BOTSWANA

Country Operational Plan (COP/ROP) 2022

Strategic Direction Summary (SDS)

April 26, 2022

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

Contents

1.0 Vision and Goal Statement

PEPFAR Botswana's vision is "**Pivoting Towards Equitable Sustainability**". Botswana is well on its way to reaching epidemic control, having nearly attained the 95-95-95 goals at 93-98-98 (preliminary BAIS V 2021). In COP22, PEPFAR/B's goals are to continue to support the Government of Botswana (GoB) to: 1) accomplish the mission to achieve and sustain epidemic control using evidence-based, equitable, person-centered HIV prevention and treatment, 2) build enduring capabilities – resilient and capacitated country health systems, communities, enabling environments, and local partners and 3) build lasting collaborations: strengthen cooperation and coordination for greater impact, burden sharing, and sustainability. These goals speak to PEPFAR/B's continued positive contributions in the implementation of the GOB's response to the HIV epidemic.

In COP22, our priority is to work with the GoB and stakeholders to develop a sustainability roadmap to help orient future PEPFAR support toward ensuring a sustainable HIV response and to pivot the PEPFAR program towards sustainable HIV epidemic control. COP22 is the starting point for PEPFAR/B to support Botswana in implementing this vision for sustainability, with a gradual shift as to not lose the gains already made. The principles from which we designed the COP22 pivot are: to improve interagency collaboration, leverage and utilize agency strengths and comparative advantages to create efficiencies for sustainability.

To achieve COP22 goals, PEPFAR/B will implement the following pivots, 1) gradually shift from direct service delivery to technical assistance across all programs, 2) increase focus on health systems strengthening and 3) re-align interagency roles and responsibilities to focus on areas of strength/comparative advantage, with focused support for clinical and community services.

The first pivot towards sustainability is the shift from direct service delivery to technical assistance across all programs. Not all programs will be shifted at the same pace or in the same way, but all programs will be involved in this gradual shift. The shift from direct service delivery to technical assistance will allow the PEPFAR/B program to have more reach and ensure the GoB is able to provide equitable, person-centered services with quality and efficiency to all the people of Botswana, leaving no one behind. In this shift, PEPFAR/B will work with the GoB to monitor goals and to support continuous improvement at the national, regional, local and site levels. The direct service delivery that continues will be largely targeted towards remaining gaps identified in BAIS V and other sources of data.

The second pivot towards sustainability will be to strengthen health systems, improve governance, and build in-country capacity so that Botswana will be able to sustain the HIV impact long into the future. Systems that will be strengthened include human resources for health (HRH), health financing (HF), data systems, surveillance, laboratory, supply chain, community health systems, clinical systems, and quality management systems.

The third pivot towards sustainability is an interagency realignment that will allow US Government (USG) agencies to focus on their area of strength/comparative advantage, with focused support for clinical and community services. Agency roles will be better defined to

encourage collaboration and synergize their efforts to bring maximum quality of services with efficiency to the people of Botswana.

In line with these pivots, PEPFAR/B has prioritized the following activities: Clinical Mentorship, community health system strengthening, Peace Corp Volunteer re-introduction, continuous quality improvement (CQI) expansion, Health Care Financing, Human Resources for Health, case-based surveillance (including recency expansion), community service delivery, integrated biological and behavioral surveillance survey (IBBSS), pediatric/adolescent cascade, DREAMS/OVC, VMMC, cervical cancer, TB preventive therapy (TPT), pre-exposure prophylaxis (PrEP), index testing, supply chain and key population (KP) services.

In COP22 PEPFAR/B will improve services for adolescents and children living with HIV (A/CLHIV), reduce HIV-related mortality, improve TPT coverage, and work with the GoB to move to 6-month multi-month dispensing (MMD). The pediatric/adolescent program will continue to leverage the community/facility coordination, scale up pediatric case finding strategies, strengthen referrals to and from the OVC program, and use clinical mentors and CQI for targeted interventions to ensure continuity in treatment and provision of person-centered care to A/CLHIV. To reduce HIV-related mortality, PEPFAR/B will support monitoring and documentation of ART optimization, retention and sustaining viral load gains among clients on ART, strengthen failure management, provide advanced HIV disease package trainings as well as monitoring for HIV mortality. This will be done by emphasizing equity for all seeking services regardless of age, gender, and sexual orientation, and establishing a national team for clinical mentoring to ensure sustainable high-quality services in all sites in Botswana. While Botswana adopted and has been implementing 3-month MMD, there are plans to review implementation with a view to inform roll out of 6-month MMD as well as strengthening documentation. Discussions at the clinical guidelines forum to include 3-month MMD for pediatrics are also underway. PEPFAR/B will prioritize TPT for CLHIV, scale up 3HP implementation and strengthen integration of TPT in core package of services including MMD and differentiated service delivery models.

In relation to prevention services, PEPFAR/B will continue to work closely with the GoB and key partners engaged in the execution of the country's health sector mandate to develop and refine innovations and adaptations to mitigate COVID-19 impact notably for cervical cancer, VMMC, TPT and the DREAMS programs. To ensure data availability, quality, and use, PEPFAR/B will continue to improve electronic medical records, interoperability, strengthen local capacity for data analysis, leverage BAIS V results, conduct IBBSS, and collaborate with other partners such as the Global Fund for coordinated delivery of the different data pieces.

For HIV testing services, in addition to the traditional HIV testing services (HTS) program, PEPFAR/B will expand recency testing in line with the national recency testing protocol. As Botswana nears HIV epidemic control, recent infection surveillance provides essential information about new HIV diagnoses, new infections, and ongoing transmission, which can be used to tailor HIV testing strategies and target effective treatment and prevention interventions including PrEP. Recency data will be used in conjunction with geographic data and other programmatic data to identify time-space clusters, potential risk networks, and sub-populations with higher HIV transmission. This will provide the basis for triggering a systematic public health response including deployment of rapid response teams. Cluster investigations will vary in

scope depending on the demographics, geography, and magnitude but could include review of epidemiological and programmatic data to verify trends, confirm epidemiological links, identify programmatic gaps and inform action measures to mitigate continued transmission risks e.g. use of PrEP and other prevention measures. A response plan will be developed to guide the response and continued surveillance to ensure that the gains on the 95-95-95 cascade are sustained.

Botswana has achieved 98% viral suppression at population level (BAIS V, 2021). However, there are still pockets of sub-populations where viral suppression is still sub-optimal especially A/CLHIV, men and KPs. PEPFAR/B should be able to achieve >80% viral suppression across all sub-populations within 2-3 years. In COP22, PEPFAR/B will close these gaps by embarking on the following: 1) providing client-centered care tailor made for those affected to ensure they adhere to treatment and thereby remain virally suppressed (this will require strong community-facility collaboration to identify, find, and link those missing from each of the three 95s and linking them to appropriate services), 2) strengthening laboratory-clinic interface to ensure timely delivery of samples to the testing laboratories through use of specimen management registers and ensuring the results are returned to clinicians through the roll out of IPMS laboratory nodes and training users on IPMS, 3) optimizing ART using DTG-based regimens, especially for CLHIV, 4) strengthening retention of clients on treatment, and 5) leveraging the private sector to support the 95-95-95 cascade through decentralized drug distribution (DDD) and viral load (VL) testing to complement services provided by GoB and civil society organizations (CSOs).

To ensure continuity of treatment and maintain the gains and sustain epidemic control, PEPFAR/B will renew its focus on community/facility collaboration that i) ensures efficient use of existing data, the patients' charter and provider's charter improve the quality of services and continuity of treatment and to identify gaps and areas of focus, ii) provides TA to GoB to implement differentiated care and innovative service delivery models in both community and clinical platforms, iii) continues to scale up technical assistance using innovative approaches to ensure compliance with adherence, addressing loss to follow-up, and ensuring strong defaulter management (including leveraging the integration of Community-based Services Guidelines); and iv) provides technical assistance to the GoB to transform the national HIV response into a person-focused, responsive, inclusive and equitable sustained response by supporting the revitalization of PHC. Furthermore, PEFPAR/B will continue to scale up client treatment literacy programs and learning experiences from PEPFAR supported QI projects, at both the facility and community levels to optimize adherence and ensure all are served irrespective of their sex, age, sexual orientation, or citizenship.

PEPFAR/B plans to reach 98% VLC & 99% VLS for adults, KP and priority populations and 90% VLC & 100% VLS for children across age/sex bands in supported districts in COP22. Other targets include: retention rate (new and continuing patients): 98%; TX_CURR: 178,522; LTT rate: 96%; HTS POS: 8,418; PrEP_NEW: 10,944; PrEP_CT: 2,442; VMMC_CIRC: 10,011; cervical cancer screening: of 36,278; TB_PREV: 87,378; AGYW_PREV): 26,290; OVC_SERV: 46,801 and OVC_HIVSTAT: 20,987.

PEPFAR/B, working with stakeholders, will adapt metrics for measuring success and impact of structural interventions. These will constitute the reporting requirements for partners implementing the KP program in FY23.

Viral Load diagnostic network optimization will be done in 46 laboratories, the clinical mentorship and CQI programs will be rolled out to all the 27 health districts, while HF, HRH, Supply Chain, Clinical Health, and Community Health system strengthening and data systems strengthening will have a national reach, thereby contributing towards program sustainability.

Significant progress has been made in most minimum program requirements (MPRs) including, test and start, index testing scale-up and HIV self-testing (HIVST), offer of PrEP, morbidity and mortality reporting and alignment of OVC package of services and enrollment. Though significant progress has been made in this regard, some gaps do exist such as implementation of same day ART initiation, which is not optimal, viral load coverage, persistent challenges with interoperability and consistent reporting and data use as well as limited ability to measure some of the MPRs.

In alignment with the overall pivot toward equitable sustainability, this year's budget reflects some key transitions. First, next year will begin a gradual shift between service delivery and non-service delivery activities. At the same time, the COP22 budget will sustain progress in key programmatic areas such as VMMC, cervical cancer, and DREAMS/OVC in alignment with overall direction from the planning level letter (PLL). In planning COP22, PEPFAR/B made deliberate efforts to engage the different stakeholders including the GoB, civil society, the UN agencies, and other development partners. This was in recognition of the different roles that each play towards the national HIV response. Participation of these different players ensures that we all stay coordinated and are all working towards achievement of national goals as stated in the NSFIII, and the views and opinions of these stakeholders expressed during the different planning platforms are considered in the overall COP planning and subsequent implementation contribution to the achievement of the national and PEPFAR goals.

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 2.51 million (2021 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 2020 GNI per capita, according to the World Bank, was $6,640. 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.

Preliminary results from the latest nationally representative population-based survey, the Botswana AIDS Impact Survey (BAIS V) were shared on World AIDS day, December 1st, 2021, by the President of the Republic of Botswana, Dr. Eric. Masisi. The survey enrolled participants between March 12 and August 16, 2021, and estimated ARV-unadjusted national HIV prevalence at 20.9% (men: 15.4%; women: 26.3%), 93.2% awareness of status among (PLHIV) (men: 90.8%; women: 94.5%), 97.9% of those aware were on ART (men: 96.9%; women: 98.4%), and 98.0% of those on ART achieved VLS (men: 96.8%; women: 98.7%). Overall VLS among all PLHIV was 89.4% (men: 85.1%; women: 91.8%.

The most recent UNAIDS Spectrum (2021) estimates PLHIV at 364,437 and incidence rate at 0.27 (6,728 new infections).

The second Botswana Behavioral and Biological Surveillance Survey (BBSS 2017) was conducted among key populations (KP) in five districts (Chobe, Francistown, Gaborone, Ngamiland South and Palapye). The data analysis shows significant progress in reaching KP, especially among female sex workers (FSWs), where prevalence decreased from 61.9% in 2012 to 42.8% in 2017 (2012, BBSS; 2017 BBSS,). In 2017, 92.9% had ever been tested for HIV, compared to 88.1% in the 2012 BBSS (about half were tested in the previous year). Access to treatment for those who knew their status improved drastically from the 2012 BBSS from 25% to 88% in the 2017 BBSS and 99% reported taking their ARVs every day. Among FSWs, HIV prevalence steadily increased by age group between 2012 and 2017 with most noticeable increase seen in the younger age groups.

In contrast, for men who have sex with men (MSM), the prevalence trend was upward, increasing from 13.1% in 2012 to 14.8% in 2017. The proportion of MSM who had ever tested increased significantly since 2012 (76% vs. 92%) and this trend was seen across districts. Testing rates were highest in Gaborone and Chobe. About 76% tested in the last 12 months compared to 80% in 2012. Most of them tested HIV negative. Plans are underway to conduct the third IBBSS to generate the much-needed new data to inform programming for these populations.

In terms of ART coverage for those who know their status, Table 2.1.1 and 2.1.2 show a national coverage estimate of 97.97%. Women age 25+ have the highest coverage at 97.99%; the lowest ART coverage is among less than 15-year-olds and males 15-24 years, 78% and 63%, respectively. Botswana's viral suppression rate is impressively high at 98% across all age and sex bands.

"Based on 2021 national program data, approximately 324,419 people were tested, about 7,615 were identified as HIV positive and approximately 9,060 initiated ART. The overall testing yield was 2.35%, while the overall ART initiation rate was 119%. 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 2.15% in 2021 (SPECTRUM, 2021). PEPFAR/Botswana's overall FY21 achievement for the percentage of pregnant women with known HIV status at antenatal care was 99.5% (16,503/16,576) and the overall achievement for PMTCT_ART was 99.4% (3,610/3,632). 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 69% according to 2021 national program data. EID continues to be a major area of focus for PEPFAR/B in FY22 and FY23.

Since the inception of the Botswana national safe male circumcision (SMC) program in 2009, a total of 273,470 voluntary medical male circumcision (VMMC) procedures have been performed, representing approximately 24% coverage in the male populations aged 15 years and older. VMMC will continue to be a major area of focus for PEPFAR/B during COP22 implementation, as the program strives to close the unmet need.

Standard Table 2.1.1

Table 2.1.1 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	2,511,393		369,885		376,813		214,455		217,690		659,509		673,041		Census 2021 Projections
HIV Prevalence (%)		14.12		0.68		0.74		5.09		2.35		30.93		19.22	UNAIDS SPECTRUM, 2021
AIDS Deaths (per year)	4923		269		276		302		245		1838		1993		UNAIDS SPECTRUM, 2021
# PLHIV	354,670		2,521		2,776		10,918		5,109		203,991		129,355		UNAIDS SPECTRUM, 2021
Incidence Rate (Yr)		0.26		0		0		0.69				0.5		0.21	UNAIDS SPECTRUM, 2021
New Infections (Yr)	6,594														UNAIDS SPECTRUM, 2021
Annual births	54546	97%													PMTCT, MoHW 2021
% of Pregnant Women with at least one ANC visit	46,872	94%	222	5%			20,317	43%			26,333	56%			BFHS, 2007

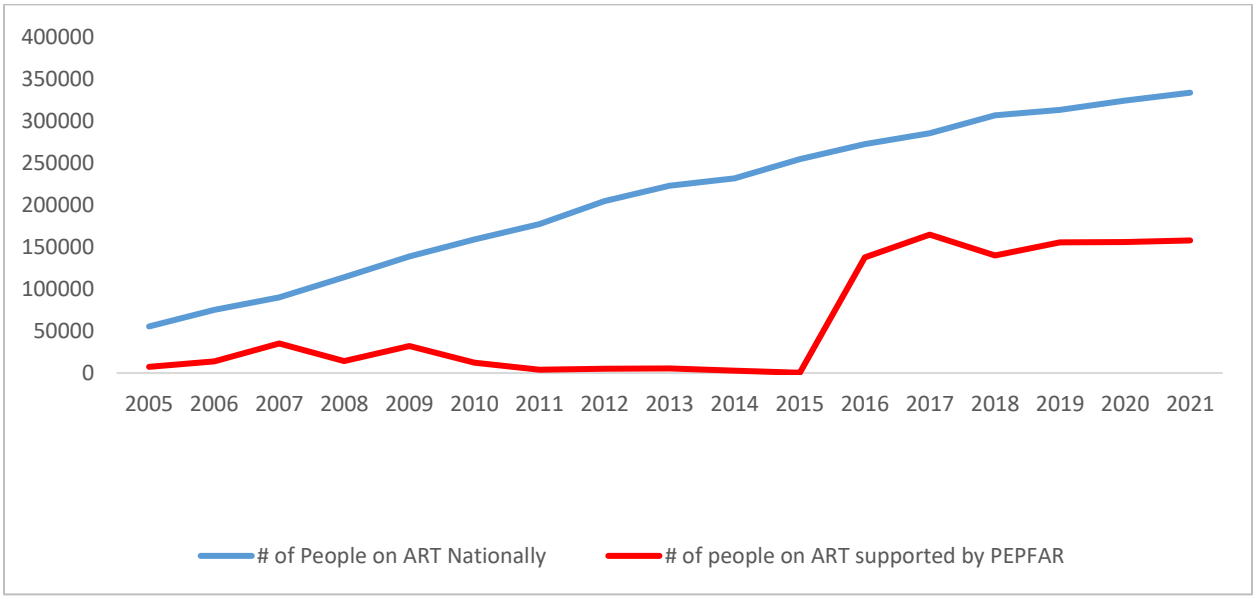
Pregnant women needing ARVs	10333	20	1				1750				8582				PMTCT, MoHW 2021
Orphans (maternal, paternal, double)	123,459		51,284		52,226		10,044		9,906		NA		NA		BAIS IV, 2013 Census 2018 Projection
Notified TB cases (Yr)	5260		156	3%	146	3%	390	7%	343	7%	1718	33%	2507	48 %	BNTP, 2016
% of TB cases that are HIV infected	2946	56	21	0.7	30	1	135	4.6	72	2.5	1224	41.6	1463	49.7	BNTP, 2016
% of Males Circumcised	273470	24%			251808	50 %			74884	34 %			71476	11 %	VMMC national program data, MoHW Sep 2021; COP 22 SPECTRUM estimates.
Estimated Population Size of MSM*	16,443														National mapping and BBSSII, 2017
MSM HIV Prevalence		19.10 %													National mapping and BBSSII, 2017
Estimated Population Size of FSW	17015														National mapping and BBSSII, 2017
FSW HIV Prevalence *		42.80 %		14.70 %				34.80 %				79.20 %			National mapping and BBSSII, 2017
Estimated Population Size of PWID	NA	NA													
PWID HIV Prevalence	NA	NA													
Estimated Size of Priority Populations (AGYW)								5.09							UNAIDS SPECTRUM, 2021
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.* **Age groups for FSW prevalence is as follows: <20, 20-29, and 40-49* *Cite sources: 2022 Spectrum Estimates and The Fifth Botswana HIV/AIDS Impact Survey (BAIS V)*														

Standard Table 2.1.2 is required with most recent data

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year**		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Estimated Total PLHIV (#)**	**PLHIV diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	2511393	14.12	354670	346458	336171	97.97	97.91	37086	5768	*6747*
Population <15 years	746698	0.71	5297	4570	4335	69	64	1418	14	*20*
Men 15-24 years	217690	2.35	5109	4290	3594	94.43	91.15	2486	144	*146*
Men 25+ years	673041	19.22	129355	124653	116691	93.45	95.21	19198	2876	*2606*
Women 15-24 years	214455	5.09	10918	10785	10500	97.88	89.91	2972	436	*782*
Women 25+ years	659509	30.93	203991	202160	201051	97.99	98.86	11012	2298	*3193*
MSM	157,592	14.80%[1]	23,324	2224	6343	82%[1]	100%[3]	25193	3333	*3173*
FSW	257,722	42.80%[1]	110,304	19,853	11653	87.6%[1]	100%[3]	33543	6203	*6183*
PWID	3392	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

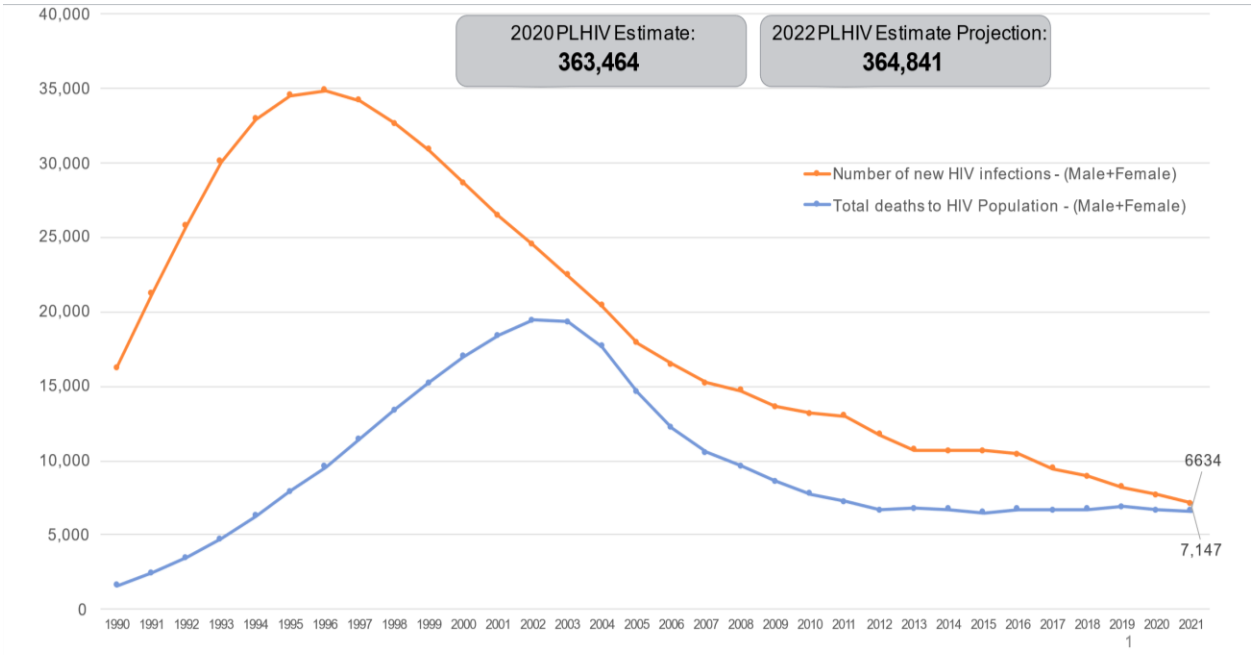
Source: 2022 Spectrum Estimates and The Fifth Botswana HIV/AIDS Impact Survey (BAIS V). KP: IBBS 2017.

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



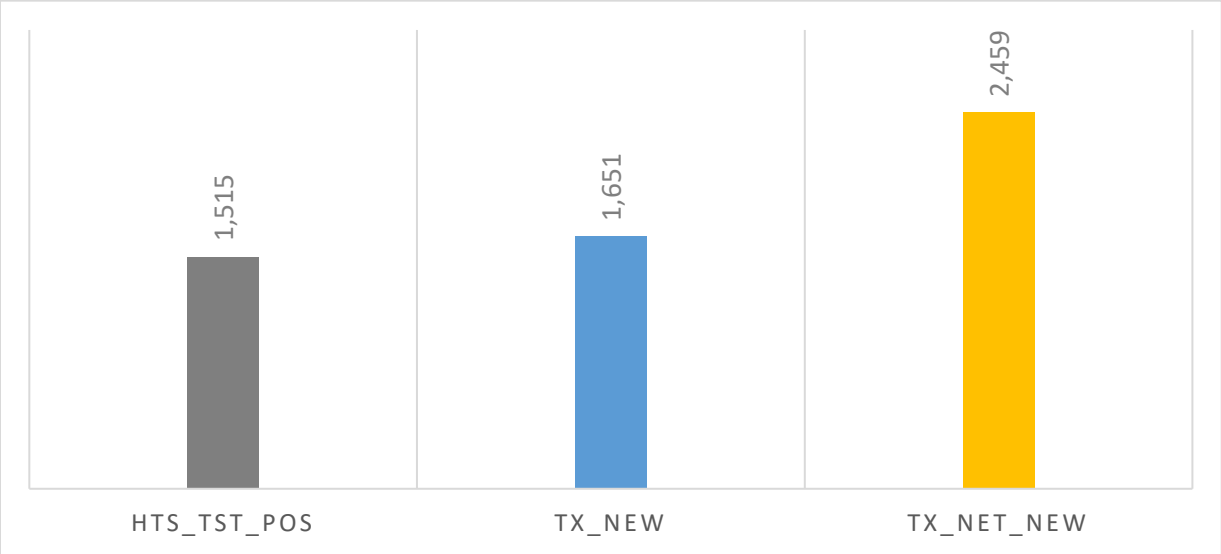
Source: 2nd 90: Clinical Cascade Single OU Dossier "Overall cascade" chapter 2022. PANORAMA.

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



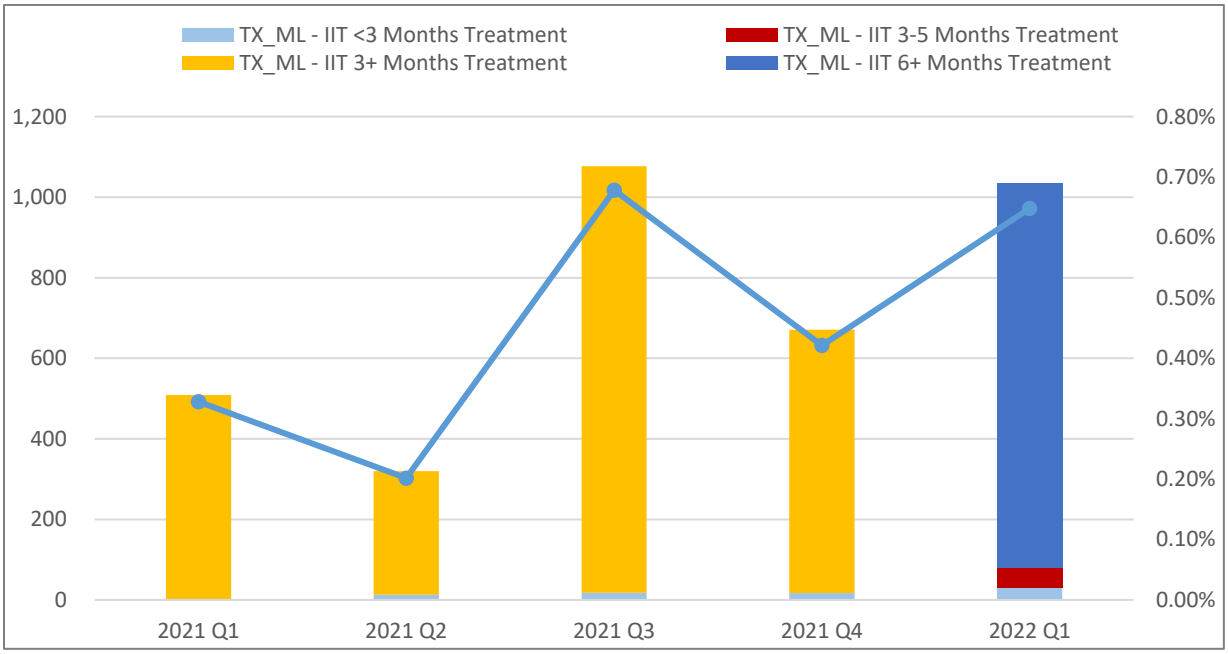
Source: 2022 Spectrum Estimates for the period of 1990 to 2021.

Figure 2.1.5 Assessment of ART program growth in FY21



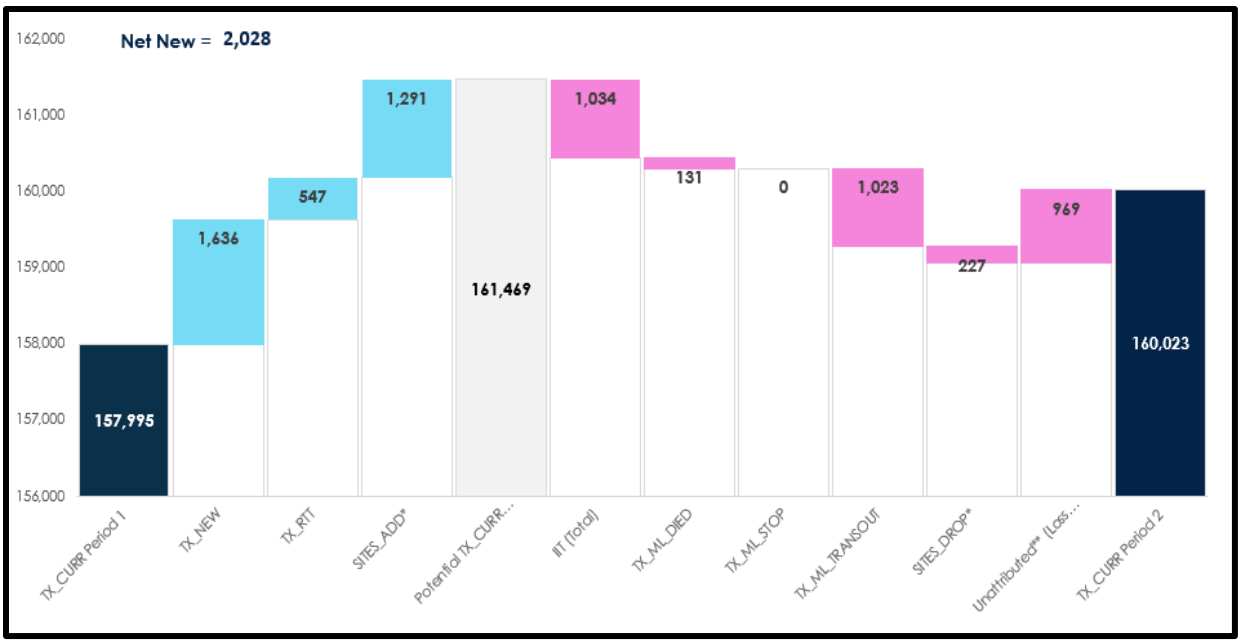
Source: PANORAMA clinical cascade, single OU dossier, single OU chapter, overall cascade page. 2nd 95 figure.

Figure 2.1.6 Clients Gained/Lost from ART by Age/Sex, FY21 Q4 & FY22 Q1



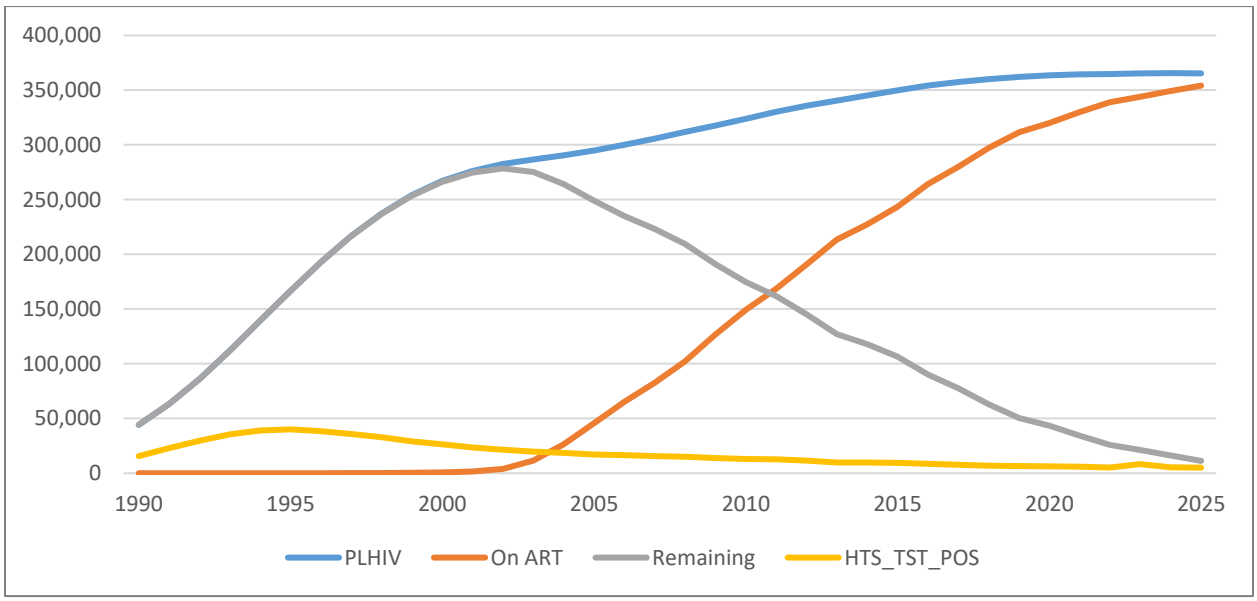
Source: PANORAMA. Treatment, single OU dossier, interruptions in treatment (IIT) chapter, IIT Trends page.

Figure 2.1.6 (A) Continuity of Treatment- Net New "Waterfall" Analysis FY22 Q1



Source: PANORAMA. Treatment, single OU dossier, Waterfall Analysis.

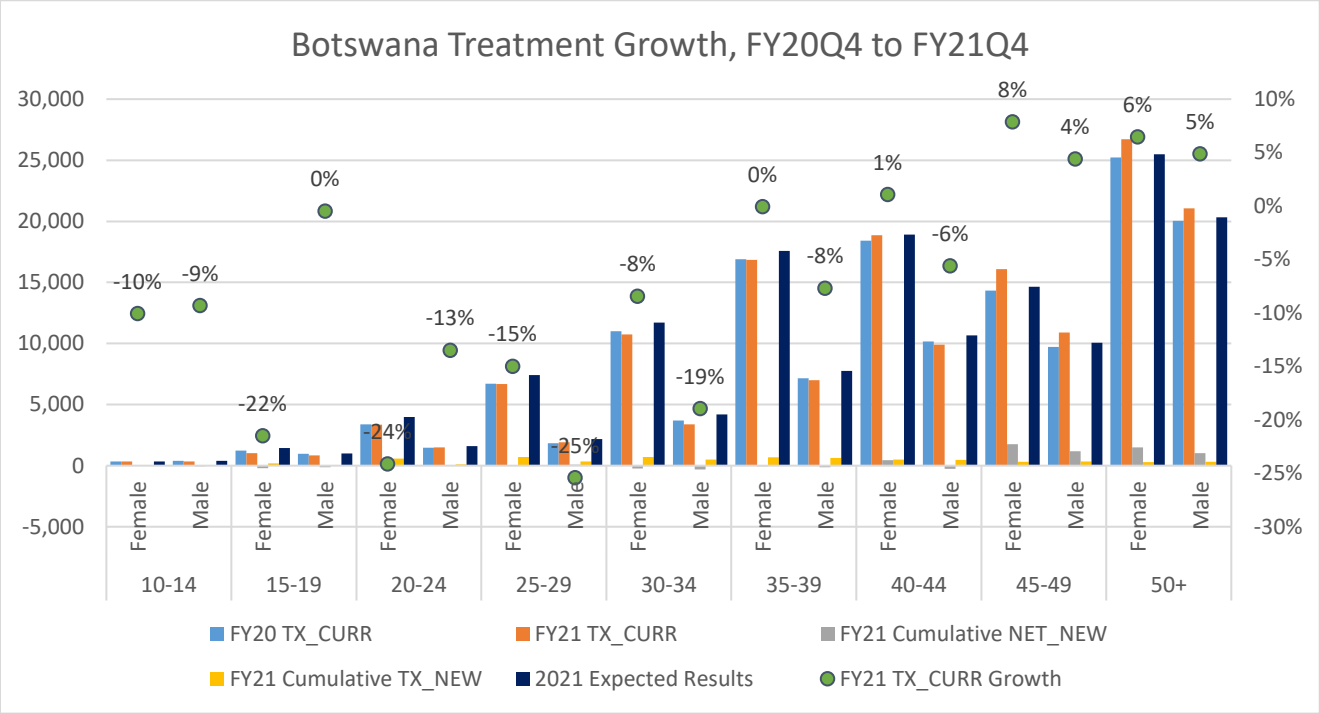
Figure 2.1.7 Epidemiologic Trends and Program Response for your Country (Figure 2.1.1.23 in COP22 Guidance)



Source: UNAIDS SPECTRUM 2022. Botswana.

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

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.



Source: PANORAMA. MER Structured Data Set.

2.2 New Areas of Focus for COP22, Including Focus on Client ART continuity

Case Finding

Adapting Social Network Testing to Reach Hard-to Reach Populations

PEPFAR/Botswana will explore adapting social network-based approaches for at risk groups in the general population. This approach, which Botswana is already using for key populations and youth, working with high-risk groups to recruit others in their social networks, will be expanded to other groups for HIV prevention and testing services. Referral for HIV testing will be voluntary and implemented only with the client's consent. This strategy will create a refined, targeted, and focused approach for high-risk populations and at-risk network members who may not be willing to test. In a blended approach, secondary distribution of HIVST kits to index clients for distribution to their partners will also be included. Innovative approaches, leveraging technologies (e.g., social media, messaging, and online platforms) to reach social networks will also be adopted.

