REPUBLIC OF BOTSWANA

# Botswana
# HIV Prevention Road Map
# 2023-2025

***Accelerating HIV prevention to end AIDS in Botswana***

**Final, November 2023**

National AIDS and Health Promotion Agency
NAHPA Botswana

UNAIDS

UNFPA

unicef
for every child

# CONTENTS

# FOREWORD

I am pleased to present Botswana's HIV Prevention Road Map 2023-2025. As a result of decades of unflinching dedication to the HIV response, this Road Map represents both our accomplishments and aspirations for the future.

As a result of Botswana's unwavering commitment, it has gained international acclaim. The country is the first high HIV burden country to be certified for achieving the required indicators for the Silver Tier on the "Path to elimination of vertical transmission of HIV" criteria. Furthermore, the results of the Fifth Botswana AIDS Impact Survey (BAIS V) demonstrated our success in meeting UNAIDS' 95-95-95 targets, with 95-98-98 (percent of persons living with HIV aware of their status, on treatment, and virally suppressed), overall and among women. There are still discrepancies, across age, gender, and geography, exposing gaps in segments of our population.

While progress has been made, Botswana remains one of the countries most impacted by the pandemic, with preventative goals lagging. In this situation, crucial populations, including adolescent girls and young women, face socio-cultural and legal barriers to accessing critical HIV services.

Against this backdrop, the 2021 United Nations High-Level meeting on HIV and AIDS marks a turning point. The publication of the Global AIDS Strategy 2021-2026 and the Global HIV Prevention Road Map 2025 provides us with the tools we need to strengthen our HIV prevention efforts. This Strategy establishes new targets and pledges, highlighting the need for 95% of persons at risk of HIV to use effective combination preventive strategies. The Road Map provides five core pillars for national HIV responses, as well as ten critical country-level measures, all with the goal of developing a data-driven, precise, people-centred, scalable, and innovative prevention approach. Renewed commitment, guided by these values, unifies leaders, countries, communities, and partners in a united objective to accelerate activities and end the AIDS epidemic by 2030.

The Botswana HIV Prevention Road Map 2023-2025 is the result of collaborative efforts, incorporating lessons learned through significant national engagements coordinated by the National AIDS and Health Promotion Agency (NAHPA) and the Ministry of Health (MoH), and Civil Society Organizations. These initiatives, which included a high-level HIV prevention summit, a National HIV Prevention Symposium, and a comprehensive Prevention Self-Assessment Tools (PSAT) exercise, were carried out in collaboration with The Joint United Nations Programme on HIV/AIDS, UNFPA, and UNICEF. These activities, informed by global and country-specific strategies, provide the core of the Road Map.

As we present this plan, we express our gratitude to the experts, healthcare professionals, and HIV-positive persons whose contributions sparked its creation. We must all work together to defend this plan and transform it into practical actions that go beyond rhetoric, paving the way for an AIDS-free future.

_____

Mr O. Letlhare
National Coordinator
National AIDS and Health Promotion Agency

# EXECUTIVE SUMMARY

The Botswana HIV Prevention Road Map for 2023-2025 presents a comprehensive strategy to address prevention gaps and achieve the 2025 targets, with the ultimate goal of eradicating AIDS by 2030. Developed through extensive national consultations by NAHPA and MoH, the Road Map is underpinned by five strategic pillars and ten country-level actions, all centred around data-driven and people-centric prevention efforts.

The Road Map's five pillars, ranging from innovative delivery models for key populations (Pillar 1) to prioritized services for at-risk young women (Pillar 2), alongside condom distribution and male circumcision (Pillar 3), fortified condom access (Pillar 4), and a strong emphasis on ARV-based prevention including PrEP (Pillar 5), collectively weave innovation and tailored approaches into a comprehensive strategy to effectively curb the spread of HIV.

Aligned with the global 2025 Road Map, this version of the Botswana plan delineates 30 specific actions accompanied by well-defined milestones. Its primary objectives are to bridge existing gaps, meet outlined targets, maximize resource utilization, and adapt strategies to the evolving context. Ensuring equity across demographics, particularly for young women, is a pivotal aspect addressed through a multi-sectoral approach.

The implementation of the Road Map, with robust government support, stands as a critical factor in the success of HIV prevention. Continuous monitoring of milestones and active engagement with relevant stakeholders are imperative. The recent National HIV Prevention Symposium held from May 3rd to 5th, 2023 facilitated progress assessment, sharing of best practices, and collaborative problem-solving.

STAYING FOCUSED ON THE FIVE PREVENTION PILLARS

**1**

**KEY POPULATIONS**

**Combination prevention and harm reduction packages**

- Expand rollout of the HIV service packages that the country developed for female sex workers, gay men and other men who have sex with men, and transgender people.
- Make service delivery platforms location and population specific, using data from mapping and size estimates and bio-behavioural surveys.
- Increase the use of online platforms e.g. virtual outreach and booking of appointments for clinical services, especially to reach those in remote settings.
- Develop standard operating procedures for female sex worker and men who have sex with men programming.
- Urgently work towards removing laws criminalizing sex work.
- Undertake research to better understand the epidemic among drug users and to determine the need for targeted programming.
- Advocate for provision of a minimum package of HIV prevention services in prisons.

**2**

**ADOLESCENT GIRLS AND YOUNG WOMEN**

**Combination prevention packages in settings with high HIV incidence**

- Further target the prevention interventions in the current national standard package for adolescent girls and young women:
  - Offer a basic package of HIV prevention interventions for all adolescent girls and young women throughout the country, and
  - Expand package of services for those at highest risk of HIV acquisition based on age (including 25-29 years) and risky behaviour.
- Develop standard operating procedures for programming for adolescent girls and young women.
- Conduct regular surveys related to the use of HIV prevention interventions among AGYW to obtain information on the effect of HIV prevention programming.

**3**

**ADOLESCENT BOYS AND MEN**

**Combination prevention packages in settings with high HIV incidence**

- Focus the current national standard package for boys and young men (15-24 years) on basic services as incidence is low or moderate in all districts in the country.
- Use newly available data to extend the basic HIV prevention packages to older men (25+ years) that are most at risk (based on age and sexual risk behaviour) and prioritise scale-up in locations with the highest burden.
- Provide HIV prevention services not only through (male friendly) static clinics, but also via mobile outreach at community level as well as through virtual platforms as men show poorer health behaviour than women in the country.
- Advocate for stand-alone services providing VMMC services as these are currently most successful in providing services and could reduce the gap towards the VMMC targets.

**4**

**CONDOM PROGRAMMING**

**Promotion & distribution of male & female condoms and lubricants**

- Fast-track promotion, demand creation and distribution for male and female condoms as well as lubricants.
- Undertake a national condom needs assessment using the UNAIDS Condom Needs Estimation Tool (CNET)
- Strengthen quantification and forecasting of condoms based on use and demand.
- Develop a multi-year procurement and supply plan for condoms.
- Fully adopt the total market approach to ensure availability and accessibility of male and female condoms, including lubricants, to the users throughout the country up to last mile supply.
- Strengthen the logistics management information system including reporting by distributors and outlets should be strengthened as there have been issues with the supply chain.

**5**

**ARV-BASED**

**PrEP, PEP, treatment as prevention**

- Continue current efforts in HIV testing and treatment to maintain the 95-95-95 targets through differentiated service delivery models to serve the different needs of populations.
- Strengthen of HIV self-testing (procurement, logistics, access, reporting).
- Increase coverage and uptake of PrEP in all districts among those at highest risk.
- Advocate for lowering the age of accessing PrEP services without parental consent from 18 to 16 years (in line with HIV testing guidelines).

BOTSWANA'S 10-POINT ACTION PLAN TO REACH 2025 TARGETS

1. Data-driven needs assessment
2. Precision prevention approach
3. Define investment needs
4. HIV prevention leadership agencies
5. Expand community-led services
6. Remove social and legal barriers
7. Integration with related services
8. Introduction of new technologies
9. Real-time programme monitoring
10. Accountability for HIV progress

## Milestones achieved by:

### March 2024

(1) National condom needs estimation completed using the UNAIDS CNET
(3) Social contracting guidelines finalized
(4) Appointment of representatives from all HIV prevention key stakeholders not included in HIV prevention technical working group finalized & Terms of References for this group revised & quarterly meetings revived
(4) Incorporation of District AIDS Coordinators under the National AIDS & Health Promotion Agency structure finalized, and coordination, standardized reporting and accountability mechanisms aligned
(5) Standard operating procedures for female sex workers and men who have sex with men HIV prevention programming for community-based and -led organisations developed
(7) New PEP guidelines that allow prescribing for all high risk exposures implemented
(9) The use of the harmonized monitoring and reporting framework for adolescents and young people institutionalized
(10) Progress on the implementation of the Road Map monitored at a quarterly basis, weaknesses identified and corrective steps documented, starting from end-2023 (on-going)
(10) Detailed accountability framework at all levels for HIV prevention developed

