

# COUNTRY COVID-19 INTRA-ACTION REVIEW REPORT



**Republic of Botswana  
Ministry of Health & Wellness**

**BOTSWANA**  
**[GABORONE, 9<sup>th</sup> -12<sup>th</sup> November /2020]**

# Table of Contents

- LIST OF ABBREVIATIONS ..... 3
- 1. RATIONALE AND METHODOLOGY OF THE REVIEW ..... 4
  - 1.1. Objectives ..... 5
    - a. General Objective ..... 5
    - b. Specific Objectives ..... 5
  - 1.2. Methods and Scope ..... 5
- 2. FINDINGS ..... 6
  - 2.1. Country-level coordination, planning and monitoring ..... 8
  - 2.2. Risk communication and community engagement..... 9
  - 2.3. Surveillance, rapid-response teams, and case investigation.....11
  - 2.4. Points of entry .....12
  - 2.5. National laboratories .....14
  - 2.6. Infection prevention and control.....16
  - 2.7. Case management.....17
  - 2.8. Operational support and logistics .....19
  - 2.9. Maintaining essential health services during an outbreak.....20
- 3. WAY FORWARD.....22
- 4. ANNEXES .....23

## LIST OF ABBREVIATIONS

---

**BPHI:** Botswana Public Health Institute

**CFR:** Case Fatality Rate

**DHS:** Director of Health Services

**EOC:** Emergency Operations Centre

**IAR:** Intra-Action Review

**IMS:** Incident Management System

**MoHW:** Ministry of Health and Wellness

**PPE:** Personal Protective Equipment

**POE:** Points of entry (POEs).

**PHEMC:** Public Health Emergency Management Committee

**RCCE:** Risk Communication and Community Engagement

**TOR:** Terms of Reference

# 1. RATIONALE AND METHODOLOGY OF THE REVIEW

---

The Coronavirus disease 2019 (COVID-19) outbreak in Botswana is now in the seventh consecutive month. To prevent the importation of cases, Botswana closed its borders on 24<sup>th</sup> March 2020- before recording any case. The first report of COVID-19 cases in the country was made on 30<sup>th</sup> March 2020 and comprised of three imported cases. After these first three confirmed cases, the state of emergency was declared for 6 months as a containment measure which was extended by another 6 months from the 28<sup>th</sup> September 2020. The outbreak has evolved from imported cases, to clusters driven by cross border movements, to early stages of community transmission.

A total of 8,225 cases have been confirmed in Botswana as of 15<sup>th</sup> November 2020. Of these, 6,820 are local transmissions out of which 1,234 of the cases are active. The total number of confirmed cases imported into the country are 1,405 comprising mainly truck drivers from neighbouring countries. Since the beginning of the outbreak in Botswana, 27 deaths have been reported. The Case Fatality Rate (CFR) is 0.33%. The total of number of tests conducted to date are 330,611 as of 15<sup>th</sup> November 2020. Of these, 107,557 tests were conducted at Points of entry (POEs). As of 15<sup>th</sup> November, the overall test positivity rate stands at 2.5%. More cases continue to be on home isolation as capacity for institutional isolation within the districts continues to pose a challenge.

Despite the rising number of cases, Botswana has done a tremendous job in slowing down the transmission and ensuring that health system capacities are not overwhelmed. The National Emergency Operations Centre (EOC) together with the management of Ministry of Health and Wellness (MoHW) continue to closely monitor the situation. Testing of symptomatic cases and their contacts and contact tracing are ongoing in all districts. The international borders remained closed until 9<sup>th</sup> November 2020 when the process of lifting of international travel restrictions began in a phased-out manner, covering 14 points of entry. All arriving travellers are expected to present a valid 72 -hour Polymerase Chain Reaction (PCR) test from departure and to be screened for COVID 19 symptoms upon entry. Returning citizens and residents without a PCR test are subjected to 14-day mandatory quarantine and PCR testing, while non-citizens are not allowed entry into the country.

Experience has shown that if the acquired gains are not sustained, more infections will be reported in the country. It is therefore important that at this point in the evolution of the epidemic a review is conducted to assess the response measures, consolidate progress and identify areas that need further improvement. Interventions that have resulted to reduced transmission in some districts need to be identified and further replicated. Gaps in preparedness and

response need to be identified and addressed to enhance capacities to suppress a resurgence of transmission of COVID-19.

The WHO Guidance for conducting a Country COVID-19 Intra-Action Review (IAR) and tools published in July 2020 were used to guide this review. An IAR is defined as a country-led, facilitated discussion that allows national and subnational stakeholders of the COVID-19 response to (i) reflect on actions being undertaken to prepare and respond to the COVID-19 outbreak at the country level in order to identify current best practices, gaps and lessons learned, and (ii) propose corrective actions to improve and strengthen the continued response to COVID-19.

## **1.1. Objectives**

### **a. General Objective**

The general objective of this review was to conduct a rapid assessment (situational analysis) in order to understand the national/sub-national COVID-19 situation and the response in Botswana.

### **b. Specific Objectives**

The specific objectives of the Botswana COVID-19 Intra-action Review (IAR) were fourfold, namely:

1. To provide an opportunity to share experiences and collectively analyze the ongoing in-country response to COVID-19 by identifying challenges and best practices.
2. To facilitate consensus building among, and the compiling of lessons learned by, various stakeholders during the response to improve the current response by sustaining best practices that have demonstrated success and by preventing recurrent errors.
3. To document and apply lessons learned from the response efforts to date to enable health systems strengthening.
4. To provide a basis to update and validate the country COVID-19 strategic preparedness and response plan and other strategic plans accordingly.

## **1.2. Methods and Scope**

The IAR involved an interactive, structured methodology using user-friendly materials and interactive facilitation techniques. The planning team identified a wide range of stakeholders to encourage a diversity of opinions. The participants have proven first-hand experience with, depth of knowledge about and different levels of responsibility for the pillar being reviewed for

the country's COVID-19 response. Partners who are currently involved in the COVID-19 response were invited. Attached is a list of participants and partners.

The first stage was a 3-hour virtual training and preparatory workshop for the identified facilitators and note takers from MOH, WHO and Partners. Identified facilitators were briefed on the objectives and outputs of the IAR and the expectations from each component working subcommittee. Relevant documents were shared with the core team of facilitators to acquaint themselves with the IAR process.

The second stage was a workshop with all pillar leads, their focal points and implementing partners' representatives to discuss on the areas that went well, went less well, best practices and challenges encountered including gaps observed in the response mechanism. This was done in groups according to the pillars. The next step was plenary where teams presented to the larger group and inputs from the group were incorporated. This took place over a period of 2 days. The workshop was conducted in Gaborone at Avani Resort and Phakalane Convention centre in large halls that allowed for adequate spacing in-line with COVID 19 social-distancing requirements. The Botswana IAR was a mixed format (onsite and online format) where thirty five participants attended the sessions physically while others participated in the discussions virtually.

The IAR review period was from March 2020 to October 2020 where all the nine COVID-19 response pillars in the Botswana National Plan for COVID-19 Health Response were reviewed. The following functional areas were reviewed:

- Pillar 1: Country-level coordination, planning and monitoring
- Pillar 2: Risk communication and community engagement
- Pillar 3: Surveillance, rapid-response teams, and case investigation
- Pillar 4: Points of entry
- Pillar 5: National laboratories
- Pillar 6: Infection prevention and control
- Pillar 7: Case management
- Pillar 8: Operational support and logistics
- Pillar 9: Maintaining essential health services and systems

---

## 2. FINDINGS

---

For each of the functional areas under review, we present the best practices and the challenges that occurred in Botswana, along with recommended actions for institutionalizing and maintaining best practices as well as addressing challenges in responding to COVID 19.

