REPUBLIC OF BOTSWANA

BOTSWANA 2013
GLOBAL AIDS REPONSE REPORT

PROGRESS REPORT OF THE NATIONAL REPONSE TO THE 2011 DECLARATION OF COMMITMENTS ON HIV AND AIDS

National AIDS Coordinating Agency

31 March 2014

(www.unaids.org/AIDSReporting)
The indicator data will be made available after a process of data cleaning, validation and reconciliation at www.AIDSinfo.com.

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ABBREVIATIONS AND ACRONYMS

ACHAP African Comprehensive HIV/AIDS Partnerships
AIDS Acquired Immune-Deficiency Syndrome

ANC	Antenatal Clinic(s)
ART	antiretroviral therapy
ARV	antiretroviral therapy
BAIS	Botswana AIDS Impact Survey
BBSS	Botswana Sentinel Surveillance Survey
BIPAI	Baylor International Pediatric AIDS Initiative
BNTP	Botswana National Tuberculosis Program
BOCCIM	Botswana Confederations of Commerce, Industry & Manpower
BWP	Botswana Pula
CBO	community-based organization
CD4	cluster of differentiation 4
CCM	Country Coordinating Mechanism
CSO	civil society organization
CRC	Convention on the Rights of the Child
DCS	Department of Clinical Services
DHAPC	Department of HIV/AIDS Prevention and Care
DHMT	District Health Management Team
DSP	Department of Social Protection
EID	Early Infant Diagnosis
EU	European Union
FBO	Faith-based Organization
FGD	Focus Group Discussion
GDP	Gross Domestic Product
GoB	Government of Botswana
HAART	Highly Active Antiretroviral Therapy
HCW	Health Care Worker
HIES	Household Income and Expenditure Survey
HIV	Human Immune-Deficiency Virus
HTC	HIV Testing and Counseling
IDCC	Infectious Disease Care Center
IDU	Injecting Drug User/ People who Inject Drugs
IEC	Information, Education, and Communication
KITSO	Knowledge, Innovation & Training Shall Overcome AIDS
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MLGRD	Ministry of Local Government and Rural Development
MOH	Ministry of Health
MSM	Men Who have Sex with Men
MTCT	Mother-to-Child Transmission
NA	Not applicable
NAC	National AIDS Council
NACA	National AIDS Coordinating Agency
NASA	National AIDS Spending Assessment
NDP	National Development Plan
NGO	Nongovernmental Organization
NSFII	National Strategic Framework II
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PLWA	People Living with HIV

PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PPP	Public-Private Partnership
PSS	Psychosocial support
SMC	Safe Male Circumcision
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
TWG	Technical working group
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	UN General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States dollar
WB	World Bank
WHO	World Health Organization

FOREWORD

Botswana is among the 189 member states who adopted the Declaration of Commitment on HIV and AIDS in 2011, and continues its commitment towards reaching the goals and targets outlined in the United Nations General Assembly Special Session on HIV and AIDS. It is therefore my pleasure to submit the Botswana 2013 Global AIDS Response Report.

This report has been compiled through a highly consultative process which called for maximum participation and has indeed received the overwhelming support it deserves from stakeholders.

The current status of the epidemic is such that Botswana is among countries in Southern Africa with the highest burden of HIV with a national HIV prevalence rate of 18.5% for the general population (aged 18 weeks and over), and an estimated HIV adjusted incidence rate of 1.35% according to the Botswana AIDS Impact Survey IV (BAIS IV, 2013). These figures show a somewhat general flat trend in the rate of new infections. Throughout this reporting period Botswana remained committed as outlined in NSF II, to continue to put its first priority on the prevention of new infections.

Overall, Botswana has made significant strides in addressing HIV, particularly in the area of biomedical prevention, where both PMTCT and ART continue with strong implementation, exceeding the targets and commitments of the 2011 United Nations Political Declaration on HIV and AIDS General Assembly. Transmission of HIV from mother to child has reduced from as high 30% before the roll out of the program to as low as 2.1% based on program data in 2013. Although remarkable successes have been achieved through our HIV response and Interventions, this report also documents our current challenges as Botswana now faces the even greater challenge of sustaining its success without significant donor support.

The leadership and coordination provided by NACA, development partners and civil society organisations has contributed enormously towards achieving our goals towards Universal Access to treatment, prevention, care and support. Government continues to increase the budget allocated for the national response and has adopted critical policies such as the National Policy on HIV and AIDS and the Public Health Act as a way of responding to current needs in the fight against the HIV epidemic.

For this reporting period, Botswana moved forward toward actualising the Second National Strategic Framework's priority goal of preventing new HIV infections, and engaged upon a

robust investment case for Botswana's HIV response in order to mitigate against decreasing international donor support and ensure ownership, commitment and sustainability.

Richard Matlhare

National Coordinator

ACKNOWLEGEMENTS

This report would not have been possible without the generous contributions of time and participation from numerous individuals from the Government of Botswana, Civil Society Organizations, Academic Institutions, Development Partners and other Key Stakeholders.

A special acknowledgement goes to the National AIDS Coordinating Agency and the Department of HIV, AIDS Prevention and Care for their continued willingness to engage in discussions and share the data and the experiences necessary to complete the 2013 GARP Report.

Appreciation also goes to the numerous organizations that were represented in focus group discussions, interviews and consensus building workshops. These include: ACHAP, BONELA, BOFWA, BONASO, BOCAIP, BONEPWA, CDC-PEPFAR, FHI-360-Tech, Men's Sector, SCMS, TEBELOPELE, UNAIDS, UNESCO, UNFPA, UNICEF as well as private sector individuals.

Botswana 2013 Global AIDS Response Report

1. Status at a glance

1.1 Introduction

Botswana continues its commitment towards reaching the goals and targets outlined in the United Nations General Assembly Special Session on HIV and AIDS. The global targets outlined in the 2011 United Nations Political Declaration of HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS, have also served to guide Botswana's HIV response toward reaching Millennium Development Goal 6 to "halt by 2015 and begin to reverse the spread of HIV and AIDS." Focused and concrete progress towards these global targets form the basis of Botswana's HIV response.

The comprehensive framework outlined by the United Nations General Assembly since 2001 reflect the ceaseless global determination to establish an AIDS free world. Botswana's part in the global struggle against HIV has been signficant and served as one of the leading examples in ART delivery for other member states to appreciate. Moving forward Botswana shares many of the struggles and successes of the global community in developing a sustainable multi-sectorial approach which is both inclusive and effective for all members of soceity.

Botswana's achievements in addressing its HIV epidemic have surpassed most countries in magnitude, focus and impact. Strong and sustained political will, generous development partner funding and impressive scientific expertise combined to create a successful HIV response never before imagined possible on the continent of Africa. However, despite meeting and in some instances exceeding the targets and commitments of the 2011 United Nations Political Declaration on HIV and AIDS General Assembly, Botswana now faces the even greater challenge of sustaining its success without significant donor support. Compounding significant financial and human resourse constraints, as well as complex and often contradictory sociocultural realities pose serious barriers to successfully implementing prevention strategies. Gender inequalities in a generalized epidemic which disproportionally affects women present formable challenges that must also be addressed moving forward. The need for health system strengthening and a revisioning of health care service delivery -- that will require up to one third of the entire county's population to interact with the healthcare system on a monthly basis – is also urgently required.

Together these factors call for an even more aggressive HIV response in Botswana then ever seen before. With financial support from external partners fading, what is clear at this juncture is that critical self-reflection, innovation and dedicated leadership are mandatory if Botswana hopes to ensure the long-term sustainability of their previously successful HIV response. Complacency at this time will herald degeneration, increased costs and ultimately a reversal of investment and previous gains.

The submission of the country's sixth UN Global AIDS Response Progress Report has served to not only quantify the global indicators but has also served as a mechanism for consensus building and agreement on priority areas within Botswana HIV response in the immediate years to come.

1.2 2013 Global AIDS Response Report (GARPR) Writing Process

To assist the National AIDS Coordinating Agency (NACA) in its task to complete the GARP report, a consultant was engaged with the following terms of reference:

- Update data on core indicators for GARP reporting to measure and report on national progress.
- Collect data and facilitate consensus building for the National Commitments and Policies Instrument (part A and B) through an inclusive consultation process.
- Analyze all collected data and reports, including but not restricted to the draft Mid-term Review Report of High Level Meeting Target by NACA (2013).
- Facilitate a stakeholder consensus workshop (Civil Society and Government Agencies).
- Produce a narrative report, including documentation of processes and best practices.

With assistance from key NACA staff and the UNAIDS Strategic Information team the consultant was able to meet with governmental representatives, civil society organizations and development partners to complete all processes outlined in the terms of reference. An inception report was presented to the GARPR technical working group and the proposed work plan was approved.

Data collection took place over a period of three weeks beginning in mid-February. The consultant embarked upon an extensive literature review, key stakeholder interviews and conducted a series of focus group discussions including civil society, governmental stakeholders, and development partners to discuss indicator results and complete part A and B of the NCPI portion of the GARP report. This process cumulated in a well-attended consensus workshop with broad multi-sectorial representation. The consultant complied all responses and presented the finalized draft of indicators and other findings to high-level officers and management within NACA and the Botswana Ministry of Health. The composite report was then submitted for comments and approval from NACA.

1.3 Status of the Epidemic

Preliminary data from the Botswana AIDS Impact Survey IV (BAIS IV, 2013) point to moderate gains across some areas in the HIV response. HIV adjusted incidence is estimated at 1.35%. HIV prevalence is estimated at 18.5% for the general population (aged 18 weeks and over), with females at 19.2% and males 14.1%, a slight increase from BAISIII, 2008 estimated at 17.6%, 20.4% and 14.2, respectively. HIV-infected infants (under 18 months) were estimated at 2.2% with 10,021 children, nearly 100% of those eligible receiving ART. Results from the 2011 Botswana Sentinel Surveillance Survey estimated HIV prevalence to be 30.4% among women ages 15-49. HIV Prevalence data varied slightly depending upon residence and district in BAIS IV with urban estimates at 17.5% and rural at 15.8%.

It is estimated that 319,750 HIV infected people were living in Botswana with 87.26% or 223,974 individuals receiving ART according to national eligibility guidelines, covering just 67% of the total HIV infected population at the end of 2013. An estimated number of 9,170 infections occurred in 2013 with 23,831 HIV-infected individuals initiated on ART. Already low Mother-to-Child-Transmission rates

continued to improve in 2013, with the 2013 BAIS IV estimates at 2.2% down from 3.9% estimated in 2008 BAIS III, representing at total of 296 HIV-infected babies born in 2013. Approximately 534 health facilities are now dispensing ART either in clinics or on outreach. According to ART Failure Management Surveys conducted in 2013, first line adult failure rates increased from less than 6% recorded in 2012 to over 10% in 2013, with pediatric first line ART failure rates at 15%.

Strong gender disparency in HIV prevalence appears throughout BAIS IV. Results estimate HIV prevalence amongst women at 20.8% as compared to men at 15.6%. When comparing HIV prevalence results by district and gender, women remained disproportionally affected with nine districts having estimated female prevalence >20% as compared to only 1 district found to have male HIV prevalence >20%. Prevalence amongst females was highest at 43.7% in the 35-39 age group in BAIS IV and as high 52.3% reported in the 2011 ANC Sentinel Surveillance Survey. This survey also highlighted the plight of poor, uneducated and unemployed women in the epidemic with HIV prevalence >35% in day labourers, domestic helpers and those women who never attended school. The survey also found that 50.2% of pregnancies were unplanned with 33.4% of mothers who did not plan pregnancies being HIV positive as compared to 27.4% of those who who did. The survey also highlighted the need for continuous HIV prevention strategies targeted at pregnant females, 10.2% of whom sero-converted during their pregnancies. Finally, findings from BAIS IV estimated that of young women with early sexual debut 25.8% did not consent at the time of intercourse.

Estimates of young males' high risk sexual behavior patterns reported in the BAIS IV data were also revealing as 48.7% ages 15-19 years reported more than one sexual partner in the past 12 months as compared to their female counterparts at 25.2%. Younger men also showed lower circumcision rates than their older male counterparts, those in the 15-19 and 20-24 year categories at 23.4% and 22.3% as compared in the 30-34 and 35-39 and 55-59 year categories at 26.5%, 30.8% and 39.2% respectively. Males were also shown to display higher discriminatory attitudes at 5.0% compared to females at 2.7%.

Condom use saw decreases among the general population, both genders, and across all ages groups with condon use in the general population falling from 90.2% recorded in the 2008 BAIS IV to 81.9% recorded in the 2012 BAIS IV. Decreased rates of condom use were evident in all females from 89.5% to 83.14% and all males from 90.4% to 81.2%. Within the 25-49 year categories condom use fell for all males from 87.8% to 77% and from 85.9% to 81% for all females as reported in BAIS III and IV respectively. Consistent condom use with casual sexual partners among 15-49 year olds stood at only 41.9%. Differences in condom use with casual versus regular partners were also recorded, higher condom use at the last sex act estimated at 71.9% for casual partners, considerably higher than with regular partners at 44.8%.

HIV testing within the general population remained dangerously low and saw little improvement, moving slightly from 61.7% recorded in 2008 BAIS III to 62.9% in 2012 BAIS IV. All testing rates across gender and age groups remained under 70% with the exception of females age 20-24 at 74.3% in the 2012 BAIS IV results. General HIV knowledge among young people also remained low with < 50% of youth across both genders being able to correctly answer basic questions related to HIV acquisition.

For the first time with the completion of the 2012 Mapping, Size Estimation & Behavioral and Biological Surveillance Survey of HIV/STI Among Select High-Risk

Sub-Populations in Botswana (BBSS), the country has established baselines with which to target prevention strategies towards key populations. HIV prevalence among female sex workers at 61.9% requires immediate action be taken toward safeguarding commercial sex workers and their partners. Interventions designed to improve current HIV testing statistics at 54.8% are also essential. Programmes designed specifically to include MSM populations, with a recorded HIV prevalence of 13.1%, will go far to eliminate stigma and discrimination. Improving the legal environment for marginalized populations is also essential for MSM, sex workers and prison inmates. Efforts directed toward addressing these key populations will go far to improve health services and prevention of the spread of HIV, as only 44.9% of both populations are currently being reached.

1.4 The Policy and Programmatic Response

The direction of the Botswana National HIV response is largely based on the priorities outlined in the National Strategic Framework II (NSFII) 2010-2016 and the National Operational Plan (NOP). The National AIDS Coordinating Agency (NACA) is responsible for aligning multi-sectorial efforts towards achieving national and international targets. The Ministry of Health implements all health related matters along with other key Ministries. Civil society organizations are both supported by NACA and private funding mechanisms. Development partners and unilateral organizations also work closely with NACA and the Ministry of Health to achieve harmonization and shared goals. NACA reports quarterly to the National AIDS Council (NAC), chaired by former president Fetsus Mogae and assisted by the current Vice President, Ponatshego Kedikilwe. This national oversight council reviews all aspects of the response and approves major guidelines changes and changes in strategy direction.