## March 2025

(1) Prevention targets at (sub)national level set and subnational HIV prevention scorecards developed
(1) Multi-media and technology-based prevention programmes targeting adolescent girls and young key populations adapted and scaled-up
(2) Social and behavioural change communication plan to reach boys/men with prevention messages and services developed & VMMC strategy revised, including programme and financial targets
(2) New granular data used to operationalize the national standard packages for HIV services for adolescents and young adults to follow a precision prevention approach
(2) People who use/inject drugs included in the bio-behavioural surveys
(3) A sufficient proportion of the HIV budget reserved for HIV prevention
(3) Social contracting guidelines implementation started
(5) The total market approach fully implemented, by piloting social marketing with community-based and -led and non-governmental organisations for a continuous flow of condoms and lubricants up to the last mile
(5) Standard operating procedures for female sex workers and men who have sex with men HIV prevention programming for community-based and -led organisations implemented
(5) Strategic framework for community-led monitoring developed and the data used in regular programme reviews together with data from the public and private sector
(6) Policy brief to advocate for decriminalization of sex work developed
(7) Condom focal persons (Health education and Promotion Officers) trained to promote condom use using the integrated condom curriculum
(7) New PrEP guidelines allowing prescription in other services implemented, and the number of outlets that distribute PrEP increased
(9)Centralised database for all programs at all levels developed
(9) Data collection tools (manual and electronic) updated to collect adequately disaggregated data by age, gender, key population status, location

## End 2025

(3) Donor fund coordination enhanced by establishing a dedicated mechanism to facilitate concerted efforts for the HIV response
(6) Policy brief developed for lowering the age for consenting to access PrEP services from 18 to 16 years
(6) Increased funding obtained to conduct human rights trainings
(7) Policies amended to allow for distribution of prevention commodities (HIV testing, PEP, condoms and lubricants) in prisons and schools/tertiary education
8) Quantification and forecasting of required quantities of HIV self-testing kits, male and female condoms and other contraceptives strengthened to ensure sustainability of supply
(8) Range and number of differentiated service delivery models for ARV-based prevention that are implemented increased
(8) QuickRes rolled-out for HIV prevention purposes (outreach - risk screening, prevention service recommendations and clinical service booking options)
(8) Implementation of injectable ARVs for prevention piloted and the cost-effectiveness in the country assessed
(9) Disaggregated data collection tools implemented


National HIV Prevention Symposium, 3-5 May 2023, Palapye

# BACKGROUND TO THE HIV PREVENTION ROAD MAP 2023-2025

In the past two decades Botswana has demonstrated commitment in the HIV response and has recently been in the limelight for reaching two major milestones. The country is the first high HIV burden country to be certified for achieving the required indicators for the Silver Tier on the "Path to elimination of vertical transmission of HIV" criteria that were introduced in 2017. Furthermore, the results of the Fifth Botswana AIDS Impact Survey (BAIS V) indicated achievement of the UNAIDS 95-95-95 targets, with 95-98-98 (percent of persons living with HIV aware of their status, on treatment, and virally suppressed), overall and among women. However, when these data are reviewed by age, gender, and geography, gaps in certain populations are identified.

Notwithstanding significant progress in the HIV response, Botswana remains one of the countries most affected by the epidemic and prevention targets have lagged behind. Key populations and adolescent girls and young women continue to face societal and legal barriers in accessing HIV services.

Following the 2021 United Nations High-Level meeting on HIV and AIDS, a new Global AIDS Strategy 2021-2026 and global HIV Prevention Road Map 2025 have been released to provide countries with the needed guidance for improving HIV prevention. The Strategy introduces a new set of targets and commitments (most importantly in this context 95% of people at risk of HIV use appropriate, prioritized, effective combination prevention) and the Road Map describes five central pillars for national HIV responses and charts ten essential country-level actions towards a more data-driven, precise, people-centred, scaled and innovative prevention response. They further provide renewed commitment and engagement of leaders, countries, communities, and partners to accelerate actions to end the AIDS epidemic by 2030.

## Objective

The Botswana HIV Prevention Road Map 2023-2025 presents several high-level key actions that are feasible to be completed by the country by 2025 to ensure coherence, effectiveness, and measurable outcomes in HIV prevention activities in order to meet the national, regional and global targets. The Road Map will be a key document to inform the writing of Botswana's GC7 Global Fund funding request, scheduled for submission in February 2024.

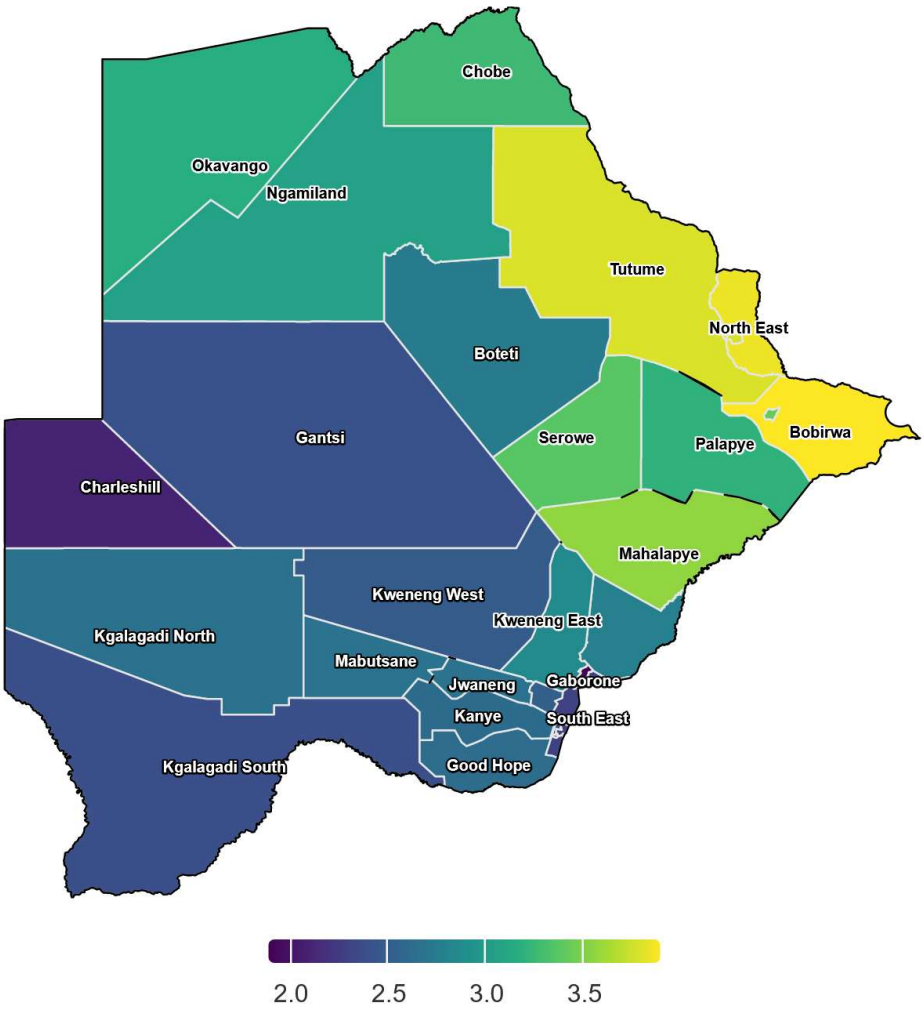
The Road Map was informed by a number of key national engagements under the leadership of the National AIDS & Health Promotion Agency (NAHPA) and Ministry of Health (MoH): 1) High-level meeting on HIV prevention that took place on 23 March 2023 to review the performance of the combination HIV prevention response and reinforce commitment from high level leadership; 2) National HIV Prevention Symposium (technical) which took place from 3-5 May 2023; 3) The Prevention Self-Assessment Tools (PSAT) completed in partnership with The Joint United Nations Programme on HIV/AIDS, the United Nations Population Fund (UNFPA) and UNICEF in February 2023 to understand how each of the five pillars perform against a set of programme management and implementation components and identify areas that need strengthening. In addition, country specific and global strategy and guidance documents were used.[1]

[1] Key documents are mentioned throughout the text of the document.

# HIV EPIDEMIC & RESPONSE

In 2022, there were an estimated 340 000 children and adults living with HIV in Botswana, with a prevalence of 21.1% among women aged 15 to 49, and 11.8% among men in the same age group. HIV prevalence among men who have sex with men and transgender people is only slightly higher compared to the general population (14.8% and 16%, respectively), while it is much higher among female sex workers (42.2%). There are currently no data available for other key populations (transgender people, people who use/inject drugs and prisoners). Although Botswana attainted a 66% reduction in new infections (adults 15+) in 2022 relative to 2010, the country missed the global target of 75% reduction in 2020. Incidence ranges from 1.9 per 1000 among adults in (Greater) Gaborone to 3.9% in Bobirwa (Figure 1) and a quarter of all infections (25.7%) occurred in the two largest cities, Gaborone and Francistown. Furthermore, 25.6% of all new adult infections in 2021 occurred among adolescent girls and young women 15-24 years (while this is only 7.0% for adolescent boys and young men). Even though no data are available specifically for Botswana, in 2021, key populations (sex workers and their clients, men who have sex with men, people who inject drugs, transgender people) and their sexual partners accounted for 51% of new HIV infections in sub-Saharan Africa (UNAIDS Global AIDS Update 2022).