Offering HIV Self-Testing Kits to Emancipated Children <15 years

In Botswana, the age for consenting to access HIV testing without parental or guardian consent is 16 years. However, emancipated minors below the age of 16 years, including those presenting at youth-friendly facilities, drop-in centers with signs of illegal abortion or pregnancy, repeated STIs, and those involved in sex work can consent and access services independently. The COP22 plan prioritizes issuing self-test kits to these emancipated minors.

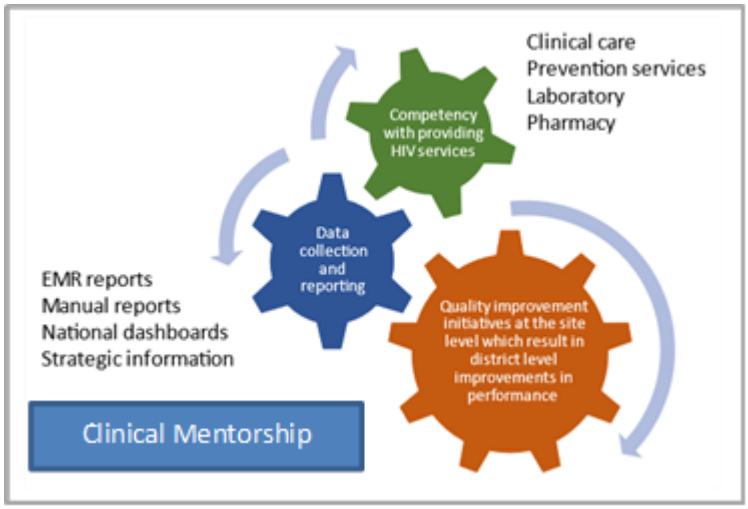
Treatment Initiation and Continuity

The Clinical Mentorship Program

Following the COP22 guidance, PEPFAR Botswana will prioritize person-centered technical interventions aimed at achieving equity and reduction of morbidity and mortality among all PLHIV seeking services regardless of age, gender, sexual orientation. and geography One key strategy to achieve this goal will be to initiate a Clinical Mentorship Program in Botswana. The goal of the program will be to enhance the capacity of health facilities in Botswana to continue to provide high quality HIV services at facility-level across the HIV care continuum through a mentorship model.

The program will aim to:

(1) Enhance competency in providing and documenting HIV services (including prevention, testing, treatment, pharmacy, and laboratory components),
(2) Improve availability and quality of data collected and reported through the electronic medical records (EMRs) data systems at site and district levels, and
(3) Improve analytics and use of site-level data for continuous quality improvement. (CQI)



The Clinical Mentorship Program will be implemented using a mixture of didactic learning followed by physical site supportive supervision and/or virtual platforms to expand its reach to different geographical locations. Supportive supervision will be done in the form of weekly ECHO virtual support meetings for clinics and ART sites. The program will build on the Botswana Ministry of Health and Wellness (MoHW) HIV Division mentorship model, which currently focuses on training-only.

The enhanced model will additionally focus on enhancing clinical services, CQI and data management. A national mentoring team is planned to be based at the MoHW main office, focusing on (prevention, TB/HIV, ART services, strategic information, health informatics, IT, and laboratory services) with the national clinical mentorship team overseeing the district mentors.

At the district level, mentoring teams will coordinate all clinical mentorship programs within the district health management team in collaboration with the program managers and health facilities managers.

The team will develop district clinical mentorship strategic and operational plans in collaboration with facility managers and implementing partners and help match mentors with mentees in the health facilities. The cadres to form this team includes doctors, nurses, pharmacists, case managers, M&E Officers, IT Officers, lab technicians and CQI officers. The clinical mentorship program will be implemented in a phased approach with the plan to cover clinics and IDCCs across the country over a two-year period. The clinical mentoring program is depicted in the framework flow diagram above.

Children and adolescents living with HIV continue to lag behind, as compared to adults, across the full treatment cascade – from low rates of case finding, linkage, retention, optimized ART treatment regimens, viral load coverage, and viral suppression. The underperformance in this population requires new strategies and a shift in focus to be adopted. Therefore, in COP22, PEPFAR/B, will strategically prioritize pediatric and adolescent friendly services in IDCCs aimed at enhancing ART related services focused on this age cohort. An innovation will be collaborative trainings aimed at equipping clinicians at district level with pediatric management of children living with HIV (CLHIV) and advance HIV care. The trainings will be aimed at pediatric supportive/mentoring as well as technical support to various failure clinics at the district level. In COP22 efforts will also be geared towards strengthening integration of non-communicable diseases (NCDs) and comorbidities management to optimize NCDs-HIV comorbidity diagnosis, treatment, and control, especially in the older cohort. This intervention will be supported by clinical mentorship across the districts.

In line with the COP22 guidance and the new MPR 9, for OUs to demonstrate advancement towards equity and elimination of stigma, and the commitment and initiative demonstrated by the Government of Botswana, PEPFAR/B will scale up care and treatment interventions for key populations in public health facilities. This will be achieved through offering the KP clinical competency program for HCWs in ART clinics focusing on KP awareness and their HIV care; strengthening patient ART referral and development of guidelines and SOPs system to facilitate smooth integration of KP groups into public health ART clinics. Clinical mentors under the clinical mentorship program will also ensure integration of KP services into the comprehensive clinical services package at district and facility level.

ART program growth through optimization of linkage to treatment activities

- Expand adult ART initiation on weekends & extended opening hours during weekdays to also cover pediatric and adolescents
- Expand treatment and viral load literacy among PLWHIV to promote adherence and positive living
- Establishing additional pediatric and adolescent friendly corners in health facilities

Optimizing ART continuity over time (Reduction of IIT), TX initiation, Retention/return to TX.

- Establish pediatric HIV care supportive/mentoring and technical support to various failure clinics at the district level
- Referral of all children and adolescents living with HIV to the OVC program
- Provide case management within facility and at community level to provide person-centered care to children living with HIV and their families

- Provide KP clinical competency program for HCWs in ART clinics
- Integration of KP services in public health facilities under the clinical mentorship program

Strengthen ART optimization, multi-month dispensing (MMD) and decentralized drug distribution (DDD) implementation

- Complete full transition of all pediatric and adolescents to dolutegravir (DTG)-based regimen
- Inclusion of 3-month MMD for children in the ART clinical care guidelines to and optimize its implementation at facility level
- Expand distribution of drugs to stable patients through post office delivery to the client's households or workplace based on client's preferences.

Viral Load Suppression

Appointment system and special days/times, profiling of each client

HCWs including HCAs will profile each client who either has an invalid viral load or is not virally suppressed. Sites will use the existing register to capture client details and the days/times that those individuals can access the service. Sites will coordinate with community programs and community health workers by sharing names to be followed up at the community levels and brought to services. The service will be tailor made according to the clients' needs

Clinical mentorship focused on A/CHLIV

These will be led by MoHW and there will be a team, across the clinical cascade that will mentor service providers at facilities.

Introduce specimen tracking system

This involves inserting tracking discs in each cooler box at site level and tracking the specimen enroute to the testing laboratories. This will assist in pinpointing bottlenecks in the specimen path.

To increase VL testing coverage, the OU will continue implementing differentiated viral load service delivery models as appropriate and in consultation with the MoHW to optimally complement the public sector's needs. PEPFAR/B will work with the differentiated viral load service providers to ensure that their services adhere to the MoHW Viral Load testing guidelines.

Prevention of Mother to Child Transmission

Strengthen pre-exposure prophylaxis (PrEP) service for HIV-negative pregnant and breastfeeding women (PBFW))

- Strengthen integration of PrEP into antenatal care (ANC), postnatal care, family planning, and other HIV prevention services for PBFW and their partners
- Strengthen PrEP screening at ANC service points and avail PrEP screening tools
- One-on-one mentorship with the facility staff on screening of PrEP
- Strengthen retesting of pregnant and breastfeeding mothers through demand creation, referral from Child Welfare Clinic CWC for maternal HIV testing services (HTS,) monitoring retesting performance/QI strengthen re-testing of PBFW

Strengthen Prevention of Mother to Child Transmission (PMTCT) data systems and usage

- Strengthen internal capacity for data use and analysis and support in PMTCT/ANC
- Expand electronic medical records sharing between PMTCT service delivery points and ART clinics to ensure continuity of care.
- Improve tracking of women across services (including through the expansion and use of electronic medical records in ANC/PMTCT settings, with linked identifiers for mothers and infants) and the use of technology driven reminders.

TB and HIV

- Introduction of c-reactive protein (CRP) blood tests to intensify case detection: Perform CRP test in all PLHIV every 6 months, along other routine tests
- Introduction of stool test in children to intensify TB case finding: Replace invasive gastric aspiration with stool test in children to strengthen testing among children
- Use MMD and differentiated service delivery (DSD) model to scale up TB preventative therapy (TPT): Expansion of TPT

Implementation of DREAMS and OVC programs

DREAMS

To leverage on agency competencies for the delivery of a comprehensive DREAMS package, the OU has agreed on some key pivots for COP22 implementation. In COP22 the program will realign focus by applying agency comparative advantages. CDC will focus on DREAMS clinical or secondary interventions while USAID will offer primary and contextual interventions. USAID will continue to implement the community program; primary and the contextual interventions across all the 8 SNUs as well as the clinical interventions in 2 SNUs with 20% of the clinical targets transitioned to CDC. CDC will implement the clinical program in all the 8 DREAMS SNUs and transition the primary interventions program to USAID for the 10–19-year-old. The focus for CDC will be on the 20–24-year cohort for HIV and violence prevention and the social asset building primary interventions. In addition, Peace Corps is expecting volunteers to have arrived in COP22 to support the DREAMS Ambassadors and other IPs across the DREAMS districts, for both the community and the clinical programs.

OVC

To increase our ability to reach an increased number of A/CLHIV, the PEPFAR/B OVC program will expand to 3 SNUs (1 existing, 2 new) that are PEPFAR supported sites and have been identified to have a high number of TX_CURR <15. These are Selibe-Phikwe and Lobatse. The focus will be to offer and provide the comprehensive OVC package of services. 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.

Implementation of VMMC interventions and services

PEPFAR/B will continue to support the provision of VMMC services in COP22 targeting eligible men aged 15 years and above in selected priority districts. The program aims to circumcise 10,000 men through DSD approach using dorsal slit surgical technique. The PEPFAR/B VMMC program will continue to target both civilians and military communities. Using the BAIS V survey

results in triangulation with existing program data, prioritization of geographic SNUs has been made with high HIV burden districts with low circumcision rate targeted in order to take them close to saturation.

In COP22, the overall target will be allocated to the high burden districts with a significant gap in VMMC including Gaborone, Kgatleng, Kweneng East, Serowe, South East and Mahalapye. Considering the progressive success in targeting males aged above 15 years over the past 3 years, the program will only focus in circumcising this age group.

COP22 priorities will include:

- Development and distribution of IEC materials commensurate with the current situations. To incorporate evidence based best practices including Human Centered Design
- Training of Interpersonal Communication (IPC) agents and providers on demand creation. To equip IPC agents and health providers with appropriate communication skills including HCD responding to identified barriers.
- Use of expert clients and VMMC role models. PEPFAR/B IPs to recruit and train clients who have through the VMMC and happy with services to become ambassador who will be supported to share real life testimonials on the experience and advantages of accessing VMMC.
- Training of media practitioners on VMMC. To disseminate accurate publicity and information on VMMC, PEPFAR/B will engage media through workshops to foster accurate reporting on VMMC to ensure positive visibility of the program.
- Scale-up Communication on VMMC in mass media, Inter-Personal Dialogue groups and social media. The VMMC program will be adopt multiple demand creation approaches customized to the different target population and commensurate with service delivery to optimize access and minimize lost to follow up.
- Use of VMMC device. To introduce Shang Ring devices as alternative to the surgical method for clients 13-14 years and older

Pre-Exposure Prophylaxis (PrEP)

The PrEP outreach goal is to ensure that every person at risk of acquiring HIV infection in PrEP-supported districts in Botswana receives appropriate PrEP information in a trusted medium.

Key activities for COP22:

- Short trainings for PrEP providers to build a supportive, non-judgmental client focused attitude and behavior. To address provider prevention method bias and address stigmatizing behaviors that discourage youth from using PrEP services, a short refresher training will be provided.
- Provision of Job Aids and Tools to Health Providers. Coping with PrEP side effects improves when users are counseled adequately and appropriately. PrEP options will be expanded in COP22. PEPFAR/B IPs will support the design and distribution of appropriate Job Aids and tools to providers.
- Use of expert clients and PrEP role models. PEPFAR/B IPs will recruit, train and activate PrEP Ambassadors who will be supported to share real life testimonials on advantages of using PrEP.

- Training of media practitioners on PrEP. To counter negative publicity and misinformation on PrEP, PEPFAR/B working with Public Affairs will organize workshops for the media to facilitate accurate reporting on PrEP and also help frame public discussions on PrEP in a way that is not stigmatizing.
- Scale-up Communication on PrEP in mass media, Inter-Personal Dialogue groups and social media. PrEP will be repositioned as a HIV Prevention choice. As per Botswana PrEP SBCC strategy, PrEP will be presented as a lifestyle choice to achieve user life goals. A multi-media approach will be used by PEPFAR/B partners. In addition, Information, IEC materials to create awareness and share knowledge will be developed for each PrEP target audience.

Above Site

Health Financing

Sustainable financing is critical for the transformation of Botswana HIV response. The Third Botswana National Strategic Framework for HIV/AIDS (2019-2023) articulates that the cost of combating the HIV epidemic is projected to increase due to the commitment to achieving universal access and changing needs of services by PLHIV. But donor funds are flatlined and declining, there is technical and allocative inefficiency in the allocation and use of resources for HIV to ensure that maximum performance is achieved with limited funding, and lack of appropriate and adequate financial data results in risk of under or over budgeting leading to lack of budget credibility. In COP22, PEPFAR Botswana will be initiating technical assistance in collaboration with key stakeholders to improve equity and efficiency of HIV spending through mobilization additional resources from the private sector and strengthening public financial management for efficient allocation, utilization & management of HIV funds by:

- Building staff capacity on budget development, execution, and negotiations, as well as effective monitoring.
- Mainstreaming HIV interventions into the national budget right from the level of DHMTs
- Facilitating evidence-based advocacy for pooled procurement to ensure that Botswana is buying ARVs at the least cost/unit price
- Strengthening dialogue between MoHW, DHMTs and MFED on budget negotiations
- Identifying and resolving bottlenecks in the flow of funds through the health system

Strengthening the health system is a process and not an event that requires a long-term agenda and inclusiveness with a coalition provided by the Government of Botswana. Hence, activities to strengthen governance of HIV response and health will be integrated with health financing interventions e.g., enhancing the capacity of MoHW/NAHPA to develop supportive policies and appropriate strategies, do strategic planning, coordinate, collaborate and provide oversight.

Human Resource for Health

A shortage of skilled and qualified healthcare workers remains a major bottleneck towards the availability of accessible high-quality HIV services & healthcare in Botswana, which is worse in hard to reach and rural areas manifesting as inequitable distribution of HCWs across the country. Another obvious gap is the Lack of an integrated, comprehensive, and readily accessible data on the health workforce in Botswana. The lack of an HRH information system makes it difficult to make decisions that will improve the planning & management of the health workforce. Supporting HRH interventions for COP22 is important to sustain the gains of the HIV response and achieve

epidemic control. In COP22, PEPFAR will initiate support in collaboration with key stakeholders to address the country's health workforce crisis characterized by health worker shortages and low performance by building national and sub-national capacity to ensure that health workers are available and qualified to provide quality, integrated HIV prevention, care, and treatment services. The following are some of the activities that will be implemented:

- Conduct HRH situation analysis to generate baseline information on the status of the health workforce in Botswana. The functional areas of Human resources management will be assessed to provide a holistic picture of the human resources for health situation in Botswana
- Conduct health Labor market analysis to better understand the factors that influence demand and supply in the health labor market and determine its capacity to deploy and retain health workers to reduce rural and urban divide
- Support the review/updating and implementation of the Botswana Human Resources for Health Strategic Plan that outlines the country's plans for strengthening the production and development of health workers; enhancing their recruitment, management, and retention; and mobilizing funds to continue strengthening HRH policy and strategy efforts.
- Establish an integrated HRH information system capable of supporting HRH planning for national & sub-national levels
- Institutionalize routine National Health Workforce Account for updated and realistic projection/estimation of staffing levels for provision of HIV services at different levels of the health system

Community Health

WHO defines primary health care as a whole-of-society approach to health and well-being centered on the needs and preferences of individuals, families, and communities. In COP22 PEPFAR/B will offer Technical Assistance (TA) to support the MoHW on its key goal of revitalizing Primary Health Care (PHC). This will be achieved through working closely with the community health and Kitso Training division to roll out the National Guideline for Implementation of Integrated Community-Based Health Services, which represents Botswana's health sector vision for a healthy and productive nation in line with Vision 2036. The goal of the guideline is to guide and standardize implementation of community-based health services in Botswana. This guideline provides technical and programmatic guidance on the implementation of the minimum package of community-based health interventions to better meet the needs and expectations of communities. PEPFAR/B will support the MoHW to roll out a training curriculum and build the capacity and competencies of community-based health worker cadres to implement person-centered integrated health services for sustained HIV epidemic control.

Given the country's proximity to reaching epidemic control, PEPFAR/B will support the MoHW to fully institutionalize community health into mainstream health as a sustainability measure to ensure continued delivery of affordable and quality health services that are cost effective and meet client's expectations. A robust community health program will enable maintenance of the gains realized and consequently sustainable epidemic control. PEPFAR/B's Community systems strengthening support will be national to enable universal health coverage. WHO defines universal health coverage as ensuring that all people have access to needed and affordable health services

including prevention, promotion, treatment, rehabilitation, and palliation, while also ensuring the use of these services does not expose the user to financial hardship and push households into poverty. The guideline will provide a harmonized and integrated approach to household needs through home visits, where a client and family health needs will be assessed, in order for tailored health services to be provided to individuals and families.

Community Health TA will be channeled towards the MoHW's mandate of revitalizing PHC. PHC implementation will ensure that people receive comprehensive health care ranging from promotion and prevention to treatment, and palliative care as close as feasible to their everyday environment. PHC is about putting communities at the center as the starting point for any development program, including health care delivery. It means not just working for the communities but with them, helping them get meaningfully involved in the planning, decision-making, and implementation processes, including, but not limited to, monitoring and evaluation. Such bottom-up approaches help build communities' confidence in health systems and create a sense of community ownership, which is a foundation for sustainability. PEPFAR/B will support primary health care through capacity building, training, and mentorship of CHWs engaged by the government (presently referred to as Health Education Assistants (HEAs), and those engaged by the CSOs and private sector to implement person centered integrated health services at the locations preferred by the clients. The health care system will be strengthened to enable the re-orientation and up-skilling of human resources for health, particularly HEAs to ensure they fully focus on implementing quality primary health care services at community level.

Botswana has a mixed health care system composed of public, private for-profit, private nonprofit (NGOs and CSOs), which is referred to as the health sector. PEPFAR/B will strengthen the country's health sector to work jointly to improve the health status of the clients. PEPFAR/B's Community Health TA will entail supporting the MoHWs Community Health division to improve coordination, leadership, governance, management and alignment of community-based health services at national, district and community levels, ensuring that health interventions are designed and delivered around the needs of patients, their families, and communities.

Botswana's future health depends on a renewed focus on communities and a health system tailored to serve them to prevent all forms of ill health. This emphasis is recognized in the 2016 WHO framework on integrated people-centered health services as a call for a fundamental shift in the way health services are funded, managed, and delivered. PEPFAR/B will offer TA to strengthen the delivery of integrated community-based health interventions anchored on the application of the WHO concept for a person-centered approach, which emphasizes the importance of a comprehensive and integrated mode as opposed to a vertical approach toward health services delivery, prioritizing the needs and expectations of individuals, families, and communities, rather than diseases. The approach integrates different levels of health service provided through a network of service providers at public, private, and community level to allow clients to receive a continuum of preventive and curative services that meet their needs over time. This minimum package of health services is aligned to the country's epidemiological priorities and supports a human rights approach to service delivery. Furthermore, PEPFAR/B will strengthen monitoring and evaluation, and information management for integrated community-based health services.

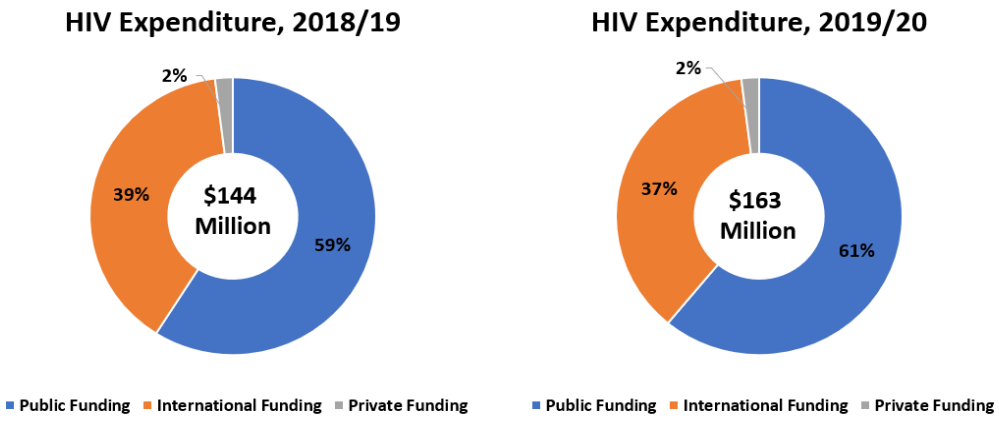
To ensure sustainability post PEPFAR funding, PEPFAR/B will provide TA to MoHW to implement social contracting and social entrepreneurship for CSOs to prepare the MoHW for long term support to the local CSOs.

Continuous Quality Improvement will be the cornerstone to ensure delivery of quality community health programs. PEPFAR/B will support the MoHWs community health division and the community-based implementing partners to integrate CQI as an integral part of programming. On an ongoing basis PEPFAR/B will support them to identify implementation bottlenecks needing course corrections, introducing change ideas as necessary and identifying ways of improving organizational processes through adopting and scaling up what works.

2.3 Investment Profile

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%.



In a 2016 publication titled Health Financing in Botswana: A Landscape Analysis supported with funding from PEPFAR, the resource requirements of HIV/AIDS programs were estimated from the HIV/AIDS Investment Case for 2015 to 2023 (Avalos and Jefferis 2015). Identifying resource gaps facilitates the outlining of possibilities for shared financial responsibility between the government, donors, private sector, and other key stakeholders in the future.

The estimated HIV/AIDS resource requirements are $300 million for 2021, $304 million for 2022, $308 million for 2023. These estimations include donor and private financing for HIV/AIDS programs. Comparing resources needed with available financing for HIV/AIDS programs, the estimated funding gap was $97 million in 2021. This gap increased to $103 million in 2022. By 2023, the HIV/AIDS financing gap would reach $109 million per year. Botswana could feasibly increase their domestic spending on HIV/AIDS and close the funding gap by curbing health care

costs, implementing long-term planning, eliminating budget rigidity, increasing fiscal space for health, and improving efficiency in health spending.

Options for increasing efficiency include use of pooled procurement and generic drugs, reform purchasing mechanisms to control costs and incentivize results, encourage competition between and among public and private providers and improve managerial practices and standard operational procedures at all levels to reduce waste and improve operations. Nevertheless, the government of Botswana maintains a high capacity to raise revenues, both through tax collection and extractive industries. The economic impact of COVID-19 on Botswana's economy however will be deep and long lasting. The average real gross domestic product (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.

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. 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. 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.

Table 2.3.1 Investment Profile (Funding Landscape) for HIV Programs

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022						
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Care and Treatment	$59,207,872	71%	1%	28%	0%	
HIV Care and Clinical Services	$9,270,369	0%	7%	93%	0%	
Laboratory Services incl. Treatment Monitoring	$2,698,715	0%	0%	100%	0%	
Care and Treatment (Not Disaggregated)	$47,238,788	89%	0%	11%	0%	
HIV Testing Services	$4,182,966	24%	17%	59%	0%	
Facility-Based Testing	$1,413,124	0%	10%	90%	0%	
Community-Based Testing	$614,714	0%	32%	68%	0%	
HIV Testing Services (Not Disaggregated)	$2,155,128	46%	17%	36%	0%	
Prevention	$23,167,182	30%	16%	55%	0%	
Community mobilization, behavior and norms change	$4,306,407	0%	15%	85%	0%	
Voluntary Medical Male Circumcision	$3,152,208	51%	6%	44%	0%	
Pre-Exposure Prophylaxis	$1,128,509	0%	44%	56%	0%	
Condom and Lubricant Programming	$282,813	0%	100%	0%	0%	
Opioid Substitution Therapy	$0					
Primary Prevention of HIV & Sexual Violence	$3,443,929	0%	28%	72%	0%	
Prevention (Not Disaggregated)	$10,853,316	49%	10%	41%	0%	
Socio-economic (incl. OVC)	$7,663,518	18%	13%	68%	0%	
Case Management	$833,128	0%	0%	100%	0%	
Economic Strengthening	$2,127,617	0%	0%	100%	0%	
Education Assistance	$118,462	0%	0%	100%	0%	
Psychosocial Support	$549,742	0%	0%	100%	0%	
Legal, Human Rights, and Protection	$2,684,552	52%	38%	10%	0%	
Socio-economic (Not Disaggregated)	$1,350,017	0%	0%	100%	0%	
Above Site Programs	$13,767,867	52%	26%	22%	0%	
HRH Systems	$320,946	0%	100%	0%	0%	
Institutional Prevention	$0					
Procurement and Supply Chain Management	$1,743,391	0%	41%	59%	0%	
Health Mgmt Info Systems, Surveillance, and Research	$3,391,367	0%	61%	39%	0%	
Laboratory Systems Strengthening	$634,094	0%	18%	82%	0%	
Public Financial Management Strengthening	$0					
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$5,078,069	92%	8%	0%	0%	
Laws, Regulations and Policy Environment	$0					
Above Site Programs (Not Disaggregated)	$2,600,000	96%	0%	4%	0%	
Program Management	$11,818,520	0%	9%	91%	0%	
Implementation Level	$11,818,520	0%	9%	91%	0%	
Total (incl. Commodities)	$119,807,925	49%	9%	42%	0%	
Commodities Only	$1,995,902	0%	50%	50%	0%	
% of Total Budget	*2%*					

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Table 2.3.2 Investment Profile (Funding Landscape) for HIV Commodities

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Antiretroviral Drugs	$619,800	0%	0%	100%	0%	
Laboratory Supplies and Reagents	$17,820	0%	100%	0%	0%	
CD4	$0					
Viral Load	$0					
Other Laboratory Supplies and Reagents	$17,820	0%	100%	0%	0%	
Laboratory (Not Disaggregated)	$0					
Medicines	$244,226	0%	0%	100%	0%	
Essential Medicines	$0					
Tuberculosis Medicines	$244,226	0%	0%	100%	0%	
Other Medicines	$0					
Consumables	$429,391	0%	72%	28%	0%	
Condoms and Lubricants	$1,440	0%	100%	0%	0%	
Rapid Test Kits	$427,951	0%	72%	28%	0%	
VMMC Kits and Supplies	$0					
Other Consumables	$0					
Health Equipment	$557,879	0%	100%	0%	0%	
Health Equipment	$557,879	0%	100%	0%	0%	
Service and Maintenance	$0					
PSM Costs	$126,786	0%	88%	12%	0%	
Total Commodities Only	**$1,995,902**	**0%**	**50%**	**50%**	**0%**	

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
Peace Corps	$1,797,678	-	-	-	Appropriated funds that support allowances, transportation, medical, and training for Peace Corps Volunteers
USAID: Emergency disaster funds for COVID-19 American Rescue Plan Act.	$8,610,000	0	3	0	Accelerate widespread and equitable access to and delivery of safe and effective COVID-19 vaccinations Reduce morbidity and mortality from COVID-19, mitigate transmission, and strengthen health systems, including to prevent, detect, and respond to pandemic threats
Total	**$10,407,678**				

2.4 National Sustainability Profile Update

The Sustainability Index Dashboard (SID) is a tool completed every two years by PEPFAR/B 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 fifth iteration of the SID in March 2022 at a multi-stakeholder consultative meeting co-convened by PEPFAR and UNAIDS. Participants included representatives from several host government ministries and departments, multilateral organizations, local non-governmental organizations (NGOs) and CSOs, US government (USG) IPs.

Table 2.4.1 Botswana SID Dashboard – Domains and Elements (2015-2021)

	2015 (SID 2.0)	2017 (SID 3.0)	2019 (SID 4.0)	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	7.70	7.50	8.29	8.57
2. Policies and Governance	6.58	7.06	8.40	7.26
3. Civil Society Engagement	5.60	6.88	5.50	6.75
4. Private Sector Engagement	3.08	5.78	6.90	6.96
5. Public Access to Information	8.00	6.00	7.00	5.67
National Health System and Service Delivery				
6. Service Delivery	6.11	6.90	6.69	5.73
7. Human Resources for Health	6.33	6.23	7.50	6.65
8. Commodity Security and Supply Chain	6.27	6.79	6.58	6.85
9. Quality Management	4.76	6.14	5.48	4.14
10. Laboratory	5.69	5.58	6.58	4.71
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	5.56	7.10	8.13	7.10
12. Technical and Allocative Efficiencies	5.75	6.89	3.83	5.40
13. Market Openness	N/A	N/A	7.59	8.33
Strategic Information				
14. Epidemiological and Health Data	5.48	4.76	5.86	5.43
15. Financial/Expenditure Data	8.33	5.83	5.83	5.83
16. Performance Data	5.77	6.66	7.67	6.81
17. Data for Decision-Making Ecosystem	N/A	N/A	7.17	7.00

	Score 8.50-10.00 Sustainable		**Score 7.00-8.49** Approaching Sustainability		**Score 3.50-6.99** Emerging Sustainability		**Score <3.50** Unsustainable

In the 2019 SID 4.0 assessment, 53% (9) of the elements scored yellow and 47% (8) scored light green. In 2021 the elements with green scoring have reduced to 29% (5) and with yellow to 71% (12) compared with 2019. The most positive trends are seen with Policies and Governance, Planning and Coordination. There were no elements that scored red. However, there are three elements that showed a significant drop compared with 2019, and overall, 9 of the 17 element scores went down from the previous SID. The elements that went down significantly are: Public Access to Information decreased from 7.00 to 5.67, Human Resources for health from 7.50 to 6.65 and Performance Data decreased from 7.67 to 6.81 respectively.

Sustainability strengths:

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

1) **Policy and Governance:** Botswana has laws and policies in place that follow the most recent WHO guidelines for initiation of ART and protect KPs 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. However, there are still some structural barriers such as prohibition of selling sex. Laws criminalizing same sex act used to exist but were decriminalized by the high court in 2021. Post the decriminalized judgment, the GoB also committed to protect, promote, and fulfill LGBTQI+ people's rights. No laws restricting access to HIV services by LGBTQI+ -- the only thing that exists is the stigma and discrimination and lack of competencies in majority of health facilities to serve LGBTQI+ community. There are also cultural and religious norms that stigmatize LGBTQI+ people.

2) **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 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 CSOs.

3) **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.

Sustainability vulnerabilities:

The 2021 SID analysis revealed vulnerabilities in five sustainability elements: civil society and private sector engagement, service delivery, quality management, laboratory, commodities, technical and allocative efficiencies, epidemiological and health data, and financial/expenditure data. As a result, in COP22, the OU will seek to strengthen the sustainability of the national HIV response with funding and technical assistance through the following programmatic objectives.

1) **Improve the linkages between facility and community-based HIV services to ensure high quality person-centered services**: This objective will be supported through targeted investments in the MPRs seeking to improve immediate and direct linkage to treatment and retention across the cascade, clients' treatment, and viral load literacy as well as through the coordination of PEPFAR partners to improve linkage to treatment, active partner notification and DSD models.

2) **Further strengthen the laboratory capacity to meet the service needs of current and future PLHIV**: For COP22 the laboratory systems strengthening support will be across the 95's and geared at assisting the government align its rapid HIV testing (RHT) algorithm to the new WHO HTS guidelines (of 3 serial tests), optimization of case finding, scale up of recency and self-testing for the 1st 95. At the government's request PEPFARF/B will also be working to assist set up of a national certification system for POCT sites. The support for TB and other OI's, will be through increasing TB screening and diagnosis, investing in new technologies for TB diagnosis in children and supporting expansion of TB-LAM. PEPFAR/B will additionally continue to work with GoB at advanced disease management.

3) **Continue to fine-tune the timely supply, distribution, and quality of key commodities**: Specific investments in COP21 have been 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 COP22.

4) **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. Botswana's budget and economy will be under enormous pressure for the next few years due to the pandemics and there is a need to ensure that domestic resources are available for HIV response as well as equitable financing to sustain the HIV response. Botswana could feasibly increase its domestic spending on HIV/AIDS by strengthening public financial management for efficient allocation, utilization & management of HIV funds

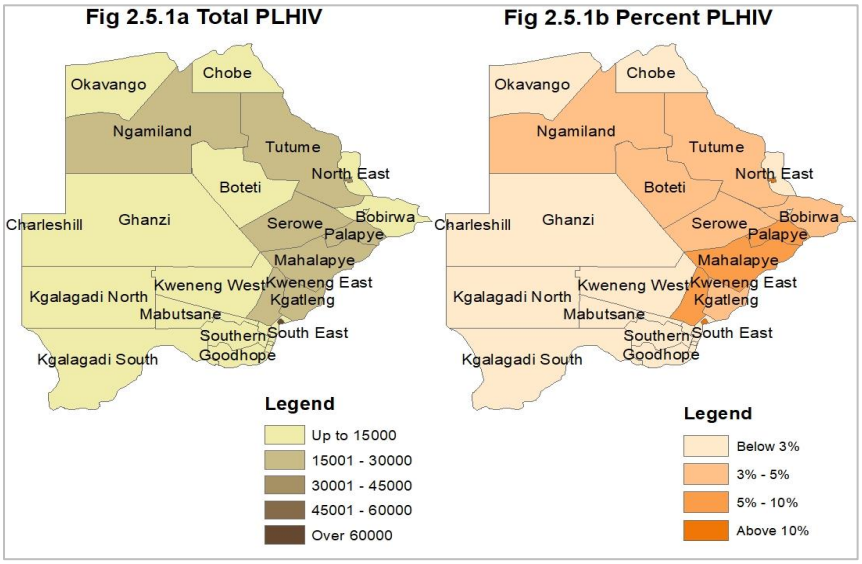
2.5 Alignment of PEPFAR investments geographically to disease burden

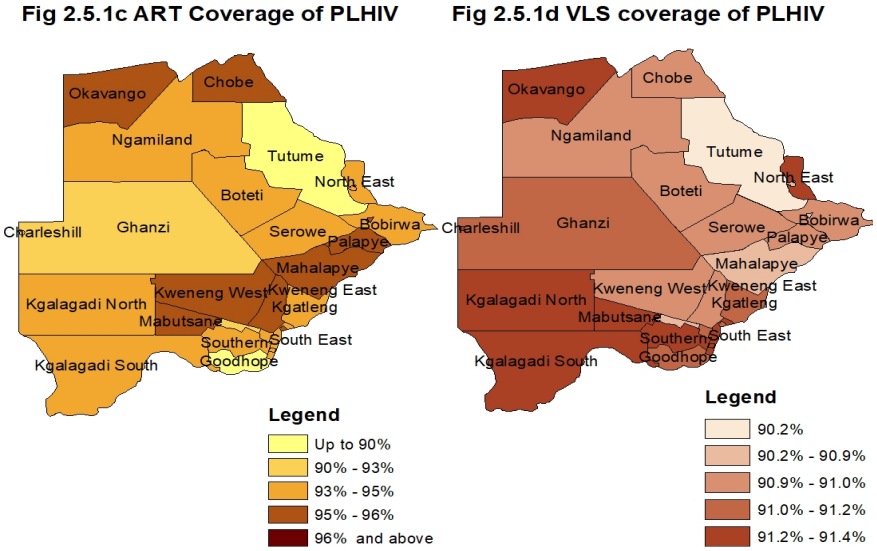
PEPFAR/B in COP19 realigned its work around the high-volume facilities, as defined by the TX_CURR >1000. An important component of the COP19 realignment was the introduction of the implementation and scale-up with fidelity of the MPRs at the selected 71 high-volume sites. The MPRs included the policy of extending treatment to non-citizens who are estimated to account for 7% of PLHIV in Botswana. The MoHW adopted this policy, and the non-citizens program was implemented across all the 27 health districts. Awaiting the availability of the

Botswana AIDS Impact Survey (BAIS V) results, the guidance was for PEPFAR/B to maintain the same geographic alignment in both COP20 and COP21.

