



BOTSWANA:

Sustainability and Transition Readiness Assessment and Roadmap for HIV and TB

*Pharos Global Health Advisors for the
Botswana National AIDS and Health Promotion Council*

APRIL 2024



Authors and Acknowledgements

This report was prepared by a team from Pharos Global Health Advisors composed of Robert Hecht, Mila Dorji, Abaleng Lesego, Keitseope Nthomang, and Qinani Dube. The report has benefitted from input from a wide range of stakeholders including members of the National AIDS and Health Promotion Council (NAHPC) and others from NAHPA, Ministry of Health, Civil Society Organizations, UNAIDS, PEPFAR, USAID, CDC, and the Global Fund. Special thanks to the team at NAHPA, led by the National Coordinator Mr. Ontiretse Letlhare, Manager Program Planning Mrs. Lefetogile Bogosing, and Chief Program Planning Officer Mr. Titus Simon, and to the team at UNAIDS Botswana led by Country Director Mr. Alankar Malviya and Fast Track Advisor Mr. Chiweni Chimbwete. Pharos also appreciates the comments and suggestions from the peer reviewers Mr. Charles Birungi and Mr. Carl Schutte.



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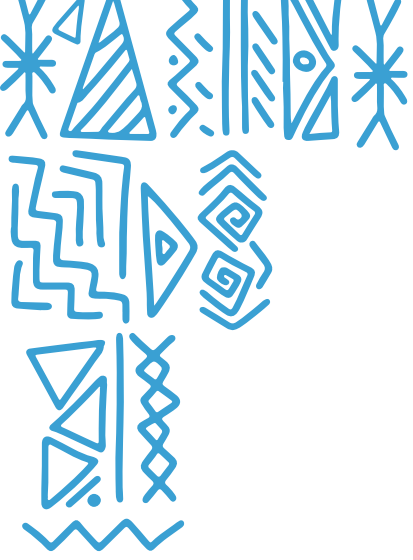
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List of Acronyms

ACHAP	African Comprehensive HIV/AIDS Partnerships
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ASLM	African Society for Laboratory Medicine
BAIS	Botswana AIDS Impact Survey
BNTF	Botswana National TB Program
BOCHAIP	Botswana Christian AIDS Intervention Program
BONASO	Botswana Network on AIDS Service Organisations
BONELA	Botswana Network on Ethics, Law and HIV/AIDS
BONEPWA	Botswana Network of People Living with HIV/AIDS
BUMMHI	Botswana-University of Maryland School of Medicine Health Initiative
BWP	Botswana Pula
C19RM	COVID-19 Response Mechanism
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CMS	Central Medical Stores
COP	Country Operational Plan
CSO	Civil Society Organization
DALY	Disability-Adjusted Life Year
DHMT	District Health Management Team
DMSAC	District Multi-Stakeholder AIDS Committee
DOT	Directly Observed Therapy
DPSM	Directorate of Public Service Management
EID	Early Infant Diagnosis
FSW	Female Sex Worker
GF	Global Fund
GoB	Government of Botswana
HABSP	Integrated HIV & AIDS Basic Services Package
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HTS	HIV Testing Services
IPMS	Integrated Patient Management System
JOC	Joint Oversight Committee
KP/KVP	Key (Vulnerable) Population
M&E	Monitoring and Evaluation

MAS	Medical Aid Scheme
MDR-TB	Multi-Drug Resistant Tuberculosis
MoF	Ministry of Finance of Botswana
MoH	Ministry of Health of Botswana
MSM	Men who have Sex with Men
NAHPA	National AIDS and Health Promotion Agency
NAHPC	National AIDS and Health Promotion Council
NASA	National AIDS Spending Assessment
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NPC	National Planning Commission
NSF	National Strategic Framework for HIV/AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	Person/People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	Persons Who Inject Drugs
S&T	Sustainability & Transition
STI	Sexually Transmitted Infection
STRA	Sustainability and Transition Readiness Assessment
TB	Tuberculosis
TG	Thematic Group
TGP	Transgender People
TSM	Technical Support Mechanism of UNAIDS
UMIC	Upper Middle-Income Country
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
USAID	United States Agency for International Development
USD	United States Dollar
USG	United States Government
VAT	Value Added Tax
VMMC	Voluntary Medical Male Circumcision
VMSAC	Village Multi-Sectoral AIDS Committee
WB	World Bank
WHO	World Health Organization



Executive Summary

The Problem and Challenge

Botswana, a pioneer in the fight against HIV, was the first country in sub-Saharan Africa to establish a free national antiretroviral treatment program. In 2022, it became the third nation globally — following Switzerland and Eswatini — to meet the UN’s ambitious 95-95-95 HIV control targets.¹ Now, as an upper-middle income country with the highest GDP (PPP) per capita in the region,² it is again poised to break new ground as one of the first African nations to significantly transition away from donor aid for HIV and towards enhanced self-reliance. Accomplishing this while maintaining the tremendous progress made to date will require accurate anticipation of financial and operational risks across the program, as well as the timely implementation of decisive mitigation actions for each.

The Third National Strategic Framework (NSF III) for HIV and AIDS (2019 – 2023) demonstrates the Government of Botswana’s commitment to continue expanding upon a strong record of success in combatting the HIV epidemic. NSF III affirms Botswana’s adoption of global targets for reaching epidemic control by 2023 and ending AIDS as a public health threat by 2030. Progress against these ambitious goals has been strong, with treatment cascade results of 95-98-98 demonstrated in the 2022 Botswana AIDS Impact Survey (BAIS V). UNAIDS Spectrum estimates from 2023 place the total number of PLHIV at 343,914 (representing 20.8% of adults over the age of 15) and the annual incidence rate at 0.29 new cases per 100 people, which represents a dramatic 63% decline since 2010 in new adult infections occurring annually. With 4,320 new infections and 3,822 AIDS-related deaths estimated to have taken place in 2022, the NSF III goal of epidemic control is nearly within grasp.

While Botswana’s HIV response can still be improved, a primary objective at this stage is to sustain the exemplary achievements made to date in the face of resource constraints and the impending prospect of declining donor funding.

1 Government of Botswana, “Botswana achieved the Joint United Nations Programme on HIV/AIDS (UNAIDS) 95-95-95 targets : results from the Fifth Botswana HIV/AIDS Impact Survey (BAIS V), 2021”, <https://programme.aids2022.org/Abstract/Abstract/?abstractid=12921>.

2 “GDP per capita, PPP (current US\$) | Data”. *Data.worldbank.org*. Retrieved 2023-08-02.

While Botswana's HIV response can still be improved, a primary objective at this stage is to sustain the exemplary achievements made to date in the face of resource constraints and the impending prospect of declining donor funding.

The Risk Assessment and Roadmap

PURPOSE

In April 2023, the Government of Botswana, with support from UNAIDS, contracted Pharos to work with key stakeholders to identify and assess the most important risks to the sustainability and eventual transition of the Botswana HIV program, and to recommend evidence-based actions to mitigate these risks.

This report presents the Sustainability and Transition Risk Assessment (STRA) and Roadmap produced through a participatory process engaging a wide range of stakeholders including the Government of Botswana, UNAIDS, donors, CSOs, and development partners. It offers a complete diagnosis and set of corresponding recommendations to sustain Botswana's response to the HIV epidemic and to prepare for its eventual transition from international to domestic support.

APPROACH

This assignment was undertaken in three phases, using an expanded version of the framework of best practices endorsed by the Global Fund.³

- 1. Inception:** An initial literature and data review was conducted to build a high-level picture of sustainability and transition risks in Botswana's HIV program. To identify and refine specific focus areas for the assessment, the team held preliminary discussions and informational interviews with a wide range of stakeholders from government, CSOs, donors, and development partners (Annex A).
- 2. Sustainability and Transition Assessment:** Following circulation and revision of an Inception Report, the team reviewed more than 150 source documents including strategic plans, progress reports, budget and expenditure data, epidemiological studies, investment cases, and efficiency analyses provided by government agencies, CSOs, donors, development partners, and academic institutions. The team also conducted more than 70 interviews and meetings, individually and in focus groups (Annex B). NAHPA and UNAIDS then facilitated the first in-country mission from May 30 to June 9, 2023. Using the additional inputs gathered during the visit, the team produced a first draft of the STRA report in July 2023.

- 3. Roadmap:** The team finally developed an HIV Sustainability and Transition Roadmap recommending specific evidence-based actions to address the risks described in the STRA. These actions were mapped to specific implementing organizations, monitoring frameworks, and timelines. A draft Roadmap was discussed and validated in a stakeholder workshop held in Gaborone 22-27 October 2023. The National HIV and Health Promotion Council (NAHPC) was briefed on 10 November.

The report below is organized into five chapters. Chapter 1 contains the introduction with the consultancy context, process and timeline, and methods and analytical framework. Chapter 2 describes the national contexts operating in-country, and Chapter 3 lays out the Risk Assessment Findings across four categories: sustainable financing, health systems strengthening, CSO engagement, and governance, coordination, and human rights. Chapter 4 summarizes the main sustainability and transition risks, while Chapter 5 presents the Sustainability and Transition Roadmap and discusses next steps for its implementation over 2024-26 and beyond.

ANALYTICAL FRAMEWORK AND METHODS

The Botswana project builds on conceptual frameworks developed by UNAIDS and the Global Fund in 2017-19, and tools and methods used in more than a dozen countries in Asia, Africa, and Latin America, drawing on S&T guidance documents published by the Global Fund in 2021-22.

To structure the analysis, the risk assessment and formulation of mitigating actions were divided into four domains that cover the key categories of risk to HIV program sustainability: financing, health system strengthening, CSO engagement, and governance, coordination, and human rights (Figure ES. 1). The STRA matrix and the Roadmap matrix of key actions both follow this four-part structure.

HIV Program Financing Outlook

Sustainability and transition challenges to the Botswana HIV response emerge sharply using a financing lens. While the treatment cascade results of 95/98/98 are impressive and have driven down the number of new infections to just 4,000 a year, the program is costly, requiring about \$120 million per year in total, of which \$74.9 million (60%) comes from the Government. These costs absorb a hefty 15% of the total health budget and 2.2% of overall government spending.

The outlook for the rest of the decade was examined using different scenarios in which costs were varied and donor assistance from PEPFAR and the Global Fund gradually

³ Global Fund for AIDS, TB, and Malaria, Guidance for Sustainability and Transition Assessments and Planning for National HIV and TB Responses, February 2021. https://www.theglobalfund.org/media/11490/core_sustainability-transition-assessments-planning-national-hiv-and-tb-responses_guidance_en.pdf

declined (see Figure ES.2). While there is much uncertainty about the exact trajectory of donor support over the next 5-10 years, these scenarios represent our best judgment based on discussions with donor representatives, international precedent, and available data. Anticipating and preparing adequately for probable decreases in donor funding is critical to ensure the HIV program does not suffer by being caught off guard.

In the most optimistic scenario, the additional funding required from the Government rises by just \$6 million a year by 2030 (less than 10% more than the \$74.5 million spent by the Government in 2022), but in the most pessimistic scenario the Government would have to allocate an extra

\$64.4 million annually by 2030 to close the gap created by increases in program costs and reductions in donor support – 86% more than what the Government expended in 2022. Sources, parameter details, and further analysis of these scenarios is provided in Chapter 3 (Figure 3.1).

The level of financial dependence on donors varies across the HIV program, as shown below. Some areas like treatment are mainly paid for by the Government, while other critical components like prevention, health systems strengthening, and HIV testing and counseling rely heavily on outside support. In planning for reductions in donor funding, these donor-backed components need to be carefully considered.

FIGURE ES.1: THE FOUR DOMAINS USED TO ASSESS SUSTAINABILITY AND TRANSITION

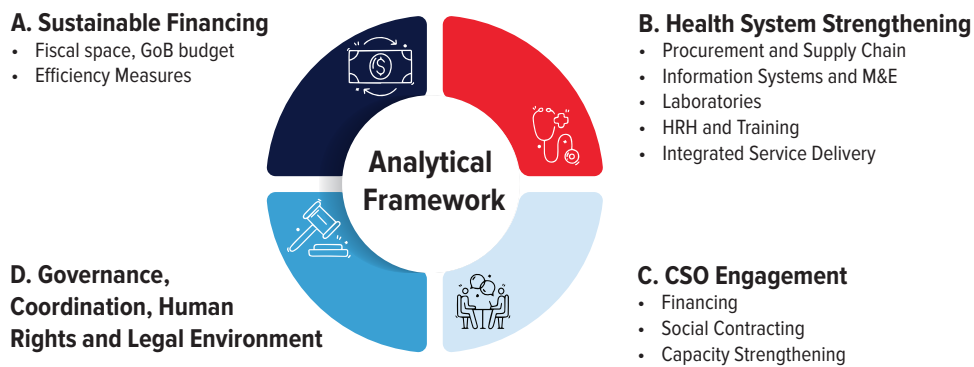


FIGURE ES.2: BOTSWANA HIV FINANCING SCENARIOS 2023-2030 (IN REAL USD)

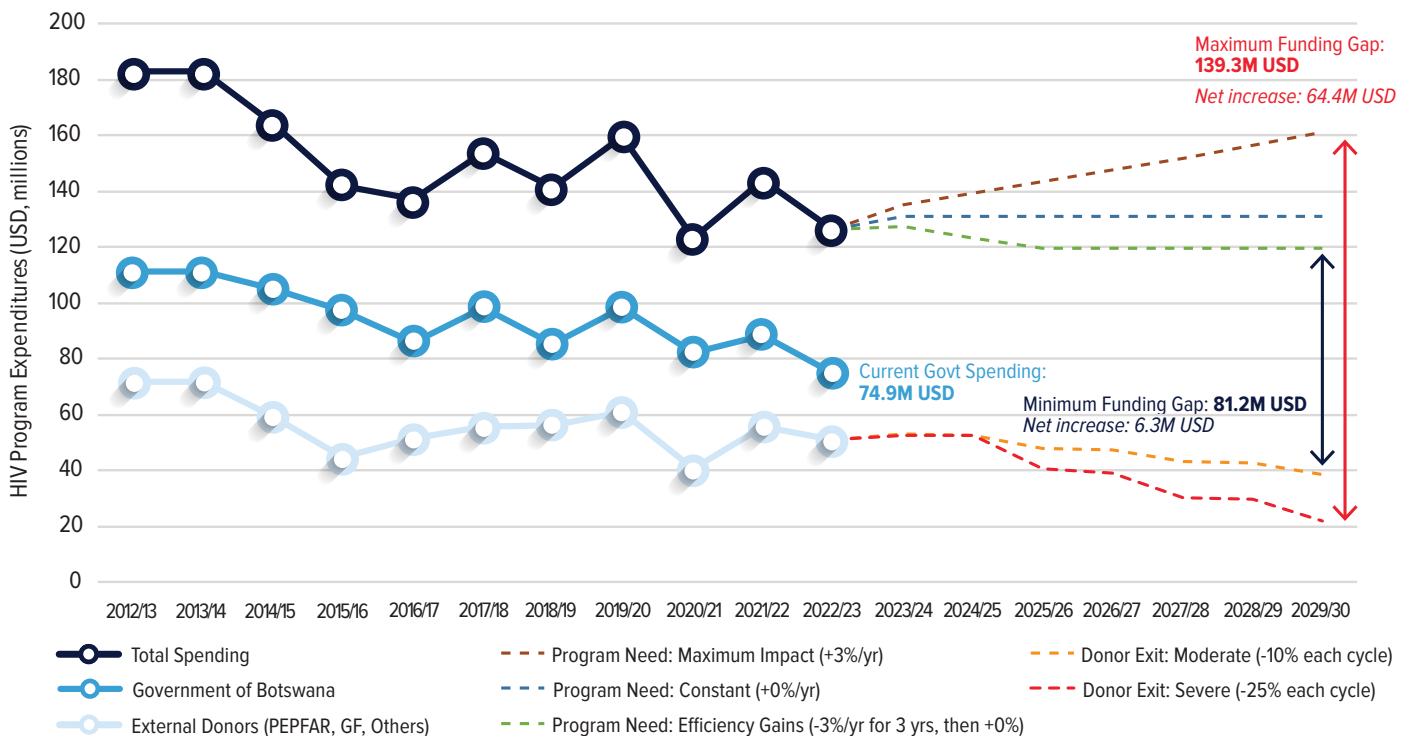
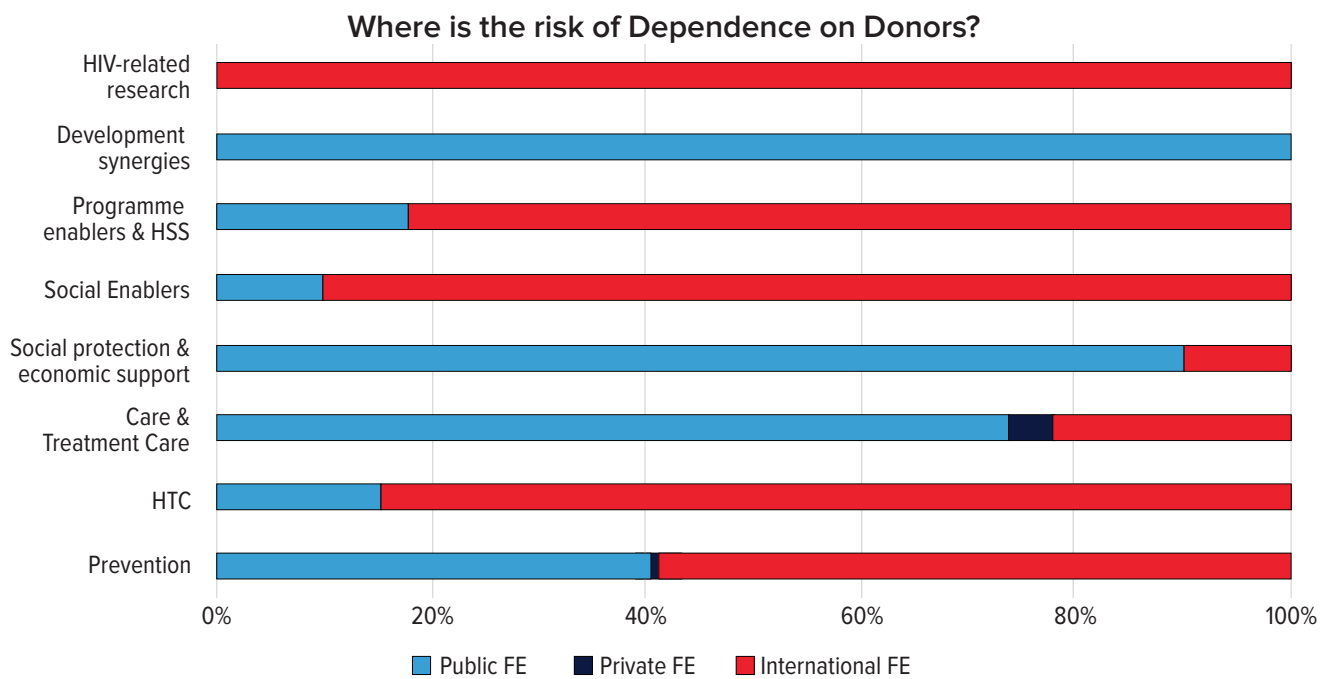


FIGURE ES.3: HIV PROGRAM AREAS BY FINANCING ENTITIES



Government: Majority funder of development synergies (100%), social protection and economic support (93%), and care and treatment (74%)

Private sector: Care and treatment (less than 1%), prevention (negligible)

Donors: Majority funders of HIV research (100%), social enablers (90%), HIV testing and counseling (85%), programme enablers and health systems strengthening (82%), and prevention (59%)

Source: Government of Botswana, National AIDS Spending Assessments (2003-2006, 2006-2008, 2009-2012, 2018-2020), <https://www.unaids.org/en/dataanalysis/knowyourresponse/nasacountryreports>.

Main Findings on Sustainability and Transition Risks

A total of 21 critical risks to the sustainability and successful transition of Botswana’s HIV program were identified. In Chapter 3, each risk is described and documented. The negative consequences of not addressing each risk are laid out, and high-level actions are proposed to mitigate the risk. Chapter 4 summarizes this information in an easy-to-use matrix. Each risk is assigned a color-coded “traffic light”, with red (9 risks) signifying severe risk, orange (7 risks) pointing to high risk, and yellow (5 risks) meaning moderate risk.

To illustrate, Figure ES.4 presents one severe risk from each of the four domains along with the recommended high-level mitigating action(s).

Main Recommended Roadmap Actions CORE AND ENABLING ACTIONS

To streamline the Roadmap and simplify follow-on implementation efforts, 5 risks were separated out that, while important, involve actions that go beyond the national HIV program and affect the entire health sector, and thus require wider buy-in from the Government, especially the Ministry of Health and Ministry of Finance. These relate to

areas like Supply Chain, Human Resources, and Health Information Systems and have been moved to a second matrix (Annex P) entitled “Roadmap of Actions for the Enabling Environment”. Furthermore, overlap and synergy between recommended actions meant that 2 risks did not require unique actions beyond those listed for other risks, and therefore were not reproduced in the Roadmap.

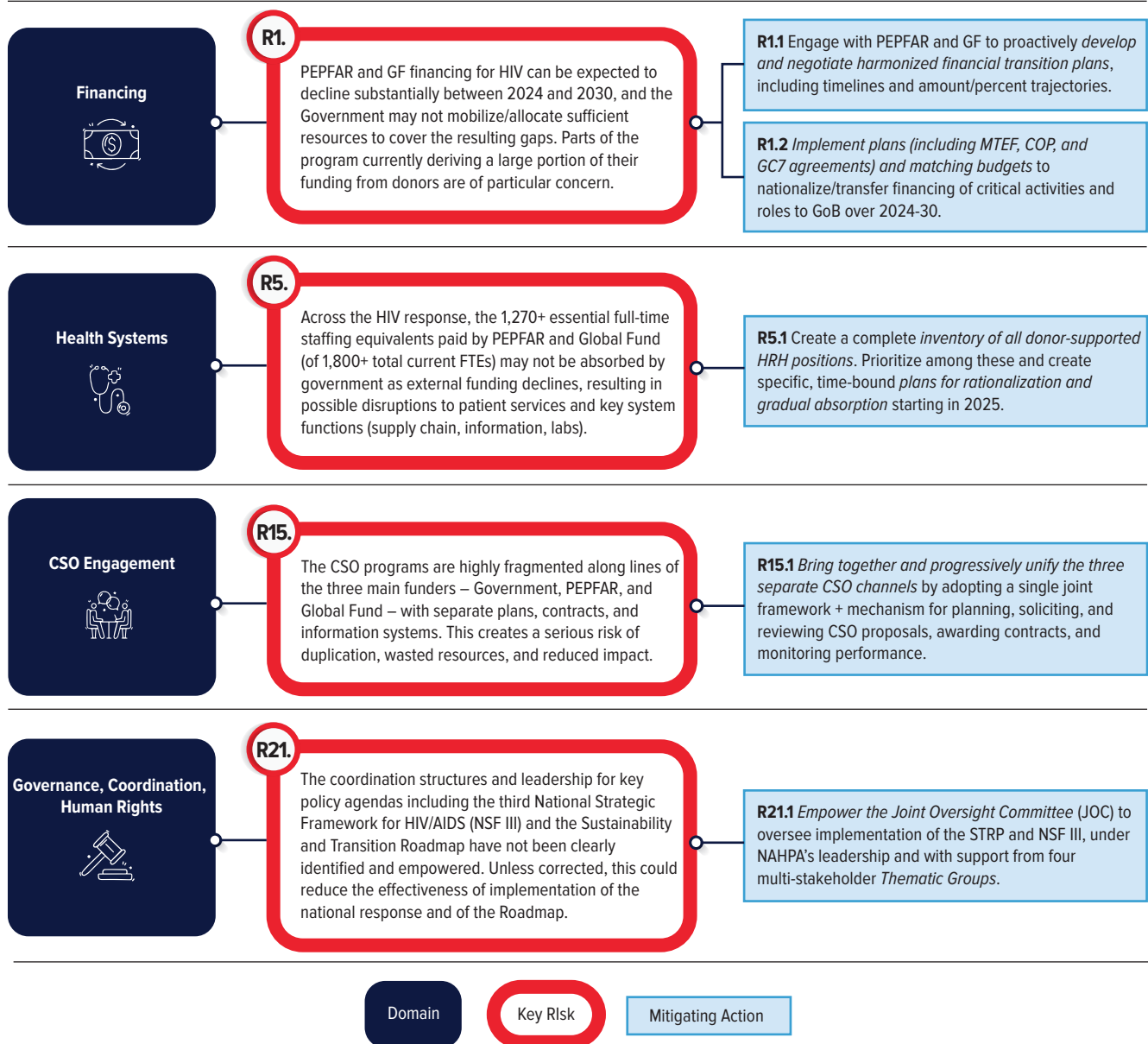
This left the main Roadmap matrices (Figures 5.1 through 5.4) with a smaller number of 14 “Core” Risks (shown in the matrix below, along with their respective color-coded severity ratings) where direct improvements in the HIV program are needed to ensure effective sustainability and transition. It is suggested that stakeholders focus on ensuring the timely implementation of the actions recommended to address these 14 Core Risks, which are detailed in Figure 5.1 through Figure 5.4.

WHAT SHOULD A STRONG ROADMAP LOOK LIKE?

As discussed during the workshop in Gaborone on 25 October, a successful Roadmap must meet the “3 Fs” criteria: Focused, Financed, and Followed to implementation, with effective monitoring and accountability:

- The Roadmap should be a concrete, action-oriented plan with full buy-in from all stakeholders, including Government, civil society, and partners.

FIGURE ES.4: EXAMPLES OF SEVERE RISKS FROM EACH OF THE FOUR DOMAINS

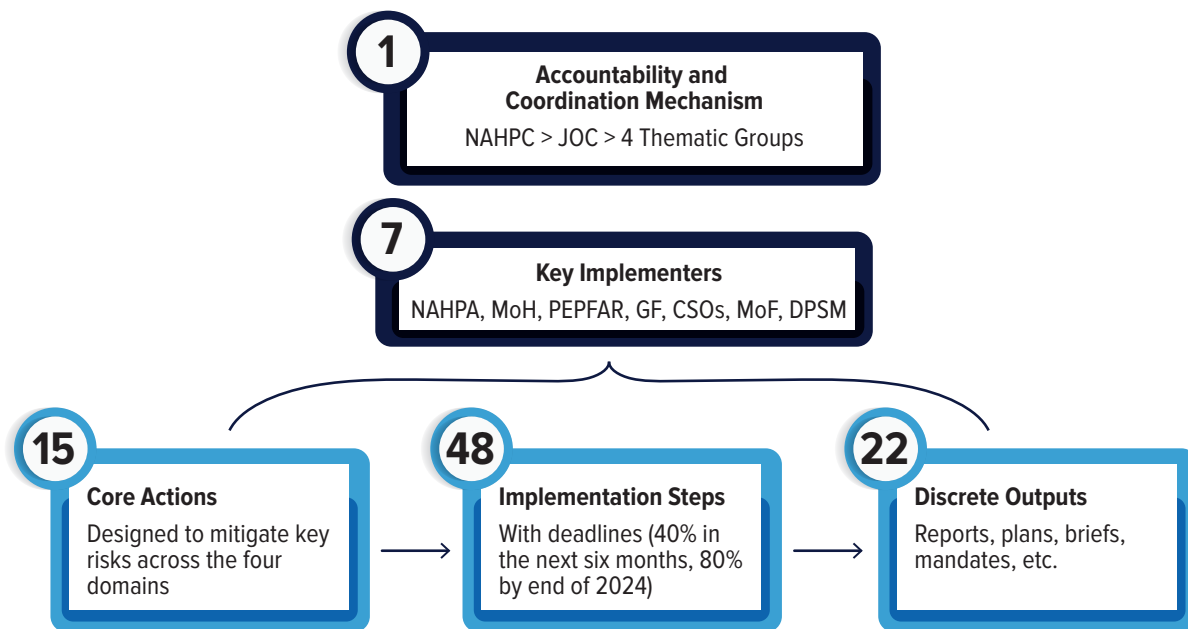


- It should present a limited number of high-value actions with roles, responsibilities, and deadlines explicitly assigned to relevant stakeholders.
- It must be backed and overseen by an institutional accountability mechanism (led by the Joint Oversight Committee of the National AIDS and Health Promotion Council) to coordinate implementation and hold all parties accountable.
- It should use focused TGs under the JOC to bring lead organizations together around key areas of the Roadmap such as Financing, Efficiency Gains, and HRH.
- Actions, timelines, and proposed financial investments should be grounded in realistic expectations for the gradual transition of donor-supported activities to the Government.

ROADMAP STRUCTURE

In Chapter 5, the first column of each matrix reproduces the key risks. For each risk, recommended “Mitigating Actions” are shown, which are further broken down into detailed “Implementation Steps.” For each step, an indication is provided of which organization/s (e.g., Ministry of Health, NAHPA, PEPFAR, Global Fund, etc.) could be considered “Responsible” for implementation and results, and which organization(s) should be “Consulted” for key inputs and coordination. The column on “Due Date” indicates the proposed deadline for accomplishing the task and/or producing the output described in the step. Discrete, directly monitorable outputs like reports, briefs, plans, and budget documents are shown in red font.

FIGURE ES.5 ROADMAP BY THE NUMBERS



HOW THE ROADMAP SHOULD BE COORDINATED AND OVERSEEN

The HIV Roadmap represents a huge effort and investment by all stakeholders – public sector, CSO, PEPFAR, Global Fund, UNAIDS, and others – to come together to identify challenges to sustainability and transition of the Botswana HIV program and forge a common plan that everyone buys into, endorses, and commits to implement. As the matrix and accompanying materials show, there are multiple actions for each stakeholder to carry out and be accountable for.

To ensure successful implementation of the Roadmap over the next three years, it is vital that the stakeholders work together starting as soon as possible, now that the Roadmap has been delivered to the National AIDS Council (this happened on 10 November 2023) and Government has signaled its intention to endorse and publish the Roadmap as an official policy document (ideally in late 2023 or early 2024).

An overall governance mechanism is needed to continuously monitor progress and problems in the sustainability and transition Roadmap, support and hold accountable all participating organizations and individuals, and improve and adjust the Roadmap over time. Based on discussions with key stakeholders, it was agreed that the role of coordinating Roadmap implementation be assigned to the NAHPC’s Joint Oversight Committee (JOC), with high level representation from MoH, MoF, DPSM, PEPFAR, Global Fund, and Civil Society.

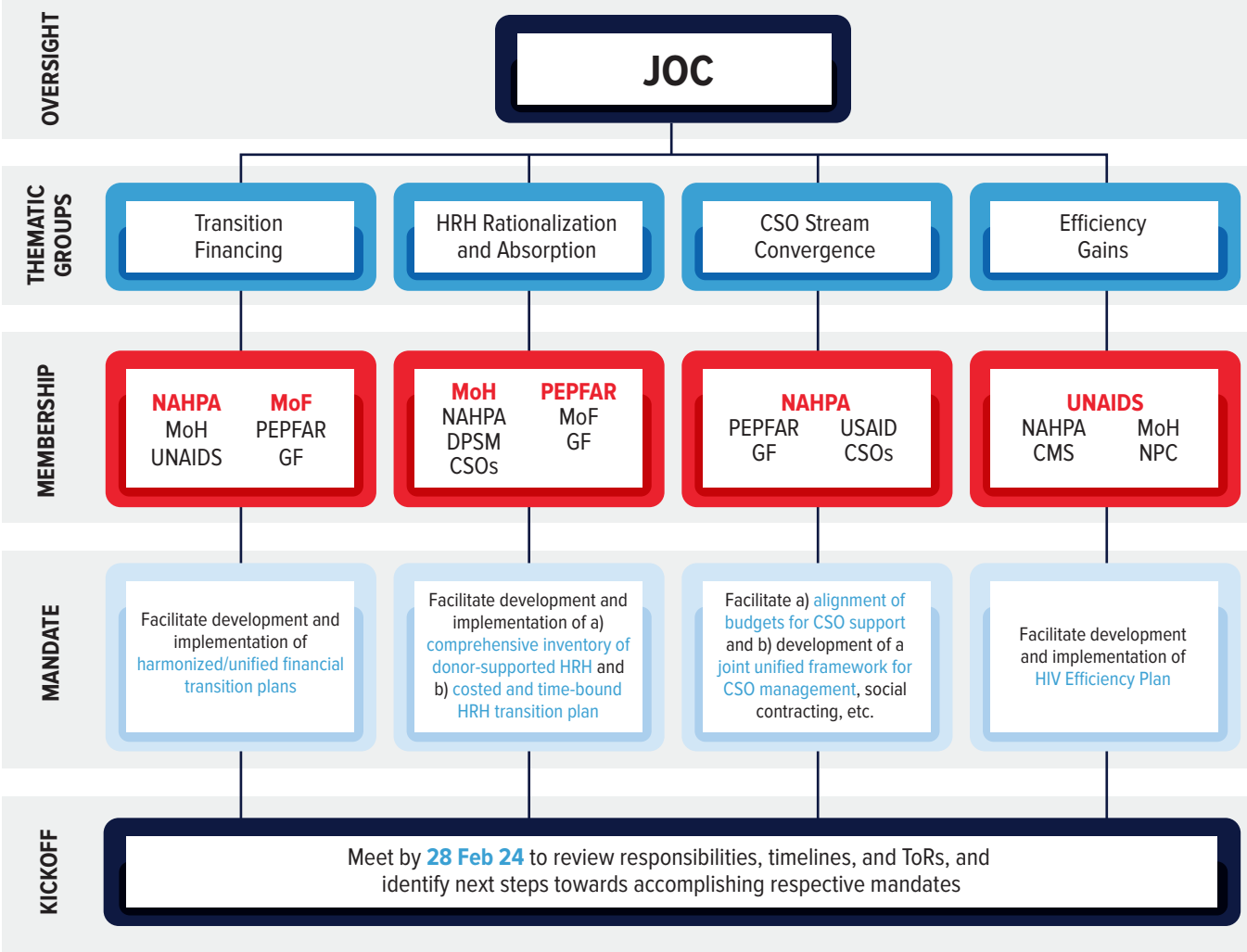
It is also recommended that several Thematic Groups (TGs) should be formed in early 2024 under the aegis of the JOC

to develop and oversee detailed work plans for key action areas such as Transitional Financing, Efficiency Gains, Transitioning and Rationalizing Donor-Supported HRH, and Converging the CSO Streams. The details of these Thematic Groups including the suggested composition, chair, and mandate for each are summarized in the chart below. Each group should be constituted by 31 January 2024 and hold their first meeting no later than 28 February 2024. In their first meeting, members can focus on reviewing responsibilities, timelines, and ToRs and on drafting their groups’ respective work plans for the year ahead. These work plans should include well-defined deliverables tied to specific deadlines.

Draft ToRs for the four TGs are shown in Annex K through Annex N. Each TG should be composed of a small number (5-10) of senior officials with technical skills and the ability to put their findings in front of top decision makers in their respective organizations. It may be necessary to augment the capacity of the TG with part time technical assistance to ensure that data are collected and analyzed, models/templates designed and used, and reports produced.

