



# PEPFAR

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

**PEPFAR Botswana**  
**Country Operational Plan (COP) 2023**  
**Strategic Direction Summary**

May 25, 2023

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## **\*Military PSNU data are non-public**

A portion of PEPFAR data relates to foreign military sites, such as bases, barracks, or military hospitals. Data originating at these sites are aggregated to each respective OU's Military PSNU and are non-public. When developing graphics for the SDS, do not include the Military PSNU, which you can find in PSNU dropdowns in Panorama. These services may be funded through a variety of implementing agencies or mechanisms, so the Military PSNU designation is not equivalent to DOD as an implementing agency.

## Vision, Goal Statement and Executive Summary of PEPFAR's investments and activities in support of the FY24-25 plan.

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PEPFAR Botswana's vision for COP23 is "Partnering to Reach the Unmet and Sustain the Response". Our goal is to maintain the progress made towards achieving the UNAIDS 95-95-95 targets and to close the remaining gaps across the People Living with HIV (PLHIV) cascade. According to the Fifth Botswana AIDS Impact Survey (BAIS V), Botswana has achieved 95-98-98 for populations aged 15-64 years. This leaves a gap of 5-2-2. According to the latest UNAIDS estimates for 2022, the 95/95/95 HIV cascade for Botswana stands at 97/97/99 (for adults 15+), with the following estimates by Botswana sub-populations (men 15+: 95:92:99; women 15+: 98:100:99; pediatrics: 58:98:98). Botswana aims to achieve 94% population level viral suppression (98-98-98) across all sub-populations, including adolescent boys and young men (ABYM), adolescent girls and young women (AGYW), adult men, children, and key populations (KP) by 2025 and reach 99-99-99 (97% population level viral suppression) across all age/sex bands and key and priority populations by 2030.

Although the rate of new HIV infections among adults aged 15+ has reduced by 63%, variable incidence exists by subpopulation and geographic area (see Table 1.1, Figure 1.1, and Table 1.2 below). Females aged 15-24 form only 9% of the population but contribute 24% of annual new HIV infections and are over two times more likely to acquire HIV compared to their male counterparts. Additionally, most new HIV infections (58%) are among the 25-49 age group, with men contributing 31% and women contributing 27%.

To address this, during COP23, the PEPFAR Botswana (PEPFAR/B) program will continue to prioritize public education campaigns that dispel HIV stigma and discrimination, structural interventions that empower women and girls to claim their sexual and reproductive health and rights and promote effective combination biomedical prevention services to promote positive health seeking behaviors and safer sexual practices between AGYW and their sexual partners.

Remarkable progress has been made in HIV testing, linkage to ART, and viral load suppression for PLHIV in Botswana. However, variable population level viral load suppression rates are still noted for adult males and children with only 57% of CLHIV and 87% of 15+ male PLHIV virally suppressed. These continuing gaps will be addressed through incorporation of psychosocial support, teen clubs, mental health support, and differentiated service delivery for A/CLHIV, while differentiated service delivery models like weekend and after-hours support, male-friendly corners and person-centered laboratory services shall be employed for men. In COP 23, PEPFAR/B will improve access to VL results through use of electronic systems by supporting EMRs and expanding lab nodes to more clinics. VL coverage will also be improved by profiling clients (to know clients better and understand their needs at a personal level) in order to tailor-make services to meet their needs. Additionally, PEPFAR/B will continue to support HIV drug-resistance testing and HIV drug-resistance surveys and surveillance to understand the kind of drug-resistance that has developed in this treatment-experienced population. This data will lead to better drug regimen choices and improved patient care.

The last Integrated Bio-behavioral Survey (IBBSS), conducted in 2017, highlighted program coverage gaps among KPs. Plans are underway to conduct the third IBBSS to generate much-needed data to inform programming for these populations. Further, data show gender disparities in access to HIV services across the general population. PEPFAR/B's use of innovative approaches to improve access and sound data to guide the provision of comprehensive person-centered prevention packages and clinical services, coupled with continued support of structural interventions that protect human rights, address stigma and discrimination, and foster enabling policies for improving access to HIV services for KPs and other priority populations will be used to close existing programmatic gaps in COP23 and beyond.

The PEPFAR Reimagined Strategy offers the PEPFAR/B program the opportunity to develop our programmatic strategy, in close collaboration with the GOB and external stakeholders, to ensure that we are achieving the UNAIDS treatment targets across all ages, genders, geographies, and population groups, reducing new HIV infections, and addressing the societal and structural drivers of inequalities with effective sustainable services.

Similarly, GOB is committing to revitalizing Primary Health Care (PHC) as an efficient and cost-effective way of delivering health services. Bringing the health system closer to the people is an important part of achieving sustainable HIV epidemic control. PHC is one of the first points of care patients seek for healthcare services. PHC revitalization will facilitate prevention, early detection of diseases, and health education that may reduce the need for more expensive treatment services. The PHC platform will contribute to Botswana achieving sustained HIV epidemic control.

In COP23, PEPFAR/B will continue to support the Government of Botswana (GOB) to accomplish their goals in terms of Health Systems Strengthening; Community Strengthening; Service Delivery Strengthening. Within Health Systems Strengthening there is a focus on revitalization of primary health care (PHC), optimization of diagnostics, strengthening supply chain management, sustainable financing, and data surveillance and BPHI. Within Community Strengthening there is a focus on leveraging Community Health Workers (CHWs), differentiated service delivery models (e.g., Drop-in-Centers), and strengthening Community-Led Monitoring (CLM). Within Service Delivery Strengthening there is a focus on clinical mentorship, person-centered service delivery, and continuous quality improvement.

In COP22, our priority was to work with the GOB and stakeholders to develop a sustainability roadmap to help orient future PEPFAR support toward ensuring a sustainable HIV response. In COP23 the program will collaborate with the Government to implement the sustainability roadmap that is on track to be completed during COP22. For COP23, the PEPFAR/B program continues the pivot begun in COP22 towards sustainable HIV epidemic control with key priorities supporting health systems strengthening efforts and strengthening of service delivery components for community platforms and GOB facility platforms.

PEPFAR/B will continue to implement the following pivots, 1) continue our gradual shift from direct service delivery to technical assistance across all programs; 2) further refine our re-alignment of interagency roles and responsibilities to focus on areas of strength/comparative advantage, with focused support within community and facility platforms ; and 3) invest strategically in health systems strengthening activities that will support the national health systems that are critical to the response and sustainable HIV programming, including human resources for health,

epidemiology/surveillance, laboratory, data systems, quality management, commodities, policy and guidance and health financing.

In alignment with Pillar 1: Health Equity for Priority Populations, PEPFAR Botswana's COP23 activities will utilize innovative and targeted testing strategies, leverage community health workers (CHWs) and use Differentiated Service Delivery (DSD) models for customer-centric services reducing stigma at service points to reach remaining hard to reach populations contributing to HIV new infections. Key milestones for measuring our progress towards Pillar 1 activities include the uptake of combination prevention services by targeted KP and PP groups, effective DSD models to keep KP and PP on treatment and virally suppressed, and marked progress in addressing structural, societal, and political drivers of inequitable access to services for KP and PP populations.

In alignment with Pillar 2: Sustaining the Response, PEPFAR/B's COP23 activities will support implementation of the Sustainability Roadmap, sustainable financing of the HIV response, GOB efforts to revitalize primary health care (including leveraging existing platforms such as mobile stops and facility outreach services to integrate HIV services), integration of non-communicable diseases into ART clinics (including training and mentorship of HCWs in NCD management and data capture), interventions targeted at reducing mortality among PLHIV (e.g. advanced HIV disease, TB, Cervical cancer) and interventions for the aging population (such as SMS reminders, pill boxes, comorbidity care and mental health). PEPFAR/B will support the Ministry of Education and Skills Development in COP 23 with the development of the national Comprehensive Sexuality Education (CSE) and life skills materials. Further support will be offered to MOESD to roll out training and capacity building workshops for teachers to ensure standardization in the delivery of the National LIVING curriculum.

In alignment with Pillar 3: Public Health Systems and Security, PEPFAR/B's COP23 activities will support key activities for strengthening/improvement of national systems that are critical to the response, including nation-wide expansion of the National mentorship program (which includes clinical, Strategic Information and laboratory) using continuous quality improvement (CQI) approaches to improve HIV services across the country, optimization of diagnostics, and human resources for health (HRH) support for both community and facility-based HIV services. PEPFAR/B will support operationalization of Botswana Public Health Institute (BPHI) through supporting its structuring and operationalization of the different BPHI pillars, capacity building of workforce across the different pillars, and HRH. PEPFAR/B will also support the field epidemiology training program (FETP) to establish cohorts of first responders in the districts. Key milestones towards measuring our progress towards Pillar 3 include establishing successful transitioning for HIV services at the community and facility levels of Health Education Assistants (HEAs) and Healthcare Assistants (HCAs) so that HEAs are doing community work and HCAs are doing facility-based work, robust staffing for HIV preventive and curative service delivery, and sustainable financing for HIV related services. For the Botswana Mentorship Program, the team will continue engagement with MOH to flesh out implementation details with TDY/ISME support on how to monitor through MER or other metrics.

In alignment with Pillar 4: Transformative Partnerships, PEPFAR/B will continue to work with a range of different government counterparts, Civil Society Organizations (CSOs), private sector

entities, and multilateral partners. This will ensure the scalability and sustainability of our HIV program. PEPFAR/B will align its strategic priorities with the priorities of the GOB to improve technical competencies, scalability, and sustainability of HIV programs. This will also include the revitalization of primary health care (PHC). PEPFAR/B will continue to collaborate with CSOs to expand their income streams through the adoption and implementation of social enterprise. In addition, PEPFAR/B leverages the capacity of the private sector to improve access and coverage through addressing gaps in service delivery (e.g., viral load testing). This helps improve the quality of services for PLHIV, specifically among priority populations. Finally, in COP 23, PEPFAR/B will also strengthen its collaboration with multilateral partners including Global Fund, WHO, UNICEF, UNAIDS, UNFPA, UNDP and UN Women to leverage each partner's convening and advocacy authority to ensure these transformative partnerships contribute to reaching the unmet and sustaining gains in the HIV response.

In alignment with Pillar 5: Follow the Science, PEPFAR/B will continue to use data to inform our programmatic design across all technical areas, including the use of BAIS V secondary analyses, HIV recency surveillance, and case-based surveillance for targeting services in highest burden districts across all ages and sexes. Further, IBBSS data will be used to inform prevention programming for key populations. PEPFAR/B will also support innovative implementation science for PrEP, and build capacity for research through operational research and surveillance. Key milestones towards measuring our progress towards Pillar 5 include successful scale up of recency surveillance and completion of the IBBSS III.

PEPFAR Botswana's goal of ending HIV/AIDS as a public health threat by 2030 can only be accomplished with continued collaboration with the GOB, Civil Society organizations (CSOs), non-governmental organizations (NGOs), community-based organizations (CBOs), other multilateral donors, universities, and the private sector. COP23 planning was an open and consultative process across all stakeholders to ensure common understanding of the new PEPFAR Reimagined Strategy and a country-led approach to its application for activity planning across multiple sectors.

Preliminary COP23 Guidance and technical considerations were shared with partners and external stakeholders in January 2023, when PEPFAR began discussions with GOB ministries to address questions and concerns and learn about priorities for the national response ahead of the release of the Planning Level Letter. Post release of final COP23 Guidance, Technical Considerations, Tools, and the PLL in February, several consultative meetings were held to further refine proposed GOB priorities in consideration of the funding envelope and PEPFAR 5x3 Reimagined Strategy. In addition to sharing drafted versions of COP23 Planning tools with stakeholders throughout the process, ad-hoc engagement meetings were held to further refine proposed PEPFAR support/ programmatic strategies as needed.

The insights of GOB and other stakeholders were critical to shaping PEPFAR's broader strategy, vision, and proposed interventions to ensure alignment with the National Strategic Framework HIV & AIDS III priorities and the efficient use of HIV and broader health resources for maximum impact and sustainability of national programming. In particular, the PEPFAR/ B team received substantial input from Ministry of Health (MoH), Ministry of Education and Skills Development (MOESD), Ministry of Local Government and Rural Development (MLGRD), Ministry of Finance

(MOF), National AIDS and Health Promotion Agency (NAHPA), the Global Fund (GFATM), UNAIDS, WHO, civil society and faith-based organizations to prioritize investments for COP23.

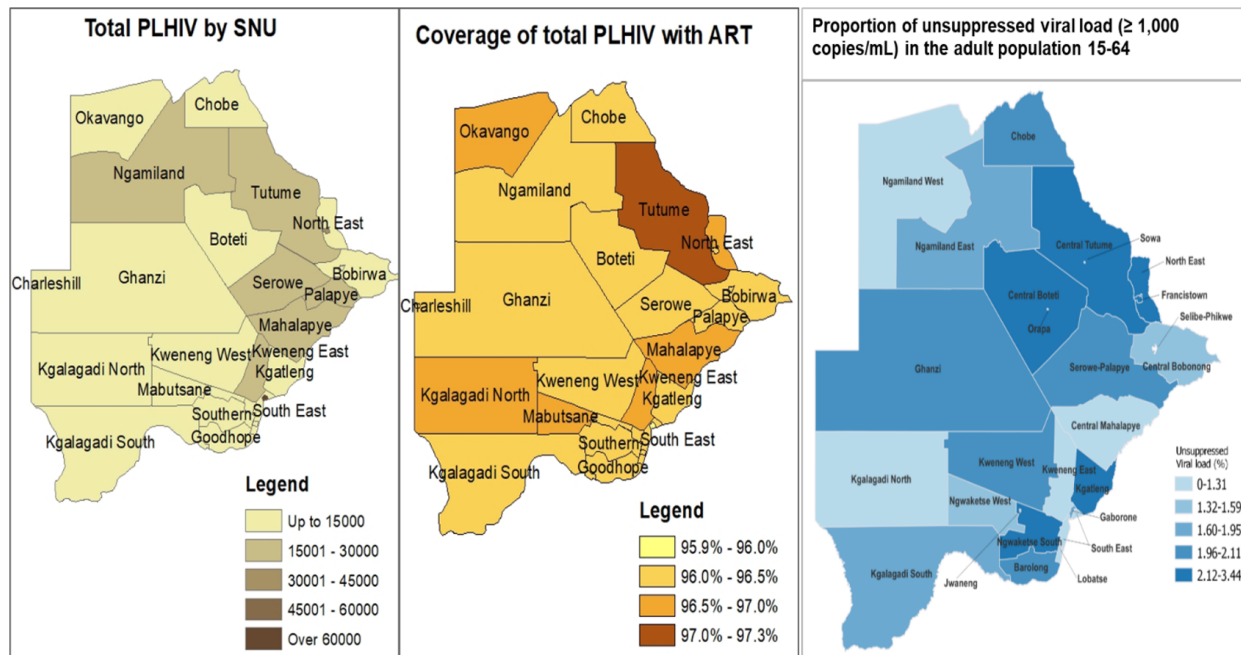
Incorporation of stakeholder feedback into the COP23 Strategy was an iterative process to identify key areas of focus and investments, including health systems strengthening and strengthening of service delivery components for community platforms and GOB clinical platforms.

Throughout COP23 planning, PEPFAR/B has been guided by the following principles: Doing no harm; Partnering with GOB and CSOs; Retaining our presence in PEPFAR districts but focusing in on targeted populations; Strengthening our support towards sustainability of the program; Using data to inform the program design and shifts in COP23; Leveraging on the synergies across the OVC, DREAMS and KP programs.

**Table 1.1 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression\***

Table 1.1 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	2651315	12,92 %	342661	333127	330281	96%	98%	354838	9546	8863
Population <15 years	850730	0,75%	6391	4724	3625	57%	98%	195505	84	148
Men 15-24 years	239344	2,06%	4931	3219	3215	65%	98%	41302	255	205
Men 25+ years	645145	19,47 %	125609	120410	118667	94%	98%	50295	3968	3372
Women 15-24 years	234680	3,98%	9330	8804	8804	94%	98%	85082	1304	1121
Women 25+ years	681416	28,82 %	196396	195970	195970	100%	98%	158654	3935	3871
MSM	157 592	14.80% <sub>1</sub>	23 324	2224	6343	82% <sup>1</sup>	100% <sup>3</sup>	25193	3333	3173
FSW	257 722	42.80% <sub>1</sub>	110 304	19 853	11653	87.6% <sup>1</sup>	100% <sup>3</sup>	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: Epi data SPECTRUM HIV estimates 2022; HIV testing and LTT ART program data; KP: IBBS 2017



**Figure 1.1 People Living with HIV (PLHIV), Treatment Coverage, and Viral Load Monitoring Coverage**

**Table 1.2 COP23 Current Status of ART Saturation**

Table 1.2 Current Status of ART Saturation				
Prioritization Area	Total PLHIV/% of all PLHIV for COP23	# Current on ART (FY22)	# of SNU COP22 (FY23)	# of SNU COP23 (FY24)
Attained	97.73%	163,588	25	25
Scale-up: Saturation	2.27%	66	2	2
Scale-up: Aggressive				
Sustained				
Central Support				
No Prioritization				
Total National				



# Pillar 1: Health Equity for Priority Populations

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Botswana's COP23 is consistent with PEPFAR's commitment to eliminate inequities in health among different populations. The PEPFAR/B will intentionally employ an equity lens approach to tailor services and eliminate inequities by prioritizing, engaging, and empowering populations who have historically lagged. A holistic, person-centered approach will be employed to ensure that service is strengthened, and barriers and vulnerabilities of underserved populations are addressed. This section highlights PEPFAR/B's strategic direction, program shifts, and alignment of resources to mitigate these equity challenges. PEPFAR/B has identified the following priority populations: adolescent girls and young women (AGYW), pediatrics, and pregnant and breastfeeding women. HIV impact remains substantially higher in these populations and gaps persist largely due to stigma, discrimination, human rights issues, power dynamics, or marginalization.

## **2.1 Plan to close gaps in the pediatric cascade**

Children are among the most underserved populations in the HIV response mainly because they rely on caregivers to represent them and facilitate access to needed health services. Consequently, compared to adult populations, they lag behind across the full treatment cascade: from low rates of case finding, linkage, retention, optimized ART treatment regimens, viral load coverage, and viral suppression. For instance, UNAIDS 2022 estimates show that in 2021, despite adults in Botswana nearing achievement of 95-95-95, the cascade for children in Botswana was only 70-69-63. PEPFAR MER data from FY23Q1 show gaps in VLS for 1-4 years and in VLC for <10 years. About half of children <15 still need to be added to MMD. Underperformance in this population will therefore require new strategies and a shift in focus. To increase the uptake of HIV testing among the pediatric population, in COP23, PEPFAR/B will support the implementation of pediatric surge strategies. This surge will focus on increasing testing among the pediatric population to identify HIV-positive children and effectively link them to ART and accelerate progress in closing gaps in the pediatric cascade. Additionally, in COP23 PEPFAR/B will strategically prioritize pediatric and adolescent-friendly services in Infectious Disease Care Clinics (IDCCs) aimed at enhancing ART-related services focused on this age cohort.

### **Pediatric case finding strategies**

Strategies for COP23 case finding among children will include the following:

1. Maximizing index testing:
  - All children with a HIV-positive biological parent will be offered HIV testing to optimize efforts in index testing of biological children under 15 years of age.
  - Supporting the review of care and treatment patient records to identify children under 15 years who have not been tested and ensuring maximum testing coverage for these clients, especially in districts with the highest gaps.
  - Supporting activities that ensure children's tracking, tracing, testing, and ensuring known positives currently not in treatment are linked to rapid treatment initiation.
  - Based on index testing principles (mother with HIV; father with HIV and mother's status not known to be negative; sibling with HIV; mother deceased), index services will also be facilitated among OVC beneficiaries. Through collaboration between facility and community platforms 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.

2. Implementing a "one-stop shop" model of services for pediatric clients by integrating HIV testing services (HTS) at entry points that support pediatric clients to ensure that screening and testing of pediatric clients are available. The strategy provides universal testing for all children presenting at select entry points. In Botswana, children under five years visit well-established child welfare clinics based on vaccination schedules and have monthly visits for child growth and development monitoring. All children with delayed growth milestones will be offered HIV testing in addition to those seen at in-patient, child welfare clinics, pediatric clinics, and receiving TB services.
3. Systematic implementation of a standardized and highly sensitive "screening-in tool" to identify children aged 2-14 years living with HIV who are presenting at OPD. The tool will have questions about previous hospitalizations and prior documented diagnoses. In addition to supporting the implementation of a screening tool, COP23 funds will also support GOB update the national HTS guidelines to introduce new interventions, including using HIV self-screening and/or provider-assisted HIV self-testing at high volume Outpatient Department (OPD) and entry points with human resources constraints.
4. Strengthening collaboration with the Ministry of Education and Skills Development (MOESD) through school nurses, guidance and counseling teachers and social workers to facilitate consent, referral pathways, and expand testing among school-age children who have risk of HIV or have been referred as biological children of index clients.
5. Leveraging OVC programs to systematically screen all beneficiaries for HIV testing needs. OVC programs are uniquely positioned to identify children including children of key populations, who are not in the care of their parents, often because their parents are living elsewhere (e.g., for work, incarcerated, or excluded and marginalized by their communities) or have died. Such children may be in OVC programs or may be in the care of relatives or other community members and assist their caretakers in accessing testing. Strengthening clinical and OVC programs' partnerships and working together as part of multi-disciplinary teams will be important to ensure that one hundred percent of biological children (under 19 years of age), with unknown HIV status, of current adults and siblings diagnosed with HIV are offered testing. The consent from a parent or caregiver (based on Botswana age of consent) will be needed, consistent with Safe and Ethical Index Testing Guidance.

### **Implement the Pediatric ART Saturation Strategy**

The pediatric ART saturation strategy will be implemented utilizing the following strategies:

1. Identifying children who have interrupted treatment and collaborating with OVC program and community partners to re-engage children back into care.
2. Ensuring all children of women on treatment have a documented HIV status, and if not, offering them HIV testing.
3. Filing audits of all patients on ART will be conducted to identify biological children of parents on ART who are eligible for testing to achieve universal testing of children contacts.
4. Identifying post-partum women who interrupted treatment and engage with community partners to re-engage them in care and facilitate access to testing for their family members as indicated.

### **Pediatric ART program growth through optimization of linkage to treatment activities**

The following activities will be carried out to ensure optimal linkage of children to treatment activities:

1. Expanding ART initiation on weekends and extending opening hours during weekdays to cover pediatrics and adolescents.
2. Establishing additional Adolescents/Children Living with HIV (A/CLHIV) friendly corners and strengthening implementation of ART family care model in health facilities.
3. The OVC program will collaborate with the Operation Triple Zero (OTZ) program, which aims to empower both male and female adolescents living with HIV to achieve 'triple zero outcomes' (zero missed appointments, zero missed doses, and zero viral load) to provide psychosocial and behavioral interventions for A/CLHIV to support these outcomes.

### **Pediatric ART retention, Viral load coverage and suppression**

To reduce HIV-related pediatric mortality, PEPFAR/B will:

1. Support monitoring and documentation of ART optimization, improved viral load coverage and suppression among children and adolescents on ART, strengthen screening and management of cases of pediatric advanced HIV disease, and monitoring for HIV mortality.
2. Provide refresher trainings on pediatric viral load monitoring (VL collection scheduling) and strengthen supportive supervision through mentorship at site level to improve clinical competence for nurse prescriber and dispensers (NPD) and doctors. This will address the main challenge of clinicians failing to strictly adhere to the 3 monthly VL collection as prescribed by the national HIV clinical guidelines.
3. Expand implementation of Family Friendly clinic days in IDCCs to provide supportive ART adherence counseling for caregivers of CLHIV.
4. Strengthen caregiver assessment and support for CLHIV with unsuppressed viral load through referral to OVC programs and facility-based social workers.
5. Develop patient profiling of unsuppressed A/CLHIV to develop a longitudinal record tracking patient level clinical, mental, and psychosocial data to develop patient-centered interventions.
6. Strengthen implementation of age-appropriate disclosure activities, Enhanced Adherence Counseling (EAC) for caregivers of CLHIV and adolescents. Provide referrals to OTZ and OVC programs for mental and psychosocial support for all eligible A/CLHIV.
7. Develop a line list of A/CLHIV without valid viral load (VL) and provide follow up for testing.

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

While Botswana adopted and has been implementing three-month multi-month dispensing (MMD), there is need for adoption and implementation of 3–6-month MMD among children and adolescents. PEPFAR/B will prioritize TB Preventative Treatment (TPT) for Children Living with HIV (CLHIV), scale up of Isoniazid (INH), and strengthen integration of direct service delivery (DSD) packages across all service points in facilities to ensure person-centered services. PEPAR/B will also work with MOH to strengthen integration of adolescent and pediatric HIV care services in clinic mobile stops/outreach services and learning institutions under the school health program.

### **Closing gaps in Pediatric cascade through Clinical Mentorship Program**

PEPFAR/B will scale up the implementation of mentorship activities aimed at improving quality of HIV care A/CLHIV. Healthcare workers in 103 facilities will be mentored to improve A/CLHIV case management and the use of dashboards, mobile apps, and appointment systems to remind clients of upcoming appointments proactively will be introduced. Clinical mentors will conduct site visits and provide supportive supervision and mentorship. They will review testing, linkage, retention, viral load coverage and suppression data for A/CLHIV. Systematic gaps and opportunities for improvement will be identified and remedial measures initiated. Additionally, the ECHO model will also be leveraged to expand opportunities for health care workers training to improve pediatric and adolescent HIV care. The program will also continue to leverage the community/facility coordination, 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.

### **2.2. Plan for services for Pregnant and Breast-Feeding Women**

Botswana is the first African country with a high HIV burden to be certified eliminating mother-to-child transmission of HIV, is aiming to move to validation of “Gold Tier” status by 2024 for triple elimination of HIV, syphilis, and hepatitis. High-burden HIV countries are defined as countries with more than 2% of pregnant women living with the virus. This great achievement is attributed to strong political will, program organization and management, clear policies, and guidelines consistent with current WHO recommendations and the well-implemented prevention of mother-to-child transmission (PMTCT) service delivery model integrated within Sexual reproductive health/Maternal and Child Health (SRH/MNCH) and HIV services. Botswana’s PMTCT program continues to perform exceptionally well in HIV testing and treatment coverage for PBFW. The MOH’s national program data show that between October 2021 and September 2022, a total of 51,127 new antenatal Clinic (ANC) attendees were registered in the 27 Districts. Out of these new ANC attendees, the overall achievement for the percentage of pregnant women with known HIV status at antenatal care was 49,805/51,127 (99%). Out of the 49,805 with known HIV status 8,738 (or 23%) were HIV positive of which 831 were newly diagnosed in the reporting period. A total of 34,158 were newly negative. (Figure 2.1)

Despite this progress, challenges remain, including 1) Inadequate retesting of pregnant women during the 3<sup>rd</sup> trimester and among breastfeeding women at postnatal clinics (PNC); 2) Suboptimal EID coverage at 2 months; 3) Inadequate uptake of PrEP; 4) Non-use of EMR reporting. COP23 interventions will help mitigate these challenges.

In COP23, PEPFAR/B will continue to support the PMTCT program 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, their infants and family receive the care they all need.

Botswana PMTCT guidelines recommend early ANC registration of all pregnant and breastfeeding women with 3 months retesting until 6 weeks of cessation of breastfeeding. Although Botswana has demonstrated a high rate of testing and treatment coverage in ANC, retesting of HIV negative women remains a challenge especially at postnatal care. PEPFAR/B will 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/Quality Improvement across health facilities, and enhancing community/facility interface.

Through support visits and mentoring, PEPFAR/B will review the sites-specific system of tracking appointments and follow up of negative HIV PBFW for their retesting. The review of the re-testing appointment system will help identify specific PBFW re-testing gaps and inform remediation through site-specific project CQIs.

Retaining mothers in care and keeping them virally suppressed is critical to preventing mother-to-child transmission of HIV, particularly in the breastfeeding period when most infant HIV acquisition occurs. UNAIDS 2023 special analysis reports that most new child infections occur in the setting of mothers infected during pregnancy or breastfeeding or mothers dropping off ART. To address this gap, in COP23 PEPFAR/B will continue to implement “Treat All strategy” and “Same day” ARV initiation. Pregnant women will be prioritized for ART initiation and those identified after hours and weekend at high volume sites will be given “red carpet” ART initiation. PEPFAR/B will strengthen the existing joint team that consists of MOH district PMTCT coordination and the implementing partner’s technical program managers to provide clinical mentorship to review retention, VL coverage and suppression data of PBFW. The review system will identify clients who have missed appointments and clients with undetectable VL. Through clinical support processes, these women will be referred by HCAs in the facility to Community Health Workers (CHWs), 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 detectable VL. Midwives will also form part of the failure clinic on the management of PBFW clients.

PrEP for Negative PBFW is an additional individual-controlled prevention strategy to reduce HIV incident infections among women of high HIV exposure. Spectrum, 2023 shows that one third (58/174) of new HIV infections occurred because of pregnant women seroconverting either during pregnancy or breastfeeding. The Government of Botswana has endorsed the integration of PrEP services into ANC, postnatal care, family planning, and other HIV prevention services for HIV negative PBFW and their partners. This will be implemented in a phased manner, starting with PEPFAR/B supported sites. In COP23, nurse/midwives at SRH will be trained and mentored to screen for and offer PrEP and provide counseling to pregnant and breastfeeding women at risk of HIV acquisition, especially among women who do not know their partners status. PEPFAR/B will also strengthen partner HIV testing to optimize PrEP use among pregnant women by improving women's awareness of her partner's HIV status. The expansion and use of electronic medical records in ANC/PMTCT settings will be strengthened to optimize PrEP uptake. SRH settings will be equipped with functional computers and nurse midwives will be capacitated to fully utilize and report through EMR.

Through the clinical mentorship program, PMTCT coordination office and IP's, district technical program managers will provide planned site visits to review PrEP ANC data on screening, eligibility, and enrollment to PrEP services. The joint visits will identify program gaps and ensure adequate remediation. The mentorship visit will also address data capturing and assessing patient flow from screening point to PrEP initiation. Youth-friendly services (YFSs) and SRH health care workers 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 strengthen post-analytic EID and VL results return and turn-around-time in the districts. The main shift in COP23 is to improve monitoring and evaluation systems and data management 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 strategies to ensure this work is done include working with the clinical mentors who will support the health facility as well as Community Health Workers (CHWs) based at community level. These cadres will work closely in a collaborative manner to ensure the missing children are traced in the community and brought back to care in the facility. The Health Care Assistants (HCAs) who are deployed at facility level in all districts will help track viral load and EID results between the facilities and HIV laboratories. The HCAs 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 for community tracing and re-engagement into care. They will provide support at the laboratory-clinic interface to track and provide follow-up for HIV services provided to HIV-exposed infants. In addition, the HCAs 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.

Community Health Workers' roles will include 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.

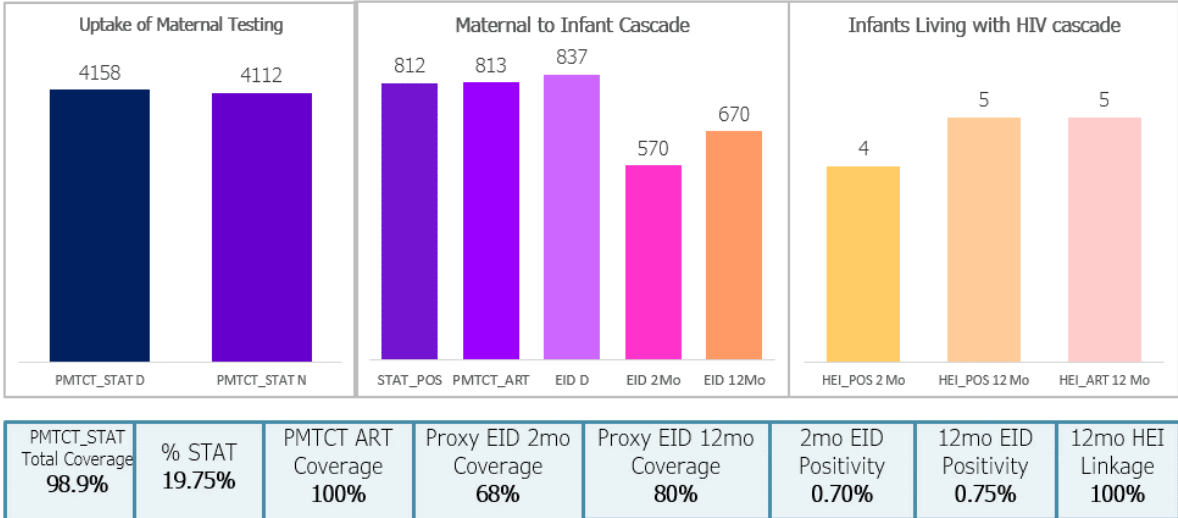
Women not registered for PMTCT will be linked to PMTCT services. All women supported under community HIV care are assessed to determine if they delivered a baby in the last 12 months to ascertain if the HIV exposed infants (HEI) ever tested for HIV. Babies that have not been tested for HIV are linked 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 COP23 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 COP23, PEPFAR/B will continue to assist the government in sustaining the country’s “Silver Tier” achievement of Path to Elimination of HIV and move the country towards WHO “Gold Tier” of the Path to Elimination of HIV, hepatitis 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 projects will help 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.

**High Testing and Treatment Coverage amongst Pregnant Women- ~100%**



Source : PEPFAR Panorama PMTCT\_HEI ( Single OU) Dashboard, accessed 23 Nov 2022

**Figure 2.1: Botswana PMTCT Cascade, October 2021-September 2022**

### **2.3. Plan for AGYW and OVC Services**

This sub-section outlines PEPFAR/B's plans to address inequalities associated with adolescent and young women, orphans and vulnerable children, and gender.

#### **2.3.1 Plan for AGYW services**

The GOB prioritizes programs for adolescent girls and young women (AGYW) and adolescent boys and young men (ABYM) as evidenced by the existence of the National Adolescent and Youth (AYP) Strategy. PEPFAR's flagship program for advancing equity in health and HIV outcomes for AGYW, DREAMS, is well aligned to this National AYP strategy. In planning for AGYW, PEPFAR/B has given considerable thought to health inequalities faced by AGYW, the gender related disparities including disproportionate HIV disease burden. PEPFAR/B will continue implementing the DREAMS program by identifying the most vulnerable and at-risk AGYW ages 10-24 years and implementing evidence-based and evidence-informed HIV and violence response interventions that address the social and structural factors that increase AGYW's risk and vulnerability to HIV. AGYW will be meaningfully engaged through leveraging DREAMS Ambassadors, Mentors, AGYW-led CSOs that have been identified, as well as AGYW's that are enrolled in the program for their participation in design, implementation monitoring of the HIV prevention program among young people.

