



FY 2015 Botswana Country Operational Plan (COP)

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Botswana.

- 1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.

- 2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

- 3) *Sustainability Index and Dashboard*

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the “FY 2015 Country Operational Plan Budget and Target Report.”

BOTSWANA

Country Operational Plan (COP) 2015

Strategic Direction Summary

June 01, 2015

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Goal Statement

The U.S.-Botswana partnership through the President's Emergency Plan for AIDS Relief (PEPFAR/B) has yielded many benefits over the years, both in responding to HIV and AIDS in-country as well as adding to the global body of knowledge about the epidemic. By strategically focusing on HIV care and treatment and scaling up other proven prevention measures such as Option B+, VMMC and HTC in key geographic settings and populations where rates of transmission and unmet need for HIV services are the highest, Botswana can significantly reduce new infections and save lives. Focusing PEPFAR resources in priority geographic areas will position the country to achieve epidemic control by 2018. Major program pivots to achieve this will include:

- Increasing the proportion of people living with HIV who are initiated and retained on ART to 80% in scale-up areas;
- Ensuring 90% initiation of HIV-infected pregnant and breastfeeding women on lifelong ART (Option B+);
- Scaling-up circumcision among 15-29 year olds, and supporting Botswana in a 6-month VMMC acceleration campaign using MoH cooperative agreement funds;
- Scaling-up gender-based violence (GBV) prevention services for adolescent girls and women;
- Mobilizing communities to link clients into the health systems, retain them in services and ensure adherence to treatment; and
- Ensuring national laboratory capacity to support increased ART initiation and other services.

In addition to the geographic focus, PEPFAR/B is focusing services in select sites for populations most at-risk for HIV, including female sex workers, men who have sex with men and a priority population of adolescent girls and young women. Orphans and vulnerable children, refugees, and people co-infected with TB/HIV will continue receiving services in relevant areas, while military personnel and their families are targeted at the camps and bases.

One of the "right things" to achieve epidemic control and save lives in Botswana is putting more people on treatment faster. But doing so will require major shifts in policy and commitment from our partners. PEPFAR/B is advocating for the revision of national treatment guidelines and the adoption of WHO-recommended CD4 500 cutoff for initiation of treatment, a shift that will increase the number of those eligible for treatment by about 47,000 nationwide and reduce new infections by an estimated 22%. PEPFAR/B has offered to support this shift through training, technical support and a re-direction of GoB cooperative agreement funds for the purchase of drugs. Furthermore, PEPFAR/B partners are aligning community-based interventions with facility-based support and rolling out evidence-based interventions to enhance adherence and retention in both ART and TB treatment for PLHIV. This focus on linkage and retention in care will ensure that patients who are started on treatment continue on it and achieve viral suppression.

PEPFAR/B has made the response to gender-based violence a priority by investing in programs and activities focused on preventing GBV and supporting Botswana's efforts to provide an effective response to this major driver of the epidemic. Other COP15 priorities include increased linkage of OVC and their family members to HIV prevention, care, and support services, providing treatment for HIV-infected refugees, and targeted condom distribution for military families.

As a designated Targeted Assistance country, PEPFAR/B support will continue to shift towards programs that emphasize provision of TA/TC. The time is now to lock Botswana on the path to an AIDS-free generation.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Botswana, a country slightly smaller than Texas with a population of approximately two million people, continues to confront a prolonged and severe HIV epidemic resulting in the second highest HIV prevalence in the world. The 2013 *Botswana AIDS Impact Survey* (BAIS IV) estimated that 18.5 % of the population was living with HIV, an increase from 17.6 % in the previous national survey conducted in 2008.

Botswana women and girls are disproportionately affected by HIV, and prevalence is higher among females (19.2%) than males (14.1%). The highest HIV prevalence in the general population is among females aged 35-39 years at 50.5% and among FSWs as a sub-population at above 60%. Adolescent girls aged 15-19 years are twice as likely to be infected with HIV as boys of the same age (BAIS IV). Tuberculosis (TB) remains the leading cause of death in PLHIV, and is responsible for 13% of adult deaths and 40% of deaths among PLHIV. Maternal mortality related to HIV complications is high and cervical cancer is the leading cause of cancer deaths among women.

Geographically, most of Botswana's HIV disease burden is found in the eastern part of the country along a major highway and rail line where the majority of the population resides. About 74% of the HIV burden, measured as the number of PLHIV residing there is found in the scale-up areas or sub-national units (SNUs), which also have the highest unmet need for anti-retroviral therapy (ART) and the highest prevalence in the country. UNAIDS estimates the total number of PLHIV in Botswana to be 321,270, of which 212,443 are on ART, representing 66% national ART coverage.

The health partnership with Botswana has resulted in a clear record of success through remarkable advances in preventing HIV in the last decade. Variations in life expectancy are a good indicator of this: after dropping from 64 years in 1990 to 49 years in 2002, life expectancy rose to 53 years in 2012, according to the World Bank. The spread of new HIV infections has also slowed sharply. Incidence decreased by 71% between 2001 and 2011, though key issues are now undermining present prevention efforts. Currently, new annual infections are estimated at about

9,100 cases¹. The mother-to-child HIV transmission rate among citizens has dropped from a peak of around 40% to nearly 2%, comparable to most Western countries. Botswana's provision of free antiretroviral treatment to its citizens has become a model for Africa and the world. However, there were 5,800 AIDS-related deaths in 2013², which leaves Botswana short of epidemic control. Continued and strategic investments are necessary to reach this critical milestone in pursuit of an AIDS-free generation.

According to the National AIDS Coordinating Agency (NACA), key drivers of Botswana's generalized epidemic continue to be multiple and concurrent sexual partnerships, adolescent and intergenerational sex, alcohol and high-risk sex, stigma and discrimination, low uptake of male circumcision, and GBV.

Persistently high infection rates among females are partly attributed to gender inequality, which puts women and girls at risk for domestic and sexual violence and compromises their ability to negotiate safer sex. According to the *Gender Based Violence Indicators Study Botswana* (GBVISB), published in March 2012, 67% of women in Botswana have experienced some form of gender violence in their lifetime and 44% of men admit to perpetrating violence against women. According to a UN situational analysis on GBV in Botswana, 53% of women had unprotected sex because their partners refused to use condoms and 23% of pregnant women experienced violence during pregnancy. Furthermore, 10-19 year-old school children surveyed in the 2010 *Botswana Youth Risk Behavior Surveillance Survey* (YRBSS) indicated that violence is a common occurrence in their lives and 13% of sexually active students identified rape as their first sexual encounter.

Access to HIV testing and counseling (HTC) continues to increase in Botswana. In the 2013 AIDS impact survey, 70% of the population aged 10-64 reported that they had tested for HIV in their lifetime and 50% reported testing in the last 12 months. However, omission of key populations (FSW and MSM) from mainstream HTC and treatment programs is a key challenge in achieving epidemic control. The need for targeted HIV testing of key populations was also highlighted by the 2012 *Behavioral and Biological Surveillance Survey* (BBSS), which found an overall HIV prevalence among FSW at 61.9%, with an estimated incidence rate of 12.5%. Additionally, only 54.8% of FSW participating in the survey had ever been tested for HIV. The BBSS also estimated HIV prevalence of MSM to be 13.1 %, higher than the prevalence of 7.5% in a comparable age group of 20-24 year old males. The incidence among MSM is 3.6% which is higher than the national incidence rate of 1.35%³. Only half of MSM surveyed reported receiving HIV related information in the past year and 50% reported having female as well as male sexual partners.

The limited uptake of VMMC is one of Botswana's biggest challenges on its path to reducing new infections and achieving epidemic control. The estimated coverage of male circumcision in

¹ UNAIDS, 2014

² UNAIDS, 2014

³ BAIS IV

Botswana was 11% in 2008⁴, and the Government of Botswana (GoB) established a target of circumcising 385,000 males by 2016 to achieve 80% coverage of this important intervention⁵. As of October 2014, just 37% of the national target (142,760 circumcisions) had been met⁶. In an effort to increase uptake of VMMC, PEPFAR/B will support the GoB in a six-month Safe Medical Circumcision (SMC) acceleration campaign to reach 35,000 men between the ages of 15-29. The campaign will be supported through the re-direction of \$5 million in cooperative agreement funds.

One of Botswana's key prevention accomplishments includes significant reduction of HIV transmission among newborns from HIV-positive mothers. In 2014, the Botswana Ministry of Health (MoH) adopted Option B+ as part of its PMTCT program and the U.S. government is supporting its nation-wide roll-out in 2015 with the purchase of ART, training and mentoring. Option B+ includes lifelong anti-retroviral treatment to HIV-positive pregnant women, regardless of their CD4 count, which helps prevent infant infections, saves mothers' lives, and reduces the numbers of orphans.

Botswana has not yet adopted the WHO-recommended CD4 500 cutoff for ART initiation, posing a challenge to achieving epidemic control. The PEPFAR/B team believes that moving from the current guidelines of initiating treatment at CD4 350 cut-off to the recommended CD4 500 cut-off would help save lives by putting more people on treatment faster and also preventing new infections. This shift increases the number of those eligible for treatment by about 45,000 nationwide by 2017, and reduces the new infections by an estimated 22%. Achieving this landmark requires major shifts in policy and commitment from our partners, and PEPFAR/B's leadership is actively advocating for the revision of national treatment guidelines. Current estimates suggest this is cost-saving in the long run by preventing new infections and hospitalizations. For program success, linkages between treatment and care will need to be strengthened, as well as adherence and retention of patients – especially adolescents – on ART. To support the MoH's adoption of a CD4 cutoff of 500, the USG has offered a one-time re-direction of the GoB's mega cooperative agreement to pay some of the incremental costs of ARVs for the first three years.

The Botswana Combination Prevention Project (BCPP) is a four-year study in 30 paired communities that will provide valuable data and insights for epidemic control in Botswana. The study is still in its initial phases, but preliminary estimates indicate that HTC and ART coverage are as high or higher than anticipated based on other data sources, and that male circumcision coverage may be higher than previously anticipated. Lessons learned from BCPP (summarized in Appendix D) informed COP15 planning. As the study completes enrollment of all 30 study communities across Botswana by the end of October, even more will be learned – information that will be extremely valuable to the MoH, PEPFAR/B team, and other stakeholders in providing an in-depth assessment of HIV epidemiology, coverage and quality of key services.

⁴ BAIS III

⁵ *VMMC National Operational Plan*

⁶ *Safe Male Circumcision (SMC) Weekly Reports*, MoH

According to the World Bank, GNI in Botswana is \$7,770 USD (an increase from \$5,840 USD in 2010) and the highest in sub-Saharan Africa. Despite Botswana's classification as an upper middle-income country, 18.4% of the population lives below the poverty line and there still exists a high income inequality, as demonstrated by a Gini Index of 61⁷.

| Table 1.1.1 Key National Demographic and Epidemiological Data | | | | | | | | | | | |
|---|-----------|-----------------|---------|---------|---------|---------|---------|---------|---------|---------|--------------------------------|
| | Total | | <15 | | | | 15+ | | | | Source, Year |
| | | | Female | | Male | | Female | | Male | | |
| | N | % | N | % | N | % | N | % | N | % | |
| Total Population | 2,024,904 | 100 | 326,939 | 16.1 | 333,075 | 16.4 | 708,894 | 35.0 | 655,996 | 32.4 | Census, 2011 |
| Prevalence (%) | | 18.6 | | 3.8 | | 3.7 | | 26.6 | | 20.4 | BAIS IV 2013 |
| AIDS Deaths (per year) | 5,800 | | No data | | No data | | No data | | No data | | UNAIDS, 2014 |
| PLHIV | 321,270 | | 5,436 | | 5,078 | | 192,180 | | 118,576 | | UNAIDS, 2014 |
| Incidence Rate (Yr) | | 1.35 | | No data | | No data | | No data | | No data | BAIS IV 2013 |
| New Infections (Yr) | 9,100 | | | | | | | | | | UNAIDS, 2014 |
| Annual births | 47,599 | | | | | | | | | | PMTCT Program data, 2013 |
| % >= 1 ANC visit | 44,790 | 94.1 | No data | No data | | | No data | No data | | | BFHS, 2007 |
| Pregnant women needing ARVs | 14,290 | 30.0 | | | | | | | | | Program data, 2013 |
| Orphans (maternal, paternal, double) | 105,322 | | 38,233 | | 40,091 | | 11,695 | | 15,303 | | BAIS IV 2013 |
| TB cases (2013) | 7,088 | | 259 | | 303 | | 2,757 | | 3,769 | | TB Program data, 2013 |
| TB/HIV Co- | 3,929 | 61 ^a | 42 | 21 | 54 | 22.8 | 1,775 | 68.5 | 2,058 | 59.1 | TB Program |

⁷ AFDB, OECD, UNDP. 2014. African Economic Outlook: Botswana. URL:
http://www.africaneconomicoutlook.org/fileadmin/uploads/aeo/2014/PDF/CN_Long_EN/Botswana_EN.pdf

| | | | | | | | | | | | | |
|--|------------------|------------------|---------|---------|---------|---------|---------|---------|---------|---------|--|----------------------------------|
| infection | | | | | | | | | | | | data, 2013 |
| Males Circumcised | 2,8576 | 24.3 | | | 20,232 | 70.8 | | | 8,344 | 29.2 | | Program data, 2014. BAIS IV 2013 |
| Key Populations | No national data | No data | No data | No data | No data | No data | 18,000 | No data | No data | No data | | |
| Total MSM* | No data | n/a ^a | | | | | | | | | | |
| MSM HIV Prevalence | 13.1% | | | | | | | | | | | BBSS, 2012 |
| Total FSW | 18,000 | n/a ^b | | | | | | | | | | Investment Case, 2014 |
| FSW HIV Prevalence | 61.9% | | | | | | | | | | | BBSS, 2012 |
| Total PWID | No data | No data | | | | | | | | | | |
| PWID HIV Prevalence | No data | No data | | | | | | | | | | |
| Priority Populations (15-24 females adolescents) | 209,001 | 100.0 | 0 | 0 | | | 209,001 | 100 | | | | Census 2011, BAIS IV 2013 |

^a Of the 7088 TB cases notified in 2013, 579 (8%) did not receive HIV testing and are therefore not counted in the denominator of the respective HIV prevalence rates

^b The methodology used to calculate size estimates for key populations does not permit a projection for the entire country. The total presented represents the sum of two size estimation activities conducted in separate cities known to have a significant number of MSM.

^c The methodology used to calculate size estimates for key populations does not permit a projection for the entire country. The total presented represents the sum of two size estimation activities conducted in separate cities known to have a significant number of FSW.

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)

| | | | | HIV Care and Treatment | | | | HIV Testing and Linkage to ART | | |
|--|------------------------------------|--------------------|-----------------|------------------------|------------|-------------------------------|-----------------------------|--------------------------------|----------------------------|----------------------|
| | Total Population Size Estimate (#) | HIV Prevalence (%) | Total PLHIV (#) | In Care (#) | On ART (#) | Retained on ART 12 Months (#) | Viral Suppression 12 Months | Tested for HIV (#) | Diagnosed HIV Positive (#) | Initiated on ART (#) |
| Total population | 2,024,904 | 18.6 | 321,270 | No data | 212,443 | No data | No data | 338,698 | 26,677 | 23,831 |
| Population less than 15 years | 65,9770 | 3.7 | 10,514 | No data | 9,071 | No data | No data | 33,980 | 1,053 | No data |
| Pregnant Women | 47,599 | 30.7 | 14,638 | No data | 7,552 | No data | No data | 46,469 | 14,290 | 1,976 |
| | | | | | | | | | | |
| MSM | 1,062 | 13.1 | 135 | No data | No data | No data | No data | 850 | 85 | No data |
| FSW | 6,195 | 61.9 | 3,934 | No data | No data | No data | No data | 4,956 | 1,289 | No data |
| PWID | No data | No data | No data | No data | No data | No data | No data | No data | No data | No data |
| Priority Pop (15-24 females adolescents) | 209,001 | 10.4 | 23,401 | No data | No data | No data | No data | No data | No data | No data |

*Data taken from the Masa National HIV Treatment Program. Data on patient's "in care" are not available as patients are not currently registered with the program until they are initiated on ART. Also, data is not available disaggregated by gender and age (except for PMTCT data).

1.2 Investment Profile

There is a shortage of reliable and relevant data that examines funding levels around HIV/AIDS programs in Botswana. However, all sources agree that the GoB is the primary funder of these programs. According to the *National AIDS Spending Assessment*⁸ (NASA), one of the most detailed sources of information regarding HIV/AIDS funding, the GoB contributed almost 70% of funding for HIV/AIDS programs in 2011/12, while external donors contributed about 30%. Currently, aside from PEPFAR there are few external funders in Botswana and so this percentage has significantly decreased (see Table 1.2.A below). According to NASA, public funding has gradually increased over a three-year period, from \$186.8 million USD in 2009/10 to \$253.5 million in 2011/12; while external sources of funding peaked in 2010/11 at \$113 million before declining slightly in 2011/12 to \$105 million. PEPFAR funding has declined to \$48 million from a funding level close to \$90 million five years ago.

Over the last decade, PEPFAR has committed more than \$700 million in Botswana's response to the HIV/AIDS epidemic. Historically, another major external donor was African Comprehensive HIV/AIDS Partnership (ACHAP), a public-private sector initiative between GoB, MSD/Merck Company Foundation and the Bill and Melinda Gates Foundation which invested \$152 million USD in HIV/AIDS support in Botswana over the last 14 years⁹. Merck and Gates investments have ceased, but ACHAP has been identified as a principal recipient in the Global Fund concept note and an implementing partner (IP) for CDC/Botswana under its new VMMC cooperative agreement. Other development partners include the EU, SIDA, and UN agencies though none significantly contribute to the response. A Global Fund concept note was submitted in January 2015 has recently been approved for \$27 million for TB and HIV programs¹⁰ over three years.

Table 1.2.A Sources of Financing for HIV/AIDS Programs (2011-12)¹¹

| Source of finance | Percentage of total financing provided |
|---|--|
| GoB Public Funds | 69.6% |
| Private Funds | 1.9% |
| External Funds (bilateral/multilateral) | 28.5% |

Source: NASA, 2012

⁸ NASA used data from a three year period: 2009/10, 2010/11, and 2011/12. Throughout the report, data are presented by year as well as a three year average or summary/total.

⁹ From *Adapting Through Crisis: Lessons from ACHAP's Contributions to the Fight Against HIV/AIDS in Botswana*, October 2014.

¹⁰ The request for funding includes the following: Prevention programs for adolescents and youth, USD \$11.7 to \$12.8 million; prevention programs for MSM and transgendered persons (TG), \$1.4 million; prevention programs for sex workers & their clients, \$1.68 million; TB care and prevention, \$5.7 million; MDR-TB, \$677,652; HIV treatment, care and support, \$1.59 million; TB/HIV/RMNCH, \$1.78 million; community systems strengthening, \$2.28 million; removing legal barriers, \$2.7 million; HMIS and monitoring and evaluation (M&E), \$641,909; procurement and supply chain management (SCM), \$794,549; laboratory systems, \$583,217; and program management, \$2.9 million.

¹¹ Public Funds: Domestic public funds include central government funds (government revenue), the World Bank reimbursable loan and the GoB's contribution to the medical scheme. Private Funds: Does not include out of pocket expenses directly paid by individuals. External Funds: Include international sources of financing with PEPFAR and ACHAP making up the major part of the contribution.

Over half (56%) of the GoB's HIV/AIDS money is spent on care and treatment (hospitals and clinics patient care, ARV drugs and lab reagents for HIV monitoring), 16% goes to OVCs which is spent mostly on food, and 14% is spent on prevention activities. An examination of the total health expenditures also found over half (53%) of the spending goes to hospital-based care, the most costly type of health care¹². Prevention spending over a three-year period of the NASA indicates a decrease by 35% from \$52.8 million USD in 2009 to \$34.2 million USD in 2011/12. Additionally, 20% of prevention spending was on community mobilization initiatives, 19% on prevention programs for youth and 15% each for PMTCT and voluntary counseling and testing (VCT). During 2011/12, only 6.6% was spent on youth, while 25.8% was spent of community mobilization initiatives, 14.8 % on PMTCT, 14.2% on VCT and 12.3% on VMMC.

Table 1.2.1 Investment Profile by Program Area (2012)¹³

| | Total Expenditure ¹⁴ | % GoB Public Funds | % Private Funds | % External Funds | Total |
|-------------------------------------|---------------------------------|--------------------|-----------------|------------------|-------|
| Treatment & Care | \$220,898,390.58 | 83% | 3% | 14% | 100% |
| Prevention | \$20,153,735.28 | 43% | 1% | 57% | 100% |
| PMTCT | \$5,069,794.75 | 93% | 0% | 7% | 100% |
| VCT | \$4,908,319.32 | 22% | 0% | 78% | 100% |
| VMMC | \$4,231,723.91 | 9% | 0% | 91% | 100% |
| Priority population prevention | NA | NA | NA | NA | NA |
| Key population prevention | NA | NA | NA | NA | NA |
| OVC | \$53,001,307.81 | 98% | 0% | 2% | 100% |
| Laboratory | NA | NA | NA | NA | NA |
| Research & surveillance | \$15,374,863.21 | 0% | 0% | 100% | 100% |
| HSS | \$1,483,972.56 | 1% | 0% | 99% | 100% |
| Program management & administration | \$35,441,855.49 | 17% | 0% | 83% | 100% |
| Human resources | \$7,816,211.59 | 0% | 0% | 100% | 100% |
| Enabling environments | \$675,260.89 | 15% | 0% | 85% | 100% |
| Total | \$369,055,435.39 | 70% | 2% | 28% | 100% |

Data source: NASA, 2012

¹² National Health Account, 2012

¹³ Available data does not disaggregate data beyond "Public Funds", "Private Funds" and "External Funds" nor does it provide some details requested in the program area.

¹⁴ Amounts in 2012 USD. Average annual conversion rate of 7.4934 used per OANDA.

Table 1.2.2 Procurement Profile for Key Commodities

| | Total Expenditure ⁷ | % GoB | % Private Funds | % External Funds | Total |
|--------------------|--------------------------------|-------|-----------------|------------------|-------|
| ARTs ¹⁵ | \$51,274,455 | 34% | 12% | 55% | 100% |
| Rapid test kits | NA | NA | NA | NA | 0% |
| Other drugs: PEP | \$69,394 | 100% | 0% | 0% | 100% |
| Lab reagents | NA | NA | NA | NA | 0% |
| VMMC kits | NA | NA | NA | NA | 0% |
| Male condoms | \$1,342,515 | 0% | 0% | 100% | 100% |
| Other commodities | NA | NA | NA | NA | 0% |
| Total | \$52,686,364 | 33% | 11% | 56% | 100% |

Data source: NASA, 2012

Increases in HIV/AIDS program costs in the face of declining donor funding may pose a challenge for Botswana, which is struggling to reduce its dependence on diamonds – a finite resource – and generate private sector led economic growth. However, one study¹⁶ published in *The Lancet* in January 2015 which examined the capacity of countries highly affected by AIDS to finance programs from domestic sources, concluded that Botswana should be able to finance its entire HIV/AIDS program without external aid.

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

| Funding Source | Total Non-COP Resources | Non-COP Resources Co-Funding PEPFAR IMs | # Co-Funded IMs | PEPFAR COP Co-Funding Contribution | Objectives |
|---|-------------------------|---|-----------------|------------------------------------|---|
| MEPI (Medical Education Partnership Initiative) | \$2,000,000 | 0 | 0 | 0 | <ul style="list-style-type: none"> -Strengthen and expand medical education at the University of Botswana School of Medicine -Enhance the teaching platform and care delivery standards of the existing health system to allow for institutional and program accreditation -Develop local research capacity for biomedical, clinical and health systems research, including the capacity to monitor, evaluate and improve clinical practice in Botswana -Create clinical teaching outreach sites to enhance learning opportunities for trainees, and to |

¹⁵ ART spending includes ARV drugs, outsourcing of ART services from the private sector, Medial Aid Scheme’s payments for private clients and payment for Norwegian personnel and health care auxiliaries by the government. The cost of most of the health care personnel and related infrastructure support has not been included.

¹⁶ Resch, Stephen; Ryckman, Theresa; and Hecht, Robert. “Funding AIDS programmes in the era of shared responsibility: an analysis of domestic spending in 12 low-income and middle income countries” *The Lancet*, Vol3. January 2015.

| | | | | | |
|---|---------------------------------------|-------------|------------------------------|-----------|---|
| | | | | | improve referral practices and access to specialist services |
| Botswana Combination Prevention Project (BCPP) ^a | | \$7,191,879 | 4 | \$510,000 | |
| Pink Ribbon Red Ribbon (PRRR) | ~\$600,000 (\$3 million over 5 years) | \$600,000 | 3 (TBD, SCMS, GoB mega-CoAg) | \$500,000 | -Scale-up See and Treat sites -Provide TA for HPV vaccination efforts -Enhance pathology services, mainly related to LEEP specimens |
| LCI funding for key pops, GBV | \$749,000 | | | | |

All data FY 2013 unless otherwise noted

^aData projected for FY 2016

1.3 National Sustainability Profile

The PEPFAR/B team completed the Sustainability Index and Dashboard (SID) in consultation with the MoH, NACA, Ministry of Local Government (MLG), Ministry of Labor and Home Affairs (MLHA), civil society organizations, and development partners, including UNAIDS, WHO, UNDP and the EU. The two elements that were assessed as “unsustainable” according to the index were *Element 7: Quality Management*, and *Element 10: Allocative Efficiency*.

Element 7: Quality Management had the lowest overall score of any element. Although a Quality Management Program exists within the MoH, the GoB has not effectively institutionalized quality management into HIV/AIDS programs. PEPFAR/B has invested close to \$4 million in Quality Improvement (QI) programs through both USAID and CDC implementing partners since 2008. In COP14, CDC Botswana invested \$500,000 to fund a QI technical advisor position within the MoH, to support the establishment of a QI program at the MoH, provide training and mentoring to address HIV quality issues, and conduct a desk review of all quality improvement initiatives in Botswana. Additionally, \$600,000 of COP14 funds from USAID will be directed to QI at the community level to jumpstart activities aimed at improving community-facility linkages and increasing retention rates.

When discussing *Element 10: Allocative Efficiency*, MoH officials stated that they use epidemiologic, service delivery and financial data to inform their annual budget planning process and submission to the Ministry of Finance (MoF). However, the GoB prioritizes equitable service delivery, with the goal of bringing health services within 8 km of every person, and does not conduct a systematic review of site-yield data to inform geographic prioritization of resources for the HIV response. Historically, PEPFAR/B has invested heavily in HMIS systems and surveillance activities in support of the MoH collecting relevant data. However, a shortage of skilled MoH epidemiology/statistics personnel limits the MoH’s ability to most efficiently use the available

epidemiological and service delivery data to drive decision making. This reflects weak QM and underscores the critical need for QI activities to reach epidemic control.

In COP15, PEPFAR/B will invest in a number of activities that address weaknesses identified in the SID:

- 1) *Element 7: Quality Management:* PEPFAR/B will invest in TA at the national, facility and community levels. At the national level, PEPFAR/B and an IP will support personnel and infrastructure within the MoH to institutionalize QA/QI processes. Aggregation and review of site-level monitoring and SIMS data in addition to other local data sources (surveys, PIMS) provide a more nuanced and comprehensive picture of coverage, service quality deficiencies, and necessary critical system support.

At the facility level, PEPFAR/B will provide targeted TA to comprehensive routine HIV testing (RHT), care, treatment, PMTCT, TB/HIV, lab, and SI services at the 33 high-volume facilities in the four scale-up SNU. The package includes: training, mentorship, SIMS visits and remediation conducted by IPs at least three times per year. In addition, a TA package focused on 30 high-volume facilities ensures that patients on ART are retained on treatment and are virally suppressed. To do this, the IP would be expected to support facilities in these districts to track ART patients who default treatment, ensure timely initiation of second-line drugs, and support ongoing adherence counselling. More importantly, the IP will support these facilities to adhere to national guidelines for VL testing at appropriate time intervals, ensure that patients receive timely VL results and that detectable VL are acted upon in a timely manner.

