REPUBLIC OF BOTSWANA

BOTSWANA 2012 GLOBAL AIDS RESPONSE REPORT

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

Reporting Period: 2010-2011

National AIDS Coordinating Agency

3/31/2012

Abbreviations and Acronyms

ANC	-	Antenatal Care
ART	-	Antiretroviral Therapy
BAIS	-	Botswana AIDS Impact Survey
BCC	-	Behavioural Change Communication
BHRIMS	-	Botswana HIV and AIDS Response Information System
BNAP	-	Botswana National AIDS Programme
BOCAIP	-	Botswana Christian AIDS Intervention Programme
BOFWA	-	Botswana Family Welfare Association
BONASO	-	Botswana Network of AIDS Service Organizations
BONELA	-	Botswana Network of Ethics, Law and HIV/AIDS
CBO	-	Community Based Organisation
CPAP	-	Country Programme Action Plans
CSO	-	Civil Society Organisation
DMSAC	-	District Multi-sectoral AIDS Committees
FBO	-	Faith Based Organisation
HAART	-	Highly Active Anti-Retroviral Therapy
M&E	-	Monitoring and Evaluation
MARPs	-	Most At Risk Populations
MCPs	-	Multiple and Concurrent Partnerships
MoESD	-	Ministry of Education and Skills Development
MOVE	-	Model of Optimizing Volume and Efficiency
MSM	-	Men who have Sex with other Men
MTP	-	Mid-Term Plan
NACA	-	National AIDS Coordinating Agency
NAC	-	National AIDS Council
NCPI	-	National Commitments and Policy Instrument
NOP	-	National Operational Plan 2011-2016
NSF	-	National Strategic Framework on HIV and AIDS
NGO	-	Non-Governmental Organisation
OVC	-	Orphans and Vulnerable Children
PEP	-	Post Exposure Prophylaxis
PLHWA	-	People Living with HIV/AIDS
PMTCT	-	Prevention of Mother-to-Child Transmission
PRISM	-	Prevention Research Initiative for Sexual Minorities
RBM	-	Results Based Management
RHT	-	Routine HIV Testing
RNPP	-	Revised National Population Policy
SADC	-	Southern African Development Community
SMC	-	Safe Male Circumcision
SRH	-	Sexual and Reproductive Health
STD	-	Sexually Transmitted Diseases
STI	-	Sexually Transmitted Infection
TB	-	Tuberculosis
UNAIDS	-	Joint United Nations Program on HIV/AIDS
UNGASS	-	UN General Assembly Special Session on HIV/AIDS
VDCs	-	Village Development Committees
VCT	-	Voluntary Counselling and Testing

WHO - World Health Organisation

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1. STATUS AT A GLANCE

1.1 Introduction

In 2001, Botswana was among the 189 countries that adopted the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Declaration of Commitment. The Declaration of Commitment is simply the global consensus on a comprehensive framework to achieve the Millennium Development Goal 6 of halting and beginning to reverse the spread of the HIV and AIDS epidemic by the year 2015. In 2006, a new Political Declaration on HIV/AIDS: Intensifying our efforts to Eliminate HIV/AIDS that recognized the urgent need to achieve access to HIV treatment, prevention, care and support was adopted.

The Declaration states that a successful national HIV and AIDS response should be measured by the achievement of concrete, time-bound targets. It also calls for careful monitoring of progress in implementing commitments and requires the United Nations Secretary General to issue progress reports. The purpose of the reports is to document challenges and constraints and recommend action to accelerate achievement of the set targets.

It is on the basis of the above-mentioned commitments that Member States who signed these declarations are required to submit UNGASS Country Progress Report to the UNAIDS Secretariat biennially. The first UNGASS reports were submitted in 2003, followed by 2005, 2008 and 2010. The 2012 Country Progress Report is the fifth of such report. The current report is designed to report progress made since the last UNGASS report, namely, 1st January 2010 to 31st December 2011.

1.2 2012 Global AIDS Response (formerly UNGASS) Report Writing Process

In order to facilitate the development of the 2012 UNGASS report, a Consultant was engaged by National AIDS Coordinating Agency (NACA) with the following Terms of Reference:

- Prepare and present an inception report
- Develop/adapt a questionnaire on Policy Index
- Facilitate consultative meetings on policy index
- Collect data not covered in the BAIS III report from relevant institutions
- Produce an analytical draft report
- Present a draft report to NACA
- Facilitate a national consensus workshop to validate the report
- Incorporate comments from the validation workshop to finalize the report
- Present final report to NACA

A Technical Working Group made up of representatives from civil society organisations, the private sector, development partners, NACA and other government ministries was convened to guide the report-writing process, while the Monitoring and Evaluation (M&E) Division at NACA coordinated the overall report-writing process.

The process began with a presentation of an Inception Report by the consultant to the Technical Working Group. The presentation mainly focused on the proposed approach to the process, particularly the methods of data collection (document and literature review; key

informant interviews, and stakeholder group meetings), as well as on agreeing on a feasible work-plan.

The document and literature review was done concurrently with the data collection over a period of three weeks. Thereafter the consultant synthesized the data and wrote the different sections of the report. Focus group discussions were organized with three groups, namely, government officials; civil society organizations; and development partners with a view facilitate the filling in of the NCPI document. The draft generated from the focus group discussions was presented at a national consensus building workshop held on the 22nd March 2012. The workshop—attended by a wide range of representatives from the different partners in the national response (see list in Annex A)—enabled partners to review each section of the report and to provide feedback and any outstanding or additional information. In order to validate the report, government officials formed a group to review the responses that they earlier provided either as individuals or groups of NCPI Part A. Development partners and representatives of civil society organizations were grouped together to review and agree on the responses of the NCPI Part B. Each group nominated a representative who then presented the responses on behalf of each group. After the workshop the consultant incorporated all comments and additional data into a final draft which was submitted to NACA for approval.

1.3 Status of the Epidemic

Despite intensive and aggressive HIV/AIDS prevention campaigns, Botswana continues to be challenged by the HIV/AIDS epidemic. According to the Botswana AIDS Impact Survey III (BAIS III), 17.6% of the population aged 18 months and above was HIV infected in 2008 compared to 17.1% in 2004.

HIV and AIDS have a strong gender dimension. According to the 2008 Botswana AIDS Impact Survey III, the HIV prevalence rate for females was 20.4% compared to 14.2% males. The HIV incidence rate also shows gender disparity where more females compared to males showed higher incidence. HIV prevalence varies by location where urban areas contain a larger share of Botswana's HIV compared to rural areas. The BAIS III showed that urban areas had HIV prevalence rate of 19.1% compared to 17.1% for rural areas.

