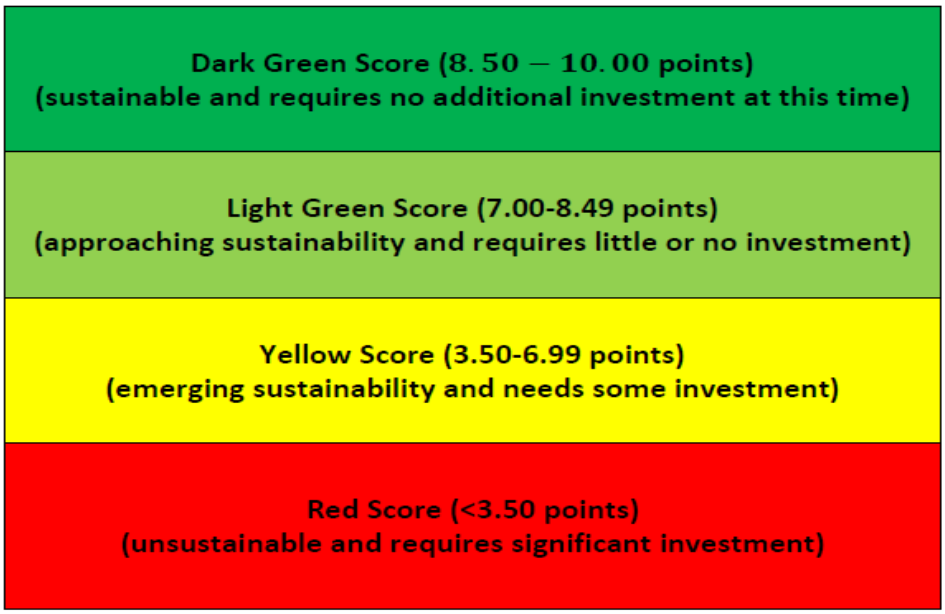
Botswana National HIV Response

2019 Sustainability Index and Dashboard (SID) Narrative Cover Sheet

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed every two years by PEPFAR/Botswana and local stakeholders to sharpen the understanding of the sustainability landscape of the country's national HIV/AIDS response and to assist all key stakeholders – particularly the Government of Botswana (GOB), PEPFAR, and the Global Fund – in making informed investment decisions. Based on responses to 110 questions, the SID assesses the current state of sustainability of Botswana's national HIV/AIDS response across 17 critical elements distributed across four domains. Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information. As the SID is completed over time, it allows stakeholders to track progress and gaps across these key components of sustainability.



Botswana Overview:

For the past 20 years, Botswana has made significant strides to bring the HIV/AIDS epidemic under control. In June 2016, the country adopted a "Treat All" policy, which offers free ART to any citizen who tests HIV positive, regardless of CD4 count. In addition to increasing the number of people on treatment, the government is also striving to refine its operational systems and its policies and guidelines to retain PLHIV on treatment, ensure they are virally suppressed, and to bring the HIV infection rate below AIDS related deaths. For example, in April 2019, the country

adopted 14 minimum program requirements from WHO normative guidance that are expected to accelerate the country's path to achieving the UNAIDS 90-90-90 goals by 2020 and the 95-95-95 goals by 2030. Overall, the sustainability of Botswana's HIV response is emerging (all 17 elements scored at a minimum in the yellow score band). The government has made steady progress in improving an enabling environment (Governance) and making adequate resource commitments (Strategic Financing) to achieve epidemic control. However, significant challenges remain, including:

- Improving the linkages between facility and community based HIV services and ensuring high quality services;
- Further strengthening the laboratory capacity to meet service needs of current and future PLHIV;
- Continuing to fine-tune the timely supply, distribution, and quality of key commodities;
- Improving the technical and allocative efficiencies in the response which is dependent on a stronger capacity for gathering and analyzing epidemiological, health, financial, and expenditure data to be used for decision-making.

The Botswana SID Process:

The 2019 SID process was planned and implemented by a working group chaired by the UNAIDS Country Director and comprised of representatives from the Ministry of Health and Wellness (MoHW), PEPFAR and civil society. The working group planned and implemented the Responsibility Matrix (RM) and SID meetings and collected reference documents to support discussions. The RM meeting took place on September 13, 2019 at UNAIDS offices and was attended by representatives from MoHW, UNAIDS, PEPFAR, the Global Fund (represented by one of the Principal Recipients of TB/HIV funding) and two civil society organizations. The SID meeting took place on September 16, 2019, with 50 representatives from civil society, multilateral organizations, several GOB ministries and U.S. Government agencies. The participants broke into four domain groups to discuss and complete the SID questionnaire. Each group was facilitated by either UNAIDS or PEPFAR staff and supported by one note taker and one rapporteur. Each group had access to a hard and/or electronic copy of 60 reference documents and the 2017 SID report. After the questionnaire was completed in breakout groups, everyone convened in a plenary session to review and discuss both the conclusions of the RM meeting and the SID dashboard.

Sustainability Strengths:

- **Policy and Governance** (**8.48** - **Light Green**): *2-4 sentences*

Botswana has recently adopted very progressive policies to accelerate its path to epidemic control. For instance, the 14 minimum program requirements (MPRs) adopted in April include commitments to provide free ART to non-citizens and to strengthen the health sector's Health Management Information Systems (HMIS) – both identified as vulnerabilities in the 2017 SID.

The MPRs also include plans for same-day initiation of ART and multi-month dispensing of ART for stable HIV-infected patients.

- **Planning and Coordination** (**8.29** - **Light Green**)

Botswana develops, implements, and oversees a costed National Strategic Framework (NSF) every five years with midterm reviews. The third iteration of the document (NSF III – 2019/2023) has been approved and launched. The development of the NSF III as well as its implementation is generally well-coordinated across all sectors and levels of government as well as between government, multilateral and donor agencies, and local civil society organizations. The National AIDS Coordinating Agency was reorganized this year to be the National AIDS and Health Promotion Agency (NAHPA). NAHPA's scope of work now includes non-communicable disease prevention and has been aligned under the Office of the President to serve as the main coordinating agency in Botswana.

- **Domestic Resource Mobilization** (**8.13** - **Light Green**)

There is a limited number of donors funding the HIV response in Botswana. The GOB covers close to 60% of the cost of the national HIV response, PEPFAR covers more than 30% and the Global Fund covers the remainder. Recent commitments to providing free ART to non-citizens and improving the country's HMIS will require additional resource commitments down road unless the country improves its procurement processes and other technical and allocative efficiencies. For example, a recent efficiency analysis (Musau et al. 2018) has demonstrated that Botswana could save more than US$ 14 million in 3 years by using a pooled procurement mechanism to purchase ARVs. The government is working with donors and multilaterals on several initiatives to further strengthen the financial sustainability of the HIV response.

Sustainability Vulnerabilities:

- **Technical and Allocative Efficiencies** (**3.83** - **Yellow**)

The capacity of the HIV response to identify and deliver the right interventions, in the right places, for the right populations, at the right time, still needs to be strengthened. This includes the country's ability to improve HIV/AIDS outcomes within the currently available resource envelop. To that end, the lack of timely and accurate commodities and patient information for decision-making, and the inefficiency of current commodity procurement processes were identified as needing attention. The vulnerability of the supply chain for ARVs in particular has even increased from the last sustainability assessment (SID 2017) due primarily to the inefficiencies of the procurement processes in place. Aware of these challenges, the government is currently working with the World Bank to identify adequate remediation. This element received the lowest of all scores.

- **Quality Management** (**5.48** - **Yellow**)

Botswana has yet to institutionalize appropriate quality management structures to support the growing need for continuous quality improvement of HIV/AIDS services, especially at the sub-national and site levels. Currently quality management/quality improvement efforts though effective are limited in reach and do not cover the entire country. Moreover, GOB does not set and/or track performance targets at the Sub-National and site levels. There has not been a response-wide quality improvement initiative since 2017. This element received the second lowest score.

Additional Observations:

Participants also shared feedback on the SID tool. The majority remarked that the tool had limitations and lacked contextual nuances. For example, one question under Section 2.8 – *Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people?* – was difficult to answer based on the Yes/No choices listed. Answer B states: *Yes, Morality Laws or Religious Norms that limit LGBTI freedom of expression*. The appearance of equating "religious norms" to "punitive laws" did not make sense to the responders and made the answer almost impossible to select. Yet, in general, all participants agreed that the SID provided a unique opportunity to reflect on the current state of Botswana HIV response and build consensus across stakeholder groups around the strengths and weaknesses worth considering. Participants also recommended the provision of a "dictionary" detailing terms along with definitions as some discussions were dominated by debating the definition of key terminologies in the questions.

Contact:

For questions or further information about PEPFAR's own efforts to support and help advance the sustainability of the HIV response in Botswana, please contact Dan Craun-Selka at craunselkadm@state.gov.

Sustainability Analysis for Epidemic Control: Botswana

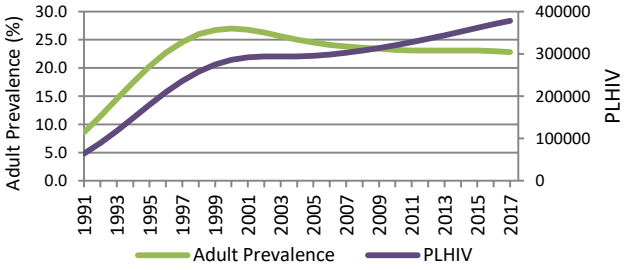
Epidemic Type: Generalized
Income Level: Upper middle income
PEPFAR Categorization: Targeted Assistance (Co-finance)
PEPFAR COP 19 Planning Level: $ 47,647,643

SUSTAINABILITY DOMAINS and ELEMENTS

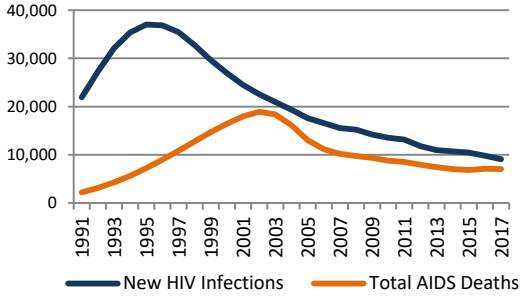
	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	7.70	7.50	8.29	
2. Policies and Governance	6.58	7.06	8.40	
3. Civil Society Engagement	5.60	6.88	5.50	
4. Private Sector Engagement	3.08	5.78	6.90	
5. Public Access to Information	8.00	6.00	7.00	
National Health System and Service Delivery				
6. Service Delivery	6.11	6.90	6.69	
7. Human Resources for Health	6.33	6.23	7.50	
8. Commodity Security and Supply Chain	6.27	6.79	6.58	
9. Quality Management	4.76	6.14	5.48	
10. Laboratory	5.69	5.58	6.58	
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	5.56	7.10	8.13	
12. Technical and Allocative Efficiencies	5.75	6.89	3.83	
13. Market Openness	N/A	N/A	7.59	
Strategic Information				
14. Epidemiological and Health Data	5.48	4.76	5.86	
15. Financial/Expenditure Data	8.33	5.83	5.83	
16. Performance Data	5.77	6.66	7.67	
17. Data for Decision-Making Ecosystem	N/A	N/A	7.17	

CONTEXTUAL DATA

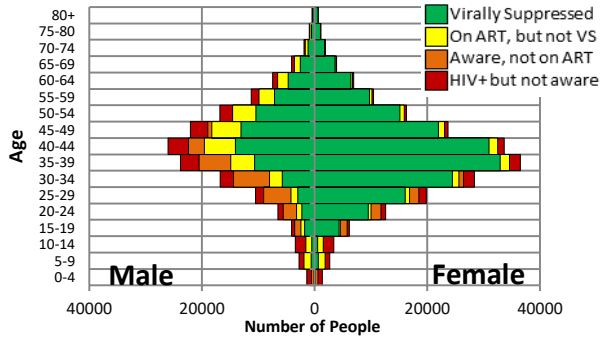
Adult Prevalence & PLHIV



New Infections & Total AIDS Deaths

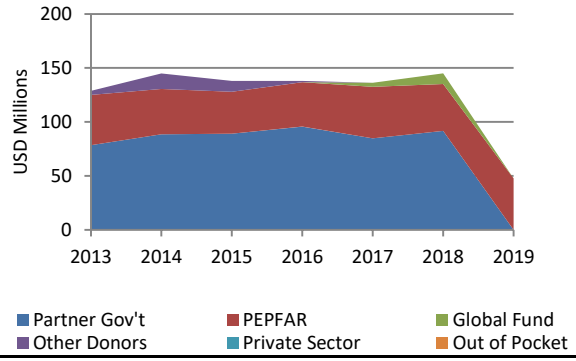


Clinical Cascade

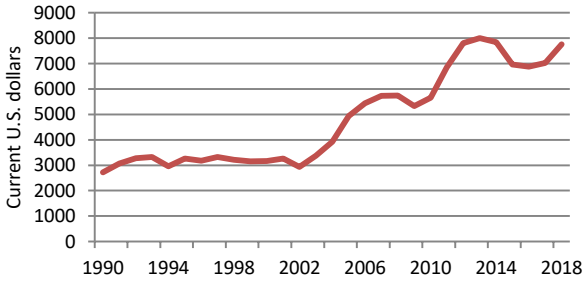


CONTEXTUAL DATA

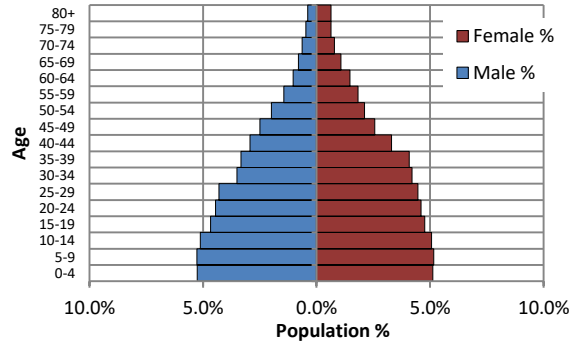
Financing the HIV Response



GNI Per Capita (Atlas Method)



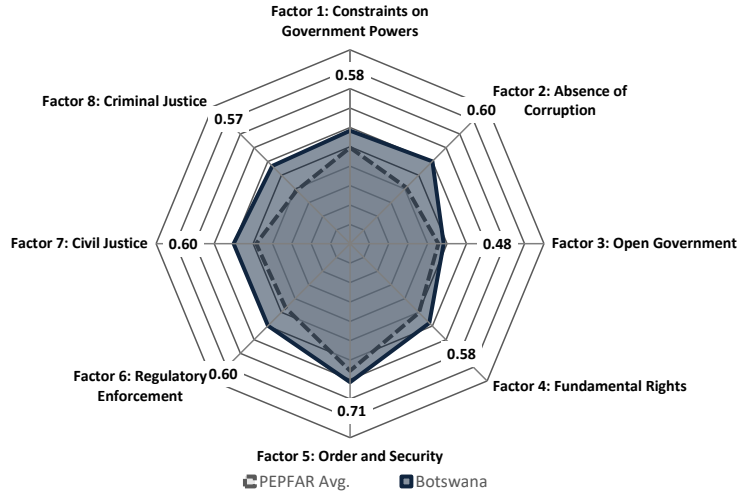
Population Pyramid (2019)

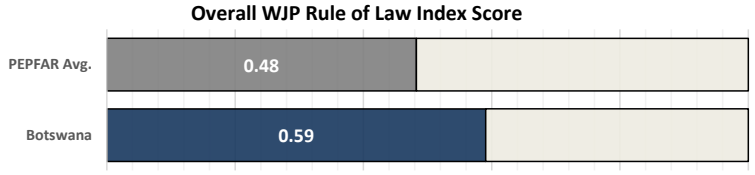


Sustainability Analysis for Epidemic Control: Botswana

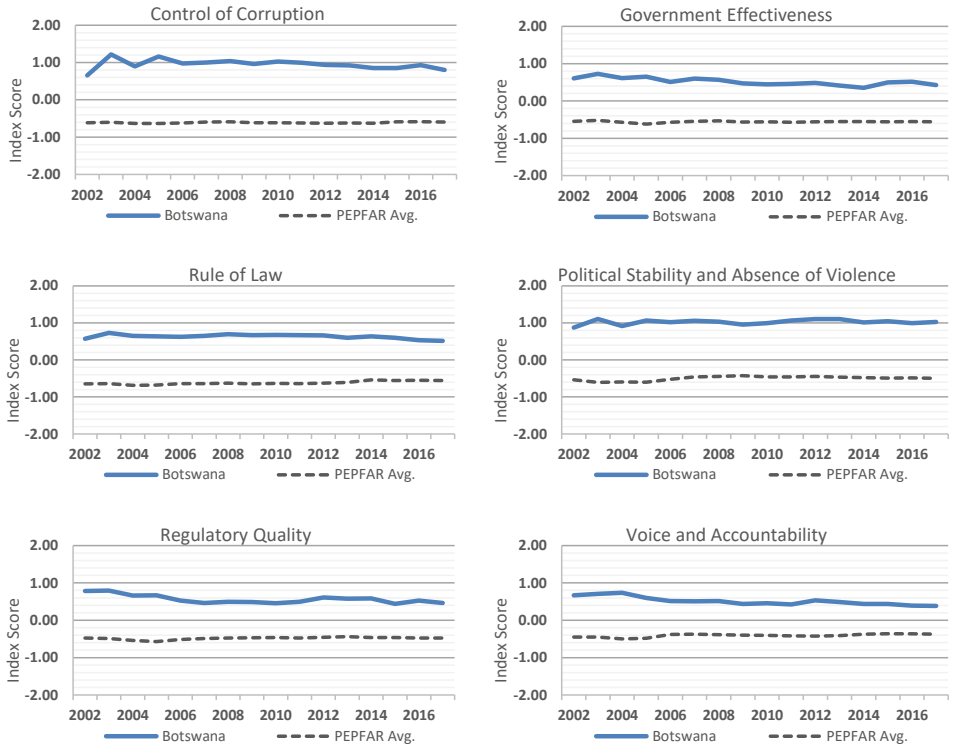
Contextual Governance Indicators

Rule of Law Index (World Justice Project)





Worldwide Governance Indicators (World Bank)



WJP's Rule of Law Index measures the general public's experience and perception across eight 'factors':

1. Constraints on Government Powers: Governmental powers are limited by both internal and external checks, including auditing and review. Governmental officials are subject to the law and sanctioned for misconduct.

2. Absence of Corruption: Government officials in all branches of government do not use public office for private gain.

3. Open Government: Citizens have open access to government information and data, complaint mechanisms, and civic participation.

4. Fundamental Rights: There is equal treatment of citizens and absence of discrimination. The rights to freedom of expression, security of the person, and due process are effectively guaranteed.

5. Order and Security: Crime and civil conflict are effectively limited. Personal grievances are not redressed through violence.

6. Regulatory Enforcement: Government regulations are effectively applied and enforced without improper influence. Due process is respected in administrative proceedings.

7. Civil Justice: Civil justice is accessible and free of discrimination, corruption and improper government influence.

8. Criminal Justice: Criminal justice is impartial, timely and effective, and free from corruption or improper government influence. There is due process of law and rights of the accused.

More information can be found at: https://worldjusticeproject.org/our-work/research-and-data/wjp-rule-law-index-2019

The World Bank Worldwide Governance Indicators (WGI) score countries based on six dimensions of governance:

1. Control of Corruption: captures perceptions of the extent to which public power is exercised for private gain, including both petty and grand forms of corruption, as well as 'capture' of the state by elites and private interests.

2. Government Effectiveness: measures the quality of public services, the quality of the civil service and its independence from political pressure, the quality of policy formulation and implementation (including the efficiency of revenue mobilization and budget management), and the credibility of the government's commitment to its stated policies.

3. Rule of Law: captures perceptions of the extent to which agents have confidence in and abide by the rules of society, and in particular the quality of contract enforcement, property rights, the police, and the courts, as well as the likelihood of crime and violence.

4. Political Stability and Absence of Violence: measures perceptions of the likelihood of political instability and/or politically-motivated violence, including terrorism.

5. Regulatory Quality: Measures perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development.

6. Voice and Accountability: captures perceptions of the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media.

More information can be found at: https://info.worldbank.org/governance/wgi/

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, create space for and promote participation of the private sector, 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 has measurable targets. ☑ 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 ☑ Strategy (or separate document) includes considerations and activities related to sustainability	1.1 Score: 2.29	The Third Botswana National Strategic Framework for HIV and AIDS (NSF III) 2019-2023; National Operational Plan Sept 2017	It is in the process of being costed; national targets have recently been set

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: 1.50	The Third Botswana National Strategic Framework for HIV and AIDS (NSF III) 2019-2023; National Operational Plan Sept 2017	Unsure of involvement from corporate sector, there is a structure for engagement in place but active participation can be improved; Private health sector is actively involved in service delivery and mentioned in document, although they weren't involved in the national planning process
1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS activities implemented 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 (including health care providers and/or other private sector partners) ☑ 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: 2.00	NSF III; National Operational Plan; District Evidence Based Plans (EBP)	NAHPA, MOHW, and National AIDS Council are coordinating mechanism; Mechanisms for tracking/mapping exist although the group questioned if these were part of routine reporting, routine reporting occurs in district multi-sectoral health committees (DMSAC) then are aggregated at the national level; Effectiveness and consistency of tracking and mapping is unclear and can be improved; routine national and district coordination meetings occur, although should be more frequent; Joint operational plans exist at district but not national level

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 either checkbox under option B)	○ A. There is no formal link between the national plan and sub-national service delivery. ◉ B. There is a formal link between the national plan and sub-national service delivery. (Check the ONE that applies.) ☐ Sub-national units have performance targets that contribute to aggregate national goals or targets. ☑ The central government is responsible for service delivery at the sub-national level.	1.4 Score: 2.50	District Evidence Based Plans (EBP)	District create plans, although they do not have targets
Planning and Coordination Score:		**8.29**		

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 WHO guidelines for initiation of ART - i.e., optimal ART regimens for all populations (including TLD as recommended)?	For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines on optimal ART regimens for each of the following: A. Adults (>19 years) ☑ Yes ☐ No B. Pregnant and Breastfeeding Mothers ☑ Yes ☐ No C. Adolescents (10-19 years) ☑ Yes ☐ No D. Children (<10 years) ☑ Yes ☐ No	2.1 Score: 0.91	Naitonal Treatment Guidelines (2016); WHO ART Guidelines	

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? Note: If one of the listed policies differentiates policy for specific groups, please note in the Notes/Comments column.	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 ☑ Policies that permit HIV self-testing ☐ Policies that permit pre-exposure prophylaxis (PrEP) ☑ Policies that permit post-exposure prophylaxis (PEP) ☐ Policies that allow HIV testing without parental consent for adolescents, starting at age 15 ☐ Policies that allow HIV-infected adolescents, starting at age 15, to seek HIV treatment without parental consent	2.2 Score: 0.61	National Health Policy 2011; National Treatment Guidelines 2016; Children's Act; Botswana HIV and AIDS Policy 2012; Public Health Act	The age for testing and treatment without parental consent is 16 in Botswana

2.3 User Fees for HIV Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for any HIV services in the public sector: clinical, laboratory, testing, prevention and others? Note: "Formal" user fees are those established in policy or regulation by a government or institution.	Check all that apply: ☑ No, neither formal nor informal user fees exist. ☐ Yes, formal user fees exist. ☐ Yes, informal user fees exist.	2.3 Score: 0.91	National Health Policy 2011; Public Health Act	Non-citizens receive free testing in public facilities, although they are not offered HIV treatment - they must pay for this in the private sector; Recently, GOB announced that it will soon extend free Tx to non-citizens.
2.4 User Fees for Other Health Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for any non-HIV services in the public sector, such as MCH/SRH, TB, outpatient registration, hospitalizations, and others? Note: "Formal" user fees are those established in policy or regulation by a government or institution.	Check all that apply: ☑ No, neither formal nor informal user fees exist. ☐ Yes, formal user fees exist. ☐ Yes, informal user fees exist.	2.4 Score: 0.91	National Health Policy 2011	There are fees for some non-HIV services for non-citizens.
2.5 Data Protection: Does the country have policies in place that support the collection and appropriate use of patient-level data for health, including HIV/AIDS?	The country has policies in place that (check all that apply): ☑ Govern the collection of patient-level data for public health purposes, including surveillance ☑ Govern the collection and use of unique identifiers such as national ID for health records ☑ Govern the privacy and confidentiality of health outcomes matched with personally identifiable information ☑ Govern the use of patient-level data, including protection against its use in crimincal cases	2.5 Score: 0.91	National Health Data Management Policy; Public health Act	

2.6 Legal Protections for Key Populations: Does the country have laws or policies that specify protections (not specific to HIV) for specific populations?	Check all that apply: Transgender people (TG): ☐ Constitutional prohibition of discrimination based on gender diversity ☐ Prohibitions of discrimination in employment based on gender diversity ☐ A third gender is legally recognized ☐ Other non-discrimination provisions specifying gender diversity (note in comments) Men who have sex with men (MSM): ☐ Constitutional prohibition of discrimination based on sexual orientation ☐ Hate crimes based on sexual orientation are considered an aggravating circumstance ☐ Incitement to hatred based on sexual orientation prohibited ☑ Prohibition of discrimiation in employment based on sexual orientation ☐ Other non-discrimination provisions specifying sexual orientation Female sex workers (FSW): ☐ Constitutional prohibition of discrimination based on occupation ☐ Sex work is recognized as work ☐ Other non-discrimination protections specifying sex work (note in comments)	2.6 Score: 0.06	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question. Employment Act Section 18	

	People who inject drugs (PWID): ☐ Specific antidiscrimination laws or other provisions for people who use drugs (specify in comments) ☐ Explicit supportive reference to harm reduction in national policies ☐ Policies that address the specific needs of women who inject drugs			
2.7 Legal Protections for Victims of Violence: Does the country have protections in place for victims of violence?	The country has the following to protect key populations and people living with HIV (PLHIV) from violence: ☑ General criminal laws prohibiting violence ☐ Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population ☑ Programs to address intimate partner violence ☐ Programs to address workplace violence ☐ Interventions to address police abuse ☑ Interventions to address torture and ill treatment in prisons ☑ A national plan or strategy to address gender-based violence and violence against women that includes HIV ☑ Legislation on domestic violence ☑ Criminal penalties for domestic violence ☑ Criminal penalties for violence against children	2.7 Score: 0.64	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question. Children's Act; Domestic Violence Act; National GBV Strategy; National Health Act; Prison's Policy; Prison's Act	Intimate Partner Violence programs exist but are limited and are not country-wide; There is work being done to establish workplace violence prevention programs, although none currently exist; There aren't interventions to prevent violence in prisons, although the prison act and prison policy denotes these protections (without specifically mentiong torture) and specifies protections for PLHIV, this question was a point of contention;

2.8 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?	**For each question, select the most appropriate option:** Are transgender people criminalized and/or prosecuted in the country? ☐ Both criminalized and prosecuted ☐ Criminalized ☐ Prosecuted ☑ Neither criminalized nor prosecuted Is cross-dressing criminalized in the country? ☐ Yes ☐ Yes, only in parts of the country ☐ Yes, only under certain circumstances ☑ No Is sex work criminalized in your country? ☐ Selling and buying sexual services is criminalized ☑ Selling sexual services is criminalized ☐ Buying sexual services is criminalized ☐ Partial criminalization of sex work ☐ Other punitive regulation of sex work ☐ Sex work is not subject to punitive regulations or is not criminalized. ☐ Issue is determined/differs at subnational level	2.8 Score: 0.74	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question.	Consentual same-sex sexual acts were decriminilized in June 2019; There are no punitive laws for LGBTI persons, however there are certain scenarios, including religious norms that present as discriminatory toward transgender and intersex persons (ex: national ID), contention on this question was related to the phrasing of the answers

Does the country have laws criminalizing same-sex sexual acts?

- ☐ Yes, death penalty
- ☐ Yes, imprisonment (14 years - life)
- ☐ Yes, imprisonment (up to 14 years)
- ☐ No penalty specified
- ☐ No specific legislation
- ☑ Laws penalizing same-sex sexual acts have been decriminalized or never existed

Does the country maintain the death penalty in law for people convicted of drug-related offenses?

- ☐ Yes, with high application (sentencing of people convicted of drug offenses to death and/or carrying out executions are a routine and mainstreamed part of the criminal justice system)
- ☐ Yes, with low application (executions for drug offenses may have been carried out in recent years, but in practice such penalties are relatively rare)
- ☐ Yes, with symbolic application (the death penalty for drug offenses is included in legislation, but executions are not carried out)
- ☑ No

Does the country have laws criminalizing the transmission of, non-disclosure of, or exposure to HIV transmission?

- ☑ Yes
- ☐ No, but prosecutions exist based on general criminal laws
- ☐ No

Does the country have policies restricting the entry, stay, and residence of people living with HIV (PLHIV)?

- ☐ Yes
- ☑ No

	Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people? ☐ Yes, promotion ("propaganda") laws ☐ Yes, morality laws or religious norms that limit LGBTI freedom of expression and association ☑ No			
2.9 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, adolescents, 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	2.9 Score: 0.91	National Health Policy 2011; Public Health Act; NSF III; Legal AID Botswana	
2.10 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.	2.10 Score: 0.91	Internal Audit Reports	Ministry of Finance audits all government ministries annually including achievement against annual targets
2.11 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.	2.11 Score: 0.91	Internal Audit Reports; Public Accounts	
	Policies and Governance Score:	**8.40**		

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: 1.67	N/A	
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 ☐ Service delivery	3.2 Score: 0.83	NSF III; Annual Program Review Meeting Minutes; Botswana - Health Financing Landscape Analysis_Final 2016	CSOs expressed that meetings with MOHW seemed to be on an ad hoc or as-needed basis - there aren't consistent channels of meaningful engagement at this point.

3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?	○ A. Civil society does not actively engage, or civil society engagement does not impact policy, programming, and budget decisions related to HIV/AIDS. ◉ B. Civil society's engagement impacts HIV/AIDS policy, programming, and budget decisions (check all that apply): ☑ In policy design ☑ In programmatic decision making ☑ In technical decision making ☑ In service delivery ☐ In HIV/AIDS basket or national health financing decisions	3.3 Score: 1.33		CSOs contribute to policy, programming, and budget, although consistent and meaningful engagement would make this engagement more impactful.
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 (not including Global Fund grants through government Principal Recipients). ○ 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 through government Principal Recipients).	3.4 Score: 0.83	CSO Budgets; Botswana - Health Financing Landscape Analysis_Final 2016	While GOB funds some 60+% of the national HIV response, it continue to fund less than 10% of CSO activities in the response.
3.5 Civil Society Enabling Environment: Are there laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition (from any Ministry or Department, at any level - national, regional, or local)? Note: This sometimes referred to as "social contracting" or "social procurement."	○ A. There is no law, policy, or regulation which permits CSOs to be funded from a government budget for HIV Services through open competition (not to include Global Fund or other donor funding to government that goes to CSOs). ◉ B. There is a law, policy or regulation which permits CSOs to be funded from a government budget for HIV services. Check all that apply: ☐ Competition is open and transparent (notices of opportunities are made public) ☐ Opportunities for CSO funding are made on an annual basis ☐ Awards are made in a timely manner (within 6-12 months of announcements) ☐ Payments are made to CSOs on time for provision of services	3.5 Score: 0.83	Guidelines for supporting non-state actors (from Ministry of Finance)	Guidelines have been developed but not yet adopted, a situation which in some instances is viewed as a lack of commitment from government.
		Civil Society Engagement Score: **5.50**		

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 the host country government have formal channels and opportunities for diverse private sector entities (including service delivery, corporations, and private training institutions) to engage and provide feedback on its HIV/AIDS policies, programs, and services? (If option B is true, check all subsequent boxes that apply.)	○ A. There are no formal channels or opportunities for private sector engagement. ◉ B. There are formal channels or opportunities for private sector engagement. i. The following private sector stakeholders formally contribute input into national or sub-national processes for HIV/AIDS planning and strategic development (check all that apply): ☐ Corporations ☑ Employers ☑ Private training institutions ☑ Private health service delivery providers ii. Stakeholders contribute in the following ways (check all that apply): ☑ The private sector contributes technical expertise into HIV program planning ☑ Data and strategic input into supply chain management for HIV commodities ☑ Service delivery and/or client satisfaction data from private service delivery providers is included in health sector and HIV program planning ☐ Data on staffing in private health service delivery providers ☐ Data on private training institution's human resources for health (HRH) graduates and placements are included in health sector and HIV program planning ☑ For technical advisory on best practices and delivery solutions	4.1 Score: 1.46	NSF III; Vision 2036; Botswana Business Coalition on AIDS (BBCA)	A representative from BBCA will participate in planning meetings, although we are unsure of the feedback loop to each corporation; Private training institutions and private health sector are engaged through MOHW although they are not engaged through NAHPA, the multi-sectoral response needs to be strengthened; There is an attempt to unify health costing in the Health Financing strategy, although it remains in draft form

	iii. The national HIV/AIDS strategic plan explicitly addresses private sector's role in the HIV/AIDS response (check all that apply): ☑ The national HIV/AIDS strategic plan has a specific section that specifies the private sector's role in the HIV/AIDS response. ☐ A recent (within past 4 years) market analysis informs the private sector strategy that is included in the HIV/AIDS strategic plan ☐ The government and private sector effectively coordinates and executes a total market approach for HIV service delivery, which accounts for whether people are able and/or willing to pay for HIV services.			
4.2 Enabling Environment for Private Corporate Contributions to HIV/AIDS Programming: Does the host country government have systems and policies in place that allow for private corporate contributions to HIV/AIDS programming?	Check all that apply: ☐ Tax policies and incentives are designed to encourage corporate social responsibility efforts from companies who are contributing financial commitments and/or non-financial resources (including, but not limited to, product donations, expertise, and employee staff time). ☑ The host country government has in-house expertise in contracting services to private sector corporations when appropriate and necessary (e.g., transportation and waste management). ☐ The host country government has standards for reporting and sharing data across public and private sectors. ☑ Regulations help ensure that workplace programs align with the national HIV/AIDS program (e.g., medical leave policies, on-site testing, on-site prevention and education, anti-discrimination policies). ☐ There are strong linkage and referral networks between on-site workplace programs and public health care facilities.	4.2 Score: 1.00	Employment Act	There is no standard reporting process for data sharing between private and public health facilities, although it is in the process of being developed; referral networks exist although they are not strong (with the exception of Debswana, which has a strong referral network)

4.3 Enabling Environment for Private Health Service Delivery: Does the host country government have systems and policies in place that allow for private health service delivery? Note: Full score possible without checking all boxes.	○ A. Private health service delivery providers are not legally allowed to deliver HIV/AIDS services. ○ B. The host country government plans to allow private health service delivery providers to provide HIV/AIDS services in the next two years. ◉ C. Private health service delivery providers are legally allowed to deliver HIV/AIDS services. In addition (check all that apply): ☑ Policies are in place to ensure that private providers receive, understand, and adhere to national guidelines/protocols for ART, and appropriate quality standards and certifications. ☑ Systems are in place for service provision and/or research reporting by private facilities to the government, including guidelines for data reporting. ☑ Joint (i.e., public-private) supervision and quality oversight of private facilities. ☐ The government offers tax deductions for private facilities delivering HIV/AIDS services. ☐ The government offers tax deductions for private training institutions. ☐ The private sector is eligible to procure HIV/AIDS and/or ART commodities via public sector procurement channels and/or national medical stores ☐ The host country government has formal contracting or service-level agreement procedures to compensate private facilities for HIV/AIDS services. ☐ HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes ☑ There are open competitions for private health care providers to compete for government service contracts ☑ There is a systematic and timely process for private company registration and/or testing of new health products (e.g., drugs, diagnostic kits, medical devices, etc.) that support HIV/AIDS programming ☐ The government effectively regulates the flow of subsidized commodities into the private sector. ☐ Private Banks or lenders provide access to low interest loans prioritizing private health sector small and medium-sized enterprise (SME) development and expansion.	4.3 Score: 1.94	National Treatment Guidelines; Private Hospitals Act	The government provides a training levy which private education institutions can apply for

4.4 Private Sector Capability and Interest: Does the private sector possess the capability to support HIV/AIDS services, and do private sector stakeholders demonstrate interest in supporting the national HIV/AIDS response?	○ A. The host country government does not leverage the skill sets of the private sector for the national HIV/AIDS response. ○ B. The private sector does not express interest in or actively seek out opportunities to support the national HIV/AIDS response. ◉ C. The private sector has expertise and has expressed interest in or actively seeks out (check all that apply): ☑ Market opportunities that align with and support the national HIV/AIDS response ☑ Opportunities to contribute financial and/or non-financial resources to the national response (including business skills, market research, logistics, communication, research and development, product design, brand awareness, and innovation)	4.4 Score: 2.50	Participant response	
		Private Sector Engagement Score: 6.90		

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 Data Transparency: Does the host country government ensure that national HIV/AIDS surveillance data and analyses are made available to stakeholders and general public in a timely and useful way?	○ A. The host country government does not make HIV/AIDS surveillance data available to stakeholders and the general public, or they are made available more than one year after the date of collection. ○ B. The host country government makes HIV/AIDS surveillance data available to stakeholders and the general public within 6-12 months. ◉ C. The host country government makes HIV/AIDS surveillance data available to stakeholders and the general public within six months.	5.1 Score:	2.00	BAIS IV; Youth Risk Behavioural and Biological Surveillance Survery II Report 2016; ANS; BBSS	There are surveys, although these surveys are typically done once every 3-5 years which are releasead within 6 months of completion
5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data available to stakeholders and the public in a timely and useful way?	○ A. The host country government does not track HIV/AIDS expenditures. ○ B. The host country government does not make HIV/AIDS expenditure data available to stakeholders and the general public, or they are made available more than one year after the date of expenditures. ◉ C. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within 6-12 months after date of expenditures. ○ D. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within six months after expenditures.	5.2 Score:	1.00	National Health Accounts Report 2015 (report on data from 2013-2014);	The reporting mechanism has changed from NASA to National Health Accounts, the last one was completed in 2015, the current version is in process but has not been endorsed by the government

5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data available to stakeholders and the public in a timely and useful way?	(●) A. The host country government does not make HIV/AIDS program performance and service delivery data available to stakeholders and the general public or they are made available more than one year after the date of programming. ( ) B. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within 6-12 months after date of programming. ( ) C. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within six months after date of programming . At what level of detail is this performance data reported? [CHECK ALL THAT APPLY] ☐ National ☐ District ☐ Site-Level	5.3 Score:	0.00	Annual Response Report	Annual Response Report existed in the past, although the form of this report has not been updated within the past few years; information is released to stakeholders, although is not formally shared with the general public
5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?	( ) A. The host country government does not make any HIV/AIDS procurements. ( ) B. The host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available. ( ) C. The host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available. (●) D. The host country government makes HIV/AIDS procurements, and both tender and award details available.	5.4 Score:	2.00	Government Gazette; PPADB Website	

5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for providing scientifically accurate education to the public about HIV/AIDS?	○ 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	NSF III (through NAHPA, MOHW, and MOBE)	
		Public Access to Information Score:	**7.00**		

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: 0.95	NSF III; Integrated Health Service Plan 2011. Treat all communication strategy 2017 . Social behavioural, cultural communication strategy for Prep is work in progress	The public facilities are not accommodating the demand optimally due to insufficeint human resources; tailored services and generating demand for HIV services happens in high volume facilities that are PEPFAR supported, which does not meet the needs of the entire country.
6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services? (Check all that apply.)	The host country has standardized the following design and implementation components of community-based HIV/AIDS 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/AIDS services in communities ☑ Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities ☑ 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: 0.79	NSF III; National Health Policy 2011. The community guidelines are still work on progress.	There are still stockouts, which makes community-based service delivery less than optimal; there isn't a standardized design and implementation of community-based HIV services or even a national refferal system; this results in each facility and community adopting separate models (in some cases inconsistent or unsustainable).
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 (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 ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services ◉ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services	6.3 Score: 1.25	Bostwana Health Accounts Report; Health and HIV/AIDS Public Expenditure review 2016; Botswana Funding Matrix 2013-2017; HIV Investment Analysis 2019	

6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services without external technical assistance from donors?	○ A. HIV/AIDS services are primarily delivered by external agencies, organizations, or institutions. ○ B. Host country institutions deliver HIV/AIDS services but with substantial external technical assistance. ◉ C. Host country institutions deliver HIV/AIDS services with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services with minimal or no external technical assistance.	6.4 Score: 0.63	NSF III; Integrated Health Service Plan 2011; Botswana Country Cooperative Strategy	
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 (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, or information is not available. ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations. ◉ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations. ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations. ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations.	6.5 Score: 0.83	Botswana Health Accounts; Botswana Funding Matrix 2013-2017; HIV Investment Analysis 2019	About 15% of the service delivery cost for KP programming is supported by the host government.
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 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	Botswana Funding Matrix 2013-2017 . Botswana GF and PEPFAR joint cascade assessment 2017.	
6.7 Management and Monitoring of HIV Service Delivery: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV service delivery activities including practice standards, quality, health outcomes, and information monitoring across all sectors. Select only ONE answer.	○ A. No, there is no entity. ○ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget. ◉ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	6.7 Score: 0.63	Quality Improvement Framework 2017; NSF III; National ART Guidelines 2016	The HIV/AIDS program team is smaller with insufficient budget; MOHW is under re-structuring.

6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	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	6.8 Score: 0.63	NSF III; Health Policy 2011; Bostwana HRH Strategic Plan; Human Development Report 2016; National Development Plan 2011. National TB/HIV bi- annual meeting reports. District level annual plans.	Usually staff planning is done for the whole national health system not specifically tailored for HIV services; staff are consistently transfered at the sub-national level and can often move from high volume facilities to low volume facilities at the national level; transfers are done randomly without any HIV staff determinants ratios - i.e. trained staff can be assigned to facilities where their skills are not relevant or needed; there is also a need for strengthening data accessibility and use.
6.9 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.	6.9 Score: 0.95	Integrated Health Service Plan	Staffing is better tailored at the sub-national level than at National level; however, it is not done optimally in either case.
		Service Delivery Score	**6.69**	

7. Health Workforce: Health workforce staffing decisions for those working on HIV/AIDS are based on use of workforce 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 Health Workforce Supply: To what extent is the clinical health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or community site level?	Check all that apply: ☑ The country's pre-service education institutions are producing an adequate supply and skills mix of clinical health care providers ☑ The country's clinical health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden ☐ The country has developed retention schemes that address clinical 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: 0.48	HRH Strategic Plan. National Health Institute Curriculums. Medical School Curriculum.	Strengthen Medical trainings and Pharmacies. The country still needs to incorporate HIV training the the health science curriculums.
7.2 Role of Community-based Health Workers (CHWs): To what extent are community-based health workers' roles and responsibilities specified for HIV/AIDS service delivery?	Check all that apply: ☑ There is a national community-based health worker (CHW) cadre that has a defined role in HIV/AIDS service delivery (e.g., through a national strategy or task-sharing framework/guidelines). ☐ Data are made available on the staffing and deployment of CHWs, including non-formalized CHWs supported by donors. ☑ The host country government officially recognizes non-formalized CHWs delivering HIV/AIDS services.	7.2 Score: 0.63	HRH strategic plan	The government has community health workers e,g Health Education assistants and community health workers from donors; Community guidelines are under development and the government will need to strengthen their use and implementation.
7.3 Health Workforce Transition: What is the status of transitioning PEPFAR and/or other donor supported HIV/AIDS health worker salaries to local financing/compensation? Note in comments column which donors have transition plans in place and timeline for transition.	○ 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	7.3 Score: 0.24	HRH Strategic Plan, PEPFAR Funding Matrix	The donors have inventory but the government does not have a transitional plan

7.4 Domestic Funding for Health Workforce: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)? (if exact or approximate percentage known, please note in Comments column)	○ 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	7.4 Score: 3.33	HRH Strategic Plan, Integrated Health Service Plan, HIV Investment Analysis 2019; National Health Report	
7.5 Pre-service Training: Do current pre-service education curricula for any health workers providing HIV/AIDS services include HIV content that has been updated in last three years? Note: List applicable cadres in the comments column.	○ 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 PLHIV ☐ Institutions track student employment after graduation to inform planning	7.5 Score: 0.83	Essential Core Competencies for Nursing related to HIV and AIDS 2009. Nurses, Medical officers, lab and pharmacy technicians.	
7.6 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)	7.6 Score: 0.95	Intergrated curriculum for MOHw	The integrated curriculum needs strengthening and oversight to ensure it is being implemented.

7.7 Health Workforce Data Collection and Use: Does the country systematically collect and use 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)	7.7 Score:	0.71	HRH Strategic plan	
7.8 Management and Monitoring of Health Workforce Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for health workforce activities in HIV service delivery sites, including training, supervision, deployments, quality assurance, and others across all sectors. Select only ONE answer.	○ A. No, there is no entity. ◉ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ○ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	7.8 Score:	0.32	Quality Improvement Framework 2017	Management and monitoring of health workforce is available for the national health workforce but not specific to HIV services; this leads to insufficent staffing and budget within HIV
		Health Workforce Score:	**7.50**		

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: 0.83	MOHW Budget Reports; Botswana Funding Matrix	
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	Botswana HIV AIDS Investment Case 2016; MOHW Budget; CMS Budget Reports; Botswana Funding Matrix	
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: 0.83	Botswana HIV AIDS Investment Case 2016; MOHW Budget; CMS Budget Reports; Botswana Funding Matrix	

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: 1.21	NSF III; Multi-Sectoral Strategy for prevention and control of non-communicable diseases; CMS Strategic Plan	
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: 0.83	Botswana HIV AIDS Investment Case 2016; CMS Budget Reports; Botswana Funding Matrix; Logistic Management System	

8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	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: 0.93	CMS Stock Report	The country is currently facing serious challenges that have led to stockouts; PEPFAR has been asked to assist with an Emergency Procurement - a situation that did not occur prior to the 2017 SID.
8.7 Assessment: Was an overall score of above 80% achieved on the 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 within the last three years. ○ B. A comprehensive assessment has been done within the last three years 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 within the last three years and the score was higher than 80% (for NSCA) or in the top quartile for the assessment	8.7 Score: 0.00	National Suply Chain Assessment	The last assessment was done 6 years ago; the system is overdue for an assessment to identify gaps and recommend how they should be addressed; existing gaps makes forecasting more difficult and stockouts a frequent threat.
8.8 Management and Monitoring of Supply Chain: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - supply chain activities including forecasting, stock monitoring, logistics and warehousing support, and other forms of information monitoring across all sectors? Select only ONE answer.	○ A. No, there is no entity. ○ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ◉ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	8.8 Score: 1.11	CMS Stock Report; NSF III	Full authority but insufficient staff and budget.
	Commodity Security and Supply Chain Score:	**6.58**		

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: 1.33	Quality Improvement Framework 2017	There are no peer learning opportunities.
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 utilized ◉ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements, and it is partially utilized. ○ D. There is a current HIV/AIDS program specific QM/QI strategy, and it is fully utilized.	9.2 Score: 1.33	Quality Improvement Framework 2017	The strategy is available but not fully implemnted especially at non - PEPFAR supported sites; key aspects of QI plans have not been implemented because the facilities were unable to sustain QI activities; QM /QI plans need to be expanded beyond PEPFAR supported site to the whole country based on recommendations from the QI framework.
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 through sharing and implementation of best practices across HIV/AIDS sites at all levels	9.3 Score: 0.67	Quality Improvement Framework 2017	There has not been any QI initiative implemented since 2017; this is due to the lack of QM/QI plan for the whole country.

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: 1.00	Quality Improvement Framework 2017	QM/QI trainings have not taken place since 2017; QM/QI trainings were re-initiated for both PEPFAR and NON-PEPFAR sites in February 2019.
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 include 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: 1.14	Quality Improvement Framework 2017	Quality management structures are only in the PEPFAR supported health districts and do not cover the entire health system; there is need to improve and have the QM/QI implementation across the country.
		Quality Management Score: **5.48**		

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 ○F. National laboratory strategic plan has been developed, approved, costed, and implemented	10.1 Score: 0.80	NSF III	
10.2 Management and Monitoring of Laboratory Services: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, purchase, and provide guidance - laboratory services at the regional and district level across all sectors? Select only ONE answer.	○A. No, there is no entity. ◉B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ○C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○D. Yes, there is an entity with authority and sufficient staff and budget.	10.2 Score: 0.44	NSF III	The GOB entity in charge has full administrative authority, but insufficient staff and budget.
10.3 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).	10.3 Score: 1.00	NSF III	Regulations exist but the quality of Labs and POCT still need some improvements.
10.4 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 by rapid testing and point-of-care testing ☑ Routine laboratory testing, including chemistry, hematology, microbiology, serology, blood banking, and malaria ☑ Complex laboratory testing, including HIV viral load, CD4 testing, and molecular assays ☑ TB diagnosis	10.4 Score: 1.00	NSF III	POCT sites are limited in the country and are currently under review for possible expansion.

10.5 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 HIV viral load instruments ☐ All HIV viral load laboratories have an instrument maintenance program ☐ Sufficient supply chain system is in place to prevent stock out ☐ Adequate specimen transport system and timely return of results	10.5 Score: 0.00	WHO evaluation report 2018, PEPFAR Lab Opitization report 2017	
10.6 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.	10.6 Score: 3.33	National Health Accounts 2013/2014; Budget in Brief 2018; NSF III	
	Laboratory Score:	**6.58**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Financing and Market Openness

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. Finally, having and effectively implementing policies that ensure leveraging markets (both nonprofit and for profit) where appropriate and enabling their participation and competition will be critical for a sustained HIV response.

Fiscal Context for Health and HIV/AIDS This section will not be assigned a score, but will provide additional contextual information to complement the questions in Domain C.			**Data Source**	**Notes/Comments**
1. What percentage of general government expenditures goes to health?	15%		National Health Accounts 2013/2014; Budget in Brief 2018; NDP 11; NSF III (pg 67)	From 2018-19 Budget Speech-BWP8.2 billion proposed (NAHPA included as part of the health budget), gives an estimated 9.1% of total budget. From 2014 National Health Accounts, 12.2%. From
2. What is the per capita health expenditure all sources?	$323.55		National Health Accounts 2013/2014; Budget Speech 2018/19; Statistics Botswana	From National Health Accounts 2014 per capita was $371.2, INT$851 (2013); using population projections from Statistics Botswana
3. What is the total health care expenditure all sources as a percent of GDP?	4.10%		National Health Accounts 2013/2014; Budget Speech 2018/19; UNICEF Policy Brief 2018	
4. What percent of total health expenditures is financed by external resources?	25%		National Health Accounts 2013/2014; NDP 11; NSF III (pg 67)	Inclusive of donor, private sector, and household contributions
5. What percent of total health expenditures is financed by out of pocket spending net of household contributions to medical schemes/pre-payment schemes?	4.20%		National Health Accounts 2013/2014	Will look for updated info/documents outside of National Health Accounts

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 Long-term Financing Strategy for HIV/AIDS: Has the host country government developed a long-term financing strategy for HIV/AIDS?	Check all that apply: ☐ A. Yes, there is a universal, comprehensive financing scheme that integrates social health insurance, public subsidies, and national budget provisions for public health aspects (e.g., disease surveillance). It includes the following (check all that apply): ☐ ARVs are covered ☐ Non-ARV care and treatment is covered ☐ Prevention services are covered ☑ B. Yes, there is an affordable health insurance scheme available (check one of the following). ☑ It covers 25% or less of the population. ☐ It covers 26 to 50% of the population. ☐ It covers 51 to 75% of the population. ☐ It covers more than 75% of the population. ☑ C. The affordable health insurance scheme in (B.) includes the following (check all that apply): ☑ ARVs are covered. ☑ Non-ARV care and treatment services are covered. ☑ Prevention services are covered (specify in comments). ☑ It includes public subsidies for the affordability of care.	11.1 Score: 0.52	Botswana Health Financing Strategy 2017 -2023; Private Health Sector Assessment; Botswana National Health Insurance Blueprint	Currently, ongoing work is being done to address a universal, comprehensive financing scheme. Government currently covers (50%) of medical aid schemes for all employees. Coverage/benefits varies based on medical scheme.

11.2 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	11.2 Score: 0.60	Budget in Brief 2018/2019	There is an allocation by Minister of Finance within the national budget for MOHW, then within that amount MOHW allocates funding by department (e.g. HIV/AIDS). This budget is further broken down by individual departments to programs. Parliament approves the detailed breakdown of budget.
11.3 Annual Goals/Targets: To what extent does the national budget contain HIV/AIDS goals/targets?	○ A. There are no HIV/AIDS goals/targets articulated in the national budget ◉ B. There are HIV/AIDS goals/targets articulated in the national budget. ☑ The goals/targets are measurable. ☑ Budget items/programs are linked to goals/targets. ☐ The goals/targets are routinely monitored during budget execution. ☐ The goals/targets are routinely monitored during the development of the budget.	11.3 Score: 0.71	Budget in Brief 2018/2019; Botswana Investment Case 2016	Details of goals/targets are in the ministerial budgets, but high level info is in national budget (Treat All). Discussion over whether ministerial budgets counts as part of national budget. In this case, yes, we included it. Monitoring of goals/targets is not regular, but is being worked on.
11.4 HIV/AIDS 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. There is no HIV/AIDS budget, or information is not available. ○ B. 0-49% of budget executed ○ C. 50-69% of budget executed ○ D. 70-89% of budget executed ◉ E. 90% or greater of budget executed	11.4 Score: 0.95	Botswana Investment Case 2016; Botswana HIV/AIDS Public Expenditure Report; HIV Investment Analysis 2019 (draft)	Question answered for national level.

11.5 Donor Spending: Does the Ministry of Health or Ministry of Finance routinely, and at least on an annual basis, collect all donor spending in the health sector or for HIV/AIDS-specific services?	○ A. Neither the Ministry of Health nor the Ministry of Finance routinely collects all donor spending in the health sector or for HIV/AIDS-specific services. ○ B. The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services. ◉ C. The Ministry of Health or Ministry of Finance routinely collects all donor spending all the entire health sector, including HIV/AIDS-specific services.	11.5 Score: 0.95	National Health Accounts 2013/2014; HIV Investment Analysis 2019 (draft); NASA 2012;	
11.6 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding? (Domestic funding excludes out-of-pocket, Global Fund grants, and other donor resources)? (if exact or approximate percentage known, please note in Comments column)	○ A. None (0%) is financed with domestic funding. ○ B. Very liitle (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	National Health Accounts 2013/2014; HIV Investment Analysis 2019 (draft); NSF III (pg 57)	
11.7 Health Budget Execution: What was the country's execution rate of its budget for health in the most recent year's budget?	○ A. There is no budget for health or no money was allocated. ○ B. 0-49% of budget executed. ○ C. 50-69% of budget executed. ○ D. 70-89% of budget executed. ◉ E. 90% or greater of budget executed.	11.7 Score: 0.95	MOHW/NAHPA Budgets; HIV Investment Analysis 2019 (draft); Health Budget Brief 2018 UNICEF; Health and HIV/AIDS Expenditure Review	
11.8 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 is seldom used. ○ C. There is a policy/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.	11.8 Score: 0.95	Health Budget Brief 2018	Done during Project Review at beginning of every budgeting cycle
Domestic Resource Mobilization Score:		**8.13**		

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? If yes, please note in the comments section when the model was last used and for what purpose (e.g., for Global Fund concept note development) (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: 2.00	Botswana Investment Case 2016; HIV Investment Analysis 2019 (draft)	Spectrum was used to inform COP19 planning; MOT was last used 2012 for planning.
12.2 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.	12.2 Score: 0.00	NSF III; IHSP	NSF III prioritizes high burden districts for more intense and comprehensive interventions and therefore more resource allocation; however, implementation has not yet started and the percentage of resources to be committed is unknown at this stage.

12.3 Information on cost of service provision: Does the host country government have a system that routinely produces information on the costs of providing HIV/AIDS services, and is this information used for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).	◉ A. The host country DOES NOT have a system that routinely produces information on the costs of providing HIV/AIDS services. ○ B. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services, but this information is not used for budgeting or planning. ○ C. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services AND this information is used for bugeting or planning purposes for the following services (check all that apply): ☐ HIV Testing ☐ Laboratory services ☐ ART ☐ PMTCT ☐ VMMC ☐ OVC Service Package ☐ Key population Interventions ☐ PrEP	12.3 Score: 0.00	HIV Investment Analysis; Botswana HTC Costing Report 2013; HIV AIDS Public Expenditure Review	Investment tracking has been institutionalized, but costing isn't done at the national level yet and expenditure analysis remains limited - there is a semi-annual budget review across government; different implementing partners collect costing information and are helping establish reporting systems for the government's reference and adoption.
12.4 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)	12.4 Score: 1.33	NSFIII; IHSP; Bostwana Health Financing Landscape Analysis; Natoinal Health Policy 2011; Botswana Investment Case 2016	Activities to improve efficiencies have been identified and prioritized; pooled procurement is done for TB commodities, and GoB has accepted the extension of this practice to other procurement areas; Public Procurement and Asset Disposal Board (PPADB) has taken steps to improve procurement competition in general across governement; recently adopted practices (March/April 2019) such as Multi-Month ARV Dispensing and Community ARV Distribution are expected to further improve service delivery efficiencies this year.

	☑ 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 (e.g., multi-month scripting, testing modalities targeted to the population profile, etc. - specify in comments)			
12.5 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.	12.5 Score: 0.50	National Health Accounts 2013/2014; CMS ART Expenditure Report; Health and HIVAIDS Public Expenditure Review; HIV market report Issue 10, Sept. 2019; Making Treat All Real: ART to Non-Citizens Buisiness Case (February 2019)	GOB is currently paying more than 50% of the benchmark price for ARVs; the sustainability of the supply chain has become alarming as the national response seek to find and treat an estimated 20,000 undiagnosed HIV positive men and 22,000 HIV positive non-citizens who are unable to afford treatment on their own; there has been discussions on the use of pooled procurement and other efficiencies to bring cost of ARVs procurements down, but there currently is no government system in place to track and analyze the costs of providing HIV/AIDS services.
Technical and Allocative Efficiencies Score:		**3.83**		

13. Market Openness: Host country and donor policies do not negatively distort the market for HIV services by reducing participation and/or competition.			**Data Source**	**Notes/Comments**
13.1 Granting exclusive rights for services or training: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies grant exclusive rights for the government or another local provider to provide HIV services?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) polices: A. Restrict the provision of any one aspect of HIV prevention, testing, counseling, or treatment services to a single entity (i.e., creating a monopoly arrangement for that service)? ☐ Yes ☑ No B. Mandate that only government facilities have the exclusive right to provide any one aspect of HIV prevention, testing, counseling, or treatment services? ☐ Yes ☑ No C. Grant exclusive rights to government institutions for providing health service training? ☐ Yes ☑ No	13.1 Score: 0.36	Handbook of HIV treatment guidelines 2016	
13.2 Requiring license or authorization: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies establish a license, permit or authorization process as a requirement of operation?	A. Are health facilities required to obtain a government-mandated license or accreditation in order to provide HIV services? [SELECT ONE] ☐ No ☐ Yes, and the enforcement of the accreditation places equal burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) and government facilities. ☑ Yes, and the enforcement of the accreditation places higher burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) than on government facilities. B. Are health training institutions required to obtain a government-mandated license or accreditation in order to provide health service training? [SELECT ONE] ☐ No ☑ Yes, and the enforcement of the accreditation places equal burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) and government institutions. ☐ Yes, and the enforcement of the accreditation places higher burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) than on government institutions.	13.2 Score: 0.18	Handbook of HIV treatment guidelines 2016	Same criteria applies to both, but level of enforcement is higher at NGOs, FBOS, CBOs, because the criteria is assumed to be met at government facilities. Therefore is not checked as rigorously in practice.

13.3 Limiting provision of certain direct clinical services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local providers to provide certain direct clinical services?	National government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local health service providers to offer the following HIV services: ☐ Prevention ☐ Testing and Counseling ☐ Treatment	13.3 Score: 0.36	Handbook of HIV treatment guidelines 2016	All licensed, local providers are free to provide all stated services.
13.4 Limiting provision of certain clinical support services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed local providers to provide certain clinical support services?	A. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from providing essential HIV laboratory services? ☐ Yes ☑ No B. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly arrangements in lab testing (i.e., arrangements where effectively only one lab service provider is allowed to conduct a certain essential HIV lab service)? ☐ Yes ☑ No C. National government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from procuring or distributing the following HIV commodities and supplies [PLEASE SPECIFY TYPE IN NOTES]: ☐ ARVs ☐ Test kits ☐ Laboratory supplies ☐ Other D. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly supply chain arrangements for HIV commodities (i.e., arrangements where effectively only one entity is able to supply a certain essential HIV commodity)? ☐ Yes ☑ No	13.4 Score: 0.36	Handbook of HIV treatment guidelines 20	

13.5 Limits on local manufacturing: Do national government policies limit the ability of the local manufacturing industry to compete with the international market?	A. Do national government policies restrict the production of HIV commodities and supplies by local manufacturers beyond international standards? ○ Yes ◉ No B. [IF YES] For which of the following is local manufacturing restricted? ☐ ARVs ☐ Test kits ☐ Laboratory supplies ☐ Other	13.5 Score: 0.36	Handbook of HIV treatment guidelines 2016	
13.6 Cost of entry/exit: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of entry or exit by a local provider?	Do local health service facilities face higher start-up or maintenance costs compared to government or donor (e.g., PEPFAR, GFATM, etc.) supported facilities (e.g., lack of access to funds, higher accreditation fees, prohibitive contracting costs, etc.)? ☑ Yes ☐ No	13.6 Score: 0.00		Local health service facilities face higher start-up costs but government is creating an enabling environment (ease of doing business)
13.7 Geographical barriers: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create geographical barriers for local providers to supply goods, services or labor, or invest capital?	A. Are certain geographical areas restricted to only government or donor-supported HIV service providers? ○ Yes ◉ No B. [IF YES] Which of the following are geographically restricted? ☐ Supplying HIV supplies and commodities ☐ Supplying HIV services or health workforce labor ☐ Investing capital (e.g., constructing or renovating facilities)	13.7 Score: 0.36		
13.8 Freedom to advertise: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the freedom of local organizations to advertise or market HIV goods or services? [Note: "organizations" in this case can refer broadly to clinical service providers and also organizations providing advocacy and promotion services.]	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the freedom of nongovernment (e.g., FBOs, CBOs, or private sector) organizations to advertise or promote HIV services either online, over TV and radio, or in public spaces? ☑ Yes ☐ No	13.8 Score: 0.00		Local organizations using donor funding that falls under the PLGHA (Protecting Life in Global Health Assistance) are limited in certain aspects of their service delivery activities; PLGHA prohibits foreign NGOs from using any funds (including non-U.S. funds) to provide information about abortion as a method of family planning and to lobby a foreign government to legalize abortion.

13.9 Quality standards for HIV services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those polices, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those polices, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality? [CHECK ALL THAT APPLY] ☐ Yes ☐ No, government service providers are held to higher standards than nongovernment service providers ☑ No, FBOs/CSOs are held to higher standards than government service providers ☑ No, private sector providers are held to higher standards than government service providers	13.9 Score: 0.00	Handbook of HIV treatment guidelines 20	Within government facilities, an assumption is often made that standards are being met. However there does seem to be recognition of the difference in implementation/enforcement.
13.10 Quality standards for HIV commodities: Do national government policies set standards for product quality that provide an advantage to some commodity suppliers over others?	Do national government policies set product quality standards on HIV commodities that advantage some suppliers over others? [IF YES, PLEASE EXPLAIN IN NOTES] ☐ Yes ☑ No	13.10 Score: 0.63		In the past, there have been issues with policy implementation regarding suppliers receiving tenders.
13.11 Cost of service provision: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of service provision for some local providers relative to others (especially by treating incumbents differently from new entrants)?	A. Do government HIV service providers receive greater subsidies or support of overhead expenses (e.g., operational support) as compared to nongovernment (e.g., FBOs, CBOs, or private sector) HIV service providers? ☑ Yes ☐ No B. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local HIV service providers over others? ☑ Yes ☐ No C. Do government health training institutions receive greater subsidies or support of overhead expenses as compared to nongovernment (e.g., FBOs, CBOs, or private sector) health training institutions? ☑ Yes ☐ No D. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local health service training institutions over others? ☑ Yes ☐ No	13.11 Score: 0.00		Government conducts objective assessment that informs selection of non-government providers which will receive funding. Criteria include if nongovernment provider is addressing a gap in services. E.g. Bamalete Lutheran Hospital receives grant to provide services similar to a government hospital.
13.12 Self-regulation: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow for the creation of a self-regulatory or co-regulatory regime?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow HIV service providers—either groups of individuals or groups of institutions—to create structural barriers (e.g., closed network systems) that may reduce the incentive of other potential providers to provide HIV services? ☐ Yes ☑ No	13.12 Score: 1.25		

13.13 Publishing of provider information: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies require or encourage information on local providers' outputs, prices, sales or costs to be published?	A. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require nongovernment (e.g., FBOs, CBOs, or private sector) health service facilities to publish more data than government facilities on the following [CHECK ALL THAT APPLY]: ☐ HIV service caseload ☐ Procurement of HIV supplies/commodities ☐ Expenses B. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require HIV commodity suppliers to publish data on the following [CHECK ALL THAT APPLY]: ☐ Distribution ☐ Sales/Revenue ☐ Production costs	13.13 Score: 1.25		There are no policy requirements, but the information is available on request.
13.14 Patient choice: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of patients to decide which providers or products to use?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of patients or specific groups of patients to choose: A. Which HIV service providers they use? ☐ Yes ☑ No B. Which HIV supplies/commodities they use (e.g., ARVs, PrEP, condoms, needles, etc.)? ☐ Yes ☑ No	13.14 Score: 1.25		Medical aid schemes have specific providers that they refer clients to. For "B", there are situations where guidelines restrict availability of certain supplies/commodities in country.
13.15 Patient mobility: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies reduce mobility of patients between HIV service providers by increasing the explicit or implicit costs of changing providers?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies impose costs or other barriers that restrict a patient's ability to transfer from a government HIV service provider to a nongovernment (e.g., FBO, CBO, or private sector) HIV service provider? ☐ Yes ☑ No	13.15 Score: 1.25		
	Market Openness Score:	**7.59**		

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.

14.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**
14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including: data collection, analysis and interpretation; data storage and retrieval; and quality assurance across all sectors. Select only ONE answer.	○ No, there is no entity. ◉ Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ○ Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ Yes, there is an entity with authority and sufficient staff and budget.	14.1 Score: 0.28	BAIS IV; ANC Surveillance, YRBBS, BBSS (I and II); NSF III	BAIS is implemented as a partnership between NAHPA, Statistics Botswana, and MOHW.
14.2 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 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	14.2 Score: 0.42	BAIS, ANC Surveillance (GOB has decided to drop ANC surveillance), YRBBS; Bostwana Population Projections; NSF III	the choice of "Substantial" refers to the fact BAIS V has been outsourced to an external agency due to the challenge of combined HIV and TB surveys.
14.3 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	14.3 Score: 0.42	BBSS 2013; BBSSII 2017	MOHW planned the KP-BBSSII, with substantial assistance from external agencies.

14.4 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	14.4 Score: 0.83	BAIS IV; BAIS V MOU; Health Financing Profile 2016	BAIS V will be majority funded by external agencies
14.5 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	14.5 Score: 0.42	BBSS 2013; BBSSII (preliminary report)	

14.6 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?	Check ALL boxes that apply below. (A.) refers to prevalence data. (B.) refers to incidence data: ☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by: ☐ Age (at coarse disaggregates) ☑ Age (at fine disaggregates) ☑ Sex ☑ Key populations (FSW, PWID, MSM, TG, prisoners) ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ Sub-national units ☑ B. The host country government collects at least every 5 years HIV incidence disaggregated by: ☑ Age (at coarse disaggregates) ☐ Age (at fine disaggregates) ☑ Sex ☑ Key populations (FSW, PWID, MSM, TG, prisoners) ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☐ Sub-national units	14.6 Score: 0.58	BAIS IV; UNAIDS modeling (https://www.unaids.org/en/regionscountries/countries/botswana); UNAIDS Annual Modeling; BCPP Incidence cohorts	BAIS V and KP-BBSSII both will measure incidence for coarse age and sex disaggregates. KP covered MSM and FSW.

14.7 Comprehensiveness of Viral Load Coverage Data: To what extent does the host country government collect/report viral load coverage data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage is known, please note in Comments column)	○ A. The host country government does not collect/report viral load coverage data or does not conduct viral load monitoring ◉ B. The host country government collects/reports viral load coverage data (answer both subsections below): Government collects/report viral load coverage data according to the following disaggregates (check ALL that apply): ☑ Age ☑ Sex ☐ Key populations (FSW, PWID, MSM, TG, prisoners) ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) For what proportion of PLHIV does the government collect/report viral load coverage data (select one of the following): ☐ Less than 25% ☐ 25-50% ☐ 50-75% ☑ More than 75%	14.7 Score: 0.63	PIMS; IPMS; UNAIDS reports; BCPP report	
14.8 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct integrated behavioral surveillance (either as a standalone IBBS or integrated into other routine surveillance such as HSS+) and size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.) Please note most recent survey dates in comments section.	○ A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM, TG, prisoners) or priority populations (Military, etc.). ◉ B. The host country government conducts (answer both subsections below): IBBS (or other integrated behavioral surveillance) for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM) ☑ Transgender (TG) ☐ People who inject drugs (PWID) ☐ Prisoners ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) Size estimation studies for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM) ☑ Transgender (TG) ☐ People who inject drugs (PWID) ☐ Prisoners ☐ Priority populations (AGYW, clients of sex workers, miliitary, mobile populations, non-injecting drug users)	14.8 Score: 0.63	BBSS 2013; BBSSII	

14.9 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	14.9 Score: 0.83	NSF III	There is not a single strategy but surveys are planned and documented with timelines.
14.10 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 all protocols.	14.10 Score: 0.83	Health Data Management Policy 2014; NSF III; BAIS IV and BAIS V Planning/MOU; Assessment of ME_HMIS of Botswana 2019	
	Epidemiological and Health Data Score:	**5.86**		

15. 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**
15.1 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	15.1 Score: 1.67	Botswana Health Financing Landscape 2016; Bostwana Health Financing Strategy 2016; HIV AIDS Investment Case 2016; Budget in Brief 2018/2019; National Health Accounts 2013/2014 (2015 report)	NAHPA is harmonizing NASA and NHA tools
15.2 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	15.2 Score: 2.50	Botswana Health Financing Landscape 2016; Bostwana Health Financing Strategy 2016; HIV AIDS Investment Case 2016; Budget in Brief 2018/2019; National Health Accounts 2013/2014 (2015 report), National HIV/AIDS Expenditure Analysis 2013-2017 (draft)	check expenditure analysis report 2013-2017 clearance
15.3 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	15.3 Score: 1.67	Botswana Health Financing Landscape 2016; Bostwana Health Financing Strategy 2016; HIV AIDS Investment Case 2016; Budget in Brief 2018/2019; National Health Accounts 2013/2014 (2015 report)	
	Financial/Expenditure Data Score:	**5.83**		

16. Performance data: Government routinely collects, reports, 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, and viral load testing coverage and suppression.			**Data Source**	**Notes/Comments**
16.1 Who Leads Collection and Reporting of Service Delivery Data: To what extent is the routine collection and reporting of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government at the national level?	○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	16.1 Score: 0.33	NSF III; Data Warehouse, IPMS, PIMS Collection	The three data systems (PIMS, IPMS, Open-MRS) are loaded into the data warehouse.
16.2 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	16.2 Score: 2.50	HIV AIDS Investment Case 2016	more data clerks are now employed by MOHW with funding from PEPFAR in COP19

16.3 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, TG, prisoners) ☑ By priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ By age & sex ☐ From all facility sites (public, private, faith-based, etc.) ☐ From all community sites (public, private, faith-based, etc.)	16.3 Score: 1.33		The group noted that AIDS-related mortality data may be overestimated (quality in question). Prison facility data includes staff not just prisoners. BDF data on military pops is routinely collected. Many organizations do not report data into GOB systems.
16.4 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	16.4 Score: 1.33		

16.5 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, viral suppression, 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 (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users), including HIV testing, linkage to care, treatment, adherence and retention, and viral load ☐ Continuum of care cascade for each relevant key population (FSW, PWID, MSM, TG, prisoners), including HIV testing, linkage to care, treatment, adherence and retention, and viral load ☑ Results against targets ☑ Coverage or recent achievements 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	16.5 Score: 0.83		AGYW data is available for analysis but is not routinely analyzed by GOB agencies. Service delivery data analysis does not use maps on a routine basis even though they exist.
16.6 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	16.6 Score: 1.33		Data quality reports published for key programs.
		Performance Data Score:	**7.67**	

17. Data for Decision-Making Ecosystem: Host country government demonstrates commitment and capacity to advance the use of data in informing government decisions and cultivating an informed, engaged civil society.			**Data Source**	**Notes/Comments**
17.1 Civil Registration and Vital Statistics (CRVS): Is there a CRVS system in place that records births and deaths and is fully operational across the country? Is CRVS data made publically available in a timely manner?	○ A. No, there is not a CRVS system. ◉ B. Yes, there is a CRVS system that... (check all that apply): ☑ records births ☑ records deaths ☑ is fully operational across the country [IF YES] How often is CRVS data updated and made publically available (select only one)? ☐ A. The host country government does not make CRVS data available to the general public, or they are made available more than one year after the date of collection. ☑ B. The host country government makes CRVS data available to the general public within 6-12 months. ☐ C. The host country government makes CRVS data available to the general public within 6 months.	17.1 Score: 1.50	2017 Stats Brief (Statistics Botswana), Department of Labour and Home Affairs; Assessment of the M&E and HIS in Botswana (June 2019); Botswana Strategy for the Development of Statistics (BSDS), Civil Registration & Vital Statistics (CRVS), 2016 Progress Report;	
17.2 Unique Identification: Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services? Do national polices protect privacy of Unique ID information?	Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services? ○ A. No, there is no national Unique Identification system used to track delivery of services for HIV/AIDS or other health services. ○ B. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS, but not other health services. ◉ C. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS and other health services. [IF YES to B or C] Are there national policies, procedures and systems in place that protect the security and privacy of Unique ID information? ☑ Yes ☐ No	17.2 Score: 2.00	National Data Management Policy; Public Health Act; Assessment of the M&E and HIS in Botswana (June 2019)	Health outcomes for PLHIV is tracked using a national unique identification system; however, the system needs improvements to allow for tracking unique ID across multiple systems for different health services; the system is used only for citizens as there is no unique ID for foreign nationals.

17.3 Interoperability of National Administrative Data: To fully utilize all administrative data, are HIV/AIDS data and other relevant administrative data sources integrated in a data warehouse where they are joined for analysis across diseases and conditions?	◉ A. No, there is no central integration of HIV/AIDS data with other relevant administrative data. ○ B. Yes, national HIV/AIDS administrative data is integrated and joined with administrative data on the following: ☐ a. TB ☐ b. Maternal and Child Health ☐ c. Other Health Data (e.g., other communicable and non-communicable diseases) ☐ d. Education ☐ e. Health Systems Information (e.g., health workforce data) ☐ f. Poverty and Employment ☐ g. Other (specify in notes)	17.3 Score: 0.00	Botswana SDS_Country Operational Plan 2019; Assessment of the M&E and HIS in Botswana (June 2019); eHealth Strategy Botswana, January 2015;	A key focus of COP19 investments is to improve the interoperability of of several health information systems, which is a preamble to improving the overall sustainability of this element.
17.4 Census Data: Does the host country government regularly (at least every 10 years) collect and publically disseminate census data?	○ A. No, the host country government does not collect census data at least every 10 years ○ B. Yes, the host country government regularly collects census data, but does not make it available to the general public. ◉ C. Yes, the host country government regularly collects census data and makes it available to the general public. [IF YES to C only] Data that are made available to the public are disaggregated by: ☐ a. Age ☑ b. Sex ☑ c. District	17.4 Score: 1.67	National Census 2011	The next national census is planned for 2021.
17.5 Subnational Administrative Units: Are the boundaries of subnational administrative units made public (including district and site level)?	○ A. No, the country's subnational administrative boundaries are not made public. ○ B. Yes, the host country government publicizes district-level boundaries, but not site-level geocodes. ◉ C. Yes, the host country government publicizes district-level boundaries and site-level geocodes.	17.5 Score: 2.00	The Local Government System in Botswana, Country Profile 2017-18 (clgf.org)	The site geocodes are being updated.
	Data for Decision-Making Ecosystem Score:	**7.17**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D