At the community level, PEPFAR/B will invest in adapting and evaluating evidence-based models to increase treatment retention and improve community-facility linkages through collaboration with community-based partners and the communities themselves, including PLHIV. PEPFAR/B will support evidenced-based QI approaches within the scale-up SNU, in order to focus on high burden areas where these initiatives can have the most impact on funding as-yet undiagnosed PLHIV and ensuring that all PLHIV complete the full cascade from diagnosis to viral suppression. Given the already high testing rates and coverage of ART according to current national guidelines, these community-based efforts will be crucial to reaching our overall coverage goals.

- 2) *Element 10: Allocative Efficiency:* USAID will provide TA to the MoH through a newly added staff member, the health financing advisor, and through an IP to analyze financing options and to improve allocative and technical efficiency of HIV services as well as to improve delivery of HIV services. Activities will include:

- a. Helping the MoH implement results of costing studies and analyses; improving the MoH capacity to use expenditure data to estimate unit costs and costs for specific services or interventions;
- b. Improving allocative efficiency through developing a better understanding of national HIV/AIDS resource flows and capacity to manage them. This will be accomplished through the use of data from the National Health Accounts and through institutionalizing the “one health tool” that allows for unit cost analysis and optimization.

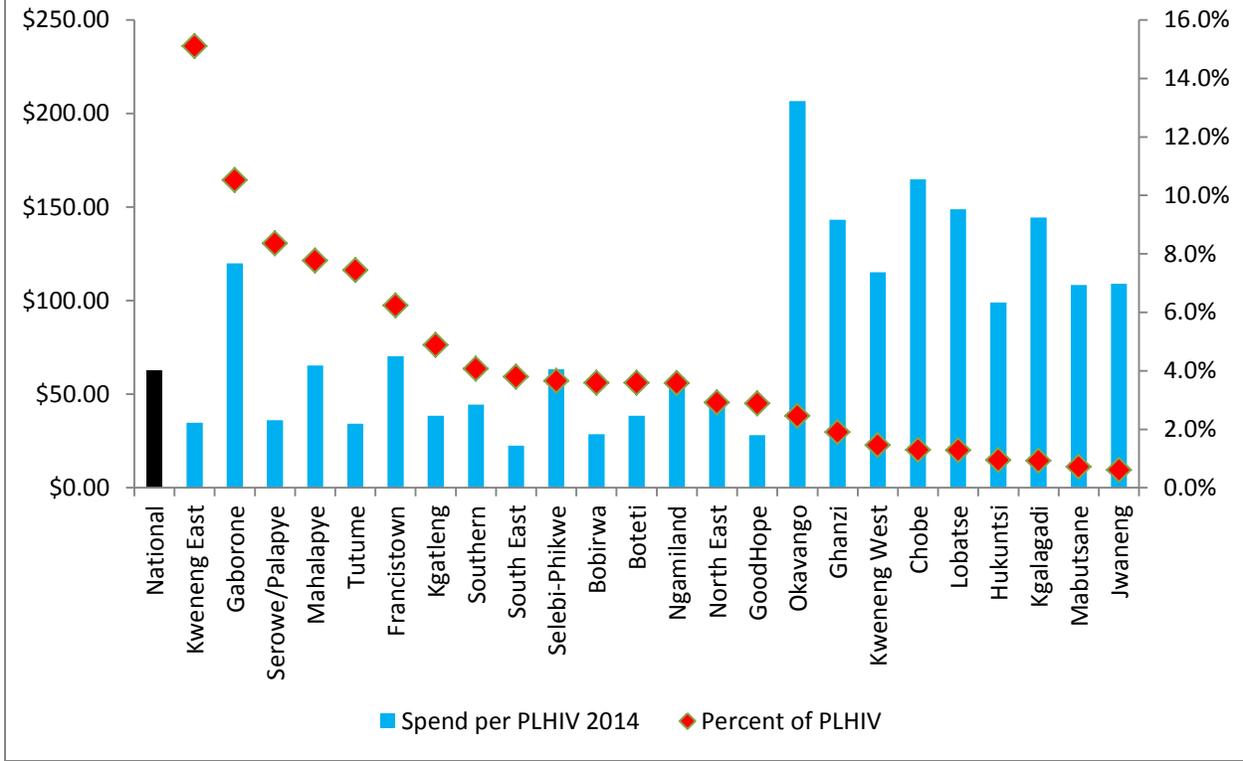
1.4 Alignment of PEPFAR Investments Geographically to Disease Burden

In order to fully analyze PEPFAR investment in Botswana, it should be noted that the majority of financing for HIV programs comes from the GoB, which equitably distributes resources across the country. The largely urban health districts, such as Gaborone and Francistown, have low GoB expenditures per PLHIV and high health care access coverage. This is in the face of comparatively high disease burden due to economies of scale in their program operations and a high proportion of patients accessing service at the referral hospitals from outside the districts. In contrast, low burden health districts, such as Jwaneng, Mabutsane, Kgalagadi, Okavango, and Chobe, have high patient expenditures.

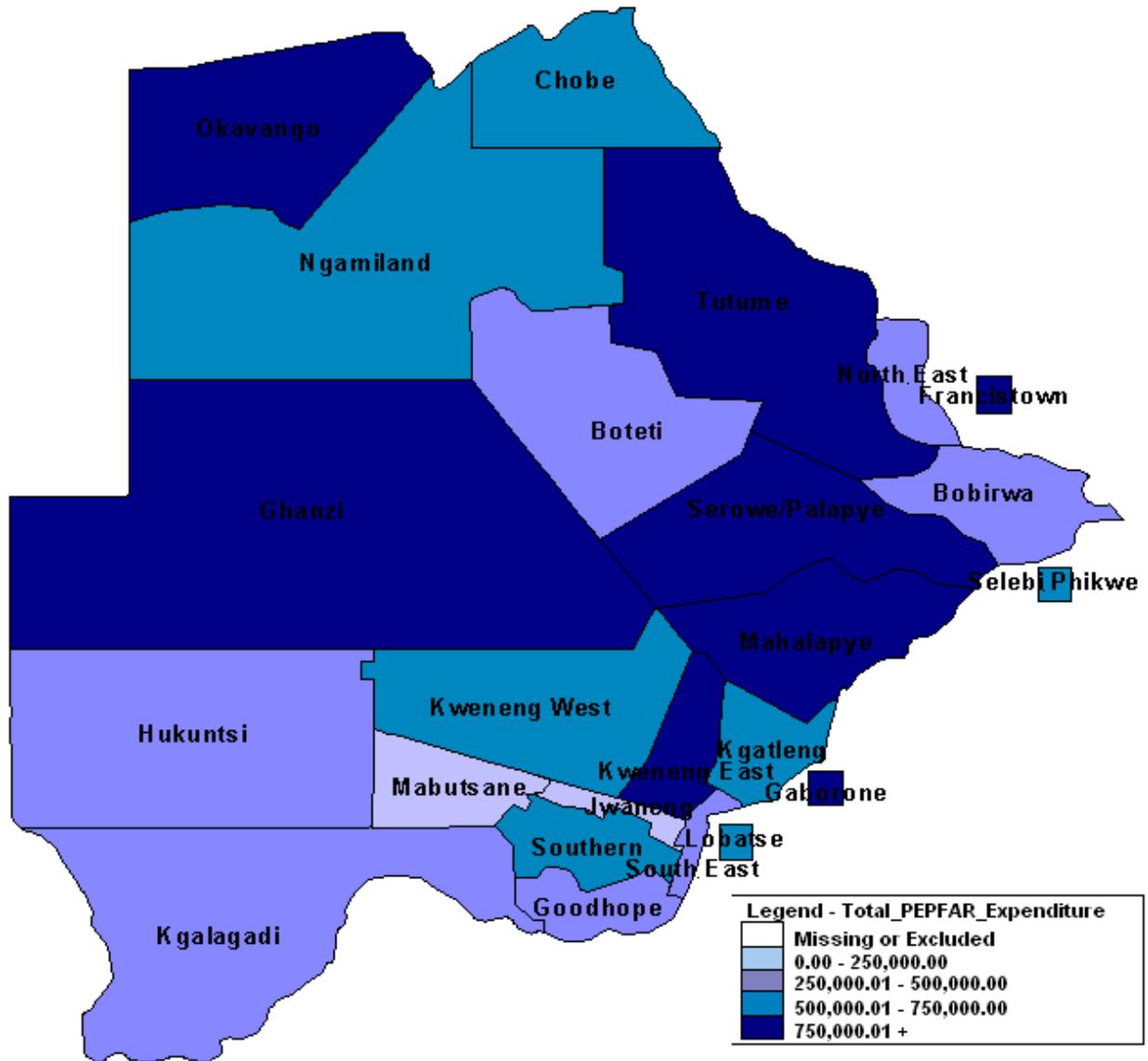
The alignment analysis of the 2014 PEPFAR investment in Botswana, which closely examined PEPFAR economic expenditure and HIV prevalence data, revealed wide variability between areas of high disease burden and low disease burden (e.g., USD expenditure per PLHIV ranges from \$23 to \$225 USD). As seen below, Figure 1.4.1 shows an overall inverse relationship between PEPFAR per-PLHIV-unit expenditures and disease burden by health districts¹⁷. Additionally, this information is visually represented in the following series of maps (Maps 1.4.2 A-D).

¹⁷ The existence of different laws/authorities (Administrative District Act, Census Act, Ministry of Finance and Development Planning Ministry of Local Government) has led to various definitions for districts in Botswana for different purposes (planning, local governance, enumeration areas, land use, development etc.). The delivery of health services has also led to another district definition based on coverage of services. Administrative districts are defined slightly differently from census districts as well as health districts. The choice of 24 districts for PEPFAR COP15 Planning was based on the health districts largely because of the availability of health services data reported by health districts, and the existence of shape files (for mapping) defined based on the health districts. Where data (in this case HIV prevalence) is available based on census districts (as is the case with BAIS IV) it is possible to map census districts to health districts, although the mapping is not 100% exact. We do not anticipate that these discrepancies constitute any drastic differences.

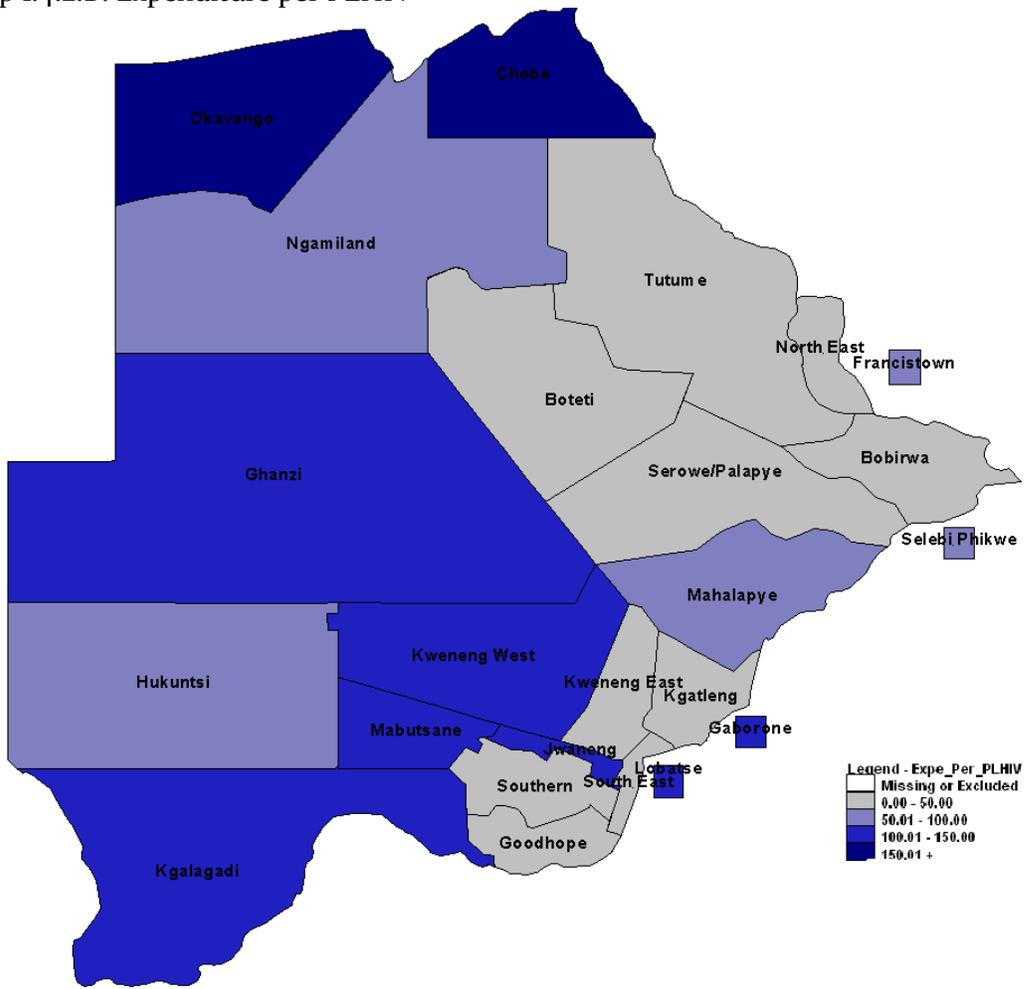
Figure 1.4.1. 2014 PEPFAR Expenditure per PLHIV & Percent of PLHIV per SNU (Health Districts*)



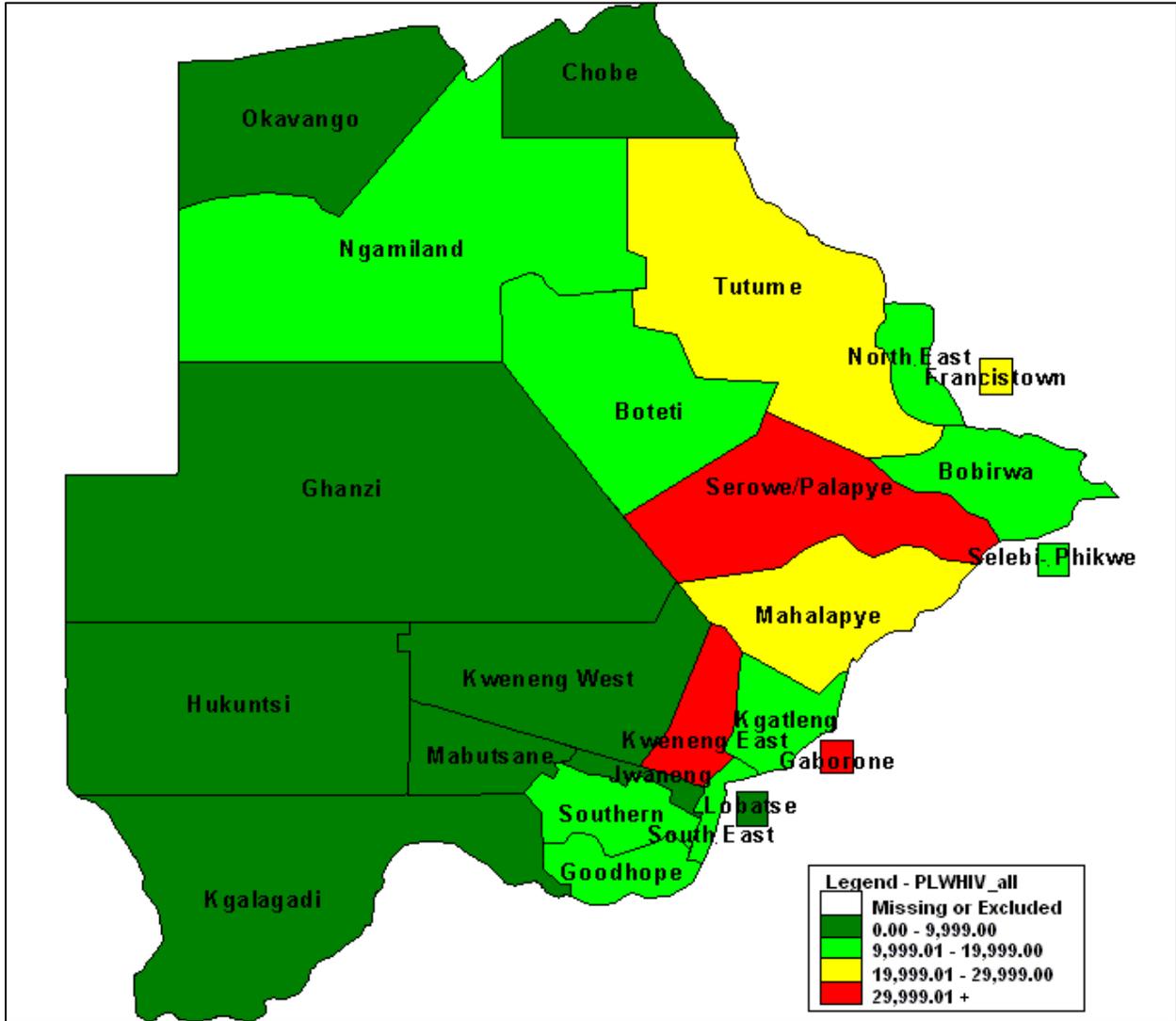
Map 1.4.2.A: Total PEPFAR Expenditures



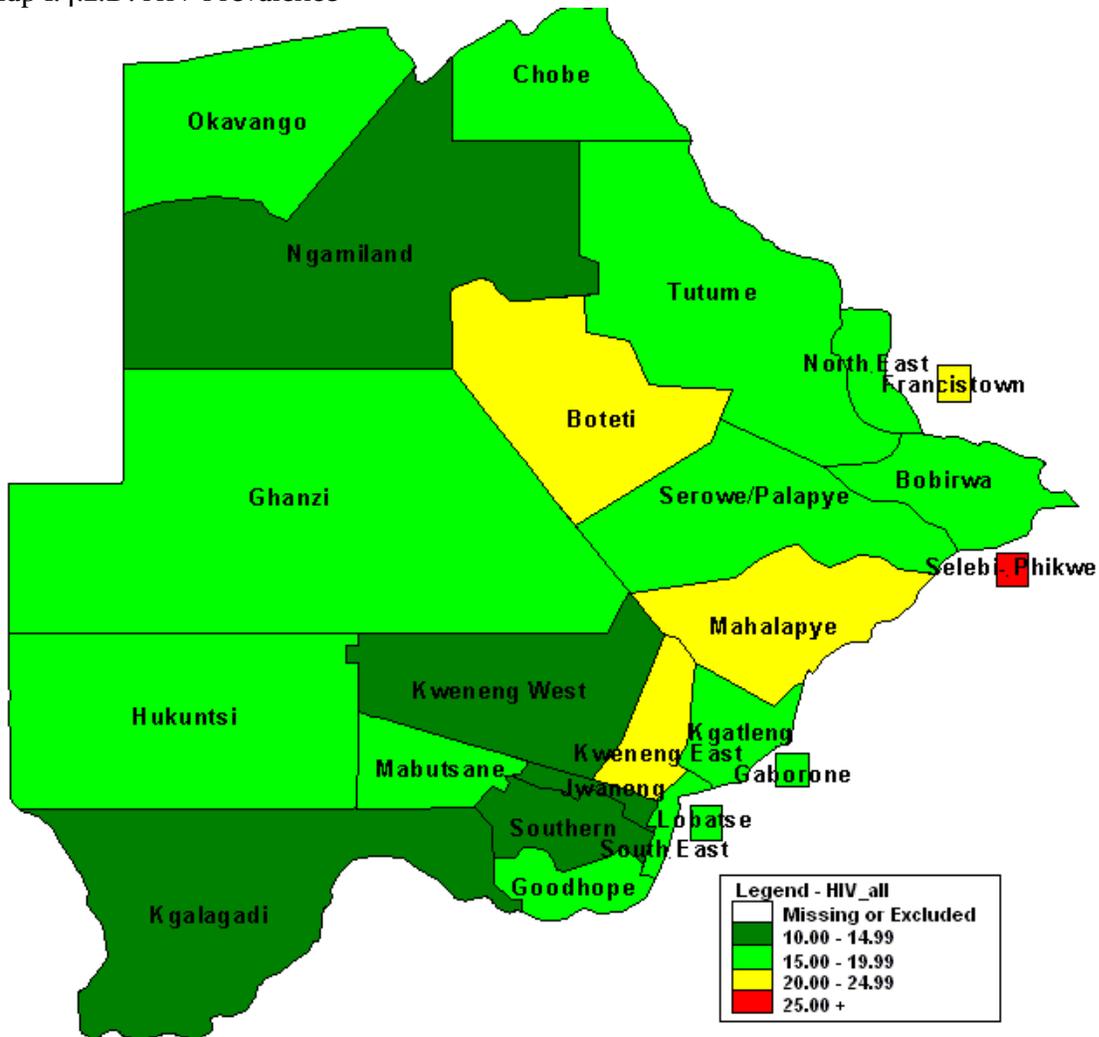
Map 1.4.2.B: Expenditure per PLHIV



Map 1.4.2.C: Number of PLHIV



Map 1.4.2.D: HIV Prevalence



Based on PEPFAR analysis and discussions with partners, facility-based programs will continue to move towards a TA focus rather than DSD, while community-based programs will combine both types of services. Both community and facility approaches will focus on high burden/prevalence health districts in order to improve HIV/AIDS service delivery, program operations, data collection, analyses, reporting, general surveillance and M&E activities. The GoB will maintain efforts in both high- and low-burden health districts, helping to continue practices which have resulted in good outcomes, as well as sharing “best practices” from other health districts (See Figure 1.4.2). PEPFAR/B’s DSD support for key populations and refugees will continue as part of the agreement with GoB.

Table 1.4.2: Based on Gender & HIV status

| Sub-National Unit (SNU) | HIV Prevalence | PLHIV | % National PLHIV in SNU |
|-------------------------|----------------|---------|-------------------------|
| National | | 321,270 | 100% |
| Greater Gaborone | 18.90% | 110,228 | 34% |
| Greater Francistown | 20.10% | 53,305 | 17% |
| Serowe/Palapye District | 17.30% | 26,842 | 8% |
| Mahalapye District | 24.50% | 24,972 | 8% |
| Southern District | 11.80% | 13,086 | 4% |
| Selebi-Phikwe District | 27.70% | 11,755 | 4% |
| Bobirwa District | 18.70% | 11,543 | 4% |
| Boteti District | 20.10% | 11,515 | 4% |
| Ngamiland District | 14.80% | 11,496 | 4% |
| Goodhope District | 19.70% | 9,262 | 3% |
| Okavango District | 15.50% | 7,891 | 2% |
| Ghanzi District | 16.50% | 6,121 | 2% |
| Kweneng West District | 11.50% | 4,695 | 1% |
| Chobe District | 18.80% | 4,171 | 1% |
| Lobatse District | 16.60% | 4,137 | 1% |
| Hukuntsi District | 17.30% | 3,031 | 1% |
| Kgalagadi District | 11.50% | 2,965 | 1% |
| Mabutsane District | 19.50% | 2,286 | 1% |
| Jwaneng District | 12.70% | 1,967 | 1% |

1.5 Stakeholder Engagement

The GoB and other stakeholders have been actively engaged with the PEPFAR/B team throughout the development of the FY15 COP. Government stakeholders include representatives from NACA, MoH, Ministry of Education and Skills Development, Ministry of Local Government and Rural Development, Ministry of Labor and Home Affairs (including the Gender Affairs Department). In advance of the planning, several high-level meetings were held between the PEPFAR leadership and ministry leadership to discuss PEPFAR 3.0, COP 2015 funding levels and earmark requirements. Technical teams were engaged at the ministries to help gather data for the SID, and leadership from the ministries met to discuss, review and comment on the SID. In addition, private meetings were held between the NACA coordinator and her team, and the deputy permanent secretary at the MoH and her team, to cover areas of the SID and to ensure comprehension.

Development partners, including UNAIDS, WHO, UNDP, UNICEF and others were briefed on the COP 2015 process by the PEPFAR/B Team during regularly scheduled development partner meetings, Global Fund meetings and through a briefing on the SID. The PEPFAR/B representative sitting on the Global Fund committee for Botswana kept the committee apprised of possible investments and vice versa for the PEPFAR/B team in order to avoid duplication of programming and funding. The Botswana Investment Case document from UNAIDS was circulated widely among the PEPFAR/B Team and used as part of the COP data collection process.

Civil society and private sector stakeholders were convened on two occasions in March to educate them on the PEPFAR pivot and to gather feedback on SID and the planned COP 15 strategy. One meeting was held in Maun and the other in Selibe-Phikwe. It was explained that the COP is monitored through routine quarterly data analysis by field teams and PEPFAR headquarters, in partnership with external stakeholders (e.g., host government, civil society and multilateral partners). Further, it was explained that critical data elements, including *Monitoring and Evaluation Reporting (MER)*, *Expenditure Analysis (EA)*, *Site Improvement Monitoring System (SIMS)*, *SID*, financial outlays, etc., will be used by PEPFAR teams in an integrated way to guide implementation decisions in order to mark progress towards sustained epidemic control.

As part of our regular COP15 consultations with GoB officials, the PEPFAR/B Team had several meetings with NACA and MoH about the GoB pipeline and proposals to use cooperative agreement funds to “big win” activities. One key shift would be in the Botswana treatment guidelines to the WHO-recommended CD4 500. PEPFAR is prepared to assist Botswana in making this transition through TA, and with a \$7.1 million redirection in cooperative agreement pipeline funds to support the efforts. Another is the redirection of \$5 million in GoB pipeline funds to support a 6-month VMMC acceleration campaign kicked-off and led by the GoB to circumcise 35,000 15-29-year-olds.

2.0 Core, Near-Core and Non-Core Activities

Throughout the COP15 process, PEPFAR/B’s key decisions were derived from the desire to undertake the right things that we are uniquely qualified to do in order to achieve epidemic control. PEPFAR/B will invest in interventions supported by evidence and focus on scale-up districts to reach 90-90-90, where we can have the greatest impact, as well as on key and priority populations. Our core activities will focus on a combination of TA at the facility-level and community-based activities to increase the numbers of PLHIV diagnosed, initiated and retained on ART. We will also increase HTC and VMMC services in scale-up areas. OVCs will be targeted in priority areas for care and support. Condom promotion and distribution will be focused on the military, while prevention, treatment, care and support will be ramped up for key and priority populations. GBV will be addressed by linking survivors to needed services as well as reducing the contextual factors that contribute to the vulnerability of young girls to HIV and GBV, which is a significant driver of the HIV epidemic and contributes to the high disparity of HIV prevalence between women and men. In addition, we will concentrate some of our TA efforts at the national level through focusing on Option B+, HTC, VMMC and the roll-out of Prepex, advocacy for

addressing GBV, support to the national TB program, and TA for national guideline and policy development. Financial support for low-yield VMMC/HTC sites will be transitioned away during this COP year, along with TA support for civil society organizational capacity building, lab construction, and several other programs. Specific details are outlined in Appendix A.

3 Geographic and Population Prioritization

The main criteria used to inform geographic prioritization of health districts or sub-national units (SNUs) was total PLHIV in the districts, ART coverage, and net new needed for ART saturation. This was accomplished using BAIS IV data and an analysis that included both gender and HIV status. In addition, clusters of districts around Botswana’s two largest cities, Gaborone and Francistown, were created to more accurately reflect the high number of people from the surrounding communities accessing treatment and care services in the cities. From the data, it became clear that the Greater Gaborone cluster (Gaborone, Kweneng East, Kgatleng, and South East) and the three additional health districts (Mahalapye, Southern and Goodhope) account for about half (49%) of the country’s HIV disease burden. In addition, these areas had some of the highest numbers in the net new needed for ART saturation. Therefore, the PEPFAR team agreed that these seven Scale-Up Districts would be the focus for meeting all 90-90-90 targets. Additionally, the Greater Francistown cluster (Francistown, North East and Tutume) along with one additional district (Serowe/Palapye) were selected as Sustained Districts to focus on viral suppression. These districts account for an additional 25% of PLHIV but have fairly high ART coverage at around 80%. Finally, five specific sites were identified for key populations based on high HIV prevalence and a high estimated population of KPs. One additional site will target a specific area with a TB prevalence 2.5 times the national average. See Table 3.1 and Figure 3.1 below.

