# Botswana

# Country Operational Plan

# FY 2014

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

# Operating Unit Overview

## OU Executive Summary

I. Country Context

The U.S.-Botswana partnership through the President's Emergency Plan for AIDS Relief (PEPFAR/B) has yielded many benefits over the years, both in responding to HIV and AIDS in-country as well as adding to the global body of knowledge about the epidemic. The 2013 launch of a joint U.S.-Botswana combination prevention trial underscores the global value of our bilateral HIV/AIDS partnership with Botswana. Botswana has made remarkable advances in preventing HIV during the last decade, and the spread of new HIV infections has slowed sharply. Botswana is one of a handful of countries that has reached the "tipping point" – where for every one new person on treatment, there is less than one person becoming newly infected. Nonetheless, significant challenges remain.

Botswana still faces a prolonged and severe HIV epidemic and has the second highest HIV prevalence in the world. The 2008 Botswana AIDS Impact Survey (BAIS III) estimated that 17.6 percent of the population older than 18 months was living with HIV, and results from the 2013 BIAS IV indicate that prevalence has not changed significantly in the last four years. National HIV prevalence is 25.4 percent among 15-49 year olds, and incidence is estimated at 1.25 percent (2012 EPP Spectrum). Currently 340,000 adults and children in Botswana are estimated to be HIV-positive, of which 226,763 are on antiretroviral therapy (ART), and 12,000 new infections occur annually.

According to the National AIDS Coordinating Agency (NACA), key drivers of Botswana's generalized epidemic are multiple and concurrent sexual partnerships, adolescent and intergenerational sex, alcohol and high-risk sex, stigma and discrimination, low uptake of male circumcision and gender-based violence (GBV). The epidemic varies within different geographical regions, communities, age groups, with urbanization and, most pronouncedly, by gender.

Batswana women and girls are disproportionately affected by HIV, and prevalence is higher among females (20.4 percent) than males (14.2 percent). The highest HIV prevalence is among females aged 30-34 years at 49 percent. Adolescent girls aged 15-19 years are twice as likely to be infected with HIV as boys of the same age. Results from the 2010 Botswana Youth Risk Behavior Surveillance Survey of schoolchildren, aged 10-19 years, funded by PEPFAR and conducted in partnership with the Ministry of Education and Skills Development (MoESD), indicated that violence is a common occurrence in the lives of young people. Over one-quarter of respondents had been involved in a physical fight in the previous year that required them to seek medical treatment. Thirteen percent of sexually active students identified rape as their first

sexual encounter.

Persistently high infection rates among females are partly attributable to gender inequality, which puts women and girls at risk for domestic and sexual violence and compromises their ability to negotiate safer sex. According to the Gender Based Violence Indicators Study Botswana, published in March 2012, 67 percent of women in Botswana have experienced some form of gender violence in their lifetime and 44 percent of men admit to perpetrating violence against women. Women in Botswana who experience GBV are 50 percent more likely to be infected with HIV than women in non-violent relationships. According to a UN situational analysis on GBV in Botswana, 53 percent of women had unprotected sex because their partners refused to use condoms and 23 percent of pregnant women experienced violence during pregnancy.

Tuberculosis (TB) remains the leading cause of death in people living with HIV (PLHIV), and is responsible for 13 percent of adult deaths and 40 percent of deaths among PLHIV. Maternal mortality related to HIV complications is high, and cervical cancer is the leading cause of cancer deaths among women. Gains made through PEFAR-funded prevention and treatment programs have been compromised by the country's high rate of under-five mortality, mainly caused by contaminated drinking water, poor sanitation and pneumonia.

The HIV epidemic has impacted the country's labor force, decreasing economic growth and investment and increasing financial outlays by the Government of Botswana (GoB) to sustain existing programs and services. [*REDACTED]*

We remain vigilant to our commitment to empower the GoB to plan, oversee, manage, deliver and finance their own HIV and AIDS response. PEPFAR's investments in the next year will take steps toward this goal, in addition to advancing quality health programs responsive to the needs of those who access them. As we begin to implement a PEPFAR sustainability plan, we will continue to work with the GoB to strengthen Botswana's ability to address the longer-term impacts of the epidemic and improve the health of its citizens.

