

Republic of Botswana



Ministry of State President National AIDS Coordinating Agency

2008 Progress Report of the National Response to the UNGASS Declaration of Commitment on HIV/AIDS

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List of Acronyms

1. ACHAP	African Comprehensive HIV/AIDS Partnership
2. AIDS	Acquired Immune Deficiency Syndrome
3. ARV	Antiretroviral
4. ART	Antiretroviral therapy
5. BBKA	Botswana Business Coalition on AIDS
6. BCIC	Behavioural Change Intervention Communication
7. BHP	Botswana Harvard Project
8. BHRIMS	Botswana HIV/AIDS Response Information Management System
9. BONASO	Botswana Network of AIDS Service Organizations
10. BONELA	Botswana Network on Ethics, Law and 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. DMSAC	District Multi-Sectoral AIDS Committee
16. FBO	Faith-based Organisation
17. HAART	Highly Active Antiretroviral Therapy
18. HIV	Human Immunodeficiency Virus
19. IEC	Information, Education and Communication
20. M&E	Monitoring and Evaluation
21. MOH	Ministry of Health
22. MOE	Ministry of Education
23. MLG	Ministry of Local Government
24. NAC	National AIDS Council
25. NACA	National AIDS Coordinating Agency
26. NGO	Non-Governmental Organization
27. NSF	National Strategic Framework
28. OVC	Orphans and Vulnerable Children
29. PLWHA	People Living With HIV/AIDS
30. PMTCT	Prevention of Mother to Child Transmission
31. STI	Sexually Transmitted Infection
32. STPA	Short Term Plan of Action
33. UNAIDS	Joint United Nations Programme on HIV/AIDS
34. UNDP	United Nations Development Programme
35. UNGASS	United Nations General Assembly Special Session
36. UNHCR	United Nations High Commission for Refugees
37. UNICEF	United Nations Children's Fund
38. USA	United States of America
39. UNFPA	United Nations Population Fund
40. VCT	Voluntary Counseling and Testing
41. WHO	World Health Organization

Foreword

The HIV/ AIDS epidemic continues to exert untold misery on Botswana's well being despite our multi-sectoral, multi-level response efforts. For over twenty years we have witnessed persistent erosion of national development efforts on many fronts, leaving behind heightened dependency rates, increased demand for both institutional and home-based care for the sick, and emotionally depressed citizens as families lose parents, guardians, breadwinners and children. This does not augur well for national social welfare, and it is against this background that Botswana renews its commitment to the Declaration of Commitment on HIV/AIDS. We recognize the need to reverse the epidemic in all its spheres of impact - there is no room for complacency.

Our national HIV/AIDS response remains steadfast and unrelenting towards the mitigation and, finally, eradication of this disease. Encouraging signs are evidenced by reduction in prevalence rates, especially amongst the younger age groups since 2003. Further, since the last UNGASS report we have continued our drive towards universal access to treatment, care and support. Coverage rates for both ART and PMTCT now exceed 80% and are amongst the highest in the world. Deaths have been reduced considerably as various sectors of our response work tirelessly to implement nationally prioritized interventions. Development partners have heeded our call to cushion high levels of programme expenditure in the areas of treatment, care and support, giving us hope to sustain these critical programmes far beyond what we could have achieved on our own.

We expect to add impetus to these inspiring signs in the foreseeable future with our revived focus on prevention, as reflected in the National Operational Plan for Scaling Up HIV Prevention in Botswana, finalized in December 2008. Botswana believes, like the rest of the world that the battle against HIV/AIDS will be won on the prevention front.

With so much collaboration between various sectors of our national response there is no doubt that together we will achieve our goal of "no new infections by 2016".

B.C. Molomo
National Coordinator
National AIDS Coordinating Agency

2.0 Status at a Glance in 2007

2.1 The 2008 UNGASS report-writing process

To undertake the development of this report, an UNGASS Task Force was convened to lead the process, made up of staff of the Botswana National AIDS Coordinating Agency (NACA) and other key stakeholders. The Monitoring and Evaluation (M&E) Advisor to NACA coordinated the overall UNGASS report-writing process.

Two consultants were commissioned to coordinate the generation of the 2007 Botswana UNGASS progress report including the facilitation of stakeholder workshops and other consultative processes. A third consultant was commissioned through the Technical Support Facility Southern Africa/UNAIDS (TSF) to provide quality assurance.

Technical Working Groups (TWGs) that were used in the last UNGASS report preparations were revived for the present report. A 'kick-start' workshop was held on the 19th November 2007 where each group was assigned a focus area and tasked to collect data as well as write sections of the report pertinent to their area.

The primary consultants synthesized data and section writings of each TWG. A national consensus workshop held on 11 December 2007 enabled a wide range of partners to review each section of the report and provide feedback and additional information that was outstanding. The consultants then incorporated all comments and additional data into the final draft which was submitted to NACA in early January 2008 for approval and subsequent submission to UNAIDS.

2.2 Status of the Epidemic

Botswana's Sentinel Surveillance surveys indicate that HIV prevalence has significantly declined, from 37.4% in 2003 to 32.4% in 2006. Also encouraging are notable declines in HIV prevalence among 15-19 and 20-24 year age groups.

The 2004 Botswana AIDS Impact Survey (BAIS II), which recorded HIV prevalence among the general population, showed an estimated HIV prevalence of 17.1%. BAIS III is scheduled to take place in 2008 and the results are expected to confirm the downward trend suggested by Sentinel Surveillance.

2.3 Botswana's Policy and Programmatic Response

Botswana's response to the epidemic began in 1987, about two years after the first AIDS case was diagnosed in the country. In response, a multi-sectoral, participatory approach was implemented in 1997 and has been on-going ever since.

In this report, progress on the national response has focused on a review of the National AIDS Policy, Mid-Term Review of the National Strategic Framework 2003-2009, and an

increase in resources allocated to national programmes and the implementation of the “Three Ones”.

2.4 UNGASS Indicator table

The UNGASS indicator overview follows in Table 2.1. Data from the 2003 and 2005 UNGASS reports have been included to show trends wherever possible (highlighted in light grey). However, as can be noted from the table, many changes have been made to the 2003 and/or 2005 indicators, thus limiting the comprehensiveness of trend analysis of some indicators over the past three reporting periods.

Table 1: UNGASS Indicator Data, Botswana 2003, 2005 and 2007

Indicator	2003	2005	2007
National Commitment and Action			
1. Domestic and international spending by categories and financing sources (US\$ Million) ¹	69.8	165.0	148.6
2. National composite Index	Annex	Annex	See Annex 2
National Programmes: Prevention			
3. % of donated blood units screened for HIV in a quality assured manner	100.0	100.0	100.0
4. % of adults and children with advanced HIV infection receiving antiretroviral therapy ²	7.3 ⁵	62.7 ⁵	83.4 ⁵
5. % of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	34.3 ⁶	60.3 ⁶	91.0 ⁶
6. % of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Not required	Not required	Data n/a
7. % of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Not required	Not required	Data n/a
8. % of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	Data n/a	Data n/a	Data n/a
9. % of most-at-risk populations reached with HIV prevention programmes	Data n/a	Data n/a	Data n/a
10. % of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	3.3 ⁷	34.3 ⁷	No new data
11. % of schools that provided life skills-based HIV education in the last academic year	100.0	100.0	100.0
National Programmes: Knowledge and behaviour			
12. Current school attendance among orphans and among non-orphans aged 10-14	Not required	Not required	Data n/a
13. % of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention	36.3 ⁷	37.6 ⁷	No new data
14. % of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention	Not required	Not required	Data n/a
15. % of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Not required	7.0 ⁷	Data n/a
16. % of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Not required	Not required	Data n/a
17. % of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months reporting the use of a condom during last sexual intercourse	Not required	Not required	Data n/a
18. % of female and male sex workers reporting the use of a condom with their most recent client	Not required	Not required	Data n/a
19. % of men reporting the use of a condom the last time they had anal sex with a male partner	Not required	Not required	Data n/a
20. % of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Not required	Not required	Data n/a
21. % of injecting drug users reporting the use of sterile injecting equipment the	Not required	Not required	Data n/a

last time they injected			
National Programmes: Impact			
22. % of young women and men 15-24 years of age who are HIV infected	Not required	13.0 ⁷	No new data
23. % of most-at-risk populations who are HIV infected	Not required	Not required	Data n/a
24. % of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy ³	Not required	92 ⁵	84.9 ⁵
25. % of infants born to HIV infected mothers who are infected	20.7 ⁶	11.5 ⁶	4.8 ⁶

Sources: See Annex 4

Notes:

1. In 2003 and 2005 this indicator read "Governments funds spent on HIV and AIDS"
2. In 2003 and 2005 this indicator did not include children
3. Indicator 24 noted 84.9% and was calculated according to the relevant UNGASS indicator definitions. However, a Kaplan-Meier survival analysis was conducted using patient-level data obtained from hospitals throughout the country. The 1-year survival estimate thus calculated was 94.1% with females having a relatively better survival than males. Those who initiated treatment with a baseline CD4 count of between 100 – 200 cells / ml had a better survival rate than those with a baseline CD4 count of < 100 (P<0.05). A Cox analysis identified baseline CD4 count and the interaction between baseline CD4 count and sex as important risk factors for patient survival.
4. Data for indicators 8, 9, 18-21 and 23 are not available.
5. Indicators 4 and 24 were calculated from ARV programme data in 2003, 2005 and 2007. The denominator for 2007 is 113 000 as produced in a recent projections workshop
6. Indicators 5 and 25 were calculated from PMTCT programme data in 2003, 2005 and 2007.
7. Indicators 10, 13, 15 and 22 were calculated from BAIS I and BAIS II in 2003 and 2005 respectively
8. Indicator 11 was calculated from Education Programme Review data (MOE).

3.0 Overview of the AIDS Epidemic

3.1 Background

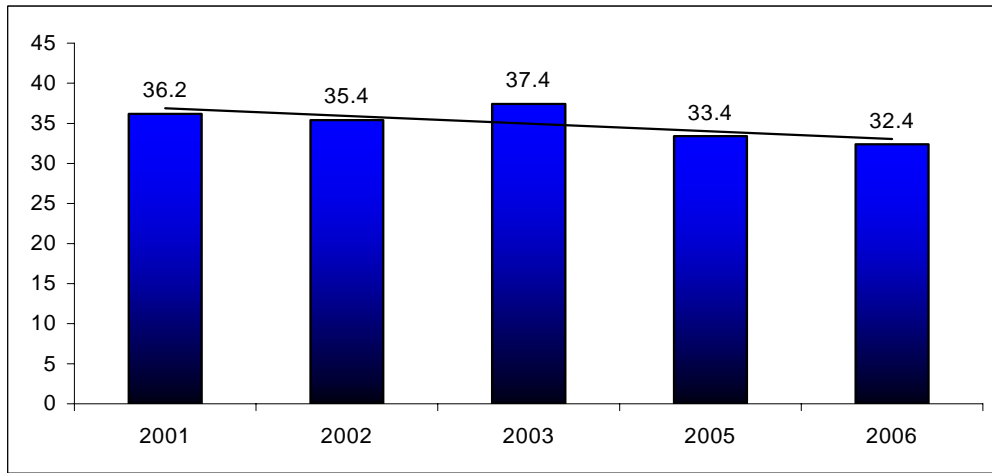
According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) *AIDS Epidemic Update* of December 2007 an estimated 33.2 million people are living with HIV globally. The bulk of the epidemic is in Sub-Saharan Africa where about 22.5 million adults and children are living with the virus. An estimated 1.7 million people were infected during that year. The scale and trends of the epidemic in the region vary considerably, with Southern Africa most seriously affected. This sub-region accounted for 35% of all people living with HIV and almost one third (32%) of all new HIV infections and AIDS deaths globally in 2007. In 2005, national adult HIV prevalence exceeded 15% in eight countries of the sub-region (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe).

3.2 Status of the Epidemic in Botswana

The Government of Botswana has commissioned the implementation of periodic nationally representative behavioural surveys known as Botswana AIDS Impact Surveys (BAIS). Two such surveys have been conducted, one in 2001 and another in 2004 and their results were reported in the 2003 and 2005 UNGASS progress reports, respectively. Preparations are currently on-going for the third survey which will be conducted in 2008. Based on the results of the 2004 survey, the national HIV prevalence in the country was estimated at 17.1%. Preliminary country estimates indicate that approximately 113 000 people had advanced HIV infection in Botswana in 2007. 91 780 persons (81.2%) were on treatment as of 30th November 2007. This included 74 273 patients in the public sector, 7 993 patients out-sourced to the private sector and 9 514 were enrolled directly in the private sector.

Given the importance of HIV/AIDS surveillance in establishing trends in HIV prevalence as well as in providing useful information for developing policy and programmes, Botswana also conducts annual HIV/AIDS surveillance among pregnant women aged 15-49 years. When it was first instituted in 1992, surveillance focused only on the collection of data to determine the magnitude and trends of the epidemic for resource mobilization and for policy development. However, as the epidemic spread it became necessary to review this strategy to include behavioural data in order to understand the dynamics of the epidemic. The Second Generation Sentinel Surveillance was therefore introduced in 2001. Results from the 2006 surveillance show that HIV prevalence among pregnant women aged 15-49 years had dropped from 33.4% in 2005 and 32.4% in 2006 (Figure 1).

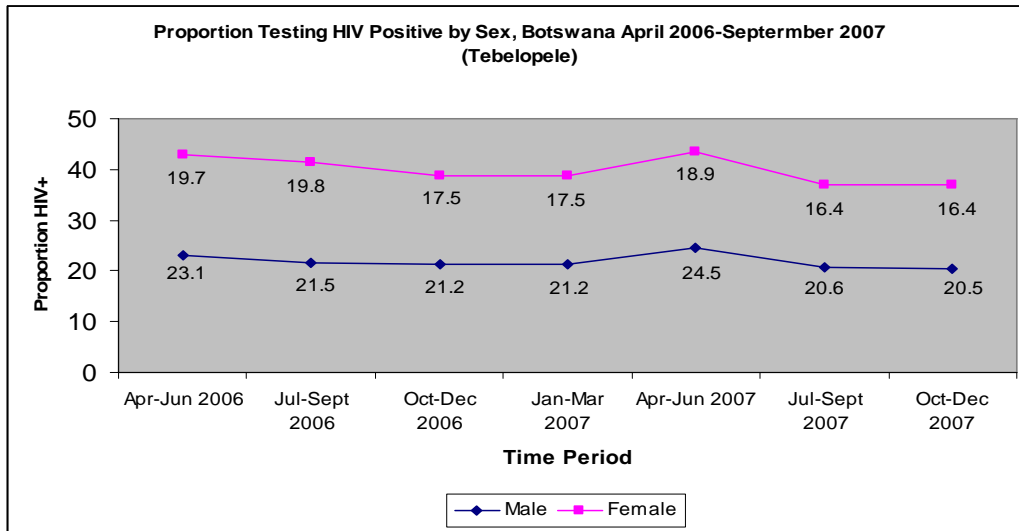
Figure 1: HIV prevalence among pregnant women, Botswana 2006



Source: 2006 Sentinel Surveillance Report

Data from Tebelopele (an NGO providing free VCT services through a network of 16 centres across the country) also shows that while HIV prevalence continues to be higher among women than men, with an average of approximately 4 percentage points difference, prevalence rates have generally decreased in the recent months (Figure 2).

Figure 2: Proportion Testing HIV-positive by sex, Botswana, January 2005- September 2007

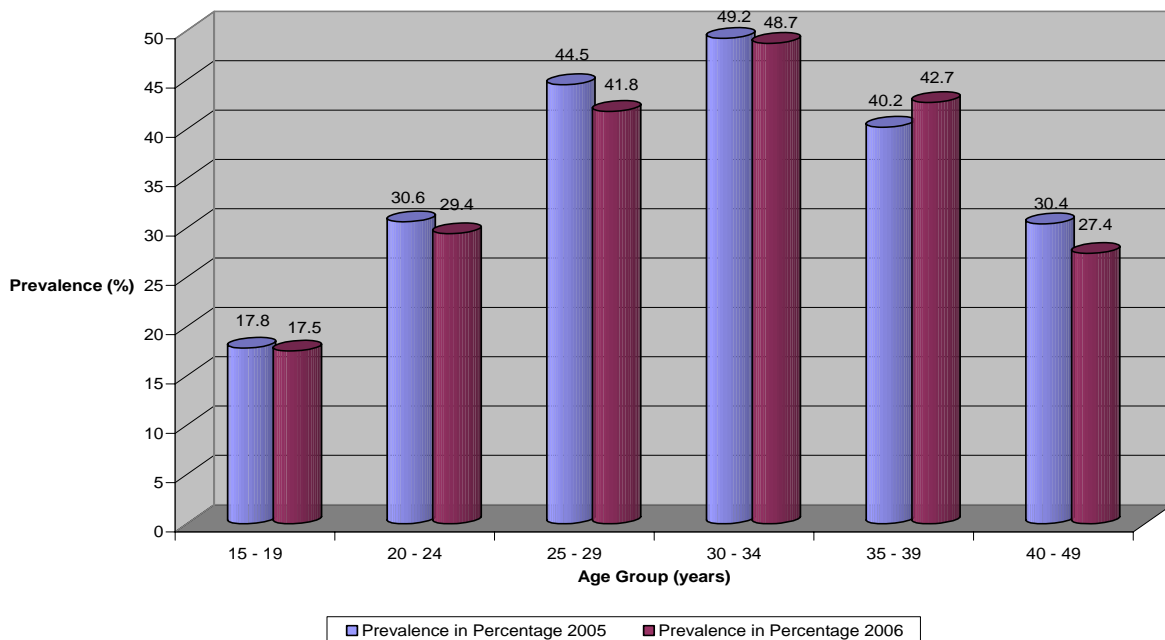


Source: Tebelopele data in the NACA report to the National AIDS Council for the period July-September 2007

HIV Prevalence by Age

Data from the 2005 and 2006 Sentinel Surveillance show a modest HIV prevalence decline in all age groups except 35-39 years (Figure 3). The most notable drop was among 40-49 year olds from 30.4% to 27.4% in 2005 and 2006 respectively, while the least was among 15-19 year olds (17.8% to 17.5%). HIV prevalence increased from 40.2% to 42.7% among the 35-39 year olds.