For ease of interpretation and use, Annex O lays out the main recommended actions by “Lead Agency”, including proposed deadlines for the first major steps in implementing that action during 2024. It is important for the success of the Roadmap to move forward decisively on each of main action areas, so that momentum is maintained. Note that all principal stakeholders, including NAHPA, Ministry of Health, Ministry of Finance, Department of Public Service Management, PEPFAR, Global Fund, Civil Society, and UNAIDS, have their “checklist of actions.”

FIGURE ES.6: THEMATIC GROUPS FOR ROADMAP IMPLEMENTATION



What Needs to Happen Next?

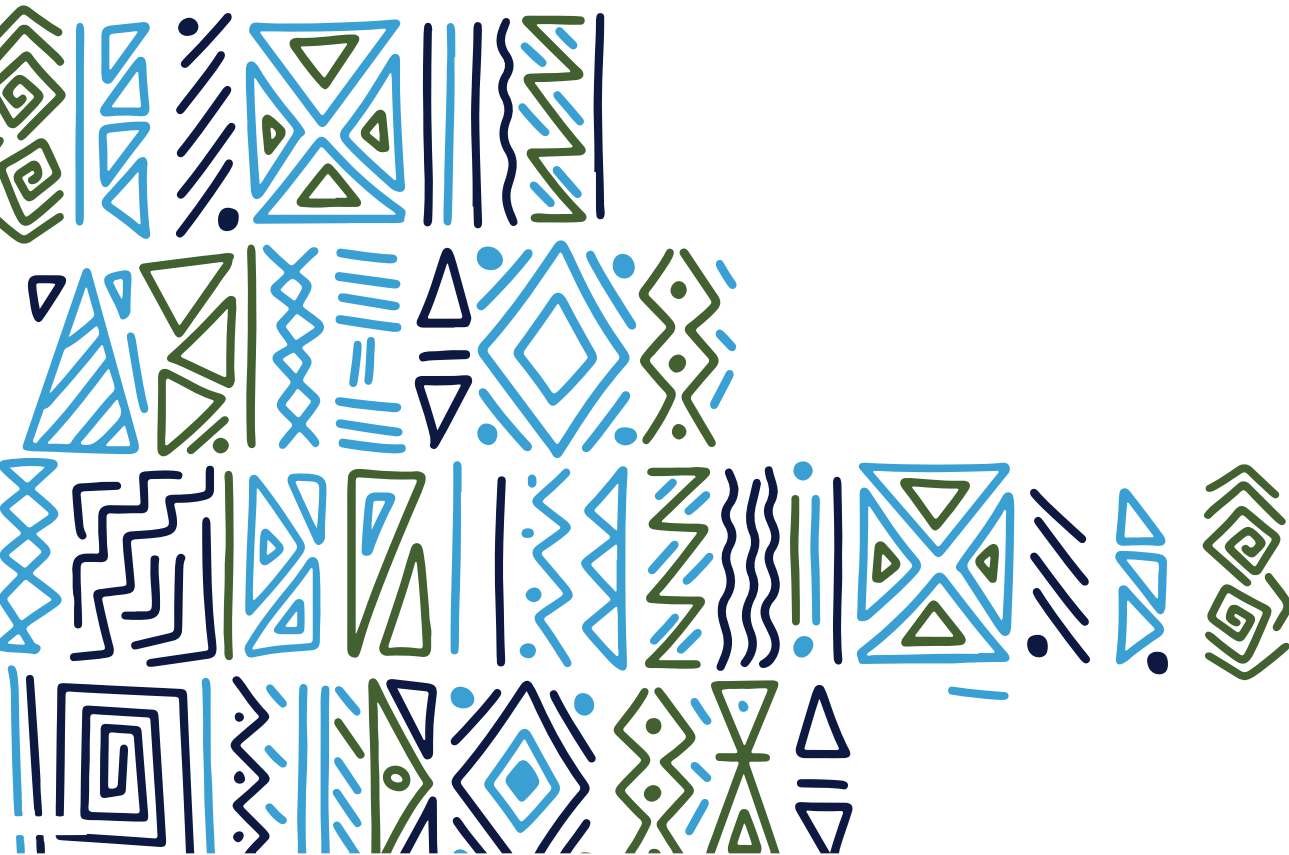
1. Moving forward from here, each stakeholder group should review, refine, and subscribe to the key list of actions that it is expected to undertake as part of the Roadmap.
2. The full STRA and Roadmap need to be endorsed by members of the Reference Group and the key institutions they represent. The Government has indicated that it intends to put this report through the standard internal review process that will lead to the Roadmap being approved by the Government and published next year as a national policy document.
3. The JOC should meet in its capacity as the coordinator of Roadmap implementation and agree on a detailed monitoring plan.
4. The Thematic Groups need to be established, develop work plans, and obtain the needed technical backing to carry out their important implementation responsibilities.
5. Finally, the major actions listed in the Roadmap need to be carried over into the key documents of the three main funding organizations (Government, PEPFAR, and Global Fund) that will drive the sustainability and transition process: the Government of Botswana’s NSF III/IV, the Medium-Term Expenditure Framework, and annual budgets; PEPFAR’s COP 24-25 and COP 26-27; and the Global Fund’s CG7 Funding Request and Grant Agreements, including its Funding Landscape Tables, grant budgets, performance frameworks, and the Government’s cofinancing commitment letter. Experience from other countries shows that the Roadmap will only have maximum impact if it is translated directly into financing decisions by the main sources of funding for the HIV response.

Conclusion

If Botswana and its partners truly commit to implementing the HIV Sustainability and Transition Roadmap, it has a good chance of once again being a pioneer and trend-setter in the Africa region, joining other UMICs like Thailand in moving largely away from external financing of the national HIV response while increasing self-reliance. At

the same time, Botswana can continue to surpass the 95-95-95 targets and utilize partnerships with civil society to reach key populations and prevent new infections. This will require that the main external partners, especially PEPFAR and the Global Fund, align their financing and focus with the Roadmap actions to be undertaken by the Government. This will make Botswana a shining example globally in how best to develop and implement a common HIV Roadmap, with respect and buy-in from everyone.

If Botswana and its partners truly commit to implementing the HIV Sustainability and Transition Roadmap, it has a good chance of once again being a pioneer and trend-setter in the Africa region, joining other UMICs like Thailand in moving largely away from external financing of the national HIV response while increasing self-reliance.





Chapter 1.

Introduction and Methodology

1.1 Rationale and Organization of this Report

This report presents the Sustainability and Transition Readiness Assessment (STRA) and Roadmap (STR) produced through the engagement of the Government of Botswana, UNAIDS, PEPFAR, The Global Fund, Civil Society Organizations, community members, and national experts facilitated by the consultants. It offers a complete diagnosis and set of corresponding recommendations with implementation plans to sustain Botswana’s response to the HIV epidemic and to prepare for its eventual transition from international to domestic support.

The report below is organized into five main chapters. Chapter 1 contains the introduction with the consultancy context, the process and timeline, and the methods and analytical framework. Chapter 2 describes the national contexts operating in-country, and Chapter 3 lays out the Risk Assessment Findings across four categories: sustainable financing, health systems strengthening, CSO engagement, and governance, coordination, human rights, and legal environment. Chapter 4 then summarizes the main sustainability and transition risks, while Chapter 5 lays out the Roadmap of recommended actions along with detailed and timebound implementation plans plus additional related materials.

1.2 Consultancy Context

Botswana, a pioneer in the fight against HIV, was the first country in sub-Saharan Africa to establish a free national antiretroviral treatment program. In 2022, it became the third nation globally — following Switzerland and Eswatini — to meet the UN’s ambitious 95-95-95 HIV control targets.^{1,2} Now, as an upper-middle income country with the highest GDP (PPP) per capita in the region,³ it is again poised to break new ground as one of the first African nations to significantly transition away from donor aid for HIV and towards enhanced self-reliance. Accomplishing this while maintaining the tremendous progress made to date will require accurate anticipation of financial and operational risks across the program, as well as the timely implementation of decisive mitigation actions for each.

The Third National Strategic Framework (NSF III) for HIV and AIDS (2019 – 2023) demonstrates the Government of Botswana’s commitment to continue expanding upon a strong record of success in combatting the HIV epidemic. NSF III affirms Botswana’s adoption of global targets for reaching epidemic control by 2023 and ending AIDS as a public health threat by 2030. Progress against these ambitious goals has been strong, with treatment cascade results of 95-98-98 demonstrated in the 2022 Botswana AIDS Impact Survey (BAIS) V. UNAIDS Spectrum estimates from 2023 place the total number of PLHIV at 343,914 (representing 20.8% of adults over the age of 15) and the annual incidence

Botswana, a pioneer in the fight against HIV, was the first country in sub-Saharan Africa to establish a free national antiretroviral treatment program. In 2022, it became the third nation globally – following Switzerland and Eswatini – to meet the UN’s ambitious 95-95-95 HIV control targets.

rate at 0.29 new cases per 100 people, which represents a dramatic 63% decline since 2010 in new adult infections occurring annually. With 4,320 new infections and 3,822 AIDS-related deaths estimated to have taken place in 2022, the NSF III goal of epidemic control is nearly within grasp.

Despite excellent progress in controlling HIV, some gaps persist. Women account for a disproportionately large share (>60%) of both existing and new infections, especially adolescent girls and young women. On the other hand, men and children lag behind women in utilization rates for testing and treatment services. Prevalence is exceptionally high among female sex workers (FSW, 42.8%), and they and other key populations (KPs) including men who have sex with men (MSM), transgender people (TGP), and people with disabilities continue to face stigma and discrimination in HIV care.⁴ Finally, treatment needs are becoming more complex with an aging PLHIV population experiencing a range of comorbidities including TB, cervical cancer, cryptococcal meningitis, pneumonia, hepatitis B and C, and non-communicable diseases (NCDs) such as cardiovascular disease and diabetes.

Under NSF III, Botswana has been focusing on scaling high-impact prevention interventions, maintaining and optimizing ART treatment for all PLHIV, and working with key and vulnerable populations. The country’s strategy also emphasizes multisectoral collaboration at the community, district, and national levels.

While Botswana’s HIV response can still be improved, a primary objective at this stage is to sustain the exemplary achievements made to date in the face of resource constraints and the impending prospect of donor phasedown and withdrawal. With this in mind, UNAIDS and the Government of Botswana agreed to work with key stakeholders to identify and assess the most important risks to the sustainability and eventual transition of the Botswana HIV program, and to recommend evidence-based actions to mitigate these risks.

1.3 Process and Timeline

The team undertook this assignment in three phases, in keeping with the Global Fund framework. All three phases of work have been shaped by the priorities expressed in numerous in-depth consultations with key leaders in

Botswana’s HIV response, especially from GoB, according to principles of strong country ownership.

PHASE 1: INCEPTION

The team first conducted an initial literature and data review to build a high-level picture of sustainability and transition risks in Botswana’s HIV program. To identify and refine specific focus areas for the assessment, the team engaged in preliminary discussions and informational interviews with a wide range of stakeholders from government, CSOs, donors, development partners, and faith-based organizations (Annex A). The team then produced a brief Inception Report laying out methodologies and early findings, which was used to kick off dialogue with the National AIDS and Health Promotion Council (NAHPC) and its secretariat Agency (NAHPA), the Reference Group, and other key stakeholders at the national level.

PHASE 2: SUSTAINABILITY AND TRANSITION READINESS ASSESSMENT (STRA)

Following circulation and revision of the Inception Report, the team undertook an extensive literature and data review covering 150+ source documents including strategic plans, progress reports, budget and expenditure data, epidemiological studies, investment cases, and efficiency analyses provided by government agencies, CSOs, donors, development partners, and academic institutions. This body of information was analyzed to extract a set of prioritized sustainability and transition risks, which were further researched, discussed, and ranked based on severity and likelihood.

NAHPA and UNAIDS then helped the team to facilitate the first in-country mission, which took place from May 30 to June 9, 2023. The team used this visit to collect additional documents and data and to engage closely with dozens of key stakeholders, focusing particularly on soliciting input regarding identified risks and potential mitigation strategies. The team was especially grateful for the opportunity to meet on multiple occasions with Vice President of Botswana, His Honor Mr. Slumber Tsogwane, and other government leaders including the Ministers of Health, Finance, Local Government and Rural Development, and State Presidency. The mission concluded with a presentation of preliminary findings to NAHPC, which was chaired by the Vice President

and included high-level representatives from MoH, MoF, MoSP, NAHPA, PEPFAR, UNAIDS, and a range of prominent CSOs and government agencies.

Using the additional inputs gathered during the visit, the team produced a draft of the STRA report, which was circulated among NAHPA, the Reference Group, and TSM for review and feedback before being finalized.

PHASE 3: SUSTAINABILITY AND TRANSITION ROADMAP (STR) DEVELOPMENT

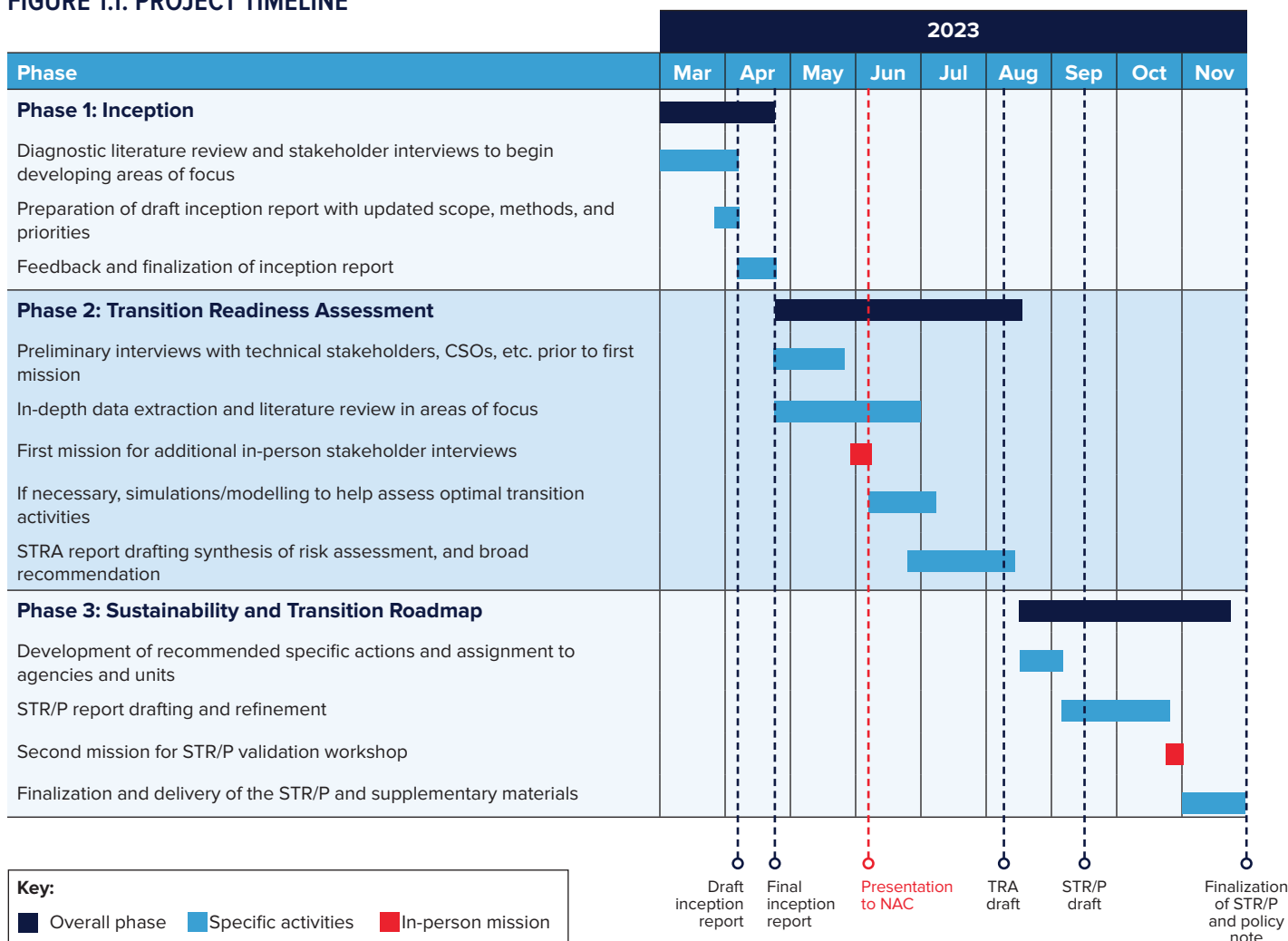
Next, an HIV Sustainability and Transition Roadmap (STR) was developed, recommending specific evidence-based actions to address the risks described in the STRA. Recommended actions were broken down into SMART implementation steps and mapped to specific implementing

organizations, monitoring frameworks, deadlines, and accountability structures. The draft STR was discussed, edited, and validated in an in-person workshop on October 25, 2023 attended by more than 80 key stakeholders. Feedback from the workshop was used to finalize the STR and executive summary.

As agreed with key stakeholders and government leaders, these materials should be used to foster high-level policy dialogue and to inform the extended Third National Strategic Framework for the 2023-2025 period as well as the Fourth National Strategic Framework to follow.

The timetable followed for this assignment is shown in the Gantt chart in Figure 1.1, highlighting the 3 phases and deliverables described above.

FIGURE 1.1: PROJECT TIMELINE

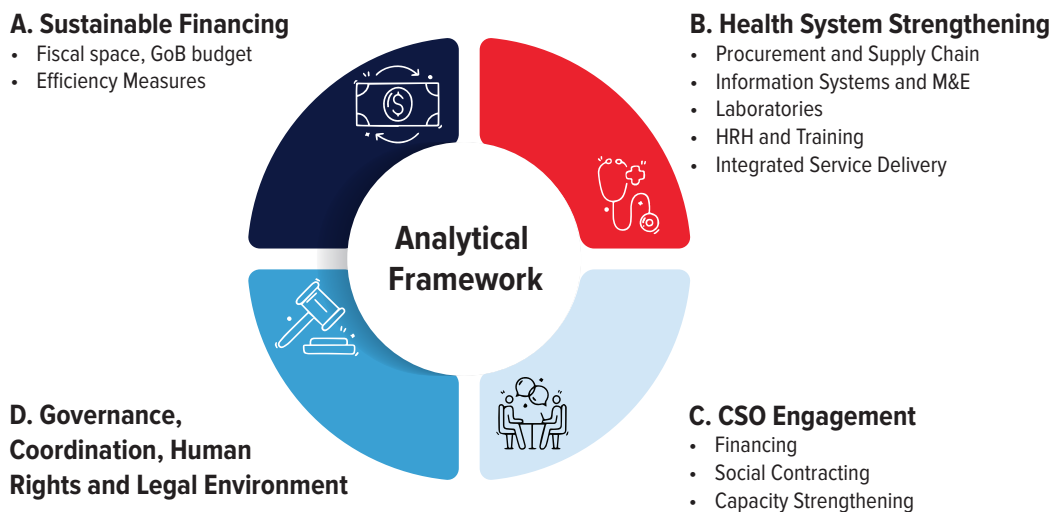


1.4 Analytical Framework and Methods

The Botswana project builds on tools and methods used in more than a dozen countries in Asia, Africa, and Latin America, drawing on S&T guidance documents published by the Global Fund in 2021 and 2022. To structure the analysis, the risk assessment and formulation of mitigating actions were divided into four domains that cover the key categories of risk to HIV program sustainability: financing, health system strengthening, CSO engagement, and human rights, legal environment, governance and coordination (Figure 1.2).

The STRA findings below are based on a comprehensive review of more than 50 key documents and datasets including national strategies, grant proposals, PEPFAR Country Operations Plans, and numerous review of HIV spending, efficiency, program implementation, CSO activities, etc. The team also conducted more than 70 interviews and meetings, individually and in focus groups, with key stakeholders. See Annex A for the list of persons interviewed and Annex B for a record of key meetings, presentations, and workshops.

FIGURE 1.2: ANALYTICAL FRAMEWORK





Chapter 2.

National Context

2.1 Socioeconomic Factors

With an estimated population of 2.35 million in 2022, Botswana is among the least densely populated countries in the world.⁵ Since achieving independence in 1966, Botswana has enjoyed strong and stable economic growth supported by sizable fiscal buffers and prudent policies. Per-capita growth rates have been among the highest in the world, averaging 4.9% between 1966 and 2022⁶. The export of diamonds discovered in the 1970s has been the primary driver of economic development, and the mining sector remains a crucial generator of national revenues despite efforts to diversify the economy. Botswana reached lower-middle income status in 1987 and upper-middle income status in 1991.

Botswana reinvests a large share of its wealth into social development. About 4.4% of GDP is spent on social welfare, 9.5% on education, 5.4% on health, and 1.6% on the fight against HIV/AIDS. These investments have helped to reduce the proportion of people living below the poverty datum line from 30.6% in 2002/03 to 16.3% in 2015/16.⁷ Extreme poverty also declined substantially during this period, falling from 23.4% to 6.5%.⁸ However, multidimensional poverty remains relatively high at 20.8%,⁹ related in part to high unemployment rates among the general population (24.5%) and among young people in particular (32.4%).¹⁰ Botswana's heavy reliance on diamond revenues also creates significant

FIGURE 2.1: DEMOGRAPHIC, ECONOMIC AND HEALTH INDICATORS OF BOTSWANA

Indicators	2018	2019	2020	2021	2022
Population, total (persons)	2.45M	2.50M	2.55M	2.59M	2.63M
Population growth (annual %)	2.0%	2.0%	1.9%	1.6%	1.6%
GDP per capita (current US\$)	6,948	6,691	5,875	7,239	7,738
GNI per capita, Atlas method (current US\$)	6,220	6,630	6,020	6,610	7,350
Health expenditure, total (% of GDP)	6.0%	6.1%	6.2%	—	—
Health expenditure per capita (current US\$)	419	409	363	—	—
Domestic general government health expenditures as % CHE	68.6%	71.4%	74.7%	—	—

economic vulnerabilities, highlighted recently by a transitory but sizable 8.7% drop in GDP in 2020 due to reduced mining exports caused by COVID-19.¹¹

2.2 Health Outcomes and National Health System

Botswana’s health status and health system reflect the country’s position as one of the most developed nations in Sub-Saharan Africa. Strong gains have been made in health outcomes, including in communicable disease control, life expectancy at birth, and infant, child, and maternal mortality, due in part to increasing control of the HIV epidemic.

The health burden in Botswana is gradually shifting toward noncommunicable diseases (NCDs). Five of the ten top causes of disability-adjusted life years (DALYs) are now NCDs, and all five are increasing. Nevertheless, HIV/AIDS, cardiovascular disease, and respiratory infections including TB – in that order – remain the leading causes of mortality.¹²

Botswana’s health system is overseen by the Ministry of Health. Services are delivered through a decentralized system which includes state-owned, private for-profit, and private non-profit medical facilities. More than 80% of the population receives care from government facilities¹³, which are grouped into 27 health districts and organized according to a hierarchical structure with 3 national referral hospitals at the top, followed by 15 district hospitals, 17 primary hospitals, 311 clinics, 351 health posts, and finally 931 mobile stops.^{14,15} The public system is complemented by 3 large private hospitals, 3 mine hospitals, 2 mission hospitals, and 354 private clinics.¹⁶ An estimated 95 percent of the overall population lives within an eight-kilometer radius of at least one health facility, but coverage is lower in rural areas (89%) than in urban areas (100%).¹⁷ Hospitals in major urban centres are also often equipped with more advanced medical technologies than rural counterparts.

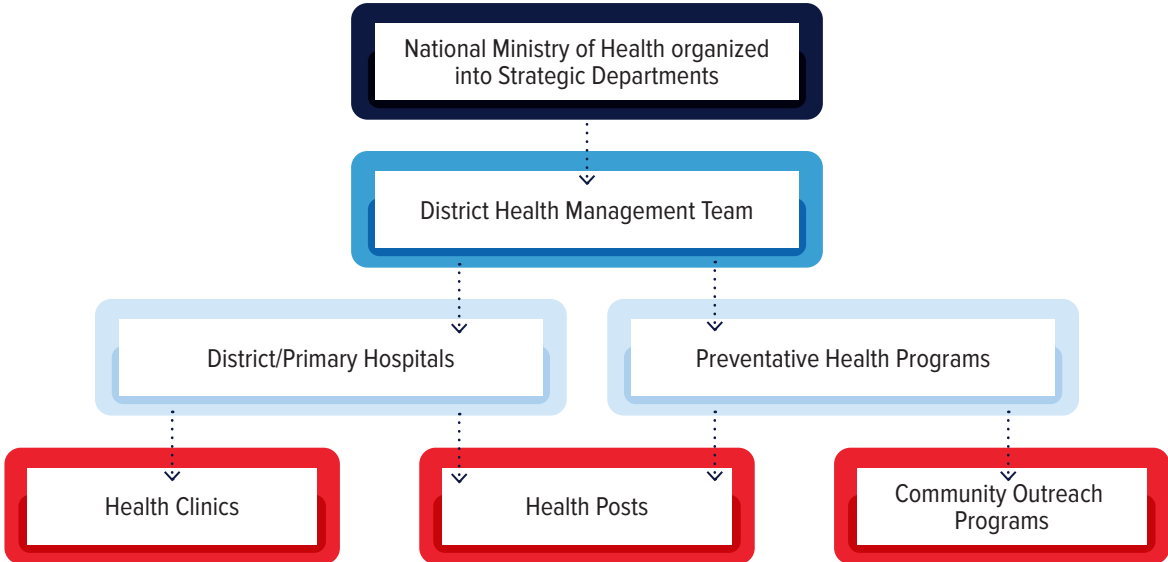
Districts are afforded a considerable degree of autonomy in setting priorities and making operational decisions.

FIGURE 2.2: KEY HEALTH STATUS INDICATORS FOR BOTSWANA AND SUB-SAHARAN AFRICA, 2020

Indicators	Botswana	Sub-Saharan Africa
Life expectancy at birth total	66	61
Total mortality rate, male (per 1,000 male adults)	292	322
Under-five mortality rate (per 1,000 live births)	36	75
Infant mortality rate (per 1,000 live births)	29	51
Maternal mortality (modeled estimate, per 100,000 live births)	186	536

Source: The World Bank, DataBank, 2020. <https://databank.worldbank.org/>.

FIGURE 2.3: MINISTRY OF HEALTH ORGANIZATIONAL STRUCTURE



Source: Achoki, T., Lesego, A. The imperative for systems thinking to promote access to medicines, efficient delivery, and cost-effectiveness when implementing health financing reforms: a qualitative study. *Int J Equity Health* 16, 53 (2017)

District health management teams (DHMTs) serve as primary implementers and represent a wide array of stakeholders from the public, private, and civil society sectors. This collaborative effort aims to ensure the delivery of comprehensive integrated health services, with a particular focus on primary health care.¹⁸

2.3 HIV Epidemiology and Services

HIV Epidemiology. The impacts of the HIV epidemic in Botswana have been among the most severe in the world. Today, 20.8% of people in Botswana between the ages of 15 and 64 continue to live with HIV – a prevalence rate surpassed only by Eswatini and Lesotho.¹⁹ Nevertheless, the nation should be commended highly for achieving monumental strides in the containment of the epidemic.

Botswana reported its first case of HIV in 1985, marking the beginning of a twenty-year period of rapidly increasing incidence and mortality. At its height in the early 2000s, the HIV epidemic was causing over 36,000 new infections and 18,000 AIDS-related deaths in the country each year.²⁰ Life expectancy, which had climbed from 50 to 63 years of age in the quarter-century of development preceding the introduction of HIV, plummeted back down to just 51 by 2001. Speaking to the UN that year, then-President Festus Mogae warned that under the crushing toll of HIV, Botswana was “faced with extinction.”

Galvanized to action by this unprecedented threat, the government and international partners invested heavily in the creation of a pioneering ART program, which began operating in 2002. The treatment program and large-scale testing and prevention interventions began to yield results over the next few years, and as the epidemiological crisis was gradually stabilized Botswana gained recognition as a regional and global leader in the response to the HIV epidemic. In 2022, UNAIDS indicated that the country was on the brink of epidemic control with approximately 4,300 new infections and 3,800 AIDS-related deaths that year. Nevertheless, prevalence remains high with over 340,000 people still living with HIV, due in part to the successes of the ART program in reducing excess deaths among the affected population. While conscientious maintenance of testing and prevention programs is still critical, it is apparent that caring for the massive PLHIV population in an equitable and cost-effective manner will be a central issue for Botswana’s HIV program moving forward.

Today, significant inequalities persist in the distribution of the HIV burden in Botswana. 2022 data indicate that women and girls make up more than 60% of both the existing population living with HIV as well as new infections. Young women between the ages of 15 and 24 are particularly vulnerable, comprising just 9% of the population but 24% of all new infections.²¹ On the other hand, men and children lag behind women in uptake of HIV services, including ART. For example, among PLHIV 97% of adult women, 87% of adult men, and just 57% of children 0-14 years of age are considered virally suppressed. Infection rates also vary widely among key vulnerable populations. Prevalence is extraordinarily high among female sex workers (42.8%), even in comparison to global (11.8%) and sub-Saharan African (36.9%) averages.²² In contrast, prevalence appears lower than the adult population average (20.8%) among men who have sex with men (14.8%) and transgender people (16.0%).²³ However, it is important to note that stigma and discrimination may distort the results of these studies by altering the rates of self-identification, testing, and status reporting by people belonging to key population groups.

Botswana has made exemplary progress against the UNAIDS Fast Track targets for elimination of HIV by 2030, which call for 95% of all PLHIV to be aware of their status, 95% of those aware of their status to be on ART, and 95% of those on ART to achieve viral load suppression. In a 2023 analysis using data from the fifth Botswana AIDS Impact Survey (BAIS V), UNAIDS reported that the country has now surpassed the 2030 targets by achieving cascade statistics of 97-97-98.²⁴ This remarkable milestone reflects the rapid progress made in Botswana over the last 10-15 years. For example, the percentage of all PLHIV initiating ART treatment has nearly doubled since 2010, up from 51% at the time to 94% today. Major drivers of these recent epidemiological improvements include the implementation of the “Treat All” ART strategy in 2016 and its subsequent expansion in 2019 to include non-citizens as well as the strong push made for the Prevention of Mother to Child Transmission (PMTCT), which resulted in an 89% decline in new child infections over the past ten years.²⁵ The strength of these results have earned Botswana wide praise as a regional leader among sub-Saharan Africa in containing the HIV epidemic. As the country moves forward, protecting and sustaining the major epidemiological gains made to date has become a key priority.

The impacts of the HIV epidemic in Botswana have been among the most severe in the world. Today, 20.8% of people in Botswana between the ages of 15 and 64 continue to live with HIV – a prevalence rate surpassed only by Eswatini and Lesotho.

HIV Services. The Ministry of Health, along with CSOs, development partners, and private sector organizations, has made a concerted effort over the past twenty years to ensure the accessibility of comprehensive HIV services to the people of Botswana. In 2002, the country initiated Masa, its first national ART treatment program, through which free ART treatment was offered for all citizens meeting certain clinical criteria.²⁶ Program eligibility was subsequently expanded, first through the implementation of the Treat All strategy in 2016 to cover all citizens living with HIV, and then again in late 2019 when the government began providing treatment to non-citizens as well.^{27,28} As a result of these policies, 93.5% of PLHIV on ART receive treatment at government facilities, with only 6.5% accessing care through private sector medical aid schemes (MASs).²⁹ The number of people receiving ART has also increased significantly more for the public sector (+10%) than for the private sector (+6%) over the last 5 years (Annex B).

Though Botswana's use of decentralized DHMTs for the delivery of health services has helped to expand HIV care coverage, availability remains constrained by a chronic shortage of qualified clinical professionals. To address this issue, task shifting practices have been adopted under which lay counselors and nurse prescribers are recruited to fill gaps in the provision of key services. Lay counselors conduct a majority of HIV testing and counseling at facilities throughout the country, while nurse prescribers are trained to prescribe and manage medications for stable patients, allowing doctors to focus on more complicated cases.^{30,31} MoH has not yet adopted a formal task shifting policy governing these practices, which would be beneficial for ensuring a consistent, evidence-driven, and harmonized approach.³²

Despite successes in its primary mandate of fighting the HIV epidemic, Botswana's vertical HIV program has had coordination difficulties with other health systems which pose a concern for long-term sustainability. The siloed nature of the program has been found to fragment service delivery, increase wait times, generate additional patient visits, and create disjointed medical records.³³ Efforts have been made to better integrate HIV care with sexual and reproductive health services, with positive outcomes. In particular, increased integration produced improvements in scheduling, referrals, community engagement, service quality, physician availability, and clinician-patient interactions, resulting in overall improvements to client and provider satisfaction and service delivery.³⁴

Key HIV services in Botswana are listed in the Integrated HIV & AIDS Basic Services Package (HABSP), last updated in 2020. These services and associated unit costs are described below.

- **Antiretroviral Therapy (ART):** The total cost of ART per patient per year including diagnostics, medication, and service delivery was estimated at BWP 2,884 (USD

\$265) in 2021. Efforts to reduce laboratory costs and antiretroviral prices are projected to bring this down to as little as BWP 1,845 (USD \$170) in the future.

- **Differentiated ART Service Delivery (DSD) Model:** The DSD model encompasses community-based interventions, including medical refills, ART adherence support, linkages to care, treatment initiation, early infant diagnosis for HIV-positive mothers, and integrated TB/HIV services. The unit cost for DSD is calculated at \$132.81 per person per year.
- **Laboratory Testing:** The average unit cost of all laboratory tests is USD \$83.84 per patient per year. This cost includes reagents for viral load tests as well as CD4, resistance-testing, haematology, special haematology, and chemistry tests.
- **Adolescent Girls and Young Women (AGYW):** The unit costs for targeted AGYW interventions range from \$258.34 to \$459.46 per person per year, excluding family planning and sanitary pad costs.
- **Key Populations (KPs):** The annual unit cost for delivering ART and care services to KPs in a community-based setting is estimated at \$569.37 per person. This includes direct service delivery expenses (74 percent) and indirect costs (26 percent).
- **HIV Testing Services (HTS):** For the general population, the unit cost of HTS is \$9.20 per person tested. This cost covers direct service delivery (79 percent) and indirect costs (21 percent).

The upcoming revised 2023 HIV/AIDS National Treatment Guidelines are expected to introduce new interventions that will further enhance the delivery of care. Point-of-care technologies, such as the triple point of care for HIV, syphilis, and hepatitis, will revolutionize testing and diagnosis, improving efficient and timely management of these infections. Additionally, the adoption of dual therapy and overall resistance testing will strengthen the clinical efficacy of treatment regimens. Preliminary costing estimates shared in key informant interviews suggest the updated guidelines will eventually prove cost-neutral, with savings from dual therapy and reduced lab requirements balanced by increased expenses from expanded screening services and improved care for advanced HIV cases involving serious comorbidities and opportunistic infections.

