PROGRESS REPORT OF THE NATIONAL RESPONSE TO THE 2001 DECLARATION OF COMMITMENT ON HIV and AIDS

BOTSWANA COUNTRY REPORT 2010

Reporting Period: 2008-2009

Joint United Programme on HIV/AIDS
UNAIDS
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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
BAIS	Botswana AIDS Impact Survey
BBCA	Botswana Business Coalition For HIV and AIDS
BCIC	Behavioural Change Intervention Communication
BHRIMS	Botswana HIV/AIDS Response Information Management System
BONASO	Botswana Network of AIDS Service Organizations
BONELA	Botswana Network on Ethics, Law and AIDS
BWP	Botswana Pula
EU	European Union
HIV	Human Immunodeficiency Virus
M&E	Monitoring and Evaluation
MLG	Ministry of Local Government
MOH	Ministry of Health
NACA	National AIDS Coordinating Agency
NGO	Non-Governmental Organization
NSF	National Strategic Framework
OVC	Orphans and Vulnerable Children
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
SADC	Southern African Development Community
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

1 STATUS AT A GLANCE

1.1 Introduction

Botswana was one of the 189 countries that adopted the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Declaration of Commitment in 2001. The Declaration reflects global consensus on a comprehensive framework to achieve the Millennium Development target of halting and beginning to reverse the spread of the HIV and AIDS epidemic by 2015. Under the terms of the Declaration, success in national HIV and AIDS responses is measured by the achievement of concrete, time-bound targets that call for careful monitoring of progress in implementing commitments. The United Nations (UN) Member States who signed the Declaration committed themselves to regularly report in the progress made on their county's response to the AIDS epidemic. The UN Secretary-General assigned the Joint United Nations Programme on HIV and AIDS UNAIDS Secretariat the responsibility of developing the reporting process, accepting reports from Member States, and preparing a regular report for the General Assembly.

Against this background, Member States who signed the Declaration submit UNGASS Country Progress Reports to the UNAIDS Secretariat every two years. The first UNGASS Country Progress reports were submitted in 2003, followed by 2005 and 2008. This 2010 Country Progress Report is therefore the fourth of such reports. In line with the UNGASS Reporting Guidelines for 2010 (UNAIDS, 2009a), the report is designed to highlight progress made since the last UNGASS report (and thus focuses on the period between January 2008 and December 2009), identify problems and constraints, and recommend actions to accelerate achievement of the targets

1.2 The 2010 UNGASS Report-Writing Process

To undertake the development of this report, a consultant was engaged by the National AIDS Coordinating Agency (NACA) and given the following Terms of Reference:

- To review previous UNGASS reports
- To collect data for the National Composite Policy Index
- To analyse all collected data
- To produce a narrative report
- To facilitate a stakeholder consensus workshop

A Technical Working Group made up of representatives from Civil Society Organisations, the Private Sector, Development Partners, NACA and other Government Ministries was convened to guide the report-writing process, while the Monitoring and Evaluation (M&E) Division at NACA coordinated the overall report-writing process.

The process began with a presentation of an Inception Report by the consultant to the Technical Working Group. The presentation mainly focused on the proposed approach to the process, particularly the methods of data collection (document and literature review; key informant interviews, and stakeholder group meetings), as well as on agreeing on a feasible work-plan.

The document and literature review was done concurrently with the data collection over a period of two weeks. Thereafter the consultant synthesized the data and

wrote the different sections of the report. The first draft of the report was sent to the Technical Working Group, through NACA for comments. The comments were incorporated and a second draft was developed. The latter draft was presented at a national consensus building workshop held on the 11th March 2010. The workshop—attended by a wide range of representatives from the different partners in the national response (see list in Annex A)—enabled partners to review each section of the report and to provide feedback and any outstanding or additional information. After the workshop the consultant incorporated all comments and additional data into a final draft which was submitted to NACA for approval.

1.3 Status of the Epidemic

Botswana is one of the nine Southern African countries that continue to bear the global burden of HIV and AIDS, with each country having an adult prevalence of more than 10 percent. The 2008 Botswana AIDS Impact Survey (BAIS) estimated that 17.6 percent of the population aged 18 months and above was HIV positive in that year. The corresponding figure in the 2004 BAIS was 17.1 percent. It is therefore evident that HIV prevalence in the country is levelling off around 17 percent. In the same vein, the preliminary results of the 2009 HIV and AIDS Sentinel Surveillance show that HIV prevalence among pregnant women aged 15-49 years[1] has been hovering around 33 percent since 2005. However, both BAIS and Sentinel Surveillance data show that HIV prevalence among young people aged 15-24 years has been declining consistently since 2001.

A study by NACA (2008b) projected that by 2009 there would be about 331 432 adults aged 15 years and above living with HIV in Botswana. The corresponding figure for children aged 0-14 years was 19 125.

According to the 2008 BAIS, females have a higher HIV prevalence, estimated to be 20.4 percent compared to the 14.2 percent for males in 2008. This pattern was also observed in the 2004 BAIS. In the latter, HIV prevalence was highest among the 30-34 year age-group for both females and males. In the 2008 survey, prevalence is now generally highest in the next age band (40-44 years). This age cohort effect is a sign of a successful HIV treatment program resulting in high survival rates.

Consistent with previous BAIS results, urban areas had higher HIV prevalence rates than rural areas in the 2008 survey.

1.4 Policy Overview

Botswana has embraced the "Three-Ones" principle: the National AIDS Coordinating Agency (*One national coordinating body)* was established in 1999; the Botswana HIV and AIDS Response Information System (BHRIMS (*One agreed national monitoring and evaluation system)* was put in place in 2001; and the first National Strategic Framework or NSF I *(One agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners)*, covered the period 2003-2009. Following an in-depth review of the NSF I, a second National Strategic Framework (2010-2016) was approved in December 2009.

Several policies, plans and legislative pieces have also been developed to support the national response. For the current reporting period these include: the National Operational Plan for Scaling-up Prevention (2008); the National HIV Treatment

[1] These are women presenting to ante-natal clinics for their first visit for their current pregnancy.

Guidelines published by the Ministry of Health in 2008; the new National Guidelines for HIV Testing and Counselling, published by the Ministry of Health in 2009; the Public Service Act of 2008 which prohibits discrimination or prejudice of employees because of an HIV positive status; and the Domestic Violence Act; No. 10 of 2008 which provides survivors of domestic violence with protection. In the context of HIV and AIDS this Act is important for removing barriers to accessing HIV prevention, treatment, care and support services for women and girls. The Children's Act of 2009 provides, among other things, guidelines for the provision of care and support for orphans and other vulnerable children.

This supportive policy and legislative environment reflects the consistent commitment of the political leadership on HIV and AIDS which has prevailed since the epidemic was declared a national emergency. The top political leadership, for example, has consistently spoken out and supported the national HIV and AIDS response at the highest level.

1.5 Programmatic Overview

There has been significant progress in developing and launching several national prevention, treatment and support programmes. For example, the Prevention-of-Mother-to-Child Transmission of HIV (PMTCT) was introduced in 1999; the National ART programme was implemented and rolled-out in 2002; Routine HIV Testing was introduced in 2004; and HIV testing was further enhanced through an increase in voluntary counselling and testing centres throughout the country. In addition the National Orphan Care and Home-Based Care programmes provide important care and support for those infected and affected by the epidemic.

In the current reporting period, key national programmes that were launched are the *Multiple Concurrent Partnership Programme* launched by NACA in 2009 to address one of the key drivers of HIV transmission in Botswana—overlapping sexual relations with more than one person; the *Safe Male Circumcision Programme*, launched in 2009 by the Ministry of Health with the aim of reducing the risk of HIV transmission in males through circumcision; and the *Botswana National AIDS Prevention Support Programme*, a World Bank-sponsored initiative to assist the Government of Botswana to increase the coverage, efficiency and sustainability of targeted and institutional-based HIV and AIDS interventions. These programmes are described in more detail in Section 3 of this report.

1.6 UNGASS Indicators

In keeping with the mandates of the UNGASS Declaration of Commitment the UNAIDS Secretariat collaborated with other stakeholders in 2002 to develop a series of core indicators to measure progress in implementing the Declaration. These indicators are divided into three categories:

- **National commitment and action indicators**. These focus on policy and the strategic and financial inputs for the national HIV and AIDS response. They also capture programme outputs, coverage and outcomes.
- **National knowledge and behaviour indicators**. These cover a range of specific knowledge and behavioural outcomes
- **Impact indicators.** These indicators focus on the extent to which national programme activities have succeeded in reducing HIV infection and its associated morbidity and mortality.

The indicator table below shows, to the extent possible, a summary of Botswana's levels and trends in the various indicators since the first UNGASS report in 2003. Further analysis of the levels and trends is provided later in Section 3 and, where deemed appropriate, in other parts of the report.

Table 1.1 UNGASS Indicators by year of UNGASS Progress Report

UNGASS INDICATOR	Year of UNGASS Progress Report				Sources/Comments
	2003	2005	2008	2010	
Financial Inputs for the National Response					
1. Domestic and international spending by categories and financing sources (US$ Million)[1]	69.8	165.0	351.6	348.2	*Source:* National AIDS Spending Assessment by NACA *Comment:* Data for the reporting period 2006-2008 was not available at the time of writing the 2008 UNGASS report and hence estimates were reported then. For the current reporting period these have been updated from 148.6 to 351.6 Million USD. The US$348.2 reported in this report is the total financial inputs for 2008. Data for 2009 was not available at the time of writing of this report.
Policy Development and Implementation Status					
2. National composite Index	Presented as an Annex				
National programmes					
3. % of donated blood units screened for HIV in a quality assured manner	100.0	100.0	100.0	100.0	*Source*: National Blood Transfusion Services
4. % of adults and children with advanced HIV infection receiving antiretroviral therapy	7.3	62.7	82.3	89.9	*Source*: National ART Programme
5. % of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	34.3	60.3	91.0	94.2	*Source:* PMTCT Programme, Ministry of Health *Comment:* Data include only women who delivered who were diagnosed with HIV infection during ANC. The registers and data collection tools have since been revised to disaggregate PMTCT during ANC and labour/delivery
6. % of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Not required	Not required	Data Unavail.	Data Unavail.	*Comment*: Although the TB monitoring system in Botswana is well developed, it still requires integration with the HIV monitoring system in order to accurately assess referrals for HIV treatment
7. % of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Not required	Not required	Data Unavail	41.2	*Source*: BAIS III
8. % of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	Not required	Not required	Data Unavail	Data Unavail	*Comment:* Efforts were made in the BAIS III to measure this. However the data and measures proved inappropriate. A Mapping exercise is currently underway to define and estimate most-at-risk populations in Botswana
9. of most-at-risk populations reached with HIV prevention programmes (PMTCT, VCT/RHT, and IPT)	Not required	Not required	Data Unavail	Data Unavail	See comment under Indicator 8 above
10. % of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	3.3	34.3	No new data	31.2	*Source: BAIS III.* *Comment* : This indicator refers only to the last 12 months for psychological, and socioeconomic support related questions and not the UNGASS recommended three (3) month
11. % of schools that provided life skills-based HIV education in the last academic year	100.0	100.0	100.0	100.0	All primary and secondary schools in the country have teachers that are trained in, and are currently teaching, life-skills-based education, which has HIV and AIDS as a major component

UNGASS INDICATOR	Year of UNGASS Progress Report				Sources/Comments
	2003	2005	2008	2010	
Knowledge and behaviour					
12. Current school attendance among orphans and among non-orphans aged 10-14	Not required	Not required	Data Unavail.	Data Unavail.	Through the National Orphan Care Programme and universal education policy almost all children in Botswana attend school regardless of their orphanhood status.
13. % of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention	36.3	37.6	No new data	42.1	*Source*: BAIS III
14. % of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention	Data Unavail	Data Unavail	Data Unavail	Data Unavail	See comment under Indicator 8 above
15. % of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Not Required	7.0	Data Unavail.	3.5	*Source*: BAIS III
16. % of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Not Required	Not Required	Data Unavail.	11.2	*Source*: BAIS III
17. % of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months reporting the use of a condom during last sexual intercourse	Not Required	Not Required	Data Unavail.	81.1	*Source*: BAIS III
18. % of female and male sex workers reporting the use of a condom with their most recent client	Not Required	Not Required	Data Unavail.	Data Unavail.	See comment under Indicator 8 above
19. % of men reporting the use of a condom the last time they had anal sex with a male partner (MSM, aged 10-64 years)	Not Required	Not Required	Data Unavail.	Data Unavail.	See comment under Indicator 8 above
20. % of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Not Required	Not Required	Data Unavail.	Data Unavail.	See comment under Indicator 8 above
21. % of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Not Required	Not Required	Data Unavail.	Data Unavail.	See comment under Indicator 8 above

UNGASS INDICATOR	Year of UNGASS Progress Report				Sources/Comments
	2003	2005	2008	2010	
Impact					
22. % of young women and men 15-24 years of age who are HIV infected	Not Required	13.0	Data Unavail.	8.0	BAIS III
23. % of most-at-risk populations who are HIV infected	Not Required	Not Required	Data Unavail.	Data Unavail.	See comment under Indicator 8 above
24. % of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Not Required	92.0	84.9	93.2	▪ Results are shown for patients starting ARVs in 2007 and their survival through 2008 – data are not yet available for 2009 because data for patients starting ARVs in 2008 and followed-up during 2009 are not yet complete. ▪ Estimates are from survival analysis of electronic patient-level data and therefore the survival function is calculated over the full data and evaluated at 12 months and not calculated directly from the numerator and denominator
25. % of infants born to HIV infected mothers who are infected	20.7	11.5	4.8	3.8	▪ The number of HIV-infected mothers was estimated as the number of mothers with a positive HIV test during ANC plus the number of mothers with positive HIV test during labour/delivery. ▪ Transmission rates were estimated as the weighted average of the estimated transmission rate from women who received antiretrovirals (2.5%) and the estimated transmission rate from women who did not receive anti-retroviral (25%). The overall rate was weighted by the percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission (Indicator 5).

Notes:

- Not Required means that countries were not required to report on that indicator in the given year
- Data Unavail means that there was either no data, insufficient data or no appropriate data to calculate the indicator in the given year.

2 OVERVIEW OF THE AIDS EPIDEMIC

2.1 Status of the Epidemic

Botswana is one of the nine Southern African countries that continue to bear the global burden of HIV and AIDS, with each of the countries having an adult prevalence of more than 10 percent. The 2008 Botswana AIDS Impact Survey (BAIS)—the third of periodic nationally representative behavioural surveys—estimated that 17.6 percent of the population aged 18 months and above was HIV positive. The corresponding figure in the 2004 BAIS was 17.1 percent. It is therefore evident that HIV prevalence in the country is levelling off at around 17 percent.

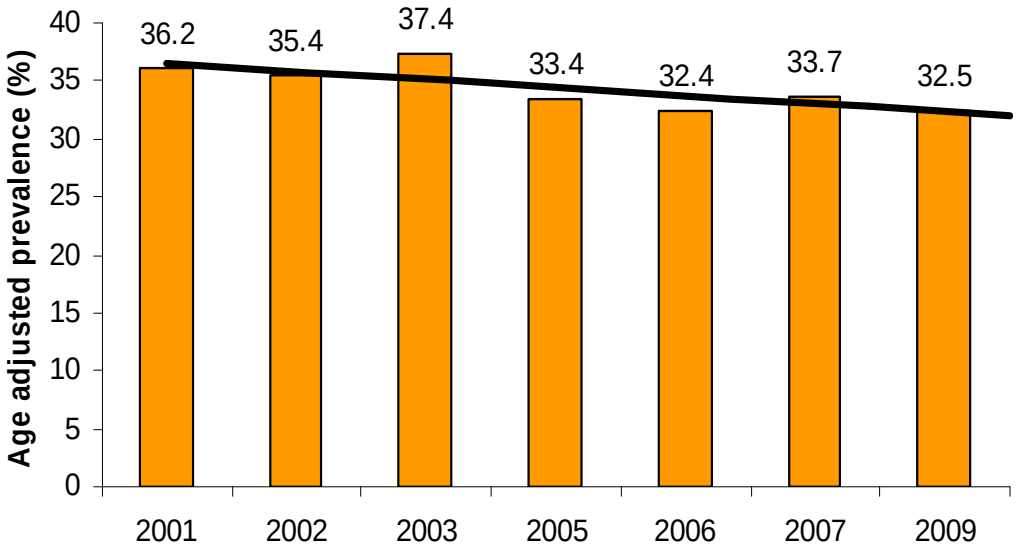
Box 2.1: Botswana HIV and AIDS Estimates and Projections: 2009

- Adults aged 15 to 49 prevalence: 24.6%
- Adults aged 15 and above living with HIV: 331 432
- Women aged 15 and above living with HIV: 192 403
- Children aged 0 to 14 living with HIV: 19 125
- Deaths due to AIDS: 8 732
- Orphans due to AIDS aged 0 to 17: 61 840

Source: HIV and AIDS in Botswana, Estimated Trends and Implications (NACA, 2008b)

The levelling off of the HIV prevalence is also evident when preliminary results of the 2009 HIV and AIDS Sentinel Surveillance are examined. As Figure 2.1 below shows, prevalence among pregnant women aged 15-49 years presenting to an ante-natal clinic for the first visit for their current pregnancy has been hovering around 33 percent since 2005.

Figure 2.1: Trends in HIV prevalence among pregnant women aged 15-49



Source: 2009 Sentinel Surveillance Report

Of the estimated 350 557 people living with HIV in Botswana as at end of 2009, 19 125 were children aged 0-14 years and about 331 432 were adults aged 15 years and above (Box 2.1). Box 2.1 shows these and other summaries of the HIV and AIDS epidemic in Botswana.

