring or receiving a disclosure of abuse can appropriately respond. Tools for screening GBV will be utilized in all the SNUs and data will be monitored to ensure that services are received and completed by survivors. The DREAMS clinical sites will offer the minimum package for post violence clinical care to all survivors of GBV and ensure screening for IPV is conducted for all those eligible to receive PrEP.

In COP20, PEPFAR/B will continue to implement PrEP in highly HIV prevalent areas and target to young women at the greatest risk. The program will continue to provide risk reduction education and condoms, and beneficiaries will receive at least monthly supportive services to identify and address sources of risk. AGYW eligible for PrEP will undergo clinical and laboratory examinations (renal function tests, Hepatitis B) before initiation on PrEP. AGYW will be supported to adhere to PrEP through ongoing counselling and use of PrEP case managers and PrEP Ambassadors. HIV testing for PrEP clients will be repeated every three months and PrEP will be provided in accordance with the national guidelines. DREAMS will expand PrEP services to include pregnant and breastfeeding AGYW. This shift is also expected to increase the number of AGYW identified at ANC who will benefit from DREAMS. PrEP services will be expanded to all DREAMS districts and offered through community and facility mechanisms. As PrEP continues to evolve, more efforts will be made to ensure that the right messaging reaches the most at-risk groups and PrEP support groups are established to normalize the use of PrEP.

Similarly, the post violence care services, especially the use of and availability of PEP will be promoted on AGYW platforms. Capacity building for clinicians on HIV prevention interventions will continue to be provided to ensure a client-centered service delivery across all facilities. PEPFAR/B will shift from emphasis on youth friendly clinics to youth friendly services across the cascade. This means extensive engagement of clinicians in all DREAMS SNU to ensure that facilities provide youth friendly services.

PEPFAR/B is also set to address the following additional Minimum Program Requirements:

- Recruit a full time PEPFAR based DREAMS Coordinator who will be responsible for providing oversight of the DREAMS program and work closely with the USG implementing agencies and the GoB DREAMS national coordination office.
- Recruit eight DREAMS ambassadors for placement across the SNU to support coordination and oversight at district-level. The PEPFAR/B will develop position descriptions to outline standardized qualification criteria.
- Recruit and hire a full time DREAMS HIV Coordinator at Peace Corps to support volunteers.
- Ensure full district coverage in all eight SNU, by partnering with schools, CSO, clinical partners and relevant government departments, such as, Ministries of Youth Sports and Culture, Agriculture and the private sector.

Monitoring and Accountability:

DREAMS IPs are managed with consistent oversight from the U.S. Government and the GoB, with regular district level coordination meetings and quarterly national coordination meetings, where results and lessons learned are shared. Monthly or bi-monthly field visits from PEPFAR staff will hold partners accountable for coordination and active bi-directional referrals.

4.3.2 Prevention: PMTCT

PEPFAR/B will continue to support the most effective PMTCT program possible by ensuring that women and their children have access to care, treatment and support in order to prevent HIV. These services include antenatal services and HIV testing during/post pregnancy; use of ART by pregnant women living with HIV; and infant HIV testing and other post-natal healthcare services. The program will continue to use both facility and community interventions to ensure these women and their infants receive the services they need.

Retaining mothers in ART programs and keeping them virally suppressed is critical to preventing mother-to-child transmission of HIV, particularly in the breastfeeding period when most of infant HIV acquisition occurs. While HIV testing and ART rates are relatively high, EID requires significant strengthening. Thus, PEPFAR/B will provide support for EID and viral load optimization. The program will work to strengthen post-analytic EID and VL results return and turn-around-time in the districts. The main strategy for ensuring this work is done including working with the VL/EID Champions who are based in the health facility as well as Community Health Workers (CHWs) based at community level. These cadres will work closely together in a collaborative manner to ensure the missing children identified in the facility are traced in the community and brought back to care.

The VL/EID Champions are qualified PMTCT lay counsellors/Health Care Assistants (HCA) who are deployed at facility level in all districts to help track viral load and EID results between the facilities and HIV laboratories. The VL/EID Champions will coordinate with CWC (Child Welfare Clinics) and Immunization clinics within the facility to track the missing children and refer them to community health workers to trace the children. They provide support at the laboratory-clinic interface to track and provide follow-up for HIV services provided to HIV-exposed infants. In addition, the VL/EID champions ensure that 1) VL test results are returned in a timely manner from labs to clinics, with priority given to 'high' VL results (because they require a clinical intervention) and pregnant and breastfeeding women (because of the short window of time to make an intervention that is effective), 2) ensure clinicians act on the results by making a clinical intervention (such as altering drug regimen) with patients if VL is high.

In terms of CHW's, their role includes 1) generating lists of index partners and children needed to return to the health facility for testing; 2) tracking and tracing women and their children in the community and supporting them to return to the health facility; 3) providing education and counseling to the women on the need to continue accessing services; and 4) providing support for adherence. Through community based IPs, PEPFAR/B will continue to assess all pregnant women supported in community HIV care programs to determine if they are registered for antenatal care and PMTCT services. Women not registered for PMTCT will be linked to PMTCT services. All women supported under community HIV care are assessed to determine if they delivered a baby in the last 12 months to ascertain if the HIV exposed infants (HEI) ever tested for HIV. Babies that have not been tested for HIV are linked to facilities for EID, and the outcomes are documented. All pregnant women under community care receive the following services: i) adherence to ART; ii) linkage of all HEI for EID after delivery, and iii) linkage of breastfeeding mothers to HIV testing every three months. PEPFAR/B will continue to strengthen facility- community collaboration to enable timely identification of infants that are not tested or have not received their results to support EID, final infant diagnosis (FID) and ART initiation for positive infants.

Furthermore, to ensure comprehensive and timely diagnosis of infants, PEPFAR/B will consider using POC testing to complement laboratory-based platforms in support of IVT and VL testing in pregnant and breastfeeding women. This will be implemented after the laboratory optimization exercise. To fight incident infections in pregnancy and breastfeeding PEPFAR/B will provide PrEP services to Pregnant and breastfeeding women (PBFW). This population has been shown to be at 3-4 times higher risk of incident HIV infections when compared to their non-pregnant counterparts.

Birth cohort registers for HIV Exposed Infants (HEIs) were developed in COP18 and are being rolled out in a phased approach manner to ensure appropriate linkage to testing, care and treatment. The roll out will be finalized in COP19. Training and mentoring of health care workers caring for infants and children with HIV exposure or infection will continue in FY21 to ensure that the children of PLHIV in care and newly diagnosed including siblings of these patients have also been evaluated for HIV infection. For instance, when managing an HEI, the health care worker should recommend to the mother to have her other children tested for HIV infection, even if they appear healthy, unless there is documentation that she did not have HIV infection at the time she was pregnant with or breastfeeding those older children. In support of

the PMTCT program, PEPFAR/B will support validation of Pre-elimination of MCTC of HIV and Syphilis through training, data collection and analysis.

Health facility QI teams will also be trained to implement CQI activities that include structured gap analysis and using data to measure progress in PMTCT. CQI will develop a project to respond to specific identified gaps across the index testing cascade at ANC: 1) Number of eligible HIV positive pregnant and breastfeeding women offered index services, 2) Proportion of Index cases who accepted index testing service, 3) Number of Index case partners and children contacted and tested for HIV.

4.3.3 Prevention: Key Populations

Botswana NSF III targets key populations for interventions. The groups prioritized are female sex workers (FSWs) and men who have sex with men (MSM). PEPFAR subscribes to the NSF III objective, “To achieve over 90% HIV prevention, treatment, care and support service coverage targets among key populations by 2023.” PEPFAR/B expands the target to include transgender and children and partners of sex workers.

Many FSWs and MSMs practice behaviors which aggravate their risk of HIV infection for HIV and STI acquisition and transmission, these include multiple concurrent partnerships, alcohol use before sex, sex with both men and women, and a lack of awareness that anal sex increases HIV risk.

In COP20 a great emphasis will be made to address stigma and structural issues which keep key populations from accessing services. The KP program will establish Virtual Outreach Workers (VOWs) to find hard to reach men. The program will also use the Expanded Peer Outreach model (EPOA) to expand their reach.

The following prevention interventions will be implemented by PEPFAR/B; -

- One-stop-shop approach encompassing prevention, networking and safe space, HIV testing, treatment initiation and support for retention and viral load all at one site.
- Provision of services through outreach at mobile clinics or drop-in centers will be enhanced due to wide dispersal of hot spots as identified in 2017 size estimation survey. Hybrid Models of service where prevention done through community groups linked to integrated but KP-friendly treatment programs either operated by Tebelopele as direct service delivery or in selected government health facilities as Technical Assistance.
- PrEP program targeting the FSWs between the ages of 16 to 24 years and MSMs in the same age bracket to keep young KP negative. Ecological prevention model in DREAMS to reach HIV negative girls selling sex.
- Condoms and lubricants distribution, stigma and discrimination training for service provider and violence mitigation training, in addition to PrEP, PEPFAR/B KP program will use risk network referrals and voluntary partner referrals (VPR).
- TB screening and linking presumptive HIV positive clients.
- KP competency training including reduction in stigma and discrimination for TA model clinic staff.

- Conduct in depth interviews with MSM to understand their preference when it comes to service delivery and incorporate the changes.
- Encouragement of clients to continue to use suggestion boxes for feedback to improve quality of services.
- Increase the number of trained outreach workers in client centred approach that include client navigation and case management.
- Diversify communication channels to include peer networks (snowballing), peer led incentive-based mobilization and one to one intercept methods at hot spots.

4.3.4 Prevention: Voluntary Medical Male Circumcision (VMMC)

In COP20, PEPFAR/B will continue to support the provision of VMMC services targeting eligible males aged 15 years and above in selected districts. The program aims to circumcise a total of 10,000 males through a DSD approach using only the dorsal slit surgical technique. Given PEPFAR guidance for COP20 raising the minimum age of eligibility for VMMC to 15 years old, and reduction in VMMC funding based on past achievements in older men, the total targets are necessarily reduced. PEPFAR/B recognizes the need for this change in minimum age eligibility for client safety and is fully supportive. The PEPFAR/B VMMC program will continue to target both the civilians and the military communities.

Using estimated model which triangulates existing program data with exiting survey data and publications, the program will continue to target high burden districts with low circumcision rate in order to take them close to saturation. In COP20 PEPFAR/B will allocate more than 70% of the overall target to high burden districts with a significant gap in VMMC including Gaborone, Kgatleng, Kweneng East, and Mahalapye. The BAIS V survey is scheduled for completion during 2020 and these results will inform future geographic targeting based on MC coverage.

The PEPFAR/B VMMC program has had progressive success targeting males aged more than 15 years of age over the past 3 years and will complete the transition to circumcising only this age group by COP20. In COP18, the evidence-based human centered design strategy was introduced through a training workshop, and implementation of these Human Centered Design (HCD) principles in COP 19 is expected to improve uptake of VMMC in older men. Additional strategies planned to increase demand of older men include enhanced engagement of community and faith-based leaders, partnership/linkage with other HIV related programs such as DREAMS and Cervical Cancer and shifting focus of school campaigns to target tertiary institutions and men sector groups. The program will continue to target Military recruits and offer circumcision service after the completion of their basic training. We aim to use lessons learnt in provision of circumcision services among the military recruit to collaborate with other Uniformed forces such as the Police and Prisons to provide circumcision service among the newly enlisted members of the force.

The effectiveness of these demand creation strategies for older men will be monitored through weekly partner management to include tracking of performance before and after implementation. Partners are expected to use an iterative process based on effectiveness and audience feedback to refine demand creation activities throughout the year. Service quality and

VMMC-related adverse event prevention and management will continue to be provided by the MoHW's CQI team across all partners. The Botswana VMMC program has transitioned to reusable kits in all static facilities and during outreach activities where possible. Disposable kits remain in use during outreach activities where on-site instrument cleaning and/or sterilization are not possible due to infrastructure constraints.

Table 4.3.4.1 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

| SNU | Target Populations | Population Size Estimate (SNUs) | Current Coverage (date) | VMMC_CIRC (in FY21) | Expected Coverage (in FY21) |
|-------------------|--------------------|---------------------------------|-------------------------|---------------------|-----------------------------|
| Military Botswana | 15 years and Older | N/A | N/A | 1,000 | N/A |
| Gaborone | | 130,444 | 30% | 2,401 | 32% |
| Kgatleng | | 38,507 | 40% | 1,501 | 44% |
| Kweneng East | | 123,895 | 17% | 2,001 | 18% |
| Mahalapye | | 55,910 | 31% | 1,603 | 34% |
| South East | | 49,751 | 15% | 802 | 17% |
| Serowe | | 20,972 | 57% | 702 | 60% |

*These are national figures extracted from national data from MOH per district inputted in DATIM APR FY18
N/B: Military Botswana cuts SNUs hence no specific population size estimate nor coverage attached to it

4.4 Additional country-specific priorities listed in the planning level letter

4.4.1 Introduction of recency testing as part of the integrated HIV case-based surveillance system

Recency testing is an innovative, evidence-based solution to be adopted in COP20 to reach epidemic control. For Botswana to assess the direction of its HIV epidemic, ongoing surveillance of newly diagnosed PLHIV will be essential. PEPFAR/B will introduce recency testing as part of the integrated HIV case-based surveillance (CBS) system, to guide epidemic control.

This analysis will be used to monitor trends in recent infection, identify subgroups and geographic locations (i.e., time-space clusters) associated with recent HIV transmission and in turn guide public health and programmatic response to ensure that interventions are efficiently and effectively targeted to those at highest risk of acquiring or transmitting HIV infection.

PEPFAR/B will implement recency nationally in a phased approach among all newly diagnosed HIV individuals aged 15 years and older who consent to the test.

In consultation with the Implementation Subject Matter Experts (ISME), PEPFAR/B will work with the MoHW (Lab, HTS & Surveillance programs) and IP's in planning and developing a comprehensive recency plan.

The plan will include:

1. Consultative meeting with MoHW on purpose of recency testing, its intended use in-country, ethical and policy guidelines.
2. Stakeholder and community consultation and agreement in reasons for recency testing, development of plan and timelines.
3. Work with PEPFAR ISME's on protocol development and Rapid Test for Recent Infection (RTRI) technology transfer requirement including in-country verification, IQC and PT requirements.
4. Training and certification of trainers by HQ ISMEs, IPs, and OU team to serve and develop a pool of in-country experts/ISMEs.
5. Planning and conducting of a series of step-down trainings and certification of testers/test providers.
6. Integration of recency testing into existing HIV testing services with trained/certified personnel.
7. Development of standardized site-level data collection tools (both paper-based and electronic) and a central dashboard to monitor quality and analyze aggregate and individual-level data in real-time.
8. Development of routine real-time data monitoring protocols to identify and develop a public health response.

4.4.2 PEPFAR support for laboratory services

Although the Government of Botswana continues to support a large proportion of the national laboratory health sector response to HIV/AIDS, gaps still remain in some areas such as viral load and EID coverage, laboratory policies and regulations, new technology transfer, lab clinic interphase, lab surveillance work and monitoring and evaluation. In COP20 PEPFAR/B will continue to work with MoHW through technical assistance utilizing PEPFAR iSME's, embedding of CDC Botswana lab staff within the MoHW and utilization of implementing partners to implement activities.

In COP20, PEPFAR/B will implement recommendations of the diagnostics network mapping and optimization exercise. We will also work with MoHW to evaluate new testing methods, review and implement testing policies and regulations, operationalize the public health lab and support capacity for management of HIV drug resistance testing, testing for TB and other OI's (HPV, and Cryptococcus antigen testing) for PLHIV. Additional support will be provided for biosafety and waste management focusing on safe disposal of guanidinium thiocyanate as well as for new technology recency rapid test technology transfer.

PEPFAR/B will work with GoB to address gaps that remain in testing areas such as viral load and EID coverage, internal and external quality control, site supportive supervision and mentorship, and monitoring of testing personnel and sites. PEPFAR/B will also work with GoB lab sector to develop lab Monitoring and evaluation systems and protocols that feedback to the national M&E structure. Through this process, lab monitoring tools, and dashboards will be developed to report and monitor lab indicators.

As a way of addressing testing interruptions due to reagent outage, PEPFAR/B will strengthen, laboratory commodities consumption reporting and forecasting. PEPFAR/B laboratory team will continue to work with MoHW to support the roll out of self-test kits. Laboratory components of PEPFAR surveys and surveillance work, will continue to be supported for COP20 through technical assistance (TA) using PEPFAR/B lab staff and CDC headquarter staff.

4.4.3 Improving quality and efficiencies of diagnostic services

In COP20, PEPFAR/B will work closely with National Health Laboratory and Botswana National Quality Assurance Laboratory to strengthen National Public Health Laboratory for diagnosis and reporting of outbreaks and other communicable diseases in Botswana. PEPFAR/B will continue to work to support the 56 testing laboratories and 900 testing sites to deliver quality testing services through training, implementation of QMS, site and personnel certification and monitoring of performance.

Through programs such as the Strengthening Laboratory Management towards Accreditation (SLMTA) program, Stepwise Process for Improving the Quality of HIV Rapid Testing/or Point of Care (SPI-RT, SPI-POCT) and standards trainings, PEPFAR/B will support the development of quality management systems in laboratories and testing sites. PEPFAR/B will also work with MoHW and other IP's to certify ancillary equipment, certify testing personnel and monitor their certification and implement protocols for post market surveillance for testing commodities.