2.4 TB Epidemiology and Services

TB Epidemiology. In 2021, Botswana had an incidence rate of 235 cases per 100,000 people, slightly above the sub-Saharan average rate of 211 cases.³⁵ TB is responsible for 3.8% of deaths in Botswana annually, making it the seventh leading cause of mortality overall and the third among communicable diseases following HIV/AIDS and

FIGURE 2.4: ESTIMATES OF TB BURDEN, 2021

Indicators (Rates per 100,000 people)	Botswana	WHO African Region
Total TB incidence	235	212
HIV-positive TB incidence	115	42
MDR/RR-TB incidence	15	7
HIV-negative TB mortality	32	31
HIV-positive TB mortality	50	12

Source: WHO, Global Tuberculosis Report 2021, October 2021, <https://iris.who.int/bitstream/handle/10665/346387/9789240037021-eng.pdf?sequence=1>.

lower respiratory infections.³⁶ Though TB incidence has been falling steadily over the last decade, case detection rates have also declined, and remain a key challenge with only 39% of new cases diagnosed and treated.³⁷

TB in Botswana is fundamentally linked to the HIV epidemic. HIV increases the incidence of active TB by weakening immune systems, while TB in turn accelerates the progression of HIV/AIDS. In the first 15 years after the establishment of Botswana’s national TB program in 1975, the country made strong progress towards the elimination of TB. However, these gains were rapidly eroded with the intensification of the HIV epidemic, as evidenced by the rapid growth in incidence rates from 202 cases per 100,000 people in 1990 to 623 in 2002. Today in Botswana, approximately 60% of people with active TB infections are estimated to also have HIV,³⁸ and TB is responsible for 40% of total mortality among PLHIV.³⁹

Multidrug-resistant (MDR) tuberculosis poses a significant challenge in Botswana. Between 1995 and 2008, there was a twelve-fold increase in the incidence rate of MDR-TB.⁴⁰ WHO data indicate that in 2021, MDR-TB accounted for 5.9% of new TB cases and 17% of previously treated cases. As treatment is successful in only 45% of MDR-TB cases in Botswana, compared with 78% of cases overall, the growing incidence of MDR-TB is cause for concern.

WHO data show that the burden of TB in Botswana is not uniformly distributed, with 60% of new cases occur among adult men, 35% among adult women, and 5% among children. One 2019 case-control study conducted across several districts also found that risk factors for TB included imprisonment, household exposure to smoking, and working in mines or enclosed spaces.⁴¹ In general, however, the scarcity of detailed epidemiological and

sociodemographic data for TB in Botswana presents a substantial obstacle to the accurate assessment of nuanced trends, especially the impact of TB on key populations. For example, the last detailed survey of national TB prevalence was conducted in 2008. An updated version of the survey, which was scheduled to be conducted alongside BAIS V in 2018, still has yet to be implemented due to technical and funding challenges.

TB Services. Botswana’s TB response is coordinated by the Botswana National TB Program (BNTP) at MoH. In keeping with the country’s decentralized model for health services, health facilities report cases to District TB Coordinators, who in turn report to BNTP. Free TB services provided by the government include testing, treatment, counselling, and rehabilitation, in addition to community education programs. Treatment is administered through Directly Observed Therapy (DOT) in both government health facilities and communities and includes special programs for coinfections with HIV.

Although most of the funding to construct and maintain health facilities and to buy TB commodities – especially key medications – comes from the state budget, external development partners such as the Global Fund, PEPFAR, and the World Bank play prominent roles as providers of financial, technical, and capacity-building support for both government and CSOs involved in the TB response. Key informant interviews indicate that health facilities which receive support from these external donors are perceived as providing superior TB services. For example, BUMMHI and PEPFAR have helped to improve the quality and timeliness of TB diagnostics in ten districts by hiring laboratory scientists and providing technical assistance for quality management systems, external quality assessments,

Though TB incidence has been falling steadily over the last decade, case detection rates have also declined, and remain a key challenge with only 39% of new cases diagnosed and treated.

Resource mobilization efforts are still needed to ensure the sustainability and eventual transition of Botswana's TB response.

proficiency testing, and clinic-lab interfacing. Case finding rates more than doubled in some facilities as a result of documentation and follow-up interventions sponsored by CDC-PEPFAR. CSOs such as BONEPWA, BOCHAIP, and Humana People to People also provide important auxiliary services such as community-based mobilization, screening, and monitoring.

Transition efforts for TB services have yielded mixed results. For instance, some Global Fund-supported human resources (such as District TB Coordinators and Data Clerks) have recently been successfully institutionalized by the government and placed on public payroll. On the other hand, KIIs also indicated that the decline in external resources associated with the gradual pullback and subsequent exit of the World Bank and KNCV Tuberculosis Foundation impacted programs delivering community and home-based care for TB greatly, damaging case finding performance and treatment coverage rates. These concerning events demonstrate that additional capacity development and resource mobilization efforts are still needed to ensure the sustainability and eventual transition of Botswana's TB response.

2.5 HIV Program Focus Areas

2.5.1 HEALTH AND HIV FINANCING

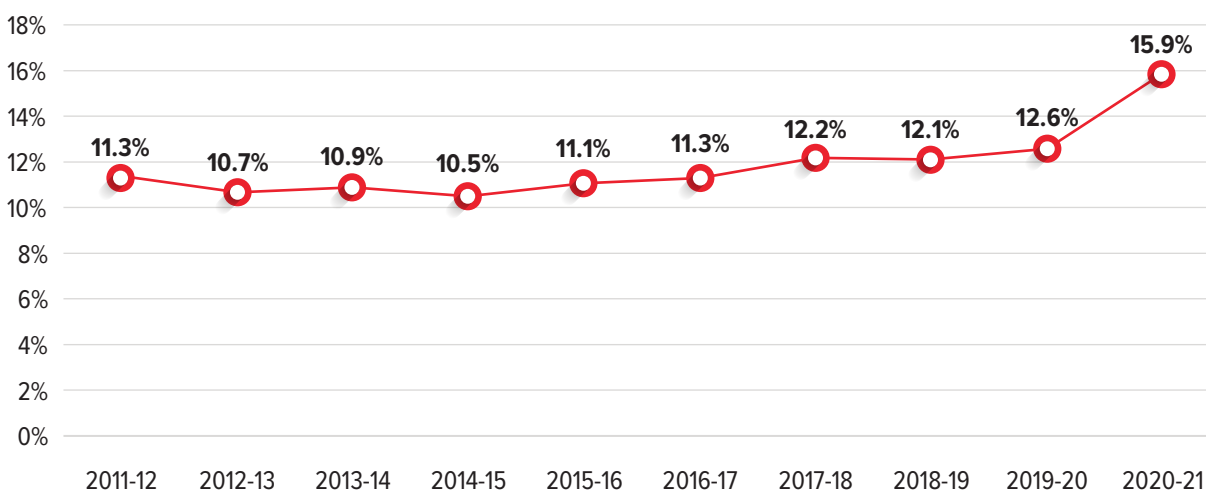
Health spending. In terms of spending, health was identified as the top national priority after education in the country's

Transitional National Development Plan for 2023-2025. Health as a portion of total governmental expenditures in Botswana has continued to gradually increase over the last decade, growing from 11.3% in 2011-12 to 12.6% in 2019-20 (Figure 2.5). As an exception to this slow and stable growth trend, an unusual spike in public funding for health was observed in 2020 due to the COVID-19 pandemic response. However, the implications of this increase for the HIV program are limited due to the targeted and short-term nature of the pandemic response funding.

HIV program financing. Financing for Botswana's HIV program derives from three main sources: government revenues, international development partners, and private entities. In recent years, public expenditures have remained relatively stable at approximately 60% of the total, with development partners contributing around 35% and the remaining <5% covered by private sources (including private insurance schemes, businesses, and out-of-pocket expenditures). Among the development partners, PEPFAR has consistently provided a large majority of external funding, while the Global Fund has played a secondary role and all other donors have gradually decreased in prominence (Figure 2.6).

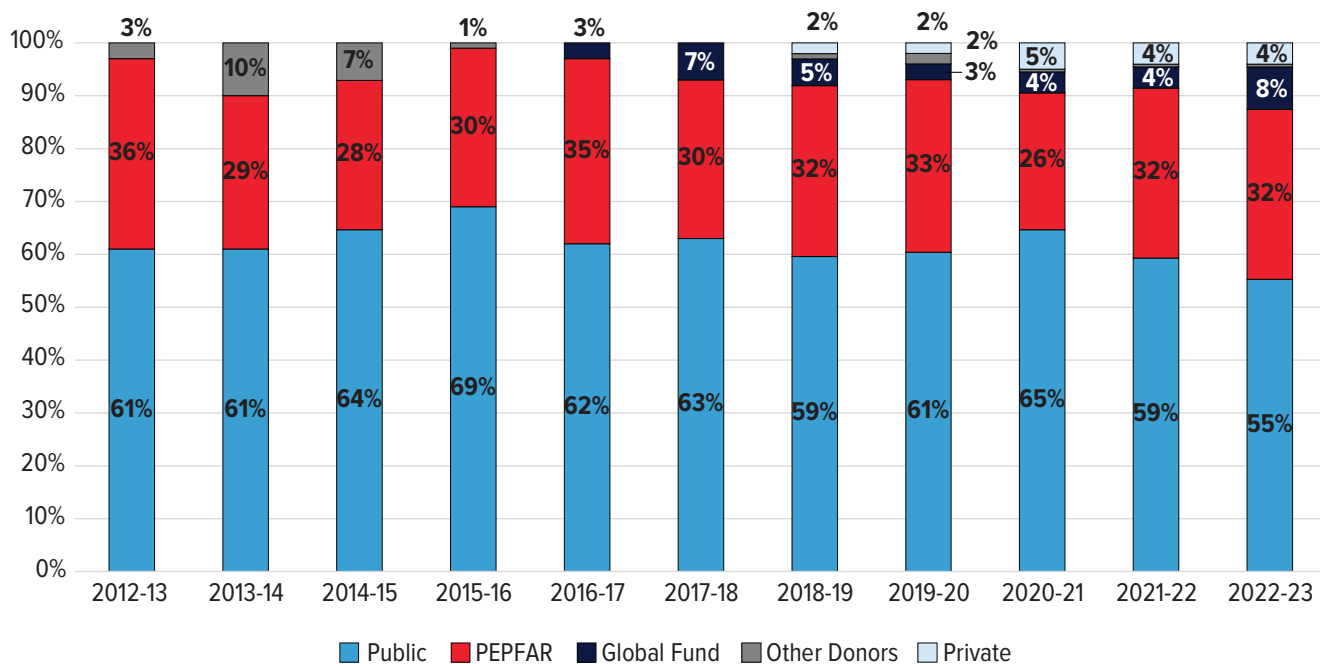
Although nominal HIV spending in BWP by the government has remained fairly constant over the last decade (Figure 2.7), consistent depreciation of the pula (Annex D) has led to a substantial decrease in real public funding for the program as measured in USD.

FIGURE 2.5: HEALTH SPENDING AS % OF TOTAL GOVERNMENT EXPENDITURES, 2011-2020



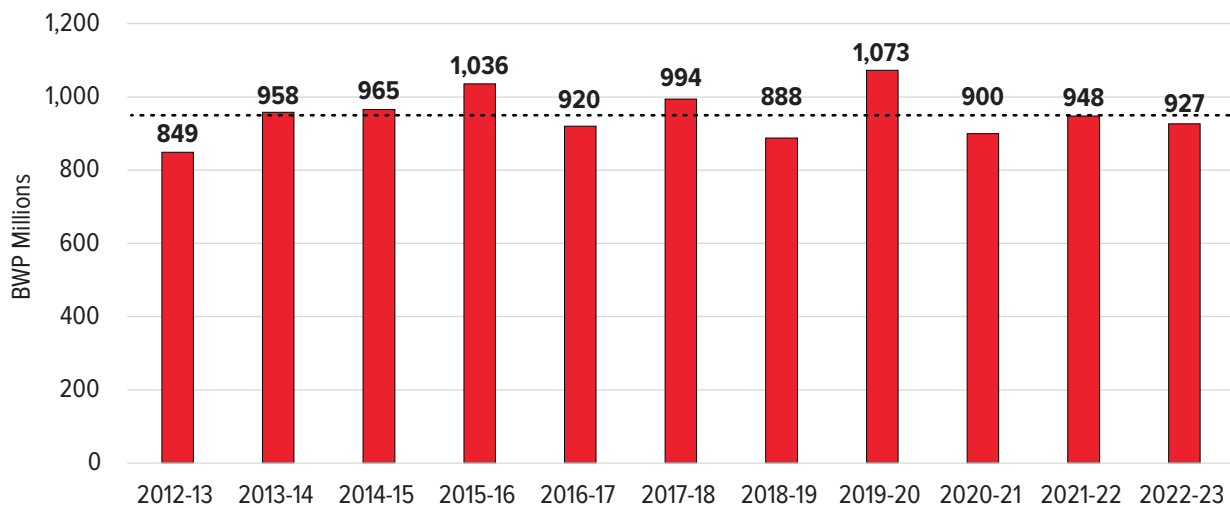
Source: Bank of Botswana, Botswana Economic and Financial Statistics – April 2023, <https://www.bankofbotswana.bw/botswana-economic-and-financial-statistics>.

FIGURE 2.6: HIV EXPENDITURES BY FINANCING ENTITY



Source: Government of Botswana, National AIDS Spending Assessment 2019-2022, Gaborone.

FIGURE 2.7: TOTAL GOB HIV EXPENDITURE BY YEAR, NOMINAL BW

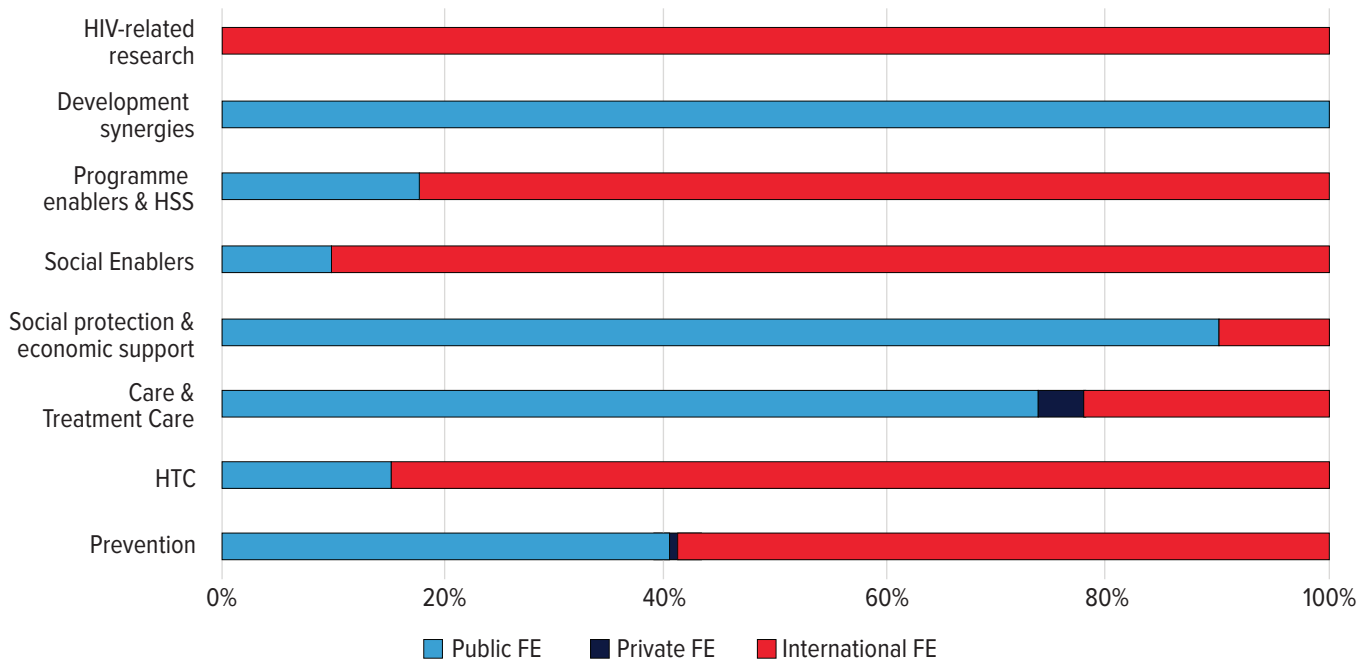


Source: Government of Botswana, National AIDS Spending Assessment, 2019-2022, Gaborone.

The shares of domestic versus external donor financing varies widely across HIV program component, with dependence on donors much higher in some areas than others (Figure 2.8). According to the latest NASA report (2018-19), government is the majority funder of development synergies (100%), social protection and economic support (90%), and care and treatment (74%), making these areas comparatively less vulnerable to negative consequences of donor transition. On the other hand, PEPFAR and GF continue to provide a majority of the financing for HIV

research (100%), social enablers (90%), HIV testing and counseling (85%), program enablers and health systems strengthening (82%), and prevention (59%), putting these parts of the program at greater risk. Apart from direct funding, a significant portion of external support arrives in the form of technical assistance and capacity building, which require specialized efforts by the government to replicate.

FIGURE 2.8: HIV PROGRAM AREAS BY FINANCING ENTITIES



Source: Government of Botswana, National AIDS Spending Assessments (2003-2006, 2006-2008, 2009-2012, 2018-2020), <https://www.unaids.org/en/dataanalysis/knowyourresponse/nasacountryreports>.

The future challenges of financing a sustained and successful national HIV response depends on several key factors, including the overall economic trends for Botswana, the share of government revenues devoted to health and to HIV, and the plans and actions of the major external funders, PEPFAR and the Global Fund. This is discussed in depth in the first part of Chapter 3.

2.5.2 HEALTH SYSTEMS FOR HIV

Human Resources for Health. Botswana faces chronic healthcare worker shortages that pose a threat to the HIV response. WHO’s 2016 Global Strategy on Human Resources for Health lays out a minimum recommendation of 4.45 doctors and nurses combined per 1,000 people. With 3.64 clinicians per 1,000 people in 2020, Botswana continues to fall short of this threshold. Doctors are also significantly underrepresented in this mix, with roughly 9 nurses to every doctor against a global standard of 3:1 (Figure 2.9). The geographic distribution of healthcare workers is also imbalanced, with a disproportionate share of health workers located in urban rather than rural districts. For example, Gaborone, Francistown, and Lobatse represent a combined 15% of the total population but host 33% of the nation’s healthcare workers. Botswana’s National Health Policy for 2011-2021 also identified high turnover rates and suboptimal skill mix as major health system bottlenecks.

Current policies are designed to adapt to clinician shortages by encouraging longer intervals between clinical visits for stable HIV patients, including through three- and six-month ART prescriptions and community-based medication refill initiatives which reduce demand at health facilities.⁴² However, monthly prescription pick-ups are still required during the initial phase of treatment. In the context of insufficient clinical staffing, these pick-ups and consultations continue to produce long queues and delayed service delivery.

Laboratory Services. The accessibility of HIV diagnostic services in Botswana has improved substantially in recent years, with the percentage of PLHIV who know their status growing from 86% in 2015 to 97% in 2022.^{43,44} Roughly 580,000 viral load and CD4 tests are conducted annually across 401 health facilities as part of routine monitoring and treatment.⁴⁵ 302 of these health facilities (75%) are located within 200 kilometres of one or more viral load testing laboratories. MoH, with support from PEPFAR, has also adopted recency testing to identify infection clusters and provide targeted treatment and prevention interventions. These services are currently being expanded from 10 to 200 sites across the country.⁴⁶

According to the 2018-20 NASA, HIV laboratory services absorb approximately USD \$22.5M annually, or 15% of total HIV expenditures. Laboratory spending is incurred by a

FIGURE 2.9: DOCTORS AND NURSES PER 1,000 POPULATION IN BOTSWANA, 2020

Indicators	2017	2018	2019	2020
Projected Total Population (Low Scenario)	2,254,021	2,288,651	2,323,493	2,358,445
Doctors				
Total Number of Medical Doctors	722	875	888	906
Density of Medical Doctors	0.34	0.38	0.38	0.38
Nurses				
Total Number of Nurses	7,290	7,634	7,663	7,679
Density of Nurses	3.23	3.34	3.30	3.26

Source: Statistics Botswana, Public Health Personnel 2020 Statistical Brief, <https://www.statsbots.org/bw/sites/default/files/Health%20Personnel%20Statistical%20Brief%202020.pdf>.

range of implementers including government laboratory services as well as PEPFAR-funded organizations such as ASLM, JHPIEGO, BUMMHI, and the University of Washington. About 8% of total spending on labs is used for capacity strengthening activities. Through these activities, MoH and donors have recently made significant improvements to laboratory services including expansions to the range of essential tests offered (Viral Load, Early Infant Diagnosis, CD4, TB Smear Microscopy, and TB GeneXpert) and implementation of a new Integrated Patient Management System (IPMS). IPMS streamlines the placement of laboratory orders and provides near real-time access to results for patients and providers. It is currently in use at 57 health facilities across the country, with plans to expand to additional facilities in the near future.

A diagnostic network optimization (DNO) assessment conducted by BUMMHI in 2021 found that although MoH possesses robust laboratory equipment and a well-defined referral system, equipment utilization remains low. The assessment also highlighted challenges such as wide variations in turnaround times for results (between 1 and 25 days), inconsistent laboratory opening times at certain sites, staffing issues, non-interfaced or analogue results reporting, and challenges in data compilation.

Botswana has recently begun working towards transitioning to a procurement reagent rental/leasing arrangement for laboratory testing instruments. Under these arrangements, suppliers provide equipment, manage maintenance services, and replenish test reagents and consumables at an agreed price per test volume. This shift aims to improve the efficiency and sustainability of laboratory services. Key informant interviews also indicate that the upcoming 2023 Treatment Guidelines for HIV are expected to include a new focus on consolidated point-of-care testing and expanded access to HIV, syphilis, and hepatitis diagnostics, particularly in remote and underserved areas.

Supply Chain Management. Within MoH, Central Medical Stores (CMS) is responsible for supply chain management. Operating from a single distribution center in Gaborone with an annual budget of approximately USD \$4.5M, CMS

delivers essential medical supplies to over 900 health facilities throughout the country. The 2018-2020 NASA details an additional USD \$250k of spending per year for the strengthening of procurement and supply chain systems for HIV, as aligned with the National Supply Chain Strategy.⁴⁷

With the help of donors like PEPFAR, Botswana has made major advances in the procurement and distribution of ART medications for HIV. As a result, ART coverage among adults nearly doubled between 2010 and 2022, increasing from 52% to 94%.⁴⁸ While PEPFAR and the Global Fund continue to support stop-gap commodity purchasing for HIV and TB, the government of Botswana is increasingly taking responsibility for procuring the majority of ART commodities.

Chronic stockouts resulting from the expiration of medicines, delays in procurement due to limited buyer power in small volume orders, inadequate staffing and skill mix, and insufficient availability of quality data at last mile and hub warehouses continue to hamper Botswana's healthcare system. A scarcity of relevant data makes it difficult to accurately assess the distribution or severity of these events. However, key informant interviews suggest that the total number of stockouts dropped by as much as 15% in both 2021 and 2022. These improvements are likely a result of efforts to capacitate CMS and DHMT staff in supply forecasting and planning, to develop a laboratory commodity specifications database, and to provide enhanced training to National Drug Quality Control Laboratory (NDQCL) staff.

CMS has recently begun to outsource the warehousing and last-mile distribution of products to a third party organization. However, interviews suggest that transportation challenges persist at the district level, with limited vehicle availability leading to the utilization of ambulances and other suboptimal means of collecting goods for service delivery sites.

Private sector. Private sector involvement in the national responses has always been limited, primarily confined to

Botswana's numerous CSOs make up a major component of the national HIV program. There are more than 80 CSOs in the country whose operations span the HIV response, including prevention, testing and counselling, treatment, palliative care, education and outreach, key populations advocacy, and demand creation for services such as ART, VMMC, and PMTCT.

the provision of ART for a small percentage of patients through medical aid schemes (MASs). Private companies have also made occasional donations to community-based organizations as part of corporate social responsibility programs.

As of February 2023, 6.5% (22,031) of PLHIV on ART were accessing treatment through MASs, representing about 8% of total national spending on treatment and 4% of overall HIV spending in Botswana. The vast majority of people on ART still prefer to access services at public facilities to avoid co-payments. Recent amendments to the VAT Act (chapter 50:03) have exempted private medical facilities from VAT. In combination the existing exemption allowed for prescription drugs, this should bring down co-payments and might increase uptake of private medical insurance if well promoted.

Though the private sector's role as a payor for HIV services is likely to remain highly limited, it is possible that private organizations may be able to assist in the provision of laboratory services and certain supply chain functions including warehousing and last mile transport/distribution. Further dialogue with private sector actors could help reveal whether expanded private sector involvement in some of these areas might result in lower costs and increased efficiencies, potentially helping to sustain the program as donor funding declines and eventually phases out. Donors can work with government to support such dialogue and planning as part of the transition process, with the goal of efficiently and sustainably utilizing private sector services and resources.

2.5.3 CSO-GOVERNMENT ENGAGEMENT

CSO Organization and Coordination. Botswana's numerous CSOs make up a major component of the national HIV program. There are more than 80 CSOs in the country whose operations span the HIV response, including prevention, testing and counselling, treatment, palliative care, education and outreach, key populations advocacy, and demand creation for services such as ART, VMMC, and PMTCT. These CSOs are coordinated and funded through three main structures associated with the three major funders of the national program: the Government of Botswana, PEPFAR, and the Global Fund.

GoB supports 73 individual CSOs and 23 associated service centers via a four-tiered management structure. At the top of this structure sits NAHPA. Directly below NAHPA is the Botswana Network of AIDS Service Organizations (BONASO), which in turn oversees a group of CSOs known as Program Area Coordinators. There are currently 12 coordinating CSOs, but as members are selected annually based on performance records, the composition and size of the group changes from year to year. Each of these organizations is responsible for between 2 and 23 smaller subgrantees, grouped thematically and distributed across a wide swath of the nation's districts. The large number of recipient CSOs in this system poses a significant challenge for NAHPA, which is inadequately resourced and capacitated to effectively operate an oversight structure of such size and complexity.

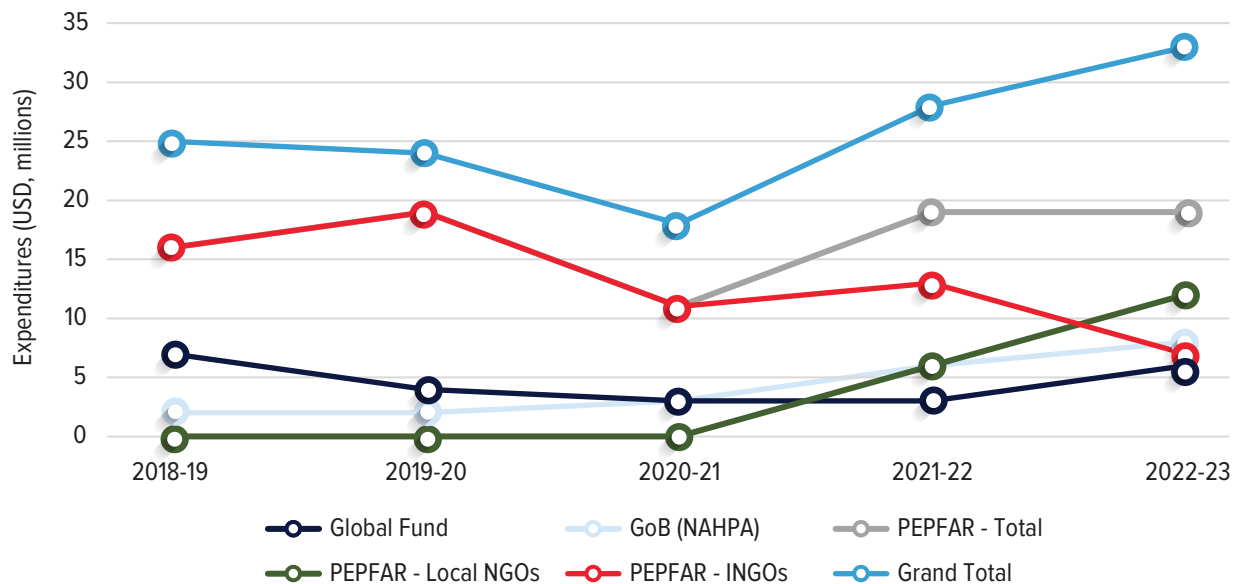
Outside the GoB system, PEPFAR funds 9 primary recipient organizations, while the Global Fund has supported 1 principal recipient (ACHAP) and 3 subrecipients. Some CSOs are included in more than one of these funding streams, and efforts to pool, compare, and coordinate grantmaking and oversight information between the three structures have been minimal to date.

Although all three of the CSO coordination structures have committed to structure their agreements with recipient organizations according to social contracting principles, assessment of a sample of contracts revealed wide variations in funding modalities, monitoring and evaluation requirements, and the types and numbers of activities/interventions stipulated, indicating a lack of cohesion in CSO contracting practices across funding entities.

CSO Funding. Since their emergence in the 1990s, the role of CSOs in Botswana's national HIV program has gradually increased in prominence. NSF III highlighted the importance of CSOs to the national response and set the target of directing at least 30% of total program funds to community response efforts by 2023.

Historically, as shown in Figure 2.10, PEPFAR (through USAID) has provided roughly two-thirds of total CSO funding (~\$18M/year). The last few years have seen a major reprioritization of these funds, which represent 35-40% of PEPFAR's total expenditures in Botswana, towards local/national organizations. In 2020/21, 34% of PEPFAR's

FIGURE 2.10: FUNDING PROVIDED TO HIV CSOS BY FINANCING ENTITY, 2018-2023



Note: To synchronize data, PEPFAR and GF's 2018 expenditure data are mapped to GoB's 2018/19 fiscal year. The same pattern continues for subsequent years.

total spending went to INGOs and just 1% to local NGOs, whereas by 2022/23, INGOs were receiving 17% and local NGOs 27%. PEPFAR spending through both international and local CSOs is largely realized through testing and prevention interventions, case management, community mobilization and behavior change campaigns, and support for interventions targeting key populations. In addition to the CSO support described above, PEPFAR also provides an average of ~\$20M/year through CDC for the direct provision of key clinical services by partners such as BUMMHI and as technical assistance for government health facilities in areas such as HMIS, surveillance, and case management. Detailed breakdowns of PEPFAR spending by program area for international and local CSOs are provided as Annex E and Annex F, respectively.

GoB, via NAHPA, has gradually increased public funding for local CSOs from USD \$2M (8% of total non-treatment HIV CSO spending) in 2018/19 to USD \$7.7M in 2022/23 (24%). However, it should be noted that these figures are overestimates, as NAHPA supports some interventions targeting NCDs in addition to those for HIV.

Finally, annual GF spending on CSOs has fluctuated in recent years, ranging from a low of \$3.4M to a high of \$7.1M. In accordance with GF policy, these resources have largely been targeted towards programs for KPs (MSM, TGP, and FSW), community systems strengthening, and programs for adolescent girls and young women.

CSO funding prospects in the immediate future appear mixed. PEPFAR, the largest funding entity, has indicated an expected budget reduction of 5% year on year from 2023 to 2025 (total reduction of 14.3%).⁴⁹ The GF has allocated

\$24M of HIV funding for the 2025-2027 grant cycle in Botswana, which would imply annual CSO funding of just under \$5M assuming ~60% of the budget is dedicated to community organizations as in previous cycles. However, actual expenditures are likely to fall short of this figure as absorption of GF resources has often faltered in the past and is currently facing significant obstacles stemming from a judicial decision blocking the GF's attempts to partner with ACHAP for the disbursement of funds to CSOs.⁵⁰ The ramping up of GoB funding for CSOs is expected to continue gradually based on past trends and statements of support made by government officials, though no specific quantitative commitments have been made to date in this regard. With PEPFAR funding anticipated to fall and the status of GF disbursements uncertain, the government's decisions in this arena will have major impacts on the future of Botswana's HIV CSOs.

CSO Capacity. Programmatic and organizational capacity among CSOs vary widely, with significant gaps noted in governance and accountability, the management of financial and human resources, and technical skills. For example, the 2021 USAID CSO Sustainability Index for Botswana reported that CSOs in the country "usually" are unsuccessful in implementing their own strategic plans. A 2021 review of the 2012 NGO Policy also found that >65% of CSOs reported having boards which were insufficiently capacitated to carry out core oversight activities and that >80% reported suffering major capacity gaps arising from high and uncontrolled staff turnover.

International development partners and CSOs have already been making substantial efforts to strengthen CSO capacity. For example, from 2011-2016, PEPFAR, USAID, and FHI

360 collaborated on the Maatla Project, a \$17M USD initiative intended to build capacity among HIV umbrella CSOs, their district-level affiliates and networks, and local District Multi-Sectoral AIDS Coordinators (DMSACs). Among other positive outcomes, the project played a key role in resuscitating several organizations previously on the brink of collapse, increased the reach and scope of HIV services provided by participating CSOs, and spearheaded the development of key governance documents for CSOs such as constitutions, HR manuals, and resource mobilization plans. Subsequent projects with development partner backing, notably the Advancing Partners and Communities initiative (APC), have continued to build on these successes. One challenge in this area is that the Government of Botswana lacks any substantive systems of its own for assessing and improving capacity among HIV CSOs. This is especially concerning given the government's prominent role in supporting CSOs financially via NAHPA.

2.5.4 GOVERNANCE, COORDINATION, HUMAN RIGHTS, LEGAL ENVIRONMENT

Governance. Responding to the rapidly increasing health burden of HIV, Botswana established the National AIDS Coordination Agency (NACA) in 1999. In 2019, NACA was rebranded as the National AIDS and Health Promotion Agency (NAHPA) and placed directly under the Office of the President. An accompanying council (NAHPC) composed of representatives from government, civil society, and development partners, is the highest national policymaking institution after the Parliament and Cabinet on issues of HIV/AIDS policy and guidelines. Additional structures such as Technical Working Groups and the Joint Oversight Committee (JOC), which oversees development, implementation, and review of the National Operational Plan for HIV/AIDS, were also launched under the leadership of NAHPC and the National Coordinator at NAHPA.

NAHPA and MoH both have significant leadership responsibilities in the national HIV response. While NAHPA's mandate is to provide oversight, coordination, and management of HIV and AIDS activities, MoH has a broader role involving legislative, policy, and programming responsibilities.^{51,52} These have included, among other items, the development and implementation of Botswana's HIV and AIDS Policy in 1993 (and subsequent reviews in 1998 and 2014) as well as advocacy work to support the passage of the Public Health Act of 2013. Despite putatively distinct mandates, KIs with government officials, CSOs, and international partners indicate that overlapping programs and operations persist between NAHPA and MoH, creating confusion and reducing efficiency in the management of key HIV services.

Befitting their prominent role in the HIV response, CSOs also sit on several key governance and coordination structures including the NAHPC, JOC, CCM, DMSACs, and VMSACs. Currently, representation is effectively facilitated through

umbrella organizations such as BONASO, BONEPWA, BONELA, and BOCHAIP. However, some representatives from smaller CSOs expressed concerns about this approach in key informant interviews, suggesting that more direct representation would be beneficial for certain governing bodies.