In COP23, PEPFAR/B will continue implementing the DREAMS program in 8 SNUs: Gaborone, Kweneng East, Kgatleng, Mahalapye, Southern, Serowe, Bobirwa and Northeast, focusing on communities with high populations of vulnerable and at risk AGYW. Botswana has mapped entry points according to the DREAMS guidance. The entry points include schools, out of school/community initiative sites where out of school AGYW gather for various community-based youth activities, sites/social clubs, and clinical settings where pregnant, breastfeeding, and parenting AGYW can be found. The program will continue to use established DREAMS eligibility criteria in alignment with PEPFAR DREAMS guidance to identify AGYW at highest risk of HIV, including targeted subpopulations of AGYW, such as AGYW living with disabilities, young women selling sex, and other key and priority populations as per PEPFAR's 5x3 strategy.

#### **Collaboration with the KP Program**

The DREAMS program will also leverage the KP program to identify and enroll young women selling sex and link them to HIV and violence prevention interventions, as well as the comprehensive economic strengthening program for retention. Additionally, DREAMS implementing partners will collaborate with the KP program for technical assistance and training on KP sensitivity for DREAMS program delivery. DREAMS and KP partners will also partner to ensure that DREAMS participants who are also members of KP and/or identify as LGBTQI+ are linked to services and interventions that best respond to their individual needs.

#### **Collaboration with OVC Program**

In COP23, the DREAMS and OVC programs will continue to collaborate to ensure that girls aged 10-17 who participate in the OVC program and meet the DREAMS enrolment criteria are linked to the DREAMS program for enrolment screening. Similarly, DREAMS participants aged 10-17 who disclose an experience of sexual violence and/or need intensive child protection support will be referred to the OVC comprehensive program for enrolment screening for her family.

#### **DREAMS Core Package**

In COP23, PEPFAR/B will continue implementing a multi-sectoral DREAMS core package with AGYW at the center. PEPFAR/B will maintain implementation of the components of the core



package interventions and associated sub-interventions that: 1) Empower adolescent girls and young women and reduce their risk; 2) Strengthen the families of AGYW; 3) Mobilize communities for change; and 4) Reduce the risk of men who are likely to be male sex partners of AGYW. The Botswana COP23 Layering Table below (Figure 2.2) describes each component of the DREAMS core package of interventions. Additionally, illustrative examples of specific evidence-based programs or curricula are given below, based on those that are listed in the DREAMS guidance. The interventions are categorized under Primary, Secondary and Contextual, reaching AGYW across all DREAMS AGYW age bands (10-14, 15-19, 20-24).

In COP23, the OU will be supporting the Government of Botswana's priorities to create a supportive environment for AGYW through systemic change and institutionalizing evidence-based programming, through supporting Ministry of Education and Skills Development (MOESD) in rolling out a Lifeskills Framework. PEPFAR/B will also support the Ministry of Local Government and Rural Development (MLGRD) with National Adoption of Parenting (parent-child communication) guidelines. The rollout of MOESD's Lifeskills Framework and MLGRD-adopted Parenting Program will reach beyond Core DREAMS SNU's, though this will occur gradually.

The GOB continues to lead DREAMS, overseeing the implementation of the DREAMS program through the National DREAMS Coordination Unit at NAHPA. The unit comprised of 4 staff: a DREAMS Coordinator, a Program Officer, an M&E Officer, and a Database Administrator. The unit provides oversight and coordination for the national DREAMS program with regular site visits, district coordination meetings and quarterly national coordination meetings. Additionally, the M&E Officer engages frequently with the DREAMS implementing partners on data-related matters to ensure timely collection, cleaning and reporting of DREAMS data. The coordination office also supports the nine DREAMS Ambassadors who serve as representatives for the DREAMS program at district level. DREAMS Ambassadors work closely with District AIDS Coordinators to provide oversight and support coordination as well as to promote DREAMS at the district level. DREAMS Ambassadors also work with communities, faith-based organizations (FBOs), and civil society organizations (CSOs) to advocate for AGYW on different district platforms. PEPFAR/B identified gaps in the national ASRH program and is working closely with the Ministry of Health to address those gaps. Three full time positions including a DREAMS Clinical Lead, ASRH Officer and Monitoring and Evaluation officer will continue to be funded to strengthen the ASRH program at the Ministry of Health.

COP23 Botswana DREAMS Layering Table				
		9-14	15-19	20-24
INDIVIDUAL	<b>Primary Individual Interventions</b>	<ul style="list-style-type: none"> <li>HIV &amp; violence prevention</li> <li>Financial literacy</li> <li>Social asset building</li> <li>Screening for HTS eligibility</li> </ul>	<ul style="list-style-type: none"> <li>HIV &amp; violence prevention</li> <li>Financial literacy/Basic Economic Strengthening</li> <li>Social asset building</li> <li>Condom education and Condom distribution for the out of school</li> <li>Screening for HTS eligibility</li> </ul>	<ul style="list-style-type: none"> <li>HIV &amp; violence prevention</li> <li>Basic Economic Strengthening</li> <li>Social asset building</li> <li>Condom education &amp; distribution</li> <li>Screening for HTS eligibility</li> </ul>
	<b>Secondary Individual Interventions</b>	<ul style="list-style-type: none"> <li>Risk-based HTS</li> <li>Condom education</li> <li>Post-violence care</li> <li>Contraceptive mix</li> </ul>	<ul style="list-style-type: none"> <li>Risk-based HTS</li> <li>Post-violence care</li> <li>Contraceptive mix</li> <li>PrEP (age 18 and above)</li> <li>Condom Distribution</li> <li>Comprehensive socio-economic approaches</li> </ul>	<ul style="list-style-type: none"> <li>Risk-based HTS</li> <li>Post-violence care</li> <li>Contraceptive mix</li> <li>PrEP</li> <li>Comprehensive socio-economic approaches</li> </ul>
	<b>Services Referred for</b>			
	Educational support, National registration, Legal protection and services, Child protection, Substance abuse rehabilitation, and Mental Health Services			
	<b>Range Individual Level Interventions including services referred for</b>	4-15	5-18	5-16
CONTEXTUAL	<b>Contextual Level Interventions</b>	<ul style="list-style-type: none"> <li>Household economic strengthening</li> <li>Community mobilization and norms change</li> <li>Parenting/ Caregiver Programming for 10-14 yr olds</li> <li>Reducing risk of sex partners (link to HTS, VMMC, Treatment)</li> </ul>		
	<b>Total Contextual Level Interventions</b>	4		

**Figure 2.2: Botswana DREAMS Layering Table**

**Primary Individual DREAMS Interventions**

Per the DREAMS layering table the following primary individual interventions that will continue to be provided to AGYW across all DREAMS age bands.

***HIV and Violence prevention***

PEPFAR/B will continue to provide HIV and violence prevention lessons using an evidence-based curriculum reaching AGYW and ABYM in the school setting. The sessions will also be rendered to AGYW Out of school in the community safe spaces. In COP23, PEPFAR/B will also support the Ministry of Education and Skills Development (MOESD) in rolling out Lifeskills Framework, a national HIV and violence prevention and comprehensive sexuality education curriculum facilitated in schools as soon as the curriculum is finalized and ready to use. The MOESD Lifeskills Framework will be sent to S/GAC for review and approval before the program transitions to use it. The rollout of MOESD’s Lifeskills Framework will be provided by trained teachers as a response to GOB priorities. HIV and violence prevention will also be rendered in the community based safe spaces targeting AGYW that are not in a school setting, Lifeskills+ curriculum embedded in UNESCO Comprehensive Sexuality Education (CSE) will be used in the community safe spaces, rendered by trained facilitators and Peace Corps Volunteers. In addition, PEPFAR/B will utilize Grass Roots Soccer+ Skillz curricula for 9–14-year-olds, which is an OGAC and MOESD approved curricula implemented in school as well as out of class settings (DREAMS safe spaces). This curriculum is suitable for both AGYW and ABYM.

***Financial literacy***

PEPFAR/B will continue to provide the standard package for financial literacy and economic strengthening program to beneficiaries using evidence-based curriculums namely LIFESKILLS+, Aflateen, Grass Roots Soccer+ Skillz curriculum targeting 9–14-year-olds and Ready to Work curricula for 15 - 24-year-olds. Financial literacy lessons will provide the AGYW with the foundational financial skills, with an add on of comprehensive economic strengthening for the

older cohort to be outlined under Secondary Individual Interventions. Financial literacy will be rendered by trained mentors.

### ***Social asset building***

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. PEPFAR/B will implement evidence-based interventions through camps and clubs to build the capacity of youth to be community leaders. Social asset building interventions will also build social capital for AGYW, to provide the necessary skills and sisterhood network, consisting of AGYW that are participating in safe space provided social asset building sessions. During social asset building sessions AGYW create long lasting networks and relationships which enhances ongoing social connection with peers. Provision of social asset building sessions will continue to be rendered using approved curricula in the community safe space facilitated by Trained Mentors and Peace Corps Volunteers. Social assets will be provided across all age bands, leverage the strength of DREAMS Ambassadors, Mentors, Facilitators and Peace Corps Volunteers to strengthen the capacity of young people to use media for SRH literacy and HIV prevention (i.e., social media, pamphlets, broader internet etc.)

### ***Screening for HTS eligibility***

There will be mobilization of AGYW for HTS uptake as well as provision of HTS assessment using vulnerability score card and national screening tool. When HIV risk has been identified an HTS referral will be provided.

### ***Condom education***

This intervention is dedicated for the older age cohort (15 - 24), provision of condom education lessons will be provided in person to AGYW and ABYM.

**Secondary Individual Interventions:** The following secondary interventions will be supported in COP23 by PEPFAR/B.

### ***Clinical services***

DREAMS clinical services are aligned with The National HIV and AIDS Programming Framework for Adolescents and Young People in Botswana, which prioritizes AGYW aged 15 to 24, tracking indicators on new infections, condom use, PrEP, and gender-based violence (GBV) services intended to effect risk reduction, behavior change and empowerment. This national framework is aligned with WHO guidance on youth friendly services.

AGYW across the age bands will continue to be offered HIV prevention, post-violence care, and sexual and reproductive health clinical services based on need. Awareness strengthening, demand creation and referrals to PrEP services will be prioritized. The clinical package includes PrEP, Post-Gender Based Violence (GBV) clinical care services including Post-Exposure Prophylaxis (PEP) and Emergency contraception (EC) for survivors of sexual violence; STI screening and treatment; contraceptive method mix; and risk screening for HTS and delivery of HTS. Advocacy efforts will be directed towards including PEP as an additional HIV prevention option outside of occupational exposures and sexual violence. These services will be provided through NGO clinics and GOB public health facilities in all eight districts. The clinical service providers will liaise with the community-based IPs to schedule service days where AGYW can receive various clinical services while attending safe space sessions in their preferred location within the community. Clinical sites will be capacitated to deliver youth friendly services and will be strengthened to increase opportunities to identify the most vulnerable and at risk AGYW as potential DREAMS participants and the clinical service providers will work towards linking AGYW

enrolled in the program through clinical platforms to the community partners to ensure the AGYW can receive the full suite of the DREAMS services. Mobilizing AGYW in the community and accompanied referrals to the facility to access youth friendly services. The PEPFAR/B will integrate new biomedical prevention interventions such as the injectable long acting cabotegravir into PrEP and other prevention platforms as products move into the global marketplace. PEPFAR/B will strengthen referral efforts of AGYW male partners to other HIV services (VMMC, PrEP, care and treatment) as needed based on their needs. The low uptake of PrEP in some SNU can be attributed to several clinical, social, and behavioral barriers. These barriers include social stigma, lack of awareness of HIV risks, concerns about PrEP side effects, and lack of access to PrEP. In order to improve clinic encounters for PrEP users, the OU will include PrEP modules under the clinical mentorship. Health care workers will be trained, coached, mentored and their supervision strengthened to ensure they provide client-centered, stigma-free PrEP services.

### ***Comprehensive socio-economic approaches***

PEPFAR/B is approved to use the Empowerment and Livelihoods for Adolescents (ELA) model as a comprehensive economic strengthening curriculum to reach AGYW aged 15-24. This approach covers sessions on employability and entrepreneurship pathways, job readiness and skills development, apprenticeship skills, business and market contextual research skills and practical skills, as well as business coaching sessions. These interventions are needed 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:** Below are strategies PEPFAR/B will use in COP23 for contextual community-based interventions.

### ***Parenting/caregiver program***

In COP23 the Parenting/Caregiver program is shifting from secondary individual interventions to contextual community-based interventions. PEPFAR/B will focus efforts on supporting the Department of Social Protection (DSP) within the Ministry of Local Government and Rural Development (MLGRD) to adopt Pinagare (a Botswana-specific adaptation of Sinovuyo) as a national curriculum for parents/caregivers, in line with GOB priorities. PEPFAR/B will simultaneously support the national adoption of Pinagare while implementing Pinagare with parents/caregivers of select DREAMS participants, specifically girls ages 10-14 who are enrolled in both the OVC and DREAMS programs.

### ***Community Mobilization***

PEPFAR/B will implement the community mobilization and norms change in all the 8 SNU. The SASA! methodology will be used for reaching communities, including intentionally targeting ABYM, male community and religious leaders, male parents/caregivers, and male partners of AGYW, 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.

**Mentor Management:** PEPFAR/B will utilize the strategies below in COP23 to support mentor management.

### ***Mentor/Ambassador Trainings***

PEPFAR/B has a clearly defined comprehensive onset and refresher training plan for mentors before they start engaging the AGYW in safe spaces and schools. PEPFAR/B reviewed all

curricula in COP22 for standardization for the purpose of continued fidelity across all curriculums. Training will continue to include technical information, facilitation, and mentorship skills. The mentors and DREAMS Ambassadors will be rigorously trained on all curricula that are rendered to the AGYW in safe spaces. Close monitoring and spot checks will be conducted to ensure fidelity and identify areas that require refresher training. Training will continue to include first-line support using the LIVES approach to equip mentors with capacity to respond to disclosure of violence, supporting children and young. As mentors encounter trauma disclosures and may be survivors themselves, mentors will continue to receive training in PSS and communication skills, so they have skills to navigate these circumstances.

### ***Supportive supervision and peer support***

Post mentor training success will be coupled with routine supportive supervision with clear roles and responsibilities and expectations from the supervisor. Supervisors will utilize ongoing evidence to provide mentors with information to link AGYW beneficiaries and themselves to relevant support or resources.

### ***Mentor Compensation***

PEPFAR/B will ensure that mentors receive remuneration and resources (wages, transport allowance, airtime allowance) needed to provide the AGYW support. Mentors will have an opportunity for ongoing mentoring and coaching provided by their supervisors, as well as peer to peer mentorship for sharing lessons and best practices. Professional development opportunities and career progression for mentors will continue to be prioritized for their career growth and advancement, within their IP and externally.

## **2.3.2 Plan for OVC Services**

As part of addressing health equity for children, the PEPFAR/B COP23 orphans and vulnerable children (OVC) program will work to support the priorities advanced by the GOB's different ministries who work to protect children (health, social, economic, education, safety, and others). For the first time, during the COP23 planning process, there was very active engagement from a number of GOB ministries that have strong involvement in providing support and services to OVCs, specifically MLGRD and MOESD. Most of the priorities they brought to the table are systems-related activities which are critical for PEPFAR support considering the state of Botswana's epidemic. Some of these activities will be discussed in detail in the relevant pillars. Additionally, also in response to a GOB priority, the OVC program will continue to reach an increased number of boys with evidence-based interventions through different group settings. Boys are reached in class through the HIV and violence prevention sessions and through the Coaching Boys into Men (CBIM) program. Both the HIV and violence and CBIM platforms use evidence-based curriculum to address issues of HIV prevention, violence reduction and promote positive behavior in the society,

In COP23, the OVC program will continue to focus on coordination with clinical programming to close the remaining cascade gaps for children and ensure service access and comprehensive support for the most vulnerable and hard to reach populations. The program will maintain its footprint in the 15 SNU, continue close collaboration and coordination with DREAMS and other PEPFAR programming platforms to efficiently reach beneficiaries in the OVC Comprehensive program with family-based case management support. In these SNU, the OVC program will target vulnerable children and their families most in need of comprehensive support, including C/ALHIV (especially those failing treatment), children of key populations, HIV-exposed infants, survivors of sexual violence, and children of PLHIV (especially children whose parents are not adherent on treatment and not virally suppressed). Other relevant vulnerabilities such as orphanhood and disability will also be addressed. The OVC program will improve clinical

outcomes for children by continuing to strengthen the facility-community interface to facilitate effective referrals and interventions that support reaching the last 5-2-2 in Botswana, such as index testing of biological children of PLHIV including children of KP.

The program will continue to reach OVC and their families through the three distinct but related models:

### **1) Comprehensive Programming Service Delivery Model (0-17 years old)**

The Botswana OVC program continues to coordinate very closely with public health facilities and NGO clinical service providers to reach adolescents and children living with HIV and to link vulnerable children to HIV testing services. In some districts, the OVC partners have received letters of support from the District Management Health Teams (DHMTs) authorizing them to work with certain health facilities to increase reach A/CLHIV. In some areas, the OVC partners have been able to work directly with health facilities where they receive lists of children who need to be followed up and linked back to care. In some cases, the OVC case worker identifies children and adolescents who are defaulting on medication while doing normal household assessments and they link these clients to the nearest health facility or to a health facility that has been identified by the client. 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 SGAC 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 (especially where the HIV mother or caregiver maybe be on defaulting on treatment or not virally suppressed). 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 SNU.

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 and child survivors of violence, the OVC program will employ some of the following strategies:

#### ***Strengthening partnership with PEPFAR implementing partners and CSOs working with KPs***

It is important to note that OVC community partners have an existing and strong partnership with the KP implementing partner and the agreement specifies how referrals are 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 for the KP program. The current engagement has seen the OVC program serving an increased number of children of key populations. With possible expansion of the KP program in COP23, the OVC program stands ready to reach out to children of the KPs being identified to make the necessary linkages.

### ***Increasing reach for children who survived sexual violence***

This is also a major priority of the government of Botswana, Ministry of Local Government and Rural Development as well as the Ministry of Education and Skills Development. 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 COP23 to increase reach for this population group include:

1. Training all OVC implementing partners on the 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 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.
2. Responding to the government of Botswana’s priority as presented by the Ministry of Local Government and Rural Development of developing a National Violence Against Children Response Plan which will be followed by training of social workers, teachers, police and health care workers, and traditional leaders, and district child protection committees on the LIVES approach. These cadres and platforms are critical in helping to identify cases of violence linking them to the relevant services.
3. 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 (10–14-year-old boys and girls)**

This PEPFAR/B supported work is in line with the GOB Ministry of Education and Skills Development’s (MOESD) program that falls within their Lifeskills Framework. There are specific portions that focus on delivery of life skills material by guidance and counseling teachers in their classrooms. GOB’s priority includes working with the MOESD to review their 2002 content and bring it to 2023 and beyond standards. This support will be provided through the OVC and DREAMS platforms. While the review work is ongoing, PEPFAR/B supported implementing partners will continue to deliver services to the 10–14-year-old boys and girls through the provision of single, evidence-based primary prevention of HIV and sexual violence intervention by trained facilitators in group settings - in schools. 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. 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.

In addition, the OVC program will support implementation of the CBIM program; an evidence-based curriculum that engages male sports teams to reduce partner violence and increase positive behavior and attitudes in society. As indicated earlier, this work will contribute to the PEPFAR/B plan of assisting the GOB come up with a response plan addressing violence against children including by children against each other.

### **3) OVC/DREAMS Service Delivery Model (10–17-year-old AGYW)**

Over the past several years, the OVC & DREAMS programs have learned a great deal about the relationship between the two programs & the importance of having a strong coordination between

the two. As a result, PEPFAR/B programmatic design aims to co-locate DREAMS programming activities in geographic locations where the OVC program exists, and vice versa.

Through OVC and DREAMS platforms, parents of 10-17-year-olds are also being reached through parenting programs 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. In COP23, this work will be expanded in response to the GOB's priority about wanting to have a national standard parenting program. The OVC and DREAMS programs will be working closely with the GOB's MLGRD and MOESD to ensure that a national standardized parenting program exists that can be implemented in both PEPFAR and non-PEPFAR supported sites.

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

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

In undertaking this approach, the OVC program will ensure that critical partnerships with the relevant Government of Botswana Ministries and Departments are maintained, that these Ministries and Departments are part of the working groups that are developing products and services that are responding to the GOB's needs; further, in most cases, the relevant GOB ministry will be in the lead to guide and coordinate the process. District structures will continue to be updated about program implementation on a quarterly basis.

Finally, PEPFAR/B plans to support OVCs through Peace Corps volunteers, as they continue to:

1. Support HIV prevention initiatives targeting OVCs through interventions like Grass Roots Soccer+ Skillz (GRS)
2. Partner with MLGRD, through Social Workers to strengthen evidence-based interventions using Camps and Clubs for OVC support.
3. Refer and link OVC to support and service points in their communities especially through the Social Workspace.
4. Educate OVC on GBV prevention strategies through school-based clubs and camps.

### **2.3.3 Advancing gender equality to achieve health equity for key and priority populations**

PEPFAR/B's GBV and gender program will be implemented with a focus on human rights and advancing gender and health equity among key and priority populations. PEPFAR/B will deliver person-centered and trauma-informed care by integrating key GBV activities throughout HIV prevention, testing, and treatment services to improve AGYW, KP, and OVC HIV clinical outcomes. The program 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 COP23 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. In addition, the program will ensure that the post violence clinical care minimum package is offered to facilitate reporting of the GEND\_GBVI indicator across all sites which meet the standards for the following services;



treatment of injuries, rapid HIV testing, STI screening and treatment, first line support (LIVES), referrals as well as PEP and EC for sexual violence survivors who reach the facility within 72 hours post their experience. The team will utilize the key strategies below across difference programs:

### **Addressing GBV and Inequalities across HIV Cascade**

1. OVC and DREAMS: Utilization of evidence-based gender norms change and HIV and GBV prevention approaches will continue to be emphasized and prioritized across programming for priority populations programming, specifically within DREAMS and OVC programs. Additionally, All IP's asking about experience of violence for determining eligibility for DREAMS and OVC programming will be trained on how to ask about violence, how to respond (provide first-line support, i.e., LIVES and LIVES CC) and know how and where to refer for clinical and/or non-clinical GBV response services. Public health facilities will be supported to continue offering minimum package of post violence care services, including PEP.
2. PrEP: All PrEP sites will conduct routine enquiry for Intimate Partner Violence (IPV) with all clients during initiation counseling and continuation visits. Survivors identified will be provided with first-line support and linked to GBV response services to increase their PrEP adherence. PrEP counselors will also support clients experiencing IPV in identifying ways they can continue to adhere to PrEP while remaining safe from harm. Some survivors of sexual violence who have received PEP will be offered PrEP based on assessment of each individual's situation.
3. 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 and those who experience violence can be linked to KP-competent post-violence clinical care services.
4. Testing: PEPFAR/B will ensure that all HIV index testing sites conduct routine enquiry for IPV for clients offered PN services. These sites will all meet WHO's minimum requirements for asking about experience of violence, including ensuring that all providers are trained on how to ask about violence, how to respond when violence is disclosed (i.e., provide first-line support), and how and where to refer for GBV response services. Moreover, minimum requirements will be ensured including privacy and confidentiality and capacity building for health care workers on LIVES. Additionally, all HIV index testing sites will track and respond to adverse events, including IPV, that may result from partner notification services.
5. 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. The LIVES training includes modules that strengthen clinicians' understanding of the intersection between violence and linkage and adherence. 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.

### **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 Training**

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.

### **Partnership and collaboration with GOB to close gender equality gaps**

PEPFAR/B will work closely with the Gender Affairs Department (GeAD) and the Department of Social Protection (DSP) to effectively respond and support survivors of GBV across different districts as well as mobilize communities to address harmful gender and cultural norms that fuel and perpetuate GBV. Key activities will include:

1. Supporting the operationalization of the One Stop Center (OSC) SOP's: PEPFAR/B will continue to work with the Gender Affairs Department (GeAD) to build on the GBV SOPs as well as to operationalize the OSC framework which is being developed in COP22. GeAD will lead in the pilot of the OSC in the country and build off from the model based on how it has been assessed. This will be done in collaboration with CSO's and other stakeholders who provide GBV prevention related services which may be either clinical or community based.
2. Resuscitation of the National GBV TWG: The government will be supported to resuscitate the nation GBV technical working group which is key in bringing stakeholders together to come up with joint interventions to address the alarming rates of GBV in Botswana. GeAD will continue to take the lead in ensuring that all the key stakeholders are members and PEPFAR/B team will ensure that key lessons from our program are shared.
3. Supporting the district gender committees: PEPFAR/B will ensure that district level structures are supported in addressing GBV issues. This support will be linked to the work of the national GBV TWG as actions and key issues will be discussed and refined at the national level. District stakeholders right from community leaders, gender activists, social workers, police, teachers, health care professionals as well as key staff from CSO's will form part of the committees for diversity in bringing up innovations to ensure GBV prevention within the district.
4. Training Social Workers on VAC case identification and first-line support using WHO's LIVES CC approach: PEPFAR/B will support the Department of Social Protection (DSP) with building capacity of social workers on VAC case identification and offering first line support to child survivors of violence. PEPFAR/B will ensure that there are clear referral and linkage mechanisms in place which will also be integrated into the OVC Data management system that PEPFAR is supporting DSP to develop.

### **2.4 Plan for KP services**

As Botswana moves beyond 95-95-95 among the overall population, an increasing proportion of the country's undiagnosed HIV cases will be found among key populations (KP). Globally, people who inject drugs (PWID) have 35 times the risk of acquiring HIV of other adults; female sex workers (FSW) have 30 times the risk of other women; men who have sex with men (MSM) have 28 times the risk of adult men in the general population; and transgender women have 14 times the risk of adult cis-gender women. Although updated risk estimates among KP in Botswana are not yet available, the risk of HIV acquisition among KPs likely exceeds that of the general

population in Botswana. In Eastern and Southern Africa, the region that includes Botswana, the proportion of new HIV diagnoses among KPs and their sexual partners has increased from 21% in 2014 to 46% in 2021.

The HIV burden among KPs is elevated not just because of their defining risk profiles, but because of the stigma and discrimination faced by KPs that often makes it harder to reach them and provide prevention and treatment services needed. GOB and PEPFAR are committed to reaching KPs with client-centered prevention, testing, and treatment services, and implementing interventions to address the structural barriers that underlie discrimination and stigma faced by KPs. Through COP21, PEPFAR/B largely supported above site and community interventions aimed at reaching KPs with high-quality, KP-competent services through NGO-run KP-competent clinics. In COP22, in response to MOH priorities, PEPFAR/B also began supporting the provision of KP services in public health facilities. In COP23 and COP24, PEPFAR/B will support KP programming at the public health facility, community, and above site levels through engagement with government, NGOs, CSOs and other stakeholders.

The PEPFAR/B key population program support in COP23 will follow the Ministry of Health approved *Botswana Guidelines & Service Package of HIV and STI Programs for Key Populations and Innovative Service Delivery Models to Improve HIV Outcomes for Key Populations in Botswana*, both of 2020, and will adhere to the *2022 Consolidated Guidelines on HIV, Viral hepatitis and STI Prevention, Diagnosis, Treatment, and Care for Key Populations* by WHO. The new WHO guidance indicates that inadequate coverage and poor quality of services for key populations undermine impact. The guidelines therefore emphasize the need to support key population communities to lead the response thus providing equitable, accessible, and acceptable services to men who have sex with men, trans and gender diverse people, sex workers, people who inject drugs and prisoners.

The achievement against the results in the PEPFAR/B KP prevention and treatment cascade in FY23 shows a successful upward trend in minimizing service gaps for key populations. The success is the result of long-term investment in local KP-led organizations that provided comprehensive person-centered services. The DSD model coupled with services through KP-competent public health services and the virtual recruitment strategies have provided for a broad and diversified menu of services that appeal to and are accessible to different KP typologies and age segments.

PEPFAR/B KP community interventions will be implemented in 10 districts while the facility-based interventions will expand to cover 16 districts. The key population program will target female sex workers (FSW), men who have sex with men (MSM), and transgender (TG) individuals, People Who Inject Drugs (PWIDs) with prevention, treatment, care, and structural interventions. The program will also focus on other high-risk groups associated with KPs, such as their sexual partners, clients, and/or children of and/or living with sex workers, people who use drugs (PWUD), among others. In addition, young women 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 start and remain on ART and be virally suppressed. In addition, the KP program will work with Botswana Prisons Services, offering comprehensive HIV services, including testing on entry and exit, reaching those in remand with PrEP services, and ensuring HIV-Positive clients are retained in services upon release.

PEPFAR/B will provide comprehensive-client-centered services to key populations through community- drop-in centers to provide comprehensive peer-led services. Clinical mentorship will be provided to 103 public health facilities and KP competency services will be mapped out and

expanded to prioritize PHF serving KP clients in addition to community service delivery points in COP23, and in COP24 will be rolled out nationally. For HIV prevention and care, members of key populations will be reached with individual and/or small group-level HIV prevention interventions designed for the respective KP sub-typology.

Structural interventions are integrated in the prevention, care and treatment cascade to protect the human rights and dignity of KPs, and to respond to violence, address stigma and discrimination, as well as fostering enabling policies, promoting legal literacy, and supporting the provision of KP Competent services. Community-based interventions will be critical to meeting the unique needs of KPs, particularly those most likely to experience stigma and discrimination at other service points.

Community-Led Monitoring and Bio-Behavioral Survey data from sub-Saharan African countries indicate that many FSWs are comfortable receiving services in public health facilities. These services have been prioritized by the Government of Botswana who would like to further strengthen integration and provision of KP services in PHFs. PEPFAR/B will therefore prioritize supporting the provision of high quality, client centered, KP friendly and KP competent services at all public facilities in Botswana. PEPFAR implementing partners will provide support for clinical mentorship for public health facility healthcare workers to reduce stigma and discrimination, including through the promotion of a zero-tolerance policy for discrimination and stigmatizing behavior by facility staff. There will be continued prioritization and strengthening of KP client confidentiality and privacy through safe and secure procedures and data systems for KP. Identification of KPs living with an undiagnosed HIV will also be prioritized through an expansion of KP-targeted self-testing and the scale-up of facility-based social network strategy testing. More details on case finding among KPs are outlined in the case finding sub-section (2.6). KPs visiting public facilities will be offered status neutral HIV combination prevention services, including PrEP and STI screening/treatment as described in section 2.7.

Men who have sex with men and transgender people still face high levels of stigma at public health facilities where providers have not been trained on KP competency. 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 HIV 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 reported the highest level of stigma and discrimination at public health facilities, which was 27% in the year preceding the study. The 2017 BBSS reported that the use of drugs among key populations was on the increase. Among MSM, 23.1% used marijuana, 2.7 % used cocaine, 0.8 % used heroin while 0.4 % injected drugs. Among FSW, 7.2% used marijuana, 0.55 % used cocaine and 0.1 % injected drugs. To break the trend of KP starting the use of injectable drugs, the KP program will implement route transition interventions that will support KPs who use drugs to avoid initiation into injecting.

In COP23 the KP program will use the “trusted access platform model” which provides for provision of community and clinical services. WHO recommends the trusted platform model as it, “supports all key populations, as individuals and communities, addressing common needs regardless of HIV status or other specific healthcare needs”. It is also a way of working with key populations communities to establish trust and improve access to services, involving close collaboration on program design, implementation, monitoring and addressing critical enablers.”

Services under trusted access platform include:

- Involvement of the population in designing/planning, implementing, and improving interventions
- Continuous high-risk venue presence

- Progressive KP mobilization and engagement
- Safe spaces
- Structural Interventions, self-help groups, community ownership
- Peer-based outreach guided by continuously updated data from high-risk venues.
- Condom/lubricants and needle exchange programming (promotion and distribution with uninterrupted supply sufficient for need)
- Accessible and respectful medical checkups
- Continuous program monitoring with monthly dashboard reviews.

Three models of service delivery for immunologically and virologically stable KP on ART will be used in conformity with the WHO Guidelines.

1. At DIC worker-managed group models, clients receive their ART refills in a group that is managed by either a professional or a lay provider. Healthcare worker-managed groups meet within and/or outside the DICs.
2. Out-of-facility individual models, clients receive some or all of their ART refills, clinical consultations, and psychosocial support outside of healthcare facilities. These models include mobile outreach, services decentralized to key population drop-in centers, digital pharmacies, or Post Office home delivery of ART.
3. A Public Health facility delivery model where services will be provided from all patients point of contact and IDCC. Patients will be referred for non-medical support to KP CSOs.

The MOH guidelines propose that, “delivery of services will be through public health facilities and NGOs which are expected to include KPs in shaping the delivery of programs, and in some cases KPs themselves will be involved in delivery of programs such as Social Behavior Change Communication (SBCC), creating demand for services and linking other KPs with services.”

The main activities for KP interventions in COP23 (table 2.1) will be as outlined in the Ministry of Health guidelines. They will include:

1. Secondary data analysis of BBSS III and dissemination of results to KP community, opinion leaders, implementers, researchers and the media.
2. Continuation of outreach activities from all the Drop-in centers.
3. Provision of Combination Prevention Package for Key Populations
4. Technical Assistance to MOH and other IPs to facilitate the provision of stigma free and KP competent services. To achieve this, IPs will offer the following.
  - KP-competency training: A centrally provided training to Health Care Workers that will focus on meeting the unique health and welfare needs of KPs, greater understanding of KP, and mitigation of KP-related stigma, discrimination, and violence. KP leaders will assist in conducting the training. In FY23 providers from 103 facilities will be trained.
  - Through the clinical mentorship program, health care workers will be coached and mentored to provide KP competent, stigma and discrimination free services.
  - Collection of client feedback: This will be facilitated by creation of a system supported by a call number/web-based system that will be managed by the KP KP community advisory board (CAB) / KP consortium and the Community-Led Monitoring service provider.
  - Development of SOPs for bi-directional service provision between community CSOs, DICs and Public Health Facilities.
  - Maintaining client centered decentralized drug delivery system for stable clients, including MMD, post office delivery, and digital lockers.