2.2 Variations in HIV Prevalence

Like its predecessors, the BAIS III revealed considerable variation in HIV prevalence across districts and population groups. The following subsections present *some* of these

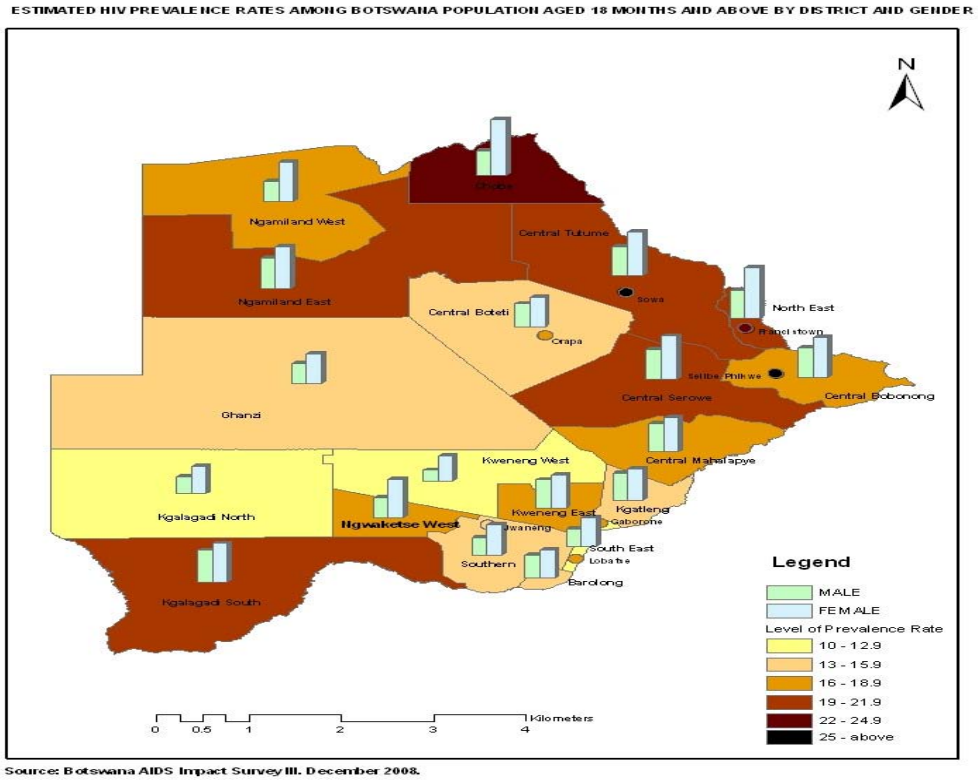
key variations in a descriptive format. That is, only the summary of the variations are presented; no attempt has been made to analyse the causality or behavioural modelling.

Further analysis of the BAIS III data is still ongoing, thus variations by other basic socioeconomic and demographic characteristics are not currently available.

Variation by district and place of residence

There is considerable variation in prevalence across districts, with the general pattern being that the northern and north-eastern parts of the country were more affected by HIV (with prevalence generally between 16 and 25 percent) compared to those districts in the southern and western parts where the prevalence was generally in the 10-15.9 percent range. The Figures 2.2 below, taken from the Statistical Report of the 2008 BAIS (Central Statistics Office, 2009), illustrate.

Figure 2.2 HIV prevalence by district, Botswana, 2008



Similar to the pattern observed in the 2004 BAIS, the results of the 2008 BAIS further showed that HIV was highest among people living in towns, followed by those in cities. The lowest prevalence was found among those living in rural areas of the country. However, the difference in prevalence between rural and urban areas in general was much narrower in 2008 compared to 2004 (Table 2.1).

Table 2.1 HIV prevalence by place of residence, Botswana 2004 and 2008

Place of Residence	2004	2008
Cities	20.2	19.1
Towns	21.3	22.1
Urban Villages	17.4	16.6
Total Urban	***18.5***	***17.9***
Rural	15.6	17.1
Total	**17.1**	**17.6**

Source: Central Statistics Office (2009). *Preliminary Botswana HIV/AIDS Impact Survey II Results: Stats Brief.* Gaborone, Central Statistics Office

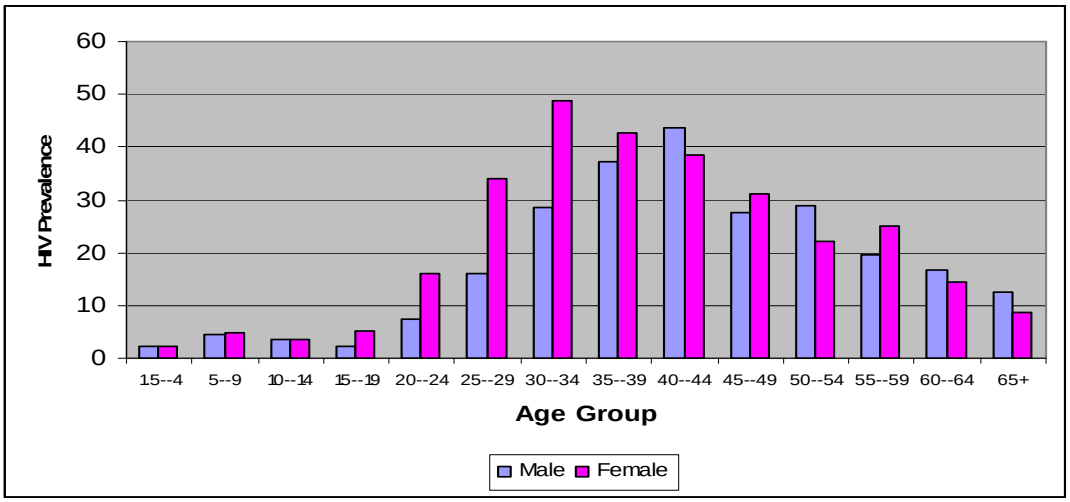
Variation by sex

Consistent with results of previous AIDS impact surveys in Botswana, and following the trend in other sub-Saharan African countries, women and girls continue to be disproportionately affected by HIV. In 2008 HIV prevalence among females (20.4 percent) was relatively higher than among males (14.2 percent).

Variation by age

Figure 2.3 below shows variation by age for both males and females. The figure shows that for females HIV prevalence is highest in the 30-34 years age-group, followed by age-group 35-39 years. Males, on the other hand, show their highest prevalence at ages 40-44 years, followed by those aged 35-39 years. For both males and females the prevalence is relatively lower at younger ages (19 years and below) and older ages (55 years and above). A clear descending trend starts at age-group 50-54 for males and at age-group 55-59 for females.

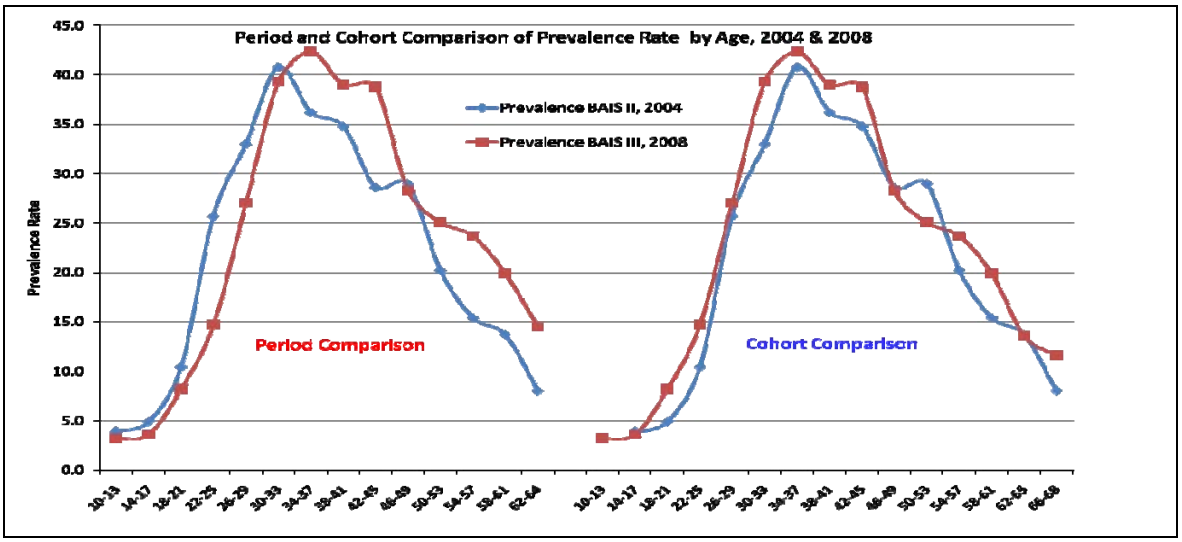
Figure 2.3 HIV prevalence by age and sex, Botswana, 2008



Source: Central Statistics Office (2009). *Preliminary Botswana HIV/AIDS Impact Survey II Results: Stats Brief.* Gaborone, Central Statistics Office

Figure 2.4 compares the period and cohort prevalence, and it shows that for each age-group, prevalence did not change much in the four years between the 2004 and the 2008 BAIS.

Figure 2.4 Period and Cohort HIV prevalence by age, Botswana 2004 and 2008



Source: Central Statistics Office (2009:7)

The figure 2.4 shows that the period comparison of HIV prevalence by age shows a shift in the HIV prevalence peak from the 30-33 year age-group in 2004 to the 34-37 year age group in 2008. The cohort comparison suggests that those who were HIV positive in 2004 have survived to the next age-group in the 2008 survey due to a successful ART treatment program.

Variation by marital status and educational attainment

- The 2008 BAIS also explored variation in HIV prevalence by educational attainment and marital status. The results, shown in Table 2.2 below, show that overall females who are cohabiting with male partners, widowed men, and people with no education tend to be the most affected by HIV.

Table 2.2 HIV prevalence by marital status and educational attainment, Botswana, 2008

Socio-demographic characteristic	HIV Prevalence	
	Male	Female
***Marital status**		
Never married	15.7	31.9
Married	22.3	20.2
Living together	31.9	**36.6**
Separated	48.8	32.6
Divorced	31.4	27.1
Widowed	**56.2**	35.8
Educational attainment		
No education	**26.0**	**30.8**
Non-formal	23.1	31.2
Primary	18.0	22.7
Secondary	15.2	26.8
Post-secondary	13.1	19.3

Source: Central Statistics Office (2009). *Preliminary Botswana HIV/AIDS Impact Survey II Results: Stats Brief.* Gaborone, Central Statistics Office

Note: *For marital status analysis was restricted to the legal age of marriage which is 18 years and above.

The 2009 Sentinel surveillance results also show similar results to those in Table 2.2. The data show that, among other things:

- Married pregnant women had the lowest HIV prevalence rate (26.0 percent), while those classified as living together had the highest HIV prevalence of 39.6 percent.
- Generally, HIV prevalence seems to be lower among those pregnant women with higher levels of education.
- The highest HIV prevalence is observed among the self-employed pregnant women (39.9%), and the lowest among their unemployed counterparts (31.8%).
- Even though the lowest prevalence is noted among the unemployed, this group constitutes over 60 percent of all HIV positive pregnant women.
- Pregnant women who were farmers and labourers had the highest HIV prevalence (more than 40 percent), followed by domestic helpers and store workers (more than 35 percent).

2.3 HIV Incidence Estimates

The BAIS for the first time included measurement of HIV incidence as an objective for measuring the impact of HIV. Incidence testing has been carried out on dried blood spot samples collected during the 2008 BAIS using the BED assay (an epidemiologic tool for estimating HIV-1 incidence with cross-sectional data). Efforts are still underway to analyse the data and make the necessary adjustments for estimating and interpreting HIV incidence.

2.4 Factors Influencing the Spread of HIV

Research has shown that a number of factors underlie the patterns of HIV prevalence presented in the foregoing section. These include, among others, engaging in multiple

and concurrent sexual partnerships, adolescent and intergenerational sex, alcohol abuse, HIV and AIDS-related stigma and discrimination, as well as gender-based violence and sexual abuse

Multiple and Concurrent Sexual Partnerships

Multiple and Concurrent Partnerships, or MCP, have been widely recognised as key drivers of HIV transmission in Botswana. Concurrent partnerships are relationships whereby an individual has overlapping sexual relationships with more than one person. It can also be described as the overlap of one or more sexual partnerships for a period of one month or longer (Mah & Halperin, 2008), in past three months (Colvin et al. 1998); or in the past year or 12 months (Global Program on AIDS, 1996 cited in Setswe, 2008). Multiple partnerships, on the other hand, are sequential or serial partnerships whereby an individual engages in a sexual relationship with only one partner, with no overlap in time with subsequent partners (Setswe, 2008)

A 2003 study by Carter et al (2007) found that 23 percent of Batswana men and women aged 15–49 years who had sex in the last 12 months reported a concurrent sexual partnership at some time while in a relationship with one or more of their most recent sexual partners. A similar percentage (23.8 percent) reported having more than one partner in the previous 12 months while 18.6 percent of sexually active respondents reported *both* concurrent and multiple partnerships. In the 2008 BAIS, 11.2 percent of men and women aged 15-49 years reported that they had sex with more than one partner in the 12 months prior to the survey. Although this figure seems low it is worrisome given the elevated risk that each of the members of any given group of sexual partners (sexual network) is exposed to over time. That is, as one person may have two to three sexual partners, so too could each of those partners have sexual relations with two or three additional people. Thus, a single individual may be linked to a large number of unknown sexual "partners", and as soon as one person in the network is infected, the risk to all others is increased (Halperin & Epstein, 2004).

Adolescent and Intergenerational Sex

As shown earlier in Figure 2.3, HIV infections are much higher for girls than for boys in the 15–24 age-group and beyond. Early exposure to older men with a longer sexual history is considered to have accounted for the higher infections among adolescent girls, thereby bringing into play intergenerational sexual intercourse as a significant risk factor. Studies (for example, Nkosana, 2006) have shown that some of the major factors that appear to drive intergenerational sexual relationships in Botswana are monetary gain and material support. Overall, the greater the economic asymmetries between partners, the greater the value of a gift, service, or money exchanged for sex, and the less likely the practice of safe sex.

Alcohol and High-Risk Sex

Several studies undertaken over the last few years have highlighted the importance of the strong linkage between alcohol consumption and elevated risk of HIV infection. Weiser et al (2006) reported a strong relationship between heavy drinking and multiple high risk sexual behaviours, including intergenerational sex, among both men and women in Botswana. By the same token, a qualitative study undertaken in liquor outlets in the towns of Mahalapye and Selebi-Phikwe by Pitso (2004) noted that heavy alcohol consumption reinforce myths, misperceptions and fears about sexuality and condom use. The 2008-2010 National Operational Plans for Scaling up Prevention also points to the significance of the relationship between the abuse of alcohol and the risk of HIV infection.

Stigma and Discrimination

HIV and AIDS-related stigma leads to discrimination, silence and shame, with the results that there are delays in diagnosis, and a limit to the delivery of behaviour change interventions to reduce HIV transmission, and access to relevant treatment and care services to reduce morbidity, mortality and negative impact.

Gender Violence and Sexual Abuse

One explanation for the gender differential in HIV prevalence and incidence rates is that women are anatomically more vulnerable to HIV and other STIs than men (Temah, 2007). However, a growing strand of literature is showing that women's socioeconomic position,

particularly economic dependency, is one of the most powerful drivers of HIV infection. It has been shown, for example, that women's comparatively limited access to, and control, of economic resources makes it more likely that they will exchange sex for money or favours, less likely that they will negotiate safe sexual practices, and less likely that they will leave a relationships that they perceive to be violent or risky –all of which are associated with risk to HIV infections (Jewkes et al, 2003; Auerbach, et al, 2006; Temah, 2007).

High population mobility

Botswana is characterised by constant population mobility which makes the country to have one of the most mobile populations in the world (Ministry of Health,1997). Traditionally Batswana have three abodes: the principal home in the village, the cattle post for pastoral farming, and the lands for arable farming. With increasing urbanisation some people have a fourth home in an urban area. For decades people have shuttled between these domiciles in a complex pattern varying across seasons and stages of individuals' life cycles. An additional source of the high population mobility in the country is the decentralised public service that consistently locates and relocates the workforce across an array of districts where their services are most required (Mokomane, 2004). As a result, it is not uncommon for married couples to live separately for long periods of time, and for young people to live away from their parental guidance. Being away from the security and stability of home and family increases the likelihood of engaging in high-risk sexual behaviours such as multiple and concurrent partnerships and intergenerational sex.

2.5 Implications for the Future

In 2005 the National AIDS Coordinating Agency (NACA) commissioned two studies to examine the economic and demographic impact of HIV, and their future implications. The summary results of these studies were presented in the country's 2008 UNGASS report.

In the current reporting period, NACA commissioned, and published the results of, a study that estimated trends and implications of HIV and AIDS in Botswana using sentinel surveillance and BAIS II data. The conclusions of this study can be summarised as follows (see NACA, 2008; Stover et al, 2008 for more details):

- The successful expansion of the national antiretroviral therapy (ART) programme has increased coverage to over 80 percent of those in need of treatment. This expansion has had significant benefits, reducing the annual number of AIDS deaths by half, and as a result, and reducing the number of new orphans each year by half.
- Due to the high number of new infections over the years, an estimated 24,000 adults become eligible for ART each year. In consequence, the need for adult ART will increase by nearly 60 percent by 2016. This presents a major challenge to maintain the current levels of high coverage.
- The Prevention of Mother-to-Child Transmission of HIV (PMTCT) programme represents a major success with over 90 percent of HIV-positive women receiving antiretrovirals to prevent transmission of HIV to their children. The programme has averted an estimated 10,000 child infections since its inception in 1999. The combined effects of the PMTCT programme and the child treatment programme have averted an estimated 11,000 child AIDS deaths. With fewer new child infections the need for child treatment is also reduced.
- Some HIV prevention programmes have been expanded and scaled up. High coverage has been achieved for voluntary counseling and testing and AIDS education in the schools. But these programmes have not been enough to make a significant difference. The proportion of adults with more than one sexual partner remains very high. A high level of partner concurrency contributes to rapid transmission of new infections. New approaches are therefore urgently needed.
- At the current rate of new infections prevalence will remain at very high levels and the burden to expand treatment programmes in the future will continue to grow.

3 NATIONAL RESPONSE TO THE EPIDEMIC

3.1 Background to the National Response

The historical evolution of the national HIV and AIDS response in Botswana started with the setting up of the National AIDS Control Programme under the Ministry of Health in 1986 (a year after the diagnosis of the first AIDS case in the country). This was followed by the development of a one-year Short Term Plan in 1987 and a broad-based five-year (1987-1993) First Medium Term Plan (MTP I). The latter aimed at expanding the response to the emerging epidemic into the domains of public health through information and education campaigns, and the expansion of testing and laboratory services.

As the epidemic intensified, reaching an HIV prevalence of 13 percent in 1995 (Ministry of Health, 1997), it became clear to the Government that HIV and AIDS were not only health problems, but that they were also development issues that cut across all sectors. Therefore the Second Medium Term Plan (MTP II), which covered the 1997-2003 period, was designed to provide a platform for a multi-sectoral national response. The MTP II created much of the multi-sectoral coordination structures that exist today. The Plan, however, was not without weaknesses. One of its main limitations was that it did not clearly highlight implementation responsibilities of the various sectors. Its objectives, indicators and funding requirement were also not explicit. The review of the Plan therefore led to the formulation of the National Strategic Framework for 2003-2009 (NSF I)—which is the first of the "Three-Ones" principles—the One agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners. In addition to rectifying the limitations of the MTP II, the NSF I was aimed at consolidating the multi-sectoral national response by providing the relevant structures and guidance to all sectors so as to enhance their engagement. To achieve this, the NSF I advanced five goal areas

i. Prevention of HIV infection;
ii. Provision of treatment, care and support;
iii. Strengthened management of the national response to HIV and AIDS;
iv. Psychosocial and economic impact mitigation; and
v. Provision of a strengthened legal and ethical environment.

