# Botswana Report **NCPI**

## NCPI **Header**

**is indicator/topic relevant?**: Yes
**is data available?**: Yes
**Data measurement tool / source**: NCPI
**Other measurement tool / source**:
**From date**: 02/11/2014
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**Additional information related to entered data. e.g. reference to primary data source, methodological concerns:**:
**Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source:**:
**Data measurement tool / source**: GARPR

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**Describe the process used for NCPI data gathering and validation**: 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. Beginning in November 2013, a small technical team was constituted to review and update the Botswana National Spectrum file both for reporting puroses and the investment case. Numerous consultative workshops then took place with MoH programmes officers, key developmental partners and civil society to validate results.

**Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions**: All consultative workshops involved extensive discussion and consensus building. There were no signficant disagreements throughout the process.

**Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like)**: none.

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

| Organization | Names/Positions | Respondents to Part A |
|---|---|---|
| MOH/ ARV | Tlotlo Nong /Data Quality Officer | A1,A2,A3,A4,A5,A6 |
| NACA | Gofaone Moatlhodi/Ass Research Officer | A1,A2,A3,A4,A5,A6 |
| NACA | B. Tshekiso/Research Officer | A1,A2,A3,A4,A5,A6 |
| UNAIDS | Mpho Mmelesi/SI Advisor | A1,A2,A3,A4,A5,A6 |
| NACA | Robert Selato/Chief Research Officer | A1,A2,A3,A4,A5,A6 |
| MOH/HTC | Sheila Lesotlho/Health Officer | A1,A2,A3,A4,A5,A6 |
| MOH/HTC | Modise Ngombo/Public Health Officer | A1,A2,A3,A4,A5,A6 |
| MOH/HTC | Mothwana Thekiso/HTC Coodinator | A1,A2,A3,A4,A5,A6 |
| NACA | K . Masupu/SME Advisor | A1,A2,A3,A4,A5,A6 |
| MOH/DPPHME | Pilatwe Pilatwe/Chief Health Officer | A1,A2,A3,A4,A5,A6 |
| NACA | Evelin Reetsang/Senior Research Officer | A1,A2,A3,A4,A5,A6 |
| MOH DHAPC | Dr B. Nkomo/Public Health Specialist | A1,A2,A3,A4,A5,A6 |
| MOH DHAPC | Koona Keapoletswe/Acting Director | A1,A2,A3,A4,A5,A6 |
| MOH DHAPC | Mr C. Ntswape/SMC Coordinator | A1,A2,A3,A4,A5,A6 |
| MOH DHAPC | Ms Clearance Abel/SOR M&E Officer | A1,A2,A3,A4,A5,A6 |
| MOH DHAPC | Dinah Ramaabya/PHO | A1,A2,A3,A4,A5,A6 |
| NACA | N. Tswetla/IEC Officer | A1,A2,A3,A4,A5,A6 |
| MOH DHAPC | Chipo Petlo/PMTCT Coordinator | A1,A2,A3,A4,A5,A6 |
| MOH DHAPC | Leu Leu /Data Manager PMTCT | A1,A2,A3,A4,A5,A6 |
| NACA | Ogomoditswe Odirile/Planning Officer | A1,A2,A3,A4,A5,A6 |
| NACA | B. Mkhweli/Development Assistance Coordination Advisor | A1,A2,A3,A4,A5,A6 |
| NACA | B Ramatlapeng | A1,A2,A3,A4,A5 |
| NACA | Lorato Mongatane /Public Relations | A1,A2,A3,A4,A5 |
| NACA | Seeletso Mosweunyane/Chief Research Officer | A1,A2,A3,A4,A5,A6 |
| NACA | Peter Chibatamoto /Policy Advisor | A1,A2,A3,A4,A5,A6 |
| NACA | Botsalano Masimolodi /Principal Research Officer | A1,A2,A3,A4,A5,A6 |
| CMS | Maimouna Ddiaye /Pharmacist | A1,A2,A3,A4,A5,A6 |
| MOH | Dr Tafuma/Program Manager | A1,A2,A3,A4,A5,A6 |
| NACA | Richard Matlhare /National Coordinator | A1,A2,A3,A4,A5,A6 |
| MOH | Bagapi Tinashe /M&E officer | A1,A2,A3,A4,A5,A6 |
| NACA | Kagiso Mokone /Data Clerk | A1,A2,A3,A4,A5,A6 |
| MOH DHAPC | Theresa P. Letlhone/Chief Health Officer | A1,A2,A3,A4,A5,A6 |
| MOH DHAPC | Carol K Moalafhi/Programme Officer | A1,A2,A3,A4,A5,A6 |
| MOH DHPAC | Penny Makuruetsa /PHO 1 | A1,A2,A3,A4,A5,A6 |
| MOH BNTP | Grace Nkubito /Public Health Specialist | A1,A2,A3,A4,A5,A6 |

## NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

| Organization | Names/Positions | Respondents to Part B |
|---|---|---|
| University of Botswana | E. M. Matshediso/ Director HIV & AIDS Coordination Office | B1,B2,B3,B4,B5 |
| UNFPA | J. Shongwe/M&E officer | B1,B2,B3,B4,B5 |
| UNICEF | Colleta Kibassa/Child Survival | B1,B2,B3,B4,B5 |
| WHO | Madididmalo Tebogo/National Program Officer | B1,B2,B3,B4,B5 |
| CDC Botswana | Janet Mwambona/PMTCT Programme Officer | B1,B2,B3,B4,B5 |
| BONEPWA | K Molosiwa/Excutive Director | B1,B2,B3,B4,B5 |
| UNAIDS | Heston Philips /SI | B1,B2,B3,B4,B5 |
| UNESCO | M Mosuma | B1,B2,B3,B4,B5 |
| SCMS | M. Ogbuabo/Advisor | B1,B2,B3,B4,B5 |
| BOCAIP | T. Monametsi/M&E Officer | B1,B2,B3,B4,B5 |
| BONELA | Nana Gleeson /SMT Operations | B1,B2,B3,B4,B5 |
| ACHAP | Frank Mwangeni/Executive Officer-Programs | B1,B2,B3,B4,B5 |
| FHI360 | Mike Mesago/Technical Officer | B1,B2,B3,B4,B5 |
| FHI360 | Onalenna Serufho/Senior M&E Officer | B1,B2,B3,B4,B5 |
| UNAIDS | Irene Maina/CMNA | B1,B2,B3,B4,B5 |
| I-Tech | Abaleng Lesego /M&E Officer | B1,B2,B3,B4,B5 |
| Tebelopele | Masego Boima/M&E Officer | B1,B2,B3,B4,B5 |
| Tebelopele | Ntlogeleng Modise /Business Development | B1,B2,B3,B4,B5 |
| Eric Mosothwane | Eric Mosothwane /Secretary | B1,B2,B3,B4,B5 |
| ACHAP | Panganai Makadzange/M&E Officer | B1,B2,B3,B4,B5 |
| BOFWA | Kabelo Kgongwana/Service Delivery Officer | B1,B2,B3,B4,B5 |
| BBCB | Frank Phatshwane/E.D. | B1,B2,B3,B4,B5 |
| Nkaikela | Phenyo Gaotlhobogwe/Director | B1,B2,B3,B4,B5 |
| BONELA | Cindy Kelemi/Director | B1,B2,B3,B4,B5 |
| BONELA | Tebogo Gareitsanye /Project Officer | B1,B2,B3,B4,B5 |
| CDC Botswana | Madididmalo Tebogo/National Program Officer | B1,B2,B3,B4,B5 |
| BONEPWA | Janet Mwambona/PMTCT Programme Officer | B1,B2,B3,B4,B5 |
| UNAIDS | K Molosiwa/Excutive Director | B1,B2,B3,B4,B5 |
| UNESCO | Heston Philips /SI | B1,B2,B3,B4,B5 |
| SCMS | M Mosuma | B1,B2,B3,B4,B5 |
| BOCAIP | M. Ogbuabo/Advisor | B1,B2,B3,B4,B5 |
| BONELA | T. Monametsi/M&E Officer | B1,B2,B3,B4,B5 |
| ACHAP | Nana Gleeson /SMT Operations | B1,B2,B3,B4,B5 |
| FHI360 | Frank Mwangeni/Executive Officer-Programs | B1,B2,B3,B4,B5 |
| FHI360 | Mike Mesago/Technical Officer | B1,B2,B3,B4,B5 |
| UNAIDS | Onalenna Serufho/Senior M&E Officer | B1,B2,B3,B4,B5 |
| I-Tech | Irene Maina/CMNA | B1,B2,B3,B4,B5 |
| Tebelopele | Abaleng Lesego /M&E Officer | B1,B2,B3,B4,B5 |
| Tebelopele | Masego Boima/M&E Officer | B1,B2,B3,B4,B5 |
| Eric Mosothwane | Ntlogeleng Modise /Business Development | B1,B2,B3,B4,B5 |
| ACHAP | Eric Mosothwane /Secretary | B1,B2,B3,B4,B5 |
| BOFWA | Panganai Makadzange/M&E Officer | B1,B2,B3,B4,B5 |
| BBCB | Kabelo Kgongwana/Service Delivery Officer | B1,B2,B3,B4,B5 |
| Nkaikela | Frank Phatshwane/E.D. | B1,B2,B3,B4,B5 |
| BONELA | Phenyo Gaotlhobogwe/Director | B1,B2,B3,B4,B5 |
| BONELA | Cindy Kelemi/Director | B1,B2,B3,B4,B5 |