In 2013, two major policy documents were completed. The Botswana National Policy on HIV and the Public Health Act, were formulated to improve legal and operational constraints in the delivery of HIV care and improve the delivery of health services overall. The Botswana National Policy on HIV, which had not been revised since 1998, intends to provide a clear and comprehensive regulatory framework to address the ever-increasing HIV policy issues and contending priorities. The Public Health Act, in seeking to protect and improve health care across all cadres of society, also intends to clarify often difficult and contenious issues surrounding the intentional spread of HIV.

Alignment and harmonization of domestic and external financial support in Botswana's HIV response took priority in 2013 as the need to improve efficiency became critical as more development partner funding was decreased. Between 2009 and 2012, PEPFAR funding alone decreased over 30 million USD. Withdrawal of donor support from the Gates Foundation also occurred in 2013 as well as complete withdrawal of support for safe male circumcision from the CDC and ACHAP. The Merck Foundation also wound down their 10 year drug donation by 90%. Therefore, strategy efforts in 2013 were directed at both determining and overcoming existing funding gaps as well as spearheading costing and financing exercises within the Ministry of Health. A Multi-sectorial Financing Technical Group was also formed. As a result a number of policy documents focused on financing were carried out; these included:

- The Botswana HIV/AIDS Partner Mapping Report 2013 (final draft complete)
- The Transitional Financing Report
- The Investment Case Report (to be completed in 2014)

- The 2013 Botswana Private Sector Health Assessment
- The costing of the Essential Health Services Package (to be completed in 2014)

Prevention efforts also remained at the forefront of the HIV response with the following policy documents developed and or completed in 2013:

- 2012 Mapping, Size Estimation & Behavioral and Biological Surveillance Survey (BBSS) of HIV/STI Among Select High-Risk Sub-Populations in Botswana
- Strategy to Elimiate Mother-to-Child-Transmission
- Stigma and Discrimination Index Study (analysis on-going)
- Prison Study (analysis on-going)

Issues of gender disparities fueling the HIV epidemic were also addressed. The Domestic Violence and Matrimonal Causes Acts, and the abolition of the Marital Powers Act allowed Botswana to make progress in addressing existing gender inequality especially in regard to the legal environment. While the HIV Policy upholds the prinicples of non-discrimination based on gender and the NSF II identifies gender equality as a guiding principle, neither document elaborates specific strategies to promote gender responsive programme implmentation. The NOP identifies a few activities for women and girls, however it does not address the structural issues driving the epidemic that make women more vulnerable to HIV and the NOP budgeting is not gender based. While the national M&E strategy provides for gender disaggregated data, only a few indicators have gender disaggregrated data routinely collected.

Civil Society has continued to complement government efforts in service delivery of HIV prevention, treatment, care and support services. They have played key roles in mobilizing community uptake of HIV services such as testing and counseling and have worked closely with government as implementing partners. Unfortunately, their role in advocacy and as watchdog has been limited, with only a few organizations capacitated to provide these roles. Funding has remained a challenge with most organizations depending heavily on government for support, compromising their ability to advocate for policy change. Weak capacity in governance, management and finance skills has led to a poorly coordinated CSO response. Furthermore, this lack of adequate capacity has led to low participation in key policy and programming dialogue platforms such as the Joint Oversight Committee and the County Coordinating Mechanism.

1.5 Indicator Data (see Annex 3)

2. Overview of the AIDS Epidemic in Botswana

2.1 Status of the Epidemic

2.1.1 Variation in HIV Prevalence

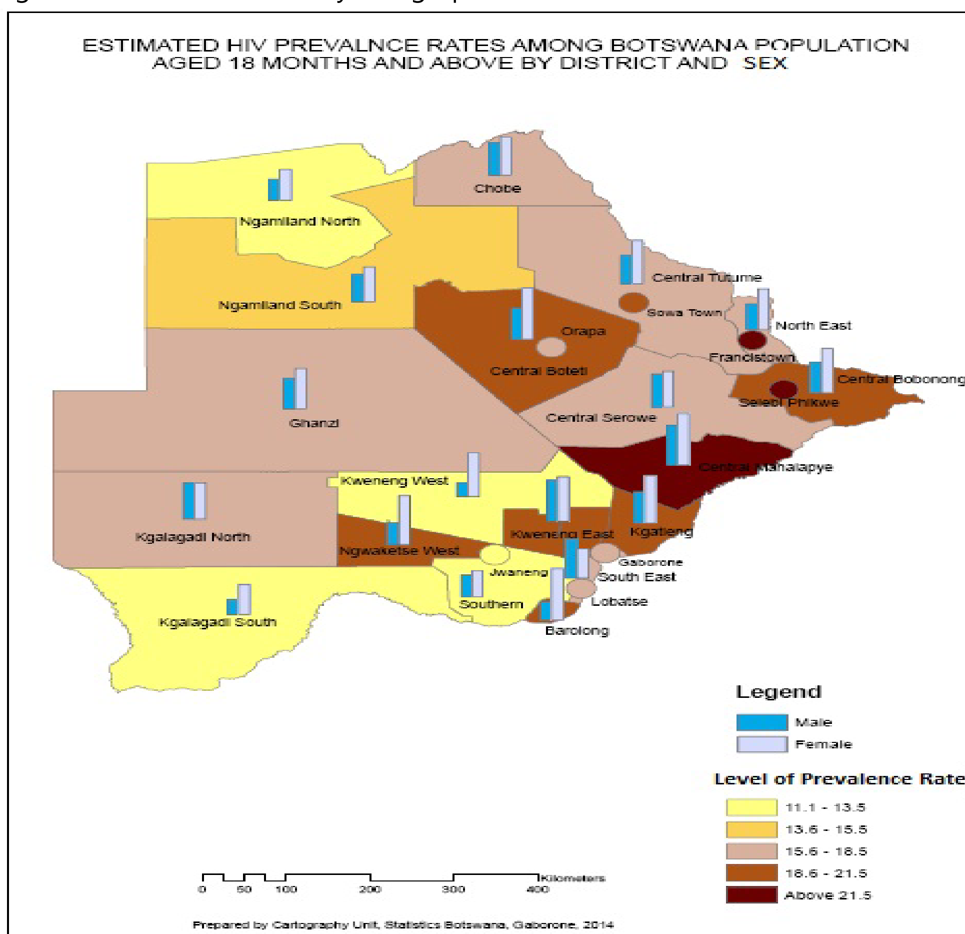
Table 1. National HIV Prevalence

	Under 18 months	18 months or over	6 weeks and above
Positive	2.2	18.5	17.0

2.1.2 Geographic Variation in HIV Prevalence

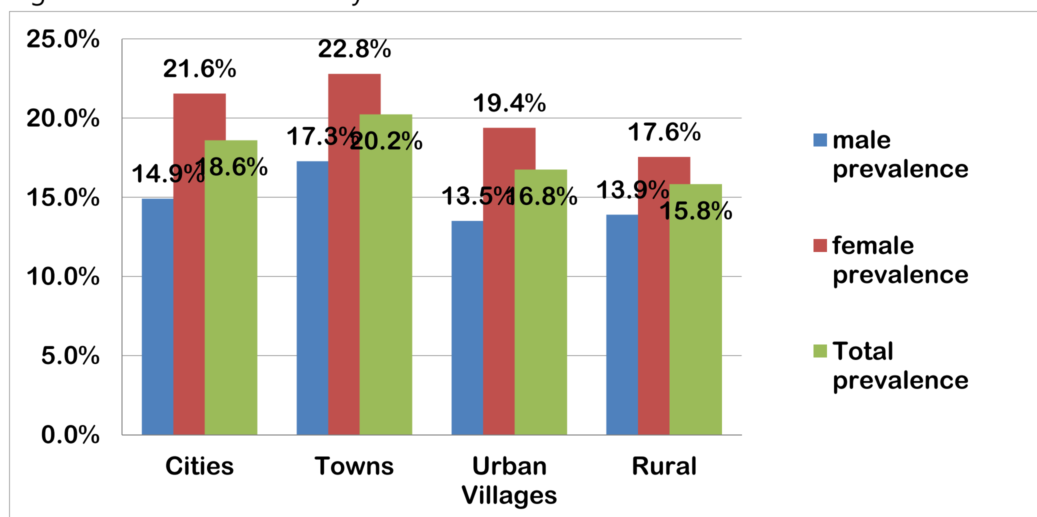
Results from the 2013 BAIS IV study reveal geographic differences in HIV prevalence by district and gender. Nine districts display HIV prevalence >20% for women. HIV prevalence is highest is Sebele Phikwe District at 27.5%.

Figure 1. HIV Prevalence by Geographic and Gender Variation



Slight variations in HIV Prevalence was seen across cities, towns, urban villages and rural areas. The highest prevalence was seen in towns at 22.8% and among males in towns at 17.3%.

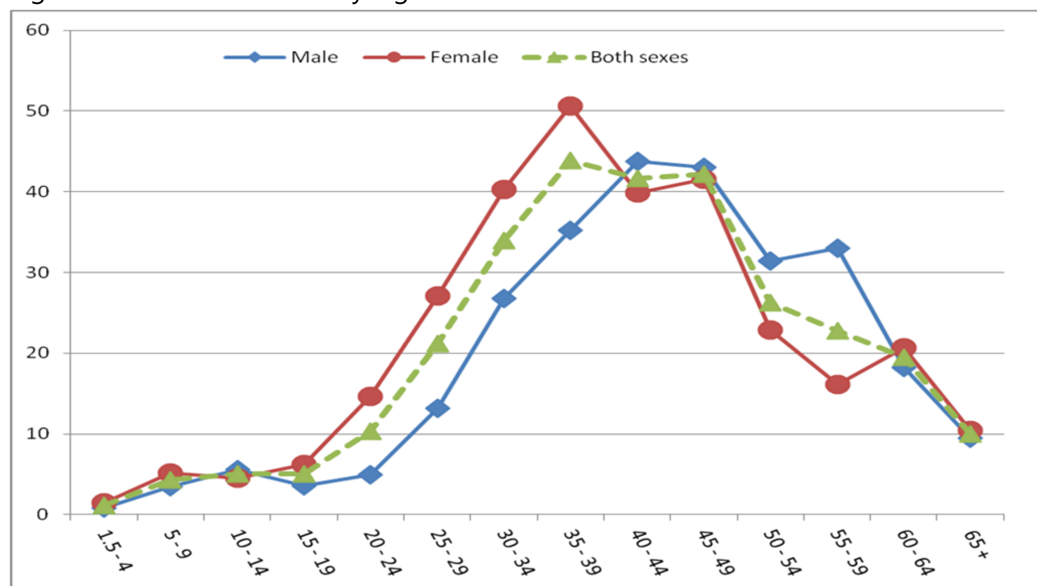
Figure 2. HIV Prevalence by Location of Residence



2.1.3 HIV Prevalence by Age and Gender

HIV Prevalence peaks for females in the 35-39 year age group at 43.7%. Male prevalence peaked a decade later in the 45-49 year age group following at 41.8%.

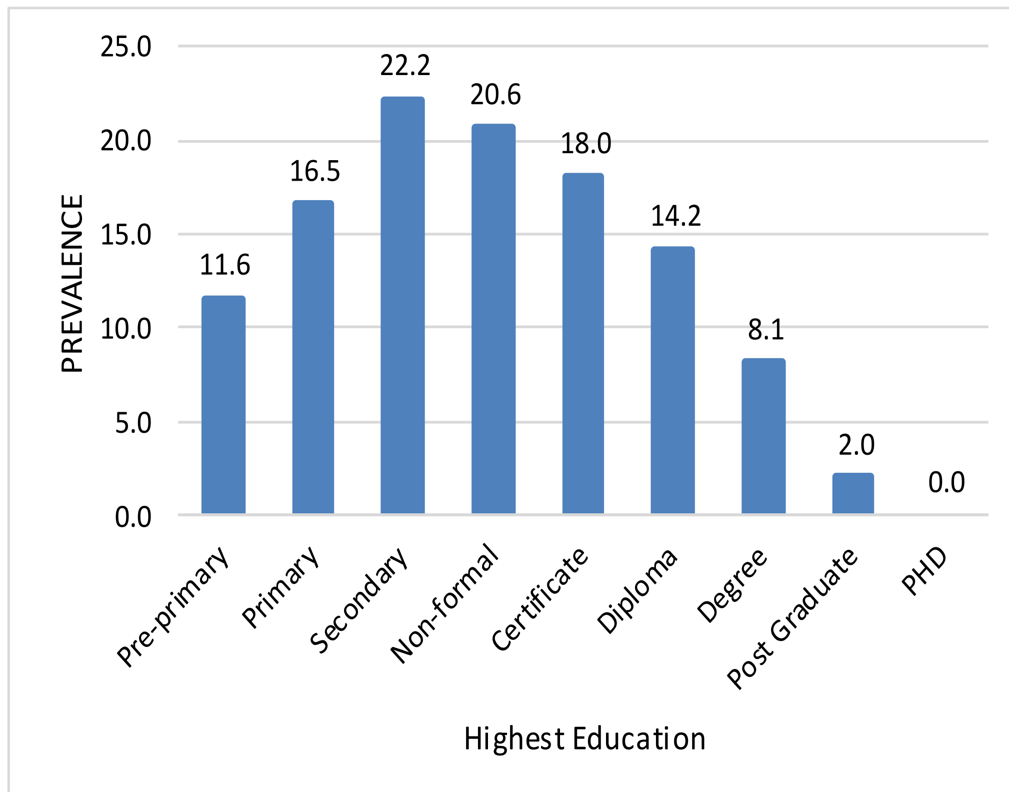
Figure 3. HIV Prevalence by Age and Gender



2.1.4 HIV Prevalence by Education Level

HIV Prevalence was highest at 22.2% for those attending school up to secondary level, followed by those with no formal education at 20.6%. HIV prevalence was seen to decline with increasing levels of education.

Figure 4. HIV Prevalence by Education Level



2.1.5 <u>HIV Incidence</u>

Adjusted incidence from 2013 BAIS IV was 1.35%. The Spectrum model estimated 2013 incidence at 0.93% representing approximately 9,170 new infections 2013.

3. National Response to the AIDS Epidemic

(Indicators and NCPI SUMMARY)

3.1. Prevention

Target 1: Reduce sexual transmission by 50% by 2015

Table 2. HIV Prevention Indicators for Young Adults

1.1 Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention					
2003	2005	2008	2010	2012	2013
36.3	37.6	37.6	43.7	43.7	47.9
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before age 15					
2003	2005	2008	2010	2012	2013
Not required	7.0	No data	5.5	5.5	4.6
1.3 Percentage of adults aged 15-24 who have had sexual intercourse with more than one partner in the last 12 months					
2003	2005	2008	2010	2012	2013
Not required	Not required	No data	24.0	24.0	15.8
1.4 Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during the last intercourse					
2003	2005	2008	2010	2012	2013
Not required	Not required	No data	90.2	90.2	81.9
1.5 Percentage of young women aged 15-24 who are living with HIV					
2003	2005	2008	2010	2012	2013
Not required	Not required	Not required	Not required	14.1	12.75(Spectrum)

Botswana continues to be significantly challenged addressing the issues surrounding the prevention of HIV transmission. While BAIS IV showed some improvements in young adults who reported more than one sexual partner in the past 12 months from 24% in 2012 to 15.8% in 2013, most other areas lacked significant gains. Of particular concern is the trend of condom use, which decreased from 90.2% in 2012 to only 81.9% in 2013. Equally noteworthy is that still after 12 years of a well-resourced HIV response and in a country of only 2.2 million people, the substantive knowledge of the basic HIV information remains low in more than 50% of the youth. The lack of data necessary to report the HIV prevalence amongst young women also requires remediation.