The support for POCT testing quality will include TA towards review and finalization of guidelines and policies, support for the trainings and site monitoring by the RHT master trainers and provision of internal quality controls and Proficiency testing. PT performance and discordance rates will also be monitored for each testing site. Starting COP20, capacity for IQC and PT for recency testing will also be developed. Through the Stepwise Process for Improving the quality of HIV Rapid Testing (SPI-RT) checklist RHT sites will be assessed and monitored

PEPFAR/B will continue in COP20 to support Proficiency testing for HIV tests including EID, VL, CD4 and TB for both facility and community testing sites. Internal and external audits of sites to determine site performance towards set standards will be done utilizing the PEPFAR and WHO approved checklists such as SIMS, SLIPTA, SPI-RT, SPI-POCT and VL/EID score card. PEPFAR/B will also work with GoB to develop a pool of master trainers and auditors for both lab-based, and non-lab based diagnostic work. Through training, mentorship and site supportive supervision/ joint site visits with GoB and other IP's, non-compliant areas or those with challenges will be remediated.

Continuous quality improvement (CQI) for testing, will be attained through implementation of components of the CQI for all testing areas, monitoring of quality indicators, utilization of

customer feedback data, continuous feedback to stakeholders on site performance and implementation of quality improvement projects. Through the PEPFAR Lab technical working group, testing site performance's will be shared and corrective actions discussed.

4.4.4 Pre-Exposure Prophylaxis (PrEP)

The Third Botswana National Strategic Framework for HIV and AIDS 2010 – 2023 recognizes PrEP as one of its priority prevention interventions. The plan aims to accelerate provision of Pre-Exposure Prophylaxis (PrEP) to 88% of people assessed to be at a substantial risk of HIV infection by 2023.

The National Framework for the Implementation of HIV Pre-Exposure Prophylaxis in Botswana (2019) details how PrEP will be rolled out. Studies have established that PrEP is an acceptable intervention for high HIV risk populations. Botswana conducted a situational analysis study in 2016 (incidence pattern model study) and 2019 (focus group discussions with young people) to inform a robust social behavior change communication on pre-exposure prophylaxis. The epidemiological situation, acceptability of PrEP, as well as behavior patterns of the targeted groups were used to design a PrEP communication strategy.

PrEP implementation began in COP18. The initial implementation targeted FSW, MSM and AGYW at high risk. Achievement against the target stood at 120%. Implementation in COP 19 was flat lined, and the Implementation partners results indicate great potential of PrEP as an important addition in HIV prevention.

In COP20, PEPFAR/B will enhance efforts to keep HIV negative AGYW, adult men, pregnant and breastfeeding women, KP, sero-discordant couples wishing to conceive negative and other populations who are unable to negotiate safe sex such as prisoners, negative by providing PrEP for those who have been assessed as being at significant and continued risk of HIV acquisition, as per the WHO guidelines. To reach these at-risk individuals, PrEP will be integrated in HIV services points such as HTS, VMMC, ANC, SRH, care and treatment. To address low demand and retention of AGYW on PrEP, and leveraging on the dramatic expansion of DREAMS, PEPFAR/B will recruit PrEP Ambassadors for each implementing district. PrEP services will be provided as part of the package of clinical services provided by DREAMS. A social media PrEP support network will be developed and operationalized in COP20 to address issues such as stigma associated with taking PrEP; to provide ongoing supportive counselling and other resources to increase retention on PrEP.

PEPFAR/B will continue to scale-up PrEP for FSW and MSM in all districts. PrEP Champions will continue to be engaged to improve uptake and retention on PrEP. Messages such as Undetectable=Untransmittable will be promoted in efforts to curb the stigma associated with taking ARV drugs. Clients found to be HIV positive during screening for PrEP services will be provided with counselling for treatment and actively linked to ART clinics for further care and treatment services. Furthermore, capacity building for health care workers to normalize PrEP and making it easily accessible will continue in all implementation sites. Capacity building for

health care workers will address clinic-based violence detection/response and community based violence prevention.

Another vulnerability that makes this population at risk of HIV infection is their inability to negotiate for safe sex, as such, PEPFAR/B will work closely with people in closed settings to provide PrEP. In addition, PrEP services will also be extended to men in the military considering their risk profiles against the background that they are usually main partners of AGYW and are most likely engage in high risk sexual activities.

In COP19, one KP member sero-converted to HIV positive while on PrEP. In COP20, PEPFAR/B will conduct ongoing pharmacovigilance to monitor and respond to severe adverse events promptly and effectively. In COP20, PEPFAR/B will support the GoB to rollout active pharmacovigilance at all sites providing PrEP services. This will involve incorporating intentional and focused activities to detect and assess for PrEP-related adverse events, including toxicity and seroconversion monitoring, into the client-centered management of PrEP clients. The complement of activities will also include developing and disseminating standardized clinical management protocols for PrEP adverse events, as well as client information, education and communication activities for the prevention and management of adverse events.

This is in line with WHO guidance, which provides that as PrEP programs scale up, it is important to integrate PrEP monitoring with existing routine HIV patient monitoring systems which should capture serious ARV-associated toxicities as part of the national health M&E system. PEPFAR/B will work with the GoB PrEP Technical Working Group to develop data elements to be reported, in order to monitor the magnitude of toxicities and their impact on discontinuation or interruption of PrEP. The data will be captured in PrEP registers and will be shared with the MoHW, to inform national PrEP programming. PEPFAR/B will work with the MoHW to revise data collection and reporting tools so that PrEP adverse events are captured.

PrEP Communication has been prioritized under COP20. A comprehensive PrEP advocacy, communication and social mobilization strategy will be implemented. The following communication activities will be implemented:

- Advocacy – engagement meetings with key stakeholders and community leaders
- General awareness creation – mass media, social media, interpersonal communication and print materials
- Targeted communication - human centered design and behavioral economics
- Supporting PrEP delivery – interpersonal communication at point of contact

Facility and Community readiness assessment will be done using stargazed tools. For AGYW sites providing PrEP will be assessed for youth friendliness. The package of PrEP services provided will include the following:

- Risk assessment
- HIV testing
- Counseling on PrEP
- Initiation of PrEP

- PrEP follow up and retention
- Discontinuation and re-initiation

PrEP provision will be linked to the index testing program. All index clients who test HIV negative will be assessed for PrEP eligibility and educated on PrEP. Those who are eligible will be referred to appropriate clinical providers for PrEP initiation.

4.4.5 Stigma Index 2.0

Country Context

There is lack of recent data on stigma and discrimination against PLHIV and key population communities in Botswana. The last stigma index survey was conducted in 2013 and the results released in 2014. The survey confirmed that stigma and discrimination remained a major barrier to effective HIV/AIDS prevention and treatment in Botswana. The survey also found two prevalent forms of stigma and discrimination in Botswana: self-stigma and external stigma. Over 10% of survey participants reported experiencing external stigma such as gossip and verbal insults and 5% reported experiencing exclusion from social gatherings. Thirteen percent had experienced external stigma at least one time in the twelve months prior to the survey. It is notable that survey respondents included only those whose status was known and who were willing to take the survey. It is possible that the fear of stigma is much higher among PLHIV who have not disclosed their status, are not on treatment, and are not yet willing to interact with the health system.

The National Strategic Framework III (NSF III – 2019/2023) adopted the programmatic objective of reducing HIV related stigma and discrimination from 13.2% in 2013 to less than 5% in 2023 for PLHIV and key populations communities. The framework outlines strategies to be adopted, including sensitizing healthcare workers in health settings, introducing stigma monitoring systems and complaints mechanisms, and conducting a new stigma index survey to inform HIV programming.

In 2019, jointly with BONEPWA, NAHPA and UNAIDS commissioned the National Stigma Index Survey with the remote support from Global Network of People Living with HIV (GNP+). In 2019, the three co-conveners, send out a call for proposal in the national newspapers calling applications from national organizations/ institutions for being an implementing partner to undertake the National Stigma Index 2.0 in Botswana. Botho University was selected through this process as an implementing partner for the National Stigma Index Survey. In turn, Botho University was contracted by UNICEF on behalf of UNAIDS and provided financial support for the phase one stage, which will be completed by 31st March 2020. A detailed inception report and a draft electronic database has been produced by the implementing partner and reviewed and cleared by all three co-conveners. Second phase will be started in April 2020, which will be supported by UNAIDS to cover, survey implementation, analysis, report production and dissemination. A national Steering Committee will be formed as part of the second phase implementation. Botswana is planning and working towards synchronizing the analysis and launch of the BIAS V report and its findings along with the National Stigma Index Survey report 2.0.

Once the revised index becomes available, PEPFAR/B will work closely with UNAIDS to support the implementation of the survey and use the survey results to inform our efforts towards stigma reduction in COP19 as well as COP20 implementation.

COP19

At present, PEPFAR/B is tackling stigma from different angles throughout COP19 activities. Botswana is signatory of the international human rights obligations and HIV-related human rights commitments made by governments in the 2011 United Nations Political Declaration on HIV and AIDS. As a result, the OU's CQI practices assess whether sites have policies or other written guidelines that describe the rights of patients and the protection of all patients from stigma and discrimination regardless of age, disability, gender identity, HIV status, race, religion, or sex. This core element of the CQI practices also assesses if staff have been trained on these guidelines and policies and requires sites to show evidence of reporting processes for discrimination along with evidence of response where applicable.

PEPFAR/B is also combating stigma and discrimination through the promotion of the "Champions" concept started in 2018 by BONEPWA and extensively adopted during COP18 Reboot (as Expert Clients) to improve treatment initiation and client retention. The approach consists of providing a platform to PLHIV groups and individuals at sites, in communities, and in the media to: a) help new patients navigate the various HIV/AIDS services and provide them with the needed support and information to get on and remain on treatment; b) encourage priority populations to seek to know their HIV status and get on treatment within 7 days if they are HIV positive, particularly young adults and men; and c) educate service providers on stigma and discrimination reduction through client-centered and client-friendly services. Multiple PEPFAR implementing partners are now working with expert clients and PLHIV support groups as a key part of the cascade, especially treatment initiation and retention. Four PLHIV are also serving as high-level Faith and Community Initiative Ambassadors and PEPFAR/B has promoted the Botswana HIV Legends through the 2020 PEPFAR calendar, which celebrates HIV activists, including PLHIV, who have worked for decades to reduce stigma and achieve epidemic control in Botswana. Along with the use of Champions in programmatic activities to speak to their communities, promote treatment literacy, and increase uptake of services, PEPFAR/B also produced radio campaigns to reach men and reduce stigma.

COP20

In COP20, in addition to intensifying the above activities to improve treatment initiation and retention, PEPFAR/B will integrate the findings of the planned Stigma Index 2.0 survey and launch new activities addressing stigma and discrimination of PLHIV. These include the implementation of MPR #11, which addresses treatment and viral load literacy and the establishment of a community-led monitoring platform, which also includes a component on patient literacy intended to promote informed decision-making from clients of HIV services and reduce both self-stigma and external stigma, especially from service providers.

4.4.6 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/B is working closely with the GoB on the completion of the BAIS V. The BAIS V was launched in March 2020 and is expected to provide preliminary results in 2020. In anticipation of these results, PEPFAR/B will develop some programmatic scenarios to be able to adapt and/or realign the program as soon as the needed data are available.

PEPFAR/B will continue to support data collection at the site-level through gap filling in human resources and supporting a site level training and mentoring program. System and user support will also be strengthened to increase use of EMRs (PIMS, IPMS, e-LMIS). PEPFAR/B will continue to support transmission of PIMS data to the NDW via mobile data networks while also improving the network speed of the Government Data Network (GDN) to improve the usability of IPMS and e-LMIS. At the NDW-level, the analytic capacity will be increased to allow for data visualization to help inform programmatic decisions. In addition, to allow for exchange of data between systems and sites, greater system interoperability will be established. This will include allowing lab requests and results to be exchanged between PIMS and IPMS, pharmacy data to be exchanged between IPMS and e-LMIS and for verification of the national ID number (Omang) within IPMS and PIMS sites on the GDN.

PEPFAR/B will work closely with GoB through the assistance of Palantir Technologies to triangulate available data through developing a data platform that connects multiple data sources from existing systems into one environment in order to simplify data visibility and analysis and enable data-driven decision making.

Through PEPFAR/B support, health districts will be capacitated to use the standardized data quality assessment SOPs and protocols to verify the completeness and accuracy of program data collected. Facilities will also be capacitated to conduct their own self-assessments at regular intervals and to consistently and continuously analyze data with the aim of program improvement at site level. PEPFAR/B will also provide technical assistance to MoHW to develop a standardized M&E system (including M&E plan with clear indicators, registers, reporting tools) to capture community level interventions.

In addition, the case-based surveillance system, which will be implemented in COP19, will be strengthened through data quality improvement and more in-depth analysis. With the introduction of recency testing in COP20, recency results will be incorporated in the CBS system, allowing for detection of clusters of recent infection at population level. Using remnant samples from viral load testing, drug resistance surveillance will also be incorporated into the CBS system. More regular and efficient sharing of mortality data with the MoHW will also be established in order to have more timely death information in CBS.

4.4.7 Gender-based Violence (GBV) Cross Cutting Program

PEPFAR/B will ensure that GBV prevention, case identification, and response activities are integrated across DREAMS, OVC, KP, PrEP, HTS, and care and treatment programming as appropriate during COP20 implementation. Addressing GBV in the context of HIV is critical as

experience of violence has a profound influence on the uptake of HIV services and is, therefore, an important component in epidemic control. The team will ensure the following are done:

a) **Addressing GBV and Inequalities across HIV Cascade**

- **Prevention:** Utilization of evidence-based HIV and GBV prevention approaches will continue to be emphasized in COP20.
- **OVC and DREAMS:** All IP's asking about experience of violence for determining eligibility for DREAMS and OVC programming will be trained on how to ask about violence, how to respond (provide first-line support, i.e., LIVES) and know how and where to refer for clinical and/or non-clinical GBV response services.
- **PrEP:** All PrEP sites will conduct routine enquiry for Intimate Partner Violence (IPV) with all clients. Survivors of GBV initiated on PrEP will be provided with first line support and linked to GBV response services in order to increase their PrEP adherence.
- **Key Populations:** All KP sites will provide post-violence clinical care and conduct routine enquiry for violence in PrEP service delivery for KP.
- **Testing:** PEPFAR/B will ensure that all HIV index testing sites conduct routine enquiry for IPV for clients offered PN services. These sites will all meet WHO's minimum requirements for asking about experience of violence, including ensuring that all providers are trained on how to ask about violence, how to respond when violence is disclosed (i.e., provide first-line support), and how and where to refer for GBV response services. Additionally, all HIV index testing sites will track and respond to adverse events, including IPV, that may result from partner notification services.
- **Care and Treatment:** Clinicians will be supported through capacity building and technical support to identify survivors of violence through either routine and/or clinical enquiry during ART initiation and routine clinical care. Furthermore, all clients identified as having experienced violence will be offered first-line support and provided with or referred to GBV clinical care. Clinicians will monitor adherence to treatment and ensure survivors of violence receive the support they need to achieve and maintain viral suppression.

b) **HIV/GBV Integration Site Monitoring:** PEPFAR/B will conduct site monitoring visits to all PEPFAR-supported settings that deliver clinical HIV services to identify strengths and best practices, as well as gaps in service provision and capacity building needs in relation to HIV/GBV service delivery. PEPFAR/B will work to ensure that sites are reporting and monitoring integrated HIV and GBV services with quality and in alignment with PEPFAR MER Guidance.

c) **Gender and Sexual Diversity:** All PEPFAR/B technical staff will be required to participate in the Gender and Sexual Diversity Training which takes place every year. The training provides a comprehensive overview of sexual diversity and the link to HIV and GBV in the context of Botswana. It offers participants an opportunity to interact with individuals of various sexual identities and orientations to better understand how to deliver HIV prevention, testing, and care and treatment services to gender and sexual

minorities (GSM). Representatives from civil society organizations working with key populations and GSM serve as panelists to share lessons learned and best practices to working with their clients in a way that respects their rights and increases their access to care services.

4.5 Commodities and Supply Chain

Commodities-related issues that have the potential affect the ability of PEPFAR to support the country's achievement of epidemic control include:

- The national supply chain issues that may negatively impact the last mile distribution of required commodities to the patient include –
 - System inefficiencies and inadequate procurement staffing at CMS
 - Insufficient forecasting technical expertise that may lead to potential stock-outs
 - And inadequate data visibility between the dispensing facilities and CMS, which results in poor consumption data that is required for a reliable and effective procurement planning by CMS.

PEPFAR continues to support capacity building and system strengthening of CMS to develop more efficient systems, and to realize associated cost savings for HIV drugs and other key commodities.

- Stock-outs of some essential commodities are periodically experienced at the national level, and PEPFAR/B has assisted GoB by doing emergency procurements of HIV rapid test kits and condoms.
- As a matter of policy, GoB also does not fund commodities such as lubricants for Key Populations, which negatively impact the efforts toward epidemic control. PEPFAR still procures those commodities.
- The country also experienced shortages of some key ARVs between September and December 2019 as a result of litigation in the courts against CMS awarded contracts by some of the losing bidders. The MoHW reached out to PEPFAR/B to assist with an emergency procurement that was approved by OGAC on October 23, 2019. The first consignment was delivered to Botswana on the first week of December 2019. By the end of February 2020 PSM has delivered 16 out of the 18 orders. As a result, the GoB will be reimbursing the USG \$5,266,413.91 from a total estimated cost of \$6,767,218.52 by the end of their fiscal Year ending March 31, 2020.