Coordination. As described in the Third National Strategic Plan (NSF III), NAHPA is responsible for overall coordination of the HIV/AIDS response (Figure 2.11). Reasonably strong coordination has been helpful to the national HIV response by increasing collaboration among implementers and funders and improving the reliability and stability of budget allocations, particularly for CSOs. However, it was observed during stakeholder consultations that gaps persist in coordination efforts. For example, NAHPA has highly limited knowledge of and visibility into funding channeled through external donors to CSOs and the private sector, and lacks full awareness of significant commodity procurements made by CSOs. Key informant interviews suggest that coordination between NAHPA and district-level institutions, such as District Commissioners and Councils, could be significantly improved.

The Country Coordinating Mechanism (CCM), established through funding from GF, is also an important coordination structure for the HIV response in Botswana. Designed to be free from government interference, it has provided a platform for marginalized key populations to contribute their voices to the national discussion and planning.

Human Rights and Legal Environment. Botswana has several laws and policies with implications for human rights protections in the HIV context (Figure 2.12). Chapter 11 of the Botswana Constitution prohibits discrimination and provides blanket safeguards for human rights. Other laws such as the Public Service Act seek to prohibit discrimination against PLHIV more specifically in areas such as employment rights. However, a 2017 LEA Report found that existing laws and policies offer insufficient protection for PLHIV, particularly for KPs. Furthermore, key informant interviews revealed that awareness and enforcement of these rules is often lacking, resulting in the persistence of stigma and sociocultural hurdles which reduce the accessibility of care.

The HIV program includes certain coordination structures relevant to this area, such as the Legal and Human Rights Coordinators Office at NAHPA. NAHPA in turn funds CSOs that work with sub-grantees to protect the rights of vulnerable populations. However, these organizations have expressed concerns that even at current funding levels, resources are insufficient to fully carry out their respective mandates. Furthermore, human rights coordination structures such as NAHPA's are often created through agreements with external donors and remain highly dependent on them for funding and resources. GoB has yet to realize commitments to fully internalize these important roles, creating an unstable situation described further in Chapter 3.

FIGURE 2.11: NAHPA COORDINATING MAP

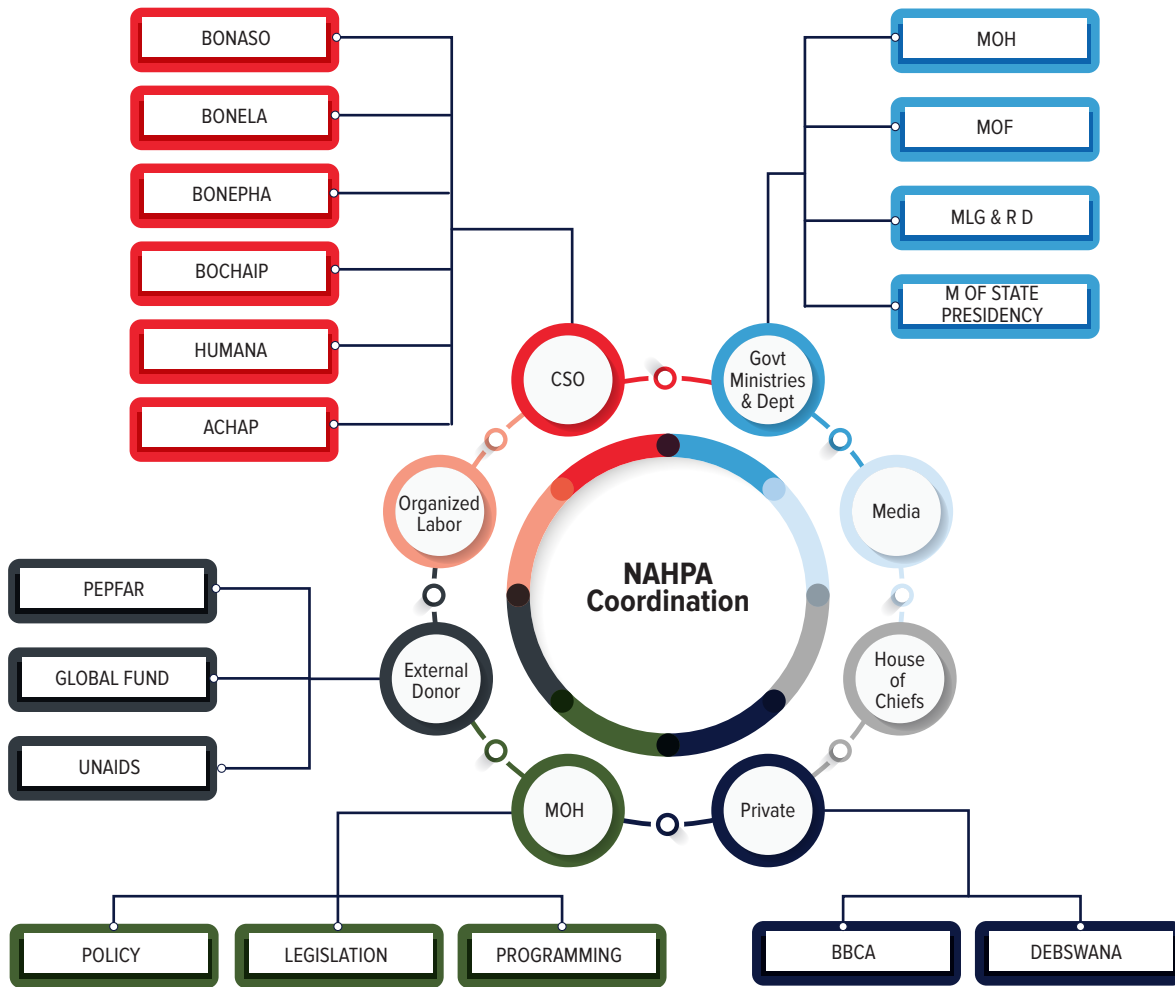


FIGURE 2.12: SELECTED HUMAN RIGHTS LAWS AND POLICIES IN BOTSWANA

Law/Policy	Target population	Protections
Botswana Constitution Chapter 11	All citizens – focus on the poor and vulnerable	Equal rights, prohibits discrimination
National Health Policy of 2011	All citizens	Access to quality health care
HIV and AIDS Policy of 1993 (updated 2014)	All citizens – focus on PLHIV	Confidentiality, quality care, non-discrimination
Botswana National Strategic Framework for HIV and AIDS (NSF III)	All citizens – focus on PLHIV	Comprehensive care, stigma reduction
National Strategic Plan to Reduce Human Rights Related Barriers to HIV and TB Services (2020-2025)	All citizens – focus on PLHIV	Removal of barriers to care, stigma reduction
Public Service Act of 2008	Government employees	Prohibits HIV-based employment discrimination
HIV and AIDS Work Place Policies	Government, private sector, and CSO employees	Non-discrimination, workplace safety





Chapter 3.

Risk Assessment Findings

3.1 Sustainable Financing

3.1.1 FISCAL SPACE AND GOB SPENDING

The three overarching financing risks facing Botswana’s HIV program, as summarized below, are hugely important. They are also highly interrelated. As donor funding gradually declines, it will be incumbent on the Government to back fill with domestic financial resources. Parts of the HIV program such as prevention and research, which rely heavily on external sources, could be especially at risk. Of course, the Government’s ability to pick up these additional cost areas will in turn depend on the country’s overall economic and fiscal situation, and the importance the Government attaches to health and to HIV in particular. On the latter, it is understandable that other health priorities such as NCDs and maternal services may also merit additional health budget resources and could put pressure on HIV. In the end, too, the speed of decline of donor financing also matters, as do measures which could be taken to improve efficiency and thus lower the overall “price tag” for the HIV program.

KEY RISKS

R1. PEPFAR and GF financing for HIV may decline rapidly between 2024 and 2030, and the Government may not mobilize/allocate sufficient resources to cover the resulting gaps, with dire consequences for the HIV program. Parts of the program currently deriving a large portion of their funding from donors are of particular concern.

R2. Government health funding needed to fill gaps left by declining donor contributions could be channeled instead **to other health priorities** such as NCDs, maternal mortality, and mental health, resulting in insufficient funding for the HIV program.

R3. As donor funding decreases, the Government may absorb all the costs currently covered by donors **without fully taking advantage of opportunities to increase efficiency in the HIV program**, leading to **long-term spending 10-20% higher** than necessary.

Modeling and Assessing the Financing Risks – Methods and Data. To assess these financing risks and challenges, we developed a spreadsheet model (available upon request) that allows for the exploration of different scenarios regarding the total program funding needs, possible efficiency gains, trends in donor funding, and the resulting gaps that will need to be filled by the Government with supplementary domestic financing by the private sector through medical aid.

Several possible scenarios were modeled to estimate emerging HIV funding gaps. Starting points were set based on baseline program expenditures from the last decade as reported in the National AIDS Spending Assessment⁵³. Future fiscal space uses IMF macroeconomic projections (International Monetary Fund, World Economic Outlook 2023)⁵⁴ and the baseline scenario assumes a constant share of the Government budget devoted to health. Reported numbers are in real US dollars using prevailing exchange rates. To construct scenarios, three options for program financial need (growing, constant, falling) and two options for donor exit (moderate and fast paced) were used for the 2023-2030 period (Figure 3.1 and 3.2).

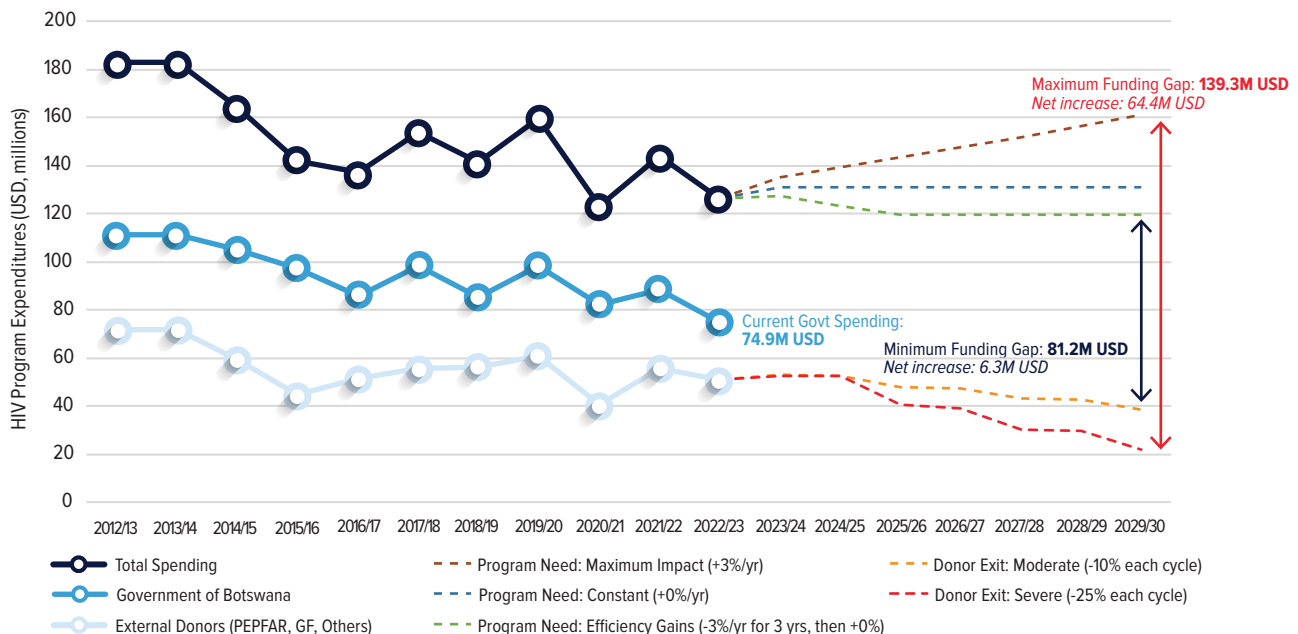
The model enables the construction of a series of scenarios that combine the options for total program financing need and donor financing. On the resource needs side, the model recognizes that Botswana has already exceeded the 95-95-95 targets, with little room for further expansion of coverage. Ageing of the PLHIV population will entail higher costs to address chronic disease co-morbidities. At the same time, efficiency improvements highlighted

below could also generate up to \$10 million in possible annual savings.

While there is uncertainty about the exact trajectory of donor support over the next 10 years, these scenarios assume a gradual decline in external financing from both the Global Fund and PEPFAR, based on discussions with donor representatives and the experience of other transitioning upper-middle-income countries. Anticipating and preparing adequately for probable decreases in donor funding is critical to ensure the HIV program is not caught off guard at the last minute.

Results. At one extreme, there is a highly challenging financing scenario in which HIV program needs grow over time as more people are covered with treatment and care for an ageing PLHIV population becomes more complex, and prevention efforts to go beyond 95-98-98, but no efficiencies are realized, and simultaneously the donors implement a rapid withdrawal of resources by reducing their contributions by 25% in each subsequent funding cycle after COP23/GC7. In this scenario, annual government spending on HIV would have to nearly double from \$74.9m in 2022/2023 to \$139.3m by 2030 – an \$64.4m increase – to fill the gap. Although projected growth in government health spending (\$114.7m/year additional by 2030, Annex G) is sufficient to cover this gap, devoting the required 55+% of the increased fiscal space for health to the HIV program will be difficult in an era of increasing pressure to expand government health services in other areas of health such as primary care, NCDs, maternal mortality, and mental health. This scenario thus presents a significant material risk to the sustainability of the program unless

FIGURE 3.1: HIV FINANCING SCENARIOS 2023-2030 (IN REAL USD)



Note: Data for 2021-2022 come from the National AIDS Spending Assessment. The projections for 2023-2030 show expected resource availability using the assumptions contained in Figure 3.2.

FIGURE 3.2: HIV FUNDING TRAJECTORIES

Options	Quantitative Representation	Description
Future HIV Financing		
Maximum Funding	Total program spending increases by 3% year over year.	<ul style="list-style-type: none"> GoB and stakeholders ambitiously aim to improve epidemic control beyond the current 95-98-98 levels and allocate additional resources to accomplishing this goal, entailing marginal cost increases for additional case finding. A net increase is also observed in program costs due to e.g. increasing burden of complex cases involving comorbidities in aging PLHIV population. Based on interviews with GoB treatment specialists/BUMMI and PEPFAR HIV testing leads.
Constant Funding	Total program spending does not change from the baseline.	<ul style="list-style-type: none"> GoB and stakeholders aim to maintain current results and allocate a constant level of resources. No net change is observed in program costs as the drivers of increasing costs (comorbidities, aging) and decreasing costs (more cost-effective interventions and treatments) cancel each other.
Efficiency Gains	Total program spending falls by 3% year over year for 3 years, then levels off.	<ul style="list-style-type: none"> GoB and stakeholders aim to maintain current results at reduced cost via efficiency gains from e.g. pooled procurement. Total program costs fall as savings from dual therapy and other newer, more cost-effective interventions are realized. Based on UNAIDS-led HIV efficiency study (2022)* and interviews with PEPFAR procurement and supply chain specialists.
Future Donor Financing Trends		
Donor Exit: Moderate	Donor contributions decline 10% cycle-over-cycle.	<ul style="list-style-type: none"> PEPFAR and GF reduce their contributions by 10% in each subsequent funding cycle (PEPFAR COP/ GF Grant Cycle) following the conclusion of COP23 and GC7. Other donors reduce spending to 50% of the recent average by 2030. Based on interviews with PEPFAR and Global Fund.
Donor Exit: Rapid	Donor contributions decline 25% cycle-over-cycle.	<ul style="list-style-type: none"> PEPFAR and GF reduce their contributions by 25% in each subsequent funding cycle (PEPFAR COP/ GF Grant Cycle) following the conclusion of COP23 and GC7. Other donors reduce spending to 0 by 2030. Assumes rapid donor exit, in line with Botswana’s entering the ranks of high-income country economies.

* UNAIDS, *Assessing the Efficiency of the National Response to HIV and AIDS*, Gaborone, January 2023.

mitigating actions, such as the creation of novel funding streams through taxes and levies, or increasing the share of overall Government spending for health from its current 12.3% share — are implemented.

At the other extreme, there is a “manageable” scenario in which Botswana maintains current program coverage and the country obtains efficiency improvements of 3% per year for 3 years (a 10% efficiency gain, lowering annual costs by \$7.2 million), and donor transition occurs more gradually, with external funding declining by 10% in each donor funding cycle. (How to achieve these efficiencies is explored in more detail below). Under this scenario, annual government spending on HIV would have to rise to \$81.2m by 2030, an increase of \$6.3m (8%) over 7 years. This would mean devoting about 5% of the projected growth in government health spending to cover the small gap in HIV spending — a significantly smaller and more manageable increase that leaves substantial budget space for other health sector priorities.

This analysis shows that under any combination of likely factors, the rest of the decade will be at least moderately (and potentially severely) challenging for Botswana financially to sustain its HIV response in the face of donor

withdrawal, even if this withdrawal takes place on a gradual and predictable basis. Key actions required include:

- Minimizing program costs by implementing all possible efficiencies (see below)
- Negotiating a gradual reduction in funding from PEPFAR and the Global Fund, among the partner agencies. Although the donors are not able to make firm quantitative commitments more than 2-3 years in the future, indicative funding trajectories PEPFAR and GF would help to guide government plans for HIV sustainability and transition.
- Planning for the almost inevitable increases in domestic public financing to fill HIV funding gaps, building the needed political support, and reflecting these increases in medium term expenditure frameworks and annual government health budgets.

The risk created by emerging funding gaps is not distributed evenly across the HIV program. As described in Chapter 2, PEPFAR and GF currently provide a majority of the financing for HIV research (100%), social enablers (90%), HIV testing and counseling (85%), program enablers and health systems

strengthening (82%), and prevention (59%). These areas are among the most likely to suffer if rapid donor exit results in insufficient funding for the overall program. Other areas such as care and treatment, which receive three-quarters of its funding from the government, are comparatively resilient to transition. However, at a more granular level even these areas have significant vulnerabilities, as highlighted by the 1,271 FTEs currently paid for by PEPFAR, of whom 394 work directly as professional clinical providers, lab/pharmacy staff, or community staff including health workers. This financial/skills risk around HRH is further discussed below.

Botswana's experience of the past decade provides grounds for optimism that future costs can be kept under control and that mobilizing the additional funds from domestic sources as donors wind down may not be too daunting. Although nominal HIV spending in BWP by the government has remained largely stable over the last decade (Figure 2.7), consistent and substantial depreciation of the pula (Annex D) has led to a 31% decrease in public funding for the program as measured in USD (Figure 3.1). As a result of this depreciation, total HIV program expenditures fell from \$183M to \$126M USD in the last ten years, while government revenues generated from mining in USD maintained their international value and increased as denominated in local currency. This reduction in real spending also reflects efforts to streamline the program and lower the cost of ARVs and other commodities as Botswana approaches epidemic control – trends that may be extended over the next few years if the country implements the recommended efficiency gains.

While it is possible that the recent trend of decreasing costs will continue, it should not be relied upon for program financial equilibrium and addressing declines in donor funding for the HIV program. The decline has been gradually leveling off over the last decade as savings driven by early epidemiological gains and the adoption of more cost-effective treatments have become more challenging to realize. Additionally, costs could begin trending upward in coming years as a result of increasing spending on treatment for an aging population of PLHIV with a growing prevalence of complex cases and NCD comorbidities.

Funding for the HIV program is not ringfenced and remains vulnerable to delays, blockages, and/or reallocations as a result of major crises. For example, GoB spending on HIV fell 16.4% from 2019-20 to 2020-21 as a result of the COVID-19 pandemic, while PEPFAR's expenditures dropped 37.0% (Figure 3.1). Though spending has largely recovered since then, future pandemics and other health crises still present a significant risk to HIV budgets and expenditures in Botswana.

3.1.2 EFFICIENCY MEASURES

Botswana's HIV program has proven both highly effective and highly resource-intensive. NSF III seeks to reduce

the financial and operational burdens of the program by pursuing improved efficiencies. This means, in part, delivering the same outputs/services at lower expenditure rates, which can be accomplished by reducing unit costs or otherwise finding less expensive combinations of inputs to achieve desired outputs.

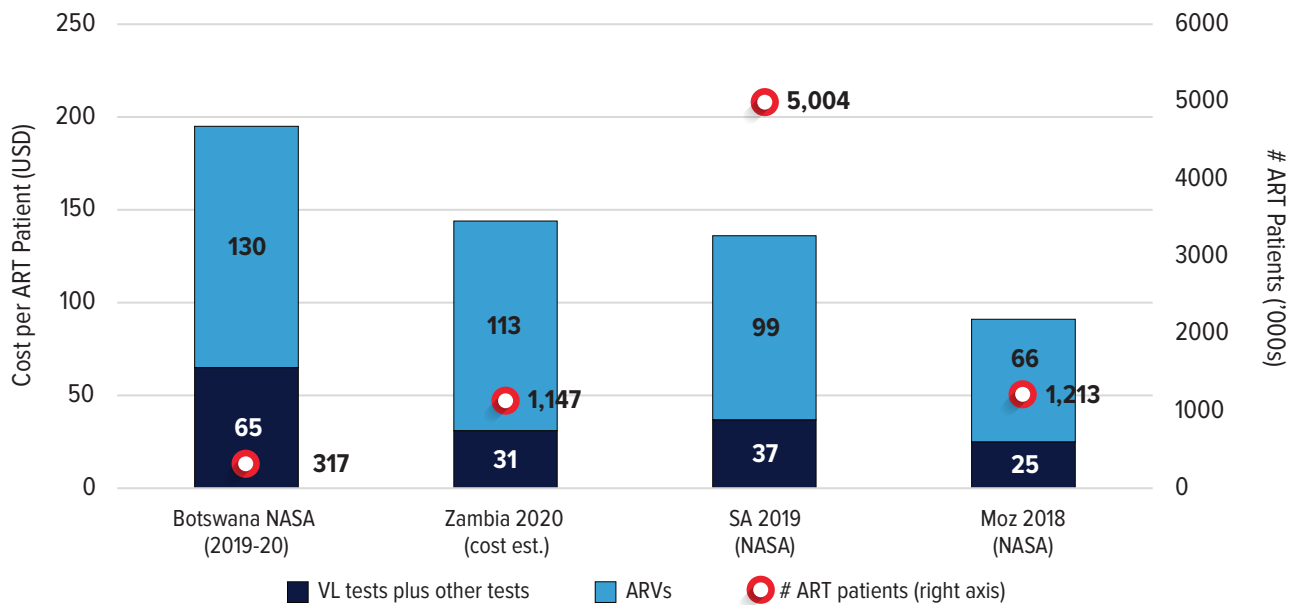
Substantial program savings have already been realized in recent years. For example, studies suggest that ART prices fell significantly in the years immediately following the implementation of the Treat All strategy in 2016, with the cost of certain generics like co-formulated tenofovir-3TC-dolutegravir (TLD) dropping to a third of original GoB projections.⁵⁵ However, it is considered “highly unlikely” that global prices for ART will decline much further. A 2021 Optima modeling study also found that allocative efficiency has already been almost fully optimized in Botswana, with little room left for additional gains.⁵⁶

Nevertheless, key informant interviews and a review of documents and data suggest that several possible avenues of efficiency improvement still remain, including increased pooled procurement for commodities, integration with primary and NCD care, consolidation of donor-funded HRH roles during transition, and the elimination of supply chain medication wastages.

Between 2018 and 2020, Botswana spent an annual average of USD \$29M on ARVs and \$16M on laboratory reagents for HIV testing. These figures represent 36% and 21% of total public expenditures on HIV, respectively.⁵⁷ A recent report found that Botswana's cost per patient for both ARVs and reagents is quite high in comparison with other countries in the region. In fact, at USD \$130 per patient per year, Botswana's cost for ARVs is nearly double that of nearby Mozambique at USD \$66 (Figure 3.3). This is partially due to Botswana's citizen economic empowerment policy, which prioritizes procurement from local companies. KIs suggest that the process of procuring from local suppliers has led to increased costs and diminished reliability and timeliness of supplies, as there are no local ARV manufacturers in Botswana to purchase from, necessitating additional expenses and logistics for frequent import orders.

Though unit cost differences have narrowed in recent years, it is still estimated that the country could save significantly by using the more efficient forms of pooled procurement. Evidence from ARV tenders awarded by CMS in October 2022 shows that Botswanan ARV prices are about 5%-10% more than those available from the Global Fund Pooled Procurement Mechanism, representing a potential excess expense of roughly US \$1.9M per year. While similar data have been difficult to obtain for laboratory commodities, one recent costing analysis emphasized the high burden of current reagent prices to the country and wrote that “advocacy for reductions in laboratory reagents and commodities should be taken up on the national and

FIGURE 3.3: REGIONAL ART UNIT COST COMPARISON, USD



global level with the same ferocity as was seen for the reduction in ART treatment costs and current demands for global COVID-19 vaccine equity.”⁵⁸

Another area for potential savings is in the indirect costs of the PEPFAR program to pay for salaries and benefits for USG management and technical personnel based in Botswana and Washington. According to PEPFAR’s own data, this “cost of doing business” amounts to as much as USD 8 million annually. As PEPFAR transitions in Botswana, much of this expense could also be realized as a saving to the national program.

Medication wastages and stockouts due to supply chain issues also introduce significant losses and inefficiencies to the HIV program in Botswana. These costly events impact service delivery and lead to expensive stop-gap procurements. The burden of these procurements has been shared with PEPFAR and other donors in the past (Figure 3.7), but in transition will come to land increasingly on GoB’s shoulders unless mitigated through, for example, better tools and training on commodity monitoring and forecasting. The implications of this ongoing challenge and potential mitigation strategies are described in Chapter 3.2.

To increase efficiency in the utilization of human and financial resources in the health system, NSF III also prioritizes the integration of HIV services with primary, SRH, and NCD care. Integration presents the opportunity to consolidate primary health care workers and managers with government programs, as well as to reduce costs for sample transport and other auxiliary services. While integration efforts and increased utilization of integrated services may require significant financial support up front, studies across Southern Africa have found long-term overall cost savings of 31-79% for integrated vs standalone HIV

services, as well as improvements in patient satisfaction and reductions in stigma.^{59, 60}

Total potential savings from efficiency enhancements could easily exceed 10 million USD annually based on the evidence described above. However, the precision of savings estimates is limited by a sparse data environment. Producing a detailed quantitative analysis encompassing all of the major avenues for efficiency gains will require substantial targeted effort as well as the overcoming of several key data gaps. Actions in this area would include determining the portion of HRH labor costs attributable to the provision of ARV treatments under both business as usual as well as various care integration scenarios; engaging in dialogue to identify specific donor-funded program management roles to be eliminated, retained, or consolidated at reduced cost; improving CMS capacity for comprehensive analysis and reporting on stockouts and wastages; updating ARV procurement data; and working with national laboratory managers to compile pricing and expenditure data for reagents and other commodities, among others. To accelerate benefits to the program, it will be important that efforts to address these data needs are pursued simultaneously alongside those to realize the underlying efficiency gains.

Accordingly, two more key actions to mitigate the overall financing risks to the HIV program include:

- Shifting purchase of ARVs and other laboratory tests and reagents to the most efficient forms of international procurement.
- Undertaking a detailed quantitative analysis of the additional monetary savings that could be generated by integrating HIV more fully into PHC, SRH, and NCD services in the Botswana context.

3.2 Health Systems for HIV

KEY RISKS

R4. A significant proportion of health care workers are leaving the public sector for alternative employment in other countries, private companies, and donor implementing partners, reducing coverage and quality of clinical services for HIV and resulting in excessive dependence on expatriate workers.

R5. Across the HIV response, the 1,270+ essential full-time staffing equivalents paid by PEPFAR and Global Fund (of 1,800+ total current FTEs) may not be absorbed by government as external funding declines, resulting in serious disruptions to patient services and to key system functions (supply chain, information, laboratories).

R6. There is no comprehensive national system for managing HRH, which severely limits the ability of HIV program managers to track, adjust, plan for, and improve HRH staffing.

R7. Continued use of domestic and local procurement mechanisms results in higher expenditures than required and prevents the realization of potential efficiency savings via international pooled procurement mechanisms (see R3).

R8. Frequent stockouts and supply chain delays in essential drugs, lab equipment, and supplies continue causing interruptions in care and reliance on emergency procurements supported by donors.

R9. Fragmentation of health information systems (patients/services, epi/surveillance, health products/logistics, laboratories) within government and between government, CSOs, and private sector causes inefficiencies, delays, higher costs, and reduced quality of data, decisions, and patient care.

R10. Continued limited and incomplete integration of HIV services with NCDs will erode leadership and public support for the HIV program, making it hard to fill financing gaps as donors taper funding.

Botswana's HIV program has many strengths, as highlighted earlier in this report. At the same time, there are numerous areas where the program can be improved to guarantee equitable access to high quality services for all of the country's citizens. Various HIV program reviews over the years have highlighted these areas and have called for enhancements in skills, coordination, and information systems.

While all of these calls for change are important, for this Sustainability and Transition Assessment we have elevated a small number of primordial threats and issues that require urgent and high level attention. These mainly relate to areas where Botswana still depends heavily on external financing and TA to implement key prevention programs such as DREAMS and treatment services and associated laboratory and other supporting interventions. The continued reliance on donor-financed (and sometimes donor-managed) human resources cuts to the core of the sustainability issues, as highlighted below. There are also more targeted issues related to supply chain and health information systems that we bring out below, to give them special emphasis.

3.2.1 HUMAN RESOURCES FOR HEALTH

Attrition. Attrition of public sector healthcare workers, who provide the vast majority of clinical services for PLHIV in Botswana, to other employers including wealthier countries,

private companies, and donor implementing partners has challenged the program since at least the early 2000s⁶¹. The recent establishment of recruitment platforms in Botswana by UK agencies seeking to hire for NHS positions has further exacerbated this situation, with around 10% (>700/7,679) of Botswana's nursing workforce signing up to work in the UK as part of a single 2022 agreement alone.⁶²

Peer-reviewed studies have identified a lack of professional fulfilment stemming from the reportedly poor quality of patient care, inconsistent supply of resources, perceptions of being undervalued in recognition and remuneration, and limited career progression opportunities as leading drivers of healthcare worker emigration from Botswana and noted that most of these factors are "intrinsic to the public health system, the biggest employer of healthcare workers in the country."⁶³ Key Informant Interviews (KIIs) conducted for this report in Mahalapye, Palapye, and Serowe DHMTs supported this analysis, with similar factors cited prominently by interviewees. To date, steps taken by GoB for health workforce retainment have been highly limited in scope, coordination, and results.

HCW attrition has significant consequences for the HIV program in Botswana. For example, it has been shown to increase workload and burnout among the remaining workforce and to undermine the coverage and quality of key services.^{64,65} It also intensifies dependence on expatriate staffing, which is already excessive with only

21% of doctors practicing in Botswana being citizens.⁶⁶ The high prevalence of migrant health workers (mostly from countries with political and economic difficulties including Zimbabwe, the DRC, and Zambia) presents an especially concerning risk as these workers are likely to return to their countries when conditions improve or to move on to countries with higher health sector salaries, potentially jeopardizing the sustainability of the HIV program.

Donor Dependence for HRH. Additionally, donors currently spend a combined \$26.8m USD annually to fund more than 2,500 positions representing over 1,800 full time equivalents in the HIV care continuum (Figure 3.4). PEPFAR provides the vast majority of this support, with the GF’s involvement limited to 115 staff covered by temporary grants of approximately \$775,000 per year from the COVID-19 Response Mechanism. Community health workers, mobilizers, testing and counselling providers, and data staff are the most common roles, representing in aggregate over 38% of USG-supported FTEs (Annex I).

A large majority of the supported positions will need to be maintained regardless of donor involvement as they underlie critical functions of the HIV system such as clinical care, social services and case management, community health interventions and outreach, data collection and management, and support for supply chains and information systems (Figure 3.4). Key informant interviews support this conclusion, with interviewees reporting that donor-funded staff are particularly crucial for the implementation of HIV interventions in high-burden districts such as Kweneng

East, Kgatleng, and Mahalapye.

Total donor-funded HRH represents about 3.2% of annual recurrent expenditures by MoH.⁶⁷ While this is by no means an insurmountable funding gap, if the government fails to recognize the functional importance of these positions in the HIV response or to engage in prioritization planning and resource mobilization efforts to ensure their continued viability, there is a substantial risk of disruption to key services and a derailment of progress achieved to date.

Timely absorption of these positions by the government, if well implemented, could produce additional cost savings due to staffing synergies and consolidation of roles as well as a shift away from the employment of international technical experts and managers towards comparatively less expensive counterparts from within Botswana (e.g. 39% of USAID human resources costs currently go into program management, Figure 3.5). However, quality could also be impacted if there is insufficient domestic capacity-building effort.