Figure 1. HIV incidence among adults 15+ years in Botswana, by district, December 2022 (Source: https://naomi-spectrum.unaids.org/)



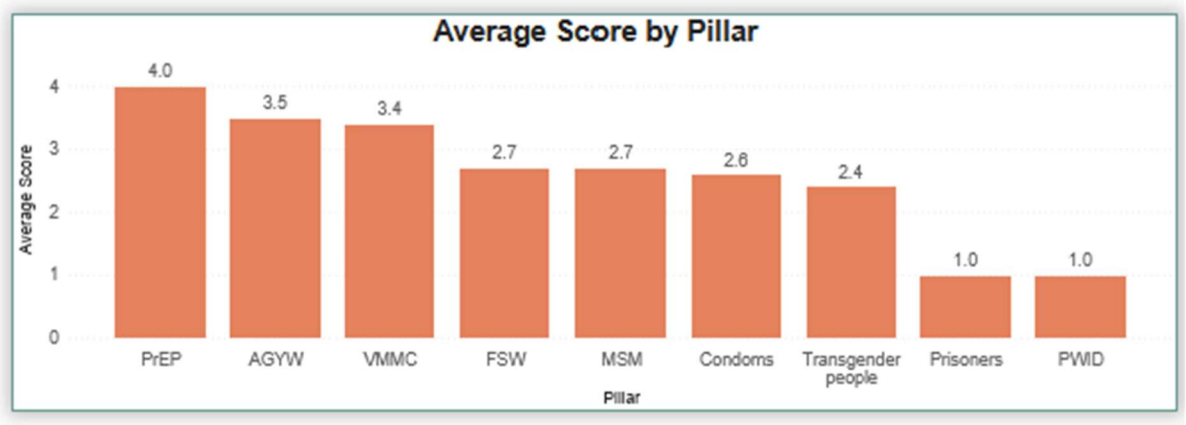
The Global HIV Prevention Coalition scorecard (Annex Figure 1) provides a summary of the country status and progress in primary HIV prevention:

- Condom use ranges from low to good among different populations: Based on BAIS IV results, condom use at last sex with non-regular partners is good among males (78.1% 15-49 and 82.0% 15-24) but moderate among females (70.0% 15-49 and 68.7% 15-24). Furthermore, it is low (76%) among female sex workers (last paid sex) and moderate (78%) among men who have sex with men (last anal sex) based on 2017 BBS data.
- The country has not reached the VMMC targets set: by the end of 2020 only 29% of the 2020 VMMC target of 280 000 had been achieved and medical circumcision prevalence is moderate among men 15-24 (66.7%) and low (48.4%) among men 15-49 based on BAIS V results.
- Even though the country has surpassed the 95-95-95 goals based on BAIS V results, based on UNAIDS estimates 9% out of all adult people living with HIV (6% of women and 14% of men) were not virally suppressed in 2021 and can transmit HIV. Antiretroviral coverage is still very good (88%) and good (74%) among female sex workers and men who have sex with men living with HIV, respectively, but lower compared to 92% among the adult population. By the end of 2021 there were just over 9 000 people actively taking oral PrEP, a fourfold increase compared to 2020.

In terms of structural barriers to accessing HIV prevention services: Sex work is being criminalized which might fuel new infections. And even though the results of the people living with HIV Stigma Index 2.0 show that overall only 3% of respondents had ever felt excluded from social, religious, or family activities because of their HIV status, men who have sex with men experienced high levels of stigma and discrimination with 50.0% reporting that they had experienced discriminatory remarks and gossip by family members. This was 12.8% for commercial sex workers (12.8%). So Botswana has partly achieved the target of 10% of people living with HIV and key populations experience stigma and discrimination.

Botswana recently completed a comprehensive Prevention Self-Assessment Tools (PSAT) exercise, reviewing the status and quality of the national programme in each of the pillars of HIV prevention. As can been seen from Figure 2, the country scored highest (out of 5) for the ARV-Based prevention programme (PrEP) and the programmes for adolescents (AGYW and VMMC – including programming for boys and men). All the results can be found here (and at the time of writing this, the reports are in the final stages).

Figure 2. Average score by Pillar (out of 5)



# STAYING FOCUSED ON THE FIVE PREVENTION PILLARS

Botswana will continue to implement a combination HIV prevention response using the five central pillars described in the global HIV Prevention 2025 Road Map to orient those efforts. The key actions to achieve them are described in the 10-point plan in the next section.

## Key populations: Implement service packages through innovative delivery models

Pillar 1

The country has developed **HIV service packages for female sex workers, gay men and other men who have sex with men, and transgender people**. In order for these services to be available throughout the country, **rollout must be expanded** utilising the service delivery model for key population programmes. It needs to be ensured that **service delivery platforms are location and population-specific, using data from mapping and size estimates and bio-behavioural surveys.** For example, dedicated key population sites with peer-led outreach and drop-in centres offering the majority of prevention services might be feasible in urban settings while in remote settings services will need to be integrated in key population friendly (mobile) clinics catering for the whole population. The **use of online platforms should be increased e.g. virtual outreach and booking of appointments for clinical services.** To ensure quality programming at scale, implementation must be done in a cost-efficient way whereby in each community ideally one organisation (e.g. community-based or -led or non-governmental organisation) provides all outreach services and refers to clinical services. In order to do so, **standard operating procedures for female sex worker and men who have sex with men programming need to be developed and implemented.** In addition, there is need to ensure that commodities included in the service packages are made available in the required quantities (e.g. male and female condoms and lubricants, contraceptives, PrEP, PEP).

In order to remove barriers to accessing HIV prevention services, **country stakeholders should urgently work towards removing laws criminalizing sex work**.

Even though there is hardly any data on people injecting/using drugs, there are organisations (Captive Eye Organization and Botswana Network Of AIDS Service Organizations (BONASO)) providing services to this group, although the focus is on non-injectable drugs and alcohol abuse. **More research is needed to better understand the epidemic among drug users and to determine the need for targeted programming** i.e. a standard package of prevention services, including harm reduction interventions, in order to prevent transmission occurring under the radar.

Finally, **a minimum package of HIV prevention services should be provided in prisons and other closed settings,** starting with HIV testing, PEP, PrEP, condoms and lubricants, as currently limited services are provided in these settings.

## Adolescent girls and young women: Focus expanded services to those at highest risk

The HIV response for adolescent girls and young women was boosted by the National HIV and AIDS Programming Framework for Adolescents and Young People in Botswana 2019-2023 and related guiding documents (Social and behaviour change communication strategy, Standard service packages). Even though this population continues to be disproportionally affected by HIV compared to the total population, the epidemic has changed (largely due to increased viral load suppression among men) and HIV incidence among adolescent girls and young women 15-24 has decreased with 49% between 2010 and 2021 in Botswana. Hence, **further targeting of the prevention interventions in the current national standard package for adolescent girls and young women is required**.

Currently, all districts in Botswana have moderate incidence among adolescent girls and young women aged 15-24 years according to district level data (NAOMI model). Guided by the UNAIDS Decision making aide for adolescent girls and young women programmes this means that **a basic package of HIV prevention interventions should be in place for all adolescent girls and young women throughout the country** provided through adolescent and youth-friendly health services, schools/tertiary education and virtually. This includes information on and access to sexual and reproductive health (SRH) services for the prevention of sexually transmitted infections (STIs), the reduction of unwanted pregnancies, and the provision of pre- and post-natal and post-abortion care. There is a need to scale-up post-exposure prophylaxis among this population.

However, the UNAIDS population size estimates tool for adolescent girls and young women indicates that within districts incidence is in general high (1-3%) among young women 15-29 with non-regular partners, and very high (>3.0%) among those part of key populations i.e. those involved in selling sex. Therefore, **an expanded package of services should be available for adolescent girls and young women at highest risk of HIV acquisition based on age and risky behaviour** (including those 25-29 years).

**Basic package for all AGYW 15-24 years**

HIV/STI risk assessment and risk reduction counselling, HIV (self) testing and treatment, active male and female condom and lubricant promotion, post-exposure prophylaxis, comprehensive sexuality education/HIV prevention communication and SRH services

**Additional prevention services for AGYW 15-24 & 25-29 years with non-regular partners and selling sex**

STI testing and treatment, HIV and STI service integration into family planning, male partner HIV testing services, community outreach, pre-exposure prophylaxis (PrEP) especially for AGYW who are part of key populations

In order to increase the cost-efficiency of programming for adolescent girls and young women costed standard operating procedures are under development for this population. These take into account prioritising those areas with the highest number of AGYW at high risk based on behavioural characteristics.

Access to primary and secondary education, parenting programmes for adolescent mothers and parents of adolescent girls, and social support and economic empowerment should be available for the most vulnerable adolescents with focus on their overall well- being, but are not the sole responsibility of the HIV programme.

There is a need to determine the mode of delivery of the national standard package for adolescent girls and young women involved in transactional sex or selling sex , and robust accountability mechanisms be established to monitor progress. Anecdotal evidence indicates that currently girls under the age of 18 that are involved in selling sex are not able to access condoms through female sex worker programming, while they can access these through programming for adolescent girls and young women.

In order to monitor the implementation packages for adolescents and young people the performance framework that was developed needs to be institutionalized. This should be accompanied by **regular surveys on outcomes related to the use of HIV prevention interventions among AGYW to obtain information on the effect of HIV prevention programming** for this population. This should also include the prevalence of gender-based violence (GBV), as there is a lack of recent data on these experiences.

National HIV Prevention Symposium, 3-5 May 2023, Palapye

## Adolescent boys and men: Focus on the provision of condoms and voluntary medical male circumcision

Since HIV prevalence among males 15-24 is low or moderate throughout all districts in the country, **there is a need to focus the current national standard package for boys and young men on basic services.** The UNAIDS population size estimates tool for adolescent girls and young women is currently extended to provide estimates for all young people and adults aged 15-49. The draft shows that incidence rates are highest among men 25-35 years, among men 15-49 years who are part of key populations and to a lesser extent those with non-regular partners, and vary by district. This **newly available data should be used to extend the basic HIV prevention packages to older men (25+ years) that are most at risk (based on age and sexual risk behaviour) and prioritise scale-up in locations with the highest incidence.**

**Basic package for boys and men – scale-up prioritized based on geography, age and risk behaviour**

HIV (self) testing, condoms, PrEP for those at high risk, PEP when needed, diagnosis and treatment of STIs and (referral to) VMMC. This should be supported by CSE and HIV prevention communication and demand creation, including the promotion of gender equitable norms and reduction of GBV

Men show poorer health behaviour seeking than women, e.g. among those 15-49 years 36.2% of males (not self-reported HIV positive) tested for HIV in the past 12 months, while this was 47.3% among females according to BAIS V data. In order to ensure that HIV prevention services reach boys and men, **HIV prevention services should be provided not only through (male friendly) static clinics (**both public and private)**, but also via mobile outreach at community level**, covering workplaces and other venues that boys and men visit (e.g., bars, clubs, places of worship, taxi ranks, markets) **as well as through virtual platforms**.

