PEPFAR BOTSWANA

COP 2021 Updates to Botswana's Country Operational Plan 2020

Strategic Direction Summary

May 12, 2021

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1.0 Goal Statement

The goal of PEPFAR Botswana's COP21 is to maintain the OU's progress from COP20 and refine efforts to eliminate policy barriers and institutionalize client-centered services that will lead to the attainment of 95-95-95 in every district, across all populations, sex, and age bands. PEPFAR/B is committed to supporting the GoB in the continued implementation of the third National Strategic Framework for HIV (2018-2023).

In response to the unique effects of the COVID-19 pandemic and corresponding response measures in Botswana, PEPFAR/B will work closely with GoB to determine the most immediate and impactful interventions needed to optimize service delivery and set the country back on the path to HIV epidemic control.

COP21 will provide targeted support to Botswana to sustain its emergency response to the COVID-19 pandemic while addressing critical program needs in the general and key population segments, including scale up of self-testing and index testing with active partner notification, roll-out of direct drug distribution, and six-month refill dispensing. PEPFAR/B will continue to conduct data analysis to inform strategy on effective interventions reaching men and young people with persistent gaps in treatment and viral suppression.

The focus of COP21 programming will be maintaining high linkage, retention, adherence, and suppression across the 71 high volume facilities in 17 districts, several key population hotspots, as well as four Wellness Centers. Our programs will continue to strengthen the integration of facility and community services around the client and their family, ensuring high quality healthcare is delivered across the continuum of care.

PEPFAR/B will continue to invest in critical partnerships with multilateral institutions and civil society organizations to ensure proper alignment and synergistic programming that cuts across both clinical and social dynamics of the HIV response, including HIV stigma and gender-based violence. Additionally, PEPFAR/B will work to further transition prime funding to local partners in line with SGAC's targets.

In response to COVID-19-related health resource shifts and temporary program pauses that occurred during FY20-21, PEPFAR/B will work closely with MOHW and key partners to revitalize prevention, care and treatment services, most notably the VMMC and cervical cancer programs.

In regard to strategic information and program monitoring, several community-based organizations will continue to serve as monitors of quality of care at the client and facility

levels; District Health Management Teams (DHMTs) will continue to monitor the implementation of the MPRs; GoB facilities will further standardize data reporting across the clinical cascade; and Community Health Workers (CHWs) will continue to engage clients at the household level to ensure that all PLHIV are immediately linked to treatment and retained in care.

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, ensuring the country adopts a direct and sustainable path toward epidemic control.

As Botswana grapples with the lingering challenges from the COVID-19 pandemic, COP21 will provide crucial investments toward a more robust, responsive health system that can confront current and future health challenges.

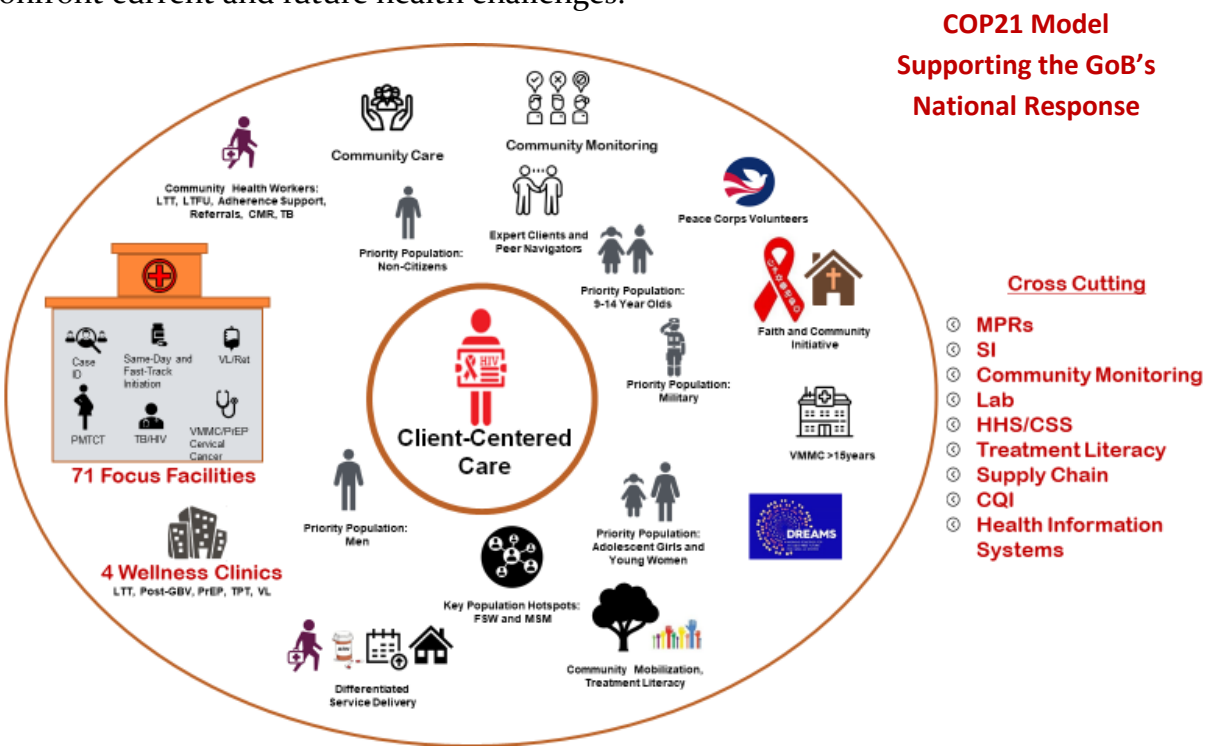


Diagram Caption: COP21 will focus on maintaining high linkage and retention through community-facility integration and will expand the use of community-led monitoring of HIV service delivery to inform policy and program interventions, as well as continuous quality improvement (CQI).

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 2.48 million (2020 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 2019 GNI per capita, according to the World Bank, was $7,650. 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. The preliminary results of the BAIS V are expected to become available during 2021. 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 (2020) estimates PLHIV at 374,729 (HIV prevalence of 15.1%) and incidence rate at 0.42 (8,863 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 97%; the lowest ART coverage is among those younger than 15 and males 15-24 years old, 78% and 63%, respectively. Botswana's viral suppression rate is impressively high at 98% across all age and sex bands.

"Based on 2020 Program data, approximately 443,601 people were tested, about 17,099 were identified as HIV positive and approximately 24,149 initiated ART. The overall testing yield was 4%, while the overall ART initiation rate was 141%. 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 99.9% and treatment uptake of 99.9% have resulted in a perinatal transmission rate of 1.7% in 2020 (SPECTRUM, 2020). PEPFAR/B's overall FY19 achievement for the percentage of pregnant women with known HIV status at antenatal care was 99.5% (18,2125/18,300) and the overall achievement for PMTCT_ART was 99.3% (4,092/4,119). 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. EID continues to be a major area of focus for PEPFAR/B in FY20 and FY21.

Since inception of the Botswana national safe male circumcision (SMC) program in 2009, a total of 274,372 voluntary medical male circumcision (VMMC) procedures were performed, representing approximately 15% 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	2,475,177	100	369,845	15.0	376,872	15.3	212,629	8.7	215,856	*8.8*	648,871	26.0	651,104	26.2	Census 2020 Projections
HIV Prevalence (%)		15.1		0.9		0.9		9.4		5.5		30.4		21.4	UNAIDS, 2020
AIDS Deaths (per year)	5,135		109		112		252		177		1,893		2,593		UNAIDS, 2020
# PLHIV	374,729		3,200		3,278		20,021		11,775		196,994		139,461		UNAIDS, 2020
Incidence Rate (Yr.)		0,42		0.03		0.03		1.17		0.35		0.69		0.50	UNAIDS, 2020
New Infections (Yr.)	8,863														UNAIDS, 2020
Annual births	52,787	97													PMTCT, FY2020
% of Pregnant Women with at least one ANC visit	54,258	97	0	0			15,701	29			38,557	71			PMTCT, FY2020
Pregnant women needing ARVs	9,754	19													PMTCT, FY2020
Orphans (maternal, paternal, double)	123,459		51,284		52,226		10,044		9,906		NA		NA		BAIS IV 2013, Census Proj 2020

Notified TB cases (Yr.)	3,121														Global TB report, 2020
% of TB cases that are HIV infected	1,296														Global TB Report, 2020
% of Males Circumcised	274,372	22			145,133	53			72,760	26			56,747 9	21	VMMC Program
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	2,475,177	15.1	374,729	350,717	336,807	90%	98%	443,601	17,099	24,149
Population <15 years	746,717	0.9	6,478	5,107	5,084	78%	98%	28,981	182	245
Men 15-24 years	215,856	5.5	11,775	7,793	7,437	63%	98%	25,3389	431	554
Men 25+ years	651,104	21.4	139,461	129,487	116,034	83%	98%	116,831	6,574	8,674
Women 15-24 years	212,629	9.4	20,021	18,064	18,054	90%	98%	94,558	2,118	2,142
Women 25+ years	648,871	30.4	196,994	190,266	190,198	97%	97%	177,792	7,748	10,648
MSM	15,759[2]	14.80%[1]	2,332[4]	222[4]	340[3]	82%[1]	100%[3]	1,257[3]	192[3]	*198*[3]
FSW	25,772[2]	42.80%[1]	11,030[4]	1,985[3]	617[3]	87.6%[1]	97.8%[3]	1,238[3]	297[3]	345[3]
PWID	339[2]	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	n/a

Figure 2.1.3 Updated National and PEPFAR Infections and All-Cause Mortality Among PLHIV

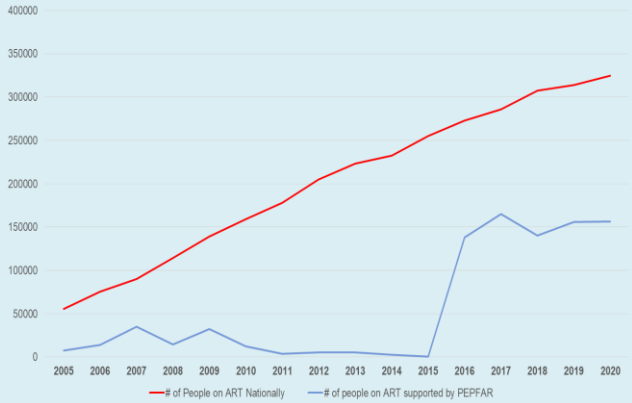


Figure 2.1.4 Updated Trend of New Trend for Individuals currently on Treatment

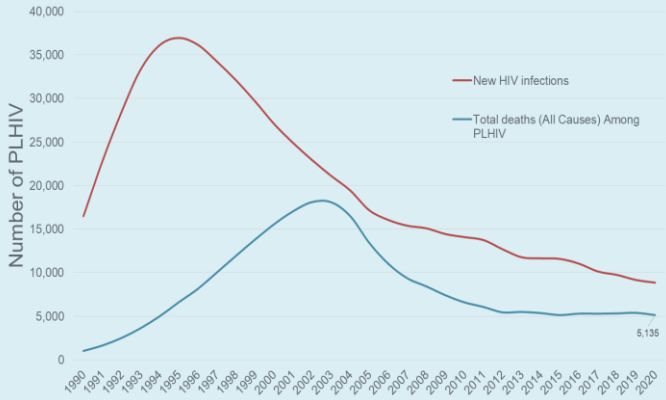
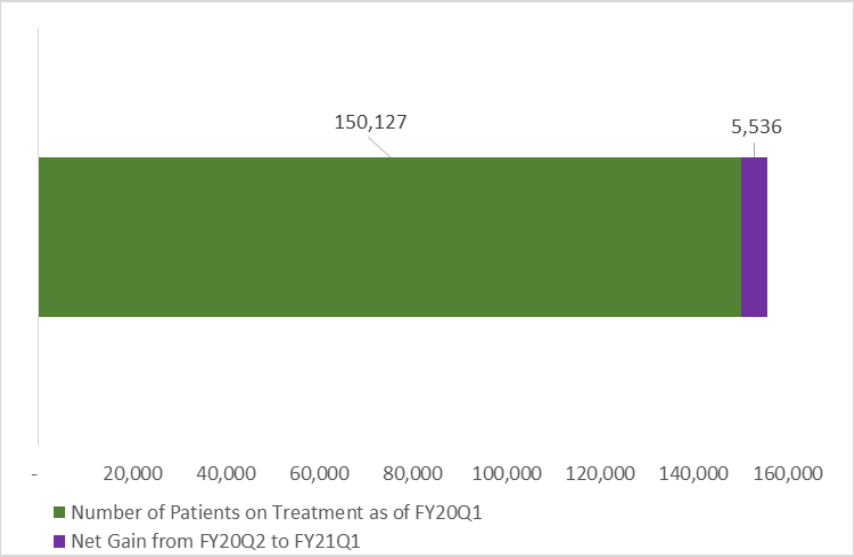


Figure 2.1.5 Progress retaining individuals in lifelong ART between FY20Q1 and FY21Q1



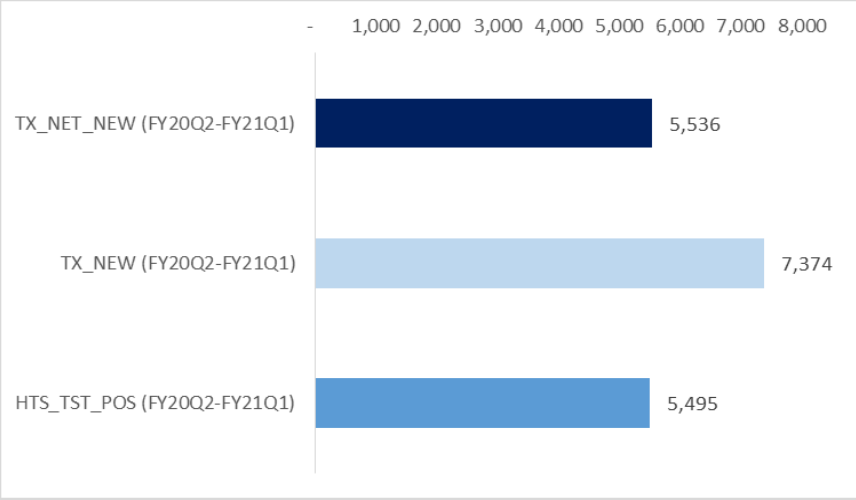


Figure 2.1.7 Epidemiologic Trends and Program Response for Botswana

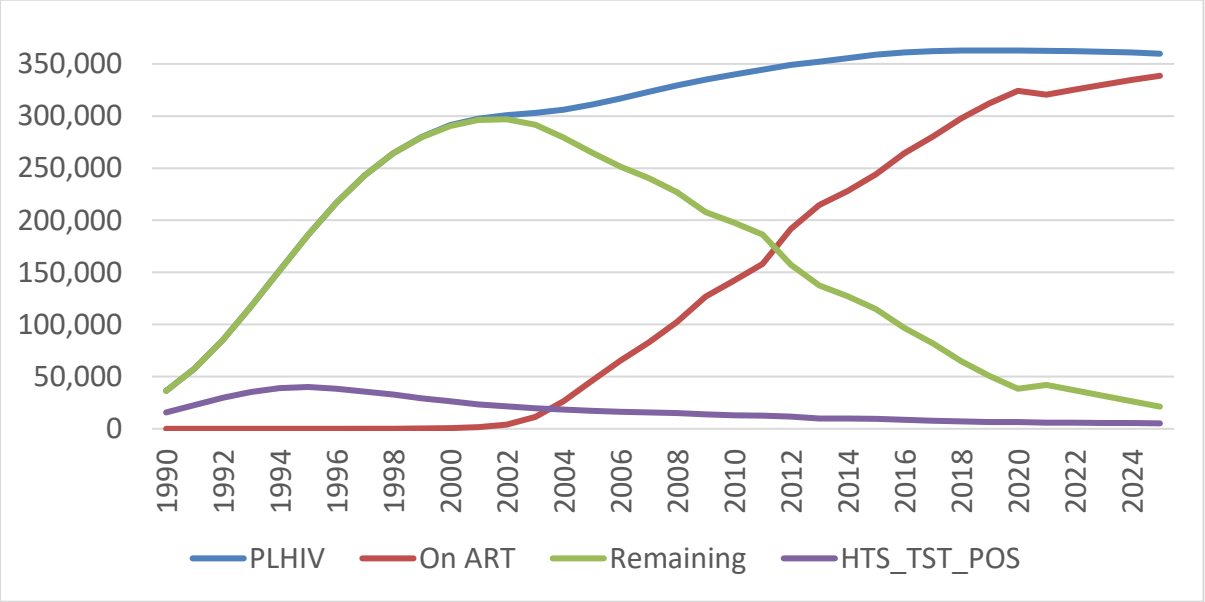
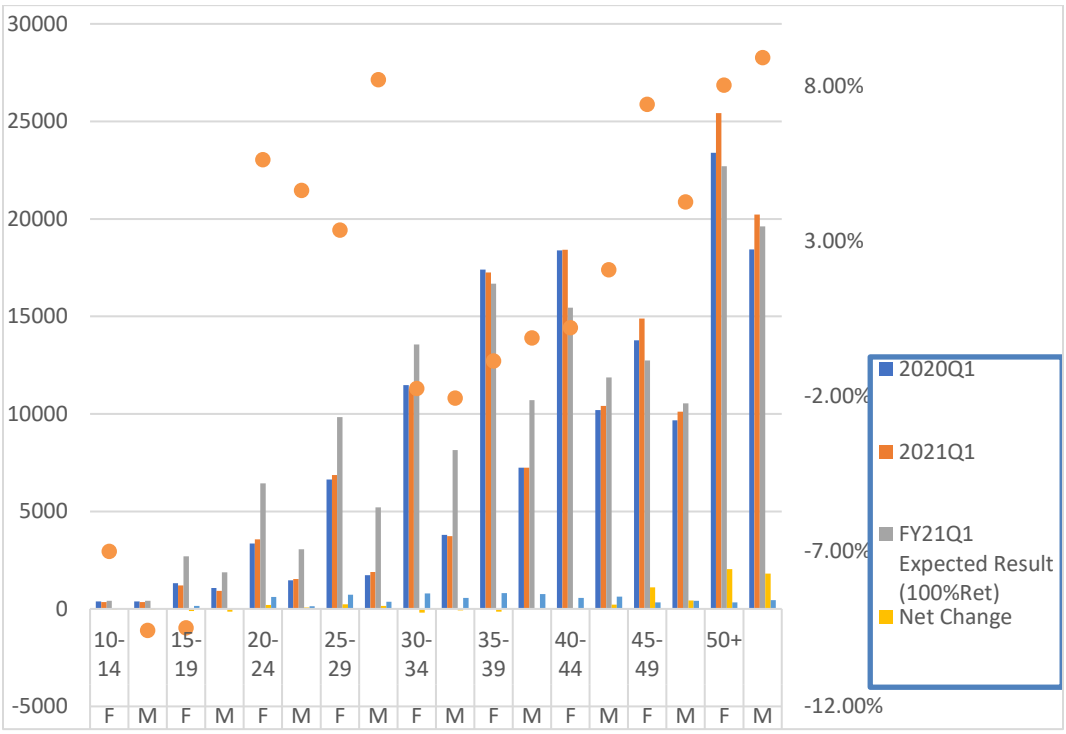


Figure 2.1.8 shows the HIV treatment growth by age/sex in order to pinpoint where there are specific areas of intervention needed to maintain and grow the HIV treatment population.