Over the period of the NSF I (2003-2009) a number of developments and achievements, particularly in the prevention and treatment areas, were made. For example, Routine HIV Testing was introduced in 2004, HIV testing was further enhanced through an increase in voluntary counselling and testing centres throughout the country; and the National ART programme was implemented and rolled-out. Against the background of these and other achievements it was deemed necessary and timely for the country to re-focus its priority to areas that address the roots of the epidemic and the country's ability to effectively deal with it. Thus a second National Strategic Framework for 2010-2016 period (NSF II) was developed and was launched in February 2010. The NSF II emphasises the need to sustain and strengthen the achievements of the NSF I through four priority areas:

i. Preventing new HIV infections
ii. Systems Strengthening
iii. Strategic Information Management; and
iv. Scaling Up Treatment, Care and Support

The NSF II was developed through a consultative and inclusive process that involved several consultations including a central-level workshop through which senior representatives from government, civil society, the private sector, religious organisations and development partners had an opportunity to evaluate and agree on emerging priority areas and lay the foundation for further consultations. Additionally four local-level consultative workshops for district stakeholders were held in the four major centres of Gaborone, Francistown, Ghanzi and Maun. Consultative meetings were also held with specific groups such as Youth; the Media; Organised Labour; monitoring and evaluation and research practitioners; private sector; and civil society. Like its predecessor, the NSF II also views HIV and AIDS as a complex and multi-dimensional problem that require a

multisectoral national response. To this end, the country multisectoral approach to addressing the epidemic prevails.

3.2 Legal Environment

Botswana has general anti-discrimination legislation in place contained in the Constitution of the country. However, there exist some laws that present obstacles to effective HIV and AIDS prevention, treatment, care, and support for vulnerable population sub-groups such as same-sex couples and sex workers. Notwithstanding this, it is noteworthy that the country has, over the years, developed laws and amendments that create an enabling environment for accelerating the national HIV and AIDS response. For the current reporting period such laws include:

- **Domestic Violence Act No. 10 of 2008.** This Act was passed to protect women in domestic relationships, and it also seeks to provide survivors of domestic violence with protection. Through the Act, it is now possible to act on cases or threats of domestic violence. This is important against the wide evidence showing that women are more vulnerable to HIV and AIDS through violence or the fear of violence, which, in turn, deters them from accessing HIV and other healthcare services, insisting on condom use, and disclosing their status to their partners.
- **Public Service Act of 2008**. Of particular interest and relevance to the national HIV and AIDS response is Section 7 (e) of this Act. It prescribes that:

> "In making decisions in respect of the appointment, or other matters affecting human resource management, every appointing authority and every supervising officer shall…*not discriminate against any employee on the basis of sex, race, tribe, place of origin, national extraction, social origin, colour, creed, political opinion, marital status, health status, disability, pregnancy or any other ground…"*

The practical effect of this provision is that no employee shall be given unfavourable treatment or prejudice because of an HIV positive status. Hence, employees will not be denied promotions or opportunities for further education because they are HIV positive. Furthermore, the provision entrenches the job security of employees living with HIV. The Act also protects job seekers from discrimination as their HIV status will not be used as a basis for employment.

However, one of the inherent limitations of the Act is that it only applies to public service officials and excludes private sector employees who are in the majority of cases victims of prejudice and discrimination in the workplace because of their actual or presumed HIV positive status (BONELA, 2009). BONELA suggests that this gap needs to be plugged by amending the Employment Act to be consistent with the new Public Service Act.

- **The Children's Care Act of 2009.** Among other things, this Act provides guidance for the provision of care and support for orphans and other vulnerable children.

3.3 Financial Inputs for the National Response

INDICATOR 1: Domestic and international AIDS spending by categories and financing sources [US$ 348.4 Million]

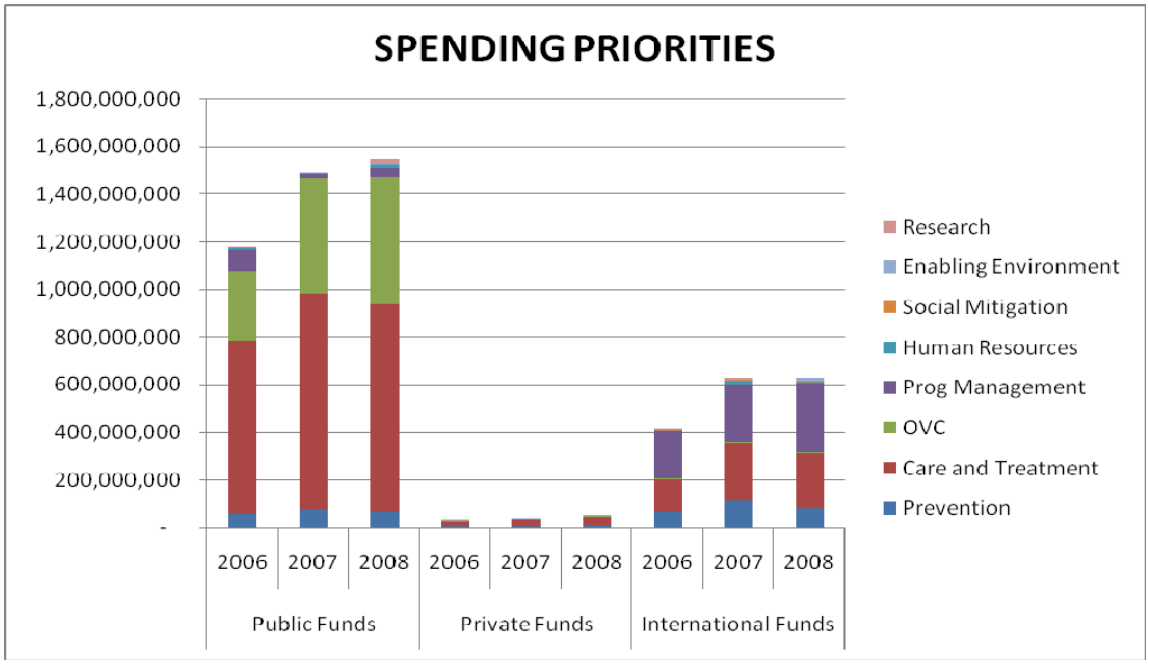
Unlike in many sub-Saharan African countries where funding for HIV and AIDS prevention, treatment and care has depended largely on external sources the national HIV and AIDS response in Botswana has been funded primarily by public revenue. At the time of writing this report, the country's National AIDS Spending Assessment (NASA) report for 2009 was not available. The most current report was that for the 2006-2008 period, the figures of which indicated that a total of BWP2.3 billion (approximately 348.4 million US Dollars) was spent on the national response in 2008. This is a slight decrease from the UD$351.6 reported in the 2008 UNGASS report and the US$165 million and the US$69.8 million reported in the 2006 and 2003 reports respectively.

Of the 2008 funds, 66 percent was from public sources; 32 percent from international partners, and 2 percent from private funds. The National Funding Matrix (Annex B) shows

a more detailed breakdown of the funding by categories and financing sources. All in all, the Matrix and Figure 3.1 below show that most of the funds were used for treatment, followed by support for orphans and other vulnerable children, and HIV prevention.

Work is currently ongoing to institutionalize the National Spending Assessment (NASA). Spending for 2009 has been estimated to be .... , however it includes public and international spending only.

Figure 3.1 Spending Priorities for the National HIV and AIDS Response, Botswana 2006-2008



Source**:** Botswana National AIDS Spending Assessment, 2006—2008; Summary of Preliminary Results

3.4 Policy Development and Implementation Status

In addition to the NSF II described earlier other national plans developed and/or launched during the current reporting period to enhance the national response include:

- The **National Operational Plan for Scaling-up Prevention** 2008-2010, launched by NACA in 2008. The Plan presents an aggressive prevention implementation programme that will fill the gaps in current programming and intensify, unify and scale up the response. It also ensures that resources are allocated to interventions with the greatest potential impact for preventing new HIV infections, and it also provides a framework for addressing cross-cutting issues such as capacity strengthening for effective implementation; coordination and management; and research monitoring and evaluation within the existing framework of the national M&E system (the Botswana HIV Response Information Management System).
- The **revised ARV Treatment Guidelines** published by the Ministry of Health in late in 2008. These guidelines are consistent with, and correlated to, existing guidelines for PMTCT, testing and Tuberculosis (TB). The new guidelines more effectively address such issues as initiation of therapy, TB/HIV co-infection, treatment failure and management, and management of opportunistic infections.
- The new **National Guidelines for HIV Testing and Counselling** that were published by the Ministry of Health in 2009. These guidelines cover the procedural and operational requirements for both Voluntary Counselling and Testing and Routine HIV Testing. They also outline directions for scaling up service provision as well as monitoring and evaluation.
- The **National HIV and AIDS Policy** has been revised and a draft is available and ready to the forwarded to Cabinet for approval.

National Composite Policy Index

INDICATOR 2: National Composite Policy Index (NCPI). Areas covered: Strategic Plan and Political Support; Human Rights; Civil Society Participation; Monitoring and Evaluation

The National Composite Policy Index measures the extent to which countries have developed policies and strategies on HIV and AIDS in the broad areas of: strategic planning; political support; HIV prevention, treatment, care and support; human rights; and civil society involvement. A number of specific policy indicators are identified for each of these policy areas. The composite index is an average of rankings (on a scale 0 – 10) of the components. Detailed results of the NCPI for the current reporting period are shown in Annex C, and they can be succinctly summarised as follows:

- The political support that has been present in Botswana since HIV was declared an emergency is still continuing. This is evident in, among other things, senior government officials and the top political leadership consistently speaking publicly and favourably about efforts to halt the spread of the epidemic. In addition the National AIDS council is chaired by the former President of Botswana and deputized by the current Vice-President. There is also continuing and increasing government budget allocation for the national HIV and AIDS response.
- The country has in place a national multisectoral strategic framework to respond to HIV and AIDS. The framework—developed through a consultative and inclusive process—prioritises areas of intervention to maximize impact of the national response to HIV and AIDS.
- Although Botswana has non-discrimination laws and regulations which specify protection for most-at-risk populations there are, at the same time laws, regulations and policies in the country that present obstacles to effective HIV prevention, and access to treatment, care and support for these populations. For example, there are laws that penalise sex work and same-sex relationships.
- Civil society has, over the years, been a key player in the national HIV and AIDS response, actively participating in strategic fora and committees such as the National AIDS Council, the Technical Working Group of the national monitoring and evaluation (M&E) system, the Country Coordinating Mechanism (CCM), and the National Technical Advisory Committee for HIV Prevention. However, civil society's effective participation continues to be constrained by lack of skilled human resources as well as financial resources.
- M&E efforts have improved since the last UNGASS report in 2008. However, there still exist multiple reporting tools and channels; a challenge therefore still remains to harmonise reporting systems. M&E progress and challenges are discussed in more detail in Section 7 of this report.
- The country is implementing a wide range of recommended treatment, care and support services. There is also access to regional procurement and supply management mechanisms for critical commodities such as ART drugs, condoms and other essential drugs.

3.5 National Programmes

Since HIV and AIDS was declared national emergency, Botswana has embarked on a number of HIV prevention efforts to reduce the spread of HIV. The first national Strategic Framework 2003-2009 had "Prevention of HIV infection" as the first of its five goals. Against this background a number of prevention programmes were established during the period of the plan and were presented in previous UNGASS reports. These include the Prevention of Mother-to-Child Transmission (PMTCT) programme, established in 1999; and the Routine HIV Testing, introduced in 2004.

Like its predecessor, the recently launched second National Strategic Framework 2010-2016 has "Preventing New HIV Infections" as the first of its four priorities. Against this background national programmes introduced in the current reporting period echo the Government of Botswana's goal of achieving "Zero New Infections by 2016". These programmes are:

- The **National Multiple Concurrent Partnerships (MCP) Campaign**, launched in March 2009 to address MCP in the country. Marketed under the name ***O icheke***

("check yourself"), the campaign addresses MCP in all its forms, but it has a strategic focus on young women engaged in MCP for personal or material gain (18-24 years), men engaged in MCP for sexual variety (25-35 years); and intergenerational sexual partnerships between older men and young, vulnerable girls (Matlhare, 2008). The campaign's approach is based on the premise that sustained behaviour change can only be achieved if there is a desire to change within the individual, and if there is an enabling environment. To this end, the campaign adopts consumer-centred messaging developed to promote the relevant benefits of behaviour change and to shift the values and norms. These messages are disseminated through multimedia channels that promote reflection, catalyse discussion and debate, leverage supportive cultural norms and encourage those at risk to identify ways to overcome barriers to change. This happens through a combination of standalone messaging, as well as the integration of MCP messages into existing HIV and AIDS and sexual and reproductive health activities.

- The **Safe Male Circumcision Programme**, launched by the Ministry of Health in 2009. The project—launched following a series of studies that showed that circumcision can reduce a man's risk of HIV infection—aims to circumcise nearly 500,000 men over five years in an effort to prevent the spread of HIV. Hospitals countrywide are scheduling and performing the procedure, and as at mid-May 2009, 50 healthcare providers, including 27 physicians, had been trained to perform surgical circumcisions. Television and radio advertisements are used to encourage men to visit clinics to undergo a safe circumcision surgery (Kaiser Foundation, 2009). The ministry of Health is training Sectors on Safe Male Circumcision. Workplace programs are educating men on SMC.
- The World Bank-sponsored **Botswana National AIDS Prevention Support Programme (BNAPS)** was launched in July 2009 to assist the Government of Botswana to increase the coverage, efficiency, and sustainability of targeted and evidence-based HIV and AIDS interventions through (i) strengthening NACA's institutional management and coordination capacity; and (ii) financing strategic and innovative HIV and AIDS-related prevention and mitigation activities in the public sector, civil society and private sector. The programme will continue until June 2014. During this period, it will spend US$7.5 million on the first component (NACA's institutional strengthening); US$20 million on HIV prevention activities in six Ministries: (Health; Works and Transport; Labour and Home Affairs; Education; Local Government; and Youth, Sports and Culture); and a total of US$22.5 million will be spent on HIV prevention activities of civil society organisations in the country

Blood safety

INDICATOR 3: Percentage of donated blood units screened for HIV with an external quality assured scheme [100%]

As reported in previous UNGASS reports, the National Blood Transfusion Service aims to ensure that all donated blood units in Botswana are screened for transfusion-transmissible infections such as HIV, Hepatitis B, and others, so that only those units that are non-reactive on screening tests are released for clinical use. As a result, universal (100 percent) screening of all donated blood is performed in Botswana. Laboratories in Botswana use standard operating procedures for the screening of blood units and for other laboratory tests. For the current reporting period (1st January 2008 and 31st December 2009), a total of 43 008 units of donated blood were screened using quality assurance methods, and out of those 28 746 units were transfused.

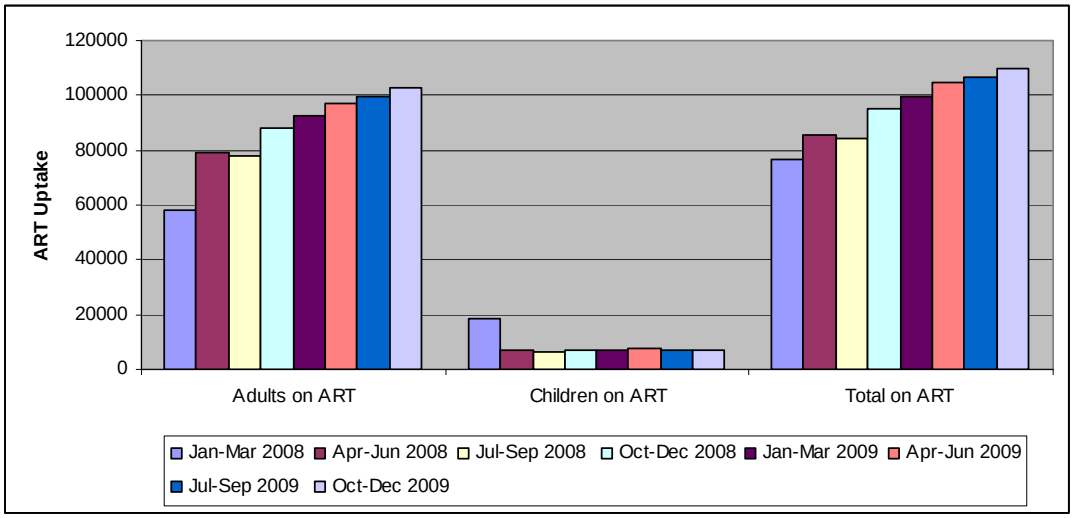
Antiretroviral therapy

INDICATOR 4: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy [89.8%]

Botswana was the first African country to provide antiretrovirals (ART) free of charge to its citizens through the National ART programme known as *MASA*. The public programme is now available in 30 hospitals and 130 satellite clinics countrywide. As of December 31st

2009, 125 991 people were being treated by the public sector (112,613 directly by the public facilities and 13,378 out-sourced through a public-private partnership) and 19,199 people were being treated directly by the private sector. Figure 3.2 shows the uptake of ART in *MASA* sites during the current reporting period.

Figure 3.2 ART Uptake on MASA Sites, Botswana, January 2008-December 2009



Source: Adapted From the National AIDS Council Quarterly Report (October to December 2009)

The total of 145,190 persons on treatment as at end of 2009 was estimated to account for 89.8% of those with advanced HIV infection in need of ART according to the Estimation and Projection Package (EPP) and Spectrum mathematical models (increasing from 117,045 and 80.7 percent respectively in 2008). The increase in uptake is also reflected in the 2009 Sentinel Surveillance data which show that a total of 30.6 percent of all pregnant and HIV positive women in 2009 were on ART as compared to 18.2 percent in 2007.

It is noteworthy that the distribution of ART clients in Botswana tends to be highly concentrated in cities and less concentrated in the urban and rural villages, thus reflecting the strategic location of ART sites as they were selected to serve places with the highest population density.