4.5.1 TLD Transition

The country is in the process of transition from Dolutegravir (DTG) and other regimens to fixed dose TLD. PEPFAR/B, mainly through the PSM Supply Chain mechanism continues to work with MoHW/CMS team on implementation of the transition plan. While the plan was to start transitioning in November 2018, a potential stockout of key first line regimen (Truvada and Atripla) in August 2018 led to a decision to fast-track the transition to an earlier date. It was in that note that the PEPFAR procured TLD shipment had to be brought into the country in August, rather than the initially planned October requested date. Subsequently, the MoHW issued a Savingram to start the TLD transition on September 1, 2018.

Current Status of the TLD Transition:

At the end of FY20 Q1 the coverage was at 181,874 of the estimated 299,500 illegible PLHIV, translating to 61% of clients eligible for TLD transition. The MoHW has undertaken to complete the transition by September 2020. The transition includes both Adults and Children who are on treatment.



A total of 155,727 clients were already transitioned to TLD by the end of December 2019, with an additional 26,147 on other DTG-based regimen for a total of 188,874.

Additionally, a decision to transition an estimated 103,000 clients who are currently on the TEE (Atripla) regimen to TLD was taken by the Ministry in November 2019. This cohort was originally planned to transition to TAF-ED but will be switched to TLD instead.

4.5.2 CMS Supply Chain Capacity Building

PEPFAR continues to support systems strengthening and build capacity at the Central Medical Stores (CMS) through the USAID-PSM mechanism at a reduced footprint due to the budget cuts in COP19. For COP20 the proposed supply chain activities will include:

- **ART Optimization:** Continue working and supporting GoB to ensure that all eligible clients are initiated on TLD and DTG based regimens, including all eligible children. Also support the implementation of differentiated service delivery by increasing MMD from three to six months and ensuring that all eligible clients are put on MMD. This will be achieved through the following activities.
 - Provision of technical assistance to support TLD optimization and ensure that the required consumption data is collected, and that the required TLD transition tools are updated accordingly
 - Work with MoHW to conduct quarterly monitoring and supervision on ART optimization and 6-month MMD implementation
 - Support health facilities in generating granular supply chain data to enable triangulation with clinical data for TLD and MMD reporting

- **Supply Chain Data Visibility:** Strengthen the collection, management and use of supply chain related data for enhanced transparency and accountability of the system. This to ensure that MoHW and CMS leadership will always have the necessary capacity to make data-driven procurement decisions. This will be achieved through:
 - Working with and supporting the Botswana Medicines Regulatory Authority (BOMRA) to promote the adoption and implementation of Global Health Standards (GS1) to ensure traceability or end-to-end visibility of all health care products coming into the country. Adoption of GS1 standards will also help curb the proliferation and use of counterfeit/substandard healthcare products in the country. This will also be achieved through stakeholder workshops and provision of the required technical assistance to BOMRA as the lead.
 - Funding and supporting the rollout of the electronic Logistics Management Information System (eLMIS) between district warehouses and last mile facilities. Connection between CMS and the district warehouses is currently funded by Global Fund, so PEPFAR will be supporting the downstream connection in COP20.
 - Developing a visualization dashboard to provide MoHW/CMS leadership and relevant staff with real-time data visibility for informed planning and decision making for supply chain.

- **Warehousing & Distribution Optimization:** Support the National Laboratory Optimization Strategy to ensure adequate and cost-efficient procurement and supply chain management for lab commodities, as well as build capacity for lab procurement staff through:
 - Providing technical assistance for the review/updating of the National Supply Chain Strategy - the current strategy was for 2014-19.
 - Assessing current capacity of pharmacies and laboratory in hospitals, clinics and health posts (where applicable) to handle storage and dispensing of distributed products and standardize capacity requirements to further strengthen appropriate storage and provision of pharmaceutical care and diagnostic support. Assess warehousing/storage capacity and infrastructure at the DHMT and last mile levels.
 - Collaborating with the GoB and supporting the development of strategies to facilitate adoption and implementation of decentralized drug distribution (DDD) models of health commodities, including options of outsourcing to the private sector where feasible. This approach is outlined in the National Strategy for Delivering Efficient, Equitable and Quality Health Services through Public-Private Sector Collaboration (2017-2022). This Strategy was signed by then Minister of Health & Wellness – Ms. Dorcas Makgatho – on May 17, 2017.

- **Procurement & Contract Management:** Strengthen capacity of CMS on procurement and contract management systems through training and mentoring and supporting MoHW in advancing pooled procurement approaches to achieve cost savings through the following:
 - Building capacity of the Contract Management Unit through technical assistance for refresher training on contract management and procurement
 - Conducting cost-efficiency analysis of central procurement at CMS and micro-procurement at District Health Management Team (DHMT) level, including exploring opportunities for pooled procurement
 - Supporting CMS in procuring/developing and implementation of eProcurement platforms for contract management
 - Continue building capacity of MoHW/CMS in forecasting and supply planning for ARVs, HIV-Lab, PrEP, TPT, and other essential medicines through training, mentoring and use of standardized automated tools with the aim of promoting sustainability
 - Provide TA to develop a procurement curriculum and train the CMS technical/procurement staff for certification to ensure professional standards and procurement procedures are followed

The supply chain implementing partner is managed centrally from their US-based headquarters. There is a small team in-country that works closely with the PEPFAR team on all commodity/supply chain related issues. Additionally, there are monthly reports submitted to the USAID Health Office in Botswana, as well as monthly scheduled telephone conferences with US and local teams to discuss and resolve pertinent issues.

ARVs: The Central Medical Stores (CMS) stock situation report for the end of February 2020 shows the following at central level for 1st & 2nd line ARVs in the country:

Table 4.5.1 - ARV supply as of February 2020

| First Line ARVs | Months of Stock at CMS | Second Line ARVs | Months of Stock at CMS |
|------------------|------------------------|------------------|------------------------|
| TEE | 3.0 | LPV/r 125 | 9.2 |
| TLD | 6.2 | ATV/r 300/100 | 9.1 |
| DTG | 14.6 | DRV600 | 11.2 |
| Truvada | 18.1 | RTV100 | 1.8 |
| ABC300 | 0 | | |
| ABC/3TC 120/60 | 3.2 | | |
| 3TC150 | 7.7 | | |
| TAF-ED | 18.9 | | |
| Combivir 300/150 | 0.5 | | |

The above shows that some drugs are below the CMS recommended minimum stock levels of three months, while some are over the maximum of 10 months recommended at the central level.

Table 4.5.2 - Planned PEPFAR Commodities for COP20

| Funding Agency | Commodity Major Category | Commodity Item | Commodity Quantity (a) | Total Item Budget (a*h) |
|----------------|--------------------------|--|------------------------|-------------------------|
| USAID | ARV | Emtricitabine/Tenofovir DF 200/300 mg Tablet, 30 Tablets | 50,468 | \$250,003.00 |
| USAID | RTKs | OraQuick® HIV Self Test | 23,940 | \$54,921.00 |
| USAID | RTKs | Tests/Kit | 3,417 | \$18,617.00 |
| HHS/CDC | ARV | Dolutegravir/Lamivudine/Tenofovir DF (TLD) 50/300/300 mg Tablet, 180 Tablets [OPTIMAL] | 42,440 | \$1,400,096.00 |
| HHS/CDC | ARV | Emtricitabine/Tenofovir DF 200/300 mg Tablet, 30 Tablets | 56,955 | \$250,032.00 |
| HHS/CDC | RTKs | OraQuick® HIV Self Test | 8,052 | \$20,130.00 |
| HHS/CDC | TB HIV | Isoniazid 300 mg Tablet, 24 x 28 Blister Pack Tablets | 12,650 | \$173,558.00 |
| HHS/CDC | Laboratory | CD4 Reagents And Consumables | 200 | \$3,000.00 |
| HHS/CDC | Laboratory | Roche VL reagents and consumables | 300 | \$240,000.00 |
| HHS/CDC | Laboratory | Other Instrument VL reagents and consumables | 50 | \$76,000.00 |
| HHS/CDC | Laboratory | Other EID Reagents and Consumables | 30 | \$24,000.00 |
| HHS/CDC | Laboratory | Hematology reagents and consumables | 10 | \$800.00 |
| HHS/CDC | Laboratory | Chemistry reagents and consumables | 3,000 | \$30,000.00 |
| HHS/CDC | Laboratory | Other reagents and consumables | 30 | \$15,000.00 |
| HHS/CDC | Laboratory | GeneXpert EID cartridges | 30 | \$9,000.00 |
| HHS/CDC | Laboratory | DBS sample collection and consumables | 30 | \$9,000.00 |
| HHS/CDC | Laboratory | Other sample collection and consumables | 50 | \$750.00 |
| HHS/CDC | Laboratory | CD4 Sample Collection | 10 | \$5,500.00 |
| HHS/CDC | Laboratory | Other reagents and consumables | 10 | \$100.00 |
| HHS/CDC | Laboratory | Other reagents and consumables | 800 | \$240,000.00 |
| HHS/CDC | TB HIV | Vitamin B6 (Pyridoxine) 25 mg Tablet, 1000 Tablets | 6,300 | \$176,463.00 |
| | | | TOTAL | \$2,996,970.00 |

Table 4.5.2 shows the planned commodities to be procured by PEPFAR under COP20. For USAID the procurement will be carried through the Global Health Supply Chain Program (PSM) mechanism, while for CDC the funding will go into the CoAg with the Government of Botswana for procurement through CMS.

4.6 Collaboration, Integration and Monitoring

4.6.1 Interagency collaboration and coordination:

PEPFAR/B interagency team understands that strong collaboration is necessary to promote the One Botswana goal. At the end of 2017, PEPFAR/B developed an Inter-Agency Guidebook. The Guidebook was created to bring a higher level of efficiency, transparency, and effectiveness to our interagency work. In Botswana, there were leadership changes in FY20 at CDC, USAID (health team) and Peace Corps and there will be additional leadership changes in the PEPFAR Coordination Office in June 2020. The new PEPFAR/B leadership team will be revisiting the Guidebook and making decisions and commitments to the ways in which we all work together more effectively and efficiently.

The entire PEPFAR interagency team is housed at the same site in Gaborone West (G-West), with agency staff intermingled throughout the office.

Peace Corps Volunteers (PCVs) are placed strategically with local implementing partners - NGOs, health facilities, and local government offices to provide long term support and capacity building in making desired changes for improved linkage and initiation/adherence with attention to:

- Programs addressing in-school and out of school youth and their supporting environments, and
- Sustainability of systems strengthening activities such as M&E and IT. For example, the Supply Chain Management program brings volunteers and their colleagues from a variety of facilities to be certified in the Logistics Management of Health Commodities.

VAST (Volunteer Activities Support and Training) grants are small grants which provide an opportunity for partners of volunteers to practice the skills learned in capacity building activities. PCVs submit reports to Peace Corps on a quarterly basis, and Program Managers visit volunteers and counterparts annually to discuss progress on work plans and offer technical support. Peace Corps also conducts quarterly calls to volunteers and counterparts/supervisors and holds regular training with volunteers and counterparts during which challenges and best practices are shared. The inter-agency team also benefits from the skills and insights of 3rd Year volunteers, who have been selected to work for a year within USG agencies to augment engagement with field-based volunteers on relevant activities.

Through the leadership of the PCO, PEPFAR/B convenes regular meetings to share information, discuss strategies and performance, plan, or make joint decisions. PEPFAR/B's standing meetings include: PEPFAR Country Team (PCT) with all PEPFAR staff across USG agencies; and

regular PEPFAR agency leads meetings with directors and deputy directors from the various agencies. PCO also works very closely with the front office at the U.S. Embassy in Botswana to ensure senior USG leadership awareness and support for the broader PEPFAR policy decision.

4.6.2 Collaboration with external stakeholders and partners

The Regional Planning Meeting (RPM) for COP19 in Johannesburg acted as a catalyst for Government of Botswana/PEPFAR/B collaboration. When the team came back from Johannesburg, the Permanent Secretary (PS) formed a multi-sectoral Health Leadership Forum that included all in country HIV stakeholders to help create a true “One Botswana” response. It also launched a platform to support and oversee the implementation of the 14 MPRs. PEPFAR’s TWG co-chairs and technical staff from the agencies work closely with a range of MoHW offices to ensure coordination and alignment of efforts in addressing the challenges facing the full implementation of the national HIV response, including case finding, linkage to care and treatment, ART initiation, retention, viral load coverage and viral load suppression. All USG agencies’ technical staff participate on all MoHW-led national TWGs where granular programmatic and related policy options are discussed, and decisions made. Open access to MoHW at all levels by the whole of PEPFAR/B remains a critical principle for PEPFAR to be able to fully support the One Botswana philosophy.

During the COP20 development process PEPFAR continued to build on the relationships and structures built during COP19 planning. There were new technical working task forces formed that met often during the planning process. The task forces were co-chaired between PEPFAR/B and the MoHW. During the COP20 process, PEPFAR/B made external partner engagement in general one of its highest priorities. This included active participation of the Global Fund, UNAIDS and WHO, and CSOs. Building on coordination with these partners’ collective advocacy for programmatic activities such as treatment for non-citizens and development of community guidelines, PEPFAR/B will continue to work with these partners and build stronger collaboration.

PEPFAR/B team members routinely coordinates and communicates with GFATM, multilateral organizations, the private sector, FBOs, and CSOs. PEPFAR/B remains committed to continued engagement and collaboration with in-country HIV stakeholders on all technical aspects of program implementation. Host government and external partners’ engagement remains critical to help guide the work of PEPFAR/B in the districts, communities, and health facilities. PEPFAR/B also participates in GFATM CCM and the Global Fund Oversight and Executive Committee.

PEPFAR/B recognizes the critical role of Faith Based Organizations (FBOs) and traditional leadership in reaching epidemic control. FBOs offer the opportunity of a turnaround strategy for countries to fully engage faith and traditional leadership in reaching epidemic control. PEPFAR/B commenced direct engagement of FBOs and traditional leaders in COP19 for them to play a critical role in reaching different priority populations with prevention, care, and treatment interventions. In COP20, the engagement with FBOs and traditional leaders will be

integrated across the entire clinical cascade and scaled up to FastTrack reaching epidemic control in Botswana.

In COP20, PEPFAR/B will coordinate the participation of GoB, GFATM, multilateral organizations, the private sector, FBOs, CSOs and USG IPs in the quarterly POART meetings with OGAC. There will be joint preparations towards the meetings and good attendance from all identified in-country stakeholders will be encouraged and facilitated. POART meeting and preparation towards it will provide Botswana HIV stakeholder community as well as the entire PEPFAR team an opportunity to discuss the PEPFAR program. It will increase data quality and transparency, as well as knowledge about the PEPFAR program priorities, targets, and results. Furthermore, POART will provide the opportunity to jointly discuss collaboration among donors, provide a closer view into PEPFAR priorities, and ensure alignment within the GoB strategic framework.

4.6.3 Collaboration and IP management and monitoring

PEPFAR/B employs multiple management approaches to improve partner performance; these are revisited annually at the time of work plan development and approval. USG Agency Managers are responsible for designing and carrying out partner management plans to ensure accountability for PEPFAR funds and program performance. The core elements of effective partner management include:

- Routine performance monitoring through USG/implementing partner review of OU, SNU, and site-level program results (including data completeness and quality), with frequency (weekly, monthly, or quarterly) determined by partner performance
- SIMS and IP management site monitoring visits, weekly MER review, review monthly site level performance reviews, and site level results verifications
- Aggressive financial monitoring to ensure 1) spending is aligned with technical and geographic priorities as defined in the implementing partner's work plan prior to signing approval vouchers and 2) spending does not exceed approved operational plan budget
- Immediate remediation planning when partner performance is of concern as identified through reboot routine site visits
- A complete evaluation, remediation, and spend plan review of any partner with <50% of target at 6 months
- Joint interagency partner meetings and site visits to ensure consistency, transparency and collaboration among all PEPFAR implementing partners

As a result of these enhanced partner management processes, PEPFAR/B is identifying issues far more rapidly than in the past and working with partners to fix issues in real time as they are identified. Technical staff of partners now review performance data more frequently (daily and weekly) and develop strategies to address gaps identified if the data trends are of concern. PEPFAR/B staff have conducted joint interagency site visits and provided real time feedback to IPs through a partner management tracker. These efforts, which will continue in COP20, resulted in significant improvements in the following areas: IP site staffing, targeted IP headquarters' technical assistance on client flow, index testing and linkage to care with ART

initiation, increased index testing and detection of men, scaling up of universal TB suspect screening, and universal screening for HIV testing eligibility in hospitals. To sustain these gains towards epidemic control in COP20, implementing partners will have to continuously improve on their performance and develop work plans and strategies that speaks to all the relevant MPRs as GoB moves forward with MPR implementation. PEPFAR/B agency and interagency partner performance assessment and management are directly tied to improved case finding, linkage, initiation on treatment, viral load coverage and suppression, with the expectation of 100% achievement of COP targets.

4.6.4 Integration of key health system interventions across the cascade

4.6.4.a Improving quality and efficiencies of service delivery through improved models of care delivery across community and facility sites

Facility-community linkages are critical for HIV prevention, care and treatment scale up, including implementation of differentiated service delivery models. PEPFAR/B will continue to strengthen community-facility linkages and support provision of HIV services for general, priority and key populations. This has been important in strengthening linkage to treatment and will be critical as PEPFAR/B supports the roll out of Active Partner Notification (APN) for HIV testing. MoHW is currently going through the process of standardizing the design and implementation of community-based services that will ensure that all representative service providers are included. In COP20, PEPFAR/B will explore and implement differentiated service delivery models that will ensure continuous and convenient care to clients where they live and work.