Young males scored more poorly than young women across all categories of prevention and knowledge of HIV. In males aged 15-19 years, 48.7% reported more than one sexual partner in the last 12 months compared to their female counterparts at 10%. While condom use in this age group was strong at 92.7%, older males aged 25-49 years who had more than one sexual partner reported condom use only 77% of the time.

The overall drop in condom use from 90.2% in 2012 to 81.9% in 2013 should be noted given the considerable recommendations made about condom use and distribution in the 2013 Review of Mid-Term Targets. Decreases in condom use or availability should be closely monitored.

NCPI Prevention Summary:
While Botswana's strategic planning and implementation efforts were perceived as strong, receiving marks (on a scale of 0-10) of 9 and 8 respectively, it was noted that indicator data tends to show little impact of prevention efforts. Recommendations that more attention and financial support is needed to focus on behavior change in addition to bio-medical prevention interventions were echoed throughout the NCPI workshops.

Key Recommendations:

- Continue funding for both bio-medical and behavioral interventions
- Consider financial support to implement the wide use of ART as "Treatment as Prevention"
- Ensure additional human resources for successful program implementation and accurate M&E efforts
- Focus attention on research to rationally and realistically address sexual practices within communities
- Identify and prioritize gender issues driving HIV transmission

Indicators for Key Populations

With the completion of the 2012 Mapping, Size Estimation & Behavioral and Biological Surveillance Survey (BBSS) of HIV/STI Among Select High-Risk Sub-Populations in Botswana, for the first time there is baseline HIV information regarding key populations.

Indicators for Sex Workers:

1.7 Percentage of sex workers reached with HIV prevention programmes: ***44.9%***

1.8 Percentage of female and male sex workers reporting the use of a condom with their most recent client: **90.1%.**

1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results: **54.8%.**

1.10 Percentage of sex workers who are living with HIV: **61.9%**

HIV prevalence among sex workers (44.9%) is more than three times higher than in the general population at 18.5%. Developing prevention interventions to address the specific needs of sex workers is therefore critically important. Improvements are also required to increase HIV testing among sex workers.

Indicators for Men Who Have Sex With Men

1.11 Percentage of MSM reached with HIV prevention programmes: ***44.9%***

1.12 Percentage of MSM reporting the use of a condom the last time they had anal sex with a male partner: ***84.2%***

1.13 Percentage of MSM that have received an HIV test in the past 12 months and know their status: ***79.6%***

1.14 Percentage of MSM who are living with HIV: ***13.1%***

The MSM indicators show similar or in some cases better results than the general population including HIV testing results at 79.6% versus 63.7% and HIV prevalence at 13.1% for MSM 18 years and older versus 18.5% for the general population aged 18 months and above. These indicators however do not address the issues of stigma and discrimination, which place HIV positive MSM populations at increased risk of HIV transmission.

NCPI Key Populations Summary

In 2013, a number of policies and legislative actions were undertaken to improve the rights of the general population to obtain health care without discrimination. However, no individual policies were put in place to safeguard the practice of sex work or the rights of sex workers or for those who choose same sex partnerships. Criminalization of sex workers and those involved in same sex relationships fuels negative public attitudes/ stigma and discrimination, which contributes to the low uptake of services by key populations. Interventions, policies and legislation to address these issues are therefore needed.

Key Recommendations:

- Develop prevention interventions specifically targeted to the needs of sex workers, including HIV testing and linkage to ART care
- Develop prevention interventions specifically targeted to the needs of

individuals who are involved in same sex relationships

- Consider the adoption of specific legislative measures to protect marginalized and other vulnerable populations from stigma and discrimination

Table 3. Indicators for Male Circumcision

1.22 Proportion of males circumcised 15-49 years)	
2008	2013
11%	25.4%
1.23 Number of males circumcised during the past 12 months according to national standard: **46,793**	

Despite considerable challenges regarding decreases in donor funded support, the Safe Male Circumcision programme within the Botswana Ministry of Health made considerable gains in 2013. Challenges moving forward include recruitment of younger males for circumcision and finding ways to improve referral services into SMC and linkages to care.

Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015

The Size Estimation and Mapping Study Among Key Populations conducted in 2012 did not identify populations of injecting drug users of any significance. However, the Ministry of Health plans to remain vigilant in monitoring signs or any significant increases in injecting drug use and will consider an HIV prevalence survey among injecting drug users should the need arise.

Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

Table 4. PMTCT Indicators

3.1 Percentage of HIV-positive women who received antiretroviral medicine to reduce the risk of mother-to-child transmission					
2003	2005	2008	2010	2012	2013

34.3	60.3	91.0	94.2	94.0	96.2

3.1a. Prevention of mother-to-child transmission during breastfeeding

2011	2012	2013
No data available	45.6	No data available

3.2 Early infant diagnosis

2011	2012	2013
45.85	38.68	47.0

3.3 Mother-to-child transmission of HIV (modeled)

2011	2012	2013
3.86	3.9	2.49

From all available data Botswana's PMTCT programme remains strong and well implemented. Special attention was taken in BAIS IV to triangulate Ministry of Health PMTCT programme data for MTCT as well as modeled rates. The estimated under 18 month HIV prevalence of BAIS IV was 2.2%. PMTCT programme reported 2.1% transmission rates and the 2013 Botswana National Spectrum model estimates were 2.49%, demonstrating agreement of the MTCT rates across three data sources.

As a mature programme Botswana's PMTCT programme is now challenged with how best to improve service delivery through integration both within the Antiretroviral Treatment Programme and within Sexual Reproductive Health. Since 2011, provision for Triple ART Prophylaxis has been provided for all pregnant HIV positive women until six weeks post delivery or for breastfeeding mother six weeks post cessation of breastfeeding. Questions concerning whether to invest in implementing Option B+ or rather to use limited resources to strengthen other aspects of the programme are under discussion.

Improvements of the monitoring and evaluation systems of the PMTCT Programme are needed. This includes implementing SMS technology for optimal delivery of laboratory test results for Early Infant Diagnosis as well as CD4 and viral load results.

Botswana supports a woman's right to choose her optimal infant feeding method, given the very diverse social and cultural circumstances facing each HIV positive mother in the country. With more than 80% of ANC attendees identifying themselves as single mothers (2011 ANC Sentinel Survey) the economic realities facing HIV positive mothers must also be considered. For these reasons, the issue of breastfeeding in Botswana has remained on the forefront of clinical care discussions. Studies to inform breastfeeding policies are also underway by the Botswana Harvard Partnership and are being closely monitored. Also under investigation are factors involved in early infant and maternal mortality. Another concern is the low male involvement with only 11% of male partners of pregnant women attending ANC testing for HIV in the past 12 months.

NCPI PMTCT Summary

In 2013, the PMTCT programme hosted successful community campaigns to improve programme uptake. The Elimination of Mother-to-Child Transmission Strategy was also completed. The need to expand integration of SRHR and PMTCT services was highlighted in focus group discussions. However, concerns over

decreased funding were widely expressed. In particular how to maintain the same level of quality care with serious human resource constraints, which impact critical components of the programme such as, lay counseling services and training for the provision for ART.

Key Recommendations:
- Implement SMS-technology to improve delivery of laboratory results for Early Infant Diagnosis, CD4 and viral load monitoring
- Continue expansion of PMTCT with SRHR and ART treatment
- Improve monitoring and evaluation systems
- Conduct a full evaluation of the PMTCT Programme

3.2 Treatment, Care and Support

Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

Table 5. Indicators for Life-Long ART

4.1 Percentage of adults and children currently receiving antiretroviral therapy among **all** adults and children living with HIV 2013: **64%**					
4.1a. Percentage of eligible adults and children currently receiving antiretroviral therapy					
2003	2005	2008	2010	2012	2013
7.3	62.7	82.2	89.9	96.1	87.2
4.2a. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy					
2003	2005	2008	2010	2012	2013
Not required	92	84.9	93.2	86.01	No data

Despite the remarkable achievements of Botswana National ART Programme, its financial long-term sustainability remains the central concern of the Botswana HIV response. Human resource constraints, decreased donor funding, weakened management and clinical supervision, training challenges and considerable M&E obstacles require urgent attention.

Serious challenges in sustaining quality HIV pediatric and adolescent ART services also exist. According to the surveys conducted by BIPAI, first line pediatric ART failure rates have been recorded as high as 30% (ranging from 23%-45% from Jan-May 2013) in some facilities. Continuity of care, a critical component of efficiency and pediatric clinical success, is lacking at most sites where HIV-infected children are

now seen. This is true for both clinical staff and psychosocial support staff. Another pressing challenge is the successful transition of young adults into adult care.

NCPI ART Summary and Recommendations:

- Improve ART services for children, adolescents and young adults
- Streamline pharmacy services to avoid long delays and queues at IDCCs
- Continue integration of health services at IDCCs
- Implement mechanisms to monitor the development of HIV drug resistance
- Improve adequate psychosocial support for HIV infected patients taking ART as well as those who are failing medications.
- Provide ART friendly services for sex workers and other marginalized populations.

Target 5: Reduce Tuberculosis deaths in people living with HIV by 50% by 2015

Table 6. TB/HIV Indicators

5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV					
2003	2005	2008	2010	2012	2013
No data	No data	No data	No data	No data	No data

In 2013, progress continued with the integration of HIV and TB services. Although monitoring and evaluation systems are not currently designed to capture incident TB cases among people on ART, finding solutions on how best to capture this and other TB/HIV information within integrated data collecting systems remain a priority. Steps towards full implementation of systems to improve the detection of TB among HIV positive patients were completed. Intensified case finding systems were operationalized within HIV clinics and joint planning meetings with TB coordinators and ART site managers were conducted. Further expansion of IT system integration is planned for 2014. The successful roll out of the Gene Xpert machine in 2013 was an important improvement in TB/HIV diagnostics for Botswana.

NCPI TB/HIV Summary

Considerable discussion within the consensus building workshop focused on the need for TB and HIV monitoring and evaluation systems to interface. Although GARPR indicators for determining incident TB cases among those on ART are not yet possible, other TB/HIV integration achievements were realized in 2013 including implementation of systems for intensified case finding.

Recommendations:

- Integrate IT and monitoring and evaluation systems for TB and HIV.
- Improve monitoring to determine incident TB cases among HIV positive patients and those receiving ART.
- Improve infection control systems at all levels of health care facilities.

Target 6: Close the global AIDS resource gap by 2015

Table 7. Financial Indicators

Domestic and international AIDS spending by categories and financing sources 2011/2012	
Domestic Contribution	International Contribution
1,977,929,988 BWP (68%) 267,287,836 USD	787,546,719 BWP (32%) 106,425,232 USD

Financial information for this indicator was extracted from the 2012 Botswana National AIDS Spending Assessment. The report covers three periods, 2009/10, 2010/11 and 2011/12. Important areas of consideration within the report include the need to find innovative ways to increase domestic and private sector contributions to HIV funding; the need to ensure that efforts at HIV prevention are adequately funded; and the need to support spending on key populations.

NCPI Summary

Regardless of the discussion topic, in all GARPR workshops, the issue of decreased funding was raised, discussed and debated. Loss of human resources due to the elimination of donor partner supported positions was cited repeatedly as the source of many coordination, implementation and monitoring and evaluation challenges. The lack of costing information and knowledge on the programmatic level was also evident. The need for training and capacity building in financial management were also highlighted.

Key Recommendations:

- HIV costing information must be shared at all levels
- Training on financial management needed at all levels
- Human resource redeployment plan needed from clinical services
- Cost effectiveness study results must be shared

3.3 Knowledge and Behavior

Table 8. Indicators for Eliminating Gender Inequalities

Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months: **3.1**					
2003	2005	2008	2010	2012	2013
No data	No data	No data	No data	No data	3.1

Focused attention is required in Botswana to address the gender inequalities fueling the HIV epidemic and causing disproportionate suffering to women. Of the 4.4% of young women who admit to early sexual debut, almost 25% of them report being forced into sexual relations. The Gender Based Violence Study completed in 2011 reported 28.9% of women >18 years had experienced at least one episode of sexual violence in their lifetime. Results from the 2011 ANC Sentinel Survey estimated that most HIV positive ANC attendees are uneducated, poor and single. The ANC survey also pointed to the unmet need for contraception with 50% of women reporting unplanned pregnancies. Improving HIV knowledge for young women < 50% of who were not able to answer basic HIV information correctly must also be addressed. Socio-economic empowerment for young women is also essential as the ANC Sentinel Psychosocial services for girls and young women who are victims of sexual violence are also lacking in Botswana. In the 2013 BAIS IV, 3.1% of women reported that they had sex without consent in the last 12 months.

NCPI Gender Summary

During the reporting period, considerable discussion focused on whether or not the Marital Act protects women against marital rape. Reports of HIV positive husbands forcing unprotected sexual relations on their HIV negative wives were an increasing occurrence. Whether the Public Health Act, which seeks to protect individuals from intentional HIV infection, might protect women in these situations was also discussed.

Discussion on how best to address the psychological needs of both HIV positive and HIV negative young women was raised. Also mentioned as requiring immediate attention is the poor implementation of HIV education in senior secondary schools including the lack of self-esteem building and avoidance of risk behaviors for girls and young women.

Key Recommendations:

- Increase opportunities for economic empowerment of young women
- Improve and expand psychological services for young women and men
- Clarify legal environment protecting HIV negative spouses from being infected by their HIV positive partners
- Complete a full evaluation of rape crisis management services for women
- Improve access to contraception for all women

Eliminating Stigma and Discrimination

Indicators for Stigma and Discrimination:

Question: Do you think a teacher with HIV should be allowed to teach?

Answered No: **13.2%**

In 2013, the HIV Stigma Index Study was conducted. Although the analysis of the study is ongoing, preliminary findings point to relatively low levels of external stigma and discrimination found within the community.

NCPI Summary

There were no significant discussions relating to HIV stigma and discrimination outside discussions of marginalized populations and no key recommendations were suggested.