Figure 3: Adjusted age-specific HIV prevalence among pregnant women by age group, Botswana 2005 and 2006



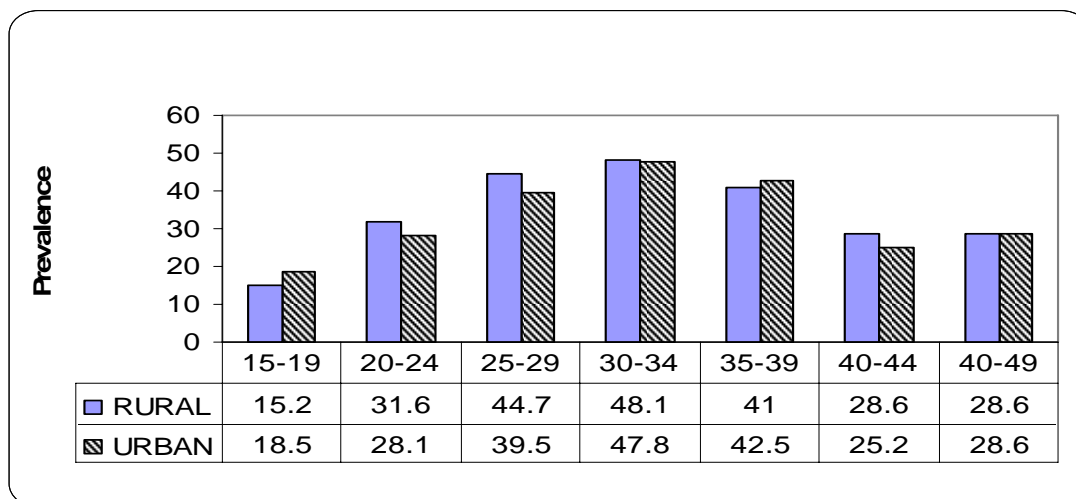
Source: 2005 and 2006 Sentinel Surveillance Report

Prevalence by District and Place of Residence

Results of the 2006 Sentinel Surveillance survey show that HIV prevalence differs widely by geographical location. According to the results, the adjusted HIV prevalence rate (which takes into account the total population of women in the reproductive age group of 15-49 years regardless of pregnancy status) in the country is 32.4%. Chobe District had the highest rate of 42% whereas Kgalagadi had the lowest at 19.1%. In general, HIV prevalence is still highest in the northern and eastern parts of the country (35.4% in Ngami, 41.1% in Selebi-Phikwe and 42% in Chobe). Health districts in Botswana are shown in Annex 4.

In terms of rural/urban residence, HIV prevalence among pregnant women who were tested in rural and urban health facilities was almost the same (34.6% and 33.9% respectively). Figure 2.3 below shows the rural/urban prevalence rates by age group in 2006.

Figure 4: Prevalence among pregnant women by location of health facilities, Botswana, 2006



Source: 2006 Sentinel Surveillance Report

3.3 Impact of the Epidemic

In 2005 the National AIDS Coordinating Agency (NACA) commissioned two studies to examine the impact of HIV and AIDS in Botswana. One study focused on the micro and macro economic impact while the other studied the demographic impact. The *key* findings of these studies are summarised below:

Economic Impact

According to the Economic Impact study report:

- AIDS will have a negative impact on the rate of economic growth in Botswana; if investment is strongly negatively affected, the rate of GDP growth will fall from a projected 4.5% a year without AIDS to an estimated 2.8% under the “AIDS-with-ART” scenario, and after 20 years the economy will be 30% smaller than it would have been without AIDS;
- The impact on the growth of average real incomes (per capita GDP) is also negative, if investment is strongly affected, averaging 1.4% a year under the “AIDS-with-ART” scenario, compared to 2.2% a year without AIDS, and would be 14% lower after 20 years. This results however, contrasts with the results of some other studies, which found that GDP per capita could plausibly rise as a result of HIV/AIDS, on the basis that the reduction in GDP growth could be smaller than the reduction in population growth;
- Due to the sharp drop in investment (and hence weak demand for labour), wages stagnate;
- Without AIDS, underemployment falls from 32% to 24% of the labour force; with AIDS there is no such decline, and underemployment remains at 30% in the with-ART scenario and rises to 35% without ART, as the slower growth of the labour force is offset by the effect of lower investment and slower economic growth;

- The greatest economic impact of HIV and AIDS is from reduced capital stock, which contributes 49% of the fall in growth, with reduced productivity (TFP) growth contributing 31%, reduced supply of skilled labour 14%, and reduced supply of unskilled labour 6%.

Demographic Impact

The report on the Demographic Impact of the epidemic concluded among others that:

- Although the provision of ART and the PMTCT programmes on a national scale has significantly reduced the number of deaths in recent years, this is expected to reverse in the not-so-distant future with the number of deaths again increasing year on year;
- The population of Botswana is expected to continue growing, albeit at a lower rate than in the past;
- As a result of the increase in population and provision of the life-prolonging ART, the number of HIV-infected people in Botswana is expected to continue growing reaching more than 350 000 by 2021
- The numbers of people on ART will also rise over the same period reaching around 124 000 (from the current 91 780) by 2021;
- HIV and AIDS has had a significant impact on the population of Botswana, with its 2021 total projected to be nearly 18% lower than it would have been in the absence of the epidemic, the number of deaths doubling, and the number of orphans increasing more than fourfold.

4.0 National Response to the AIDS Epidemic

4.1 Policy Development and Implementation Status

The Government of Botswana started responding to the HIV epidemic and AIDS as early as 1987, about two years after the first AIDS case was diagnosed in the country. The response began with the establishment of the National AIDS Control Programme and the development of an emergency response plan known as the Short Term Plan. This was followed by a Medium Term Plan I (1989-1993). The National Policy on HIV/AIDS was developed in 1993 and this was followed by the Medium Term Plan II (1997-2002). Unlike its predecessor, the Medium Term Plan II adopted a multi-sectoral and participatory approach, which represented a major policy shift from viewing HIV/AIDS as just a health problem to include developmental dimensions. The Medium Term Plan II was reviewed in 2002 and the results significantly informed the development of the National Strategic Framework for HIV/AIDS (NSF) (2003-2009), by highlighting strengths to build on and weakness to address. The goals of the NSF (2003-2009) are: (1). Prevention of HIV infection, (2). Provision of Care and Support, 3.) Strengthened Management of the National Response to HIV/AIDS, (4). Psycho-social and Economic Impact Mitigation and (5) Provision of a strengthened Legal and Ethical Environment.

During the current reporting period, a number of efforts were made to strengthen the National Response. These include the review of the National AIDS Policy and the Mid-term Review of the National Strategic Framework for HIV/AIDS (2003-2009) undertaken in 2007. The Mid-Term Review of the NSF (2003-2009) was undertaken to “document key themes and emerging issues, and to recommend appropriate action aimed at greater achievement of the National response over the remainder of the plan period” (NACA, 2007:6)

As can be seen in Tables 2 and 3, a brief trend analysis was conducted on the National Composite Policy Index (NCPI) survey results for all years of UNGASS reporting (2003, 2005 and 2007).

The NCPI surveys show that HIV/AIDS strategy development has improved most notably during the 2005-2007 reporting period with recommendation for the National Strategic Framework (NSF) to include most-at-risk groups, especially those that had traditionally been excluded by national interventions. The mid-term review of the NSF raised discussion over the need for the national response to HIV/AIDS to address needs of displaced populations, prisoners, sex workers and MSMs and recommendations were made to that effect. This is a positive development because it is viewed as setting the tone for a possible review of legislation that outlaws practices such as men having sex with men (MSM) and commercial sex thus, improves service delivery to them.

Table 2: NCPI trend analysis, Policy / strategy development and implementation, Botswana 2007

YEAR	GAPS AND SUBSEQUENT IMPROVEMENTS NOTED IN NCPI SURVEYS
Area: Policy / strategy development and implementation	
2003	<ol style="list-style-type: none"> 1. Only general non-discriminatory provision in the constitution 2. Non-discrimination laws for only women and youth 3. General policy to ensure equal access to prevention and care for most-at-risk is implied in the HIV/AIDS policy. It includes women, youth and OVC but does not include sex workers, MSM and prisoners.
2005	<ol style="list-style-type: none"> 1. NSF does not address migration issues 2. Lacking policy for most-at-risk populations, other than work done by NGOs for sex workers
2007	<ol style="list-style-type: none"> 1. Recommendations made for expansion of NSF to address most-at-risk target groups, covering workplace, schools, prisons and cross-cutting issues of poverty, human rights, stigma & discrimination; PLWHA involvement and gender. 2. NSF has an operational plan with goals, budget and an M&E framework. 3. Development partner plans & programmes are aligned with the NSF. 4. Improvement in the use of impact study results on informing socio-economic planning & resource allocation decisions. 5. Universal Access commitments have been included in the NSF, operational plan and budget. 6. Country has developed a Health system strengthening plan. 7. Lacking policy or strategy to address IDU in prevention.

Table 3: NCPI trend analysis, Human Rights, Botswana 2007

YEAR	GAPS AND SUBSEQUENT IMPROVEMENTS NOTED IN NCPI SURVEYS
Area: Human Rights	
2003	<ol style="list-style-type: none"> 1. Generic provision for ethical research of HIV/AIDS in National Health Policy, Public Health Act, National HIV/AIDS policy
2005	<ol style="list-style-type: none"> 1. Only general non-discriminatory provision in the constitution, none specific to gender, health status or other grounds 2. Non-discrimination laws for only women and youth 3. Laws & regulations exist that present obstacles to effective HIV prevention and care for most-at risk populations. 4. General policy to ensure equal access to prevention and care for most-at-risk is implied in the HIV/AIDS policy and would not include sex workers, MSM and prisoners. 5. HIV screening policy exists for expatriates seeking employment and renewal of contracts. 6. Draft ethical research policy for HIV/AIDS exists. 7. Lack of data collection on human rights and HIV/AIDS. 8. No independent national institutions for protection of human rights. 9. Lacking focal points within government to monitor HIV-related human rights abuses. 10. No indicators or benchmarks to measure compliance of human rights standards.
2007	<ol style="list-style-type: none"> 1. Absence of legislation that protects PLWHA – however legislative review completed to address some of the pertinent issues 2. Lack of legislation to protect most-at-risk groups (other than women; however these do not protect against marital rape). 3. 4. Laws exist that present obstacles to effective HIV prevention, treatment, care & support for most-at-risk groups. 5. Gaps exist in service delivery for most-at-risk populations. 6. Lack of human rights monitoring & enforcement mechanisms. 7. Mid-term review of NSF increased recognition of many most-at-risk populations

The remainder of this section discusses the changes made in national commitment and implementation of key programmes and strategies in the current reporting period by different sectors involved in the national response.

4.2 Public Sector Response

Changes in Key Prevention Programmes and Strategies

National Blood Transfusion Services

**UNGASS Indicator 3: % of donated blood units screened for HIV in a quality assured manner
(2003=100%; 2005=100%; 2007=100%)**

The National Blood Transfusion Service aims to ensure that all donated blood units in Botswana are screened for transfusion-transmissible infections such as HIV, Hepatitis B, and others, so that only those units that are non-reactive on screening tests are released for clinical use. Laboratories in Botswana use Standard Operating Procedures (SOP's) for the screening of blood units and for other laboratory tests. Laboratories also regularly participate in a quality assurance assessment scheme. Universal (100%) screening of all donated blood is performed in Botswana. Between 1st October 2006 and 30th September 2007, a total of 22 801 units of donated blood were screened using quality assurance methods; 16 985 units were transfused during the same period.

Youth HIV Prevention and Blood Safety Project

Geared at promoting behaviour change and HIV prevention amongst young people, this project was launched by the Ministry of Health in November 2003 and implemented by the Botswana Family Welfare Association (BOFWA), Botswana Christian AIDS Intervention Programme (BOCAIP) and the Youth Health Organisation (YOHO) in 2004 with financial support from the African Comprehensive HIV and AIDS Partnerships (ACHAP). The project uses the "Pledge 25 Club" strategy which involves recruiting young blood donors and encouraging those who are HIV-negative to retain their status. So far, a total of 1 432 young people have been reached. Of these 1 186 (83%) are in-school youth while the remaining 246 or 27% are out-of-school youth. Seventy-six of the out of school youth and 452 in-school youth have pledged to regularly donate blood.

Although the initiative has faced a number of challenges such as the high mobility of school-going youth and the poor reporting by some Pledge 25 clubs, it has been successful in mobilising the youth, particularly those in school, to form Pledge 25 clubs. A large number of these young people have pledged to continue donating blood on a regular basis. This is a positive move towards prevention of HIV infection among the youth as regular blood donation motivates them to maintain their negative HIV status.

Prevention of Mother-to-Child Transmission (PMTCT) Programme

UNGASS indicator 5:	% of HIV-positive pregnant women who received anti-retroviral to reduce the risk of mother-to-child transmission (2003=34.3%; 2005=60.3%; 2007=89.9%)
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The Government of Botswana established the first National PMTCT programme in Africa in 1999. From the two initial pilot sites in the cities of Gaborone and Francistown, the programme was rolled out country-wide and by November 2001 all public health facilities offered PMTCT services. The main goal of the programme is to improve child survival and development through the reduction of HIV related morbidity and mortality. The strategies adopted to achieve this goal include:

- Community mobilization through the use of multimedia, i.e. nationwide dissemination of information about the PMTCT program through pamphlets, posters, radio and television talk shows
- Post-test counselling and continued psychosocial support to pregnant women, their partners and families,
- Provision of Antiretroviral interventions such as early CD4 count testing, provision of ARV therapy/prophylaxis, and evaluation and referral for treatment for opportunistic infections.
- Modified obstetric practices, which include the introduction of a special package for safe motherhood, such as encouragement for early antenatal clinic visits, follow-up until birth, reduction in the number of episiotomies performed during labour, introduction of the use of a silicon cap instead of a metal cap for vacuum extraction to reduce injuries to the infants scalp.
- Infant Feeding—provision of free infant formula to all infants born to HIV-positive mothers who meet the AFASS (WHO) criteria. AFASS assessment evaluates whether the mother can ensure infant feeding that is Accessible, Feasible, Affordable, Sustainable, and Safe (AFASS).

The main achievements of the PMTCT programme for the current reporting period includes an increase in the uptake of the programme from 60.3% at the end of 2004 to 89.9% in March 2007. This achievement, together with the increase in the PMTCT *testing* uptake from 49% in 2002 to 83% in March 2007, has led to the reduction of mother-to-child transmission of HIV from 40% in 2001 to 4% in 2007. The countrywide introduction of the Routine HIV Testing (RHT) using the rapid test kit in January 2004 has particularly ensured rapid increase in the program uptake because more pregnant women are able to test and know their HIV status early, which maximizes programme benefits. The programme's other achievements include:

- Adaptation of the UN Framework on HIV and infant feeding to the Botswana situation;

- The introduction, into the PMTCT programme, of lay counsellors who were trained to perform Routine HIV testing using rapid test kits, helped to reduce the burden on nurses and midwives.
- Adaptation of the WHO/CDC Generic PMTCT Training package which is a standardized training package for PMTCT programs was adapted to the Botswana context.
- Involvement of civil society to provide ongoing psychosocial support services was implemented through the support of the Botswana Christian AIDS Intervention Program (BOCAIP) and the Botswana Network of People living with HIV/AIDS (BONEPWA+). The duo were subcontracted by Pathfinder International through PEPFAR and involved peer mothers who are trained to recruit expecting mothers into the program and provide ongoing psycho-social support and follow-up.
- The introduction of Dried Blood Spot (DBS) HIV Testing for Infants has helped to increase the number of infants who are tested for HIV. Previously infants were tested at 18 months, but by that time most were lost to follow-up. Currently testing for HIV is performed earlier, at 6 weeks using the dried blood spot test, which requires only a minimum volume of blood (a spot) to be taken from the infant using a prick method. This method is easier for all health workers to perform as compared to the previously complicated phlebotomy which could only be performed by specialized personnel. The DBS also ensures easy transportation of the specimen.