- Establishment of data protocols on how to transfer, transmit, and manage KP records of all referred clients.
  - Provision for the use of virtual strategies, SMS reminders, and calls to ensure the clients do not miss their appointments and remain adherent.
5. Establishment of KP Community Advisory Board (CAB ) / KP Consortium: The MOH Guidelines also implore the KP program implementers to include KP Community Empowerment, Ownership, and Leadership. The interventions delivered through a community empowerment model include sustained engagement with local key populations to 1) raise awareness about their rights, 2) facilitate meaningful participation, 3) establish key-population-led services, and 4) form collectives/ networks and coalitions that determine the range of services to be provided. Community empowerment is a necessary component of key population interventions and should be led by key populations. Successful programs have empowered key populations and increased community ownership and leadership by educating the community about their rights and creating community committees to formalize the community's meaningful participation in intervention. The Guidelines provide for the establishment of a Community Advisory Board (CAB) or Consortium charged with the responsibility of building linkages between KP members and implementing partners and advise and monitor comprehensive service delivery at program level. "Through meaningful and genuine partnerships, the CAB will ensure creation and ownership of a safe environment where KPs are empowered to lead as role models and make decisions within the program."
- Roles and Responsibilities of CAB:
    - Facilitate linkage between the community and implementing partners.
    - Advise the program on comprehensive service delivery to address the needs of the community.
    - Advise the community on access to comprehensive services provided by the program.
    - Help the community to voice their concerns to the program and vice versa.
    - Support the program and the community to develop rules of engagement within the program keeping community interests in mind.
    - Conduct community engagement and dialogue to get feedback
    - Follow up action taken on advice/ information and assess how it benefits the community.
    - Hold regular CAB meetings.
    - Visit program sites and interact with the community.
    - Understand and review action plan / work plan and support the project in designing the program of the following year by giving suggestions.
    - Participate in project activities, such as trainings, functions, events, etc.
    - Bring important issues, problems faced by the community (including rumors), and solutions to the attention of the program on a routine basis.
    - Suggest strategies to address challenges faced by the project, informed by experiences and expertise of CAB members.
    - Advise and support (when needed) in advocacy with program stakeholders.
    - Ensure that the community is handled ethically, without stigma and discrimination, with a positive attitude.
6. Maintain safe spaces or Drop-in Centers (DICs): "The role of drop-in centers is critical given the fact that male and female sex workers/MSM/TG/PWID, especially those who operate from streets, do not have a place where they can safely rest, wash, or meet. Given the extreme and rampant human rights violations of key populations, safe spaces are often the only places key population members can access health care, legal counseling, and other HIV-prevention services."

7. Violence Prevention and Response: There is growing recognition that HIV-prevention policies and programs focusing on key populations must incorporate violence prevention and response strategies. The key strategies include group discussion, affirming key populations' identity and rights, and participatory documentation of threats and advocacy for an enabling environment. LIVES training will be offered to staff, strengthen facility and community response.
8. Promoting the Safety and Security of Key Populations: Partnership with the police to ensure that KP are protected from harassment, abuse and violence will continue. Partnership with SADC, Global and NAHPA in responding to issues of violence against key population members.
9. Strengthening Management and Organizational Capacity and funding of KP led organizations: The KP prime Partners will conduct Organizational Capacity assessment for KP local partners and develop a transition plan for the CSOs to receive direct funding in COP24. Working with NAHPA, PEPFAR/B will promote social contracting and social enterprise schemes for the KP-led CSO partners. Guidance resources include Key population trusted platforms Considerations in planning and budgeting for a key population platform to deliver scaled quality HIV prevention and treatment services and for addressing critical enablers (2020) and Differentiated Service Delivery for HIV: A decision Framework for Differentiated Antiretroviral Therapy Delivery for Key Populations

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**Table 2.1: PEPFAR/B COP23 KP Interventions, approaches, and partnerships**

<b>Services definition under the MOH KP Guidelines</b>	<b>Approach adopted by PEPFAR/B</b>	<b>Type of intervention</b>	<b>Collaborators/Partners</b>
a. Comprehensive condom and lubricant programming	Continued condom stewardship by MOH/IPs	Training and advocacy	NAHPA, MOH, UNFPA, CMS
b. Harm reduction interventions for substance use, especially needle/syringe programs and opioid substitution therapy	Support self-referrals, peer referrals and family referral strategies.	Expand the STI/KP competence manual to cover PWID issues. Advocate for the new clinical guidelines to include harm reduction	MOH, UNODC, CMS
c. Behavioral interventions	Support new KP strategy development	National above site. Facilitation in workshop and integration of recommendations into the KP program design	MOH, UNAIDS, NAHPA, INGO, KP CSOs
d. Voluntary Medical Male circumcision for HIV prevention	Advocate for expansion biomedical interventions in the Botswana Guidelines & Service package of HIV & STI programs for KP to include VMMC information and referral pathways	Technical Assistance and referrals	PHF and MOH
e. HIV testing and counseling.	Continue blended social network strategies and facility- based index and community-based index testing. Increase availability of HIV Self-test kits.	Roll out test neutral approach.	CSOs, DIC and PHF
f. HIV treatment and care. (This should include ART, PMTCT, drug interactions and nutrition.)	Treatment will be offered at DICs, PHF and Private clinics for MSM with medical schemes. Pregnant FSW will be referred for PMTCT; U=U and treatment literacy will be maintained	Direct service delivery and referrals	CSOs, DIC and PHF
g. ARV Related Prevention. This should include Pre-exposure prophylaxis (PrEP), Post-exposure prophylaxis (PEP) and early initiation of ART.	Test neutral with option for Treatment or PrEP. Review of PEP policy to expand PEP for non-occupational reasons. Introduce new PrEP technologies and a community delivery platform.	Differentiated service delivery with same day treatment initiation, warm referrals and MMD	CSOs, DIC and PHF
h. Prevention and management of co-infections and other co- morbidities, including viral hepatitis.	TB prevention therapy, STI and Hepatitis and cervical cancer screening and referral for management	Syndemic approach to disease screening and management and inclusion of NCD screening alongside HIV screening	CSOs, DIC and PHF
i) Mental health conditions	Refresher training in mental health to service providers at DICs	Referral to mental health management	CSOs, DIC and PHF and Private medical providers
j. Prevention and management of STIs	Condom/lubricant promotion; referral for treatment; Syndromic management of STI	Enhanced Condom education and Active referrals and counselling	CSOs, NAHPA, DICs, PHF and other media partners
k. Access to SRH services (FP, Cervical screening, and contraceptives)	Screening for cervical cancer will use a self-collection approach and samples taken to MOH labs. FP will be provided at DIC, PHF and private pharmacies	The use of hub and spoke model	CSOs, PHF, private pharmacies and shops for condoms and lubricants.
l. Additional above site activities will include: HRH for KP coordination at MOH, KP competency services, National TWGs,	PEPFAR will provide technical assistance and resources while MOH will provide additional resources, leadership, coordination, monitoring and reporting	Partnership and leveraging of resources for sustainability	PEPFAR/B, MOH, INGOs, KP CSOs



CAB-LA Implementation research, LIFT-EMR for KP			
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## 2.5. Plan to address Stigma, Discrimination, Human Rights, and structural barriers

UNAIDS describes stigma as a dynamic process of devaluation that significantly discredits an individual in the eyes of others. Within 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.

Despite a clear commitment by different stakeholders, including NAHPA and the Ministry of Health, to address human rights, stigma, and discrimination, there remain substantial social, political, and structural barriers that impact the delivery of HIV prevention, testing, and treatment services to vulnerable populations. These barriers include reports of healthcare facility staff who are unwilling to provide services to key population community members.

The Botswana report on the Assessment of Legal and Regulatory Framework for HIV, AIDS and Tuberculosis of 2017 noted that HIV related stigma exacerbated the impact of HIV and discrimination was an issue of concern.

Stigma and discrimination (S&D) have impacted 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. Social support is important in combating S&D.

Stigma reduction is vital to the success of HIV prevention, care, and treatment efforts. HIV related 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 central importance of addressing S&D remain significant barriers to progress at both the global and national levels. Ending S&D against people living with HIV (PLHIV), key populations (KPs), and other vulnerable populations and improving their access to and uptake of comprehensive HIV services remain cornerstones of PEPFAR’s human rights agenda.

Although HIV and AIDS related stigma has progressively decreased as reported in progressive Botswana AIDS Impact surveys (BIAS)BAI it is still above 10%. Different age groups and genders experience different levels of stigma. Members of the key population have experienced higher levels of stigma than members of the general population. From BAIS I, BAIS II, BAIS III and BAIS IV the youth 10-19 have experienced the greatest level of stigma which was at 68.4% at BAIS I and 29% at BAIS IV. For all age groups the reported stigma at BAIS I was 60.2% and was 17.3% at BAIS IV.

The 2022 Botswana Stigma index reported that 16.7% of 18–24-year-olds missed a dose of ART due to fears of others finding their HIV status against a national average of 7.4% for all ages. The same type of fears led to 15.6% of persons ages 18-24 years interrupting or stopping their HIV treatment. The same study reported high levels of stigma among members of the key population where 50% reported experiencing discrimination from family members due to their gender identity.

Further, 33.3% of members of the key population felt excluded from family activities due to their gender identity. (Botswana Stigma Index 2022).

Key populations, especially MSM and transgender, still face stigma at MOH 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.

In response to addressing the negative effects of stigma and discrimination, PEPFAR/B, in collaboration with the Ministry of Health, NAHPA, CSOs and other multilateral partners, is following the UNAIDS 2025 targets aimed at reaching the new 10:10:10 strategies. The first 10, sets a target to ensure that less than 10% of people living with HIV and key populations experience stigma and discrimination.

The new PEPFAR Reimagined Strategy has put in place measures to combat stigma and discrimination, advance equity for underserved communities, and prevent and combat discrimination or exploitation based on race, religion, gender identity or sexual orientation. The PLL underlines PEPFAR's commitment to ensure that these principles are upheld, promoted, and advanced in all PEPFAR programs. In addition, PEPFAR/B will address structural barriers to facilitate the creation of an enabling environment for HIV service delivery.

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.

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, PEPFAR/B 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.

In COP23 PEPFAR/B will promote PEPFAR and MOH's zero tolerance policy on KP/HIV-associated discrimination by supporting the following activities towards reduction of stigma and discrimination among key populations and to those that provide services to key populations:

1. Increase awareness of invisible stigma among those that provide services to key populations. This will be done through awareness raising activities. All persons that interact with key populations will be required to take an MOH-approved two-day training on key populations sensitization, which is facilitated to KP leaders themselves along with other providers. The code of conduct will be referenced to inform or guide staff on ethical practices.
2. Addressing stigma across the key population ecology, family, workmates, and those in key populations network. This will be accomplished through awareness raising of stigma

and its harmful consequences. This will be done through supporting a national key population pitso (gathering) which among other topics will address stigma.

3. PEPFAR/B will work with implementing partners to integrate interventions that address stigma in all their communication campaigns, including U=U messaging.
4. Have all PEPFAR/B key population implementation partners documenting and responding to violence and discrimination faced by key populations.
5. Strengthening the capacity of key populations organizations to address stigma, violence, and discrimination.
6. Aligning with the U.S. Department of State to streamline Human Rights and Stigma, Violence and Discrimination reduction.
7. Work with the Global Fund program in implementing Human Rights Interventions.

## **2.6. HIV Testing Plan**

PEPFAR/ Botswana's COP23 overall goal for HIV testing services and case finding is to provide and sustain person-centered, equitable, quality, safe and ethical differentiated HIV testing services – ensuring confidentiality, correct results, counseling, and connection to appropriate services to reach the remaining 5% (children and infants, AGYWs, KPs & Men) —across geographies and populations. Through facility and community platforms, HIV testing services will be broadened towards status-neutral testing to actively support linkage to treatment for those who test HIV positive and engagement in prevention -for all who test HIV negative. This shift in approach will broaden HTS beyond case-finding and will include: targeting services to populations with ongoing risk of HIV acquisition by expanding access to HTS and actively linking clients to prevention services, supporting the early identification of new HIV-positive cases through index testing and partner notification, social network-based testing and expanding HIVST, and linkage to and support for sustained engagement in treatment services for those who test positive, as well as linkage and re-engage persons living with HIV who are not on treatment. PEPFAR Botswana will also promote HIV testing by facilitating facility – community interface and partnerships between health facilities and youth-focused community platforms to implement joint programming and/or bi-directional referral processes.

### **2.6.1 Case finding plans for reaching youth and adolescents**

The program will explore strategies to expand the reach for testing and identify cases among the youth and adolescent populations, including:

- Increasing accessibility to services at youth-friendly clinics by extending services to after-school hours and weekends and ensuring that trained adolescents and youth deliver services. Meaningful engagement of adolescents and youth in continuous program review and implementation will also be critical.
- Demand creation strategies will be explored using digital and virtual platforms, including social media, and short message services explicitly targeted to youth and adolescents to increase awareness of HTS services and bolster HTS.
- The use of innovative approaches, including HIVST distribution via digital platforms to expand reach and uptake among youth and adolescents, will be explored to increase access to HIV testing and prevention services. Digital platforms will be crucial delivery points for adolescents and youth because this subgroup favors them and because they are anonymous. Anonymity makes it easier for adolescents and youth to ask questions and seek advice about health issues.
- To strengthen an enabling environment for improving health and well-being amongst youth and adolescents, the program will also support GOB MOH with updating and aligning

national guidelines and policies that limit the uptake and continuity of HIV testing services, eliminate barriers to HTS and close the gaps among this priority population.

- Increasing HTS accessibility at DREAMS platforms like safe spaces provides an opportunity to reach beyond the adolescent girls and young women directly involved in DREAMS programming. DREAMS participants have a unique voice and potential influence with their peers and could be engaged to help normalize HIV service uptake among their peers (e.g., encouraging youth in their communities to know their HIV status and their testing options).
- The use of innovative approaches, including HIVST distribution via community youth platforms and organizations, religious leaders working with HIV groups to reach young people and adolescents to increase access to HIV testing and prevention services.

### **2.6.2 Testing Plan for AGYW Services**

To reach and identify adolescent girls and young women, the case-finding strategy among AGYW will include the following:

- A strong integration of HIV testing across the health care provision system for AGYW: offering of HIV testing at antenatal, family planning, TB, STI and inpatient services, as well as promoting the use of the HIV risk assessment tool and offering HIV self-testing to improve testing outcomes.
- Strengthening program implementation across the facility and community structures to better reach adolescents that do not routinely use health services. Implementing partners will continue to provide targeted HIV testing through HIV prevention programming, including DREAMS for those at-risk and vulnerable AGYW, OVC, and PrEP programs.
- 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.
- The use of HIV self-testing will enhance the reach of index testing to young people who still wish to remain anonymous and not willing to test in the other platforms.
- With lessons learnt from the KP program, all digital/online platforms will be used to reach AGYW and encourage them to know their HIV status. This subgroup favors digital platforms because they are anonymous. Online outreach makes the program relevant to AGYW and young urban populations.

### **2.6.3 Testing plans for reaching men**

Although great strides have been made in engaging men in care, program data and BAIS V data show that men have lower HTS and ART coverage as compared to women. In FY23, PEPFAR/B will target men through facility and community platforms as follows:

1. Scaling-up index testing to reach men
  - Using antenatal Care (ANC/PMTCT) HIV testing to generate index clients, PEPFAR/B will continue 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.
  - Partner notification approaches will also 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.

- Review of Viral Load data to identify unsuppressed women to generate index clients: 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.
2. In COP23, PEPFAR Botswana will also focus on strengthening the routine and standard offering of and integration of voluntary HTS into clinical services for men: primary care, outpatient clinics, TB, viral hepatitis and STI, and VMMC services.
  3. PEPFAR/B will additionally support assisted and unassisted HIV self-testing for patient populations with a particular focus on men and key populations, including (1) patients in the queues waiting to consult clinicians; (2) for partners of pregnant and breastfeeding women; 3) women presenting at facilities for TB treatment; 4) sexual partners of AGYW, and (5) through KP program sites.
  4. To improve the quality of HIV case finding services for men, the program will continue to support male-friendly services. Additionally, in COP23, existing structures will be leveraged, and male-friendly health services will be expanded from 12 to 16 high-volume public health facilities to provide comprehensive and targeted male-friendly HIV services, making them inclusive, friendly, and accessible to men.
  5. Among men, knowledge of where to test and motivation to get tested may be low. Therefore, to increase the uptake of HTS among men, demand creation intervention for HTS will be implemented to reach men who are unaware of HTS options or unwilling to seek services. PEPFAR Botswana will implement evidence-based platforms for delivering demand creations. Peer-led interventions, through the deployment of male champions at health clinics, and as well as the roll-out of digital platforms and tools, appealing to younger men as well as working men, that will facilitate anonymous HIV risk screening and self-assessment, facilitate risk exposure notification, and direct clients to where they can access HIV testing, including HIVST distribution, wellness screening and prevention services, will be implemented.
  6. PEPFAR/B will also explore social network-based approaches for reaching—men by working with high-risk groups of men, community adherence 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 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.

#### **2.6.4 Scale-up of HIV Self Testing**

In addition to index partner testing services, the MOH is committed to scaling up HIV self-testing as a strategy for hard-to-reach at-risk populations, including men not accessing services. HIVST is 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. HIVST has been 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. HIVST will continue to be provided in conjunction with active partner notification and screening for high-risk populations. Those that screen positive will do a confirmatory test for HIV

positive and will be actively linked, initiated on treatment, and provided ongoing support for adherence.

### **2.6.5 Testing for Key Populations**

The BAIS V was concluded in 2021, but it was not designed to capture HIV information on key populations, and the third Integrated Bio-Behavioral - Survey (IBBSS 3) is being done in COP22. In COP23, it is hoped that IBBSS III should have been conducted and completed in locations with the highest estimates of key populations, and/or those that reflect the HIV epidemic of the country. The IBBSS II (2017) revealed that among FSWs, HIV prevalence steadily increases by age group. Declines between 2012 and 2017 were seen most noticeably in the younger age groups. Among MSM, HIV prevalence steadily increases by age group and doubles in the 40-49 age group. PEPFAR/B's case finding among key population strategies therefore focuses on an improved HIV screening tool that can identify the FSWs at the highest risk. PEPFAR/B will prioritize MSM, FSW, PWIDs, transgender people, people in prisons, and partners and children of KP. Case finding for KPs will leverage both facility and community platforms.

#### **Facility based case finding for reaching KP**

In COP23, PEPFAR Botswana will continue improving public facility KP programming and scaling up differentiated HTS services. The main case-finding strategies include the following:

1. The program will strengthen and continue the implementation of index testing and partner notification services among KP; scale up social network-based testing and risk-network referral approaches, as well as HIV self-testing to reach KPs and other HTS models to improve testing efficiency while reaching the highest risk groups.
2. Risk screening tools will be scaled up to reduce over-testing and HIV fatigue among those reached regularly, and a blended social network strategy/index testing approach will be used to find KP individuals who do not know their status.
3. The program will increase the utilization of HIV self-testing in PrEP programs for re-initiation and continuation, ensuring the monitoring of the distribution to track and differentiate HIVST intended for case finding.
4. Innovative approaches, leveraging technologies (e.g., social media, messaging, and online platforms) to reach social networks, will also be adopted and scaled up to forge a demand for HIV testing and prevention services among members of key populations. HIVST via digital platforms to expand reach and uptake among KP will also be explored.
5. Additionally, engagement and close collaboration with CSOs and community groups to ensure the presence of community-led monitoring and receive feedback on the quality of HTS delivered and how the HTS providers can best provide packages of services that adequately respond to the Community-led monitoring feedback will be supported.

#### **Community-based case finding plans for Reaching KP**

The program will prioritize high-yielding case finding strategies from the community. These strategies include:

- The expansion of Enhanced Peer Outreach Approach (EPOA) that engages individuals at high risk or those living with HIV to recruit members of their social and risk network for HTS. EPOA includes performance-based incentives that provide peers with increasing benefits in return for achieving measurable service benchmarks and coupons to track referrals, testing and linkage to treatment.
- Using recency test results, the program will engage key population members that are newly diagnosed with HIV to identify their sexual partners and members of their networks.
- The program will expand HIVST for KPs and their clients. This will overcome stigma and discrimination and fear of loss of confidentiality. The program will engage the KP community on HTS and introduce testing for triage using self-test kits. Key populations in high-risk settings, for example, those selling sex in a brothel are at elevated HIV risk and will be provided HIVST. They also do not have the opportunity to leave their places of work which also serves as their homes. In addition, PEPFAR/B will also target MSM, who occasionally congregate at a site/home where there is a cookout and high-risk sex can follow. HIVST in this setting is indicated.
- KP community providers will conduct a single rapid diagnostic test. KPs with a reactive test will be linked immediately to a facility for further HIV testing and treatment. Those with non-reactive results will be recommended for enrolment into PrEP and other prevention services. The program will enhance the use of ICT to engage and recruit the online population of KP, especially those visiting matchmaking and dating sites. Online outreach makes the program relevant to young and urban populations.
- Expand use of virtual and ICT platforms for HTS by online platforms where mostly MSM wishing to remain anonymous will book an appointment with a choice of services either at a NGO clinic or at a private practitioner. 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. The program will enhance virtual recruitment to reach, motivate, and recruit the online population of KP, especially those visiting matchmaking and dating sites. Online outreach makes the program relevant to young and urban populations.
- Use blended Index Testing and Social Network Strategy to reach partners and children of KP. Partners and children of FSWs will be referred for HIV testing/self-testing and those who test positive will be fast tracked into treatment. Biological children of KPs will be elicited and referred to OVC partners for continued support.
- Index testing and mobile testing modalities will be used as outreach at community level - these will be used as complementary modalities. In COP23 PEPFAR/B planned to build the capacity of KP model clinics to add to the differentiated models of service delivery for virtual outreach. Index testing among regular partners of MSM will be rolled out with specific consideration and monitoring of IPV. The use of HIV self-testing will enhance the reach of index testing to KP partners who still wish to remain anonymous.
- The hard-to-reach KPs in remote safari hotels and camps in the Delta and Chobe areas will be reached through outreach services. The KP program in Maun also covers the hotels in the Okavango Delta. Services in these areas are provided each quarter. At every visit about 20 FSW and MSM are provided with services. To minimize costs, the site visits are conducted in collaboration with DHMT through the

District Multisectoral team. The program leverages existing structures to save on transport costs by sharing vehicles. In addition, the team does not stay at the expensive lodges but instead stays in camps and facilities within US Government per diem rates.

### **2.6.6 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. HTS will also be a valuable tool to monitor and refine prevention programming.

Consistent access to person-centered, evidence-based HIV prevention services is essential to ending HIV/AIDS as a public health threat. Prevention-focused HTS also provides an opportunity for individuals with high, ongoing risk to be diagnosed earlier should HIV seroconversion occur. PEPFAR/B will support GOB mandate of offering and provision of safe and ethical HTS as part of standard of care within prevention programming (e.g., KP, PMTCT, PrEP, and VMMC services) and testing positivity within prevention programming is expected to be very low.

Provision for HIV testing services for prevention will be integral to PEPFAR/B's status-neutral approach to HIV services. A status-neutral approach means that all people are directly linked to services appropriate to their health needs (notably prevention or ART services) regardless of HIV status. Within HTS, this starts with mitigating barriers to testing (including HIV self-testing) and supporting immediate, seamless linkage to treatment and/or prevention services.

#### **Testing for PrEP**

In Botswana, testing is provided as part of a package for PrEP enrollment to ensure HIV negative status. MOH guidelines require HIV testing for at-risk patients enrolled on PrEP every three months. PEPFAR/B will continue what is working with an emphasis on scaling up PrEP and identifying and addressing new gaps through both community and facility-based approaches. This will involve promoting testing for partners of AGYW and KP already taking PrEP. HIVST will be used for continuation and re-initiation for PrEP.

#### **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. A holistic facility & community intervention that incorporate all aspects of the HIV cascade (case finding, ART initiation/management, continuity of treatment, and viral load collection/management), the management of preventable childhood diseases (e.g., TB), and the facilitation of access to the different services available through the OVC program including those that promote adherence for children who are on ART would be offered at all HTS points. This is using HTS platform as an entry point and key opportunity for linkage to person – centered, high impact prevention programming for individuals who are HIV seronegative and HTS as an important step in reengagement to HIV treatment services.

#### **Testing for DREAMS**

In Botswana, HIV testing is not a requirement for enrollment in the DREAMS program. However, to secure the gains of the program and expand its impact for adolescent girls and young women PEPFAR/B will strategically implement HIV-testing strategies leveraging the DREAMS platforms to maximize linkage to prevention and treatment services. Innovative solutions to reach undiagnosed adolescent girls and young women and link, initiate, and maintain them on treatment



for example, innovative community-based testing (social networking testing in safe spaces and differentiated approaches to case finding among adolescent girls and young women, including expanded self-testing), would be used. Where appropriate, AGYW will also be issued with self-test kits to reach their partners.

### **2.6.7 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 COP23, recency implementation will be sustained at the current COP22/FY23 sites. Based on the protocol, all newly diagnosed HIV individuals aged 16 years and older who consent to the test are eligible for recency testing. As the country closes the remaining gaps in the 1<sup>st</sup> 95 gaps, recency testing will be implemented following an approved protocol 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 diagnoses, 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 ongoing mentorship and support. Results will inform prioritization and mapping of transmission hotspots, targeting prevention and treatment services to disrupt further transmission. A public health response framework that leverages recency testing (including identification and response to recent HIV clusters) and informs programming is being developed, with implementation scheduled for FY24.

### **2.7. Prevention plan that promotes equity**

PEPFAR/B recognizes the significant unmet need for HIV prevention that persists in Botswana despite the achievement of the 95-95-95 HIV treatment targets. PEPFAR/B will therefore focus on prevention with an equity lens—especially for AGYW, OVC, KP and Pregnant and breastfeeding women (PBFW). These populations will be targeted with holistic, person-centered prevention care. HIV prevention services will include PrEP and PEP, risk reduction education and counseling, condoms, and lubricants, VMMC and harm reduction interventions.

#### **2.7.1 Implementation of PrEP interventions and services**

PEPFAR/B will partner with the Government of Botswana to create a conducive environment to integrate new biomedical interventions to the already existing ones as new scientific evidence emerges. Event-Driven PrEP will be initiated in COP 23. Through collaboration with GoB and Botswana Harvard AIDS Institute Partnership, a feasibility study will be conducted to determine CAB-LA product acceptability, among the potential targeted population. PEPFAR/B will participate in the National PrEP TWG to facilitate adoption of new commodities and improve access and equity by reviewing strategic documents such as the PrEP implementation Framework and the Social Behavioral Communication and Change Strategy.

PEPFAR/B will partner with the Ministry of Health, NAHPA, Civil Society and Private Sector to strengthen equitable PrEP access by expanding distribution points of oral PrEP to reach priority populations (KP, AGYW), pregnant and breast-feeding women, male partners of AGYW and GBV

survivors. Linkage between PrEP and PEP will be strengthened, and PEPFAR/B will advocate for provision of PEP to cover other potential exposures beyond the 2 entry points being post sexual exposure and occupational. PrEP delivery will be expanded to other service delivery points such as Drop-in Centers, DREAMS safe spaces, Antenatal Care/Postnatal Care, ART, Family Planning and HIV Testing service delivery points and community pharmacies. PEPFAR/B will leverage on the expansion of the HIV status neutral testing approach to increase demand for PrEP, those who test negative will be offered an opportunity to opt for PrEP using an informed choice and gain framed counseling. PEPFAR/B will engage with medical aid administrators to explore collaboration in PrEP delivery. In addition, PEPFAR/B will adopt new WHO HIV self-testing guidelines that emphasize use of HIV self-test kits for PrEP reviews.

Differentiated Service Delivery models will be strengthened which include multi month dispensing, community initiations and refills to enhance access and retention for those who are still at substantial risk of acquiring HIV & AIDS through delivery of client centered services. PEPFAR/B will strengthen demand creation, client navigation and PrEP dispensing through use of digital platforms such as Know Now, E Yarona, Youth Spot and Cookie Jar. Interpersonal communication for demand creation and retention will be strengthened through engagement of PrEP Ambassadors and task shifting for some cadres.

Also, PEPFAR/B will partner with the Government of Botswana to create a conducive environment to integrate new biomedical interventions to the already existing ones as new scientific evidence emerges. A study or technical assistance on evidence utilization will be done to determine CAB-LA acceptability, uptake, product availability, and effective use amongst the targeted population. PEPFAR/B will participate in the National PrEP TWG to advocate for policy advocacy for inclusion of new commodities in strategic documents such as PrEP implementation Framework and the Social Behavioral Communication and Change Strategy to improve access, equity, and product scalability.

To strengthen early identification of Intimate Partner Violence, all PrEP service providers will be trained on GBV First Line Response (LIVES) to be able to conduct Routine IPV inquiry or Clinical enquiry and provide relevant post GBV care services including referrals to other service providers.

### **2.7.2 Implementation of Voluntary Male Medical Circumcision interventions and services**

PEPFAR/B support to Voluntary Male Medical Circumcision (VMMC) services will continue in COP23, targeting eligible men aged 15 years and above in selected priority districts using a DSD and TA model. A technical assistance approach will be used to support the program at both the National and district level, by strengthening the coordination office and deployment of competent VMMC staff to conduct collaborative support supervision and mentorship, and quality assurance to MOH VMMC service providers. This will increase coverage through the opening of multiple static and outreach service provision points and additional SNUs with the aim of circumcising 10,702 men using a dorsal slit surgical technique. The PEPFAR/B VMMC program will continue to target mainly the civilian population but with services available to all including military populations. The program will leverage the efforts of reaching out to men in hard-to-reach areas and with poor health seeking behavior with a comprehensive package of health care including HIV services. Using the BAIS V survey results, in triangulation with existing program data, prioritization of geographic SNUs has been made targeting districts with high HIV burden and low circumcision rates to bring them close to saturation.

The overall COP23 target will be allocated to the high-burden districts with a significant gap in VMMC coverage including Gaborone (55%), Kgatleng (58%), Kweneng East (59%), Serowe (56%), South East (59%), Moshupa (42%), Bobirwa (42%), Palapye (47%), Southern (42%) and Mahalapye (69%) districts respectively.

COP23 priorities for VMMC Programming will include:

1. Strengthening Demand Creation for VMMC among the target population of males 15 years and above through:
  - Incorporating evidence-based best practices including Human Centered Design in communication and the use of expert clients as ambassadors.
  - Capacitating Interpersonal Communication (IPC) agents and health providers with appropriate communication skills to respond to community barriers and training media practitioners for accurate dissemination.
  - Using demand creation data to customize strategies for different populations in rural and urban.
  
2. VMMC service delivery will be strengthened through:
  - Supporting the national coordination office to decentralize capacity building and Continuous Quality Improvement through the establishment of Training of Trainers (TOTs)
  - Targeted outreaches for male predominant establishments to bring services closer and user-friendly.
  - Introducing the Public Private Partnership to extend services to those seeking private care
  - Ensuring quality assurance through the provision of VMMC minimum package of HIV testing, STI screening and treatment, circumcision and post-operative care, and active linkage to other sexual and reproductive services, care and treatment for those diagnosed HIV positive. Active identification and management of adverse events.
  - Strengthening utilization of the electronic medical record system.

## Pillar 2: Sustaining the Response

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

### **The Convening Entities in Botswana**

A multisectoral approach defines the current response and implies that all sectors and levels of government, civil society, the private sector, the media, and development partners have a shared responsibility in the fight against HIV/AIDS. The three most important stakeholders are the government (the public sector), civil society and the private sector. The districts through District Multisectoral AIDS Coordinating Committees, (DMSAC's) enable interaction between government, civil society organizations and the private sector in implementing HIV strategies/programs.

In 1999 President Mogae declared HIV/AIDS a national emergency, and in response to the National AIDS Council (NAC) was established. The NAC is the highest coordinating and decision-making body, mandated to advise the government of Botswana on HIV/AIDS matters; the Joint Oversight Committee serves as an advisory body to the NAC. At the same time NAC's secretariat, the National AIDS & Health Promotion Agency (NAHPA), was created. NAHPA's role is to be the national coordinator of the multi-sectoral response with a broad mandate that includes formulating and reviewing policy, facilitating implementation, mobilizing resources, and strengthening institutional capacity, as well as to coordinate, monitor and evaluate programs. The Ministry of Health (MOH) implements interventions for the health sector response: prevention, HIV testing services, care and treatment, PMTCT, TB/HIV, Key Populations, DREAMS, OVC, sexually transmitted infections, community intervention programs, etc. For local governments the multi-sectoral response has entailed a decentralization of the response. This has been achieved through the creation of - DMSAC's, that have the mandate to manage and coordinate the district-level response according to the unique needs in each district.

Civil society organizations (CSOs) have formed several networks. The umbrella organization for CSOs concerned with HIV/AIDS related issues is called the Botswana Network of AIDS Organizations (BONASO). BONASO's goal is to coordinate NGOs concerned with HIV/AIDS. Botswana Network of People Living with HIV and AIDS (BONEPWA+) and Botswana Network on Ethics, Laws, and AIDS (BONELA) are examples of the different NGO networks that deal with HIV/AIDS related issues and are representative of the stakeholders of civil society.

The private sector formed a coalition to coordinate HIV/AIDS interventions, the Botswana Business Coalition on AIDS (BBCA) which is a service organization with the aim of building the capacity within private entities to help them deal with the situation that they are faced with due to HIV/AIDS in the workforce. BBCA's vision is to ensure that every private sector company in Botswana develops a policy on HIV/AIDS that is then practically implemented.

The Joint Oversight Committee and Partnership Forum comprises all stakeholders (including Joint United Nations Program on HIV/AIDS, the World Health Organization, PEPFAR, Global Fund) and manages the national response by agreeing on priority areas described in the National Strategic Framework thereby minimizing duplication of efforts. Hence, they create more systematic, unified, and consolidated partner technical assistance that is sustainable and locally led for greater impact.

### **Assessing and addressing health systems gaps in alignment with national priorities**

In 2022, the World Health Organization supported an independent international team led by the Ministry of Health, to conduct a comprehensive review of the Botswana health sector. Over the last decade, the government of Botswana was guided by the National Health Policy launched in 2011. Since the policy was adopted, the health sector landscape has changed, with demographic and epidemiological changes, global and regional shifts from the MDG era to the SDGs, and now revitalization of Primary Health Care (PHC). Information for the comprehensive review was collected and collated through a rapid review process and findings were to be used to adopt policy, strategic and operational focus to the changes within which the health sector is operating. Key health systems gaps reported are summarized below:

#### **1. Health Workforce: Technical, Managerial & administrative**

- The achievement of desired outcomes is hampered by the absence of a complete and comprehensive data set on the health workforce.
- The wage bill for the country is large and a national cap has been put on increases in the remuneration and recruitment of new staff. The salary stagnation and lack of an attractive retention package continues to fuel the high staff attrition rate, especially amongst doctors. and nurses

#### **2. Health Products: Medicines, Vaccines, traditional products, medical products of human origin**

- Inadequate progress was noted in capacity to manage procurement and supply chain management, and the capacity for estimating and quantifying commodity requirements across all programs.
- The intermittent availability of drugs in the country has negatively impacted service delivery.
- The small population size leads to delays in orders from manufacturers and unnecessarily higher costs due to the impact of economies of scale, or lack thereof.

