
# Botswana

# Operational Plan Report

# FY 2012

# Operating Unit Overview

## OU Executive Summary

The U.S.-Botswana health partnership is strong and effective. We prioritize evidence-based interventions and constantly evaluate the efficacy of our programs. Two developments have led us to reconsider some of our prior decisions about the activities we should support in the 2012 Country Operational Plan (COP). First, the Government of Botswana has committed to begin anti-retroviral treatment at CD4<350 on April 1, 2012. This decision creates additional burdens on an already strained Botswana health system. Second, certain medical interventions--specifically, Prevention of Mother to Child Transmission (PMTCT), Voluntary Medical Male Circumcision (VMMC), and "treatment as prevention"--are documented to be effective in preventing new infections. This change in the GOB treatment threshold, coupled with the weight of the scientific evidence supporting these interventions, requires us to readjust our approach. We continue to support plans to “graduate” Botswana within the context of PEPFAR, but are mindful that the country continues to have the second highest prevalence rate in the world. Our minor course correction will have a major impact on the ultimate success of the HIV/AIDS response in Botswana, affecting whether the graduated programs will flourish or flounder. Readjusted, our partnership should become capable of delivering something that up until now has seemed out of reach: a sharply declining HIV infection rate and a graduating program with a sustainable legacy and unquestioned efficacy.

Record of Success

Our health partnership with Botswana has resulted in a clear record of success. HIV-associated mortality has been reduced by more than half since treatment became available, and the rate of new infections has declined. Botswana’s blood safety, HIV treatment, and Prevention of Mother to Child Transmission (PMTCT) programs are models for their coverage and quality of services. The percent of donated blood that is positive for HIV declined from 7.5% in 2003 to 1.0% in 2010. The rate of mother to child HIV transmission in Botswana has declined to <4%. The Masa treatment program now covers 96% of persons eligible for treatment at CD4 <250 cells/mm3.

Country Ownership

Our country ownership trajectory is also advanced. In May 2011, in consultation with the Government of Botswana (GOB), we planned a transition towards full country ownership of the HIV programs by 2016, with a decline in programmatic funding over the next five years to a plateau level that prioritizes strategic interventions and technical assistance. In this context, we embarked on a process to “graduate”

treatment, PMTCT, and blood and injection safety within the next three years and significantly reduce funding to all remaining programs by 2016, when we plan to fund program areas to fill gaps that will likely exist. In order to minimize the impact on service delivery and to foster sustainability over the next five years, we will provide technical assistance (TA) to all four program areas (Prevention, Health System Strengthening, Strategic Information, and Care and Treatment). Baseline funding and TA are key components to the TA model still being developed for a post-2016 PEPFAR program. We are committed to continually assessing the latest developments to ensure that we implement only the most cost-effective and evidence-based interventions.

Evidence-Based Interventions

In light of recent scientific advances such as the HPTN 052 study, President Obama and Secretary of State Clinton have outlined a strategy to focus on evidence-based interventions that will have the maximum impact on the incidence of new infections. To achieve our shared goal with the GOB, an "AIDS free generation" that would ease the unsustainable treatment burden currently being shouldered by the GOB, we will support Botswana's effort to expand the ARV treatment program to include patients with CD4 <350 cells/mm3. Further, GOB is committed to expanding treatment for HIV-positive pregnant women (universal HAART) to further reduce MTCT to <1%. The decision to expand treatment creates additional burdens on already strained Botswana health services and comes at a time of declining donor funding. In this regard, we strongly feel that additional short term surge funds are necessary to ensure GOB success with this critical initiative. We have requested an additional $5 million in FY 2012. These additional funds would be used to strengthen the supply chain, enhance laboratory capacity, support ongoing health system strengthening activities emphasizing human resources for health, and train ARV treatment providers. None of the additional requested funds would be used for purchasing ARVs.

Holding Ourselves Accountable

At the same time, we recognize that as responsible recipients of taxpayer's money, we are obligated to assess the outcomes and impact of all of our funded programs, and to make cuts if and when those programs fail to deliver results. We strongly support evidence-based and outcomes-based programming. As a result of our additional funding request, plans and timelines for treatment program graduation have changed slightly, but our commitment to increasing country ownership has not.

The program outlined in the 2012-2013 two-year COP cycle aims to maintain the impact of past investments, increase sustainability, continue the evaluation of cost-effective investments, and enhance the GOB's capacity to provide services while moving towards greater country ownership. The end result will be a program that continues to support a national response that meets the needs of the country and establishes a foundation for the GOB to provide services as PEPFAR resources decline.

COP 12 Builds on our Successes

Epidemiological Context

Botswana is a sparsely populated country with an estimated 2.0 million people with one of the highest HIV prevalence rates in the world. In 2011, there were an estimated 350,000 Batswana living with HIV, with

nearly 19,000 new infections. The HIV infection rate for persons with TB disease is 67.8%; an estimated 40% of deaths among persons living with HIV are due to tuberculosis.

Overall, HIV prevalence has remained stable over the last several years. The Botswana AIDS Impact Survey (BAIS) showed that the national HIV prevalence was 17.1% in 2004 and 17.6% in 2008 for persons above 18 months of age. However, the Botswana Antenatal Sentinel Surveillance Survey showed that the HIV prevalence among pregnant women declined from 36.2% in 2001 to 31.8% in 2009. Further, HIV prevalence among pregnant women aged 15–19 years declined from 24.7% in 2001 to 13.2% in 2009.

According to the 2008 BAIS, 56% of Batswana aged 10-64 years reported having been tested for HIV infection at least once and 41% of persons aged 15-49 years reported having been tested in the past 12 months. Prevention of mother to child transmission of HIV (PMTCT) services reach over 95% of pregnant Batswana women, resulting in HIV transmission to less than 4% of infants born to HIV-positive mothers. However, male circumcision is still low at only 11.2%.

As of December 2011, 178,684 patients were receiving antiretroviral therapy (ART) in Botswana, which represents 96% of the 185,963 HIV-positive Batswana adults and children in need of ART, based on the current national program standard <250 CD4 treatment criteria.

Historical context

In 2010, the PEPFAR Botswana team analyzed the role of country ownership and sustainability in achieving long-term program success. Our strategic approach, called “The Journey of PEPFAR (JOP),” guided our investments in Botswana. Following JOP 1.0, 1.5, and 2.0, we outlined clear strategies to achieve country ownership over the next 3-5 years.

The 2012 COP is the first year of a two-year plan for funding four broad program areas:

- Prevention
- Health system strengthening
- Strategic information, and
- Care and treatment in Botswana.

The COP includes a detailed FY 2012 budget totaling $80,933,962, with both programmatic and management and operations costs. An in depth analysis of pipeline was undertaken to justify FY 2012 funding levels by budget code. Detailed technical area narratives, implementing mechanisms, and partner narratives as well as budget code narratives are also included.

As in 2011, COP 2012 identifies TB/HIV integration as an important area to strengthen. However, in a major change since COP2011, GOB has made a strong commitment towards voluntary medical male circumcision (VMMC), including a shift to allow circumcision service delivery by PEPFAR-funded partners and use of the MOVE model. COP 2012 represents the continuation of prior efforts focused on preventing new infections and caring for those affected by HIV. Our work will build upon past successes while filling critical gaps identified in the Partnership Framework.

Key Developments

In 2010 we signed the Partnership Framework (PF) with the GOB. The PF identified priority areas of intervention with indicators and annual targets. Also outlined within the PF were other implementing partners and GOB contributions. Based on the GOB's National Strategic Framework II, which includes the PF as well as other GOB and development partner programs, the GOB developed the National Operational Plan (NOP), which is in the final stages of costing. The NOP is a serious attempt by the GOB to understand the cost of the national response as presented in the PF.
Botswana has not been immune to the affects of the global economic crisis, which comes at a time when other implementing partners (IP) are making plans to decrease their assistance. The African Comprehensive HIV/AIDS Partnership (ACHAP) has set a course for phasing out the donation of branded antiretroviral drugs (ARVs) over the next five years. Furthermore, the GOB has started downsizing the civil service – including health care workers. The civil service will be reduced by 5% per year for the next three years. These events could have negative impacts on the Botswana national response if the GOB, donor agencies, and IP do not plan more effectively. This dialogue is starting through the NACA Partnership Forum and the recently launched GOB PEPFAR Coordination Forum.

PEPFAR Focus in FY2012

Voluntary Medical Male Circumcision (VMMC) - PEPFAR Botswana has supported VMMC since 2005. After considerable discussion with the GOB, including interventions by Ambassador Gavin with senior GOB Ministers, we believe the GOB is committed for the first time to large-scale VMMC. The targets are ambitious but achievable and we intend to coordinate closely with the GOB and implementing partners like ACHAP to reach the goals established. The FY 2011 VMMC budget is being augmented with FY 2012 funding ($8.8 million) with a target of performing more than 36,000 circumcisions by implementing partners by December 2012, with that number expected to increase significantly as the program matures. PEPFAR investments in VMMC are viewed as a short-term intervention with high impact. Successful attainment of established targets will be paramount to ensure cost-effectiveness and continued financial

support.

TB/HIV - As in previous years, the goal of the TB/HIV program is to reduce the morbidity, mortality, and socio-economic impact of tuberculosis. TB is the leading cause of death among persons with HIV, accounting for approximately 40% of mortality. There has been a steady increase in the number of cases of multi-drug resistant TB (MDRTB) over the past decade. OGAC identified TB/HIV as a priority in 2011 and the in-country PEPFAR management team endorsed increased funding for TB/HIV in FY 2012. FY 2012 and future support will focus on supporting the GOB with the implementation of isoniazid preventive therapy (IPT), infection control, intensified case finding, integration with HIV services, and monitoring and evaluation.

The GOB has few dedicated staff to address TB cases; hence PEPFAR will continue to fund a number of positions within the MOH. These positions are likely to continue into the foreseeable future (2012-2015) given the lead time required to make substantive personnel changes.

HSS - Previous PEPFAR funding was used for the development of a ten-year Health Sector and Essential Health Service Plan delineating services at each delivery level. The plan covers the six WHO health system building blocks and lays out the roadmap for a more equitable, effective, and efficient health sector to deliver quality health services.

Over the next four years, PEPFAR will support the implementation of critical health reforms included in the plan:

- Institutional review and reorganization of health care delivery by strengthened District Health Management Teams (DHMT)
- Improving strategic planning, implementation, and monitoring of services
- Implementing quality management structures and an accreditation process
- Reviewing health financing and cost effectiveness, and
- Strengthening supply chain management systems for drugs and other medical commodities.

The outcome will be fully functional DHMTs with authority and skills to manage all resources (human, financial, and other) and deliver quality services.

We will work with local civil society organizations (CSO) to strengthen their capacity to support HIV/AIDS and related health service delivery. The program will enable the three national network organizations to improve management systems of both headquarters and affiliates so that they qualify for USG direct grants and increase country ownership. The program will develop Non Governmental Organization's (NGO) and CSO's abilities to run their organizations in a business-like way.

If successful, these activities will increase the demand for services like prevention, HIV counseling and testing, community TB care, palliative care, and for services to assist orphans and vulnerable children.

Global Fund - The Global Fund (GF) cancelled Round 11 in November 2011 and subsequently established a Transitional Funding Mechanism (TFM) to provide funding for the continuation of activities currently financed. Botswana is developing a TFM proposal for TB/HIV activities for submission to the GF by March 31, 2012. The country has also submitted a request for $2 million in bridge funding to continue TB/HIV activities funded under the Round 5 grant pending consideration of the TFM application. The ability of the GOB to secure GF support will be crucial to fill identified funding gaps in the future.

GHI - This strategy supports the GOB's Integrated Health Services Plan, as well as the Second National Strategic Plan for HIV and AIDS, and builds upon the Botswana Partnership Framework for HIV and AIDS.
Public health is the core of the U.S. Mission's work in Botswana, where five USG agencies have part or all of their staff and resources dedicated to health assistance (Department of State, Centers for Disease Control and Prevention, USAID, Department of Defense, and U.S. Peace Corps). The strategy lays out an overarching approach for the USG health team for the next five years (2011-2015), and covers all USG health assistance, including PEPFAR, as well as other programs, such as grants for research and medical education.

PMTCT - The Botswana PMTCT program is considered to be one of the country’s greatest successes in HIV prevention programming. PEPFAR has supported the GOB to test pregnant Batswana women for HIV, provide early infant diagnosis for HIV-exposed infants, initiate antiretroviral treatment for HIV positive pregnant women and exposed infants, and provide continued care and support.
In FY 2012 the focus for PMTCT will be to improve the comprehensiveness of the program and transition to full country ownership. Some activities that need to be addressed before PMTCT can be fully transitioned to GOB include 1) integrating sexual and reproductive health services, 2) improving infant feeding practices, 3) expanding early infant diagnosis and linkages, and 4) strengthening information systems to monitor results. FY 2012 funding will help the GOB to address these issues and ensure that the other parts of a comprehensive PMTCT program are supported.

Partnership Framework Implementation Plan (PFIP) Monitoring

The goals and objectives outlined in the Botswana Partnership Framework (PF) are linked to specific Government of Botswana plans outlined in the National Development Plan 10 (NDP 10) and the Second National Strategic Framework for HIV and AIDS, 2009-2016 (NSF II). Many of the PEPFAR-supported

objectives in these documents contain baselines, indicators, and targets, which will be the starting point for those included in the National Operational Plan (NOP).

The following tasks are already underway as the NOP is undergoing final approvals:

- The Technical Planning Groups (TPG), which were originally technical working groups that developed the PF, have developed the draft NOP and have looked at the baselines, indicators, and targets in the national plans and how these will be inclusive of the PEPFAR requirements.
- The TPGs have analyzed the Government's planned seven year targets and developed appropriate algorithms to estimate how PEPFAR is expected to contribute to those targets over the next five years. This is important because, as the GOB's planning cycle goes through 2016, it is necessary for all NDP 10 and NSF II targets in the NOP to show how PEPFAR will contribute toward those targets through 2014 (i.e., through the end of PEPFAR II). The NOP, which is in essence the PFIP, is in the final stages of costing and once finalized will be launched. This will serve as the guiding document for PF implementation and monitoring towards the established targets.

The Management and Support Committee (MSC) with assistance from the TPGs has the responsibility for managing the NOP development process and the Joint Oversight Committee (JOC) has the responsibility for reviewing and approving the final plan and oversight of its implementation. The JOC has met twice since the signing of the PF and is currently waiting for the final costing and launch of the NOP.

Through the NACA Development Partners Forum and the JOC it is envisioned that updates will be presented on progress towards achieving the targets outlined in the PF on a quarterly basis. Also, through the recently established MOH/PEPFAR Coordination Forum areas of concern during the implementation of the NOP can be highlighted, monitored, and reported on in a transparent manner and adjusted accordingly.

Our country ownership discussions identified five change themes that we have addressed in COP2012:

- Effective coordination, joint planning and performance management;
- Maximize stakeholder impact;
- Ramp up impact of high priority programs;
- Establish national evaluation and research programs; and
- Effective cost management.

Effective coordination and joint planning with the GOB and other implementing partners: PEPFAR is funding a position within the MOH Office of Strategic Management to help MOH senior management to address constraints strategically. The GOB PEPFAR Coordination Forum was established to highlight and resolve issues that stand in the way of effective and efficient program implementation.

Maximize stakeholder impact through national capability building: The recently awarded Civil Society

Strengthening (CSS) project through USAID will focus on this second change theme. The goal of the program is to strengthen the capacity of the civil society sector in Botswana to support HIV/AIDS and related health service delivery. The program, which incorporates coaching and training, will develop NGO and CSO management abilities to run their organizations; govern and manage their Boards; plan and manage finances, staff, and volunteers; and mobilize resources from new non-governmental sources.

Ramping up impact of high priority programs: The proposed FY 2012 investments in VMMC and TB/HIV support this theme. The GOB understands the timely nature of the VMMC investment and acknowledges the short term need (2-3 years) for a significant surge in services to meet the established targets. Implementing partners and the GOB have committed themselves to achieving significant impacts that will reduce the burden of HIV transmission as well as save tens of millions of dollars over the long-term through reduced HIV treatment costs. The national target group for the VMMC program is primarily HIV negative men 0 – 49 years with PEPFAR and ACHAP prioritizing those who are 15 – 49 years old. However, those above this age group are also circumcised if they present themselves at the health facility.

PEPFAR investments in TB/HIV are also in line with the Global Health Initiative (GHI) for Botswana. While PEPFAR will be focusing on technical support for pre-service and in-service training for HCWs and updating TB laboratory services, there is a need for the GOB to have a more integrated approach to TB programs. Of late, there has been a more deliberate approach to integrate TB/HIV programming between the main MOH departments dealing with these two diseases. Along with the more focused approach is the development of action plans for the "three I's" (Intensified Case Finding, Infection Control, and IPT) and early initiation of ART in HIV positive TB patients, done collaboratively by HIV and TB programs. Another GOB focus is the decentralization of MDR-TB treatment centers beyond Gaborone and Francistown to Maun, Serowe, and Ghanzi combined with development of a network for MDR-TB surveillance and management. Lastly, there is an effort to revamp the National Advisory Committee on TB/HIV to improve its role of policy oversight on TB/HIV prevention, treatment, care, and support. The GOB has started to provide leadership through various national strategic plans and policies on TB and TB/HIV, and is currently finalizing a costed medium-term strategy on all aspects of TB control.

Establish national research and evaluation program incorporates some of the SI activities that PEPFAR will invest in FY 2012. The PEPFAR M&E activities under SI will provide funding to the MOH to strengthen the national network of M&E officers in health districts. The activities are to 1) place a senior M&E advisor at MOH to increase data use and provide feedback to the districts; 2) improve accuracy and timeliness of national morbidity and mortality statistics; 3) develop and implement national data quality assurance standards and tools; and 4) support the use of the existing District Health Information System (DHIS) for national reporting of all health indicators to eliminate duplication of effort. The GOB and

development partners understand the importance of timely planning, establishing achievable targets, and collecting accurate and reliable data at both the National and District levels to make informed decisions and allocate resources. NACA, through the delivery unit, is starting to collect monthly district program performance data which will enable data quality and flow improvements by highlighting areas for JOC to support in order to reduce bottlenecks.

In 2012, SI will work with NACA and MOH to expand the scope of the BAIS survey and to return the results of rapid HIV testing to participants. Based on comparisons of antenatal clinic (ANC) survey results with routinely collected PMTCT data, SI will support the transition away from the survey and toward routine data collection. FY 2012 funding will continue to support the biannual Botswana Youth Risk Behavioral Surveillance Survey (BYRBSS) to collect data on both HIV and non-HIV related risk factors. The GOB is planning to absorb the costs for this survey during FY 2014. The GOB will use data collected from routine data and surveys to disseminate information which will provide for a culture of information use and planning.

Effective cost management has been supported through a number of costing exercises funded by PEPFAR such as ART, OVC services, the NOP, and National Health Accounts. Ongoing costing exercises are focused on VMMC, HTC, ART using CD4 of 350, health services, and the national TB program. Most of the cost exercises to date have been at the request of the MOH or NACA showing the clear desire for accurate information and to use results to improve program effectiveness and efficiencies. The GOB has limited skills for costing analysis. It is envisioned that FY 2012 funds will continue to support the requests of the GOB and work with the MOH and NACA to develop local capacity to conduct costing analyses. A centrally funded TA costing team will likely carry out a Fiscal Space Analysis during the second quarter of FY 2012. This will allow the PEPFAR team to develop a comprehensive strategy to build capacity within the GOB and support studies and development of new policies for financing HIV/AIDS and health care in Botswana.

To date the GOB has borne the lion’s share of the costs for implementing the national response and this alone is testament to their leadership in the fight against HIV/AIDS. The GOB owns the response, but moving forward there is a greater need for new, targeted interventions where contributions and technical assistance from donors may be necessary. Ultimately it is the Botswana government and people who will benefit from a healthier population and more sustainable health care system.

Central Initiatives

PPP –Currently two PPPs are underway and more will be developed. We will work closely with NACA, ACHAP, and the Leadership Forum to engage and build a stronger private sector partnership.
The MOH has had difficulty providing sufficient technical support to keep up with the IT growth in the health sector. At the same time, Botho College has recently expanded from an institution only offering training and diploma courses to a full service college offering degree programs as well. The first class of graduates was more than 800 students and there is concern that the market will not be able to absorb all of these recent graduates. Therefore, Botho College, in collaboration with CDC Botswana, offered to fund three consecutive one-year attachments in the district health management offices for recent graduates. FY 2012 represents the second year of PEPFAR funding for this activity.

The centrally funded PPP advisor will be brought on board as part of the PEPFAR team early this year to liaise with technical leads from USG agencies, Government of Botswana Ministries, and civil society organizations to identify bottlenecks that might be cleared with private sector expertise; provide technical advice and expertise across the USG as requested; and work in close collaboration with financial, contractual, and program support offices within the relevant USG agencies to develop, implement, and evaluate PPPs.
Gender Challenge Fund - The HIV-MARPS project through RTI is incorporating the GHI principle of focusing on women, girls, and gender equality by ensuring that female sex workers, and other vulnerable women, have access to HIV services, STI screening and treatment, as well as other social services in their respective communities.

On gender based violence, PCI will work with implementing partner Kagisano Women's Shelter Project and other stakeholders to identify safe havens for survivors of abuse; disseminate simple user friendly guides on the major laws affecting women and children; use sports to motivate men to be role models and initiate "men make a difference" support groups to change males norms on gender; support and strengthen established GBV referral systems; and raise community awareness on women and children inheritance and property rights. PCI will work with the Women Affairs Department and other stakeholders to identify, document, and disseminate promising gender related practices. Additionally, PCI will implement a youth project around youth behavior change; gender and sexual reproductive health using Information Communication Technology (ICT) that include health discussions using cell phones and the internet, linking with referral points for services. PCI will use this platform to raise awareness on GBV and factors that facilitate it among youth.
Medical Education Partnership Initiative (MEPI) - The University of Botswana School of Medicine (UB SOM) is the lead partner in a three-partner consortium that has received a five-year, $10 million grant. In partnership with the University of Pennsylvania School of Medicine and the Harvard School of Public Health, the UB SOM proposes an approach to problem-based learning and community-oriented medical education in Botswana with four main objectives:

1. Strengthen and expand medical education at the UB SOM - MEPI support will facilitate the integration of public health education and training at the University of Pennsylvania for upper year residents, continuing medical education for clinicians, career development for health professionals, and additional training for UB SOM faculty.
2. Enhance the teaching platform and care delivery standards within the existing health system to allow for institutional and program accreditation - Accreditation generates confidence in educational institutions and health professionals. It will encourage young doctors to remain in Botswana to practice and, by establishing a rigorous academic environment, it will attract and retain more highly qualified academic faculty.
3. Develop local research capacity for biomedical, clinical and health services research - MEPI support will facilitate student and faculty exchanges for those wishing to conduct research in the basic and clinical sciences. The Health Services Research Unit will be created and will serve as a hub for innovative health services research and multidisciplinary, locally-driven research training at the UB SOM and in the Southern African region.
4. Transform current HIV clinical outreach sites into general medical educational facilities that enhance learning opportunities for students while improving access to clinical services for high risk populations.

MEPI is currently in its second year. During FY 2011 MEPI received $1.85 million of central funding, down from $2.0 million during FY 2010. A carryover was expected from year one due to the late start and delays with procurement and hiring of staff. Hiring has been extremely challenging as UB has not authorized the SOM to pay competitive salaries for physicians. Ambassador Gavin has raised this matter at the highest levels of the University and the Ministry of Education. Other activities under MEPI are progressing well, with the exception of monitoring and evaluation which is still a challenge to be addressed in this current year.

Appendix 1

PEPFAR Botswana Program Areas and OGAC Budget Code Cross Reference

Prevention

| Botswana Program Area | OGAC Budget Code | OGAC Budget Code Description |
|---|---|---|
| PMTCT | MTCT | PMTCT |

| | | | |
|---|---|---|---|
| BCC | HVAB | | Abstinence/Be Faithful |
| | HVOP | | Other Sexual Prevention |
| HCT | HVCT | | Counseling and Testing |
| Blood Safety | HMBL | | Blood Safety |
| Injection Safety | HMIN | I | Injection Safety |
| Male Circumcision | C | IRC | Male Circumcision |

Treatment, Care and Support

| Botswana Program Area | OGAC Budget Code | OGAC Budget Code Description |
|---|---|---|
| Treatment | HTXD | ARV Drugs |
| | HTXS | Adult Treatment |
| | PDTX | Pediatric Treatment |
| Care and Support | HBHC | Adult Care and Support |
| | PDCS | Pediatric Care and Support |
| TB/HIV | HVTB | TB/HIV |
| OVC/Gender | HKID | OVC |
| Lab | HLAB | Laboratory Infrastructure |

System Strengthening

| Botswana Program Area | OGAC Budget Code | OGAC Budget Code Description |
|---|---|---|
| Health System Strengthening | OHSS | Health System Strengthening |
| Civil Society Strengthening | OHSS | Health System Strengthening |

Strategic Information

| Botswana Program Area | OGAC Budget Code | OGAC Budget Code Description |
|---|---|---|
| Research and Surveillance | HVSI | Strategic Information |
| Monitoring and Evaluation | HVSI | Strategic Information |
| Information Systems | HVSI | Strategic Information |

Management

| Botswana Program Area | OGAC Budget Code | OGAC Budget Code Description |
|---|---|---|
| Program Management | Support | M&O Management and Operations |
| Public Diplomacy and Communications | M&O | Management and Operations |

* IDUP – There are currently no PEPFAR-funded activities targeting injecting drug users in Botswana.

Appendix 2
Technical Area Narratives (see attached)

## Population and HIV Statistics

| Population and HIV Statistics | | | | Additional Sources | | |
|---|---|---|---|---|---|---|
| | Value | Year | Source | Value | Year | Source |
| Adults 15+ living with HIV | 300,000 | 2009 | UNAIDS Report on the global AIDS Epidemic 2010 | | | |
| Adults 15-49 HIV Prevalence Rate | 25 | 2009 | UNAIDS Report on the global AIDS Epidemic 2010 | | | |
| Children 0-14 living with HIV | 16,000 | 2009 | UNAIDS Report on the global AIDS Epidemic 2010 | | | |

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|---|---|---|---|---|---|---|
| Deaths due to HIV/AIDS | 5,800 | 2009 | UNAIDS Report on the global AIDS Epidemic 2010 | | | |
| Estimated new HIV infections among adults | 13,000 | 2009 | UNAIDS Report on the global AIDS Epidemic 2010 | | | |
| Estimated new HIV infections among adults and children | 14,000 | 2009 | UNAIDS Report on the global AIDS Epidemic 2010 | | | |
| Estimated number of pregnant women in the last 12 months | 48,000 | 2009 | State of the World's Children 2011, UNICEF. | | | |
| Estimated number of pregnant women living with HIV needing ART for PMTCT | 13,000 | 2010 | Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011 | | | |
| Number of people living with HIV/AIDS | 320,000 | 2009 | UNAIDS Report on the global AIDS Epidemic 2010 | | | |
| Orphans 0-17 due to HIV/AIDS | 93,000 | 2009 | UNAIDS Report on the global AIDS Epidemic | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | 2010 | | | |
| The estimated number of adults and children with advanced HIV infection (in need of ART) | 170,000 | 2010 | Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011 | | | |
| Women 15+ living with HIV | 170,000 | 2009 | UNAIDS Report on the global AIDS Epidemic 2010 | | | |

## Partnership Framework (PF)/Strategy - Goals and Objectives

| Number | Goal / Objective Description | Associated Indicator Numbers | Associated Indicator Labels |
|---|---|---|---|
| 1 | Reduce new HIV infections by 50%. | | |
| 1.1 | Objective 1: To increase the adoption of safer sexual behaviors and practices. | P8.10.N | P8.10.N Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15. |
| 1.2 | Objective 2: To increase demand and coverage for safe male circumcision. | P5.1.N | P5.1.N Number of male circumcisions performed according to national or international standards, within the reporting period |
| 1.3 | Objective 3: To expand access to quality HIV testing and counseling services | P11.2.N | P11.2.N Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their |

| | | | |
|---|---|---|---|
| | | | results |
| 1.4 | Objective 4: To increase access to quality PMTCT services. | P1.2.N | P1.2.N Percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery |
| | | P1.7.N | P1.7.N Percentage of infants born to HIV-infected mothers who are infected |
| 1.5 | Objective 5: To provide quality, safe, adequate and accessible blood and blood products. | P2.4.N | P2.4.N Percent of blood units collected and screened by the NBTS network which are identified as reactive for HIV by a NBTS network laboratory |
| 2 | To increase the GOB, civil society, and private sector ability to sustain high quality, cost effective HIV services | | |
| 2.1 | Objective 1: To integrate and strengthen the national health system structures for effective service delivery. | H2.1.N | H2.1.N Number of new health care workers who graduated from a pre-service training institution within the reporting period |
| 2.2 | Objective 2: To provide sustainable financial support for cost effective interventions in the national response. | H3.1.N | H3.1.N Domestic and international AIDS spending by categories and financing sources |
| 3 | To strengthen Strategic Information management of the national response to enhance evidence based planning | | |
| 3.1 | Objective 1: Strengthen the strategic information management systems at all levels. | H7.2.N | H7.2.N Existence of one agreed upon M&E plan for overall national monitoring and evaluation |

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|---|---|---|---|
| 4 | To provide comprehensive and quality treatment care and support services to people infected and affected by HIV | | |
| 4.1 | Objective 1: To decrease the morbidity and mortality of PLWHA. | P1.2.N | P1.2.N Percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery |
| | | T1.2.N | T1.2.N Percent of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) |
| | | P1.7.N | P1.7.N Percentage of infants born to HIV-infected mothers who are infected |
| 4.2 | Objective 2: To reduce the burden of TB in Botswana, particularly amongst those infected by HIV/AIDS. | C3.2.N | C3.2.N Percent of estimated HIV-positive incident TB cases that received treatment for TB and HIV |
| | | C3.3.N | C3.3.N Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings |
| 4.3 | Objective 3: To strengthen laboratory services for improved service delivery | H1.1.D | H1.1.D Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests |
| | | H1.2.D | H1.2.D Number of testing facilities (laboratories) that are accredited according to national or international standards |

## Agencies

**In what way does the USG participate in the CCM?**
Voting Member

**What has been the frequency of contact between the Global Fund Secretariat (Fund Portfolio Manager or other Geneva-based staff) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.**
1-3 times

**What has been the frequency of contact between the Local Fund Agent (LFA) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.**
4-6 times

**Has the USG or is the USG planning to provide support for Round 11 proposal development? Support could include staff time, a financial contribution, or technical assistance through USG-funded project.**
CCM is not planning to submit proposals

**Are any existing HIV grants approaching the end of their Phase 1, Phase 2, or RCC agreement in the coming 12 months?**
Yes

**If Yes, please indicate which round and how the end of this grant may impact USG programming. Also describe any actions the USG, with country counterparts, is taking to enable continuation of any successful programming financed through these grants.**
"The 5th round TB Grant Phase 2 is coming to an end at the end of this year and MOH who is the Principal Recipient is in the process of implementing the closure plan. The aim of the unsuccessful 10th round application was to ensure continuation and expansion of TB/HIV interventions that were being supported through the 5th round TB grant. There will therefore be funding implications when the 5th round TB grant comes to an end at the end of this year.
"

**In your country, what are the 2-3 primary challenges facing the Global Fund grant implementation and performance (for example, poor grant performance, procurement system issues, CCM governance/oversight issues, etc)? Are you planning to address those challenges through any activities listed in this COP?**
Redacted

**Did you receive funds for the Country Collaboration Initiative this year?**
No

**Is there currently any joint planning with the Global Fund?**
Yes

**If Yes, please describe how the joint planning takes place (formal/informal settings; the forums where it takes place (CCM?); timing of when it takes place (during proposal development, grant negotiation, COP development, etc.); and participants/stakeholders). Also describe if this joint planning works well and its effects (has it resulted in changes in PEPFAR programming, better anticipation of stock-outs and/or TA needs, better communication with PR, etc.)**
Redacted

**Has the USG stepped in to prevent either treatment or service disruptions in Global Fund financed programs in the last year either during or at the end of a grant? Such assistance can take the form of providing pharmaceuticals, ensuring staff salaries are paid, using USG partners to ensure continuity of treatment, , or any other activity to prevent treatment or service disruption.**

## Public-Private Partnership(s)

| Created | Partnership | Related Mechanism | Private-Sector Partner(s) | PEPFAR USD Planned Funds | Private-Sector USD Planned Funds | PPP Description |
|---|---|---|---|---|---|---|
| | PCI ARV | 12817:Prev | Mascom | | | CDC is working |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Reminders | ention, Strengthening Health and SI Systems and Access To Quality HIV/AIDS Services Through Support Programs Conducted By The Government Of Botswana | | | | with GOB, Positive Innovation for the Next Generation (PING), and Mascom to send SMS text reminders to ART patients in the Masa treatment program with noted adherence problems. Mascom, a leading provider of mobile telephony in Botswana, is providing free airtime, ISP service and token prizes for patient successes. During FY11, a small pilot was conducted with Masa ART patients. Evaluation of the pilot is being conducted. Future expansion of the program may |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | include 1) increasing follow-up of children born to HIV+ mothers for HIV testing at 8 weeks and 18 months, 2) sending notification of availability of laboratory test results for the Early Infant Diagnosis program to facilities and patients, 3) referring VCT clients for safe male circumcision (if HIV negative) or treatment (if HIV positive), 4) tracking TB cases and monitoring adherence, and 5) increasing donor participation in blood drives. The implementing mechanism is Cardno |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | Emerging Markets USA, the CDC PPP mechanism. This activity is planned to continue through FY13. |
| | TBD - Treatment PPP | 12762:Public-Private Partnerships in PEPFAR countries | TBD | | | The treatment team aims to leverage PEPFAR resources to approach the mining and tourism sectors for targeted staff PPP opportunities. As this is the most highly trained, most mobile cadre of employee in Botswana, there is a belief that this area is ripe for harvesting. As a middle income country with a globalized epidemic, corporate social responsibility is on everyone's mind, and this seed money |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | should get the program kicked off in a big way. |
| | TBD - PPP General | 12762:Public-Private Partnerships in PEPFAR countries | TBD | | | The TBD - PPP General funds will be used to encourage PPPs in multiple program areas. |
| | TBD - OVC Gender PPP | 13669:OVC-Gender | TBD | | | The main goal of the OVC and Gender project is to bring more focus on women and children on issues of HIV and AIDS prevention, care and support as they are impacted by HIV and AIDS in a unique way. For women, this has been exacerbated by their role within society and their biological vulnerability to HIV infection. The project aims to empower children to grow up being aware of the challenges facing women |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | and how to address these and to address issues of child-headed households and sexual abuse. The project will seek the involvement of the private sector to contribute to the development and upbringing of Botswana's orphaned and vulnerable children in an organized and sustainable manner. |
| | NIIT District Health IT Officers | 12817:Prevention, Strengthening Health and SI Systems and Access To Quality HIV/AIDS Services Through Support Programs Conducted By The | NIIT / Botho College | | | With CDC funding through its PPP mechanism with Cardno Emerging Markets USA, the National Institute for Information Technology (NIIT) and GOB have developed a district-level, one-year IT |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Government Of Botswana | | | | internship program for NIIT graduates. In FY11, 20 NIIT graduates were placed with District Health Management Teams (DHMT) where they provided assistance to district health officials and health facilities staff to support the functioning of the MOH computer network. In five pilot districts, NIIT interns worked on the deployment and support of electronic registers for PMTCT and HTC. CDC and GOB staff provide strategic and technical guidance on the project's implementation and monitoring plan, while NIIT |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | was responsible for overall administration, implementation, and monitoring. NIIT supervisors assessed the performance and development needs of the interns and provided them with relevant additional training. |

## Surveillance and Survey Activities

| Surveillance or Survey | Name | Type of Activity | Target Population | Stage | Expected Due Date |
|---|---|---|---|---|---|
| N/A | 2011 HIIV Drug resitance among ANC population | HIV Drug Resistance | Pregnant Women | Data Review | N/A |
| N/A | ANC Sentinel Surveillance (2011) | Sentinel Surveillance (e.g. ANC Surveys) | Pregnant Women | Other | N/A |
| N/A | Assessing the Utility of Prevention of Mother to Child Transmission Program Data for HIV Surveillance | Evaluation of ANC and PMTCT transition | Pregnant Women | Publishing | N/A |
| N/A | Behavioral Surveillance Survey among Learners Aged 10-19 in Botswana | Population-based Behavioral Surveys | Youth, Other | Publishing | N/A |
| N/A | Botswana AIDS Indicator Survey IV | Population-based | General Population | Implementation | N/A |

| | | | | | |
|---|---|---|---|---|---|
| | | Behavioral Surveys | | | |
| N/A | Characterization, Validation and Application of New HIV-1 Incidence Assays to Detect Recent HIV-1 Infections in Botswana | Recent HIV Infections | Pregnant Women | Implementation | N/A |
| N/A | Counseling and Testing Outreach- Selebi/Phikwe and Bobirwa | Evaluation | General Population | Publishing | N/A |
| N/A | Infant Mortality Surveillance in Botswana | HIV-mortality surveillance | Other | Implementation | N/A |
| N/A | Integrated HIV Serological and Behavioral Surveillance among Persons Attending Alcohol Consumption Venues in Gaborone, Botswana | Sentinel Surveillance (e.g. ANC Surveys) | Other | Data Review | N/A |
| N/A | MARPS Assesment | Population size estimates | Female Commercial Sex Workers, Injecting Drug Users, Mobile Populations | Data Review | N/A |
| N/A | Monitoring adverse events after male circumcision | Sentinel Surveillance (e.g. ANC Surveys) | Other | Development | N/A |
| N/A | Multiple Concurrent Partnerships Study Supporting Campaign Development, Monitoring and Evaluation | Evaluation | General Population | Development | N/A |

# Budget Summary Reports

## Summary of Planned Funding by Agency and Funding Source

| Agency | Funding Source | | | | Total |
|---|---|---|---|---|---|
| | Central GHP-State | GAP | GHP-State | GHP-USAID | |
| DOD | | | 2,220,017 | | **2,220,017** |
| HHS/CDC | 2,786,962 | 7,147,000 | 40,590,368 | | **50,524,330** |
| HHS/HRSA | | | 3,487,509 | | **3,487,509** |
| PC | | | 1,999,400 | | **1,999,400** |
| State | | | 276,769 | | **276,769** |
| State/AF | | | 1,350,000 | | **1,350,000** |
| USAID | | | 16,075,937 | | **16,075,937** |
| **Total** | **2,786,962** | **7,147,000** | **66,000,000** | **0** | **75,933,962** |

## Summary of Planned Funding by Budget Code and Agency

| Budget Code | Agency | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | State | DOD | HHS/CDC | HHS/HRSA | PC | State/AF | USAID | AllOther | |
| CIRC | | 375,000 | 7,230,588 | | | | 1,249,290 | | **8,854,878** |
| HBHC | | | 3,263,111 | 444,000 | | | | | **3,707,111** |
| HKID | 35,964 | | 800,000 | | 700,000 | | 2,990,380 | | **4,526,344** |
| HLAB | | 160,017 | 1,980,024 | 680,000 | | | 1,000,000 | | **3,820,041** |
| HMBL | | | 575,290 | | | | | | **575,290** |
| HMIN | | | 362,790 | | | | | | **362,790** |
| HTXD | | | 3,817,187 | | | | 733,401 | | **4,550,588** |
| HTXS | | | 1,555,290 | | | | | | **1,555,290** |
| HVAB | | 140,000 | 629,406 | | | | 56,796 | | **826,202** |
| HVCT | | 450,000 | 5,377,730 | | | | 200,000 | | **6,027,730** |
| HVMS | 204,841 | 195,000 | 8,398,908 | | 1,299,400 | | 738,250 | | **10,836,399** |
| HVOP | 35,964 | 475,000 | 1,346,124 | | | | 1,956,796 | | **3,813,884** |


| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| HVSI | | 375,000 | 4,752,348 | 763,509 | | | 100,000 | | **5,990,857** |
| HVTB | | 50,000 | 3,222,073 | 900,000 | | | 1,300,000 | | **5,472,073** |
| MTCT | | | 2,424,579 | 200,000 | | | 530,024 | | **3,154,603** |
| OHSS | | | 3,979,402 | 500,000 | | 1,350,000 | 5,221,000 | | **11,050,402** |
| PDCS | | | 584,190 | | | | | | **584,190** |
| PDTX | | | 225,290 | | | | | | **225,290** |
| | **276,769** | **2,220,017** | **50,524,330** | **3,487,509** | **1,999,400** | **1,350,000** | **16,075,937** | **0** | **75,933,962** |

# National Level Indicators

## National Level Indicators and Targets

Redacted

# Policy Tracking Table

| Policy Area: Counseling and Testing | | | | | | |
|---|---|---|---|---|---|---|
| **Policy: Reduction in age of consent for testing from 21 to 16 years** | | | | | | |
| **Stages:** | **Stage 1** | **Stage 2** | **Stage 3** | **Stage 4** | **Stage 5** | **Stage 6** |
| **Estimated Completion Date** | 2008 | 2008 | 2009 | 2009 | TBD | TBD |
| **Narrative** | Relevant stakeholders include PEPFAR, Implementing Partners and the Government of Botswana. | Current age of consent is 21 years. Seen as a barrier to access HCT services by young people. National AIDS Council recommended reducing the age to 16. | Stakeholders came together to develop the Public Health Bill which includes the reduction of the age of consent to 16. Policy development process supported by Ministry of Health. | Policy document drafted and sent to Cabinet and Parliament. Currently going through parliamentary review processes. | TBD | TBD |
| **Completion Date** | | | | | | |
| **Narrative** | | | | | | |

# Technical Areas

## Technical Area Summary

**Technical Area:** Care

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HBHC | 3,707,111 | 0 |
| HKID | 4,526,344 | 0 |
| HVTB | 5,472,073 | 0 |
| PDCS | 584,190 | 0 |
| **Total Technical Area Planned Funding:** | **14,289,718** | **0** |

**Summary:**
Major accomplishments in last 1-2 years
A number of significant accomplishments have occurred during the past 2 years. For Positive Health, Dignity and Prevention (PHDP), a national strategy for 2009-2016, an implementation plan for 2010-2016, and an implementation plan for civil society for 2010-2016 were all developed and disseminated. In Sexually Transmitted Infections, a syndromic approach to diagnosis and treatment has resulted in a more effective national program. For TB/HIV the national laboratory was recently renovated and is working towards accreditation. Progress has also been made in increasing HIV testing rates among persons with TB. For OVC, PEPFAR continued to work with the Government of Botswana (GOB) and civil society organizations (CSO) to implement programs that support the national priorities. As a result, the following were achieved 1) roll out of the psychosocial support training to ten of the sixteen districts by end of 2010, 2) development of a data base for the nutrition rehabilitation program to move the program from capturing data manually to an electronic system, 3) costing analysis of selected OVC programs in Botswana to give the GOB information related to cost for the OVC program, 4) development of a user friendly guide for the care of OVC, 5) assessment of the implementation of Botswana's OVC programs, and 6) printing of 500 copies of the Children's Act of 2009 and distributing to the service providers throughout the country.
Key priorities and major goals for next two years
External funding for Care and Support is scheduled to end with the 2014 COP. Priority areas identified in the Journey of PEPFAR 2.0 prior to program graduation were STI, palliative care, cervical cancer prevention, and PHDP. For TB/HIV the priority areas were the 3 I's (isoniazid preventive therapy (IPT), infection control, intensified case finding) and Multi Drug Resistant Tuberculosis (MDRTB). For OVC, the program's key priorities include 1) strengthening civil society organizations' capacity to work with OVC to provide good quality services especially in the areas of psychosocial support (PSS) and integrated early childhood development (IECD), 2) increasing access of OVC and their families to livelihood opportunities, 3) supporting the GOB to implement guidelines and policies that address the needs of vulnerable children, and 4) strengthening of coordination, monitoring, and evaluation structures. Efforts involving HIV, TB, and under 5 child mortality support the Global Health Initiative (GHI) strategy for Botswana.
Alignment with government strategy and priorities
The fourth goal of the National Strategic Framework on HIV and AIDS II (NSF II) focuses on treatment, care, and support. Programming for the three areas of TB/HIV, OVC, and adult and pediatric care and support is guided by the provisions of this framework. This document has also informed the

development of the USG-GOB Partnership Framework which was signed in 2010. Currently the GOB is finalizing the National Operational Plan (NOP), a plan that will operationalize both the NSFII and Partnership Framework.

Contributions from or collaboration with other development partners

For the OVC program, UNICEF is the other development partner that provides support in Botswana. The UNICEF and PEPFAR OVC programs collaborate closely to support the GOB OVC program, to eliminate duplication of efforts, and ensure that support is channeled to address existing gaps. Technical assistance for Care and Support activities is provided by WHO. TB/HIV activities are supported by ACHAP, WHO, and the Global Fund.

Policy advances or challenges

The expanded use of narcotics for pain relief in the palliative care program still needs GOB approval. The national IPT program has essentially stopped enrolling new patients as the government is deciding how to proceed with these activities. Turnover in leadership and lack of funding in Botswana National Tuberculosis Program have compromised the effectiveness of national efforts. A draft national policy on orphans and vulnerable children was finalized in 2009, and is still yet to be approved by cabinet.

Efforts to achieve efficiencies

Through PEPFAR support, the national OVC program is currently working on developing a data-base to strengthen coordination efforts. The database will centralize data for OVC in one place. The current electronic system captures orphans only; vulnerable children are captured using a manual system.

Efforts to build evidence base

Results of the IPT study in Botswana, which was partially supported by PEPFAR, influenced WHO recommendations for isoniazid preventive therapy in persons with HIV. Results of the pilot program using the See and Treat approach for cervical cancer were presented at an international scientific meeting and have helped to persuade the GOB to approve this approach for use in Botswana.

Adult Care and Support

Support from the Presidents' Emergency Plan for AIDS Relief (PEPFAR) has assisted the Government of Botswana to respond to challenges that HIV and AIDS present to the country. The most recent Botswana AIDS Impact Survey (BAIS) done in 2008 indicated that the national HIV prevalence rate was 17.6%. The same survey conducted in 2004 showed a national prevalence of 17.1%. This shows that HIV prevalence remained stable over the last 4-5 years. The incidence rate is 2.9%. With this incidence rate combined with high coverage with ART, the number of PLWHA will increase with time. These individuals will require continuous care and support services. The partnership framework emphasized the need to integrate services in order to address issues of access to quality care. The strategic goal is to provide comprehensive and quality treatment, care, and support services to people infected and affected by HIV. The strategic objective is to increase access to HIV/AIDS comprehensive quality treatment, care, and support services.

The Care and Support program provides services to people infected and affected by HIV/AIDS. The program encompasses a broad array of clinical, psychological, social, spiritual, and preventive care for both adults and children. It includes palliative care; Positive Health, Dignity and Prevention (PHDP); care for the caregivers; cervical cancer prevention; care and support for refugees; sexually transmitted infections; safe motherhood; opportunistic infections management; and community-based care. The program's strategic goal is to scale up care and support services to children, adolescents, and adults with an emphasis on improving the coverage and the quality of care and support services through strengthening managerial and technical assistance as well as strengthening long-term capacity for comprehensive service delivery. This includes building the capacity of both the government primary health care system and civil society organizations. Currently the health care sector provides care and support both in institutions and at the community level. Implementation of the PHDP minimum package ensures provision of integrated services to People Living With HIV/AIDS (PLWHA). The Botswana minimum package of PHDP services includes: psychological support services, HIV counseling and testing, ART provision, cotrimoxazole prophylaxis, STI screening and treatment, TB testing and treatment, Preventing Mother To Child Transmission (PMTCT), provision of male and female condoms, nutrition, sexual and reproductive health, referrals and follow-up, behavior change communication interventions for

reduction of risky behaviors, stigma and discrimination, and palliative care.

Pediatric Care and Support

As depicted in the partnership framework, the goal of the care and treatment program is to strengthen the provision of universal access to quality HIV/AIDS services in Botswana by 2016. The overall strategic objective in this area is to decrease morbidity and mortality among PLWHA. To this end specific objectives include improving pediatric and adolescent access and adherence to treatment, strengthening human capacity development, implementing nutrition programs, and integrating care and support services such as OVC, PMTCT, HIV Counseling and Testing (HCT), and home-based care.

Infant and child mortality in Botswana continues to be dramatically affected by the HIV epidemic. HIV continues to contribute to a high proportion of deaths in children younger than five years old, more than 50% by some estimates. Child mortality for younger than five years old is high at 120 per 1,000. Reasons for this high mortality are unclear and may relate to intrauterine HIV infection, HIV drug exposure, formula use, or other factors. With support from UNICEF, the national ARV program (the MASA program) hired a pediatric advisor to oversee pediatric care and treatment in the country. PEPFAR-funded efforts to reduce under 5 child mortality support Botswana's GHI targets.

As part of long-term human capacity development, the PEPFAR-supported national HIV training program Knowledge, Innovation, and Training Shall Overcome (KITSO) is continuing to give week-long pediatric HIV/AIDS management courses in an effort to decentralize pediatric expertise and care to all parts of Botswana. This course utilizes trainers from the GOB and United States Government (USG) partners such as Baylor and the University of Pennsylvania. These activities will continue with USG support in FY2012.

The 2007 data show that nationwide, 78% of all HIV-exposed infants were tested before the age of six months. Cotrimoxazole (CTX) is provided for all exposed infants from age six weeks until they have a negative HIV test along with nutritional support. The 2007 data also show that among infants older than 9 weeks old, more than 70% were already taking daily CTX at the time they arrived for their first HIV test. HIV-infected infants are referred to the MASA Program, which provides pediatric ART at all sites which provide adult ART.

The "MASA Expert Patient" project supported by PEPFAR at the national level has been established to identify and refer children who need testing to health facilities; follow children from PMTCT and Under 5 Clinics who need care and refer them to the point of service sites for anti-retroviral therapy; and provide psychosocial support and appropriate referrals as needed.

The expert patients have been functioning from clinics where children are most often seen and also in the community. They have joined with community-based organizations (CBO) and NGOs in the respective communities to leverage resources in carrying out their duties, as there are other community resources that will add value to child survival.

It is hoped that through this program care will be expanded to many more children. Currently less than 10% of the over 170,000 patients on ART in Botswana are children. Even though the exact number of children in need of care in Botswana is not known, because of the high prevalence of HIV, it is expected that more children will be identified and cared for. In Botswana most children receive care and support and highly active anti-retroviral therapy (HAART) through the 32 ART sites and 198 satellite clinics.

In the effort to expand comprehensive care, support, and treatment services for children exposed, infected or affected by HIV and minimize mortality and improve quality of life, PEPFAR will continue to support the MOH in early identification of HIV exposure and infection status; linkage, referral, and retention in care; CTX prophylaxis; treatment adherence support; opportunistic infection prevention, diagnosis, and treatment; linkage to child survival interventions; improved quality of life through appropriate pain assessment and management; and provision of psychological, social, and spiritual support.

TB/HIV

Tuberculosis (TB) remains a major public health problem in Botswana and is responsible for 13% of adult deaths and 40% of deaths among people living with HIV/AIDS (PLWHA). According to the 2010 WHO Global TB Report, Botswana reported 8,781 TB patients in 2009. Eighty percent of TB patients in 2010 were tested for HIV. HIV prevalence in TB patients was 65%. Of co-infected patients 70% received

cotrimoxazole preventive therapy and 45% received antiretroviral therapy (ART), compared to 31% and 36% respectively in 2009. Revision of the national treatment guidelines in late 2011 is anticipated to lead to further improvement in the management of HIV+ TB patients. Multidrug-resistant TB (MDRTB) is a growing problem, increasing among new patients from 0.8% to 2.5% between 2002 and 2008.

The Botswana Partnership Framework aligns PEPFAR support to the national TB strategic plan that is based on the Stop TB Strategy; the WHO Interim Policy on Collaborative TB/HIV activities; international guidance on MDRTB; and the Three I's (infection control, isoniazid preventive therapy, and intensified case finding). The key priorities and major goals to improve TB/HIV activities in the next two years are:

1. To strengthen TB and program planning, implementation, and monitoring and evaluation (M&E) in order to enhance the quality of DOTS services provided.
2. To improve and expand the quality of TB laboratory services through enhancing methods for rapid TB diagnosis and strengthening the national external quality assurance (EQA) program.
3. To expand and strengthen TB/HIV services by enhancing provider-initiated HIV testing and counselling (PITC), early initiation of ART, provision of cotrimoxazole in HIV-positive TB patients, and the Three I's.
4. To support surveillance and management of MDRTB.
5. To contribute to health systems strengthening by providing technical assistance to develop national guidelines, policies and operational tools and by supporting training of health care workers (HCW).
6. To engage people with TB and affected communities in TB control.