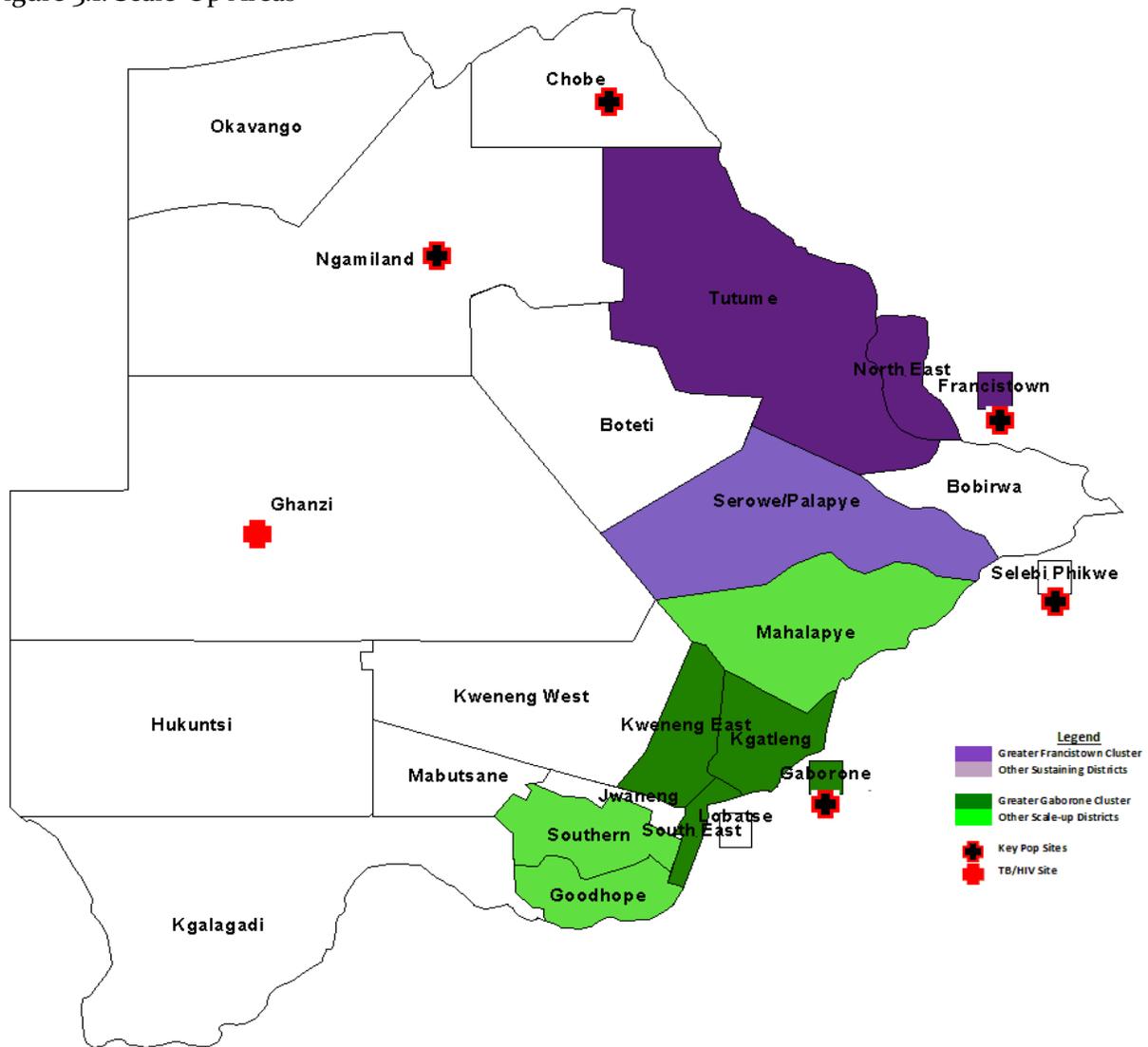
Table 3.1: Scale-Up Areas

| SNU 2 | Total PLHIV | % of PLHIV | Current on ART | ART Coverage | Unmet Need (all PLHIV) | Unmet need (per national guidelines) | Net New Needed for Saturation |
|--------------------------------|-------------|------------|----------------|--------------|------------------------|--------------------------------------|-------------------------------|
| National | 321,270 | 100% | 212,433 | 66% | 108,837 | 31,743 | 44,583 |
| Scale-Up SNUs (PLHIV +9000): | | | | | | | |
| Greater Gaborone | 110,228 | 34% | 55,281 | 50% | 54,947 | 29,277 | 32,902 |
| Mahalapye District | 24,972 | 8% | 14,676 | 59% | 10,296 | 3,822 | 5,302 |
| Southern District | 13,086 | 4% | 8,038 | 61% | 5,048 | 2,115 | 2,431 |
| Goodhope District | 9,262 | 3% | 4,449 | 48% | 4,813 | 2,355 | 2,961 |
| Sustained SNUs (ART coverage): | | | | | | | |
| Greater Francistown | 53,305 | 17% | 41,937 | 79% | 11,368 | (510) | 707 |

| | | | | | | | |
|--|--------|----|--------|------|---------|---------|---------|
| Serowe/Palapye District | 26,842 | 8% | 20,900 | 78% | 5,942 | (399) | 574 |
| Population Focus (Net new needed for saturation under 2000): | | | | | | | |
| Selebi-Phikwe District | 11,755 | 4% | 7,441 | 63% | 4,314 | 1,136 | 1,963 |
| Ngamiland District | 11,496 | 4% | 15,112 | 131% | (3,616) | (6,471) | (5,915) |
| Ghanzi District | 6,121 | 2% | 3,171 | 52% | 2,950 | 1,156 | 1,725 |
| Chobe District | 4,171 | 1% | 3,481 | 83% | 690 | (173) | (144) |

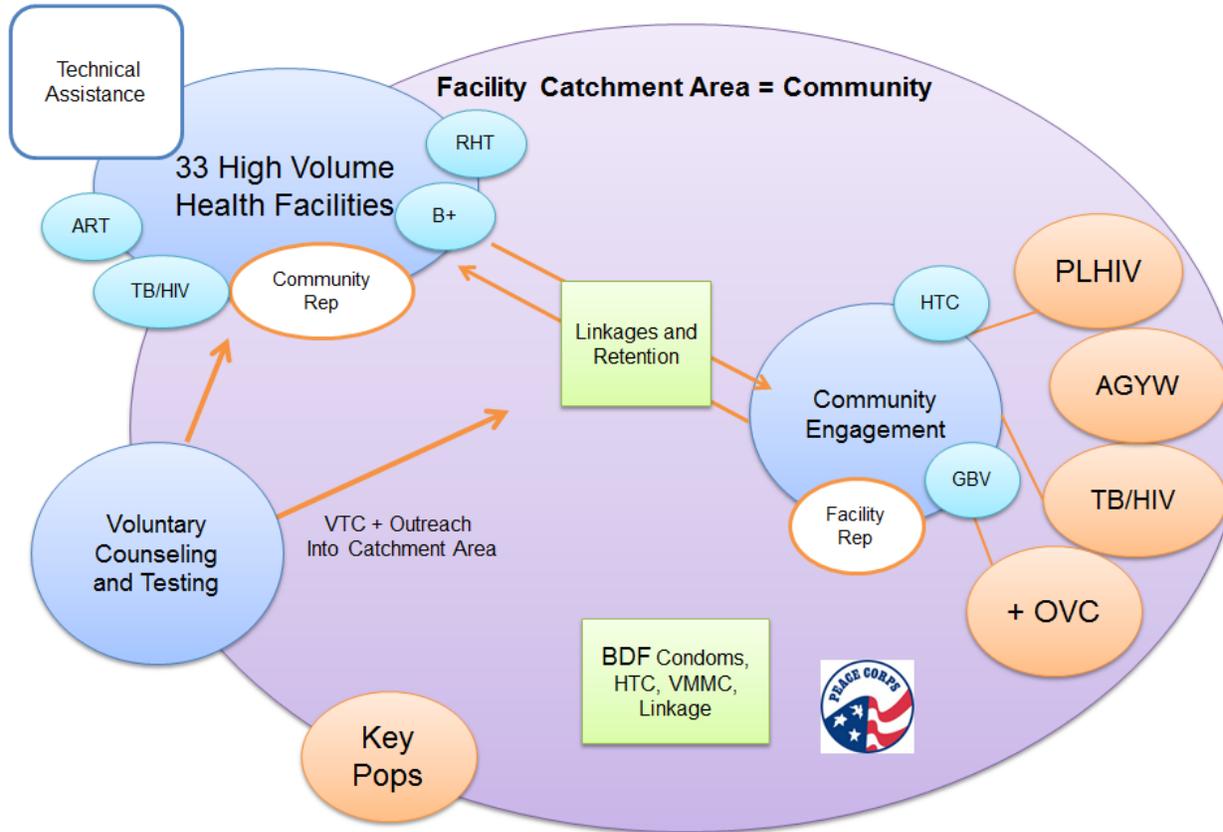
Greater Gaborone includes Gaborone, Kweneng East, Kgatleng, and South East.
Greater Francistown includes Francistown North East, and Tutume.

Figure 3.1: Scale-Up Areas



In the Scale-Up Districts to Reach 90-90-90 PEPFAR will support program services at 33 high-volume facilities including TA as appropriate per location. Figure 3.2 below represents the continuum of care model in scale-up areas. Meanwhile, Sustained Districts will receive targeted TA focused on viral suppression activities at 30 high-volume facilities.

Figure 3.2: PEPFAR Supported Continuum of Care Model for Scale-Up Districts



PEPFAR/B will focus on KPs (FSW and MSM) as the needs of these groups are largely unaddressed by other partners and because they are high-risk populations with a higher incidence than the general population (see section 1.o). Furthermore, as documented in section 1.o, AGYW aged 15-24 are a priority population since they are twice as likely to acquire HIV as their male counterparts and more likely to become victims of gender inequality and GBV, key drivers of the epidemic. While AGYWs will receive prioritized attention in all Scale-Up Districts to Reach 90-90-90, FSW and MSM interventions will occur at five aggressive scale-up sites.

PEPFAR/B has also identified four other important populations including military personnel, OVC, HIV/TB co-infected patients and refugees who must be targeted in COP15 on the path to reaching epidemic control. Military personnel have high HIV prevalence rates, with more disposable income and greater mobility than the general population. Military personnel will be targeted with specific VMMC and HTC campaigns, unique to the needs of their mostly all-male population. Given the mobility and disbursement of military personnel, services implemented in collaboration with the defense forces include established barracks that do not fall into the scale-up areas. OVC have a higher HIV prevalence than the general population under the age of 18 (5.2% vs. 3.5%¹⁸). They are also far more likely than other children to move from being “affected” by the virus to becoming infected, as well as facing other risks, making them an important focus population in order to prevent new infections.¹⁹ This is especially true for adolescent girls who have lost a mother and who are then more likely to engage in risky sexual behavior.²⁰ People with TB are a high-yield population for HIV testing and new ART initiations given the high co-infection rate in Botswana (61% of TB patients are PLHIV) and the immediate eligibility for ART of HIV/TB co-infected patients.

Current facility and community-based care and treatment programs have and will continue to appropriately prioritize integrated TB/HIV programming in scale-up SNU in order to reach this population. Given the high rate of TB transmission and increasing rate of TB/HIV co-infection in the Ghanzi district, on-going programs targeting TB/HIV patients will be sustained. In Ghanzi TB prevalence is two and a half times the national average: over 1000 per 100,000 compared to 337 per 100,000²¹. Given that TB remains the cause of 40% of AIDS-related deaths in Botswana, the uncontrolled TB epidemic in this part of the country is a threat to the efforts to prevent TB/HIV co-infection in the rest of the country, particularly given the mobility of the population. Finally, refugees will remain an important population to support as non-citizens do not have access to ART, except through PEPFAR support. The refugees live in Duwki Refugee Camp in Tutume District.

¹⁸ BAIS IV

¹⁹ Operario D, Underhill K, Chuong C, Cluver L. (2011). HIV Infection and Sexual Risk Behavior Among Youth who have Experienced Orphanhood: Systematic Review and Meta-Analysis. *International Aids Society*. 14:25.

²⁰ Ibid

²¹ TB program data, 2013

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Priority Populations

4.1 Targets for Scale-Up Locations and Priority Populations

Driven by the analysis of epidemiological data and considering the importance of location and population to accelerate epidemic control, the PEPFAR/B goal in COP15 is to optimize evidence-based clinical interventions (e.g. ART, VMMC, and PMTCT/Option B+ services) and non-clinical interventions (e.g. linkage and retention strategies and quality improvement) in scale-up areas with 74% of PLHIV. These achievements would significantly reduce the number of new HIV infections and deaths among PLHIV and reduce the number of perinatal transmissions to near zero.

Based on these data as well as financial information, the following targets have been set and in FY16 PEPFAR/B will:

- Support testing for 360,347 persons by providing DSD for 134,444 persons in community-based HTC settings in the scale-up SNUs and 219,903 persons through targeted TA in facility-based, government-supported RHT sites in the scale-up SNUs. Targeted TA will also be provided at the BDF military camps to reach 6,000 military personnel and their families with HTC services.
- Achieve 70% ART coverage by APR16 and 80% by APR17 in scale-up SNUs to achieve epidemic control. Net new needed to saturation of 80% by APR17 in the scale-up SNUs is 43,595 and PEPFAR's contribution (82.4%) is 35,923. The 35,923 target is to be achieved in FY15 (5,689), FY16 (17,283), and FY17 (12,950). The target for FY16 is 31,207 (17,283 are net new needed for saturation plus 15% lost-to-follow-up of total on ART in the scale-up districts in FY16 [92,827]). The FY17 target is 26,317 (net new needed for saturation plus 15% lost-to-follow-up of total on ART in the scale-up districts in FY17 [103,604]). Targets are set assuming the GoB will implement CD4 500. These targets will need to be adjusted if the national treatment guidelines remain a CD4 cutoff of 350 cells/ μ l.
- Provide TA to initiate 90% of HIV-infected pregnant and breast-feeding women in the scale-up areas on lifelong ART, optimize ART retention and adherence of mother-infant pairs in MCH clinics, and ensure 90% of HIV-exposed infants receive DNA PCR tests by eight weeks of age. A total of 4,435 additional HIV-infected pregnant women will need to be enrolled in lifelong ART to reach 90% coverage countrywide.
- Support community activities focusing on linkages to care, adherence and retention and 36,688 PLHIV will receive services outside of the health facility. In the scale-up areas, QI work with community-based organizations will contribute to increasing the treatment retention rate within FY16.
- Reach 5,364 FSW and MSM through prevention activities, representing 80% of target KPs in selected sites.

- Reach 20,000 adolescent girls and young women with prevention activities and 13,620 AGYW through technical assistance in the scale-up areas.
- Reach 11,118 OVC with care and support services, including linkage to HIV prevention, testing and treatment, and 1,500 OVC through technical assistance.
- Provide post-GBV care services to 1,500 GBV survivors and implement GBV prevention activities in scale-up areas.
- Support VMMC services. An estimated 109,908 males who are 15-29-years-old are in one scale-up SNU, with a circumcision prevalence of 27%. A total of 48,810 will need to be circumcised in this SNU to achieve 80% coverage for VMMC. The target for 2016 is set at 14,600 circumcisions in this SNU, which will take it to 49%. Scale-up to the full 80% coverage target for impact will be achieved by September 2017. Targeted TA will also be provided at the BDF military camps to reach 1,400 military personnel with VMMC services.
- A total of 35,000 circumcisions will be performed during the accelerated six-month VMMC campaign (August 2015-February 2016) in twelve targeted health districts including Gaborone and Kweneng East.

Table 4.1.1: ART Targets in the Scale-up SNUs

| | Total PLHIV | Expected Current on ART | Additional Patients Required for 80% Coverage | PEPFAR Contribution to 80% coverage | Target Current on ART (APR 2016) | Newly Initiated in FY16 |
|--------------------|-------------|-------------------------|---|-------------------------------------|----------------------------------|-------------------------|
| Greater Gaborone | 110,228 | 50,345 | 32,902 | 27,308 | 64,999 | 23,447 |
| Mahalapye District | 24,972 | 12,104 | 5,302 | 4,188 | 14,526 | 3,885 |
| Southern District | 13,086 | 6,955 | 2,431 | 1,969 | 7,889 | 1,649 |
| Goodhope District | 9,262 | 3,967 | 2,961 | 2,457 | 5,413 | 2,226 |
| Total | 157,548 | 73,370 | 43,595 | 35,923 | 92,827 | 31,207 |

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Scale-up SNUs

| | Tested for HIV | Identified Positive | Enrolled on ART |
|------------------------------------|----------------|---------------------|-----------------|
| Clinical care patients not on ART | n/a | n/a | - |
| TB-HIV Patients not on ART | 2,185 | 1,058 | 1,255 |
| HIV-positive Pregnant Women | 14,180 | 1,419 | 2,661 |
| Other priority and key populations | 355,352 | 42,642 | 27,291 |
| | | | - |
| Total | 371,717 | 45,119 | 31,207 |

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

| Target Populations | Population Size Estimate (scale-up SNUs) | Coverage Goal | APR 16 Target |
|--------------------|--|---------------|---------------|
| FSW | 5786 ^a | 80% | 4629 |
| MSM | 919 ^b | 80% | 735 |
| AGYW (15-24) | 103,039 | 20% | 20,000 |
| | | | |
| | | | |
| Total | 110,296 | | 25,364 |

^aThe total population of FSW in Gaborone, Francistown and Chobe was estimated at 4,153 FSW during the 2012 Mapping, Size Estimation & BBSS. An additional 300 FSW are included for Chobe based on increased sex work in the area related to a major construction project. An additional 1742 was included for Ngamiland and Selebi-Phikwe.

^bThe estimated population size for MSM includes only Francistown and Gaborone.

^cThis includes all AGYW, 15-24 years in the 5 scale-up districts as detailed in the 15-24 data set 10%.

^dThis figure includes the total number of PLHIV residing in the 13 scale-up districts with the highest HIV prevalence

Table 4.1.5: Targets for OVC and Linkages to HIV Testing, Care and Treatment

| | Estimated # of Children PLHIV (<15) | Target # of active OVC (FY16 Target) OVC_SERV | Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target) OVC_ACC |
|-------------------------|-------------------------------------|---|--|
| Greater Gaborone | 3,361 | 5,343 | 3,205 |
| Mahalapye District | 969 | 1,741 | 1,045 |
| Southern District | 363 | 759 | 455 |
| Goodhope District | 377 | 358 | 215 |
| Greater Francistown | 1,457 | 1,431 | 858 |
| Serowe/Palapye District | 847 | 850 | 510 |
| Ngamiland District | 407 | 505 | 303 |
| Selebi-Phikwe District | 497 | 132 | 79 |
| Total | 8,278 | 11,119 | 6,670 |

Table 4.1.6: CDC Sites in Scale-Up Areas

| Subnational Unit | Site Name | Total # on ART |
|---------------------|-------------------------------|----------------|
| Greater Gaborone | PMH | 7,945 |
| Greater Francistown | Nyangabgwe RH | 6,034 |
| Greater Gaborone | Nkoyaphiri Clinic | 3,822 |
| Greater Gaborone | Phase II Clinic | 3,746 |
| Greater Francistown | Tutume Primary Hospital | 3,726 |
| Mahalapye | Mahalapye DH | 3,605 |
| Southern | Kanye SDA Hospital | 3,464 |
| Greater Francistown | Tonota Clinic | 3,194 |
| Greater Gaborone | Scottish Liv. Hospital | 2,926 |
| Greater Francistown | Area W Clinic | 2,898 |
| Mahalapye | Airstrip Clinic | 2,776 |
| Serowe/Palapye | Sekgoma MH | 2,761 |
| Greater Francistown | Botswelelo Clinic | 2,478 |
| Greater Gaborone | Bontleng Clinic | 2,398 |
| Greater Francistown | Masunga PH | 2,363 |
| Greater Gaborone | Tlokweng Main Clinic | 2,349 |
| Greater Gaborone | Thamaga PH | 2,344 |
| Greater Francistown | Jubilee Clinic | 2,342 |
| Mahalapye | Sefhare PH | 2,337 |
| Greater Gaborone | Baylor | 2,302 |
| Greater Gaborone | Phuthadikobo Clinic | 2,218 |
| Serowe/Palapye | Palapye PH | 2,214 |
| Goodhope | Goodhope PH | 2,119 |
| Greater Gaborone | Deborah Retief Memorial Hosp. | 2,040 |
| Greater Gaborone | Bamalete Lutheran Hosp. | 1,884 |
| Southern | Moshupa Clinic | 1,872 |
| Greater Gaborone | Village Clinic | 1,832 |
| Greater Gaborone | Broadhurst Clinic | 1,739 |
| Serowe/Palapye | Serowe Clinic | 1,710 |
| Mahalapye | Shoshong Clinic | 1,685 |
| Greater Gaborone | Morwa Clinic | 1,677 |
| Greater Francistown | Gerald Estate Clinic | 1,423 |
| Greater Gaborone | Broadhurst Clinic 3 | 1,421 |
| Serowe/Palapye | Kediretsewe Clinic | 1,395 |

| | | |
|----------------------------|----------------------|-------|
| Serowe/Palapye | Lerala Clinic | 1,389 |
| Greater Gaborone | Mogoditshane Clinic | 1,360 |
| Greater Francistown | Masego Clinic | 1,254 |
| Southern | Kanye Main Clinic | 1,196 |
| Serowe/Palapye | Kadimo Clinic | 1,192 |
| Serowe/Palapye | Nutrition Clinic | 1,156 |
| Serowe/Palapye | Ext 3 Clinic | 1,152 |
| Greater Francistown | Nata Clinic | 1,091 |
| Greater Gaborone | Old Naledi Clinic | 1,081 |
| Serowe/Palapye | Newtown Clinic | 1,053 |
| Greater Francistown | Botshelo Clinic | 1,042 |
| Greater Francistown | Tatitown Clinic | 1,027 |
| Greater Gaborone | Gabane Clinic | 1,025 |
| Serowe/Palapye | Lotsane Clinic | 1,022 |
| Greater Francistown | Sebina Clinic | 989 |
| Greater Francistown | Borolong Clinic | 978 |
| Serowe/Palapye | Mmashoro Clinic | 928 |
| Greater Francistown | Gweta PH | 889 |
| Serowe/Palapye | Maunatlala Clinic | 869 |
| Greater Francistown | Mokgoro Clinic | 866 |
| Greater Francistown | Tsamaya Clinic | 835 |
| Goodhope | Mmathethe Clinic | 788 |
| Serowe/Palapye | Maokatumo Clinic | 786 |
| Greater Gaborone | Makakatlela | 779 |
| Greater Gaborone | Metsimotlhabe Clinic | 723 |
| Mahalapye | Xhosa | 612 |
| Mahalapye | Mookane Clinic | 602 |
| Goodhope | Pitsane Clinic | 469 |
| Goodhope | Phitshane Molopo | 299 |

Table: COP15 Treatment Targets and Eligible Patients Under CD4 350 and CD4 500

| | Current on treatment (FY15) | Set Target (COP15, to reach 80% ART coverage) | Eligible not on treatment (CD4<350) | Eligible not on treatment (CD4<500) |
|--------------------------------|------------------------------------|--|---|---|
| National | 229133 | | 20533 | 66838 |
| 11 SNUs | 157138 | | | |
| 63 facilities | 128522 | | | |
| 4 Scale-up SNUs | 89343 | | 14,220 | 46,289 |
| | | | | |
| 33 facilities(Scale-up) | 73370 | 31207 | 11719 | 38146 |

Note: UNAIDS spectrum file, March 2015 estimated the total number of HIV positive patients not on treatment at 20,533 and 66,838 based on CD4<350 and CD4<500 respectively. We proportionately distributed to the health districts based on the total PLHIV percent in these districts and allocated to the 33 facilities based on the proportion of total patients on ART from these facilities to the total in the district. PEPFAR/B set COP15 treatment targets based on what it takes to support the goal of achieving epidemic control by 2017 (reach 70% ART coverage by FY16 and 80% by FY17 as described on pg. 27 of this SDS). It also assumes that the GoB will adopt CD4 500 from the current National Guideline that is at CD4 350. The COP15 target set (31,207) is 2.7X the number (11,719) of HIV positives that are eligible under the current guideline. Moreover, the treatment targets are also constrained by the HTC positivity yield. Due to HTC financial constraints and to balance the budget, PEPFAR/B used HTC HIV positivity yield from what is currently observed of about 7% to 12%. The GoB has indicated a possible change to CD4 500 in April of 2016 with the next budget cycle. Once policy change is enacted, it takes a few of months to translate the policy to programs and roll out nationally. Consensus at the Frankfurt review was to go with these ambitious but desirable targets. PEPFAR/B plans through its facility and community level HTC supports to identify HIV positive patients and roll out pre-ART care program to link the identified patients into care and those eligible to treatment. Once the Guideline changes, PEPFAR will refer back to the pre-ART database to link those who newly become eligible to treatment. PEPFAR/B will track progress both by CD4 350 and CD4 500 criteria and HTC positivity yield and may need to adjust targets at a future date accordingly.

4.2 Key and Priority Population Prevention

PEPFAR/B will prioritize prevention activities among KPs (FSW and MSM) in select areas, and priority populations consisting of AGYW. In addition, prevention efforts will continue to focus on important populations such as military personnel. In the coming year, emphasis will be placed on the following core prevention interventions: increased access to and uptake of comprehensive prevention services for FSW and MSM in defined areas with known concentrations of KPs including Gaborone, Francistown, Ngamiland, Selebi-Phikwe and Chobe; evidence-based interventions for AGYW; continued support to the piloting of the GBV referral system; and targeted condom distribution for the military and KPs. The key program components will be aligned to the core package outlined in the COP 15 Technical Considerations (page 141)²². Significant efforts will be made through public diplomacy and other avenues to address stigma and discrimination and facilitate an enabling environment.

²² These include, HIV counseling and testing, screening and treatment of STIs, risk reduction education and skills provision, condom distribution and training on correct and consistent use, screening and referrals for TB treatment, ART initiation or referral for HIV positive FSWs, referral to PMTCT services, counseling for family planning and provision of family planning services, referrals for economic empowerment training and care and retention services.

All prevention interventions will be supported with in-country funds, excluding funds through the Local Capacity Initiative to support KP advocacy. The PEPFAR/B team anticipates that as a result of these prevention efforts, particularly at the community level, male clients of FSW will be reached, including mine workers and mobile populations such as truckers.

PEPFAR/B's decision to focus on these populations reflects a strategic shift emphasizing groups most critical to epidemic control based on HIV prevalence and, where available, incidence by geographic regions and districts. BAIS IV, BYRBSS and BBSS data within the national and district level were used to prioritize high impact, evidence-based interventions that address current coverage gaps in the continuum of care cascade for key and vulnerable populations to complete the core, near-core and non-core analysis. The alignment of prevention interventions for priority populations in high disease burden districts is enhanced by PEPFAR/B's commitment to strategic linkages between programs to increase yield for services like VMMC, post-GBV care, HTC, PMTCT and ART including retention and adherence. Prevention interventions include both facility and community-based approaches supported where possible by QI interventions to increase the ability to achieve targets. The PEPFAR/B team is working with IPs to significantly reduce support in low-yield sites and low prevalence/burden geographic areas. This has started with a re-focusing of COP14 pipeline funds and will continue in COP15 with some activities ending while others are redesigned to align with the country's new priorities. The support that is provided in COP15 will focus on targeted populations with high impact interventions. Peace Corps (PC) will continue to involve volunteers in support of prevention activities including teen clubs for PLHIV and camps for AGYW in priority areas and other geographic areas where volunteers are already living and working. Moving forward, PC will align PEPFAR financial support of new volunteer placements with PEPFAR/B's priority areas. AYGW interventions will be focus on the AGYW, their sexual partners, their families and their communities with specific emphasis on reducing HIV transmission, addressing GBV and improving livelihoods of households²³. The AGYW program will include curriculum based, age-appropriate, HIV prevention skills and sexuality education (SASA) and also draw from the outlined DREAMS package. Community leaders and families will be actively engaged to address harmful gender norms and ensure protection of girls and women and stigma reduction.