Low participation in pharmaceutical manufacturing by developing countries (mostly in Africa) also affects aspirations of sustainable procurement.

- Refer to Section 4.6 for planned PEPFAR support in COP23.

### 3. Delivery systems: Primary care, secondary care, tertiary care

- There has been a shift in focus from primary health care (PHC) to a more curative approach. This has meant that the emphasis on prevention is still lagging.
  - Limited focus on primary health care was due to the advent of the HIV epidemic. The current momentum on PHC globally provides an opportunity to refocus the efforts once again to PHC.
- PHC provides space for the delivery of services at all levels as articulated in the National Guidelines on Health services Integration and therefore argues for “a comprehensive delivery of integrated services within the context of the continuum of care approach, recognizing that providing preventive, promotive and curative interventions throughout the life cycle is the most effective way to reduce mortality and improve health outcomes. The guidelines also provide on the PHC approach to suit each context for the provision of person-centered integrated services. The model of integrated services will be informed by the nature of the facility, the population size, the services being provided and the model of integration to be applied. Botswana applies four different models of service integration depending on nature of the facility (National Guidelines on Health Services Integration, 2021, page 27):
  - The community model: Services delivered by community health care workers and volunteers.
  - Kiosk Model: Health Posts & small Clinics with Maternity and Clinics without Maternity.
  - Supermarket Model: Clinics with Maternity and Clinics without Maternity
  - Mall model: Primary, district and referral hospitals
- These models do not exist in isolation but rather form part of an overarching PHC system that connects different levels of care, from community to hospitals through referral pathways.
- In COP23, PEPFAR will support the Primary Health Care Revitalization agenda of the GOB to sustain the current gains of the response and reach the unreached (5-2-2) by:
  - Strengthening the governance of PHC revitalization at the national and sub-national levels
    - Primary healthcare investment case. Develop an investment case for the government’s PHC revitalization. The investment case will estimate resources needed to revitalize Botswana’s PHC and identify financial gaps and opportunities for resource mobilization. In addition, the investment case will demonstrate the anticipated Return on Investment by investing in community HIV & health programs. A communication and advocacy plan for the eventual approval of a PHC revitalization strategy will be developed and disseminated.
    - Development and operationalization of a Roadmap for primary healthcare revitalization. This is support to map out the roadmap that will be taken for PHC revitalization. The focus of the analysis will be to determine priority PHC interventions and providers to include in the PHC revitalization plan. These inputs will inform MOH

planning to create more politically feasible and effective strategies and purchasing arrangements.

- Institutionalize community-based platforms into PHC
- Development and operationalization of Community Health Strategy: There is need for a specific National Community Health Strategic Plan that articulates:
- Streamline community structures/processes & improve the capacity of GOB to implement community health services. Improve delivery of integrated community-based health interventions through provision of standardized minimum package vis-à-vis the National Guideline for Implementation of Integrated Community-Based Health Services.

#### **4. Financial management: Revenue raising, pooling, purchasing & management.**

- The provider-purchaser split is blurred, and this negatively impacts the institutionalization of effective strategic purchasing mechanisms. The Ministry of Health acts as the provider of health services, while at the same time responsible for the procurement of health commodities and equipment for the public health sector. This affects the linkage of resources to outputs and accountability of the different health care providers from whom the Government purchases services.
- The allocation of funds is skewed towards curative health services. The insufficient primary health care was compounded after ownership of clinics changed from the local governments to the MOH.
- There is no framework to guide health financing in the country as the health financing strategy is still in draft form and was developed in 2018 before the emergence of the current global, regional, and country health development agenda.
- Refer to Section 3 on “Efficiencies and plans to sustain efficiencies” for planned PEPFAR support in COP23.

#### **5. Health Information: Routine HMIS, surveillance, vital statistics, research**

- The data generation in the country remains manual and as such continues to be plagued by errors and inconsistencies in reporting in different districts and it is complicated by the manual system of reporting to DHIS 2. The shortage of M&E officers at both national and district levels further aggravates the situation of quality of the data as most of the officers are handling different programs, and hence have high workloads.
- The systems for data generation are not interoperable i.e., they cannot exchange the information hence some of the data have to be entered manually.
- The use of data for decision making remains suboptimal as most of the health care workers prefer not to use the electronic systems and resort to manual systems making consolidation and analysis of the data difficult.
- Refer to Section 7.3 for planned PEPFAR support in COP23.

The National Development Plan (NDP 11) is the first medium term plan towards the implementation of the country’s Vision 2036, running from April 2017-March 2023; as of April 1, 2023, NDP 11 has been extended for two years as the Transitional National Development Plan (TNDP 2023-2025) leading to NDP 12.

For sustainable health and health care strategies for all, the NDP 11 prioritizes the review and successful implementation of the Essential Health Service Package (EHSP) to ensure universal

health coverage, improve access to health services; reduction of referrals and unnecessary delays in reaching care; enhancement of equity; and promotion of utilization of health services by all. The NDP 11 makes specific emphasis on overhauling of supply chain management; implementing quality improvement framework and initiatives; enhancing integration of health services in priority areas such as HIV, TB, sexual reproductive health and rights, mental health, maternal and child health and rehabilitation; maximizing efficiency gains in the health sector; strengthening the stewardship role of GOB in the health system and effectively regulating both public and private health providers; as well as monitoring and evaluation of health sector initiatives.

The third National Strategic Framework on HIV and AIDS (NSF III) is a five-year plan, 2018/19-2022/23 (Now extended to 2027/2028) that details principles, priorities, and actions to guide a collective multi-sectoral national response to the HIV epidemic.

NSF III focuses on five (5) key performance areas with clear performance objectives, namely, Targeted HIV primary prevention, HIV Treatment Care and Support, Stigma and Discrimination, Systems Strengthening and Strategic Information Management. The major shifts in the response to HIV adopted by NSF III include embracing the Treat All strategy aimed at initiating all people living with HIV on treatment regardless of their CD4 cell count, changing the way HIV Testing Services, linkage to care, treatment and support interventions are delivered for sustainability, revitalization of primary health care with a focus on the community-based delivery of integrated quality care and targeting specific population groups and geographic locations for the HIV response.

PEPFAR/B is aligning the 5X3 strategy with the NSF III towards building a capable, resilient, enduring, and inclusive national health system to achieve equitable and measurable sustainability. This includes evolving HIV services from an emergency response and vertical program to a comprehensive and integrated one aligned with supporting institutionalized chronic care service delivery models to realize efficiencies, reduce management and implementation costs for, and to maintain high-quality client care. Delivering HIV services integrated with NCDs through routine PHC will strengthen the national health system to be able to deliver the range of services that the country needs according to their own priorities and policy direction. Hence, systems investments for COP23 are designed to address most of the gaps/bottlenecks identified in the Botswana comprehensive health sector review that would have hindered progress towards HIV epidemic control and barriers for sustaining previous gains.

### **Efficiencies and plans to sustain efficiencies**

The 2021 Sustainability Index and Dashboard showed that Botswana's HIV/AIDS program is not operating at an optimal level of allocative and technical efficiency with a score of 5.40 (Yellow) even though it was an improvement over that of 2019 which was 3.83 (Yellow). Botswana's health system therefore requires enhancement of allocative efficiency to ensure that resources effectively target health interventions that can create the greatest health value for money, while technical efficiency actions are needed to ensure the HIV interventions are using resources effectively to maximize programmatic impact. Efficiency enhancement would also strengthen MOH's position in mobilizing resources and policy support from the Ministry of Finance & Development and other partners. Improving technical efficiency is one of the strategies to increase domestic financing of the program: rather than raising more funds, the programs will be implemented in a more efficient manner so that existing resources stretch further.



The inefficiencies identified are increasing the costs of the HIV/AIDS program at a time when it should be exercising greater discipline to control costs and make its case to the government that it deserves more resources because it is able to use what it has efficiently. Whereas some of the inefficiencies can be addressed immediately, others will require greater effort and time as well as collaboration across sectors to make them happen. Some require a review of policies that govern what and how services are delivered, and to whom. Some inefficiencies identified are: (i) the allocation of funding with little spent on primary health care, as a result, referral hospitals are overwhelmed with demand and district hospitals are underutilized; (ii) centralized management, with little flexibility in budgeting and budget execution, prevents facilities from finding ways to spend more efficiently; and (iii) supply chain management processes which results in frequent stock-outs

From the reviewed studies in this landscape analysis, it is evident that inefficiency remains one of the key health financing systems challenges that need to be addressed in Botswana's health system. Botswana could feasibly increase their domestic spending on HIV/AIDS and close the funding gap by curbing health care costs, implementing long-term planning, cutting budget rigidity, increasing fiscal space for health, and improving efficiency in health spending.

The areas of improvement can be grouped into the following categories:

1. Procurement and use of HIV/AIDS supplies: Buying drugs and other essential commodities through pooled mechanisms will result in bulk purchasing that will help to drive down prices, resulting in cost savings.
2. Sustainable Financing: Botswana has one of the highest per capita health expenditures in Africa. This is not reflected in Botswana's performance in health indicators. Hence, HIV/AIDS sustainable financing remains an important area of focus for Botswana's health systems financing, primarily because a significant share of health spending in Botswana is attributed to HIV/AIDS. To achieve its goals of reaching HIV/AIDS epidemic control and attaining UHC, the GOB must explore instruments to expand the health revenue base, increase efficiency gains, and improve the overall sustainability of the sector, such as:
  - Increasing domestic public spending through budget advocacy and public financial management (PFM).
    - Budget advocacy will entail empowering civil society, the media, and parliamentarians with the skills to advocate more effectively and collaboratively on public health expenditures for priority health services as a crucial component of strengthening country capacity for effective multi-stakeholder engagement and accountability, and progress toward UHC.
      - Delivering a budget training to civil society actors would empower them to become joint players in improved accountability and efficiency in the use of public funds. This is a particularly exciting opportunity given that civil society is often ignored when it comes to the national budget development and execution due to limited budget knowledge and limited access to budget information.
3. Strengthening PFM will help increase domestic resources for health and HIV/AIDS, improve utilization & management resources and address inefficiencies (technical & allocative) to optimize resource utilization.
  - Increasing the literacy of health program managers and budget holders around PFM is a backbone for efficient financial flows.

- Capacity-building on financial management, budget development, execution, and negotiations, as well as effective monitoring.
    - Strengthening dialogue between MOH and MFED will improve alignment between the PFM system and health financing system.
- 4. Improve quality and harmonization of health financing data by supporting sustained and sufficient domestic capacity building for long-term production and use of NHAs & NASAs.
  - Well-coordinated, harmonized, and integrated data systems constitute the foundation for ensuring that decision makers have the right information to shape health financing policy and promote evidenced-based planning. Harmonization of resource tracking data collection provides efficiency gains through a single data collection effort that fulfills the data needs for both System of Health Accounts (SHA) and National AIDS Spending Assessment (NASA)
- 5. Implement Activity Based Costing and Management (ABC/M) to generate data to understand the cost of HIV services.
  - ABC/M can improve the efficiency, and quality of HIV service delivery and broader health services
  - Information from ABC/M will enable constructive dialogue with Ministry of Finance and facilitate optimization of resources going to the health sector while ensuring quality of health outcomes
- 6. Strengthen social contracting to sustain financing of local partners and build strong local systems & country owned response.
- 7. Provide technical & financial support to finalize health financing strategy for overall health financing reform.
- 8. GOB Integration of services: Duplication between the MOH and NAHPA in service provision has also been cited, where both have similar programs such as behavior change communication serving the same patients. In addition, deployment of Health care workers- CW at health posts and clinics does not seem to consider the skills mix needed at these facilities, undermining the integration policy.
- 9. Contract management at Central Medical Stores (CMS): Strengthening contract management practices at CMS and digitalization of the system will improve performance of CMS to ensure uninterrupted availability of medicines and other essential commodities.
- 10. HIV & Health Resource Tracking: Botswana's NSF III mandates the institutionalization of resource tracking and efficiency analyses to advance Botswana's ownership of the national HIV response. Botswana's budget and economy will be under enormous strain for the next few years due to the effect of 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.

At a programmatic level, one of the key strategies for leveraging program efficiencies that PEPFAR/B will build on is scaling up of the Botswana National Mentorship program. Since 2002, the Botswana MOH-HIV division has led a successful National ART program, putting over 300,000 people living with HIV on antiretroviral therapy. Central to this success, was the capacity building of health care workers (HCW) through developing training to equip the HCW to take care of patients with HIV at a central level. While initial trainings took HCW out of the facility, using the mentorship program will allow the decentralized training to be implemented at facility level through

the strategic placement of mentors at district level to facilitate opportunities for maximizing resources.

In COP23, the mentorship will be expanded to other program areas including Laboratory and Strategic Information, building on the established clinical mentorship approach implemented in COP22. The approach will be augmented through the presence of clinical mentors at district level with a core mandate to provide support to the implementation, documentation, and continuous quality improvement of interventions for a sustained epidemic control. The program also aims to continue its support of the MOH and District Health Management Teams (DHMTs) with technical assistance and health systems strengthening as PEPFAR-supported HIV and AIDS activities continue their transition to the GOB.

Other PEPFAR/B COP23 strategies consistent with sustaining the response through highlighting efficiencies will include:

- Optimizing use of healthcare cadres based on resource needs of clients.
- Identifying and sharing best practices for strengthening continuity of treatment
- Identifying best practices of supporting TA-only sites in preparation for transition from PEPFAR to GOB

### **Approach for country-led sustainability planning and implementation**

NAHPA in response to the Global Fund, NAHPA planned to conduct a Transition Readiness Assessment and develop a Transition Plan/Roadmap which was initially planned to be completed by December 31, 2022. PEPFAR/B decided to leverage the process, so it became the Sustainability and Transition Readiness Assessment (STRA) and the Sustainability and Transition Plan/Roadmap (STP/R). Hence, it will be a single Sustainability and Transition Readiness Assessment & Sustainability and Transition Plan/Roadmap for the country that the GOB and all donors/partners will develop and work with. To support the process, a STRA & STP/R National Reference Group formed in August 2022 which includes -NAHPA, MOH, WHO, UNAIDS, CSO, CCM/GF and PEPFAR.

The Terms of Reference for the Sustainability and Transition Readiness Assessment and Sustainability and Transition Plan/Roadmap development have been finalized and two local consultants were engaged by UNAIDS to do some groundwork in preparation for the Sustainability and Transition Readiness Assessment. The consultants submitted a report titled Assessing the Efficiency of the National Response to HIV and AIDS that will feed the STRA to be done.

A task team, which was constituted from the National Reference Group, evaluated applications, and identified consultants who will conduct the Sustainability and Transition Readiness Assessment, and further develop the Sustainability and Transition Plan/Roadmap. The consultants identified include one global agency and two local consultants to work with them for skills transfer and local capacity building [one from Academia and/or a research institution and the other was selected from the open market]. This work began in March 2023.

The overall purpose of the STRA & STP/R is to undertake an assessment of Botswana's readiness to fully transition its national AIDS response from external international donor funding to domestic funding, as well as develop a comprehensive multi-year plan for doing so while ensuring the sustainability of the fight against HIV/AIDS towards elimination by 2030.

The STRA & STP/R to be completed by July 2023 will be done in phases as below:

1. Phase I: Inception.

- During the first phase of the assignment, the Pharos team will work closely with the National AIDS and Health Promotion Council (NAHPC), its secretariat National AIDS and Health Promotion Agency (NAHPA), the Joint Oversight Committee (JOC) as the Reference Group (RG) and its related TWGs (composed of NSF III thematic TWGs representation), District Multisectoral AIDS Committees (DMSACs) and the related Village Multisectoral AIDS Committees (VMSACs), Ministry of Health (MOH) and the related Regional/District Health Management Teams (R/DHMTs), Ministry of Finance (MoF), UNAIDS, the Global Fund Country Coordinating Mechanism (CCM) and country team, PEPFAR, civil society organizations, community and other stakeholders to define and refine the areas of focus for the sustainability and transition assessment. The guidance document [“Guidance for Sustainability and Transition Assessments and Planning for National HIV and TB Responses”](#) developed by Pharos Global Health Advisors on behalf of the Global Fund will provide the framework for organizing the scope, topics, and process for the entire exercise.

2. Phase 2: Conduct Sustainability and Transition Readiness Assessment (STRA)

- Once the Inception Report is drafted and circulated for comment and feedback, the team will undertake extensive literature review necessary to facilitate accomplishment of the objectives. This will include, among others, structure mandates, organizational development including the necessary skill sets, governance/coordination and implementation arrangements, resourcing, work undertaken on HIV and health financing, strategic investments, transition planning, etc. This phase will benefit from recently completed activities, including: The Fifth Botswana AIDS Impact Survey (BAIS V), the harmonized SHA/NASA data collection tools, the Botswana OPTIMA HIV modeling (Allocative Efficiency), and the costed HIV and AIDS Basic Services Package (HABSP) among others. The Pharos team will also extract relevant data from a range of documents furnished by the Global Fund, UNAIDS, PEPFAR, and others. The Pharos team will identify and assess key sustainability and transition risks, including external financing and domestic fiscal space, health systems challenges (human resources, information systems, procurement and supply chain), governance and institutional structures, human rights, and partnerships between government and civil society. To conduct the risk assessment, the Pharos team will firstly conduct a stakeholder mapping exercise, followed by a meeting with key stakeholders. Data will be collected through virtual as well as face-to-face interviews and workshops as applicable to obtain information, undertake the diagnostic analysis, and identify priorities. Key informants will be identified in consultation with the NAHPA, JOC, RG, CSOs, MOH, MOF, UNAIDS, TGF-CCM and country team, USG/PEPFAR, and others. These stakeholders will include national government officials, local authorities, TGF Principal Recipients, Civil Society representatives, service providers, and development partners including CCM representatives among others.

3. Phase 3: Sustainability and Transition Roadmap/Plan (STR/P) Development.

- Using the STRA report findings and recommendations from Phase 2, an HIV Sustainability and Transition Roadmap/Plan (STR/P) will be developed. The STR/P will use the key identified challenges from the STRA as a starting point for

recommended specific actions which can be costed and assigned to specific implementing organizations in Botswana. The STR/P will make suggestions for an M&E framework and process for oversight of workplan implementation against specific deliverables and milestones. Related change management (structures, processes, etc.) will also emerge from this phase. Further, the STR/P should feed into the Fourth National Strategic Framework (NSF IV) for the period 2023/24 - 2027/28 and be used to foster high level policy dialogue. A short policy briefing note or deck for in-country decision makers such as the health minister, budget director in the finance ministry, and heads of UN agencies and other partners may be developed to elevate the main findings and recommendations of the STR/P.

The key deliverables of the STRA and STR/P expected to be disseminated are: An inception report and STRA report.

The COP23 PEPFAR guidance states that sustaining the HIV response over a long term will require on the one hand the development of a measurable sustainability roadmap as well as engaging in international integrated planning to ensure strategic allocation of resources at a policy level and on the other hand at a programmatic level accelerating integration of HIV services delivery into local health systems including sharing some costs. Therefore, at a program level PEPFAR/B will optimize the implementation of integrating NCDs into HIV services and HIV services into other primary health care platforms such as the mobile stops.

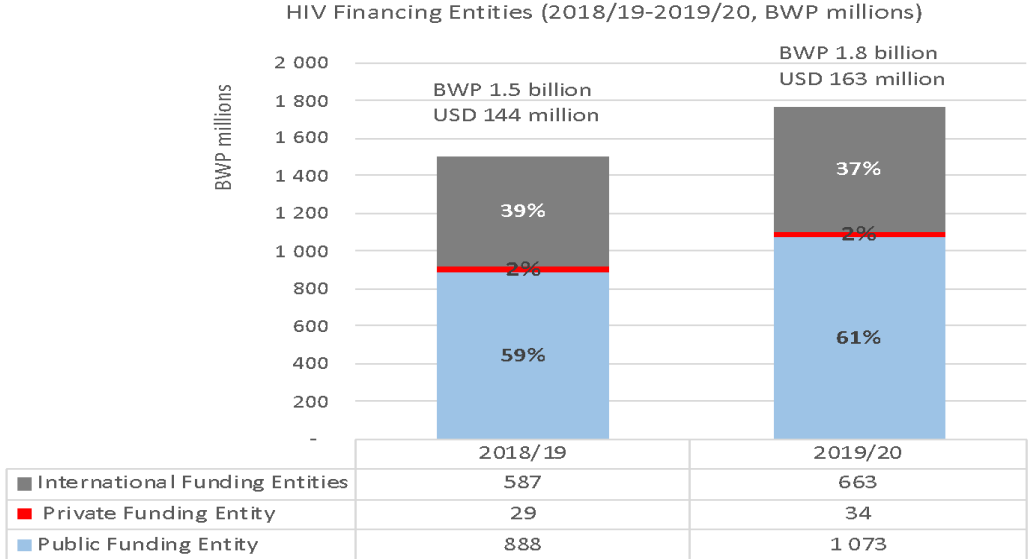
As PEPFAR looks towards long-term sustainability of programs, maintenance of durable viral suppression using person-centered services is a critical priority. A substantial proportion of PLHIV on optimized ART will likely need little support to remain engaged in care; however, a sizable group may cycle in and out of care and require more intensive case management and management of advanced disease. For long-term, sustainable planning, it is important to assess the proportion of PLHIV who have low and high resource needs and target the delivery of services accordingly. Furthermore, impactful, and cost-effective care and treatment packages are needed to sustain epidemic control.

#### **How HIV Response is funded in Botswana**

The GOB contributes more than 60 percent of the identified costs of HIV/AIDS programs which is nearly half of its health budget, or about 2.55% of Gross Domestic Product (GDP). Projections show that the HIV/AIDS response will remain an important driver of domestic health spending over the next decades. 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/B and GF. An estimated \$964 million was spent on HIV/AIDS over the six-year period from 2012 to 2018; GOB contributed 64%, PEPFAR/B 31%, private sources 3% and GF 2%.

The preliminary findings of the National AIDS Spending Assessment (NASA) 2018/19 to 2019/20, showed that spending on the HIV national response in Botswana Pula (BWP) fluctuated slightly between 2012/13 and 2018/19, increasing from BWP 1.395 billion in 2012/13 to BWP 1.505 billion in the financial year 2018/19, before increasing to BWP 1.1770 billion in 2019/20; an increase of 18% from 2018/19 (Figure 3 below). The response is mostly financed from the public resources (59% in 2018/19 and 61% in 2019/20), with external financing contributing 39% and 37% in

2018/19 and 2019/20 respectively. There is limited private sector spending (less than 2%), by private medical aid schemes for the provision of ARVs to about 20k members of the schemes.



**Figure 3: HIV Financing Entities in Botswana**

In a 2016 publication titled “Health Financing in Botswana: A Landscape Analysis”, supported with funding from PEPFAR/B, the resource requirements for HIV/AIDS programs were estimated using the HIV/AIDS Investment Case for the years 2015 to 2023 (Avalos and Jefferis 2015). The estimations included public, private and donor financing for HIV/AIDS programs. Finding resource gaps eases 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.

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-digit 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. The COVID-19 pandemic has impacted the funding of health care and will continue to do so over the near future. Notably it has reduced the fiscal spending for health due to a drop in the country’s revenue especially from diamonds 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.

## **How Gaps or Misalignments Identified in Appendix E of COP22 have been addressed**

### ***HMIS***

Data Availability, Quality, and Utilization are still the technical directives that PEPFAR/B will support in COP23 across several program areas. 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 will have activities implemented to strengthen.

### ***Laboratory Systems***

In COP23, the laboratory systems strengthening support will be across the three 95's and geared at assisting the government to 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. 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. 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. Also, PEPFAR/B will continue to work with GOB on Quality of laboratory testing through support for QMS and accreditation maintenance. Laboratories 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. As Botswana works towards epidemic control and sustaining investments, PEPFAR/B will work to strengthen the Laboratory 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.

### ***Supply Chain***

Over the years PEPFAR/B has invested in providing technical assistance and investments toward building a resilient and sustainable national supply chain for health commodities and medical equipment. Key among them are activities supporting ART optimization to scale up the implementation of multi-month ART dispensing, supporting the expansion of an e-LMIS from district warehouses to the last mile facilities, and the development and use of an e-procurement platform to improve contract management at CMS. In COP23, PEPFAR/B will continue to support and provide Technical Assistance to the national health supply chain to help build a sustainable and robust system. COP23 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. Also, in COP23 PEPFAR/B will support the procurement of stop-gap commodities for the national response to prevent the disruption of services, while the government of Botswana continues to procure almost all of the required commodities.

## **Policy**

The contribution of governance to improved effectiveness and efficiency of health and HIV service delivery is hampered by lack of knowledge of policy frameworks and failure to implement them. Following the dissemination of the findings of the 2022 Botswana Comprehensive Health Sector Review (2010-2022), MOH is leading the review of the 2011 Health Policy and other health sector policy instruments with a vision of creating an enabling environment in which all people living in Botswana can achieve and maintain the highest levels of health and well-being.

1. National Health Policy 2023-36
2. First National Health Strategic Plan 2023-7
3. New Essential Health Service Package
4. Human Resources for Health operational strategy
5. Health sector decentralization toolkit
6. Health sector financing strategy
7. Assessment of the Functionality of the District Health system
8. A comprehensive district health system approach
9. Re-commitment to PHC and community health services - a more efficient and cost-effective way of delivering the services.
10. The National Supply Chain Strategy

The ongoing health reforms will impact the national HIV response. In COP23, PEPFAR/B will provide support as needed to key aspects of the reforms to facilitate the sustained HIV epidemic response and the achievement of Universal Health Coverage and Health Security against emerging and new health threats. PEPFAR/B will provide technical assistance to GOB on the National Health Policy, National Health Strategic Plan, and Essential Health Service Package, HRH operational strategy, Health Sector Financing Strategy and PHC Revitalization.

### **How PEPFAR/B is engaging in Integrated National Planning**

Coordination and harmonization of development partners' and different stakeholders support to ensure maximum impact of the multi-sectoral response remains a challenge. There is a need to continue to strengthen coordination, joint planning, and performance management within the national response for effective utilization of resources. The National Operational Plan (NOP) provides a platform for achieving joint planning and the structures that have been set up for NOP development and implementation oversight need to be strengthened and supported and their effectiveness reviewed regularly.

The Joint Oversight Committee includes all stakeholders who participate in the HIV national response. The committee agreed on priority areas described in the National Strategic Framework III (NSF III). This JOC oversees the development, implementation, and review of the NOP. A National Monitoring and Evaluation Plan has also been developed for effective monitoring of the NSF III.

Lack of clarity in roles and responsibilities among stakeholders which often leads to duplication of efforts have been a major challenge. However, that has improved with more joint planning activities. There is less duplication and more efficiency in the use of resources. Activities are



prioritized and funding is based on programs that show results, therefore improving resource management.

In addition, the MOH 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; and as well as between government, multilaterals/donor agencies, and local CSOs.

### **How PEPFAR/B is building the capacity of local and regional institutions through Government to Government (G2G) and other mechanisms**

PEPFAR/B will leverage the conducive environment, capable government and CSO mechanisms to scale up HIV services and strengthen local systems. PEPFAR/B will make investments directly into CSOs to deliver services and strengthen their capacity in areas such as leadership and governance, resource mobilization, technical capacity to deliver integrated community-based services, financial management, advocacy, Human Resource, and legal compliance.

To enhance domestic funding, PEPFAR/B will support GOB technically with social contracting. Social contracting is a process whereby governments bring CSOs into the service delivery mix, by providing them with funding and responsibility for the delivery of some of the services that are traditionally delivered by government. In 2017 and 2018, the Government of Botswana published Policy Guidelines for Financial Support to Non-Governmental Organizations (Policy Guidelines), to strengthen administrative procedures and to enhance efficiency and effectiveness of Government's support to NGOs.

In line with the third National Strategic Framework (NSF III) and the UNAIDS goal to end the epidemic by 2030; PEPFAR/B supported NAHPA and the MOH to develop a Social Contracting Fund Strategy. The Strategy is intended to guide engagement with CSOs to deliver certain services on behalf of the health sector. More specifically, the strategy is geared towards facilitating the attainment of all the goals and targets set under NSF III to End AIDS by 2030 as they lay out the parameters under which funding will be disbursed to the CSOs to deliver quality goods and services to clients on behalf of the government. Also, PEPFAR/B is supporting CSOs to develop and implement business models to generate funds for self-financing that will complement and support improvements to public health care under the model social enterprise.

In COP23, potential for expanding G2G agreements with other ministries will be explored as the program works towards increasing direct funding to local organizations which includes the GOB.

Botswana's plans for sustainability for an HIV response are articulated in the Third National strategy on HIV and AIDS and present strategies of how the response will be realized. These include among others; the submission that focus will be put on increasing financing of the HIV response through Government funding, levies, insurance schemes and improving allocating and implementation efficiency of HIV programs. Resources will be optimized through integration of services to ensure sustainability of the response. The integration of HIV prevention, care and support services into routine health services has been prioritized. This includes reinvigorating the primary health care approach to service delivery, redefining multisectoral approach for delivery of HIV services and integration of HIV into universal health care coverage (NSF III-page 76).

## Pillar 3: Public Health Systems and Security

In line with the PEPFAR 5x3 reimagined strategy, PEPFAR/B undertook a series of consultative meetings with the host government (different ministries) and stakeholders (WHO, Global fund, UNAIDS, CSO's), as well as representatives of different priority populations to come to a decision on the gaps that exist in-country and the areas to be prioritized for support under the pillar 3 of Health systems and security. Throughout this consultative process, host government priorities and recommendations were given due consideration and ranked for support.

With the Achievement of UNAIDS target of 95:95:95, PEPFAR/B health systems strengthening, and above site investments are geared at addressing the remaining 5-2-2 gaps, prioritizing the underserved populations as well as sustaining the gains that the country has so far made.

These PEPFAR health systems strengthening 2023 investments will also encourage inclusiveness and population centeredness by promoting interaction between the government, CSOs, communities, households, the private sector, and other stakeholders. In addition, the investments will promote equity to reach the poor, underserved, marginalized and vulnerable to ensure that everyone, everywhere have equal access to quality person-centered HIV/AIDS services.

Though there were more barriers identified through stakeholder discussions, PEPFAR/B together with GOB prioritized the following systems strengthening areas for COP23 implementation.

1. Strengthening of the National Public Health Institute
2. Quality Management and Continuous quality Improvement
3. Person-centered approaches, HIV comorbidities & mental health
4. TB/HIV services
5. Laboratory systems (VL, EID, DNO, etc.)
6. Human resources for health HRH
7. Supply chain modernization and adequate forecasting

### **4.1 Strengthen Regional and National Public Health Institutions investments**

PEPFAR support for the Botswana Public Health Institute (BPHI) will be aimed at building systems towards the global goal of ending HIV/AIDS as a public health threat by 2030 and sustainability through strengthening public health systems. PEPFAR/B support for the BPHI will ensure capacity for the BPHI to:

1. Integrate PEPFAR supported HIV systems with BPHI-led public health systems.
2. Strengthen laboratory systems to achieve HIV service delivery targets.
3. Strengthen Surveillance system to achieve desired HIV outcomes.
4. Lead the provision of health information and vital statistics that can be used to accelerate ending HIV/AIDS as a public health threat by 2030.
5. Lead surveys such as the Botswana HIV impact assessment survey (BAIS) a population-based HIV impact assessment (PHIA) to assist the BPHI to facilitate HIV control.
6. Develop and operationalize an emergency operation center support for outbreak management to minimize impact on HIV systems.
7. Build public health workforce.

PEPFAR/B will work with GOB to leverage on PEPFAR platforms to support the operationalization of the BPHI. The support will include both financial as well as technical assistance towards capacity building for the BPHI pillars of laboratory, surveillance, workforce development, outbreak management and workforce development as prioritized by the MOH. There will also be support towards positions to kick start the BPHI functions. The prioritized areas of support as highlighted by the Government of Botswana were agreed to during a COP23 multistakeholder consultative meeting.

Botswana's move to speed up the establishment of the BPHI will also address some of the several technical areas that the country did not perform well as indicated by the current joint external evaluation of IHR core capacities (2017). These low performing indicators include IHR coordination, emergency preparedness and response, multisectoral collaboration, managing chemical events, and local health commodities production capacity. PEPFAR/B will continue to work with other stakeholders such as WHO and Africa CDC to provide the technical assistance (TA) required to resolve the challenges identified through the JEE. PEPFAR/B will continue to work with WHO and GOB in development of the plans such as the Botswana national action plan for global health security (NAPHS) in the development of the public health emergency operation center that the country has highlighted as needing urgently, and as a core member of the strengthening and using emergency response groups (SURGE) team.

As in other countries, the Botswana achievements made through PEPFAR were affected by the COVID-19 pandemic. Examples of these included a reduction in viral load coverage as molecular technology and staffing were re-purposed and prioritized for COVID-19 testing. The health system in general was also weakened. This realization necessitated Botswana to accelerate the operationalization of its public health institute to manage and coordinate emerging public health threats responses which could impact their health as well as the HIV response. The government's push towards BPHI formation through the presidential directive of September 2020, and a complementary start off budget, showed the government buy-in and political will to see the establishment of the BPHI realized. PEPFAR/B will continue in COP23 in the work to assist the BPHI start off as a department within the Ministry of Health with a GOB vision to become a state-owned enterprise through a multistakeholder approach.

Leveraging of PEPFAR resources towards health security will go a long way in ensuring that PEPFAR gains are preserved and there is sustainability.

#### **4.2 Quality Management Approach and Plan**

PEPFAR/B will work with the MOH through a Quality Management Approach and Plan to incorporate elements that include:

1. Quality planning. PEPFAR/B's support will ensure that the OU has policies (development of the strategic plan), workplans tools and guidelines (review the QI Framework) in place to support quality assurance and quality improvement activities,
2. Quality Assurance tools, i.e., site improvement through monitoring systems (SIMS) and National standards (accreditation) tools in alignment with HIV/AIDS programs and patients' safety to support sustainability of the program and its adaptation to the national context,

3. Quality improvement interventions tailored to the national context and aiming to create a culture of quality.

Continuous Quality Improvement will be the cornerstone to ensure delivery of quality health programs. PEPFAR/B will support the MOH HIV/AIDS division and its 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, scaling up what works and sharing best practices. Continuous quality improvement activities will be prioritized across different health system levels (community, facility, district and national) to eliminate challenges and gaps that make health services effective, client centered and safe.