With support from key partners, the MOH has drafted action plans to scale up the Three I's and early initiation of ART in TB patients. PEPFAR support has contributed to the development of national TB and HIV M&E systems. Funding will be requested to build on these platforms to harmonise and coordinate integrated reporting of PEPFAR TB/HIV indicators, to facilitate the collection of WHO-recommended indicators in line with the action plans for the Three I's, and to catalyse the development of the Three Interlinked Patient Monitoring Systems for HIV care/ART, Maternal and Child Health (MCH)/PMTCT, and TB/HIV. Funds will be requested to continue supporting key positions in both the TB and HIV programs to facilitate the rapid reintroduction of the national IPT program that was stopped in early 2011 and to train HCW on the Three I's (including the revised IPT approach) and on the redesigned TB and HIV M&E systems.

With PEPFAR support, early initiation of ART for HIV-positive TB patients has been integrated into current HIV and TB care and treatment strategies. Trainings on the new care and treatment strategy have begun, including to private practitioners (physicians, pharmacists, and laboratory scientists). Support will be requested for the roll out of these trainings in the public and private sectors and for enhanced supportive mentoring visits to improve the implementation of the revised approach. Advocacy will continue for the provision of ART in TB treatment areas in order to create a "One Stop Shop" for HIV-TB dually infected patients. Efforts to integrate TB and HIV care are consistent with the GHI strategy for Botswana.

The MOH coordinates partner activities through a national TB Partnership Forum headed by the TB program. This partnership includes the funding of technical and civil society organisation (CSO) partners. It meets regularly to review progress in achieving national strategic targets on TB/HIV. In addition, the PEPFAR TB/HIV technical working group coordinates implementing partners' activities in line with government priorities to ensure adequate technical and geographic coverage of TB/HIV services. PEPFAR is funding the bulk of technical assistance in the development of a new national strategic plan for TB (including MDRTB and TB/HIV) that is based on the Partnership Framework and international evidence-based strategies. The plan will serve as the primary document for coordinating partner activities in TB/HIV.

Funds will be requested to continue the standardisation of TB and HIV recording and reporting tools, to strengthen supportive mentoring and supervisory visits to the districts, and to support national program

evaluations by MOH and other stakeholders. These activities will enable assessment of the impact of activities and adjust program implementation to improve outcomes.

PEPFAR supports the positions of the national EQA specialist at the National TB Reference Laboratory (NTRL) and the expansion and strengthening of the national laboratory network. Liquid culture methods and fluorescent microscopy have been introduced with PEPFAR support. Funds will be requested to continue these activities. The TB/HIV Research Section of CDC Botswana is using a phased implementation approach to introduce Cepheid Xpert® MTB/RIF in ten sites under operational study conditions. Lessons learnt from this project will be applied to guide the national TB laboratory diagnostic strategy to improve TB case-finding through integrating the technology into the current national laboratory network in 2013 and beyond.

Food and Nutrition

PEPFAR Botswana does not currently have specific programs funded for food and nutrition. The narrative on OVC covers our current activities in this area.

Orphans and Vulnerable Children (OVC)
Botswana has a national program that ensures that OVC have access to basic necessities such as food, education, and health care. By July 2011, 41,784 orphans and 37,179 vulnerable children were registered under this program. The numbers for orphans are not expected to go up dramatically during the coming years as more and more parents live longer now to take care of their children because of the availability of anti-retroviral drugs. The numbers of vulnerable children, however, are expected to increase as many families are not able to adequately provide for their children. During 2010, 7,160 orphans exited the program because they turned 18 years while 3,689 entered the program. Even though a large number has exited the program, some of them continue to receive government assistance as needy students because they come from families that are not able to meet their needs in terms of food and school uniforms.

During the next two years, the Botswana PEPFAR OVC program's primary goals for supporting children and their households affected by HIV/AIDS will include:

• Strengthening civil society organizations' capacity to work with OVC to provide good quality services especially in the areas of psychosocial support (PSS) and IECD.
• Increasing access of OVC and their families to livelihood opportunities.
• Supporting the GOB to implement guidelines and policies that address the needs of vulnerable children.
• Strengthening of coordination, monitoring, and evaluation structures.

PEPFAR Botswana goals are in line with the national priorities as well as other donors' goals such as UNICEF. UNICEF Botswana is the only other donor covering children issues in Botswana. PEPFAR Botswana, UNICEF Botswana, and the GOB have a good relationship. For example the three have collaborated very well during the development of the National Plan of Action for OVC which UNICEF financially supported as well as the design of the PEPFAR-funded OVC and Gender project which was awarded in June 2011. This collaboration ensures that all proposed interventions by UNICEF and PEPFAR are consistent with national priorities.

In addition to the GOB program, there are a number of CSOs throughout the country that are working in the area of OVC providing an array of services. As a result, one of the challenges that the program is facing is coordination and proper implementation of policies. In 2010, PEPFAR Botswana supported an assessment that was conducted to identify barriers that hinder proper implementation of the OVC program. The assessment identified nine barriers; three of these pointed to weaker systems: 1) weak coordination, monitoring, and evaluation systems; 2) inadequate policy understanding, dissemination,

implementation, and training; and 3) inadequate referral systems. Through the newly awarded OVC and Gender project, support will be provided to GOB and CSOs to address some of these issues. Some of the activities that will support system strengthening include policy support (development, dissemination, and implementation), database development and linkages to national M&E systems, and capacity building for gender analysis.

As highlighted above, one of the primary goals for PEFPAR Botswana is to increase access of OVC and their families to livelihood opportunities so as to strengthen them economically and increase their capacity to provide food for themselves. This goal is addressed by objective 1 of the OVC and Gender project which is to “improve livelihoods of households for vulnerable adolescents, especially girls and vulnerable women”. The activities proposed to achieve this objective include 1) increasing participation of vulnerable households, including men, in economic strengthening activities (financial literacy and business management skills, small business development, and savings and loan groups) and 2) increasing livelihood opportunities for vulnerable youth (job readiness preparation, enrollment in vocational training institutions, small business development, access to credit and grants, and use of Information, Communications and Technology (ICT). To address the issue of food security, focus will be on working with families to start backyard vegetable gardens in order to feed their families as well as sell everything that is in excess of what the family needs.

Currently the program supports three major projects: 1) the Nutrition Rehabilitation Program (NRP) with the Ministry of Health (MOH); 2) the National OVC Program with the Ministry of Local Government (MLG); and 3) the OVC and Gender project with an international partner. All these programs provide services to eligible children from 0-18 years. The projects provide different services and have established linkages with providers in health care, education, psychosocial support, and prevention. However most of the services are not yet integrated and referrals between services are not very smooth. The new OVC and Gender project has been designed to promote provision of integrated services using the approved GOB Family Care Model. In addition, the project will work closely with the relevant GOB ministries to strengthen referrals between services.

Cross Cutting Areas

Public Private Partnerships (PPP)
The OVC and Gender project has a PPP component. The PPPs are currently being developed and are expected to bring more funding to the project and increase its sustainability.
Gender
In line with the PEPFAR Gender Strategy and the GHI principles the Care and support portfolio is improving women’s health by supporting the cervical cancer prevention program through partnership with the University of Pennsylvania. This initiative includes brief morning health education talks on development of cervical cancer to all patients attending the ARV clinic. Those patients presenting at the screening clinic receive screening for pre cancer lesions using a combination of visual inspection after acetic acid (VIA) and digital cervicography followed by treatment using cryotherapy. The pilot for this initiative is currently running in two facilities and to date 1125 women were screened and 525 women received treatment of pre-cancer lesions. The MOH has recently approved this approach and would like to roll it out to other facilities. In FY12, PEPFAR plans on providing technical assistance to support this initiative beyond the pilot sites.
The care and support team and implementing partners will benefit from gender analysis training conducted through the OVC and Gender project and this will help the team to reprogram and make their programs gender sensitive.

MARPs
The GOB does not provide ARVs to non-citizens. PEPFAR has supported care and treatment programs for the 3,000 refugees living at the camp in Dukwe. Through a collaboration with the Red Cross, we are

now supporting health care providers in the camp so that ARV services are provided on site. In the past, refugees had to travel to Francistown for care.
Human Resources for Health (HRH)
PEPFAR continues to support pre-service training in areas such as palliative care at the national Institutes for Health Sciences. PEPFAR also provides substantial support to faculty at the University of Botswana's School of Medicine which has recently started its third year of operation. In-service training for health care workers is provided on a wide range of topics by our university partners (Baylor, University of Washington, Harvard, and University of Pennsylvania).
Laboratory
Efforts for laboratory accreditation are ongoing. Currently three public laboratories have been accredited by (South Africa National Accreditation System (SANAS). Additional laboratories are participating in the Strengthening Laboratory Management Towards Accreditation (SLMTA) program as they work towards accreditation.
Strategic Information
Mobile telemedicine is an inexpensive and effective method to expand specialist care in underserved areas. Since 2008, PEPFAR has implemented several types of mobile phone health (mHealth) initiatives in clinics throughout Botswana. In COP 2012, PEPFAR will support the expansion of the existing mobile telemedicine initiatives in collaboration with the MOH to increase specialist access in underserved areas and provide training and technical assistance to local clinicians in order to effectively utilize these systems. PEPFAR will also work with the University of Botswana School of Medicine to integrate health informatics into their curriculum.
Capacity Building
PEPFAR provides extensive technical assistance either through staff seconded to the MOH or through short-term temporary duty (TDY) assignments for the national TB program. By providing support, we hope to improve its capacity to deal with high rates of HIV/TB coinfection and increasing levels of MDRTB.

**Technical Area:** Governance and Systems

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HLAB | 3,820,041 | 0 |
| HVSI | 5,990,857 | 0 |
| OHSS | 11,050,402 | 0 |
| **Total Technical Area Planned Funding:** | **20,861,300** | **0** |

**Summary:**
1 Introduction
Major actors in the Botswana health system include the Ministries of Health (MOH), Local Government (MLG), Education, Finance and Development Planning, Labor and Home Affairs (MLHA), the National AIDS Coordination Agency (NACA), and the Office of the President (OP). Amongst these, the Government of Botswana (GOB) is the principle provider of health services with 68% of total health expenditures (THE) from public sources. The MOH has the mandate to provide health services and this is done through a de-concentrated system of service delivery. Within the MOH, the key players are the departments of Corporate Services, Health Policy Development, Monitoring and Evaluation (DPHDME),

Clinical Services, HIV/AIDS Prevention and Care (DHAPC), and Public Health. Also of importance are the new Office of Strategy Management and the semi-autonomous bodies, the Health Inspectorate and the professional councils. The public service commission sits under the OP and is critical in issues of human resources for health. The Department of Social Services, responsible for the social welfare workforce and the orphans and vulnerable children programs, and the District AIDS Coordination (DAC) offices, fall under the MLG, while the Women's Affairs Department is in the MLHA.

Donor expenditures in health are less than 12% of THE and few donors are working in HIV/AIDS. Development partners worth noting include the Africa Comprehensive HIV/AIDS Partnership (Gates/Merck), United Nations agencies, the World Bank and the European Union (EU). The country has not been very successful in its bids for Global Fund. The private sector is small, but growing, with private expenditures at 20% of THE.

Botswana had one of the most developed public health systems in Africa with impressive successes in health indices until the early nineties when HIV/AIDS became the most significant social and public health problem. The country has led an impressive response, but at a cost to the overall health system. The HIV epidemic has severely stressed the health systems' foundation impacting on resources, non-HIV conditions and diseases and quality of care. The once strong emphasis on primary health care has been transformed to a medical model with emphasis on hospital care and, as a result, meeting the Millennium Development Goals is proving a challenge.

Botswana faces numerous challenges in the health sector with the shortage of skilled, motivated staff being the most critical. Human resource management (HRM) in health is characterized by inadequate systems, weak policy implementation and insufficient HRM skills resulting in inequitable distribution of staff, low morale and high turnover. At the facility level, drugs and commodities are often in short supply, quality of care is poor, equipment is not maintained and the referral system doesn't work. Overall, health service planning has been ad hoc, standard operating procedures inadequate and health financing neglected. Civil society has remained nascent owing to the presence of strong government providing free education, health care and other social services.

Currently, the health sector is undergoing reform with a key element the transfer of primary health care facilities from MLG to MOH and restructuring of the District Health Management Teams (DHMT). The rapid manner in which the clinics were transferred has had a number of unintended consequences and challenges associated with resourcing the newly formed DHMTs abound. A major focus of the current reforms will be strengthening of the DHMTs and decentralizing authority in the areas of human resources, finance, procurement, training, surveillance and quality assurance.

The approach of PEPFAR Botswana will be to ensure that USG investments encourage country ownership and support country-led plans in line with the second GHI principle. To that end, the Partnership Framework is aligned to the NACA National Operational Plan. PEPFAR Botswana also supported the development of the MOH Integrated Health Sector Plan (IHSP), a blueprint for the health sector for the next 10 years. This national health plan includes all GHI targets, promotes primary health care and prevention and strengthening the health system to become more efficient, effective and sustainable. As we transition to plateau funding, all PEPFAR and GHI activities will align with the IHSP. A special focus will be placed on assisting MOH transform DHMTs into fully functional health management entities, improve human resource management and strengthen civil society.

2 Global Health Initiative (GHI)

The MOH IHSP and GHI provide an opportunity for the USG to refocus its health assistance portfolio in Botswana. The Botswana draft GHI strategy is built upon, and aligned, to the IHSP. While the budget level for PEPFAR continues to decline, GHI gives the USG the opportunity to transition programs to local

ownership while ensuring integration of HIV services within the broader health system, and impacting health outcomes beyond HIV. In addition, GHI gives the USG an opportunity to build a program uniquely suited to Botswana's long-term health and development needs, strengthening the community-level response, building local research capacity, and providing technical assistance (TA) to the GOB. USG is will leverage funding from other development partners including EU, World Bank, UNICEF, UNFPA, WHO.

USG's support will focus on transitioning to a post-emergency HIV response and strengthen Botswana's ability to mitigate the long-term impacts of the HIV epidemic.

1. Transition to a post-emergency HIV response. The USG plans to: 1) Strengthen strategic information (SI) capacity, systems, and processes. The transition will require strong disease surveillance and program data (including financial data) at both the central and district levels; 2) Strengthen program management and coordination. The country ownership project documented a broad range of capacity weaknesses within the GOB and civil society, demonstrated by lack of financial and costing data, poor coordination, and overall weak civil society. The USG will continue support of existing health system strengthening (HSS) activities to improve management and coordination. 3) Provide flexible international TA. TA will be needed on demand if monitoring shows transitioning programs are underperforming. The USG will provide high-caliber resources as needed.

2. Strengthen Botswana's ability to respond to the long-term impacts of the HIV epidemic. The USG will: 1) Support efforts to improve financing for non-clinical, community-level service delivery. While the GOB has the capacity to fund HIV-related clinical services such as PMTCT and ART, financing for civil society and community-based organizations is lacking in Botswana. USG will continue its support to local organizations, and efforts to increase the private sector's involvement in the national response. In addition, USG resources will support efforts to secure Global Fund and other funding for NGOs. 2) Support research and development of local research capacity. This will include high-level USG leadership engagement to advocate for the importance of research efforts by US institutions, while encouraging local partnerships. 3) Provide ongoing international TA. In addition to TA required during the transition period, priority areas needing longer-term TA will be identified to impact health systems and health outcomes.

3 Leadership and Governance and Capacity Building
A major focus of capacity building for PEPFAR Botswana is to strengthen leadership and governance at MOH and in civil society, while the private sector remains an important partner in service provision. It is important to note that most health care in the country is provided by government and donor-supported parallel services do not exist. MOH and NACA have clear responsibility and accountability for the HIV response. With the transition to a post-emergency phase of the epidemic, PEPFAR and other partners are increasingly focused on building strong, sustainable systems, strengthening prevention, improving quality, empowering civil society and improving the public health surveillance system.

Having identified the need for data for decision making as a priority in equipping leadership to design, manage and monitor HIV programs, PEPFAR Botswana will continue to strengthen information capacity, systems and processes. The current data gathering and analysis systems are weak and information is not readily available or effectively used to support decision-making. USG support will build on, and strengthen, existing systems for better evidence based planning.

Leadership and governance at MOH will be strengthened in several ways. First, PEPFAR will assist with the implementation of the IHSP. The plan covers the six WHO health system building blocks and lays out the roadmap for 'a more equitable, effective and efficient health sector to deliver quality health services'. It also outlines critical reforms needed immediately to enable improved leadership and governance of the health sector. Over the next 4 years, PEPFAR will support the implementation of reforms included in the

plan. These include: (i) reorganization of the health delivery model and strengthening the DHMTs; (ii) strengthening human resource management; (iii) improving data-driven strategic planning, implementation and monitoring of services; (iv) implementing quality management structures and an accreditation process; (v) improving health financing and cost effectiveness, and; (vi) strengthening supply chain management systems. The outcome of PEPFAR support will be fully functional DHMTs with authority and skills to manage all resources (human, financial, other) and deliver quality services. An effective policy monitoring and evaluation system will be supported to promote an enabling environment for an effective continuum of response. PEPFAR will also strengthen district-level systems to coordinate HIV/AIDS services in hard to reach areas. This will include activities to strengthen district councils and District Multi-sectoral AIDS Committees (DMSACs) to lead and manage district-level HIV/AIDS responses and will lead to vibrant, cohesive and comprehensive community programs. In 2016, PEPFAR technical assistance will continue in the areas of health sector monitoring, DHMT support, financial reform and supply chain management.

Secondly, PEPFAR is supporting the development of an Office of Strategy Management within the MOH that will drive strategy implementation and monitor the achievement of set targets, and a delivery unit at NACA focused on achieving the goals of the Second National Strategic Framework for HIV/AIDS (NSF II) and the Partnership Framework. At the operational level, leadership and management capacity building is provided within several quality improvement programs and a leadership and management development program is being designed for managers within the public health system. Leadership and governance in the civil society sector will be strengthened through a program to build sustainability at all levels, and includes partnerships with the public and private sectors. Building the capacity of civil society organizations to directly receive USG funds will leverage additional resources.

4 Strategic information
The overall goal of strategic information support is to provide quality data for evidence-based decision making by the GOB. PEPFAR funds will be used to advance national capacity in health informatics and monitoring and evaluation (M&E).

Informatics support: PEPFAR support has been used to create the M&E system for the antiretroviral treatment (ARV) program. The system uses patient information management system (PIMS) electronic registers to capture clinical, laboratory, and pharmacy data at the point of care in all 32 hospitals and 276 clinics in Botswana. Monthly reports are generated and patient level data are available for operations research. In contrast, data from the PMTCT and routine HIV testing in clinical settings (RHT) programs are currently captured in log books and reported nationally as aggregate data. The development and deployment of e-registers for PMTCT and RHT through the PIMS system was piloted in five districts in 2010-11. Evaluation of the e-registers pilot is being conducted to develop a more efficient and cost-effective model for the remaining 24 districts. The long term sustainability of the e-registers will depend on the government plan to expand the Integrated Patient Management System (IPMS), which is proprietary software that currently covers only seven large hospitals and 16 associated clinics. PEPFAR will continue to assist the MOH, DHPDME, through support to the University of Pennsylvania, to develop an informatics blueprint. The objective of this project is to identify and better integrate electronic health and business information systems at the MOH. PEPFAR will support data integration of different systems at MOH (e.g., TB and HIV data) using middleware software.

M&E capacity development: The focus of M&E capacity development is to strengthen the national network of M&E officers in health districts through four activities. The activities are to: 1) place a senior M&E advisor at MOH to increase data use and provide feedback to the districts; 2) improve accuracy and timeliness of national morbidity and mortality statistics; 3) develop and implement national data quality assurance standards and tools, and; 4) support the use of the existing District Health Information System (DHIS) for national reporting of all health indicators to eliminate duplication of effort. The national M&E network provides data to monitor the critical HIV programs in Botswana. The challenge is the turnover of

M&E officers in the districts. PEPFAR will graduate support for M&E training though the Institute of Development Management (IDM) and instead work with the University of Botswana (UB) Schools of Medicine, Nursing, and Public Health to implement a broader curriculum of M&E, surveillance, and epidemiology. COP12 funding will be used to second two critical positions; 1) a senior M&E advisor to DHPDME, and 2) an M&E specialist to the DHAPC. Computer support in the districts has been identified as a critical human resource issue. PEPFAR will continue to support the placement of recent information technology (IT) graduates to all districts through a public private partnership with Botho College. We expanded on the success of this project using OGAC challenge grant funds in COP 12 to place an additional cadre of IT graduates at the each of the 8 health training institutes.

PEPFAR will also work with District AIDS Coordinators (DACs), DMSACs and civil society organizations to ensure collection of quality data on community service delivery. This will be done in such a way that it is harmonized with and easily integrated into existing government systems. This will ensure that HIV/AIDS data are collected at all levels of the HIV/AIDS response.

Know your epidemic: In COP11, PEPFAR supported a small study to determine the feasibility of using existing PMTCT program data to replace antenatal clinic (ANC) sentinel surveillance surveys. Results of the study showed that the estimated HIV prevalence was not significantly different between the two data sources. Coverage of the PMTCT program in Botswana is estimated to be 94%. Based on this information, PEPFAR will no longer support ANC surveys, but will support the transition from ANC surveys to routine surveillance (i.e., specimen collection and testing) for HIV prevalence, incidence, and resistance through the PMTCT program.

5 Service Delivery
Botswana faces a significant, generalized HIV epidemic with 25% of individuals 15-49 years of infected with HIV (2008) and has responded with comprehensive, fully integrated prevention, treatment, care and support services accessible nationwide. The continuum of response is provided through a network of government health facilities in a de-concentrated service delivery model. The new National Health Policy and IHSP provide the structure for a strengthened response based on epidemiological data and PEPFAR is supporting M&E at all levels as described above. The IHSP emphasizes a lifespan approach to good health and the new UB School of Medicine is training doctors in family medicine to promote comprehensive health care for the patient in the context of the family and the community, emphasizing disease prevention and health promotion.

Botswana has reached notable achievements in both ARV coverage and PMTCT. In 2002, Botswana initiated a national HIV treatment program with the goal of universal access to treatment for all eligible citizens. Based on data from July 2011, a total of 170,430 people in Botswana were currently receiving ARVs. This represents 95% of the 179,569 who are eligible for treatment. Eighty-two percent of patients on ARVs are treated in the public sector, 10% are outsourced to private providers by the GOB, and 8% are cared for through private insurance. Treatment is available at 32 ARV sites and 198 satellite clinics located throughout the country. In addition, PEPFAR has assisted the GOB to provide serial HIV testing of pregnant women, early diagnoses for HIV exposed infants, ARV for HIV positive pregnant women and exposed infants, and improved continuity of peri-natal care and support. These efforts have resulted in a dramatic decline in vertical transmission from approximately 35-40% in 1998 to <4% in 2011. PMTCT has also demonstrated that provision of integrated services both enhances national capacity and dramatically reduces the burden of HIV.

There are multiple efforts underway to link individuals and family units to HIV-related services. Emphasis is now being placed on strengthening natural linkages between the gateway service of HIV testing with blood donation, partner testing, male circumcision (MC), community-based care and facility-based treatment services. Programs are in place to connect eligible men/partners with HIV testing and MC programs across various catchment points, including testing male partners of women in PMTCT care.

While these efforts show promise, more emphasis is needed. Few interventions exist that target high risk populations including sex workers and men who have sex with men, but plans are in place to evaluate the locations and needs of these groups. As over two-thirds of TB patients in Botswana are infected with HIV, yet only 42% of co-infected individuals are taking ARVs, renewed efforts are also underway to ensure two-way HIV and TB screening.

Provision of HIV services involving prevention, care and treatment is almost entirely managed by the GOB, with support from civil society and the private sector, with comparatively less direct service provision by PEPFAR. Our goal is to enhance existing government programs, identify perceived gaps in services, and provide technical assistance. This includes a significant effort in supporting the strengthening of civil society organizations in both organizational and service delivery areas. These efforts will not only strengthen current service delivery efforts at the community level, but will also insure that PEPFAR programs are sustainable and supported by the GOB.

6 Human Resources for Health (HRH)
PEPFAR Botswana is assisting GOB to increase the density, balance the distribution and improve performance of the health workforce by focusing on pre-service education, human resources management, attraction and retention and regulation. The second priority of NSF II is to improve competencies, skills and retention of human resources for the national response at all levels. PEPFAR is the single donor in the country's HRH efforts and this poses a limitation on the leveraging of funds.

Pre-service Education (PSE): PEPFAR supports pre-service training of allied health care workers (e.g. laboratory technicians and pharmacy technicians), midwives and health care assistants (HCA) through salary support to faculty at Institutes of Health Sciences and the UB and tuition for HCA training. PEPFAR continues to strengthen pre-service education by building capacity of faculty and providing resource material. The UB School of Medicine received a Medical Education Partnership Initiative award that will also assist to increase in number of local doctors. Over the next two years, PEPFAR will support the upgrading of 400 lay counselors to HCAs.

Human Resources Management and Planning: Since 2009, PEPFAR Botswana has supported the implementation of a human resource information system (HRIS) at MOH. The current priorities are to roll the HRIS out to the districts, continue integrating HRIS with other information systems and apply technologies to improve data quality.

In-service Training: Since 2004, PEPFAR has supported the coordination of HIV in-service training by building the foundation of the KITSO Training Coordination Unit. However, the country does not have any formal continuing professional development (CPD) programs and the next step will be to work with the regulatory bodies to develop CPD programs.

Capacity Building of Regulatory Bodies and Professional Associations: PEPFAR will continue support to build capacity in the regulatory bodies (Botswana Health Professions Council and Nurse and Midwifery Council of Botswana) to enable them to ensure the country has a competent workforce. In 2012, this will focus on required licensing examinations and implementing CPD programs, as well as overall capacity building.

Recruitment and Retention: Attrition of health workers from the public health sector is high. In 2010, PEPFAR funded an assessment of attraction and retention and found that attrition was linked to perceived unfair management practices such as transfers, lack of recognition and supervision, and poor housing and career opportunities. The focus of the 2012 assistance will be to support the implementation of the attraction and retention strategy which includes a review of the transfer policy, establishing a health leadership program and providing rural area housing through a loan guarantee mechanism to assist staff retention in rural areas.

Transitioning PEPFAR Supported Staff to Local Ownership: In 2011, PEPFAR funded 191 positions in GOB most of which were filling gaps (service delivery) and not building sustainability within the government. In 2011, a new policy was drafted to address the sustainability and efficiency of PEPFAR funded positions. This will allow the phase out of service delivery positions within three years and maintain only technical assistance positions requiring a local counterpart resulting in a much smaller number of supported staff.

Support Improved Models of Service Delivery: The scaling up of HIV treatment has resulted in task shifting of some duties from doctors to nurses and from nurses to HCAs and lay counselors, but there is a shortage of these front line workers and those available are insufficiently trained. PEPFAR will invest in upgrading of 400 lay counselors to HCAs to improve their skills and enable them to be sustained in the government system. This will add to the PEPFAR target of training 140,000 new health workers.

7 Laboratory Strengthening

The laboratory network in Botswana is referral based; primary-level hospital labs support peripheral health units (clinics, health posts and mobile posts); district and referral hospital labs support regional and national levels and special reference labs for TB, HIV and blood transfusion. There are 45 government labs, two HIV reference labs, one national TB reference lab, a national quality assurance lab, a National Blood Transfusion Service and a national health laboratory. Together they support outbreak responses, surveillance, training, specialized testing and a quality management system. In addition, there are 15 private labs, 700 HIV routine testing sites and 35 voluntary counseling and testing (VCT) centers.

PEPFAR worked closely with the MOH to develop a five-year laboratory strategic plan which addresses quality management and laboratory accreditation, a draft national medical laboratory policy, and national medical laboratory standards. PEPFAR also supported the development of a laboratory logistic system to monitor stock imbalances within the laboratory network and collect accurate national quantification of essential laboratory commodities. In addition, PEPFAR supported the expansion of laboratory space and the development of a laboratory information system to improve laboratory testing and turnaround time. Finally, PEPFAR built, equipped and staffed a National Quality Assurance Laboratory to support the National External Quality Assurance Program and the Proficiency Testing Scheme.

Expansion of the lab workforce is also a priority for PEPFAR and MOH. Pre-service training of diploma-level medical lab techs is offered at the Institute of Health Sciences, while UB offers an upgrade degree program and a four-year degree program in laboratory sciences. PEPFAR supported the two institutions in the development of curriculum and increasing laboratory and teaching capacity by providing lecturers.

PEPFAR provided financial and technical support to transform the existing National Health Laboratory into a National Public Health Laboratory (NPHL). A priority for PEPFAR will be to further develop and strengthen the NPHL to carry the essential core functions of a public health laboratory. The second priority will be to support the implementation and monitoring of the five-year strategic plan in the area of the Laboratory Quality Management System, establishment of a system to monitor the quality of laboratory reagents, facilitate and advocate for equipment standardization and equipment maintenance service plan. PEPFAR will also prioritize improving diagnostic and monitoring of TB, HIV, and other diseases of public health importance by improving point of care tests as recommended by WHO and CDC, and decentralizing culture and drug susceptibility testing for TB. PEPFAR will continue providing support to the Logistic Management Unit, crucial for managing logistics data, and coordinating the logistics system between the Central Medical Stores, the laboratory services and the laboratory network in the country.

8 Health Efficiency and Financing

Since 2004, the proportion of THE from the Botswana government has been at or above the Abuja target of 15%. However, there are weaknesses in public health financing and health sector costing and, as such, the national health budget continues to be based on prior budgets rather than actual costs. This results in inefficient resource allocation. The key priorities in health financing are to ensure equity, effectiveness and efficiency in resources allocation that will improve health outcomes.

Costing and Cost Effectiveness: PEPFAR Botswana strongly supports and funds costing exercises to assist GOB improve the cost effectiveness of the national HIV response. To this end, PEPFAR Botswana has supported the costing of NACA's national operational plan (NOP) and is supporting the development of a resource mobilization strategy for the NOP. In addition, PEPFAR has also funded an assessment of the cost effectiveness of ARV treatment, costing of MC services and, in COP 11/12, the costing of all health services provided in public health facilities. The objective is to institutionalize health sector cost monitoring to inform the national heath budgeting process and develop a sustainable health-financing model, which will ensure that revenue collection, pooling of resources and purchasing of services are cost efficient.

Expenditure Analysis: PEFPAR assisted the MOH to conduct National Health Accounts (NHA) for 2008 – 2010 and is assisting in the institutionalization of the process. PEPFAR provides in-kind, as well as financial, support to improve the quality and quantity of data used in the NHA. The support involves building capacity at MOH to undertake NHA. In order to ensure sustainability, MOH will be capacitated to link NHA to policy requirements and use it as a core activity within MOH policy and planning functions.

Resource Tracking and Effectiveness Analysis: PEPFAR continues to contribute towards resource tracking and effectiveness analysis. The support involves building structures and systems for monitoring resource allocation by funding National AIDS Spending Assessment (NASA) and eventually institutionalizing it at NACA. This support includes building capacity for routine NASA. The capacity of MOH and NACA to conduct effectiveness analysis to maximize efficiency of resource allocation will be strengthened.

Innovative Funding Schemes & Other Financing Options: The focus will be on building grant management and oversight technical capacity and will include developing a comprehensive grant oversight plan at NACA, as well as exploring the use of dashboard technology to oversee PEPFAR funds. PEPFAR will provide assistance in the development of proposals and document consolidation for donors such as Global Fund. Furthermore, funds will strengthen the oversight capacities of the national procurement body to improve supply management.

9 Supply Chain and Logistics

10 Gender

The Botswana AIDS Impact Survey III (BAIS III) showed an estimated national HIV prevalence of 17.6 percent, 20.4% among females and 14.2% among males. This high prevalence among females is attributed to several factors, including: women's inability to negotiate for safe sex; gender-based violence (GBV); and multiple concurrent partners (MCP). Adolescent females are approximately three times more likely to be infected with HIV than males of the same age. The highest prevalence rate reported in BIAS III was for females aged 24 -30 at 48.9%.

To address these factors, PEPFAR Botswana is supporting the Women's Affairs Department (WAD) in the Ministry of Labor and Home Affairs to implement the National Gender and Development Policy and the Domestic Violence Act. District level workshops for GOB officials, non-governmental organizations and community leaders will be conducted to clarify these policies and allow each district to develop and implement an action plan. Community mobilization approaches including Journey of Life and

Community Capacity Enhancement for Community Conversations will be used to facilitate dialogue amongst communities on gender-related attitudes and practices; and, to promote positive attitudes and behaviors for men/boys and women/girls. Simple user-friendly guides on the major laws affecting women and children will be disseminated at village and district level to ensure that women and girls and men and boys are aware of these laws and are able to use them for their protection. Platforms that bring men together, such as “Men make a difference” support groups, will also be used as avenues to disseminate the policies and guidelines that promote legal protection for women.

In FY 12, district officials, PEPFAR staff and implementing partner staff will be trained to carry out gender analysis and incorporate these findings into project design and implementation plans. Gender analysis and gender programming will ensure that the strengths, capacities and risks that may be particular to girls, women, boys and men are built into programs to better achieve objectives. Gender programming will enhance the quality and effectiveness of PEPFAR and GOB programs and systems. Technical assistance will be provided to improve gender-disaggregated data collection and allow for better gender analysis. This will also guide future research.

**Technical Area:** Management and Operations

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HVMS | 10,836,399 | |
| **Total Technical Area Planned Funding:** | **10,836,399** | **0** |

**Summary:**
(No data provided.)

**Technical Area:** Prevention

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| CIRC | 8,854,878 | 0 |
| HMBL | 575,290 | 0 |
| HMIN | 362,790 | 0 |
| HVAB | 826,202 | 0 |
| HVCT | 6,027,730 | 0 |
| HVOP | 3,813,884 | 0 |
| MTCT | 3,154,603 | 0 |
| **Total Technical Area Planned Funding:** | **23,615,377** | **0** |

**Summary:**
Botswana is a land-locked country approximately the size of Texas (232,000 square miles), boarded by

Zambia to the north, Zimbabwe to the east, South Africa to the south, and Namibia to the west. Eighty four percent of the country is covered by the Kalahari Desert and the western areas are sparsely populated, whereas the eastern portion of the country is more densely populated with major urban centers, large towns, and villages. The major industries of Botswana include mining (diamonds, uranium, gold), agriculture, construction, and tourism. Although data are still preliminary, the 2011 census estimates the national population to be 2.1 million. Bostwana is divided into nine administrative districts and 29 health districts. Political and executive functions are operated by administrative districts through the Ministry of Local Government, whereas public health functions are addressed through health districts, through the Ministry of Health.

Botswana faces a prolonged and severe HIV epidemic. Although HIV prevalence is declining, the 2008 Botswana AIDS Indicator Survey (BAIS III) estimates that 17.6% of the population is living with HIV/AIDS. HIV incidence is relatively stable at an estimated 1.2%, yet new infections continue to surpass AIDS deaths. For these reasons, HIV prevention is the leading priority for Government of Botswana (GOB) and PEPFAR in combating the epidemic (Botswana Partnership Framework, 2010; Botswana Modes of Transmission Study, 2010).

HIV prevalence is concentrated in adolescent and adult populations, with 25.4% prevalence among 15-49 year olds (19.8% among men, 29.6% among women). Prevalence is lowest among adolescents 15-19 years old (3.6%) and highest among adults 35-39 years old (41.6%). Among women, prevalence ranges from 5% to 50%, peaking at age 30-34. Among men, prevalence is lower and peaks later, ranging from 2% to a peak of 44% at age 40-44. Recent surveys indicate that HIV prevalence and incidence are declining in younger groups and increasing in older groups. HIV prevalence among pregnant women declined from 36% in 2001, to 33% in 2009, with the greatest reductions among pregnant women aged 15–19 years (25% in 2001 to 13% in 2009) (BAIS III). Estimated HIV prevalence in 26 districts and sub-districts ranges from 16% in Kweneng East to 35% in Selebi-Phikwe. HIV prevalence is highest in rural areas (27%), compared with cities and towns (25%) and urban villages (24%) (BAIS III).

The key drivers of the HIV epidemic in Botswana are low prevalence of male circumcision, inconsistent condom use, excessive alcohol use, multiple heterosexual sexual partnerships, and intergenerational and transactional sexual relationships. Social and cultural factors, such as low marriage rates, high population mobility, and prolonged separation of families and partners contribute to these issues. Gender inequality has been identified as a factor in women's vulnerability. Adolescent females are approximately three times more likely to be infected with HIV than males of the same age. Higher prevalence among females is attributed to several factors including women's inability to negotiate for safe sex and gender-based violence (GBV). Marginalized populations are also at heightened risk, including sex workers and men who have sex with men, as both of these sexual behaviors are not only stigmatized but also illegal in Botswana (Botswana Modes of Transmission Study, 2010).

The PEPFAR Prevention portfolio includes six programs: Prevention of Mother to Child Transmission (PMTCT), Blood Safety, Injection Safety, Voluntary Medical Male Circumcision (VMMC), Behavior Change Communication (BCC) and HIV Testing and Counseling (HTC). Our vision is to transition the prevention program to plateau funding and a technical assistance model by graduating mature programs with country ownership (PMTCT, Blood Safety), scaling up the reach and coverage of the VMMC program in the next three fiscal years (2012-2014), and rolling out combination prevention activities, especially at community level, to achieve greater impact while beginning the transition of the BCC, HTC, and Injection Safety programs to greater country ownership over the next five years.

The PEPFAR Prevention team consists of staff from CDC, USAID, Peace Corps, DOD, and the State Department. CDC comprises the largest membership with eight staff in Gaborone and five in Francistown, while USAID has seven members.

Most at risk populations (MARP) in Botswana include sex workers and their clients, men who have sex with men (MSM), and mobile populations. Other vulnerable groups include persons engaged in transactional and intergenerational sexual relationships, workers separated from family members, including truckers and migrant workers, prisoners and members of the military. There is a paucity of empirical evidence to quantify the size of the most at risk populations and the epidemiologic profile of HIV among these groups. In 2007, a needs assessment among female sex workers revealed that women pursued sex work for basic and luxury material gain, had an average sexual debut of age 17, had participated in sex work for an average of four years, with an average of four clients per day and 50% condom use with clients (Sharma, O'Malley, 2007). Although only 1.2% of women in the BAIS III survey admitted to exchanging sex for money, and only 1.6% of men surveyed admitted to paying for sex, HIV prevalence among these respondents was disproportionally high (37% and 24% respectively).

While the rate of HIV among people who inject drugs (PWID) in neighboring South Africa is estimated to be 12%, no PWID studies have been conducted to date in Botswana. In FY 2010 and 2011, PEPFAR reprogrammed funds to support a needs assessment, mapping and Integrated Behavior and Biological Surveillance Survey for female sex workers, MSM, and PWID populations. These activities will help the GOB and PEPFAR team better understand the parameters, programmatic coverage and gaps that address these groups. The Survey protocol is developed and costed and will be implemented in early 2012. It will yield data for programmatic use in late 2012.

According to BAIS III, male circumcision coverage in Botswana was estimated at 11.2% nationally in 2008. Circumcision for adult initiation is not widely practiced among most cultural and ethnic groups in Botswana, but occasional widespread ceremonies are conducted. Integrated circumcision services are being scaled up in a phased manner with the first phase to cover 26 government hospitals and six health clinics. The second phase will cover the 12 government health facilities, four private practice clinics, and six Botswana Defence Force clinics. The program produced 21,700 adolescent and adult circumcisions through these efforts. The pediatric VMMC program is scheduled to begin in 2013. The new service delivery model, with dedicated high volume adult and adolescent sites has been launched and is described in detail later.

Differential gender roles are largely thought to contribute to disproportionate rates of HIV among men and women in Botswana. Women and girls are socially and economically less empowered than men, and thus more vulnerable to sexual relationships that are related to these constructs. Young women in Botswana have earlier sexual debuts and older sex partners than their male counterparts, which exposes them to wider sexual networks and increased HIV/STI risk. In every age category except 40-44 years, the rate of HIV prevalence is higher among females than males.

According to BAIS III, over 8,100 HIV infections occur annually in Botswana among persons 15-49 years old. The next 1000 infections would likely occur among this age group, with around 535 occurring among heterosexuals who are married or cohabiting, 183 among persons engaging in casual heterosexual sex, 104 among MSM, 55 among steady partners of persons engaging in casual heterosexual sex, 49 among sex workers, 28 among the clients of sex workers, 18 among PWID, 16 from unsafe medical injections, five from blood transfusions, four among female partners of sex work clients, one among female partners of MSM, and <1 among partners of PWID. While this epidemic profile is likely to change with broader coverage of male circumcision, it demonstrates that heterosexual relationships with multiple partners, whether concurrently or sequentially, contribute most to the HIV epidemic in Botswana.

The use of epidemiologic data from BAIS and other sources is integral to accurate planning of the GOB and PEPFAR prevention portfolios. These data have demonstrated that, despite significant reductions in AIDS deaths following widespread ARV provision, new infections in Botswana are relatively stable and prevalence remains high. For these reasons, the GOB has reiterated its dedication to primary

prevention. With PEPFAR's focus on evidence-based prevention programming, the portfolio has recently shifted from a focus on BCC stand alone interventions to combination prevention with BCC supporting scaled-up biomedical interventions. Approximately 36% of the PEPFAR prevention portfolio for FY 2012 is devoted to scaling-up the VMMC program, while the successful PMTCT, Injection Safety, and Blood Safety programs are transitioning to greater local ownership. The HTC programming remains proportionally level in terms of funding, but with renewed efforts to reach broader population coverage. Stand alone workplace and alcohol programs have been dropped from the BCC portfolio; school-based programs remain level. BCC activities for MARP and youth and those that support gender and community mobilization are being redesigned to promote health seeking behaviors including VMMC, HTC, PMTCT, and STI and TB diagnosis and treatment.

The key accomplishments in recent years include significant reduction of HIV transmission among newborns from HIV positive mothers, as well as reduction of medical transimission from unsafe injections and blood transfusions. The key priorities over the next two years include wide scale-up and coverage of VMMC and broader coverage of HTC, with greater emphasis on identifying and linking discordant couples to appropriate treatment and prevention services. These priorities are in close alignment with GOB priorities outlined in the 2010 Partnership Framework, the National HIV Strategic Framework II (2010-2016) and the National Operational Plan (2011—2016).

Contributions from other key donors are also considered carefully during program planning. The Bill and Melinda Gates Foundation, through the African Comprehensive HIV/AIDS Partnership (ACHAP), contributes significantly to HIV prevention in Botswana, particularly in the area of VMMC. The MOH, ACHAP, and PEPFAR met frequently in the last half of FY 2011 to plan the implementation of the national VMMC program for FY 2012. This close collaboration is improving program coverage, reducing duplication and gaps, and improving cost efficiency. The managers of the Botswana National AIDS Prevention Support (BNAPS) Program, funded by the World Bank, are collaborating with the USAID Maatla Civil Society Strengthening Project to develop district and community prevention activities funded by BNAPS with Maatla support to build the management skills of the local NGOs. UNFPA and PEPFAR are working together on sexual and reproductive health interventions including promotion and distribution of male and female condoms, and GBV awareness, support services, policy development and implementation.

Policy advances of note that affect the prevention portfolio include an approved decrease in the age of consent for HIV testing from 21 years to 16, and adopting certain task shifting efficiencies in male circumcision service delivery. Policy challenges include continued free provision of infant formula for HIV positive mothers upon delivery, regardless of CD4 count or ARV regimen, a modification of the recent WHO breastfeeding guidance.

Building the evidence base through evaluation of the impact of prevention programs in Botswana will largely result with the implementation of the new PEPFAR Combination Prevention project with the MOH, Harvard University, Harvard Botswana Partnership (BHP), CDC/Atlanta and CDC/Botswana. This multi-year project intends to scale up HIV prevention, care, and treatment services to reach upwards of 80% of targeted communities with HTC, PMTCT, and SMC services, along with broader ART eligibility criteria. The goal of the project is to reduce HIV incidence in intervention communities by at least 50% compared to control communities. Harvard University and BHP will spearhead the evaluation component, with a CDC cooperative agreement of $20 million over four years, while MOH and CDC will implement the enhanced prevention, care, and treatment services to reach >80% saturation. This funding will be provided centrally through CDC/Atlanta; not via the COP process. The results of this study will have tremendous implications for cost-efficient and effective service delivery and programming not only for Botswana, but for all countries with high burden, generalized HIV epidemics.

PMTCT

The Botswana PMTCT program is considered one of the country's greatest HIV prevention successes, with over 90% of women covered with at least one PMTCT intervention, and nearly 100% of pregnant women tested for HIV. PEPFAR has supported the GOB to test pregnant women for HIV, provide early infant diagnosis for HIV-exposed infants, initiate ART for HIV-positive pregnant women and exposed infants, and provide continued care and support. These efforts have resulted in a dramatic decline in vertical transmission from approximately 35-40% in 1998 to <4% in 2011, considered to be "virtual elimination" of MTCT.

The current PMTCT program in Botswana is now largely GOB owned and operated and follows a modification of WHO Option B. Mothers receive standardized, routine, opt-out HIV rapid testing, and either prophylaxis or treatment depending on eligibility. Retesting of HIV negative pregnant women during the third trimester was recently introduced. Exposed infants receive prophylaxis soon after delivery and are tested for HIV at six weeks of age. In 2010, the modified WHO Option B program began in a staggered rollout plan. This modification stipulates that pregnant HIV positive women will receive triple ARV prophylaxis and be supported with HAART for six months should they opt to breastfeed. Infant formula is supplied free by the GOB for one year and exposed infants are retested by rapid HIV tests at 18 months.

Through direct funding to the MOH, partner funding and direct technical assistance, CDC/Botswana continues to provide training, mentoring, data analysis, and other support to the GOB PMTCT program. Investment in health information systems remains vital to ensure that the PMTCT program can generate and use strategic information to monitor progress in scaling up PMTCT services and assess the effects of the program. In FY 2010, new and streamlined electronic registers for ante-natal and post-natal care were piloted in five districts using PEPFAR funds. In FY 2011-2012, the new tools will be rolled-out to all districts.

Despite huge success, critical gaps remain in the PMTCT program. FY 2012 PEPFAR funds are directed to improve integration of sexual and reproductive health within PMTCT to prevent unintended pregnancies and ensure HIV-free children through improved infant feeding practices, early infant diagnosis and linkage of infants to care and treatment services. Gaps remain in the efficiency of CD4 testing, national infant testing program, and under- five mortality, and malnutrition. Given these challenges, priorities of the PEPFAR PMTCT program include mentoring, support, training, research, and program evaluation to reduce these critical gaps and improve the comprehensiveness of the program, while transitioning to full country ownership.

HIV Testing and Counseling (HTC)
In Botswana, HTC services are offered through two complementary approaches—provider-initiated counseling and testing, known in Botswana as routine HIV testing (RHT), and voluntary counseling and testing (VCT). The implementation of this strategic mix of HTC approaches has resulted in expanded services and national coverage. In addition to supporting VCT services through the Tebelopele Centers, PEPFAR has supported the strengthening of GOB's RHT program.

Approximately 56% of persons have ever been tested for HIV and the 42% of persons tested in the past year have been roughly evenly distributed between VCT and RHT services. Historically, the GOB has provided a greater proportion of HTC funds towards RHT than VCT. This is the key reason why the PEPFAR prevention allocation for HTC in FY 2012 attempts to provide a counterbalance to this investment and maintain higher funding for VCT while still supporting RHT efforts.

The biggest challenge in the HTC program to date is the implementation of RHT by GOB providers and facilities. Despite an "opt-out" policy for HIV testing at all government facilities, where all consulting clinicians should offer and perform HIV testing, these services are largely left to lay counselors. PEPFAR has supported training 800 clinicians to perform RHT, but only an estimated 30% are performing

RHT. Reasons include the view that testing is a non-nursing duty, heavy workloads, and lack of support from supervisors. With PEPFAR support and advocacy, we hope that RHT implementation can be improved. RHT is uniquely poised for country ownership as GOB facilities have the broadest reach of healthcare services and RHT is a more sustainable HTC strategy than VCT. Models of efficiency of clinician testing compared with lay counselor referred testing are needed to improve the uptake and strategic implementation of this program.

As serostatus-based HIV prevention programming begins with knowledge of HIV status, HTC is the gateway for prevention, care, and treatment services. Thus, linkages to services for both HIV-negative and positive persons and outreach to the client's networks are crucial for continuity of care. Current efforts to link clients include Tebelopele's post-test clubs, which offer support to clients after testing regardless of HIV status and a referral system to track male Tebeleopele clients who reach circumcision clinics. While limited data exist to report the success or challenges of these approaches, less than 10% of VCT clients are tracked through this system. Various strategies are being considered to improve linkages, including "expert patient" and brief case management models. The PEPFAR vision for HTC is to gradually reduce financial support of VCT through 2015, to evaluate and strengthen the uptake of RHT, and increase access to HTC for neglected and hard to reach populations including MARPs, youth, and couples by assessing and expanding the targeted interventions that have been initiated by PEPFAR partners to date.

Condoms

Condoms are a key component in the minimum package of services for all populations and in all prevention and care activities. A recent study by Population Services International (PSI) on condom use in Botswana revealed that only 56.3% of 18-34 year olds consistently used a condom with their non-marital, non-cohabiting partner in the previous 12 months. For the same group, one factor positively associated with consistent usage was perceived availability. The GOB through the Central Medical Stores (CMS) of the MOH is responsible for procurement and distribution of male and female condoms nationwide. The Dutch government funds condom social marketing activities through PSI who works in close collaboration with the MOH prevention program and CMS. CMS delivers condoms to MOH facilities while PSI delivers to bars and hot-spots.

PEFPAR provided support in FY 2010 and 2011 to address numerous problems with the national condom program. These include the operationalizing a Condom Technical Working Group (TWG) led by the MOH with members from development partners and civil society; to strengthen condom logistics management at CMS; operationalizing the condom testing facility at the national laboratory to facilitate quality control testing in Botswana, and providing in-kind condoms to CMS and PSI in case of emergency stock-outs. Such an emergency did occur in 2011, when the local condom manufacturer delivered sub-standard product to CMS and stocks to MOH facilities and the PSI social marketing program almost ran out. In early FY 2012, USAID provided nine million condoms to the MOH. Six million branded condoms for PSI and 15 million more condoms for CMS will arrive later in FY 2012. A recent audit of the local condom manufacturer concluded that operations could resume. PEPFAR is urging CMS to include suppliers from outside of Botswana to avoid a repeat situation. No further PEPFAR condom procurements are anticipated but condoms will be one of the first products included in the CMS Logistics Management Information System (LMIS) that will track consumption data at all MOH facilities and improve ordering and distribution of this critical prevention commodity.

FY 2012 funds will continue to support condom quality control testing and the development of an action plan to implement the new National Condom Strategy. Condom promotion and proper use will be linked the VMMC, PMTC and HTC programs as well as the Positive Health, Dignity and Prevention (PHDP) activities aimed at people living with HIV/AIDS. MARP and gender programs will focus on empowering women to get their partners to use condoms and in collaboration with UNFPA and PSI, PEPFAR will further explore female condom use and acceptance to determine if new interventions are merited.

Voluntary Medical Male Circumcision (VMMC)
With over 60% effectiveness in reducing male acquisition of HIV and only 11.2% circumcision prevalence in the adult male population in Botswana, VMMC has the potential for very high impact. Surveys in Botswana demonstrate that 81% of men are willing to be circumcised and 96% of parents favor male circumcision for their sons.

There have been challenges within the VMMC program but the GOB appears poised to support broad programmatic scale-up. Plans for FY 2011-2012 funds include expanding dedicated service delivery sites nationwide and adopting the VMMC MOVE model (Model for Optimizing Volume and Efficiency). Because task shifting certain surgical procedures to nurses (cutting, mattress sutures, and anesthesia administration) is limited by Botswana policy, the MOH agreed to a new “Botswana MOVE model” that includes one physician, five nurses, and one auxiliary in a three-bed surgical theater set-up. Additional efficiencies include forceps-guided circumcision, along with electrocautery, outreach and community campaigns, and use of disposable VMMC kits. Mobile services are under consideration by the MOH, and large, temporary tents are already in use by the Botswana Defence Force (BDF) and PEPFAR partners. Dedicated space is now provided for VMMC, including rooms for pre/post operative care and observation, and separate areas for group education, and private HTC. The MOH has also agreed to dedicated VMMC sites funded by PEPFAR and ACHAP within MOH facilities suffice, as well as the use of prefabricated clinics and tents on the grounds MOH and BDF facilities.