II. PEPFAR Focus in FY 2014

1. Averting Gender Based Violence (GBV)

Gender-Based Violence is considered a key driver of the HIV epidemic in Botswana and requires immediate attention if we are to meet the GoB's goal of "no new infections by 2016" and advance the President's AIDS-free Generation Initiative. Gender inequities and GBV can negatively affect prevention efforts, service utilization, treatment adherence and health outcomes. Addressing gender norms from a

public health perspective makes sense. It also meets the expectations of a number of USG and agency-specific guidance and policies, which collectively elucidate the United States' commitment to promoting gender equality as an integral component of foreign assistance and development efforts.

FY 2014 COP investments in gender and GBV activities support PEPFAR Botswana's goal of "building the capacity of GoB, implementing partners, and communities, to raise awareness and respond effectively to GBV" by focusing on the following three objectives: (1) Assisting GOB and civil society to expand comprehensive, quality GBV services to survivors throughout the country; (2) Increasing awareness of GBV in Botswana by supporting development and implementation of community action plans to prevent GBV and mitigate impact; and (3) Assisting the GoB to implement surveillance and monitoring systems to track GBV events, improve interagency management and multi-sectorial reporting, and monitor achievements of programs related to GBV.

PEPFAR Botswana is employing a three-pronged approach to these objectives by taking advantage of strong partners with existing capacity and infrastructure; building the foundation for a comprehensive, integrated approach to GBV in two districts; and, building capacity and technical assistance (TA) at the national level. Funding decisions were guided by the new PEPFAR Gender Strategy, GoB and Mission priorities. We considered results from the Youth Risk Behavior Surveillance Survey and new activities will focus on violence prevention in schools and GBV awareness, sensitization, and service integration. New activities funded in FY 2014 COP support PEPFAR Botswana's three objectives, link to ongoing activities funded in FY 2013 COP and fill remaining gaps. {Refer to PEPFAR FY 2014 Program to Address GBV in Botswana and M&E Plan}

2. Addressing the needs of Key Populations

Key populations in Botswana include sex workers and their clients, men who have sex with men (MSM), and mobile populations, such as truck drivers. There was a paucity of empirical evidence to quantify the size and the epidemiological profile of HIV among these groups in Botswana. To address this, PEPFAR funded a bio-behavioral survey of sex workers and MSM that was conducted in three Botswana communities (Gaborone, Francistown and Kasane) in 2012. Attempts to use the survey to quantify the number of injecting drug users were unsuccessful; prevalence of injecting drug use is thought to be very low in Botswana. Results indicated that the size of the sex worker population in the three communities was approximately 4,000, with HIV prevalence estimated at 61.9 percent and HIV incidence at 12.5 percent. For MSM, the size of the population in Gaborone and Francistown was estimated to be 781, HIV prevalence was estimated at 13.1 percent and incidence at 3.6 percent. Sex workers and MSM are also at heightened risk because both sexual behaviors are not only stigmatized, but also illegal in Botswana (Botswana Modes of Transmission Study, 2010).

Following release of the survey results, the Ministry of Health (MoH) requested PEPFAR assistance in establishing a pilot test and treat program for FSW and MSM in Gaborone and Francistown. PEPFAR redirected $250,000 in the cooperative agreement with the GoB to support this effort and additional funds are included in the FY 14 COP to ensure the needs of this underserved community are addressed. PEPFAR anticipates funding the pilot at two facilities and scale-up to additional sites will be supported by the GoB.

In FY 2014, PEPFAR plans to provide a comprehensive package of preventive and clinical health services to reduce risk of HIV and STI infection among sex workers and their clients, and to improve their physical and mental health. Support will include both advocacy and service delivery. The aim is to create an environment in which comprehensive services are provided in settings that ensure privacy and accessibility. Services will be provided in convenient drop-in centers located in close proximity to where sex workers conduct business. These centers will be open at times that cater to the schedules of sex workers, including weekends and evenings. In addition to core services, the drop-in centers will serve as a resource and meeting place for longer-term interventions such as support groups, counselling services, GBV and livelihood programs.