## 2.1. Country-level coordination, planning and monitoring

### Observations

Best practices	<ul style="list-style-type: none"> <li>- Activation of a technical multi sectoral response structure based at the MOH facilitated mobilization and deployment of resources as well as coordination of the various pillars of the response thereby delaying the importation and spread of COVID 19 in the country.</li> <li>- The government demonstrated its commitment by establishment of the presidential task team and made a declaration of a state of public health emergency. This enabled the country to focus on COVID-19 preparedness and response activities including strengthening of human resource and infrastructure capacities.</li> <li>- Multi-stakeholder involvement facilitated sharing of responsibilities and resources hence establishing a holistic response.</li> </ul>
Challenges	<ul style="list-style-type: none"> <li>- Lack of adequate numbers of experienced human resource to fully manage emergency preparedness and response resulted in delays and in fragmentation of the multi sectoral response.</li> <li>- Non alignment of multi layered coordination structures arising from lack of an established EOC resulted in poor definition of the incident management structure and in difficulty in adapting to the evolving nature of the disease.</li> <li>- Delays in the development and dissemination of guidelines emanated from lack of role clarity on development and constant review of guidelines.</li> <li>- Limited linkages between the National and Subnational coordination mechanisms to ensure Realtime information flow and follow up of critical actions for implementation</li> </ul>

### Recommended actions



## a. For immediate implementation:

- Enhance the capacity of the emergency preparedness and response teams at national and subnational level
  - Fast track the establishment of a fully functional EOC at national level
  - Reactivate the Incident Management System (IMS) coordination structures at the Ministry of Health and Wellness (MoHW) with support of the Director of Health Services (DHS) and partners, and ensure that the relevant pillars of COVID-19 preparedness and response are in place with clear leadership and terms of reference (TORs).
  - Train the Public Health Emergency Management Committee (PHEMC) on Incident Management Structures and EOC roles and functions
  - Clarification of the roles, TORs and responsibilities of the PHEMC, NEOC, Presidential Task Force

## b. For mid to long term to improve response to next waves of COVID-19 outbreak:

- Fast - track establishment of Botswana Public Health Institute (BPHI) with the all the relevant infrastructure, equipment and human resource.

## 2.2. Risk communication and community engagement

### Observations

Best practices	<ul style="list-style-type: none"> <li>- In the beginning of the response, there was prompt release of information and updates as the pandemic progressed which increased public awareness and trust in the MoHW as a source of critical information.</li> <li>- The appointment of the Presidential Task Team revealed commitment from the highest office to support the fight against COVID 19 and increased public sense of safety and security even within a global crisis. It also eased access to media slots in both national broadcasting services</li> <li>- The MoHW was focused on the national communication strategy and delegating communication at district level to DHMT which facilitated a wider reach of key messages and a feedback mechanism from the communities.</li> </ul>
----------------	--

Challenges	<ul style="list-style-type: none"><li>- Lack of a Risk Communication and Community Engagement (RCCE) strategy before the response led to poor coordination of activities.</li><li>- Diversion from the newly established Risk Communication Engagement Strategy to attend to COVID Task Team requests resulted in fragmentation of the multisectoral response.</li><li>- Lack of synergy with communications team from the Presidential Task Team resulted in duplication of information and key messaging disseminated to the public and loss of trust in the MoHW from the public as a source of COVID 19 information.</li></ul>
<b>Recommended actions</b>	
<p>a. For immediate implementation:</p> <ul style="list-style-type: none"><li>- Review and disseminate the COVID 19 RCCE strategy to sub-national level</li><li>- Streamline and align the information management and flow between the RCCE Technical Team and MoHW top management</li><li>- Enforce the Public Health Social Measures (PHSM) at the community level</li></ul>	

## 2.3. Surveillance, rapid-response teams, and case investigation

### Observations

Best practices	<ul style="list-style-type: none"> <li>- Surveillance and contact tracing guidelines and SOPs were developed, which enabled timely initiation of screening at Points of Entry (POEs), early case detection and contact tracing.</li> <li>- Surveillance tools were developed and disseminated for use, this facilitated standardized data collection at subnational level.</li> <li>- Health Care Workers (HCWs) were trained on surveillance SOPs, tools and guidelines</li> <li>- COVID-19 surveillance tools were incorporated into the District Health Information Software 2 (DHIS2) thereby enabling electronic data collection.</li> <li>- Contact tracing was promptly initiated in the initial stages of the response</li> </ul>
Challenges	<ul style="list-style-type: none"> <li>- The establishment of parallel reporting structures and poor adherence to the Integrated Disease surveillance and Response (IDSR) system of reporting resulted in poor data quality, delayed case notification, poor follow up of cases and contacts and lack of accurate real time data to inform the response.</li> <li>- Use of multiple data collection systems by MoHW and Partners resulted in generation of fragmented data and inaccurate data analysis.</li> <li>- Lack of event-based surveillance (EBS) and community-based surveillance (CBS) systems led to difficulty in detection of alerts and late detection of community cases.</li> <li>- COVID-19 mortality surveillance which is necessary for detection of community deaths is not yet established.</li> <li>- The National Rapid Response Team (RRT) is not fully operational to supporting DHMTs in investigation of events/cluster.</li> <li>- The DHMTs Rapid Response Team (RRT) is not fully operational thus investigation of alerts/events/cluster outbreaks is not carried out at the DHMTs level.</li> </ul>

- 
- No established Alert Management System for community and health facility alerts

### Recommended actions

#### a. For immediate implementation:

- Designate and deploy surveillance officers at District Health Management Team (DHMT) level and urgently roll out IDSR across all levels
- Establish an alert management system at National and Subnational level and avail the necessary tools to support the function
- Implement event-based surveillance, community-based surveillance and mortality surveillance at the health facility and community level
- Train and operationalize the RRT structures at national and subnational level
- Avail and roll out the surveillance and contact tracing guidelines and SOPS
- Present daily situation reports with clear analysis of the trends and identifying the relevant high impact actions in the hotspots
- Reorganize the current methodology and strategy of contact tracing and ensure that the necessary resources are availed in order to be able to find and follow up over 90% of contacts.
- Avail and deploy the required resources for the MOH at the subnational level to support operations

#### b. For mid to long term to improve response to next waves of COVID-19 outbreak:

- Establish a robust ILI/ARI/SARI sentinel surveillance system to be able to detect COVID like illnesses

## 2.4. Points of entry

### Observations

Best practices	<ul style="list-style-type: none"> <li>- Screening at designated points of entry (POEs) promoted early detection, containment and management of imported cases.</li> <li>- Ownership of the Port health program by the DHMT led to improved implementation of response activities at the POEs</li> <li>- Support from the ministry by provision of financial, material and human resources improved service delivery at POEs</li> <li>- Training of port health staff at the POEs on Infection Prevention and Control (IPC) measures, Personal Protective Equipment (PPE), reporting tools and testing was carried out.</li> </ul>
Challenges	<ul style="list-style-type: none"> <li>- The port health system is not fully established, and a port health response strategy and an operational framework have not been established, this led to poor coordination and implementation of the response.</li> <li>- The initial design of the POEs did not take public health issues into account, this led to lack infrastructure/space for implementation of public health related activities.</li> <li>- Poor communication links with inland health services led to inadequate provision of medical services lack of a clear referral system from POEs for public health events</li> </ul>
<b>Recommended actions</b>	
<p>a. For immediate implementation:</p> <ul style="list-style-type: none"> <li>- Provide direct operational support (material, financial and human resource) to the current POEs that are in place to be able to find, detect, confirm, identify contacts for quarantine and provide management to suspected cases</li> </ul> <p>b. For mid to long term to improve response to next waves of COVID-19 outbreak:</p> <ul style="list-style-type: none"> <li>- Formation of a high level multisectoral advisory body on Port Health</li> <li>- Upgrade the current POE programming into a division with the relevant structures and resources to effectively support the port health services across all points of entry</li> </ul>	