The PEPFAR vision is to support the GOB national targets of 385,000 adult and adolescent VMMC procedures by 2016. PEPFAR-specific targets include completing 21,000 VMMC procedures in FY 2012, and 65,000 procedures in FY 2013. This projection is based on the use of FY 2011 funds to support five dedicated PEPFAR VMMC teams during the last half of FY2012, and FY 2012 funds to support four more teams (nine total teams) in FY2013. PEPFAR is gradually modeling improvement in efficiency and productivity after teams, and encouraging adoption of “start and hold” implementation plans to ensure quality, safety, and minimum standards are met before new sites are launched. To ensure that we meet targets, MOH agrees that VMMC personnel seconded through PEPFAR funds will work exclusively on VMMC matters at dedicated sites and will not be integrated into other service provision. The proposed FY2012 PEPFAR budget demonstrates the renewed commitment by MOH to rapidly scale-up the VMMC program. This represents a 30% increase in FY 2012 funding over FY 2011. The budget includes funding for the VMMC Unit of the MOH Department of HIV/AIDS, Prevention and Care (DHAPC) and the BDF, as well as five implementing partners (Jhpiego, I-Tech, PSI, Tebelopele, and SCMS) to focus on service delivery, demand creation, HTC, and VMMC-commodities and logistics. In addition, a portion of this budget is allocated for two new coordination staff to be seconded to the MOH. These coordinators will provide technical and managerial assistance to existing MOH staff structures, orchestrate a rapid, systematic scale-up plan, and provide clear, timely progress reports. Following a massive VMMC scale up through FY2015, the adult VMMC program would graduate. PEPFAR support would then transition to pre-service training of new providers and technical assistance in the integration of neonatal circumcision service delivery.

Positive Health Dignity and Prevention (PHDP)
The PHDP program in Botswana has made substantial progress despite numerous challenges and setbacks. The most notable achievements are the finalization of the PHDP National Strategy (2009-2016), the national PHDP Implementation Plan, and the Implementation Plan for Civil Society Organizations (CSO). In both CDC/Botswana and in the MOH, the PHDP program consisted of minimal staff and had not yet been a part of the Prevention team activities until this year. Although the key PEPFAR PHDP seconded staff position at MOH is currently vacant, the MOH has started the recruitment process and committed that this position will report directly to the MOH Director of DHAPC.The GOB PHDP policies and implementation plans include a very comprehensive minimum package of services. The minimum package includes: risk reduction, condom use, partner disclosure, partner testing,

adherence counseling, family planning, pregnancy planning, STI and TB screening and treatment, and legal assistance. The goal for the next year is to coordinate PEFPAR and the GOB activities to implement PHDP. The PEPFAR team will also work with the GOB to hire and train a PHDP staff member who will be able to advocate for PHDP activities within the MOH and facilitate the integration of PHDP services into existing MOH programs. These implementation plans have not yet been launched, but they will include linkages to other programs support for stronger referral systems. The USAID Maatla Civil Society Strengthening project will facilitate the linkages between the MOH and CSOs and support the roll-out the PHDP program with their partner BONEPWA+, the Botswana Network of PLWHA. The development of these approaches will be integral to the Combination Prevention project, and lessons learned will be documented carefully for national implementation consideration.

Most-at-Risk Populations (MARPs)

In 2008, PEPFAR initiated a five-year MARP Prevention project implemented through sub-grants to eight local NGOs. The MARP target groups at that time were: young women 15-29 years old in cross-generational and/or transactional relationships; female sex workers (FSW) and their clients; and migrant male populations whose work separated them from their primary partners and families. In 2010, the MOH draft strategy for MARPs continued to focus on these same high risk groups, which include a large portion of the Botswana population. The recent MOH initiative to conduct a MARP assessment focused on FSW, men who have sex with men (MSM) and people who inject drugs (PWID) marks a change in the definition of MARP in Botswana. Following a review of the PEPFAR MARP Prevention project in December 2011, the MOH requested the implementing partner to modify the activities to concentrate on FSW. A project assessment to be carried out in early 2012 will recommend statement of work and budget revisions to reflect the GOB's more focused approach. FY 2012 funding of $800,000, will be the final tranche for the project that ends September 2013. MARP activities under the project focus on the comprehensive prevention package that includes condom promotion and distribution, STI screening and treatment, HTC, peer education outreach, risk reduction and counseling, developing target group driven education and communication materials, making referrals for substance abuse, HIV/AIDS treatment and care, post-exposure prophylaxis, psycho-social and legal support. Even where services are theoretically available, FSWs face substantial obstacles to accessing them. To address this, MOH and project staff at central and district levels are strengthening the referral system. District Referral Committees established in some of the project areas (Francistown, Selebi-Phikwe, and Tlokweng) are regularly monitoring referrals to improve health service delivery to MARPs. Liaison activities with other GOB service providers such as the police in Tlokweng have also sensitized officials and reduced stigma for MARPs.The National AIDS Council (NAC) is advocating for changes in Botswana law so that MSM and commercial sex work is no longer illegal. The PEPFAR team continues to monitor and track the public debate and is poised to support activities for MSM if that is requested by the GOB and funding is available through the MARP program or through preprogramming. Other PEPFAR MARP interventions supported by DOD include peer education and condom procurement and promotion with the BDF, are continuing with remodeled approaches to improve effectiveness.

General Population

The key strategic mix of interventions for the general adult populations (age 15-49) is through the implementation of comprehensive, linked, prevention activities in the new Combination Prevention Project with CDC, Harvard University and Botswana Harvard Partnership. This multi-year project will scale up HIV prevention, care, and treatment services to reach at least 80% coverage in targeted communities. Referrals will be monitored regularly, and emphasis will be placed on providing timely, quality service retaining persons in care, treatment and prevention services. The results of this study will have tremendous implications for comprehensive, effective service delivery and programming not only for Botswana, but for all countries with high burden, generalized HIV epidemics.

Most prevention areas demonstrate natural overlap for strategic mixes of programs. In Botswana, examples include mixing community outreach with mobile HIV testing and VMMC to both improve

efficiency and client satisfaction. In certain PMTCT clinics, the rate of partner testing (22%) is double the national average, demonstrating an ideal teachable moment when couples are concerned for their own health and the health of their infant. Other strategic program mixes in prevention include promoting blood donor clubs among low risk youth, and encouraging risk reduction and commitment to donating to a safe blood supply, as well as incorporating injection safety and sharps exposure prevention training into routine service delivery.

Other changes in the General Population portfolio include shifting the BCC programs from focusing on small-scale, stand-alone interventions to supporting larger-scale and more cost-effective approaches, such as a new national mass media campaign linked to community and interpersonal activities promoting VMMC and couples testing. One remaining youth program includes CDC and Peace Corps support of the school-based life skills curricula “Living” in junior and senior secondary schools. Currently 83% of schools are using this standard curriculum. PEPFAR supports training, mentoring, and procurement of supplies for the Living program. In addition, a new centrally funded Public Health Evaluation, Project AIM, will use a three-arm group randomized study to compare the current Living program with Project AIM. This project helps youth develop skills to use in developing a positive future self, including career development skills. It will be implemented in 2012 and results will be disseminated widely for overall school-based HIV program improvement.

Cross Cutting- HSS/HRH

PEPFAR is assisting in institutionalizing the lay counselor cadre that has been largely responsible for the success of, the PMTCT, RHT and ART programs. This cadre will remain paraprofessional, but will be upgraded and workers renamed health care assistants. This will expand their skills and help retain them in the facilities. Non-professionals are provided with pre- and in-service training and supervision according to their job descriptions. Pre-service training of health care auxiliaries/assistants is outsourced to an accredited local institution.

Medical Transmission

The aim of the Injection Safety program is to support the GOB in preventing medical transmission of HIV and other bloodborne pathogens, particularly preventing occupational exposure among healthcare workers (HCW) across all sectors of service delivery. The program has strengthened national infection prevention and control structures through the implementation of a variety of interventions in occupational health, phlebotomy, and healthcare waste management. Through financial support and technical assistance, PEPFAR assisted the MOH to develop Hepatitis B vaccination guidelines, injection safety training manuals, and pre-service training materials. In health districts with PEPFAR-supported injection safety interventions, the use of HIV post exposure prophylaxis (PEP) by HCW improved from 29% in 2004 to 58% in 2008, and needlestick injuries reduced by 70%. These approaches will not only be fundamental to making safety a professional norm, but will also ensure that health services are delivered in a safe manner to the community. The project staff will review progress towards targets every quarter and through continuous supervisory monitoring of the Project’s interventions. Monitoring will be combined with technical assistance aimed at improving quality assurance and services. PEPFAR will to continue to provide TA to the GOB to implement a national Infection Prevention and Control program and policy for HCWs, provide improved pre-service training in infection control best practices and disseminate best practices across all areas of medical service delivery.PEPFAR support to the GOB goal of improving the safety and adequacy of the blood supply has yielded remarkable success through Blood Center construction and renovation, equipment procurement, policy and guidelines, and personnel provision. To date, HIV and other transfusion transmissible infections (TTI) in discarded donated blood have dropped dramatically from 9.9% in 2004 to 2.5% in 2010. In addition, the supply of safe blood has increased from >13,000 donated units in 2004 to >20,000 units in 2010. Despite these successes, the safe blood supply is still inadequate by WHO standards and the National Blood Transfusion Service (NBTS) has relied heavily on PEPFAR support for staffing critical positions. The vision of the Blood Safety program is to fully graduate the PEPFAR-supported positions to the GOB by 2013, and improve blood supply adequacy by integrating blood donation activities with other HIV prevention programs, including Pledge 25 Clubs for donor recruitment, accreditation of NBTS to ensure continued quality, strengthening monitoring and data management systems, and integrating blood safety with other programs such as HTC and VMMC.

Gender

Social and cultural norms in Botswana contribute to gender inequality by socialising young girls and women to be submissive and therefore unable to take charge of their sexual relationships and negotiate condom use. Male norms also discourage men and boys to access health services because hospitals are seen as places for women and children (Lesetedi, 2009). In addition, the unemployment rate for women is 31% compared with 21% for men. Poverty among women can enable dependency on intimate partners for survival, making them more likely to be vulnerable to HIV infection and GBV. Women often engage in intergenerational sex, transactional sex, and commercial sex work because of financial dependence or lack of economic empowerment (Image, 2008; Open Society Institute, 2009). PEPFAR and the GOB prioritize the empowerment of women and men to respond effectively to HIV/AIDS and emphasize the need to critically address cultural, social and economic aspects of gender. This gender response is aligned to the PEPFAR gender strategy, GHI principles and the Botswana National Strategic Framework II (NSFII).In FY 2012, prevention efforts will focus on addressing male norms and behaviours, reducing violence and coercion, analyzing and programming for gender more systematically, increasing women's access to income and productive resources, and improving monitoring and evaluation.The BDF HIV prevention project for military personnel and their families will more profoundly deal with masculinity issues that affect uptake and quality of services including male circumcision, couple testing and prevention of GBV. Under the PMTCT program, the peer mothers activity will continue to encourage male participation. The VMMC program that mobilizes men and boys for male circumcision will address male norms by conducting outreach sessions at soccer matches, work places and strategic areas to reach out to men, while women will be asked to take a leading role in encouraging their sons and partners to circumcise. The Living school based life skills program includes two modules that address male norms, which will raise boys' awareness and foster a different outlook on gender relations for the next generation. The HTC program will continue to focus on social marketing and community mobilization to target more couples and men to test through testing campaigns such as "Passport to Life," "Couples who test together stay together," and "Life Fest" aimed at specific population segments that encourage men and other marginalized groups to test for HIV and adopt safe sex practices. Both USAID and State Department will support economic strengthening and livelihood activities for groups of women working on small business projects like horticulture and dressmaking to generate income and ensure food sustainability for their households.

Activities to prevent and mitigate GBV will be funded in FY 2012. In collaboration with the Women's Affairs Department, the OVC and Gender Project will conduct a campaign and facilitate community and family discussions aimed at changing behaviors and attitudes about GBV. Kagisano Women's Shelter Project initiate support groups to change male norms on gender, strengthen GBV referral systems, and raise community awareness on women and children inheritance and property rights. Peace Corps will continue to support Women Against Rape (WAR) and Kagisano Women's Shelter with volunteers who provide capacity building. The HIV MARP project NGOs will facilitate GBV awareness workshops with community members, police officers, sex workers and health care providers. Peace Corps supported Girls Leading our World (GLOW) Clubs and Camps will continue to empower girls and boys and teach students about GBV. PEPFAR will support the GOB national campaigns to highlight key messages on the rights of children, women and gender issues. In FY 2012, gender analysis training courses will be held for PEPFAR staff and partners to develop skills in gender integration. Training and support from the PEPFAR Gender Specialist will ensure that the strengths, capacities and risks that may be particular to girls, women, boys and men are built into programs to better achieve objectives in order to enhance the quality and effectiveness of PEPFAR and GOB programs and systems.

Strategic Information

Strategic information is used extensively in PEPFAR Prevention program planning, although key challenges remain. Because of poor representation of school age youth in BAIS III, FY 2012 funds will be used to support the Botswana Youth Risk Behaviour Surveillance Survey (BYRBSS) to understand HIV risk factors affecting this age group. There is a lack of data to assess the continuum of care in Botswana from HIV testing through ARV treatment. Monitoring and evaluation data for the Masa ARV treatment

program are captured through the Patient Information Monitoring System (PIMS II) in outpatient clinics. PEPFAR support was used to develop the PIMS II system for the Masa program. Data for RHT and PMTCT are captured through log books and aggregated for reporting. To integrate these data sources at the patient level, PEPFAR supported the expansion of PIMS II though the development and deployment of electronic registers for RHT and PMTCT in five pilot health districts In FY 2011. In FY 2012, PEPFAR will support the development of an electronic register for VMMC and the deployment of electronic RHT and PMTCT registers to the remaining 24 districts. In a public private partnership with a local telecommunications provider (MASCOM), PEPFAR is developing three SMS messaging systems to improve prevention service delivery. The first is to improve the timeliness in returning test results to health care providers from the two early infant diagnosis national reference laboratories. The second is to improve linkage to appropriate care and prevention services among Tebelopele VCT clients. The third is to improve follow up of VMMC clients.

Capacity Building
Botswana is fortunate to have a strong national government with substantial capacity compared with neighboring southern African countries. However, as HIV is still hyperendemic, improvements are still needed before full independence from donor funding can be achieved. Capacity building through individual education and mentoring, organizational strengthening, and improving system efficiencies is integral to all Prevention activities, with all planning, decision-making, and actions taken in full collaboration with GOB and civil society counterparts. The key capacity building priorities of the PEPFAR Prevention team are the program areas planned for graduation, namely PMTCT and Blood Safety. PMTCT service delivery is largely provided directly by the GOB, but PEPFAR plays a role in training service providers, providing technical updates, advocating for best practices, and demonstrating real-time programmatic use of monitoring data in Francistown. The Blood Safety program is in the midst of an exit strategy from PEPFAR funding, with key positions, supplies, and activities being taken over by the GOB. PEPFAR is assisting these programs to evolve from direct financial support to a technical assistance model.The PEPFAR Prevention team also provides capacity building in new and growing programs, such as VMMC. With strong advocacy and mentorship from PEPFAR, the GOB has rapidly progressed on many policy and practice positions that were hampering forward movement. In civil society, USAID works with local NGOs to improve rigor and efficiency, as well as diversify funding streams. Peace Corps is expanding the volunteer pool to provide development and prevention education expertise to a cross section of CBOs and government ministries. Other Prevention activities, such as the national campaign, purposely include targets to increase the capacity of NACA by PSI and CDC counterparts. In this activity, selected NACA advisors will shadow PSI experts through the full spectrum of campaign development, and CDC will assist NACA in launching a new clearinghouse to improve quality control reviews of health messaging campaigns supported by the GOB.Part of the PEPFAR legacy in Botswana will be leaving systems that monitor quality, not just quantity of prevention services. Each area of the Prevention portfolio includes monitoring for continuous quality improvement, and GOB counterparts are being actively mentored to take over these responsibilities. The PEPFAR prevention team takes program monitoring even further with carefully designed program evaluation activities and rigorous research studies. In each activity, counterparts from the GOB and civil society groups are involved to gain firsthand knowledge and experience. As PEPFAR eventually moves to a technical advisory role, programmatic, monitoring, and research activities will be handed over to counterparts gradually, with a lasting effect in improving technical capacity in Botswana.

**Technical Area:** Treatment

| Budget Code | Budget Code Planned Amount | On Hold Amount |
|---|---|---|
| HTXD | 4,550,588 | 0 |
| HTXS | 1,555,290 | 0 |

| | | |
|---|---|---|
| PDTX | 225,290 | 0 |
| **Total Technical Area Planned Funding:** | **6,331,168** | **0** |

**Summary:**
United States Government (USG) assistance over the period of the President's Emergency Plan for AIDS Relief (PEPFAR) in Botswana has focused on strengthening the national HIV program, referred to as the MASA program. Two partners who directly provide care and support or ARV have been supported from the inception of PEPFAR in Botswana and these are the Botswana Harvard Partnership (BHP) and Baylor. Despite the exemplary response Botswana has pioneered, there have been significant challenges and the USG assistance will continue to assist the Government of Botswana (GOB) to focus on human resource and infrastructure. The principal clinical challenge is the resurgence of TB in Botswana.

Another challenge for the GOB has been the procurement and logistics of drugs, including antiretrovirals (ARV) and related commodity supplies, such as laboratory reagents. Since FY 2008, the Supply Chain Management Systems (SCMS) began to work with Central Medical Stores (CMS), the Drug Registration Unit (DRU), and other relevant GOB organizations to improve the quality of these services. This assistance will continue through 2012-2013 with oversight support for a national patient data management system which includes pharmacy data. This strengthening of systems will continue even though the USG support for ARV drug procurement is decreasing significantly. The GOB currently funds 80% of the MASA program costs. In addition to the support for logistics and procurement, PEPFAR funds will continue to support the data management section of the MASA program through secondment of epidemiologists and statisticians to the Monitoring and Evaluation (M&E) Section of the Ministry of Health (MOH).

The GOB is currently developing a medical school at the University of Botswana to train doctors within Botswana. PEPFAR-supported partners BHP, UPenn, and Baylor provide faculty that is developing and reviewing curriculum on an ongoing basis in order to have integrated pre-service HIV training.

These USG-funded training partners will continue plans for integration of their services with the medical school. As participants in the initial development of the MASA program, they helped develop a national curriculum for HIV care providers known as KITSO, a master trainer program for both adult and pediatric patients, and the nurse prescriber and dispenser task shifting initiatives. All these training programs focus on decentralized ARV services for outlying and remote areas of the country in an effort to provide services to affected communities.

Both the BHP and Baylor will continue to provide training and mentoring on HIV care. They will expand their services to all principle sites in Botswana through outreach, particularly in the area of TB/HIV management for both public and private health care providers. Both partners will continue to improve the integration of their activities with each other and with the GOB to be consistent with the strategic plan for long-term capacity building, national program ownership, and sustainability.

Infrastructure in the public health system is strong and support from the Gates Foundation and industry sponsors allowed the Ministry of Health (MOH) to roll out a national ARV program, the MASA program, in 2002. As of July 2011, MASA is treating a total of 170,430 patients with ARV, including almost 16,514 patients outsourced to private practitioners and 13,849 seen by private practitioners through health insurance schemes. An estimated 94.9% of the 179,569 Batswana in need of ARV are currently receiving treatment. Currently, approximately 4% of adult patients are on second-line ARV.

The small, but underserved, population of registered refugees with HIV in the United Nations High Commission for Refugees (UNHCR) camp in Dukwe is not eligible for GOB-funded ARV. Since 2009 a USG-funded ARV program implemented by the Botswana Red Cross Society has been operating in the camp.

Based on plans made in 2010 and reviewed in 2011, the Treatment program is scheduled for "graduation" in 2013. This means that the 2013 COP will be the last year that external funding for Treatment activities will be budgeted by PEPFAR Botswana. This decision was based on the strength of the Treatment program and the high level of country ownership for Treatment activities that has existed for many years. As the Treatment program transitions to "graduation", remaining COP funding will be directed mainly towards training and mentoring efforts and away from supporting the purchase of commodities. For example, the budget for ARVs was reduced from $4 million in 2011 to $2 million in 2012.

These plans are consistent with the Global Health Initiative (GHI) strategy for Botswana which calls for a transfer of selected programs to the GOB over the next 2-5 years. The long term plan is for PEPFAR Botswana to move to a technical assistance model with a limited budget to support external partners. This is a reflection of the strength of the GOB's HIV response.

Adult Treatment

I. Access and Integration
The current treatment guidelines are those of 2008. However, the 2011 revised national treatment guidelines are almost ready for release. Botswana will be shifting to the 350 cc/mm3 threshold pending approval of the Permanent Secretary for the Ministry of Health in line with WHO recommendations. It is anticipated that ARV coverage estimates may decrease from the current level of 95% to approximately 75% at the time of this change. Coverage will initially decrease as the population of HIV+ eligible persons will increase by approximately 25,000 to 30,000 when the CD4 cutoff is changed. This will be an added burden on the budget for ARV drugs procurement and comes at a time when the PEPFAR treatment budget for drugs has been reduced by 50%. However there have not been any changes in terms of drug regimens and laboratory monitoring protocols in the new guidelines. The first and second line ARV regimens remain the same.
The time frame for implementation of the new guidelines is still unknown. The currently circulating draft staggers implementation over a period of 1-2 years starting with the rolling out of universal HAART for all pregnant women and patients with malignancies.
Botswana has already reached the target of universal access for treatment (94.9%) with 170,430 of the projected 179,569 adults and children in need of ARV at the end of July 2011 on treatment. PEPFAR funding for treatment is scheduled to end after COP 2013. PEPFAR would then focus treatment activities on providing technical assistance to the GOB. It is anticipated that there would be no new initiative from other partners like African Comprehensive HIV/AIDS Partnership (ACHAP) in supporting ARV treatment during the next 2 years. It is expected that the GOB would remain the major financer of the ARV treatment program possibly with Global Fund support.
The high TB/HIV co-infection rates in Botswana are such that TB is the leading cause of mortality in AIDS patients in Botswana followed by pneumonias and malignancies. Currently integration of services for co-infection is of importance for both the national HIV and TB programs. Guidelines and policy for TB/HIV management are undergoing revision. Both public and private sector health care providers are being trained in integrated management of TB/HIV not only at the secondary and tertiary levels of clinical care but also at the primary level. Emphasis on training and infrastructure for infection control are a priority for both PEPFAR and the GOB.
Isoniazid Preventive Therapy (IPT) intervention activities have been put on hold while the GOB looks into recent research findings on the benefits of IPT over a longer period than the previous six months that was in the national guidelines.
II. Quality and Oversight

Botswana has one of the most robust ARV treatment programs in Africa. Quarterly program meetings with implementing partners are held and partners submit quarterly progress reports that provide a framework for monitoring progress. The Botswana national ARV treatment training curricula is aligned to the national HIV treatment guidelines for all levels of health care workers offering care and treatment services.
In collaboration with the MOH and PEPFAR, training manuals on CD4, viral loads, hematology, chemistry, and microbiology (including TB and STI) have been developed and are being used.
The M&E staff seconded to the MOH has assisted the national program with the following interventions for quality control and assurance: 1) an electronic monitoring system for tracking clinical, laboratory and pharmaceutical results for ARV patients, 2) an electronic monitoring system for the ARV program, including a minimum set of PEPFAR and national program indicators, data capture instruments and mechanisms, reporting guidelines, schedules, and instruments developed and distributed to ARV sites, and 3) training of staff and regular on-site mentoring.
III. Sustainability and Efficiency
A Costing and Forecasting TWG has been set up in the Department of HIV Prevention and Care with membership consisting of all internal and external stakeholders including donors like PEPFAR, ACHAP, the Clinton Foundation, and partners such as SCMS. This TWG has the responsibility of developing and reviewing the forecasts and costs associated with the antiretrovirals used in the program. Changes in treatment guidelines are usually discussed in this workgroup. Costing has been done for different scenarios including universal HAART for pregnant women with and without formula-feeding for infants. ACHAP also provides the following ARVs for the program – Raltegravir, Efavirenz 200mg, Efavirenz 50mg, Efavirenz 600mg, and the fixed dose combination containing Efavirenz 600mg, Tenoforvir 300mg and Emtricitabine 200mg. Funding from the Clinton Foundation has ended. The GOB has applied for Global Fund support. Procurement of ARVs goes through the framework contracts which CMS has in place and as much as possible, ARVs procured are registered with the DRU. Botswana benefits from the Clinton Foundation negotiated prices for ARVs.
Brand name ARVs are only procured when there is no generic alternative or when the generic alternative is found to be more expensive. Strengthening of data management from ARV sites to the Logistics Management Unit at the central level is being prioritized to ensure accuracy of forecasts to further minimize wastage through drug expiration.
ARV Failure
Botswana has a team of experts working under the leadership of the MOH as a committee overseeing issues of treatment failure. Experts are drawn from training institutions, among them BHP, Baylor, University of Pennsylvania, and the University of Botswana School of Medicine. They have formed failure clinics in designated secondary and tertiary level institutions. Such cases can then be referred to specialists for management.
At the MOH, a well established Drug Regulatory Unit (DRU) supported by PEPFAR carries out training and mentoring of pharmacists. Training topics include pharmacovigilance, good clinical practice, good manufacturing practices, inspections, evaluations of biopharmaceutical products, and dossier reviews for medicines registration. PEPFAR funding also supports short-term technical assistance whenever necessary to help strengthen capacity at the DRU. PEPFAR has supported benchmarking visits to internationally recognized agencies such as the United States Food and Drug Administration.
Pediatric Treatment
The focus in 2012-2013 is the continued improvement of pediatric HIV care and treatment together with improved data collection, analysis and use by the national program. Also continued collaboration by all implementing partners is of importance to increase the number of children accessing treatment and the improvement of AIDS-free survival in this population. It is especially important for the so-called forgotten adolescent males and females living with HIV.
One of the major accomplishments of the last 1-2 years was that the program, working on a very detailed in-service curriculum, managed to train and mentor more that 80% of doctors, laboratory scientists, pharmacy personnel, and nurses in pediatric care and treatment competences tailored to their specialty. This has provided an opportunity for children to be managed at sites closer to their homes.

The figure for children on ARV stands at 5.3% (9,073) of the total of 170,430 patients currently on HAART. The target for new enrollments is 300 children annually in 2012-2013.
A key priority is to continue scaling up treatment for all pediatric patients in need and to improve tracking systems for those that are “lost” following birth to an HIV+ mother.
The 2009 MASA external program evaluation report disseminated to all stakeholders in May 2011. It serves as a reference for all pediatric aspects of care.
PEPFAR staff take part in both the pediatric TWG and the adolescent TWG organized by the MOH.
Cross Cutting Priorities
Supply Chain
Currently Botswana does not have any pharmaceutical industrial base. All drugs and related commodities of any type are imported. We have a well staffed and experienced MOH team under the National Drug Quality Control Laboratory (NDQCL) that is mandated to test all drug for safety, efficacy, and quality.

Assistance is provided by Supply Chain Management Systems (SCMS), a consortium of 18 partners. The overall objective of SCMS is to strengthen national supply chain management systems for ARVs and other commodities through capacity building, provision and designing of standardized tools, staff training, strategic planning, and provision of short-term technical assistance.

SCMS activities supported through PEPFAR are conducted in partnership with the MOH. Government units supported through this partnership include CMS, DRU, the Drug Management Unit (DMU), NDQCL, the National HIV Surveillance Unit, and MASA.

The MOH has a Technical Working Group which includes all relevant stakeholders including SCMS. This TWG has a regular schedule of meetings; the group oversees pharmaceutical and laboratory commodity product quantifications and forecasting based on consumption data.

The MOH through this committee and relevant offices of the Government, such as DRU, serves as a risk mitigation unit overseeing the strategy to monitor and if possible prevent drug and other related commodity stockouts. To date, there have been no widespread stockouts of ARVs in Botswana.

In Botswana, with technical expertise and funding from PEPFAR, a Logistics Management Information System (LMIS) has been developed and is awaiting full implementation starting with District Health Teams (DHMT), CMS, and the MOH.

The main challenges in the supply chain are that the structure of the CMS is still in flux and local staff needs to upgrade their skills in procurement, storage, cold chain maintenance, and distribution. It was planned that CMS would be a parastatal organization, but with change of top management at the MOH that is no longer the plan. Currently all senior management at CMS is made up of international experts brought in two years ago by SCMS with PEPFAR funding. These staff are to help improve systems to insure they run efficiently and effectively. In the last few months, local managers have been appointed to take over from selected international staff.

ARV Drugs: Pediatric Section
From the most recent MASA report 5.3% of 170,430 patients or 9,073 on HAART at the end of July 2011 were children <12 years of age. The pediatric TWG and the National Treatment Guidelines committee oversee ARV drug selection and forecasting while the Drug Management Unit working together with DRU, NDQCL, and CMS manage the registration, quality assurance, procurement, storage and distribution of all ARVs. Stavudine has been removed from treatment for adults except where options are limited or as a short term measure. It remains for pediatric treatment as a second line ARV. PEPFAR provides funding for strengthening the procurement system and building capacity. Systems are being developed in Botswana to oversee all medical and drug logistics with a goal of preventing stockouts.

Laboratory

The MOH laboratory services have developed a five-year laboratory strategic plan which covers laboratory quality management and accreditation. Three public health laboratories have been accredited by the SANAS (South Africa National Accreditation System). A draft national medical laboratory policy and a national medical laboratory standard have also been developed.

The public laboratory network in Botswana is a referral system comprised of successive levels of health facilities each having increasing degrees of service: a) primary level hospital laboratories support peripheral health units which consist of clinics, health posts, and mobile posts; b) district level hospital laboratories include mission and mine hospitals; c) referral hospital laboratories support regional and national levels; and d) reference laboratories are special laboratories for TB, HIV and blood transfusion services.

There are currently 45 government laboratories -- 39 hospital- or clinic-based laboratories, two HIV reference laboratories, a national TB reference laboratory, a national quality assurance laboratory, a national blood transfusion service laboratory, and a national health laboratory which operates as the national public health laboratory. Together they support outbreak response, surveillance, training, specialized testing, and national quality assurance. In addition, there are 15 private laboratories, more than 700 HIV routine testing sites as well as 35 voluntary counseling and testing centers. Following the Maputo declaration, a laboratory logistic system was developed to monitor stock imbalances within the laboratory network and collect accurate national data for essential laboratory commodities.

Even though Botswana has experienced some stock outs, there is an improvement of the supply chain in the country. The next step will be to roll out the Logistic Management System to all facilities, strengthen the Logistics Management Unit (LMU) at CMS, and train more laboratory staff on quantification and monitoring of supplies.

Gender

The Botswana AIDS Impact Survey III (BAIS III) estimated national HIV prevalence at 17.6 percent; 20.4% among females and 14.2% among males. This high prevalence among females is attributed to several factors, including: women's inability to negotiate for safe sex; gender-based violence (GBV); and multiple concurrent partners (MCP). Adolescent females are approximately three times more likely to be infected with HIV than males of the same age. The highest prevalence rate reported in BIAS III was for females aged 24-30 at 48.9%.
Proportionate to the prevalence rates, treatment statistics reflect that there are more women in the programme than men. As of July 2011, 61% of persons receiving ARVs in Botswana were female. Based on MASA Data and the spectrum modeling, 100% of the women who are eligible for treatment are on treatment and 80% of the men who are eligible for treatment are on treatment. There is no substantial inequity by gender in accessing treatment services. Following the gender analysis planned under Governance and systems strengthening through the OVC and Gender project, the treatment team will be able to conduct a gender analysis and deliberately make the program gender sensitive beyond access and efforts will be made to ensure that the number of males who are eligible for treatment are enrolled.

Strategic Information

In Botswana, there were an estimated 363,000 persons living with HIV in 2011, of which nearly 180,000 (50%) were in need of ARV treatment. Currently, 170,000 (95%) are on ARV treatment. In COP 2012, PEPFAR will continue to support M&E for the MASA treatment program, including the secondment of an M&E specialist and data warehouse manager to the MOH. PEPFAR will also support the Patient Information Management System (PIMS) II which electronically captures ARV patient data from hospitals

and clinics. EPP/Spectrum models are used to estimate and project numbers of patients with advanced HIV infection in need of ARV treatment. One M&E challenge for treatment is that persons who are HIV positive, but not on treatment, may be lost to follow up. To improve M&E for the MASA program, a pre-ART register could improve tracking of patient follow-up and CD4 testing according to the national treatment guidelines. In addition, the number of clients who receive an HIV-positive test result at the Tebelopele voluntary counselling and testing program, but are not linked to appropriate care, is unknown.

Human Resources for Health and Capacity Building

There is shortage of skilled health care workers (HCW) to provide quality HIV services in Botswana. The PEPFAR country team strategy for Human Resources for Health (HRH) is to increase the number of health workers and ensure an appropriately skilled, motivated, well-distributed and productive workforce providing quality health services effectively and efficiently to all the people living in Botswana. Task shifting has been introduced to address the shortage of health care workers. Nurses, health care assistants, and lay counselors are involved in the task shifting, however some of these health care workers are insufficiently trained for performing the work they are assigned. PEPFAR`s plan is to invest in training of lay counselors, health care assistants, allied health care workers, and midwives. Another effort is to strengthen pre-service education by ensuring health training institutions develop the capacity to consistently and sustainably produce competent graduates who will be able to provide quality HIV services. PEPFAR has contributed to strengthening in-service training coordination at the MOH. The MOH in turn guided all training programs to provide high quality HIV in-service training for health care providers in the country. Regulatory bodies are developing skills to design and support implementation of Continuous Professional Development programs to ensure good standards of practice are put in place for quality and safety of care. The non-clinical, public health workforce will be strengthened by building their capacity in disease surveillance and program monitoring.

The NSF II has two objectives related to capacity building related to treatment activities:
1) to strengthen community and health systems capacity for the provision of quality comprehensive and sustainable HIV and AIDS services, and
2) to increase access to HIV and AIDS comprehensive quality treatment, care and support services.
Both of these objectives are supported by activities implemented under the Health System Strengthening portfolio of PEPFAR Botswana as described below.

• Quality Improvement/Assurance
o Quality Assurance/Leadership Development Program
o HIV Quality Management
o Sustainable Management Development Program
o Strengthening of the Health Inspectorate
o Development of standard operating procedures
o Management and leadership training for managers and supervisors
• Integration of HIV and AIDS content into all pre-service training
• In-service training and mentoring by government and partners and support to the HIV training coordinating unit
• Website for health worker continuing education
• Strengthening of the professional councils and professional and facility regulation
• Strengthening of civil society organizations and networks
• Development of a national community mobilization strategy and implementation of participatory community mobilization activities implemented at the district level.

Public Private Partnerships
In a public private partnership with a local telecommunications provider, the Kgakololo (Setswana for “reminder”) SMS project pilot tested sending twice daily text reminders to take ARVs over a six month

period to patients that had previously been identified with ARV adherence issues. The project is being evaluated by comparing laboratory values (CD4 count and viral load) in the six months prior to the Kgakololo intervention with the six months during intervention and by a patient satisfaction survey.

MARPs

Population groups in which most-at-risk behaviors are concentrated include sex workers and their partners, migrant workers, men who have sex with men (MSM), and injecting drug users (IDU). Information on the size of various risk groups in Botswana is limited. The following information is available from the last national survey (BAIS III) that was done in 2008. [BAIS IV is scheduled to be conducted in 2012.] 1.2% of female respondents aged 15-49 years reported having had sex in exchange for money while 1.6% of male respondents aged 15-49 years reported having paid for sex in the 12 months preceding the survey. The prevalence of HIV among the female respondents who exchanged sex for money was estimated at 37.4% and at 23.8% among male respondents aged 15-49 years who paid for sex. 1.2% of male respondents aged 15-49 years reported having had sex with a male partner. Information on all drug use without specifying injection was collected. About 3% of the respondents reported using drugs for recreation; 5.7% among males and 0.5% among females. IDU is not believed to be widespread in Botswana. It is unclear what contribution MARPs make to the overall prevalence in Botswana where 25% of persons 15-49 years of age are infected with HIV.

## Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

| Indicator Number | Label | 2012 | Justification |
|---|---|---|---|
| P1.1.D | P1.1.D Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results) | n/a | Redacted |
| | Number of pregnant women who were tested for HIV and know their results | 0 | |
| P1.2.D | P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery | n/a | Redacted |
| | Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission | 0 | |
| | Number of HIV-positive pregnant women identified in | 0 | |

| | | | |
|---|---|---|---|
| | the reporting period (including known HIV-positive at entry) | | |
| | Life-long ART (including Option B+) | 0 | |
| | Newly initiated on treatment during current pregnancy (subset of life-long ART) | | |
| | Already on treatment at the beginning of the current pregnancy (subset of life-long ART) | | |
| | Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery) | 0 | |
| | Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY) | 0 | |
| | Single-dose nevirapine (with or without tail) | 0 | |
| P4.1.D | P4.1.D Number of injecting drug users (IDUs) on opioid substitution therapy | n/a | Redacted |
| | Number of injecting | 0 | |

| | | | |
|---|---|---|---|
| | drug users (IDUs) on opioid substitution therapy | | |
| P5.1.D | Number of males circumcised as part of the minimum package of MC for HIV prevention services per national standards and in accordance with the WHO/UNAIDS/Jhpiego Manual for Male Circumcision Under Local Anesthesia | 27,956 | Redacted |
| | By Age: <1 | 0 | |
| | By Age: 1-9 | | |
| | By Age: 10-14 | | |
| | By Age: 15-19 | | |
| | By Age: 20-24 | | |
| | By Age: 25-49 | | |
| | By Age: 50+ | | |
| P6.1.D | Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection through occupational and/or non-occupational exposure to HIV. | 0 | Redacted |
| | By Exposure Type: Occupational | 0 | |
| | By Exposure Type: Other | 0 | |

| | | | |
|---|---|---|---|
| | non-occupational | | |
| | By Exposure Type: Rape/sexual assault victims | 0 | |
| P7.1.D | P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions | n/a | Redacted |
| | Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People Living with HIV (PLHIV) interventions | 500 | |
| P8.1.D | P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required | n/a | Redacted |
| | Number of the target population reached with individual and/or small group level HIV prevention interventions that are | 204,066 | |

| | | | |
|---|---|---|---|
| | based on evidence and/or meet the minimum standards required | | |
| P8.2.D | P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required | n/a | Redacted |
| | Number of the target population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required | 1,050 | |
| P8.3.D | P8.3.D Number of MARP reached with individual and/or small group level HIV preventive | n/a | Redacted |

| | | | |
|---|---|---|---|
| | interventions that are based on evidence and/or meet the minimum standards required | | |
| | Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required | 10,000 | |
| | By MARP Type: CSW | 5,200 | |
| | By MARP Type: IDU | 0 | |
| | By MARP Type: MSM | 0 | |
| | Other Vulnerable Populations | 4,800 | |
| P11.1.D | Number of individuals who received T&C services for HIV and received their test results during the past 12 months | 80,200 | Redacted |
| | By Age/Sex: <15 Female | | |
| | By Age/Sex: <15 Male | | |
| | By Age: <15 | 4,200 | |
| | By Age/Sex: 15+ Female | | |
| | By Age: 15+ | 76,000 | |
| | By Age/Sex: 15+ Male | | |
| | By Sex: Female | 44,100 | |
| | By Sex: Male | 36,100 | |

| | | | |
|---|---|---|---|
| | By Test Result: Negative | | |
| | By Test Result: Positive | | |
| C1.1.D | Number of adults and children provided with a minimum of one care service | 45,741 | Redacted |
| | By Age/Sex: <18 Female | | |
| | By Age/Sex: <18 Male | | |
| | By Age: <18 | 18,071 | |
| | By Age/Sex: 18+ Female | | |
| | By Age: 18+ | 27,670 | |
| | By Age/Sex: 18+ Male | | |
| | By Sex: Female | 26,372 | |
| | By Sex: Male | 19,369 | |
| C2.1.D | Number of HIV-positive individuals receiving a minimum of one clinical service | 11,390 | Redacted |
| | By Age/Sex: <15 Female | | |
| | By Age/Sex: <15 Male | | |
| | By Age: <15 | 2,535 | |
| | By Age/Sex: 15+ Female | | |
| | By Age: 15+ | 8,855 | |
| | By Age/Sex: 15+ Male | | |
| | By Sex: Female | 6,897 | |
| | By Sex: Male | 4,493 | |
| C2.2.D | C2.2.D Percent of | 9 % | Redacted |

| | | | |
|---|---|---|---|
| | HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis | | |
| | Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis | 1,063 | |
| | Number of HIV-positive individuals receiving a minimum of one clinical service | 11,390 | |
| C2.3.D | C2.3.D Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food | n/a | Redacted |
| | Number of clinically malnourished clients who received therapeutic and/or supplementary food during the reporting period. | 960 | |
| | Number of clients who were nutritionally assessed and found to be clinically malnourished during the reporting period. | | |
| | By Age: <18 | | |
| | By Age: 18+ | | |
| C2.4.D | C2.4.D TB/HIV: | 22 % | Redacted |

| | | | |
|---|---|---|---|
| | Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting | | |
| | Number of HIV-positive patients who were screened for TB in HIV care or treatment setting | 2,500 | |
| | Number of HIV-positive individuals receiving a minimum of one clinical service | 11,390 | |
| C2.5.D | C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment | 2 % | Redacted |
| | Number of HIV-positive patients in HIV care who started TB treatment | 250 | |
| | Number of HIV-positive individuals receiving a minimum of one clinical service | 11,390 | |
| C4.1.D | C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months | n/a | Redacted |

| | | | |
|---|---|---|---|
| | of birth | | |
| | Number of infants who received an HIV test within 12 months of birth during the reporting period | 0 | |
| | Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positive at entry) | 0 | |
| | By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months | 0 | |
| | By timing and type of test: virological testing in the first 2 months | 0 | |
| C5.1.D | By Age: <18 | 6,950 | Redacted |
| | By Age: 18+ | 50 | |
| | Number of adults and children who received food and/or nutrition services during the reporting period | 7,000 | |
| | By: Pregnant Women or Lactating Women | 0 | |
| T1.1.D | By Age/Sex: <15 Female | 58 | Redacted |
| | By Age/Sex: <15 Male | 57 | |
| | By Age/Sex: 15+ Female | 63 | |

| | | | |
|---|---|---|---|
| | By Age/Sex: 15+ Male | 59 | |
| | By Age: <1 | 36 | |
| | By: Pregnant Women | 0 | |
| | Number of adults and children with advanced HIV infection newly enrolled on ART | 237 | |
| T1.2.D | Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) | 7,980 | Redacted |
| | By Age/Sex: <15 Female | 1,021 | |
| | By Age/Sex: <15 Male | 564 | |
| | By Age/Sex: 15+ Female | 3,586 | |
| | By Age/Sex: 15+ Male | 2,509 | |
| | By Age: <1 | 58 | |
| T1.3.D | T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy | 95 % | Redacted |
| | Number of adults and children who are still alive and on treatment at 12 months after initiating ART | 76 | |
| | Total number of adults and children | 80 | |

| | | | |
|---|---|---|---|
| | who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up. | | |
| | By Age: <15 | 61 | |
| | By Age: 15+ | 19 | |
| H1.1.D | Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests | 0 | Redacted |
| H1.2.D | Number of testing facilities (laboratories) that are accredited according to national or international standards | 2 | Redacted |
| H2.1.D | Number of new health care workers who graduated from a pre-service training institution or program | 265 | Redacted |
| | By Cadre: Doctors | 0 | |
| | By Cadre: Midwives | 0 | |
| | By Cadre: Nurses | 0 | |
| H2.2.D | Number of community health and para-social workers who successfully completed a pre-service training | 1,276 | Redacted |

| | | | |
|---|---|---|---|
| | program | | |
| H2.3.D | The number of health care workers who successfully completed an in-service training program | 10,620 | Redacted |
| | By Type of Training: Male Circumcision | 381 | |
| | By Type of Training: Pediatric Treatment | 480 | |

# Partners and Implementing Mechanisms

## Partner List

| Mech ID | Partner Name | Organization Type | Agency | Funding Source | Planned Funding |
|---|---|---|---|---|---|
| 7319 | Partnership for Supply Chain Management | Private Contractor | U.S. Agency for International Development | GHP-State | 5,733,715 |
| 7320 | Regional Procurement Support Office/Frankfurt | Other USG Agency | U.S. Department of State/Bureau of African Affairs | GHP-State | 1,200,000 |
| 7321 | Research Triangle International | Private Contractor | U.S. Agency for International Development | GHP-State | 600,000 |
| 7324 | FHI 360 | NGO | U.S. Agency for International Development | GHP-State | 2,520,000 |
| 9910 | National Alliance of State and Territorial AIDS Directors | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 500,000 |
| 9915 | American Society for Microbiology | Private Contractor | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 350,000 |
| 9920 | Association of Public Health Laboratories | NGO | U.S. Department of Health and Human | GHP-State | 500,000 |

| | | | | | |
|---|---|---|---|---|---|
| | | | Services/Centers for Disease Control and Prevention | | |
| 9923 | John Snow, Inc. | Private Contractor | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 237,500 |
| 9924 | Baylor University | University | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 630,900 |
| 9925 | Botswana Harvard AIDS Institute | Private Contractor | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Central GHP-State, GHP-State | 2,850,000 |
| 9962 | Johns Hopkins University Bloomberg School of Public Health | University | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 685,000 |
| 10303 | Pathfinder International | NGO | U.S. Department of Health and Human Services/Centers | GHP-State | 600,000 |

| | | | | | |
|---|---|---|---|---|---|
| | | | for Disease Control and Prevention | | |
| 10312 | Population Services International | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 1,200,000 |
| 10313 | University of Pennsylvania | University | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 2,511,350 |
| 10315 | American International Health Alliance Twinning Center | NGO | U.S. Department of Health and Human Services/Health Resources and Services Administration | GHP-State | 150,000 |
| 10485 | American Society of Clinical Pathology | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 256,188 |
| 11063 | Population Services International | NGO | U.S. Department of Defense | GHP-State | 900,000 |
| 11577 | U.S. Department of Defense | Other USG Agency | U.S. Department of Defense | GHP-State | 810,017 |

| | | | | | |
|---|---|---|---|---|---|
| | (Defense) | | | | |
| 11586 | MULLAN & ASSOCIATES | Private Contractor | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 1,180,000 |
| 11589 | University Research Corporation, LLC | Private Contractor | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 1,476,557 |
| 11708 | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention (HHS/CDC) | Implementing Agency | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 450,000 |
| 12008 | Johns Hopkins University Bloomberg School of Public Health | University | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 3,240,000 |
| 12762 | Cardno Emerging Markets | Private Contractor | U.S. Department of Health and Human Services/Centers for Disease Control and | GHP-State | 450,000 |

| | | | | | |
|---|---|---|---|---|---|
| | | | Prevention | | |
| 12817 | Government of Botswana | Host Country Government Agency | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 14,628,439 |
| 12946 | Project Concern International | NGO | U.S. Department of Defense | GHP-State | 315,000 |
| 12975 | KNCV Tuberculosis Foundation | NGO | U.S. Agency for International Development | GHP-State | 300,000 |
| 13079 | IntraHealth International, Inc | NGO | U.S. Agency for International Development | GHP-State | 800,000 |
| 13091 | Education Development Center | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 450,000 |
| 13316 | Botswana Harvard AIDS Institute | Private Contractor | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 100,000 |
| 13369 | University of North Carolina at Chapel Hill, Carolina Population Center | University | U.S. Agency for International Development | GHP-State | 100,000 |
| 13480 | Management | NGO | U.S. Agency for | GHP-State | 300,000 |

| | | | | | |
|---|---|---|---|---|---|
| | Sciences for Health | | International Development | | |
| 13563 | Population Services International | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 750,000 |
| 13566 | Tebelopele Voluntary Counseling and Testing | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 5,150,000 |
| 13646 | University of Washington | University | U.S. Department of Health and Human Services/Health Resources and Services Administration | GHP-State | 3,337,509 |
| 13669 | Project Concern International | NGO | U.S. Agency for International Development | GHP-State | 3,490,380 |
| 13780 | FHI 360 | NGO | U.S. Agency for International Development | GHP-State | 200,000 |
| 14481 | TBD | TBD | Redacted | Redacted | Redacted |
| 14487 | Association of Schools of Public Health | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and | GHP-State | 100,000 |

| | | | | | |
|---|---|---|---|---|---|
| | | | Prevention | | |
| 14488 | Foundation for Innovative New Diagnostics | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 160,254 |
| 14489 | Futures Group | Private Contractor | U.S. Agency for International Development | GHP-State | 400,000 |
| 14491 | TBD | TBD | Redacted | Redacted | Redacted |
| 14512 | TBD | TBD | Redacted | Redacted | Redacted |
| 14530 | African Field Epidemiology Network | NGO | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 70,000 |
| 14532 | University Research Corporation, LLC | Private Contractor | U.S. Agency for International Development | GHP-State | 100,000 |
| 14662 | TBD | TBD | Redacted | Redacted | Redacted |
| 14686 | University of Washington | University | U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | GHP-State | 1,940,000 |
| 14707 | U.S. Department of State | Other USG Agency | U.S. Department of State/Bureau of African Affairs | GHP-State | 100,000 |
| 14790 | U.S. Department | Other USG | U.S. Department | GHP-State | 50,000 |

| | | | | | |
|---|---|---|---|---|---|
| | of State | Agency | of State/Bureau of African Affairs | | |

# Implementing Mechanism(s)

## Implementing Mechanism Details

| | |
|---|---|
| **Mechanism ID: 7319** | **Mechanism Name: Supply Chain Management System (SCMS)** |
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: Partnership for Supply Chain Management | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 5,733,715** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 5,733,715 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Botswana experienced supply chain challenges which necessitated the invitation of the Partnership in Supply Chain Management Project (SCMS) to provide technical assistance beginning in 2007.
The objective of SCMS is to improve the supply chain management of HIV/AIDS medicines and related commodities through strategic planning and provision of short term technical assistance to the Ministry of Health (MOH) to build capacity, provide/design standardized tools, and train MOH staff to institutionalize new practices and management systems. SCMS has also developed monitoring and evaluation tools and a Performance Management Plan (PMP) and trained MOH staff to use the tools to ensure sustainability of system improvements. By including development of supply chain management curricula at local training institutions, SMCS strengthened in-country training structures which will ensure a continuation of the introduced improvements beyond the life of SCMS project.
This approach is in line with the Partnership Framework signed between the Government of Botswana (GOB) and the USG in December 2010, taking into account the second phase of PEPFAR, which encourages USG support to shift from providing emergency support to focusing on developing

sustainable systems for Botswana's HIV/AIDS response.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 882,211 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Increasing gender equity in HIV/AIDS activities and services
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **7319** |
| **Mechanism Name:** | **Supply Chain Management System (SCMS)** |
| **Prime Partner Name:** | **Partnership for Supply Chain Management** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVTB | 700,000 | 0 |

**Narrative:**

The burden of TB infection in Botswana, particularly co-infection with HIV, has created the need to

introduce more robust diagnostic technologies to enable early TB diagnosis and treatment. There is also a need to expand TB diagnostic capacity in the country. To support the MOH in FY 2011, SCMS procured Mycobacterium Indicator Tube (MGIT) and PCR equipment and the required reagents for TB diagnosis. With the introduction of these technologies, TB diagnosis has been reduced from eight weeks using the conventional Lowenstein Jensen (LJ) culture method to six weeks by MGIT and one week by PCR. The National TB Reference Laboratory (NTRL) has been implementing a quality management system and the laboratory is now in the process of being accredited. One of the requirements for accreditation is that all equipment should be calibrated on a regular basis. SCMS has been outsourcing equipment calibration for NTRL since the Biomedical Engineering Services at MOH does not have the capacity to do the work. In FY 2012, SCMS will continue to support the NTRL with procurement of reagents and supplies for the new technologies. SCMS will also continue to outsource maintenance and calibration services for NTRL, while providing technical assistance to Biomedical Engineering Services to develop systems and build staff capacity to sustain these initiatives.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | HLAB | 1,000,000 | 0 |

**Narrative:**

At the inception of the SCMS project in 2007, the knowledge base of laboratory personnel on supply chain management of health commodities was very limited. Laboratory logistics systems, both the inventory control system (ICS) and the logistics management information system (LMIS), were not established. Supply chain decision making was not evidence-based since there was no logistics information flow between the central level and users. These deficiencies culminated in stock outs from inadequate forecasts and/or high expiries due to overstocking. Interruption in testing was common which sometimes hampered timely antiretroviral treatment initiation and/or monitoring. SCMS, in partnership with the MOH, has been strengthening systems for laboratory commodities. As a first step, SCMS provided capacity building trainings in basic principles of logistics management systems, quantification, and supply planning. Automated tools for quantification and supply planning, namely the Laboratory Quantification Tool and the Pipeline Tool, were introduced. SCMS leveraged knowledge gained through these trainings by working with the MOH to design a laboratory logistics system. In FY 2011, the system was rolled out to 42 laboratories through a training-of-trainers model. Notable achievements realized included 89 lab personnel with competency in lab logistics system; implementation of the system at 67% (28/42) of trained facilities, which are now following best practices in warehouse management; 67% LMIS reporting rate compared to none at baseline. Other achievements include transfer of the management of lab commodities supply chains from the National Health Laboratory to CMS. Trainings have been provided to Biomedical Engineering Services staff to

build their capacity in lab equipment maintenance including calibration, as this is critical in laboratory accreditation and in decreasing equipment downtime. In FY 2012, system strengthening efforts will focus more on achieving a high level of country ownership and sustainability, as well as strengthening partnerships with other implementing partners towards achieving the ultimate goals--continuous availability of health commodities, reduced expiries, and improved customer satisfaction. Rollout of the lab logistics system will continue. Systems for lab commodities managed outside laboratories, e.g., rapid diagnostic kits and test tubes, will be integrated within the medicine logistics system. SCMS will continue to work with the Biomedical Engineering Services to strengthen systems for laboratory equipment maintenance. Technical assistance will be provided for automation and integration of ICS and LMIS within the Laboratory Information System and with the electronic medical record system where possible. The lab commodities security forum will be strengthened to incorporate lab logistics monitoring and supervision functions within the laboratory services management structures; and post-market surveillance for lab reagents, particularly rapid diagnostic kits, will be established. To sustain these activities, a supply chain management curriculum that includes training in lab logistics systems will be provided to medical technology students at the Institute of Health Sciences and UB. Waste management systems for laboratories will be developed and documented.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | OHSS | 1,801,000 | 0 |

**Narrative:**

These activities address a range of supply chain management problems which still affect the supply and distribution of medicines and other health commodities to facility level. Firstly, the ongoing management support to Central Medical Stores (CMS) will continue throughout FY 2012. This support will include the completion of several strategic projects which were initiated in 2009. In response to a request from the MOH, SCMS has been providing a team of senior managers to CMS since 2009 to help solve long-standing management problems. The MOH requested SCMS support to push CMS towards operational excellence and to be seen as a benchmark organization in sub-Saharan Africa.
FY 2012 funds will be used for capacity building and mentoring of locally-appointed CMS managers who will manage CMS when the SCMS managers depart. This is the most important activity in ensuring that the work completed by SCMS is fully sustainable. Funds also will be used to complete the development of the Logistics Management Unit (LMU). The LMU is responsible for collecting, analyzing and disseminating logistics data from end user facilities. The remit of the LMU is gradually expanding to accommodate new commodity groups; by the end of the FY 2012, the LMU will be processing data for ARVs, lab supplies, TB drugs and a range of essential medicines. These data are vitally important for accurate procurement planning and ensuring that distribution to end users is in line with actual needs

There will be consolidation and continuation of the new procurement strategy introduced by the SCMS team, which includes framework contracts that have proved highly successful in increasing medicine availability and rationalizing stockholdings. The ongoing management support will consolidate these gains and extend the use of the contracts to new commodity groups. Funds will be used to complete the ISO accreditation process, and embed the quality management culture. CMS will be ready for its first assessment by the Botswana Bureau of Standards by the end of 2011. Following that assessment, remedial work may be required to address any shortcomings identified by the assessors. Once CMS gains ISO accreditation, the focus will shift to ensuring that the quality management culture is firmly embedded within the organization.