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



2.2 Activities and Areas of Focus for COP21

Activities	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 and Risk Network Referral (RNR)	Task shifting of new roles to peer navigators
Reach People who Use Drugs, prisoners and ex-convicts	Expansion of PrEP to other KP their networks and other KP sub-populations
Through OVC, reach **HIV + adolescent girls** and children of KP while also reaching adolescent girls at high risk of getting HIV through DREAMS.	Have destigmatized environment where children of FSW can receive testing and other OVC related services.
Linkage & Retention Strategies (General Population)	
Promote U=U (Undetectable=Untransmittable) and increase treatment literacy	ART initiation on weekends & extended opening hours during weekdays
	Provide clinical services for non-citizens Expand treatment literacy
	Differentiated service delivery, including Community-initiated ART and community Refill models
	Establishing men's corners in health facilities
Linkage of pediatrics to OVC programs and linkage of HIV positive OVCs to pediatric programs	Develop SOPs and MOUs between HIV care and treatment and OVC IPs to enable optimized inter-referrals Keep a line list of OVCs accessing pediatric services and pediatrics accessing OVC services to ensure all the children receive services
Strengthen Community- Facility Interface to optimize client's continuity in care	Develop SOPs to guide the implementation of interventions/activities and the collaboration of all actors/stakeholders at the Community-Facility interface Develop MOUs between Facility and Community IPs outline roles and responsibilities towards facilitating optimized referral of clients and preventing interruption of treatment
Decentralized Drug Delivery through the post office models	Distribution of drugs to stable patients through post office delivery to the client's households, or workplace based on client's preferences. This client centered model decongests the health facilities,

	gives clinicians an opportunity to focus on unstable clients and enables reach to populations who experience work constraints, and find it challenging to visit health facilities during normal working hours
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	Ensure continuity of care and delivery of convenient client centered services
Use of DDD Model	Home deliveries, smart-lockers, pharmacy models
Use of Virtual platforms	Virtual peer navigation and treatment literacy through online support groups
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	
Maintenance of COP 20 priorities	Roll out of Lab IPMS module Interoperability of system (IPMS and PIMS) Strengthen lab clinic interface Line list for VL follow up in the community and merging of appointment Increase access to VL testing by availing HR to do phlebotomy and results follow up Strengthen community-facility interphase Lab CQI activities to improve VL coverage Enhance differentiated service delivery models for VL testing to improve coverage Viral load literacy Increase coverage across all age groups and SNUs especially A/CLHIV
CQI	
Dissemination of the patient's charter and health provider's charter to help advance a culture of CQI by integrating CQI approach into the health system	Dissemination of patient's rights and charter to include client centered approach Continuous Quality Improvement initiative through process re-engineering at site level Intensive site level monitoring and mentorship with improved CQI capacity at site level Training and use of SIMS as a QA tool to increase the impact of PEPFAR programs on the HIV epidemic Deployment of minimal personnel to support CQI

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	
Virtual Mobilization, Virtual Peer Preventive services. Use Violence and Impunity Prevention (VIP business card linked to legal support) to address proactively address stigma	Provide Client-centered services that are safe ,, ethical and meet the needs and situation of each MSM
Expand KP competence training and stigma free services at MOHW and private facilities	Expand access points through a differentiated service delivery model
Scale up PrEP for case-finding and combine index testing with HIV self-testing and Risk Network Referral (RNR)	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 Technical support provided by COP20 grantees	
OVC	
CLHIV: expand OVC comprehensive program to 3 new SNUs with PEPFAR supported sites and high numbers of TX_CURR <15 (Francistown, Palapye and Tutume)	Focus on increasing reach for the current prioritized OVC sub-populations especially adolescents and children living with HIV (A/CLHIV)
	Link children of HIV+ mothers to HTS
	Continue facilitating MOUs between clinical and OVC IPs for enhanced bi-directional referrals.
DREAMS	
Increase reach to AGYW with the comprehensive Economic strengthening model (ELA) for retention	Strengthen bi-directional referrals
	Engage DREAMS Ambassadors to increase visibility of the program
	Strengthen DREAMS communication strategies for; AGYW recruitment, PrEP & GBV demand creation

2.3 Investment Profile

A major constraint of the Botswana public health system is inefficiencies in spending that affect the availability of funding for critical needs, such as HRH, not the overall availability of funding.[1] 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. In 2020, COVID-19 caused a drastic downturn in international diamond sales and a halt to international tourism resulting in a 24 percent GDP contraction in the second quarter of 2020.

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 2021, the GoB announced a $6.45 billion budget equivalent to approximately 35% of 2019 GDP, resulting in a $55 million deficit for the 2021-2022 fiscal year.[2] Diamond sales are projected to increase in 2021 which will help Botswana's economy in the short-term, but it is unclear when or if sales will reach pre-pandemic levels. The economic impact of COVID-19 on Botswana's economy however will be deep and long lasting.[3] 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 force [1]. 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 System of Health Accounts (SHA) was 2013/14. In NASA reports for the years 2006-2012, about $1.46 billion was expended on the national HIV response; 66% of this was funded GoB, 32% by international partners and 2% by domestic private sources. SHA 2013/14 estimated that Total Health Expenditure in Botswana grew from about $57 million in 2000 to about $835 million by 2013/2014 and per capita health spending grew from $366 to $428 from 2009/10 to 2013/14.

[1] https://saiia.org.za/wp-content/uploads/2021/04/AGDP-BAPS-Report-BOTSWANA-March2021-FINAL-WEB.pdf
[2] 2021 budget speech by Honorable Dr. Thapelo Matsheka, Minister of Finance and Economic Development. Delivered to the National Assembly on 1st February 2021. Available at: www.finance.gov.bw
[3] https://www.worldbank.org/en/country/botswana/overview#1

GoB, 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: GoB, PEPFAR and GF. An estimated $964 million was spent on HIV/AIDS over the six year period from 2012 to 2018; GoB contributed 64%, PEPFAR 31%, private sources 3% and GF 2%.

COVID-19 pandemic has impacted the funding of health care and will continue to do so over a considerable period. Notably it has reduced the fiscal space for health due to a drop in the country's revenue especially from diamond and tourism.[4] As part of other analytics and metrics, it becomes important to track HIV/AIDS and Health expenditures routinely to institutionalize efficiency and effectiveness of spending in the health system.

[4] https://www.worldbank.org/en/country/botswana/overview#1

Figure 2.3.1 Botswana Annual Investment Profile by Program Area (2012/13-2017/18)

Table 2.3.1 Annual Investment Profile by Program Area (2012/13-2017/18)					
Program Area	**Total Expenditure $**	**GoB (%)**	**PEPFAR (%)**	**GF (%)**	**Others (%)**
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	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	91,142,450	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 2.3.2 Annual Procurement Profile for Key Commodities FY2020

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	

*Carried over from COP20 SDS

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration FY2020

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration FY2020					
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	1,453,630	-	-	-	Appropriated funds that support allowances, transportation, medical, and training for Peace Corps Volunteers
Total	**1,453,630**				

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. The next SID is expected to commence in Q3 FY21.

	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

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

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. 2018[5]) 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

[5] 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.

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 the planned Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections as well activities addressing CQI across the cascade. PEPFAR/Bw will assist GOB with EQA for TB testing as well as for servicing and maintenance of equipment.

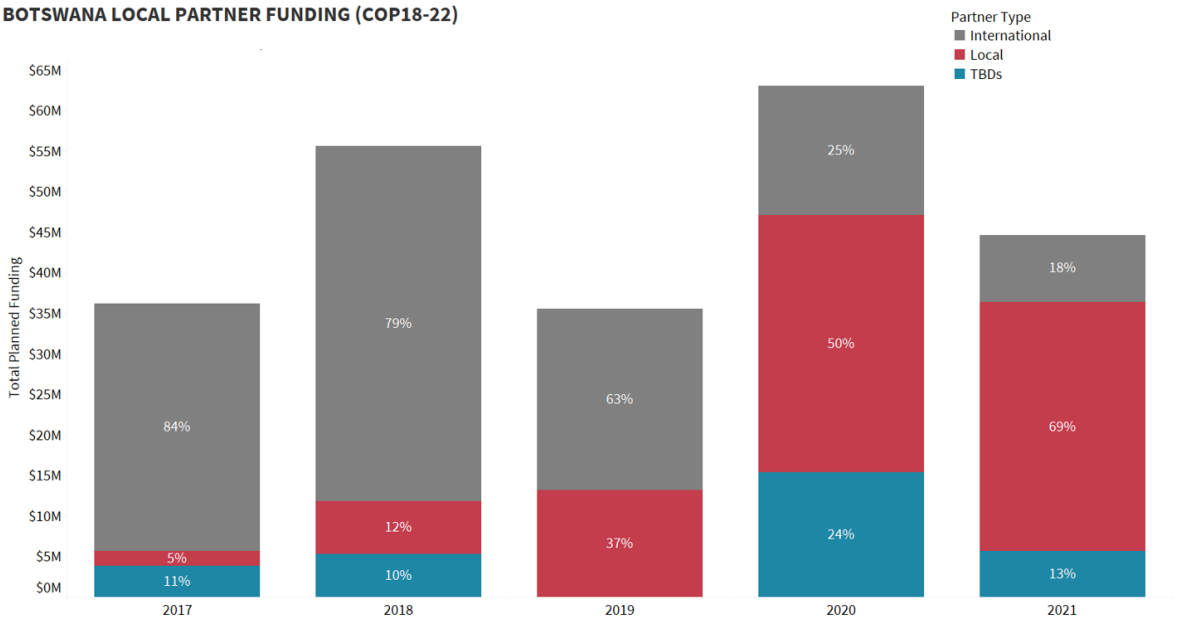
iii. **Continue to fine-tune the timely supply, distribution, and quality of key commodities**: Specific investments in COP20 are being implemented to address gaps in the supply chain in collaboration with the Global Fund. Key among them are activities supporting ART optimization to scale up the implementation 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. Botswana will continue to build on progress in these areas in COP21.

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 has been OU providing technical assistance during COP20 to support the WHO-led SHA/NASA activities that will bring resource tracking up to date and strengthen the MOHW's ability to conduct these in the future. Support in COP21 will ensure institutionalization of the MOHW's capacity in these areas.

OGAC previously mandated a shift from international to local partners across its portfolio. The 2019 PEPFAR/B Expenditure Report (ER) in Figure 2.4.1, shows a year-to-year increase, with a dramatic increase in FY20 and FY21, as the portion of the PEPFAR program managed by local partners increased from 5% in FY17 to 37% in FY19 to an expected 69% in Fy21. The increase in local partner expenditure was because of increased prime funding of local partners by CDC (35% to 99%) and USAID (3% to 59%). In addition, the PEPFAR

Coordinator's Office programmed $400k for Community-let Monitoring through local organizations.

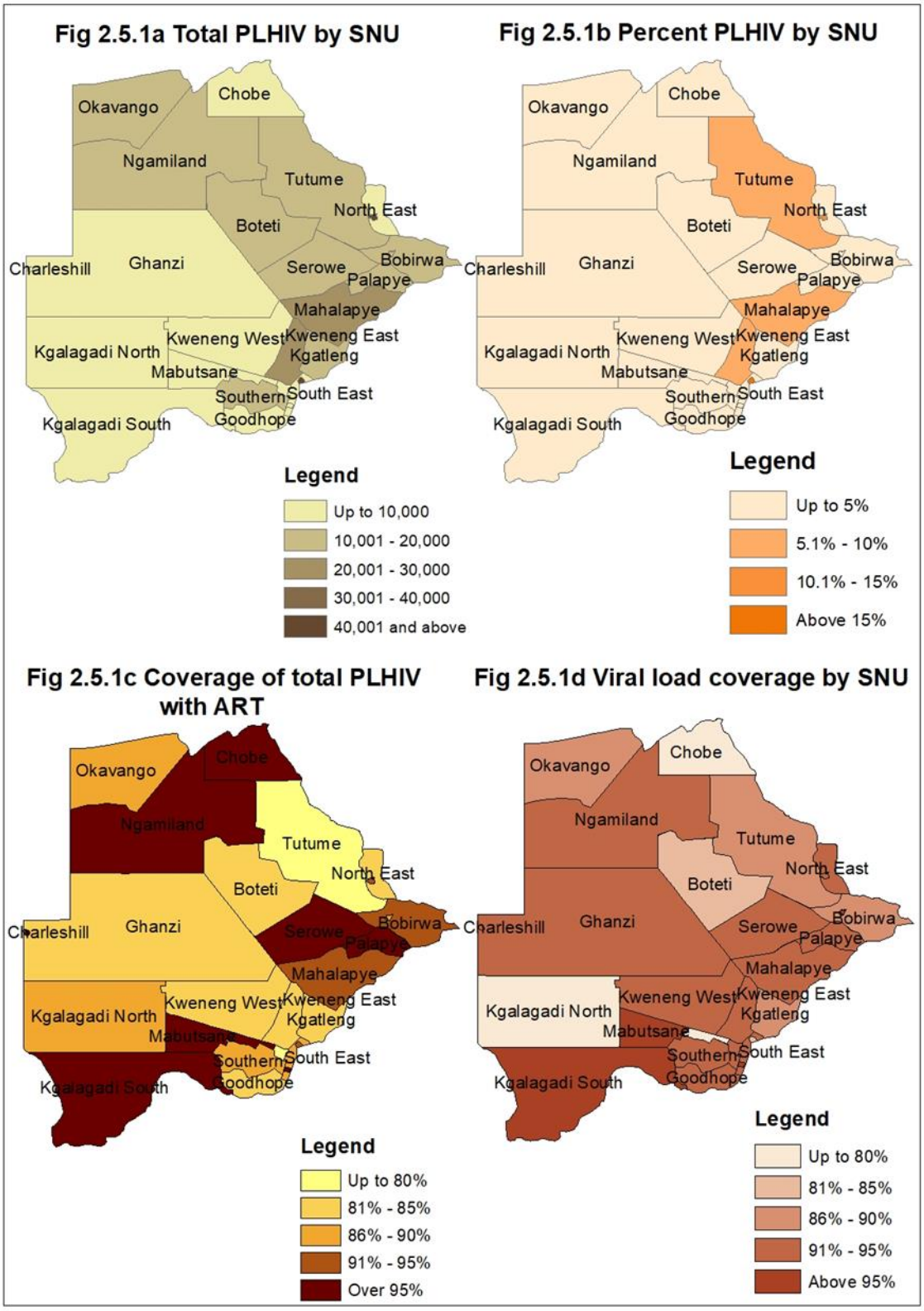
Figure 2.4.1: ER Integrated Analytics Dashboard (Local Partner Transition)



In FY21, all three of CDC's TBDs that were in COP 20 were awarded to 2 local partners which brought CDC's implementing partner total to 4 local partners. These partners are the Government of Botswana, the African Comprehensive HIV/AIDS Partnership (ACHAP), Botswana Training and Education Center for Health (B-TECH) as well as Botswana-University of Maryland School of Medicine Health Initiative (BUMMHI). There is one TBD to be awarded so final numbers are not available.

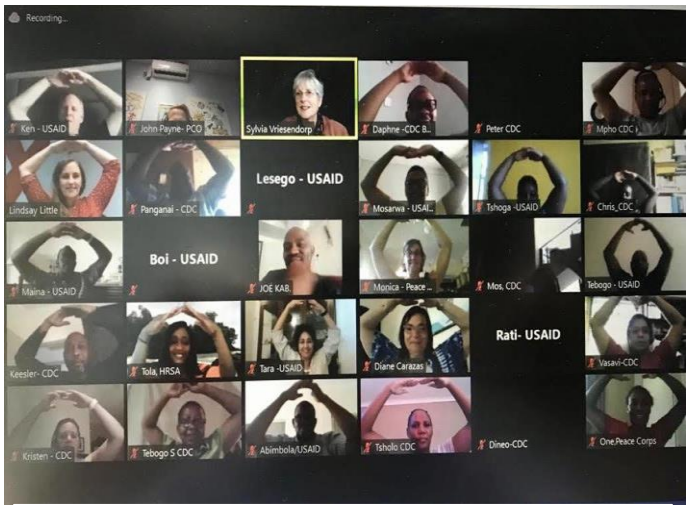
In COP21, USAID/Botswana will invest significant amount of its funding in the five local/indigenous prime partners that were transitioned to receive direct PEPFAR funding last year, increasing their funding from $4.2 million in COP20 to $12,355,085 million in COP21. This amount is approximately 60% of USAID/Botswana's program funds. As a result of increased funding to the local organizations, USAID/Botswana's international partners will see reduced funding allocations in COP21. For example, Project Concern International's (PCI) funds will reduce from $6,450,823 million in COP20 to $3,092,557 million in COP21. In the case of APC 2.0/FHI360, USAID/Botswana made a decision to fold the activities being implemented by this implementing partner under the EpIC/FHI360 mechanism, reducing the total funding of these 2 mechanisms from $7,764,284 in COP20 to $4,312,592 in COP21. This shift reduces USAID's international mechanisms from three to two.

2.5 Alignment of PEPFAR investments geographically to disease burden



2.6 Stakeholder Engagement

COP21 process has been open and consultative, and the plan reflects the strong engagement with and input from a range of stakeholders. Collaboration with stakeholders has held strong this year despite the virtual environment throughout the planning process. In particular, the PEPFAR/B team received substantial input from MOHW, NAPHA, GFATM, UNAIDS, WHO, civil society and faith-based organizations to prioritize investments included in COP21. PEPFAR/B also worked with implementing partners, local and international, to evaluate partner performance and progress towards goals in order to refine COP20 implementation and focus COP21 planning efforts. Private sector collaboration will continue through multilateral stakeholder engagement platforms. 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 progr and attitudes that stakeholders identified through our engagement process and human-centered design workshops.



Pictured above: COP21 Interagency Planning Retreat

The COP21 guidance, tools and planning level letter were shared with external stakeholders in January and PEPFAR engaged in one-on-discussions to address questions or concerns in advance. Our COP21 stakeholder engagement process continued with stakeholder meetings with more than 175 partner representatives and stakeholders from GoB, implementing partners, donors/multilaterals, civil society, and the private sector. (see Appendix E Stakeholder and Partner List.) The stakeholder meeting was virtual and highly interactive. Stakeholders participated in two days of small group sessions with representation from stakeholders across break out rooms according to technical area focus to provide inputs on key priorities of focus for on the PEPFAR/B COP21 strategic direction. Agency Headquarter personnel also joined the retreat virtually, and all participants provided comments on the proposed PEPFAR/B planning direction for COP21.

The third consultation was held with representatives of civil society through in-person discussions of COP21 strategy and future routinized CSO meetings with PEPFAR/B. Listening sessions were also held with SGAC Chair and PEPFAR Program Manager (PPM) and the PEPFAR Country Coordinator. This dialogue shed light on gaps in programming and implementation challenges from representatives of vulnerable populations. In COP 21, PEPFAR/B will continue to work closely with the GoB, multilateral partners, and community partners to carry out ICT, self-testing, same day treatment initiation, and scale up viral load, CBS and recency testing to find the remaining cases and get them virally suppressed.

Finally, in preparation for the COP21Virtual Regional Planning Meeting in April, PEPFAR/B held consultative meetings with GoB (MoHW, NAPHA), and multilateral partners to dive deeper into national priorities for health systems strengthening, to review and discuss the final COP21 strategy, data analyses, and to coordinate the activities proposed in the American Rescue Plan Act (ARPA) proposal submitted in COP21. Over 130 stakeholders and partners joined the virtual planning meeting to finalize the COP21 plan as "One Botswana".

Caption: COP21 Virtual Planning Meeting held April 28-29, 2021

3.0 Geographic and Population Prioritization

3.1 General Population

Botswana is currently conducting the fifth Botswana AIDS Intervention Survey (BAIS V) with preliminary results expect later this year. Unless these indicate the need to make programmatic and/or geographic shifts, PEPFAR/B will continue to implement in the current 71 facilities and surrounding communities. These sites were selected for COP20 implementation based on the 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.

