2016 Sustainability Index and Dashboard Summary: Botswana

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed periodically by PEPFAR teams and partner stakeholders to sharpen the understanding of each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to 90 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with other contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

Dark Green Score (8.50-10 points) **(sustainable and requires no additional investment at this time)**
Light Green Score (7.00-8.49 points) **(approaching sustainability and requires little or no investment)**
Yellow Score (3.50-6.99 points) **(emerging sustainability and needs some investment)**
Red Score (<3.50 points) **(unsustainable and requires significant investment)**

Botswana Overview: Botswana, a country slightly smaller than Texas with a population of approximately two million people, continues to confront a prolonged and severe HIV epidemic resulting in one of the highest HIV prevalence rates in the world. The Government of Botswana (GoB) has demonstrated strong leadership and Botswana was one of the first countries to provide free anti-retrovirals (ARVs) to all citizens who qualified with CD4 levels of 350 or below, or signs of AIDS-defining illnesses. Now the GoB is adopting Test and Start (T&S), a policy to provide treatment to any citizen who tests positive regardless of his CD4 count. While the GoB is the primary funder of most HIV/AIDS activities in Botswana, external funds are being sought to assist with the initial purchase of drugs for the start-up of T&S. To lower costs, Botswana must look at increasing efficiencies within the system since it has one of the most expensive HIV care and treatment programs of any low- or middle-income country in the world[1]. Also of concern is the country's deteriorating medical supply chain. Challenges with warehouse management of the Central Medical Stores and distribution of commodities have led to shortages and stock-outs, including country-wide shortages of rapid test kits (RTKs) starting in August 2015 and lasting for several months.

SID Process: PEPFAR and UNAIDS Botswana co-convened the HIV/AIDS Sustainability Index and Dashboard (SID) process for 2016 and jointly created a list of participants for each of the four SID domains. Participants were invited from various GoB ministries, United Nations development partners, civil society organizations, private sector organizations and USG agencies. An updated SID 2.0 tool was given to participants with a copy of domain questions prior to the meeting. Participants were asked to review this copy and to bring relevant data

[1] According OGAC, treatment in Botswana is one of the most expensive in the world, with direct spending per patient living with HIV ranging from $800 to $1,200 annually. Comparatively, South Africa spends about $300 per person living with HIV (PLHIV) and Malawi spends about $183 per PLHIV annually. Botswana has a very expensive and clinical approach to HIV because the GoB uses top-of-the-line drugs; both CD4 and viral load testing; and physician care for initiation and follow-ups. The government also maintains HIV treatment clinics separate from general care clinics and dispensaries.

sources to the meeting. During the domain meetings, participants discussed each question and arrived at a collective answer with supporting data. After the four domain meetings, the draft of each SID domain was sent to all of the domain invitees for further vetting and the collection of additional data sources. The first draft was presented to higher level external partners on February 19th and shared and discussed with external partners on March 23rd. This SID process involved many of our external partners and elicited rich discussions regarding HIV/AIDS program sustainability in Botswana.

Sustainability Strengths:

- **Planning and Coordination** (7.70, light green): Botswana has a multi-year national strategy and coordinates national HIV program implementation. Botswana is currently developing a National Strategic Framework III, which will be in place by the end of 2016 and replace NSF II, 2011-2016. Most sectors participated in the development of this national strategy. The National AIDS Coordinating Agency (NACA) has been the lead governmental coordinating body for Botswana's HIV/AIDS response along with the National AIDS Council. Currently, NACA is transitioning from an independent body under the Office of the President to one embedded within the Ministry of Health (MoH).

- **Public Access to Information** (8.00, light green): The GoB widely disseminates information regarding HIV/AIDS through the publication of the Botswana AIDS Impact Survey (BAIS), the National AIDS Spending Assessment (NASA), and the National Health Accounts (NHA) – though usually with a 1-3 year time lag. Performance and service delivery data are reported in the Global AIDS Progress Report, which is published every two years. Data are also reported through district AIDS reports. HIV/AIDS related procurement occurs through normal government channels and procurements and tenders are published in the Government Gazette and local newspapers. However, the process does not really result in cost efficiencies since local bids are sometimes selected over lower-cost foreign bids. Both NACA and the MoH provide accurate information about HIV/AIDS.

- **Financial/Expenditure Data** (8.33, light green): Though usually with a time lag, the GoB collects, tracks, analyzes and makes available financial/expenditure data related to HIV/AIDS. The GoB takes the lead with some external technical assistance. Almost all financing for the collection and dissemination of expenditure data comes from the GoB. While reports like NASA are conducted every three years, the GoB uses the previous year's budget, allocation and spending to determine budget allocations for the new fiscal year. The GoB conducts health economic studies and analyses, usually utilizing external technical assistance. Recently, the GoB, working with the USG and other development partners, has been involved with many costing activities in preparation for moving to T&S.

Sustainability Vulnerabilities:

- **Commodity Security and Supply Chain** (6.27, yellow): Though yellow, this was one of the areas of greatest concern for participants in the SID process, especially as

Botswana prepares to move to T&S. Botswana has experienced severe issues with its supply chain system including stock-outs of RTKs. Emergency supplies were requested and approved from OGAC. Botswana has a supply chain plan and conducts supply chain assessments, however, the real problem – the functionality of the supply chain, or lack thereof – is not adequately captured by the SID questions. Most supply chain troubles are linked back to the poor performance of the contractor who received the award through a sole source bid. The contractor was supposed to sub-contract in areas where it lacked expertise, like information systems. It did, but dropped the sub-contractors once they received the awards. At this time, the MoH is planning to re-tender this contract and start with a new provider on May 1, 2017. The MoH continues to pay the current contract in full, despite poor performance.

- **Quality Management** (4.76, yellow): This is an area of weakness for Botswana and COP15 resources worked to address this. There has been improvement with quality management and we expect to see more growth in this area as we continue to provide support and resources during COP16. Currently there is no QI strategy for HIV within MoH, however, there is a QI framework in developmental stage that will guide the development of other documents. Documentation of QI activities has been a challenge, but programs are working closely with partners to inculcate the culture of documentation of QI activities.

Additional Observations:

- Although **Private Sector Engagement** scored in the red (3.08), it is not listed above as a PEPFAR Botswana priority because it's a small sector in Botswana and the GoB provides most resources to address the HIV epidemic. Private sector engagement is not a core activity for PEPFAR/B. The U.S. Mission in Botswana will include private sector engagement activities under the Integrated Country Strategy (ICS), which is currently being updated. The private sector can be included in gender-mainstreaming activities, external partner engagement and through health diplomacy messaging. This lack of private sector engagement might present an opportunity for the GoB to build more on private sector funding sources as external funds continue to decline.
- When Botswana moves to T&S the **Policies and Governance** (6.58, yellow) score should increase as the country currently has a policy of CD4 350.
- A primary weakness of **Service Delivery** (6.11, yellow) in Botswana is the lack of financing of services and service delivery directly targeting key populations. While the GoB does provide HIV/AIDS services to all citizens it does not specifically fund nor provide services directly targeting key populations.
- **Domestic Resource Mobilization** (5.56, yellow) can be improved with the inclusion of HIV/AIDS goals/targets in the national budget. Furthermore, the GoB faced challenges with spending down budgeted items in supply chain procurement.
- The GoB takes a position of equity and provides funding to all districts with allocation based on facilities per district. The national budget by district is not available to determine the proportion of funds allocated to high burden geographic areas. Addressing this could raise **Technical and Allocative Efficiencies** (6.11, yellow).

- **Performance Data** (5.77, yellow) could be strengthened by the coordination of information systems. The GoB is moving in this direction with a recently adopted e-health strategy. The final draft is almost ready. The strategy is meant to harmonize these systems and provide guidance moving forward.

Contact: For questions or further information about PEPFAR's efforts to support sustainability of the HIV response in Botswana, please contact Dan Craun-Selka, PEPFAR Coordinator at CraunselkaDM@state.gov.