## A.I Strategic plan

**1. Has the country developed a national multisectoral 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 costed National Operational Plan (NOP), as well as a Monitoring and Evaulation 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.**

**1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?**: National AIDS Coordinating Agency (NACA) The Office of the President

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

**Education**:

**Included in Strategy**: Yes

**Earmarked Budget**: Yes

**Health**:

**Included in Strategy**: Yes

**Earmarked Budget**: Yes

**Labour**:

**Included in Strategy**: Yes

**Earmarked Budget**: Yes

**Military/Police**:

**Included in Strategy**: Yes

**Earmarked Budget**: Yes

**Social Welfare**:

**Included in Strategy**: Yes

**Earmarked Budget**: Yes

**Transportation**:

**Included in Strategy**: Yes

**Earmarked Budget**: Yes

**Women**:

**Included in Strategy**: Yes

**Earmarked Budget**: Yes

**Young People**:

**Included in Strategy**: Yes

**Earmarked Budget**: Yes

**Other**:

**Included in Strategy**: No

**Earmarked Budget**: 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 multisectoral 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

**SETTINGS**:

**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?

**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

**Prison inmates**: Yes

**Sex workers**: Yes

**Transgender people**: Yes

**Women and girls**: Yes

**Young women/young men**: Yes

**Other specific key populations/vulnerable subpopulations [write in]:**:

: 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 multisectoral strategy include an operational plan?**: Yes

## 1.7. Does the multisectoral strategy or operational plan include:

**a) Formal programme goals?**: Yes

**b) Clear targets or milestones?**: Yes

**c) Detailed costs for each programmatic area?**: Yes

**d) An indication of funding sources to support programme implementation?**: No

**e) A monitoring and evaluation framework?**: Yes

**1.8. Has the country ensured “full involvement and participation” of civil society in the development of the multisectoral strategy?**: Active involvement

**IF ACTIVE INVOLVEMENT, briefly explain how this was organised.**: 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 the NOP, National AIDS Council, and the Joint Oversight Committee which oversees monitoring the implementation of NSFII.