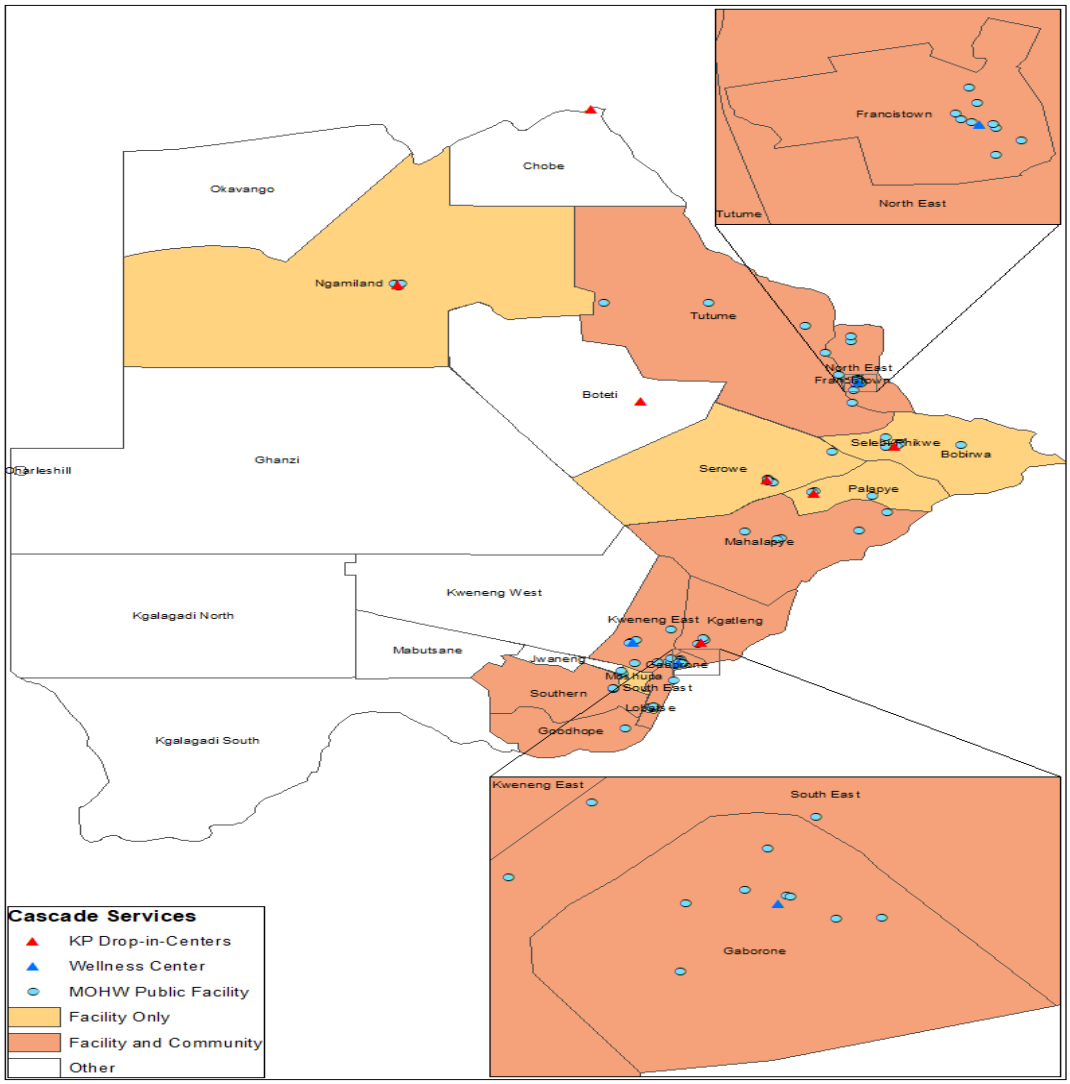


Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP21	# Current on ART (FY21)	# of SNU COP20 (FY21)	# of SNU COP21 (FY22)
Sustained	339,423 (90.6%)	153,548	17	19
Central Support	35,306 (9.4%)	37	10	8

3.2 OVC and AGYW

In COP21, the OVC program will expand to 3 new SNUs that already have a PEPFAR presence and high TX_CURR<15; Francistown, Palapye and Tutume. The move is in line with the COP21 PLL about increasing reach for adolescents and children living with HIV (A/CLHIV) and offering them OVC services. The other OVC sub-populations to be reached include: i) children of HIV positive mothers/care-givers, ii) children of female sex workers, iii) 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. Additionally, the program will continue facilitating MOUs between clinical and OVC IPs for enhanced bi-directional referrals as well as strengthening direct working relationships with the health facilities/clinics in the SNUs where the OVC partners are implementing this type of work to ensure continuity of work beyond PEPFAR days. 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 8 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.

The DREAMS program will continue implementation in the 8 SNUs with interagency collaboration to ensure that the most vulnerable AGYW are reached with age-appropriate interventions. Based on COP20 guidance, the OU revised its eligibility criteria for DREAMS. All IPs continue to use this same tool to identify the most vulnerable AGYW and enroll them in the program. Furthermore, the DREAMS Ambassadors that were hired at the start of COP20 implementation will work closely with IPs to ensure program visibility at the SNUs as well as provide progress updates at various district structures. There will be

more focus on reaching adolescent girls at highest risk of HIV as well as AGYW living with disabilities in COP21 as they are vulnerable to HIV infection. The PLL has also emphasized the need to continue leveraging on the Comprehensive Economic Strengthening (ES) interventions where the OU will use the ELA model by BRAC as a focused strategy to retain older AGYW in the program. The program will continue exploring different ways of implementing the program during COVID-19 times to ensure increased reach of the most vulnerable AGYW while also ensuring implementation of evidence-based curricula with fidelity and strengthening bi-directional referrals. With the electronic database complete and in use and all IPs trained on its use, it is expected that the program will continue to improve its data capturing, analysis and reporting on the program implementation and that availability of this data will enable the OU to track its progress towards saturation across the different age-bands in all the SNUs.

3.3 Key Populations

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 prevention, treatment and care. PEPFAR/B KP intervention will be implemented in the following districts: Boteti, Chobe, Francistown, Gaborone, Kweneng East, Ngamiland, Palapye, Serowe, Selibe-Phikwe, and South East. In COP 21 district and national coordination forums will be established to build synergy among the implementing partners and ensure that referrals are completed, de-duplicated and correctly captured by the district and national M&E systems.

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. HIV negative women who sell sex and abuse drugs will be initiated into PrEP and those that are HIV positive will be provided with support to remain on ART and be virally suppressed. In addition, the KP project will work with Botswana Prisons services to train the prison nurse prescribers on PrEP.

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. In COP

21 Global Fund will move out of Boteti, Francistown, Ngamiland and Palapye to districts currently not covered by PEPFAR's Key Population program.

Botswana has a large service coverage gap for FSW. The BBSS 2017 indicated that 51.6% of FSW had taken a HIV test in the last 12 months compared to 61.2% of MSM that had a recent HIV Test. 77% of transgender persons reported receiving a HIV test in the previous 12 months. In FY 20, Global Fund services reached 34% key populations and PEPFAR reached 68% of key populations with prevention services in districts with KP interventions. In addition, GF annually tested 35% of key populations in four districts while PEPFAR offered targeted testing to 65% of the KP in ten districts. Whereas there has been a great increase in number of FSW on ART at 88% (2017 BBSS) compared to 25% in 2012 (2012 BBSS), ART for MSM lags at 82%. These rates are far lower than the rate of general population members on ART.

Key populations, especially MSM and transgender, still face high levels 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.

The 2017 BBSS reported that the use of drugs among key populations was on the increase. Among MSM, 23.1% used weed, 2.7 % used cocaine, 0.8 % used heroine while 0.4 % injected drugs. Among FSW, 7.2% used weed, 0.55 % used cocaine and 0.1 % injected drugs.

In FY20 Botswana Network of AIDS Services Organizations (BONASO) approached FHI360-EpiC to include these special sub-populations of the KP in their programming. BONASO and Captive Eye have won the trust and confidence of PWUD in these trap houses. In COP21 this initiative will be included in the KP portfolio.

To break the trend of KP starting the use of injectable drugs, the KP program will have two interventions; the first intervention will target route transition interventions that will support KPs who use drugs to avoid initiation into injecting. To minimize HIV transmission through the use of contaminated needles, the project will encourage KPs who are injecting to transition to non-injecting routes of administration. The second intervention level will be to target the KP currently mixing their ARVs with other substances to make it a stimulant- "nyaope" to stop this behavior as it misuses ARVs and

may affect adherence for those currently on ARVs once they divert some of their pills to make “nyaope”. The 2017 BBSS indicate that 0.1% of FSW were using “nyaope”.

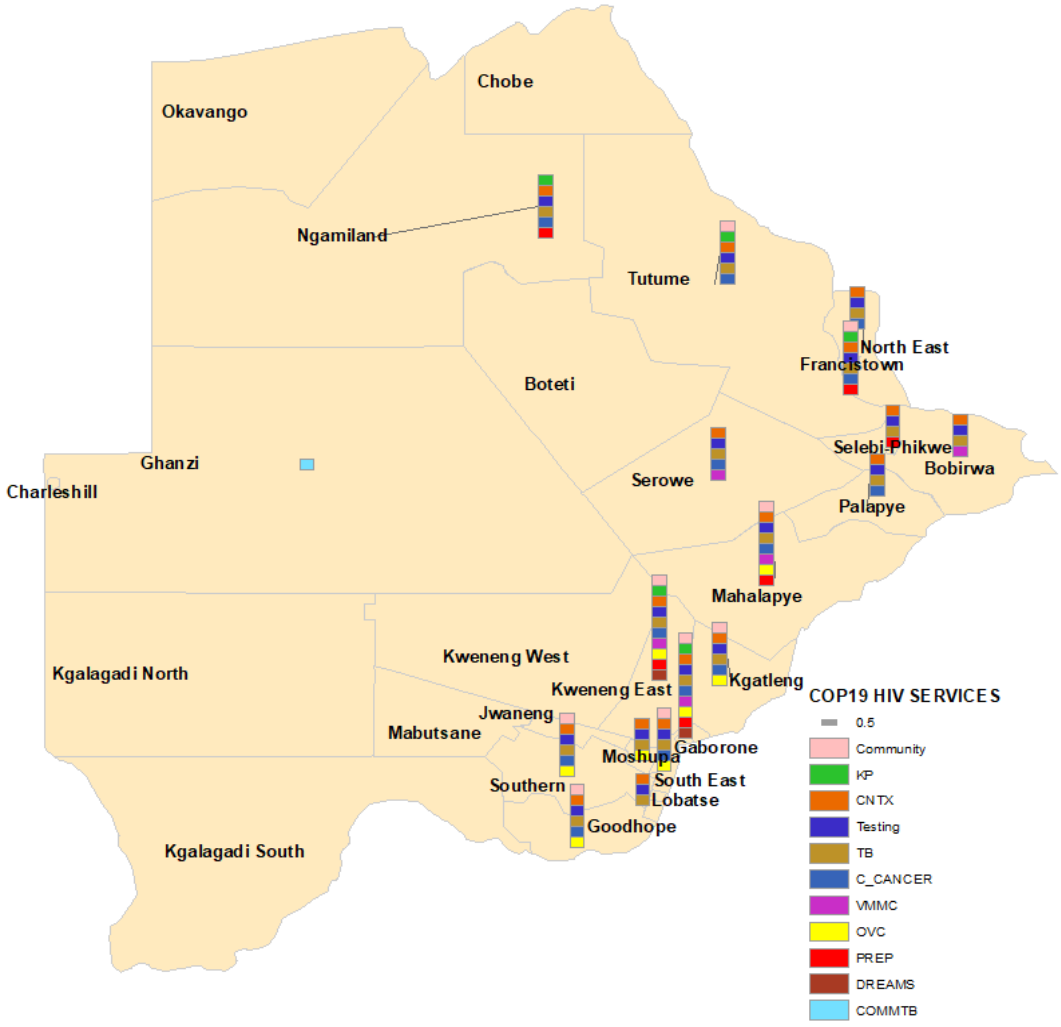
The interventions used will follow the guidelines of implementing a combination approach for HIV/STI/TB prevention among key populations based on an established World Health Organization (WHO) Framework. The combination approach takes into consideration the many interacting factors that lead to increased risk and vulnerability among key populations by using a mix of biomedical, behavioral, and structural interventions outlined in the section below.

In tandem with the WHO Consolidated guidelines on HIV prevention, diagnosis, treatment, and care for key populations -2016, the drug users will be provided with the following core interventions,

- Condoms, lubricants and safer sex promotion and provision
- Provision of PrEP and referral for PEP when applicable
- HIV testing services
- Antiretroviral therapy (ART)
- Evidence-based psychosocial interventions
- Prevention, diagnosis, and treatment of STIs and referral for hepatitis and tuberculosis (TB) management
- Targeted information, education, and communication (IEC) for people who use stimulant drugs and their sexual partners
- Prevention and management of overdose and acute intoxication (work with BOSASENET)
- Referral for Family Planning and other Reproductive Health Services
- Nutritional Support

All the core interventions will be adapted to the specific needs of different key populations and work with parents, families, communities, and other key stakeholders who will include Government of Botswana and other local organizations.

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 COP21, PITC in general/universal OPD had been transitioned to GoB since COP20 FY20. Technical assistance is being provided to ensure the adaption and implementation of screening tools across GoB facilities.

COP21 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) and testing for PrEP. Social network and index testing will also be supported to optimize key populations services.

Case-based surveillance including recency, is supported to monitor and characterize newly identified positives to further optimize case finding. Leveraging on COP19 Faith and Community Initiative, local and faith leaders to promote HIVST among men and youth in an integrated manner.

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

In COP21, 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 WHO and PEPFAR guidance; c) scaling-up HIV self-testing to enhance partner notification and deploying HIVST self-test kits as an adaptive COVID-19 strategy by distributing kits to index clients so that partners can self-screening themselves prior to coming to the facility a d) leveraging the Faith and Community

Initiative (FCI) platform to reach men and youth; and e) conducting recency testing for all newly identified PLHIV.

Below is a detailed description of the case finding strategies approved in the COP21 PLL letter for Botswana across genders and age groups, including adolescents and 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 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. The 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. HIVST kits will also be distributed to HIV positive pregnant women so that male partners can self-screen themselves prior to coming to the facility. This will ensure that only

partners who are most likely to have HIV will come to the facility for confirmatory HIV testing

- *Review of Viral Load data to identify unsuppressed women to generate index clients:* Adults and children identified as unsuppressed through viral load chart review, will be considered 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 counterparts[6]. PEPFAR/B will continue to support index elicitation and testing of men whose HIV positive female partners 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 HIVST kits will be distributed to HIV positive pregnant women so that male partners can self-screen themselves prior to coming to the facility. This will ensure that only partners who are most likely to have HIV will come to the facility for confirmatory HIV 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+ 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 to their female counterparts. COP21 strategic approach involves conducting partner elicitation among all HIV positive men in order to access their female counterparts. Additional *adult women* will also 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.

[6] PEPFAR COP20 Country Operational Plan: Guidance for all PEPFAR countries

- *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. HIVST kits will also be distributed to HIV positive adult men so that female partners can self-screen themselves prior to coming to the facility. This will ensure that only partners who are most likely to have HIV will come to the facility for confirmatory HIV testing. 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 COP21 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 post-partum 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 COP21, index testing the most effective and efficient way for reaching undiagnosed children and adolescents with HIV. With attention to family testing, COP21 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 among childrenCOP20 support will ensure 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 caseworkers will assess all HIV-infected women whose children are registered in the OVC program to ensure all their biological children are tested.

- Providing parents (index clients) with HIVST kits to screen biological children over 2 years of age will be supported.

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 community 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 COP21, 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 as appropriate. Those with non-reactive results will be recommended for enrolment into PrEP and other prevention services.
- The program will enhance virtual recruitment to reach, motivate, 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. It is also a safer recruitment platform during COVID-19 pandemic.

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 COP21 PEPFAR/B has planned to expand the capacity of KP model clinics to add to the differentiated models of service delivery. 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 COP21, priority will be given to targeted mobile outreach strategies at hot spots. Index testing among regular partners of MSM will be rolled expanded observing 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 tourism sector was adversely affected by COVID-19 which led to closures of many hotels. 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. To minimize costs,

the site visits are conducted in collaboration with DHMT through the District Multisectoral team.

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 COP21, PEPFAR/B plans to distribute approximately 22,699 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,) AGYW newly initiated in PrEP to take home for their male sex partner (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 and use of HIVST as an adaptive measure during COVID-19 among the general population and among KPs in COP21. Taking into account the 75% index testing contribution to the overall new HIV positive clients identified and an average of 1.5 sex partners per HIV positive client (based on previous index testing elicitation estimates), and the impact COVID-19 had on HIV testing services provision at the different facilities the plans to provide up to 5 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, children of sex workers, partners of AGYW, 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 integrate self- screening to hard-to-reach men and AGYW 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	2539	7537
TB_STAT	110	327
PMTCT_STAT_POS	253	751
HTS_TST_POST_ANC1_POS	31	92
VMMC_POS	33	98
INDEX Comm	1253	3720
INDEX Comm (KP)	242	718
MOBILE_COM_POS (KP)	127	377
VCT_POS (KP)	3	9
OTHER_COM_POS (KP)	607	1802
FCI Networks		
TOTAL	5198	15431

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, therefore PEPFAR/B plans to continue to implement and expand COP020 linkage strategies in COP21.

Immediate ART initiation and overall LTT has been steadily increasing since FY19 and FY 20 going into FY21 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 COP21, 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 GOB accredited 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 comprehensive HIV 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 *treatment interrupters (*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:

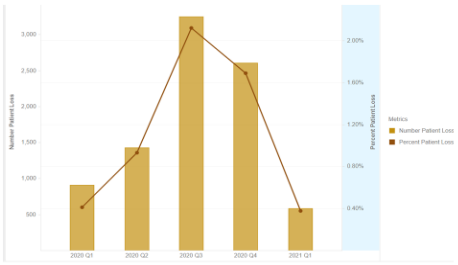
- Integrated services, where HIV testing, and treatment is packaged with other services such as sexually transmitted infections and TB at a single site
- Intensified post-test counselling and education
- Assistance with transport, client accompaniment, and warm handover of clients.
- Treatment navigation
- 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
- Use of virtual platforms for service delivery when physical contacts with providers are not possible for clients to prevent disruption of services

4.2.1 Retaining clients on treatment and ensuring viral suppression

Population	Proposed Interventions
Children	Linkage of pediatrics to OVC programs and linkage of HIV positive OVCs to pediatric programs Development of SOPs/ MOUs between HIV care and treatment clinics and OVC programs to enable optimized inter-referrals Pediatric and adolescent friendly services Convenient appointment times in consideration of school hours Structured support to caregivers by community health workers Use of appropriate pediatric formulations Mental Health and Psychosocial Support (MHPSS)
AGYW and ABYM	Adolescent and youth friendly services

	Psychosocial support Peer support models Targeting adolescents and caregivers with family interventions
Men	Multi Month Scripting and Dispensing (MMS/MMD) Decentralized Drug Delivery (DDD) through Community Medication Refills and post office delivery. 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

Overall Patient Loss is <2.5% in the last year, and declining even further in recent quarters



The chart shows a decline in overall patient loss in FY20Q1 (Source: PEPFAR panorama). But there is still a need to focus on specific groups and populations identified to be most at risk consistent with the COP21 Guidance and program data. These groups include children aged 0-4, young women aged 15-19 and 20-24, and men aged 25-29 and specifically focusing on all HIV infected children and adolescents as well as 15–35-year-old asymptomatic clients to ensure that they are maintained on treatment and virally suppressed. Therefore, based on the observations reiterating the need to point to continue have targeted interventions and additional services beyond the core package focusing on these subpopulations' needs. PEPFAR/B will in COP21 work with UNICEF as a strategic partner with expertise and skills in pediatric and adolescents care packages to support retention among children and Adolescents living with HIV (C/ALHIV). The UNICEF expertise will among others be utilized to strengthen the capacity of HCW to deliver quality Mental and Psychosocial support services (MHPSS) as well as support the digital and innovative programming for adolescents living with HIV especially in the context of COVID-19.

Table 4.2.1. Priority populations and specific PEPFAR /B COP21 retention interventions

Table 4.2.1 shows the specific COP21 additional interventions for the priority populations. Based on PEPFAR's number one treatment priority of facilitating continuous ART, PEPFAR/ B through the IPs has started work with facility and community IPs to strengthen the community facility interphase to optimize client's continuity in care through developing SOPs that will enable referral of clients between the facility and community IPs. The SOPs will clearly outline the key roles at facility and community levels, the client handover timelines, joint meetings to monitor progress and CQI activities to ensure optimized interphase. Furthermore, the existing reboot and COP20 interventions will be continued in COP21 to ensure maintenance of the improved retention. PEPFAR/B will continue to implement a case management approach using expert clients, Community Health Workers (CHW), Health Education Assistants (HEA), case managers and social workers to support continuity in 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, will be enhanced. The use of differentiated service delivery such as MMD and DDD will continue to improve retention. In COP21, 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 levels 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 and DDD 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 HEA, s 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 continuity in treatment 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 to achieve a patient- and family -centered approach. Integration however requires an increased number of HCW 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 continue in treatment and are virally suppressed in order to achieve epidemic control. PLHIV that interrupt treatment 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 minimal package of services 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 tailored to meet clients' specific needs.

