African Collaborative
For Health Financing
Solutions

Landscape Analysis
Botswana
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Abbreviations

ART    Antiretroviral Therapy
ACS    African Collaborative for Health Financing Solutions
ARV    Antiretroviral
BOMaid Botswana Medical Aid Society
BPOMAS Botswana Public Officers Medical Aid Scheme
BWP    Botswana Pula
DEA    Data Envelopment Analysis
DHMT   District Health Management Teams
NRH    National Referral Hospitals
EHSP   Essential Health Services Package
GDP    Gross Domestic Product
GoB    Government of Botswana
HFG    Health Finance and Governance
HFTWG  Health Financing Technical Working Group
IHSP   Integrated Health Services Plan
IT     Information Technology
MAS    Medical Aid Schemes
MoHW   Ministry of Health and Wellness
NACA   National AIDS Coordinating Agency
NBFIRA Non-Bank Financial Institutions Regulatory Authority
NCD    Non-communicable Diseases
PFM    Public Financial Management
PPME   Policy Planning Monitoring and Evaluation
PPP    Public Private Partnership
SMT    Senior Management Team
UNAIDS Joint United Nations Program on HIV/AIDS
UNICEF United Nations Children’s Fund
USAID  United States Agency for International Development
WHO    World Health Organization
SHOPS  Strengthening Health Outcomes through the Private Sector
PSA    Private Sector Assessment
SI     Strategic Information
1. Introduction

1.1. Background

The African Collaborative for Health Financing Solutions (ACS) is a five-year USAID-funded project that seeks to advance UHC in SSA. More specifically, ACS works with countries to help them identify operational challenges to advancing implementation of health financing policies that support movement towards UHC, and to support building multi-stakeholder processes and collective solutions in and among countries, including developing targeted learning agendas, communications opportunities and advocacy and accountability activities. ACS sees a key role for regional organizations to work in tandem with countries to help support them to reach their goal by leveraging their unique convening power, position, and potential to advocate and spur more accountability to commitments. ACS aims to bolster capacity at the country and regional level to build stronger linkages between countries and both traditional regional institutions and some of the newer regional networks and dynamic approaches, to apply knowledge and evidence-based solutions that advance implementation.

ACS Botswana, one of ACS’ implementation countries, is a 2-year USAID-funded project focused on assisting the Government of Botswana to advance UHC and ensure sustainability of gains made in the health. More specifically, ACS will work the Government of Botswana (GoB) to help identify operational challenges to advancing implementation of health financing policies, including HIV/AIDS sustainability strategies and policies that support movement towards UHC. ACS believes that Sustainable Financing for HIV/AIDS response is central to achieving UHC in Botswana, as such, ensuring financial and programmatic sustainability of HIV/AIDS programs and services requires taking a view of implementation that moves beyond intervention-specific technical assistance and aligns with and feeds into broader health systems and UHC efforts at the country level.

Working with the government, other in-country stakeholders, SFI and the USAID Botswana Mission, ACS will support in-country platforms and capacity building of local actors to implement a series of activities related to sustainable financing of HIV/AIDS and the health system. Through this work in Botswana, and at the regional level, ACS will support the achievement of a set of technical goals related to HIV/AIDS sustainable financing and the health system situated within the context of national UHC and sustainability objectives. This work will primarily be carried forward by supporting country-level actors through inclusive, evidence-based multi-stakeholder processes to ensure ongoing health financing activities are achieved in a collaborative, efficient and ultimately sustainable fashion.

Building out from in-country consultation process to landscape and leverage USAID implementing partners’ and other efforts, ACS will work with existing platforms at the country level to organize and implement activities, encouraging broadening representation and inclusion from across vested groups where strategic and based on stakeholder mapping. ACS will provide ongoing facilitation support as well as targeted technical support and complementary accountability and monitoring for interventions as appropriate to strengthen implementation. ACS will also nurture regional learning between Botswana and Namibia, and other countries working on similar challenges to stimulate progress and problem-solving.

In addition, ACS sees a key role for regional organizations to work in tandem with countries to help support them to reach their goals by leveraging their unique convening power, position,
and potential to advocate and spur more accountability to commitments. ACS aims to bolster capacity at the country and regional level to build stronger linkages between countries and both traditional regional institutions and some of the newer regional networks and dynamic approaches to apply knowledge and evidence-based solutions that advance implementation.

As a starting point, ACS identified the need to conduct landscape analysis of ongoing or recently completed UHC, health financing, including relevant HIV/AIDS activities. The process of the development of this landscape analysis includes a desk review of published documents and consultations with key stakeholders on current and past analysis and planned activities on UHC, health financing, including relevant HIV/AIDS sustainable financing activities. This landscape analysis is also informed by the ACS project scoping held in July 2018 and the Health Finance and Governance Project handover mission held in September 2018.

This landscape analysis aims to:

- Provide a comprehensive architecture of UHC, health financing, including HIV/AIDS sustainable financing in Botswana.
- Inform the development of ACS Botswana work plan activities.
- Form the basis for identifying potential partners for the ACS project.

### 1.2. Country Context

Botswana is an upper middle-income country in Southern Africa, with a sparsely distributed population of 2,266,857 and a per capita GDP of US$ 7140.47 in 2017. As one of the rapidly growing economies in the Sub Saharan African region, the country experienced rapid economic growth and has used its strong macroeconomic environment to build social protection programs that are fully financed from own resources leading to improved living conditions, reduction in poverty and improved access to social services including health. However, despite these noteworthy improvements, Botswana remains one of the countries with high inequality, with the Gini Coefficient increasing over the years, standing at 0.49 in 2009/10 and 0.60 in 2015. Poverty also remains high for an upper middle-income country, with nineteen percent (19%) of the population categorized as poor, and 16% living in absolute poverty.

#### 1.2.1. Health Sector Context

##### 1.2.1.1. Health Service Delivery

Botswana runs a pluralistic health care system (a mix of public, private and Non-Governmental Organization provision). The public sector dominates the health system, with more than 80% of services accessed through a network of public health facilities based on the primary health care model. About 96 percent of the population lives within an eight-kilometer radius of a health center. The greatest challenge to UHC remains in rural areas, where improved access has not necessarily translated to utilization of high-quality services. Coverage in rural areas is estimated at an average of 89 percent of the population living within the 8km radius to the nearest health facility compared to urban areas with 96%. In view of the strong financial protection that the government offers to its citizens, there is potential for improving utilization of services and high-quality interventions, implying that Universal health coverage (UHC) is a real possibility in Botswana. The public health care delivery system comprises of six levels -

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4. Republic of Botswana, Ministry of Health (2009), National Health Service Situational Analysis
national referral hospitals (3 in Botswana – 1 hospital being a psychiatric hospital), district hospitals, primary hospitals, clinics, health posts and mobile stops. A 450 bed Medical Teaching Hospital is expected to open in March 2019\(^6\). There are limited public sector health care services (including clinics and health posts) for specific subpopulations, such as the Botswana Defense Force (BDF), Police, and Prisons services.

The private health sector market comprises mainly of people covered under voluntary Medical Aid Schemes (MAS), where approximately 18% of population is insured by MAS, majority of which are in urban areas. Perceived low quality of health care services and long waiting periods in the public sector are associated with demand for services in the private sector. There are strategies in place by the government to create greater opportunities for the growth of private health sector role. The HIVAIDS epidemic is one of the programs which created strong incentives for government to partner with the private sector. One key example of these has been the expansion of access to HIV treatment through Public Private Partnerships (PPPs) model. Through the ART PPPs model, government provided ARVs to MAS, then MAS would package and label for each patient and deliver to providers, then uninsured accessed ART drugs through private providers who were then reimbursed through MAS. MAS also provides ART cover through the private sector facilities to their members. Private sector also plays a role in health commodities through distribution, warehousing, dispensing pharmaceuticals and laboratory services.\(^7\)

1.2.1.2. Health Service organization and Management
The Ministry of Health and wellness (MOHW) is responsible for health sector stewardship, responsible for oversight and coordination of the health service provision, including the formulation of policies, regulations and norms, standards and guidelines for health services. In 2010 primary health care services were relocated from the Ministry of Local Government and Rural Development (MLGRD) to the MOHW, in an effort to increase efficiency and also to ensure a continuum of care from preventive to curative to rehabilitative services (through more effective referral mechanisms). This reorganization and the relocation of primary health care made the MOHW the country’s main public sector health care provider, with more than 80 percent of people receiving care from public facilities and programs. As part of the devolution of authority, there are 27 District Health management Teams (DHMTs), responsible for the planning, implementation, management, and provision of primary health care services, in addition to the monitoring and evaluation of all services from the primary level (Community Based Services, Primary Hospitals, and Primary Health Centers/Clincs) to district hospitals. The DHMT’s network of health facilities include, the District and Primary Hospitals, clinics, health posts and mobile stops, as well as community-based health prevention and health promotion services.

1.2.1.3. Health Financing Context
Botswana’s rapid economic growth has enabled the country to invest substantially in the health sector. The government is the major source of financing providing 65% of Total Health Spending (THE), employers 16 %, households 12% and donors 7%. Per capita spending on health increased from Int$270 (BWP 348) in 1995 to Int$851(BWP 1491) US$428\(^8\) in 2013 while THE as a share of GDP was 6.3%. Government health spending as a percentage of total general government expenditure was 12% while household direct out of pocket spending for health (OOPs) was 4.2% of THE\(^8\). Although the OOPs remains low in Botswana the extent to

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\(^6\) Republic of Botswana 2018 State of the Nation Address
\(^7\) Strengthening Health Outcomes through the Private Sector (SHOPS) (2013)
\(^8\) Republic of Botswana (2016), 2013/14 National Health Accounts Report
which this is likely to be catastrophic has never been explored. A nominal cost recovery system of BWP 5 (approximately US$ 0.45) is charged to citizens for outpatient services in public facilities, with exemptions for vulnerable populations. Other additional charges include admission fees, ambulance charges, and charges for private patients and non-citizens. There have however been concerns about the inefficiencies associated with the collection of user fees at the point of services and their potential as an additional source of revenue for the health sector. A study by Moalosi (1991) showed that the share of user fees as a percentage of MoHW recurrent expenditure drastically dropped from 7% in 1973/74 to 0.9% in 1991.  

Figure 2: Total Health Spending by Source of Financing

| Source: Botswana Health Accounts 2013/14 |

1.2.1.4. HIV/AIDS Financing

Botswana is one the countries that have made progress in the response to HIV&AIDS. The government of Botswana makes substantial investments in the HIV/AIDS epidemic control, spending nearly half of the health sector budget which is about 2.55 percent of Gross Domestic Product (GDP), on its HIV/AIDS response (Cali and Avila 2016). Similarly, Botswana has benefitted from substantial donor funding in support of HIV/AIDS response overtime where in the 2013/14 fiscal year alone, donors contributed over one-third of the country’s total spending on HIV/AIDS (MoHW, 2016a). These investments in HIV/AIDS resulted in impressive progress toward the 90-90-90 Global HIV/AIDS Targets and as such the country is well positioned to surpass these targets if these investments are sustained and coverage is extended to the most at risk populations. In June 2016, Botswana adopted the Treat All Strategy, which calls for all Batswana who test positive for HIV, regardless of their CD4 count, to receive antiretroviral therapy (ART) for the rest of their lives. However, concerns have been noted about the exclusion of the non-citizens living in Botswana by the treat all strategy. The treat all strategy has put pressure on the domestic funds, increasing the financing requirements for HIV/AIDS control whilst the country still needs to ensure that there are sufficient resources to address other common health issues such as Non-Communicable Diseases are increasingly becoming a health threat in Botswana. For example, the treat all strategy is projected to require about BWP3.0 Billion to be spent on HIV/AIDS in 2017 and to cost a total of BWP13.3 Billion from  

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2017 to 2021. On the other hand, National Development Plan (NDP 11) has made budgetary provisions amounting to BWP8.6 Billion only (GoB 2017), leaving a need for additional funding amounting to BWP4.7 Billion to be mobilised as a matter of urgency to close the financial gap for the Treat All strategy.

Figure 3: HIV Spending by source of financing

1.2.1.5. Supply Chain Management
The Central Medical Stores (CMS) is responsible for the supply chain management of all health commodities including medicines in the public sector. As at August 2018, the average availability of vital drugs at public health facilities was at 84.7 percent against a 97 percent target. In view of the fact that availability of drugs continues to be one of the challenges facing Botswana’s health care system, one of the strategies put in place to improve availability of drugs, medicines and medical supplies in health facilities (hospitals, clinics and health posts) across the country over the past three years, was to grant authority to District Health Management Teams (DHMTs) to procure items that are out of stock at the Central Medical Stores (CMS) from the private market through micro procurement until a permanent solution is put in place.

1.2.1.6. Human Resources for Health
Unavailability of qualified staff remains one of the major bottlenecks towards the availability of quality health care in Botswana. The training of health care professionals is provided for by a combination of in-country and out-of-country institutions, with a heavy reliance on out-of-country arrangements. These health workforce shortages in Botswana have created major gaps in the availability of quality healthcare because of factors such as increased workload partly related to the HIV/AIDS response, emigration and mal-distribution of HR, inadequate number of tertiary training institutions, and inadequate plans to attract and retain health workers. Based on the 2015 MoHW establishment register, the distribution of staff posts by type and level of service reveals that an estimated 52 percent of the health sector workforce allocated to PHC services (assuming that health service staff under the DHMTs, clinics, and

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Source: Botswana Health Accounts 2013/14
most primary hospital services including clinics with maternity wards focus on PHC service delivery). District general hospital and mission hospital staff account for 15 percent of the workforce, and national referral hospitals account for 14 percent.\(^{11}\)

1.2.1.7. Health Information

Availability and quality of data are essential for the evaluation and planning of health programs. Botswana uses three types of electronic health information systems to collect health data. Various efforts have been made by different stakeholders across levels to establish and implement the required Health information systems. WHO, in its CSI guidelines, stated that “effective response to HIV at the country level requires strategic information that is systematically collected and consolidated, analyzed and applied”.

The main electronic systems that are currently in use are as follows:

- **Integrated Patient Management System (IPMS)**
  This is a proprietary system used to collect patient level data and is available mainly in hospitals and clinics that have internet. Utilization of the system is highly dependent on the availability and speed of the internet.

- **District Health information Software (DHIS 2)**
  This is open source software and is mainly used for aggregated data collection and Management. It is accessed mainly from DHMT and other clinics that have a government network system. Its use is expanding into collection of client level data using Tracker Capture as in the Malaria and OVC programs.

- **Patient Information Management System (PIMS)**
  PIMS is a Local Area Network (LAN) system developed to collected patient data at facilities where there is no internet connectivity.

All of these systems are used to collect health-related information and none of them collect any financial information on the patient level although IPMS has the functionality for collecting financial information at patient level (Billing and Accounts Receivable module).

Development of SOPs for data quality assurance, national monitoring and evaluation plan and development of M&E structures are steps in the right direction for strengthening HIS.

Despite MoHW efforts to improve the Information and Communication Technology (ICT) platforms at public health facilities, the existing systems remain fragmented (at both the patient and district levels). The current Health Management Information System (HMIS) is not able to deliver the timely information that is required for decision making and supporting planning, resource allocation, performance management, accountability, oversight, and monitoring and evaluation of the health delivery networks.

1.2.1.8. Health Sector Regulation

The health sector in Botswana is regulated through the Public Health Act. Health professionals are accredited by health and allied professional councils in accordance with the Medical, Dental and Pharmacy Act and the Nurses and Midwives Act. Efforts to review and merge the two health professional acts are ongoing. The Ministry of Health is also responsible for licensing, regulating, and registering private health facilities and practitioners to ensure that the health services provided to the population by the private health sector are safe, appropriate and effective. The medicine regulation and control is guided by the provisions of the Medicines and

Related Substances Act (MRSA 2013), However, MOHW still plays a major role in formulating policies and procedures to be implemented by Central Medical Stores (CMS) in its regular operations. Much as the Ministry of Health and Wellness is responsible for regulating the health sector, the revised National policy (2011) has recommended the need to strengthen the regulatory arm of the health Sector through separation of health service delivery and regulation. The establishment of the semi-autonomous Medicine Regulatory Authority has already been effected as one of the efforts to separate regulation and service delivery.