Human Resources Information Systems. Shortcomings in national Human Resources for Health (HRH) information systems and inventories pose another risk to the sustainability of the HIV program by undermining planning and management of the health workforce. A 2010-2013 collaborative effort between MoH and the USAID-funded IntraHealth initiative produced a national-level instantiation of the latter’s integrated Human Resources Information System (iHRIS), which was subsequently used to support

FIGURE 3.4: DONOR-FUNDED POSITIONS BY PROGRAM AREA, 2022 (FTEs)

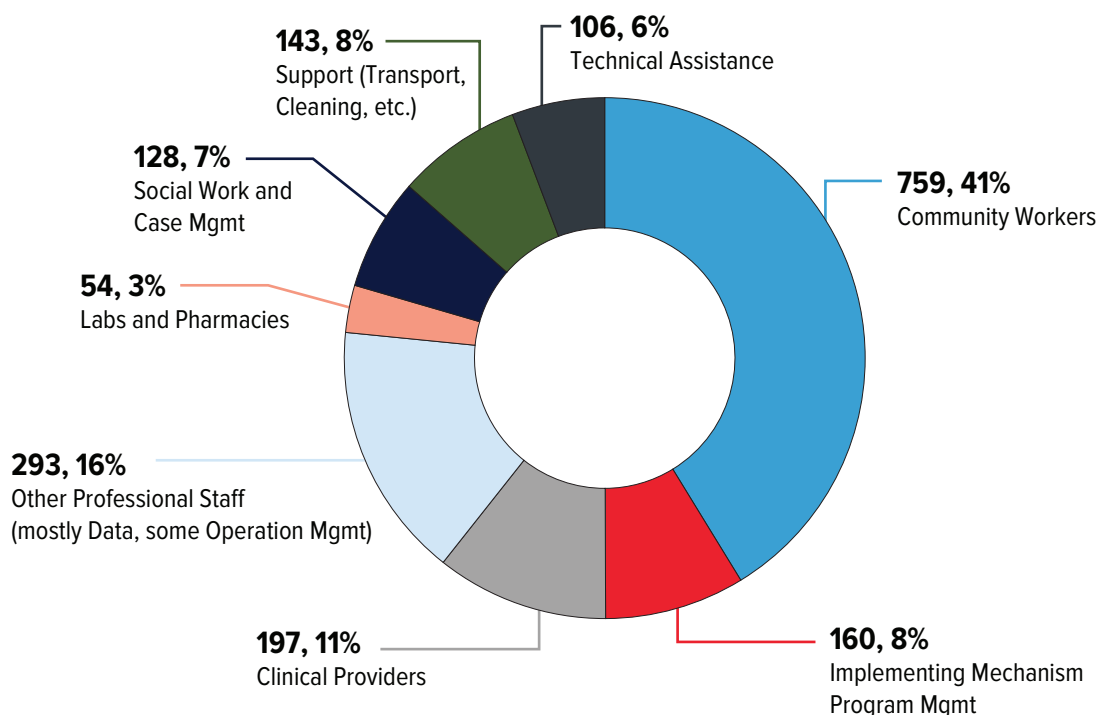
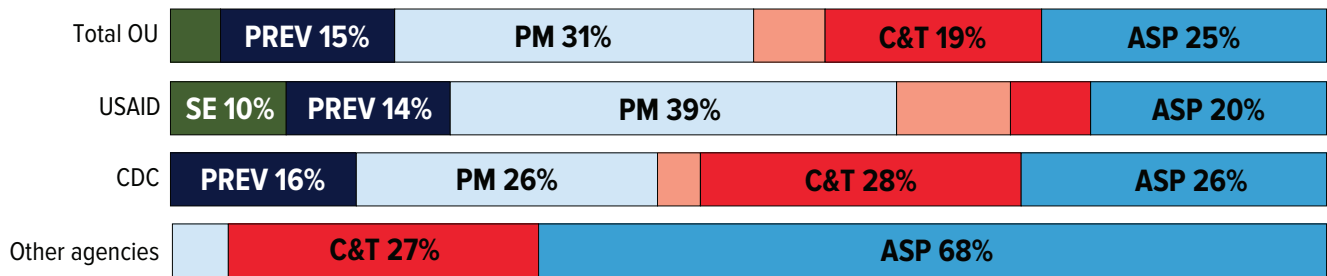


FIGURE 3.5: US GOVERNMENT SUPPORT BY PROGRAM AREA



Source: United States of America Government, PEPFAR Human Resources for Health, HR Inventory FY22 (document delivered to study team by PEPFAR Country Coordinator on June 9, 2023).

the KTCU training program. However, KIs indicate that adoption and utilization of iHRIS remain incomplete and that HRH data is still fragmented across several organizations including MoH’s Department of Policy, Planning, Monitoring, and Evaluation; the Ministry of Education and Skills Development; the Botswana Health Professions Council; the Nursing and Midwifery Council of Botswana; and the WHO country office.⁶⁸ Without unified, comprehensive, and timely data on the number, skills, and distribution of healthcare professionals across districts, program administrators face significant difficulties identify emerging gaps and areas of need. Shortages and imbalances in staffing can result, leading to inadequate service delivery and compromised care for people living with HIV. It also becomes problematic to evaluate and scale interventions and policies aimed at strengthening HIV HRH, such as training programs (e.g. KTCU, integrated curriculum) and staff retention strategies. Finally, as the HIV landscape in Botswana evolves, with changing demographics, treatment guidelines, and service delivery models, it becomes crucial to adopt a proactive approach to HRH planning. The lack of a high-quality information system makes it challenging to forecast future HIV HRH requirements, identify emerging skill gaps, and develop strategies to address these challenges, threatening the sustainability and effectiveness of Botswana’s HIV response.

To address these significant risks related to HRH, key required actions include:

- Developing and implementing a detailed plan for phased absorption of PEPFAR-funded positions, based on a careful assessment of staffing need, cost of absorption, and Government-PEPFAR agreement on the sequencing of such personnel transfers
- Implementing a more effective HRH information system that supports transition of PEPFAR-funded HIV staff as part of Botswana’s overall health human resources plans for recruitment, training, deployment, and retention
- Continuing to address the overall issue of health worker attrition/brain drain as it affects not only HIV but all parts of the Botswana health system

3.2.2 SUPPLY CHAIN MANAGEMENT

Donor-funded HR. Critical positions within the supply chain system, such as logisticians, supply chain assistants, and IT officers are funded by USAID and the GF (see Figure 3.6 below). As donor funding is anticipated to decrease in future grant cycles, maintenance of the supply chain is at risk if the GoB does not absorb these positions. There is also a lack of quality supply chain data which hinders calculating accurate consumption rate estimates and forecasting.

Contract Management. The Central Medical Stores (CMS) has insufficient human resources to manage its high volume of contracts (over 400) and agreements. This leads to costly micro-procurement, legal disputes that disrupt procurement, delays in initiating new contracts, and worsened supplier relationships. This ultimately causes stock-outs of essential products, such as for male and female condoms in 2021 (PEPFAR procured 18 million condoms, half the consumption rate, as a stop gap measure).

Procurement of HIV lab commodities as well as HIV drugs is also affected by inadequate human resources to manage the supply chain, as shown in the expiry of large HIV-related framework contracts in 2022. Mahalapye district suffered from frequent equipment breakdowns of Analyzers used in chemistry, CD4, and VL testing, leading to service interruptions. Failure to address these issues compromises access to vital commodities, disrupts service delivery, and increases costs for the health system (see Annex H for examples).The MoH’s reliance on external partners to fill emergency gaps in funding for HIV products, commodities, and laboratory equipment poses a significant risk to supply chain sustainability. Even though 70% of the GoB health budget is allocated to the HIV response, donors are still relied upon.

For instance, the implementation of the Botswana HIV Treat All Strategy in 2016 required the procurement of Dolutegravir 50mg. In this case, USAID, through its Global Supply Chain partner (GHSC-PSM), stepped in and procured, with PEPFAR funding, the first consignment valued at USD 10.5 million and a total of USD 19.9 million over 2017-23) as a stop-gap measure.

FIGURE 3.6: EXAMPLES OF DONOR SUPPORT FOR SUPPLY CHAIN HRH BY YEAR

Category	Category Description	Support Description	2017	2018	2019	2020	2021	2022	2023
Health Systems Strengthening	HRH	Seconded staff to CMS x 2 (Quantification and logistics management)					\$1,489,540		
	HRH	Seconded staff to the DHMT x (18 Site Monitors)		\$114,788					
	HRH	Seconded staff to the DHMT x (18 Site Monitors and 4 IT officers)							\$581,116
	HRH	Seconded staff to CMS x 1 (Contract Management)							\$36,700

FIGURE 3.7: PEPFAR PROCUREMENTS OF KEY HIV PROGRAM INPUTS BY YEAR

Category	Category Description	Support Description	2017	2018	2019	2020	2021	2022	2023
HIV Drugs	Adult ARV	Dolutegravir 50 mg Tablet, 30 Tablets (Aurobindo)	\$10,498,556						
	Adult ARV	Dolutegravir/Lamivudine/Tenofovir DF 50/300/300 mg Tablet, 30 Tablets (Mylan)			\$6,576,285				
	PrEP ARV	Emtricitabine/Tenofovir DF 200/300 mg Tablet, 30 Tablets (Hetero)					\$318,509		
	Paediatric ARV	Abacavir 20 mg/mL Solution w/ Syringe, 240 mL (Hetero)				\$45,247			
	Paediatric ARV	Dolutegravir 10 mg Scored Dispersible Tablet, 90 Tablets (Mylan) (Cartonless)							\$58,510
Prevention Device	Condoms	Mal Condom (Latex) Lubricated, No Logo, 53 mm, 3,000 pieces		\$980,195					
	Lubricants	Personal Lubricants			\$46,609				
Logistics: Warehousing	Warehousing and Storage	Leased Warehouse for CMS					\$197,377		
	Warehousing and Storage	Leased Warehouse for Kgatieng DHMT							\$54,504
Medical Device	Rapid Test Kits	Asante HIV-1 Rapid Recency Assay, 100/Pk					\$10,450		
	Rapid Test Kits	HIV-1/2, OraQuick Self Test, 250 Tests					\$21,600		
	Rapid Test Kits	Determine HIV 1/2 Serum/Plasma 100TEST/K & Unigold HIV 1/2 Serum/Plasma 20TEST/K	\$622,705						
Medical Equipment	Cervical Cancer	Equipment and Instruments for Cervical Cancer			\$493,676				

Source: Report and data provided to study team by Chemonics office in Gaborone and by PEPFAR supply chain specialist, June 2023.

Pricing preference for domestic suppliers. As mentioned above in the discussion of potential efficiency gains, the Government’s implementation of a local preference to stimulate economic development and citizen participation poses a significant sustainability risk, with this preference resulting in a 10-20% premium being paid to local manufacturers. Key Informant Interviews (KIIs) also revealed that this preference has contributed to stock-outs, delays in medicine deliveries, and frequent court trials.

Special procurement guidelines for health products. The lack of a tailored procurement procedure for the public health sector is a significant risk. The Public Procurement and Asset Disposal Board (PPADB) is responsible for adjudicating and awarding tenders for works, services, and supplies. However, there are no specific provisions to procure health commodities, creating challenges for ensuring adequate quality, safety, and affordability of health system products. The “one size fits all” approach and the

absence of differentiation for pharmaceuticals result in a lengthy and complex process that is predisposed to episodic supply issues associated with open tendering. This has led to delays in procuring essential medicines, making them unaffordable and unreliable for the health system. If a tailored procurement process specifically designed for the public health sector, particularly for medicines, is not institutionalized, the consequences can be severe.

Addressing the challenge of low availability of key medicines and commodities necessitates implementing sustainable solutions, including improving forecasting and quantification processes, conducting coordinated national surveys of medicine needs, and establishing incentives for proper medicines quantification. The high levels of stockouts, particularly in semi-rural and rural areas, highlights the need for comprehensive solutions to ensure adequate supply of both drugs and non-drug commodities.

To address these significant risks related to Procurement and Supply Chain, key required actions include:

- Developing and implementing a detailed timebound plan to hand over donor funded positions for district stock management, HQ contract management, etc to the Government, ensuring adequate national budget for these posts
- Minimizing the need for emergency procurement through improved quantification and planning, and establishing a Government fund for unavoidable emergencies, thus ending reliance on donors
- Examining whether the current preference for domestic suppliers should be maintained, by weighing the extra commodity costs of this program against the economic empowerment benefits
- Considering whether to develop a set of procurement rules that take into account the special characteristic of pharmaceutical purchases (quality, supplier reliability, timeliness), that would replace the current Government procurement guidelines for HIV commodities.

3.2.3 LABORATORIES

Excessive turnaround times for laboratory testing pose a significant risk to Botswana's HIV program. Reliance on public laboratories and insufficient human resources contribute to the issue. Turnaround times are particularly

concerning for viral load tests, the results of which are reportedly delayed three to six months after sample collection. Delayed results can lead to prolonged uncertainty about treatment effectiveness and impede timely adjustment of antiretroviral treatment. This can impact the health outcomes of PLHIV, as delays may result in treatment failure, viral resistance, and increased risk of disease progression. Delayed results also interfere with data monitoring and evaluation, making it challenging to assess intervention impacts, identify gaps in care, and make necessary adjustments to improve HIV service quality.

As with other health systems functions such as supply chain management, Botswana's laboratory system relies heavily on PEPFAR-financed technical expertise and other inputs. The PEPFAR COPs for 2023-25 allocate an average of approximately USD 2 million per year to laboratories to cover these items.⁶⁹ Possible loss of technical skills during a transition from donor financing could lead to a decline in quality and quantity of laboratory services, compromise quality of HIV care, and result in a setback in the overall HIV response.

3.2.4 HEALTH INFORMATION SYSTEMS AND MONITORING AND EVALUATION

In the realm of Health Informatics and Monitoring and Evaluation (M&E), the HIV response in Botswana faces crucial risks and potential consequences that cannot be overlooked. The availability and reliability of accurate data are essential for effective decision-making and strategic planning in the fight against HIV/AIDS. However, these vital components of the health system heavily rely on external support, particularly from CDC and other donors.

Dependence on external funding and expertise. Discussions with KIIIs revealed that CDC funds and supports a significant number of personnel through its direct funding, totaling 27 posts, in Health Informatics and M&E units at both national and district levels through NAHPA. Additionally, BUMMHI provides donor-supported health informatics roles for another 27 officers at the DHMT level. These officers strengthen the availability of data at source and aggregate at DHMT. Furthermore, these professionals play a critical role in ensuring the operationalization of the Datawarehouse (2 BUMMHI officers complementing 2 MoH personnel), which serves as the central repository for programmatic data in Botswana.

Possible loss of technical skills during a transition from donor financing could lead to a decline in the quality and quantity of laboratory services, compromise the quality of HIV care, and result in setbacks to the overall HIV response.

The vulnerability lies in the heavy reliance on donor funding to sustain the availability, accessibility, and reliability of HIV-related health data. If donor funding declines or ceases altogether, the consequences could be severe.

Without a well-functioning health information system, the ability to track and respond effectively to the HIV epidemic would be compromised, jeopardizing the gains made in the HIV response in Botswana.

Low Government priority on M&E. Within the 27 District Health Management Teams (DHMTs), there is typically only one M&E officer responsible for handling multiple programs, including collating and inputting paper-based data into electronic systems, conducting analysis, and generating reports. In contrast, donor-supported programs often have dedicated officers for these tasks.

According to insights from key informant interviews, it is estimated that at least 428 personnel are required to effectively run a fit-for-purpose health information management system (HIMS) for HIV/AIDS from the DHMT to the national level. However, recognizing the high estimated capacity, a rationalization exercise conducted by the Informatics and M&E units reduced this number to 80 officers through a staffing norms assessment rationalization using the Workload Indicators of Staffing Need (WISN) approach. Despite this assessment, the response or implementation from the Ministry of Health and the Directorate of Public Service Management (DPSM) is still pending.

It is essential to recognize and address these risks and vulnerabilities promptly. By building local capacity, training and retaining qualified personnel, and developing sustainable financing mechanisms for Health Informatics and M&E are crucial steps to mitigate the potential consequences.

In the context of the HIV response in Botswana, one of the hurdles that the Ministry of Health faces is the centralized recruitment system for the health workforce and civil servants in general. While donors often step in to address personnel gaps through their funding, the MoH, under the government structures, lacks the flexibility and agility to swiftly respond to these emerging needs. Traditional roles and positions tend to take precedence, leaving little room for the inclusion of new and essential roles that may exist solely for the purpose of grant or donor funding. Consequently, once the donor-supported projects come to an end, these roles may be lost or overlooked, leading to a lack of continuity and accountability in monitoring transition plans.

To avoid the derailment of the HIV response in Botswana, it is crucial to address this domestic risk and strengthen the capacity of the MoH to adapt to changing workforce needs.

Critical actions include:

- Revisiting recruitment processes, ensuring the inclusion of emerging roles in the health system, and establishing accountability measures to monitor the transition plans beyond donor-supported projects.

Incomplete integration of HIV information systems. The health informatics unit within MoH envisions a transition from paper-based to electronic systems for service delivery at healthcare sites. While public hospitals are connected to the Integrated Patient Management System (IPMS), District Health Information System (DHIS 2), and Open-Medical Record System (OpenMRS), there are still gaps in connectivity and utilization of digital platforms in public clinics. The Smart Botswana initiative, specifically the “Village connectivity” project, aims to extend connectivity to key government landmarks, including schools, laboratories, and clinics in both urban and rural areas.

Additionally, the three main data systems utilized for HIV care and treatment in Botswana (IPMS, OpenMRS, and DHIS 2) operate at different levels (capacities and breadth) of the health system without interfacing with each other. This leads to gaps and duplication of patient records, hindering longitudinal monitoring and posing challenges in tracking treatment interruptions and patient mobility. The absence of linking mHealth applications to eRecord systems further exposes the HIV program to data-related concerns, which could jeopardize the credibility of reported outcomes and impeding effective program planning and evidence-based decision-making.

Poor connectivity further exacerbates these challenges. The government data network, on which all ministries, including the Ministry of Health, rely on, is slow, unreliable, and impedes productivity. The HIV program has relied on donor support to address connectivity issues, through provision of modems but devices provided often become underutilized due to inconsistent data provision by the MoH. While the village connectivity initiative offers potential, connectivity remains a key issue that must be overcome to achieve equitable services and quick access to health information across the health sector.

To avoid undermining the HIV program as donors reduce their support, it is crucial for the MoH and relevant stakeholders to complete the integration of the HIV information systems and prioritize addressing the infrastructural and connectivity hurdles. This includes investing in adequate devices where infrastructure accessibility is limited, improving connectivity and bandwidth, ensuring consistent data provision and prioritizing an interoperability solution.

3.3 TB Program Sustainability and HIV/TB Integration

KEY RISKS

R11. While the TB program has made important progress in incidence rates, limited data availability and inadequate performance on case detection and cure rates could allow for significant avoidable illness and deaths, especially among HIV positive individuals.

R12. Staffing of the national TB program remains heavily dependent on donor support, as well as insufficient in quantity and capacity.

R13. The lack of integration of the TB program with Botswana’s HIV program is inefficient and fails to capture potential synergies between the efforts to fight the twin diseases which are very closely inter-related in the country. The result is unnecessary and wasteful spending that inflates the overall cost of HIV/TB control during a time of transition where external funding is reduced and Government budgets are under pressure.

Several risks were identified during the TRA that have the potential to undermine sustainability of the TB programme and its successes to date (e.g. decline from 855 cases per 100,000 people in 2002 to 230 cases per 100,000 people in 2021 (WHO, 2020/21), and to spill over to the HIV programme. This is underscored by the fact that less than 50% of HIV-positive TB patients were initiated on antiretroviral therapy (ART) in 2017. Given that co-infection rates stand at an estimated 45%, neglecting efforts towards screening, active case finding, capacity building, and diagnostic management and inadequate staff have significantly impeded the TB response and have negative consequences for HIV.

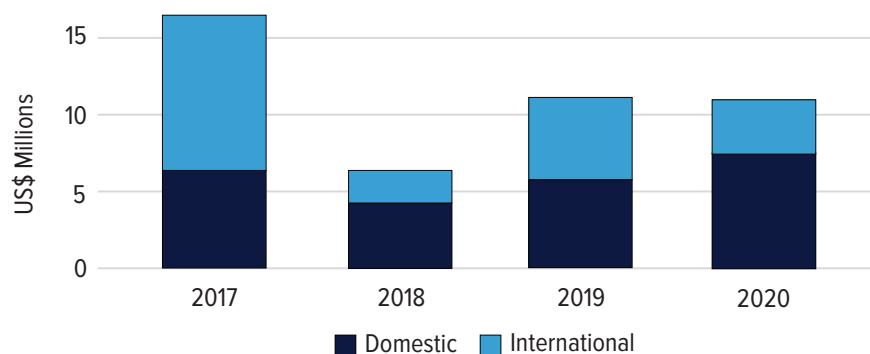
Donor financial dependence. The current financial landscape for the Botswana National Tuberculosis Programme (BNTP) indicates significant donor dependence. Between 2017 and 2020, domestic funding fluctuated between roughly $\frac{1}{3}$ and $\frac{2}{3}$ of total programme expenditures. Of this, MoH’s recurrent budget for coordination of the national TB programme, excluding drugs and commodities,

is estimated by BNTP administrators at approximately USD 500,000 annually. In comparison, recent annual budgets of PEPFAR-CDC and the Global Fund to support the TB programme in Botswana have averaged around USD 1.5 million and USD 500,000, respectively.

Moreover, a significant challenge lies in the legal dispute that has hindered the disbursement of funding from the Global Fund for community-based screening and monitoring for TB. This impasse jeopardizes the reach and impact of vital TB programs, leaving vulnerable populations without access to essential TB services.

In the past, the BNTP program benefited from substantial funding provided by Global Fund, World Bank, KNCV, CDC, and USAID, which supported a robust staff complement of 25 positions at the national level. However, since the grant period ended, the national level now operates with a mere three (3) MoH funded positions, with minimal support from Global Fund for a key position in Active Case Finding and TB/HIV support coordination, as well as M&E oversight by CDC BUMMHI.

FIGURE 3.8: FUNDING FOR TB (USD, MILLIONS)



Source: 33. WHO, Global Tuberculosis Report 2021, October 2021, <https://iris.who.int/bitstream/handle/10665/346387/9789240037021-eng.pdf?sequence=1>.

This scale-down in technical capacity and expertise is not limited to the national level alone; it is acutely felt at the district level as well. District coordinating officers now find themselves with the burden to implement un-resourced districts plans, limited TB workforce comprising just one TB coordinator, support staff, and a driver, despite the vast size and workload in the district. The result is an overwhelming challenge for these coordinators to cope with the mounting work demands, compromising the coverage and effective delivery of essential TB services.

The stark shortage of skilled personnel (including just 5 staff at national level) negatively impacts service delivery, as experienced staff members are stretched thin, leading to potential delays in diagnosis, treatment initiation, and patient follow-ups. Staff attrition is also reportedly high, with people leaving the program for greener pastures in large numbers. This, in turn, jeopardizes the overall success of the TB Program and risks a potential resurgence of TB cases.

Another area where donor dependence is highly risky for the TB program is in the realm of laboratory diagnostics. Historically, donor support has been instrumental in providing critical laboratory equipment and commodities, including over 30 GeneXpert machines for TB diagnosis, along with the necessary cartridges and reagents. However, with the decline in funding and the withdrawal of donor assistance, the availability of essential laboratory supplies has become precarious, leading to stock-outs and equipment breakdowns. The stock-out of cartridges for GeneXpert machines has forced the program to resort to sputum smear microscopy, which is known to be less sensitive and may miss cases of TB (Khadka P). This shift from the WHO-recommended and more advanced Xpert MTB/RIF testing to less effective methods which compromises the accuracy and timeliness of TB diagnosis. See comments below from the annual report: *“Due to shortages of testing cartridges and reagents, bacteriological confirmation was a challenge across the country”*

Risks associated with weak HIV-TB integration. The Tuberculosis National Response in Botswana faces a significant risk and consequence arising from the lack of integration

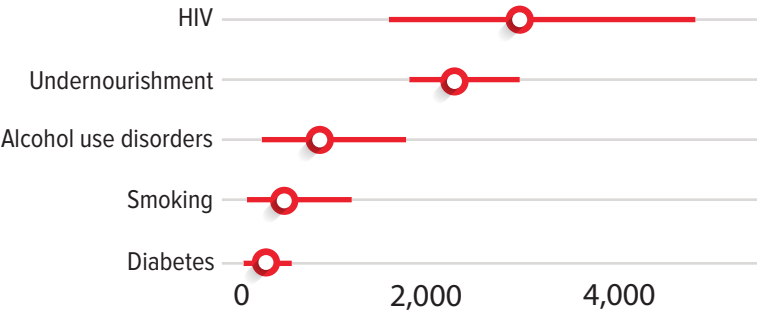
between the TB and HIV programs. Despite HIV being a leading attributable risk factor for TB (Figure 3.9), the TB Program in Botswana operates as a standalone entity within the Disease Control Division of the Department of Public Health, physically separated from the HIV department.

This non-integration inhibits the seamless collaboration required to address the complex interplay between the two diseases, ultimately impacting the overall effectiveness of both programs. Synergies that could arise from collaboration between TB and HIV initiatives may not be fully harnessed, leading to potential duplication of efforts and inefficiencies. This fragmentation of efforts may also affect resource allocation, potentially leading to suboptimal utilization of available funds and resources. Moreover, the physical separation of the TB Program from the HIV department as well as coordination (NAHPA) perpetuates a perception that TB is of lesser priority in the overall health agenda.

To mitigate these risks to the sustainability and success of TB control in the country, in the face of declining donor support, several key actions are required, including:

- Re-examining the financial needs of the program and the mix of domestic and external funding, in order to develop a sustainable financing plan for the next 5-7 years as donors reduce their support. There needs to be a corresponding Government commitment to replacing donor financing and including these increased amounts in annual budgets.
- Developing and implementing detailed plans for adequate staffing of the TB program and the progressive absorption of donor-financed HR positions, as well as transition of laboratory activities (equipment, consumables, and maintenance) from donors to government support.
- Revisiting the integration of TB with HIV in terms of organizational structures, budgets, and implementation of activities, both at HQ levels and on the ground in districts, health facilities, and communities.

FIGURE 3.9: NUMBER OF TB CASES ATTRIBUTABLE TO 5 LEADING RISK FACTORS IN BOTSWANA, 2021



Source: 33. WHO, Global Tuberculosis Report 2021, October 2021, <https://iris.who.int/bitstream/handle/10665/346387/9789240037021-eng.pdf?sequence=1>.

3.4 CSO-Government Engagement

KEY RISKS

R14. The very large annual spending on CSOs to support community HIV services (essentially prevention and KVP services) of around USD40 million a year is heavily donor-financed, at around 75% of the total. There is a major risk that these donor funds invested annually by PEPFAR and Global Fund in CSO-delivered HIV services will not be adequately replaced by Government as donors taper funding.

R15. The CSO programs are highly fragmented along lines of the three main funders – Government budget, PEPFAR, and Global Fund – with separate plans, contracts, and information systems. This creates a serious risk of duplication, wasted resources, and reduced impact.

R16. Even though performance based social contracting is supposed to be the norm, based on a 2019 Government policy on social contracting, such performance-based contracting and financing has not been implemented fully. As donors gradually withdraw from Botswana and the Government becomes the dominant funder of civil society-led work in prevention, community-based HIV services, and KP services, there is a risk that social contracting will not be adopted widely, resulting in additional inefficiencies and lower impact.

R17. CSO capacity building and coordination efforts have received substantial funding but have not been fully effective in creating and retaining personnel and skills for sustained high performance by the CSO community. There is a risk that weak capacity and limited coordination will undermine the performance and effectiveness of CSO contributions to the national HIV responses, especially as a large portion of the capacity building has been funded by donors and may not be continued after transition.

Donor dependence. As described in Chapter 2, CSO-led community HIV services are an important and robust part of Botswana’s response. Around three quarters of the USD 40 million spent on CSOs for KVPs and prevention are paid for by PEPFAR and the Global Fund, with an important minority share coming from the Government via NAHPA. Picking up this USD 30 million tab as part of donor transition could be a significant budgetary challenge for Botswana. However, international precedent and key informant interviews indicate a strong possibility that donors will prioritize CSOs in the allocation of their remaining resources throughout the transition process, cushioning the fiscal blow in this area. Furthermore, an evidence-based assessment and rationalization of resources provided to CSOs should be carried out as part of government’s absorption of support responsibilities, providing the opportunity to further streamline program budgets.

Fragmentation and inefficiency. As described earlier, the CSO contribution is very rich but highly fragmented. Within the Government-financed program run by NAHPA, the money is spread thinly with many organizations being funded, limiting the opportunity for impact. During the financial year 2021/22, 73 CSOs and support groups were funded. Compare this to one principal recipient and three sub-recipients for the GF during NFM2 and NFM3 and thirteen prime recipients for PEPFAR in 2022. At the same time, the three parts of the CSO-led response – Global Fund via ACHAP, PEPFAR/USAID via several large INGOs and

national NGOs, and NAHPA with its 73 groups – operate quite separately from each other, using different budgets, contracting mechanisms, and monitoring systems. There is no meaningful coordination and exchange of information and practices across the three channels. Our interviews showed that main external donors and NAHPA have no overall idea of how much money is channeled through to CSOs. From a sustainability perspective, this creates a large inefficiency risk, with duplication, mixed and confusing signals from funders to CSOs, and failure to capture synergies and shared learnings.

Incomplete social contracting. Even though the Government approved a social contracting policy several years ago and both PEPFAR and Global Fund state that they would like to move toward “payment for results” as a way of maximizing the use of funding for Botswana’s HIV CSOs, none of the three channels has fully adopted the social contracting model. In fact, there is widespread recognition that the ongoing NAHPA program with CSOs does not monitor and pay for performance using outputs and outcomes, as per the social contracting policy. The Global Fund grant is currently supporting work with NAHPA to try to move more fully toward social contracting, but there is still a distance to travel on this. Without across the board adoption of social contracting and/or other forms of payment for results, there is a similar risk of inefficiency and excessive spending at a time when donors are transitioning and Government funds must be optimized.

Inadequate and unsustainable capacity building and coordination among CSOs. While gaps still exist and more capacity is needed, local CSOs who have gone through capacity building training have been successful in transforming Botswana's sociocultural landscape by removing some of the sociocultural barriers that promote stigma and discrimination among PLWHA and other key populations. CSOs' efforts, in particular, BONELA and BONEPWA have over the past several decades contributed to the enactment of relevant legal instruments, policies and programs that sought the protection of human rights of poor marginalized population groups, especially key populations. Significant steps in the advancement of gender equality and non-discrimination on the basis of HIV status is also attributable to work of CSOs. In fact, some CSOs argue and reasonably so, that Botswana's huge success in attaining both NSF111 and UNAIDS fast track goals is a result of their efforts.

At the same time, capacity strengthening has been hard to sustain, and the CSO community continues to suffer from capacity limitations. A study conducted by the EU in 2018 (Government of Botswana Non-State Actors Capacity Building Program) on CSO networking strategies revealed that CSOs are affected by weak coordination structures and strategies that compromise their effectiveness and long term sustainability. Another study conducted by the EU/Government of Botswana Empowerment of Non-State Actors in 2015 showed that CSOs' contribution is limited by insufficient resources which make them focus on short-term projects with limited impact. The CSOs Sustainability Index study by USAID (2020) revealed that many CSOs in Botswana lack the institutional capacity and resources to ensure good governance. Most do not have resources to invest in annual general meetings. CSOs are run often without functioning organizational structure and management skills. CSOSI (2020) further found that many CSOs invest significant resources to train staff only to have them leave for employment elsewhere. Most CSOs depend on Government for funding and have no Resource Mobilization strategies in place that would propel them toward sustainability.

All of these issues in capacity and coordination of CSOs generate a significant sustainability risk as external financing is expected to decline.

To address these four CSO-related risks, a set of key actions is required, including:

- Devising a plan, led by the Government and with full buy-in from PEPFAR and the Global Fund, that sets out a timeline and targets for increased domestic financing for CSO-led HIV activities over 2024-30, based on an agreed estimated trajectory for the donors to gradually taper their funding support for CSOs. The plan will then need to be subjected to annual joint monitoring and dialogue among the three key funding organizations.
- Developing and agreeing again among the three main organizations (PEPFAR, GF, Government) on a plan to converge and eventually merge the three CSO-financing channels, so that a single funding and contracting mechanism emerges over the next few years.
- Adopting and applying a single unified policy and approach to social contracting for all CSO-led HIV activities in Botswana, so that all CSOs are paid in a similar fashion based on their outputs and impacts.
- Pursuing the diversification of funding streams for CSOs, for example by linking CSOs to other development sectors or scaling up social enterprise and private sector reimbursement schemes already in use by many organizations
- Setting aside a reasonable percentage of funds for CSO capacity building and coordination from all three sources (PEPFAR, GF, Government) to create and support a single unified capacity building program and coordination mechanism for the next 3-5 years, using lessons learned and best practices in CSO capacity building, in order to avoid the rapid weakening of many of the national CSOs that has been observed in multiple recent studies.

Around three quarters of the USD 40 million spent on CSOs for KVPs and prevention are paid for by PEPFAR and the Global Fund, with an important minority share coming from the Government via NAHPA.

3.5 Human Rights, Governance, and Coordination

KEY RISKS

R18. The Health and Human Rights unit in NAHPA is minimally staffed under a temporary matching funds arrangement with the Global Fund. Unless the Government follows through on prior commitments to institutionalize and absorb the program including providing funding and adequate staffing, it will be discontinued during transition or if Global Fund fails to renew the arrangement, jeopardizing advocacy and coordination of legal protections for PLHIV and vulnerable KPs.

R19. Key populations rely heavily on donor-funded services delivered by CSOs, reporting less stigma and discrimination than in government facilities. Interruptions to the operation of these services caused by transition could undermine and potentially reverse gains in HIV control among key populations. There is an added risk that these CSOs may be under-resourced to perform their service, advocacy, and legal reform efforts.

R20. Mandates and divisions of labor across Government are not well clarified, especially between NAHPA and MoH at both national and district levels, resulting in fragmentation, duplication, wasting of resources, and a weakening of proactive leadership of the national HIV response, including in the planning and coordinating of the transition process. Unless coordination is strengthened, Botswana will not be able to sustain or surpass strong results achieved to date.

R21. The coordination structures and leadership for key policy agendas including the third National Strategic Framework for HIV/AIDS (NSF III) and the Sustainability and Transition Roadmap have not been clearly identified and empowered. Unless corrected, this could reduce the effectiveness of implementation of the national response and of the Roadmap.

While Botswana has made important strides in human rights and anti-discrimination related to HIV and has invested heavily in institutions and structures to lead and coordinate the national response, there are several important weaknesses and issues that generate serious risks to sustained successes in the future as donor funding wanes.

Human Rights and Legal Protections. With further support from the Global Fund in 2019, NAHPA established a Health and Human Rights Unit coordinated by the Legal and Human Rights Officer. This unit has been doing valuable work, but the Government's commitment to absorb the unit and its personnel into the civil service has not yet been honored. This is an important sustainability issue.

In addition, Botswana's KVP legal and human right services are heavily funded by the two donors. These services, led by groups including Bonela, Bonepwa, and Tebelopele, which is the main operator of voluntary non-governmental testing centers. Most KPs prefer to test at Tebelopele rather than government clinics due to delays, stigma and discrimination, etc. According to a recent report, "*Tebelopele* has been well used and has performed at least 1 HIV test for 11% of Botswana's adult population in the first 5 years of its operation. A population-based survey of adults in 2003 revealed that of people who had ever been tested for HIV, 37% had been tested at a *Tebelopele*. The acceptability of Tebelopele was especially notable among young people: 73% of men and 42% of women aged 15 to 24 years who had been tested for HIV had done so at a *Tebelopele*."⁷⁰ If Tebelopele were to lose funding in transition, testing rates would likely decrease, especially among KPs.

The Penal Code Amendment Bill No. 29 of 2022 may also hope to reduce discrimination. Section 164 (a) and (c) of the Penal Code (Cap. 08.01), which criminalizes carnal knowledge between two adults against the order of nature, has been used against gays and lesbians. This section was declared unconstitutional by the Court of Appeal. This is a major achievement led by LEGABIBO, another CSO with major donor funding.

Thus while the legal environment in Botswana regarding HIV is not entirely hostile, it is generally seen as a risk to program sustainability in the face of declines to donor funding.

Governance and Coordination. While many actors are involved in the national HIV response, there are some issues with clarity of mandates and roles, and coordination structures are not optimally utilized, in part because of confusion over leadership roles. If these governance and coordination issues are not resolved, they create a risk of reduced impact on the HIV epidemic and weaker accountability for performance and results.

An example of unclear roles and mandates: Duplication of effort and lack of clarity on the roles and responsibilities between MoH and NAHPA. During TRA interviews, it was reported that MoH has a fully-fledged Unit responsible for HIV prevention. The Unit is responsible for health promotion, oversees prevention and treatment at various clinical sites e.g. male circumcision (VMMC). The MoH is also responsible for the monitoring of the treatment and adherence portion of the cascade. The same roles are

played by NAHPA, leading to duplication of efforts and wasteful expenditure.

Another example – it is currently unclear who will take responsibility (MoH or NAHPA) for monitoring the implementation of the third National Strategic Framework (NSF III 2019 – 2023). Without clear decision and action on this, the JOC and TWGs will not be in a position to perform their roles effectively as subcommittees of the NAHPC. Similarly, it is currently unclear who will take the lead in formulating, implementing, and monitoring the HIV Sustainability and Transition Roadmap that will emerge from this report in a few months' time.