Regulations for the Domestic Violence Act of 2008 have recently been finalized, which provide protocols and guidelines for responding to and addressing domestic violence. The PEPFAR/B team is supporting implementation of these regulations, as well as the Children's Act of 2009, which is a crucial component of the child protection system and critical for addressing violence against children. PEPFAR/B is also providing advocacy and TA to develop policy for KPs. This effort capitalizes on newly expressed interest and commitment by the GoB to address the HIV risks of KPs, particularly FSW, while facilitating the supportive environment and legal framework

²³ Interventions will focus on targeted risk assessment and risk information/skills/counselling, condom promotion and negotiations, addressing sociocultural factors which increase vulnerability of girls to HIV, increase uptake of HIV prevention, treatment and care services including HTC, PMTCT, post GBV care, STI & cervical cancer screening, TB testing and reproductive health.

for KP activities. The PEPFAR/B team believes that TA in these key policy areas will foster improved and expanded service delivery, funded with domestic or other donor resources.

The team plans to reach 80% of the KP targets in all selected KP sites for all the targets, including prevention, treatment and care and support.

4.3 Voluntary Medical Male Circumcision (VMMC)

The WHO and UNAIDS recommend that VMMC be offered to heterosexual men in combination with other evidence-based HIV risk reduction interventions in settings with generalized HIV epidemics and low prevalence of circumcision. PEPFAR/B is working with the GoB to scale-up VMMC coverage to 80% among males 15–29 years in one scale-up SNU, Greater Gaborone, which has a substantial proportion of unmet need. Part of the Greater Gaborone SNU, Gaborone and Kweneng East, have high HIV disease-burden and represent 34% of the total population of men between 15–29 years old.

In 2015, PEPFAR/B will provide DSD using surgical and PrePex devices as well as focused TA to provide for VMMC among males 15–29 years. Age-appropriate VMMC services to males outside the target age cohort of 15–29 years will be provided on a walk-in basis at PEPFAR supported sites. Focused TA will be provided to the MoH with the goal of increasing coverage outside of PEPFAR/B's two scale-up SNUs for FY15. The pipeline redirection of \$5 million from the MoH cooperative agreement to support a 6-month VMMC acceleration campaign is expected to provide a catalyst to scale-up VMMC services in other areas where DSD was never initiated by PEPFAR. At the guidance of the PEPFAR/B team, the campaign will make use of five mobile surgical vehicles from the GoB and capitalize upon recent task shifting/sharing practices for PrePex device and surgical services respectively. The Global Fund will invest \$2,147,661 for recruitment and retention of mobile clinic staff and complementary VMMC services in other areas.

Beyond guidance implementing the MoH VMMC campaign, PEPFAR/B will focus TA in FY15 on select PEPFAR indicators to ensure quality of services, including VMMC site adherence to the WHO minimum package²⁴ and active referral of clients testing HIV positive at VMMC sites (~1.2 – 2% of all clients) to HIV care and treatment. TA designed to generate robust data for decision-making and improve service quality will be provided by conducting SIMS, data quality assessments (DQA), external quality assurance (EQA), and continuous quality improvement (CQI) on a quarterly basis. PEPFAR also plans to support training and mentorship of M&E officers at VMMC sites and a VMMC modeling study to help MoH refine and refocus the national program in 2016. Botswana Defense Force (BDF) High Command and the U.S. Defense HIV/AIDS Prevention Program (DHAPP) are being actively engaged to facilitate data flow from the military sites. The plan is to reach 80% of the military population with VMMC services. Finally, PEPFAR support for early infant male circumcision (EIMC) activities will include providing TA for the

²⁴ This includes counseling on risk reduction and safer sex, HCT, STI screening and treatment, provision of male and female condoms, quality circumcision, post-operative follow-up and systematic assessment of adverse events.

integration of EIMC in maternal and neonatal child health programs as well as in-service training and mentoring of nurses and midwives.

4.4 Preventing Mother-to-Child Transmission (PMTCT)

The Botswana PMTCT program is almost exclusively GoB funded and implemented countrywide. Despite a strong national PMTCT program, which achieved very high coverage of HIV-infected pregnant women earlier than most other PEPFAR-supported countries, with low HIV-positivity rates among tested HIV-exposed infants, overall coverage for testing of HIV-exposed infants at 4-6 weeks remains low in Botswana. In FY 2014, the program was set to graduate and cease receiving external funding from PEPFAR, however, PEPFAR/B responded to a GoB's request to support Option B+ implementation.

In COP15, PEPFAR/B will support the vision to “achieve epidemic control and reduce the number of perinatal HIV transmissions to near zero within Botswana before 2018,” through initiating 90% of HIV-infected pregnant and breast feeding women on lifelong ART (Option B+). As the country implements Option B+, PEPFAR will support the strengthening of early infant diagnosis to ensure 90% of HIV-exposed infants receive DNA PCR tests by 8 weeks after birth and a final HIV diagnosis at 18 months or after weaning, when breastfeeding. Reaching the set target will be achieved through the following core activities: national TA for PMTCT on Option B+ national roll-out (training of eligible health care workers, especially the nurse prescribers countrywide) and supporting strategies to optimize ART retention and adherence among HIV-positive pregnant and breast feeding women. Currently, data on adherence and retention on PMTCT clients is not readily available, a gap that needs to be filled as B+ is implemented especially because clients who are not ill and enrolled on lifelong ART may not see the importance of continuing medication. PEPFAR/B will therefore support the GoB to develop and deliver integrated HIV service package to mother-infant pairs (MIP); the ‘one stop shop’ at MCH clinics and use of innovative ways for improving access to and retention in PMTCT care. At the site level, core activities will be DSD for refugees in Dukwi refugee camp. Near-core activities will include targeted site-level quality assurance and quality improvement interventions including strengthening of M&E systems and implementation of a robust tracking system to report on Option B+ initiation, mother and infant tracking using cohort monitoring strategy for retention and adherence and early infant diagnosis as well as for improving linkages to care with community-based interventions. PEPFAR/B and IPs will conduct SIMS+ to assess PMTCT program performance and remediation respectively at the identified 63 high-volume sites in the priority areas at least 4 times a year. These sites shall report selected clinical service quality indicators, for real time monitoring. This undertaking will allow for a learning curve with rapid corrective measures as B+ is rolled-out countrywide.

4.5 HIV Testing and Counseling (HTC)

To achieve epidemic control before 2018 based on the UNAIDS 90:90:90, the HTC interagency team assumed that Botswana has to ensure that at least 90% of the PLHIV know their status.

Based on the estimated number of PLHIV with unknown diagnosis and the HTC positive yield, a target of 49,226 PLHIV would need to be identified in FY16 by testing 514,506 clients. Selected scale-up districts for DSD of HTC were based on those with the highest unmet need for ART and need to support a proposed transition to treatment initiation at a CD4 count of 500. Specifically, PEPFAR will support DSD for community-based testing in the scale-up SNU (see Table 3.1). HTC services will target older males, TB/HIV patients, OVC and families, AGYW and KPs using the HTC modalities most likely to increase the identification of new HIV diagnoses among these populations.

The adopted service delivery package and TA approach for the PEPFAR/B HTC program in the scale-up SNU will include:

- DSD support for high burden geographic districts through: community-based HTC at high-volume and high-yield sites; expanded outreach in high prevalence geographic areas; targeted mobile testing in high risk areas including farms, construction sites and mines; and targeted specialized services for KP in priority hotspots and geographic districts.
- Prioritizing implementation of activities to ensure HIV positive persons are successfully linked to care and treatment, as well as documentation of linkage to care efforts.
- TA to MoH to optimize HTC services and achieve a higher HIV-seropositive yield by strengthening RHT using evidence-based, structural interventions (e.g., re-directing how lay counselors are used in facility settings).
- TA to BDF to maximize reach of testing services for military personnel by ensuring quality assurance, quality improvement and targeting of HTC services in 10 sites/military camps.

It is assumed that implementation of this strategic approach and modalities will increase the current yield of VCT to 12%.

In districts where PEPFAR/B already has or will be scaling back testing services, the GoB's RHT program will continue to identify newly diagnosed PLHIV in those geographic areas. Additionally, PEPFAR/B will support strengthening capacity of the Botswana National Quality Assurance Laboratory (BNQAL) to assure the quality of rapid testing

4.6 Facility and Community-Based Care and Support

In the scale-up SNU for COP15, there are an estimated 157,548 PLHIV. PEPFAR/B will provide support at the national and priority area levels to increase new patients enrolled in care. Support will also be provided in communities to optimize linkage to and retention in care and treatment across the cascade. PEPFAR/B SIMS visits have identified gaps in linkages across facility-based partners, and among service providers. These gaps are in the following core essential elements (CEEs): patient tracking for pre-ART patients, facility linkage to community care and support services, STI screening, ART and adolescent support services.

PEPFAR/B support focuses on building strong linkages between facilities and communities to ensure a closed loop (continuum of care) of all health services and referrals to and from the

community-based settings. PEPFAR/B will also work closely with NACA HTC initiatives under the Community Acting Together to Control HIV (CATCH). This is an initiative launched by NACA, MLG, MoH, UNAIDS, and community partners to expand grass-roots HIV response under local leadership. Community support will include strengthening the referrals for HIV/AIDS programs between health facilities and community-based interventions. To facilitate this, pre-ART tools (register and patient record tools) have been developed and they will serve as a start to improving pre-ART care, especially linkages to care and regular CD4 monitoring for patients who are not immediately eligible for treatment. Health care workers will be trained on the use of the register and patient records. Furthermore, collaboration with civil society and community-based organizations (CBOs) will be strengthened in order to improve timely initiation of ART among patients diagnosed as HIV-positive, and retention and adherence once initiated on ART. The focus of PEPFAR/B care and support site-level core services will be in the scale-up SNU's. The package of services in the scale-up SNU's includes:

- Support for retention of pre-ART and ART clients including linking for CD4 monitoring
- Engagement of community members, facility staff and PLHIV in QI at the community-level to build the Botswana-specific evidence-base for locally-relevant community-based linkage and retention models
- Positive health, dignity, and prevention (PHDP) minimum package of services
- Adherence counseling and support
- Regular assessment and documentation of clinical and psychosocial needs with linkage to other facility and community-based services as appropriate
- Community treatment support

It is expected that the Targeted TA for care and support activities at the scale up SNU's would ensure linkage and retention of patients in care with timely initiation of ART, for example a functional pre-ART care system, and this will address the second 90 of UNAIDS 90:90:90 goal. The sustaining districts will be provided support to retain patients on treatment so that they are virally suppressed. This will be done through enhanced facility based ongoing treatment adherence counselling at the various supported sites within the sustaining SNU's.

4.7 TB/HIV

As cited earlier in section 1.0, 61% of TB patients are HIV-positive and TB remains the leading cause of death for PLHIV in Botswana²⁵. In light of this, the 2011 Botswana TB treatment guidelines recommend starting ART in all HIV-positive TB patients regardless of CD4 cell count. Although ART provision for HIV-positive TB patients has risen in Botswana from 45% in 2010 to 72% in 2013, there remains a significant gap. Additionally, the number of notified TB patients (i.e. those who are diagnosed and started on treatment) is substantially less than the estimated number of TB cases due to the fact that the TB case detection rate is only 75-85%. Consequently, ART coverage among HIV-positive TB patients is much lower when based on the estimated HIV-

²⁵ WHO Global TB Report, 2014

positive incident TB cases leaving an ART coverage gap of 41% of HIV-positive TB patients to reach the 90% target.

In the last few years, PEPFAR/B support for TB/HIV activities has resulted in several notable successes including increased ART uptake among TB/HIV co-infected patients from 45% in 2010²⁶ to 72% in 2012 and HIV testing rates of 91% among TB patients²⁷. However, TB screening rates among HIV patients remain unknown due to poor recording and reporting systems. Additionally, as highlighted in the WHO's Global TB report 2014, Botswana has the highest rate of TB patients (49%) being referred by the community, indicating strong community interest and involvement in the identification and care of TB patients. Additionally, 65% of TB patients are enrolled in community TB care²⁸, which reduces the financial and technical strain on both the health system and the patient.

Given the 61% TB/HIV co-infection rate in Botswana, TB care sites are potential high-yield locations to identify patients who are eligible for ART and should be among focus areas for epidemic control. Strategies for improving identification of TB/HIV patients and increasing ART uptake among this population to the FY16 target of 90% in the scale-up SNU's and will include:

- Continuing to scale-up improved case finding, including community referrals and effective use of GeneXpert platforms and lab quality assurance activities which ensure accurate and rapid TB diagnoses
- Improving case management to increase ART initiation through linkages between TB and ART sites, training of health care workers (HCW), intensifying mentoring, and supporting supervisory activities (including SIMS)
- Engaging communities and CBOs further in TB screening, ensuring HIV testing in TB patients, case finding and community-level integration of TB/HIV activities, including community-based directly observed therapy (DOT) and contact tracing Introduction of pre-ART registers to strengthen M&E systems and ensure that all eligible patients are initiated on ART as soon as possible
- Infection control and isoniazid preventive therapy (IPT)

Furthermore, we must ensure continued coordination and TA support for the national TB program at the MoH level, including integration of M&E for TB and HIV, and a specific focus on aligning PEPFAR and potential Global Fund-financed TB-HIV activities to leverage and best utilize both investments. This will entail ensuring that there is no duplication geographically and programmatically through dialogue and coordination. In Ghanzi, where TB/HIV efforts are of particular importance given the high TB transmission rates, only community TB/HIV efforts including intensified case finding, TB screening, HIV testing and linkage to TB and HIV care, treatment and adherence support will continue to be provided. The Targeted TA support at the

²⁶ WHO Global TB Report, 2011

²⁷ WHO Global TB Report, 2014

²⁸ National TB Program Report, 2012

facility level is anticipated to increase the number of TB/HIV patients initiated timely on ART. It is also envisioned that through TA the IP would support the TB screening of all HIV infected patients at every patient encounter, hence more TB cases detected and managed in a timely manner.

4.8 Adult Treatment

Botswana has a generalized HIV epidemic that has seen a steady rise in prevalence from 17.1% in 2004, to 17.6% in 2008, and now 18.5% in 2013. The current estimate is that 52% of PLHIV are currently on treatment in the scale-up SNUs that PEPFAR/B proposes to support. PEPFAR/B will technically support 33 high volume sites in the scale-up SNUs.

In FY16 PEPFAR/B will support the following:

- Supporting the GoB to change the CD4 count at initiation from 350 cells/ μ l to 500 cells/ μ l;
- Conducting national trainings to ensure that a competent workforce exists that can implement the care and treatment programs including the new guidelines for Option B+ and 2013 WHO recommendations including CD4 500 ;
- Mentoring, conducting SIMS+, and providing SIMS+ remediation at the 63 high-volume sites to optimize ART coverage for groups already eligible regardless of CD4 count (PMTCT Option B+, TB/HIV, children under 5 years of age) and ensure high quality services are provided to all PLHIV;
- Implementing a test and offer program for FSWs who are Botswana nationals;
- Providing clinical care and treatment of HIV for refugees in the camp at Dukwi;
- Support communities to link clients into the health systems, retain them in services, and ensure adherence to treatment.

In COP 2015, the PEPFAR treatment program plans to continue to support the Dukwi refugee camp and the test and offer program for FSW in five KP scale-up sites. Currently, the ART program does not incorporate focused QA/QI interventions; thus PEPFAR Botswana will be providing TA to the MoH to strengthen this aspect of the program. There have been recent ART drug and laboratory reagent stock-outs especially for viral load testing. Cross-cutting support for ART will focus on strengthening laboratory testing. Some of the weaknesses identified during the SIMS visits in the treatment domain were poor documentation, unavailability of standard operating procedures (SOP), and poor linkage to communities. PEPFAR/B intends to work closely with both facility and community-based partners to develop SOPs and improve collaboration in order to increase uptake of services and retention in care. Providing targeted TA to support health care workers (HCW) to ensure that there are standard procedures for identifying and tracking ART patients who have defaulted on their appointments and developing relevant SOP's that can be followed without fail. Following this will enable patients on treatment to achieve viral suppression. This addresses the third-90 of the 90-90-90 goals and reduces new HIV infections, treatment as prevention.

4.9 Pediatric Treatment

Thanks to the success of the long-running and highly effective PMTCT program for citizens, few Batswana children are identified as HIV-positive and currently 10,514 Batswana children are living with HIV. By the end of October 2014, there were 8,129 Batswana children on ART, 88 % of the projected 9,286 eligible for treatment. In late 2013, Botswana adopted the WHO recommendation for universal ART for all children under 5. Older children are initiated at CD4 count 350 cells/ μ l and below, the same as for adults. With the end of the funding to the Botswana-Baylor program, the Botswana Red Cross Society will be the only PEPFAR/B direct service provider for pediatric treatment with their work in the Dukwi refugee camp.

For COP15, PEPFAR/B plans to continue supporting pediatric services at Dukwi. In addition, PEPFAR/B will continue SIMS+ and remediation in the 63 sites in the scale-up areas. HCW attrition and transfer of trained staff to non-pediatric positions are an ongoing challenge, hence the need to continue to support the GoB on training efforts. Currently, the pediatric treatment program does not have focused QA/QI interventions and thus PEPFAR/B will be providing TA in this area, at the national and facility level, in scale-up areas. Adolescent non-adherence to treatment is another challenge which PEPFAR/B would like to continue addressing in the scale-up areas. At the community level, PEPFAR/B will support efforts to improve linkages between pediatric care and treatment, PMTCT and OVC programs to ensure that the few children diagnosed HIV-positive are linked to and retained in care. Ensuring adequate testing and follow-up of results for HIV-exposed children remains another challenge to improving pediatric HIV care and treatment. One of the weaknesses identified during the SIMS visits in the pediatric treatment domain was poor documentation and unavailability of SOPs. PEPFAR/B through its implementing partners will work towards development of these SOPs and improvement in documentation as well as use of program data to improve services. Regarding drug resistance and appropriate drug switches, targeted TA will provide support to HCW to ensure that there is a timely drug switch for patients failing their current treatment regimen. This will lead to virologic suppression and therefore addresses the third-90 of the 90-90-90 goals.

4.10 OVC

BAIS IV estimated a total of 130,879 OVC in Botswana of which 7,079 (5.4%) are estimated to be living with HIV. The GoB's OVC program provides basic needs that include food, toiletries and shelter. PEPFAR/B has been implementing complementary programs that address existing gaps, such as linking OVC and their family members to health and HIV/AIDS services particularly HTC, PMTCT, ART, VMMC and post-GBV care. The beneficiaries also benefit from child and social protection, psychosocial support, disclosure and ART adherence counseling, group-based household economic strengthening, youth livelihood programs, early childhood development and educational support. PEPFAR OVC interventions are implemented by CBOs at the community level, in close coordination with community members and relevant health care facilities.

Going forward the OVC program will deliberately focus on adolescent girls, ensuring that they are linked to relevant prevention, treatment and care services. Adolescent girls are a priority population for OVC because of their increased vulnerability to acquiring HIV. While fewer

children are now being born with HIV because of the nation-wide PMTCT program, many adolescents were born prior to the PMTCT era. It is therefore extremely important to identify adolescent girls and link them to HTC. The program will also target adolescent OVC with livelihood programs, social protection services, educational support and linkages to SRH and post-GBV services. In addition, PC will continue to make volunteer placements with OVC centers in scale-up areas. Implementation will use a mix of service delivery and TA. TA will be provided to CBOs by prime partners to ensure high quality service delivery, strengthen M&E for compliance with reporting requirements and to address SIMS+ findings. For the GoB, TA focuses on development and implementation of national policies and guidelines and M&E including conducting national surveys and administering tools to measure the strength of the national social service system. SIMS visits revealed a lack of written SOPs. The prime partners are addressing the issues and follow up visits will be arranged within 6 months to determine progress made.

5.0 Program Activities to Support Other Locations and Populations

5.1 Package of Services in Other Locations and Populations

The services that PEPFAR/B intends to maintain in Chobe target KPs; services in Ghanzi will target people living with TB/HIV. We are referring to these as aggressive scale-up sites. The package for KP includes HTC, STI diagnosis and referral, condom distribution, peer education, community-based outreach, addressing stigma and discrimination, and ensuring linkage to HIV treatment and care. The TB/HIV sustained package includes HTC for TB patients and families, screening for TB among PLHIV, contact tracing for family members, linking patients to HIV and TB treatment and care services, and promotion of adherence and retention in TB/HIV care.

The National TB Program Reports provides data on national estimates for TB/HIV while the BBSS provides estimates for KP. Program data at the national level was used to determine the number of people reached as well as unmet needs. This process informed the expected volume of beneficiaries. The required resources were calculated based upon the targets stated below and the unit expenditure derived from the FY2014 expenditure analysis data.

5.2 Transition Plans for Redirecting PEPFAR Support to Scale-Up Locations and Priority Populations

Over the next year, PEPFAR/B support for OVC and AGYW in non-scale-up areas (Lobatse, Mabutsane, Kasane, Okavango and Ghanzi) will be transitioned to scale-up areas only. This is primarily due to the fact that the current projects targeting these population groups in non-priority areas are coming to an end in May and June 2016. Because this is the last year of implementation for these projects, transition plans are being finalized to articulate how beneficiaries will be linked to other service providers where possible. This will allow PEPFAR/B to focus on projects in scale-up areas where the need for services targeting OVC and AGYW is the

greatest. The expected number of OVC to be affected by this transition out of non-priority districts is 3,427.

The PC transition plan involves aligning PEPFAR-supported volunteers to the scale-up areas in the COP15 implementation period. PC will place new PEPFAR-funded volunteers first in the scale-up area with the highest burden, then in the scale-up area with the second highest burden, etc., until all PEPFAR-supported volunteers have been assigned sites. It is possible that a small number of volunteers may be placed outside of the scale-up areas once sites have been saturated in those districts, in which case PC will next place volunteers in sustained areas with the highest disease burden. PC will continue to place volunteers nationwide, as there are more volunteers, than PEPFAR-funding. PC will also continue to set nationwide targets and report at the “community site” SNU level, and will continue to report the good work done by all volunteers.

PEPFAR/B will also transition 18 non-core technical investments as per the table in Appendix A. Of these 18 investments, nine will ultimately be transitioned to the MoH after priority activities have been completed²⁹; one will be transitioned to the BDF³⁰; two will be refocused in order to align with PEPFAR guidance³¹; five will be closed/halted³²; and one investment involved training providers to teach other providers without PEPFAR support³³. PEPFAR/B is developing transition plans for each of these investments in order to proactively address and ameliorate any potential challenges that could arise. (See Appendix A.3)

²⁹ palliative care, human resource information system, health policy costing studies, blood and injection safety, TB/HIV strengthening MDR-TB management and drug resistance survey, PMTCT, cervical cancer program manager, support for development of curricula for CPD and for in-service training and lab activities in the cooperative agreement with GoB.

³⁰ peer education for behavior change

³¹ QI for maternal mortality and civil society organizational capacity building

³² Assisting the GoB in outsourcing con-clinical services, BCC mass communication plans, construction, support for GAP genotyping lab and purchasing of laboratory equipment.

³³ VMCC: in-service training of providers in surgical, PrePex device and EIMC procedures

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Activities required to improve quality care across the HIV/AIDS continuum and continuously improve the health delivery system and health outcomes are interspersed throughout COP15 program areas.

6.1 Laboratory Support

Although the GoB supports a large proportion of the national response to the HIV/AIDS epidemics, gaps still remain in the quality of testing, procurement and availability of reagents and supplies that lead to disruptions in provision of testing. There is a need to address these gaps to improve efficiency in service delivery. In support of the rollout of Option B+, moving to CD4 500 for ART initiation, and ensuring quality testing for ART monitoring, PEPFAR/B will focus on the following interventions:

- 1) Provision of TA to optimize and strengthen laboratory testing:
 - a. Networks for specimens and results referrals;
 - b. Capacity to conduct HIV drug resistance testing within Botswana;
 - c. Operationalization of the National Public Health Laboratory;
 - d. Optimal coverage of RHT, EID, CD4, and VL
- 2) Site monitoring and quality improvement activities:
 - a. Roll-out of Strengthening Laboratory Management Towards Accreditation (SLMTA);
 - b. Use of Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA) and the SIMS check lists to conduct assessments in scale-up areas;
 - c. Training and mentorship of laboratory staff in scale-up areas;
 - d. Strengthening proficiency testing and coverage for HIV Rapid Test, CD4, and viral load (VL).
- 3) Cost saving measures:
 - a. Provision of TA to support equipment harmonization (i.e., decentralized versus centralized testing);
 - b. Support revision of the national testing guideline to move from parallel to serial testing
 - c. Preparation of proficiency material in country by the National Quality Assurance laboratory for RHT, CD4, VL, and TB GeneXPERT

| 1. Brief Activity Description | Deliverables | | Budget codes and allocation (\$) | | 6. Implementing Mechanism(s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|---|--|--|----------------------------------|--|---------------------------------|--|----------------------------|--------------------------|----------------|----------------------------------|-----------------------|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care (LTC) | 10. ART uptake | 11.*Other Combination prevention | 12. Viral suppression |
| Provide TA to strengthen specimen and referral networks | 80% of results will reach clients within specified Turn Around Time (TAT) | 90% of results will reach clients within specified TAT | \$0 | HLAB \$200,000 | CDC BW/HQ | Domestic & Service Access & Demand 11.8 (Y) | X | X | X | X | X |
| Provide TA for roll out of new POC technologies (CD4, VL, EID) | To shorten the period between HIV diagnosis and referral to care by 50% | To shorten the period between HIV diagnosis and referral to care by 80% | HTXS \$0 | HTXS \$50,000 | CDC HQ/BW | Domestic & Service QMS 0.8 (R) | X | X | X | X | X |
| Roll out of SLMTA to remaining laboratories and do follow up for priority labs | Improved quality of testing in the laboratories. 70% of labs in scale-up areas to perform tests according to SOPs. | 70% of the labs in scale-up areas to attain a minimum of 2 star rating on the SLIPTA checklist | \$0 | HLAB \$150,000 HLAB \$160,000 (reprogramming) | CDC BW/ASLM | Domestic & Service QMS 0.8 (R) | X | X | X | X | X |
| Conduct quality audits | | | \$0 | HLAB \$150,000 | | Domestic & Service QMS 0.8 (R) | X | X | X | X | X |
| Provide tailored mentorship per each facility in scale-up areas | 70% of labs and testing sites attain a minimum of 80% in Proficiency Testing (PT) | All labs and testing sites attain a minimum pass rate of 80% in PT | \$0 | HLAB \$200,000 | CDC BW/DOD | Domestic & Service QMS 0.8 (R) | X | X | X | X | X |
| Provide TA to Botswana National Quality Assurance Laboratory (BNQAL) for preparation of proficiency testing materials for HIV, CD4, EID, Chemistry, Hematology and VL testing | Able to monitor quality of testing country wide. Availability of data # testing facilities # enrolled in PT % of labs who performed well | Use of PT data to inform mentoring and training activities | HLAB \$375,000 | HLAB \$375,000 | CDC BW/ITECH | Domestic & Service QMS 0.8 (R) | X | X | X | X | X |

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| Provide TA to support implementation of equipment harmonization | Equipment operating at 70% capacity. | Equipment operating at 80% capacity 10%cost reduction on reagents | \$0 | HLAB \$200,000 | SCMS/CDC | Domestic & Service Commodity & Supply 13.4 (LG) | X | X | X | X | X |
|---|--------------------------------------|--|-----|-------------------|----------|---|---|---|---|---|---|

6.2 Strategic information (SI)

Current and future SI activities will mainly focus on supporting program needs for data to achieve epidemic control. As part of support for epidemic control, a site-based information system to monitor and evaluate key indicators at the 63 high volume sites will be implemented and funded as part of QA/QI systems for epidemic control. Moreover, data from SIMS+ and remediation efforts will be collected and analyzed to inform programs and above site level actions. Additionally, QI activities focused at the intersection of the community and facility level will help to inform the evidence base for the best model for linkage and retention for Botswana. QI efforts help to improve the availability of quality data to measure the effects of “tests of change” being implemented by QI teams. With a mature ART program and scarce information on the burden of drug resistance, an acquired drug resistance (ADR) survey is planned for FY 2016 to provide information on the performance of the national ART program. This survey will generate information on the level of viral suppression among patients on ART for 12 months as well as those on ART for 48 months or more. Outcome measures on the quality of first-and-second-line treatment offered in Botswana will be evaluated through this survey and will inform program planning. This survey will provide a national baseline on HIV drug resistance and will complement surveillance activities such as early warning indicator system. Additionally, in FY15 through FY16, the Violence against Children Survey (VACS) will be completed. The survey is expected to give national and subnational estimates on different forms of violence against children. HIV testing is incorporated in the survey and will help establish the association between violence and HIV amongst children aged 13-24. OVC program will also be supported through collection of the essential survey indicators (MER 1.5 outcome indicators) together with conducting the national situation analysis that was last done in 2008.