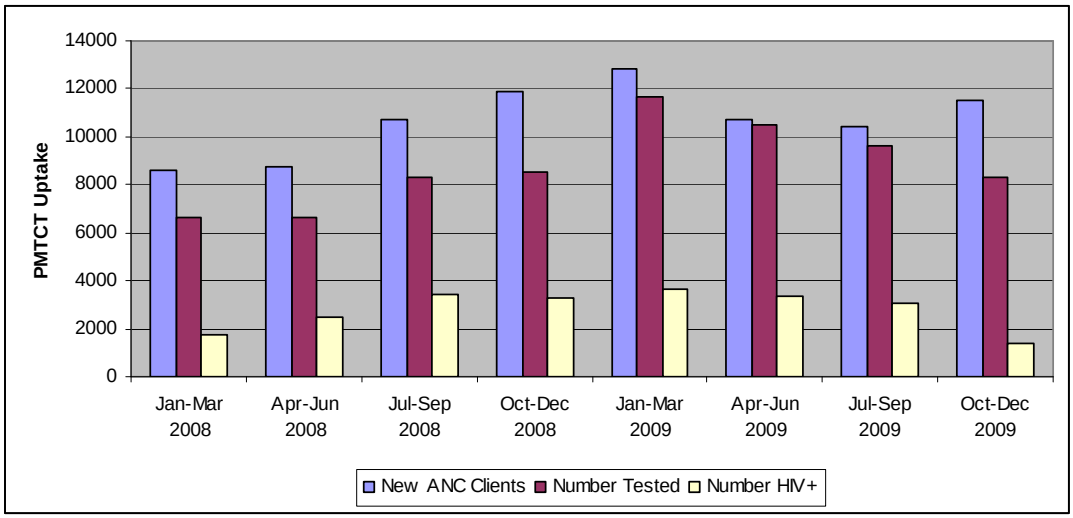
Prevention-of-Mother-to Child-Transmission of HIV

INDICATOR 5: Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission [94.2%]

The Government of Botswana established the first national Prevention of Mother-to-Child Transmission (PMTCT) programme in Africa in 1999. PMTCT's primary goal is to prevent transmission of HIV to unborn babies from their infected mothers. Pregnant women who present themselves to antenatal care services (ANC) are offered HIV testing and those found HIV positive are advised to enrol in the programme. The PMTCT achieved significant uptake in 2002 following the start of the ARV programme and it increased as lay counsellors were deployed to ANC clinics in 2003, and routine HIV testing became national policy in 2004.

Data from the Ministry of Health show that the proportion of pregnant women in Botswana tested for HIV infection during antenatal care has increased from 49 percent in 2002 to 91 percent in 2009. Uptake of PMTCT interventions among those testing positive has increased from 27 percent in 2002 to 94 percent in 2009. Figure 3.3 below shows the uptake during the current reporting period.

Figure 3.3 PMTCT Uptake, Botswana, January 2008-December 2009



Source: Adapted From the National AIDS Council Quarterly Report (October to December 2009)

Treatment of Tuberculosis

INDICATOR 6: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

Botswana is not reporting on this indicator as no data is available

Generally, Tuberculosis (TB) is the single most common cause of death in HIV infected individuals. Thus, effective management of TB has a significant impact in reducing mortality. It is against this background that all districts in Botswana are required to report monthly to the Botswana National TB Programme of the Ministry of Health the number of newly registered HIV positive TB-patients who are enrolled on ART. Although the TB monitoring system in Botswana has been developed , it still requires integration with the HIV monitoring system in order to accurately assess referrals for HIV treatment. In consequence, the country has not been able to report on the UNGASS Indicator 6.

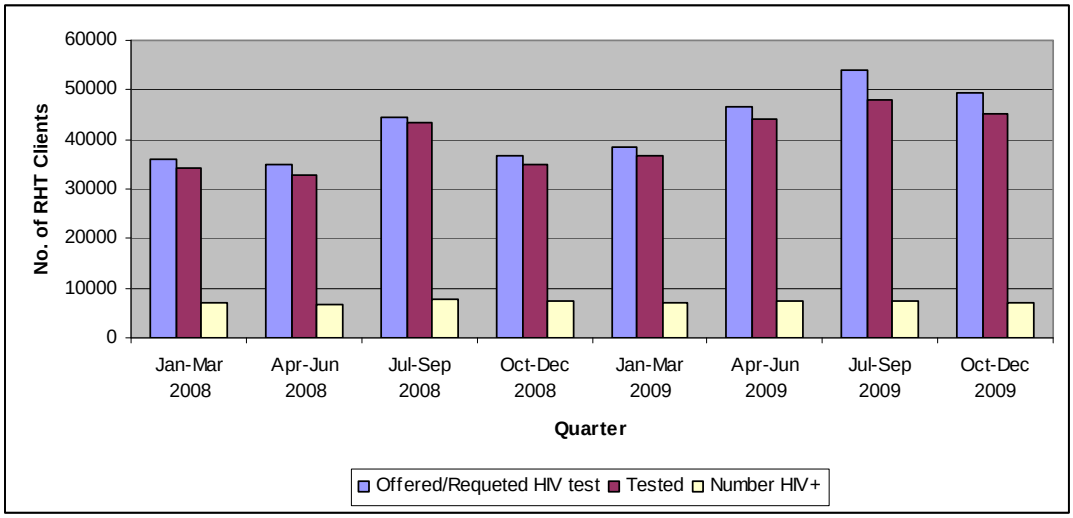
HIV testing

INDICATOR 7: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results [41.2%]

Voluntary counselling and testing (VCT) for HIV is one strategy that has been shown to enhance safe sexual behaviour and hence lead to a lower risk of HIV infection. Counselling is particularly important because it may lead to behaviour change by helping people evaluate their current level of risk, providing them with the motivation and self-efficacy to curb primary and secondary infections, and allowing them the opportunity to engage in problem solving regarding challenging scenarios such as negotiating condom use (Denison et al, 2006).

In Botswana VCT is administered by four main service providers: the Botswana Family Welfare Association (BOFWA), the Botswana Christian AIDS Intervention Programme (BOCAIP), Tebelopele (an NGO with a network of VCT centres in all the 24 health districts in the country), and through Routine HIV Testing (RHT)—the routine, but non-mandatory HIV testing that is offered to all public health centre clients. RHT was introduced in all health facilities in Botswana in January 2004. Figure 3.4 shows the RHT uptake for the current reporting period.

Figure 3.4 RHT Uptake, Botswana, January 2008-December 2009



Source: Adapted From the National AIDS Council Quarterly Report (October to December 2009)

The increasing uptake of HIV testing shown in Figure 3.4 is further reflected in the in the 2008/2009 Annual Report of Tebelopele which shows that the network's clients uptake increased from a total of 3 783 in 2000 to 650 000 as at March 31st 2009. The number of repeat testers at Tebelopele also increased from 5.2 percent in 2000 to 35.7 percent in 2008/2009 mainly due to ongoing campaign to encourage people to test for HIV as part of a healthy lifestyle. Out of a total of 163 095 people seen in Tebelopele centres countrywide in 2008/2009, 98.2 percent received counselling and testing while 1.8 percent received counselling only.

The 2008 BAIS findings revealed that 41.2 percent of the population aged between 15-49 years had been tested for HIV in the last twelve months and they know their results.

INDICATOR 8: Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results

Botswana is not reporting on this indicator as no data is available

There is currently no appropriate data to analyse the extent of condom use, and indeed, any sexual behaviour of most-at risk populations (MARPs) in Botswana. This is largely because the lifestyles of these groups, for example, same-sex relationships and sex work are illegal in the country. As a result these groups of people are usually not easy to identify as they fear being arrested or stigmatized. To overcome the paucity of data relating to these populations, a MARPS rapid assessment was carried out in 2009 and it was agreed that there was need to do the following, both of which are currently under way:

- Develop an Operational Plan for MARPs.
- Carry out a situation analysis including mapping of MARPS during the first half of 2010. this will entail a desk review and qualitative assessment, followed by a mapping and size estimation.

An attempt was also made to get information on MARPS from BAIS III data, however with BAIS being a cross-sectional household survey, it was not feasible to obtain accurate data on men who have sex with men, and on sex workers.

Reach of HIV prevention programmes

INDICATOR 9: Percentage of most-at-risk populations reached with HIV prevention programmes

Botswana is not reporting on this indicator as no data is available

As stated above, there is currently no appropriate data to adequately examine the sexual behavior of most-at-risk populations in Botswana. Attempts have however been made by civil society organisations, particularly the Botswana Network on Ethics Law and HIV and AIDS (BONELA) to reach most-at-risk populations with HIV prevention programmes. For example, in January 2009 BONELA's Prevention Research Initiative for Sexual Minorities (PRISM) programme launched a Needs Assessment Report on the Lesbian, Gay, Bisexual and Transgendered community in Botswana. According to BONELA, the report highlighted that some of the key barriers preventing most-at-risk population accessing HIV prevention services, and exercising their rights to access such services was a lack of knowledge about what those services and rights are, as well as the discriminatory and exclusive practices of many organisations providing those services. To this end the report made it clear that there is an urgent need to educate society at large—at both individual and organisational levels—on prevention, human rights and the general wellbeing of most-at-risk populations.

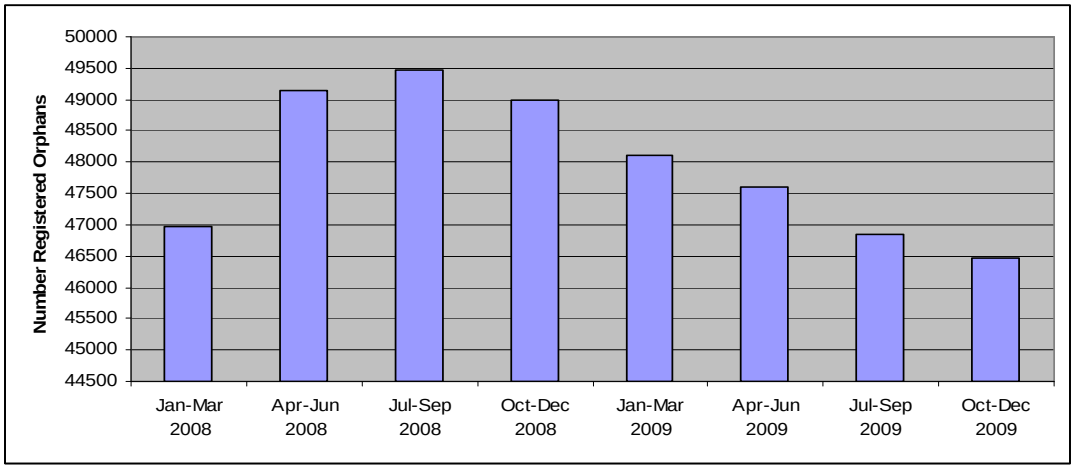
Care for orphans and vulnerable children

INDICATOR 10: Percentage of orphaned and vulnerable children aged 0-17 years whose households received free basic external support in caring for the child [31.2%]

HIV and AIDS have orphaned a large number of children in Botswana. In response the Government of Botswana through the Ministry of Local Government established the National Orphan Care Programme in 1999 to provide food baskets, support with educational necessities, psychological counselling and to facilitate the waiving of school fees for orphans.

Figure 3.5 shows that the number of registered orphans decreased consistently in the current reporting period. This decrease is also reflected in the decrease in Indicator 10 since the last UNGASS report. These decreases could partly be a reflection of the fact that more people are on ART treatment thus resulting in fewer deaths, fewer orphans, and fewer number of households receiving free basic external support in caring for orphans and other vulnerable children. It could also be partly due to the national assessment conducted in 2006 which led to a reduction in the number of registered orphans, mainly due to streamlining of the support structure to exclude people who were found not to qualify to be in the Orphan Care Programme.

Figure 3.5 Number of Registered Orphans, Botswana, January 2008-December 2009



Source: Adapted From the National AIDS Council Quarterly Report (October to December 2009)

Life-skills-based education

INDICATOR 11: Percentage of schools that provided life-skills-based HIV education in the last academic year [100%]

Botswana has taken cognisance of the fact that life-skills-based education helps young people to understand and assess the individual, social and environmental factors that

arise and lower the risk of HIV transmission. As a result all primary and secondary schools in the country have teachers that are trained in, and are currently teaching, life-skills-based education, which has HIV and AIDS as a major component. To further capacitate teachers in this area, the Ministry of Education and the Centers for Disease Control (CDC)-Botswana developed, in the current reporting period, a comprehensive set of culturally appropriate, behaviour change-focused and interactive national materials to educate primary and secondary school students about HIV and AIDS and other sexually transmitted diseases, and to teach them skills to make healthy choices. It is expected that by September 2010, all 31 000 teachers in the primary and secondary schools in the country will be prepared to use the materials in their classrooms.

3.6 Knowledge and Behaviour

Knowledge

INDICATOR 12: Current school attendance among orphans and non-orphans aged 10-14

Botswana is not reporting on this indicator as no data is available

Orphanhood is frequently accompanied by prejudice and increased poverty, factors that can further jeopardize children's chances of completing school education. It is important therefore to monitor the extent to which support programmes succeed in securing the educational opportunities of orphaned children. There is currently no data available to calculate this indicator in accordance with the UNGASS guidelines (UNAIDS, 2009a:50). However the current practice in Botswana suggests that there is very little difference in school attendance of orphans and non orphans. Firstly, one of the main objectives of the National Orphan Care Programme discussed earlier, and also in Section 4 of this report, is to ensure that orphans remain in school by waivering school fees and providing the children with educational necessities.

Secondly, Botswana has achieved universal access to primary education, which provides a strong basis for the higher goal of 10 years of basic education (the 10-14 age group is covered by these years). From 1995-2000, the estimated net enrolment rate for children aged 7-13 was consistently above 95 percent, peaking at 100 percent in 1999 and 2000. Over the same period, the gross enrolment ratio was at least 11 percentage points higher than the net enrolment ratio. In addition to improved access to education, progression from one level of study to another has also improved (Ministry of Education, 2009). These statistics indicate that there is wide school attendance among children in Botswana, regardless of the orphanhood status.

INDICATOR 13: Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission [42.1%]

The risk of acquiring HIV infection, especially among young people, has been known to be high and to be driven by, among other things, lack of functional knowledge about the modes of HIV transmission. In recognition of this the Government of Botswana in collaboration with civil society organisations and development partners has over the years embarked on a number of behaviour change communication and media campaigns to provide young people with appropriate information and skills to make informed, responsible choices about sex and relationships, and to prevent the spread of HIV. This is in addition to life-skills based education provided in schools as described above.

Available evidence suggests that such efforts are bearing some fruit. For example, the results of the 2008 BAIS showed that the overall percentage of respondents aged 15-24 who both correctly identified ways of preventing HIV and who reject major misconceptions about HIV transmission was 42.1 percent, up from the 37.6 percent and the 36.3 percent revealed by the 2004 BAIS and 2001 BAIS respectively.

INDICATOR 14: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Botswana is not reporting on this indicator as no data is available

See comment under Indicator 8

Sexual behaviour

INDICATOR 15: Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15 [3.5%]

The positive impact of behaviour change communication and media campaigns is further reflected in the decreasing trend in the age at sexual debut. According to the BAIS III results, only 3.5 percent of young people aged 15-24 years reported that they had sex before the age of 15 years, down from the 7.0 percent reported at the time of 2004 BAIS.

INDICATOR 16: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months [11.2%]

As stated earlier in the report, research points to the fact that the drivers of HIV transmission in Botswana include multiple concurrent sexual partnerships. Results of the 2008 BAIS show that among the population aged 15-49 years, the percentage of those who have had sexual intercourse with more than one partner in the last 12 months is 11.2 percent. This indicator is important for understanding the overall number of people with multiple partners, but it does not contain any information about how many of these partnerships are concurrent. To address this, the UNAIDS Monitoring and Evaluation Reference Group has developed a new indicator for concurrent partnerships that focuses on the number of people who have more than one partner at the same time. The 2008 BAIS did not include one of the key questions to measure this, but other research in Botswana can provide useful supplemental information on concurrent partnerships. In particular, in late 2007 Population Services International conducted a nationally representative survey that examined sexual behaviours, and found that 17.5% of men and 17% of women reported having concurrent partnerships at the time of the survey. This is among the highest nationally representative figures reported globally, and shows a gender symmetry that is very unusual.

It can be expected that as the MCP programme expands throughout the country, this figure will be considerably reduced by the time of the next UNGASS report.

Condom use

INDICATOR 17: Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse [81.1%]

Public sector condom distribution in Botswana is managed by the Central Medical Stores, (CMS) a department of the Ministry of Health. Between January and December 2009 the CMS distributed a total of 19,815,800 male condoms. Female condoms were also distributed albeit on a smaller scale. In addition to the free provision of both male and female condoms at all government health facilities ,in the workplace and non-traditional sites, there continues to be procurement and distribution of condoms by civil society partners, particularly Population Services International Botswana (PSI). In 2009 PSI distributed 9,741,346 condoms (both the Lovers Plus brand, which are sold, and freely distributed).

These high volumes of distributed condoms largely explain the high proportion for Indicator 17. However, that close to 20 percent of sexually active people still do not use condoms during high risk sex warrants attention.

INDICATOR 18: Percentage of sex workers reporting the use of a condom with their most recent client

Botswana is not reporting on this indicator as no data is available

See comment under Indicator 8

INDICATOR 19: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Botswana is not reporting on this indicator as no data is available

See comment under Indicator 8

INDICATOR 20: Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

Botswana is not reporting on this indicator as no data is available

Safer injecting and sexual practices among injecting drug users are essential, even in countries where other modes of HIV transmission predominate, because: (i) the risk of HIV transmission from contaminated injecting equipment is extremely high; and (ii) injecting drug users can spread HIV (e.g. through sexual transmission) to the wider population. Botswana is, however, not reporting on this indicator as no data is available

Use of sterile equipment

INDICATOR 21: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

Botswana is not reporting on this indicator as no data is available

See comment under Indicator 20

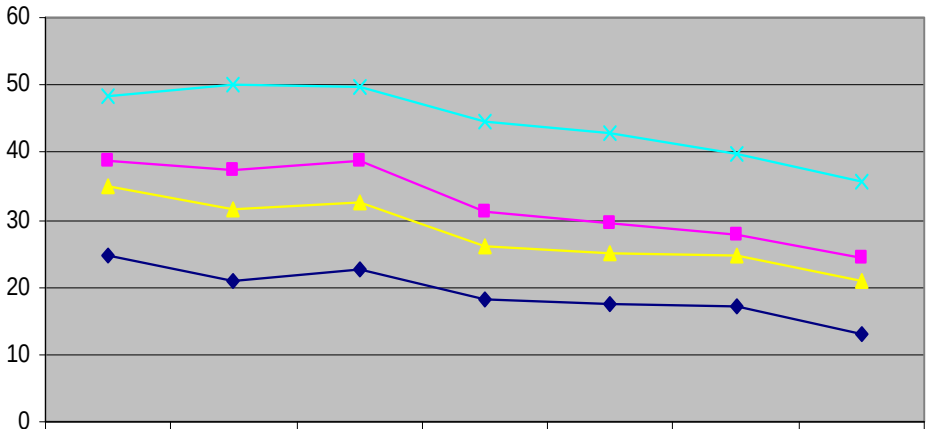
3.7 Impact

HIV prevalence

INDICATOR 22: Percentage of young people aged 15–24 who are HIV infected [8 percent]

Although young females continue to be at higher risk of HIV infection than their male counterparts (Figure 2.3), an encouraging development revealed by the BAIS III results is the notable overall declines in HIV prevalence aged 15-24 years: 8 percent in 2008, down from the 13 percent reported in the 2004 BAIS. The downward trend in this age-group is also reflected in the Sentinel Surveillance data which show that HIV prevalence among young pregnant women has been consistently decreasing since 2005 (Figure 3.6).