The HIV prevalence among adults aged 15 – 49 years in Botswana was found to be at 25% while prevalence among pregnant women was estimated at 30.4% (MoH ANC Surveillance Report, 2011). According to the 2010 estimates and projections exercise conducted by NACA, it was estimated that the total number of persons living with HIV/AIDS in Botswana as of December 2009 was 316,363 of whom, 179,151 (57%) were females while 137,212 (43%) were males. Of the total number living with HIV/AIDS 15,888 (5%) were children aged less than 15 years old (NACA, 2010). Furthermore, an estimated total of 16,216 new HIV infections occurred in 2009, the majority (95%) of which were among adults 15 years or older. An estimated total of 9,214 deaths occurred, which is still unacceptably high. However, there has been a decline in the number of children less than 15 years newly infected with HIV among whom the number of new infections declined from 4,082 in 2001 to 1,074 in 2007 and 886 in 2009, a total decline of 78% between 2001 and 2009. Similarly, the number of deaths due to advanced AIDS has declined over the 8 year period especially among children less than 15 years old. This is due to the significant achievements of the Botswana government in scaling up HIV/AIDS Care and Treatment as well as PMTCT.

At this level of magnitude, the potential impact of the HIV/AIDS epidemic in Botswana is tremendous. First, the impact of HIV on mortality and socio-economic development has been unprecedented threatening to reverse the gains made by Botswana in development. Because of the high levels of HIV infection and mortality, life expectancy in Botswana has dramatically decreased - from 65 years in 1990 to 35 years in 2005 (UNFPA 2006). Secondly, at this level of incidence, the need for ART is likely to increase by 60% from 120,000 in 2007 to 190,000 in 2016 even if the high rates of coverage are maintained (Stover et. al., 2009). This will have major cost implications on the national HIV response. It is thus important to focus the national response towards reducing the number of new infections. That is," Botswana should turn off the tap and not just mop the floor".

Results from the incidence model of the modes of transmission – know your epidemic study show that the largest proportion of new infections (57%), are expected to occur among supposedly low risk heterosexual populations which include married couples and those living together. Individuals engaged in casual heterosexual sex and their partners will contribute 29% of the new infections (15% among the CHS group and 14% among their partners). Men who have sex with men and their partners will contribute 6% while sex workers, their clients and partners of their clients will contribute 7%. Small proportions of infections are expected to occur as a result of medical injections, blood transfusions and injecting drug use (IDUs).

Access to antiretroviral treatment stood at 95% of those eligible for treatment. A total of 194 clinics are now dispensing antiretroviral medicines. This has ensured that more HIV infected Batswana can live longer and healthier lives, with life expectancy of people living with the virus having improved from 45 years in 2001 to 65 years in 2010 (State of Nation Address, 2011). According to the World AIDS Day Speech of 2011, the national estimates and projections, AIDS deaths have reduced by around 60% since the ARV program was introduced, from an estimated 14 700 in 2003 to 6 200 by the end of 2010.

1.4 Policy and Programme Response

Botswana has embraced the "Three-Ones" principle: the National AIDS Coordinating Agency (*One national coordinating body)* was established in 1999; the Botswana HIV and AIDS Response Information System (BHRIMS (*One agreed national monitoring and evaluation system)* was put in place in 2001; and the first National Strategic Framework or NSF I *(One agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners)*, covered the period 2003-2009. Following an in-depth review of the NSF I, a second National Strategic Framework (2010-2016) was approved in December 2009.

In order to support the national response to the epidemic, several policies, plans, strategies, laws and guidelines have been developed. For the 2010-2011 reporting period, these include: National HIV and AIDS Policy; the National Operational Plan ; Community Mobilization

Strategy; Mainstreaming Strategy; Positive Health Dignity and Prevention strategy; Civil Society Capacity Building Strategy; ANC Sentinel Surveillance Report; Modes Of Transmission Report; National AIDS Council women's sector strategy; TB/HIV Policy Guidelines which aims to improve treatment through intensified case findings and improved infection control and the Revised National Population Policy in 2010.

In the 2010-2011 reporting period, key national programmes, policies and strategies were launched and these are: the Draft Botswana National policy on HIV and AIDS, 2010; the Ministry of Education & Skills Development Strategic Framework for HIV & AIDS 2011-2016; the ART Treatment Guideline Revisions & Impact on Programme Sustainability of 2012; national guidelines on mainstreaming HIV and AIDS Gender and Human Rights; the Revised National population Policy of 2010; the National Condom Marketing Strategy & Implementation Plan 2012-2016; the National Mainstreaming Strategy for Botswana of 2012; the National Capacity Building Strategic Framework for Botswana HIV & AIDS Service Organizations 2010-2016; and the National Monitoring & Evaluation Plan for the National Operational Plan for HIV and AIDS 2012-2016. These programmes/policies/strategies are described in detail in Section 3 of this report. The industrial property act was amended in 2010 to facilitate access to affordable medicines and disgnostics.

The creation of a supportive policy and legislative environment is a testimony of the commitment of the political leadership to address HIV and AIDS. From time to time, the leadership has consistently spoken out and supported initiatives to address the national HIV and AIDS response at the highest level.

The Government of Botswana, with the support of the development partners, civil society organizations and the private sector, has developed and launched various national prevention, treatment, care and support policies and programmes to address HIV and AIDS scourge. Examples of programmes developed and launched with regards to HIV and AIDS include but are not limited to the Prevention of Mother-to-Child Transmission (PMTCT) introduced in 1999 whose aim is to improve the survival and development of children by reducing HIV related morbidity and mortality. Its main objective is to reduce the number of new paediatric infections occurring through mother-to-child transmission; the national Antiretroviral Treatment (ART) in traduced in 2002; Routine HIV Testing introduced in 2004; national Voluntary Counselling & Testing centres in 2002; and National Orphan Care and Community Home Based Care in 2002 to provide care and support for the HIV/AIDS infected and affected people.

1.5 UNGASS indicators

In keeping with the mandates of the UNGASS Declaration of Commitment the UNAIDS Secretariat collaborated with other stakeholders in 2002 to develop a series of core indicators to measure progress in implementing the Declaration. These indicators are divided into three categories:

National commitment and action indicators. These focus on policy and the strategic and financial inputs for the national HIV and AIDS response. They also capture programme outputs, coverage and outcomes.

National knowledge and behaviour indicators. These cover a range of specific knowledge and behavioural outcomes

Impact indicators. These indicators focus on the extent to which national programme activities have succeeded in reducing HIV infection and its associated morbidity and mortality.