Sustainability Analysis for Epidemic Control: Botswana

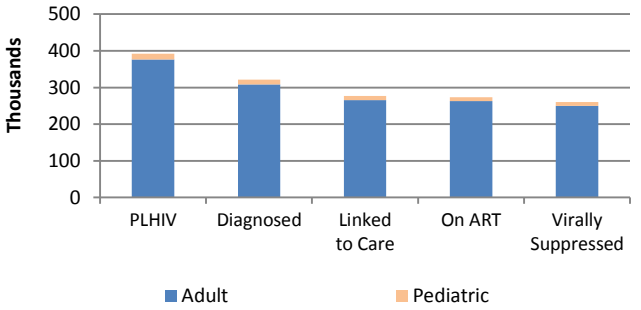
Epidemic Type: Generalized
Income Level: Upper-middle Income
PEPFAR Categorization: Targeted Assistance (Co-finance)
PEPFAR COP 16 Planning Level: $43.2 Million

SUSTAINABILITY DOMAINS and ELEMENTS

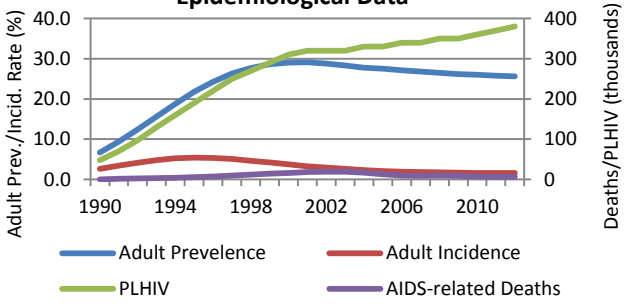
	2016	2017	2018	2019
Governance, Leadership, and Accountability				
1. Planning and Coordination	7.70			
2. Policies and Governance	6.58			
3. Civil Society Engagement	5.60			
4. Private Sector Engagement	3.08			
5. Public Access to Information	8.00			
National Health System and Service Delivery				
6. Service Delivery	6.11			
7. Human Resources for Health	6.33			
8. Commodity Security and Supply Chain	6.27			
9. Quality Management	4.76			
10. Laboratory	5.69			
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	5.56			
12. Technical and Allocative Efficiencies	5.75			
Strategic Information				
13. Epidemiological and Health Data	5.48			
14. Financial/Expenditure Data	8.33			
15. Performance Data	5.77			

CONTEXTUAL DATA

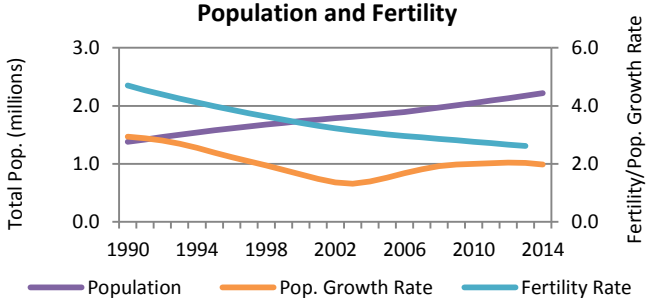
National Clinical Cascade



Epidemiological Data

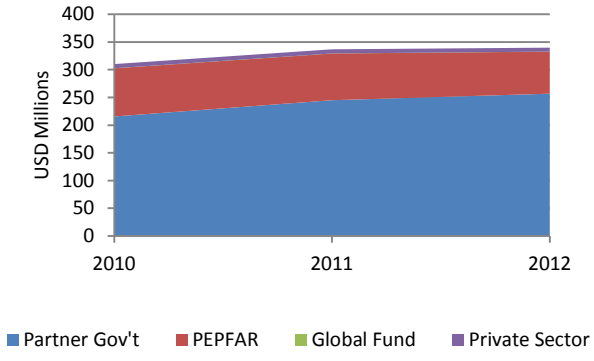


Population and Fertility

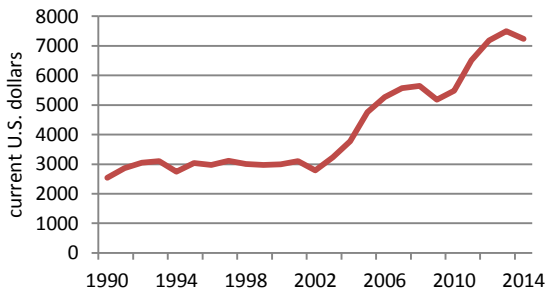


CONTEXTUAL DATA

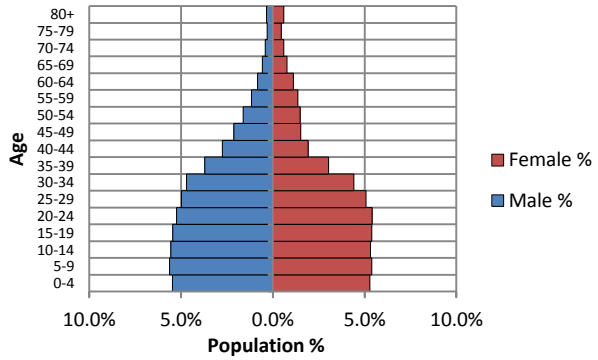
Financing the HIV Response



GNI Per Capita (Atlas Method)



Population Pyramid (2015)



Domain A. Governance, Leadership, and Accountability

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, provides accurate information and education on HIV/AIDS, and supports mechanisms for eliciting feedback. Relevant government entities take actions to create an enabling policy and legal environment, ensure good stewardship of HIV/AIDS resources, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

1. Planning and Coordination: Host country develops, implements, and oversees a costed multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector.			**Data Source**	**Notes/Comments**
1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	○ A. There is no national strategy for HIV/AIDS ◉ B. There is a multiyear national strategy. Check all that apply: ☑ It is costed ☑ It is updated at least every five years ☑ Strategy includes all crucial response components for prevention and treatment (HIV testing, treatment and care [including children and adolescents], PMTCT, transition from 'catchup' to sustainable VMMC if country performs VMMCs, scale-up of viral load, EID, and other key metrics) ☐ Strategy includes explicit plans and activities to address the needs of key populations. ☑ Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children	1.1 Score: 2.20	National Strategic Framework (NSF) II, 2011-2016 which includes the National Operational Plan for NSF (costed) and an M&E Plan.	Currently developing NSF III, will be in place by the end of 2016. Please note that the government is revising guidelines for viral load testing with the implementation of a test and treat strategy mid-2016. Strategy not explicit, includes some key populations (e.g., FSW), but not all (e.g., MSM).
1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?	○ A. There is no national strategy for HIV/AIDS ◉ B. The national strategy is developed with participation from the following stakeholders (check all that apply): ☑ Its development was led by the host country government ☑ Civil society actively participated in the development of the strategy ☐ Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy ☑ Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR) ☑ External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy	1.2 Score: 2.00	National Strategic Framework (NSF) II; National Operational Plan for NSF.	Private health sector institutions participates in national level planning but not at the facility-level.

1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS implemented activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?	Check all that apply: ☑ There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc. ☐ The host country government routinely tracks and maps HIV/AIDS activities of: ☐ civil society organizations ☐ private sector ☐ donors ☐ The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes. ☑ Joint operational plans are developed that include key activities of implementing organizations. ☐ Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.	1.3 Score: 1.00	National Operational Plan; NACA; Partners Forum, NACA Coordination Assessment 2010; National AIDS Council chaired by the Vice President.	NACA has been the lead governmental coordinating body for the HIV/AIDS response along with the National AIDS Council. Currently NACA is transitioning from an independent body to one embedded within the MOH, with the intent to better coordinate government activities. The Partners Forum is the venue for stakeholders to coordinate and track activities. While the mechanism has been in place, the forum is not functionally tracking or mapping partner activities hence some gaps and duplication exist. The National Operational Plan is one effort to jointly plan across implementing organizations; however focus is primarily on the public sector.
1.4 Sub-national Unit Accountability: Is there a mechanism by which sub-national units are accountable to national HIV/AIDS goals or targets? (note: equal points for B and C)	○ A. There is no formal link between the national plan and sub-national service delivery. ◉ B. Sub-national units have performance targets that contribute to aggregate national goals or targets. ○ C. The central government is responsible for service delivery at the sub-national level.	1.4 Score: 2.50	District Multi-Sectoral AIDS Committees (DMSAC)	DMSACs set district-level targets and report contributions to national goals.
	Planning and Coordination Score: 7.70			

2. Policies and Governance: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.			**Data Source**	**Notes/Comments**
2.1 WHO Guidelines for ART Initiation: Does current national HIV/AIDS technical practice follow current or recent WHO guidelines for initiation of ART?	For each category below, check no more than one box that reflects current national policy for ART initiation: A. Adults (>19 years) ☐ Test and START (current WHO Guideline) ☐ CD4 <500 B. Pregnant and Breastfeeding Mothers ☑ Test and START/Option B+ (current WHO Guideline) ☐ Option B C. Adolescents (10-19 years) ☐ Test and START (current WHO Guideline) ☐ CD4<500 D. Children (<10 years) ☐ Test and START (current WHO Guideline) ☐ CD4<500 or clinical eligibility	2.1 Score: 0.36	Botswana National HIV/AIDS Treatment Guidelines (2012)	GOB is currently finalizing new treatment guidelines to support a national test and treat strategy planned to launch in April 2016. Current 2012 guidelines continue to promote treatment for PLHIV with CD4<350, Option B+, and test and treat for children <5 years of age.

2.2 Enabling Policies and Legislation: Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery?	Check all that apply: ☑ A national public health services act that includes the control of HIV ☐ A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART ☐ A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits ☑ Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months) ☐ Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months) ☐ Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready ☑ Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS	2.2 Score: 0.61	2012 HIV/AIDS guidelines; Public Health Act 2014; Children's Act 2009 and National Plan of Action for the Care of OVC, 2010-2016	While 2012 treatment guidelines speak to nurses prescribing ability (and there is a handbook on nurse prescribers as well), however the scope of practice for nurses does not stipulate HIV and treatment as part of their work. An official policy will not be developed until the completion of an ongoing desk review; however, some task shifting is happening ad-hoc in some facilities. The new treatment guidelines to support Test and Treat in April 2016 include a move to less frequent clinical visits, lab work, and ARV pickups.
2.3 Non-discrimination Protections: Does the country have non-discrimination laws or policies that specify protections (not specific to HIV) for specific populations? Are these fully implemented? (Full score possible without checking all boxes.)	Check all that apply: Adults living with HIV (women): ☑ Law/policy exists ☐ Law/policy is fully implemented Adults living with HIV (men): ☑ Law/policy exists ☐ Law/policy is fully implemented Children living with HIV: ☑ Law/policy exists ☑ Law/policy is fully implemented Gay men and other men who have sex with men (MSM): ☐ Law/policy exists ☐ Law/policy is fully implemented	2.3 Score: 0.63	This question aligns with the United Nations NCPI 2014. Public Service Act 2008; Employment Act 2012; Children's Act; Penal Code	Constitution has an anti-discriminatory law but does not refer to specific populations. Public Service Act 2008 protects rights of employees. Employment Act of 2012. Children's Act is implemented. Penal Code enforces rights of young girls as does the Children's Act.