Figure 3.6 HIV prevalence among pregnant women aged 15-29, Botswana 2001-2009



	2001	2002	2003	2005	2006	2007	2009
15-19	24.7	21	22.8	18.1	17.5	17.2	13
20-24	38.7	37.4	38.6	31.2	29.4	27.9	24.3
15-24	35.1	31.6	32.5	26.1	25	24.6	20.9
25-29	48.4	50	49.7	44.5	42.8	39.7	35.8

Source: Ministry of Health (2009) *Botswana Generation HIV/AIDS Sentinel Surveillance Preliminary Results*

INDICATOR 23: Percentage of most-at-risk populations who are HIV infected
Botswana is not reporting on this indicator as no data is available

See comment under Indicator 8

Treatment

INDICATOR 24: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy [93.2%]

Botswana's ART programme has been very successful at retaining patients in care and maintaining low rates of mortality. Survival is monitored through analysis of electronic patient-level data entered on-site at ARV facilities and it indicates that overall, over 93 percent of the 11,295 patients who initiated therapy at a hospital in 2007 were still receiving care at a hospital 12 months later. Therefore, this analysis assumes that all who remained in care at 12 months were still on ARV therapy. Data from patients lost to follow-up were censored as many were likely to have transferred their HIV treatment and care to clinics (analyses of the electronic patient-level data are underway to definitively quantify survival on therapy including losses to follow-up).

INDICATOR 25: Percentage of infants born to HIV infected mothers who are infected [3.8%]

Botswana's effective PMTCT programme provides HIV testing and ARV intervention to most pregnant women as most of these women attend ANC and deliver in the healthcare setting. For HIV positive pregnant mothers whose CD4 count is 250 or above and who present no clinical signs of AIDS, prophylaxis (Zidovudine) is administered from 28 weeks of pregnancy through to delivery, while those whose CD4 count is lower than 250, treatment (ART) is administered immediately. The latter group stays in ART even after delivery while the former stops Zidovudine treatment at delivery depending on the results of the tests carried out at that stage. Therefore, transmission rates have been maintained below 5 percent, and piloting of universal ART for pregnant women in Botswana in 2010 is expected to further decrease transmission rates.

4 BEST PRACTICES

4.1 Introduction

The *Guidelines on Construction of Core* Indicators for the 2010 UNGASS reporting instructed that, for the purpose of sharing lessons learned with other countries, this section

> "should cover detailed examples of what is considered a best practice in-country in one or more of the key areas, such as political leadership; a supportive policy environment; scale up of effective prevention programmes; scale-up of care, treatment and/or support programmes; monitoring and evaluation, capacity building; infrastructure development" (pg 79).

Taking into consideration the following criteria needed in selecting a 'Best Practice": ' Effectiveness, Ethical Soundness, Relevance, Reliability and Sustainability (UNAIDS, 2000), participants at the national consensus-building workshop identified the following national programmes as some of Botswana's best practices that are worth sharing with the global community. It is noteworthy that the first two were also identified as best practices by a national exercise commissioned by NACA in 2007 to identify and document such best practices on HIV and AIDS (NACA, 2007).

4.2 Best Practices

Prevention of Mother to Child Transmission (PMTCT) Programme

The Botswana PMTCT Programme (Prevention of Mother to Child Transmission) was introduced in 1999 when it was piloted in the country's two main cities of Gaborone and Francistown. This initiative made the Government of Botswana the first in Africa to establish a national PMTCT programme

By July of 2000 national roll out commenced and all public health facilities were offering the service by November of 2001. The PMTCT programme provides prophylaxis (Zidovudine) to all eligible positive pregnant women, and a 12 month supply of formula feed to babies who have been exposed to HIV. The programme has successfully adapted the UN framework on HIV and infant feeding. The PMTCT programme has a specific child survival goal: to improve both the development and survival of the child through the reduction of morbidity and mortality.

Over the years the PMTCT programme has had major achievements in terms of access, testing of pregnant mothers, HIV positive mothers taking up HIV prophylaxis and treatment (See Figure 3.3), and the proportion of new-borns tested at 6 weeks (down from the 18 months as was the case in the past). This largely explains the steady decrease in the proportion of infants born to HIV positive mothers who are infected (UNGASS indicator 25). As shown in Table 1.1 this proportion decreased from 20.7 percent at the time of the 2003 UNGASS report to 3.8 percent in 2007.

Other achievements that the programme can certainly take credit for in recent times are the scaling up of male involvement. This appears to have had additional benefits, not only in PMTCT, but more broadly across the public health domain. It is now less frowned upon to see men playing an active role in parent and child health as opposed to the old 'mother and child health' (MCH) practice. Psycho-social support and couples counselling are additional value added and vital support services that are offered as part of the programme.

Despite the phenomenal success of the programme, it is not without challenges. It is common practice for mothers to leave babies with grandparents or other caregivers. These caregivers are often not aware that the child has been exposed to HIV. This poses a problem to health workers who are bound by ethics not to disclose such information and

therefore to test the child at the required time. Another problem associated with babies being left with the grandmother or other caretakers is the safe preparation of formula feed. Repeated pregnancies by women who are HIV positive and already on ART is yet another serious challenge to the programme. It obviously implies unsafe sex, thereby increasing the possibility of re-infection and the transmission of a of drug–resistant strain of HIV, as well as having a debilitating effect on the health of the women..

Routine HIV Testing

Routine HIV Testing (RHT) is provider initiated testing that has been adopted as an integral part of clinical services provided in public health facilities. It provides an opt-out policy for HIV testing. Other health facilities such as the Botswana Family Welfare Association have also adopted this policy. The RHT process includes simplified pre-test education, HIV testing and post-test counselling. RHT does not endorse mandatory or coercive HIV testing. This is generally well accepted by those who are offered the test, with testing uptake rates as high as 91.7 percent in the October–December quarters of 2009 (RHT programme data from National AIDS Council report).

Antiretroviral Therapy

A mixture of political will, sound macro-economic planning and the escalating HIV prevalence in the country all played a role in Botswana becoming the first country on the African continent to introduce and roll out an anti-retroviral programme on a large scale. The programme, named *MASA (*a Setswana word for 'new dawn') was launched in 2004 and has since brought hope, light and signified a new beginning for many. As stated earlier, the programme is now available in 30 hospitals and 130 satellite clinics in the country and its current uptake of 89.8 percent (at the end of 2009), among those in need of treatment, is a definite increase from the 63 percent noted at the end of 2004.

MASA is revered by many not only for its ability to prolong life but more so for the tangible change that it brings about in the quality of life. The programme provides a care package that goes beyond the mere provision of life saving of drugs (at no cost). Valuable dietary information along with a supplementary food basket forms part of the programme. This has additional benefits. For example, the infected individual get to take care of themselves; it reduces the dependency burden; and the care and support provided by the programme is seen to have immense psycho-social benefits as well as prevention benefits to be gained. *MASA* also exemplifies the function of the Private Public Partnership (PPP) where private hospitals, medical practitioners, and mine hospitals provide treatment, care and support services to the public as an extension of government services.

National Orphan Care Programme

The National Orphan Care Programme is an HIV and AIDS mitigation programme through which the government, led by Ministry of Local Government, provides care and support to orphans. As part of the Family Care Model, Botswana sought to integrate both Community Home Based Care and Orphan Care programmes into a family focused support system. The Orphan Care programme ensures that orphans remain in school; they are provided with appropriate nutritional supplements and are helped to overcome the feeling of loss and trauma following the death of parents. This is done through the free provision of food baskets, free schooling, support with educational necessities and psychosocial counselling, among other things.

Government's support to orphans is complemented by active participation of relatives and non-government organizations; a functioning tripartite relationship between government, the community and the private sector.

4.3 Conclusion

The 2007 *Documenting of National Best Practices on HIV and AIDS (*NACA, 2007) and the 2008 UNGASS Progress Report present other best practice innovations in the country covering different aspects of the national response: prevention; provision of treatment care and support; strengthened management of the national response; and provision of a strengthened legal and ethical environment.

5 MAJOR CHALLENGES AND REMEDIAL ACTIONS

5.1 Introduction

In the 2008 UNGASS Country Progress Report, a number of challenges faced by the public sector, civil society, private sector and development partners in their efforts to achieve the UNGASS goals and targets were highlighted. This section presents the challenges as outlined in the 2008 report, and reports on the progress made regarding each identified challenge. Challenges experienced in the current reporting period, and proposed remedial actions to address the challenges are also discussed.

5.2 Sector-wide Challenges in 2008 and Progress Made

Public sector	Progress since 2008
Challenge 1: Poor coordination and harmonisation of the different stakeholders to ensure maximum impact of the multi-sectoral response	▪ NACA received technical assistance in the form of a Development Assistance Coordination Advisor who assists with aspects of partnership coordination. ▪ After years of inactivity the Botswana HIV and AIDS Partnership Forum—the advisory arm of NACA—was revived in 2008 with new Terms of Reference. Research and anecdotal evidence indicate that the Partnership Forum continues to grow in strength and purpose and efforts are underway to ensure it produces substantive inputs into the national response. ▪ In late 2009 NACA commissioned an assessment of coordination, harmonisation and alignment within the HIV and AIDS national response in Botswana. The report of the assessment is currently being finalised. It is expected that the results of the assessment will be used to further improve programming, management and coordination functions as well as to foster increased levels of engagement, participation, harmonization, and alignment by all national and international partners in the national HIV and AIDS response. ▪ Key principles of joint planning and review, and mutual accountability for results, are being worked out in the development and implementation of the second National Strategic Framework operational plan.
Challenge 2: Poor policy implementation due to long consultative processes that often result in delays in policy implementation	▪ The revised National HIV and AIDS policy is being finalised.
Challenge 3: Mainstreaming—there has not been sufficient clarity on the concepts of mainstreaming HIV and AIDS to move the process forward. Additional challenges for mainstreaming include implementation capabilities as well as leadership for the process**.**	▪ NACA in conjunction with other partners is working with the Public Sector Reforms Unit to move the mainstreaming strategy onto the reforms agenda. In particular, NACA did the following: o Collaborated with the Southern African Development Community (SADC) to pursue mainstreaming agenda on a regional basis; o Collaborated with UNDP to review constraints to mainstreaming and make recommendations for effective mainstreaming to take place; o Developed a concept paper for effective mainstreaming; and o Undertook training of focal persons on mainstreaming and developed action plans to move the agenda forward. ▪ Mainstreaming has been written into the new National Development Plan and the expectation is that this will give new impetus to the mainstreaming strategy
Challenge 4: Resource constraints. Given that Botswana is now classified as an upper middle class country, many donor agencies are pulling out of the country to focus on poorer countries. This has resulted	▪ Botswana National HIV and AIDS Prevention Support Programme will augment funds to partly address this challenge. ▪ Bilateral relationships have been established to

in financial and skilled manpower shortages in many areas	provide the necessary technical skills for the national response. For example, as part of an agreement signed in 2002, Cuban health professionals work in several hospitals and clinics that specialise in treating those living with HIV and AIDS in Botswana. Another example is the American Peace Corps volunteers who are assigned as counterparts to District AIDS Coordinators in schools, clinics and NGOs, an effort to close capacity gaps in the implementation of HIV and AIDS programmes at the district level, ▪ the EU Non State Actors programme—a Government of Botswana programme supported by the European Union—is providing non-State actors in the country with skills, capacity and financial resources that can enhance their meaningful and effective contribution to development process including the national HIV and AIDS response.
Civil Society	
Challenge 1: With the departure of many donor agencies from Botswana many local civil society organisations have been left competing for the little funds that are available and finding it difficult to fund their activities or programmes.	▪ The situation has not improved particularly as the country did not get successive Global Fund rounds of funding. Nevertheless the country continues to submit Global Fund proposals with a strong civil society capacity-building and implementation responsibility. ▪ A civil society capacity-building strategy is under development. It is proposed that funding be put in one basket and distributed according to programmes in place. ▪ The Botswana National HIV and AIDS Prevention Support Programme (BNAPS) which has a strong civil society implementation and capacity-building component will greatly assist in overcoming this challenge.
Challenge 2: Many local NGO's are poor at networking and forming strategic partnerships with other NGO's in the regional and in the international arena to broaden their scope of work, and to increase donor support for those programmes that might need regional intervention	▪ Some progress has been made in this area; although some civil society organisations have initiated partnerships, efforts are still being made to address the challenges
Challenge 3: Some civil society organisations (CSOs)often fail in their mandates and they close down because of poor financial management, poor labour practices and lack of accountability	▪ The BNAPS Programme is providing capacity strengthening to civil society organisations in five districts in the first two years and will then expand coverage to the rest of the districts. ▪ Training on project management, computer skills development, M&E etc is taking place
Challenge 4: Lack of skilled and trained manpower, especially in the area of managerial and technical assistance hampers the delivery of effective and efficient services by civil society organisations	▪ Skilled and trained manpower remain inadequate. Where skilled people are found, insufficient remuneration remains a challenge as this has to be considered within the broader overall available programme finances. There is also no guarantee of continued employment as the staff are often given one to two year contracts. In consequence there is a high turnover as people look for more permanent employment. ▪ Civil society organisations continue to rely largely on volunteers which is a good sign for sustainability but remains a challenge in terms of overall speed of service delivery
Private Sector	
Challenge 1: The Botswana Business Coalition on AIDS's has a staff of three people—but is expected to cover the entire country. This is inadequate and results I problems of coordination and management.	▪ Three additional staff (Programme manager, Finance Manager, Writer/Editor) were employed in 2008. M&E Officer will be recruited during 2010/2011.
Challenge 2: Except for a few large companies that are mainly in the mining and financial services area, very few companies have HIV and AIDS policies**.**	▪ The mainstreaming guidelines under development will greatly assist to further address this challenge
Development partners	
Challenge 1: Poor clarity of roles and responsibilities	▪ The second National Strategic Framework (NSF II)

among stakeholders which often leads to duplication of efforts and delay of implementation on intervention strategies.	clearly spells out the roles and responsibilities of each sector. ▪ Operationalisation of the second NSF through a comprehensive National Operational Plan will help eliminate or limit duplication.
Challenge 2: Problems of poor coordination and harmonisation of the multi-sectoral response adversely affect efficiency and effectiveness of developmental partners.	▪ The Botswana HIV and AIDS Partnership Forum and the assessment of coordination, harmonisation and alignment within the HIV and AIDS national response, discussed earlier, will help address this challenge.
Challenge 3: Lack of local capacity to implement specialised programmes and projects	▪ Capacity in information, education and communication; behaviour change; and M&E is beginning to improve because of capacity-building offered by development partners in these areas
Challenge 4: Bureaucratic procedures of different organizations are also a challenge as they often result in delays in the disbursement of funds for important national projects	▪ See responses for challenges 1 and 2 (Development Partners).

5.3 Challenges in the Current Reporting Period and Proposed Remedial Actions

Challenges in current reporting period	**Proposed remedial actions**
Public Sector	
▪ Reduced budget allocations and expenditure as a result of the global economic crisis ▪ Behaviour-focused interventions have been given less attention than the bio-medical interventions ▪ Low level of leadership commitment at district and community levels compared to national level.	▪ Increased international technical and financial support ▪ Re-engineering of processes. For example. Some important policies and procedures such as the Wellness Policy and the Public Service Code of Conduct on HIV/AIDS Review have not been approved or implemented.
Civil Society	
▪ Inadequate financial and technical support, as well as lack of capacity to mobilise resources for sustainability of their programmes ▪ Reduced financial support from donors due to the global economic crisis ▪ High turnover of employees ▪ Increased workload and fatigue for national partners as a result of different donor programmatic and financial requirements.	▪ Improve coordination of support to CSOs through shared funding. ▪ Training of civil society organisation in financial planning and accountability. ▪ M&E capacity building at grassroots level. ▪ Develop a staff retention strategy .
Private Sector	
• Lack of capacity to mobilise resources • Sustainability of BBCA	• Implementation of the Botswana Business Coalition on AIDS' Sustainability Strategy. • Strengthen Public-Private Partnerships to address inadequate financial and technical support.
Development Partners	
▪ Financial challenges largely owing to the global economic crisis ▪ High turn over of staff in projects supported by development partners. ▪ Harmonisation, coordination and alignment of development partners' support still remain a challenge. ▪ Bureaucratic procedures of different partners resulting in delays in the disbursement of funds	▪ Creation of a common fund and sharing of additional resources. ▪ Manage limited resources by collaboration of efforts, in order to harness opportunities and achieve better coverage. ▪ Implement recommendations of the coordination, harmonisation and alignment needs assessment. ▪ Conduct customer satisfaction surveys to identify areas that need improvement in service delivery Re-engineering of processes to improve service delivery ▪

6 SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

6.1 Introduction

Although the Botswana government is providing the bulk of funding for HIV and AIDS programmes in the country, development partners are important players in the national HIV and AIDS response. As the National Funding Matrix in Annex B shows, most of the development partners' funds are used for activities and programmes related to treatment, OVC support and HIV prevention.

6.2 Key Support Received Since Last UNGASS Progress Report

Since the last UNGASS report, two major programmes were launched by development partners to provide financial and technical support as well as capacity-building for the national HIV and AIDS response. These are:

i. The **Botswana National AIDS Prevention Support programme**, discussed earlier in the report, will provide about US$50 million between 2009 and 2014 to assist the Government of Botswana as well as the private sector and civil society to increase coverage, efficiency, and sustainability of targeted and evidence-based HIV and AIDS interventions in the country.
ii. The European Union supports the Government of Botswana's **Non-State Actors (NSA) Capacity Development Programme**. This programme, implemented through the Ministry of Finance and Development Planning, is aimed at providing NSAs in Botswana with skills, capacity and financial resources that can enhance their meaningful and effective contribution to development processes including the national HIV and AIDS response

6.3 Challenges in 2008 and Progress Made

Several key areas of support needed by national partners from development partners where highlighted in the 2008 UNGASS report. These included improved harmonization and alignment of support with national policies and procedures; increased funding and capacity building; up-scale of support for prevention; and strengthening of civil society, with particular focus on addressing the absorption capacity. A number of initiatives and activities that have the potential to address these issues were launched or took place during the current reporting period. Key among these are:

- The revival of the Botswana HIV and AIDS Partnership Forum (BAPF). Set up in 2003 the BAPF is an the advisory body to NACA established to provide a platform for information-sharing on HIV and AIDS issues and to promote increased and harmonised support for initiatives aimed at scaling up the national response in line with the NSF I (NACA, 2008). After some years of inactivity, the Forum was revived in 2008 with the following new Terms of Reference to help provide substantive inputs into national response to HIV and AIDS.