2. OVERVIEW OF THE AIDS EPIDEMIC

2.1 Status of the epidemic

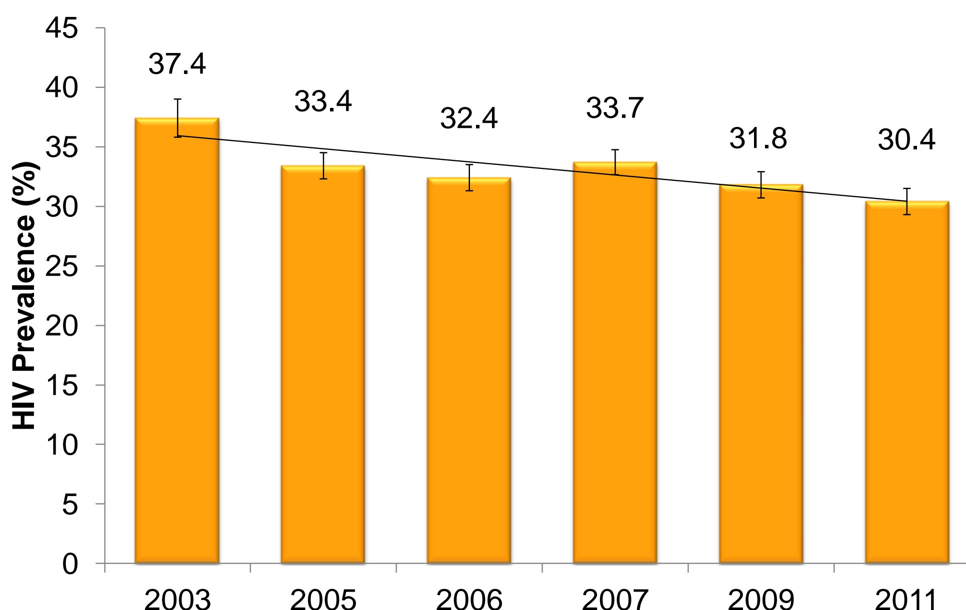
According to the Joint United Nations Programme on AIDS (UNAIDS), at the end of 2010 an estimated 34 million people were living with HIV worldwide, up 17 % from 2001. The increase in the number of people living with HIV reflects the continued large number of new HIV infections and a significant expansion of access to antiretroviral therapy, which has helped reduce AIDS-related deaths, especially in more recent years. This source also states that the epidemic in Botswana, Zambia and Namibia appear to be declining. Botswana is also cited as a country where a drop in HIV prevalence was significant among pregnant women attending antenatal clinics (UNAIDS, 2011). The 2008 Botswana Impact Survey, which is a population-based survey, showed that HIV prevalence was estimated at 17.6 % of the population aged 18 months and above and the corresponding figure for 2004 BAIS was 17.1 %. The evidence discernable from these two data sets suggests that HIV prevalence may be leveling off.

Box 2.1: Botswana AIDS Epidemic Statistics

- Pregnant women aged 15-49 prevalence in 2011: **30.4%**
- Estimated incidence rate for 2011: **2.72%**
- Total estimated HIV infection in 2011: **296,005**
- Total number on HAART in 2011: **178,684**

Sources: 2011 ANC HIV Incidence; 2011 ANC Sentinel Surveillance Survey; 2012 `ART Treatment Guidelines

Figure 2.1. Adjusted HIV prevalence trends among pregnant women aged 15-49



Source: 2011 Sentinel Surveillance Report

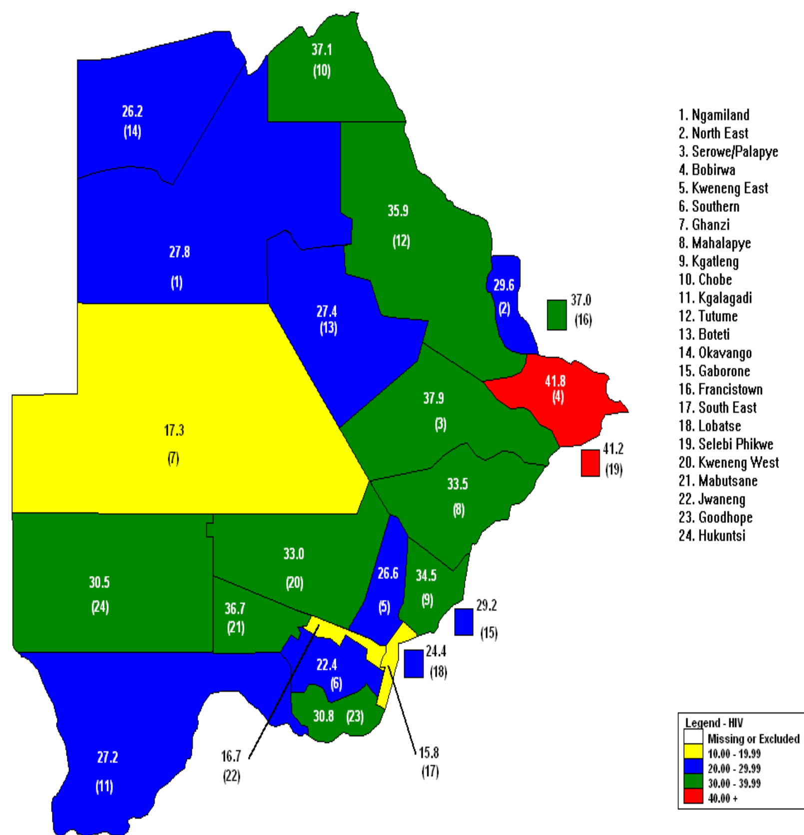
Figure 1 above shows that HIV prevalence among pregnant women aged 15-49 years attending antenatal clinic has been declining over the years. HIV prevalence declined from 37.4 % in 2003 to 30.4 % in 2011.