In addition to the continuation of the successful management support at CMS, these funds will also be used to support the implementation of the new Medicines LMIS across Botswana. This new system addresses a wide range of shortcomings in the way that hospitals and clinics manage inventory, collect data and calculate order quantities. The LMIS is being rolled-out in conjunction with the MOH and UNFPA, beginning with a training-of-trainers program. In this regard, the FY 2012 funds will be used to train health workers down to the health facility level, and substantial TA will assist the MOH to monitor and evaluate the results as the system is put in place.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | CIRC | 1,249,290 | 0 |

**Narrative:**

The GOB made a commitment to achieving the goal of “Zero New Infections by 2016” and has identified Voluntary Male Medical Circumcision (VMMC) as an additional low-cost prevention strategy to prevent further HIV transmission in the country. The MOH is currently making efforts to scale-up VMMC service delivery throughout the country, with its main objective being to provide VMMC services to 80% of HIV negative men aged between 0-49 years within a five-year program, requiring the provision of a total of nearly 385,000 circumcisions.

In order to achieve this ambitious goal, the VMMC program will be scaling up at a much faster pace. PEPFAR is committed to providing support aimed at making VMMC safe and as such is providing funds for the procurement of supplies and equipment. This requires an efficient procurement system to purchase 60,000 VMMC kits, 60,000 HIV test kits and supplies, 18 Diathermy machines, medical equipment for four additional (nine total) sites, and two clinics-in-a-box; and a well-functioning supply chain management system to deliver VMMC kits and equipment to key locations throughout the country in a timely fashion to meet the anticipated demand without any interruptions. The storage and distribution of these kits and machines will be in line with the established government mechanisms through Central Medical Stores. With funds from FY 2012, SCMS will provide technical assistance to strengthen the VMMC kits supply chain management to all GOB agencies including the MOH and the

Botswana Defense Force. SCMS will also assist the National VMMC Technical Working Group with reliable systems for forecasting, procurement, supply planning, distribution, consumption reporting, monitoring and evaluation. Monitoring and evaluation tools will be developed and MOH counterparts trained to institutionalize and ensure country ownership and sustainability.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 100,000 | 0 |

**Narrative:**

The Botswana National Strategic Framework II 2010 – 2016, calls for an increased focus on prevention activities that are directly linked to the Vision 2016 goal of “no new infections.” The HIV/AIDS epidemic in Botswana is driven largely through sexual transmission and the availability and correct use of condoms play a critical role in the response to the Botswana epidemic. In addition, condoms are an important tool in family planning and STI prevention programs.

Botswana has been experiencing condom management challenges including limited coordination and information-sharing between key actors for decision-making. Weaknesses in forecasting and procurement are based on inadequate information and erratic distribution with data only available for the number of condoms issued from the central level. Data on indicators of availability, consumption and accessibility at service delivery points do not exist.

SCMS will use FY 2012 funds to strengthen the condom logistics management system (inventory management and LMIS), which will improve logistics data recording and reporting throughout the supply chain. This will help the MOH to forecast condom requirements and prevent condom stock-outs at all levels and will help ensure that only condoms of acceptable quality are available at all levels of the condom supply chain. SCMS will achieve this by including condoms in the LMIS and training health workers to use the system including the monitoring and evaluation tools. SCMS will collaborate with the MOH and UNFPA to finalize the condom strategy, which encompasses capacity building within the MOH to sustain condom management initiatives. SCMS will also work with the National Drug Quality Control Laboratory to strengthen the quality analysis of condoms procured for national use. This work will cover both male and female condoms in support of new gender initiatives being developed by the MOH and PEPFAR partners.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 150,024 | 0 |

**Narrative:**

Previously, early infant diagnosis (EID) commodities were distributed from the national health laboratory, while the distribution of the rest of the PMTCT supplies was handled by Central Medical Stores (CMS). In FY 2011, SCMS successfully facilitated transfer the distribution mechanisms for EID commodities to

CMS to improve efficiency and customer service.
SCMS continued to procure EID collection kits in FY 2011, as well as provide technical assistance in forecasting and supply planning of these commodities. In FY 2012, SCMS will continue to procure EID commodities. However, for sustainability and country ownership, at the end of FY 2011 the MOH is expected toprovide funds for these commodities through the CMS budget.
Logistics management activities such as capacity building in management of health commodities and logistics management information systems (LMIS) reporting for all PMTCT supplies, including EID commodities is integrated within the Medicine's LMIS, which is currently being rolled out countrywide.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXD | 733,401 | 0 |

**Narrative:**

In 2007, SCMS in partnership with the MOH, identified supply chain challenges to include weak procurement, supply planning, and inventory management and distribution processes at Central Medical Stores (CMS) and health facilities leading to overstocking, expiries, and stockouts of health commodities. The Drug Regulatory Unit (DRU) had a backlog of applications for market authorization due to understaffing, weak processes, and an outdated information management system. The National Drug Quality Control Laboratory (NDQCL) did not have enough physicochemical and microbiological capacity to be able to perform priority drug tests to support drug regulation and procurement activities. SCMS has built the capacity of the DRU and NDQCL in drug registration, records information management systems, and pharmaceutical analysis. By training DRU staff on specialized regulatory topics and SIAMED, developing a robust records management system, introducing application evaluation retreats, and building the capacity of the Drugs Advisory Board, the backlog in applications for market authorization was cleared. The DRU is able to review all applications as soon as they are submitted, thus providing timely support for CMS drug procurement. SCMS partnered with the U.S. FDA to train NDQCL staff in physicochemical analysis and antimicrobial limit testing and established collaborative linkages with the University of Botswana (UB) and North West University in South Africa. SCMS has provided a team of technical experts to transform CMS management and technical assistance for the development of a procurement training program at the Public Procurement and Asset Disposal Board (PPADB).
In FY 2012, SCMS will establish structures to institutionalize the supply chain management system at the MOH, CMS and health facilities. They will establish a commodity security coordinating forum at the MOH, a Logistics Management Unit (LMU) at CMS, and a Laboratory Management Information System that will extend to the District Health Management Team level. Monitoring and evaluation systems and tools at PPADB and DMU will be strengthened to sustain the improvement efforts. Systems for continuous human capacity development will be strengthened to ensure long term availability of human

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|---|
| resources that are needed to operate and maintain an efficient supply chain management system. This includes training of trainers and the roll out of logistics management systems by MOH staff, procurement training by PPADB trainers, introduction of logistics training at health staff training institutions including the UB, and collaboration between the North West University and UB for training of drug analysts. Private sector pharmacists will be trained by the MOH to evaluate drug applications for the DRU to counteract the effects of staff attrition. SCMS will also use budgeted funds for software and IT development support and procurement to establish logistics systems to facilitate submission of reports to the LMU for aggregation and analysis for decision making. |

## Implementing Mechanism Details

| **Mechanism ID: 7320** | **Mechanism Name: RPSO laboratory construction projects** |
|---|---|
| Funding Agency: U.S. Department of State/Bureau of African Affairs | Procurement Type: USG Core |
| Prime Partner Name: Regional Procurement Support Office/Frankfurt | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 1,200,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 1,200,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Funds will support three projects with a total of seven structures - 5 District Labs, National Health Lab and National TB Reference Lab Francistown.

1) $550,000 will plus up the five district laboratories to be built. They will be identical multipurpose labs. This will reduce design expenses and leverage training effect for laboratory technicians who may be working at multiple sites. The structures are single story.

2) $400,000 of the new funds is to plus up a new national health laboratory that will be constructed in Gaborone. The old laboratory was not suitable for renovation. The new laboratory will be a biosafety

level 3 facility able to perform molecular and other specialized tests to monitor communicable diseases. The lab will also serve as a center of excellence with training and quality assurance capabilities.
3) $250,000 of the new funds is to plus up the building of a TB Reference laboratory in Francistown to support TB diagnostic efforts in the northern half of Botswana. Because of delays in construction and inflation of the cost of building materials, the funds allocated were not enough to cover all the expenses. FY12 funds will cover the budget shortfall. Original funding for this project was in COP07.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Construction/Renovation | 1,200,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

TB

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **7320** |
| **Mechanism Name:** | **RPSO laboratory construction projects** |
| **Prime Partner Name:** | **Regional Procurement Support Office/Frankfurt** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | OHSS | 1,200,000 | 0 |

**Narrative:**

| |
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| Funds will support three new laboratory construction projects: 1) Five district laboratories will be built. 2) A new national health laboratory will be constructed in Gaborone as it was determined that the current laboratory was not suitable for renovation. The new laboratory will be a biosafety level 3 facility able to perform molecular and other specialized tests to monitor communicable diseases. The lab will also serve as a center of excellence with training and quality assurance capabilities. 3) A TB Reference laboratory to support TB diagnostic efforts in the northern half of the country will be constructed on the grounds of the referral hospital in Francistown. |

## Implementing Mechanism Details

| **Mechanism ID: 7321** | **Mechanism Name: HIV Prevention for MARP** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: Research Triangle International | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 600,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 600,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Botswana Council of Churches & Kgolagano College | Botswana Family Welfare Association | Light and Courage Centre Trust |
| Matshelo Community Development Association (MCDA) | Nkaikela Youth Group | Silence Kills Support Group |
| Tebelopele Voluntary Counseling and Testing | True Men | |

## Overview Narrative

The Botswana HIV Prevention for Most-at-Risk Populations (MARP) Project provides funding and technical support to eight local civil society organizations (CSO) to build their organizational capacity, provide quality services to targeted MARPs, and promote a sustainable continuum of prevention to care

through national and local collaboration.
The project team developed and is implementing locally appropriate behavior change communication strategies that move beyond abstinence and fidelity to motivate sustained behavior changes among the target populations. They engage and mobilize communities, including formal and informal opinion leaders, in changing behavioral norms. They bring services, such as voluntary counseling and testing (VCT), closer to the target populations with outreach activities. They reduce barriers to access to care, including changing provider attitudes towards the target MARP, making services more user-friendly, creating strong referral networks, and engaging both clients and providers in defining and monitoring service quality. Project efforts are coordinated with the broader national response, including the planned multiple concurrent partnerships (MCP) campaign, the ongoing voluntary male medical circumcision (VMMC) campaign, and related projects, to promote message consistency.
The target populations include: young women 15-29 years old in cross-generational and/or transactional relationships; female sex workers (FSW) and their clients; and, migrant male populations whose work separates them from their primary partners and families. Eight local implementing partners (sub-partners) receive funding to roll-out HIV prevention services to MARP in five districts--Tlokweng, Gaborone, Selebi-Phikwe, Francistown and Kasane.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Mobile Population
Family Planning

## Budget Code Information

| Mechanism ID: | 7321 | | |
|---|---|---|---|
| Mechanism Name: | HIV Prevention for MARP | | |
| Prime Partner Name: | Research Triangle International | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | HVOP | 600,000 | 0 |

**Narrative:**

In FY2012, the Botswana HIV Prevention for MARP Project will continue to implement activities that adhere to PEPFAR guiding principles that are aligned to Botswana's national HIV/AIDS priorities. Activities will strengthen the quality of HIV prevention services for MARP and provide technical assistance and key resources to build the capacity of implementing partner CSOs to provide high-quality HIV/AIDS-related services. The project will incorporate Global Health Initiative (GHI) principles including a focus on women, girls, and gender equality by ensuring that FSWs and other vulnerable women have access to HIV services. It will provide STI screening and treatment, as well as other social services in respective communities. Through the provision of technical assistance and financial resources to eight local CSOs that will eventually be able to manage and monitor their programs and mobilize alternative program resources, the project will promote country ownership and investment in country-led plans. Working in close collaboration with District Multi-sectoral AIDS Committees ( DMSAC) in the five districts where activities are being implemented, will ensure that HIV prevention efforts for MARP are integrated into HIV care and treatment services, STI screening and treatment, family planning and reproductive health, and other clinical services through referrals and client follow-up. By focusing on strengthening data collection and reporting for all sub-partners and providing technical assistance in the use of data for program decision making, the project will promote learning and accountability through monitoring and evaluation.
In FY2012, the project will develop a risk reduction tool for young women engaged in cross-generational/transactional sexual relationships and train peer educators in risk reduction assessment. RTI staff will continue to participate in National Technical Working Groups for HIV prevention, multiple-concurrent partners (MCP), and voluntary male medical circumcision (VMMC). Newly developed MARP education and communication materials with targeted messages incorporating the benefits of condom use, VMMC, early STI screening, and treatment will be printed and disseminated.

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| MARP HIV prevention guides that incorporate young women's vulnerability to HIV/AIDS will be developed. Positive Health Dignity and Prevention (PHDP) activities for MARP will be implemented and a continuous assessment of the impact of BCC and peer education training will be carried out. |

## Implementing Mechanism Details

| **Mechanism ID: 7324** | **Mechanism Name: Botswana Civil Society Strengthening Program** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: FHI 360 | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 2,520,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 2,520,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The Botswana Civil Society Strengthening Program, titled Maatla, which means "strength" in Setswana, was designed to significantly and sustainably strengthen the capacity of civil society organizations (CSO) in Botswana to deliver HIV/AIDS and related health services. Implemented by FHI360, the project is strengthening the quality and reach of CSO HIV/AIDS services at a national level by strengthening management systems of four key NGO networks (Botswana Network of AIDS Service Organizations (BONASO), Botswana Network of People Living with HIV/AIDS (BONEPWA+), Botswana Council of Non-Governmental Organizations (BOCONGO) and Botswana Christian AIDS Intervention Program (BOCAIP)) and their members and affiliates. Beginning in year three, USAID will provide direct grants to two of these organizations (BONEPWA+ and BOCAIP) to continue service delivery, while Maatla continues to build their overall management capacity. In four focus districts (Ngamiland, Okavango, Ghanzi and Chobe) the Maatla program will support district-level CSO coalitions and district-level government structures to develop and implement HIV/AIDS activities that are based on evidence and

effectively engage with and mobilize communities across the district to improve service delivery for target populations.

The Maatla project will contribute towards the Global Health Initiative goals by engaging with and building the capacity of local actors to ensure country-owned programming which is sustainable beyond the life of the project. FHI360 will work intensively with BONASO and BOCONGO to transition ownership of capacity building efforts to them before the project ends in 2016.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 2,000,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
TB

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **7324** | | |
| **Mechanism Name:** | **Botswana Civil Society Strengthening Program** | | |
| **Prime Partner Name:** | **FHI 360** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |

| | | | |
|---|---|---|---|
| Care | HKID | 50,000 | 0 |

**Narrative:**

FHI 360 will collaborate with the USAID-funded OVC and Gender project being implemented by Project Concern International (PCI) and its partners to strengthen the capacity of CSOs in Botswana to deliver services targeting OVC. CSOs serving OVC are constantly challenged by the multi-dimensional needs of this population and by the complex set of interventions and services needed to improve their quality of life. The Maatla program will collaborate with PCI to enhance the capacity of CSOs to identify, reach and support particular groups of marginalized, highly vulnerable children, and to ensure implementation of national guidelines for OVC care. Maatla will contribute towards achieving the PEPFAR OVC goals by building capacity within local communities to respond to the needs of OVC.

Working in its four focus districts (Ngamiland, Okavango, Ghanzi and Chobe), FHI 360 will use the outcomes of its capacity assessments to determine the level of technical competence amongst CSOs in providing comprehensive quality care to vulnerable children and their families. FHI 360 will work with PCI to develop comprehensive capacity building plans tailored to the specific needs of CSOs implementing OVC programs which are in-line with national standards and protocols. Working at the national level with the NGO networks, and at the district level through CSO coalitions and local government structures, FHI 360 will support the dissemination and implementation of key national documents, such as the Guidelines on the Care of OVC and the Manual on Providing Psychosocial Support to OVC. Use of the newly developed PEPFAR Transition Toolkit for HIV positive Adolescents will also aid in systematizing services for this population.

The Maatla program will also collaborate with PCI to strengthen the capacity of CSOs in the targeted districts to provide quality early childhood care and education services, as established in the Early Childhood Care and Education Policy of 2001. Specific activities will include: cascading dissemination of protocols designed to guide the provision of early childhood services; strengthening the capacity of CSOs to mobilize their communities and increase awareness and demand among families; and, supporting CSOs to leverage resources to help sustain early childhood services.

The program will also work with key government and CSO stakeholders to establish the new structures stipulated in the Children's Act: the Village Child Protection Committees (VCPC), the Children's Consultative Forum, the Children's Council, and the Children's Courts. The establishment of the VCPCs will be prioritized, since they are an essential structure for improving the identification and support of OVC within their communities and for monitoring their well-being. The program will strengthen the ability of CSOs to support the VCPCs and ensure they fulfill their roles and responsibilities in accordance with the Act.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVTB | 300,000 | 0 |

**Narrative:**

FHI 360 will strengthen the capacity of CSOs in Botswana to deliver tuberculosis (TB) and HIV-related services at community level. Community-based TB services delivered through CSOs have the potential to contribute towards the goals of the MOH National TB Control Program (NTCP) Strategic Plan by improving TB diagnosis, improving treatment outcomes, and increasing access to and demand for HIV-related treatment, care and support.

FHI 360 will work in its four focus districts (Ngamiland, Okavango, Chobe and Ghanzi) with district health services and CSOs to increase community involvement in TB case finding, treatment and prevention.

FHI 360 will improve community-based direct observation of treatment (DOT) by working with local NTCP staff and leaders of CSOs to form DOT teams or strengthen them where they exist. Training will utilize tools developed by the World Health Organization (WHO) and the Botswana MOH. FHI 360 will also establish and strengthen referral networks to help community-based DOT volunteers ensure suspected TB cases reach a TB diagnostic center.

FHI 360 will support the TB Advocacy, Communication and Social Mobilization Strategy (ACSM) by enhancing the capacity of NTCP staff, local health centers and CBOs at the district level in using cross-cutting strategic behavioral communication (SBC). SBC will be used to raise awareness about the major challenges which are unique to the targeted, remote districts where the Maatla program is being implemented, and to increase TB awareness, reduce stigma, facilitate risk assessment for case detection and referral, increase treatment literacy and adherence, and foster family and community support.

In order to address the specific needs of high-risk groups, FHI 360 will build the skills of local partners to capitalize on existing entry points where TB education, detection, sputum collection and referrals can be integrated. Specific activities will include: training staff and supervisors working with OVC in targeted regions to recognize children and youth with symptoms of pulmonary or extra-pulmonary TB; clarifying or establishing local referral networks for TB diagnosis and treatment, and communicating with local HIV/ART clinics and OVC organizations; providing training or refresher training for CSO staff implementing behavior change interventions reaching out to vulnerable women, mobile men, and at-risk youth; an, supporting TB/HIV coordination teams at district level to identify TB/HIV co-infection services and possible gaps in supported health facilities.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | OHSS | 1,670,000 | 0 |

**Narrative:**

Civil society organizations (CSO) in Botswana have the potential to play an important role in the national HIV response. However, the country's civil society is small and faces multiple challenges including lack of long-term funding, lack of systems and structures, and low technical capacity. Maatla will build upon

previous capacity building efforts to ensure that the CSOs in Botswana are better able to deliver HIV/AIDS and related health services, and to ensure that capacity building continues beyond the life of the project. Project activities are aligned to the national Civil Society Capacity Building Framework that was finalized in 2011.
The Maatla team will focus national-level capacity building on four NGO networks that have mandates as leaders of the civil society response to HIV/AIDS--BONASO, BONEPWA+, BOCAIP and BOCONGO. Support will include not only training, but also long-term mentoring, coaching, twinning and secondments. BOCCIM is providing on-going support for partnerships between CSOs and the private sector for targeted mentoring in specific skill areas. WUSC has placed one volunteer Organizational Development (OD) Adviser in each organization to facilitate and coordinate OD efforts. The Maatla program will support BONASO and BOCONGO to sustain capacity building of CSOs over the long term by engaging them in the strategic management of the Maatla project, supporting them to access funding for their members and affiliates, and by gradually transitioning the capacity building implementation role from FHI 360 to the networks themselves.
The Maatla program will build upon and adapt the CSO coalition model used by NCONGO to strengthen the district HIV/AIDS and health responses. NCONGO's model includes formal capacity building for CSOs in Ngamiland and Okavango Districts, as well as joint planning and program implementation. NCONGO will implement capacity building activities at its Learning and Innovation Site in Maun (LISN) using different modalities, including training, coaching through one-on-one, or small group site visits, as well as community-based training, roundtables and CSO forums. NCONGO will collaborate with BOCCIM to support twinning and mentoring with local businesses through the BOCCIM business councils at district level, and with BOCONGO non-health sector NGOs. Capacity building of local government will be implemented by FHI 360's core partner NASTAD, and will entail in-service training for district staff, to be followed-up with one-on-one situational coaching and mentorship. NASTAD will promote and strengthen linkages between the CSO coalitions, DHMTs, DACs, and DMSACs through its interactions.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVCT | 200,000 | 0 |

**Narrative:**

HIV counseling and testing (HCT) plays an instrumental role in the Botswana NSF II 2010-2016. Two priority areas are Preventing New Infections and Scaling-Up Treatment, Care and Support. Both require accessible, high quality HCT, which cannot be delivered by the Government of Botswana (GOB) alone. The Maatla program will enhance the capacity of CSOs to: create awareness of and demand for and referral to HCT; strengthen the human resources needed to provide HCT; and, enhance the quality of HCT service delivery.

FHI 360 and its partners will collaborate with Tebelopele in four focus districts (Ngamiland, Okavango, Ghanzi and Chobe) to ensure that HCT is promoted by CSOs and is delivered to required national standards. The Maatla team will ensure district-based CSOs are competent in planning, implementing, monitoring and evaluating community mobilization activities and, as needed, serving as satellite sites for Tebelopele. The selected CSOs will be given training and on-going technical support to achieve these required standards, as well as measurable operational and programmatic targets that will contribute to reaching district-defined HCT goals.

Through the establishment of and support to district-based CSO coalitions, as well as linkages with the BONEPWA+ centers of excellence, Maatla will support the design of community education and mobilization strategies to increase HCT for specific populations. This will include infants, through greater access to early infant diagnosis (EID), adolescents, and orphans and vulnerable children (OVC).

FHI 360 and its partner NASTAD will work with the DMSACs and DACs in planning service delivery to ensure that CSO promotion and referral for HCT reaches the least covered geographic areas and most at-risk populations (MARP), including women and girls, their partners and other men. These groups are under-represented according to HCT statistics in the focus districts. FHI 360 will offer district-level referral network training to support referral networks including regular meetings, service directories, referral forms, and focal persons.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 300,000 | 0 |

**Narrative:**

Civil society organizations (CSO) play a fundamental role in HIV/AIDS prevention programming in Botswana. However, the National Strategic Framework II-- 2010-2016 (NSF II) identified a number of gaps including insufficient targeting of services, poor community engagement, limitations in the generation and use of data, and insufficient implementation capacity in communities.

Using its “prevention readiness” assessment with the four national NGO Networks, the Maatla Project is developing and implementing a targeted plan of action with each. The “prevention readiness” assessment determines the NGO’s: understanding of the drivers of HIV transmission for specific target groups; appreciation of specific entry points for combination prevention activities that are targeting specific audiences, including most-at-risk populations (MARP); and knowledge and use of evidence-based behavioral, biomedical, and structural prevention strategies, policies and priorities. The Maatla program is focusing on the national NGOs to increase use of evidence-based interventions amongst their members and affiliates, while drawing upon existing materials and resources such as the materials used in the FHI 360 “Basha Lesedi” project, the Johns Hopkins University “Go Girls!” initiative, and the RTI HIV Prevention Project for MARP.

The NSF II specifically highlights that previous prevention strategies in Botswana have overlooked the

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| prevention aspects of care and support for people living with HIV (PLWHA). The Maatla program is working with BONEPWA+, CDC and the Ministry of Health (MOH) to develop a strategic plan to roll out the Positive Health, Dignity and Prevention (PHDP) program—a comprehensive package services that includes: risk reduction, identification of discordant couples and partner disclosure, partner testing, adherence counseling, reproductive health services including STI screening, TB screening, referral for cervical cancer screening for HIV positive women as well as legal and religious referrals. With continuing management support from Maatla, USAID plans to provide direct funding to BONEPWA+ in early in FY 2013, to expand the PHDP program to several BONEPWA+ support groups in hard-to-reach areas.<br>At the district level, Maatla will work with the CSO coalitions and local government structures to ensure that all entry points for multi-sectoral prevention programming are clearly identified, and services and referrals, especially for MARP, are well defined and operational. FHI 360 will provide focused technical assistance, training, and coaching to individual CSOs based on the outcomes of the technical capacity assessments. Maatla project core partner NASTAD will build the capacity of the District Multi-Sectoral AIDS Committees (DMSAC) and District AIDS Coordinators (DAC) to lead the planning and coordination of the multi-sectoral district prevention responses through one-to-one coaching and mentoring. |

## Implementing Mechanism Details

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|---|---|
| **Mechanism ID: 9910** | **Mechanism Name: Capacity Building Assistance for Global HIV/AIDS Program Development through Technical Assistance Collaboration with NASTAD** |
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: National Alliance of State and Territorial AIDS Directors | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 500,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 500,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The objective is to: 1) strengthen the capacity of public sector staff to plan, manage, and evaluate HIV prevention, care, and treatment programs at national and local levels; 2) build organizational capacity of public sector offices to support the delivery of national and local HIV programs, and; 3) create sustainability in national and local HIV programs. National Alliance of State & Territorial AIDS Directors (NASTAD) works with Ministry of Local Government (MLG) and National AIDS Coordinating Agency (NACA) to institutionalize the Community Capacity Enhancement Program (CCEP) in line with the goals of the 2nd National Strategic Framework for HIV and AIDS (NSF II) and the Partnership Framework. The implementation of CCEP and the National Community Mobilization Strategy (NCMS) will benefit other social development areas, and is aligned to the national rural development strategy. Technical assistance to MLG will focus on two model districts, strengthen alignment with government strategies and ensure implementation of CCEP with fidelity. NASTAD will support 14 project officers for the last year and train trainers and facilitators. NASTAD will work with MLG to fully integrate the NCMS and CCEP into the district structures and strengthen monitoring and evaluation. In line with NSF II, NASTAD proposes to work with MLG to implement a training program designed to qualify District AIDS Coordinators (DACs) as “public health managers”. This program will build the capacity of the DAC office staff to provide public health leadership needed for an effective district level HIV/AIDS response.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 328,570 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

(No data provided.)

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **9910** |
| **Mechanism Name:** | **Capacity Building Assistance for Global HIV/AIDS Program** |
| **Prime Partner Name:** | **Development through Technical Assistance Collaboration with NASTAD** |
| | **National Alliance of State and Territorial AIDS Directors** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | OHSS | 500,000 | 0 |

**Narrative:**

Community participation in the HIV/AIDS response in Botswana remains weak. In response to this gap, NACA has developed the NCMS upon which the CCEP strategy will be anchored. NASTAD will continue to provide technical assistance for the implementation of CCEP, with a focus on quality assurance by supporting implementation with fidelity and ensuring that training is sustained. NASTAD will work with the Ministry of Health to include CCEP in the training of health education assistants. CCEP training will be cascaded and NCMS will be translated into district level implementation, with linkages to district plans for greater effectiveness. NASTAD and MLG will provide joint technical support, coaching and mentoring to two models sites through monthly visits.

Two skills refinement workshops for national trainers and model site review meetings will be held. During these workshops, master trainers (14) will learn to do process review and refine trainers' skills to align with NSF II's Operations Plan (NOP) and NMCS. The skills refinement workshop will review progress and ensure linkages with targets, in addition to sharpening facilitation skills. A total of 90 trainers will be trained. Based on a standard best practice selection criterion, NASTAD and MLG will facilitate assessment, selection and documentation of best practices. NASTAD will support bi-annual master trainers' and national technical working group progress meetings to review and track the performance of the program.

A District Multi-sectoral AIDS Committee (DMSAC) needs assessment conducted in 2007, as well as the country ownership exercise, identified strengthened coordination as a priority area for the response. The DAC office, the DMSAC secretariat and responsible for strategic direction and leadership and coordinating the response at district level, needs to be equipped with public health leadership competencies customized for application in the district HIV/AIDS response. This will position the DAC and the DAC's office for effective leadership and optimal use of resources whilst ensuring that response

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| activities adequately address drivers of the epidemic and weaknesses in all HIV/AIDS-related services. In this regard, NASTAD will develop the Applied Public Health Program Management Training Curriculum. The curriculum will be piloted with the participation of MLG and 10 candidates will be trained during the first year. The program will be aligned to other initiatives that focus on the DMSAC and DAC capacities, including the implementation plan for country ownership and the NOP, as well as MLG's implementation plan for the new DMSAC communication strategy. Strengthening of DMSAC capacity through better skilled DACs will have the spillover effect of improving leadership for other health initiatives, as DMSAC members are drawn from civil society organizations and district health management. |

## Implementing Mechanism Details

| **Mechanism ID: 9915** | **Mechanism Name: Capacity building assistance for global HIV/AIDS microbiological labs** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: American Society for Microbiology | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 350,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 350,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The American Society of Microbiology (ASM) is a life science society composed of over 42,000 scientists and health professionals. ASM's mission is to promote research and training in microbiological sciences and to assist communication between scientist, policy makers and the public to improve health, economic well-being, and the environment. ASM goals are to develop and package training tools using new and existing resources through a consensus approach; monitor and evaluate progress and impact in order to identify best practices; and create sustainability at national levels through quality assured programs and

working with in-country partners. ASM is funded by PEPFAR to build capacity in different countries. In Botswana, ASM has worked with Ministry of Health (MOH) laboratory employees to strengthen the microbiology network and to establish an external quality assurance (EQA) program for acid fast bacilli (AFB) microscopy. ASM mentors staff at different facilities and trains them to run the program themselves by training trainers in different microbiology disciplines. This ensures sustainability once PEPFAR funding ends. ASM has also been in the country working closely with the MOH laboratories prior to PEPFAR funding. ASM's approach to strengthening laboratory capacity includes insuring countries have ownership of the programs they develop as they are ultimately responsible for implementing them; establishing South-to-South collaborations involving sharing of evaluated, culturally appropriate, highly effective strategies and programs; and encouraging south-to-north collaborations in order to continue to strengthen the cadre of highly competent microbiologist mentors for countries.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

TB

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **9915** | | |
| **Mechanism Name:** | **Capacity building assistance for global HIV/AIDS microbiological labs** | | |
| **Prime Partner Name:** | **American Society for Microbiology** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |

| | | | |
|---|---|---|---|
| Care | HVTB | 350,000 | 0 |

**Narrative:**

In FY 2012 funding is requested for ASM to provide continued technical support to Botswana for clinical microbiology with respect to laboratory diagnostics for common opportunistic infections. ASM will also provide guidance for expansion of services of the National Health Laboratory (NHL) clinical microbiology laboratory as a national public health laboratory. ASM will continue support to the National TB Reference Laboratory for TB diagnostics and the TB external quality assurance (EQA) program. ASM's objectives are to:

1. improve human resource capacity for clinical microbiology diagnostics by (a) strengthening and expanding core functions of the NHL Microbiology Laboratory. Consultants will continue to improve surveillance of communicable diseases by providing training for detection and identification of sexually transmitted infections, diarrheal outbreaks, and respiratory outbreaks using molecular and automated methods; (b) strengthening monitoring of antibiotic resistance nationwide; (c) strengthening the Botswana clinical microbiology laboratory network; and (d) strengthening in-service and continuing medical education for microbiology by reproducing the model developed for AFB smear microscopy. 2. improve quality of laboratory services by (a) supporting the national microbiology EQA program. Consultants will continue to strengthen the bacteriology EQA program and support competency assessments of microbiology laboratory staff; (b) supporting the national AFB microscopy EQA program; and (c) designing a mycology training package for the referral laboratories in Gaborone as well as in Francistown. 3. devise networking / strengthening mechanisms for addressing communication gaps between microbiologists and the clinicians to maximize impact.

## Implementing Mechanism Details

| **Mechanism ID: 9920** | **Mechanism Name: Partnership to assist PEPFAR build quality laboratory capacity** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Association of Public Health Laboratories | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| Total Funding: 500,000 | Total Mechanism Pipeline: N/A |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 500,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Association of Public Health Laboratories (APHL) is a membership organization composed of public health laboratories. Its member organizations with approximately 5,000 professionals provide a readily available resource of training laboratories and experienced experts to assist and support others in completing diverse tasks to support HHS/CDC including strategic planning for national laboratory networks, implementing training programs, planning and managing renovation projects, implementing laboratory management information systems, and procuring equipment and supplies.

APHL goals are to advance training, recruitment, and retention of a competent workforce to meet public health laboratory needs; enhance the visibility, status and influence of the public health laboratory community through effective advocacy, partnerships, and public relations; improve the informatics and knowledge management capabilities of APHL and its members; advance the development and use of comprehensive quality systems and practices for public health laboratories at the local, state, national, and international level.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

(No data provided.)

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **9920** |
| **Mechanism Name:** | **Partnership to assist PEPFAR build quality laboratory capacity** |
| **Prime Partner Name:** | **Association of Public Health Laboratories** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | HLAB | 500,000 | 0 |

**Narrative:**

Using the APHL methodology described in the “Guidebook for Implementation of Laboratory Information Managemeny Systems (LIMS)”, APHL collaborated with BOTUSA and the MOH to develop the scope of work (SOW) and assessed selected laboratory sites to identify paper-based strengthening activities and high level functional requirements for LIMS implementation. Following that APHL assisted BOTUSA and MOH to develop and pilot LIMS to support HIV/AIDS care and treatment and the laboratory network system in Botswana. APHL will continue to provide technical assistance to the LIMS working group which has representation from CDC, MOH and other stakeholders in Botswana. In consultation with CDC and MOH, APHL will assess new sites for LIMS implementation and roll out the system to more facilities. APHL will provide technical assistance to selected sites (about ten sites) identified for phase 3 of the LIMS expansion project through meetings with key stakeholders, procurement of computer hardware and software and consultant support. Specific LIMS expansion project activities will include:
1. APHL will continue to monitor and evaluate the current LIMS implementation sites.
2. APHL will conduct in-country laboratory assessments. This will yield the following deliverables:
a. Documentation of current laboratory work and data flows.
b. Documentation of current information technology (IT) and laboratory equipment infrastructure.
c. A final report containing all documentation collected and recommendations on IT infrastructure needs to support an LIMS. This report will also contain recommendations on training needs of the laboratory as well as recommendations for on-going in-country support of the hardware and supporting software (operating system, etc).
3. APHL will convene and facilitate at least two LIMS technical working group meetings in-country to support the MOH’s LIMS expansion project. These meetings are key to success as they enable support staff from the Ministry to monitor progress of the project, make informed decisions based upon the status

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| of the expansion implementations and to plan for future activities. APHL and CDC Botswana supported the MOH to develop and implement a five-year strategic plan. As a result a quality assurance laboratory was developed through the support of PEPFAR. Funding is requested to support the laboratory to fully implement the external quality assurance program in the country by providing proficiency testing panel to all the laboratories; organize a benchmark trip to a well-established proficiency testing laboratory; and provide short term technical assistance to the quality assurance laboratory. |

## Implementing Mechanism Details

| **Mechanism ID: 9923** | **Mechanism Name: CDC Botswana Injection Safety Project** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: John Snow, Inc. | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 237,500** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 237,500 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

From March 2004 to March 2010, John Snow Inc Research & Training Institute, Inc. (JSI R&T) took the lead in implementing a centrally-funded injection safety project (the Making Medical Injections Safer, “MMIS”, Project), aimed at preventing the medical transmission of HIV and other bloodborne pathogens in healthcare settings in a number of countries, including Botswana. In April 2010 JSI R&T started a new bilateral project, the CDC Botswana Injection Safety Project (“BISP”, hereafter referred to as “the Project”), transferring the Project’s core implementation to a model of transitioning to country ownership, whereby the Ministry of Health (MOH) in the Division of Environment & Occupational Health (DEOH) will take the lead on implementing activities. The Project’s aim is to make injection safety interventions within

the MOH a critical strategy for sustaining the gains achieved over the past six years under the centrally funded approach. The primary focus for the Project during COP12 will be to decentralize, institutionalize and sustain injection safety, healthcare waste management and infection prevention and control interventions at the district level through the District Health Management Teams. The Project will assist the MOH in developing support structures, to include the National Infection Prevention and Control Policy, which will help guide the decentralization and sustainability of the Project's interventions beyond the life of the Project (currently set to end in September 2014).

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

(No data provided.)

## Budget Code Information

| **Mechanism ID:** | **9923** | | |
|---|---|---|---|
| **Mechanism Name:** | **CDC Botswana Injection Safety Project** | | |
| **Prime Partner Name:** | **John Snow, Inc.** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | HMIN | 237,500 | 0 |
| **Narrative:** | | | |
| The CDC Botswana Injection Safety Project is aimed at preventing the medical transmission of HIV and | | | |

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| bloodborne infections (e.g. hepatitis B and C) in healthcare settings in Botswana. The Project contributes to the Botswana Partnership Framework in reducing new HIV infections. Since 2011, the project is implemented by the MOH with technical support from JSI R&T. The Project has scaled-up to all 29 health districts in the country by conducting a Training of Trainers activity that will be critical in supporting the District Infection Prevention Coordinators under the district health management team in institutionalizing the Project's interventions. The district team will be supported by the Project team under the leadership of the National Injection Safety Coordinator, based at the MOH headquarters, supported by the Project. At the core of the Project's health systems strengthening approach is the development of the National Infection Prevention and Control (IPC) Policy. It is expected that the policy will guide the decentralization, institutionalization, sustainability and overall capacity building of the Project's interventions beyond the life of the bilateral five-year funding cycle. Equally important during this period will be the strengthening of institutional resources, such as: the training of Infection Prevention & Control Coordinators; continuous support of TOTs; the implementation of injection safety guidelines, service norms and standards; promoting the utilization and accessibility of post-exposure prophylaxis for HIV and hepatitis B; and the provision of hepatitis B vaccinations to healthcare workers. The project aims to train 3, 645 staff during FY 2012. The training will be conducted by district and hospital based trainers with support from MOH and JSI teams. These approaches will not only be fundamental to making safety a professional norm, but will also ensure that health services are delivered in a safe manner to the community. The project staff (EOHD and JSI R&T) will review progress towards targets every quarter and through continuous supervisory monitoring of the Project's interventions. Monitoring will be combined with technical assistance aimed at improving quality assurance and services. |

## Implementing Mechanism Details

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|---|---|
| **Mechanism ID: 9924** | **Mechanism Name: Pediatric HIV/AIDS Care and Outreach** |
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Baylor University | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| | |
|---|---|
| **Total Funding: 630,900** | **Total Mechanism Pipeline: N/A** |

| Funding Source | Funding Amount |
|---|---|
| GHP-State | 630,900 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Through the funding provided by this project, the Botswana-Baylor Children's Clinical Centre of Excellence (COE) is able to help drive the scale-up and assurance of quality pediatric and adolescent HIV care in Botswana, including increases in the number of children and adolescents accessing care and support. Training of health care providers on pediatric and adolescent treatment guidelines is a key focus of this project. The COE's activities remain important to insure universal access to comprehensive, high-quality HIV treatment services for pediatric and adolescent populations in Botswana. Refinement of direct clinical approaches; complicated case management; task-shifting; training; and dissemination of best practices to local implementers are all key components of COE's program. The TB/HIV component of the COE's activity stems from challenges facing children and adolescents with respect to access to effective diagnosis, treatment, and cure for TB. Currently only a small proportion of pediatric TB patients are diagnosed, and many health care workers lack the expertise and the experience to diagnose TB in children. The best practices developed by the COE, including its failure management clinics and Teen Club programs, are in the process of being brought to scale throughout Botswana - a key focus of the COE's ongoing efforts. As well, developing and implementing in concert with the Ministry of Health (MOH) the training of nurses in advanced HIV management is in process and is an important part of the COE's FY 2012 approach. All of the COE's programs are in the process of stepwise transition to the MOH, the National AIDS Coordinating Agency, the University of Botswana or other national entities, as appropriate and agreed between partners.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 363,100 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Child Survival Activities
Mobile Population
TB
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **9924** |
| **Mechanism Name:** | **Pediatric HIV/AIDS Care and Outreach** |
| **Prime Partner Name:** | **Baylor University** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVTB | 120,900 | 0 |

**Narrative:**

Botswana-Baylor Children's Clinical Center of Excellence (COE) will continue to improve the scope and quality of diagnosis and treatment of pediatric tuberculosis in Botswana. This will be achieved through the training of health care workers in paediatric sputum induction and paediatric TB care and treatment. This will also be achieved through the technical support by on-site mentoring of trained health care workers at pilot sites by specially trained TB nurses and auxiliaries. The COE will spearhead the expansion of sputum induction activities as well as diagnosis and treatment of pediatric TB/HIV throughout Botswana by being involved with new sites.

Access to effective diagnosis, treatment and cure for TB patients remains a challenge for the paediatric population in Botswana. Only a small proportion of paediatric TB patients are diagnosed. Many health care workers lacks the expertise and the experience to diagnose TB in children.

There is a limited budget to train health care workers in sputum induction beyond the four pilot sites in Gaborone, Serowe, Maun, and Francistown despite the need in and interest from other sites. High staff turn-over in Botswana's national health care system results in the loss of trained personnel to other departments or facilities that do not usually perform sputum induction. This creates the need to train a new cadre of health care workers time and again. There is little we can do programmatically to maintain them in their trained function due to MOH policies. Other challenges include lost, contaminated, or mislabeled sputum samples; the impact of the public service strike in 2011; and the closure of the national TB laboratory for several months while it was being renovated.

The long-term plan is for this activity to build the capacity of health care workers through on-going training and mentorship; to increase the number of microbiologically confirmed cases of TB in children; and to integrate the current activities into the Botswana National TB Program.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | 310,000 | 0 |

**Narrative:**

Botswana-Baylor objectives for FY 2012 include 1) strengthening referral and consultation services for HIV/AIDS and TB/HIV care, with careful focus on appropriate decentralization, capacity-building, linkages, adolescent services, capacity-building with local NGO partners, and strengthening of community-based care, 2) strengthening paediatric ART failure management at decentralized sites beyond Gaborone; 3) strengthening best practices development at sites beyond Gaborone; 4) developing and strengthening additional specialized mentoring and training of nurse prescribers; 5) strengthening in-service training for health care providers; 6) expanding teacher training; 7) expanding the scope of in-reach and adolescent programs and working with the MOH toward institutionalization into Botswana's national care and treatment approach; and 8) finalizing and implementing the model for adolescent transition to adult care.

The program is aiming at scaling-up and assuring the quality of pediatric and adolescent care in the country. Through this activity we anticipate an increase in the number of children and adolescents accessing care and support. Training of health care providers on pediatric and adolescent treatment guidelines will continue to take place.

Pediatric and adolescent client numbers have increased at Baylor's Center of Excellence (COE) and the outlying centers it supports through outreach. This number is increasing for those in care and support services. The outreach services have been progressing well. As the pediatric cohort graduates to the adolescent stage, Baylor is now planning to renovate an adjoining plot in Gaborone and open an

adolescent center. We are developing an algorithmic model for adolescent transition to adult care at the COE. We are also rolling-out specialized mentoring in paediatric ART failure management to decentralized MOH ART sites across Botswana. We are developing recognized care best practices, including In-reach and Teen Club; communicating these to the wider care and treatment community; and rolling-out satellite Teen Clubs across Botswana.

The main challenge for in- and pre-service training has been due to economic constraints with the MOH reducing funding for training activities during the government financial year April 2010 - April 2011. The MOH obligations cover the cost of participants' travel and imprests. However, for FY April 2011 to April 2012 the MOH has availed some funding for training and we were able to reach the FY 2011 training targets. Training was also affected by the public service strike of May-June 2011.

The long-term activity plan is to collaborate with the Government of Botswana to insure good country ownership recognizing that technical expertise and capacity building in health centers is still needed. Botswana-Baylor care activities will continue a stepwise transition to the University of Botswana, MOH, and Botswana National TB Program as appropriate.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | PDTX | 200,000 | 0 |

**Narrative:**

The objective of the treatment program is to scale up of pediatric ART services nationwide. We will continue to strengthen referral and consultation services for HIV/AIDS and TB/HIV with a focus on appropriate decentralization and capacity-building. By providing supportive on-site, mentorship we are able to strengthen paediatric HIV/AIDS and TB/HIV treatment through in-service training. We have assisted with the development of national guidelines on the care and treatment of HIV-positive adolescents and younger children. We continue to expand and strengthen the specialized mentoring for the management of paediatric ART failure at decentralized Ministry of Health sites. We were able to open several new failure mentoring sites in FY 2011. We expanded and strengthened best practices developed and proven at the COE over the years, including the USAID AIDSTAR-One-recognized Teen Club and In-reach programs. We pioneered additional specialized mentoring and training of nurse prescribers beyond that received in the standard national training course. The goal being to expand their scope and abilities because of the shortfall of skilled health care providers in Botswana who can scale-up and sustain the ART program.