2. Universal Health Coverage (UHC)

2.1 Global Context
Since some years to date, the notion of Universal Health Coverage (UHC), or Universal Coverage (UC) - has been put in front of the international and national health and development agendas. In 2012, the sixty seventh United Nations General Assembly approved a resolution that “Encourages Member States, in collaboration with other stakeholders where applicable, to plan or pursue the transition of their health systems towards universal coverage”\textsuperscript{12}. In the context of the World Health Organization, UHC refers to a goal where all people can access health services, of good quality, whenever they need without the fear of suffering impoverishment and financial hardships due to payments of such services\textsuperscript{13}. The 2030 agenda for sustainable development has extended an opportunity for governments and the international community to renew their commitment to improving health. Due to the realization that health system strengthening is central to sustainable development goals (SDGs) Goal 3, target 3.8, of the 17 sustainable development goals emphasize the need for countries to continue commitments to pursue their paths towards universal health coverage (UHC). Two indicators were adopted by the UN Statistical Commission in March, 2017, to monitor progress towards SDG target 3.8 on UHC, namely the coverage of essential health services (SDG indicator 3.8.1) and the proportion of households with large expenditures on health as a share of total household consumption or income (SDG indicator 3.8.2).

Conceptually, UHC is about objectives in terms of what countries strives to achieve, i.e. taking into account the three dimensions of; equity in service use according to need to improve equity in health, quality improvement for improving health and universal financial protection. The SDGs agenda is built on the principle of “leaving no one behind” as such UHC needs to be built on foundations of progressive universalism, rights and equity.

2.2 UHC in Botswana
Like many countries, the Government of Botswana, through its long-term development strategies i.e. Vision 2036, National Development Plan 11, National Health Policy (2011), has committed to the goal of Universal Health Coverage. The revised National Health Policy (2011) for Botswana envisions “an enabling environment whereby all people living in Botswana have the opportunity to achieve and maintain the highest level of health and well-being” (MOHW; 2011). To realize this vision, the country is striving to achieve universal health coverage for current and future generations, and to finally bring the HIV/AIDS epidemic under control.

Health Financing is one of the key elements of UHC. Botswana’s commitment to the UHC goal is evidenced by its current health system which is built on a financing mechanism that has in many ways a solid base i.e. the financing system in Botswana is an essential constituent of a

\textsuperscript{13} World Health Organization (2010); The WHO World Health Report 2010; “Health Systems Financing: The Path to Universal Coverage”.
strong public financing that has enabled Botswana to develop a robust health system where affordability of health services have been largely guaranteed. The positive health system achievements that have been observed in Botswana's health system are demonstrated by key indicators, such as the level of out-of-pocket (OOP) spending which accounts for only around 4% of total health expenditure implying that in Botswana financial protection is guaranteed as such people do not face financial barriers in accessing health services and do not face financial hardship for having to pay directly for the health services they need.

Essential service coverage is another dimension used to track progress towards (UHC). In Botswana, geographic distribution and access to health facilities is largely guaranteed, with coverage estimated at 96 percent and 89 percent of the population living within the 8km radius to the nearest health facility in urban areas and rural areas respectively\textsuperscript{14}. The greatest challenge to UHC remains in rural areas, where improved access has not necessarily translated to utilization of high-quality services. Despite the country's efforts to ensure the shortest distance to the nearest facilities, challenges related to availability of the essential services including essential medicines and shortages of health workforce at health facilities remain some of the challenges and hinder the country's progress towards UHC. Disparities in availability of services at the different facilities, particularly those in remotest areas of the country also threatens health service provision in Botswana.

3 Relevant policies / strategies guiding UHC agenda in Botswana

3.1 Vision 2036 (2017-2036)
Following and building on the Republic of Botswana’s first national vision 2016 (1966-2016), the Vision 2036 outlines the transformational agenda that defines Botswana’s aspirations and goals for its people. With the aim of ‘Achieving Prosperity for All” the vision is anchored on seven Pillars, within which the UHC agenda fits on the vision’s Pillar 2 of Human and Social Development, where the Government of Botswana has made recognition that it is the responsibility of the state to guarantee access to health care services of the highest standard attainable, specifically aiming to reduce HIV/AIDS to minimal levels as well as tackling Non-Communicable Diseases for Batswana to live longer and healthy lives.

3.2 National Development Plan 11 (2017-2023)
The National Development Plan (NDP 11) is the first medium term plan towards the implementation of the country’s Vision 2036, running from April 2017 to March 2023. Taking into consideration the development challenges facing the Botswana, the NDP 11 advocates for various policies and strategies for all sectors of the economy to promote the country’s development as well as give the estimated financial resources that are likely to be available to Government, as well as their proposed allocations between the recurrent and development budgets.

For the health sector, four strategic approaches to health service delivery during the NDP 11 period include strengthening prevention interventions; improvement of access to quality health care services for all; strengthening rehabilitation services; and sustainable health and health care services for all.

\textsuperscript{14} Republic of Botswana, Central Statistics Office (2007) Botswana Demographic and Health Survey
Strategies for strengthening preventative health care services include strengthening collaborative partnerships and addressing social determinants of health in all sectors through an engagement of civil society organizations and non-state actors in health sector response; addressing key drivers of the HIV epidemic such as gender based violence, substance abuse and other social ills; revitalizing the primary health care approach including decentralization and enhancing structures at district level on primary health, strengthening integration and coordination of services; promotion of healthy life style to increase public ownership and responsibility on health issues and reducing morbidity and mortality from preventable diseases; adequate provision of nutrition and ensuring food security; promotion of good sanitation and use of potable water; and promotion of gender and age sensitive health care services.

For sustainable health and health care strategies for all, the NDP 11 prioritizes the review and successful implementation of the Essential Health Service Package to ensure universal coverage, improve access to health services; reduction of referrals and unnecessary delays in reaching care; enhancement of equity; and promotion of utilization of health services by all. The NDP 11 further makes specific emphasis to overhauling of supply chain management; implementing quality improvement framework and initiatives; enhancing integration of health services in priority areas such as HIV, TB, sexual reproductive health and rights, mental health, maternal and child health and rehabilitation; maximizing efficiency gains in the health sector; strengthening the stewardship role of Government in the health system and effectively regulating both public and private health providers; as well as monitoring and evaluation of health sector initiatives.

3.3 The National Health Policy (NHP) 2011-2021
The National Health Policy (2011) guides the health sector in Botswana. The Integrated Service Plan (IHSP) was developed as the health sector’s strategic guiding document for implementation of the NHP. The NHP and IHSP have outlined reforms in critical areas of service delivery, human resources for health, healthcare financing, health management information systems, governance and leadership. The IHSP describes the goal of service delivery as the attainment of universal coverage of a high-quality essential health services package through: (a) scaling up utilization of a well-defined and comprehensive essential health service package; (b) redefining existing service delivery levels and delineating types of health services for each level of the health care to ensure continuity and harmonized referral and supervisory functions; (c) increasing and strengthening partnerships with the private sector and NGOs; (d) community involvement to ensure effective demand for health services; and (e) promoting community participation in the planning and delivery of health services.

The third National Strategic Framework on HIV and AIDS (NSF III) is a five-year plan (2018/19-2022/23) that details principles, priorities, and actions to guide a collective multi-sectoral national response to the HIV epidemic. The strategy informs, measurable decision about the direction Botswana wish to take towards ending AIDS by 2030. This roadmap (NSF III) will guide and support co-ordination of the multi-sectoral national response to HIV and AIDS in the country and leave no one behind. The strategy is evidence-based, results-oriented and is aligned to the eleventh National Development Plan (NDP 11), National Vision 2036, SADC Revised Regional Indicative Strategic Development Plan 2015-2020 and Sustainable Development Goals (SDGs). During implementation of NSF III, Botswana shall use evidence, innovations, leverage on new technologies and approaches to accelerate realization of elimination of AIDS by 2030 including zero-new infections and zero AIDS related deaths as well as zero discrimination vision.
NSF III development process has unfolded into an all-inclusive and intensive multi-level participatory national HIV and AIDS Strategic Planning Process (SPP). Stakeholders from national level, all administrative districts including sub districts, civil society, selected communities, development partners and private sector were consulted through workshops, focus group discussions, Kgotala meetings and key informant interviews.

The methodology for the assignment comprised document review; purposively selected and held Kgotala meetings in Maun, Molepolole, Tsabong and Tutume; workshop consultations with representatives from all District Multi-sectoral AIDS Committees (DMSACs) held in Gaborone, Francistown, Jwaneng and Maun; purposively sampled Key Informant Interviews (KII) and Focus Group Discussions (FGDs) from districts with low, medium and high HIV incidence or prevalence as derived using Incidence Patterns model. Technical Planning Teams and Joint Oversight Committee provided the technical input, oversight and rich experiences that were greatly beneficial to the strategy development process. The development process was divided into five phases including situation analysis, assessment of the national response policy environment, and development of a national response issues paper, drafting, validation and finalisation of the strategy.

The vision, mission, goal, performance areas and performance area objectives for NSF III are:

**Vision:** Paving way to ending the HIV/AIDS epidemic in Botswana by 2030

**Mission:** Enhancing efficiencies through an integrated approach towards HIV epidemic control by 2023

**Goal:** Zero new HIV infections by 2023

NSF III focuses on five (5) key performance areas with clear performance objectives, namely, Targeted HIV primary prevention, HIV Treatment Care and Support, Stigma and Discrimination, Systems Strengthening and Strategic Information Management. Botswana is in its last sprint towards ending AIDS by 2030. Premised on the principle of “not leaving any one behind”, NSF III has adopted a shift in strategies and innovations to match with the diversity of the epidemic. The major shifts in the response to HIV adopted by NSF III include embracing the Treat All strategy aimed at initiating all people living with HIV (PLHIV) on treatment regardless of their CD4 cell count, changing the way HIV Testing Services (HTS), linkage to care, treatment and support interventions are delivered for sustainability, revitalization of primary health care with a focus on the community-based delivery of integrated quality care and targeting specific population groups and geographic locations for the HIV response.

In the next five years, the national response will focus on:

i. HIV Targeted Primary Prevention
ii. Treatment, care and support
iii. Improved Sustainable National Response Financing
iv. Strengthening Health and Community systems
v. Strengthening Strategic Information Management

The NSF III interventions will be implemented using rights-based and people-centered approaches. Further, the national response will fast track sustainable financing mechanisms and ensure progressive integration of the HIV response into broader health programs and services. These approaches will be aligned to the principles of primary health care and universal health coverage without leaving anybody behind for optimum uptake of continuum of HIV services.
NSF III is a turnaround strategy for action with district targets derived from national targets by all in the response based on the following enablers:

- Provision of services targeting sub-populations (adolescent girls and young women; infants and children under 15 years; men; key and vulnerable populations) by geographic locations
- Revitalizing primary health care with a target of at least 30% services being delivered through community health structures such as community health care groups / worker, community prescribing and dispensing systems
- Accelerating behavioural social marketing approaches to create demand for HIV services;
- Provision of a mix of innovative testing services at all service points in all health facilities and in communities (HIV self-testing, index partner testing and test for triage);
- Provision of integrated HIV, STI, TB, SRHR and NCD screening and linkage to care, treatment and support services;
- Provision of PreP to key populations and vulnerable young women;
- Use of innovative ways (technology, home visit and mobile outreach) to track hard to find HIV positives and linking them to care, treatment and support services;
- Institutionalization of a sustainable health financing strategy that pools resources through health insurance and taxes (alcohol and tobacco taxes) and strengthening of Public-Private Partnerships (PPP).
- Development of a harmonized and functional national M and E system
- Effective coordination and leadership of the multi-sectoral response
- Transformational leadership, change and risk management as well as mobilizing and engaging health professionals and communities.
- Optimize human resources and maximize financial resources.

It is envisaged that if the strategies are efficiently and effectively implemented by the different role players at different levels in the multi-sectoral response, NSF III will be set to achieve the goal of “Zero new HIV infections by 2023”.

4. Completed UHC & Sustainable Financing Analyses/Activities

The Ministry of Health and Wellness and NACA have conducted several analyses relevant for sustainable health financing for UHC as well as sustainable financing for HIV/AIDS for epidemic control.


The Botswana National Health Financing Strategy (2019-2023) was prepared by the Ministry of Health and Wellness, Government of Botswana, with support from the United States Agency for International Development (USAID) through the Health Finance and Governance project implemented by Abt Associates.

The Health Financing Strategy 2019-2023 outlines the Government of Botswana’s (GOB) plan for building its health financing structure. The strategy has its foundations in the country’s vision 2036 which aspires guaranteed access to health care services of the highest standard attainable to Batswana, specifically aiming to reduce HIV/AIDS and Non Communicable Diseases, the National Development Plan (NDP) 11 which calls for a health financing strategy
to enable a “sustainable health financing system... to achieve the principles of financial protection, high efficiency levels, equity, and quality” (MoFDP 2015) and the National Health Policy (NHP), whose financing goal is to “raise and allocate sufficient resources and putting in place appropriate payment arrangements to ensure that all people living in Botswana have access to a range of cost effective health interventions at an affordable price regardless of their economic status”. The policy calls for the Ministry of Health and Wellness (MOHW) to “develop a health financing strategy that will guide the financing of the entire health sector and the attainment of universal coverage of a high-quality package of essential health services. The development of the strategy came upon the realization that the country faces an increase in the resources needed to address critical health issues. Specific to this is the increasing financial requirements in the short term for HIV/AIDS control due to the adoption of the Treat All Strategy in June 2016, which calls for all Batswana who test positive for HIV to receive antiretroviral therapy (ART) for the rest of their lives. The burden of other health conditions such as Non-Communicable Diseases (NCDs) and Maternal Mortality have also been on the rise contributing to the increases in the costs of providing health care. Inefficiencies in Botswana’s health care system have also exacerbated increasing health care costs.

The process for developing this Health Financing Strategy comprised three activities: individual consultations with health sector stakeholders, HFTWG meetings, and background research and analytics, i.e. the strategy is the culmination of a year-long consultative process led by the Health Financing Technical Working Group (HFTWG) - comprising of representatives from various government ministries, Medical Aid Schemes (MAS), Academia, and International Organizations - with technical support provided by the World Health Organization (WHO) at the initial stage of the process to develop health financing situational analysis and the United States Agency for International Development (USAID)-funded Health Finance and Governance (HFG) project in collaboration with the MOHW continued and finalized the strategy.

The Health Financing Strategy 2019-2023 identifies four main challenges facing the health system, sets clear goals to focus the efforts of the GOB and other stakeholders, and delineates the concrete actions that the country will take to overcome these challenges as shown in Figure 1 below;

Figure 1: Linking Botswana’s Health Financing Challenges, Goals, and Actions
The Health Financing Strategy proposes a number of health financing reforms as follows:

- The universal health services package that includes HIV services in order to sustain HIV/AIDS epidemic control and address national health priorities. This process will be informed by an actuarial analysis of the package which will estimate the amount of financing needed to guarantee future provision of the services to the entire population.
- Diverse resource mobilization options will be considered in order to select appropriate financing mechanisms. Options to be considered include mobilizing resources through health insurance, as well as allocating a larger share of alcohol and tobacco taxes and value-added tax to the health sector.
- A legal process that guarantees allocation of sufficient resources to finance a universal health services package. The MOHW and other stakeholders will support the drafting of legislation to legally obligate the country to allocate the resources needed to provide a subsidized universal health services package.
- Strengthening MOHW capacity to develop strategic priorities and improve resource allocation. The MOHW will: a) conduct and apply needs assessments to inform decisions about introducing new technologies; b) develop processes for making strategic decisions about investing in capital development projects, taking into consideration existing utilization patterns and reasons behind patient behavior; c) support planning of a workforce of the future by evaluating human resources deployment and composition and developing policies to incentivize task shifting and

Source: Botswana Health Financing Strategy 2019-2023
task sharing; d) develop mechanisms for regularly revising the essential medicines list to ensure it includes only essential, cost-effective medicines; e) develop a mechanism for routinely reviewing and revising the essential health services package to ensure it is cost effective, covers HIV services, guarantees affordable access to the basic services needed to promote a healthy population, and is affordable given expected resources available for health.

- Introduction of strategic purchasing to incentivize providers to deliver specific outcomes at the lowest possible cost. Botswana will explore health financing reforms to split the MOHW’s dual role of purchaser and provider and introduce a new purchasing dynamic between the purchaser and providers. This will pave the way for payment reforms that shift away from historical line-item budgets to mechanisms that pay for performance and incentivize the efficient use of resources.