3.4 Impact Alleviation

Table 9. Indicators for impact alleviation

10.1 Current school attendance among orphans and non-orphans (10-14 years old, primary school age, secondary school age)		
2011	2012	2013
No data	98.4	97.5

10.2 Proportion of the poorest households who received external economic support in the last 3 months		
2011	2012	2013
No data	No data	No data

The Ministry of Local Government reports that at the end of December 2013 there were 37,402 orphans registered in Botswana with an additional 31,526 vulnerable children listed. Despite decreases in overall numbers, existing orphans still require considerable assistance to move successfully into adulthood. Estimates of school attendance serve as a proxy for the general state of orphan care. Challenges identified by local government include: Low uptake of Early Child Development services; Inadequate staffing to deal with multiple OVC programmes and initiatives; and rising costs of quality care.

Results from 2013 BAIS IV showed an unemployment rate of those 19 years and above at 19.8%. The Botswana Core Welfare Indicator Survey (BCWIS) of 2009/10 rated national unemployment at 17.6%.

NCPI Summary
There were no significant discussions relating to orphans care or external economic support during the NCPI workshops.

4. Best Practices

4.1 Botswana's PMTCT Programme

Botswana's Prevention of Mother to Child Transmission Programme marked the country's first public provision of ART in 1999. Originally launched in Francistown and Gaborone, the PMTCT programme now extends to 634 health care facilities providing ART services. Continual revisions of PMTCT guidelines and improvements in clinical care have allowed the Botswana PMTCT programme to prevent HIV infection in over 13,000 HIV exposed infants annually.

In 2010 the PMTCT Program launched one of the first triple ART prophylaxis programmes in the world, bringing Botswana's MTCT rate to as low as 2.49% (Spectrum National Model 2013). Improvements in service delivery now underway include integrating PMTCT services with sexual reproductive health and intensified case finding for tuberculosis in HIV positive pregnant mothers.

Activities to improve the return of early infant diagnosis lab results and overall mother/baby tracking are targeted for 2014.

With the strong research support from Botswana Harvard Partnership, the PMTCT continues to engage in cutting edge research studies for expectant HIV positive mothers and their babies. The results of on going trials investigating the effectiveness and safety of HIV positive mothers breastfeeding will help to answer complex clinical and social concerns in this regard. Translating research findings into successful implementation projects at the ground level also remains a challenge for the programme moving forward.

4.2 Botswana's ART Programme

Launched in January 2002, the Botswana National ART Programme (originally known as "Masa" meaning "New Dawn" in Setswana) has been successfully operating for the past 12 years. Acknowledged as a pioneer and leader in public ART service delivery, Botswana ART treatment programme demonstrated to the world that Africa could safely and successfully administer ART on a population wide basis. Now with over 220,000 patients on treatment and an estimated 87% coverage of those in need at the end of 2013, Botswana's continues to offer high quality ART treatment, care and support free to its citizens.

Treatment eligibility to CD4 count of 350 was implemented in 2012 and treatment outcomes have remained impressive with cumulative first line failure rates of 10%. Provision for viral load monitoring and HIV resistance testing since the programme's inception proved instrumental in achieving high impact results with ART treatment.

Now faced with the realities of decreasing funding support as well as those of a maturing ART programme, the long-term sustainability of the ART treatment programme remains at the forefront of concern. Finding mechanisms and innovations for cost efficiency to improve service delivery are now critical if Botswana expects to maintain the high quality of ART, which is now available.

4.3 NACA Support of Radio and Television HIV Edutainment

Makgabaneng and Mareledi Radio and TV Drama

Makgabaneng is an edutainment radio serial drama presented in Setswana, focusing on behavior change and designed to support the nation's HIV prevention and mitigation goals. The highly successful drama was launched in 2001 targeting audiences 10-49 years old. Over the years it has reached thousands of listeners across Botswana and has continued to enjoy a very dedicated following. Radio drama themes have addressed important community concerns related to HIV/AIDS such as delaying initiation of sex, being faithful, cultural expectations, accessing HIV services and offering support to people living with HIV/AIDS. Makgabaneng radio programme was the first use of public media in Botswana to encourage public dialogue around the previously taboo subjects of culturally accepted sexual behavior. It was the first radio drama that attempted to educate the public on basic HIV

information including how to access HIV treatment, care and support services. Although its impact is difficult to measure, because of its sustained success and appreciation within the community, it is likely Makgabaneng positively affected the lives of many Batswana with regard to HIV education and public discourse.

In addition to being featured on Radio Botswana 1 and 2 (RB1 & RB 2) three times a week, Makgabaneng also reaches thousands of listeners through different mediums such as Road Shows and Health Fairs, Teen Magazine, and School Rallies. From April 2013 to September 2013 alone over 20,000 people attended these edutainment events across Botswana. It was directly from Makgabaneng's Listening and Discussion Groups that the idea to launch the now successful television drama called "Mareledi" was started.

"O se tshege yo o weleng, mareledi a sa le pele"
(Translation of the Setswana proverb: "Don't laugh at the one who has fallen, while it is still slippery ahead of you")

After many years of anticipation, Mareledi HIV television drama was launched on the 2nd of December 2013. A visual version of Makgabaneng Radio drama, it addresses similar issues. Airing twice a week on Botswana Television (BTV), it has so far captivated audiences with high television ratings. The use of innovative media pathways are growing increasingly important among youth in Botswana as evidenced by the Wise Up Campaign at multimedia HIV communication platform in 2013.

5. Major Challenges and Remedial Actions

In this section of the report key challenges identified in the 2012 Country Progress Report as well as those identified in the Botswana 2013 Mid-Term Review of the 10 Targets and Elimination Commitments of the 2011 United National General Assembly Political Declaration on HIV/AIDS will be discussed. Strategies already underway to overcome problematic areas in the HIV response are noted as well as further recommendations to improve issues moving forward.

5.1 Progress on Key Challenges Previously Identified

<u>Progress made on key challenges identified in the 2012 GARPR & MTR of the 10 Targets and Elimination Commitments of the 2011 United Nations General Assembly Political Declaration on HIV/AIDS</u>

There were a number of achievements realized in 2013 toward the commitments made by the 2011 UN General Assembly towards the elimination of HIV/AIDS. Prioritizing areas to be supported in light of diminished resources required critical analysis of financial systems and management to enable informed decision making and policy development moving forward.

While a number of attempts were made at addressing some of the major challenges and concerns identified in the 2012 report, programmatic issues identified even in the 2010 Country Progress Report have remained problematic.

With the completion of the Mid-Term Review of the Political Declaration, more focus was placed on the areas requiring immediate focus and attention. Both reports are summarized by focus area together below in Table10 to bring key challenge areas into alignment and harmonize reporting recommendations.

Table 10. Progress & key challenges identified in the 2012 Global AIDS Response Progress Report and the Mid-Term Reviews of the Political Declaration 2013

Key Challenges/ Recommendations from 2012	Remedial Actions	Further Recommendations
PREVENTION		
Greatly scale up prevention programmes, including combination prevention *(MTR)*	- Largest Combination Prevention Trial now taking place in 30 communities, MoH in collaboration with CDC and BHP - SMC continue to scale up despite lack of funding from development partners	- Share findings of the BCPP trial as soon as possible to assist with improved prevention implementation - Continue to strongly upscale Prevention efforts - Continue to strongly support SMC
Low Comprehensive HIV Knowledge among young people aged 15-24 at 47.9% *(MTR)*	- Pilot project using conventional and electronic media use specifically targeted for youth: - Pilot projects underway	- Continued use of electronic media targeted at youth (i.e. Twitter, SMS technology, Facebook
Low Uptake of SMC *(GARPR & MTR)*	- Reinvigorate SMC programme now with decreased funder support	- Improve patient tracking into care. - Continue with SMC community campaigns
Teachers are not capacitated on life skills programme *(MTR)*	-	- Capacitate teachers in like skills programmes designed to address HIV issues.
Support Peer Education Programmes *(MTR)*	-	- Ensure Peer Education programmes are functioning
Develop HIV behavior change interventions designed for families *(MTR)*	-	- Use innovative tools to reach families and their children
CONDOMS		
Improve forecasting for condom procurement	HIV commodities to join costing and forecasting TWG	- Continue commodities integration -
Consider peer condom distribution		Pursue new avenues for condom distribution innovation
Develop new national condom brand	MOH is conducting market research	Continue to pursue new avenues for condom branding
PMTCT		
Development and finalization of national infant feeding policy	- HIV and TB Clinical Care Guidelines Committee have	- Complete a PMTCT programme evaluation to

particularly for positive mothers already on ART since 2nd trimester to take up exclusive breastfeeding	endorsed a women's right to choose her preferred feeding methods along with the AFASS recommendations - Following the outcome of BHP's 5-year study to determine safety of breastfeeding in Botswana - infant-feeding recommendations to HIV positive mothers be revised.	determine outcomes of recently implemented TAP -
Integrate SRH in HIV services	- Expand SRHR and HIV integration Pilot Program in Districts and facilities	Roll out SRHR/HIV integration to more districts.
Improve Early Infant Diagnosis system	-	- Implement SMS technology for mother and baby tracking and improve laboratory turn around times
IEC		
Use media to combat complacency and increase demand for services (i.e. HCT, SMC, treatment)	- Large Prevention Campaigns completed in 2013 (Testing, SMC, Youth Wise Up) - 2 HIV sponsored TV shows running	- Upscale use of digital technologies for IEC purposes: Twitter, SMS, Facebook, etc. -
Conduct process review of OVC and CHBC programmes		- OVC programme evaluation requested - CHBC programme evaluations scheduled for 2015
SUSTAINABILITY /HEALTH SYSTEMS		
Conduct efficiency studies for integration and delivery of HIV services	- Studies underway completion expected in 2014 - Transitional Financing Report completed	-
Continue to support capacity building in finance and management skills	- Management and finance workshops ongoing (DPPM&E, NACA-BNAPS)	-
Use investment framework to revisit resource mobilization	Finance TWG established	-
Conduct Investment Case for Botswana on AIDS	Development of Investment Case funded and underway	- Complete Investment Case in 2014
Donor funding steadily declining	- Completed Phase I costing of the ESHP - Direct costing of HIV programmes scheduled for 2014 - Completed Transitional Financing Report	- Complete efficiency gains study - Capacitate health managers on finance management
Inadequate Private Sector involvement *(GARPR 2012)*	- ART Private Public Partnership stopped - BNTP – TB PPP established -	- Re-evaluate ART Private Public Partnership programme - Coordinate and integrate PPP programmes

SUPPLY CHAIN/PROCUREMENT		
Use of TRIPS Flexibilities through pooled procurement and regional collaboration *(MTR)*	- Renewal of MoU with CHAI for lowest ART procurement price - Expansion of drug costing and forecasting TWG to include TB, SRH and other essential drugs - Workshops and TWG formed to review TRIPS flexibilities	- Integration of procurement TWG (ART, TB, SRH) - Expansion of effective forecasting and drug costing mechanisms
Fully implement framework contract with pharmaceutical companies and establish regional distributions hubs to reduce possible drug stock-outs	- Outsourcing of CMS	- Improve M&E stock systems -
GENDER		
Gender integration programming into all development planning processes *(MTR)*	-	- Support gender survey and studies and surveillance
Coordinate stakeholders working on Gender to establish sufficient dialogue	- Gender Affairs Department restructured to inclusive of development and gender -	- Appoint gender coordinators within programmes
Develop appropriate M&E structures and indicators to correctly capture GBV	- Indicators under development	-
Conduct community campaigns to sensitize on all type of GBV.	-	-
HUMAN RIGHTS		
- Unsupportive legal environment for marginalized HIV populations - Limited human rights and legal literacy across all levels of society *(GARPR 2012)*	- Completion of BBSS Study - BBSS Study strategic plan being developed - Expansion of pilot free legal aid to the general population - BBSS Study completed 2013 -	- Complete BBSS Strategy for MARPS - Provide free condoms and ART to all inmates
- Sex workers and MSM are not recognized publicly or able to disclose their activities to health care workers and obtain adequate health care *(GARPR 2012)*	- BBSS Study completed 2013 - BBSS Strategic Plan under development.	
- Lack of independent Human Right Commission		- Advocate for independent human rights commission
- Public education on the rights of survivors of GBV		-
- Prisoners have no right to receive free condom *(GARPR 2012)*		- Work within the legal mechanisms available to authorize free condom distribution to all inmates -

TREATMENT CARE & SUPPORT		
Development of HIV Drug Resistance Strategy *(MTR)*	Botswana National HIV and TB Drug Resistance Strategy and Operation Plan Developed 2013-2017	- Fast track - Implementation of Integrated Specialty Centres in 2014
Efficiency review for ART program is urgency needed *(MTR)*	- Costing of the Essential Health Services Package underway - Transitional Financing Report completed 2013	- HIV Programme direct costing to be completed by July 2014 - ESHP costing continuing into 2014
Continue training and mentoring health care workers on ART dispensing *(MTR)*	- A total of 547 ART nurse dispensers have been trained to date (80 trained in 2013) -	- Challenge: PEPFAR master trainers funding to stop September 2014.
Integrate TB, SRHR, & ART Programme	- Integration demonstration pilot underway for 2014	- Continue to roll out integrated Specialty Clinics in 7 Districts
CIVIL SOCIETY		
- Non affiliation of some CSOs to the umbrella body - Fragmentation of CSOs - No coordinating bodies for CSOs *(GARPR 2012)*	- Reestablishment of the BONEPWA - Reestablishment of BONASO	- Increase funding for CSOs.
- Weak capacity of CSOs to write funding proposals *(GARPR 2012)*	- Capacity building workshops held	- Continue capacity building mechanisms for CSOs
- Weak capacity to engage in high level meetings and provide advocacy, ethics and legal perspectives -	- BNAPS project funding capacity building of 55 CSO	- On-going support for capacity building required
OVC		
- OVCs weaned from programme too quickly and not seen through young adulthood with proper support. - Implement the Botswana National Plan of Action on OVCs 2010-1016	- Recommend situational analysis of Orphans and Vulnerable children (last one done in 2007) - Support for OVCs extended to post-secondary education in partnership with MOESD	- Request situational analysis for OVCs

5.2 Challenges faced during 2013 that hindered the national response and progress towards achieving targets

The most important challenge that faced the Botswana HIV response in 2013 centered around decreased funding by development partners and how to ensure the long-term financial sustainability of providing free ART and quality HIV services. Decreases in human resources secondary to budget cuts and Government of Botswana downsizing also impacted negatively on HIV programs that no longer had the necessary personnel to effectively meet their targets. For these same reasons M&E efforts in the districts were hard hit with only 12 districts out of 27 having health care officers available to complete routine monitoring and evaluation tasks.

Additional challenges centered on improving prevention efforts in light of dwindling resources; expanding the use of media and improve youth involvement; maintaining the same level of service for ART; providing adequate psycho-social support for those failing treatment and how best to integrate SRHR and TB service delivery into ART programmes.