The objectives for FY 2012 are to 1) improve the quality of care and life for children and adolescents living with HIV/AIDS; 2) reduce morbidity and mortality in this age group; 3) support quality service

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| delivery; 4) strengthen treatment technical policies; 5) strengthen paediatric ART failure management at decentralized sites beyond Gaborone;6) strengthen best practices development at sites beyond Gaborone; 7) develop and strengthen additional specialized mentoring and training of nurse prescribers; and 8) move services closer to the people.<br><br>Pediatric and adolescent HIV treatment has long lagged behind the adult program. Pediatric and adolescent activities are important to insure universal access to comprehensive, high-quality HIV treatment services for populations in all districts and settings in Botswana. Key components of Botswana-Baylor's program are refinement of direct clinical approaches; complicated case management; task-shifting; training; and dissemination of best practices to local implementers.<br><br>Progress to date includes outstanding clinical outcomes for treatment of HIV in children and adolescents in Botswana. The diverse training programs have met many levels of community need throughout the country. The failure clinic mentoring program has been groundbreaking; its expansion to decentralized Ministry of Health sites in Botswana continues. The adolescent program has been successfully rolled-out to decentralized sites utilizing community service organization partners. Challenges include expanding the nurse prescriber corps at COE and beyond; transitioning adolescents to adult care; and dealing with the reduction in the number of specialized providers assigned to the COE. Long-term plans are focused on continuing the stepwise transition of activities to the Government of Botswana. |

## Implementing Mechanism Details

| **Mechanism ID: 9925** | **Mechanism Name: Support of training of HIV health care providers in Botswana** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Botswana Harvard AIDS Institute | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 2,850,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| Central GHP-State | 2,786,962 |

| | |
|---|---|
| GHP-State | 63,038 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The Botswana Harvard Partnership (BHP) is developing a sustainable training capacity in clinical care and treatment of HIV; expanding CD4, viral load, and other laboratory testing; and strengthening the Ministry of Health (MOH) monitoring and evaluation (M&E) capacity for HIV. The Clinical Master Trainer (CMT) Program provides on-site training and mentoring and telephone support. These activities ensure that health professionals are up-to-date in all aspects of HIV treatment and care, improve their skills on a continuous basis, and receive technical mentoring. The CMT Program is also responsible for the introduction of new treatment guidelines for HIV-infected women in the national PMTCT program. BHP will provide training, mentoring and support to health workers in all districts in the country on these new guidelines. A new activity for CMT in FY 2012 is assisting in the national roll out of universal HAART for pregnant women. The Laboratory Master Trainer (LMT) Program was developed to support the goal of establishing decentralized laboratories capable of performing CD4, viral load, and other tests to relieve the country's two National HIV Reference Laboratories. Seven laboratory master trainers are providing training in conducting these tests, using a similar site support approach as the CMT Program. The goal is to create adequate capacity at the local level for laboratory tests. BHP supports the M&E Unit in the MOH through seconded staff. The strategic aims of the program are for the MOH to 1) support e-health and the Global Health Initiative, 2) develop and deploy country-owned, sustainable information systems, and 3) provide information to improve programs.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Safe Motherhood
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **9925** |
| **Mechanism Name:** | **Support of training of HIV health care providers in Botswana** |
| **Prime Partner Name:** | **Botswana Harvard AIDS Institute** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | HVSI | 1,120,000 | 0 |

**Narrative:**

Botswana Harvard AIDS Institute continues to strengthen the National M&E system of MOH through strategic secondment of nine PEPFAR-funded information management staff to DHAPC and 16 data entry clerks to healthcare facilities. These officers have in turn led the development of M&E within DHAPC and supported other departments within MOH. Key successes from the previous year include 1) the development and deployment of an integrated electronic patient information management system (e-registers) for ART, PMTCT, Sexual and Reproductive Health, HTC, pharmacovigilance; appointment booking; and stock management to five districts, 2) mentoring and IT support to train both facility-based health practitioners, local IT support staff, and district M&E Officers on the use and maintenance of the electronic patient information management system, 3) reporting to national and international organizations 4) progress made on the development of e-registers for nutrition and child health, and 5) demonstrated the use mobile phone messaging for appointment reminders and laboratory result notifications. MOH policy supports integration and delivery of quality information for program management, performance monitoring, and evidence-based policy-making. MOH has a strategic objective to improve information, communication, and technology by maximizing utilization of available resources and by improving information management and research. It intends to do this through implementation of e-health and integration of existing health information systems. During FY 2012, the M&E Unit with support from PEPFAR will continue leading the development of M&E tools, indicators and

reports for all programs within DHAPC and explore integration opportunities with other MOH departments such as Department of Health Policy Development Monitoring and Evaluation (DHPDME) and Department of Public Health (DPH) within MOH. The focus of these efforts has been the ARV, PMTCT, HTC, SMC and CHBC programs. Standard M&E tools are nearly final and are aligned with NACA's M&E Framework for the National Operational Plan 2011-16. PEPFAR funds will be used to further develop and expand the DHAPC data warehouse to enable ministry-wide health data to be captured and integrated. Currently, patient-level electronic data are being collected on a quarterly basis from ART facilities and BOMAID and then integrated in the DHAPC data warehouse using computer programs developed by the M&E team. PEPFAR will support the development, deployment, and support for e-registers to the remaining 24 health districts and their interface with mobile phone messaging systems; auditing and training on data quality and development of procedures and tools for data quality management; and development and coordination of a quality management program for the health sector response to HIV/AIDS. The M&E Unit will also continue transitioning from PEPFAR funded staff to Government hired employees for sustainability. Leadership, management and coordination roles are being transitioned to the M&E coordinator hired in April 2011. Skills to develop and manage the data warehouse are being transferred to a GOB employee. Data entry clerks will be absorbed by GOB.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 500,000 | 0 |

**Narrative:**

This is a new activity for the Clinical Master Trainer (CMT) program. The objective is to train health care providers on the provision of PMTCT universal HAART and guide implementation in selected districts. Activities will include a) the development of training materials in line with the new national ART treatment and PMTCT guidelines; b) printing of training manuals; c) selection of the sites for universal HAART for PMTCT; d) training of health personnel from the selected districts; e) site support, clinical mentoring, coaching, and supportive supervision for newly trained sites and the original phase one sites; f) coaching PMTCT program staff on the guidelines and supportive supervision of MOH facilities; g) training health care workers (HCW ) on use of the PMTCT registers in the electronic medical record system; and h) facilitating monthly reporting based on the reporting tool for PMTCT. This activity is in line with PEPFAR's goal to increase PMTCT coverage and effectiveness and to heighten linkages with family planning and safe infant and young child feeding practices. It also supports a primary goal of the second phase of PEPFAR which is focused on building the capacity of partner countries to respond to HIV/AIDS effectively. As recommended in the PEPFAR guidance, there is a renewed effort on the integration of programs such that efficiency and continuum of care for HIV-infected pregnant women and their infants are ensured. The project also focuses on women, which is in keeping with GHI objectives. Anticipated challenges include ensuring that HCW are adequately trained and empowered to give

appropriate counseling messages regarding infant feeding in the background of HIV. The new PMTCT guidelines allow for breastfeeding with the use of antiretroviral prophylaxis. This is a new concept for health care providers in Botswana who have traditionally recommended that HIV-infected women formula feed. Changing the mindset of these HCW will be challenging.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXS | 1,230,000 | 0 |

**Narrative:**

In FY 2011 the Clinical Master Trainer (CMT) program trained 672 health care workers (HCW) on anti-retroviral therapy (ART) and palliative care service delivery. These included 41 HCW in AIDS clinical care fundamentals, 230 HCW in introduction to AIDS care, 258 HCW in ARV prescribing for nurses, 113 HCW in ARV dispensing for nurses, and 30 HCW in pharmaco-vigilance. CMT supported and mentored 32 hospitals and >120 ART clinic sites. The ART nurse training curriculum was completed. CMT fielded an average of 600 calls for telephone support per quarter. The Laboratory Master Trainers (LMT) added two additional labs for CD4 counts and seven labs for viral load bringing CD4 labs to 23 and viral load labs to 17. CMT trained 41 laboratory technicians on the current laboratory manual (three were trained centrally and 38 were trained on-site) and ten laboratory technicians were trained on TB microscopy. One lab assessment was done for upgrading. The External Quality Assurance (EQA) program continues and the lab training curriculum has been completed. All 23 CD4 and 17 viral load laboratories are being supported. The CMT will continue to 1) train nurse dispensers and prescribers; 2) train health care providers on implementation of quality assurance activities at ART sites; 3) provide continuing medical education at the district level and telephone support; and 4) continue development of training materials for the roll out of the universal PMTCT HAART program and failure management. The LMT will continue to 1) provide support for CD4, viral load, hematology, chemistry , and microbiology; 2) train on Laboratory Information System issues related to data management, reagent logistics, and quality assurance; and 3) support External Quality Assurance (EQA) activities. Challenges in FY 2011 included the track 1 transition for BHP which included funding and restructuring issues and the government-wide strike which affected training plans.

## Implementing Mechanism Details

| Mechanism ID: 9962 | Mechanism Name: U2G/PS001309 -- Pre service training |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Johns Hopkins University Bloomberg School of Public Health | |

| | |
|---|---|
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 685,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 685,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The goal of this pre-service education project is to ensure that the health training institutes (HTIs) develop the capacity to produce healthcare professionals who graduate with the knowledge, and skills, they need to provide quality HIV services upon deployment, and that students, faculty, and staff of the HTIs, are supported by a comprehensive workplace wellness program that promotes the health and wellbeing of this critical workforce. The project develops capacity among faculty and clinical preceptors to enable them to integrate HIV/AIDS into their courses and practical instruction. The objectives of the pre-service education project are to strengthen the role of HIV/AIDS Training Coordinator at the Ministry of Health (MOH), to improve pre-clinical education in HIV/AIDS, to build bridges between pre-clinical education and clinical practice, to promote task shifting, and to keep the health workforce healthy, as well as to collaborate with the Nursing and Midwifery Council of Botswana in developing licensure examinations. The project will be implemented in the eight health training institutions. The target population for the project will be faculty and preceptors for all the programs in the HTIs and the institution management. The project is building a cadre of master trainers in each institution thereby creating sustainability. Monitoring and evaluation of the project activities is being implemented in collaboration with the MOH.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 685,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Workplace Programs

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **9962** | | |
| **Mechanism Name:** | **U2G/PS001309 -- Pre service training** | | |
| **Prime Partner Name:** | **Johns Hopkins University Bloomberg School of Public Health** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Governance and Systems | OHSS | 685,000 | 0 |

**Narrative:**

The health training institutions in Botswana do not have sufficient capacity to produce health workers who graduate with knowledge, skills and confidence they need to provide quality HIV/AIDS services upon deployment. In addition, HTIs are challenged with shortages of trained faculty equipped with good teaching skills and the ability to incorporate HIV/AIDS content into their lessons. Jhpiego will address these challenges by continuing activities begun in 2008. During COP 12:

Objective 1: To strengthen the role of the HIV/AIDS Training Coordinator at the MOH
The MOH HIV/AIDS Training Coordinator will be assisted to independently facilitate the three core courses: Effective Teaching Skills, Preceptor Skills Development and Student Performance Assessment.

Objective 2: To improve pre-clinical education in HIV/AIDS in the eight HTIs
Jhpiego will observe and provide support to master trainers as they train in the three core courses and the Multimedia for Learning workshops. Jhpiego will introduce two training activities, effective leadership and management, and instructional design faculty, and develop orientation program for

faculty. In collaboration with MOH, Jhpiego will implement an e-learning program for faculty of the HTIs.

Objective 3: To build bridges between pre-clinical education and clinical practice
Clinical updates in TB and HIV knowledge, skills and practice will continue to be provided to faculty and preceptors at each HTI. Jhpiego will introduce a new training activity in simulation training, and develop a mentorship program for preceptors. The national working and technical working groups will have their annual meetings. Jhpiego, in collaboration with the MOH, will pilot test and develop an implementation plan to fully implement the preceptorship program. Jhpiego will facilitate formation of journal clubs in the institutions.

Objective 4: To promote task shifting
Jhpiego will continue discussions with the MOH regarding task shifting and implement identified activities. Recommendations on task shifting from the clinical and education leaders will be discussed with MOH leaders.

Objective 5: To keep the health workforce healthy
Jhpiego, in collaboration with MOH, will pilot test a wellness program for students in selected institutions and develop a plan to implement the wellness program for students of the HTI's.

Objective 6: Support to the Nursing and Midwifery Council of Botswana (NMCB)
Jhpiego, in collaboration with MOH, will pilot test licensure examinations for nurses, which were developed during COP 11. Structure, policy and procedures needed to develop and administer the examinations will be developed.

These activities will serve to produce a more skilled workforce in HIV/AIDS better able to address HIV prevention, care, treatment and support services in the communities in which they work.

## Implementing Mechanism Details

| **Mechanism ID: 10303** | **Mechanism Name: Peer Mothers** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Pathfinder International | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |

| | |
|---|---|
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 600,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 600,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Botswana Council of Churches | | |

## Overview Narrative

Pathfinder International works together with Botswana Ministry of Health and local NGOs to provide education and psychosocial support to pregnant women and mothers living with HIV, to prevent mother to child transmission of HIV (PMTCT) and promote maternal health and child survival.
While pregnant HIV positive women in Botswana have the advantage of greater access to PMTCT services than their counterparts in other African countries, many of their other needs remain unmet. Psychosocial support and counseling services are still lacking in many instances. Clinical staff is overburdened and unable to offer the necessary support, and family members who could be taking over this important role tend to hold traditional and cultural beliefs that contradict PMTCT practices. To prevent overall HIV transmission and improve maternal and child health gender norms, attitudes and behaviors must change. In FY 2012 Pathfinder will develop and implement innovative approaches to improve project efficiency in Francistown, Serowe, Palapye, Boteti and Chobe districts. The funding will also be used to build local and organizational capacity of Botswana Council of Churches (the current implementing local NGO) to expand and strengthen delivery of strategic, sustainable, integrated, evidence based, and high quality PMTCT services at the community level. In order to promote sustainability, Pathfinder will work to build their capacity and skills to fundraise, build private sector partnerships, and identify viable income generating activities. In addition Pathfinder will advocate for the integration of the peer mothers program into existing maternal, neonatal, and child health (MNCH) services in all public health facilities.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 600,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Safe Motherhood
Family Planning

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **10303** | | |
| **Mechanism Name:** | **Peer Mothers** | | |
| **Prime Partner Name:** | **Pathfinder International** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | MTCT | 600,000 | 0 |

**Narrative:**

The successes of the Botswana PMTCT program in preventing transmission of HIV from mother to child are well known. However, along with CDC/Botswana, Pathfinder has identified gaps that currently exist within the PMTCT program that negate some of these successes. As such, while the PMTCT activities will be a continuation of those that have been implemented since September 2009, during FY 2012 the focus will shift to focus more on increasing access to postnatal care and family planning, reducing serocoversion among pregnant women initially testing negative and ensuring HIV free survival of infants by promoting safe infant feeding practices, early infant diagnosis and treatment. Additional emphasis will be placed on ensuring that HIV positive mothers access CD4 count testing , that HIV exposed infants access PCR testing and linkage to care in a timely manner, and that male partners of pregnant women are reached through education and prevention counseling. It is believed that this shift will largely

contribute towards better maternal, paternal, and child health outcomes
During FY 2012, program strategies will include peer counseling, clinic talks, support groups, and outreach activities including home visits. Daily activities for trained Peer Mothers will include identification of PMTCT clients accessing antenatal services, and registering them into the peer mother model. Registration process involves conducting risk assessment profiling and identifying client's gaps in information, behaviors and skills. The identified issues are then used to jointly come up with a plan that will guide service provision. Service is provided in the facility and/or home setting depending on the client's preference. The aim is to reach a minimum package of care which includes counseling and education on 80% of the planned sessions. Those reached with minimum package will continue to access services through support group meetings. Existing materials are used to re enforce messages and these materials will be reviewed regularly to ensure appropriateness.
During the implementation process, Pathfinder's performance monitoring system that provides standardized tools to assess progress against work plan targets will be strengthened through quarterly reviews. Pathfinder will also build local and organisational capacity of Botswana Council of Churches to expand and strengthen delivery of strategic, sustainable, integrated, evidence based and high quality PMTCT services at community level. The long term plan is for the program to be eventually absorbed by the Government of Botswana. This year, a new evaluation and mentoring partnership with the Mothers to Mothers (M2M) program of South Africa will be initiated. Along with M2M, Pathfinder will develop a program enhancement plan to improve efficiencies and impact. By the end of the COAG, an exit strategy will be developed which aligns this community program to existing health systems. Such programs will include maternal and child health programs, sexual reproductive health, and others, In this way BCC and its local structures will play their role as per their mandate under the guidance, support and coordination of the Ministry of Health which is in line with the national strategic plan and country ownership.

## Implementing Mechanism Details

| **Mechanism ID: 10312** | **Mechanism Name: Behavior Change Information and Communication for Safe Male Circumcision** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Population Services International | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |

| | |
|---|---|
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 1,200,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 1,200,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Population Services International (PSI) is a key partner to the Ministry of Health in delivering evidence-based Behavior Change Communication for HIV prevention. The goal of this project is to contribute to efforts to prevent new HIV infections in Botswana through safe male circumcision (SMC). The specific purpose of this project is to increase SMC prevalence while avoiding risk compensation among circumcised men by improving and strengthening the delivery of the behavior change communications component of Botswana's national SMC Strategy, as led by the Ministry of Health (MOH). To contribute to this goal and purpose, this project will work towards achieving the following objectives:

1. Increase the level of accurate knowledge of the benefits and limitations of SMC,
2. Increase motivation of the target population to request SMC,
3. Establish SMC as a cultural norm

The focus for FY 2012 is on five high volume SMC dedicated sites hosted by PEPFAR implementing partners. Other MOH sites will be supported based on service availability. This will be implemented alongside the MOH through helping district management teams (DHMTs) plan for demand creation activities and will use local community based organizations (CBOs) and theatre groups for group discussions following messaging. In an effort to improve program and implementation efficiencies and achieve cost effectiveness, PSI Botswana will highlight SMC role within a wider integrated HIV prevention strategy and will leverage additional resources from the private sector. PSI Botswana will target in-school and out-of school youth, older men, and their families throughout the implementation of the program. Process and outcome evaluations will be conducted to measure campaign reach and linkages to prevention services.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 120,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Workplace Programs

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10312** |
| **Mechanism Name:** | **Behavior Change Information and Communication for Safe Male Circumcision** |
| **Prime Partner Name:** | **Population Services International** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | CIRC | 1,200,000 | 0 |

**Narrative:**

BBotswana will focus its efforts on demand creation through interpersonal communications (IPC) and mid-media community mobilization activities (Jam sessions, edutainment events through theatre, music and dance, road shows and school events) with particular emphasis on the following areas:
Targeted Activities:
- 13-19 year old men: This group has the lowest HIV prevalence and may not yet be sexually active. These adolescents are impressionable and most are still in school. School campaigns will be implemented for this group. They will also be reached through edutainment activities at public places during school breaks.
- 20-39 year old men: This group is sexually active. They make individual decisions about their sexual

lives and some are married. They will be targeted at workplaces where PSI will collaborate with Wellness Coordinators in places of employment to educate employees on the importance of SMC and direct them to both public and private sector service centers.
Small group sessions will be conducted for mobile populations such as construction workers and uniformed forces such as police and prisons officers at their work places.
Collaboration with and support to MOH and DHMTs:
- PSI Botswana will support district health teams (DHMT) in nine PEPFAR-supported high volume SMC sites, as well as other priority districts to help DHMTs plan for upcoming and future demand creation activities.
- PSI Botswana will support the MOH in the development and implementation of detailed work plans for demand creation activities.
- PSI Botswana will reinforce SMC orientation to community-based organizations (CBO) and theatre groups in targeted districts to incorporate SMC in their community outreach activities.
- PSI Botswana will support MOH to develop Information, Education, and Communication materials for use in SMC demand creation activities.
SMC Referral System:
PSI Botswana will work with MOH and other partners, i.e. Jhpiego and I-TECH to develop a comprehensive referral mechanism which will ensure that:
- PSI Botswana mobilized clients are tested on-site during demand creation activities prior to referral for SMC.
- Service providers are involved in the planned referral system using referral cards and client registries to track the client from mobilization to service provision.

## Implementing Mechanism Details

| **Mechanism ID: 10313** | **Mechanism Name: Technical assistance for training health care providers - University Pennsylvania** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: University of Pennsylvania | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| Total Funding: 2,511,350 | Total Mechanism Pipeline: N/A |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 2,511,350 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The Botswana-University of Pennsylvania (BUP) aims to build capacity throughout Botswana in response to the HIV/AIDS epidemic. BUP trains health care providers in prevention and treatment of HIV/AIDS and its complications and supports development of post-graduate training programs at the University of Botswana (UB).

BUP has developed educational programs and consultative services to compliment clinical care and build capacity of Botswana health care providers, focusing on complicated aspects of HIV management and related medical conditions including multi drug-resistant TB (MDR-TB), the “See and Treat” approach to cervical cancer prevention, and enhanced diagnosis of pediatric TB. Formal didactic training and direct clinical teaching and mentoring target physicians and nurses at 23 health facilities in 11 districts in both inpatient and outpatient settings.

Strong partnerships with the MOH and UB School of Medicine (SOM) to build capacity, share consultative expertise in HIV and co-infection management, and support informatics infrastructure and integration will encourage future sustainability and country ownership. BUP’s engagement with UB SOM provides teaching and mentoring to pediatric, internal medicine, and family medicine residents as well as medical students. In coming years BUP will intensify support to MOH and UB SOM to develop and integrate telemedicine and informatics in programs and infrastructure, extending service coverage, knowledge access, and service provision.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 2,316,183 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Child Survival Activities

TB

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **10313** |
| **Mechanism Name:** | **Technical assistance for training health care providers - University Pennsylvania** |
| **Prime Partner Name:** | **University of Pennsylvania** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | 1,111,350 | 0 |

**Narrative:**

Botswana-University of Pennsylvania (BUP) aims to increase the quality of care received by HIV-infected adults by providing outreach to the southern districts, collaborating with the University of Botswana School of Medicine (UBSOM), and developing adult inpatient care guidelines. BUP provides continuing medical education and specialist services to eight hospitals on a monthly basis. Our program provides training and support to the districts, improving care while decreasing the need for referrals. In future, outreach services will transition to the Department of Medicine at Princess Marina Hospital with provision by MOH specialists. BUP provides 40% of the staffing for the Department of Medicine (DOM) for training of residents and medical students. Through our collaborations with the DOM we continue to support training of future Batswana specialists, some of whom may join the faculty. In collaboration with our partners, we will draft six national guidelines and begin training and implementation for all. Pilot implementation will first occur in FY 2012 at three hospitals. The adult inpatient guideline steering committee is currently reviewing the first three drafts; another three drafts are in development. An outcomes evaluation will examine the impact of one guideline on improved practice and health outcomes. The pilot “See and Treat” (SAT) program aims to improve the health of HIV+ women. It provides cervical

care to HIV+ women through screening for and treatment of pre-cervical cancer lesions in Gaborone. BUP established the program at a community clinic in Gaborone with colposcopy and loop electrosurgical excision procedure (LEEP) occurring at the nearby Princess Marina Hospital (PMH). Strong linkages exist between the SAT clinic and other service providers including the sexually transmitted infection clinic, infectious disease care centers, and PMH gynecology clinic. Our referral clinic also provides treatment to patients referred for management of abnormal Pap smears. The program will extend services to Francistown to cater for the northern part of the country by training an additional medical officer in colposcopy and LEEP. The program will continue providing expert advice to the National Cervical Cancer Prevention Committee, National HIV Specialist Committee, and others as requested. We will build capacity of health care workers to provide quality care and treatment services for cervical cancer prevention. We will strengthen women's health pre- and in-service training programs for health care workers and continue to deliver lectures on cervical cancer prevention to various organizations including the HIV society, UBSOM, and others. A weekly quality assurance meeting led by a specialist gynecologist reviews all pictures taken by nurses at the SAT clinic. After March 2012, a program evaluation will consider the numbers screened and treated in the program's first three years and estimate impact on disease prevention.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVTB | 950,000 | 0 |

**Narrative:**

Botswana-University of Pennsylvania (BUP) TB/HIV Program improves the prevention, diagnosis, and treatment of adult and pediatric patients with TB/HIV and drug resistant (DR)-TB through clinical, teaching and technical support to the Ministry of Health (MOH), Botswana National TB Program (BNTP), and University of Botswana School of Medicine (UBSOM). The objectives for FY 2012 are to 1) strengthen clinical care of all TB/HIV and DR-TB patients; 2) optimize referral systems and provide consultative and outreach services to medical care providers of TB/HIV and DR-TB patients; 3) enhance pediatric TB diagnosis by training nurses nationwide to do gastric aspirates; 4) prevent new TB cases through isoniazid preventive therapy (IPT) in children and tracing of all case contacts; 5) provide TB/HIV and DR-TB clinical training and mentoring for clinicians and UBSOM students and residents; 6) enhance UBSOM's clinical education capacity through curriculum and guideline development and use of novel education tools; and 7) provide TB/HIV and DR-TB technical assistance to MOH.

Despite Botswana's HIV successes, several key challenges remain such as TB/HIV co-infection, increasing DR-TB, pediatric TB, and the health system's capacity to respond to an evolving HIV epidemic. Princess Marina and Nyangabgwe Referral Hospitals' (PMH and NRH) TB/HIV clinics provide referral care for complicated TB/HIV, including a majority of DR-TB cases. The PMH clinic serves as a

teaching site for DR-TB clinicians and UB trainees. MOH staffs five DR-TB centers in Botswana with regular outreach support from BUP specialists. Nationwide outreach visits include significant support to UB Department of Family Medicine (DFM) in Maun and Mahalapye. BUP teaches an advanced TB/HIV curriculum to doctors, nurses, and UB students. Two BUP specialists teach on the UB inpatient medical teaching service at PMH. BUP created a TB/HIV elective for UB students. In 2011, BUP specialists provided technical support to revision of the National TB Manual, National TB/HIV Policy Guideline, TB Infection Control Guidelines, DR-TB Management Guidelines, and Integrated Management of Childhood Illness. We continue to assist with development of the Global Fund Application, BNTP Strategic Plan, National HIV Guidelines revision, MOH's Pediatric Technical Working Group, and IPT Taskforce. BUP has supported TB contact tracing established in Gaborone and trained community volunteers.

Future plans are to continue direct TB/HIV clinical mentoring to doctors selected by MOH to staff DR-TB centers; assist MOH to develop a sixth DR-TB center; improve patient referral and consultation between outreach sites and PMH TB/HIV clinic; begin a weekly family TB/HIV clinic at PMH for adult and pediatric referrals and UB trainee teaching; continue UB adult inpatient medical teaching and begin for pediatrics; continue clinical mentoring for UB trainees at PMH TB/HIV clinic and transfer clinic leadership to UB; increase support to UB DFM through outreach visits and guideline development; assist UB to optimize general pediatric in- and out-patient curricula for trainees; expand enhanced pediatric TB diagnosis to three new districts and support existing sites using scaled withdrawal; expand TB contact tracing through community training; and continue TB/HIV and DR-TB technical support as requested by MOH.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | HVSI | 450,000 | 0 |

**Narrative:**

The Health Informatics Program of the Botswana- University of Pennsylvania (BUP) focuses on supporting the Ministry of Health's (MOH) strategies related to optimizing health information systems (HIS); improving and integrating telemedicine and disease surveillance initiatives including those enhancing HIV/AIDS interventions to expand the reach of specialty care in Botswana; and collaborating with the University of Botswana (UB) and other local stakeholders to build awareness and capacity for health informatics nationwide.

The objectives for FY 2012 are to 1) expand and upgrade existing mobile telemedicine initiatives in collaboration with MOH in order to increase specialist access in underserved areas and provide training and technical assistance to local clinicians in order to effectively utilize these systems; 2) host, with local partners, a national health informatics conference in early 2012 and continue to foster collaboration and

training of local partners from the conference through smaller working group meetings; 3) collaborate on development of an information systems blueprint for HIS within the MOH; and 4) work closely with UB School of Medicine (SOM) to integrate health informatics into their curriculum, as well as create opportunities for faculty development.

Mobile telemedicine has proven to be an inexpensive and effective method to expand specialist care and disease surveillance in underserved areas. The 2012 national informatics conference will highlight the importance of health informatics and create a forum for all local stakeholders in Botswana to meet and explore opportunities for collaboration. Health Programme Development, Monitoring, and Evaluation (HPDME) is a new department in the MOH which is tasked with formulating an information systems blueprint for HIS within the MOH.

Since 2008, BUP has conducted research and implemented several types of mobile phone health initiatives in numerous clinics throughout Botswana. BUP is part of the technical working group within the MoH and has worked with HPDME since October of 2010. HPDME has expressed interest in advisory support from health informatics specialists at BUP. BUP completed and delivered an introductory health informatics workshop curriculum to 76 medical students at UB SOM, in collaboration with a UB SOM faculty member and a few guest speakers from the MOH.

The long-term plan is for BUP to integrate the mobile telemedicine system, including key staff, into the MOH in the coming years. BUP will also support a public-private partnership between two key partners in Orange Botswana (a mobile phone provider) and the MOH. BUP will continue to facilitate local collaboration and capacity building. Since HPDME is a new department and contains skill gaps related to health informatics, BUP will share its health informatics specialties and train members of the group upon request. BUP will work to integrate informatics into curriculum and empower the faculty to manage those components on their own in coming years through programs in faculty development.

## Implementing Mechanism Details

| **Mechanism ID: 10315** | **Mechanism Name: International AIDS Education & Training Centers TA - Twinning** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration | Procurement Type: Cooperative Agreement |
| Prime Partner Name: American International Health Alliance Twinning Center | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |

| | |
|---|---|
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 150,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 150,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

American International Health Alliance (AIHA) provides coordination of the partnership between the Institute of Health Sciences (IHS) and African Palliative Care Association (APCA), whose overall goal is to strengthen the capacity of health training institutions to provide quality palliative care education and training for healthcare workers in Botswana in order to improve care for patients in end-of-life stages due to HIV/AIDS or other illnesses.

This palliative care partnership will contribute to the Partnership Framework initiative to increase access to quality end-of-life care for terminal AIDS patients, as well as PEPFAR's goal of providing technical assistance to the Government of Botswana in the formulation of palliative care policy.

The target population of this program is allied health students and faculty at IHS locations in Gaborone, Ramotswa, Kanye, Molepolole, Serowe, Francistown, and Lobatse. The development of this curriculum is expected to end in two to three years by which time training of lecturers and implementation will be completed and activities carried forward by IHS itself. The Ministry of Health (MOH) Palliative Care unit is also involved in these activities, and it is expected that MOH will continue their support even after PEPFAR funding has ended.

An evaluation of the program will take place during this fiscal year. IHS faculty will receive training from APCA in Monitoring and Evaluation processes, and students will be evaluated on quality of care services provided and knowledge of palliative care principles. The evaluation will measure the progress and effectiveness of palliative care integration and implementation in the various IHS campuses.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Impact/End-of-Program Evaluation

## Budget Code Information

| Mechanism ID: | 10315 | | |
|---|---|---|---|
| Mechanism Name: | International AIDS Education & Training Centers TA - Twinning | | |
| Prime Partner Name: | American International Health Alliance Twinning Center | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HBHC | 150,000 | 0 |

**Narrative:**

This partnership supports the integration and scale up of palliative care curriculum in the Institute of Health Sciences (HIS) pre-service training programs in general nursing, family nursing, dentistry, and pharmacy. The palliative care curriculum has been integrated into four IHS campus locations. The final three locations will be integrated in FY 2012.

Though most of the partnership activities are directed towards curriculum improvement and faculty development, direct service provision takes place by means of a one-week rotation through cooperating hospices. Students get hands-on learning experiences around pain control, spiritual, and psychosocial end-of-life care.

AIHA will work with IHS to enhance the palliative care learning resources at IHS Gaborone and other campuses. This includes support for books, journals, and medical databases regarding palliative care, as well as support for internet capabilities so that students are more effectively able to conduct online

| |
|---|
| research.<br>AIHA and APCA (African Palliative Care Association) will provide financial and technical support for a palliative care association to be developed in conjunction with the Ministry of Health Palliative Care unit. The association will be a sustainable body to carry forward palliative care advocacy and education throughout Botswana.<br>Two faculty members will participate in a masters-level distance-learning course in palliative care in order to obtain the high-level knowledge and expertise needed to contribute to policy development and continued curriculum inputs. Through these measures, it is hoped that palliative care programming will be sustainably institutionalized at IHS and that inputs and advocacy for palliative care will also take place at a national level.<br>A program evaluation will be implemented to monitor the quality of students' skills and knowledge in the area of palliative care. A graduate-level student intern will be employed to assist with program evaluation data collection and research activities. |

## Implementing Mechanism Details

| **Mechanism ID: 10485** | **Mechanism Name: PEPFAR lab training project** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: American Society of Clinical Pathology | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 256,188** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 256,188 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

PEPFAR supports health systems strengthening to improve efficiency and to promote evidence-based approaches. The laboratory program is working towards strengthening a sustainable and integrated

laboratory network. This is in line with the Botswana's Medical Laboratory Strategic Plan. A Global Healthcare Public Foundation (AGHPF) is the implementing organization for the laboratory program through the American Society for Clinical Pathology (ASCP). AGHPF is supporting laboratories in Botswana in setting standards and building capacity for laboratory accreditation. An accreditation system necessitates establishment of a quality management system (QMS) based on the 12 quality systems essentials. This will ensure accurate, reliable, timely laboratory results; effective diagnosis of diseases; rational use of drugs; control of diseases of public health importance; and safe laboratories to work in. Currently laboratory infrastructure and quality assurance are weak with many laboratories operating unmaintained equipment, uncontrolled reagents, and inadequate staff. The goal is to provide technical assistance toward accreditation of laboratories. The objectives are to 1) document QMS as per ISO 15189 (standard for medical laboratories); 2) conduct assessment and implementation of laboratory QMS; and 3) train and mentor towards quality manual and QMS development. Currently AGHPF works with five laboratories. AGHPF is working closely with already accredited laboratories in country to provide acquired accreditation skill and training. AGHPF will work with the quality assurance unit in country and build capacity to become a key mentoring partner. AGHPF will provide quarterly reports to CDC as well as conduct audits of the laboratories twice a year.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Malaria (PMI)

TB

## Budget Code Information

| Mechanism ID: | 10485 | | |
|---|---|---|---|
| Mechanism Name: | PEPFAR lab training project | | |
| Prime Partner Name: | American Society of Clinical Pathology | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Governance and Systems | HLAB | 256,188 | 0 |

**Narrative:**

In FY 2012 AGHPF will focus on four main objectives:
1. Document Quality Management System (QMS) as per ISO 15189 (standard for medical laboratories) through conducting site visits and evaluations of two laboratories - National Health Laboratory (NHL) and Princess Marina Hospital Laboratory (PMH). Identify deviations and non-conformities, prepare work plan and timeline, facilitate the review and completion of QMS manuals per ISO 15180, provide on-site training and mentoring, and provide status reports to CDC Botswana and ASCP on NHL and PMH.
2. Conduct assessment and implementation of laboratory Quality Management System as per ISO 15189.
Conduct site visits at two laboratories - Nyangabgwe Reference Hospital Laboratory (NRHL) and National TB Reference Laboratory (NTRL). Consultants will prepare work plans and timelines for the two laboratories and provide assistance for implementation of South African National Accreditation System (SANAS) audit and corrective actions.
3. Train and mentor towards quality manual and Quality Management System development as per ISO 15189. Conduct site visits to PMH and NRHL. In FY 2012 AGHPF will provide workshop and mentoring for quality officers and assist with correcting nonconformities for all labs. The two laboratories, namely NRHL and PMH, will be prepared and presented for pre-assessment by SANAS.
4. Support SANAS assement fees for the two laboratories (PMH and NRHL).

## Implementing Mechanism Details

| **Mechanism ID: 11063** | **Mechanism Name: Prevention OP,CIRC and HVCT** |
|---|---|
| Funding Agency: U.S. Department of Defense | Procurement Type: Grant |
| Prime Partner Name: Population Services International | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |

| | |
|---|---|
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 900,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 900,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Goal is to develop an HIV/AIDS prevention program for the Botswana Defense Force (BDF) aimed at contributing in reducing incidence of HIV/AIDS and the prevalence of other sexually diseases amongst members of the BDF and to mitigate the impact of HIV/AIDS on the BDF community through : 1. Support Project Concern International (PCI) to provide quality trainings to the BDF Peer Educators in integrated prevention education and integrated behavior change communication through assistance with the development of a training curriculum and training tools and manuals 2. Support through the annual Voluntary Counseling and Testing Campaign to increase uptake of HIV Counseling and Testing (HCT) 3. Support to the Expansion of Safe Male Circumcision (SMC) and, 4. Procurement and educational promotion of camouflage condoms 5. Support to all Communication activities through the emphasis of an integrated prevention intervention package and messaging. Population Services International (PSI) Botswana will work with BDF in SSKB, Village Garrison, Glen Valley, Thebephatswa, Eastern Military Garrison (Selibi-Phikwe), the two military garrisons in Francistown, and the Maun base camp.PSI Botswana will work through an integrated prevention strategy (SMC, HCT , Condoms and MCP) to maximize resources and build efficiencies within its implementation activities. Approaches from PSI's TRaC research tool will be integrated into prevalence and behavioral research within BDF to provide insights into underlying determinants of behavior that will be targeted by the project and PSI Botswana will monitor trends. Input indicators will track if preconditions for programmatic activities are underway as planned, whilst output indicators will provide a measure of impact.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 150 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Military Population
Mobile Population
Workplace Programs

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **11063** | | |
| **Mechanism Name:** | **Prevention OP,CIRC and HVCT** | | |
| **Prime Partner Name:** | **Population Services International** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | CIRC | 150,000 | 0 |

**Narrative:**

Support to the expansion of Safe Male Circumcision in the BDF
Safe Male Circumcision (SMC) has recently been recognized as an important addition to the HIV/AIDS response, as it reduces a man's risk of getting infected by 60%. No other once-off intervention has been demonstrated to be nearly as effective as SMC. In light of this evidence, the Government of Botswana has adopted a national SMC strategy, which aims to circumcise 80% of HIV-negative men within five years (from a baseline of fewer than 20%). PSI is currently working in collaboration with Ministry of Health as its preferred partner to develop a national communications campaign on SMC.
SMC is an ideal addition to the integrated HIV prevention response in the BDF for several reasons. The objective of the SMC program is twofold: a) to promote a proven HIV prevention intervention and; b) to disseminate information that is critical in ensuring that the intervention has its desired effect in particular,

to ensure that men understand they need to wait for 6 weeks after being circumcised before resuming sexual activity in order for the wound to heal, and to ensure that men who have been circumcised continue to practice safe sexual behaviors.
Messages on SMC will be integrated into the supportive media (including posters integrating HCT and SMC messages), billboards, as well as radio and TV. A variety of supportive IEC materials will also be produced and disseminated. SMC communication will be integrated in the HCT Sekwata campaign that will be implemented twice during this period. PSI is currently conducting a national mass media campaign on SMC for the Ministry of Health, and will align BDF's SMC campaign with the National campaign for consistency of messaging.
In addition, PSI will assist the BDF with procurement of minor equipment, such as examination couches and screens, and with the recruitment of nurses and counselors on an as needed basis.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVCT | 450,000 | 0 |

**Narrative:**

1. Support to the Sekwata Voluntary Counseling and Testing Campaign
Voluntary Counseling and Testing (VCT) is a particularly important part of the HIV/AIDS response within the BDF, and ensuring that soldiers know their HIV status is critical. The objective of the overall campaign is to ensure that at least 6,000 soldiers are tested annually (PSI will not be directly providing HCT services).
For this reason, the BDF has held an annual campaign to promote VCT, called Sekwata since the inception of the project. During this period there will be two Sekwata campaigns. The main focus of these campaigns will be VCT; however Safe Male Circumcision will be integrated as a component of the Sekwata campaign.
PSI's role in supporting the campaign is to utilize its expertise in behavior change communication to design, develop and implement a VCT campaign that is both engaging and informative. This will involve the development of mobile billboards and posters to promote and integrate HIV prevention messages, as well as takeaway items such as leaflets and flyers that will encourage participation in BDF's HIV prevention activities.
2. Supportive communications activities
Through the peer education activities and campaigns described above, the contact that a typical soldier is likely to have with the HIV prevention messages will be periodic (during Sekwata campaigns or a visit to a medical facility) rather than frequent. For behavior change to occur, it is important to complement these activities with communications messages that the soldiers will be exposed to more regularly.
The primary way to do this is to take advantage of the fact that soldiers are spending a considerable portion of their lives on BDF camps, therefore HIV prevention messages will be placed around the

camps.
The following approaches will be used to disseminate messages around camps:
• Billboards: 12 mobile billboard trolley banners will be developed and utilized during each campaign activity. Messages developed around key thematic areas will be produced and flighted three times a year. These will be to maintain interest in the campaigns as well as maintain message visibility around the 10 camps nationwide.
• Takeaway Items: PSI will produce takeaway materials and print materials in a variety of formats, including items such as; wrist bands, t shirts, brochures, and other easy-to-carry items that allow soldiers to absorb information in an unhurried, private setting.
When a campaign is underway, all of these channels will be focused on promoting the campaign messages. The mobile billboards will be displaying HIV and AIDS prevention messages and the takeaway items will relate to VCT, SMC and condoms. At the moment, campaign messaging has been focused particularly on VCT; however, as discussions have been held to add SMC and condom campaigns to the Sekwata umbrella. PSI will assist in the development of messages for these focus areas.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 300,000 | 0 |

**Narrative:**

1. Support to the BDF Peer Education Program
Through discussions with BDF and PCI, it has been agreed that PCI will organize and coordinate peer educator trainings at BDF camps across the country and PSI will contribute to these trainings. The trainings will be focused on four behavioral messages: 1) Safe Male Circumcision (SMC);
2) Voluntary Counseling and Testing (VCT);
3) Correct and Consistent Condom use; and
4) Multiple Concurrent Partnerships (MCP).

IEC materials such as information leaflets, flipcharts, and cue cards will be developed in close collaboration with the BDF and PCI. These materials will serve as communication aides for the peer educators during mobilization for the uptake of SMC, VCT, and condoms throughout the life of the project. PSI will train BDF peer educators on how to use the materials.

2. Procure and Support the Sekwata Condom Brand
Correct and Consistent Condom use plays a big role in HIV/AIDS prevention. In the previous year, PSI procured approximately 3.2 million condoms specifically branded for the BDF. This year, PSI will complement the procurement of 3.2 million Sekwata branded condoms with correct and consistent

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| condom use education, targeted at the armed forces and their community. Condom specific IEC materials such as brochures, cue cards, and posters will be distributed to soldiers and placed around condom dispensers as well as in medical base facilities. To reinforce the information and provide more education on correct and consistent condom use, PSI will conduct condom promotion activities such as road shows with audience appealing activities, such as theater and popular artists at various BDF camps. |

## Implementing Mechanism Details

| **Mechanism ID: 11577** | **Mechanism Name: Department of Defense (DOD)** |
|---|---|
| Funding Agency: U.S. Department of Defense | Procurement Type: USG Core |
| Prime Partner Name: U.S. Department of Defense (Defense) | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 810,017** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 810,017 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The United States Department of Defense HIV/AIDS Prevention Program, utilizing PEPFAR funding continues to support the Botswana Defence Force' s (BDF) efforts to prevent new HIV infections and mitigate the impact of HIV and AIDS among the BDF, their dependents, and civillian personnel. In 2009 DHAPP supported the BDF in conducting their first Seroprevalence and Behavioral Epidemiology Risk Survey(SABERS). Dissemination meetings were held and a final report was presented in early 2010.The current planning, interventions and programming are aligned with the recommendations resulting from the analysis of the survey findings. In addition to the SABERS, the BDF also undertook an in-depth study of their peer education program. In COP 12, DOD will continue to support execution of of the Botswana Defence Force's new Five-year Plan to combat HIV/AIDS within the military and will build upon the existing bilateral relationship. Programs to be supported include scaling up Safe Male Circumcision (SMC),support for training in TB Case Management and infection control, strenghthening of the laboratory capacity including laboratory accreditation. The BDF will pilot an Information System to enhance

monitoring and reporting and support outpatient clinical care.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 60,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Military Population
Mobile Population
TB

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **11577** | | |
| **Mechanism Name:** | **Department of Defense (DOD)** | | |
| **Prime Partner Name:** | **U.S. Department of Defense (Defense)** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HVTB | 50,000 | 0 |
| **Narrative:** | | | |

DOD/PEPFAR support for TB activities in the Botswana Defence Force has in the past been limited to support for training activities. The BDF did an assessment of their TB needs and identified several gaps causing limitations to their ability to provide effective care and treatment for those infected with TB. These include: 1) infrastructure, 2) equipment, 3) transportation, 4) human resources, and 5) training. While the needs may be great, due to limited funding, the scope of the support is reduced. To address infrastructure needs, small changes in clinic space will be made to improve infection control. DOD support will provide computers for improved monitoring of TB cases. Case management has not been as good as it might be due to a lack of transportation for monitoring of active TB cases. Funds will be used to improve staff access to TB patients including home visits. BDF will address personnel needs for TB cases. DoD will continue to support training for TB case management addressing case management, documentation, infection control, contact tracing, monitoring and evaluation, management support, and community level TB programs.
COP FY2012 funding will support the BDF TB program to procure seven (7) motorcycles that will be used by service providers when conducting home visits to ensure that clients are adhering to medication. The funding will also be used to further train health care providers, especially middle and high level managers, in areas such as TB/HIV case management, documentation, infection control, contact tracing, monitoring and evaluation. The training will be conducted in collaboration with the national TB and HIV programs and will be embedded into the national training plan for TB/HIV. Each motorcycle will cost 30,000 BWP, which is approximately $4615 per motorcycle.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | HLAB | 160,017 | 0 |

**Narrative:**

In the past fiscal years, PEPFAR has supported construction of prefab laboratories for three BDF camps across the country and procurement of laboratory equipment to roll out CD4 and viral load testing to more facilities. Training was also provided to the BDF laboratory staffs in quality management system, rapid HIV testing, and TB AFB microscopy. The laboratory network of the BDF is composed of about six labs. In FY 2012 one priority is to strengthen the BDF laboratory network by providing a sustainable Laboratory Information System (LIS) to all the BDF laboratories. Another priority is to develop the quality management system of the BDF laboratory network using the training package developed by the Centers for Disease Control and Prevention referred to as Strengthening Laboratory Management Towards Accreditation . The ultimate goal is to enroll these laboratories in the WHO stepwise accreditation process. FY 2012 funds will also be used to strengthen equipment maintenance and calibration capacity in the BDF laboratories. An additional focus for PEPFAR will be to provide technical assistance to develop and strengthen the Sir Seretse Khama Barracks to carry out disease surveillance for HIV, TB,

and sexually transmitted infections.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | HVSI | 375,000 | 0 |

**Narrative:**

DOD/PEPFAR support for SI activities in the BDF has provided tangible results for the BDF including their first HIV Seroprevalence and Behavioral Epidemiology Risk Survey (SABERS), an evaluation of the effect of camouflage graphics packaging on condom use, and a review of their prevention program monitoring. The BDF is requesting support to conduct a follow-up survey to the 2009 SABERS that will also be the baseline for a BDF cohort study. The cohort study will also support the the 2012 BAIS IV survey through the serial collection of blood samples for incidence calibration and provide data to evaluate the impact of the BDF prevention program including MC. HMIS will be supported through the electronic MC monitoring tools. DOD will partner with the BDF to build off of the MC electronic tools platform and adapt and existing electronic medical record system to provide electronic medical records for the outpatient clinics.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | CIRC | 225,000 | 0 |

**Narrative:**

Botswana Defence Force has embraced the national initiative to roll out the safe male circumcision campaign in all BDF camps. This force wide campaign is aimed at providing the services to uniformed members of the BDF, civilian employees, spouses, and dependents. The services will also be extended to member organizations of the National Men Sector Committee such as the Police Service and Department of Prisons and Rehabilitation Services. Targeting members of the BDF is therefore, ideal for reaching large numbers of HIV negative sexually active men as part of the broader intergration into existing military HIV prevention program. Safe Male Circumcision education will also be offered to recruits in their training settings so they might be circumcised upon completion of their training.The goal is to provide Male Circumcision services to members of the BDF and member organisations of the National Men Sector aged 15-49 eligible men. This goal will be met through careful planning with the BDF Male Circumcision Coordinator, Commanding Officers, and Coordinator of the National Men Sector Committee. An outreach calender will be scheduled to address operational units through drama groups, SMC peer educators, and nurses providing Male Circumcision specific education and HIV counselors/testers. Clients in need of the circumcision will be actively scheduled to acccomplish this important goal. HIV Counselor/Testers will be trained to provide Safe Male Circumcision counseling and they will also conduct outreach for mobilisation campaigns. Funds will be used to provide technical

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| assistance from US DOD personnel and procure commodities and equipment as needed. |

## Implementing Mechanism Details

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|---|---|
| **Mechanism ID: 11586** | **Mechanism Name: Building Human Resource Capacity to support Prevention, Care and Treatment, Strategic Information and Other HIV/AIDS Programs in the Republic of Botswana under the President's Emergency Plan for AIDS Relief** |
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: MULLAN & ASSOCIATES | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 1,180,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 1,180,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The purpose of this cooperative agreement is to provide support and capacity building across a range of key issues in the fight against HIV/AIDS and address key areas of the Botswana PEPFAR Partnership Framework. Capacity building is achieved through training, mentoring and support undertaken in key HIV/AIDS programs, and healthcare management, end of program evaluations assessing, and supply of technical staff to MOH to achieve greater health system strengthening and integration.

Activities undertaken cover the entire country, from the remotest of health posts to hospitals in the capital city. The target population is primarily heath care workers in both the government and private sector health system. In 2012 in-service training to be provided includes technical workshops and will reach a

target of 1319 trainees. Activities undertaken for capacity building impact health system strengthening, and the general population receiving services, e.g. mothers and babies benefiting from early infant diagnosis of HIV and improved infant feeding education and support, and the provision of TB/HIV training to private practitioners.

As a local partner, our long term goal is to ensure that a stronger health care system has been developed that can be maintained, updated and managed by the relevant ministries. Given the need for cost efficiency, every effort is made to ensure optimal impact and value for money.

In support of the work undertaken, two all terrain vehicles were purchased under this mechanism in January 2010 and these are in full time use by the field teams.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 814,750 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
TB
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **11586** |
| **Mechanism Name:** | **Building Human Resource Capacity to support Prevention, Care and Treatment, Strategic Information and Other HIV/AIDS Programs in the Republic of Botswana under the President's Emergency Plan for AIDS Relief** |
| **Prime Partner Name:** | **MULLAN & ASSOCIATES** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVTB | 100,000 | 0 |

**Narrative:**

Private Practitioners TB Training - The Botswana National TB Strategic Plan seeks to involve all health care providers in TB control. The TB private practitioners training activity supports the Botswana National Tuberculosis Control Program's public private mix (PPM) by involving all relevant health care providers in delivering good quality TB services to all sectors of the population. The PPM aims to provide guidelines that will direct how collaboration of the private sector with the public health sector in patient management will be done. It is recognized that training is a key component in achieving the PPM goal to engage all health care providers in TB care and control in order to improve access and ensure compliance with national TB control guidelines. Support will be provided for the participation of private practitioners (medical officer, nurses, pharmacists, and laboratory personnel) to attend training sessions conducted by the MOH in collaboration with their training partners in TB.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | HLAB | 100,000 | 0 |

**Narrative:**

The laboratory support activity builds capacity in laboratories throughout Botswana.

Activities will include in-service training to ten laboratory staff from laboratories throughout the country in the fields of bio-safety, tuberculosis, grant protocol writing, laboratory detection, identification and quantification as well the diagnosis of malaria.

The support of a seconded staff member in data management at the TB reference laboratory will be ongoing as well as in-service training to support the Laboratory Information Management System.

A workshop will be supported to provide technical updates and shared experiences in order to increase

knowledge and skills of the laboratory network in Botswana.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | OHSS | 300,000 | 0 |

**Narrative:**

The overall objective of the two activities in this program area is to support the national health system to become a more efficient and cost effective in delivering needed HIV and other health services. Health services in Botswana are plagued with operational challenges that often can be rectified by facility management and staff without external resources and support. Capacity building in management strives to ensure quality service delivery through improvements in planning, implementation and monitoring across the spectrum of health services in the Botswana health arena and supports Ministry of Health public sector reforms – including policy reforms linking areas such as stigma and gender issues to HIV, and ties directly into MOH performance improvement policies.

Sustainable Management Development Program (SMDP):
The above challenges are being addressed through support to the SMDP program. The SMDP program delivers in-service training to public health managers to develop leadership skills and uses process improvement methodologies to improve service delivery. The training is composed of both classroom lecture modules and the implementation of a project in the workplace under the mentorship of the course tutors. Healthcare managers in all areas of the health system geographically and programmatically are targeted ensuring linkages across all services.

The Botswana National HIV/AIDS Strategic Frameworks (NSF) I and II address the ethical, legal and human rights aspects of the HIV epidemic through the Ethics, Law and Human Rights (ELHR) Sector. This sector has been understaffed and underfunded since the beginning of NSF I.

National Aids Coordinating Agency (NACA) Ethics, Law and Human Rights Coordinator:
The above challenge is being addressed by providing a policy advisor to NACA to implement the ELHR sector plans and run the ELHR secretariat of the National Aids Council. This assistance helps to move the Ethics, Law and Human Rights agenda forward in the national response and encompasses policy and legal reform.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVCT | 300,000 | 0 |

**Narrative:**

National HIV Testing and Counseling (HTC) Workshop
The program objective is to build capacity through targeted training, technical updates and program evaluations in order to increase the knowledge and skills of HIV testing and counseling (HTC) providers and to support greater integration of HTC programs into other prevention programs.

In FY 2012, training will be provided to HTC counselors to share programmatic and procedural updates, improve patients to care and treatment, as well as conduct partner and discordant couples counseling and testing. Further, training will be conducted with HTC counselors and other providers placed at Safe Male Circumcision (SMC) sites to provide pre and post circumcision operative counseling, HIV counseling and testing, post operation follow up, and other SMC training needs. PEPFAR funds will also support the provision of mentoring and support to the SMC counselors through regular counselor supervision and support visits with a view to assuring the quality of counseling services provided and to prevent counselor burnout.

COP 2012 funds will also support the production and printing of information-education-communication (IEC) for the promotion of HTC services and training materials.

Technical updates, training, and shared experience workshops will be conducted throughout Botswana.

Routine HIV Testing (RHT) Evaluation
Additional support will be towards the end of project evaluation of the Routine HIV Testing strengthening project in five University Research Company supported districts. This project which was initially funded in FY 2011. This will be a process evaluation which will assess the RHT Improvement Strategy/Model with the view of informing future efforts, the impact of the project in areas such as increased testing and integration in relation to care and support. It will also serve to guide Ministry of Health on the sustainability and absorption of this program as well as inform them on any challenges relating to policy issues.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 380,000 | 0 |

**Narrative:**

Activities in this program area support capacity building and program activities in prevention of mother-to-child transmission of HIV (PMTCT) to healthcare workers of all cadres in all healthcare facilities throughout Botswana. System strengthening is supported in the integration of various services. Program areas covered are early infant diagnosis; follow up of mother child pairs, linkages to care and treatment, sexual reproductive health and family planning, infant and young child feeding practices.

Global Health Initiative (GHI) health related wrap around areas encompass gender issues, women focused activities, child survival, and safe motherhood.

Early Infant Diagnosis Training (EID)
The training of clinicians across the country in Dried Blood Spot collection, and in-field mentorship and support to enhance implementation. This training is for use of DBS cards for blood collection and not laboratory analysis. Mentorship of health care workers on Infant and Young Child Feeding practices, Sexual Reproductive Health and the recently introduced triple prophylaxis (universal access to Highly Active Antiretroviral Treatment) for pregnant HIV infected women are being integrated into the EID project. This strategic approach is part of a holistic approach to the PMTCT program. Mentorship and support of PMTCT activities will facilitate a more integrated, coordinated, and comprehensive program that is in line with the strategic plans for PEPFAR and local stakeholders. In future, it is hoped that E-Registers will be introduced into the mentoring and support of the EID program.