In COP22, implementation will follow the same alignment with the non-citizens program now transitioning to become part of the general population treatment program. Through this geographic alignment the PEPFAR/B SNUs represent the districts with the highest total number of PLHIV (Figure 2.5.1b). Regarding treatment coverage, some PEPFAR/B SNUs show coverage below 90% (Figure 2.5.1c), the targets for COP22 are therefore set such that the treatment gaps are closed in every 5-year age-sex bands.

Figure 2.5.1 is required in map form; Minimum elements for display include the following: total PLHIV by SNU, percent PLHIV by SNU, coverage of total PLHIV with ART, and viral load suppression coverage by SNU.





2.6 Stakeholder Engagement

COP22 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 COP22.

PEPFAR/B also worked with implementing partners, local and international, to evaluate partner performance and progress towards goals through the Community Led-Monitoring (CLM) which is a community led quality improvement initiative, to refine COP21 implementation and focus COP22 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.

CLM partner feedback during COP22 discussions noted gaps in the government facilities on key issues around provision of privacy and confidentiality, lack of service provider sensitivity towards client needs, long waiting times and lack of some commodities, such as condoms, lubricants, dental dams, and finger cots. Especially for KPs, recommendations for greater utilization of community-led programming were noted. Hence, for COP22, the Clinical Mentorship Program, CQI initiatives, strengthening of KP services in public health facilities and community-led initiatives will improve the quality of the services through routine feedback and plans for action.

In COP21 and COP22, PEPFAR/Botswana will maintain relationships with the three PLWHA-led CLM partners and add a fourth KP-led partner specific to KP services. CLM will be utilized to gain input about HIV services in a routine and systematic manner that empowers communities to offer recommendations that translate into action and change within health facilities and community providers. CLM will be a routinized and cyclical process presented quarterly, triangulating these inputs with MER results and SIMS scores. These results will be made accessible as possible for use by all stakeholders while ensuring safety and confidentiality.

The COP22 guidance, tools and planning level letter were shared with external stakeholders in January and PEPFAR engaged in one-on-one discussions to address questions or concerns in advance. The COP22 was developed in close consultation with representatives from PEPFAR field teams, host government, implementing partners, multilateral organizations, and civil society organizations, demonstrating the collective commitment of all partners to transparency, accountability, and impact. This was also a unique opportunity to create, innovate, build, and set strategic directives and priorities critical for the country's progress towards controlling the HIV epidemic and maintaining control.

The stakeholder meeting or planning retreat was virtual and highly interactive. More than 175 stakeholders participated in three days full of plenaries, small group sessions organized by

technical areas including fruitful discussions around program gaps, key priorities, and inputs to around sustainability of the national HIV response.

Agency Headquarter personnel also joined the retreat virtually, and all participants provided comments on the proposed PEPFAR/B planning direction for COP22.

This dialogue sheds light on gaps in programming and implementation challenges from representatives of vulnerable populations. In COP22, 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 COP22 Virtual Regional Planning Meeting, PEPFAR/B held consultative meetings/calls with GoB (MoHW, NAPHA), and multilateral partners to dive deeper into national priorities for health systems strengthening, to review and discuss the final COP22 strategy. Over 88-90 key stakeholders joined the virtual planning meeting to finalize the COP22 plan as “One Botswana”.

2.7 Stigma and Discrimination

COP22 Interagency Planning Retreat

UNAIDS describes stigma as a dynamic process of devaluation that significantly discredits an individual in the eyes of others. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy. When stigma is acted upon, the result is discrimination that may take the form of actions or omissions. Discrimination refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group—in the case of AIDS, a person’s confirmed or suspected HIV-positive status—irrespective of whether there is any justification.

Stigma reduction is vital to the success of HIV prevention, care, and treatment efforts. HIV related stigma and discrimination (S&D) continue to adversely affect the health and wellbeing of millions of people around the world—infringing upon the rights of those affected and undermining the effectiveness of HIV responses. The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) acknowledges the central importance of addressing S&D, which remain significant barriers to progress at both the global and national levels. Ending S&D against PLHIV, KPs, and other vulnerable populations and improving their access to and uptake of comprehensive HIV services remain cornerstones of PEPFAR’s human rights agenda.

In response to addressing the negative effect of stigma and discrimination, PEPFAR Botswana Planning Level letter spells out the need to support diversity, equity, inclusion, and accessibility as well as to advance equity for underserved communities and prevent and combat discrimination or exploitation based on race, religion, gender identity or sexual orientation. The PLL underlines the PEPFAR commitment to ensure that these principles are upheld, promoted, and advanced in all PEPFAR supported programs. In addition, PEPFAR Botswana will address structural barriers to facilitate the creation of an enabling environment for HIV service delivery.

Statistics of stigma in Botswana

There is lack of recent data on stigma and discrimination against PLHIV and KP 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.

The Botswana Network of People Living with HIV/AIDS (BONEPWA), The GoB National AIDS and Health Promotion Agency (NAHPA) and UNAIDS have commissioned the National Stigma Index Survey with remote support from Global Network of People Living with HIV (GNP+). 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 COP22.

PEPFAR/B is tackling stigma that affects the general population and the key populations. Botswana is a 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 uses SIMS to 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 tool 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.

Stigma and discrimination have impacted on HIV clients in several ways. Some have delayed taking a HIV test when they feel that their family and friends might discriminate against them should they have a HIV positive result. Non-disclosure of HIV status to partners or children could be a manifestation of a community that has not overcome HIV related stigma.

In COP22, PEPFAR/B will continue combating stigma and discrimination through:

- Implementing social support activities.
- Health System investments in activities that enhance trust to overcome perceived or real stigma especially for marginalized groups and members of the key populations.
- Promotion of the "Champions" concept which was started in 2018 by BONEPWA and extensively adopted during COP18 Reboot (Expert Clients). 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
    c) educate service providers on stigma and discrimination reduction through person-centered and client-friendly services.

- Multiple PEPFAR implementing partners working with expert clients and PLHIV support groups as a key part of the cascade, especially in treatment initiation and retention.
- Continued engagement of four PLHIV who serve as high-level Faith and Community Initiative Ambassadors
- Promoting of 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.
- Use of Champions in programmatic activities to speak to their communities, promote treatment literacy, and increase uptake of services,
- Producing radio campaigns to reach men and reduce stigma.

In COP22, 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.

Additional interventions designed to address stigma and discrimination in COP22.

- Interventions to mitigate harmful policies and social norms that impede access to services.
- Documenting and responding to violence and discrimination faced by key populations (KPs), AGYW including other priority populations (PPs)
- Strengthening the capacity of key population organizations to expand and implement educational and training opportunities that prevent stigma and mitigate against its impact
- Strengthening the KP competency of HIV service providers.
- Working with Department of State to streamline Human Rights and Stigma, Violence and Discrimination reduction

- Working with Global Fund's Human Rights Interventions program which seeks to remove human rights-related barriers to accessing services

3.0 Geographic and Population Prioritization

Table 3.1 is required; it should be completed to show the current status of ART saturation and progress towards 95/95/95 across all SNUs as applicable

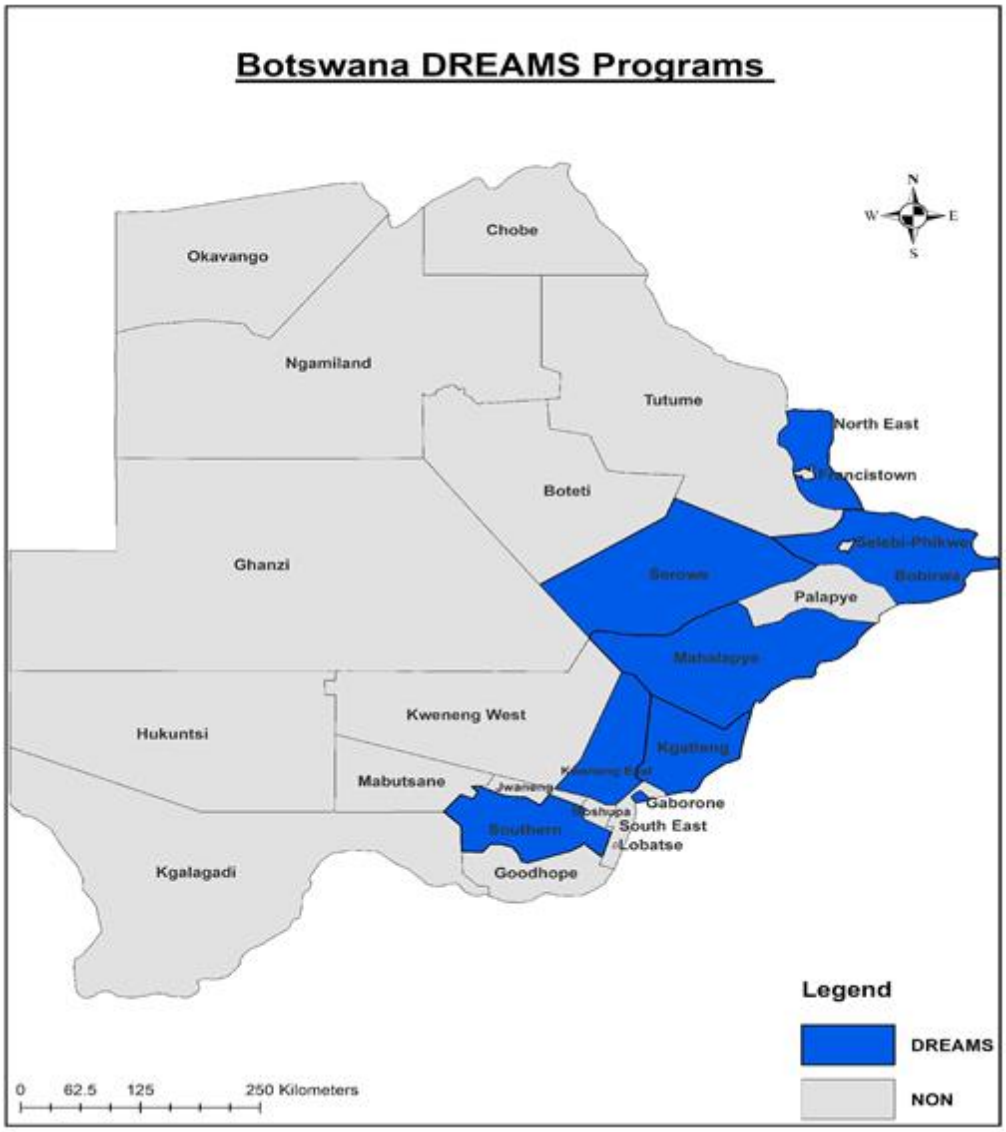
Table 3.1 Current Status of ART saturation				
A. Prioritization Area	***B. Total PLHIV/% of all PLHIV for COP22**	***C. # Current on ART (FY21)**	**D. # of SNU COP21 (FY22)**	**E. # of SNU COP22 (FY23)**
Attained	54%		0	26
Scale-up Saturation	47%	1726	0	1
Scale-up Aggressive	0	0	0	0
Sustained	0%	156272	27	0
Central Support	N/A	N/A	N/A	N/A
* Column B source: COP22 Datapack BQ/BT (TX_CURR FY22 / SubNat TX_CURR FY23) * Column C data source: COP22 Datapack Colum Z				

Following the release of the BAIS V preliminary results PEPFAR/B conducted SNU classification where 26 of the 27 SNUs are classified as attained and one as scale-up saturation. The classification also assessed unmet need by age and sex. The treatment coverage of above 90% is observed for females aged 15 and above, while for males it is observed for those aged 35 years and above. Target setting in the 27 districts for COP22 remains aligned with the Botswana long-term goal of maintaining the epidemic control gains following the release of BAIS V preliminary results. The aim is to reach or exceed 81% coverage across all age/sex bands within each district. To close the treatment gap, the bulk of the targets will be for both male and female pediatrics and males aged 15 to 34 years where a treatment coverage of below 90% is observed.

OVC and AGYW

In COP22, the OVC program will expand to 3 SNUs (1 existing, plus 2 new) that already have a PEPFAR presence and high TX_CURR<15: Selibe-Phikwe and Lobatse. The move is in line with the COP22 guidance which continues to emphasize the need to increase reach for adolescents and children living with HIV (A/CLHIV), offering them enrollment into the OVC program and ultimately providing OVC services to those enrolled. The other OVC sub-populations to be reached include: i) children of HIV positive mothers/caregivers, 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.

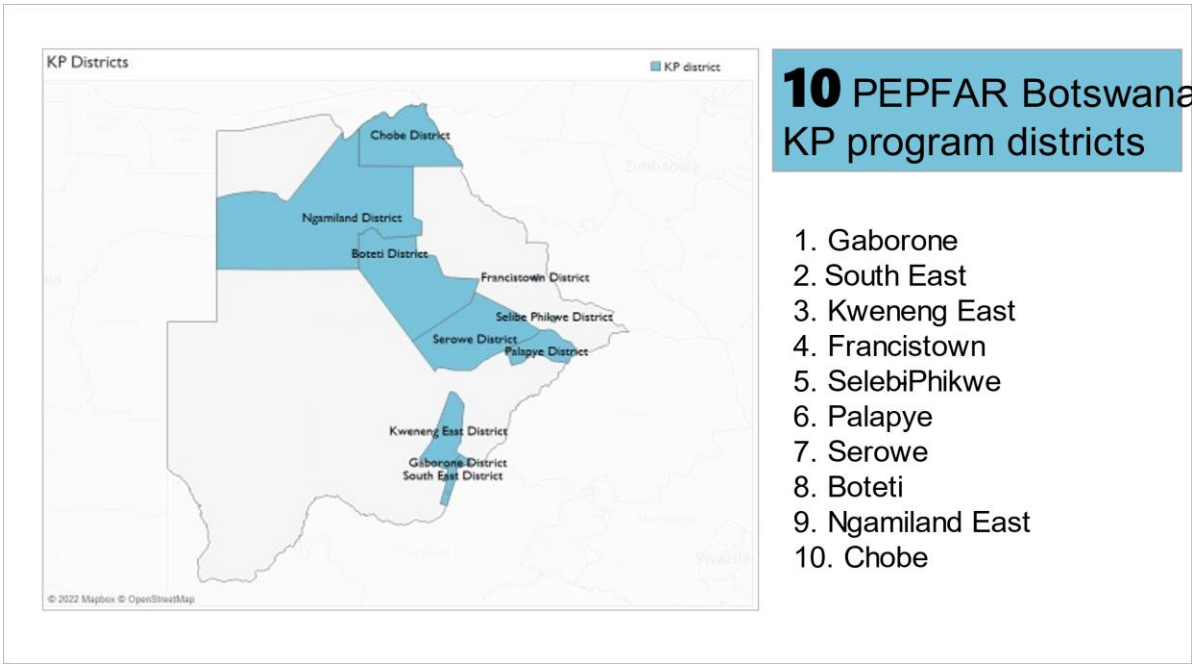


The DREAMS program will continue implementation in the 8 SNUs with interagency collaboration to ensure that the most vulnerable AGYW are reached with age-appropriate interventions as per the eligibility criteria for DREAMS. The DREAMS National Coordination Office continues to work with all IPs to ensure the use of a standardized tool to identify the most vulnerable AGYW and enroll them in the program. This same tool has been customized to the National DREAMS Database (NDDB) used by all IPs implementing DREAMS. Furthermore, the DREAMS Ambassadors work closely with IPs to ensure program visibility at the 8 SNUs as well as provide progress updates at various district structures. Botswana will continue to focus and expand its reach to adolescent girls at highest risk of HIV, AGYW living with disabilities as well as young women selling sex in COP22 due to their high vulnerability to HIV infection. The COP

guidance 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, especially that the school system has introduced measures to reduce the number of learners in the school premises at a time, hence a new way of doing things and engaging beneficiaries. The program will ensure implementation of evidence-based curricula with fidelity and strengthening bi-directional referrals. With the use of the NDDB and continuous capacity building around 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 layering and saturation across the different age-bands in all the SNUs.

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. KP sites rationalization was made in COP21 where for maximization of resource use and avoiding program overlap the country was zoned into PEPFAR/B supported districts and Global Fund supported districts. In COP22, PEPFAR supported districts are Boteti, Chobe, Francistown, Gaborone, Kweneng East, Ngamiland, Palapye, Serowe, Selibe-Phikwe, and South East.



In COP22 PEPFAR devised a new strategic framework that looks at: agency comparative advantage, removing competition, ensuring collaboration, aligning with GOB, and doing no harm. In the new framework, USAID will support direct service delivery for KPs using an NGO/CSO service delivery model. In COP22, KPs services in public health facilities will be supported by USAID and CDC in the ten PEPFAR districts. To enhance coordination and bi-directional referral, there will be district and national coordination forums where IPs, MoHW and Global Fund representatives will meet on regular basis. They meetings will be used 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.

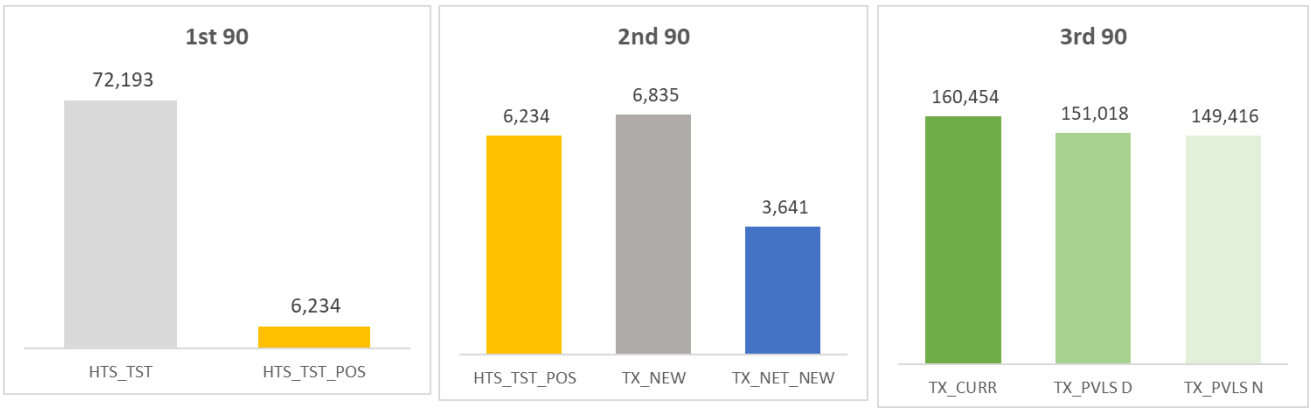
The KP program will target female sex workers (FSW), men who have sex with men (MSM), and transgender (TG) individuals, with structural interventions and prevention, care, and treatment services. Access and availability of comprehensive KP services will be enhanced by developing and implementing a sustainable, evidence based and competent KP service delivery framework in public health facilities. The program will also focus on other priority groups associated with KPs, such as social and sexual partners, clients, and/or children of and/or living with key populations, among others. Young Sex workers who sell sex in DREAMS intervention districts will be recruited into DREAMS to benefit from among other services, economic empowerment. 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.

Reproductive Health services will be provided either directly or through referrals. Cervical cancer and STI screening and management services will be offered. Other health services to be provided will include TB preventative services as well as TB treatment. As part of the structural interventions, screening for Gender Based Violence for all KP will be done before initiation into PrEP and as part of active patient notification and index testing. Post GBV support and services will be provided.

Where applicable, children of key population will be referred to the OVC program.

4.0 Person-centered Program Activities for Epidemic Control

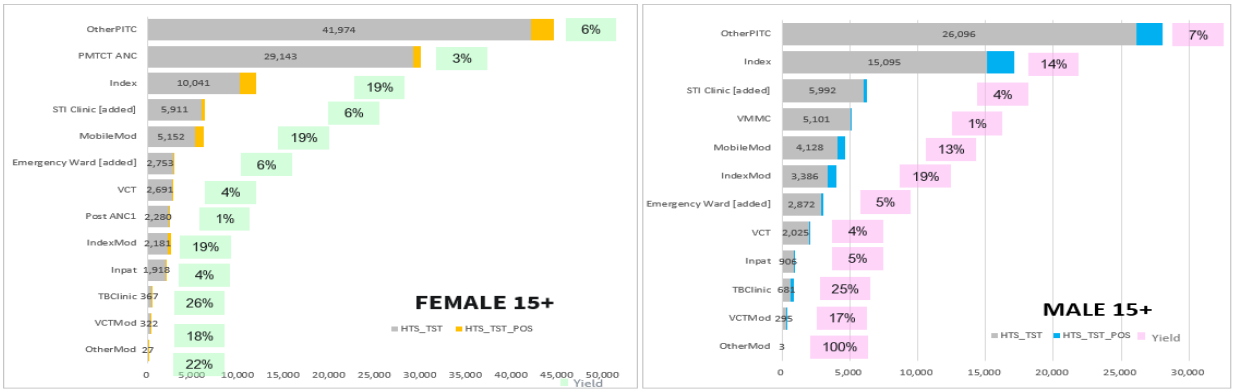
Figure 4.0.1 Overview of 95/95/95 Cascade, FY21



Source: This visual comes from the clinical cascade, single OU dossier, overall cascade page. Botswana.

4.1 Finding people with undiagnosed HIV and getting them started on treatment

Figures 4.1.1/4.1.2 Testing Volume and Yield by Modality and Age/Gender, FY21

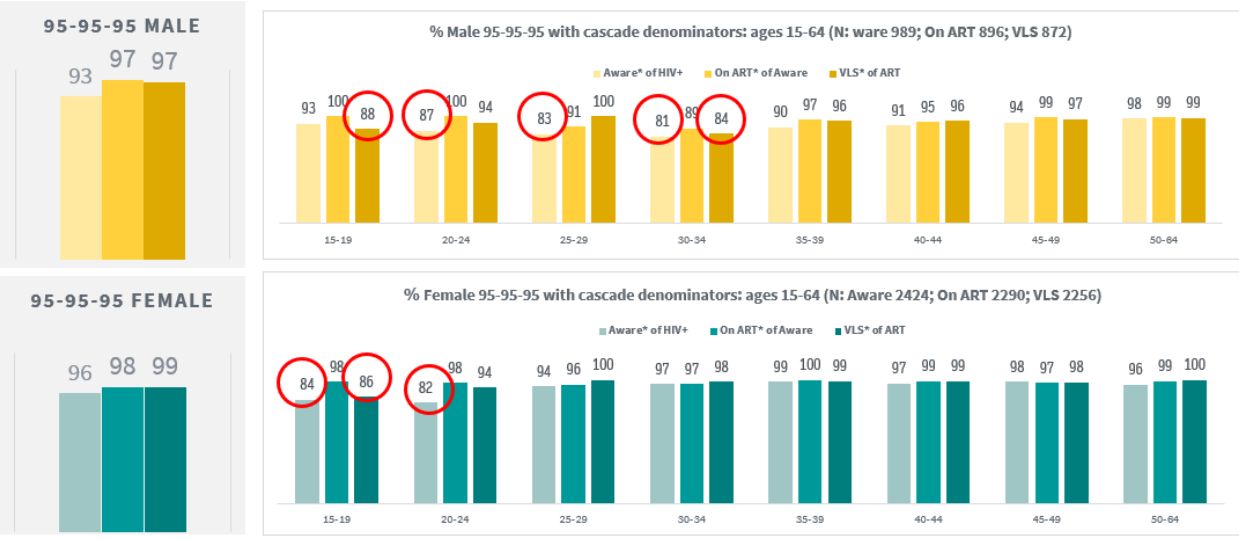


In the previous COP, PEPFAR/B shifted to a highly targeted case-finding approach for overall HIV testing, utilizing active partner notification services to reach all exposed contacts (sexual partners and biological children) of all newly diagnosed PLHIV. Botswana has adopted active partner notification, and training of providers has been conducted in PEPFAR supported districts which make up 16 of the 27 health districts in Botswana. In FY22, index testing was scaled up for all newly identified PLHIV, and adults and children identified as unsuppressed through viral load chart reviews were considered index clients and prioritized index services. HIV self-testing (HIVST) was leveraged to expand partner notification reach and HTS services to priority populations with the most significant gaps, including men, AGYW and KPs.

COP21 funds were also directed to support two other case-finding modalities, including testing at ANC and TB clinics while testing for prevention for Circumcision, VMMC and DREAMS programs was also supported. In contrast among KPs, VCT modality, social network and index testing were essential modalities. Implementing case-based surveillance, including recency, was supported to monitor further and characterize newly identified positives to optimize case findings. Figure 4.1.2 above on case finding results by modality and yield for FY22Q1 show that Other PITC, index testing PMTCT/ANC and mobile testing for KPs successfully found HIV positives for females and males. The highest yielding modalities for FY22Q1 among the general population for both females and males are index and TB clinic. At the same time, for KPs, the most yielding modalities included mobile testing and VCT implemented at the different drop-in centers.

Botswana is a country approaching equitable epidemic control, requiring the HTS program to reach, test, and identify the remaining undiagnosed PLHIV if the country is to close the remaining gap in the UNAIDS's 95–95–95 targets. Through community and facility approaches, PEPFAR/Botswana's overall goal is to provide person-centered, equitable, quality, safe and ethical HIV testing services while also ensuring effective linkage of all those newly diagnosed positives to treatment and the high-risk negatives to prevention services. The overall goal is to provide recency testing to all eligible PLHIV, including KPs. Based on the preliminary BAIS V data, Botswana has met the UNAIDS' 95-95-95 treatment targets for age groups 35-65, with gaps still existing among young males aged 15-34 years and children under 15 years (see Figure 4.1.3 below).

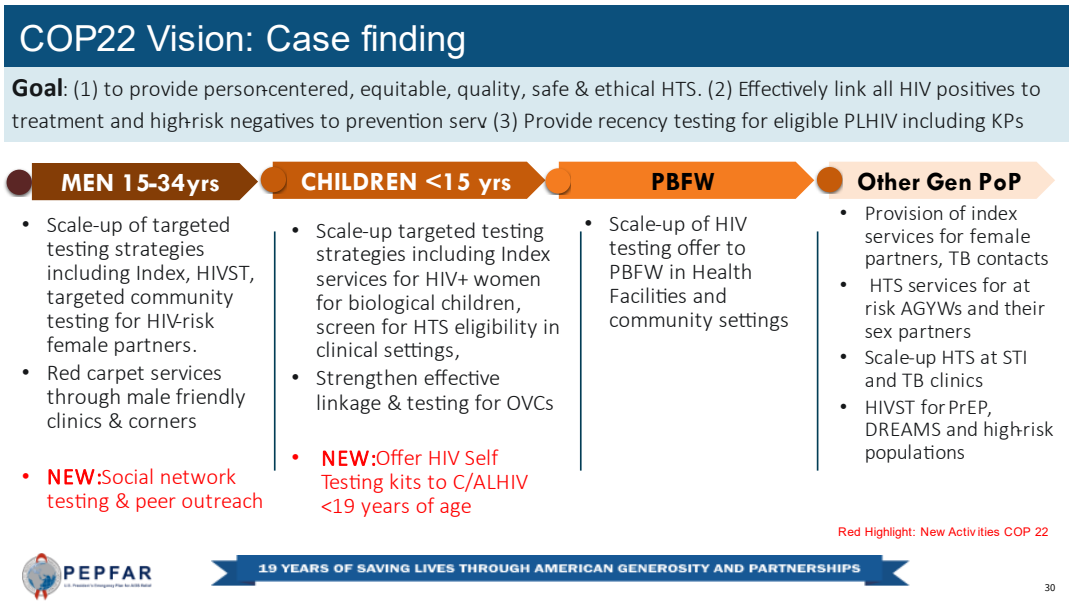
Figure 4.1.3: BAIS V: Progress towards 95-95-95



- This report is based on preliminary data which is subject to change, and is not for distribution.

PEPFAR/Botswana's COP22 HTS priority strategies are targeted at closing the remaining gap among men 15-34 years and children <15 years by optimizing facility and community case-finding by 1) continuing scaling up of index and HIVST, 2) adapting social network testing, 3) scale-up peer network outreach testing, 4) refining pediatric case-finding strategy, 5) continuing testing for prevention interventions (targeting at-risk AGYW, PrEP, DREAMS, VMMC), 6) providing HIV testing services for KPs in the community, government facilities and NGO clinics, 7) continuing with scale-up of recency testing to all eligible newly identified PLHIV. Figure 4.1.4 summarizes the COP22 HIV case finding vision and finding strategies by priority populations.

Figure 4.1.4 COP22 Case finding vision and strategies by priority populations



4.1.1: Overall COP22 Case finding Vision and strategies

The overall case finding goal for COP22 is: 1) to provide person-centered, equitable, quality, safe & ethical HTS; 2) ensure effective linkage of all HIV positives to treatment and high-risk negatives to prevention services and 3) provide recency testing for eligible PLHIV including KPs. The main priority strategies include scaling-up index and HIV self-testing, social network testing, peer network outreach to target men 15-34 years of age while, interventions for pediatric case finding will also be implemented.

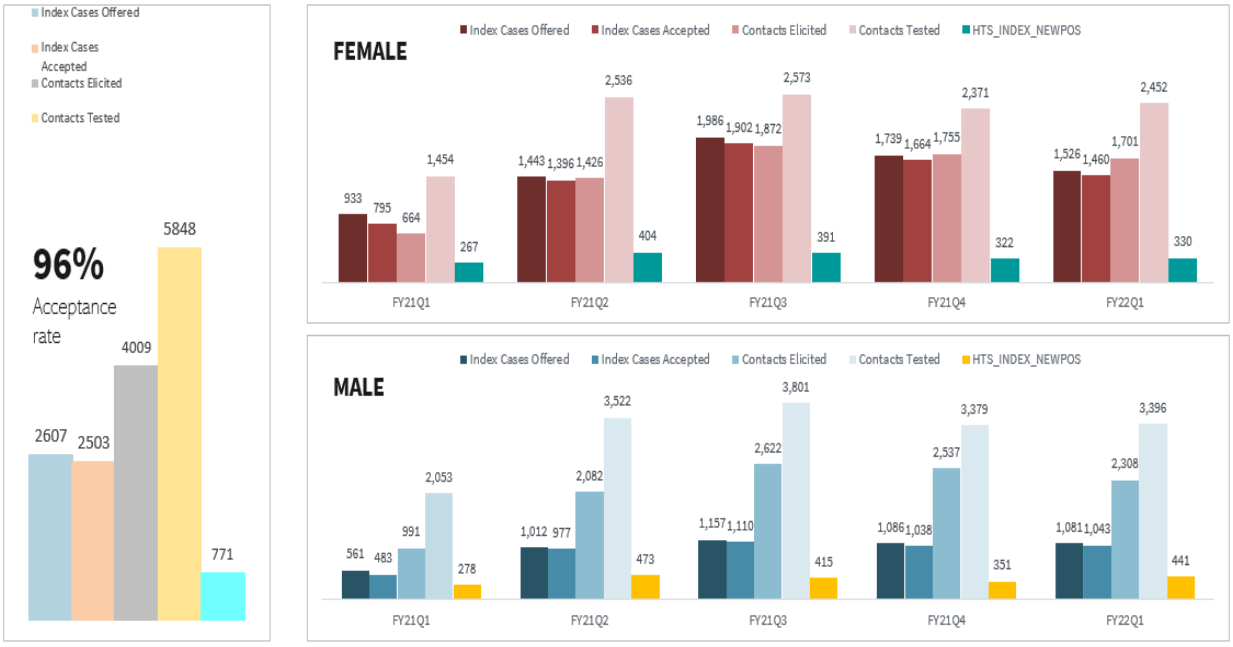
4.1.1.1 Case finding strategies for men 15-34 years

The MoHW began the rollout of a comprehensive strategy for a phased index testing provider training and implementation at high burden PEPFAR supported districts in COP21. Through COP22 plans, PEPFAR/B intends to support the continued rollout of this strategy to the remaining districts. The overall strategy involves training providers in complying with the new voluntary active partner notification standard operating procedure (SOPs) that emphasizes the need for adherence to WHO's 5Cs, intimate partner violence screening and adverse events monitoring. The SOP emphasizes that no index contacts are to be contacted when intimate partner violence (IPV) is detected.

Scaling-up index testing to reach men:

Utilizing Antenatal Care (ANC/PMTCT) 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. Index testing is crucial for reaching undiagnosed men who would otherwise not access services (see Figure 4.1.5 below). In COP22, PEPFAR/B plans to scale-up coverage of safe and ethical index testing (100% offer of index testing) to all HIV positive pregnant women to reach their male counterparts through partner notification services in facility and community settings. 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 without any impact on the services they receive. 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). Technical assistance for MoHW to ensure Index partner testing training, use of standardized registers, and IPV screening tools will be scaled-up to facility and community platforms to ultimately achieve national rollout.

Figure 4.1.5: FY21-FY22Q1 Quarterly Index testing Cascade



Review of Viral Load data to identify unsuppressed PLHIV to generate index clients: All unsuppressed PLHIV including HIV positive women already on ART and children identified as unsuppressed through viral load review will be considered index clients and offered partner notification services.

Elicitation through other testing points: the program will continue to elicit partners of newly identified positives identified through the standard of care diagnostic testing in sexually transmitted infections (STI) clinics and other testing points, including community index, family planning, and inpatient.

Targeted community testing for men and AGYW: to maximize impact, community-based testing would be highly targeted and focused on reaching men, KPs and their partners, young people and other vulnerable populations who may be less likely to be seen or tested in facilities and would be limited to high-burden geographic areas or non-facility locations (e.g., bars, clubs, places of worship, workplaces, or mobile outreach).

PEPFAR/B will explore adapting social network-based approaches for reaching men and KPs by working with high-risk groups to recruit others in their social network and drug using partners for HIV testing, voluntary and implemented only with the client's consent and contacts. This novel strategy will create a refined, targeted, and focused approach for high-risk populations who may not be willing to test, especially youth and male networks. Also included are the secondary distribution of HIVST kits to partners, social contacts, and innovative technologies (e.g., social media, messaging, and online platforms) to reach social networks.

Testing of patients with TB symptoms as a strategy for reaching men
Presumptive TB identification is significantly higher in men than women, reinforcing this strategy's value for identifying men. All patients presenting at TB clinics will be tested for TB and offered HTS with a voluntary assisted partner notification as a strategy to reach men.

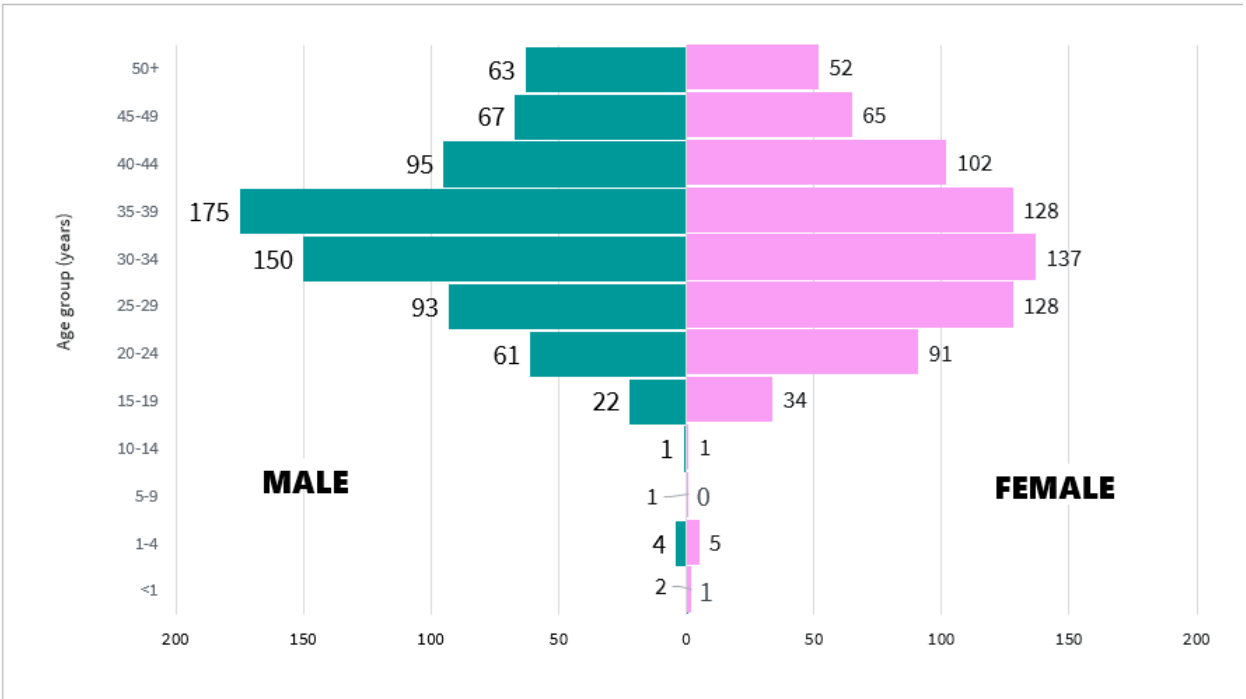
Scaling up HIV self-testing: (HIVST)
In addition to index partner testing services, the MoHW is committed to scaling up HIV self-testing as a strategy for hard-to-reach at-risk populations, including men not accessing services. HIVST would be an effective tool for expanding access to individuals at risk who may not otherwise test and individuals at ongoing risk who may need to test more frequently. This may include underreached and underserved individuals, including men and youth. During COP21, especially during COVID-19 restrictions, HIVST were acceptable and feasible in a variety of settings and populations, with no potential nor documented social harms and misuse. HIVST has demonstrated effectiveness in reaching individuals who might not otherwise test. The MoHW and CSOs will continue to provision of HIVST in conjunction with active partner notification and screening for high-risk populations. Those confirmed as HIV positive will be actively linked, initiated on treatment, and provided ongoing support for adherence.