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

**1.9. Has the multisectoral 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 multisectoral strategy?**: 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 develop-ment 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 [write in]**: 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 evalua¬tion informed resource allocation decisions?**: 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 stockouts. Additional pharmacy techinicans 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?

**a) HIV Counselling & Testing with Sexual & Reproductive Health**: Many

**b) HIV Counselling & Testing and Tuberculosis**: Many

**c) HIV Counselling & Testing and general outpatient care**: Many

**d) HIV Counselling & Testing and chronic Non-Communicable Diseases**: Many

**e) ART and Tuberculosis**: Many

**f) ART and general outpatient care**: Few

**g) ART and chronic Non-Communicable Diseases**: Many

**h) PMTCT with Antenatal Care/Maternal & Child Health**: Many

**i) Other comments on HIV integration:** : In 2013, integration intiatives 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?**: 9

**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 elgibility was increased to all Batswana children under 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

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

**A. Government ministers**: Yes

**B. 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 Fetsus 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 Ponatshego Kedikilwe. There is a Parlimentary committee on Health and HIV/AIDS to address HIV issues directly.

**2. Does the country have an officially recognized national multisectoral 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 multisectoral HIV coordination body:

**Have terms of reference?**: Yes

**Have active government leadership and participation?**: Yes

**Have an official chair person?**: 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 coordinationbetween government, civil societyorganizations, 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 stakeholders, manages the national response and prioritizes implementation of the NSFII to minimize duplication of efforts. The Districts (through the District Multisectorial 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 sustainabilty 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 incon-sistent 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 Bostwana 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:**: 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?**: 9

**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 Parlimentary AIDS Committee. The Office of the President continues to steward the National AIDS repsonse. 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

### 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:

**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 [write in]**: 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 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?**:

**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 populations [write in]:**: Refugees (who receive ART as part of UNHCR and PEPFAR programmes)

: 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) 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 populations 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

**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 [write in]:**:

: 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 communi-cation 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 mobilised 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?

**People who inject drugs**:

**Men who have sex with men**: Stigma and discrimination reduction,Targeted information on risk reduction and HIV education

**Sex workers**: Condom promotion,HIV testing and counseling,Targeted information on risk reduction and HIV education

**Customers of sex workers**: Condom promotion

**Prison inmates**:

**Other populations [write in]:**:

:

**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?**: 8

**Since 2011, what have been key achievements in this area:**: The completion of the Botswana Behavioral and Biological Surveillance Study with strategic plans under development. Successful HIV Testing and Counseling campaigns held in 2013 Wise Up for Youth campaigns PMTCT campaigns

**What challenges remain in this area:**: Human resource shortages due decreases support from development partners Decreased funding, downsizing of the government workers Continue decreases in development partner funding. Focusing the attention and research necessary to rationally and realistically address sexual practices within communities. Identify and prioritize gender issues driving HIV transmission.

**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 eligibilty for life-long ART and optimize treatment as preventions The development of innovative prevention training models for the community and health care workers w which are sustainable

## 4.1. To what extent has HIV prevention been implemented?

**The majority of people in need have access to…**:

**Blood safety**: Strongly agree

**Condom promotion**: Strongly agree

**Economic support e.g. cash transfers**: N/A

**Harm reduction for people who inject drugs**: N/A

**HIV prevention for out-of-school young people**: Agree

**HIV prevention in the workplace**: Strongly agree

**HIV testing and counseling**: Strongly agree

**IEC on risk reduction**: Strongly disagree

**IEC on stigma and discrimination reduction**: Strongly disagree

**Prevention of mother-to-child transmission of HIV**: Strongly agree

**Prevention for people living with HIV**: Strongly agree

**Reproductive health services including sexually transmitted infections prevention and treatment**: Strongly agree

**Risk reduction for intimate partners of key populations**: Strongly disagree

**Risk reduction for men who have sex with men**: Disagree

**Risk reduction for sex workers**: Agree

**Reduction of gender based violence**: Agree

**School-based HIV education for young people**: Agree

**Treatment as prevention**: N/A

**Universal precautions in health care settings**: Agree

**Other [write in]:**:

: N/A

**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 of HIV prevention programmes in 2013?**: 8

## A.V Treatment, care and support

**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 resistane 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 of development partner support Establishment of HIV & TB Integrated Specialty Centers 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…**:

**Antiretroviral therapy**: Strongly agree

**ART for TB patients**: Strongly agree

**Cotrimoxazole prophylaxis in people living with HIV**: Strongly agree

**Early infant diagnosis**: Agree

**Economic support**: Agree

**Family based care and support**: Disagree

**HIV care and support in the workplace (including alternative working arrangements)**: Disagree

**HIV testing and counselling for people with TB**: Strongly agree

**HIV treatment services in the workplace or treatment referral systems through the workplace**: Disagree

**Nutritional care**: Agree

**Paediatric AIDS treatment**: Agree

**Palliative care for children and adults Palliative care for children and adults**: Agree

**Post-delivery ART provision to women**: Strongly agree

**Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)**: Strongly agree

**Post-exposure prophylaxis for occupational exposures to HIV**: Strongly agree

**Psychosocial support for people living with HIV and their families**: Agree

**Sexually transmitted infection management**: Strongly agree

**TB infection control in HIV treatment and care facilities**: Disagree

**TB preventive therapy for people living with HIV**: N/A

**TB screening for people living with HIV**: Agree

**Treatment of common HIV-related infections**: Strongly agree

**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 substitu-tion 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?**: 9

**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?**: 7

**Since 2011, what have been key achievements in this area:**:

**What challenges remain in this area:**:

## A.VI Monitoring and evaluation

**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 continous training, mentoring and supervision for implementation of the M&E planned activities Furhter 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 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 indi-cators) with the national M&E plan?**: Yes, some partners

**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:**:

**Behavioural 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 standardised 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?

**In the Ministry of Health?**: Yes

**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 or Part-time? | Since when? |
|---|---|---|
| Manager, Research& Monitoring & Evaluation | Full-time | 2010 |
| Chief Research Officer | Full-time | 2009 |
| Principle Research Offficer | Full-time | 2009 |
| Research Officer | Full-time | 2011 |
| Assistant Research Officer | Full-time | 2003 |
| Data Clerk | Full-time | 2001 |
| | Full-time | |

| POSITION [write in position titles] | Fulltime or Part-time? | Since when? |
|---|---|---|
| Temporary M&E staff | Temps plein | 2012 |
| Temporary M&E staff | Temps plein | 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-affliation 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.

**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, but only some 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

**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 reserach 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.

: Yes

**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 on-going 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?**: 4

**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

**1. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) has civil society contrib¬uted to strengthening the political commitment of top leaders and national strategy/policy formulations?**: 3

**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 repre¬sentatives 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)?**: 3

**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?**: 4

**b. The national HIV budget?**: 4

**c. The national HIV reports?**: 3

**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?

**a. Developing the national M&E plan?**: 4

**b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?**: 3

**c. Participate in using data for decision-making?**: 3

**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. organisations and networks of people living with HIV, of sex workers, community based organisations , and faith-based organizations)?**: 4

**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:

**a. Adequate financial support to implement its HIV activities?**: 2

**b. Adequate technical support to implement its HIV activities?**: 3

**Comments and examples:**: In 2013, funding support for CSOs dramaticaly 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**:

**People living with HIV**: 51–75%

**Men who have sex with men**: >75%

**People who inject drugs**:

**Sex workers**: >75%

**Transgender people**: >75%

**Palliative care** : <25%

**Testing and Counselling**: 25-50%

**Know your Rights/ Legal services**: >75%

**Reduction of Stigma and Discrimination**: 51–75%

**Clinical services (ART/OI)**: <25%

**Home-based care**: 51–75%

**Programmes for OVC**: 25-50%

**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?**: 7

**Since 2011, what have been key achievements in this area:**: The Botswana Civil Society Strategy was completed. Botswana Network of AIDS Service Organizations (BONASO) and Botswna 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 developement 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