Determinants of Malnutrition Study
A community based study to determine the socio-cultural, biological, and behavioral factors associated with infant malnutrition will be conducted in households in study districts as determined by MOH. This study will also have a qualitative component that includes interviews and focus group discussions targeted at mothers with children who have been identified as malnourished. This project supports integration of PMTCT program in areas of gender issues (women's rights and socio-economic status), child survival, and safe parenting.

Sexual Reproductive Health (SRH) integration to HIV/AIDS services
This program seeks to focus on the integration of SRH into HIV services across the healthcare system in Botswana. Activities will include the dissemination of IEC materials to healthcare workers across all the spectrum of health care facilities, mentoring and training of healthcare workers and assistance in setting up of systems to facilitate this integration. The objective is to increase uptake of SRH services among HIV infected women in multiple clinical settings over time as they receive antenatal care, labor and delivery, post partum and HTC and HIV care and treatment.

## Implementing Mechanism Details

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|---|---|
| **Mechanism ID: 11589** | **Mechanism Name: Building Human Resources Capacity to support Prevention, Care and Treatment, Strategic Information and other HIV/AIDS Programs in the Republic of Botswana under the Presidents Emergency Plan for AIDS** |

| | |
|---|---|
| | **Relief** |
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: University Research Corporation, LLC | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 1,476,557** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 1,476,557 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Botswana Red Cross | University of Medicine and Dentistry, New Jersey | |

## Overview Narrative

The overall goal of this cooperative agreement is to build human resource capacity to support prevention, care and treatment, strategic information and other HIV/AIDS programs in the Republic of Botswana. University Research Co., LLC (URC) works with the Ministry of Health (MOH) in: (a) assessing the effectiveness of various HIV/AIDS implementation strategies; (b) designing/recommending interventions for enhancing HIV/AIDS and TB programme impact; and (c) providing technical assistance for implementing specific technical strategies for HIV/AIDS and TB. URC works directly in six districts in Botswana, but supports sub-partners and MOH to work nationally. The primary target population is health care workers, and health facility clients and their immediate families. In FY 2012, URC will continue to work with the MOH to strengthen Routine HIV Testing (RHT). URC will also assist the Botswana National Tuberculosis Program (BNTP) to address drug resistance tuberculosis. URC will continue to work with government facilities and build the capacity of MOH staff at national and district level to take over activities lessening our support over time. URC will also provide sub-grantee support to three key partners: 1) The Nursing Association of Botswana (NAB) implements a program to promote the wellbeing of health care providers; 2) The Botswana Red Cross (BRC) will increase refugee access to antiretroviral therapy, and; 3) The University of Medicine and Dentistry of New Jersey will work with the MOH to

integrate sexual and reproductive health into the prevention of mother-to-child transmission of HIV (PMTCT) program. Emphasis will be placed on ensuring accurate and timely reporting, support visits, adequate documentation and regular consultation with CDC, MOH and other partners.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 100,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Increasing gender equity in HIV/AIDS activities and services
TB
Family Planning

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **11589** |
| **Mechanism Name:** | **Building Human Resources Capacity to support Prevention, Care and Treatment, Strategic Information and other HIV/AIDS Programs in the Republic of Botswana under the Presidents Emergency Plan for AIDS Relief** |
| **Prime Partner Name:** | **University Research Corporation, LLC** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | 400,000 | 0 |

**Narrative:**

The Caring for the Caregivers Project aims to promote and enhance the health and wellbeing of all health professionals and support staff. The Nurses Association of Botswana (NAB) has been working with health care providers throughout the country to promote the health and wellbeing of health care providers through personal and professional support to empower them in their role as health care providers.
The program has provided palliative care services, psychosocial support, and spiritual care and support to nurses and other health workers through health worker support groups. NAB has offered care and support to individual health care providers affected by HIV/AIDS and other diseases and health-related conditions and helped develop wellness centers for health care workers to address their health and related needs in a private and protected environment.
NAB proposes to continue to scale up the establishment of support groups in district hospitals in Botswana. In addition, NAB will work to strengthen the capacity of existing support groups. NAB will train additional facilitators for support groups and provide psycho-social support and spiritual care to individuals and groups of health workers.
NAB will also provide individual and group care and support to nurses and health care workers infected or affected by HIV/AIDS, other diseases, and health-related conditions. NAB will continue to play a critical role in advocating and lobbying for policies affecting service provision and working conditions of nurses and health workers.
NAB will strengthen the monitoring of its activities to assess the impact and effectiveness of the program. This will be done through regular support visits by the NAB coordinator and staff. Regular feedback meetings with key stakeholders will be held. All these initiatives will be dependent upon timely and accurate reporting of activities.
Through an agreement with the Botswana Red Cross Society (BRCS), URC will continue to provide care and support services to the refugees in the camp in Dukwi. Services will include treatment of opportunistic infections including TB, cervical cancer screening, provision of cotrimoxazole, malaria prevention and treatment, and a variety of other clinical services for persons infected with HIV. The recent hiring of a doctor and nurse will allow services to be provided on-site. In the past, patients were transported to Francistown for care.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVTB | 250,000 | 0 |

**Narrative:**

Botswana has a TB incidence of 536/100,000, a smear slide positive incidence of 181/100,000 (2008), a TB case detection rate of 68% and a treatment success rate of 64.5%.

Multidrug resistant (MDR) and extensively drug resistant (XDR) TB remain a worrying concern. Botswana

has a high estimated MDR TB burden (2.5% among all TB cases), a high HIV prevalence (17%) and a high annual TB default rate of (10% for drug sensitive TB).

In FY 2011 URC assisted the BNTP to establish current status of TB and MDR-TB in Botswana through a seconded MDR-TB advisor. URC worked in two districts supporting implementation of improved recording for drug resistant TB, implementation of BNTP TB infection control guidelines, and helped address cross border control of MDR/XDR-TB.

URC will continue to support the BNTP in four key activity areas to consolidate gains made in FY 2011. We propose to exclude one activity which is the cross border management of MDR-TB. This activity will be coordinated at a supranational level. To compensate URC will strengthen its work at the national level to improve the programmatic management of MDR-TB and also provide more in-depth district support.

Strengthening national and district level responses for preventing and controlling MDR/XDR TB: URC will work with the BNTP to strengthen the programmatic response to MDR and XDR-TB expanding our support from two to four districts, working with TB coordinators to ensure correct use of TB registers, provide mentorship, monitor implementation of directly observed therapy (DOT), infection control, assess intensive case finding and enhance linkages to HIV services.

URC's MDR-TB specialist at the national level will transfer skills and capacities in MDR-TB programmatic management to an understudy BNTP staff member to ensure sustainability in the long term.

URC also proposes in FY 2012 to support four quarterly meetings on the programmatic management of MDR-TB to help update health care providers on the correct implementation of MDR-TB treatment and improve the management of MDR/XDR TB.

Enhancing implementation of infection control policies and guidelines: URC will hold trainings for coordinators and health care providers to entrench the implementation of the national infection control policies and guidelines. These trainings will be complementary to the clinical training on management of MDR/XDR-TB. We propose to train 75 health care providers. URC will also continue it work in supporting infection control risk assessments and assist in developing facility infection control plans.

Strengthening surveillance of MDR/XDR-TB: URC will continue to support the BNTP to improve recording and surveillance for MDR-TB by ensuring that quarterly and annual reports for MDR-TB management are produced, together with other partners ensure ongoing mentoring and supervision at the 5 MDR-TB initiation sites. URC will also assist the BNTP revise and update the MDR-TB guidelines and registers. URC will continue to assist in the roll-out of the electronic open medical record system for

multi-drug resistant TB. URC coordinate with the National TB Reference Laboratory to help assist in improving access to diagnostics for MDR-TB including Gene Xpert and culture.

Supporting advocacy, social mobilization and communication of MDR/XDR-TB: URC will continue to provide support in the development of materials and brochures to improve community linkages and response.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVCT | 576,557 | 0 |

**Narrative:**

URC provides support to the MOH in strengthening uptake and quality of Provider-Initiated Testing and Counseling (PITC), referred to in Botswana as Routine HIV Testing (RHT). URC works with MOH to strengthen RHT through development of guidelines, training materials, job aids, training, improvement of data collection; strengthening supervision and management through mentoring. In FY 2012, URC will consolidate its activities in the five districts they currently cover. These are Kweneng East, Kweneng West, Good Hope, Charles Hill and Mahalapye. Funds will support activities geared towards addressing major challenges and gaps identified during the FY 2011 implementation period.

To address challenges related to Health Care Workers (HCW) poor implementation of RHT following training, COP 12 funds will support a prioritized in-facility training and mentoring model. This model will involve conducting on-the-job RHT trainings at high-volume health facilities. Post training follow-up, mentoring and support will be strengthened to increase testing yield by trained HCW. Cost-efficient training strategies will include using government conference facilities and institutions where the cost for accommodation and per diem are low. Careful selection of HWC for training will be done to ensure appropriate HCW are trained, to enhance performance following training. Other methods for selection, such as an application process and the piloting of District Trainers' (DT) model, will be explored. To enhance sustainability, DT including previously trained HCW will be expected to take over RHT training activities in their respective districts. A minimum of 5 districts are targeted and two DT will be trained for each district. Initially, DT will train with URC trainers until they have developed skills to conduct trainings on their own.

URC will continue to work with RHT focal persons in the five districts, targeting five high volume facilities, and linking to the safe male circumcision programme in each district. Intensive bi-monthly mentorship support, use of facility based targets, facility improvement plans, observed practice and self-assessment checklists will be implemented. Lower volume facilities will be supported through regular contact phone calls, quarterly visits and attendance to a total of four quarterly district level experience sharing

workshops bringing together all five districts.

In FY 2012, URC will work with district Monitoring and Evaluation (M&E) officers to distribute RHT registers, and improve data collection and reporting. Feedback to facilities on timeliness and correctness of reporting will be emphasized to facilitate the development and periodic reviews of facility based targets.

To further enhance sustainability of RHT at national, district and facility level, funds will support the documentation of project protocols, tools, systems, processes and lessons learned to ensure that project gains are maintained and replicated in other districts. These documents will be shared at monthly, quarterly and annual meetings with CDC and MOH.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 0 | 0 |

**Narrative:**

The goal of the program (funded with $120,000 prior year pipeline) is to provide capacity development to the Ministry of Health's Department of HIV/AIDS Prevention and Care and Sexual and Reproductive Health Division for the integration of family planning services and HIV care and treatment. The François-Xavier Bagnoud Center (FXB) at the University of Medicine and Dentistry of New Jersey (UMDNJ) proposes to support CDC Headquarters (HQ) and CDC Botswana, to expand family planning and safer pregnancy education and support in HIV settings through the development of job aids and client information, education and communication (IEC) materials. These materials will be developed for the Botswana Ministry of Health as a generic package that can be adapted for use in other CDC partner countries.

A. Activity Description

The objective for this activity is to develop a set of comprehensive materials to support family planning service provision in HIV settings. These materials will facilitate counseling and provision of family planning methods, increasing overall uptake of family planning among HIV-infected women and men. They will also support the delivery of coordinated, consistent family planning messages throughout all settings where sexual and reproductive health services are provided or where they may be integrated into HIV services, including antenatal care, labor and delivery, post-partum care, HIV counseling and testing, and HIV care and treatment settings. The proposed project is based on preliminary in-country assessments conducted by CDC-HQ. FXB will work with the Botswana MOH, other in-country partners, and the MCH branch of the Division of Global HIV/AIDS, CDC-HQ to facilitate the following tasks.

Phase 1: Planning
FXB will conduct desk review to identify job aid and IEC materials needs; identify existing materials that are intended to facilitate counseling and provision of family planning methods in HIV settings in Botswana and other countries in Africa including posters and other audiovisual materials; attend two-day meeting at CDC-HQ to discuss findings of CDC SRH/HIV needs assessment; support additional needs assessment and in-country information gathering with CDC-Botswana and MOH; draft brief guidance memo for MOH regarding implementation, monitoring, and evaluation of the job aids and IEC materials.

Phase 2: Materials Development
This will include a review outline for job aids and IEC materials with CDC-HQ, CDC Botswana and MOH. This will be followed by development piloting and revision of materials after review by CDC and MOH Botswana.

Phase 3: Approvals and Launch (To be implemented by CDC Botswana and MOH)
MOH and CDC approvals for finalized materials will be obtained. MOH will convene sensitization and materials launch meetings for relevant stakeholders, departments, and District Health Management Teams.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXD | 250,000 | 0 |

**Narrative:**

The government of Botswana is hosting more than 3,400 recognized refugees in Botswana, most residing in Dukwi Refugee Camp within Dukwi Village along the Kasane-Maun highway in the Tutume sub-district, Central District. The refugee community includes individuals from over a dozen countries including Namibia, Angola, Zimbabwe, Democratic Republic of Congo, Burundi, Rwanda, Somalia, Sudan, Eritrea, Ethiopia, Kenya, Liberia, and Uganda.
No accurate figures exist for the HIV prevalence in the camp. However, the government does not provide antiretroviral therapy (ART) and prevention of mother-to-child transmission of HIV (PMTCT) for HIV-positive pregnant women. The Government of Botswana (GOB) has stipulated that GOB programs cannot provide ART and PMTCT services to refugees, although it will permit these services to be provided through donor agencies. The US Government through PEPFAR program has committed to providing these services to the refugee population.
In FY 2011, the Botswana Red Cross Society (BRCS) supported by the United Nations High Commissioner for Refugees (UHCHR) and URC provided ARV treatment and PMTCT to refugees at the Dukwi clinic. There are currently 214 refugees accessing ART at Dukwi. All consenting refugees who test HIV positive receive a complete panel of blood tests including CD4 tests, full blood counts, and

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| kidney function and those that qualify clinically are eligible for antiretroviral therapy.<br>The BRCS will continue to partner with MOH and URC to provide ARV treatment services for refugees at Dukwi. Specifically the support through the URC grant will provide laboratory monitoring of CD4 counts and viral loads and allow for the quantification, procurement and prescription of ART for all refugees newly qualified to access or currently on ART.<br>BRCS will continue to provide staff support through a doctor, pharmacist and nurse who will assist the existing staff at the government-owned Dukwi clinic. URC will provide ongoing support to mentor staff at Dukwi, align procurement to US government guidelines, ensure quality implementation through MOH standards, and facilitate timely reporting. |

## Implementing Mechanism Details

| **Mechanism ID: 11708** | **Mechanism Name: HHS/CDC Core activities** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: USG Core |
| Prime Partner Name: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention (HHS/CDC) | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 450,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 450,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

There are differences in TB and HIV prevalence and population dynamics between the Western and Southern areas of Botswana which offer a unique opportunity for the study and comparison of the transmission dynamics of TB and MDR TB in stable/aggregated and dynamic/open populations and determine the effect of HIV on these transmission dynamics. Molecular epidemiology provides unique opportunities to understand crucial aspects of the transmission dynamics of TB in the community that

could lead to successful public health interventions.

This Molecular Epidemiology Program will be a collaborative project between the Government of Botswana, the Botswana-University of Pennsylvania Partnership and CDC. We will combine classical epidemiologic methods and molecular epidemiology to determine the transmission dynamics of TB in closed/clustered (Western region) and open/dynamic (Southern region) populations in Botswana and the effect of HIV infection and drug-resistance on TB transmission in these settings. Mathematical models of TB epidemics using real-world data generated will be developed to measure the effectiveness of different public health interventions to interfere with TB transmission and to guide the Ministry of Health to direct infection control measures towards hotspots of TB transmission in the country.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Construction/Renovation | 250,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

TB

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **11708** |
| **Mechanism Name:** | **HHS/CDC Core activities** |
| **Prime Partner Name:** | **U.S. Department of Health and Human Services/Centers for Disease Control and Prevention (HHS/CDC)** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVTB | 450,000 | 0 |

**Narrative:**

Of the $450,000 set aside for the TB/HIV Program, $200,000 will be for cost share operational expenses. An additional $250,000 will be used to procure and set up a containerized BioSafety Level (BSL) 3 lab in Ghanzi. This lab will be used to conduct DNA fingerprinting of TB isolates from the Ghanzi area which has the highest TB rates in the country. The data will be used by the National Tuberculosis Program to direct infection control measures towards hotspots of TB transmission in the country. The Molecular Epidemiology Program is a collaborative project with the Government of Botswana, the University of Pennsylvania, and CDC and is funded by CDC and NIH.

## Implementing Mechanism Details

| **Mechanism ID: 12008** | **Mechanism Name: Expansion of Safe Male Circumcision Services to Prevent HIV** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Johns Hopkins University Bloomberg School of Public Health | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 3,240,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 3,240,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

John Hopkins University (JHPIEGO) supports the CDC and Government of Botswana (GOB) in promoting primary prevention of HIV by scaling up provision of Safe Male Circumcision (SMC) services in Botswana

- consistent with PEPFAR's goals and priorities - with the ultimate goal of building technical and management capacity of the government to continue this work after the project ends. During Project Year 4 (FY2012), JHPIEGO will increase its efforts towards Safe Male Circumcision Service provision by conducting over 13,000 circumcision procedures towards the national target of 385,000 circumcisions by the end of project. Concerted efforts will also be made towards continued mentoring of the service providers at the appointed sites in order to maintain the quality of services stipulated in the Botswana guidelines for Safe Male Circumcision. In the same year JHPIEGO will also conclude and analyze the data from the Active Clinical Monitoring of Adverse Events study. The findings of the study will be used to guide the project further in terms of quality of services being offered to the circumcised men. Once the rollout plan for Early Infant Male Circumcision (EIMC) is finalized, JHPIEGO will make plans for the training of the identified cadres and sites as this is also an area of priority for the GOB. To ensure that the project is on track, continuous monitoring and evaluation will be done in the year and appropriate reports submitted accordingly.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 769,500 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation

## Budget Code Information

| Mechanism ID: | 12008 | | |
|---|---|---|---|
| Mechanism Name: | Expansion of Safe Male Circumcision Services to Prevent HIV | | |
| Prime Partner Name: | Johns Hopkins University Bloomberg School of Public Health | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | CIRC | 3,240,000 | 0 |

**Narrative:**

The principal goal of this activity is to scale up Safe Male Circumcisions (SMC)in Botswana. Jhpiego hopes to achieve this by addressing six main objectives:
Objective 1: To strengthen the collaboration between MOH National SMC technical working group, CDC and other partners, JHPIEGO will participate in SMC project meetings and sharing best practices.
Objective 2: To increase SMC service delivery, Jhpiego will use FY 2012 funds to support seven dedicated SMC teams comprising of seven doctors, 35 nurses, 7 Auxiliary nurses, 7 site administrators, and seven receptionists. Using delayed FY 2011 funds, Jhpiego plans to conduct 13200 SMC procedures in FY 2012 with three teams being service delivery on a staggered basis. With FY 2012 funds, Jhpiego will expand to seven full teams with a target of 50000 SMC procedures to be completed in FY 2013. Models for volume and efficiencies (MOVE) will be used as a scale-up strategy for SMC.
Objective 3: To continue training health care workers in SMC, in FY 2012, 40 health care workers primarily working at dedicated sites will be trained by Jhpiego. This is in line with the new strategic direction agreed to by MOH and partners. MOH-approved revision of the current SMC training materials will be conducted during 2012. Overall, SMC training will be scaled down from previous years as direct service delivery increases.
Objective 3: To support the Early Infant Male Circumcision (EIMC), Jhpiego will complete the development of the EIMC curriculum and support the MOH with drafting the rollout plans. The rollout itself will be deferred until the adult program is launched as priority is placed on scale up of the adolescent and adult SMC program.
Objective 5: To integrate EIMC and adolescent/adult SMC into pre-service education curriculum for Botswana health professionals,
Jhpiego will continue to engage relevant stakeholders in this integration exercise. This builds on integrating activities and training conducted and completed in FY 2011, using revised materials. Jhpiego will look into possibilities of integrating SMC training into the Botswana Medical school as pre-service training.
Objective 6: To develop systems for quality assurance and Monitoring and Evaluation (M&E) , Jhpiego will support clinical monitoring and reporting of SMC. It will also provide training and mentoring on monitoring and evaluation to GOB healthcare workers. A study on active surveillance of Adverse Events related to SMC will be completed in the 2nd and 3rd quarters of FY 2013. The data analysis, report

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| writing and dissemination of the results will be performed during the latter part of that period. The findings of the study are expected to influence the revision of the national SMC M&E framework.<br>Objective 7: To establish Private Public Partnerships (PPP) for SMC, Jhpiego will continue to support the Botswana Family Welfare Association (BOFWA) to start offering SMC services at another one of their sites. This will complement the facility in Mochudi, Kgatleng district and will be done through the recruitment and seconding of an additional SMC team (one medical officer and three nurses), refurbishment and equipment. Further support will be provided through regular mentoring and support supervision. This initiative is expected to yield another 13800 circumcisions during the year.<br>Objectice 8: Procurement of a limited amount of SMC supplies as a contigency to stock outs experienced at Central Medical Stores (CMS). |

## Implementing Mechanism Details

| **Mechanism ID: 12762** | **Mechanism Name: Public-Private Partnerships in PEPFAR countries** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Cardno Emerging Markets | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 450,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 450,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Botho College | | |

## Overview Narrative

This is the second year of the activity. IT graduates from Botho college are being placed at the DHMT to provide IT support to the DHMT and clinics. Interested recent graduates are identified through a competitive process and selected candidates are offered a one-year, PEPFAR-supported paid

attachment. These funds are expected to cover approximately 46 IT officers. The site assignments will be made after a needs assessment. This proposal also seeks to expand the district health IT officer project into the Institutes of Health Sciences (IHS). IHS is the largest teaching institute for health professionals in the country, yet most graduates are not intimately acquainted and/or trained on the technology that is utilized at service delivery points. Funds from this proposal would place one IT officer at each of the eight IHS facilities in the country.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 450,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

(No data provided.)

## Budget Code Information

| **Mechanism ID:** | **12762** | | |
|---|---|---|---|
| **Mechanism Name:** | **Public-Private Partnerships in PEPFAR countries** | | |
| **Prime Partner Name:** | **Cardno Emerging Markets** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Governance and Systems | HVSI | 450,000 | 0 |
| **Narrative:** | | | |
| The aim of this activity is to solidify the progress that has been made in other areas of technology | | | |

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| deployment by providing adequate IT support. Without such support, the roll-out of electronic medical records, among many other technology tools, will not be capable of reaching its maximum potential. Currently, through a public private partnership (PPP) that PEPFAR/Botswana supports, Botho College places IT attachments in districts to assist small health facilities that are not receiving adequate support for their technological infrastructure. The output indicator will be the number of facilities and programs reporting in a timely fashion. This proxy indicator sheds light on how well systems are functioning. Through the use of trend data, timely reporting comparisons to previous years will be conducted as well as form a baseline for monitoring facility reporting following the project's completion. This district health IT officer project was designed to be funded by PEPFAR/Botswana for three consecutive one-year attachments, at which point the Government of Botswana (GOB) would consider absorption or project completion. This is the second year of the project. The project has received high praise from GOB and this proposal would extend the project to other areas in need of technological support. Graduates of this internship have been hired by GOB. |

## Implementing Mechanism Details

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|---|---|
| **Mechanism ID: 12817** | **Mechanism Name: Prevention, Strengthening Health and SI Systems and Access To Quality HIV/AIDS Services Through Support Programs Conducted By The Government Of Botswana** |
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Government of Botswana | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 14,628,439** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 14,628,439 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Building upon the strong national health infrastructure, the Government of Botswana (GOB) has initiated and sustained a multilevel, multi-sector response to HIV/AIDS.

The National HIV/AIDS response is embodied in the National Strategic Framework and involves several governmental bodies. These include the Ministry of Health (MOH), the Ministry of State President (which houses the National AIDS Coordinating Agency), Ministry of Local Government (MLG) and Ministry of Education (MOE).

Major Activities: The GOB supports national programs for prevention, care and treatment including behavior change communication, HIV-testing services, Prevention of Mother to Child Transmission services, Orphans & Vulnerable Children, opportunistic infections, sexually transmitted diseases, ARV treatment and services. The GOB supports surveillance, blood safety, and monitoring and evaluation (M&E) programs. Linkages between PMTCT and Family planning are also emphasized. The GHI principles of capacity building through training, mentorship and support are also incorporated in these projects. Funding in FY 2012 will be given to the implementation of activities in the laboratory strategic plan identified as priorities by PEPFAR for system strengthening. GOB through the MLG and NACA will also be working on initiatives geared at building the capacity of OVC service providers, particularly community service organizations (CSO) to improve service delivery as well as empowering families and communities to offer OVC care at community levels. Scaling up of e-registers, lay counselor training, palliative care and injection safety activities will also be carried out during FY2012 using pipeline funds.

### Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

| Budget Code | Recipient(s) of Support | Approximate Budget | Brief Description of Activities |
|---|---|---|---|
| HVTB | Government of Botswana | 0 | TB activities |
| OHSS | Government of Botswana | 0 | provides secretariat support to the country coordinating mechanism (governance structure at country level) and mobilizes all stakeholders for global |

| | | | |
|---|---|---|---|
| | | | fund grant implementation, debottlenecking and mobilization of technical support |

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Economic Strengthening | 10,600 |
| Education | 100,000 |
| Food and Nutrition: Commodities | 92,000 |
| Food and Nutrition: Policy, Tools, and Service Delivery | 43,830 |
| Human Resources for Health | 1,195,459 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Workplace Programs
Family Planning

## Budget Code Information

| Mechanism ID: | 12817 |
|---|---|
| Mechanism Name: | Prevention, Strengthening Health and SI Systems and Access To Quality HIV/AIDS Services Through Support Programs Conducted By The Government Of Botswana |
| Prime Partner Name: | Government of Botswana |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HBHC | 1,000,000 | 0 |

**Narrative:**

The Care and Support program provides care and support services to people infected and affected by HIV/AIDS. The program encompasses a broad array of clinical, psychological, social, spiritual, and preventive care for adults. It includes palliative care, care for the caregivers, cervical cancer prevention, care and support for refugees, sexually transmitted infections, safe motherhood, opportunistic infections management, and community-based care.

The program's strategic goal is to scale up care and support services to adults with an emphasis on improving the coverage and the quality of care and support services through strengthening managerial and technical assistance as well as strengthening long-term capacity for comprehensive service delivery. This includes building the capacity of both the government primary health care systems and civil society organizations. Currently the health care sector provides care and support both in institutions and at the community level. The care and support program ensures provision of integrated services to infected and affected individuals. The integrated services include psychological support services, HIV counseling and testing, pre-HAART monitoring, cotrimoxazole prophylaxis, sexually transmitted infections screening and treatment, cervical cancer screening and treatment, sexual and reproductive health, referrals and follow-up, and palliative care.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 800,000 | 0 |

**Narrative:**

Support for the OVC program will focus on the following; 1) strengthening the coordination of OVC service providers at national, district and community levels as a matter of priority. Particular reference will be to build the capacity of the newly established District Child Protection Committees for operational efficiency as well as to facilitate for and to manage joint effort on OVC, care and support. This is expected to minimize waste emanating from duplication of services to the same clientele; 2) activities geared at empowering civil society organizations as well as families and communities to offer comprehensive, quality and sustainable care and support interventions to OVC in their localities. Emphasis will be on community responses to enhance ownership, not just over dependence on

government driven OVC interventions through welfare support. Activities will include training communities to be able to identify OVC at risk and provide assistance as well as referral to and link them with available service providers in their areas; 3) economic strengthening to most vulnerable families as a means to enhance their graduation from social welfare systems is a critical area of focus. In FY12, such families with be targeted with interventions to facilitate for their exit from welfare through economic empowerment initiatives in line with the Botswana drive to eradicate poverty. This will include activities geared towards food security in partnership with the Ministry of Agriculture These initiatives will also target families of and OVC under institutional care to prepare them for re-integration with the rest of the world; 4) enhancement of alternative care for OVC, particularly through adoption and foster care. Adoption Act of 1952 is in the process of being reviewed as it is no longer coherent with the current challenges. Foster care program needs to be resuscitated. The country has few over flowing OVC institutional care facilities whose maintenance is very costly as proven by recent studies, therefore adoption and foster care are healthier and affordable alternatives. Support will cover the review of the Adoption Act as well as Foster care interventions; 5) improvement of M&E systems through database development and piloting in 2012. Stakeholders and users will be trained and there will be a mid-year pilot review. All of these efforts will be supported by the design and production of appropriate IEC materials and publications for maximum reach and timely responses; 6) improving coverage of malnourished children as well as strengthen institutional capacity in other districts; 7) training of health workers, NGOs and community-based organizations caring for OVCs in order to improve care of OVCs and referrals of malnourished children; 8) a bench marking trip to Malawi to learn how the Positive Deviance/ Hearth approach is implemented to empower communities to address childhood malnutrition; and 8) procuring therapeutic supplementary food used for treatment of acute malnutrition in children.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVTB | 900,000 | 0 |

**Narrative:**

TB/HIV FY 2012 funds will support collaborative activities designed to integrate clinical management, treatment and strategic information for both the Botswana National TB Program (BNTP) and the Department of HIV/AIDS Prevention and Control (DHAPC). Specifically, the budget provides salary support for all of the existing program personnel who are positioned within the DHAPC. Funds for laptops are needed for use by officers as they travel to districts on support visits as well as during trainings. Other related equipment is needed for day to day office operations.

As part of a new TB/HIV integrated approach, revision of current isoniazid preventive therapy (IPT) policy and clinical guidelines will require printing, training seminars, and improved clinical monitoring. Information, education and communication (IEC) materials will also be developed. Twice yearly

meetings of TB coordinators provide for monitoring and evaluation of TB/HIV activities by the central level staff as well as mentoring of the district staff. Patient and heath care worker education will also be emphasized. Improved TB/HIV collaborative activities will need proper documentation to demonstrate best practices. This will be achieved through the development of the TB/HIV collaborative website, which in turn will allow routine program monitoring to be shared across sites and districts. Results from operational research will be shared in local and international scientific meetings, hence the budget for international travel for BNTP and DHAPC staff.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | PDCS | 274,190 | 0 |

**Narrative:**

The Care and Support program provides care and support services to children infected and affected by HIV/AIDS. The program encompasses a broad array of clinical, psychological, social, spiritual, and preventive care. Infant and child mortality in Botswana continues to be dramatically affected by the HIV epidemic, and HIV continues to contribute to an alarmingly high proportion of deaths of children younger than five years old, more than 50% by some estimates. Child mortality for younger than five years old is high at 120 per 1,000. Reasons for this high infant and child mortality are unclear and may relate to intrauterine HIV infection, HIV drug exposure, formula use, or other factors related to the HIV epidemic. The program's strategic goal is to scale up care and support services to children and adolescents with an emphasis on improving the coverage and the quality of care and support services through strengthening managerial and technical assistance as well as strengthening long-term capacity for comprehensive service delivery.

This includes building the capacity of both the government primary health care systems and civil society organizations. Currently the health care sector provides care and support both in institutions and at the community level. The care and support program ensures provision of integrated services to infected and affected individuals. The integrated services include psychological support services, HIV counseling and testing, pre-HAART monitoring, cotrimoxazole prophylaxis, referrals and follow-up, and palliative Care. "The MASA Expert patient" project supported by PEPFAR at the national level has been established to identify and refer children who need testing to health facilities; follow-up on children from PMTCT and under 5 clinics who need care and refer them to the point of service sites for anti-retroviral therapy (ART); and provide psychosocial support and appropriate referrals as needed.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | HLAB | 811,821 | 0 |

**Narrative:**

Since FY 2006, PEPFAR has supported improvement of laboratory infrastructure and quality assurance in the country. To date three public health laboratories have been accredited by the South African National Accreditation System (SANAS) to the ISO 15189 Standard. A Laboratory Information System has been piloted at four sites and is now being rolled out to ten additional laboratories. The Laboratory Service has developed a 5-year National Laboratory Strategic Plan (2009 – 2014) that spells out the objectives and activities that the ministry wants to engage in to improve laboratories in the country. Funding in FY 2012 will be given to the implementation of activities in the laboratory strategic plan identified as priorities by PEPFAR for system strengthening . FY 2012 funding will continue supporting the laboratory services in the following areas :

1. In the MOH, we will a) support salaries of staff at the National TB Reference Laboratory and Nyangabgwe Hospital Laboratory; b) continue the implementation of the Strengthening Laboratory Management Towards Accreditation (SLMTA) training package by conducting support visits to laboratories; c) support the National Quality Assurance scheme through procurement of External Quality Assurance panels and strengthening of accredited laboratories and those enrolled in the accreditation process; d) improve laboratory space to meet the ISO standard; e) roll out the new rapid HIV test training manual and implement the post marketing of rapid diagnostic test strategy developed by CDC in Botswana.

2. Botswana Bureau of Standards (BOBS) will continue working with four district laboratories to get them accredited. Four new laboratories will be added to BOBS' portfolio this fiscal year to take them through the whole Quality Management System (QMS) process. Funding will also be used to enroll ten laboratories through the Strengthening Laboratory Management Towards Accreditation (SLMTA) process. BOBS will continue to train MOH personnel in the Understanding of ISO 15189:2007, documentation, and auditing. Funding will also support calibration of equipment at the chosen laboratories.

3. Funding will be used to support the University of Botswana Medical Laboratory Science Department to support training of laboratory scientists. Two lecturers will be trained in problem based learning and flow cytometry. Ffunding will be used to support training of clinical lab preceptors at different clinical laboratories where students do their internships to strengthen the clinical laboratory experiential learning of the students. Funding will also be used to develop Continuing Medical Education in the fields of biostatistics and method validation.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | HVSI | 2,280,000 | 0 |

**Narrative:**

Ministry of Health: DHAPC/NHL: PEPFAR supported HIV sentinel surveillance among pregnant

women at antenatal clinics (ANC sentinel surveillance) in collaboration with the Division of HIV/AIDS Prevention and Care since 2006. A 2011 PEPFAR funded study showed that the HIV prevalence data are comparable when using ANC sentinel surveillance or PMTCT program registers. COP12 funding will be used to strengthen routine surveillance using PMTCT clinic data that will be obtained by scanning PMTCT registers and routine HIV testing registers. In future years, these data will be captured using electronic registers at hospitals and clinics. PEPFAR support will also be used to support the development of a routine specimen collection and testing system at the National Health Laboratory to replace ANC surveillance ($280,000).

DHPDME : The objectives of Leadership Capacity Building at Department of Health Policy Development, Monitoring and Evaluation (DHPDME) are to strengthen the national network of M&E officers in health districts, improve accuracy and timeliness of national morbidity and mortality statistics, develop and implement national data quality assurance standards and tools, promote operations research using existing program data, and support the use of the existing District Health Information System (DHIS) for national reporting of all health indicators. The Department is new but has a broad mandate to coordinate health data reporting and use and to harmonize health information systems across the Ministry of Health. ($500,000)

Ministry of Education: PEPFAR will continue to support the biannual Botswana Youth Risk Behavioral Surveillance Survey (BYRBSS) with the Ministry of Education and Skills Development. The BYRBSS collects data on both HIV and non-HIV related risk factors among students aged 10-19 years enrolled in Botswana school. Increased funding will be used to introduce biomarker collection and voluntary HIV counseling and testing for students and staff. ($500,000)

NACA: PEPFAR funding will be used to expand the scope of the 2012 Botswana AIDS Impact Survey (BAIS). The activities include revising the survey questions, supporting and expanding laboratory testing (incidence and resistance), ensuring return of rapid HIV test results and post-test counseling to participants, and electronic data capture of survey responses using hand held computers or digital tablets. ($1,000,000 – pipeline)

PEPFAR will continue to support the Advanced M&E training project to design and implement a master's level curriculum for monitoring and evaluation as part of the epidemiology/statistics curriculum at the new School of Public Health at the University of Botswana. The target for this program includes physicians and nurses in preservice training and the existing cadre of 48 information management officers (IMOs) in the districts that were trained and deployed by PEPFAR support during the last four years. ($100,000).

Since 2007, PEPFAR has supported Basic M&E training for HIV program officers through the Institute of Development Management (IDM) in Botswana. In COP11, there were 119 students who successfully completed the training. NACA will assume responsibility for the program after COP12. ($100,000)

MLG: PEPFAR will support one position at the Ministry of Local Government to coordinate the 24 recently absorbed M&E Officers at the District AIDS Coordinator Offices. This position will be absorbed in 2013. ($35,000)

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | OHSS | 2,223,229 | 0 |

**Narrative:**

In April 2010, Botswana- Ministry of Health (MOH) underwent a major transformation where Primary Health Care relocated to MOH; this was not properly implemented and resulted in unclear organizational structures and systems in District Health Management Teams operations. This also affected the corporate functions because some of the functions have been decentralized to DHMT. The country spends a considerable amount of resources on health but effective funds allocation and use is questionable, this is related to weak health financing systems, weak public health expenditure reviews and lack of regular health sector costing. Quality Management Systems is lacking, which contribute negatively to the health outcomes. There is inadequate skilled health workforce and high staff turnover in the Public Health Sector; this is linked to unfair and poor management practices. The Government of Botswana receives PEPFAR funds and it is imperative to have well established financial management systems that will ensure proper maintenance of expenditure tracking and internal audits. The COP 12 funds will assist MOH to embark on the process of decentralizing functions and building capacity of the DHMT to deliver effective and efficient services to their communities through, a three year implementation plan for Integrated Health Service Plan, re-organization of health care delivery by strengthening DHMT within purview of MOH and re-organization of health delivery model by recommended levels of health care focusing on the EHSP. The funds will support initiation of reforms in health financing. The other support will be capacity building activities of the staff. DHMT will be trained on District Health Systems and MOH will be capacitated to manage change. PEPFAR will continue supporting the government in management of funds by engaging a consultant to assist in internal audits and paying the salary of an Administrative Officer.

The funds will be used to review Human Resources for Health management structures, establish Health Leadership Management Program and train Public Healthcare system leaders. Review of transfer policy will be funded to develop clear deployment and transfer guidelines. The funding will also include support of assessment of the workload for general administration and develop the staffing norms. There will also be support of salaries of faculty at University of Botswana and Health Training Institutions that are responsible for production of new Allied Health Care workers (Pharmacy and Laboratory). Quality Management Systems will be improved by strengthening Botswana Health Inspectorate (BHI). The focus will be on strategy development and implementation, development of Health Inspectorate public education resources, strengthening of HI to acquire membership for International Society for Quality in Health. Quality management trainings will also be offered that will include HealthQual training. The funds will continue supporting the salary of Community Capacity Enhancement Program Coordinator to strengthen capacity of Botswana Government and Community Based Organization to use Community

Conversation to enhance delivery of HIV prevention interventions.
OHSS is linked to other functional areas and there is coordination of quality health services and training of new health care workers. Other public health programs benefit from the HIV funding support. PEPFAR works with other donors such ACHAP in leveraging of funds for HIV and TB.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | CIRC | 500,000 | 0 |

**Narrative:**

In an effort to streamline Safe Male Circumcision (SMC) service delivery, the MOH will achieve the following six objectives in COP12: 1) Human resources- six doctors will continue to be supported through PEPFAR. In addition, three nursing positions have been converted to two program officers to support the SMC unit at MOH to support SMC service delivery and demand creation coordination at MOH; 2) Demand creation- Targeting in-and-out of school youth as well as the community at large in the 16 high volume districts. We also plan to continue using multi media mass media channels for demand creation; 3) Supplies- Procurement of SMC supplies for integrated service delivery sites; procurement of Early Infant Male Circumcision (EIMC) devices and general supplies; 4) Training- Targeted training and mentorship of SMC dedicated teams; the trainer of trainer (TOT) model will be used at integrated SMC sites; training of relevant health care providers on EIMC site preparation and piloting of EIMC; 5) Printing – The adult SMC training curriculum is being revised in quarter 4 (FY 2011/12); printing of developed EIMC curriculum; 6) Early Infant Male Circumcision (EIMC)- While adult SMC is a priority, we plan to initiate implementation of the EIMC for sustainability of the programme. Coordination of the national SMC program continues to be supported by PEPFAR, including technical working group meetings, trainings, and dissemination of information and procedures.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMBL | 550,000 | 0 |

**Narrative:**

The World Health Organization (WHO) estimates that about 5% of new HIV infections in developing and transitional countries are attributable to unsafe blood and unsafe injection practices and occupational exposure (WHO, 2008). Transfusion of unsafe blood remains the highest mode through which HIV and other infections can be transmitted if access to safe and adequate blood supply is limited. A situational analysis of the National Blood Transfusion Service conducted by Safe Blood for Africa Foundation in 2002 revealed that the service was collecting only 30% of units of blood required annually and the HIV prevalence in donated blood was standing at 9% with a total discard rate due to transfusion transmissible infections (HIV, Hepatitis B, Hepatitis C and syphilis) of 15%. The implementation of Blood Safety and Youth HIV prevention program with the funding of African Comprehensive HIV AIDS Partnership

(ACHAP)from 2003 to 2005 and PEPFAR from 2004 to date provided infrastructure development, acquisition of additional equipment, hiring of staff, and technical assistance from Safe Blood for Africa Foundation. PEPFAR support of the GOB goal of improving the provision of a safe and adequate blood supply has yielded remarkable success through Blood Center construction and renovation, equipment procurement, policy and guidelines, and personnel provision. HIV and other transfusion transmissible infections (TTI) in discarded donated blood has dropped dramatically from 9.9% in 2004 to 2.5% in 2010. In addition, the supply of safe blood has increased from 13,000 donated units in 2004 to 20,000 units in 2010. The vision of the Blood Safety program is to fully graduate the PEPFAR-supported personnel positions by 2013, and improve blood supply adequacy by integrating blood donation activities with other HIV prevention programs. In 2012, PEPFAR and the Government Of Botswana (GOB) will engage in a process to implement a sustainability plan with the aim of reducing reliance of the Blood Safety program on external financial and technical resources. Key aspects of the graduation plan will include: ending PEPFAR funded positions by 2013, purchasing the last batch of critical equipment, strengthening hospital transfusion committees and sub-contracting Pledge 25 Club for donor recruitment. In addition, accreditation of NBTS to ensure continued quality, strengthening M&E and data management systems and integrating blood safety with other programs such as HIV counseling and testing and voluntary safe male circumcision.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HMIN | 100,000 | 0 |

**Narrative:**

The Botswana CDC Injection Safety Project (BCISP) is aimed at preventing medical transmission of HIV and bloodborne infection (viral hepatitis) in the Botswana healthcare settings. The project contributes towards the Botswana Partnership Framework of reducing new HIV infections by 50%.
The project has since 2011 scaled-up to all 29 health districts, starting with training of trainers, development and implementation of healthcare worker safety programs such as Hepatitis B guidelines and resuscitating the development of the Infection Prevention and Control policy and the associated monitoring and evaluation strategies, training staff on healthcare waste management. The activities will be implemented utilizing existing structures, in particular the District Health Management teams (DHMTs) and the key staff led by the national injection safety coordinator based at MoH headquarters employed with PEPFAR support. The main objective of the project is to strengthen the health system through the development of the national Infection Prevention and Control (IPC) Policy. The policy will guide the institutionalization and sustainability of the project interventions beyond the life project funded by the US Government. During this planning period the other measures aimed at strengthening of institutional resources such as training of Infection Prevention & Control Coordinators, continuous support of training through training of trainers (TOTs), implementation of injection safety guidelines, service norms and

standards, promoting utilization and accessibility of post exposure prophylaxis of HIV and hepatitis B, as well as provision of hepatitis B vaccination. The project will promote the sustained strategy by having project staff within MoH and the district management teams to lead implementation of the project. The project will continue the integration and promoting of safety concepts into the teaching curricula of Institute of Health Science. The MOH will utilize the project in the implementation of a health information system database that will be used to capture monthly data on occupational injuries, post exposure prophylaxis (PEP) usage, hepatitis B vaccination coverage to promote evidence based decision making as a benchmark and implementation improvement. Measure of progress towards targets will be reviewed every quarter and through continuous supervisory monitoring of the project interventions. Monitoring will be combined with technical assistance from JSI which will be aimed at improving quality assurance and services.During COP12, PEPFAR will fund three positions at MOH in the Division of Environmental and Occupational Health, implementation of the Infection Prevention and Control policy and project monitoring in all the 29 health districts.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 15,000 | 0 |

**Narrative:**

Ministry of Education and Skills Development implements a curriculum based life skills project, called "Living," targeting learners from primary level to junior 6-13, secondary level 13-16, senior secondary 17-18 years. The project comprises of reproducing life skills curriculum, learner's worksheets, Teachers guides, and a monitoring plan. Topics are divided into target age groups such that Primary school materials focuses on abstinence and delayed sexual debut, while Junior and Senior Secondary School curricula include male and female adolescents who are sexually active. In addition to the Life skills Curricula, the Ministry of Education runs a Television program in which 25 out-off-school youth will participate to dialogue with 25 secondary school Peer Educators who will be trained as mentors for the 10 regions. They will mentor both learners and teachers with skills that help them to reduce the risk of HIV key drivers such as Multiple Concurrent Partnerships; Adolescent and Intergenerational Sex; Alcohol and Drug Abuse; Stigma and Discrimination and Gender-based Violence and Sexual Abuse. This project targets both boys and girls equally. Peer Education is a joint effort between MOE and Education Development Center (EDC) another CDC partner. $15,000 for AB

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVCT | 400,000 | 0 |

**Narrative:**

Through PEPFAR support, the Counseling and Testing Program of MOH provides coordination, monitoring; technical support and guidance to all HIV testing and counseling (HTC) service providers

nationwide, with the goal of expanding access to quality services. Although the program targets the general population, specific targeted groups for COP 12 comprise men, couples, youth and other groups in hard to reach areas including high risk groups. In order to expand accessibility of HTC services; support Safe Male Circumcision (SMC) scale up and increase proportion of people who know tale their HIV status, COP 12 funds will largely support building capacity and providing support to Health Care workers (HCW) to provide HTC services. Activities supported will include the training of HCW at integrated SMC sites to provide Routine HIV Testing (RHT); Couple HIV Counseling and Testing, and the roll out of the Counselor Supervision program. The Counselor Supervision Program will be rolled out in both government and civil society settings.COP 12 funds will also support the consolidation of ongoing activities. In this regard, quality assurance and Monitoring and Evaluation activities will be prioritized. Activities will include HCW support and mentoring visits; dissemination and operationalization of HTC guidelines and standards; dissemination of HTC registers; orientation of HCW on the new HTC registers and the development of User manuals for the register. Funds will also be used to support a single position at the counseling and testing unit to strengthen their capacity to implement activities and provide technical oversight to the national HTC program. This will also build their capacity to take over implementation and monitoring of the RHT improvement project that University Research Company (URC) is currently implementing once URC cooperative agreement expires in 2013. Following the evaluation of alternative rapid HIV test kits, the national rapid test algorithm changed slightly in 2010 with the addition of a new rapid HIV test kit. COP 12 funds will therefore support the retraining of providers on the new algorithm. Additional activities that will be supported include the strengthening and integration of Positive Health Dignity and Prevention (PHDP) services in HTC programs such as the provision of ongoing supportive counseling to PLWHIV. Funds will also support training of providers in 32 Infectious Disease Control Centres (IDCCs) to implement the minimum package of PHDP services onsite where HIV care and treatment services are regularly provided.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 507,600 | 0 |

**Narrative:**

NACA: The project aims to support the Government of Botswana – National AIDS Coordinating Agency (NACA) in the development and implementation of a strategic and multi-faceted HIV prevention communications campaign that links behavior change with prevention services. NACA will provide coordination and leadership and build capacity of national organizations and local authorities. NACA will partner with Population Services International (PSI) to implement the campaign in selected districts. The project will use strategies such as mass media communication, key stakeholder sensitization, media advocacy and community-based interventions that aim to change societal norms and individual behaviors. Key activities that will be funded are training of program coordinators and health care workers

at national and district level, design, develop and produce Information Education and Communication (IEC)/ Behavior Change Communication (BCC) materials, conduct advocacy workshops with community leadership in the districts, coordinate the implementation of interpersonal communication, work within workplace establishments and other small group interventions in selected districts, establish a National Clearing House project that will review and approve all IEC/BCC materials as well as linking the campaigns to Botswana HIV Response Management Information Systems (BHRIMS).

The Ministry of Education and Skills Development will conduct two day training workshop in for four new senior secondary schools reaching approximately 200 teachers aged 22–60 per school. These teachers will use teacher guides and life skills curriculum to reach learners aged 6-18 years old. The project will also be introduced in Teacher Training Colleges, so that they do not only know about Life Skills when they are in classes. Another component of this project is to Link up Schools to the Tebelopele Voluntary Counseling and Testing Centers to allow for both teachers and student to test for HIV.

Ministry of Health: PHDP – With the Positive Health Dignity and Prevention (PHDP) strategic and implementation plans developed with previous COP funds, prior year pipeline funds will largely support the roll out of the implementation plan. Activities supported will include capacity building efforts in different sectors through training of providers; review of policies and guidelines; implementation of the minimum PDHP package; mentoring and support visits; development of counseling protocols; educational materials; piloting implementation of PHDP activities in six districts; and a position of a coordinator to drive implementation of PHDP interventions.
Civil Society Organizations (CSO) will be supported to work closely with government health facilities to strengthen referral linkages and provision of post -test support services. Sites will be strengthened to put systems in place to ensure that HIV positive people are linked to the National ARV program; regularly screened for STI as part of prevention; provided with ongoing support including family planning counseling; provided with condoms and referral for cervical cancer screening for HIV positive women.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 450,000 | 0 |

**Narrative:**

The activities under this cooperative agreement include building the capacity of the MOH to address all issues pertaining to the prevention of mother to child transmission of HIV (PMTCT). Although the Botswana PMTCT program has done relatively well in terms of preventing vertical transmission, other aspects of the program are still lagging behind. In particular, rates of unintended pregnancies in HIV infected women remain high and adoption of safe infant feeding practices remains problematic. Strengthening of these other prongs of PMTCT will ensure greater HIV- free survival of children and

improved health outcomes for infected women. CDC support to the Ministry of Health for PMTCT related activities for COP2012 will be directed at the PMTCT, Sexual Reproductive Health (SRH) and Infant Nutrition Units.

The Infant Nutrition Program continues to promote and support optimal infant and young child feeding (IYCF) practices. IYCF practices in Botswana remain unsatisfactory and more efforts are needed to build capacity of health personnel to strengthen child growth monitoring and promotion (CGMP) and nutritional surveillance. This will include, in part, development and dissemination of appropriate IEC materials such as the CGMP training manual for health workers and other educational materials on complementary feeding.

Health workers (HW) will also need mentoring on the management of acute, severe malnutrition that continues to be a challenge in the country. PEPFAR support in FY 2012 will focus on training of HW on community based management of acute malnutrition (CMAM), development and reviewing training materials to align them with the WHO guidelines and procurement of CMAM and inpatient therapeutic products. HW will also be trained on the Baby-Mother Friendly Hospital Initiative Counseling Course focused on improving infant feeding practices in the context of HIV/AIDS.

Funding for the PMTCT unit will focus on training HW on updated PMTCT guidelines. Botswana is currently scaling up to provide triple prophylaxis (Option B of the new WHO guidelines) for all its pregnant HIV infected women. Update trainings are an essential element as through them, the PMTCT program is able to not only inform HW on the latest information, but also to keep contact with health providers, share experiences, discuss implementation challenges and successes and together map a way forward for improving the quality of PMTCT program.

The SRH needs of HIV infected people have remained neglected since the onset of the epidemic. In order to better address this gap, SRH and HIV services need to be better integrated, and HW need to be empowered to be able to tackle the SRH needs of PLWHA. PEPFAR support for the SRH Unit will go towards revision and printing of the Family Planning procedures manual, register and client card. Some funding will also go towards update trainings of HW on family planning issues with a renewed focus on the HIV infected population. The unit is also in the process of recruiting one SRH Training coordinator whose mandate will be to coordinate trainings at the district level and build capacity in the MOH. This position is funded in FY2012.

These areas of support are in keeping with PEPFAR's strategies to improve the effectiveness of PMTCT and related programs. Linkages between PMTCT and Family planning are also emphasized. The GHI principles of capacity building through training, mentorship and support are also incorporated in these projects.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXD | 3,516,599 | 0 |

**Narrative:**

Central Medical Stores is the Government of Botswana's procurement and distribution organisation for health sector commodities. CMS' goal is to support the HIV/AIDS programme by ensuring that commodities are available at all times for prevention, diagnosis and treatment activities. MOH ARV clinic upgrade activities. Botswana, a country with a population of more than 1.8 million people, is one of the countries with the highest HIV prevalence in the world.