2.2 Variation in HIV prevalence

A review of both the BAIS III findings and ANC sentinel surveillance reveals heterogeneity by age and sex, geographic location, marital status and educations status. ,

2.2.1 Variation by geographic location

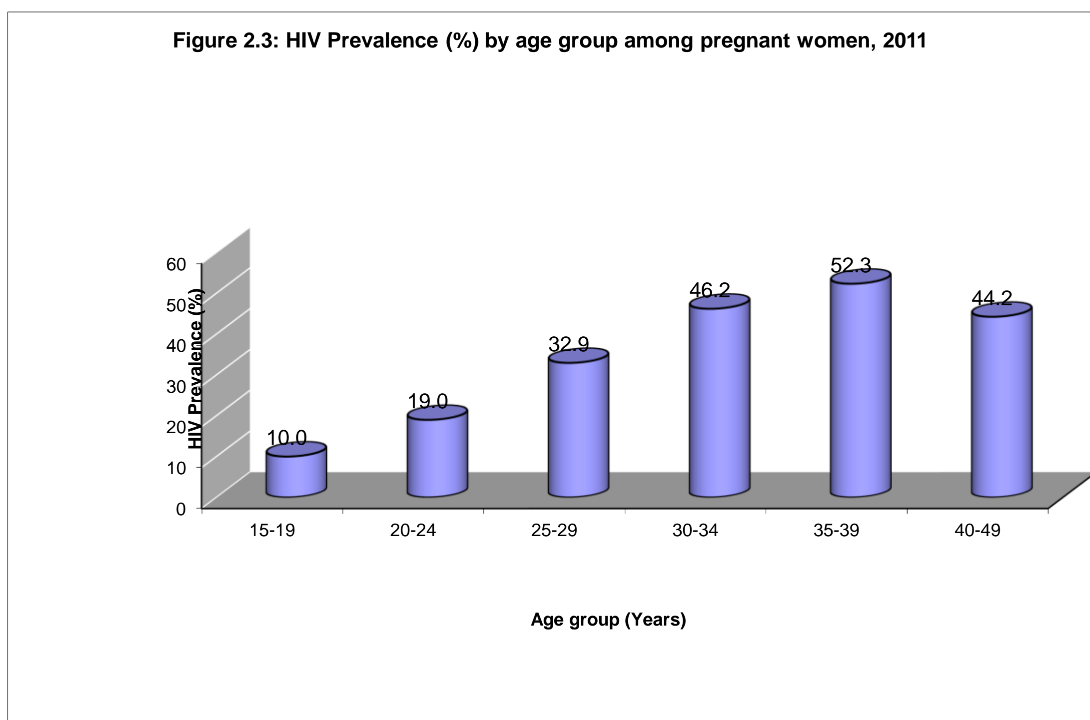
HIV prevalence varies in terms of geographic divisions such as districts and rural-urban differentials. The 2008 BAIS III results indicate geographic differentials by urban rural HIV prevalence where HIV prevalence was 17.9 % in urban areas compared to 17.1 % in rural areas. The 2011 surveillance results similarly show differences in HIV prevalence by district. Figure 2.2 below presents a geographic distribution of HIV prevalence among age-adjusted HIV prevalence. From this figure, Bobirwa and Selibe Phikwe recorded the highest HIV prevalence rates of 41.8 % and 41.2 %, respectively. The lowest HIV prevalence rate was recorded Southeast standing at 15.8 %.



Source: 2011 Sentinel Surveillance Report

2.2.2 Variation by age

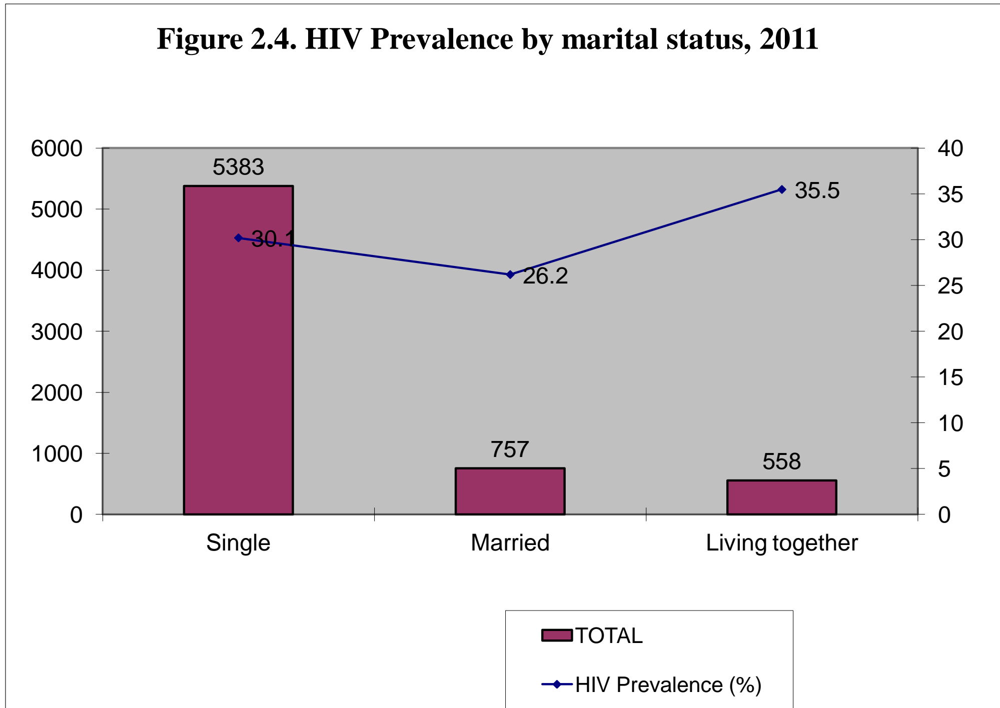
Figure 2.3 shows that the HIV prevalence increases gradually with age. HIV prevalence was lowest (10%) among the 15 to 19 year age group and highest in the age group of 35-39 years (52.3%). The 2008 BAIS survey shows a similar age distribution of HIV prevalence. The trend implies a cohort effect of the younger age groups adding onto the prevalence as they become older.



Source: 2011 Sentinel Surveillance Report

2.2.3 Variation by marital status

The 2011 Sentinel Surveillance report shows that HIV prevalence also varies by marital status. Figure 2.4 below shows that HIV prevalence is highest among women who reported that they were living together with their partners, estimated at 35.5% and the lowest prevalence is among married women, at 26.2%. Women reporting that they were single had an HIV prevalence of 30.1%.