III. Progress and Future

Partnership with the Government of Botswana (GoB)

Botswana's HIV and AIDS response has evolved over the years due to political support, community involvement and commitment and funding from development partners like PEPFAR. Preliminary findings from the Botswana National AIDS Spending Assessment (NASA) for calendar year 2011-2012 indicates that the annual HIV and AIDS investment in Botswana is (BWP) P2.67 billion (USD $302,333,775). Nearly 80 percent of funds are "public funds" that include central government funds, World Bank reimbursable loans and Medical Aid. PEPFAR remains the primary source of international funding, and there is limited funding from the private sector. Public spending is primarily on care and treatment services for people living with HIV and AIDS, which includes the procurement of ARV drugs and laboratory reagents for HIV monitoring.

The GoB is faced with challenges in identifying the appropriate mix of best practices and approaches that will expand upon its successes. Programs hailed for being effective, including ART, PMTCT and behavior change communication, have been unable to prevent an average of 12,000 new infections each year. *[REDACTED]*

PEPFAR has been supporting the GoB to maximize the quality, coverage and impact of its HIV and AIDS national response since September 2005. A 'mega' cooperative agreement (CoAg) between the Department of Health and Human Services/Centers for Disease Control and Prevention (CDC) and the GoB has been in place since April 2011 to support 55 discrete activities across five Ministries.

*[REDACTED]* Eighty-four percent of the GoB CoAg budget is slated for the Ministry of Health (MOH), while the remaining amount is disbursed been the National AIDS Coordinating Agency (8 percent); the Ministry of Education and Skills Development (4 percent); the Ministry of Local Government and Rural Development (4 percent); and the Ministry of Labour and Home Affairs (0.3 percent).

Funding is managed on a reimbursement basis pending provision of documentation satisfying USG auditing standards. To ensure the GoB "draws down" on its pipeline and reconciles receipts, no new FY 2014 COP funds will be allocated. *[REDACTED]*

As part of our regular COP 14 consultations with GoB officials, the PEPFAR Team notified the National AIDS Coordinating Agency, the GoB's designated primary POC for PEPFAR issues, about the GoB pipeline and the implications for COP 14. NACA officials conceded the problem and characterized the USG funding decision as "reasonable." *[REDACTED]*

We will continue to proactively liaise and engage with the GoB to ensure the PEPFAR investment is carefully monitored and priority activities are funded. FY 2012/13 funds withheld by CDC are being critically reviewed to ensure they meet both GoB and USG Mission priorities. Activities that are no longer identified as relevant will be reprogrammed during the next OGAC Operational Plan Update Cycle.

IV. Program Overview

Prevention

The PEPFAR 'Guidance for the Prevention of Sexually Transmitted HIV Infections' published in August 2011 has shaped the design of the prevention program in Botswana. Other key documents that have influenced the Botswana prevention strategy include the 'Technical Guidance on Combination HIV Prevention Addressing Prevention Programs for Men who have Sex with Men' (May 2011) and the recently released PEPFAR Gender strategy (December 2013).

Blood Safety (BS)

In FY 2013, the National Blood Transfusion Service (NBTS) collected 18,573 units of whole blood and 1

percent was found reactive for HIV. For a population the size of Botswana at least 40,498 units of blood are required per year, yet currently only 45 percent is collected. In FY 2013, we conducted a rigorous program portfolio review that revealed gaps in quality, donor mobilization and retention, data utilization, blood supply and service costing. We believe addressing these gaps are critical in ensuring the investments PEPFAR has made in Botswana are sustainable.

In FY 2014, we have consolidated all of our blood safety activities under the American Association for Blood Banks (AABB). AABA will provide targeted TA to the NBTS for the development of a national blood donor mobilization and retention strategy. With this investment we aim to improve the collection of whole blood, reduce HIV reactivity to less than 1 percent, and facilitate an on-site, in-service training of NBTS staff to address critical TA needs.