	Migrants: ☑ Law/policy exists ☐ Law/policy is fully implemented People who inject drugs (PWID): ☐ Law/policy exists ☐ Law/policy is fully implemented People with disabilities: ☑ Law/policy exists ☐ Law/policy is fully implemented				

	Prisoners: ☐ Law/policy exists ☐ Law/policy is fully implemented Sex workers: ☐ Law/policy exists ☐ Law/policy is fully implemented Transgender people: ☐ Law/policy exists ☐ Law/policy is fully implemented Women and girls: ☑ Law/policy exists ☑ Law/policy is fully implemented			
2.4 Structural Obstacles: Does the country have laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services? Are these laws/policies enforced? (Enforced means any instances of enforcement even if periodic)	Check all that apply: Criminalization of sexual orientation and gender identity: ☑ Law/policy exists ☐ Law/policy is enforced Criminalization of cross-dressing: ☐ Law/policy exists ☐ Law/policy is enforced Criminalization of drug use: ☑ Law/policy exists ☑ Law/policy is enforced Criminalization of sex work: ☑ Law/policy exists ☐ Law/policy is enforced	2.4 Score: 1.04	Penal Code: Chapter 08:01 Section 155 (Prostitution), Section 164 and 167 (Homosexuality); New Public Health Act, National HIV/AIDS Policy NCPI 2014 HIV policy on ban of condoms in prisons. Botswana Prisons HIV policy 2003. Public Health Act 2014 re disclosure of status.	HIV testing allowed for youth >= 16 years of age.

Ban or limits on needle and syringe programs for people who inject drugs (PWID):

- ☐ Law/policy exists
- ☐ Law/policy is enforced

Ban or limits on opioid substitution therapy for people who inject drugs (PWID):

- ☐ Law/policy exists
- ☐ Law/policy is enforced

Ban or limits on needle and syringe programs in prison settings:

- ☐ Law/policy exists
- ☐ Law/policy is enforced

Ban or limits on opioid substitution therapy in prison settings:

- ☐ Law/policy exists
- ☐ Law/policy is enforced

Ban or limits on the distribution of condoms in prison settings:

- ☑ Law/policy exists
- ☐ Law/policy is enforced

Ban or limits on accessing HIV and SRH services for adolescents and young people:

- ☑ Law/policy exists
- ☐ Law/policy is enforced

Criminalization of HIV non-disclosure, exposure or transmission:

- ☑ Law/policy exists
- ☐ Law/policy is enforced

Travel and/or residence restrictions:

- ☐ Law/policy exists
- ☐ Law/policy is enforced

	Restrictions on employment for people living with HIV: ☐ Law/policy exists ☐ Law/policy is enforced			
2.5 Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?	There are host country government efforts in place as follows (check all that apply): ☑ To educate PLHIV about their legal rights in terms of access to HIV services ☐ To educate key populations about their legal rights in terms of access to HIV services ☑ National law exists regarding health care privacy and confidentiality protections ☑ Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	2.5 Score: 1.07	Public Health Act 2014 2014 UN NCPI report, pg 49	For last check-box, note that GOB does provide financial support to PLHIV who have faced discrimination but they do not extend this support to key populations.
2.6 Audit: Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)?	○ A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry. ○ B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more. ◉ C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.	2.6 Score: 1.43	Panel of experts, February 2016.	Financial audits
2.7 Audit Action: To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS?	○ A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted. ○ B. The host country government does respond to audit findings by implementing changes as a result of the audit. ◉ C. The host country government does respond to audit findings by implementing changes which can be tracked by legislature or other bodies that hold government accountable.	2.7 Score: 1.43	Public Accounts Committee	Public Accounts Committee that ministries are accountable to re financial and performance (against funding) audits. Done on demand. Not routine.
		Policies and Governance Score: 6.58		

3. Civil Society Engagement: Local civil Society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions.			**Data Source**	**Notes/Comments**
3.1 Civil Society and Accountability for HIV/AIDS: Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response?	○ A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response. ◉ B. There are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it does not happen. ○ C. There are no laws or policies that prevent civil society from providing an oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight.	3.1 Score: 0.83	Expert panel of Civil Society representatives, Feb 5, 2016.	Ad hoc role for CSOs; not organized or consistent;
3.2 Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels or opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services (not including Global Fund CCM civil society engagement requirements)?	Check A, B, or C; if C checked, select appropriate disaggregates: ○ A. There are no formal channels or opportunities. ○ B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback. ◉ C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☑ During strategic and annual planning ☑ In joint annual program reviews ☑ For policy development ☑ As members of technical working groups ☑ Involvement on government HIV/AIDS program evaluation teams ☑ Involvement in surveys/studies ☐ Collecting and reporting on client feedback	3.2 Score: 1.43	Partner Forum, National AIDS Council, TWG, Global Fund Concept note, TB/HIV meeting, TB evaluation CSO involvement, MLG supports CSOs	BBSS included CSO representation. Partner Furum not meeting regularly.

3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy and budget decisions related to HIV/AIDS?	◉ A. Civil society does not actively engage, or civil society engagement does not impact policy and budget decisions related to HIV/AIDS. ○ B. Civil society's engagement impacts HIV/AIDS policy and budget decisions (check all that apply): ☐ In advocacy ☐ In programmatic decision making ☐ In technical decision making ☐ In service delivery ☐ In HIV/AIDS basket or national health financing decisions	3.3 Score: 0.00	Expert panel of Civil Society representatives, Feb 5, 2016.	A national umbrella organization exists (BONEFA) but the group is not very engaged or effective.
3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)? (if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)	○ A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources. ○ B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources. ◉ C. Some funding (approx. 10-49%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ D. Most funding (approx. 50-89%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants).	3.4 Score: 1.67	NACA data source, email communication with J. Moremi February 2016.	Majority of CSO funding comes from donors; however NACA provides 12-19% of funds. World Bank loan from 2014 was noted as a domestic source.
3.5 Civil Society Enabling Environment: Is the legislative and regulatory framework conducive to Civil Society Organizations (CSOs) or not-for-profit organizations to engage in HIV service provision or health advocacy?	○ A. The legislative and regulatory framework is not conducive for engagement in HIV service provision or health advocacy ◉ B. The legislative and regulatory framework is conducive for engagement in HIV service delivery and health advocacy as follows (check all that apply): ☑ Significant tax deductions for business or individual contributions to not-for-profit CSOs ☑ Significant tax exemptions for not-for-profit CSOs ☑ Open competition among CSOs to provide government-funded services ☑ Freedom for CSOs to advocate for policy, legal and programmatic change ☑ There is a national public private partnership (PPP) technical working group or desk officer within the government (ministry of health, finance, or president's office) in which CSOs or non-profit organizations participate/engage.	3.5 Score: 1.67	National Policy for Non-Governmental Organisations, Ministry of Labour and Home Affairs, February 2001 Box 4: Recent court cases such as registration of LEGABIBO and ARVS for foreign inmates.	Partners Forum is venue for PPP and CSO participation; although currently not functioning well.
		Civil Society Engagement Score:	**5.60**	

4. Private Sector Engagement: Global as well as local private sector (both private health care providers and private business) is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, innovation, and as a key stakeholder to inform the national HIV/AIDS response. There are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs, services and fiscal management of the national HIV/AIDS response. The public uses the private sector for HIV service delivery at a similar level as other health care needs.			**Data Source**	**Notes/Comments**
4.1 Government Channels and Opportunities for Private Sector Engagement: Does host country government have formal channels and opportunities for diverse private sector entities to engage and provide feedback on its HIV/AIDS policies, programs, and services?	○ A. There are no formal channels or opportunities ○ B. There are formal channels or opportunities, but private sector is called upon in an ad hoc manner to provide inputs and feedback ◉ C. There are functional formal channels and opportunities for private sector engagement and feedback. Check all that apply: ☑ Corporate contributions, private philanthropy and giving ☐ Joint (i.e. public-private) supervision and quality oversight of private facilities ☐ Collection of service delivery and client satisfaction data from private providers ☑ Tracking of private training institution HRH graduates and placements ☐ Contributing to develop innovative solutions, both technology and systems innovation ☑ For technical advisory on best practices and delivery solutions	4.1 Score: 0.83	Botswana Business Coalition for AIDS (BBCA)	Are some donations but how does that relate to feedback? Public tracking of HRH graduates placements. PPM Policy for TB Program (2012)- calls for public-private oversight of private facilities for TB care however as this policy is being implemented the uptake is low (email, Feb 2016). GoB supports some students at private training facilities and tracks their placement.