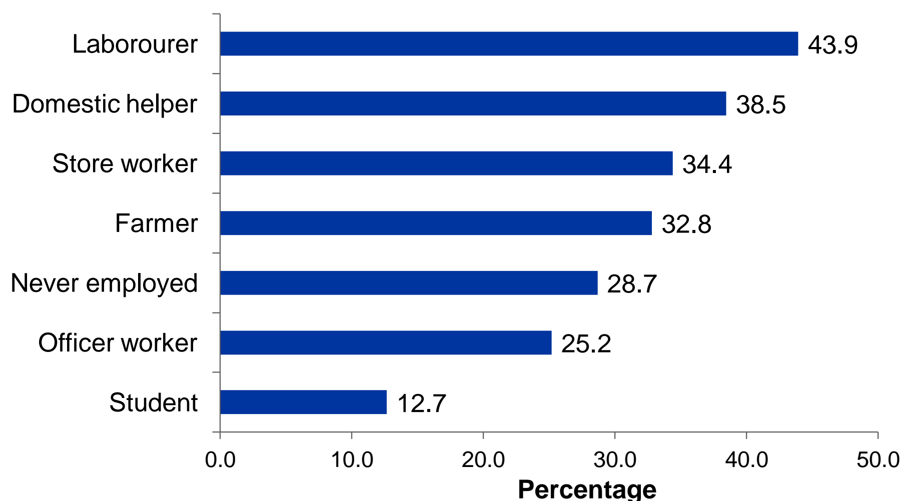


Source: 2011 Sentinel Surveillance Report

2.2.4 Variation by occupational status

Figure 2.5 below presents variation in HIV prevalence according to occupational status. From this figure, it is evident that labourers had the highest HIV prevalence standing at 43.9%. The student population showed the lowest prevalence of 12.7%.

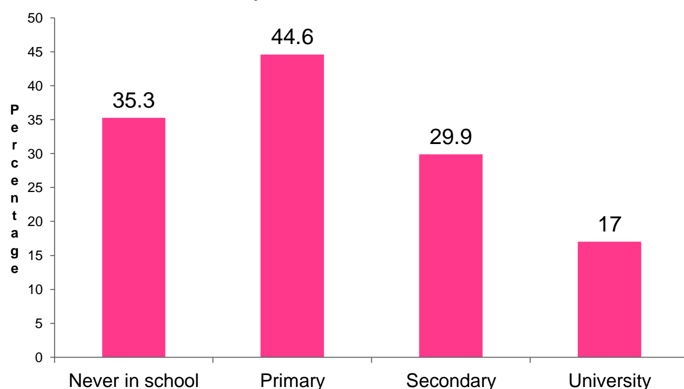
Figure 2.5: Prevalence of HIV among pregnant women by type of occupation



2.2.5 Variation by educational status

The 2011 Sentinel Surveillance results show that women with primary education has the highest HIV prevalence of 44.6% and women with university education has the lowest prevalence estimated at 17%.

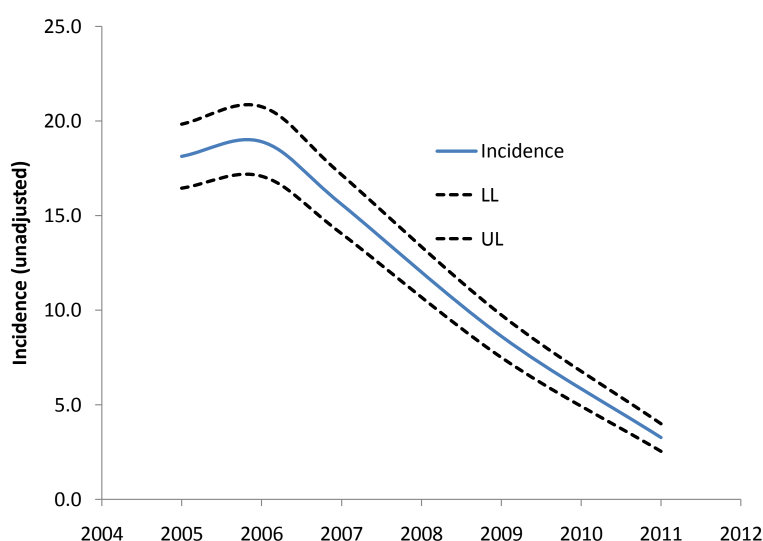
Figure 2.6: HIV prevalence among pregnant women by level of education



2.3 HIV Incidence Estimates and Trends

Data collected from ANC were used to estimate trends in incidence rates among pregnant women presenting at the clinic. Figure 2.7 shows a declining trend in HIV incidence among pregnant women between 2007 and 2011.The annual incidence rate was estimated at 2.7% in 2011. This is in comparison to an estimated annual incidence rate of 1.5% in the population based survey BAAIS III (2008).

Figure 2.7: Trends (Unadjusted Incidence)



2.4 Factors Influencing the Spread of HIV

In Botswana, the HIV and AIDS epidemic is largely driven through sexual transmission. As such, behaviour change has been recognized as the only long term solution to the prevention of the HIV and AIDS epidemic. The National Strategic Framework 2011-2016 (NSF II) identifies five key drivers of the epidemic that still present major obstacles to preventing new HIV infections:

2.4.1 Multiple and Concurrent Sexual Partnerships

Although BAIS III was not designed to measure sexual concurrency, other studies in Botswana have measured concurrency of sexual partnerships and found them to be a driver of the epidemic in Botswana (Modes of transmission study, 2010). Not to be confused with culturally permitted polygamy, multiple concurrent partnerships are a tolerated pattern of sexual relationship in sub-Saharan Africa. In the BAIS III, 21% of males reported having sex with more than one sexual partner (multiple partnerships) in the 12 months preceding the survey compared to 2.3% of females. HIV prevalence among persons reporting multiple

partnerships was 16% for males and 34% for females (NACA & CSO, 2009; BAIS III statistical report, 2009).

The incidence model shows that casual heterosexual sex defined as sex with more than one sexual partner, usually a non-regular, non-cohabiting partner during the last 12 months contributes significantly to the proportion of new infections. Persons reporting casual heterosexual sex and their partners contributed a total of 28.04% of new infections although they account for 21.55% of the general population.

The second driver has to do with the level of condom use within the context of multiple concurrent sexual partnerships. In Botswana, although self-reported rates of condom use are high, qualitative studies suggest that condoms are only used initially with a new partnership but as the partnership evolves, condoms are used less frequently and then not always correctly or consistently. There is very little information on consistent condom use from behavioural surveys. The closest indicator is condom use at last sex. In BAIS III, 55% of the respondents used a condom the first time they had sexual intercourse with their most recent sexual partners. However the use of condom declined with subsequent partners. About 50% used a condom during their last sexual intercourse with the most recent partner while only 43.6% reported using condom always with the same most-recent partner.

2.4.2 Adolescent and Intergenerational Sex

The 2006 sero-prevalence study of pregnant mothers confirmed that about 55% of the total population was initiated to sexual intercourse by age 19 and around 8% have had sex by age 15. Adolescent girls have been identified as more at risk of HIV infection than boys. For instance, infections are three times higher for girls than boys aged 15-19 years and are significantly higher at every other age group to 24 years and beyond.