Overall, SI activities will help to ensure availability of data to measure components of the SID, in particular those areas with low scores: Allocative Efficiency, Technical Efficiency, and QM. Allocative Efficiency will be examined through the analysis of relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data will be used to assess high impact program services and interventions being implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time). Technical Efficiency will be addressed through evaluation of enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, to be able to achieve improved HIV/AIDS outcomes within the available resource envelope. Finally, QM will be examined through the measurement of quality of HIV/AIDS services in relation to established national/global standards that are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence).

| 1. Brief Activity Description | Deliverables | | Budget codes and allocation (\$) | | 6. Implementing Mechanism(s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|---|--|--|---|-----------|---------------------------------|---|----------------------------|--------------------------|----------------|----------------------------------|-----------------------|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care (LTC) | 10. ART uptake | 11.*Other Combination prevention | 12. Viral suppression |
| Surveillance | | | | | | | | | | | |
| Conduct ART drug resistance survey | Protocol development | ART drug resistance survey conducted and results disseminated to support ART program planning | \$200,000 | \$100,000 | APHL | | | | | | X |
| Second round of Bio Behavioral Surveillance Survey (BBSS) among Key Population in Gaborone, Francistown and Kasane. Baseline information was gathered in 2012 to generate prevalence and incidence statistics concerning risk factors for and occurrence of HIV and other STIs among FSWs and MSMs. | Consultations with GoB and partners completed Formation of technical working group for BBSS which endorsed the Survey study design, development and approval of protocols, and implementation plans | Data collection Analysis and finalization of report Dissemination of findings Plan for recommendations and findings | \$0 | \$500,000 | Measure Evaluation | Epi and Health data (13.5) | X | X | X | X | X |
| Conduct the Violence Against Children Survey | Protocol finalization Ethics application and approval | Data collection Data analysis and report writing Dissemination of findings | HVSI 1,530,000 (Applied pipeline) | \$0 | GoB | | | | | | |
| Data availability and use | | | | | | | | | | | |
| Conduct M&E support to the scale-up areas with 74% of PLWHIV | Scale-up areas supported through DQA activities Scale-up areas trained and mentored on collection of mortality data Support trainings on utilization of DHIS | Supported districts reporting improved data quality Supported districts having up-to-date mortality data Use DHIS data to conduct sub-national and site-level planning | \$0 | \$600,000 | I-TECH | Epi and Health data 13.5 Performance data (15) | X | X | X | X | X |
| GBV Referral system and Operations Research | Protocol developed and approved | Formal 12- month pilot process completed | \$600,000 (HVOP) | \$400,000 | MEASURE IV | Uptake of services | X | X | X | | |

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| | Initial pilot six-month phase completed | Operations Research data analyses and report produced | | | | Performance data (15) | | | | | |
| Data quality assessments & SIMS visits | Selection of IPs requiring SIMS visits | DQAs and SIMS visits conducted for selected IPs | \$0 | \$100,000 | MEASURE IV | Performance data (15) | | | | | |
| Gender Analyses | Discussions with GoB, UNAIDS, and other stakeholders to plan data analyses Identification of available information on Gender in Botswana | Gender analyses conducted Reports shared with stakeholders | \$80,000 (HVOP) | \$0 | MEASURE IV | Rights to Access Services Performance Data | X | X | X | X | X |
| OVC National Situational Analysis | Discussions with GoB, UNAIDS, UNICEF and other stakeholders to plan and finalize scope and protocol development and ethics approval | Collection of data, report sharing and dissemination | \$800,000 (HKID) | \$200,000 (HKID) | CRS | Epi and health data 13.5 performance data (15) | X | X | X | X | |
| MER 1.5 data collection | Development of SOW, ethics approval | Collection of data and report sharing | \$300,000 (HKID) | \$100,000 (HKID) | | | X | X | X | X | |
| Support PIMS II maintenance | Mentoring and support to PIMS sites in the scale-up areas | Availability of patient level data | HVSI \$510,000 (Applied pipeline) | \$600,000 | TBD | | X | X | X | X | X |
| Data warehouse at MOH | Support the development and use for linkage to care of the data warehouse at MOH | | \$100,000 | \$100,000 | ITECH | | X | X | X | X | X |

6.3 Health System Strengthening (HSS)

The PEPFAR/B is at a critical juncture. As PEPFAR resources are on a course of decline, PEPFAR/B investments in HSS will protect the accomplishments made by the PEPFAR program to date, maximize returns on current PEPFAR investments in the health system by building upon and evolving the current portfolio of HSS activities and leveraging efforts by other partners and the GoB, and promote greater ownership of the HIV response by the GoB. Additionally, the current HSS activities articulated in COP15 emphasize use of PEPFAR HSS funds to fill in health systems-related gaps that have been identified by the MoH, SID tool and the gap analysis. HSS activities provide an important contribution to addressing certain unsustainable elements, as demonstrated in the SID. The resulting HSS portfolio disperses limited resources across most of the health systems “building blocks”. These activities complement other (e.g., program system support) activities in achieving epidemic control and also ensuring control can be sustained. All HSS activities fall under near core-activities in COP15. As per the COP guidance, HSS activities are short term/time limited investments or activities that are critical and /or directly support achieving core activities and cannot yet be done well by other partners or the host government to control the HIV epidemic.

Health Financing supports epidemic control through ensuring appropriate levels of financial and human resources are available across the HIV-care continuum, particularly within identified high HIV-burden health districts. According to an examination of gaps, bottlenecks, structural and cultural barriers and SID findings, technical and allocative efficiency were identified as critical weaknesses in health financing and strategic investment. To address these weaknesses and gaps, PEPFAR/B will work to ensure that HIV service availability is an integral consideration of health financing strategies and reforms required for a sustainable country-led HIV response, by:

- Increasing technical efficiencies in delivery of HIV services. Activities will include:
 - Helping the MoH implement results of costing studies and analyses; improving the MoH capacity to use expenditure data to estimate unit costs and costs for specific services or interventions;
- Improving allocative efficiency through developing a better national understanding of national HIV/AIDS resource flows and capacity to manage them. This will be accomplished through the use of data from National Health Accounts, and institutionalization of the *One Health* tool that allows for unit cost analysis and optimization considering: key cost drivers and the efficiency of service delivery models;
- Operationalizing the health financing strategy and ensuring incorporation of HIV financing into future financing reforms (e.g., SHI, Medical AIDS schemes, cost recovery);
- Exploring funding sources and funding strategies to transition the GoB from PEPFAR funding;
- Assisting MoH with mobilizing adequate resources from reliable sources to pay for health needs.

Supply Chain - An effective supply chain system that ensures the availability of an adequate quantity of all HIV-related commodities to health facilities is critical to achieving epidemic control. Institutionalizing an integrated supply chain information system across relevant districts, improving commodities quantification, the supply planning process and contract management approaches will collectively help establish an effective system (minimizing commodities stock outs; 2) optimizing laboratory and other equipment allocation; 3) improving specimen transportation to facilities for analysis and results flow back to facilities to inform clinical care; and 4) improving delivery of contracted supply chain services. Supply chain activities will build on the investments that USAID has already made in improving the Central Medical Stores (CMS) and address the weak elements of the supply chain system also identified by the SID analysis. Proposed COP15 activities will focus on increasing capacity in district-level SCM necessary to ensure availability of HIV commodities while also protecting improvements made in central-level SCM. PEPFAR/B will provide targeted TA to the GOB to improve all elements of the supply chain at all levels of the system. PC will continue to provide supply chain training to volunteers serving in clinics and district health management teams so they can build capacity at the field level to better order and manage needed supplies.

Quality Improvement (QI) is a systematic and continuous means of improving health care services and ultimately the health status of targeted populations³⁴. QI focuses on ways in which the system supporting health service delivery needs to be modified to achieve desired health outcomes. It focuses on *changing the system* to engender continuous improvement in service quality. The need for QI across the HIV/AIDS continuum of care was identified as in strong need of attention in the SID analysis to achieve epidemic control and strategically maximize program impact. QI is particularly critical to enhancing health care worker skills, job performance, productivity and retention. QI initiatives in COP15 will be appropriately aligned to PEPFAR/B geographic areas and will span all program areas and levels of the system (community, facility and above site-levels) in need of change to increase access to and availability and quality of care among patient populations to achieve epidemic control. PEPFAR/B will address documented barriers to retention, and evaluate the effectiveness of locally-relevant methods for addressing these barriers. PEPFAR will provide TA to the MoH to operationalize its national quality improvement framework and a QI operational plan for HIV/AIDS-specific interventions at multiple system levels including community³⁵.

³⁴ QI is inherently a means of improving the system through incremental and tested improvements in the quality of services where they are being provided. Shared QI learning and mentoring at higher levels of the system (e.g. district, national) similarly contributes to strengthening overall programs and, over time, the whole health system. As COP15 community level QI efforts will be closely linked to helping improve clinical cascade indicators (in particular, treatment retention), those funds fall under the Care and Treatment budget.

³⁵ QI activities at the facility level will specifically target identified structural barriers (limited hours, fees, frequency of visits, etc.); address drug shortages and clinic wait times; and improve data-based systems to facilitate patient monitoring and tracking. At the community level, QI activities will focus on addressing barriers to retention and adherence by considering psycho-social and economic factors and better linking communities to high volume/high burden facilities. QA at the community level will also support CD4 point of care testing in targeted districts to help improve treatment uptake and ultimately reduction of viral load.

| 1. Brief Activity Description | Deliverables | | Budget codes and allocation (\$) | | 6. Implementing Mechanism(s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|--|--|---|----------------------------------|----------------------|---------------------------------|---|----------------------------|--------------------------|----------------|----------------------------------|-----------------------|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care (LTC) | 10. ART uptake | 11.*Other Combination prevention | 12. Viral suppression |
| <p>Supply Chain</p> <ul style="list-style-type: none"> Support to MoH's SCM system through strengthened MoH contract, and HIV/AIDS commodities and essential drugs management; and improved supply planning and forecasting for procurement at central and district level. Support PPADB to improve governance processes as they relate to drug procurement and distribution. | <p>Relevant MoH staff trained in contract management.</p> <p>Stock management improved for HIV commodities and distribution at central and site-level. Increased use of data management systems for timely decision making at district level.</p> <p>Operationalization of the Supply Chain Strategy.</p> <p>Improved tendering including policy for supply chain contracts.</p> | <ul style="list-style-type: none"> Number of outsourced contracts routinely reviewed for performance and quality of deliverables. Decrease in % of health facilities that experience stock -outs, expiries and overstock for HIV/AIDS commodities. Increased number of staff trained to generate reports and analyze data using a data management system | \$0 | OHSS/ \$1,500,000 | GHSC | Domestic Program and Service Delivery /13.4 light green | X | X | X | X | X |
| <p>Health Financing</p> <p>TA to MoH for improving allocative and technical efficiency of HIV services and analysis of financing options to increase resources for quality HIV service delivery</p> | <p>Increased domestic spending /re-allocation towards HIV and AIDS</p> <p>Analysis of National Health Accounts data</p> <p>Finalization of the MoH's health financing strategy aligned to UHC.</p> | <p>Dissemination of Health Financing Strategy</p> <p>Operationalization of the Health Financing Strategy</p> | \$0 | OHSS/ \$750,000 | HFG (ABT) | Health Financing and Strategic Investments/ o.o Red (allocative efficiency); technical efficiency 7.5 yellow and Resource generation 15 light green | X | X | X | X | X |

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| | | | | | | and commitments 7.0 yellow | | | | | |
| <p>Quality Improvement</p> <p>TA to at community level for improving HIV service delivery and patient health outcomes through a QI approach.</p> | <p>QI Operational plan developed for specific HIV interventions at all levels including community Improved QI processes and innovative approaches tested in high burden areas</p> | <p>Improvements in PEPFAR indicators in targeted sites reflecting use of QI approach and tools</p> <p>Strengthened MoH ability to continue use of QI approach and support system changes needed to achieve and sustain epidemic control</p> | <p>HTXS: \$ 1,500,000</p> | <p>HTXS: \$1,500,000</p> | <p>ASSIST (URC)</p> | <p>Domestic Program and service delivery – Quality Management – 0.8 Red</p> | X | X | X | X | X |
| <p>Continuous Quality Improvement</p> <p>TA to MOH - support building and institutionalizing host country capacity to monitor and continually improve the quality of HIV programs</p> | <p>Site-level Monitoring System developed and functional</p> <p>Collation, analyses, and synthesis of data from Site-level monitoring system, SIMS+, and other data sources to inform remediation and above site policy and system improvements</p> <p>Build institutional capacity within the MOH to continuously generate, analyze, and use data to improve its HIV/AIDS programs (data for decision-making culture) leading to improvements in allocative and technical efficiencies</p> | <p>Transfer operation of the Site-level Monitoring System</p> <p>Collation, analyses, and synthesis of data from Site-level monitoring system, SIMS+, and other data sources to inform remediation and above site policy and system improvements</p> <p>Build institutional capacity within the MOH to continuously generate, analyze, and use data to improve its HIV/AIDS programs (data for decision-making culture) leading to improvements in</p> | <p>HTXS: 900,000</p> | <p>HTXS: 900,000</p> | <p>I-TECH</p> | <p>Epi and Health data 13.5 Performance data (15)</p> | X | X | X | X | X |

| | | | | | | | | | | | |
|--|--|---------------------------------------|--|--|--|--|--|--|--|--|--|
| | | allocative and technical efficiencies | | | | | | | | | |
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7.0 Staffing Plan

This COP represents the strong inter-agency collaborative efforts of the PEPFAR/B team and reflects our commitment to make difficult decisions to transition the PEPFAR program to a targeted assistance model. We have conducted a strategic review of our partners and consolidated mechanisms to ensure program efficiencies. Our “staffing for results” exercise guided decisions on how the PEPFAR program should be staffed to ensure better oversight of PEPFAR’s investment in Botswana. During FY2014 and into FY2015, CDC HQ and the Mission Front Office have supported a restructuring of the M&O platform to increase the technical capacity of the country office as well as managerial accountability. CDC support in Botswana has continued transitioning from a mixed model of service delivery and TA to a primarily TA model. The SI and lab team have added locally employed staff to increase focused monitoring and to assess, analyze and evaluate the impact of national programs. These positions are all repurposed and no new CDC LES positions will be added. In FY 2014, USAID Botswana shifted from a “non-presence country” to a “presence country” with the assignment of two direct hire, Foreign Service Officers – a USAID representative who will work 20 percent on PEPFAR, and a Supervisory Health Officer who will replace the USPSC who has been the Country Director for PEPFAR. The Peace Corps Botswana program is focused on addressing HIV/AIDS. As such, there is a great level of collaboration between PC and all other USG Agencies operating in Botswana. PC shares information across agencies, facilitates site visits for various staff, places volunteers directly with USAID, CDC and PEPFAR, and fully participates in PEPFAR coordination activities. The DOD works with the BDF and provides opportunities for collaboration with agencies interested in working with military or the men’s sector. The DOD PEPFAR program is led by the OSC Chief and technical support is provided by a program officer (LE-position). The PEPFAR Coordination Office is staffed with a PEPFAR Coordinator (USDH, USAID-PSC), Deputy PEPFAR Coordinator (USAID-PSC), Communications Specialist (LE position) and Health Policy Advisor (EFM position).

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

| Level of Implementation | Core Activities | Near-core Activities | Non-core Activities |
|-------------------------|--|---|--|
| Site level | <ul style="list-style-type: none"> ▪ PMTCT – site-specific TA and DSD for FSWs and refugees ▪ HTC services in scale-up areas with linkage to prevention, care, and treatment services (including TB/HIV/OVC). ▪ OVC support - care and support in scale-up areas ▪ DSD VMMC services in one scale-up SNU among men 15-29 ▪ Prevention for AGYW and KPs ▪ Linkage to care, retention, and adherence - for enhanced uptake of services in scale-up areas ▪ Treatment - site-specific TA in scale-up areas and DSD for FSWs and refugees, and ARV purchase for adoption of Option B+ and CD4 500 ▪ Care and support – site-specific TA in priority areas and DSD for FSWs, refugees, OVC, and TB/HIV populations ▪ TB/HIV - site-specific TA in scale-up areas and DSD for DOTS in scale-up sites ▪ GBV- link survivors to service delivery in scale-up areas ▪ Condom promotion and distribution for KPs and military populations | <ul style="list-style-type: none"> ▪ Cervical cancer “screen and treat” ▪ Provision of lab supplies for USG-supported service delivery sites ▪ Targeted site level quality assurance and quality improvement interventions ▪ GBV – reducing the contextual factors that contribute to the vulnerability of young girls to HIV and GBV ▪ M&E systems supported to strengthen linkages to care and patient tracking ▪ Family planning services for KP ▪ Develop and implement SMS-based information system to monitor and evaluate key treatment and quality indicators at high volume ART sites within the scale-up areas | <ul style="list-style-type: none"> ▪ Construction of laboratories and clinics ▪ TA for civil society organizational capacity building ▪ Low yield VMMC/HTC sites ▪ GBV - integration of GBV in HTC |

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| Sub-national level | | <ul style="list-style-type: none"> ▪ TA support for the national and district level MoH DHIS Systems ▪ Support for M&E in scale-up areas ▪ VMMC demand creation in one scale-up SNU ▪ HSS support includes quality improvement TA ▪ Support MoH efforts to improve both technical and allocative efficiencies of HIV services and financing ▪ Strengthening collaboration between CBOs and District Health Management Teams (DHMT) to improved linkages between facility and community based services and improved data availability ▪ Engagement of community leaders at district level to influence gender norms and uptake of services ▪ Support of the district level GBV referral system and associated operational research | |
| National level | <ul style="list-style-type: none"> ▪ TA for PMTCT regarding Option B+ and national roll-out of B+ ▪ TA to MoH on revision of HTC national guidelines ▪ TA to MoH on VMMC for roll-out of Prepex and demand creation at community-level ▪ TA for treatment and care, including task shifting, training and mentoring HCWs on national guidelines, support adoption of CD4 500, adherence, and pre-ART ▪ GBV – advocacy for improved policies addressing gender inequality as a driver of the epidemic ▪ TB/HIV activities supporting the national TB program to improve case finding, testing and ART coverage ▪ Development of a package of services for KPs ▪ TA to MLGRD on OVC programming | <ul style="list-style-type: none"> ▪ TA to MoH on cervical cancer ▪ HSS support for supply chain governance management ▪ HSS TA for health financing to assist the MoH to transition from donor assistance ▪ Quality improvement TA to MoH to improve HIV outcomes. ▪ Continued support for strategic information surveillance surveys and national level information systems. ▪ TA for lab, including diagnostics, monitoring, and quality management/assurance/ improvement ▪ Teen clubs for PLHIV | <ul style="list-style-type: none"> ▪ Broad BCC messaging for general population prevention ▪ TA for palliative care ▪ TA support for the human resource information systems (IRIS) ▪ TA support to assist GoB in outsourcing non-clinical services (SHOPS) ▪ TA support for quality improvement for maternal mortality ▪ Support for blood safety and injection safety ▪ Roll-out of the gender analysis and mainstreaming curriculum ▪ Roll-out of the MoH GBV protocols ▪ Paying for laboratory accreditation fees |
| | | | |
| Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15 | | | |
| HTC | Core Activities | Near-core Activities | Non-core Activities |
| | <ul style="list-style-type: none"> ▪ DSD support for high volume/high yield sites in geographic districts and areas with the highest unmet | <ul style="list-style-type: none"> ▪ Provide TA to the BDF to improve the quality and targeting of HTC services in scale-up sites. | <ul style="list-style-type: none"> ▪ PEPFAR support transitioned from low yield and low prevalence VCT sites |

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| | <p>need for ART and support for a proposed transition to treatment initiation at CD4 500.</p> <ul style="list-style-type: none"> Scale-up of targeted outreach services in scale-up SNUs Targeted mobile testing in high risk areas including farms, construction sites and mining areas FSW - targeted for test and offer services in Kasane Linkage to care model from BCPP project adapted and implemented TA to MoH to strengthen RHT as a strategy for increasing reach and yield and to | | |
| VMMC | Core Activities | Near-core Activities | Non-core Activities |
| | <ul style="list-style-type: none"> VMMC – support for increased uptake of services for HIV-negative men 15-29 years in one scale-up SNU through static, mobile/outreach services, and time-limited campaigns TA to support scale up of PrePex device services through training-of-trainers and national roll-out in general and military populations TA to support quality of VMMC services at supported SNUs through SIMS, EQA, CQI, DQA | <ul style="list-style-type: none"> Targeted demand creation through advocacy, community involvement, and mapping of scale-up SNUs | <ul style="list-style-type: none"> TA for EIMC integration in MNCH program for sustainability TA for training nurses and midwives in adolescent/adult and EIMC services |
| Care and Treatment (Including PMTCT and TBHIV) | Core Activities | Near-core Activities | Non-core Activities |
| | <ul style="list-style-type: none"> TA for training and mentoring health care workers in HIV and TB management and SIMS remediation Pre-ART care system linkages established TA at the national level supporting TB program and TB survey Support to MoH for screening 90% of HIV positive patients for TB Support to MoH for enhancing ART coverage to TB/HIV patients Support for adopting CD4 500 Support for implementing Option B+ Paediatric SOP development ART retention and adherence optimization including linkages with community-based interventions Pilot of “see and treat” for FSW DSD for PMTCT, Treatment, TB, and care and support for priority population Intensified case finding at the community and clinic level ART QA/QI Program PLHIV - comprehensive PHDP services implemented | <ul style="list-style-type: none"> Cervical cancer “screen and treat” Policy change promotion for implementation of “GeneXpert” M&E at the SNU level TB infection control strengthening TB/HIV integration at community level and strengthen referral systems | <ul style="list-style-type: none"> Palliative Care EID data entry |
| Prevention | Core Activities | Near-core Activities | Non-core Activities |
| | <ul style="list-style-type: none"> KP FSW - development and implementation of the minimum package of services using a community-integrated and clinic-based reach-test-treat-retain cascade in population focus sites | <ul style="list-style-type: none"> Clients of sex workers – preventive services including condoms, test referrals. TA and advocacy to the GoB at the national and district level to develop policy and | <ul style="list-style-type: none"> Mass BCC messaging for general population prevention |

| | | | |
|------------|---|---|--|
| | <ul style="list-style-type: none"> ▪ AGYW - implement a comprehensive package of services to increase service uptake and reduce contextual factors that contribute to vulnerability ▪ Targeted condom promotion and distribution to priority populations (e.g. military) ▪ PLHIV - implement comprehensive PHDP services to prevent morbidity and HIV transmission to sexual partners and children ▪ GBV – TA to the GoB for the development and implementation of a site-level GBV referral system ▪ GBV survivors - support establishment of community-based safe spaces - including drop-in centres in KP districts ▪ Post-GBV care, referrals and linkages to appropriate clinical services | <p>guidelines and build capacity for developing comprehensive services for KP</p> <ul style="list-style-type: none"> ▪ Address stigma and discrimination ▪ Community competence building ▪ TA to GoB to develop a national KPs strategy and operational plan. ▪ Education and community mobilization standardization ▪ Adult-child communication ▪ Economic strengthening/cash transfers ▪ Support for policy implementation ▪ TA to service providers to create SOPs for post-GBV care. | |
| OVC | Core Activities | Near-core Activities | Non-core Activities |
| | <ul style="list-style-type: none"> ▪ Identification of children, adolescents and family members made vulnerable by or to HIV/AIDS ▪ Assessing child, adolescent and family socio-economic status and risk for health, safety, stability and being in school ▪ Developing strengths based case management plans for children and families with monitoring of referral completion and stated case closure goals ▪ Implementing special studies to identify gaps in programming impact: these include MER 1.5 and national situation analysis for OVC ▪ Promotion of HIV testing of OVC program participants, including EID, and confirmatory HIV testing ▪ Referral to interventions focused on keeping adolescents HIV free for those who test HIV negative, especially adolescent girls ▪ Coordination with commodity and counselling providers to ensure that dual protection is accessible to adolescent OVC ▪ Integrating ART adherence assessment, counselling and support into routine household support for family members with HIV ▪ Facilitating uptake of and monitoring completion of referrals for: <ul style="list-style-type: none"> ○ Nutrition and food security programs ○ TB/HIV testing, treatment and care services for all children and partners of index cases ○ Age specific health care needs such as adolescents for SRH and FP services especially adolescent girls and | <ul style="list-style-type: none"> ▪ Strengthen referral mechanisms for cross referrals ▪ M&E systems for national child protection and social welfare efforts ▪ Advocacy and policy efforts to improve safety and protection from violence ▪ Strengthen community structures for mediation of child abuse ▪ Support for community education councils and parent-teacher associations to provide support to OVC ▪ Support market linked vocational training and other individuals HES activities ▪ Carrying out market assessments for Income Generating Activities (IGAs) | <ul style="list-style-type: none"> ▪ Large scale child rights awareness campaigns ▪ Dissemination of child protection laws ▪ Carrying out home visits for solely for the purpose of clinical linkages |

| | | | |
|------------------------------|---|--|--|
| | <p>immunization for Under 5's.</p> <ul style="list-style-type: none"> ▪ Supporting community and national level child protection/GBV prevention and response activities, and referrals to other services ▪ Addressing psychosocial health among children and their caregivers through individual, group based and relationship based activities. ▪ Positive parenting skills (including discipline, communication on adolescent risk, HIV disclosure) ▪ Facilitating Household Economic Strengthening (HES) activities, such as savings groups ▪ Integrating Early Childhood Development into HIV care and treatment for children under 5 ▪ | | |
| Cross-cutting | Near-core Activities | | Non-core Activities |
| Laboratory | <ul style="list-style-type: none"> ▪ Roll-out SLMTA to remaining laboratories and do follow-up for priority labs ▪ Provide TA to Botswana National Quality Assurance Laboratory (BNQAL) for preparation of proficiency testing materials for HIV, CD₄, EID | | <ul style="list-style-type: none"> ▪ Laboratory accreditation funding support |
| | Near-Core Activities | | |
| HSS | <p>HRH</p> <p>Supply chain:</p> <ul style="list-style-type: none"> ▪ Targeted TA support to MoH's SCM system to strengthen both contract and commodities management <p>Health Financing</p> <ul style="list-style-type: none"> ▪ TA to MoH for improving allocative and technical efficiency of HIV services and analysis of financing options for increasing resources for quality HIV service delivery ▪ Support efforts to transition away from donor dependence <p>Quality Improvement</p> <ul style="list-style-type: none"> ▪ TA to MoH, community and facility level for improving HIV service delivery and patient health outcomes through a quality improvement approach ▪ Site-level monitoring system of key indicators in high-volume sites in scale-up areas | | |
| | Near-core Activities | | |
| Strategic Information | <p>Surveillance</p> <ul style="list-style-type: none"> ▪ ART drug resistance survey conducted ▪ Second round of BBSS among KPs in population focused sites <ul style="list-style-type: none"> ▪ TA to KP partners to conduct formative assessments. <p>Data availability and use</p> <ul style="list-style-type: none"> ▪ DQA activities at priority locations and among KP routinely conducted ▪ District-level mortality data collection systems strengthened ▪ Technical support to strengthen HIV monitoring through establishment of an early indicator warning system based on 2013 WHO indicators ▪ Technical support to retrospectively analyse data on linkage to care ▪ Technical support in applying the spectrum modelling technique and using it to guide planning at the district level ▪ Technical support for strengthening systems that support linkages to care among PEPFAR-supported community-based organizations (CBOs) with health facilities, including systems to monitor retention in care, ART drug resistance, and loss to follow up on KP interventions. ▪ Technical support on gender analysis, GBV referral system and operations research to generate data on GBV ▪ Support to OVC program to generate evidence needed to inform evidence based programming ▪ Data quality assessments & SIMS visits | | |

| | |
|--|---|
| | <p>Health information systems</p> <ul style="list-style-type: none"> ▪ Technical support to strengthen utilization of integrated aggregate data collection systems (DHIS) ▪ Support for training to promote collection, utilization, and storage of data in data warehouses from Patient Management Information System (PIMS II) sites, especially in scale-up areas ▪ Develop and implement SMS-based information system to monitor and evaluate key treatment and quality indicators at high volume ART sites within the scale-up areas |
|--|---|

