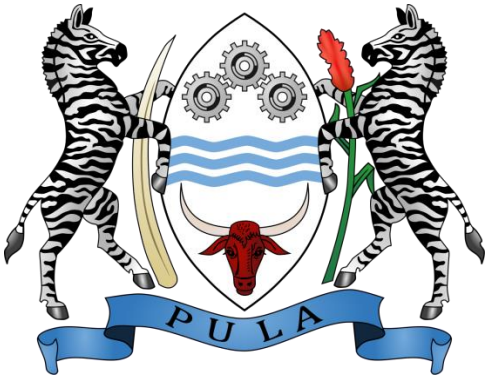

Republic of Botswana

GLOBAL AIDS MONITORING REPORT

INDICATORS FOR MONITORING THE 2016 UNITED NATIONS POLITICAL DECLARATION ON HIV AND AIDS

BOTSWANA

DRAFT

NATIONAL AIDS COORDINATING AGENCY

MINISTRY OF MINISTRY OF HEALTH AND WELLNESS

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1.0 Introduction

1.1 Purpose of the Global AIDS Monitoring Report

In 2016, the United Nations Member States adopted a political declaration on a fast track process to accelerate the fight against HIV and end the AIDS epidemic by 2030. The 2016 Political Declaration focuses on the next 15 years, with a renewed focus on integrating the global HIV response into the broader development agenda. There has been global agreement on the Sustainable Development Goals (SDG), including a target to end the AIDS epidemic.The declaration was made in support of the SDG 3 aimed at promoting good health and wellbeing with a target of ending AIDS by 2030. The declaration is also built on three previous political declarations adopted in 2001, 2006 and 2011.

The Member States further requested the Joint United Nations Programme on HIV and AIDS (UNAIDS) to assist countries to report annually on the AIDS response based on the ten commitments. The Secretary-General would then provide the General Assembly a global annual report on progress achieved in realizing the commitments made in the present Declaration. The reporting process is guided by an online Global AIDS Monitoring (GAM) tool that has a set of indicators that integrates indicators for monitoring and reporting on the health sector response to HIV (previously called Universal Access indicators) and also aligned with the SDGs indicators. The new Global AIDS Monitoring tool reduces monitoring burden experienced by countries, offers better programmatic utility, assists countries with understanding their epidemics and reallocation of resources. Further, the tool provides a more complete view of the AIDS response in a given country context.

The Government of Botswana has adopted the Fast track targets, including 90-90-90 treatment cascade targets and ending AIDS into key national strategies, with the adoption of the Treat All strategy, development of the HIV Testing Services (HTS) Strategy and a review of the Treatment guidelines. As with other Political declarations (2001, 2006 and 2011), the success of an AIDS response is measured through concrete time-bound targets. The 2017 Global AIDS Monitoring is the first year after the transition from the Millennium Development Goals to the Sustainable Development Goals and also the first year of reporting using a new HIV monitoring framework for 2016–2021.

The report focuses on components of on-line data reporting on the indicators (including expenditure on AIDS), National Commitment and Policy Instruments (NCPI) and a narrative report. The NCPI is an integral component of Global AIDS Monitoring aimed at measuring progress in developing and implementing policies, strategies and laws related to the HIV response. The NCPI supports countries in assessing the status of their HIV epidemic and response and identifying barriers, gaps and facilitators to strengthen the response. The report will assist Botswana in focusing the response on areas where action is most needed to reach set targets by 2030. The report also captures challenges, constraints and recommended actions to accelerate reaching the targets.

1.2 Process

This report is generated from an analysis of standard indicators outlined in the GAM guidelines for 2017 that is available on the UNAIDS Website. The guidelines provide details of core indicators and process of conducting the assessment. The indicators in the GAM tool are

grouped by the 10 Fast Track commitments to end AIDS by 2030. The process mainly focused on 2016 data collection from national programs on indicators of the fast track targets, WHO Universal Access Health sector indicators and NCPI.
In addition, a national stocktaking exercise was undertaken to assess current interventions and review national targets based on NDP11 and the 2016 Political Declaration Targets. The consultation clarified roles and responsibilities of Government, Civil Society, Communities, Private Sector and International partners.