4.6.4.b Improving quality and efficiencies of service delivery through Community-led monitoring of treatment services

In COP20, PEPFAR/B will collaborate with GoB ministries, the NAHPAs, as well as other key in-country HIV stakeholders to establish a Community-led Monitoring mechanism as mandated in COP20 guidance. The community of CSOs in Botswana have had meetings to determine the framework for Community-led Monitoring in Botswana. Priority areas that were identified for monitoring by CSOs in Botswana are:

1. Quality of Services
2. Stigma & Discrimination
3. Adherence
4. Commodity Availability

During the consultative meetings, the CSOs established an operational goal for the Community Monitoring activity:

“Community groups will serve as monitors to ensure that service providers are implementing client-centered approaches that combine service quality management and patient feedback to identify and implement differentiated service delivery models that continuously improve the client experience.”

The GoB, GF and UNAIDs have both been consulted about the Community Monitoring program and will provide input and guidance on standardized tools and approaches. It is envisaged, at least during the first year, that the activity will build upon existing community based programs and platforms in country. The PEPFAR/B Coordination Office will have a dedicated staff member assigned to this activity and will issue RFAs publicly for CSOs to competitively bid and process applications within COP19 to ensure that Community-led Monitoring starts October 1, 2020.

4.6.4.c Laboratory (VL) activities across the cascade

Per Botswana guidelines, viral load is provided three times for those newly started on treatment, twice annually for stable adult patients, and four times a year for children. All 24 viral load laboratories are connected to an integrated patient management system (IPMS) information system, however, most district hospitals and clinics are not connected to IPMS and are instead either connected to PIMS or are paper based.

Since the implementation of the reboot interventions, viral load coverage improved from 83% to 96% in COP18, remained at 96% for COP19 and dipped to 84% as the 18 new GOB sites started reporting. In COP20, PEPFAR/B will provide the necessary support to GoB to improve viral load coverage and suppression. Lessons learnt from the diagnostic mapping will be implemented to optimize VL coverage across the OU including equipment and HRH placement, review of VL referral networks, and rationalization of VL laboratory testing sites. As part of strengthening the lab M&E, quality indicators that assist in increasing VL coverage including turnaround times, equipment and reagent outage will be monitored. A viral load dashboard will be developed to track indicators across sites. Quality testing for VL labs will be assured through QMS implementation utilizing the WHO SLMTA program and sites mentorship. The sites will also be monitored through site supportive supervision and audits using SLIPTA, viral load score cards, SIMS and other check lists. Continuous quality improvement will be implemented. Through addressing gaps identified through audits, monitoring of quality indicators, and customer/stakeholder feedback. The facilities will work with the Community partners to develop line lists for missing VL results follow up. As a way of addressing testing interruptions due to reagent outage, PEPFAR/B will strengthen, laboratory commodities consumption reporting and forecasting including VL commodities.

4.6.5 Improving integration of key health system interventions

4.6.5.a Use of unique identifiers across sites and programs in clinical settings

Botswana has not had a challenge with the use of unique identifiers because the national identity number (OMANG), is used for this purpose. For citizens, OMANG will continue to be used as a unique identifier for patients. For non-citizens, a sequential numbering system with a 'NC' prefix has been developed by the MoHW for use as ID's for patients. Each non-citizen patient will be allocated a single NC based number which they will be expected to present at all facilities where they will be receiving care. This will help in the unique identification of each non-citizen patient. They will however continue to present other forms of identification such as passports, when available.

4.6.5.b Human Resources for Health (HRH)

Inadequate HRH in the health facilities and communities is a challenge to delivering needed HIV services to clients where they are. There is an urgent need by GoB to respond to challenges related to HRH that includes lack of functional human resources information system, loss of highly trained health workers to the private health sector in Botswana, non-replacement of retired or demised health care workers. This situation has been aggravated by embargo on recruitment, which has prevented the replacement of those who have left and recruitment of new staff. To address this key system barrier, PEPFAR supports engaging health care workers in Botswana to achieve epidemic control; the number of health care workers supported has increased over the years. Transition of PEPFAR's investments in HRH for sustaining epidemic control to the public sector is impeded by the existing embargo and public sector fiscal constraints. To enhance the impact and sustainability of HIV service delivery in Botswana in COP20, PEPFAR/B will engage GoB and in-country HIV stakeholders to:

- Standardize remuneration provided to cadres of health care workers who support HIV response in the health facilities and communities
- Develop and implement a sustainable transition plan, that includes minimizing the number of new staff hired by PEPFAR, for staff to be absorbed into GoB system

4.6.5.c Supply Chain

A strengthened supply chain management is important to achieve epidemic response. PEPFAR/B will continue to provide technical support and capacity building to the MoHW/NAHPA through Central Medical Store to ensure that there is a fully functional GOB-led HIV/AIDS commodities and supply chain management system, which can guarantee 100% commodity security for all HIV-related commodities, such as pharmaceuticals and laboratory commodities. PEPFAR/B will continuously engage appropriate actors at all levels of governance to prevent a similar stock out of ARVs that Botswana experienced early COP19 that led to the pause of MMD.

4.7 Targets by population

Table 4.7.1 ART Targets by Prioritization for Epidemic Control

| ART Targets by Prioritization for Epidemic Control | | | | | | |
|--|-------------|-------------------------|---|-----------------------|----------------------------|-----------------------|
| Prioritization Area | Total PLHIV | Expected current on ART | Additional patients required for 80% ART coverage | Target current on ART | Newly initiated (APR FY21) | ART Coverage (APR 21) |
| | | (APR FY20) | | (APR FY21) | TX_NEW | |
| Sustained | 308,298 | 171,121 | 0 | 171,986 | 4,354 | 89% |
| Central Support | 51,885 | 848 | 0 | 969 | 96 | 91% |
| Total | 360,183 | 171,969 | | 172,955 | 4,450 | |

Table 4.7.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

| VMMC Coverage and Targets by Age Bracket in Scale-up Districts | | | | | |
|--|--------------------|---------------------------------|-------------------------|--------------------|-----------------------------|
| SNU | Target Populations | Population Size Estimate (SNUs) | Current Coverage (date) | VMMC_CIR (in FY21) | Expected Coverage (in FY21) |
| Military Botswana | 15 years and Older | N/A | N/A | 1,000 | N/A |
| Gaborone | | 130,444 | 30% | 2,401 | 32% |
| Kgatleng | | 38,507 | 40% | 1,501 | 44% |
| Kweneng East | | 123,895 | 17% | 2,001 | 18% |
| Mahalapye | | 53,910 | 31% | 1,603 | 34% |
| South East | | 49,751 | 15% | 802 | 17% |
| Serowe | | 20,972 | 57% | 702 | 60% |

Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

| Target Populations | Population Size Estimate (DREAMS SNUs) and disease burden | Coverage Goal (in FY21) | FY21 Target |
|--------------------|---|-------------------------|-------------|
| PP_PREV | 175,362 | 19% | 33,927 |
| KP_PREV | 9,973 | 75% | 7,480 |
| TOTAL | 185,335 | 22% | 41,407 |

Table 4.7.4 Targets for OVC and Linkages to HIV Services

| Table 4.7.4 Targets for OVC and Linkages to HIV Services | | | | |
|--|-----------------|--|--|---|
| SNU | | Estimated # of Orphans and Vulnerable Children | Target # of active OVC (FY21Target) OVC_SERV | Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC* |
| Bobirwa District | | 10009 | 3078 | 3133 |
| Boteti District | | 4083 | 300 | 295 |
| Chobe District | | 5165 | 348 | 345 |
| Francistown District | | 6838 | 177 | 175 |
| Gaborone District | | 2512 | 5383 | 5117 |
| Gantsi District | | 3275 | 234 | 231 |
| Goodhope District | | 463 | 260 | 233 |
| Jwaneng District | | 425 | 30 | 29 |
| Kgalagadi District | Kgalagadi North | 1286 | 48 | 48 |
| | Kgalagadi South | | 196 | 194 |
| Kgatleng District | | 6378 | 7771 | 7625 |
| Kweneng East District | | 12871 | 6673 | 6108 |
| Kweneng West District | | 3961 | 143 | 143 |
| Lobatse District | | 2343 | 70 | 70 |
| Mabutsane District | | 935 | 121 | 121 |
| Mahalapye District | | 9825 | 5608 | 5543 |
| Ngamiland District | | 7444 | 213 | 211 |
| North East District | | 6267 | 2075 | 2286 |
| Okavango District | | 4799 | 241 | 237 |
| Selibe Phikwe District | | 1937 | 216 | 215 |
| Serowe District | Serowe | 12513 | 1983 | 2074 |
| | Palapye | | 331 | 326 |
| South East District | | 4056 | 853 | 784 |
| Southern District | Southern | 6943 | 3462 | 3471 |
| | Moshupa | | 41 | 41 |
| Tutume District | | 15901 | 222 | 220 |
| TOTAL | | 130229 | 40077 | 39275 |

4.8 Cervical Cancer Program Plans

In COP18, PEPFAR/B worked with the MoHW National Cervical Cancer Prevention Program (NCCPP) to adapt the existing program M&E tools to capture disaggregated data that will be reportable in DATIM and implement the cervical cancer prevention strategic shift. Following the strategic shift in COP18, a situational assessment was conducted, and all relevant policies and tools are in place to support program implementation. In COP18 PEPFAR/B started the implementation of a scale-up plan to increase screening for cervical cancer among women living with HIV (WLHIV) aged 25-49 years at PEPFAR supported high volume ART sites and ensure access to treatment when appropriate.

In COP19, PEPFAR/B continued to build on the existing platform and strategies to increase cervical cancer screening among WLHIV aged 25-49 on treatment with OU target of 32,359 WLHIV to be screened. The program is implemented in 29 PEPFAR supported facilities of which two are referral hospitals, eight districts hospitals, four primary hospitals and 15 clinics. At these facilities, cervical cancer screenings are offered at various service delivery points (i.e. IDCC, ANC, and maternity ward). Visual inspection with acetic acid (VIA) method is used to screen women while treatment options available in Botswana include cryotherapy for small lesions and Loop Electrosurgical Excision Procedures (LEEP) for eligible large lesions. All the 29 sites offer VIA screening while 15 of the sites provide VIA and LEEP services.

In COP20, PEPFAR/B will continue to build on the existing platforms, strategies and previous cervical cancer investments in COP18 and COP19 applying a client centered approaches to increase cervical cancer screening among WLHIV aged 25-49 on ART. A total of \$1,000,000 is budgeted in COP20 with an associated target of 32,393 WLHIV to be screened. The COP20 screening target represents 54.3% of the total WLHIV on ART at PEPFAR supported sites. We will continue to work with MoHW and the implementing partner to strengthen cervical cancer screening services by building capacity to increase number of sites providing screening and treatment in the supported districts and strengthen the referral for screening and treatment for all eligible clients. We will continue to utilize linkage officers to increase awareness for cervical cancer screening and treatment, linkage to cervical cancer services, as well as tracking referrals. In addition, close collaboration with care and treatment implementing partners and the facility ARV staff will ensure appropriate health education services are available, promoting successful and systematic linkage to cervical cancer prevention and treatment services for WLHIV are tracked. Cervical cancer screening campaigns will utilize facility mobile clinics to enhance visibility in all supported districts to complement and increase demand and offer services to those who were not reached during routine clinic days. PEPFAR/B will continue to be support cervical cancer program using existing MoHW health education platforms, collaboration with HIV advocacy groups and community mobilization mechanisms to increase community awareness of cervical cancer screening among WLHIV.

To meet the COP20 target, the program will continue to implement the screening hub and spoke strategies with the addition of high-volume ART sites (screening spokes) to feed the existing treatment hubs. Frequent transfer of trained providers resulting in disruption in the provision of services in facilities continues to be a challenge faced by the program. The program will continue to collaborate with the MoHW and DHMTs to encourage retention of trained staff

and sustain provision of services. Training of service providers for screening and treatment in CO2o will be decentralized to the districts, an approach which is cost-effective with the objective to constitute a larger pool of service providers and minimize the impact of transfers and attrition. The program's technical advisors and mentors will continue to provide mentorship to newly trained staff and ensure ongoing supervision post-certification as needed. This will help reduce the rate of unnecessary referrals for large lesions treatment. Five screening hubs will be added to the existing sites and at least ten screening spokes will be added to the screening sites network to increase availability of services and ease access for WLHIV in surrounding areas. Partner performance will be monitored through weekly tracking of performance indicators and the use of continuous quality improvement approach to improve program performance.

In COP2o, PEPFAR/B cervical cancer program will introduce thermocoagulation technique as a treatment option in high volume ART sites and support HPV DNA testing innovations for cervical cancer screening through self-collection for HPV DNA testing in Kweneng East and Gaborone districts and will work closely with the laboratory team to ensure timely release and availability of result using laboratory testing platforms. To align more with the COP2o PLL Guidance to enhance client and family centered services, PEPFAR/Botswana will enhance the complement of services offered by Nurse Practitioners (NP) and Medical Officers (MO) who provide HIV prevention, care and treatment services to FSW at drop-in centers to include HPV DNA screening services.

HPV DNA self-collection kits will be provided to FSW following a comprehensive education and counselling on cervical cancer screening and treatment services, including referral pathways for VIA screening and treatment following positive high-risk HPV DNA testing results. The NP or MO at the drop-in centers will facilitate and manage the specimen and result logistic to ensure efficient and timely service delivery. Female Sex Workers residing outside of Gaborone and Kweneng East districts will be provided cervical cancer screening using HPV DNA self-collection testing services. The cervical cancer HPV DNA screening and management for FSW will be provided with the same guiding principles that the GoB adheres to, including voluntarism, informed consent and confidentiality. Funding for cervical cancer screening services and management for FSWs will be with KP funds, through the EpiC Project, not from the specific cervical cancer earmark.

The Botswana MoHW's cervical cancer program has existing capacity to provide treatment services for women with large lesions and those diagnosed with a clinical suspicion of cancer. Currently, eligible women are linked to LEEP/colposcopy within a week, where all investigations including biopsy are performed by the LEEP doctor before referral to specialized care. Women with clinical suspicion of cancer will be referred to the treatment referral centers for further investigations and treatment, and these sites are Nyangabgwe Referral Hospital for the Northern region and Princess Marina Hospital for the Southern region. A couple of private hospitals in the Southern region also provide cancer treatment. The implementing partner will work closely with MoHW staff to ensure transportation of client is available for successful referral and patient hand over. Tracking of patient's referral will be done in collaboration with cancer treatment centers to make sure that the program accounts for all referred clients and establish whether they are receiving the appropriate treatment and care.

4.9 Viral Load and Early Infant Diagnosis Optimization

Botswana has 24 viral load laboratories spread throughout the 27 health districts, six of these are also EID laboratories. All these laboratories have a laboratory information system (LIS) which is part of the Integrated Patient Management System (IPMS). All these are government owned and supported laboratories and they use conventional molecular platforms for both viral load and EID testing. In FY20Q1, viral load coverage was at 84% and suppression is 99%. However, EID coverage remains low at 55% at 2 months and 66% by 12 months of age at the end of APR19. Viral load coverage has dropped to 84% from 95%. This drop was due to the addition of the 18 GoB sites which had a coverage of 44%. These sites had documentation and reporting challenges.

In COP20, PEPFAR/B in collaboration with the Botswana government will complete the laboratory diagnostic network optimization exercise to ensure appropriate procurement and placement of instruments. This exercise will review the following: 1) number and location of laboratories, 2) instrument type, 3) sample referral and transportation systems, 4) utilization and capacity of equipment, 5) data systems and connectivity, 6) supply chain, and 7) HR rationalization. PEPFAR/B will implement some reboot strategies that have been shown to work in improving viral load coverage. These strategies include continued support in capturing of laboratory results through placement of data clerks at facilities. These data clerks will be responsible for ensuring that all patients have a valid viral load results prior to consultation. Additionally, viral load blood collection appointment system will be adopted at the 18 GOB sites. PEPFAR/B will continue; 1) to strengthen the laboratory and clinic interface through mentorship and site support visits to ensure proper results management, 2) strengthen results management through training and roll out of the integrated specimen and results management register, 3) supporting viral load data access and reportability through the use viral load dashboards, 4) introduction of SMS technology for EID and viral load test appointments and results to send reminders to patients, 5) supporting commodities management at facilities and 6) introduction of line list for continuous viral load follow up in the community. In COP20 we will also support the development of the laboratory M&E structures and reporting dashboards to ensure timely reporting of all laboratory indicators. All viral load requests for pregnant and breast-feeding mothers will be tagged and processed as priority in the laboratories. Viral load champions will be engaged to follow up their results to ensure results availability. IPMS lab nodes will continue to be rolled out to all clinics with a government data network. Additionally, we will support government i on the interoperability between IPMS and PIMS data systems.

For EID, PEPFAR/B will continue to support data entry clerks at high volume sites for improved patient care at national level to improve analysis and reporting and troubleshooting of PMTCT data that EID. Data Clerks deployed at six laboratories that perform EID will continue to support the laboratory-clinic interface to track and provide follow-up for HIV services provided to HIV-exposed infants. The same initiative of using FCTOs and data clerks will be engaged to ensure that all EID results are filed before clients come for their review. Additionally, PEPFAR/B will ensure that there is coordination between the child welfare clinic, post-natal clinic and ante-natal clinic so that all exposed children are tested on time.

