REPUBLIC OF BOTSWANA

Ministry of State President

National AIDS Coordinating Agency (NACA)

Botswana HIV/AIDS Response Information Management System (BHRIMS)

Status of the 2002 National Response to the UNGASS Declaration of Commitment on HIV/AIDS

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Health facilities in Botswana
Status of the 2002 National Response to the UNGASS Declaration of Commitment on HIV/AIDS

The HIV prevalence in the country appears to have stabilised over the last five years

The Government of Botswana was among the 189 countries that signed the document of commitment on the declaration of United Nations General Assembly Special Session on HIV/AIDS in June, 2001 in New York, USA. Since then the people of Botswana have remained committed in their response and have sustained the momentum of the political commitment to address the epidemic.

The HIV prevalence in the country appears to have stabilised over the last five years as revealed by the annual HIV sentinel surveillance efforts. The pattern is evident from data generated from the voluntary counselling and testing centres as well as the PMTCT services.

From reported surveys, specific behaviours support the plateau of the epidemic in the country. These include high condom use, reduced number of sexual partners, high awareness level especially among the ages 15-19yrs and 20-24years. Based on these encouraging findings, we are intensifying our local efforts to ensure a complete turn around of the epidemic in the country.

The National AIDS Council, which I chair, made up of seventeen sectors, meet every quarter to review the progress of implementation of intervention programmes as well as remove all barriers that may constrain the national efforts. These sectors include: health; local; education; agriculture; youths; labour; children; women; faith based; ethics, legal and human rights; private sector, civil society; men sector; sports and recreation; trade and industries, finance and police service.

We are at the point of finalizing the third National Strategic Framework (2003-2009) and currently reviewing the National HIV/AIDS Policy aimed at improving the policy environment of the response. We are also in the process of reviewing the multisectoral response from the context of completeness, duplication of efforts and its entire coordination mechanism during the reporting period.

Our partnerships with donor agencies, bi-/multi-laterals, UN agencies and international NGOs have increased several fold over the years. Substantial resources have been mobilized to compliment the current level of financial and technical resources available in the country. These developments will in no little way provide the needed policy environment for effective implementation of planned intervention programmes to take place in the country.

We have sustained our local efforts to provide free condoms, provision of national voluntary counselling services, scale up the national Antiretroviral drugs and Prevention of Mother-To-Child Transmission programme. Our orphan care and community home based care programme have undergone revisions intended to improve the effectiveness of care for all affected and infected persons in the country. These efforts have contributed tremendously to the reduction the burden of the epidemic in the country.

The next few years will be very challenging for our country as the impact of the epidemic especially among those already infected will be greatest. We look forward to the international community to provide the needed moral, financial and technical support to succeed in our national efforts.

His Excellency Festus Mogae, PH, MP
President of the Republic of Botswana
(Chairman of the National AIDS Council)
Through submission of this report on Core Indicators to the UN General Assembly in March 2003, Botswana is fulfilling its reporting requirements on its HIV/AIDS national programme outcomes and national impact objectives of the Declaration.

At the 2001 United Nations General Assembly Special Session on HIV/AIDS, the Government of Botswana along with 189 other Member States adopted the Declaration of Commitment (DoC) on HIV/AIDS. The Declaration called for a new type of framework for an expanded global response to the epidemic through setting of goals and targets intended to address all dimensions of the pandemic. Through submission of this report on Core Indicators to the UN General Assembly in March 2003, Botswana is fulfilling its reporting requirements on its HIV/AIDS national programme outcomes and national impact objectives of the Declaration.

The report on the status of the National commitment to UNGASS declaration is the first of its kind in the country. The government of Botswana mobilized all the needed technical and financial resources to develop the report. The preparation of this report entailed a process that called for contribution from a broad range of stakeholders. A Reference Group from the Botswana HIV/AIDS Response Information Management System (BHRIMS) technical working group provided guidance to the Consultant who was recruited to assist in the preparation of this report. The format and tools provided by UNAIDS, Geneva were utilized in the development of the report.

Two national partnership fora were organized to build consensus and provide consultations on data generated. Stakeholders who contributed immensely to the report include representatives of government sectors, NGOs/CBOs, PLWAs, development partners, the private sector and academic institutions. We thank them all for their contribution to assist this process.

This report is a synthesis of all information provided by stakeholders. It harmonizes the existing realities with respect to the magnitude of the epidemic, the policy environment, the resource inputs, commitments, actions, challenges and recommendations on the existing constraints. The preparation of this report provided a wonderful opportunity for us to update the status of the national response while appreciating the existing challenges that lie ahead.

Not only will this report inform the UNGASS secretariat on the commitment and action of the Republic of Botswana, it will also be utilized locally by all stakeholders in the country aimed at sharing information, identifying duplication of efforts, as well as reinforcing the current level of political commitment to combat the HIV/AIDS epidemic.

I recommend the report to all stakeholders at home and abroad in order to understand the current status of the HIV epidemic and its local response in Botswana.

Hon Joy Phumaphi
Hon Minister of Health
Vice Chairperson of the National AIDS Council
Acknowledgements

The generation of the 2002 HIV/AIDS Status of the National Commitment to the UNGASS declaration involved a systematic consultative and consensus building process. The National AIDS Council provided the entire needed political environment for the data to be generated. All stakeholders and development partners were actively involved to ensure that the most accurate and reliable data on the impact of the HIV/AIDS commitments, actions, challenges and programme data were provided.

We are grateful to the technical staff of the Botswana HIV/AIDS Response Information Management System (BHRIMS) at NACA and the BHRIMS Technical Working Group who laboured relentlessly to ensure that the deadline of the report was met.

The input of all ministries, civil society organizations, the United Nations family, development partners, the private sector and districts was very impressive and encouraging. It shows the beginning of the Operationalization of the National monitoring and evaluation system and its usefulness in the country.

We are really indebted to all your technical inputs and objective critique that yielded this high quality report.

Finally, I would like to express my profound gratitude to ACHAP, UNICEF and UNAIDS for all the financial support in the consultancy services, national partnership forum, reference group meetings and printing of the final report.

AB Khan, MD, MPH
National Coordinator
National AIDS Coordinating Agency (NACA)
## LIST OF ACRONYMS

1. ACHAP - African Comprehensive HIV/AIDS Partnership  
2. AIDS - Acquired Immune Deficiency Syndrome  
3. ARV - Anti-Retroviral  
4. ASRH - Adolescent Sexual Reproductive Health  
5. BBCA - Botswana Business Coalition For HIV/AIDS  
6. BCIC - Behavioural Change Intervention Communication  
7. BHP - Botswana Harvard AIDS Institute Partnership  
8. BHRIMS - Botswana HIV/AIDS Response Information Management System  
9. BONASO - Botswana Network of AIDS Service Organizations  
10. BONELA - Botswana Network of Ethics & Law on HIV/AIDS  
11. BONEPWA - Botswana Network for People Living With HIV/AIDS  
12. BOTUSA - Botswana USA Partnership  
13. CBO - Community Based Organization  
14. CHBC - Community Home Based Care  
15. DFID - Department for International Development (UK)  
16. DMSAC - District Multi-Sectoral Aids Committee  
17. DoC - Declaration of Commitment  
18. HAART - Highly Active Antiretroviral Therapy  
19. HBC - Home Based Care  
20. HIV - Human Immunodeficiency Virus  
21. IEC - Information, Education and Communication  
22. JICA - Japanese International Cooperation Agency  
23. MOH - Ministry of Health  
24. MOE - Ministry of Education  
25. MLG - Ministry of Local Government  
26. NAC - National AIDS Council  
27. NACA - National AIDS Coordinating Agency  
28. NGOs - Non Governmental Organizations  
29. NSF - National Strategic Framework  
30. OVC - Orphans and Vulnerable Children  
31. PLWAs - People Living With AIDS  
32. PMTCT - Prevention of Mother To Child Transmission  
33. PSI - Population Services International  
34. SIDA - Swedish International Development Agency  
35. STI - Sexually Transmitted Infections  
36. TCM - Total Community Mobilization  
37. UNAIDS - The Joint United Nations Programme on HIV/AIDS  
38. UNDP - United Nations Development Programme  
39. UNGASS - United Nations General Assembly Special Session  
40. UNICEF - United Nations Children’s Fund  
41. USA - United States of America  
42. UNFPA - United Nations Fund for Population Activities  
43. VCT - Voluntary Counselling and Testing  
44. WHO - World Health Organizations  
45. YOHO - Youth Health Organization
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1.0 STATUS AT A GLANCE IN 2002

National Commitment & Action

1. National Composite Policy Index [1.0]
2. Government funds spent on HIV/AIDS [US$ 69.8 million]

Additional

3. Development partners spent US$ 41.8 million
   (Government of Botswana Commitment only)

National Programme & Behaviour Change

Prevention

4. 100% of schools have teachers who have been trained in life-skills-based education and who taught it during the last academic year.
5. 70% large enterprises/companies/ministries have HIV/AIDS workplace policies and programmes.
6. 34.3% of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT.
7. 2.7% of VCT uptake among age groups 15-64+ in the Tebelopele centres in 2002 (BOTUSA).

Additional

8. 15% of National donated blood are discarded, 9% due to HIV and 6% due to other diseases.

Care/Treatment

9. 30% of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled.
10. 7.3% (8,000) of people with advanced HIV infection receiving ARV combination therapy.

Additional

11. The national bed occupancy rate is estimated at 50-70% largely due to HIV/AIDS.
12. 57% of households who require home based care are currently receiving home based care packages.

Knowledge/Behaviour

13. 32.5%(M); 39.9%(F) of respondents aged 15-24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention. (Target: 90% by 2006; 95% by 2009)
14. 88.3%(M); 75.3%(F) of people aged 15-24 years reporting the use of a condom at last act with non-marital and non-cohabiting partner.

Additional

15. 34.1% of persons aged 15-49 years have adopted HIV prevention behaviours in the country.
16. 38.5% rate of condom use with non-regular partners in the last 12 months.
17. Median age at first sex is 19 years for males and 17 years for females.
18. 10.6% of people aged 15-24 years report more than one sex partner in the past 12 months.

Impact alleviation

19. 2:7 Ratio of orphaned to non-orphaned children aged 10-14 years who are currently attending school.
1.0 STATUS AT A GLANCE IN 2002

20. Total registered orphans in 2002 was 37,850.

Impact

21. 21.0% young people aged 15-19 years are HIV infected.
22. 37.4% young people aged 20-24 years are HIV infected.
   (Target: 25% reduction in most affected countries by 2005; 25% reduction globally by 2010)

23. 21% to 40% of infants born from HIV infected mothers are likely to be HIV infected.
   (Target: 20% reduction by 2006; 50% reduction by 2009)

Additional

24. 2.4% Syphilis prevalence.
25. Projected 6% annual HIV incidence.
2.0. OVERVIEW OF THE HIV/AIDS EPIDEMIC

Box 1: Facts in Brief:
- More than one in three Batswana between 15 and 49 are HIV+
- An estimated 320,000 Batswana are living with HIV (0-64+ years)
- An estimated cumulative 138,000 Batswana have died of AIDS by 2002; an additional 263,000 are likely to die by 2010 in the absence of ARV treatment

Source: HIV/AIDS IN BOTSWANA, 2002

2.1 Background

HIV/AIDS has become a serious social, health and development problem in many countries around the world, particularly in Sub-Saharan Africa. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that in the year 2002, 3.1 million people died of AIDS. The majority, 2.4 million, were Sub-Saharan Africans. In addition, in the same year, 42 million people were estimated to be infected with HIV, and, of these, 29.4 million lived in Sub-Saharan Africa. Approximately 14 million children also had been orphaned by HIV/AIDS, with 11 million of them in Sub-Saharan Africa. Yet Sub-Saharan Africa contains only 11% of the world’s population.

Botswana’s HIV prevalence of 35.4 percent among women aged 15-49 years remain among the highest in the world. The epidemic, at this high prevalence level, is having a major negative impact on Botswana’s small population of 1.7 million.

2.2 Status of the Epidemic in Botswana

The lengthy incubation period is one reason that HIV/AIDS is often called a “hidden epidemic.” The idea of a “hidden epidemic” can be seen in the HIV/AIDS pyramid. The tip shows that 2,500 AIDS cases have been reported as of 2002. However, there is much more to the epidemic than the number of reported AIDS cases.

The true number of AIDS cases in Botswana is not known. However, as seen in the blue portion of the pyramid, it is estimated that almost 28,000 adults and children had developed AIDS by the end of 2002.

The red portion of the pyramid indicates the much larger number of people who are infected with HIV but have not yet developed AIDS. Many of these people show no symptoms and do not even know that they are infected. The worst of the epidemic is yet to come as these HIV infected people will ultimately develop AIDS. As there is no cure for AIDS and no effective vaccine, most of them are likely to die within the next decade.
2.0. OVERVIEW OF THE HIV/AIDS EPIDEMIC

Fig 1. HIV/AIDS Pyramid in Botswana

2.2.1 Adult Prevalence

In Botswana, the percentage of 15-49 year olds antenatal clinic attendees infected with HIV (prevalence) increased from 13.8 percent in 1992 to 35.4 percent in 2002. This represents more than a doubling of the prevalence in 10 years. There is some evidence, however, that in recent years the prevalence may be reaching a plateau, since from 1999 to date it has not significantly increased or decreased.

Although the prevalence at the national level is 35.4 percent, there is considerable variation across districts. The consistently high HIV prevalence in the northern district of Boteti, Bobirwa, Chobe, Francistown, Mahalapye, Ngami, North East, Okavango, Selebi/Phikwe, Serowe/Palapye, Southern districts and Tutume is of concern. In contrast, there is relatively low prevalence in the southern district of Gantsi, Hukuntsi, Goodhope, Kalagadi, Kgatleng, Kweneng East, Kweneng West, and South East. Additional information is needed to understand the major geographical, cultural, behavioural and social determinants that can explain why these differences exist.

The geographical pattern of HIV may be directly related to the existence of truck routes and mining activities. HIV/AIDS has become an endemic health problem in Botswana, affecting urban and rural areas with equal ferocity. Although in the early stages of the epidemic the prevalence in urban districts appeared to be higher than in rural districts, the distinction has become blurred in recent observations. In fact, the 2002 survey reveals slightly higher rates in rural than in urban areas.

Fig 2. HIV Prevalence Rate Among Sentinel Surveillance Sites

Fig 3. HIV Prevalence rate by age and rural/urban sentinel surveillance in 2002

The age pattern of HIV infection indicates that the 15-19 years age group demonstrated the lowest HIV prevalence in 2002. The 25-29 age group had the highest HIV prevalence at 50 percent.
2.0. OVERVIEW OF THE HIV/AIDS EPIDEMIC

2.3 Situational Analysis

The AIDS epidemic has presented unprecedented challenges to Botswana, as it has in other countries. Coordination of national response stakeholders has been one of the major challenges. Currently, Botswana has adopted a multi-sectoral approach, coordinated by the National AIDS Coordinating Agency (NACA). To date, at least nine of the seventeen sectors have either developed policies or are in the process of doing so. Eleven out of fifteen ministries have HIV/AIDS coordinators. The process of mainstreaming HIV/AIDS at the sectoral levels started in 2001 and is on-going. All ministries have started their own workplace programmes with components for behaviour change communication, peer education and condom distribution.

At the district level, all districts have established district multi-sectoral AIDS committees. Large-scale vertical programmes such as Prevention Of Mother To Child Transmission (PMTCT), Home Based Care (HBC), and Orphan And Vulnerable Children (OVC) programmes are being implemented in the districts, although there is some variability as to the levels of coverage and uptake. The anti-retroviral therapy programme is currently being implemented in four sites with another nine planned in 2003. VCT is being implemented in all districts while the stand-alone VCT (“Tebelopele”) centres are now operating in 16 of the 24 districts.

These efforts are beginning to show results. There is beginning to emerge a consistent plateau pattern in the HIV prevalence in some age-groups and even a decline in others. Behavioural indicators corroborate these observed patterns.

2.3.1 A Ray of Hope: Botswana’s Youth

Just as there are major differences between the geographic areas of the country, so there are differences between demographic groups. In particular, consistent evidence from sentinel surveillance data indicate that the HIV prevalence in the 15-19 age group is lower than in higher age groups and has been stable or even declining over the recent past. In 1995, prevalence in the 15-19 age group was the same as for the whole 15-49 population (32.4 percent). In 2002 the 15-19 year olds prevalence had declined to 22 percent, while that for the entire 15-49 age group had increased to 35.4 percent.