5.3 Concrete remedial actions that are planned to ensure achievement of agreed targets

- Increased access to ART was achieved with the additional roll out of ART to 534 health care facilities in 2013, expanding ART service delivery points by an additional 250 sites.
- Implementation of the Elimination of Mother-to-Child-Transmission Strategy
- The completion of the Botswana Behavioral Study for Key Populations and development of the Strategic Plan to address key populations
- Development and implementation of the National HIV/TB Drug Resistance Surveillance Strategy
- Completion of the Prison Study
- Completion of the Stigma Index Study
- On going Costing of the Essential Health Services Package at MoH
- Costing of the ART programme in 2014

6. Support from the Country's Development Partners

Despite continued and progressive decreases in development partner funding, Botswana continued to receive significant assistance from international research and development agencies. Beginning in 2010, the shift toward higher-level technical assistance over direct monetary funding and human resource support has had a direct impact at an implementation level. These challenges are now evidenced in severe limitations in monitoring and evaluation efforts at the district level as well as growing ART treatment failure at the clinical level. So although Botswana continues to receive assistance with strategic direction and policy development, implementation of such plans continues to fall short of expectations.

Development partner shift towards research-based approaches to prevention and the use of "Treatment as Prevention" spearheaded the launch of the "Combination Prevention Trial" in 2013. This four year research collaboration between the Ministry of Health (MoH), the Centers for Disease Control (CDC) and the Botswana Harvard Partnership (BHP) plans to investigate whether a combination of intensified prevention efforts, including HIV home testing and initiation of ART, can significantly decrease HIV incidence in 30 epidemiologically matched communities. The study will also determine the costs involved in such efforts and test different strategies to deliver such care in the most cost effective matter. The National Institute of Health (NIH), the CDC as well as the Ministry of Health have provided significant funding for this research project.

Alignment of purposes and harmonization of targets and indicators continued amongst development partners and UN agencies in 2013. The Joint Oversight Committee and the Partnership Forum met regularly to discuss improvements in HIV assistance and strategic support. UN agencies aligned themselves through the platform of an AIDS Joint Team, and as part of the Component Coordination Group for Health and HIV, to support the implementation of the GoB-UN Programme Operational Plan. Continued and significant financial and technical support was seen in 2013 by: ACHAP, The Botswana-Harvard Partnership, Baylor Pediatric

Center of Excellence, CDC-PEPFAR, EU, FHI 360, I-Tech, UNAIDS, UNDP, UNFPA, UNHCR, UNICEF, University of Pennsylvania, and WHO.

7. Monitoring and Evaluation Environment

Consensus from the highest to the lowest at management and implementation levels and across all sectors points to the weaknesses inherent in the current HIV monitoring and evaluation systems. Reliable data must form the basis of prioritizing programmatic interventions and evaluation of current systems. As cost efficiencies are central to long-term sustainability of the Botswana HIV response addressing the weakened M&E system is now critical. While plans are underway within the Ministry of Health to improve and expand monitoring and evaluation systems, these plans may take some time to be realized. In the meantime, measures should be taken to maximize the use of technological innovation to integrate disparate systems now running in order to optimize evidence-based planning.

The Monitoring and Evaluation Focus Group Discussion as part of the NCPI report writing section were the most informative and participatory. Current challenges and suggestions for remediation were also shared.

7.1 Overview of M&E Systems

7.1.1 NACA

Currently, the National Aids Coordinating Agency does not have a centralized HIV database. Strategic HIV information is stored on various departmental excel spreadsheets and there are no uniform mechanism in place for data sharing or integration. All health related information utilized by NACA is provided by the Ministry of Health and directly from the district level as well as from development partners and research institutions as required. Civil society data is also captured on excel spreadsheets as required for international reporting structures and surveys.

7.1.2 Civil Society, Development Partners & Research Institutions

There are currently no uniform HIV data collection systems, reporting mechanisms or M&E protocols in place for CSO, development or research partners to utilize. Unilateral organizations maintain their own databases with little to no data sharing of information to key HIV governmental departments or amongst themselves. Furthermore, there is currently no central database or information repository to maintain HIV related research and information nor is there a currently a national genetics database with which to store HIV genetic sequences or information.

7.1.3 The Ministry of Health

There are two patient-level medical databases now operating in HIV facilities in Botswana one known as IPMS (Integrated Patient Management System), which is a centralized system, and PIMS II (Patient Information Management System), which is a decentralized system. The IPMS was first introduced in 2004 with the intention of

serving as the main IT medical system for the country. It is a large medical operating system designed for use at both inpatient and outpatient medical facilities. It is web-based, requiring Internet connectivity. While it can be adapted to specific HIV service delivery needs, it requires considerable financial investment in order to do so. In 2013, IPMS was running in 11 out of 28 referral and district hospitals covering approximately 75% of inpatient bed capacity.

The PIMS II system, introduced in 2002, was specifically designed to meet the growing needs for a patient-level HIV outpatient medical IT system in Botswana. The prototype was designed by the Department of HIV/AIDS Prevention and Care and has been continually upgraded to improve its functionality. It now includes PMTCT, SRH, Nutrition, TB, routine HIV testing, pharmacy, laboratory and HIV co-morbidities information. Over the years, large investments in design and ground-level training have been made in the PIMS II system, which was operating at 280 HIV outpatient sites in 2013.

The District Health Information System (DHIS) for aggregated general health district level information was also implemented although it is not currently providing HIV specific information.

7.2 M&E Challenges – NCPI Summary

Issues regarding inadequate national and district level HIV monitoring and evaluation systems have become one of the key challenges facing the Botswana HIV response. Providing adequate HIV monitoring across widely diverse settings and amongst numerous development and research partners with a "one size fits all" system has proven to be fraught with difficulties. Focus now should center on systems integration and technological innovation to overcome M&E integration barriers.

No other focused group discussion during the GARP Report writing process was as engaging or dynamic as the one focused on monitoring and evaluation. Challenges and lessons learned were shared with enthusiasm and problem areas critically put forward.

Indicators

- Due to high staff turn over there is need for continuous training, mentoring and supervision for implementation of the M&E planned activities.
- There remains poor consensus on which indicators are necessary from civil society and further harmonization of all HIV indicators is still required.
- National baseline figures and target setting is still lacking for many indicators
- Some development partners continue to more strongly align their indicators to donor requirements than to national M&E requirements.

Human Resource Constraints

- Critical shortage of staff at all levels and especially in the districts at implementation level
- Shortage of M&E skilled staff
- Retention of M&E skilled staff
- Inadequate opportunities for postgraduate training in M&E
- M&E officers at the district level have responsibilities other than M&E and this compromises their work. M&E officers therefore lack motivation to provide quality data or take ownership of their results.

Civil Society

- Non-affiliation of some NGOs to the umbrella body so their information is overlooked and not gathered centrally
- Inadequate coordination and adherence to reporting mechanisms
- Lack of electronic reporting system and national database
- Multiple and fragmented reporting systems
- M& E Feedback mechanisms are not non existent

Data Quality and Its Use
- Data quality is problematic at all levels
- M& E Reports are not complied in a timely manner and therefore quality of data is often compromised
- Lack of an official M&E annual report
- Missing data and information gaps often prevent research from moving forward.
- Users are often not computer literate leading to lost of data and poor data quality

Infrastructure
- Poor use of the latest IT technologies
- Power and therefore Internet connectivity becoming increasingly unreliable
- Some facilities do not have basic computer systems and IT support is nonexistent

Advocacy
- Inadequate advocacy for M&E at higher levels of Government
- No ownership of data at higher levels
- There are no national champions for M&E

7.3 Remedial Actions Planned to Overcome M&E Challenges

Key NCPI Recommendations

NACA

- Complete an IT and M&E evaluation to recommend improvements in data collection, sharing, and storage.

Civil Society, Development Partners and Research Institutions

- In 2013 considerable financial support was provided by NACA to CSOs in order to reinvigorate various organizations to serve in the capacity of umbrella organizations to improve central data collection mechanisms.

- Plans to encourage research institutions to consider depositing their older research data sets into repositories at academic institutions such as the University of Botswana medical school should be initiated in collaboration with NACA and the Ministry of Health.

- Development partners should be encouraged to refrain from implementing IT systems which are incompatible with the national M&E strategies or national IT systems.

Ministry of Health & District Plans

- Currently the Ministry of Health is undergoing a major restructuring that includes major improvements in IT and monitoring and evaluation systems, assisted by the Department of Science and Technology.

- The restructuring is based on the plans to decentralize implementation strategies to districts, allowing districts to manage their own budgets and utilize their own data.

- The Ministry of Health will provide policy and oversight still requiring accurate data and monitoring and evaluation systems to be in place in order to successfully provide evidence based policy direction and oversight.

- On-going support to continue to improve M&E systems for HIV integration plans including but not limited to SRHR, TB, PMTCT and NCDs is being provided by development partners.

- Plans to address critical M&E human resources shortage should be initiated as a matter of urgency.

7.4 Need for technical assistance and capacity building

The following areas were identified as key areas requiring capacity building and technical assistance during the GARPR processes:

- Informatics and bioinformatics specialists
- IT expertise and database development
- HIV and TB drug resistance specialists
- Surveillance expertise
- Experience in systems integration
- Develop post graduate M& E curriculum
- Supply chain management and procurement
- Expertise in data warehouse development and data archiving

ANNEX 1

Consultation/preparation process for the country report on monitoring the process towards the implementation of the Declaration of Commitment on HIV and AIDS:

With assistance from key NACA staff and the UNAIDS Strategic Information team the consultant was able to meet with governmental representatives, civil society organizations and development partners to complete all processes outlined in the terms of reference. An inception report was presented to the GARPR technical working group and the proposed work plan was approved.

Data collection took place over a period of three weeks beginning in mid-February. The consultant embarked upon an extensive literature review, key stakeholder interviews and conducted a series of focus group discussions including civil society, governmental stakeholders, and development partners to discuss indicator results and complete part A and B of the NCPI portion of the GARP report. This process cumulated in a well-attended consensus workshop with broad multi-sectorial representation. The consultant complied all responses and presented the finalized draft of indicators and other findings to high-level officers and management within NACA and the Botswana Ministry of Health. The composite report was then submitted for comments and approval from NACA.

2014 Global AIDS Response Progress Report Attendance at Focus Group Discussions and Consensus Workshop

Name	Organization	Position
Tlotlo Nong	MOH DHAPC	Data Quality Officer
Gofaone Moatlhodi	NACA	Ass Research Officer
B. Tshekiso	NACA	Research Officer
Mpho Mmelesi	UN AIDS	SI Advisor
Robert Selato	NACA	CRO
Sheila Lesotlho	MOH/HTC	Health Officer
Modise Ngombo	MOH/HTC	PHO
Mothwana Thekiso	MOH/HTC	HTC Coodinator
K . Masupu	NACA	SME Advisor
Pilatwe Pilatwe	MOH/DPHME	Chief Health Officer
Evelin Reetsang	NACA	Senior Research Officer
E. M. Matshediso	UB	Director HIV & AIDS Coordination Office
J. Shongwe	UNFPA	M&E officer
Colleta Kibassa	UNICEF	Child Survival
Madididmalo Tebogo	WHO	NPO
Dr Janet Mwamona	CDC Botswana	PMTCT Programme office
Dr B. Nkomo	DHAPC- MOH	PHS

Koona Keapoletswe	MOH-DHAPC	Acting Director
Mr C. Ntswape	DHAPC- MOH	SMC Coordinator
K Molosiwa	BONEPWA	Excutive Director
Ms Clearance Abel	DHAPC- MOH	SOR M&E Officer
Dinah Ramaabya	DHAPC- MOH	PHO
N. Tswetla	NACA	IEC Officer
Chipo Petlo	DHAPC-PMTCT	PMTCT Coordinator
Leu Leu	MOH-DHAPC	Data Manager
Ogomoditswe Odirile	NACA	Planning Officer
Heston Philips	UN AIDS	Strat Intervention
M Mosuma	UNESCO	
B. Mkhweli	NACA	DACA
M. Ogbuabo	SCMS/CMS	Advisor
T. Monametsi	BOCAIP	M& E Officer
B Ramatlapeng	NACA	Member of Meeting
Lorato Mongatane	NACA	Public Relations
Seeletso Mosweunyane	NACA	Chiefs Research Officer
Nana Gleeson	BONELA	SMT Operations
Peter Chibatamoto	NACA	Policy Advisor
Frank Mwangeni	ACHAP	Executive Officer-Program
Onalenna Serufho	FHI360	Senior M&E Officer
Mike Mesago	FHI360	Mike Mesago
Botsalano Masimolodi	NACA	Principal Research Officer
Nokathula Majingo	MOH	Principal Health Officer
Maimouna Ddiaye	CMS	Pharmacist
Taurese Tafuma *	MOH	Program Manager
Irene Maina	UNAIDS	CMNA
Abaleng Lesego	I-tech	M&E officer
Richerd Matlhare	NACA	National Condinator
Masego Boima	Tebelopele	M&E officer
Ntlogeleng Modise	Tebelopele	Business Development
Bagapi Tinashe	MOH-HPDUE	M&E officer
Eric Mosothwane	Men Sector	Secretary
Panganai Makadzange	ACHAP	M&E specialist
Kagiso Mokone	NACA	Data Cleark
Kabelo Kgongwana	BOFWA	Service Deliver Officer
Frenk Phatshwane	BBCB	E.D
Phenyo Gaotlhobogwe	Nkaikela	Director
Cindy Kelemi	BONELA	Director
Tebogo Gareitsanye	BONELA	Project Officer
Theresa P. Letlhone	MOH-DHAPC	Chief Health Officer
Carol K Moalafhi	MOH-DHAPC	Programme Officer
Penny Makuruetsa	MOH-DHAPC	PHO I
Grace Nkubito	MOH-DPH- BNTP	PHS

ANNEX 2

National Commitments and Policy Instrument (NCPI)

A.I STRATEGIC PLAN BOTSWANA – 2013

Has the country developed a national multi-sectorial strategy to respond to HIV? YES

IF YES, what is the period covered: 2011-2016

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.

The NSF II has 4 priority areas and includes a coasted National Operational Plan (NOP), as well as a Monitoring and Evaluation Plan. The NOP articulates the activities to be implemented in a Results Based Management Approach.

IF YES, complete questions 1.1 through 1.10. IF NO, go to question 2.

Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectorial strategy to respond to HIV?

National AIDS Coordinating Agency (NACA), the Office of the President

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

SECTORS	INCLUDED IN STRATEGY	EARMARKED BUDGET
Education	Yes	Yes
Labour	Yes	Yes
Health	Yes	Yes
Military/Police	Yes	Yes
Social Welfare	Yes	Yes
Transportation	Yes	Yes
Women	Yes	Yes
Young People	Yes	Yes
Other	NO	

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

1.3. Does the multi-sectorial strategy address the following key populations/other vulnerable populations, settings and cross cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Discordant couples	No	
Elderly persons	No	
Men who have sex with men	No	
Migrants/mobile populations	No	
Orphans and other vulnerable children		Yes
People with disabilities		Yes

People who inject drugs	No	
Sex workers	No	
Transgender people	No	
Women and girls		**Yes**
Young women/young men		**Yes**
Other specific vulnerable subpopulations	No	
Prisons	No	
Schools		**Yes**
Workplace		**Yes**
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination		**Yes**
Gender empowerment and/or gender equality		**Yes**
HIV and poverty		**Yes**
Human rights protection		**Yes**
Involvement of people living with HIV		**Yes**

IF NO, explain how key populations were identified?