In order to reach VMMC targets, services need to reach greater numbers of uncircumcised boys and men, especially in those areas with the highest incidence and with a low circumcision rate, by improving demand creation – using the human-centred design approach that has been successfully piloted – and access. Since **stand-alone services** are currently most successful in **providing VMMC services**, these **should be scaled-up**. The VMMC strategy that is currently being updated should take the above into account as well as the results of the PSAT, and integrate cultural practices.

## Condom programming: Increase the supply and improve and diversify the distribution of male and female condoms and lubricants

Condoms remain a low-cost option for the prevention of HIV - but also of other sexually transmitted infections and unwanted pregnancy - especially for the large numbers of people in the country who are at moderate risk of acquiring HIV. Hence **it is important that promotion, demand creation and distribution for male and female condoms as well as lubricants is fast-tracked**, especially for new users and those at highest risk of HIV acquisition. Furthermore, there is need to **use the UNAIDS Condom Needs Estimation Tool to estimate the country needs and commodity costs.**

Besides successes achieved after the development of the National comprehensive condom programming strategy and costed implementation plan (2020-2023), several challenges remain in the condom programme pathway, most importantly: insufficient supply to fulfil the need as well as persistent stockouts of condoms; weak supply chain (incorrect distribution of available stock over different outlets (leading to stock outs in one place while condoms expire elsewhere); limited distribution channels and outlets preferred by users; supply of female condoms only in the public sector and no supply of lubricants in the public sector; monitoring and ensuring quality assurance of all condom including those in the private sector.

**There is an urgent need to strengthen quantification and forecasting of condoms based on use and demand** to improve procurement and supply of male and female condoms and lubricants. **A multi-year procurement and supply plan for condoms should be developed. The total market approach should be fully adopted to ensure availability and accessibility of male and female condoms, including lubricants, to the users throughout the country up to last mile supply:** using not only the public and private sectors, but also social marketing (e.g. community-based -led and non-governmental organisations), expand distribution channels for condoms and lubricants in and beyond the health facilities. The latter includes outlets (e.g. bars, taxi ranks), and peer and community-led distribution. In order to track distribution and uptake through each of these channels, **the logistics management information system (LMIS) including reporting by distributors and outlets should be strengthened,** including use of the electronic LMIS (eLMIS). Quality assurance of condoms should be extended to products offered by the private sector as this those are currently not tested in-country.

In addition to the abovementioned outlets, the country should make condoms and lubricants available in prisons and other closed settings, and consider the accessibility of condoms within schools/tertiary education.

Furthermore, condoms and other prevention commodities and communication materials should be available in a format that is accessible to people with disabilities.

## ARV-based prevention: Broader focus on antiretroviral-based prevention, including offering PrEP to populations at greatest risk

To ensure that all people living with HIV become virally suppressed, **current efforts in HIV testing and treatment need to continue through differentiated service delivery models to serve the needs of different populations**. **The use of self-testing should be strengthened (procurement, logistics, access, reporting).** Furthermore, in the prevention response limited attention is paid to the HIV prevention benefits of treatment, hence HIV prevention communication should have an increased focus on the message of undetectable = untransmittable, or U=U.

The new HIV guidelines to be released in November expand eligibility of the use of PEP as a prevention option to all possible exposures to HIV. Before that, PEP was only available for the management of survivors of rape and sexual assault and for reducing occupational risk, but not for use after unprotected sex or unsafe injecting of drugs or outside clinical settings. Awareness of this change should be raised among providers and potential users (which is also the case for self-testing as well as PrEP), and the supply needs to be aligned to the new demand. Data regarding the uptake of PEP within all settings should be collected and reported.

According to BAIS IV results, only 28.3% of adults 15-49 had ever heard of PrEP and 11.7% had ever taken it. Although **PrEP** should be available to all that request it as a HIV prevention choice, **coverage and uptake in all districts should be increased especially among those at highest risk:** all key populations (including male sex workers) and adolescent girls and young women involved in transactional sex, and their sexual partners, as well as those who engage in high-risk sexual activities (such as multiple concurrent partnerships) as per 2023 Botswana Integrated HIV Clinical Care Guidelines. To improve initiation and retention, these services should be implemented using differentiated service delivery models based on the 2022 WHO guidance on Differentiated and simplified pre-exposure prophylaxis for HIV prevention: integrating PrEP into existing service delivery platforms; advocate for inclusion of ART prescribing and dispensing module in pre-service training for nurses and medical doctors: introducing event-driven PrEP (ED-PrEP) for men having sex with men that have multiple partners; using multi-month dispensing through different channels. Furthermore, **the age of accessing PrEP services without parental consent should be reduced to 16 years** (currently 18 years and older, with exception of emancipated minors) in line with HIV-testing guidelines. The scale-up of PrEP at (sub)national levels should be guided by a target setting exercise, employing the PEPFAR PrEP-it or the UNAIDS PrEP target-setting tools for key and high-priority populations. Demand creation should specifically focus on the prioritized populations, and should take into account stigmatizing behaviours that discourage people from using PrEP services.

New forms of PrEP have become available and a submission for registration of long acting injectable PrEP (CAB-LA) in the country has been done in May 2023. Even though the Dapivirine vaginal ring (DVR) was registered in 2022 (recommended by WHO for women at substantial risk of HIV infection) it is not included in the guidelines due to its low efficacy of about 35-50%. Before rolling out and creating a demand for new PrEP options, there should be careful considerations with respect to the cost implications and prioritized populations.

# BOTSWANA'S 10-POINT ACTION PLAN TO REACH 2025 TARGETS

The Road Map addresses the need for a national HIV prevention plan to ensure coherence, effectiveness, and measurable outcomes in prevention activities. In order to do so the country set a total of **30** key overarching actions with related milestones, due dates and accountable entities for the ten priority action areas that are adapted from the global 2025 Road Map. The key priorities related to the five pillars are included here as well. These actions are aimed to address current prevention gaps and barriers to reach 2025 targets and get on track to end AIDS by 20**30**.

Table 1 presents the results of the GPC survey conducted in March 2023. The survey asks about some specific actions in line with the milestones in the global Road Map. Results show that the country is already doing well on five of the ten actions, in three areas more progress is needed, and especially in the areas of precision prevention approach and accountability for HIV progress more work needs to be done which is reflected in the actions below. However, the results should be interpreted keeping in mind that the survey asks about high level, strategic actions (including e.g. if certain milestones are developed), while the country actions listed below focus on working towards implementing these. Furthermore, some activities that are about to be completed are already included e.g. the current costed prevention plan as completed. Other activities have been done in the past, but need to be repeated with more recent data e.g. HIV prevention funding expenditure analysis. Annex Table 1 provides more detailed information on how each of the then actions was scored.

Table 1. Status of the global 10-point action plan for Botswana, March 2023

| ACTION POINT FROM THE GLOBAL HIV PREVENTION 2025 ROAD MAP | BOTSWANA STATUS<br>**March 2023** |
|---|---|
| 1. Data-driven needs assessment | |
| 2. Precision prevention approach | |
| 3. Define investment needs | |
| 4. HIV prevention leadership agencies | |
| 5. Expand community-led services | |
| 6. Remove social and legal barriers | |
| 7. Integration with related services | |
| 8. Introduction of new technologies | |
| 9. Real-time programme monitoring | |
| 10. Accountability for HIV progress | |

| | | | | | |
|---|---|---|---|---|---|
| | Done[2] | | Partially done / In progress | | Not done |

[2] The status is based on a limited set of activities in each area, however, the 30 key actions include other critical elements that the country should still address in these areas.