Specifically, the following phases were undertaken:

- Data collection from programmes and population of the online GAM tool to measure and report on national progress;
- Collection of data from relevant data sources and facilitate a consensus building for the National Commitments and Policies Instrument (part A and B) through an inclusive consultation process;
- Analysis of all collected data and relevant reports, and national documents (strategies, guidelines, policies);
- Facilitation of a stakeholder validation workshop (for Civil Society, Government Agencies and Development Partners) to analyse indicator data including on AIDS expenditure and policy (NCPI);
- Drafting of a narrative report, including documentation of processes gaps, challenges and next steps towards achieving the fast track commitments; and
- National stocktaking and target setting based on data from GAM exercise.

2. Assessment Findings

The findings of the assessment are presented according to the Fast Track Commitments. The findings from the online GAM tool are further discussed in light of the NCPI findings, national strategies and discussions from consultative meetings.

2.1 Commitment 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

An analysis of the national HIV response described in the 2016 Investment Case, indicated that the Treat All strategy would decrease the number of HIV infections, deaths and treatment costs leading to long-term sustainability. Following the analysis, the Government of Botswana adopted and launched the Treat All strategy on 1st June 2016. Prior to the Treat All strategy, the eligibility criteria had been set at a CD4 count of 350 or less.

An analysis of the program data indicates that a total of 492,786 people were tested for HIV in 2016, yielding a positivity rate of 5.9% (29,238). Almost two-thirds (62%) of the people who tested HIV positive in 2016 were females (18,130) compared to their male counterparts (11,108). The country initiated 24,642 on ART, resulting in 1,343 less HIV infections overall by the end of 2016. However, at the launch of the Treat All Strategy in June 2016, the target was to initiate 38,000 new patients on ART thereby averting 1,465 new HIV infections by end of 2016.

As part of the country's contribution to the global target of ensuring that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020,

according programme data, 86% of Batswana who were living with HIV knew their HIV status by end of 2016. Of those HIV positive Batswana who knew their status, 74% were on treatment and 94% of those on treatment had suppressed the virus by 2016. The target could not be reached because of challenges experienced with procurement and distribution of HIV test kits, sub-optimal coordination and demand creation for HIV testing. Other challenges were:

- Delay in moving from parallel testing to serial testing;
- Delay in finalization of the HIV Testing Services (HTS) strategy;
- Non-application of innovations that address low yield such as self-testing;
- Focus on sexually transmitted infection (STI) and tuberculosis (TB) clinics;
- Inclusion of key population hotspots;
- Index case testing; and
- Contact tracing.

An analysis of the data collected by the National Commitments and Policy Instrument (NCPI) that is aimed at measuring progress in developing and implementing policies, strategies and laws related to the HIV response shows that the Government of Botswana is in the process of improving the Supply Chain Management (SCM) of HIV test kits across districts for better distribution and also strengthening the forecasting for test kits. The preparations for launching HTS Guidelines, HTS Strategy and Implementation Plan (based on the WHO recommendations) are at an advanced stage. The HTS strategy will provide a platform for innovative testing that will achieve the 2020 targets. The country is also planning to adopt self-testing as an add-on innovation to other initiatives that are currently implemented, such as client-initiated testing and counselling; provider-initiated testing and counselling; routine antenatal testing; community-based testing and counselling; home testing and lay provider testing. The training of HIV testers on serial testing will also be prioritized.