In 2013, The Mapping, Size Estimation & Behavioral and Biological Surveillance Survey (BBSS) of HIV/STI among Select High-Risk Sub-Populations in Botswana was completed to address these information gaps in regard to key populations. The analysis is now on-going.

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
People living with HIV		**Yes**
Men who have sex with men		**Yes**
Migrants/mobile populations		**Yes**
Orphans and other vulnerable children		**Yes**
People with disabilities		**Yes**
People who inject drugs	**No**	
Sex workers		**Yes**
Transgender people		**Yes**
Women and girls		**Yes**
Young women/young men		**Yes**
Other specific vulnerable subpopulations	**No**	

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

1.6. Does the multi-sectorial strategy include an operational plan? **YES**

1.7. Does the multi-sectorial strategy or operational plan include:

Formal programme goals?	**Yes**	
Clear targets or milestones?	**Yes**	
Detailed costs for each programmatic area?	**Yes**	
An indication of funding sources to support programme implementation?		No
Monitoring and evaluation framework?	**Yes**	

1.8. Has the country ensured "full involvement and participation" of civil society in the development of the multi-sectorial strategy?

Active involvement	Moderate involvement	No involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organized:

- Consultations were held with broad civil society (National and International NGOs, CBOs, Private Sector, FBOs and People Living with HIV) representations during the development of both the National Strategic Plan II and National Operational Plan.
- Civil Society were also members of the Technical Planning Groups in the development of NOP, National AIDS Council Joint Oversight Committee that oversees monitoring the implementation of NSFII.

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case

1.9. Has the multi-sectorial strategy been endorsed by most external development partners (bi-laterals, multi-laterals)? **YES**

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national Multi-sectorial strategy?

Yes- All partners	**Yes - Some partners**

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why?

- While the biomedical funding and technical support provided by development partners is aligned with NSFII, the degree to which development partners prefer to support biomedical or behavioral interventions has posed programmatic planning and implementation challenges.

• Also noted were decreases in funding from development partners for monitoring and evaluation purposes making the implementation and sustainability of the National Monitoring and Evaluation Plan very difficult.

2.1. Has the country integrated HIV in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS		
Common Country Assessment/UN Development Assistance Framework	Yes	
National Development Plan	Yes	
Poverty Reduction Strategy	Yes	
National Social Protection Strategic Plan	Yes	
Sector-wide approach		N/A
Other [write in]		

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

HIV-RELATED AREA INCLUDED IN PLAN (S)		
Elimination of punitive laws		No
HIV impact alleviation (including palliative care for adults and children):	Yes	
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	
Reduction of stigma and discrimination	Yes	
Treatment, care, and support (including social protection or other schemes)	Yes	
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	
Other –Inclusion of non-nationals in ART access		No

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

YES

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?

LOW					HIGH
0	1	2	3	4	5

4. Does the country have a plan to strengthen health systems? **YES**

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications and children

- Health Systems Strengthening sections were included in NSFII.
- Provision for ART has been decentralized to all health facilities, regardless of their level.
- The Drug Costing and Forecasting Technical Working Group provide accurate forecasts preventing ART drug stock outs.
- Additional pharmacy technicians have been supported through the BNAPS programme.
- ART clinics were set up in two prisons - one is Gaborone and one is Francistown.
- Increased provision for access to ART by decentralization of ART care to 534 clinics from 280 clinics in 2012.

5. Are health facilities providing HIV services integrated with other health services?

AREA	MANY	FEW
HIV Counseling & Testing with Sexual & Reproductive Health	**Many**	
HIV Counseling & Testing and Tuberculosis	**Many**	
HIV Counseling & Testing and general outpatient care	**Many**	
HIV Counseling & Testing and chronic Non-Communicable Diseases	Many	
ART and Tuberculosis	Many	
ART and general outpatient care		Few
ART and chronic Non-Communicable Diseases	Many	
. PMTCT with Antenatal Care/Maternal & Child Health	Many	
Other comments on HIV integration		

In 2013, integration initiatives included integration of Sexual Reproductive Health and HIV services in 3 districts and 8 facilities and further progress was made with HIV and TB integration efforts and implementation.

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy-planning efforts in your country's HIV programmes in 2013?

VERY POOR									EXCELLENT
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area?

- In 2012: The ART Clinical Treatment Guidelines changed CD4 eligibility from 250 to 350 for Batswana citizens. The Botswana TB/HIV Policy Guidelines were developed and disseminated
- In 2013, the Adolescent ART Guidelines were completed and disseminated Treatment eligibility was increased to all Batswana children less than 5 years of age. A national condom strategy was developed and disseminated A faith-based strategy was developed and disseminated A PHDP Strategy was developed and disseminated.

What challenges remain in this area?

- Due to the economic downturn, Government of Botswana downsizing and decrease development funding, implementation of the many of the HIV related strategic plans will continue to be challenged.
- Implementation of well laid plans and strategies therefore remain problematic.

A.II POLITICAL SUPPORT AND LEADERSHIP BOTSWANA

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

Government ministers: YES

Other high officials at sub-national level: YES

1.1 In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV? YES

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

- The Government of Botswana continues to fund the country's HIV/AIDS response providing an estimated 70% of all financing, exceeding the funding

recommendations specified in the Abuja Declaration. President Lieutenant General Seretse Khama Ian Khama presided over the 2013 World AIDS Day Commemorations and meets regularly with the Minister of Health and NACA officials to remain updated on the status of the HIV epidemic.

- The former President Festus Mogae continues to champion the HIV/AIDS response at all levels of government and society, at home and abroad and chairs the National AIDS Council (NAC), assisted by the Vice President. There is a Parliamentary committee on Health and HIV/AIDS to address HIV issues directly.

2. Does the country have an officially recognized national multi-sectorial HIV coordination body (i.e., a National HIV Council or equivalent)? YES

IF NO, briefly explain why not and how HIV programmes are being managed:

2.1. IF YES does the national multi-sectorial HIV coordination body

Have terms of reference? YES

Have active government leadership and participation? YES

Have an official chairperson? YES

IF YES, what is his/her name and position title? Mr. Richard Matlhare, National Coordinator, NACA

Have a defined membership? YES

IF YES, how many members? 36

Include civil society representatives? YES

IF YES, how many? 10

Include people living with HIV? YES

IF YES, how many? 10

Include the private sector? YES

Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting? YES

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

IF YES, briefly describe the main achievements

- The Joint Oversight Committee and Partnership Forum, which includes all HIV/AIDS stake holders, manages the national response and prioritizes implementation of the NSFII to minimize duplication of efforts.

- The Districts (through the District Multi-sectorial AIDS Coordinating Committees) promote interaction between government, civil society organizations and the private sector to implement HIV strategies and programmes.

What challenges remain in this area?

The global economic downturn, government downsizing and continued decreased financial support from development partners now pose serious obstacles to the long term sustainability of the national HIV response.

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

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

Capacity-building	**Yes**	
Coordination with other implementing partners	**Yes**	
Information on priority needs	**Yes**	
Procurement and distribution of medications or other supplies	**Yes**	
Technical guidance	**Yes**	
Other [write in]		**No**

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

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

IF YES, name and describe how the policies / laws were amended:

In 2013: The Public Health Act was passed within Parliament to improve the delivery of health care services in Botswana.

The Botswana National Policy on HIV and AIDS (revised edition 2012)

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

- However, there remain serious concerns over HIV issues of confidentiality and disclosure within the Public Health Act that will require close monitoring with its implementation.
- Homosexuality & sex work remains illegal, with the potential to drive these populations underground.
- Condoms in prison are not illegal however they are not distributed because this would be in conflict with the government's laws against homosexuality.

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2013?

VERY POOR										EXCELLENT
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area?

The Government of Botswana continues to provide the largest portion of funding for the national HIV response.

There is an active Parliamentary AIDS Committee.

The Office of the President continues to steward the National AIDS response.

The Vice President, three Ministers and one member of Parliament serve on the National AIDS Council as members.

What challenges remain in this area?

The realities of the global economic downturn and need for the Government of Botswana to downsize as well as decreased funding from development partners now challenge the gains made in Botswana -- Despite the strong political will. The legal environment to support prevention, treatment and care of Key Populations and other vulnerable populations is inadequate.

A.III HUMAN RIGHTS BOTSWANA 2013

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Select yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
People living with HIV		**Yes**
Men who have sex with men		**Yes**
Migrants/mobile populations		**Yes**
Orphans and other vulnerable children		**Yes**
People with disabilities		**Yes**
People who inject drugs	**No**	
Sex workers		**Yes**
Transgender people		**Yes**
Women and girls		**Yes**
Young women/young men		**Yes**
Other specific vulnerable subpopulations	**No**	

1.1. **Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?** YES

IF YES to Question 1.1. or 1.2. briefly describe the content of the/laws:

The constitution of Botswana (Bill of Rights) section 3-19 also provides for the protection of fundamental rights and freedoms of individuals including the right to be free from inhuman and degrading treatment, which has been widely interpreted to include the right to be free from stigma and discrimination. Employment Act (Amendment of 2012) and the Public Service Act also provide for non-discrimination on the basis of health.

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

Government is currently implementing legal aid services for the general population. However, this is not specifically targeting human rights violations. Currently there is no Human Rights Commission functioning in Botswana.

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

The courts (of Law) have progressively interpreted the constitution to address (to some extent) HIV related stigma and discrimination.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups? YES

IF YES, for which key populations and vulnerable groups?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
People living with HIV	**No**	
Elderly persons	**No**	

Men who have sex with men		Yes
Migrants/mobile populations		Yes
Orphans and other vulnerable children	No	
People with disabilities	No	
People who inject drugs		Yes
Prison Inmates		Yes
Sex workers		Yes
Transgender people		Yes
Women and girls	No	
Young women/young men	No	
Other specific vulnerable subpopulations	**No (**refugees who receive ART as part of UNHCR and PEPFAR**)**	

Briefly describe the content of these laws, regulations or policies:

There are possibilities of the mis-use of the recently adopted Public Health Act in threatening the confidentiality of persons living with HIV, if its implementation is not closely monitored. Sodomy laws (penal code) section 164 and 165 "acts against the order of nature" a criminal offence. Prostitution, in terms of section 155,156,157 and 158 of penal code anyone who knowingly lives wholly or in part from the proceeds of prostitution is guilty of an offence. Botswana Prison's HIV/AIDS Policy of 2003 prohibits availing condoms to inmates Cabinet Directive 002 & 004 authorizes access to free ART to Botswana citizens only. The Domestic Violence Act does not address marital rape

Briefly comment on how they pose barriers:

The above referenced laws may pose difficulties for the government, development partners or CSOs to develop provision and programmes targeted at improving access to specific services for key and vulnerable subpopulations. Criminalization of same sex relationships fuels negative public attitudes/ stigma and discrimination which contributes to the low uptake of services by marginalized populations The ARV program guidelines exclude all foreigners' access to free ARV treatment, (e.g. prison inmates and refuges). Marital rape is a particular concern for women especially in cases of HIV discordancy.

A.IV PREVENTION BOTSWANA 2013

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

IF YES, what key messages are explicitly promoted?		
Delay sexual debut	Yes	
Engage in safe(r) sex	Yes	
Fight against violence against women	Yes	
Greater acceptance and involvement of people living with HIV	Yes	

Greater involvement of men in reproductive health programmes	**Yes**	
Know your HIV status	**Yes**	
Males to get circumcised under medical supervision	**Yes**	
Prevent mother-to-child transmission of HIV	**Yes**	
Promote greater equality between men and women	**Yes**	
Reduce the number of sexual partners	**Yes**	
Use clean needles and syringes: No Use condoms consistently	**Yes**	
Other		No

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

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people? YES

2.1.Is HIV education part of the curriculum in:

Primary schools? YES

Secondary schools? YES

Teacher training? YES

2.2.Does the strategy include

a) Age-appropriate sexual and reproductive health elements? YES

b) Gender-sensitive sexual and reproductive health elements? YES

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

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

Briefly describe the content of this policy or strategy:

Within the National Operational Plan (NOP) of the National Strategic Framework II (NSFII): Identifies addressing HIV prevention, care and support for key populations as one of the prioritized areas for the national HIV prevention response. - The NOP has mainstreamed interventions that will promote and strengthen human rights strategies including interventions that address issues of stigma, discrimination, and universal access to HIV and AIDS services by all people, including key populations and other vulnerable groups. - Communities are targeted to adequately mobilized specific interventions that target MARPS and other vulnerable groups.

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

Check which specific population and elements are included in the policy or strategy

	IDU	MSN	Sex Workers	Customers of sex work	Prison Inmates	Other
Condom Promotion		X	X	X		
Drug substitution therapy						
HIV testing and counseling		X	X	X	X	

Needle and syringe exchange						
Reproductive health including sexually transmitted infections, prevention and treatment		**X**	**X**	**X**		
Stigma and Discrimination		**X**	**X**	**X**	**X**	
Targeted information on risk reduction and HIV education		**X**	**X**		**X**	
Vulnerability reduction (income generation)						

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2013?

VERY POOR										EXCELLENT
0	1	2	3	4	5	6	7	**8**	9	10

Since 2011, what have been key achievements in this area?

The completion of the Botswana Behavioral and Biological Surveillance Study with strategic plans now under development. Successful HIV Testing & Counseling Campaigns held in 2013 Wise Up for Youth campaign PMTCT campaigns.

What challenges remain in this area?

- Human resource shortages due to decreased donor funding
- Decreased funding,
- Downsizing of the government workers
- Continue decreases in development partner funding.
- Finding the means necessary to rationally and realistically address sexual practices within communities.

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

IF YES, how were these specific needs determined?

Research, surveys, surveillance and operational studies Assessments/Evaluations Community Consultations Analysis of (Routine) Programme Data

IF YES, what are these specific needs?

Additional Human Resources for programme implementation and accurate M&E Behavioral interventions supported financially in addition to bio-medical prevention options. Additional resources to increase eligibility for life-long ART and optimize treatment as preventions The development of innovative training models, which are sustainable.

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to:	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4	N/A
Blood safety				X	
Condom promotion				X	
Economic support e.g. cash transfers					X
Harm reduction for people who inject drugs					X
HIV prevention for out-of-school young people			X		
HIV prevention in the workplace				X	
HIV testing and counseling				X	
IEC on risk reduction	X				
IEC on stigma and discrimination reduction	X				
Prevention of mother-to-child transmission of HIV				X	
Prevention for people living with HIV				X	
Reproductive health services including sexually transmitted infections prevention and treatment				X	
Risk reduction for intimate partners of key populations	X				
Risk reduction for men who have sex with men		X			
Risk reduction for sex workers			X		
Reduction of gender based violence			X		
School-based HIV education for young people			X		
Treatment as prevention					X
Universal precautions in health care settings			X		
Other [write in]					X

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation?