- Reforms in pharmaceutical policies to improve procurement, distribution, and use of medicines. Botswana will institutionalize recent improvements and leverage regional collaboration to reduce drug costs, test the informed push model of distribution to improve central medical store performance, introduce mobile phone technology to support better communication across levels/tiers of the procurement chain, and review utilization patterns of generic drugs and address any barriers to expanding their use.

- Update and modernize the public financial management, accounting, and information systems to operationalize health financing reforms - building up public finance management, accounting, and information systems to improve the collection of data needed to implement and manage health financing reforms - to allow the MOHW and other stakeholders to collect information on demographics, utilization of services, and cost of services. This information can then be used to target vulnerable groups and assess the equity of the health system by gender, income, and geographic location.

- Engagement of the MFED Public-Private Partnership Unit to develop guidelines for the prioritization and management of PPPs in Health. Limited contract management experience and the lack of clear policy guidelines have hindered the development of PPPs in the health sector. MOHW will engage the MFDP PPP unit to prioritize key PPP opportunities and strengthen MOHW contract management capabilities. The public-private partnerships will aim to integrate and strengthen the health system to increase access, availability, affordability, and acceptability of public and private health services.

- Coordination with private sector networks to develop payment and billing systems that facilitate true public-private health systems partnerships. The MOHW currently lacks systems to bill and receive reimbursement from MAS or to contract private providers. Billing and payment systems that are compatible with the private sector would allow MAS to reimburse the MOHW when a MAS member receives care at an MOHW facility. Further, these systems will enable the MOHW to contract private providers to fill gaps in service provision. Such interactions will help the MOHW and other public sector authorities to better understand the requirements for managing and expanding strategic purchasing and engaging with private sector actors.

- Establishment of a system of national reference tariffs for health services. The MOHW will work with both public and private providers and MAS to develop a fair payment system that determines national references for health services. This system will help control costs, maintain the affordability of premiums, and guarantee the financial sustainability of the health system.

- The need to explore of health insurance reforms to empower citizens as consumers of health services. An insurance system would progressively expand choice to allow Batswana to choose the insurance plan or health provider that works best for them and
their family and would guarantee portability by expanding public and private options in the health system.

- Establishment of a legal right to a health benefit plan, including medicines that enables citizens to hold government accountable for providing the services to which they are entitled. Batswana will have guaranteed access to all services defined in the universal health services package. The GOB will develop formal mechanisms for citizens to appeal for access to services that are improperly denied.
- Establishment of a new mechanisms for transparency and accountability in the health sector. Botswana will create new governance initiatives with wide representation, including civil society organizations, with a mandate to facilitate citizen participation in ensuring equitable and universal access to a high-quality package of health services. These governance initiatives will establish mutual accountability between civil society and government.

The Health financing strategy is currently undergoing government consultation to prepare for its presentation for cabinet approval.

4.2 Botswana National Health Insurance Blueprint (2018)
The Botswana National Health Insurance Blue Print was produced by Gutierrez, Jose Carlos, Jonathan Cali, Marjan Inak, and Carlos Avila, on behalf of Abt Associates in September 2018. This was produced as part of the USAID’s Health Finance & Governance Project.

As part of the HFG project on support to the GoB to develop the Health Financing strategy, the Botswana Health Financing Technical Working Group recommended the creation of a new National Health Insurance System with a view towards tackling the challenges facing the health sector. The HFTWG believed that the insurance reforms will bring value to Botswana’s health system by modernizing the health sector and enable the system to better respond to the needs of all Batswana.

The insurance policy options report presents an overview of health insurance systems and explores how insurance reforms could improve the efficiency and sustainability of Botswana’s health system (Gutierrez and Avila 2016). The report describes how the creation of an insurance system would split the dual role – purchaser and provider – that the MOHW currently plays. The introduction of a new insurance agency as a separate purchaser would transform how resources are allocated, shifting from a supply-based model rooted in historical line item budgeting to a demand-based model where resources are allocated according to the needs of consumers. In 2017, the HFTWG met in March, June, and October to refine a potential health insurance reform proposal, which is outlined in the Draft Health Insurance Blueprint Document. The Health Insurance Blueprint outlines one potential approach to designing a national health insurance system for Botswana. The Blueprint presents a health insurance design framework based on Wang et al. (2012) and adapted for Botswana. The framework encompasses six insurance design elements: a) revenue generation, b) population coverage, c) benefit plans, d) provider payment, e) operational processes, and f) insurance governance. Each element seeks to answer a basic question related to the design of an insurance system:

- Financing – Where will the money come from?
- Population coverage – Who will be covered?
- Benefit package– What services will be covered?
- Provider payment – How will providers be paid?
- Operational processes – How will the system operate?
- Insurance governance – How will the insurance system be regulated and governed?
For each design element, the report presents definitions and key issues, describes the specific challenges that the element presents in Botswana, and proposes a set of policy recommendations. The purpose of the recommendations is to describe a suggested way forward, and to stimulate dialogue and begin narrowing to the decisions that policymakers face in the design of an insurance system. From revenue generation to insurance governance, each design element merits further discussion within the HFTWG and with other stakeholders before the GOB decides on a reform proposal. Thus, the Blueprint concludes with a call for additional feasibility studies to determine whether the health insurance route is appropriate for Botswana and with a suggested reform sequence in the event that the GOB decides to move forward with health insurance reform.

4.3 Strategic Purchasing of Health Care Services in Botswana (2018)

The report was developed by Strizrep, Tihomiron behalf of Abt Associates as part of the USAID’s Health Finance and Governance (HFG) project support to the Ministry of Health and Wellness (MoHW). The report outlines designing new provider payment mechanisms for Primary Health Care (PHC) to incentivize efficiency and improve health outcomes.

This report provides a set of recommendations to the Government of Botswana for establishing a roadmap for the implementation of primary health care (PHC) financing reform and to support efforts aimed at achieving effective and sustainable universal health coverage in Botswana. The report highlights that in order to maximize the health, economic, and political benefits of public health spending, it is vital to allocate funds with maximum efficiency and this will requires spending resources primarily on cost-effective PHC interventions including disease prevention and curative care delivered at the community and health center level.

The report recommends changes on the current system to move toward a contemporary payment system for PHC services based on capitation with various risk adjustment factors, as well as performance and quality indicators. The need to develop an innovative model for PHC financing and prioritization of the PHC system is also recommended. The report suggests that reforming payment mechanisms will provide policymakers with new tools to influence provider behavior and ultimately achieve policy objectives in the prioritization of resources and better outcomes, while improving efficiency.

The report identified the key elements of the strategic purchasing as follows;

- Establishment of the cost centers on the DHMT level- setting the total financing pool for each DHMT in order to have a better understanding of all sources of revenue and all types of expenditure of DHMTs.
- Development of per capita PHC budget allocation system - developing a per capita PHC budget allocation system for Botswana as follows; calculating the base per capita rate; Calculating the risk-adjustment coefficient; and determining each DHMT’s per capita allocation
- Development of P4P component - reimbursing DHMTs for interventions performed or making part of their earnings contingent on meeting pre-agreed targets.
- Establishment of the contractual relationship between the MoHW and DHMTs- where MoHW enters into annually renewable agreements with DHMTs and in these agreements, the concept of performance will refer to health improvement, achievements in quality and cost control, access to care, and other similar objectives.
- Increased autonomy of service providers - facilities are given flexibility and freedom to manage resources in a way that increases the quantity and quality of the health services they provide.
• Improvement of the information systems - the creation of monitoring systems for PHC using the existing hospital information systems where the development of electronic medical records for PHC could be done in a phased manner, e.g., starting with the development of electronic registers of patients with HIV/AIDS, cancer, diabetes, and high blood pressure.

• Monitoring and evaluation - effective monitoring and evaluation system and good contract management. Monitoring processes to include the development of tools for tracking providers’ behavior.

• Change management - put in place clear communication strategies, both internal and external; identify agents of change that will move PHC payment reform to the desired state, as well as make other people accept the change with positive attitudes.


This report was produced by Keith Jefferis for the Abt Associates as part of the USAID’s Health Finance and Governance Project. The main purpose of this report is to estimate the potential revenue that could be gained from health insurance contributions raised through a levy on incomes. His analysis followed the recommendation by stakeholders in the Health Financing Technical Working Group on the introduction of a National Health Insurance (NHI) System as one potential approach to finance and reorganize the health sector so as to introduce new mechanisms and incentives for strategic purchasing. The proposed NHI reforms are described in detail in the NHI Blueprint Report (Gutierrez et al. 2018), which suggested a modest levy of 2 percent of employee wages (1 percent from the employee and 1 percent from the employer) as one source of potential financing for the Botswana NHI.

A modeling exercise was undertaken to estimate a number of scenarios with varying assumptions about the levy rate and the cost of the health services package to be provided by the potential NHI scheme. The analysis further explored the potential cross-subsidization arrangement proposed in the NHI Blueprint, which entails a separate NHI Fund and NHI Scheme.

The fiscal space analysis revealed that a 2% levy on wages would raise only 11.5 percent of the total estimated cost of providing the UHSP benefit package to the entire population. The analysis also estimated the revenue from contributions that could be collected from informal sector workers, and the results indicate that given the size of the informal sector, the low average income, the high cost of collection, and likely low compliance, very little resources could be raised by introducing premiums for the informal sector. The analysis revealed that cross-subsidization arrangements proposed in the NHI Blueprint report are not feasible in the short to medium term. The analysis recommended that given the low potential revenue to be raised through introduction of the NHI, the introduction of NHI or other health financing reforms should focus more on creating a purchaser-providers split as a way to introduce mechanisms for accountability and incentives for efficiency, rather than focusing on generating new revenue. The main highlight from the report is that much as financial sustainability of the health system requires health financing reforms that secure more resources, it also requires the need to make better use of existing resources. Thus Botswana’s health system should focus first on introducing purchasing reforms that enable modern provider payment systems to incentivize quality and efficiency. Through making better use of existing resources and safeguarding the financial sustainability of the health system, Botswana can ensure continued progress towards universal health coverage for current and future generations of Botswana.
4.5 Opportunities to improve the efficiency of HIV/AIDS services in Botswana (2018)

The report was produced in September 2018, by Musau Stephen, Qinani Dube, Heather Cogswell, Batsile Peloewetse, Marjan Inak, and Claire Jones on behalf of Abt Associates as part of the USAID’s Health Finance and Governance (HFG) Project support to Botswana. The objective of this study was to assess the efficiency of Botswana’s national HIV/AIDS response program as implemented by the Ministry of Health and Wellness (MOHW).

The scope of the activity was limited to an assessment of technical efficiency by carrying out a quantitative analysis of antiretroviral drug (ARV) procurements and conducting key informant interviews of MOHW and NACA staff at the national, district, and facility levels.

Various opportunities for efficiency improvement were identified of which the MOHW and other key stakeholders could immediately address and achieve significant savings in the costs to the program, especially in the procurement of antiretroviral drugs. The analysis highlighted that some of the findings may require a longer timeframe to implement as they require changes in systems or policies or can only be effected through the MOHW coordinating with other ministries or stakeholders.

The key findings are as follows:

Supply chain – ARVs: savings could be realized if all ARVs were procured under pooled procurement mechanisms such as that operated by the Global Fund.

Supply chain – laboratory: Lack of reagents leads to failure or delay in testing, wastage due to expiry of reagents pushed to facilities by the Central Medical Stores (CMS), monitoring of laboratory testing to match patient numbers to reagents and test kits used in order to determine how many need to be procured not in place. Delays and loss of laboratory results between referral laboratories and health posts that have no laboratories were also revealed by the study.

Prevention of mother-to-child transmission: Infant formula expensive component of the costs of the PMTCT program as such need to promote breast feeding which will increase the survival rates of infants and save money on infant formula milk. Challenges related to unavailability of PMTCT to non-citizen mothers not legally married to Batswana fathers, although the baby can be treated after birth. This has been noted to increase the chance of the baby being born HIV positive and hence requiring more costly treatment than if the mother had been allowed to receive PMTCT services.

Integration – Services: Child welfare and HIV testing: babies brought for their child welfare check-up not tested for HIV at the same clinic as would be expected in an integrated service, Fragmentation of volunteerism under the tuberculosis, malaria, PMTCT, and other programs where each program has its own volunteers. Unavailability of an effective system for monitoring the performance of the volunteers has been noted. The need for a holistic approach where volunteers are trained to cover all diseases and paid a single amount to cover their work is recommended.

Duplication between the MOHW and NACA in service provision has also been cited, where both have similar programs such as behavior change information and communication (BCIC)) serving the same patients. Whereas NACA was established as a coordinating body, there are aspects of implementation in behavior change communication interventions which is duplication of what the MOHW already does.
Integration – Human resources for health: The study also reveals deployment of nurses at health posts and clinics does not seem to consider the skills mix needed at these facilities, undermining the integration policy.

Information systems: Health Information Management Systems (HIMS) inconsistencies exist, where some facilities use the Integrated Patient Management Systems (IPMS) and some still relying on paper-based records. Issues around data quality i.e. timeliness, completeness and accuracy are a challenge.

Monthly community home-based care (CHBC): supplies are provided to all patients without any means testing to determine who is truly unable to pay. The CHBC program could be losing money by failing to mean test.

Behavior change communication: Insufficient investment in community approaches that have been proven effective in increasing use of ANC. Too much focus made to treatment and other non-community-based approaches that are very costly.

Treat All policy: The study noted high defaulting rates among teens. This has been linked to the fact that treatment is started before the patient has fully internalized the HIV-positive status and, because they are not feeling ill, they do not take their responsibility for adherence to treatment seriously.

Prevention: Unavailability of condoms to teenagers despite the fact that teens in high schools are sexually active. Study also highlights increases in sexually transmitted infection rates despite availability of condoms, indicating potential failures somewhere in the system that will eventually show up as new HIV-positive cases. Access to ART by non-citizens (e.g., truck drivers) transiting through Botswana cannot and other non-citizens (undocumented migrant workers) cited as a challenge to preventing HIV/AIDS transmission.

The study recommended the need to review the findings above in order to determine which inefficiencies can be corrected immediately and which ones require more time to implement. The study also noted that NACA has committed itself to prepare an Action Plan to set timelines and responsibilities for acting on these findings.

4.6 Developing a Framework for Setting Health Service Tariffs in Botswana (2018)
This report was produced by prepared by Jose Carlos Gutierrez and Ric Marshall on behalf of Abt Associates as part of the USAID support Health Finance and Governance project. The report provides a description of the current tariff-setting landscape in Botswana, presents the findings of HFG’s proof of concept tariff-setting exercise, and outlines the proposed tariff-setting framework. The report also provides a set of recommendations for strengthening the ministry’s capability to develop tariffs based on cost and activity data and to propose a framework for developing an annual cycle for setting reference tariffs.

The report distinguishes price and tariff as follows: price being the amount providers charge and consumers pay whereas reference tariff is an amount that provides a reference point in relation to prices for payers, providers, and other actors.

Key findings from the report:
- A system of tariffs requires data on complete episodes of care such as the data on full admission; discharge record for inpatient care needs, as well as actual unit cost for each episode to be used as the basis for the tariff calculation.
• Tariff setting in the public sector:
  o MoHW does not have a standard tariff list or schedule for use in public health facilities, some price lists are currently used for purchasing of inputs, and are generally imported from South Africa and indexed to Botswana values by a conversion factor.
  o The quality and comprehensiveness of data remains a challenge: Whereas tariff setting requires reporting of complete episodes of care such as the full admission–discharge record for inpatient care and cost data, activity data for most public hospitals have very limited diagnoses coding and no major procedure-coding.
  o The Integrated Patient Management System (IPMS) provides a solid basis for data quality assurance, but requires systematic improvements and operationalisation of some functions/modules.

• Tariff setting in the private sector:
  o Medical Aid Schemes (MAS) used to negotiate tariff rates and increases with the various professional groups; until in 2012 when enforcement of competition policy to guards against anticompetitive practices such as collusion and abuse of dominance came into play through the Competition Authority.
  o MAS now negotiate tariffs exclusively with hospitals or large provider groups and set their tariff (a maximum allowable amount that they will pay), and providers set their own tariff (a minimum amount that they will accept to provide the care), which may be higher than the MAS tariff resulting in balance billing –
  o Increases in balance billing prevails, as providers charge patients as they wish. This practice results in higher out-of-pocket payments, which isn't supportive of the principles of pre payment and financial protection arrangements.