## 1 Data-driven needs assessment: ADDRESS DATA GAPS HAMPERING ASSESSING HIV PREVENTION NEEDS

In order to conduct a data-driven assessment of (sub)national progress in implementing HIV prevention programmes, data gaps need to be addressed. Once more data is available the country can create Prevention cascades to visualize the gaps in each step of the programming (reach and use of prevention services).

| ACTION | CURRENT STATUS (GAPS, BARRIERS) | MILESTONE (DUE BY) | ACCOUNTABLE ENTITY |
|---|---|---|---|
| Prevention targets should be developed at (sub)national level and should be monitored annually | The targets of the National Strategic Framework for HIV & Aids 2019-2023 (NSF III) (detailed in the National M&E plan) have been updated with BAIS V data | Prevention targets at (sub)national level set and subnational HIV prevention scorecards developed by March 2025 | MoH NAHPA |
| Ensure data-driven condom programming | Old data on the condom need, as well as distribution and uptake through all channels | National condom needs estimation completed using the UNAIDS CNET by March 2024 | NAHPA (UNAIDS, UNFPA) |
| Using technology to enhance HIV prevention interventions for young people (adolescent girls, young key populations). | Young people are difficult to reach with existing HIV prevention interventions | Multi-media and technology-based prevention programmes targeting adolescent girls and young key populations adapted and scaled-up by March 2025 | NAHPA Limkokwing University of Creative Technology SADC |


National HIV Prevention Symposium, 3-5 May 2023, Palapye

## 2 Precision prevention approach: ADOPT A PRECISION PREVENTION APPROACH

In order for prevention programming to be sustainable, service delivery (platforms and interventions) need to be tailored to the need of populations based on locations and individuals risk (people-centred precision prevention response).

| ACTION | CURRENT STATUS (GAPS, BARRIERS) | MILESTONE (DUE BY) | ACCOUNTABLE ENTITY |
|---|---|---|---|
| Improved - location and risk specific - programming for boys and men with a focus on reaching them with HIV prevention communication, HIV testing services, STI diagnosis and treatment, condoms and voluntary medical male circumcision, using the UNAIDS framework for male engagement in HIV | VMMC targets are not reached and there is a need for increased demand creation on HIV prevention services as per VMMC Strategy, integration with other services and virtual outreach. Newly available data should be used to prioritize scale-up of HIV prevention packages based on geography, age and sexual risk behaviour. The current National safe male circumcision strategy ended in 2022 | Social and behavioural change communication plan to reach boys/men with prevention messages and services developed & VMMC strategy revised, including programme and financial targets by March 2025 | MoH (Civil Society) |
| Use new HIV incidence data and global guidance to better target the HIV prevention service provision to adolescent girls and young women and male partners based on age and risk behaviour (with special focus on young key populations) | Applying the UNAIDS Decision making aide, it becomes clear that many adolescent girls and young women that are not at highest risk are currently reached with low cost-efficient interventions. At the same time, the response for male partners / boys and men should be more targeted. | New granular data used to operationalize the national standard packages for HIV services for adolescents and young adults to follow a precision prevention approach by March 2025 | NAHPA MoH (UNAIDS, UNFPA, UNICEF, USAID, Civil Society) |
| Establish the need for standardized (prevention) programming for people who use/inject drugs | There is limited data on people who use/inject drugs (e.g. drug use and other high risk behaviours, HIV prevalence, use of HIV services) despite some service provision being in place | People who use/inject drugs included in the bio-behavioural survey by March 2025 | MoH (USAID, TGF) |

## 3 Define investment needs: DETERMINE COUNTRY INVESTMENT NEEDS FOR HIV PREVENTION RESPONSES

To ensure sustainable financing for HIV prevention, current expenditure needs to be monitored, finances need to be managed well, and public financing for community-based services should be promoted. In due course financing for key and vulnerable populations needs to be increased (as these groups drive the epidemic) and be less dependent on donor funding. A transition *(to domestic funding)* readiness assessment is currently ongoing.

| ACTION | CURRENT STATUS (GAPS, BARRIERS) | MILESTONE (DUE BY) | ACCOUNTABLE ENTITY |
|---|---|---|---|
| Conduct regular analysis of HIV expenditure data to determine the level of expenditure for prevention (by pillar, by implementer, resource) to inform programme decision-making and financial target setting | In 2018/19 12% and in 2019/20 11% of HIV funding expenditure was for prevention (compared to a global target of 25%). In light of plateauing/decreasing donor funding, there is a risk that HIV prevention budget is cut to sustain HIV testing and treatment services. | A sufficient proportion of the HIV budget reserved for HIV prevention by March 2025 | NAHPA<br>MoH<br>(UNAIDS) |
| Improve financial management (absorption capacity) for HIV prevention, especially with respect to donor funding | Low absorption rates, especially for funding from donors who largely fund the prevention pillars (except condoms). This impacts on planning and execution of activities in communities | Donor fund coordination enhanced by establishing a dedicated mechanism to facilitate concerted efforts for the HIV response by end 2025 | NAHPA |
| Implement social contracting mechanisms to facilitate government funding for Civil Society implementers of HIV prevention services | Social contracting guidelines are currently under development – these will promote accountability, efficiency, and professionalism in service delivery by Civil Society organizations | Social contracting guidelines finalized by March 2024 and implementation started by March 2025 | NAHPA<br>MOH<br>Civil Society |

## 4 HIV prevention leadership agencies: HIV PREVENTION LEADERSHIP IN PLACE AT ALL LEVELS

The NSF III / National Operational Plan for HIV and AIDS 2021-2024 clearly lists the roles and responsibilities for key institutions in the coordination and implementation of a multi-sectoral HIV response[3]. This still holds for the HIV prevention Road Map. However, the structures for oversight and management of the HIV prevention response should be strengthened and effectively utilised, especially at sub-national levels.

| ACTION | CURRENT STATUS (GAPS, BARRIERS) | MILESTONE (DUE BY) | ACCOUNTABLE ENTITY |
|---|---|---|---|
| Include representatives from all HIV prevention key stakeholders (public sector/private sector/Civil Society/development partners) in the HIV prevention Technical Planning Group and related Technical Working Groups | Representation of the private sector, community-based and -led and non-governmental organisations and beneficiaries in HIV prevention technical planning/working is currently limited | Appointment of representatives from all HIV prevention key stakeholders not included in HIV prevention technical working group finalized & Terms of References for this group revised & quarterly meetings revived by March 2024 | NAHPA |
| Incorporate the District Multisectoral AIDS Committee (DMSAC) under NAHPA, for coordination, reporting and accountability purposes | District-level programming is very important in the precision prevention approach, but currently the DMSAC are not reporting to NAHPA so the latter does not have oversight of what is implemented and ensure alignment with national processes | District AIDS Coordinators incorporated under the NAHPA structure and coordination, standardized reporting and accountability mechanisms aligned by March 2024 | NAHPA |

National HIV Prevention Symposium, 3-5 May 2023, Palapye

[3] NAHPA is coordinating the non-health/community response through social contracting mechanism with CSOs. NAHPA also works with Ministry of Finance, Ministry of Education, Ministry of Youth Empowerment, Sport and Culture.

## 5 Expand community-led services: STRENGTHEN COMMUNITY-BASED AND -LED HIV PREVENTION SERVICES

In order to work towards reaching the global target of 80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community-led organizations, these should be strengthened in the country. This includes fostering partnerships with community-based and -led organizations, key populations, and affected communities to ensure their voices are heard, their needs are addressed, and their active participation is integrated into prevention strategies. There is a need for cost-effective platforms for services (e.g. UNAIDS key population trusted access platforms) and improving community-led monitoring and surveillance.

| ACTION | CURRENT STATUS (GAPS, BARRIERS) | MILESTONE (DUE BY) | ACCOUNTABLE ENTITY |
|---|---|---|---|
| Increase cost-efficiency of programming for female sex workers and men who have sex with men in communities in order to scale-up by adapting service provision packages and modalities to location and risk profile | Multiple organisations are each providing a limited number of services to the same key populations, requiring each to be present at all locations throughout the country. Costed SOPs for female sex workers and men who have sex with men programming are under development | SOPs for female sex workers and men who have sex with men* HIV prevention programming for community-based and -led organisations developed by March 2024 and implemented by March 2025<br>*These are currently developed for the two largest groups, development of SOPs for transgender people and people who inject drugs might follow in future. | NAHPA<br>MoH<br>Civil Society<br>UNAIDS<br>UNFPA<br>UNICEF<br>TGF<br>USAID |
| Collect data at community level and incorporate HIV prevention data from all sectors when reporting on progress in prevention programming to inform decision-making | There is no national community-led monitoring framework. HIV prevention data from different sectors are collected through different systems (which do not all report into the National Data Warehouse) | Strategic framework for community-led monitoring developed and the data used in regular programme reviews together with data from the public and private sector by March 2025 | NAHPA<br>MoH<br>Civil Society |
| Use community-based and -led and non-governmental organisations for social marketing of condoms to improve the last-mile supply | Although included in the National comprehensive condom programming strategy & Costed implementation plan (2020 – 2023) the TMA has not been implemented fully. Private sector is supported from quality assurance of products, market segmentation & targeting etc.), but social marketing left behind. | Total market approach fully implemented by piloting social marketing with community-based and -led and non-governmental organisations for a continuous flow of condoms and lubricants up to the last mile by March 2025 | NAHPA<br>Civil Society |

## 6 Remove social and legal barriers: REMOVE SOCIAL AND LEGAL BARRIERS TO HIV PREVENTION SERVICES

In order to reach the 10-10-10 global targets for removing societal and legal barriers to HIV services[4], changes in legal and policy frameworks are needed, as well as changes in the way key and vulnerable populations are treated by Society. A more comprehensive list of activities is included in the National Strategic Plan to Reduce Human Rights – Related Barriers to HIV and TB Services 2020 – 2025 which addresses human rights-related barriers faced by all key and vulnerable populations in the country.

| ACTION | CURRENT STATUS (GAPS, BARRIERS) | MILESTONE (DUE BY) | ACCOUNTABLE ENTITY |
|---|---|---|---|
| Lower the age for parental consent for accessing PrEP to 16 years, so that guidance is harmonized | The age for consenting to access HIV testing and PrEP without parental or guardian consent is 16 and 18 years, respectively, with certain exceptions. [Note that there are ongoing discussions on the correct age of parental consent, also for HIV testing.] | Policy brief for lowering the age for consenting to access PrEP services from 18 to 16 years developed by end 2025 | NAHPA<br>MoH<br>(UNAIDS, WHO, UNICEF) |
| Ensure that healthcare workers, law makers, members of the judiciary, police and other law enforcement personnel receive training on human rights and non-discriminative attitudes relating to key populations | Results of the people living with HIV Stigma Index 2.0 show considerable proportions of members of key populations avoided seeking health services because they were worried someone may learn of their sexual preferences or risk behaviour. There is currently a lack of funding for the delivery of human rights trainings | Increased funding obtained to conduct human rights trainings by end 2025 | NAHPA<br>Civil Society |
| Remove laws criminalizing sex work | Selling sex is prohibited by law which may impact health care seeking behaviour by those involved in selling sex | Policy brief to advocate for decriminalization of sex work developed by March 2025 | NAHPA<br>Civil Society |

[4] The 2021 UN Political Declaration on HIV and AIDS and the Global AIDS Strategy (2021–2026) require that countries undertake reforms so that, by 2025: Less than 10% of countries have legal and policy frameworks that lead to the denial or limitation of access to HIV-related services; Less than 10% of people living with HIV and key populations experience stigma and discrimination; Less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence.