Injection Safety (IS)

PEPFAR Botswana's IS program has supported the development of the National Infection Prevention and Control (IPC) Policy that has now been implemented in all 29 districts in the country. In FY 2013, we reduced our programmatic budget by 85 percent. The GoB has indicated that PEPFAR support for injection safety is of lower priority, and we believe the transition of our injection safety program is appropriate. No new FY 2014 dollars have been allocated.

VMMC

At the inception of PEPFAR's VMMC program in 2009, PEPFAR adopted a multi-partner model for provision of services in Botswana. Service delivery was implemented at a static MOVE site with minimal outreach services. Due to the poor performance of Botswana's national program, including the high-cost per patient circumcised and the failure to meet targets, the program was restructured during the FY 2013 COP review to a single-partner model. Jhpiego was selected as the implementing partner for all CDC-funded activities related to the VMMC program.

Jhpiego operates three teams covering (i) Greater Gaborone and the Kgalagadi districts, with a hub at Nkoyaphiri clinic; (ii) Kweneng East and Kweneng West districts, with a hub in Molepolole/Scottish Livingstone Hospital; and (iii) Mahalapye district, with a hub in the Mahalapye hospital. Activities in each outreach area were divided into three phases: preparatory, demand creation, and service delivery. The effectiveness of demand creation activities were enhanced by recruiting locally-based mobilizers and by securing support of traditional leaders and local authorities. Clinical teams spent 60-75 percent of their work time on outreach activities as opposed to between 25-30 percent prior to the demonstration period.

The number of circumcisions completed reached 4,618 clients over a three month time period, representing 38.5 percent of the annual target of 12,000 set for FY 2014. This achievement is an increase of 142.4 percent over the preceding three months, and 211.8 percent over the number of clients seen between October and December 2012 under the multi-partner model. The VMMC-related adverse event (AE) rates for the quarter in review were 0.13 percent (6 moderate AEs). All clients who tested HIV positive were referred to treatment, care and support services provided at the MoH facilities adjacent to or co-located with the VMMC services.

The significant improvements in program performance can be attributed to better operational efficiencies. In FY 2014, we continue to fund JHPIGO as the primary implementing partner for VMMC activities. Coverage of this critical intervention is low in Botswana and is an area that must be optimized to reach the goal of an AIDS Free Generation. Program improvements since the restructuring in 2013 show that this can be done. New opportunities include PrePex and provision of VMMC services through five mobile clinics purchased by the MOH with non-PEPFAR funds. PEPFAR Botswana has submitted a proposal to OGAC for supplemental resources to expand VMMC activities.

HIV Testing and Counseling (HTC)

In Botswana, HTC is offered through two complementary approaches—provider-initiated counseling and testing (known as routine HIV testing or RHT) and voluntary counseling and testing (VCT). VCT is provided by CBOs, while RHT is offered by government health facilities in all 29 health districts in Botswana. The proportion of Batswana who have ever tested and know their HIV status is estimated at over 56 percent.

PEPFAR has supported the strengthening of GoB's RHT program through the development of policies, guidelines, M&E tools and HTC protocols. Limited collaboration between community VCT partners and GoB facilities and weak referral and linkages to prevention, care and support limit the efficacy of services.

In FY 2013, PEPFAR shifted to a more focused, cost-efficient and geographically-targeted program that involves increasing use of data to identify more HIV infected clients and reach key populations. A greater emphasis will be placed on targeted outreach testing in high prevalence districts and in high risk groups through non-governmental organizations (NGOs). Strengthening linkages to services for both HIV-negative and -positive persons for continuity of care will also be key. In FY 2014, we have reduced the HCT budget for Tebelopele from $4M in FY 2013 COP to $2.8M. We believe this reduction will help transition PEFPAR-funded activities to a more sustainable model, and we will continue to monitor the quality of services provided.