This "ray of hope", is consistent with information contained in the Survey report of Botswana’s youth behaviour. The observation is that there is a high level of awareness of HIV and knowledge of how to prevent it, but knowledge is low (fig. 11). Condom use for sexually active youth (under age 24) is high, reaching between 88.3% (M) and 75.3%(F) percent. Multiple partnering, another high-risk behaviour, is lower among sexually active females than among their male counterparts (as shown in fig. 15). Given the size and the strategic importance of the youth in the prevention of HIV; the youth age-groups present themselves as a good target for achieving Botswana’s long term vision of an "AIDS-free generation".

Fig 4. Trends in HIV Prevalence by Age Group 1992-2002

2002 Second Generation HIV Surveillance Report
2.0. OVERVIEW OF THE HIV/AIDS EPIDEMIC

The current national response to the epidemic is, as noted above, beginning to show results with the overall HIV prevalence rate stabilizing. The future trajectory of the epidemic will depend on continuing future efforts and successful implementation of programmes. Based on the past trend of the epidemic, and using standard epidemiological models, it is possible to postulate the future trajectory of HIV prevalence. The fitted curve implies that the prevalence rate reached a maximum between 1999 and 2001 and will gradually decline thereafter. Projections shown below are based on this trajectory. If HIV/AIDS programme efforts are intensified it is likely that the prevalence curve will fall more steeply.

On the basis of the 2002 population projection, HIV estimates and the prevalence, the cumulative HIV positive Batswana was 320,000 for all ages. Because the prevalence rate is expected to stabilize and then decline over the next few years, the estimated HIV positive population will likely hover around the 300,000 mark for the remainder of this decade.

The number of new AIDS cases will increase slightly between 2002 and 2010. From a level of around 28,000 in 2002, the number of new AIDS cases will increase to approximately 33,900 in 2005 and then start to decline, falling back to about 31,200 by 2010.

2.3.3 Impact of the Epidemic

The latest statistics from the Central Statistics Office indicates that about 18% of all deaths were attributed to HIV/AIDS.

Child survival indicators are continuing to deteriorate because of the epidemic. The 2001 census shows an increase of IMR from 48 in 1991 to 56 deaths per 1000 live births in 2001. The Under 5 Mortality Rate increased from 62 to 74 deaths per 1000 live births in 2001. The census results also revealed that the death rates increased among almost all age groups.

The age specific death rates among the 25-29 age group almost doubled from 7.3 to 16 deaths per 1000 people. This rate almost tripled among the 30-34 years age group from 8.5 to 23.6 deaths per 1000. While the male age specific death rates almost doubled between the inter censal period, the female age specific death rate almost tripled. Life expectancy at birth has dipped from 65 years a decade ago to 55.7 years. This is almost equal to the life expectancy 30 years ago.

One of the worst impacts of AIDS deaths to adults is an increase in the number of orphans.
2.0. OVERVIEW OF THE HIV/AIDS EPIDEMIC

Because the epidemic is so severe in Botswana, it will have a major impact on the size and structure of the population. First, mortality will be increased. Secondly, women that are HIV infected have notably lower fertility by about 30%.

The number of orphans is estimated to be around 67,000.

About 21 to 40% of babies born from HIV infected mothers are likely to be infected with HIV without PMTCT programme; based on the UNAIDS estimates for Africa.

The preceding projections are likely to be much lower when the national ARV programme has been rolled out.

2.3.4 Population Size and Structure

Because the epidemic is so severe in Botswana, it will have a major impact on the size and structure of the population. HIV/AIDS affects two key demographic variables. First, mortality will be increased. A wide-spread programme that makes anti-retroviral therapy available would reduce mortality and therefore extend average life expectancy. Secondly, women that are HIV infected have notably lower fertility by about 30%. Both of these translate to fewer births.

Total population growth in Botswana has been falling recently, even without the AIDS epidemic due to naturally decreasing fertility with economic and social changes. As can be seen from the figure, the impact of AIDS will actually stabilize population growth levels to that of 1999.

In addition to its effects on the total population, the epidemic will affect the age structure in ways that can be detrimental to the country. In particular the middle age group- the 25 – 50 years group- will experience important declines in size. This is because the HIV prevalence in this age group is high. With such a large impact on this age group, which is also the prime working age group, we expect to see severe shortages of labour, especially skilled labour.
2.0. OVERVIEW OF THE HIV/AIDS EPIDEMIC

The HIV/AIDS epidemic is a development crisis in Botswana and will be the most significant problem facing the country over the next decade. The Botswana government has developed an aggressive multi-sectoral strategy to confront the epidemic on all fronts. This includes creation of national and district-level responses in the areas of workplace programs, prevention of mother to child transmission, prevention efforts through behavioural change, care and support, through a combination of home-based care and anti-retroviral therapy: impact mitigation through programmes such as orphans and vulnerable children.
3.0 NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

3.1 National Commitments:

3.1.1 Commitment to Provision of Financial Resources

Estimated direct HIV/AIDS related expenditure of the Government of Botswana in 2002/03 is USD 69.8 million. However this figure does not reflect all the indirect cost related to the HIV/AIDS epidemic such as infrastructural development, drug procurement, training costs, hospital recurrent budget and others. However additional resources (USD 41.8 million) were also mobilised from development partners.

3.1.2 Commitment to the Coordination of the National HIV/AIDS Response

The National Response to HIV/AIDS is coordinated by a multisectoral National AIDS Council (NAC) chaired by His Excellency, President Festus G. Mogae. The secretariat of the National AIDS Council is the National AIDS Coordinating Agency (NACA). The National AIDS Council (NAC) has representatives from all seventeen sectors including civil society, private sector and the public sectors.

The National multi-sectoral Response is guided by a National AIDS Policy 1998; (currently under review). The National Strategic Framework NSF (2003-2009) with the ultimate goal of preventing new HIV infections by 2016 in line with the National Vision Council targets is about to be finalized. The National HIV/AIDS Response has also been aligned with the National Development Plan 9 (2003-2009). The NSF has been approved for implementation in 2003 by NAC.

The government has also established HIV/AIDS sector committees in all Ministries aimed at mainstreaming HIV/AIDS into sector plans and programmes. These sectors include health, education, local government, agriculture, labour, youth, sports, women, men, faith based, civil society, Legal, ethics and human right and the private sector, just to name a few.

As part of the Government Commitment, all Ministries have been directed to have full time AIDS Coordinators to assist sectors to coordinate, plan, implement sector responses and monitor and evaluate the impacts of its actions. In 2002, out of the 15 ministries, 11 have full time AIDS Coordinators.

The District Response is coordinated centrally through the Ministry of Local Government. So far 15 districts have recruited and posted full time AIDS Coordinators. A District Multisectoral AIDS Committees coordinates the District response in all districts of the country.

3.1.3 Commitment to Prevention of New Infection

In 2002, Government released a national code of conduct for all public employees in relation to HIV/AIDS prevention, care, mitigation, non-discrimination and support services. The code of conduct was fully operationalized in the country in the reporting year. All Sectors involved in the National Response had strategic workplans that were implemented in 2002 through the Coordinating Ministries. Other areas of commitment include large scale community mobilisation and behavioural changes at all levels.

3.1.4 Commitment to Civil Society Coordination

To better coordinate the National response, key coordination network organizations such as...
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BONASO (network for AIDS service organizations), BONEPWA (network for People Living With HIV/AIDS), BONELA (network for ethics and law on HIV/AIDS), and BBCA (Botswana Business Coalition for HIV/AIDS) have been established with the support of the Government.

In 2002, BONASO put in place a Civil Society Strategic Plan aimed at improving information sharing mechanisms locally and regionally, improving the coordination of NGO activities, developing NGO institutional capacity, providing leadership in advocacy initiatives to influence favourable government policy decisions and promotion of NGO networking and partnership building.

3.1.5 Commitment of Development Partners

Botswana has received extensive support from development partners. These include the UN family, African Comprehensive HIV/AIDS Partnership (ACHAP), Botswana Government and USA Centres for Disease Control and prevention (Botswana USA-CDC Partnership-BOTUSA Project), Botswana Harvard Partnership, Swedish International Development Agency (SIDA), the UK Department for International Development (DFID), and United States Agency for International Development (USAID). An Expanded Theme Group for HIV/AIDS in addition to the UN Theme Group became fully operational incorporating all development partners during the reporting year. The Ministry of Finance chaired the HIV/AIDS donors coordination forum during the reporting year.

3.1.5.1 UN Agencies Commitment to the National Response

The UN family has an integrated Plan that was evaluated in 2002. As part of the specific UN agency support to the National Response the following commitment was made by the different Agencies. The commitment to the National Response are well articulated in the UN Development Assistance Framework (UNDAF)

1. United Nations Development Programme (UNDP)

UNDP through the Programme support document mobilized $9.7 million (1997-2002) to mainstream HIV/AIDS into districts and sectors in the country, provided support to district multisectoral response, established and strengthened NGO/CBO networks, supported the HIV/AIDS response among disciplined forces and strengthened the capacity for policy analysis of the response through socio-economic impact research.

2. World Health Organization (WHO)

The WHO supported the National Response with $1.76 million on prevention, care and support, mitigation and institutional capacity and research during 2002.


UNICEF contributed to the national response close to US1.5million, generated through core and domain services to support initial child centred interventions contained in the GoB/UNICEF Country Programme of Cooperation. These interventions were closely focused on training, capacity building, programmatic and operations research, policy development, monitoring and evaluation and broad based advocacy and social mobilisation. Core programmes supported were: PMTCT, Adolescent prevention, Orphan Care and support.
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4. The Joint United Nations Programme on HIV/AIDS (UNAIDS)
The United Nations Joint Programme on HIV/AIDS (UNAIDS) committed $1.32 million to the National Response through technical assistance to NACA for the development of the Botswana HIV Response Information Management System (BHRIMS); initiated the development of the National Strategic planning process, coordination of UN Theme Group Projects and the management of the Urban Youth Project on behalf of the UN theme Group.

5. United Nations Fund for Population Activities (UNFPA)
The United Nations Population Fund (UNFPA) committed the sum of USD 1.6m to the UNFPA is committed to support the National response in the following areas: to strengthen the capacity, co-ordination and implementation of Sexual Reproductive, Health and population development strategies; to improve access to information, HIV/AIDS by youth in the country; and to secure RH commodities including condoms.

3.1.5.2 Other Partnerships

a) The African Comprehensive HIV/AIDS Partnership (ACHAP)
As a model innovation, Government provided the needed environment for private sector-public sector partnerships. In partnership with Bill and Melinda Gates Foundation and Merck Company Foundation established ACHAP to coordinate the disbursement of USD100 million in Botswana over a period of five years (2000-2005).

In 2002, ACHAP disbursed USD7.96 million but has already committed approximately USD43 million over the five years of the project to programs. 39% of the USD43 has been committed to prevention, 36% to care, 8% to support and 17% to Institutional Capacity Development.

b) Botswana Harvard AIDS Institute Partnership (BHP)
This is a partnership between the Government of Botswana and the Harvard AIDS Institute. A Total sum of USD7 million was mobilized in 2002 to support the response through this partnership.

c) Botswana Government and USA Centres for Disease Control and prevention (Botswana USA-CDC Partnership- BOTUSA Project)
The Government of Botswana through its partnership with the US Centres for Disease Control and prevention (CDC) have so far deployed five staff of the CDC to Botswana-four medical epidemiologist and one public health adviser. These staff has been assigned to government and NGO to implement urgently needed services as well as conduct of needed staff. CDC Global AIDS (GAP) resources have also helped mobilized hundreds of local technical and support staff for HIV prevention, care and surveillance.

The BOTUSA project supported the National Response in 2002 with USD6.4 million.

d) SWEDISH Government (SIDA)
SIDA supported the mainstreaming of HIV/AIDS into the Ministry of Local Government mandates, During the reporting period of 2002, the total budget provided was USD290,333.

e) People’s Republic of China
The People’s Republic of China supported the
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3.2.1.2 Review of National HIV/AIDS Policy

In 2002, Government put in place the machinery to revise the National Policy (1998). The final policy is expected to be operational by June, 2003. The current National Composite Policy index is 1.0 in 2002.

3.2.1.3 Sustained Commitment of the National AIDS Council

In 2002 government approved the inclusion of two new sectors into the multisectoral framework: faith-based and the HIV/AIDS legal, ethics and human rights sectors. The National AIDS Council Chaired by HE, President Festus Mogae consistently sustained the momentum of the quarterly council meetings to review the progress of national response throughout the year. The NACA also provided the secretariat support and technical guidance to NAC on a continuous basis and during the quarterly meetings and reporting periods.

3.2.1.4 Botswana HIV/AIDS Response Information management system: National Monitoring and Evaluation system

As part of National commitment to ensure accountability in the national response, Government established a National Monitoring and Evaluation infrastructure called the “Botswana HIV/AIDS Response Information..."
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Management System" (BHRIMS) in 2002 through the assistance of the UNAIDS.

3.2.1.5 Coordination of Second Generation HIV/AIDS Surveillance system

As part of the efforts to operationalize the BHRIMS, in 2002, Government launched the implementation of the Second Generation HIV/AIDS Surveillance concept through the launching of the 2002 Second Generation HIV surveillance report.

3.2.1.6 Coordination of HIV/AIDS Research

Government has demonstrated enormous commitment to establish a system through the BHRIMS in collaboration with the Ministry of Health, to coordinate HIV/AIDS Research in the country for implementation.

Specific researches conducted in 2002 include update of AIDS cases in the Country, Evaluation of the STI Syndromic strategy, preparation for vaccines, molecular characterization and identification of immuno-dominant regions of HIV1 subtype C, preparation for Microbicide trials in the country, epidemiology of TB and HIV research, operational studies to improve TB prevention, diagnosis and treatment.

The Government of Botswana has commissioned a National incidence study through a new technique called detuned assay. A study on population segmentation to inform behavioural change interventions in specific target populations was also commissioned in 2002. The first National HIV/AIDS related behavioural impact study was officially released for utilization in the country in 2002.

3.2.2 Strengthening Coordination of Health Sector Response

In 2002, a review exercise was undertaken of the role of the AIDS/STD Unit, (Ministry of Health) within the context of a multi-sectoral response. The exercise recommended an upgrading of the unit into a department.

The responsibilities of this new department will include among others the management of the following programmes: Clinical Management, STDs, Home Based Care, Counselling, IEC, Surveillance and Research and NGO technical support.

Also during the reporting period the Health sector Strategic plan was being developed for implementation in 2003. The national guidelines on Clinical Management of HIV/AIDS related illness were successfully revised in 2002 as well as the national ARV guidelines. However, the guidelines on Clinical Management were revised but are yet to be harmonised with training modules.

3.2.2.1 National ARV (HAART) Programme

As part of the national comprehensive HIV Care Policy, Government established in 2002 four National HAART sites provided with the needed human and institutional resources including free Antiretroviral (ARV). These four sites cater for all PLWHA who qualify on clinical grounds.

3.2.2.2 National STI Management

Botswana is implementing a comprehensive STI syndromic management strategies nationwide. The treatment of STI in the country is free of charge in all public health care providing institutions.
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3.2.2.3 Workplace Programmes

Government is committed in sustaining the national workplace programme through the Ministry of Health. It includes distribution of free male and female condoms, promotion of HIV prevention services and initiatives. In order to provide adequate technical support for ministerial committees, counsellors were trained in most ministries to support those affected and infected. Another strategy that was added in 2002 to the workplace programme was the use of peer educators at the workplace by most sectors.

3.2.2.4 Behavioural Change Intervention and Communications

Specific programmes such the Behavioural Change Intervention and Communications have been established. There is a national IEC Board that coordinates all behavioural change interventions and communication interventions undertaken nationally.

3.2.2.5 National Condom Procurement and distribution

The Government sustained its efforts to centrally procure, stores and distribute free condoms nationally in 2002. In 2002, the Government of Botswana procured 31 million condoms for the public sector and 4.4 million condoms for PSI.

The ratio of condom distribution per sexually active person 15-59 was 44 condoms per person in 2002. This has been an improvement from 1997 where the ratio was 11 condoms per person.

Also, the Government established a local quality assurance system for condom quality assessment. In 2002, 95% of all condoms distributed by the central medical stores met these quality assurance standards.

3.2.2.6 Voluntary Counselling and Testing

In 2002, Government in collaboration with development partners established additional nine stand-alone VCT centres in addition to the existing seven stand-alone and integrated VCT services in hospitals.

3.2.2.7 National HIV/AIDS Call Centre

As part of efforts to reinforcing the current response to HIV/AIDS, information technology has also been applied and a call centre has been established. This National HIV/AIDS Call Center aims at providing the general public with access to information and relevant referrals was operational in 2002.