- Establish cross border collaboration mechanisms to support and enhance the existing capacities for control of cross border diseases/infections

## 2.5. National laboratories

### Observations

Best practices	<ul style="list-style-type: none"> <li>- Utilization of good strategic partnerships towards response for diagnostics and detection allowed for establishment and decentralization of COVID testing, development of national testing algorithm and guidelines and establishment of testing capacity in non-health sector for back up purposes.</li> <li>- Timely mobilization of resources towards laboratory response facilitated availing of commodities at the shortest time, increased staffing and decentralization of testing.</li> <li>- Establishment of an independent procurement system for COVID commodities aided in ensuring testing continuity and increased testing capacity in line with disease progression.</li> <li>- Systematic decentralization of COVID-19 testing across the country led to improved access to COVID -19 testing at all POEs and improved Turn Around Time (TAT).</li> <li>- Utilization of robust quality management systems for laboratory testing.</li> </ul>
Challenges	<ul style="list-style-type: none"> <li>- Lack of laboratory emergency response structures and procedures led to a slow start up of COVID-19 testing in-country and a delay in development of laboratory response plan and procedures</li> <li>- Slow implementation of laboratory processes led to a slow TAT at some testing sites and remains a challenge</li> </ul>

- There is a challenge in obtaining sufficient numbers of skilled laboratory personnel needed for the emergency response partly due to lack of a legal provision (waiver) to allow non-certifiable technical staff to do ancillary jobs in the lab
- Increased out sourcing costs for some emergency response laboratory processes.
- Poor management of laboratory cold chain commodities
- Inadequate laboratory containment spaces for the pathogen at laboratory sites
- Slow uptake of technology by private sector labs stemming from inadequate skills and lack of facility requirements for the technology at the private sector.
- There are challenges in in-country regulation for the technology resulting from uncoordinated donations as well as lack of regulatory instruments and bodies.
- Logistics and commodities management remains a challenge ensuing from lack of positions within the public health lab structure, procedures and adequate space.
- There is minimal data management and utilization for decision making and lack of laboratory surveillance processes due to inadequate numbers of skilled personnel at the laboratory.

### Recommended actions

#### a. For immediate implementation:

- Urgently define a lab testing strategy for Botswana
- Strengthen structures for public health laboratory regulation and monitoring for compliance by developing a public health lab policy, standards for public health labs and setting up a monitoring committee for public health laboratories.
- Strengthen public health laboratories to manage cold chain commodities by conducting a needs assessment, purchasing necessary equipment and developing national SOPS.
- Improve Turn Around Time (TAT) and access to results by conducting a review of TAT for different testing facilities, an inventory of sites needing government network connectivity (GDN) and training sites on specimen management.

- Strengthen data management and utilization at NPHL by conducting a needs assessment for data management skills & staffing for public health laboratories, developing data management SOP's, data sharing & reporting Protocols and access control and audit trail systems for data
- Strengthen commodities acquisition, forecasting and management by developing and documenting emergency procurement processes and procedures, procedures and structures for commodities utilization reporting and train staff in forecasting and supply chain management.

b. For mid to long term to improve response to next waves of COVID-19 outbreak:

- Capacitate the NHL to perform Public health laboratory functions by putting in place the appropriate structure, scope, skills and staffing numbers.

## 2.6. Infection prevention and control

### Observations

Best practices	<ul style="list-style-type: none"> <li>- Establishment of an IPC team allowed for coordination of all IPC activities nationally and collaboration of IPC stakeholders</li> <li>- IPC trainings for DHMT IPC TOTs, POEs, health workers and other relevant stakeholders enhanced district response readiness to Covid-19 and public awareness on COVID-19 preventive measures</li> <li>- Development and dissemination of IPC guidelines, SOPs and IEC materials facilitated mapping of IPC processes, standardization of measures in health facilities and mobilization of resources</li> <li>- Assessment of district isolation facilities readiness for Covid-19 highlighted the IPC gaps in districts and mitigation measures</li> <li>-</li> </ul>
Challenges	<ul style="list-style-type: none"> <li>- Inadequate hand wash stations in health care facilities compromised IPC practices</li> <li>- Lack of active IPC committees leading to ineffective coordination of IPC activities in the districts and hospitals</li> <li>- Poor adherence to health facility design recommendations at isolation facilities increases the risk of nosocomial infections</li> </ul>



- Lack of adequate resources to conduct HCW training
- Inadequate IPC monitoring and evaluation mechanisms resulting in limited generation of data/information to guide decision making.
- Lack of adherence to IPC measures at holding bays of truck drivers increases the risk of disease spread.

### Recommended actions

#### a. For immediate implementation:

- Equip health care facilities with sufficient numbers of handwashing stations
- Review and disseminate Botswana IPC guidelines and SOPS
- Conduct HCW training on IPC practices
- Develop IPC monitoring and evaluation framework and tools

#### b. For mid to long term to improve response to next waves of COVID-19 outbreak:

- Establish IPC committees at district and facility level to monitor IPC practices and investigate HCW infections

## 2.7. Case management

### Observations

#### Best practices

- Development of case management guidelines standardized patient care across the districts and enhanced accountability of MOHW
- Training of health care workers Increased their confidence of in management of COVID-19 suspects and positive patients
- Quarantine and isolation of returning citizens enhanced containment of the disease and reduced disease importation

	<ul style="list-style-type: none"> <li>- Provision of psychosocial support to clients &amp; their families affected &amp; infected with COVID 19 enhanced adherence to treatment and quarantine/ isolation health measures.</li> <li>- Identifying and designation case management centers and isolation facilities some key DHMTs and National level</li> </ul>
Challenges	<ul style="list-style-type: none"> <li>- Delayed psychosocial support to HCWs led to fear and anxiety among HCWs</li> <li>- The limitation in number of available treatment centers at present has resulted in competition for resources, overwhelming of the treatment center and long waiting times for admission of cases.</li> <li>- Lack of regular case management reports has brought about difficulty in assessing progress of the pandemic and in future planning.</li> <li>- Poor coordination in case management between private hospitals and government hospitals causes delays in patient management and increased transmission of COVID-19 for untraced cases</li> <li>- Shortage of human resource sources delays in care for COVID-19 suspects and in burnout and demotivation of staff.</li> <li>- Challenges in transportation of COVID-19 leads to delays in referral of patients to the treatment center.</li> </ul>
<b>Recommended actions</b>	
<p>a. For immediate implementation:</p> <ul style="list-style-type: none"> <li>- Re-activate the case management pillar with clear TORS that are well defined</li> <li>- Update and disseminate the case management guidelines</li> <li>- Deploy a team of data managers in the pillar to provide daily analysis of the case management indicators and evolution of the disease</li> <li>- Fast track the preparation of the identified isolation facilities to be able to receive patients at subnational level</li> <li>- Conduct trainings for HCW on case management</li> <li>- Establish information sharing between MoHW and private sector managing COVID-19 cases</li> <li>- Develop/define a referral pathway for COVID-19 Positive cases</li> </ul>	

- Avail resources to the DHMTs to ensure evacuation of the positive cases that meet the requirements for care at treatment units
  