Care and Treatment

The GoB has led the Care and Treatment response in Botswana, and PEPFAR continues to fill critical gaps through TA and by building local capacity. PEPFAR's care and treatment investments are evidenced based and aligned with the GoB's National Strategic Framework on HIV and AIDS II (NSF II) and USG-GoB Partnership Framework (PF).

PEPFAR will incorporate guidance from the PEPFAR Quality Strategy and PEPFAR Linkage, Engagement and Retention Strategy into programmatic activities. Funding in FY 2014 COP has been allocated for quality efforts in both prevention and treatment programs. These efforts will incorporate ongoing practices already in place, such as the Site Monitoring System used by CDC, laboratory accreditation efforts and training and mentoring activities for health care providers participating in the national HIV treatment program.

Key priorities for the next two years include the provision of CTX (Cotrimoxazole) prophylaxis, TB screening and pre-ART care, including Positive Health, Dignity and Prevention (PHDP). For TB/HIV, priority areas include isoniazid preventive therapy (IPT), infection control and intensified case finding, as well as an increased focus on addressing Multi-Drug Resistant Tuberculosis (MDR-TB). Our priorities include strengthening the linkages between clinical and community care for OVCs and their family members; strengthening M&E for OVC with an emphasis on program evaluations; and, supporting the GoB implementation of guidelines and policies that address the needs of vulnerable children. Other priorities include increasing access to livelihood opportunities – such as education – for OVCs and their families, and strengthening the capacity of local CSOs to deliver services.

Results from a PEPFAR-supported IPT study – a clinical trial aimed at determining the efficacy of continuous isoniazid TB preventive therapy among PLHIV as compared with the standard 6-month regimen – influenced the WHO recommendations for IPT in PLHIV. Results of the pilot program using the "See and Treat" approach for cervical cancer helped persuade GoB to approve use of this approach in its national strategy.

Treatment

Based on data from the PEPFAR Blueprint, Botswana's ratio of new HIV infections to the increase in new patients on treatment (the "tipping point") was 0.5 in 2011, suggesting that the country is getting ahead of the epidemic.

Botswana adopted a CD4 cutoff of 350 in April 2012. *[REDACTED]* Treatment coverage and retention in

care remain high. In 2013, the MoH decided that ARVs would become available at all health facilities in the country (n=676). As of November 2013, there were 34 ART sites and 524 satellite clinics dispensing ARVs. A total of 226,763 patients are currently receiving ART in Botswana. Of these, 63 percent are female and 4 percent are children under 13 years of age.

PEPFAR funding for ARV purchases ended in the FY 2013 COP. PEPFAR's main focus is now on providing TA to the GoB, training and mentoring health care providers and strengthening the supply chain. In light of the new Care and Treatment earmark, PEPFAR will reintroduce ARV purchases in FY2014 COP to support GoB change in policy of the move from Option B to Option B +. The total cost of ARV purchases for option B+ is $1.25 million. PEPFAR-funded direct provision of HIV treatment is restricted to two programs: Botswana Baylor Children's Centre and the Dukwi Refugee Camp. With Baylor, PEPFAR supports several nursing staff in a pediatric HIV treatment center in Gaborone. Refugees with HIV in the UNHCR camp in Dukwi are not eligible for GoB-funded ARVs. Since 2009, a USG-funded ARV program implemented by the Botswana Red Cross Society (BRCS) has been operating in the camp. Of the 3,508 refugees in the camp, there are 267 (8%) on ART and another 32 being monitored pre-ART.

Botswana has one of the most successful PMTCT programs in sub-Saharan Africa. In 2011, 98% of women who received antenatal care were tested for HIV, 93% of HIV-positive pregnant women received antiretroviral prophylaxis to prevent mother-to-child transmission, and the rate of HIV infection among infants less than 18 months tested by PCR was <4%. Because PMTCT was considered to be a mature program that was being successfully managed by the MoH, PEPFAR decided in 2010 that it was a good candidate for "graduation" – graduation being defined as the cessation of funding for external partners for PMTCT activities.