VERY POOR										EXCELLENT
0	1	2	3	4	5	6	7	8	9	10

A.V TREATMENT, CARE AND SUPPORT BOTSWANA

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services? YES

If YES, Briefly identify the elements and what has been prioritized:

- TB/HIV collaboration and integration
- SRH/HIV collaboration and integration
- Pediatric and Adolescent Treatment, Care and Support
- Psychosocial support for PLWAs and their families
- Increased Treatment eligibility criteria for Adults,
- Adolescents & Children Management of ART treatment failure and HIV drug resistance surveillance
- Palliative care
- OI Management
- STI Management
- CHBC

Briefly identify how HIV treatment, care and support services are being scaled-up?

- Continued decentralization of HIV services
- Continued increases of financial commitment and support from the Government of Botswana
- Advocacy, community mobilization and advertising of ART messages Coordination
- Harmonization and alignment of development partner support Establishment of HIV & TB Integrated Specialty Centres in 7 districts

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

The majority of people in need have access to	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4	N/A
Antiretroviral therapy				X	
ART for TB patients				X	
Cotrimoxazole prophylaxis in people living with HIV				X	
Early infant diagnosis			X		
Economic support			X		
Family based care and support			X		
HIV care and support in the workplace (including alternative working arrangements)		X			
HIV testing and counseling for people with TB				X	
HIV treatment services in the workplace or treatment referral systems through the workplace		X			

Nutritional care			X		
Paediatric AIDS treatment			X		
Palliative care for children and adults Palliative care for children and adults			X		
Post-delivery ART provision to women				X	
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)				X	
Post-exposure prophylaxis for occupational exposures to HIV				X	
Psychosocial support for people living with HIV and their families			X		
Sexually transmitted infection management				X	
TB infection control in HIV treatment and care facilities		X			
TB preventive therapy for people living with HIV					X
TB screening for people living with HIV			X		
Treatment of common HIV-related infections				X	
Other [write in]					

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV? YES

Please clarify which social and economic support is provided:

Income generation activities Social Safety Security Net (Food baskets, etc.) Palliative care services Orphan care services Positive Health Dignity and Prevention programme

3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV? YES

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

IF YES, for which commodities?

- ART Condoms Lab Reagents

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?

VERY POOR										EXCELLENT
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area?

- Continued decentralization of ART provision to all levels of health care facilities (534)
- Increase treatment Adult eligibility to CD4 count <350
- Increase treatment eligibility for all children under 5 years of age
- High ART coverage (approximately 89%)
- High PMTCT uptake 93% Increasingly positive survival rates
- Availability of Raltegravir and Darunavir required for deep salvage patients

What challenges remain in this area?

- Due to decreases in human resources patient support has suffered.
- 1st line failure rates have almost doubled in 1 year.
- The long-term financial sustainability of the programme remains in question.
- Critical shortages of skilled human resources at all levels of management
- Weak clinical supervisory structures from the national level to the ground level
- Aging laboratory infrastructure and critical shortages of lab personnel Innovation required to redesign clinical training models in a more sustainable manner

6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children? **YES**

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

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

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?

VERY POOR										EXCELLENT
0	1	2	3	4	5	6	7	8	9	10

(7 highlighted)

Achievements: The number of registered orphans and vulnerable children continue to decline.

Challenges: Low uptake of Early Child Development services, inadequate staffing to deal with multiple OVC programmes and initiatives and rising costs of care.

A.VI MONITORING AND EVALUATION BOTSWANA 2013

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

Briefly describe any challenges in development or implementation:

- Due to high staff turn over there is need for continuous training, mentoring and supervision for implementation of the M&E Plan and activities
- Further harmonization of all indicators is still required
- There remains poor consensus on which indicators are necessary from the community and civil society
- Baseline figures and target setting is still lacking for some indicators
- Although written as a 5-year plan - The national M&E Plan was not completed until one year its time frame in 2012.
- The M&E plan is not annualized

1.1. IF YES, years covered:

2011-2016

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

Yes All Partners	Yes Some Partners	No

Briefly describe what the issues are:

Some partners continue to more strongly align their indicators to donor requirements and not necessarily to the national M&E requirements.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	Yes	
IF YES, does it address:		
Behavioral surveys	Yes	
Evaluation / research studies	Yes	
HIV Drug resistance surveillance	Yes	
HIV surveillance	Yes	
Routine programme monitoring	Yes	
A data analysis strategy		No
A data dissemination and use strategy		No

A well-defined 50 standardized set of indicators that includes sex and age disaggregation (where appropriate)	Yes	
Guidelines on tools for data collection	Yes	

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

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities? 8%

4. Is there a functional national M&E Unit? YES

Briefly describe any obstacles:

- Shortage of staff at all levels but especially in the districts at the ground level
- Shortage of M&E skilled staff (most staff are new)
- Retention of M&E staff
- Inadequate opportunities for postgraduate training in M&E
- Some M&E officers at the district level are responsibilities other than M&E On the implementation level some M&E officers
- Lack motivation to provide quality data or take ownership of their work

4.1. Where is the national M&E Unit based? **The Ministry of Health**

In the National HIV Commission (or equivalent)? YES

Elsewhere? NO

If elsewhere, please specify:

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles]	Fulltime	Part-time?	Since when?
Manager, Research & Monitoring	X		2010
Chief Research Officer	X		2009
Principle Research Officer	X		2009
Research Officer	X		2011
Assistant Research Officer	X		2003
Data Clerk	X		2001
Temporary staff			
Temporary M&E Staff		X	2012
Temporary M&E Staff		X	2012

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system? YES

Briefly describe the data-sharing mechanisms: All ministries and NGO's are requested to report directly to NACA quarterly for inclusion in the national NAC report.

What are the major challenges in this area?
• Non-affiliation of some NGOs to the umbrella body so information is not gathered centrally Inadequate coordination and adherence to reporting mechanisms • Lack of electronic reporting system and national database • Multiple and fragmented reporting systems • Weak coordination updating the national indicators and revision tools • Feedback mechanism is not optimal • Data quality is problematic at all levels Reports are not complied in a timely manner and therefore quality of data is often compromised

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

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

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

Programme data are deposited into a national excel spreadsheet and updated on a quarterly basis. However, there is a need for a more robust national M&E database. It is managed by the NACA M&E team.

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes All of the above	Yes But only some of the above	No None of the above

IF YES, but only some of the above, which aspects does it include?

Content and geographical coverage of HIV services, but not on key population or non-nationals

6.2. Is there a functional Health Information System?

At national level: YES

At subnational level: YES

IF YES, at what level(s)?

National and District levels

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

Estimates of Current and Future Needs	Estimates of Current Needs only	No

7.2. Is HIV programme coverage being monitored? YES

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

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

IF YES, for which population groups?

Pregnant Women

Briefly explain how this information is used:

Estimated ART coverage are used for forecasting and costing ART use PMTCT results initiated research to find the reason for high maternal mortality.

(c) Is coverage monitored by geographical area? YES

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

District and National levels

Briefly explain how this information is used:

District information is widely disseminated

Drug forecasting and costing purposes

Policy decision making Academic and operational research

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

9. How are M&E data used?

For programme improvement? YES

In developing / revising the national HIV response? YES

For resource allocation? YES

Other [write in]

There is no official annual report although every quarter the NAC received updated national M&E reports.

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:

Missing data and information gaps often prevent research from moving forward. There is an urgent need to address these data gaps.

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

At national level? YES

IF YES, what was the number trained 86

At Subnational level? YES

IF YES, what was the number trained: 71

At service delivery level including civil society? YES

IF YES, how many? 14

10.1. Were other M&E capacity-building activities conducted other than training? YES

IF YES, describe what types of activities:

Training of Ministry of Health's AIDS coordinators on new data collection tools

Routine data quality assessment is ongoing

Data quality training for program officers at MoH is on-going MAPIE training for cloud computing

11. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?

VERY POOR										EXCELLENT
0	1	2	3	**4**	5	6	7	8	9	10

Since 2011, what have been key achievements in this area?

- Indicators for NOP have been defined
- BAIS IV completed – analysis on-going
- Stigma Index Study completed – analysis on-going
- Prison Study – analysis ongoing

What challenges remain in this area?

- Inadequate advocacy for M&E at higher levels of Government Poor use of the latest IT technologies
- No ownership of data at higher levels Infrastructure issues such a power and Internet becoming increasingly unreliable.
- Users are not computer literate leading to lost of data and poor data quality
- Work is interrupted by power outages
- Even basic computers are lacking in some facilities
- Need for a postgraduate education course in M&E
- M&E fragmented at all levels
- Funding issues increase as development partners continue to decrease their financial support
- Data does not accurately reflect the situation on the ground
- There are no champions for M&E

B.I CIVIL SOCIETY INVOLVEMENT BOTSWANA 2013

To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

Civil society organizations have been strongly engaged in the strengthening of political commitment and strategy/policy development since the beginning of the AIDS response in Botswana. However, more recently, there are fewer CSOs that have the capacity to engage the government at high levels (with the exception of the Botswana Network on Ethics, Law and HIV/AIDS - BONELA).

Due to funding challenges civil society remains poorly organized lacking platforms for communications channels to be alerted when various high level meetings take place or to receive feedback after such meetings occur.

Therefore many previously active civil society organizations are often no longer represented in high level strategy meetings. During 2013, in an attempt to alleviate some these issues and reinvigorate CSOs, the Botswana Network of AIDS Services Organizations (BONASO) was funded to again serve as an umbrella organization to improve CSO coordination and communications. However, issues of inclusiveness and a widening gap between CSOs and political leaders remain.

2. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

The major CSO networks were highly involved in both planning and budgeting of NSFII initially, however some grassroots organizations were not involved often lacking the capacity to participate in planning processes. Furthermore, many CSOs that could be involved lacked the resources to enable them to go into districts and conduct the necessary ground level planning consultations.

3. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?

LOW					HIGH
0	1	2	3	4	5

The national HIV budget?

LOW					HIGH
0	1	2	3	4	5

The national HIV reports?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

The NSFII and the NOP include civil society priorities. However, these and other reports (e.g., The National Strategy for Civil Society) are poorly disseminated causing implementation challenges at all levels. Furthermore, few CSOs submit their annual reports and so their activities and perspectives are very often not appreciated or included in national reports.

4. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?

Developing the national M&E plan?

LOW					HIGH
0	1	2	3	4	5

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

LOW					HIGH
0	1	2	3	4	5

Participate in using data for decision-making?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

In 2013, civil society organizations were involved in the creation of the National M&E Development Plan. CSOs also participate in the Joint Oversight Committee, the Partnership Forum and the Strategic Information TWG where M&E data is regularly presented and reviewed. However, very few CSOs have M&E technical staff to analyze and use their own data effectively.

5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society representation in HIV efforts inclusive of diverse organizations (e.g. organizations and networks of people living with HIV, of sex workers, community based organizations, and faith-based organizations)?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

Generally, diverse representation exists among CSOs in Botswana. In 2013, the Size Estimation of HIV/STI Among Select High Risk Subpopulations in Botswana Study (BBSS) went far to provide an understanding of communities previously left out of the national HIV response.

Furthermore, people with disabilities were also included for the first time in the National AIDS Council (NAC). However despite these improvements there still remains much work to be done to improve the inclusiveness of marginalized populations in the HIV response.

6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access?

Adequate financial support to implement its HIV activities?

LOW					HIGH
0	1	2	3	4	5

Adequate technical support to implement its HIV activities?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

In 2013, funding support for CSOs dramatically declined. It was one of the worst years for financial support since the national HIV response began. This was a direct consequence of the effects of the global economic downturn and decreased donor support. Generally, CSOs have poor accounting capacity and many CSOs do not necessarily provide the services (or account for the services) they were funded to complete. Despite the technical support available to alleviate these issues in the form of training and individual capacity development from I-Tech, UNAIDS and NACA, there are often not enough programme M&E officers available within CSOs to fully take advantage and benefit from such support.

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

Prevention for key-populations	<25%	25 % - 50%	51% - 75%	>75%
People living with HIV			X	
Men who have sex with men				X
People who inject drugs				
Sex workers				X
Transgender people				X
Palliative care	X			
Testing and Counseling		X		
Know your Rights/ Legal services				X
Reduction of Stigma and Discrimination			X	
Clinical services	X			

(ART/OI)				
Home-based care			X	
Programmes for OVC				

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2013?

VERY POOR										EXCELLENT
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area?

- The Botswana Civil Society Strategy was finalized. Botswana Network of AIDS Service Organizations (BONASO) and Botswana Network of People Living with HIV/AIDS (BONEPWA) were re-established and funded again to serve as a CSO coordinating agencies.
- The largest portion of the BNAPS budget went to support 55 CSOs to improve the national HIV response.
- Information was used for advocacy purposes (e.g. BONELA survey results were used to advocate for the inclusion of MARPs issues in the National AIDS Policy).
- The "Maatla" Project assisted with the development and training needs of CSOs. FHI 360 also support the capacity building of civil service organizations

What challenges remain in this area?

- Continued decreases in funding and support to CSOs by development partners and limited funds to implement the recently completed Botswana National Civil Society Strategy
- Lack of reporting on outcome/impact indicators to NACA Professional capacity building within most CSOs remains weak

B.II POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation? **YES**

IF YES, describe some examples of when and how this has happened:

In 2013, the completion and results of the Botswana Behavioral Surveillance Study (BBSS) stimulated a national dialogue about how to best serve these key populations. The study was

also presented to the National AIDS Council (NAC) who directly tasked the Departments of Health and Labour and Home Affairs to develop effective strategies to improve services and address the unique needs of key populations.

Also in 2013:

• The Botswana Stigma Index Study was completed with analysis on going

• The Botswana Prison Study was completed with analysis on going

• The HIV/AIDS Policy was developed and widely disseminated

• The Public Health Bill was adopted in Parliament.

B.III HUMAN RIGHTS BOTSWANA 2013

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
People living with HIV		**Yes**
Men who have sex with men	**No**	
Migrants/mobile populations		**Yes**
Orphans and other vulnerable children		**Yes**
People with disabilities		**Yes**
People who inject drugs	**No**	
Prison Inmates	**No**	
Sex workers	**No**	
Transgender people	**No**	
Women and girls		**Yes**
Young women/young men		**Yes**
Other specific vulnerable subpopulations	**Farm workers and camp workers**	**Yes**

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination? YES

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:

The Constitution of Botswana (Bill of Rights) section 3-19 provides for the protection of the fundamental rights and freedoms of individuals including the right to be free from inhuman and degrading treatment, which has been widely interpreted to include the right to be free from stigma and discrimination.

The Employment Act (Amendment of 2012) provides for non-discrimination on the basis of health status. The Public Service Act also protects the rights of employees.

Briefly explain what mechanisms are in place to ensure that these laws are implemented: Government is currently implementing legal aid services for the general

population. However, this is not specifically targeting human rights violations. Currently there is no Human Rights Commission functioning in Botswana.