## 7 Integration with related services: INTEGRATION OF HIV PREVENTION INTO RELATED SERVICES

To improve HIV prevention outcomes, it is important that HIV prevention services are provided at different service delivery points in order to increase the reach of people that need these services. Botswana already has a national strategy to integrate services for sexual and reproductive health rights and HIV and since 2018 UNFPA has been supporting the Ministry of Health to scale up the integration of Sexual Gender Based Violence Services.

| ACTION | CURRENT STATUS (GAPS, BARRIERS) | MILESTONE (DUE BY) | ACCOUNTABLE ENTITY |
|---|---|---|---|
| Promote the use of / create demand for condoms for three public health concerns: HIV, other STIs and unintended pregnancies | Condom use is moderate among AGYW and MSM, and low among FSW. There is a need for condoms to be promoted as an effective means to ensure sexual and reproductive health. | Condom focal persons (Health education and Promotion Officers) trained to promote condom use using the integrated condom curriculum by March 2025 | MoH<br>Civil Society |
| Integrate PrEP provision into out-patient departments, sexual and reproductive health services, ante-/postnatal care services, and also distribute PrEP via other outlets | PrEP is currently only available in ARV clinics where it can be prescribed by nurse practitioners. The new HIV guidelines to be disseminated in November 2023 will allow wider prescription/distribution. | New PrEP guidelines allowing prescription in other services implemented, and number of outlets that distribute PrEP increased by March 2025 | MoH |
| The new HIV guidelines to be disseminated in November 2023 will make PEP available for all high risk exposures (e.g. condom bursts) | PEP can currently only be prescribed for use after occupational exposures and survivors of rape | New PEP guidelines implemented that allow prescribing for all high risk exposures by March 2024 | MoH |
| Include a minimum package of HIV prevention commodities in prison health care services as well as schools/tertiary education | Limited provision of prevention commodities in prisons and other closed settings, as well as schools/tertiary education | Policies amended that allow for distribution of prevention commodities (HIV testing, PEP, condoms and lubricants) in prisons and ) schools/tertiary education by end 2025 | MoH<br>NAHPA |

## 8 Introduction of new technologies: ADOPTING NEW HIV PREVENTION COMMODITIES AND SERVICE DELIVERY PLATFORMS

As new HIV prevention technologies become available over time, these will need to be registered, implementation needs to be piloted, costs assessed and further rollout conducted.

| ACTION | CURRENT STATUS (GAPS, BARRIERS) | MILESTONE (DUE BY) | ACCOUNTABLE ENTITY |
|---|---|---|---|
| Scale up the use of HIV self-testing among key populations and other high risk populations (and partners) that are hard to reach by regular HIV testing services | There is a severe shortage of HIV self-test kits. There also have been persistent stockouts of other commodities (male and female condoms and other contraceptives). | Quantification and forecasting of required quantities of HIV self-testing kits, male and female condoms and other contraceptives strengthened to ensure sustainability of supply by end 2025 | MoH |
| Fasttrack adoption, implementation and asses the use of injectable ARVs for prevention | Registration for CAB-LA has been filed by ViiV Healthcare, rilpivirine is in the process of being registered to be used as an injectable ARV | Implementation of injectable ARVs for prevention piloted and the cost-effectiveness in the country assessed by end 2025 | MoH |
| Increase the initiation and retention on ARV-based prevention (PrEP among key populations and others at high risk of HIV acquisition and ART for people living with HIV) | Implementation of differentiated service delivery models for PrEP and ART is limited (private pharmacy model, e-lockers, drone delivery system, other alternative pick-up points) | Range and number of differentiated service delivery models for ARV-based prevention that are implemented increased by end 2025 | MoH<br>Private sector<br>Civil Society<br>Development partners |
| Rollout telemedicine / virtual platforms for HIV prevention for all populations. [This should be accompanied by increased internet connectivity for facilities.] | Small scale use of QuickRes (online reservation and case management tool) for ARV clinics | QuickRes for HIV prevention purposes rolled-out (outreach - risk screening, prevention service recommendations and clinical service booking options) by end 2025 | MoH<br>Civil Society<br>Developmental partners |

## 9 Real-time programme monitoring: SYSTEMS FOR ROUTINE HIV PREVENTION MONITORING IN PLACE

The country has a National Monitoring and Evaluation Plan that is linked to the National Operational Plan for HIV and AIDS. When specifically looking at HIV prevention, in order to regularly establish progress in programming, prevention coverage and outcome indicator data ideally needs to be collected on an individual level, across all service providers in a uniform way. [Note that there are also more general barriers hindering improvement of routine prevention monitoring like electricity problems and lack of internet connectivity for facilities and organisations.]

| ACTION | CURRENT STATUS (GAPS, BARRIERS) | MILESTONE (DUE BY) | ACCOUNTABLE ENTITY |
|---|---|---|---|
| Implement the Government Digitalization project | There are multiple instances of DHIS at programme level that are feeding into the national DHIS | Centralised database for all programs at all levels developed by March 2025 | MoH |
| Report district level aggregated data by age, gender, and key population status at both district and national level | The District Health Information System (DHIS2) does not collect data by key population status or for adolescent girls and young women. Having age, gender-specific and KP data on district level is important to adapt programming for different locations. | Data collection tools (manual and electronic) updated to collect adequately disaggregated data by age, gender, key population status, location) status by March 2025 and implemented by end 2025 | MoH<br>NAHPA<br>WHO |
| A performance framework including indicators and targets to track implementation progress and performance of the response for adolescents and young people has been developed but not implemented consistently | There is limited data on HIV and sexual and reproductive health services use among adolescents and young people. | Use of the harmonized monitoring and reporting framework for adolescents and young people institutionalized by March 2024 | NAHPA<br>MoH<br>UNICEF |

## 10 Accountability for HIV progress: HOLD ALL STAKEHOLDERS ACCOUNTABLE FOR HIV PREVENTION MILESTONES

This Road Map is backed up by the government's strong political will and commitment towards HIV prevention. Listed actions should be implemented to drive the prevention agenda forward and ensure effective utilization of the dedicated budget for HIV/AIDS. It is important to monitor if these milestones are reached by the indicated deadline and if not, discuss the way forward with the accountable entity.

| ACTION | CURRENT STATUS (GAPS, BARRIERS) | MILESTONE (DUE BY) | ACCOUNTABLE ENTITY |
|---|---|---|---|
| Develop a sound accountability framework (as per global Road Map guidance) to achieve clarity and transparency about the commitments and responsibilities of all stakeholders in the response. | Accountable entities have been identified by country stakeholders for each of the 30 milestones included in this Road Map under the ten-point action pan, but an overall accountability framework is currently lacking. | Detailed accountability framework at all levels for HIV prevention developed by March 2024. | All stakeholders led by NAHPA |
| Monitor the national and district implementation of the country Road Map (from both technical and financial perspective) and hold the entities for each of the actions accountable | The NSF III / National Operational Plan for HIV and AIDS 2021-2024 indicate institutional arrangements for coordination and implementation, but a clear accountability framework is missing | Progress on the implementation of the Road Map monitored at a quarterly basis, weaknesses identified and corrective steps documented, starting from March 2024 (on-going) | All stakeholders led by NAHPA |