4.2 Private Sector Partnership: Do private sector partnerships with government result in stronger policy and budget decisions for HIV/AIDS programs?	○ A. Private sector does not actively engage, or private sector engagement does not influence policy and budget decisions in HIV/AIDS. ◉ B. Private sector engagement influences HIV/AIDS policy and budget decisions in the following areas (check all that apply): ☐ In patient advocacy and human rights ☐ In programmatic decision making ☐ In technical decision making ☐ In service delivery for both public and private providers ☐ In HIV/AIDS basket or national health financing decisions ☑ In advancing innovative sustainable financing models ☑ In HRH development, placement, and retention strategies ☐ In building capacity of private training institutions ☐ In supply chain management of essential supplies and drugs	4.2 Score: 0.37	BBCA - PPP financing	Historically there was a PPP for treatment of stable ART patients by private insurance organizations but that ended in 2014. Debswana - how do we count their contribution to response? Boitekanelo College - training HRH with GOB contributions

4.3 Legal Framework for Private Health Sector: Does the legislative and regulatory framework make provisions for the needs of the private health sector (including hospitals, networks, and insurers)?	The legislative and regulatory framework makes the following provisions (check all that apply): ☑ Systems are in place for service provision and/or research reporting by private sector facilities to the government. ☑ Mechanisms exist to ensure that private providers receive, understand and adhere to national guidelines/protocols for ART. ☐ Tax deductions for private health providers. ☐ Tax deductions for private training institutions training health workers. ☑ Open competition for private health providers to compete for government services. ☐ General or HIV/AIDS-specific service agreement frameworks exist between local government authorities/municipalities and private providers at the sub-national unit (e.g. district) levels. ☑ Freedom of private providers to advocate for policy, legal, and regulatory frameworks. ☑ Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between public and private providers.	4.3 Score: 1.04	Panel of experts, February 2016.	Box 1: partly. Routine reporting by some private sector facilities to gov.
4.4 Legal Framework for Private Businesses: Does the legislative and regulatory framework make provisions for the needs of private businesses (local or multinational corporations)?	The legislative and regulatory framework makes the following provisions (check all that apply): ☐ Tax deductions for health-related private businesses (i.e. pharmacists, supply chain, etc.). ☐ Systematic and timely process for private company registration and/or testing of new health products; drugs, diagnostics kits, medical devices. ☑ Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between local government and private business. ☐ Corporate Social Responsibility (CSR) tax policies (compulsory or optional) contributing private corporate resources to the HIV/AIDS response. ☑ Workplace policies support HIV-related services and/or benefits for employees. ☑ Existing forums between business community and government to engage in dialogue to support HIV/AIDS and public health programs.	4.4 Score: 0.83	Public Health Act (anti-discrimination against workers); Botswana PPP Policy and Implementation Framework, 2009	Box 2: Systematic but not timely. Department within MOH responsible for PPPs Health Policy Development

4.5 Private Health Sector Supply: Does the host country government enable private health service provision for lower and middle-income HIV patients?	◉ A. There are no enablers for private health service provision for lower and middle-income HIV patients. ○ B. The host country government enables private health service provision for lower and middle-income patients in the following ways (check all that apply): ☐ Private for-profit providers are eligible to procure HIV and/or ART commodities via public sector procurement channels and/or vertical programs. ☐ The private sector scope of practice for physicians, nurses and midwives serving low and middle-income patients currently includes HIV and/or ART service provision.	4.5 Score: 0.00	Expert panel, Feb 5, 2016.	Services provided by GoB
4.6 Private Health Sector Demand: Is the percentage of people accessing HIV treatment services through the private sector similar to (or approaching) the percentage of those seeking other curative services through the private sector?	◉ A. The percentage of people accessing HIV treatment services through the private sector is significantly lower than the percentage seeking other curative services through the private sector. ○ B. The percentage of people accessing HIV treatment services through the private sector is similar to (or approaching) the percentage seeking other curative services through the private sector due to the following factors (check all that apply): ☐ HIV-related services/products are covered by national health insurance. ☐ HIV-related services/products are covered by private or other health insurance. ☐ Adequate risk pooling exists for HIV services. ☐ Models currently exist for cost-recovery for ART. ☐ HIV drugs are not subject to higher pharmaceutical mark-ups than other drugs in the market.	4.6 Score: 0.00	Expert panel, Feb 5, 2016.	Most people access services through the GoB.
		Private Sector Engagement Score: 3.08		

5. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards , etc.) related to HIV/AIDS. Program and audit reports are published publically. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information.			**Source of Data**	**Notes/Comments**
5.1 Surveillance and Survey Transparency: Does the host country government ensure that HIV/AIDS surveillance and survey data, or at least a summary report of data, and analyses are made available to stakeholders and general public in a timely way?	○ A. The host country government does not make HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public, or they are made available 3 or more years after the date of collection. ◉ B. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within 1-3 years. ○ C. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within the same year.	5.1 Score: 1.00	BAIS	
5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data, or at a minimum at least a summary of it, available to stakeholders and the public in a timely way?	○ A. The host country government does not make HIV/AIDS expenditure summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of expenditures. ◉ B. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public or website within 1-3 years after date of expenditures. ○ C. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public within 1 year after expenditures.	5.2 Score: 1.00	NASA; NHA	
5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data (or at a minimum of summary of it) available to stakeholders and the public in a timely way?	○ A. The host country government does not make HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of programming. ○ B. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1-3 years after date of programming. ◉ C. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1 year after date of programming .	5.3 Score: 2.00	2013 GAPR(Global AIDS progress report) annually since 2013, DMSAC reports	GAPR Report is every two years rather than annual, but it is a regularly occuring public accounting of national HIV/AIDS program progress and results. Civil Society orgs state that District AIDS Committee CHANGEreports are also shared at the district level.

5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?	○ A. Host country government does not make any HIV/AIDS procurements. ○ B. Host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available. ○ C. Host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available. ◉ D. Host Country government makes HIV/AIDS procurements, and both tender and award details available.	5.4 Score: 2.00	Government Gazette - 15 Pula available to public, includes procurements and tnders. Award details published in daily PPAD newspaper.	Procurement done through normal gov procurement channels. However, process does not really result in cost efficiencies - sometimes local bids selected over lower-cost bids.
5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for educating the public about HIV?	○ A. There is no government institution that is responsible for this function and no other groups provide education. ○ B. There is no government institution that is responsible for this function but at least one of the following provides education: ☐ Civil society ☐ Media ☐ Private sector ◉ C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.	5.5 Score: 2.00	MoH and NACA	
		Public Access to Information Score: 8.00		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A

Domain B. National Health System and Service Delivery

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

6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.			**Data Source**	**Notes/Comments**
6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	☑ Public facilities are able to tailor services to accommodate demand (e.g., modify or add hours/days of operations; add/second additional staff during periods of high patient influx; customize scope of HIV services offered; adapt organization/model of service deliver to patient flow) ☑ Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics) ☑ There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services	6.1 Score: 1.11	Expert panel, Feb 5, 2016.	Clinics often need a directive from MoH to alter services; however a few examples indicate ability to tailor to accommodate clients. Examples: i) some clinics expanded to 24 hour services; and ii) smaller clinics now provide ART in response to client demand.
6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services?	The host country has standardized the following design and implementation components of community-based HIV services through (check all that apply): ☑ Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services ☑ National guidelines detailing how to operationalize HIV services in communities ☑ Providing official recognition to skilled human resources (e.g. community health ☑ Providing financial support for community-based services ☑ Providing supply chain support for community-based services ☐ Supporting linkages between facility- and community-based services through formalized bidirectional referral services (e.g., use of national reporting systems to refer and monitor referrals for completeness)	6.2 Score: 0.93	APC delivery model NSF II details testing operations in communities NOP - national strategies and training at community level MOH provides certificate to skilled community health workers	Historically CBOs focused on prevention not direct service delivery. Now they are moving into this work area and developing formalized referral systems.
6.3 Domestic Financing of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services in high burden areas (i.e. excluding any external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services in high burden areas ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services in high burden areas ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services in high burden areas ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services in high burden areas ◉ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services in high burden areas	6.3 Score: 1.67	NASA, NASA Powerpoint, 2013	