Recommendations:
• Improvement in activity and cost data presents fundamental underpinnings of the establishment of the national tariff-setting cycle in Botswana i.e adoption of clinically meaningful diagnostic groups and the systematic collection of cost data related to each category can allow providers, payers, and regulators to establish benchmarks for what a particular type of service should cost. Ultimately, the information generated through the adoption of DRGs would contribute to the overall goals of the tariff-setting system — facilitating a transparent mechanism for assessing the value of services and pricing them appropriately.
• Botswana should adopt the publication of National Reference Tariffs for a comprehensive range of clearly defined episode-of-care based health care products (beginning with DRG-defined episodes for hospital inpatient services).
• Botswana should adopt episode-of-care (initially DRG-based for inpatients) counting, coding, costing, and tariffing i.e. a patient episode should be the unit of counting and coding, that the patient episode is essentially the 'product' being 'purchased.
• Botswana should implement an annual tariff-setting cycle to ensure that tariffs are adjusted appropriately to reflect providers’ evolving cost structures.
• Botswana should develop a tariff-setting roadmap that assists the MoHW and its partners in progressively refining and maintaining the framework components - roadmap outlining phased implementation and providing a useful planning and program management aid.

4.7 Actuarial Costing Analysis to Support Botswana National Health Insurance (2017)
The report was produced by Kelly, Eamon (2017) on behalf of Abt Associates as part of the USAID’s HFG assistance to the MOHW. This entails conducting an actuarial analysis to fully
understand the resource needs for sustainable provision of the Universal Health Service Package (UHSP). The actuarial analysis looked at the current disease burden and costs of delivering health care services to determine the current and projected costs of delivering a defined package of services to Batswana.

The actuarial analysis examined seven primary drivers of health costs: 1) the target population, 2) the demographics and socio-economic profile of the target population, 3) disease burden and service usage, 4) current health system characteristics and utilization, 5) health policy, 6) health costs and financing, and 7) current health insurance options. Data on these seven areas were gathered from the MOHW, Statistics Botswana, and the three largest insurance providers: BPOMAS, BOMaid, and Pula. The analysis was conducted by an experienced actuary using the priorities set by the MOHW and laid out in policy documents to determine the appropriate scope of the analysis.

The projected costs presented in the actuarial analysis can be used for determining the appropriate, affordable scope of services that should be included in the EHSP, as the current policy of providing all services to all Batswana may prove to be unsustainable in the future. The actuarial analysis can also provide recommendations for government subsidies and premiums in the event that Botswana opts to transition toward health insurance.

**4.8 Botswana HIV/AIDS Investment Case (2016)**

The Botswana HIV/AIDS Investment Case (IC) was developed through a collaborative effort between the Ministry of Health and Wellness, the National AIDS coordinating Agency and UNAIDS. The development of the report followed a consultative and consensus building process with all key stakeholders involved in the HIV/AIDS response. Ava Avalos, Heston Phillips and Keith Jefferis led the modelling analysis and report writing.

The investment case report outlines the challenges facing the HIV response by analyzing trends and gaps in HIV planning, program implementation and funding landscapes. It is through this analysis that the Government of Botswana came to the realization that providing universal access to ART treatment is the most important step that the country needed to take to safeguard Botswana's future against the devastation of HIV, strengthen the healthcare system and advance the Nation's development goals. Primarily, the investment case provides justification to refocus the HIV response and reallocate funding resources and identifies interventions that are most likely to deliver the greatest impact to end AIDS in Botswana.

The investment case analysis was undertaken at a time when the eligibility criteria for ART treatment was CD4 350, and it revealed that due to declines in available financing (driven by slow economic growth and declines in donor funding) and increases in costs, the HIV financing gap would increase by approximately BWP900 million a year. The modelling results showed that under the CD4 350 and enhanced (CD4 500) scenarios, the financing gap would keep increasing because of rising total costs and constrained financing whilst in the Treat All scenario, the initial financing gap would be at its largest, reaching P1.2 billion in 2017 and later close due to the impact of declines in costs attributed to decreases in infections decrease. The IC projected reductions in the financing gap under the Treat All scenario from 2018. The analysis further estimated that between 2015 and 2030, the return on strategic investment in a comprehensive Treat All Strategy could lead to an estimated decrease in 118,410 HIV infections and approximately 54,072 HIV related deaths.
This analysis formed the basis and justification for the government of Botswana to make commitments towards introduction of the treat all strategy in June 2016, where all citizens who tested HIV positive were eligible to enroll for ART treatment regardless of their CD4 count.

### 4.9 Improving Efficiency to Achieve Health System Goals in Botswana - Background Paper for Botswana’s Health Care Financing Strategy (2016)

This background paper was prepared by Sharon Nakhimovsky, Jonathan Cali, Hailu Zelelew, and Carlos Avila on behalf of Abt Associates under USAID’s support through the Health Finance and Governance project.

The background paper on Improving Efficiency to Achieve Health System Goals in Botswana first identifies the sources of inefficiencies in Botswana’s health system and suggests reforms the GOB might adopt to address them. Cross-cutting areas considered include: resource allocation by level of care, hospital management, public financial management (PFM), the procurement and use of technologies, and drug policy and supply chain management. The paper then looks at inefficiency specifically in the health financing functions (raising and pooling revenue, and purchasing services) and considers how insurance reform could improve health system efficiency.

The analysis of the health system identifies several sources of inefficiency. One is the allocation of funding, with little spent on primary care at lower-level facilities while a great deal is spent at hospitals. As a result, referral hospitals are overwhelmed with demand and district hospitals are underutilized. Centralized management, with little flexibility in budgeting and budget execution, prevents facilities from finding ways to spend more efficiently. Lack of a strategic planning process for capital investments, such as building infrastructure and purchasing medical equipment, also results in wasted capacity and skews the distribution of resources. Inadequate information technology (IT) and technical capacity at the central medical store and the facility level inhibit rigorous procurement, forecasting, and planning for effective supply chain management, which results in frequent stock-outs. Overemphasis on addressing IT deficiencies and insufficient investment in improving health information systems overall reduce opportunities for routine monitoring of efficiency indicators that can allow facilities to improve efficiency in locally-specific ways.

Recommendations to address these challenges range from creating new processes for compiling and applying cost-effectiveness data, to purchasing decisions to building capacity in health information systems and supply chain management at the facility level. As these examples show, not all of the recommendations are specific to health financing, but all can contribute to a more efficient health system.

A look at health financing flows specifically reveals another set of inefficiencies. The paper highlights that having many small insurance schemes mean risk pools in Botswana’s private sector are fragmented, i.e. aspects of duplication in areas such as systems for advertising, management and administrative staff salaries distributed across the different schemes which serve relatively few beneficiaries. There is also duplication in publicly financed health coverage. BPOMAS members, whose premiums are subsidized by GOB, access services both through BPOMAS and at nearly-free public facilities. The efficiency paper also suggests that Botswana’s proposed benefits package does not prioritize cost-effective interventions or exclude many interventions that public financing should not cover. The paper then discusses the benefits and risks of integrating risk pools, reallocate funding to cost-effective interventions through a health benefit plan, and establishing processes for strategic
purchasing. It encourages the GOB to consider these options, and the experiences other countries have had implementing them, as it works to improve efficiency of health spending.

### 4.10 Health Financing in Botswana: A Landscape Analysis (2016)

This publication was produced by Cali, Jonathan and Carlos Avila (2016) and was undertaken as HFG’s initial activity to support the development of the Health Financing strategy for Botswana. It entailed review of the health financing strategy activities, previous studies and discussions carried out by the government of Botswana and the different consultants on health financing matters. The analysis was undertaken to provide a thorough understanding of the present health financing situation in Botswana as the necessary starting point for a health financing strategy. It provides an understanding of the government’s fiscal space, current health expenditures and past trends, and future financing requirements that will help identify and anticipate the challenges facing the health system and opportunities for the health financing strategy to address them.

The landscape analysis was conducted by the Health Finance and Governance Project (HFG), supported by the United States Agency for International Development (USAID), in collaboration with the Ministry of Health, Republic of Botswana. The analysis was validated by the HFTWG to reach a consensus on policy options for further study. The HFTWG comprised of representatives from the following institutions were present: Ministry of Health (HPDME and Finance Unit), UNAIDS, UNICEF, BOMAID, South View, NBFIRA, USAID, Ministry of Finance (Macroeconomics, Pensions and Insurance), Institute of Development Management (IDM), WHO, UNDP, University of Botswana School of Public Health, Careena Health, Ministry of Local Government, Associated Fund Administrators (BPOMAS and Pula).

Key Highlights of the landscape analysis are as follows;

- The health financing situation in Botswana is highly dependent on the macroeconomic context of the country and Botswana is still in good fiscal standing compared to other countries in sub-Saharan Africa.
- Botswana’s GDP growth rate expected to average 4.8% from 2017 to 2022 before declining to 3% lower during the 2020s implying that the government of Botswana has a window of opportunity now to invest in improving the efficiency of the health system and contain the growth in health care costs while economic and government revenue growth are still strong.
- Botswana’s level of health spending per capita is above average compared to other similar countries-health care spending per person increased from Int$270 (BWP 348) in 1995 to Int$851 (BWP 1491) in 2013.
- HIV/AIDS expenditure constitutes nearly 50 percent of Botswana’s total health expenditure and the expenditure on HIV/AIDS likely to increase in the short term once the country adopts the “Test and Treat” guidelines.
- In long term, adopting the “Test and Treat” guidelines is projected to produce cost savings due to reductions in the prevalence and associated treatment costs of opportunistic infections such as tuberculosis.
- An estimated BWP 2.52 billion was needed to finance the primary care portion of the EHSP through the public sector in 2015 and a total of BWP 27.2 billion is needed from 2015 to 2023. About BWP 1.25 billion was spent on primary care in 2015, leaving a gap of BWP 1.57 billion of unfunded need. The gap is projected to rise to BWP 1.95 billion annually by 2023.
• The total cumulative financing gap for HIV/AIDS from 2015 to 2023 would be BWP 6.93 billion and the gap would increase further if the government adopts the new “Test and Treat” strategy.

• An estimated BWP 240 million was spent on policy, planning, monitoring and evaluation in 2015 and the landscape analysis estimated no additional need for financing these activities and thus no financing gap.

• The cumulative aggregate gap over the nine-year period is BWP 23.18 billion and almost all of this gap will need to be filled with new public and private funding and through efficiency gains.

• Botswana’s health financing strategy should strengthen the health system, expand universal health coverage, and ultimately improve health by defining a path for increasing financial risk protection and efficiency and reducing fragmentation, health coverage gaps, and health financing inequities while ensuring the sustainability of the health financing system.

The HFTWG and other health system stakeholders have agreed that the following are the four strategic objectives for the Botswana’s health financing strategy: Mobilizing resources for health; Enhancing efficiency in the allocation and use of resources for health; Strengthening partnerships between public, nonprofit, and for-profit health care providers, as well as public and commercial financing schemes and Developing an insurance-based system for all Batswana.

The 2013/14 HA exercise was conducted by a multidisciplinary NHA technical working group team, led by the Department of Health Policy Development, Monitoring and Evaluation of the Ministry of Health and Wellness, and technically supported by the United States Agency for International Development (USAID)-funded Health Finance and Governance (HFG) project led by Abt Associates, and the World Health Organization (WHO).

The Botswana’s 2013/2014 HA was the first of its kind produced using the System of Health Accounts (SHA) 2011 framework. It provides details on health care spending flows and distribution from government, external donors, private employers, non-government organizations (NGOs), medical aid schemes and households. The analysis breaks down health care spending into the standard classifications defined by the SHA 2011 framework, namely source of financing, financing scheme, financing agent, type of provider, type of activity, and disease/health condition. Botswana’s objective in conducting the 2013/2014 HA was to track the magnitude and flow of spending from all sources in the health system down to how the funding was ultimately used to deliver health goods and services as well as draw policy implications from the NHA findings.

Key findings from the 2013/14 HA analysis are as follows:
• Total health expenditure (THE) in Botswana for fiscal year 2013/2014 was Botswana Pula (BWP) 7,801,524,020, of which 97% of health care funds were recurrent expenditure and spent on providing health services consumed within the period of HA analysis, and 3% were capital expenditure and spent on the services whose benefits were consumed for more than a year.

• Health spending as a proportion Gross Domestic Product (GDP) was slightly higher than 6%, and per capita spending was BWP 3,712. Government was the major source of financing (65% of THE), followed by employers (both for-profit and parastatal; 16%), households (12%) and donors (7%).

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• Government schemes are the largest financing schemes, representing 65% of THE. Medical aid schemes account for 16% and employer schemes for 9% of THE. Donor and NGO schemes together constitute 7% of THE, and household out-of-pocket payments 4%.
• Majority of spending is incurred at public hospitals (37%) and health centres (14%). Curative care represents 55% of THE, of which 25% goes to treating outpatients and 30% goes towards inpatient services.
• 20% of THE, goes to preventive services, and planning, management, and administration account for 11% of THE.
• A breakdown of THE by disease shows that
  o 33% of THE is allocated to treating infectious and parasitic diseases; 50% of infectious disease spending goes to HIV and AIDS and other sexually transmitted diseases. Non-communicable diseases (NCDs) comprise 14%, reproductive health 12%, injuries 6% and nutritional deficiencies less than 1% of THE.
  o Government predominantly funds reproductive health services at 92% while donors’ contributions to reproductive health are very low.
  o With regards to HIV/AIDS funding Government and donors account for 57% and 38% of the overall HIV spending, respectively, whereas 5% of HIV spending is shared amongst NGOs, households, and employers.
  o The government is the primary source of funding for NCD goods and services; it contributes 79% of total NCD spending. Employers and households both contribute 10% and external donors contribute less than 1%.

From the HA findings the following policy implications were drawn;
• Government continues to be the dominant source of health financing in Botswana, indicating a sustainable health care system. However, the government share of THE has been declining since 2002/2003 therefore the need for Botswana to explore alternative sources of funding for health.
• The significant increase in the private sector health financing as a source over the past 10 years represents an opportunity to expand domestic resources for health in Botswana, as such needs to be strengthened further to diversify the sources of domestic financing and reduce the burden on the government.
• The need for GOB to maintain the current low levels of out-of-pocket spending on health to enhance Botswana’s financial protection against catastrophic health expenditures for its population ultimately paving way for attainment of UHC.
• Continue to increase share of resources to allocate to preventive care to improve quality, accessibility, and allocative efficiency. While spending on preventive care as a proportion of THE has doubled since 2009/2010, continuing to increase investments in preventive care could improve access to health service in remote areas, reduce future costs of care, and improve health outcomes particularly reduced the NCDs and HIV/AIDS which occupy the largest burden of disease and consumes the largest share of THE.
• GOB needs to continue increasing the proportion of government health spending as a share of total general government spending to achieve the Abuja target of allocating 15% of General Government spending on health.
• Allocate more resources to primary care vs. secondary and tertiary care to align Botswana’s spending is with the Alma Ata declaration on primary health care that the country has adopted, this means the country needs to improve allocative efficiency.
The 2013/14 HA recommended the following:

- The need for GoB to institutionalize HA to ensure regular and timely expenditure data for evidence-based health financing policy formulation and planning.
- Engaging and sensitizing stakeholders at the beginning of the HA process (and throughout), with more emphasis on private sector involvement.
- Strengthening and harmonization of health information systems to advance disease, provider, and function allocations.

4.12 Measuring technical efficiency of the provision of antiretroviral therapy among public facilities in Botswana (2016)

This publication was produced by Cogswell, Heather, Sharon Nakhimovsky, Jose Gutierrez, Sophie Faye, Christopher Cintron, Romana Haider, and Carlos Avila on behalf of Abt Associates under the HFG Project support by the United States Agency for International Development in September 2016.

The objective of the study was to analyze variations in the cost and efficiency of providing outpatient ART in public facilities in Botswana. An activity-based costing approach to collect data on the costs of delivering ART. A random sample of 120 facilities providing adult ART outpatient services in Botswana included all 29 hospitals in the country and a representative sample of 73 clinics and 18 health posts was used. Clinical records for 2,241 adult patients on first line ART and 152 patients on second line were also sampled. Unit costs (per patient per year) were constructed for three main cost categories: antiretroviral drugs (ARVs), laboratory tests, and human resources. Data Envelopment Analysis (DEA), a nonparametric technique, to estimate output-oriented efficiency scores and identifies the most efficient facilities relative to others was used. The most efficient facilities were those that maximized outputs (number of patients receiving ART) given the number of inputs (ARVs, laboratory tests, number of full-time equivalent staff, and supplies). A regression analysis was applied to study factors driving differences in technical efficiency.