Table A.3 Transition Plans for Non-core Activities

| Transitioning Activities | Type of Transition | Funding in COP 15 | Estimated Funding in COP 16 | # of IMs | Transition End date | Notes |
|---|--|--------------------------|------------------------------------|-----------------|----------------------------|--|
| Palliative Care | Transition to government after priority activities completed | \$0 | \$0 | 1 | End-2015 | Support to AIHA ended with COP 14 funding of \$150,000. |
| QI for Maternal Mortality | Refocused on National Level QI | \$0 | \$0 | 1 | End-2015 | A QI initiative had narrowly focused on maternal mortality – beginning with COP14 funds these interventions will be refocused at national /district/clinic QI engagement |
| Human Resource Information System (IRIS) | Transition to government after priority activities completed | \$0 | \$0 | 1 | End-2015 | 15 Months of COP 13/14 pipeline will allow this to transition to GoB in 2015 |
| Healthy Policy Costing Studies | Transition to | \$0 | \$0 | 1 | End-2015 | Actual and normative costing |

| | | | | | | |
|--|--|-----|-----|---|------------|--|
| | government | | | | | study to be completed with COP 14 funding in 2015. Outputs will be utilized for health financing activities in COP 15. |
| Assist GoB in Outsourcing Non-Clinical Services (SHOPS) | Close activity | \$0 | \$0 | 1 | End-2015 | Contracts outsourcing intervention with MoH to conclude with COP 14 pipeline in mid-2015. |
| Construction | Completion of construction | \$0 | \$0 | 1 | End-2015 | Planned construction of laboratories has been completed except for National Public Health which should be finished by September 2015. Security upgrades at PEPFAR facility has not yet begun, but is fully funded. |
| Civil Society Organizational Capacity Building | Activities will be refocused on technical capacity for testing, referrals, and adherence. | \$0 | \$0 | 1 | End-2015 | Transitioning from the organizational development space. Activities will be refocused on technical capacity for testing, referrals, and adherence. |
| BCC Mass Communication Plans | Shuga, a TV drama series which has been broadcast across Africa since November 2009, will be closed. | \$0 | \$0 | 1 | End-2015 | No new funding to be allocated; Shuga series to be made available to PCVs to supplement prevention activities |
| Peer Education for Behavior Change | Support to BDF on assessment and training of peer educators and training on theater (drama groups) | \$0 | \$0 | 1 | End - 2015 | Support to BDF through PCI ended with COP 2014 funding; we are using pipeline to fund the program in this financial year as we graduate to BDF. |

| | | | | | | |
|---|---|-----------|-----|---|----------------|---|
| TB/HIV Strengthening MDR-TB Management and Drug Resistance Survey (DRS) | Transition MDR-TB case management to trained medical officers who will then be supervised by government physicians | \$0 | \$0 | 1 | March 2015 | DRS has been defunded in COP14. Trained MoH medical officers will implement MDR-TB management activities in the districts and be back-stopped by government physicians. |
| PMTCT | Transition to government after priority activities completed except for one PFP to sunset in March 2016 | \$0 | \$0 | 1 | March 2016 | PMTCT was scheduled to graduate in COP 14. No funds have been allocated since then. |
| VMMC - In-service Training of Providers in Surgical, PrePex Device and EIMC Procedures | Trained TOTs to cascade training to other providers | \$300,000 | \$0 | 1 | End-2015 | --- |
| Cervical Cancer Program Manager | Transition to government | \$0 | \$0 | 1 | End March 2015 | Support to ITECH for this position ended in COP 14 |
| Blood and Injection Safety | Provide TA towards stepwise accreditation for Botswana in six blood centers. | \$0 | \$0 | 1 | End -2017 | Transition to government after remediation activities and step 3 accreditation are completed. This is estimated to take 18-24 months. |
| Support for GAP Genotyping Lab | Activities will stop as the lab will be handed over to other stakeholders | \$0 | \$0 | 1 | End-2015 | --- |
| Purchasing of Laboratory Equipment | This activity will end as there will be no new labs constructed. Purchase of equipment in future will be done by MoH. | \$0 | \$0 | 1 | End-2015 | --- |
| Support for Development of Curricula for CPD and for In-Service Training | Activities will be transitioned to the MoH | \$0 | \$0 | 1 | End-2015 | --- |
| Lab Activities in CoAg with GOB | MoH to take up the | \$0 | \$0 | 1 | End-2015 | MOH: Pre- and in-service |

| | | | | | | |
|---------------|------------|------------------|------------|-----------|-----|--|
| | activities | | | | | training and development of quality management systems. BOBS: Training and equipment maintenance. UB: Capacity building for the MLS program. |
| Totals | --- | \$300,000 | \$0 | 18 | --- | --- |

APPENDIX B

B.1 Planned Spending in 2016

| Table B.1.1 Total Funding Level | | |
|---------------------------------|---------------|---------------|
| Applied Pipeline | New Funding | Total Spend |
| \$ 9,036,327 | \$ 38,963,673 | \$ 48,000,000 |

| Table B.1.2 Resource Allocation by PEPFAR Budget Code | | |
|---|--------------------------------------|------------------|
| PEPFAR Budget Code | Budget Code Description | Amount Allocated |
| MTCT | Mother to Child Transmission | \$ 81,064 |
| HVAB | Abstinence/Be Faithful Prevention | \$ 61,113 |
| HVOP | Other Sexual Prevention | \$ 2,508,155 |
| IDUP | Injecting and Non-Injecting Drug Use | \$ 0 |
| HMBL | Blood Safety | \$ 66,626 |
| HMIN | Injection Safety | \$ 0 |
| CIRC | Male Circumcision | \$ 269,399 |
| HVCT | Counseling and Testing | \$ 1,504,392 |

| | | |
|--------------|---------------------------------|----------------------|
| HBHC | Adult Care and Support | \$ 8,419,387 |
| PDCS | Pediatric Care and Support | \$ 1,832,770 |
| HKID | Orphans and Vulnerable Children | \$ 3,368,319 |
| HTXS | Adult Treatment | \$ 4,809,017 |
| HTXD | ARV Drugs | \$ 205,550 |
| PDTX | Pediatric Treatment | \$ 453,875 |
| HVTB | TB/HIV Care | \$ 4,147,165 |
| HLAB | Lab | \$ 627,637 |
| HVSI | Strategic Information | \$ 787,558 |
| OHSS | Health Systems Strengthening | \$ 763,746 |
| HVMS | Management and Operations | \$ 9,057,900 |
| TOTAL | | \$ 38,963,673 |

APPENDIX C

Acronym List

| Abbreviation | Definition |
|---------------------|--|
| ACHAP | African Comprehensive HIV/AIDS Partnership |
| AGYW | adolescent girls and young women |
| AIDS | Acquired Immunodeficiency Syndrome |
| ANC | antenatal care |
| APR | annual program results |
| ART | anti-retroviral therapy |
| ARV | anti-retroviral drugs |
| BAIS III | 2008 Botswana AIDS Impact Survey |
| BAIS IV | 2013 Botswana AIDS Impact Survey |
| BBS | Behavioral and Biological Surveillance Survey |
| BCC | behavioral change communication |
| BDF | Botswana Defense Force |
| BNQAL | Botswana National Quality Assurance Laboratory |
| BRCS | Botswana Red Cross Society |
| CBO | community-based organization |
| CEE | core essential element |
| CMS | central medical stores |
| CoAg | cooperative agreement |
| CQI | continuous quality improvement |
| DHAPP | Defense HIV/AIDS Prevention Program |
| DOT | directly observed therapy |
| DQA | data quality assessment |
| DSD | direct service delivery |
| EID | early infant diagnosis |
| EIMC | early infant male circumcision |
| EQA | external quality assurance |
| EU | European Union |

| | |
|----------|--|
| FSW | female sex worker |
| GBV | gender-based violence |
| GNI | gross national income |
| GoB | Government of Botswana |
| HAART | highly active anti-retroviral treatment |
| HCW | health care worker |
| HEI | HIV-exposed infants |
| HIV | Human Immunodeficiency Virus |
| HMIS | health management information system |
| HTC | HIV testing and counseling |
| IP | implementing partner |
| IPT | isoniazid preventive therapy |
| KP | key populations |
| LTFU | lost to follow-up |
| M&E | monitoring and evaluation |
| MLG | Ministry of Local Government |
| MLHA | Ministry of Labor and Home Affairs |
| MNCH | maternal, neonatal and child health |
| MoF | Ministry of Finance |
| MoH | Ministry of Health |
| MSM | men who have sex with men |
| NACA | National AIDS Coordinating Agency |
| NASA | National AIDS Spending Assessment |
| OGAC | Office of the U.S. Global AIDS Coordinator |
| OVC | orphans and vulnerable children |
| PC | Peace Corps |
| PCR | polymerase chain reaction |
| PCV | Peace Corps Volunteer |
| PEPFAR/B | PEPFAR Botswana |
| PHDP | positive health, dignity, and prevention |
| PLHIV | people living with HIV |
| PMTCT | prevention of mother-to-child HIV transmission |
| QA/QI | quality assurance and quality improvement |
| QI | quality improvement |

| | |
|--------|--|
| RHT | routine HIV testing |
| SCM | supply chain management |
| SID | Sustainability Index and Dashboard |
| SIDA | Swedish International Development Cooperation Agency |
| SIMS | Site Improvement Monitoring System |
| SMC | safe medical circumcision |
| SMS | short message system |
| SNU | sub-national unit |
| SOP | standard operating procedures |
| SRH | sexual and reproductive health |
| STI | sexually transmitted infection |
| TA | technical assistance |
| TA/TC | targeted assistance or technical collaboration |
| TB | Tuberculosis |
| TG | transgendered persons |
| TWG | technical working group |
| UN | United Nations |
| UNAIDS | United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| VCT | voluntary counseling and testing |
| VMMC | voluntary medical male circumcision |
| WHO | World Health Organization |

APPENDIX D

BCPP Lessons Learned For COP 15 Submission

The Botswana Combination Prevention Project provides valuable data and insights for epidemic control in Botswana. The study is still in its initial phases and preliminary data has been shared with OGAC and with the PEPFAR team in Botswana. For example, the preliminary coverage estimates indicate that HIV testing and ART coverage are as high or higher than anticipated based on other data sources, and that MC coverage may be higher than previously anticipated. To date, however, preliminary study data is not representative of national trends because initial activities have only been completed in a small number of communities, all in the southern region and closer to the capital. By the end of October 2015, the study should have completed initial activities in all study communities across Botswana and the initial data will be extremely valuable to the MOH, PEPFAR Botswana team, and other stakeholders in terms of providing an in-depth assessment of HIV epidemiology, coverage and quality of key services.

Lessons learned in implementation of the components of the Combination Prevention package are already being shared, and include the following:

1. HIV Testing and Counseling in BCPP is performed by the same implementing partner, Tebelopele, which is involved in national testing activities, and the partner is actively involved in using lessons from BCPP to inform the strategies it uses programmatically. Among key lessons from HTC to date are:
 - a. the study's combined home-based and mobile HTC approach has identified significant numbers of previously undiagnosed HIV infected community members, many who are already eligible for ART at CD4<350.
 - b. Testing uptake among males has been higher in the mobile versus home-based settings
 - c. Short-term campaign-based community testing strategies face significant challenges due to absence from homes for commuters, agriculturalists, and persons who are away for extended periods for a variety of reasons. The study is developing strategies to reach high community coverage rates using multiple modalities to try to overcome the challenges associated with short-term campaign-based approaches only.
2. Linkage to Care is essential in order to reap the benefits of identification of HIV-infected persons through HIV Testing programs. The study has been able to demonstrate ~70% linkage at the local clinic among newly-diagnosed persons, using an approach with designated staff, procedures and data support. Linkage to care for persons identified as known HIV+s in the community who are not currently in care has been lower, but seems to be rising with successive communities as the study rolls out. In both cases, substantial numbers of

community residents have expressed that they are receiving or prefer to receive care and treatment services at a clinic *not* in their community of residence, mostly due to logistical concerns (commuting), desire to attend larger better equipped facilities (hospitals vs. small community clinics) or due to stigma issues. The study team has sought approval of a modified protocol which will allow use of the MOH national data warehouse to determine what proportion of people actually are receiving care outside of their communities, and this data will be critical to inform the Ministry of Health ongoing efforts to decongest large facilities by encouraging people to receive services in smaller facilities closer to their homes.

3. Pre-ART care is critical for BCPP because it serves as the source population for expanded ART eligibility in the study. Activities strengthening pre-ART care and lessons learned from BCPP have been shared with the team charged with strengthening pre-ART care nationally, and vice versa.
4. Expanded Antiretroviral Therapy for those with CD4>350 but Viral Load >10,000 has been implemented and has had high acceptability and uptake in Botswana, despite concerns to the contrary. Proposed study modifications to provide ART for CD4<500 in intervention communities will result in BCPP serving as a 'pilot' for the future national shift to ART for CD4<500.
5. Safe Male Circumcision activities have demonstrated ongoing challenges with uptake, although some headway has been made. Despite giving specific referrals to male community HIV Testing clients to visit SMC services available in the local community, attendance has been low, and the majority of completed circumcisions have come from direct home-based mobilization efforts done by the SMC implementing partner, rather than through referrals of HTC clients.
6. PMTCT: the study intervention package included Option B+, for which acceptability and uptake were high although the numbers of pregnant women identified were lower than anticipated, perhaps because of lower fertility in Botswana than in other African countries. The study has found that coordination at the facility level between the ANC staff/procedures and those of the HIV clinic ('Infectious Disease Consultation Clinic') are critical to allow women to initiate ART as part of PMTCT, and then continue it lifelong as part of Option B+. Option B+ has subsequently become part of national policy in Botswana. Lessons from BCPP are being shared as part of the implementation beginning April 2015.
7. Laboratory Systems: the study has highlighted substantial challenges with laboratory support for HIV care and treatment, especially in the areas of specimen transport and return of results, stock outs/equipment breakdowns and laboratory quality deficiencies. Laboratory challenges have resulted in significant numbers of persons eligible for ART not initiated onto ART in a timely fashion in study communities. Remediation of these issues in Combination Prevention Communities will result in lessons learned that will also be applied within the national program of MOH referral labs supporting HIV care and treatment facilities.
8. Data Systems remain a key area for improvement. Overall, staff capacity at health facilities to optimally utilize any of several electronic medical record systems used in different health facilities remains a challenge. Nationally, the Ministry of Health is proceeding with the rollout of a proprietary integrated data management system (IPMS) which requires real-time connectivity in order to be used. With real-

time connectivity an ongoing challenge, there continue to be many patient and laboratory records which are captured on paper and never back-entered into the electronic system, hampering monitoring and evaluation efforts. BCPP is now engaging with the Ministry of Health staff to understand the HIV data and procedures at the national data warehouse, and expects that many lessons learned in support of the study will be meaningful nationally.

9. Retention and Adherence-to-ART activities in combination prevention community clinics are being strengthened now, and lessons learned are anticipated in coming months.

Botswana COP15 Targets by District: Clinical Cascade

| | Number of individuals who received HIV Testing and Counseling services for HIV and received their test results | Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load | Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load | Number of adults and children newly enrolled on antiretroviral therapy (ART) | Number of adults and children currently receiving antiretroviral therapy (ART) |
|-------------------------|--|---|---|--|--|
| Bobirwa District | 5,055 | 1,060 | 3,201 | 782 | 2,922 |
| Boteti District | - | - | - | - | - |
| Chobe District | 575 | - | - | - | - |
| Francistown District | - | 204 | 296 | 448 | 19,501 |
| Gaborone District | 130,939 | 18,620 | 41,544 | 13,481 | 36,569 |
| Ghanzi District | - | - | - | - | - |
| Goodhope District | 16,913 | 3,133 | 6,319 | 2,226 | 5,413 |
| Hukuntsi District | - | - | - | - | - |
| Jwaneng District | - | - | - | - | - |
| Kgalagadi District | - | - | - | - | - |
| Kgatleng District | 23,309 | 3,240 | 7,337 | 2,311 | 6,407 |
| Kweneng East District | 115,166 | 10,392 | 23,526 | 7,412 | 20,547 |
| kweneng West District | - | - | - | - | - |
| Lobatse District | - | - | - | - | - |
| Mabutsane District | - | - | - | - | - |
| Mahalapye District | 31,428 | 4,212 | 12,711 | 3,103 | 11,604 |
| Ngamiland District | - | 101 | 155 | 112 | 145 |
| North East District | - | - | - | - | 3,248 |
| Okavango District | - | - | - | - | - |
| Selibe-Phikwe District | - | - | - | - | - |
| Serowe/Palapye District | - | - | - | - | 17,892 |
| South East District | 7,534 | 1,358 | 3,074 | 969 | 2,685 |
| Southern District | 24,003 | 2,211 | 8,451 | 1,648 | 7,889 |
| Tutume District | - | 70 | 355 | 60 | 12,234 |
| Other_ Botswana | 6,000 | - | - | - | - |
| Total | 360,922 | 44,601 | 106,969 | 32,552 | 147,056 |

Botswana COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

| | Number of the target population who completed a standardized HIV prevention intervention including the minimum components | Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required | Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS |
|-------------------------|---|---|---|
| Bobirwa District | 822 | - | 131 |
| Boteti District | 174 | - | 15 |
| Chobe District | 845 | 1,184 | 59 |
| Francistown District | 572 | 1,107 | 438 |
| Gaborone District | 6,215 | 2,148 | 1,328 |
| Ghanzi District | 230 | - | 15 |
| Goodhope District | 2,242 | - | 373 |
| Hukuntsi District | 351 | - | 43 |
| Jwaneng District | 67 | - | 110 |
| Kgalagadi District | 422 | - | 15 |
| Kgatleng District | 2,597 | - | 1,225 |
| Lweneng East District | 6,364 | - | 2,654 |
| Lweneng West District | 661 | - | 29 |
| Lobatse District | - | - | 15 |
| Mabutsane District | 163 | - | 15 |
| Mahalapye District | 2,694 | - | 1,827 |
| Ngamiland District | 545 | 442 | 578 |
| North East District | 96 | - | 29 |
| Okavango District | 134 | - | 15 |
| Selebe-Phikwe District | - | 483 | 132 |
| Serowe/Palapye District | 94 | - | 924 |
| South East District | 1,986 | - | 487 |
| Southern District | 5,760 | - | 1,051 |
| Tutume District | 586 | - | 1,111 |
| Other_ Botswana | - | - | - |
| Total | 33,620 | 5,364 | 12,619 |

Botswana COP15 Targets by District: Breastfeeding and Pregnant Women

| | Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results) | Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery |
|-------------------------|--|---|
| Bobirwa District | 537 | 305 |
| Boteti District | - | - |
| Chobe District | - | - |
| Francistown District | - | - |
| Gaborone District | 6,562 | 1,493 |
| Ghanzi District | - | - |
| Goodhope District | 787 | 243 |
| Hukuntsi District | - | - |
| Jwaneng District | - | - |
| Kgalagadi District | - | - |
| Kgatleng District | 1,188 | 271 |
| Kweneng East District | 3,814 | 868 |
| kweneng West District | - | - |
| Lobatse District | - | - |
| Mabutsane District | - | - |
| Mahalapye District | 2,133 | 786 |
| Ngamiland District | - | - |
| North East District | - | - |
| Okavango District | - | - |
| Selibe-Phikwe District | - | - |
| serowe/Palapye District | - | - |
| South East District | 498 | 113 |
| Southern District | 1,676 | 463 |
| Tutume District | 70 | 16 |
| Other_ Botswana | - | - |
| Total | 17,265 | 4,558 |

**Botswana COP15 Targets by District:
Tuberculosis (TB)**

| | Number of registered new and relapsed TB cases with documented HIV status | The number of registered TB cases with documented HIV-positive status who start or continue ART |
|-------------------------|---|---|
| Bobirwa District | 100 | 61 |
| Boteti District | - | - |
| Chobe District | - | - |
| Francistown District | - | - |
| Gaborone District | 1,066 | 650 |
| Ghanzi District | - | - |
| Goodhope District | 158 | 96 |
| Hukuntsi District | - | - |
| Jwaneng District | - | - |
| Kgalagadi District | - | - |
| Kgatleng District | 193 | 117 |
| Kweneng East District | 619 | 378 |
| Kweneng West District | - | - |
| Lobatse District | - | - |
| Mabutsane District | - | - |
| Mahalapye District | 396 | 242 |
| Ngamiland District | - | - |
| North East District | - | - |
| Okavango District | - | - |
| Selibe-Phikwe District | - | - |
| Serowe/Palapye District | - | - |
| South East District | 81 | 49 |
| Southern District | 278 | 170 |
| Tutume District | - | - |
| Other_ Botswana | - | - |
| Total | 2,891 | 1,763 |

Botswana COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

| | Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program |
|-------------------------|--|
| Bobirwa District | - |
| Boteti District | - |
| Chobe District | - |
| Francistown District | 600 |
| Gaborone District | 600 |
| Ghanzi District | - |
| Goodhope District | - |
| Hukuntsi District | - |
| Jwaneng District | - |
| Kgalagadi District | - |
| Kgatleng District | - |
| Kweneng East District | 14,600 |
| kweneng West District | - |
| Lobatse District | - |
| Mabutsane District | - |
| Mahalapye District | - |
| Ngamiland District | - |
| North East District | - |
| Okavango District | - |
| Selibe-Phikwe District | - |
| Serowe/Palapye District | - |
| South East District | - |
| Southern District | - |
| Tutume District | - |
| Other_ Botswana | 1,400 |
| Total | 17,200 |



HIV/AIDS Sustainability Index and Dashboard

To assist PEPFAR and government partners in better understanding each country's sustainability landscape and making informed investment decisions, PEPFAR teams and stakeholders completed the inaugural Sustainability Index and Dashboard (SID) during COP 2015. This new tool assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements, scores for which are displayed on a color-coded dashboard. As the SID is completed over time, it will allow stakeholders to track progress across these components of sustainability. On the pages that follow, you will find the 2015 country dashboard as well as the questionnaire responses that determined the scores. The legend for the colors depicted on the dashboard is below.

Table 1: Sustainability Element Score Criteria

| |
|--|
| Dark Green Score (sustainable and requires no additional investment at this time) |
| Light Green Score (approaching sustainability and requires little or no investment) |
| Yellow Score (emerging sustainability and needs some investment) |
| Red Score (unsustainable and requires significant investment) |

Sustainability Analysis for Epidemic Control: Botswana

Epidemic Type: Generalized/Concentrated
Income Level: Upper Middle
PEPFAR Categorization: Targeted Assistance
COP 15 Planning Level: \$48 million

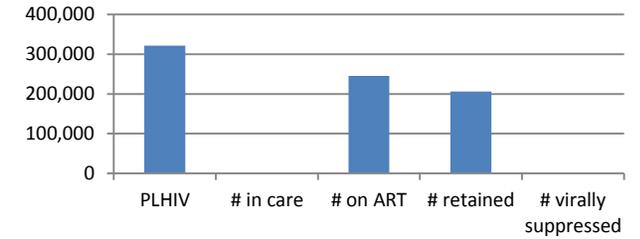
SUSTAINABILITY DOMAINS AND ELEMENTS



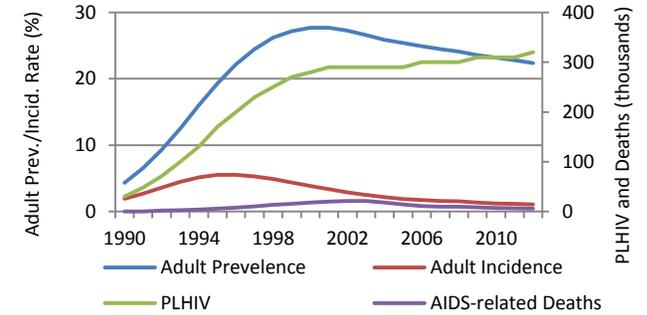
| Institutionalized Data Availability | | Score |
|--|--|-------|
| 1. Epidemiological and Health Data | | 17.1 |
| 2. Financial/Expenditure Data | | 11.5 |
| 3. Performance Data | | 16.0 |
| Domestic Program and Service Delivery | | |
| 4. Access and Demand | | 11.8 |
| 5. Human Resources for Health | | 9.0 |
| 6. Commodity Security and Supply Chain | | 9.4 |
| 7. Quality Management | | 1.6 |
| Health Financing and Strategic Investments | | |
| 8. DRM: Resource Generation | | 15.0 |
| 9. DRM: Resource Commitments | | 12.0 |
| 10. Allocative Efficiency | | 6.0 |
| 11. Technical Efficiency | | 8.0 |
| Accountability and Transparency | | |
| 12. Public Access to Information | | 12.0 |
| 13. Oversight and Stewardship | | 19.0 |
| Enabling Environment | | |
| 14. Policies, Laws, and Regulations | | 7.0 |
| 15. Planning and Coordination | | 11.0 |

CONTEXTUAL DATA

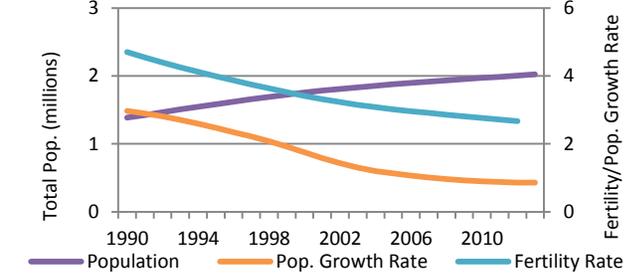
Care and Treatment Cascade



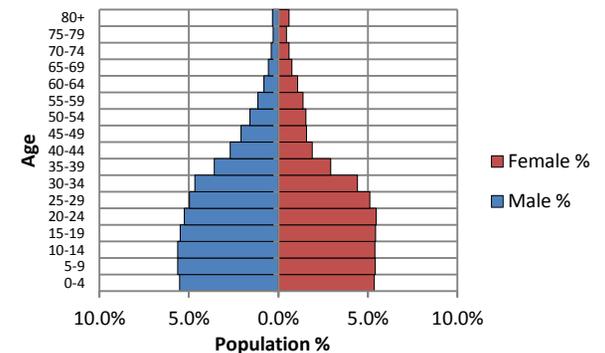
Epidemiological Data



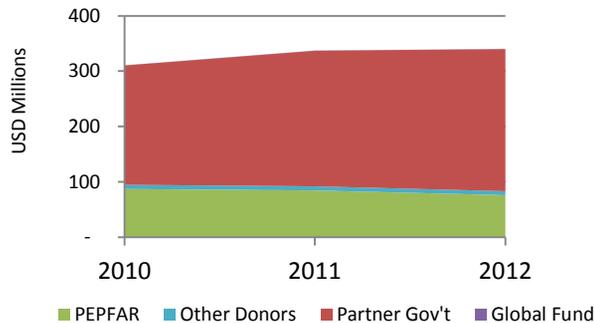
Population and Fertility



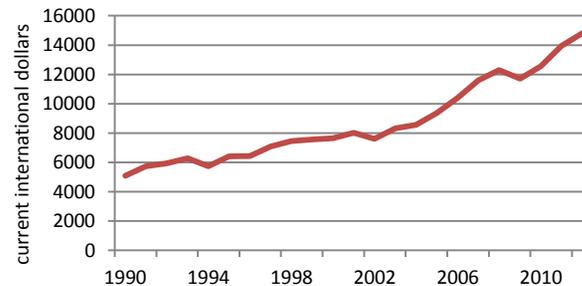
Population Pyramid (2014)



Financing the HIV Response



GNI Per Capita (PPP)