3.2.2.8 Prevention of Mother to Child Transmission

Botswana also has rolled out its PMTCT programme that promotes free AZT and Nevirapine to all HIV positive pregnant women in the country. In 2002, the government continued to provide free infant formula for mothers who choose to formula feed.

3.2.3 Local Government Response

As part of the decentralized response of Government, the Ministry of Local Government established the HIV/AIDS Coordinating Unit with five additional staff to liaise between the districts and the central government. At the district level, 15 District AIDS Coordinators (DACs) were recruited trained and assigned responsibilities for all districts. In 2002, all staff
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were recruited, trained and became fully functional. The aim of setting up these structures was to strengthen the district response through providing support for the District Multi Sectoral HIV/AIDS Coordinating Committees (DMSACs). These Committees are represented by government sectors, the private sector, parastatals, NGOs and CBOs, Members of Parliament, District Council, the District Health Team, Traditional authority, People Living With HIV/AIDS groups and the Land Board. In partnership with development partners, the Ministry of Local Government implements activities in the following areas:

- Mainstreaming HIV/AIDS into the district development planning process;
- Introducing the Family Care Model for providing holistic care for orphans, home based care patients and affected families;
- Strengthening the coordination functions of the District Multi-sectoral HIV/AIDS Coordinating Committees (DMSACs) through the DACs;
- Protecting the workforce through AIDS in the Workplace programme;
- Establishment of the district component of the Botswana HIV/AIDS Response Information Management System (BHRIMS) to monitor the district multi-sectoral response.

3.2.3.1 National Orphan Care and Community Home Based Care

In 2002, 37,850 orphans were registered throughout the country. As part of the interventions, a food basket and additional support for schooling are provided free to all registered orphans.

Similarly, there is also a National Home Base Care programme for terminally ill patients including AIDS patients. In 2002, 6,380 patients were registered, of this number, 4,115 patients benefited from the clinical medical assistance as well as food baskets aimed at meeting their nutritional needs. This represents an increase from 1058 in 2001.

Government also approved the implementation of the Family Care Model aimed at providing integrated care including psychosocial support for affected households in 2002. The Ministry of Local Government coordinates the Family care model. Orphan and home based care services are currently available in all districts, the training on the model for implementation is on-going 2003.

3.2.4 Education Sector response

The Ministry of Education remains committed to supporting the National Vision Council Goal of "HIV/AIDS Free Generation by 2016" through improvement of access to HIV/AIDS information among young people and adults. It is also our responsibility to enhance capacity of teachers on HIV/AIDS in the country through the Teacher Capacity Building project for HIV/AIDS prevention in the country.

HIV/AIDS Infusion into School Curriculum

Efforts made so far include incorporation of HIV/AIDS issues into subject curricular and course programmes at all levels, review of primary school curricula, development of pre-primary curriculum and development of HIV/AIDS related policy on early childhood. In the past year the Ministry undertook the following activities in order to ensure prevention of HIV/AIDS spread and mitigate the impact of HIV/AIDS:

HIV/AIDS Research

Conducted Baseline Studies in schools to inform Program development, implementation,
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Monitoring and Evaluation of MOE programmes[ Behavioral Change Communication Program, HIV/AIDS Material Development for primary and Secondary schools and Teacher Capacity Building Project for HIV/AIDS Prevention. A Desk review was also carried out to inform the Monitoring and Evaluation aspect of Teacher Capacity Building Program.

Development of HIV/AIDS Materials
Produced HIV/AIDS self-instructional booklets for primary schools written in Setswana and English. Booklets have also been translated into braille for Visually Impaired Children.

Psycho-social support
Psychosocial support in form of counselling is continually offered in educational institutions. Walk in clients from local communities are also counselled. Teachers have also been trained on Population and Family Life and Life Planning Skills which address amongst others Adolescent Sexual Reproductive Health and issues of HIV/AIDS.

Training on Life Skills based HIV/AIDS Education
By end of 2002, every primary and secondary school in the country have had a teacher trained in life skill based education including HIV/AIDS. Through all the schools in the country, a period have been set aside once a week for teaching Guidance and Counseling which incorporates HIV/AIDS education.

Collaboration with Development Partners
In 2002, the main development partners that supported the education sector response in the country were UNDP, UNICEF, AYA, BOTUSA, UNDP and ACHAP.

3.2.5 Actions through Development Partnership

3.2.5.1 United Nations Agencies (UNDP, UNAIDS, WHO, UNFPA, UNICEF)

1. United Nations Development Programme (UNDP)

In 2002, UNDP provided assistance in the following areas:
- Supported the establishment of the National HIV/AIDS Help line.
- Supported the conduct of situational and response analysis at the districts and sectoral levels.
- Supported the mainstreaming of HIV/AIDS into 15 sectoral mandates.
- Built capacity on HIV/AIDS and development for all stakeholders.
- Provided technical support to NACA and other stakeholders.
- Implemented districts and sectoral operational plans.
- Supported the establishment of Nkaikela Youth Group-commercial sex workers group partnership.
- Supported the establishment of teacher Capacity building Project on HIV/AIDS.
- Provided support to strengthen the institutional capacity of BONEPWA, BONASO and BONELA.

2. Joint United Nations Programme on HIV/AIDS (UNAIDS)

During the reporting period, the UNAIDS sup-
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Supported the National Response with the following:

Technical Assistance for the National Response.

- Provided an M&E specialist for NACA; recruited one consultant to initiate the National strategic planning process; provided technical assistance to review the HIV/AIDS coordination structures in the country as well as development of terms of reference for the HIV/AIDS coordination for the business sector.
- UNAIDS also recruited consultants to facilitate the development of the country proposal to the Global funds.
- UNAIDS mobilized resources for two UN theme Group projects implemented by WHO (increase access to sexual and reproductive services by youths and capacity building and mobilization for combating stigma.
- UNAIDS supported the MOH in the management of Urban Youth Project to identify urban youth needs and priorities, in community mobilization, capacity building of CBO and development of monitoring and evaluation plans.
- UNAIDS provided support for the evaluation of the UN integrated work plan on HIV/AIDS, facilitated the coordination of the UN theme Group and Technical Working Group on HIV/AIDS.

3. The United Nations Children’s Fund (UNICEF)

During 2002, UNICEF provided assistance in the following areas:

- Technical assistance to strengthen National and District capacity to plan, implement and monitor PMTCT programme.
- Supported the development of Lay Counsellors training curriculum and manual.
- Supported the training of 159 lay Counsellors for PMTCT programme.
- Supported National and District level training of 135 TOTs on breast feeding and HIV, infant and young child feeding.
- Supported the reactivation of the baby mother friendly hospitals in the country.
- Supported National, regional and districts meetings and trainings related to PMTCT, EPI and nutrition.
- Supported the development of a communication strategy for up scaling PMTCT activities nation wide.
- Supported the development of the draft infant and young child feeding policy.
- Supported the evaluation of the infant feeding practices in PMTCT and Non-PMTCT sites.
- Supported the training of 14 districts OVC program officers and coordinators in child care.
- Supported BOCAIP in the training of 236 HIV/AIDS community based counsellors.
- Supported COCEPWA, a PLWA support group in the training of 106 child peer counsellors.
- Strengthened capacity of NGO and CBO on Home based care and OVC.
- Supported training of two government and NGO partners in M&E through Evalnet courses.
- Trained 20 reporters and producers including the private sector on HIV/AIDS reporting on children issues.
- Provided technical assistance in the development of the National M&E baseline information.
- Provided technical support in the development of the National M&E indicators.
- Provided technical support in the development of BHRIMS.
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4. The World Health Organization (WHO)

The following support was provided by WHO for the National response:
- Institutional strengthening, capacity building, service delivery in ARV treatment, CBC services and STI management.
- Conducted studies on stigma, competences of volunteers, effectiveness of ARV, effectiveness of syndromic approach on STI management.
- Developed situation analysis of palliative care in HIV/AIDS and cancer.

5. United Nations Funds for Population Activities (UNFPA)

The following support was provided:
- Supported BNYC to establish two (2) Youth Activity Centres in Kasane and Kachikau to ensure that information and knowledge about ASRH and HIV/AIDS issues, rights and services are accessible to adolescents/youth.
- Integrated ASRH, Gender issues, STIs including HIV/AIDS in the regular activities of the youth clubs and groups by adolescents and youth.
- Implemented a project for the full participation and involvement of adolescents/youth in ASRH and HIV/AIDS information and service provision at all levels (development, implementation, monitoring and evaluation of project).
- Assisted BNYC with project personnel and youth peer volunteers to run the youth centres.
- Carried out a mapping exercise to provide analytical information on ASRH programs as well as the coverage of such programs.
- Assisted Government to procure 50,000 Female Condoms.
- Contributed to staff capacity building for BNYC and Government (FHD and Population Secretariat).
- Collaborated with the Country Support Team in Harare to provide technical assistance for both the evaluation of 3rd UNFPA/GOB Country Programme, Development of the 4th Country Programme outline which focuses on HIV/AIDS/SRH and development of component projects under 4th Country Programme.
- Mobilised Resources for the 4th Country Programme (USD 5m) to be implemented for a five year (5) period 2003 -2007.
- Assisted the Secretariat of the National Council on Population at the Ministry of Finance & Development planning to undertake a study on RH problems of teenage child bearing.
- Launched the popular version of the National Population Policy.
- Produced and disseminated population and development newsletter, which contained aspects of HIV and AIDS.
- Provided technical Assistance for SRH commodity logistics management study particularly assessing the status of condoms in the country.
- Supported two (2) senior personnel from Government to attend Commodity Logistics Management workshop in China.
- Assisted MOH to update/develop policy guidelines and services standards to help in the provision of quality ASRH services. The National SRH programme framework document was also launched in November 2002 that will be implemented by all partners countrywide.
- Trained 65 participants from seven (7) CBOs on HIV/AIDS project management.
- Assisted BNYC to develop Youth Strategic Development framework for ASRH/HIV/AIDS for Chobe.
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3.2.5.2 Public-Private Partnership (The African Comprehensive HIV/AIDS Partnership)

Key actions within the reporting period is as follows:

1. Institutional Capacity Development

   - ACHAP supported NACA to develop the National Strategic Framework.
   - ACHAP has also started a project to develop a leadership tool in the management of the nation’s response.
   - ACHAP has seconded a Behavioural Change Advisor, a Clinical Care Advisor and an Admin Support Staff to NACA. ACHAP has also seconded an Operations Manager and an IEC Consultant to the ARV programme.
   - ACHAP has also recruited 33 Health Care Workers to support the ARV programme and 8 laboratory technicians to support the strengthening of the National HIV/AIDS Reference Laboratory.
   - ACHAP has also provided the following short-term consultancies on BCIC segmentation, development of National Strategic Framework, development of Safe blood, Evaluation of Health Workers training programme, administrative improvement of referral system and costing of BHRIMS. It provided training and development of human capacity for government and non-governmental organizations as follows in 2002.
     - 105 individuals trained in Project Management.
     - 255 people trained in proposal writing.
     - 35 people in ACHAP supported programmes trained in Monitoring and Evaluation.
     - 24 people received Media training.
     - 70 hospital staff received basic computer training.

2. Strengthening Health Care Systems

2.1 ARV PROGRAMME

   Recruitment and training of health care workers
   ACHAP was committed to recruiting and funding posts for 54 Health Care Workers (HCW).

   ACHAP in collaboration with the KITSO training Programme provided training for Health Care Workers. In 2002, KITSO trained 366 health care professionals in AIDS Clinical Care, 10 members of the nursing faculty attended the Arthur Ashe Program in AIDS Medicine, Boston, USA; 11 Health professionals participated in the pilot course on Medication Adherence Counselling, 217 Health professionals and support staff attended a laboratory training course.

   ACHAP and the MOH have also established partnerships with three internationally renowned academic institutions, namely University of Pennsylvania, University of Amsterdam, Chelsea and Westminster Hospital also for transfer of skills. Each expert health care worker comes to Botswana and provides both theoretical and practical training in AIDS management for a period of between 3 – 6 months. So far, 13 HIV/AIDS “experts” were brought into the country in 2002 and they trained 590 health care workers in the four national ARV sites.

   Infrastructure development
   ACHAP was committed to building treatment centers at 4 hospitals and 16 clinics. These are expected to be completed by June 2003.

   Drug procurement and storage
   By December 2002, Merck & Co had provided mainly Stocrin, 200mg 90’s to the government
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of Botswana free of charge, 5974 units of Stocrin, 200mg 90's were donated during the reporting period.

Establishment of laboratory infrastructure
ACHAP supported this initiative by purchasing the majority of the equipment at the reference laboratory for over $1m and recruited and funded eight laboratory technicians.

Implementation of IT to support the ARV program
ACHAP is supporting the development of the Integrated Patient Management System (IPMS) that commenced in 2002. It also supported the development and implementation of an interim access based database in all 4 ARV sites.

Information, Education and Communication (IEC).
In 2002, ACHAP procured the services of an IEC consultant to work closely with the local IEC counterpart in the ARV team. The IEC team has developed and distributed IEC materials on general ARV awareness and adherence using ordinary materials such as booklets, posters, patient videos etc and also using an interactive education tool that is in both Setswana and English.
A Masa newsletter, targeting all health care workers, government officials, and other organisations working in HIV/AIDS was also developed and is distributed quarterly. This newsletter functions to update stakeholders on the progress and new developments in the ARV programme.

Health Resource Centers
ACHAP provided in 2002 six (6) Health Resource Centers (HRC's) at the district hospitals in Serowe, Maun, Selebi-Phikwe, Mahalapye, Kasane and Molepolole. Thus far, Health Resource Centres have been erected at all of the district hospitals except Kasane. These centres are used for training and information sharing.

2.3 Condom Distributions and Marketing
ACHAP commissioned behaviour science research undertaken by the University of Botswana on the usage, beliefs and attitudes of men and women on condom use. ACHAP in collaboration with the Ministry of Health and PSI have developed a programme for implementation in 2003 to enhance the distribution and communication on condoms.

2.4 Behavioural Change Communication
ACHAP in collaboration with NACA, the University of Botswana (UB) and Monitor, a private consulting company commenced in 2002 a pilot behavioural segmentation exercise.

3. Strengthening Community Resources and other Initiatives to enhance prevention care and support services.

Teacher Capacity Building Program (TCB)
By end of January 2003, 325 schools out of the 979 schools, technical colleges and education centers had been installed with all the equipment, the equipment has been tested and operators at the schools have been trained.

Small Grant Project managed by BONASO
By December 2002, 185 projects were received by BONASO, 141 (76.2%) were reviewed by PRC and 52 (28.1%) were funded. For the year 2002, P1.6 million were disbursed to projects. Projects funded include Community Mobilization, Education and Prevention, Support, Care and Treatment, Socio-economic Impact Mitigation, Capacity Building and Institutional Strengthening.
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COCEPWA
With ACHAP support, COCEPWA has been able to grow in 2002 from two centers to six centers in Gaborone, Francistown, Mopopolo, Serowe, Maun and Mochudi, a newly established center. COCEPWA has a full-time staff compliment of 44 and to date COCEPWA has 1214 members approximately 0.5% of all PLWHA’s.

BOCAIP
Provided financial and technical support estimated at over P4 million.

House of Hope
ACHAP also assisted the House of Hope during the reporting period to build an orphan care day center to accommodate 200 orphans. The present facilities are able to accommodate only 50 orphans. Construction of this orphan care center is expected to start in mid February 2003.

Traditional Healers
To date ACHAP and MoH have undertaken an audit of approximately 1000 traditional healers in the country. This started in 2002.

Alcohol and HIV/AIDS
ACHAP has been a key partner with NACA, the Ministry of Health, the private sector and the civil society to build capacity within the National Drug Control Coordinating Council (NDCCC) in the Office of the President to develop the multisectoral response.

Meetings of the TWG organized in late November and early December 2002 have set in motion sectoral discussions on alcohol abuse and its relation to HIV/AIDS in Botswana.

3.2.5.3 The BOTUSA Project
(a collaboration of the Botswana government and U.S.A Centers for Disease Control and Prevention)

The project has supported the national response in the following areas:

1. Prevention

Voluntary Counselling and Testing
In collaboration with the Ministry of Health, BOTUSA has opened 16 "Tebelopele" VCT centers in support of Botswana’s “Know Your Status” campaign. Demand for HIV testing is high – 30,000 clients were counselled and tested in 2002.