Early exposure to older men with longer sexual history are considered to have accounted for the higher infections among adolescent girls, thereby bringing into play intergenerational sexual intercourse as a significant factor. For as long as young girls and boys are attracted to the monetary gain and the material support they receive from their older sexual partners, intergenerational sexual relationships will remain a key driver of HIV and AIDS. Previous studies have found that the greater the economic asymmetries between partners, the greater the value of a gift, service, or money exchanged for sex, and the less likely the practice of safer sex.

2.4.3 Alcohol and High-Risk Sex

The consumption of alcohol has been identified to be associated with several risks, including that of contracting HIV. The misuse of alcohol and other recreational drugs have been consistently correlated with a number of social and health-related problems such as gender violence, risky sexual behaviors and non-adherence to treatment for AIDS and TB for both men and women.

According to BAIS III 37.4% of the population aged 10 – 60 years reported ever taking alcohol, 48.9% males and 27.7% females. By marital status the highest proportion of alcohol consumption was found among those living together (52.1%) followed by those who were separated 41.7%. It is worth noting that the majority (62.7%) had been intoxicated at least once in the 4 weeks preceding the survey (NACA & CSO, 2009).

2.4.4 Stigma and Discrimination

HIV/AIDS-related stigma and the resulting discriminatory acts create circumstances for spreading HIV. The fear of being identified as HIV-positive prevents people from learning their sero-status, changing unsafe sexual behaviors and caring for people living with HIV and AIDS. Stigma and discrimination severely restricts access to and utilization of relevant services and products, thereby increasing the risk and vulnerability to HIV infection.

According toa study carried out in 5 countries in southern Africa (Botswana, Mozambique, Lesotho, South Africa and Swaziland) Botswana was cited as one of the most visible Positive Health Dignity and Prevention strategy 2010 – 2016, implemented by BONEPWA (NAPSAR Review, Network of people living with HIV, Southern Africa Region, a review of strategies and programs)

2.4.5 Gender Violence and Sexual Abuse

The position of women in society, especially adolescent girls, is one of the drivers of the AIDS epidemic. Because women generally tend to possess little power over their own bodies, they are put at risk of HIV infection by a combination of the social acceptance of male partners having more than one sexual relationship, inability to negotiate condom use and sexual exploitation, especially the younger girls. Thus, socially as well as biologically, they are more susceptible to HIV infection. Empirical evidence in the region suggests that gender violence and sexual abuse are on the rise and these could be associated with increased risk of HIV infection.

The Gender Based violence indicators Botswana provides alarming statistics on the prevalence of gender based violence in the country. Almost 70% of women interviewed had experienced GBV at least once in their lifetime, and nearly 30% over the last year. This figure is 24 times higher than what is reported to the police. This information will be used to inform the National Action Plan to end Gender Violence.

3. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

3.1 Background to the national response to the epidemic

The Medium-term Plan II (MTP-II) provided a platform for a multi-sectoral national response and created a multi-sectoral coordination mechanism that exist to this day. However, one of the major weaknesses identified was that it did not clearly identify implementation responsibilities of the various sectors involved in the national response to the epidemic. The review of the MTP-II gave birth to the formulation of the National Strategic Framework for 2003-2009 (NSF-I)which is the first of the "Three-Ones" principles – the agreed HIV and AIDS Action Framework that provides the basis for coordinating the work for all sectors. The NSF-I also consolidated the multi-sectoral national response by providing the relevant structures and guidance to all sectors in order to enhance their engagement.

The National AIDS Council (NAC), chaired by His Excellency the former President of Botswana, is the highest national policymaking institution after the Parliament and Cabinet on issues of HIV/AIDS policy and implementation guidelines, has established various technical multi-sectoral sub-committees. A Parliamentary Select Committee on HIV/AIDS has been formed to ensure that HIV/AIDS remains a priority on the political and economic agenda of the country. The National AIDS Control Programme was begun in 1987, and in 1992, the AIDS/STD Unit was established. Based on the lessons learnt from 1992 to 1999, and given the expanded multi-sectoral approach, the Government in 2000 created the National AIDS Coordinating Agency to coordinate the implementation of the multi-sectoral national response, in addition to providing policy guidance to other sectors.

District and sub-district multi-sectoral AIDS committees have been created mainly to coordinate and promote response programmes at the local level. Other interventions include the nation-wide prevention of mother-to-child transmission, voluntary counselling and testing, provision of highly-active antiretroviral therapy to the public at no cost, community home-based care, and orphan and vulnerable children programme.

Other partners involved in the fight against HIV/AIDS include the private sector and civil society who are leading some of the targeted strategies in the NOP such as Stigma Reduction Campaing, Legal Aid program, Positive Health Dignity and Prevention for people living with HIV and the food security project for people living with HIV and AIDS. On the Greater Involvement of People Living with HIV (GIPA) principle we see involvement of PLWHA in the National AIDS Council, and the Joint Oversight Committee. The private sector has formed a coalition—Botswana Business Coalition on AIDS—to coordinate HIV/AIDS interventions. Civil society organizations have formed several networks, such as Botswana Network of AIDS Service Organizations, Botswana Network of People Living with HIV/AIDS, Botswana Network of Ethics, Law and HIV/AIDS, and Botswana Christian AIDS Intervention Programme, to support and promote coordination, networking, and collaboration among them.

The National Policy on HIV/AIDS was developed in 1993 and reviewed in 1998 to incorporate home-based care as a major component of the epidemic. The Policy was also reviewed in 2007 to incorporate new developments.

3.2 Changes in the national commitment and programme implementation during 2010-2011

3.2.1 National Programmes

Since Botswana declared HIV and AIDS a national emergency, the country has developed and implemented various policies and programmes with a view to prevent HIV infection. Both the first and second National Strategic Framework for HIV/AIDS have identified "Prevention of HIV Infection" as the first line of defence against HIV scourge. It is on the basis on this background that national programmes are introduced in the current reporting period to achieve Botswana's goal of achieving "Zero New Infection by 2016". The policies and programmes introduced during the 2010-2011 reporting period are as follows:

- **National Strategic Framework for HIV and AIDS (2010 to 2016)**
Whilst the first National Strategic Framework (NSF I) has made significant achievements particularly in the area of treatment care and support through programs such as PMTCT and ARV , other areas such as prevention did not gain much ground. The second National Strategic Framework (2010 to 2016) therefore attempts to address two important areas. For the successful implementation of NSF II, all partners in the national response are to align their efforts to the strategy. In NSF II drivers of the epidemic have been identified as multiple and concurrent partnerships, low rates of male circumcision, adolescent and intergenerational sex, gender inequalities and gender based violence, substance abuse and stigma and discrimination. Having identified various challenges under prevention such as underfunding for prevention, limited capacities for prevention, weak community ownership, the following priorities were set in order to maximize the impact of HIV and AIDS;
    1. Preventing new infections
    2. Systems strengthening
    3. Strategic Information
    4. Scaling up Treatment Care and Support
- **The National Operational Plan of NSF II (2010-2016)**
Within the four priority areas, NSF II presents key strategies for implementation through the National Operational plan, outlining all activities under each area to be implemented through joint action and joint planning. This has lead to the creation of a joint oversight committee which oversees the development, implementation and review of the National Operational Plan. A National Monitoring and Evaluation Plan has also been developed for effective monitoring of the NSF II.