Botswana will ensure viral load and EID coverage of PLHIV and HIV exposed children in far to reach areas and where there is need by considering adopting POC systems. This decision will be dependent on the lab optimization outcome. Currently, the country has more than 30 GeneXpert machines which are stationed in the laboratories but not at POC sites. All the viral load and EID laboratories will be monitored for continuous quality control compliance using the viral load/EID score card checklist and the other external assessment. Furthermore, PEPFAR/B will ensure quality of testing for both viral load and EID testing by supporting equipment calibration and external quality control monitoring at sites level.

A total of \$3,637,150 has been allocated to supporting the above activities in the FAST.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

PEPFAR- supported above site or systems support activities strengthen host government health system for successful implementation of HIV prevention, care, and treatment services. Systems investments implemented at the above-site level are designed to address the most critical systems-based barriers that inhibit epidemic control. COP20 above site investments align with the key systems barriers identified in the SID 4.0 findings and with the GoB and in-country HIV stakeholders' agenda of optimizing opportunities to leverage and complement each other to ensure optimum return on investments as Botswana approaches epidemic control.

PEPFAR/B COP20 above site activities focuses on addressing the following areas of system barriers with the proposed activities:

1. Insufficient capacity to collect, manage and use routine program data in a timely manner
 - Build the National Data Warehouse capacity to house and analyze patient-level data in order to identify leaks in the clinical cascade
 - Establish data exchange through the interoperability layer in the National Data Warehouse - e.g. sending lab orders from PIMS to IPMS, verify Omang numbers in IPMS and PIMS on the GDN
2. Lack of data systems in country to track the layering of DREAMS services
 - Development of a data warehouse to track DREAMS layering and report on AGYW_PREV
3. Inefficient procurement and contract management system, and poor data visibility between central medical store and last mile delivery points
 - ART optimization; strengthen data visibility; strengthen procurement and contract management
4. Lack of data to effectively target high risk populations and military base
 - Conduct a SABERS to understand the current HIV epidemic in the Botswana Defense Force to strategically target higher risk camps and populations
5. Insufficient capacity for clinical waste management and lack of procedures on dealing with new waste disposal methods

- Support biosafety/biosecurity and waste management guidelines including disposal of dangerous waste

PEPFAR/B above site investments in COP20 respond to critical gaps, barriers, or bottlenecks impeding the delivery of HIV/AIDS services. Only activities essential to achieving epidemic control are proposed. PEPFAR/B will focus on improving Health Management Information System, HIV/AIDS supply chain and security of key commodities, clinical waste management and availability of appropriate data for HIV programming among the military. A summary of the proposed activities is presented below:

5.1 Strengthen the capacity of GoB to collect, manage and use routine program data

Data management and collection limits the GoB's ability to monitor the response to the HIV epidemic. PEPFAR/B has been working closely with the MoHW leadership in COP 19 on the data alignment and strengthening site level patient record keeping. Data merging for IPMS and PIMS exists at the national data warehouse, however, the exchange is in one direction. The systems need to be modified for bi-directional exchange and interoperability. In COP20, PEPFAR/B will continue to work with the MoHW to improve the Electronic Medical Record Systems around the country and take proactive steps to integrate the various data systems so that accurate data can be obtained in a timely manner.

Critical barriers to be addressed include:

- Insufficient capacity within MoHW to develop and rollout a centralized version of PIMS
- The stand-alone version of PIMS hinders real time sharing of key patient data across sites and systems
- Inadequate maintenance support to GDN infrastructure and lack of network connectivity for sites not on the GDN
- Lack of an interoperability layer to enable core systems to share data between sites and with the national data repository in close to real-time mode
- Inadequate capacity of the data warehouse (DW) to manage and process huge amounts of transactional data that will be available following PIMS centralization
- Limited ability of the DW to show dynamic dashboards for key epidemic control indicators
- Lack of standardized M&E system (including M&E plan with clear indicators, registers, reporting tools) to capture community level interventions

These are to be achieved through the following activities/interventions:

- Provide support to coordinate EMR system development and utilization – Continued support of mobile data for PIMS transmission to the National Data Warehouse and development of the centralized EMR

- Strengthen HRH and data quality at site-level (facilities and laboratories) to ensure timely capturing of clinical and lab data
- Capacity building through mentorship, training, and supervisory support to capacitate District M&E officers, Program Focal persons and facility-based data clerks on identified M&E technical areas - including coordination of workshops and collaborative forums to facilitate data use
- Strengthening data transmission (increase connectivity speed on GDN) and interoperability between systems - including sending lab orders from PIMS to IPMS, verify Omang numbers in IPMS and PIMS on the GDN, SMS technology to send reminders on clinical activities
- Providing technical assistance to update registers, EMRs, and reporting tools to reflect program and indicator changes (including community data capturing tools) and strengthen system and user support to EMRs at site level
- Provide technical assistance to develop a standardized M&E system (including M&E plan with clear indicators, registers, reporting tools) to capture community level interventions
- Strengthening Data Warehouse analytics and HIV case-based surveillance (CBS) for tracking of outcomes for HIV positive individuals - including recency and drug resistance
- Supporting the Health Statistics Unit on QI/QA for ICD coding and capturing of morbidity and mortality (TX_ML) data to improve tracking of patient outcomes

PEPFAR/B will strengthen community HMIS. In COP19, modifications will be made to EMRs to accommodate tracking HIV+ clients, in the facility and community, who have not initiated on treatment, those on treatment but are defaulters/lost to follow up, and those who are not virally suppressed. In COP20 M&E tools that capture tracking efforts will be available and used to update EMRs with the outcome(s) of tracking and tracing for each client assigned for tracing at community level.

5.2 Establish GoB data systems to track the layering of DREAMS services

Both COP19 and COP20 planning level letters emphasized the need to have a DREAMS database to enable tracking of layered services across partners implementing DREAMS in Botswana. This was done because at the time, implementing partners working on DREAMS had systems that were not harmonized and there was no national electronic database to capture DREAMS reporting at the national DREAMS Coordination Office. This all made reporting on DREAMS complicated and challenging. In responding to this challenge, Botswana programmed \$300,000 to Project Concern International (PCI) to develop a DREAMS data management system. This process has started and continues to go well, and it is being implemented in two phases. Phase one of implementation involved having the current DREAMS IPs working together to harmonize and align their digital systems in order to track layering across partners. These

partners will be able to report on DREAMS indicators using their DHIS2 databases starting FY20 Q2. Phase Two of the activity will involve working at national level with the DREAMS Coordination Unit based at NAHPA. The plan is to build an integrated DREAMS database that will combine data collected by all partners implementing in COP19. This system will be housed by the GoB, at either NAHPA or MoHW. Through this system, Botswana will improve efficiency in terms of data storage and retrieval, effective DREAMS layering, fast data processing, accurate reporting and to quickly generate ad-hoc reports. As DREAMS is expanding to an additional six SNU's, there was need to put additional resources (COP20) to be able to expand this project to the new SNU's; i) ensuring the new SNU's are included in reporting at national level and ii) ensuring the additional implementing partners being engaged for COP20 implementation also have systems to enable them to report on DREAMS layering. Additionally, the resources will allow PCI to continue providing technical assistance to the DREAMS implementing partners as well as the DREAMS Coordination Office to ensure the system works optimally.

5.3 Strengthen procurement and contract management systems

A strengthened and secure national supply chain system is vital to achieve and sustain epidemic control. The GoB funds about 95% of all HIV related commodities used for the response. A commitment yet to seen in any other country. But procurement and contract management are deficient and data visibility between central medical store and last mile delivery points is unreliable.

In COP20, PEPFAR/B will continue to support the MoHW through CMS to:

- Strengthen capacity of CMS on procurement and contract management systems through training and mentoring and support MoHW in advancing pooled procurement approaches to achieve cost savings
- Optimize ARVs by offering TLD to all eligible patients, transitioning to all eligible children DTG based regimens and implementing 3-6 months of MMD
- Strengthen the collection, management and use of supply chain related data for enhanced transparency and accountability of the supply chain system; and support building sustainable capacity in the area. Notably, PEPFAR/B will support the implementation of international pharmaceutical standards (GSI Healthcare standards/barcoding) to ensure visibility through the supply chain in the areas of product and location identification, data capture, and master data management. This will also ensure safe medicines/medical products & help prevent counterfeit/sub-standard products from entering the country. Furthermore, PEPFAR/B will provide TA to the MoHW to develop an electronic logistics management information system (eLMIS) that will be interoperable with the HMIS and CMS warehouse management system (PULSE).

5.4 Establish systems in the military that capture data

The Seroprevalence and Behavioral Epidemiological Risk Survey (SABERS) is aimed at helping the military better understand their HIV epidemic by linking HIV testing with demographic and

behavioral risk factors. There are numerous national HIV surveillance studies such as population-based HIV impact Assessment (PHIA), Demographic and Health Survey (DHS) and others like Botswana AIDS Impact Survey (BAIS), but SABERS is the only study to quantify HIV prevalence in military populations. SABERS measure and captures unique features of military service and its association with HIV infection, which the PHIA, DHS and BAIS can't do. The military tends to be a "closed" and very mobile community. They are stationed in the camps, performing border patrols and doing anti-poaching activities, hence not easily accessible by the civilian studies. As a result, it is true that national HIV prevalence may not reflect military HIV prevalence. SABERS offers other valuable information about risk behaviors that could affect other STI's such as syphilis, gonorrhoea, chlamydia, hepatitis B and C and without such data it will be difficult to tailor prevention, care and treatment strategies for the military population, as well as formulating and adopting appropriate military specific HIV/AIDS policies. It is only with such health data that we can develop evidence based biomedical, behavioral and structural interventions.

- According to the Military Sustainability dashboard (MILSID 2019), lack of data to advise programming is a key gap in the Military HIV response. The last SABERS was done in 2009 and it is recommended that SABERS should be done at least after every 5 years. Hence the beneficial need to implement SABERS soon.
- In order for the military to contribute significantly to Botswana's programmatic plan for epidemic control, it is important that we understand the current state of the HIV epidemic in the military; the military is a key priority population and very much relevant in the HIV/AIDS landscape.
- Health data from the SABERS will be key in determining where to focus our efforts in terms of programmatic implementation and efficient use of resources; hence steering away from a uniform program approach across all the military camps.
- The MILSID also clearly indicates that the Military HIV response is very much sustainable, and all key systems are working well. The only issue that we have is lack of current health data which will be closed once the SABERS is done.

5.5 Improve GoB's capacity for clinical waste management

Laboratories tend to work in silos, and there is a lack of standard monitoring and feedback mechanism available. There are national guidelines available for biosafety and security for disposal of dangerous waste management, however the implementation and adherence to these guidelines at laboratories as well as facilities (especially at points of care) is poor.

In COP20, PEPFAR/B will work closely with National Health Laboratory and Botswana National Quality Assurance Laboratory to strengthen National Public Health Laboratory for diagnosis and reporting of outbreaks and other communicable diseases in Botswana. This will include revamping the existing real-time reporting system, DHIS2 based aggregate monthly reporting and training of HCWs and policy/decision makers on early warning systems and routine feedback to facilities on remedial actions. Furthermore, PEPFAR/B will support biosafety/biosecurity and waste management guidelines including disposal of dangerous waste.

6.0 USG Operations and Staffing Plan

6.1 Long-Term Vacancies

- USAID's Strategic Information Specialist local position is currently under recruitment. Interviews are expected to be held in late March 2020.
- Peace Corps and DoD do not have any Long-Term Vacancies.
- A new PEPFAR Coordinator and a new Deputy Coordinator in the PEPFAR Coordination Office will be recruited during COP 19 and both should come on board in June 2020.
- CDC Botswana has only one long-term vacancy (Program Management Assistant) which will be filled as soon as the position completes AF classification. Unfortunately, classification has been ongoing for over 18 months, thus created the long-term vacancy.

6.2 New Positions

There are 4 new positions in COP20.

PEPFAR Coordination Office

In line with the priorities and minimum program requirements outlined in the COP20 PLL, PEPFAR/B will create two new positions in the PEPFAR Coordination Office to manage respectively the community-led monitoring platform to be established and the expansion of DREAMS activities to six new SNU.

- **Community-Led Monitoring Grants Manager** This position will oversee multiple small grants and collaboration with community groups, CSOs, and patient/beneficiary groups to address, persistent problems and barriers to effective, client-centered services and improved health outcomes at the site level. This position will be for Local Staff and filled by October 1, 2020.
- **DREAMS Coordinator** with the quadrupling of DREAMS funding and geographical coverage in COP20, PEPFAR/B is creating a dedicated DREAMS Coordinator position. The position will oversee inter-agency coordination of DREAMS activities as well as liaise with the GoB's DREAMS coordination team and other donors supporting AGYW-focused programming such as UNICEF and the Global Fund. This position will be based in the PEPFAR Coordination Office, as outlined in the PLL and filled by October 1, 2020.

Peace Corps

DREAMS HIV Coordinator In order to provide adequate support and constant connection among PEPFAR implementing agencies and partners, it is of utmost importance that Peace Corps hires a full time DREAMS HIV Coordinator who will report directly to the Director of Programming and Training and serve as the link between Peace Corps and the other implementing agencies. The DREAMS HIV Coordinator will work together with Peace Corp's M&E staff strategically to make certain that targets and high-quality care and support are offered to our shared clients.

USAID

Local Partner Management Specialist In an effort to prioritize PEPFAR mandate of transitioning USG resources to host-country local partners, USAID/Botswana plans to transition approximately 30% of its COP20 program investment to five new local implementing partners - an increase from 5% in COP19. To ensure optimal oversight and partner management and performance, USAID/Botswana seeks to hire a locally recruited full-time Local Partner Management Specialist to support this substantial increase in project management load. The Specialist will work closely with local partners to strengthen their financial management and data systems and enhance their organizational governance. The incumbent will also provide partners with technical guidance to monitor their portfolios across key PEPFAR priorities and ensure implementation with fidelity.

6.3 Overview of the CODB

As part of the COP20 process and with the understanding that we were to flatline the Agencies' CODB budgets, PEPFAR/B examined its interagency staffing footprint and organizational structures. The overall Botswana CODB in COP20 increased by 15% from COP19. The increases were due to required staffing and programmatic instructions in the PLL (affecting STATE and PC) and increased regional and ICASS costs (affecting USAID). The staffing profile reflects cross-cutting technical support to the priority budget codes.

| M&O Budget by Agency | | | |
|---------------------------------|----------------------|--------------------------------|---------------------|
| Agency | COP19 M&O | COP20 Budgeted, M&O | Difference |
| Totals | \$ 12,045,609 | \$ 14,279,888 | \$ 2,234,279 |
| DOD | 172,000 | \$ 174,355 | \$ 2,355 |
| HHS/CDC | 6,348,645 | \$ 6,348,645 | 0 |
| HHS/HRSA | 0 | 0 | 0 |
| PC | \$ 2,225,797 | \$ 3,654,797 | \$ 1,429,000 |
| State | \$ 454,949 | \$ 629,431 | \$ 174,482 |
| USAID | \$ 2,844,303 | \$ 3,472,660 | \$ 628,357 |

USAID

USAID's CODB increased by \$628,357 from COP19 levels. Almost 50% of this total increase (around \$316K) is USAID/Botswana's increased contribution to USAID/Southern Africa platform for cost of doing business; this amount increased from \$200,000 in COP19 to \$516,000 in COP20. These costs are for the support USAID/Botswana receives in areas such as human resources, acquisition and assistance, financial management, program office and legal support. In the past these costs were subsidized through the pipeline left in USAID/Southern Africa's

regional PEPFAR program. Beginning in COP20, however, USAID/Botswana, and all other USAID Missions under the Southern Africa Mission, will be responsible for paying these costs in full out of their country PEPFAR funds. Another large portion of this year's CODB increase, about \$246K, is for ICASS and HQ's IT Services Tax. These costs were underestimated in COP19, whereas this year they are costed based on actual invoices. The ICASS budget, went up from \$385,000 in COP19 to \$590,812 in COP20. The last bit of increase in CODB of about \$130K is for Locally Recruited Staff salaries and benefits line item. Close to \$85K of this amount will be used to recruit the proposed Local Partner Management Specialist position mentioned above. The rest is to increase funding for three local positions from planned 50% in COP19 to 100% in COP20. These positions were approved in COP18 but were not recruited until COP19. Therefore, in COP19, knowing that these positions will not be onboard for the entire year and due to limited funding, they were budgeted at 50% only. Additionally, as in past COPs, USAID's CODB includes the PEPFAR Coordinator and Deputy Coordinator salary support. Because of this, the USAID/Botswana COP20 staffing footprint appears to be 20, while functionally it is 18 staff who will manage USAID programs.

CDC

CDC's CODB remained the same as COP 19. CDC M&O funds and some of its administrative staff included in COP20 funding support the management and associated procurement of the Gaborone West "GWest" facility shared by CDC, USAID, DoD and the PEPFAR/B Coordination Office, which are not located within the US Embassy compound.

DOD

DOD's CODB increased 1.3% to support a modest salary increase for the LES Program Manager with all other areas remained the same as COP19.