ARV therapy was introduced in the country in 2002 and since then more than 32 hospitals and 200 clinics and health posts are now dispensing ARVs.

According to July report, more than 70,000 patients out of 140,000 were on ARV treatment in the clinics and health posts. This shows that with time more patients will be accessing treatment in facilities close to their homes.

According to NDP 9, Ministry of Health is planning to roll out ARV services to all clinics in the country which are more than 286. This is expected to ease movement of patients from one place to the other in search of services as integrated approach to provision of care is being envisaged.

Context

There has been an increase in number of people who are accessing ARV services in the clinics. This is going according to MOH plan of decongesting the hospitals and while strengthening provision of ART services in the clinics.

On economic terms, more people are expected to access treatment in their areas hence reducing the cost incurred when seeking services in areas far from their villages. Again it is expected that there will be a reduction in patients who are defaulting as services will be close to these patients and clinics will be able to follow them.

Clinics upgrade is important as it allows patients to source ARV services from facilities in their areas. Ministry of Health is currently working on relieving hospitals from running IDCCs and this has put a strain on the current clinics and health posts. It is therefore important that these facilities are strengthened, increase working space and also have nurses who can be able to prescribe and dispense. Networking of facilities will improve communication and flow of data from and between facilities and thus improve on the type of data that is generated.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | HTXS | 300,000 | 0 |

**Narrative:**

The Ministry of Health (MOH) subcontracts with Airborne Lifeline to transport HIV/AIDS specialists from Princess Marina Hospital in Gaborone and Nyangagbwe Referral Hospital in Francistown to remote sites in Botswana on a scheduled basis. During site visits medical professionals, mainly from Baylor and the University of Pennsylvania, treat patients (approximately 450 per month) and train other health care providers. Airborne Lifeline also transports anti-retroviral (ARV) drugs, medical equipment, and other

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|---|
| commodities to these remote clinics in a secure and timely manner. Laboratory specimens such as CD4 samples can be transported back to central laboratories on the return flights.<br>Airborne Lifeline began flight operations in Botswana in May 2007 and received its first PEPFAR grant in April 2008. Airborne Lifeline currently flies to nine sites: Hukuntsi, Tsabong, Ghanzi, Gumare, Kasane, Maun, Saronga, Kang, and Shakawe.<br>Given the proposed FY 2012 reduction of 40% in Airborne's PEPFAR funding, the MOH will be consulted as to whether to eliminate service to certain locations, utilize smaller/slower aircraft, or eliminate cargo shipments. |

## Implementing Mechanism Details

| **Mechanism ID: 12946** | **Mechanism Name: Prevention AB and OP** |
|---|---|
| Funding Agency: U.S. Department of Defense | Procurement Type: Grant |
| Prime Partner Name: Project Concern International | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 315,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 315,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Project Concern International (PCI) will focus on behavioral interventions geared to motivate behavior change in young people, couples and families and military civilian employees of the BDF. The interventions will incorporate the ABC approach, and address key drivers of the risk such as MCP. The overall objective is to strengthen the existing BDF HIV Prevention Program. Will focus on non-clinical HIV prevention services, like male and female condom demonstration and distribution, HIV counseling and testing .HIV prevention activities will be implemented through mutually reinforcing strategies consisting of peer education, behavior change communication strategies and active leadership involvement and support at Unit and Garrison level. Information about the program will be disseminated to target populations through public announcements at parade squares, campaigns and training workshops. Key

implementers of the program constitute peer educators, counselors and HIV/AIDS committees coordinated by HIV/AIDS focal persons in the Garrisons under the leadership and guidance of the Garrison commander, and the HIV/AIDS Coordinator's Office. To enhance integrated and coordinated program planning and implementation, an updated Implementation Structure with clear roles and responsibilities, an M&E Plan and standardized tools will be used by all HIV/AIDS program implementers in the BDF, including peer educators, and counselors . The expected outcomes will be: Improved BDF skills and systems for designing and implementing effective HIV prevention activities; fully committed leadership; improved coordination among relevant Units for HIV prevention; improved capacity to implement, monitor, evaluate and document BDF HIV prevention activities.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 50,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Military Population
Mobile Population
TB

## Budget Code Information

| Mechanism ID: | 12946 | | |
|---|---|---|---|
| Mechanism Name: | Prevention AB and OP | | |
| Prime Partner Name: | Project Concern International | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | HVAB | 140,000 | 0 |

**Narrative:**

Abstinence and Being Faithful efforts will mainly focus on behavioral interventions that are geared to motivate sexual behavior change among military personnel, civilian personnel and their dependents. The 2010 BDF HIV Prevention Program Review exercise identified multiple concurrent partnerships, alcohol abuse incorrect and inconsistent condom use, poor relationship management skills as some of the perceived key risky behaviors that must be addressed in The BDF. Therefore, behavior change interventions will seek to promote secondary abstinence, reducing multiple concurrent partners, equipping targets populations with requisite relationship management skills, and related social and community norms that impact these behaviors. Updated training manuals, public announcements at parade squares, sports competitions, pre – post deployment forums, workshops, national & international commemorations days, campaigns, theatre, peer education will be the main methods used to achieve the intended objectives.

Activities will mainly constitute: a) conducting a series of family dialogues around issues of HIV risk behaviors such as incorrect and inconsistent condom use, alcohol abuse, multiple concurrent partnerships. Family dialogues will target couples, families and young people in all military garrisons.

b) continuously refining existing Behavior Change Communication (BCC) material and intensifying BCC through theatre and other material adapted from within and without Botswana

c) assessing and conducting life skills' training using a standardized life skills training manual, especially targeting recruits and cadets. Life Skills training will aim to develop skills and attitudes needed to form and maintain long term, mature, monogamous and satisfying relationships

d) conducting training workshop on condom demonstration, correct and consistent use of condoms, and . In addition, life skills training will aim to achieve (secondary) abstinence, delay in onset of sexual relations, monogamy, fidelity and sexual partner reduction

e) conducting regular joint monitoring visits involving PCI, BDF and OSC personnel to track implementation progress and conduct data quality audits, in line with the M&E Plan

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 175,000 | 0 |

**Narrative:**

The 2010 BDF HIV Prevention Program Review exercise identified multiple concurrent partnerships,

alcohol abuse incorrect and inconsistent condom use as the perceived key risky behaviours that must be addressed in The BDF. To achieve the desired results, focus will be on a) strengthening the peer education program b) encouraging active leadership involvement & support to the HIV prevention program, and c) effective coordination and integration of HIV prevention services' delivery in the BDF.
3.1 Peer Education: According to the 2010 BDF HIV Prevention Review exercise, peer education was found to be ineffective even by peer educators themselves despite numerous peer education trainings that BDF has conducted over the years for its peer educators. Key challenges of the peer education program were found to be a) lack of practice (and mentoring) as peer educators b) lack of resource such as condom demonstration models and transport c) lack of standardised peer education training manuals and clear practice standards d) unclear core responsibilities of peer educators e) lack of recognition, and support for peer education efforts by fellow peers and by their commanders. Core activities will include a) rolling – out refresher peer education training workshops using a standardised peer education training manuals. The training manual will incorporates practice standards and contemporary topics including safe male circumcision (SMC), multiple concurrent partnerships (MCP) b) working closely with Population Services International (PSI) and other BDF key stakeholders
.3.2 Leadership involvement and support to the BDF HIV Prevention Program; The 2010 BDF HIV Prevention Program Review exercise revealed that although the program has been in existence since 1997, and HIV/AIDS committees "exist", active leadership involvement and support to the program is still lacking. This was mainly attributed to the perception that HIV/AIDS is not a Command function. The leadership also lacked requisite knowledge and skills to guide, mentor and provide the much needed leadership to the program. To increase leadership involvement, support and accountability for planning and management of the BDF HIV Prevention Program, PCI will work very closely with Unit and Garrison commanders in planning and implementing approved HIV prevention activities. Key activities will consist of a) institutionalising the annual workplanning process b) conducting regular training workshops for the field leadership c) conducting quarterly review meetings with the field leadership and c) revamping HIV/AIDS committees to ensure that they are representative of the BDF community, and function effectively and d) conducting regular training workshops targeting HIV/AIDS committee chairpersons and Unit and Garrison leaders, and introducing incentives for best performing leaders
3.3 Coordination & Integration of BDF HIV/AIDS activities:Focus will be on strengthening coordination and integration of HIV prevention services' delivery in the BDF by a) facilitating an annual participatory HIV/AIDS workplan development processes involving key program implementers b) assisting BDF to track implementation of the HIV prevention activities c) improving the Supply Chain Management System for condom procurement, distribution and utilisation d) facilitating annual Program Review Forums for key program implementers and stakeholders, including the Unit and Garrison commanders.
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## Implementing Mechanism Details

| Mechanism ID: 12975 | Mechanism Name: TB Care 1 |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: KNCV Tuberculosis Foundation | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| Total Funding: 300,000 | Total Mechanism Pipeline: N/A |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 300,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The goal of the TB CARE 1 project is to facilitate capacity building, accelerate TB/HIV collaborative activities, support multi-drug resistant (MDR)-TB management, and TB infection Control (IC) by providing long and short term technical assistance to the Botswana National Tuberculosis Program (BNTP) and the National TB Reference Laboratory (NTRL). In addition to providing two long-term advisors, KNCV Tuberculosis Foundation headquarters staff provides country visits and administrative support for the Botswana-based staff to ensure high quality technical assistance appropriate to meet the needs of the BNTP. Given the operational challenges faced by the BNTP, the support also strengthens the laboratory services for TB control and program management of patients dually infected with TB/HIV, with or without drug resistant tuberculosis. In partnership with the Ministry of Health (MOH), KNCV Tuberculosis Foundation provides support to the NTRL so that it can develop into a well-functioning laboratory, fully equipped and capable of performing the roles and responsibilities needed for supporting excellent clinical management of drug susceptible and resistant TB, routine drug resistance surveillance, and quality assurance of TB microscopy.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 300,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

TB

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **12975** | | |
| **Mechanism Name:** | **TB Care 1** | | |
| **Prime Partner Name:** | **KNCV Tuberculosis Foundation** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HVTB | 300,000 | 0 |

**Narrative:**

KNCV TB CARE I will continue collaboration with the MOH and other partners to improve TB control in Botswana. A Senior Technical Advisor has been placed at the Botswana National Tuberculosis Control Program (NTCP) and will provide support in six technical areas: programmatic management of drug resistant tuberculosis (PMDT); laboratory strengthening; TB/HIV collaborative activities; monitoring and evaluation; community DOTS; and, TB infection control. Laboratory strengthening activities will continue with support from the current Chief Medical Laboratory Technician, who will work closely with MOH staff to further build capacity of the national laboratory network and the NTRL quality management systems. KNCV will provide backstopping visits (two country visits per year by senior international technical advisors) to further provide in-country technical support as well as desk support from The Netherlands and from the Kenya Regional Office for PMDT, M&E, Laboratory strengthening, TB/HIV collaborative activities, Community DOTS, Global Fund TB Round 11 proposal development, and human resources development.

## Implementing Mechanism Details

| **Mechanism ID: 13079** | **Mechanism Name: CapacityPlus** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: IntraHealth International, Inc | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 800,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 800,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

CapacityPlus, a USAID-funded global project, strengthens Human Resources for Health (HRH) policy, planning, and management so that effective implementation of HRH initiatives can be sustained. To facilitate action, countries need evidence-based, costed, implementable HRH strategic plans, anchored by a policy framework that supports HRH plans with necessary legislation and regulation.

In Botswana, CapacityPlus will build on existing work in two areas. First, CapacityPlus will work with the Botswana Ministry of Health (MOH) HRH and planning departments to strengthen the availability and use of high quality health workforce information through a strengthened national human resources information system (HRIS). Second, CapacityPlus will also work with the Botswana Health Professions Council (BHPC) and the Nursing and Midwifery Council of Botswana (NMCB) to strengthen their registry systems and continuing professional development (CPD) programs. The project will work with the BHPC to take their continuing medical education (CME) framework to full implementation, and NMCB to implement a CPD program and track the credits in a strengthened registry system.

CapacityPlus will develop local capacity and sustainability for the management and use of health worker data through identification, training and mentorship of in-country, and institutional human resources. All

hardware costs will be kept at a minimum and, wherever possible, open-source technologies will be preferred due to their low cost and global support community.

Evaluation of the programmatic areas will be based on the HRH data demand and information use for decision making and planning as evidenced, for example, by the use of routine or ad-hoc reports and the councils' active use of the CPD/CME program.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 550,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

(No data provided.)

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **13079** | | |
| **Mechanism Name:** | **CapacityPlus** | | |
| **Prime Partner Name:** | **IntraHealth International, Inc** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Governance and Systems | OHSS | 800,000 | 0 |
| **Narrative:** | | | |
| In Botswana, CapacityPlus will build on existing work in two areas. First, CapacityPlus will work with the | | | |

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|---|
| Botswana Ministry of Health (MOH) HRH and planning departments to strengthen the availability and use of high quality health workforce information through a strengthened national human resources information system (HRIS). Second, CapacityPlus will also work with the Botswana Health Professions Council (BHPC) and the Nursing and Midwifery Council of Botswana (NMCB) to strengthen their registry systems and continuing professional development (CPD) programs. The project will work with the BHPC to take their continuing medical education (CME) framework to full implementation, and NMCB to implement a CPD program and track the credits in a strengthened registry system.<br><br>CapacityPlus will develop local capacity and sustainability for the management and use of health worker data through identification, training and mentorship of in-country and institutional human resources. All hardware costs will be kept at a minimum and, wherever possible, open-source technologies will be preferred due to their low cost and global support community.<br><br>Evaluation of the programmatic areas will be based on the HRH data demand and information use for decision making and planning as evidenced, for example, by the use of routine or ad-hoc reports and the councils' active use of the CPD/CME program. |

## Implementing Mechanism Details

| **Mechanism ID: 13091** | **Mechanism Name: Implementing the Living Life Skills Curriculum in Botswana** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Education Development Center | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 450,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 450,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

This is a continuation of the project which started in 2010 and will be in Year 3 in 2012/2013. The goal is to prevent new HIV infection among teachers and learners and the objectives are to: 1) build capacity of teachers through pre-service training to implement effective and comprehensive life skills programs; 2) strengthen the existing monitoring system to maximize outcomes; 3) support the Ministry of Education and Skills Development (MOESD) to sustain the program; and 4) develop peer education programs in the schools and the community. Education Development Center, Inc (EDC) works with the MOESD in all 10 educational regions of Botswana. As part of transitioning full ownership of the program to the MOESD, EDC has started working with MOESD to share costs of training teachers and officers from all departments in all regions. In 2011 EDC covered training of education officers with cost sharing for venue, accommodation and transport costs. EDC is capacitating officers to train teachers in the life skills curriculum, “Living,” and to monitor and support the use of Living materials at the school level. Through the trainings, EDC is ensuring that each region develops an action plan on training of teachers in schools in the region. In response to the evidence-based findings from the Process Evaluation Report by EnCompass LLC in 2010, EDC, together with Peace Corps Volunteers, is also coaching and mentoring teachers to use the Living curriculum effectively. EDC, in partnership with the University of Botswana, will work with the MOESD to conduct monitoring activities in sampled schools in each region over the next 3 years.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Education | 225,000 |
| Gender: Reducing Violence and Coercion | 225,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **13091** |
| **Mechanism Name:** | **Implementing the Living Life Skills Curriculum in Botswana** |
| **Prime Partner Name:** | **Education Development Center** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVAB | 450,000 | 0 |

**Narrative:**

EDC's activities are in support of the implementation and enhancement of the Botswana Ministry of Education life skills project. All activities proposed by EDC have been discussed with and approved by the Ministry of Education. EDC targets three groups: 1) teachers ages 22–60; 2) learners ages 6-19, including male and female adolescents who are sexually active; and 3) young men and women ages 25–49 where HIV prevalence is 40. Interactions with each group are adapted to be sensitive to developmental stage. Curricula for younger learners includes life skills development and approaches HIV and sexual health topic in an age appropriate manner. EDC will continue to visit schools and work with teachers in groups of 20 over two-hour sessions to address specific challenges with using the "Living" life skills curriculum. Based on past experiences using the "Living" materials, EDC has found that schools are willing to release teachers for brief intervals to improve effective use of the materials in the classroom. This form of mentoring is especially acceptable to schools as it is conducted within the school and teachers do not need to be away from the classroom for a whole week to attend a training workshop somewhere else. The exercises help teachers to be more effective since life skills and HIV education have to be infused in all the subjects across the curriculum. When the exercise is done, teachers are helped to form teams for on-going coaching and mentoring activities in the school which they can also apply to other subjects. EDC will capacitate peer education groups in secondary schools by training two learners per school as Peer Counselors over a two-day session. "Living" equips both learners and teachers with skills that help them to minimize the impact of the HIV key drivers, in particular: Multiple Concurrent Partnerships, Adolescent and Intergenerational Sex, Gender-based Violence and Sexual Abuse. In line with the National Strategic Framework II and the Global Health Initiative Guidance on Women, Girls and Gender Equality Principal, EDC targets both males and females because full gender equality can only be realized if men and women are empowered. EDC builds the

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| capacity of officers in the MOESD to ensure that the project is mainstreamed throughout the Ministry. EDC will work with the Colleges of Education and the University of Botswana to mainstream Living in their teacher pre-service programs. EDC works with Stepping Stones International and the Department of Out-of-School Education and Training of MOESD, to train community facilitators and out-of-school youth. For quality assurance, EDC developed tools which will be used by Education Officers and School Management to monitor implementation. EDC will conduct annual National Education Summits where each region will present on the progress of Living. EDC will develop booklets on aspects of the training which will be accessible to all teachers and the communities. EDC will link with Tebelopele Voluntary Counseling and Testing Centers to provide a platform for teachers, officers and learners over age 15 (age of consent is 16) to test for HIV. EDC will conduct monitoring activities each year to establish the extent of implementation. EDC will use the findings from Project AIM as evidence-based programming to inform the direction of the project. In Year 4, EDC will develop protocols for summative evaluation which will be conducted in Year 5 and reported to MOESD. |

## Implementing Mechanism Details

| **Mechanism ID: 13316** | **Mechanism Name: Pediatrics** |
|---|---|
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Botswana Harvard AIDS Institute | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 100,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 100,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The Botswana Harvard Partnership (BHP) program has two goals: 1) to improve identification, care and treatment of children exposed or living with HIV and/or TB and 2) to build capacity of the Government of

Botswana to respond to HIV through training. A new activity in FY 2012 is a research study entitled “An Analysis of Risk Factors for Adverse Pregnancy Outcomes among HIV-infected and HIV-uninfected Women in Botswana and 2-year Infant Mortality by HIV Exposure, PMTCT Prophylaxis Strategy, and Feeding Method”. The first part of the protocol has already been completed and results disseminated in-country. The second part of the protocol involves a prospective study to follow HIV-exposed and HIV-unexposed infants for two years to identify risks for early mortality. High infant mortality, particularly among HIV-exposed infants, is a concern in Botswana. This study will describe two year morbidity and mortality among children in Botswana who are HIV-unexposed, HIV-exposed but uninfected, and HIV-infected. It will also describe survival by infant feeding strategy among HIV-exposed and HIV-unexposed children and HIV-free survival by PMTCT strategy among HIV-exposed children. Study findings will inform policy decisions regarding obstetrical and neonatal management, antiretroviral use in pregnancy, and early infant feeding recommendations for HIV-infected women. These findings will be applicable to other countries as well when disseminated through conferences and publications. This activity is in keeping with the GHI strategy which is focused on women and acceleration of results through research and innovation.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Child Survival Activities

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **13316** |
| **Mechanism Name:** | **Pediatrics** |
| **Prime Partner Name:** | **Botswana Harvard AIDS Institute** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | MTCT | 100,000 | 0 |

**Narrative:**

A new activity in FY 2012 is a two year infant mortality study examining HIV exposure, PMTCT prophylaxis strategy, and feeding method. Study findings will inform policy decisions regarding obstetrical and neonatal management, antiretroviral use in pregnancy, and infant feeding recommendations for HIV-infected women in Botswana and other countries as well.

This study will enroll newborn infants at 4 locations in Botswana: Francistown; Maun; Mochudi; and Ramotswa. Two additional locations may be added in the future, depending on accrual: Molepolole and Gaborone. Children will be followed until 24 months of age. Before discharge from the maternity ward to home, women will be approached by trained research assistants and asked to consent for basic follow-up of their child every 3 months until 2 years of age. This follow-up will occur either by direct contact or by a scripted cell phone interview.

In total, we will enroll 3,000 infants and follow them through 2 years of age. Enrollment will be restricted to 1,500 infants born to HIV-infected women, and 1,500 site-matched infants born to HIV-uninfected women. At birth, we will collect maternal and child demographics; maternal HIV status; and pregnancy and birth characteristics (including antiretroviral exposures). Infants born to HIV-infected women will have a heel-stick dried blood spot HIV PCR which will be stored for later testing if the child is found to be HIV-infected or if untested. Mothers who tested HIV-negative within the past 6 months will be asked to repeat HIV testing as available per Botswana government protocol. HIV-infected women who qualify for a CD4 or viral load test will be encouraged to receive this through the government, and results will be recorded. In addition, all women will have a finger stick for filter paper dried blood spot storage, for later viral load, genotyping, or HIV testing if required.

At 1, 3, 6, 9, 12, 15, 18, and 24 months of age, infants will be followed by trained research assistants who will complete a 10-minute questionnaire that includes vital status of the child and mother, hospitalizations, feeding method, infant HIV status, and PMTCT prophylaxis method if applicable. We will also capture geographic and seasonal information for all outcomes. This will occur by calling the cell phone number(s) provided. Mothers or caregivers who cannot be located will be scheduled for direct follow-up by research assistants.

The goals of the study are to 1) to describe 2-year mortality among children in Botswana who are HIV-unexposed, HIV-exposed but uninfected, and HIV-infected; 2) to describe HIV-free survival by maternal PMTCT strategy among HIV-exposed children; and 3) to describe HIV-free survival by infant feeding strategy among HIV-exposed children.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Treatment | PDTX | 0 | 0 |

**Narrative:**

The pediatric program goals are to 1) improve identification of and the care and treatment for children and adolescents exposed or living with HIV and/or TB and 2) build the capacity of the Government of Botswana's HIV/AIDS response through collaborative training. The pediatric program has provided site support and clinical mentoring, in-service lectures, set up pediatric treatment failure registries, contributed to the pediatric TB algorithm, offered telephone support for pediatric queries, and followed up with sites for initiation of positive HIV results. The pediatric program has also provided clinical mentoring and lecturing for the new University of Botswana School of Medicine residents. Training has lagged behind due to non-completion of the adolescent HIV training manual and changing of almost all HIV-related programs necessitating material review and updating. The program should get on track this financial year. Botswana Harvard AIDS Institute will continue to support capacity building in all segments of pediatric HIV/AIDS treatment and care through updating of knowledge of best practices, providing pediatric clinical training, mentoring, and supporting health personnel to ensure that minimum required standards of care are continually met. With HAART, more HIV infected children are entering into adolescence. Issues relating to adolescent care have assumed prominence. Although there are no clearly defined adolescent treatment guidelines, limited adolescent focused programs exist to address this emerging need. Botswana Harvard AIDS Institute in collaboration with other stakeholders will 1) develop a framework that comprehensively addresses adolescent HIV/AIDS treatment; 2) train ARV nurse prescribers and dispensers on pediatric HIV/AIDS treatment; 3) mentor and support the adolescent ART program; 4) complete the adolescent treatment and care training manual for health care providers; 5) train health care providers on the completed manual; and 6) coordinate access to other existing community-based adolescent resources and programs though integration of services.

## Implementing Mechanism Details

| **Mechanism ID: 13369** | **Mechanism Name: MEASURE Evaluation Phase III** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |

| Prime Partner Name: University of North Carolina at Chapel Hill, Carolina Population Center | |
|---|---|
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 100,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 100,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

MEASURE Evaluation Phase III continues the program's ten year initiative to improve the collection, analysis and presentation of data to promote better use in planning, policymaking, managing, monitoring, and evaluating of population, health, and nutrition programs. The program aims to accomplish this through achieving the following six results: increased user demand for data and tools, increased individual and institutional capacity in monitoring and evaluation; increased collaboration and coordination in obtaining and sharing health sector data; improved tools, methodologies and technical guidance; increased availability of data, methods and tools, and increased facilitation of data use.

In Botswana in 2010, MEASURE Evaluation provided training and support to introduce routine data quality assessments (RDQA) to PEPFAR implementing partners. The next step will be to guide the Government of Botswana to develop a strategy, tools and implementing plan to institutionalize RDQAs in the Ministry of Health (MOH) Monitoring and Evaluation system. With FY 2011 funding, the preliminary plan has been developed and a series of pre-testing and training activities are set to begin in early 2012. Funds will be need in FY 2012 to fully fund the program so that it will be institutionalized within the MOH.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 40,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

(No data provided.)

## Budget Code Information

| Mechanism ID: | 13369 | | |
|---|---|---|---|
| Mechanism Name: | MEASURE Evaluation Phase III | | |
| Prime Partner Name: | University of North Carolina at Chapel Hill, Carolina Population Center | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Governance and Systems | HVSI | 100,000 | 0 |

**Narrative:**

Quality data is a cornerstone for evidence-based decision making. Although Botswana has a relatively well-developed IT infrastructure, there are serious problems with data capturing, processing and reporting. Staff engaged in routine data capturing and reporting do not have the necessary training and skills. At management level, there is little understanding and support for data quality assessments.

To ensure that the data reported by different stakeholders implementing health programs meet the minimum standards for data quality, PEPFAR Botswana provided FY 2011 funds to the USAID Measure Evaluation project to support the MOH Department of Health Policy Development Monitoring and Evaluation (DHPDME) and the Technical Working Group for data quality to: 1) assist MOH to finalize the National Data Quality Action Plan; 2) adapt routine data quality audit tools to the Botswana context ; 3) develop standard operating procedures for data management; 4) Pilot test the tool and disseminate the SOPs: 5) develop M&E matrices for all MOH Programs; and, 6) develop a Health Data Management Strategy.

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| COP12 funds will support the last phases of implementation of the developed strategies and standard operating procedures. Support will also go towards building capacity of MOH staff to independently conduct data quality audits and to implement data quality improvement plans. |

## Implementing Mechanism Details

| **Mechanism ID: 13480** | **Mechanism Name: USAID - Local - GHCS (State) - MSH (674-A-00-10-00060-00)** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Management Sciences for Health | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 300,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 300,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Building Local Capacity (BLC) is a five-year project which aims to strengthen the sustainability, quality and reach of HIV/AIDS organizations to implement policies and health services for those infected and affected by HIV in Botswana, Lesotho, Namibia and Swaziland. In Botswana, the program contributes to achieving improved delivery of quality health care services through the application of leadership and management practices, utilization of service data, work climate improvement and sound management systems. The objective responds to 2 strategic objectives of Goal 2, Capacity Building and Health Systems Strengthening, of the Government of Botswana (GOB) National Strategic Framework II (2010-2016).

The program is presently being implemented in 13 health facilities. This number will increase in FY 2012 to 16 to meet received expressions of readiness for accreditation. It will continue to target health managers in the Ministry of Health's (MOH) Health Inspectorate and Clinical Services Departments and

District Health Management Teams (DHMTs).

Lessons learnt from FY 2011 have informed the adoption of an integrated approach of quality improvement and leadership (QIL) and introduction of activities to improve coordination and supportive supervision. This will reduce the number of workshops and overall costs. BLC will continue to explore incremental cost-share from GOB as it continues to demonstrate political will for the accreditation of public health facilities. Emphasis will be placed on technical assistance, accompaniment and participatory skills development for MOH staff and DHMTs to become better drivers of the accreditation process. BLC will continue to pursue and report on results-oriented indicators.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 100,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

(No data provided.)

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **13480** |
| **Mechanism Name:** | **USAID - Local - GHCS (State) - MSH (674-A-00-10-00060-00)** |
| **Prime Partner Name:** | **Management Sciences for Health** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and | OHSS | 300,000 | 0 |

| | | | |
|---|---|---|---|
| Systems | | | |

**Narrative:**

Botswana has had one of the most developed public health systems in Africa with impressive key successes in improving health indices. However, HIV/AIDS remains the most significant social and public health problem in the country and meeting the Millennium Development Goals is proving a major challenge. Responding to the HIV epidemic has severely stressed the otherwise strong health systems' foundation and quality has been compromised.

In response, BLC will focus on strengthening institutional systems across the three tiers of the national response, namely MOH, DHMTs and health facilities, so that they can continuously improve the quality of healthcare. From within the Management Sciences for Health global approach to system strengthening, BLC will adapt and develop targeted interventions to address the prioritized systems barriers articulated in the Botswana/USG Partnership Framework. BLC will provide technical assistance to build leadership and governance and empower teams to identify and overcome priority challenges that impede quality care. It will, in partnership with the Council for Health Service Accreditation in South Africa (COHSASA), continue to implement the QIL project to improve quality service delivery. BLC will incorporate coordination and supportive supervisory components to its assistance to enhance transparency, decision making, and accountability. BLC will also focus on human resources by using proven approaches, innovations, and tools to strengthen human resources management systems and improve workplace climate.

BLC will continue to partner with COHSASA to support the expressed interest in accreditation of public facilities to meet international standards of care. The program is presently being implemented in 13 health facilities. This number will increase in FY 2012 to 16 to meet received expressions of readiness for accreditation. In addition, BLC will facilitate the development of a pilot MOH quality improvement (QI) structure with representatives of the Gaborone, Serowe and Selebi Phikwe DHMTs to demonstrate continuous improvement of health care service delivery in 18 facilities in the first instance. BLC will assist in the development of operational systems for the structure that focuses on developing appropriate skills for leadership, coordination and scaling-up of the QI and accreditation process across Botswana. BLC and COHSASA will approach this in a way that the QI structure incrementally takes on the leadership and roles in the process by training appropriate staff to identify challenges and plan appropriate actions. BLC will work with the MOH to facilitate periodic stakeholder forums with representatives from USG and the three tiers to share and promote lessons from the BLC approach.

The QIL project is implemented to address the root causes of the challenges in improving service elements in facilities based on the COHSASA accreditation system with the understanding that improvements in the critical service elements of management, clinical services and clinical support services will lead to direct improvements in the broader HIV services such as HIV investigations and counseling, antiretroviral therapy dispensing and administration; and improvements of in-patient and out-patient care.

## Implementing Mechanism Details

| | |
|---|---|
| **Mechanism ID: 13563** | **Mechanism Name: Providing Technical Assistance for the Development of National Campaigns** |
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Population Services International | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 750,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 750,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

This is a continuation of a three year project to provide technical support to the National AIDS Coordinating Agency (NACA) to strengthen its capacity to develop the HIV/AIDS National Campaign. The goal of this project is to develop and implement strategic and multi faceted HIV prevention communication campaigns in order to increase the adoption of safer sexual behaviors and uptake of HIV prevention services. Through this project PSI Botswana aims to achieve the following objectives:

1. Increase opportunity, ability and motivation of the target population to reduce high-risk sexual behavior
2. Strengthen capacity of Government of Botswana (GOB) to design, plan, coordinate, implement and evaluate HIV communication campaigns
3. Develop a comprehensive monitoring and evaluation plan
4. Develop a sustainability plan that will ensure GOB's ability to design, plan, coordinate, implement and evaluate future HIV communication campaigns independently.

PSI Botswana will build the capacity of NACA and Ministry of Health (MOH) to develop and implement effective communication campaigns and structures through a participatory approach. This work will be

carried out across priority health districts to be agreed with MOH and NACA which could potentially include Gaborone, Francistown, Mahalapye, Lobatse, Kanye, Kweneng and Serowe.
Population Services International (PSI) Botswana will work with the District Multi-Sectoral AIDS Committees to engage community level civil society organizations (CSO) in the implementation of campaign activities.
PSI Botswana will also conduct quantitative formative assessments for the identified theme areas.
To build program efficiencies and achieve cost effectiveness, PSI Botswana will ensure campaigns use an integrated messaging approach.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **13563** |
| **Mechanism Name:** | **Providing Technical Assistance for the Development of National Campaigns** |
| **Prime Partner Name:** | **Population Services International** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Prevention | HVOP | 750,000 | 0 |

**Narrative:**

The goal of this project is to provide technical assistance to the Government of Botswana (GOB) to develop and implement strategic and multi faceted HIV prevention communication campaigns in order to increase the adoption of safer sexual behaviors and uptake of HIV prevention services. Through this project Population Services International (PSI) - Botswana aims to achieve the following objectives over the life of the project: 1) increase opportunity, ability and motivation of the target population to reduce high-risk sexual behavior, through supporting the current National SMC project; 2) strengthen capacity of GOB to design, plan, coordinate, implement and evaluate HIV communication campaigns by identifying and training 9 GOB campaign leaders; 3) develop a comprehensive monitoring and evaluation plan; and 4) develop a sustainability plan that will ensure GOB's ability to design, plan, coordinate, implement and evaluate future HIV communication campaigns independently.

PSI Botswana will build the capacity of the National AIDS Coordinating Agency (NACA), Ministry of Local Government (MLG) and Ministry of Health (MOH) to develop and implement effective communication campaigns and structures that can be maintained long term and institutionalized within NACA, MLG and MOH systems through a participatory approach. The campaign work will be carried out across identified priority health districts to be agreed with MOH, MLG and NACA which could potentially include Gaborone, Francistown, Mahalapye, Lobatse, Kanye, Kweneng, Maun and Serowe. The selection of health districts will however be finalized through upcoming consultations with stakeholders.

During the COP 11 period, PSI Botswana consulted with stakeholders to identify themes for the national campaigns relevant for the 15-49 year age range (inclusive of both men and women, rural and urban populations, and most at risk populations). Through a participatory effort with MOH, MLG and NACA, the themes selected for the national campaigns have been identified to be Safe Male Circumcision (SMC) and HIV Testing and Counseling (HTC). While qualitative formative assessments for both thematic areas will be conducted during the life of the project, in COP 12, PSI will conduct qualitative formative assessment for SMC, and for HTC in year two. In an effort to build program efficiencies and achieve cost effectiveness, in COP 12, PSI Botswana will use the Communication & Education budget in this project to support the existing SMC National Project. This budget will be used to increase the number of IEC materials, promotional materials, mass media and community events available to support the current national SMC project, pending agreement with key MOH, NACA and MLG stakeholders. Currently there are no PEPFAR indicators for mass media, so although this is likely to be a major activity area PSI will therefore not report on prevention indicators for number of people reached by individual or small group interventions. However, we will provide narrative updates in our quarterly reports.

## Implementing Mechanism Details

| | |
|---|---|
| **Mechanism ID: 13566** | **Mechanism Name: Expanding Access and** |

| | |
|---|---|
| | **Enhancing Quality of Integrated HTC Services** |
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Tebelopele Voluntary Counseling and Testing | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 5,150,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 5,150,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Botswana Christian AIDS Intervention Program | | |

## Overview Narrative

In collaboration with Government of Botswana (GOB), Tebelopele VCT Centers (TVCT) works to increase access to and utilization of high quality, integrated confidential Voluntary Counseling and Testing (VCT) & Provider- Initiated Testing and Counseling (PITC) services throughout Botswana.

TVCT services will reach men, women, youth and couples with increased efforts to reach under serviced groups like men and people in rural areas. To reduce the cost of outreach services, TVCT will identify and build capacity of local Civil Society Organizations (CSO) to provide services in remote areas. To leverage resources, TVCT will collaborate with Population Services (PSI) Botswana, CSO and GOB to strengthen linkages with Safe Male Circumcision (SMC). Innovative methods, including piloting point-of-care CD4 cell counting and use of cell phone technology will be evaluated and implemented to enhance post-test services and strengthen client referral. To complement GOB's Routine HIV Testing (RHT) program, TCVT will work with the Ministry of Health (MOH) and PEPFAR supported SMC partners to enhance counseling and testing in public health facilities in four to eight dedicated SMC sites. TVCT will further augment services by integrating psychosocial support, TB screening, risk reduction counseling, and support for disclosure to promote positive health, dignity and prevention.

TVCT will provide mentoring support to counselors and participate in MOH's quality assurance activities

for rapid HIV testing. TVCT's Monitoring and Evaluation (M&E) system will be reviewed to enhance tracking of clients and integration of new services. To enhance sustainability beyond PEPFAR, TVCT will work to expand its donor base through actively engaging GOB and other potential donors.

**Global Fund / Programmatic Engagement Questions**

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?

| Budget Code | Recipient(s) of Support | Approximate Budget | Brief Description of Activities |
|---|---|---|---|
| HVTB | Government of Botswana | 290000 | TB Screening using a questionnaire and referral to government health facilities |

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 400,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Mobile Population
TB

Workplace Programs
Family Planning

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **13566** | | |
| **Mechanism Name:** | **Expanding Access and Enhancing Quality of Integrated HTC Services** | | |
| **Prime Partner Name:** | **Tebelopele Voluntary Counseling and Testing** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HBHC | 600,000 | 0 |

**Narrative:**

With PEPFAR Botswana support, the Government of Botswana has developed the Positive Health Dignity and Prevention (PHDP) strategic plan (2009–2016) to harmonize and integrate the many prevention approaches in existing prevention, treatment, care, and support services in the country. A National PHDP Implementation Plan (2010 – 2016) was also developed to effectively guide implementation of activities and achieve the desired results. A civil society organizations' (CSO) PHDP Implementation Plan (2010 – 2016) was also developed to serve as a blue print for the effective implementation of activities related to People Living with HIV AIDS (PLWHA) and ensure the continuum of care between the health care facility and the community of PLWHA. The PHDP goal is to reduce new HIV infections, HIV re-infection, sexually transmitted infections and promote the well being of PLWHA. The strategic objective is to improve the quality of service delivery by providing integrated and comprehensive PHDP services. The CSO will complement Government of Botswana's (GOB) efforts by integrating and strengthening service provision to PLWHA. Implementation will be guided by the Botswana minimum package of PHDP services at health facility and CSO levels. During FY 2012, Tebelopele Voluntary Counseling and Testing (TVCT) will work closely with Ministry of Health (MOH) to integrate and deliver the minimum package of PHDP services at selected 5 high volume sites. As a first critical step, TVCT will work to ensure that HIV infected clients get linked to services and enrolled in post test services. To ensure early care and treatment, all HIV infected clients will be referred to the ARV treatment program and other relevant programs at both TVCT and GOB supported PITC and post-test services. PLWHA will be educated on the importance of correct and consistent condom use and will be provided with an adequate supply of condoms. In addition, risk reduction counseling will be provided to address partner reduction and alcohol reduction. All negative or unknown status partners of PLWHA will be offered HIV testing at least every year. Discordant couples will be identified and provided with appropriate prevention counseling and services. Regular Sexually Transmitted Infections (STI) verbal

screening and referral for treatment will be part of routine care and prevention for PLWHA. Provision of family planning education and counseling or safer pregnancy counseling will be provided to HIV-positive women and their partners as part of routine care to reduce unintended pregnancy and prevent maternal-to-child transmission. All HIV positive women will be referred for screening of cervical cancer. TVCT will work closely with the MOH in this endeavor to improve linkages and strengthen provision of PHDP services with the following targets during the reporting period: 1680 discordant couple counseling sessions, 9,456 clients referred for post test services, follow up of all clients referred will be conducted, psychological support services will be provided to 1,440 clients, STI verbal screening and referral to 660 clients, education and provision of male and female condoms to all PLWHA, which is an estimated 10,000 clients during the reporting period.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | HVSI | 250,000 | 0 |

**Narrative:**

Tebelopele Voluntary Counselling Testing and Centres (TVCTC) is engaged in an effort to improve its internal processes and data management capabilities. The current system has been identified to have deficiencies and weaknesses. The primary weakness emanates from the fact that data collection is done in stand-alone mode. This means software versions need on be managed for over 200 mobile workstations. Stand-alone applications also cause a weakness in the collaborative effort of managing clients and client codes nationally. Tebelopele will aim to establish a secure and centralized Client Management module that ensures improved management of client codes for a better referral, possible follow-up and overall improved client experience.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | CIRC | 300,000 | 0 |

**Narrative:**

Tebelopele will hire and train 15 counselors and place them at dedicated safe male circumcision (SMC) sites across the country. The counselors will provide HIV counseling and testing, pre and post operative counseling, post operation follow up, linking patients to care and treatment as well as partner and discordant couples counseling and testing.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVCT | 4,000,000 | 0 |

**Narrative:**

FY 2012 funds will support Tebelopele Voluntary Counseling & Testing (TVCT) Center's operations including personnel, infrastructure, management, logistics, supplies, and Monitoring and Evaluation (M&E) for the provision of VCT services to 106,000 clients (95% of these are clients >15 years). TVCT will intensify efforts in collaboration with civil society organizations (CSO) to target men in work places and through sports to increase the proportion of males receiving VCT from the current 46% to 50%. To strengthen counseling and testing in both VCT and routine HIV testing (RHT) settings, PEPFAR funds will also support the provision of counselor supervision, mentoring and support at regular VCT sites and at the dedicated SMC sites with a view of preventing counselor burn out and assuring the quality of counseling services.

To enhance its VCT services and maximize benefits to clients, FY 2012 funds will support TVCT in integrating other interventions into VCT services including Family Planning (FP) education and counseling, SMC education, counseling and referral, screening for Tuberculosis (TB) and alcohol abuse. TVCT will also provide Post-Test Club services including on-going prevention education, risk-reduction counseling, psychosocial support, and support for disclosure. Activities will include reviewing counseling protocols to incorporate counseling and screening for SMC, alcohol abuse and TB; targeted referral for both systems to ensure that men identified reach the SMC sites; and the development of TB screening tools. The review of protocols will include development of prevention messages to clients which reinforce those developed in Sexual Behavior Change Communication (SBCC) campaigns in the country.

TVCT will form key strategic partnerships aimed at introducing innovative and cost-effective HTC service delivery models. TVCT will partner with Population Services International (PSI)-Botswana to increase demand and uptake for HTC services. PSI –Botswana will support TVCT in designing evidence-based, social marketing models for HTC demand creation, branding and increasing awareness of HTC and addressing drivers of the epidemic. TVCT will partner with Botswana Christian AIDS Intervention Program (BOCAIP) and Humana People to People (HPP) to support youth VCT and community mobilization respectively. Additionally, ten CSO located in remote and hard-to-reach areas will be identified and trained to provide VCT services in those areas. This strategy will cut the cost of outreach and enhance sustainability. With FY 2012 funds, TVCTC will also collaborate with CDC/Botswana and Government of Botswana (GOB) to pilot point-of-care CD4 measurements and investigation using the VCT infrastructure to offer rapid CD4 tests.

To improve referral and referral linkage to onward care, support and treatment, TVCT plans to implement a new innovative referral strategy. PEPFAR funds will also support the piloting of cell phone Short Message System (SMS) -based technology to enhance client referrals.

## Implementing Mechanism Details

| Mechanism ID: 13646 | Mechanism Name: International Training and |
|---|---|

| | |
|---|---|
| | **Education Center for Health (ITECH)** |
| Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration | Procurement Type: Cooperative Agreement |
| Prime Partner Name: University of Washington | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 3,337,509** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 3,337,509 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

I-TECH is a collaboration between the University of Washington (UW) and the University of California, San Francisco (UCSF). I-TECH's mission emphasizes working with local partners to develop skilled healthcare workers, strengthening national health systems, and ensuring sustainability by promoting local ownership. I-TECH's strengths lie in the areas of health system strengthening, health workforce development, operations research and evaluation, and prevention, care and treatment of infectious diseases. Since 2004, I-TECH's overall goal in Botswana is to provide technical assistance to strengthen government health systems and to ensure that health care providers across the public and private sectors deliver high-quality care for HIV/AIDS patients in Botswana. I-TECH works in collaboration with the Centers for Disease Control and Prevention Global AIDS Program in Botswana, the Botswana Ministry of Health, the Ministry of Local Government, and the University of Botswana in the areas of health service delivery, human resources for health, and research.

I-TECH has also established strong linkages with other partner organizations such as the African Comprehensive HIV/AIDS Partnership (ACHAP), Botswana Harvard Partnership (BHP), Population Services International (PSI), Johns Hopkins program for international education in gynecology and obstetrics (jhpiego),Botswana University of Pennsylvania (UPENN) Partnership (BUP), and Associated Fund Administrators (AFA) in the private sector. I-TECH Botswana supports programs in care and support, prevention of mother to child transmission (PMTCT), tuberculosis (TB/HIV), laboratory

infrastructure (LAB), strategic information (SI), and other health systems strengthening (OHSS).

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Child Survival Activities

Safe Motherhood

TB

## Budget Code Information

| **Mechanism ID:** | **13646** | | |
|---|---|---|---|
| **Mechanism Name:** | **International Training and Education Center for Health (ITECH)** | | |
| **Prime Partner Name:** | **University of Washington** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Care | HBHC | 294,000 | 0 |
| **Narrative:** | | | |
| I-TECH has successfully collaborated with the MOH's National Sexually Transmitted Infections (STI) Training and Research Center (NSTRC) to improve management of STI in primary care settings in Botswana. I-TECH assisted the NSTRC in designing and implementing a training package on the revised national STI syndromic management guidelines and the STI training curriculum. I-TECH also | | | |

helped train more than 5,000 HCW using the STI curriculum and strengthened the NSTRC's supportive supervision and monitoring and evaluation capabilities by training district trainers. In 2007 I-TECH began supporting the NTSRC to implement clinical mentoring among their district trainers and healthcare providers. I-TECH also supported the STI unit to develop useful training materials including the "STI Trigger" video, and the "Sensitive Pelvic Examination" video. The STI program illustrates the two core principles of GHI namely building sustainability through health system strengthening and encouraging country ownership and investing in country led plans. In FY 2010, I-TECH supported salaries for an STI Regional Coordinator and Principal Health Officer working with most at risk populations (MARPS). In FY 2011, I-TECH supported the salary for the STI Principal Health Officer (PHO). With I-TECH providing technical assistance, the STI unit developed guidelines for sexual partner tracing (SPT) and distributed SPT slips to 29 districts. Through I-TECH support, an operational plan for MARPS was developed and 20 health care workers (HCW) and 10 peer educators were trained to provide services to MARPS. Sex workers in Gaborone and Tlokweng were screened to establish baseline information. In FY 2012, salary support will be provided to the STI PHO. The PHO will assist with the coordination and implementation of STI activities including supportive supervision, clinical mentoring, HIV/STI surveillance, support of the NTSRC, and monitoring and evaluation of STI programs. In FY 2012, I-TECH will second a women's health program manager (WHPM) to the Department of Public Health at the MOH to scale up cervical cancer "see and treat" implementation. The scale up was recently sanctioned by the MOH after a successful pilot conducted by the Botswana UPenn Partnership proved that "see and treat" is a viable option for Botswana. The WHPM will conduct a needs assessment, develop a comprehensive operational plan together with other stakeholders, and oversee implementation and coordination of activities related to the scale up. There are no direct PEFPFAR targets for these seconded positions. I-TECH successfully transitioned and integrated the STI activities it supported into the STI unit at the MOH. I-TECH will ensure a transition plan is developed for the absorption of the seconded STI PHO. I-TECH will ensure the cervical cancer "see and treat" operational plan has key stakeholder buy- in.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HVTB | 900,000 | 0 |

**Narrative:**

Tuberculosis (TB) remains a major public health problem in Botswana. The 2009 prevalence rate according to the World Health Organization was 694 per 100,000 while the co-infection rate with HIV was 66%. Multi-drug resistant TB (MDRTB) is also on the rise with an estimated 220 and 150 cases among new and retreatment patients respectively. Results from MDRTB studies indicate that Mycobacteria other than tuberculosis (MOTT) contribute to a number of pulmonary infections and are treated with ineffective TB treatment regimes. I-TECH supports the Botswana National Tuberculosis Program (BNTP) in line with the GHI core principles of building sustainability through health system strengthening,

promoting learning and accountability through monitoring and evaluation (M&E), and accelerating results through research. In 2007, I-TECH helped develop a TB training curriculum for healthcare workers (HCW) in collaboration with several partners. Over 3,000 HCWs have since been trained using the curriculum. In subsequent years, I-TECH has supported clinical mentoring in four districts and improved clinical outcomes for patients with TB. I-TECH's M&E support has improved data quality and strengthened national systems. TB data is currently utilized to make programmatic decisions in all districts in Botswana. I-TECH is currently conducting research on MOTT to better understand the epidemiology of the disease and associated risk factors in Botswana as well as to provide appropriate treatment options. In FY 2012, I-TECH will continue to support five seconded positions at the BNTP, namely physician trainer, physician mentor, nurse trainer/mentor, M&E specialist, and M&E understudy. I-TECH will conduct four national TB clinical case management trainings for 100 HCW, two TB/HIV training of trainers for 50 HCWs, and four MDRTB clinical seminars for 100 TB clinicians. Mentoring support will expand to 13 districts. M&E systems will continue to be strengthened both at the national and district level through regular data audits and feedback. I-TECH will conclude the MOTT study during FY 2012. I-TECH will develop and finalize plans for transitioning seconded positions and programs to the MOH consistent with PEPFAR II and GHI goals. The PEPFAR indicator relevant to these activities is H2.3.D "number of HCW trained who successfully completed an in-service training program". I-TECH has established strong linkages with other organizations that play important roles in supporting BNTP activities including the African Comprehensive HIV/AIDS Partnership (ACHAP), Botswana UPENN Partnership, and the Global Fund. BNTP leads all TB programs thus ensuring local ownership and sustainability. I-TECH will work with BNTP to ensure that the MOH absorbs seconded staff and that appropriate capacity is built within the unit.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | HLAB | 680,000 | 0 |

**Narrative:**

The HIV/AIDS epidemic in Botswana has resulted in a need for highly skilled laboratory personnel who have specialized diagnostic and management skills. The MOH has made training and placement of medical laboratory scientists a top priority. I-TECH has utilized its extensive global experience in strengthening laboratory services to support MOH and the University of Botswana (UB) in addressing this need. I-TECH's support for laboratory infrastructure is in line with GHI core principles of building sustainability through health systems strengthening and encouraging country ownership and investing in country-led plans. In 2007, I-TECH seconded a laboratory scientist to the Botswana Harvard HIV Reference Laboratory (BHHRL) to build capacity through training and to perform DNA PCR testing for HIV-exposed infants. In 2008, in collaboration with the UB and MOH, I-TECH supported the

establishment of a Bachelor of Science (BSc) degree in medical laboratory sciences (BSc MLS). Quality assurance and quality control (QA/QC) are critical components of good laboratory practice. Since 2008, I-TECH has collaborated with the national quality assurance laboratory (NQAL) to strengthen QA/QC activities in Botswana by seconding key staff to the NQAL. Three seconded laboratory scientists perform QA/QC activities and build capacity of laboratory and non-laboratory based health care workers (HCW) in testing and good laboratory practice. I-TECH has achieved several notable accomplishments. Since the onset of support, DNA PCR turnaround times at the BHHRL have dropped from six weeks to one week. DNA PCR specimen rejection rates have dropped from 6% to 2% due to rigorous training of HCW. I-TECH staff at the NQAL has trained over 1,800 laboratory and non-laboratory based HCWs in rapid HIV testing. All public laboratories in Botswana participate in proficiency testing and QA/QC pass rates for laboratories have increased from 49% to 98 %. Three public laboratories in Botswana are now accredited; a number of others are working towards accreditation. At UB, I-TECH seconded three key personnel who have developed and supported a one-year bridging program which aims to upgrade laboratory technicians to laboratory scientists. A total of 29 laboratory scientists have graduated from two intakes so far. A third intake of laboratory technicians has recently joined UB and will graduate in 2012. Meanwhile a four-year BSc MLS curriculum has been developed at UB through I-TECH support in order to further augment the bridging course and produce more laboratory scientists. The first intake for this program will commence in August 2012. In FY 2012, I-TECH will support salaries, travel, and professional development of three laboratory scientists at NQAL, one laboratory scientist at BHHRL, and the program coordinator at UB. There are no direct PEPFAR indicators for I-TECH seconded positions. I-TECH has strong linkages with other stakeholders in laboratory programs such as the Institute of Health Sciences and the American Society of Microbiology. I-TECH's laboratory programs strive toward sustainability. Through pre-service training and other capacity building activities, Botswana will have a skilled workforce that will support laboratory systems into the future. I-TECH will work closely with the MOH and UB to develop a transition plan for seconded positions and programs.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | HVSI | 763,509 | 0 |

**Narrative:**

Health data is critical for ensuring accountability, appropriate policy formulation, program improvement, and appropriate resource allocation. However, in Botswana, monitoring and evaluation (M&E) is a relatively new field and health information systems are not well harmonized. Strengthening strategic information systems within the Ministry of Health (MOH) will benefit not only HIV/AIDS programs but also other public health programs targeted by the Global Health Initiative (GHI). I-TECH is well-positioned to support strategic information (SI) activities due to its achievements in support of national surveillance

systems, national M&E systems, and national Health Information Management Systems (HIMS).
Since 2007, I-TECH played a key role in developing a new M&E cadre: district M&E Officers. I-TECH successfully transitioned this project to the Government of Botswana in FY2010. Since 2008, I-TECH has provided technical assistance to the MOH through the secondment of a Senior Epidemiologist and M&E Specialist. In 2009, I-TECH also conducted a national Data Quality and Data Flow Assessment to inform SI needs. I-TECH has worked with the MOH to upgrade the District Health Information Systems (DHIS) software to a web-based version. Additionally, in 2010, I-TECH collaborated and subcontracted to a local partner, the Botswana Association for Positive Living (BAPL), in the creation of a health data messaging service to improve HIMS interoperability.
FY 2012 funds will continue to support national surveillance, M&E, and HIMS activities which are in-line with the GHI philosophy of helping to 'build on and expand existing country-owned platforms'.
To strengthen surveillance systems and build local technical skills, funds will be used to continue seconding a Senior Epidemiologist to the Department of HIV/AIDS Prevention and Care as well as an M&E Specialist to the Department of Health Policy, Planning, Monitoring, and Evaluation (DHPDME). Plans to fully transition these positions to the MOH will be finalized. Additional support to DHPDME will include building the M&E capacity of the District Health Management Teams; increasing the use of the DHIS; and improving the timeliness of national morbidity and mortality statistics.
I-TECH has built strong partnerships with multiple organizations working to strengthen strategic information (SI) systems in Botswana and will continue to utilize these resources to build support for the implementation of SI activities. I-TECH's experience with district M&E systems will be utilized to support activities related to strengthening DHPDME.
There are no relevant PEPFAR indicators for these activities.
Transition plans will be finalized for the MOH to absorb or graduate seconded staff positions. Country ownership will be promoted by aligning activities with country-owned plans and objectives related to SI.
The implementation of new technologies related to HIMS is in-line with the GHI philosophy of 'innovate for results'.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | OHSS | 500,000 | 0 |

**Narrative:**

The Ministry of health like many other government entities faces serious project implementation challenges. Among the worst affected have been donor funded projects which in most cases have lacked internal oversight and leadership to ensure that they are delivered on time and on budget. In light of this, in 2009, MOH established a project management office (PMO) to help plan, manage and coordinate MOH projects. In 2011 the PMO evolved into an office of strategy management (OSM) which

is expected to provide a comprehensive solution to the problems of project management and operational strategy. The success of the OSM is dependent on strong leadership and project management expertise.