  - to provide an opportunity for NACA to update members on progress, achievements and challenges in the implementation of the national strategic framework and make recommendations to address identified gaps;
  - to recommend and advocate to key stakeholders for support to areas where accelerated resources may be required from identified programmatic gaps and priorities within the framework of the national strategic framework;
  - to provide a platform for members from different sectors represented to inform the Forum of relevant initiatives undertaken either on a bilateral or multilateral basis within the context of their contribution to the national response, and how these initiatives link to the national strategic framework and are coordinated with NACA; and

- to identify key policy and programmatic issues and needs on HIV and AIDS, and to provide necessary support to address them;

The membership of the Forum is open to all key stakeholders of the national response through their self-coordinating and network entities including: NACA, line Ministries; bilateral and multilateral development partners; civil society umbrella organisations; the private sector; research institutions and academia; the media; and Parliamentary AIDS Committee. The forum meets every quarter. The Forum secretariat is provided by NACA.

The Terms of Reference and composition of the forum is expected to greatly improve coordination, harmonisation and alignment in the national response and do reduce duplication and overlaps in development partners'' support. A Steering Committee of the Forum was also established in 2008 to help drive the work of the Forum and identify key outputs and outcomes as well as providing a clear link between the Forum and other mechanisms or structures in the country. The steering committee is set to be the focal point for joint planning and review under the second NSF.

- An assessment of the coordination, harmonisation and alignment of partners in the national response was commissioned by NACA in November 2009. It is expected that the results of the assessment will be used to further improve coordination functions as well as foster increased levels of engagement, participation, harmonization, and alignment by national and development partners.

6.4 Current Challenges and Remedial Actions Needed

Despite the above remedial actions, development partners still faced some challenges during the current reporting period. These included financial challenges (mainly due to the global economic crisis) which affected development partners' support to government and civil society organisations. High turn over of staff in projects supported by development partners remained a major challenge. Other challenges, discussed earlier in Section 5 were:

- Poor clarity of roles and responsibilities among stakeholders which often leads to duplication of efforts
- Weak coordination among partners which adversely affect input of developmental partners;
- Bureaucratic procedures of different organizations which often result in delays in the disbursement of funds

To overcome financial challenges development partners suggest the harmonisation of development support efforts through pooled funding and mobilisation of additional resources.. High staff turnover, on the other hand, can be addressed by putting in place longer employment contracts that will afford skilled workers more job security and ensure continuity in the implementation of projects.

For national partners, the following are some of the actions that are deemed important for development partners to undertake to ensure achievement of the UNGASS targets:

- The development partners need to improve coordination amongst themselves;
- Active participation and involvement on national commemorative activities such as the World AIDS day;
- Organised continuous capacity building and technical support for national partners to build requisite skills;
- Greater involvement in operations research
- Mentorship of civil society organisations on the interpretation and application of UNGASS targets to civil society programmes;
- Better coordinated technical assistance;
- Strategic information management and sharing;
- Support in assessing progress in the national M&E system.

7 MONITORING AND EVALUATION

7.1 Introduction

The Monitoring and Evaluation (M&E) of the national HIV and AIDS response in Botswana is carried out through the national M&E system known as the *Botswana HIV and AIDS Response Information System (BHRIMS)*. Established in 2001 as the third of the "Three-Ones" principle—One agreed national Monitoring and Evaluation system—BHRIMS has the following objectives according to the first national strategic framework 2003-2009:
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1. To establish a monitoring and evaluation infrastructure;
2. To support the storage and analysis of all available HIV and AIDS data at different levels in the country;
3. To improve the accessibility of HIV and AIDS information and data;
4. To increase the utilisation of available reports and data for action; and
5. To maintain institutional memory of the National HIV and AIDS response

In order to deliver on these objectives a national M&E task force, known as BHRIMS Technical Working Group (TWG) was formed in 2003, with the following specific Terms of Reference, to:

- Provide technical guidance in the implementation of the BHRIMS concept;
- Provide Technical guidance on the BHRIMS policy, strategies and plan of action;
- Provide technical guidance in the Finalization of the National Core and Performance Indicator;
- Provide technical guidance in the development of Process indicators for Sectors and Districts;
- Provide technical guidance in the harmonization and development of data collection tools and realistic pathways;
- Provide technical guidance in the development and implementation of capacity building plan on M&E for the country; and
- Provide technical guidance in the utilization of generated M&E data in the country.

7.2 Major Achievements

BHRIMS has been able to meet its objectives over the years, albeit with challenges. Among key achievements are the following:

- Development of an M&E system with defined national indicators which are aligned with global ones to guide regular data collection and reporting. The system has also achieved some level of harmonization at district, national, regional and global levels. Accordingly, data collection tools have been developed and a system of data generation designed to yield requisite data at regular scheduled intervals. This includes quarterly programme performance reports and biennial reports on national commitments such as SADC and UNGASS. For outcome and impact monitoring and evaluation data is collected through an annual Surveillance programme and a population-based survey (Botswana AIDS Impact Survey) which is conducted every four years.
- Development and implementation of a national M&E training curriculum has led to major improvement in both the quantity and quality of M&E expertise at different levels and sectors of the national response. This has in turn fed positively into the quality of M&E products such as reports and general practice, thus contributing significantly to the emergence of an M&E culture in the country.
- Development of M&E infrastructure. Heavy investment has been made in providing modern equipment required for a fully functional M&E system. This includes computers, projectors, internet service, and use of email for information sharing and dissemination.
- Deployment of District M&E Officers has improved M&E capacity at this critical level of the national response. Together with M&E training, this has contributed immensely to the growth of M&E in Botswana.

- Development of a national evaluation agenda guided by stakeholders priorities as a strategy to deliver user-relevant information to promote utilization of M&E products in programme management decision making.
- Development of a National M&E Framework for HIV Prevention.

7.3 Challenges in 2008 Report and Progress Made

2008 Challenge	Progress made
Disharmony within the national M&E system	▪ A consultancy coordinated at national level by NACA and led by the Ministry of Local Government is currently underway. The purpose of the consultancy is to document the current HIV data flows in Botswana, identify its strengths and weakness in relation of data quality, and propose alternatives. ▪ Alignment and harmonization of M&E systems has been prioritised in the NSF II 2010–2016. The process of developing an operational plan to implement the objectives is ongoing
Staggered development of eBHRIMS	• Progress has been made in ensuring that data at the district level can be captured electronically; however, linkages to transfer the data electronically to the national level still need to be developed
Absence of a consistent and reliable information dissemination system	▪ NACA website was launched in February 2010 and this will provide a platform for information sharing. National documents such as NSF II, BAIS III report, HIV Prevention Strategy, UNGASS 2010 Country Report, upcoming national events (World AIDS day and national HIV/AIDS Conference etc. will be available on the website). Other sectors will also be supported by linking them to the website. ▪ The NSF II includes a strategy for information dissemination and knowledge management. ▪ An email list of all district M&E officers is currently used to send reports to the officers and the District AIDS Coordinators for their use and for information dissemination.

7.4 M&E Challenges in the Current Reporting Period

Notwithstanding the achievements outlined above, BHRIMS has faced some challenges. For the current reporting period these included:

- **Inadequate human resources** – despite efforts noted above to develop M&E in the country, significant gaps still exist in this area, especially at the programme level. Trained staff deviate from M&E functions as they progress professionally, which raises the need for replacement. In some cases, responsibility for M&E is not clearly defined, making it difficult for targeted training. This has tended to frustrate the philosophy of BHRIMS that seeks to promote generation of strategic information at all levels instead of a "conveyor belt" through which data is transmitted from collection points to the national level.
- **Weak linkage between the M&E system and data generation points** – data collection in the programme context is assigned to staff who have specialized core mandates, and therefore do data collection only when they have spare time from their core duties. This tends to compromise data completeness, quality, processing and reporting.
- **Inadequate harmonisation of M&E systems**-when it was established, BHRIMS was envisioned to create a "one stop shop" for all HIV and AIDS information. This has turned out to be a challenge mainly due to lack of harmony between the various subsystems that feed into it. As a result there exists a real risk of duplication. Most importantly however, is the systems' shortfall in meeting some information needs for stakeholders. This challenge is exacerbated by evolving information needs resulting from changing programme focus as strategies are adjusted to tackle emerging challenges.

- **Slow implementation of the national evaluation agenda** – evaluation is a necessarily rigorous and thorough undertaking, requiring high level of technical expertise. It is also relatively expensive, especially in cases where comprehensive designs are employed. To this end, inadequate human resources, particularly skilled and technical staff, makes the managing of evaluations to ensure delivery of expected output a major challenge. These factors have tended to combine and slacken implementation of the national evaluation agenda.
- **Limited research and evaluation capacity in the national response**. This remains a challenge, even though efforts are currently underway in some districts between NACA and the Ministry of Local Government to build research capacity.

7.5 Proposed Remedial Actions

The following remedial actions are recommended to address the challenges discussed above.

Challenges in current reporting period	Proposed Remedial Action
Inadequate human resources	Need to advocate for the development of a scheme of service for M&E Officers (Cadre)
Weak linkages system between the M&E system and data generation points	Advocate for the integration of M&E into the day-to-day running of organizations that generate data.
Inadequate harmonization of M&E system	Revitalization of the BHRIMS Technical Working Group.
Slow implementation of the national evaluation agenda	▪ Resource mobilization ▪ Determine and share responsibilities among partners.
Limited capacity for research and evaluation in the national response	Continue to build research and evaluation capacity

REFERENCES

Auerbach, J.D., Hayes, R.J. and Kandathi, S.M. (2006). 'Overview of effective and promising interventions to prevent HIV infection' In D.A. Ross, B. Dick and J. Ferguson (eds.*), Preventing HIV/AIDS in Young people: A Systematic Review of the Evidence from Developing Countries*. Geneva: World Health Organisation.

BONELA (2009). *BONELA Applauds Government for Passing Public Service Act.* Available at www.bonela.org/press/13jan09.html. Retrieved 26th February 2010.

Carter, M. W., Kraft, J. M., Koppenhaver, T., et al. (2007). 'A bull cannot be contained in a single kraal': Concurrent sexual partnerships in Botswana. *AIDS and Behavior*, 11(6), 822-830.

Colvin, M., Abdool Karim, S. S., Connolly, C., Hoosen, A. A., & Ntuli, N. (1998). HIV infection and asymptomatic sexually transmitted infections in a rural South African community. *International Journal of STD and AIDS, 9*:548–550

Denison, J.A., Lungu, N., Dunnett-Dagg, W.A., McCauley,A. & Sweat, M.D (2006). Social relationships and adolescents' HIV counseling and testing decisions in Zambia, *Horizons Research Summary*. Washington, DC: Population Council

Halperin, D., & Epstein, H. (2004). Concurrent sexual partnerships help to explain Africa's high HIV prevalence: Implications for prevention. *Lancet, 364*(9428), 4–6.

Jewkes, R.K., Levin, J.B., and Penn-Kekana L.A. (2003). 'Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study, *Social Science and Medicine,* Vol. 56: 125-134.

Kaiser Foundation. (2009). *Botswana Health Officials Announce HIV-prevention Project to Circumcise 80% of Eligible Men Over Five Years.* Available at www.medicalnewstoday.com. Retrieved 19th February 2010.

Mah, T., Halperin, D.T. (2008) Concurrent sexual partnerships and the HIV epidemic in sub-Saharan Africa: The evidence to move

Matlhare, R.K.(2008) *Addressing Multiple & concurrent Sexual partnerships: the Botswana National MCP Plan.* Paper presented at the 2nd Botswana International HIV Conference, Gaborone

Ministry of Education (2009). *Access to Basic Education***.** Available at www.moe.gov.bw. Retrived March 17 2010

Ministry of Health (1997). *Botswana HIV and AIDS: Second Medium Plan.* Gaborone: AIDS/STD Unit.

Mokomane, Z. 2004. *No Rings Attached: An Exploration of the Levels, Patterns and Socio-demographic Implications of Cohabitation in Botswana*. Ph.D Thesis. Canberra: The Australian National University

NACA (2007). *Documenting of National Best Practices on HIV and AIDS.* Gaborone: National AIDS Coordinating Agency.

NACA (2008). *Progress Report of the National Response to the UNGASS Declaration of Commitment on HIV/AIDS*

NACA (2009). *The Second Botswana National Strategic Framework for HIV and AIDS 2010-2016.* Gaborone: national AIDS Coordinating Agency.

NACA (2008) HIV AIDS in Botswana- Estimated Trends and Implications based on surveillance and modelling. Gaborone: national AIDS Coordinating Agency

Nkosana, J. M. (2006). *Intergenerational sexual relationships in urban Botswana*. PhD thesis, Department of Public Health, University of Melbourne

Pitso, J.M.N. (2004). Does alcohol use take away condom use? Qualitative evidence from Selibe Phikwe and Mahalapye town districts, Botswana. *African Journal of Drug and Alcohol Studies*, 3(1&2): 53-73

Population Services International, Multiple Concurrent Partnerships among Men and Women aged 15-34 in Botswana. Available at psi.org/resources/publications

Setswe, 2008 Why is MCP important in HIV prevention? Paper presented at a UNAIDS consultation on MCP, 17 September 2008. Availabe at www.hsrc.ac.za

Stover J, Fidzani B, Molomo BC, Moeti T, Musuka G (2008). Estimated HIV Trends and Program Effects in Botswana. *PLoS ONE* 3(11): e3729

Temah,C.T. (2007). *Gender inequality and HIV/AIDS epidemic in sub-Saharan Africa Available at* www.csae.ox.ac.uk/conferences/2007-EDiA-LaWBiDC/papers/037-Tsafack.pdf. Retrieved September 25th 2008.

UNAIDS (2009a). *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators, 2010 Reporting*. Geneva: UNAIDS.

UNAIDS (2009b) *Epidemiological Fact Sheet on HIV and AIDS, Botswana: 2008 Update.* Geneva: UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance

Weiser SD, Heisler M, Leiter K, Percy-de Korte F, Tlou S, et al. (2006) Routine HIV Testing in Botswana: A Population-Based Study on Attitudes, Practices, and Human Rights Concerns. PLoS Med 3(7)

Weiser, S. D., Leiter, K., Heisler, M. et al (2006) A Population-Based Study on Alcohol and High-Risk Sexual Behaviors in Botswana. *PLoS Med*., 3(10): e392

ANNEX A: List of participants at National Consensus building Workshop

NAME	DESIGNATION	ORGANIZATION
TSELAYAKGOSI, Monica, A.	Programme Planning Manager	NACA
BAINGANA, Emmanuel	Monitoring & Evaluation	UNAIDS
BODIKA, Stephane	Monitoring & Evaluation/Surveillance AOW	BOTUSA
BURTON, Reginah	Principal IEC Officer	NACA
CHIBATAMOTO, Peter	Policy Advisor	NACA
CHINGOMBE, Innocent	Monitoring & Evaluation	ACHAP
EMMANUEL, Joshua, A.	Chief CAPP	UNICEF
JOHN, Botswelelo, B.	Ministry AIDS Coordinator	Ministry of Health
KASPER, Toby	Country Representative	PSI
KIBASSA, Colleta	UNICEF Advisor	UNICEF
LEDIKWE, Jenny	Monitoring & Evaluation	I-Tech/University of Washington
LEE, Anne	Peace Corps Volunteer	BONEPWA+
MAAPATSANE, Keitumetse	Chief Health officer	Ministry of Local Government
MAINA, Irene	Partnership Advisor	UNAIDS
MAKUNGA, Boitumelo	Wellness Coordinator	Attorney Generals Chambers
MAROWA, Evaristo	Country Coordinator	UNAIDS
MATLHARE, Richard	National Coordinator	NACA
MBISE, Malebogo	Senior Admin Officer	Ministry of Agriculture
MKHWELI, Bonnet	Development Assistance Coordination Advisor	NACA
MOLAPISI, Osman	Ministry AIDS Coordinator	Ministry of Agriculture
MOTSATSING, Daniel	Executive Secretary	BONASO
NCUBE, Buhle	HIV Officer	WHO
NKWE, Nthabiseng	Advocacy Officer	BONELA
PHATSHWANE, Frank	Coordinator	BBCA
PHETOGO, R.	HIV/AIDS Coordinator	Botswana Defense Force
RADIFALANA, Tiny	Ministry AIDS Coordinator	Ministry of Minerals, Energy and Water Resources
RAMOSWEU, Matshidiso	Programme Manager	Tebelopele
RATSATSI, Bojelo	Senior Staff Officer, Health & Safety	Botswana Police Service
REETSANG, T.D	Ministry AIDS Coordinator	Ministry of Trade and Industry
THEKISO, Thatayotlhe	Monitoring & Evaluation	BOCAIP

UNGASS SECRETARIAT

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ANNEX B: National Funding Matrix

National Funding Matrix 2008

COUNTRY: Botswana

Contact person at the National AIDS Authority/Committee (or equivalent)

Name: Mr. R. Matlhare

Title: National Coordinator

Contact Information for National AIDS Authority/Committee (or equivalent).

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TEL: +267 371-0314
FAX: +267 371-0312
Email: rmatlhare@gov.bw

Reporting Cycle: 2008 calendar year

Local Currency: Botswana Pula (BWP)

Average exchange rate with US Dollars during the reporting cycle:

- 2008—1 BWP ≈ 0.1478 US$

Methodology
Methodology is described in detail in the *Botswana National AIDS Spending Assessment (2006-2008) report* available from the National AIDS Coordinating Agency at the above address.