Peace Corps

Botswana currently has a total of 140 Volunteers working to support PEPFAR efforts in country. Forty-One of those volunteers will be directly supporting PEPFAR DREAMS activities and will be strategically placed in the DREAMS growth areas. Peace Corps' CODB in COP20 increased due to an increase of 21 volunteers for the DREAMS program. The large increase is due to the PCV costs of \$2,785,219, up from \$1,785,219 in COP 19 where PEPFAR directly supported only 20 volunteers. This offers renewed responsibilities and targets for Peace Corps. Peace Corps, because volunteers are connected to communities and agencies, are strategically placed to be the bridge between service and community. Peace Corps' CODB budget includes \$531,643 in Applied pipeline

State (PEPFAR Coordination Office)

State's CODB increased from \$454,949 to \$629,431. This increase was to cover the DREAMS Coordinator and Community Monitoring Grants Manager. There were increases in ICASS and Computer Services ITS Tax associated with this. All other budget areas remained flat.

APPENDIX A -- PRIORITIZATION

Table A.1 Continuous Nature of SNU Prioritization to Reach Epidemic Control

| SNU | COP | Prioritization | Results Reported | Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------|-------|----------------|------------------|---|------|------|------|------|------|-------|-----|-------|------|-------|------|-------|------|-------|------|-------|------|-------|------|-------|------|------|------|---------------------|--|--|--|
| | | | | Treatment Coverage at APR by Age and Sex | | | | | | | | | | | | | | | | | | | | | | | | Overall TX Coverage | | | |
| | | | | <1 | | 1-4 | | 5-9 | | 10-14 | | 15-19 | | 20-24 | | 25-29 | | 30-34 | | 35-39 | | 40-44 | | 45-49 | | 50+ | | | | | |
| F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | | | | |
| Bobirwa District | COP19 | Sustained | APR20 | 10% | 8% | 5% | 5% | 47% | 45% | 31% | 33% | 70% | 42% | 72% | 36% | 84% | 32% | 68% | 41% | 68% | 51% | 71% | 58% | 71% | 61% | 69% | 63% | 62% | | | |
| | COP20 | Sustained | APR21 | 64% | 67% | 72% | 69% | 71% | 70% | 42% | 42% | 61% | 49% | 64% | 44% | 66% | 40% | 69% | 45% | 68% | 53% | 59% | 54% | 55% | 52% | 55% | 52% | 57% | | | |
| Francistown District | COP19 | Sustained | APR20 | 32% | 32% | 28% | 27% | 119% | 117% | 86% | 77% | 120% | 94% | 137% | 90% | 141% | 97% | 147% | 90% | 153% | 102% | 154% | 120% | 156% | 132% | 154% | 140% | 134% | | | |
| | COP20 | Sustained | APR21 | 136% | 124% | 99% | 99% | 155% | 154% | 85% | 84% | 145% | 107% | 157% | 92% | 166% | 78% | 175% | 96% | 174% | 120% | 151% | 131% | 141% | 131% | 141% | 131% | 140% | | | |
| Gaborone District | COP19 | Sustained | APR20 | 27% | 29% | 21% | 21% | 121% | 119% | 79% | 79% | 123% | 111% | 133% | 100% | 143% | 80% | 152% | 87% | 156% | 108% | 157% | 126% | 159% | 136% | 158% | 142% | 136% | | | |
| | COP20 | Sustained | APR21 | 123% | 123% | 99% | 98% | 151% | 151% | 83% | 83% | 139% | 103% | 150% | 87% | 158% | 75% | 167% | 92% | 166% | 115% | 145% | 125% | 134% | 125% | 135% | 125% | 134% | | | |
| Goodhope District | COP19 | Sustained | APR20 | 0% | 0% | 11% | 11% | 76% | 77% | 51% | 49% | 76% | 65% | 83% | 59% | 86% | 49% | 89% | 102% | 91% | 70% | 92% | 80% | 92% | 84% | 92% | 87% | 84% | | | |
| | COP20 | Sustained | APR21 | 0% | 0% | 75% | 77% | 81% | 79% | 46% | 47% | 71% | 57% | 76% | 51% | 78% | 45% | 82% | 52% | 81% | 61% | 70% | 63% | 65% | 62% | 66% | 62% | 67% | | | |
| Kgatleng District | COP19 | Sustained | APR20 | 17% | 17% | 8% | 8% | 56% | 59% | 38% | 40% | 65% | 53% | 77% | 48% | 75% | 44% | 81% | 47% | 77% | 58% | 80% | 67% | 78% | 70% | 78% | 72% | 70% | | | |
| | COP20 | Sustained | APR21 | 132% | 139% | 76% | 77% | 91% | 91% | 53% | 52% | 81% | 64% | 86% | 56% | 89% | 50% | 93% | 59% | 92% | 69% | 80% | 72% | 75% | 70% | 75% | 69% | 76% | | | |
| Kweneng East District | COP19 | Sustained | APR20 | 8% | 8% | 6% | 6% | 36% | 36% | 24% | 24% | 52% | 40% | 56% | 37% | 57% | 32% | 61% | 38% | 58% | 45% | 62% | 54% | 58% | 58% | 56% | 57% | 53% | | | |
| | COP20 | Sustained | APR21 | 84% | 85% | 65% | 65% | 59% | 59% | 36% | 36% | 50% | 41% | 53% | 37% | 55% | 34% | 57% | 39% | 55% | 44% | 48% | 44% | 45% | 43% | 45% | 43% | 47% | | | |
| Lobatse District | COP19 | Sustained | APR20 | 0% | 0% | 27% | 27% | 106% | 115% | 76% | 85% | 122% | 109% | 162% | 147% | 152% | 215% | 157% | 159% | 149% | 108% | 151% | 118% | 152% | 132% | 150% | 135% | 142% | | | |
| | COP20 | Sustained | APR21 | 139% | 100% | 115% | 118% | 181% | 185% | 101% | 98% | 164% | 124% | 178% | 104% | 186% | 86% | 197% | 107% | 196% | 135% | 170% | 147% | 159% | 146% | 160% | 148% | 158% | | | |
| Mahalapye District | COP19 | Sustained | APR20 | 17% | 16% | 8% | 9% | 70% | 68% | 45% | 46% | 95% | 78% | 98% | 76% | 97% | 69% | 99% | 76% | 95% | 102% | 96% | 94% | 102% | 96% | 97% | 97% | 93% | | | |
| | COP20 | Sustained | APR21 | 122% | 122% | 75% | 74% | 88% | 88% | 51% | 51% | 79% | 63% | 84% | 55% | 87% | 49% | 91% | 58% | 90% | 68% | 78% | 70% | 73% | 69% | 73% | 69% | 74% | | | |
| Moshupa District | COP19 | Sustained | APR20 | 0% | 0% | 13% | 13% | 45% | 42% | 30% | 29% | 53% | 48% | 59% | 49% | 62% | 50% | 67% | 52% | 66% | 50% | 66% | 58% | 70% | 60% | 67% | 66% | 61% | | | |
| | COP20 | Sustained | APR21 | 42% | 42% | 62% | 62% | 72% | 71% | 43% | 43% | 63% | 50% | 66% | 45% | 69% | 41% | 72% | 47% | 70% | 54% | 61% | 56% | 57% | 54% | 57% | 54% | 58% | | | |
| Ngamiland District | COP19 | Sustained | APR20 | 17% | 17% | 17% | 16% | 81% | 84% | 64% | 54% | 94% | 69% | 118% | 60% | 119% | 60% | 120% | 62% | 113% | 76% | 114% | 88% | 115% | 96% | 113% | 102% | 100% | | | |
| | COP20 | Sustained | APR21 | 70% | 70% | 89% | 85% | 115% | 114% | 64% | 64% | 104% | 82% | 111% | 71% | 120% | 64% | 127% | 70% | 126% | 87% | 110% | 94% | 102% | 95% | 102% | 95% | 101% | | | |
| North East District | COP19 | Sustained | APR20 | 0% | 0% | 6% | 6% | 42% | 42% | 52% | 27% | 73% | 62% | 82% | 52% | 89% | 46% | 89% | 55% | 88% | 71% | 88% | 75% | 90% | 79% | 85% | 83% | 79% | | | |
| | COP20 | Sustained | APR21 | 0% | 0% | 66% | 67% | 74% | 74% | 44% | 44% | 66% | 53% | 69% | 46% | 72% | 42% | 75% | 49% | 91% | 58% | 74% | 56% | 64% | 58% | 59% | 60% | 61% | | | |
| Palapye District | COP19 | Sustained | APR20 | 33% | 33% | 29% | 31% | 114% | 115% | 75% | 75% | 124% | 102% | 129% | 100% | 137% | 107% | 143% | 106% | 149% | 101% | 153% | 120% | 154% | 131% | 153% | 137% | 133% | | | |
| | COP20 | Sustained | APR21 | 124% | 105% | 90% | 100% | 140% | 141% | 78% | 77% | 133% | 100% | 144% | 85% | 152% | 73% | 161% | 89% | 159% | 111% | 139% | 121% | 130% | 121% | 130% | 121% | 129% | | | |
| Selibe Phikwe | COP19 | Sustained | APR20 | 12% | 11% | 11% | 11% | 65% | 63% | 41% | 43% | 77% | 53% | 86% | 47% | 88% | 46% | 85% | 47% | 85% | 60% | 87% | 89% | 88% | 96% | 168% | 101% | 91% | | | |
| | COP20 | Sustained | APR21 | 104% | 104% | 80% | 82% | 112% | 109% | 62% | 63% | 96% | 76% | 104% | 66% | 108% | 59% | 116% | 70% | 115% | 79% | 101% | 86% | 94% | 86% | 93% | 86% | 93% | | | |
| Serowe District | COP19 | Sustained | APR20 | 38% | 33% | 27% | 26% | 114% | 113% | 77% | 75% | 134% | 94% | 134% | 90% | 141% | 95% | 146% | 95% | 149% | 101% | 154% | 120% | 154% | 131% | 153% | 137% | 133% | | | |
| | COP20 | Sustained | APR21 | 174% | 124% | 93% | 95% | 148% | 146% | 82% | 81% | 141% | 104% | 152% | 89% | 160% | 75% | 169% | 92% | 167% | 116% | 146% | 126% | 136% | 126% | 137% | 127% | 135% | | | |
| South East District | COP19 | Sustained | APR20 | 0% | 0% | 9% | 9% | 34% | 33% | 20% | 35% | 46% | 38% | 54% | 38% | 55% | 38% | 59% | 38% | 56% | 43% | 56% | 48% | 52% | 52% | 51% | 52% | 50% | | | |
| | COP20 | Sustained | APR21 | 83% | 88% | 65% | 63% | 61% | 61% | 37% | 37% | 51% | 42% | 55% | 37% | 57% | 34% | 59% | 39% | 57% | 44% | 50% | 45% | 46% | 44% | 46% | 44% | 48% | | | |
| Southern District | COP19 | Sustained | APR20 | 13% | 13% | 7% | 7% | 44% | 44% | 30% | 30% | 54% | 45% | 66% | 42% | 65% | 34% | 71% | 46% | 67% | 56% | 67% | 63% | 68% | 61% | 64% | 61% | 60% | | | |
| | COP20 | Sustained | APR21 | 236% | 158% | 77% | 72% | 82% | 81% | 48% | 48% | 71% | 57% | 76% | 50% | 79% | 45% | 82% | 52% | 81% | 61% | 70% | 63% | 65% | 62% | 66% | 62% | 67% | | | |
| Tutume District | COP19 | Sustained | APR20 | 15% | 15% | 20% | 17% | 71% | 90% | 52% | 47% | 76% | 62% | 87% | 54% | 85% | 51% | 92% | 55% | 97% | 67% | 93% | 82% | 94% | 89% | 94% | 89% | 84% | | | |
| | COP20 | Sustained | APR21 | 139% | 146% | 82% | 77% | 93% | 93% | 54% | 53% | 83% | 66% | 89% | 58% | 92% | 51% | 96% | 60% | 95% | 71% | 82% | 74% | 77% | 71% | 78% | 72% | 78% | | | |

APPENDIX B – Budget Profile and Resource Projections

B.1. COP20 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP20 Budget by Program Area

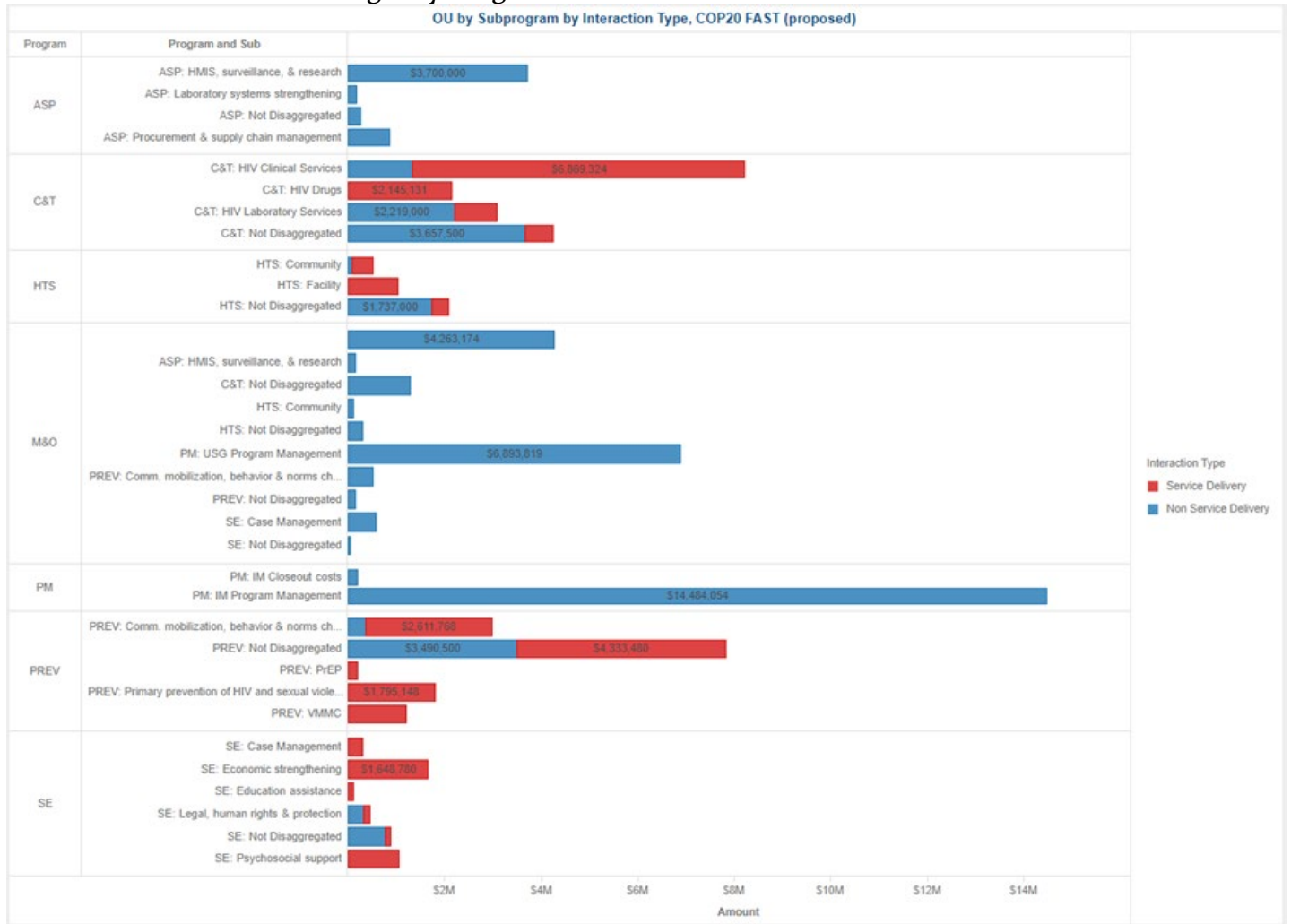


Table B.1.2 COP20 Total Planning Level

| COP20 Total Planning Level | | | |
|----------------------------|--------------|--------------|---------------|
| Applied Pipeline | New Funding | FY19 Funding | Total Spend |
| \$5,396,449 | \$63,308,551 | \$5,000,000 | \$ 73,705,000 |

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)

| Resource Allocation by PEPFAR Budget Code (new funds only) | | |
|--|---|------------------|
| PEPFAR Budget Code | Budget Code Description | Amount Allocated |
| MTCT | Mother to Child Transmission | \$ 360,840 |
| HVAB/Y | Abstinence/Be Faithful Prevention/Youth | \$ 2,360,027 |
| HVOP | Other Sexual Prevention | \$ 15,732,630 |
| IDUP | Injecting and Non-Injecting Drug Use | \$ - |
| HMBL | Blood Safety | \$ - |
| HMIN | Injection Safety | \$ - |
| CIRC | Male Circumcision | \$ 1,648,857 |
| HVCT | Counseling and Testing | \$ 4,927,649 |
| HBHC | Adult Care and Support | \$ 4,498,741 |
| PDCS | Pediatric Care and Support | \$ 888,652 |
| HKID | Orphans and Vulnerable Children | \$ 4,525,814 |
| HTXS | Adult Treatment | \$ 19,956,057 |
| HTXD | ARV Drugs | \$ 2,187,618 |
| PDTX | Pediatric Treatment | \$ - |
| HVTB | TB/HIV Care | \$ 1,200,000 |
| HLAB | Lab | \$ 250,000 |
| HVSI | Strategic Information | \$ 2,324,302 |
| OHSS | Health Systems Strengthening | 357,143.0 |
| HVMS | Management and Operations | 7,090,218.0 |
| TOTAL | | \$ 68,308,548 |

B.2 Resource Projections

Review of the OU and IP performance were done at program technical working groups to review what worked, what needed improvement, deliberated over current mechanisms to implement in COP20, what is needed as per COP20 PLL and OU priorities. The agency leads and Front office also reviewed the key priorities as highlighted in the COP20 PLL to ensure more focused programming for the OU. Data sources used to plan for COP20 funding include FY19 expenditure report, COP19 FAST, COP20 targets and above site activities as planned for in COP20. COP19 funding amounts were adjusted based on upward and downwards shifts in program areas scope to calculate the required funding amount needed for COP20 program area per beneficiary type. Some activities were kept at stable budget as from COP19 looking at the OU focus on sustaining the gain. Downwards funding shifts were made on program areas such as testing and ART treatment initiations as the OU is sustaining the gains in treatment services. Of the \$ 73,705,000 funding amount, \$7,500,000 is held at SGAC (currently as TBD IM# 81484) for post-BAIS programmatic updates.