Despite its achievements, the programme still faces the following challenges:

- *Male involvement and participation* in the programme still remains a challenge with only 9% of males being involved as at 2007, compared to 6% in 2006 and 3% in 2005. It is noteworthy, however, that the increase in male involvement from 2006 to 2007 was mainly due to a male involvement multimedia campaign which started in November 2006 throughout the country to sensitize and encourage men to test for HIV with their partners at all stages of pregnancy.
- *Repeated pregnancies in HIV positive pregnant women.* Information from the PMTCT programme reveals that some women, who already know their HIV positive status, still fall pregnant. Collaboration is therefore ongoing between the PMTCT program and Sexual and Reproductive Health Unit to review the family planning guidelines and integrate HIV issues to be part of the family planning package. Family planning information is also being made available for mothers through the PMTCT program.
- *Cultural beliefs in infant feeding.* Social and cultural perceptions, coupled with fear of stigma and discrimination act as barriers to uptake of formula-feeding among some women. For example, some mothers feel that a woman who does not breastfeed may not be accepted in the community, especially if she has no adequate support to cope with family, community and social pressures.

Sexually Transmitted Infections (STI) Control Programme.

This programme was established in 1989 to provide comprehensive syndromic management and treatment of STIs countrywide, free of charge. Against the background of strong evidence supporting several biological mechanisms through which STIs facilitate HIV transmission by increasing both infectious and HIV susceptibility, the programme's main objective is to contribute to the reduction of HIV transmission through reduction of other STIs. The programme has had several achievements since the last UNGASS progress report and these include:

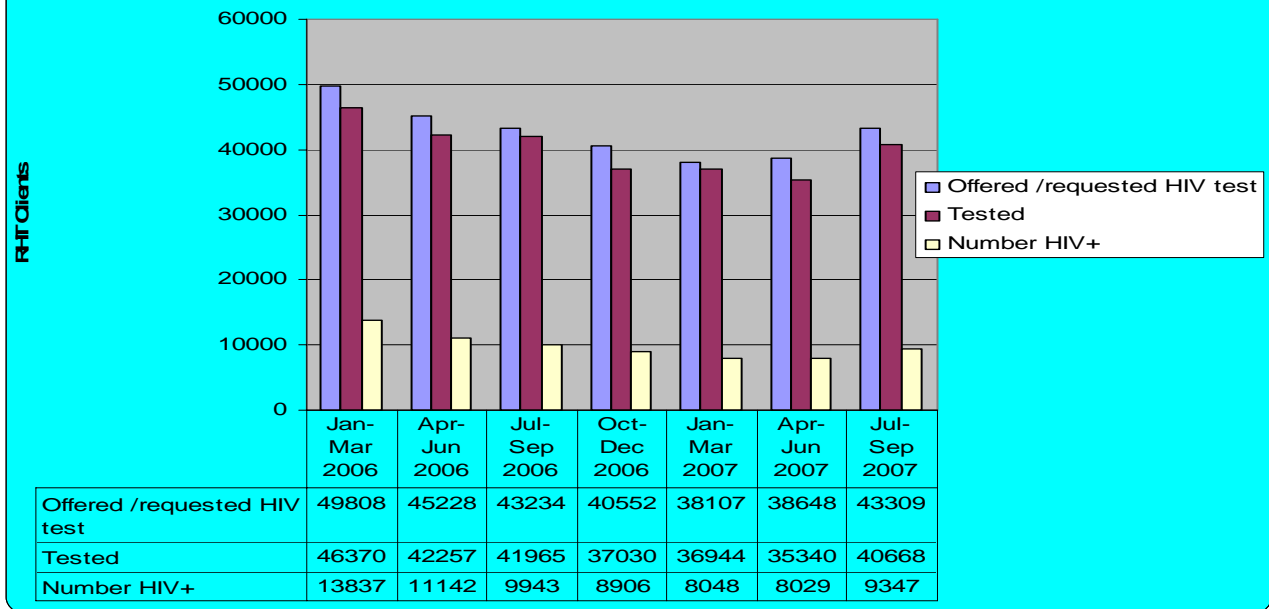
- The reviewing of STI management guidelines to incorporate treatment of Herpes Simplex Virus (HSV2), routine HIV testing and behavioural change communication (BCC) particularly on risk reduction counselling.
- Roll acyclovir for treatment of HSV2 had reached all the 24 health districts by November 2007.
- 4,060 health care practitioners including private practitioners have been trained on the newly revised STI guidelines throughout the country.
- Clinical mentoring has been introduced to five health districts with the purpose of strengthening quality care.
- Surveillance systems have been strengthened: For example, STI sentinel sites have been established in 8 districts to monitor trend of STIs; data collection for 2007 microbial surveillance has been on-going from November 2007.
- STI M&E Systems have been strengthened: 150 STI district trainers of trainers were trained in 24 districts country-wide. These will serve as programme focal persons at the district level. Three annual STI monitoring workshop were also held in 2005/2006, 2006/2007 and 2007/2008.
- STI service delivery in cross border and high transit sites have been assessed and strengthen in 3 districts of Kasane, Tlokweng and Serowe/Palapye. Further expansion to 5 more districts is on-going.
- Plans to re-introduce male circumcision as an additional HIV prevention are on-going.

Routine HIV Testing

The current reporting period has seen a significant increase in the take-up of HIV testing. Routine HIV Testing (RHT), which was introduced in all health facilities in Botswana in January 2004, entails routine, but non-mandatory HIV testing to all public health centre clients. Its main objectives are to make more people aware of their status, facilitate supportive counselling, behavioural change, early assessment for ART, early access to home based care and stigma reduction. Data from the Ministry of Health indicate that by September 2007 RHT uptake stood at 93% (Figure 5).

Figure 5: Routine HIV testing uptake in Botswana, January 2006 – September 2007

Figure: Routine HIV testing uptake in Botswana, January 2006-September 2007



Source: NACA Report to the National AIDS Council for the period July-September 2007

Condom Procurement and Distribution:

Public sector condom distribution is managed by the Central Medical Stores, (CMS) a department of the Ministry of Health. Between July and September 2007 the CMS distributed 1 893 900 free male condoms to all government health facilities (Figure 3.3). Female condoms were also distributed albeit on a smaller scale. In the social marketing sector, Population Services International Botswana (PSI) sold and distributed more than 6.8 million condoms in the current reporting period.

The Botswana government's commitment to HIV prevention was further reflected in April 2006 when the Minister of Finance announced that condoms will join other products that will be exempted from Value Added Tax.

Key Treatment, Care and Support Programmes and Strategies

UNGASS Indicator 4: % of adults and children with advanced HIV infection receiving antiretroviral therapy (2003=7.3%; 2005=62.7%; 2007=82.3%)

Anti Retroviral Therapy (ART)

Botswana was the first African country to provide free ART to its citizens through the National ART programme known as MASA. The programme is now available in 32 sites (government referral and primary hospitals, as well as clinics) in the country. According to the Ministry of Health, as of November 30th 2007, 91 780 persons (82.3% of those with advanced HIV infection) were on treatment. This consists of 74 273 patients in the public

sector, 7 993 patients out-sourced to the private sector and 9 514 were enrolled directly in the private sector.

National Orphan Care Programme

The programme was started in 1999 to provide food baskets, psychological counselling and to facilitate the waivering of school fees for orphans. At the end of December 2005, there were 52 537 registered orphans in the programme and by March 2007 this figures had increased to 53 395 and the children are retained in education¹. The Orphan Care Programme was evaluated in 2006, and a national situation analysis is currently on-going to provide data for an evidence based national policy on orphans and vulnerable children

Community Home Based care (CHBC) Programme

In 1995, the government of Botswana established Community Home Based Care (CHBC) programme to complement the over stretched health system in caring for terminally ill patients including People Living with HIV and AIDS (PLWHA). In cognizance of shortage of skilled human resource within the government health facilities to deliver CHBC services, community mobilization was adopted as one of the major strategic intervention of the CHBC programme. The community response has been very positive and today more than 300 community based organizations participate in the delivery of CHBC services. These organizations provide a variety of HIV/AIDS services through out the country. Achievements of CHBC in the Current reporting period include the following:

- Development of Palliative Care—Curriculum development and training modules for all cadres including informal caregivers
- Adoption of WHO IMAII Guidelines for palliative Care
- Trained 20 Palliative Care master trainers and 147 service providers on Palliative care
- Review of CHBC directory
- Development of a Palliative Care Documentary

Challenges

- Shortage of manpower to roll out Palliative Care Programme both at Ministry of Health and Ministry of Local Government.
- Shortage of transport
- Shortage of palliation drugs e.g. morphine

Care for Care Givers Programme

This programme, which, at the time of the last UNGASS Progress Report was at needs assessment phase, was eventually established and registered as a Trust in May 2006. The main objective of the programme is to provide holistic care to healthcare workers and their families. This includes group and individual counselling services, stress management as well as creative art therapies and training. The programme also has a clinical component

¹ Mid-Term Review Final Report, pp 24
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specifically designed to offer the healthcare workers optimal counselling and HIV and AIDS testing and treatment.

HIV/AIDS in the Workplace Programme

The HIV/AIDS in the Workplace Programme was established in 1991, as a strategy to mitigate the impact and challenges of the HIV/AIDS epidemic and related issues among the workforce in different workplaces. The priority areas for the programme include:

- Establishment of coordination structures at health facilities to facilitate the implementation of the Workplace Wellness Program (Multidisciplinary Workplace Wellness Committees, training of Peer educators and identification of Focal persons).
- Provision of wellness services for health workers in a user-friendly environment that promotes access to prevention, care, treatment and support.
- Capacity building for health workers on HIV and AIDS, promotion of a healthy work environment, management of work related stress to reduce burnout and promote productivity.
- Establishment of a monitoring & evaluation framework for the Workplace Wellness program and development of a data base.

The staff from the Workplace and HIV and AIDS Unit in the Ministry of Health is currently participating in the finalization of the draft Workplace Wellness Policy which being spearheaded by the Department of Public Service Management and which will hopefully be operational by the beginning of the next National Development Plan in 2009. This policy will set the foundation for the formulation of the health sector guidelines or protocols in line with international provisions.

Between November 2006 and February 2007 the Workplace Program team embarked on a nationwide sensitization of health managers on the program and their role as custodians of scarce human resource. A total of 142 managers from hospitals and the headquarters were sensitized. District Health Team managers have also been sensitized.

The Workplace Wellness Programme national coordinating unit has also trained 340 Peer Educators from all the 28 hospitals in the country as well as from the Ministry of Health headquarters, Central Medical Stores and the National Health Laboratory. Trainings were conducted from November 2006–December 2007. In addition some health facilities have trained 174 Peer Educators to increase their capacity and also conducted meetings to sensitize staff on the program to promote ownership.

A conceptual model for the Workplace Wellness Program that stipulates the Minimum Package for its implementation has been developed. Further, guidelines and training manuals have been developed to empower health workers to adopt health behaviours that

will reduce health risks and encourage the seeking of health services early given emerging diseases such as MDR and X Tuberculosis.

Sixty workers have been trained as trainers of trainers on stress management and team building modules.

4.3 Civil Society Response

4.3.1 Key prevention Programmes and strategies

Civil society organisations in the country are involved in a number of innovative strategies to prevent HIV infection. These include the following: :

- Zebbras for Life, Test for Life campaign which has been implemented by Tebelopele since November 2006. This campaign strategy, which uses the popularity of the national football team, "The Zebras", involves the presentation of fashionable bracelets as an incentive to test for HIV. Tebelopele statistics confirm that this approach has been successful: At 55 events in 41 different locations, the campaign empowered 4,969 people to know their status. These events increased testing demand by approximately 300%. Moreover, 58% percent of those testing were men, up 12% compared to Tebelopele's regular efforts.
- Couples Counselling and Testing. Tebelopele has always encouraged couples testing. And the organisation marked February 2007 as a Month of Love using the popular slogan, "Couples who test together stay together." Throughout the country, Tebelopele VCT centres planned and held 'Love Fests' that encouraged couples to test together. Each centre was given an opportunity to plan and implement their own event. While in 2006, only two events took place in Gaborone and Francistown, in 2007 there were 15 events throughout the country resulting in 1 538 clients (comprising of 476 couples) tested during all the love fests.
- Itshupe ka Botala, or "Go Blue" Campaign, is a new effort by Tebelopele to provide testing services at more client-friendly places, such as near shops, hang-out spots and transit hubs. This is designed to alleviate VCT access challenges that have been experienced despite the fact that Tebelopele has 16 VCT centres and makes regular mobile outreaches. The new planned outreaches, which are planned to start in January 2008, will offer greater convenience without diminishing existing services.

4.3.2 Key Knowledge and Behaviour Programmes and Strategies

"Make an impression" -Campaign Strategy (developed by who?)

The "Make an impression" campaign was developed as a multi-media campaign that was focused on correct and consistent condom use amongst 15-24 year olds. It aimed at getting the target group to practice safe sex at every sex act through the use of television as the lead medium and radio, print and outdoor advertising as support media to convey "consistent condom" messages. All concepts developed depicted the target groups'

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interests and lifestyle through creative and dynamic use of graphics, audio and visual technique.

PSI Life-Skills Programme

PSI Botswana has developed a life-skills programme called *Choose Life*. This is basically a multimedia health communication initiative whose primary target audience is in and out of school youths aged 8-18 years. The programme provides the young people with appropriate information and skills to help them make informed, responsible choices about sex, their sexuality and relationships. The mandate of the programme is to promote behaviour change.

In the current reporting period two booklets were launched: (1) *Enough is Enough: Stop the Abuse of Women and Girls* and (2) *Life skills for young Botswana*. A total of 400 000 and 320 000 copies of the two books respectively have been distributed to schools and NGOs around the country. Activities such as radio promotions, road shows and write-in competitions were undertaken to support the booklets and to ensure that the target audiences get the message.

4.4 Private Sector Response

Botswana Business Coalition on AIDS

The Botswana Business Coalition on AIDS (BBCA) was established in 1994 with its strategic objectives being to (a) assist the private sector in developing HIV and AIDS workplace policies and programmes, (b) support the private sector in accessing existing government services, and (c) assist the government and its partners in reaching more people and increasing HIV and AIDS services uptake. In 2004, BBCA conducted a Needs Assessment Survey to examine the private sector's response and needs analysis. The survey results, which were also cited in the 2005 UNGASS progress report, showed that only 18% of the companies surveyed had HIV and AIDS policies, fewer small companies had policies than large or medium-sized companies and not many companies had mainstreamed HIV and AIDS into their corporate strategies. Major progress was, however, noted when BBCA undertook a Programme Impact Evaluation in 2006. The evaluation showed that, of the companies evaluated:

- 39.9% had developed policies on HIV and AIDS;
- 41.7% had appointed an HIV and AIDS Coordinator/ Focal person;
- 59.1% had allocated financial resources for HIV and AIDS interventions; and
- 22.9% had workers' HIV and AIDS Committees.

5.0 Best Practices

5.1 Introduction

The *Guidelines on Construction of Core Indicators* for the 2008 UNGASS reporting instructed that, for the purpose of sharing lessons with other countries, this section

“should cover detailed examples of what is considered a best practice in-country in one or more of the key areas, such as political leadership; a supportive policy environment; scale up of effective prevention programmes; scale-up of care, treatment and/or support programmes; monitoring and evaluation, capacity building; infrastructure development” (pg 88).

This section benefits from results of a nation-wide study commissioned by NACA in 2007 to identify and document National Best Practices on HIV and AIDS. In selecting best practices, all studied programmes and projects were given a score out of the maximum allocated for eight factors: accessibility, effectiveness, ethical soundness, innovativeness, relevance, replicability, sustainability and cost-effectiveness. Those that scored between 0-5 were regarded as ‘poor’, 6-10 was regarded as ‘fair’, 11-15 as ‘good’ and 16-20 as ‘excellent’.

The study report presents all those programmes and projects that scored between 11 and 20 (those ranked as good and excellent) in each of the five key goal areas of Botswana’s National Strategic Framework on HIV and AIDS 2003-2009: (1) Prevention; (2) Provision of Treatment, Care and Support; (3) Strengthened Management of the National Response; (4) Psycho-social and Economic Impact Mitigation and (5) Provision of a Strengthened Legal and Ethical Environment. For the UNGASS report however, a few best practices have been selected for sharing with the rest of world, partly because the main report is yet to be finalized. For each presented case, a brief description of the programme or project is given. This is followed by the major strengths that led to it being identified as a ‘best practice’ and finally by its key challenges.

5.2 Prevention

Example of a Best Practice in Behaviour Change

This programme is being implemented by the Men Sector which was formed as part of the government’s response to HIV and AIDS in 2000. Membership of this sector is open to any organisation that is predominantly male and current members include the Botswana Defence Force, the Botswana Police Service, the Botswana Local Police, Botswana Prisons Service, House of Chiefs, Ministers Fraternal, the Society of Men Against AIDS in Botswana (SMAABO) and the Scouts Association. The sector has adopted a variety of strategies on the promotion of HIV and AIDS education to achieve their objectives. As part of their activities to inform, educate, promote behaviour change and greater involvement

of men, sub-committees are formed and orientated through workshops at district level. Members of such committees include ordinary people in the community who serve as community outreach educators by going into neighbouring villages to provide education as well as forming village sub-committees. The aim is to reach as many communities as possible. Wherever an audience is identified, an opportunity is taken to promote HIV/AIDS education and voluntary counseling and testing.