1. Multi Month Dispensing (MMD) and fast track refills

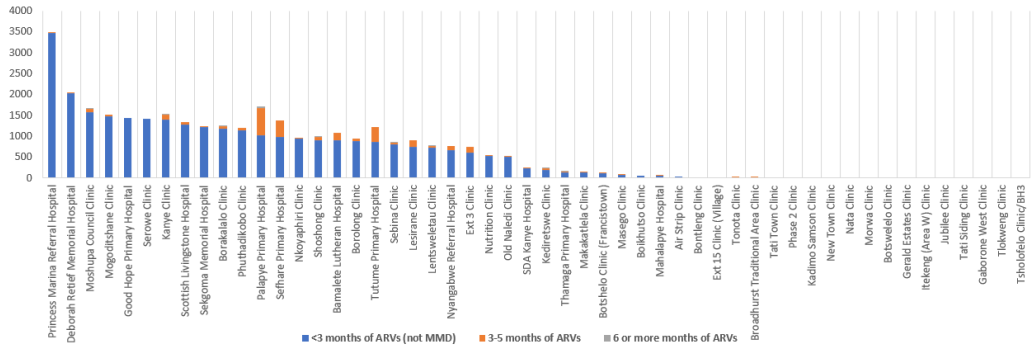
MMD brings an opportunity for improved retention in care and reduces the burden at clinical sites. Stable and eligible clients will receive multi-month scripting (MMS) of six months and MMD of three to six months according to the government of Botswana's set guidance, and a fast track refill model will 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.

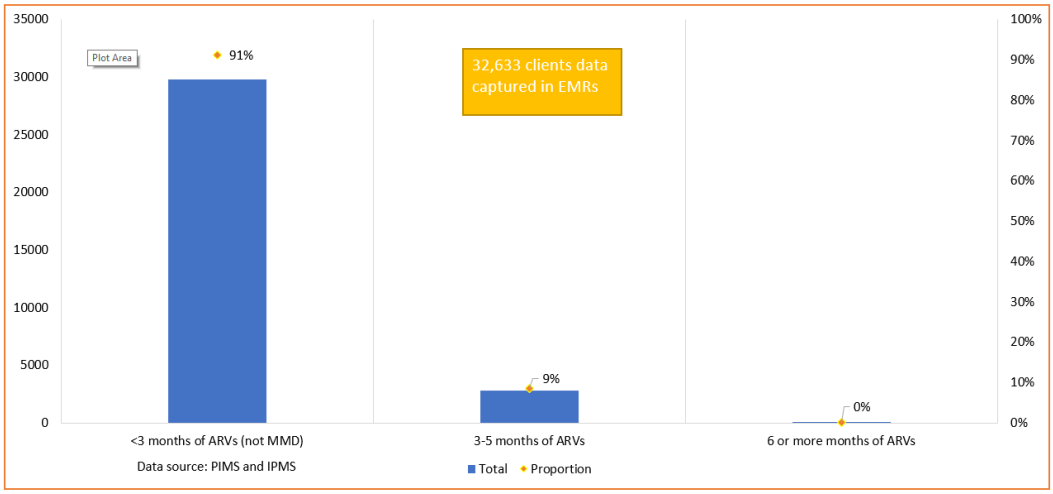
Limited National data for clients on MMD

Interventions

- MoHW and PEPFAR partners developing a data capturing and reporting tool to monitor implementation.
- MMD indicators to be included in the patient data management systems used at health facilities



Jan-Mar 2021 ARV MMD dispensing data (n=52 sites)



2. Decentralized Drug Distribution (DDD)

a) 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.

b) Post office delivery models

This DDD model entails the distribution of drugs to stable patients through the post office, which delivers the drugs to the client's households, or to the client's workplace based on client's preferences. This client centered model decongests the health facilities, gives clinicians an opportunity to focus on unstable clients and enables reach to populations who experience work constraints, and find it challenging to visit health facilities during normal working hours.

3. Community ART initiation

This differentiated service delivery will continue to be implemented in COP21 as an option to meet client needs and preferences. 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 expert clients and Community Health Workers to

advance FCI implementation by promoting treatment literacy, retention, and VL suppression. Expert clients and Community Health Workers will also be assigned "difficult clients" for community tracking and linkage to treatment and offer one-on-one support to encourage adherence.

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	• MMD • DDD (CMR, CAGS, Post office etc.) • 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	• MMD • DDD (CMR, CAGS, Post office etc.) • 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+	• Track and link back treatment interrupters • 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	• Track treatment interrupters • 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 COP21, 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 COP21 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_AFTERHOURS	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 AFTERHOURS	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*	Quarterly

		community traced in the community and linked to treatment	
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	*Virologic HIV test by 2 months of age traced by community health workers and linked to testing*	Quarterly

4.2.7 TB/HIV services

Globally, the reduction in TB incidence between 2015 and 2019 was 9% (from 142 to 130 new cases per 100,000 population). In the WHO African Region, several countries in southern Africa achieved impressive reductions of 4–10% per year since 2015, following a peak in the HIV epidemic, and the expansion of TB and HIV prevention and care (WHO Global TB report 2020). Botswana's estimate TB incidence for 2019 was 253 per 100,000 population which is a 9% reduction from 2018 (275 per 100,000 population). This reduction may be partly attributable to high ART coverage. However, despite a decline in tuberculosis notification and a high ART coverage among TB patients who are HIV positive (92%), TB/HIV comorbidity remains 49% (WHO Global TB report 2020). 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 COP20 and COP21.
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 coinfected.
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 COP21 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 COP21 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 drastically 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 drastically reduced, we continue to see an increased need to focus on specific sub-populations of the vulnerable children that are directly affected by the epidemic & ensuring that they receive the services they need to enable them to thrive, grow up healthy and become resilient. COP21 is guiding OVC programs to intentionally target these children and offer and provide them the relevant OVC services using differentiated service delivery (DSD) models that include the OVC comprehensive, OVC preventive and OVC DREAMS. The specific OVC sub-populations that COP21 will focus on include: i) children and adolescents living with HIV (A/CLHIV), ii) children of HIV+ caregivers (especially the mothers), iii) children of female sex workers, iv) survivors of sexual violence, v) HIV Exposed Infants, vi) Orphans, vii) 9–14-year-old boys and girls and viii) vulnerable AGYW 10-17 years old. To increase our ability to reach an increased number of A/CLHIV, the PEPFAR/B OVC program will expand to 3 SNUs that PEPFAR supported sites and have been identified to have high number of TX_CURR <15. These include Francistown, Palapye and Tutume.

Table below shows how the Botswana program will continue to respond to this pivot in COP21; OVC sub-populations and the applicable DSD model.

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

Prioritized sub-populations	Applicable Differentiated Service Delivery Model
• Adolescents and children living with HIV • Children of HIV+ mothers/caregivers • Children of female sex workers • Survivors of sexual violence • HIV Exposed Infants • Orphans	***Comprehensive Programming*** • 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
• 9-14-year-old boys and girls ○ Primary prevention of sexual violence and HIV	***Preventive Programming*** • 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 0ld boys and girls in one classroom are assessed for OVC services and only girls are assessed for DREAMS eligibility. The facilitator doing assessments initiate referrals as necessary to the relevant programs and make follow up to ensure referrals are completed.

• Vulnerable AGYW 10-17 years old	***OVC/DREAMS Programming***
	• Layered interventions are provided by both platforms;
	  ○ The AGYW is placed into a safe space via the DREAMS program and receive applicable services via the safe space (social asset building)
	  ○ The AGYW receives applicable OVC services that are otherwise not available through the DREAMS program

The below provides details of how these sub-groups will be identified including some of the critical approaches and interventions.

- ***Comprehensive Programming Service Delivery Model***

The Botswana OVC program has traditionally had a pediatric clinical provider (Baylor) as a sub-partner under the 1 large OVC program implemented by Project Concern International (PCI). 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 while some have received letters of support from the District Management Health Teams (DHMTs) authorizing them to work with certain health facilities to increase reach for adolescents and children living with HIV (A/CLHIV). Peace Corps Volunteers (PCVs) doing OVC work are expected to be placed in some health facilities in their area of services. 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 Q1 it was 10%. With the call from OGAC to offer OVC services to 90% of children and adolescents living with HIV, the PEPFAR Botswana 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 will be implemented now in COP20 and into COP21 to significantly increase these numbers and ensure we are tracking 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 side.
    - 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. Using the snowball model has worked in the past to bring more adolescents to be part of the teen clubs (clubs where HIV positive adolescents meet in a safe space to address issues of adherence as peers); this will continue in COP21. 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.

- *Strengthen partnership with other implementing partners working in the clinical space*: PEPFAR provides support to the MOHW via several implementing partners who already have a presence in the 75 health facilities receiving PEPFAR support. A preliminary review based on a mapping exercise that PEPFAR Botswana 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 expects PCVs to be placed in health facilities across the country. To ensure these partnerships yield the results expected, the OVC program started reaching especially to the District Health Management Teams in the SNUs where they work to have a better understanding of what they needed to do to strengthen their relationship with health facilities. In some SNUs, the DHTMs have provided letters of support to the OVC IPs instead of entering into a MOU. The OVC IP next step is to engage closely with the clinical partners to negotiate signing of memorandum of understanding (MOUs) and development of standard operating procedures (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. This will especially be an area of focus as COP21 is highly focused on finding and linking pediatrics to HIV care and treatment services.

- *Strengthen partnership with other civil society organizations working with adolescents and children living with HIV*: Several other civil society organizations

(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 especially if these organizations are present in the SNUs that the PEPFAR OVC program works in.

Work with 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.

In terms of reaching Children of female sex workers, the OVC program is employing some of the following strategies:

- *Strengthening partnership with PEPFAR implementing partners and other civil society organizations working with the key populations*: The process of setting up an MOU with FHI360, currently implementing the EpIC KP program is underway. 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 EpIC program. The current engagement has seen the OVC program serving an increased number of children of key populations which currently (FY21 SAPR) stands at 676. In SNUs where the EpIC program does not have a presence, the OVC IP will identify other existing CSOs and work with them in this area. 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 COP21. 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 FY20Q4, the Botswana OVC program had identified and served 93 survivors of sexual violence. There is need to prioritize this OVC sub-population and ensure relevant service provision. Some of the strategies to be employed in COP21 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. There is a training manual

designed by a PEPFAR supported OVC IP some years back and adopted by GoB. 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 need to review the manual and update with current data as well as ensure there is a service directory attached to the manual to make service referrals easier.

- *In some select SNUs, some 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. Additionally, through Baylor, the grannies were trained 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 was planned to continue in COP21 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. However, due to COVID-19, plans to implement this work was interrupted as partners had to significantly scale down on group-based type of interventions. Depending on how the situation unfolds during COP21 implementation, it is highly likely that this strategy will be implemented. 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 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 & sensitive transition process for all the beneficiaries that do not meet the current focus sub-populations. By FY21 SAPR, there are only 705 OVC who do not meet the criteria of these sub-populations

whereas when we started COP21 implementation we had over 3,000. IPs continue to work closely with other stakeholders to graduate these children from the program but after careful assessment of their families. This is being done to create room to enroll new beneficiaries. Enrollment of new beneficiaries will align with the maintenance phase of the program so that we enroll only numbers that we can adequately maintain & support with the available resources. This process will be conducted in close collaboration with the government of Botswana relevant Ministries.

- ***Preventive Programming Service Delivery Model***

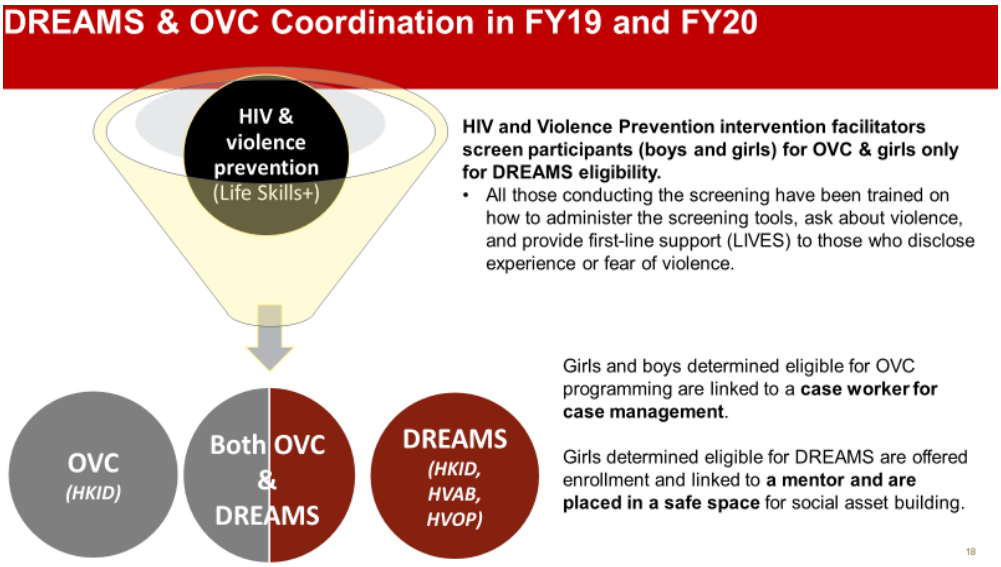
In the past 4 years, the PEPFAR/B OVC program continued to shift focus to the 9-14-year-old group for both boys and girls, targeting them with primary prevention of sexual violence and HIV. The focus started during COP17 implementation in the two DREAMS SNUs where PEPFAR/B is implementing both DREAMS and OVC via one implementing partner, PCI. The program has since been extended to non-DREAMS SNUs and this will continue in COP21. 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-olds are in school. This therefore requires close coordination and collaboration with the relevant GoB ministry, in this case, 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 an agreed upon 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, as a result there are times when the IPs may go for extended periods without delivering any lessons if for example schools are closed or learners are taking examinations. During the current COVID-19 pandemic, the program has greatly suffered as schools were closed for extended periods in 2020 and once opened, the schedule changed completely only providing limited time frames for “other curricula activities” such as the HIV and Violence prevention program. While the OU had planned to use two curricula in COP20, only one ended up being use: LIFESKILLS+ by USAID while the one that was planned to be used by PCVs was not used as PCVs were evacuated at the start of the COVID-19 pandemic and have not yet returned to post. The LIFESKILLS curriculum has been 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.

OVC/DREAMS Service Delivery Model

Over the past three years, the OVC & DREAMS programs learned a lot about the relationship between the two programs. The below pictorial from the PEPFAR/Botswana DREAMS & OVC presentation used at the COP20 Regional Planning Meeting held in Johannesburg nicely summarizes this relationship & the importance of having a strong coordination between the two programs.



The COP20 expansion of DREAMS into other SNUs and having new IPs doing DREAMS work, makes it very important to have strong coordination mechanisms between the different players. This will include:

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

In doing all this work, the OVC program will ensure that critical partnerships with the relevant Government of Botswana Ministries and Departments are maintained and that these Ministries and Departments are continually updated on work being done at district level.

4.3.1. b Prevention: DREAMS programming with AGYW

PEPFAR/B will continue supporting the Determined, Resilient, AIDS-free, Mentored, and Safe (DREAMS) program by identifying the most vulnerable adolescent girls and young women (AGYW) ages 10-24 years through school and community-based interventions. A client-centered approach will be initiated in all service points to ensure that the most vulnerable are offered relevant prevention options. PEPFAR/B has been implementing the DREAMS program for the past 3 years in 2 SNU's. In COP 20 the program was expanded to 6 additional SNUs in line with OGAC priorities of reducing new HIV infections amongst AGYW.

This scale up was however affected by the advent of the COVID-19 pandemic as some IPs could not go ahead with in-person trainings which were to be facilitated by curriculum developers based out of Botswana. Curriculum had to be revised to comply with COVID-19 mitigations. This therefore led to some discussions to explore virtual trainings based on the type of curriculum and the associated requirements. In addition, the interventions within the DREAMS package were either stalled or reduced as implementing partners devised alternative models of implementation.

PEPFAR/B's COP 21 DREAMS program will maintain 8 SNU's (Gaborone, Kweneng East, Kgatleng, Mahalapye, Serowe, Bobirwa, North East, and Southern). In collaboration with the Ministry of Health and Wellness (MOHW) and the Ministry of Basic Education (MoBE), schools where DREAMS is being implemented will be linked to local health facilities offering adolescent and youth friendly services in order to expand the provision of biomedical SRH services, mixed contraception methods including condoms, STI screening and treatment, PrEP, clinical post-violence care services and referral for services such as HTS counseling, care and treatment services for AGYW based on need and age cohort. The DREAMS program will work closely with the GF recipient partners, UNICEF and other stakeholders to discuss and explore existing opportunities for collaboration and facilitate geographic expansion and saturation.

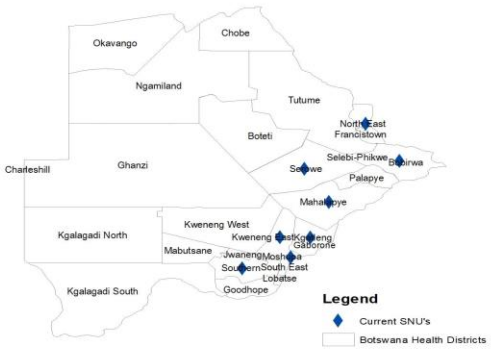
NAHPA has developed a National Programming Framework for Adolescents and Young People (AYP) in Botswana which guides all activities for young people including AGYW in

the country. This AYP strategy promotes an integrated service delivery system where youth are provided with a combination of services aimed to keep them healthy. This integrated services delivery system has ideally ensured that AGYW are offered a complementary, multidisciplinary, holistic approach, including primary care, reproductive and sexual health care, STI/ HIV testing and treatment, substance abuse treatment, mental health care, and education and counseling. DREAMS fits neatly within this strategy and interfaces with GF programs dovetailing services for AYP. AGYW often feel anxious to receive services in a setting that would stigmatize them. Integrated service settings, such as school-based, community-based health platforms and school linked health centers, are therefore critical as they do not expose what services young people are seeking.

DREAMS FOOTPRINT

DREAMS SNU	AGYW Incidence	Total PLHIV
Bobirwa District	1.30	20,713
Gaborone District	0.72	45,362
Kgatleng 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

DREAMS COP21 SNUs



PEPFAR/B's COP20 DREAMS program has successfully expanded to six more SNUs as per the requirements of the COP20 PLL: Bobirwa, Kgatleng, Mahalapye, North East, Serowe and Southern. 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.

DREAMS Package of Interventions (COP20 Updated Layering Table)

COP20 Updated Botswana DREAMS Layering Table

		9-14	15-19	20-24
INDIVIDUAL	**Primary Individual Interventions**	· HIV & violence prevention · Financial literacy · Social asset building · Screening for HTS eligibility	· HIV & violence prevention · Financial literacy · Social asset building · Condom education · Screening for HTS eligibility	· HIV & violence prevention · Financial literacy · Social asset building · Condom education & distribution · Screening for HTS eligibility
	Secondary Individual Interventions	· Risk-based HTS · Condom education · Post-violence care · Contraceptive mix	· Risk-based HTS · Post-violence care · Contraceptive mix · PrEP (age 18 and above) · Condom Distribution · Combination socio-economic approaches	· Risk-based HTS · Post-violence care · Contraceptive mix · PrEP · Combination socio-economic approaches
		Services Referred for Educational support, National registration, Legal protection and services, Child protection, Substance abuse rehabilitation, Mental Health Services		
	Range Individual Level Interventions including services referred for	4-13	5-16	5-15
CONTEXTUAL	**Contextual Level Interventions**	· 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		

Note: *The COP20 layering table will be adopted for COP21 as there are no changes in the interventions or program implementation model.*

- ***Primary Individual Interventions:*** In order to reach the most vulnerable AGYW, PEPFAR/B's DREAMS program is designed as an interagency collaboration building on COP 20 lessons learned. S/GAC approved curricula is used to ensure provision of HIV and violence prevention to DREAMS participants, including their classmates - both boys and girls - within the eligible age cohorts (9-24years). OU will use the following age-appropriate curricula for these interventions; LIFESKILLS+, ELA and

Grassroots Soccer. Social asset building sessions will be provided through safe spaces for in-and-out of school AGYW to empower them to reduce their risk of acquiring HIV. The OU will continue providing the standard package for financial literacy and economic strengthening program to beneficiaries through the use of LIFESKILLS+, Aflateen and Ready to Work curriculums. The economic strengthening interventions will be enhanced to provide necessary skills to promote self-sufficiency and resilience to overcome economic disparity using the Empowerment of Livelihoods for Adolescents (ELA) model.