Given that Botswana is near epidemic control and COP23 guidance to pivot from scaling up to closing gaps, PEPFAR/B will implement an integrated Continuous quality Improvement (CQI) program and support sites to mitigate challenges across the continuum of care. Sites with poorer linkages, higher interruptions in treatment (IIT) rates, lower viral load coverage or high viral loads will be prioritized for enhanced mentorship support and tailor-made CQI interventions.

The CQI teams will also be trained and supported to assess sites for client-centeredness as well as whether they are men- and youth-friendly and used to identify any performance issues that need some course corrections. 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, processes, and corrective measures. Further cross training of HCW will take place through the use of learning collaboratives. 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.

PEPFAR/B will continue implementing SIMS until a national quality management and assurance tool for HIV service provision is developed and operationalized. Data quality assurance and management activities will be conducted to ensure that data utilized is accurate and implementation standards are adhered to.

PEPFAR/B will continue to work with the government in their quest to accredit high volume clinical sites through the regional accreditation entity Council of health accreditation of Southern Africa (COHSASA). PEPFAR/B will continue in COP23 to support quality of diagnosis and accreditation by supporting.

1. Quality trainings such as: Strengthening Laboratory Management Towards Accreditation (SLMTA), Stepwise Laboratory Quality Improvement Process Toward Accreditation (SLIPTA), Quality control (QC) and Method Validation and International standard organization (ISO) 15189:2022 Standard. The OU will work with the University of Botswana for adaptation of these trainings for sustainability.
2. Transition of accredited laboratories from the 2012 standard to the new standard.

3. Accreditation of the remaining viral load laboratories. So far there are two laboratories ready to apply to accreditation and this will bring the total number of accredited laboratories to 11.
4. Revitalization of the laboratory mentorship program through hiring a National Laboratory Mentorship Coordinator who will coordinate all the mentorship activities using the available Laboratory Master Trainers for the different programs (VL/EID, CD4, TB, HTS, Microbiology).
5. Proficiency testing
6. Certification of Rapid HIV testing sites through Stepwise Process for Improving Quality of HIV Rapid HIV Testing (SPI-RT) in partnership with the University of Botswana

Continuous monitoring of sites for quality will be done through processes such as data audits, community led monitoring, utilization of Site improvement through monitoring systems (SIMS) and other specific tools such as VL/ EID score card, SPI-RT, SLIPTA. Remediation of challenges identified will also be followed up.

PEPFAR/B will continue to work at ensuring that the national quality documents such as the recently developed patients and provider charters are utilized and the quality strategy is implemented. CQI national structures will be strengthened through support for CQI positions at national and district level.

PEPFAR/B will continue implementing SIMS until a national quality management and assurance tool is developed and operationalized. Data quality assurance and management activities will be conducted to ensure that implementation standards are met. Continuous quality improvement activities will be prioritized across different health system levels (community, facility, district and national) to eliminate challenges and gaps that make health services effective, client centered and safe.

#### **4.3 Person-centered care that addresses comorbidities posing a public health threat for People with HIV (Advanced Disease, TB, Hypertension) plus mental health services**

Reducing mortality is a critical component of sustaining the HIV response through maintaining treatment continuity and viral load suppression especially among children under 5 years and adults over 50 years. PEPFAR highlights the implementation of person-centered-services as key to reducing mortality and improving the quality of life of the above identified priority groups. Therefore, in COP23, PEPFAR/B will optimize person-centered services in both facility and community platforms through the continued support for delivery of age-appropriate DSD services.

#### ***Integration of HIV services into Primary Health Care service delivery system***

The COP23 guidance on person-centered care aligns with the Botswana MOH priority for primary health care as well as the NAHPA strategy for non-communicable diseases in that both emphasize the need to integrate HIV services into other program areas to implement person-centered approaches. Person-centered care facilitates treating multiple conditions at once to reduce multiple visits and facility waiting times. PEPFAR/B additionally identified common elements which will sustain the HIV response which include strategies to reduce new infections and as well as investments by the national governments to sustain the essential HIV services using domestic resources. Others include HIV services integrated into broader public care delivery systems, a public health system with the capacity to monitor and track HIV.

In COP23 the OU will work closely with GOB and other stakeholders in providing comprehensive person-centered healthcare services through supporting the implementation of MOH's Primary Health Care Revitalization plan as guided by the National Guidelines on Health Services Integration (MOH & UNFPA, 2021) and National Guideline for Implementation of Integrated Community-Based Health Services, (ICBHS) MOH, 2020. In line with the four (4) MOH approaches for integration of health services at primary care level (mall, supermarket, kiosk and community), PEPFAR/B will strengthen integration of HIV services at both non-HIV and HIV services points integrating services at hospital, clinic, health post and clinic-mobile stop levels.

1. Depending on the integrated health services package and integration model, the OU will support the integration of HIV services such as HIV testing and linkage to ART, screening for TB and TPT enrolment, HIV prevention services like PrEP, PMTCT as well as other HIV related support services like cervical cancer screening, NCDs/HIV comorbidity management, ART dispensing/refills and sample collection.
2. Working with MOH, PEPFAR/B will support integration of HIV services into non-HIV platforms in hospital and clinic level providing implementing the provision of PrEP at Child Welfare Clinic (CWC), Ante-Natal Clinics (ANC), General Out-Patient Department (OPD) and Youth Friendly Service centers (YFS).
3. The OU will support provision of quality integrated HIV services through implementing CQI activities and site level clinical competence coaching through the mentorship program.
4. At clinic, health post and clinic-mobile stop level the OU will work closely with MOH to strengthen outreach services and expand the array of integrated HIV services to include HIV testing, screening for TB, linkage to ART, HIV prevention services – PrEP, PMTCT and other HIV related support services such as ART dispensing and sample collection for clinics.

#### ***Integrating of Priority populations into HIV service platforms for equity***

Further the OU will also continue to support integration of priority populations such as key populations (KP), men and aging PLHIV into public health facilities providing them with person-centered sexual reproductive health services, HIV prevention and care services in line with their health needs. The OU will also implement integration of aging PLHIV-centered services into IDCCs through activities focused on screening and management of age-associated comorbidities such as NCDs and other psychiatric conditions, providing support for age-appropriate supportive adherence counseling activities on pill fatigue, polypharmacy, and the procurement and use of pill boxes.

#### ***Strengthening diagnosis, treatment, and control of HIV-NCD comorbidity***

Furthermore, in COP23 PEPFAR/B will support MOH efforts of integrating non-communicable diseases management into HIV care through improving integration of awareness and prevention activities, diagnosis, treatment, and control of common non-communicable diseases (NCDs) - hypertension, diabetes mellitus, dyslipidemias, and psychiatric condition into HIV care at ART clinics. The OU will support the implementation of the following activities:

- Standardizing management of HIV-NCD comorbidity through development of an HIV-NCD integration standard operating procedure including protocols, training plans, and monitoring plans.

- Provide technical assistance to MOH IDCCs in the procurement of NCDs screening and monitoring equipment such as BMI scales, glucometers, sphygmomanometer, ophthalmoscope.
- Standardizing HIV-NCD comorbidity care EMR platforms for capturing of relevant indicators across the NCDs clinical cascade.
- Through Mentorship strengthen clinicians' competence in management of the HIV-NCDs comorbidity, strengthening site level EMR use for data capturing and reporting on NCDs care in PLHIV.
- Continue supporting capacity building for NPD trainings through the AHD trainings covering HIV-NCD comorbidity clinical management.

### **Implementation of Cervical Cancer Prevention services**

In COP23, PEPFAR/B will continue to support the provision of cervical cancer screening using visual Inspection with acetic acid (VIA) and Human Papilloma Virus (HPV) DNA methods, and pre-cancerous lesions treatment by cryotherapy, thermal ablation, Loop Electrosurgical Excision Procedures (LEEP) or cone biopsy. The program will aim at reaching 27,555 women aged 25-49 years with high-quality services expanding coverage to all PEPFAR/B SNU and IDCCs. COP23 priorities will include:

1. Strengthening Demand Creation for Cervical Cancer screening and treatment among WLHIV aged 25- 49 years.
  - Enhance the linkage system across the IDCCs with increased sensitization and active linkage of eligible clients at both facilities and in the community.
  - Utilization of social media platforms for demand creation.
2. Strengthening Service delivery
  - Through the HUB and Spoke model bring services closer and user-friendly.
  - Technical support to the National Cervical Cancer Prevention coordination office to provide overall guidance and capacity building of new providers.
  - Establishment of Training of Trainers (TOTs) to decentralize training, support supervision, and mentorship to the regional level to effect efficiencies and ensure quality assurance.
  - Improve the “screen, triage, and treat” initiative to increase access and achieve same-day treatment.
  - Expansion of HPV DNA testing including self-sample collection through multiplexing of the platform.
  - Private Partnership to extend services to those seeking private care.
  - Strengthening utilization of the electronic medical record system.

### **4.4 TB/HIV Services**

TB is the leading cause of death in people living with HIV (PLWH) and while anti-retroviral therapy (ART) reduces the risk of TB by about 64% (Lawn and Wood 2012), the risk of getting TB remains high in PLWH compared to HIV-uninfected patients.

Botswana's estimated annual TB incidence for 2021 was 235 per 100,000 population which is a 7% reduction from 2020 (253 per 100,000 population). This reduction may be partly attributable

to high ART coverage due to expansion of the test and treat strategy. However, despite a decline in tuberculosis notification and a high ART coverage (96%) among TB patients who are HIV positive, TB/HIV comorbidity remains 48% (WHO Global TB report 2021). For more than eight years, tuberculosis preventive treatment (TPT) was a missed opportunity. In 2019, through outstanding leadership and collaboration, TPT for HIV-positive persons was introduced and implemented, paused due to Covid 19, and was reintroduced in 2021.

In the past year (FY22), among 1510 TB patients identified, 1464 (97%) knew their HIV status and 272/282 (96%) co-infected patients were initiated on ART in PEPFAR/B supported districts. Although high HTS and ART coverage is being achieved among identified TB/HIV patients, the following major gaps remain in Botswana hence the need for increased effort to control the HIV and TB epidemic:

- Co-infection rates of TB and HIV are unacceptably high (48%, FY22Q4) especially among known HIV positive on ART. TPT greatly reduces development of TB disease and mortality and all eligible people living with HIV need TPT. GOB transitioned from the use of INH (6H), to newly adopted 3HP (short regimen), so TPT needs to be scaled up in COP23 and COP24. TPT coverage among pediatrics and children who are contacts of patients with confirmed TB disease is suboptimal.
- Supply chain of TB commodities remains suboptimal.
- TB case findings among PLHIV for both pediatrics and adults remain suboptimal. TB screening performance among PLHIV has been exceptional in Botswana, but TB screening positive yield remains low. Standardized symptom screen alone is not sufficient for TB screening among people living with HIV and should be complemented with more-sensitive and setting-specific, WHO-recommended screening tools. Utilization of molecular WHO-recommended diagnostic and drug susceptibility testing as first test is also suboptimal.
- Contacts of TB confirmed patients' needs to be timely traced and followed to screen and diagnose early as a TB transmission prevention measure. Routine contact investigations for all contacts of confirmed TB cases needs to be scaled up across all districts.
- Continuous quality improvement on the barriers and gaps identified in the use of standardized tools, complete documentations, availability of commodities and reporting of achievements.

To address the above gaps, PEPFAR/B through MOH and other stakeholders will strengthen and maintain the following strategies and activities in COP23:

Accelerating actions on TB prevention is critical to end TB. PEPFAR/B through strengthened Facility-Community linkages will implement the activities and interventions below in COP23 to expand and sustain the coverage of TPT in Botswana:

1. Technical assistance through mentorship to scale up TPT services with intensified 3HP implementation among both children and adults.
2. Technical assistance through mentorship and twin supervision to health care workers on initiating and monitoring adverse events among TPT eligible clients.
3. Adequate follow-up of patients for adherence, completion of TPT and documentation of adverse events.



4. Technical assistance to operationalize the national TPT guidelines and appropriate utilization of registers and monitoring tools.
5. Support the supply chain of commodities e.g., 3HP.
6. Strengthen integration of TPT in core package of services including MMD, DDD and DSD Model.
7. Support the procurement and availability of TPT commodities.

To get back on track to meet TB case notification targets, the priority is to find all people with TB, including those who may not present with TB symptoms. PEPFAR/B will strengthen case finding strategies in COP23.

- Strengthen interventions to find children and adolescents with TB should be part of the overall case finding efforts including contact investigations and child-friendly diagnostics including mWRD testing for non-sputum-based samples – Stool test.
- Provide technical assistance to strengthen mentoring and supervision to health care workers on TB/HIV services, including quality of sputum collection & testing.
- Provide technical assistance to strengthen mentoring and supervision to health care workers on TB/HIV services, including quality of sputum collection & testing.
- Strengthen utilization of Xpert MTB/RIF testing as initial diagnosis and drug susceptibility testing.
- Provide the necessary support to ensure quality TB screening and HIV testing of all presumptive TB patients are done.
- Considering the limitations of symptom screening, adopt the new WHO recommended screening guidelines (2021) to significantly scale up systematic screening for TB using digital Chest X-rays (CXR) and computer aided detection (CAD) software.
- Integrate contact investigation and other active TB case finding activities with efforts to also identify people without signs and symptoms of TB infection who will benefit from TPT.
- Decentralize TB screening and testing into primary health care facilities, as well as community and household levels including through mobile stops.
- Remote monitoring of Gene Xpert machines through G X Alert, focused on its functionality and utilizations.
- Promote decentralized diagnostic networks and integrated testing for TB with other diseases including through multiplex diagnostic testing platforms. E.g., bi-directional testing for TB and COVID-19 in populations at risk for both diseases, integrated sample referral system for TB and HIV programs in high TB and HIV settings.
- Strengthen TB/covid 19 bidirectional screening and testing.
- Use of connectivity solutions to enable automated reporting by diagnostic devices.

Accelerating actions on early diagnosis and successful treatment are critical to end TB. PEPFAR/B will focus on the activities and interventions below in COP23 to maintain HIV testing and ART/ATT coverage:

- Provide the necessary support to ensure HIV testing is done among all presumptive TB patients.
- Provide technical assistance to health care workers to strengthen follow activities (tracing and tracking) on patients who missed HIV testing and ART Initiation.
- Adopt shorter, all-oral and patient-friendly anti-TB treatment (ATT) regimens recommended by WHO – this includes the 4-month DSTB regimen for children and adults.

- Management of existing conditions and co-morbidities that are disproportionately high among people with TB in the country.eg Diabetes.
- Continue to provide community and household-based ATT, adherence support and infection control.
- Ensuring uninterrupted supply of medicines: use of Quan-TB and pooled procurement of TB drugs and commodities
- Adequate management of adverse drug reactions and comorbidities.

PEPFAR/B will continue to improve and maintain timely and effective TB/HIV Data quality and reporting in COP23:

1. Provide technical assistance to strengthen TB data quality, availability and use through electronic medical records (EMR) DHIS & OpenMRS data platform use.
2. To provide the necessary support to ensure EMRs link with lab modules for timely reporting of results.
3. In-service training of health care workers on monitoring and documentation of TPT doses taken and related adverse events.
4. Monitor implementation using key indicators to track progress and adjust programming:
5. Deploy digital innovations to track and link people to appropriate care.

***Strengthening implementation of Advanced HIV Disease diagnosis and treatment package; TB/HIV comorbidity***

The OU will further strengthen integration of diagnosis and management of HIV comorbidity with communicable diseases in IDCCs. TB/HIV comorbidity screening and management efforts and optimize TPT uptake among PLHIV will be supported by monitoring activities and capacity building for NPD support for on-site and virtual support for TB/HIV co-infection case management especially for PLHIV initiating ART. Technical assistance through mentorship will be provided, to scale up TPT services with intensified 3HP implementation among both children and adults, with increased integration of TPT in the core package of services including MMD, DDD and DSD Models.

PEPFAR/B will continue to work closely with MOH to close gaps in implementation of WHO-recommended and PEPFAR-adopted package of diagnostics and treatment for advanced HIV Disease (AHD), as the implementation of the package remains suboptimal as characterized by a low CD4 count testing rate. By end of FY22, (NDW) only 73% of PLHIV starting ART had CD4 count baseline investigation done subsequently affecting uptake for related tests such as cryptococcal meningitis and TB screening for those with low CD4 count. The low implementation of the AHD package is in part due to challenges in ensuring clinician adhere to the AHD guidelines through supportive supervision while other challenges include laboratory – CD4 machine out-of-service, reagents being out of stock. In COP23, efforts will be focused on optimizing early diagnostics and treatment of AHD as follows:

1. Through the Mentorship program site level mentoring and monitoring will be provided to clinicians implement the WHO-recommended package of diagnostics and treatment for AHD among PLHIV (adults and CLHIV) specially to strengthen CD4 count testing uptake for all eligible PLHIV (ART pre-initiation baseline, ART virologic failure and baseline tests for re-initiations).

2. Strengthen laboratory-clinic interface for flagging of CD4 count results less than 200 for screening cryptococcal meningitis.
3. Optimize TB screening through TB-LAM testing for advanced disease management and the increase in TB screening & diagnosis.
4. Continue roll-out capacity building of AHD management trainings in all the districts aimed at improving clinical competence in early diagnosis and accurate management through the standard AHD package.

#### **4.5 Laboratory Systems (VL, EID, DNO, etc.)**

The primary goal of being on antiretroviral therapy is to achieve viral load suppression and all PLHIV should achieve that. In Botswana viral load testing is done on 3 - 6 months intervals and PEPFAR/B will align with the Handbook of Botswana 2016 Integrated HIV Clinical Guidelines as it supports viral load testing implementation through direct service delivery and technical capacity building.

Botswana has made significant strides by reaching the 95-98-98 of the UNAIDS targets, however, there remains a gap of 5-2-2 to be addressed. There are still gaps in viral load coverage and suppression amongst key populations and priority populations (A/CLHIV, FSW, MSM and PBFW) and some SNU. PEPFAR/B will strengthen client-centered services to ensure that client drug pickups harmonize with viral load testing time, adopt DSD models that include viral load blood collection in community settings and leverage on the private sector capacity to address any viral load testing gaps. Facility community interface will be strengthened further to ensure tracing and tracking of clients who have missed their appointments and delivery of enhanced adherence counseling for clients who have detectable viral load by multi-disciplinary teams. PEPFAR/B will build the capacity of service providers to be able to do timely switches during client failure and monitoring of HIV drug resistance.

PEPFAR/B will explore innovative ways to ensure that viral load testing results reach the clinicians and clients at the shortest possible by use of interoperable information management systems, use of SMS etc.

PEPFAR/B will support GOB to transition to multi-disease testing and diagnosis to improve efficiency and sustainability. In COP23/24 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 SNU. Our vision is to reach 98% viral load coverage and 100% viral loads suppression across age and sex bands through activities that will sustain 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, roll out 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 by 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 by continuing interfacing of 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 the government to do equipment maintenance, leveraging decentralized service delivery models to improve VL access for KP, interoperability of EMRs, optimizing the laboratory referral system and supporting HIV drug resistance (HIVDR) monitoring.

We will also improve efficiencies by embarking on equipment multiplex to bring services closer to the people and developing regulatory frameworks and policies. PEPFAR/B will continue to Support the MOH to ensure external and internal control (EQA/IC) program are in place to regularly assess the quality of testing sites and ensures that they meet national standards. Support will also be provided to the National Quality Assurance lab to strengthen proficiency testing (PT) programs to regularly assesses tester competency and ensures that all testers meet national standards.

As we move towards more TA, the laboratory will work closely with other programs to build a comprehensive 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 interface
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
7. Implementation of CQI projects.

The OU will also integrate laboratory QMS trainings into the University of Botswana to ensure sustainability.

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

### **Early infant diagnosis (EID)**

Despite the GOB's achievement of the WHO "Silver Tier" status, there are still challenges in the PMTCT program, including EID coverage. EID continues to be covered at 7 laboratories with good coverage utilizing DBS samples collected from babies by trained HCW at SRH points. These labs additionally all utilize an integrated patient management information system (IPMS) for their Lab information Systems (LIS). PEPFAR/B continues to support these EID sites through above site

activities to support continuity of testing, QMS (ancillary equipment certification, biosafety & accreditation), results availability/ access, and HRH capacity building. EID additionally continues to be supported by the GOB as a prioritized laboratory result utilizing direct “alert” laboratory result communication strategies. PEPFAR Botswana will work with GOB lab services utilizing the newly drafted national point of care (POCT) policy and DNO findings to see if there are areas that necessitate EID POCT equipment placement.

Despite these efforts, EID coverage at 2-months continues to be suboptimal due to several factors including lack of follow up of pregnant women once they exit the delivery sites. In COP23, PEPFAR/B will continue to support the EID testing for the PMTCT program through site supportive supervision and mentoring. Comprehensive and timely diagnosis of infants will also be strengthened through implementation of birth cohort registers for HIV Exposed Infants (HEIs) using EMR. Through this expansion and use of electronic medical records in ANC/PMTCT settings, HEI will be tracked to optimize mother-baby pair approach.

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. Through community-based health care workers, PEPFAR/B will continue to link HIV exposed infants (HEI) not tested for HIV, to facilities for EID.

In support of the national PMTCT program maintenance of the WHO “Silver Tier” achievement and a move towards the “Gold Tier”, during COP23, PEPFAR/B will work with GOB through utilization of CQI tools to attend to the under-performing areas such as number of infants done EID as well as number of children contacted and tested for HIV from index case partners.

#### **Diagnostic network optimization**

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 low. 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, long results turnaround times, laboratory opening times for some sites and staffing (Figures 4.5.1, 4.5.2, and 4.5.3). Additionally, there is equipment that is still not interfaced, challenges with data accessibility and electronic data entry for some sites referring to the labs.

COP22 focused on closing the identified gaps during the assessment and COP23 we will do another assessment to check whether the system has been optimized and to map a way forward. Efforts will still be put in place to improve the lab clinic interface through provision of lab nodes and roll out of specimen registers. To date the OU has managed to come up with real time dashboards which allows the laboratory service to visualize turnaround times for different laboratories in real time at a click of the button as shown below.

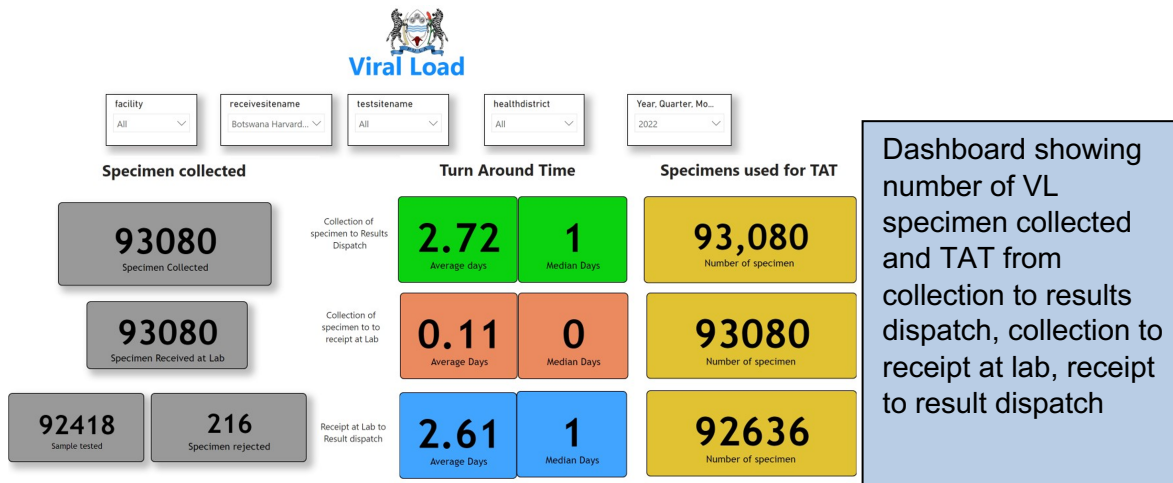


Figure 4.5.1: Viral Load Specimen and TAT Dashboard

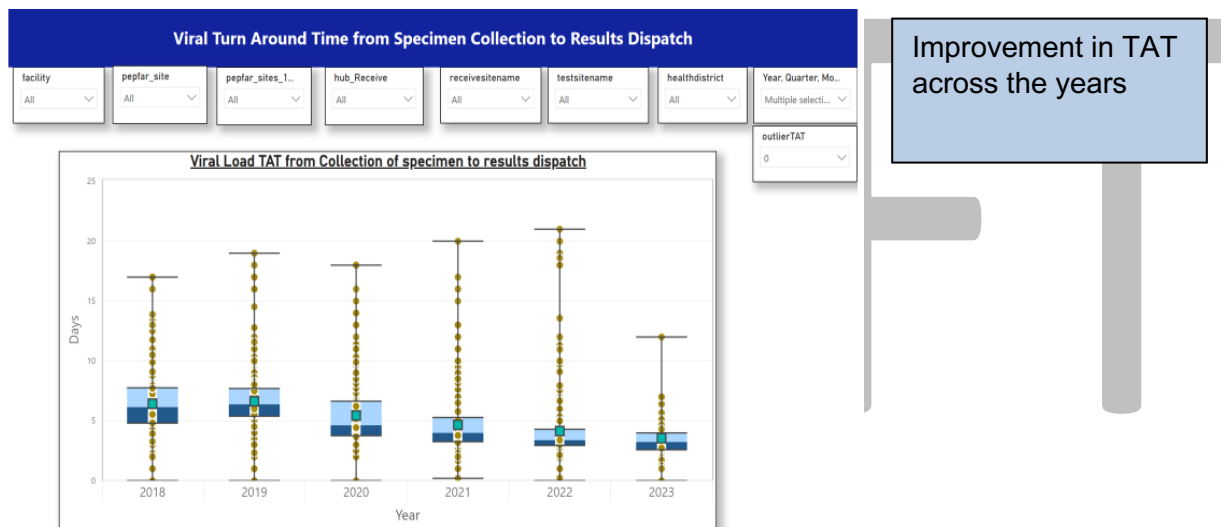
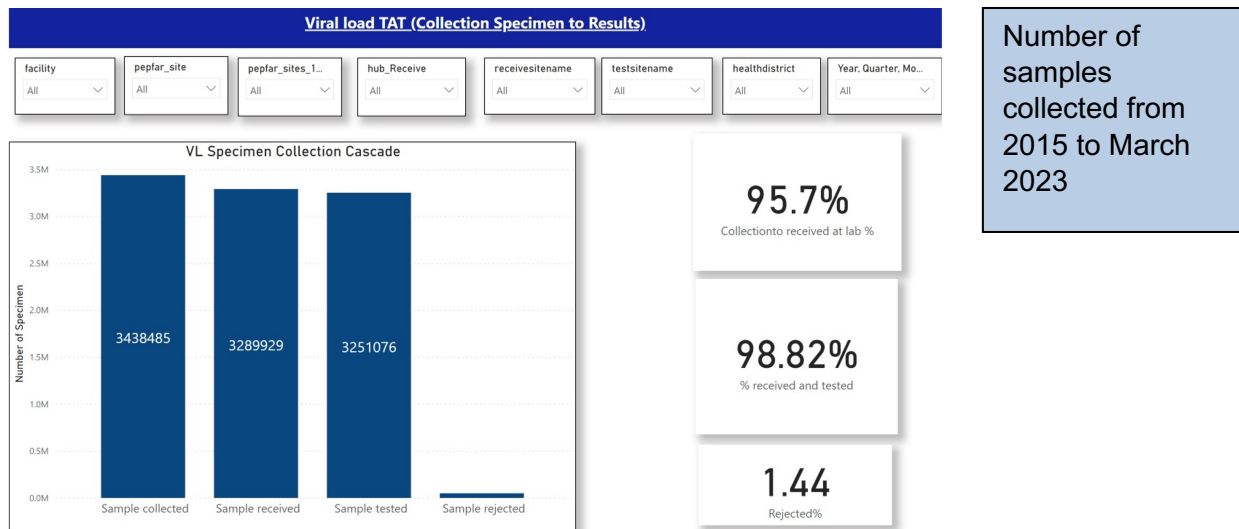


Figure 4.5.2: Viral Load TAT Dashboard Trends Dashboard



**Figure 4.5.3: Viral Load Specimens Collected Dashboard**

#### 4.6 HRH (priorities, national capacity to manage workforce, aligning to government planning, pay and cadres, etc.)

PEPFAR/B will continue the dialogue with the MOH 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. A shortage of skilled and qualified healthcare workers remains a major bottleneck towards the availability of accessible high-quality HIV services & healthcare in Botswana. This is worse in hard-to-reach and rural areas manifesting as inequitable distribution of HCWs across the country; an outcome of ineffective health workforce planning and management. 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 COP23 is important to sustain the gains of the HIV response and achieve epidemic control. In COP23, PEPFAR/B 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 activities that will continue from COP22 or be started in COP23:

1. Build capacity for health workforce planning and management of appropriate departments, units, and individuals in the MOH to optimize workforce utilization & investment for sustained epidemic control.
2. Complete the 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.

3. Complete the Health Labor Market Analysis (HLMA) 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 divides.
4. Workload assessment will be conducted by applying the Workload Indicator of Staffing Needs (WISN) method to determine the number of health workers of each cadre required to address workload at national, district, and facility levels.
5. The national HRH TWG will be reconstituted and strengthened with the core team developing the HRH strategy and plan. The HRH TWG and core team will be able to analyze, interpret, and use the evidence generated from the baseline assessment, HLMA and WISN to facilitate an inclusive HRH strategy planning and development process.
6. 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.
7. Continue with establishing an integrated HRH information system capable of supporting HRH planning for national and sub-national levels, and professional regulatory councils.
8. 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.
9. Initiate the development of a transition plan to absorb all HCWs currently supported by PEPFAR/B to ensure continuity of service delivery.
  - Continue to support training and competency certification for the different HCW to build capacity.
  - Expand the Mentorship program in line with the movement from direct service delivery to technical assistance to include other areas such as laboratory and strategic information.
  - Support adaptation of training courses for country ownership
  - Work with ministerial health workforce leadership to formalize the informal health workforce to sustain support for services.
  - Support GOB to work across ministries in identifying strategic approaches to sustain a public health work cadre to support HIV testing services at the facility level, through integration of nurse traineeship.

#### **4.7 Supply Chain modernization and adequate forecasting**

Although Botswana predominantly funds the public health supply chain and thus can be said to have country ownership, there are still gaps in the system that require strengthening and the support of PEPFAR and other multilateral organizations.

This support will ensure that the country has a resilient and sustainable supply chain that will underpin the current achievement of the UNAIDS goal of 95-98-98 Botswana has attained; and most importantly, “the goal to end HIV/AIDS as a global health threat by 2030” as outlined in the Botswana Planning Level Letter (PLL) by the U.S. Global AIDS Coordinator – Dr. John Nkengasong (dated February 15, 2023).



In COP23, the following areas are planned to be supported by PEPFAR/B under Pillar 3: Public Health Systems & Security, Supply Chain Modernization and Adequate Forecasting:

1. End-to-end supply chain data visibility
  - Support Central medical stores (CMS) and MOH to plan a transition from paper-based systems to digital systems for supply chain to improve end-to-end data visibility, management, and use of data for decision making, and expanding/rolling out an electronic management information system (eLMIS) between CMS, district warehouses, and the downstream health facilities across the country.
  - Supporting Botswana medicines regulatory authority (BoMRA) on implementation of the global health (GS1) traceability standards to prevent entry and use of falsified and counterfeit health products in Botswana. As well as the post market surveillance of products to ensure they are safe for use.
2. Forecasting and Supply Planning
  - Continue to build capacity and sustainability in forecasting and supply planning for all products procured and distributed by CMS.
3. Strengthening the Procurement, Contract Management & Supplier Relationship areas
  - Build CMS capacity to improve procurement and contract management practices and efficiency through the use of digitalized tools.
  - Continue to support the Contract Management Unit by providing training and mentoring of staff.
  - Supporting CMS on supplier relationship management to ensure on-time delivery and reliability of their suppliers, as well as improve responsiveness and reliability of the suppliers.
4. Strengthening of last mile warehousing & distribution
  - Working with other multilaterals to support warehousing optimization at district and downstream levels, as well as distribution to the downstream facilities.
  - Use private sector engagement to strengthen and improve district level and downstream warehousing and distribution where possible.
5. Support CMS transformation
  - Working with other multilaterals to support CMS with both the transformation plan and implementation technical assistance.
6. Continue to support the GOB to strengthen supply chain systems to assure continuous diagnostic services provision.

## Pillar 4: Transformative Partnerships

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The successful and efficient implementation of the PEPFAR/B program will be achieved through transformative partnerships with a range of different government counterparts, Civil Society Organizations (CSOs), universities, private sector entities, and multilateral partners. This will ensure the scalability and sustainability of our HIV program.

PEPFAR/B already has a strong partnership and direct funding relationship with the GOB through a cooperative agreement covering the last 15-years. This government-to-government (G2G) agreement includes funding for comprehensive HIV service provision (TB, PMTCT, HTS, etc.) ensuring high-quality HIV services are available in public health facilities for all population groups as well as broad systems strengthening activities including laboratory, strategic information, policy, and guidance.

The G2G funding fits in PEPFAR/B's model of sustainability for HIV programs and reducing direct service delivery (DSD) to technical assistance (TA). This funding forms the foundation of the strategy to build and support local capacity to sustain the gains of the PEPFAR program by capacitating GOB, who form the foundation of the HIV response. Through this G2G funding, PEPFAR is able to work directly with GOB to leverage implementation of activities on existing GOB structures, including HRH and procurement and management of commodities. PEPFAR/B has used this mechanism to provide direct technical assistance from PEPFAR to GOB, ensuring programs that were important to achieve the UNAIDS targets (Botswana 95:98:98) are transitioned out from DSD to TA for GOB uptake and ownership. Since GOB is the main custodian of PEPFAR programs, working closely through G2G funding ensures sustainability of programs as PEPFAR moves from funding IP's, associated with higher overhead charges, to increased government funding and responsibility with less overhead charges, achieving more for less and creating a better platform for PEPFAR transition. Importantly, PEPFAR/B works closely with the GOB to develop absorption and transition plans for all positions that are supported through the G2G mechanism.

This strategic G2G partnership will continue in COP23 and beyond. In addition to the direct funding assistance, PEPFAR/B provides technical assistance (TA) in different focus areas such as the development of the national DREAMS database, health information registry, the OVC database, drug forecasting and contract management, provision of KP competency training, development of HRH, health financing, social contracting strategies, organizational and management capacity, among others. PEPFAR/B will continue to work closely with GOB to build capacity through embedding technical staff within targeted MOH technical areas. Through expansion of the clinical mentorship to a Botswana Mentorship Program that includes other technical areas (Lab, SI & CQI), PEPFAR/B will continue its transition in provision of direct service delivery (DSD) to Technical Assistance (TA). PEPFAR/B will align its strategic priorities with the priorities of the GOB to improve technical competencies, scalability, and sustainability of HIV programs. This will also include the revitalization of primary health care (PHC) and integration of PHC and NCD care within HIV services.