National HIV Prevention Symposium, 3-5 May 2023, Palapye

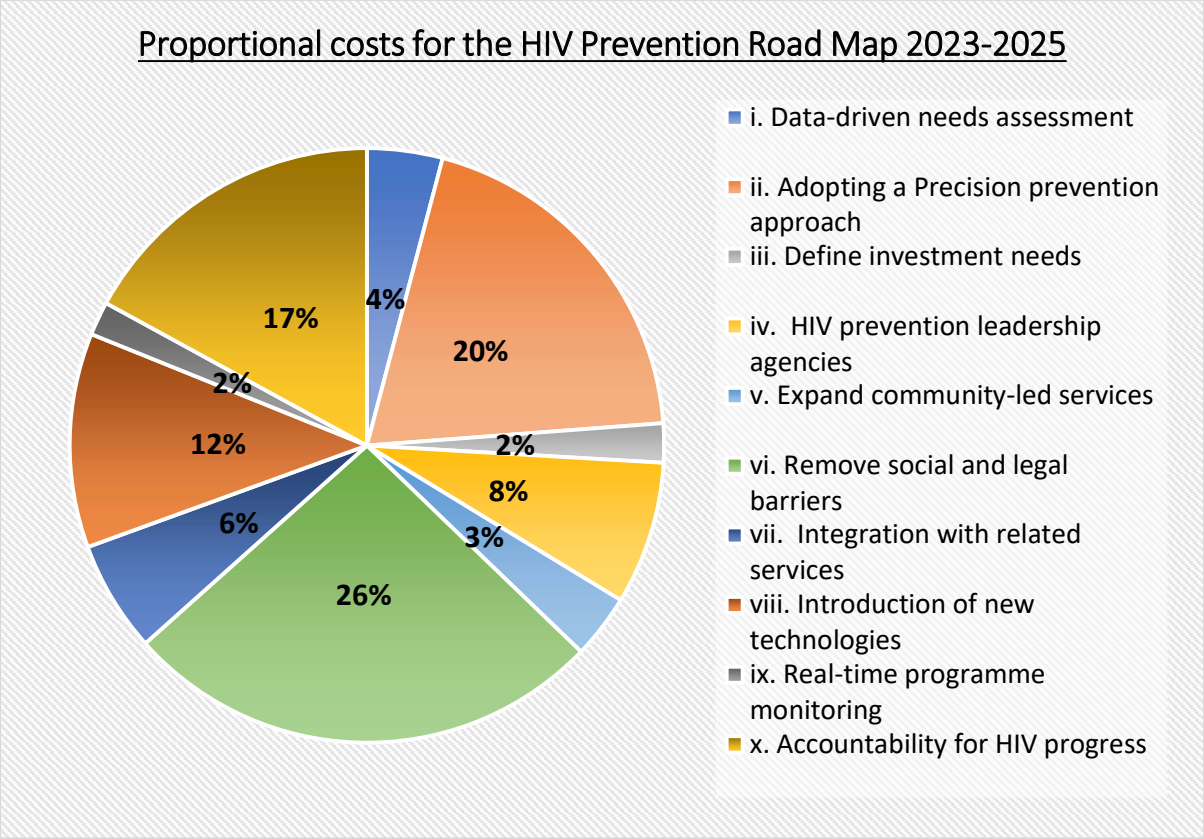
# COSTING OF THE ROAD MAP

The process of costing this prevention Road Map was widely consultative, beginning with a review of the HIV & AIDS Basic Service Package (HABSP) costs which utilized economic based costing (estimates) and gradually shifting to activity-based costing. Population size estimates and quantities were derived from the latest available Spectrum estimates, IBBS data, and data from MoH, MoE, PEPFAR COP 22, UNAIDS, Civil Society and other implementing partners from active programmes within the country. This included the input of programme managers within government, partners and communities. Where data was not readily available, for example for innovative activities and technologies, information was sought from the originators of these technologies. Best practices implemented at regional level and not yet implemented in Botswana were estimated using assumptions at regional level adapted to Botswana's context and using local unit costs. Costs for this prevention Road Map 2023-2025 should be read as a subset of the national HIV programme costs. The cost of Botswana's 10-point action plan is estimated at $32.6 million over three years. This in addition to the treatment and other commodity costs. This cost will include $11.6 million during the fiscal year 2023-2024, with about 40% of the costs related to startup costs. The second (2024-2025) and third (2025-2026) year costs are estimated at $10.5 million each.

| Botswana's 10-point Action Plan to reach 2025 Targets (USD) | 2023 | 2024 | 2025 | 3 YEARS |
|---|---|---|---|---|
| 1. Data-driven needs assessment | 717,800 | 309,200 | 310,384 | 1,337,384 |
| 2. Precision prevention approach | 542,313 | 2,979,694 | 2,893,231 | 6,415,238 |
| 3. Define investment needs | 263,996 | 163,996 | 263,996 | 691,989 |
| 4. HIV prevention leadership agencies | 1,967,000 | 281,700 | 287,334 | 2,536,034 |
| 5. Expand community-led services | 441,904 | 342,141 | 348,984 | 1,133,029 |
| 6. Remove social and legal barriers | 2,759,804 | 2,842,598 | 2,927,876 | 8,530,277 |
| 7. Integration with related services | 689,500 | 689,500 | 594,500 | 1,973,500 |
| 8. Introduction of new technologies | 1,880,672 | 1,003,072 | 912,373 | 3,796,117 |
| 9. Real-time programme monitoring | 427,625 | 81,000 | 92,875 | 601,500 |
| 10. Accountability for HIV progress | 1,904,401 | 1,806,184 | 1,838,757 | 5,549,342 |
| **Total HIV Prevention Road Map** | **11,595,015** | **10,499,084** | **10,470,311** | **32,564,410** |

The cost of implementing the HIV prevention Road Map will amount to roughly 6% of Botswana's current annual HIV programme spend but is expected to boost incidence reduction through the adoption of precision prevention, removing human rights and social barriers, integrating new technologies and adopting community-led programming for key populations, among other measures.

The chart provides proportional costs for implementation of the Road Map, out of which 26% and 20% will be required to continue efforts for removing social and legal barriers and adopting a precision prevention approach, respectively. Other major cost items will comprise expanding accountability for HIV progress, and introducing new technologies, which will account for 17% and 12% of the costs, respectively.




Major cost drivers within the continuing programme to remove social and legal barriers include reducing gender inequality, harmful gender norms and sexual- and gender-based violence, continued support to the human rights and health unit under MoH and partners, addressing and reducing stigma and discrimination against people living with HIV and/or TB, key and other vulnerable populations. Main cost drivers within the precision prevention approach include improved location and risk specific programming for boys and men, adolescent girls and young women and key populations with a focus on reaching them with HIV prevention communication, HIV testing services, STI diagnosis and treatment, condoms, and VMMC, using the UNAIDS framework for Male Engagement and the Decision-making Aide for Adolescent Girls and Young Women. Investments will be required to map higher risk populations more precisely across the 27 health districts, schools and communities, add service delivery sites, providing infrastructure, outreach, human resources and new technologies. Detailed costing information is available on request from the UNAIDS country office.

**Attaining Value for Money and Sustainability**

Attaining value for money in this instance implies that investments in HIV prevention will progressively be made more efficient, economical, effective and equitable. Sustainability here refers to domestic stakeholders' (government, local private sector and civil society) ability to maintain impactful programmes at optimal funding and coverage levels even after development partner transitioning out. This section focuses on allocative efficiency and economy, since "Equity" is assumed to be implicit in the Road Map as it seeks to ensure that missing populations are covered, including key populations, high risk adolescent girls and young women and their male partners or clients. "Effectiveness" (or attainment of desired impact and coverage results) is implicit in the allocative efficiency discussion since allocative efficiency compares amounts spent to results.

**Sustainability:** Sustainability of the HIV prevention programme will be attained through increased domestic ownership by way of transition planning, progressive integration and individualisation of the precision prevention approaches in more public health facilities across the country and community units (CBOs, key population networks, communities, drop-in centres, schools and safehouses) located in various regions. Progressive transition of the HIV programme financing to domestic resources will also ensure increased ownership of the response. Standard Operating Procedures for service provision by CBOs to sex workers, men who have sex with men and adolescent girls and young women are in development, which seek to integrate the programmes into collaborative, domestically-led planning structures.

**Operational efficiency:** Operational efficiencies in general service delivery will be attained through economies of scope and scale:

1. By ensuring that optimal numbers of key populations and the most vulnerable populations receive comprehensive prevention packages in nearby or mobile drop-in centres (DICs) or schools, with scale up beginning in higher incidence-higher density areas of the North and East of the country within the first year, and gradually moving to the lower incidence-lower density areas in the south and west of Botswana.
2. The ability to reach all populations including key populations and adolescent girls and young women and their male partners/clients with a menu of services, close to where they live and work, results in a high level of operational efficiency. The DICs are a one-stop centre, located in strategic areas based on a user-centred design, able to attract the hardest-to-reach and most vulnerable populations.
3. Maximizing prevention efforts and infrastructure among key populations and adolescent girls and young women and their male partners/clients who may comprise upwards of 75% of new infections currently.[5]
4. Focusing on the five prevention pillars; integrating and individualizing the response.
5. Reducing the ratio of clients to peers, and optimizing services beginning with higher incidence-higher density geographical areas.
6. By continuously monitoring the programme and increasing the uptake of lower cost, high-yield programme modalities, including testing methods such as self-testing, and ensuring availability of a broad range of service packages in the same site. Testing yields of above 15% for both sexes have been achieved through index case testing and partner notification (PNS), and social networking services with e.g. female sex workers, men who have sex with

[5] Spectrum 2022, UNAIDS Epidemic Update - Sub Saharan Africa (2022)

men. All services including laboratory tests such as test for hepatitis B, which is a pre-requisite for initiation of PrEP, are free to clients. DICs and the surrounding community programme play a crucial role in epidemic control.

7. Increasingly task sharing with communities. CSOs play important roles in reaching key populations through strong referral linkages such as peers and outreach workers and ensuring referrals to biomedical services, in SBCC and in the provision of youth friendly services, often at lower costs.

**Allocative Efficiency:** While a focused allocative efficiency study is yet to be performed, a 2021 study[6] modelled on Botswana 's current HIV strategy and levels of financing found that prevention services in Botswana have comparatively high unit costs compared to the region's, making them less attractive investment options unless efficiencies can be gained through changes in how they are delivered. This was the case for including HIV prevention programmes for female sex workers ($253 according to HABSP) and for men who have sex with men ($166); and VMMC ($238). It recommended a reduction in unit costs for female sex workers programming and VMMC by 25% and a 63% reduction in men who have sex with men programming unit costs. However, unit costs were then calculated using much lower targets than GAS target numbers of key populations and vulnerable populations (given the historical gaps in coverage) a fact that may have augmented the costs per person reached in these populations. For example, due to data reliability and availability issues especially at community level, the number of female sex workers were previously estimated through the IBBS / Achap studies at 6,700 and the number of men who have sex with men at 2,000, while programmes (PEPFAR COP 22) now estimate their respective numbers at 22,000 and 16,000 respectively. Still, allocative efficiencies ought to be continually sought.