Pregnant and breastfeeding women (PBFW) are at a 3-4 times higher risk of acquiring HIV infections when compared to their non-pregnant counterparts. PEPFAR/B will continue to support index elicitation and testing of men whose HIV positive female partners are pregnant or breastfeeding, 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. Women presenting at health facilities for TB treatment will also be leveraged to reach their male sex partners through HIVST.

4.1.1.2 Reaching children < 15 years

Case finding among children and adolescents remains low in both age and sex (refer to Figure 4.1.6 below). PEPFAR/B team will refine the current pediatric Case finding strategy to prioritize the following

Figure 4.1.6: FY22 Q1 HTS_POS Pyramid by Age & Sex



Scale-up review of care and treatment records:

- Targeted support will be provided to review care and treatment patient records to identify children <15 years who have not been tested in districts with the highest treatment gap. COP22 funds will support activities that ensure children's tracking, tracing, and testing. Known positives currently not in treatment will be linked to rapid treatment initiation.

Index services for children

- All children with an HIV positive biological parent will be offered HIV testing.
- Collaboration with OVC program: 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.

HIV self-testing for children <15 years:

In Botswana, the age for consenting to access HIV testing without parental or guardian consent is 16 years. However, emancipated minors below the age of 16 years, including those presenting at youth-friendly facilities, drop-in centers with signs of illegal abortion or pregnancy, repeated STIs, and those involved in sex work can consent and access services independently. COP22 plan prioritizes issuing self-test kits to these emancipated minors.

4.1.1.3 Other general population testing

In COP22, PEPFAR/B will also support additional general population case finding interventions to expand access to priority sub-populations with ongoing risk who may not be reached through

targeted approaches suggested in sections 4.1.1 and 4.1.2 above. COP22 PEPFAR/B case finding priorities for the general population include a) offering index testing b) secondary distribution of HIV self-test kits to reach sex partners of male clients, c) HTS for AGYW and their sex partners and d) conducting recency testing for all eligible newly diagnosed PLHIV. Below is a detailed description of the proposed case finding strategies.

Offering index services to female sex partners, including at TB clinics

All newly diagnosed, virologically unsuppressed men and those identified through TB will be used to generate index clients. HIV testing of TB clients identifies a higher proportion of men compared to their female counterparts. PEPFAR funds will support partner elicitation among all HIV positive men to access their female counterparts for testing. Women will also be reached through all newly identified men from other modalities.

Utilization of HIVST to complement voluntary Active Partner Notification services

HIVST kits will be distributed to adult men who choose to bring the HIVST kit home for their partners to self-screen. Men presenting for TB treatment in facilities and community settings will also be leveraged to reach their female sex partners through HIVST.

HTS for AGYW and their sex partners

Adolescent girls and young women (AGYW) ages 15-24 years are disproportionately affected by HIV/AIDS. PEPFAR/B will, through an expanded and enhanced prevention package delivered through community and facility approaches and peer interventions, expand HIV testing referrals. Reaching diverse male sexual partners of AGYW with HIV services will be supported through an enhanced focus on increased enrolment on PrEP, index elicitation and issuing HIV self-test kits for secondary distribution.

Conducting recency testing for all newly diagnosed PLHIV

In line with COP22 PLL and MoHW strategic plan, recency testing will be offered to all newly diagnosed HIV individuals aged 16 years and older who consent to the test (see 4.1.5 below for a detailed description of the PEPFAR/B recency implementation plan)

4.1.1.4 HTS for prevention monitoring

HIV testing services (HTS) directly contribute to HIV prevention outcomes when individuals with a seronegative HIV status are offered appropriate HIV prevention services and linking those who test HIV negative to person-centered prevention services is essential. HTS can also be a valuable tool to monitor and refine prevention programming. The following are priorities for HTS prevention:

Testing Pregnant and Breastfeeding women (PBFW)
Pregnant and breastfeeding women (PBFW) are at a 3-4 times higher risk of acquiring HIV infections when compared to their non-pregnant counterparts. PEPFAR will continue to ensure all pregnant women are tested at their antenatal clinic visits. Maternal re-testing will also be

supported, especially for high-risk postpartum mothers who previously tested HIV negative, including among key populations.

Testing for PrEP
In Botswana, testing is provided as part of a package for PrEP enrollment to ensure HIV negative status. MoHW guidelines require HIV testing for at-risk patients enrolled on PrEP every three months.

Testing for Orphans and Vulnerable Children (OVC)
OVC program beneficiaries will continue to be routinely assessed for the need for HIV testing and those with a need for testing linked to an HIV testing site.

Testing for DREAMS
In Botswana, HIV testing is not a requirement for DREAMS enrollment in the program. However, at-risk and vulnerable AGYW are linked to HTS services.

Testing for VMMC
HIV testing is not a prerequisite for accessing VMMC services. However, clients accessing services are assessed and offered HTS based on individual clients' risk behaviors with immediate linkage to prevention services (including PrEP), for high-risk individuals who are HIV seronegative, while those diagnosed HIV positive are actively linked to same-day treatment.

4.1.1.5 Recency testing

Recency testing data provides one source of information to identify potential hotspots of ongoing HIV transmission that may signal a greater need for prevention activities. In COP22, and as specified in the Botswana Planning Level Letter (PLL), it is required to have recency testing at scale across all PEPFAR-supported sites. This is for all newly diagnosed HIV individuals aged 16 years and older who consent to the test. Based on preliminary BIAS V data, (ARV unadjusted) Botswana has met the last two UNAIDS's 95-95-95 treatment targets. As the country closes the remaining gaps in the 1st 95 gaps and nears epidemic control, recency testing will be rolled out using the approved protocol on a phased approach 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 surveillance will provide essential information about new HIV diagnosis, new infections, and ongoing HIV transmission, and can be used to tailor HIV testing strategies and target effective treatment and prevention interventions, including PrEP. Additionally, triangulating data from other sources such as program data will enhance the ability of the program to detect ongoing transmission and gaps in the clinical cascade and target the response. Technical assistance will be leveraged to ensure the rollout of training and mentorship, with results used to inform prioritization and mapping of transmission hotspots, targeting prevention and treatment services to disrupt further transmission. In COP22, recency testing will be scaled up from the current 10 to additional PEPFAR supported sites. The approach is to offer recency to newly diagnosed HIV individuals aged 16 years and older who consent to the test. A public health response framework that leverages recency testing (including identification and response to recent HIV clusters) and informs programming will be developed and implemented.

4.1.1.6 Case Finding among Key Populations

Botswana is planning a third national Integrated Biological and Behavioral Survey (IBBSS) for KPs to provide up-to-date estimates on HIV prevalence and progress toward 95-95-95 targets among KPs. The survey design process has begun, and data collection will be in COP22. The BBSS III will follow a key population size estimation survey to determine locations with the highest estimates of key populations.

The 2017 BBSS indicated that only 51.6% of FSW knew their while 69.7% on MSM knew their HIV status. Treatment coverage among FSW was 87.6% while among MSM it was 73.5%. PEPFAR program data for FY20 shows that Viral Coverage for key populations was only 86% compared to 98% of the general population (BAIS V).

Based on 2017 BBSS the gap to reaching 95:95:95 among key Populations is large. Comparing FSW to women in general population, FSW are at 52:88:86 (BBSS 2017 and PEPFAR FY20 Annual report) while women in the general population are at 95:99:99 (BAIS V) Based on the 2017 BBSS, the gap to reaching 95-95-95 among KPs is large.

To enhance case findings for FSW and MSM, PEPFAR/B will refine the mobilization and recruitment strategy for individuals to be targeted with HTS. In collaboration with MoHW, and using a clinical mentorship approach, KP programming will also be provided in public health facilities, following the capacity strengthening of implementers to provide KP-competent services. In COP22, KP specific high yielding HTS interventions for prioritization will build on current activities supported through Tebelopele Wellness Centers to expand public health facilities' services. PEPFAR/B will:

- Expand the Enhanced Peer Outreach Approach (EPOA) to engage individuals at high risk or those living with HIV to recruit members of their social and risk network for HTSS. EPOA includes performance-based incentives that provide peers with increasing benefits to achieving measurable service benchmarks and coupons to track referrals, testing and linkage to treatment.
- Continue to implement HIVST delivered through both assisted and unassisted models with implementing partners directed to report any instances of any adverse event associated with HIVST, e.g., self-harm of a reactive HIV self-test. HIVST will help overcome stigma, discrimination, and fear of loss of confidentiality among KPs. The program will also engage the KP community on HTS and introduce testing for triage using self-test kits. Key populations in a high-risk setting, for example, those selling sex in a brothel, are at elevated HIV risk and will be provided HIVST. 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.
- Enhance the use of Information Communication Technology (ICT) to engage and recruit the online population of KP. The KnowNow virtual platform will be officially launched with great publicity to increase client flow to this virtual platform.
- Expand social networks through screening and index testing for all eligible KPs.

- Support competency training for providers to ensure that HIV testing strategies align with WHO and MoHW standards of 5Cs, monitoring of intimate partner violence screening, adverse event monitoring, and ensuring the safety and security of KPs.
- Implement peer navigation to optimize service provision across the cascade.

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 the 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 NGO clinics, private practitioners, or government facilities. In COP22, PEPFAR/B has planned to build the capacity of KP interventions implementation to add to the differentiated models of service delivery for virtual outreach. Virtual outreach is a modality used to reach KPs who would otherwise not present to the facilities. These are classified as smart sellers (high-end sex workers) and older MSM who are professional.

In COP22, priority will be given to targeted mobile outreach strategies at hot spots. Index testing among regular partners of MSM will be rolled out with specific consideration and monitoring of IPV. The use of HIVST will enhance the reach of index testing to KP partners who still wish to remain anonymous. Using the blended index and social network testing, the program will ramp up testing and link children of FSWs to services. Biological children of KPs will be elicited and referred to the OVC partners for continued support.

The KP HTS program will conduct acceleration activities in all KP districts in the hotspots that have become active after the COVID-19 restrictions were eased. 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. In FY22, the project penetrated a new network of Transgender (TG) people in Chobe. Transgender services will be expanded in COP22 OP through targeted messaging and snowballing to identify new transgender networks.

There will be follow-up on all service providers that offer index testing to ensure that ethical testing conforms to the 5Cs and is maintained. All providers will be trained on Partner Notification Services.

4.2 Ensuring viral suppression and ART continuity

Following the BIAS V announcement of treatment coverage at 98% of all aware of their status, the COP22 interventions will be focused on sustaining the high ART initiation and retention on treatment. The MoHW has adopted rapid ART initiation as part of the MPRs, 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 sustaining the second and third 95 goals.

Immediate ART initiation and overall LTT has been steadily increasing. In FY22 Q1, the overall LTT stood at 114% for the ages 15+ and 113% for the under 15, indicating high linkage rates. Same Day (SD) initiation rate were at 76% for PEPFAR sites, and at a low of 49% nationally in FY22 Q1. In COP22, PEPFAR/B will implement clinical mentorship, including use of extended

hours and weekend ART services in facilities mostly using TA approach and minimal DSD to address gaps for both adults, pediatric and adolescents to ensure that patients who have a positive HIV test result have access to immediate ART initiation. /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. 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.

For COP22 PEPFAR/B will continue to support the GOB accredited Wellness centers as a complementary alternative to government health facilities, to enable reaching patients who will not access traditional health facilities. Through the Wellness centers, person-centered comprehensive services are 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 centers introduced men and adolescent-friendly corners, an innovation that offers a great opportunity to serve hard to reach populations and ensure adherence. To expand services to the hard-to-reach populations, especially men, PEPFAR/B will continue to implement community ART initiation through the wellness center’s mobile outreaches.

As described in Section 1, PEPFAR will continue to fund the general population and KPs in TWCs in COP22. However, based on the community/clinical realignment, after COP22 PEPFAR will only provide funding for KP services in TWCs. 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 community-based cadres for follow-up. Community IPs will support facility IPs to track and link to treatment both prospective clients who tested positive at the facilities but do not link to treatment within 3 days and treatment interrupters. PEPFAR/B will continue to track reasons for defaulting to be able to minimize these numbers.

The following good practices will be implemented to optimize LTT at community and facility level:

- 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
- 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 person-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 peds, AGYW, and men.

- Use of virtual platforms for service delivery when physical contacts with providers are not possible for clients to prevent disruption of services

Given that Botswana is near epidemic control and COP22 guidance to pivot from scaling up to closing gaps, PEPFAR/B will implement an integrated clinical mentorship and CQI program and support sites to mitigate challenges across the continuum of care. Sites with poorer linkages, higher IIT rates, lower viral load coverage or high viral loads will be prioritized for enhanced mentorship support and tailor-made CQI interventions. The clinical mentorship will build on the MoHW-HIV division led mentorship model implemented through the Kitso Training unit and will be enhanced to anchor supportive supervision and continuous quality improvement as cornerstones to strengthen the capacity of public health facilities to continuously optimize implementation of MPRs across all ages and gender, more specifically MMD and other person-centered interventions as they enhance adherence and retention. While 3-month MMD rates significantly improved from 3% in FY20Q1 to 48% in FY22Q1, MMD among pediatrics and adolescents remains suboptimal and will be addressed through use of clinical mentors, training more HIV specialists to address MMD related gaps in this population. Data documented in PEPFAR panorama shows 3-6MMD month is higher among the adult population for both males and females at 52% and 55% respectively and lower for pediatric clients at 35% for males and 38% for females.

In COP21, PEPFAR/ B through the IPs started work with facility and community IPs to strengthen the community-facility interface to optimize client's continuity in care through developing SOPs that enables referral of clients between the facility and community IPs. The SOPs clearly outlines the key roles at facility and community levels, the client handover timelines, joint meetings to monitor progress and CQI activities to ensure optimized interface. PEPFAR/B will continue granular site support targeting sites with gaps.

Continuation of the case management approach using expert clients and community-based cadres to support continuity in treatment and remediation measures initiated in sites with noted gaps will be the focus. Compliance with the use of the MoHW follow up registers for missed appointments and interruption in treatment, and peer support groups for adherence to treatment for all age and sex bands, will be enhanced through the district mentors who will in turn be supported through a national level mentorship and supervision structure. PLHIV that interrupt treatment are at high risk for virologic failure and poses 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, treatment interrupters, clients with a detectable viral load, pregnant women, TB/HIV co-infected, and those with other opportunistic infections.

At community level the clients are supported with minimum 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. Novel tele-mentorship approaches such as virtual platforms will be used to provide the needed clinical mentorship support in order to ensure a person-centered approach to retention, PEPFAR/B will further intensify TA to dispensing units to better measure the uptake of MMD.

In COP22, mentoring of pharmacy staff on utilizing the pharmacy appointment modules on Patient Information Management System (PIMS) and Integrated Patient Management System (IPMS) will be optimized in Non-PEPFAR sites within the supported districts. Sustaining of improved retention rates will also be realized through continued engagement of expert clients and community cadres at national, facility and community levels using peer support and stigma reduction messaging. Peer support and feedback from community led monitoring 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.

Quality improvement

CQI teams will be supported to assess sites for client-centeredness as well as whether they are men- and youth -friendly. The CQI teams will also be used to identify any performance issues that need some course corrections and change ideas will be introduced as needed to improve and sustain good performance. Working with the DHMTs, implementing partners and the community led monitoring partners, 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.

Multi-Month Dispensing (MMD) and Decentralized Drug Distribution (DDD)

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 health education assistants (HEAs) community health workers, and expert clients for tracing at household level with provision of feedback to clinicians for coordinated proactive monitoring and support. PEPFAR/B will continue to scale up technical assistance and mentorship 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 treatment literacy programs as part of the MPRs 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. More nurse prescribers and dispensers will be trained through the Kitso training unit 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. PLHIV that interrupt treatment are likely to fail virologically and pose a risk of continued HIV transmission. The BAIS V preliminary report and PEPFAR COP22 priority areas have

highlighted gaps in HIV case-finding, linkage, treatment, and viral load coverage/suppression for pediatric and adolescent people living with HIV. In COP22 the pediatric and adolescent HIV care programming will be prioritized and given added support to ensure that the OU strategically addresses the pediatric and adolescent HIV care gaps. By the end of FY21, Q1 51/71 PEPFAR/B sites had fully transitioned their pediatric patients to DTG-based regimen and efforts will continue to be made to ensure full optimization of this group as this will significantly contribute to this age cohort achieving optimal viral suppression. This gap will be closed through strategies such as the provision of high quality pediatric and adolescent care through a clinical mentoring at facility level, continuous trainings on pediatric HIV care packages and monitoring of HCWs as well as implementation of CQI to address the observed gaps in pediatric clinical care.

Additionally, strategies will be put in place to support and strengthen screening and provision of advanced HIV disease care management in pediatrics and adolescents through establishing district level clinical mentors to ensure sustainability of high-quality pediatric and adolescent services in all ART PEPFAR/B sites in Botswana. In this way mentored pediatric case management within facility and at community level will ensure person-centered care to children living with HIV and their families. Additional strategies will include use of clinical virtual platforms for advanced HIV disease care and pediatric and adolescents care packages trainings using virtual platform linking specialists support provided by the mentors to mentees in different geographical locations. The virtual platform will further support post training mentoring and will also be used for pediatric and adolescents clinical case management reviews with district mentors and mentees.

With a higher TX_IIT than TX_RTT observed in FY21, Q1 the OU will work on optimizing case management both within the facility and community to account for all children who interrupted treatment. This will be achieved through augmenting the current community-facility case management tracking activities with the clinical mentorship interventions specific to pediatrics at district level and such activities include: strengthen the existing package of services through continuous monitoring and feedback to the multidisciplinary team providing services to the children and adolescents living with HIV, linkage with the OVC program will also be optimized to ensure that children and their caregivers gain from the OVC service package. MMD 3 – 6 months prescription increased from 32% at FY21, Q1 to 61% at FY22, Q1 showing relatively good uptake which will be sustained going into COP22 through ongoing discussions in rolling out <3months MMD to other SNUs and its adoption in the current clinical guidelines. To further strengthen pediatric and adolescent patients' retention on ART, the OU will leverage the community-facility case management as well as referrals to the OVC for targeted interventions:

- Strengthen LTT and same day initiations through leveraging on the existing adult weekend and afterhours services to target enrolment for pediatrics on ART.
- Extend Facility fast track refills and appointment systems to times convenient for school going children and adolescents.
- Facilitate referral of all pediatric and adolescent patients living with HIV to the OVC program to optimize support across their treatment cascade.
- This should include incorporating findings from community-led monitoring and any relevant quality improvement and/or assurance efforts.

Figure 4.2.1 TX CURR Duration by Trends

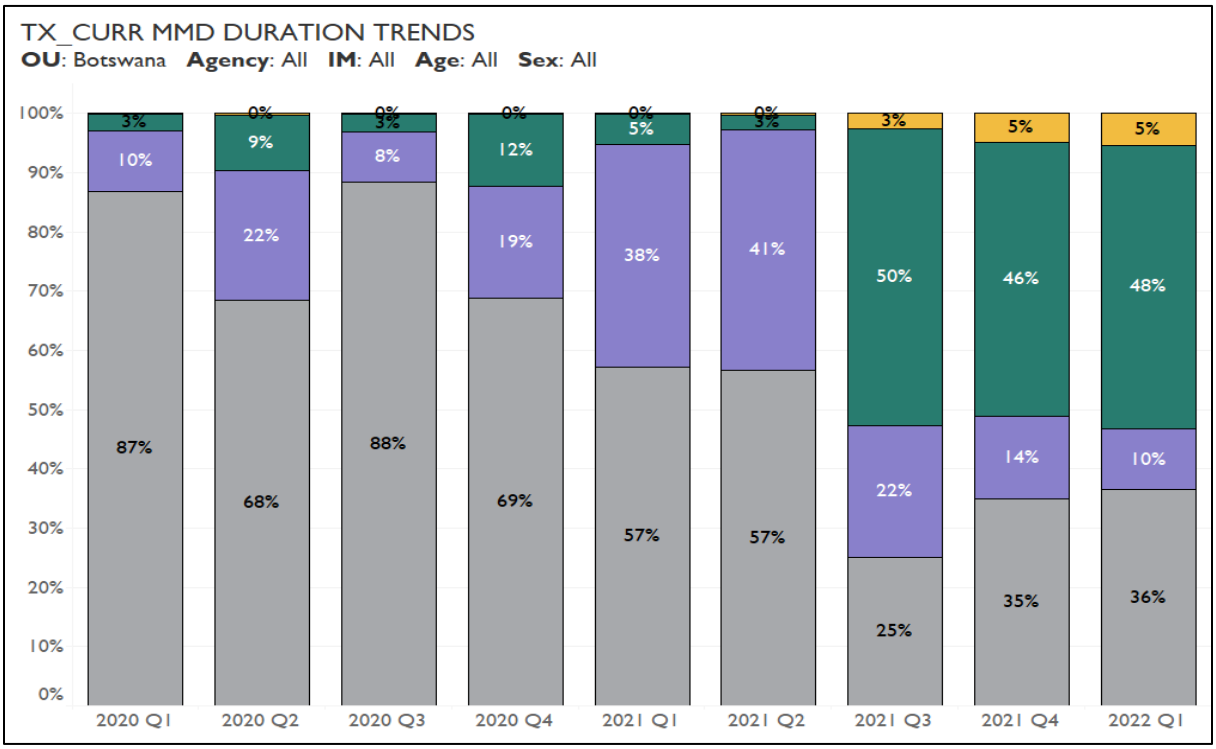


Figure 4.2.2 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, FY21

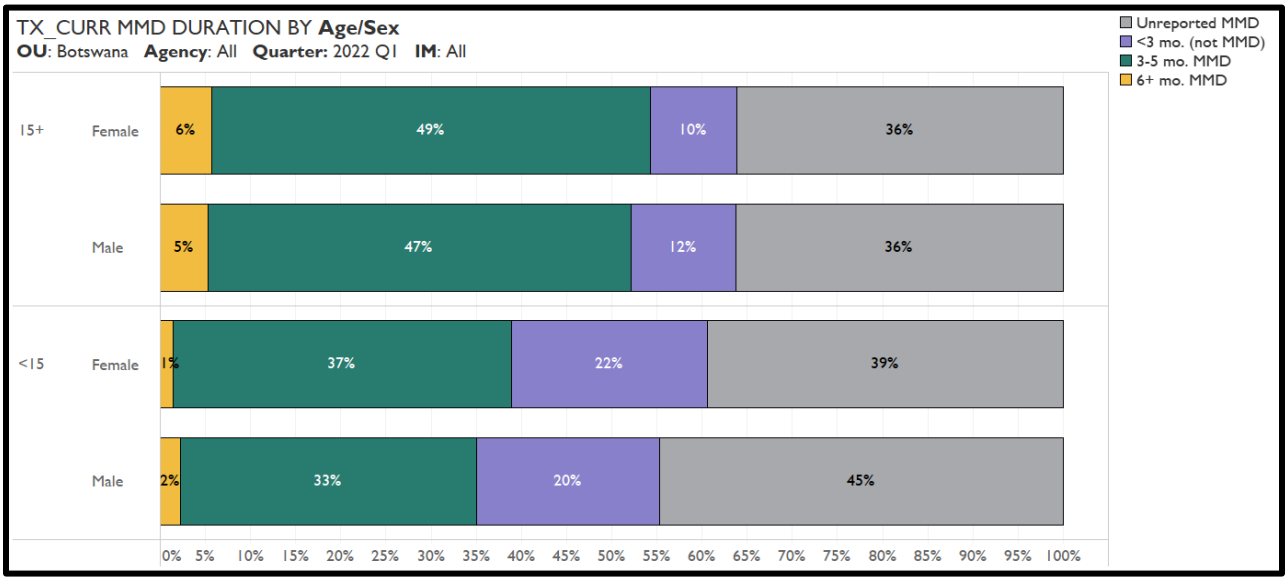
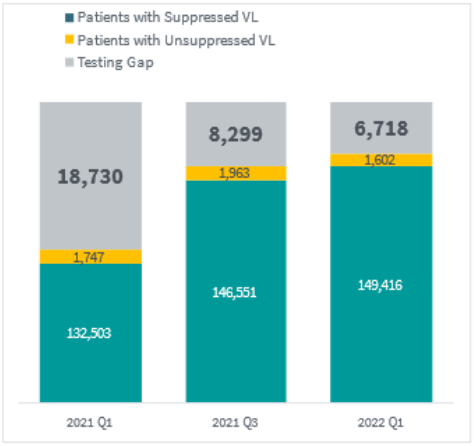


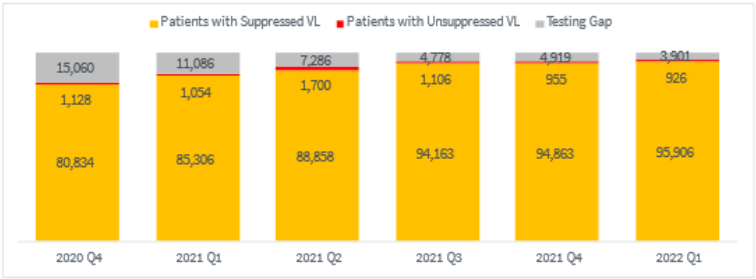
Figure 4.2.2 Viral Load Outcomes, FY22

Context
Lifting of testing and increased client follow up (QIPs) led to reduction in the testing.

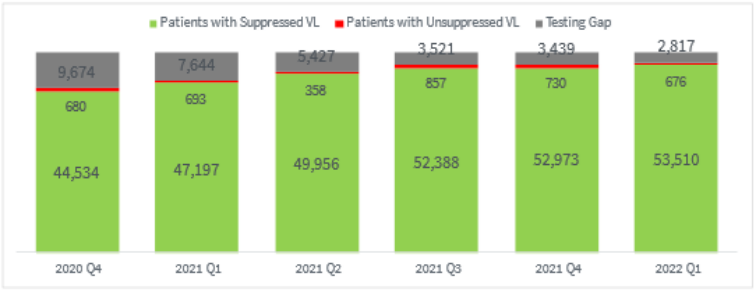


Source: Testing Dossier Panorama

FEMALE



MALE



Monitoring Community Work through Custom Indicators

The community service delivery program is designed to link and keep people on lifelong ARVs. Most of the work will be at community level, providing person-centered care services so that the clients are supported where they are with what they need, and ensuring strengthened community/facility linkage across the different areas of the HIV spectrum. Most of the targets associated with community health work are monitored using custom indicators which do not appear in PEPFAR's systems of records such as the data-pack and DATIM.

Custom indicator reference sheets for the custom indicators have been cleared by the inter-agency and finalized. Custom indicators are documented in the partner's Performance Monitoring Plan (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. Results are reported on and analyzed quarterly together with MER indicators.

This enables 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 the table below:

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 community traced in the community and linked to treatment*	Quarterly
TX_NEW _LEG	Treatment	*Number of persons previously diagnosed with HIV (Known/legacy positive) who did not initiate on treatment within 28 days of diagnosis and were referred to community, traced and initiated on treatment*	Quarterly
TX_PVLS_COMM	Viral suppression	*Number of ART clients who are eligible for VL test (missed and reminders) and those with unsuppressed VL tracked by community health workers*	Quarterly
TX_ML_COMM	Treatment	*Number of ART clients who are eligible for VL test (missed and reminders) and those with unsuppressed VL tracked by community health workers*	Quarterly
TX_CURR_COMM REFILL	Treatment	*Number of ART clients receiving their drugs through community home delivery*	Quarterly
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

4.3 Prevention, specifically detailing programs for priority programming

DREAMS:

PEPFAR/B will continue supporting the DREAMS program by identifying the most vulnerable adolescent girls and young women (AGYW) ages 10-24 years through school, clinical and community-based interventions. A person-centered approach will be initiated in all service points to ensure that the most vulnerable are offered appropriate prevention options. In COP22, PEPFAR/B will continue implementing the DREAMS program in 8 SNUs; Gaborone, Kweneng East, Kgatleng, Mahalapye, Southern, Serowe, Bobirwa and Northeast which were all selected based on the number of total PLHIV 15-24 years above 10,000 and incidence amongst adolescents over 0.6.

COP22 Program Shifts and approach to delivering the DREAMS comprehensive services

- Implementation of the Primary interventions using LIFESKILLS+ across the 8 SNUs taking into consideration the transition from CDC.
- Transition 20% of the DREAMS clinical interventions targets (PrEP for AGYW and GEND_GBV) in Gaborone and Kweneng East to CDC.
- Implement community mobilization and norms change through SASA! as well as the Parenting program through Sinovuyo (PINAGARE) in all the 8 SNUs.
- Implementation of the comprehensive economic strengthening interventions using ELA by BRAC in all 8 SNUs.

- Expansion within DREAMS SNUs to cover more facilities
- Maintain implementation of DREAMS in 8 SNUs (facility and primary interventions)
- 40% of community interventions targets will be maintained by CDC whereas 60% will be transitioned to USAID at the start of COP22
- Avail PrEP services to pregnant and breastfeeding AGYW and partners of AGYW
- Continue supporting the Coordination office positions & DREAMS communication

- PC is expecting 8 DREAMS response volunteers to work at the district level supporting DREAMS Ambassadors and IPs.
- Prioritizing all the DREAMS districts except Gaborone.
- Implement School and community-based HIV and sexual violence prevention as well as social asset building (girls 10-24 yrs.) using GRS curriculum.
- Deliver the combination socio-economic approaches through ELA, community mobilization and norms change through SASA!
- Support linkage to clinical services.

In order to leverage on agency competencies and to improve efficiency of the delivery of a comprehensive DREAMS package, the OU has agreed on some key pivots for COP22 implementation. USAID will continue to implement the community program; primary and the contextual interventions across all the 8 SNUs as well as the clinical interventions in 2 SNUs with 20% of the clinical targets transitioned to CDC. CDC will implement the clinical program in all the 8 DREAMS SNUs and transition the primary interventions program to USAID for the 10-19 year olds. The focus for CDC will be on the 20-24yr cohort for HIV and violence and social asset building primary interventions. In addition, the Peace Corps is expecting volunteers to have arrived in COP22 to support the DREAMS Ambassadors and other IPs across the DREAMS districts, for both the community and the clinical programs.

The clinical and community partners will strengthen the referral pathways and improve quality of services offered and ensure that new strategies are utilized to increase enrollment and completion rates. The potential return of Peace Corp volunteers is expected to increase yield in coverage as well as the number of AGYW enrolled in DREAMS and completing the program.

PEPFAR/B will continue to support NAHPA, MoHW and other agencies to strengthen coordination and implementation of DREAMS through the support of the PEPFAR DREAMS Coordinator, the National DREAMS Coordinator, and the inter-agency team. The 8 DREAMS Ambassadors will continue to i) support the program at district level by working with DREAMS implementing

partners, ii) ensure visibility of DREAMS, and iii) engage stakeholders through various forums and share the progress and impact of DREAMS.

Botswana COP21 Layering Table

PEPFAR/B updated the layering table in COP21 to ensure that AGYW are receiving age-appropriate packages of comprehensive services at both community and clinical spaces.

COP21 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 · Basic Economic Strengthening · Social asset building · Condom education & distribution · Screening for HTS eligibility
	Secondary Individual Interventions	· Risk-based HTS · Condom education · Post-violence care · Contraceptive mix · Parenting/ Caregiver Programming	· Risk-based HTS · Post-violence care · Contraceptive mix · PrEP (age 18 and above) · Condom Distribution · Comprehensive socio-economic approaches · Parenting/ Caregiver Programming (17yrs & below)	· Risk-based HTS · Post-violence care · Contraceptive mix · PrEP · Comprehensive socio-economic approaches
		Services Referred for Educational support, National registration, Legal protection and services, Child protection, Substance abuse rehabilitation, and Mental Health Services		
	Range Individual Level Interventions including services referred for	4-15	5-18	5-16
CONTEXTUAL	**Contextual Level Interventions**	· Household economic strengthening · Community mobilization and norms change · Reducing risk of sex partners (link to HTS, VMMC, Treatment)		
	Total Contextual Level Interventions	3		

Note: *The COP21 layering table will be adopted for COP22 unless there are changes in the interventions or program implementation model.*

- ***Primary Individual Interventions:*** To reach the most vulnerable AGYW, PEPFAR/B's DREAMS program is designed as an interagency collaboration building on COP20 lessons learned and what has already been done during the two quarters of COP21. S/GAC approved curricula is used to ensure provision of HIV and violence prevention to DREAMS participants, within the eligible age cohorts (10-24years); for school going age, this includes their classmates - both boys and girls. OU will use the following age-appropriate curricula for these interventions; LIFESKILLS+, and Grassroots Soccer. However, there is a plan to move to the national LIVING curriculum owned by the Ministry of Basic Education (MoBE) as soon as the curriculum is finalized and ready to use. This curriculum will be sent to S/GACA for review and approval before the program transitions to use it. 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 using LIFESKILLS+, Aflateen and Ready to Work curricula for the different age bands. 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. The basic economic

strengthening for ages 20-24 is only used for young women who meet the criteria to access these services.

- ***Secondary Individual Interventions:***
    - ***Clinical services:*** These interventions will continue to be offered to AGYW across the age bands with the aim of addressing their sexual and reproductive health needs and support them to increase their chances of remaining HIV negative. In COP22, PEPFAR/B will continue to implement DREAMS clinical services with fidelity as part of the 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) and Emergency contraceptive (EC) for survivors of sexual violence; STI screening and treatment as well as risk screening HTS, and contraceptive methods mix which will be provided through community outreach using the clinical platforms that include Tebelopele Wellness Centers (Gaborone & Kweneng East) and government of Botswana 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 will be strengthened to increase opportunities to identify the most vulnerable AGYW as potential DREAMS beneficiaries. PEPFAR Botswana will integrate new biomedical prevention interventions such as the Dapivirine Vaginal Ring (DVR) and injectable long acting cabotegravir into PrEP and other prevention platforms as products move into the global marketplace.
    - ***Parenting/caregiver program:*** Parents and caregivers of DREAMS beneficiaries ages 10-17 will be reached to discuss issues surrounding HIV, gender-based violence, child-parent communication as well as building their skills to support AGYW through Sinovuyo curriculum – which has since been given a Setswana name Pinagare. This program allows for joint sessions between parents/caregivers and the adolescent girls to ensure common understanding and practical sessions on the theory that has been delivered by the trained facilitators.
    - ***Comprehensive socio-economic approaches:*** PEPFAR/B is approved to use the ELA model as an economic strengthening curriculum. This approach covers sessions on employability & Entrepreneurship pathways, job readiness & skills development, apprenticeship skills, business and market contextual research skills and practical skills, as well as business coaching sessions. These interventions are needed in order to ensure that young women have the skills to become self-sustainable and financially independent which will make an impact in their lives.

Contextual community-based interventions: PEPFAR/B will implement the community mobilization and norms change in all the 8 SNUs. SASA! methodology will be used for reaching communities and ensuring that GBV and HIV issues are discussed. The implementing partners will continue to work with community activists to deliver the sessions and ensure that there is ownership in addressing GBV at community level. The community leaders will be engaged to address harmful cultural gender norms which contribute to the incidents of GBV.

Strategies to respond to minimum requirements and program guidance:

1) ***Scale up PrEP for AGYW in DREAMS SNUs***

PrEP is an essential part of the DREAMS core package as it directly reduces HIV acquisition for the AGYW. PrEP will aggressively be scaled up during COP22 through:

- Introduction of new PrEP commodities which provide second line options for those who cannot tolerate oral PrEP e.g., DVR, Cab LA.
- Strengthening the use of Differentiated Service Delivery models such as MMD, Fast track refills, Community PrEP initiations, and refills (including at Safe spaces).
- Extend PrEP to AGYW who are experiencing violence, those who are pregnant and those who are breastfeeding.
- Establishment of Pre-PrEP Users clubs in Safe spaces to provide education and counseling on PrEP amongst AGYW.
- Engage and build capacity of PrEP ambassadors to support demand creation efforts and retention on PrEP for those who are still at substantial risk of acquiring HIV.
- Use self-testing amongst AGYW continuing with PrEP for periodic HIV testing at month 3 intervals.
- Improve provider competencies to enhance delivery of AGYW centered services.
- Upscale targeted communication to reduce PrEP stigma, increase awareness, health literacy and uptake.