- b. For mid to long term to improve response to next waves of COVID-19 outbreak:
  - Integrate case management of COVID -19 into continuity of services.
  - Prepare the DHMTs to have isolation and treatment centers that are able to receive positive cases
  -

## 2.8. Operational support and logistics

### Observations

Best practices	<ul style="list-style-type: none"> <li>- A multisectoral Team with various skills was involved in the operational support &amp; logistics at national level and district level</li> <li>- Listing of daily actionable plans with to-do activities and responsibilities matrix enhanced effective planning and accountability</li> <li>- Timely data collection and report generation led to informed and timely decision making</li> <li>- Development of a mechanism and tool for distributing PPEs based on Daily districts needs assessment improved infection prevention and control</li> <li>- Coordination of Quality Control for procured PPEs and other COVID-19 supplies optimized HCW protection</li> </ul>
Challenges	<ul style="list-style-type: none"> <li>- Unavailability of PPEs due to failure to plan for procurement</li> <li>- Lack of a logistician and expertise in data management (M&amp;E) to analyze trends and share data for decision making and prioritization of procurement</li> <li>- Lack of a risk management plan caused ineffective supply chain management processes hence affecting end users</li> <li>- Unclear specifications for certain lab commodities led to procurement of commodities that didn't pass quality controls</li> </ul>

	<ul style="list-style-type: none"> <li>- Delay in prompt mobilization of resources for effective fleet management at national level caused constraints in implementation of the national response</li> </ul>
<b>Recommended actions</b>	
<p>a. For immediate implementation:</p> <ul style="list-style-type: none"> <li>- Set up a system for both emergency/ non-emergency procurement</li> <li>- Design/deliver training package on data management that can effectively project consumption rates.</li> <li>-</li> </ul> <p>b. For mid to long term to improve response to next waves of COVID-19 outbreak:</p> <ul style="list-style-type: none"> <li>- Carry out pooled procurement of essential and emergency products using global pool procurement facilities</li> <li>- Recruit human resource skilled in data management and logistics</li> <li>- Maintain agreed PPE/vital commodities stock level to cater for public health emergencies</li> <li>-</li> </ul>	

## 2.9. Maintaining essential health services during an outbreak

### Observations

<b>Best practices</b>	<ul style="list-style-type: none"> <li>- Establishment of a mechanism for weekly monitoring of key indicators of essential health services aided in identification and attention to challenges in maintaining essential health services.</li> <li>- Recruitment of temporary health workers to augment existing staff complement facilitated continuity of service provision.</li> <li>- Prioritization of medical &amp; surgical services allowed for decongestion of facilities and reduced the risk of nosocomial infections</li> <li>- Psychosocial support to health care workers affected &amp; infected with COVID 19 was provided:</li> </ul>
-----------------------	---

Challenges	<ul style="list-style-type: none"> <li>- Re-deployment of staff to quarantine sites to support the COVID response adversely affected programme coordination, implementation and monitoring.</li> <li>- Decreased access to essential services which was exacerbated in vulnerable populations led to a reduction in Key Performance Indicators (KPIs) and increased the risk of morbidity &amp; mortality.</li> <li>- Closure of some facilities caused a disruption in service delivery and a decrease in access to essential health services</li> </ul>
<b>Recommended actions</b>	
<p>a. For immediate implementation:</p> <ul style="list-style-type: none"> <li>- Strengthen M&amp;E mechanism in order to identify warnings of any disruption of health service provision.</li> <li>- Improve planning and adherence to standards of procurement and distribution.</li> <li>- Include Essential Health Services when planning for response to the outbreak (involve key players in provision of EHS).</li> <li>- Identify focal point for EHS at DHMT level to coordinate the delivery of the agreed package</li> <li>- Develop a national action plan for ensuring continuity of health services</li> </ul> <p>b. For mid to long term to improve response to next waves of COVID-19 outbreak:</p> <ul style="list-style-type: none"> <li>- Adopt and adapt the 2020 WHO guidelines for continuity of essential health services.</li> </ul>	

### 3. WAY FORWARD

---

1. The COVID-19 Pillar leads, and co-leads will continue working with the Presidential Task Force and the management of MOHW to finalize the best practices; challenges and the prioritized activities in the immediate and medium to long term to improve the response and ensure some of the activities are institutionalized as part of the routine work and incorporated in the long term strategic goals
2. The Pillar leads and co leads supported by WHO will prepare and finalize the meeting report within two weeks of completing the IAR.
3. The finalized report will be presented to the Top Management of MOHW and the Incident Manager for endorsement to facilitate the implementation of the recommended actions to improve the current national COVID-19 response.
4. The IAR findings will be used to inform discussions on the current COVID-19 response and to update the current COVID-19 strategic plan to ensure immediate and medium to long term sustainability of national COVID-19 response actions.
5. A monitoring and evaluation tracking tool will be developed to track and monitor successful implementation of review recommendations.
6. Respective pillar heads will be responsible for follow up of response actions agreed upon and will hold biweekly meetings to ensure follow up of the implementation of recommendations. The incident manager will be responsible for coordination of the process.

### 3. ANNEXES

- *Annex 1: Inter-Action Review action plan (based on the note taking template with responsibilities, deadline for implementation, resources, indicators)*

<b>PILLAR 1: COUNTRY-LEVEL COORDINATION, PLANNING AND MONITORING</b>				
<b>Recommended Actions</b>	<b>Desired Date for Completion</b>	<b>Responsible Focal Point</b>	<b>Required Support</b>	<b>Indicators</b>
<i>a. For immediate implementation:</i>				
1.  <i>Fast - track establishment of Botswana Public Health Institute</i>	<i>March 31st 2021</i>	<i>Director of Health Services</i>	<i>Financial support</i>	<i>Availability of Funds</i>
			<i>Human Resource</i>	<i>No. of Human Resource recruited and deployed at the PHI Types of skilled personnel</i>
			<i>Infrastructure, resources</i>	<i>Availability of office space</i>
			<i>Equipment</i>	<i>Availability of relevant equipment</i>

				<i>Finalization of BPHI strategic documents (policy, strategic and operational plans)</i>	<i>Availability of approved documents</i>
2.	<i>Capacity building on Emergency Preparedness and Response</i>	<i>30th November 2020</i>	<i>Incidence Manager</i>	<i>Financial support</i>	<i>Availability of funds</i>
				<i>Participants</i>	<i>Number of top management officers, trained on IMS at national and subnational level</i>
3.	<i>Strengthen the Public Health Emergency Preparedness and Response Committee (PHEPR)</i>	<i>30th November 2020</i>	<i>DHS</i>	<i>MoHW executive support</i>	<i>MEMO Circular Number of meetings conducted with minutes Number of reports from pillars</i>
4.	<i>Revise the existing COVID-19 guidelines.</i>	<i>31st December 2019</i>	<i>DHS</i>	<i>Technical (Content Experts)</i>	<i>Number of guidelines revised and disseminated</i>

### **PILLAR 2: RISK COMMUNICATION AND COMMUNITY ENGAGEMENT**

<b>Recommended Actions</b>	<b>Date of Desired Achievement</b>	<b>Responsible and Focal Point</b>	<b>Required Support</b>	<b>Indicators</b>
<i>a. For immediate implementation</i>				



1.	<i>Disseminate the already existing COVID 19 RCCE strategy to sub-national level</i>	<i>Friday 11 December 2020</i>	<i>Responsible: CHO HPED Focal Point: PHO – HPED</i>	<i>Financial support 30 Pax Accommodation – 2 nights Transport</i>	<i>proportion of Districts who have developed an Operational Strategy from RCCE</i>
2.	<i>STREAMLINE and align the information management and flow between the RCCE Technical Team and MoHW top management</i>				<i>Reports of coordination meeting between top management and technical team</i>