Strengths

- The men's sector has been seen to promote the Greater Involvement of People Living with HIV/AIDS (GIPA) principle through effective collaboration on activities, and participation by PLWHAs in workshops and Health Fairs.
- Innovation can be seen in a number of strategies adopted by the sector for the purposes of community outreach. Health Fairs have demonstrated success in both numbers attending and testing for HIV.
- The creation of district sub-committees can be seen as a success in different dimensions. First, being capacity building to local communities who in turn pass their skills on to others; second, is the aspect of involving communities within their own education and development to ensure buy-in as well as ownership; and thirdly adopting an innovative and effective strategy to reach a wide audience.

Challenges

Despite the impressive efforts by the Men Sector, men are yet to participate as extensively as women in all areas of the national response HIV and AIDS, eg their involvement in promoting PMTCT uptake is less than satisfactory. This however should serve as pointers to potential areas of focus for this sector.

5.3 Treatment, Care and Support

Example of a Best Practice under workplace: Debswana Workplace Programme

The Debswana Workplace AIDS and Awareness Programme was first introduced in 1991 and 1992 in the diamond-mining towns of Jwaneng and Orapa, respectively. The programme sensitises staff on issues of HIV and AIDS through education with the main aim of promoting prevention of new infections, and controlling of the epidemic for the benefit of employee as well as the company. The programme started providing free Anti Retroviral Therapy (ART) to HIV infected employees in May 2001 thus making Debswana the first mining company in Southern Africa to provide ART to its employees. Key elements of the programme include a clearly defined Workplace Policy, an AIDS Management System HIV and AIDS awareness programmes, HIV/AIDS education and training, counseling support, voluntary counseling and testing, condom distribution, and treatment for HIV and AIDS infected workers, their registered spouse and children. The prevention aspects of the programme are extended to the community and surrounding villages. The mine hospitals also operate the MASA programme (National ARV

programme) on behalf of the Government of Botswana. This benefits members of the community and surrounding villages who are not employed by the mines.

Strengths

The programme is highly relevant in terms of the NSF goals of prevention, and care and support.

- Efficacy has clearly been demonstrated in the successful development of a workplace programme that brings huge benefits to employees and their families, as well as the communities in which the mines operate.
- The provision of free ART treatment to employees, their spouses and families renders the programme highly accessible to its target beneficiaries.
- The Public Private Partnership formed in 2003 between Debswana and the Government of Botswana that provides for the government MASA programme to be operated from the mine facilities has been instrumental in bringing treatment to the people. In particular it has enabled government to increase ARV access to citizens in surrounding communities without incurring infrastructural and staff costs.
- The development of a workplace policy that clearly defines everyone's roles contributes amongst other things to the well being of the employee, protection of the rights of the employee and is an effective management tool.
- The implementation of the AIDS Management System is a very important aspect of the HIV and AIDS programme. The system promotes quality of programme management and delivery, and allows for the organisation to be audited in terms of management practices.
- The mines' community outreach programmes further strengthen the accessibility area of best practices. In Jwaneng and Orapa the HIV/AIDS coordinating facilities is situated within easy access to the community. The services provided include VCT, capacity building through training for counseling, education and presentations and workshops.
- Debswana has established a Corporate Social Investment (CSI) Fund as part of their outreach activities. The mines are responsible for their own budgets in this regard. Through these funds a variety of groups who have benefited include support groups, youth groups, and individual members of the community and surrounding areas identified as needy.

Challenges

Although Debswana has not undertaken any study on the topic, behaviour change is viewed as a significant challenge particularly in the mines. Debswana plans to embark on more evidence-based research to gauge risky behaviour and respond accordingly.

5.4 Strengthened Management of the National Response

Example of a Best Practice under strengthened management: HIV Surveillance and Research

Sentinel Surveillance was first introduced by the World Health Organisation as a cost-effective method to determine HIV prevalence in the 1980s. Several countries have taken up the concept and used it as a key source of information to monitor the disease. This global perspective provides a standard form of measure across countries. As stated earlier, Botswana has been conducting annual sentinel surveillance among pregnant women aged 15 to 49 years since 1992 and this surveillance continues to be seen as an important aspect of the country's response to HIV and AIDS.

The surveillance exists primarily to provide timely, accurate and up-to-date information within the health ministry but it is also a vital source of information across sectors. Sentinel data is also available on the web and shared globally across several fora. Sharing of information of this nature demonstrates a level of openness and shows the extent to which Botswana has come face to face with the AIDS epidemic. This to some extent is thought to have played a role in motivating international donor interest to support Botswana in its local response.

Strengths

The study found that Sentinel Surveillance is highly relevant to the NSF, specifically in the key goal area of Strengthen/Improved Management. It is seen as an effective way of informing policy and decision making, by providing reliable estimates of HIV prevalence. In addition to being used to inform and guide policy makers the results from sentinel surveys also inform the public of the HIV situation in the country.

The programme has demonstrated effectiveness in management of surveillance data. The timeliness with which information is made available continually allows for quick reaction to changes in patterns and trends of the disease. The accuracy, speed and consistency with which this information is captured is very impressive. The programme is seen as cost effective and efficient in several ways. Firstly it targets pregnant women who are visiting antenatal clinics, in this manner the women are not put under undue strain as they were to have blood drawn anyway. At the national level government resources are spared on several levels one of which is by ensuring that the sentinel surveillance is harmonized with the four-yearly Botswana AIDS Impact Survey. Another area of strength within the programme is the formation of a Technical Work Group that serves to provide guidance to the surveillance process. This demonstrates commitment and ownership of the programme at a national level.

Challenges

The multisectoral response to HIV and AIDS requires that the national response must step outside the health sector if significant advances are to be made against the AIDS epidemic. The Surveillance and Research programme was found to be the only programme of repute working within this key goal area. Notwithstanding the fact that the programme is well resourced and has the backing of national government, networking and partnerships outside of government would provide for a wider audience.

5.5 Psycho-social and Economic Impact Mitigation

Example of a Best Practice under Impact Mitigation: Youth Psycho-social Initiative

This youth-run psycho-social initiative is a coalition of four churches in Gaborone (Anglican, Church of the Nazarene, Roman Catholic Church and the Salvation Army) which was formed in April 2002. The Salvation Army Psychological Social Support (SAPSSI) has 800 registered children and a reach of about 3 000 children throughout Botswana.

The centre, small as it maybe and stretched for resources, has both a manual and electronic resource centre which provides children of all school going age with access to the internet and world wide web 'on their door step'. The same premise runs a daycare/pre school facility for children in the 2 to 5 year old age group. This demonstrates a service that carries children from a very young age through to their adolescent years.

While direct beneficiaries of this programme are children, there is an additional value observed by the consultancy to care-givers. Grandparents or single parents are likely to find a significant part of their day freed up from care giving duties. This enables them to become gainfully employed or economically active in some way or another that they may not have if they were providing full time care to infants.

The programme aims to address the psycho-social issues faced by children who have been left either orphaned or vulnerable as a result of HIV/AIDS. SAPSSI sees the approach which uses the five elements of education, physical, emotional, spiritual and social as essential to the development of children. The organisation feels that the latter three elements are often overlooked by many programmes purporting to offer care hence resulting in a short fall of the provision of holistic support that is needed by growing children.

Strengths

Accessibility is the strongest element of this programme out of all the organisations surveyed. Although based in the capital city of Gaborone the activity is very much a rural in its set up. It has its base in the heart of Old Naledi, which without a doubt is one of the

most impoverished population centres in the country. Its location ensures that residents of this neighbourhood are in walking distance of the services that are on hand at the centre.

Aside from the one private sector institution ethics was generally high, above 16.00 points for all the groups that qualified as best practices. Of interest, two of the top three groups scoring over 19.00 on the ethics criteria both have a religious footing in their mandate.

A further area of interest drawn out from this organisation is that of its ethical soundness. The programme has a mixture of children regardless of their HIV status. Programme Management staff and the children are all unaware of the HIV status of any of the participants. The programme is run simply on the level of need required regardless of if or how beneficiaries may or may not have become orphaned.

Challenges

This programme currently has funding for less than one year and relies on part time professional staff. This presents a narrow funding base scenario that leaves them vulnerable. Foreign donor support covers most of the recurrent expenditure and the group uses its proposal writing skills to solicit on going financial support. The financial manager offers his time totally pro-bona giving the programme a cost effective rating among those of the higher scoring programmes. It is however uncertain as to how long they will be able to retain such services.

6.0 Major Challenges and Remedial Actions

6.1 Introduction

In the 2005 UNGASS Country Progress Report, the key challenges to achieve the UNGASS targets were reported and discussed according to four sectors: public sector, civil society, development partners and private sector. Table 4 summarizes the challenges that were identified in each of these sectors.

Table 4: Summary of sector-wide challenges, Botswana, 2007

Public sector

- Poor Coordination and harmonisation of the different stakeholders to ensure maximum impact of the multi-sectoral response
- Poor policy implementation due to long consultative processes
- Mainstreaming—there has not been sufficient clarity on the concepts of mainstreaming to move the process forward. Additional challenges for mainstreaming include implementation capabilities as well as leadership for the process.
- Resource constraints. Given that Botswana is now classified as an upper middle class country, many donor agencies are pulling out of the country to focus on poorer countries. This has resulted in financial and skilled manpower shortages in many areas.

Civil Society

- With the departure of many donor agencies from Botswana many local civil society organisations have been left competing for the little funds that are available and finding it difficult to fund their activities or programs.
- Many local NGO's are also poor at networking and/or even considering forming strategic partnerships with other NGO's in the regional and international arena to broaden their scope of work and increase their donor support for those programs that might need regional intervention
- Accountability More than often, NGOs' fail in their mandate and they close down because of poor financial management, poor labour practices and lack of accountability
- Lack of skilled and trained manpower, especially in the area of managerial and technical assistance also hampers the delivery of effective and efficient services by NGO's

Development partners

- Poor clarity of roles and responsibilities among stakeholders which often leads to duplication of efforts and delay of implementation on intervention strategies.
- Problems of poor coordination and harmonisation of the multi-sectoral response adversely affect input of developmental partners.
- Lack of local capacity to implement specialised programmes and projects
- Bureaucratic procedures of different organizations are also a challenge as they often results in delays in the disbursement of funds for important national projects. e

Private sector

- The Botswana Business Coalition on AIDS's (BBCA's) small secretariat—which comprises of only three people—is but is expected to cover the country. This leads to problems of co-ordination given the when looking at the various relationships that have to be managed,
- Except for a few large companies that are mainly in the mining and financial services area, very few companies have HIV and AIDS policies

6.2 Progress made since last UNGASS progress report

- Since the last UNGASS report, major strides have been accomplished within PMTCT, HIV testing, STI management, condom supply and distribution. But it has also become very clear that not enough efforts have been put into behaviour change and that a major thrust is needed to scale up prevention towards universal access, both by sustaining and improving upon the achievements and by increased focus on behaviour change and addressing the key drivers of the epidemic
- All stakeholders have realized the importance of scaling up prevention. There has also been a realization of the importance of addressing the key drivers of the epidemic through evidence-based interventions.
- In April 2006, NACA developed a National Strategy for Behaviour Change interventions and communication for HIV and AIDS. The major challenges for the strategy so far have been identified (1). Promotion of a comprehensive approach to prevention and the formation of effective partnerships to do so; (2). Keeping track of the factors fuelling the epidemic (evidence based planning); (3). Prevention with positives; (4). Mobilization of communities; (5). Male involvement)
- The recent Mid-Term Review of the NSF found that there has been limited investment in primary prevention interventions, particularly those aimed at behavioural change and has recommended a prevention agenda driven and managed through a vigorous and imaginative public-private partnership on AIDS prevention.
- Currently Botswana is developing a comprehensive national prevention plan that will drive the implementation of the recommendations from the above initiatives.

6.3 Challenges faced in the current reporting period

This section is largely informed by reports from two national processes that took place since the last UNGASS progress report: (1) the national consultative forum held to develop a draft Roadmap for scaling-up towards Universal Access to prevention, Treatment, Care and Support (UA), held in February 2006; (2) the workshop on UA held in July 2006 to finalise the draft UA Roadmap and (3) the Mid-Term Review of the Botswana National Strategic Framework for HIV/AIDS 2003-2009 (MTR) which was undertaken in the first half of 2007.

Obstacles to achieving UNGASS prevention targets

- Reliance on facility-based HIV testing. While first time testing (both VCT and RHT) in facilities has increased significantly services are still not easily accessible and available in many parts of the country, especially the rural areas.
- Low acceptability of abstinence. Despite the wide variety of youth and faith-based programmes such as Pledge 25, and those through BOCAIP, BOFWA, and AYA, have developed initiatives to promote abstinence and maintenance of HIV negative status, there is still a degree of scepticism among sections of the population about the feasibility and acceptability of the abstinence agenda for sexually active adults. There

seems, however, to be relatively wide acceptance of abstinence among sexually emerging adolescents and young people. This, unfortunately, is hampered by issues such as sexual abuse (mainly rape, incest and defilement) of young girls.

- Inconsistent and incorrect condom use. Although condom use has generally increased, problems remain with female empowerment to negotiate consistent condom use, with the scale and reliability of condom supply and distribution especially in remoter areas, and with take up of the female condom. Use of the female condom remains poorly understood, and BCIC support is extremely needed.
- Limited targeting of high risk populations. The consultation process for the Mid-Term Review of the National Strategic Framework 2003-2009, identified high risk populations such as prisoners, men who have sex with men, people with disabilities, especially learning difficulties, illegal immigrants, displaced persons and sex workers. Although recent research² suggests that many sex workers in Botswana engage in unprotected sex, the extent to which these and other high risk populations are major drivers of the epidemic is not clearly understood.
- Repeat Enrolment in Prevention of Mother to Child Transmission (PMTCT). Although there has been an impressive improvement in the uptake of PMTCT, the battle is not yet won in that a number of HIV positive pregnant women are repeat enrollers in PMTCT, presenting with second and third pregnancies. Data from surveys done in the country's second city of Francistown reveal that 65% of pregnancies among HIV positive and HIV negative women were unplanned, and 35% were unwanted³. Given the existing uneven power relations between men and women and pervasive gender violence, it is extremely difficult for women to make unilateral decisions on family planning, condom use etc. Their male partners more often than not have the final say, yet male involvement in PMTCT remains marginal. Although some progress is reported, through targeted IEC and BCIC initiatives (from 4% male involvement in 2005 to 8% in 2007,⁴ it is not entirely clear what dimensions of 'male involvement' are being measured).

In addition to the relative weakness in primary prevention and family planning, the counselling and support services for HIV+ mothers to make appropriate infant feeding choices for the first 6 months of their babies' lives are under-developed. Consequently that child survival is compromised.

Obstacles to achieving UNGASS treatment care and support targets

- Non Adherence

² The International Training Center for HIV /The Matshelo Community Development Association HIV needs assessment of female sex workers in major towns, mining towns, along major roads in Botswana draft report 1 April 2007 p6

³ IATT draft report (March 2007) p13

⁴ Ministry of Health PMTCT data

The prevailing HIV and AIDS related stigma and discrimination in the country plays a major role in low levels of disclosure and poor adherence as the patient takes treatment in secret—something that may not always be feasible

- Orphans and Vulnerable Children
 - Material relief has remained the principal focus of the orphan care programme, without comparable psycho-social support, child welfare monitoring and HIV education and prevention.
 - Other children made vulnerable by the epidemic are not eligible for Short Term Plan of Action (STPA) registration and benefits.
 - There is no national child welfare policy to guide interventions for all vulnerable children, including HIV+ children.
 - Considerable social and political unease is expressed about the sustainability of a 'culture of dependency', and lack of clearly articulated graduation strategies for orphaned children reaching 18 years.
 - Poor socio-economic status to meet other basic needs: The OVCs and/or their guardians often sell or exchange the food rations and other safety nets for cash and other commodities
 - Stigma—some parents or guardians as well as some school-going teenagers resist registration because of the stigma attached to those enrolled in the programmes and also threats to their self-esteem.
 - NGOs and CBOs providing care and support services to OVCs are concentrated on the eastern part of the country leaving other areas without adequate services
- Home-based care
 - Stigma in enrolment
 - Poor remuneration and insufficient resources (particularly transport) for workers resulting in high staff attrition
 - Guidelines are not standardized by districts resulting in inconsistent interpretation
- Counselling and psychosocial support
 - Staff shortage
 - Dependence on volunteers who often lack adequate training
 - NGOs and CBOs providing counselling and psychosocial support services are concentrated on the eastern part of the country leaving other areas without adequate services
- Voluntarism

ART, and a number of other key programmes (PMTCT, HBC, OVC) rely on volunteers, lay counsellors and community support groups, to provide a comprehensive and effective service. Community-based support groups to assist with partner and family disclosure, adoption of prevention behaviours, treatment literacy and adherence support remain weak and incapacitated. The major challenge faced is the

sustainability of responses that rely on voluntarism given the continuing high prevalence rates.