2) Improve mentoring

Training	**Supportive Supervision & Peer support**	**Compensation**
3–5-day training session covering: ✓ Introduction to DREAMS ✓ Introduction to Safe Spaces ✓ Understanding the Walkable Community ✓ Establishing Community-based Platforms ✓ Assessing and Tracking Asset Building ✓ Building Human/Health Assets ✓ Building Economic Assets ✓ Training Design Principles - what is mentoring, types of mentoring and mentoring process ✓ Assessing and Identifying Vulnerabilities - LIVES training ✓ Mentor Roles, Ethics and Conduct ✓ Program Planning ✓ Mentor Management ✓ Supervision ✓ Monitoring and Evaluation	**Monthly Coaching Sessions that include:** ✓ Money skills ✓ People Skills ✓ Communication skills ✓ Work Skills ✓ Entrepreneurial skills Monthly coaching sessions with mentor leaders and their peers Weekly checkups and case conferencing with mentor leaders through WhatsApp One-on-one engagement with mentor leaders for supervision Spot checks in safe spaces conducted by mentor leaders Weekly check ins with mentor coordination officers for supervision and guidance	Stipend per Safe Space per month **Mentor vs mentee ratio;** mentors for age band 9-14 manage 1 safe spaces at a time mentors for age band 15-19 manage 1-2 safe spaces at a time mentors for age band 20-24 manage 1-3 safe spaces at a time

3) ***Enhance economic strengthening (ES)approaches***

PEPFAR/B will continue to utilize the Empowerment of Livelihoods for Adolescents (ELA) curriculum which was developed by BRAC. In COP20, the OU started working on a comprehensive model and engaged BRAC to ensure that there is a framework to guide agencies on the delivery of ELA based on the capacity and knowledge of implementing partners in the delivery of economic strengthening packages.

An engagement contract was signed with BRAC for the implementation of the ELA at the beginning of COP20. BRAC worked with IPs to implement the assessment phase of the ELA model package, which would be used to determine the best package for Botswana context. Partner Interviews were conducted, and meetings set up to discuss the content and the resources needed for successful implementation. The second leg of interviews were with stakeholders such as supermarkets, guardians of the DREAMS girl's, the Ministry of Employment, Labor Productivity and Skills Development and District AIDS Coordinators. Following these engagements, BRAC conducted focused group discussions with DREAMS AGYW to assess their knowledge, skills and needs. The ES framework which was developed assisted in ensuring that the Botswana Program is strengthened through the following:

- Integration, learning and adaptation on economic strengthening best practices as well as the utilization of safe spaces to deliver ELA.
- Effective training approaches and program support provided to mentors to inform BRAC's assessment and recommendations around economic strengthening and integration of components of ELA model.

In COP22, PEPFAR/B will continue to prioritize ES as a strategy to retain young women in the program as well as for recruiting young women selling sex into DREAMS. The following will be used in addition to the theoretical delivery of the program:

- ***Job Placements:*** Young women will be supported to find employment by ensuring that the OU collaborates closely with employers from various sectors. This will assist in keeping young women engaged hence reducing risky sexual behaviors which may lead to contracting HIV due to inability to meet their basic needs.

- ***Job shadowing:*** The ELA sessions delivered to AGYW will prompt them to define and identify their preferred career paths. This will assist in ensuring that they are placed with the correct sectors to learn the industries, the skills and the needed requirements and qualifications for one to succeed. Implementing partners will continue to support AGYW to acquire the needed skills which will ultimately allow them to do what they like and what they can thrive in.

- ***Youth Business seminars:*** In COP22, the OU will continue to engage with different stakeholders from government, private sector and international partners to ensure that the right connections are made for the DREAMS beneficiaries. AGYW will be supported to participate in business seminars and conferences that are relevant to their preferred career paths so that they can have the opportunity to network and learn from others who are ahead in various business sectors.

- ***Linkage to business startup opportunities;*** Young women who are ready to tap into business start-up support will be linked to the relevant resources such as the Botswana popularly known Citizen Entrepreneurial Development Agency (CEDA) and the government's Youth Development Fund (YDF) and other opportunities which will

open more doors for them. Establishments such as the Local Enterprise Authority (LEA) for business development skills. More opportunities will be explored even in the international space for exposure and learning purposes.

Monitoring and Accountability

DREAMS:

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 sub Working Group for M&E that comprises all partners, GoB and USG. The TWG meetings are held regularly to provide updates on implementation, including successes, challenges, review of tools, review of performance and ways to improve programming. The TWG also looks at the operations of the National DREAMS Database (NDDB) and reporting. The NDDB is utilized by all DREAMS implementing partners and capacity is provided to efficiently utilize the system as all data entry, analysis and reporting is done on NDDB managed by the National DREAMS Coordination Office at NAHPA but housed at MoHW.

OVC:

The Botswana COP22 PLL mandates the OU to continue finding and supporting orphans and vulnerable children and their families with more emphasis placed on actively facilitating testing for all children at risk of HIV infection, and linkage to treatment and providing support and case management for vulnerable C/ALHIV. It is important to also consider the total estimated coverage of OVC programs compared to the number of C/ALHIV current on treatment across the OU and supported by PEPFAR. The OVC program will continue 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 for COP22 includes: 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 2 SNUs that receive PEPFAR support and have been identified to have a high number of TX_CURR <15. These are Selibe-Phikwe and Lobatse.

OVC Program delivery models

1) Comprehensive Programming Service Delivery Model

The Botswana OVC program has traditionally had a pediatric clinical provider (Baylor) as a sub-partner under the Global Communities (GC) mechanism. This has made it easier to make linkages for HIV+ A/CLHIV served by Baylor in the different sites to get linked to the OVC program. Additionally, other OVC 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 once they return to Botswana as they had to be evacuated due to COVID. All these relationships have made it possible for the OVC program to reach the number of adolescents and children living with HIV. With the call from OGAC to offer OVC services to 90% of children and adolescents living with HIV, the PEPFAR/B OVC program will continue to intensify its strategy for reaching this population group as well as reaching others such as HEI and children of HIV positive mothers. The community OVC partners will continue to strengthen collaboration with clinical partners and ensure that there are MOUs guiding their engagement. In addition, case managers will be capacitated to support their clients to access clinical services and ensure that they are linked to the right providers based on their identified needs, most importantly OVC partners will actively work to identify children who are HIV+ and are not on treatment and link them to treatment. Structures where OVC are supported to remain on treatment will be utilized to ensure that they adhere to treatment and remain virally suppressed. DHMTs will be engaged to ensure that facilities work with OVC community partners to offer comprehensive and person-centered services across all the OVC SNUs.

PEPFAR/B will continue to work with CSOs to 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 CSOs working with the KPs*: It is important to note that OVC community partners engaged FHI360, currently implementing the EpIC KP program in COP20 to discuss collaboration and linkage of clients. The agreement specifies 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. 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.
- *Increasing reach for children who survived sexual violence is also a priority for COP22.* 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). There is a need to prioritize this OVC sub-population and ensure relevant service provision across all the SNUs. Some of the strategies to be employed in COP22 to increase reach for this population group include:
- *Training all OVC implementing partners on the World Health Organization (WHO) LIVES approach:* All personnel supporting OVC program beneficiaries will be trained on providing first line support to survivors of gender- based violence. This will ensure that t the “no harm” standard is adhered to because providers will know how to ask, how to identify and whom to refer survivors to. Linkages will be made to both the comprehensive psychosocial support services as well as the post GBV clinical services.

- *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.

- *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.

2) Preventive Programming Service Delivery Model

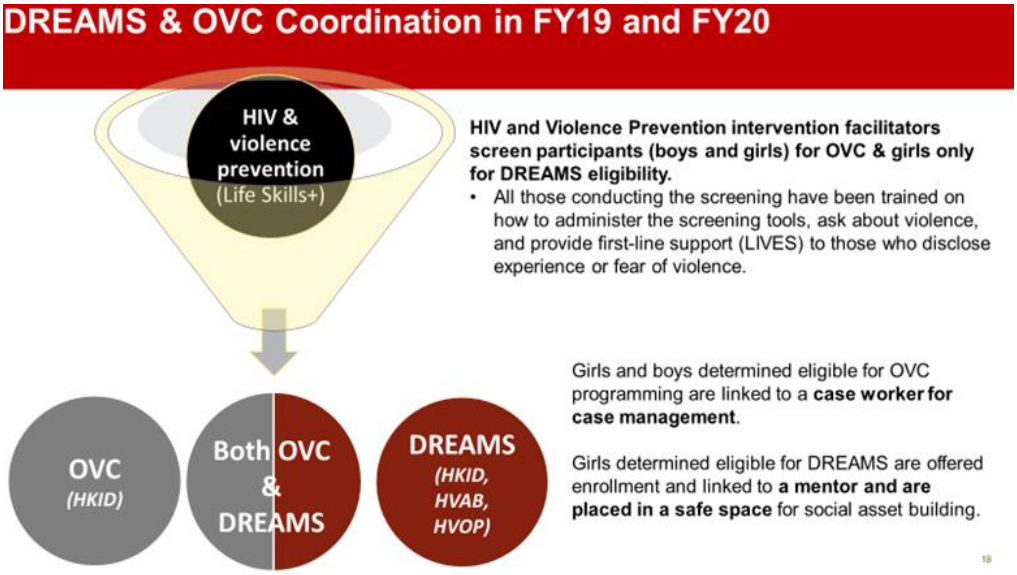
PEPFAR/B will continue to deliver services to the 10–14-year-olds through the provision of single, evidence-based primary prevention of HIV and sexual violence intervention by trained facilitators in group settings. This model does not require case management of individual beneficiaries nor tracking against any graduation benchmarks while they are in the program. 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 10-14-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). Either towards the end of the curricula or at mid-point, all 10-14 years old boys and girls in one classroom are assessed for OVC services and only girls are assessed for DREAMS eligibility. The facilitator doing assessments initiate referrals as necessary to the relevant programs and make follow up to ensure referrals are completed.

Over the years of implementing this work, the implementing partners continue to engage the regional education offices to allow them access into schools. Once the working relationships and agreements have been established with the school management, IPs work closely 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 the schedule changed completely only providing limited time frames for "other curricula activities" such as the HIV and Violence prevention program. The schools also adopted the double shift system which was meant to limit the time spent at school and the number of learners in the school premises at a time which ultimately reduced time for engaging learners leaving the program with very limited time to deliver the HIV and Violence prevention interventions. With the current high vaccination rates in the

country, we will continue to monitor the situation especially on whether the GoB would revert to the schedule that was in place before COVID started.

3) OVC/DREAMS Service Delivery Model

Over the past five years, the OVC & DREAMS programs learned a lot about the relationship between the two programs. The below pictorial from the PEPFAR/B 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.



Through OVC and DREAMS platforms, parents of 10-17-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 with their children. The evidence-based curriculum which is being implemented (SINOVUYO – PINAGARE) allows for the caregiver/parent and child to attend sessions together to both share their views and what they believe works best in strengthening their relationship and fostering open conversations about HIV and Violence.

Strong coordination mechanisms between the different players have been very important across the two programs. Botswana will continue to ensure the following:

- 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.

Prevention of Mother-to-Child Transmission (PMTCT)

Botswana is the first African country with a high HIV burden to be certified for the path to eliminating mother-to-child transmission of HIV by the World Health Organization (WHO). High-

burden HIV countries are defined as countries with more than 2% of pregnant women living with the virus. The country has achieved “Silver Tier” status, which moves it closer to eliminating mother-to-child HIV transmission. This great achievement is highly attributed to strong program organization and management, clear policies, and guidelines consistent with current WHO recommendations and the well-implemented PMTCT service delivery model integrated within SRH/MNCH and HIV services.

Botswana PMTCT program continues to achieve exceptionally good performance in HIV testing and treatment coverage for PBFW. In the past year (FY21), a total of 16,561 new ANC attendees were registered in PEPFAR supported sites. Out of these new ANC attendees, the overall achievement for the percentage of pregnant women with known HIV status at antenatal care was 100% (16,561/16,561). 99% (3,609/3,631) of HIV-positive pregnant women received ART to reduce risk of mother-to-child-transmission during pregnancy and delivery. Of these, 342 were newly enrolled into the ART program and 3,267 were already on ART.

In COP22, 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 to prevent transmission of HIV from the mother to their infant in all efforts to eventually eliminate mother to child transmission of HIV in Botswana. 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.

Botswana PMTCT guidelines recommends early ANC registration of all pregnant and breastfeeding women with 3 months retesting until 6 weeks of cessation of breast feeding of the negative results. Although Botswana has demonstrated high rate of testing and treatment coverage; retesting of negative women remains suboptimal. Through clinical site mentorship, PEPFAR/B will review sites specific system of tracking appointment and follow up of negative HIV PFBW for their retesting. The review of re-testing appointment system will identify specific PBFW re-testing gaps and address them accordingly through sites-specific) project CQIs.

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. UNAIDS special analysis, 2021 reports that most new child infections occurred in the setting of mother infected during pregnancy or breastfeeding or mother dropped off ART. This is also attested by national annual review of PMTCT audit forms that showed that treatment interruption and non-adherence to ART treatment are contributing factors to unsuppressed VL amongst PFBW which may lead to an increased risk of mother to child transmission of HIV.

To address this gap, during COP22 PEPFAR/B will strengthen the existing joint team that consists of MoHW district PMTCT coordination and the Implementing Partner’s technical program managers to provide sites clinical mentorship support visits to review retention, VL coverage and suppression data of PBFW. The review system in place will be able to identify clients who have missed appointment and client with undetectable VL. Through clinical mentorship, these women will be referred by Clinical Mentor in the facility to Community Health Workers for follow up and tracing in the community. Midwives will be capacitated to review clients VL and to provide

adequate adherence counseling of patients with detestable VL. Midwives will also form part of the failure clinic on the management of PBFW clients.

PrEP for Negative PBFW is an additional strategy to reduce HIV incident infections among women of high HIV exposure. In COP22, PEPFAR/B will strengthen integration of PrEP into ANC, post-natal care, family planning, and other HIV prevention services for HIV negative PBFW and their partners. This will be done through optimizing PrEP screening at ANC service points and avail PrEP screening tools. Through clinical mentorship program, PMTCT coordination office and IP's district technical program manager will provide planned site visits to review PrEP ANC data on screening, eligibility, and enrollment to PrEP services. The joint visit will identify programs gaps and ensure adequate remediation. The mentorship visit will also address data capturing and assessing patients flow from screening point to PrEP initiation. Youth friendly services and SRH will be capacitated with adequate skill to incorporate DREAMS and PrEP services for AGYW PBFW.

While HIV testing and ART rates are relatively high, EID requires significant strengthening. To 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 shift in COP22 is to improve monitoring and evaluation systems and data management and to be able to track disaggregated EID/VL testing and suppression data for pregnant women from the general population and ensure that all infants and young children exposed to HIV receive comprehensive care and are monitored until final HIV outcome. Tracking of HEI through the expansion and use of electronic medical records in ANC/PMTCT settings will also be strengthened to optimize mother-baby pair approach.

Additional strategy for ensuring this work is done include working with the Clinical Mentors who will be 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 Clinical Mentors are qualified 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 Clinical Mentors 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 Clinical Mentors will 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

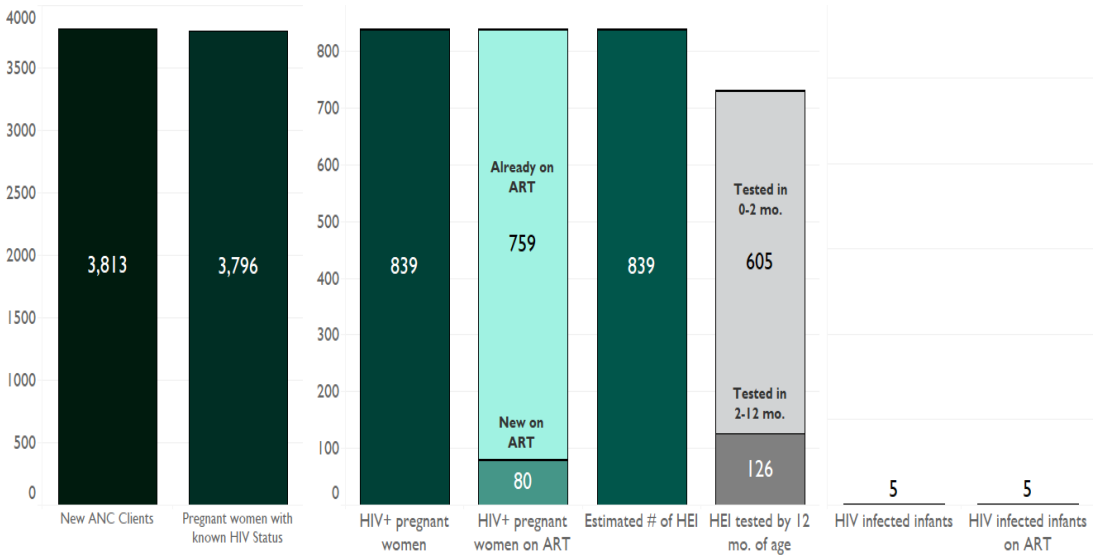
women supported in community HIV care programs to determine if they are registered for antenatal care and PMTCT services.

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 strengthen implementation of birth cohort registers for HIV Exposed Infants (HEIs) using EMR. Training and mentoring of health care workers caring for infants and children with HIV exposure or infection will continue in FY22 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 national PMTCT program achievement, during COP22 PEPFAR/B will continue to assist the government in sustaining country ‘’Silver Tier” achievement of Path to Elimination of HIV and move the country towards WHO “Gold Tier” of the Path to Elimination of HIV 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 PMTCT cascade: 1) Number of eligible HIV positive pregnant and breastfeeding women offered re-testing, PrEP and VL services, 2) Number of infants done EID, 3) Number of Index case partners and children contacted and tested for HIV.

Figure 4.3.1 PMTCT Cascade



% pregnant women with known HIV status	% pregnant women who are HIV+	% HIV+ pregnant women on ART	% HEI who received an HIV test by 12 mo. of age	% HIV+ infants identified	% HIV+ infants on ART
100%	22%	100%	87%	0.68%	100%

Key Populations

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. The KP program will target female sex workers (FSW), men who have sex with men (MSM), and transgender (TG) individuals, People Who Use Drugs (PWUDS) with prevention, treatment, care, and structural 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. In addition, Young Girls who sell sex will be reached through the DREAMS program. 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 program will work with Botswana Prisons services to train the prison nurse prescribers on PrEP.

PEPFAR/B provides comprehensive-person-centered services to KPs through community-led integrated programming that provides options for clinical services at peer-led facilities, public health facilities and private medical service providers. A metric to assess the readiness of Public Health Facilities to serves KP will be put in place. Members of KPs are reached with individual and/or small group-level HIV prevention interventions designed for the respective KP sub-type. AllKP members are offered HIV testing unless they had previously been tested positive for HIV.

The KPs are offered comprehensive prevention packages, and care services through differentiated service delivery models, providing services in locations where KPs can be served without discrimination. The prevention and care services are accessed through KP drop-in centers, online and personalized outreach, and alternative pick-up points, such as one-stop-shops that provide community-based treatment initiation and refills in addition to testing services. Structural interventions are integrated in the prevention, treatment, and care cascade to protect the human rights and dignity of KPs, and respond to violence, address stigma and discrimination, as well as fostering enabling policies, promoting legal literacy, and support the provision of KP-competent services. The program has inbuilt resilience to respond to potential COVID-19 disruptions.

PEPFAR/B, Global Fund and GoB 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 KPs. In COP22 Global Fund will start KP program in Lobatse, Tutume, Kalagadi, Ghanzi and Jwaneng.

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 KPs with prevention services in districts with KP interventions. In addition, GF annually tested 35% of KPs 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.

KPs, 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 KPs was on the rise. 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, 0.5% 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 people who inject drugs (PWID) in these PWID hotspots. The intervention with PWID that was initiated in COP21 will be scaled up in COP22.

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 PEPFAR/B KP program follows the WHO Consolidated Guidelines on HIV Prevention Diagnosis, Treatment and Care for Key Populations. As per these guidelines PEPFAR/B interventions are tailored for KP-specific populations designed toreach, provide prevention interventions, test, treat and ensure treatment continuity for KPs to achieve durable, undetectable viral load (VL). As per PEPFAR COP22 Guidelines, PEPFAR/B will strengthen engagement with KP partners and their social and sexual networks.

Key components of all KP programs include:

- Scaling up differentiated, person-centered HIV prevention, diagnosis, and treatment services, utilizing a case management approach, where desired by KP, to ensure each individual receives all needed services.
- Partnering with community and civil society groups to improve the quality of KP programs and service delivery organizations.
- Develop and implement a standardized minimum package of services for all KP service providers.
- Strengthen capacity of implementers to provide KP-competent services
- Building the capacity of KP-led service sub-partners to prepare them for direct funding in COP23.
- Partnering with Global Fund to design advocacy, training, build KP community agency and leaders organize their sensitization to address the legal and policy environment, including reducing stigma and discrimination present in public and private HIV and other service settings, strengthening the KP-competency of service delivery providers, and ensuring zero-tolerance policies regarding discrimination among PEPFAR-funded staff and partners.
- Through training, monitoring, reporting and development of service charters ensure all KP services are free of stigma and discrimination.
- PEPFAR/B KP team will establish a KP liaison group with the Political Affairs section of the US Embassy in Gaborone. This group will ensure KP issues reflected in the Integrated Country Strategy (ICS) are adequately addressed. Issues that affect constitutional rights of Key Populations, discriminatory and human rights will be addressed.
- Working with MoHW, Global Fund and other stakeholder, PEPFAR/B will lead in conducting KP size mapping and the third national IBBSS.
- Establish a data protection system to ensure that the collection of KP data is confidential, high-quality, accurate and safely collected and securely stored.
- An Interagency KP working group will be established to strengthen coordination with other PEPFAR program areas, including DREAMS, OVC and labs to ensure the availability of drugs and commodities to KP-differentiated sites such as community-based service points.
- PEPFAR/B will work with MoHW to revitalize the national KP TWG for strong coordination with other partners and donors and to build a high quality, sustainable KP program at the national level.

- Two PEPFAR/B agencies will be reporting on the KP program. As stated in Section 1, in future PEPFAR funding periods, USAID will continue to provide support through CSOs and KP competency trainings to public health facilities, while CDC will provide support to the GOB to provide KP clinical services in public health facilities. Targets for clinical services in public health facilities will be shared equally between CDC and USAID in COP22, with a transition to CDC reporting all targets starting COP23.
- KnowNow virtual platform supported by QuickRes system will be used to help clients assess their own sexual health risk, receive tailored service recommendations, and book appointments across TWC clinics and private facilities. KnowNow is also used to report services provided to clients during their appointment. Virtual outreach workers (VOWS) are assigned appointments on KnowNow back end to view clients' status and provide follow-up services.
- Condoms, lubricants, and safer sex promotion will be conducted at all points of physical contact with KPs.
- PEPFAR/B will scale up PrEP Provision to KPs by 46% from the COP21 figures.
- Support for gender affirming care for TG clients; ensuring that specific DICs are offering gender affirming care and referring for provision of Gender Affirming Hormone Therapy (GAHT) services.
- Services for KPs who use drugs will be provided with the following services, will include, 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); HIV testing, ART; referral for Family Planning and other Reproductive Health Services; nutritional support.

Structural Interventions for the KP program

Structural barriers do inhibit KP clients receiving quality services. PEPFAR/B working with other key stakeholders including Global Fund and Government of Botswana agencies has put in place interventions that will address policy barriers, societal, family, community and health system stigma discrimination and violence as well as psychosocial barriers. Following are priority areas of intervention in COP22.

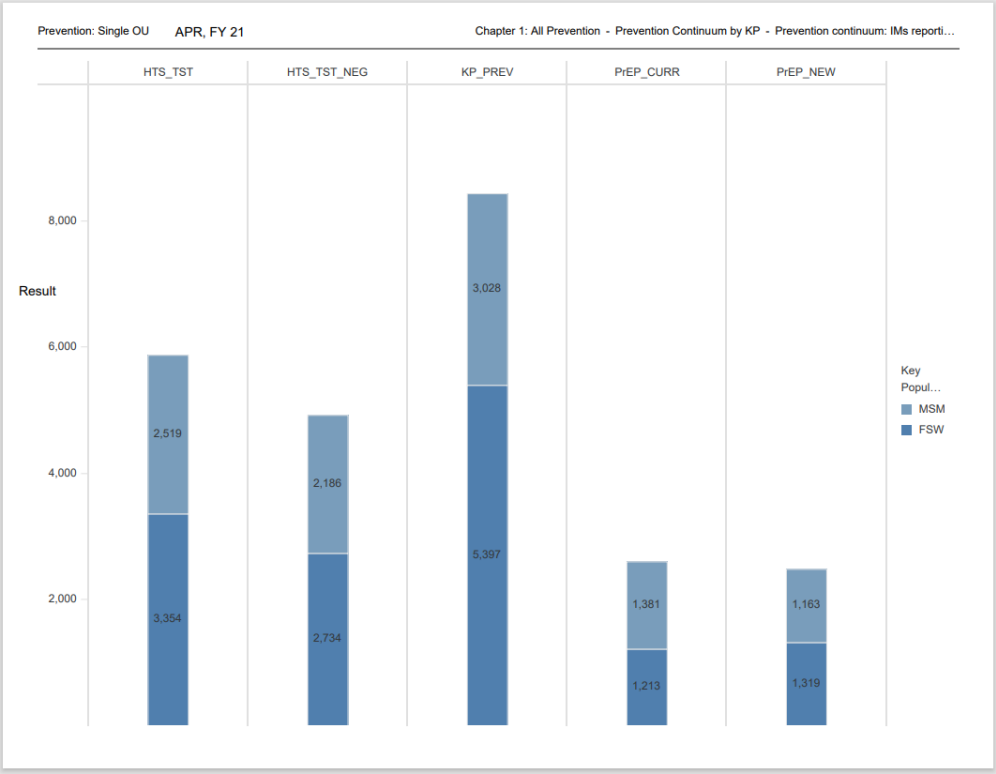
- Policy-related interventions
    - Fostering Enabling Policy Environments
    - Supporting decriminalization/ anti-discrimination advocacy at all levels
    - Engaging law enforcement and legal services to address Stigma Discrimination and Violence that affect KP
    - Work with the Department of State in Human Rights violation documentation and response.
- Action against stigma and discrimination
    - Introducing stigma monitoring systems
    - Promotion of anti-stigma champions
    - Scaling KP competency training in community and facility health services
- Building community agency for sustainable KP programming
    - KP-led CSO capacity strengthening
    - Community centered KP programming
    - Establish a Human Rights (HR) Violation Response & Reporting System

- Promote treatment literacy including U=U
- KP socio-economic empowerment through DREAMS

KP Service Models

1) Expanded Peer Outreach model
2) Combining Index testing with social network testing
3) Linking Index testing to self-testing
4) Multi-month dispensing for both PrEP and antiretroviral treatment (ART) that are dispensed through drop-in centers, clinics, and Post Office Services
5) Clinical Services through KP-competent public and private health providers
6) Scaled-up online and virtual approaches for engaging, linking, and retaining clients (and their social networks) into care.
7) Development of data system that does not expose KPs to harm
8) Provision of differentiated service delivery for KPs Living with HIV to include use of community and post office refills.
9) Complement GoB VL lab services with private providers services where VL Coverage is below 80% for any KP sub-population
10) Use Differentiated Service Delivery Model PrEP and also introduce PrEP innovations like Event Driven (ED-PrEP) for MSM
11) Promote social contracting and social enterprise schemes for the KP-led CSO partners.

Figure 4.3.2 Prevention Continuum by Key Population Group



VMMC

PEPFAR/B will continue to support the provision of VMMC services in COP22 targeting eligible men aged 15 years and above in selected priority districts. The program aims to circumcise 10,000 men through Direct Service Delivery (DSD) approach using dorsal slit surgical technique. The PEPFAR/B VMMC program will continue to target both civilians and military communities. Using the BAIS V survey results in triangulation with existing program data, prioritization of geographic SNUs has been made with high HIV burden districts with low circumcision rate targeted in order to take them close to saturation.

In COP22, the overall target will be allocated to the high burden districts with a significant gap in VMMC including Gaborone, Kgatleng, Kweneng East, Serowe, South East and Mahalapye. Considering the progressive success in targeting males aged above 15 years over the past 3 years, the program will only focus in circumcising this age group.

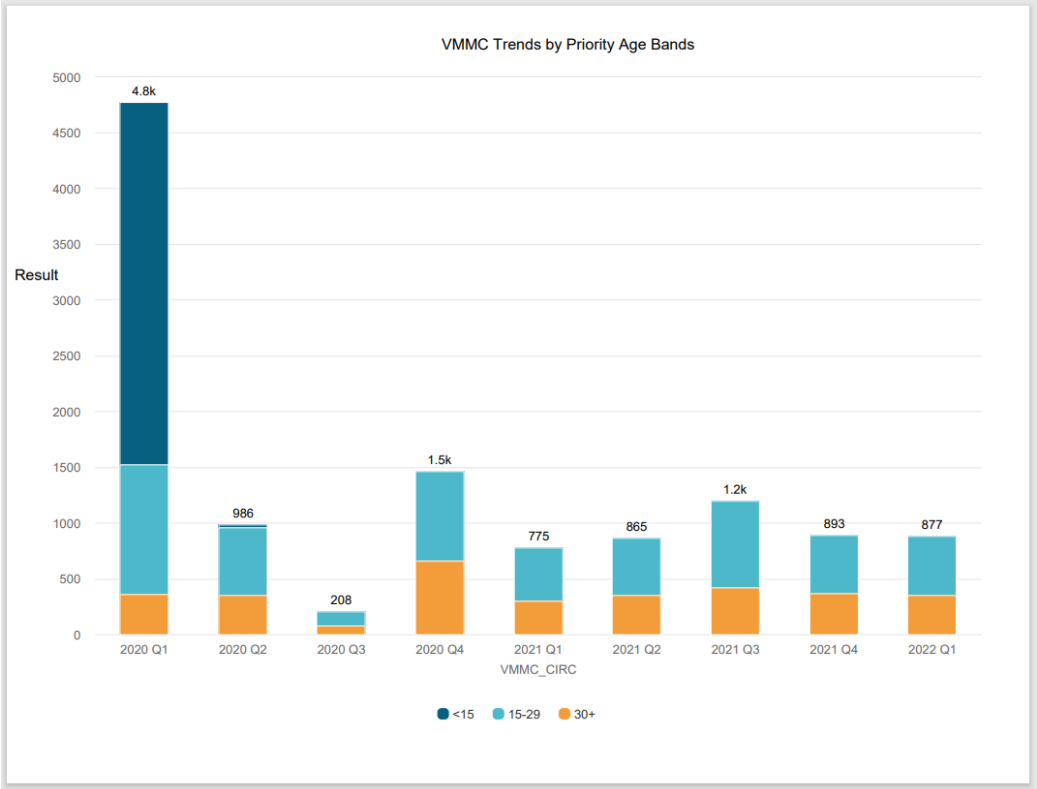
COP22 priorities will include: enhancing demand creation through evidence-based human centered design strategy aimed at addressing the community barriers to accessing VMMC services. Lack of mutual benefit, fear of pain, fear of lost wages and six weeks abstinence have been highlighted in previous studies as main community barriers. IEC materials will be designed and tailor-made to respond to these barriers. Data driven demand creation efforts will be used to determine which strategies are working, when and where in order to optimize resources. Targeted population demand creation strategies will be employed to increase uptake in specific populations including workplaces, secondary schools, tertiary institutions, and farms. Collaboration with other PEPFAR IPs, FBOs and CBOs will be strengthened to build synergies and enhance efficiencies in service delivery. Engagement of community and faith-based leaders, strengthening linkages with other HIV-related programs such as DREAMS and Cervical Cancer screening and shifting focus of school campaigns to target tertiary institutions is expected to enhance access by older men.

In COP22, PEPFAR/B will improve service delivery through demand-driven, targeted outreaches that bring services closer to the target population. Public Private Partnership (PPP) will be implemented to expand services to clients attending private health facilities. Shang Ring device will be introduced to circumcise clients aged 13-14 years. The program will continue to target military recruits and offer VMMC after they complete their basic training. Collaboration with other uniformed forces such as the police and prisons will be enhanced, and lessons learnt in working with military applied to contextualize and strengthen VMMC coverage among members of the force.

Quality assurance will be strengthened through decentralized continuous quality improvement (CQI) initiative with regional ToTs spearheading support supervision and mentoring. To optimize resources and enhance progress towards sustainability, the program will shift to reusable kits. However, disposable kits will remain in use during outreach activities where on-site instrument cleaning and sterilization are not possible due to infrastructure constraints. Notifiable Adverse Events (NAE) will be reported through online mechanism in DATIM. Service quality and VMMC-related adverse event prevention and management will continue to be provided by the MoHW's CQI teams across all partners.

In COP22, PEPFAR/B will enhance Monitoring and Evaluation by strengthening utilization of the electronic medical record (EMR) system to collect, manage and report VMMC program data. The program will optimize the existing PIMS system.

Figure 4.3.3 VMMC Quarterly Trends by Age, Botswana -FY20Q1 to FY22Q1



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

PEPFAR/B has faced many challenges including COVID-19 as a program during this period. Despite these challenges, what remains true is the strength and resilience of PEPFAR/B in partnership with the GoB, multi-laterals, CSOs, the private sector, and communities – through our teams, and our programs amid dueling pandemics. COP22 (for implementation in FY2023) represents a pivotal year for PEPFAR/B, as Botswana has reached the agreed upon UNAIDS 95/95/95 benchmarks for attaining epidemic control at 93/98/98. While pivoting from “scaling to close gaps” to “sustaining” epidemic control, PEPFAR/B must ensure HIV program and population equity, address outstanding barriers that threaten to derail progress made in reducing new HIV infections and associated mortality, and tailor our programs to serve all populations. The planning level letter specifically highlighted the following as PEPFAR/B country specific priorities that will need to be addressed during COP22:

1. Data availability, quality, and use. PEPFAR Botswana to institutionalize a focus on data availability, quality, and use to support decision-making.
2. Persistent gaps in case-finding, linkage, treatment, and viral load coverage/suppression for pediatric and adolescent people living with HIV.
3. Lagging performance in the context of the COVID-19 pandemic for the following:
    a. TB Preventive Therapy (TPT) service delivery

b. Cervical cancer screening services for people living with HIV
c. VMMC
d. DREAMS prevention services

4.4.1 Data availability, quality, and use

Data collection, use, and analysis and improved data quality are essential for better understanding of the HIV epidemic and sustaining epidemic control efforts in Botswana. PEPFAR/B is applauded for working closely with the GoB on the completion of the BAIS V amid COVID-19 pandemic. The BAIS V remarkable preliminary result of 93/98/98 coming out of the survey is highly commendable. These results helped PEPFAR/B develop informed programmatic decisions for COP22. In COP22, PEPFAR/B's priority is to work with the GOB and stakeholders to pivot the PEPFAR program to support activities to maintain HIV impact and attain sustainable epidemic control. A major pivot towards sustainability is the shift from Direct Service Delivery (DSD) to Technical Assistance (TA) across all programs. The shift from DSD to TA will allow the PEPFAR/B program to have more reach, to ensure the GOB is able to provide equitable, person-centered services with quality and efficiency to all the people of Botswana, leaving no one behind. Direct service delivery that continues remaining will be targeted and focused to remaining gaps identified in BAIS V and other sources of data. Based on these results, another deliberate informed decision was to do a program realignment that will allow USG agencies to focus on their area of strength/comparative advantage, with a division between Clinical and Community Services. Agencies roles will be better defined to encourage collaboration and synergize their efforts to bring maximum quality of services with efficiency to the people of Botswana.

In COP22 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). Our goal is to achieve an interoperable health information system for person-centric care, surveillance, and program monitoring and reporting. 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. 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.

Through PEPFAR/B support, health districts will continue to be capacitated to use the standardized data quality assessment SOPs and protocols to verify the completeness and accuracy of program data collected. Facilities will also be capacitated to conduct their own self-assessments at regular intervals and to analyze data consistently and continuously 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, will be strengthened through data quality improvement and more in-depth analysis. With the introduction of recency testing in COP21, 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 to have more timely death information in CBS.

4.4.2. Persistent gaps in case-finding, linkage, treatment, and viral load coverage/suppression for pediatric and adolescent people living with HIV.