Since the Road Map costing is additional, and only seeks to optimize the effect of existing prevention and treatment programmes, this section analyses the additional or "Marginal" cost per infection averted, rather than the cost.

A rapid (2023) modelling assuming 2025 targets are met (with ART coverage at 98%, PrEP at 90%, VMMC at 90% and condoms use at 98%), using the combination prevention fractal[7] shows that the incidence of new infections could be reduced from 0.0032 to between 0.001 and zero. This means that close to 3,791 additional new infections could be averted according to the latest available data (Spectrum Naomi, December 2022). If 90% of new infections (mean) are averted through additional actions in the Road Map, this would amount to 3,574 new infections. At an average cost of $10.8 Million, assuming all components have a similar weighting, the interventions that add the least cost per infection averted include real time programme monitoring for increased precision prevention (additional $56 per infection averted), defining investment needs through activities such as landscaping analyses, improving allocative efficiency, equity and engagement of all sectors (additional $65), expanding community-led services ($106), data driven needs assessment ($124) and integration at ($184) as shown on the table.

[6] Improving the Allocative Efficiency of the HIV Response in Botswana: Findings from an Optima HIV Modeling Analysis. Washington DC: World Bank. License: Creative Commons Attribution CC BY 4.0

[7] Replacing VM in the model with condoms delivered through SBCC.

| 10 Point action plan per intervention | Annual Average cost (USD) | Marginal cost per new infection averted (USD) |
|---|---|---|
| 9. Real-time programme monitoring | 200,500 | 56.10 |
| 3. Define investment needs | 230,663 | 64.54 |
| 5. Expand community-led services | 377,676 | 105.67 |
| 1. Data-driven needs assessment | 445,795 | 124.73 |
| 7. Integration with related services | 657,833 | 184.06 |
| 4. HIV prevention leadership agencies | 845,345 | 236.53 |
| 8. Introduction of new technologies | 1,265,372 | 354.05 |
| 10. Accountability for HIV progress | 1,849,781 | 517.57 |
| 2. Precision prevention approach | 2,138,413 | 598.32 |
| 6. Remove social and legal barriers | 2,843,426 | 795.59 |
| Total HIV Prevention Road Map | 10,854,803 | |

It is important to note that since the weighting has not been varied to match the individual contribution of each intervention to averting new infections, the interventions that add the least may not necessarily contribute the most to averting new infections, unless where previous reports / studies have arrived at this conclusion, for example in the case of community-led service delivery, integration and removing barriers. The information should therefore only be used for allocation purposes, where lower cost items can be funded entirely, while higher cost items can be prioritized geographically, for instance where stigma, criminalization, violence and incidence are highest.

# Annex 1 – Tables and Figures

Table 1. Detailed status of the global 10-point action plan for Botswana, March 2023

| 2025 HIV Prevention Road Map Action | Road Map Baseline Survey components considered for overall Road Map Action scoring | Botswana |
|---|---|---|
| 1. Data-driven needs assessment | > HIV prev response epidemic patterns analysis | |
| | > Consultation meetings to identify barriers | |
| | > Listing of the identified barriers | |
| | Overall | |
| 2. Precision prevention approach | > developed a prevention Road Map or plan | |
| | > Set granular HIV prevention targets | |
| | > Translate national targets to subnational targets | |
| | > Differentiated HIV prevention packages | |
| | > Packages for AGYW where relevant | |
| | > SOPs or implementation guides in place for relevant pillars | |
| | Overall | |
| 3. Define investment needs | > Budget/costed HIV prevention plan | |
| | > Dialogue to address prevention funding gap | |
| | | |
| 4. HIV prevention leadership agencies | >Multi-sector HIV prevention leadership exist | |
| | >The entity is functional shown by meetings held | |
| | >Milestones developed to reinforce HIV prevention leadership entities | |
| | Overall | |
| 5. Expand community-led services | >government convening of relevant communities | |
| | >Public funds being allocated to NGOs | |
| | >Any laws or policies impacting NGOs | |
| | >Any targets set on community-led services | |
| | >Milestones on community-led services | |
| | Overall | |
| 6. Remove social and legal barriers | >Legal, policy and strutural barriers in strategy | |
| | >Milestone to addess the barriers | |
| | Overall | |
| 7. Integration with related services | >Integration milestone developed | |
| | >Are the milestones listed | |
| | Overall | |
| 8. Introduction of new technologies | >Actions for new prevention technologies | |
| | >Milestone on new prevention technologies | |
| | Overall | |
| 9. Real-time programme monitoring | >Data triangulationfor coverage of programmes | |
| | >Developed subnational Scorecards? | |
| | >HIV prevention funding expenditure analysis done? | |
| | >Cost-effectiveness in programe reviews | |
| | Overall | |
| 10. Accountability for HIV progress | >Table3 of the 2025 Road Map followed | |
| | >Accountability framework in line with Road Map | |
| | Overall | |

| | Done[8] | | Partially done / In progress | | Not done |
|---|---|---|---|---|---|

[8] The status is based on a limited set of activities in each area, however, the 30 key actions include other critical elements that the country should still address in these areas.

Figure 1. Botswana Global HIV prevention coalition country scorecard 2022

| Botswana | BWA | Based on most recent available data. | Version | 2.02. | 2022 |
|---|---|---|---|---|---|

**Output (coverage)**

| | |
|---|---|
| **Condoms** | |
| Number of condoms distributed and sold / year (in millions) | 17 |
| Number of condoms distributed/sold per couple-year (age range 15-64) | 24 |
| Estimated condom distribution need met (%) | id |
| **Voluntary medical male circumcision (VMMC)** | |
| Number of VMMCs performed / year (in thousands) | 4 |
| % of annual VMMC target achieved | 6 |
| | |
| **ARV-based prevention** | |
| Composite PrEP score (0-10) | 8 |
| Number of people who received PrEP at least once in the past 12 months | 9064 |
| % of PLHIV on ART | 92 |
| **Key populations** | |
| *Sex workers (SW)* | |
| Population size estimate for sex workers | 6700 |
| % of SWs who received at least two HIV prevention interventions (past 3 mo) | 90 |
| Prevention strategy includes core elements of SW prevention package | > Half |
| *Gay men and other men who have sex with men (MSM)* | |
| Population size estimate for men who have sex with men | 2600 |
| % of MSM who received at least two HIV prevention interventions (past 3 mo) | 75 |
| Prevention strategy includes core elements of MSM prevention package | < Half |
| *People who inject drugs (PWID)* | |
| Population size estimate for people who inject drugs | id |
| % of PWID who received at least two HIV prevention interventions (past 3 mo) | id |
| Prevention strategy includes core elements of PWID harm reduction package | None |
| *Structural barriers and enablers* | |
| Criminalization of sex work | Yes |
| Criminalization of same-sex sexual acts | No |
| Criminalization of drug use/consumption or possession for personal use | Yes |
| Criminalization of transgender people | No |
| **Adolescent girls, young women (AGYW) & partners in high-HIV incidence settings** | |
| % of priority locations/districts with dedicated programs for AGYW & partners | 33 |
| Educational policies on HIV & sexuality education (secondary school) | Yes |
| Laws requiring parental consent for adolescents to access HIV testing services | Yes, <16 |
| Provider-initiated condom promotion integrated into SRH services | Yes |
| HIV testing services integrated with SRH services | Partial |

**Outcome (service use/behaviour)**

| | | | |
|---|---|---|---|
| Condom use with non-regular partners (%) | Women 15-49 | 70.0 | |
| | Men 15-49 | 78.1 | |
| | | | |
| % of 2020 VMMC target achieved | Men | 29 | |
| National male circumcision prevalence (%) | Men 15-24 | 66.7 | |
| | Men 15-49 | 48.4 | |
| % of national PrEP need met | All pop. | id | |
| % of PLHIV virally surpressed | Women 15+ | 94 | |
| | Men 15+ | 86 | |
| Condom use / last paid sex (%) | Sex workers | 76 | |
| | Men 15-49 | id | |
| % on ART | SWs LHIV | 88 | |
| Condom use / last anal sex (%) | MSM | 78 | |
| % on ART | MSM LHIV | 74 | |
| | | | |
| % with safe injecting practices | PWID | id | |
| % on opioid substitution therapy | | id | |
| % on ART | PWID LHIV | id | |
| % of people who avoided health care because of stigma and discrimination | Sex workers | id | |
| | MSM | id | |
| | PWID | id | |
| | Transgender | id | |
| Condom use with non-regular partners (%) | Women 15-24 | 68.7 | |
| | Men 15-24 | 82.0 | |
| % who completed lower secondary education | Girls | 92 | |
| % of women experienced physical or sexual violence from husband/partner | Women 15-19 | id | |
| | Women 15-49 | id | |

**Impact**



**HIV prevalence**

| | | | |
|---|---|---|---|
| Sex workers <25 years | id | | |
| Sex workers all ages | 42,2 | | |
| MSM <25 years | id | | |
| MSM all ages | 14,8 | | |
| PWID <25 years | id | | |
| PWID all ages | id | | |
| Women 15-24 | 6,6 | | |
| Men 15-24 | 3,5 | | |
| Adults, 15-49 | 18,6 | | |

**Summary Scores**

| | |
|---|---|
| AGYW | |
| 3 | |
| Sex workers | |
| 7 | |
| MSM | |
| 8 | |
| PWID | |
| id | |
| Condoms | |
| id | |
| VMMC | |
| 2 | |
| ART | |
| 9 | |
| PrEP | |
| 8 | |

Note: The scorecard has been manually updated with data on condom use and voluntary medical male circumcision prevalence using 2021 BAIS V results.