Prevention of mother-to-child HIV transmission
The project helped develop videos and other educational materials used nationwide, trained counsellors, and provided technical assistance and support in 2002. BOTUSA has helped improve infrastructure by providing portacabins to be used for counselling in 200 clinics nationwide, and is helping establish a multidisciplinary, PMTCT program in Francistown.

Behavioural Change Communications
In collaboration with government and other stakeholders, BOTUSA developed an entertaining, highly popular Setswana radio serial drama, "Makgabaneng", focusing on culturally specific AIDS-related issues. Nearly 200 episodes have been aired throughout the country.

Youth
Technical and financial support was provided to the Youth Health Organization (YOHO), a youth-run NGO, to offer comprehensive youth reproductive health education and mobilization.
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Total Community Mobilization
BOTUSA also supports in collaboration with government a nationwide door-to-door HIV education programme. The programme provides person-to-person HIV education and condom distribution.

School Education
In collaboration with Ministry of Education BOTUSA supported the ongoing development of Botswana-specific HIV/AIDS materials for all Botswana students at the primary and secondary levels.

Workplace
During the reporting period, BOTUSA pilot tested and distributed a workplace peer counselling curriculum and facilitators’ manual with local businesses.

2. Comprehensive Care, Treatment and Support Isoniazid Preventative Therapy for Tuberculosis (IPT)

In collaboration with the Ministry of Health, the project successfully piloted the IPT programme and is supporting the nationwide implementation.

HIV Therapy
The project has conducted training for health workers and is increasing laboratory capacity for monitoring patients on HIV drugs.

Sexually Transmitted Disease Treatment
In collaboration with the Ministry of Health, BOTUSA has helped evaluate the syndromic management algorithms and update the treatment guidelines.

3. Surveillance, Monitoring and Evaluation
A CDC epidemiologist is working full time with NACA to strengthen capacity in surveillance and program monitoring and evaluation.

The BOTUSA project has successfully introduced the electronic TB register, a computerized TB surveillance system in Botswana and six other countries.

4. Research

TB Research
Active research is ongoing on the epidemiology of TB/HIV, as well as studies to improve TB prevention, diagnosis, and treatment.

Microbicide research
Preparations are underway to conduct a phase III clinical trial of Carraguard(TM), a seaweed-based vaginal microbicide women could use to prevent transmission of HIV and other STDs.

3.2.5.4 Government of Botswana and USA Peace Corp Volunteer Programme

In 2002, Botswana and US Governments reached an agreement to allow an initial cadre of twenty (20) Peace Corp volunteers to provide human resources for the district HIV/AIDS Response in 2003.

3.2.5.5 Botswana Harvard AIDS Institute Partnership

The following support was provided:

- Launching of HIV Research and reference laboratory.
- In collaboration with the government of Botswana launched the clinical and research laboratory in the country in 2002. The laboratory has the capacity of HIV diagnosis, monitoring of disease progression-CD4 cell
counts and viral load in plasma, chemistry, haematology, Chlamydia PCR, syphilis serology, hepatitis B, C serology, urinalysis and pregnancy; virus isolation and culture as well as DNA sequencing.

**Genetic analysis of HIV-1C**
The genetic analysis of HIV-1C in infants is currently on going in collaboration with the government of Botswana.

**PMTCT Trial**
We also successfully launched the ‘MASHI’ study (breastfeeding vs infant formula feeding) on PMTCT in the country during the reporting year, 2002.

**Infant Outcomes**
In collaboration with the Ministry of Health, BHP commenced an infant outcome study in the country in 2003.

**HIV Vaccine Trials**
In 2002, Botswana commenced infrastructure development, community awareness aimed at preparing the ground for a vaccine trials in the country.

**Research on Family Health Needs**
A research on behavioural family health was also commissioned in the country during the reporting year.

**Training**
In collaboration with a development partner in the country commissioned training programmes referred to as KITSO and Forgarty in the country.

### 3.2.6 Disciplined Forces HIV Response

Within the disciplined forces and services made up of the Botswana Police Service, Botswana Defence Force and Prison Services there is an advanced HIV response in the country.

**Botswana Defence Force**
Full time focal persons were appointed in 2002. Strategic Plan of action was completed for all the forces. Specifically activities undertaken in 2002 include prevention activities, training of peer educators, situation analysis and outreach programmes.

Other activities include an Alcohol and HIV/AIDS Programme, promotion of discouragement against rape and sexual assaults, incorporation of AIDS into training curriculum, advocacy and sensitization for men participation in the national response, condom promotion and ARV campaigns.

**Botswana Police Services**
During the reporting year the following activities were carried out. Organisation of 4 workshops for senior and middle level management, review of peer educators and counsellors roles, conduct of needs assessment to mainstream HIV/AIDS into police curriculum, participation in the World AIDS day and HIV fair, training of 40 peer educators, appointment of AIDS focal person and AIDS committees at the units and divisional levels, conduct of weekly prayers to support the affected and infected.

### 3.2.7 Civil Society Response and Coordination

In 2002, Botswana Network of AIDS Service Organizations (BONASO) had a total of 57 members made up of NGO, CBO and the private sector. The Civil society Networking umbrella provided support through mobilization of small grants from Government, GOB/UNDP Project Support Document, ACHAP, JAICA, BMS, DFID to fifty two (52)
3.0 NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

Home Base Care Projects, PLWA support Groups, Palapye Hospital, Theatre Groups, NGO and Village AIDS Committee and DMSAC in 2002.

**Institutional Capacity Building**
Organised 4 workshops on proposal writing, project monitoring and evaluation, financial management and Cyber café in collaboration with BMS and SAFAIDS.

**Coordination and Networking of members**
Sustained the production and distribution of quarterly newsletter to all members, sustained its membership to ICASO, SANASO and AfricaSO

**Resource Mobilisation**
Mobilise resources from JAICA, to support the procurement of equipment for 8 of its members; during the same reporting period mobilised P1.6 million from ACHAP to support 52 community based project in the country,

**Mobilisation of and Support For NGOs**
Mobilise CBOS and NGOs to participate actively during the 2002 World AIDS Day and HIV fair.
They were also visibly involved in the National HIV/AIDS Fair of 2002 and World vision cycle relay aimed at raising awareness on HIV/AIDS, production of PLWA testimonies in video, IEC materials development.
Supported the production of one video documentary of PLWA testimonies for launching in 2003.

**National Policy Environment**
BONASO is an active member of NAC and sustained its contribution to National policy review and decision making process throughout the reporting period.

3.2.7.1 Network of People Living with HIV/AIDS

There is a national coordinating umbrella of PLWA in the country aimed at supporting other PLWA support groups at the grass root levels (BONEPWA).

BONEPWA, the PLWA coordinating network was fully strengthened in 2002 to improve quality of life for PLWA. The network is guided by an executive board, which met in 2002 to review the goals and achievements of the organization.

The major actions in 2002 were financial support for seven PLWA support groups, In 2002, 30 PLWA were trained on field outreach programmes, 27 new PLWA support groups were formed and supported, organized a National AIDS Conference for PLWA in the country, developed and launched a national website for PLWA, conducted a feasibility study for supporting members of BONEPWA, other major activities include documentation of testimonies by PLWA to provide psycho-social support for others.

The following development partners provided financial and technical support to BONEPWA: Government, UNICEF, ACHAP, WUSC, Norwegian Church Aid, HIVOUS, Ca sales distribution and BONASO.
In 2002, the PLWA involvement reached its peak, as they became members of the National AIDS Council (NAC), were involved in the development of the NATIONAL STRATEGIC FRAMEWORK and BHRIMS, evaluation of the UNDP/GoB PSD.
3.0 NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

3.2.7.2 Actions by PLWA Support Groups (Coping Centre for People Living with AIDS)

COCEPWA is the largest PLWA support group in the country. In 2002, the total number of branches increased to five covering large towns and villages.

During the reporting period, the Support Groups had reached over 1214 PLWHA and one-third of the members were trained on ARV, Basic information on HIV, PMTCT, community mobilization, proposal writing and counselling in 2002. Also a public speakers programme was also developed; trained counsellors for all the five national centres recruited and placed. Due to its achievements, it has attracted over 2 International and 140 local volunteers were mobilized providing technical support to all the centres in the country.

The support group also established a PLWA Buddy Programme in 2002 aimed at providing support for each other, drug adherence, safe sexual practices and coping capabilities.

3.2.7.3 Youth Response (Youth Health Organization)

A National Youth based and youth run organization, "Youth Health Organization (YOHO), currently implements four major programme activities, i.e. peer education, media and advocacy, theatre and arts and research and evaluation.

During the reporting period, three affiliate sites in Ghantsi, Chobe and Moiyabana were established. The organization raised 2000 pints of safe blood for transfusion in the country, trained 30 volunteers on peer education; three employees are currently undergoing training on media and theatre art.

A nation-wide month of youth against AIDS was also organized by the organization in 2002. Other activities in 2002 include development of youth specific IEC materials. YOHO also launched the Bosele International Theatre festivals to raise HIV/AIDS awareness among Youths in the country in 2002.

3.2.8 Condom Social Marketing

As part of the national commitment on prevention of new infections, the Population Services International in collaboration with other partners commenced the social marketing on female condoms in 2002; launched a "Choose Life Youth Project" targeting in and out of school youths specifically on life skills.

The PSI also sustained the media and advocacy component of the Tebelopele stand-alone VCT projects during the reporting period. A total of USD5 million was mobilized by PSI from ACHAP, Soul City, DFID, AYA, BOTUSA and Government in 2002 for all the its projects in the country.

3.2.9 HIV/AIDS Legal, Ethics and Human Rights Response

Major actions of the HIV/AIDS legal, ethics and human right sector through BONELA in the country for 2002 include the following: free legal services for PLWA targeted for employment and discrimination, technical support to health sector policy, development of proposal on the review of the National Laws and regulations in order to remove legal barriers.

3.2.10 Faith Based Response

Faith Based Sector developed a clear strategic plan of action to mobilize all Moslem, Christians, and traditional religion to join in the
3.0 NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

fight against HIV/AIDS. The faith-based organization was also included in the highest policy decision-making body in the country (National AIDS Council).

3.2.10.1 Botswana Christian AIDS Intervention Programme (BOCAIP)

BOCAIP, as a member of the faith based response is committed to the mobilisation of the church organisations to a more systematic and effective approach in serving our communities at the grassroots level. It finalized its strategic plan for implementation in 2002 after an indebt situation analysis. BOCAIP expanded from 9 centres by the end of 2001 to 11 by the end of 2002.

The M & E unit participated in a number of evaluative exercises during the course of the year. These were the Brystol Myers and Squibb Summative evaluation done at the end of the year and the initial Formative evaluation done at the beginning of the year. At the same time, the team conducted a Situational analysis with the programme management team.

The following were summary achievements in 2002:

- The Strategic plan was finalised and adopted by the national management committee
- A clientele based situational Analysis of our response was also done and the information served as the basis upon which the strategic plan was developed
- In the various programmes of BOCAIP, we were able to reach about 70 161 people. These had a clear presentation on the facts about HIV/AIDS prevention messages.
- In our youth programmes, 177 are involved in various projects. Of these 44 are male and 133 are females.
- We have 4 support groups in which PLWA’s have their needs met.
- In the case of orphan care, BOCAIP has over 258 orphans in various places in the country being taken care off. These are in Molepolole, Ramotswa and Maun. Other places like Sehitwa are at initiation stages.
- Training of lay people in counselling and home based care support. A total of 447 were trained during the course of the year.

The following financial and technical support was received from government and development partners:

**Table 1: Sources of BOCAIP Financial Resources**

<table>
<thead>
<tr>
<th>Source</th>
<th>Financial Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>NACA:</td>
<td>Technical Support</td>
</tr>
<tr>
<td>ACHAP:</td>
<td>Technical support &amp; Financial support (Pula 4,045,976.40)</td>
</tr>
<tr>
<td>MM-CIDA:</td>
<td>Financial Support (Pula 561,821.91)</td>
</tr>
<tr>
<td>SIDA:</td>
<td>Financial Support (Pula 372,807.91)</td>
</tr>
<tr>
<td>UNICEF:</td>
<td>Financial Support (Pula 275,883.00)</td>
</tr>
<tr>
<td>German Embassy</td>
<td>(Pula 32,176.42)</td>
</tr>
<tr>
<td>BMS:</td>
<td>(Pula 747,321.48)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>P6,035,987 ($1,005,997)</strong></td>
</tr>
</tbody>
</table>

UNICEF also purchased five vehicles for Bana Ba Keletso, Motse Wa Tsholofelo, Sehitwa Orphan care Project and Tsabong to start orphan care.

During the reporting period, it also raised P2 600 000.00 (US$433,333) had been raised, through orphan care and support project proposals submitted to Bristol Myers Squibb, Swedish SIDA and UNICEF.

By end of 2002, BOCAIP had established 11
3.0 NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

centers throughout the country. The centers are now in Gaborone, Ramotswa, Molepolole, Lobatse, Masunga, Francistown, Selebi Phikwe, Kanye, Tsabong, Serowe and Maun.

BOCAIP has reached over 70 000 attendants in their community mobilization and outreach activities and has trained 447 HIV/AIDS volunteer counselors.

3.2.11 HIV/AIDS Related Hospices

There are two religious based hospices in the country. They cater for the terminal ill and the families of affected and infected. Other activities include provision of in-come generation skills, care for orphans, operation of day care centres for HIV infected mothers and their children.

3.2.12 Private Sector Response in the country

In, 2002 the following private sector organizations had developed HIV/AIDS Workplace Policy and strategies: Botswana Power Cooperation, Barclays bank, Shell, First national bank, DEBSWANA, Botswana life. These companies are some of the largest private sector employers in the country.

In addition, there was full scale implementation of workplace programme activities such as medical aids support services (Treatment of Opportunistic infections and ARV) condom promotion and distribution, development and distribution of integrated IEC materials among others. Within the banks in the reporting year of 2002 an exchange programme of HIV/AIDS strategies was launched and implemented.

1. Barclays Bank

In 2002, Barclays launched the ART programme for staff and their registered dependants subsequent to an Un-linked anonymous testing amongst all staff members. In the same year, they also determined the economic burden of sickness related to HIV/AIDS among their workforce. Other activities carried out during the reporting period were awareness campaign among staff, distribution of condoms in all branches, training and placement of Peer educators in all 54 Barclay’s outlets.

In order to mitigate the impact of absenteeism and death of staff on work productivity, the Bank as part of its response strategy to HIV/AIDS introduced an innovative system of human resource management strategy. Also in the reporting, the bank introduced incentives for staff to participate in community HIV/AIDS initiatives. The bank has also established a budget line to support Community Based Organizations.

2. First National Bank (FNB)

In the same year, the bank commenced provision of guidance and counselling service for their employees. It also recruited a full time HIV/AIDS Coordinator to implement and monitor the in-house HIV/AIDS programmes.

3. Debswana

This is a diamond mining company in partnership with the government of Botswana. It is one of first companies that initiated a comprehensive private sector response to HIV/AIDS in the country.

By 2002, it had provided HAART to 186 staff with AIDS. Some of the major activities for the reporting year include provision of HIV/AIDS education and counselling services to its workforce and surrounding communities. It also fully implemented a care and support programme that includes home based care services. It also established a functional HIV/AIDS resource cen-
3.0 NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

4. Botswana Power Corporation (BPC)
BPC has had a Workplace HIV/AIDS policy in place since 1995. By 2002, BPC has established Coordination Units in all the districts where it operates. Other achievements in 2002 was the formation of 4 drama groups, 58 trained peer educators, and an in-house IEC production capacity which produces a quarterly newsletter and HIV/AIDS information pamphlets for the employees. BPC also distributed free condoms to its entire staff during the reporting period. It recruited two full time coordinators on the HIV/AIDS programme in the year 2002. BPC also approve and supported the national response with the budget equivalent of $20,000 on HIV/AIDS intervention programmes during the period.

5. Botswana Confederation of Commerce and Industry (BOCCIM)
During the reporting period, a corporate HIV/AIDS intervention strategy was being developed for the private sector. USD25,000 was mobilized from the Global Business Coalition on HIV/AIDS. BOCCIM has approved the establishment of a private sector coordination unit on HIV/AIDS in its umbrella bodies in 2000. It currently has membership of 1600. The National AIDS Council also approved BOCCIM as a member of the council in 2002. In the reporting year commissions a study on the impact of HIV/AIDS on migrant workers in the country.

6. Bank of Botswana (BoB)
The BoB has an HIV/AIDS workplace programme with a full time coordinator in place. It has a clinic which provides ARV and treatment of opportunistic infections for its workers.