PEPFAR/B COP22 goal for pediatric and adolescent people living with HIV is to decrease HIV Morbidity and Mortality among this population. The BAIS V results show a significant gap for ART coverage among children below the age of 15 for both males and females. In COP22 PEPFAR/B will leverage the community-facility case management as well as referrals to the OVC program for targeted interventions to ensure continuity in treatment and provision of person-centered care to children living with HIV. To address persistent EID challenges among children less than 18 months, PEPFAR B will continue to utilize EID/VL champions through clinical mentorship approach to track infants who need EID. Optimization of mother baby pair strategy will be scaled up. In addition, PEPFAR/B will develop clinic-lab working group to address EID/VL specimen flow and TAT. Support will be provided to review patient care and treatment records to identify children <15 years not yet tested, while known positives currently not in treatment will be linked for rapid treatment initiation. Additionally, PEPFAR/B will facilitate provision of high quality pediatric and adolescent care through use of clinical mentors, continuous training and monitoring as well as implementation of CQI to address the observed gaps. Establishing district level clinical mentors to ensure sustainability of high-quality pediatric and adolescent services in all ART sites in Botswana. During COP22 PEPFAR/B will ensure full transition of all pediatrics to DTG-based regimen and that all children living with HIV eligible for MMD are enrolled. PEPFAR/B will optimize viral load testing and tracking of children & adolescents and through the community facility interface. Use of ECHO and virtual platforms to provide mentorship on pediatric and adolescent care packages to district mentors will be implemented as well.

4.4.3. Lagging performance in the context of the COVID-19 pandemic

a) **TB Preventive Therapy –** A shorter 3HP TB prophylaxis regimen has been introduced and will be scaled up in COP22 to improve TPT coverage. TPT will also be implemented through DSD models including MMD and expanded to household contacts.

b) **Cervical cancer screening –** To address the underperformance due to COVID-19 in COP22 PEPFAR/B will aim to reach all eligible WLHIV aged 25-49 years with cervical cancer screening and pre-cancer treatment. We will continue strengthening the existing hub/ spoke model to bring services closer to our target population. We will utilize the HPV DNA testing transitioning to screen, triage and treat approach recommended by PEPFAR. Collaborating with other program including KP and community general population programs, will leverage on its other activities to reach HIV+ women 25-49 in the communities and provide cervical cancer screening services through community self-collection or referral to screening facilities.

c) **VMMC –** PEPFARB/ will increase VMMC uptake to over 80% saturation of men aged 15 years and above, through the implementation of effective demand creation interventions by implementing the Person-Centered Design which addresses specific community barriers. PEPFAR/B will continue the provision of diverse approaches for service delivery,

continuous quality improvement of VMMC minimum package and Monitoring and Evaluation of VMMC services**.**

d) **DREAMS -** The vision of the PEPFAR/B DREAMS program is to successfully implement an agreed upon pivot so that by the end of COP22 USAID will transition from providing clinical services CDC transitions from providing community services, including HIV and Violence prevention and economic strengthening interventions. While doing this, the program will ensure to uphold the agreed upon principles of do no harm and ensuring that services are not interrupted. PEPFAR/B will strengthen bi-directional referrals between clinical and community service providers and ensure retention of the older AGYW enrolled in the program. COP22 guiding principles that include increased focus on issues of mentoring, economic strengthening, and reaching out to KP AGYW will receive increased attention.

4.4.4 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 COP22 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 COP22.
- **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, using, 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 and continuation visits. 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. Partners will be trained on how to provide first line support (LIVES) to ensure that there is no harm to clients.
- **Testing:** PEPFAR/B will ensure that all HIV index testing sites conduct routine enquiry for IPV for clients offered partner notification 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. PEPFAR/B will use these sessions to draw lessons that will inform programming to ensure equity in the provision of services at both community and clinical platforms. The GSD Training will be extended to all DREAMS and OVC implementing partners to allow them to continue addressing the needs of gender and sexual minorities within their programs to ensure the delivery of person-centered interventions and inclusiveness.

4.5 Additional Program Priorities

There remain local policy gaps that need to be changed to adapt to the changing epidemic and new biological technologies to facilitate reaching epidemic control. The following policy areas were identified in NSF III as policy areas that need to be addressed:

1. Developing a policy on HIVST. Current HIV testing policy indicates that testing should only be done in a health facility and by a trained provider.

   ACTION: HTS TWG to engage MoHW to review and revise this policy in COP22.

2. Revision of current HIV testing policy for unaccompanied minors below the age of 16 years. The requirement of parental consent reduces access to HIV testing for emancipated minors and youth-in school.

   ACTION: HTS TWG to engage MoHW to review and revise downwards the age of HTS for youth.

3. Strengthen policy and legal environment to address gendered vulnerabilities, including in relation to higher risks of HIV acquisition, and their impact on HIV testing, disclosure, treatment, and adherence:

ACTION: PEPFAR/B will work with Global Fund and NAHPA to act on the recommendations from the ongoing Legal Environment Assessment report.

4. Some barriers identified impede access or fail to facilitate access to health services for people with disabilities include:
    a. Lack of legislation targeting people with disabilities
    b. The revised Policy on Disability is not yet approved
    c. Lack of strategy to address the needs of people with disabilities
    d. inadequate data on people with disabilities and health needs and gaps

5. Botswana citizens are provided with HIV-related health services free of charge, while non-citizens access services at subsidized rates

6. Botswana has not yet introduced legal reforms that address consensual same-sex relations and acts associated with sex work in line with contemporary developments and trends around the world.

    ACTION: PEPFAR/B will advocate for strengthening of legal and policy provisions to ensure adequate protection of PLHIV, vulnerable and key populations, prisoners, migrants, and some provisions being advocated for to include consideration for extending HIV services free of charge to non-citizens

7. Advocate for legal reviews and build institutional capacity for implementation of laws related to gender equality, rights of children, adolescents, and young people:

    ACTION: PEPFAR/B will work with State to consider revision of laws on marital rape, giving effect to legislation protecting gender equality and discrimination, and review of existing consent law to align it with international and regional guidelines. In addition, communities, civil society organizations, networks of PLHIV and youth will be sensitized on gender equality and laws and policies hindering children, adolescents and young people access to health services.

8. Current post-exposure prophylaxis (PEP) policy limits PEP availability thus increasing likelihood of infections to those exposed to sexually incidents that could lead to acquisition of HIV.

    ACTION: PEPFAR/B will work with GOB to Improve protocols and processes for managing PEP for child sexual abuse, defilement, statutory rape, rape, and sodomy: This includes ensuring that PEP is available to both male and female survivors, establishing protocols and systems for legal referral and support, and establishing protocols and systems for psycho-social support and counselling including referral. Improve monitoring and reporting on PEP service uptake: Botswana will update data collection.

9. Unclear policy on task shifting especially with regards to remuneration, deployment, and utilization of nurses at ART service delivery

10. The 2016 HIV Clinical Treatment Guidelines do not provide guidance for new PrEP technologies like new oral PrEP formulations, Event-Driven PrEP (ED–PrEP) for MSM, Cabotegravir Long-Acting (CAB-LA) injectable PrEP and Dapivirine Vaginal Ring (DVR PrEP).

    ACTION: PEPFAR/B Prevention TWG is already working with MoHW PrEP TWG to update the guidelines to include new PrEP technologies, as well as to introduce additional oral PrEP options

The policy on HIV self-testing could reduce the achievement of the self-testing targets. In FY20 APR the achievement on self-testing at OU level was at 80%. This was partly contributed by a shortage of HIV Self testing kits. Lack of clear guidelines on HIVST could in future impact the scale -up of HIVST if this approach was challenged in a court of law.

The requirement of students under 16 years to get parental consent before taking a HIV test as is required in DREAMS program slows down the enrollment process as the students feel that seeking parental consent might be tantamount to informing their parents that they are already sexually active.

ACTION: In COP22, PEPFAR/B will utilize Antenatal Care (ANC/PMTCT) 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% of pregnant women receive ANC services, with 98% of them tested for HIV through the PMTCT program. Index testing is crucial for reaching undiagnosed men who would otherwise not access services. In COP22 PEPFAR/B plans to scale-up coverage of safe and ethical index testing (100% offer of index testing) to all HIV positive pregnant women to reach their male counterparts through partner notification services in facility and community settings. 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 without any impact on the services they receive. 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). Technical assistance for MoHW to ensure Index ipartner testing training, use of standardized registers, and IPV screening tools will be scale-up to achieve national roll-out ultimately.

In addition, PEPFAR/B will ensure:

- All children with an HIV positive biological parent will be offered HIV testing.
- Collaboration with OVC program: 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.

For Community-Led Monitoring (CLM), PEPFAR/B formed an oversight committee in COP21, named the Community Consultative Group (CCG) comprising of community representatives, PEPFAR/B staff, as well as representatives from the MoHW and Local Government (LG). The CCG selected three local CSOs to initiate monitoring and feedback processes with PEPFAR/B-supported sites, as well as to develop core and custom indicators for CLM. An additional CSO will be recruited in the current COP, with a mandate to focus on monitoring key populations' community services. The three current CLM partners are receiving technical assistance from the International Treatment Preparedness Coalition (ITPC) to:

- Conduct a health care capacity/gap assessment
- Conduct a desk review of the program documents
- Review existing indicators and tools

- Develop a harmonized CLM framework inclusive of indicators, data collection methods and tools, to inform a common advocacy agenda
- Scoping of other CSOs to support CLM implementation, covering private sector and community-based health services provision, especially for key and vulnerable populations

Some of the main findings and recommendations from their assessments are summarized below:

Finding	Recommendations
Inequitable services	Avail services to ALL PEPFAR/B supported and unsupported sites
Limited KP and youth-competent services	Enhance HCW's KP and youth service delivery competency, and adopt a person-centered service provision approach
Health Programs Knowledge gap	Scale up HCW training and community sensitization on PrEP, GBV, HIVST and other health programs

In COP22, PEPFAR/B will maintain the four local CSOs for CLM, who are expected to have completed national core and custom indicators for CLM at SNU and national levels, as well as localized indicators for direct feedback and change at specific PEPFAR/B-supported sites.

Partner Management

In order to ensure accountability for PEPFAR funds and program performance, PEPFAR/B will continue to implement different activities to improve implementing partner performance; and these will be revisited annually at the time of work plan development and approval with each IP. The main activities carried out by PEPFAR/B for effective partner management include:

- Routine performance review meetings between PEPFAR/B Technical Program Managers and IPs, which are held at different frequencies to monitor program performance and ensure that any remediation actions are instituted timely.
- 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 that expenditures remain within approved operational plan budgets, and are aligned with technical and geographical priorities as defined in the implementing partners' work plans
- A complete evaluation, remediation, and spend plan review of any partner with an achievement of <50% against target at 6 months of implementation
- Joint interagency partner meetings and site visits to ensure consistency, transparency, and collaboration among all PEPFAR implementing partners.

The efforts listed above became reduced at the height of the COVID-19 pandemic, with restrictions imposed on travel and gatherings, and as the situation evolves, these efforts will be scaled up even more. 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 Commodities

ARVs & Rapid Test Kits:

ARVs:

- The previous framework contracts have expired recently for most ARVs, and the Central Medical Stores (CMS) is only doing micro-procurement until new tenders are finalized. An Invitation to tender (ITT) has been issued for new framework contracts. It will take about 3 – 6 months to have the new framework contracts in place. In the next COP period, all ARVs are expected to be on a 3-year long framework contract. And this is expected to alleviate the late deliveries that are being encountered for several products:
    - TLD: supply has been stable since it was first introduced in Botswana in 2018. There has never been a central stockout. Facilities are also adequately stocked with no reports of stockouts. A sustained supply of TLD is expected during COP22 period.
    - TAF-ED: is the next most consumed ARV whose consumption continues to rise due to some patients shifting from TLD after experiencing renal toxicity with a prolonged use of a relatively higher dose of Tenofovir. CMS has experienced low stock levels of TAF-ED recently due to delayed deliveries. There is currently an overdue shipment of 234,070 packs on order expected before end of April 2022. Given the difficulties experienced in 2021 with getting this product on time, a similar challenge of transient low central level stock may be expected at least until new framework contracts are signed.
- The two other ARV products that have been experiencing temporary shortages and low stock levels at CMS in 2021 are TE (Truvada) and DTG-50, the main factor being delayed deliveries as indicated above.
- Except the three products mentioned above (TAF-ED, TE, and DTG-50), CMS has had a stable supply of all other ARV products including pediatric formulations such as DTG-10 and ABC/3TC 120/60. With additional funding from USAID COVID Supplemental Funds for Commodities, we are procuring 9,905 packs of DTG-10, the first shipment is expected to be delivered in April 2022. At the current rate of consumption, this shipment is expected to cover the demand for the next one year.

Rapid Test Kits (RTKs)

HIV Tests:

Following the delays with extending the framework contracts, CMS is experiencing low stock levels of some Vital, Essential, and Non-Essential (VEN) medicines and Lab products including RTKs (Determine and Unigold). The CMS stock level for Determine is 2.3 months, and Unigold is currently stocked out. CMS is procuring small quantities to fill the short-term gap while a long-term 3-year framework contract is still being processed. Assuming the two RTKs will be on a long-term contract, there is no expectation of supply gaps during the COP22 period.

HIV Self-Tests and Recency

The two products are currently being procured by PEPFAR only, while GoB is yet to procure them up to this point. We anticipate that the government will start procuring the commodities either during the current COP or by COP22. HIVST has been implemented for the past four COPs, while recency is only being rolled out in COP21.

Condoms:

The country continues to experience recurrent stockouts of both female and male condoms as communicated with PEPFAR Botswana in the last quarter of the 2021 calendar year. As a stop-gap measure, PEPFAR procured 18 million male condoms through the Emergency Condom Fund. The condoms have all been delivered and already distributed to facilities across the country. The 18 million only represents half the annual consumption for the country, and CMS has already ordered to avoid another stock-out. UNFPA supports the country with forecasting and supply planning for sexual reproductive health commodities.

Laboratory Commodities:

Botswana is working to transition to a reagent rental/leasing arrangement for laboratory testing instruments including Viral Load, EID, CD4, Chemistry, Hematology, microbiology, and others.

This procurement model involves provision of test instruments by suppliers whereby the suppliers will manage the maintenance services and replenishing of the test reagents and consumables at an agreed price per test volume. It will be a significant shift from the current model of capital investment in procuring lab analyzers and separate contracts replenishing reagents and consumables.

The expectation is that the country will benefit from improved efficiencies in the supply chain of laboratory reagents and consumables because of reduced instrument down-time for maintenance, and reduced stockout and wastage of reagents. The country will also benefit from better access to the latest and advanced diagnostic equipment without a need for capital investment.

The Central Medical Stores (CMS) is currently drafting an Invitation to Tender (ITT), and the process is expected to be finalized before the end of 2022.

VMMC:

The demand creation for VMMC was hampered by COVID-19 over the last two years. As a result, the consumption for VMMC is quite low and the product is overstocked at 40.1 months at CMS. The overstocked kits are expiring by July 2022. There is no new shipment on order currently due to uncertainties with the low consumption rates. The MoHW is working to strategize on increasing the demand; and procurement decisions will be based on this ongoing effort.

Planned Commodities for COP22

Minor Category	Item	Commodity Quantity	Total Item Budget
Self-Testing	OraQuick® HIV Self-Test, 250 Tests	151 kits	$75,500
Recency Testing	Asante HIV Rapid Recency Assay, Bulk Format, 100 Tests/Kit	81 kits	$38,4750
TB Pharma Prophylaxis	Vitamin B6 (Pyridoxine) 50 mg Tablet, 1000 Tablets	600	$3,780
ARVs for PrEP	Emtricitabine/Tenofovir DF 200/300 mg Tablet, 30 Tablets	68,960	$291,038

TB Pharma Prophylaxis	Rifapentine/Isoniazid 300/300 mg Film-Coated Tablet, 3 x 12 Blister Pack Tablets	9,120	$136,800
Other RTKs/Products	TB-LAM	6,400	$30,080
ARVs for PrEP	Cabotegravir	200	$3,800
ARVs for PrEP	Dapivirine Vaginal Ring	200	$3,800
Other Reagents and Consumables	Creatinine (for PrEP)	3,900	$19,500
		Total Budget	**$602,773**

4.7 Collaboration, Integration and Monitoring

The PEPFAR/B Interagency Guidebook developed in 2017 serves to provide a higher level of efficiency, transparency, and effectiveness to our interagency work. The USG health team including PEPFAR Coordination office have observed leadership transitions in FY22, and this accords an opportunity for the new PEPFAR/B leadership team to revisit the Guidebook and making any necessary revisions and recommendations on ways we can all work together more effectively and efficiently. The majority of the PEPFAR interagency team is housed at the same site in Gaborone West (G-West). 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. The COP22 PEPFAR/B realignment process is one of the major factors anticipated to contribute to improving the interagency working relations and collaboration.

4.7.1. Strengthening cross-technical collaborations and implementation across agencies and with external stakeholders, including the GFATM and MoHW

Similar to COP21 planning, the PEPFAR/B COP22 planning process continued to embrace the "One Botswana" response. Though challenged by the limitations brought about by the COVID-19 pandemic, the PEPFAR/B team leveraged technology and various virtual platforms to ensure engagement of the GoB civil society, and the private sector in the planning process. This started with the planning retreat that was held in January 2022T. he GoB and CSOs were provided an opportunity to work with the PEPFAR/B team in identifying and agreeing on priority areas for COP22. These stakeholders also actively participated in the virtual planning meeting with S/GAC held on March 15-17, 2022. 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. All USG agencies' technical staff participate 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 COP22 development process, PEPFAR continued to build on the relationships and structures built during COP21 planning, making external partner engagement one of its highest priorities. These external partners included: The Global Fund, UNAIDS, WHO, CSOs and the private sector. 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.

In COP22, 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.

4.7.2 Strengthening IP management and monitoring and the implementation of innovative strategies across the cascade, with fidelity and at scale, to improve impact within shorter time periods

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 COP22, 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 COP22, 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.

4.7.3. Improving integration of key health system interventions, including Human Resources for Health (HRH) and laboratory (VL) activities across the cascade;

HRH and improved laboratory systems are some of the key COP22 PEPFAR/B above site priorities. Other priorities aimed at improving health system interventions across the cascade include CQI, surveillances, surveys, health informatics, supply chain and commodities management, health financing, community systems strengthening, and clinical systems strengthening. These health systems strengthening activities are geared towards building a capable, resilient, enduring, and inclusive national health system for sustainable HIV epidemic control. Specific for HRH we endeavor an equitable and optimal distribution of the health workforce to achieve HIV epidemic and ensure sustainable response. Health worker shortage is a reality; therefore, strengthening the health workforce and the GOB's ability to monitor and manage the health workforce is the absolute key to achieving HIV epidemic control and ensuring a sustainable response. This will require a long-term frame and incremental changes as well as a good situational analysis that will provide a starting point to understand Botswana HRH gaps for appropriate interventions. In COP22, to increase domestic functional responsibility, PEPFAR will support the Government of Botswana to improve HRH planning & management by:

- Conducting HRH situation analysis
- Updating National HRH policies & strategies for long term sustainability of HIV response

- Establishing an integrated HRH information system for comprehensive HRH capture & utilization of data for decision making & equitable deployment

- Institutionalizing routine National Health Workforce Account for updated and realistic projection or estimation of staffing levels for provision of HIV services at different levels of the health system

- Supporting HRH deployment reconfiguration in line with the TA vision

For laboratory systems we will implement an optimized diagnostic network for VL/EID, TB and other co-infections to reduce morbidity and mortality across various age groups but more importantly on the aging population of our PLHIV. PEPFAR/B will continue to work with the GoB on skills transfer, optimizing systems for diagnostics, quality of testing and accreditation. We are still experiencing gaps in PRT participation and performance, TB detections rates. Lab clinic interphase and laboratory data utilization towards decision making. For COP22 Under laboratory strengthening for the 1st 95, we will this year assist the government to align its RHT algorithm to the new WHO HTS guidelines (of 3 parallel tests for screening). We will also support optimization of case finding as well as the scale up of recency and self-test. At the government's request we will also be working to assist them set up a national certification system for POCT sites. For the second 95 for TB and other OI' we will be investing in new technologies for TB diagnosis for children and supporting expansion of TB-LAM. We will additionally continue to work at advanced disease management and the increase in TB screening & diagnosis. Our reach for TB expert EQA is at 86% and we are also working towards 100% reach.

4.7.4. Improving integration of quality and efficiencies in service delivery through improved models of care delivery across community and facility sites;

Building CQI Culture is an on-going activity in which the whole country is involved in different activities to make sure quality care is sustained. CQI will be scaled-up countrywide in phases overtime starting with sites within PEPFAR districts to the rest of the country in the next few years. PEPFAR/B is in the process of developing and reviewing patients and providers' charters to include person-centered approaches and it will be disseminated in COP22. For COP22 PEPFAR/B there is a clear program realignment that will allow USG agencies to focus on their area of strength/comparative advantage, with a division between Clinical and Community Services. The community – facility interface will continue to be strengthened to minimize service interruptions and loss of clients between the continuum of care with integration of quality throughout.

4.7.5. Community-led monitoring of treatment services

PEPFAR/B has been successful forming the Oversight Committee/Community Consultative Group (CCG) which comprises of community representatives Government (MoHW, LG), During COP21 PEPFAR/B issued NOFO and 3 CSOs Partners were awarded and initiated monitoring and feedback processes with PEPFAR/GoB sites. Plans are in place to secure 4th partner with focus on monitoring KP and community services. Recruited ITPC for technical support Working to develop core & customized indicators. For COP22 PEPFAR/B plans to maintain the four partners and there is an expectation to have national core indicators to assess national and local level, as well as localized indicators for direct feedback and change at specific PEPFAR/GoB sites. In COP22 the PEPFAR/Botswana team will work closely with the CLM partners and stakeholders to routinely incorporate the findings into its programs.

4.7.6. Ensuring above-site program activities are mapped to key barriers and measurable outcomes related to reaching epidemic control; and monitored in an ongoing manner.

4.8 Targets by population

The targets for the following four tables should be generated using data from the COP22 approval memos:

Standard Table 4.8.1 (required)

Table 4.8.1 ART Targets by Prioritization for Epidemic Control					
Prioritization Area	**A. Total PLHIV**	**B. Expected current on ART (APR FY22)**	**D. Target current on ART (APR FY23) TX_CURR**	**E. Newly initiated (APR FY23) TX_NEW**	**F. ART Coverage (APR 23)**
Attained	330443		177101	8592	93%
Scale-Up Saturation	5215		2477	276	95%
Sustained		174367			
Total	**335658**	**174367**	**179578**	**8868**	

Standard Table 4.8.2 (required)

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations: Males 15 years and above**	**Population Size Estimate (SNUs)**	**Current Coverage (date)**	***VMMC_CIRC* (in FY23)**	**Expected Coverage (in FY23)**
Mahalapye District	Males 15 years and above	51369	65%	893	66%
Gaborone District	Males 15 years and above	164020	53%	4405	59%
Kgatleng District	Males 15 years and above	40321	59%	1358	65%
Kweneng East District	Males 15 years and above	67234	60%	1596	63%
Serowe District	Males 15 years and above	38094	54%	907	60%
South East District	Males 15 years and above	20960	59%	852	64%
	Total/Average	**381998**	**57%**	**10011**	**62%**

Standard Table 4.8.3 is required

Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate*** **(SNUs)**	**Disease Burden***	**FY23 Target**
[AGYW at risk of HIV acquisition, female sex workers, Males who have sex with males, People in prisons and other enclosed settings] *Indicator Codes*			
PP_PREV	**413158**	**3.70%**	**32041**
AGYW_PREV	**221992**	**5.86%**	**26290**
KP_PREV	**Data not available**	**Data not available**	**10033**

*Source: COP22 Data Pack v27.

Standard Table 4.8.4 is required

Table 4.8.4 Targets for OVC and Linkages to HIV Services					
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY23 Target)** **OVC_SERV Comprehensive**	**Target # of OVC (FY23 Target)** **OVC_SERV Preventative**	**Target # of active OVC (FY23 Target)** **OVC_SERV DREAMS**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target)** **OVC***
Bobirwa		1009	1883	1854	1244
Boteti		0	20	0	0
Mahalpaye		2728	1525	1268	3003
Palapye		300	20	0	312
Selibe Phikwe		123	0	0	113
Serowe		968	1355	1220	1118
Tutume		436	20	0	460
Chobe		0	20	0	0
Gantsi		0	10	0	0
Kgalagadi North		0	20	0	0
Kgalagadi South		0	20	0	0
Kgatleng		2649	663	384	1953
Kweneg East		4720	1641	1595	4424
Kweneng West		0	30	0	0
Francistown		662	10	0	668
North East		818	1850	1054	988
Ngamiland		0	20	0	0

Okavango		0	10	0	0
Gaborone		3539	1424	1359	3638
South East		1052	10	0	909
Goodhope		663	20	0	541
Lobatse		123	10	0	119
Mabutsane		0	20	0	0
Moshupa		70	10	0	72
Southern		1715	389	266	1544
TOTAL		**21575**	**11000**	**9000**	**21106**

4.9 Cervical Cancer Program Plans

PEPFAR/B has refocused its efforts to provide cervical cancer screening and treatment of pre-invasive lesions to women living with HIV (WLHIV) in areas of high HIV prevalence through service delivery platforms due to increased risk of progression. In COP21, the program increased access to high quality cervical cancer screening among WLHIV aged 25-29 reaching to 13518, women representing 42% of 32,394 annual target across the 29 sites in 16 districts supported by PEPFAR. 116% of the women with invasive lesions received treatment. Visual Inspection with acetic acid (VIA) and Human Papilloma Virus (HPV) DNA methods of screening were used, and pre-cancerous lesions were treated by cryotherapy and thermal ablation while large lesions were treated by Loop Electrosurgical Excision Procedures (LEEP) and cone biopsy.

In COP22, PEPFAR/B will continue building on the platforms, strategies, and cervical cancer, optimizing the best practices like people-centered approaches to enhance cervical cancer screening. OU's target of 36298 representing 55% of women living with HIV in the age group will be reached with screening services in COP22 with an earmark budget of $1,000,000.

COP22 priorities will include:

- Enhancing 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 by minimizing missed opportunity.
- Improving access to laboratory testing platforms and commodities to support HPV DNA self-collection services and increased demand creation.
- Expanding the high-performance HPV DNA testing through multiplexing of available molecular equipment and use of Point of care will facilitate transitioning to screen, triage and treat approach recommended by PEPFAR.
- Public Private Partnership MoHW initiatives to extend service to the population preferring access to private practitioners.
- Use of handheld Mobile Colposcopies for Expanded Visual Assessment (EVA) of large precancerous lesions by medical officers at LEEP sites to enhance remote support

To meet the COP22 target, the program will continue to implement the hub and spoke model in collaboration with MoHW to bring services closer to the target population. The cervical cancer services will be expanded to 15 sites in additional to the existing 28 PEPFAR supported facilities

The program will continue VIA and HPV DNA methods of screening women while treatment options will include cryotherapy and thermal ablation for small lesions, Loop Electrosurgical Excision Procedures (LEEP) and cone biopsy for eligible large lesions. All the 43 sites will offer VIA screening while 15 of the sites provide VIA and LEEP services.

PEPFAR/B will strengthen the ToT model of capacity building adopted by MoHWO to increase the pool of service providers while promoting retention of trained staff and allocation to cervical cancer service points reducing unnecessary referrals. Linkage officers will proactively remind all eligible clients ahead of scheduled ART visit. Missed clients will be followed through phone calls and enhancing collaborations with other PEPFAR funded community-based organizations. PEPFAR/B will continue to enhance client and family-centered services, by extending cervical cancer screening services to FSW creating awareness through

KP peers and linked for VIA screening and treatment following positive high-risk HPV DNA testing results. The cervical cancer HPV DNA screening and management for FSW will follow GoB guiding principles, including voluntarism, informed consent, and confidentiality.

The Botswana MoHW's cervical cancer program provides treatment services for women with large lesions and those diagnosed with a clinical suspicion of cancer at Nyangabgwe and Princess Marina referral Hospitals for the Northern region and Southern regions respectively. The program will support the PEPFAR/B will enhance the. EVA will facilitate mentoring and appropriate management of complicated cases by available specialists at referral hospital and strengthen linkages.

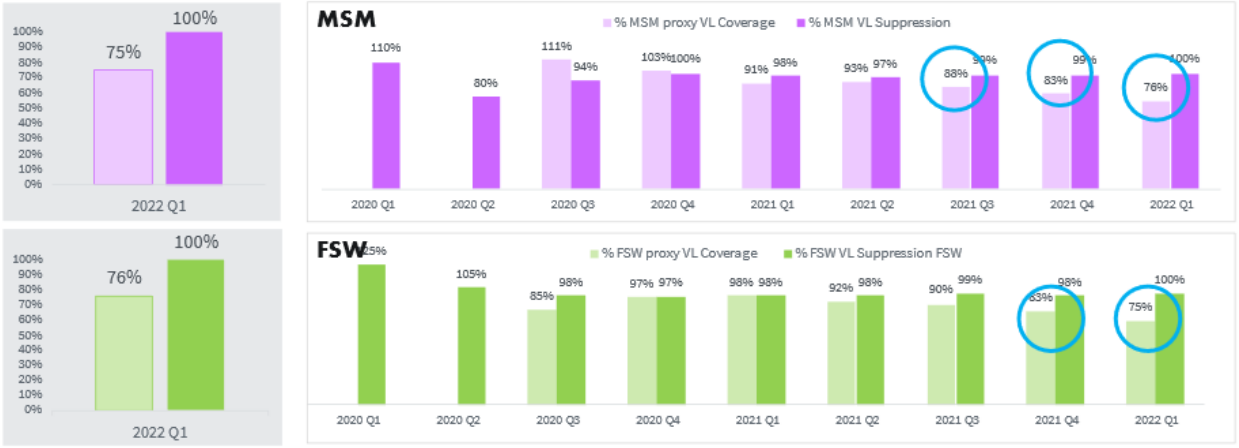
Cervical cancer mobile electronic medical records (EMR) app will be used to facilitate real-time quality data reporting.

Collaboration with community-based organization will be promoted to increase community awareness of cervical cancer screening among WLHIV. COVID-19 precautions will continue to be observed to ensure safety of clients and staffs through; 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.

4.10 Viral Load and Early Infant Diagnosis Optimization

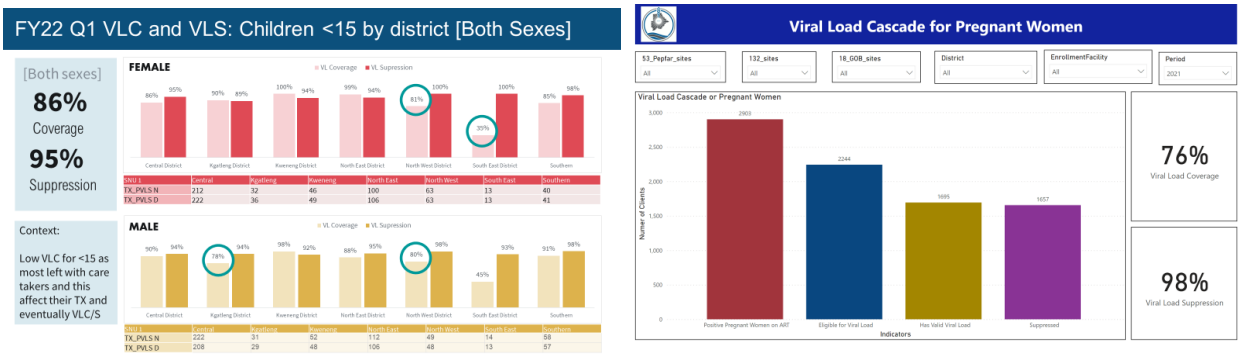
Although Botswana has attained 93-98-98 there are still gaps in viral load coverage with KPs (A/CHLIV, FSW, MSM and PBFW and some SNUs) being more affected as seen in the figures below.

In COP22 PEPFAR/B's goal is to optimize diagnostic network activities for VL/EID, TB and other co-infections to reduce morbidity and mortality across age groups, sub populations and SNUs. Our vision is to reach 98% Viral Load Coverage and 100% Viral Load Suppression across age and sex bands through activities that will sustaining high VLC/S, improving VL access for KPs and A/CLHIV and optimizing the VL diagnostic network.



As an OU we aim to sustain the current high viral load coverage and suppression through supporting people-centered services, strengthening clinic-lab interface, maintaining VL line list at all sites, support scale up of specimen & results management registers, introduction of specimen tracking system, optimizing ART treatment and ensure retention of clients on TX. Specifically, the OU will have targeted activities to improve VL coverage and suppression amongst A/CHLIV, FSWs, and MSM as these are the populations that have continually reported coverage levels below the national ones.

These will be done through establishment of people-centered program for children and adolescents; equitable people centered VL services for FSW and MSM, which will include creation of appointment system, special days/times for blood collection, profiling of each client, optimized treatment regimen for all populations including pediatric DTG and clinical mentorship focused on A/CHLIV. The aim is to close the existing gaps especially amongst this special groups but tailor making services that take into consideration their needs and challenges and factors that hinder them from accessing services.



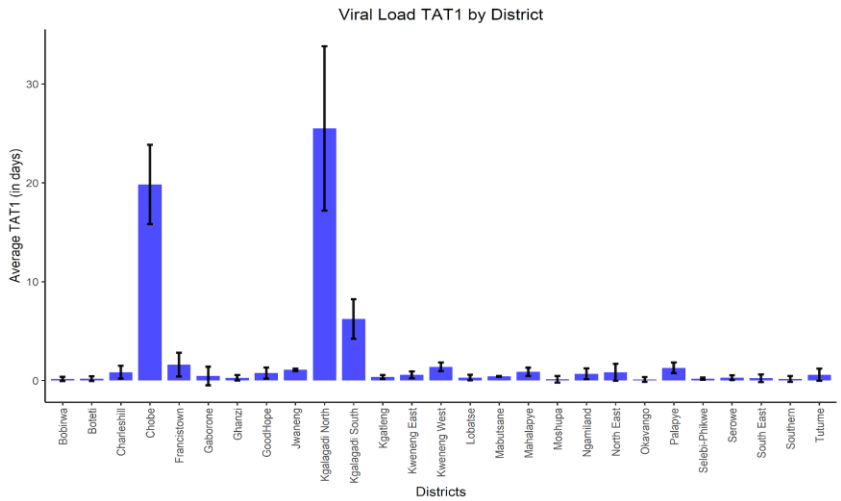
Additionally, PEPFAR/B will optimize VL testing through interfacing of the newly acquired VL equipment, rolling out lab nodes to sites with government data network to improve results access, continue implementation of quality management system (QMS) and accreditation of VL laboratories. PEPFAR/B will support government to do equipment maintenance, leveraging decentralized service delivery models to improve VL access for KP, interoperability of EMRs, optimizing laboratory referral system and supporting HIV drug resistance (HIVDR). monitoring.

In COP22 PEPFAR/B goal is to optimize Diagnostic network activities for VL/EID, TB and other coinfections to reduce morbidity and mortality across age groups, sub-populations and SNUs. PEPFAR/B aims to ensure 98% VLC & 99% VLS amongst and 90% VLC for children. Our vision

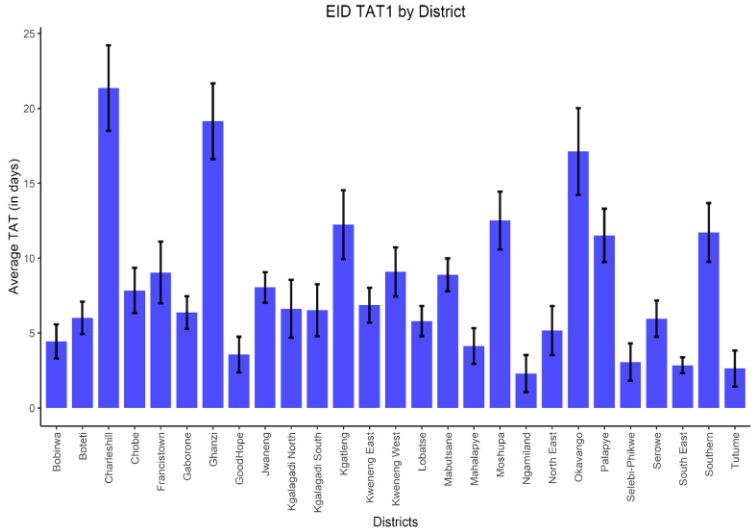
is to reach 98% Viral Load Coverage and 100% Viral Load Suppression across age and sex bands through sustaining high VLC/S, improving both VLC/S amongst KPs and A/CLHIV and optimizing the VL diagnostic network. As an OU we aim to sustain the current high viral load coverage and suppression through supporting client centered services, strengthening clinic-lab interface, maintaining VL line list at all sites, support scale up of specimen & results management registers, introduction of specimen tracking system, optimizing ART treatment and ensure retention of clients on TX.