6.4 Remedial Actions Required

Prevention

- The strategic emphasis should now move towards out-reach. In particular, testing at workplaces, wellness events, sporting events, via mobile outreach to remote communities, and door-to-door should all be significantly scaled up.
- Detailed behavioural research is necessary to support fine-tuning of targeted behaviour change interventions, including abstinence and delayed sexual debut for both primary and secondary school level children.
- There is need for a comprehensive strategy for marketing and management of male and female condoms, with the support of appropriate BCIC interventions addressing issues of sexual norms and practices in a gendered context. The strategy should include a campaign to promote use of the female condom, specifically targeting young single women (based on the success of the female condom with this group of women in Zimbabwe and other countries).
- There is need for a consistent, high profile BCIC campaign specifically targeting these acknowledged drivers of the epidemic: multiple concurrent partnering and inter-generational sex. Such a campaign needs to focus specifically on young people and socio-cultural perceptions and constructs related to gender, sex and sexuality. Behavioural research should be undertaken to focus on the drivers of local patterns of sexual partnering to inform closely targeted BCIC interventions. This must include scaling up of interventions to address gender violence and issues of gender equity.
- Fully staffed health facilities should provide open access, and via partnerships with NGOs /CBOs, conduct vigorous outreach programmes to all sex workers and their clients. Targeted interventions including peer outreach programmes should be rapidly extended to all known commercial sex work sites.. Civil society organizations working with all high risk populations should be fully capacitated to scale up their prevention and support efforts.
- PMTCT in the longer term should develop towards a comprehensive⁵, streamlined service: a 'one-stop' facility for testing, prophylaxis, ART, family planning, prevention, child nutrition and early childhood monitoring. However, these will only bear fruit if linked to specific interventions to address gendered roles in sexuality and to secure the full involvement of men in all aspects of PMTCT, especially family planning. In the short term there is a unique opportunity to strengthen the prevention and family planning limbs of the PMTCT programme, and provide on-going nutritional counselling (on the AFASS⁶ principles) to HIV positive mothers for the first 6 months

⁵ The full range of intervention to prevent mother to child transmission includes: primary prevention of HIV infection in women; prevention of unintended pregnancies in women living with HIV; prevention of transmission from women living with HIV to their infants; and provision of care, treatment and support for women living with HIV and their families (WHO Infant Feeding Technical Consultation Consensus Statement 2006)

⁶ AFASS acceptable, feasible, affordable, sustainable, safe

after delivery⁷. These developments will require training for all PMTCT service providers at district, clinic and community level in infant nutrition, BCIC and family planning.

Treatment, Care and Support

- It is recommended that a national strategy on stigma and discrimination be developed
- The psycho-social care of OVC and adults should be outsourced to properly capacitated, sustainable NGOs/CBOs to be carefully considered in each mitigation programme.
- Service providers for both OVC and HBC undergo a systematic capacity building programme to enable them to provide comprehensive palliative and end-of-life care for people living with HIV/AIDS including proper management of associated chronic health conditions, psycho-social care and pain relief.

⁷ National PMTCT Guidelines on infant feeding counselling (2006)

7.0 Support Required from Country's Development Partners

7.1 Introduction

This section presents (a) the key support received from and, (b) actions that needs to be taken by development partners to ensure achievement of the UNGASS targets.

7.2 Key support received since last UNGASS progress report

In the last UNGASS report, three key areas of support needed from the development partners where highlighted (a) Continuous funding for HIV and AIDS; (b) Alignment of development partners' intervention to the priorities set up by the government, and (3) Strengthen capacity building. Since 2005 there have been improvements within all the three areas but they continue to be important also for the future.

Continuous funding for HIV and AIDS

- There has been an increase in funding for HIV and AIDS.
- The World Bank is currently advanced in the process of securing Botswana a loan under the buy-down mechanism which will further boost funding for HIV.
- NASA also showed how funding from development partners complement government spending/fill the gaps e.g. prevention

Alignment of development partners' intervention to the priorities set up by the government

- The Country Harmonization and Alignment Tool (CHAT) was piloted in Botswana in 2006. There were a number of positive findings, especially when it comes to development partners aligning their programming plans and strategies to the NSF, however less progress have been made when it comes to alignment and harmonization of monitoring and evaluation and financial support.
- The 2007 re-launching of the Government/Development Partners Coordination Forum under the chair of Ministry of Finance, Development and Planning was an important step towards encouraging enhanced engagement with development partners for improved and harmonized financial and technical support to complement domestic resources and fill identified gaps. Complementary to this forum, the Botswana HIV/AIDS Partnership forum was also re-launched in 2006. The Partnership forum is open to all key stakeholders of the national response to HIV/AIDS and the overall purpose is to provide a platform for information sharing on HIV/AIDS issues and to promote increased and harmonized support for initiatives on AIDS with the goal to scale up the national response to the epidemic consistent with the National Strategic Framework.

Strengthen capacity building.

- Capacity building is also been high on the agenda. However there is still room for improvement; technical assistance does not always have a sufficient component of skills transfer

7.3 Actions needed by development partners:

- The key areas of support mentioned in 2005 are still valid. Although much has been achieved, the process of harmonization and alignment, continuous and increased funding and a focus on capacity building and sustainability must continue. Development partners must embrace the recommendations of the Global Task Team to 'make the money work'.
- Other areas in need of support are upscale of prevention with focus on behaviour change, strengthening of civil society, addressing the absorption capacity.
- All development partners partook in the review of the National Strategic Framework 2003-2009 and there is consensus of the findings and way forward. Currently an operational plan is being developed for the remainder of the period (end 2009) that will bring all stakeholders together. In addition the national operational plan for prevention currently being developed will provide a framework/guide for development partners to contribute towards scaling up prevention.
- Global Fund is another area where development partners need to strategically contribute so as to increase the funding.

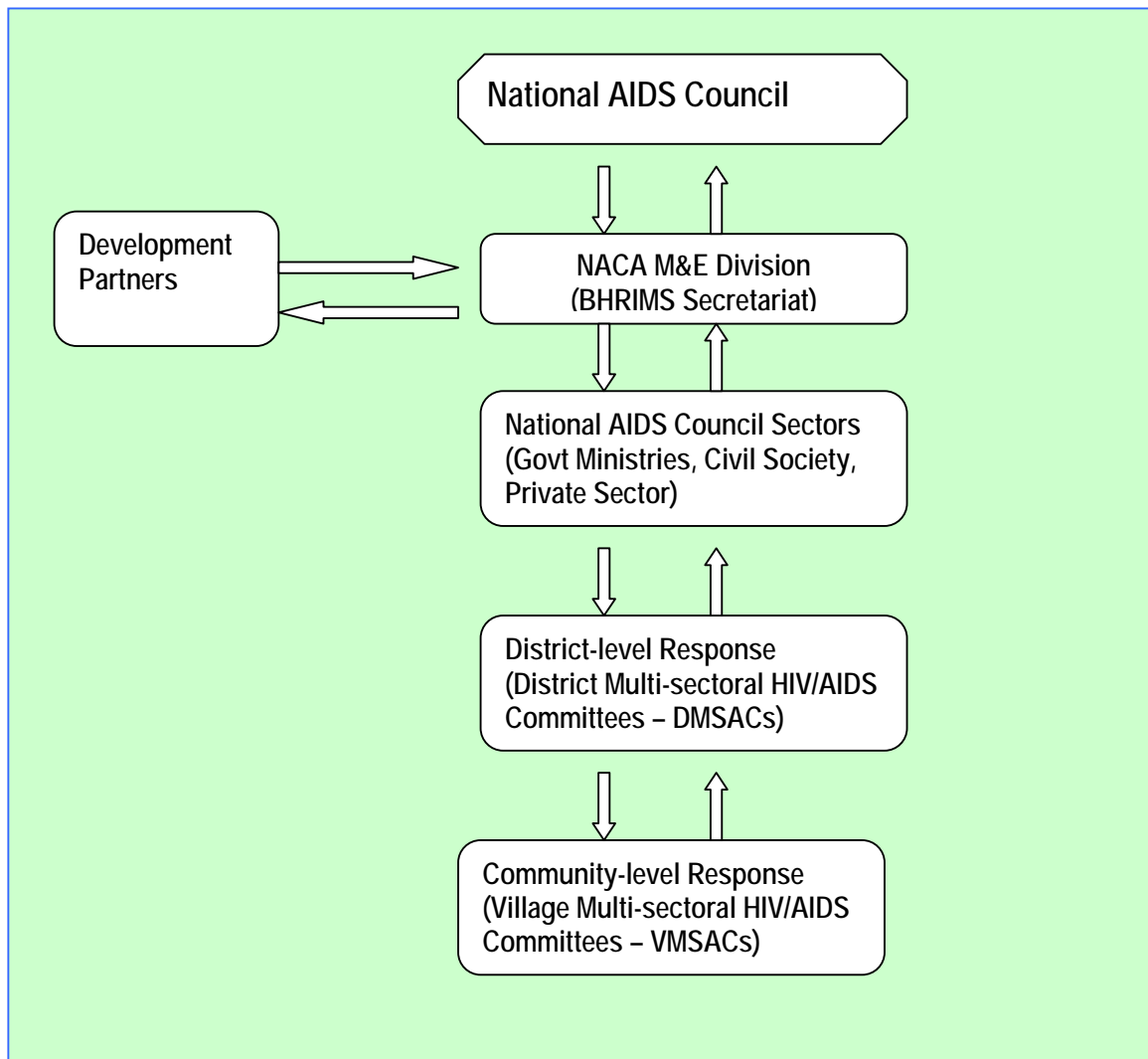
8.0 Monitoring and Evaluation Environment

8.1 Overview of M&E in the country

The Botswana HIV and AIDS Response Information Management System (BHRIMS) is the vehicle to manage and evaluate the implementation of the National response to the HIV and AIDS epidemic through the 2003-2009 National Strategic Framework (NSF). BHRIMS was developed in 2001 and its goal is to reduce the spread of HIV and mitigate its impact through effective and efficient monitoring and evaluation of the national multi-sectoral HIV and AIDS response (Republic of Botswana, 2002:90). This means that:

1. BHRIMS recognizes the existence of multiple response structures (government ministries, civil society, development partners and private sector) and the fact that they generate various data related to the programmes they are implementing.
2. BHRIMS links these sectors through a network of information sharing structures that ultimately feeds into the National AIDS Coordinating Agency (NACA). Sector and programme specific data collection tools have been constructed to meet identified information needs.
3. At each level, data analysis is carried out to give a picture of the performance of response efforts. For example, data collection in the districts feeds into District Multi-sectoral HIV and AIDS Committees (DMSACs) whose mandate is to coordinate response programmes at district level. At NACA, a quarterly report on national programme performance is prepared from the tools and reported to the National AIDS Council (NAC) for informed policy decision-making.
4. BHRIMS, together with the National Strategic Framework 2003-2009 and NACA, combine to satisfy the internationally recommended principle of the "Three Ones". Figure 8.1 below summarises the structure of BHRIMS.

Figure 6: Structure of BHRIMS



8.2 Objectives of BHRIMS

The 2003-2009 National Strategic Framework document outlines the objectives of the BHRIMS as follows:

1. To establish a monitoring and evaluation infrastructure
2. To support the storage and analysis of all available HIV and AIDS data at different levels in the country
3. To improve the accessibility of HIV and AIDS information and data
4. To increase the utilisation of available reports and data for action
5. To maintain institutional memory of the National HIV and AIDS response

8.3 Progress Made on UNGASS 2005 Challenges

Progress made towards challenges identified in previous UNGASS is listed in Table 5.

Table 5: Progress made on challenges since 2005

No.	2005 Challenge	2007 Progress Made
1	Shortage of M&E Skills	<ol style="list-style-type: none"> a. Development of a National M&E curriculum addressing data quality, analysis, and interpretation especially at Sector and District levels b. Institution of Development Management (IDM) identified and contracted to train stakeholders c. 191 programme staff trained in basic M&E d. Data Management and Analysis course designed and deployed at the University of Botswana <ol style="list-style-type: none"> i. 44 newly recruited M&E officers trained ii. 14 analysts trained in SPSS
2	Lack of an explicit, consolidated budget for monitoring and evaluation	<ol style="list-style-type: none"> a. M&E has since been recognized as a critical aspect of programme development, which needs to be budgeted for at design stage – this is a recommendation in the midterm review of the National Strategic Framework, completed in mid-2007 b. An initiative to promote joint planning among all partners in the national HIV/AIDS response is seen as holding potential to address this challenge
3	Absence of a unified database and hence a largely paper-based BHRIMS which affected the lead-time from data generation to reporting, dissemination and feedback	<ol style="list-style-type: none"> a. eBHRIMS developed and deployed in all Districts <ul style="list-style-type: none"> o indicator module o data entry module o District report generator b. Towards the Third One - Integration with DHIS, CRIS, District reporting <ul style="list-style-type: none"> o ICT Assessment done in all Districts and Ministries o Basic computer training for personnel o Computer equipment purchased and deployed

No.	2005 Challenge	2007 Progress Made
4	Slow pace of implementation of the Minimum BHRIMS Package.	<ul style="list-style-type: none"> o eBHRIMS training provided to personnel in all the 27 districts. a. Institutional capacity building–M&E skills, ICT training, equipment procurement; b. 44 M&E Officers deployed to all districts; c. Monitoring the implementation of the National Strategic Plan (2003-2009)–mid-term review accomplished and finalised in 2007; d. Monitoring and evaluating the BHRIMS – Evaluated as part of the MTR 2007
5	Despite noted commitment to implementation of the “Three Ones” some development partners seem not to adhere to established reporting lines.	<ul style="list-style-type: none"> a. Development of a National Operational Plan and annual review established late 2007 b. A Mapping exercise to establish stakeholders’ information needs is about to be undertaken to ensure that BHRIMS collects and reports relevant information thus minimizing temptation to set up disjointed systems

8.4 Major achievements of BHRIMS since 2005 UNGASS Report

- 8.4.1 Development of eBHRIMS, the electronic version of BHRIMS was successfully done in 2006 and deployed at the district level, and users trained. Support is on-going with routine field visits. Plans are at an advanced stage to take eBHRIMS development to the sector level and ultimately to NACA.
- 8.4.2 A national M&E curriculum was developed in late 2006 through a highly participatory consultative process that drew stakeholders from across the national HIV/AIDS response. A target of 160 programme level staff was set to be attained by August – 157 people were trained by the set date. The course is currently being evaluated and training is expected to resume at the beginning of 2008. It is also expected that the course will be accredited through Botswana Training Authority (BOTA) in 2008.
- 8.4.3 BHRIMS is in the process of developing a national evaluation agenda for HIV/AIDS interventions in Botswana. This is a case study carried out in partnership with the Monitoring and Evaluation Reference Group (MERG), and lessons learnt from this process are expected to inform development of guidelines for evaluation agenda setting globally.
- 8.4.4 BHRIMS is in the process of developing a national research agenda for HIV/AIDS interventions in line with the key goals of the national response as spelt out in the National Strategic Framework 2003-2009. The Southern African Development Community (SADC) has come on board so as to ensure that the process benefits from and inform similar exercises regionally.
- 8.4.5 BHRIMS has just concluded a process of documenting best practices in the area of HIV/AIDS in Botswana, which was spearheaded by the Research Sub-Committee of the BHRIMS technical working group. This is an effort that seeks to promote

- effective programming for adoption and adaptation within various response contexts in the country.
- 8.4.6 A total of 60 M&E Officers have been recruited and deployed at the districts to address dire shortage of M&E skills at this level. This is expected to improve reporting as well as data quality, analysis, interpretation, and information dissemination especially at lower levels of the multi-level national HIV/AIDS response.
- 8.4.7 Botswana hosted multi-country study tour teams from Namibia, Vietnam and Zimbabwe in March 2007. The teams came to learn from the BHRIMS experience in terms of information systems development so as to apply some of the observed best practices in their respective countries.
- 8.4.8 BHRIMS conducted both a Demographic and Economic Impact assessments of HIV/AIDS Impact in 2006.
- 8.4.9 Preparations for a population-based survey with a biomarker component (Botswana AIDS Impact Survey III) are on-going, with the objective being to measure both HIV incidence and prevalence. Data collection is expected to start in May 2008.
- 8.4.10 UNGASS reporting has now been recognized as a permanent activity for the BHRIMS Technical Working Group, which remains vibrant as the national HIV/AIDS M&E Reference Group. The Evaluations Sub-committee of TWG carries the mandate to coordinate UNGASS report preparation.

8.5 Challenges for BHRIMS and identified responses

Despite the foregoing achievements, BHRIMS has identified some challenges that hamper smooth implementation of monitoring and evaluation activities. Major challenges and the corresponding identified response are noted in Table 6.