PEPFAR/B also maintains strong partnerships with CSOs to strengthen their capacity in areas of leadership and governance, strategic information, financial management, legal compliance, program and technical development, human resource management and resource mobilization.

PEPFAR/B will collaborate with CSOs to expand their income streams through the adoption and implementation of social enterprise. To leverage domestic funding, PEPFAR/B will collaborate with GOB to make social contracting more efficient in delivering HIV programs to priority populations. PEPFAR/B will collaborate with CSOs to expand their income streams through the adoption and implementation of social enterprise.

The Government of Botswana recognizes and appreciates CSOs as key partners in development including the role they have been playing in the national HIV response. Government's desire and commitment to work with NGOs is in line with Vision 2036, which provides the long-term socio-economic development framework for Botswana. Vision 2036 states that "Civil society organizations will be partners and legitimate actors in the national development process. We will empower our civil society organizations to undertake those functions that are complementary to government development efforts. Our civil society will be vibrant, representing the voices of the community, especially the disadvantaged" (Vision 2036, Page 27). In COP23, PEPFAR Botswana will support the GOB to establish and implement social contracting (enhance sustainable public financing of services provided by civil society organizations) by:

- Collaborating with NAHPA to finalize the "The Government of Botswana Fund Strategy for CSO-led HIV Services". The Fund Strategy will determine how CSOs will be engaged to deliver services on behalf of the health sector in alignment with Policy Guidelines for Financial Support to NGOs of 2017 and NSF III.
- Supporting activities across NAHPA and relevant ministries that will ensure domestic finances are available for social contracting mechanisms. Advocacy briefs will be developed to engage politicians, policy makers and health managers to advocate for annual predictable financing to be included as a budget line item for social contracting.
- Strengthening the engagement Between CSOs and Government. Collaborative fora and National dialogues will be organized that will include stakeholders. The engagements will focus on developing/adapting regulatory processes for selecting CSOs for contracting using best practices globally on transparent review and accountability processes. In addition, the stakeholder's engagement will facilitate consensus on deliverables, timeframe, coverage, scale, targets, and indicators to report with funds for social contracting included in NSF III.
- Building the capacity of GOB and CSOs to effectively implement and monitor social contracts. Support will be provided to establish systems for monitoring & evaluation to be able to maintain the critical role of CSOs in the HIV response via quality implementation and monitoring of publicly financed services.

PEPFAR Botswana will collaborate with all stakeholders involved with the ongoing development of the Sustainability and Transition Roadmap/Plan to develop appropriate milestones or benchmarks that will be used to monitor the success of social contracting in Botswana.

In addition, private sector engagement has been an important tool to address gaps in service delivery (e.g., viral load testing). PEPFAR/B leverages the capacity of the private sector to improve access and coverage, therefore improving the quality of services for PLHIV among priority populations. PEPFAR/B will explore further partnerships in drug manufacturing, modernization of supply chain, delivery of services such as PrEP to priority populations to improve access and uptake and ensure the sustainability of the gains made.

PEPFAR/B continues to work with key partners such as WHO, UNAIDS, UNICEF, and Global fund (GF) in the global HIV response in areas that these entities have strengths in. The planning with Global Fund ensures that there are efficiencies in resource utilization and synergies are established.

Global Fund was involved throughout the PEPFAR COP23 planning process and contributed to the OU prioritized areas of support. Additionally, PEPFAR is represented in Global Fund stakeholder discussions for funding. WHO and UNAIDS form part of the critical stakeholders and were engaged throughout the COP 23 deliberations. Information from these partners is also utilized to focus discussions on areas such as Spectrum estimates, and new guidelines including testing algorithms. WHO continues to be a critical partner in technical assistance in health security through the utilization of its partners, such as Africa CDC, while UNAIDS is also working with PEPFAR to reach the underserved populations.

PEPFAR/B is working closely with both WHO and Global Fund to build the capacity of the GOB for outbreak management through the establishment of the Botswana Public Health Institute, including its emergency operation center, development of HCW capacities through field epidemiology training program (FETP), strengthening and using emergency response groups (SURGE), rapid response teams training and other technical trainings.

PEPFAR/B's ongoing collaboration with the Global Fund will in COP23 involve conducting the sustainable and transition readiness assessment. The findings from this assessment will inform the development of the PEPFAR/B Sustainability Road Map which will serve as a guidepost to ensure that all gains achieved through PEPFAR support are maintained. In COP 23, PEPFAR/B will also strengthen its collaboration with Global Fund by conducting joint planning and information sharing activities to ensure efficient coordination, program complementarity (technically and financially) and leverage each other's convening and advocacy authority. The same approach will be extended to other multilateral partners including WHO, UNICEF, UNAIDS/UNICEF, UNFPA, UNDP and UN Women. PEPFAR/B will advocate for participation in the Country Coordinating Mechanism (CCM) to ensure these transformative partnerships contribute to reaching the unmet and sustaining gains in the HIV response.

## Pillar 5: Follow the Science

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This section addresses the USG plan for COP23 strategies to follow the science through amplifying surveillance, applied epidemiology and implementation science initiatives. In this regard, PEPFAR Botswana prioritizes HIV surveillance activities (Recent infection monitoring, Case based surveillance, Mortality and Morbidity surveillance) to complement the other pillars. PEPFAR Botswana will also support rapid incorporation and use of behavioral science results by supporting BAIS V secondary analysis and IBBS secondary analysis. Furthermore, PEPFAR Botswana will support the implementation of other implementation science activities related to PrEP.

### **5.1 Implementation science**

#### ***CAB-LA Feasibility/Acceptability Study***

In COP23, PEPFAR will support the GOB to accelerate adoption of new biomedical interventions such the use of long-acting injectable cabotegravir (CAB-LA). The MOH is fully supportive of the introduction of CAB-LA as a response to WHO's recommendation to be used as a new pre-exposure prophylaxis (PrEP) technology to strengthen accessibility and uptake for individuals at substantial risk of HIV infection. Although CAB-LA roll out is not anticipated in COP 23, a feasibility/acceptability study is being proposed to provide a basis for evidence-based programming, to enhance product availability, acceptability, uptake, and effective use. This will be done in collaboration with a local partner to strengthen their capacity to advocate for, design, and implement product introduction activities and research.

### **5.2 Recent Infection Surveillance, Case Based Surveillance (CBS), Morbidity and Mortality Surveillance**

#### ***HIV recent infection surveillance***

PEPFAR Botswana will continue to implement the HIV recent infection surveillance in a phased approach following the approved protocol and the latest Scientific Advisory Board (SAB) recommendations. To ensure implementation with fidelity, PEPFAR Botswana will continue to conduct monitoring visits and provide technical assistance.

#### ***Case Based & Morbidity and Mortality Surveillance***

In COP23, PEPFAR Botswana will continue supporting case-based surveillance and use of unique identifiers for sites reporting data through EMRs into the National Data warehouse. This activity has been successfully implemented in COP22. As a result, a longitudinal database of HIV positive clients from the point of diagnosis throughout the course of the disease has been generated and presented through dashboards, monthly infographics, quarterly and annual reports. The challenge to be addressed in COP23 will be to facilitate improved reporting rates across facilities (private- and paper-based) as well as enhancing the ability of EMRs to capture all the sentinel events as part of the larger case-based surveillance system. Implementing this strategy will give a better representative of our clients as an OU and respond to any gaps that would be identified through this case-based surveillance analysis.

Additional data from morbidity and mortality surveillance is crucial in completing the case surveillance cascade. In COP23, the morbidity and mortality surveillance will be implemented through additional analysis of coded data from causes of death to inform public health interventions. PEPFAR Botswana will continue to implement recent infection surveillance at the high-volume SNUs following the current use of RITA data that incorporates viral load to monitor the trends. This is used to inform programmatic decisions and public health responses.

### ***Key population IBBSS, Drug Resistance and BAIS V data secondary analysis***

In COP22, Botswana is conducting a third national Integrated Biological and Behavioral Survey (IBBSS III) to provide up-to-date estimates on HIV prevalence and progress toward 95-95-95 targets among Key Populations (KPs). It is envisioned that the IBBSS results will be available at the start of FY24. PEPFAR/B with key stakeholders plans to conduct secondary data analysis for IBBSS in COP23 to inform programming, advocacy and provide deeper understanding of other aspects of key populations that affect the epidemic dynamics including migration and social networks that are not included in the original survey design. The support in COP23 will also include dissemination of results to the media, local leadership and potential funders and stakeholders that shape public opinion and provide the data for key populations at the district levels. The IBBSS data will also enhance the country's HIV profile analysis in terms of understanding potential risk of priority populations.

In addition to the IBBS, a secondary analysis of BAIS V data will be conducted during COP23 to inform programming and help in building a further understanding of related determinants of health's around risk perception, treatment, prevention adherence, stigma reduction.

As Botswana has a treatment-experienced ART population, it is crucial to estimate the level of drug resistance amongst the unsuppressed yet adhering patients. This will also answer the drug resistance component of the case-based surveillance as a sentinel event. These analyses will give the OU a better guide as to what evidence-based behavioral and social science-based approaches are in play to help deliver on specific programmatic goals. This knowledge will also help to further pivot the program and refocus the prevention and treatment services toward closing gaps, having more coverage, and maintaining the gains. This will further assist to reach those populations that were identified as not doing well in reaching epidemic control.

# Strategic Enablers

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## **Community Leadership**

### **7.1.1 Plans for Community-Led Monitoring, noting briefly how CLM has been used to inform the program.**

PEPFAR/B began implementation of Community Led Monitoring (CLM) in COP 21, it is conducted by independent local CSOs in communities where PEPFAR is providing direct service delivery and technical assistance to achieve epidemic control. CLM is an accountability mechanism, it fills the gap of M&E systems by gathering qualitative and quantitative and observational data from the client and community perspective to assess the accessibility, availability, acceptability, affordability, equity, and quality of the services they receive. It promotes and facilitates the use of real-time information for service providers and decision makers to design and implement services that are people-centered and responsive to the community. CLM is central to a person-centered approach because it puts communities' needs and voices at the center of the HIV response.

The sub-populations reached include people living with HIV, AGYW, service providers and community opinion leaders and leadership. CLM activities will be extended to key populations through an appointment of a CSO who will lead a KP-focused grant and PEPFAR/B will strengthen the utilization of CLM results to inform program planning and implementation at community, district, and national level in COP23. PEPFAR/B in collaboration with the Community Consultative Group will support MOH and NAHPA to develop a CLM framework aligned to Botswana community leadership context.

### **7.1.2 Community leadership and Stakeholder Involvement in COP23**

To achieve alignment with national priorities and strive for investment alignment with other donors, PEPFAR/B held several consultative and consensus reaching meetings with GOB, CSOs, multilaterals and other stakeholders. Even before the official launch of the COP23 process, the PEPFAR/B Interagency team conducted a series of listening sessions with GOB and CSOs and other stakeholders, in order to hear and understand their programmatic needs for COP23 and to also share more about PEPFAR's new strategic direction. This was followed by a series of COP23 engagements with stakeholders. The purpose of the engagements was to ensure that PEPFAR/B priorities for COP23 are aligned with GOB and CSOs priorities, also identifying opportunities to leverage multilaterals, CSOs, GOB and Global Fund investments.

GOB, CSOs and individuals representing key and priority populations were also involved in prioritization discussions of PEPFAR/B investments for COP23 which led to leveraging PEPFAR investments for non-traditional programming such as Primary Health Care Revitalization following an alignment of PEPFAR/B, GOB and CSOs priorities to strengthen health systems. These were guided by the PEPFAR 5X3 strategy and the national priorities. This year, the COP23 planning process included GOB representatives from the Ministry of Health and National AIDS and Health Promotion Agency (NAHPA). Additionally, this year, government representation was also expanded to include the Ministry of Basic Education and Skills Development (MOESD) and Ministry of Local Government and Rural Development (MLGRD) and the Ministry of Finance to further augment the traditional GOB participation. Other critical stakeholders that were engaged included representatives of priority populations which involved representatives of AGYW programming (DREAMS Ambassador), faith-based and KP-led/preferred organizations. Multilateral organizations including UNAIDS, WHO, UNICEF, Global Fund and UNHCR also had active participation in each of the meetings and engagements. Further, PEPFAR/B will strengthen

stakeholder engagement by conducting annual activity alignment with Global Fund to enhance joint program planning and implementation. Also, representation of critical stakeholders will be extended to representatives of people living with HIV and the Private Sector.

### **7.1.3 Plans for utilizing/leveraging community platforms**

PEPFAR/B will leverage community structures such as village/ward leadership (Dikgosi), village development committees, community-based organizations, support groups for PLHIVs, traditional healers' associations, religious institutions, , village health committees, village youth committees, child protection committees, village multi sectoral committees, Parents Teachers Associations and Farmers Associations for program planning, implementation, and performance tracking. This will strengthen community leadership and enhance resilience to potential emerging public health threats.

### **Innovation**

PEPFAR/B will continue existing and initiate new interventions/approaches to develop sustainable country capacity in policy, planning, leadership, accountability, and program management. In COP23 PEPFAR/B innovations include:

1. Continuing with implementing the capacity strengthening plan for the MOH developed in FY23 using findings of the capacity needs assessment of the MOH. The MOH had highlighted multiple areas of capacity strengthening required at the national and subnational levels such as generating and using data for decision making, health financing, health systems strengthening, organizational development, developing and implementing policies and strategic plans, and strengthening the areas of change management, private sector and multisectoral engagement, health financing and public financial management, human resources for health, planning and management, mentoring and guiding subnational teams, and stewardship functions.
2. Conducting economic analysis to inform the development of PHC investment case, national HRH policy, finalization of the health care financing strategy and other policy instruments that are deliverables of the ongoing health reforms in Botswana.
3. Commencing the institutionalization of routine National Health Workforce Account guided by the multisectoral stakeholders national HRH TWG. The National Health Workforce Account will ensure that the HRIS is updated and can be used for realistic projection/estimation of staffing levels for provision of HIV services at different levels of the health system.
4. Implementing Activity Based Costing and Management (ABC/M) to generate technically sound and robust evidence to inform decision-making that will enhance value for money by more effective allocation and efficient utilization of resources for HIV/AIDS. The MOF mandates that funding be spent on time and efficiently before agreeing to allocating additional funds to health or HIV/AIDS. This innovation will present key areas where there are quality gaps, identify areas for task shifting for more efficient and effective capacity use and generate more accurate costs for each service, identifying shared costs and cross-subsidization of HIV to the health system or vice versa.



## Leading with Data

### **Data systems and interoperability: Unified health information ecosystem**

Digital Health is one of the key priorities for both PEPFAR and the Government of Botswana (GOB). In COP23, PEPFAR/B will continue supporting health information systems interoperability, which is critical to share data in real time, prevent duplicate through multiple capture of the same patient-level data on different data systems and improving data quality. In addition, the interoperability platform for health information exchange developed in COP21 will continue to be supported to ensure lab orders and results exchange between the different EMRs, OpenMRS (Centralized EMR), PIMS and IPMS are in real time and to improve turnaround time of results from clinicians to patients. Requirements and design of community HIS will commence in COP23 to fill in the long existing gap of community health data availability in the national data warehouse to provide a more complete, longitudinal patient record.

In COP23, key to sustainability are the efforts to institutionalize the capacity development of Botswana MOH at national, regional, district and site level through the SI Mentorship to ensure the workforce have the knowledge, skills, and abilities to accurately record person-centric services; continually review and resolve potential data quality issues; appropriately manage data sets, develop and use of data analytics tools and dashboards, and other outputs for data use to inform program improvements and services delivery in a timely manner.

### **Digital Health Support for Community Health Services**

The GOB has had EMRs in public health facilities since the early 2000's with the introduction of a fully-fledged, proprietary electronic health record management system called IPMS covering mainly hospitals and high-volume clinics. Another EMR, PIMS, which was PEPFAR supported, was also introduced around that period as well to cater for clinics and health posts that were electrified but did not have IPMS, due to its prohibitive user and site licensing model. However, with the introduction of other programs such as DREAMS and OVC it became evident that the existing systems were not built to handle custom data and workflow requirements of such programs, hence the development of data systems for OVC and DREAMS. In COP22, GOB is setting up district data centers at 5 districts to support improved data quality at district level. However, some of the community health services remain without electronic data collection tools. All these electronic data collection tools are very critical as each addresses a niche of the health data needs but on the whole complement each other towards ensuring complete electronic patient health records in the national data warehouse for reporting and supporting program improvement.

The GOB is prioritizing the revitalization of Primary Health Care (PHC) with an emphasis on the role of Community Health Workers (CHW) and digitization. PEPFAR has been supporting the GOB PHC initiative with technical assistance that has developed new integrated community care guidelines, training curriculum and detailed data requirements. For HIV programming, community service delivery is a vital part of treatment and prevention strategies and in addition to quality data capture, there is an urgent need for digital tools that support community health worker services, decisions, workflows and referrals to and from facility services. PHC approach means systems need to be planned with a wide range of stakeholders across health programs and funding sources.

PEPFAR/B technical assistance will support development of a community data systems road map, GOB led governance structures and coordinated implementation. TA will support requirements and design processes that ensure community data systems are CHW and patient centered to move beyond data capture and support workflows and decision support. The community data systems will align with broader health architecture to achieve interoperability, and seamless flow of securely identified client level data between facility and community services for individual follow up and service delivery. Community data systems investments will establish a foundation that unlocks future use cases including outcome measures for effectiveness of health services and use of predictive analytics to target health services to those most at risk.

Most epidemics begin in communities and PEPFAR/B will ensure that the support to community data systems include the capability to support community surveillance. Community surveillance units and stakeholders will be included in the design and governance structures to contribute requirements. Efforts will be made to identify community data streams that can be extracted and made available in an MOH data warehouse for monitoring through recently deployed dashboards capabilities supported through COVID funding. Community data systems will also be implemented to it.

#### **Support GOB data systems to track the layering of DREAMS services.**

DREAMS program reporting is done through a DHIS2 system named the National DREAMS Database (NDDB) which is hosted at the Ministry of Health (MOH). For COP23, PEPFAR/B will continue providing technical assistance to the National DREAMS Database to track and support layering of AGYW. The technical assistance will be to build competency and capacity building (skills transfer) to the GOB HIS officers for the NDDB.

#### **OVC Monitoring & Evaluation System Support**

To maximize the use of data and science to inform effective programming and sustainability, in COP23 the OVC PEPFAR program will continue support for national OVC monitoring and evaluation (M&E) systems, including a national OVC M&E framework and an electronic case management system to facilitate health and social welfare service delivery for vulnerable children. This will include review, development and institutionalization of the DSP M&E framework PEPFAR/B will also assist in the development of the DQA guidelines and implementation of the first OVC data verification by DSP.

PEPFAR/B will leverage results from a USAID-funded (non-PEPFAR) malnutrition study to inform improved support for the OVC program.

#### **Data collection backup & quality of Data in the NDW: National Data Repository update frequency**

This activity is a continuation from COP22 and will be continued in COP23 to ensure that gains made are maintained and improved. Data backup collection to the national data warehouse (NDW) will continue to be strengthened by ensuring eligible sites consistently submit automated monthly backups through mobile networks and extending the availability of courier services for backup collection. This activity is crucial to increase data availability, ensure evidence-based decision making, real-time reporting and improve patient management and outcomes.

In addition to backups collection, in COP23 PEPFAR/B will continue supporting the NDWs extract, transform and load (ETL) processes currently in place in COP22 to ensure data will get deduplicated, analyzed and reported. It also generates site specific data quality reports highlighting challenges identified for corrective action and support case-based surveillance and visualizations through dashboards.

HRH for the NDW will continue to be supported in COP23 to ensure addition of more data sources such as patient level data from the private sector health facilities, and to ensure sustainability, capacitate MOH staff on NDW management and analytics.

To ensure laboratory testing data availability, PEPFAR/B will continue to support equipment interfacing and site connectivity to the laboratories through introduction of lab nodes.

### **Health informatics and Data Analytics: data availability and accessibility**

Data systems (PIMS, IPMS, DHIS2 etc.) continue to play a pivotal role in the collection of electronic patient-centric data from source systems to the NDW. In COP23, PEPFAR/B will support the MOH to implement two new high-priority activities:

1. Open MRS roll-out: A new data system called the centralized EMR is currently under development and is expected to be rolled out in phases, starting in COP22. This is an open source, free (Digital health public goods) centralized system that will enable sites on the GDN and those with internet connectivity to share patient level data in real time. This will reduce gaps in patient level data particularly for those who seek services across multiple facilities that currently run PIMS, a standalone system. This data will also be available to the data warehouse in real-time thereby facilitating timely analysis and reporting.
2. Data Centers at District-level: MOH is setting up 5 district data centers in COP22 to enable increased patient level data collection and data capture at district level, across different disease areas. In COP22, PEPFAR will support equipment IT procurement for this activity and investments will continue to be made in this area in COP23 to support HRH, travel and logistics for site support visits and data quality assessments. This activity will be leveraged by the SI National Mentorship program to ensure trained, high skilled and empowered district level data managers. This will also strengthen DHMT leadership to coordinate data management practices, processes, and standards in an efficient, effective, and consistent manner.

## Target Tables

**Target Table 1: ART Targets by Prioritization for Epidemic Control**

Target Table 1 ART Targets by Prioritization for Epidemic Control							
Prioritization Area	Total PLHIV (FY23)	New Infections (FY23)	Expected Current on ART (FY23)	Current on ART Target (FY24) TX_CURR	Newly Initiated Target (FY24) TX_NEW	ART Coverage (FY24)	ART Coverage (FY25)
Attained	333745	4467	179468	192352	6273	97%	97%
Scale-Up Saturation	7765	88	112				
Scale-Up Aggressive							
Sustained							
Central Support							
Commodities (if not included in previous categories)							
No Prioritization							
<b>Total</b>	<b>341510</b>	<b>4555</b>	<b>179580</b>	<b>192352</b>	<b>6273</b>	<b>97%</b>	<b>97%</b>

**Target Table 2: VMMC Coverage and Targets by Age Bracket in Scale-up Districts**

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 (in FY23)	VMMC_CIRC (in FY24)	Expected Coverage (in FY24)	VMMC_CIRC (in FY25)	Expected Coverage (in FY25)
Bobirwa District	Males 15 years and above	28715	42%	855	45%	855	48%
Mahalapye District	Males 15 years and above	48973	63%	1419	66%	1419	69%
Palapye District	Males 15 years and above	40290	47%	1098	50%	1098	53%
Serowe District	Males 15 years and above	33512	53%	1137	56%	1137	59%
Kweneng East District	Males 15 years and above	101389	58%	1532	59%	1532	60%
Kgatleng District	Males 15 years and above	46138	55%	901	57%	901	59%
Gaborone District	Males 15 years and above	132494	54%	1874	56%	1874	58%
South East District	Males 15 years and above	20928	57%	809	61%	809	65%
Moshupa District	Males 15 years and above	17036	42%	310	44%	310	46%
Southern District	Males 15 years and above	31892	42%	765	45%	765	48%
	<b>Total/Average</b>	<b>501367</b>	<b>53%</b>	<b>10700</b>	<b>56%</b>	<b>10700</b>	<b>59%</b>

**Target Table 3: Target Populations for Prevention Interventions to Facilitate Epidemic Control**

<b>Target Table 3 Target Populations for Prevention Interventions to Facilitate Epidemic Control</b>				
<b>Target Populations</b> [AGYW at risk of HIV acquisition, female sex workers, Males who have sex with males, People in prisons and other enclosed settings]	Population Size Estimate*	Disease Burden*	FY24 Target	FY25 Target
	(SNUs)			
<i>PP_PREV (15-24)</i>	<b>459763</b>	<b>3.01</b>	<b>27180</b>	<b>27180</b>
<i>AGYW_PREV (10-24)</i>	<b>186647</b>	<b>3.03</b>	<b>20001</b>	<b>2001</b>
<i>KP_PREV</i>	<b>n/a</b>	<b>n/a</b>	<b>10429</b>	<b>10429</b>

DRAFT

**Target Table 4: Targets for OVC and Linkage to HIV Services**

<b>Target Table 4 Targets for OVC and Linkages to HIV Services</b>					
<b>SNU FY24</b>	<b>Estimated # of Orphans and Vulnerable Children</b>	<b>Target # of active OVC</b>	<b>Target # of OVC</b>	<b>Target # of active OVC</b>	<b>Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files</b>
		<b>OVC_SERV Comprehensive</b>	<b>OVC_SERV Preventative</b>	<b>OVC_SERV DREAMS</b>	
Bobirwa District		2373	1320	1471	2205
Boteti District		0	100	0	0
Charleshill District		0	75	0	0
Chobe District		0	100	0	0
Francistown District		809	200	0	649
Gaborone District		3193	1026	1030	2874
Gantsi District		0	150	0	0
Goodhope District		748	100	0	461
Jwaneng District		0	100	0	0
Kgalagadi North District		0	150	0	0
Kgalagadi South District		0	150	0	0
Kgatleng District		4174	663	384	2667
Kweneng East District		5828	1140	559	4592
Kweneng West District		0	75	0	0
Lobatse District		275	50	0	235
Mabutsane District		0	75	0	0
Mahalapye District		3299	1425	429	2773
Moshupa District		126	75	0	106
Ngamiland District		0	100	0	0
North East District		1266	1348	814	1231
Okavango District		0	75	0	0
Palapye District		436	100	0	374
Selibe Phikwe District		286	75	0	246
Serowe District		1735	1355	1033	1514
South East District		1257	75	0	852
Southern District		2195	1153	1138	1596
Tutume District		569	75	0	485
<b>FY24 TOTAL</b>		<b>28569</b>	<b>11330</b>	<b>6858</b>	<b>22860</b>
<b>FY25 TOTAL</b>		<b>28569</b>	<b>11330</b>	<b>6858</b>	<b>22860</b>

## Core Standards

This section provides PEPFAR Botswana’s COP23/ROP23 priorities for supporting the Government of Botswana to address the core program standards described in section 3.3 of COP23 Guidance. These narratives provide the following information: 1) the status of policy and implementation; 2) PEPFAR’s contribution to national response for this standard; 3) Reference or link to existing plan or policy, where applicable and 4) Plans for FY24 (and FY25 for bilateral OUs) to advance each core standard.

Core Standards	STATUS
<b>Case Finding</b>	
<p>1) Offer safe and ethical index testing to all eligible people and expand access to self- testing, ensuring that all HIV testing services are aligned with WHO’s 5 Cs. Index testing services should include assessment of and appropriate follow-up for intimate partner violence. Offer HIV testing to every child under age 19 years with a biological parent or biological sibling living with HIV.</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and in implementation, monitoring ongoing.</li> <li>● <b>Status Update:</b> Following the GOB’s adoption of Active Partner Notification and development of associated tools, including registers, forms, and training materials to ensure roll-out of index services with safety, GOB has completed training of Health care workers (HCWs) providing index testing in the 19 PEPFAR-supported districts. To ensure adherence to WHO 5Cs, assessment of IPV screening, and monitoring &amp; documentation of adverse events, GOB, through PEPFAR support, started the implementation of mentoring and supervisory support for HCWs.</li> <li>● <b>COP23 Implementation Activities:</b> COP23 funds will support GOB plans to expand Active Partner Notification and HIV Self-testing training services to the remaining eight districts to ensure parity in coverage. The focus is on above-site mentorship and a public health response without DSD site-level case-finding activities.</li> </ul>
<b>Care and Treatment</b>	
<p>2) Fully implement Test and Start policies, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (&gt;95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and in implementation, but direct and immediate linkage to treatment not yet above 95% across age, sex, and risk groups.</li> <li>● <b>Status Update:</b> <ul style="list-style-type: none"> <li>● 44.4% Same Day Rate- National Data Warehouse</li> <li>● 70.3% Same Day Rate- PEPFAR Program Data</li> </ul> </li> <li>● <b>COP23 Implementation Activities:</b> PEPFAR/B will continue to support efforts to improve immediate linkage to treatment rates across age, sex, and risk groups. Site</li> </ul>

	<p>level mentorship activities by clinical mentors will include supportive supervision, virtual coaching sessions, ART Initiations daily data review, CQI initiatives expansion of AHD trainings will be implemented to close gaps in facilities and subpopulations with low same day ART initiation rate.</p>
<p>3) Rapid optimization of ART by offering TLD to all PLHIV weighing <math>\geq 30</math> kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are <math>\geq 4</math> weeks of age and weigh <math>\geq 3</math> kg, and removal of all NVP- and EFV-based ART regimens.</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and implementation fully met.</li> <li>● <b>Status Update:</b> The country adopted and started TLD transition on September 1, 2018. The transition covered adults (including women of childbearing age) and children on treatment.</li> <li>● At the end of FY21 APR the transition coverage was 83.1% and by FY22 Q2 90% of PLHIV were on DTG based regimen including TLD while the remaining 10% were not eligible for DTG-based regimen transition and remained on other ART regimens. The rollout of pediatric DTG started in August 2021 and is almost complete.</li> <li>● <b>COP23 Implementation Activities:</b> Continued efforts to complete rollout of pediatric DTG regimens.</li> </ul>
<p>4) 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.</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and in implementation, but partially met.</li> <li>● <b>Status Update:</b> MMD: In COP21, 3MMD policy had been adopted and in implemented in all 75 PEPFAR supported health facilities; by FY22 APR, 3MMD stood at 65% compared to 48% in FY21 APR in 75 PEPFAR supported sites.</li> <li>● 6 months MMD stood at 19% (FY22 APR) and more than half of all patients are on 3 – 6 MMD since Q3 of FY21.</li> <li>● &gt;3 months to &gt; 6 months MMD remained suboptimal nationally at 59% by FY23, Q2 (NDW) and MMD reporting in 75 PEPFAR sites improved from 87% in FY22 Q1 to 98% by FY22 Q4. While MMD reporting nationally stood at 93% by FY23 Q2 (NDW). This is due to: <ul style="list-style-type: none"> <li>○ Continued mentorship for facilities with established appointment systems.</li> <li>○ Increased utilization of EMRS by HCWs.</li> <li>○ Inclusion of data elements that capture implementation of MMD in the country's DHIS2.</li> <li>○ Clinical Mentorship will be implemented to build capacity of HCWs – NPDs, doctors, pharmacy techs in ART MMD guidelines, support supervision, virtual and physical</li> </ul> </li> </ul>



<p style="text-align: center; font-size: 48px; opacity: 0.3; font-weight: normal;">DRAFT</p>	<p>coaching to improve HCWs MMD clinical competence, implement CQI projects at sites with low MMD records.</p> <ul style="list-style-type: none"> <li>○ These innovations will continue to be scaled and monitored in COP23.</li> </ul> <p>DDD: According to FY 22 APR a total 1,317 clients enrolled in Decentralized Drug Distribution and received their refills through different modes. A total of 507/1317(38%) used the post office, and the remaining 810/1317 (62%) the Community Medication Refills using either CHW or client models.</p> <p><b>COP23 Implementation Activities:</b> PEPFAR/B will support site level supervision, mentorship, innovative approaches, and technical assistance to improve facility level MMD underreporting:</p> <ul style="list-style-type: none"> <li>○ Improved site level support supervision and mentorship for facilities with MMD data capturing and reporting.</li> <li>○ Improve utilization of EMRS or use of manual data capturing for MMD</li> <li>○ The decision to start 6-month MMD has not yet been adopted in the latest Botswana Integrated HIV Clinical care guidelines (at final review stage). 6months MMD is special circumstances such as foreign travel and education.</li> <li>○ Expand the DDD models and innovations to include among others digital lockers for medication dispensing</li> <li>○ Support expansion of Community Medication Refills, integrating ARV, AAT, TPT, and NCDs at community and household level through the CHW cadres</li> </ul>
<p>5) All eligible PLHIV, including children and adolescents, who screen positive for TB receive molecular WHO-recommended diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB 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.</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and in implementation, but partially met.</li> <li>● <b>Status Update:</b> <ul style="list-style-type: none"> <li>● MOH 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 and distributed. By FY22 Q4, cumulatively 61 212 eligible clients were initiated on TPT, COP20 TPT target was 88 173 in PEPFAR supported sites.</li> <li>● Currently, eighteen (18) health districts out of 27 have been given green light to implement TPT, beyond the 75 PEPFAR sites. GOB transitioned</li> </ul> </li> </ul>

	<p>from the use of INH (6H), now switched to 3HP (short regimen), which was started in October 2022, in PEPFAR districts. MOH procured 67 000 packs of 3HP, and 32 000 packs have been ordered from Central medical Stores (CMS) to facilities, and around 8000 clients have already been initiated on 3HP. After a pause to TPT rollout by MOH due to policy issues and Covid 19 outbreak, TPT has been reintroduced and in FY22Q2/Q4, all districts were re-sensitized and HCWs trained to initiate 3HP. According to MOH TPT rollout plan, the program started in PEPFAR supported districts (also includes non-PEPFAR sites), then scaled to GOB PEPFAR supported sites then nationally to cover all Non PEPFAR sites.</p> <ul style="list-style-type: none"> <li>• TB services are fully integrated into the HIV clinical care package at no cost to the patient. All PLHIV are screened for TB in every encounter, and screening rate stands at 104% (FY22Q4).</li> <li>• <b>COP23 Implementation Activities:</b> To continue technical assistance through mentorship, to scale up TPT services with intensified 3HP implementation among both children and adults, with strengthened integration of TPT in core package of services including MMD, DDD and DSD Model.</li> </ul>
<p>6) Implementation of WHO – recommended and PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals presenting with advanced disease including those starting treatment, re-engaging in treatment after an interruption of ≥ 1 year, or virally unsuppressed for ≥ 1 year, and all children &lt; 5 years old who are not stable on effective TLD other DTG-based regimens</p>	<ul style="list-style-type: none"> <li>• <b>Implementation Status:</b> Core Standard adopted and in implementation, but partially met.</li> <li>• <b>Status Update:</b> <ul style="list-style-type: none"> <li>• In COP22, PEPFAR/B and MOH are working closely to close gaps in implementation of WHO-recommended and PEPFAR-adopted package of diagnostics and treatment for Advanced HIV Disease (AHD), including the following: <ul style="list-style-type: none"> <li>▪ Implemented “reflex” testing, providing CrAg screening on any samples with CD4 count &lt;100 cells/mm3 to rule amount cryptococcal meningitis.</li> </ul> </li> <li>• Capacity building for clinicians on Advanced HIV Diseases Training curriculum and virtual support for AHD case management with 577 trained on AHD and 17 certified as HIV specialists in private and public health facilities in COP23. Cumulatively, a total of 763 clinicians had been trained on AHD by end of COP21.</li> <li>• <b><u>Barriers: Implementation of the package remains suboptimal</u></b></li> <li>• By end of FY22, (NDW) only 73% of PLHIV starting ART had CD4 count baseline investigation.</li> <li>• Demand for capacity building – clinical competence for early diagnosis and treatment for AHD among HCWs.</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>● <b>COP23 Implementation Activities:</b> <ul style="list-style-type: none"> <li>● Expand Advanced HIV Diseases Trainings and AHD case management support through clinical mentorship program virtual platform – ECHO- and site level support.</li> <li>● Clinical mentors will provide site level support to NPD and doctors to optimize accurate diagnosis and management of AHD in line with WHO – recommended and PEPFAR-adopted package for AHD. Implement CQI initiatives to improve implementation of AHD package.</li> <li>● Optimize CD4 testing through site supervision, strengthening laboratory support i.e., functional machines, and reagents</li> </ul> </li> </ul>
<p>7) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and in implementation, but partially met.</li> <li>● <b>Status Update:</b> According to 2022 national program data, despite high coverage of HIV testing and enrolling HIV-infected pregnant women on life-long ART, early infant diagnosis (EID) coverage at 4-6 weeks remained low at 75%. Documented VL coverage for priority population is still suboptimal, however VL suppression is good at 98%. DNO activities are ongoing.</li> <li>● <b>COP23 Implementation activities:</b> EID continues to be a major area of focus for PEPFAR/B in FY23. The OU has now developed a real time dashboard using Power Bi to allow real time visualization of results and sample turnaround time.</li> <li>● <b>Data from the Lab shows that EID specimens are being tested and released well on time from the NDW dashboards, see table below (Figures 9.1 and 9.2).</b> However, there is still a gap in measuring the EID coverage. Therefore, in COP23 PEPBFAR/B will continue analytics using NDW data to be able to pair every EID test with an HIV+ woman who has delivered to be able to ensure that all HIV exposed infants are tested.</li> </ul>
<p><b>Prevention and OVC</b></p>	
<p>8) 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</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and in implementation.</li> <li>● <b>Status Update:</b> PrEP FY22 APR results show 138% of targeted clients (general populations) were initiated on PrEP and 113% of targeted KP clients were initiated on PrEP (Panorama). PrEP is currently provided to all populations at risk of HIV acquisition with exception of Prisoners. Beginning in COP22, PrEP will be made available to prisoners and other clients in closed settings.</li> </ul>