Botswana National Spending Matrix	Financing Sources										
Jan to December 2008	Public Funds		FS.02 Private Funds				FS.03 International funds				
Cur							Bilaterals	Multilaterals		Total International	Grand Total
	Central/National Gvt.	Public Funds Sub total	For-profit institutions and corporations	Not-for-profit institutions	Private financing sources n.e.c. Total	Total Private Funds	Direct bilateral contributions Total	Multilateral Agencies Total	All Other international Total		
Grand Total	1,549,573,817	1,549,573,817	45,189,626	1,486,101	5,998,716	52,674,443	491,126,207	9,788,146	255,558,240	756,472,593	2,358,720,853
Prevention	68,083,122	68,083,122	5,392,612	-	3,263,389	8,656,001	95,783,438	3,610,174	34,038,527	133,432,139	210,171,262
Communication for social and behavioural change	4,766,314	4,766,314	187,320		899,302	1,086,622	9,641,604	174,827	43,648	9,860,079	15,713,015
Community mobilization Total	577,638	577,638					1,628,682	62,768	4,979,644	6,671,094	7,248,732
Voluntary counselling and testing (VCT)	7,067,023	7,067,023	404,418			404,418	39,987,542		10,934,363	50,921,905	58,393,346
Risk-reduction for vulnerable and accessible populations							3,314,716		-	3,314,716	3,314,716
Prevention – youth in school Total	6,695,047	6,695,047	1,300			1,300	2,855,021	45,432	863,177	3,763,630	10,459,977
Prevention – youth out-of-school Total							3,069,377		863,177	3,932,554	3,932,554
Prevention of HIV transmission aimed at people living with HIV (PLHIV)	1,082,591	1,082,591					778,294		19,371	797,665	1,880,256
Prevention programmes in the workplace Total	12,841,668	12,841,668	3,952,612			3,952,612	366,460		-	366,460	17,160,740
Condom social marketing	85,987	85,987			2,364,087	2,364,087	8,845,777	101,488	12,136,749	21,084,014	23,534,088
Prevention, diagnosis and treatment of sexually transmitted infections (STI)									1,738,265	1,738,265	1,738,265
Prevention of mother-to-child transmission (PMTCT) Total	32,039,948	32,039,948					6,011,396		-	6,011,396	38,051,344
Male circumcision Total							710,541	378,141	-	1,088,682	1,088,682
Blood safety Total							11,682,296		571,719	12,254,015	12,254,015
Safe medical injections Total							4,300,000		-	4,300,000	4,300,000
Prevention activities not disaggregated by intervention	2,794,858	2,794,858	846,962			846,962	2,582,544		1,888,414	4,470,958	8,112,778
Prevention activities n.e.c.	132,048	132,048					9,188	2,847,518	-	2,856,706	2,988,754
Care and treatment	869,687,872	869,687,872	38,255,304	-	-	38,255,304	101,003,798	27,064	153,706,026	254,736,888	1,162,680,064
Outpatient care	329,577,992	329,577,992	37,966,526			37,966,526	89,716,669		153,706,026	243,422,695	610,967,213
Inpatient care Total	540,108,458	540,108,458	288,778			288,778	2,929,965		-	2,929,965	543,327,201
Care and treatment services not disaggregated by intervention							8,357,164		-	8,357,164	8,357,164
Care and treatment services n.e.c.	1,422	1,422						27,064	-	27,064	28,486
Orphans and vulnerable children (OVC)	537,222,113	537,222,113	-	1,107,789	2,243,100	3,350,889	8,323,854	-	161,484	8,485,338	549,058,340
OVC Education Total	47,256,235	47,256,235		166,903		166,903			12,904	12,904	47,436,042
OVC Basic health care	32,526	32,526		1,588		1,588	2,034,484		-	2,034,484	2,068,598
OVC Family/home support Total	450,219,822	450,219,822					286,820		5,780	292,600	450,512,422
OVC Community support Total	95,376	95,376		803,792		803,792	375,984		142,800	518,784	1,417,952
OVC Social Services and Administrative costs	31,475,994	31,475,994		30,904		30,904	98,373		-	98,373	31,605,271
OVC Institutional care Total				104,602		104,602			-	-	104,602
OVC Services not disaggregated by intervention					2,243,100	2,243,100	5,505,533		-	5,505,533	7,748,633
OVC services n.e.c.	8,142,160	8,142,160					22,660		-	22,660	8,164,820
Programme management and administration	41,279,337	41,279,337	1,490,310	341,999	-	1,832,309	236,740,516	4,016,757	56,138,993	296,896,266	340,007,912
Planning, coordination and programme management	29,678,327	29,678,327	1,379,968	304,355		1,684,323	205,536,566	2,333,342	39,433,293	247,303,201	278,665,851
Administration and transaction costs associated with managing and disbursin	356,650	356,650					343,623		746	344,369	701,019
Monitoring and evaluation Total							13,466,041	1,450,519	2,798,333	17,714,893	17,714,893
Operations research Total	122,452	122,452					3,556,811		11,426,901	14,983,712	15,106,164
Serological-surveillance (serosurveillance) Total							2,507,523		-	2,507,523	2,507,523
HIV drug-resistance surveillance Total								232,896	-	232,896	232,896
Drug supply systems Total							2,992,585		-	2,992,585	2,992,585
Information technology Total	71,032	71,032					55,859		-	55,859	126,891
Patient tracking							78,870		-	78,870	78,870
Upgrading and construction of infrastructure Total	11,050,876	11,050,876	92,500	37,644		130,144	8,202,638		2,479,720	10,682,358	21,863,378
Programme management and administration n.e.c			17,842			17,842			-	-	17,842
Human resources	15,162,210	15,162,210	51,400	4,513	-	55,913	43,996,308	340,516	3,519,416	47,856,240	63,074,363
Monetary incentives for human resources Total	13,000,176	13,000,176					1,162,644		-	1,162,644	14,162,820
Formative education to build-up an HIV workforce							927,784		2,326,132	3,253,916	3,253,916
Training Total	2,162,034	2,162,034	51,400	4,513		55,913	41,781,844	340,516	1,042,716	43,165,076	45,383,023
Human resources not disaggregated by type Total							124,036		-	124,036	124,036
Human resources n.e.c. Total									150,568	150,568	150,568
Social protection and social services (excluding OVC)	-	-	-	-	-	-	382,581	-	-	382,581	382,581
Social protection through monetary benefits Total							382,581		-	382,581	382,581
Enabling environment	592,466	592,466	-	31,800	492,227	524,027	1,850,714	1,793,635	7,993,794	11,638,143	12,754,636
Advocacy Total									78,617	78,617	78,617
Human rights programmes Total					4,007	4,007	40,969	845,389	10,775	897,133	901,140
AIDS-specific institutional development Total	446,111	446,111		31,800		31,800	1,608,165	947,226	4,518,779	7,074,170	7,552,081
AIDS-specific programmes focused on women Total									360,556	360,556	360,556
Enabling environment not disaggregated by type Total					420,995	420,995	93,479		2,196,018	2,289,497	2,710,492
Enabling environment n.e.c. Total	146,355	146,355			67,225	67,225	108,101	1,020	829,049	938,170	1,151,750
HIV and AIDS-related research (excluding operations research)	17,546,697	17,546,697	-	-	-	-	3,044,998	-	-	3,044,998	20,591,695
Epidemiological research Total	17,546,697	17,546,697							-	-	17,546,697
HIV and AIDS-related research activities not disaggregated by type Total							1,353,333		-	1,353,333	1,353,333
HIV and AIDS-related research activities n.e.c. Total							1,691,665		-	1,691,665	1,691,665

ANNEX C: National Composite Policy Index

COUNTRY: Botswana

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

Mr R. K. Matlhare

Signed:_____

Postal Address: National AIDS Coordinating Agency
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Gaborone, BOTSWANA

TEL: +267 371-0314
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Email: rmatlhare@gov.bw

Date of submission: 31 March 2010

NCPI RESPONDENTS

NCPI - PART A [Administered to government officials]

Organization	Names/Positions	Respondents to Part A [indicate which parts each respondent was queried on]				
		AI	AII	AIII	A. IV	A.V
Administration of Justice	C. Hirschfeld			√	√	
Ministry of Health	M. Anderson			√	√	√
Ministry of Health	T. Chadborn			√	√	√
Ministry of Health	B.B. John			√	√	
Directorate of Public Service Management	M.C. Moncho			√	√	
Ministry of Agriculture	M. Mbise			√	√	
Ministry of Education and Skills Development	P. Bareetsi			√	√	
Ministry of Education and Skills Development	T.C. Zulu			√	√	√
Ministry of Infrastructure, Science and Technology	T. Molemogi			√	√	
Ministry of Labour and Home Affairs	E. Pule			√	√	
Ministry of Labour and Home Affairs	M. Thathana			√	√	
Ministry of Local Government and Housing	M. Tau			√	√	
Ministry of Minerals, Energy and Water Resources	T. Radifalana			√	√	
Ministry of Trade and Industry	T.D. Reetsang			√	√	
National AIDS Coordinating Agency	Mr. BC Molomo	√	√			
National AIDS Coordinating Agency	Mr. R. Matlhare			√		
National AIDS Coordinating Agency	Ms. M. Mmelesi					√
National AIDS Coordinating Agency	B. Fidzani					√
National AIDS Coordinating Agency	L. Moremi			√	√	
Office of the Auditor General	C. J. Muke			√	√	
Office of the President	O.M. Kgabo			√	√	

NCPI - PART B [Administered to civil society organizations and development partners]

Organization	Names/Positions	Respondents to Part B [indicate which parts each respondent was queried on]			
		B.I	B.II	B.III	B.IV
African Comprehensive HIV/AIDS Partnership	I. Chingombe			√	√
Botswana Network of AIDS Service Organisations	B. Mothuba		√	√	√
Botswana Network on Ethics, Law and AIDS	U. Ndadi	√			
ITech	J. Ledikwe			√	
Tebelopele	M. Boima		√	√	
Tebelopele	M. R. Sokwe		√	√	
UNFPA	J. Shongwe		√		
WHO	B. Ncube		√	√	√

Part A [Administered to government officials]

I STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

Yes	No	Not Applicable (N/A)

Period covered: 2003-2009 (first National Strategic Framework) and 2010-2016 (second National Strategic Framework)

***IF YES*, complete questions 1.1 through 1.10.**

1.1 How long has the country had a multisectoral strategy?

Number of Years: **8 Years**

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Sectors	**Included in strategy**	**Earmarked budget**
Health	**Yes**	**Yes**
Education	**Yes**	**Yes**
Labour	**Yes**	**Yes**
Transportation	**Yes**	**Yes**
Military/Police	**Yes**	**Yes**
Women	**Yes**	**Yes**
Young people	**Yes**	**Yes**

Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

Through programmes, some of which are cross cutting. The budget is program specific not sector specific

1.3 Does the multisectoral strategy address the following target populations, settings and cross-cutting issues?

Target populations	
a. Women and girls	**a. Yes**
b. Young women/young men	**b. Yes**
c. Injecting drug users	**c. Yes**
d. Men who have sex with men	**d. Yes**
e. Sex workers	**e. Yes**
f. Orphans and other vulnerable children	**f. Yes**
g. Other specific vulnerable subpopulations*	**g. Yes**
Settings	
h. Workplace	**h. Yes**
i. Schools	**i. Yes**
j. Prisons	**j. Yes**
Cross-cutting issues	
k. HIV and poverty	**k. Yes**
l. Human rights protection	**l. Yes**
m. Involvement of people living with HIV	**m. Yes**
n. Addressing stigma and discrimination	**n. Yes**
o. Gender empowerment and/or gender equality	**o. Yes**

* Sub-populations other than injecting drug users, men who have sex with men and sex workers, that have been locally identified as being at higher risk of HIV transmission (e.g., clients of sex workers, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners).

1.4 Were target populations identified through a needs assessment?

Yes	**No**

IF NO, explain how were target populations identified?

- Consultation and consensus
- Other research initiatives

1.5 What are the identified target populations for HIV programmes in the country?

- HIV positive populations
- Orphans and vulnerable children
- Sex workers
- HIV negative populations
- Pregnant women

1.6 Does the multisectoral strategy include an operational plan?

Yes	**No**

1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	**Yes**	
b. Clear targets or milestones?	**Yes**	
c. Detailed costs for each programmatic area?		**No**
d. An indication of funding sources to support programme implementation?		**No**
e. A monitoring and evaluation framework?		**No**

1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

Active involvement	Moderate involvement	No Involvement

IF active involvement, briefly explain how this was organised:

- As part of the technical working groups
- As part of reference groups (steering committees)
- As part of those being consulted
- As part of appraisal processes

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes	No

1.9 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners	Yes, some partners	No

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes	No	N/A

2.1 ***IF YES***, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	**Yes**		
b. Common Country Assessment / UN Development Assistance Framework	**Yes**		
c. Poverty Reduction Strategy		**No**	
d. Sector-wide approach			**N/A**
e. Other:			

* Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, sex workers, injecting drug users, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For

the purpose of the NCPI, the private sector is considered separately.

2.2 ***IF YES***, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)		
HIV prevention	**Yes**	
Treatment for opportunistic infections	**Yes**	
Antiretroviral treatment	**Yes**	
Care and support (including social security or other schemes)	**Yes**	
HIV impact alleviation	**Yes**	
Reduction of *gender* inequalities as they relate to HIV prevention/treatment, care and/or support	**Yes**	
Reduction of *income* inequalities as they relate to HIV prevention/treatment, care and /or support	**Yes**	
Reduction of stigma and discrimination	**Yes**	
Women's economic empowerment (e.g. access to credit, access to land, training)	**Yes**	

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes	**No**	**N/A**

3.1 ***IF YES***, to what extent has it informed resource allocation decisions? **5**

Low				High	
0	1	2	3	4	**5**

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes	**No**

4.1 ***IF YES***, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioural change communication	**Yes**	
Condom provision	**Yes**	
HIV testing and counselling	**Yes**	
Sexually transmitted infection services	**Yes**	
Antiretroviral treatment	**Yes**	
Care and support	**Yes**	

If HIV testing and counselling *is provided* to uniformed services, briefly the approach taken to HIV testing and counselling (e.g. indicate if HIV testing is voluntary or mandatory etc):

Voluntary testing and counselling using public facilities as well as their dedicated facilities.

6. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes	**No**

7. **Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?**

Yes	No

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes	No

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes	No

7.2 Have the estimates of the size of the main target populations been updated?

Yes	No

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs	Estimates of current needs only	No

7.4 Is HIV programme coverage being monitored?

Yes	No

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes	No

(b) ***IF YES***, is coverage monitored by population groups?

Yes	No

(c) Is coverage monitored by geographical area?

Yes	No

IF YES, at which geographical levels (provincial, district, other)?
National and district

Briefly explain how this information s used:
For programme and policy formation, implementation, monitoring and evaluation.

?

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes	No

Overall, how would you rate *strategy planning efforts* in the HIV programmes in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	**8**	9	10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:
Limited resources and limited implementation capacity.

II POLITICAL SUPPORT

Strong political support includes: government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings; allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	Yes
Other high officials	Yes
Other officials in regions and/or districts	Yes

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes	No

2.1 ***IF YES***, when was it created?

Year: **1998**

2.2 ***IF YES***, who is the Chair?

Name: **F.G Mogae** Position/Title: **Former President of the Republic of Botswana**

2.3 ***IF YES***, does the national multisectoral AIDS coordination body:

Have terms of reference?	Yes
Have active government leadership and participation?	Yes
Have a defined membership? ***IF YES***, how many members? 40 Include civil society representatives? ***IF YES***, how many? 10 Include people living with HIV? ***IF YES***, how many? Include the private sector?	Yes Yes Yes Yes
Have an action plan?	Yes
Have a functional Secretariat?	Yes
Meet at least quarterly? Review actions on policy decisions regularly? Actively promote policy decisions? Provide opportunity for civil society to influence decision-making? Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes Yes Yes Yes Yes

4. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes	No	N/A

IF YES, briefly describe the main achievements:
- Information sharing;

Consensuse building
- Harmonisation
- Alignment
- Coordination of assistance

Briefly describe the main challenges:

- Meaningful partnership where there is less reliance on Government

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

Percentage: **10-15 %**

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	**Yes**	
Technical guidance	**Yes**	
Procurement and distribution of drugs or other supplies		**No**
Coordination with other implementing partners	**Yes**	
Capacity-building	**Yes**	
Other: **Operational costs including wages and salaries.**	**Yes**	

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes	**No**

6.1 ***IF YES***, were policies and laws amended to be consistent with the National AIDS Control policies?

Yes	**No**

Overall, how would you rate the *political support* for the HIV programme in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	**8**	9	10

Since 2007, what have been key achievements in this area:

- Strengthened political support
- Resource mobilization and allocation

What are remaining challenges in this area:

Cascading of the political support

III PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*?

Yes	No	N/A

1.1 ***IF YES***, what key messages are explicitly promoted?

√ Check for key message explicitly promoted

a) Be sexually abstinent	✓
b) Delay sexual debut	✓
c) Be faithful	✓
d) Reduce the number of sexual partners	✓
e) Use condoms consistently	✓
f) Engage in safe(r) sex	✓
g) Avoid commercial sex	✓
h) Abstain from injecting drugs	N/A
i) Use clean needles and syringes	✓
j) Fight against violence against women	✓
k) Greater acceptance and involvement of people living with HIV	✓
l) Greater involvement of men in reproductive health programmes	✓
m) Males to get circumcised under medical supervision	✓
n) Know your HIV status	✓
o) Prevent mother-to-child transmission of HIV	✓

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	No

2. Does the country have a policy or strategy promoting HIV related reproductive and sexual health education for young people?

Yes	No	N/A

2.1 Is HIV education part of the curriculum in:

Primary schools?	Yes	
Secondary schools?	Yes	
Teacher training?	Yes	

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes	No

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes	No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions *for most-at-risk or other vulnerable sub-populations?*

Yes	No

IF NO, briefly explain:

The Research Triangle Institute recently started some work on Most At Risk Populations (MARPS). RTI and Ministry of Health are in the process of developing a strategy for MARPS.

IF YES, how were these specific needs determined?

They were determined as specific needs of districts and communities as identified in the sentinel and BAIS I and II surveys.

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	**Agree**		
Universal precautions in health care settings	**Agree**		
Prevention of mother-to-child transmission of HIV	**Agree**		
IEC* on risk reduction	**Agree**		
IEC* on stigma and discrimination reduction	**Agree**		
Condom promotion	**Agree**		
HIV testing and counselling	**Agree**		
Harm reduction for injecting drug users			**N/A**
Risk reduction for men who have sex with men			**N/A**
Risk reduction for sex workers			**N/A**
Reproductive health services including sexually transmitted infections prevention and treatment	**Agree**		
School-based HIV education for young people	**Agree**		
HIV prevention for out-of-school young people			
HIV prevention in the workplace	**Agree**		

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	**8**	9	10

Since 2007, what have been key achievements in this area:

- Percentage of pregnant women who accessed quality PMTCT services was 91% in 2007.
- Condom procurement and distribution by Central Medical Stores between July and September 2007 to all government health facilities was 1,893,900 (male condoms), PSI sold and distributed more than 6.8 million condoms.