6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services in high burden areas without external technical assistance from donors?	○ A. HIV/AIDS services in high burden areas are primarily delivered by external agencies, organizations, or institutions. ○ B. Host country institutions deliver HIV/AIDS services in high burden areas but with substantial external technical assistance. ◉ C. Host country institutions deliver HIV/AIDS services in high burden areas with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services in high burden areas with minimal or no external technical assistance.	6.4 Score: 0.74	Expert panel, Feb 5, 2016.	PEPFAR and Global Fund provide technical assistance.
6.5 Domestic Financing of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services to key populations in high burden areas (i.e. without external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	◉ A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations in high burden areas.	6.5 Score: 0.00	Expert panel, Feb 5, 2016; Government data: NASA, NHA.	MOH policy is to provide HIV/AIDS treatment and care to any PLHIV citizen in Botswana, regardless of gender, identity, or occupation and in fact MOH covers cost of ARVs for all citizens. However in practice, no budget line item targets key populations. Instead, MOH requested funds for KP but asked that the money go directly to Botswana Family Welfare Association (BOFWA) for KP services.
6.6 Domestic Provision of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services to key populations in high burden areas without external technical assistance from donors?	◉ A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions. ○ B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.	6.6 Score: 0.00	Expert panel, Feb 5, 2016.	MOH policy is to provide HIV/AIDS treatment and care to any PLHIV citizen in Botswana, regardless of gender, identity, or occupation. However in practice, there are no services targeting FSW or MSM and annectdotal reports of discrimination in facilities may discourage routine use. Efforts to indirectly support services for KP through support of BOFWA continue
6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services in high HIV burden areas?	The national MOH (check all that apply): ☑ Translates national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☐ Uses epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☑ Assesses current and future staffing needs based on HIV/AIDS program goals and ☑ Develops sub-national level budgets that allocate resources to high burden service delivery locations. ☐ Effectively engages with civil society in program planning and evaluation of services . ☐ Designs a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.7 Score: 0.56	HRH Plan, staffing norms, National budget, Expert panel, Feb 5, 2016.	Data is used to measure geographic access to services but not to measure effectiveness of programs. HRH Plan and staffing norms used to plan for staffing across entire MOH including HIV/AIDS. Staffing for HIV/AIDS base on number of patients on ARVs. National budget allocates resources by district. Huge gap in engagement with SOs for planning and evaluation; need participation on both sides. Training is targeted based on need; allocated by staffing and patients.

6.8 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Sub-national health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☑ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☑ Effectively engage with civil society in program planning and evaluation of services. ☑ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.8 Score: 1.11	DMSAC workplans	DHMT uses data to look at services, e.g., PMTCT.
		Service Delivery Score	**6.11**	
7. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.			**Data Source**	**Notes/Comments**
7.1 HRH Supply: To what extent is the health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or comm site level?	Check all that apply: ☐ The country's pre-service education institutions are producing an adequate supply and skills mix of health care providers ☐ The country's health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden ☑ The country has developed retention schemes that address health worker vacancy or attrition in high HIV burden areas ☑ The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children	7.1 Score: 0.67	Scarce Skills is an allowance given to compensate for rural placement. This applies to civil service jobs nationalwide, not just HIV/AIDS. Social Development Framework, 2010	There is a shortage of Doctors in Clinics. There are only 669 doctors country wide (old number from Health Professionals / Bots Professional Councils). HRIS is not up and running, so records of total doctors and nurses are unavailable. The MOH concurs there is a shortage of doctors but believes the number of nurses are adequate. The MOH cannot produce a vacancy report as their Infinium data is currently being migrated to their Oracle system. Regarding pre-service training, institutions are producing adequate numbers but GOB is not placing adequate numbers into service.
7.2 HRH transition: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?	○ A. There is no inventory or plan for transition of donor-supported health workers ◉ B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support ○ C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented ○ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	7.2 Score: 0.33	Botswana PFP documentation	PEPFAR is currently supporting very few HCWs providing direct services -- there is an inventory, but no formal plan for the transition of these positions.

7.3 Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)?	○ A. Host country institutions provide no (0%) health worker salaries ○ B. Host country institutions provide minimal (approx. 1-9%) health worker salaries ○ C. Host country institutions provide some (approx. 10-49%) health worker salaries ○ D. Host country institutions provide most (approx. 50-89%) health worker salaries ◉ E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries	7.3 Score: 3.33	PEPFAR funded positions budget. MoH Budget	Apart from the PEPFAR support, virtually all HCW are paid for by the GOB.
7.4 Pre-service: Do current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?	◉ A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years) ○ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☐ Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☐ Institutions maintain process for continuously updating content, including HIV/AIDS content ☐ Updated curricula contain training related to stigma & discrimination of PLWHA ☐ Institutions track student employment after graduation to inform planning	7.4 Score: 0.00	Lab Curriculum, and other curricula dated before 2012 New Univ of Botswana curricula to be evaluated/updated after 4 years.	Most curricula last updated in 2008 - curriculums available in hard copy only. MOH states that the curricula are currently undergoing a review and update, however the lecturers have been using the updated guidelines to train new HCW.
7.5 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (if exact or approximate percentage known, please note in Comments column)	Check all that apply among A, B, C, D: ☑ A. The host country government provides the following support for in-service training in the country (check ONE): ☐ Host country government implements no (0%) HIV/AIDS related in-service training ☐ Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training ☐ Host country government implements some (approx. 10-49%) HIV/AIDS in-service training ☐ Host country government implements most (approx. 50-89%) HIV/AIDS in-service training ☑ Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training ☑ B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS ☐ C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians ☑ D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden areas)	7.5 Score: 1.00	2012 National guidelines and KITSO program	Different programs are at different stages of institutionalization. For example the Corporate Services Department "Leadership and Management" course is managed by GOB and the GOB is now budgeting for this training course, although this was PEPFAR funded. Another example is the Kitso training - historically funded by PEPFAR through BHP, now the Kitso training unit is housed at MOH and funded by PEPFAR through the GOB Mega-COag, and will also be supported through the new TBD FOA. Continuing education program for MOH nurses but under-developed for other clinicians. Database to track training exists but use for allocating staff is inadequate.

7.6 HR Data Collection and Use: Does the country systematically collect health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?	○ A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management ○ B. There is no HRIS in country, but some data is collected for planning and management ☐ Registration and re-licensure data for key professionals is collected and used for planning and management ☐ MOH health worker employee data (number, cadre, and location of employment) is collected and used ☐ Routine assessments are conducted regarding health worker staffing at health facility and/or community sites ◉ C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country: ☑ The HRIS is primarily financed and managed by host country institutions ☑ There is a national strategy or approach to interoperability for HRIS ☐ The government produces HR data from the system at least annually ☐ Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)	7.6 Score: 1.00	Panel of experts, February 2016. Follow-up email from GoB, February 2016.	ORACLE is a database tracking system for all civil servants. An HRIS pilot, funded by PEPFAR, was specific for HRH in 2 districts; however it was never adopted nationally.
	Human Resources for Health Score	**6.33**		

8. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, diagnosis and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.			**Data Source**	**Notes/Comments**
8.1 ARV Domestic Financing: What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known. ○ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ◉ E. Most (approx. 50 – 89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.1 Score: 0.63	CMS Records, per February 4, 2016 email from Malebogo Tlotleng ·CMS/LMU personnel, per February 3, 2016	Current April-2015/March-2016 CMS expenditure for ARVs - USD 38,626,700 (BWP 432,811,073; Rate - 1 USD:11.49 BWP; www.oanda.com; 2/10/2016) The Meck donation of ARVs amounting to USD88,744.50 which was promised in 2014/2015 was delivered to CMS during the 2015/2016 GOB financial year; this is a negligible amount of CMS ARV expenditure
8.2 Test Kit Domestic Financing: What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known ○ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50-89%) funded from domestic sources ◉ F. All or almost all (approx. 90%+) funded from domestic sources	8.2 Score: 0.83	Tebelopele POC Rosina Thabeng, 5 February 2016	General consensus is that domestic funding is >90%. Tebelopele funding is 5% of their requirements (email from Tebelopele POC Rosina Thabeng, 5 February 2016)

8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? *Note:* The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs. (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known ◉ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50-89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.3 Score: 0.00	CMS records, per February 5, 2016 Domain mtg	Per CMS, the GOB has a budget for condoms but prior donations are still being distributed (from PSI and UNFPA, 2013)
8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?	○ A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP). ◉ B. There is a plan/SOP that includes the following components (check all that apply): ☑ Human resources ☑ Training ☑ Warehousing ☑ Distribution ☑ Reverse Logistics ☑ Waste management ☑ Information system ☑ Procurement ☑ Forecasting ☑ Supply planning and supervision ☑ Site supervision	8.4 Score: 2.22	The Botswana National Supply Chain Strategy 2014-2019 ·Standard Operating Procedures Manual for the Logistics Management of Health Commodities in Botswana --This document includes job aids for technical tasks ·Supportive supervision and on-the-job training guidelines	While there is a national strategy, costing and implementation of the strategy is lagging behind; contract management is weak - contractor for outsourced warehousing distribution performs below agreed performance level - critical data that drives the supply chain not provided, the country continues to experience stockouts because inaccurate forecasts due to lack of data, coupled with a weak procurement department
8.5 Supply Chain Plan Financing: What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)? (if exact or approximate percentage known, please note in Comments column)	◉ A. This information is not available. ○ B. No (0%) funding from domestic sources. ○ C. Minimal (approx. 1-9%) funding from domestic sources. ○ D. Some (approx. 10-49%) funding from domestic sources. ○ E. Most (approx. 50-89%) funding from domestic sources. ○ F. All or almost all (approx. 90%+) funding from domestic sources.	8.5 Score: 0.00	CMS	Supply chain plan has not been costed and funding information is not available.