- ***Secondary Clinical Interventions:*** In COP 21 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) care services including Post Exposure Prophylaxis (PEP) for survivors of sexual violence; STI screening and treatment as well as risk screening HTS, and contraceptive methods mix which will be provided at the community-level through clinical platforms that include Tebelopele Wellness Centers (Gaborone & Kweneng East) and 37 youth friendly public health facilities in all eight districts as well as via community platforms through the CSOs implementing DREAMS. 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. PEPFAR Botswana will integrate new bio medical prevention interventions such as the Dipivefrine Vaginal Ring (DVR) and injectable long acting cabotegravir into PrEP and other prevention platforms as products move into the global marketplace.

- ***Contextual community-based interventions:*** PEPFAR/B will implement the community mobilization and norms change in all the 8 SNUs. SASA! will be used for reaching communities and ensuring that GBV and HIV issues are discussed. Furthermore, parents and caregivers of DREAMS beneficiaries ages 10-17 will be reached to discuss issues surrounding HIV, child- parent communication as well as building their skills to support AGYW through Sinovuyo – which has since been given a Setswana name Pinagare. Household economic strengthening interventions will also be implemented as part of the contextual interventions. PEPFAR/B is approved to use the ELA model as an economic strengthening curriculum with Ready to Work and Aflateen used to offer the standard package for financial literacy and economic strengthening Completion of the DREAMS primary interventions and secondary interventions as needed is critical if we are to make an impact in the

lives of AGYW. Additionally, we need to reach an increased number of AGYW in COP21 in order to work towards 75% saturation in the DREAMS implementation SNUs.

In line with the COP19 MPR to develop a national DREAMS M&E system, PEPFAR/B has been able to successfully complete this requirement in COP20. The system went LIVE in November 2020 with all the IPs trained for its use. The IP which supported the OU to develop the system, worked with all DREAMS IPs to harmonize and align their digital systems to track layering, to conduct regular system data entry check-ins, shared system documentation, shared data mapping and ensured that historic data import was completed on time. All IPs are now reporting using the DHIS2 database. In COP20, the developer supported the maintenance and provided technical support to GoB to ensure successful transfer of the system as well as the integration in all DREAMS SNUs as of COP20. This support will continue in COP21 to ensure that the national DREAMS Coordination Office at NAHPA is fully capacitated to use the system and to support IPs and to also ensure that any maintenance that is needed is provided.

The Government of Botswana (GoB) continues to lead DREAMS, overseeing the implementation of the DREAMS program through the National DREAMS Coordination Unit at NAHPA. This is a unit of three people: DREAMS Coordinator and two DREAMS M&E Officers. 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 Officers engage frequently with the DREAMS implementing partners on data-related matters to ensure timely collection, cleaning and reporting of DREAMS data. The coordination office also supports DREAMS Ambassadors who serve as representatives for the DREAMS program at district level. DREAMS Ambassadors work closely with District AIDS Coordinators to provide oversight and support coordination as well as to promote DREAMS at district level. DREAMS Ambassadors will work with communities, FBOs, and CSOs to advocate for AGYW on different district platforms. In order to successfully serve AGYW, mitigation measures against COVID-19 have been put in place and observed. These include bookings for PrEP refills, virtual trainings, virtual safe spaces, mass gathering restrictions, home quarantines for exposed staff or providers, social distancing measures, and personal protective actions.

In addition, PEPFAR/B has engaged a DREAMS Coordinator who sits in the PEPFAR office and works closely with agencies to ensure collaboration across the different components of the program. This Coordinator also works with NAHPA to ensure successful

implementation of the program, support to districts and to IPs. Furthermore, the Coordinator is the point of contact between OGAC and the Botswana interagency DREAMS team.

In COP21 PEPFAR/B will support the engagement of youth mentors to act as case managers to their peers and help them navigate through different service points in facilities. E.g.., ANC, FP, HTS, and STI Mentors work closely with other service providers such as trained counselors, clinicians, medical officers, and social workers to refer cases that are beyond their scope.

Table 4.3.3: Illustration of COP21 Implementation by Agencies and SNUs

COP21 DREAMS Interagency Collaboration

SNUs		INTERVENTIONS & IMPLEMENTING AGENCIES		
SNU Name	Type of SNU	Primary Community-based Interventions	Secondary Clinical Interventions	Contextual Community-based Interventions
Bobirwa	Current			
Serowe				
North East				
Kgatleng				
Mahalapye				
Southern				
Gaborone				
Kweneng East				

To maximize efficiency and optimize existing resources, Peace Corps, USAID and CDC will implement various components of the DREAMS core package of interventions; ensuring that all components of the core package are implemented at each SNU as per the COP20 DREAMS layering table. Table 4.3.3 shows the SNUs, implementing agencies, and respective interventions in COP21. Clinical sites will continue to be capacitated to deliver youth friendly services and sites that have dedicated youth friendly centers will continue to be strengthened in order to increase opportunities to identify the most vulnerable AGYWs as potential DREAMS beneficiaries. The health and safety of the beneficiaries is paramount; thus, all clinical providers will adhere to COVID-19 mitigation protocols and ensure services are delivered in a timely and safe manner. PEPFAR/B will ensure existing entry points and referrals are optimized and appropriate new ones are established. The full package of community-based and clinical DREAMS services outlined in the DREAMS

Layering table will be implemented. Existing service delivery platforms (i.e., ANC, FP, HTS, STI, etc.) will be utilized as per S/GAC guidance.

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 COP21 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.

Table 4.3.5 DREAMS Saturation Estimates Across Age Bands and SNUs

	Botswana Saturation assumptions calculations											
PSNU	Age	Sex	Estimated AGYW Population	Estimated AGYW LHIV	Estimated AGYW LHIV who know their HIV status	Estimated HIV Prevalence [%] among AGYWs	Estimated AGYWs receiving ART	Estimated AGYWs on ART & virally suppressed	Estimated AGYWs of an HIV Negative status	Saturation target at 75% acceptence rate	Rounded targets FY21	Rounded targets FY22
			175,362	10,157	8,697	2	6,960	6,195	165,205	56,564	24,517	24,898
Bobirwa District [#SNU] [gGqaAXuUGpb]	10-14	Female	4,722	158	88	3.34%	70	27	4,564	1,062	287	776
Bobirwa District [#SNU] [gGqaAXuUGpb]	15-19	Female	4,297	292	265	6.79%	122	116	4,005	1,289	348	941
Bobirwa District [#SNU] [gGqaAXuUGpb]	20-24	Female	4,375	591	537	13.51%	295	280	3,784	1,969	729	1240
Gaborone District [#SNU] [VB7am4futjm]	10-14	Female	17,620	345	193	1.96%	228	87	17,275	3,955	1433	1221
Gaborone District [#SNU] [VB7am4futjm]	15-19	Female	16,033	639	581	3.99%	711	675	15,394	4,810	1700	1448
Gaborone District [#SNU] [VB7am4futjm]	20-24	Female	16,325	1,295	1,177	7.93%	1,720	1,634	15,030	7,346	3525	3001
Kgatleng District [#SNU] [yNcvm7JYBfi]	10-14	Female	5,201	120	67	2.31%	46	17	5,081	1,170	662	538
Kgatleng District [#SNU] [yNcvm7JYBfi]	15-19	Female	4,733	223	203	4.70%	138	131	4,510	1,420	767	653
Kgatleng District [#SNU] [yNcvm7JYBfi]	20-24	Female	4,819	451	410	9.36%	334	317	4,368	2,169	1171	998
Kweneng East District [#SNU] [Uz8LWtC0\	10-14	Female	16,736	415	252	2.48%	92	35	16,321	3,766	1402	1194
Kweneng East District [#SNU] [Uz8LWtC0\	15-19	Female	15,228	768	698	5.04%	247	235	14,460	4,568	1709	1455
Kweneng East District [#SNU] [Uz8LWtC0\	20-24	Female	15,506	1,556	1,414	10.04%	598	568	13,950	6,978	3345	2850
Mahalapye District [#SNU] [iY69BUSqcnC	10-14	Female	7,282	226	127	3.10%	105	40	7,056	1,638	885	754
Mahalapye District [#SNU] [iY69BUSqcnC	15-19	Female	6,626	417	379	6.30%	251	238	6,209	1,998	1073	914
Mahalapye District [#SNU] [iY69BUSqcnC	20-24	Female	6,747	846	769	12.54%	609	579	5,901	3,086	1640	1397
North East District [#SNU] [nszh0FzynAQ]	10-14	Female	3,004	92	52	3.06%	36	14	2,912	676	188	488
North East District [#SNU] [nszh0FzynAQ]	15-19	Female	2,733	170	155	6.23%	80	76	2,563	820	221	599
North East District [#SNU] [nszh0FzynAQ]	20-24	Female	2,783	345	314	12.40%	194	184	2,438	1,252	463	789
Serowe District [#SNU] [YmeyoDakwFX]	10-14	Female	2,833	85	48	3.01%	103	39	2,748	687	172	465
Serowe District [#SNU] [YmeyoDakwFX]	15-19	Female	2,578	158	144	6.13%	177	168	2,421	773	209	564
Serowe District [#SNU] [YmeyoDakwFX]	20-24	Female	2,625	320	291	12.20%	428	407	2,305	1,181	437	744
Southern District [#SNU] [LEUjALXlnGD]	10-14	Female	4,427	98	55	2.20%	51	19	4,329	996	538	458
Southern District [#SNU] [LEUjALXlnGD]	15-19	Female	4,028	181	165	4.49%	95	90	3,847	1,208	653	556
Southern District [#SNU] [LEUjALXlnGD]	20-24	Female	4,101	366	333	8.93%	230	219	3,735	1,845	997	849

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 20 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 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 PEPFAR/B will continue to strengthen the use of NDDB in order to strengthen documentation of bi-directional services in COP 21.

- *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 partners 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 COP21. 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 fairly 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 was expanded in COP20 and will continue in COP 21. 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 team learnt that this new development yields some results as it has responded to the needs of AGYW and will be expanded to COP21 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 has been gradually introduced in the DREAMS program as well targeting older AGYW.

Additionally, in response to COP20 guidance on the need to strengthen the economic strengthening component of the program, PEPFAR/B reviewed the models that S/GAC had recommended. All agencies made a decision to move ahead with the Empowerment and Livelihoods for Adolescents (ELA) by BRAC. While agencies and implementing partners are at different levels of engaging BRAC, considerable progress has been made across the board. Implementation of this model will continue during COP21.

- *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 gives stakeholders an opportunity to review data, identify gaps and collaborate on identifying and implementing solutions. The M&E system will be expanded in COP21 to facilitate and strengthen partner collaboration based on access to reliable data.

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

- *Peace Corps Virtual Service Pilot Project (VSPP):* In COP21, PEPFAR/B will utilize Peace Corps' Virtual Service Pilot Project (VSPP) participants to support recruiting and retaining AGYW in DREAMS. Through the VSPP, 8 former Botswana Peace Corps Volunteers selected to provide remote/virtual support will twin with their counterparts (DREAMS Ambassadors) to develop recruitment strategies for each SNU.

- *Redecoration of Youth Spaces:* In order to make health services youth friendlier, PEPFAR/B will support MOHW and MOBE to redecorate youth spaces such as waiting and consultation rooms. The youth spaces will be reinvigorated to provide young people with youth friendly sexual and reproductive health (SRH) information

in a private and safe space, and intensify discussions on SRH, social and economic issues within communities. Youth spaces will be equipped with televisions, computers, printers, outdoor sports equipment, indoor games, and audio-visual materials. The spaces will be directly managed by Site Coordinators and supported by Health education assistants.

- *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. DREAMS Ambassadors will work with church-based youth groups to recruit AGYW into DREAMS.

- *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. This has become even more important during the COVID-19 pandemic where sometimes either the participant or mentor or facilitator are not able to attend sessions in person due to quarantine or isolation status. 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 COP21 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 highly at risk AGYW 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.

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 72 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 at select service delivery points 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 COP21, PEPFAR/B will introduce new biomedical interventions such as long-acting injectable cabotegravir (CAB-LA) and the Dipivefrine Vaginal Ring (DVR). PrEP expansion efforts will continue in high HIV prevalent areas and target 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 be initiated on the same day with blood drawn for renal function and Hepatitis B with results availed on their 2nd visit hence the lack of results on the first day does not hinder them from being initiated. 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 have been 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 continue to 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 has shifted from emphasis on youth friendly clinics to youth friendly services. This means extensive engagement of clinicians in all DREAMS SNUs to ensure that facilities provide youth friendly services.

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. There is a national Technical Working Group for M&E that comprises of all partners, Civil Society, GoB and USG. The TWG meetings are held regularly to provide update on implementation, including successes, challenges and ways to improve

programming. The TWG also looks at the operations of the national DREAMS database and reporting.

4.3.2 Prevention: PMTCT

PEPFAR/B will continue to support the most effective PMTCT program possible by ensuring that pregnant and breastfeeding women and their children have access to care, treatment and support in order to prevent transmission of HIV from the mother to their infant. 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. Recommendations from the diagnostic network mapping, will also be used to inform decisions on where to deploy point of care testing methodologies. 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 continues to be scaled up across the country and is expected to be finalized during COP20/FY21 implementation. 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 COP21 a great emphasis will be made to address stigma and structural issues which keep key populations from accessing services. Especially now in the context of COVID-19, 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 HIV negative FSWs and high-risk HIV-negative MSMs. in.
- Ecological prevention model in DREAMS to reach HIV negative girls highly at risk.
- 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 COP21, 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 10,010males through a DSD approach using only the dorsal slit surgical technique. PEPFAR/B recognizes the need for change in minimum age eligibility for client safety and is fully supportive and plans to uphold the safety of both clients and providers during the COVID-19 pandemic. 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 COP21 PEPFAR/B will allocate more that 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 2021 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 COP21. 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. Due to COVID-19 challenges the implementation of HCD delayed and has only been re-started in Q3 of COP20 implementation. 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 leant 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**	**1,200**	**N/A**
Gaborone		**159,643**	**19%**	**2,401**	**20%**
Kgatleng		**39,245**	**20%**	**1,501**	**24%**
Kweneng East		**65,439**	**22%**	**2,001**	**25%**
Mahalapye		**49,999**	**20%**	**1,603**	**23%**
South East		**20,401**	**21%**	**602**	**24%**
Serowe		**37,077**	**17%**	**702**	**19%**

*These are national figures extracted from Census Population projections and national VMMC program data from MOH per district inputted in SPECTRUM APR FY20
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 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 COP21 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 COP21, PEPFAR/B will implement recommendations of the diagnostics network mapping and optimization exercise. We will also work with MoHW to evaluate new testing methods, develop and review testing policies and regulations, operationalize and support 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 to scale up biosafety and waste management policy. In COP 21 the recency technology will be scaled up to cover 12facility and 2 community sites

PEPFAR/B will continue to 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 developed will be utilized to report and monitor lab indicators.

. PEPFAR/B laboratory team will continue to work with MoHW to support the scale up of self-test kits. Laboratory components of PEPFAR surveys and surveillance work, will continue to be supported for COP21 through technical assistance (TA) using PEPFAR/B lab staff and CDC headquarter staff.

4.4.2 Improving quality and efficiencies of diagnostic services

In COP21, 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 work with the health laboratory sector to implement the regulatory

documents in-line with international standards. PEPFAR/B laboratory work will continue 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 and implementation 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 COP21, 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 COP21 to support Proficiency testing for HIV tests including EID, VL, CD4, TB and POCT 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 ad corrective actions discussed.

4.4.3 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 begun 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 COP21, PEPFAR/B will enhance efforts to keep HIV negative AGYW, adult men, pregnant and breastfeeding women, KP, sero-discordant couples and other populations who are unable to negotiate safe sex such as prisoners and ex-convicts, 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, Family Planning, ANC, MCH, care and treatment. To address low demand and retention of AGYW on PrEP, and leveraging on the 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 COP21 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, Transgender, 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 FY21, three KP members sero-converted to HIV positive while on PrEP. In COP21, PEPFAR/B will conduct ongoing pharmacovigilance to monitor and respond to severe adverse events promptly and effectively. In COP21, 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 in COP21. 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
- Virual/Online targeted posting and advertisements

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 HIV testing program. All clients who test HIV negative will be assessed for PrEP eligibilty, Intimate partner violence, and educated on PrEP. Those who are eligible will be referred to appropriate clinical providers for PrEP initiation. Pending approvals PEPFA/B will introduce new biomedical interventions related to PrEP such as long-acting injectable cabotegravir (CAB-LA) and the Dapivirine Vaginal Ring (DVR).

4.4.4 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, sent 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. Botswana is planning and working towards synchronizing the analysis and the finalization 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 COP21.

COP21

At present, PEPFAR/B is tackling stigma from different angles throughout COP20 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.

In COP21, 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 capitated 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 COP21 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 COP21.
   - **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 during initiation counseling. 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.

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

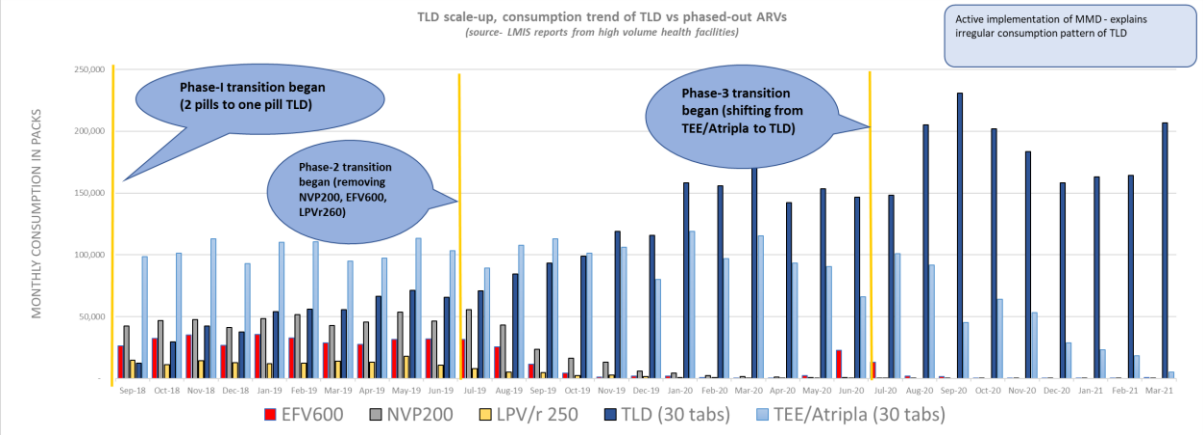
Commodities-related issues that have the potential affect the ability of PEPFAR to support the country's achievement of epidemic control include:

- The national supply chain issues that may negatively impact the last mile distribution of required commodities to the patient include –
    - System inefficiencies and lack of qualified and adequate staffing at Central Medical Stores (CMS)
    - Insufficient forecasting technical expertise that may lead to potential stock-outs
    - Inadequate and unreliable 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.
    - The country has not experienced any stockouts of ARVs in the past year.

4.5.1 TLD Transition

Current Status of the TLD Transition

TLD transition continues to be scaled-up; with 77% of clients switched to DTG-based regimen by March 2021, of which 71% are on TLD. And as indicated in the graph TLD is now the primary 1st Line regimen, replacing DTG+TE and TEE. Phasing out of legacy ARVs (NPV, EFV and LPV/r) is also almost completed.



4.5.2 CMS Supply Chain Capacity Building

PEPFAR continues to support systems strengthening and build capacity at the CMS through the USAID-PSM mechanism at a reduced footprint due to the budget cuts in COP19. For COP21 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

- 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

- **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:
  - Funding and supporting enhancement of visibility by upgrading manual tools to electronic modules at selected sites. Connection between CMS and the district warehouses is currently funded by Global Fund, so PEPFAR will be supporting the enhancements of downstream connection in COP21.

- **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.
  - 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.