What are remaining challenges in this area:

Behavioural change

* IEC = information, education, communication

Overall, how would you rate *policy* efforts in support of HIV prevention in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10
Since 2007, what have been key achievements in this area: *What are remaining challenges in this area:*											

5. Has the country identified specific needs for HIV prevention programmes?

Yes	**No**

IF YES, how were these specific needs determined?

- They were determined as specific needs of districts and communities as defined in the sentinel surveillance and BAIS I & II surveys

IV TREATMENT, CARE AND SUPPORT

1. **Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).**

Yes	No

1.1 ***IF YES***, does it address barriers for women?

Yes	No

1.2 ***IF YES***, does it address barriers for most-at-risk populations?

Yes	No

2. **Has the country identified the specific needs for HIV treatment, care and support services?**

Yes	No

IF YES, how were these determined?
Statistics from Routine Programme Monitoring and Evaluation data. Data from HIV surveys were also Used to forecast through projections and modelling.

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access		
Antiretroviral therapy	**Agree**		
Nutritional care	**Agree**		
Paediatric AIDS treatment	**Agree**		
Sexually transmitted infection management	**Agree**		
Psychosocial support for people living with HIV and their families	**Agree**		
Home-based care	**Agree**		
Palliative care and treatment of common HIV-related infections	**Agree**		
HIV testing and counselling for TB patients	**Agree**		
TB screening for HIV-infected people	**Agree**		
TB preventive therapy for HIV-infected people	**Agree**		
TB infection control in HIV treatment and care facilities	**Agree**		
Cotrimoxazole prophylaxis in HIV-infected people	**Agree**		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	**Agree**		
HIV treatment services in the workplace or treatment referral systems through the workplace		**Don't Agree**	
HIV care and support in the workplace (including alternative working arrangements)	**Agree**		
Other: *[write in]*	**Agree**		

3. **Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?**

Yes	No

4. **Does the country have access to *regional* procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?**

Yes	No

IF YES, for which commodities?:

Antiretroviral therapy drugs, condoms and substitutional drugs for treatment of opportunistic infections.

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009?										
2009	Very poor									Excellent
0	1	2	3	4	5	6	7	8	**9**	10

Since 2007, what have been key achievements in this area:

- ✓ Periodic review of clinical guidelines with eligibility (CD4 count 250)
- ✓ Task shifting scales up ARV therapy
- ✓ Extending prescribing and dispersing to clinics

What are remaining challenges in this area:

- Inadequate human resources
- Issues of medication adherence
- Inadequate mechanisms to measure quality of care

5. **Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?**

Yes	No	N/A

5.1 ***IF YES***, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

5.2 ***IF YES***, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

5.3 ***IF YES***, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

IF YES, what percentage of orphans and vulnerable children is being reached?
Close to 100 percent.

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?										
2009	Very poor									Excellent
0	1	2	3	4	5	6	7	**8**	9	10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

I MONITORING AND EVALUATION

1. Does the country have *one* national Monitoring and Evaluation (M&E) plan?

Yes	**In progress**	**No**

1.1 ***IF YES***, years covered: 2003-2009

1.2 ***IF YES***, was the M&E plan endorsed by key partners in M&E?**YES**

Yes	**No**

IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes	**No**

1.4 ***IF YES***, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	**Yes, most partners**	Yes, but only some partners	**No**

IF YES, but only some partners or IF NO, briefly describe what the issues are:

Reporting lines have clearly been outlined, however there still remains a challenge to harmonize reporting with partners, leading to some programmes having to report the same information twice.

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	**Yes**	No
IF YES, does it address:		
routine programme monitoring	**Yes**	No
behavioural surveys	**Yes**	No
HIV surveillance	**Yes**	No
Evaluation / research studies	**Yes**	No
a well-defined standardised set of indicators	**Yes**	No
guidelines on tools for data collection	**Yes**	No
a strategy for assessing data quality (i.e., validity, reliability)	**Yes**	No
a data analysis strategy	**Yes**	No
a data dissemination and use strategy	**Yes**	No

3. Is there a budget for implementation of the M&E plan? YES

Yes	In progress	No

3.1 ***IF YES***, what percentage of the total HIV programme funding is budgeted for M&E activities? approx 1% in the2009 budget

3.2 ***IF YES,*** has *full* funding been secured?

Yes	**No**

4. Are M&E priorities determined through a national M&E system assessment?

Yes	**No**

IF NO, briefly describe how priorities for M&E are determined:

Through the BHRIMS Technical Working Group

5. Is there a functional national M&E Unit?

Yes	In progress	No

5.1 ***IF YES***, is the national M&E Unit based

in the National AIDS Commission (or equivalent)?	**Yes**	No
in the Ministry of Health?	Yes	**No**
Elsewhere?	Yes	**No**

5.2 ***IF YES***, how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff:		
Position:	Full time / Part time?	Since when?:
M&E Advisor	Full time	2003
Chief Research Officers x2	Full time	2009
Principal Research Officer	Full time	2009
Senior Research Officer	Full time	2009
Assistant Research Officer	Full time	2008
Assistant Research Officer x2	Full time	2007 and 2009

5.3 ***IF YES***, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	No

IF YES, briefly describe the data-sharing mechanisms: Data from facilities is compiled by M&E officers and programme officers at district level and sent to the relevant ministry or Head Quarters for aggregation into a national report, which is then forwarded to NACA for compilation of the National AIDS Council report.

What are the major challenges? Data quality and completeness of data reported and timeliness of reporting

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No regularly	Yes, but meets irregularly	Yes, meets

6.1 Does it include representation from civil society? **YES**

Yes	No

IF YES, briefly describe who the representatives from civil society are and what their role is: The BHRIMS TWG is chaired by Civil Society (BONASO).

7. Is there a central national database with HIV- related data? YES

Yes	No

7.1 ***IF YES***, briefly describe the national database and who manages it

There is a central repository of National data managed by the Monitoring and Evaluation at NACA

7.2 ***IF YES***, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

a. **Yes**, **all of the above**
b. Yes, but only some of the above:
c. No, none of the above

7.3 Is there a functional* Health Information System?

At national level	Yes	**No**
At sub-national level ***IF YES***, at what level(s)? ***Data is entered into e***-BHRIMS (cris) at district level*[write in]*	**Yes**	No

*(*regularly reporting data from health facilities which are aggregated at district level and sent to national level;*
and data are analysed and used at different levels)

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?

Yes	**No**

9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

Low				High	
0	1	2	**3**	4	5

Provide a specific example:
Development of the NSF II

What are the main challenges, if any?
Timeliness of the availability of data for informaing policies and strategies

9.2 for resource allocation?:

Low				High	
0	1	2	**3**	4	5

Provide a specific example:
Resource allocation in the National AIDS Spending Assessment

What are the main challenges, if any?
Competing priorities such treatment versus prevention

9.3 for programme improvement?:

Low				High	
0	1	2	**3**	4	5

Provide a specific example:
- National AIDS Council Report
- BAIS report

What are the main challenges, if any?
Data use at the facility level and service delivery level is low

10. Is there a plan for increasing human capacity in M&E at national, sub-national and service-delivery levels?:

a. **Yes**, at all levels

b. Yes, but only addressing some levels:

c. No

10.1 In the last year, was training in M&E conducted

At national level?	**Yes**	No
IF YES, Number trained: 40 (M&E training)		
At sub-national level?	**Yes**	No
IF YES, Number trained: 70 (District research training)		
At service delivery level including civil society?	**Yes**	No
IF YES, Number trained: 15 (M&E training)		

10.2 Were other M&E capacity-building activities conducted other than training?

	Yes	**No**

IF YES, describe what types of activities:

- The National M&E training curriculum was revised
- District research training and mentoring

Overall, how would you rate the *M&E efforts* of the HIV programme in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	**7**	8	9	10

Since 2007, what have been key achievements in this area:

- Successfully conducted the 2008 BAIS
- Development and implementation of an M&E training curriculum
- Development of a national Evaluation Agenda

What are remaining challenges in this area:

- Inadequate Human Resources
- Weak linkages between the M&E system and data generation points
- Limited integration of M&E into planning
- Capacity challenges and resource challenges
- Slow implementation of the national evaluation agenda

Part B

[Administered to representatives from civil society organizations and development partners]

I HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

Yes	No

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

Yes	No

2.1 ***IF YES***, for which populations?

a. Women	**Yes**	
b. Young people	**Yes**	
c. Injecting drug users	**Not applicable**	
d. Men who have sex with men	**Not applicable**	
e. Sex Workers	**Not applicable**	
f. Prison inmates		**No**
g. Migrants/mobile populations		**No**

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Use of the court system by aggrieved persons law enforcement agencies.

Briefly describe the content of these laws:

- Domestic violence act regulates relationships in families; among people living together; relatives living with couples/ families, etc.
- Children's Act looks at children's right in relation to the UN Convention on the Rights of the Child

Briefly comment on the degree to which they are currently implemented:

- Domestic Violence Act was passed in 2008. In 2009 awareness was raised about the Act.
- Children's Act was passed in 2009

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

Yes	No

3.1 ***IF YES***, for which subpopulations?

a. Women		
b. Young people		
c. Injecting drug users		

d. Men who have sex with men	**Yes**	
e. Sex Workers	**Yes**	
f. Prison inmates	**Yes**	
g. Migrants/mobile populations	**Yes**	

If YES, briefly describe the content of these laws, regulation or policies:

- There are laws that penalise sex work.
- There are laws that penalise same sex engagement; referring to "canal knowledge against the order of nature". The law on homosexuality is however silent.

Briefly comment on how they pose barriers:

- Admission of sex work is against the law- sex workers cannot disclose this to health workers, as such impedes on any programmes that may be targeted towards this group.
- Sex workers have 10+ partners per night, experience repeated STIs because of the nature of sex work. It is difficult to trace STI partners "Partner tracing".
- It is difficult to report abuse, sexual violence, rape,etc.
- Homosexuals cannot disclose sex and anal STIs, as such no preventative measure have been put in place for them.
- Prison mates have no access to condoms but treatment.
- Immigrants have no access to free ARV treatment and all other diseases.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes	**No**

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

There is mention of respect of human rights in the National Strategic Framework looking at ethics, law and human rights.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

Yes	**No**

IF YES, briefly describe this mechanism:

- Document cases of discrimination through the Legal AID programme. Take up cases; legal representation on the HIV/AIDS cases and social responsibility/ humanization basis.
- Police
- Ombudsman

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes	**No**

IF YES, describe some examples:

- There is BONEPWA+, forums such as the National AIDS Council, CCM, Government and NACA
- There is a rehabilitation programme for sex workers
- There is the People living with HIV/AIDS week before 1st December every year.

7. Does the country have a policy of free services for the following:

a. HIV prevention services	**Yes**	
b. Antiretroviral treatment	**Yes**	
c. HIV-related care and support interventions	**Yes**	

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes	**No**

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes	**No**

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes	**No**

9.1 ***IF YES***, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes	**No**

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes	**No**

11. Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes	**No**

11.1 ***IF YES***, does the ethical review committee include representatives of civil society including people living with HIV?

Yes	**No**

12. Does the country have the following human rights monitoring and enforcement mechanisms?

– Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombud- s persons which consider HIV-related issues within their work

Yes	**No**

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes	**No**

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	**No**

13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

Yes	**No**

14. Are the following legal support services available in the country?

– Legal aid systems for HIV casework

Yes	**No**

– Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes	**No**

– Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes	**No**

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes	**No**

IF YES, what types of programmes?

Media	**Yes**	
School education	**Yes**	
Personalities regularly speaking out	**Yes**	

Overall, how would you rate the *policies, laws and regulations* in place to promote and protect human rights in relation to HIV in 2009?										
2009 Very poor										Excellent
0	1	2	**3**	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

The domestic violence act no 10 of 2008 was passed to protect women in domestic relationships. Evidence shows that women are more vulnerable to HIV/AIDS through violence or fear of violence.

The public service act of 2008 which protects employees from unfavourable treatment because of HIV positive test.

The childrens care act of 2009 provides guidance for the provision of care and support for OVC.

What are remaining challenges in this area:

- There are no HIV specific laws regulating the Private Sector employment. There are still dismissals of HIV+ persons in this sector without any reasonable accommodation or empathy for the sick person.
- The law criminates sex work and Men Who Sleep with other Men (MSM) and this makes it difficult to get services.
- People who are HIV+ are criminalized in case of rape case, those HIV+ get steeper sentences for rape compared to other people.

Overall, how would you rate the *effort to enforce* the existing policies, laws and regulations in 2009?											
2009	Very poor										Excellent
	0	1	2	**3**	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:
People employed in the Public Sector will not be discriminated against in general.

What are remaining challenges in this area:
The same as in 2007.

II CIVIL SOCIETY* PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

Low				High	
0	1	2	3	**4**	5

Comments and examples:
The prevention, Treatment and Advocacy project, which is aligned to the goal of reduction of new infections has enlisted the support and participation of members of the Parliament at its formative stages.

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

Low				High	
0	1	2	3	**4**	5

Comments and examples:
Civil Society participation in the technical review processes of the National Strategic Plan. The plan is still to be costed.

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in

a. the national AIDS strategy?

Low				High	
0	1	2	3	**4**	5

b. the national AIDS budget?

Low				High	
0	1	**2**	3	4	5

c. national AIDS reports?

Low				High	
0	1	2	**3**	4	5

* Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, injecting drug users, sex workers, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. developing the national M&E plan?

Low				High	
0	1	2	3	**4**	5

b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

Low				High	
0	1	2	3	**4**	5

c. M&E efforts at local level?

Low				High	
0	1	**2**	3	4	5

Comments and examples:
M&E is still largely undeveloped at community level with little or no systems.

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

Low				High	
0	1	2	**3**	4	5

Comments and examples:
Networks of people living with HIV are included together with faith based communities but the challenge is with organizations of sex workers as they are perceived to be operating outside the legal framework.

6. To what extent is civil society able to access:

a. adequate financial support to implement its HIV activities?

Low				High	
0	**1**	2	3	4	5

b. adequate technical support to implement its HIV activities?

Low				High	
0	1	**2**	3	4	5

Comments and examples:
The Civil Society is highly constrained both technically and financially to be able to implement its programmes effectively.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for youth	<25%	**25-50%**	51–75%	>75%

Prevention for most-at-risk-populations				
- Injecting drug users	**<25%**	25-50%	51-75%	>75%
- Men who have sex with men	**<25%**	25-50%	51-75%	>75%
- Sex workers	**<25%**	25-50%	51-75%	>75%
Testing and Counselling	<25%	25-50%	**51–75%**	>75%
Reduction of Stigma and Discrimination	<25%	**25-50%**	51–75%	>75%
Clinical services (ART/OI)*	**<25%**	25-50%	51–75%	>75%
Home-based care	<25%	25-50%	**51–75%**	>75%
Programmes for OVC**	<25%	25-50%	**51–75%**	>75%

**ART = Antiretroviral Therapy; OI = Opportunistic infections*
***OVC = Orphans and other vulnerable children*

Overall, how would you rate the efforts to increase *civil society participation* in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	**5**	6	7	8	9	10

Since 2007, what have been key achievements in this area:
Participation in strategic for a and community, National AIDS Council, BHRIMS, CCM, etc.

What are remaining challenges in this area:

Meaningful and deliberate support to ensure that Civil Society programmes are actually initiated and implemented.

III PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes	No

IF YES, how were these specific needs determined?

These are areas such as male circumcision, reduction of multiple concurrent partnerships, PMTCT, etc that are determined resulting from research outcomes.

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	**Agree**		
Universal precautions in health care settings	**Agree**		
Prevention of mother-to-child transmission of HIV	**Agree**		
IEC* on risk reduction			**N/A**
IEC* on stigma and discrimination reduction	**Agree**	**Don't Agree**	**N/A**
Condom promotion	**Agree**	**Don't Agree**	**N/A**
HIV testing and counselling		**Don't Agree**	**N/A**
Harm reduction for injecting drug users		**Don't Agree**	**N/A**
Risk reduction for men who have sex with			**N/A**
Risk reduction for sex workers	**Agree**	**Don't Agree**	**N/A**
Reproductive health services including sexually transmitted infections prevention	**Agree**	**Don't Agree**	**N/A**
School-based HIV education for young people	**Agree**	**Don't Agree**	**N/A**
HIV Prevention for out-of-school young	**Agree**	**Don't Agree**	**N/A**
HIV prevention in the workplace	**Agree**	**Don't Agree**	**N/A**

* IEC = information, education, communication

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	**5**	6	7	8	9	10

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:

IV TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes	No

IF YES, how were these specific needs determined?

No specific knowledge/ details on the selection process say for home based care but for treatment, studies informed policy decisions and the national roll out of the ART programme was as a result of consultations with multi sectoral partners and the determined leadership at the national level.

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access		
Antiretroviral therapy	**Agree**		
Nutritional care		**Don't Agree**	
Paediatric AIDS treatment	**Agree**		
Sexually transmitted infection management	**Agree**		
Psychosocial support for people living with HIVand their families	**Agree**		
Home-based care	**Agree**		
Palliative care and treatment of common HIV-related infections	**Agree**		
HIV testing and counselling for TB patients	**Agree**		
TB screening for HIV-infected people	**Agree**		
TB preventive therapy for HIV-infected people	**Agree**		
TB infection control in HIV treatment and care facilities	**Agree**		
Cotrimoxazole prophylaxis in HIV-infected people	**Agree**		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	**Agree**		
HIV treatment services in the workplace or treatment referral systems through the workplace	**Agree**		
HIV care and support in the workplace (including alternative working arrangements)	**Agree**		
Other programmes: ▪ Peer counselling and peer education in the workplace ▪ General health education	**Agree**		

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	**8**	9	10

Since 2007, what have been key achievements in this area:

- Reduction in waiting lists
- Increase in qualifying CD4 count from 200 to 250

What are remaining challenges in this area:
Repeat pregnancies by women on ART

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	No	N / A

2.1 ***IF YES***, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

2.2 ***IF YES***, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

2.3 ***IF YES***, does the country have an estimate of orphans and vulnerable children being reached
by existing interventions?

Yes	No

IF YES, what percentage of orphans and vulnerable children is being reached? %
Close to 100 percent of those who are registered

Overall, how would you rate the efforts to *meet the HIV-related needs* of orphans and other vulnerable children in 2009?										
2009 Very poor										Excellent
0	1	2	3	4	5	6	7	8	**9**	10

Since 2007, what have been key achievements in this area:

Access to the food basket and school needs has improved

What are remaining challenges in this area:
At 18 years orphans are weaned put of the programme and they face challenges such as poverty, unemployment and other psychosocial needs.