OU will also strive to improve VL coverage and suppression amongst A/CHLIV, FSWs, and MSM as these are the populations that have continually reported coverage levels below the national ones. These will be done through establishment of people-centered program for children and adolescent equitable client centered VL services for FSW and MSM, creation of appointment system and special days/times, profiling of each client, optimized treatment regimen for all populations including pediatric DTG and clinical mentorship focused on A/CHLIV. The aim is to close the existing gaps especially amongst this special groups but tailor making services that take into consideration their needs and challenges and factors that hinder them from accessing services. Additionally, PEPFAR/B will optimize VL testing through interfacing of the newly acquired VL equipment, rolling out lab nodes to sites with government data network to improve results access, continue implementation of quality management system (QMS) and accreditation of VL laboratories, equipment maintenance, leveraging decentralized service delivery models to improve VL access for KP, interoperability of EMRs, optimizing laboratory referral system and supporting HIVDR testing.

PEPFAR/B conducted a diagnostic network optimization (DNO) assessment in COP21 which showed that though we have robust lab equipment and a defined referral system, the equipment utilization is still. VL/EID equipment utilization ranged from <5%% to 50% across the various platforms. The DNO exercise also identified the following challenges: sample and result referral network, sample transportation, laboratory opening times for some sites and staffing. Additionally, there is equipment that is still not interfaced, challenges with data accessibility and electronic data entry for some sites referring to the labs. These lead to long TAT at some facilities as shown below.



Long VL TAT in Chobe, Kgalagadi N&S



Long *TAT for Charleshill, Ghanzi and Palapye*

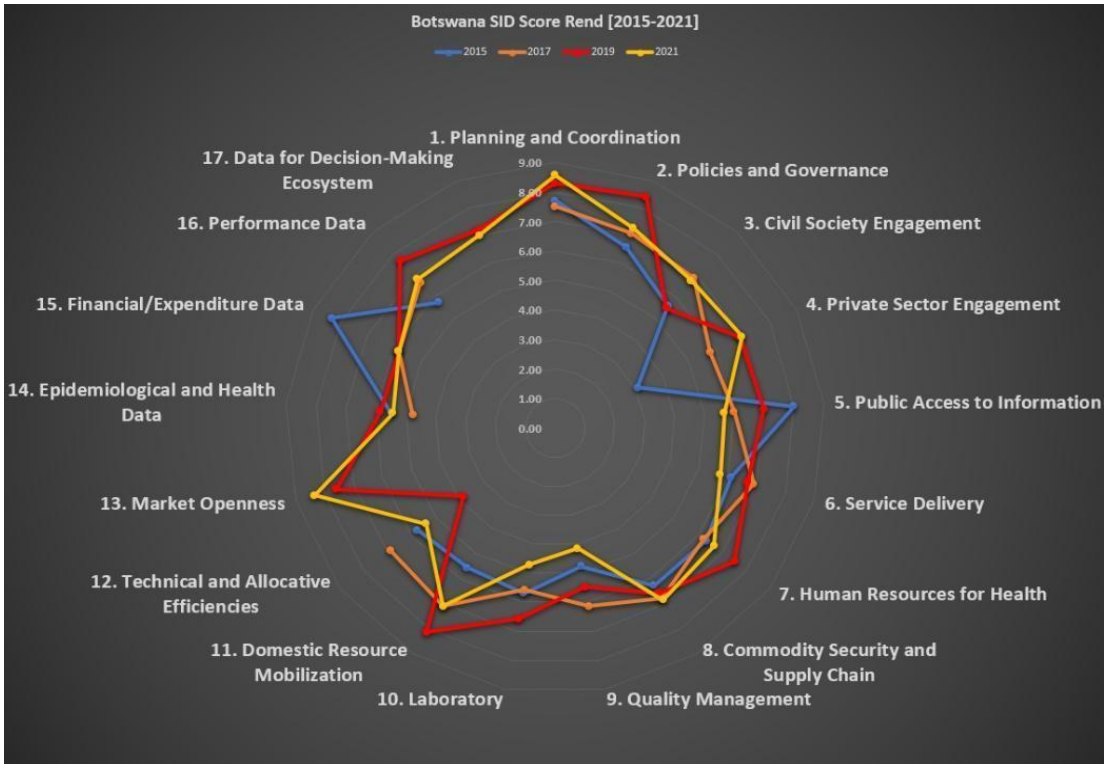
Therefore, in COP22, PEPFAR/B will close these gaps by focusing on increasing access to results and results utilization through installation of IPMS lab nodes, interoperability of IPMS and PIMS, equipment interface, strengthening lab-clinic interface and training IPMS super users who will train and mentor others at site level. We will also improve efficiencies by embarking on equipment multiplex to bring services closer to the people and developing regulatory frame works and policies.As we move towards more TA, the laboratory will work closely with other programs to build a comprehensive clinical mentorship program. This will be built on the manpower that already exists at labs and will start off with the 7 focus areas: 1) Clinic lab interphase, 2) Sample and results management and referral, 3) Strengthen PT participation and performance, 4) Development and implementation of QMS, 5) Selection and monitoring of Quality Indicators, 6) Strengthen Biosafety and waste management, and 7). Implementation of CQI projects.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

PEPFAR supported health systems strengthening activities towards building a capable, resilient, enduring, and inclusive national health system for sustainable HIV epidemic control.

Systems investments implemented at the above-site level are designed to address the most critical systems-based barriers that inhibit epidemic control as well as prevent sustenance of implemented activities. The areas of health systems investments for COP22 were prioritized from the recommendations from multi stakeholder consultative meeting for the health systems strengthening stakeholders as well as taking into consideration the SID 2021 highlighted areas that showed a decline in performance in comparison to SID 2019 (average of 6.57 to 5.62) and therefore needed strengthening. MER indicator performance of an area as well as Minimum program requirement (MPR) performance were also factored in during the prioritization.

SID provides a sustainability analysis for HIV epidemic control; it is used to measure programmatic and financial sustainability across 17 elements under four sustainability domains.



The SID scores provided data to identify priority areas for investment that will advance Botswana sustainability agenda. The radar chart includes the scores across all the elements for the four SID done so far. Comparing Botswana 2021 SID scores with that of 2019, the health system was doing better between 2017 and 2019 than after 2019.

This could be due to the impact of COVID-19 pandemic and an indication for more investments in improving Botswana health system to be able to sustain the gains of HIV response and achieve an AIDS free generation. Furthermore, investments were prioritized based on interventions needed to ensure Botswana has the capability to sustain the gains of HIV response and build a strong, resilient, and inclusive health system.

In addition to prioritizing PEPFAR/B systems strengthening investments with the key system barriers identified in the SID findings, areas identified as not funded through other stakeholders were also prioritized so as to optimize and complement donor funding and achieve a return on investments as Botswana approaches epidemic control. All areas of the national health system and service delivery SID domain 02 showed a decline in the 2-year period. Though most of this decline could be linked to the pandemic, there were other causes as noted in the responses to the sustainability index dashboard matrix tool and highlighted as needing strengthening. The Minimum program requirements addressing the health system strengthening domain (MPR 5, 11, 15 and 16) were also.

The determination of which priority areas will be prioritized for COP22 was done through a combination of processes that looked at the following.

- The ranking of the priorities under each area. Review of past investment for relevance and impact.
- Engagement with several actors to determine current above site needs and gaps relative to epidemic control priorities.
- The scores for 2021 SID and the trend of scores from previous SIDs.
- MPR & MER performance data
- Prioritization of host country and key stakeholder recommendations.

Throughout the consultative process, host government priorities and recommendations were given due consideration. To keep Botswana HIV response on track, PEPFAR above site 2022 investments will encourage inclusiveness and population centeredness by promoting interaction between the government, CSOs, communities, households, the private sector, and other stakeholders. In addition, PEPFAR investments will promote equity to reach the poor, underserved, marginalized and vulnerable to ensure that everyone, everywhere have equal access to HIV/AIDS services.

The ultimate goal of the systems investments at country level will be the indication that the system is adequately functioning. Though there were more barriers identified through stakeholder discussions, PEPFAR/B prioritized the following systems strengthening areas for COP22 implementation.

- Human resources for Health (HRH)
- Health Financing
- Collecting, managing, and using routine program data
- Supply chain and commodities management
- Continuous Quality Improvement (CQI)
- Laboratory systems
- Community systems strengthening
- Clinical systems strengthening

This COP year PEPFAR/B systems strengthening support will go towards support for new surveys, continuation of ongoing surveillances and their scaleup for timely information provision and for informed decision making, investment in CQI and scaling it up in proportion and direction of the program, support for data systems to get more data electronically available in our systems and accessible to users. Support will also be provided to policies that are required for efficiencies and effectiveness of processes and procedures such as for HRH, supply chain management, laboratory and CQI.

PEPFAR/B will continue to work on supporting government on Supply and commodities management, implementation of the Integrated training curriculum by the Kitso training Unit, as well as strengthening both the clinical and community health systems. Small investments will be made on commodities, as more work is done in assisting Government to streamline procurement process to avoid stockouts.

5.1 Strengthen Policies and procedures for Human resources for health (HRH)

The Botswana 2021 SID scores showed sustainability vulnerabilities in the health workforce area. There are challenges in the needed health workforce to ensure that the HIV responses is equitable in Botswana. PEPFAR in addition to working with Government of Botswana in building capacity of staff at national and sub-national levels will, strengthen HRH through technical assistance and strengthening of policies and process for HRH.

Botswana as other developing countries experiences real shortages of health workers. Building up this health workforce will be an absolute key to achieving HIV epidemic control and ensuring a sustainable response. This however requires a long-term frame and incremental changes, a good starting point of which will be to conduct a situation analysis to better understand Botswana HRH gaps for appropriate interventions.

In COP22, to increase domestic functional responsibility, PEPFAR will support the Government of Botswana to improve HRH planning & management by:

- Conducting HRH situation analysis
- Updating National HRH policies & strategies for long term sustainability of HIV response
- Establishing an integrated HRH information system for comprehensive HRH capture & utilization of data for decision making & equitable deployment
- Institutionalizing routine National Health Workforce Account for updated and realistic projection or estimation of staffing levels for provision of HIV services at different levels of the health system
- Supporting HRH deployment reconfiguration in line with the TA vision of the GOB

Timelines, benchmarks, and outcomes have been adequately defined for proposed human resources for health systems strengthening interventions and they will be done over time in an incremental manner.

5.2 Strengthen health financing

Health financing was also identified as an area of vulnerability needing investment. Interventions to address existing and emerging gaps for health financing were prioritized to address the areas of Technical and Allocative Efficiencies, Financial/Expenditure Data and Domestic Resource Mobilization, as well as ensuring that necessary budget lines are mainstreamed into the national budget to support HIV response.

Botswana's budget and economy will be under enormous pressure for the next few years due to the pandemics and there is need to ensure that domestic resources are available for HIV response as well as an equitable financing to sustain HIV response.

Botswana could feasibly increase its domestic spending on HIV/AIDS by strengthening public financial management for efficient allocation, utilization & management of HIV funds.

In COP22, to increase domestic fiscal responsibility, PEPFAR will support the Government of Botswana by:

- Identifying and resolving bottle necks in the flow of funds through the health system
- Promoting transparency and accountability in resource allocation process and decisions
- Invest in a decentralized routine tracking of HIV expenditure
- Operationalizing strategies to improve PPP to increase access to resources from the private sector
- Strengthening social contracting to sustain financing of local partners and build strong local systems & country owned response

5.3 Strengthen the capacity of GoB to collect, manage and use routine program Data

5.3.1 Surveys and surveillances

Recency, CBS, IBSS & PrEP Ring demonstration project

The MPR 16 for the scale-up of Case Based Surveillance (CBS) and use of unique identifiers has also not been achieved due to challenges in systems interoperability and lack of inclusion of non-citizens in being uniquely identified. PEPFAR investments in this area, will be towards improving the achievement of this MPR by incorporating a way of uniquely inputting non-citizen as well as continuing to link the different systems**.** PEPFAR will also support scale up of recency and CBS. Recency will be scaled up from the 10 sites for phase 1 in COP 21 (6 public facilities and 4 TWCs at PEPFAR supported districts). Recency will be expanded in line with the national protocol, with the ultimate aim of reaching national coverage and to develop Recency response RTeams that will be capacitated in responding to clusters of new infections.

In COP22, we will support the PrEP Dapivirine Vaginal Ring demonstration project. The MoHW is fully supportive of the introduction of new longer-term PrEP methods and this project will allow Botswana to understand the acceptability and issues related to one of these methods as Botswana moves its PrEP program forward. We will also support the IBSS, as it was highlighted as a great need by GOB in order to have key population data in addition to the BAIS V data for informed planning and programming. Support towards the IBSS is also in line with the PLL technical directives for PEPFAR/B to Conduct an IBBS and PLHIV Stigma Index 2.0.

BAIS V data were used by the OU to start to pivot the program and address areas and populations that were identified as not doing well in reaching epidemic control. Prevention and treatment services were refocused toward closing gaps, having more coverage and maintaining gains.

5.3.2 Data systems and interoperability

5.3.2.1 Strengthen the data collection, analytic dashboards and reporting system for effective delivery of OVC

This activity is a continuation from COP21 and will continue into COP22. Through this activity, PEPFAR/Botswana will continue to strengthen the development and roll-out of a National OVC Data Management System which will function on the ONA mobile data collection and visualization platform. This work, which is being done in partnership with UNICEF, supports the Ministry of Local Government and Rural Development, Department of Social Protection (MLGRD/DSP) to address the reporting, analysis and monitoring gaps identified in the OVC service delivery system. Progress made so far include finalization of data collection tools, setting up the 5 GoB servers dedicated to this project and other IT related issues. This will be followed by piloting at district level before roll-out can happen nationally. COP22 support will include completion of the roll-out, training of system users on the use of the system including access to automatic data analysis and visualization tools like dashboard, charts, and maps which are very critical tools for data visibility, real time reporting where decision making information is urgently required. This technical assistance builds on 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.

5.3.2.2 Support GoB data systems to track the layering of DREAMS services

DREAMS program reporting is done through a DHIS based National DREAMS Database (NDDB) which is hosted at the Ministry of Health and Wellness (MoHW). The system was launched in November 2020 and officially handed over to GoB in July 2021. In COP21, PEPFAR supported training of the users and secondment of an M&E Advisor and a Data analyst to implement data quality initiatives and facilitate data analysis and reporting. In COP22, additional HR support will be provided in the form of an IT officer to support the help desk and provide system maintenance back-end support. This position will be funded through the GoB cooperative agreement mechanism. Global Communities will provide capacity building (skills transfer) to the officer to ensure they are competent in working with the system.

5.3.3 Data collection backup & completeness of Data in the NDW

The 2021 SID Domain 4 for Strategic information also showed as with the other Botswana SID domains, a general decline in comparison to SID 2019 (6.63 to 6.27) with epidemiology and health data (5.86-5.43) as well as performance data (7.67-6.81) being the most affected.

Additionally, through the PLL, Data Availability, Quality, and Use was identified as one of the technical directives that as a country Botswana still needed to work on. Issues of data quality, data for decision making, and improvement of electronic medical records, including ongoing work on HMIS interoperability with the government as well as strengthening local capacity for data analysis and use of strategic information still need to be strengthened.

A review of the MPR 13 on reporting and monitoring of morbidity and mortality showed that we are still experiencing challenges in this area especially with EMR utilization and reporting in general. Data at some sites is also still in the paper form. SIMS results also indicated challenges on the area on data reporting consistencies especially and HTS_TST (53% red and yellow

scores combined for FY21) TX_NEW (44% red and yellow scores combined for FY21) to be one of the low scoring SIMS areas for COP 21.

To try and address this, more investments will be made towards collection of electronic data and its back up so that data can be available at the national data warehouse for easy access and use for decision making. To address the challenges of data completeness, data entry will be monitored through the utilization of dashboards.

We still have gaps in EMR utilization, there is still a sub-optimal use of EMRs by clinicians. Investments will be made towards training for utilization of EMR as well as to work towards optimizing data input, accessibility & utilization. We will also invest more into, data getting into one national data warehouse for more availability, accessibility, and timely utilization.

The use of unique identifiers for non-citizens, will also be prioritized.

5.4 Strengthen supply chain through procurement and contract management systems & provide stop gap purchases

PEPFAR continues to support and provide Technical Assistance to the national health supply chain to help build a sustainable and robust system.

Progress has been made in implementation of 3-month MMD; ART optimization of DTG-based regimen where the country is currently around 90% or more, as well as the development & use of a web-based dashboard for supply chain data. Remaining gaps include transitioning from 3 to 6 month MMD; MoHW/CMS leading the forecasting and supply planning activities; supply chain data capturing and use for decision making on procurement; contract management strengthening; and lack of an electronic Logistics Management Information System for real-time data.

COP22 planned activities include strengthening of CMS capacity in contract management, for forecasting, and for supply planning as well as strengthening supply chain data collection in the DHIS2 platform to allow for interoperability across the health information system.

PEPFAR/B in COP22, will also support purchase of some stop Gap commodities for HIV, TB and PrEP, to prevent pause in service, while the government of Botswana continues to buy the majority of commodities.

5.5 Establish infrastructure for continuous quality management and build CQI culture

Through SIMS comprehensive assessments, the overall summary performance for FY21 was shown to show an improvement compared to the previous years to 81% green scores. We still have challenges (19% yellow and red scores) in data reporting consistencies especially TX_NEW and HTS_TST, Viral loading monitoring for pregnant women, partner services, community – based linkage and retention support, routine testing of children in our facilities and testing interruptions in a few of our laboratories. These challenges are being addressed through CQI projects. MPR 1
The MPR 11 for Effective QA and CQI into site and program management is still not yet met. Implementation is limited to PEPFAR support sites. Going forward in COP22 we will be working to scale-up CQI to even non-PEPFAR sites.

In COP 22, PEPFAR/B will support the phased scale-up of CQI countrywide to include non - PEPFAR supported sites. The patients and providers charters currently under review to include person-centered approaches will also be disseminated to all sites.

PEPFAR/B will continue in the quest to build a CQI Culture nationally through development of the national CQI strategic plan, trainings, supporting sites in monitoring quality indicators, engaging in quality improvement projects, and supporting learning collaboratives to make sure quality care is sustained in-line with the clinical mentorship program countrywide.

5.6 Strengthen laboratory systems

PEPFAR/B will continue to work with the Government on skills transfer, optimizing systems for diagnostics, quality of testing and accreditation as well as strengthening of the laboratory structures and regulatory framework.

For COP22 the laboratory systems strengthening support for the 1st 95, will be to assist the government align its RHT diagnosis algorithm to the new WHO HTS guidelines (of 3 serial tests) We will also support optimization of case finding, the scale up of recency and self-test. At the government's request PEPFAR/B we will also be working to assist set up a national certification system for POCT sites.

For COP22 the laboratory systems strengthening support will be across the 95's and geared at assisting the government align its RHT algorithm to the new WHO HTS guidelines (of 3 serial tests), optimization of case finding, scale up of recency and self-test for the 1st 95. At the government's request PEPAR/B will also be working to assist set up a national certification system for POCT sites. The support for TB and other OI', will be through increasing TB screening and diagnosis, investing in new technologies for TB diagnosis in children and supporting expansion of TB-LAM. PEPFAR/B will additionally continue to work with GoB at advanced disease management. The support for general laboratory test results access by PEPFAR/B will be through support of equipment interfacing and roll out of IPMS laboratory nodes to remaining sites that are on government data network.

PEPFAR/B will contribute towards strengthening the Laboratory regulatory framework through development and implementation of laboratory policies and guidelines that include strategic plan, and material sharing agreements.

There are still gaps in PT participation and performance, TB detections rates. Lab clinic interphase and laboratory data utilization towards decision making. Our reach for TB expert EQA is at 86% and more work will go towards improving the coverage.

PEPFAR/B will continue to work with GoB on Quality of laboratory testing through support for QMS and accreditation maintenance. Labs will be supported through training, mentorship and site supportive supervision. Additionally, labs will be continually assessed through different tools (SLIPTA, SIMS, VL/EID score card) to assess if there is improvement in their service quality

POCT sites will continue to be supported for their RHT CQI activities to ensure that more are mentored and audited for improvement so as to meet the level 4 point of care testing (SPI_RT) testing standards. PEPFAR/B will be working with government and TA from CDC HQ to establish a national POCT certification system.

As Botswana works towards epidemic control and sustaining investments done, we will work to strengthen the Lab M&E, QMS and accreditation. As PEPFAR/B pivots towards more TA, the laboratory program will be re-focused to be part of the comprehensive clinical mentorship program by contributing the laboratory component of this mentorship program.

This will be built on the human resources that we already have at labs and will start off with the identified eight priority areas for the government of Botswana laboratory program of biosafety biosecurity and waste management, development and implementation of QMS, sample management and referral, PT participation and performance, selection and monitoring of quality indicators, lab clinic interphase and prioritized technical laboratory skills.

5.7 Strengthen clinical systems

In addition to providing support to the government on varied areas of clinical systems strengthening through technical assistance and embedding, COP22 focus for PEPFAR will be to build sustainable systems through establishment of a clinical mentorship program that is all encompassing of all health care cadres with an aim to reach all districts. In COP22, the infrastructure for the mentorship program will be built, and sites will be rolled into the mentorship program to eventually reach national coverage in future COP years.

Support will also go towards the MoHW's effort to build the knowledge and skills of HCW for the delivery of quality HIV combination, prevention care and laboratory services through support to the Kitso training unit. The Kitso training unit of the ministry of Health will be supported to provide in-service training using the integrated training curriculum to establish effective, efficient, harmonized, comprehensive and coordinated HIV/AIDS prevention and care training programs for Health Care providers that are standardized and sustainable. COP22, support will also be aimed at strengthening supportive supervision and mentorship as part of the overall effort to strengthen the health care delivery system.

5.8 Strengthen community health systems

Community systems structures provide a critical link between the community and health facility/clinical responses and are important to achieve epidemic control and sustaining response**.** Underlying systems challenges that lead to weakening of the system need to be addressed as we build towards a strong public health system with adequate infrastructure that will sustain community led and community-based response/interventions.

The landscape for HIV service delivery is dynamic and requires re-tooling of technical competencies and capacities of community structures and actors to refocus programs appropriately. The COVID pandemic demonstrated the importance of having a robust community system to ensure access. Furthermore, the pandemic suggests a rebuilding of community health system tailored to the country's context. This is in line with the MoHW's overall primary health care agenda, which has the ultimate goal of bringing services to where people need them.

In COP22, to contribute to achieving epidemic control and sustaining the response, PEPFAR will support activities towards linking communities to the overall health system for improved access to HIV services. The capacity of CHWs will be improved to implement a wide spectrum of HIV interventions, including demand creation for HIV testing services, ART, PMTCT, VMMC,

TB treatment, adherence counseling and support, provision of support to OVCs & DREAMS, KP services etc.

PEPFAR will support the MoHW to operationalize The National guideline for the implementation of integrated community-based health services. PEPFAR will provide support to the national Department of Community Health Services to roll out the guidelines. This will include secondment of staff to the department.

In addition, PEPFAR will support the continued strengthening of the community data system to ensure that it is being used universally and is feeding into the national data system. Further, PEPFAR will work with MoHW to understand how it can better understand its community HRH needs and how it can coordinate this with the national HRH activities. Finally, this will all be closely linked to Botswana's PHC revitalization agenda.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

Each PEPFAR/B implementing agency monitors their staff alignment to the PEPFAR/B strategic goals as well as planning for the program's management and operation's needs. This includes ensuring the staff capacity is utilized for program monitoring, partner management and technical support.

In the absence of Volunteers, Peace Corps staff have been charged with building and maintaining relationships directly with communities formerly served by Volunteers. Direct services and capacity building trainings have been offered to communities on topics including prevention and youth empowerment. These direct engagements continue to deepen relationships between Peace Corps and communities served and will enable a more rapid roll-out of joint Volunteer/Community led activities beginning in COP22. This strategic shift in activities has been achieved with no changes to the existing staffing structure. With the demand that comes with management of Local Partners, the USAID staffing footprint has had to keep up with the need. USAID has been approved to add one local staff member to support local IP needs

6.1 Long-Term Vacancies

Peace Corps, CDC, and DoD do not have any Long-Term Vacancies. USAID has a vacant position for Senior Adolescent and Youth Advisor and PEPFAR Coordinator position. These positions are currently under recruitment and will be filled before the end of FY22. State (PEPFAR Coordination Office) also has three additional vacant positions, Communications Specialist, Public Health Administrative Management Assistant and PEPFAR Community Grants Coordinator) which will also be filled before the end of FY22.

6.2 New Positions

OGAC has approved additional funding to support one position, Accountant, to support USAID local partner transition work.

USAID

Accountant

USAID/PEPFAR has 6 local partner IMs and their COP22 budget is 57**%** of USAID's total IM budget. This position will provide local IPs with Financial Management mentorship and monitoring of their alignment with USG Financial management regulations and reporting requirements. Included in the scope is also financial planning, management and reporting. This position will ensure appropriate and timely reporting on all USG requirements including VAT, accruals and audits. There is currently no designated position to support local partners on Finance and accounting, the workload has been shared by Program Managers with support from Office of Acquisition and Assistance and Regional Finance Office in Pretoria, South Africa

CDC

Health Policy and Communications

CDC will repurpose an existing local position that will not impact the overall staffing footprint for the purpose of strengthening health policy and communications. The repurposed CDC position will serve as the locally-employed senior public health policy and communication advisor to the CDC Botswana Country Director and senior leadership. This position will work closely with the Public Affairs office within the US Embassy and the Botswana PEPFAR Coordinator's office to ensure accurate and useful information about CDCs work is communicated with the public. This position will also work closely with CDC headquarters to ensure all CDC policies are followed in communicating health information. The individual will advise on long term planning of technical and strategic direction of all public health programs implemented, funded and/or supported by CDC Botswana. This position will provide advice to the Country Director in support of strengthening the relationship and health diplomacy between the USG and the GoB. The position will be responsible for advising the Country Director on the host country policy environment and the best positioning of CDC to support Botswana's national public health portfolio.

6.3 Overview of the Cost of Doing Business (CODB)

As part of the COP22 process, PEPFAR/B examined its interagency staffing footprint and organizational structures. The overall Botswana CODB in COP22 reduced by 4% from COP21. The reduction was mainly due to PCs realignment for projected intakes of volunteers and DOD's zero funding in COP22. The staffing profile reflects cross-cutting technical support to the priority COP22 strategies.

CODB by Agency			
Agency	**CODB COP21 Total**	**CODB COP22 Total**	**Difference**
Totals	**$14,279,888**	**$14,515,919**	**$236,031**
DOD	$164,787	$0	**(164,787)**
HHS/CDC	$ 6,302,580	$6,302,280	**(300)**
HHS/HRSA	0	0	**0**
PC	$3,715,071	$2,964,944	**(750,127)**
State	$629,890	$629,890	**0**
USAID	$3,703,890	$4,041,564	**337,674**
Total	**14,516,218**	**$13,938,678**	**(577,540)**

CDC

CDC's COP22 CODB remained consistent with COP20 and COP21 funding levels. Included in CDC's CODB budget is funding to support management and upkeep of the Gaborone West "G-West" facility shared by CDC, USAID, DoD and the PEPFAR/B Coordination Office. This facility is located outside the US Embassy compound. Facility costs supported by CDC include routine

maintenance and upkeep of the physical infrastructure, emergency maintenance and repairs, routine janitorial services, maintenance and upkeep of the grounds, trash collection and removal, physical security, and security system upgrades and, all procurements in support of these facility maintenance services. While CDC's CODB funding has remained level since COP20, increased facility maintenance costs are anticipated in COP22 due to the need to replace all security cameras within the shared facility. Additionally, CDC anticipates some construction related costs may be incurred in COP22 as a result of an extended timeline of completion of the construction of the "Safe Haven" spaces at G-West. A portion of CDC Management and Operations staff level of effort also goes to support these services and upkeep for the shared facility.

Peace Corps

Peace Corps' budget was reduced in COP22, all of which is allocated in the CODB category in accordance with global financial planning guidance for Peace Corps. This reduction is a realignment between projected intakes of Volunteers in COP22, which is reduced from COP21 plan levels. Peace Corps/Botswana currently has plans to bring 90 new Volunteers to support PEPFAR efforts in country beginning at the end of COP21 and extending into COP22. Of these 90, 13 will serve short term, high impact assignments as Peace Corps Response Volunteers in each DREAMS district around the country. Twenty-five of those Volunteers will serve full two-year assignments in support of PEPFAR DREAMS activities and the majority of them will be strategically placed in the DREAMS growth areas. 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 is exclusively applied pipeline at $2,964,944.

State (PEPFAR Coordination Office)

State's CODB has remained flat from COP21 to COP22.

USAID

USAID's CODB increased by $337,674 (9%) from COP21 levels due to the new local position approved by OGAC, increased ICASS (16%) and staffing relocation costs, increases on the LES (22%) and international (8%) positions pay structure.

APPENDIX A -- PRIORITIZATION REQUIRED

Table A.1 COP22 SNU Prioritization to Reach Epidemic Control

	<01		01-04		05-09		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
District Name	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Overall
Bobirwa District	0.0000	0.0000	0.666295	0.168201	0.570496	0.405616	0.483365	0.573775	0.950816	0.656914	0.972456	0.746637	0.979751	0.764811	0.982157	0.783571	0.947642	0.837119	0.995209	0.886188	0.997118	0.936658	0.996341	0.958666	94.81%
Boteti District	0.0000	0.0000	0.674039	0.177451	0.663082	0.432569	0.581832	0.641941	0.943754	0.667247	0.96378	0.759164	0.971548	0.777822	0.976309	0.792678	0.933582	0.844389	0.993246	0.892009	0.996196	0.940135	0.994564	0.960839	94.55%
Charleshill District			0.28554	0.140908	0.493643	0.318232	0.331726	0.450568	0.927963	0.625962	0.926424	0.672234	0.943826	0.732025	0.956314	0.733853	0.882979	0.795102	0.983856	0.855583	0.991874	0.921273	0.992373	0.949472	92.66%
Chobe District	0.0000	0.0000	1.227993	0.298483	1.004028	0.625276	0.955676	0.988265	0.959776	0.648278	0.974131	0.737475	0.980736	0.759865	0.986234	0.785027	0.954963	0.837301	0.996824	0.886283	0.997188	0.934915	0.996917	0.957364	95.44%
Francistown District	0.1429	0.1250	0.507839	0.122075	0.449725	0.286391	0.41794	0.430361	0.940315	0.634628	0.962102	0.73058	0.970173	0.751838	0.975119	0.769953	0.929466	0.826793	0.992894	0.87915	0.995516	0.932033	0.994787	0.955778	93.64%
Gaborone District	0.0909	0.0909	0.673053	0.201481	0.585185	0.415264	0.48352	0.596835	0.937383	0.666992	0.95915	0.75445	1.269089	0.773806	0.973451	0.7907	0.927089	0.843033	0.992175	0.890836	0.995251	0.938993	0.994319	0.960407	94.70%
Gantsi District	0.0000	0.0000	0.669827	0.152047	0.511422	0.384569	0.380595	0.521038	0.838579	0.555522	0.885534	0.657516	0.906999	0.685032	0.920692	0.704103	0.811039	0.768552	0.974581	0.832129	0.982934	0.904825	0.981785	0.937199	90.21%
Goodhope District	0.0000	0.0000	0.561302	0.156939	0.524827	0.39122	0.431241	0.560534	0.83666	0.502991	0.884485	0.614987	0.905488	0.640358	0.918119	0.663341	0.805887	0.737449	0.972934	0.809525	0.984026	0.887796	0.979658	0.925779	89.36%
Jwaneng District	0.0000	0.0000	0.465199	0.128091	0.451146	0.355232	0.362016	0.483281	0.897967	0.630803	0.935867	0.716901	0.947655	0.738827	0.95522	0.76041	0.883548	0.817455	0.986019	0.871626	0.991531	0.928494	0.990227	0.952624	92.53%
Kgalagadi North District	0.0000	0.0000	1.230635	0.208634	0.663271	0.456545	0.463369	0.61502	0.936493	0.620721	0.958012	0.722032	0.964695	0.744593	0.966344	0.758467	0.916218	0.814645	0.989512	0.872968	0.995786	0.926126	0.994688	0.952043	93.91%
Kgalagadi South District	1.0000	1.0000	0.759278	0.174953	0.563496	0.432461	0.500812	0.610088	0.909109	0.572712	0.936691	0.700315	0.949924	0.71307	0.958332	0.727852	0.888967	0.793492	0.986493	0.853915	0.992705	0.916763	0.990208	0.943977	93.04%
Kgatleng District	0.0000	0.0000	0.842605	0.226006	0.659642	0.443317	0.549357	0.655873	0.929085	0.662689	0.950798	0.746238	0.961522	0.761697	0.967379	0.781408	0.915154	0.833533	0.989791	0.883059	0.99397	0.934377	0.99299	0.957138	94.26%
Kweneng East District	0.1667	0.1667	0.737734	0.165278	0.523998	0.382968	0.435124	0.545761	0.964234	0.691575	0.978234	0.775562	0.983413	0.793097	0.985854	0.810805	0.955763	0.857842	0.995789	0.90169	0.997598	0.945129	0.99705	0.964577	95.35%
Kweneng West District	0.0000	0.0000	0.477833	0.147906	0.5772	0.429644	0.467533	0.601114	0.977057	0.678139	0.986535	0.762277	0.992544	0.780317	0.992604	0.792851	0.976697	0.846923	0.997974	0.89271	0.999244	0.940177	0.998333	0.96169	95.28%
Lobatse District	0.0000	0.0000	0.486262	0.166075	0.539193	0.39868	0.439017	0.552475	0.893102	0.632882	0.934857	0.725985	0.947668	0.751721	0.953475	0.765804	0.883117	0.824477	0.985891	0.876397	0.991563	0.930453	0.989695	0.953988	93.44%
Mabutsane District			0.604349	0.236494	0.823849	0.528869	0.690105	0.782134	0.988589	0.676392	0.96308	0.769442	0.980703	0.760408	0.98401	0.783652	0.951695	0.834485	0.996615	0.890908	0.996974	0.937904	0.997009	0.960082	95.41%
Mahalapye District	0.2000	0.2000	0.824932	0.215535	0.705669	0.495169	0.596388	0.724294	1.015165	0.740178	1.012895	0.816957	1.010416	0.831936	1.009542	0.845611	1.017064	0.885833	1.003323	0.921554	1.002209	0.956718	1.0025	0.972303	97.31%
Moshupa District	0.0000	0.0000	0.738794	0.196765	0.661549	0.44477	0.537814	0.647033	0.947912	0.657168	0.971358	0.751128	0.974097	0.771621	0.97895	0.788318	0.938513	0.840097	0.993711	0.890691	0.996051	0.938896	0.995602	0.959881	94.86%
Ngamiland District	0.0000	0.0000	0.662965	0.163817	0.593149	0.366966	0.55039	0.562245	0.953738	0.656454	0.974146	0.749717	0.979669	0.771023	0.983446	0.789175	0.950011	0.841542	0.995322	0.890275	0.997456	0.938465	0.996749	0.960225	94.86%
North East District	0.0000	0.0000	0.612347	0.138576	0.468039	0.579073	0.3841	0.492648	0.944181	0.624857	0.964891	0.713655	0.974228	0.74269	0.977715	0.759563	0.936705	0.818024	0.993323	0.871258	0.995882	0.927951	0.996015	0.952697	94.30%
Okavango District	0.0000	0.0000	0.561803	0.165236	0.536018	0.414878	0.438751	0.569878	1.005614	0.677223	1.00139	0.768841	1.004086	0.783477	1.003353	0.800873	1.002418	0.851263	1.001509	0.89879	1.000854	0.942854	1.000842	0.963461	96.52%
Palapye District	0.0000	0.0000	0.708575	0.181888	0.636409	0.409904	0.572421	0.612556	0.987509	0.67497	0.997176	0.768357	0.998909	0.785866	0.999142	0.802033	0.990039	0.852313	1.00012	0.897844	1.000122	0.942806	1.000089	0.96304	96.01%
Selibe Phikwe District	0.0000	0.0000	0.930882	0.249559	0.652116	0.480727	0.556668	0.685121	0.952149	0.678314	0.970037	0.762328	0.977399	0.782535	0.980495	0.798444	0.94186	0.848854	0.994659	0.895856	0.996519	0.942195	0.995606	1.024706	94.91%
Serowe District	0.2500	0.2500	0.616288	0.148845	0.555652	0.377536	0.476881	0.548701	0.958824	0.656931	0.975353	0.748606	0.981452	0.76951	0.98433	0.786785	0.952741	0.84035	0.995503	0.888197	0.997319	0.937757	0.996772	0.95965	94.74%
South East District	0.0000	0.0000	1.326703	0.218007	0.585855	0.442018	0.501243	0.623734	0.935707	0.646861	0.952332	0.750145	0.966841	0.765421	0.969437	0.780794	0.920817	0.835902	0.990952	0.885279	0.994389	0.935511	0.993474	0.958728	94.44%
Southern District	0.0000	0.0000	0.807487	0.206312	0.667012	0.470285	0.546043	0.680063	0.929239	0.635817	0.955493	0.73786	0.964336	0.751703	0.971073	0.774194	0.920197	0.828338	0.991167	0.880774	0.994884	0.93188	0.993796	0.955962	94.24%
Tutume District	0.2500	0.2500	1.696124	0.383263	1.15025	0.824458	1.159512	1.356953	0.928236	0.497532	0.954556	0.586323	0.96499	0.604581	0.970273	0.6201	0.916825	0.668808	0.99121	0.714456	0.994564	0.760612	0.993371	0.781907	98.37%