ARVs: The Central Medical Stores (CMS) stock situation report for the end of May 2021 shows the following at central level for 1st & 2nd line ARVs in the country:

Table 4.5.1 - ARV supply as of May 2021

First Line ARVs	Months of Stock at CMS	Second Line ARVs	Months of Stock at CMS
TEE	Replaced with TLD	LPV/r 125	14.8
TLD	13	ATV/r 300/100	13.6
DTG	2.7	DRV600	0.7
Truvada	2.6	RTV100	2.0
ABC300	7.5		
ABC/3TC 120/60	23.4		
3TC150	24.1		
TAF-ED	8.8		
Combivir 300/150	15		

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 COP21

Mechanism ID	Major Category	Item	Commodity Quantity	Total Item Budget
18252	ARV	Emtricitabine/Tenofovir DF 200/300 mg Tablet, 30 Tablets	54,000	$ 270,000
18252	ARV	Dolutegravir/Lamivudine/Tenofovir DF (TLD) 50/300/300 mg Tablet, 90 Tablets	10,600	$ 349,800
84043	TB	Vitamin B6 (Pyridoxine) 50 mg Tablet, 1000 Tablets	776	$ 21,728
84043	TB	Rifapentine/Isoniazid 300/300 mg Film-Coated Tablet, 3 x 12 Blister Pack Tablets	4,000	$ 200,000

84043	TB	Other TB Pharma 1 (specify)	1,607	$ 22,498
84043	RTKs	Other Self-Test 1 (specify)	66,667	$ 200,001
84043	RTKs	Asante HIV Rapid Recency Assay, Bulk Format, 100 Tests/Kit	136	$ 64,600
81557	RTKs	OraQuick® HIV Self-Test, 250 Tests	21	$ 16,800
81557	RTKs	Asante HIV Rapid Recency Assay, Bulk Format, 100 Tests/Kit	10	$ 4,750

Table 4.5.2 shows the planned commodities to be procured by the OU under COP21 at a budgeted cost of $1,150,177.

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. There were leadership changes in FY20 at CDC, USAID (health team), and Peace Corps, as well as in the PEPFAR Coordination Office in September 2020. The new PEPFAR/B leadership team will be revisiting the Guidebook and making revisions and recommendations on ways we can all work together more effectively and efficiently.

With the exception of Peace Corps and HRSA, the entire PEPFAR interagency team is housed at the same site in Gaborone West (G-West).

Peace Corps Volunteers (PCVs) are placed strategically with local implementing partners - NGOs, health facilities, schools and local government offices to provide technical assistance and capacity building support for PEPFAR programs with a special focus on youth aged 10-24. More specifically, Volunteers implement/support:

- HIV and GBV prevention programs addressing in-school and out of school youth and their supporting environments, and
- DREAMS and other OVC programs;

- Systems strengthening organizational development, monitoring and evaluation, information technology and supply chain management.

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: 1) PEPFAR Management Team (PMT) made up of Deputy Directors, TWG Co-Chairs, the PCO, and Agency Leads (optional), 2) PEPFAR Country Team (PCT) with all PEPFAR staff across USG agencies; 3) regular PEPFAR agency leads meetings with directors from the various agencies; and 4) regular TWG meetings with representation from the interagency teams. 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

COP21 planning embraced the "One Botswana" response. Though challenged by the limitations brought about by the current pandemic, the PEPFAR/B team leveraged technology and various virtual platforms to ensure engagement of the GoB and civil society in the planning process. This started with the planning retreat that was held in early January 2021 and before the official COP-planning pause in February. The GoB and CSOs were provided an opportunity to work with the PEPFAR/B team in identifying and agreeing on priority areas for COP21. These stakeholders also actively participated in the virtual planning meeting with S/GAC held on April 28 and 29. TWG co-chairs and technical staff from the agencies work closely with a range of MoHW offices and other GoB ministries such as the Ministries of Local Government and Basic Education to ensure coordination and alignment of efforts in addressing the challenges facing the full implementation of the national HIV response, including prevention, case finding, linkage to care and treatment, ART initiation, retention, viral load coverage, and viral load suppression. All USG agencies' technical staff participated on relevant 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 COP21 development process, PEPFAR continued to build on the relationships and structures built during COP20 planning, making external partner engagement one of

its highest priorities. These external partners included: The Global Fund, UNAIDS, WHO, and CSOs. Building on coordination with these partners' collective advocacy for programmatic activities such as treatment for non-citizens and adoption of community guidelines, PEPFAR/B will continue to work with these partners and build stronger collaboration.

PEPFAR/B team members routinely coordinate and communicate with Global Fund, 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 in order for them to help reach different priority populations with prevention, care, and treatment interventions. In COP21, 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 COP21, PEPFAR/B will coordinate the participation of GoB, Global Fund, 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 attendance from all identified in-country stakeholders will be encouraged and facilitated. POART meetings and related preparation process will provide Botswana HIV stakeholder community as well as the entire PEPFAR team an opportunity to discuss the PEPFAR program at least on a quarterly basis. This exercise 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

Technical Staff and Project 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 performance review of OU, Sub-National Unit, and site-level program results analysis (including data completeness and quality), with frequency (weekly, monthly, or quarterly) determined by partner performance
- SIMS and IP management site monitoring visits, weekly MER reviews, monthly site level performance reviews, and site level results verifications
- In-depth 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
- 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 will be identifying issues far more rapidly than in the past, working with partners to address the 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 in the past conducted joint interagency site visits and provided real time feedback to IPs through a partner management tracker. While these efforts were affected by the COVID-19 pandemic, as the situation improves, these efforts will continue in COP21, and should result 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 COP21, implementing partners will have to continuously improve their performance and develop work plans and strategies that adequately address all the relevant MPRs. 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 and complementary service delivery models. PEPFAR/B will continue to strengthen community-facility linkages and support provision of HIV services for general population, priority, and key populations. This has been an important factor in strengthening linkage to treatment and will be critical as PEPFAR/B supports the roll out of Active Partner Notification (APN) for HIV testing. The MoHW is currently going through the process of standardizing the design and implementation of community-based services to ensure that all representative service providers are optimally complementing the GoB's HIV mandate. In COP21, PEPFAR/B will continue to implement differentiated service delivery models that are client-centered and 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 COP21, PEPFAR/B will collaborate with relevant GoB ministries, NAHPA, as well as other key HIV stakeholders to continue implementation of the Community-led Monitoring (CLM) activity as mandated in COP21 guidance.

PEPFAR/B recognizes and values the critical role civil society organizations (CSOs) and communities play towards achieving epidemic control in Botswana. PEPFAR/B allocated $400k of COP20 funding to support the provision of grants to CSOs to routinely collect patient and provider level data related to the quality of services provided at the site level. The objective for CLM in COP20 was to establish a country framework for the launch and implementation of CLM activities in Botswana. This includes the development of an agreed methodology, set of standards, and an oversight committee to ensure that CLM investments align with guiding principles. COP20 CLM implementation has served as a dynamic learning process and was amenable to reviews by the oversight committee. CLM is managed and coordinated though the PEPFAR Botswana Coordination Office.

CLM has three major components:

1. CSO data collection of the patient and clinical staff experience at the site level
2. Quarterly review of the data at the county level through a CSO Coordination Mechanism

3. Establishment of a data collection platform (with data interoperability capabilities into existing data platforms).

In COP21, CSOs will continue to be funded for implementing CLM activities through the PEPFAR Coordination Office. COP21 notification of funding opportunities will be finalized and ready for announcement in late 2021. Successful COP21 grantees will receive technical support from the CSO groups who led the effort in COP20.

4.6.4.c Laboratory (VL) activities across the cascade

Per Botswana guidelines, viral load testing is provided three times for those newly started on treatment, twice a year 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)., All other public clinics, health posts, and Tebelopele Wellness Clinics, however, are not connected to the IPMS, and are instead either connected to PIMS or employ a paper-based data collection system.

The OU's VL coverage dropped from 96% in FY19 Q4 to 88% in FY21 Q2. This dip is due to the halt in VL testing as a mitigation measure to curb the spread of COVI19, as well as inadequate supply of needed reagents in the country. In COP21, PEPFAR/B will provide the necessary support to improve viral load coverage and suppression. Lessons learnt from the diagnostic mapping will be implemented to optimize VL coverage across the OU including 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 provide TA to GoB to 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 to serve as an ID for these patients. Each non-citizen patient is allocated a single NC based number which they are expected to present at all facilities where they receive care. They will however continue to also present other forms of identification such as passport, 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. The economic downturn of COVID-19 has worsened the HRH inadequacy at all levels national, district and site levels. 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 COP21, 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

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 government to prevent any potential stock out of ARVs and other related commodities in Botswana.

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 (APR FY21)**	**Additional patients required for 80% ART coverage**	**Target current on ART *TX_CURR* (APR FY22)**	**Newly initiated (APR FY22) *TX_NEW***	**ART Coverage (APR 22)**
Sustained	**339,423**	**172,501**	**0**	**173,913**	**5,016**	**90%**
Central Support	**35,306**	**454**	**0**	**454**	**1**	**91%**
Total	**374,729**	**172,955**	**0**	**174,367**	**5,017**	

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 (in FY21)**	***VMMC_CIRC* (in FY22)**	**Expected Coverage (in FY22)**
Military Botswana	Males 15 years and Older	**N/A**	**N/A**	**1,200**	**N/A**
Gaborone		**159,643**	**19%**	**2,401**	**20%**
Kgatleng		**39,245**	**20%**	**1,501**	**24%**
Kweneng East		**65,439**	**22%**	**2,001**	**25%**
Mahalapye		**49,999**	**20%**	**1603**	**23%**
South East		**20,401**	**21%**	**602**	**24%**
Serowe		**37,077**	**17%**	**702**	**19%**

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 FY22)	FY22 Target
PP_PREV	**175,362**	**19%**	**31,741**
KP_PREV	**9,973**	**75%**	**7,480**
TOTAL	**185,335**	**22%**	**39,221**

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 (FY22Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY22 Target) OVC*
Bobirwa District		10,009	1,206	1,500
Francistown District		6,838	676	704
Gaborone District		2,512	3,455	3,546
Goodhope District		463	703	515
Kgatleng District		6,378	2,483	1,659
Kweneng East District		12,871	4,700	4,401
Mahalapye District		9,825	2,906	3,261
North East District		6,267	909	1,133
Serowe District	Serowe	12,513	1,073	1,336
	Palapye		251	261
South East District		4,056	1,014	873
Southern District		6,943	1,770	1,577
Tutume District		15,901	308	320
TOTAL		**130,229**	**21,453**	**21,086**

4.8 Cervical Cancer Program Plans

In COP20, PEPFAR/B continued to build on the existing platform and strategies designed in COP18 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 COP21, PEPFAR/B will continue to build on the existing platforms, strategies and cervical cancer investments in previous years applying client centered approaches to increase cervical cancer screening among WLHIV aged 25-49 on ART. A total of $1,000,000 is budgeted in COP21 with an associated target of 32,394 women living with HIV (WLHIV) to be screened. The COP21 screening target represents 55% of the total WLHIV age 25-49 on ART at PEPFAR supported sites. To meet the COP21 target, the program will continue to implement the hub and spoke strategy. In partnership with MoHW and the implementing partner, the cervical cancer screening services will be strengthened through building capacity, training, education, and mentorship. COP21 priorities include; improving access and availability of screening and treatment services in the supported districts, optimizing active referral and linkage to cervical cancer services for all eligible clients and improving access to laboratory testing platforms and commodities to support HPV DNA self-collection services. Convenient screening modalities such as VIA and HPV DNA self-collection testing will be promoted. Linkage officers will help increase awareness on the benefits of cervical cancer prevention and early treatment. These officers will ensure timely linkage to cervical cancer services, as well as track referrals.

In COP21, PEPFAR/B will continue to enhance client and family centered services, by enhancing 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 transportation, processing, and result logistics to ensure efficient and timely service delivery. Female Sex Workers who opt for it 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.

Close collaboration with care and treatment implementing partners, the facility ARV staff and key stakeholders serving key populations (KP) will ensure appropriate health education services are available as well as promote and track successful and systematic

linkage to cervical cancer screening and treatment services in public facilities for eligible WLHIV. PEPFAR/B cervical cancer program will optimize precancerous treatment options, such as cryotherapy and thermocoagulation services, in high volume ART sites. 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. 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 handover. 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. To strengthen these linkages, PEPFAR/B has supported MoHW to introduce handheld Mobile Colposcopies for Expanded Visual Assessment (EVA) of large precancerous lesions by medical officers at LEEP sites. These are linked to a server for sharing of information to facilitate mentoring and appropriate management of complicated cases by specialists at UB medical school or referral hospitals. Support for capacity building on use of colposcopies will be required in COP21.

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, increase capacity through training and mentorship to sustain provision of services. Training of service providers for screening and treatment in COP21 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. Partner performance will be monitored through weekly tracking of performance indicators and the use of continuous quality improvement approach to improve program performance. Cervical cancer mobile electronic medical record (EMR) app will facilitate real-time quality data reporting.

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.

PEPFAR/B will work with the implementing partner and MoHW to ensure COVID-19 protocols are adhered to. To ensure that the safety of all clients and health care workers is paramount, the implementing partner will enhance effective strategies such as; 1) promoting routine cervical cancer screenings during routine medical visits, 2) optimizing use of appointment reminders, 3) maximizing virtual platforms (i.e. such as social medical, SMS text messaging, etc.) in combination with IEC (information, education, and communication) material to increase demand, and 4) ensuring appropriate personal protective equipment (PPE) is available.

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 FY21Q1, viral load coverage was at 88% and suppression is 99%. EID coverage has improved from 55% to 74% at 2 months and from 66% to 89% at 12 months of age at the end of APR20. Viral load coverage has dropped to 84% from 95%. This drop was due to the temporary pause that was introduced in FY20Q2 as a mitigation measure against COVID-19. The pause was lifted in FY21Q1 however, coverage continued to drop to 80% in FY21Q2. IPs are continuing to follow up of clients with invalid VL and bring them back to facilities for blood collection. Facilities have been assisted with temporary phlebotomists to cope with the demand.

In COP21, PEPFAR/B will maintain COP20 activities through collaboration with the Botswana government to 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 COP21 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. To address the low VL testing coverage, the OU will employ a two-pronged approach. 1) continue providing needed TA and capacity building to select public sector labs to optimize their ability to cover more clients, 2) continue implementing differentiated service delivery models as appropriate and in consultation with the MOHW to optimally complement public sector's needs. This will include building the capacity of select differentiated service delivery models to ensure full adherence to national required standards. IPMS lab nodes will continue to be rolled out to all clinics and Tebelopele centers with a government data network. These interventions will ensure more clients who need the VL test are able to access it. Additionally, we will support the government 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.

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. COP21 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 COP21 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. 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
3. 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

4. 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 COP21 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 quality, availability and use for decision-making remains critical for attaining and sustaining the 95/95/95 commitment for GOB and PEPFAR/B. PEPFAR/B has been working closely with the MoHW leadership in COP 20 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 COP21, 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 by utilizing available data interoperability solutions that harmonize and triangulate across EMRs, commodities, pharmacy dispensation, laboratory data, HRH and other data.

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
- 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 national data warehouse (NDW) to manage and process huge amounts of transactional data that will be available following PIMS centralization

- Limited ability of the NDW to show dynamic dashboards for key epidemic control indicators
- Limited capacity to plan and implement district and site level DQAs, inadequate utilization and analysis of available data

In order to address the challenges highlighted, PEPFAR/B will work closely with the GoB to ensure quality data is collected through the performance of DQAs, and improvement of electronic medical records, including ongoing work on PIMS interoperability and IPMS. This objective will 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 NDW and development of the centralized EMR
- Strengthen HRH at site-level (facilities and laboratories) to ensure timely capturing of clinical and lab data by maintaining data entry clerks and M&E officer positions
- Support planning and implementation of district level data quality assessments and improvement initiatives (DQA/DQI) to improve data quality
- Support capacity building of District M&E officers and data entry clerks through training, mentorship and learning collaboratives to optimize data generation, capturing, analysis and use
- Support district level M&E symposiums to promote data analysis and use for decision making during annual district planning meetings
- Strengthening data transmission from non-GDN PIMS sites to NDW and inter-operability 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 and notifications to patients directly from EMRs
- Strengthen NDW analytics and HIV case-based surveillance (CBS) tracking health outcomes of PLHIV. Support will also go towards strengthening recency surveillance and HIV drug resistance surveillance using remnant samples from routinely collected blood samples
- 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 through continued support for the ICD coders

PEPFAR/B will strengthen community HMIS. In COP20 and into COP21, 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 COP21 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 Strengthen the data collection, analytic dashboards and reporting system for effective delivery of OVC services

In COP21, the OVC program aims to strengthen the development of standardized data collection tools and analytic dashboards to address the reporting, analysis and monitoring gaps identified in the OVC service delivery system for the Department of Social Protection under the Ministry of Local Government and Rural Development (MLGRD/DSP). The system development is placed on indicator driven case-management to support social work practitioners at district level to be professionally aligned to both international and national reporting requirements in the way they deliver OVC programs. Hence, the implementation of the tools, data use through use of the analytic dashboard and a digital database will provide policy makers at DSP with a standard to integrate policy education and institutionalize monitoring and improved data use for OVC programs. This is also intended to encourage a programming approach by social workers that tracks achievement of key policy indicators through the process of OVC case management, need identification, design of intervention plan, determination and delivery of service packages including their coordination.

The establishment of OVC Data Base System is currently ongoing through UNICEF support including the deployment of a data management system on to the Ministry 5 servers at the Department of Information Technology (DIT). The support that UNICEF is providing does not include access to automatic data analysis and visualization tools like dashboard, charts, and maps which are very critical tools for real time reporting where decision making information is urgently required. This limitation will also make it difficult to establish the efficiency and effectiveness of the system in helping DSP to identify and address current OVC program data collection, management and reporting needs. This is where the PEPFAR OVC Program support will be aimed at to address this gap. The support will also include piloting of the system and tool at the district level.

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

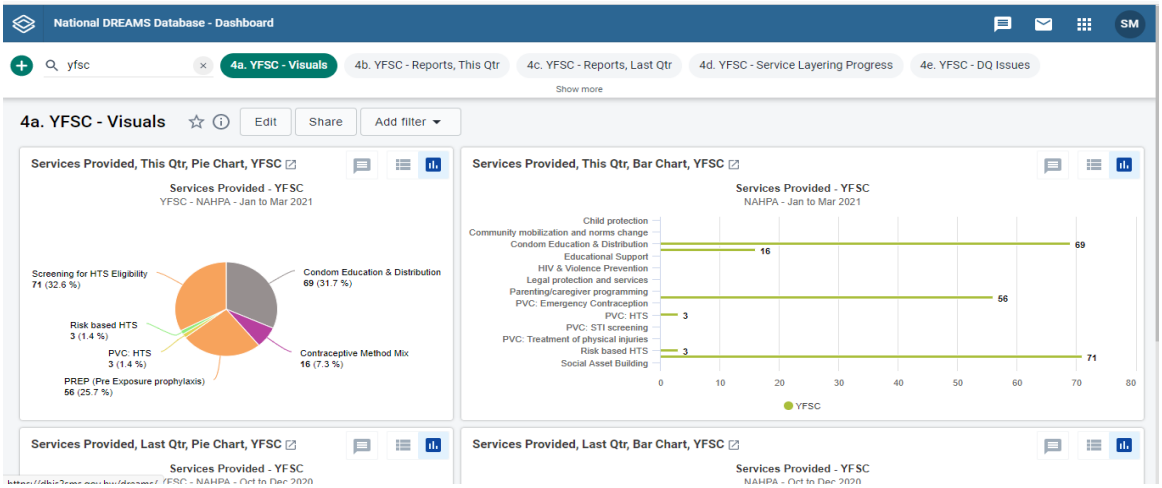
Previously, the DREAMS program in Botswana relied on USAID/HQ for technical support to compile the AGYW_PREV data. This gap motivated the development of the national DREAMS Data Base. In response to the COP19 PLL, PEPFAR/B included plans to develop a national DREAMS data management system. The National DREAMS Database (NDDB) uses DHIS2 which is hosted at the Ministry of Health and Wellness (MOHW) and went live in November 2020. All data related to AGYW lifecycle in DREAMS is captured (*Client registration, Screening, Enrollment, Services, Referrals and Exit)* in this system.