Coordination challenges are also evident in the insufficient communications and collaboration between NAHPA and MoH, at national and district levels. Structures work in isolation and independently of others. Lack of commitment by some key stakeholders to work together was reported; for example, certain institutions were reported to be missing NAHPC, JOC and TWGs meetings consistently. Even at district level, senior officers such as the District Commissioners had neglected DMSACs and hardly attend their meetings. At best, they delegate very junior officers to chair such meetings, which effectively undermines joint planning and decision making and frustrates the national response. Strengthened coordination would also help eliminate CSO funding overlaps between NAHPA, PEPFAR, and GF – discussed in CSO section.

To address these risks in human rights and legal environment, and in governance and coordination of Botswana's HIV response, a set of actions is urgently required, including:

- Institutionalizing the Human Rights Unit in NAHPA, with posts absorbed into the civil service
- Assessing the funding needs of the key CSOs working in human rights and legal services for KVPs, and ensuring that these funds are maintained through an orderly transition from donors to Government
- Creating a special task force reporting to the NAHPC and its chair, the Vice President of the country, to re-examine and clarify the roles of respective Government institutions, especially NAHPA and MoH, in areas such as HIV prevention. The task force would also identify the terms of reference of NAHPA and MoH in monitoring the implementation of NSF III's extension period and in leading and monitoring the implementation of the HIV Transition Roadmap.
- Streamlining coordination structures at national and district level to avoid duplication and "fatigue", and simultaneously reinforcing the importance of participating in the remaining coordination bodies and activities, with special oversight by NAHPC to ensure that coordination is taken seriously in practice.

Mandates and divisions of labor across Government are not well clarified, especially between NAHPA and MoH at both national and district levels, resulting in fragmentation, duplication, wasting of resources, and a weakening of proactive leadership of the national HIV response, including in the planning and coordinating of the transition process. Unless coordination is strengthened, Botswana will not be able to sustain or surpass strong results achieved to date.








Chapter 4.

Summary of Main Sustainability and Transition Risks






Introduction. In the matrix below we summarize the 21 key risks to successful sustaining Botswana’s currently outstanding national HIV program in the face of transition away from donor financing and other technical support. Each of these risks has been highlighted in Chapter 3 – a description of the risk, the evidence to back up our views of its relevance and importance, and a quick statement of the required and recommended actions to address and mitigate the risk.



The following tables shows these risks “at a glance” and rates them according to our judgment of the severity of the risk. A red light is for the top priority risks that we believe demand special attention and urgent action. Orange lights indicate risks which, while still important, can be considered slightly lower priority. Yellow lights are considered the least critical of the three; however, both orange and yellow risks are still items of significant concern for which mitigation measures should be pursued aggressively, as long as the red ones are fully addressed. The recommended activities to counter each risk represent preliminary suggestions; Chapter 5 presents a much-improved and more detailed set of actions which describe precisely what needs to be done, when, by whom, and indicators that can be used to monitor progress. Chapter 5 thus constitutes the Sustainability and Transition Roadmap that Botswana needs to follow in the coming years.

4.1 Sustainable Financing




KEY RISKS	LEVEL	RECOMMENDED ACTIVITIES
R1. PEPFAR and GF financing for HIV can be expected to decline rapidly between 2024 and 2030, and the Government may not mobilize/allocate sufficient resources to cover the resulting gaps. Parts of the program currently deriving a large portion of their funding from donors are of particular concern		<ul style="list-style-type: none"> Government to negotiate a longer-term and more predictable trajectory for PEPFAR and GF up to 2030 – signed transition plans Develop and implement plans and budgets to nationalize/transfer financing of critical activities to GoB over 2024-30 – and include in Medium Term Expenditure Framework
R2. Government health funding needed to fill gaps left by declining donor HIV contributions may not be fully allocated because of other legitimate competing health priorities such as NCDs, maternal mortality, and mental health, resulting in insufficient funding for the HIV program		<ul style="list-style-type: none"> Increase advocacy with MoF and SP to raise the absolute amount of government money for HIV from \$90m a year to \$120m+ by 2026 and \$160m+ by 2030, even if this means increasing HIV's share of govt health spending Negotiate for and secure an increase in GGHE/GGTE from ~11% today to up to 15% by 2030 to ensure adequate funding across all health priorities (Abuja target) Discuss and agree with MoF to dedicate to HIV program shares of Special Funds tapping levies (alcohol, tobacco, sugary drinks)
R3. As donor funding decreases and fiscal responsibility is increasingly transferred to the Government, it may not take full advantage of opportunities to increase efficiency in the HIV program, leading to long-term spending 10-20% higher than necessary and avoidable fiscal bottlenecks		<ul style="list-style-type: none"> Develop and implement an HIV efficiency plan with concrete annual targets overall and for specific areas of potential savings Set up Government-donor committee to monitor efficiency gains performance

4.2 Health System Strengthening



KEY RISKS	LEVEL	RECOMMENDED ACTIVITIES
R4. A significant proportion of health care workers will continue to leave the public sector for alternative employment in other countries, private sector, and donor agencies, reducing coverage and quality of clinical services for HIV and perpetuating dependence on expatriate workers		<ul style="list-style-type: none"> Conduct a comprehensive HRH review and implement measures (training, supportive supervision, incentives, etc.) to attract and retain government health care workers, including for the HIV program
R5. Across the HIV response, the 1,270+ essential full-time staffing equivalents paid by PEPFAR and Global Fund (of 1,800+ total current FTEs) may not be absorbed by government as external funding declines, resulting in possible disruptions to patient services and key system functions (supply chain, information, labs)		<ul style="list-style-type: none"> Create a comprehensive inventory of donor-funded posts (type, location, cost, need to absorb) Develop a national plan to replace/absorb these posts over 2024-28, with annual targets, and agree with PEPFAR and Global Fund on yearly actions to be taken Estimate costs of HR transitions and incorporate in MTEF and annual ministry budgets Monitor and report results to NAHPC and leading ministries and GF/PEPFAR
R6. There is no comprehensive national system for managing HRH, which severely the ability of HIV program managers to track, adjust, plan for, and improve HRH staffing.		<ul style="list-style-type: none"> Design and implement a national HRH information and management system and test its fidelity and effectiveness in relation to the plan for absorption of donor-funded HIV workers (see risk/recommendation above)
R7. Government does not address weaknesses in CMS contract management and district/last mile supply chain currently funded by donors, leading to frequent stock outs of HIV drugs and diagnostics.		<ul style="list-style-type: none"> Expand staffing and replace donor-financed positions in CMS, especially related to central contract management and district-level HIV products distribution and inventory management
R8. Maintaining the status quo in procurement of HIV drugs and lab equipment & supplies results in continuing interruptions/stockouts and higher prices than could be obtained		<ul style="list-style-type: none"> Adopt global pooled procurement, with estimated cost savings of \$2M+ annually Replace donor-funded emergency procurement with national policy – agree with MoF that HIV commodity budgets will be protected and budget releases expedited



KEY RISKS	LEVEL	RECOMMENDED ACTIVITIES
R9. Fragmentation of health information systems (patients/ services, epi/surveillance, health products/logistics, laboratories) within government and between government, CSOs, and private sector causes inefficiencies, delays, higher costs, and reduced quality of data, decisions, and patient care		<ul style="list-style-type: none"> Revisit the recommendations of the 2020 Data and Digital Priorities report from MoH and establish detailed implementation plans, including timelines and responsible parties Increase financial, human, and training resources for the Botswana Health Data Collaborative (BHDC) and formalize their mandate to coordinate for HIS improvements Establish clear tripartite frameworks for the coordination and reporting of data using MoAs
R10. Continued limited and incomplete integration of HIV services with NCDs will erode leadership and public support for the HIV program, making it hard to fill financing gaps as donors taper funding		<ul style="list-style-type: none"> Set timebound and monitorable targets for integration (staff, services, M&E) of HIV and NCDs Publish an annual progress report and disseminate results to national leadership and the public

4.3 Sustaining the Tuberculosis Response





KEY RISKS	LEVEL	RECOMMENDED ACTIVITIES
R11. While the TB program has made important progress in incidence rates, the inadequate levels of case detection and cure rates cause significant avoidable illness and deaths, especially among HIV positive individuals		<ul style="list-style-type: none"> Review the performance of the national TB program and raise the level of ambition, setting higher achievable targets for case detection and treatment success rates and for drug resistant TB
R12. The national TB program remains heavily dependent on outside funding, especially for key staff positions, making it vulnerable to donor winddown or withdrawal of financing. At the same time, the leadership and staffing of the TB program are inadequate for the tasks at hand		<ul style="list-style-type: none"> Re-examine the financial needs of the TB program and the mix of domestic and external funding, and develop a sustainable financing plan for the next 5-7 years as donors reduce their support. There needs to be a corresponding Government commitment to replacing donor financing and including these increased amounts in annual national budgets Develop and implement detailed plans for improved staffing of the TB program and the progressive absorption of donor-financed HR positions, as well as transition of laboratory activities (equipment, consumables, and maintenance) from donors to government
R13. Lack of integration of TB with Botswana's HIV program is inefficient and fails to capture potential synergies between the efforts to fight the twin diseases. The result is unnecessary and wasteful spending that inflates the overall cost of HIV/TB control during a time of transition when external funding is likely to fall and Government budgets to come under increased pressure.		<ul style="list-style-type: none"> Revisit the integration of TB with HIV in terms of organizational structures, budgets, and implementation of activities, at HQ levels and on the ground in districts, health facilities, and communities Develop and implement an action plan to exploit the synergies of integration.

4.4 CSO Engagement

KEY RISKS	LEVEL	RECOMMENDED ACTIVITIES
R14. The very large annual spending on CSOs to support community HIV services (essentially prevention and KVP services) of around USD40 million a year is heavily donor-financed, at around 75% of the total. There is a major risk that these donor funds invested annually by PEPFAR and Global Fund in CSO-delivered HIV services will not be adequately replaced by Government as donors taper funding		<ul style="list-style-type: none"> Agree across GoB, PEPFAR, and GF on an overall budget for CSO contracting and develop a plan for transitioning shares from donors to Government over 5 years Incorporate agreements in Government budgets, PEPFAR COP budgets and sustainability roadmap, and Global Fund grant documents Form an inter-agency committee and conduct annual joint monitoring of financial transition and convergence (see below)
R15. The CSO programs are highly fragmented along lines of the three main funders – Government budget, PEPFAR, and Global Fund – with separate plans, contracts, and information systems. This creates a serious risk of duplication, wasted resources, and reduced impact		<ul style="list-style-type: none"> Start immediately the process for convergence of the three channels for HIV partnership with CSOs – including gradual pooling of funds Adopt a single framework for planning, soliciting and reviewing CSO proposals, awarding contracts, and monitoring performance Provide TA to Government (NAHPA) to set up this unified SC system

KEY RISKS	LEVEL	RECOMMENDED ACTIVITIES
R16. Even though performance based social contracting is supposed to be the norm (2019 Government policy on SC), such performance-linked contracting and financing has not been implemented fully. As donors gradually withdraw from Botswana and the Government becomes the dominant funder of civil society-led work in prevention, community-based HIV services, and KP services, there is a large risk that social contracting will not be adopted, resulting in additional inefficiencies and lower impact		<ul style="list-style-type: none"> As part of convergence, form an action-oriented working group composed of PEPFAR, GF, and NAHPA specialists in CSO contracting, drawing on expertise from beyond e.g., UNAIDS, and international experience Adopt a single unified policy and administrative framework for all CSO contracting, emphasizing performance-based financing and rigorous M&E Monitor and report annually on progress in implementing social contracting, and evaluate its benefits
R17. CSO capacity building and coordination efforts have received substantial funding but have not been fully effective in creating and retaining personnel and skills for sustained high performance by the CSO community. There is a risk that weak capacity and limited coordination will undermine the performance and effectiveness of CSO contributions to the national HIV responses, especially as a large portion of the capacity building has been funded by donors and may not be continued after transition.		<ul style="list-style-type: none"> Set aside an appropriate amount of funds for CSO capacity building and coordination from all three sources (PEPFAR, GF, Government) to create and support a single unified capacity building program and coordination mechanism for the next 3-5 years, using lessons learned and best practices in CSO capacity building

4.5 Human Rights and Legal Environment, Governance and Coordination

KEY RISKS	LEVEL	RECOMMENDED ACTIVITIES
R18. The Government does not institutionalize the HIV Human Rights program in NAHPA or absorb the posts and costs, which relies on the Global Fund for 50% of its support, as GF funding tapers		<ul style="list-style-type: none"> Government to follow through on its commitment to institutionalize the Human Rights team and absorb posts and budget, by 2025 Global Fund to agree with Government on timebound transition plan for Human Rights activities in the next GC7 grant (2025-27)
R19. Key populations rely heavily on donor-funded services delivered by CSOs, reporting less stigma and discrimination than in government facilities. Disruptions to the operation of these services caused by transition could undermine and potentially reverse gains in HIV control among key populations		<ul style="list-style-type: none"> Allocate additional Government budget to combatting stigma and discrimination, including via increased support for CSOs working with KPs and expanded KP representatives in key committees/WGs. Ensure that convergence and budget absorption by the Government goes seamlessly for critical subset of CSOs that implement legal and anti-stigma and discrimination services Improve M&E for stigma and discrimination, e.g. via establishment of bi-annual surveys
R20. Mandates and divisions of labor across Government are not well clarified, especially between NAHPA and MoH at national and district levels, resulting in fragmentation, duplication, wasting of resources, and a weakening of proactive leadership of the national HIV response, including in planning and coordinating the transition process. Unless coordination is strengthened, Botswana will not be able to sustain or surpass strong results achieved to date		<ul style="list-style-type: none"> Create a special task force reporting to the NAHPC and its chair, the Vice President of the country, to re-examine and clarify the roles of respective Government institutions, especially NAHPA and MoH, in areas such as HIV prevention and KVPs Revisit and revise mandates, structures, and coordination mechanisms Ensure maximum efficiency of NAHPC, JOC and TWGs with improved terms of reference, budgets, and sanctions for non-participation Develop and implement systematic planning and monitoring sessions involving NAHPA, MoLG, MoH, PEPFAR, GF, and CSOs in each district, and report results to JOC/NAHPC
R21. The coordination structures and leadership for key policy agendas including the third National Strategic Framework for HIV/AIDS (NSF III) and the Sustainability and Transition Roadmap have not been clearly identified and empowered. Unless corrected, this could reduce the effectiveness of implementation of the national response and of the Roadmap.		<ul style="list-style-type: none"> Streamline coordination structures at national and district level to avoid duplication and “fatigue” Simultaneously reinforce the importance of full participation in NSF III monitoring and Roadmap implementation by stakeholders including NAHPA, MoH, Civil Society, PEPFAR, Global Fund, and UNAIDS, with special oversight by NAHPC to ensure that coordination are participation are taken seriously in practice



Chapter 5.

Sustainability and Transition Roadmap

5.1 What Should a Strong Roadmap Look Like?

As discussed during the Roadmap workshop in Gaborone on 25 October 2023, a successful Roadmap must meet the “3 Fs” criteria: Focused, Financed, and Followed to implementation, with effective monitoring and accountability.

The Roadmap should be a concrete, action-oriented plan with full buy-in from all stakeholders, including Government, civil society, and partners. It should present a limited number of high-value actions with roles, responsibilities, and deadlines explicitly assigned to relevant stakeholders. It must be backed and overseen by an institutional accountability mechanism (led by the Joint Oversight Committee of the National AIDS and Health Promotion Council) to coordinate implementation and hold all parties accountable for their respective responsibilities. Where needed, it should also use focused Thematic Groups under the JOC to bring lead organizations together around key areas of the Roadmap such as Sustainable Financing, Efficiency Gains, and HRH Transition. Actions, timelines, and proposed financial investments should be grounded in realistic expectations for the gradual transition of donor-supported activities to the Government over time.

5.2 Development and Structure of the Roadmap

Based on the identification, assessment, and ranking of risks to the HIV program (see Chapters 1-4) as well as substantial written, virtual, and in-person feedback from a wide range of key stakeholders, the team has drafted the Roadmap matrix below.

The first column of the matrix reproduces the key risks highlighted earlier in this report for each of the four pillar areas along with their color-coded severity ratings. For each risk, recommended “Mitigating Actions” are shown. In comparison with the precursor actions developed in Chapter 4 as part of the STRA phase, these actions have been greatly refined to be more specific, detailed, and focused for results. Mitigating Actions are further broken down into detailed “Implementation Steps.” For each step, the key organization/s (e.g., Ministry of Health, NAHPA, PEPFAR, Global Fund, etc.) are highlighted as “Responsible” for implementation and results, and which organization(s) should be “Consulted” for key inputs and coordination. The column on “Due Date” indicates the proposed deadline for accomplishing the task and/or producing the output described in the step. Discrete, directly monitorable outputs like reports, briefs, plans, and budget documents are shown in red font.

The matrix and accompanying materials reflect current best judgments about the details of what needs to be done to address the main sustainability and transition risks facing Botswana’s HIV program.

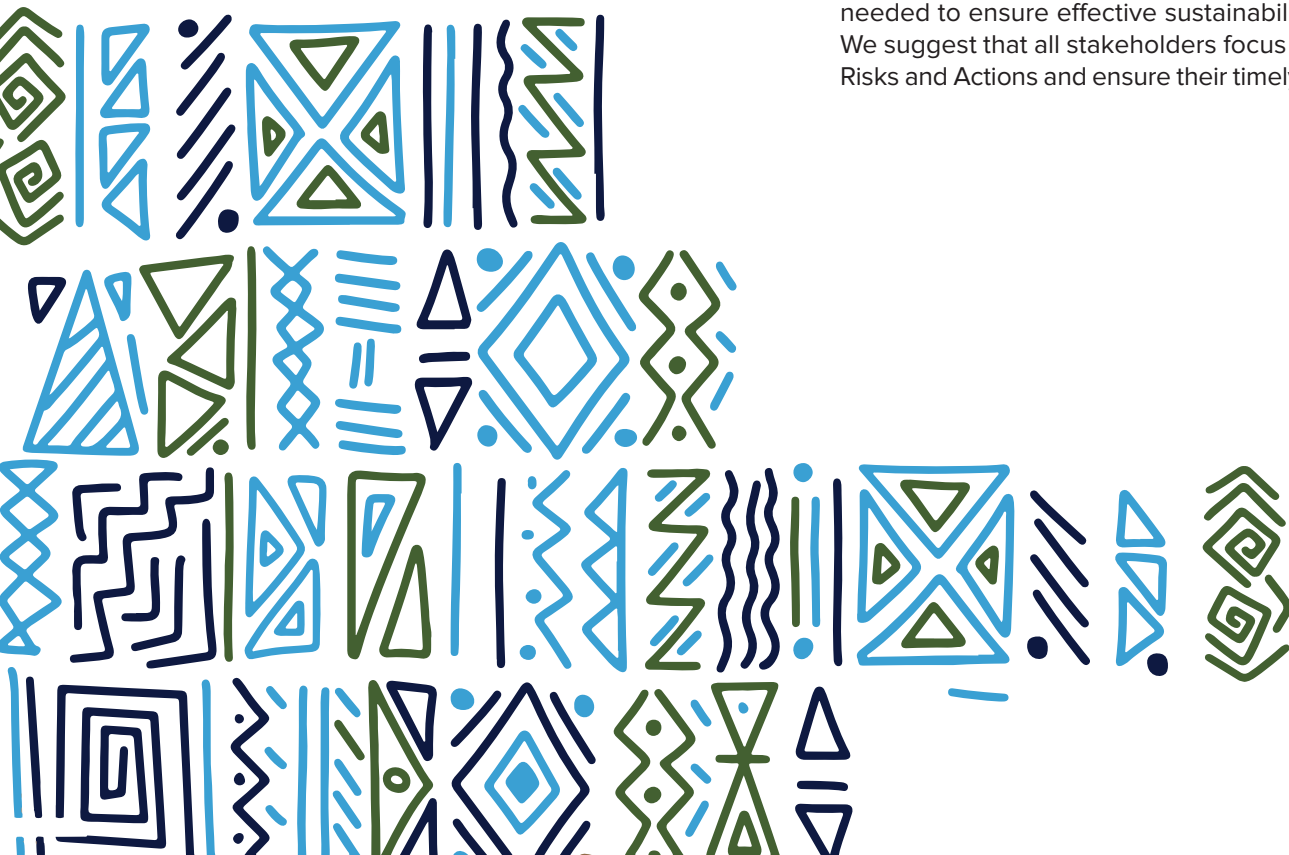
The matrix and accompanying materials reflect current best judgments about the details of what needs to be done to address the main sustainability and transition risks facing Botswana’s HIV program. They have been discussed, revised, and improved through extensive collaboration with key stakeholders across Government, civil society, and international organizations, beginning with virtual and written feedback in September 2023 and continuing in-person during the validation workshop held in Gaborone on 25 October 2023. As part of the workshop, Mitigating Actions were debated and edited, and the nature and timing of Implementation Steps modified based on the detailed knowledge of stakeholders regarding processes and constraints in-country. Despite all of this work, the contents of the matrix are simply a starting point for action. Further development in certain areas as well as periodic stocktaking, evaluation, and adjustment will be important to ensuring that the Roadmap remains fit for purpose in the months and years to come.

5.3 Content of the Roadmap

Botswana stakeholders identified a total of 21 major risks to Sustainability and Transition, as part of the Sustainability and Transition Readiness Assessment (drafted in June and finalized in August 2023). See Chapter 4.

To streamline follow-on implementation efforts, the 5 risks that, while important, involve actions that go beyond the national HIV program and affect the entire health sector, and thus require wider buy-in from the Government, especially the Ministry of Health have been separated out. These relate to overall policy and programs in areas like Supply Chain, Human Resources for Health policy and data, and Health Information Systems. These have been moved to a second matrix (Annex P) entitled “Roadmap of Actions for the Enabling Environment”. Two additional risks were consolidated into the others based on overlap and synergy.

This leaves the primary Roadmap matrix (Table 5.1) with a smaller and more manageable number of 14 “Core” risks where direct improvements in the HIV program are needed to ensure effective sustainability and transition. We suggest that all stakeholders focus on these 14 Core Risks and Actions and ensure their timely implementation.



ROADMAP MATRIX KEY:

Key Risk

Mitigating Action

Implementation Step

Responsible

Consulted

Due Date

FIGURE 5.1: ROADMAP OF CORE ACTIONS BY RISK: FINANCING

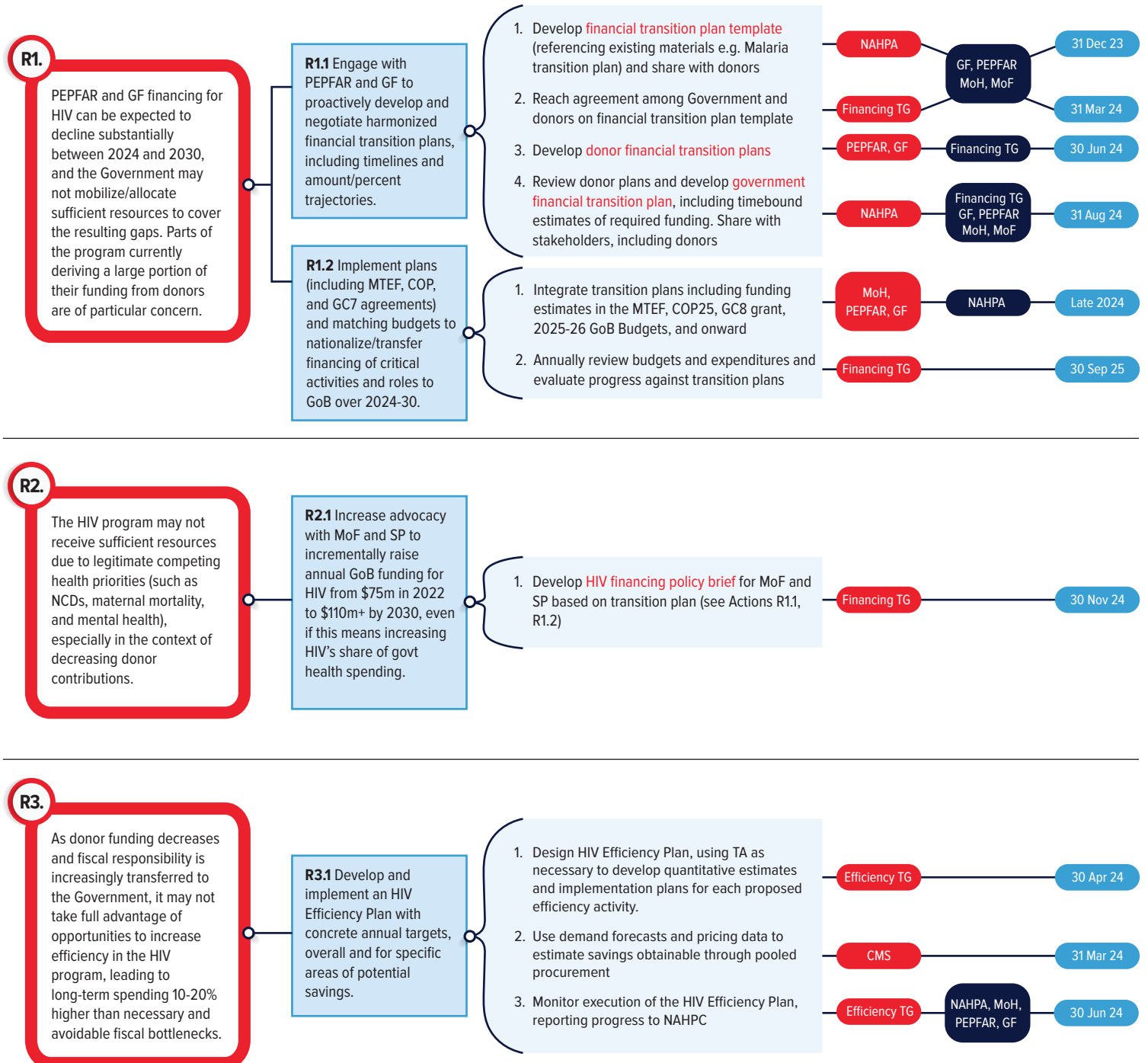


FIGURE 5.2: ROADMAP OF CORE ACTIONS BY RISK: HEALTH SYSTEMS/TB

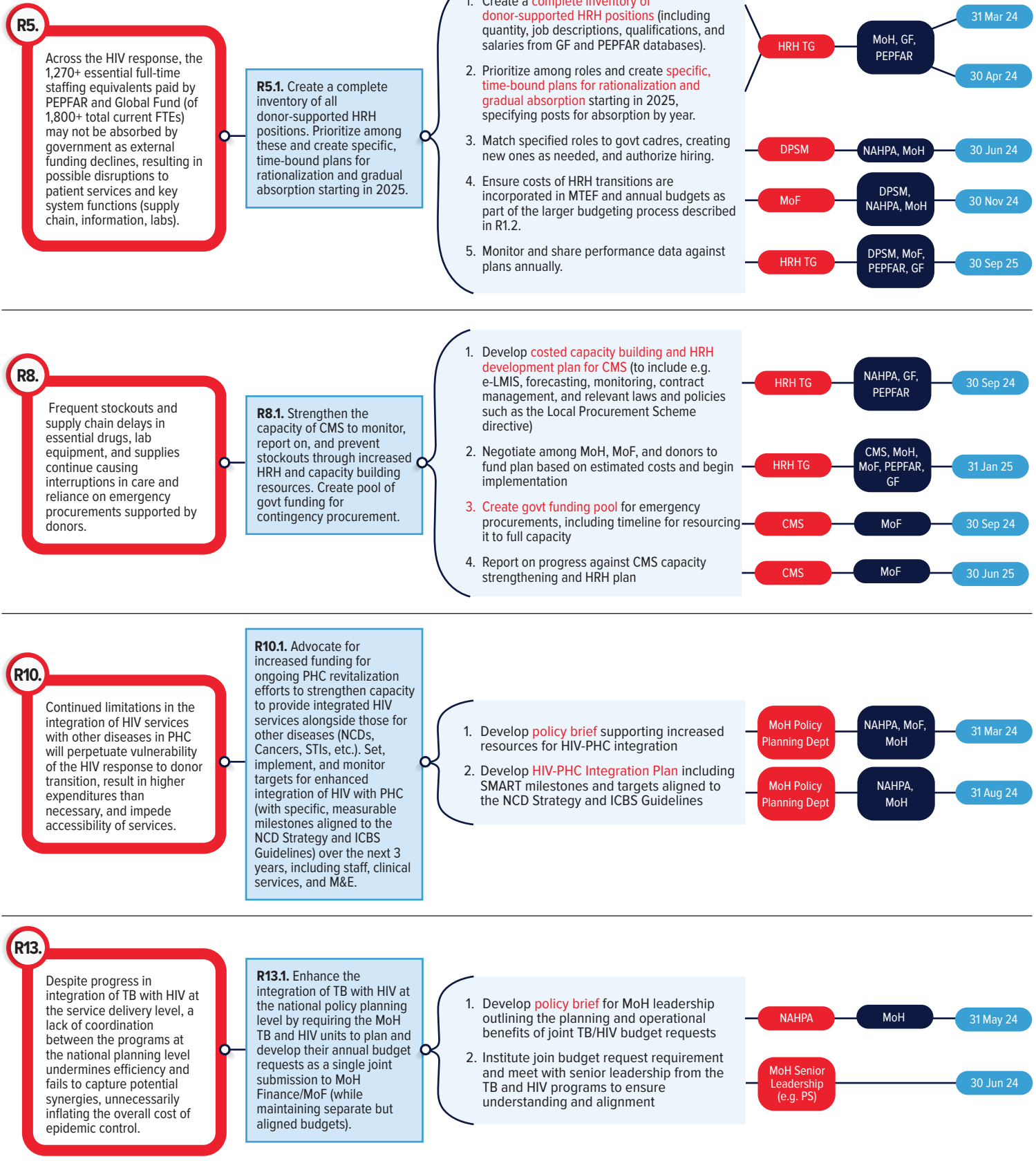


FIGURE 5.3: ROADMAP OF CORE ACTIONS BY RISK: CSO ENGAGEMENT

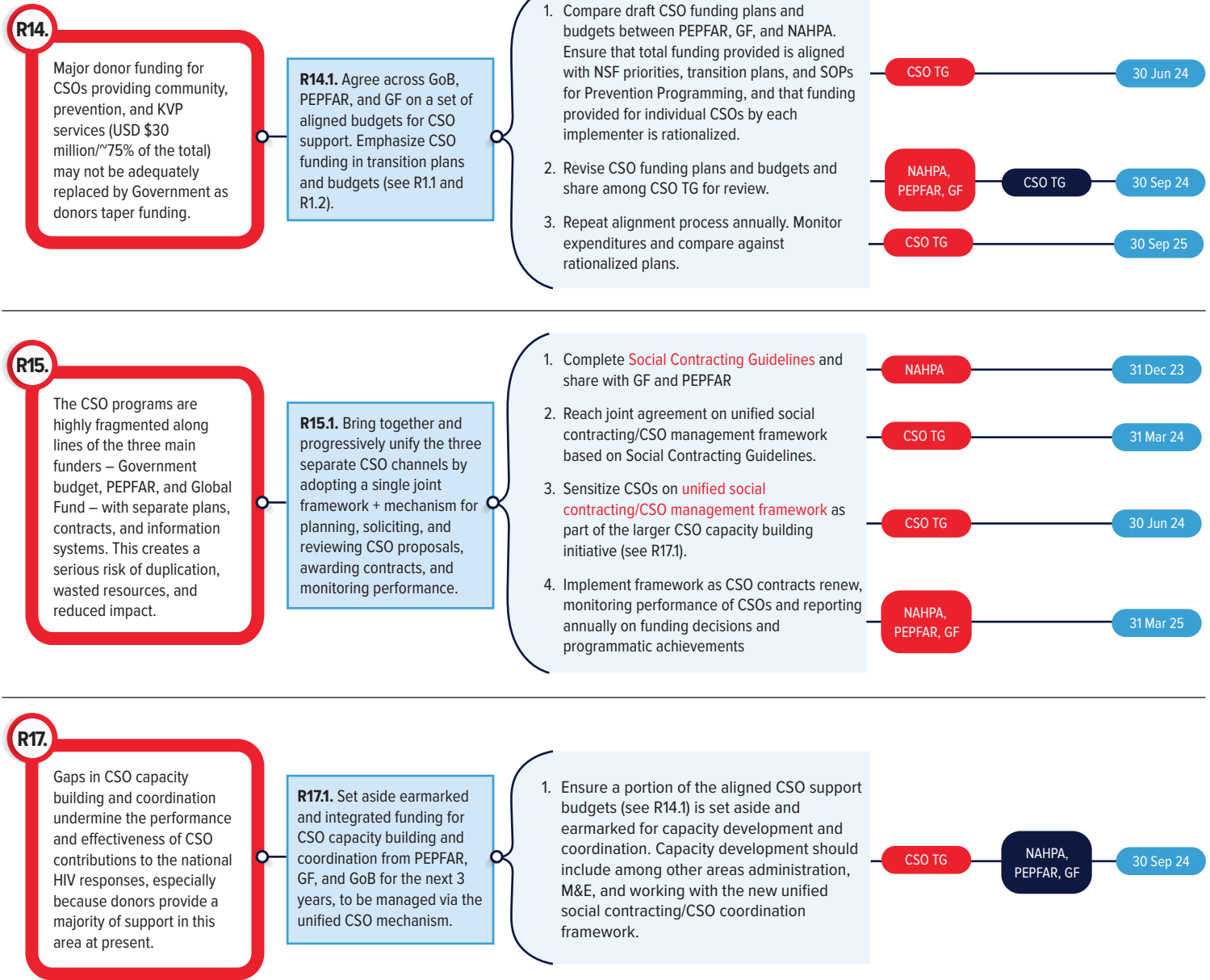


FIGURE 5.4: ROADMAP OF CORE ACTIONS BY RISK: HUMAN RIGHTS, GOVERNANCE, AND COORDINATION

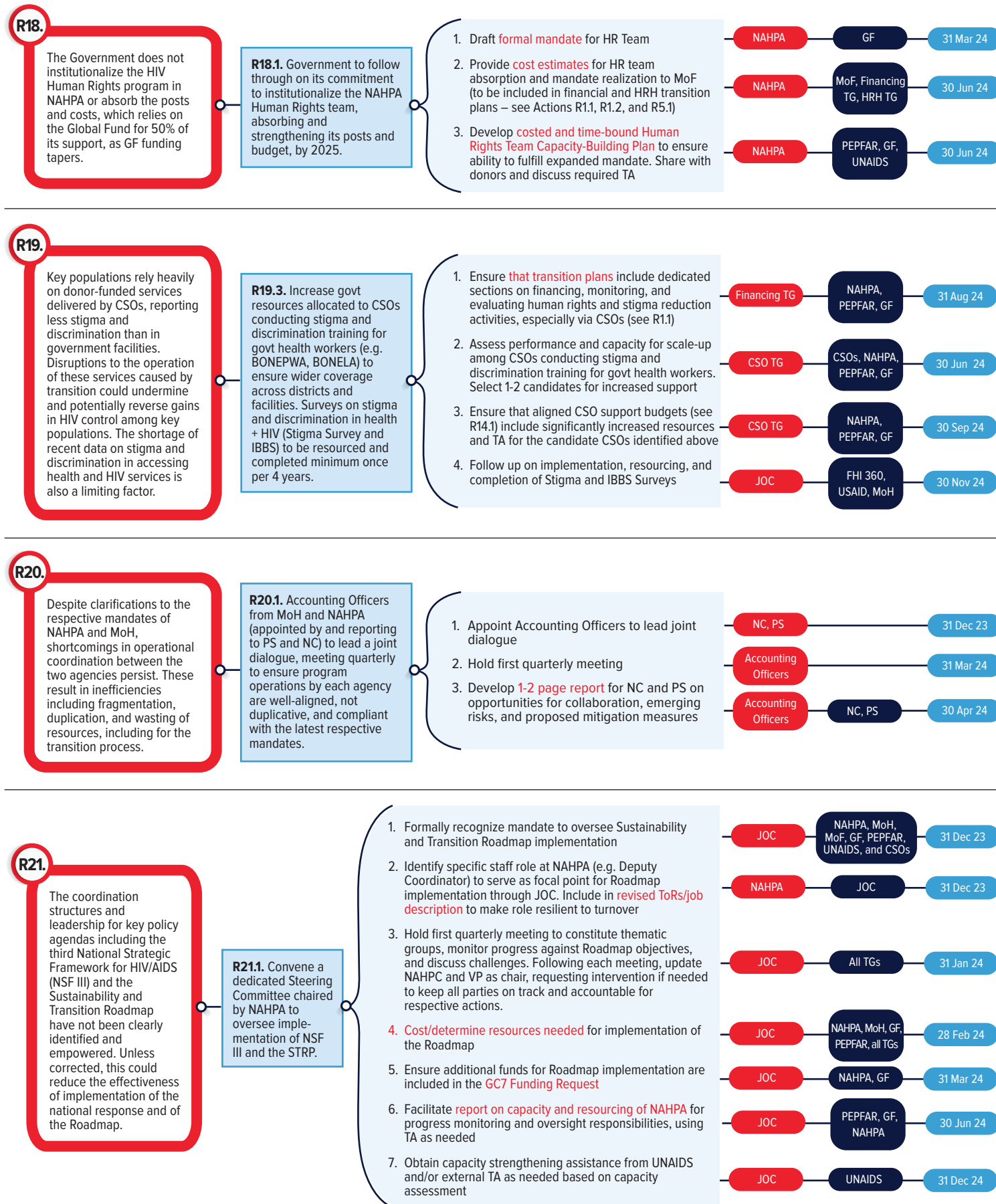
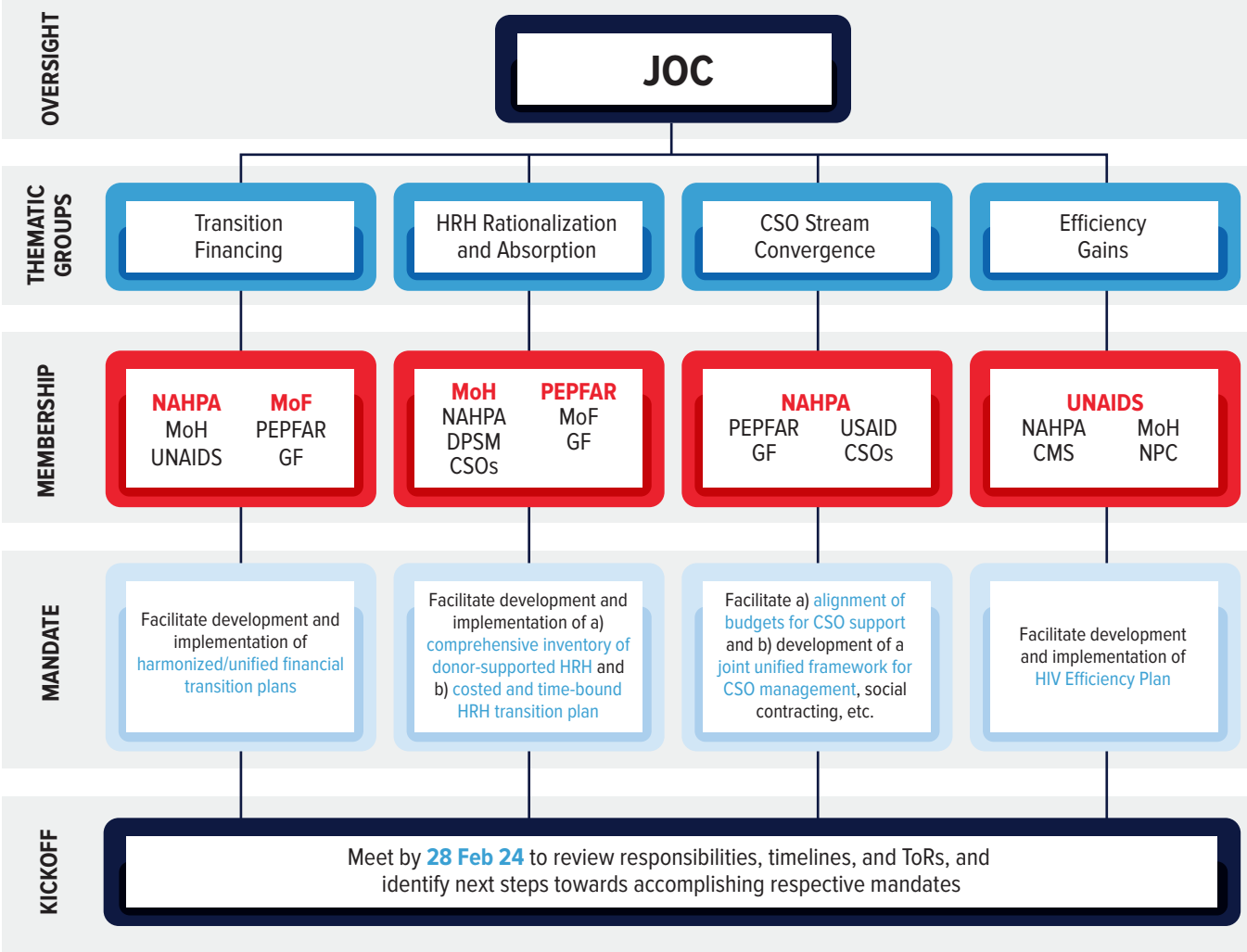


FIGURE 5.5: THEMATIC GROUPS FOR ROADMAP IMPLEMENTATION



The HIV Roadmap represents a huge effort and investment by all stakeholders – public sector, CSO, PEPFAR, Global Fund, UNAIDS, and others – to come together to identify challenges to sustainability and transition of the Botswana HIV program and forge a common plan that everyone buys into, endorses, and commits to implement.

5.4 Thematic Groups

It is recommended that several Thematic Groups (TGs) should be formed in early 2024 under the aegis of the Joint Oversight Committee (JOC) of the National AIDS and Health Promotion Council (NAHPC) to develop and oversee detailed work plans for key action areas such as Transition Financing, Efficiency Gains, Transitioning and Rationalizing Donor-Supported HRH, and Converging the CSO Streams.

The details of these Thematic Groups including the suggested composition, chair, and mandate for each are summarized in Figure 5.5 above. Draft ToRs for the four TGs are shown in Annex K through Annex N.

Each group should be constituted by 31 Jan 24 through the JOC and hold their first meeting no later than 28 Feb 2024. In the first meeting, members can focus on reviewing responsibilities, timelines, and ToRs and on drafting their groups’ respective work plans for the year ahead. These work plans should include well-defined deliverables tied to specific deadlines.

Each TG will be composed of a small number (5-10) of senior officials with technical skills and the ability to put their findings in front of top decision makers in their respective organizations. It may be necessary to augment the capacity of the TG with part-time technical assistance to ensure that data are collected and analyzed, models/templates designed and used, and key reports produced.

5.5 How the Roadmap Should Be Coordinated and Overseen

The HIV Roadmap represents a huge effort and investment by all stakeholders – public sector, CSO, PEPFAR, Global Fund, UNAIDS, and others – to come together to identify challenges to sustainability and transition of the Botswana HIV program and forge a common plan that everyone buys into, endorses, and commits to implement. As the matrix and accompanying materials show, there are multiple actions for each stakeholder to carry out and be accountable for.

To make the Roadmap and its implementation successful over the next three years, it is vital that the stakeholders work together starting as soon as the Roadmap is delivered to the National AIDS Council (this happened on 10 November 2023) and taken up by the Government

for its endorsement and publication (ideally in late 2023 or early 2024).

An overall governance mechanism is needed to continuously monitor progress and problems in the Sustainability and Transition Roadmap, support and hold accountable all participating organizations and individuals, and improve and adjust the Roadmap over time. Based on discussions with key stakeholders, it is recommended that the role of coordinating Roadmap implementation be assigned to the JOC, with high level representation from MoH, MoF, DPSM, PEPFAR, Global Fund, and Civil Society. The JOC reports to the NAHPC and can brief the Office of the President on progress in carrying out the Roadmap.

5.6 Ensuring Implementation of Roadmap Actions and Steps in 2024

The matrix of Actions and Steps contains a robust set of activities that need to be planned and carried out in 2024 and beyond. It can be useful to visualize these activities by quarterly timelines and implementing agency, as shown in the tables below. Timelines of actions for each Thematic Group are also provided in their respective draft ToRs (Annex K through Annex N).

Q4 2023			
IMPLEMENTATION STEP	RESPONSIBLE	OVERSIGHT TG (if any)	DUE DATE
Develop financial transition plan template (referencing existing materials e.g. Malaria transition plan) and share with donors	NAHPA	Financing TG	31 Dec
Complete Social Contracting Guidelines and share with GF and PEPFAR	NAHPA	CSO TG	31 Dec
Appoint Accounting Officers to lead joint dialogue	NC, PS		31 Dec
Formally recognize mandate to oversee Sustainability and Transition Roadmap implementation	JOC		31 Dec
Q1 2024			
IMPLEMENTATION STEP	RESPONSIBLE	OVERSIGHT TG (if any)	DUE DATE
Hold first quarterly meeting to constitute thematic groups, monitor progress against Roadmap objectives, and discuss challenges. Following each meeting, update NAHPC and VP as chair, requesting intervention if needed to keep all parties on track and accountable for respective actions.	JOC		31 Jan
Cost/determine resources needed for implementation of the Roadmap	JOC		28 Feb
Reach agreement among Government and donors on financial transition plan template	Financing TG		31 Mar
Use demand forecasts and pricing data to estimate savings obtainable through pooled procurement	CMS	Efficiency TG	31 Mar
Create a complete inventory of donor-supported HRH positions (including quantity, job descriptions, qualifications, and salaries from GF and PEPFAR databases).	HRH TG		31 Mar
Develop policy brief supporting increased resources for HIV-PHC integration	MoH Policy Planning Dept		31 Mar
Reach joint agreement on unified social contracting/CSO management framework based on Social Contracting Guidelines.	CSO TG		31 Mar
Draft formal mandate for HR Team	NAHPA		31 Mar

Q1 2024			
IMPLEMENTATION STEP	RESPONSIBLE	OVERSIGHT TG (if any)	DUE DATE
Hold first quarterly meeting	Accounting Officers		31 Mar
Ensure additional funds for Roadmap implementation are included in the GC7 Funding Request	JOC	Financing TG	31 Mar
Q2 2024			
IMPLEMENTATION STEP	RESPONSIBLE	OVERSIGHT TG (if any)	DUE DATE
Design HIV Efficiency Plan , using TA as necessary to develop quantitative estimates and implementation plans for each proposed efficiency activity.	Efficiency TG		30 Apr
Prioritize among roles and create specific, time-bound plans for rationalization and gradual absorption starting in 2025, specifying posts for absorption by year.	HRH TG		30 Apr
Develop 1-2 page report for NC and PS on opportunities for collaboration, emerging risks, and proposed mitigation measures	Accounting Officers		30 Apr
Develop policy brief for MoH leadership outlining the planning and operational benefits of joint TB/HIV budget requests	NAHPA		31 May
Develop donor financial transition plans	PEPFAR, GF	Financing TG	30 Jun
Match specified roles to govt cadres, creating new ones as needed, and authorize hiring.	DPSM	HRH TG	30 Jun
Institute join budget request requirement and meet with senior leadership from the TB and HIV programs to ensure understanding and alignment	MoH senior leadership (PS)		30 Jun
Sensitize CSOs on unified social contracting/CSO management framework as part of the larger CSO capacity building initiative (see R17.1).	CSO TG		30 Jun
Assess performance and capacity for scale-up among CSOs conducting stigma and discrimination training for govt health workers. Select 1-2 candidates for increased support	CSO TG		30 Jun
Facilitate report on capacity and resourcing of NAHPA for progress monitoring and oversight responsibilities, using TA as needed	JOC		30 Jun
Q3 2024			
IMPLEMENTATION STEP	RESPONSIBLE	OVERSIGHT TG (if any)	DUE DATE
Review donor plans and develop government financial transition plan , including timebound estimates of required funding. Share with stakeholders, including donors	NAHPA	Financing TG	31 Aug
Develop HIV-PHC Integration Plan including SMART milestones and targets aligned to the NCD Strategy and ICBS Guidelines	MoH Policy Planning Dept		31 Aug
Ensure that transition plans include dedicated sections on financing, monitoring, and evaluating human rights and stigma reduction activities, especially via CSOs (see R1.1)	Financing TG		31 Aug
Develop costed capacity building and HRH development plan for CMS (to include e.g. e-LMIS, forecasting, monitoring, contract management, and relevant laws and policies such as the Local Procurement Scheme	HRH TG		30 Sep
Create government funding pool for emergency procurements, including timeline for resourcing it to full capacity	CMS	Financing TG	30 Sep
Ensure a portion of the aligned CSO support budgets (see R14.1) is set aside and earmarked for capacity development and coordination. Capacity development should include among other areas administration, M&E, and working with the new unified social contracting/CSO coordination framework	CSO TG		30 Sep
Ensure that aligned CSO support budgets (see R14.1) include significantly increased resources and TA for the candidate CSOs performing stigma and discrimination training for government health workers	CSO TG		30 Sep
Q4 2024			
IMPLEMENTATION STEP	RESPONSIBLE	OVERSIGHT TG (if any)	DUE DATE
Develop HIV financing policy brief for MoF and SP based on transition plan (see Actions R1.1, R1.2)	Financing TG		30 Nov
Ensure costs of HRH transitions are incorporated in MTEF and annual budgets as part of the larger budgeting process described in R1.2.	MoF	HRH TG	30 Nov

IMPLEMENTATION STEP	RESPONSIBLE	OVERSIGHT TG (if any)	DUE DATE
Follow up on implementation, resourcing, and completion of Stigma and IBBS Surveys	JOC		30 Nov
Obtain capacity strengthening assistance from UNAIDS and/or external TA as needed based on capacity assessment	JOC		31 Dec

5.7 Actions by Lead Agency

For ease of interpretation and use, Annex O lists the main recommended Mitigating Actions by Lead Agency, including proposed deadlines for the first major steps in implementing that action during the coming year of 2024. It is important for the success of the Roadmap to move forward decisively in 2024 on each of main Action areas, so that momentum is maintained.

Note that all principal stakeholders, including NAHPA, Ministry of Health, Ministry of Finance, Department of Public Service Management, PEPFAR, Global Fund, Civil Society, and UNAIDS, have their “checklist of actions.”

5.8 What Needs to Happen Next?

1. Moving forward, each stakeholder group should review, refine, and verbally subscribe to the key list of actions that it is expected to undertake as part of the Roadmap. See Annex O and Figure 5.1 through Figure 5.4.
2. The full STRA and Roadmap need to be endorsed by members of the Reference Group and the key institutions they represent. The Government has indicated that it intends to put this report through the standard internal review process that will lead to the Roadmap being approved by the Government and published next year as a national policy guidance document.
3. The JOC’s capacity as the overall coordinator of Roadmap implementation needs to be assessed and strengthened, and a detailed monitoring plan established.
4. The Thematic Groups need to be established, develop their work plans, and receive the needed technical backing to carry out their important implementation and coordination responsibilities.

5. Finally, the major actions listed in the Roadmap need to be carried over into the key documents of the three main funding organizations (Government, PEPFAR, and Global Fund) that will drive the sustainability and transition process: the Government of Botswana’s NSF III/IV, the Medium-Term Expenditure Framework, and annual budgets; PEPFAR’s COP 24-25 and COP 26-27; and the Global Fund’s CG7 Funding Request and Grant Agreements, including its Funding Landscape Tables, grant budgets, performance frameworks, and the Government’s cofinancing commitment letter. Experience from other countries shows that the Roadmap will have maximum impact if it is translated directly into financing decisions by the main sources of funding for the HIV response.

5.9 Conclusion

If Botswana and its partners truly commit to implementing the HIV Sustainability and Transition Roadmap, the country will once again be a pioneer and trend-setter in the Africa region, joining other UMICs like Thailand in moving largely away from external financing of the national HIV response while increasing self-reliance and sustaining a highly successful HIV program. By following the Roadmap, Botswana can continue to surpass the 95-95-95 targets and utilize partnerships with civil society to reach key populations and prevent new infections. This will require that the main external partners, especially PEPFAR and the Global Fund, align their financing and focus with the Roadmap actions to be undertaken by the Government. This will also make Botswana a shining example globally in how best to develop and implement a common HIV Roadmap, earning the respect and buy-in of all stakeholders.

If Botswana and its partners truly commit to implementing the HIV Sustainability and Transition Roadmap, the country will once again be a pioneer and trend-setter in the Africa region, joining other UMICs like Thailand in moving largely away from external financing of the national HIV response while increasing self-reliance and sustaining a highly successful HIV program.

Annexes

Annex A: List of Organizations and Individuals Consulted

Type	Organization	Interviewee/Participant	Title
CSO	ACHAP	Blessed Monyatsi	Programs Manager
CSO	ACHAP	Khumo Seipone	Chief Executive Officer
CSO	ATN	Thabo Katlholo	Executive Director
CSO	BBCA Mahalapye	Frank Mosikare	Programmes
CSO	BBCA Mahalapye	Gladys Phokoje	Coordinator
CSO	BBCA Mahalapye	Rose Ramatsitla	Programmes
CSO	BHUMMI	Botshelo Kgwaadira	Senior Technical Advisor-Tuberculosis
CSO	BHUMMI	Ndwapi Ndwapi	Chief Executive Officer
CSO	BOCHAIP - Gaborone	Boitumelo Morapedi	Technical Director
CSO	BOCHAIP - Gaborone	Bonolo Kelefang	Programmes manager
CSO	BOCHAIP - Gaborone	Dr. Nankie Ramabu	M&E Specialist
CSO	BOCHAIP - Gaborone	Lorato Mphusu	Executive Director
CSO	BOCHAIP - Gaborone	Mpiwa Moatshe	Acting Finance and Administration Manager
CSO	BOCHAIP - Gaborone	Pelontle Gakelebale	HR Manager
CSO	BOCHAIP - Serowe	Milton Innyambo	Coordinator
CSO	BONASO	Gobe Taziba	Executive Director
CSO	BONELA	Nana Gleeson	Finance and Resource Mobilization Manager
CSO	BONEPWA, Marang - Serowe	Edmond Bodilenyane & support group members	
CSO	Botswana Network of Mental Health	Charity Kennedy	Executive Director
CSO	Business Botswana Coalition on AIDs (BBCA)	Mr. Frank Phatshwane	Executive Director
CSO	DREAMS - Serowe	Ms Tduetso Ditlele	Coordinator
CSO	Humana - Palapye	Eldah Mudongo	Coordinator
CSO	LEGABIBO	Botshelo Moilwa	Executive Director
CSO	LEGABIBO	Thato Moruti	Programme Manager
CSO	Makgabaneng	Tony Buru	Executive Director
CSO	Mopipi International - Gaborone	Macintoch Mapai	Finance manager
CSO	Mopipi International - Gaborone	Ms Mpho Fani	Coordinator
CSO	Mopipi International - Gaborone	Resego Nthaga	M&E
CSO	Mopipi International - Palapye	Scara Karabo	Coordinator
CSO	Sizonke - Palapye	Baking Ndaba	Coordinator
CSO	Sizonke - Palapye	Tosh Beka	Programmes
CSO	Tebelopele - Gaborone	Bruce Jeremia	
CSO	Tebelopele - Gaborone	Dr. Gaone Makwinja	Executive Director
CSO	Tebelopele - Gaborone	Mpho Leonard	

Type	Organization	Interviewee/Participant	Title
CSO	Tebelopele - Gaborone	Oteng Magano	
CSO	Tebelopele - Gaborone	Rapelang R. Monnaatlala	Business Development Manager
CSO	Tebelopele - Mahalapye	Boineelo Diseko	Coordinator
Dev. Partner	GiZ	Daniel Bagwitz	Country Director, Botswana and SADC
Dev. Partner	Global Fund	Anthony Kinghorn	Health Financing Specialist
Dev. Partner	Global Fund	Betty Ochieng	Fund Portfolio Manager, Botswana
Dev. Partner	Global Fund PMU	Diana Meswele	Human Rights and Key Populations Coordinator
Dev. Partner	Global Fund PMU	Disang Mokwape	Finance Director
Dev. Partner	Global Fund PMU	Gaolathe Matshwere	Program Officer
Dev. Partner	Global Fund PMU	Hamilton Mogatusi	Grant Coordinator
Dev. Partner	Global Fund PMU	Kealeboga Lekgathanye	Monitoring and Evaluation
Dev. Partner	PEPFAR	Emmanuel Mafoko	PEPFAR DREAMS Coordinator
Dev. Partner	PEPFAR	Grace O. Ajayi	Deputy PEPFAR Country Coordinator
Dev. Partner	PEPFAR	Steve Hong	CDC Director
Dev. Partner	PEPFAR	Yemi Oshodi	Interim PEPFAR Botswana Country Coordinator
Dev. Partner	PEPFAR/ USAID	Abimbola Kola-Jebutu	Health Systems & Finance Advisor
Dev. Partner	PEPFAR/ USAID	Tebogo Kamodi	Development Assistance Specialist- HIV
Dev. Partner	PEPFAR/CDC	Catherine Motswere Chirwa	Public Health Specialist-PMTCT
Dev. Partner	PEPFAR/CDC	Joe Kabomo	Monitoring, Reporting and Evaluation Specialist at Peace Corps
Dev. Partner	PEPFAR/CDC	Lisa Esapa	Cooperative Agreements
Dev. Partner	PEPFAR/CDC	Mosetsana Modukanele	Laboratory Systems Specialist
Dev. Partner	PEPFAR/CDC	Mothusi Keatshotswe	TB/HIV Specialist
Dev. Partner	PEPFAR/CDC	Peter Loeto	HTS Coordinator
Dev. Partner	PEPFAR/CDC	Phenyo Lekone	Strategic Information Lead
Dev. Partner	PEPFAR/CDC	Ronald Wandira	Male circumcision (MC) and Cervical Cancer (CECAP) programs
Dev. Partner	PEPFAR/USAID	Lesego Kitso	Supply Chain Specialist
Dev. Partner	PEPFAR/USAID	Morongwa Dikgang	Project Management Specialist
Dev. Partner	UN	Zia Choudhury	UN Resident Coordinator
Dev. Partner	UNAIDS	Alankar Malviya	UNAIDS Botswana Country Director
Dev. Partner	UNAIDS	Chiweni Chimbwete	Fast Track Advisor
Dev. Partner	UNDP	Balázs Horváth	UNDP Representative
Dev. Partner	USAID Chemonics	Ashenafi Desta Hordofa	Logistics Management Unit (LMU) Advisor
Dev. Partner	USAID Chemonics	Oatsi Bolotsang	M&E Supply Chain Officer
Dev. Partner	USAID Chemonics	Omphile Badubi	Supply Chain Technical Advisor
Dev. Partner	USAID Chemonics	Phetogo Phoi	Country Director
Dev. Partner	WHO	Josephine Namboze	WHO Representative
Dev. Partner	WHO	Josephine Namboze	WHO Representative
Dev. Partner	WHO	Tebogo Madidimalo	Head of Communicable Diseases cluster
Govt	CMS	Bene Paramadhas	Chief Pharmacist - Procurement Unit
Govt	CMS	Kereng Mphoyakgosi	Procurement Unit
Govt	CMS	Kesego Phuthego	Finance
Govt	CMS	Kesetsenao Petso	HR and Administration
Govt	CMS	Onalenna Seitso Kgokgwe	DPS/Acting Head of Central Medical Stores

Type	Organization	Interviewee/Participant	Title
Govt	CMS	Paulina Tsiu	Contracts
Govt	CMS	Tebogo Gobotswang	LMU
Govt	MoF	Boipelo Molefe	Chief Economist, Development Cooperation
Govt	MoF	Boniface Mphetlthe	Secretary for Budget
Govt	MoF	Kealeboga Molelowatladi	Ag. Permanent Secretary
Govt	MoF	Olebogeng Moipisi	Director of Recurrent budget
Govt	MoF	Peggy Serame	Minister of Finance
Govt	MoF	Phineas Kgosimotho	Ag. Director and Desk Officer for Ministry of Health
Govt	MoF	Sayed Timuno	Director, Research Department
Govt	MoF	Tuelo Lebentlele	Principal Economist, Development Cooperation
Govt	MoH	Bene Ntwayagae	VMC Coordinator
Govt	MoH	Edwin Dikoloti	Minister of Health
Govt	MoH	Elang Thomas	Training Coordinator
Govt	MoH	Eldah Dintwa	Prevention Coordinator
Govt	MoH	Grace Muzwila	Permanent Secretary of Health
Govt	MoH	Judith Nawa	Director - Health Services Monitoring & Evaluation, Quality Assurance (HSMEQA)
Govt	MoH	Kerileng Matsilo Thela	Deputy Director, Health Policy, Planning, and Financing
Govt	MoH	Max Kapanda	Principal Medical Officer National ART Program
Govt	MoH	Onalenna Mokwena	Health Financing Specialist
Govt	MoH	Phapizo Gilbert	Active Case Finding Officer Seconded to MoH by Global Fund
Govt	MoH	Shepard Shamu	Senior Technical Advisor-Health Financing
Govt	MoH	Thamiso Sebolao	Health Financing Officer
Govt	MoH	Tony Chebani	Chief Health Officer - Health Services Monitoring & Evaluation, Quality Assurance (HSMEQA)
Govt	MoH	Tuduetso Molefhi	National TB Coordinator
Govt	MoLGD	Eric Molale	Minister of Local Government and Development
Govt	NAHPA	Chawapiwa Mahlaya	National Dreams Coordinator
Govt	NAHPA	Kabo Moseki	Chief Executive Coordinator - Country Coordinating Mechanism
Govt	NAHPA	Lefetogile Bogosing	
Govt	NAHPA	Mogorotsi Maphane	PEPFAR Grant Coordinator
Govt	NAHPA	Ontiretse Letlhare	National Coordinator
Govt	NAHPA	Titus Simon	
Govt	NAHPA	Wabona Seitshiro	Program Manager
Govt	Office of the President	Slumber Tsogwane	Vice President/Acting President
Private	BPOMAS	Dr Lorato Mangadi	Operations Manager
Private	BPOMAS	Thulaganyo Molebatsi	CEO
Private	MediTech/ Segofala Health	Kabelo Mokgacha	Managing Director
Private	MediTech/ Segofala Health	Sushanth Pillai	Managing Director

Annex B: Process Documentation of Meetings, Presentations, and Workshops

Date	Organization	Topic
28 Mar 23	Reference Group & JOC	Kickoff Meeting
25 Apr 23	Mopipi	STRA Risks and Evidence
25 Apr 23	Legabibo	STRA Risks and Evidence
26 Apr 23	BBCA	STRA Risks and Evidence
27 Apr 23	BONASO	STRA Risks and Evidence
2 May 23	Makgabaneng	STRA Risks and Evidence
9 May 23	Anti-Tobacco Network	STRA Risks and Evidence
10 May 23	Botswana Network of Mental Health	STRA Risks and Evidence
23 May 23	Mahalapye DHMT	STRA Risks and Evidence
23 May 23	Tebelopele Mahalapye	STRA Risks and Evidence
24 May 23	Serowe DHMT	STRA Risks and Evidence
24 May 23	BOCHAIP Serowe	STRA Risks and Evidence
24 May 23	DAC Serowe	STRA Risks and Evidence
25 May 23	Palapye DHMT	STRA Risks and Evidence
25 May 23	DAC Palapye	STRA Risks and Evidence
25 May 23	BONELA	STRA Risks and Evidence
30 May 23	NAHPA	STRA Risks and Evidence
30 May 23	UNAIDS Country Director, PEPFAR Director, CDC	STRA Risks and Evidence
31 May 23	BONELA	STRA Risks and Evidence
31 May 23	Tebelopele	STRA Risks and Evidence
31 May 23	Office of the Vice-President + Ministers and Cabinet members	Presentation of Preliminary Risks and Evidence
31 May 23	Chemonics Botswana	STRA Risks and Evidence
2 Jun 23	MoH (CMS)	STRA Risks and Evidence
2 Jun 23	GF	
2 Jun 23	PEPFAR - CDC	STRA Risks and Evidence
5 Jun 23	BHUMMI	STRA Risks and Evidence
5 Jun 23	FHI 360	STRA Risks and Evidence
6 Jun 23	Debswana	STRA Risks and Evidence
6 Jun 23	Lucara	STRA Risks and Evidence
6 Jun 23	FNB	STRA Risks and Evidence
6 Jun 23	BPOMAS	STRA Risks and Evidence
6 Jun 23	Private Medical Association	STRA Risks and Evidence
7 Jun 23	Reference Group & JOC	Presentation of STRA
8 Jun 23	NAHPC	Presentation of STRA
9 Jun 23	MoH (Director of Health Services)	STRA Risks and Evidence
9 Jun 23	MoH (Partnerships)	STRA Risks and Evidence
9 Jun 23	DREAMS	STRA Risks and Evidence
9 Jun 23	Palladium	STRA Risks and Evidence
12 Jun 23	BONEPWA	STRA Risks and Evidence
12 Jun 23	BOCHAIP	STRA Risks and Evidence
12 Jun 23	ACHAP	STRA Risks and Evidence
12 Jun 23	BONASO	STRA Risks and Evidence
13 Jun 23	UNAIDS	STRA Risks and Evidence
13 Jun 23	GIZ	STRA Risks and Evidence

Date	Organization	Topic
13 Jun 23	CDC (HMIS)	STRA Risks and Evidence
14 Jun 23	MoH (KITSO Training)	STRA Risks and Evidence
14 Jun 23	PEPFAR-USAID	STRA Risks and Evidence
15 Jun 23	MoH (HMIS)	STRA Risks and Evidence
15 Jun 23	MoH (CMS)	STRA Risks and Evidence
15 Jun 23	MoH (STI, Treatment, Prevention, VMMC, PMTCT, HMIS, Clinical Services, Policy and Planning)	STRA Risks and Evidence
15 Jun 23	UN Council Botswana (UNAIDS, UNICEF, WHO, WB, UNDP, UNFPA)	Presentation of STRA
16 Jun 23	UNDP	STRA Risks and Evidence
16 Jun 23	CCM	STRA Risks and Evidence
20 Jun 23	Avenir Health	STRA Risks and Evidence
21 Jun 23	UNAIDS	Presentation of STRA
22 Jun 23	HMIS IPMS MEDITECH	STRA Risks and Evidence
26 Jun 23	GF	STRA Risks and Evidence
13 Jul 23	WHO	STRA Risks and Evidence
19 Jul 23	BUMMHI TB/HIV	STRA Risks and Evidence
20 Jul 23	BNTF	STRA Risks and Evidence
21 Jul 23	PEPFAR - CDC TB	STRA Risks and Evidence
26 Jul 23	GF PMU TB	STRA Risks and Evidence
15 Aug 23	Reference Group	Presentation of STRA
16 Oct 23	Reference Group & JOC	Presentation of draft Roadmap
25 Oct 23	Various (80+ participants)	Roadmap Validation Workshop
26 Oct 23	PEPFAR	Roadmap and Implementation Plan
26 Oct 23	MoH (Senior Leadership from Various Units)	Roadmap and Implementation Plan
27 Oct 23	DPSM	Roadmap and Implementation Plan
27 Oct 23	MoF	Roadmap and Implementation Plan
27 Oct 23	GF implementation plan and roadmap	Roadmap and Implementation Plan
27 Oct 23	NAHPA	Roadmap and Implementation Plan
10 Nov 23	Presentation of Roadmap to NAHPC	Roadmap and Implementation Plan

Annex C: ART Coverage by Public vs Private Sector

Indicator	2018	2019	2020	2021	2022 (Projection)
Total # of PLHIV accessing ART	313,283	313,850	330,728	335,262	345,079
# PLHIV accessing ART in private sector	20,731	19,881	20,079	22,020	22,047
% PLHIV Private Sector	6.62%	6.33%	6.07%	6.57%	6.39%
# PLHIV accessing ART in public sector	292,552	293,969	310,649	313,242	323,032
% PLHIV Private Sector	93.38%	93.67%	93.93%	93.43%	93.61%

Source: Botswana Council of Medical AIDS Schemes, Annual Report 2022, Gaborone.

Annex D: BWP to USD Conversion Rate 2012-2023



Source: International Monetary Fund, Exchange Rate Archives, Washington, DC. https://www.imf.org/external/np/fin/data/param_rms_mth.aspx.

Annex E: PEPFAR Spending on INGOs by Program Area and Intervention

	2021	2022
INGOs	14,633,132	9,838,910
Above site programs (ASP)	771,303	893,707
HMIS, surveillance, & research	329,688	103,444
Human resources for health		160,350
Laboratory systems strengthening	205,037	335,366
Laws, regulations & policy environment		
Not Disaggregated		
Policy, planning, coordination & management of disease control programs		49,139
Procurement & supply chain management	236,578	245,408
Care and Treatment (C&T)	2,222,001	1,630,551
HIV Clinical Services	1,920,729	1,112,197
HIV Drugs	230,334	106,803
HIV Laboratory Services		350,235
Not Disaggregated	70,938	61,316
HIV Testing Services (HTS)	532,329	341,960
Community-based testing	404,059	341,960
Facility-based testing		
Not Disaggregated	128,270	
Program Management (PM)	4,104,209	3,322,514
IM Closeout costs	223,545	
IM Program Management	3,880,664	3,322,514
Prevention (PREV)	5,143,969	2,400,005
Comm. mobilization, behavior & norms change	997,336	1,225,474
Not Disaggregated	2,067,059	171,485
PrEP	174,124	43,320
Primary prevention of HIV and sexual violence	1,781,288	736,113
VMMC	124,162	223,613
Socio-Economic (SE)	1,859,321	1,250,173
Case Management	242,452	278,384
Economic strengthening	709,690	220,918
Education assistance	105,982	25,226
Legal, human rights & protection	139,373	64,422
Not Disaggregated	310,575	505,691
Psychosocial support	351,249	155,532

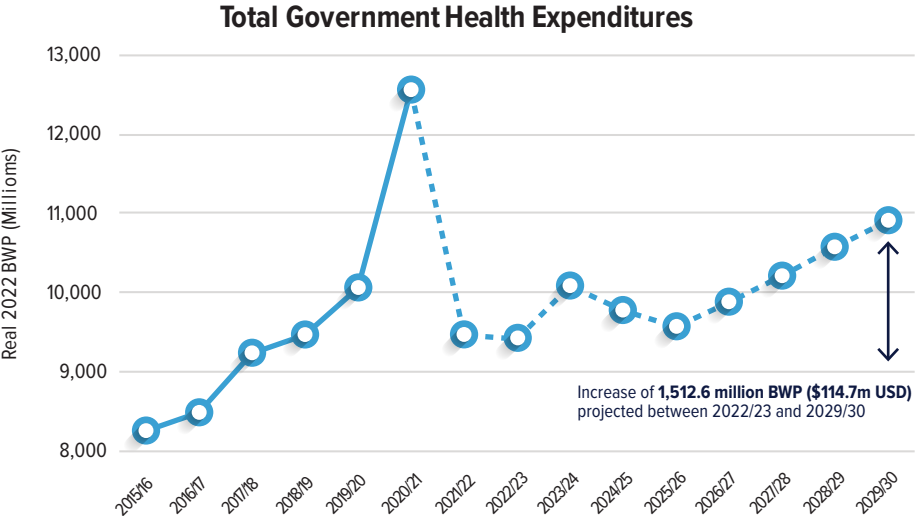
Source: Unpublished data provided by PEPFAR/USAID Botswana Office, hand delivered by PEPFAR county coordinator to study team on Friday June 9th.