- The **Draft Botswana National Policy on HIV and AIDS** is under review to be tabled in the July 2012 parliament. The Policy has four objectives and are stated as: (i) prevent the spread of HIV infection and reduce the socio-economic impact of this disease; (ii) create a policy environment for the provision of adequate and equitable care and support to those infected and affected with HIV and AIDS; (iii) to reduce HIV and AIDS related stigma and discrimination towards persons infected with or affected by HIV and AIDS and draw attention to the compelling public health

rationale for overcoming stigmatization and discrimination against them in society; (iv) promote coordination in order to enhance implementation of the National Response to HIV and AIDS; and (v) provide platform to support legislative and legal reform that recognizes the impact HIV and AIDS has on individual and community rights.

- The **Ministry of Education & Skills Development (MoESD) Strategic Framework for HIV and AIDS 2011-2016** The strategy will enable the Ministry of Education and Skills Development in Botswana to set out its approach and plans to mitigate the impacts of HIV and AIDS in the education sector specifically, and for the country more broadly. The strategy is targeted at teachers, pupils in primary, secondary and senior secondary schools, students in teacher training and vocational training institutions, employees of the MoESD. It addresses issues such as the integration and infusion of HIV and AIDS into the curriculum, schools and school governance in relation to HIV and AIDS, student issues and affairs, organizational and institutional issues related to HIV and AIDS, teacher and staff issues etc. This strategy excludes the Higher education sector (universities), except for areas related to teacher training and development. The HIV and AIDS strategy will ensure that there is a seamless link with national HIV and AIDS strategies, and in particular that there is a clear alignment with the outcomes delineated in the second National Strategic Framework for HIV and AIDS 2011-2016
- The **ART Treatment Guideline Revisions & Impact on Programme Sustainability** will be launched in March, 2012. These guidelines are meant to integrate treatment advances in Adults & Pediatrics Care, PMTCT, Sexual Reproductive Health, TB/HIV and Cancer/HIV. All Clinicians treating HIV-infected patients are expected to provide "Comprehensive & Integrated Care" including:
    - SRH services
    - Couple & Family HIV Testing
    - TB and Cervical Cancer screening
    - Screening & Treatment of Co-Morbidities
    - Monitoring of Adverse Drug Reactions

  The threshold for beginning life-long HAART will be increased from CD4 count of <250 to CD4 ≤ 350 effective April 1 2012. All HIV positive pregnant women are provided with universal HAART.

  All HIV patients with TB and/or any cancer are immediately eligible to being on ART regardless of their CD4 count

- The **Revised National Population Policy** of March 2010 whose goal is to improve the quality of life in Botswana. The Revised National Population Policy (RNPP) sets HIV and AIDS targets and strategies that need to be reached by 2016 and beyond.

- The **National Condom Marketing Strategy and Implementation Plan 2012-2016** whose objective is to increase demand for condoms while addressing barriers to correct and consistent condom use in all sexually active populations in order to prevent HIV/STI transmission and unplanned pregnancies. It will also ensure timely access to reliable condoms through programmes that address the current coverage gap. Its purpose is to create an enabling environment which contributes to condom availability - free or at affordable prices - through an effective and efficient service delivery system.

- The **National Mainstreaming Strategy for Botswana** of 2012. The purpose of this strategy is to provide a framework for addressing one or more cross-cutting issues as an integral function of all sectors. And the goal of the Strategy is for all sectors to progress towards the realisation of Vision 2016, through mainstreaming relevant cross-cutting issues into their work. The Strategy represents a fundamentally different approach, as it is not linked to any one issue. Instead it can be applied to one or many cross-cutting issues, such as poverty, gender, human rights, HIV and AIDS, disability, climate change, the environment, children and youth, corruption, crime and so on.
- The **National Capacity Building Strategic Framework for Botswana HIV and AIDS Service Organizations** 2010-2016 of 2010. This framework designed upon the realization that many CSOs do not have the organizational and technical capacities needed for designing, implementing, monitoring and sustaining effective HIV and AIDS interventions. Therefore, the goal of this Strategy is to provide a framework that will ensure a coordinated civil society organization response, and will enable civil society to become an effective stakeholder and contributor in the provision of comprehensive and quality prevention, treatment, care and support services.
- The **National Monitoring & Evaluation Plan for the National Operational Plan for HIV and AIDS 2012-2016** is a document that guides the response to HIV and AIDS with essential information on core indicators that measure the effectiveness of the national response to HIV and AIDS. It is designed to guide the overall monitoring and evaluation to ensure successful implementation of programmes. The Plan is based on the logic framework which links the impact, outcomes, outputs, and inputs for each priority area of the National Operational Plan with a budget estimate for activities during the plan period.
- The **Botswana National Plan of Action for Orphans and Vulnerable Children 201-2016** aims:
    - To serve as a catalytic initiative for an evidence based multi-sectoral and multi-level response to the challenges faced by OVC within the National Strategic Frameworks (Vision 2016, NDP 10, NSF II)
    - To facilitate decentralized operational planning by districts, villages and sectoral actors;
    - To provide a tool for communicating among the key players in the response to OVC at all levels including key issues that require consensus for efficient and effective response to OVC
    - To provide a long term perspective toward planning for OVC within a broader child protection framework in Botswana and
    - To facilitate the operationalization of the Children's Act 2009 and associated regulations as they relate to OVC

- In April 2010 there was a development of **User Friendly Guidelines on the Care of OVC**, (blending the 2008 Guidelines and Children's Act 2009.) The purpose of developing this document was to simplify and create user-friendly documents for consumption by all, especially children.
- The **Child Sexual Abuse Communication Strategy 2010-2014**

    - To provide strategic direction and develop a framework of action for the prevention and management of Child Sexual abuse and human rights aspects of child sexual abuse in Botswana.
- The **Positive Health Dignity Prevention Strategy 2010**
  This is an approach that focuses on interventions specifically designed to help PLWHA protect themselves from re-infection and infections with other STI's helping them prevent infecting other partners. It also focuses on interventions that promote dignity and wellbeing of PLWHA.