*[REDACTED]* Historically, PEPFAR funding for PMTCT has focused on operational research, training and mentoring, and support for centralized functions at the MoH. Except for a small number of pregnant refugees at the camp in Dukwi, PEPFAR has not provided funding for direct clinical services. Pipeline funding for the MoH should help ensure that the transition to a TA model is done gradually enough that programmatic activities are not disrupted. As part of graduation plans, and on the recommendation of the Deputy Principles, PEPFAR will hire one locally employed M&E officer dedicated to PMTCT to closely monitor program indicators. If problems are identified early, we would plan to intervene and provide additional support.

TB/HIV

Tuberculosis (TB) remains the leading cause of death in people living with HIV, and is responsible for 13 percent of adult deaths and 40 percent of deaths among PLHIV. In the 2013 WHO Global TB Report,

Botswana reported 6,223 TB patients in 2012. Ninety-five percent of TB patients in 2012 were tested for HIV and prevalence among TB patients was 63 percent. Of the co-infected patients, 95 percent received cotrimoxazole (CTX) preventive therapy and 65 percent received antiretroviral therapy (ART) in 2012. Multi-drug resistant TB (MDR-TB) is a growing problem, increasing among new patients from 0.8 percent to 2.5 percent between 2002 and 2008. Another MDR-TB survey will be conducted in 2014 and will provide updated information. Progress in testing and linkages to treatment have improved – HIV testing rates among people with TB rose from 80 percent in 2011 to 95 percent in 2012, and ART initiation among co-infected patients increased from 45 percent in 2010 to 65 percent in 2012.

Integration of services for co-infection is important to both the national HIV and TB programs. Botswana guidelines and policy for TB/HIV management have been revised. 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. The GoB has identified TB/HIV support as a high PEPFAR priority, and in FY 2014 we have continued to fund program activities at FY 2013 levels ($5M).

Health Systems Strengthening

To date, PEPFAR has focused its Health System Strengthening (HSS) on filling gaps based on MoH requests. This led to a dispersal of resources dispersed across most of the health system's "building blocks" and a large number of implementing mechanisms. While this strategy met the requests of MoH program and activity managers, it lacked strategic direction. In an effort to address decreasing PEPFAR resources and transition the program to greater country ownership, PEPFAR requested an inter-agency TDY to guide the development of a more strategic approach to setting HSS priorities and making HSS investments for FY 2014.

The TDY team recommended that PEPFAR could better use limited resources by making HSS investments that: built on previous HSS investments best positioned to make an impact over the next five years while also consolidating activities into a limited number of priorities to achieve measureable impact; better aligning investments with MoH plans and strategies; and, mitigate health system risk to achieving PEPFAR prevention as well as care, support and treatment goals.

To ensure HSS activities in Botswana have a sustained impact on a national scale, program activities were consolidated to three priority areas:

1. Enhancing capacity of civil society organizations (CSO) to improve access to delivery of health services;

2. Ensuring that HIV services availability is integrated into health financing strategies and reforms required for a sustainable country-led HIV response; and,
3. Capacitating districts to maintain/expand delivery of HIV services (primarily District Health Management Teams, also District AIDS Coordinators) in the context of decentralized governance and organization of services.

In addition to consolidating programs from 15 to 11 Implementing Mechanisms, PEPFAR will develop a high-level M&E plan to hold the GoB accountable for transforming support into a more effective HIV response. Fundamental to this M&E plan will be milestones by which to measure GoB commitment at multiple points in time. To ensure these activities receive adequate oversight, as part of our "staffing for results" exercise, we re-aligned positions to monitor Implementing Mechanisms more directly. {See the attached Recommendations for PEPFAR/Botswana Health Strengthening Systems Investment for specific details}

Strategic Information

The rollout of the PEPFAR-supported integrated HIV data system (PIMS II) nationwide will improve the management of HIV-positive clients as they traverse the continuum of care. PIMS II also includes a pre-ART register that will improve tracking of patients. In FY 2014, we have adopted the new OGAC M&E guidelines and continue to conduct routine partner reviews and Data Quality Assurance Assessments. We will also conduct three program evaluations to monitor the USG investment in Botswana, focusing on programs that address GBV, OVCs and supply chain management.