Annex F: PEPFAR Spending on Local NGOs by Program Area and Intervention

LOCAL NGO	26,855,519	28,230,563
Above site programs (ASP)	1,592,227	1,223,816
HMIS, surveillance, & research	1,592,227	1,136,346
Laboratory systems strengthening		87,470
Care and Treatment (C&T)	9,012,648	7,860,837
HIV Clinical Services	5,451,886	3,924,318
HIV Drugs	231,289	
HIV Laboratory Services	1,751,240	2,554,943
Not Disaggregated	1,578,233	1,381,576
HIV Testing Services (HTS)	1,638,913	849,752
Community-based testing	193,675	221,369
Facility-based testing	992,408	585,562
Not Disaggregated	452,830	42,821
Program Management (PM)	7,630,256	7,919,091
IM Closeout costs	114,860	13,307
IM Program Management	7,515,396	7,905,784
Prevention (PREV)	5,598,571	7,227,966
Comm. mobilization, behavior & norms change	1,549,940	1,643,356
Not Disaggregated	2,769,586	2,704,151
PrEP		192,112
Primary prevention of HIV and sexual violence	112,825	1,510,129
VMMC	1,166,220	1,178,218
Socio-Economic (SE)	1,382,904	3,149,101
Case Management	156,936	365,295
Economic strengthening	472,804	1,451,543
Education assistance		77,965
Legal, human rights & protection	89,522	93,467
Not Disaggregated	262,452	823,052
Psychosocial support	401,190	337,779

Source: Unpublished data provided by PEPFAR/USAID Botswana Office, hand delivered by PEPFAR county coordinator to study team on Friday June 9th.

Annex G: Projected Growth in Government Health Expenditures



Note: Assuming 12.3% GHE-D/GGE-D ratio
 Source: International Monetary Fund, World Economic Outlook 2023, <https://www.imf.org/en/Publications/WEO/Issues/2023/10/10/world-economic-outlook-october-2023>;
 Bank of Botswana, Botswana Economic and Financial Statistics, <https://www.bankofbotswana.bw/botswana-economic-and-financial-statistics>.

Annex H: Mahalapye District Stockouts 2021-2023

Stock-outs	Creatinine (Renal function test_ ARV drug therapy monitoring)	AST (Liver function test_ ARV drug therapy monitoring)	ALT (Liver function test_ ARV drug therapy monitoring)
Stock out episode: 2020	1/5/2020: No stock available, test suspended		
	14/5/2020: Hospital resorts to Micro-procurement		
	1/6/2020: No stock available, running only urgent tests		
	21/7/2020: Hospital resorts to Micro-procurement		
	14/8/2020: Delivery of stock received from CMS		
Stock out episode: 2021		29/11/2021: low stock only running urgent tests	29/11/2021: No stock, test suspended
Stock out episode: 2022		23/3/2022: Almost four months later delivery received from CMS and supply stabilized	4/3/2022: No stock, testing suspended. Testing suspended for over two (2) weeks; 23/3/2022: stocks delivered

Source: Mahalapye DHMT Laboratory (May 2023), data handed to study team during district field visit, May 2023.

Annex I: PEPFAR HRH Support 2022

FY2022 HRH Staffing Footprint Summary Grid					
Cadre Group Category	Employment Title	Total Annual FTEs	% of FTEs	Individuals	% of Individuals
Total		1,839.94	100.00%	2,502	100.00%
Community Staff	Community Health Worker	222.74	12.11%	235	9.39%
	Community Mobilizer / Facilitator	148.89	8.09%	204	8.15%
	DREAMS Mentor	77.26	4.20%	210	8.39%
	Economic Strengthening Facilitator	16.75	0.91%	17	0.68%
	Expert Client	49.00	2.66%	49	1.96%
	HIV Diagnostic Assistant	13.00	0.71%	13	0.52%
	Lay Counselor	69.03	3.75%	98	3.92%
	Lay worker providing adherence support	20.00	1.09%	20	0.80%
	Linkage Navigator	50.00	2.72%	80	3.20%
	Other community-based cadre	4.32	0.23%	18	0.72%
	Peer Educator	27.89	1.52%	46	1.84%
	Peer Navigator	49.44	2.69%	54	2.16%
	Prevention of HIV and Sexual Abuse Facilitator	11.00	0.60%	15	0.60%
Implementing Mechanism Program Management Staff	Accounting Staff	13.34	0.72%	17	0.68%
	Administrative Staff	32.50	1.77%	52	2.08%
	Finance Staff	34.74	1.89%	55	2.20%
	Other Program Management Staff	69.54	3.78%	114	4.56%
	Procurement / Grants Management Staff	9.64	0.52%	19	0.76%
Laboratory	Laboratory Assistant/Phlebotomist	31.42	1.71%	35	1.40%
	Laboratory Technologist/Technician	10.50	0.57%	11	0.44%
Medical	Clinical Officer	13.33	0.72%	14	0.56%
	Doctor	4.33	0.24%	6	0.24%
	Medical Assistant	6.00	0.33%	6	0.24%
Nursing / Midwifery	Auxiliary Nurse	3.75	0.20%	6	0.24%
	Nurse	38.54	2.09%	46	1.84%
Other Clinical Provider	Other clinical provider not listed	2.92	0.16%	3	0.12%
	Testing and Counseling Provider	128.08	6.96%	146	5.84%
Other Professional Staff	Biostatistician	0.85	0.05%	3	0.12%
	Data Clerk	120.75	6.56%	132	5.28%
	Data Managers	3.89	0.21%	7	0.28%
	Data Officer	81.00	4.40%	90	3.60%
	Epidemiologists	1.85	0.10%	3	0.12%
	Facility Administrator	0.55	0.03%	1	0.04%
	Human Resource Manager	12.28	0.67%	18	0.72%
	Information Systems Worker	31.83	1.73%	50	2.00%
	Laboratory Manager	11.50	0.63%	16	0.64%
	Other Professional Staff	25.93	1.41%	53	2.12%
	Pharmacy Manager	2.42	0.13%	3	0.12%
Pharmacy	Pharmacy Assistant	2.42	0.13%	3	0.12%
	Pharmacy Technician	10.00	0.54%	21	0.84%

FY2022 HRH Staffing Footprint Summary Grid					
Cadre Group Category	Employment Title	Total Annual FTEs	% of FTEs	Individuals	% of Individuals
Social Work and Case Management	Case Manager/ Case Worker	86.48	4.70%	96	3.84%
	Child/Youth Development Worker	13.61	0.74%	43	1.72%
	Social Welfare Assistant	5.00	0.27%	5	0.20%
	Social Worker	22.75	1.24%	23	0.92%
Support Staff	Central / Regional Warehouse Worker	1.17	0.06%	3	0.12%
	Cleaner / Janitor	28.67	1.56%	31	1.24%
	Other supportive staff not listed	44.95	2.44%	56	2.24%
	Transportation Staff for Commodities and Patient Samples	1.00	0.05%	1	0.04%
	Transportation Staff for Personnel	66.73	3.63%	83	3.32%
Technical Assistance Staff	Logistics Manager	0.92	0.05%	1	0.04%
	M&E Officer / Advisor	58.38	3.17%	73	2.92%
	Supply Chain Advisor	1.73	0.09%	2	0.08%
	Technical Advisor	36.12	1.96%	74	2.96%
	Trainer	9.21	0.50%	22	0.88%

Source: Unpublished data provided by PEPFAR/USAID Botswana Office, hand delivered by PEPFAR county coordinator to study team on Friday June 9th

Annex J: HRH Absorption/Handover Template

Example Entry #1	
Role	CMS Logistics Officer
Job Description	Manage and optimize the supply chain operations for healthcare commodities, ensuring timely delivery and accurate inventory management to support public health needs
Qualification Criteria	Bachelor's Degree
Employer	GoB - CMS
Number of Personnel	5
Full-Time Equivalents	4.5
Annual Pay (USD)	16,000
Annual Pay Financed by Donor (USD)	16,000
Other Donor Support for Role	Biannual capacity building workshops
Deadline for Handover/Transition of Support	31 Dec 26
Other Notes	Transition 2 FTEs in 2025 and 2.5 FTEs in 2026

Annex K: Draft Terms of Reference for Transition Financing TG

Thematic Group for Transition Financing Botswana HIV Sustainability and Transition Roadmap Implementation and Oversight of Recommended Actions

Preamble. Botswana and its national and international partners are committed to sustaining the country's HIV response and ensuring a smooth transition from external to domestic financing and resources over the next 6 years to 2030 and beyond. To achieve this, they subscribe to the HIV Sustainability and Transition Roadmap developed and adopted in 2023. The Roadmap contains 22 recommended actions, of which 15 directly relate to HIV and another 7 to the enabling environment in the health sector overall

A number of the actions pertain to ensuring effective transitional financing for the national HIV program during donor reduction and withdrawal. Since the design and execution of transitional financing plans is key to the success of the Roadmap, the Government has decided to set up an ad hoc Thematic Group to oversee, implement, coordinate, and monitor progress in this area over the next 3 years. These terms of reference define the objectives, membership, and modus operandus for the Transition Financing TG as well as an initial list of its key activities, deliverables, and deadlines.

Objectives of the TG. The main objectives of the HIV Transition Financing TG are to:

- Develop a detailed work plan of actions for 2024-26
- Assign responsibility for their execution
- Create a set of monitoring indicators for each action
- Review reports of performance from the lead organization for each action
- Help ensure effective coordination and solve problems with delays or bottlenecks in execution
- Report to the JOC oversight body on progress in ensuring effective transitional financing for HIV

Membership and Coordination. The Transition Financing TG will be chaired by a senior official of NAHPA and a senior official from MoF. Its membership will be limited to a small number of relevant senior officials, including representatives from:

- Ministry of Health
- PEPFAR
- The Global Fund
- UNAIDS
- Civil Society

Initial List of Key Tasks, Deliverables, and Timelines. The HIV Transition Financing TG's overall job is to identify areas of major savings and to plan and carry out measures to achieve those savings over the next three years. Tasks are likely to include, but not be limited to, the implementation and/or oversight of the following:

1. Develop an initial financial transition plan template by 31 Dec 2023, referencing existing materials such as the Malaria Transition Plan
2. Facilitate review, discussion, and finalization of the template by 31 Mar 2024. This includes coordination between Government, PEPFAR, and the Global Fund.
3. Assist the JOC in ensuring that additional funds for Roadmap implementation are included in the GC7 Funding Request to the Global Fund
4. Development of donor financial transition plans by PEPFAR and GF according to the agreed-upon template by 30 Jun 2024
5. Facilitate review, discussion, and finalization of the donor financial transition plans, including ensuring that they include dedicated sections on financing, monitoring, and evaluating human rights and stigma reduction activities, especially via CSOs
6. Assist CMS in creating a government funding pool for emergency procurements and a timeline for resourcing it to full capacity
7. Develop an HIV financing policy brief for MoF and the State Presidency based on the review of donor transition plans by 30 Nov 2024
8. Collect relevant financial and operational data to ensure that transition plans and government responses are carried out as agreed, and help to resolve any bottlenecks encountered
9. Meet quarterly to review progress in ensuring effective financial transition

Monitoring and Reporting From the outset, the Financial Transition TG should develop and enforce a monitoring system that gathers together data on process, output, and outcome indicators, for each agreed task and component of financial transition plans. The TG's secretariat will be composed of staff from NAHPA plus technical assistance as needed. They will be responsible for producing quarterly and annual reports for the TG, which will then deliver these reports to the JOC.

Annex L: Draft Terms of Reference for HRH TG

Thematic Group for HRH Rationalization and Absorption Botswana HIV Sustainability and Transition Roadmap Implementation and Oversight of Recommended Actions

Preamble. Botswana and its national and international partners are committed to sustaining the country's HIV response and ensuring a smooth transition from external to domestic financing and resources over the next 6 years to 2030 and beyond. To achieve this, they subscribe to the HIV Sustainability and Transition Roadmap developed and adopted in 2023. The Roadmap contains 22 recommended actions, of which 15 directly relate to HIV and another 7 to the enabling environment in the health sector overall.

A number of the actions pertain to ensuring that donor-supported human resources for health (HRH) in the HIV program are effectively assessed, rationalized, and absorbed by the Government. Data from donors suggest that PEPFAR and GF currently support more than 1,800 full-time equivalents (FTEs) in the program.

Since effective rationalization and absorption of donor-supported HRH is key to the success of the Roadmap, the Government has decided to set up an ad hoc Thematic Group to plan, implement, coordinate, and monitor progress in this area over the next 3 years. These terms of reference define the objectives, membership, and modus operandus for the HRH TG as well as an initial list of its key activities, deliverables, and deadlines.

Objectives of the TG. The main objectives of the HRH TG are to:

- Develop a detailed work plan of actions for 2024-26
- Assign responsibility for their execution
- Create a set of monitoring indicators for each action
- Review reports of performance from the lead organization for each action
- Help solve problems with delays or other bottlenecks in execution
- Report to the JOC oversight body on progress in the effective assessment, rationalization, and absorption of donor-supported HRH in the HIV response

Membership and Coordination. The HRH TG will be chaired by a senior official of MoH and a senior official of PEPFAR. Its membership will be limited to a small number of relevant senior officials, including representatives from:

- NAHPA
- DPSM
- The Global Fund
- Ministry of Finance
- Civil Society

Initial List of Key Tasks, Deliverables, and Timelines. The HRH TG's overall job is to assess donor-supported HRH in the HIV program and to plan and carry out measures to rationalize and absorb those roles over the next several years. Tasks are likely to include, but not be limited to, the following:

- Facilitate the development of a comprehensive inventory of donor-supported HRH
 - Develop a costed and time-bound HRH rationalization and absorption plan, making use of the template plan included as an Annex to the HIV Sustainability and Transition Readiness Roadmap
1. Create a complete inventory of donor-supported HRH positions (including quantity, job descriptions, qualifications, and salaries from GF and PEPFAR databases) by 31 Mar 2024
 2. Prioritize among roles and create specific, time-bound plans for rationalization and gradual absorption starting in 2025, specifying posts for absorption by year by 30 Apr 2024.
 - The HRH Absorption/Handover Template included as an Annex to the HIV Sustainability and Transition Readiness Roadmap can serve as a starting point for this activity.
 3. Work with DPSM to match specified roles to government cadres, creating new ones as needed, and authorize hiring by 30 Jun 2024.
 4. Develop a costed capacity building and HRH development plan for CMS (to include e.g. e-LMIS, forecasting, monitoring, contract management, and relevant laws and policies such as the Local Procurement Scheme directive) by 30 Sep 2024.
 5. Ensure costs of HRH transitions are incorporated in the MTEF and annual budgets as part of larger budgeting processes, beginning with 2025 annual budgets.
 6. Collect operational and budgetary data related to HRH from Government and donors to monitor progress against the HRH transition plan, assisting in resolving bottlenecks as needed.
 7. Meet quarterly to review progress in HRH rationalization and absorption

Monitoring and Reporting. From the outset, the HRH TG should develop and enforce a monitoring system that gathers together data on process, output, and outcome indicators, for each task and each donor-supported role to be rationalized and/or absorbed. The TG's secretariat will be composed of staff from NAHPA, MoH, and DPSM plus technical assistance as needed. They will be responsible for producing quarterly and annual reports for the TG, which will then deliver these reports to the JOC.

Annex M: Draft Terms of Reference for CSO Engagement TG

Thematic Group for CSO Engagement Botswana HIV Sustainability and Transition Roadmap Implementation and Oversight of Recommended Actions

Preamble. Botswana and its national and international partners are committed to sustaining the country's HIV response and ensuring a smooth transition from external to domestic financing and resources over the next 6 years to 2030 and beyond. To achieve this, they subscribe to the HIV Sustainability and Transition Roadmap developed and adopted in 2023. The Roadmap contains 22 recommended actions, of which 15 directly relate to HIV and another 7 to the enabling environment in the health sector overall.

A number of the actions pertain to enhancing contracting, coordination, and financing of CSOs in the fight against HIV. Analysis indicates that fragmentation of CSO funding and management into three separate streams operated by NAHPA, PEPFAR, and the Global Fund impedes coordination, leading to duplicative efforts, gaps, and inconsistent approaches to CSO management.

Since improved CSO engagement is key to the success of the Roadmap, the Government has decided to set up an ad hoc Thematic Group to plan, implement, coordinate, and monitor progress in this area over the next 3 years. These terms of reference define the objectives, membership, and modus operandus for the CSO Engagement TG as well as an initial list of its key activities, deliverables, and deadlines.

Objectives of the TG. The main objectives of the CSO Engagement TG are to:

- Develop a detailed work plan of actions for 2024-26
- Assign responsibility for their execution
- Create a set of monitoring indicators for each action
- Review reports of performance from the lead organization for each action
- Help solve problems with delays or other bottlenecks in execution
- Report to the JOC oversight body on progress in enhancing contracting, coordination, and financing of CSOs

Membership and Coordination. The CSO Engagement TG will be chaired by a senior official of NAHPA. Its membership will be limited to a small number of relevant senior officials, including representatives from:

- PEPFAR
- The Global Fund
- Civil Society

Initial List of Key Tasks, Deliverables, and Timelines. The CSO Engagement TG's overall job is to develop a plan to unify and improve the three streams of CSO contracting and financing, and to implement and monitor that plan over the next three years. Tasks are likely to include, but not be limited to, the following:

- Oversee and assist NAHPA in completing their Social Contracting Guidelines by 31 Dec 2023 and sharing them with GF, PEPFAR, and Civil Society
- Reach joint agreement among key stakeholders (NAHPA, PEPFAR, GF, Civil Society) on a unified social contracting/CSO management framework based on the Social Contracting Guidelines by 31 Mar 2024.
- Sensitize CSOs on the unified social contracting/CSO management framework by 30 Jun 2024 as part of the larger CSO capacity building initiative.
- Assess performance and capacity for scale-up among CSOs conducting stigma and discrimination training for government health workers. Select 1-2 candidates for increased support by 30 Jun 2024.
- Ensure a portion of the aligned CSO support budgets is set aside and earmarked for capacity development and coordination by 30 Sep 2024. Capacity development should include among other areas administration, M&E, and working with the new unified social contracting/CSO coordination framework.
- Ensure that aligned CSO support budgets include significantly increased resources and TA for the candidate CSOs previously identified as high performers in the domain of stigma and discrimination training for government health workers.
- Collect operational and financial data as well as CSO contracts to monitor progress in improving CSO management and funding.
- Meet quarterly to review progress in unifying and improving the CSO funding and management streams.

Monitoring and Reporting. From the outset, the CSO Engagement TG should develop and enforce a monitoring system that gathers together data on process, output, and outcome indicators, for each task and each stage of assessing, improving, and unifying the three disparate CSO funding and management streams. The TG's secretariat will be composed of staff from NAHPA plus technical assistance as needed. They will be responsible for producing quarterly and annual reports for the TG, which will then deliver these reports to the JOC.

Annex N: Draft Terms of Reference for Efficiency TG

Thematic Group for Efficiency

Botswana HIV Sustainability and Transition Roadmap Implementation and Oversight of Recommended Actions

Preamble. Botswana and its national and international partners are committed to sustaining the country's HIV response and ensuring a smooth transition from external to domestic financing and resources over the next 6 years to 2030 and beyond. To achieve this, they subscribe to the HIV Sustainability and Transition Roadmap developed and adopted in 2023. The Roadmap contains 22 recommended actions, of which 15 directly relate to HIV and another 7 to the enabling environment in the health sector overall.

A number of the actions pertain to enhancing efficiency in the use of resources to combat HIV. Earlier studies and preliminary estimates suggest that 5-10% of the \$120 million currently spent on HIV in Botswana could be saved through smart measures.

Since improved efficiency is key to the success of the Roadmap, the Government has decided to set up an ad hoc Thematic Group to plan, implement, coordinate, and monitor progress in raising efficiency over the next 3 years. These terms of reference define the objectives, membership, and modus operandus for the Efficiency TG as well as an initial list of its key activities, deliverables, and deadlines.

Objectives of the TG. The main objectives of the HIV Efficiency TG are to:

- Develop a detailed work plan of actions for 2024-26
- Assign responsibility for their execution
- Create a set of monitoring indicators for each action
- Review reports of performance from the lead organization for each action
- Help solve problems with delays or other bottlenecks in execution
- Report to the JOC oversight body on performance, results, and impacts on the efficient use of resources for the HIV response

Membership and Coordination. The Efficiency TG will be chaired by a senior official of UNAIDS. Its membership be limited to a small number of relevant officials, and will include senior officials of:

- Ministry of Health
- PEPFAR
- The Global Fund
- UNAIDS
- Civil Society

Initial List of Key Tasks, Deliverables, and Timelines. The HIV Efficiency TG's overall job is to identify areas of major savings and to plan and carry out measures to achieve those savings over the next three years. Tasks are likely to include, but not be limited to, the following:

1. Develop an initial HIV Efficiency Plan by 30 April 2024 which points to each major area of savings
2. Within such a plan, estimate potential savings amounts
 - This includes oversight of CMS's task to use demand forecasts and pricing data to estimate savings obtainable through pooled procurement by March 31, 2024.
3. For each area, weigh the gains in savings against the difficulty of implementing the proposed measures.
4. Earlier work suggests that savings may be considerable in the following areas, which merit further analysis and action:
 - Procurement of HIV drugs and tests at lower cost
 - Procurement of lab equipment and reagents at lower cost
 - Replacing donor-funded health workers with national staff (this requires close collaboration with the HRH TG)
 - Integrating HIV staff and services with other primary care and NCD staff and services
 - Reducing or rationalizing HIV training programs
 - Rationalizing funding transferred to CSOs for HIV-related prevention, treatment, and other services (this requires close collaboration with the CSO TG)
 - Other known or suspected areas where savings are possible
5. Collect data from those implementing cost-savings measures
6. Meet quarterly to review progress in implementing such measures

Monitoring and Reporting. From the outset, the Efficiency TG should develop and enforce a monitoring system that gathers together data on process, output, and outcome indicators, for each agreed area where cost-savings are to be pursued. The TG's secretariat will be composed of staff from NAHPA plus technical assistance as needed, especially through UNAIDS. They will be responsible for producing quarterly and annual reports for the TG, which will then deliver these reports to the JOC.

Annex O: Selected Actions by Implementer

	Actions by NAHPA	Due Date
1	Convene and lead joint committee (JOC) with MoH, MoF, PEPFAR, and GF to oversee HIV Transition Roadmap implementation. Beneath this JOC, develop and set up small, action-oriented Thematic Groups (TGs) in 4 Sub-Roadmap areas: Financing, Efficiency, HRH, and CSOs, with clear terms of reference, deliverables for 2024, and a small membership of technically qualified and empowered members from the key agencies involved	TGs constituted and initial meeting held by 28 Feb 2024, meetings quarterly from 31 Mar 2024
2	Participate in the Transition Financing, HRH, CSO Engagement, and Efficiency Thematic Groups, and contribute to their tasks and responsibilities as defined in their TORs (Annex K through Annex N) and in the Roadmap of Core Actions (Figure 5.1 through Figure 5.4)	Ongoing
3	Develop the financial transition plan template (referencing existing materials e.g. Malaria transition plan) and share with donors	31 Dec 2023
4	Complete Social Contracting Guidelines and share with GF and PEPFAR	31 Dec 2023
5	Appoint an Accounting Officer to lead the joint dialogue with MoH, meeting quarterly to align operations and plans	31 Dec 2023
6	As part of the Financing TG, help facilitate agreement among Government and donors on the financial transition plan template	31 Mar 2024
7	Institutionalize the Human Rights team within NAHPA, including the developing a new formal mandate and initiating the process of securing funding for the team's needs	31 Mar 2024
8	Develop policy brief for MoH leadership outlining the planning and operational benefits of joint TB/HIV budget requests	31 May 2024
9	Review donor plans and develop government financial transition plan , including timebound estimates of required funding. Share with stakeholders, including donors	31 Aug 2024
10	Lead the negotiation and finalization of a combined financing plan for 2024-26, to be signed and endorsed by Government, PEPFAR, and Global Fund	30 Nov 2024
11	As part of the Financing TG, develop HIV financing policy brief for MoF and the Office of the State Presidency based on transitional financing plans	30 Nov 2024

	Actions by Ministry of Health	Due Date
1	Appoint Accounting Officers to lead joint dialogue with NAHPA, meeting quarterly to align operations and plans	31 Dec 2023
2	As part of the HRH TG, assist in creating a complete inventory of donor-supported HRH positions (including quantity, job descriptions, qualifications, and salaries from GF and PEPFAR databases).	31 Mar 2024
3	Develop policy brief supporting increased resources for HIV-PHC integration	31 Mar 2024
4	As part of the Efficiency TG, assist in creating the HIV Efficiency Plan , using TA as necessary to develop quantitative estimates and implementation plans for each proposed efficiency activity.	30 Apr 2024
5	Prioritize among roles and create specific, time-bound plans for rationalization and gradual absorption starting in 2025, specifying posts for absorption by year.	30 Apr 2024
6	Institute joint budget request requirement and meet with senior leadership from the TB and HIV programs to ensure understanding and alignment	30 Jun 2024
7	Develop HIV-PHC Integration Plan including SMART milestones and targets aligned to the NCD Strategy and ICBS Guidelines	31 Aug 2024
8	In collaboration with the HRH TG, develop a costed capacity building and HRH development plan for CMS (to include e.g. e-LMIS, forecasting, monitoring, contract management, and relevant laws and policies such as the Local Procurement Scheme directive)	30 Sep 2024
9	Work with CMS to create a government funding pool for emergency procurements, including a timeline for resourcing it to full capacity	30 Sep 2024
10	Ensure that the specific efficiency measures related to pooled procurement, emergency procurement, HRH absorption and task shifting, and HIV/TB integration are planned and carried out in a diligent manner	Progress reviewed annually from 30 March 2025
11	Implement the multiple specific mitigating actions aimed at strengthening national capacity in supply chain and emergency procurement, HMIS/M&E, and HRH management, as part of improvements to the enabling environment for the success of the HIV program (see Annex P)	Progress reviewed annually from 28 Feb 2025

Actions by Ministry of Finance		Due Date
1	As a key leader of the Financing TG, assist NAHPA in developing the financial transition plan template	31 Dec 2023
2	Help facilitate agreement among Government and donors on the financial transition plan template	31 Mar 2024
3	Assist the Financing TG in ensuring that additional funds for Roadmap implementation are included in the GC7 Funding Request	31 Mar 2024
4	As a key leader of the Financing TG, assist NAHPA in reviewing donor plans and developing government financial transition plan , including timebound estimates of required funding. Ensure that plans include dedicated sections on financing, monitoring, and evaluating human rights and stigma reduction activities, especially via CSOs. Share with stakeholders, including donors	31 Aug 2024
5	As a key leader of the Financing TG, contribute to the development of an HIV financing policy brief for MoF and SP leadership based on transition plans	30 Nov 2024
6	Ensure that Government targets/commitments for domestic financing of HIV are reflected in the MTEF and annual government budgets	Annually from Feb 1 2025

Actions by PEPFAR		Due Date
1	Review financial transition plan template developed by NAHPA and reach agreement on it with Government and other donors	31 Mar 2024
2	Contribute to the HRH TG's efforts to create a complete inventory of donor-supported HRH positions (including quantity, job descriptions, qualifications, and salaries)	31 Mar 2024
3	Commit to the CSO TG and reach joint agreement on unified social contracting/CSO management framework based on Social Contracting Guidelines	31 Mar 2024
4	Develop PEPFAR financial transition plan based on agreed-upon template	30 Jun 2024
5	Review government and Global Fund financial transition plans and ensure PEPFAR/USG plans, including COPs and budgets, are well-aligned	31 Aug 2024
6	As a key leader of the CSO TG, ensure that aligned CSO support budgets include earmarked portions for capacity development, coordination, and scale-up of selected CSOs performing stigma and discrimination training for government health workers	30 Sep 2024
7	Assist MoH in strengthening national capacity in supply chain and emergency procurement, HMIS/M&E, and HRH management, as part of improvements to the enabling environment for the success of the HIV program	Progress reviewed annually from 28 Feb 2025

Actions by Global Fund		Due Date
1	Review financial transition plan template developed by NAHPA and reach agreement on it with Government and other donors	31 Mar 2024
2	Contribute to the HRH TG's efforts to create a complete inventory of donor-supported HRH positions (including quantity, job descriptions, qualifications, and salaries)	31 Mar 2024
3	Commit to the CSO TG and reach joint agreement on unified social contracting/CSO management framework based on Social Contracting Guidelines	31 Mar 2024
4	Assist NAHPA in developing a formal mandate for the Human Rights Team	31 Mar 2024
5	Assist NAHPA in developing cost estimates for Human Rights Team absorption as well as a costed and time-bound capacity-building plan to ensure ability to fulfill expanded mandate	30 Jun 2024
6	Develop Global Fund financial transition plan based on agreed-upon template	30 Jun 2024
7	Review government and PEPFAR financial transition plans. In collaboration with Government, support the development and approval of a GC7 grant and budget well-aligned to the Roadmap including financial transition plans, CSO coordination efforts, etc.	31 Aug 2024
8	As a key leader of the CSO TG, ensure that aligned CSO support budgets include earmarked portions for capacity development, coordination, and scale-up of selected CSOs performing stigma and discrimination training for government health workers	30 Sep 2024
9	Assist MoH in strengthening national capacity in supply chain and emergency procurement, HMIS/M&E, and HRH management, as part of improvements to the enabling environment for the success of the HIV program	Progress reviewed annually from 28 Feb 2025

Actions by Civil Society Organizations		Due Date
1	Join discussions with NAHPA, PEPFAR, and GF on continuity of financial support during transition to CSOs specializing in human rights, legal protections, anti-stigma and discrimination, and advocacy, especially with regards to efforts towards HRH absorption and improved efficiency	30 Jun 2024
2	Participate in the development and review of financial transition plans by Government, PEPFAR, and Global Fund, focusing on the roles and responsibilities of CSOs	31 Aug 2024
3	Participate in discussions with the CSO TG to help shape the alignment of budgets for CSO support as well as the development and implementation of the joint social contracting and performance monitoring framework and CSO capacity strengthening plan	31 Mar 2024

Actions by UNAIDS		Due Date
1	Assist key leaders (JOC, TGs, NAHPA, MoH, donors) in organizing and implementing all parts of the Roadmap, and facilitating convenings among the main stakeholders	Meetings quarterly from 31 Dec 2023
2	Commission technical assistance in key areas, such as (a) joint financial planning and budgeting among Government, PEPFAR, and GF, (b) further efficiency studies and development and monitoring of the efficiency plan, (c) completion of the HRH inventory and development of the plan to rationalize/absorb donor-funded essential personnel, and (d) design and review of the plans to converge Government, PEPFAR, and Global Fund channels/modalities for financing CSOs to deliver community-based and prevention-focused HIV services	Various
3	Conduct a periodic independent review of the HIV Sustainability and Transition Roadmap, as a trusted broker who can objectively assess progress and setbacks and recommend remedial measures.	Biannually from 30 Jun 2024

Annex P: Roadmap of Actions to Strengthen the Enabling Environment for Sustainability and Transition

KEY RISK	MITIGATING ACTION	LEAD	YEAR(S)
FINANCING			
R2. The HIV program may not receive sufficient resources due to legitimate competing health priorities (such as NCDs, maternal mortality, and mental health), especially in the context of decreasing donor contributions.	R2.2 Negotiate for and secure an increase in GGHE/GGTE from ~12% today to at least 14% by 2030 to ensure adequate funding across all health priorities and safeguard the HIV program from the growing requirements of other health areas, e.g. PHC and NCDs.	MoH	2024
HEALTH SYSTEMS/TB			
R4. Many health care workers will continue to leave the public sector for employment in other countries, private sector, and donor agencies, reducing coverage and quality of clinical services for HIV and perpetuating dependence on expatriate workers.	R4.1. Conduct a comprehensive HRH review and implement measures (training, supportive supervision, incentives, etc.) to attract and retain government health care workers, including for the HIV program.	MoH, DPSP	2024-25
R6. Uptake of systems for managing national HRH remains low, severely limiting the ability of HIV program managers to track, adjust, plan for, and improve HRH staffing.	R6.1. Promote the widespread adoption and utilization of a quality data system for HRH planning and management, particularly as a key input required for successful absorption of donor-funded HRH.	MoH, PEPFAR, GF	2024-25
R9. Fragmentation of health information systems (patients/services, epi/surveillance, health products/logistics, laboratories) within government and between government, CSOs, and private sector causes inefficiencies, delays, higher costs, and reduced quality of data, decisions, and patient care.	R9.1. Increase financial, human, and training resources for the Botswana Health Data Collaborative (BHDC) and formalize its mandate as the lead implementers for HIS improvements, as outlined in the 2020 Data and Digital Priorities report from MoH.	MoH	2024-25
	R9.2. Establish and implement clear frameworks for the coordination and reporting of health and HIV data between Government, donors, CSOs, and private sector using MoAs.	MoH, BHDC	2025-26
R11. While the TB program has made important progress in incidence rates, the inadequate levels of case detection and cure rates cause significant avoidable illness and deaths, especially among HIV positive individuals.	R11.1. Review performance and set higher targets for the national TB program, especially for case-detection, cure rates, and control of drug resistant TB. Pursue advocacy efforts for the allocation of additional resources as needed to enable achievement of the new targets.	MoH	2024-25
R12. The national TB program remains heavily dependent on outside funding, especially for key staff positions. At the same time, the leadership and staffing of the TB program are inadequate for the tasks at hand.	R12.1. Re-examine the financial, staffing, and capacity needs of the TB program and develop a sustainable financing plan for the 2024-2030 period, including government commitments to replace donor resources and budgets aligned with those commitments.	MoH, PEPFAR, GF	2024

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