### **PILLAR 3: SURVEILLANCE, RAPID-RESPONSE TEAMS, AND CASE INVESTIGATION**

<i>Recommended Actions</i>	<i>Desired Date for Completion</i>	<i>Responsible Focal Point</i>	<i>Required Support</i>	<i>Indicators</i>
<i>a. For immediate implementation:</i>				
1. <i>Refresher training for sub national surveillance officers on COVID-19 reporting structures and tools</i>	<i>Dec 2020</i>	<i>Surveillance team</i>	<i>IT services for virtual connectivity</i>	<i>Proportion of districts with the surveillance officers trained on disease surveillance</i>

2.	<i>Finalize and disseminate surveillance guidelines and SOPs</i>	<i>Nov 2020</i>	<i>Surveillance team</i>	<i>Financial resources</i>	<i>-Guidelines finalized -Proportion of districts who received reviewed guidelines and SOPs</i>
3.	<i>Refresher Training on reporting and information flow according to the IDSR guidelines</i>	<i>20/11/2020</i>	<i>Surveillance team</i>	<i>Technical expertise</i>	<i>- Number of health care workers trained on IDSR and information flow</i>
...	<i>Establish Covid19 mortality surveillance system</i>	<i>30/11/2020</i>	<i>Surveillance team</i>	<i>Technical Expertise</i>	<i>Number of community deaths investigated Or Proportion of district investigating and reporting community death</i>
	<i>Activate the National RRT</i>	<i>30/11/2020</i>	<i>IM</i>	<i>Financial resources</i>	<i>RRT constituted Number of events investigated</i>
<i>b. For mid to long-term implementation to improve the ongoing response to COVID-19 outbreak (including for next waves):</i>					
1.	<i>Refresher training on the use of DHIS tracker system for COVID-19 surveillance</i>	<i>31/03/2021</i>	<i>Health Informatics</i>	<i>Technical Expertise</i>	<i>Number of health care workers trained on use of DHIS tracker for surveillance</i>

2.	<i>Setting up of EBS and CBS</i>	<i>31<sup>st</sup>/ 03/2021</i>	<i>Surveillance team</i>	<i>Technical expertise Financial resources</i>	<i>Guidelines and SOPs fo CBS/EBS in place and reports generated from the CBS structures</i>
3.	<i>Training on EBS and CBS</i>	<i>31/03/2021</i>	<i>Surveillance team</i>	<i>Technical expertise Financial resources</i>	<i>Number of districts trained on EBS and CBS</i>

<b>PILLAR 4: POINTS OF ENTRY</b>					
<i>Recommended Actions</i>	<i>Desired Date for Completion</i>	<i>Responsible Focal Point</i>	<i>Required Support</i>	<i>Indicator</i>	
<i>a. For immediate implementation:</i>					
1	<b>Create port health desk at all POEs</b>	31 Dec 2020	DHS/DPSHSM	<i>Financial support</i>	<i>proportion of POEs with functional HEALTH DESKS</i>
				<i>Human resource</i>	

2	<b>Provision of mini clinics, and repurposing of clinics in all airports</b>	31 Dec 2020	DHS/DPSHSM	Financial support	Proportion of Functional mini clinics established at airports
				Human resource	
3	<b>Procurement of port health infrastructure, equipment</b>	31 Mar 2021	Port health unit/ procurement	Financial support	7 vehicles purchased for transfer of suspects travelers to quarantine facilities
					(Provide numbers) Thermal scanners, porta cabins purchased
					Availability of PPE
4	<b>Provision of psychosocial support for port health staff</b>	31 Dec 2020	DHMT	Human resource	Number of port health staff who have received psychosocial support
				Financial support	
5	<b>IPC Training for port health staff</b>	31 Dec 2020	DHMT	Financial support	Proportion of Port Health with Training conducted on IPC and report available
				Human resource	

6	<b>Develop guidelines, SOPs, contingency plans port health</b>	30 June 2021	Port health unit	Technical support	Proportion of Port Health who developed and disseminated guidelines, SOPs, and contingency plans
				Financial support	
<i>b. For mid to long-term implementation to improve response to the next waves of COVID-19 outbreak:</i>					
1.	<b>Upgrade port health programme to a division</b>	30 Apr 2021	DHS	Financial support	Port health division incorporated in the MOHW structure
				Human resource	
2.	<b>Development of multi sectorial Port health strategic framework</b>	31 Dec 2021	IHR/ Port health unit	Technical support	Signed Strategy document
				Financial support	M&E framework
					Implementation plan
3.	<b>Formation of high-level port health advisory body</b>	30 Apr 2021	DPS HSM	Full participation of different stakeholders	Established, functional committee with TORs
				Financial support	
				Full support from MOHW	

4	<b>Bilateral agreements with neighboring countries</b>	30 June 2021	IHR/DHS	Commitment of ministry management	Signed MOU
5	<b>Remodeling of POEs</b>	31 Dec 2025	DPSHSM	Financial support	proportion of Remodeled POEs
				Collaboration of different stakeholders	

### PILLAR 5: NATIONAL LABORATORIES

	<b>Recommended Actions</b>	<b>Desired Date for Completion</b>	<b>Responsible Focal Point</b>	<b>Required Support (Mainly Ta And Financial)</b>	<b>Indicators</b>
<i>a. For immediate implementation:</i>					
1.	Capacitate NHL to perform Public health lab function.		MOHW leadership	Conduct an audit on capacity of NHL to perform public health functions	Audit report

	<ul style="list-style-type: none"> <li>- Structure</li> <li>- scope</li> <li>- skills</li> <li>- staffing numbers</li> </ul>			Development and approval of n NPHL functional structure	NPHL structure, & scope developed
				Develop and approve an NHL staffing structure	NPHL approved structure
2.	<p>Set up a multi sectoral public health laboratory structure</p> <ul style="list-style-type: none"> <li>- advisory</li> <li>- linkage</li> </ul>		MOHW leadership	Set up a public health laboratory advisory structure	Public health laboratory advisory body established with TOR's and functional
				Map the interrelationship between the public health laboratory structure	Map of PHL stakeholders and roles
3.	Development of public health laboratory response procedures and processes		NHL leadership	Identify a consultant to lead the operationalization of the public health laboratory functions	TOR of consultant and signed contract available
				Develop a strategy to convert NHL into a public health lab coordinating entity	strategy to convert NHL into a public health lab available
...4.	Develop skills and knowledge of staff at the NHL to perform NPHL functions		NHL leadership	Conduct a skills inventory of laboratory staff	Skills inventory list
				Identify training requirement for the NPHL staff	Training plan available

				<i>Identify surge staff for emergency response at public health laboratories</i>	<i>Data base of surge staff for emergency response in public health lab</i>
5.	<i>Strengthen public health laboratories to manage cold chain commodities</i>  <i>-training,</i> <i>-equipment,</i> <i>-procedures</i>		<i>Lab managers and NHL leadership</i>	<i>Conduct a needs assessment of public health labs for cold chain commodities management</i>	<i>Fully established cold chain at the NHL that is operational</i>
				<i>Purchase cold chain equipment for key public health laboratories</i>	<i>Invoices of purchased equipments</i>
				<i>Develop national SOP's for laboratory cold chain commodities management</i>	<i>SOPS developed and validated</i>
				<i>Place</i>	
6.	<i>Strengthen public health laboratories to handle various organism of public health importance</i>  <i>-Facility requirement</i> <i>- staff skills</i> <i>- international certification</i>		<i>NHL leadership and Lab managers</i>	<i>Conduct a review of public health lab spaces for emergency organism containment</i>	<i>Report of the review</i>
				<i>Identify needs for dangerous goods training and certification</i>	<i>Need assessment report</i>
				<i>Identify needs for biosafety training and certification</i>	<i>Need assessment report</i>
7.	<i>Strengthen structures for public health</i>		<i>MoHW management and NHL leadership</i>	<i>Develop public health lab policy</i>	<i>Policy document developed</i>