Although antiretroviral therapy is not provided in community settings (such as outside health-facilities) for people who are stable on antiretroviral therapy in Botswana, the following service provision modalities are included in the national policy on antiretroviral therapy for adults, adolescents and children:

- Tuberculosis (TB) service providers provide antiretroviral therapy in TB clinics;
- Antiretroviral therapy providers provide TB treatment in antiretroviral therapy settings;
- Maternal, new-born and child health service providers provide antiretroviral therapy in maternal, new-born and child health (MNCH) clinics;
- Nutrition assessment, counselling and support provided to malnourished people living with HIV;
- Primary health care providers provide antiretroviral therapy in primary health care settings;
- Patient support;
- Antiretroviral therapy delivered in the community as part of a differentiated care model;
- Antiretroviral therapy providers carry out cardiovascular disease screening and management; and
- Antiretroviral therapy providers carry out mental health screening and treatment.

The NCPI has also revealed that as part of the efforts to enhance access to HIV-related products and/or other health products, Botswana has taken steps to implement Trade-related aspects of intellectual property rights (TRIPS) flexibilities through domestic legislation. In 2013, a

national workshop was held on TRIPS and access to medicines. A technical working group was established to review priority recommendations by using TRIPs flexibilities. Through the *Industrial Property Act* and the *Industrial Property Act Regulations of 2012,* Botswana has domesticated TRIPS flexibilities including compulsory licensing, parallel importation, pre- and post-patent application challenges, patent examination and a list of exclusions from patentability. It has been indicated that the Industrial Property Act and the Medicines and Related Substances Act of 2013 are not harmonised. Further, the Medicines and Related Substances Act (which does not have implementation guidelines) does not incorporate TRIPS flexibilities and has not been implemented yet.

2.2 Commitment 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

Research has indicated that early infant diagnosis (EID) facilitates provision of life-saving care to infants infected with HIV and enables access to HIV prevention information and support for those testing negative. In Botswana, a total of 11,887 pregnant women living with HIV gave birth and 5,900 infants received a virological HIV test within two months of birth during 2016 translating to an early infant diagnosis rate of 49.6%. The positivity rate was 0.4%. The same program data estimated 0.9% (107) of children to have been newly infected with HIV from mother-to-child transmission among women living with HIV delivering in 2016. In preventing the mother-to-child transmission of HIV, 94.2% of pregnant women living with HIV received antiretroviral medicine to reduce the risk of MTCT of HIV in the same reporting period.

In addition to health problems experienced by women when infected with gonorrhoea, chlamydia and syphilis, these three common sexually transmitted infections (STIs) can also lead to miscarriages or infect babies before or during delivery. Infected babies usually have serious health issues such as infections of the eye, joints, or blood; blindness; or breathing problems. It is critical for an infected woman to receive treatment before the pregnancy or before delivery. The NCPI indicates that although Botswana has a national policy and plan for the elimination of mother-to-child transmission of syphilis which is integrated with HIV, these STIs are not tracked among women attending antenatal care services at any visit.

The country has a national plan for the elimination of mother-to-child transmission (MTCT) of HIV with a target for the mother-to-child transmission rate set at less than 1% by 2020. Botswana has guidelines that recommend treatment of all pregnant women and breastfeeding women for life with DTG and Truvada. Further, the country also recommends four weeks dosage of AZT, 3TC and NVP for preventing the mother-to-child transmission of HIV among HIV-exposed infants. The country also recommends both breastfeeding (first 6 months of exclusive breast feeding) and replacement feeding for HIV-exposed infants. However, the choice is determined by the individual and also the environmental settings. This is also supported by food and nutrition support initiatives that are integrated within PMTCT programmes.

All health facilities in Botswana provide services for preventing mother-to-child transmission and have community accountability mechanisms in place. The community accountability communities are supported by District AIDS Multisectoral Committees (DAMSACs) and District Health Management Committees (DHMTs) that include community based organizations. During the DMSAC and DHMT meetings held on a quarterly basis, civil society organizations are provided with an opportunity to provide comments on any health

interventions being implemented at the local level. All the health facilities offer targeted interventions to ensure that human rights considerations are addressed as part of PMTCT programmes. The following interventions are implemented as part of PMTCT services offered:

- Voluntary and informed consent as sole basis for testing and/or treatment for HIV;
- Voluntary and informed consent as sole basis for abortion, contraception and/or sterilization of women living with HIV;
- Confidentiality and privacy;
- Prevention of grave or systematic human rights abuses as part of PMTCT programme;
- Due diligence to address any human rights abuses as part of PMTCT programmes.