3.2.13 University of Botswana Response
The University of Botswana, as an institution of higher learning, recognizes the HIV/AIDS epidemic as a serious threat to the well being and continued development of the nation. The University not only fights the spread of HIV within its own community, but also contributes to the national effort through education, research, awareness-promotion, behaviour-change and other innovative initiatives in line with the National Policy on HIV/AIDS. Because of the broadness and complexity of HIV/AIDS the University of Botswana has adopted a multi-sectoral approach in dealing with HIV/AIDS so as to encourage everybody to take part and to address the problem from different perspectives.

HIV/AIDS committee
The university has a full time HIV/AIDS Coordinator. This officer works with a 20 member HIV/AIDS Committee whose main mandate is to coordinate HIV/AIDS activities on campus and to provide a forum where representatives from various faculties and units can meet once a month to share their projects and decide on the way forward. The Committee has representation of both students and staff.

HIV/AIDS Policy
The University has an HIV/AIDS Policy in place to address HIV/AIDS issues as they relate to students and staff. Formulating the policy was part of the University of Botswana’s draft five-year (2001-2005) HIV/AIDS strategic plan.
3.0 NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

The Society Against HIV/AIDS (SAHA), a student organization, has ongoing outreach activities made possible through funding from the American Embassy. They have been able to organize and conduct awareness creating workshops with youth in other tertiary institutions as well as for secondary school students.

Collaborative work on HIV/AIDS

- In March 2002, Tebelopele Voluntary Counselling and Testing Centre opened a satellite at the University. A counsellor comes twice a week to offer counselling and testing services.
- The University has developed partnership with the Botswana Harvard Partnership to run monthly seminar series on HIV/AIDS. These lecture series are intended to further strengthen the University of Botswana’s existing Information, Education and Communication (IEC) strategy on HIV/AIDS. These seminars are coordinated through the Centre for Continuing Education and are open to the public rather than to the University community only.
- The Society Against HIV/AIDS (SAHA), a student organization, has ongoing outreach activities made possible through funding from the American Embassy. They have been able to organize and conduct awareness creating workshops with youth in other tertiary institutions as well as for secondary school students.

Incorporating HIV/AIDS into the curriculum

The different faculties and departments are currently working on incorporation of HIV/AIDS into the curriculum. The faculty of Education through the Department of Nursing Education has introduced a course on HIV/AIDS called "The HIV/AIDS Education, Prevention and Control Course" that is taken by student teachers and any other students who are interested in the course. Informing the student teachers should have a multiplier effect because they will in turn go and teach students at primary and secondary schools.

Research

Members of staff and students continue to conduct research on HIV/AIDS as a way of trying to enrich their knowledge as well as that of the nation at large. The Office of Research and Development has taken a lead in coordinating and encouraging research on HIV/AIDS.

Service departments

The University of Botswana is able to run all the programmes through the various departments and units that are already in place to offer different services on HIV/AIDS. The service departments include:

- The Health Services
- The Careers and Counselling Centre, and
- The Health and Wellness Centre
4.0 NATIONAL PROGRAMMES AND BEHAVIOUR CHANGE

4.1 Programmes aimed at Prevention of New HIV Infections:

4.1.1 Behaviour Change Interventions and Communications

Behaviour Change Interventions and Communications (BCIC) Advisory Board
A multi-sectoral, twenty-five-member BCIC Advisory Board was set up to assist and advise NACA and all HIV/AIDS stakeholders on BCIC programmatic issues.

Bus Shelter Advertising
A long-term advertising campaign involving 100 bus-shelters is being implemented in all the twenty-seven District Multi-Sectoral AIDS Committee (DMSAC) areas. We are exploring the possibility of reinforcing this campaign with similar posters, leaflets, radio jingles on all local radio stations and television spots.

Production of Brochure on BCIC Materials Development Guidelines
Over 1,000 copies of the BCIC Brochure offering guidelines on behavior change communications materials development for implementing partners was printed and distributed.

World AIDS Day (WAD) Campaign Activities
An estimated 4,000 people marched to the Boipuso Hall in the capital city, Gaborone, to commemorate the 2002-2003 WAD Campaign on December 1, 2002 based on the theme set by UNAIDS of “stigma and discrimination: live and let live”.

Development and piloting an HIV/AIDS fair concept
Working from this WAD theme, NACA decided to develop and pilot an HIV/AIDS fair concept that could travel to each of the districts, thereby disseminating the campaign benefits nationally.

Production of NACA Newsletter
Over 1,000 copies of the NACA newsletter “E Bolotse,” (bearing many articles on HIV/AIDS issues and events, was distributed to all HIV/AIDS stakeholders and potential partners in the fight against HIV/AIDS.

Development and Piloting Audience Segmentation Exercise
With support from one of its development partners, ACHAP, NACA is piloting an HIV/AIDS behavioral segmentation at the University of Botswana, through one of the world’s leading market research firms, the Monitor Group.

Pilot Mobile Campaign for Remote Areas
A mobile advertising and social marketing campaign is being piloted and evaluated in four districts of Kgalagadi, Kweneng, Northwest and Southeast during the next six months.

Training and Capacity-Building Programme for BCIC
NACA has developed and is sourcing funds to institute a sustainable Training and Capacity-Building Programme in behavior change interventions and communications planning. The programme will also offer technical support on behavior change interventions and communications to implementing partners.

Resource Centre Activities
NACA is developing a National HIV/AIDS Resource Centre to collect and store specialized information on HIV/AIDS. It aims to assemble materials that can support NACA and implementing partners in their fight against HIV/AIDS.
4.0 NATIONAL PROGRAMMES AND BEHAVIOUR CHANGE

Bill Board Advertising
Over twenty-seven billboards carrying HIV/AIDS messages have been sustained throughout the country during the reporting period.

Dustbin Advertising
Dustbin advertising involving over 100 units is underway in areas of population concentration around the capital city, Gaborone.

Serial Radio Drama
In collaboration with one of the development partners, BOTUSA Project, NACA set up a Radio Serial Drama, Makgabaneng, which deals with general life challenges, including HIV/AIDS. The programme has been running for more than a year now.

Radio Jingles
Since the beginning of 2002 NACA has broadcast 300 HIV/AIDS messages on local radio stations.

BTV Talk Shows Programmes
Eight programmes per months on Botswana Television are dedicated to HIV/AIDS issues.

Newspaper Articles
Over 20 articles on HIV/AIDS issues and events were publicized in all the local newspapers per month.

Magazine Articles
More than 10 articles on HIV/AIDS issues and events were publicized in selected local magazines per month.

Press Conferences
NACA in collaboration of Ministry of Health and other stakeholders held at least two press conferences per quarter to brief the press on developments in the national fight against the HIV/AIDS epidemic.

4.1.2 Total Community Mobilization on HIV/AIDS (TCM)

The Government of Botswana provided $1,35 million to TCM project activities for implementation in collaboration with development partners, government ministries and the districts. BOTUSA also provided an additional $340,000 through technical support and establishment of linkages with programmes implemented by BOTUSA.

The Total Community mobilization strategy (TCM) which is being implemented by the Humana People to People expanded its activities in nine (9) districts areas in 2002. Programmes covered include workplace, school education and community mobilization programmes.

During the reporting period also, 450 Field officers were recruited and trained in HIV/AIDS Counselling, PMTCT, ARV and other HIV/AIDS related topics.

Other activities include visitation to 450 households, one to one education on HIV/AIDS prevention, care and support to 127,055 households and 341,221 individuals. Over 4,989 people were mobilized as Community Volunteers and 382,059 people received HIV/AIDS information and 30,318 HIV/AIDS Talk sessions during the reporting period.

In addition, TCM initiated 61 income-generating projects, distributed 2,011,603 condoms, and conducted 507 workplace HIV/AIDS programmes, 338 HIV/AIDS, in schools, and 276 rallies all over the country.

4.1.3 The Teacher Capacity Building Programme (TCB)

In 2002 the Government successfully establis-
4.0 NATIONAL PROGRAMMES AND BEHAVIOUR CHANGE

A Teacher capacity Building Programme with the Ministry of Education. The TCB is a national distance learning Television programme in HIV/AIDS targeting primarily teachers and in school youths in primary, secondary and tertiary institutions.

It is modelled on a successful TV programme in Brazil called "TV Escola". In the reporting period, 325 out of the total 979 schools, technical colleges and education centres in Botswana were provided with television sets and video machines to view and record these programmes for use in the classrooms. The first TV programme is expected to be launched in March 2003.

So far the following actions have been undertaken during the reporting period:
- Development of HIV/AIDS curriculum for the project
- Development of television programme using studio equipments
- Recruitment of technical consultants to build local capacity
- Development of Project Monitoring and Evaluation system,
- Training and mobilization of institutions, councillors and education authorities

4.1.4 Prevention of Mother to Child Transmission (PMTCT) Programme

The goal of the program is to improve the survival and development of children by reducing HIV related morbidity and mortality. Its main objective is to reduce the number of new paediatric infections occurring through mother-to-child transmission by 50% by the end of 2009.

The programme offers antiretroviral prophylaxis, Zidovudine orally to pregnant women from 34 weeks of gestation until delivery and babies are given Zidovudine syrup for 4 weeks starting within 8-10 hours after birth. Cotrimoxazole for prevention of pneumocystis carinii pneumonia (PCP) pneumonia starting from 6 weeks of age until at least 12 months. Infant formula feeding is currently provided free of charge and optional.

Statistics collected through routine monthly district reports indicate that some good progress has been made. The uptake (defined as the proportion of HIV infected women identified through counselling and HIV testing and given Zidovudine to prevent mother-to-child transmission of HIV) has increased from 8% in December 1999 to 34.3% in 2002.

The HIV prevalence among pregnant women in the country is 35.4%. About 16,284 pregnant women were estimated to be HIV positive in 2002. In 2002, the PMTCT programme was approved by the national AIDS Council for nation-wide coverage.

In the reporting period the government also approved an additional ARV drug, Nevirapine to the current regimen aimed at improving efficacy and compliance.

Total number of HIV+ pregnant women provided with ART therapy in December, 2002 within the public sector was 309 accounting for only 1.8% of the eligible population. The current estimated level of reduction in mother to child transmission is 21.9%.

From the inception of the program up to the end of June 2002, over 3,382 babies have received Zidovudine for PMTCT.

The proportion of women accessing different PMTCT interventions has increased as indicated in the table.
4.0 NATIONAL PROGRAMMES AND BEHAVIOUR CHANGE

Table 2: PMTCT UPTAKE in 2002

<table>
<thead>
<tr>
<th></th>
<th>December 1999</th>
<th>June 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women counselled on PMTCT</td>
<td>60%</td>
<td>74%</td>
</tr>
<tr>
<td>Pregnant women tested for HIV after counselling</td>
<td>40%</td>
<td>54%</td>
</tr>
<tr>
<td>HIV positive women given Zidovudine</td>
<td>30%</td>
<td>60%</td>
</tr>
</tbody>
</table>

This indicates that some good progress has been made in the areas of counselling, acceptance of HIV testing and administration of Zidovudine. However, there are challenges and constraints that need to be addressed in order to increase this uptake further.

Major actions of the programme during the reporting period were:

- Sensitisation of community leaders and members of district multisectoral AIDS committees.
- Development, production and distribution of target specific education materials including three videos.
- Revision of PMTCT training curriculum and materials including the development of a handbook for counsellors.
- Training of over 60% of all health workers including doctors, nurses, midwives, social workers, pharmacy technicians and laboratory technicians.
- Creation of 297 posts of lay counsellors: 260 for the clinics and 37 for the hospitals. 159 have been recruited, trained and posted.
- Two warehouses have been secured in Gaborone and Francistown for storage of infant formula.
- The PMTCT program monitoring system has been developed and integrated into the MCH monitoring system.
- Introduction of Nevirapine in the PMTCT programme from January 2003 to improve the efficacy of the current drug protocol.
- The training of health workers on the new protocol including Nevirapine was completed on the 11 December 2002.
- A 5-year free donation of Nevirapine has been secured from Boehringer Ingelheim.
- Extension of the UNICEF/GlaxoSmithKline donation in kind of Zidovudine to cover women needed AZT through mid 2003.

4.1.6 Control of Sexually Transmitted Infections (STI)

In Botswana, all public health facilities that manage STIs, practise the syndromic management approach. The prevalence of syphilis among STI patients declined from 10 % in 1993 to 2.4 % in 2002.

Similarly, Gonorrhoea also declined from 12 % to 3 % in the same reporting period. The drugs for STD management are provided free of charge in 2002 to all patients. However, Chlamydia is still on the increase in the country.

Fig 10. STI among women using family planning services in Botswana

Source: Ministry of Health: Evaluation of STI Report, 2002

4.1.7 Blood Safety

The implementation of the National Policy on Blood Transfusion and safety was sustained in
4.0 NATIONAL PROGRAMMES AND BEHAVIOUR CHANGE

2002. The policy stipulates an integrated blood transfusion service. The current national structure consists of the National Blood Centre, 2 Regional Blood Transfusion Centers, Primary Hospital and District Hospital Blood Banks.

Total number of blood transfusions in 2002 was 10,200. All blood for transfusion was pre-tested for HIV and Hepatitis in the country in 2002. The HIV prevalence among blood donors is observed to be 9%.

4.1.8 AIDS at the Workplace

The Community Health Services Division, MoH, manages the AIDS in the workplace programme. The programme targets youths, men, and women at the workplace through IEC. The programme is succeeding in sensitisation of senior management and workers on the variety of issues affecting workplace policies. Training of peer educators/ counsellors remains an ongoing activity.

Over 500 organizations established HIV/AIDS in the workplace programmes in 2002, and demand from organizations to develop HIV/AIDS program and training of peer educators/ counsellors continues to increase. The posting of a private sector HIV/AIDS Coordinator is expected to accelerate these interventions.

4.1.9 Clinical Management of Opportunistic infections and HIV-related illness:

Treatment of opportunistic infections has been available in Botswana since early 1990s. During the reporting period the clinical management guide was updated and health workers were trained on the guidelines.

4.1.9.1 Isoniazid Preventive Therapy

In collaboration with BOTUSA, a pilot of the Isoniazid Prophylactic Treatment Programme (IPT) was successfully implemented in 2002. This will be rolled out countrywide in 2003.

4.1.9.2 Prevention and Control of Tuberculosis (TB)

TB is the leading HIV associated opportunistic infection in Botswana and accounts for 30-40% of AIDS related deaths.

Existing interventions include the short – course DOT strategy. This services are available in all health facilities establishment of HIV services in the country.

Also, in 2002, an electronic TB register and a computerised TB surveillance system was implemented in Botswana with the assistance of BOTUSA.

4.1.9.3 Provision of Antiretroviral Therapy (ART)

Provision of antiretroviral therapy to all HIV/AIDS infected Batswana is one of the highest priorities of the GoB. The ARV programme is of national scale but was restricted to four central sites in 2002 due to institutional limitations.

By end of the reporting period about 8,000 persons receiving ARV therapy in Botswana were enrolled and treated with ART from public and private health facilities.

There does exist ARV training programme to empower health workers to provide adequate treatment services to eligible patients. A National wide ARV resistance monitoring
system is also in place in collaboration between NACA and the BHP.

The performance in 2002 is as stated below:

<table>
<thead>
<tr>
<th>Performance (2002)</th>
<th>3rd. Quarter</th>
<th>4th. Quarter</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients enrolled</td>
<td>3,624</td>
<td>5,201</td>
<td></td>
</tr>
<tr>
<td>On ARV therapy</td>
<td>2,797</td>
<td>3,983</td>
<td></td>
</tr>
<tr>
<td>Deaths to date</td>
<td>235</td>
<td>*319</td>
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</table>

Other logistical supplies such as gloves, mac-kintosh, bedpans and disinfectants among others are provided to maximize protection to both patients and care providers. Income generating activities also forms an integral part of the CHBC programme.

4.1.11 Counselling and Psychosocial Support

Psychosocial support is a key component of health sector response to HIV/AIDS in Botswana. Ongoing counselling helps individuals accept their HIV status and facilitating information sharing with partners or close family members who may also participate in counseling.

Since the programme commenced over a 1000 counsellors have been trained. A similar programme is also being established for health workers caregivers.

Expanding accessibility of counselling services and assuring quality through monitoring and evaluating activities remains a priority of the government. Because of the ever-increasing demand for HIV/AIDS prevention and care, additional counsellors are being recruited and trained.