Table 6: Challenges for BHRIMS and identified responses, 2007

No.	2007 Challenge	Identified Response
1	Disharmony within the national M&E system	<ul style="list-style-type: none"> Efforts to align the national HIV/AIDS M&E system through the Harmonization Sub-committee of the BHRIMS Technical Working Group. A mapping exercise of stakeholders' information needs will be conducted (funding for the exercise is already secured). The product is expected to lead to the revision of existing BHRIMS data collection tools with a view to address identified information needs, and to clarify roles and responsibilities of various data generating agencies to avoid duplication of effort.
2	Staggered development of eBHRIMS	<ul style="list-style-type: none"> Exploration of developing modules of BHRIMS, with the preferred option to adapt existing off-the-shelf software where feasible and develop modules from scratch when necessary. This process is led by the Informatics Sub-committee of BHRIMS TWG.

No.	2007 Challenge	Identified Response
3	Absence of a consistent and reliable information dissemination system	<ul style="list-style-type: none"> <li data-bbox="558 178 1247 413">• Tackling dissemination challenges through the development of an interactive website where up-to-date HIV/AIDS materials from across the national response would be accessible. This initiative is led by NACA. Alternative channels of information dissemination will be researched as internet access remains relatively low in many parts of the country.

8.6 Conclusion

BHRIMS has doubtlessly entered into a stage where a lot of pieces are beginning to fall in place – as the system continues to deliver critical information for effective management of the national HIV/AIDS response, new challenges such as ensuring that such information reaches the rightful audience are beginning to take centre stage. This calls for exploration of innovative options that will take information to the people who need it. It is also time to review the adequacy of the system to ensure that it answers the information needs of its broad range of stakeholders. The role of information and communication technology is widely recognized in BHRIMS circles as holding a potential for bridging the information divide within the national HIV/AIDS response.

Annex 1: Consultation/preparation process

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

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	<input type="checkbox"/> Yes	No
b) NAP	Yes	<input type="checkbox"/> No
c) Others (please specify)	Yes	<input type="checkbox"/> No

2) With inputs from

Ministries:		
Education	<input type="checkbox"/> Yes	No
Health	<input type="checkbox"/> Yes	No
Labour	Yes	<input type="checkbox"/> No
Foreign Affairs	Yes	<input type="checkbox"/> No
Others (Please specify)	<input type="checkbox"/> Yes	No

- Ministry of Finance and Development Planning (Central Statistics Office)
- Ministry of Local Government

3) Was the report discussed in a large forum? Yes No

4) Are the survey results stored centrally? Yes No

5) Are data available for public consultation? Yes No

Name / title:

B.C. Molomo
National Coordinator

Date: _____

Signature: _____

Annex 2: National Funding Matrix

Cover Sheet

Please provide the following information when submitting the completed National Funding Matrix.

Country: Botswana

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

Name: Mr. B. C. Molomo **Title:** National Coordinator

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

Address: Private Bag 00463 Gaborone **Email:** bmolomo@gov.bw

Telephone: (267) 3710314 **Fax:** (267) 3710312/3

Reporting Cycle: 2006 calendar year _____ or fiscal year _____

For a fiscal year reporting cycle, please provide the start and end month/year:

___ / ___ to ___ / ___

Local Currency: Botswana Pula (BWP)

Average exchange rate with US dollars during the reporting cycle: \$1 = P6.00

Methodology:

(Please confirm which methodology – National AIDS Spending Assessments, National Health Accounts or Resource Flows Surveys – supplied the data for the National Funding Matrix. In addition, please provide information on how and where to access the full report from whichever methodology was used to collect the data.)

Unaccounted Expenditures:

(Please specify if there were expenditures for activities in any of the AIDS Spending Categories or subcategories that are not included in the National Funding Matrix and explain why these expenditures were not included.)

Budget Support: Is budget support from an international source (e.g. a bilateral donor) included under the Central/National and/or Sub-national sub-categories under Public Sources of financing?

Yes ___ No ___

Botswana Domestic Spending Data		National Funding Matrix											
		AIDS Spending Categories by Financing Sources											
Fiscal Year:		01 April 2006 to 31 March 2007											
Total		Public Sources					International Sources						
AIDS Spending Categories	All Funding Sources	Public Sub-total	Central /National	Sub-National	Dev. Bank Reimbursable	All Other Public	International Sub-total	Bilateral	UN Agencies	Multilateral			
										Dev. Bank Non-Reimbursable	All Other International agencies		
Pula		Pula	Pula	Pula	Pula	Pula	Pula	Pula	Pula	Pula	Pula	Pula	
TOTAL (Local Currency)		891,772,202.82	813,841,118.88	813,841,118.88	-	-	-	77,931,083.94	71,853,333.51	-	2,828,962.68	-	3,248,787.75
Prevention (subtotal)		61,267,780.95	44,351,598.39	44,351,598.39	-	-	-	16,916,182.56	13,667,394.81	-	-	-	3,248,787.75
1.1	Mass Media	1,293,262.85	1,293,262.85	1,293,262.85									
1.2	Community mobilisation	13,672,934.82	9,971,604.75	9,971,604.75				3,701,330.07	475,671.92				3,225,658.15
1.3	Voluntary counseling and testing	2,016,600.42	52,856.75	52,856.75				1,963,743.67	1,963,743.67				
1.4	Programs for vulnerable and special populations	4,675.00	-	-				4,675.00	4,675.00				
1.5	Youth in school	1,285,986.90	-	-				1,285,986.90	1,285,986.90				
1.6	Youth out of school	-	-	-				-	-				
1.7	Prevention programs for PLHA	4,669,433.00	4,669,433.00	4,669,433.00				-	-				
1.8	Programs for sex workers and their clients	-	-	-				-	-				
1.9	Programs for MSM	-	-	-				-	-				
1.10	Harm reduction programs for IDUs	-	-	-				-	-				
1.11	Workplace activities	5,871,575.66	5,871,575.66	5,871,575.66				-	-				
1.12	Condom social marketing	-	-	-				-	-				
1.13	Public and commercial sector condom provision	-	-	-				-	-				
1.14	Female condom	321,554.39	321,554.39	321,554.39				-	-				
1.15	Microbicides	-	-	-				-	-				
1.16	Improving management of STIs	24,650.60	2,857.10	2,857.10				21,793.50					21,793.50
1.17	Prevention of mother-to-child transmission	26,770,283.28	22,167,958.89	22,167,958.89				4,602,324.39	4,602,324.39				
1.18	Blood safety	5,334,992.93	-	-				5,334,992.93	5,334,992.93				
1.19	Post exposure prophylaxis	-	-	-				-	-				
1.20	Safe medical injections	-	-	-				-	-				
1.21	Male circumcision	-	-	-				-	-				
1.22	Universal precautions	-	-	-				-	-				
1.99	Others/Not-elsewhere classified	1,831.10	495.00	495.00				1,336.10					1,336.10
Care and Treatment (subtotal)		565,747,003.85	526,536,945.72	526,536,945.72	-	-	-	39,210,058.13	39,145,320.43	-	64,737.70	-	-
2.1	Outpatient care	-	-	-				-	-				
2.2	provider initiated testing	-	-	-				-	-				
2.3	Opportunistic infection prophylaxis	1,351,519.15	-	-				1,351,519.15	1,351,519.15				
2.4	Antiretroviral therapy	206,145,444.31	171,943,770.15	171,943,770.15				34,201,674.16	34,201,674.16				
2.5	Nutrition support	-	-	-				-	-				
2.6	Specific HIV laboratory monitoring	-	-	-				-	-				
2.7	Dental care	-	-	-				-	-				
2.8	Psychological care	2,674.00	-	-				2,674.00	2,674.00				
2.9	palliative care	965,583.84	-	-				965,583.84	965,583.84				
2.10	Home-based care	75,421,130.45	75,421,130.45	75,421,130.45				-	-				
2.11	Additional/informal providers	-	-	-				-	-				
2.12	Hospital care	279,172,045.12	279,172,045.12	279,172,045.12				-	-				
2.13	Opportunistic infection treatment	2,623,869.28	-	-				2,623,869.28	2,623,869.28				
2.99	Others/Not-elsewhere classified	64,737.70	-	-				64,737.70			64,737.70		
Orphans and Vulnerable Children (subtotal)		182,617,201.00	181,569,579.00	181,569,579.00	-	-	-	1,047,622.00	1,047,622.00	-	-	-	-
3.1	Education	-	-	-				-	-				
3.2	Basic health care	-	-	-				-	-				
3.3	Family/household support	-	-	-				-	-				
3.4	Community support	-	-	-				-	-				
3.5	Administrative costs	1,047,622.00	-	-				1,047,622.00	1,047,622.00				
3.9	Orphan Care Program	181,569,579.00	181,569,579.00	181,569,579.00				-	-				

	Program Management and Administration Strengthening (sub-total)	80,886,798.47	60,685,866.77	60,685,866.77	-	-	-	20,200,931.70	17,436,706.72	-	2,764,224.98	-	-
4.1	Program management	10,528,505.95	9,925,115.50	9,925,115.50				603,390.45	603,390.45				
4.2	Planning and coordination	10,182.00	-					10,182.00	10,182.00				
4.3	Monitoring and evaluation	613,216.35	-					613,216.35	613,216.35				
4.4	Operations research	-	-					-					
4.5	Sero-surveillance	-	-					-					
4.6	HIV drug-resistance surveillance	-	-					-					
4.7	Drug supply systems	-	-					-					
4.8	Information technology	2,230,761.17	2,230,761.17	2,230,761.17				-					
4.9	Supervision of personnel	-	-					-					
4.10	Upgrading laboratory infrastructure	12,226,591.42	-					12,226,591.42	12,226,591.42				
4.11	Construction of new health centres	44,942,971.35	43,818,065.40	43,818,065.40				1,124,905.95	1,124,905.95				
4.99	Others/Not-elsewhere classified	10,334,570.23	4,711,924.70	4,711,924.70				5,622,645.53	2,858,420.55		2,764,224.98		
	Incentives for Human Resources (subtotal)	66,068.50	66,068.50	66,068.50	-	-	-	-	-	-	-	-	-
5.1	Monetary incentive for physicians	-	-					-					
5.2	Monetary incentive for nurses	-	-					-					
5.3	Monetary incentives for other staff	-	-					-					
5.4	Formative education and build-up of an AIDS workforce	-	-					-					
5.5	Training	66,068.50	66,068.50	66,068.50				-					
5.9	Others/Not-elsewhere classified	-	-					-					
	Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	-	-	-	-	-	-	-	-	-	-	-	-
6.1	Monetary benefits	-	-					-					
6.2	In-kind benefits	-	-					-					
6.3	Social services	-	-					-					
6.4	Income generation	-	-					-					
6.9	Others/Not-elsewhere classified	-	-					-					

	Enabling Environment and Community Development (sub-total)	218,237.05	-	-	-	-	-	218,237.05	218,237.05	-	-	-	-
7.1	Advocacy and strategic communication	-	-	-	-	-	-	-	-	-	-	-	-
7.2	Human rights	-	-	-	-	-	-	-	-	-	-	-	-
7.3	AIDS-specific institutional development	-	-	-	-	-	-	-	-	-	-	-	-
7.4	AIDS-specific programs involving women	218,237.05	-	-	-	-	-	218,237.05	218,237.05	-	-	-	-
7.9	Others/Not-elsewhere classified	-	-	-	-	-	-	-	-	-	-	-	-
	Research excluding operations research which is included under (sub-total)	969,113.00	631,060.50	631,060.50	-	-	-	338,052.50	338,052.50	-	-	-	-
8.1	Biomedical research	-	-	-	-	-	-	-	-	-	-	-	-
8.2	Clinical research	-	-	-	-	-	-	-	-	-	-	-	-
8.3	Epidemiological research	969,113.00	631,060.50	631,060.50	-	-	-	338,052.50	338,052.50	-	-	-	-
8.4	Social science research	-	-	-	-	-	-	-	-	-	-	-	-
8.5	Behavioural research	-	-	-	-	-	-	-	-	-	-	-	-
8.6	Research in economics	-	-	-	-	-	-	-	-	-	-	-	-
8.7	Research capacity strengthening	-	-	-	-	-	-	-	-	-	-	-	-
8.8	Vaccine-related research	-	-	-	-	-	-	-	-	-	-	-	-
8.9	Others/Not-elsewhere classified	-	-	-	-	-	-	-	-	-	-	-	-
	Source: Government of Botswana Vote ledgers 1 April 2006 to 31 March 2007												
	PEPFAR Expenditure Tracking Schedules prepared by GDBS												
	NOTES:												
	Incentives for doctors and nurses can not be split. They are provided in activity line. They are classified under personal emoluments and Cuban personnel												
	UN Agencies support is not passed through the Govt. They directly pay for activities supporting HIV/AIDS at source												
	Funding for the Orphan Care programs is provided as lump sum and not split. For that reason, we have not split it into education, family support or basic health care. Splitting it would have meant that we make some assumptions												
	Recurrent expenditure missing.												

Annex 3: National Composite Policy Index (NCPI) 2007

COUNTRY: Botswana

Name of the National AIDS Committee Officer in charge:

Mr. B. Molomo

Signed:

Postal address: National AIDS Coordinating Agency
Private Bag 00463 Gaborone, BOTSWANA
Tel: (267) 3710413
Fax: (267) 3710312
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Date of submission: 31 January 2008

NCPI Respondents

NCPI - PART A [to be administered to government officials]

Organisation	Name/Position	Respondents to Part A [indicate which parts each respondent was queried on]				
		A.I	A.II	A.III	A.IV	A.V
Ministry of Trade & Industry	Dimakatso Toitoi	√	√	√	√	√
Min Of Health	Khumo Seipone	√	√	√	√	√
Min of Environment Wild Life and Tourism	Onneile Motsie	√	√	√	√	√
Min of Education	Judith Nawa	√	√	√	√	√
Min of Youth Sports and Culture	Kefilwe Molefii	√	√	√	√	√
Botswana Defence Force	Major Molate	√	√	√	√	√
Min of Local Government	Kemelo Mophuting	√	√	√	√	√
Min of Agriculture	Setso-O-Setso	√	√	√	√	√
Min of Lands & Housing	L. Moremi	√	√	√	√	√
Min of Minerals Energy & Water Resource	Tinny Radifalana	√	√	√	√	√
Min of Labour & Home Affairs	Kushata Mosienyane	√	√	√	√	√
Directorate of Public Service Management	Mmaoneka Makati	√	√	√	√	√
Min of Works & Transport	Tuduetso Molemogi					
Min of Communication Science & Technology	Thuto Tomeletso	√	√	√	√	√
Botswana Police Service	Bojelo Ratsatsi	√	√	√	√	√
Min of Finance & Development Planning	Nthoyapelo Motshwane	√	√	√	√	√

NCPI - PART B [to be administered to nongovernmental organizations, bilateral agencies, and UN organizations]

Organisation	Name/Position	Respondents to Part B [indicate which parts each respondent was queried on]			
		B.I	B.II	B.III	B.IV
BONASO	Daniel Motsatsing, Executive Director	√	√	√	√
BONASO	Tebogo Monametsi, Information Officer	√	√	√	√
BONEPWA	Rosemary Mokgosi, Programme Officer	√	√	√	√
BONELA	Oratile Moseki, Training and Advocacy Officer	√	√	√	√
NAC SECTOR on Ethics, Law And Human Rights	Diana Meswele, NAC Sector Coordinator	√	√	√	√
BBCA	Frank Phatshwane, Programmes Officer	√	√	√	√

BOCAIP	Irene Kwape, Executive Director	√	√	√	√
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PART A: (Administered by Government Officials)

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy/action framework to combat AIDS?

Yes Period covered: 2003-2009 Not Applicable (N/A) No

IF NO or N/A, briefly explain: N/A

IF YES, complete questions 1.1 through 1.10; otherwise, go to question 2.

1.1 How long has the country had a multisectoral strategy/action framework?

Number of Years: 5 years

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

Sectors included	Strategy/Action framework		Earmarked budget	
Health	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Education	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Labour	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Transportation	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Military/Police	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Women	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No
Young people	Yes <input checked="" type="checkbox"/>	No	Yes <input checked="" type="checkbox"/>	No

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

IF NO *earmarked budget*, how is the money allocated?

N/A

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

Target populations

- | | | | |
|---|--------|---|----|
| a. Women and girls | a. Yes | ✓ | No |
| b. Young women/young men | b. Yes | ✓ | No |
| c. Specific vulnerable sub-populations ¹ | c. Yes | ✓ | No |
| d. Orphans and other vulnerable children | d. Yes | ✓ | No |

Settings

- | | | | |
|--------------|--------|---|----|
| e. Workplace | e. Yes | ✓ | No |
| f. Schools | f. Yes | ✓ | No |
| g. Prisons | g. Yes | ✓ | No |

Cross-cutting issues

- | | | | |
|--|--------|---|----|
| h. HIV, AIDS and poverty | h. Yes | ✓ | No |
| i. Human rights protection | i. Yes | ✓ | No |
| j. Involvement of people living with HIV | j. Yes | ✓ | No |
| k. Addressing stigma and discrimination | k. Yes | ✓ | No |
| l. Gender empowerment and/or gender equality | l. Yes | ✓ | No |

1.4 Were target populations identified through a process of a needs assessment or needs analysis?

Yes ✓ No

IF YES, when was this needs assessment/analysis conducted? Year: **2001**

IF NO, how were target populations identified?