Although the country has national guidelines recommended for treating all infants and children living with HIV irrespective of symptoms countrywide, it does not have a specific strategy or plan to ensure that adolescents born with HIV are not lost to follow-up as they transition into adult HIV care. Further, cohorts of children receiving antiretroviral therapy are only monitored by Botswana-Baylor Children's Clinical Centre of Excellence. This centre is the product of a partnership between BIPAI, the Princess Marina Hospital in Gaborone, and the government of Botswana and ensures that these children are alive and receiving antiretroviral therapy. The centre provides primary and specialty medical care and social services for HIV-infected infants, children and their families and children are monitored in national registers at 6 month and 12 month intervals. In addition to the programmes implemented by the centre, the public health facilities offer growth monitoring and nutrition programmes for children integrated with HIV testing and treatment countrywide.

2.3 Commitment 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners

The global community acknowledges that new infections can be averted if countries with high HIV prevalence revitalize the prevention programme. The target places particular emphasis on men who have sex with men, transgender people, sex workers, people who inject drugs, prisoners and adolescent girls and young women in certain high-burden settings. This commitment argues for intensified combination prevention in high-prevalence areas, including:

- Voluntary medical male circumcision;
- Condoms High coverage of key populations;
- Pre-exposure prophylaxis for specific populations;
- Young women and girls;
- Cash transfers; and
- Focused communication and demand creation, using new and digital media.

2.3.1 Safe Male Circumcision

With an estimated 9,300 new HIV infections among the 15 year old and above recorded in 2015, Botswana adopted voluntary safe male circumcision (SMC) programme in 2009 to reduce the risk of female-to-male transmission of HIV by at least 60%. Although the population based data collected through the fourth Botswana AIDS Impact Survey (BAIS IV) conducted in 2013 indicates a circumcision rate of 23.4%, a review of the SMC program reports indicates that the number of circumcised males (including neonates) has increased from 11% (42,350) in 2008 to 48.6% (187,085) in December 2016. A total of 24,042 HIV negative males (infants and adults) were circumcised in 2016 as shown in Figure 1.

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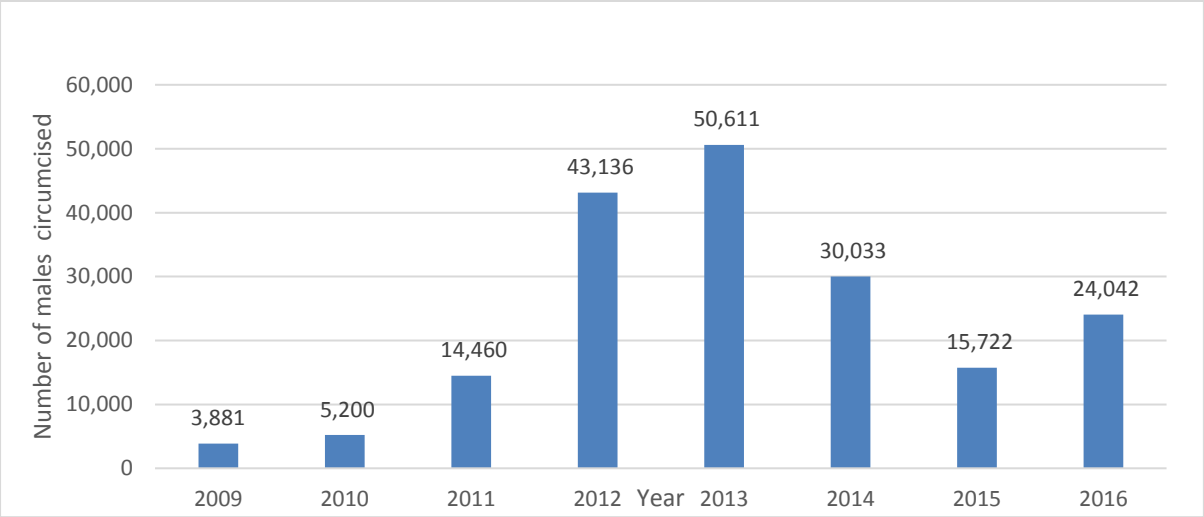
Figure 1: Number of Males Circumcised by Year (2009 -2016)