Counselling is limited to immediate pre and post testing periods. Follow-up supportive counselling is very limited and needs of special groups such as children; the youth and the disabled have not been addressed.
4.0 NATIONAL PROGRAMMES AND BEHAVIOUR CHANGE

4.1.12 Voluntary Counselling and Testing (VCT)

The Government in collaboration with BOTUSA established 16 Tebelopele centres that offer VCT services in the districts. VCT services are also offered in government health care institutions however, these require further strengthening in order to cope with the demand for services. Increasing accessibility and improving the quality of VCT services and standardization of VCT operations both in public and private institutions remains the key focus of the government.

4.1.13 Orphan Care Programme

In 1993, a National Programme of Action for the Children of Botswana identified AIDS orphans and HIV positive children as a target group requiring particular public attention. Subsequently, a Short Term Plan of Action (STPA) identified the immediate needs of orphans and articulated a national response. In this connection, the aforementioned Acts are currently being reviewed to accommodate the specific needs of HIV/AIDS orphans. In 2002, the total number of orphans registered with the government is 37,850. All registered orphans are provided with a food basket which is worth 216 pula. When the orphan reaches school going age, the government also provides with support needs such as school uniforms, shoes and some stationary. The Government's total budget for its Orphan Care programme is US 13 million for 2002.

Box 4: Impact alleviation at a glance

2:7 orphaned to non-orphaned children 10-14 years of age who are currently attending school

Source: Botswana AIDS Impact Survey (BAIS – 2001)


Fig 11. Knowledge of HIV/AIDS among men and women: Percentage with correct responses on all five knowledge questions

The knowledge required to inform positive behaviour is still very low in the country. The knowledge level of 15-49years seems not statistically different from those ages 15-24years. The level of misconceptions in the society with respects to HIV/AIDS is still very high among different age groups.

Fig 12. Percent of respondents who had 1 or multiple partners the last year of those who had sex

Those with multiple sexual partners are relatively very low but still important enough to turn around the epidemic negatively. This is also supported by the findings as follows:
4.0 NATIONAL PROGRAMMES AND BEHAVIOUR CHANGE

Fig 13. Condom use at last act with a non-marital non-cohabiting partner by age group, BAIS 2001

The condom use level among different age groups is very impressive in the country.

Fig 14. HIV prevalence by condom use and gender, Tebelopele VCT first attenders, 2000-2002, Botswana

The positive results of condom use among clients of VCT centers is as shown. The positive correlation is currently being used in the development of messages in the country.

Fig 15. Number of sexual in the last 12 months

The HIV prevalence over the last few years appear to be stabilized. This picture may not be unconnected with the positive behavioral patterns seen.

BEHAVIOUR DURING AND AFTER STD

Fig 16. Causes of Genital Ulcer Disease in Botswana

STI prevalence among sexually active women seems to be on the decline except for Chlamydia Trachomatis that is still on the increase.
5.0 Major Challenges Faced and Actions Needed to achieve the Goals/targets

The challenges encountered by Government sectors include: Inadequate re-programming HIV/AIDS activities according to structural changes and reforms. Inadequate human resources; inadequate training; competing priorities between HIV/AIDS activities and main sectoral responsibilities of staff; lengthy and tedious government funding process which results in delays in implementation; issue of stigma and confidentiality still not addressed adequately; inadequate linkages between central and districts especially in coordinating HIV/AIDS activities within Ministries.

Others include: inadequate capacity and resources to scale up interventions; high attrition rate among trained staff; Changing pattern of STIs with increase in viral STIs; inadequacy of ongoing and supportive counselling; inadequate of integration of VCTs into the health system; inadequate national policy on counselling; insufficient involvement of men in PMTCT; expansion and sustainability of ARV programmes;

Blood transfusion programmes overburdened with additional diagnostic support; inadequate support for blood donor services; inadequate systematic behavior change sentinel surveillance system.

However, the major challenges that require immediate actions are as stated below:

5.1 National Coordination

Co-ordination and Funding
- Strengthening the linkages and co-ordination between the central and the district levels
- Managing the competing priorities between HIV/AIDS activities and the "core business" of sectors
- Clarifying of role and responsibilities of stakeholders
- Improving the lengthy and tedious funding process

- Non existence of a formalized forum for sectoral HIV/AIDS Coordinators to share experiences

Human Resources
- Appropriate Human Resource Planning
- Recruitment of qualified staff with the appropriate skill mix
- Improving the procedures required to recruit staff
- Decreasing the high attrition of staff, especially trained staff
- Improving the capacity for training staff

Stigma and Confidentiality
- Decreasing Stigma.
- Increasing the uptake of VCT services.
- Increasing the involvement of men in HIV/AIDS programmes such as the PMTCT programme.

Programming
- Integration and mainstreaming of HIV/AIDS programmes into Health Services
- Strengthening Monitoring and Evaluation to inform program design and to identify programmes appropriate for scaling up.

5.2 Programme implementation Challenges

- Shortage of manpower at all levels (national, district and facility) remains the major constraint to the successful implementation of the program.
- The staffing at national level is insufficient for proper monitoring of program implementation in the districts and appropriate technical support to the implementing districts.
- At facility level, more counsellors are needed in order to ensure that every woman visiting the health facilities have access to quality PMTCT counselling in order to enable her to make informed decisions about joining the program.
- Stigma and discrimination are a major cha-
5.0 Major Challenges Faced and Actions Needed to achieve the Goals/targets

The main challenges faced are:

- Inadequate coordination among development partners, donor agencies as well as National counterparts;
- Inadequate of clarity among stakeholders on roles and responsibilities;
- Duplication of efforts;
- Inadequate of local capacity to implement certain specialized programme areas such as programmes on youths;
- Poor absorptive capacity of resources provided leading to slow disbursement of funds due to bureaucratic procedures;
- Inadequate ASRH/HIV/AIDS interventions for the 10-14 year olds

5.4 Challenges faced by the Civil Society Response

Challenges identified by the Civil Society Organizations are:

- Inadequate human resources for programmes implementation.
- Inadequate funding for non-programmes and operational activities.
- Inadequate support for supplies and equipment.
- Inadequate sustainability of programmes funded by donors agencies at the end of the funding period.
- Difficulty in accessing funds as a result of bottle necks created by development partners;
- NGOs lack capacity and support to decentralize programmes to rural areas.
- The spirit of volunteerism is not coordinated to support NGO’s needs for support in programmes.

5.5 Action needed achieved to overcome challenges

1. The Government of Botswana is about to implement the National Development Plan 9 (NDP9). This is expected to strengthen the institutional capacity.

2. The full scale implementation of the national strategic frame work is expected to mobilize more resources to all stakeholders.

3. The BHRIMS National Monitoring and Evaluation Training Programme is also expected to develop M&E capacity for all programme in the country and sectors.

4. The NDP9, NSF and the BHRIMS projects will minimise the current existing challenges.
6.0 National Data Collection Plan

Through the BHRIMS department of the National AIDS Coordinating Agency (NACA) in collaboration with development partners and research institutions conduct the following studies as outlined in the data collection plan for 2003, 2004 and 2005:

A lot of technical expertise and financial resources will be required to implement the scheduled data collection plan below:

<table>
<thead>
<tr>
<th>Table 4: Data Collection Plan</th>
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<tr>
<td><strong>Data collection plan (2005 reporting)</strong></td>
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<tr>
<td>Household surveys</td>
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<td>Health facility surveys</td>
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<td>School-based surveys</td>
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<td>Workplace surveys</td>
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<tr>
<td>Desk review</td>
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<td>Annual review of National response</td>
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</table>

7.0 Support required from country’s development partners

The Government of Botswana will highly appreciate the support of development partners in the following areas:

1. Support the development of human Resource Plan for the country
2. Support the review of National Policy
3. Support the operationalization of the Botswana HIV Response Information management system
4. Support the review of the status of the National Multisectoral Response
5. Facilitate the implementation of the data collection plan
6. Support process to clarify the roles and Responsibility of the coordinating institutions in the national response
7. Support Harmonize the input of development partners in the national Response
8. Sustain NGO activities at the community levels
The response of Government and other stakeholders to contain the HIV/AIDS epidemic has been intense and several intervention programmes have been put in place. Many reports have been and continue to be generated about the Botswana Response to the epidemic and different types of data flows routinely within the system. The generation of all this information has however been uncoordinated and unsystematic. Furthermore, indicators and data collection methods have not been standardized.

The need for the establishment of a Monitoring and Evaluation System to gain better understanding of HIV/AIDS interventions in the country, generate adequate information on the response, and improve the utilization of generated information for programme planning, policy formulation and appropriate allocation of available resources is therefore imperative. The Botswana HIV Response Information Management System (BHRIMS) is the vehicle to monitor and evaluate the implementation of the National response through the National Strategic Plan (2003-2009).

BHRIMS is developing a sustainable national multi-level monitoring and evaluation infrastructure, using a multi-sectoral approach that will provide the most efficient, high quality, standardized, relevant and timely information about the National response through the implementation of the National Strategic Plan. It is also aimed at ensuring an accountability, accurate and timely data collection for appropriate policy formulation, review and program improvement and to direct resources to the most vulnerable groups in the country.

The objectives of BHRIMS are:
- To build National Monitoring and Evaluation Institutional Capacity
- To monitor the implementation of the National strategic Plan
- To evaluate the implementation of the National strategic Plan
- To monitor and evaluate the BHRIMS

The expected outcomes are the following:
- Ensure the generation of high quality, timely and relevant information on the National Response
- Improve the culture of information accessibility, sharing and utilization
- Generate information to influence policy decisions, programme review and development
- Use the lessons learnt from the implementation of the National strategic plan (2003-2009) and BHRIMS for future strategic planning.

1. Institutional Capacity Building on monitoring and evaluation

In order to successfully implement BHRIMS, the needed institutional infrastructure will be built at the National and district levels. Also a National Monitoring and Evaluation Training Programme will be developed to build the human resource capabilities to sustain the national system. The Monitoring and evaluation institutional capacity building strategy will involve the following:

- **Human resources recruitment:** Recruitment of relevant M&E personnel.
- **Development of M&E human resources:** Conducting of training needs assessment on monitoring and evaluation, development of training modules, training of trainers and phased in training of field officers locally and internationally over the period of the National strategic plan.
- **Infrastructure development:** Development of the BHRIMS secretariat at NACA, BHRIMS units at designated sectors and all districts and projects as well as among development partners.
- **Informatics development:** Conduct initial informatics needs assessment at the national, Sectoral and district levels in order to ascertain the data solution needs for the development of informatics in the country.
8. Monitoring and evaluation environment: Botswana HIV Response Information Management System (BHRIMS)

2. Monitoring of the National Response guided by the implementation of the National Strategic Framework

The National monitoring system will be done on quarterly basis for programme implementation at the National and districts levels and programme impact monitoring on annual basis for annual sentinel surveillance and biennially for the behavioral surveillance system. This is divided into Programme management monitoring and Programme impact monitoring:

- **Programme management monitoring**
  - Development of National BHRIMS Plan and Policy
  - Development of national core and programme indicators
  - Generation of baseline information on the indicators
  - Development and piloting of the summary data collection tools
  - Quarterly data collection, collation, analysis and reporting
  - Quarterly feedback on the report
  - Development of an HIV/AIDS financial monitoring system
  - Implementing of a HIV/AIDS financial monitoring system

- **Programme impact monitoring**
  - Bio-medical Surveillance: ANC HIV Sero-prevalence survey, STI prevalence survey, AIDS Case monitoring, HIV incidence studies
  - Behavioural Surveillance Survey
  - Coordination of Basic & operational research
  - Sharing of experiences local, regional and international
  - Mortality data
  - Annual HIV research forum


HIV/AIDS Information management system will be developed at the National, Sectors and district in order to improve accessibility, tracking of best practices and utilization of the generated information for policy formulation. This will also involve streamlining the National data flow and pathway system, minimize duplication of data reporting forms and overburdening of the data producers. All levels will be empowered to utilize information generated for action.

All districts, sectors, programmes and projects will use the BHRIMS secretariat as the repository of all HIV/AIDS/STI data in the country. All programme data generated must be collated centrally at the district level and transferred on monthly basis for further collation centrally. All sectoral data inclusive of the local government data must be transferred on monthly basis to the BHRIMS secretariat at NACA for further analysis, policy interpretation and utilization.

4. Evaluation of the National Response guided by the implementation of the National Strategic Framework

Formative evaluation of the national response will be done as annual review of the implementation of the operational plan of action. These findings will be used to inform on the priority areas of the subsequent year. At the end of three years (2005) a mid-term evaluation of the National Response will be conducted to assess the effectiveness of the National Strategic Framework. This evaluation, or audit, will compare the data collected over the period against National Strategic Framework in order to review the achievement of goals and objectives as well as the prescribed and implemented interventions. Also to be evaluated will be client satisfaction with the quality of service provision.

5. Monitoring and evaluation of the BHRIMS

BHRIMS will also be strictly monitored to ensure that it serves its purpose of development. The monitoring will involve biannual audit of the data collection, quality and data management system, biannual audit of the information dissemination and feedback, Evaluation of information utilization for policy and programme development, mid term and terminal evaluation of BHRIMS.
Preparation/consultation process for the National Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible in filling out the indicators forms?

   a) NAC or equivalent          Yes
   b) NAP                        Yes
   c) Others                     Yes
      Central Statistics Office

2) With inputs from:

Ministries:
   Education                    Yes
   Health                       Yes
   Labour                       Yes
   Foreign Affairs              No
   Others                       Yes
      Central Statistics Office

Civil society organizations    Yes
People living with HIV/AIDS    Yes
Private sector                 Yes
UN organizations               Yes
Bilaterals                     Yes
International NGOs             Yes
Others                         Yes
All members of the National AIDS Council

3) Was the report discussed in a large forum? Yes
   At National AIDS Council, National Partnership Forum, Technical Levels respectively

4) Are the survey results stored centrally? No
   It was a desk review and the data is stored centrally in BHRIMS

5) Is data available for public consultation? Yes

Name/Title: Dr K.V Masupu

Date: 24th March, 2003

Signature:
Annex 1

Consultation/Preparation Process for the National Report on Monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

**Policy Environment**
The National AIDS Council chaired by His Excellency, the President, directed the Report writing process. The Council approved the active participation of all the 17 sectors within the council during the data generation and consensus building process. The final report was also endorsed by the council before submission to UNAIDS Geneva. Overall the council met three times to deliberate and finalise the report.

**Coordination of the Reporting Development Process**
The National AIDS Coordinating Agency through its monitoring and evaluation system, BHRIMS, coordinated the process of data collection, consultations and consensus building.

**Recruitment of Consultants**
The National AIDS Coordinating Agency through the financial assistance from ACHAP recruited a consultant to facilitate the process of data collection, collation and reporting writing.

**Reference Group**
Technical Representatives from NACA, UNAIDS, PSI, UNDP, UNICEF, BONASO, MOA who are also member of the BHRIMS technical working were assigned to guide the consultant and act as reference group during the process. The Reference met about four times during the period.

**Technical Working Group**
The BHRIMS Technical Working, which is made up of monitoring and evaluation experts from all sectors, met twice to validate the report.

**National Partnership Forum**
Two national partnership fora were organized to consult and build consensus on the analysed data and the report content prior to endorsement by the National AIDS Council.

**Total Cost**
The total cost of data collection, analysis, report writing, consultations and consensus building meetings on the report was approximately USD$35,000.