	<i>laboratory regulation and monitoring for compliance</i> <ul style="list-style-type: none"> <li>- Policies</li> <li>- Regulations</li> <li>- personnel</li> </ul>			<i>Develop standards for public health labs</i>	<i>Laboratory SOPs developed</i>
				<i>Set up a monitoring committee for public health laboratories</i>	<i>Monitoring committee with TOR's</i>
8.	<i>Strengthen structures for public health laboratory technology transfer</i> <ul style="list-style-type: none"> <li>-skills</li> <li>-training processes</li> <li>-</li> </ul>		<i>NHL leadership (partners)</i>	<i>Set up a public health lab training unit, including virtual training capacity</i>	<i>Training unit available in the NHL structure</i>
				<i>Cross train Lab master trainers in multiple technologies</i>	<i>Training plan developed</i> <i>Proportion of Lab staff trained</i>
				<i>Develop training curricula and procedures</i>	<i>Training curricula developed</i>
9.	<i>Strengthen laboratory surveillance processes and procedures</i> <ul style="list-style-type: none"> <li>-national processes</li> <li>-procedures</li> <li>-Equipment</li> </ul>		<i>NHL leadership working through partners</i>	<i>Set up national public health lab surveillance processes</i>	
				<i>Document PHL surveillance procedures</i>	<i>SOP for laboratory surveillance disseminated</i>
10	<i>Improve TAT and results access</i>		<i>MOHW Sites</i>	<i>Conduct a review of TAT for different testing facilities</i>	<i>Review report with analysis of TAT data of different testing facilities</i>

	<ul style="list-style-type: none"> <li>-data network availability</li> <li>-Lab nodes access</li> <li>- specimen rejection issues</li> <li>- lack of electronic ordering of tests by sites manual ordering sites.</li> <li>-IPMS utilization</li> <li>-Equipment interfacing</li> <li>-Inter-operability of information management systems</li> </ul>		NHL management	<ul style="list-style-type: none"> <li>Conduct inventory of sites needing government network connectivity (GDN)</li> </ul>	Sites inventory available
				<ul style="list-style-type: none"> <li>Train sites (problematic) on specimen management</li> </ul>	<ul style="list-style-type: none"> <li>Proportion of sites trained on specimen management</li> </ul>
11	<ul style="list-style-type: none"> <li>Strengthen data management and utilization at NPHL</li> <li>-skills</li> <li>-processes and procedures</li> <li>- access control</li> </ul>		NHL management Partners	<ul style="list-style-type: none"> <li>Conduct needs assessment for data management skills &amp; staffing for public health laboratories</li> </ul>	<ul style="list-style-type: none"> <li>Need assessment report</li> </ul>
				<ul style="list-style-type: none"> <li>Develop data management SOP's</li> </ul>	<ul style="list-style-type: none"> <li>Data management report available</li> </ul>
				<ul style="list-style-type: none"> <li>Develop data sharing &amp; reporting Protocols</li> </ul>	<ul style="list-style-type: none"> <li>Data sharing SOPs developed</li> </ul>
				<ul style="list-style-type: none"> <li>Develop access control and audit trail systems for data</li> </ul>	<ul style="list-style-type: none"> <li>Audit report</li> </ul>

12	Strengthen commodities acquisition forecasting and management - training - monitoring - SOP's		CMS	Develop and document emergency procurement processes and procedures	Emergency procurement SOP developed
				Develop procedures and structures for commodities utilization reporting	SOP for commodities utilization developed
				Train staff in forecasting and supply chain management	Proportion of staff trained in forecasting and supply chain management
<i>b. For mid to long-term implementation to improve response to the next waves of COVID-19 outbreak:</i>					
1.	Capacitate NHL to perform Public health lab function.		MOHW leadership	Recruit for critical public health laboratory positions to drive the different PHL areas	proportion of staff deployed to drive PHL
				Provide a mentorship/ twinning program for NHL with other countries	Number of international travels for mentorship
3.	Development of public health laboratory response procedures and processes		NHL and other PHL sector players	Develop equipment and skills inventory for sectors involved in public health laboratory response	Inventory report
				Identify surge staffing for multisectoral public health laboratory response	Data base of surge staff available

4.	<i>Develop skills and knowledge of staff at the NHL to perform NPHL functions</i>		<i>NHL leadership and partners</i>	<i>Develop training curricula for short term courses</i>	<i>Training curricula developed</i>
				<i>Train staff on short courses needed for their functions</i>	<i>Training plan Proportion of staff trained</i>
5.	<i>strengthen public health laboratories to manage cold chain commodities</i>		<i>NHL leadership</i>	<i>Purchase cold chain 24-hour monitoring devises for laboratories.</i>	<i>Invoices of the cold chain 24-hour monitoring devises</i>
				<i>Train staff at national level in dry ice and liquid nitrogen handling</i>	<i>Proportion of staff trained on dry ice and liquid nitrogen handling</i>
				<i>Develop infrastructure for cold chain commodities storage at select regional laboratory levels (N/S)</i>	
6.	<i>Strengthen public health laboratories to handle various organism of public health importance</i>		<i>NHL leadership and partners</i>	<i>Train staff in International air transportation authority (IATA) packaging and shipping</i>	<i>Proportion of staff trained on International air transportation authority (IATA) packaging and shipping</i>
				<i>Train staff in biosafety and implement annual biosafety certification international requirements</i>	<i>Proportion of staff trained on biosafety and implement annual biosafety certification international requirements</i>
				<i>Train select staff members in Biosafety level III/IV containment</i>	<i>Proportion of staff trained on Biosafety level III/IV containment</i>

				<i>Develop infrastructure to handle Biosafety level III organisms at regional levels.</i>	
7.	<i>Strengthen structures for public health laboratory regulation and monitoring for compliance</i>		<i>NHL and MOHw (regulatory)</i>	<i>Set up a compliance monitoring body for public health labs and point of care testing sites</i>	<i>TORs and focal persons designated</i>
				<i>Finalize point of care policy</i>	<i>Point of care policy finalized</i>
8	<i>Strengthen structures for public health laboratory technology transfer</i>		<i>NLH leadership and partners</i>	<i>Identify a pool of master trainers for PHL procedures</i>	<i>Data base of masters trainers available</i>
				<i>Develop a systematic mentorship and site support structure and process for PHL</i>	<i>Proportion of mentorship visit to testing sites conducted</i>
				<i>Develop verification/ validation structures for new technologies</i>	<i>TOR of validation structures and members designated</i>
				<i>Develop a specimen inventory and access control system</i>	
				<i>Develop a mentorship system for the public health laboratory</i>	