Domain A: Institutionalized Data Availability

What Success Looks Like: Using local and national systems, the Host Country Government collects and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

| | | | Source of data | Notes/Comments |
|---|---|-----|---|--|
| <p>1.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV and OVC, HIV incidence, HIV prevalence, viral load, AIDS-related mortality rates, and co-infection rates.</p> | | | | |
| <p>Q1. Who leads: Who leads/manages the planning and implementation of HIV/AIDS epidemiological surveys and/ or surveillance (convenes all parties and makes key decisions)?</p> | <p><input checked="" type="radio"/> A. Host Country Government/other domestic institution</p> <p><input type="radio"/> B. External agency with host country government</p> <p><input type="radio"/> C. External agency, organization or institution</p> <p><input type="radio"/> D. Not conducted</p> | 4.5 | <p>BAIS IV report (Nov 2013), YRBSS report, HIV Sentinel Surveillance survey (2011).</p> | <p>Statistics Botswana Leads the implementation of surveys, relevant government ministry leads the planning for each survey (i.e. MOE leads the YRBSS, NACA leads BAIS).</p> |
| <p>Q2. Who finances: Within the last three years, what proportion of the latest HIV/AIDS epidemiological data survey did the host country government fund?</p> | <p><input checked="" type="radio"/> A. 80-100% of the total cost of latest survey was financed by Host Country Government</p> <p><input type="radio"/> B. 60-79% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> C. 40-59% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> D. 20-39% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> E. 10-19% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> F. 0-9% of the total cost of latest survey financed by Host Country Government</p> | 5 | <p>NEED BAIS IV budget to document this assertion. Current answer based on email from CDC SI team lead, dated February 2nd, 2015.</p> | <p>According to the CDC SI team BAIS cost 3.68 million of which PEPFAR funded a portion and GOB funded 3.1 million = 84% .</p> |
| <p>Q3. Comprehensiveness of Prevalence and Incidence Data: Does Host Country Government collect HIV prevalence and or incidence data?</p> | <p><input type="radio"/> No, the government does not collect HIV prevalence or incidence data</p> <p><input checked="" type="radio"/> Yes, the government collects (check all that apply):</p> <p><input checked="" type="checkbox"/> A. HIV prevalence</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by key population</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Sub-national data</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected every 3 years</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data analyzed for trends</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data made publicly available</p> <p><input checked="" type="checkbox"/> B. HIV incidence</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by key population</p> | 4.4 | <p>BAIS IV report (Nov 2013), BBSS report 2012</p> | <p>Responses are based on the last BAIS IV survey and the BBSS survey. BAIS data is collected every 4 years.</p> |

| | | | | |
|---|--|-----|---|---|
| | <input type="checkbox"/> Sub-national data <input type="checkbox"/> Collected every 3 years <input checked="" type="checkbox"/> Data analyzed for trends <input checked="" type="checkbox"/> Data made publicly available | | | |
| Q4. Comprehensiveness of Viral Load Data: Does Host Country Government collect viral load data? | <input type="radio"/> No, the government does not collect viral load data <input checked="" type="radio"/> Yes, the government collects viral load data (check all that apply): <input type="checkbox"/> Collected by age <input type="checkbox"/> Collected for children <input type="checkbox"/> Collected by sex <input type="checkbox"/> Collected by key population <input type="checkbox"/> Sub-national data <input type="checkbox"/> Collected every 3 years <input type="checkbox"/> Data analyzed to understand trends | 1.6 | BHP quarterly report - reports total tests done for gov labs. | Absolute numbers of tests performed are reported by partners, but not analyzed by result. Per the national guidelines, viral load is conducted regularly for patient case management purposes, and tracked in patient charts. However this data is not aggregated in a central system or analyzed for trends. |
| Q5. Key Populations: Does the Host Country Government conduct size estimation studies for key populations? | <input type="radio"/> No, the host country government does not conduct size estimation studies for key populations <input checked="" type="radio"/> Yes, the government conducts key population size estimates (check all that apply): <input checked="" type="checkbox"/> Men who have sex with men (MSM) <input checked="" type="checkbox"/> Female sex workers <input type="checkbox"/> Transgender <input checked="" type="checkbox"/> People who inject drugs (PWID) <input type="checkbox"/> Government finances at least 50% of the size estimation studies <input checked="" type="checkbox"/> Government leads and manages the size estimation studies | 1.6 | BBSS 2012 | BBSS received PEPFAR funding, but was led and managed by the GOB. The BBSS attempted to survey PWID but was unable to find sufficient PWID, so PWID were then removed from the survey. |

Epidemiological and Health Data Score:

17.1



| 2. Financial/Expenditure data: Government collects, tracks and analyzes financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS from all financing sources, costing, and economic evaluation for cost-effectiveness. | | Source of data | Notes/Comments |
|--|---|----------------|---|
| Q1. Expenditure Tracking: Does the host country government have a nationally | <input type="radio"/> No, it does not have a national HIV/AIDS expenditure tracking system <input checked="" type="radio"/> Yes, the government has a system to collect HIV/AIDS expenditure data (check all that applies): <input checked="" type="checkbox"/> A. Collected by source of financing, i.e. domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others | 3 | 2012 NASA report Recurrent NASA conducted every three years. |

| | | | | |
|--|--|-----|--|--|
| <p>agreed upon expenditure tracking system to collect HIV/AIDS expenditure data?</p> | <input checked="" type="checkbox"/> B. Collected by expenditures per program area, such as prevention, care, treatment, and health systems strengthening <input type="checkbox"/> C. Collected sub-nationally <input type="checkbox"/> D. Collected annually <input checked="" type="checkbox"/> E. Data is made publicly available | | | |
| <p>Q2. Quality of Expenditure Tracking: Is the Host Country Government tracking expenditures based on international standards? What type of expenditure data are available in the country, i.e. NHA, NASA, others:</p> | <input type="radio"/> No, they are not using any international standards for tracking expenditures <input checked="" type="radio"/> Yes, the national government is using international standards such as WHO National Health Accounts (NHA), National AIDS Spending Assessment (NASA), and/or methodology comparable to PEPFAR Expenditure Analysis or the Global Fund new funding tracking model. | 5 | NASA 2012 and NHA | Botswana has 2012 NASA report and NHA survey ongoing. |
| <p>Q3. Transparency of Expenditure Data: Does the host country government make HIV/AIDS expenditure data (or at a minimum a summary of the data) available to the public?</p> | <input type="radio"/> No, they do not make expenditure data available to the public Yes, check the one that applies: <input type="radio"/> A. Annually <input type="radio"/> B. Bi-annually (every two years) <input checked="" type="radio"/> C. Every three or more years | 1 | 2012 NASA | NASA publicly available, conducted every three years |
| <p>Q4. Economic Studies: Does the Host Country Government conduct special health economic studies or analyses for HIV/AIDS, i.e. costing, cost-effectiveness, efficiency?</p> | <input type="radio"/> No, they are not conducting special health economic studies for HIV/AIDS <input checked="" type="radio"/> Yes, check all that apply: <input checked="" type="checkbox"/> A. Costing studies or analyses <input checked="" type="checkbox"/> B. Cost-effectiveness studies or analyses <input type="checkbox"/> C. Efficiency studies or analyses <input type="checkbox"/> D. Cost-benefit studies or analyses | 2.5 | HTC costing study, Costing for CD4 250-350 move (USAID), Effectiveness of Dr. vs. Nurse prescribers (6 June 2013, Monyatsi et al.), Essential health service package (2010). | Most of these received some funding support from PEPFAR. |

Financial/Expenditure Data Score: 11.5

| <p>3. Performance data: Government collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data is analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including adherence and retention.</p> | | Source of data | Notes/Comments | |
|---|--|----------------|--|---|
| <p>Q1. Collection of service delivery data: Does the host country government have a system to routinely collect/report HIV/AIDS service delivery data?</p> | <input type="radio"/> No, the government does not have an HIV/AIDS service delivery data collection system <input checked="" type="radio"/> Yes, service delivery data are collected/reported for (check all that apply): <input checked="" type="checkbox"/> A. For HIV Testing <input checked="" type="checkbox"/> B. For PMTCT <input checked="" type="checkbox"/> C. For Adult Care and Support <input checked="" type="checkbox"/> D. For Adult Treatment <input checked="" type="checkbox"/> E. For Pediatric Care and Support <input checked="" type="checkbox"/> F. For Pediatric Treatment | 7 | Monthly HAART update, TB annual report, HTC, PMTCT | For Care and Support - TB data is collected, but pre-ART data is not. The MOH, with CDC support, has created registers and indicators for pre-ART care. The next step is implementing these registers/indicators. |

| | | | | |
|---|---|-----------|---|--|
| | <input checked="" type="checkbox"/> G. For AIDS-related mortality | | | |
| Q2. Analysis of service delivery data: Does the Host Country Government routinely analyze service delivery data to measure Program performance? i.e. continuum of care cascade, coverage, retention, AIDS-related mortality rates? | <input type="radio"/> No, the government does not routinely analyze service delivery data to measure performance <input checked="" type="radio"/> Yes, service delivery data are being analyzed to measure (check all that apply): <input type="checkbox"/> A. Continuum of care cascade, including testing, care, treatment, retention and adherence <input checked="" type="checkbox"/> B. Results against targets <input checked="" type="checkbox"/> C. Coverage <input type="checkbox"/> D. Site specific yield for HIV testing (HTC and or PMTCT) <input checked="" type="checkbox"/> E. AIDS-related death rates | 3 | Monthly report from MASA - HAART program. | MOH states that sites are tracking adherence of their patients and could provide information on their adherence, although this is not being tracked at HQ level. |
| Q3. Comprehensiveness of service delivery data: Does the host country government collect HIV/AIDS service delivery data in a manner that is timely, accurate and comprehensive? | <input type="radio"/> No <input checked="" type="radio"/> Yes, service delivery data are being: (check all that apply): <input checked="" type="checkbox"/> A. Collected at least quarterly <input checked="" type="checkbox"/> B. Collected by age <input checked="" type="checkbox"/> C. Collected by sex <input checked="" type="checkbox"/> D. Collected from all clinical sites <input type="checkbox"/> E. Collected from all community sites <input type="checkbox"/> F. Data quality checks are conducted at least once a year | 4 | Monthly MASA report - HAART update | |
| Q4. Transparency of service delivery data: Does the host country government make HIV/AIDS program performance and service delivery data (or at a minimum a summary of the results) available to the public routinely? | <input type="radio"/> No, they do not make program performance data available to the public Yes, check the one that applies: <input checked="" type="radio"/> A. At least annually <input type="radio"/> B. Bi-annually <input type="radio"/> C. Every three or more years | 2 | Monthly MASA report - HAART update | Monthly reports provided to MOH, and HAART update provided to wide array of partners/stakeholders, including civil society. |
| Performance Data Score: | | 16 | | |

THIS CONCLUDES THE SET OF QUESTIONS ON THE INSTITUTIONALIZING DATA AVAILABILITY DOMAIN

Domain B. Domestic Program and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving HIV/AIDS prevention, care and treatment services and interventions. There is a high demand for HIV/AIDS services, which accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and or are affected by the HIV/AIDS epidemic.

4. Access and Demand: There is a high uptake of HIV/AIDS prevention, care and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS, especially among those in the lowest socio-economic quintiles.

| | | | Source of data | Notes/Comments |
|---|--|--------------------|--|--|
| <p>Q1. Access to ART: What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?</p> | <p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing ART.</p> | <p>Q1 Score: 4</p> | <p>Denominator from Master Health Facility list of 2012. Numerator is from the ART dispensing roll-out schedule which shows how many facilities are dispensing ART, July 2014. - Also available in HAART update.</p> | <p>Every district in the country has a prevalence above 10%. 575/674 facilities nationally (85%) are providing ART services; in the 12 highest prevalence districts, this figure is even greater.</p> |
| <p>Q2. Access to PMTCT: What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?</p> | <p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input checked="" type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing Option B+.</p> | <p>Q2 Score: 0</p> | <p>Letter from GOB affirming support for Option B+ (20 August 2014)</p> | <p>Botswana's PMTCT program has been very successful, with 93% of positive pregnant women receiving prophylaxis, and 2013 Spectrum-estimated transmission rate of 2.49%. Botswana has adopted Option B+ in concept, and implementation is scheduled to begin in April.</p> |
| <p>Q3. Who is delivering HIV/AIDS services: What percent of Care and Treatment clients are treated at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p> | <p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. 80% or more of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> B. 50-79% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> | <p>Q3 Score: 3</p> | <p>Available in HAART update monthly MASA report.</p> | <p>Only about 7% in private service delivery.</p> |

| | | | | |
|--|--|---------------------|---|--|
| <p>Q4. Services to key populations: What percent of key population HIV/AIDS prevention program clients receive services at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p> | <p><input checked="" type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. 80% or more of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> B. 50-79% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> | <p>Q4 Score: 0</p> | <p>The 2012 BBSS covers only 3 service delivery sites, so cannot generalize from that data to the entire country.</p> | <p>Only FSW and MSM were included in the BBSS study. There is no data available for PWID and transgender individuals. The MOH states that they are working with CBOs to provide advanced services, and working with the EU and UNFPA on integrating 9 clinics.</p> |
| <p>Q5. Uptake of services: What percent of PLHIV are currently receiving ART? 76%</p> | <p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. 80% or more of PLHIV are currently receiving ART</p> <p><input checked="" type="radio"/> B. 50-79% of PLHIV are currently receiving ART</p> <p><input type="radio"/> C. 20-49% of PLHIV are currently receiving ART</p> <p><input type="radio"/> D. Less than 20% of PLHIV are currently receiving ART</p> | <p>Q5 Score 3</p> | <p>Monthly Masa report (numerator) and UNAIDS estimates (denominator).</p> | <p>245,340/321,270 (approximately 76% of PLHIV). The current national guidelines include eligibility criteria of CD 4 350.</p> |
| <p>Q6. Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?</p> | <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations.</p> <p><input checked="" type="radio"/> Yes, there are efforts by the government (check all that apply):</p> <p><input checked="" type="checkbox"/> educates PLHIV about their legal rights in terms of access to HIV services</p> <p><input type="checkbox"/> educates key populations about their legal rights in terms of access to</p> <p><input checked="" type="checkbox"/> National policy exists for de-stigmatization in the context of HIV/AIDS</p> <p><input checked="" type="checkbox"/> national law exists regarding health care privacy and confidentiality protections</p> <p><input type="checkbox"/> government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found</p> | <p>Q6 Score 1.8</p> | <p>National Policy on HIV/AIDS (Section 5.3.3, section 7) (2012); Public Health Act (2006)</p> | <p>The MOH states they have rolled out a PHDP strategy in a phased approach across Botswana.</p> |
| <p style="text-align: right;">Access and Demand Score</p> | | <p>11.8</p> | | |

| 5. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors. | | Source of data | Notes/Comments |
|---|--|--------------------|--|
| <p>Q1. HRH Sufficiency: Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?</p> | <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not available</p> <p><input checked="" type="radio"/> A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand</p> <p><input type="radio"/> B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply)</p> <p><input type="checkbox"/> HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand</p> <p><input type="checkbox"/> HIV community-based service sites have adequate numbers of staff to meet the HIV patient demand, and CHWs have appropriate linkages to high HIV burden/ volume community and facility sites</p> | <p>Q1 Score: 0</p> | <p>Deputy PEPFAR Coordinator meeting with MOH Deputy Perm. Secretary on February 20, 2015.</p> <p>Also recent remarks by Minister of Health that country needs to recruit doctors from abroad due to insufficient numbers in the country.</p> <p>There is a shortage of Doctors in Clinics. There are only 669 doctors country wide (old number from Health Professionals / Bots Professional Councils). HRIS is not up and running, so records of total doctors and nurses are unavailable. The MOH concurs there is a shortage of doctors but believes the number of nurses are adequate. The MOH cannot produce a vacancy report as their Infinium data is currently being migrated to their Oracle system.</p> |
| <p>Q2. HRH Transition: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?</p> | <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers</p> <p><input checked="" type="radio"/> B. There is an inventory and plan for transition of donor-supported workers but it has not been implemented to date</p> <p><input type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has been only partially implemented to date.</p> <p><input type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan</p> <p><input type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated</p> | <p>Q2 Score: 1</p> | <p>Botswana PFP documentation</p> <p>PEPFAR is currently supporting 40 HCWs providing direct services -- there is an inventory, but no formal plan for the transition of these positions.</p> |
| <p>Q3. HRH Financial reform: Has financial reform been undertaken in the last 5 years to address government financing of health workers?</p> | <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. No financial reform has been undertaken in the last 5 years to address government financing of health workers</p> <p><input checked="" type="radio"/> B. Financial reforms have been undertaken in the last 5 years to address government financing of health workers (check all that apply):</p> <p><input checked="" type="checkbox"/> Wage reform to increase salaries and or benefits of health workers</p> <p><input checked="" type="checkbox"/> Increase in budget allocation for salaries for health workers</p> | <p>Q3 Score: 2</p> | <p>Draft Retention Strategy 2011; State media speeches around HCW salary increases</p> <p>Wage increases were noted for HCW in 2014. This information was shared in radio and newsprint.</p> |
| | <p>Check the one answer that best describes the current situation:</p> | <p>Q4 Score: 0</p> | <p>Lab Curriculum, and other curricula dated before 2012</p> <p>Most curricula last updated in 2008 - curricula available in hard copy only</p> |

| | | | | |
|---|--|--------------------|---|---|
| <p>Q4. Pre-Service: Does current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?</p> | <p>A. HIV/AIDS content used by pre-service institutions is out of date (has not been updated within the last 3 years) - For example, an average national score of RED in SIMS AS-SF "Pre-Service Education" CEE</p> <p><input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):</p> <p><input type="checkbox"/> content updated for all HIV/AIDS services</p> <p><input type="checkbox"/> updated content reflects national standards of practice for cadres offering HIV/AIDS-related services</p> <p><input type="checkbox"/> updated curriculum is problem based/competency based</p> <p><input type="checkbox"/> updated curriculum includes practicums at high volume clinical/ social services sites</p> <p><input type="checkbox"/> institutions that track students after graduation</p> | | <p>curricula dated before 2012</p> | <p>curricula available in hard copy only. MOH states that the curricula are currently undergoing a review and update, however the lecturers have been using the updated guidelines to train new HCW.</p> |
| <p>Q5. In-Service: To what extent is the country institutionalizing PEPFAR/other donor supported HIV/AIDS in-service training (IST) into local training systems?</p> | <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. National IST curricula institutionalizes PEPFAR/other donor-supported HIV/AIDS training.</p> <p><input checked="" type="radio"/> B. There is a strategy for institutionalizing PEPFAR/other donor-supported IST training and it is being implemented.</p> <p><input type="radio"/> C. There is a strategy in place for institutionalizing PEPFAR supported IST training but it is not being fully implemented to date.</p> <p><input type="radio"/> D. There is not a strategy in place for institutionalizing PEPFAR/other donor supported IST training.</p> | <p>Q5 Score: 2</p> | <p>2012 National guidelines and KITSO program</p> | <p>Different programs are at different stages of institutionalization. For example the Corporate Services Department "Leadership and Management" course is managed by GOB and the GOB is now budgeting for this training course, although this was PEPFAR funded. Another example is the Kitso training - historically funded by PEPFAR through BHP, now the Kitso training unit is housed at MOH and funded by PEPFAR through the GOB Mega-COag, and will also be supported through the new TBD FOA.</p> |
| <p>Q6. HRIS: Does the government have a functional Human Resource Information System (HRIS) for the health sector?</p> | <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. No, there is no HRIS</p> <p><input type="radio"/> B. Yes, the government does have a HRIS (check all that apply)</p> <p><input type="checkbox"/> The HRIS is primarily funded by host country institutions</p> <p><input type="checkbox"/> There is a national interoperability strategy for the HRIS</p> | <p>Q6 Score: 0</p> | | <p>HRIS is supposed to be piloted in 2015. Infinium software is what MOH is using now, and it is currently being migrated to the Oracle based HR system, therefore the GOB cannot currently produce a vacancy report.</p> |

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| | <input type="checkbox"/> The government produces HR data from the HRIS at least annually <input type="checkbox"/> The government uses data from the HRIS for HR planning and management | | | |
| Q7. Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are funded with domestic resources? | Check the one answer that best describes the current situation: <input type="radio"/> This information is not known <input type="radio"/> A. Less than 20% <input type="radio"/> B. 20-49% <input type="radio"/> C. 50-79% <input checked="" type="radio"/> D. 80% or more | Q7 Score: 4 | PEPFAR funded positions budget. | Apart from the 40 HCWs that receive PEPFAR support, virtually all HCW are paid for by the GOB. |

Human Resources for Health Score

9

| 6. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality. | | Source of data | Notes/Comments |
|---|--|----------------|--|
| Q1. ARV domestic financing: What is the estimated obligated funding for ARV procurement from domestic public revenue (not donor) sources? | Check the one answer that best describes the current situation: <input type="radio"/> This information is not known <input type="radio"/> A. 0-9% obligated from domestic public sources <input type="radio"/> B. 10-29% obligated from domestic public sources <input checked="" type="radio"/> C. 30-79% obligated from domestic public sources <input type="radio"/> D. 80% or more obligated from domestic public sources | Q1 Score: 2 | CMS Records, per February 19, 2015 email from Chibuike Ogbuabo. According to the figures provided by CMS, the GOB paid for 394,945 units of Atripla during this financial year, out of a total (including the Merck donation) of 1,114,559 units. That comes to 35.4% paid for by the GOB. The true figure may be a bit higher once 2nd line ARVs, etc. purchased by GOB are taken into account, but it's clear that the answer still falls well within the 30-79% range of answer C. PEPFAR is providing a very small portion of ARVs in support of Option B+ and for refugees at Dukwi and for Key Pops test and treat. |
| Q2. Test Kit domestic financing: What is the estimated obligated funding for Rapid Test Kits | Check the one answer that best describes the current situation: <input type="radio"/> This information is not known <input type="radio"/> A. 0-9% obligated from domestic public sources <input type="radio"/> B. 10-29% obligated from domestic public sources | Q2 Score: 3 | PEPFAR country team knowledge - After consultation with NACA and MOH, SID development core group with technical staff from USAID and CDC reached a General consensus that the GOB must be funding over 80% of test kits. Tebelopele budget includes stop gap funding in case of test kit stock outs. |

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| <p>from domestic public revenue (not donor) sources?</p> | <p><input type="radio"/> C. 30-79% obligated from domestic public sources</p> <p><input checked="" type="radio"/> D. 80% or more obligated from domestic public sources</p> | | <p>decision on March 4th, 2015.</p> | |
| <p>Q3. Condom domestic financing: What is the estimated obligated funding for condoms from domestic public revenue (not donor) sources?</p> | <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input checked="" type="radio"/> A. 0-9% obligated from domestic public sources</p> <p><input type="radio"/> B. 10-29% obligated from domestic public sources</p> <p><input type="radio"/> C. 30-79% obligated from domestic public sources</p> <p><input type="radio"/> D. 80% or more obligated from domestic public sources</p> | <p>Q3 Score: 0</p> | <p>Information provided by MOH Head of Division and Public Health Specialist, Department of HIV/AIDS Prevention and Care via email 5 March 2015.</p> | <p>PEPFAR only buys Sekwata condoms for BDF campaigns. Information provided by the MOH indicates that the GOB has been distributing only donated condoms (from PSI and UNFPA) since 2013.</p> |
| <p>Q4. Supply Chain Plan: Does the country have an agreed-upon national supply chain plan with an implementation plan or a thorough annually-reviewed supply chain SOP?</p> | <p><input type="radio"/> A. No, there is no plan or thoroughly annually reviewed supply chain SOP</p> <p><input checked="" type="radio"/> B. Yes, there is a Plan/SOP. It includes these components: (check all that apply)</p> <p><input checked="" type="checkbox"/> Human resources</p> <p><input checked="" type="checkbox"/> Training</p> <p><input checked="" type="checkbox"/> Warehousing</p> <p><input checked="" type="checkbox"/> Distribution</p> <p><input type="checkbox"/> Reverse Logistics</p> <p><input type="checkbox"/> Waste management</p> <p><input checked="" type="checkbox"/> Information system</p> <p><input checked="" type="checkbox"/> Procurement</p> <p><input checked="" type="checkbox"/> Forecasting</p> <p><input checked="" type="checkbox"/> Supply planning and supervision</p> | <p>Q4 Score: 3.4</p> | <p>The Botswana National Supply Chain Strategy 2014-2019</p> | |
| <p>Q5. Stock: Do Public and Private Sector Storage facilities (Central and intermediate level) report having HIV and AIDS commodities stocked according to plan (above the minimum and below the maximum stock level) 90% of the time?</p> | <p><input checked="" type="radio"/> A. No, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) less than 90% of the time</p> <p><input type="radio"/> B. Yes, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) 90% or more of the time</p> <p><input type="checkbox"/> Both public and (if they exist in the country) private storage facilities at central level</p> <p><input type="checkbox"/> Both public and (if they exist in the country) private storage facilities at intermediate level</p> | <p>Q5 Score: 0</p> | <p>SCMS data on stock levels/stock-outs of ARVs for the last 12 months (provided to PEPFAR in February 2015)</p> | <p>"Observations" of central facilities take place monthly; stock-outs occurred in six of the last twelve months.</p> |
| | <p><input type="radio"/> A. No assessment has been conducted nor do they have a system to oversee the supply chain</p> <p><input checked="" type="radio"/> B. Yes, an assessment was conducted but they received below 80%</p> | <p>Q6 Score: 1</p> | <p>Botswana National Supply Chain Assessment Results (2013)</p> | <p>SCMS assessment report did not have an aggregate score, but no section scored above 75%.</p> |

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| <p>Q6. Assessment: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment?</p> <p>(If a different credible assessment of the national supply chain has been conducted, you may use this as the basis for response. Note the details and date of the assessment in the "source of data" column.)</p> | <p><input type="radio"/> C. No assessment was conducted, but they have a system to oversee the supply chain that reviews:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Commodity requirements <input type="checkbox"/> Commodity consumption <input type="checkbox"/> Coordinates procurements <input type="checkbox"/> Delivery schedules <p><input type="radio"/> D. Yes, an assessment was conducted and they received a score that was 80% or higher</p> | | | |
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Commodity Security and Supply Chain Score **9.4**

7. Quality Management: Host country ensures that HIV/AIDS services are managed and provided in accordance with established national/global standards and are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence). Host country has institutionalized quality management approaches in its HIV/AIDS Program that ensure continued quality during and following donor to government transitions.

| | Source of data | Notes/Comments |
|--|-----------------------|--|
| <p>Q1. Existence of System: Does the government have a functional Quality Management/Quality Improvement (QM/QI) infrastructure?</p> <p><input checked="" type="radio"/> A. No, there is no QM/QI infrastructure within national HIV/AIDS program or MOH</p> <p><input type="radio"/> B. Yes, there is a QM/QI infrastructure within national HIV/AIDS program or MOH. The infrastructure (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Routinely reviews national HIV/AIDS performance and clinical outcome data <input type="checkbox"/> Routinely reviews district/regional HIV/AIDS performance and clinical outcome data <input type="checkbox"/> Prioritizes areas for improvement | <p>Q1 Score: 0</p> | <p>Maternal mortality reduction unit has QI teams. Otherwise, no QI infrastructure exists in Botswana.</p> |
| <p>Q2. Strategy: Is there a current (updated within the last 2 years) national QM/QI strategy that is either HIV/AIDS program-specific or includes HIV/AIDS program-specific elements?</p> <p><input checked="" type="radio"/> A. No, there is no HIV/AIDS-related QM/Q strategy</p> <p><input type="radio"/> B. Yes, there is a QM/QI strategy that includes HIV/AIDS but it is not current (updated within the last 2 years)</p> <p><input type="radio"/> C. Yes, there is a current QM/QI strategy that includes HIV/AIDS program specific elements</p> <p><input type="radio"/> D. Yes, there is a current HIV/AIDS program specific QM/QI strategy</p> | <p>Q2 Score: 0</p> | <p>No strategy exists.</p> |
| <p>Q3. Guidelines: Does national HIV/AIDS</p> <p><input type="radio"/> A. No, the national practice does not follow current WHO guidelines for PMTCT or ART</p> <p><input checked="" type="radio"/> B. Yes, the national practice does follow current WHO guidelines for:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> PMTCT (option B+) | <p>Q3 Score: 1.6</p> | <p>Botswana National HIV/AIDS Treatment Guidelines (2008)</p> <p>Option B+ was recently approved as new policy, and will be implemented starting April, 2015. Adult ART still at CD4<350.</p> |