**Data Collection Period**
The planning, data collection and analysis, consultation and consensus building was from December-mid March 2003.
Annex 1

List of Contributors

The list of those who actively participated at the different stages of the report writing process are as follows:

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### Annex 1

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<tr>
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<td>- AFA/BBCA</td>
</tr>
<tr>
<td>24</td>
<td>Dr. W. Jimbo</td>
<td>- Public Health Specialist, ASU</td>
</tr>
<tr>
<td>25</td>
<td>Mr. D. Motsatseng</td>
<td>- BONASO</td>
</tr>
<tr>
<td>26</td>
<td>Major General J.G. Tlhokwane</td>
<td>- BDF</td>
</tr>
<tr>
<td>27</td>
<td>Mr. T.E. Tsimako</td>
<td>- Botswana Police</td>
</tr>
<tr>
<td>28</td>
<td>Mr. P.D. Chengeta</td>
<td>- BFTU</td>
</tr>
<tr>
<td>29</td>
<td>Rev. R. Hambira</td>
<td>- BCC</td>
</tr>
<tr>
<td>30</td>
<td>Mr. M. Gaalefswes</td>
<td>- OP</td>
</tr>
<tr>
<td>31</td>
<td>Mrs. L. Dambe</td>
<td>- AG's Chambers</td>
</tr>
<tr>
<td>32</td>
<td>Ms. B. Mguni</td>
<td>- AG's Chambers</td>
</tr>
<tr>
<td>33</td>
<td>Mr. D.C. Ngele</td>
<td>- BONEPWA</td>
</tr>
</tbody>
</table>

**IN ATTENDANCE**

<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
<th>Position/Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>Dr. K. Seipone</td>
<td>- ASU</td>
</tr>
<tr>
<td>35</td>
<td>Mrs. M. Jarvis</td>
<td>- GPH</td>
</tr>
<tr>
<td>36</td>
<td>Ms. N. Motshwane</td>
<td>- HIV/AIDS Coordinator, MFDP</td>
</tr>
<tr>
<td>37</td>
<td>Ms. D.S. Toitoi</td>
<td>- HIV/AIDS Coordinator, MTI</td>
</tr>
<tr>
<td>38</td>
<td>Mr. A.B. Kamanga</td>
<td>- DSR, MLHA</td>
</tr>
<tr>
<td>39</td>
<td>Mrs. M.J. Legwaila</td>
<td>- Women's Affairs, MLHA</td>
</tr>
<tr>
<td>40</td>
<td>Ms. Kojane</td>
<td>- Culture &amp; Youth, MLHA</td>
</tr>
<tr>
<td>41</td>
<td>Ms. T.V. Mosele</td>
<td>- Director Min. Management, MTI</td>
</tr>
<tr>
<td>42</td>
<td>Dr. G.P. Obita</td>
<td>- ACU, MLG</td>
</tr>
<tr>
<td>43</td>
<td>Mr. S.O. Setso</td>
<td>- HIV/AIDS Coordinator, MOA</td>
</tr>
<tr>
<td>44</td>
<td>Mr. R.M. Mukuwa</td>
<td>- Labour, MLHA</td>
</tr>
<tr>
<td>45</td>
<td>Ms. K. Mosienyane</td>
<td>- HIV/AIDS Coordinator, MLHA</td>
</tr>
<tr>
<td>46</td>
<td>Mr. B.D. Leburu</td>
<td>- BONELA/ Monthe Marumo and Co.</td>
</tr>
</tbody>
</table>

**SECRETARIAT**

<table>
<thead>
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<th>Name</th>
<th>Position/Office</th>
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</thead>
<tbody>
<tr>
<td>47</td>
<td>Dr. A.B. Khan</td>
<td>- Coordinator, NACA</td>
</tr>
<tr>
<td>48</td>
<td>Dr. K.V. Masupu</td>
<td>- Epidemiologist, NACA</td>
</tr>
<tr>
<td>49</td>
<td>Dr. M. Gboun</td>
<td>- M &amp; E Officer, NACA/UNAIDS</td>
</tr>
<tr>
<td>50</td>
<td>Mr. A. Whendero</td>
<td>- IEC, NACA</td>
</tr>
<tr>
<td>51</td>
<td>Mrs. M.A. Telayakgosi</td>
<td>- PPM, NACA</td>
</tr>
</tbody>
</table>
## Annex 2

### National Composite Policy Index Questionnaire

#### Strategic plan

<table>
<thead>
<tr>
<th>Question</th>
<th>Comments</th>
<th>Answer</th>
</tr>
</thead>
</table>
| 1. Has your country developed multisectoral strategies to combat HIV/AIDS (Multisectoral strategies should include, but not be limited to, the health, education, labour, and agriculture sectors)? | Comments: National Strategic Framework 2003-2009  
| 3. Does your country have a functional national multisectoral HIV/AIDS management/coordination body (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months)? | Comments: National HIV/AIDS Coordinating Agency (NACA) | Yes    |
| 4. Does your country have a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months)? | Comments: National AIDS Coordinating Agency (NACA) | Yes    |
| 5. Does your country have a functional HIV/AIDS body that assists in the coordination of civil society organizations (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months)? | Comments: NACA, BONASO, BOCCIM | Yes    |
| 6. Has your country evaluated the impact of HIV/AIDS on its socio-economic status for planning purposes? | Comments: Government of Botswana in collaboration with UNDP conducted the Socio-Economic Impact of HIV/AIDS in Botswana in 2000 | Yes    |
| 7. Does your country have a strategy that addresses HIV/AIDS issues among its national uniformed services, including armed forces and civil defense forces? | Comments: Men Sector response made up of Botswana Defence Force, Botswana Police Service, Immigration and Prisons all have policies and strategies. | Yes    |
## Prevention

1. Does your country have a general policy or strategy to promote information, education and communication (IEC) on HIV/AIDS?
   - **Comments:** National IEC Strategy for HIV/AIDS Prevention and Control in Botswana
   - **Yes**

2. Does your country have a policy or strategy promoting reproductive and sexual health education for young people?
   - **Comments:** National Sexual and Reproductive Health Programme Framework
   - **Yes**

3. Does your country have a policy or strategy that promotes IEC and other health interventions for groups with high or increasing rates of HIV infection? (Such groups include, but are not limited to, IDUs, MSM, sex workers, youth, mobile populations and prison inmates.)
   - **Comments:** National IEC Strategy (section on target groups)
   - **Yes**

4. Does your country have a policy or strategy that promotes IEC and other health interventions for cross-border migrants?
   - **Comments:** National IEC Strategy (section on truck drivers, migrant workers)
   - **Yes**

5. Does your country have a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities? (These commodities include, but are not limited to condoms, sterile needles and HIV tests.)
   - **Comments:** National Strategic Framework 2003-2009
   - **Yes**

6. Does your country have a policy or strategy to reduce mother-to-child HIV transmission?
   - **Comments:** National Strategic Framework 2003-2009
   - **Yes**

## Human Rights

1. Does your country have laws and regulations that protect against discrimination people living with HIV/AIDS (such as general non-discrimination provisions and those that focus on schooling, housing, employment, etc.)?
   - **Comments:** Botswana Constitution, Public Service Act and HIV/AIDS Code of Conduct for public servants
   - **Yes**

2. Does your country have laws and regulations that protect against discrimination groups of people identified as being especially vulnerable to HIV/AIDS (i.e., groups such as IDUs, MSM, sex workers, youth, mobile populations, and prison inmates)?
   - **If yes please list groups:** Youth and Women
   - **Comments:** Botswana Constitution, Public Service Act and HIV/AIDS Code of Conduct for public servants
   - **Yes**
### Annex 2

#### 3. Does your country have a policy to ensure equal access for men and women to prevention and care, with emphasis on vulnerable populations?

**Comments:** National Health Policy, National HIV/AIDS Policy  

| Yes |

#### 4. Does your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee?

**Comments:** Public Health Act, National Health Policy, National HIV/AIDS Policy  

| Yes |

### Care and Support

#### 1. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups? (Comprehensive care includes, but is not limited to, VCT, psychosocial care, access to medicines, and home and community-based care.)

**If yes, please list.**  
Groups: Youth, OVC, Women  
Commodities: HAART, Food basket, IPT  

**Comments:** Public Health Act, National Health Policy, National HIV/AIDS Policy, MTP11 (Cabinet Directives on PMTCT, ARV and CHBC)  

| Yes |

#### 2. Does your country have a policy or strategy to ensure or improve access to HIV/AIDS-related medicines, with emphasis on vulnerable groups? (HIV/AIDS-related medicines include antiretroviral and drugs for the prevention and treatment of opportunistic infections and palliative care.)

**If yes, please list.**  
Groups: Youth, OVC, Women  
Commodities: HAART, Food basket, IPT  

**Comments:** Public Health Act, National Health Policy, National HIV/AIDS Policy, MTP11 (Cabinet Directives on PMTCT, ARV and CHBC)  

| Yes |

#### 3. Does your country have a policy or strategy to address the additional needs of orphans and other vulnerable children.

**Comments:** Short Term Plan of Action on Care of Orphans in Botswana 1999  

| Yes |
## Annex 3

### National Return Forms

#### UNGASS Indicators: National Return Form

**Country:** Botswana

#### NPBI-1

**Life-skills-based HIV/AIDS education in schools**

<table>
<thead>
<tr>
<th>Data collection period (day/month/year)</th>
<th>Ministry of Education</th>
<th>Routine School Performance Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1 Jan 2002 to 31 Dec 2002</td>
</tr>
</tbody>
</table>

#### PART I: 

##### Data requirements

<table>
<thead>
<tr>
<th>Urban</th>
<th>Rural</th>
<th>National</th>
<th>Urban</th>
<th>Rural</th>
<th>National</th>
</tr>
</thead>
</table>

#### NUMERATOR

**Instructions:**

i) Select only those schools that provided information (excluding “don’t know”) to all 3 questions (i.e. questions 1 to 3 below).

ii) Line 1: enter the number of schools that stated that they had a teacher trained in the last 5 years to teach life-skills-based HIV/AIDS education.

iii) Line 2: enter the number of schools that answered “yes” to the question in line 1 and who also reported that their trained teachers taught HIV/AIDS education on a regular basis to all classes in the last academic year.

1. School has at least one teacher trained in the last 5 years to teach life-skills-based HIV/AIDS education.

- Public sector schools
- Private sector schools

2. School has staff member(s) trained to teach HIV/AIDS education in the last 5 years who has taught the subject on a regular basis to all classes in the last academic year.

- Public sector schools
- Private sector schools

#### DENOMINATOR

3. Number of schools surveyed

- Public sector schools
- Private sector schools

4. Total number of schools in the country:*

- Public sector schools
- Private sector schools
- Public and private sector schools

#### PART II:

**Indicator computation**

5. Divide the number of schools (public & private) that reported having a staff member trained to teach HIV/AIDS life-skills-based education (line 2) by the total number covered by the survey (line 3) and multiply the result by 100.

**INDICATOR SCORES BY TYPE & LOCATION OF SCHOOL**

6. Calculate the weighted average of the urban and rural indicator scores (line 5) using the number of schools in urban and rural areas (line 4) as the weights.

**INDICATOR SCORES BY TYPE OF SCHOOL (NATIONAL)**

*From Ministry of Education statistics.*
### Annex 3

**UNGASS Indicators: National Return Form**

**Country:** Botswana

#### NPBI-2

**Workplace HIV/AIDS control**

<table>
<thead>
<tr>
<th>Source of data used: name</th>
<th>No survey done so far</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of data used: type</td>
<td></td>
</tr>
<tr>
<td>Date data collected</td>
<td></td>
</tr>
</tbody>
</table>

#### PART I:

**Data requirements**

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### FORMAL SECTOR EMPLOYMENT

1. Formal sector workforce ('000s)
2. Population aged 15-64 years ('000s)

<table>
<thead>
<tr>
<th>Formal sector employment rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

#### PART II:

**Indicator computation**

1. Divide the number of employers with comprehensive workplace policies (line 13) by the total number of employers in the sample (line 14) and multiply the result by 100.

**DENOMINATOR**

<table>
<thead>
<tr>
<th>Number of employers in sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
</tr>
<tr>
<td>25</td>
</tr>
<tr>
<td>30</td>
</tr>
</tbody>
</table>

**INDICATOR SCORES BY EMPLOYMENT SECTOR**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Public sector</th>
<th>Private sector</th>
<th>All employers in sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DATA NOT AVAILABLE
### Annex 3

#### UNGASS Indicators: National Return Form

**Country:** Botswana

**NPBI-3**

**Sexually transmitted infections: comprehensive case management**

<table>
<thead>
<tr>
<th>Data source: name</th>
<th>Observational Health Facility Survey for the evaluation of STD Case Management in Primary Health Care Facilities in Botswana, MOH/WHO, 1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data source: type</td>
<td>Health Facility Survey</td>
</tr>
<tr>
<td>Data collection period</td>
<td>(day/month/year)</td>
</tr>
</tbody>
</table>

#### PART I: Data requirements

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>20+</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>All ages</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>&lt;20</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>20+</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>All ages</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**NUMERATOR**

**Instructions:**

i) Select only those patients for whom provider-client interactions were observed on all 4 aspects

ii) Lines 1-4: enter the number of patients for whom the correct procedures were followed by category of patient (i.e., sex/age group)

iii) Line 5: enter the number of patients for whom the correct procedures were followed on all 4 aspects

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History-taking</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Examination</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Diagnosis &amp; treatment</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Counselling covering partner notification, condom use &amp; HIV testing</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

|                  | N/A   | N/A     | N/A        |
| Number of STI patients for whom correct procedures were followed on all of the above | N/A | N/A | N/A |

**DENOMINATOR**

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Number of respondents for whom provider-client interactions were observed on all of the above 4 aspects (lines 1-4)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
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</table>

**PART II: Indicator computation**

**INDICATOR SCORES BY SEX & AGE GROUP**

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Divide the number of respondents who received correct treatment for all 4 aspects (line 5) by the number whose treatment was observed on all 4 aspects (line 6) and multiply the result by 100.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
## Annex 3

**UNGASS Indicators: National Return Form**

### MTCT: antiretroviral prophylaxis

**Country:** Botswana

<table>
<thead>
<tr>
<th>Source of data used:</th>
<th>MTCT Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>name</td>
<td>Routine Programme Monitoring Data and Surveillance</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Source of data used:</th>
<th>type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Routine Programme Monitoring Data and Surveillance</td>
</tr>
</tbody>
</table>

| Date data collected | (day/month/year) | 1 1 2002 to 30 12 2002 |

### PART I: Data requirements

<table>
<thead>
<tr>
<th></th>
<th>Public sector</th>
<th>Private sector</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NUMERATOR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Number of HIV+ pregnant women provided with ARV therapy to reduce the risk of MTCT in the last month</td>
<td>3651</td>
<td>0</td>
<td>3651</td>
</tr>
</tbody>
</table>

|                     |               |                |       |
| **DENOMINATOR**     |               |                |       |
| 2. Number of women who gave birth in the last 12 months* | 30074 | | |
| 3. HIV prevalence in pregnant women (%)** | 35.4 | | |
| 4. Estimated number of HIV+ pregnant women in the country in the last 12 months | 10647 | | |

To calculate line 4.: multiply line 2 by line 3, and divide the product by 100.

### PART II: Indicator computation

<table>
<thead>
<tr>
<th><strong>INDICATOR SCORES BY HEALTH SECTOR</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Divide the number of HIV+ pregnant women provided with ARV therapy (line 1) by the relevant sector by the number of HIV+ pregnant women in the country (line 4) and multiply the result by 100.</td>
<td>84.2</td>
<td>0</td>
</tr>
</tbody>
</table>

---

* Use national Central Statistics Office estimates of current annual births.

** In most countries, national sentinel surveillance estimates of HIV prevalence among antenatal clinic attendees can be used.

Note: The National Programme data uptake reflects 27% due to data gaps.
# UNGASS Indicators: National Return Form

**Country:** Botswana

## PART I: Males Females Both sexes

### NUMERATOR

1. Number of people receiving ARV therapy at the beginning of the year ('000)
   - Public: NA
   - Private: NA
   - Total: NA

2. Number of people who commenced treatment in the last 12 months ('000)
   - Public: 1.6
   - Private: NA
   - Total: 2.4

3. Number of people receiving ARV therapy at the start of the year who died during the year ('000)
   - Public: 0.08
   - Private: NA
   - Total: 0.12

4. Number of people for whom treatment was discontinued for other reasons ('000)
   - Public: 0.01
   - Private: NA
   - Total: 0.02

5. Number of people receiving ARV therapy at the end of the year ('000)
   - Public: 1.51
   - Private: NA
   - Total: 1.51

### DENOMINATOR

6. Number of people (adults and children) with HIV infection in the total population ('000)*
   - Total: 160

7. Percentage of people with HIV who are at an advanced stage of infection**
   - Total: 15

### INDICATOR SCORES BY SEX & HEALTH SECTOR

8. Number of people with advanced HIV infection ('000)
   - Total: 24

### ART II: Indicator computation

9. Divide the number of people with advanced HIV infection currently receiving ARV therapy (line 5) by the total number with advanced HIV infection (line 8) and multiply the result by 100.

* From national HIV sentinel surveillance estimates.