8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock levels?	Check all that apply: ☑ The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities ☐ Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time ☑ MOH or other host government personnel make re-supply decisions with minimal external assistance: ☑ Decision makers are not seconded or implementing partner staff ☑ Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects ☑ Team that conducts analysis of facility data is at least 50% host government	8.6 Score: 1.48	·LMIS reports ·APR data ·LMU staff personnel	These are not the right questions to show the holes that exist in supply chain. (per Phetogo) On monthly basis, facilities submit to the LMU reporting & requisition forms containing essential logistics data, including re-supply data, all logistics data is managed at the LMU by host country staff
8.7 Assessment: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment or top quartile for an equivalent assessment conducted within the last three years? (if exact or approximate percentage known, please note in Comments column)	○ A. A comprehensive assessment has not been done ◉ B. A comprehensive assessment has been done but the score was lower than 80% (for NSCA) or in the bottom three quartiles for the global average of other equivalent assessments ○ C. A comprehensive assessment has been done and the score was higher than 80% (for NSCA) or in the top quartile for the assessment	8.7 Score: 1.11	Botswana National Supply Chain Assessment Results (2013)	SCMS assessment report did not have an aggregate score, but no section scored above 75%.
	Commodity Security and Supply Chain Score:	**6.27**		
9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services			**Data Source**	**Notes/Comments**
9.1 Existence of a Quality Management (QM) System: Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels?	○ A. The host country government does not have structures or resources to support site-level continuous quality improvement ◉ B. The host country government: ☑ Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement ☐ Has a budget line item for the QM program ☐ Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions	9.1 Score: 0.67	Quality Management File DHAPC 14/45 Vol 1	Structure: · National level: QI technical working group comprising program focal persons, M&E focal, IT focal and representatives from funding and implementing partners. · District level: led by the District health management team (DHMT) · Facility level: Facilities have QI teams with dedicated focal persons and other program representatives (this is for the 12 Pepfar supported districts) Budget line: There is an existing budget line/code though it is currently not funded MOH has identified the need for an integrated QM system but for now the QM is focused on accreditation primarily.

9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.)	◉ A. There is no HIV/AIDS-related QM/QI strategy ○ B. There is a QM/QI strategy that includes HIV/AIDS, but it is not current (updated within the last 2 years) ○ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements ○ D. There is a current HIV/AIDS program specific QM/QI strategy	9.2 Score: 0.00	MOH Quality Improvement Framework Ref HI 15/11 I(14)	Currently there is no QI strategy for HIV within MOH; however, there is a QI framework in developmental stage that will guide the development of other documents.
9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting?	○ A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting. ◉ B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply): ☐ The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement ☑ There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities ☐ There is documentation of results of QI activities and demonstration of national HIV program improvement	9.3 Score: 0.67	Quality Management File DHAPC 14/45 Vol 1 for minutes/ Real-time reporting system to be found at https://dhis2sms.gov.bw	There are multiple data collection methods currently in use: · Monthly reporting of programmatic activities from facilities to DHMT, and onward transmission to the national level where analysis is conducted. · Real-time reporting and feedback of key programmatic indicators for HTC, ARV, PMTCT, and TB using DHIS (District Health Information System) mobile for the purposes of quality improvement. · Documentation of QI activities has been a challenge, but currently the programs are working closely with the partners to inculcate the culture of documentation of QI activities.
9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services?	○ A. There is no training or recognition offered to build health workforce competency in QI. ◉ B. There is health workforce competency-building in QI, including: ☑ Pre-service institutions incorporate modern quality improvement methods in curricula ☑ National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services	9.4 Score: 2.00	Quality Management A guide for Professional Health Care Providers 2012/ KITSO Integrated curriculum (in progress)	· Pre-service training at health institutes incorporate QI · Handbook developed to guide healthcare workers on quality management · QI module is part of the integrated HIV/TB/SRH curriculum for in-service training. QI has been included as a module of integrated HIV/TB/SRH curriculum currently being developed. This will ensure that HCW undergoing this training will graduate with competency in QI.

9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?	The national-level QM structure: ☑ Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convenes meetings that includes health services consumers ☑ Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement Sub-national QM structures: ☑ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convene meetings that includes health services consumers ☑ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement Site-level QM structures: ☑ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement	9.5 Score: 1.43	Quality Management File DHAPC 14/45 Vol 1 for updated minutes	National level: · QI technical working group comprising key program focal persons and representatives from funding and implementing partners. · Provides oversight to national QI and meets weekly to review analysed data to guide evidence-based remedial actions District level: · The DHMT have QM that coordinate QI across all programs including HIV · Periodically convene multi-stakeholder meetings to address issues pertaining to programs and their quality. · Review their district data periodically (M&E officer and head of preventive) Site-level: Healthcare workers identify and undertake continuous quality improvement in their specific programmatic areas with technical support from implementing partners
	Quality Management Score:	**4.76**		
10. Laboratory: The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV.			**Data Source**	**Notes/Comments**
10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?	○ A. There is no national laboratory strategic plan ○ B. National laboratory strategic plan is under development ○ C. National laboratory strategic plan has been developed, but not approved ◉ D. National laboratory strategic plan has been developed and approved ○ E. National laboratory plan has been developed, approved, and costed	8.1 Score: 1.25	Health Sector Lab Sector Plan 2014-2019	
10.2 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (if exact or approximate percentage known, please note in Comments column)	◉ A. Regulations do not exist to monitor minimum quality of laboratories in the country. ○ B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). ○ C. Regulations exist, but are minimally implemented (approx.. 1-9% of laboratories and POCT sites regulated). ○ D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). ○ E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). ○ F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated).	8.2 Score: 0.00	Expert panel, Feb 5, 2016.	

10.3 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression?	◉ A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control ○ B. There are adequate qualified laboratory personnel to perform the following key functions: ☐ HIV diagnosis in laboratories and point-of-care settings ☐ TB diagnosis in laboratories and point-of-care settings ☐ CD4 testing in laboratories and point-of-care settings ☐ Viral load testing in laboratories and point-of-care settings ☐ Early Infant Diagnosis in laboratories ☐ Malaria infections in laboratories and point-of-care settings ☐ Microbiology in laboratories and point-of-care settings ☐ Blood banking in laboratories and point-of-care settings ☐ Opportunistic infections including Cryptococcal antigen in laboratories and point-of-care settings	8.3 Score: 0.00	Expert panel, Feb 5, 2016.	Insufficient staff to meeting international standards.
10.4 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	○ A. There is not sufficient infrastructure to test for viral load. ◉ B. There is sufficient infrastructure to test for viral load, including: ☑ Sufficient viral load instruments and reagents ☑ Appropriate maintenance agreements for instruments ☐ Adequate specimen transport system and timely return of results	8.4 Score: 1.11	Expert panel, Feb 5, 2016.	Although there is sufficient equipment it is not used to maximum capacity. Also, ancillary equipment needed for HIV/AIDS-related care, is lacking adquate maintenance agreements.
10.5 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)? (if exact or approximate percentage known, please note in Comments column)	○ A. No (0%) laboratory services are financed by domestic resources. ○ B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources. ○ C. Some (approx. 10-49%) laboratory services are financed by domestic resources. ○ D. Most (approx. 50-89%) laboratory services are financed by domestic resources. ◉ E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.	8.5 Score: 3.33	Expert panel, Feb 5, 2016; MOH Budget; NASA	
	Laboratory Score:	**5.69**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Investments, Efficiency, and Sustainable Financing

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

11. Domestic Resource Mobilization: The partner country budgets for its HIV/AIDS response and makes adequate resource commitments and expenditures to achieve national HIV/AIDS goals for epidemic control in line with its financial ability.			**Data Source**	**Notes/Comments**
11.1 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?	○ A. There is no explicit funding for HIV/AIDS in the national budget. ◉ B. There is explicit HIV/AIDS funding within the national budget. ☑ The HIV/AIDS budget is program-based across ministries ☐ The budget includes or references indicators of progress toward national HIV/AIDS strategy goals ☐ The budget includes specific HIV/AIDS service delivery targets ☐ National budget reflects all sources of funding for HIV, including from external donors	11.1 Score: 1.39	National Budget and NACA	Each Ministry has a line item for HIV. NACA controls remaining discretionary HIV/AIDS budget. By April 2016 NACA's budget will be combined within the MOH budget.
11.2 Annual Targets: Did the most recent budget as executed achieve stated annual HIV/AIDS goals? (if exact or approximate percentage known, please note in Comments column)	◉ A. There are no HIV/AIDS goals/targets articulated in the national budget ○ B. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but none (0%) were attained. ○ C. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but very few (approx. 1-9%) were attained. ○ D. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and some (approx. 10-49%) were reached. ○ E. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and most (approx. 50-89%) were reached. ○ F. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and all or almost all (approx. 90%+) were reached.	11.2 Score: 0.00	National budget	