1 **SCALE-UP: Saturation** | **Districts:** Goodhope

26 **Attained** | **Districts:** Bobirwa, Boteti, Charleshill, Chobe, Francistown, Gantsi, Goodhope, Jwaneng, Kgalagadi North, Kgalagadi South, Kgatleng, Kweneng East, Kweneng West, Lobatse, Mabutsane, Mahalapye, Moshupa, Ngamiland, North East, Okavango, Palapye, Selibe Phikwe, Serowe, South East, Southern, Tutume

APPENDIX B – Budget Profile and Resource Projections

B.1. COP22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP22 Budget by Program Area

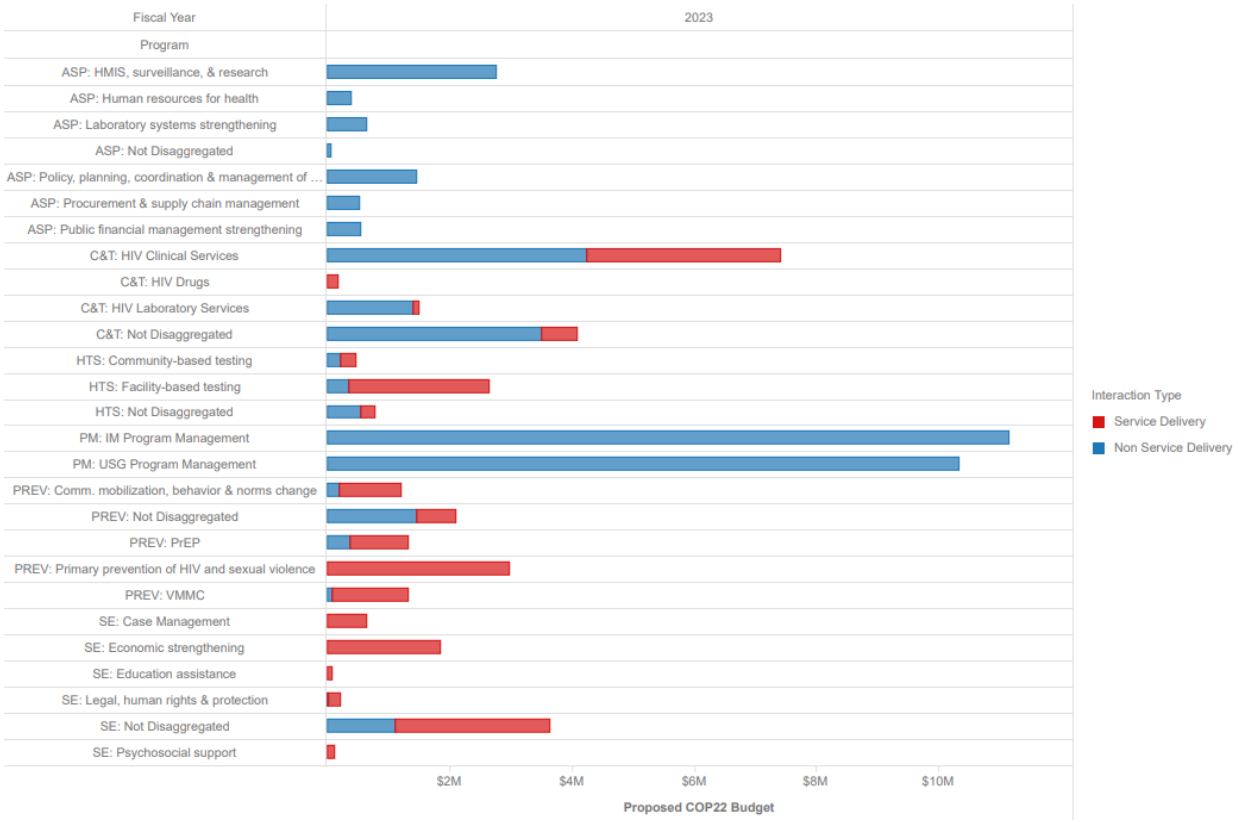


Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$41,294,173**	**$19,061,506**	**$60,355,679**	**68%**	**32%**	**100%**
C&T	**Total**	**$9,135,402**	**$4,032,855**	**$13,168,257**	**69%**	**31%**	**100%**
	HIV Clinical Services	$4,235,348	$3,181,021	**$7,416,369**	57%	43%	**100%**
	HIV Drugs		$180,000	**$180,000**		100%	**100%**
	HIV Laboratory Services	$1,403,600	$90,000	**$1,493,600**	94%	6%	**100%**
	Not Disaggregated	$3,496,454	$581,834	**$4,078,288**	86%	14%	**100%**
HTS	**Total**	**$1,113,827**	**$2,759,898**	**$3,873,725**	**29%**	**71%**	**100%**
	Community-based testing	$208,113	$249,329	**$457,442**	45%	55%	**100%**
	Facility-based testing	$355,001	$2,282,950	**$2,637,951**	13%	87%	**100%**
	Not Disaggregated	$550,713	$227,619	**$778,332**	71%	29%	**100%**
PREV	**Total**	**$2,086,708**	**$6,833,671**	**$8,920,379**	**23%**	**77%**	**100%**
	Comm. mobilization, behavior & norms change	$193,090	$1,015,489	**$1,208,579**	16%	84%	**100%**
	Not Disaggregated	$1,451,218	$642,179	**$2,093,397**	69%	31%	**100%**
	PrEP	$373,100	$946,842	**$1,319,942**	28%	72%	**100%**
	Primary prevention of HIV and sexual violence		$2,969,161	**$2,969,161**		100%	**100%**
	VMMC	$69,300	$1,260,000	**$1,329,300**	5%	95%	**100%**
SE	**Total**	**$1,110,250**	**$5,435,082**	**$6,545,332**	**17%**	**83%**	**100%**
	Case Management		$639,472	**$639,472**		100%	**100%**
	Economic strengthening		$1,850,000	**$1,850,000**		100%	**100%**
	Education assistance		$80,000	**$80,000**		100%	**100%**
	Legal, human rights & protection	$6,500	$204,000	**$210,500**	3%	97%	**100%**

	Not Disaggregated	$1,103,750	$2,541,110	**$3,644,860**	30%	70%	**100%**
	Psychosocial support		$120,500	**$120,500**		100%	**100%**
ASP	**Total**	**$6,370,768**		**$6,370,768**	**100%**		**100%**
	HMIS, surveillance, & research	$2,754,168		**$2,754,168**	100%		**100%**
	Human resources for health	$382,500		**$382,500**	100%		**100%**
	Laboratory systems strengthening	$651,000		**$651,000**	100%		**100%**
	Not Disaggregated	$60,000		**$60,000**	100%		**100%**
	Policy, planning, coordination & management of disease control programs	$1,449,350		**$1,449,350**	100%		**100%**
	Procurement & supply chain management	$525,000		**$525,000**	100%		**100%**
	Public financial management strengthening	$548,750		**$548,750**	100%		**100%**
PM	**Total**	**$21,477,218**		**$21,477,218**	**100%**		**100%**
	IM Program Management	$11,144,736		**$11,144,736**	100%		**100%**
	USG Program Management	$10,332,482		**$10,332,482**	100%		**100%**

Table B.1.3 COP22 Total Planning Level

Metrics	Proposed COP22 Budget	Proposed COP22 Budget	Proposed COP22 Budget
Operating Unit	**Applied Pipeline**	**New**	**Total**
Total	**$9,464,363**	**$50,891,316**	**$60,355,679**
Botswana	$9,464,363	$50,891,316	**$60,355,679**

Table B.1.4 COP22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics	Proposed COP22 Budget						
	Beneficiary	**C&T**	**HTS**	**PREV**	**SE**	**ASP**	**PM**	**Proposed COP22 Total**
Botswana	**Total**	**$13,168,257**	**$3,873,725**	**$8,920,379**	**$6,545,332**	**$6,370,768**	**$21,477,218**	**$60,355,679**
	Females	$1,098,292		$5,904,808	$5,383,092	$221,000	$3,865,969	**$16,473,161**
	Key Pops	$1,188,595	$333,295	$887,032	$200,000			**$2,608,922**
	Males	$199,500		$1,260,000			$540,000	**$1,999,500**
	Non-Targeted Pop	$10,612,570	$3,540,430	$776,139	$111,768	$5,988,218	$16,942,277	**$37,971,402**
	OVC				$850,472	$150,000	$128,972	**$1,129,444**
	Priority Pops	$69,300		$92,400		$11,550		**$173,250**

B.2 Resource Projections

The COP22 planning cycle occurred as restrictions on travel and in-person interactions stemming from COVID-19 began to ease. Long awaited data were available for decision making, including the results of the recent BAIS V, which demonstrated significant progress across the country toward controlling the HIV/AIDS epidemic in Botswana. Based on the latest data and input from key stakeholders, PEPFAR Botswana outlined a new set of priorities for COP22 in line with the objective to maintain the gains the country has made in reaching epidemic control. In addition, a new programmatic vision from Agency leads called for a strategic realignment of activities between USAID and CDC focusing on agency comparative advantages working in clinical and community settings. Agency leads and Front Office also reviewed the key priorities as highlighted in the COP22 PLL to ensure focused and adaptive programming for the OU in response to the predicted working environment.

While overall funding is mostly level with COP21, PEPFAR Botswana was tasked with new priorities in COP22 to address or improve upon including improved data availability, quality and use; TPT service delivery and cervical cancer screening enhancements; and expanded services to adolescent and pediatric people living with HIV. Agency leads agreed to work from COP21 top-line numbers as a baseline and identify key programmatic shifts to accomplish OU goals. As a first step, the OU identified activities to scale back to make room for new growth. DOD's and HRSA's exit from PEPFAR Botswana yielded some savings. Peace Corps will use their applied pipeline in COP22 resulting in a reduction of $0.75 M as compared to their COP21 approved funding level. Beyond these adjustments, CDC and USAID identified activities which could be either reduced or eliminated.

Other activities were identified for realignment between CDC and USAID based on the community and clinical split. To better leverage community-focused competencies of USAID, $1.19 M allocated to CDC for community-based interventions in COP21 has been realigned to USAID in COP22. And to better leverage key clinical strengths of CDC, $0.49 M allocated to USAID for clinical interventions in COP21 has been realigned to CDC. This strategic realignment will begin in COP22, to be fully realized by the beginning of COP23.

Activities identified at the outset of the budget negotiation process that would have a reduced focus in COP22 yielded $1.82M in available funds. These funds were divided evenly between CDC and USAID and allocated according to shared OU priorities. These included programmatic changes to implement new strategies for COP22. Core activities were kept at similar funding levels from COP21 to sustain successes from the prior year.

APPENDIX C – Tables and Systems Investments for Section 6.0 REQUIRED

The Key Systems Barriers-E, Table 6-E tab, and SRE Tool-E tab of the Table 6 and SRE Excel workbook should be saved as a PDF and attached here in Appendix C. The final Excel workbook should be considered a part of the SDS and submitted at the same time.

Key Systems Barriers	 Botswana COP22 Table 6 SRE v8_04.2(
Table 6	 Botswana COP22 Table 6 SRE v8_04.2(
SRE-E tab	 Botswana COP22 Table 6 SRE v8_04.2(

APPENDIX D– Minimum Program Requirements REQUIRED

This should be addressed in narrative in the sections above however in this section succinctly note if the program is meeting or not meeting the minimum program requirement. Address assessment of MPRs by SNU and by proportion of sites meeting standards, as applicable. The minimum requirements for continued PEPFAR support include:

MPRS	STATUS
Care and Treatment	
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	• **MPR adopted and in implementation**, but direct and immediate linkage to treatment not yet above 95% across age, sex, and risk groups. • 49 % Same Day Rate- National Data Warehouse • 76% Same Day Rate- PEPFAR Program Data • **Barrier:** Implementation of same day is not optimal
2) Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	• **MPR adopted and in implementation, but partially met.** Current implementation at more than 83.1%. (FY21 APR) 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 FY21 Q2. TLD transition was completed by September 2021. • The transition covered adults (including women of childbearing age) and children on treatment. • TLD transition documented at 83.1% by FY21 Q4 for adult populations. The rollout of pediatric DTG started in August 2021 and is almost complete. • **Barrier:** Not all sites reported especially sites without pharmacists.
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	• **MPR adopted and in implementation, but partially met.** 3M-MMD policy adopted and in implementation in all the 75 PEPFAR supported health facilities; 48% 3MMD rate-(Panorama); 22% 3 MMD-Rate (National Data Warehouse). • More than half of all patients are on 3 -6+MMD since Q3 of FY21

	● There is a substantial reduction in unreported MMD from 87% by FY20 Q1 to 36% by FY22 Q1. This is due to: ○ Continued mentorship for facilities with established appointment systems ○ Increased utilization of EMRS ○ Inclusion of data elements that capture implementation of MMD in the country's DHIS2 ○ These innovations will continue to be scaled and monitored in COP22 **Barrier:** Underreporting by some facilities. MoHW is monitoring patients' level of adherence to 3 MMD to be able to decide on when to transit to 6 MMD.More than half of all patients are on 3 -6+MMD since Q3 of FY21 ○ There is a substantial reduction in unreported MMD from 87% by FY20 Q1 to 36% by FY22 Q1 ○ This is due to: ○ Continued mentorship for facilities with established appointment systems ○ Increased utilization of EMRS ○ Inclusion of data elements that capture implementation of MMD in the country's DHIS2 ○ These innovations will continue to be scaled and monitored in COP22 ○ 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.
4) All eligible PLHIV, including children and adolescents, - should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	● **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 Q4, 58 129 eligible patients were initiated on TPT, COP20 TPT target was 158 173 in PEPFAR supported sites. ● Twelve health districts out of 27 are currently implementing TPT. GoB stopped the use of INH (6H) & Pyridoxine, now switching to recently adopted 3HP (short regimen), which is procured and ready to be distributed. After a pause to administering TPT by MoHW due to policy issues and Covid 19 outbreak, TPT has been reintroduced across the districts. According to proposed plan, enrollment will start in Bummhi PEPFAR supported sites, then scaled to GOB PEPFAR supported sites then nationally to cover Non PEPFAR sites. In FY22Q2, districts were re-sensitized and HCWs trained to initiate 3HP.
5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and	● **MPR adopted and in implementation, but partially met.**

ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	• **Barrier:** Uneven site-level viral load coverage. Persistent challenges with EID at 2 mo. High number of new HIV diagnoses with late-stage disease.
Case Finding	
6) Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	• **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. • **Barrier:** Need to strengthen mentoring and supervisory support
Prevention and OVC	
7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	• **MPR adopted and in implementation.** • PrEP FY21 APR results of 164% of clients were initiated on PrEP (Panorama). PrEP is currently provided to all populations at risk of HIV acquisition with exception of Prisoners. In COP22 PrEP will be made available to these population. • Botswana has scaled up PrEP by 45% from a target of 7,564 in COP 21 to a target of 10,945 PrEP_NEW for COP 22 to make it available to these populations.
7.1 (COP22 PLL) Decentralized and differentiated service delivery models for PrEP with a focus on KP groups and AGYW,	• **MPR adopted and in implementation, but partially met.** • DREAMS classifies PrEP as Secondary service which is currently only provided at clinics. Reclassification is required to have PrEP e.g Dapivirine vaginal Ring provided at community setting
7.2 (COP22 PLL) PrEP should be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations	• **MPR adopted and in implementation.** • Botswana has scaled up PrEP by 45% from a target of 7,564 in COP21 to a target of 10,945 PrEP_NEW for COP22
8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing	• **MPR adopted and in implementation.** -Program aligned to the 3 program status of OVC: comprehensive, preventive and DREAMS. -Program continues to increase reach for the prioritized OVC sub-populations as follows:

support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	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 and offering 90% of them enrollment into the OVC comprehensive program. -Expanding reach for 9–14 year-olds with HIV and violence prevention through OVC and DREAMS platforms.
Policy & Public Health Systems Support	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	● **MPR adopted and in implementation, but partially met.**
10) Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	● There are no formal or informal user fees to access HIV and related health services in Botswana. ● PrEP is currently provided for free at GOB and NGO facilities
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	● **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. GOB has different program standards and structures for implementation as well as regulation. ● 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. ● **Barrier:** Implementation limited to PEPFAR sites. There is need to strengthen the CQI national structure
12) Evidence of treatment literacy 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.	● **MPR adopted and in implementation, but partially met.** ● 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. ● **Barrier:** Limited ability to measure
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	● **MPR adopted and in implementation.** ● 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.
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	● **MPR adopted and in implementation, but partially met.** ● 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. ● **Barrier:** limited ability to measure
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	● **MPR adopted and in implementation.** ● 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. ● Still experiencing challenges with EMR utilization and reporting in general. ● EMR under-utilization resulting in backlogs for certified deaths. Incomplete reported mortality data at the wards resulting in undiagnosed deaths. ● Data at some sites is still in the paper form
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	● **MPR adopted and in implementation, but partially met.** ● 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. ● Persistent challenges with interoperability and consistent reporting and data use. Challenges in inclusion of no-citizens in being uniquely identified.

NEW APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic REQUIRED

To end HIV/AIDS in Botswana, the Government of Botswana (GoB) must demonstrate a long-term commitment to addressing policy, governance and operational issues that affect sustaining the gains of the response and facilitating attaining epidemic control. Sustainable control of the HIV/AIDS epidemic requires host governments to take full ownership of the response and make it stakeholder inclusive (i.e., other ministries besides Health, e.g., Finance, Labor, Education, etc., and CSOs, the private sector and the community at large). The response should also be person centered and equitable for the poor, underserved, marginalized and vulnerable populations.

Some key sustainability questions that PEPFAR Botswana will put forward to GoB and other stakeholders to identify potential opportunities for increasing domestic responsibility of the HIV response and actions that can be taken to achieve sustainable control of the HIV/AIDS epidemic include the following:

- Are there stable and diversified funding mechanisms in place to finance the HIV response?
- Is there a projected trend of declining new HIV infections and AIDS-related deaths?
- Will HIV remain in the national policy agenda?
- Are the legal and policy environments conducive for an effective response?
- Are the social and environmental contexts enabling for a long-term and effective response?
- Will current programs and interventions be able to evolve from an emergency response to a long-term main-streamed approach?
- How will the right to HIV services be protected for populations who might be excluded from decision-making?

1. Misalignments between Investments and Outcomes

Moving towards long-term sustainability requires that investments in the HIV response contribute to improvements in the systems and capacities that are critical to achieving and maintaining epidemic control. The following sustainability-focused analytics and metrics discusses areas where there may be misalignments between PEPFAR investments and intended national outcomes:

A. Program Expenditures vs. SID Score Trends and Responsibility Ratings:

Table E.1.1. Trends in Investments and SID Scores for System-Related Elements

Systems	Cumulative Investments 2019-2022	2015 (SID 2.0)	2017 (SID 3.0)	2019 (SID 4.0)	2021 (SID 5.0)
HMIS	$7,483,259	5.48	4.76	5.86	5.43
LAB	$692,684	5.69	5.58	6.58	4.71
S. CHAIN	$1,872,256	6.27	6.79	6.58	6.85
POLICY	$4,251,235	6.58	7.06	8.40	7.26

Source: Financial Management Dossier. Financial Attribute by Interaction type. 2021 SID

Total investments on systems by PEPFAR from 2019-2022 is $14,299,434 i.e., an average of about $3.6 million in the last four years. About 52% of this investment was expended to strengthen Health Management Information System, 29% to develop supportive policies, 13% to strengthen supply chain and 5% to strengthen the Laboratory System.

As shown in Table E.1.1., despite the investments on HMIS and Laboratory System, they remain fragile and need some investment to strengthen them for sustainable HIV response. Even though supply chain improved across the years, it requires some investments to ensure long-term sustainability. The policy environment is approaching sustainability and requires less investment to provide an enabling environment for sustainable HIV response.

Responsibility Matrix

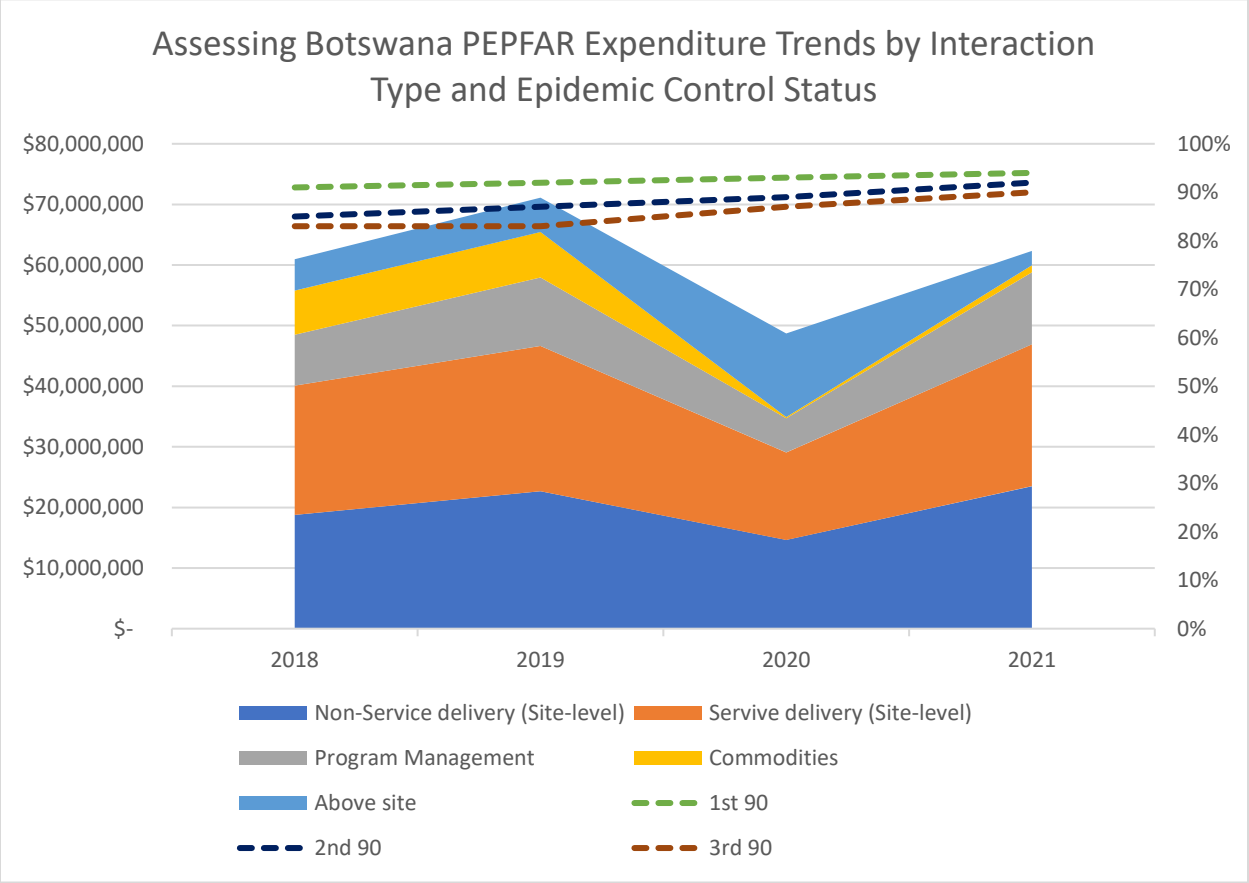
The biennial Responsibility Matrix collaboratively populated by major funders for HIV response in Botswana (GoB, PEPFAR, GF & Private Sector) in 2021 showed that the GoB is increasingly taking functional responsibility of the national HIV response across the different functional elements. From the responsibility matrix, Botswana is 100% primarily responsible for commodities, and health workforce. Even though GoB is not fully responsible for site level programs (About 80%), they are fully responsible (100%) for site level programs strategy formulation and planning.

This confirms that the GoB is not only financially responsible for the response but also functionally responsible. Hence, there is an enabling environment in Botswana for greater domestic responsibility or ownership of the HIV response. This will contribute positively to developing sustainability road maps for the country.

B. Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country's Status of Achieving HIV/AIDS Epidemic Control:

In COP22, PEPFAR Botswana will begin to focus more investments on technical assistance to the Government of Botswana and transition some activities to the government to be able to sustain current gains and facilitate sustained epidemic response. It is expected that non-service delivery and service delivery site level, and commodities investments will start to decrease. Increased investments are anticipated on above site activities that will transform the response and increase the capabilities of the government to take ownership of the response.

Figure E.1.3. Assessing Botswana's PEPFAR Expenditure Trends by Interaction Type and Epidemic Control Status

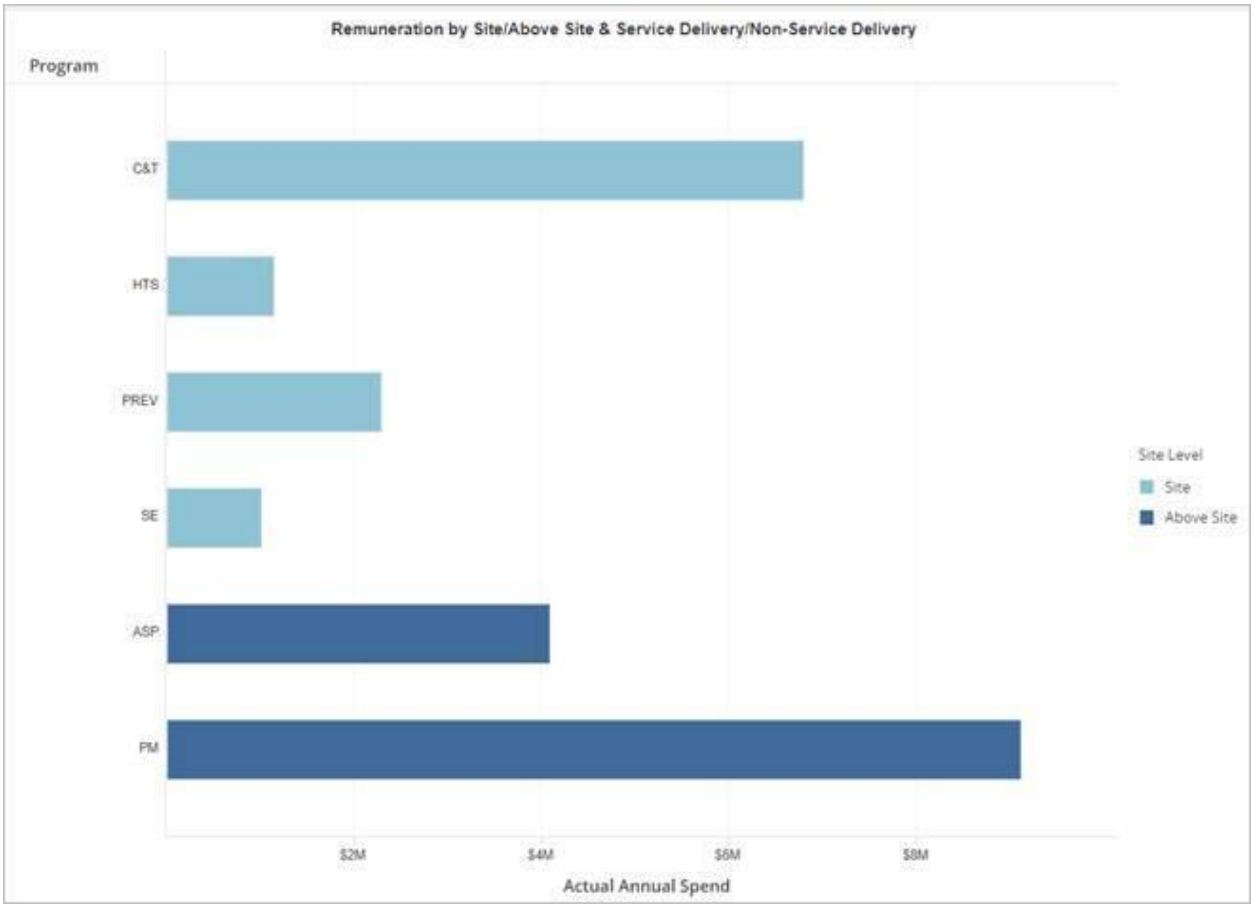


Source: Financial Management OU Dossier. Financial trend- Service delivery expenditure trend module. 90s data Spectrum data 2022

C. HRH Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery:

PEPFAR Botswana invests in HRH to be able to sustain the response. Staff remunerations are provided for site and above site level activities that are service delivery or non-service delivery in nature. In FY21, more that $24 million dollars was spent to engage human resource for the national response. The largest proportion of this amount was expended on program management as shown in figure E.1.4. Care and treatment activities was the program area with the next highest expenditure on HRH.

Figure E.1.4. Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery (2021 Actual Annual expend)



Source: Panorama HRH Inventory Dossier. HRH Remuneration by Site.

PEPFAR Botswana will continue the dialogue with the MoHW and other stakeholders, to plan for requirements for health workforce sustainability and ensure optimized PEPFAR HRH staffing investments complement government and private sector staffing availability and needs.

2. Areas for Transition

Sustaining the current HIV response goes beyond domesticating responsibilities; it also entails having a clear transition plan for roles and responsibilities for the key activities that are currently supported by multilateral partners (such as supply chain, site visits/supportive supervision, and front-line service delivery roles). There is also a need for improved oversight and coordination of all stakeholders to effectively leverage and utilize available resource. Sustainability will require the host government to focus in the two key dimensions (i.e., Functional and Financial) for sustainable provision of high-quality HIV services at both community and facility level in alignment with national standards

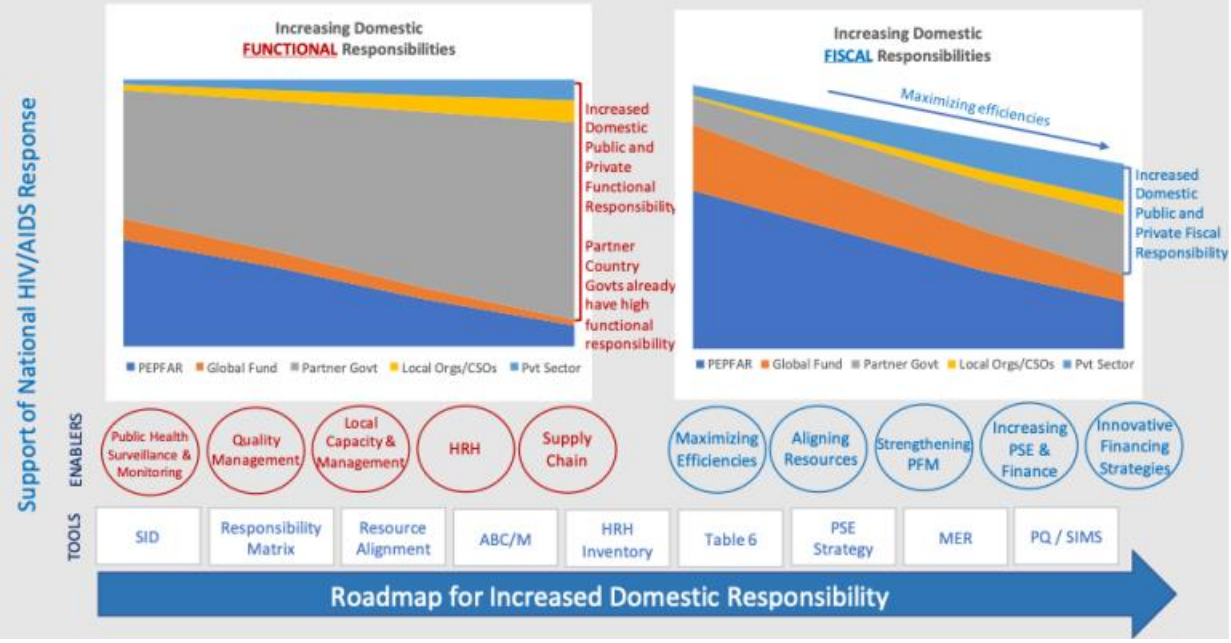
- Functional Dimension is the ability of structures and processes of government to have the capacity to continue performing their functions and successfully plan and manage HIV programs with little or no technical assistance. Achieving this would require

management, governance, organizational, supply chain and human resources planning structures to be strengthened.

- Financial Dimension is the ability of the government to generate, use and mobilize their own resources to effectively prioritize, allocate, account and report HIV service delivery activities. This dimension focuses on improving financial management, costing, budgeting, and resource mobilization.

PEPFAR Botswana will be supporting the MoHW to conduct a rapid sustainability assessment in COP22 to better understand the progress towards sustained HIV response in Botswana, the factors influencing it and any potential risks towards sustainability. The proposed rapid sustainability assessment for Botswana HIV response will be conducted using components and parameters of the framework presented in COP22 guidance shown below:

Figure 5.2.1: Achieving HIV epidemic control and ensuring a sustainable response



Results of the sustainability assessment will be triangulated with the SID, the Responsibility Matrix, Table 6, Resource Alignment, HRH Inventory, MER, and other sources to:

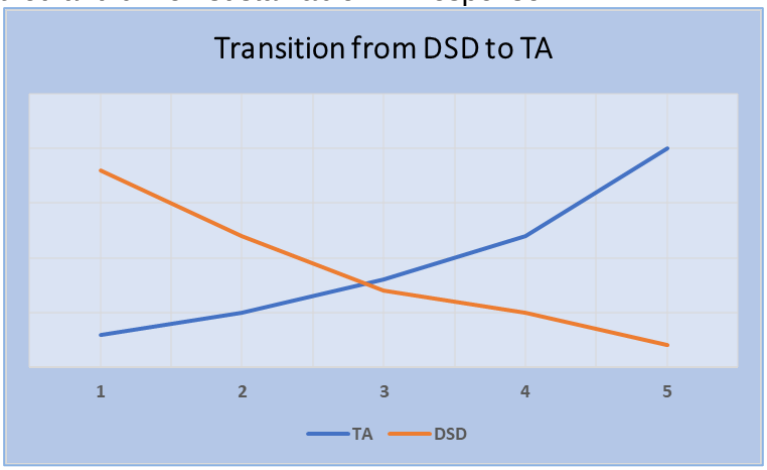
i. Identify areas that could be considered ‘low-hanging fruit’ for host government to take on greater responsibility in the short-term
ii. Inform the development of a sustainability road map with an estimated timeframe for the host government to assume full responsibility for the HIV response
iii. Identify any risks on program activities to be able to develop potential strategies to mitigate any risks and their potential impact
iv. Develop appropriate indicators (simple & composite) that stakeholders can jointly use to track the progress towards a sustainable HIV response

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

Sustainable transition must include the following steps:

I. Developing a national sustainability roadmap
II. Engagement and involving all key stakeholders
III. Effectively communicate the plan
IV. Supporting midterm evaluations
V. Strengthening of financial, technical, and management capacity
VI. Use of Monitoring & Evaluation tools.

Hence, in COP22, PEPFAR Botswana will support the development of a sustainability road map to guide transition to a government led and driven sustainable HIV response.



PEPFAR Botswana will support GoB with identifying the most meaningful and cost-effective platform to convene stakeholders towards driving consensus that will ensure the momentum towards a sustained response is maintained and jointly owned.

Sustaining HIV epidemic control will require a combined effort and contribution by PEPFAR, GoB, civil society, private sector partners, and other stakeholders such as the Global Fund and other donors operating in the country.

The goal of the sustainability road map is to systematically propose, implement and monitor an operational framework within which the leadership and funding of the HIV response in Botswana at the national and sub-national levels is gradually transitioned to the government, to assure sustainability in the long term.

The implementation of the sustainability road map will be a phased approach over 5-7 years; the last will be the sustained phase that describes a response that is government led, predominantly funded with domestic funds (public and private) and achieves the provision of quality HIV services for People Living with HIV/AIDS in Botswana. There are risks that are likely to disrupt the implementation of this sustainability road map; they will be identified by stakeholders and mitigation plan(s) such as the one below will be developed and included in the sustainability road map:

Table 5.3.1: Risks to implementing Sustainability Road Map and Mitigation strategies

s/n	Anticipated Risks	Probability (High, Medium, Low)	Impact (High, Medium, Low)	Risk mitigation strategies (How can state prepare if this risk does take place)
1	Delay in active engagement and follow up in annual budgeting & planning processes	High	High	Improve communication and high-level advocacy to national & sub-national structures for the funding of HIV/AIDS in their budgets Improve Public Financing Management in MoHW and NAHPA to increase Fiscal space for HIV and Health

APPENDIX F –List of Acronyms

Abbreviatio	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 AYP	Anti-Retroviral Drugs 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 COR	Cost of Doing Business 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 DSD	Direct Service Delivery 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