** Use default estimate of 15% if locally-specific data are not available.
## Annex 3

### NPBI-6

**Injecting drug users: safe injecting and sexual practices**

<table>
<thead>
<tr>
<th>Data source: name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Data source: type</td>
<td></td>
</tr>
<tr>
<td>Data collection period (day/month/year)</td>
<td></td>
</tr>
</tbody>
</table>

### PART I:

#### Data requirements

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All ages</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### NUMERATOR

1. Injected drugs sometime in the last month
2. Injecting drug users in the last month who avoided sharing injecting equipment in the last month
3a. Injecting drug users in the last month who had sexual intercourse in the last month
3b. Injecting drug users in the last month who avoided sharing injecting equipment but had sexual intercourse in the last month
4a. Injecting drug users in the last month who used condoms during the most recent sexual intercourse (in the last month)
4b. Injecting drug users in the last month who never shared injecting equipment and used condoms during the most recent sexual intercourse (in the last month)
5. Avoided sharing injecting drug equipment and used condoms during most recent sexual intercourse in the last month (line 4b)
6. Avoided sharing injecting drug equipment and either avoided having sex or used condoms during most recent sexual intercourse (all in the last month) (line 2 - line 3b + line 4b)

#### DENOMINATOR

7. Numbers of respondents who reported having injected drugs in the last month and having had sex in the last month

### PART II:

#### Indicator computation

8. Divide the number of respondents who reported having avoided shared injecting drug equipment and avoiding having unprotected sex in the last month (line 5) by the total number who reported having injected drugs and having had sex in the last month (line 7) and multiply the result by 100

* This information can be used to calculate the proportion of all recent injecting drug users (i.e., including those who did not have sex in the last month) who avoided all forms of behaviour associated with risk of HIV transmission within the last month. In calculating this proportion, line 1 (rather than line 7) must be used as the denominator.
### UNGASS Indicators: National Return Form

**Country:** Botswana

#### NPBI-7

Young people’s knowledge about HIV prevention

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Data source: type</td>
<td>Household Survey</td>
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<td>Data collection period (day/month/year)</td>
<td>18/1/2001 to 5/3/2001</td>
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</table>

**PART I: Males Females Both sexes**

<table>
<thead>
<tr>
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<th>Urban</th>
<th>Rural</th>
<th>National</th>
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<th>Rural</th>
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</tr>
</thead>
</table>

**NUMERATOR**

Instructions:

1. Select only those respondents who gave answers (including “don’t know”) to all 5 questions
2. Lines 1-5: enter the number of respondents who gave the correct answer by category of respondent (i.e., male-urban, male-rural, etc.)
3. Line 6: enter the number of respondents who gave the correct answers to all 5 questions

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>248</td>
<td>127</td>
<td>295</td>
</tr>
<tr>
<td>2</td>
<td>120</td>
<td>60</td>
<td>180</td>
</tr>
<tr>
<td>3</td>
<td>220</td>
<td>110</td>
<td>330</td>
</tr>
<tr>
<td>4</td>
<td>160</td>
<td>88</td>
<td>248</td>
</tr>
<tr>
<td>5</td>
<td>154</td>
<td>72</td>
<td>226</td>
</tr>
<tr>
<td>6</td>
<td>295</td>
<td>166</td>
<td>461</td>
</tr>
</tbody>
</table>

**DENOMINATOR**

7. Numbers of respondents (aged 15-24) who gave answers (including “don’t know”) to all of the above 5 questions or had never heard of AIDS
8. Percentage of the national population (aged 15-24) who live in urban areas*

**PART II: Indicator computation**

**INDICATOR SCORES BY SEX & RESIDENCE**

9. Divide the number of respondents who gave the correct answers to all 5 questions (line 6) by the number who answered all 5 questions (line 7) and multiply the result by 100.

**INDICATOR SCORES BY SEX (NATIONAL)**

10.i) Calculate the weighted average of the urban and rural indicator scores (line 9) using the percentages who live in urban and rural areas (line 8) as the weights.

*From National Census Office statistics.*
### Annex 3

**UNGASS Indicators: National Return Form**

**Country:** Botswana

#### NPBI-8

**Title:** Young people’s condom use with non-regular partners*

<table>
<thead>
<tr>
<th>Data source: name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Data source: type</td>
<td></td>
</tr>
<tr>
<td>Data collection period (day/month/year)</td>
<td>to</td>
</tr>
</tbody>
</table>

#### PART I: Males Females Both sexes

<table>
<thead>
<tr>
<th>Data requirements</th>
<th>Urban</th>
<th>Rural</th>
<th>National</th>
<th>Urban</th>
<th>Rural</th>
<th>National</th>
<th>Urban</th>
<th>Rural</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NUMERATOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Instructions:**


ii) Select only those respondents (aged 15-24) who gave answers (excluding "don’t know") to all of questions 2 to 5 below

i) Line 2: enter the number of respondents who stated that they had commenced sexual activity

iv) Line 3: enter the number of respondents who stated that they had had any form of sexual relationship in the last 12 months

v) Line 4: enter the number of respondents who stated that they had had a non-regular sexual partner in the last 12 months (NB: a ‘non-regular’ sexual partner here is someone the respondent was not married to and not cohabiting with at the time they had sex)

vi) Line 5: enter the number of respondents who answered “yes” to the question in line 2 and who reported using condom when they last had sex with this non-regular partner

1. Median age at first sex*

2. Commenced sexual activity

3. Sexual partner within the last 12 months*

4. Non-regular sexual partner within the last 12 months*

5. Had a non-regular sexual partner within the last 12 months and used a condom the last time had sex with this partner

#### DENOMINATOR

6. Numbers of respondents (aged 15-24) who reported having had a non-regular sexual partner in the last 12 months (i.e., line 4 above)

7. Percentage of the national population (aged 15-24) who live in urban areas**

#### PART II: Indicator computation

**INDICATOR SCORES BY SEX & RESIDENCE**

8. Divide the number of respondents who reported using condoms with their last non-regular partner (line 5) by the number who reported having had a non-regular sexual partner in the last 12 months (line 6) and multiply the result by 100.

**INDICATOR SCORES BY SEX (NATIONAL)**

9. i) Calculate the weighted average of the urban and rural indicator scores (line 8) using the percentages who live in urban and rural areas (line 7) as the weights.

ii) Take the simple average of the national scores for men and women to get the combined score.

---

* The data collected here also provide the information needed for the first two additional indicators recommended in the UNGASS indicator guidelines

** From National Census Office statistics (as for NPBI-1).
### NPBI-9a

**Orphans’ school attendance (boys)**

#### Data source: name

#### Data source: type

#### Date collection period (day/month/year)

<table>
<thead>
<tr>
<th>Indicator of orphan school attendance</th>
<th>Children in school</th>
<th>Total children</th>
<th>Children in school: % of total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Urban</td>
</tr>
<tr>
<td>URBAN &amp; RURAL COVERAGE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Enter percentages of all urban &amp; rural households in the country that were sampled in the population survey</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NON-ORPHANS’ SCHOOL ATTENDANCE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Non-orphans (both parents alive)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
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<td></td>
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<tr>
<td>14</td>
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<td></td>
<td></td>
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<tr>
<td>10-14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORPHANS’ SCHOOL ATTENDANCE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. All orphans (either parents dead)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>11</td>
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<tr>
<td>10-14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Paternal orphans (only father dead)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>10</td>
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<tr>
<td>10-14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Maternal orphans (only mother dead)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>11</td>
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<td>12</td>
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</tr>
<tr>
<td>10-14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Double orphans (both parents dead)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
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<td>14</td>
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<td></td>
</tr>
<tr>
<td>10-14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INDICATOR SCORES BY RESIDENCE**

7. Divide the rate of school attendance among double orphans (line 6) by the rate for non-orphans (line 2) and multiply the result by 100.

**INDICATOR SCORES ADJUSTED FOR DIFFERENCES IN AGE**

8. Age-standardized ratios

* National rates will be computed by adjusting for any differences in the coverage of urban and rural households in the survey (i.e., using the information given in line 1) and in numbers of orphaned and non-orphaned children per household in urban and rural areas. The numbers of double orphans (line 6) should equal the number of all orphans (line 3) minus the number of paternal (line 4) and maternal (line 5) orphans.

---

### UNGASS Indicators: National Return Form

**Country:** Botswana

#### Orphans’ school attendance (girls)

<table>
<thead>
<tr>
<th>Data source: name</th>
<th>Data source: type</th>
<th>Date collection period (day/month/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>npbi-9b</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Indicator of orphan school attendance

<table>
<thead>
<tr>
<th>Children in school</th>
<th>Total children</th>
<th>Children in school: % of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>Rural</td>
<td>Urban</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urban %</td>
</tr>
</tbody>
</table>

#### URBAN & RURAL COVERAGE

1. Enter percentages of all urban & rural households in the country that were sampled in the population survey.

#### NON-ORPHANS’ SCHOOL ATTENDANCE

2. Non-orphans (both parents alive)

<table>
<thead>
<tr>
<th>Ages</th>
<th>10</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>10-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### ORPHANS’ SCHOOL ATTENDANCE

3. All orphans (either parents dead)

<table>
<thead>
<tr>
<th>Ages</th>
<th>10</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>10-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Paternal orphans (only father dead)

<table>
<thead>
<tr>
<th>Ages</th>
<th>10</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>10-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Maternal orphans (only mother dead)

<table>
<thead>
<tr>
<th>Ages</th>
<th>10</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>10-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Double orphans (both parents dead)

<table>
<thead>
<tr>
<th>Ages</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>10-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### INDICATOR SCORES BY RESIDENCE*

7. Divide the rate of school attendance among double orphans (line 6) by the rate for non-orphans (line 2) and multiply the result by 100.

#### INDICATOR SCORES ADJUSTED FOR DIFFERENCES IN AGE*

8. Age-standardized ratios

* National rates will be computed by adjusting for any differences in the coverage of urban and rural households in the survey (i.e., using the information given in line 1) and in numbers of orphaned and non-orphaned children per household in urban and rural areas. The numbers of double orphans (line 6) should equal the number of all orphans (line 3) minus the numbers of paternal (line 4) and maternal (line 5) orphans.
### Annex 3

**UNGASS Indicators: National Return Form**

**Country:** Botswana

#### II-1a

**Reduction in HIV prevalence**

<table>
<thead>
<tr>
<th>Data source: name</th>
<th>Sentinel Surveillance among pregnant women 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data source: type</td>
<td>Botswana national data</td>
</tr>
<tr>
<td>Data collection period</td>
<td>1 Jul 2002 to 20 Sep 2002</td>
</tr>
</tbody>
</table>

#### PART I:

**Data requirements**

<table>
<thead>
<tr>
<th></th>
<th>Capital city</th>
<th>Other urban areas</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV+ Tested</td>
<td>HIV+ %</td>
<td>HIV+ Tested</td>
<td>HIV+ %</td>
</tr>
<tr>
<td>1. 15-year-olds</td>
<td>0</td>
<td>0.0</td>
<td>15</td>
</tr>
<tr>
<td>2. 16-year-olds</td>
<td>1</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>3. 17-year-olds</td>
<td>2</td>
<td>14.3</td>
<td>16</td>
</tr>
<tr>
<td>4. 18-year-olds</td>
<td>3</td>
<td>13.8</td>
<td>25</td>
</tr>
<tr>
<td>5. 19-year-olds</td>
<td>10</td>
<td>29.2</td>
<td>63</td>
</tr>
<tr>
<td>6. 20-year-olds</td>
<td>8</td>
<td>16.6</td>
<td>25</td>
</tr>
<tr>
<td>7. 21-year-olds</td>
<td>21</td>
<td>35.4</td>
<td>77</td>
</tr>
<tr>
<td>8. 22-year-olds</td>
<td>20</td>
<td>33.3</td>
<td>81</td>
</tr>
<tr>
<td>9. 23-year-olds</td>
<td>25</td>
<td>35.3</td>
<td>103</td>
</tr>
<tr>
<td>10. 24-year-olds</td>
<td>18</td>
<td>36.2</td>
<td>93</td>
</tr>
</tbody>
</table>

11. Percentage of the national population (aged 15-24) who live in capital city, other urban & rural areas

|  | 13 | 33 |

#### PART II:

**Indicator computation**

**INDICATOR SCORES BY URBAN/RURAL RESIDENCE**

| 12. 15-19-year-olds | 15 | 20.3 | 105 | 19.8 | 117 | 58.3 | 26.1 |
| 13. 20-24-year-olds | 92 | 23.1 | 339 | 30.9 | 111 | 47.3 | 51.0 |
| 14. 15-24-year-olds | 107 | 34.4 | 544 | 31.1 | 172 | 27.0 | 42.8 | 34.3 |

* From National Census Office statistics
### Annex 3

**UNGASS Indicators: National Return Form**

**Country:** Botswana

**11-1b Reduction in HIV prevalence**

Complete only those sections that are considered relevant to the country.

<table>
<thead>
<tr>
<th>Data requirements</th>
<th>Data source:</th>
<th>Capital city</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete only those sections that are considered relevant to the country</td>
<td>Name</td>
<td>Type</td>
</tr>
<tr>
<td>1. Female sex workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Clients of female sex workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Injecting drug users</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Men who have sex with men</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Other (specify): _____________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 3

UNGASS Indicators: National Return Form

**Country:** Botswana

### 11-2 Reduction in mother-to-child transmission

**Data source:**
- **Data source: name**
- **Data source: type**
- **Data collection period**

**PART I:**

<table>
<thead>
<tr>
<th>Data requirements</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Proportion of HIV+ pregnant women provided with ARV treatment*</td>
<td>T 0.3</td>
</tr>
<tr>
<td>2. MTCT rate in the absence of any treatment (%)</td>
<td>v 25.0</td>
</tr>
<tr>
<td>3. Efficacy of treatment provided (proportionate reduction in MTCT rate)</td>
<td>e 0.5</td>
</tr>
</tbody>
</table>

List below the 3 most common forms of treatment provided during the last 12 months and the %’s of all treatment that each represents.

<table>
<thead>
<tr>
<th>Form of Treatment Provided</th>
<th>% of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PART II:**

**Indicator computation**

**INDICATOR SCORE**

4. Calculate the indicator score using the formula:

\[ \text{score} = \left( \frac{T 
(1-e) + (1-T)}{T} \right) \times v \]

**Score:** 20.7

* From national programme and behaviour indicator 4.
COUNTRY MONITORING AND EVALUATION SHEET

COUNTRY: Botswana AS OF: March 2003

1. Existence of national M&E plan
   Yes: In progress: Yes:
   Years covered: Years covered:

2. Existence of a national M&E budget
   Yes: Yes In progress: Yes:
   Amount: $20 million Years covered:
   Years covered: 2002-2009

3. Amount secured as of today: $1.2 million

4. Existence of an M&E unit for HIV/AIDS within
   National AIDS Council Ministry of Health Elsewhere:
   Yes No Ministry of Education (TCB), Ministry of local Government, ARV Programme, UNICEF, ACHAP, BOTUSA, PMTCT Programme, VCT programme, TB programme, BOCAIP and Botswana Police

5. M&E focal point on HIV/AIDS within the government
   Name: Dr. K. V. Masupu
   National AIDS Coordinating Agency, Private Bag 00463, Gaborone, Botswana
   Telephone: 3903188
   Email: kmasupu@gov.bw

6. Existence of information systems:

   Health Information System
   National level: No:
   Sub-national*: No:
   * If yes, please specify the level, i.e., district

   Education Information System
   National level: No:
   Sub-national*: No:
   * If yes, please specify the level, i.e., district


3. Situation and Response Analysis for the Urban Youth Project in Botswana

4. Government of Botswana, Ministry of Health (Family Health Division) - 2001


8. Medium Term Plan II for HIV/AIDS (3 Sept 1997)


12. Baseline Study on Knowledge, Attitudes, Behaviours and Practices of Adolescents and Youth on Sexual and Reproductive Health :- UNICEF, AYA Botswana, UNAIDS, PSI

13. Baseline Study for The Community Home Based Care Programme for Terminally ill


16. Facilitator’s manual : HIV/AIDS Counselling in the Workplace :-: Centres for Disease Control and Prevention, Occupational Health Unit / Ministry of Health, BOTUSA Project


Selected bibliography

22. Information handbook HIV/AIDS Counseling in the Workplace -: CDC, Ministry of Health (Occupational Health Unit), BOTUSA Project


24. UNGAS Indicators - NACA, Ministry of State President – 25-27 June 2001


26. The Short Term Plan of Action on Care of Orphans in Botswana: Ministry of Local Government Lands and Housing / Social Welfare Division

27. HIV/AIDS Policy Guidelines: Ministry of Trade, Industry, Wildlife & Tourism (Sep 2001)


31. Telling The Story: Southern Sub-Saharan Africa UNAIDS project funded by the UN Foundation. UNAIDS 02/09/2003

32. Response to HIV/AIDS/STI Prevention, Care and Support: Health Sector Plan (draft); April 2003 – March 2005, Ministry of Health Secretariat Oct 31, 2002


38. National Sexual and Reproductive Health Programme Framework -: Ministry of Health