11.3 Budget Execution: For the previous three years, what was the average execution rate for budgeted domestic HIV/AIDS resources (i.e. excluding any donor funds) at both the national and subnational level? (If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)	○ A. Information is not available ○ B. There is no national HIV/AIDS budget, or the execution rate was 0%. ○ C. 1-9% ○ D. 10-49% ◉ E. 50-89% ○ F. 90% or greater	11.3 Score: 1.67	Monthly budget expenditure rates	Some challenges with spending down budgeted items in supply chain procurement. GOB Fiscal year 2014-2015: warranted provision 352,862,455.07 actual expenditure 348,569,337.83 percent expenditure 98.78% GOB Fiscal year 2015-2016 to date: warranted provision 560,365,220.00 actual expenditure 432,811,072.83 percent expenditure 77.23%
11.4 PLACEHOLDER for future indicator measuring country's financial ability to pay for its HIV response (will not be included in SID for COP 16)				
11.5 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding (excluding out-of-pocket and donor resources)? (if exact or approximate percentage known, please note in Comments column)	○ A. None (0%) is financed with domestic funding. ○ B. Very little (approx. 1-9%) is financed with domestic funding. ○ C. Some (approx. 10-49%) is financed with domestic funding. ◉ D. Most (approx. 50-89%) is financed with domestic funding. ○ E. All or almost all (approx. 90%+) is financed with domestic funding.	11.6 Score: 2.50	Sept. 2013 USAID Transitional Financing Report National Health Accounts (preliminary data Dec 2015)	55.2% domesic public and 2.9% domestic private for 2012, for a domestic total of 58.1% (these figures represent an adjustment of the NASA figures, which were 69.6% and 1.9%, respectively, for domestic public and domestic private).
	Domestic Resource Mobilization Score:	**5.56**		

12. Technical and Allocative Efficiencies: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time). Unit costs are tracked and steps are taken to improve HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources).			**Data Source**	**Notes/Comments**
12.1 Resource Allocation Process: Does the partner country government utilize a recognized data-driven model to inform the allocation of domestic (i.e. non-donor) public HIV resources? (note: full score achieved by selecting one checkbox)	○ A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources. ◉ B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply): ☐ Optima ☑ Spectrum (including EPP and Goals) ☐ AIDS Epidemic Model (AEM) ☑ Modes of Transmission (MOT) Model ☐ Other recognized process or model (specify in notes column)	12.1 Score: 1.43	Spectrum (2014-2015) MOT (2010)	Spectrum (2014-2015) used by UNAIDS for Investment Case and Test and Treat costing exercise. MOT (2010) used by NACA
12.2 High Impact Interventions: What percentage of site-level point of service HIV domestic public sector resources (excluding any donor funds) are being allocated to the following set of interventions: provision of ART, VMMC, PMTCT, HTC, condoms, and targeted prevention for key and priority populations? (if exact or approximate percentage known, please note in Comments column)	○ A. Information not available ○ B. No (0%) site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ C. Minimal (approx. 1-9%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ D. Some (approx. 10-49%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ◉ E. Most (approx. 50-89%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ F. All or almost all (approx. 90%+) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.	12.2 Score: 1.07	NASA (2012 report)	258 mil Pula for activities outside of these high impact interventions (e.g., management, HRH, research) out of 2.2 billion Pula (27%) - check slide from Dr. Sun

12.3 Geographic Allocation: Of central government HIV-specific resources (excluding any donor funds) allocated to geographic subunits in the most recent year available, what percentage is being allocated in the highest burden geographic areas (i.e. districts that cumulatively account for 80% of PLHIV)? (if exact or approximate percentage known, please note in Comments column)	◉ A. Information not available. ○ B. No resources (0%) are targeting the highest burden geographic areas. ○ C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas. ○ D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas. ○ E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas. ○ F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.	12.3 Score: 0.00	Per MOH Staff at SID meeting, Feb 8, 2016	GOB takes position of equity and provides funding to all districts with allocation based on facilities per district. Disease burden by district is available but national budget by district is not available to allow us to determine the proportion of funds allocated to high burden geographic areas.
12.4 Data-Driven Reprogramming: Do host country government policies/systems allow for reprograming domestic investments based on new or updated program data during the government funding cycle?	○ A. There is no system for funding cycle reprogramming ◉ B. There is a policy/system that allows for funding cycle reprogramming, but it is seldom used. ○ C. There is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data ○ D. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data	Q3 Score: 0.48	Per MOH Staff at SID meeting, Feb 8, 2016.	Prior to end of year, MOH reviews unspent funds and may reallocate to a specific tangible item (e.g., procurement of medicines or equipment). Any unused money by end of year from MOH goes back to treasury and gets reallocated in following fiscal year.
12.5 Unit Costs: Does the host country government use recent expenditure data or cost analysis (i.e. data from within the last three years) to estimate unit costs of HIV/AIDS services for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).	○ A. The host country government does not use recent expenditure data or cost analysis to estimate unit costs ◉ B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply): ☑ HIV Testing ☑ Care and Support ☑ ART ☑ PMTCT ☑ VMMC ☐ OVC Service Package ☐ Key population Interventions	12.5 Score: 1.43	Essential health package study (Oct 2015)	The MOH completed a study on costing the essential health package, have costed out ARV regimens, PMTCT, etc. PEPFAR has supported a number of these studies, so this is not yet routinely and regularly conducted by the GOB.

12.6 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?	Check all that apply: ☐ Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies ☐ Reduced overhead costs by streamlining management ☑ Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc. ☐ Improved procurement competition ☐ Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years) ☑ Integrated HIV into primary care services with linkages to specialist care (need not be within last three years) ☑ Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years) ☑ Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years) ☐ Developed and implemented other new and more efficient models of HIV service delivery (specify in comments)	12.6 Score: 0.63	Costing studies; New Treatment Guidelines; email from procurement expert.	Costing studies completed but translation of findings into improved operations is in development. Efficiencies are under consideration in the new Treatment Guidelines (due 2016) to reduce frequencies of clinical visits, lab testing, ARV pickups. 3rd Box: Yes-- through the establishment of 2-3 year framework contracts; emergency procurements, reduced product expiries, and fixed pricing for the life of the contract. Box 4: International-- yes Local contracts-- no In an effort to promote local suppliers, the local pricing is not competitive. Once local suppliers have obtains products from international manufacturers
12.7 ARV Benchmark prices: How do the costs of ARVs (most common first line regimen) purchased in the previous year by the partner government using domestic resources compare to international benchmark prices for that year? (Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)	○ A. Partner government did not pay for any ARVs using domestic resources in the previous year. ○ B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen. ◉ C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen. ○ D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen. ○ E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen.	12.7 Score: 0.71	CMS Records, per February 17, 2016 email. WHO Global Price Reporting Mechanism (http://apps.who.int/hiv/amds/price/hdd/Default.aspx)	Per ARV quantification data extract from Quantimed for GOB 16/17 financial year, the annual cost for Atripla first-line regimen for 2015/2016 was $132.74. That is 18% above the 2015 international median annual cost for TDF/FTC/EFV treatment ($112.14). From data provided by CMS the current price for Atripla is $10.02. However, data used for quantification provides average price for procurements done in the whole year, including prices paid for emergency orders. (Ideally the analysis should be based on a number of ARVs and not one) Dr. Sun - efficiency gains are lost when GOB has to pay for emergency ARV procurement at much higher cost. Can we see if data is avail on coss for routine vx emergency procurements.
Technical and Allocative Efficiencies Score:		**5.75**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN C

Domain D: Strategic Information

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

13.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV, HIV incidence, HIV prevalence, viral load and AIDS-related mortality rates.			**Data Source**	**Notes/Comments**
13.1 Who Leads General Population Surveys & Surveillance: To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ○ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ◉ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies	13.1 Score: 0.71	BAIS IV report (Nov 2013), YRBSS report, HIV Sentinal Surveillence survey (2011).	Statistics Botswana Leads the implementation of surveys, relevant government ministry leads the planning for each survey (i.e. MOE leads the YRBSS, NACA leads BAIS). BAIS is done with minimal TA; however TA is provided from external partners for YRBSS and MOPS. HIV Sentinel Surv has been delayed due to a change in protocol that has received external TA. An upcoming Violence Against Children survey will receive substantial TA.
13.2 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ◉ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies	13.2 Score: 0.48	BBSS 2012	Substantial TA from WHO and PEPFAR
13.3 Who Finances General Population Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ◉ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	13.3 Score: 1.25	BAIS IV budget	According to the CDC SI team BAIS cost 3.68 million of which PEPFAR funded a portion and GOB funded 3.1 million = 84% .

13.4 Who Finances Key Populations Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (approx. 90% +) is provided by the host country government	13.4 Score: 0.42	BBSS 2012	Primary funding for the BBSS came from PEPFAR ($400,000) and WHO ($50,000). MOH donated all the lab reagents needed for testing under the BBSS.
13.5 Comprehensiveness of Prevalence and Incidence Data: To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregations, populations and geographic units? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by: ☑ Age ☑ Sex ☑ Key populations (FSW, PWID, MSM/transgender) ☑ Priority populations (e.g., military, prisoners, young women & girls, etc.) ☑ Sub-national units ☑ B. The host country government collects at least every 5 years HIV incidence disaggregated by: ☐ Age ☐ Sex ☑ Key populations (FSW, PWID, MSM/transgender) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) ☐ Sub-national units	13.5 Score: 0.60	BAIS IV report (Nov 2013), BBSS report 2012	Responses are based on the last BAIS IV survey and the BBSS survey. BAIS data is collected every 4 years and provides detailed prevalence data with the exception of KP data. Estimates from BAIS for KP depend on derived variable for KP identification. BBSS data is used to estimate KP prevalence; data is collected in select locations only.