9.	<i>Strengthen laboratory surveillance processes and procedures</i>		MOHW	<i>Develop a national public health laboratory surveillance structure</i>	<i>Designate Lab surveillance officers</i>
				<i>Equip targeted laboratories with surveillance equipment</i>	
10	<i>Improve TAT of results and results access at sites</i>		Sites	<i>Conduct training of the sites on ordering tests on IPMS</i>	<i>Proportion of site trained on ordering tests on IPMS</i>
				<i>Conduct training of sites on results accessing in IPMS</i>	<i>Proportion of site trained on results accessing in IPMS</i>
				<i>Strengthen specimen transportation from sites</i>	
				<i>Interphase lab analyzers with IPMS</i>	<i>lab analyzers Interphased with IPMS</i>
				<i>Provide for GDN and lab nodes at all requesting sites</i>	<i>Proportion of sites equipped with GDN and lab nodes</i>
				<i>Provide for inter-operability of different Government data systems</i>	<i>Different Government data systems interoperable</i>
11	<i>Strengthen data management and utilization at NPHL</i>		NHL leadership And partners	<i>Develop data reporting structures for public health labs.</i>	<i>Functional data reporting structure in place</i>

				<i>Train NHL staff on data manipulation for decision making</i>	<i>Proportion of staff trained on data management and analysis for decision making</i>
				<i>Develop data sharing agreements for NHL</i>	<i>Data sharing agreement</i>
				<i>Develop material transfer procedures for BW</i>	
				<i>Develop laboratory M&amp; E structures including reportable indicators &amp; dashboards</i>	<i>Dashboard accessible online</i>
12	<i>Strengthen commodities forecasting acquisition and management</i>		<i>CMS</i>	<i>Develop commodities utilization monitoring structures</i>	<i>commodities utilization monitoring structures functional</i>

## PILLAR 7: CASE MANAGEMENT

<i>Recommended Actions</i>		<i>Desired Date for Completion</i>	<i>Responsible Focal Point</i>	<i>Required Support</i>	<i>Indicators</i>
<i>c. For immediate implementation:</i>					
1.	<i>Reactivation of the CM team</i>	<i>30/11/2020</i>	<i>Director Health Services</i>	<i>Technical expertise (HR)</i>	<i>CM reactivated – members</i>
				<i>Financial Support</i>	<i>Documentation/minutes from weekly/monthly meetings</i>
				<i>Approval from MOHW in a written form</i>	<i>TOR for the team</i>
2.	<i>Update and harmonization of guidelines</i>	<i>30/11/2020</i>	<i>Case Management Technical working group</i>	<i>Technical expertise (HR) Financial Support</i>	<i>Guidelines updated</i>
3.	<i>Refresher Training of HCW at MOHW and in the DHMTs on case management (Clinical, isolation and quarantine)</i>	<i>31/12/2020</i>	<i>Case Management Technical working group</i>	<i>Technical expertise (HR) Financial Support</i>	<i>Proportion of HCW trained Training report</i>
3.	<i>Establish information sharing between MOHW and private sector managing covid-19 cases</i>	<i>31/12/2020</i>	<i>Director Health Services Case Management Technical working group</i>	<i>Technical expertise (HR)</i>	<i>Communication established MOU</i>
				<i>Financial Support</i>	<i>Report of coordination meetings</i>



3.	<i>Establish/Deploy Data analysis team for case management to generate real time data on a daily basis</i>	31/12/2020	<i>Case Management Technical working group Surveillance CDC</i>	<i>Technical expertise (HR) Financial Support</i>	<i>Team established with TOR Real time data reported</i>
4.	<i>Fast track and prepare the identified COVID-19 treatment centers to receive COVID-19 patients</i>	31/12/2020	<i>Director Health Services DPS-Health Service Management DPS – Corporate services</i>	<i>Technical expertise (HR)  Financial Support</i>	<i>Number of treatment centers established  Number of treatment centers operational</i>
5	<i>Develop/define a referral pathway for COVID-19 Positive cases</i>	30/11/2020	<i>DPS-Health Service Management Case Management Technical working group</i>	<i>Technical expertise (HR) Financial Support</i>	<i>Referral guideline developed</i>
6.	<i>Ensure appointment one national guideline committee</i>	30/11/2020	<i>Director Health Services</i>	<i>Technical expertise (HR) Financial Support</i>	<i>Guideline committee established with clear TOR</i>
<i>d. For mid to long-term implementation to improve response to the next waves of COVID-19 outbreak:</i>					
1.		31/03/2021		<i>Financial support</i>	<i>Operational treatment centers</i>

	<i>Treatment centers operationalized</i>		<i>Director Health Services DPS-Health Service Management DPS – Corporate services</i>	<i>HR</i>	
2.	<i>Integrate case management of COVID-19 into continuity of services</i>	<i>31/03/2021</i>	<i>DPS-Health Service Management Case management TWG</i>	<i>Technical expertise</i>	<i>COVID-19 management integrated into continuity of services</i>
3.	<i>ICU capacity in DHMTs</i>	<i>31/03/2021</i>	<i>Director Health Services DPS-Health Service Management DPS – Corporate services Case management TWG</i>	<i>Financial support</i>	<i>Number of DHMTs with ICU capacity</i>
				<i>Technical expertise</i>	<i>TOR and contract of consultant</i>
4	<i>Hospital readiness to manage COVID-19 positive cases</i>	<i>31/01/2021</i>	<i>DPS-Health Service Management Case management TWG</i>	<i>Technical support</i>	<i>proportion of identified hospitals able to manage COVID-19 cases</i>
				<i>Technical expertise</i>	<i>TOR and contract of consultant</i>

--	--	--	--	--	--

### PILLAR 8: OPERATIONAL SUPPORT AND LOGISTICS

<i>Recommended Actions</i>	<i>Desired Date for Completion</i>	<i>Responsible Focal Point</i>	<i>Required Support</i>	<i>Indicators</i>
<i>e. For immediate implementation:</i>				
1. <i>Enforcement of PPE utilization guidelines</i>	<i>31st December 2020</i>	<i>Director Health Services</i>	<i>Lobby DHMTs Heads to enforce PPE utilization guidelines</i>	<i>Number of PPEs utilized properly as per guidelines</i>
2. <i>Set up a system for both emergency/ non-emergency procurement SOPs</i>	<i>31st December 2020</i>	<i>DPS Corporate Services</i>	<i>Technical Support for a Logistician</i>	<i>Full functional Estimation/Quantification systems set up</i>
			<i>Financial Resources for training</i>	<i>proportion of Procurement and supply chain staff trained on estimation etc</i>
3. <i>Design/deliver training package on data management mechanism that can</i>	<i>31st December 2020</i>	<i>DPS Corporate</i>	<i>Technical support</i>	<i>Number of quality reports analysed for decision making</i>
			<i>Financial resources for training</i>	<i>proportion of Logistics and Informatics staff trained on</i>

	<i>effectively project consumption rates.... Request for technical support from WHO/USAID with data management experts to build capacity of logistics committee with informatrix</i>				<i>supply chain data management/analysis</i>
<i>f. For mid to long-term implementation to improve response to the next waves of COVID-19 outbreak:</i>					
1.	<i>Pooled procurement of essential and emergency products using global pool procurement facilities like SADC, COVAX, WHO, UNICEF</i>	<i>31st March 2021</i>	<i>DPS Corporate Services</i>	<i>Consultative meeting with stakeholders</i>	<i>Turn around time</i>
				<i>Procurement plan</i>	<i>Value of Money indicators</i>
				<i>Financial resources</i>	
2.	<i>Employ logisticians responsible for both emergency and non-emergency supply chain</i>	<i>31<sup>st</sup> March 2021</i>	<i>DPS Corporate Services</i>	<i>Creation of positions of Logisticians in the Establishment Register</i>	<i>Number of logisticians employed</i>
				<i>Financial resources for salaries for staff</i>	
3.		<i>31<sup>st</sup> March 2021</i>	<i>DPS Corporate Services</i>	<i>Creation of positions of Data Management</i>	<i>Positions created</i>