Source: Ministry of Health and Wellness (2016). SMC Performance Report

2.3.2 Key Populations

Interviews with key stakeholders indicated that data on estimates; prevalence; knowledge of status; ART coverage; condom use; HIV prevention programmes; syphilis among sex workers; viral hepatitis and pre-exposure prophylaxis (PrEP) among key populations was not collected in 2016. The data on safe injecting practices among people who inject drugs; needles and syringes distributed per person who injects drugs; and coverage of opioid substitution therapy was also not collected.

The last survey Mapping, Size Estimation and Behavioural Biological Surveillance Survey (BBSS) of HIV and STI among select high risk sub-populations in Botswana was conducted in 2012. This data has been reported to UNAIDS previously as shown in Table 1 below. The second survey on key populations is currently underway and the data will be available by the end of 2017.

Table 1: The 2012 Biological and Behavioural Surveillance Survey Key Indicators

Key Population	Indicator	Francistown	Gaborone	Kasane
FSW	Size estimate (number)	1065	2722	366
	HIV Prevalence (%)	53.5	65.5	68.5
	Syphilis prevalence (%)	1.6	3.7	14.5
	Condom use (% of sex workers reporting using a condom with their most recent client)	90.7	89.7	92.5
MSM	Size estimate (number)	319	462	
	HIV Prevalence (%)	11.7	12.3	
	Syphilis prevalence (%)	0.7	4.2	

Source: Ministry of Health and Wellness (2012). Biological and Behavioural Surveillance Survey

Although Botswana has made significant progress in addressing the HIV epidemic, the country still experiences implementation challenges related to complex procurement and supply chain management, discriminatory and coercive practices that deter access to services and discriminatory gender norms that prevent some key populations and vulnerable groups such as women and girls from making decisions about their own health. Although the NCPI has indicated that progressive jurisprudence in Botswana has helped to safeguard the rights of all people to equality and non-discrimination, including people living with HIV and vulnerable populations such as women, there are still some gaps and challenges that have been identified within Botswana's current legal and policy framework where discriminatory and punitive laws, policies and practices create barriers to access to prevention, treatment, care and support for all people, including vulnerable and key populations.

An analysis of the NCPI reveals that Botswana does not have a national prevention strategy to reduce new infections among and provide services to gay men and other men who have sex with men. Further, the country has not set national prevention targets for gay men and other men who have sex with men for 2020. However, the country has conducted a Legal Environment Assessment (LEA) for HIV with a focus on key and vulnerable populations. Since the country is in the process of developing the third National Strategic Framework (NSF III) on HIV and AIDS, the LEA recommendations will be incorporated into the new national strategy and targets will be set.

In June 2016, HIV and TB Clinical Care Guidelines recommended PrEP for persons at high risk of HIV infection (annual incidence of more than 3%) within the private sector. With support from UNAIDS, the Ministry of Health and Wellness undertook a feasibility analysis to provide PrEP in the public sector. The country has conducted an impact and cost-effectiveness of PrEP for selected districts and the preliminary results indicate that most cost-effective group is female sex workers. The country has recently taken a decision to roll out PrEP to selected key populations.