13.6 Comprehensiveness of Viral Load Data: To what extent does the host country government collect/report viral load data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage known, please note in Comments column)	○ A. The host country government does not collect/report viral load data or does not conduct viral load monitoring ◉ B. The host country government collects/reports viral load data (answer both subsections below): According to the following disaggregates (check ALL that apply): ☑ Age ☑ Sex ☐ Key populations (FSW, PWID, MSM/transgender) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) For what proportion of PLHIV (select ONE of the following): ☐ Less than 25% ☐ 25-50% ☑ 50-75% ☐ More than 75%	13.6 Score: 0.60	Panel of experts, February 2016.	Absolute numbers of test performed are reported by partners, but not analyzed by result. Per the national guidelines, viral load is conducted regularly for patient case management purposes, and tracked in patient charts. This data is captured in the MOH data warehouse but may not be routinely analyzed for trends. BHP (ended 2015) did some reporting on lab testing during life of training project.
13.7 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct IBBS and/or size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.)	○ A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM) or priority populations (Military, etc.). ◉ B. The host country government conducts (answer both subsections below): IBBS for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM)/transgender ☑ People who inject drugs (PWID) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) Size estimation studies for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM)/transgender ☐ People who inject drugs (PWID) ☑ Priority populations (e.g., military, prisoners, young women & girls, etc.)	13.7 Score: 0.95	BBSS 2012	BBSS received PEPFAR funding, but was led and managed by the GOB. The BBSS attempted to survey PWID but was unable to find sufficient PWID, so PWID were then removed from the survey. Military and Prisoner population prevalence surveys completed by GOB but data is confidential.
13.8 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?	◉ A. There is no national HIV surveillance and surveys strategy, or a national surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys ○ B. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), but the strategy does not outline a timeline for data collection for all relevant population groups ○ C. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), and outlines a timeline for data collection for all relevant population groups	13.8 Score: 0.00	Panel of experts, February 2016.	National HIV surveillance and survey strategy remains in draft form.

13.9 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	○ A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply): ☑ A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data ☐ A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance ☐ Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection ☑ An in-country internal review board (IRB) exists and reviews reviews all protocols.	13.9 Score: 0.48	HRDC - IRB Policy and Planning division - surveillance unit	
	Epidemiological and Health Data Score:	**5.48**		
14. Financial/Expenditure data: Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness.			**Data Source**	**Notes/Comments**
14.1 Who Leads Collection of Expenditure Data: To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data?	○ A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years ○ B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions ○ C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with substantial external technical assistance ◉ D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with some external technical assistance ○ E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance	14.1 Score: 1.25	2012 NASA Report; pending NHA (2016)	NASA data to be updated every 3 years. Currently analyzing new NHA data to inform NASA. PEPFAR and WHO provided TA for the NHA data collection and analysis.
14.2 Who Finances Collection of Expenditure Data: To what extent does the host country government finance the collection of HIV/AIDS expenditure data (e.g., printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ◉ F. All or almost all financing (90% +) is provided by the host country government	14.2 Score: 3.33	Pending NHA report.	Data collection financing primarily from GOB, some additional funds from WHO and UNAIDS.

14.3 Comprehensiveness of Expenditure Data: To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area?	○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ◉ B. HIV/AIDS expenditure data are collected (check all that apply): ☑ By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ By expenditures per program area, such as prevention, care, treatment, health systems strengthening ☑ By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel ☐ Sub-nationally	14.3 Score: 1.25	2012 NASA Report; pending NHA (2016); HPP costing for Essential Health Service Package (EHSP, 2015)	Recurrent NASA conducted every 3 years
14.4 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?	○ A. No HIV/AIDS expenditure data are collected ○ B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago ○ C. HIV/AIDS expenditure data were collected at least once in the past 3 years ○ D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures ◉ E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures	14.4 Score: 1.67	MOH budget from Government Budgeting and Accounting System.	Annual MOH budget process looks at previous government budget, allocation, and spending to determine budget allocation for new year.
14.5 Economic Studies: Does the host country government conduct health economic studies or analyses for HIV/AIDS?	○ A. The host country government does not conduct health economic studies or analyses for HIV/AIDS ◉ B. The host country government conducts (check all that apply): ☑ Costing ☑ Economic evaluation (e.g., cost-effectiveness analysis and cost-benefit analysis) ☐ Efficiency analysis (e.g., efficiency of service delivery by public and private sector, resource allocation) ☐ Market demand analysis	14.5 Score: 0.83	HTC costing study, Costing for move to Test & Treat (2015/16), Effectiveness of Dr. vs. Nurse prescribers (6 June 2013, Monyatsi et al.),HHPP costing for Essential Health Service Package (EHSP, 2015), HPP costing of select HIV/AIDS services (2015).	Most of these received some funding support from PEPFAR. Efficiency study for SRH/HIV linkages (2016) HFG (Abt assoc) conducting ART Efficiency study (2015-16) WB efficiency study is at the data analysis stage though there are some gaps in available data. Analysis should be completed by April 2016.
	Financial/Expenditure Data Score:	**8.33**		
15. Performance data: Government routinely collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention.			**Data Source**	**Notes/Comments**
15.1 Who Leads Collection of Service Delivery Data: To what extent is the routine collection of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government?	○ A. No system exists for routine collection of HIV/AIDS service delivery data ◉ B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions ○ C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution ○ D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution ○ E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government	15.1 Score: 0.33	DHIS, PIMS; IPMS; ETR; Open-MRS; data warehouse	Systems are uncoordinated. MOH recently adopted an e-health strategy, final draft is almost ready. Strategy is meant to harmonize these systems and provide guidance moving forward.

15.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No routine collection of HIV/AIDS service delivery data exists ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ◉ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	15.2 Score: 2.50	Panel of experts, February 2016.	Distribution of paper-based tools and maintenance of e-systems is funded by government. However gaps exist in the system and MOH overall expenditures on M&E are very low. Government is committed to IPMS while other systems are supported externally.
15.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government routinely collects & reports service delivery data for: ☑ HIV Testing ☑ PMTCT ☐ Adult Care and Support ☑ Adult Treatment ☑ Pediatric Care and Support ☑ Orphans and Vulnerable Children ☑ Voluntary Medical Male Circumcision ☐ HIV Prevention ☑ AIDS-related mortality ☑ B. Service delivery data are being collected: ☐ By key population (FSW, PWID, MSM/transgender) ☐ By priority population (e.g., military, prisoners, young women & girls, etc.) ☑ By age & sex ☑ From all facility sites (public, private, faith-based, etc.) ☐ From all community sites (public, private, faith-based, etc.)	15.3 Score: 1.00	Monthly HAART update and quarterly reports from TB, HTC, PMTCT	For Care and Support - TB data is collected, but pre-ART data is not. The MOH, with CDC support, has created registers and indicators for pre-ART care. The next step is implementing these registers/indicators. Pre-ART pilot was conducted in 2015. Those data are available although report is not publicly released yet. Condom distribution data is collected and reported however consumption data is not collected. Other HIV prevention activities (e.g., life skills training) are not routinely collected. AIDS-related mortality is collected however there is a multi-year lag in producing analyses. Currently not all community sites are routinely collected.
15.4 Timeliness of Service Delivery Data: To what extent are HIV/AIDS service delivery data collected in a timely way to inform analysis of program performance?	○ A. The host country government does not routinely collect/report HIV/AIDS service delivery data ○ B. The host country government collects & reports service delivery data annually ○ C. The host country government collects & reports service delivery data semi-annually ◉ D. The host country government collects & reports service delivery data at least quarterly	15.4 Score: 1.33	Quarterly program reports for most programs - HTC, PMTCT, TB, treatment,etc.	Quarterly program reports for most programs - HTC, PMTCT, TB, etc. HAART data is collected quarterly but due to staff vacancy the HAART report was not published quarterly in 2015

15.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?	○ A. The host country government does not routinely analyze service delivery data to measure program performance ◉ B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply): ☐ Continuum of care cascade for each identified priority population (e.g., military, prisoners, young women & girls, etc.), including HIV testing, linkage to care, treatment, adherence and retention ☐ Continuum of care cascade for each relevant key population (FSW, PWID, MSM/transgender), including HIV testing, linkage to care, treatment, adherence and retention ☑ Results against targets ☑ Coverage of key treatment & prevention services (ART, PMTCT, VMMC, etc.) ☐ Site-specific yield for HIV testing (HTC and PMTCT) ☐ AIDS-related mortality rates ☐ Variations in performance by sub-national unit ☐ Creation of maps to facilitate geographic analysis	15.5 Score: 0.33	Health Statistics Report, 2009; Maternal Mortality Ration 2008-2013, 2013.	Data is being collected and select programs are using it to measure program performance (e.g., PMTCT, VMMC). District DHMTs use data to measure against their district-level targets. National target setting and measurement of performance is inadequate. Unclear how the district targets map to national targets. Drug forecasting uses HAART data to refine procurement projections.
15.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?	○ A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply): ☐ A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance ☐ A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of key HIV program indicators, which are led and implemented by the host country government ☑ Standard national procedures & protocols exist for routine data quality checks at the point of data entry ☐ Data quality reports are published and shared with relevant ministries/government entities & partner organizations ☐ The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans	15.6 Score: 0.27	SOPs	No plan/strategy articulated and shared regarding routine assessments. Standard operating procedures exist to assure data quality.
		Performance Data Score: 5.77		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D