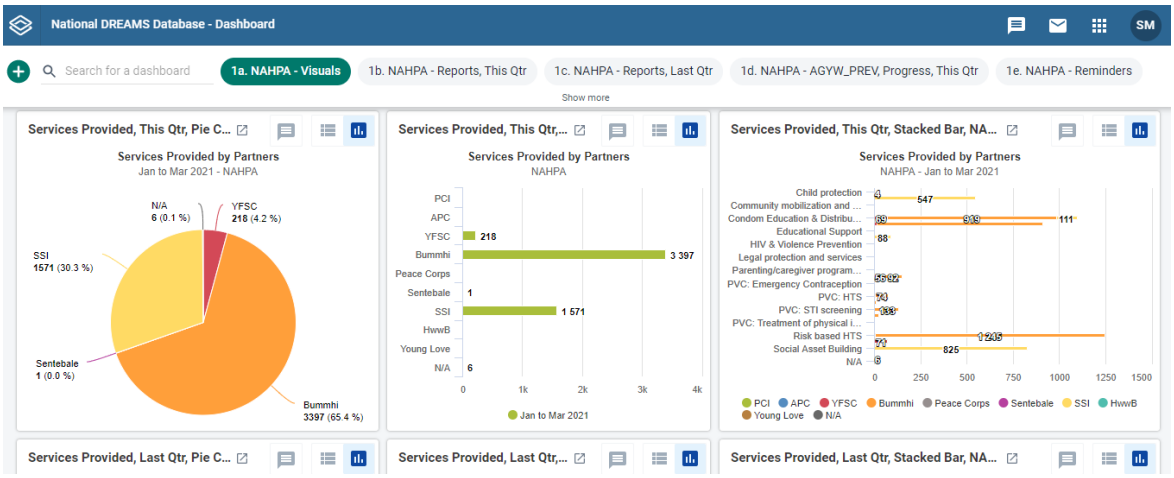
In COP21, PEPFAR/B will continue to provide technical assistance to the DREAMS implementing partners as well as the DREAMS Coordination Office to ensure that the system is maintained and working optimally. The National DREAMS Coordination office at the National AIDS and Health Promotion Agency (NAHPA) has engaged two M&E/Data managers to work closely with the implementing partner that developed the system to support users and troubleshoot bugs in the system.

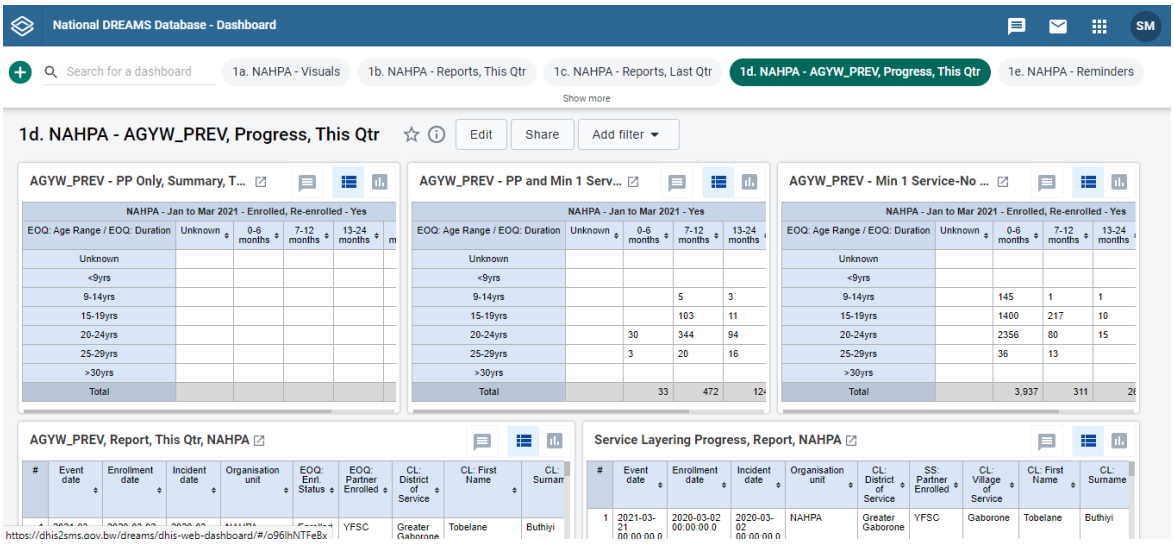
Development and User Acceptance Testing of NDDB was done from June to September 2020. More than 125 users have been trained in NDDB so far. Since Nov 2020, all partners have been using the NDDB to capture the DREAMS data.

NAHPA uses the NDDB to manage DREAMS implementation across all SNUs and implementing partners and tracks the service layering for the clients, generates AGYW_PREV reports as well as other necessary reports required by various stakeholders. The system has eased reporting as it highlights data quality issues, has pre-defined dashboards and tables for easy visualization, and pivot tables can be used to generate vast reports. The NDDB has a add on feature called “Partner File Manager”. This allows implementing partners who have their own electronic reporting systems to upload data in bulk from their systems into the NDDB. The FY-21 Q2 (SAPR) reports were generated from the NDDB by NAHPA. Figures below are sample dashboards and reports from the NDDB.

SAMPLE DASHBOARDS AND REPORTS







5.3 Strengthen procurement and contract management systems

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

In COP21, PEPFAR/B will continue to support the MoHW and the CMS to:

- Strengthen capacity of CMS on procurement and contract management systems through training and mentoring
- Support MoHW in advancing pooled procurement approaches to achieve cost savings
- Strengthen forecasting of ARVs and other essential commodities; supply chain plan and management; and budget development and execution
- 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
- 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 and help prevent counterfeit/sub-standard products from entering the country.
- 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, gonorrhea, 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 2020), 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

Though laboratory standards on waste management exist through safety manuals, there are still some types of laboratory generated waste that the Laboratory sector in-country do not have capacity to dispose. Additionally, management of clinical waste from community testing sites as well as waste management standards across different sectors of the government are varied, resulting in the waste not being managed adequately as it moves across the different sectors.

In COP21, PEPFAR/B will work closely with the laboratory sector and other stakeholders to develop clinical waste management policies that can be used across sectors. Furthermore, PEPFAR/B will review and support the roll out of biosafety/biosecurity and waste management guidelines including disposal of dangerous waste in the laboratory sector.

6.0 USG Operations and Staffing Plan

6.1 Long-Term Vacancies

- **Project Management Specialist- Local Partners** position is currently under recruitment. Interviews are expected to be held in June 2021.
- Peace Corps and DoD do not have any Long-Term Vacancies.
- Bilateral Health Specialist will be recruited for the PEPFAR Coordination Office during COP20. Interviews are expected to be held August 2021.
- 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 is one new position in COP21.

USAID

Senior Advisor, Adolescent and Youth

USAID/PEPFAR budget for DREAMS significantly increased in COP20, comprising 57% of USAID/PEPFAR's COP21 program budget. This position will provide high level state-of-the-art technical and programmatic leadership to the USAID Botswana health portfolio for adolescents and youth across the HIV cascade. There is currently no designated staff person in the team for DREAMS or AGYW and the heavy workload in this area has been shared by other project managers. The Advisor will provide cohesive country-specific technical and programmatic leadership for strategy development, project design, planning, implementation, monitoring and reporting that assists with achieving maximum PEPFAR targets results pertaining to adolescent and youth programming with special emphasis on

programs for AGYW. The incumbent will serve as the USAID representative in policy, strategic, and technical engagements with the host-country government, USG interagency, international and bilateral organizations, civil society organizations and donor agencies to address technical issues and coordinate efforts in implementation of HIV/AIDS services targeting adolescents and youth.

6.3 Overview of the CODB

As part of the COP21 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 COP21 increased by 2% from COP20. The increases were due to required staffing and programmatic instructions in the PLL and increased regional and ICASS costs. The staffing profile reflects cross-cutting technical support to the priority budget codes.

M&O Budget by Agency			
Agency	**COP20 Budgeted, M&O**	**COP21 Budgeted, M&O**	**Difference**
Totals	**$14,279,888**	**$14,515,919**	**$236,031**
DOD	$174,355	$164,787	**($9,568)**
HHS/CDC	$6,348,645	$6,302,580	**($46,065)**
HHS/HRSA	0	0	**0**
PC	$3,654,797	$3,715,071	**$60,274**
State	$629,431	$629,591	**$160**
USAID	$3,472,660	$3,703,890	**$231,230**

USAID

USAID's CODB increased by $231,230 (6%) from COP20 levels due to the new position listed above, Senior Advisor, Adolescent and Youth. USAID/PEPFAR budget for DREAMS significantly increased in COP20, comprising 57% of USAID/PEPFAR's COP21 program

budget. There is currently no designated staff person in the team for DREAMS or AGYW and the heavy workload in this area has been shared by other project managers.

CDC

CDC's CODB remained the same as COP20. 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 decreased by 5.8% due to the significant decrease in travel expenses as a result of COVID-19 travel restriction and lock-down.

Peace Corps

Peace Corps/Botswana currently has plans to bring 103 new Volunteers to support PEPFAR efforts in country in the next fiscal year. Of these 103, eight of will serve short term, high impact assignments as Peace Corps Response Volunteers in each DREAMS District around the country. Forty-two of those Volunteers will serve full two year assignments in support of PEPFAR DREAMS activities and will be strategically placed in the DREAMS growth areas. Despite Peace Corps' overall budget falling slightly in COP21, CODB increased slightly in adherence with revised global financial planning guidance for Peace Corps. Peace Corps is strategically positioned to serve as a bridge between service providers and the community given their connection to communities and partner agencies. Peace Corps' CODB budget includes $2,524,840 in applied pipeline.

State (PEPFAR Coordination Office)

State's CODB increased from $629,431 to $629,591. This increase was to cover the increase in ICASS and Computer Services ITSO Tax. 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 95-95-90 (90%))Overall																							
				Treatement Coverage at APR by Age and Sex																							
				<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
Bobirwa	COP20	Sustained	APR21	0%	0%	67%	67%	56%	56%	86%	85%	94%	69%	94%	61%	97%	70%	98%	80%	98%	85%	98%	89%	98%	89%	95%	81
District	COP21	Sustained	APR22	100%	100%	67%	67%	56%	56%	86%	85%	113%	69%	94%	61%	105%	70%	98%	80%	98%	86%	98%	89%	98%	90%	95%	81
Fransitow	COP20	Sustained	APR21	0%	0%	88%	88%	61%	62%	92%	92%	94%	75%	94%	68%	98%	77%	100%	86%	100%	91%	100%	94%	100%	94%	96%	86
n District	COP21	Sustained	APR22	225%	200%	131%	125%	61%	62%	93%	92%	95%	75%	94%	68%	98%	77%	101%	87%	101%	91%	101%	94%	101%	95%	97%	86
Gaborone	COP20	Sustained	APR21	0%	0%	62%	59%	42%	42%	73%	73%	92%	70%	92%	62%	96%	71%	98%	82%	99%	87%	100%	91%	100%	91%	96%	83
District	COP21	Sustained	APR22	186%	186%	108%	104%	45%	46%	73%	73%	93%	73%	94%	62%	96%	71%	99%	82%	100%	87%	100%	91%	100%	92%	96%	83
Goodhope	COP20	Sustained	APR21	0%	0%	100%	100%	47%	47%	79%	79%	77%	62%	77%	54%	84%	62%	89%	73%	91%	78%	92%	82%	93%	83%	87%	75
District	COP21	Sustained	APR22	0%	0%	100%	100%	47%	47%	79%	79%	77%	62%	78%	55%	84%	63%	89%	73%	91%	78%	92%	82%	93%	83%	87%	75
Kgatleng	COP20	Sustained	APR21	0%	0%	29%	29%	25%	25%	47%	48%	75%	59%	74%	51%	81%	60%	87%	71%	90%	77%	91%	82%	92%	83%	84%	74
District	COP21	Sustained	APR22	200%	200%	57%	57%	25%	25%	47%	48%	76%	59%	82%	53%	85%	60%	90%	71%	90%	78%	91%	85%	93%	83%	84%	74
East	COP20	Sustained	APR21	0%	0%	73%	73%	54%	54%	81%	81%	80%	60%	80%	53%	84%	61%	87%	71%	88%	76%	88%	79%	89%	80%	85%	72
District	COP21	Sustained	APR22	167%	167%	82%	82%	54%	54%	81%	81%	80%	60%	80%	53%	86%	62%	88%	71%	88%	76%	89%	80%	89%	80%	85%	73
Lobatse	COP20	Sustained	APR21	0%	0%	100%	100%	69%	65%	108%	108%	95%	71%	93%	61%	102%	72%	109%	87%	112%	95%	114%	102%	115%	104%	105%	92
District	COP21	Sustained	APR22	100%	100%	133%	133%	69%	65%	108%	108%	97%	73%	100%	90%	106%	128%	111%	105%	112%	95%	114%	102%	115%	104%	105%	92
Mahalapye	COP20	Sustained	APR21	0%	0%	80%	90%	61%	60%	92%	91%	97%	73%	97%	66%	99%	75%	100%	85%	100%	89%	100%	93%	100%	93%	97%	85
District	COP21	Sustained	APR22	167%	167%	80%	90%	61%	60%	92%	91%	97%	74%	125%	66%	114%	75%	100%	85%	110%	89%	100%	93%	100%	93%	97%	85
Moshupa	COP20	Sustained	APR21	0%	0%	100%	100%	58%	58%	86%	87%	76%	57%	75%	50%	80%	58%	84%	68%	86%	74%	87%	78%	87%	78%	82%	71
Disttict	COP21	Sustained	APR22	100%	100%	150%	150%	58%	58%	86%	87%	76%	67%	86%	63%	84%	64%	84%	74%	86%	78%	87%	78%	87%	78%	82%	90
Ngamiland	COP20	Sustained	APR21	0%	0%	83%	83%	61%	61%	92%	92%	100%	75%	101%	66%	107%	76%	110%	88%	111%	94%	112%	99%	112%	99%	107%	90
District	COP21	Sustained	APR22	100%	100%	133%	133%	61%	61%	92%	92%	103%	75%	104%	66%	108%	78%	118%	89%	112%	95%	113%	99%	113%	100%	108%	90
North East	COP20	Sustained	APR21	0%	0%	100%	75%	53%	53%	84%	84%	80%	58%	79%	50%	85%	58%	89%	70%	90%	76%	91%	81%	91%	82%	85%	73
District	COP21	Sustained	APR22	0%	0%	100%	75%	53%	53%	84%	84%	80%	58%	79%	50%	85%	59%	89%	70%	90%	76%	91%	81%	91%	82%	85%	73
Palapye	COP20	Sustained	APR21	0%	0%	57%	71%	47%	45%	74%	74%	104%	78%	105%	70%	107%	80%	108%	90%	108%	94%	107%	97%	107%	98%	106%	89
District	COP21	Sustained	APR22	300%	200%	143%	157%	60%	59%	74%	74%	116%	78%	107%	70%	108%	81%	108%	91%	108%	95%	108%	98%	108%	98%	106%	90
Phikwe	COP20	Sustained	APR21	0%	0%	50%	50%	27%	27%	53%	53%	93%	70%	92%	63%	96%	72%	98%	82%	99%	87%	99%	90%	99%	90%	96%	82
District	COP21	Sustained	APR22	100%	100%	100%	100%	37%	37%	53%	53%	93%	71%	93%	63%	99%	73%	100%	83%	100%	87%	100%	90%	100%	91%	96%	82
Serowe	COP20	Sustained	APR21	0%	0%	129%	129%	97%	97%	123%	123%	101%	74%	101%	66%	104%	75%	105%	86%	105%	92%	105%	96%	105%	96%	103%	87
District	COP21	Sustained	APR22	250%	250%	129%	129%	97%	97%	123%	123%	101%	74%	103%	66%	105%	75%	106%	87%	106%	92%	106%	96%	106%	96%	103%	87
South East	COP20	Sustained	APR21	0%	0%	67%	67%	44%	44%	74%	70%	84%	62%	84%	54%	89%	63%	92%	74%	94%	79%	94%	83%	94%	84%	90%	76
District	COP21	Sustained	APR22	100%	100%	133%	133%	56%	56%	74%	70%	85%	72%	86%	76%	92%	74%	95%	82%	96%	90%	97%	83%	96%	84%	91%	76
Southern	COP20	Sustained	APR21	0%	0%	75%	75%	52%	52%	82%	81%	83%	62%	83%	54%	89%	63%	93%	74%	94%	80%	95%	84%	95%	85%	90%	77
District	COP21	Sustained	APR22	300%	200%	75%	75%	52%	52%	82%	81%	86%	62%	96%	54%	99%	63%	94%	74%	94%	80%	95%	85%	95%	85%	90%	77
Tutume	COP20	Sustained	APR21	0%	0%	138%	138%	111%	111%	111%	111%	70%	48%	69%	42%	72%	49%	74%	58%	74%	63%	74%	66%	75%	67%	71%	60
District	COP21	Sustained	APR22	100%	100%	138%	138%	111%	111%	111%	111%	70%	54%	71%	42%	73%	49%	74%	58%	74%	63%	74%	67%	75%	67%	71%	61

APPENDIX B – Budget Profile and Resource Projections

B.1. COP21 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP21 Budget by Program Area

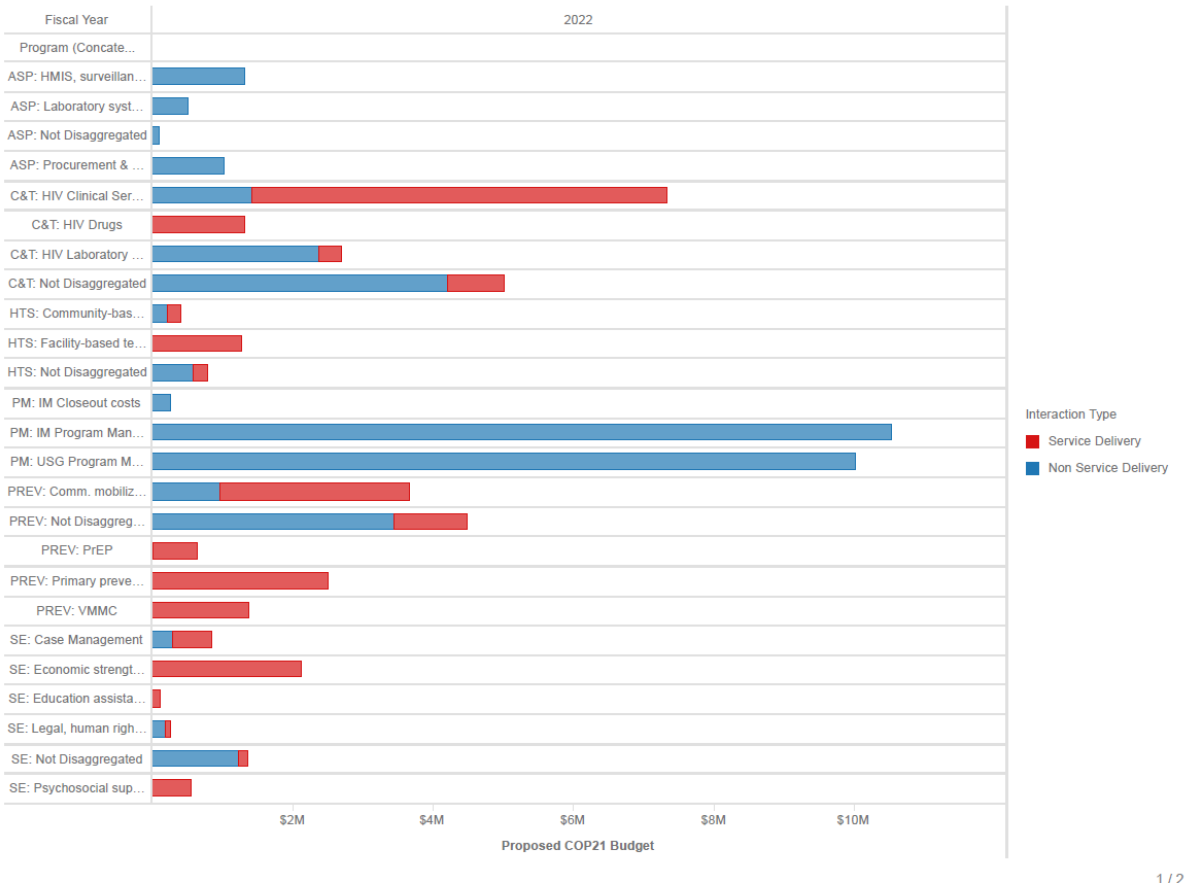


Table B.1.2 COP21 Total Planning Level

Fiscal Year	2022	2022	2022
Metrics		Proposed COP21 Budget	
Operating Unit	Applied Pipeline	New	Total
Total	$8,573,458	$51,905,042	$60,478,500
Botswana	$8,573,458	$51,905,042	$60,478,500

B.2 Resource Projections

The COP21 review cycle occurred in the midst of broad travel restrictions, unprecedented levels of remote work, and generally reduced capacity from host country partners resulting

from COVID-19. This operating environment limited availability of high quality data for long-term decision making. Working from existing information, the OU agreed to adopt an incremental approach during the current planning cycle, taking OU and IP performance into account at program and technical working group levels. Agency leads and Front office also reviewed the key priorities as highlighted in the COP21 PLL to ensure focused and adaptive programming for the OU in response to the new working environment. Data sources used to plan for COP21 funding relied on the FY20 expenditure report, COP20 FAST, COP21 targets and site activities as planned for in COP21. In light of a funding reduction for COP21, planning ceilings were adjusted for each implementing agency based on the approved COP20 funding divisions. Agencies recommended programmatic changes to accommodate reduced funding while taking into account key requirements for COP21 program area per beneficiary type. Some activities were kept at consistent funding levels from COP20 to sustain successes from the prior year. The OU reduced Care and Treatment program area activities from PLL earmarks because no BAIS conditional funding or other ambition funding was allocated in COP21.