2.4 Commitment 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

The fast-track commitment to eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020 can be achieved when data is available to assess whether inequalities exist in HIV outcomes. Data for the reporting period was not collected. The data that is available is based on the GBV Indicator Study that was conducted in 2012. In 2012, the study showed that 67% of women in Botswana have experienced some form of GBV in their lifetime. The study further revealed that most violence occurred within intimate relationships with a record of 29% of women reporting to have experienced intimate partner violence (IPV) in 2012 alone. Twenty four percent (24%) of pregnant women also reported having experienced GBV during their pregnancy. In 2013, the Botswana AIDS Impact Survey results showed that 24.8% of females with early sexual debut reported not giving consent at the time of intercourse. In the population of women aged 15 to 49, an estimated 3.1 percent reported sex without consent in the 12 months prior to the survey.

However, Botswana is currently collecting data for the second Gender Based Violence (GBV) Indicator study and results are expected at the end of 2017. Research indicates that gender inequality adversely affects the health of many women and girls throughout the world. Measuring levels of gender equality can assist in interventions and programmes that address gender inequality and women's human rights as critical efforts to reduce health inequities. Countries need to assess whether their monitoring and evaluation systems are capturing data on gender inequality and HIV and to analyse data on the HIV epidemic and response from a gender perspective.

The NCPI reveals that Botswana has a national strategy that addresses gender-based violence and its linkages to HIV. The strategy is also supported by legislation on domestic violence that has provisions on physical violence; sexual violence; emotional violence; economic violence; explicit criminalization of marital rape and protection of unmarried intimate partners. Some of these provisions have been implemented involving court injunctions for the safety and security of survivors and protection services for survivors of domestic violence, such as legal services or shelters. Parental and spousal consent for accessing services is another factor that shapes universal access. Botswana has a law requiring parental consent for adolescents younger than 16 years to access HIV testing, treatment and sexual and reproductive health services. However, the country does not have a law that requires spousal consent for married women to access sexual and reproductive health services.

With the view of protecting key populations and people living with HIV from violence, Botswana has service delivery points that provide the following appropriate medical and psychological care and support for women and men who have been raped and experienced incest, in accordance with the recommendations of the 2013 WHO Guidelines on responding to intimate partner violence and sexual violence against women:

- First-line support or what is known as psychological first aid;
- Emergency contraception for women who seek services within five days;
- Safe abortion if a woman becomes pregnant as a result of rape in accordance with national law; and

- Post-exposure prophylaxis for sexually transmitted infections and HIV (within 72 hours of sexual assault) as needed.

It has also been demonstrated the world over that stigma and discrimination are barriers to uptake of HIV and AIDS services. The Stigma Index survey conducted in 2013 shows that internalised stigma (24%) is higher compared to external stigma (13%) and the national population based surveys (BAIS) have also shown that the percentage of women and men expressing accepting attitudes (all accepting attitudes) towards PLHIV dropped from 64.8% in 2008 (BAIS III) to 23.8% in 2013 (BAIS IV).

Despite the levels of stigma prevailing in Botswana, the NCPI shows that the country has policies requiring healthcare settings to provide timely and quality health care regardless of gender, nationality, age, disability, ethnic origin, sexual orientation, religion, language, socio-economic status, HIV or other health status, or because of selling sex, using drugs, living in prison or any other grounds. These policies are consistently implemented and health care workers are also targeted with interventions that build their human rights competencies required to address stigma and discrimination and gender-based violence. However, the NCPI indicates that Botswana does not have laws criminalizing the transmission of, non-disclosure of or exposure to HIV transmission although prosecutions exist based on general criminal laws. It should also be noted that people living with HIV are not restricted for entry, stay or residence.

2.5 Commitment 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year

In addressing this commitment, Botswana recognizes that adolescent reproductive health merits special consideration because the population of the country is young and faces vulnerability leading to an increasing rate of adolescent pregnancies and sexually transmitted infections including HIV. An analysis of the national programmes indicates that data the number of women and men 15-24 years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission was not collected in 2016.