	<i>Deployment of data management experts to logistics committee</i>			<i>Experts in the Establishment Register</i>	
				<i>Financial resources for salaries for staff</i>	<i>Financial resources availed</i>
4	<i>Maintenance of agreed PPE/vital commodities Stock level to cater for public health emergencies</i>	<i>31<sup>st</sup> December 2021</i>	<i>Director of Procurement</i>	<i>Technical assistance for development of PPE/vital commodities Stock level matrix</i>	<i>Stock level matrix availed</i>

### PILLAR 9: MAINTAINING ESSENTIAL HEALTH SERVICES AND SYSTEMS

<i>Recommended Actions</i>	<i>Desired Date for Completion</i>	<i>Responsible Focal Point</i>	<i>Required Support</i>	<i>Indicators</i>	
<i>a. For immediate implementation:</i>					
1.	<i>Strengthen M&amp;E mechanism in order to identify warning events about any disruption of Health services provision.</i>	<i>31st December 2020 One month and continue Weekly throughout any disease outbreak in the country.</i>	<i>1. Program leadership at all levels. 2. M&amp;E and informatics office</i>	<i>Leadership at all levels  -Additional staff for adequate health data management. (Make</i>	<i>Timely quality Reports on performance of essential health services and COVID 19 emergency response.</i>

				<p>sure that EHS data is not ignored)</p>	
				<p>-Provision of essential equipment for M&amp;E, -Staff training in data management. - Data utilization by all levels</p>	
2.	<p>Improve appropriate planning and adherence to standards of procurement and distribution.</p>	<p>Immediately</p>	<p>-Program leadership at all levels (procurement &amp; distribution). -Pharmacists -CMS</p>	<p>Ministry of Health and wellness and development partners</p>	<p>Availability &amp; maintenance of recommended stock levels of all essential commodities Stock out less than 5 days for essential medicines Or proportion of essential medicines with stock out less than 5 days</p>
3.	<p>Include Essential Health Services when planning for response to the outbreak (involve key players in provision of EHS)</p>	<p>Immediately</p>	<p>DHS RRT at all levels Program Coordinators at all levels.</p>	<p>Public Health Educated officers who know its value in a health care system to ensure population resilience</p>	<p>continuity EHS integrated in the emergency response plans</p>
				<p>Established Public Health systems for all areas</p>	

<i>b. For mid to long-term implementation to improve the ongoing response to COVID-19 outbreak (including for next waves):</i>					
2.	<i>Adopt and adapt the 2020 WHO guidelines on/ for continuity of essential health services</i>	<i>30<sup>th</sup> June 2021</i>	<i>DHS Primary Health Care (PHC) Support MOHW</i>	<i>TA from WHO</i>	<i>Availability of Botswana guidelines for continuity of essential health services during an epidemic</i>

*Annex 2: List of participants and Intra-Action Review team*

<b>Name Surname</b>	<b>Organization</b>
Nokuthula Majingo	Ministry of Health and Wellness
Keoratile Ntshambiwa	Ministry of Health and Wellness
Dorcas Thobega	Ministry of Health and Wellness/ National Health Lab
Lenkwetse Bolaane	Ministry of Health and Wellness
Kadelo Kyonywana	ACHAP
Dr Orapeleng Phuswane	Ministry of Health and Wellness
Malebogo Letswee	Ministry of Health and Wellness
Lynn lirare	Ministry of Health and Wellness /University of Botswana
Nesredin Jami	Ministry of Health and Wellness
Joel Motswagole	World Health Organization
Faith Mafa	Ministry of Health and Wellness
Naane Portia	Ministry of Health and Wellness / University of Botswana
Virginia letsatsi	FHI 360
Dr Chidzani Mbenge	Ministry of Health and Wellness / University of Botswana
Lesego Releseng	Greater Gaborone District Health Management Team
Naledi Mokgethi	Ministry of Health and Wellness
Moemedi Rambikela	Ministry of Health and Wellness
Keatkuetse Siamisang	Ministry of Health and Wellness
Onalenna Ntshebe	Ministry of Health and Wellness
Gontse Tshisimogo	Ministry of Health and Wellness
Rina Katholo	Ministry of Health and Wellness
B Kgosiemang	Greater Lobatse District Health Management Team
Dr B Lecoge	Kgatleng District Health Management Team
Mmakgoma M Raesma	Ministry of Health and Wellness
Basego Mothawaeng	Ministry of Health and Wellness
Tantamika Mudiayi	Ministry of Health and Wellness /TB control program
Lesego Mokganya	Ministry of Health and Wellness /Sexual and Reproductive health
G Senzi	Ministry of Health and Wellness
Dr Mpairwe Allan	World Health Organization
Dr O Ratshipa	Ministry of Health and Wellness
Fossouo Viviane	World Health Organization
Dr Violet Mathenge	World Health Organization
Kentse Moakofhi	World Health Organization
Dr Madidimalo Tebogo	World Health Organization
Sidney Kololo	Ministry of Health and Wellness



## Annex 3: Agenda of the review

## NATIONAL IAR WORKSHOP AGENDA

• Date: 9<sup>th</sup> to 12<sup>th</sup> November 2020

Location: Gaborone

TIME	SESSION	LEAD
<b>DAY 1</b>		
<b>Chair : Mr S. Kolane</b>		
08:00-08:15	Registration and administrative arrangements	Admin
08:15-08:25	Introductions	Chair
08 :25-09 :00	Opening Remarks	MOH-Mr Kolane
09:00-09:30	COVID-19 overview	MOH-Dr Rasthipa
09:30-10:00	Intra-Action Review Objectives and Methodology	WHO-Dr Allan
10:00-10:15	Discussion	MOH /WHO/Participants
10:15-10:45	Coffee break	Admin
10:45-11.30	Introduction to group work	Ms Kentse Moakofhi
11.30-13:00	<b>Session 1 - What worked well? What worked less well? And why?</b> <i>Participants work in groups to identify the challenges and best practice of the response linking provincial findings and recommendations to the national picture.</i>	Facilitators, group leaders, note takers
13:00-14:00	Lunch	Admin
<b>Chair: Dr Allan</b>		
14:00-14:30	<b>Session 1 - What worked well? What worked less well? And why?</b> <i>Participants work in groups to identify the challenges and best practice of the response linking provincial findings and recommendations to the national picture.</i>	Facilitators, group leaders, note takers
14 :30-15 :30	<b>Plenary feedback from session 1: Key Highlights</b>	Groups
15:30-16 :00	Coffee break	Admin
16 :00-17 :00	<b>Session 2 – What can we do to improve for next time?</b> <i>Participants work in groups to identify what can be done to strengthen the ongoing COVID-19 response, given the discussions in Session 1.</i>	Facilitators, group leaders, note takers
17 :00	<b>End of Day</b>	
<b>DAY 2</b>		
<b>Chair: Ms Moakofhi Kentse</b>		
08 :30-09 :00	<b>Recap of Day 1</b>	Note takers
09:00-10 :00	<b>Plenary feedback from session 2: Key highlights</b>	Groups/Pillars

TIME	SESSION	LEAD
10:00-11:00	<b>Session 3 – Recommendations:</b> <i>discussion in plenary on key findings and recommendations arising from the group sessions</i>	Pillar leads
11:00-11:30	Coffee break	Admin
11:30 – 12:00	<b>Session 4 – Next steps and way forward</b>	Pillar leads
12:00 – 12:30	Closing Remarks	Mrs Majingo N
12 :30	Lunch and Departure	All