APPENDIX C – Table 6

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

Funding Agency	MechName	PrimePartner	Mech ID	COP20 Program Area	COP20 Beneficiary	Intervention in FAST?	Activity Budget	COP20 Activity Description	COP21 activity description	SID Element	SID Scores	Key Systems Barrier	Intervention Start	Intervention End	Relevant Indicator or Measurement Tool	COP20 Baseline Data	Continuing in COP 21 yes/no	Cop 21 Activity description as applicable	Mechianism and budget	Notes/ comments
USAID	Botswana (	Project Concer	17861	ASP: HMIS, sur	Females: Yo	Yes	$600,000	Development of a dataware house to track DREAMS layering and report on AGYW_PREV	Program and data quality management	16. Perform	7.67	PEPFAR/Botswana must update its data systems to track the layering of DREAMS services	COP20	COP21	Reporting on MER Indicator (AGYW_PREV)	Preparatory activities				
USAID	GHSC-PSM	Chemonics Int	18220	ASP: Procurem	Non-Targete	Yes	$847,256	ART optimization; strengthen data visibility; strengthen procurement and contract management	Forecasting, supply chain plan, budget, and implementation	8. Commod	6.58	Inefficient procurement and contract management system. Insufficient data visibility between central medical store and last mile delivery points	COP19	COP21	Commodity availability and security; no stock outs	Preparatory activities	Yes	Strenghthen procurement and Contract Management through training. Connect DHMT Warehouses with facilities through eLMS	USAID Global Supply Chain Program (PSM) - Budget TBD	
HHS/CDC	Quality HIV	MINISTRY OF F	18252	ASP: HMIS, sur	Non-Targete	Yes	##########	Build the National Data Warehouse capacity to house and anlyze patient-level data in order to identify leaks in the clinical cascade.	HMIS systems	14. Epidem	5.86	Insufficient capacity to collect, manage and use routine program data in a timely manner	COP19	COP20	Number of PLHIV with known HIV status with complete clinical cascade data in the DW.	230,000	Yes	Strenghten Data Warehouse analytics and HIV case-based surveillance (CBS) for tracking of outcomes for HIV positive individuals - inlcuding recency and drug resistance		
DOD	VMMC/Lab	JHPIEGO CORP	70001	ASP: HMIS, sur	Priority Pop	Yes	$160,000	Conduct a SABERS to understand the current HIV epidemic in the BDF to strategically target higher risk camps and populations	Surveillance	14. Epidem	5.86	Lack of current data to effectively target high risk populations and garrisons	COP19	COP20	Survey findings and report available	Preparatory activities	NO (not yet im	N/A	N/A	
HHS/CDC	[Placehold		84042	ASP: HMIS, surveillance, & research-NSD	Non-Targete	Yes	##########	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	HMIS systems	14. Epidem	5.86	Insufficient capacity to collect, manage and use routine program data in a timely manner	COP19	COP22	Number of data excahnge mechanisms implemented	1	yes	Strengthen data transmission (increase connectivity speed on GDN) and inter-operability 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	18163 (BTECH) 460.000	
HHS/HRSA	Technical a	UNIVERSITY OF	18163	ASP: HMIS, sur	Non-Targete	Yes	$140,000	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. Data merging for IPMS and PIMS exists at the national data warehouse, however, the mechanism is one direction. The systems need to be	HMIS systems	14. Epidem	5.86	Insufficient capacity to collect, manage and use routine program data in a timely manner	COP20	COP21	Number of data excahnge mechanisms implemented	0	Yes	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. Data merging for IPMS and PIMS exists at the national data warehouse, however, the mechanism is one direction. The systems need to be	$164,228	
HHS/HRSA	Technical a	UNIVERSITY OF	18163	ASP: Laborator	Non-Targete	Yes	$175,000	Support biosafety/biosecurity and waste management guidelines including disposal of dangerous waste. 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	Lab quality improvement and assurance	10. Laborat	6.58	Insufficient capacity for clinical waste management and lack of procedures on dealing with new waste GTC	COP20	COP21	National Biosafety/biosecurity guidelines	0	Yes	Support biosafety/biosecurity and waste management guidelines including disposal of dangerous waste. 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. Laboratories work in silos, and there is a lack of standard monitoring and feedback mechanism available.	$167,184	
HHS/CDC	[Placehold		84042	ASP: HMIS, sur	Non-Targete	Yes	$0	Strenghten HIV Case-Based Surveillance (CBS) for tracking of outcomes for HIV positive individuals identified at PEPFAR and non-PEPFAR supported HIV care sites across the country	Surveillance	14. Epidem	5.86	Insufficient capacity to collect, manage and use routine program data in a timely manner	COP18	COP21	Number of PLHIV with known HIV status reporesented in the CBS dataset	230000	Yes but merged as per cell S7	See cell S7	See Cell T7	
HHS/CDC		UNICEF	160032	N/A	N/A	N/A	N/A	New activity	Lab quality improvement and assurance			lack of up to date policies and guidelines on ALHIV	N/A	N/A	policy documents and guidelines	N/A	N/A	stratergy and Guidelines to adress policy and programme gaps for care and treatment go Adolescents and young people living with HIV.	UNICEF $30,000	
HHS/CDC		WHO	160031	N/A	N/A	N/A	N/A	New activity				lack of up to date guidelines and policy documents in line with international standards	N/A	N/A	policy documents and guidelines	N/A	N/A	Development and review of lab regulatory processes and documents.	WHO $150,000	

COP 21 new activities

Funding Agency	MechName	PrimePartner	Mech ID	COP20 Program Area	COP20 Beneficiary	Intervention in FAST?	Activity Budget	COP21 Activity Description		SID Element	SID Scores	Key Systems Barrier	Intervention Start	Intervention	Relevant Indicator or Measurement Tool	Comments			
USAID	Placeholder - 160043		160043	ASP: HMIS, su	OVC	Yes	$200,000	Strengthen the data collection and reporting system for effective delivery of OVC services for Ministry of local government and rural	HMIS systems	Performar	N/A	Insufficient capacity to collect, manage and use routine program data in a timely manner	COP21		Number of OVC reached with OVC interventions				
HHS/CDC	Placeholder - 160031		160031		Adolescents and Young adults and	yes	$30,000	strategy and Guidelines to adress policy and programme gaps for care and treatment go Adolescents and young people living with HIV.			N/A	lack of guiding documents to standardize management of adolescents and	COP21		availability of guidelines. Number of target population reached				
HHS/CDC	Placeholder - 160032		160032		Non targeted populatio	yes	$150,000	Development and review of lab regulatory processes and documents.		Laborator	N/A	lack of guidelines and l	COP21		Availability of guidelines and policies				
HHS/HRSA		TBD		C&T: Non Disaggregated-NSD			$385,000	National Quality Improvement: Funds will be utilized in providing											
HHS/HRSA		TBD		C&T: Non Disaggregated-NSD			$140,000	DHIS2 Support to MoHW: Funds will be utilized to provide monitoring and											
HHS/HRSA		TBD		ASP: Laboratory Systems Strengthe			$175,000	Laboratory Systems Strengthening: Funds will be utilized to support updating											
USAID	Meeting Targets and Maintaining Epidemic Control (EpiC)		81557	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Adults		$50,000	Technical Assistance to MoHW to upgrade/update iHRIS	14. Epidemiological and Health Data			Non-availability of HRH data for adequate HRH Management and decision making	COP21		Strengthen the tools and processes for managing information on HRH to improve planning and developing human resources				

APPENDIX D– Minimum Program Requirements

	POLICY	STATUS FOR COP21 IMPLEMENTATION
CARE & 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.	MPR adopted and in implementation, but direct and immediate linkage to treatment not yet above 95% across age, sex, and risk groups In FY21 Q1, the overall LTT stood at 92% while the Same Day (SD) initiation rate improved from 57% in FY20 Q1, to 78% in FY 21 Q1 and Fast Track (FT) initiation rate improved from 73% in FY20 Q1 to 85% in FY 21 Q1.
	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	MPR adopted and on course; implementation at more than 75%. The country TLD transition was adopted and started September 1, 2018. At the end of FY21 Q1, the transition coverage was 67%, and it increased to 77% by the end of FY 21 Q2. TLD transition is expected to be completed by September 2021. The transition covers adults (including women of childbearing age) and children on treatment. . September 2020 deadline was not met due to COVID-19 impact on pharmaceutical production interruptions, but now on course again. GoB working on procuring DTG-based regimens for children weighing >20kg; pediatric formulations not yet available in country. Plans to procure DTG10 for Pediatrics by GoB at an advanced stage, quantification already done. PEPFAR also to procure DGT10 through the COVID-19 Supplemental Funds for Commodities

	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	MPR adopted and in implementation, but partially met. 3M-MMD policy adopted and in implementation in all the 75 PEPFAR supported health facilities; MOHW is monitoring patients' level of adherence to 3 MMD to be able to decide on when to transit to 6 MMD. There is no system yet to adequately monitor the implementation of MMD; available EMR not utilized due to internet connectivity challenges. MMD indicators to be included in patient data management systems used at health facilities. 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. COP21 will focus on a) expanding to 6M-MMD and b) improving supply chain efficiencies. PEPFAR implementing partners currently working with MoHW to develop the MMD data capturing tool at dispensing points. This will inform the adoption of 6 months MMD. Supply Chain IP supervisory visits to 27 facilities revealed that 3 months MMD was already being implemented in all those facilities, while 3-6 months was implemented as needed in some facilities (e.g., for students studying in neighboring countries and people going on extended work trips/assignments away from their routine places of work)
	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	MPR adopted and in implementation, but partially met. 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 D1nd 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. After a pause to administering TPT by MoHW due to reported adverse reaction, TPT has been reintroduced across the districts. In FY21Q1, districts were re-sensitized and HCWs trained to re-initiate TPT.

CASE FIN DING	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	MPR adopted and in implementation; monitoring ongoing. 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. Site certification and certification of all HCWs successfully completed. The next steps are to ensure collaboration with the newly established community-led monitoring platform to monitor clients' experience at sites.
PREVENTION & OVC	6. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9–14-year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management.	MPR adopted. -Program aligned to the 3 program status of OVC: comprehensive, preventive and DREAMS -Program pivoted to increase reach for the prioritized OVC sub-populations as follows: o Children and adolescents living with HIV o Survivors of sexual violence o Children of HIV+ mothers and HIV+ caregivers o Children of female sex workers o HIV exposed infants o Orphans o 9–14-year-olds -Strengthened partnerships with health facilities to increase reach of adolescents and children living with HIV with comprehensive OVC services. -Expanding reach for 9–14-year-olds with HIV and violence prevention through OVC and DREAMS platforms
Prevention & PrEP		MPR Fully Adopted In COP21, PrEP will be rolled out nationally and offered to additional sub-populations to include PBFW, discordant couples wishing to conceive, men in the military and other high-risk and closed settings. COP21 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. Introduction of Event-driven PrEP for MSM has been included in revised PrEP policy. In addition the private sector engagement and community will be engaged in providing PrEP refills.

	7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	
POLICY & PUBLIC HEALTH SYSTEMS	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.
	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	MPR adopted and in implementation, at different levels national wide All PEPFAR supported sites use SIMS on quarterly basis to monitor and improve quality while non- PEPFAR sites use National health standards for their organizational assessment both at National and Primary Health Care levels. All PEPFAR IPs have incorporated CQI into their programs and have annual CQI workplans for advancement of CQI. Ministry of Health and Wellness conducted Baseline, progress, and external quality surveys on national health standards for quality monitoring. MOHW is reviewing the patient's charter and developing provider's charter to incorporate client-centered approach. In addition, MOHW in 2020 launched Botswana health data collaborative (BHDC) in which the National CQI TWG, is one of its TWGs working towards the attainment of the SGD Goal 3. There is CQI Digital platform that is being used from the beginning of FY21 for monitoring and documentation of CQI projects, including visualization of SIMS dashboards in all Ministry of health facilities in the country.
	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.
	Clear evidence of agency progress toward local, indigenous partner direct funding	as the portion of the PEPFAR program managed by local partners increased from 5% in FY17 to 37% in FY19 to an expected 69% in Fy21. The increase in local partner expenditure was because of increased prime funding of local partners by CDC (35% to

		99%) and USAID (3% to 59%). In addition, the PEPFAR Coordinator's Office programmed $400k For Community-let Monitoring through local organizations.
	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). COP20-21 Focus: 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.
	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 capturers 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 COP20. COP20-21 Focus: improve the quality and completeness of the data reported; and increase the availability of data for decision making.
	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 patient 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 COP20 APR. COP20-21 Focus: 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- American Rescue Act (ARPA) Activities

Background

The American Rescue Plan Act (ARPA) COVID-19 Appropriation for PEPFAR designates ($250,000,000) to the Department of State "to support programs for the prevention, treatment, and control of HIV/AIDS to prevent, prepare for, and respond to coronavirus, including to mitigate the impact on such programs from coronavirus and support recovery from the impacts of the coronavirus. PEPFAR Botswana will receive $3,000,000 of these funds to focus on mitigating COVID-19 impact on PEPFAR programs and beneficiaries and support program recovery from the impact of the coronavirus. These interventions are aligned with the broader USG global COVID-19 response and recovery strategy and objectives.

The Botswana ARPA strategy aims to 1) Prevent, prepare for, and respond to Coronavirus, focusing in infection, prevention and control programming; and 2) Mitigate COVID-19 Impact on PEPFAR programs and beneficiaries for COVID-19 and to inform both IPC practices and epidemiologic surveillance, focusing on extraordinary logistics and commodity costs associated with COVID-19, laboratory systems, and repair of program injury.

Botswana's ARPA proposal is a collaborative effort between Government of Botswana, CDC, HRSA, USAID and their implementing partners. Agencies leveraged their strengths to optimize resources and improve outcomes at national, regional, facility & community levels. Activities include: scaled-up Differentiated Service Delivery; support to DREAMS program recovery; strengthened clinical and lab practices through trainings, virtual learning and CQI; purchasing IPC commodities; vaccination program's M&E support; building the capacity of laboratory & surveillance systems to identify, investigate, and analyze COVID-19 variants.

Responsiveness to COVID-19 and PEPFAR

PEPFAR Botswana's HIV/TB program has been significantly impacted by the COVID-19 pandemic. For the past 12 months. Intermittent lockdowns, curfews, and interzonal

restrictions have all negatively impacted access to HIV Services. As cases and morbidity continue to rise, healthcare system is overburden with increasing inpatient admittance coupled with limited commodities and front-line worker capacity.

Many programs were halted or reduced because the government deemed them non-essential. Healthcare facilities have not been functioning at full capacity due to clinical staff being repurposed to support COVID-19 activities (testing, clinical services, etc.). Lockdowns to decongest facilities has also prevented many from accessing services.

Overall, activities are designed to reduce contact between clients and health care workers, through barriers, reduced traffic at facilities, training and mentoring of staff to better protect themselves and their clients against infection, strengthening virtual platforms, and ensuring that contact is necessary and numbers attending each PEPFAR activity are minimized. These interventions will also have a positive impact on PEPFAR programs. By restoring and strengthening trust of clients in health care and other staff, clients will be inclined to continue to seek out health services, and by making services more accessible and safer to PEPFAR clients or potential clients this will improve service delivery.

Supporting and Protecting PEPFAR Services

The activities will protect PEPFAR services by ensuring appropriate support at each level of implementation. IPC measures in facility and community settings will prevent transmission of COVID-19 infections. Trainings will prepare clinicians to respond to pandemics and address HIV care and psychosocial support. Increasing resources for community programs will reduce risk of COVID-19 transmission and ensure beneficiaries continue to receive HIV prevention, care, and treatment services. Strengthening laboratory and surveillance capacity will enhance early disease detection and monitoring, vaccine effectiveness, and ongoing treatment monitoring for HIV patients. Finally, purchasing commodities (i.e. drugs, IPC structures, multi-functional laboratory equipment, etc.) will ensure HIV services are maintained.

Gaps Addressed

The activities proposed complement efforts by the host country government, specifically by monitoring the impact of the vaccination program through rapid detection and evaluation; monitoring coverage of the vaccine in targeted populations; testing to inform management of exposures and early detection; and ensuring health care workers have the

appropriate virtual training in infection control protocols and continuous quality improvement, and supporting measures to reduce contact while ensuring optimal service delivery. The proposals have the support of the host country government.

Non duplication and coordination

The proposed USG activities were discussed during a consultative meeting on April 14, with GOB and multilateral partners, including Global Fund, WHO and UNICEF. The USG team presented its activities proposed for the ARPA funds and received feedback from the group. The feedback received indicated the ARPA proposal is aligned to GOB needs and is complimentary to activities supported by other donors. The MoHW provided additional written feedback to the team ranking priorities and areas for focus that were incorporated into the proposal.

Monitoring and Evaluation

Details for M&E are still being developed. PEPAR/Botswana will work with community-led monitoring initiative to ensure progress is tracked for accountability. Key indicators as defined in the activity table will help measure performance and identify lessons learned.

Proposed Activities

The specific proposed activities and interventions are listed in the table below.

Gaps to be Addressed	Activities	Outcomes
Program disruptions due to lock downs and other COVID-19-related issues	❖ DDD/PPP to strengthen community-based service delivery ❖ Strengthening social media and workforce to improve DREAMS activities	Increased achievement against PEPFAR targets
Insufficient COVID-19 protection and infection control at facilities for staff and clients	❖ Purchase and install barriers, tents, and other supplies at PEPFAR-supported facilities ❖ Developing/strengthening SOPs for infection control/protection ❖ Training staff on COVID-19 protocols ❖ Strengthen routine COVID-19 testing for staff	Fewer COVID-19 infections at PEPFAR sites and among PEPFAR staff

Inadequate surveillance (including pharmacovigilance) and storage of specimens	❖ Genomic sequencing ❖ Strengthen M&E for COVID-19 vaccine program	Better understanding of the COVID-19 pandemic in Botswana and of vaccine roll out
Lack of e-learning systems and modules to assure safety while ensuring quality assurance around COVID-19 protocols in facilities	❖ Develop e-learning systems & infrastructure for facility CQI	Develop e-learning systems in alignment with COVID-19 protocols to reduce transmission

APPENDIX F– 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. Government Implementation Coordination Office (GICO)
5. Ministry of Basic Education
6. Ministry of Tertiary Education, Research, Science and Technology
7. Ministry of Nationality, Immigration and Gender Affairs
8. Ministry of Employment, Labor Productivity, and Skills Development
9. Ministry of Youth Empowerment, Sports, and Cultural Development
10. Ministry of Finance and Development Planning
11. Botswana Defense Force

B. Prime Partners

1. African Comprehensive HIVAIDS Partnership (ACHAP)
2. Botswana Christian AIDS Intervention Program (BOCAIP)
3. Botswana University of Maryland School of Medicine Health Initiative (Bummhi)
4. B-TECH
5. FHI 360/APC
6. FHI 360/EpiC
7. Global Health Supply Chain-PSM/Chemonics
8. Hope Worldwide Botswana
9. Humana People to People
10. Jhpiego
11. Project Concern International (PCI)
12. Results for Development (R4D)/ACS Project
13. Stepping Stones International
14. Tebelopele Wellness Centre
15. Univ. of Washington International Training and Education Center for Health (I-TECH)

C. Sub Partners

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

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

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
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. Baikagisesha Youth Rehabilitation Centre (BAYOREC)
9. Batswana 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. Seventh Day Adventist Church
65. Skill Share International Botswana
66. SRHR Africa Trust Botswana
67. Spiritual Assembly of Bahai
68. THC Foundation
69. Thusang Bana Centre
70. Ultimate Youth with Destiny
71. University of Botswana
72. Urban Rhythm Youth Centre
73. WoMen Against Rape (WAR)
74. Youth for Christ Botswana
75. 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

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
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	Tenofivir 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
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