N/A

1.5 What are the target populations in the country?

Sexually active population, children, displaced population, prisoners, sex workers, pregnant women, Orphans and Vulnerable children, PLWA and mobile population.

1.6 Does the multisectoral strategy/action framework include an operational plan?

Yes ✓ No

1.7 Does the multisectoral strategy/action framework or operational plan include:

- | | | | |
|--|-----|---|----|
| a. Formal programme goals? | Yes | ✓ | No |
| b. Clear targets and/or milestones? | Yes | ✓ | No |
| c. Detailed budget of costs per programmatic area? | Yes | ✓ | No |
| d. Indications of funding sources? | Yes | ✓ | No |
| e. Monitoring and Evaluation framework? | Yes | ✓ | No |

1.8 Has the country ensured “full involvement and participation” of civil society in the development of the multisectoral strategy/action framework?

Active involvement Moderate involvement No involvement

IF active involvement, briefly explain how this was done:

Consultations with all stakeholders

IF NO or MODERATE involvement, briefly explain:

1.9 Has the multisectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals; multi-laterals)?

Yes No

1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multisectoral strategy/action framework?

Yes, all partners Yes, some partners No

IF SOME or NO, briefly explain:

N/A

2. Has the country integrated HIV and AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide Approach?

Yes No N/A

2.1 IF YES, in which development plans is policy support for HIV and AIDS integrated?

a) b) c) d) e) other

2.2 IF YES, which policy areas below are included in these development plans?

[Check for each policy/strategy included]

Policy Area	Development Plans				
	a)	b)	c)	d)	e)
HIV Prevention	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Treatment for opportunistic infections	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Antiretroviral therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Care and support (including social security or other schemes)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
AIDS impact alleviation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	√	√	√	√
Reduction of stigma and discrimination	√	√	√	√
Women's economic empowerment (e.g. access to credit, access to land, training)	√	√	√	√
Other: <i>[write in]</i>	N/A	N/A	N/A	N/A

3. Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes?

Yes No N/A

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

Low						High
0	1	2	3	<input checked="" type="checkbox"/> 4	5	

4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?

Yes No

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

Behavioural change communication	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Condom provision	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
HIV testing and counselling (*)	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
STI services	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Treatment	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Care and support	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Other: PMTCT, ARV, IPT	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>

***What is the approach taken to HIV testing and counselling? Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain:**

HIV testing is voluntary with an opt-out option.

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

Yes No

5.1 Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?

Yes No

5.2 Have the estimates of the size of the main target population sub-groups been updated?

Yes No

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

Estimates and projected needs Estimates only No

5.4 Is HIV and AIDS programme coverage being monitored?

Yes No

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

Yes No

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

Yes No

IF YES, which population sub-groups?

- Orphans
- Children
- Men and women
- Orphan and vulnerable children
- Pregnant women

(c) IF YES, is coverage monitored by geographical area?

Yes No

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

- National
- District
- Community

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

Yes No

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005?

2007	Poor											Good	
		0	1	2	3	4	5	6	7	8	9	10	
2005	Poor												Good
		0	1	2	3	4	5	6	7	8	9	10	

Comments on progress made in strategy planning efforts since 2005:

- There is significant reduction of new HIV infections among young people

- PMTCT is hope for survival of babies born to infected mothers
- Strategic planning efforts are expanded to districts and community levels for 2007, as compared to 2005 where it was limited to National Level.
- More human resource capacitation in key areas such as M&E, Research and budget allocation

II. POLITICAL SUPPORT

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

President/Head of government	Yes ✓	No
Other high officials	Yes ✓	No
Other officials in regions and/or districts	Yes ✓	No

2. Does the country have an officially recognized national multisectoral AIDS management/coordination body? (National AIDS Council or equivalent)?

Yes ✓ No

IF NO, briefly explain:

2.1 IF YES, when was it created? Year: 2002

2.2 IF YES, who is the Chair?

His Excellency the President

2.3 IF YES, does it:

Have terms of reference?	Yes ✓	No
Have active Government leadership and participation?	Yes ✓	No
Have a defined membership?	Yes ✓	No
Include civil society representatives? (*)	Yes ✓	No
IF YES, what percentage? [write in]		
Include people living with HIV?	Yes ✓	No
Include the private sector?	Yes ✓	No
Have an action plan?	Yes ✓	No
Have a functional Secretariat?	Yes ✓	No
Meet at least quarterly?	Yes ✓	No
Review actions on policy decisions regularly?	Yes ✓	No
Actively promote policy decisions?	Yes ✓	No
Provide opportunity for civil society to influence decision-making?	Yes ✓	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes ✓	No

(*) If it does include civil society representatives, what percentage?

3. Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/ programmes?

Yes ✓ No

3.1 IF YES, does it include?

Terms of reference	Yes ✓	No
Defined membership	Yes ✓	No
Action plan	Yes ✓	No
Functional Secretariat	Yes ✓	No
Regular meetings (*)	Yes ✓	No
	Frequency meetings:	
	Quarterly	

IF YES, What are the main achievements?

- Funding
- Policy Reviews
- Research
- Compilation of Best practices
- Annotated Bibliography

IF YES, What are the main challenges for the work of this body?

- Coordination of different stakeholders
- Human resource capacity

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

Data not available

5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?

Information on priority needs and services	Yes ✓	No
Technical guidance/materials	Yes ✓	No
Drugs/supplies procurement and distribution	Yes	No ✓
Coordination with other implementing partners	Yes ✓	No
Capacity-building	Yes ✓	No
Other:		

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

Yes ✓ No

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

Yes✓ No

6.2 IF YES, which policies and legislation were amended and when?

Policy/Law: National Policy on HIV&AIDS

Year:2007

Overall, how would you rate the political support for the HIV and AIDS programmes in 2007 and in 2005?

2007 Poor 0 1 2 3 4 5 6 7 8 9 10 Good

2005 Poor 0 1 2 3 4 5 6 7 8 9 10 Good

2005 Poor 0 1 2 3 4 5 6 7 8 9 10 Good

2005 Poor 0 1 2 3 4 5 6 7 8 9 10 Good

2005 Poor 0 1 2 3 4 5 6 7 8 9 10 Good

Comments on progress made in political support since 2005:

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

Yes No

3. Does the country have a policy or strategy to promote information, education and communication (IEC) and other preventive health interventions for vulnerable sub-populations?

Yes No

IF NO, briefly explain: N/A

3.1 IF YES, which sub-populations and what elements of HIV prevention do the policy/strategy address?

[Check for policy/strategy included]

	IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Other sub-populations
Targeted information on risk reduction and HIV education			√		√	OVC
Stigma & discrimination reduction						PLWA
Condom promotion			√			
HIV testing & counseling					√	OVC
Reproductive health, including STI prevention & treatment					√	OVC
Vulnerability reduction (e.g. income generation)			√			
Drug substitution therapy						
Needle & syringe exchange						

Overall, how would you rate policy efforts in support of HIV prevention in 2007 and in 2005?

2007	Poor											Good	
		0	1	2	3	4	5	6	7	8	9	10	
2005	Poor												Good
		0	1	2	3	4	5	6	7	8	9	10	

Comments on progress made in policy efforts in support of HIV prevention since 2005:

4. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?

Yes No

IF NO, how are HIV prevention programmes being scaled-up? N/A

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts* in need?

[Check the relevant implementation level for each activity or indicate N/A if not applicable]

HIV prevention programmes	The activity is available in		
	all districts in need	most districts in need	some districts in need
Blood safety	<input checked="" type="checkbox"/>		
Universal precautions in health care settings	<input checked="" type="checkbox"/>		
Prevention of mother-to-child transmission of HIV	<input checked="" type="checkbox"/>		
IEC on risk reduction	<input checked="" type="checkbox"/>		
IEC on stigma and discrimination reduction	<input checked="" type="checkbox"/>		
Condom promotion	<input checked="" type="checkbox"/>		
HIV testing & counseling	<input checked="" type="checkbox"/>		
Harm reduction for injecting drug users	N/A		
Risk reduction for men who have sex with men	N/A		
Risk reduction for sex workers			<input checked="" type="checkbox"/>
Programmes for other vulnerable subpopulations	<input checked="" type="checkbox"/>		
Reproductive health services including STI prevention & treatment	<input checked="" type="checkbox"/>		
School-based AIDS education for young people	<input checked="" type="checkbox"/>		
Programmes for out-of-school young people	<input checked="" type="checkbox"/>		
HIV prevention in the workplace	<input checked="" type="checkbox"/>		

Other:

* Districts or equivalent geographical/de-centralized level in urban and rural areas

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007?

2007	Poor											Good
	0	1	2	3	4	5	6	7	8	9	10	
2005	Poor											Good
	0	1	2	3	4	5	6	7	8	9	10	

Comments on progress made in policy efforts in support of HIV prevention since 2005:

- Improvement in implementation of activities

IV. TREATMENT, CARE AND SUPPORT

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

Yes ✓ No

1.1 IF YES, does it give sufficient attention to barriers for women, children and most-at-risk populations?

Yes ✓ No

2. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes ✓ No N/A

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?

N/A

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

[Check the relevant implementation level for each activity or indicate N/A if not applicable]

HIV treatment, care and support services	The Service is available in		
	all districts* in need	most districts* in need	some districts* in need
Antiretroviral therapy	✓		
Nutritional care	✓		
Pediatric AIDS treatment	✓		
Sexually transmitted infection management	✓		
Psychosocial support for people living with HIV and their families	✓		
Home-based care	✓		
Palliative care and treatment of common HIV-related infections	✓		
HIV testing and counseling for TB patients	✓		
TB screening for HIV-infected people	✓		
TB preventive therapy for HIV-infected people	✓		
TB infection control in HIV treatment and care facilities	✓		
Cotrimoxazole prophylaxis in HIV-infected people	✓		

IV. MONITORING AND EVALUATION

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

Yes **Years covered:** In Progress No
2003-2009

1.1. IF YES, was the M&E plan endorsed by key partners in M&E?

Yes No

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

Yes No

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

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

2. Does the Monitoring and Evaluation plan include:

a data collection and analysis strategy?	Yes <input checked="" type="checkbox"/>	No
behavioral surveillance?	Yes <input checked="" type="checkbox"/>	No
HIV surveillance?	Yes <input checked="" type="checkbox"/>	No
a well-defined standardized set of indicators?	Yes <input checked="" type="checkbox"/>	No
Guidelines on tools for data collection?	Yes <input checked="" type="checkbox"/>	No
a strategy for assessing quality and accuracy of data?	Yes <input checked="" type="checkbox"/>	No
a data dissemination and use strategy?	Yes <input checked="" type="checkbox"/>	No

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

Yes **Years covered:** In Progress No
2003-2009

3.1. IF YES, has funding been secured?

Yes No

4. Is there a functional M&E Unit or Department?

Yes In Progress No

IF NO, what are the main obstacles to establishing a functional M&E Unit/Department?

4.1. IF YES, is the M&E Unit/Department based

In the NAC (or equivalent)?	Yes ✓	No
In the Ministry of Health?	Yes	No
Elsewhere?		

4.2. IF YES, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

Number of permanent staff: 7

M&E Advisor	Full time	Since 2003
Principal research officer	Full time	Since 2003
Research Officer	Full time	Since 2002
Assistant research Officers	Full time	Since 2007
Data Entry Clerk	Full time	Since 2002
Number of temporary staff	2	

4.3. IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit/Department for review and consideration in the country's national reports?

Yes ✓ No

IF YES, does this mechanism work? What are the major challenges?

- Timely Reporting: reports are paper based therefore, it takes a long time to process them
- Data management and quality

4.4. IF YES, to what degree do UN, bi-laterals, and other institutions share their M&E results?

Low High

0 1 2 3 4 5

5. Is there an M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No Yes ,but meets irregularly Yes, meets regularly ✓

IF YES, Date last meeting:

5.1. Does it include representation from civil society, including people living with HIV?

Yes ✓ No

IF YES, describe the role of civil society representatives and people living with HIV in the working group:

- To operationalize the terms of reference for the working group
- Report progress on programmes

6. Does the M&E Unit/Department manage a central national database?

Yes No N/A

6.1. IF YES, what type is it?

Excel Based data base

6.2. IF YES, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?

Yes No

6.3. Is there a functional* Health Information System (HIS)?

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

National level Yes No

Sub-national level Yes No

(* If Yes, at what level(s)?

Districts

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

Yes No

7. To what extent are M&E data used in planning and implementation?

Low High

0 1 2 3 4 5

What are examples of data use?

- PMTCT Uptake
- Orphans and Vulnerable children
- Rapid testers
- First time testers
- Proportion of people on ARV's

What are the main challenges to data use?

- Data Quality

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

At national level?	Yes ✓	No
IF YES, Number of individuals trained	56	
At sub-national level	Yes ✓	No
IF YES, Number of individuals trained	125	
Including civil society?	Yes ✓	No
IF YES, Number of individuals trained	55	

Overall, how would you rate the M&E efforts of the AIDS programme in 2005 and in 2007?

2007	Poor	0	1	2	3	4	5	6	7	8	9	10	Good
2005	Poor	0	1	2	3	4	5	6	7	8	9	10	Good

Comments on progress in M&E 2007:

- There is a national M&E Curriculum
- Many people have been trained using this curriculum
- M&E Officers have been hired for the districts
- All districts have infrastructure in place
- Computer training and management has been carried out

PART B: (Administered by Civil Society)

I. HUMAN RIGHTS

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

No

1.1 IF YES, specify:

2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?

Yes

2.1 IF YES, for which sub-populations?

Women	Yes	
Young people	Yes	
IDU		No
MSM		No
Sex Workers		No
Prison inmates		No
Migrants/mobile populations		No
Other:		

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

The Constitution protects against discrimination on the basis of gender.

Although Botswana enacted the Marital Power Act in December 2004 there is still no law that protects women against domestic violence. A draft bill on Domestic Violence has been presented to Parliament but it does not include a provision on marital rape, nor does it create any positive obligations on the state to implement safe house support, training for police, etc.

Botswana has ratified but not domesticated CEDAW.

IF YES, Describe any systems of redress put in place to ensure the laws are having their desired effect:

There are no such systems in place.

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

Yes

3.1 IF YES, for which sub-populations?

Women		No
Young people	Yes	
IDU	Yes	
MSM	Yes	
Sex Workers	Yes	
Prison inmates	Yes	
Migrants/mobile populations	Yes	
Other:		

IF YES, briefly describe the content of these laws, regulations or policies and how they pose barriers:

- Young people: The age of consent without a guardian for HIV- testing (and for all other treatment) is 21 whilst the age of consent for sex is 16
- IDU: injecting drug use is illegal and IDU's are not recognised as a vulnerable sub-population
- MSM and Prison Inmates: The Penal Code criminalises 'Acts against the order o nature' which includes anal sex and hence MSM as a sub-population are not recognized. Also, prevention programmes including access to condoms are not available in prisons.
- Sex Workers: Living off the benefits of prostitution is illegal hence sex workers are not a recognized sub-population.
- Migrants: Only citizens of Botswana can access free services (e.g. ARV and PMTCT). Registered refugees are also denied access to free state-provided treatment and are currently being supported in small numbers by resource limited civil society groups prominently faith based organisations.

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

Yes

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

No⁸

IF YES, briefly describe this mechanism:

⁸ The sector on ethics, law and human rights of the National AIDS Council is currently in the process of initiating a monitoring tool to assess the extent and nature of discrimination experienced by PLHIVs. But there is no such monitoring tool for all other marginalized groups.

6. Has the Government, through political and financial support, involved most-at-risk populations in governmental HIV policy design and programme implementation?

No

IF YES, describe some examples:

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

HIV prevention services	Yes	
Anti-retroviral treatment	Yes	
HIV-related care and support interventions	Yes	

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies:

Due to resource constraints, these services, especially ARV, are not freely available (except condoms and VCT) to non-citizens nor refugees. There is also a gap when it comes to targeting services to specific groups, especially most-at-risk populations. Service provision is more generalised.

8. Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support? In particular, to ensure access to women outside the context of pregnancy and childbirth?

Yes⁹

9. Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support

No

9.1 Are there differences in approaches for different most-at-risk populations?

No

IF YES, briefly explain the differences:

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

⁹ There is equal access but it is not equitable. There is still a need to provide equitable services to increase male uptake

Yes¹⁰

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

Yes

11.1 IF YES, does the ethical review committee include civil society and people living with HIV?

No

IF YES, describe the effectiveness of this review committee:

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

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

No

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

No

- **Performance indicators or benchmarks for:**

a) compliance with human rights standards in the context of HIV efforts

No

b) reduction of HIV-related stigma and discrimination

No

IF YES, on any of the above questions, describe some examples:

¹⁰ The policy is not enforced by law. The state itself pre-test non-citizens before employment.
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13. Have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

Yes¹¹

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

- Legal aid systems for HIV/AIDS casework

No

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

Yes

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

Yes

15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?