### 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 VULNERABLE SUBPOPULATIONS**:

**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 [write in]:**: 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 protect 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 exacrtly 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 VULNERABLE SUBPOPULATIONS**:

**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

**Other specific vulnerable populations [write in]:**: 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 threatening the confidentiality of persons living with HIV, if it 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 equaltiy 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).**

**Antiretroviral treatment**:

**Provided free-of-charge to all people in the country**: No

**Provided free-of-charge to some people in the country**: Yes

**Provided, but only at a cost**: Yes

**HIV prevention services**:

**Provided free-of-charge to all people in the country**: No

**Provided free-of-charge to some people in the country**: Yes

**Provided, but only at a cost**: Yes

**HIV-related care and support interventions**:

**Provided free-of-charge to all people in the country**: No

**Provided free-of-charge to some people in the country**: Yes

**Provided, but only at a cost**: Yes

**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?**: No

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

**a. 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

**b. 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 Presidental 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?

**a. Legal aid systems for HIV casework**: Yes

**b. 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 [write in]:**:

: 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?**: 6

**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 Behavorial Surveilance 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 HIV disclosure might threaten confidentialty and must be monitored closely. Crimminalization of key populations remain 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?**: 6

**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 confidentialty and disclosure associated with the implementation of the Public Health Act, which might negatively impact on already poor HIV testing trends.

## B.IV Prevention

**1. 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 NOP, 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 margalized 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?

**The majority of people in need have access to...**:

**Blood safety**: Strongly agree

**Condom promotion**: Agree

**Harm reduction for people who inject drugs**: Strongly disagree

**HIV prevention for out-of-school young people**: Disagree

**HIV prevention in the workplace**: Strongly agree

**HIV testing and counseling**: Strongly agree

**IEC on risk reduction**: Agree

**IEC on stigma and discrimination reduction**: Agree

**Prevention of mother-to-child transmission of HIV**: Strongly agree

**Prevention for people living with HIV**: Strongly agree

**Reproductive health services including sexually transmitted infections prevention and treatment**: Agree

**Risk reduction for intimate partners of key populations**: Agree

**Risk reduction for men who have sex with men**: Strongly disagree

**Risk reduction for sex workers**: Strongly disagree

**School-based HIV education for young people**: Agree

**Universal precautions in health care settings**: Agree

**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?**: 8

**Since 2011, what have been key achievements in this area:**: Completion of the Botswana Behavorial 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 upscaling 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

**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 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 Centers 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…**:

**Antiretroviral therapy**: Strongly agree

**ART for TB patients**: Strongly agree

**Cotrimoxazole prophylaxis in people living with HIV**: Strongly agree

**Early infant diagnosis**: Agree

**HIV care and support in the workplace (including alternative working arrangements)**: Agree

**HIV testing and counselling for people with TB**: Strongly agree

**HIV treatment services in the workplace or treatment referral systems through the workplace**: Disagree

**Nutritional care**: Agree

**Paediatric AIDS treatment**: Agree

**Post-delivery ART provision to women**: Strongly agree

**Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)**: Strongly agree

**Post-exposure prophylaxis for occupational exposures to HIV**: Agree

**Psychosocial support for people living with HIV and their families**: Agree

**Sexually transmitted infection management**: Strongly agree

**TB infection control in HIV treatment and care facilities**: Agree

**TB preventive therapy for people living with HIV**: N/A

**TB screening for people living with HIV**: Strongly agree

**Treatment of common HIV-related infections**: Strongly agree

**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?**: 8

**Since 2011, what have been key achievements in this area:**: Continued decentralization of ART provision to all health care facilities Increase treatment eligibility to CD4 count <350 Increase treatment eligibility for all children under 5 years fo 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 Pallative 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

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

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

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

**3. 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?**: 9

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

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