The costing analyses focused on cost per patient per year, stratified by level of care. Treatment costs varied widely between health posts and clinics. It was estimated that in 2014, the national average ART unit cost is US$283 per patient per year (US$361 at health posts, US$309 at hospitals, and US$254 at clinics). ARVs represented 44 percent of the average total unit cost across all levels of care, and when stratifying, they are the largest component cost in hospitals and clinics, while human resources are the largest in health posts. ARV unit costs are the least variable, with a median of $125. Lab unit costs have intermediate variability among the three cost categories and fall between $60 and $90. Human resource costs are highly variable with a median of $55.1

The DEA results suggest that 69 percent of hospitals and 63 percent of clinics are technically efficient and operating on the efficiency frontier, relative to their peers at that level of the health system. No differences in technical efficiency were found among health posts. Comparing performance across different type of facilities, indicated hospitals have a higher proportion of technically efficient units compared to clinics; however, clinics have a slightly higher average efficiency score. DEA results indicated that inefficiencies in clinics appear to result from a high number of staff (both clinical and non-clinical) in relation to the volume of patients. The regression model shows that a higher average number of lab tests per patient and a higher proportion of clinical staff in facilities are associated with a significant decrease in efficiency scores. Given the large variations in human resource costs seen between health posts and higher levels of care, a more rigorous planning process is needed to determine the distribution of clinical and non-clinical staff. One available option that suits this need is the WHO’s
Workload Indicators of Staffing Need (WISN) tool. Using four main types of data - number of staff trained for an activity, time needed to perform the activity, available staff time, and frequency of the activity - WISN can help identify staff maldistribution, excessive or deficient workloads, skill-mix imbalances and opportunities for task sharing (WHO 2016b).

The analysis further reveals that total costs are driven by the frequency and unit costs of each service delivery component, whereas Adult patients had an average of three ambulatory visits per year and 4.4 lab tests across all levels of care, even among health posts and clinics relying on a well-functioning inter-facility network for test samples and results. Viral load and CD4 tests were most common, each with average annual utilization of 1.7 tests per patient in hospitals and slightly lower utilizations in clinics and health posts. Careful adherence to routine laboratory monitoring guidelines will help facilities maximize lab efficiency moving forward. Botswana might further reduce lab unit costs by adopting the 2016 WHO guidelines, which call for only annual viral load testing in stable patients and the cessation of CD4 testing where viral load monitoring is routinely available (WHO 2016a).

With regards to drugs, the study shows that ARV drugs represent the main cost driver of ART care. little variation was observed in overall or first line ARV unit costs between the three levels of care, but the same is not true for the doubly expensive second line drugs. ARVs account for nearly half of the total unit cost at clinics, yet the average costs of first and second line regimens are lower at clinics than at hospitals or health posts. Closer analysis of ART regimens, particularly second line regimens, is needed to discern what regimens are optimally efficient. As more patients initiate ART under “Treat All,” more will inevitably require costly second line ARVs, making their efficient use critical to ART programming sustainability. Patients are benefit from less treatment variance; a significant proportion of patients (95 percent) receive fixed dose combinations, mainly emtricitabine+tenofovir+efavirenz (37 percent) and lamivudine+zidovudine (47 percent). The shift towards one daily pill not only simplifies treatment, but also reduces dosing errors, the number of hospitalizations and even the likelihood of developing HIV resistance. Nearly 95 percent of first line patients and 87 percent of second line patients comply with national and WHO ARV guidelines. Patients at all levels of care have almost a quarterly clinical check and receive on average at least one viral load and CD4 test per year, with hospital and clinic patients receiving closer to two of each.

The analysis further shows that implementing differentiated models of care based on viral load outcomes can make care more patient-centric while reducing service delivery, and lab monitoring resource needs for stable, asymptomatic patients. i.e. by implementing one or a combination of differentiated models of care, Botswana could lower annual patient costs and better allocate resources, allowing for improved health system efficiency.

Findings suggest that HIV clinics in Botswana comply with national and international guidelines. Clinics achieve lower unit costs by providing services to many more patients, suggesting economies of scale. On average, clinics serve 400 patients per clinical FTE compared to 341 in hospitals and 77 in health posts. Treatment costs are higher in health posts, mainly attributable to more staff treating fewer patients, suggesting diminishing marginal returns as ART coverage expands into rural areas with low patient volumes.

The report also suggests that implementation of the Treat All Strategy in Botswana represents a stress test for the health system in accelerating access to treatment to nearly 330,000 people living with HIV. As such, there is potential for Botswana to reduce unit costs and improve efficiency of ART services in three main areas: ARV procurement, routine lab monitoring, and clinical staffing.
The report further suggests that:

- Botswana’s facilities have room to increase outputs (number of patients on ART) under the current set of inputs (physical or financial) across all levels of care and future reduction in ARV costs can be achieved through techniques including volume forecasting and price benchmarking.
- Updated international guidelines on routine monitoring to reduce excessive testing will lower lab costs.
- Rebalancing of human resources through task sharing and task shifting can condense variance, reduce average costs, and ultimately improve efficiencies in the delivery of ART services in Botswana.
- Strengthening these areas and the overall health system will help Botswana continue its impressive progress towards an AIDS-free generation.


The publication was developed by the World Bank Group in response to the request by the Ministry of Health and the National AIDS Coordinating Agency. The main purpose of evaluating the performance of Botswana's health system (with respect to achieving its objectives of improving health outcomes, financial protection, and consumer responsiveness in an equitable, efficient and sustainable manner), as part of the support to the government’s overall goal of achieving universal health coverage. The review also assessed performance in terms of time-series comparisons of inputs, outcomes, and health financing features; global comparisons holding income and health spending constant; assessing financial protection and equity by income class; and analyzing sustainability through a fiscal space analysis of the most recent macroeconomic and health expenditure information.

Key findings from the report are as follows:

- The burden of non-communicable diseases, and high rates of HIV/AIDS and TB, are driving demand and utilization for health services and posing a major challenge to health care organization and financing in Botswana.
- A combination of population-level and individual strategies at the health system level is needed to effectively deal with this complex dual epidemiological profile.
- The HIV/AIDS response will remain an important driver of domestic health spending over the next decades.
- Given data limitations, further work needs to be done with respect to quantifying the health sector inefficiencies, with respect to efficiency in financing, administration, and delivery of services.
- Health equity and financial protection in Botswana are guaranteed, the share of household budgets spent on health is low, representing only 0.7 percent of total expenditures in 2009-2010.
- Only 4 percent of households spend more than 10 percent of non-food consumption on health. The poor, in particular, were found to be largely protected from health spending shocks.
- A larger share of total expenditures among households is in the highest quintile implying health payments in Botswana are progressive.

4.14 Botswana’s Universal Health Service Package (2017)

The Botswana’s Universal Health Service Package was developed by the Thematic Group for Botswana’s Universal Health Service Package as one of the Health Financing Strategy’s
strategic actions which recommended the need to update the Essential Health Service Package (EHSP) that was developed by MOHW in 2010.

The UHSP was developed as part of the USAID’s Health Finance and Governance project (HFG) in collaboration with the MoHW established UHSP Thematic Group to lead the process. The UHSP Thematic Group included representatives of the MOHW including DHMTs and Health facilities representatives, representatives of Medical Aid Schemes and private sector providers.

The UHSP was developed under the principles that: it reflects priorities of health system stakeholders, is responsive to the health needs of the population, including those related to HIV and AIDS care and treatment and the prevention and control of NCDs, and informed by actuarial analysis to ensure it can be provided sustainably. The methodology for the process included multiple criteria to produce ranked interventions for inclusion in the UHSP, follow-up meetings stakeholders and MoHW senior Management team to reassess and confirm the selected interventions in light of Botswana’s health sector priorities.

The process for developing the UHSP in Botswana used explicit priority setting as the basis for improving Botswana’s long-term health financing sustainability and developing a proposal for national health insurance plan. Steps for Prioritizing Services to Cover in Botswana’s National Health Insurance are as follows:

- Define the decision problem
- Create list of interventions to serve as starting point
- Select criteria
- Compile data
- Rank interventions
- Calculate aggregate ranking

The UHSP identified approximately 72 health conditions including those related to HIV/AIDS as Botswana health system priorities that will be responsive to the health needs of Batswana.

The objectives of this priority setting process were to:

- Review the EHSP for Botswana,
- To apply methods for iterative priority setting to ensure resources are directed towards addressing the health conditions that are deemed most important to Batswana; and
- Compile inputs for a framework on updating the package through technically rigorous and socially sensitive priority-setting processes.

Challenges encountered during the prioritization activity, are highlighted as follows: quality and applicability of the data mainly unavailability of disease burden data for some interventions, latest inpatient discharge and outpatient attendance data dated at 2010 and only reflected one year of data rather than an average across multiple years, and a significant percentage of visits were grouped together in general categories. In addition, comparable cost effectiveness ratios for the interventions in the list were not available, leaving the TWG to rely on experience - rather than data-driven knowledge to inform the process.

4.15 Cost-Benefit Analysis of Outsourcing Cleaning Services at Mahalapye Hospital, Botswana (2015)

This publication was developed on behalf of Abt Associates by Cali, J., H. Cogswell, M. Buzwani, E. Ohadi, and C. Avila in June 2015 as part as USIAD’s technical assistance to the
Ministry of Health and Wellness - Office of Strategy Management (OSM) by the USAID supported Health Finance and Governance (HFG) project.

The aim of the analysis was to explore the costs and cost drivers of providing nonclinical support services at health facilities in Botswana to assist the MoHW with planning, managing, and implementing its outsourcing strategy and program. The Ministry’s efforts to outsource non-core services came in line with the Government of Botswana (GoB) efforts to implement a long-term strategy to diversify the economy, create opportunities for growth in the private sector, and increase the efficiency of the public sector. Outsourcing service delivery is one of four main approaches to privatization outlined in the GoB’s policies, and the Ministry of Health (MoHW) was one of the Ministry’s identified as pilot for privatization policy by initiating outsourcing of nonclinical services at seven regional and district hospitals.

The report analyses the costs and benefits of outsourcing nonclinical services and provides health authorities and managers with best practices and recommendations for determining whether they should outsource and at what price, the analysis was based on a cost-benefit analysis of cleaning services at Mahalapye General Hospital, and observations from outsourcing in six other hospitals in Botswana.

This methodology followed a retrospective cost-benefit analysis of outsourcing cleaning services at Mahalapye General Hospital using the hospital manager’s perspective when calculating costs and benefits of two alternatives: outsourcing, and ‘insourcing’, or providing services inhouse. The analysis employed an ‘ingredients’ costing approach and monetizes the benefits of outsourcing by weighting the costs of the two alternatives by a ‘quality factor’ derived from a service quality survey, in which hospital managers rated the observed quality of cleaning services before and after outsourcing.

There result on Cost-benefit, value for money and ‘hospital cleanliness per pula spent’ showed that outsourcing services, compared to the status quo, would result in approximately (BWP) 5 million ($524,135) in additional hospital expenditures over a five-year period. Furthermore, after taking into account improvements in quality, the cost-benefit ratio showed that for every dollar paid to private cleaning services, more than five cents would be returned per square meter of hospital floor cleaned. This represents aggregated net gains for Mahalapye Hospital of approximately BWP 1.7 million ($182,365) over a five-year period. Applying a sensitivity analysis showed that varying the assumptions made regarding the costs of operations, training, and management of outsourcing cleaning services, and varying the discount rate, have a minimal impact on the results. The conclusion drawn from the analysis is that outsourcing cleaning services delivered greater value for money than insourcing under all scenarios tested. The study recommended that as a way forward hospitals should collect more-detailed information on the costs of providing nonclinical services in-house, the units of production of services to be outsourced, and the monetary value of increased quality of outsourced services, in order to fully inform their decisions regarding the outsourcing process.

The study highlighted the following lessons for hospital managers currently outsourcing or considering outsourcing in the future:

1. Assessing the value of outsourcing and making informed decisions requires detailed information on the status quo: hospital managers need to collect accurate data on staff salaries, benefits, and time worked; the unit price and rate of consumption of supplies; the unit price, age, and maintenance costs of equipment; the personnel costs of training facilitators and participants; the personnel costs of management; and the unit price and amount of utilities consumed by the service to be outsourced. It is also vital for managers
to collect data on the production units of services they wish to outsource, such as the size of the floor area to be cleaned (in square meters) and the quantity of linens to be laundered each month (in kilograms).

2. Outsourcing can be more costly than insourcing: The annual real financial cost of the contract for outsourcing cleaning services at Mahalapye Hospital (BWP 6.0 million) is approximately BWP 1.1 million more than the annual cost of insourcing (BWP 4.9 million). In addition, the hospital still has to incur costs above and beyond the contract cost to manage the vendor, train cleaners, and provide utilities. Hospitals should consider the costs they will continue to incur after outsourcing when negotiating contracts and evaluating bids. After these costs were included, the annual cost of outsourcing was BWP 1.3 million ($140,000) higher than the annual costs of insourcing.

3. Benefits are just as important as costs for decision-making: Even if outsourcing is more costly than providing a service in-house, it may still be justified if it delivers a significant increase in the level of quality of the service. If justifying paying more for a better service, however, hospitals must commit to vigorously monitoring the quality of services provided by private vendors and hold them accountable for the quality of the services. It is also important for hospitals to include in their analysis the intangible benefits of outsourcing, such as improved adherence to guidelines and improved availability of supplies, potential reduction in infections, and opportunities to gain experience with the private sector.

4. Hospitals and vendors could both gain from closer collaboration: Closer collaboration between hospitals and vendors through sharing of information, joint monitoring of quality, and joint training could lower the costs and increase the benefits of outsourcing. Hospitals could build trust with vendors, and facilitate cooperation on other issues, by sharing information on the current costs of providing the service in-house and giving the vendors a base price upon which to make their bid. Conducting quality assurance in a collaborative rather than confrontational manner, such as through joint ‘walk-abouts’, could result in better-quality outcomes. Finally, joint orientation and training sessions, where hospital staff teach infection control practices to the vendor’s cleaning staff, could also improve the quality of services, by transferring knowledge on infection control and other hospital-specific cleaning methods with which vendors have little experience.

5. The costs and benefits of outsourcing should improve over time. Hospitals should reassess the costs and benefits of outsourcing periodically, as they are likely to improve as vendors and hospital managers gain experience with the outsourcing process. Costs may decrease as vendors increase efficiency and hospitals improve their ability to negotiate lower contract prices, while benefits may increase as vendors improve the quality of their services and hospitals increase their capacity to enforce adherence to quality standards.

4.16 Botswana Private Health Sector Assessment (PSA) (2013)
This publication was produced by the Strengthening Health Outcomes through the Private Sector (SHOPS) project engaged by the USAID to conduct a private health sector assessment (PSA) in 2013 to examine Botswana’s private health sector and develop recommendations for leveraging private health sector resources – including financing, personnel, and pharmaceutical commodities and supplies – in support of the country’s HIV response. The report outlines the size, composition, and prospects for growth of private practice and the private commercial supply chain in Botswana, detailing the policy environment for the private health sector. The PSA report also discusses significant barriers to growth in the private health sector.
The assessment also paid attention to innovative strategies that can leverage the private sector to sustain key PEPFAR investments in safe male circumcision, HIV counseling and testing, and antiretroviral therapy. The report presents several opportunities to improve the revenue diversification potential of PEPFAR-funded nongovernmental organizations (NGOs) offering critical HIV prevention services, as well as strategies to increase the provision of safe male circumcision in the private sector through networking, reinforcement, and a more accurate medical aid scheme tariff.

The methodology followed was an extensive review of available published and gray literature pertinent to the objectives of the assessment. The SHOPS team conducted over 80 stakeholder interviews in May 2013, which helped reveal the prevailing attitudes of public and private sector actors, donors, and implementers toward existing constraints and challenges in further leveraging Botswana's private health sector.

The report also presented a roadmap for increasing private health financing sources through the existing medical aid schemes and revealed that medical aid schemes represent a significant opportunity for increasing domestic financing of health services, but their growth is inhibited by a number of factors, mainly high levels of fragmentation in the medical aid industry, the cost of their products, and concerns over their regulation.

The assessment identified key opportunities within the private sector as; expanding the use of contracting arrangements between public facilities and the private sector actors, strengthening private sector representation to broker more effective service delivery partnerships, and shaping an effective enforcement system to ensure quality in the private health sector.