<p>partners of index cases, key populations and adult men engaged in high-risk sex practices)</p>	<ul style="list-style-type: none"> <li>● <b>COP23 Implementation Activities:</b> In COP 23, PEPFAR/B will actively scale up advocacy for updates to the national PrEP guidelines to include Cabotegravir Long-Acting Injectable PrEP and ensure an enabling environment for successful implementation. In addition, the OU will advocate for the inclusion of PEP in the national ART guidelines for HIV prevention.</li> </ul>
<p>8.1 Decentralized and differentiated service delivery models for PrEP with a focus on KP groups and AGYW</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and in implementation, but partially met.</li> <li>● <b>Status Update:</b> 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.</li> <li>● <b>COP23 Implementation Activities:</b> Continued support of PrEP DSD models for KP and AGYW</li> </ul>
<p>8.2 (COP22 PLL) PrEP should be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standards adopted and in implementation.</li> <li>● <b>Status Update:</b> Botswana has scaled up PrEP targets by almost 20% from COP22 targets – 14,708 targeted in COP23.</li> <li>● <b>COP23 Implementation Activities:</b> The government has endorsed integration of PrEP for PBFW into antenatal care (ANC), postnatal care, family planning, and other HIV prevention services. This integration will be done in a phased manner starting with PEPFAR supported sites. PEPFAR/B will continue to support phased integration across service delivery sites in COP23</li> </ul>
<p>9) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and in implementation.</li> <li>● <b>Status Update:</b> PEPFAR/B has long adopted this standard which has been applied to all the sites where PEPFAR/B is supporting OVC service delivery. The program will continue to offer the comprehensive program to the OVC and their families focusing on priority sub-populations which includes: <ul style="list-style-type: none"> <li>○ Children and adolescents living with HIV</li> <li>○ Survivors of sexual violence</li> <li>○ Children of HIV+ mothers and HIV+ caregivers</li> <li>○ Children of female sex workers</li> <li>○ HIV exposed infants</li> <li>○ Orphans</li> <li>○ 10–14-year-old boys and girls</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>• Community Service Providers (CSP's) support OVC beneficiaries and their families through case management where a package of services is offered. Within this package is the socio-economic interventions where building skills starts with basic financial literacy using Aflateen through the school-based program. Families of OVC are supported through the Women Empowered (WE) savings group model to ensure financial sustainability. This has also been seen to improve clinical outcomes for families as they are able to support themselves and focus more on adherence to HIV treatment and achieve viral suppression.</li> <li>• <b>COP23 Implementation Activities:</b> The program will continue to offer the comprehensive program to the OVC and their families, with continued focus on priority sub-populations</li> </ul>
<b>Policy &amp; Public Health Systems Support</b>	
<p>10) 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.</p>	<ul style="list-style-type: none"> <li>• <b>Implementation Status:</b> Core Standard adopted and in implementation, but partially met.</li> <li>• <b>Status Update:</b> The UNAIDS 2020 data on laws and policies scorecard, eastern and southern Africa, indicates that Botswana has removed 4/8 punitive laws scoring 50%. The laws and policies that still exist and limit HIV and AIDS response thus engraining inequality are, <ul style="list-style-type: none"> <li>• Laws that criminalize sex work- this could lead police harassment of sex worker and non-response to safety and security concerns for FSW especially when they experience abuse and violence. Members of LGBTIQ+ community who experience violence at home and social places are hard pressed when seeking justice.</li> <li>• Criminalization of possession of small amounts of drugs- this leads to police raids on drug houses that leading to PWID going underground thus fueling HIV transmission.</li> <li>• Laws that criminalize the transmission of non-disclosure of or exposure to HIV- this policy is still in the Botswana HIV policy. Many young people fear disclosure of HIV for fear of stigma but also fear that it could lead them not be recruited for employment in uniform services.</li> <li>• Policy requiring parental consent for adolescents to access HIV testing – this locks out several young persons that will require parental consent to</li> </ul> </li> </ul>

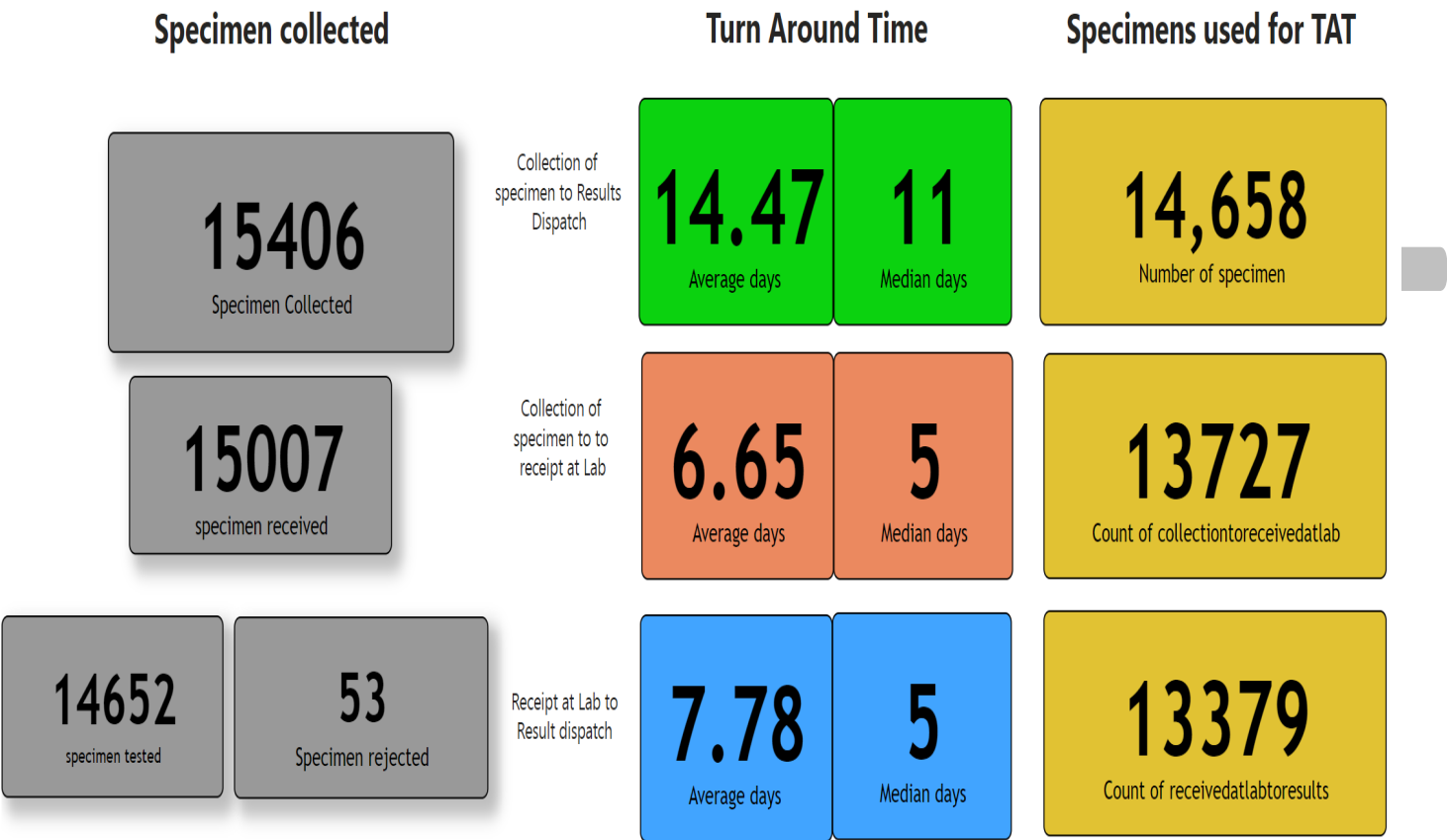
	<p>access HIV testing which is an entry point to prevention and treatment services.</p> <ul style="list-style-type: none"> <li>● <b>COP23 Implementation Activities:</b> Continued engagement with GOB and external stakeholders to advocate for policy changes advancing equity, human rights, and stigma and discrimination reduction.</li> </ul>
<p>11) 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.</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and completed.</li> <li>● <b>Status Update:</b> 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. Transition completed in COP 22 and non-citizens are part of the Botswana National ART Program.</li> <li>● <b>COP23 Implementation Activities:</b> Non-Applicable</li> </ul>
<p>12) <b>Integrate effective quality assurance (QA) and continuous quality improvement (CQI) practices into site and program management.</b> Program management must apply ongoing program and site standards assessment—including the consistent evaluation of site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including implementing partner agreements and work plans should align with national policy in support of Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core standard adopted and in implementation, at different levels national wide.</li> <li>● <b>Status Update:</b> Establishing 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 over time starting with sites within PEPFAR districts to the rest of the country in the next few years.</li> <li>● The core standard for Integrating effective QA and CQI practices into site and program management is ongoing and still not yet met. Implementation has been extended to the clinical mentorship sites and all PEPFAR supported sites both facility and community sites.</li> <li>● <b>COP23 Implementation Activities:</b> In our efforts to prompt CQI culture nationally, PEPFAR/B will continue to scale-up QA using the SIMS 4.2 tool and CQI to cover non-PEPFAR sites and support development of the national CQI strategic plan (which will guide the quality management implementation), trainings, supporting sites by monitoring quality indicators, engaging in quality improvement projects, and supporting learning collaboratives for sharing best practices to make sure quality care is sustained in-line with the clinical mentorship program countrywide. All PEPFAR /B IPs work plans are in support of the QA/QI interventions.</li> </ul>
<p>13) 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</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and in implementation, but partially met.</li> <li>● <b>Status Update:</b> U=U messaging is currently being implemented, but at interpersonal levels as a demand creation activity for viral load testing; U=U I provided during</li> </ul>

<p>U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.</p>	<p>adherence counselling sessions prior to the client starting treatment and during follow up visits to improve treatment literacy and viral load testing uptake at community and facility level. It is done by multidisciplinary teams, the clinicians and community health workers (who are in some instances Expert Clients) supporting PLHIVs on treatment. PEPFAR support is embedded into the TA provided to HCWs through Clinical training, Clinical Mentorship, and CHWs implementing the Positivity Health and Dignity Package for children and adults. Lastly, U=U is also discussed during PLHIV support group education and counselling sessions.</p> <ul style="list-style-type: none"> <li>● <b>COP23 Implementation Activities:</b> PEPFAR/B provision of TA to develop U = U messaging to upscale demand for viral load testing amongst all the sub populations.</li> </ul>
<p>14) 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</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and in implementation.</li> <li>● <b>Status Update:</b> To enhance local capacity for sustainable HIV response, PEPFAR/B directly funds a good number of CSOs/NGOs and GOB through MOH and NAHPA. Furthermore, in line with PEPFAR recommendations, PEPFAR/B increased funding to local partners across agencies between COP20-COP21. Selected KP-Led organizations are sub-partners to International Implementing Partners to be able to build their capacity for future direct funding from USG.</li> <li>● <b>COP23 Implementation Activities:</b> In FY24 &amp; FY25, Botswana plans to implement activities to establish and operationalize Social Contracting and Social Enterprise to enhance the sustainability of Local Partners especially CSOs.</li> </ul>
<p>15) Support coordinates efforts that enable GOB to take on increasing leadership and management of all aspects of the HIV response, including building program capacities and capabilities, financial planning, and demonstrable evidence of year after year increased resources expended</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and in implementation, but partially met.</li> <li>● <b>Status Update:</b> In COP22, PEPFAR prioritized the capacity strengthening of the MOH to steward the health sector. Capacity needs will be assessed, findings will be used to develop capacity strengthening plans that will be implemented in FY24 &amp; FY25. In COP22, Botswana is collaborating with UNAIDS and Global Fund with Coordination by NAHPA to conduct a Sustainability and Transition Readiness Assessment and to develop a Sustainability and Transition Plan/Roadmap</li> <li>● <b>COP23 Implementation Activities:</b> PEPFAR/B will support the implementation of the Sustainability and Transition Plan/Roadmap in FY24 &amp; FY25. For COP23 planning, PEPFAR/B engaged several times with the host government and other key</li> </ul>

	<p>stakeholders to prioritize programs and activities to be funded by PEPFAR for FY24 &amp; FY25</p>
<p>16) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and in implementation.</li> <li>● <b>Status Update:</b> In COP23, the morbidity and mortality surveillance will be implemented through additional analysis and coding of morbidity and mortality data at source. PEPFAR/B is working closely with GOB to start implementing ICD-11 which has been introduced lately by GOB. Furthermore, PEPFAR/B is supporting HRH (coders) who are seconded to the Health Statistics unit to strengthen the coding capacity.</li> <li>● <b>COP23 Implementation Activities:</b> Continued support of the use of ICD-11 for tracking of morbidity and mortality outcomes for PLHIV.</li> </ul>
<p>17) Scale-up of best practices for public health case surveillance and unique identifiers for patients across all sites.</p>	<ul style="list-style-type: none"> <li>● <b>Implementation Status:</b> Core Standard adopted and in implementation, but partially met.</li> <li>● <b>Status Updates:</b> Case Based surveillance (CBS) is implemented following an approved protocol. It is currently implemented at all facilities that submit data to the NDW using EMRS. These sites represent 85% of HIV data, nationally. To date, close to 346,000 unique records were identified in the NDW and their sentinel events tracked across the cascade. To further inform public health surveillance programming, PEPFAR/B is also implementing an approved protocol for recent infection surveillance. Additionally, PEPFAR/B is working with GOB to strengthen the morbidity and mortality surveillance. The CBS, recent infection surveillance and mortality datasets are being merged to further document trends of new infections as well as document final mortality outcomes for PLHIV as a CBS sentinel event.</li> <li>● <b>COP23 Implementation Activities:</b> PEPFAR/B will continue to work with the GOB MOH to strengthen HIS interoperability, consistent reporting, and data use for monitoring and evaluation. In FY24 &amp; FY25, PEPFAR/B will continue to support the utilization of case-based surveillance and facilitate data reporting from non-EMR sites, strengthen mortality surveillance and recency surveillance implementation. Additional data from Drug resistance surveillance (protocol recently approved in FY22) will bolster case surveillance sentinel events.</li> </ul>



**Figure 9.1: Early Infant Diagnosis Dashboard**



**Table 9.2: Baby Mother Pairing Dashboard Information**

<b>Table 9.2: Baby Mother Pairing Dashboard Information</b>					
<b>Delivery Facility</b>	<b>2022</b>			<b>Results</b>	
	<b>Live Births (HIV+)</b>	<b>Matched (Paired)</b>	<b>Proportion Paired</b>	<b>HIV Negative</b>	<b>HIV Positive</b>
Athlone Hospital	194	104	54%	104	0
Bamalete Lutheran Hospital	209	121	58%	121	0
Bobonong Primary Hospital	207	116	56%	116	0
Deborah Retief Memorial Hospital	270	131	49%	131	0
Gantsi Primary Hospital	142	56	39%	56	0
Good Hope Primary Hospital	82	46	56%	45	1
Gumare Primary Hospital	157	76	48%	76	0
Gweta Primary Hospital	64	32	50%	32	0
Hukuntsi Primary Hospital	62	27	44%	27	0
Kanye S.D.A Hospital	302	153	51%	153	0
Kasane Primary Hospital	83	62	75%	62	0
Lethakane Primary Hospital	158	73	46%	70	3
Letsholathebe II Memorial Hospital	326	138	42%	137	1
Mahalapye Hospital	445	251	56%	248	3
Masunga Primary Hospital	74	42	57%	42	0
Mmadinare Primary Hospital	69	43	62%	43	0
Nyangabgwe Referral Hospital	999	448	45%	447	1
Palapye Primary Hospital	366	206	56%	205	1

Princess Marina Referral Hospital	<b>501</b>	242	48%	240	2
Rakops Primary Hospital	<b>45</b>	24	53%	24	0
Scottish Livingstone Hospital	<b>619</b>	302	49%	302	0
Sefhare Primary Hospital	<b>120</b>	78	65%	78	0
Sekgoma Memorial Hospital	<b>504</b>	254	50%	253	1
Selibe Phikwe Government Hospital	<b>281</b>	165	59%	164	1
Thamaga Primary Hospital	<b>149</b>	87	58%	87	0
Tsabong Primary Hospital	<b>70</b>	35	50%	35	0
Tutume Primary Hospital	<b>236</b>	113	48%	113	0
<b>Total</b>	<b>6734</b>	<b>3425</b>	<b>51%</b>	<b>3411</b>	<b>14</b>

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# USG Operations and Staffing Plan to Achieve Stated Goals

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Over the past few years, the OU has had a decreased staffing footprint in country due to staff recruitment and retention challenges, as well as the lingering impact of COVID-19 on Peace Corps Volunteer in-country presence. The OU is focused on to right-sizing in-country staffing positions to fill key vacancies such as the PEPFAR Coordinator position, which has been vacant since March 2022, the Community Grants Coordinator position, who would support the CLM program and to right-size the Peace Corp Volunteer presence in Botswana. Other key vacancies, such as the Deputy Director for Health at USAID and the Deputy Branch Chief for CDC have been vacant for significant time.

Meanwhile, as the OU works to further build upon the country's recent HIV/AIDS programmatic gains, the OU has begun to transition from direct service delivery towards technical assistance. Hence, staffing needs across the OU have also had to be visited and adjusted to align with the many pivots in the OU's programmatic strategy as we work toward sustainability. The long-term staffing plans outlined below aim to support the OU's goal of right-sizing to align with our programmatic direction:

## **Long-term Vacant Positions:**

### **CDC**

As indicated above, CDC's staffing footprint is related to the OU's operational strategy. As the OU moves to a technical assistance platform to ensure sustainability of the 95-98-98 achievement, staffing has shifted. Staffing decisions were made using the PEPFAR 5x3 strategy.

CDC has two positions that have been vacant for more than 12-months.

One position for a Communications Specialist is currently undergoing the reclassification process. This position was included and approved in the COP22 SDS. CDC is awaiting the classification result from State Department's Regional Classification Center so that recruitment for this vacancy may begin. The repurposed Communication Specialist position has been an unmet need and approved as part of COP22. This position will work closely with other OU Communication Specialists and Public Diplomacy to monitor the Botswana communications related to PEPFAR programs and manage release of material to improve awareness.

Additionally, CDC's Strategic Information Deputy Branch Chief position has been vacant for more than 18 months. CDC has covered this position through details in FY23. Recruitment for this vacancy will take place in FY24. The backfilling of the Strategic Information (SI) Deputy Branch Chief position under recruitment will support availability of high-quality data for decision making COP, and other provide support to staff providing technical assistance for surveillance and monitoring and evaluation activities. SI is a core CDC function. This position will support data needs across the OU.

Another current vacancy for CDC is the Senior Lab Advisor. This position is currently under recruitment and is anticipated to be filled by the end of FY23. Backfilling the Senior Laboratory Advisor will ensure the CDC laboratory team has the capacity to provide technical assistance in line with PEPFAR 5x3 alignment, supporting integration of PEPFAR laboratory programs across

the Ministry of Health and Botswana Public Health Institute. Support for laboratory services is a core CDC function.

The Facilities Engineer is currently under recruitment and are anticipated to be filled by the end of FY23. The Facilities Engineer is supported by CDC but serves the facility needs of the interagency OU staff, including the PCO, USAID, State, and CDC. The Facilities Engineer position became vacant this year with the departure of the recently hired staff member.

### **Peace Corps**

Peace Corps Botswana will continue to scale program operations through the end of COP22 and into COP23, with 80% of onboard Volunteer strength expected to be restored by the end of COP23. In addition to this focus on scale, post leadership is presently focused on Volunteer effectiveness. Senior members of the programming team are engaged in a program review process to better align our service model with the overall needs of the Botswana Government. We expect that this may yield some changes to how we staff our program to support Volunteers, but the specific outcomes will depend on outputs of this analysis. In parallel, direct services and capacity building trainings will continue with communities on topics including prevention and youth empowerment.

### **STATE (PEPFAR Coordination Office):**

The PEPFAR Coordination Office currently has 4 vacant positions for i) PEPFAR Coordinator; ii) Communications Specialist; iii) Bilateral Health Specialist; and Community Grants Coordinator. These positions are all currently under recruitment and will be filled before the end of FY23. More information about each position is provided below:

1. PEPFAR Coordinator – This position has been vacant since March 2022. An individual has been identified to fill the position using the State LNA mechanism. The individual is currently undergoing security and medical clearance.
2. Communications Specialist – This position has been vacant for approximately 15 months. A local hire has accepted the position and is undergoing security and medical clearances. They are expected to start in Q3 FY23.
3. PEPFAR Community Grants Coordinator – This position has been vacant for approximately 18 months. An EFM accepted the position in November, but a lapse in an MOU between S/GAC and State/AF has prevented the further recruitment process. This has posed a significant challenge as the OU works to strengthen the CLM program to align with S/GAC guidance and PEPFAR Botswana needs.
4. Public Health Administrative Management Assistant (Bilateral Health Specialist) – This position has also been vacant for approximately 18 months. Similar to the Community Grants Coordinator position, a lapse in an MOU between S/GAC and State/AF has prevented further recruitment of the position.

### **USAID**

USAID has three vacant positions for i) Senior Adolescent and Youth Advisor; ii) Accountant; and iii) Senior HIV Advisor. These positions are all currently under recruitment and will be filled before the end of FY23. More information about each position is provided below:

1. Senior Adolescent and Youth Advisor - Following COP22 approval, USAID HQ identified a C3 (New Entry Foreign Service Officer) to fill the position. The individual was slated to

join the team during the summer of 2023 following completion of their foreign language training. Unfortunately, the identified candidate pulled out of this assignment. This was followed by assigning another C3 who also pulled out of the assignment. Because of this the agency reverted to engaging someone as a Personal Services Contractor (PSC). There have also been significant delays due to the need to obtain an NSDD-38 for this position. The NSDD-38 was approved in March 2023, and recruitment for this position through a PSC is currently ongoing.

2. Accountant - This local hire position was established in COP22. Recruitment for the position is active and should be filled before the end of FY23.
3. Senior HIV Advisor - The contract for this position ended in November 2022 and recruitment to find a suitable candidate took longer than expected. However, a candidate has been identified, and the offer has been accepted. The candidate is currently undergoing security and medical clearances; they are expected to assume duty before the end of FY23.

## **Proposed New Positions**

### **CDC**

1. District Level Technical Advisors (3) - In COP23/FY24 CDC will plan to recruit three additional technical staff to be embedded with the MOH at district level. This is part of CDC's overarching strategy to shift from DSD to TA. This plan includes embedding technical staff within key offices of the MOH to build technical capacity and improve efficiencies with the CDC GOB CoAg. The need for the three District Level Technical Advisors was identified through strategic planning and identification of gaps or deficiencies in the current program, with input from the Government of Botswana, as part of our pivot from direct service provision to technical assistance. Staff to complete the work at the central and district level was not sufficient. The GOB is in favor of these new district level positions as they will offer enhanced technical assistance for the Mentorship Program, use of data for decision making, organizational capacity building at the DHMT level, and CoAg efficiencies. The staff will, support Pillar 2 and Pillar 3 focus areas, provide technical assistance at the district level, support program at the district level as applicable per COP23, and support mentorship and QA (SIMS)/QI activities. In COP23 the Mentorship Program is intended to include 8 new districts in addition to the 19 already PEPFAR supported hence the need for more technical assistance. The baseline level of effort for these positions, and the effect on other CDC positions, will be closely monitored to adjust staffing needs in the future, as we complete the pivot to a technical assistance model. These positions will be cost effective, with expected decreases in local travel expenses currently required for program manager travel to districts for program support, mentorship, and SIMS activities. As these are newly proposed positions, each position will need to undergo the classification process through State Department's Regional Classification Center. The start date for these new positions is anticipated to be no earlier than Q3 FY24.

## Peace Corps

1. Driver - Peace Corps has proposed adding one driver to our staffing level for COP23. This addition will support Peace Corps/Botswana's renewed focus on rural site placements for Volunteers. It also reflects a focus on staff welfare and safety as we transition away from a predominantly self-drive program to one supported more by a staff of professional drivers. This position will be hired locally.
2. Communications Specialist - The Peace Corps proposes repurposing an existing local position that will not impact the overall staffing footprint for the purposes of strengthening Peace Corps Mission Messaging and expanding our impact. The repurposed Peace Corps position will serve as the locally-employed communications specialist to Peace Corps Botswana team. This position will work closely with the Public Affairs office within the US Embassy and the PEPFAR/B Coordinator's office to ensure accurate and useful information about Peace Corps' work is communicated with the public. This position will also work closely with Peace Corps Washington to ensure all Peace Corps policies are followed in official communication. The position will be responsible for advising the Country Director on the host country communication environment and the best positioning Peace Corps to support Botswana's vision for public health awareness raising and advancement.
3. Program Review - In addition to the above changes, Peace Corps Botswana is presently engaged in a thorough program review to better understand how our Agency's offering aligns with the Government of Botswana. It is expected that there may be staffing changes as a result of this review, but the exact outcomes are uncertain. Through this process, Peace Corps may identify positions which should be modified, or repurposed. Any staffing changes proposed will be headcount and budget neutral.

## USAID

1. Orphans and Vulnerable Children (OVC) Specialist - USAID is the main implementer of the OVC portfolio in PEPFAR/B. The OVC portfolio contributes a substantial amount of financial resources to USAID/PEPFAR. Until COP19, USAID had a full time OVC Specialist who was promoted to the position of Deputy Director and this position was never filled as the Deputy Director continued to provide technical leadership to the OVC portfolio. In recent times, USAID's OVC technical leadership has been divided between the Deputy Director and a OVC Strategic Information (SI) Advisor. While the SI Advisor is somewhat knowledgeable about the program, they have limited technical knowledge and they are already stretched in their SI responsibilities. Due to USAID's limited footprint (20), efforts to distribute responsibilities of the OVC Advisor among existing staff have not been successful as explained above. It has also not been possible to repurpose any position to carry out these responsibilities as all positions are currently relevant in the new, just reimagined PEPFAR and every position is overstretched. It has become critical to bring in a new person to fully take on the responsibilities of the OVC portfolio; this will be a local hire to take on a position that has been vacant for more than four years. There are specific activities that require a specific OVC Advisor on a daily basis. Examples of these activities include; serving in the PEPFAR relevant technical working groups (TWGs), serving & representing PEPFAR in the national relevant TWGs, day to day partner management and providing technical support to the implementing partners to ensure that their

implementation is aligned to their approved work plans, conducting site visits and SIMS on time, serving as Agreement/Contracting Officer Representative (A/COR), reviewing partner quarterly reports and tracking their performance against their targets, developing slides for certain critical points in the life of PEPFAR such as during COP, POARTs, and most importantly engaging closely with the host government ministries and departments that work to deliver on the mandate of the OVC portfolio. With COP23, USAID will expand its engagement in this space under both the OVC and DREAMS portfolios.

**Major changes to CODB:**

As part of the COP23 process, PEPFAR/B examined its interagency staffing footprint and organizational structures. The staffing profile reflects cross-cutting technical support to the priority COP22 strategies. The overall Botswana CODB in COP22 increased by 3.6% from COP22. The increase was mainly due to proposed increases from USAID and CDC. The staffing profile reflects cross-cutting technical support to the priority COP23 strategies (Table 3 below).

**Table 3: CODB by Agency**

<b>CODB by Agency</b>			
<b>Agency</b>	<b>CODB COP22 Total</b>	<b>CODB COP23 Total</b>	<b>Difference</b>
<b>Totals</b>	\$13,938,678	\$14,451,045	<b>\$512,367</b>
<b>HHS/CDC</b>	\$6,302,280	\$ 6,386,961	<b>\$84,681</b>
<b>PC</b>	\$2,964,944	\$ 2,964,944	<b>\$0</b>
<b>State</b>	\$629,890	\$ 136,844	<b>(\$493,046)</b>
<b>State/AF</b>	\$0	\$ 493,046	<b>\$493,046</b>
<b>USAID</b>	\$4,041,564	\$ 4,469,250	<b>\$427,686</b>

**CDC**

As part of the COP23 process, PEPFAR/B examined its interagency staffing footprint and organizational structures.

CDC is planning a marginal increase to COP23 CODB compared 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 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 COP23 due to the age of the facility and increasing maintenance requests. Additionally, CDC anticipates some construction related costs may be incurred in COP23 as a result of an extended timeline to complete installation of new exterior doors for Buildings A and B 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.

**State (PEPFAR Coordination Office)**

State's CODB has remained flat from COP22 to COP23.

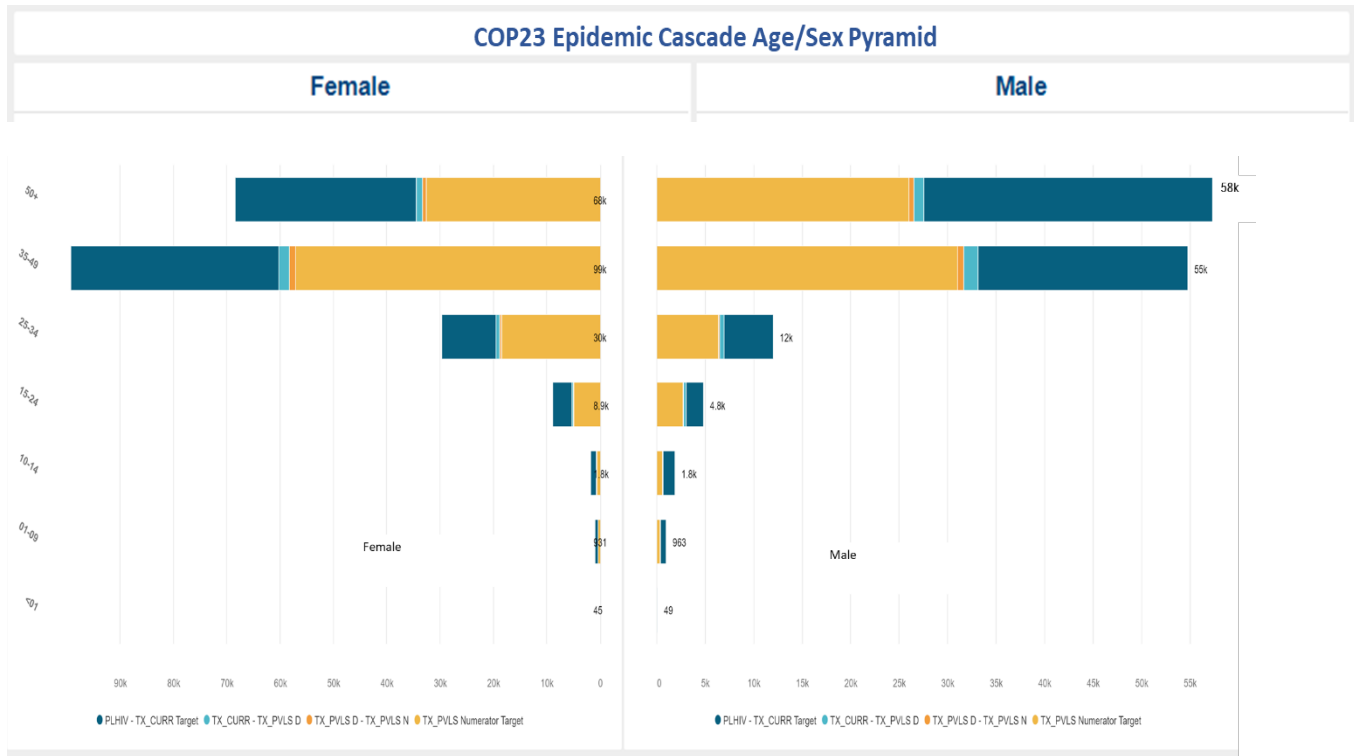
**USAID**

In COP23, USAID's cost of doing business will increase from \$4,041,564 to \$4,469,250. The reason for this increase is attributed to: i) proposed one local hire; ii) ICASS increased from \$514,601 to \$748,848 to align with the current costs; iii) Increase in both program travel and training costs after budget cut in previous years due to COVID travel restrictions.

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# APPENDIX A -- PRIORITIZATION

Figure A.1 COP23 Epidemic Control Cascade Age/Sex Pyramid.



Note: Number scales may not align across the female and male visuals.