I-TECH continues to meet the GHI goal of “collaborating for impact” by supporting strategic secondments at MOH.

Since FY 2011, I-TECH has seconded the manager in the OSM to oversee MOH strategy development and implementation of critical initiatives through project management and performance improvement measures. In addition, I-TECH has seconded a Finance Advisor to the MOH department of HIV/AIDS prevention and care (DHAPC) to monitor and strengthen systems for effective utilization of PEPFAR funds.

In FY 2011, I-TECH provided technical assistance to begin building the capacity of the MOH OSM and PMO to lead strategic planning and develop a country-owned plan that improves coordination among the Government of Botswana, donors, and partners. In addition, priority MOH projects were scoped with MOH department and project leads and the management of these key projects commenced. In the same fiscal year, I-TECH built the MOH DHAPC capacity to effectively budget, monitor, and report on PEPFAR expenditures, with a goal of improving programmatic implementation and fiscal management.

FY 2012 funds will be used to continue to second the manager of OSM to oversee MOH strategy development and implementation and to second the DHAPC Finance Advisor to monitor PEPFAR expenditures and strengthen systems for effective utilization of funds. Linkages with MOH departments, PEPFAR and other donors have been established as a result of OSM activities. The Finance advisor has forged partnerships with the National AIDS Coordinating Agency (NACA) and MOH constituents receiving PEPFAR funds.

Secondment of the OSM manager is a key investment in a country-owned and coordinated health plan for long-term sustainability. Secondment of the Finance Advisor builds DHAPC’s capacity to manage funding for effective program implementation.

I-TECH will work closely with the MOH on a transition plan for these secondments in FY 2012.

In 2007, the MOH introduced a PEPFAR-supported wellness programme to ensure the wellness of healthcare workers and improve employee morale and productivity. It is anticipated that the wellness program through its productive employees will meet the goals of the OSM. In keeping with the GHI philosophy of “innovate for results,” it is important to evaluate this approach to improving the effectiveness and sustainability of the healthcare system. I-TECH is well-positioned to conduct this evaluation, having completed several other national evaluations in Botswana. In FY 2012, I-TECH will conduct an evaluation of the Wellness Program to document the outcomes and achievements, identify areas for program improvement in Botswana, and provide guidance for other countries implementing similar programs.

There are no PEPFAR targets relevant for these activities.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Prevention | MTCT | 200,000 | 0 |

**Narrative:**

Prevention of Mother to Child Transmission (PMTCT) coverage and effectiveness is a PEPFAR program priority for FY 2012. Through support from PEPFAR, the Government of Botswana and other partners, Botswana boasts a very robust PMTCT program, with uptake reported at 94% in 2010. In line with the Global Health Initiative philosophy of 'do more of what works', it is important to continue to support the PMTCT program. To maintain the gains on this investment, it is critical to ensure that national, district, and clinical site levels have the capacity to routinely collect high-quality data and use this data to monitor the quality of PMTCT services. Since FY 2008, I-TECH has been involved in a number of activities to support improvements in PMTCT data quality, management, and utilization.

I-TECH has supported the PMTCT Data Manager position at the Ministry of Health (MOH) since October 2008. This includes supporting the Data Manager to provide training and supportive supervision in the field. I-TECH also supported the revision of the national PMTCT data collection tools and registers to ensure that these instruments were relevant and in-line with revised treatment guidelines. Additionally, I-TECH has supported the rollout of an electronic medical records system to improve capture of patient-level PMTCT data. To improve data use, I-TECH provided training for national PMTCT staff on the use of statistical analysis software. Finally, I-TECH has engaged Document Management System (DMS) to conduct ongoing entry of data related to early infant diagnosis. In FY 2010, I-TECH began the process of transitioning this activity to the MOH.

In FY 2012, funds will support the secondment of the Data Manager to the PMTCT Unit. Funds will also support the Data Manager's quarterly travel to the field to conduct data audits and provide training and support to the districts and facilities. Funds will continue to support a vendor agreement with DMS for entry of early infant diagnosis data.

I-TECH will ensure that initiatives to improve PMTCT data quality and use are integrated into Strategic Information activities through work at the national-level with the Department of Policy, Planning, Monitoring, and Evaluation and through work at the district-level with Monitoring and Evaluation (M&E) Officers.

The PEPFAR indicator relevant for these activities is H2.3.D: Number of health care workers who successfully completed an in-service training program (PMTCT). The target will be 60 health care workers trained by the Data Manager on activities related to data quality and data use to ensure implementation of quality PMTCT service provision.

To promote sustainability, FY 2012 activities will include transitioning activities conducted by the Data Manager and by DMS to MOH by the end of the year. During the year, the PMTCT Data Manager will continue to provide training and build the capacity of health care workers in the districts and at the facilities to be able to effectively utilize the data systems. This will strengthen the PMTCT program further.

## Implementing Mechanism Details

| **Mechanism ID: 13669** | **Mechanism Name: OVC-Gender** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Project Concern International | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 3,490,380** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 3,490,380 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Project Concern International's (PCI) Botswana OVC and Gender Project, funded by PEPFAR through USAID, will improve the quality of life of OVC and their parents/caregivers and improve gender-based responses and programming in HIV/AIDS activities in Botswana. PCI/Botswana will achieve this in close partnership with implementing organizations Catholic Relief Services (CRS), Hope World Wide Botswana (HWWB), Humana People to People (HPP), Marang Child Care Network Trust (MCCNT); the Government of Botswana (GOB); and a diverse array of community and private sector organizations. The project will operate in Central, Kweneng, Southern, Southeast, Chobe, Francistown, Northwest, Ghanzi, and Kgalagadi Districts while helping to catalyze enhancements in other districts through national initiatives. The program is designed to achieve the following four objectives: livelihoods of households for vulnerable adolescents, especially girls and vulnerable women, improved; developmental interventions for vulnerable children and adolescents improved; risk of neglect, exploitation and abuse of vulnerable children, adolescents and women reduced; development, implementation and coordination of national frameworks and policies that address the needs of children and women improved. These objectives and related results will be achieved through the following key methodologies: community mobilization; gender analysis and mainstreaming; comprehensive family care (CFC); The GROW Model of community development and household economic strengthening and integrated early childhood development (IECD).

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Economic Strengthening | 300,000 |
| Education | 500,000 |
| Food and Nutrition: Commodities | 75,000 |
| Food and Nutrition: Policy, Tools, and Service Delivery | 25,000 |
| Gender: Reducing Violence and Coercion | 400,000 |
| Human Resources for Health | 693,829 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **13669** |
| **Mechanism Name:** | **OVC-Gender** |
| **Prime Partner Name:** | **Project Concern International** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Care | HKID | 2,940,380 | 0 |

**Narrative:**

In partnership with the Department of Social Services (DSS) and eight (8) local implementing partners PCI will continue to strengthen services provided to orphans and vulnerable children (OVC) and their families. PCI will support District Child Protection Committees (DCPC) in project districts to mobilize communities using the Journey of Life (JOL) and Community Conversations models that identify and assist vulnerable families and children and create a supportive environment. Using the Comprehensive Family Care model, partners' skills will be strengthened to assess and register families for services and monitor action plans developed at the community level. To further strengthen the community mobilization component, PCI will work with NACA and other stakeholders to roll out the National Community Mobilization Strategy.

PCI partners will provide financial literacy and small business management skills to older OVCs both boys and girls. Partners will identify and link young people with small business grants provided by the Government of Botswana (GOB) through the Citizen Entrepreneurship Development Agency (CEDA) and the Ministry of Youth Sports and Culture (MYSC). In partnership with Local Enterprise Authority (LEA), those who receive grants will be supported with skills to monitor the small businesses. Partnerships will be established with local financial and other businesses to assist with job readiness skills development activities including training, mentoring, and financial support. Based on the value chain assessment of entry level employment carried out in the past year, PCI will work with the Botswana Confederation of Commerce, Industry and Manpower (BOCCIM), the Ministry of Labor and Home Affairs (MLHA), the MYSC, and Botswana National Youth Council to pilot test activities that will strengthen the link between training provided by vocational institutions and companies needs. Business professionals will be mobilized to provide pro bono services through their corporate social responsibility programs to assist in skills development among young people. Towards building skills of young people in information communication technology (ICT), PCI will pilot ICT café schemes in partnership with PING, a local IT NGO, and BOTHO College in some project districts.

In partnership with the Ministry of Education (MOE), DSS and Marang, PCI will mentor and coach partners to develop and implement integrated early childhood development (IECD) action plans. By working hand in hand with District Child Protection Committees (DCPC), PCI will build local capacity and ensure that community level IECD services are managed according to GOB guidelines and are sustained after the project ends. PCI will provide in-service training to staff and volunteers from local community organizations on developing, implementing and monitoring IECD activities and will provide support in monitoring the work of parents-teacher associations on IECD. IECD master trainers from PCI implementing partner organizations will assist community organizations to develop community-based low cost IECD services and ensure proper case management of the children registered for services.

Mentoring and technical support will ensure that the most vulnerable children have access to services including life skills training for young people and support for special groups such as HIV+ teens.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | OHSS | 150,000 | 0 |

**Narrative:**

PCI will provide technical assistance and local cost support to WAD and DSS to implement OVC and gender policies and laws including the National Gender and Development Policy, the Children's Act of 2009, and the Domestic Violence Act. PCI will work very closely with a local partner Marang to do this work. Gender sensitization and mainstreaming activities will be organized and carried out by District Multi-Sector AIDS Committees (DMSAC), District Child Protection Committees (DCPC), District Health Management Teams (DHMT), District Youth Councils (DYC), gender-based violence service providers, and other community organizations. PCI will provide technical assistance to WAD District Gender Officers to coordinate and plan gender interventions at district level through the DCPCs, traditional leaders and other districts structures; develop gender interventions to address gender based violence; and promote collection of data for gender disaggregated reporting at DMSAC level.

PCI will support WAD to strengthen the National Gender Commission/Council once it is formed and ensure linkages with the National Children's Council. DSS will be provided with technical support to strengthen the National Children's Council and ensure linkages with DCPCs. PCI will work with the Ministry of Education Preschool Division in the dissemination of the revised National Policy on Integrated Early Childhood Development through different national and district forums. Technical support will be provided to WAD and DSS to submit scheduled international and regional reporting commitments on gender equality and children's rights.

PCI will collaborate with FHI360 to provide technical guidance to NACA, DSS, WAD and the Ministry of Local Government in the use of data for planning. Through this team PCI in collaboration with FHI360 will provide technical support in the use of tools for data collection to ensure that they are appropriately applied in collecting gender-disaggregated data and used for gender analysis.

In partnership with WAD, DSS, Marang and DCPCs, PCI will support the development and implementation of regional children's forums in accordance with the Children's Act to increase participation of children in policy planning and implementation. PCI will also work with WAD and DSS to review their systems, structures and skills to determine the capacity support areas needed to enable them to effectively lead gender and OVC programming in Botswana. PCI will support DSS and WAD to carryout national campaigns including Sixteen Days of Activism against Violence on Women, Family Day, and the Day of the African Child as platforms highlighting key messages on the rights of children and women and gender issues.

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | HVOP | 400,000 | 0 |

**Narrative:**

PCI will provide technical support and sub-grants to implementing partners to roll out gender interventions and lead in facilitating coordination with other stakeholders in the program districts. The approach has three core elements: promotion of gender equality; engagement of men/boys and women/girls; and, fostering of resiliency in the face of gender-related threats to health and well-being of both sexes. PCI and implementing partners will conduct activities to promote gender equity and will work with Women's Affairs Department (WAD) in the implementation of policies that promote and protect women and children's rights. Activities will include: strengthening WAD systems for enforcement of policies and laws; engaging young people, including boys and young men to develop innovative projects to address gender among youth; providing technical support to WAD in collaboration with National AIDS Coordinating Agency (NACA) to conduct a gender audit of the national response on HIV/AIDS. Community mobilization approaches such as Journey of Life (JOL) and Community Capacity Enhancement for Community Conversations (CCE-CC) will be used as tools to facilitate dialogue amongst communities on gender-related attitudes and practices and to promote positive attitudes and behaviors for men/boys and women/girls that will address the gender-related drivers of the AIDS epidemic in Botswana.

PCI activities to address gender-based violence (GBV) will be implemented with Kagisano Women's Shelter Project and other stakeholders such as Childline. These activities will include: identification of safe havens for survivors of abuse; dissemination of simple user-friendly guides on the major laws affecting women and children; use of sports to motivate men to be role models and initiation of "man make a difference" support groups to change male norms on gender; support to strengthen established GBV referral systems; and, community awareness raising on inheritance and property rights of women and children. PCI will work with WAD and other stakeholders to identify, document and disseminate promising gender-related practices. Additionally, PCI will implement a youth project with PING, a local IT NGO, around youth behavior change, gender and sexual reproductive health using Information Communication Technology (ICT) through Young Africa Live activities that include health discussions using cell phones and internet; interactive amplification platform to generate public peer group dialogue; and, linking with referral points for services. PCI will use this platform to raise awareness on GBV and factors that facilitate it among youth in order to identify and implement interventions that will reduce GBV and HIV transmission.

PCI activities to address economic strengthening and livelihoods will be based on the Grassroots Building our Own Wealth (GROW) model for savings and loans to partners following the initial training and adaptation of the model. Groups of women in project districts will be trained and mentored on GROW savings and loans. Specifically Kgetsi Ya Tsie will be supported with technical assistance and

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| grants to manage GROW savings and loans and other livelihoods initiatives including Food for Life and Honey for Life that will empower women and contribute to the reduction in HIV transmission. |

## Implementing Mechanism Details

| **Mechanism ID: 13780** | **Mechanism Name: FHI PTA** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: FHI 360 | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 200,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 200,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The Botswana HIV/AIDS National Strategic Framework II (NSF II 2010-2016) calls for an increase in HIV prevention services for most at risk and hard to reach populations as a key prevention strategy. However, very little is known about sub-populations in Botswana thought to be at highest risk of HIV infection including sex workers, sexual minorities, prisoners, and people who inject drugs (PWID). In 2010, the Ministry of Health (MOH) requested PEPFAR support to design and conduct an integrated behavioral and biological surveillance survey (BBSS) to generate baseline information on the incidence and prevalence of HIV, the prevalence of other sexually-transmitted infections (STI), and the risk factors for HIV among the most at risk populations of female sex workers (FSW), men having sex with men (MSM), and PWID. The information gathered by this study will help the MOH and its partners to better plan and target programs and interventions to reduce the spread of these infections among these sub-populations. In FY10 and 11, USAID reprogrammed $400,000 to support this effort, but due to the high cost of STI testing, an additional $200,000 is required to fully fund the survey, which is scheduled to begin in June 2012.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

(No data provided.)

## Budget Code Information

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|---|---|---|---|
| **Mechanism ID:** | **13780** | | |
| **Mechanism Name:** | **FHI PTA** | | |
| **Prime Partner Name:** | **FHI 360** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Prevention | HVOP | 200,000 | 0 |

**Narrative:**

Very few studies have been conducted on most-at-risk populations in Botswana. Given the relatively limited information available about FSW, MSM and PWID sub-populations, there is a need for robust data to determine whether they contribute disproportionately to HIV transmission. As a result, a bio-behavioral survey, which would generate accurate data on the population size of these sub-populations, their risk behaviors, HIV prevalence and HIV incidence was deemed crucial for Botswana's response to the HIV epidemic, particularly as it relates to policy development, the planning and targeting of interventions, and resource allocation decisions.

The specific objectives of this study are to: 1. estimate the incidence and prevalence of HIV infection

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| among FSW, MSM and PWID in Botswana; 2. estimate the size of the FSW and MSM populations in three districts of Botswana; 3. measure the prevalence of syphilis, gonorrhea, and Chlamydia among FSW, MSM and PWID; 4. identify the main risk factors for HIV and other STIs among FSW, MSM and PWID in Botswana; and, 5. strengthen the capacity of local institutions to conduct mapping, size estimation, and integrated biological and behavioral surveillance of HIV and other STIs among these sub-populations in Botswana.<br><br>The design and implementation of this study is a collaborative effort led by the MOH Department of HIV/AIDS Prevention and Care and the National Health Laboratory including the Botswana-Harvard AIDS Institute for HIV Research and Education, with technical assistance and funding from FHI 360 through the Preventive Technical Assistance (PTA) Project. Local non-governmental and community-based organizations working with the targeted sub-populations are also participating in the design and implementation of the study including the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) and Nkaikela Youth Group. |

## Implementing Mechanism Details

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|---|---|
| **Mechanism ID: 14481** | **TBD: Yes** |
| **REDACTED** | |

## Implementing Mechanism Details

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|---|---|
| **Mechanism ID: 14487** | **Mechanism Name: African Health Workforce Project** |
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Association of Schools of Public Health | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

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|---|---|
| **Total Funding: 100,000** | **Total Mechanism Pipeline: N/A** |
| **Funding Source** | **Funding Amount** |

| | |
|---|---|
| GHP-State | 100,000 |

## Sub Partner Name(s)

| | | |
|---|---|---|
| Emory University | | |

## Overview Narrative

The Association of Schools for Public Health is a cooperative agreement that supports U.S. universities to advance public health research and programs domestically and overseas. The scope of work includes health workforce development and specifically the African Health Profession Regulatory Collaborative for Nurses and Midwives (ARC). ARC is a four year regional initiative with the following objectives: 1) Ensure that global quality standards of practice are harmonized in the East Central and Southern Africa Health Community (ECSA) region; 2) Ensure that national regulatory frameworks are updated to reflect nationally approved reforms to practice and education; 3) Strengthen the capacity of regulatory councils to conduct key regulatory functions; and 4) Establish sustainable African health leadership in nursing and midwifery practice and regulation.

The geographic coverage for ARC includes the 14 countries of ECSA. The target population is the nursing and midwifery leadership of these countries, drawn from the nursing council, ministry of health (MOH), nursing association, and educational institutions. The strategy for cost efficiency and transition to partner government is to build the capacity within ECSA to incrementally assume full management of the initiative over the four year period. ECSA is a regional African inter-governmental health organization that promotes regional cooperation in health among member states. Monitoring and evaluation plans include development of a scientific framework that documents the progress of participating countries and regulatory changes relative to baseline indicators. It also includes monitoring of country planning processes and the degree to which program plans are implemented.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 100,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

(No data provided.)

## Budget Code Information

| Mechanism ID: | 14487 | | |
|---|---|---|---|
| Mechanism Name: | African Health Workforce Project | | |
| Prime Partner Name: | Association of Schools of Public Health | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Governance and Systems | OHSS | 100,000 | 0 |

**Narrative:**

PEPFAR has encouraged key reforms in the pre-service education, tasks, and training of nurses and midwives in Botswana, which are not reflected and institutionalized in the legislative and regulatory framework governed by the Council. This is due in part to weakness in the institutional capacity of the Nursing and Midwifery Council of Botswana (NMCB). NMCB, along with a team from MOH participated in the first ARC workshop in Nairobi in 2011, but were unsuccessful in their bid for the first round of support. In FY 2012, ARC will invite a national leadership team from Botswana to participate in a south-to-south collaborative, whereby the Registrar, Chief Nursing Officer, representatives of the nursing and midwifery council and the professional association, and member of the academic sector will work together to achieve measurable improvement in an area of regulation that they prioritize and define. ARC will support the team's achievement through a direct grant, ongoing technical assistance, and by supporting the participation of the team in quarterly ARC 'learning sessions', where the Botswana team will learn and share with four other country teams in the region working on similar activities, as well as contribute to key tools and resources made available for the region, through collaborating partner ECSA. Example activities include: creating a continuing professional development program, revising scopes of practice, and creating advanced cadres. ARC will further conduct institutional strengthening of the council, through training and mentorship in planning, grants and project management, monitoring and evaluation, and quality improvement. Linkages across functional areas include tackling this key systems issue in

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| workforce development while also enhancing leadership and governance of the health system by national and regional African institutions. |

## Implementing Mechanism Details

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|---|---|
| **Mechanism ID: 14488** | **Mechanism Name: Building global capacity for diagnostic testing of TB, Malaria & HIV** |
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: Foundation for Innovative New Diagnostics | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 160,254** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 160,254 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The Foundation for Innovative New Diagnostics (FIND) is a not-for-profit organization whose main aim is to address the urgent need for better diagnostic tests for poverty-related diseases. FIND is devoted to developing and implementing affordable, easy to use and cutting-edge diagnostic technologies for the developing world. FIND builds and sustains effective partnerships with all those involved in diagnostics - both the public and private sectors. These partnerships and a quality-assured project management framework enable FIND to accelerate products through a well-defined value chain, from discovery and proof of principle, to development, evaluation, WHO endorsement, and implementation of new technologies.

In Botswana FIND has partnered with Global Innovative Solutions (GIS) to improve the quality of laboratory services by strenghthening the country's monitoring and evalution system. GIS is a non-profit organization (501(c)3) designed to assist local and international healthcare partners and clients with implementing and monitoring their programs and activities through project and logistics management. GIS

supports on-site activities by assisting with networking, relationship and capacity building, arranging all logistics, and monitoring and evaluating impact for partners. GIS is committed to building human capacity in resource-limited countries in an efficient and sustainable manner.  GIS in collaboration with FIND, received a 5-year cooperative agreement from the Centers for Disease Control and Prevention to support TB, malaria, and HIV activities in resource limited countries.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Malaria (PMI)
TB

## Budget Code Information

| Mechanism ID: | 14488 | | |
|---|---|---|---|
| Mechanism Name: | Building global capacity for diagnostic testing of TB, Malaria & HIV | | |
| Prime Partner Name: | Foundation for Innovative New Diagnostics | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Governance and Systems | HLAB | 160,254 | 0 |
| **Narrative:** | | | |

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| On September 2, 2010, the Centers for Disease Control and Prevention (CDC) awarded the Foundation for Innovative New Diagnostics (FIND) a five year cooperative agreement to build global capacity for diagnostic testing of tuberculosis (TB), malaria and HIV through laboratory strengthening and integration of services under the President's Emergency Plan for AIDS Relief (PEPFAR II). FIND, together with its partner Global Implementation Solutions (GIS), will implement activities that strengthen the quality of laboratory services, introduce new and more rapid diagnostic tools, increase human resource capacity and support the integration of laboratory services for diagnostic testing of TB, malaria and HIV. FIND's project approach involves leadership in laboratory service integration, developing national standardized monitoring and evaluation plans, reviewing past policies and strategic plans to identify needs and gaps, and creating timelines that pave the way forward.<br>FIND and GIS assisted the Ministry of Health in the implementation of strategic goals and objectives in the Botswana National Laboratory Strategic Plan related to monitoring and evaluation. GIS conducted a country-wide laboratory assessment to determine its readiness for monitoring and evaluation of laboratory indicators followed by a three day stakeholders meeting, which served to introduce monitoring and evaluation concepts. The FY 2012 funds will be used to develop and establish a monitoring and evaluation framework and to develop a core set of indicators for the Botswana MOH laboratory services. Technical assistance will also be provided to support the capacity building of the monitoring and evaluation specialist and the MOH laboratory services through active mentoring and training. |

## Implementing Mechanism Details

| **Mechanism ID: 14489** | **Mechanism Name: Health Policy Project** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: Futures Group | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 400,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 400,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Issued under the USAID Health Policy Initiative (HPI) indefinite quantity contract (IQC), this task order project on costing is a three-year project developed in response to the PEPFAR country teams' requests for a mechanism to generate data on cost-effective interventions for health services and programs to support evidence-based decision making. The project supports missions in the areas of HIV/AIDS, family planning/reproductive health and maternal health, and health systems strengthening.
The purpose of this implementing mechanism is to generate data on cost-effective interventions for health services and programs to support evidence-based decision-making and strengthen host country strategic information capacity. This is a global mechanism that is aligned to the Botswana Partnership Framework and the Botswana Integrated Health Sector Plan and which aims to assist host country governments to implement cost-effective HIV programs. To this end, Futures will provide: national, regional and local leaders and stakeholders costing data for policy and programmatic decision making; direct technical assistance to evaluate and assess resource allocation for public health programming and cost effective policy priorities; conduct training to bolster in-country expertise among policy national regional and local leaders and stakeholders to utilize, analyze, interpret, and present timely and accurate costing data for evidence-based decision-making and advocacy; publish, disseminate, and present relevant information to inform host country policy makers with cost data for decision-making information and analysis for program planning, and document processes for replicating this work. In Botswana, focus will be on National Health Accounts and health service costing.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

(No data provided.)

## Budget Code Information

| Mechanism ID: | 14489 | | |
|---|---|---|---|
| Mechanism Name: | Health Policy Project | | |
| Prime Partner Name: | Futures Group | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Governance and Systems | OHSS | 400,000 | 0 |

**Narrative:**

Despite large increases in health spending per annum in the Botswana health system, there has never been a comprehensive assessment conducted on the cost of providing health care, which is important for assessing the efficiency of the health system. The latest NHA has revealed that Botswana is over the Abuja target, yet underachieving in the Millennium Development Goals largely caused by high spending in clinical care at the expense of primary health care and prevention. There are also questions as to whether the current financing system remains viable in the current economic climate. The new National Health Policy and Integrated Health Service Plan calls for a review of health financing in the country. Data on both health expenditures and the cost of providing health care are needed to guide policy development.

The first National Health Accounts (NHA) was completed in 2006 and a second round (2007-10) is currently being finalized. NHA will be institutionalized within the MOH with FY 2011 funding. In FY 2012, the MOH will conduct the next round of NHA. Technical assistance will be needed to ensure that the processes are followed accurately and to support the analysis and development of policy briefs. This will be the last year of support to NHA.

In addition, the GOB will undertake a study to determine the cost of health services. Such an undertaking will look at inputs and how they vary between health facilities in relation to outputs as measured by utilization of services. The utilization of services will include inpatient and outpatient services and other ancillary services such as drug prescriptions, laboratory tests, radiology and other diagnostic procedures. This will help to track if there are changes in inputs including technology, prices and productive efficiencies, which might need reallocation of resources. In summary, the study will specifically address the following: 1) estimating unit costs and conducting comparisons among health facilities; 2) assessing efficiency using health facility service indicators; and, 3) assessing availability of

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| health personnel providing health services. This funding will be used to engage a technical partner to undertake the study while building the capacity of the MOH to do so in future. The partner, along with MOH staff, will collect data on: 1) Recurrent Costs: a) direct costs (labor, drugs, other supplies and food); b) indirect costs(all costs which cannot be directly identified with any of the departments/cost areas, i.e., administration staff costs, utilities, insurance, etc.); 2) Capital Costs; 3) Health facility indicators: bed occupancy rates, bed turnover rates, average length of stay; and, 4) Staff availability: against the recommended established in selected health facilities. The outcome will be a breakdown of the unit cost of providing health services for inpatient day, outpatient visit, and health facility services indicators (bed occupancy rates, bed turnover rates, and average length of stay) and staff availability in health facilities. This information will be used to inform health financing policy and rationalization of budget allocations. This will be the last year of funding for health services costing.<br><br>This is a focused HSS intervention with linkages to all other technical areas. Health financing reform will assist the government identify wastage which should free funds for HIV/AIDS prevention, care and treatment. |

## Implementing Mechanism Details

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|---|---|
| **Mechanism ID: 14491** | **TBD: Yes** |
| **REDACTED** | |

## Implementing Mechanism Details

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|---|---|
| **Mechanism ID: 14512** | **TBD: Yes** |
| **REDACTED** | |

## Implementing Mechanism Details

| | |
|---|---|
| **Mechanism ID: 14530** | **Mechanism Name: HQ buy in for the Strengthening and the Development of Applied Epidemiology and Sustainable Public Health Capacity through Collaboration, Program Development and Implementation, Communication and Information Sharing** |
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and | Procurement Type: Cooperative Agreement |

| | |
|---|---|
| Prevention | |
| Prime Partner Name: African Field Epidemiology Network | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 70,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 70,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The African Field Epidemiology Network (AFENET), created in 1975, is a non-profit organization and networking alliance dedicated to helping Ministries of Health (MOHs) in Africa build strong, effective, sustainable programs and capacity to improve public health systems on the African continent. The AFENET secretariat, which oversees the organization's day-to-day activities, is located in Kampala, Uganda. AFENET works with MOHs and other public health institutions to strengthen their countries' epidemiology workforce through Field Epidemiology Training Programs (FETPs) and Field Epidemiology and Laboratory Training Programs (FELTPs), which are residency-based programs in applied epidemiology and laboratory practice. A combination of classroom-based instruction and mentored practical work allows residents to receive hands-on multi-disciplinary training in public health surveillance, outbreak investigation, laboratory management, program evaluation, and other aspects of epidemiology research and methods.

AFENET's objectives are: 1) to strengthen field epidemiology capacity in Africa, 2) Enhance public health laboratory capacity in Africa, 3) Strengthen surveillance systems for priority communicable and non-communicable diseases (including maternal and child health, HIV/AIDS, tuberculosis, malaria), and 4) Advance the sharing of regional expertise in field epidemiology and laboratories.

AFENET will help Botswana develop an FELTP by providing logistical and technical support.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 70,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

(No data provided.)

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **14530** |
| **Mechanism Name:** | **HQ buy in for the Strengthening and the Development of Applied Epidemiology and Sustainable Public Health Capacity through Collaboration, Program Development and Implementation, Communication and Information Sharing** |
| **Prime Partner Name:** | **African Field Epidemiology Network** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | OHSS | 70,000 | 0 |

**Narrative:**

The Botswana Ministry of Health (MOH) does not have a trained public health workforce or surveillance and response system that can respond to routine public health work or public health emergencies. While there are trained personnel in the country, they are not being used optimally in disease surveillance and response and the MOH has not developed a career path for this cadre within the health workforce. MOH is implementing a multi-disease surveillance and response strategy through the Integrated Disease Surveillance Report without a trained public health workforce in place at all levels of service delivery. Since 1975, CDC has collaborated with Ministries of Health around the world to

enhance international public health capacity through FELTPs. The FETP was modeled after the Epidemic Intelligence Service (EIS) and has since evolved to include the laboratory component. FELTPs nurture a culture of evidence-based decision-making as program graduates investigate disease outbreaks, strengthen surveillance and laboratory systems, and serve as mentors for future public health officers in their country. FELTPs are tailored to strengthen public health capacity in accordance with each country's culture, national priorities, established relationships, and existing public health infrastructure. AFENET is the CDC partner that implements FELTPs and provides technical assistance. There is considerable interest in starting an FELTP in Botswana, particularly in the joint training of field epidemiologists and public health laboratorians. The MOH and the U.S. Centers for Disease Control and Prevention (CDC) are collaborating to develop a public health laboratory which will need a trained workforce. There is a desire to match both the two-year and the short course FELTP training components to actual public health positions (existing and new) that will improve public health surveillance and response systems in Botswana. The University of Botswana (UB) and the MOH are developing a School of Public Health that could be a suitable venue for the two-year FELTP. There will need to be alignment between the FELTP and the existing postgraduate public health programs at UB. The UB School of Medicine is also a recipient of the Medical Education Partnership Initiative and will also have a role to play in FELTP. In addition, the diploma-level health training institutes have a rich history of training nurses, medical laboratory technologists, and other cadres that are currently providing public health service. These institutes could be involved in the short course component of the FELTP. A FELTP pre-assessment was conducted in Botswana in February 2011. This will be followed by a more rigorous assessment in February 2012. It the interim conducting short course trainings will help fill the gap by training health care professionals at the district level and providing some of the basics of field epidemiology until the FELTP is developed. In 2012, 30 health workers will be strategically selected to undergo the training. Short courses are generally two weeks in length followed by a three month project and covers: Outbreak Investigation, Surveillance Evaluation, Quality Laboratory Management, and Public Health Laboratory for Epidemiologists.
This is a focused HSS intervention with linkages to all other technical areas and will benefit PMTCT which is experiencing challenges with periodic diarrhea outbreaks and high infant morbidity and mortality.

## Implementing Mechanism Details

| **Mechanism ID: 14532** | **Mechanism Name: Health Care Improvement Project (HCI)** |
|---|---|
| Funding Agency: U.S. Agency for International Development | Procurement Type: Contract |
| Prime Partner Name: University Research Corporation, LLC | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |

| | |
|---|---|
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 100,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 100,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

Health Care Improvement Project (HCI) adapts modern quality improvement approaches to the needs of USAID-assisted countries, and seeks to institutionalize improvement as an integral element of delivering health services. HCI builds on the world's largest body of experience in applying modern improvement methodologies in developing countries. The most widely used methodology is the improvement collaborative, which organizes a group of facility-level teams to work on a single area of service delivery. The collaborative model has been successfully applied to scaling up improved practices, through a process of planned spread through the health system. HCI provides technical assistance in the full range of modern quality improvement approaches.

As a follow-on to an assessment visit in February 2012, HCI will provide consultations to the Ministry of Health and other stakeholders to support the development of a quality improvement strategy for the Ministry. The strategy will include methods to involve senior management in quality improvement activities, building a system and structure to support improvement activities at the facility level (this will likely build on existing supervision structures), using new and existing data sources to monitor improvement efforts; a system for building improvement skills among health workers and managers. HCI will facilitate ministry staff to form a task team of ministry staff (and partners as needed) to develop the strategy and will provide technical assistance periodically.

## Cross-Cutting Budget Attribution(s)

(No data provided.)

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Child Survival Activities

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **14532** | | |
| **Mechanism Name:** | **Health Care Improvement Project (HCI)** | | |
| **Prime Partner Name:** | **University Research Corporation, LLC** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Governance and Systems | OHSS | 100,000 | 0 |

**Narrative:**

A strong health system is one which can reliably deliver the right services at the right time to patients as they need them. Quality improvement is an important component of building a strong health system because it provides the people within the system (clinicians, para-clinical staff, managers, patients and others) with the skills to identify gaps where they are failing to provide the right services, identify the reasons for the gaps, and test solutions until they are able to provide care which is responsive to patients' needs.

Most quality improvement work happens at the level where patients and providers meet. Because of this there is a need for support at the facility level to help form quality improvement teams, support them as they start improvement work and help keep them working in line with ministry priorities. HCI will work with the ministry to set up mechanisms to provide this support to facility level improvement teams.

HCI will work with the Ministry of Health QI Task Team to identify priorities for developing a strategy for

| |
|---|
| quality improvement. The expected priorities will include: developing mechanisms to involve senior leadership in improvement activities; building a system and structure throughout the ministry to support facility level improvement activities; developing a monitoring system for improvement activities; developing an approach for building improvement skills among health workers and managers.<br>HCI will provide technical assistance as the group works addressing these areas and developing a strategy for quality improvement.<br><br>The deliverable will be a quality improvement strategy that will support other health systems strengthening activities aimed at building a sustainable health delivery system. |

## Implementing Mechanism Details

| | |
|---|---|
| **Mechanism ID: 14662** | **TBD: Yes** |
| **REDACTED** | |

## Implementing Mechanism Details

| | |
|---|---|
| **Mechanism ID: 14686** | **Mechanism Name: Expansion of Male Circumcision Services for HIV Prevention** |
| Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention | Procurement Type: Cooperative Agreement |
| Prime Partner Name: University of Washington | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| | |
|---|---|
| **Total Funding: 1,940,000** | **Total Mechanism Pipeline: N/A** |
| **Funding Source** | **Funding Amount** |
| GHP-State | 1,940,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

I-TECH is a collaboration between the University of Washington (UW) and the University of California, San Francisco (UCSF). I-TECH's mission emphasizes working with local partners to develop skilled healthcare workers, strengthening national health systems, and ensuring sustainability by promoting local ownership. I-TECH works in collaboration with the Centers for Disease Control and Prevention Global AIDS Program in Botswana, the Botswana Ministry of Health (MOH), and the Ministry of Local Government, in the areas of health service delivery, human resources for health, and research.
In FY 2012 I-TECH will continue to support two Safe Male Circumcision (SMC) teams (two doctors, 10 nurses, two auxiliaries, two site administrators, and two receptionists) for service delivery. Models for Optimizing Volume and Efficiencies (MOVE) will be used to support SMC scale-up, with 9,000 male circumcision procedures targeted for I-TECH teams during FY 2012. I-TECH is also projected to train 60 health care workers. In addition, I-TECH will second a national SMC Project Manager and SMC Logistics officer to the MOH to support coordination of the national SMC program.
I-TECH has also established strong linkages with other partner organizations such as the African Comprehensive HIV/AIDS Partnership (ACHAP), Botswana Harvard Partnership, Population Services International, JHPIEGO, University of Pennsylvania, and Associated Fund Administrators in the private sector. I-TECH Botswana supports programs in care and support, prevention of mother to child transmission (PMTCT), tuberculosis (TB/HIV), laboratory infrastructure, strategic information (SI), other health systems strengthening (HSS), and safe male circumcision (SMC).

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Human Resources for Health | 589,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **14686** |
| **Mechanism Name:** | **Expansion of Male Circumcision Services for HIV Prevention** |
| **Prime Partner Name:** | **University of Washington** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Prevention | CIRC | 1,940,000 | 0 |

**Narrative:**

Since 2009, I-TECH Botswana has supported the Government of Botswana's effort to scale up safe male circumcision (SMC) services in the following areas: capacity building through training of over 300 healthcare workers (HCW), quality assurance through on-site mentoring, service delivery at high volume SMC sites, monitoring and evaluation (M&E), and capacitating the SMC supply chain system.
In FY 2012 I-TECH will continue to support two Safe Male Circumcision (SMC) teams (two doctors, 10 nurses, two auxiliaries, two site administrators, and two receptionists) for service delivery. Models for Optimizing Volume and Efficiencies (MOVE) will be used to support SMC scale-up, with 9,000 male circumcision procedures targeted for I-TECH teams during FY 2012. I-TECH is also projected to train 60 health care workers. In addition, ITECH will second a national SMC Project Manager and SMC Logistics Officer to the MOH to support coordination of the national SMC program. ITECH will procure a limited amount of SMC supplies as a contigency to stock outs exprienced at Central Medical Stores.
I-TECH will work closely with key stakeholders and partners (MOH, CDC, African Comprehensive HIVAIDS Partnership (ACHAP), John Hopkins University (JHPIEGO), and Population Services International (PSI) and ensure that the SMC program is well coordinated, resources are appropriately utilized, services are not duplicated, and data on the program is readily available for decision making and program performance monitoring. The SMC program is country owned and led and aims to mount a sustainable response to the HIV epidemic by addressing the national prevention efforts.

## Implementing Mechanism Details

| | |
|---|---|
| **Mechanism ID: 14707** | **Mechanism Name: Ambassador"s PEPFAR Small Grants Program** |
| Funding Agency: U.S. Department of State/Bureau of African Affairs | Procurement Type: USG Core |
| Prime Partner Name: U.S. Department of State | |

| | |
|---|---|
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 100,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 100,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The U.S. State Department is an active participant of the PEPFAR Team in addressing the HIV/AIDS epidemic in Botswana. Through grants to community projects, the Ambassador's PEPFAR Small Grants Program encourages self-reliance within local communities and demonstrates the U.S. Embassy's interest in the welfare and social development of Botswana. In FY 2012 funding priority will be given to projects that respond to the Ambassador's strategic priorities which are youth, economic diversity and health. The U.S. Embassy Grants Officer will sign the Small Grant agreements and obligate PEPFAR funds. Grants will normally range from $5,000 to $25,000. We anticipate this year's grants will fund programs that target youth with life-skills, provide recreational activities such as drama, sports and music; prepare youth for the job market, encourage them to apply for projects to improve their livelihoods and engage them in non-educational programs. We may also provide support for orphanages, preschools, and day-care centers which support orphans and children infected and affected by HIV/AIDS; support prevention efforts such as providing income generating projects for HIV infected women and community based education efforts that promote testing. Support will also be extended to programs that that address gender and take into account how gender issues impact HIV/AIDS. It is estimated that with these funds we will reach an additional five to ten communities serving 5,000 to 20,000 people.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Economic Strengthening | 30,000 |
| Education | 30,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities

## Budget Code Information

| | | | |
|---|---|---|---|
| **Mechanism ID:** | **14707** | | |
| **Mechanism Name:** | **Ambassador''s PEPFAR Small Grants Program** | | |
| **Prime Partner Name:** | **U.S. Department of State** | | |
| **Strategic Area** | **Budget Code** | **Planned Amount** | **On Hold Amount** |
| Governance and Systems | OHSS | 100,000 | 0 |

**Narrative:**

The U.S. State Department is an active participant of the PEPFAR Team in addressing the HIV/AIDS epidemic in Botswana. Through grants to community projects, the Ambassador's PEPFAR Small Grants Program encourages self-reliance within local communities and demonstrates the U.S. Embassy’s interest in the welfare and social development of Botswana. In FY 2012 funding priority will be given to projects that respond to the Ambassador's strategic priorities which are youth, economic diversity and health. The U.S. Embassy Grants Officer will sign the Small Grant agreements and obligate PEPFAR funds. Grants will normally range from $5,000 to $25,000. We anticipate this year's grants will fund programs that target youth with life-skills, provide recreational activities such as drama, sports and music;

| |
|---|
| prepare youth for the job market, encourage them to apply for projects to improve their livelihoods and engage them in non-educational programs. We may also provide support for orphanages, preschools, and day-care centers which support orphans and children infected and affected by HIV/AIDS; support prevention efforts such as providing income generating projects for HIV infected women and community based education efforts that promote testing. Support will also be extended to programs that that address gender and take into account how gender issues impact HIV/AIDS. It is estimated that with these funds we will reach an additional five to ten communities serving 5,000 to 20,000 people. |

## Implementing Mechanism Details

| **Mechanism ID: 14790** | **Mechanism Name: Public Affairs/Public Diplomacy (PA/PD) Outreach** |
|---|---|
| Funding Agency: U.S. Department of State/Bureau of African Affairs | Procurement Type: USG Core |
| Prime Partner Name: U.S. Department of State | |
| Agreement Start Date: Redacted | Agreement End Date: Redacted |
| TBD: No | New Mechanism: N/A |
| Global Fund / Multilateral Engagement: N/A | |
| G2G: N/A | Managing Agency: N/A |

| **Total Funding: 50,000** | **Total Mechanism Pipeline: N/A** |
|---|---|
| **Funding Source** | **Funding Amount** |
| GHP-State | 50,000 |

## Sub Partner Name(s)

(No data provided.)

## Overview Narrative

The Public Affairs Section will use PEPFAR funds allotted to it under the COP for 1) public and press outreach activities and 2) small grants with a particular focus on or opportunity for public outreach or promotion of USG health-related activities.

Public and press outreach activities will focus on messaging to convey to the Batswana public what USG support has accomplished, what activities we are currently engaged in, and what areas we expect to focus on in the future. These public outreach activities will include material, program, and logistical support surrounding thematic events like World AIDS Day, 16 Days of Activism Against Gender Violence,

TB Day, and others. Public outreach activities will also include elements of a directed media campaign to push the broad message of the USG health activities trajectory, specifically to mitigate any potential negative narrative of funding cuts.

Small grant activities will include support for, among others, a training project focused on gender-based violence, a girls' sports program focused on HIV awareness, and a youth empowerment project aimed vulnerable youth with support from the State Department (ECA) Arts Envoy program.

## Cross-Cutting Budget Attribution(s)

| | |
|---|---|
| Gender: Reducing Violence and Coercion | 7,000 |

## TBD Details

(No data provided.)

## Motor Vehicles Details

N/A

## Key Issues

Increasing women's legal rights and protection

## Budget Code Information

| | |
|---|---|
| **Mechanism ID:** | **14790** |
| **Mechanism Name:** | **Public Affairs/Public Diplomacy (PA/PD) Outreach** |
| **Prime Partner Name:** | **U.S. Department of State** |

| Strategic Area | Budget Code | Planned Amount | On Hold Amount |
|---|---|---|---|
| Governance and Systems | OHSS | 50,000 | 0 |

| **Narrative:** |
| --- |
| The Public Affairs Section will use PEPFAR funds allotted to it under the COP for 1) public and press outreach activities and 2) small grants with a particular focus on or opportunity for public outreach or promotion of USG health-related activities.<br><br>Public and press outreach activities will focus on messaging to convey to the Batswana public what USG support has accomplished, what activities we are currently engaged in, and what areas we expect to focus on in the future. These public outreach activities will include material, program, and logistical support surrounding thematic events like World AIDS Day, 16 Days of Activism Against Gender Violence, TB Day, and others. Public outreach activities will also include elements of a directed media campaign to push the broad message of the USG health activities trajectory, specifically to mitigate any potential negative narrative of funding cuts.<br><br>Small grant activities will include support for, among others, a training project focused on gender-based violence, a girls' sports program focused on HIV awareness, and a youth empowerment project aimed vulnerable youth with support from the State Department (ECA) Arts Envoy program. |

# USG Management and Operations

**1.**

Redacted

**2.**

Redacted

**3.**

Redacted

**4.**

Redacted

**5.**

Redacted

## Agency Information - Costs of Doing Business

## U.S. Agency for International Development

| Agency Cost of Doing Business | GAP | GHP-State | GHP-USAID | Central GHP-State | Cost of Doing Business Category Total |
|---|---|---|---|---|---|
| ICASS | | 147,000 | | | 147,000 |
| Management Meetings/Professional Developement | | 20,400 | | | 20,400 |
| Non-ICASS Administrative Costs | | 116,483 | | | 116,483 |
| Staff Program Travel | | 59,000 | | | 59,000 |
| USG Staff Salaries and Benefits | | 508,959 | | | 508,959 |
| **Total** | **0** | **851,842** | **0** | **0** | **851,842** |

## U.S. Agency for International Development Other Costs Details

| Category | Item | Funding Source | Description | Amount |
|---|---|---|---|---|
| ICASS | | GHP-State | | 147,000 |
| Management Meetings/Professional Developement | | GHP-State | conferences & travel to USAID/SA | 20,400 |

| | | | | |
|---|---|---|---|---|
| Non-ICASS Administrative Costs | | GHP-State | rental for 2 houses (USAID owns 2 and rents 2); utilities & guard services for 4 residences; offices supplies and courier services | 116,483 |

## U.S. Department of Defense

| Agency Cost of Doing Business | GAP | GHP-State | GHP-USAID | Central GHP-State | Cost of Doing Business Category Total |
|---|---|---|---|---|---|
| Computers/IT Services | | 5,000 | | | 5,000 |
| ICASS | | 30,000 | | | 30,000 |
| Staff Program Travel | | 118,100 | | | 118,100 |
| USG Staff Salaries and Benefits | | 41,900 | | | 41,900 |
| **Total** | **0** | **195,000** | **0** | **0** | **195,000** |

## U.S. Department of Defense Other Costs Details

| Category | Item | Funding Source | Description | Amount |
|---|---|---|---|---|
| Computers/IT Services | | GHP-State | | 5,000 |
| ICASS | | GHP-State | | 30,000 |

## U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

| Agency Cost of Doing Business | GAP | GHP-State | GHP-USAID | Central GHP-State | Cost of Doing Business Category Total |
|---|---|---|---|---|---|
| Capital Security Cost Sharing | | 113,966 | | | 113,966 |

| | | | | | |
|---|---|---|---|---|---|
| Computers/IT Services | | 605,000 | | | 605,000 |
| ICASS | 286,209 | 397,741 | | | 683,950 |
| Institutional Contractors | 875,000 | 1,397,500 | | | 2,272,500 |
| Non-ICASS Administrative Costs | 1,975,060 | | | | 1,975,060 |
| Staff Program Travel | 248,891 | 278,535 | | | 527,426 |
| USG Staff Salaries and Benefits | 3,761,840 | 118,400 | | | 3,880,240 |
| **Total** | **7,147,000** | **2,911,142** | **0** | **0** | **10,058,142** |

## U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

| Category | Item | Funding Source | Description | Amount |
|---|---|---|---|---|
| Capital Security Cost Sharing | | GHP-State | | 113,966 |
| Computers/IT Services | | GHP-State | | 605,000 |
| ICASS | | GAP | | 286,209 |
| ICASS | | GHP-State | | 397,741 |
| Non-ICASS Administrative Costs | | GAP | | 1,975,060 |

## U.S. Department of State

| Agency Cost of Doing Business | GAP | GHP-State | GHP-USAID | Central GHP-State | Cost of Doing Business Category Total |
|---|---|---|---|---|---|
| ICASS | | 49,000 | | | 49,000 |
| Staff Program Travel | | 2,000 | | | 2,000 |
| USG Staff Salaries | | 225,769 | | | 225,769 |

| | | | | | |
|---|---|---|---|---|---|
| and Benefits | | | | | |
| **Total** | **0** | **276,769** | **0** | **0** | **276,769** |

## U.S. Department of State Other Costs Details

| Category | Item | Funding Source | Description | Amount |
|---|---|---|---|---|
| ICASS | | GHP-State | | 49,000 |

## U.S. Peace Corps

| Agency Cost of Doing Business | GAP | GHP-State | GHP-USAID | Central GHP-State | Cost of Doing Business Category Total |
|---|---|---|---|---|---|
| Computers/IT Services | | 500 | | | 500 |
| Non-ICASS Administrative Costs | | 36,300 | | | 36,300 |
| Peace Corps Volunteer Costs | | 1,593,600 | | | 1,593,600 |
| Staff Program Travel | | 9,200 | | | 9,200 |
| USG Staff Salaries and Benefits | | 359,800 | | | 359,800 |
| **Total** | **0** | **1,999,400** | **0** | **0** | **1,999,400** |

## U.S. Peace Corps Other Costs Details

| Category | Item | Funding Source | Description | Amount |
|---|---|---|---|---|
| Computers/IT Services | | GHP-State | | 500 |
| Non-ICASS Administrative Costs | Operational expenses to support volunteers and general programming | GHP-State | Telephone, Communications, Postage, Mailing, Utilities, Printing, Equipment Maintenance, Office | 36,300 |

| | | | | |
|---|---|---|---|---|
| | | | supplies | |