Key constraints include the small population size creating a small market for the private sector, human resources for health shortages, and the reliance on a transitioning public sector supply chain for key public-private partnerships in HIV treatment.

Key recommendations from the PSA are as follows;

- **Need to better leverage the private health sector**: Specific recommendations include strengthening private sector representation with the Ministry of Health on critical issues of registration, licensure, enforcement, clinical dimensions and implications of contracting models, and access to new information on clinical best practices and advances in medicine, supporting the transfer of enforcement responsibilities to the Botswana Health Professionals Council to improve oversight (and thus quality) of private practitioners, exploring partnership models, including mobile facilities to strengthen primary health care and building on Ministry of Health contracting experiences to maximize the use of existing private human resources through contracting-in of private providers.

- **Increasing the role of private financiers could reduce the expected funding gap**: Considerations to consolidate existing medical aid schemes to make them fewer, larger, and stronger schemes that can take advantage of economies of scale and larger risk pools to lower costs, developing lower cost insurance products and distribution channels that can target low-income workers and younger, healthier clients, developing modified plan choices in the public and private sectors taking into account the possibility of mandated coverage, creating a supportive regulatory environment, including the resolution of supervisory concerns about collusion between and among the medical aid schemes and providers and developing stronger risk sharing arrangements among the parties.
• Sustaining PEPFAR investments in NGO sustainability, safe male circumcision, HIV counseling and testing, and HIV treatment: Focus to be made to-
  o **NGO Sustainability:** Brokering linkages – where appropriate – between NGOs and Botswana corporations to help diversify revenue and cross-subsidize operations for NGOs while providing necessary health services to Botswana’s private sector.
  o **Safe Male Circumcision:** Leveraging the private health sector to deliver safe male circumcision by advocating for more medical aid schemes to cover it as an HIV preventative benefit; support actuarial analysis for a more accurate tariff; consider networking or other reinforcement mechanisms for private providers.
  o **HIV Counseling and Testing:** Pursuing the appropriate options to increase private sector provision of HIV counseling and testing, whether through Ministry of Health contracting NGOs, training and utilizing private laboratories and pharmacies in counseling and testing, or conducting an independent actuarial analysis and advocating increased medical aid scheme coverage.
  o **HIV Treatment:** Conducting cost analysis for outsourcing antiretroviral procurement to a third-party; assess the implication of revising the evaluation criteria for bids; conduct a cost analysis to understand the scalability and expansion of the existing public-private partnership model for delivering antiretroviral therapy


The report was produced by Stegman P, Ohadi E, Buzwani M, Cogswell H, and Avila C, on behalf of Abt Associates under the USAID’s HFG Project. It presents the methodology and findings of a study done to estimate the current costs of non-clinical services (i.e., cleaning, laundry, catering, and grounds maintenance) at public hospitals. The need for this study arose out of the progress the Ministry of Health (MOHW) has been making in the implementation of its outsourcing plan, laid out in Health Services Outsourcing Strategy and Programme 2011-2016.

The analysis was conducted by USAID supported Health Finance and Governance Project in Collaboration with the Ministry of Health and Wellness, Office of Strategy Management.

The specific objectives of the Botswana cost benchmarking study for non-clinical services as outlined in the work plan were to:
  o Calculate the total estimated monthly and annual costs for each non-clinical service in each of the sampled hospitals
  o Provide estimates of the total direct and indirect costs for each non-clinical service in each of the sampled hospitals
  o Identify the cost drivers for each non-clinical service
  o Make recommendations on use of the study results, areas needing further investigation, and application of the costing tool.

Methods: An ingredients approach was used for the costing analysis whereby all the inputs, direct and indirect, were identified, quantified, their monetary values determined, and their contribution to the overall cost tallied. The analysis was undertaken from the public sector perspective, specifically looking at what it costs the public sector health system, both at MOHW and facility levels, to provide non-clinical services. The study analyzed the direct costs (human resources, equipment, consumables, etc.) and indirect costs (training, management, operational costs, etc.) of delivering these services at a sample of district hospitals that are currently not outsourcing to the private sector: Deborah Retief, Goodhope, Gumare; and two where outsourcing has started: Athlone and Mahalapye. The study results identify, among
other things, total cost for each service delivered, cost by facility, and the cost drivers for each service. The participating district hospitals were purposively selected to represent the varied conditions of facilities in the public sector health system: from older hospitals (Deborah Retief) to new, modern facilities (Mahalapye), and from hospitals like Athlone, serving more urban, built-up areas, to more remote and rural locations (Gumare).

The study revealed that, overall, direct costs were the greatest proportion of costs for the delivery of non-clinical services, accounting for, on average, over 80% of total cost across facilities. Indirect costs made up just under 18%. The primary cost driver in the direct costs, and overall, was supplies, averaging about 64% of all direct costs and 53% of total costs. This was followed by human resource costs, which averaged around 24% of direct costs and just under 20% of total costs. Of the indirect costs, management and operational costs are the most important drivers. Management costs average about 54% of all indirect costs and 9% of total costs. Operational costs account for on average about 42% of indirect costs and 7% of total costs.

According to the data, the total costs for non-clinical service delivery ranged from about US$415,000 (BWP 3.7m) in Gumare Primary Hospital, to nearly US$1.5m (BWP 14.6m) in Mahalapye Hospital. The most costly non-clinical service to deliver is catering, costing on average just under US$366,000 (BWP 3.4m) per year. Catering costs the most at Mahalapye Hospital, around US$870,000 (about BWP 8.1m). The least costly service to delivery is grounds maintenance, costing on average about US$36,900 (BWP 343,500).

Unavailability of data was cited as the main limitation of the study especially indirect cost data.


The publication was done by the Merz & McLellan Botswana (Pty) Ltd (trading as HLSP), A Member of the Mott MacDonald Group as consultancy services to the MoHW.

The analysis was undertaken out of MoHW’s interests to explore the possibility of introducing a formula-based approach to allocating resources for district health services. The need for a formula was based on concerns that the current approach - based largely on historical allocations and incremental budgeting – does not reflect real need and does not offer the best use of its limited resources.

This report reviews the need for a resource allocation formula in Botswana and the feasibility of introducing one. It reviews a range of possible ways of implementing a formula-based approach and maps out some of the steps which would be needed where the approach to be adopted.

Methodology: The first step to the approach was an attempt to estimate current levels of spending at the district level and identify the relevant budget lines for inclusion. Following that, an iterative process of identifying criteria, finding ways of measuring them, and weighting their relative importance was undertaken. Other factors considered included the timing of introduction and the period of introduction. Assessment of the implications of a formula based on the overall resource envelope followed (if the overall budget is increasing there are less likely to be big losers and the process is likely to be more politically acceptable). The underlying assumptions and various scenarios considered were set out in an Excel model prepared by the consultant. This was used to test new scenarios or the implications of using different assumptions. Key Scenarios used were as follows:
<table>
<thead>
<tr>
<th>Scenario</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 1</td>
<td>100% Population Based</td>
</tr>
<tr>
<td>Scenario 2</td>
<td>80% Population Weight</td>
</tr>
<tr>
<td>Scenario 3</td>
<td>60% Population Weight</td>
</tr>
<tr>
<td>Scenario 4</td>
<td>40% Population Weight</td>
</tr>
<tr>
<td>Scenario 5</td>
<td>Cost Based (100%)</td>
</tr>
<tr>
<td>Scenario 6</td>
<td>60:40 Population – Poverty</td>
</tr>
<tr>
<td>Scenario 7</td>
<td>60:40 Population – Health</td>
</tr>
<tr>
<td>Scenario 8</td>
<td>60:40 Population – Cost</td>
</tr>
<tr>
<td>Scenario 9</td>
<td>Scenario 3 - HIV 100%</td>
</tr>
<tr>
<td>Scenario 10</td>
<td>Scenario 5 - Increase Adjustment for Cost</td>
</tr>
</tbody>
</table>


Weighting factors were also applied as follows:

**Weighting within individual criteria**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>Population (100%)</td>
</tr>
<tr>
<td>Poverty</td>
<td>Poverty Ratio (50%) Literacy/Numeracy (25%) Access to Piped Water (10%) Proportion of Population in Paid Employment (10%)</td>
</tr>
<tr>
<td>Health</td>
<td>HIV/AIDS (50%) Notifiable Diseases (50%)</td>
</tr>
<tr>
<td>Costing</td>
<td>Rural areas – 100% uplift Mixed areas – 50% uplift</td>
</tr>
</tbody>
</table>


The analysis demonstrated that in almost all scenarios the formula would involve a reallocation of resources from rural to urban areas. Only in the very extreme scenario – heavily weighted towards costs – do allocations shift away from urban areas. The need to explore if poor geographical allocation of resources is a major issue in Botswana was highlighted.

The analysis also showed that if budget growth is slow and/or a short transition period is used, there is the possibility that some districts will get a reduction in per capita allocations.

The report recommended that if MoHW choose to proceed with a formula, the following actions are necessary prior to implementation:

- Discussion and agreement of the approach with the districts: Discussions on both the concept and content of the formula taking into account that resource allocation is more a political than a technical issue as such important that the districts buy in to the approach. Such discussion should focus heavily on agreeing the criteria to be used and their weightings rather than on specific budget allocations. The latter runs the risk of districts trying to promote formulae which benefit them.
- Commissioning specific studies. The analysis demonstrated that little is known on a range of important issues such as cross district flows (the extent to which people in one district use services located in another) and the relative costs of delivering services in remoter areas. It would be useful to commission studies on these issues before establishing a formula.
- Improving timeliness and quality of data. The data available at the time of the analysis did not form a sound basis for establishing a formula. Data for some of the criteria was
outdated. Data on expenditure was only available for 2012/13 when the analysis took place. More up to date information would be required

- Changing budget code: In line with decentralization processes budget codes need to be amended to reflect changing structures in consultation with the Ministry of Finance and Economic Development. This was seen as necessary to allow disaggregation of spending both by geography (district) and function (referral hospital, district hospital, primary hospital, DHMT, clinics).
- Improvements in tracking of CMS disbursements to facilities was also cited as necessary.


This publication was produced by Menon, V., P. Iyer, and W. Mosime on behalf of the Health Policy Project. This publication estimated resource needs for key health interventions offered under Botswana’s Essential Health Services Plan 2013–2017. Washington, DC: Futures Group, Health Policy Project.

The study comprises of two parts. In Part I, the Health Policy Project (HPP) technical team assessed the unit costs of providing specific HIV interventions at two levels of service delivery. In Part II, the team used the OneHealth tool (WHO PMNCH, n.d.) to project (between 2013 and 2017) the overall resource requirements for providing EHSP services, based on normative inputs.

For phase one, the technical team assessed direct and indirect costs of delivering HIV-related interventions at two facilities Goodhope Primary Hospital and Bontleng Clinic. In turn, costs were collected for six interventions from these two facilities: (1) additional ART for tuberculosis (TB)/HIV patients, (2) safe male circumcision, (3) co-trimoxazole for TB/HIV patients, (4) postexposure prophylaxis (PEP), (5) screening people living with HIV for TB, and (6) condoms. Direct costs included personnel, drugs, and supplies, and indirect costs included management and support staff, utilities, supply chain, equipment, and building and vehicle operational costs. The results showed that in overall, across both facilities, the primary drivers of the direct unit cost were drugs and supplies and personnel. For indirect costs, building and vehicle and facility management costs contributed the least to total costs across both facilities. Poor record keeping was cited as a challenge that made it difficult to assess patient volume data. One other limitation encountered was the inconsistencies in the application of intervention guidelines across facilities.

Phase two of the study entailed a normative costing of the Essential Health Service Package (EHSP) using the OneHealth tool (Futures Institute, n.d.). The analysis focused on eight disease areas: maternal health, child health, immunization, malaria, TB, HIV, non-communicable diseases (NCDs), and mental, neurological, and substance abuse disorders (MNSADs). Data on information such as targets, implementation, and costs of drugs and commodities were obtained from MOHW program managers and from documents. For all disease areas, the data collection sheets were designed around the One Health input process and customized. These customized data collection sheets were used to collect data from key respondents from the disease programs and supplemented as necessary with national and international guidelines. All cost inputs were validated with program managers. The study aimed to include health systems costs such as costs for infrastructure, human resources, logistics, health information systems, governance, and health financing. However, due to challenges of unavailability of data for health systems costs (data missing or not robust), the
decision to exclude costs of the health system was made and the study focused only on the clinical health services delivery.

The results of the analysis of the eight disease areas covered under EHSP using One Health showed that, a minimum, US$2,360.8 million will be required to provide coverage for these diseases over five years (2013 to 2017).

4.20 Ministry of Health Organizational Review (2013/14)
As part of implementation of the revised National Health Policy (2011) the MoHW engaged HLSP (a member of the Mott MacDonald Group) consultancy team to review and revise the organization and management structure of the MoHW to respond to new developments and challenges, in order to gain and maintain high efficiency in the provision of health care services. The restructuring exercise looked at the organizational structure for the Ministry of Health at Central and District level taking into consideration the National Health Policy (NHP), the Integrated Health Services Plan (IHSP), the Essential Health Services Package EHSP), and complements the report on the proposed functional structure dated 30th of May 2013.

The main reasons for the restructuring of the Ministry of Health in Botswana at this particular point in time are the following:

- To accommodate the transfer of Primary Health Care (PHC) services from MoLGRD to MoHW and ensure a continuum of care of preventive, promotive, curative and rehabilitative services.
- To strengthen the structures and systems to deliver quality health services from community level through the health post and clinics up to district hospitals that provide 2nd level referral services.
- To create an environment whereby the Essential Health Service Package (EHSP) is implemented in an integrated manner rather than through vertical programs.
- To support the process of decentralization / deconcentration that delegates authority from central level to the districts, i.e. creating a leaner headquarters with expanded authority and functions of DHMTs.
- To strengthen bottom up planning, priority setting, monitoring and evaluation of health service provision.
- To clearly distinguish between policy and strategy development at central level and service delivery at district level.
- To build towards a clear separation of the delivery of health services and health regulation.

The overall methodological approach to develop a functional structure was proposed to and approved by a joint meeting of the Organization and Management (O&M) and Human Resource (HR) Thematic Working Groups (TWG). The main components of the methodology were as follows:

- Document review to ensure that the proposed organizational structure fits well within the current policy and legislative environment and the on-going reform processes.
- International benchmarking to ensure that best practices and lessons learnt are incorporated.
- Review of the various organizational structures that have been operational over the past decade.
- Semi-structured interviews / consultations with staff at central and district level to identify challenges, overlaps, grey areas, duplication and opportunities for improvement.
• Group discussions and presentations of different drafts to Senior Management for input, feedback and further guidance.
• The proposed functional structure was approved by Senior Management in May 2013 and subsequently the team of consultants started the development of a detailed organizational structure.

The organizational review was guided by the following principles:
• The structure must be “fit for purpose”, i.e. focus on desired contribution and outcome.
• The arrangement and organization of functions should be program rather than disease based.
• The organogram should facilitate maximum effectiveness and efficiency.
• The design of the organogram should build on previous reorganization efforts and recognize work already done.
• The new structure should reflect clear lines of authority, reporting and accountability.

The organizational review process distinguished the relationship between national level and district health system as follows:

<table>
<thead>
<tr>
<th>National level</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stewardship</strong></td>
<td>Implement and enforce regulations; interpret and implement policies, e.g. essential health package; interpret and enforce standards; partnership establishment through private/public mix, community involvement and multi-sectoral approach; identify areas for operational research; conduct health systems research; take part in national surveys; take part in piloting interventions of national priority; conduct cost effective public health intervention; put HMIS into operation by collecting, processing and analysing data; use information for evidence based comprehensive health planning; link HMIS data with research; dissemination of district health information</td>
</tr>
<tr>
<td>Regulatory functions; policy formulation; standards setting; liaison with bilateral and multilateral agencies; formulation of strategic research priorities and plans; establishment of HMIS</td>
<td></td>
</tr>
<tr>
<td><strong>Resource generation</strong></td>
<td>Assessment of local HR needs; rational deployment and utilisation of HRH; continuing professional development of the health workforce and orientation of community based health workers; identifying physical infrastructure and equipment needs; routine maintenance of physical infrastructure and equipment items; identifying and procurement of drug and other essential supplies’ requirements; proper storage, distribution and use of essential drugs and supplies</td>
</tr>
<tr>
<td>Development of a national human resource development strategy and plan; training of high and mid-level health professionals; development of national health infrastructure development and maintenance plan; development of a national equipment policy; policy development on procurement and rational use of essential supplies, including drugs</td>
<td></td>
</tr>
<tr>
<td><strong>Service delivery</strong></td>
<td>Identification of health care needs and prioritisation of health service delivery in accordance with identified needs; provision of identified and prioritised health care in an integrated, continuous and comprehensive manner; encourage community based care; identification and involvement of all stakeholders; development and</td>
</tr>
<tr>
<td>Tertiary level health care service provision; technical back up and supportive supervision; standards setting; quality improvement; monitoring and evaluation; provision of incentives for service organizations and providers</td>
<td></td>
</tr>
</tbody>
</table>
### National level

**Financing**

Budgeting; financing strategies; donor coordination; development of pooling mechanisms (e.g. insurance and prepayment schemes); development and use of purchasing mechanisms (e.g. contracting); maintenance of national health accounts

### District

Implementation of annual work plans; ensuring customer/ client satisfaction

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**5 Ongoing Analysis/Activities**

**5.1 National Health Accounts Exercise for 2014/15, 2015/16, 2016/17 and 2017/18**

The Ministry of Health and Wellness and the National AIDS Coordinating Agency through the technical support from WHO are in the process of undertaking the National Health Accounts including disease and primary care (PHC) expenditure analysis for the period 2014/15, 2015/16, 2016/17 and 2017/18.