APPENDIX C – Tables 6 and SRE

Table 6-E (Entry of Above Site Programs Activities)

| Funding Agency | Prime Partner | COP20 Program Area | COP20 Beneficiary | COP20 Activity Category | Key Systems Barrier | Intervention Start | Intervention End | COP20 Benchmark |
|----------------|-------------------------------|--|--|--|--|--------------------|------------------|--|
| USAID | Project Concern International | ASP: HMIS, surveillance, & research-NSD | Females: Young women & adolescent females | Program and data quality management | PEPFAR/Botswana must update its data systems to track the layering of DREAMS services | COP20 | COP21 | System completed and functional |
| USAID | Chemonics International | ASP: Procurement & supply chain management-NSD | Non-Targeted Pop: Not disaggregated | Forecasting, supply chain plan, budget, and implementation | Inefficient procurement and contract management system. Insufficient data visibility between central medical store and last mile delivery points | COP19 | COP21 | A more resilient and reliable supply chain system |
| HHS/CDC | MINISTRY OF FINANCE | ASP: HMIS, surveillance, & research-NSD | Non-Targeted Pop: Not disaggregated | HMIS systems | Insufficient capacity to collect, manage and use routine program data in a timely manner | COP19 | COP20 | 300,000 |
| DOD | JHPIEGO CORPORATION | ASP: HMIS, surveillance, & research-NSD | Priority Pops: Military & other uniformed services | Surveillance | Lack of current data to effectively target high risk populations and garrisons | COP19 | COP20 | Completed SABERS |
| HHS/CDC | | ASP: HMIS, surveillance, & research-NSD | Non-Targeted Pop: Not disaggregated | HMIS systems | Insufficient capacity to collect, manage and use routine program data in a timely manner | COP19 | COP22 | 4 |
| HHS/HRSA | UNIVERSITY OF WASHINGTON | ASP: HMIS, surveillance, & research-NSD | Non-Targeted Pop: Not disaggregated | HMIS systems | Insufficient capacity to collect, manage and use routine program data in a timely manner | COP20 | COP21 | By the end of COP20, interoperability between IPMS, PIMS (for lab orders and clinical cascade data) and the national birth and death registry should be operational. |
| HHS/HRSA | UNIVERSITY OF WASHINGTON | ASP: Laboratory systems strengthening-NSD | Non-Targeted Pop: Not disaggregated | Lab quality improvement and assurance | Insufficient capacity for clinical waste management and lack of procedures on dealing with new waste GTC | COP20 | COP21 | 40 laboratories & 53 PEPFAR supported facilities trained, mentored and adhered to guidelines |
| HHS/CDC | | ASP: HMIS, surveillance, & research-NSD | Non-Targeted Pop: Not disaggregated | Surveillance | Insufficient capacity to collect, manage and use routine program data in a timely manner | COP18 | COP21 | 300000 |

SRE Tool E (Entry of Surveillance, Surveys, Research and Evaluation Activities)

SRE Tool-E (Entry of Surveillance, Surveys, Research and Evaluation Activities)

| Funding Agency | Prime Partner | COP20 Program Area | COP20 Beneficiary | Project Title | Project Start COP Year | Project End COP Year |
|----------------|--|--|--|---------------|------------------------|----------------------|
| USAID | Project Concern International | ASP: HMIS, surveillance, & research-NSD | Females: Young women & adolescent females | | | |
| USAID | Chemonics International, Inc. | ASP: Procurement & supply chain management-NSD | Non-Targeted Pop: Not disaggregated | | | |
| HHS/CDC | MINISTRY OF FINANCE AND DEVELOPMENT PLANNING | ASP: HMIS, surveillance, & research-NSD | Non-Targeted Pop: Not disaggregated | | | |
| DOD | JHPIEGO CORPORATION | ASP: HMIS, surveillance, & research-NSD | Priority Pops: Military & other uniformed services | SABERS | COP18 | COP20 |
| HHS/HRSA | UNIVERSITY OF WASHINGTON | ASP: HMIS, surveillance, & research-NSD | Non-Targeted Pop: Not disaggregated | | | |
| HHS/HRSA | UNIVERSITY OF WASHINGTON | ASP: Laboratory systems strengthening-NSD | Non-Targeted Pop: Not disaggregated | | | |

APPENDIX D– Minimum Program Requirements

| | | Minimum Program Requirement | Detailed Narrative for the sections | Succinctly note if the program is meeting or not meeting MPR | | Assessment and informed COP20 planning |
|--------------------|---|--|---|--|---|--|
| | | | | Program is meeting/not meeting MPR | If not meeting MPR, why and plans to ensure program meets MPR | |
| Care and Treatment | 1 | Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. | In FY20 Q1, the overall LTT was at 89% while the Same Day (SD) initiation rate improved from 54% in FY19Q4 to 57 % in FY20Q1 and FT initiation rate improved from 70% in FY19Q4 to 73% in FY20Q1. | MPR adopted and in implementation, but direct and immediate linkage to treatment not yet above 95% across age, sex, and risk groups. | Main Focus: a) strengthen the COP18 reboot lessons in the 52 PEPFAR-supported sites, including adding more Nurse Prescribers (NP) for extended hours and weekend ART service; and b) provide TA to GoB to optimize linkage to treatment through integration of ART services into outpatient departments, train GoB NP to serve as "Fast Track Champions," incorporate ART initiation in non-ART clinic days, and use the 30 day starter packs as a means to operationalize the same day and fast-track ART initiation minimum requirements already adopted. | Assessment completed; information used to inform COP20 activities. |
| | 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 weighing >20kg, and removal of all nevirapine-based regimens | The country TLD transition was adopted and started September 1, 2018. At the end of FY20 Q1, the coverage was 181,874 of the estimated 299,500 eligible PLHIV (61% of clients eligible for TLD transition). TLD transition to be completed by September 2020 - including 103,000 clients on TEE (Atripla) who were initially planned to transition to TAF-ED will now be transitioned to TLD. The transition covers adults (including women of childbearing age) and children on treatment. | MPR adopted and in implementation, but partially met. | GoB working on procuring DTG-based regimens for children weighing >20kg; pediatric formulations not yet available in country. | Assessment completed; information used to inform COP2020 activities. |

| | Minimum Program Requirement | Detailed Narrative for the sections | Succinctly note if the program is meeting or not meeting MPR | | Assessment and informed COP20 planning |
|---|--|---|--|--|--|
| | | | Program is meeting/not meeting MPR | If not meeting MPR, why and plans to ensure program meets MPR | |
| 3 | Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents | 3M-MMD policy adopted and in implementation; 6M-MMD planned to start in January 2020. Due to shortage of ARVs experienced around September/October 2019, the MoHW ordered a temporary pause on implementing MMD in November 2019. The ARV situation has stabilized, and the pause has been lifted. The decision to start 6M-MMD has not yet been officially communicated by the MoHW, but in FY20 Q1, 18,000+ clients were on 3M-MMD and 170+ were on 6M-MMD. | MPR adopted and in implementation, but partially met. | COP20 will focus on a) expand 6M-MMD and b) improve supply chain efficiencies. | Assessment completed; information used to inform COP2020 activities. |
| 4 | All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient | MoHW adopted the provision of TPT to all HIV-positive persons in April/May 2019. In August/September 2019, over 600 HCW from all health districts were trained on TPT and registers were updated. Dind distributed. By FY20 Q1, 11,606 eligible patients were initiated on TPT and by mid-Q2 32,175 patients were initiated on TPT - COP19 TPT target is 72,272. Thirteen health districts out of 27 are currently implementing TPT. GoB currently using INH (6H) & Pyridoxine but has adopted 3HP and ready to start procuring it. | MPR adopted and in implementation, but partially met. | COP20 focus includes a) cover all health districts and facilities, and b) routinize the provision of TPT as an integral part of the HIV clinical care package. This effort will involve addressing the occasional shortage of drugs and providing post-training mentoring and supervision to the HCWs for continuous quality improvement activities, especially for the use of standardized tools, completeness of documentations, tracking of commodities, and reporting of achievements. | Assessment completed; information used to inform COP2020 activities. |

| | Minimum Program Requirement | Detailed Narrative for the sections | Succinctly note if the program is meeting or not meeting MPR | | Assessment and informed COP20 planning |
|--------------|--|---|---|--|--|
| | | | Program is meeting/not meeting MPR | If not meeting MPR, why and plans to ensure program meets MPR | |
| 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 | <p>Botswana has 24 VL labs with 6 of them offering EID testing as well. All testing uses conventional analyzers and there is no POCT for VL and EID at the moment. All VL and EID labs are on IPMS.</p> <p>However, only 75 clinics and 26 hospitals are on IPMS. This affects results flow from the labs to the facilities and results in low VL and EID coverage across facilities.</p> <p>In COP19, the Diagnostic network optimization mapping data gathering will be completed, and findings shared.</p> <p>COP20 will focus on the implementation of the recommendations from the diagnostic network mapping for VL/EID, TB and other coinfections to ensure improved coverage results turnaround time and 100% access to EID. With the addition of 18 GoB sites in COP19 to VL coverage reporting, the OU performance dropped from 96% VL coverage to 84 %. EID coverage remains low at 55% at 2 months.</p> | MPR adopted and in implementation, but partially met. | <p><u>Planned Activities for VL coverage:</u> 1. Mentor the 18 new sites on VL coverage reporting requirements; 2. Implement lessons learnt from the reboot in these new sites at both clinic and labs. These include HRH, follow up of sample & results, monitoring of clinic turnaround times, enhancing access and usage of IPMS and DHIS data systems, client literacy and follow up of clients; 3. Continuous monitoring of the already good performing sites through multi-stakeholder site visits to maintain a coverage of greater than 95%; and 4. Auditing of VL/EID labs.</p> <p><u>Planned Activities for EID coverage:</u> 1. HRH placement and training on sample collection results follow up; 2. Targeted placement of Point of care test at difficult to reach areas (based on findings from lab optimization exercise); 3. Intensifying of follow up of mother -infant pairs to increase access to EID testing; 4. Utilization of SMS technology to manage appointments and share result and EID/VL champions for tracking infants who need EID and mothers who need VL; and 5. form clinic-lab working group & champions to address EID/VL specimen flow and TAT.</p> | |
| Case Finding | 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 must be tested for HIV | GoB has adopted Active Partner Notification and adapted relevant guidelines, tools and materials to ensure roll-out of index services with safety. Training of HCWs providing index (with strong emphasis on ethical provision of services based on WHO's 5Cs) has been rolled-out. The goal is to ensure certification of all HCWs successfully completing the training. The next steps are to ensure collaboration with the newly established community-led monitoring platform to monitor clients' experience at sites. | MPR adopted and in implementation; expected to be met by COP19 APR. | | |

| | Minimum Program Requirement | Detailed Narrative for the sections | Succinctly note if the program is meeting or not meeting MPR | | Assessment and informed COP20 planning |
|--------------------|-----------------------------|---|--|---|---|
| | | | Program is meeting/not meeting MPR | If not meeting MPR, why and plans to ensure program meets MPR | |
| Prevention and OVC | 1 | Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) | GoB adopted PrEP as a combination prevention strategy in the 2016 national ART guidelines and NSF III (2019/2023) identifies PrEP as a key prevention intervention. PrEP is currently offered to KPs (FSWs and MSM) countrywide but in limited number of facilities and to AGYW in 2 DREAMS districts. GoB is committed to scaling up PrEP with a national roll out and an expansion to include AGYW in and outside DREAMS districts, adult men engaged in high risk sex practices, key populations, PBFW and sero discordant couples. | MPR adopted and in implementation, but partially met. | In COP20, PrEP will be rolled out nationally and offered additional sub-populations to include PBFW, discordant couples wishing to conceive, men in the military and other high-risk settings. COP20 activities will also include client literacy and demand creation for PrEP, and pharmacovigilance across the program to monitor for and respond to any adverse events that may arise. |
| | 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 | In COP20, the OVC program will pivot to focus more on children directly affected by the epidemic, which includes increasing the reach to adolescents and children living with HIV with OVC services, ensuring the HIV status of all children in the program is known (HIV negative or positive), and linking those who are HIV positive to care and treatment and ensuring that all children served who are at risk of HIV are linked to HTS. Increasing the reach to 9-14-year-old boys and girls with primary prevention of HIV and violence is also another point of focus. | MPR adopted and in implementation, but partially met. | COP20 Focus: 1) actively facilitate testing for all children at risk of HIV infection by a) documenting the HIV status of all OVC enrolled in the comprehensive program and ensuring all those deemed at risk of HIV are linked to HTS and followed up to ensure referral completion and b) training OVC service providers on self-testing to increase uptake & use of self-testing kits among families with OVC; 2) facilitate linkage to treatment and provide support and case management for vulnerable children and adolescents living with HIV by a) expanding partnerships with IPs in the clinical space via signing MOUs & SOPs for bi-directional referrals, b) strengthening partnerships and bi-directional referrals with other CSOs serving children & adolescents living with HIV, c) strengthening and expand the teen club model used for providing treatment adherence support among peers; and 3) reduce risk for adolescent girls in high HIV burden areas and for 9-14 year old girls and boys through primary prevention of sexual violence and HIV by a) ensuring implementation of evidence-based curricula for primary prevention of sexual violence and HIV with fidelity in all OVC SNUs in close coordination with DREAMS activities, and b) assessing all girls in the OVC |

| | Minimum Program Requirement | Detailed Narrative for the sections | Succinctly note if the program is meeting or not meeting MPR | | Assessment and informed COP20 planning |
|--|-----------------------------|---|--|--|--|
| | | | Program is meeting/not meeting MPR | If not meeting MPR, why and plans to ensure program meets MPR | |
| | | | | program for DREAMS eligibility and linking them appropriately. | |
| Policy & Public Health Systems Support | 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 | There are no formal or informal user fees to access HIV and related health services in Botswana. | MPR adopted and met. | |
| | 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 | Botswana developed a QI framework in 2017 and has now integrated a QI team into the MoHW's Department of M&E, but the implementation of the framework is challenged by the limited number of skilled staff. Quality Management activity are mainly limited to PEPFAR/B Implementing Partners and supported districts. In COP19, the OU is implementing several activities to scale up CQI practices across all sites nationwide. These include: regular bilateral consultative meetings with MoHW/HSME/QA; 14 prioritized districts for performance improvement are developing QI work plans; SIMS refresher training to MoHW HIV program managers planned for FY20 Q2, prior to conducting SIMS baseline assessments; and sharing of best practices through national learning collaborative meetings. | MPR adopted and in implementation, but partially met. | <u>COP20 Focus:</u> Monitor CQI activities at all sites using the national quality health standards and SIMS; routinize the newly established QI collaborative meetings and quality Forums at district, regional and national levels; review of patient's charter to include client-centered approaches and MoHW priorities in quality improvement; develop the health provider's charter to promote service quality across the health system; strengthen national and district level M&E capacity to manage data for HIV Programs and utilize DHIS II system (including DQA/DQI); and integrate recommendations from the community-led monitoring platform into CQI activities. |

| | Minimum Program Requirement | Detailed Narrative for the sections | Succinctly note if the program is meeting or not meeting MPR | | Assessment and informed COP20 planning |
|---|--|---|--|--|--|
| | | | Program is meeting/not meeting MPR | If not meeting MPR, why and plans to ensure program meets MPR | |
| 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 | Treatment and VL literacy activities have been implemented through the concepts of “Champions” (for Treatment & VL) and “Ambassadors” (for PrEP & DREAMS). In COP19, these activities are being intensified to improve immediate and direct linkage to treatment and retention along MoHW campaign on “Health Services with a Human Face” and the FCI activities targeting men and AGYW. | MPR adopted and in implementation, but partially met. | <u>COP20 Focus:</u> Strengthen literacy on HIV/AIDS services through the Champions and Ambassadors concepts; use the community-led monitoring platform to improve patient literacy on HIV/AIDS services and identify appropriate differentiated services delivery models to deliver services in a targeted manner and improve service uptake; and reinforce the understanding of U=U among the general population. | |
| 4 | Clear evidence of agency progress toward local, indigenous partner direct funding | The OU is making progress toward local partner direct funding. For COP19, agencies are at different level of performance: CDC is at 42% of performance while USAID is initiating 4 prime local partners totaling \$650,000 to meet its 6% prime funding. | MPR adopted and in implementation, but partially met. | <u>COP20 objectives on local partner direct funding:</u> CDC is currently consolidating its IPs, which could drastically improve prime funding level to local partners; USAID plans to directly fund five new local prime partners totaling \$6.67 million to increase its performance to 30%. | |
| 5 | Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended | Botswana funds over 60% of its response; since August 2019, GoB has adopted a policy shift to include non-citizens in the national response by offering free ART to non-citizen PLHIV; Over 1000 non-citizens have been put on ART since then (FY20 Q1). Botswana could achieve more health outcomes with this funding level if it could further improve the technical and allocative efficiencies of the national response (SID 2019). | MPR adopted and met. | <u>COP20 Focus:</u> provide GoB with additional financial support to increase the number of non-citizens PLHIV on treatment to the levels of citizens; and address the sustainability vulnerabilities identified through the SID 2019 process - i.e. strengthen labs capacity to meet service needs, fine-tune the timely supply, distribution, and quality of key commodities, and address other key technical and allocative inefficiencies. | |

| | Minimum Program Requirement | Detailed Narrative for the sections | Succinctly note if the program is meeting or not meeting MPR | | Assessment and informed COP20 planning |
|---|--|--|--|--|--|
| | | | Program is meeting/not meeting MPR | If not meeting MPR, why and plans to ensure program meets MPR | |
| 6 | Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity | Mortality data is being integrated into the National Data Warehouse with initial analysis to be conducted by the end of FY20 Q2. Data capturees and data diagnostic coders have been recruited. Training on medical certification of causes of death and verbal autopsy methods for reporting on mortality is scheduled for March 2020. MoHW has established a Health Data Collaborative. One of the related TWG is tasked with increasing the availability and use of vital statistics data. The OU should be capable of reporting on morbidity and mortality by the end of COP19. | MPR adopted and in implementation; will be met COP19 APR. | <u>COP20 Focus:</u> improve the quality and completeness of the data reported; and increase the availability of data for decision making. | |
| 7 | Scale-up of case-based surveillance and unique identifiers for patients across all sites. | For citizens, the national ID number (Omang) is used as the unique identifier; for non-citizens, a sequential numbering system with a 'NC' prefix has been developed by MoHW for use as a patient ID. Non-citizen patients will be allocated a single NC-based number to present at facilities for care and will serve as unique identifier of each non-citizen patient, along with other forms of IDs such as passports, when available. The case-based surveillance (CBS) protocol has been approved by the local IRB and is currently under-review at CDC. The CBS system will draw information from existing data sources, such as the electronic medical records, in order to create a longitudinal record of every PLHIV in Botswana. CBS dataset will be generated for analysis by COP19 APR. | MPR adopted and in implementation, but not yet met. | <u>COP20 Focus:</u> generate CBS dataset for analysis; improve CBS data quality and completeness; reduce data capturing errors in the EMR; and incorporate drug resistance recency data in the CBS analysis. | |