Yes

IF YES, what types of programmes?

Media	Yes	
School education	Yes	
Personalities regularly speaking out	Yes	
Other:		

Overall, how would you rate the <i>policies, laws and regulations</i> in place to promote and protect human rights in relation to HIV and AIDS in 2007 and 2005?										
2007	Poor									Good
		0	1	2	3	4	5	6	7	8 9 10
2005	Poor									Good
		0	1	2	3	4	5	6	7	8 9 10
Comments on progress made since 2005:										
- The Mid term review of the National Strategic Framework has recognized most-at-risk populations.										

¹¹ Some have been sensitized but not trained. But it is done only by civil society and not in a sustained manner and to the extent that the members can address the issues meaningfully.

- There have been an increasing number of good policies being put in place but the challenge still remains that they are not legally enforceable.

Overall, how would you rate the <i>effort to enforce</i> the existing policies, laws and regulations in 2007 and 2005?										
2007	Poor									Good
		0	1	2	3	4	5	6	7	8 9 10
2005	Poor									Good
		0	1	2	3	4	5	6	7	8 9 10
<i>Comments on progress made since 2005:</i>										
- In the public service policies are easily enforceable but other sectors need policies to be backed by law.										

II. CIVIL SOCIETY PARTICIPATION

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

Low High
0 1 2 3 4 5

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

Low High
0 1 2 3 4 5

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

a) in both the National Strategic plans and reports?

Low High
0 1 2 3 4 5

b) in the national budget?

Low High
0 1 2 3 4 5

4. Has the country included civil society in a National Review of the National Strategic Plan?
Yes

IF YES, when was the Review conducted? Year: 2007

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity?

Low High
0 1 2 3 4 5

List the types of organizations representing civil society in HIV and AIDS efforts:

NGO's, CBO's, FBO's, Youth, Media, PLHIV, Human Rights, Academia, Women, VCT providers, Private Sector.

6. To what extent is civil society able to access

a) adequate financial support to implement its HIV activities?

Low High
 0 1 2¹² 3 4 5

b) adequate technical support to implement its HIV activities?

Low High
 0 1 2 3 4 5

Overall, how would you rate the efforts to increase <i>civil society participation</i> in 2007 and 2005?											
2007	Poor					Good					
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor					Good					
	0	1	2	3	4	5	6	7	8	9	10
Comments on progress made since 2005:											
<ul style="list-style-type: none"> - There is still room for improvement, especially when it comes to <i>meaningful</i> participation and <i>increased legitimacy</i> of the voice of civil society 											

¹² There are funds available, but the mechanisms to access those funds are too cumbersome
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III. PREVENTION

1. Has the country identified the districts (or equivalent geographical/decentralized level in need of HIV prevention programmes) in need of prevention programmes?

Yes¹³

IF NO, how are HIV prevention programmes being scaled-up?

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts in need?

Note: This does not address issues of quality and standards of services

(Check the relevant implementation level for each activity N/A if not applicable)

HIV prevention programmes	The service is available in		
	all districts in need	most districts in need	some districts in need
Blood safety	X		
Universal precautions in health care settings	X		
Prevention of mother-to-child transmission of HIV	X		
IEC on risk reduction	X		
IEC on stigma and discrimination			X
Condom promotion		X	
HIV testing & counselling	X		
Harm reduction for injecting drug users			
Risk reduction for men who have sex with men			
Risk reduction for sex workers			X
Programmes for other most-at-risk populations			X
Reproductive health services including STI prevention & treatment	X		
School-based AIDS education for young people	X		
Programmes for out-of-school young people		X	
HIV prevention in the workplace		X	
Other programmes; <i>[write in]</i>			

¹³ All districts have been identified as being in need, but differing contextual needs of districts have not been identified.

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and 2005?												
2007	Poor										Good	
		0	1	2	3	4	5	6	7	8	9	10
2005	Poor											Good
		0	1	2	3	4	5	6	7	8	9	10
<i>Comments on progress made since 2005:</i>												
<ul style="list-style-type: none"> - Although implementation has increased there are still issues of quality assurance and proper targeting of interventions 												

IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes¹⁴

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?
[write]:

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts in need?

(Check the relevant implementation level for each activity or indicate N/A if not applicable)

HIV and AIDS treatment, care and support services	The service is available in		
	all districts in need	most districts in need	some districts in need
Antiretroviral therapy	X		
Nutritional care	X		
Paediatric AIDS treatment			X
Sexually transmitted infection management	X		
Psychosocial support for people living with HIV and their families			X
Home-based care	X		
Palliative care and treatment of common HIV-related infections	X		
HIV testing and counselling for TB patients	X		
TB screening for HIV-infected people	X		
TB preventive therapy for HIV-infected people	X		
TB infection control in HIV treatment and care facilities	X		
Cotrimoxazole prophylaxis among HIV-infected people	X		
Post exposure prophylaxis (e.g. occupational exposures to HIV, rape)	X		
HIV treatment services in the workplace or treatment referral systems through the workplace			X
HIV care and support in the workplace (including alternative working arrangements)			X

¹⁴ All districts have been identified as being in need, but differing contextual needs of districts have not been identified.

Other programmes: [write in]			
------------------------------	--	--	--

Overall, how would you rate the efforts in the <i>implementation</i> of HIV treatment, care and support programmes in 2007 and 2005?												
2007	Poor									Good		
		0	1	2	3	4	5	6	7	8	9	10
2005	Poor											Good
		0	1	2	3	4	5	6	7	8	9	10
Comments on progress made since 2005:												
<ul style="list-style-type: none"> - Although implementation has increased there are still issues of quality assurance, proper targeting of interventions, access and resource sustainability 												

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

	<25%	25-50%	50-75%	>75%
Prevention for youth				
Prevention for vulnerable sub-populations				
- IDU	<25% ¹⁵	25-50%	50-75%	>75%
- MSM	<25%	25-50%	50-75%	>75%
- Sex workers	<25%	25-50%	50-75%	>75%
Counselling and testing	<25%	25-50%	50-75%	>75%
Clinical services (opportunistic infections/ART)	<25%	25-50%	50-75%	>75%
Home-based care	<25%	25-50%	50-75%	>75%
Programmes for OVC	<25%	25-50%	50-75%	>75%

3. Does the country have a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)?

¹⁵ There are no specific HIV programmes for IDU in the country
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Yes ✓	No	N/A
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3.1 IF YES, is there an operational definition for OVC in the country?

Yes

3.2 IF YES, does the country have a national action plan specifically for OVC?

Yes

3.3 IF YES, does the country have an estimate of OVC being reached by existing intervention?

Yes

IF YES, what percentage of OVC is being reached? 50%

Annex 4: National Return Forms

Blood Safety

Percentage of donated blood units screened for HIV in a quality-assured manner

Indicator Relevance

Type and Name of Data	Blood Usage Monthly Report		
Measurement Tool			
Data Collection Period (month/year) = (M/YYYY)	Month	Year	
	From:	1 st January	2006
	To:	31 st December	2006

Comments

INDICATOR VALUES

<u>Numerator</u> Number of donated blood units screened for HIV in blood centres/ blood screening laboratories that have both: (1) followed documented standard operating procedures and (2) Participated in an external quality assurance scheme	22801
<u>Denominator</u> Total number of blood units donated	22801
<u>Indicator Value</u> Percent	Disaggregated Values 100%

**** The data should reflect the previous 12 months**

HIV Treatment Antiretroviral Therapy

Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

Indicator Relevance

2006 Indicator Values Site electronic application and
Type and name of Data monthly ARV Site Manager's Report
Measurement Tool

2007 Indicator Values Same as above
Type and name of Data
Measurement Tool

2006 Indicator Values Month Year
Data Collection period From: January 2002
(month/year) = (M/YYYY)

To: December 2006

2007 Indicator Values Month Year
Data Collection Period From: January 2002
(month/year) = (M/YYYY)

To: November 2007

Comments The figures are as at November 2007

INDICATOR VALUES FOR 2006

<u>Numerator</u> Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period	All adults & Children	Disaggregated Values			
		Sex		Age	
		Males	Females	<15	15+
	79 490				

<u>Denominator</u> Estimated number of adults and children with advanced HIV infection	All adults & Children	Disaggregated Values			
		Sex		Age	
		Males	Females	<15	15+
	110 000				

<u>2006 Indicator Value</u> Percent	All adults & Children	Sex		Age	
		Males	Females	<15	15+
	72.2				

INDICATOR VALUES FOR 2007

<u>Numerator</u> Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period	All adults & Children	Disaggregated Values			
		Sex		Age	
		Males	Females	<15	15+
	91 780				

<u>Denominator</u> Estimated number of adults and children with advanced HIV infection	All adults & Children	Disaggregated Values			
		Sex		Age	
		Males	Females	<15	15+
	110 000				

<u>2007 Indicator Value</u> Percent	All adults & Children	Sex		Age	
		Males	Females	<15	15+
	83.4				

Prevention of Mother to-child Transmission

Percentage of HIV-infected women who receive antiretrovirals to reduce the risk of mother-to-child transmission

Indicator Relevance

Indicator relevant to our country – data entered

2006 Indicator Values

Type and Name of Data Measurement Tool

PMTCT Programme Data

2007 Indicator Values

Type and Name of Data Measurement Tool

Indicator relevant to our country – data not available

2006 Data Collection Period

(month/year) = (M/YYYY)

Month

Year

2006

From: January

To: December

2006

From: Month

Year

2007 Data Collection Period

(month/year) = (M/YYYY)

To:

Comments

INDICATOR VALUES FOR 2006

Numerator

Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce the mother-to-child transmission

12934

Denominator

Estimated number of HIV-infected pregnant women in the last 12 months

14215

2006 Indicator Value

Percent

90.99%

INDICATOR VALUES FOR 2007

Numerator

Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce the mother-to-child transmission

Denominator

Estimated number of HIV-infected pregnant women in the last 12 months

Indicator Value

Percent

Co-Management of Tuberculosis and HIV Treatment

Percentage of estimated HIV-positive incident TB

Indicator Relevance	Indicator relevant to our country – data not available		
Type and Name of Data			
Measurement Tool			
Data Collection Period (month/year) = (M/YYYY)	Month	Year	
	From:		
	To:		
Comments			

INDICATOR VALUES

<u>Numerator</u>			
Number of adults with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines) within the reporting year			
	All cases	Male	Female
	<input type="text"/>	<input type="text"/>	<input type="text"/>

<u>Denominator</u>			
Estimated number of incident TB cases in people living with HIV			
	<input type="text"/>	<input type="text"/>	<input type="text"/>

<u>Indicator Value</u>	Disaggregated Values		
Percent		Sex	
	All cases	Male	Female
	<input type="text"/>	<input type="text"/>	<input type="text"/>

Life Skills – based HIV Education in Schools

Percentage of Schools that provided life skills – based HIV education in the last academic year

Indicator Relevance

Type and Name of Data Education Program Review
Measurement Tool
Data Collection Period Month Year
(month/year) = (M/YYYY)
From: 1st January 2007
To: 31st December 2007

Comments

Number of Schools in Country 974

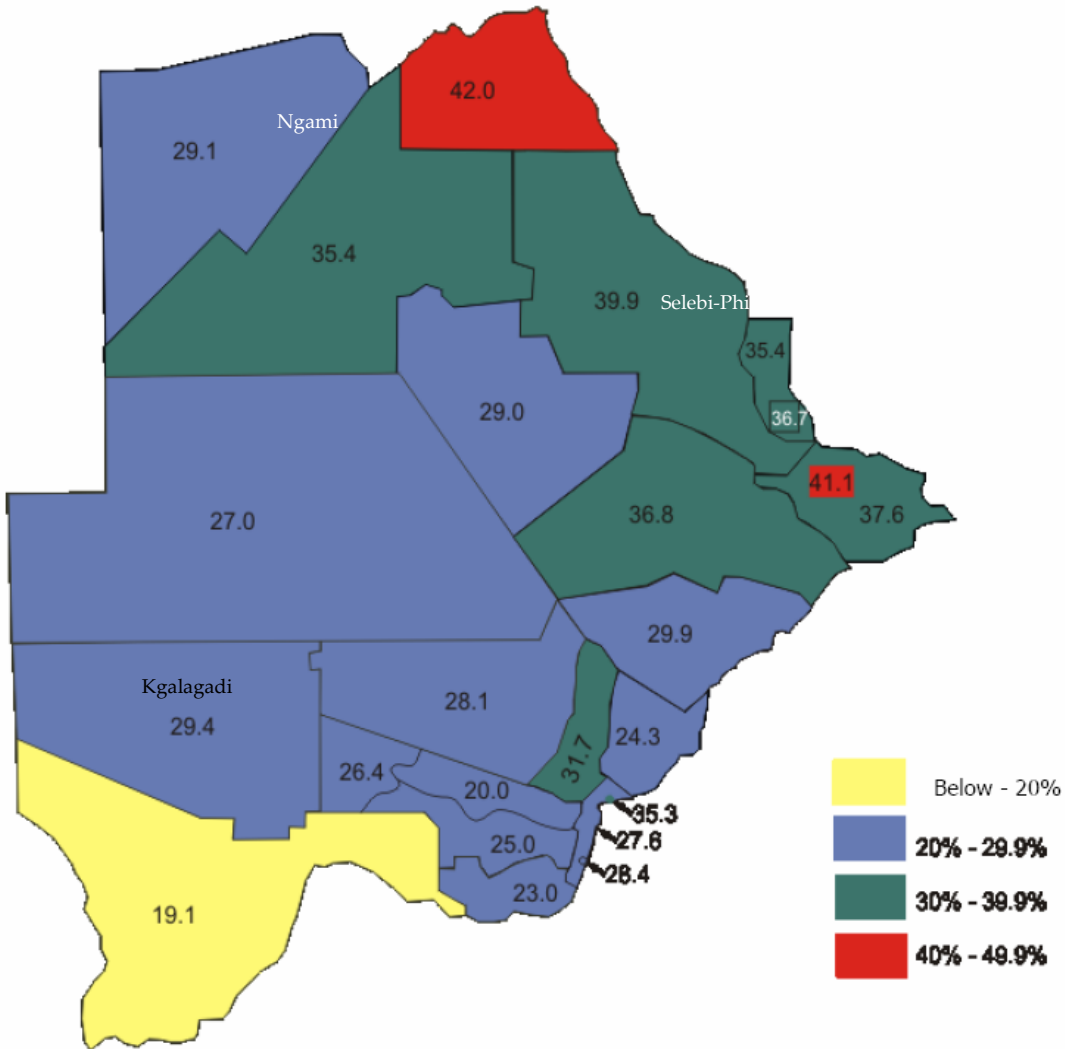
INDICATOR VALUES

<u>Numerator</u> Number of schools that provided life skills – Based HIV education in the last academic Year	All Schools	Disaggregated Values	
		Primary	Secondary
	974	741	233

<u>Denominator</u> Number of schools surveyed	All Schools	Disaggregated Values	
		Primary	Secondary
	974	741	233

<u>Indicator Value</u> Percent	All Schools	Disaggregated Values	
		Primary	Secondary
	100	100	100

Annex 5: Geographic distribution of adjusted HIV prevalence rate among pregnant women 15 - 49 years by district, 2006 Sentinel Surveillance Survey, Botswana



Source: 2006 Sentinel Surveillance Report

Annex 6: Assemblage of Sector Inputs to the 2007 UNGASS report

Sector Inputs towards the Status of the 2007 National Response to the UNGASS Declaration of Commitment on HIV and AIDS

Coordination of the Reporting Development Process

The National AIDS Coordinating Agency (NACA), through the Information Management Division coordinated the processes of data collection, collation, consensus building and report writing. All sectors—Government, development partners, civil society and the private sector were fully involved in the data generation and consensus building process.

Recruitment of Consultants

NACA in collaboration with financial support from the African Comprehensive HIV/AIDS Partnership (ACHAP) and UNAIDS, engaged three consultants to facilitate the process of data collection, collation, synthesis and report writing.

BHRIMS Technical Working Group

The BHRIMS Technical Working Group, which is composed of monitoring and evaluation experts from all sectors, was involved and updated during the course of report generation.

UNGASS Core Working Group

Technical Representatives drawn from the BHRIMS TWG including NACA, UNAIDS,, ACHAP, Ministry of Health, Ministry of Education and BONASO were assigned to guide the consultancy team and also act as a reference group during the undertaking.

Consensus Building Workshops

A one-day 'kick-start' workshop which drew participants from all sectors was held on 19th November 2007 where TWGs were each was assigned a focus area and tasked to collect data pertinent to their area. They were also responsible for writing those sections of the report in their focus area.

The primary consultants synthesized the data and section writings of each TWG . A national consensus building workshop which also drew participants from all sectors was held in order to review the draft report and to obtain comments and recommendations for the final draft from all the stakeholders.

A one-day workshop, which drew participants from all sectors, including civil society, private sector, development partners and Government

Total Cost

The total cost of data collection, analysis, report writing, consultations and consensus building workshop on the report was approximately USD\$ 40,000.00.

Data Collection Period

The planning, data collection and analysis, consultation and consensus building was from November 2007-January 2008.

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

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