Specifically, the exercise entails provision of technical support and training to the country HA technical working group on System of Health Accounts (SHA) 11 approach to enable them to undertake the analysis, support the preparation and presentation of results on key policy issues in a format that can be disseminated publicly; support the development of the institutionalization plan as an effort towards making the data collection and analysis processes routine. The expected deliverables from this exercise are; a) Health accounts results/ tables; b) Policy briefs and short analytical reports c) Institutionalization plan available and lessons learnt document.

**5.2 HIV/AIDS Investment and Analysis Optima Analysis on Allocative Efficiency**

The Government of Botswana through the National AIDS Coordinating Agency and the Ministry of Health and Wellness in collaboration with the World Bank and UNAIDS are jointly undertaking a rapid tracking and analysis of HIV investments in line with the 2018 Global AIDS Monitoring (GAM) Indicator 8.1 and the Optima Analysis on Allocative Efficiency. The study will comprise of two phases, phase 1 being the HIV investments analysis and phase 2 being the Optima Analysis on Allocative Efficiency.

The Botswana HIV investments analysis comes in as an effort to close the gap due to the inability of the country to produce NASAs making it difficult to report HIV/AIDS financing key indicators, such as UNGASS/GARPR/GAM of which Botswana has not reported since 2013. This investment analysis covers six (6) year period from 2012/13 to 2017/18.

The objectives of the Botswana HIV investments analysis are to; a) track and analyze the HIV investment profile of Botswana for the period 2012/13 to 2017/18; and b) collate available data on volumes of HIV/AIDS services delivered/coverage from all available sources. The HIV investment analysis seeks to answer five key policy questions: a) How much was spent on HIV? b) Where did the money come from? c) On what programs was the money spent on? d) Execution rate: what is the expenditure rate of budgets and what are the challenges with budgets’ execution (absorptive capacity or timing of disbursements)? And d) Program coverage, unit cost and outcomes using the program classifications in GAM Indicator 8.1 framework as well as key service delivery modalities.
The information generated from the analysis will form a basis for HIV/AIDS expenditure trend analysis over a six-year period (2012/13-2017/18), as well as inform the completion of the GAM National Funding matrices over the same period. The information collected during this exercise will also inform the Optima analysis on allocative efficiency planned for early 2019.

Phase two of this analysis will involve undertaking the Optima Analysis on allocative efficiency focusing on the joint 2019/20 budget allocations aimed to facilitate the country’s fast track commitments.

5.3 Analyzing impact of Provision of ART to Non-citizens
This analysis is undertaken by a core group with representation from the MOHW, the National AIDS Coordinating Agency (NACA), UNAIDS, the United States President’s Emergency Plan for AIDS Relief (PEPFAR), and MEASURE Evaluation (funded by the United States Agency for International Development [USAID] and PEPFAR).

The methodology for the analysis includes a desk review and secondary data (related to Botswana’s demography, financial, and HIV status synthesis as the foundation of a detailed economic analysis of the Botswana’s investments in ART services. The analysis aims to demonstrate the costs and benefits of extending ART to non-citizens, as well as demonstrating how Botswana’s paths to HIV epidemic control are linked to sustainable financing for its national HIV response. The study will also consolidate profile of the non-citizen population, distinguishing those who currently do not receive ART treatment. It will also describe the current policy environment in Botswana and in neighboring countries, to contextualize the need to provide ART to non-citizens.

In addition to the economic analyses and profile of non-citizens, the expected deliverables for this study include the development of key policy recommendations (policy brief) to the Government of Botswana for providing antiretroviral (ARV) treatment to non-citizens who cannot afford and the roadmap for investing in treatment for non-citizens through the Treat All strategy.

5.4 Primary Health Care Transformation
Considering that the top 5 causes of mortality in Botswana are predominantly primary health issues, the government of Botswana through the Ministry of Health and Wellness envisages transformation of the health system that is centered on primary health care. As the initial stages of this transformation, the Ministry of Health and Wellness currently leads the exercise to develop the structural reform for primary health care in Botswana. This thinking is about designing a coordinated health system that will prevent the current over utilization of high cost tertiary level care for conditions that require or can be addressed at primary care facilities. This transformation will focus on strengthening prevention interventions to ensure risk factors for the top causes of mortality are addressed.

5.5 Botswana Health Information Management System Assessment
This piece of work is led by the Ministry of Health and Wellness in collaboration with the WHO Country Office. The technical support for the work is provided by the Global Fund (RFP TGF-18-013 MECA) technical support.

This exercise aims to assess and propose strategies for strengthening the national and disease specific HIMS. Specifically, the work entails conducting a situational analysis of the multiple national disease specific health information management systems and data quality processes across stakeholders including donors, disease programs and provide recommendations on
appropriate measures for streamlining and strengthening HIMS and data quality assurance and improvement activities to improve performance health sector.

Specific activities of this work are as follows:

- To conduct a desk review and interviews with stakeholders on the HIMS/M&E strategic initiatives within the health sector such as the review of National Health Sector Strategic Plan, Monitoring and Evaluation Plans, Health Information Management Policies, e-Health Strategy, data collection tools and guidelines with the view to harmonize them.
- Assess existing software/technological systems including aggregate systems, disease specific systems (HIV/AIDS. Malaria, SRH, TB, Maternal and Child health data management systems), electronic medical records and other information technologies with the aim of streamlining and strengthening the HIS and IT infrastructure to provide an enabling environment for effective M&E and data use at both public and private sectors.
- Assess data quality tools and processes across all stakeholders and disease programs.

6 Committees guiding the UHC & HIV/AIDS Response Processes

The following are some of the main working committees established to ensure effectiveness in the delivery of health care services in Botswana as a move towards UHC as well as driving the HIV/AIDS response.

6.1 National Level

6.1.1 Botswana Health Partners Forum (BHPF)
Botswana Health Partners Forum was established late in 2012 as the main platform for health sector dialogue in Botswana. The forum has been conceptualized as a dialogue of two broad constituencies comprising the Government of Botswana and its Health partners. The Forum is governed by the BHPF Co-Chair Committee, composed of the Permanent Secretary in the Ministry of Health and Wellness and the elected Co-Chair of the Health Partners constituency, supported by the WHO Country Representative. The Co-Chairs meet periodically to set the agenda and organize the aspects related to dialogue and review sessions of the Forum.

- **Government of Botswana (GoB)** refers to all Government agencies – all Ministries and offices with a direct stake and involvement in the health sector, including broader aspects of control and prevention of HIV/AIDS at central and district levels, public sector providers and its facilities.
- **Health Partners** refer to all non-GOB stakeholders in the Botswana Health Sector like bilateral donors; UN agencies; for profit private sector companies; local and international not for profit and community-based organization; academic and other training institutes. Health Partners are seen as a single diverse constituency for the purpose of simplifying formalized sector wide dialogue and engaging with Government under the auspices of BHPF. For internal dialogue HP constituency meets as the “Health Partners Group” (HPG) facilitated by the HP Co-Chair and supported by the WHO Representative.

6.1.2 National AIDS Council (NAC)
The National AIDS Council (NAC) was established through a Presidential Directive, CAB 28/95, during MTP II alongside the first National AIDS Policy as the highest national level coordinating body with a mandate to oversee and advise government on policy matters on the multi-sectoral response. NAC continues its work as an oversight body chaired by the President
of the Republic of Botswana. The NAC membership consists of political and traditional leadership and accounting officers. The membership of NAC is attached as Annex 1.

NACA is the secretariat of NAC with a mandate to coordinate and lead the multi-sectoral AIDS response in the country. NACA continues to facilitate interaction of technical experts from various fields and sectors in the national response through structures such as Joint Oversight Committee (JOC), National response fora (Partnership Forum, Academia, CSO, GOB, Development Partners and Private Sector) and Technical Planning Team (TPTs) to guarantee comprehensiveness and quality.

6.1.3 The Parliamentary Portfolio Committee on Health and HIV/AIDS

The Botswana Parliament’s Health and HIV/AIDS Committee sensitizes the public, promote and leads campaigns against the spread of HIV/AIDS in partnership with the National AIDS Council. Members of Parliament, as representatives of the people, make use of other tools such as motions, and questions to ensure that constituent’ needs are addressed.

Operations of the Committee in Botswana.

The vision of the Committee is outlined as “a catalyst in the effective control and management of HIV/AIDS,” and its mission as “to sensitize the public, to promote and lead the campaign against the spread of HIV/AIDS in partnership with National Aids Council (NAC).”

Terms of the committee

1. To ensure and foster the highest political engagement and leadership in the multi-sectoral fight against HIV/AIDS across the political spectrum;
2. To promote and lead prevention and mitigation efforts of HIV/AIDS by political leadership at both the local and national levels;
3. To guide and closely monitor the implementation of the national expanded response to HIV/AIDS as outlined in the Botswana Second Medium Term Plan II (MTP-II) for HIV/AIDS;
4. To mobilize extra budgetary resources, if need be, to facilitate effective management of the HIV/AIDS epidemic.
5. To liaise with the National AIDS Council in the development, review and adoption of necessary and critical national policies and laws, and when necessary to ensure effective control and management of the HIV/AIDS.

The Botswana committee has built strong and positive cooperation between Parliament, the Executive and all stakeholders. This has transformed the role of parliament and taken it beyond the traditional role of scrutiny/oversight on the executive towards a more active catalytic role on AIDS.

6.1.4 Health Sector Reform Thematic Working Groups

During the National Health Policy revision / development process in 2011, the Ministry of Health (MoHW) established six (6) Thematic Working Groups (TWGs) that were tasked with ensuring that new global and national issues in relation to the six health system’s building blocks / functions were included in the revised NHP. In order to ensure ownership by key stakeholders and enabling processes of the implementation of the Revised National Health Policy through Integrated Health Service Plan (IHSP), the TWGs were revitalized in 2013/14 to provide critical input at various steps of the health sector reform as proposed in the revised National Health Policy.

The TWGs were organized along the six health system functions / building blocks, i.e.
• TWG health service delivery
• TWG HR / health workforce
• TWG health information
• TWG medical products, vaccines and technology
• TWG health financing
• TWG Organization and Management (Leadership and governance).

The deliverables of the TWGs were to be presented and approved by the Health Sector Steering Committee (HSSC).

6.1.4.1 The Health Sector Steering Committee (HSSC)

1. Purpose
The Health Sector Steering Committee (HSSC) will provide the governing structure for various projects, programs and initiatives funded by the government of Botswana or any other development partners. The HSSC will coordinate the inputs of the various technical assistance and thematic working groups formed as per the initiative for the SWAp in Botswana.

2. Scope of the Committee
• Provide an overall guidance for the coordination of all projects, programmes and initiatives in the health sector of Botswana.
• Approve the work plans of all the thematic working groups.
• Approve deliverables of the Consultancy services provided for the Change Management and Reorganization project.
• Ensure that there is wide consultation on the review of the National Health Policy and the development of IHSP.
• Overview and coordinate all inputs of different projects and harmonies and align them as deemed necessary.
• Leverage resources as necessary to ensure full implementation of IHSP equitably.
• Coordinate Annual Review of health sector and approve a report for BHPF.

3. Method of Working
The committee will
• Meet quarterly and as when necessary
• The Department of HPDME (MOH) will be responsible to provide Secretariat support for the HSSC.

6.1.4.2 Health Financing Technical Working Group

1. Purpose
The purpose of the TWG is to provide technical input in and to facilitate development of a comprehensive but prioritized range of policy options for health system financing in Botswana in the medium and longer term. These should cover revenue collection, pooling and purchasing, as well as any institutional, regulatory or service frameworks to implement financing mechanisms effectively. The HF TWG should place emphasis on universal health coverage, particularly coverage of the poor and other vulnerable populations, as well as ensuring efficiency and sustainability of the health sector.

2. Scope of Work
• Ensure the analysis of the current and potential levels of health system resource needs and availability by sources and health financing agents in Botswana using existing information.
• Facilitate the generation of any additional information that may be required to supplement already available information, including technical oversight of work to establish costs of the Essential Health Services Package (EHSP).
• Advice on the development of further revenue collection, pooling and strategic purchasing policy options for pro-poor health financing, taking into account the total financial envelope required to deliver the IHSP and institutional, regulatory and other key considerations.
• Contribute to the development of a Health Financing Strategy for Botswana, which incorporates preferred options for financing of the health sector.
• Advise in / contribute to the piloting and implementation of the Health Financing Strategy and its components.
• Contribute to the development of a resource allocation formula for public sector services in Botswana.

3. **Specific tasks**

• Contribute to reviewing available information including studies that assess the strengths, weaknesses, opportunities and threats (SWOTs) related to:
  o Existing revenue collection mechanisms in the country.
  o Existing revenue pooling and risk sharing mechanisms in the country.
  o Existing provider payment mechanisms in the country.
  o Resource requirements for the health system.
  o Other key institutional, legal, and regulatory or health system’s issues that may influence resource mobilization and efficient use of health sector financing.
• Contribute to the development, and when necessary update, a Roadmap for investigating and planning priority health financing options.
• Where necessary, contribute to updating or refining estimates - to at least 2020 - of additional resources which may be available through new sources of revenue or efficiency gains within the public or private health sectors.
• Advise in / contribute to the development of a Health Financing Strategy that emphasizes adequate, equitable financing of the health system.
• Advise on the EHSP Costing study to ensure that the outputs are appropriate and useful to Botswana, and to refine estimates of potential resource gaps to at least 2020.
• Contribute to / advise in the development of a Budget / Resource Allocation Formula to ensure equitable access to the EHSP and other relevant services across communities and districts.
• Contribute to / advise in the development of policies and plans, based on accurate and reliable health information, as required for elaborating and operationalizing the Health Financing Strategy or its components. This may include: exploring the feasibility and further details of options such as a compulsory medical insurance scheme for the formal sector employees and recommendations on ways of engaging with medical aid schemes and health insurance providers to finance the demand-side especially of poorer groups of the population.
• Assist in the definition of ToRs, mobilization of resources, technical oversight and facilitation of any Technical Assistance (TA) that may be required for technical or process-related work to produce the above deliverables, and which maximizes institutional capacity building for the MoHW and other stakeholders.
• Facilitate efficient access for consultants and / or other TWGs to information required to make sound health financing policy and planning decisions.
• Provide recommendations on ways of engaging with private health service providers through PPP, health franchising, outsourcing etc.
• Contribute to / advise in the development of a framework for monitoring the implementation of the policy and measuring its impact.
• The Health Financing TWG may devolve processes to Sub-Groups which oversee specific areas of work or sub-projects. These may, for example, include Sub-Groups on the EHSP costing, Private Sector Finance and Public Sector Finance issues.

4. Method of Working
The Technical Working Group will:
• Meet as and when necessary
• Co-opt additional members as deemed necessary.

6.1.4.3 Organization and Management Technical Working Group (OM TWG)
1. Purpose
The overall purpose of the Organization and Management Technical Working Group (O&M TWG) is to inform the MoHW of changes that require appropriate responses / action related to the MoHW leadership and governance processes. The TWG contributes to updating the MoHW on changes that require adaptation of health sector policies and frameworks, the regulatory framework, the accountability framework, consultative processes with all health partners including private and external partners and strengthens the oversight role of the MoHW.