APPENDIX E– PEPFAR/B

Stakeholders and Partners

A. Government of Botswana

1. National AIDS and Health Promotion Agency (*implementing partner*)
2. Ministry of Health and Wellness (*implementing partner*)
3. Ministry of Local Government and Rural Development
4. Ministry of Basic Education
5. Ministry of Tertiary Education, Research, Science and Technology
6. Ministry of Nationality, Immigration and Gender Affairs
7. Ministry of Employment, Labor Productivity, and Skills Development
8. Ministry of Youth Empowerment, Sports, and Cultural Development
9. Ministry of Finance and Development Planning
10. Botswana Defence Force

B. Implementing Partners

1. African Comprehensive HIV/AIDS Partnership (ACHAP)
2. ABT Associates/SHOPS Plus
3. Botswana Harvard Partnership
4. Botswana University of Maryland School of Medicine Health Initiative (BUMMHI)
5. Botswana University of Pennsylvania Partnership (BUP)
6. Stepping Stones International
7. GHSC-PSM (Chemonics)
8. FHI 360/APC
9. FHI 360/EpiC
10. JHPIEGO
11. Project Concern International (PCI)
12. Results for Development (R4D)/ACS Project

E. Private Sector Organizations

1. Associated Fund Administrators
2. Aviwe Healthcare and Training Institute
3. Botswana Business Coalition on HIV/AIDS
4. Captive Eye
5. Careena Centre for Health
6. Debswana
7. Duma FM

13. Univ. of Washington International Training and Education Center for Health (ITECH)

C. Local Implementing Partners

1. Bakgatla Bolokang Matshelo
2. Botswana Baylor Children's Centre of Clinical Excellence
3. Botswana Christian AIDS Intervention Program (BOCAIP)
4. Botswana Faith Based Network on HIV/AIDS (BOFABONETHA)
5. Botswana GBV Prevention and Support Centre
6. Botswana Institute for Technology, Research, and Innovation (BITRI)
7. Hope World Wide Botswana
8. Humana People to People
9. Kuru Development Trust
10. Lesbians, Gays, and Bisexuals of Botswana (LeGaBiBo)
11. Matsheng Community Development Assn. Trust
12. Men for Health and Gender Justice
13. Mothers Union
14. Nkaikela Youth Group
15. Silence Kills Support Group
16. Sisonke Botswana
17. Tebelopele

D. Multilateral Organizations

1. European Union Delegation
2. Global Fund CCM
3. SADC Secretariat
4. IOM
5. UNAIDS
6. UNDP
7. UNICEF
8. UNFPA
9. UN Women
10. World Health Organization

8. Eminent Gray
9. Gabz FM
10. Hotwire
11. Independence Surgery
12. Indus Healthcare
13. Premiere
14. Social Dialogue

15. Success Capital

16. Viamo

F. Civil Society Organizations

1. African Methodist Episcopal Services Trust
2. African Union Youth Club Botswana
3. Anglican Diocese
4. Ark and Mark Trust
5. Bamalete Lutheran Hospital
6. Bana Ba Letsatsi
7. Botswana Association for Psychosocial Rehabilitation (BAPR)
8. Baikagishesha Youth Rehabilitation Centre (BAYOREC)
9. Botswana Against Drunk Driving
10. Bobonong Home Based Care Trust
11. Botsogo Association of the Disabled
12. Botswana Council of NGOs (BOCONGO)
13. Botswana Council of Women
14. Botswana Family Welfare Assn (BOFWA)
15. Botswana Institute of Clinical Laboratory Professionals
16. Bomme Isago Organization
17. Bona Naledi Society
18. Botho University
19. Botswana Network of AIDS Service Organizations (BONASO)
20. Botswana Network on Ethics, Law and HIV/AIDS (BONELA)
21. Botswana Network of People Living with HIV/AIDS (BONEPWA+)
22. Botswana Retired Nurses Society (BORNUS)
23. Botswana Council of Churches
24. Botswana Council of Women
25. Botswana Flying Mission
26. Botswana HIV Clinicians Society
27. Botswana Muslim Association
28. Botswana Network for Mental Health
29. Botswana Red Cross Society
30. Botswana Scouts Association
31. Botswana Society for the Deaf
32. Botswana Student Network
33. Botswana YALI Alumni Network
34. Camphill Trust
35. Catholic Diocese
36. Center for Youth of Hope (CEYOHO)
37. Childline Botswana
38. Cynthia Childcare Counseling Trust
39. Ditshwanelo Centre for Human Rights
40. Evangelical Fellowship of Botswana
41. Family of Hope Services
42. Friends of Diversity
43. Gender Links
44. INK Centre for Investigative Journalism
45. Lenkokame Foundation
46. Leretlhabetse Support Group
47. Letsema Resource for Women in Politics
48. Light and Courage Centre Trust
49. Machaneng Achievers Association
50. Maipelo Trust
51. Makgabaneng
52. Marang Child Care Network Trust
53. Men and Boys for Gender Equality
54. Molao Matters
55. Mwatumwaya Rehabilitation Center
56. Ngamiland Council of NGOs (NCONGO)
57. Open Baptist Church
58. Organization of African Instituted Churches
59. Otse Community Home-Based Care
60. Positive Moments Support Group
61. Prison Fellowship International
62. Queen Esther International
63. Rainbow Identity Association
64. Sentebale
65. Seventh Day Adventist Church
66. Skill Share International Botswana
67. SRHR Africa Trust Botswana
68. Spiritual Assembly of Bahai
69. THC Foundation
70. Thusang Bana Centre
71. Ultimate Youth with Destiny
72. University of Botswana
73. Urban Rhythm Youth Centre
74. WoMen Against Rape (WAR)
75. Young Love
76. Youth for Christ Botswana
77. Zion Christian Church

APPENDIX F – Acronym List

| Abbreviation | Definition |
|---------------------|---|
| ABYM | Adolescent Boys and Young Men |
| ACHAP | African Comprehensive HIV/AIDS Partnership |
| A&E | Accident and Emergency |
| AGYW | Adolescent Girls and Young Women |
| AIDS | Acquired Immunodeficiency Syndrome |
| ALT | Agency Leads Team |
| ANC | Antenatal Care |
| AOR | Agreement Officer Representative |
| APC | Advancing Partnerships in Communities (FHI360) |
| APR | Annual Performance Review |
| ART | Anti-Retroviral Therapy |
| ARV | Anti-Retroviral Drugs |
| AYP | Adolescents and Young People |
| ASRH | Adolescent Sexual and Reproductive Health |
| BAIS | Botswana AIDS Impact Survey |
| BBSS | Behavioral and Biological Surveillance Survey |
| BCPP | Botswana Combination Prevention Program |
| BDF | Botswana Defense Force |
| BNTB | Botswana National Tuberculosis Program |
| BUMMHI | Botswana University of Maryland Medical Health Initiative |
| BUP | Botswana University of Pennsylvania |
| CBS | Case-Based Surveillance |
| CCM | Country Coordinating Mechanism |
| CDC | Center for Disease Control and Prevention |
| CEDA | Citizen Entrepreneurial Development Agency |
| CETA | Common Elements Treatment Approach |
| CHW | Community Health Worker |
| CM | Case Manager |
| CMS | Central Medical Stores |
| Co-Ag | Cooperative Agreement |
| CODB | Cost of Doing Business |
| COR | Contracting Officer Representative |
| COP | Country Operational Plan |
| CPT | Cotrimoxazole Preventative Therapy |
| CQI | Continuous Quality Improvement |
| CSO | Civil Society Organization |
| DHIS | District Health Information System |
| DHMT | District Health Management Teams |
| DoD | Department of Defense |
| DOT | Directly Observed Therapy |
| DQA | Data Quality Assessment |
| DQI | Data Quality Improvement |
| DSD | Direct Service Delivery |
| DSD | Differentiated Service Delivery |
| DTBE | CDC/Division of Tuberculosis Elimination |

| | |
|-------|--|
| DTG | Dolutegravir |
| DW | Data Warehouse |
| EA | Expenditure Analysis |
| EC | Expert Client |
| EFV | Efavirenz Sustiva ARV |
| EID | Early Infant Diagnosis |
| EMR | Electronic Medical Record |
| EpiC | Meeting Targets and Maintaining Epidemic Control Project |
| EPOA | Enhanced Peer Outreach Approach |
| EQA | External Quality Assurance |
| FAST | Funding Allocation to Strategy Tool |
| FBLO | Facility Based Linkage Officers |
| FBO | Faith-Based Organizations |
| FCTO | Facility Case Tracking Officer |
| FP | Family Planning |
| FSW | Female Sex Worker |
| FY | Fiscal Year |
| GBV | Gender-Based Violence |
| GDN | Government Data Network |
| GF | The Global Fund |
| GFATM | The Global Fund for AIDS, TB and Malaria |
| GHSC | Global Health Supply Chain Program |
| GIS | Geographical Information System |
| GNI | Gross National Income |
| GoB | Government of Botswana |
| HCA | Health Care Auxiliary / Health Care Assistant |
| HCD | Human Centered Design |
| HCW | Health Care Worker |
| HEA | Health Education Assistant |
| HEI | HIV Exposed Infant |
| HEW | Health Education Worker |
| HIS | Health Information Systems |
| HIV | Human Immunodeficiency Virus |
| HIVST | HIV Self Testing |
| HLF | Health Leadership Forum |
| HRH | Human Resources for Health |
| HTC | HIV Testing and Counseling |
| HTS | HIV Testing Services |
| HWG | Health Working Group |
| ICPN | Index Client Partner Notification |
| IABD | It's a Beautiful Day |
| ICPT | Index Client Partner Testing |
| ICS | Integrated Country Strategy |
| IDCC | Infectious Disease Control Centers |
| ICT | Information and Communications Technology |
| IEC | Information, Education and Communication |
| IP | Implementing Partner |
| IPBS | Integrated Planning and Budgeting System |
| IPMS | Integrated Patient Monitoring System |
| IPT | Isoniazid Preventive Therapy |
| IPV | Intimate partner violence |
| IQC | Internal Quality Control |

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| ISME | Implementation Subject Matter Expert |
| IT | Information Technology |
| ITECH | International Training and Education Center for Health |
| KP | Key Populations |
| LCI | Local Capacity Initiative |
| LEA | Local Enterprise Authority |
| LEEP | Loop Electrosurgical Excision Procedures |
| LIS | Laboratory Information System |
| LMIS | Logistics Management Information System |
| LMU | Logistics Management Unit |
| LTC | Linkage to Care |
| LTT | Linkage to Treatment |
| LTFU | Loss-To-Follow-Up |
| LPV/r | Lopinavir/Ritonavir ARV |
| M&E | Monitoring and Evaluation |
| MAT | Medication-Assisted Therapy |
| MCH | Maternal and Child Health |
| MFDP | Ministry of Finance and Development Planning |
| MMD | Multi-month Dispensing |
| MMS | Multi-Month Scripting |
| MNIGA | Ministry of Nationality, Immigration, and Gender Affairs |
| MoBE | Ministry of Basic Education |
| MoHW | Ministry of Health and Wellness |
| MoTE | Ministry of Tertiary Education |
| MPR | Minimum Program Requirements |
| MSM | Men Who Have Sex with Men |
| NACA | National AIDS Coordinating Agency |
| NAHPA | National AIDS & Health Promotion Agency |
| NASA | National AIDS Spending Assessment |
| NCCPP | National Cervical Cancer Prevention Program |
| NCD | Non-communicable Disease |
| NGO | Nongovernmental Organization |
| NIH | National Institutes of Health |
| NPD | Nurse Prescriber (and Dispenser) |
| NSF | National Strategic Framework |
| NVP | Nevirapine |
| OGAC | Office of the Global AIDS Coordinator |
| OI | Opportunistic Infection |
| OMRS | Open Medical Record Systems |
| OPD | Out-Patient Department |
| OU | Operating Unit |
| OVC | Orphans and Vulnerable Children |
| PACT | Peer Approach to Counselling Teens |
| PBFW | Pregnant and breastfeeding women |
| PC | Peace Corps |
| PCI | Project Concern International |
| PCO | PEPFAR Coordination Office |
| PCT | PEPFAR Country Team |
| PCV | Peace Corps Volunteer |
| PEP | Post Exposure Prophylaxis |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PEPFAR/B | PEPFAR/Botswana |

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| PHDP | Positive Health, Dignity, and Prevention |
| PIMS | Patient Information Management System |
| PITC | Provider Initiated Testing and Counselling |
| PLHIV | People Living With HIV |
| PLL | Planning Level Letter |
| PMH | Princess Marina Hospital |
| PMT | PEPFAR Management Team |
| PMTCT | Prevention of Mother-to-Child HIV Transmission |
| PN | Peer Network |
| POART | PEPFAR Oversight and Accountability Results Team |
| POC | Point of Contact |
| POCT | Point of Care Testing |
| PP | Priority Population |
| PPP | Public-Private Partnerships |
| PR | Principal Recipient |
| PrEP | Pre-Exposure Prophylaxis |
| PS | Permanent Secretary |
| PSM | Procurement and Supply Management |
| PT | Proficiency Testing |
| Q1 | Quarter One |
| QI | Quality Improvement |
| RPM | Regional Planning Meeting |
| RTK | Rapid Test Kits |
| SCM | Supply Chain Management |
| SCMS | Supply Chain Management System |
| SD | Same Day |
| SDS | Strategic Direction Summary |
| SI | Strategic Information |
| SID | Sustainability Index and Dashboard |
| SIMS | Site Improvement Monitoring System |
| SMS | Short Message System |
| SNU | Sub-National Unit |
| SOP | Standard Operating Procedures |
| SRE | Surveillance/Surveys, Evaluations and Operations Research |
| SRH | Sexual and Reproductive Health |
| STI | Sexually Transmitted Infection |
| SW | Social Worker |
| TA | Technical Assistance |
| TAF-ED | Tenofovir Alafenamide-Emtricitabine/Dolutegravir ARV |
| TB | Tuberculosis |
| TEE | Tenofovir/Emtricitabine/Efavirenz ARV |
| TLE | Efavirenz/Lamivudine/Tenofovir Disoproxil Fumarate ARV |
| TLD | Tenofovir/Lamivudine/Dolutegravir ARV |
| TPT | TB Preventative Therapy |
| TWC | Tebelopele Wellness Center |
| TWG | Technical Working Group |
| TX | Treatment |
| U=U | Undetectable=Untransmittable |
| UN | United Nations |
| UNAIDS | United Nations Programme on HIV/AIDS |
| USAID | United States Agency for International Development |
| USD | United States Dollars |

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|-------|---|
| USG | United States Government |
| VAST | Volunteer Activities Support and Training |
| VL | Viral Load |
| VMMC | Voluntary Medical Male Circumcision |
| WHO | World Health Organization |
| WLHIV | Women Living with HIV |
| YFC | Youth Friendly Clinic |
| YFS | Youth Friendly Service |