# APPENDIX B – Budget Profile and Resource Projections

Table B.1.1: COP22, COP23/FY 24, COP 23/FY25 Budget by Intervention

Operating Unit	Country	Intervention	Budget		
			2023	2024	2025
<b>Total</b>			<b>\$60,355,679</b>	<b>\$57,641,428</b>	<b>\$54,471,001</b>
Botswana	<b>Total</b>		<b>\$60,355,679</b>	<b>\$57,641,428</b>	<b>\$54,471,001</b>
	Botswana	ASP>HMS, surveillance, & research>Non Service Delivery>Military	\$11,550		
		ASP>HMS, surveillance, & research>Non Service Delivery>Non-Targeted Populations	\$2,371,618		
		ASP>Health Management Information Systems (HMS)>Non Service Delivery>AGYW		\$116,250	\$109,856
		ASP>Health Management Information Systems (HMS)>Non Service Delivery>Non-Targeted Populations		\$2,232,672	\$2,109,869
		ASP>Health Management Information Systems (HMS)>Non Service Delivery>OVC		\$255,000	\$240,974
		ASP>Human resources for health>Non Service Delivery>Non-Targeted Populations	\$382,500	\$550,000	\$519,749
		ASP>Laboratory systems strengthening>Non Service Delivery>Non-Targeted Populations	\$703,600	\$602,020	\$568,907
		ASP>Laws, regulations & policy environment>Non Service Delivery>OVC		\$64,000	\$60,480
		ASP>Management of Disease Control Programs>Non Service Delivery>Non-Targeted Populations		\$1,221,996	\$1,154,783
		ASP>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	\$60,000		
		ASP>Procurement & supply chain management>Non Service Delivery>Non-Targeted Populations	\$525,000	\$712,500	\$673,311
		ASP>Public financial management strengthening>Non Service Delivery>Non-Targeted Populations	\$548,750	\$550,000	\$519,749
		ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Key Populations		\$70,000	\$66,150
		ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Non-Targeted Populations		\$1,040,047	\$982,842
		C&T>HIV Clinical Services>Non Service Delivery>AGYW	\$319,995	\$144,500	\$136,552
		C&T>HIV Clinical Services>Non Service Delivery>Children	\$511,000	\$692,450	\$654,364
		C&T>HIV Clinical Services>Non Service Delivery>Key Populations	\$542,650	\$516,510	\$488,100
		C&T>HIV Clinical Services>Non Service Delivery>Non-Targeted Populations	\$2,861,703	\$5,678,322	\$5,365,999
		C&T>HIV Clinical Services>Service Delivery>AGYW	\$56,000		
		C&T>HIV Clinical Services>Service Delivery>Children	\$105,000	\$80,000	\$75,600
		C&T>HIV Clinical Services>Service Delivery>Key Populations	\$280,291	\$770,619	\$728,232
		C&T>HIV Clinical Services>Service Delivery>Non-Targeted Populations	\$2,813,330	\$2,775,891	\$2,623,210
		C&T>HIV Clinical Services>Service Delivery>Pregnant & Breastfeeding Women		\$525,571	\$496,663
		C&T>HIV Drugs>Service Delivery>Non-Targeted Populations	\$180,000		
		C&T>HIV Laboratory Services>Non Service Delivery>Children		\$57,000	\$53,865
		C&T>HIV Laboratory Services>Non Service Delivery>Military	\$69,300		
		C&T>HIV Laboratory Services>Non Service Delivery>Non-Targeted Populations	\$1,334,300	\$1,337,478	\$1,263,914
		C&T>HIV Laboratory Services>Service Delivery>Non-Targeted Populations	\$90,000	\$78,789	\$74,455
		C&T>HIV/MTB>Non Service Delivery>Non-Targeted Populations		\$498,820	\$471,384
		C&T>HIV/MTB>Service Delivery>Non-Targeted Populations		\$323,826	\$306,015
		C&T>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	\$3,170,662		
		HTS>Community-based testing>Non Service Delivery>Key Populations	\$175,676	\$116,892	\$110,463
		HTS>Community-based testing>Non Service Delivery>Non-Targeted Populations	\$32,437	\$42,000	\$39,690
		HTS>Community-based testing>Service Delivery>Key Populations		\$141,739	\$133,943
		HTS>Community-based testing>Service Delivery>Non-Targeted Populations	\$249,329	\$457,298	\$432,145
		HTS>Facility-based testing>Non Service Delivery>Children		\$153,016	\$144,600
		HTS>Facility-based testing>Non Service Delivery>Non-Targeted Populations	\$355,001	\$1,292,110	\$1,221,041
		HTS>Facility-based testing>Service Delivery>Non-Targeted Populations	\$2,282,950	\$1,616,272	\$1,527,373
		HTS>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	\$550,713		
		HTS>Not Disaggregated>Service Delivery>Non-Targeted Populations	\$70,000		
		PM>IM Closeout costs>Non Service Delivery>AGYW		\$200,000	\$188,999
		PM>IM Closeout costs>Non Service Delivery>Non-Targeted Populations	\$21,500	\$50,000	\$47,250
		PM>IM Program Management>Non Service Delivery>AGYW	\$3,865,969	\$2,112,100	\$1,995,928
		PM>IM Program Management>Non Service Delivery>Non-Targeted Populations	\$7,002,095	\$5,948,245	\$5,621,076
		PM>IM Program Management>Non Service Delivery>OVC	\$128,972	\$360,889	\$341,040
		PM>USG Program Management>Non Service Delivery>AGYW	\$878,244	\$94,792	\$89,578
		PM>USG Program Management>Non Service Delivery>Non-Targeted Populations	\$8,484,007	\$8,905,544	\$8,415,718
		PM>USG Program Management>Non Service Delivery>OVC	\$970,231	\$1,170,231	\$1,105,865
		PREV>Condom & Lubricant Programming>Non Service Delivery>Key Populations		\$13,000	\$12,285
		PREV>Non-Biomedical HIV Prevention>Non Service Delivery>Key Populations		\$131,726	\$124,481
		PREV>Non-Biomedical HIV Prevention>Service Delivery>Key Populations		\$247,340	\$233,736
		PREV>Not Disaggregated>Non Service Delivery>AGYW	\$1,451,218	\$2,666,142	\$2,519,497
		PREV>Not Disaggregated>Non Service Delivery>Non-Targeted Populations		\$473,805	\$447,744
		PREV>Not Disaggregated>Service Delivery>AGYW	\$642,179	\$272,500	\$257,511
		PREV>Not Disaggregated>Service Delivery>Non-Targeted Populations		\$292,696	\$276,597
		PREV>Not Disaggregated>Service Delivery>OVC		\$120,000	\$113,400
		PREV>PrEP>Non Service Delivery>AGYW	\$350,000	\$80,000	\$75,600
		PREV>PrEP>Non Service Delivery>Military	\$23,100		
		PREV>PrEP>Service Delivery>AGYW	\$397,250	\$447,500	\$422,886
		PREV>PrEP>Service Delivery>Key Populations	\$161,792	\$212,404	\$200,721
		PREV>PrEP>Service Delivery>Non-Targeted Populations	\$387,800	\$645,293	\$609,800
		PREV>VMMC>Non Service Delivery>Military	\$69,300		
		PREV>VMMC>Non Service Delivery>Non-Targeted Populations		\$105,742	\$99,926
		PREV>VMMC>Service Delivery>Non-Targeted Populations	\$1,260,000	\$1,368,000	\$1,292,756
		PREV>Violence Prevention and Response>Non Service Delivery>AGYW		\$1,240,000	\$1,171,797
		PREV>Violence Prevention and Response>Service Delivery>AGYW		\$247,500	\$233,886
		PREV>Violence Prevention and Response>Service Delivery>Key Populations		\$146,913	\$138,832
		PREV>Violence Prevention and Response>Service Delivery>OVC		\$2,289,739	\$2,163,798
		SE>Case Management>Non Service Delivery>OVC		\$460,000	\$434,699
		SE>Case Management>Service Delivery>Key Populations		\$190,000	\$179,550
		SE>Case Management>Service Delivery>OVC	\$639,472	\$358,000	\$338,309
		SE>Economic strengthening>Non Service Delivery>AGYW		\$302,574	\$285,932
		SE>Economic strengthening>Service Delivery>AGYW	\$1,850,000	\$1,050,000	\$992,247
		SE>Economic strengthening>Service Delivery>OVC		\$49,700	\$46,966
		SE>Education assistance>Non Service Delivery>AGYW		\$329,591	\$311,463
		SE>Education assistance>Service Delivery>OVC	\$80,000		
		SE>Psychosocial support>Non Service Delivery>AGYW		\$302,574	\$285,932
		SE>Psychosocial support>Service Delivery>OVC	\$120,500	\$43,300	\$40,918
			\$10,918,695		

**Table B.1.2: COP22, COP23/FY 24, COP 23/FY25 Budget by Program Area**

Operating Unit	Country	Program	Budget		
			2023	2024	2025
<b>Total</b>			<b>\$60,355,679</b>	<b>\$57,641,428</b>	<b>\$54,471,001</b>
Botswana	<b>Total</b>		<b>\$60,355,679</b>	<b>\$57,641,428</b>	<b>\$54,471,001</b>
	Botswana	C&T	\$13,241,857	\$13,479,776	\$12,738,353
		HTS	\$3,873,725	\$3,819,327	\$3,609,255
		PREV	\$8,920,379	\$11,000,300	\$10,395,253
		SE	\$6,545,332	\$3,085,739	\$2,916,016
		ASP	\$6,423,368	\$7,414,485	\$7,006,670
		PM	\$21,351,018	\$18,841,801	\$17,805,454

**Table B.1.3: COP22, COP23/FY 24, COP 23/FY25 Budget by Beneficiary**

Operating Unit	Country	Targeted Beneficiary	Budget		
			2023	2024	2025
<b>Total</b>			<b>\$60,355,679</b>	<b>\$57,641,428</b>	<b>\$54,471,001</b>
Botswana	<b>Total</b>		<b>\$60,355,679</b>	<b>\$57,641,428</b>	<b>\$54,471,001</b>
	Botswana	AGYW	\$17,224,007	\$9,606,023	\$9,077,664
		Children	\$847,000	\$982,466	\$928,429
		Key Populations	\$2,608,922	\$2,557,143	\$2,416,493
		Military	\$173,250		
		Non-Targeted Populations	\$37,402,825	\$38,799,366	\$36,665,303
		OVC	\$2,099,675	\$5,170,859	\$4,886,449
		Pregnant & Breastfeeding Women		\$525,571	\$496,663

**Table B.1.4: COP22, COP23/FY 24, COP 23/FY25 Budget by Initiative**

Operating Unit	Country	Initiative Name	Budget		
			2023	2024	2025
<b>Total</b>			<b>\$60,355,679</b>	<b>\$57,641,428</b>	<b>\$54,471,001</b>
Botswana	<b>Total</b>		<b>\$60,355,679</b>	<b>\$57,641,428</b>	<b>\$54,471,001</b>
	Botswana	Cervical Cancer	\$1,000,000	\$1,162,945	\$1,098,981
		Community-Led Monitoring	\$400,000	\$527,500	\$498,486
		Core Program	\$35,039,365	\$38,037,603	\$35,945,437
		DREAMS	\$19,145,542	\$12,324,464	\$11,646,586
		OVC (Non-DREAMS)	\$1,000,472	\$2,371,374	\$2,240,942
		Surveillance and Public Health Response	\$1,384,000	\$884,800	\$836,134
		USAID Southern Africa Regional Platform	\$517,000	\$517,000	\$488,564
		VMMC	\$1,869,300	\$1,815,742	\$1,715,871

## B.2 Resource Projections

In alignment with OGAC's "Reimagining PEPFAR", the COP23 planning process was very different than previous years. While the Country Team maintained a strong focus on evidence-based decision making and data sources such as the BIAS V, this year also included a more inclusive planning process with increased stakeholder engagement. Through numerous Stakeholder Engagement meetings including the Johannesburg COP23 Co-Planning meeting, PEPFAR Botswana outlined a new set of priorities for COP23 in line with the objective to focus on equity for all populations, close the remaining gaps for achieving HIV epidemic control, and to maintain the gains the country has made in surpassing the 95:95:95 goals.

Notably, PEPFAR Botswana received a 5% reduction in total funding for the OU in COP23 year 1 and another 5% reduction in year 2. This forced the OU to find efficiencies within current programming as well as reprioritize certain program areas to align with the new funding level as well as priorities expressed by the GOB and CSOs.

For the first time in COP23 the PLL established agency level budgets at the outset of the process. This helped to alleviate some interagency tensions in the OU. All agencies reviewed programming in line with PEPFAR's 5x3 strategic pillars and GOB priorities and were used to contribute to the OU's COP23 programming.

As another significant change, the Botswana COP23 PLL removed some of the previous budget controls such as the DREAMS initiative. In recognition of Botswana's outstanding progress and surpassing the UNAIDS 95:95:95 goals, greater flexibility was assigned to the OU to program resources to address the remaining gaps in HIV epidemic control, improve equity, and focus on long-term sustainability of the program. One example of this was the absence of the DREAMS Initiative control in the COP23 PLL. Programming and funding for DREAMS activities that are in line with the OVC earmark were still included despite the absence of an explicit budget requirement, but the OU did reduce planned DREAMS initiative funding from \$19.1M in COP22 to \$12.3M in COP23. Even in a reduced budget environment, this allowed flexibility to the OU to increase planned funding for other areas of Prevention program funding (non-DREAMS) from \$8.9M in COP22 to \$11M in COP23. In response to priorities from Stakeholders, prevention activities will expand in COP23 to include additional focus on Adolescent Boys and Young Men, Key Populations, and improved accessibility of PrEP. Other funding shifts in COP23 across program areas include additional funding for Above-Site Programs.

Together, these shifts are in response to stakeholder input as well as position the OU well for long-term sustainability of the of the gains made in the program.

## APPENDIX C – Above site and Systems Investments from PASIT

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Country teams will report on their PASIT investment strategy, addressing the following points: Not all the activities could be funded due to budget deficiencies. The OU discussions over the funding, included identifying the gaps and remediation activities. These activities were prioritized with input from the stakeholders (government across different ministries, WHO, UNAIDS, CSO & representatives of priority groups) to finally end up with a prioritized list of activities to fund.

Different gaps across program areas continue to be identified through utilization of auditing/ monitoring tool such as SIMS. The key system gaps that exist include HCW skills, lack of policies and guidelines, lack of structures to coordinate outbreak response, inadequate data for program management, lack of data to guide decisions, and suboptimal service delivery, these deficiencies are addressed in the PASIT through investments in HRH (systems, deployment, and skills training), laboratory, supply chain management, Data systems, surveys and surveillance systems. Public health institute and health security is also a new area that most countries are trying to start off including Botswana and it is also addressed in the PASIT. Continuous quality improvement is also a new concept that still needs work on for integration into service delivery.

Government of Botswana funds almost 70% of the response while PEPFAR and other funders fund less than 30%. The decision on the areas of funding is made after intensive consultation of all stakeholders including government and other funders such as global fund. Most of the PASIT investments are to do with areas that the host country may not be funding initially but are needed to be functional to reach epidemic control and to sustain the country. Examples of these include new innovations that the host country may still be lacking expertise in such as new surveys/ research to inform public health response. New technologies that may need to be started off by PEPFAR and transferred to the host country. New commodities that may be beneficial to PLHIV and are being used in other countries. New guidelines and guidance that PEPFAR due to its global footprint may be aware off and having the technical expertise on it while the host government is still challenged in its development and implementation. All PASIT investments have timelines, benchmarks and outcomes defined to support monitoring of progress. Digital investments made, address systems gaps that include manual capturing of data at site, lack of electronic systems, low reporting rates, low utilization of systems, long results turnaround time, issues with system interoperability, and low reporting rates. The investments include support for:

- The national data warehouse
- Data entry
- Inter-operability

The indications that the system is functioning will be seen from achievement of the set milestones for each system investment as well as results from system monitoring through the following as is applicable.

- SIMS scores
- MER indicator performance
- Other audit scores (VL/EID score card, SLIPTA scores, SPI-RT)

**Table C.1 Above Site Investments in the COP23 PASIT**

<b>Funding Agency</b>	<b>Sub-Program Area</b>	<b>Activity Category</b>	<b>COP 23 Beneficiary</b>	<b>Unique Activity Title</b>	<b>Short Activity Description</b>	<b>Gap Activity Will Address</b>	<b>Activity Budget</b>
USAID/WCF	ASP: Procurement & supply chain management	Forecasting, supply chain plan, budget, and implementation	Non-Targeted Populations	Supply Chain Management	Provision of technical assistance and capacity building in the areas of forecasting and supply planning; data visibility, quality and use in effective procurement; contract and supplier relations management and electronic contract management system in CMS	Lack of data visibility for SCM	\$712,500
USAID	ASP: Surveys, Surveillance, Research, and Evaluation (SRE)	Surveys	Key Populations	IBBSS III implementation	Conduct and disseminate an estimation of the population size and assess progress toward reaching 95-95-95 among FSW, MSM, and TG people in Gaborone	Lack of recent HIV data & risk behaviours	\$70,000
USAID	ASP: Human resources for health	HRH planning, management and governance	Non-Targeted Populations	Health System Strengthening	Development & implementation of a National HRH Strategic plan, and establishment & operationalization of HRHIS at MOH to improve HRH Planning & Management	Insufficient & inequitable distribution of HRH	\$550,000
USAID	ASP: Public financial management strengthening	Technical and allocative efficiencies	Non-Targeted Populations	Health System Strengthening	Conduct baseline diagnostics and use findings to develop an operational plan that will be implemented by the MOH and MOFD to strengthen public financial management for efficient allocation, utilization & management of HIV funds	Technical & allocative inefficiency	\$550,000
USAID	ASP: Management of disease control programs	Oversight, technical assistance, and supervision to subnational levels	Non-Targeted Populations	Resilient Community Platforms	Integration of HIV with PHC & mainstream community health activities into health care delivery at national and sub-national levels	Weak PHC & community structures for HIV & health	\$240,627
USAID	ASP: Management of disease control programs	Oversight, technical assistance, and supervision to subnational levels	Non-Targeted Populations	Resilient Community Platforms	Integration of HIV with PHC & mainstream community health activities into health care delivery at national and sub-national levels	Weak PHC & community structures for HIV & health	\$246,000

HHS/CDC	ASP: Health Management Information Systems (HMIS)	Systems development, operations, and maintenance	Non-Targeted Populations	EMR and HIMS support	Support the Government with the management of HIE platform to ensure timely Lab data exchange between EMRs	Delayed turn around time of patient lab results	\$175,000
HHS/CDC	ASP: Surveys, Surveillance, Research, and Evaluation (SRE)	Surveillance	Non-Targeted Populations	Support for BPHI positions	Support the hiring of Surveillance staff for BPHI operationalization readying them to be transitioned to Government	Skilled staff shortages at the BPHI	\$101,200
HHS/CDC	ASP: Laboratory systems strengthening	Lab quality improvement and assurance	Non-Targeted Populations	Lab support for BPHI	Support for lab trainings for BPHI staff who are implementing the Public Health Lab functions pillar	sub optimal capacity of staff on NPHL functions	\$125,120
HHS/CDC	ASP: Management of disease control programs	Oversight, technical assistance, and supervision to subnational levels	Non-Targeted Populations	QMS & CQI position support	Support for positions and activities related to implementation & accreditation of quality services for HIV programming	lack of skilled staff on CQI and QMS	\$547,869
HHS/CDC	ASP: Health Management Information Systems (HMIS)	Systems development, operations, and maintenance	Non-Targeted Populations	M&E Specialist	HRH support to the M&E department through the hiring of an officer to support the Government on M&E related functions to facilitate adherence to timely reporting of PEPFAR related requirements(e.g data alignment)	Lack of skilled M&E staff at HQ	\$40,000
HHS/CDC	ASP: Surveys, Surveillance, Research, and Evaluation (SRE)	Surveillance	Non-Targeted Populations	Recent infection surveillance	Support the roll out of recent infection surveillance activities to more sites	Limited coverage of recent infection surveillance	\$200,000
HHS/CDC	ASP: Surveys, Surveillance, Research, and Evaluation (SRE)	Surveillance	Non-Targeted Populations	Data management for Drug Resistance	support for data management activities for drug resistance surveillance, including the ability to merge the DR data with the CBS for completing the DR sentinel event.	Missing DR information on CBS data sets	\$24,000
HHS/CDC	ASP: Health Management Information Systems (HMIS)	Workforce training in systems or processes	Non-Targeted Populations	Mentorship	National SI mentorship	The current mentorship is limited to clinical	\$160,000
HHS/CDC	ASP: Health Management Information Systems (HMIS)	Workforce training in systems or processes	Non-Targeted Populations	Tracking of morbidity and mortality	support the hiring and training of HRH for coding patient outcomes (Morbidity and mortality) using the newly endorsed ICD11	Lack of trained staff in the use of ICD	\$86,400



HHS/CDC	ASP: Surveys, Surveillance, Research, and Evaluation (SRE)	Surveillance	Non-Targeted Populations	IBBSS data analysis	Support the IBBSS secondary data analysis to respond to additional programming initiatives	additional programming data needs	\$34,000
HHS/CDC	ASP: Surveys, Surveillance, Research, and Evaluation (SRE)	Surveillance	Non-Targeted Populations	Case Based Surveillance	Strengthen HIV case-based surveillance (CBS) for tracking of outcomes for uniquely identified HIV positive individuals from point of diagnosis to final outcome across the cascade	lack of updated patient level data for programming	\$123,600
HHS/CDC	ASP: Surveys, Surveillance, Research, and Evaluation (SRE)	Surveillance	Non-Targeted Populations	BAIS V Secondary data analysis	To support the Government with additional data analysis of BAIS V dataset in responding to additional programming initiatives that could not be answered by the published study results	limited knowledge based on available results	\$34,000
HHS/CDC	ASP: Health Management Information Systems (HMIS)	Systems development, operations, and maintenance	Non-Targeted Populations	EMR support	To provide technical assistance for system and user support to ensure the utilization of EMRs in providing services across the service delivery points	sub optimal utilization of EMR	\$397,128
HHS/CDC	ASP: Health Management Information Systems (HMIS)	Systems development, operations, and maintenance	Non-Targeted Populations	Open MRS support	To support the roll out of Open MRS to all eligible facilities (which are on the GDN or have internet connectivity)	Delayed patient level data flow	\$315,335
HHS/CDC	ASP: Surveys, Surveillance, Research, and Evaluation (SRE)	Surveillance	Non-Targeted Populations	FETP training	Support the Government in the implementation of FETPs to enhance the capacities of health workers to respond to outbreaks, ability to analyse data and detect diseases of public health threats through the lense of integration of services	suboptimal numbers of HCW trained in FETP	\$368,000
HHS/CDC	ASP: Health Management Information Systems (HMIS)	Systems development, operations, and maintenance	Non-Targeted Populations	Support for NDW	support the positions for NDW management and data analytics to ensure timely processing and analysis of data in the repository	lack of skilled HRH for NDW	\$177,600
HHS/CDC	ASP: Health Management Information Systems (HMIS)	Systems development, operations, and maintenance	Non-Targeted Populations	District Data centers support	support the establishment of data centers to facilitate district based M&E capacities to collect, analyze and respond timely to any data needs and programming from their data.	lack of data mgt at district levels	\$124,000

HHS/CDC	ASP: Laboratory systems strengthening	Laboratory infrastructure and equipment management systems	Non-Targeted Populations	Lab optimization	Support lab optimization for VL, EID, TB and other co-infections through conducting diagnostic networks	delayed transmission from lab analysers to EMRS	\$120,000
HHS/CDC	ASP: Laboratory systems strengthening	Laboratory information systems	Non-Targeted Populations	lab clinic interface	Support Lab equipment interface and lab nodes to reduce the TAT for lab results	delayed results from the lab to the clients	\$260,000
HHS/CDC	ASP: Health Management Information Systems (HMIS)	Systems development, operations, and maintenance	Non-Targeted Populations	Data transmission	Provide support to coordinate EMR system utilization through HRH and support procurement of mobile data for PIMS transmission to the National Data Warehouse and sms reminders to clients	delayed transmission from sites outside GDN	\$41,468
HHS/CDC	ASP: Surveys, Surveillance, Research, and Evaluation (SRE)	Surveillance	Non-Targeted Populations	Clinical service competencies	Clinical services competencies - support evidence generation for clinical services, outbreak response and management, logistics	delayed response to outbreaks by clinicians	\$35,247
HHS/CDC	ASP: Laboratory systems strengthening	Laboratory policy , budgets, and strategic plans	Non-Targeted Populations	Lab policy and strategy	Finalization of lab policy and implementation of lab strategic plan	lack of policy guiding diagnostics	\$96,900
HHS/CDC	ASP: Health Management Information Systems (HMIS)	Strategic planning, policy, and governance support	Non-Targeted Populations	management and Operations	Funding towards program staff travel to monitor program implementation	monitoring of PEPFAR investments	\$95,269
HHS/CDC	ASP: Health Management Information Systems (HMIS)	Strategic planning, policy, and governance support	Non-Targeted Populations	management and Operations	Funding towards internationally recruited USG staff salaries and benefits	lack of USG international hires	\$81,536
HHS/CDC	ASP: Health Management Information Systems (HMIS)	Strategic planning, policy, and governance support	Non-Targeted Populations	management and Operations	Funding towards locally recruited USG staff salaries and benefits	lack of LES recruited staff	\$55,561
USAID	ASP: Laws, regulations & policy environment	Assessing impact of policies and regulations on HIV	Key Populations	Comprehensive Drop in Centers	Develop legal and policy frameworks to facilitate the registration and accreditation of comprehensive DICs as one-stop-shops to expand availability of KP competent & supportive services to KPs by KP-led organizations	DICs not accredited to offer KP clinical services	\$400,000

# APPENDIX D –Visual Resources

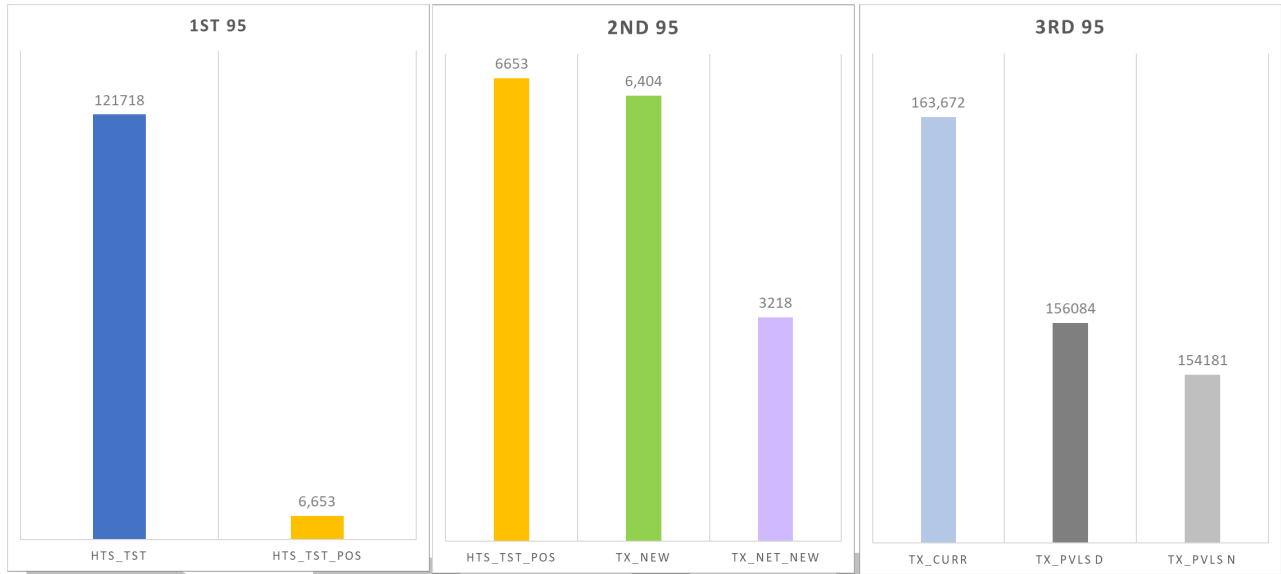


Figure D.1: Overview of 95/95/95 Cascade, FY23

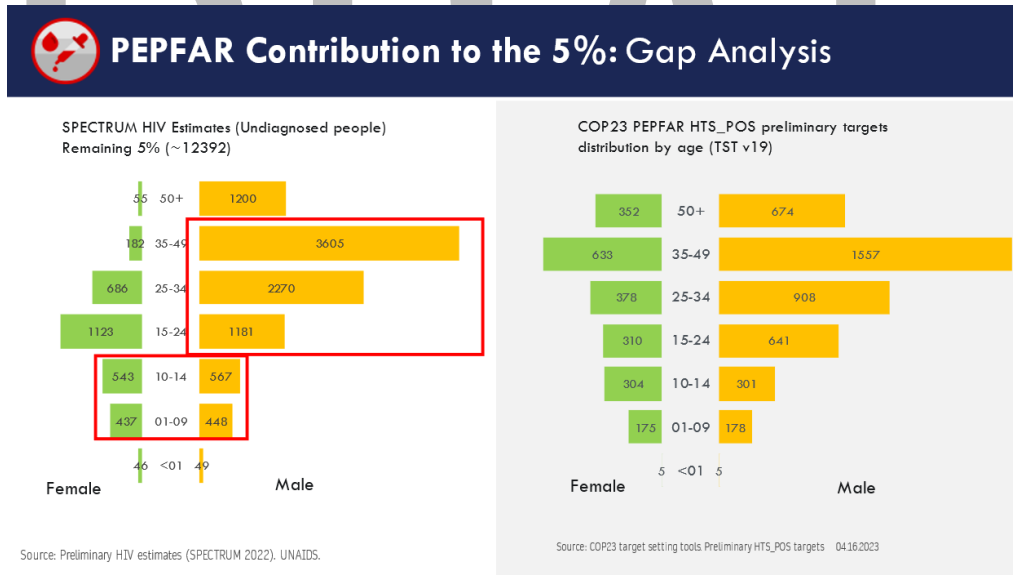


Figure D.2: PEPFAR Contribution to the remaining 5%. COP23 Gap Analysis. Botswana.

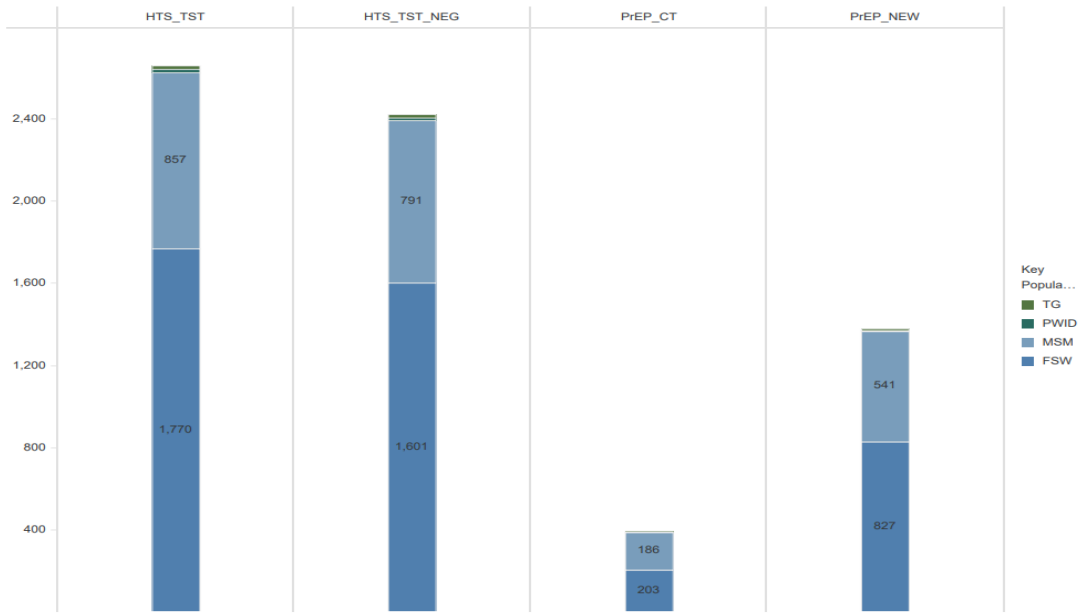


Figure D.3: Prevention Continuum by Key Population Group

VMMC Trends by Priority Age Bands

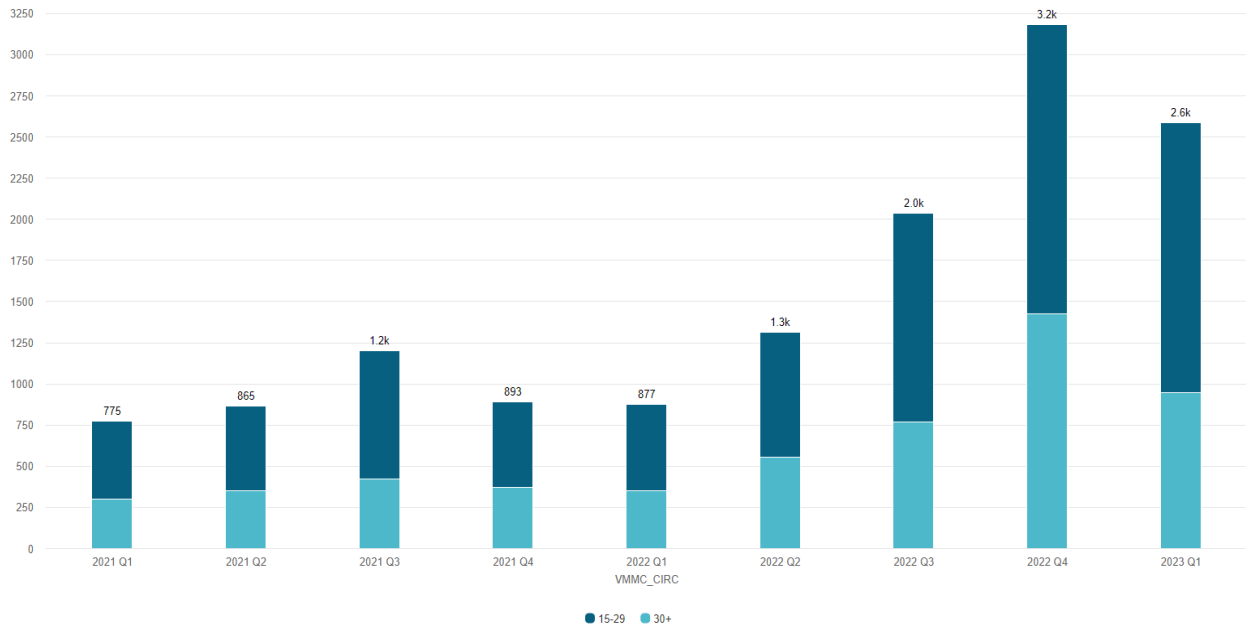


Figure D.4: VMMC Quarterly Trends by Age (optional if OU has VMMC investments and/or targets)