2. Scope of Work
• Provide guidance and input in the organizational restructuring process of the central MoHW and the DHMT structures.
• Advise on appropriate options for the organizational structure including the required revision of functions and roles for different departments and divisions at central MoHW level and of the DHMTs.
• On request, provide technical support and updated input to the Botswana Health Partners Forum (BHPF).
• Contribute to the establishment of and support the Change Management Unit in its facilitation of change processes.
• Provide mentoring support to the MoHW and DHMT staff on new roles and responsibilities.

3. Specific tasks
• Provide technical guidance in the organizational restructuring of the MoHW with emphasis on the core functions of the MoHW.
• Provide guidance in determining the functions that can be decentralised to the DHMTs.
• Provide guidance in conducting gap analyses to inform the on-going organizational restructuring process based on international best practice.
• Oversee and advise in the development of plans / roadmaps for the implementation of the reform process and facilitate consensus building on the most appropriate consecutive phases of the reforms.
• Provide guidance and technical input in the phased implementation of the organizational reform and the rationalisation of the number of health districts.
• Contribute to the identification of issues related to the restructuring that require review and possible adaptation of relevant health acts.
• Provide advice in the analysis of emerging issues and challenges related to policy formulation and adoption, intersectoral collaboration, community ownership and participation, harmonisation and alignment, regulation, and the oversight role of the MoHW including the required transparency and accountability processes.
• Contribute to the identification of emerging issues and challenges related to the management processes of the health sector.
• Provide technical backstopping on organizational reform and management issues to the BHPF.
• Facilitate an assessment of the current management systems including that of the Development Partners and other key stakeholders aimed at identifying mechanism(s) that should be rationalised and / or strengthened.

4. **Method of Working**
The Technical Working Group on Organization and Management will:
- Meet as and when necessary
- Set up smaller task forces to facilitate the work of the group
- Co-opt additional members as deemed necessary.

6.1.4.4 **Human Resources Technical Working Group**

1. **Purpose**
The purpose of the HR Technical Working Group (HR TWG) is to provide technical input and advice on health workforce issues relevant to the implementation of the IHSP, especially the implementation of the overall health workforce strategic plan. The HR TWG should also provide support to the OM/GL TWG in the reorganization of the MoHW and the DHMTs to ensure that health workforce issues are carefully considered and appropriately addressed in this reorganization.

2. **Scope of Work**
- Contribute to / provide technical input in health workforce planning, development and management processes.
- Provide technical input and advice in the formulation and implementation of pre-and in-service training policies.
- Provide advice to the MoHW on appropriate health workforce strategies, including the strengthening of processes in relation to recruitment, in-service training, performance improvement / appraisals, career development and staff retention.
- Provide technical input and advice in the development of JEDs.
- Provide support and advice to the MoHW in appropriately addressing health workforce issues related to the MoHW and DHMT organizational restructuring process.

3. **Specific tasks**
- Oversee and advise in the identification of challenges in the implementation of the health workforce plan and possible solutions to address the identified challenges.
- Provide technical support and advice to the OM/GL TWG in health workforce issues related to the health sector reform process.
- Facilitate the continuous assessment of future health workforce needs to ensure that health workforce planning, development and management processes address key health workforce issues and challenges related to the implementation of the EHSP and IHSP, including appropriate staff distribution, skills mix and career development.
• Provide technical support and advice in the revision of the health workforce plan with particular focus on the first 3 years and taking the EHSP into consideration.
• In consultation with the Ministry of Education and other Academic organizations, provide technical input and advice in the development of a medium and long-term health professionals’ development / production plan, including modalities for continuous professional development (CPD) of the health workforce.
• Facilitate the identification of appropriate modalities to in-service and post-graduate training of highly skilled health professionals.
• Provide technical input and advice in the development of health workforce management training curricula and guidelines.

4. Method of Working

The HR Technical Working Group will:
• Meet as when necessary
• Co-opt additional members as deemed.

6.1.4.5 Health Information and Monitoring and Evaluation Technical Working Group

1. Purpose
The overall purpose of the HI/M&E Technical Working Group will be to contribute to establishing an integrated M&E system for the Botswana Health Sector that ensures the availability of accurate, reliable and timely information for planning, management and decision making.

Objectives:
• To provide technical expertise in delineating a pathway for an integrated M&E framework that ensures a harmonized health information system;
• To provide technical input in the development of a draft Health Information Policy;
• To ensure that emerging issues in relation to health information are identified and contribute to addressing these.

2. Scope of Work
• Contribute to conducting a situation analysis (SWOT) of the health information system and the planning mechanisms at all levels of the health system (from community to central level).
• Contribute to / advise in the development of appropriate core indicators for the monitoring and evaluation of the implementation of IHSP to ensure that the goals of the revised National Health Policy are met.
• Advise in / contribute to the formulation of a Capacity Development plan to ensure that the health information system for effective and timely M&E is implemented in accordance with intended standards.
• Advise in / contribute to the development of policies and relevant procedures that aim at improving the performance of the health information system in monitoring and evaluating the implementation of IHSP.

3. Specific tasks of the TWG:
• Facilitate and advise on assessing the information flow of all health related data generated by: the registration of vital statistics, patient-based (including Electronic Medical Records - EMR), health facility based (HMIS) and population based
information systems, surveillance, research, health sector reports, programme monitoring activities and evaluations;

- Advise on appropriate methods to identify data needs for communities, health facilities – service provision points, districts and national level;
- Facilitate and advise on the development of a framework for an appropriate information flow;
- Facilitate and advise on the development of appropriate routine data collection tools;
- Advise on appropriate methods to identifying and addressing capacity needs for the integrated M&E for each level;
- Facilitate and advise on the development of a plan for an integrated health sector M&E framework;
- Propose policy recommendations for strengthening M&E including HMIS;
- Advise on the identification / development of appropriate (core) indicators to measure the performance of the national health system’s functions;
- Provide technical input in setting realistic IHSP implementation targets / objectives to be achieved by the MoHW during specified periods of time;
- Contribute to the development of comprehensive and uniform planning and evaluation tools;
- Contribute to the development of an appropriate departmental M&E structure at the MoHW;
- Based on the adopted health information and M&E framework, support the drafting of a HI / M&E Act that covers the public and private sector, mandatory reporting requirements prescribed by international agreements / international Health Regulation, personal data security / confidentiality, ethical code of conduct for research including ethical clearance, etc.

4. Method of Working
The Technical Working Group will

- Meet as and when necessary;
- Co-opt additional members as deemed necessary.

6.1.5 HIV/AIDS - Strategic Information Technical Working Group (SI TWG)
Coordinated by NACA, SI TWG provides an oversight role in generation, management and utilization of strategic information in close collaboration with partners at community, district and national levels. In line with the principle of one monitoring and evaluation system, NACA SI TWG is responsible for providing leadership in ownership, collection, compilation, analysis, dissemination including feedback and use of strategic information from all stakeholders.

6.2 District Level

6.2.1 District Multi Sectoral AIDS Committee (DMSAC)
The District Multi-sectoral AIDS Committees (DMSACs) coordinates, plan and monitor HIV/AIDS response at district/sub district level. They are chaired by the District Commissioner who falls under Ministry of State President while the secretariat cadres such as the District AIDS Coordinator (DAC) reports to Ministry of Local Government and Rural Development (MLGRD) and the DHMT head reports to the MoHW. They advocate against stigma and discrimination for PLWHA. They also advocate for HIV testing and mainstreaming into social and economic programing. The District AIDS Coordinating (DAC) office is the secretariat of DMSAC. DMSAC works with the following sub committees:
Technical Advisory sub – committee  
Planning sub - committee  
Information, Information and Communication sub – committee  
Community Home based and Orphan Care sub – Committee

The district AIDS coordinating office under Primary Health Care in the Ministry of Local Government and Rural Development is the secretariat for DMSACs.

6.3 Community level
At community level, there are two structures, the Village Health Committees (VHC) and Village Multi-sectoral AIDS Committees (VMSACs).

6.3.1 Village Multi-sectoral AIDS Committees (VMSACs).
The roles and functions of VMSAC revolve around planning, implementation, coordination and monitoring of village level response. VMSAC are voices of advocacy for the community in matters related to stigma and discrimination and other barriers that impede the HIV/AIDS response, advocacy to ensure access to available programs as well as mobilization of resources from various sources.

6.4 Regional Level

6.4.1 The SADC Parliamentary Forum Standing Committee on HIV/AIDS
This Plan of Action of the Southern Africa Development Community Parliamentary Forum (SADC-PF)'s Standing Committee on HIV and AIDS aims to strengthen the role Members of Parliament in the fight against HIV and AIDS.

Member Nations: Angola, Botswana, D R Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, ESwatini, Tanzania, Zambia, Zimbabwe

7 Conclusion and Way Forward
The landscape analysis reveals that a lot of analyses on Health Financing (HF) including sustainable HIV/AIDS financing has been done in Botswana with evidence of some overlaps and to some extent duplication in analytical work. However, little has been done with regards to translating existing health financing analyses into action. This provides an opportunity for the ACS project to focus its support more in translating existing health financing analyses into practical implementation. In designing activities for the ACS support to the government of Botswana, the following needs to be taken into consideration:

1. Addressing health systems inefficiencies is a priority for Botswana health financing’s system
From the reviewed studies in this landscape analysis, it is evident that inefficiency remains one of the key health financing systems challenges that need to be addressed in Botswana’s health system. The analyses point out evidence of inefficiencies from both the allocative and technical efficiencies perspectives. The allocative inefficiencies are demonstrated by the significant disparities in allocation of resources between program areas as well as across levels of care. In addition, making the best use of the resources allocated to different health care interventions (technical efficiency) poses a challenge that needs to be addressed particularly considering the declines in revenues from the traditional sources of funds. The projected declines in Botswana’s revenues for health clearly point out that additional or more resources for health will become less likely in the near future,
as such improving efficiency of health systems becomes more important to address health service delivery challenges as well as enhance the move towards UHC.

The 2010 World Health Report by WHO provides analysis of the ten leading sources of inefficiency in health systems and estimated that 20–40% of total spending in health was consumed in ways that do not necessarily or do little to improve people’s health, as such emphasizing the importance of improving efficiency of national health care systems and better use of available funding. Botswana’s health system therefore requires enhancement of allocative efficiency to ensure that resources effectively target health interventions that can create the greatest health value for money, while technical efficiency actions are needed to ensure that interventions are done in the right way, in the right place and at the right time. Efficiency enhancement would also strengthen MOH’s position in mobilizing resources and policy support from MFDP and other partners.

Enhancing efficiency also needs to be linked to the development of a suitable public-private mix in the delivery of health services and its supporting activities, e.g. contracting out services to the private sector. This will however require that the pros and cons on the efficiency gains be carefully assessed prior to entering into contracting out. Developing contract models and a specific PP-mix strategy will be necessary.

As much as a lot of work has been done in analyzing inefficiencies in Botswana’s health systems particularly those inefficiencies related to the HIV/Aids response, more work needs to be done for prioritizing and possibly quantifying the inefficiencies and their causes in the Botswana health system. Sources of inefficiencies such as budget formation, execution and reporting have been cited as some of the drivers of inefficiency in Botswana as such important to them into account when estimating the magnitude of efficiency gains and designing interventions that enhance efficiency in the health system. This calls for strengthened dialogue between the Ministry of Finance and the Ministry of Health.

HIV/AIDS sustainable financing remains an important area of focus for Botswana’s health systems financing primarily because a significant share of health spending in Botswana is attributed to HIV/AIDS. Enhancing efficiency in the HIV/AIDS response is therefore vital for sustainability of Botswana’s health financing system.

2. Health financing is not a panacea, but needs be complemented by other health policy tools.

The goal of UHC has many dimensions that need to be taken in to account along effective health financing solutions. Health finance solutions for UHC require to be complemented by quality, availability, accessibility, acceptability in health care delivery. There are multiple health system areas across the other health system building blocks that link to health financing in all possible ways. That said, effective health financing solutions on their own cannot result in UHC without parallel strategies to address challenges relating to medicine supply chains, health information systems, health workers, consumer empowerment and health system regulatory mechanisms such as licensing, certification and accreditation. The combination of these health sector strategies addressing all the “building blocks” in a coherent and coordinated manner will be key to advancing universal health coverage (UHC) in Botswana.

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3. Institutionalization of resource tracking is relevant for describing HIV/AIDS and Health financing architecture

Most of the health financing analyses included in this landscape analysis referred to findings from both the NHA and NASA analyses to describe HIV/AIDS and broader health resources flows, magnitude and use. This demonstrates the importance of health expenditure tracking in describing the country’s health financing architecture.

The latest analysis of a wholistic health expenditure analysis dates as at 2013/14 financial year, which is 5 years away from the current financial year, this analysis may not necessarily present the most recent picture of the reality on the ground. It is therefore necessary for the government to harmonize and institutionalize health and HIV/AIDS expenditure tracking for effective health financing policy formulation and informing resource allocation decisions.

4. Sustainable financing for HIV/AIDS response remains central to achieving UHC in Botswana

Botswana’s HIV/AIDS response plays an important role in the broader context of Botswana’s health and health spending. This makes the HIV/AIDS response highly relevant for the outlook of Botswana’s health financing system and opportunities for attaining UHC. Evidence of projected declines in external financing for HIV/AIDS implies that the pressure on domestic financing will increase correspondingly due to the needs of the HIV/AIDS response i.e. while it is acknowledged that the contribution of HIV/AIDS to the burden of disease is declining, treatment needs are still increasing and will persist over a short term. Sustaining the gains and continuing progress towards an AIDS-free generation will remain critical for achieving UHC in Botswana, as such strategies for enhancing the movement towards UHC should consider sustainable financing strategies for ensuring the HIV/AIDS epidemic control.

5. Availability of quality data is a challenge that hampers comprehensive health financing analyses

From the analyses included in this landscape review, it came out clearly that availability of timely and disaggregated data on disease/programme areas, health service utilisation, health expenditure, health service unit costs etc. is a challenge that hampers comprehensive health financing analyses. Detailed information on costs, expenditure, unit costs of health services and financial is also relevant to inform budgeting. Given the importance of the health information, the Government of Botswana needs to prioritize investments in integrated health information management systems, capturing data in all aspects of the six health systems building blocks, both at national and district level to enhance undertaking of health system analyses that are relevant for informing evidence-based health policy decision making.

6. Leveraging opportunities in private sector & reducing fragmentation in financing and service provision between Public and Private sectors can support HIV/AIDS sustainable financing, paving way towards UHC.

Botswana health system needs to balance the mandates and contributions of the public and private sectors in financing and delivery of health services i.e. private providers, insurers and for-profit companies in the health sector should complement and reinforce the services financed and delivered by the public sector. Evidence has demonstrated that when governments partner with the private sector UHC becomes more affordable, and ultimately health outcomes are improved. Engaging other players such as the private sector in scaling
up programs such as PHC, HIV/AIDS etc. to the hard to reach areas and key populations could improve Botswana’s health outcomes and pave way towards UHC. The need to clearly define the roles of private health funders and government funding is necessary. This should include creating linkages between the roles of private health care funders e.g. Medical Aid Schemes (MAS) with the set health system and financing policy objectives e.g. financing for HIV/AIDS epidemic control or UHC.

7. Health Financing Policy options need to consider the country’s macroeconomic and fiscal context
Government’s role in financing health services remains critical for all health systems, as such Botswana’s Macroeconomic, Fiscal, and Public Finance Management (PFM) contexts need to be considered whenever policy decisions on health financing are made. Effective health financing policies would need to consider; the size of the economy, the rate at which the economy is growing and the stability and broad-based nature of that growth. For example, Botswana’s economy has remained predominantly mining dominant for long, with efforts to diversify the economy so far not yet yielded the positive results. This would also need to be taken into account when designing health financing policies or solutions.

8. Structured collaboration with civil society can facilitate engagement on health financing priorities.
Civil society will always remain a critical player in the delivery of health care. However, most often the civil society is left out in health financing dialogue and priority setting. Participation or involvement of the civil society in majority of health financing activities is evident, as such there is need to strengthen collaboration with the civil society on health financing dialogue. If empowered through involvement, knowledge and information, the civil society can play a role in ensuring accountability by those in possession of public funds. Social accountability is viewed as one of the mechanisms to improve governance, enhance effectiveness through better service delivery and empowerment16. In addition CSO can also play a great role on the acceptability of public health policies and contribute to encourage citizens interact with health facilities/services.

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