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| <p>technical practice follow current WHO guidelines for PMTCT and ART?</p> | <p><input type="checkbox"/> Adult ART</p> <p><input checked="" type="checkbox"/> Pediatric ART</p> <p><input type="checkbox"/> Adolescent ART</p> <p><input type="checkbox"/> Test and treat for specific populations</p> | | | | |
| <p>Q4. QI Data use: Does the host country government monitor and use data for HIV/AIDS quality improvement?</p> | <p><input checked="" type="radio"/> A. No, there is no monitoring for HIV/AIDS quality improvement</p> <p><input type="radio"/> B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes:</p> <p><input type="checkbox"/> All sites</p> <p><input type="checkbox"/> Use of data to determine quality of program or services</p> <p><input type="checkbox"/> Making recommendations and action plan for mid-course corrections</p> | <p>Q4 Score: 0</p> | | <p>There is no quality improvement infrastructure at GOB.</p> | |
| <p>Q5. Post-transition: Does the host country government monitor whether the quality of HIV/AIDS service outcome is maintained at sites where PEPFAR/other donors have transitioned from a direct implementation role?</p> | <p><input checked="" type="radio"/> A. No, there is no quality monitoring at sites post-transition</p> <p><input type="radio"/> B. Yes, there is quality monitoring at transition sites. Monitoring includes:</p> <p><input type="checkbox"/> All transition sites</p> <p><input type="checkbox"/> Review of service outcomes</p> <p><input type="checkbox"/> Client feedback on changes in quality</p> <p><input type="checkbox"/> Quality improvement action plan</p> <p><input type="radio"/> C. PEPFAR/other donors have never supported direct service delivery in the country</p> | <p>Q5 Score: 0</p> | | <p>PEPFAR in Botswana is providing only limited direct service delivery. The PEPFAR team is unaware of any quality monitoring at sites that have transitioned.</p> | |
| <p>Quality Management Score</p> | | <p>1.6</p> | | | |

THIS CONCLUDES THE SET OF QUESTIONS ON THE DOMESTIC PROGRAM AND SERVICE DELIVERY DOMAIN

Domain C. Health Financing and Strategic Investment

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

| 8. Domestic Resource Mobilization: Resource Generation: The host-country government costs its national HIV/AIDS response, solicits and generates revenue (including but not limited to tax revenues, public sector user fees, insurance, loans, private sector and other strategic partnerships, and/or other innovative sources of financing) and allocates resources to meet the national budget for HIV/AIDS. | | Source of data | Notes/Comments |
|--|--|--------------------|--|
| <p>Q1. Domestic budget: Is there a budget line item for HIV/AIDS in the national budget?</p> | <p><input type="radio"/> A. No, there is no budget line item for HIV/AIDS in the national budget</p> <p><input type="radio"/> B. Yes, there is an HIV/AIDS budget line item under the Health budget</p> <p><input checked="" type="radio"/> C. Yes, there is an HIV/AIDS program-based budget across ministries</p> <p><input type="radio"/> D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators</p> | <p>Q1 Score: 4</p> | <p>NACA; national budget</p> <p>Each Ministry has a line item for HIV. NACA controls remaining discretionary HIV/AIDS budget.</p> |
| <p>Q2. Budgetary Framework: Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?</p> | <p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program</p> <p><input type="radio"/> C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program</p> | <p>Q2 Score: 3</p> | <p>June 2014 IMF TA Report on Introducing an MTEF</p> <p>GOB now using MTFF, which informed the 14/15 budget. GOB has committed to implementing MTEF by 2016.</p> |
| <p>Q3. Fiscal Policy: Does the country pass the MCC scorecard indicator for fiscal policy? (Countries without an MCC scorecard: Is general government net lending/borrowing as a percent of GDP averaged across 2011-2013 greater than (i.e. more positive than) -3.1 percent?)</p> | <p><input checked="" type="radio"/> Yes</p> <p><input type="radio"/> No</p> | <p>Q3 Score: 4</p> | <p>OGAC-provided data sheet (follows tab E)</p> <p>0.09% - YES it is more positive than -3.1%</p> <p>derived from: http://www.mcc.gov/pages/election/scorecards</p> |
| <p>Check the appropriate box for your country's income category: FOR LOW INCOME</p> | <p><input type="radio"/> A. More than 16.4% (i.e. surpasses category mean)</p> <p><input type="radio"/> B. 14.8%-16.4%, (i.e. 90-100% of category mean)</p> | <p>Q4 Score: 4</p> | <p>OGAC-provided data sheet (follows tab E)</p> <p>36.60%</p> <p>Original Source: IMF Government Finance Statistics</p> |

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| <p>Q4. Domestic public revenue: What was annual domestic government revenue as a percent of GDP in the most recent year available? (domestic revenue excludes external grants)</p> | <p><input type="radio"/> C. Less than 14.8%, (less than 90% of category mean)</p> <p><u>FOR LOW MIDDLE INCOME</u></p> <p><input type="radio"/> D. More than 22.3% (i.e. surpasses category mean)</p> <p><input type="radio"/> E. 20.1-22.3% (i.e. 90-100% of category mean)</p> <p><input type="radio"/> F. Less than 20.1% (less than 90% of category mean)</p> <p><u>FOR UPPER MIDDLE INCOME</u></p> <p><input checked="" type="radio"/> G. More than 27.8% (i.e. surpasses category mean)</p> <p><input type="radio"/> H. 25.0%-27.8% (i.e. 90-100% of category mean)</p> <p><input type="radio"/> I. Less than 25.0% (less than 90% of category mean)</p> | | | |
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| Score for Domestic Resource Mobilization: Resource Generation: | 15 |
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| <p>9. Domestic Resource Mobilization: Resource Commitments: Host country government makes adequate multiyear resource commitments to achieve national HIV/AIDS goals for epidemic control and in line with the available fiscal space. These commitments for the national HIV/AIDS program ensure a well-trained and appropriately deployed workforce, functioning health systems, sufficient commodities and drugs, and local institutions at all levels able to perform activities and carry out responsibilities.</p> | | Source of data | Notes/Comments |
|---|--|-----------------------|--|
| <p>Q1. Benchmarks for health spending:</p> <p>African countries: Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)?</p> <p>Non-African countries: Is government health expenditure at least 3 percent of GDP?</p> | <p><input checked="" type="radio"/> A. Yes</p> <p><input type="radio"/> B. No</p> | <p>Q1 Score: 5</p> | <p>OGAC-provided data sheet (follows tab E)</p> <p>Original sources: WHO and World Bank, NHA</p> <p>According to the NHA 2012 and the annual GOB budget speech, GOB is contributing 15% of government expenditure on health.</p> |
| <p>Q2. Domestic spending: What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)?</p> <p><u>58.1</u> %</p> | <p><input type="radio"/> A. Less than 10%</p> <p><input type="radio"/> B. 10-24%</p> <p><input type="radio"/> C. 25-49%</p> <p><input checked="" type="radio"/> D. 50-74%</p> <p><input type="radio"/> E. 75% or Greater</p> | <p>Q2 Score: 7</p> | <p>Sept. 2013 USAID Transitional Financing Report</p> <p>55.2% domestic public and 2.9% domestic private for 2012, for a domestic total of 58.1% (these figures represent an adjustment of the NASA figures, which were 69.6% and 1.9%, respectively, for domestic public and domestic private).</p> |

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| <p>Q3. Key population spending: What percent of key population-specific interventions are financed with domestic public and domestic private sector funding (excluding out of pocket expenditure)?</p> | <p><input checked="" type="radio"/> A. None or information is not available</p> <p><input type="radio"/> B. 1-9%</p> <p><input type="radio"/> 10-24%</p> <p><input type="radio"/> 25-49%</p> <p><input type="radio"/> 50-74%</p> <p><input type="radio"/> 75% or Greater</p> | <p>Q3 Score: 0</p> | | <p>No documented budget for key pops activities.</p> |
| <p>Score for Domestic Resource Mobilization: Resource Commitments:</p> | | <p>12</p> | | |

| <p>10. Allocative Efficiency: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time).</p> | | <p>Source of data</p> | <p>Notes/Comments</p> |
|---|--|-----------------------|---|
| <p>Q1. Data-driven allocation: Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?</p> | <p><input type="radio"/> A. No, data are not used annually</p> <p><input checked="" type="radio"/> B. Yes, data are used annually. Check all that apply:</p> <p><input checked="" type="checkbox"/> Epidemiological data are used</p> <p><input checked="" type="checkbox"/> Health/service delivery data are used</p> <p><input checked="" type="checkbox"/> Financial data are used</p> <p><input type="checkbox"/> There is integrated analysis across data streams</p> <p><input type="checkbox"/> Multiple data streams are used to model scenarios</p> | <p>Q1 Score: 6</p> | <p>Meeting with MOH Deputy Perm. Secretary El Halabi on 2/20/15.</p> <p>The MOH states that they use program, epi, and financial data in their budget planning process for submission to the MOF each year.</p> |
| <p>Q2. Geographic allocation: Does the host country</p> | <p><input checked="" type="radio"/> A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites</p> <p><input type="radio"/> B. Less than 20% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p> | <p>Q2 Score: 0</p> | <p>GOB prioritizes equitable service delivery, with the goal of bringing health services within 8 Km of every person.</p> |

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| <p>government use data to determine the appropriate number and location of HIV/AIDS service sites (proportional to yield or burden data)?</p> | <p><input type="radio"/> C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p> <p><input type="radio"/> D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p> <p><input type="radio"/> E. 80% or more of HIV/AIDS service delivery sites yield 80% or more of new positive HIV test results or ART clients</p> | | | |
| <p>Q3.Data driven reprogramming: Do host country government policies/systems allow for reprograming investments based on new or updated program data during the government funding cycle?</p> | <p><input checked="" type="radio"/> A. No, there is no system for funding cycle reprogramming</p> <p><input type="radio"/> B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used</p> <p><input type="radio"/> C. Yes, there is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data</p> <p><input type="radio"/> D. Yes, there is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data</p> | <p>Q3 Score: 0</p> | | <p>Any unused money goes back to treasury and gets reallocated in following fiscal year.</p> |
| <p>Allocative Efficiency Score:</p> | | <p>6</p> | | |



| <p>11. Technical Efficiency: Through enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, the host country is able to achieve improved HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). Thus, maximizing investments to attain epidemic control.</p> | <p>Source of data</p> | <p>Notes/Comments</p> | | |
|---|---|------------------------------|--|---|
| <p>Q1. Unit costs: Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services?</p> <p>(note: full score of five points can be achieved without checking all disaggregate boxes).</p> | <p><input checked="" type="radio"/> A. No</p> <p><input type="radio"/> B. Yes (check all that apply):</p> <p><input type="checkbox"/> Annually</p> <p><input type="checkbox"/> For HIV Testing</p> <p><input type="checkbox"/> For Care and Support</p> <p><input type="checkbox"/> For ART</p> <p><input type="checkbox"/> For PMTCT</p> | <p>Q1 Score: 0</p> | <p>Essential health package study (ongoing).</p> | <p>The MOH is currently doing a study on costing the essential health package, have costed out ARV regimens, and point to the Transitional Financing report on unit costs. PEPFAR has supported a number of these studies, so this is not yet routinely and regularly conducted by the GOB.</p> |

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| | <input type="checkbox"/> For VMMC <input type="checkbox"/> For OVC Service Package <input type="checkbox"/> For Key population Interventions | | | |
| Q2. Improving efficiency: Which of the following actions is the Host Country Government taking to improve technical efficiencies? | Check all that apply: <input type="checkbox"/> Using findings from cost-effectiveness or efficiency studies to modify operations or interventions <input type="checkbox"/> Streamlining management to reduce overhead costs <input checked="" type="checkbox"/> Reducing fragmentation to lower unit costs, i.e. pooled procurement, resource pooling <input type="checkbox"/> Improving procurement competition <input type="checkbox"/> Integration of HIV/AIDS into national or subnational insurance schemes (private or public) <input checked="" type="checkbox"/> Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact <input type="checkbox"/> Geographic targeting in high burden/high yield sites to increase impact <input type="checkbox"/> Analysis of expenditure data to establish appropriate range of unit costs | Q2 Score: 1 | In a meeting on 20 February 2015 with the Deputy PS of MOH, the Ministry cited work done in the GOB TWG on procurement/ forecasting as evidence of contracts supporting pooled procurement. The PEPFAR SID working group concurred with this assertion in a meeting on 4 March 2015. | The MOH cites CMS framework contracts on generics in support of this question. |
| Q3. Loss ratio: Does host country government have a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery (not administrative/overhead costs)? | <input type="radio"/> A. No <input checked="" type="radio"/> B. Yes | Q3 Score: 3 | 2012 NASA | NASA explicitly breaks out what is spent on program management and administration, as opposed to expenditures at the point of care or service delivery. |
| Q4. Benchmark prices: Are prices paid by the government for first-line ARVs and Test Kits within | Check boxes that apply: <input type="checkbox"/> They are not paying for any ARVs <input type="checkbox"/> They are not paying for any test kits | Q4 Score: 4 | CMS Records, per February 19, 2015 email. WHO Global Price Reporting Mechanism (http://apps.who.int/hiv/amd) | Per CMS Records, GOB price in 14/15 financial year for Atripla first-line regimen is \$11.86 per pack, which works out to an annual cost of \$144.30. That is 6.9% above the 2014 international median annual cost for |

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| 5% variance of international benchmark prices (UNAIDS Investment Case)? | <input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for first line ARVs <input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for test kits | | s/price/hdd/Default.aspx) | TDF/FTC/EFV treatment (\$135.04). |
| Q5. ART unit costs: Have average unit costs for providing ART in the country reduced within the last two years? Unit cost 2009-10: \$ Unit cost 2011-12: \$ | <input checked="" type="radio"/> A. No <input type="radio"/> B. Yes | 0 | February 20, 2015 meeting with MOH Deputy Perm. Secretary El Halabi. | Per MOH, unit costs have increased over last two years as GOB takes on greater financing responsibility for ART. |
| Technical Efficiency Score: | | 8 | | |

THIS CONCLUDES THE SET OF QUESTIONS ON THE HEALTH FINANCING AND STRATEGIC INVESTMENT DOMAIN

Domain D. Accountability and Transparency

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders (donors) for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, and provides mechanisms for eliciting feedback.

| | | Source of data | Notes/Comments |
|--|--|----------------------|--|
| <p>12. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically.</p> | | | |
| <p>Q1. OBI: What is the country's "Open Budget Index" score? (Alternative for countries lacking an OBI score: What was the country's score on the most recent Public Expenditure and Financial Accountability Assessment (PEFA) for PI-10: "Public Access to Fiscal Information"?)</p> | <ul style="list-style-type: none"> <input type="radio"/> A. Extensive Information (OBI Score 81-100; or PEFA score of A- or better on element PI-10) <input type="radio"/> B. Significant Information (OBI Scores 61-80; or PEFA score of B or B+ on element PI-10) <input checked="" type="radio"/> C. Some Information (OBI Score 41-60; or PEFA score of B-, C or C+ on element PI-10) <input type="radio"/> D. Minimal Information (OBI Score 21-40; or PEFA score of C- or D+ on element PI-10) <input type="radio"/> E. Scant or No Information (OBI Score 0-20; or PEFA score of D or below on element PI-10) <input type="radio"/> F. There is neither Open Budget Index score nor a PEFA assessment to assess the transparency of government budget | <p>Q1 Score: 6.0</p> | <p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Open Budget Index (http://survey.internationalbudget.org/) and PEFA data (www.pefa.org)</p> <p>Botswana scored 50 on the OBI.</p> |
| <p>Q2. National program report transparency: Does the host country government make an annual national HIV/AIDS program progress report and or results publically available?</p> | <ul style="list-style-type: none"> <input type="radio"/> A. No, the national HIV/AIDS program progress report or presentation of results is not made public <input checked="" type="radio"/> B. Yes, the national HIV/AIDS program progress report and/or results are made publically available (Check all that apply): <ul style="list-style-type: none"> <input checked="" type="checkbox"/> On Website <input checked="" type="checkbox"/> Through any type of media <input checked="" type="checkbox"/> Disseminate print report or presentation of results | <p>Q2 Score: 6.0</p> | <p>2013 GAPR report, DAC reports</p> <p>GAPR Report is every two years rather than annual, but it is a regularly occurring public accounting of national HIV/AIDS program progress and results. Civil Society orgs state that District AIDS Committee (DAC) reports are also shared at the district level.</p> |
| | <ul style="list-style-type: none"> <input checked="" type="radio"/> A. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically | <p>Q3 Score: 0.0</p> | <p>The PEPFAR team is not familiar with any HIV/AIDS audit being conducted, or made public.</p> |

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| <p>Q3. Audit transparency: Does the host country government make an annual national HIV/AIDS program audit report publically available?</p> | <p><input type="radio"/> B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply:</p> <p><input type="checkbox"/> On website</p> <p><input type="checkbox"/> Through any type of media</p> <p><input type="checkbox"/> Disseminate print report</p> | | | |
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Public Access to Information Score: 12



| <p>13. Oversight and Stewardship: Government institutions are held accountable for the use of HIV/AIDS funds and for the results of their actions by the electorate and by the legislature and judiciary. Public employees are required to account for administrative decisions, use of resources, and results obtained. There is timely and accurate accounting and fiscal reporting, including timely audit of public accounts and effective arrangements for follow-up. There are mechanisms for citizens and key stakeholders to review and provide feedback regarding public programs, services and fiscal management.</p> | <p align="center">Source of data</p> | <p align="center">Notes/Comments</p> | | |
|--|--|---|---|--|
| <p>Q1. Availability of Information on Resources Received by Service Delivery Units. PEFA score on PI-23 was C or higher in most recent assessment.</p> | <p><input type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input type="radio"/> B. PEFA was conducted and score was below C</p> <p><input type="radio"/> C. PEFA was conducted and score was C</p> <p><input type="radio"/> D. PEFA was conducted and score was B</p> <p><input checked="" type="radio"/> E. PEFA was conducted and score was A</p> | <p>Q1 Score: 5.0</p> | <p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p> | <p>2013 PEFA.</p> |
| <p>Q2. Quality and timeliness of annual financial statements. PEFA score for element PI-25 was C or higher in most recent assessment.</p> <p>Actual scores are ____</p> | <p>Check A or B; if B checked, select appropriate disaggregates:</p> <p><input type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input checked="" type="radio"/> B. PEFA was conducted and score was C or higher for:</p> <p><input checked="" type="checkbox"/> (i) Completeness of the financial statements</p> <p><input checked="" type="checkbox"/> (ii) Timeliness of submission of the financial statements</p> <p><input checked="" type="checkbox"/> (iii) Accounting standards used</p> | <p>Q2 Score: 5.0</p> | <p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p> | <p>2013 PEFA.</p> |
| | <p>Check A, B, or C; if C checked, select appropriate disaggregates:</p> | | <p>Partner Forum, National AIDS Council,</p> | <p>BBSS included CSO representation.</p> |

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| <p>Q3. Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels and opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services?</p> | <p><input type="radio"/> A. No, there are no formal channels or opportunities</p> <p><input type="radio"/> B. No, there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and feedback</p> <p><input checked="" type="radio"/> C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply:</p> <p><input checked="" type="checkbox"/> During strategic and annual planning</p> <p><input checked="" type="checkbox"/> In joint annual program reviews</p> <p><input checked="" type="checkbox"/> For policy development</p> <p><input checked="" type="checkbox"/> As members of technical working groups</p> <p><input checked="" type="checkbox"/> Involvement on evaluation teams</p> <p><input type="checkbox"/> Giving feedback through social media</p> <p><input checked="" type="checkbox"/> Involvement in surveys/studies</p> <p><input type="checkbox"/> Collecting and reporting on client feedback</p> | <p>Q3 Score: 5.0</p> | <p>TWG, Global Fund Concept note, TB/HIV meeting, TB evaluation CSO involvement, MLG supports CSOs</p> | |
| <p>Q4. Civil society Enabling Environment: What score did your country receive on the 2013 Civicus Enabling Environment Index (EEI), which measure the socio-cultural, socio-economic and governance environments for civil society?</p> <p>If your country is not included in the EEI, are there any laws or policies that prevent a full range of civil society organizations from providing oversight into the government's HIV/AIDS response?</p> | <p><input type="radio"/> A. EEI score of 0-0.38; or if no EEI score, there are laws or policies that restrict civil society playing an oversight role</p> <p><input type="radio"/> B. EEI score of 0.39-0.50; or there are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it is not accepted by government</p> <p><input checked="" type="radio"/> C. EEI score of 0.51 - 0.76; or there are no laws or policies that prevent civil society from playing a role in providing oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight</p> | <p>Q4 Score: 4.0</p> | <p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Civicus Enabling Environment Index (civicus.org/eei/)</p> | <p>Botswana score was 0.58. Some of the CSOs are funded by the government.</p> |
| <p>Oversight and Stewardship Score:</p> | | | <p>19</p> | |

THIS CONCLUDES THE SET OF QUESTIONS ON THE ACCOUNTABILITY AND TRANSPARENCY DOMAIN

Domain E. Enabling Environment

What Success Looks Like: Relevant government entities demonstrate transparent resolve and take actions to create an enabling policy and legal environment, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

14. Policies, Laws, and Regulations: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.

Source of data

Notes/Comments

Q1. Structural obstacles: Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support?

- A. No, there are no such laws or policies
- B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score):
- Criminalization of HIV transmission
 - HIV testing disclosure policies or age requirements
 - Non-disclosure of HIV status laws
 - Anti-homosexuality laws
 - Anti-prostitution legislation
 - Laws that criminalize drug use, methadone use or needle exchange

Q1 Score: 0.0

Penal Code: Chapter 08:01 Section 155 (Prostitution), Section 164 and 167 (Homosexuality); New Public Health Act, National HIV/AIDS Policy

Q2. Access protection: Is there a National HIV/AIDS Policy or set of policies and laws that creates a legal and policy environment that ensures non-discriminatory and safe access to HIV/AIDS services, providing social and legal protection where those rights are violated?

(note: full score of six points possible without checking all boxes)

- A. No, there are no such policies or laws
- B. Yes, there are such policies and laws. Check all that apply:
- For people living with HIV
 - For men who have sex with men
 - For transgendered persons
 - For sex workers
 - For people who inject drugs
 - For children orphaned or affected by HIV/AIDS

Q2 Score: 3.0

National HIV/AIDS policy 2012, Childrens Act 2009, Domestic Violence Act

Civil Society points out that the Domestic Violence Act is not specific in any way to HIV.

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| | <input type="checkbox"/> For young girls and women vulnerable to HIV <input checked="" type="checkbox"/> For survivors of gender-based violence | | | |
| Q3. Civil society sustainability: Does the legislative and regulatory framework make special provisions for the needs of Civil Society Organizations (CSOs) or give not-for-profit organizations special advantages? | <input type="radio"/> A. No, there are no special provisions or advantages for CSOs <input checked="" type="radio"/> B. Yes, there are special provisions and advantages for CSOs. Check all that apply: <input type="checkbox"/> Significant tax deductions for business or individual contributions to not-for-profit CSOs <input checked="" type="checkbox"/> Significant tax exemptions for not-for-profit CSOs <input type="checkbox"/> Open competition among CSOs to provide government-funded services <input type="checkbox"/> Freedom for CSOs to advocate for policy, legal and programmatic change | Q3 Score: 1.0 | NGO policy , Botswana Unified Revenue Services (BURS) | The Civil Society orgs state that they do receive tax exemptions through BURS. |
| Q4. Enabling legislation: Are there policies or legislation that govern HIV/AIDS service delivery? | <input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, there are. Check all below that are included: <input checked="" type="checkbox"/> A national public health services act that includes the control of HIV <input type="checkbox"/> A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services | Q4 Score: 3.0 | 2012 HIV/AIDS guidelines; Public Health Act | While 2012 treatment guidelines speak to nurses prescribing ability (and there is a handbook on nurse prescribers as well), however the scope of practice for nurses does not stipulate HIV and treatment as part of their work. MOH has no legal recourse. The legal environment does not support this in a sustainable way until the scope of work for nurses is revised. |
| Policies, Laws, and Regulations Score: | | 7 | | |

| 15. Planning and Coordination: Senior policy makers prioritize health and the HIV/AIDS response. Host country develops, implements, and oversees a multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated. | | Source of data | Notes/Comments |
|---|--|----------------|--|
| Q1. National Strategy: Does the country have a | <input type="radio"/> A. No, there is no national strategy for HIV/AIDS <input checked="" type="radio"/> B. Yes, there is a national strategy. Check all that apply: <input checked="" type="checkbox"/> It is multiyear | Q1 Score: 4.0 | National Strategic Framework (NSF) II; National Operational Plan for NSF |

| | | | | |
|---|--|----------------------|---|---|
| <p>multi-year, costed national strategy to respond to HIV?</p> | <p><input checked="" type="checkbox"/> It is costed</p> <p><input checked="" type="checkbox"/> Its development was led by the host country government</p> <p><input checked="" type="checkbox"/> Civil society actively participated in the development of the strategy</p> | | | |
| <p>Q2. Data driven prioritization: Did the host country government develop the strategy using a data-driven prioritization approach, which coordinates the investment of multiple sources of funding, i.e. Investment Case?</p> | <p><input checked="" type="radio"/> A. No data-driven prioritization approach was used</p> <p><input type="radio"/> B. Yes, a data-driven prioritization approach was used but it did not coordinate the investment of multiple funding sources</p> <p><input type="radio"/> C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources</p> | <p>Q2 Score: 0</p> | <p>2014 Botswana Investment Case</p> | <p>Investment Case used a data-driven approach to determine priorities, but these have not yet been integrated into the national strategy; next NSF due in 2016.</p> |
| <p>Q3. CCM criteria: Has the country met the minimum criteria that all CCMs must meet in order to be eligible for funding by the Global Fund?</p> | <p><input type="radio"/> A. No or there is no CCM</p> <p><input checked="" type="radio"/> B. Yes, with conditions</p> <p><input type="radio"/> C. Yes</p> | <p>Q3 Score: 1</p> | <p>Global Fund Eligibility List 2014: CCM criteria report from GMS</p> | |
| <p>Q4. Coordination of national response: Does the host country government coordinate (track and map) all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, to avoid duplication and gaps?</p> | <p><input type="radio"/> A. No, it does not track or map all HIV/AIDS activities</p> <p><input checked="" type="radio"/> B. the host country government coordinates all HIV/AIDS activities. Check all that apply:</p> <p><input checked="" type="checkbox"/> Of Civil Society Organizations</p> <p><input type="checkbox"/> Of private sector</p> <p><input type="checkbox"/> Of donor implementing partners</p> <p><input type="checkbox"/> Activities are tracked or mapped</p> <p><input type="checkbox"/> Duplications and gaps are addressed</p> <p><input checked="" type="checkbox"/> Joint operational plans are developed that include key activities of all implementing agencies</p> | <p>Q4 Score: 2.0</p> | <p>National Operational Plan; NACA; Partners Forum, NACA Coordination assessment 2010</p> | <p>There is a Partners Forum where updates are provided by each stakeholder, but some gaps and duplications persist. While strategy documents exist, there is a lack of partner mapping. National Guidelines for HIV/AIDS could be considered an effort to coordinate national HIV treatment.</p> |
| | <p><input type="radio"/> A. No</p> | <p>Q5 Score: 4.0</p> | | <p>CSO active in advocacy, service delivery, and participate in TWGs. During CSOs consultations,</p> |

Q5. Civil society engagement: Is there active engagement of diverse non-governmental organizations in HIV/AIDS advocacy, decision-making and service delivery in the national HIV/AIDS response?

B. Yes, civil society (such as community-based organizations, non-governmental organizations and faith-based organizations, local leaders, and/or networks representing affected populations) are actively engaged. Check all that apply:

- In advocacy
- In programmatic decision-making
- In technical decision-making
- In service delivery

held the week of February 16th in Maun, and March 16th in Selibe-Phikwe, CSOs confirmed they felt included in advocacy, programmatic, technical decision making and service delivery.

Planning and Coordination Score:

11

THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN