

UNAIDS

An Evaluation of the contribution of the UNAIDS Joint Programme to strengthening HIV and Primary Health Care outcomes

Country case studies

Botswana



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Abbreviations and acronyms

AGYW	adolescent girls and young women
AIDS	acquired Immuno-deficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
AYP	adolescents and young people
CATCH	communities acting together to combat HIV
CE	country envelope
CHW	community health worker
CMS	central medical stores
CSE	comprehensive sexuality education
CSO	civil society organisation
DHIS2	district health information system version 2
DHMT	district health management team
DMSACs	district multi-sectoral AIDS co-ordination bodies
FSWEHG	Euro Health Group
FGD	focus group discussion
FSW	female sex worker
GBV	gender-based violence
GDP	gross domestic product
GF	The Global Fund
HALE	healthy life expectancy
HIV	human immuno-deficiency virus
HRH	human resources for health
IDCC	infectious disease control clinic
IPMS	integrated patient management system
Joint Programme	UNAIDS Joint Programme
JPMS	joint programme monitoring system
KI	key informant
KII	key informant interview
KP	key population
MAS	medical aid scheme
M&E	monitoring and evaluation
MoH	ministry of health
MoESD	ministry of education and social development
MSM	men who have sex with men
NAHPA	national AIDS and health promotion agency
NCD	non-communicable disease
NGO	non-governmental organisation
NSF III	Botswana national strategic framework for HIV & AIDS 2019-2023
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PHC	primary health care
PIM	patient management system
PLHIV	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
RMNCAH	reproductive, maternal, newborn, child and adolescent health

RSSH	Resilient and Sustainable Systems for Health
SADC	Southern African Development Community
SCI	service coverage index
SDG	sustainable development goals
SGBV	sexual and gender-based violence
SIDA	Swedish International Development Cooperation Agency
SRA	strategic result area
SRHR	sexual and reproductive health and rights
UBRAF	unified budget results and accountability framework
UHC	universal health coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children’s Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework
VMMC	voluntary medical male circumcision
WHO	World Health Organization

Glossary of key terms

Term	Definition
Communities	Groups of people that may or may not be spatially connected, but who share common interests, concerns or identities. These communities could be local, national or international, with specific or broad interest ^a
Community-led (AIDS) responses	Actions and strategies that seek to improve the health and human rights of their constituencies, specifically informed and implemented by and for communities themselves and the organizations, groups and networks that represent them ^b
Community engagement	A process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes ^c
Comprehensive HIV services	Services provided across a continuum that addresses the prevention, testing, treatment and care needs for people living with and affected by HIV. This may include combination HIV prevention, HIV testing, ART, management of co-morbidities and coinfections (e.g., TB, STIs, viral hepatitis, cervical cancer, NCDs, mental health conditions, etc.), and specific services and interventions for key and other populations (e.g. PrEP, harm reduction, condoms, lubricant).
Comprehensiveness of care	The extent to which the spectrum of care and range of available resources responds to the full range of health needs of a given community. Comprehensive care encompasses health promotion and prevention interventions, as well as diagnosis and treatment or referral and palliation. It includes chronic or long-term home care and, in some models, social services ^d
Differentiated service delivery	An approach that simplifies and adapts HIV services to better serve the needs of people living with HIV and to optimize the available resources in health systems ^e
Empowerment	The process of supporting people and communities to take control of their own health needs resulting, for example, in the uptake of healthier behaviours or an increase in the ability to self-manage illnesses. ^d
Essential public health functions	The spectrum of competences and actions that are required to reach the central objective of public health — improving the health of populations. This document focuses on the core or vertical functions: health protection, health promotion, disease prevention, surveillance and response, and emergency preparedness. ^d
Health system	All organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, family caregivers; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; and occupational health and safety legislation. The WHO health system framework identifies six health system "building blocks": leadership and governance, health financing, health workforce, health services, health information systems, and medical products, vaccines and technologies ^f
Health benefits packages	The type and scope of health services that a purchaser buys from providers on behalf of its beneficiaries. ^d
Integrated health services	The management and delivery of health services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services through the different functions, activities and sites of care within the health system. ^d

Term	Definition
Interlinkages	Joined or connected, with the parts that are joined often having an effect on each other
Key populations / vulnerability	<p>Key populations are groups that have a high risk and disproportionate burden of HIV in all epidemic settings. They frequently face legal and social challenges that increase their vulnerability to HIV, including barriers to accessing HIV prevention, treatment and other health and social services. Key populations include gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs.</p> <p>Vulnerability refers to unequal opportunities, social exclusion, unemployment or precarious employment (and other social, cultural, political, legal and economic factors) that make a person more susceptible to HIV infection and developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk, and they may be outside of their control. These factors may include: lack of the knowledge and skills required to protect oneself and others; limited accessibility, quality and coverage of services; and restrictive societal factors, such as human rights violations, punitive laws or harmful social and cultural norms (including practices, beliefs and laws that stigmatize and disempower certain populations). These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.^g</p>
Multisectoral action on health	Policy design, policy implementation and other actions related to health and other sectors (for example, social protection, housing, education, agriculture, finance and industry) carried out collaboratively or alone, which address social, economic and environmental determinants of health and associated commercial factors or improve health and wellbeing
People-centred care	An approach to care that consciously adopts the perspectives of individuals, carers, families and communities as participants in and beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care also requires that people have the education and support they need to make decisions and participate in their own care. ^d
Person-centred care	Care approaches and practices in which the person is seen as a whole, with many levels of needs and goals, the needs being derived from their personal social determinants of health. ^d
Primary care	A key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care. ^d
Primary Health Care	A whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities. ^d
Primary health care-oriented systems	Health system organized and operated to guarantee the right to the highest attainable level of health as the main goal, while maximizing equity and solidarity. A primary health care-oriented health system is composed of a core set of structural and functional elements that support achieving universal coverage and access to services that are acceptable to the population and equity enhancing. ^d
Service package	A list of prioritized interventions and services across the continuum of care that should be made available to all individuals in a defined population. It may be endorsed by the government at national or subnational levels or agreed by actors where care is by a non-State actor ^d
Synergy	The interaction of elements that when combined produce a total effect that is greater than the sum of the individual elements

Term	Definition
Universal Health Coverage	Ensured access for all people to needed promotive, preventive, resuscitative, curative, rehabilitative, and palliative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose any users to financial hardship. ^d
Vertical programmes	Health programmes focused on people and populations with specific (single) health conditions. ^d
Vulnerable populations	Vulnerable populations are groups of people that are vulnerable to HIV infection in certain situations or contexts, such as infants, children and adolescents (including adolescent girls and young men in sub-Saharan Africa), orphans, people with disabilities and migrant and mobile workers. They may also face social and legal barriers to accessing HIV prevention and treatment. These populations are not affected by HIV uniformly in all countries and epidemics and may include key populations. Each country should define the specific populations that are vulnerable and key to their epidemic and response, based on the epidemiological and social context. ^e

Sources for glossary:

- a) Community engagement: a health promotion guide for universal health coverage in the hands of the people. Geneva: World Health Organization; 2020
- b) Community-led AIDS responses: final report based on the recommendations of the multistakeholder task team [Internet]. UNAIDS; 2022 [cited 2023 Apr 29]. Available from: <https://www.unaids.org/en/resources/documents/2022/MTT-community-led-responses>
- c) WHO community engagement framework for quality, people-centred and resilient health services. Geneva: World Health Organization; 2017
- d) Operational Framework for Primary Health Care. Geneva: World Health Organization and UNICEF; 2020
- e) Updated recommendations on service delivery for the treatment and care of people living with HIV. Geneva: World Health Organization; 2019
- f) Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. [Internet]. World Health Organization; 2007 [cited 2023 Apr 7]. Available from: <https://www.who.int/publications/i/item/everybody-s-business---strengthening-health-systems-to-improve-health-outcomes>
- g) UNAIDS terminology guidelines, 2015. https://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf

Executive summary

Introduction

The purpose of this case study was to generate evidence and learnings from the different ways in which the UNAIDS Joint Programme has supported countries to leverage PHC and HIV linkages across various contexts. The case study used a mixed methods approach combining qualitative and quantitative methods for data collection and analysis. An initial document and data review was supplemented by primary data collection through key informant interviews and focus group discussions with key stakeholders from the national and district levels (Kgatleng). Altogether, 86 key informants representing government, UNAIDS and Cosponsors, development partners, health facility staff and civil society organisations/key population groups shared their experiences through one-on-one interviews and focus group discussions.

Communicable diseases dominate in Botswana, with HIV remaining the leading cause of death, although non-communicable diseases are rapidly increasing. Despite a high prevalence of HIV, Botswana's HIV response has been very successful, achieving all three of its 95-95-95 targets in 2021. Nonetheless female sex workers, men who have sex with men and transgender face barriers to accessing care and services. The revitalisation of PHC and the integration of PHC and HIV are policy priorities in Botswana, however progress has been uneven and integration of HIV services is not yet fully implemented.

Key findings

The Joint UN Team on AIDS is applying the two PHC approach pillars of multisectoral action and policy and community empowerment and engagement to its work on HIV, yet less so on the first pillar of the PHC approach (integrated service delivery with an emphasis on primary care). Efforts of the Joint UN Team on AIDS on integration of systems that support integrated service delivery is even less pronounced. There is further no clear joint strategy or joint plan related to HIV-PHC integration, although individual Cosponsors are implementing activities *individually* that support integration.

The Joint Programme is however seen as having an important role in bringing partners together on issues of mutual interest and providing technical assistance and international evidence, norms and guidance to inform best practice – but this has not been fully leveraged to support HIV and PHC integration.

Several enablers for integration in Botswana were identified, together with key barriers to the integration of HIV within the broader health system, which include: lack of clarity about how integration should be implemented; unclear roles and responsibilities of major actors; insufficient coordination; and concerns about the risk of reduced quality of care and reversing the achievements of the HIV response. Key populations are a priority but there are also concerns that these might be excluded from routine integrated services, so the approach to integration and linkages will need to be designed and implemented with this in mind.

There are examples of where HIV investments, learnings, and infrastructure have supported or informed broader health priorities, programmes and services in Botswana. The Botswana COVID-19 response was widely viewed as built on the experience and systems developed by the HIV response. Further untapped opportunities were identified, including: wider adoption of multisectoral approaches for other diseases and the extensive use of lay providers and community workers in general health promotion.

Conclusions and considerations on the way forward

While integration of HIV with PHC is a policy priority in Botswana, and efforts have been made to achieve this at service delivery level, there is not a clear shared understanding of the form that integration should take and how systems and programmes can be operationally integrated. Different populations require different service delivery models and hence one model of integrated service

delivery will not work for all. Detailed technical discussion of how different interventions and systems should or should not be integrated is required and the Joint Programme could facilitate and support this, including helping to ensure that the needs of key and marginalised populations are addressed.

The Joint UN Team on AIDS in Botswana could spearhead a detailed assessment of the key aspects of HIV integration within primary care/related disease programmes, convening partners for alignment on HIV integration and providing technical assistance as needed, paying particular attention to integrating the systems which support the services (e.g. information systems, human resources, supply chain, financing etc) to ensure sustainability.

Joint planning within the Joint UN Team on AIDS on integrating HIV with other services/ PHC and ensuring their capacity and funding in-country to support these activities is essential. HIV and PHC integration and linkages should be a standing agenda item in Joint Team meetings.

1 Introduction and context

1.1 Purpose and scope of the case study

This case study contributes to a global evaluation to identify opportunities and imperatives for the work of the UNAIDS Joint Programme (Joint Programme)¹ in relation to the intersections and integration of HIV and primary health care (PHC) in the future. The evaluation is primarily designed for learning and planning purposes. The main objective is to conduct a forward-looking process evaluation that identifies opportunities for the Joint Programme to strengthen HIV and PHC integration and linkages, and to assess what the Joint Programme has achieved since 2020 in relation to these aspects. The purpose of carrying out country case studies was to generate evidence from the different ways in which the Joint Programme has supported countries to leverage PHC and HIV linkages across various contexts.

Four countries were selected for the country case studies: Angola, Botswana, Indonesia, and Pakistan. The selection was based on criteria including relevance of the evaluation topic for UNAIDS country offices, the Joint Programme and country governments, geographic diversity, and a diversity in HIV epidemiology and health system contexts.

In this case study we focused on the country level work of the UNAIDS secretariat and the four UNAIDS Cosponsor agencies: WHO, UNICEF, UNFPA and UNESCO who are active in the field of HIV and PHC related work. The timeframe for the evaluation was restricted by scope in accordance with the evaluation's terms of reference to include the period from January 2020 until July 2023

1.2 Approach/Methods/Limitations

Approach and methods - A document review was supplemented by primary data collection through key informant interviews (KIIs) and focus group discussions (FGDs) undertaken in country during the period 31 July – 04 August 2023 with key stakeholders from the national and district levels (Kgatleng).

Key stakeholders were purposely selected to take part in key informant interviews and focus group discussions in order to collect relevant information and evidence at the national and provincial levels. The evaluation team conducted 23 KIIs with representatives of the Joint Programme, government (including departments of the Ministry of Health (MoH)² at national and district level and the National AIDS and Health Promotion Agency (NAHPA), other development partners and international and local non-governmental organisations (NGOs) and civil society organisations (CSOs). In addition, it made a visit to a District to meet a District Health Management Team (DHMT) and visit to a clinic and conducted a focus group discussion with representatives of people living with HIV. Key informant interviews were conducted using a semi-structured interview guide that listed a predetermined set of questions related to the themes of this country case study. The interview guide/focus group discussion guide is available in Annex 1 and the full list of those interviewed in KIIs and FGDs is included in Annex 2.

Documents, including government publications, academic publications and reports from the UN Joint Programme Monitoring System (JPMS) were reviewed (full list in Annex 3).

Data from KIIs and FGDs were recorded in notes, analysed, and organised according to evaluation themes and content. Coding all qualitative data and populating the evaluation evidence matrix by sub-question and evaluation question supported the triangulation process with the evidence gathered from documents.

¹ The UN Joint Programme on AIDS includes the UNAIDS Secretariat and 11 UN agencies known as 'Cosponsors'.

² Ministry of Health and Wellness is also sometimes used to refer to this Ministry. In this report Ministry of Health (MoH) is used throughout for consistency.

Limitations of the study included the short time in-country which limited both the number of interviews possible (two were conducted remotely after the end of the visit) and the amount of travel possible outside Gaborone. Furthermore, the Joint Programme lacks a fully developed set of indicators for its work on HIV and PHC integration. The extent to which the evaluation was able to assess measurable progress or results which can be attributed to the Joint Programme was therefore limited.

Botswana is in the process of scaling up integration of HIV with both wider sexual and reproductive health and rights (SRHR) services and non-communicable disease (NCD) programmes specifically and PHC more generally, as part of its goal to reach Universal Health Coverage (UHC) - further details are in section 2) so the extent of integration of services varies in different parts of the country and the experiences of key informants (KIs) varied. Nonetheless valuable information was gathered on the current position, achievements to date and priorities for the future which informed the recommendations of this study.

2 Introduction to the national PHC and HIV context

2.1 Overview of health context

2.1.1 Key demographic, socio-economic and burden of disease/health data

Botswana is a landlocked country located in the centre of Southern Africa, bordered by Zambia, Zimbabwe, Namibia, and South Africa. Despite the relatively large land area of 581,730 km², the total population is only 2 588 423. Gross Domestic Product (GDP) per capita is US\$ 7737³ a relatively high figure for Sub-Saharan Africa, fuelled by the minerals economy, which contributes about 50% of GDP and an increasingly important tourism sector currently contributing an estimated 12% of GDP.

Botswana has a youthful population: 30.3% are aged 10-24 years, while only 4% are aged over 65 years. Early and unintended pregnancies are common: the contraceptive prevalence rate is 53% (married women 64%) and the total fertility rate is 3.1 births per woman. The unmet need for FP is 17.3%.⁴

Over the past 20 years Botswana's progress on mortality rates has been mixed. The mortality rate for children under 5 years of age reduced from 74.0 per 1000 live births in 2000 to 34.9 per 1000 live births in 2021, while the infant mortality rate reduced from 35.1 to 28.3 deaths per 1000 live births over the same period, but the neonatal mortality rate increased from 8.1 to 18.0 deaths per 1000 live births over 2000-2021. The maternal mortality ratio increased from 181.6 per 100 000 live births in 2000 to 185.9 per 100 000 live births in 2020.⁵

Since 2010, the Health Life Expectancy (HALE) for Botswana has improved slightly, from 50.6 to 53.9 years – an increase of only 3.3 years – remaining lower than the global average (63.7) and regional average for WHO Africa (56 years). Based on the current trends in maternal mortality ratio, neonatal, child and under-5 mortality, it is unlikely that the country will reach the set 2030 Sustainable Development Goals (SDGs) targets.⁶

³ The World Bank 2022 (<https://data.worldbank.org/country/botswana?view=chart> accessed on 06 September 2023 (2022 figure based on current US dollars)

⁴ Satellite session on the integration of SRHR, HIV and GBV services. Geneva: Joint United Nations Programme on HIV/AIDS, United Nations Children's Fund, United Nations Population Fund and World Health Organization; 2021 (https://esaro.unfpa.org/sites/default/files/pub-pdf/2gether4_srh_presentation_integration.pdf, accessed 24 April 2023).

⁵ [SDG Country Profiles](https://unstats.un.org/sdgs/dataportal/countryprofiles/bwa#goal-3), United Nations Department of Economic and Social Affairs, SDG Indicators Database (<https://unstats.un.org/sdgs/dataportal/countryprofiles/bwa#goal-3> accessed 06 Sept 2023).

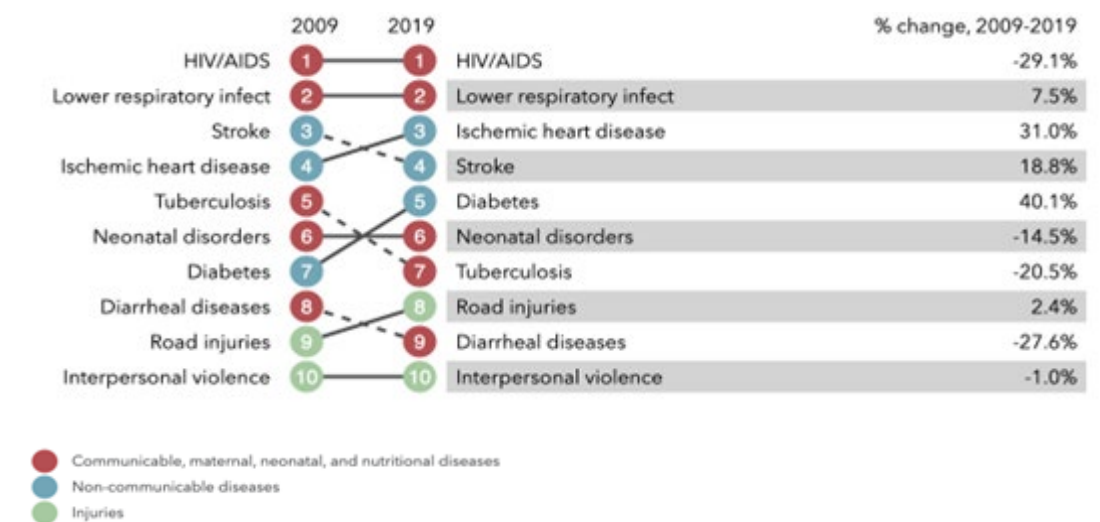
⁶ Comprehensive Review of the Health Sector: 2010-2022 and priorities moving forward. Ministry of Health, Government of Botswana. 2022

The burden of disease in the country is dominated by communicable diseases, with HIV remaining the leading cause of death, although there has been a 36% decline in the number of AIDS-related deaths between 2010 and 2022⁷. Notable however is the rise in lower respiratory infections by 7.5% and rise in NCDs (ischemic heart disease by 31%, diabetes by 40%).⁸

The burden of NCDs and their risk factors are on the increase in Botswana. In 2019, deaths among women due to heart disease, stroke and diabetes together exceeded deaths due to HIV, while the figures for men still show HIV-related deaths exceeding those for the three NCDs⁹. Although services for the treatment of hypertension, diabetes and chronic respiratory diseases are available across all levels of health facilities, there are often stock outs of essential medicines and diagnostics. Cervical and breast cancer screening have started, but there is a need for better data on screening coverage. Mental health services are not available in all health facilities.

Gender based violence (GBV) is addressed by multiple sectors, including local government, judiciary, police, and social services but remains a challenge, with one in three women reported to experience it in their lifetime.¹⁰

Figure 1: Top 10 causes of total number of deaths in 2019 and percent change 2009–2019, all ages combined¹¹



2.2 National PHC policy and programmatic response and challenges

2.2.1 Health sector strategic plans and reforms

The revitalisation of PHC and the integration of PHC and HIV are policy priorities for Botswana and other health policies are being updated to reflect this. The Government of Botswana has a 20-year plan known as Vision 2036¹² accompanied by the National Development Framework 11 2022 (NDP 11) to deliver the Vision 2036 and the SDGs. The NDP 11 identifies enhancing the integration of

⁷ <https://aidsinfo.unaids.org/> (accessed 21 September 2023)

⁸ Institute for Health Metrics and Evaluation (IHME) 2023 (<https://www.healthdata.org/botswana>, accessed 19 August 2023)

⁹ WHO Country Data (<https://data.who.int/countries/072> accessed on 06 Sept 2023)

¹⁰ Comprehensive Review of the Health Sector: 2010-2022 and priorities moving forward. Ministry of Health, Government of Botswana. 2022

¹¹ Comprehensive Review of the Health Sector: 2010-2022 and priorities moving forward. Ministry of Health, Government of Botswana. 2022

¹² Vision 2036 – Achieving Prosperity for All . Presidential Task Team, Government of Botswana; July 2016

health services in priority areas – such as HIV, TB, SRHR, mental health, maternal and child health and rehabilitation, measures towards the prevention, treatment, rehabilitative and palliative care for those affected by NCDs, and revitalisation of PHC – as a key strategic approach to be adopted for achieving health goals and targets.

Botswana is in the process of reviewing and updating the National Health Policy 2010-2020 (NHP) and the Integrated Health Service Plan (IHSP) 2010-2020 to reflect the SDGs and the changed health context post-COVID-19. The IHSP operationalises the NHP, and the Ministry of Health (MoH) Strategy (2017-2023) is aligned to it.¹³

The Government has adopted a national strategy for Integrated Sexual and Reproductive Health and Rights/ HIV Services following a successful pilot undertaken as part of the UNFPA and UNAIDS supported ‘SRHR/HIV Linkages’ pilot project (2011-2015). Subsequently, the national SRHR/HIV Scale-up Plan was developed, with the objective of increased access to, and use of, a broad range of quality services for SRH and HIV prevention, treatment, care and support, with linkages to sexual and gender-based violence (SGBV) services. This was aligned to strategic guidance provided through Vision 2036, as well as the IHSP.

In 2017, through a Botswana Government National Commitment Letter, MoH committed to the Global Strategy for Women’s Children’s and Adolescent’s Health (2016-2030). Following this commitment, the Botswana Integrated Reproductive, Maternal, Newborn, Child and Adolescent’s Health (RMNCAH+N) Strategy (2018-2022)¹⁴ was developed. The integration agenda embraces the PHC approach and is anchored in the RMNCAH+N Strategy. In so doing, it broadens the scope of integration to include other diseases and conditions, including NCDs, which are rapidly increasing in Botswana (see Figure 1).¹⁵ This constitutes a fundamental shift, from the current vertical clusters of integrated programme models, such as expanded HIV services including TB and diabetes or integrated HIV and SRH services, to a comprehensive approach that focuses on the client in a holistic manner, as the National Guidelines on Health Services Integration acknowledges: “Service integration efforts within the health sector to date have been described by stakeholders as rather “piecemeal”, resembling vertical delivery, with combinations such as HIV/TB; SRHR/HIV, SRHR/HIV/SGBV, HIV/TB/Malaria, HIV/SRHR/NCDs etc.”¹⁶

Universal health coverage (UHC) is recognized as the overarching objective of actions within the health sector. An Essential Health Services Package (EHSP) was developed in 2010 with a goal of guiding provision of high-quality services towards attainment of UHC. This package comprises services for SRH, child health, communicable diseases and NCDs (including HIV) and is now being updated to shift to a focus on age cohorts.

In order to define how the shift to integrated people-centred quality health services based on the needs of the different age cohorts will take place, and the systems and structures required to support them, Botswana is undertaking a comprehensive review process that will include: i) development of an UHC roadmap; ii) review of the essential health service packages; iii) Human Resources for Health (HRH) Strategy development; iv) development of the Health Partners Framework, v) review of the draft Health Financing Strategy; vi) National Health Insurance Feasibility Study; and vii) Health Sector Monitoring and Evaluation Plan.

¹³ National Guidelines on Health Services Integration: Reproductive, Maternal, Newborn, Child, and Adolescent, Health, +Nutrition, Non-Communicable Diseases & Other Services. Ministry of Health Republic of Botswana, UNFPA; December 2021

¹⁴ Botswana Integrated Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH+N) Strategy (2018–22)

¹⁵ Botswana Multi-sectoral Strategy for Prevention and control of NCDs 2018-2023. MoH; 2018

¹⁶ National Guidelines on Health Services Integration: Reproductive, Maternal, Newborn, Child, and Adolescent, Health, +Nutrition, Non-Communicable Diseases & Other Services. Ministry of Health Republic of Botswana, UNFPA; December 2021

2.2.2 Leadership and responsibilities for delivering PHC at all levels

Botswana is divided into 18 health districts with health services structured across four levels: hospitals (referral, district, and primary), clinics, health posts, and mobile stops. According to the Master Facility List, there are 819 facilities in total, of which 605 are public, 208 private and two missionaries.

DHMTs have been established with functional structures for the provision of better services (PHC/community health services, integrated health services, technical services and nursing care). There are functional platforms (committees) at village, community and district levels that ensure partnership/stakeholder involvement in the planning and implementation of health interventions.

The government has developed and is in the process of implementing its decentralisation policy, including the decentralisation of roles and responsibilities to DHMTs. There is commitment at all levels to see a better performing and more responsive health delivery system.

The National Guidelines on Health Services Integration¹⁷ set out clear co-ordination structures at all levels, including roles and responsibilities, under a National Reference Committee chaired by the Deputy Permanent Secretary, Prevention, MoH. The Reference Committee membership includes MoH and NAHPA managers, development partners, leaders of key CSO networks and national CSOs and relevant non-health institutions. The work of the Reference Committee includes: “Coordinate interagency support for integrated service delivery, including from development partners, the United Nations family, international NGOs etc., to facilitate harmonised implementation and avoid duplication”.¹⁸ A RMNCAH+N Technical Working Group (TWG) provides technical support to the Reference Committee.

2.2.3 Community structures and engagement

There is recognition that communities are at the centre of PHC and an ambition to bring patient-centred quality services closer to the people. Through the commitment to ‘revitalise PHC’, the aim is to refocus on the traditional community structures that played a critical role in the health sector prior to the HIV epidemic.

As part of the strategy to revitalise PHC and the refocus on communities, the country adopted the Harmonisation of Botswana’s Community Health Workers Groups: Primary Health Care-Community Health Worker (PHC-CHW) Coordination Strategy in 2017. This reflects the commitment of the Botswana Government to institutionalise community health workers (CHWs) as part of the health sector. The 2020 National guidelines for implementation of integrated community-based health services in Botswana¹⁹ operationalise the Harmonisation Strategy and provide clear guidance to ensure that CHWs are well coordinated, monitored and incentivised to deliver integrated community-based health services. The guidelines focus on the vertical integration of different levels of health services provided through a network of service providers in public, private, community and traditional settings to allow clients to receive a continuum of preventive and curative services that meet their needs over time. The focus on a revitalised PHC system requires a paradigm shift from curative to preventative services.

The guidelines also unpack the minimum service package for this level, which aligns to the Integrated RMNCAH+N Strategy, and identifies cadres of CHW (three grades of CHWs plus volunteers) responsible for services.

¹⁷ National Guidelines on Health Services Integration: Reproductive, Maternal, Newborn, Child, and Adolescent, Health, +Nutrition, Non-Communicable Diseases & Other Services. Ministry of Health Republic of Botswana, UNFPA; December 2021

¹⁸ National Guidelines on Health Services Integration: Reproductive, Maternal, Newborn, Child, and Adolescent, Health, +Nutrition, Non-Communicable Diseases & Other Services. Ministry of Health Republic of Botswana, UNFPA; December 2021

¹⁹ National guideline for implementation of integrated community-based health services in Botswana. Ministry of Health and Wellness, Gaborone: Government of Botswana; 2020.

Community structures such as support groups for people living with HIV, religious leaders, traditional governance structures at village level, etc participate actively in creating demand for services, for example, mobilising people for the COVID-19 vaccinations. The country has also implemented a school health programme with teams of dental therapists, nutrition officers and social welfare officers visiting public schools.

2.2.4 Role of private sector

Approximately 83% of the population relies on the nearly free public system for their health care while the remaining 17% uses private providers and are covered by one of the country's nine commercial medical aid schemes (MAS)²⁰. These schemes make fee for service payments to private facilities for the clients who are covered. The public sector also outsources services to the private sector especially specialised services.

Out of pocket payments are mainly incurred by people using the private sector who are uninsured or for services that are not covered by MAS. Even for those covered, there may be co-payments, which can be a barrier to accessing services, to an extent that even those with insurance prefer to access services in the public sector where there is no co-payment.

2.2.5 Health systems and service delivery challenges and social inequities affecting access to health services

The UHC service coverage index (SCI) score for Botswana is 54 (out of a possible 100), below the global average (67) and the average of other Upper Middle-Income Countries (UMICs). Out of the four components within the UHC SCI, 'service capacity', covering system elements, has the lowest score (41), with RMNCAH and NCD standing at 54 and 53 respectively.

The government has made significant investments in infrastructure and about 95% of the population lives within eight kilometres of a health centre. Nonetheless, "while there have been significant investments in the health system capacities, these investments have not been harmonised and coordinated, dampening their overall impact on utilisation of essential health and related services. Infrastructure investments are not well harmonised with staffing and other inputs needed to ensure functionality and readiness needed to increase on the health services outcomes the population needs".²¹

Shortages of health workers are a major problem. Low salaries and lack of an attractive retention package continue to fuel the high staff attrition rate, especially amongst doctors, who leave for the private sector or service overseas. Furthermore, inefficiencies in procurement, supply chain management and systems for forecasting and quantifying commodity requirements across all levels hinder service delivery. Stockouts of essential medicines (including HIV test kits) are frequent.

Data collection remains largely paper-based at the facility level, increasing errors and the burden of reporting for health workers. There are efforts to automate data collection in the country including the Integrated Patient Management System (IPMS) (used in hospitals only to collect patient clinical management information – mostly HIV treatment and management and diagnostic information), the Patient Management System (PIM) (used in clinics with maternity units for HIV/AIDS), and the District Health Information System version 2 (DHIS2) (used for aggregating health data from all facilities within the country). The country has other software for TB data, OpenMRS, and various mobile-based applications for data collection. These are fragmented and limit access to data, particularly at lower levels of the health system.

²⁰ Health Financing in Botswana: a landscape analysis MoH and USAID 2016 quoted in: Comprehensive Review of the Health Sector: 2010-2022 and priorities moving forward. Ministry of Health, Government of Botswana. 2022

²¹ Comprehensive Review of the Health Sector: 2010-2022 and priorities moving forward. Ministry of Health, Government of Botswana. 2022

2.3 Overview of the national HIV epidemic and response

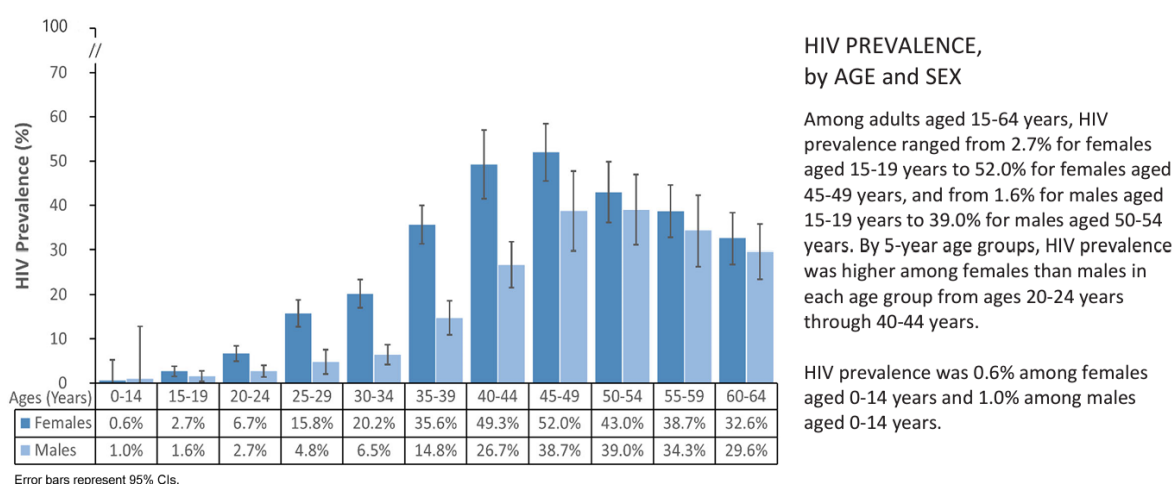
2.3.1 Key epidemiological HIV data, trends, and data on key population groups vulnerable or affected by HIV, key geographies

Despite having high prevalence rates of HIV, Botswana is also viewed as an exemplar of a national public health response due to its rapid multisectoral, multilevel, integrated responses to the epidemic which have been very successful.

Prevalence: Botswana has the third highest prevalence of HIV in the world,²² with an estimated prevalence in adults (15-49 years) of 16.4% (21% among women and 12% among men), corresponding to approximately 340 000 people (15 years and above) living with HIV according to the most recent UNAIDS estimates²³.

Prevalence varies between age groups. Women have the highest prevalence rates for each age group with the highest rate of 52% amongst women aged 45-49 years (see Figure 2). Prevalence also varies by district, with the lowest rates in Gabarone (11.1%) and the highest in Central Mahalapye (33.3%).²⁴

Figure 2: Prevalence of HIV by age and sex, Botswana 2021²⁵



According to most recent estimates by UNAIDS, the HIV incidence per 1000 population is 3.32 [2.65 - 4.12] among adults aged 15-49 in Botswana with 4300 new cases estimated in 2022. Since 2010 there has been a 66% reduction in the number of new HIV infections in Botswana, and since 2020 a 18% reduction according to UNAIDS epidemiological estimates.²⁶

Most new HIV cases are among women (63%)²⁷ and the 2022 National HIV estimates found that 24% of new infections are in adolescent girls and young women although they only account for 9% of the population.²⁸ Condom use at high-risk sex among young people 15-24 years is lower among females and has declined in recent years.²⁹

²² World Bank, Total prevalence of HIV (population aged 15-49), accessed 24 May 2023, https://data.worldbank.org/indicator/SH.DYN.AIDS.ZS?locations=BW&most_recent_value_desc=true

²³ UNAIDS, *Country factsheets: Botswana* (2022) - <https://www.unaids.org/en/regionscountries/countries/botswana>

²⁴ BAIS V Preliminary Report, Statistics Botswana, September 2022

²⁵ BAIS V Preliminary Report, Statistics Botswana, September 2022

²⁶ <https://aidsinfo.unaids.org/> accessed 21 September 2023

²⁷ UNAIDS, *Country factsheets: Botswana* (2022) - <https://www.unaids.org/en/regionscountries/countries/botswana>

²⁸ HIV AIDS in Botswana 2022. Ministry of Health, NAHPA & UNAIDS; 2022

²⁹ HIV AIDS in Botswana 2022. Ministry of Health, NAHPA & UNAIDS; 2022

The estimated number of **AIDS-related deaths** in Botswana (all ages) has also seen a decreasing trend with a 36% reduction since 2010, however with less clear reduction since 2020.³⁰

2.3.2 The aims and strategic orientation of the current NSP and progress against 95-95-95 targets

Botswana has a robust and effective HIV programme, but certain critical gaps remain. From 2000 onwards Botswana established one of Africa's largest public sector HIV and AIDS treatment programmes. This was done through infrastructure development, including the construction of 35 Infectious Disease Care Clinics (IDCCs), training of about 7000 health workers and lay personnel, and provision of equipment to support laboratory diagnostic and monitoring services.

The HIV response in Botswana is coordinated by the NAHPA. NAHPA's mandate has been extended to include NCDs. "In order for the nation to benefit from the model NAHPA has successfully employed over the years in coordinating the response to HIV and AIDS, Cabinet approved the expansion of NAHPA's mandate in 2018 to include Non-Communicable Diseases (NCDs). This means NCDs will also benefit from the experience NAHPA has gained over the years in coordinating efforts against AIDS."³¹

The Third National Strategic Framework on HIV and AIDS (NSF III)³² seeks to expand an integrated approach to the delivery of HIV and AIDS services to ensure efficiency in critical areas such as human and financial resources, and to increase service coverage. NSF III also aims to strengthen coordination of the multisectoral HIV response with an emphasis on "one monitoring and evaluation (M&E) framework" for the national HIV response.

The Handbook of the Botswana 2016 HIV Integrated Clinical Care Guidelines gave further traction to the integration of SRHR and HIV services. This was followed by the development of the RMNCAH+N Strategy which broadened the scope of integration. Guidance for other programme- and service-specific efforts that are client-centred and seek an integrated modality include (but not limited to) the:

- e-Health Strategy (2020-2024)
- MoH Strategic Plan (2017-2023)
- School Health Strategy
- Third National Strategic Framework Multisectoral for HIV and AIDS (2019-23) "Enhancing efficiencies through an integrated approach"
- Botswana Integrated HIV and AIDS Basic Services Package; the harmonisation of Botswana's CHW Groups
- National Guidelines for Implementation of Integrated Community Based Health Services
- Botswana Health Data Collaborative Road Map "Towards a Harmonised Health Information and Monitoring and Evaluation System in Botswana"

Progress on 95-95-95 Targets

Countries have committed to achieving the global HIV 95-95-95 targets³³. With continued annual progress, Botswana achieved all three targets in 2021 according to UNAIDS special analysis in 2023 (Figure 3), and Botswana was thus one of the first countries with a high burden of HIV to do so. In 2022, an estimated 97% of people living with HIV (PLHIV) were aware of their HIV status, 97% of

³⁰ <https://aidsinfo.unaids.org/> accessed 21 September 2023

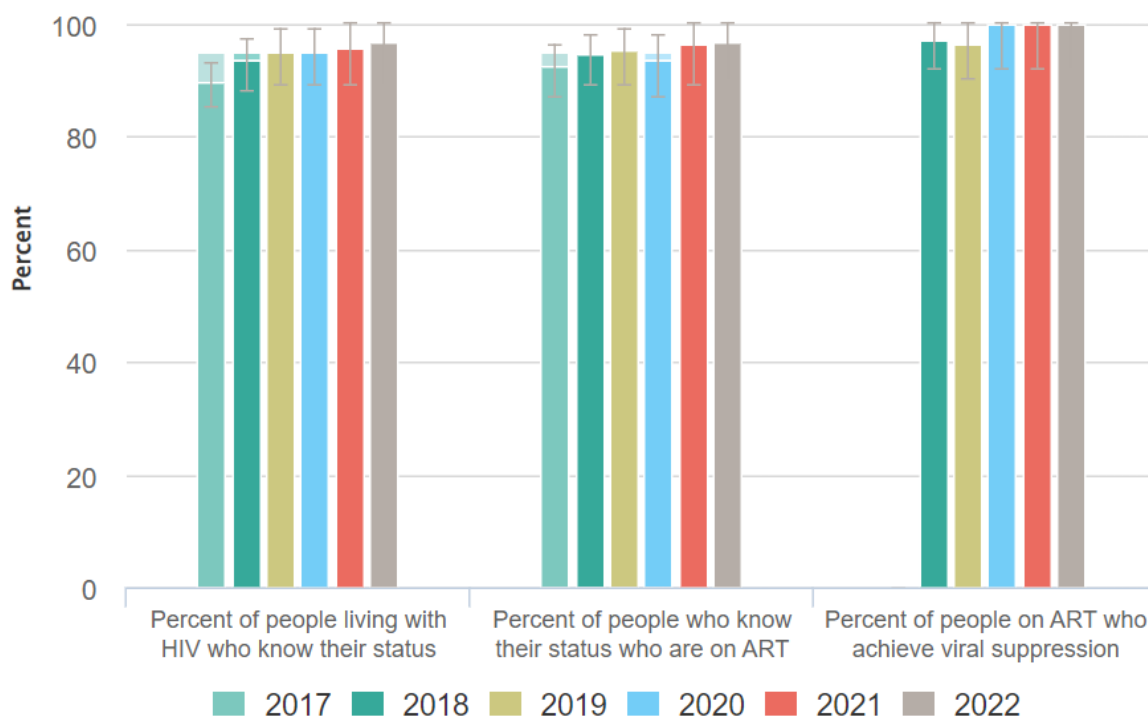
³¹ The Third Botswana National Strategic Framework for HIV & AIDS: Enhancing Efficiencies through an Integrated Approach 2019-2023. Government of Botswana; 2019

³² The Third Botswana National Strategic Framework on HIV & AIDS: Enhancing Efficiencies through an Integrated Approach 2019-2023. Government of Botswana; 2019

³³ (95 per cent of people living with HIV know HIV status; 95 per cent of all people diagnosed with HIV on ARVs; 95 per cent of all people receiving antiretroviral therapy to have viral suppression by 2025)

PLHIV were on anti-retroviral therapy (ART), and more than 98% of PLHIV on ART had achieved viral suppression.

Figure 3: Progress against 95-95-95 targets in Botswana 2017-2022³⁴



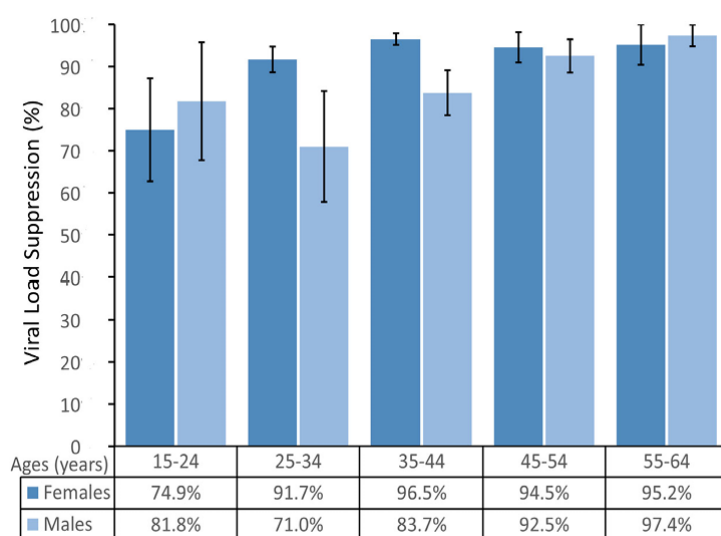
The percentages achieving viral load suppression were overall higher for women than for men and with large age group variations according to a recent national impact analysis (see Figure 4)³⁵. Among adults living with HIV in Botswana, the percentage of those on ART achieving viral load suppression ranged from 75% among females aged 15-24 years to 96.5% among females aged 35-44 years, and from 71% among males aged 25-34 years to 97.4% among males aged 55-64 years. There are also differences between districts. Central Mahalapye has one of the highest percentages of adults on ART who have achieved viral suppression, at 97.1%, despite having the highest prevalence of HIV.³⁶

³⁴ UNAIDS special analysis 2023, (<https://aidsinfo.unaids.org/> - accessed 21 September 2023)

³⁵ BAIS V Preliminary Report, Statistics Botswana, September 2022

³⁶ BAIS V Preliminary Report, Statistics Botswana, September 2022

Figure 4: Prevalence of viral load suppression among adults living with HIV³⁷



Error bars represent 95% CIs.

Progress towards EMTCT of HIV

Botswana initiated its prevention of mother-to-child transmission program in 1999, rapidly achieved national coverage and successively implemented more effective treatment regimens based on WHO guidance. With implementation at scale, the first elimination impact indicator, the estimated mother-to-child transmission rate reduced to 1.9% in 2019, below the less than 5% needed for EMTCT. High HIV prevalence, however, made it impossible in 2019 to reach the second elimination impact indicator. As such, Botswana is now on the “path to elimination”.³⁸ This achievement was partially attributed to the country’s commitment to national ANC coverage and early implementation of “Option B+,” a plan for treating all pregnant and breastfeeding women living with HIV with a triple antiretroviral (ARV) treatment at the time of diagnosis.

The recommendations to achieve full EMTCT includes to strengthen and update; programme management, policies and implementation strategies; the national data monitoring and analysis system; laboratory testing and quality assurance; and human rights protections including increasing meaningful engagement of women living with HIV at all levels. Botswana has further been strongly recommended by WHO and partners to continue its commitment to strengthen its syphilis programme and begin planning for EMTCT of Hepatitis B virus.³⁹

Key and vulnerable populations

The NSF III recognizes female sex workers, men who have sex with men (MSM) and transgender as key populations in Botswana and refers to clients of sex work potentially serving as an epidemiological bridge for transmitting HIV to the general population. Non-citizens (7% of the population) were also noted as a group needing special attention. The global fund baseline assessment however refers to several additional key and vulnerable populations in Botswana (Table 2).

³⁷ BAIS V Preliminary Report, Statistics Botswana, September 2022

³⁸ Press release: Botswana is first country with severe HIV epidemic to reach key milestone in the elimination of mother-to-child HIV transmission, UNAIDS, December 2021,

https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2021/december/emtct_botswana

³⁹ WHO website story: Botswana: fulfilling the promise of an AIDS free generation in Africa:

<https://www.who.int/about/accountability/results/who-results-report-2020-mtr/country-story/2021/botswana>

Table 1: Key and vulnerable populations in Botswana⁴⁰

Key populations	Vulnerable Populations
-People living with HIV (PLHIV) -Sex workers -Gay men and other men who have sex with men (MSM) -Transgender people -Other LGBT persons -People who inject drugs -Prison inmates	Adolescent girls/young women 'Non-citizens'—particularly refugees, asylum seekers, and undocumented foreigners People with disabilities Remote area dwellers

The most recent Botswana IBBS study (2017)⁴¹ focused on female sex workers and men who have sex with men and showed:

- The population estimate for female sex workers (FSW): 6718 across the 12 study districts; with Greater Gaborone and Greater Francistown having the highest absolute number of female sex workers (estimated as 1641 and 687 respectively).
- The total population estimate for MSM: 2625
- HIV prevalence is particularly high among FSW: 42.8% compared with 25% for females aged 15 and above. FSW are three times more likely to be newly infected with HIV than other adult females
- HIV prevalence among MSM: 14.8% and MSM are three times more likely to be newly infected with HIV than other adult males
- Rates of active syphilis have increased among MSM and FSW
- Consistent condom use among FSW (47.9%) and among MSM (59.4%) and lower than for the general population reported condom use
- HIV testing among FSW is insufficient at just over 50% (% who were tested within the last 12 months)
- ART coverage for FSW: 87.6%; ART coverage for MSM: 73.5%.

The background search, including the above IBBS, found limited data and attention to people who inject drugs (PWID), and transgender people in Botswana. PWID were not surveyed through the IBBS surveys in 2012 nor in 2017. A recent publication highlights a pattern of high-risk behaviors and stigma and discrimination faced by transgender people in Botswana.⁴² Furthermore, the population size estimates might be biased due to stigma, and potentially higher for sex workers if the definition of transactional sex was to include all relationships where exchange of goods and services take place.⁴³

Barriers to HIV prevention and services

Despite making significant progress towards 95-95-95, there are barriers to accessing care and a related high proportion of late presenters, with 25% of new infections, and especially among men, diagnosed with advanced HIV disease. Due to traditions of women as caretakers and early

⁴⁰ National Strategic Plan to Reduce Human Rights – Related Barriers to HIV and TB Services : Botswana 2020 – 2025. https://www.theglobalfund.org/media/10418/crg_humanrightsbotswana2020-2025_plan_en.pdf

⁴¹ HIV AIDS in Botswana 2022 Factsheets. MoH, NAHPA and UNAIDS; 2022

⁴² Keatlaletse Siamisang et al. High-risk behaviors and factors for HIV and sexually transmitted infections among transgender people in Gaborone, Botswana: results from a national survey. Pan African Medical Journal. 2022;41(128). 10.11604/pamj.2022.41.128.32430

⁴³ Ministry of Health and Wellness, NAHPA and UNPFA. Innovative service delivery models to improve HIV outcomes for key populations in Botswana; July 2020

consultations with healthcare through childbearing, women are more likely to use health services which could explain some of this observed variance. Among adolescents however the picture is different with girls and women (aged 15-24) lagging behind with only 75% achieving viral load suppression compared to 82% among males from the same age group⁴⁴. The recent UNICEF country office annual report 2022⁴⁵ reported reasons to include a lack of youth-friendly services, stigma and discrimination and other determinants which continue to pose barriers for HIV treatment adherence among adolescents. Stigma related to HIV and key populations has also been reported in other literature as a barrier to accessing care. The latest stigma index report from Botswana⁴⁶ dated back to 2014, with an ongoing survey at present being implemented. Data from 2014 indicated that 9% of PLHIV surveyed had been denied access to reproductive health services.

Reports further describes that key populations in Botswana are often marginalised, stigmatized and discriminated against. Sex work and same sex relationships have up until recently been illegal, making access to comprehensive services by lesbians, gay, bisexual and transgender people and sex workers difficult. While sex work remains illegal, a court case in 2019 ruled that it was not lawful to criminalize same-sex relationships⁴⁷.

Ramogola-Masire et al. (2021)⁴⁸ in a recent publication recommended moving from a biomedical model of ensuring availability of testing and treatment towards a biopsychosocial approach that addresses stigma to ensure quality of life and social integration for people living with HIV. In addition, the authors suggested that, given Botswana's history of integrated PHC and the high proportion of the adult population on ART (over 300 000, over 20% of adults), there is a need to integrate ART with PHC. This is the path that Botswana is now following.

2.4 HIV financing and PHC/UHC interlinkages

2.4.1 Current financing for HIV and extent to which HIV services are included in any UHC/health insurance system or health services packages

Botswana has increased government funding for health. According to the WHO Global Health Expenditure Database⁴⁹ in 2020 Botswana's Domestic General Government Health Expenditure (GGHE-D) was 12% of General Government Expenditure (GGE). The government is the main source of health expenditure with Domestic General Government Health Expenditure (GGHE-D) at 75% of Current Health Expenditure (CHE). Out of pocket expenditure (OOP) is low at 5% of CHE and external health expenditure is 6% of CHE. In per capita terms, government expenditure (GGHE-D) is US\$271 while OOP is US\$17 per capita and external health expenditure is US\$21.

Spending on HIV has also increased, according to the 2020 National AIDS Spending Assessment. The government provides the largest share (59% of total HIV spending in 2018/19 and 61% in 2019/2020). International partners' contribution declined over the same period from 39% to 37%, with the Global Fund, PEPFAR, USAID and CDC the main donors, while the private sector contributed 2% in both years.⁵⁰ In 2019/20, total HIV spending was 1% of GDP and 22% of the total health budget, with an average spending on HIV of US\$71 per capita and US\$433 per PLHIV. In 2019/20,

⁴⁴BAIS V Preliminary Report, Statistics Botswana, September 2022

⁴⁵ UNICEF Country Office Annual Report 2022 Botswana - Update on the context and situation of children

⁴⁶ PLHIV Stigma Index Survey Report Botswana 2014 <https://www.stigmaindex.org/wp-content/uploads/2022/04/Botswana-SI-Report-2014.pdf>

⁴⁷ Ministry of Health and Wellness, NAHPA and UNPFA. Innovative service delivery models to improve HIV outcomes for key populations in Botswana; July 2020

⁴⁸ Botswana's HIV Response: Policies, Context and Future Directions. Ramogola-Masire et al; J Community Psychol. 2020 April ; 48(3): 1066–1070. doi:10.1002/jcop.22316.

⁴⁹ WHO Global Health Expenditure Database (<https://apps.who.int/nha/database/ViewData/Indicators/en> accessed 06 Sept 2023)

⁵⁰ This low figure could be due to poor reporting.

45% of HIV spending was on PLHIV, (mostly on treatment and care services) with only 1% of total HIV spending allocated to programmes targeting key populations.⁵¹

2.4.2 HIV and PHC integration aspects

As described in section 2.2, Botswana has strong policy commitments to revitalise PHC and to integrate health services. It recognises that to achieve meaningful UHC, a shift is needed from health systems designed around diseases and institutions, to those designed for people and with people. The PHC approach demands a commitment to moving beyond the health sector and mainstreams a government-led approach to health in all aspects of development, including non-health policies, with a strong focus on equity and interventions that encompass the entire life cycle.

PHC in its broad definition is a whole-of-government and whole-of-society approach with three main components: (a) primary care and essential public health functions as a core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities.

The NSF III⁵² aims to ‘take HIV and AIDS out of isolation’ by integrating HIV services with other health services to improve health outcomes and contribute to the achievement of UHC. Integration is to be implemented phased, and the strategy specifies to integrate the following services:

1. HIV and TB services
2. HIV and SRHR services
3. HIV and other STI services
4. HIV and NCD management

The NSF describes the progress to date in integrating HIV with TB, SRHR, STI and NCD services. It notes the main gaps and challenges, which mostly concern weak systems supporting the wider health services and proposes strategies to address these. However, the NSF III does not as such aim to address integration at system level (procurement, data, financing etc.).

Despite the enabling policy environment for service integration, progress towards integration of HIV services in Botswana has been uneven and still in process of being fully implemented. Integration has started and many HIV services can be accessed at public health facilities, but the process is still on-going.

Work to empower communities has started at national level. New cadres of multipurpose CHWs have been defined and it is expected that CHWs will build the capacity of communities to respond to and own their health issues. Respondents recognised that programmes need to start with communities e.g. for Voluntary Medical Male Circumcision (VMMC) by involving men. A ‘Peer mothers’ programme has been created where HIV infected mothers mentor others in the community and empower them. Experience from community systems strengthening is not only used in the health sector but is also used beyond health in agriculture.

Many partners stressed the need for integration of HIV with PHC: “It is critical that PHC is adopted if we are to close the targets by using community level interventions to identify pockets of people missed. One pointed out that the majority of people with HIV are dying of co-morbidities (increasingly NCDs), meaning if those are not tackled, then deaths will continue and HIV interventions will not bring mortality down. “People living with HIV are now living longer and thus affected by other lifestyle diseases, hence it would be critical to ensure they get comprehensive services.” Others noted that clients preferred integration as it saved them time and money and that it was also better for the health system as scarce resources and staff could be deployed more efficiently.

One respondent pointed out that the Botswana HIV programme has always followed the PHC approach: HIV treatment and testing is available from public facilities at decentralised levels; HIV

⁵¹ HIV AIDS in Botswana 2022 Factsheets. MoH, NAHPA and UNAIDS; 2022

⁵² The Third Botswana National Strategic Framework for HIV & AIDS: Enhancing Efficiencies through an Integrated Approach 2019-2023. Government of Botswana; 2019

programmes pioneered home-based care and the involvement of people living with the disease; and the HIV response is co-ordinated by NAHPA outside the MoH to facilitate the multi-sectoral response. Others conceded that while the PHC approach had largely been applied for HIV programming, it had developed its specialised stand-alone model for laboratories, pharmacy, education and awareness raising, etc. Some mentioned that these supporting systems now needed to be re-integrated for better efficiency and to build on the experience of HIV delivery platforms.

Integration can take many forms however and is often differently understood by different actors. A WHO briefing document identifies 6 main forms of integration and the key issues to be addressed for each.⁵³ These forms varied from a package of preventive and curative health interventions for a particular population group; to multi-purpose service delivery points; to the vertical integration of different levels of service through referral systems; to working across sectors; among others. In each instance detailed questions need to be answered about who will deliver which services to whom and where and how these services will be supported by systems for staffing, labs, supply chain, data etc.

Integration also depends on perspective:

- For **users**, integration means health care that is seamless, smooth and easy to navigate. Users want a coordinated service which minimises both the number of stages in an appointment and the number of separate visits required to a health facility. They want health workers to be aware of their health as a whole and for health workers from different levels of a system to communicate well.
- For **providers**, integration means that separate technical services (and their management support systems) are provided, managed, financed and evaluated either together, or in a closely co-ordinated way.
- For **senior managers and policymakers**, integration happens when decisions on policies, financing, regulation or delivery are not inappropriately compartmentalized. This means bringing together different technical programmes, but also considering the whole network of public, private and voluntary health services, rather than looking at the public sector in isolation.

The briefing paper concludes that: “Integration can be broken down into a series of practical questions about who does what at what levels of a health system. Being clear about these questions can be the basis for constructive discussions about the development of integrated health services”.⁵⁴

In planning for the integration of HIV and PHC programmes it is important therefore to start with detailed discussions about what should be integrated and how. There can be no blueprint for integration since the epidemiology, health systems and political context vary in each country and so every country must work out for itself the form that integration should take and the process to achieve it.

⁵³ WHO Integrated Health Services – what and why? Technical Brief No.1, 2008

⁵⁴ WHO Integrated Health Services – what and why? Technical Brief No.1, 2008

3 Introduction to the UNAIDS Joint Programme strategic orientation and approaches

3.1 Joint team on AIDS plans in Botswana

Priorities in the UN Joint Team on AIDS workplans for 2020-21 and 2022-23 are aligned to country priorities in NSF III, HIV epidemiology and HIV prevention and treatment service gaps. The major focus is on HIV prevention focusing on adolescent girls and young women (AGYW) and youth through Comprehensive Sexuality Education (CSE) (known as ‘Life skills’) programmes in schools, Teen clubs out of schools and developing integrated Youth Friendly Services (YFS). The second major focus has been shifting from a national, standardised, approach to a focus on key, priority populations and locations, with district level targets for specific populations.

3.2 Overview of UNAIDS secretariat and Cosponsors’ main activities and funding as per Joint Plans in Botswana

Below is an overview of workplan priorities during the period 2020-2021 and 2022-2023 respectively. Annex 3 summarises the funding allocations, funding sources and activities of the Joint UN Team on AIDS’s plans for 2020-21 and 2022-23. Section 4.2 will go into more details on the analysis of the workplans and activities.

Priorities of the 2020-2021 Workplans for Joint UN Team on AIDS - Botswana

In 2020 and 2021 the UN Joint Team on AIDS received US\$ 300 000 each year from the Unified Budget Results and Accountability Framework (UBRAF).⁵⁵

Under the 2020-2021 UN Joint Team on AIDS Botswana workplan, two high priority areas were identified:

- 1) ‘Revitalise HIV Combination Prevention for AGYW and their male sexual partners’ with eight deliverables (Strategic Result Area (SRA) 3 in the 2016-21 UBRAF indicators);
- 2) ‘Shifting from a national approach to priority populations and locations with district level targets’ with two deliverables (SRA7).

There are no activities identified in the 2020-21 workplan under SRA 8: ‘People-centred HIV and health services are integrated in the context of stronger systems for health’. It is important to note that many activities in the UBRAF workplan are funded from ‘Cosponsor non-core funds’ and not the country envelopes. (see Annex 3 for details of workplan)

Priorities of the 2022-2023 Workplans for Joint UN Team on AIDS - Botswana

In 2022-23 the UBRAF budget for Botswana was US\$390 000 for each year. The 2022-23 workplan and activities continue the focus on HIV prevention, particularly for adolescents and young people and on gender equality and empowerment. In the Botswana UN Joint Team on AIDS workplan for 2022-2023 no funding is shown as allocated to the 3 key activities related to integration⁵⁶ and their status is reported as “Activity Status: Not started”. In the JPMS reports for 2022, Botswana confirmed no support or activities for:

⁵⁵ JPMS extracts for Botswana.

⁵⁶ 9.1. Support scaling up of integrated SRHR and HIV services: Provide technical assistance to support scaling up of integrated SRHR and HIV services (UNFPA & UNAIDS Secretariat);

9.2. SRHR and HIV services for older women of reproductive age: Exploring Populations not adequately covered or served such as older women of reproductive age & strengthening their access to SRH and HIV services; (UNFPA)

9.3. Support the alignment of national targets to 2025 targets: Support the alignment of national targets to the Global AIDS Strategy 2025 targets (UNFPA & UNAIDS Secretariat).

- UBRAF Output 3.2.2 Number of countries supported by the Joint Programme which have HIV services for children integrated into at least 50% of Primary Health Care sites
- UBRAF Output 9.1.1 Number of countries supported by the Joint Programme to have HIV antiretroviral services, for both treatment and prevention purposes, organized and financed as part of overall health systems, including through Primary Health Care
- UBRAF Output 9.1.2 Number of countries supported by the Joint Programme, that have included cervical cancer screening and treatment for women living with HIV in the national strategies, policies, plans or guidelines for HIV, cancer, cervical cancer, noncommunicable diseases or other health areas
- UBRAF Output 9.2.1 Number of countries supported by the Joint Programme to generate data and evidence or revise social protection policies or programmes to enhance comprehensiveness and adequacy for the inclusion of people living with, at risk of and affected by HIV.

3.3 Main partnerships engaged in implementing the Joint Plans

In Botswana the main partners for the Joint UN Team on AIDS are government ministries and agencies. These include the MOH on integrated services and differentiated service delivery models, NAHPA on HIV prevention, and the Ministry of Education and Social Development (MOESD) on CSE.

In terms of major programmatic activities which are directed to (but outside UBFRAP) the integration of HIV with PHC, the most significant partnership in the period has been the 2gether4SRHR programme funded by SIDA. This regional partnership brought together four UN agencies – UNAIDS, UNFPA, UNICEF and WHO to advance SRHR in Eastern and Southern Africa (ESA). The programme built on the results of the SIDA-funded Linkages Project implemented by UNFPA and UNAIDS under the Expanded Accelerated AIDS Response Programme (see Section 4.2 for more details).

4 Findings

4.1 EQ1: To what extent is there conceptual clarity and internal coherence within the Joint Programme and external coherence with other actors in relation to leveraging HIV and PHC integration and linkages?

SUMMARY OF FINDINGS – EQ 1

- Most of the Joint UN Team on AIDS agencies consulted expressed support for the concept of integration, however the understanding of “integration”, and the outcomes expected from it, varies between agencies. Others highlighted the potential risks to the significant achievements to date of the HIV response in Botswana from integration within a much weaker primary health care system.
- Overall, the Joint UN Team on AIDS agencies are all clear that their priority is to support government policies (which include an emphasis on integration). Other external partners such as USAID, CDC and the Global Fund also prioritize integration so there is broad consensus that the concept is important, but less coherence *on how* to support proper integration of HIV within the broader health system without losing the gains. Alignment on integration aspects was absent - this related to strategies, guidelines for implementation and programming for integration.

- Although there are limited planned activities targeting the UBRAF HIV-PHC integration result area, Joint UN Team on AIDS agencies in Botswana are conducting several activities *individually* which support integration and are promoting the PHC approach in the HIV response. Not having specific funded activities in the UBRAF workplan related to HIV integration aspects may have discouraged alignment of UN agency efforts.
- The evaluation found that there is a need to coordinate and align resources and efforts towards integration and expressed concerns of Joint UN Team on AIDS agencies working in siloes on the HIV integration agenda.

4.1.1 What does the Joint Programme aim to achieve through strengthening HIV and PHC alignment, integration, and interlinkages? To what extent is there conceptual clarity?

Most of the UN Joint Team on AIDS agencies consulted expressed support for the concept of integration, however the understanding of integration, and the outcomes expected from it, varies between agencies. Among the Cosponsors interviewed, most expressed support for the concept of integration of HIV and PHC. “Integration is important. We cannot afford to work in silos with the limited resources. Integration to me is planning together, budgeting together and implementing together and maximize resources in terms of personnel.”

Most of the respondents understood integration in terms of integrated service delivery or ‘one stop shops’. Respondents noted that integrated services should save clients time and money and that it was an efficient way of utilising resources and staff. There was almost no mention of integrating other health system building blocks which support service delivery. Respondents differed in terms of whether they saw integration as adding services to the HIV package or a much broader approach in which HIV would be brought into wider primary care services. Different co-sponsors focused on aspects of integrated services most relevant to their mandate. It seems there is little conceptual clarity or consensus about what is to be achieved. Although the Joint UN Team on AIDS has very limited planned activities targeting the UBRAF HIV-PHC integration result area, UNAIDS and its Cosponsors in Botswana are conducting some activities individually which support integration and taking the PHC approach in HIV programming, particularly prevention. Thus, the work which UNICEF and UNESCO support on introducing CSE to schools is based on empowering children, teachers and parents to discuss and access information and make informed choices using a PHC approach, combining multi-sectoral action and community engagement, to engage the different communities. UNAIDS work on the First Lady initiative is using advocacy to engage young people and religious leaders with messages about HIV and SRH. UNFPA has provided significant support to operationalising and scaling up the integration of SRHR and HIV and UN Women has supported gender equality and human rights. All of these interventions use the PHC approaches of multisectoral action to engage and empower communities. Apart from UNFPA’s work on the integration of HIV and SRHR services however, these activities are not aimed at the pillar of PHC related to integrating services.

Some questioned whether integration of HIV with primary care services was right for all client groups however. Some respondents pointed out that now that the cohort of people living with HIV is aging, it has become essential to address the multiple health problems which may affect each client rather than simply focus on one disease, so integration made sense. Others suggested that integration might work for adolescents via integrated YFS but may not be appropriate for other sub-populations such as sex workers or MSM who may want to receive HIV services separate from the general public health services. Additionally, some questioned whether integration would reach the remaining 5% of people that Botswana needs to reach in its testing and treatment cascade and if not, whether HIV integration was an appropriate strategy to pursue.

Others highlighted the potential risks to the achievements to date of the HIV response from integration with a much weaker PHC system and the lack of a shared vision. They suggested that gradual ‘alignment’ would be better than integration. “The lack of rigour and scientific evidence on other diseases has led to failures in their response and integration. We just need to get those right for us to align with HIV and not necessarily integrate with HIV”; “The vision for PHC is not shared and resources available are not clear. HIV programmes are risk averse, afraid of losing gains. There is a high-level vision for integration but fiefdoms at the mid-levels.”

4.1.2 To what extent are relevant HIV/PHC goals, plans, strategies, and activities harmonised and aligned internally within the Joint Programme at country levels?

Evidence suggests that Joint Programme agencies are largely operating in a siloed manner on HIV integration aspects and with alignment challenges, with the exception being PMTCT efforts. The Joint Programme country summary report for 2022⁵⁷ notes: “The Joint team plans jointly but Cosponsors implement silos.” As expressed by key informants: “At the end of the day we are assessed on agency focus but it should be such that joint components and activities are assessed. If we plan together, we then will work together to address gaps. Of course, there are agency specific gaps but where necessary let's mobilise resources to act and respond together.” and “Different strategies and approaches to integration among different agencies and implementing partners is also a challenge. “We need to standardise what integration is and how it should be done to avoid all agencies doing it in their own ways.”

Most respondents stressed that they tried to ensure the UN was consistent in its communications and ‘spoke with one voice’ but most also noted that they felt they did not know all that the other co-sponsors were doing and that they only had a partial picture. “We plan together for the country envelope, but we implement separately.” “We are still not achieving delivering as one – we aspire but it is not easy.”

One said that the support to Botswana’s Preventing Mother to Child Transmission (PMTCT) programme was a good example of collaboration: “PMTCT is a classic example of UN agencies working together facilitated by Joint Programme technical assistance. For example, when we needed data quality UNAIDS would come in, while on issues of infant feeding UNICEF would come in and WHO support the aspect of treatment.”

The Joint Programme does not always present a clear strategy or division of labour externally. There were instances where external partners felt the Cosponsors were more competitive than complementary, such as two agencies seeming to want to do the same thing. Another challenge raised was nomenclature: different agencies used different terms for the same concept or had similar initiatives with different names. It was suggested that the Government of Botswana should standardise terms for all agencies. One external respondent felt that WHO was interested in integration, but the other UN agencies were not and questioned whether they supported the concept.

Not having specific funded activities in the UBRAF workplan related to HIV integration aspects and global UBRAF outcomes have discouraged alignment of agency efforts. The Joint UN Team on AIDS workplans in Botswana for the period 2020-2023 only to a limited extent include specific activities related to integration of HIV and reporting only cover the activities funded from the UNAIDS Country Envelope and do not capture the wider activities, relevant to Joint programme priorities, which are undertaken separately by co-sponsors with other funding sources. The Botswana Joint Programme agencies are required to report progress to the Joint Programme Monitoring System (JPMS) against the UBRAF indicators for integration. The Joint Programme agencies in Botswana produce a Joint Programme workplan, which covers activities funded by the UBRAF, but it does not cover all other relevant Cosponsor activities funded from other sources. “As the Joint Programme, what is discussed is what will be jointly implemented. We are tracking only activities that have been jointly agreed on.”

⁵⁷ 2022 JPMS Country Summary Report, Botswana

4.1.3 How does the UN Joint Team on AIDS's work on HIV and PHC integration and linkages complement and harmonise with the efforts of national governments and external actors?

The UN agencies consulted stated that once the government has adopted a certain vision, it is necessary for the Joint Programme to ensure that it is implemented and rally behind that. “As UN bodies we need to come together and harmonise how we support government. Government trusts UN bodies and as a Joint Programme we need to leverage on that and harmonise our efforts.” Most respondents (government at all levels and external partners) were able to cite several examples of UN support in areas relevant to their work (although not always concerning integration).

Integration has started and many HIV services can be accessed at public health facilities, but the process is still on-going and PLHIV differed in their experiences. There are still many facilities, especially in remote areas, where integration has not happened yet. Some representatives from PLHIV support groups still need to go to different institutions for each service they need, one noting that even a referral hospital could not provide comprehensive services, while others were able to receive all their services at the same facility.

There were many examples given by UN agencies and external partners of *individually* supporting the Government's integration agenda, but not coordinated by the UN Joint Team on AIDS as such, nor under the UBRAF. Many documents have been developed for Botswana to accelerate and operationalise the HIV integration and PHC, such as implementation guidelines and key surveys were supported by WHO, UNAIDS and UNFPA and that support is acknowledged in the documents. Support for Botswana's Fifth AIDS Indicator Survey (BAIS V) was a key achievement as it brought in partners, including multiple UN agencies, with some partners providing funding and others Technical Assistance (TA). The NSF III stresses integration of HIV services, and UNAIDS, UNDP, UNFPA, WHO, UNICEF (and CDC, PEPFAR and USAID) are thanked for their support to the development of NSF III in the document.⁵⁸

UNFPA and WHO provided normative guidance to support the integrated community-based health services guidelines⁵⁹ development, with USAID and PEPFAR support. The guidelines were developed to build a strong CHW workforce that is a vital component of the primary health care strategy for delivering people-centred care. Botswana is now rolling out the guidelines, with training of CHW to integrate communicable and non-communicable diseases, child and maternal services, sexual and reproductive health and rights, rehabilitative and palliative care, and health promotion and prevention services.

Several respondents pointed out that a general alignment on the integration aspects was absent - this related to strategies, guidelines for implementation and programming for integration. This was not just concerning the UN Joint Programme agencies: “Plans are not well aligned inside and outside the Joint Team”. One stated: “There is a lot of fragmentation in the country”, and described how many strategies were developed, but implementation has been a challenge. “NDP 11 should be basis for all sectors to draw from, but it is not happening. In terms of strategies, guidelines, systems are building up but only players are disintegrated.

The lack of a clear shared vision on integrating HIV at the technical level was mentioned by many. While the overall government vision for integration is clear, respondents mentioned a lack of understanding of what exactly integration is and the form it should take in their technical area. “... it seems like we have not really given integration the thought it deserves. It looks like a lot of work will go to CBOs, for decongestion [of facilities] but I don't think we thought of how we are going to make it work. There is a lot of confusion for us...”

⁵⁸ The Third Botswana National Strategic Framework for HIV & AIDS 2019-2023, Government of Botswana, 2019

⁵⁹ National guideline for implementation of integrated community-based health services in Botswana. Ministry of Health and Wellness. Government of Botswana; 2020

The evaluation found that there is a need to coordinate and align resources and efforts towards integration. “Service integration efforts within the health sector to date have been described by stakeholders as rather “piecemeal”, resembling vertical delivery of super programmes, with combinations such as HIV/TB; SRHR/HIV, SRHR/HIV/SGBV, HIV/TB/Malaria, HIV/SRHR/NCDs etc.⁶⁰ and as expressed by a key informant.: “we do not have solid guidelines for integration of HIV within PHC, hence there tend to be opportunities where HIV management could have been done better. Another noticeable thing is that PHC guidelines mention certain conditions while HIV guidelines would mention others – they need to be harmonised.”

4.2 EQ2: To what extent is the Joint Programme applying the PHC approach⁶¹ to HIV responses and what are the achievements and lessons learned?

SUMMARY OF FINDINGS - EQ 2

- Although individually some Joint UN Team on AIDS agencies are supporting integration of HIV into the broader health system, primary care, or with other services, the Joint UN Team on AIDS in Botswana has no clear joint strategy or joint plan related to this area.
- The Joint UN Team on AIDS through its joint UBRAF workplan is applying the PHC approaches of multisectoral action and policy and community empowerment and engagement to its work on HIV with several recent examples and results noted.
- The Joint UN Team on AIDS in Botswana has been part of, and benefited from, several regional Joint Programme initiatives to strengthen financing for HIV and many respondents saw integration of HIV with primary care as a sustainable solution for the HIV response. The Joint UN Team on AIDS agencies are supporting various key pieces of work which will inform discussions on the future financing of HIV and PHC programmes.
- Enablers for integration in Botswana were identified as: High level policy environment with a clear PHC and integration vision; delivery of regional programmes and commitments on integration; service delivery packages/ minimum packages targeted to different population; and leadership.
- Several key barriers to integration of HIV within the broader health system in Botswana were identified and included: lack of clarity about *how* integration should be implemented; unclear roles and responsibilities of major actors; insufficient coordination; fear of losing titles and positions; risk of reduced quality of care and losing achievements of the HIV response; human resources for health shortages; earmarked funding and the supporting health system not being integrated nor designed to support integration.
- The evaluation noted general consensus among key informants that integration needs to be implemented in a phased approach, carefully designed and considering benefits and risk, potential entry points and services to be integrated, while adding enough resources to ensure quality of care. Furthermore, integration efforts need to be closely monitored and evaluated to inform potential scale-up.
- Many respondents assessed the need for technical discussion of the details of how different interventions and systems should or should not be integrated and this would seem a potential role for the Joint UN Team on AIDS to play.

⁶⁰ National Guidelines on Health Services Integration: Reproductive, Maternal, Newborn, Child, and Adolescent, Health, +Nutrition, Non-Communicable Diseases & Other Services. Ministry of Health Republic of Botswana, UNFPA; December 2021

⁶¹ PHC approach defined as: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities

4.2.1 What has been achieved since 2020 in terms of applying a PHC approach⁶² to HIV response?

Achievements related to the first pillar of the PHC- approach: “Primary care and essential public health functions as the core of integrated health services”.

Although individually some Joint UN Team on AIDS agencies are supporting integration of HIV into the broader health system, primary care, or with other services, the Joint UN Team on AIDS in Botswana has no clear joint strategy or joint plan related to this area.

From 2020 to date the UN Joint Team on AIDS in Botswana focus has been on addressing HIV prevention through a variety of approaches including programmes for adolescents, school programmes and an initiative targeting youth led by Botswana’s First Lady. These approaches have been based on the PHC approaches of multisectoral action and community engagement and have targeted a range of health outcomes beyond HIV. Regarding the first pillar of the PHC approach, “integration with a focus on primary care/essential public health functions”, the Joint UN Team on AIDS had very limited activities or spending related to integration aspects, and no funding against the specific integration result areas in the UBRAF (see Annex 3).

This does not mean however that individual UNAIDS Cosponsor agencies have not been active in this area of HIV – PHC primary care interlinkages. These activities were just not generally funded by the UBRAF and are not recorded on its planning and monitoring systems.

Most respondents and the document review provide several examples of work which the UNAIDS Cosponsors have supported, either singly in the areas of their mandate or jointly in regional programmes such as 2gether4SRHR – all activities however outside the UBRAF. Partners acknowledged that UN agencies provided technical assistance to government and partners on integration especially around development of guidelines and capacity building.

WHO was recognised for a lot of work under PHC revitalisation, integration and NCDs. Respondents noted that WHO has helped in planning, training and capacity development, and financing. WHO has also been active on pillars of health system strengthening and sustainability. They are currently supporting the review of the National Health Policy using the health sector findings. The thrust of the document’s recommendations is to be a PHC approach through an essential health package based on the needs of different age cohorts. WHO is supporting the revision of the Essential Health Service Package in an integrated manner focusing on Districts as the core of PHC. Currently WHO is planning to collaborate with partners for the implementation of the policy directions in the new National Health Policy.

UNAIDS jointly with WHO supported the Ministry of Health in the revision of integrated TB HIV guidelines. The guidelines cover expansion of HIV testing services, PrEP services to pregnant and breastfeeding women and MSM , TG and FSW, Sexual Reproductive Health commodities, GBV referral, ART treatment optimization, adequate forecasting and supply chain, improved laboratory mechanisms.⁶³

UNFPA has supported the MoH to develop national guidelines on integration of RMNCAH+N, NCDs + & other Services⁶⁴. The Guidelines provide broad guidance on the actions and processes at service delivery levels required to respond holistically to all health needs of clients, including defining SRH, HIV and SGBV service packages for different levels of the integrated care model. The work UNFPA has done in supporting the development of integrated service delivery guidelines is an important first

⁶² PHC approach defined as: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities.

⁶³ Joint Programme 2022 Reporting: Country summary report, Botswana

⁶⁴ National Guidelines on Health Services Integration: Reproductive, Maternal, Newborn, Child, and Adolescent, Health, +Nutrition, Non-Communicable Diseases & Other Services. Ministry of Health Republic of Botswana, UNFPA; December 2021

step and sets out how services should be delivered at different levels and the process to be followed in introducing the changes at the different facility levels, but the guidelines do not cover the supporting health systems. UNFPA has been instrumental in bringing together partners and CSOs for discussions around integration and has been involved in the development of guidelines and documents. UNFPA is seen as a co-sponsor that has led the drive for integration particularly in adolescent sexual and reproductive health (ASRH), setting youth friendly services up and running in an integrated manner. “UNFPA has been very instrumental in all engagement- providing funding and TA.”

Within the evaluation temporal scope period (2020-2023), UNFPA also supported the Ministry of Health (MoH) to assess the extent of SRH/HIV and SGBV in 13 districts using the minimum integration service package and update SRHR/HIV and SGBV data. The mixed methods research specifically examined i) the extent of integration of the minimum service package, ii) the enabling factors for integration of services, iii) nation-wide scale-up approaches, and, iv) recommendations to address identified challenges and gaps. The level of integration was estimated at 46 percent for both 2020 and 2021. Across the 13 districts, hospitals generally showed higher levels of integration followed by the lower-tier facilities (health posts).

To amplify lessons learned from the scale-up of SRH, HIV, and GBV integrated service delivery in Botswana, various knowledge management products were developed and disseminated to a broad-based range of stakeholders and these include; a case study on how Botswana transitioned from pilot to 13 districts and the accomplishments related to the integration of SRHR, HIV, SGBV, and other services in those districts. The case study further provides practical examples of integration in action including lessons learned and the benefits for clients that can be amplified nationally and at the regional level.

To address quality gaps in SRH including post abortion care, family planning, HIV and GBV service integration, UNFPA collaborated with WHO to develop three Policy briefs that explore gaps and opportunities for improving the uptake of contraceptives, reducing unintended pregnancies and the need for a multifaceted approach to prevent unsafe abortion as a means to reducing maternal mortality in Botswana.

2gether4SRHR was a joint United Nations (UN) regional programme that combined the efforts of UNAIDS, UNFPA, UNICEF and WHO to improve the sexual and reproductive health and rights (SRHR) of all people in Eastern and Southern Africa (ESA), particularly adolescent girls, young people, and key populations (KP). The Programme was funded by SIDA and aimed to fast-track the attainment of the 2030 targets of Sustainable Development Goal (SDG) 3, improve the health and well-being for all at all ages, and SDG 5, achieve gender equality and empower all women and girls.⁶⁵ In Botswana it supported a pilot project, the ‘SRHR/ HIV Linkages’ project, to demonstrate and learn lessons from integrating health services which has provided the evidence on which the current plans for scaling up integration are based. UNFPA supported service delivery under the Linkages project while UNAIDS supported the M&E components.

Some of the lessons learnt from the ‘SRHR/ HIV Linkages’ project emerged from the 2016 Customer Satisfaction Survey, in which both providers and clients welcomed integration and appreciated its advantages and convenience. Building on these lessons, UNFPA has supported the development of the National guidelines on health services integration on reproductive, maternal, newborn, child and adolescent, health and nutrition, non-communicable disease and other services, promoting the health at all stages of life of an individual.⁶⁶ Additionally, **UNFPA and UNAIDS** documented and shared a best practice report from one facility in the pilot of the SRHR and HIV linkages project in

⁶⁵ 2gether4SRHR Mid-Term Review Report. Geneva: Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, United Nations Children’s Fund, World Health Organization; 2018 (https://esaro.unfpa.org/sites/default/files/pub-pdf/2gether_4_srhr_mid-term_review_report_2020_final_1.pdf, accessed 24 April 2023).

⁶⁶ National guidelines on health services integration: Making health systems work. 2021, WHO/ UNFPA

select facilities in Botswana.⁶⁷ Botswana is now using three models of HIV-SRH integration (Kiosk, Supermarket and Mall) for different levels of facility (health posts, clinics and hospitals) to scale up the provision of integrated services from 54 to 123 sites in 12 districts.⁶⁸

Achievements of the second and third pillars of the PHC- approach: “Multisectoral action and policy and empowered people and communities”

UNAIDS has been instrumental in other areas of applying the PHC approach, such as multisectoral actions, empowerment of people and communities and creating an enabling environment. UNAIDS and the Global Fund supported the MOH and NAHPA to develop a five-year national comprehensive plan to remove human rights and gender related barriers to HIV and TB services in Botswana. This contributes to multisectoral policy and action towards addressing inequalities and delivering socially acceptable services free of stigma and achieve equity for health services for marginalized and highly affected communities.⁶⁹ UNAIDS has also supported strengthening the response of CSOs to HIV and is supporting using VMMC as an entry point to provide men with other services, revising VMMC strategy to make it broader.

Advocacy is another key area of activity for UNAIDS. “Advocacy is conducted through the First Lady as Ambassador under UNAIDS. A strategy was developed to facilitate her to empower youth and influence youth. This brought together partners to support this initiative where the First Lady has even had dialogue with community leaders on cultural norms hindering access to services among adolescents and young people (AYP) and also influencing the set-up of a unit on GBV at the Police.”

Other examples supporting the PHC approach of multisectoral action and community empowerment, include the support **UNICEF** has provided for youth programmes, nutrition programmes, HIV programmes and the USAID-funded Dreams project to reduce HIV/AIDS among AGYW. The education sector’s Life Skills Framework was sponsored by UNICEF through financing and providing a consultant. Youth Empowerment is done with UNICEF and UNFPA support.

UNESCO has also been significantly involved in the Life Skills programme. UNESCO provided funding and consultant for a UNESCO tool to assess how Comprehensive Sexuality Education (CSE) has been integrated. **UNESCO, UNICEF and UNAIDS** are supporting the Education Plus initiative, launched by the First Lady. This is being used to strengthen young people’s responses to HIV, especially AGYW.

4.2.2 What is the Joint Programme doing to build political commitment for sustainable HIV financing in the context of PHC?

The Joint UN Team on AIDS agencies are supporting various key pieces of work which will inform discussions on the future financing of HIV and PHC programmes. Included in the Joint UN Team on AIDS workplan under Result output 8 (‘Fully funded HIV response) is the fact that UNAIDS is leading a team of consultants working on the development of a Transition Readiness Assessment and Sustainability Road Map. WHO is supporting Botswana’s new Health Financing Strategy which is at an advanced stage and will soon be circulated for validation. Support is being given for the development of tariffs for health services so that people with health insurance can pay and claim back from their insurance when they use public services.

To support sustainability, efficiency and effectiveness in the HIV response, the World Bank has worked with partners to conduct allocative and implementation efficiency studies and support key

⁶⁷ Best practice report for SRHR and HIV linkages project in Botswana: Mochudi Clinic 1, Kgatleng district Botswana, July 2016

⁶⁸ 2gether4SRHR Mid-Term Review Report. Geneva: Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, United Nations Children’s Fund, World Health Organization; 2018 (https://esaro.unfpa.org/sites/default/files/pub-pdf/2gether_4_srhr_mid-term_review_report_2020_final_1.pdf, accessed 24 April 2023).

⁶⁹ National strategic plan to reduce human rights related barriers to HIV and TB services 2020- 2025, Botswana,

databases, knowledge-sharing and capacity building in 20 countries including Botswana.⁷⁰ The World Bank is currently conducting a public expenditure review for the government. Based on its findings they will determine what to support in the future.

The regional Joint Programme has been part of several regional initiatives to strengthen financing for HIV. Regionally, the Joint Team has provided technical assistance at country and regional levels to strengthen health financing and the integration of HIV services in the region. The Southern African Development Community (SADC) was supported to complete the SADC Road Map for Sustained Health, HIV and AIDS Response to fast-track progress towards HIV targets, in line with Universal Health Coverage and the SDGs. In 2020-2021, the regional Joint Team contributed to the development of a position paper on the status of laws and international agreements in SADC member states to intensify advocacy for increased domestic funding to address SRHR and gender inequalities. The Joint Programme also mobilized US\$ 6 million to guarantee continuity of SRHR services during the COVID-19 pandemic.⁷¹ Botswana was one of the beneficiaries of these regional Joint Programme initiatives.

2gether4SRHR supported a desk review on sustainable funding in SADC which supported finalisation of regional sustainable financing frameworks that will guide countries on resource mobilisation. The draft report included lessons learned from costing, budgeting and financing adolescent and youth SRH services. In addition, technical assistance was provided to countries in developing adolescent SRHR strategies and plans, costing and developing investment cases, and reviewing the quality and use of the costing studies.⁷²

Regional and country-level advocacy by 2gether4SRHR has heightened attention on the need for increased regional, domestic and international resources for SRHR. Technical support to six countries resulted in National Strategic Plans that include financing for integrated HIV, SRHR, and SGBV services. Technical support to five countries for Global Fund funding requests resulted in grant implementation with participation from CSOs and partners working on integrated service delivery. The 2gether4SRHR Programme supported the EAC to develop a resource mobilization strategy for Universal Health Coverage that advocates for increased domestic and international investments for SRHR, HIV and SGBV services. In addition, 2gether4SRHR supported SADC to validate the sustainable financing monitoring⁷³.

Many respondents saw integration of HIV within primary care as a solution for the future sustainability of HIV programmes. It was stated that service delivery within primary care is cost-effective, and the country has enough resources but there are inefficiencies. The government is trying to reorient health financing to reduce costs and increase efficiency and sustainability. Integration was noted by many to increase efficiency by reducing duplication. Others expressed that stand-alone HIV programmes are not sustainable and do not work for the patients themselves as they do not address other health issues and are not patient centred. Investment in the HIV response must trickle to other areas and improve the health service in its entirety.

⁷⁰ Organizational Report 2020-2021 Performance Monitoring Report. Geneva: Joint United Nations Programme on HIV/AIDS; 2022. (https://www.unaids.org/en/resources/documents/2022/PCB50_UBRAF_PMR_Organizational_Report, accessed 24 April 2023).

⁷¹ Regional and Country Report: UNAIDS 2020-2021 performance monitoring report. Geneva: Joint United Nations Programme on HIV/AIDS; 2022

⁷² 2gether4SRHR Mid-Term Review Report. Geneva: Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, United Nations Children's Fund, World Health Organization; 2018 (https://esaro.unfpa.org/sites/default/files/pub-pdf/2gether_4_srhr_mid-term_review_report_2020_final_1.pdf, accessed 24 April 2023).

⁷³ 2gether4SRHR Mid-Term Review Report. Geneva: Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, United Nations Children's Fund, World Health Organization; 2018 (https://esaro.unfpa.org/sites/default/files/pub-pdf/2gether_4_srhr_mid-term_review_report_2020_final_1.pdf, accessed 24 April 2023).

4.2.3 What are the main enablers and barriers to strengthen HIV and PHC integration and linkages? How is the Joint Programme addressing these at country level?

Identified enablers to strengthen HIV and PHC integration and linkages

Enablers for integration in Botswana were identified as: High level policy environment with a clear PHC and integration vision; delivery of regional programmes and commitments on integration; service delivery packages/ minimum packages targeted to different population; and leadership.

The high-level policy framework in Botswana is considered the most important enabler for the HIV/PHC integration agenda. Several strategic documents and guidelines facilitate integration, despite their shortcomings as described later in this section.

Lessons from a regional joint programme funded by SIDA - 2gether4SRHR – have been instrumental in driving the integration agenda forward in Botswana. Respondents noted that delivery of regional programmes and commitments such as the ESA Ministerial commitment and the regional 2gether4SRHR programme brought them together. Experience from the implementation of the Linkages project in pilot districts showed that leadership involvement and stakeholder engagement are critical, as are peer-to-peer approaches to capacity building, the use of support groups and an emphasis on early detection, early diagnosis and early treatment.

Respondents further stressed the importance of leadership at various levels: there should be good linkages between Ministry and District leadership and also with leaders from other sectors. The process of integration should be delivered and led by the DHMT, while the District Commissioner coordinates all HIV issues.

Most of the co-sponsors have a small presence in Botswana and staff working on HIV and PHC/health are a small group and many noted that personal relationships facilitate working relationships: “We work with each other well and ensure we update each other.”

Another enabler of integration of HIV and PHC includes the development of service delivery packages/ minimum packages targeted to different populations, “that will ensure that there are no missed opportunities to identify disease at an early stage and treat it and prevent progression to end stage or complications that will need tertiary care, without the client asking.”⁷⁴ This was demonstrated by the integration of SRHR and HIV pilot and documented as a best practice. The EHSP is currently being revised to reflect the new priorities including integration.

Identified barriers to strengthen HIV and PHC integration and linkages

Several barriers to integration of HIV within the broader health system in Botswana were identified and included: lack of clarity about *how* integration should be implemented; unclear roles and responsibilities of major actors; insufficient coordination; fear of losing titles and positions; risk of reduced quality of care and losing achievements of the HIV response; human resources for health shortages; earmarked funding and the supporting health system not being integrated nor designed to support integration.

Key informants expressed that as much as strategies and guidelines are in place for integration, implementation is still challenging, and lacks granularity in planning. “We have many documents, but implementation is a challenge.” The lack of clarity on technical implementation is exacerbated by the partial implementation of existing policies and lack of operational frameworks to guide implementation. A respondent noted that “Models and guidelines are in place but are not accompanied by any risk assessment and how to mitigate those risks during implementation, making intervention a bit difficult.”

⁷⁴ Ministry of Health, The Essential Health Service Package for Botswana, 2010

It was also noted that integration will need to be planned with care, with consideration given to what is integrated and what is not. “Implementation is not well thought through”. “Integration needs to be planned as a phased approach where some services take a slow process of integration and others remain with dedicated staff and resources”.

Insufficient co-ordination and lack of clarity about the roles different bodies should play, in particular NAHPA and MoH, is another frequently mentioned barrier. Respondents noted the fragmented structures and multiple separate divisions of the MoH which is undergoing a very lengthy process of restructuring. Confusion between the roles of NAHPA and MoH was highlighted, as was the disconnect between the high policy level with its strong focus on integration and the technical teams who must make it happen. “Policy and programming at central MoH is still not that integrated with each programme planning and implementing on its own at that level, but at district level there is integration. We need to bring structures together at the top.”

The movement of NCDs to NAHPA meant some health interventions are under NAHPA while others are with MoH, thus creating a great need for coordinated planning. “MoH is seen as the implementer while NAHPA will have the funding. Money is channelled through NAHPA and MoH request funding from NAHPA. There is a lack of alignment with programmes and planning between NAHPA and MoH.”

It was clear there was much confusion about the NAHPA role. Distribution of staff between MoH and NAHPA was reported to need re-alignment. “You will find that people who are required at MoH are sitting at NAHPA. The national condom estimator is at NAHPA but the MoH buys the condoms.” In some cases, there was mention of duplication, with focal persons for the same thing at both NAHPA and MoH, leading to confusion about who is responsible to whom. The KP managers in MoH and NAHPA were cited as an example.

Examples of insufficient coordination between disease –specific areas were also mentioned: “I think for policies there is a lot of alignment, but the challenge is programming. For example, TB and HIV are linked but coordination is so disintegrated. There is fragmentation within the MOH. Even for training you find that each programme has its own training plans and programmes. Within the Global Fund grant some TB and HIV activities are integrated and some are separate. Even you find that when TB is planning for training then HIV is at same time planning to go on a site visit. There is a lot of duplication. We need those synergies to align well and plan together.”

The evaluation further identified that integration may create fear of losing positions or roles. There is a perception that some staff are being territorial and resisting change with technical teams operating to protect their own space and expertise. While service providers are integrated, technical staff are specialised. “There is resistance because people see themselves being at risk of their jobs being taken away by new developments.” “MOH integration models are available with easy steps to follow, but implementers are so territorial. This happens with CSOs and even across government programmes.” Some highlighted that this is also an issue for UN agency staff. “Integration means someone’s job is on the line because UNICEF, UNFPA, UNAIDS etc. would want to remain relevant.”

Fear of reduced quality of care and losing the impressive achievements of the HIV response was another concern raised. Some respondents had concerns about reversing the achievements of the HIV response and dilution of impact as a result of integration and reduced funding for HIV. Another mentioned potential compromises to the quality of care, if services are provided by staff who deliver a range of health care rather than by staff who are specialised and highly trained in HIV interventions. They suggested that regular evaluation of integration models could help mitigate potential risks. A related risk that was mentioned is task shifting, with technical or clinical responsibilities given to a health worker who is less well trained or experienced. Another noted that it will take time for other programmes and health services to use lessons from the HIV response to enhance these programmes and services.

Others were concerned about focus. “For example, those doing VMMC indicate that since integration started, the numbers have gone down as staff lose focus due to having to deal with many service types. They compete for attention, and some may have to suffer.”

It was suggested that HIV programmes are less easy to integrate into other programmes and services because of the parallel structures that have been established. Some respondents suggested however that they were working on changing this because “Now HIV is no longer an emergency we have to balance resources.”

The evaluation further revealed that the supporting health system is not integrated nor designed to support integration. Some respondents commented on the need for health systems to be designed and strengthened to support integration of service delivery. This includes adapting supportive supervision tools to support the provision of different services and addressing stock outs and other supply chain problems that hinder delivery of integrated services. “The lack of HIV test kits and family planning commodities is a problem and is mainly due to Central Medical Stores (CMS) supply chain management. An assessment of the CMS supply chain identified a lot of gaps including lack of prioritization and delays in procurement.” Others noted that while HIV drugs are always in stock, the same quantification, forecasting and procurement processes are not used for other commodities. For instance, condom supplies are a problem, even though they are important for HIV and STI prevention and family planning.

While HIV has good systems for M&E, M&E is less strong for other services delivered by primary care. Others noted that the national planning process is not integrated with DHMT planning and hence, “budgets sent to DHMTs are not well informed and do not meet lower-level needs.” Again, there were concerns that merging systems could reduce HIV performance: “Even with HIV we still have multiple systems but bringing other diseases might worsen the situation. “

Earmarked funding and multiple funding partners are other obstacles. Many respondents said that earmarked funding for specific diseases or programmes is a barrier to integration. “We are donor driven and have targets to meet so we might find it impossible to screen for other things that are not covered under our funding scope.” “We as CSOs do not have joint planning as we fight for clients, and this is caused by funders ... and we have to meet their targets. Donors plan for you and you find that there are conflicts because there is duplication. NAHPA asks for proposals at short notice and gives targets. There is no joint planning.” One respondent concluded: “I am more excited to see the approach that seems to force partners towards integration”.

The issue of earmarked funding constrains the Joint Programme also. UN agencies may be funded to support HIV but when the country focus is integration it may not be easy for them to support this. An example was given that the UN agencies have little funding for TB and hence have little incentive or scope to support TB, despite it being one of the most common opportunistic infections and causes of death among PLHIV in Botswana.

Human Resources for Health (HRH) shortages, workload issues and funding shortages are key barriers to integration of services. Some respondents mentioned a shortage of staff for training on the integrated curriculum and said that some of service providers felt that providing integrated services is time consuming and can be overwhelming. “We need to reflect on what can be integrated and what cannot so that we don’t impact quality. Too much integration in a facility may for example lead to burn out as documented by the lessons learned from the SIDA funded integration programme⁷⁵. Integration often comes without adding additional resources, with an example from TB shared: “TB and HIV were partly integrated, now TB is being absorbed into PHC but is not properly resourced and there is a resurgence again.”

The evaluation noted general consensus among key informants that integration needs to be implemented in a phased approach, carefully designed with granularity and carefully considering benefits and risks, potential entry points and services to be integrated, while adding enough resources to ensure quality of care. Furthermore, integration efforts need to be closely monitored and evaluated to inform potential scale-up.

⁷⁵ Botswana knowledge sharing and learning symposium on the scale-up of integrated SRH, HIV & SGBV and other services: summary report. Ministry of Health, Republic of Botswana, UNFPA, Government of Sweden, 2gether4SRHR; 24 May 2022.

Many respondents assessed the need for technical discussion of the details of how different interventions and systems *should or should not be integrated* and this would seem a potential role for the Joint UN Team on AIDS to play.

While barriers such as staff shortages and earmarked funding may be hard for the UN Joint Team on AIDS to address, barriers such as the lack of technical clarity and co-ordination for integration and the need for the redesign and strengthening of health systems to support integrated services are clear opportunities for the UN Joint Team on AIDS in Botswana to support. This could build on and extend the work that WHO has been supporting on laboratory systems and supply chain strengthening and UNAIDS support to M&E systems.

4.3 EQ3: To what extent is the Joint Programme using investments, infrastructure, innovations, and lessons learned from the HIV response, including adaptations during the COVID-19 pandemic, to improve broader health outcomes?

SUMMARY OF FINDINGS – EQ 3

- The expectation of Botswana’s policy emphasis on integration is clearly that its strong HIV programme should provide a platform for strengthening other PHC services including NCD services by building on HIV investments, experience, skills and systems.
- Several examples were given of where HIV investments, learnings, and infrastructure have been expanded to include and support or have informed broader health priorities, programmes and services in Botswana - although these activities were not supported nor coordinated by the Joint UN Team on AIDS as such.
- The Botswana COVID-19 response was perceived by many to have been built on the experience and systems developed by the HIV response. The response to COVID-19 stimulated innovations, many of which are still in use and some of which are being adopted more widely and beyond HIV. The Joint UN Team on AIDS played a catalytic role and helped to amplify the response to the pandemic through actions at the country and regional levels.
- Untapped opportunities included: a wider adoption of multisectoral approaches for other diseases; close collaboration with development partners for PHC to co-ordinate inputs and maximise synergies; using investments in strong HIV supply chain management for other drugs/commodities; and the extensive use of lay providers and community workers in general health promotion.

4.3.1 To what extent is the Joint Programme leveraging HIV investments, knowledge, infrastructure, approaches, and innovative models developed by the HIV response to strengthen broader health outcomes? Are there any untapped opportunities?

The expectation of Botswana’s policy emphasis on integration is clearly that its strong HIV programme should provide a platform for strengthening other PHC services including NCD services by building on its experience, skills, and systems. As the NSF III reads: “In order for the nation to benefit from the model NAHPA has successfully employed over the years in co-ordinating the response to HIV and AIDS, Cabinet approved the expansion of NAHPA’s mandate in 2018 to include Non-Communicable Diseases (NCDs).”⁷⁶

Respondents agreed with this emphasis, pointing out that while the country has had great success in its response to HIV, its other health indicators are not consistent with its status as an upper middle-

⁷⁶ The Third Botswana National Strategic Framework on HIV & AIDS: Enhancing Efficiencies through an Integrated Approach 2019-2023. Government of Botswana; 2019

income country. Since the development of the HIV programme over past decades was seen by some to have been at the expense of the previous well-established and successful PHC programme in Botswana, it was thought to be right that the system should be rebalanced and the systems and experience which HIV had built up with dedicated resources over past decades should now be used to provide broader benefits. “Since the programme which is doing well is HIV, why not utilize that platform to enhance and focus on PHC?” “HIV is well-funded and has infrastructure, we could leverage on this to integrate SRH.”

Several examples were given of where HIV investments, learnings, and infrastructure have been expanded to include and support or have informed broader health priorities, programmes, and services in Botswana. However, these activities were not supported or coordinated by the Joint UN Team on AIDS as such, but rather by individual UNAIDS Cosponsors, government, CSOs etc.

Exemplified includes:

- The broadened role of NAHPA to include NCDs, however with conflicting views on whether this has been an appropriate approach.
- The new Integrated community-based care guidelines and community services model, builds on the experience of the HIV home-based care programme and the HIV programme’s experience with community-based workers.
- WHO supporting Central Medical Stores (CMS) to replicate HIV quantification processes for TB and cervical cancer commodities. The drug forecasting committee initially mainly focused on ARVs, but now has a wider mandate. This is helping to strengthen the supply chain for many services.
- HIV has well developed tools, e.g., for screening for STIs and GBV, and for online appointment booking for young people, and the contact tracing systems for STIs is now based on the HIV cascade model.
- The TB programme was felt to have learnt much from HIV and services such as bi-directional screening are now integrated.
- The HIV programme has addressed issues such as client confidentiality and consent. These issues have subsequently arisen about consent for services in SRHR and client confidentiality and Botswana is now engaged in harmonising age of consent, with support from legal and other experts from the Joint Programme.
- The Communities Acting Together to Combat HIV (CATCH) model has been successful and has been adopted by the malaria programme.
- Using the HIV experience of peer educators, Botswana has established peer groups in schools which have been used to build capacity and share messages across all health challenges.
- District Multi-Sectoral AIDS Coordination bodies (DMSACs) were established by the HIV programme and in some districts are now used as broader health planning forums. In this way, service planning is becoming integrated and is supporting the integration of services.
- WHO has supported TB/HIV integration, and this has generated lessons for integration of NCDs.
- HIV NGOs are also broadening their focus to address other health problems and leveraging their experience in HIV, e.g. in M&E.

There are further multiple examples of how the Botswana COVID-19 response built on the experience and systems developed by the HIV programme. Respondents highlighted the one government approach, the importance of already having community and district structures in place, and the role of HIV laboratories.

Yet untapped opportunities were also identified through this evaluation. HIV systems, learnings and experience in Botswana could be used to strengthen PHC going forward by a wider adoption of multisectoral approaches for other diseases, intensive fundraising, and close collaboration with development partners for PHC, using investments of strong HIV supply chain management for other

drugs/commodities, and the extensive use of lay providers and community workers in general health promotion.

4.3.2 To what extent is the Joint Programme using and promoting wider adoption of adaptations in service delivery developed in response to COVID-19 to improve broader health outcomes?

The unprecedented health emergency of COVID-19 caused disruption in the HIV response and threatened to reverse the gains achieved in Botswana. While the HIV response proved resilient, through use of innovations and a people-centred approach, COVID-19 showed that without strong, fit for purpose health systems, aspects of PHC and preventative care were at risk. COVID-19 also highlighted the weaknesses in social protection systems in the region.⁷⁷

The role of the Joint UN Team on AIDS during the COVID-19 response was seen as critical by many respondents. The Joint UN Team on AIDS workplan for 2021 noted “Planned activities will make every effort to encompass integrated COVID-HIV-SRHR messaging and awareness-raising and ensure continuity of services for AYP and KPs left behind in government social protection measures. Use of multiple approaches such as mass media (radio and TV), internet and social media, and peer-to-peer communication to share COVID and HIV/SRHR- related information to ensure LNOB in new normal already tested and found successful by partners during COVID lockdowns and restrictions.” One respondent noted “I attended some meetings funded by UN agencies to address the COVID-19 through review of situation and strategy review. It was done very fast when the UN stepped in.”

The response to COVID-19 stimulated innovations, many of which are still in use and some of which are being adopted more widely. The Joint UN Team on AIDS played a catalytic role and helped to amplify the response to the pandemic through actions at the country and regional levels. Laboratory equipment and commodities were repurposed for COVID-19. Where the same reagents were used, this diverted resources from HIV viral load monitoring. WHO is supporting the development of the National Laboratory Policy and Strategic Plan which will cover all diseases.

Responding to COVID-19 forced all programmes to review their procedures and to innovate:

- “COVID-19 helped start thinking about reprogramming.”
- Multi-month dispensing of ARVs was extended from 1-2 months’ supply to 3-6 months’ supply during COVID-19. The HIV programme also changed to reviewing stable patients every 6 months and now most patients are on this system.
- Many PLHIV went home. They were afraid to access treatment at home clinics for fear of disclosure but could communicate with health workers by WhatsApp to get their medication. In some cases, PLHIV were able to get medication from CHWs who were trained to provide home refills.
- COVID-19 also catalysed increased emphasis on electronic data collection and processing.

Some innovations developed by the HIV programme in response to COVID-19 are now being used by other programmes. UNAIDS helped with messaging and support for PLHIV and this has been integrated into PHC. Virtual-consultations were introduced in some facilities during COVID and these have continued. Multi-month dispensing has been adopted by other health services, as has the use of different delivery mechanisms for medication, such as the use of couriers. Some programmes are also considering the use of drones to deliver medications to some areas. ‘Block booking’,⁷⁸ introduced by HIV programme to avoid congestion in facilities, is now being used to manage client load and waiting times in facilities which are offering integrated services.

⁷⁷ Regional and country report 2020-2021 Performance Monitoring Report, UNAIDS/PCB(50)/22.10

⁷⁸In which an appointment is given to each client at which they can access repeat services thus managing client load and waiting times.

4.4 EQ4: To what extent does the Joint Programme ensure that equity, gender, and human rights issues, including the needs of key populations, are sufficiently addressed when leveraging HIV and PHC interlinkages and integration?

SUMMARY OF FINDINGS – EQ 4

- Different populations require different service delivery models and hence one model of integrated service delivery will not work for all. Respondents were divided over whether integrated services would reduce stigma.
- Key populations such as MSM and FSW were felt to be critical groups which might be excluded from routine integrated services yet a priority to reach.
- Stigma, including self-stigma, and discrimination, continue to be barriers to accessing care.
- There was recognition of Joint UN Team on AIDS action to address stigma and discrimination including in service delivery settings and UNAIDS and its Cosponsors were seen by many as having a unique advantage in advocating for and supporting the most marginalised groups.
- Although individually some Cosponsors are supporting integration of HIV into broader health systems and other sectors, the Joint UN Team on AIDS has no clear strategy or planned activities to do this in Botswana.
- The Government of Botswana is considering social contracting of CSOs/NGOs to target KPs.

4.4.1 Which locations and population groups are potentially benefiting or being left behind?

Different populations require different service delivery models, and one model of integrated service delivery will not work for all. Key populations such as MSM and FSW were felt to be critical groups which might be excluded from routine integrated services yet a priority to reach. As one respondent put it: “If we don’t programme for them then we will have a hot spot that affects the achievement of national targets. HIV testing for KPs yields 35% cases whereas national yield is 5%.” The NSP III also takes note of barriers for key populations to accessing mainstream services because of fears of stigma and discrimination and the legal environment.

KP services are currently housed under the MoH STI programme, which brings together stakeholders, including UN agencies, for discussion and planning. Most support for KPs is provided by development partners via NGO or CSO projects, rather than by routine government health services. Attempts are being made to extend integrated services to KPs. Through PEPFAR, some implementing partners have engaged with public health care workers and are sensitising them to provide services to KPs in public sector facilities. Many CSOs are starting to integrate SRH into their services and some HIV sites are now expanding their services. The Government of Botswana is considering social contracting of CSOs/NGOs to target KPs through NAHPA. Young people, including those living with HIV, were also identified as a population group that needs focused and specific support.

4.4.2 How is the Joint Programme supporting countries to ensure stigma and discrimination free services for people living with HIV and vulnerable and key populations in all service delivery settings, including primary care?

All respondents in Botswana agreed that stigma, including self-stigma, and discrimination continue to be barriers to accessing care. PLHIV gave various examples. Replacing patient cards required a different process for HIV patient cards: “If I lose my IDCC card I have to go to the police and face people I do not know. It's not the same requirement for other diseases like diabetes.” In some

facilities, the queuing point for ARVs is open, with clear signs that it is for PLHIV and this makes some people reluctant to collect their medication.

“PrEP enrolment is good, but retention is not good as clients do not want to go back to sites dedicated to HIV related services, hence our current effort to integrate some of these services.”

Respondents acknowledged that there was no easy answer: if they queue with other people at a primary care facility, then they are identifiable because their patient cards are a different colour, but to have a separate facility also means people will know.

Respondents were divided over whether integrated services would reduce stigma. Some felt that integration could help to reduce stigma. “Integration also reduces stigma especially for people living with HIV. In some of the facilities where care is provided, and service is integrated they do not feel stigmatized hence retention level is high.” “People now understand that HIV is a chronic condition, hence integration of other conditions with HIV services. Yes, there will be stigma initially but eventually [it will] go away.”

There was much recognition of Joint UN Team on AIDS action to address stigma and discrimination. This includes efforts to reduce stigma and discrimination towards KPs. “UN advocacy was key to recent updates in legislation.” A National Stigma Reduction plan has been in place since 2020 but is not much used so an action plan is being developed as well as key messages and the Joint Programme is providing TSM support for this. The Joint UN Team on AIDS is also supporting the implementation of the Stigma Index for PLHIV and other key and vulnerable populations.⁷⁹

Other examples cited by respondents included: a UNFPA and UNAIDS symposium on stigma and discrimination and Joint Programme support for developing the national strategic plan to reduce human rights related barriers to HIV and TB services⁸⁰ and a population self-assessment for people living with HIV and TB to reduce stigma, as well as guidelines and other documents aimed at addressing structural and legal barriers that limit access to services for key populations and other marginalised and vulnerable populations.⁸¹

The UNAIDS and Cosponsors were seen by many as having a unique advantage in advocating for and supporting the most marginalised groups. The UN agencies have been supportive on issues concerning KPs and other vulnerable groups and in bringing government, CBOs and NGOs together. “The other benefit is that we are able to serve the least served population.” It was noted that the Batswana are generally conservative people, and that advocacy needs to be sensitive to this. “WHO and UNAIDS are consistently working with us in space of integration, but UN agencies are cautious not to dictate to countries. Partners support efforts for government to move in the right direction. Government has asked partners to be patient with Government as they programme themselves around KP.”

⁷⁹ National strategic plan to reduce human rights related barriers to HIV and TB services, Botswana, 2020- 2025

⁸⁰ National strategic plan to reduce human rights related barriers to HIV and TB services, Botswana, 2020- 2025

⁸¹ National strategic plan to reduce human rights related barriers to HIV and TB services, Botswana, 2020- 2025

4.5 EQ5: What is the added value of the Joint Programme in terms of leveraging HIV and PHC interlinkages and to what extent is the Joint Programme sufficiently resourced to pursue this?

SUMMARY OF FINDINGS – EQ 5

- The provision of technical assistance was the area of added value mentioned most often.
- The Joint Programme can provide international evidence, norms and guidance to inform best practice and can also provide catalytic funding where the government is financing programmes to move forward agendas and inform policy debates.
- The Joint UN Team on AIDS is seen as having an important convening role: bringing partners together on issues of mutual interest. There is much demand for support for coordination as well as for capacity building, strengthening M&E and resource mobilisation and as neutral advisors who can advise on international best practices. Some respondents noted that there is not much investment in research by the Joint UN Team on AIDS despite the needs in country for evaluation of pilot projects and evidence on which to base new policies.
- The UNAIDS and co-sponsors' ability to be strategic is constrained by limited, decreasing and earmarked funding. Related to the declining budgets, almost all respondents mentioned the low levels of staffing in country of the UN agencies.

4.5.1 What is the added value of the Joint Programme in terms of leveraging HIV and PHC interlinkages? (Joint Programme ways of working, collaboration, synergies, and comparative advantages)?

The provision of technical assistance was the area of added value mentioned most often. A strength of the UN agencies is that they can bring in technical assistance, often at short notice, and this is highly appreciated. "WHO is always ready for support especially with technical assistance." "They always come and are supportive."

The Joint Programme has access to international evidence, norms and guidance to inform best practice. The UN is seen as a respected neutral partner, because of its ability to provide technical advice and guidance. Unlike bilateral donors it is not seen as political or pushing certain agendas. "The UN is respected, all listen." This puts the UNAIDS and Cosponsors in a highly influential position. There is a great demand for advice on best practice to guide Botswana's reforms. "There is a great vision for PHC but fears remain in tampering with HIV gains. The PHC vision is broader hence UN programmes need to shed light on other areas and guide on other sectors and models."

The Joint Programme can also provide catalytic funding to move forward agendas and inform policy debates. Although the resources of the UNAIDS and Cosponsors are limited, they can provide small amounts of catalytic funding and can often do this faster than other partners.

The Joint UN Team on AIDS is seen as having an important convening role. Bringing partners together on issues of mutual interest means available funds can be used in a more efficient way towards government prioritized needs and also avoids duplication.

There is much demand for Joint UN Team on AIDS support for coordination, as well as for capacity building, strengthening M&E and resource mobilisation. This was reflected by quotes of key informants provided below:

- "The UN needs to invest in building local capacity for coordination."
- "UN support is required to strengthen coordination and joint planning. There is a lot of double dipping especially by CSOs. You find that Global Fund is supporting testing and PEPFAR is supporting the same thing."

- “The Joint UN Team on AIDS could play a valuable role to bring in more sectors. Government departments listen to the UN. The Joint UN Team on AIDS can play a big role in ensuring coalitions.”
- “The Joint UN Team on AIDS should support more on grant application, proposal writing as is the case with other countries.”
- “Despite PHC and integration call we still need to jump into areas that are designed to cater for special needs. WHO measurement for PHC is a good start and can be customized for each country and context: defining the metrics for success”
- “Some programmes are implemented and work well but they are never scaled up or at least continued and sustained. They need to be documented, learned from and scaled up. We don’t know who is doing what.” “The Joint Team needs to take active involvement at higher levels and TWG to share their expertise and use lessons and best practices. Could they support evaluation of programmes and share the learning?”
- “There should be capacity building for CSOs as well as government.”
- “All our partners report through government systems. We use indicators agreed with Government. Even the generated data we use is the same that is in the government systems. The biggest gap is real time. Internet connectivity in rural areas is a challenge as sometimes when there is no internet, they capture data manually. Maybe UN would come in with technology that can work offline.”

4.5.2 To what extent does the Joint Programme have the necessary skills and resources to contribute to strengthening HIV and PHC integration and linkages?

The UNAIDS and Cosponsors’ ability to be strategic is constrained by limited, decreasing and earmarked funding. Respondents pointed out that although they are aware of strategic priorities, they cannot always respond due to earmarked funding. As noted under EQ2.3, TB is one of the most common opportunistic infections and causes of death among PLHIV in Botswana, but the UN agencies have little funding for TB and hence have little incentive or scope to support TB because much of their funding is tied to HIV. Some respondents noted that there is not much investment in research by the Joint Programme, despite the need in country for evaluation of pilot projects and evidence on which to base new policies.

Related to declining budgets, almost all respondents mentioned the low levels of staffing of the UN agencies in country. The UN presence is very small in Botswana and the limited number of staff is a constraint. Efforts are made to recruit people who are versatile and can cover a wide range of areas, but this can lead to individuals being a focal point for too many issues and affect the quality of support provided. “I think they are thin on the ground, e.g. one agency is barely available to put together significant support and another has one person advising on too many areas that they are not able to comprehensively deliver on.”

Respondents noted the value of being able to build relationships with partners on the ground, but this is undermined when UN agencies with limited staff rely on consultants. In addition, lack of staff to implement can lead to delayed or slow spending by Cosponsors of donor funds which can result in donors becoming reluctant to provide further funding.

5 Conclusions and considerations going forward

5.1 Conclusions

The global reporting systems for planning and reporting of the Joint Programme activities facilitate the different co-sponsors in country to plan and deliver shared resources and commitments, and efforts are made beyond that to harmonise the activities of different agencies, but these are not always successful. Within the Joint UN Team on AIDS, respondents stated that they did not always know what others are doing, and this situation was echoed among wider partners also. This was the case more generally but also for aspects related to integration of HIV within the broader health system.

Botswana has a conducive policy environment for integrating HIV services with other services within primary care and largely buy-in from all actors that this path is necessary to ensuring sustainability of HIV efforts and gains. Although *individually* some Joint UN Team on AIDS agencies are supporting integration of HIV into the broader health system, primary care, or with other services, the Joint UN Team on AIDS in Botswana has no clear joint strategy or joint plan related to this area. This presents as a missed opportunity for closely aligned work and joint action across the Joint UN Team on AIDS in Botswana to support policy implementation.

While the Joint UN Team on AIDS is not planning or reporting activities under the HIV integration result areas of the UBRAF, most Joint UN Team on AIDS activities are directly applying the other two pillars of the PHC approach (community empowerment and multisectoral action) to the HIV response. This is not surprising: the HIV response has been characterized by these approaches, which are now established best practice. Further, the Joint UN Team on AIDS interventions in these areas are extending beyond a narrow focus on HIV to encompass, SRHR, GBV, mental health and wider health issues. In this way, the Joint UN Team on AIDS can be seen to be taking a PHC approach for wider health outcomes.

In some cases “integrated” programmes are being offered by expanding HIV services to offer additional services to HIV patients only (e.g. CSOs offering cervical cancer screening as part of their services for PLHIV). While this may be a pragmatic approach to phasing the implementation of integration, it **creates risks of inequity in access** if those services are not made accessible to people not infected by HIV and could create super-programmes with their own vertical supporting systems which would not address broader integration with PHC for wider health outcomes in the general population.

Further, although progress is being made in scaling up integration at the *service delivery level*, there has been **little attention to integrating the systems which support the services** (e.g. information systems, human resources, supply chain, financing etc) despite some individual efforts by Cosponsors such as WHO. These systems were often noted as barriers to integration and offer opportunities for the Joint UN Team on AIDS to engage with technical assistance to support their redesign.

The strong HIV programme in Botswana and its robust supporting systems were recognised by many to offer the opportunity to share knowledge, experience and platforms which could be extended to wider services benefiting wider populations and addressing broader health objectives. The COVID-19 response in Botswana was built on its HIV programme’s community systems and structures and laboratory systems. This gives an example of what is possible when the HIV programme’s learning and experience is leveraged for other programmes directed at other health outcomes.

It is not possible to discern a unified strategy or approach to integration by the Joint UN Team on AIDS despite multiple highly valued interventions by individual Cosponsors which support introducing a PHC approach to HIV programming, integrating HIV into wider primary care services and building on the experience and systems developed by HIV to strengthen broader health

outcomes. Again, this issue is mirrored in the wider Botswana health sector which respondents felt was characterised by fragmentation and a lack of coordination.

While there is a stated, high-level policy priority for integration of HIV and PHC in Botswana, and many efforts at the service level to progress this, there is not a clear shared understanding of the form that integration should take and how systems and programmes can be operationally integrated. This is true within the UN Joint Team on AIDS and more widely within the Government of Botswana and its funding and implementing partners. The detailed technical discussions about which services should be integrated, for which groups and at what level, together with how health systems should be reconfigured to support them, do not appear to be taking place.

Multiple barriers to implementing integration were identified however, many concerning the supporting health systems required to make it work. These barriers will need to be systematically discussed and addressed to ensure a shared understanding and vision and buy-in from the key players in the technical agencies and government departments in order for the country's ambition for integration to be realised. This is an opportunity for the Joint UN Team on AIDS to support the development of a shared vision of the form of integration which Botswana wants to achieve.

Access to services for key populations is a priority for the national HIV response, however with an identified risk that such populations may be excluded from services provided by public health facilities. Different models of care for their needs must be considered and assessed for their acceptability to these groups. The work of the Joint UN Team on AIDS on stigma and discrimination is critical and must be built on during decisions about what models of care should be offered, to ensure acceptability and access to services for all those who need them.

The Joint UN Team on AIDS are seen as respected advisors who can advise on international best practices and provide TA to assist with policy and guideline development. The Joint Programme can also provide small amounts of catalytic funding to move forward agendas and inform policy debates. Joint UN Team on AIDS is seen as having a convening role, not just in bringing Cosponsors together, but more widely. **This gives them a position of great influence.**

Supporting research and evaluation and documenting experience and sharing learning will be very important as models of care are developed with the health systems to support roll out. This critical area of support appears to be lacking and could be a valuable contribution by the Joint UN Team on AIDS.

Given the repeated requests for coordination by all respondents, **supporting and building the capacity of the relevant Government departments to lead and coordinate the technical discussions needed to develop plans for a considered, phased approach to integration, would seem an urgent task for which the Joint UN Team on AIDS is ideally placed.** There is a real opportunity for the Joint UN Team on AIDS to assist the country to determine how to achieve its goals, but first the Joint UN Team on AIDS will internally need to achieve consensus on its vision and strategy for supporting integration and building government capacity to lead the process.

5.2 Considerations for strengthening Joint Programme contributions to alignment and integration

The following presents a summary of considerations for strengthening Joint Programme contributions to HIV/PHC alignment and integration in Botswana.

Assessment on HIV integration aspects in Botswana

As a first step, the Joint UN Team on AIDS in Botswana could spearhead a detailed assessment to determine various crucial aspects of HIV integration within primary care/related disease

programmes. This analysis should be initiated with an assessment of HIV inequalities in Botswana⁸² succeeded by an analysis identifying models of care for different population groups, the risks and benefits and the systems needed to support them, assessing the resources required for a successful integration and gauging the existing political will to support these endeavours. Through this process the Joint UN Team can leverage insights garnered from pilot integration projects in Botswana and build on the experience of the on-going integration efforts. These findings will serve as valuable reference points to inform discussions and guide future integration efforts effectively.

Convening partners for alignment on HIV integration with primary care/ broader health systems and providing technical assistance as needed

Convening partners and facilitating technical discussions on the desired operationalization of integration is a role that the Joint UN Team on AIDS could play based on the analysis described above and supporting the Government with technical information and assistance, evidence, and experience of best practice elsewhere. The Joint Team in Botswana in close collaboration with the Government would benefit from building a shared, aligned agreement and understanding of “HIV integration within the broader health system” in Botswana – including its operationalization. This work could centre on the National Reference Committee led by the MoH which involves all the key players including NAHPA and the UN agencies but will need to also encompass the various technical working groups for the different health systems and services which are to be integrated.

There is an opportunity to build on the Joint Programme’s advocacy for key populations and engage them in deciding the final form that integration should take for services targeting key populations. Further, the strong links and learnings of the Joint UN Team on AIDS on working with PMTCT integration and communities to roll out integration effectively could be tapped into.

Convening also development partners/donors around this agenda will be critical to have alignment on funding aspects. Regular assessments of integration efforts as it progresses will be important to help mitigate potential risks as they arise and allow outcomes to be assessed.

Joint planning on integrating HIV with other services/ PHC within the Joint UN Team on AIDS

Informed by the analysis and alignment discussions, joint planning for activities related to supporting the integration of HIV with other services or with primary care should be developed as part of the next UBRAF cycle and country envelopes. The plan and funding towards this should be aligned to Government priorities, policies, guidelines and funding streams and should outline clear objectives, timelines, and responsibilities for the relevant agencies within the Joint UN Team on AIDS, including how the different agencies with their different mandates can work together and complement each other's actions.

Ensuring UN Joint Team on AIDS capacity and funding in-country to support the above activities

The support described above would need to be technically informed by health systems expertise but should ideally be led by Joint UN Team on AIDS in-country staff, since strong relationships and a good understanding of local context will be needed to negotiate many of the barriers. Processes such as integration are always contested and will require a sensitivity to political economy and local culture to implement. Resource constraints and the limitations of staff availability imply that the Joint UN

⁸² UNAIDS has published a “ framework for understanding and addressing HIV-related inequalities, UNAIDS; 2022; (https://www.unaids.org/sites/default/files/media_asset/framework-understanding-addressing-hiv-related-inequalities_en.pdf)

Team on AIDS agencies will need to carefully consider their staffing skill sets and ensure they can bring the right balance of technical and local expertise through balancing in-country staff skills with technical assistance from other levels (regional/HQ).

Similarly, budgets are constrained and identifying funds to support this could be prioritized for the next country envelope funding and potentially supplemented with other funding sources such as through collaborations with the Global Fund (GF) or USAID/CDC/PEPFAR. The Funding Request to the GF which is about to be prepared offers a timely opportunity to include a request for health systems support through the Resilient and Sustainable Systems for Health (RSSH) component.

HIV and PHC integration and linkages should be a standing agenda item in Joint Team meetings

HIV-PHC integration and interlinkages should be a regular agenda item in Joint UN Team on AIDS meetings with this work co-led by UNAIDS and WHO. Topics for discussion and review during these meetings could include:

- information on equity for prevention and access to care as programmes and services are integrated (particularly for KPs);
- extension of social and legal protections achieved by the HIV programme to other programme areas and populations;
- redesign of M&E systems to include community level information systems and ensure interoperability between systems.

Annexes

Annex 1: KII guide

Note: the following guide is tailored to the Joint Team, we also developed tailored guides targeting the following categories of key informants:

- Global Fund, PEPFAR, BMGF, USAID, international NGOs etc.
- Government Ministry/central staff
- Facility staff/Service providers (government and or private/NGO)
- Community led/based organizations, Key population groups
- Academic/research organizations.

Country case studies - Key Informants Interview Guides

The UNAIDS Joint Programme contribution to strengthening HIV and Primary Health Care outcomes: interlinkages and integration

Interview guide for Joint Programme Cosponsors in country

Introduce the consultants and key informants. Note names and positions.

Introduce the assignment: Euro Health Group has been contracted to conduct an evaluation of the UNAIDS Joint Programme's work on leveraging the HIV and PHC interlinkages in order to strengthen these and identify opportunities for the UNAIDS Joint Programme work on PHC in the future.

The evaluation will identify how efforts to address HIV have been – conceptually and operationally – linked to the PHC approach and whether or how this can be further strengthened. The evaluation should capture the HIV-PHC interface, drawing on where things stand based on current experience and the way forward. The timeframe of the evaluation is from 2020 to date. At country level the UNAIDS Joint Programme on HIV includes the UNAIDS Secretariat Country Office and up to 11 Cosponsors. In this evaluation we are focusing on the work of WHO, UNICEF, UNFPA and the World Bank in addition to UNAIDS Country Office.

The evaluation will not only assess how the Joint Programme has supported integration of HIV into PHC and how HIV integration has improved HIV prevention, testing and treatment outcomes but also how this has strengthened PHC outcomes more broadly, e.g., improving the ability of PHC to care for people with chronic illnesses.

All information provided to the evaluation team will be kept confidential, and potential citations will not be traceable to any person or their details.

Thank you for your willingness to talk to us.

List of questions

- Can you describe any recent examples from your country where the Joint Programme has contributed to strengthen:
 - integrated service delivery (including in primary care)
 - multisectoral action and policy
 - empowerment of communities

Any notable achievements since 2020?

How is progress tracked?

Probing Qs

- Can you mention any recent examples of Joint Programme activities at country level to build political commitment for sustainable financing and delivery of integrated HIV services (e.g., comprehensive HIV services in health benefit packages)?
- Any recent examples of Joint Programme multisectoral actions and policy?
- To what extent is the Joint Programme promoting community-led approaches for demand generation and service delivery when appropriate? (and how can this potentially be improved?)
- Where does the Joint Programme *add value* through its joint ways of working on HIV and PHC integration and linkages? (e.g., convening power, collaboration, synergies etc) Probe: How is the Joint Programme using its *comparative advantage*, resources and ways of working to support HIV and PHC integration and linkages at country level? (Joint Programme leadership, advocacy, policy dialogue, convening, funding, guidance, technical support, strategic information at global, regional and country levels)
- To what extent do you think the Joint Programme has appropriate and adequate skills and resources to leverage the HIV and PHC interlinkages? What, if any, are the main gaps, and where should the Joint Programme strengthen its capacity?)
- What are the *main barriers* to integrating HIV into PHC and how is the Joint Programme addressing these, at country level? (Probing: are Joint Programme partners at the UHC table when discussing UHC/PHC etc?)
- What are the *key enablers* to advance HIV and PHC integration? (Probing: How is the Joint programme tapping into these?)
- How is the Joint Programme identifying and assessing the *main barriers and challenges to, and risks of*, HIV integration in PHC?
- To what extent do you think that the Joint Programme has leveraged on HIV assets (investment, learnings, approaches, innovations) for broader health gains? Specific examples Any specific examples? (Probe: are there any missed opportunities?)
- What is the Joint Programme doing to ensure *equitable access* to HIV services delivered through a PHC approach? Which locations and population groups are potentially benefiting /or being left behind?
- Where should the Joint Programme focus its *efforts in the future* on HIV and PHC integration and linkages to maximize HIV and broader health outcomes? What should it do better or differently going forward (probing: Missed opportunities for the Joint Programme on the HIV-PHC interfaces) How can the Joint Programme best contribute to ensuring the equity, quality and sustainability of HIV services that are integrated with, or linked to, PHC?)
- Is there an imperative to integrate HIV more in PHC? How can this support HIV outcomes? How can it support broader health outcomes?
 - To what extent are relevant plans, strategies and activities related to HIV and PHC harmonized and aligned *internally* within the Joint Programme (UNAIDS, WHO, UNICEF, UNFPA, WB) at the country level? And *externally*? (Global fund, PEPFAR etc?)
- What can and should the Joint Programme do in the future to maximize on the interlinkages between HIV and PHC?

Annex 2: List of key informants

Names	Position	Institution
UNAIDS and Cosponsors in country		
Alankar Malviya	Country Director	UNAIDS
Nametsego Tswetla	Equality and Rise for All Officer	UNAIDS
Mpho Mmelesi	Strategic Information Advisor	UNAIDS
Chiweni Chimbwete	Fast track advisor	UNAIDS
Martin Mosima	National Programs Officer	UNESCO
Kefilwe Koogotsitse	Programs Specialist	UNFPA
Ruben Antonio Pages	Chief-Adolescent Development	UNICEF
Tebogo Madidimalo		WHO Country Office
Josephine Namboze	Country Representative	WHO Country Office
Ms Boingotlo Ramontshonyana		WHO Country Office
Other development partners (Global Fund, PEPFAR, BMGF, USAID, international NGOs etc)		
Khumo Seipone	Chief Executive Officer	African Comprehensive HIV and AIDS Partnership (ACHAP)
Thato Pelaelo	Director of Operations	African Comprehensive HIV and AIDS Partnership (ACHAP)
Blessed Monyatsi	Project Manager	African Comprehensive HIV and AIDS Partnership (ACHAP)
Mooketsi Ramakele	Business Development Officer	African Comprehensive HIV and AIDS Partnership (ACHAP)
Kabelo Kgongwana	Project Manager	African Comprehensive HIV and AIDS Partnership (ACHAP)
Otsile Modisaotsile	Technical Lead	African Comprehensive HIV and AIDS Partnership (ACHAP)
Vanessa Mannathoko	M&E Officer	African Comprehensive HIV and AIDS Partnership (ACHAP)
Wame Dikobe	Chief of Party	FHI360
Thandie Tumelo	Programs Director	Global Communities
Gaolatlhe Matswiri	Programme Officer	Global Fund
Grace Ajayi	PEPFAR Country Office Coordinator	PEPFAR
Emmanuel Mafoko	PEPFAR Dreams Coordinator	PEPFAR
Paul Motshome	HIV Care and Treatment Specialist	Centres for Disease Control (CDC)
Mosarwa Segware	Deputy Health Officer -Director	USAID
Tebogo Komadi	Clinical Advisor	USAID
Meagan Mattingly	Senior. Regional Health Advisor USAID/Southern Africa	USAID

Chris Obanubi	Senior HIV Advisor	USAID
Abimbola Kola-Jebutu		USAID
Morongwa Dikgang		USAID
Ratanang Balisi		USAID
Government Ministry/central staff		
Martin Keabona	Health, Safety and Environment Officer	Ministry of Education and Skills Development
Jane Gaongalelwe	HIV and AIDS Life Skills Program Officer	Ministry of Education and Skills Development
Karabo Thokwane	Director – Clinical Services	Ministry of Health – Clinical Services
Bornapate Nkomo	HIV /AIDS Programme Head	Ministry of Health – Clinical Services
Lynn Tjirare	Public Health Specialist	Ministry of Health – Clinical Services
Samuel Kolane	Director – Public Health	Ministry of Health – Public Health
Kereng Molly Rammipi	Chief Health Officer -SRH	Ministry of Health –SRH Programme
Galaletsang Mudongo	Coordinator- Health Services	Ministry of Health –SRH Programme
Eldah Dintwa	HIV Prevention Head	Ministry of Health-HIV/AIDS Division
Dr Lynn Tjirare Tuisiree	Public Health Specialist	Ministry of Health-HIV/AIDS Division
Kemmonyse Kusi	STI & KP Program Coordinator	Ministry of Health-HIV/AIDS Division
Bene Ntwaagae	VMMC Coordinator	Ministry of Health-HIV/AIDS Division
Gothusang Tawana	Hepatitis program Coordinator	Ministry of Health-HIV/AIDS Division
Jessica Mafa-Setswalo	PMTCT Program Coordinator	Ministry of Health-HIV/AIDS Division
Goabaone Pankie Mogomotsi	HTS Program Coordinator	Ministry of Health-HIV/AIDS Division
Josephine Tlale	CQI Coordinator	Ministry of Health-HIV/AIDS Division
Gadzanani Jabulani	BCIC Officer	Ministry of Health-HIV/AIDS Division
Elang Thomas	KITSO training Coordinator	Ministry of Health-HIV/AIDS Division
Robert Selato	R,M&E -Head	National AIDS and Health Promotion Agency (NAHPA)
Lefetogile Bogosing	Programs Coordinator	National AIDS and Health Promotion Agency (NAHPA)
Bame Shatera	Focal Person -NCDs	National AIDS and Health Promotion Agency (NAHPA)
Mr Mathumo	Director – Health Promotion	National AIDS and Health Promotion Agency (NAHPA)
Onteretse Letlhare	National Coordinator	National AIDS and Health Promotion Agency (NAHPA)
Elizabeth Koko		National AIDS and Health Promotion Agency (NAHPA)
Facility staff/Service providers (government and or private/NGO)		
Josephine Baffor	Acting Principal Nursing Officer 1	Kgatleng District Health Management Team
Senzeni Manosi	Nursing Officer	Boseja II Clinic

B. Moalusi	Chief Nursing Officer	Kgatleng District Health Management Team
Bonang Bome	Health Information Assistant	Kgatleng District Health Management Team
Kedumetse Gake	Principal Registered Nurse	Kgatleng District Health Management Team
Boikobo Mosikwa	M&E Officer	Kgatleng District Health Management Team
D. Segofebe	Nursing Office 1	Kgatleng District Health Management Team
Moemedi Tshwenyane	District Lead	Kgatleng District Health Management Team
Kabo Semphadile	Senior Health Officer	Kgatleng District Health Management Team
Gontse Gopolang	PHET	Kgatleng District Health Management Team
Keneilwe Molefe	PHI CHN officer	Kgatleng District Health Management Team
Mavis Monau	PHI Intern	Kgatleng District Health Management Team
Bame Kgope	HPI	Kgatleng District Health Management Team
Gorata Aron	M&E	Kgatleng District Health Management Team
Vincent Ratladi	PRW/YPS	Kgatleng District Health Management Team
Gomolemo Mpapho	Registered Nurse	Kgatleng District Health Management Team
Berlinah Radikgomo	Chief Registered Nurse	Mochudi II Clinic
Community led/based organisations, Key population groups		
Nankie Ramabu	Director: Monitoring and Evaluation	Botswana Christian AIDS Intervention Program (BOCAIP)
Kgoreletso Molosiwa	Director	Botswana Network of People Living with HIV and AIDS (BONEPWA+)
Gasekgale Moalosi	Programs Manager	Botswana Network of People Living with HIV and AIDS (BONEPWA+)
Adloa Kentshitsuwe	M&E Officer	Botswana Network of People Living with HIV and AIDS (BONEPWA+)
Representative	Member	Old Naledi Support Group
Representative	Member	Old Naledi Support Group
Representative	Member	Old Naledi Support Group
Representative	Member	Old Naledi Support Group
Representative	Member	Old Naledi Support Group
Representative	Member	Positive Moments Support Group
Representative	Member	Positive Moments Support Group
Representative	Member	Positive Moments Support Group
Representative	Member	CEYOHO Support Group
Representative	Member	CEYOHO Support Group
Representative	Member	CEYOHO Support Group
Representative	Member	CEYOHO Support Group
Representative	Member	Old Naledi Support Group

Annex 3: UBRAF workplans, Joint UN Team on AIDS, Botswana 2020 - 2023

Table 1. Botswana Joint UN Plan on HIV/AIDS 2020-2023: activities and source of funding

Co-sponsor and funding source	Activities	2020-US\$	2021-US\$	2022-US\$	2023-US\$	Total
UNAIDS Secretariat non-core funds	Revitalize HIV Combination Prevention for AGYW and their male sexual partners: Improve quality and validity of programme data on path to elimination of mother to child transmission. Provide Technical assistance to develop a transitional readiness assessment and sustainability plan, provide technical assistance to support scaling up of integrated SRHR and HIV services, Support the alignment of national targets to the Global AIDS Strategy 2025 targets	0.00	0.00	30,000.00	0.00	30,000.00
UNAIDS Cosponsor country envelope (CE) funds		0.00	0.00	0.00	0.00	0.00
UNICEF Cosponsor non-core funds	Revitalize HIV Combination Prevention for AGYW and their male sexual partners: Domesticating the Global HIV prevention coalition agenda to support the implementation of 10 roadmap actions in country, particularly in high priority districts, Testing of a multi-pronged intervention package on clinical, psychosocial and behavioral outcomes of a cohort of ALHIV on ART; Mid-line data collection, Support teen clubs and young adult support groups. Scale up implementation of national packages of high impact interventions for AYP/AGYW and ALHIV, Validation of eMTCT of HIV and Syphilis, Quality treatment and care for ALHIV, including mental health and psychosocial support. Testing and evaluation of differentiated service delivery models of care for ALHIV/AYPLHIV, Leverage Technology for Development to increase access to AYP-friendly health and HIV services mental health and psychosocial support.	395,900.00	172,000.00	200,000.00	50,000.00	817,900.00

UNICEF Cosponsor country envelope (CE)	Domesticating the Global HIV prevention coalition agenda to support the implementation of 10 roadmap actions in country, particularly in high priority districts: Scale up implementation of national packages of high impact interventions for AYP/AGYW and ALHIV, Introduction and roll out of PoC diagnostics. Improve Early Infant Diagnosis and Viral Load testing in hard-to-reach areas, Strengthen Capacity, evaluate and scale up peer led combination HIV Prevention services	0.00	90,000.00	120,000.00	77,000.00	287,000.00
UNFPA Cosponsor non-core funds	Revitalize HIV Combination Prevention for AGYW and their male sexual partners: Domesticating the Global HIV prevention coalition agenda to support the implementation of 10 roadmap actions in country, particularly in high priority districts, Review and develop innovative condom distribution channels, strengthen condom programming, Support scaling up of integrated SRHR and HIV services, SRHR and HIV services for older women of reproductive age, Support the alignment of national targets to 2025 targets	100,440.00	27,480.00	0.00	0.00	127,920.00
UNFPA Cosponsor country envelope (CE)	Revitalize HIV Combination Prevention for AGYW and their male sexual partners: Domesticating the Global HIV prevention coalition agenda to support the implementation of 10 roadmap actions in country, particularly in high priority districts, Piloting comprehensive models of service delivery for Key populations, Develop Standard Operating Procedures for delivery of quality high impact HIV and SRHR interventions. Shifting from a national approach to priority populations and locations with district level targets: Priority planning for geographical locations and populations, 2018 National and sub-national HIV estimates produced and used for evidence based planning. Scale up Quality services for AGYW in Okavango, Scale up combination prevention for Key Populations (FSW)	169,456.00	90,000.00	70,000.00	56,000.00	385,456.00
UN Women Cosponsor non-core funds	Provide support and accelerate the implementation of the newly developed strategic Framework of the First lady of Botswana as a UNAIDS Special Ambassador for the engagement and empowerment of young people in Botswana: Gender equality dialogues with traditional leaders. Support young women dialogues and socio economic empowerment programmes, Capacitate Networks of WLHIV in leadership, monitoring HIV and Gender equality	0.00	16,200.00	70,000.00	70,200.00	156,400.00

<p>UN Women Cosponsor country envelope (CE)</p>	<p>Revitalize HIV Combination Prevention for AGYW and their male sexual partners: Provide support and accelerate the implementation of the newly developed strategic Framework of the First lady of Botswana as a UNAIDS Special Ambassador for the engagement and empowerment of young people in Botswana. Include social and structural intervention strategies in the implementation roadmap established for combination prevention, thus addressing structural drivers of gender inequalities and responding to symptoms i.e. GBV, child marriage etc. Support young women dialogues and socio economic empowerment programmes, HE for SHE model to empower communities to identify and address harmful norms which breed inequalities</p>	<p>50,009.00</p>	<p>60,156.00</p>	<p>100,000.00</p>	<p>77,000.00</p>	<p>287,165.00</p>
<p>UNESCO Cosponsor non-core funds</p>	<p>Revitalize HIV Combination Prevention for AGYW and their male sexual partners: Work with the Ministry of Basic Education to strengthen evidence and good practice in the delivery of SRH and HIV services to learners in schools and surrounding communities through provision of support to the operationalization of the School Health Policy, implementation of the Advocacy Plan for the development of Retention EUP Policy and Support the implementation of the Parents Child Communications Manual (PCC) to facilitate alignment. Support the education sector's response to HIV through improved access to services for learners; Roll out of Ministry of Basic Education GBV Standard Operating Procedures, Roll out of the UNESCO Sexual Reproductive Health Religious Leaders Manual. Undertake high-level national condom advocacy meeting to advance comprehensive condom programming. Scale up Comprehensive Sexuality Education, Operationalization of the ESA Commitment 2022-2025, Capacity building for Religious leaders on SRHR and Sexuality Education</p>	<p>20,601.00</p>	<p>35,000.00</p>	<p>55,000.00</p>	<p>55,000.00</p>	<p>165,601.00</p>
<p>UNESCO Cosponsor country envelope (CE)</p>	<p>Revitalize HIV Combination Prevention for AGYW and their male sexual partners: Work with the Ministry of Basic Education to strengthen evidence and good practice in the delivery of SRH and HIV services to learners in schools and surrounding communities through a study on learners' access to SRH services including HIV prevention, treatment and care. Support the education sector's response to HIV through improved access to services for learners; Operationalization and Implementation of the School Health Policy in the Education Sector. Implementation of School Related GBV program, Implement Parent Child Communication Manual</p>	<p>29,999.00</p>	<p>59,784.00</p>	<p>60,000.00</p>	<p>42,000.00</p>	<p>191,783.00</p>

WHO Cosponsor non-core funds	Revitalize HIV Combination Prevention for AGYW and their male sexual partners: Improving quality and validity of programme data on path to elimination of mother to child transmission; Quality treatment and care for ALHIV, including mental health and psychosocial support, e-Systems Development. Revision of VMMC Strategy, Forecasting of HIV laboratory Supplies.	0.00	53,500.00	15,000.00	0.00	68,500.00
WHO Cosponsor country envelope (CE)	Revitalize HIV Combination Prevention for AGYW and their male sexual partners: Improving quality and validity of programme data on path to elimination of mother to child transmission. Address human rights and gender related barriers to eMTCT. Support commodity availability for the lab supplies. Strengthening the STI/syphilis Data process. Improving the results turnaround times. Advocacy for Appointment of the NVC members: to drive triple elimination validation exercise and their orientation	50,536.00	0.00	40,000.00	21,000.00	111,536.00
		816,941.00	604,120.00	760,000.00	448,200.00	2,629,261.00

Annex 4: Documents reviewed and/or referenced

- 2020 Annual Narrative Report (2gether4SRHR). Geneva: Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, x World Health Organization; 2020 (https://esaro.unfpa.org/sites/default/files/pub-pdf/2020_annual_narrative_report_final_1.pdf, accessed 24 April 2023).
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- Additional Fast-track Funding Request Form. Global Fund COVID-19 Response Mechanism (C19RM); Feb 2022
- Best practice report for SRHR & HIV Linkages project in Botswana: Mochudi Clinic1, Kgatlang District, Botswana. Gaborone; UNFPA, UNAIDS, Government of Sweden, EU and Ministry of Health; July 2016
- Botswana Country Operational Plan 2023, strategic direction summary, PEPFAR (not published)
- Botswana Country Report: a qualitative study on attitudes, perceptions and experiences on comprehensive sexuality education in schools and communities in Botswana. Government of Botswana & UNESCO, nd.
- Botswana Funding Request TB/HIV Allocation Period 2020-2022 March 2020.
- Botswana Health Data Collaborative Roadmap 2020-2025. Botswana Health Data Collaborative, World Health Organisation; 2020
- Botswana’s HIV Response: Policies, Context and Future Directions. Ramogola-Masire et al; J Community Psychol. 2020 April ; 48(3): 1066–1070. doi:10.1002/jcop.22316.
- Botswana Integrated Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH+N) Strategy (2018–22)
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- BOTSWANA Mid-term Assessment Global Fund Breaking Down Barriers Initiative, Global Fund April 2021 (crg_2021-midtermassessmentbotswana_report_en.pdf (theglobalfund.org) accessed 28 July 2023)
- Botswana Multi-Sectoral Strategy for the Prevention and Control of Non-Communicable Diseases 2018-2023. Ministry of Health and Wellness, Republic of Botswana, WHO; 2018
- Comprehensive Review of the Health Sector: 2010 – 2022 and Priorities Moving Forward. Ministry of Health, Republic of Botswana; 2022.
- Country progress report – Botswana. Global AIDS Monitoring; 2021

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(<https://doi.org/10.1371/journal.pone.0204840>)

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