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

The courts (of Law) have progressively interpreted the constitution to address (to some extent) HIV related stigma and discrimination. Very often the general public are unaware of what exactly constitutes their legal rights.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations? **YES**

2.1. IF YES, for which sub-populations?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
People living with HIV	**No**	
Men who have sex with men	**No**	
Migrants/mobile populations		**Yes**
Orphans and other vulnerable children	**No**	
People with disabilities	**No**	
People who inject drugs		**Yes**
Prison Inmates		**Yes**
Sex workers		**Yes**
Transgender people		**Yes**
Women and girls	**No**	
Young women/young men	**No**	
Elderly People	**(No)**	

Briefly describe the content of these laws, regulations or policies:

- There are possibilities of the mis-use of the recently adopted Public Health Act in threatening the confidentiality of persons living with HIV if its implementation is not closely monitored.
- Sodomy laws (penal code) sections 164 & 165 states that, "acts against the order of nature" is a criminal offense. Prostitution, in terms of section 155, 156, 157 and 158 of the penal code states that anyone who knowingly lives wholly or in part from the proceeds of prostitution is guilty of an offense.
- Prison Health policy prohibits the free access of condoms to prison inmates.
- The Ministry of Health provides free access to ART to Botswana citizens only.
- The Domestic Violence Act does not address or protect women from marital rape.

Briefly comment on how they pose barriers:

The above referenced laws make it difficult for government, development partners or CSOs to develop provision and programmes targeted at improving access to specific services for those vulnerable subpopulations most at-risk.
Criminalization fuels negative public attitudes/stigma and discrimination against marginalized populations contributing to their often-low uptake of public health services.

The health policies exclude foreign nationals and prison inmates from receiving free life saving ART.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV? YES

Briefly describe the content of the policy, law or regulation and the populations included.

- The Gender Based Violence Act protects men and women generally from violence directly solely on the basis of their gender.
- The Domestic Violence Act protects men and women from home based and family initiated violence. However, this act does not protect women from marital rape.

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

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

NSFII Overall Strategic Objective #6: To improve ethical and legal environment towards universal access of HIV and AIDS services.

The Botswana National Policy on HIV and AIDS, Section 1.6 states that the policy reflects the right to life, liberty and security of persons as well as the notions of self-determination, gender equality, communal responsibilities, non-discrimination, human treatment, privacy and equality under the law.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations? YES

IF YES, briefly describe this mechanism:

The Botswana Network on Ethics, Law and HIV/AIDS (BONELA) provides free legal aid to those in need of legal representation in regard to HIV and AIDS.

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).

	Provided free-of-charge to all people in the country		Provided free-of-charge to some people in the country		Provided, but only at a cost	
	Yes	No	Yes	No	Yes	No
Antiretroviral treatment		X	X		X	
HIV prevention services		X	X		X	
HIV-related care and support interventions		X	X		X	

If applicable, which populations have been identified as priority, and for which services?

HIV positive pregnant women (PMTCT and Life-Long ART) HIV positive Adolescent and young adults (Life-Long ART, HIV Prevention services)

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support? **YES**

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth? **YES**

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support? **YES**

IF YES, Briefly describe the content of this policy/strategy and the populations included:

The Key Populations Operational plan for key populations is now under development. However, this plan does not include non-nationals.

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations? **NO**

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

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

IF YES, briefly describe the content of the policy or law:

Section 7.1.1 of the Botswana National Policy on HIV and AIDS, states: There should be no mandatory pre-employment testing of citizens of Botswana. However, Section 7.1.2 of the Botswana National Policy on HIV and AIDS states: where circumstances demand, mandatory HIV testing may be required.

Additionally, HIV testing is required before acceptance into the military and is required for non-nationals seeking government employment.

10. 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: **YES**

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

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

- Every four years the BAIS Survey collects data on stigma and discrimination among the general population.
- The HIV Stigma Index Study was conducted in 2013.
- Both of the civil society organizations, BONELA and Ditshwanelo, are involved in promotion and protection of Human Rights.
- There also exists an office of Ombudsman with the Office of Presidential Affairs.

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)? **YES**

b. Programmes for members of the judiciary and law enforcement46 on HIV and human rights issues that may come up in the context of their work? **YES**

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

Legal aid systems for HIV casework: **YES**

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

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

IF YES, what types of programmes?

Programmes for health care workers: YES

Programmes for the media: YES

Programmes in the work place: YES

Other : NO

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?

VERY POOR										EXCELLENT
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area?

- Adoption of the Botswana National Policy on HIV and AIDS
- Adoption of the Public Health Act Completion of the Botswana Behavioral Surveillance Study to highlight the needs of key populations
- Completion of the Stigma Index Study to determine the current state of discrimination and stigma
- Completion of the Prison Study to determine the prevalence and sexual behavior among inmates

What challenges remain in this area?

- Aspects of the Public Health Act in regard to disclosure might threaten confidentiality and must be monitored closely.
- Criminalization of key populations remains in place.
- Lack of access to free life saving ART for non-nationals
- Lack of condoms to prison inmates
- Lack of free ART to non-national prison inmates
- Lack of protection for women in cases of marital rape

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?

VERY POOR										EXCELLENT
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area?

Adoption of the Botswana National Policy on HIV and AIDS

Adoption of the Public Health Act

The implementation of legal aid services across the country

What challenges remain in this area?

- Overcoming cultural barriers to alternative lifestyles and tolerance to difference.
- The criminalization of sex work.
- Issues regarding confidentiality and disclosure associated with the implementation of the Public Health Act, which might negatively impact on already poor HIV testing trends.

B.IV PREVENTION BOTSWANA 2013

Has the country identified the specific needs for HIV prevention programmes? **YES**

IF YES, how were these specific needs determined?

Broad consensus workshops were conducted to complete both NSF II and the NPO, which both prioritize HIV prevention measures as the number one priority for Botswana's National HIV response.

The country also supported the completion of the Botswana Behavioral Surveillance Study (BBSS) to determine the specific needs of key populations.

Additionally the Prison Study once analyzed will also provide important information regarding the need to safeguard the lives of inmates and prison staff alike.

IF YES, what are these specific needs?

Continued funding for both bio-medical and behavioral interventions.

Customized programmes to address the special needs of key and vulnerable populations including non-nationals.

Funding limitations prevent increased CD4 thresholds to optimize treatment as prevention options.

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to:				
	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4	N/A
Blood safety				X	
Condom promotion			X		
Harm reduction for people who inject drugs	X				
HIV prevention for out-of-school young people		X			
HIV prevention in the workplace				X	
HIV testing and				X	

counseling					
IEC on risk reduction			X		
IEC on stigma and discrimination reduction			X		
Prevention of mother-to-child transmission of HIV				X	
Prevention for people living with HIV				X	
Reproductive health services including sexually transmitted infections prevention and treatment			X		
Risk reduction for intimate partners of key populations			X		
Risk reduction for men who have sex with men	X				
Risk reduction for sex workers	X				
School-based HIV education for young people			X		
Universal precautions in health care settings			X		
Other [write in]					

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?

VERY POOR										EXCELLENT
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area?

- Completion of the Botswana Behavioral Surveillance Study (BBSS).
- Successful Routine Testing Campaigns
- Use of conventional and social media for IEC campaigns (SMS technology, twitter, and Facebook) PMTCT Campaigns Completion of the Elimination of Mother-to-Child-Transmission Strategy
- The continued up scaling of Safe Male Circumcision

What challenges remain in this area?

- Decreased funding from development partners for various prevention strategies.
- Human resource constraints for programme implementation.
- Decreased funding for HIV prevention trainings.

B.V TREATMENT, CARE AND SUPPORT BOTSWANA

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services? YES

IF YES, Briefly identify the elements and what has been prioritized

- TB/HIV collaboration and integration
- SRH/HIV collaboration and integration Paediatric and Adolescent
- Treatment, Care and Support
- Psychosocial and economic support for PLWAs Management of treatment of ART failure management and HIV drug resistance surveillance
- STI Management
- OI Management
- Updated Clinical Care Guidelines
- Palliative Care
- Nutrition for PLWA CHBC

Briefly identify how HIV treatment, care and support services are being scaled-up?

- Continued decentralization of HIV services
- Continued increases of financial commitment and support from the Government of Botswana Advocacy, community mobilization and advertising
- Coordination, harmonization and alignment of development partner support
- Establishment of HIV & TB Integrated Specialty Centres in 7 districts

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

HIV treatment, care and support services	The majority of people in need have access to:				
	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4	N/A
Antiretroviral therapy				X	
ART for TB patients				X	
Cotrimoxazole prophylaxis in people living with HIV				X	
Early infant diagnosis			X		
HIV care and support in the workplace (including alternative working arrangements)			X		
HIV testing and counseling for people with TB				X	
HIV treatment services in the workplace or treatment referral systems through the workplace		X			
Nutritional care			X		
Paediatric AIDS treatment: Agree			X		
Post-delivery ART provision to women				X	
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)				X	
Post-exposure prophylaxis for occupational exposures to HIV			X		

Psychosocial support for people living with HIV and their families			X		
Sexually transmitted infection management				X	
TB infection control in HIV treatment and care facilities			X		
TB preventive therapy for people living with HIV					X
TB screening for people living with HIV				X	
Treatment of common HIV-related infections				X	
Other [write in]					

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

VERY POOR										EXCELLENT
0	1	2	3	4	5	6	7	**8**	9	10

- Since 2011, what have been key achievements in this area:
- Continued decentralization of ART provision to all health care facilities (534)
- Increase treatment eligibility to CD4 count <350
- Increase treatment eligibility for all children under 5 years for age
- High national ART coverage (87%) High national PMTCT uptake 93% Increasingly positive survival rates over time (quantify survival rates)
- Availability of Raltegravir and Darunavir required for deep salvage patients Decentralization of HIV services to 534 outreach sites
- Developed the Palliative Care Strategy
- STI Management guidelines updated to cater to care for key populations

What challenges remain in this area?

Due to decreases in human resources patient support has suffered.

1st line failure rates have almost doubled in 1 year

The long-term financial sustainability of the programme

Critical shortages of skilled human resources at all levels of management

Weak clinical supervisory structures from the national level to the ground level

Poor M&E infrastructure

Does the country have a policy or strategy to address the needs of orphans and other vulnerable children? **YES**

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

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

Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

VERY POOR										EXCELLENT
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area: **(see above)**

What challenges remain in this area: **(see above)**

ANNEX 2

Indicator Overview Table

Target and indicator	Year of UNGASS Progress Report						GARPR 2013 Sources & Comments
	2003	2005	2008	2010	2012 GARPR	2013	
Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015							
Indicators for the general population							
1.1 Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention	36.3	37.6	37.6	43.7	43.7	**47.9**	**Source:** Preliminary Results BAIS IV
1.2 Percentage of young women and men aged 15-49 who have had sexual intercourse before the age of 15	Not required	7.0	No Data	5.5	5.5	4.6	**Source:** Preliminary Results BAIS IV
1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Not required	Not required	No Data	24.0	24.0	15.8	**Source:** Preliminary Results BAIS IV
1.4 Percentage of adults 15-49 who had more than one sexual partner in the past 12 months and who report the use of a condom during last intercourse	Not required	Not required	No data	90.2	90.2	81.9	**Source:** Preliminary Results BAIS IV
1.5 Percentage of							

women and men aged 15-49 who received an HIV test in the past 12 months and know their results	Not required	Not required	No data	61.7	61.7	63.8	**Source:** Preliminary Results BAIS IV
1.6 Percentage of young women aged 15-24 who are living with HIV	Not required	Not required	Not required	Not required	14.1	12.75	Spectrum
Indicators for sex workers							
1.7 Percentage of sex workers reached with HIV prevention programmes	No data	No data	No data	No data	No data	44.9	**Source:** BBSS Survey 2013
1.8 Percentage of female and male sex workers reporting the use of a condom with their most recent client	No data	No data	No data	No data	No data	90.1	**Source:** BBSS Survey 2013
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	No data	No data	No data	No data	No data	54.8	**Source:** BBSS Survey 2013
1.10 Percentage of sex workers who are living with HIV	No data	No data	No data	No data	No data	61.9	**Source:** BBSS Survey 2013
Indicators for men who have sex with men							
1.11 Percentage of men who have sex with men reached with HIV prevention programmes	No data	No data	No data	No data	No data	44.9	**Source:** BBSS Survey 2013
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No data	No data	No data	No data	No data	84.2	**Source:** BBSS Survey 2013
1.13 Percentage of men who have sex with men	No data	No data	No data	No data	No data	79.6	**Source:** BBSS Survey 2013

that have received an HIV test in the past 12 months and know their results							
1.14 Percentage of men who have sex with men who are living with HIV	No data	No data	No data	No data	No data	13.1	**Source:** BBSS Survey 2013
Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015							
Indicators for injection drug users: There is no Botswana specific data for this subpopulation							
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths							
PMTCT Indicators							
3.1 Percentage of HIV positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	34.3	60.3	91.0	94.2	94.0	96.2	**Source:** PMTCT Programme data
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Not required	Not required	Not required	Not required	45.9	47	**Source:** PMTCT Programme data
3.3 Mother-to-child transmission of HIV (modeled)	Not required	Not required	Not required	Not required	3.6	2.49	**Source:** Spectrum 2014
Target 4: Half of the 15 million people living with HIV on antiretroviral treatment by 2015							
ART Indicators							
4.1 Percentage eligible adults and children currently receiving antiretroviral therapy	7.3	62.7	82.2	89.9	96.1	**88%**	**Source: ART Programme data with 2013 National Spectrum Model** .
% adults & Children receiving ART therapy among all adults and children living with HIV= 64%						**64%**	**Source: ART Programme data with 2013 National Spectrum**

							Model
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Not required	92.0	84.9	93.2	95.0	**No data**	
Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015							
TB/HIV Indicators							
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	No data	No data	No data	No data	No data	No data	
Target 6: Reach a significant level of annual global expenditure (US22-24 billion) in low-and middle-income countries							
Financial Indicators							
6.1 Domestic and international AIDS spending by categories and financing sources	69.8	**165.0**	**351.6**	**348.2**	**147.2**	**$399 million USD**	**2011-2012 NASA**
Target 7: Critical enablers and synergies with development sectors							
Indicators ***7.1 National Commitments and Policy Instruments (NCPI), Prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes stigma and discrimination and monitoring and evaluation. Presented in Annex 1***							
7.2 Proportion of ever married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Not required	Not required	Not Required	Not required	**28.9***	**3.1**	**Source: BAIS IV**
		*** Source:** Draft "The War At Home Gender Based Violence Indicator Study Botswana", March 2012 *Comments*: The figure from the above study was based on respondents aged 18 years and above rather than 15-49 years.					
7.3 Current school attendance among orphans and among non-orphans	Not required	Not required	Data not available	Data not available	No data	**97.5**	**Source: BAIS IV**

aged 10-14							
7.4 Proportion of the poorest households who received external economic support in the past 3 months	Not required	Not required	Not Required	Not Required	No data	**No data**	