However, the second Botswana Youth Risk Behavioural and Biological Surveillance Survey was conducted among 7,205 students aged between 13 and 19 years in 2016. The survey indicates that 75.7% of all students knew the relationship between HIV and AIDS. About 80% knew that a healthy looking person can be infected by HIV and only 12.5% of students viewed people infected with HIV in a bad way. Most of the students knew that a pregnant woman infected with HIV can transmit the virus to her unborn child (88.5%), that risk of transmission can be reduced by antiretroviral drugs (95%) and that HIV can be transmitted through breastfeeding (88.1%).

The NCPI data indicates that the country has education policies that guide the delivery of life skills-based HIV and sexuality education according to international standards at primary, secondary and tertiary levels. Further, young people (15-24 years old) are provided a platform to participate in developing policies, guidelines and strategies relating to their health.

2.6 Commitment 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C

Although the Ministry of Health and Wellness does not routinely record cases of hepatitis (B and C), services are provided on a cases by case basis. According to the National Tuberculosis Programme annual reports and antenatal care sentinel surveillance reports, TB remains a public health emergency in Botswana. The situation is worsened by high TB and HIV co-infection. In 2016, there were 4,854 cases of TB recorded, of which 4,082 were new cases and 692 were relapse cases. Out of the 4,854 TB cases, 1,188 were HIV positive female cases and 1,485 were male positive TB cases. All of these co-infected people were on TB and ARV therapy.

In 2015, Botswana reported 356 TB cases (including those co-infected with HIV and TB) per 100,000. In the 1990s, tuberculosis rates began to rise due to the increase in HIV prevalence. The number of TB cases increased from 200 cases per 100,000 in 1990 to 620 cases per 100,000 in 2002. In 2015, a total of 2,693 (60%) of TB patients were infected with HIV. The Ministry of Health and Wellness reports that TB incidence has declined from 344 cases per 100,000 in 2013 to 306 cases per 100,000 in 2014. In 2013, 61% of notified TB cases were co-infected with HIV.

A historical analysis of the TB epidemic has revealed that the highest TB notification rates have been in south-western Botswana (mainly in Ghanzi/Charles Hill and Kgalagadi districts compared to all other districts across the country). These two districts a have considerable number of indigenous San people (referred to as Basarwa). The major contributory factors to the high rates of TB transmission in these districts are related to:

- Poverty and social deprivation;
- High population mobility;
- Significant prevalence of substance abuse such as alcoholism; and
- Traditional life style and unconducive living condition (housing condition).

Other populations at risk of TB transmission include those in congested settings such as Dukwi Refugee Camp where the clinic servicing the refugee camp notified 13 cases of TB in 2012. Other important key populations at higher risk include prison inmates, children, remote farming communities, mine workers and mining communities (particularly the three major mines of Orapa, BCL and Jwaneng). The Ministry of Health indicates that although people in these mines are vulnerable to TB, the number of cases has been declining since 2007 as shown in Figure 1 below due to comprehensive health care infrastructure at the mines. Although a downward trend in absolute cases has been sustained in mining communities, the trend is still a significant burden.

3. Conclusion

The analysis of the national response based on the GAM indicators has shown that despite implementation challenges, the adoption of the Treat All strategy in June 2016 averted 1,465 HIV infections by the end of 2016. The strategy also resulted in an increase of ART initiations and new community initiatives. However, the supply chain management process and monitoring and evaluation system need to be improved to overcome the challenges with

implementation and data management. There is also a need to reconsider best models for demand creation, behaviour change, restructuring HTS, addressing human resources for health limitations and capacity within the Ministry of Health and Wellness to reach the 2020 targets and end AIDS by 2030. The Ministry should also fully integrate HIV, TB services and SRHR services and improve development partner coordination.

Although Botswana has made significant progress in addressing the HIV epidemic and made progressive jurisprudence safeguarding the rights of all people to equality and non-discrimination, including people living with HIV and vulnerable populations such as women, there are still some gaps and challenges that have been identified within Botswana's current legal and policy framework where discriminatory and punitive laws, policies and practices create barriers to access to prevention, treatment, care and support for all people, including vulnerable and key populations.