4 NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI)

Areas covered are: Strategic plan; Political support and leadership; Human Rights; Prevention; Treatment, care and support; Monitoring and evaluation

The NCPI instrument measures progress in the development and implementation of national HIV policies, strategies and laws. The NCPI has been updated to reflect new HIV programmatic guidance and to be consistent with the 2011 Political Declaration on HIV/AIDS. The majority of questions are identical to the 2005, 2007 and 2009 NCPI to allow for trend analysis. Detailed results of the NCPI for the current reporting period are shown in Annex C. Below is a summary of NCPI results.

- The political support that has been present in Botswana since HIV was declared an emergency is still strong. Evidence of this among others, is discernible from senior government officials and top political leaders consistently speaking publicly and favourably about efforts to halt the spread of the epidemic.
- The country now has a National Operational Plan for HIV and AIDS derived from the second National Strategic Framework for HIV and AIDS (2012-2016) .A National HIV and AIDS Monitoring & Evaluation Plan was developed including core indicators to measure performance and effectiveness of the national response to HIV and AIDS.
- Although the Constitution of Botswana provides for the protection of fundamental human rights and freedom of individuals, there are no non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups such as people living with HIV, sex workers, transgendered people, and migrants. Because HIV prevention has been identified as priority number one in the national response and key populations are identified as needing special attention if the country is to achieve zero new infections by 2016, government has taken the initiative to know the size of the key populations, the specific behaviours associated with these groups, their geographical location, etc by conducting a MARPs situation analysis.
- Realizing that civil society organizations have and continue to play a critical role in the fight against HIV and AIDS, the Government of Botswana has developed a Capacity Building Strategy for CSOs 2010-2016 to strengthen their engagement in delivering their mandates.

5. INDICATORS

Table 1.1 TARGETS AND INDICATORS

Target and indicator	Year of UNGASS Progress Report					Sources: Comments
	2003	2005	2008	2010	2012	
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[1]	36.3	37.6	37.6	43.7	43.7	Source: BAIS III
1.2 Percentage of young women and men who have had sexual intercourse before the age of 15[2]	Not required	7.0	Data unavail	5.5	5.5	Source: BAIS III
1.3 Percentage of adults 15-49 who have had sexual intercourse with more than one partner in the last 12 months[3]	Not required	Not required	Data unavail	24.0	24.0	Source: BAIS III
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[4]	Not required	Not required	Data unavail	90.2	90.2	Source: BAIS III
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results[5]	Not required	Not required	Data unavail	61.7	61.7	Source: BAIS III
1.6 Percentage of young women aged 15-24 who are living with HIV	Not required	Not required	Not required	Not required	14.1	Source: BAIS III
Indicators for sex workers						
1.7 Percentage of sex workers reached with HIV	No data	No data	No data	No data	No data	*Comments*: Mapping of key populations is ongoing

prevention programmes						
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	*Comments*: Mapping of key populations is ongoing
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	*Comments*: Mapping of key populations is ongoing
1.10 Percentage of sex workers who are living with HIV	No data	No data	No data	No data	No data	*Comments*: Mapping of key populations is ongoing
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	*Comments*: Mapping of key populations is ongoing
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	*Comments*: Mapping of key populations is ongoing
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	No data	No data	No data	No data	No data	*Comments*: Mapping of key populations is ongoing
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	*Comments*: Mapping of key populations is ongoing
Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015						
Indicators						
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programme	No data	No data	No data	No data	No data	*Comments*: Mapping of key populations is ongoing
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	No data	No data	No data	No data	No data	*Comments*: Mapping of key populations is ongoing
2.3 Percentage of people who inject drugs who report using sterile injecting equipment the last time they injected	No data	No data	No data	No data	No data	*Comments*: Mapping of key populations is ongoing

2.4 Percentage of people who inject drugs 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	*Comments*: Mapping of key populations is ongoing
2.5 Percentage of people who inject drugs who are living with HIV	No data	No data	No data	No data	No data	*Comments*: Mapping of key populations is ongoing
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths						
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	Source: 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	Source: Programme data
3.3 Mother-to-child transmission of HIV (modeled)	Not required	Not required	Not required	Not required	3.6	Source: Programme data
Target 4: Half 15 million people living with HIV on antiretroviral treatment by 2015						
Indicators						
4.1 Percentage eligible adults and children currently receiving antiretroviral therapy	7.3	62.7	82.2	89.9	96.1	Source: Source: Programme data *Comments*: The 2012 estimate is preliminary as the Spectrum model which estimates the denominators has not been finalized and the current approved estimate that have been used relate to treatment guidelines in 2011 with eligibility criteria for treatment at CD4<250.
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	**Source**: Source: Programme data *Comments*: The figure is based on the Integrated Care Initiative of 2010 where records were extracted from patient files. Patients transferred out have been excluded because patients transferred in were not included in the data collection.

Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015						
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	
Target 6: Reach a significant level of annual global expenditure (US22-24 billion) in low-and middle-income countries						
Indicators						
6.1 Domestic and international AIDS spending by categories and financing sources	69.8	165.0	351.6	348.2	147.2	Source: Botswana UNGASS Progress Report 2010 *Comments*: The 2012 figure was estimated from National Health Accounts of 2009. The data used are skeletal and this may explain the low figure shown in 2011 (BWP 986,408,864, assuming exchange rate of US$1 = BWP 6.7).
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 as an Annex 2	
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	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. So this figure is purely an rough estimate.
7.3 Current school attendance among orphans and among non-orphans aged 10-14	Not required	Not required	Data unavail	Data unavail	No data	

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	

Notes: [1] In the 2010 UNGASS Report, the indicator showing 42.1% was calculated using the total number of people (aged 15-24) in the sample including those who did not answer the questions on HIV and knowledge as the denominator. The denominator also includes people who indicated that they had never heard about HIV and AIDS. The denominator for the corrected version (43.7%) excludes people who did not answer the questions as well as those who reported to have never heard about HIV and AIDS.

[2] In the 2010 report the indicator (3.5%) was calculated using the total number of people (15-24) in the sample including those who did not answer the questions as the denominator. The denominator also includes people who indicated that they have never had sex. The denominator for the corrected version (5.5%) excludes people who did not answer the question as well as those who reported to have never had sex.

[3] In the 2010 report the indicator (11.2%) was calculated using the total number of people (aged 15-49) in the sample including those who did not answer the question as the denominator. The denominator also includes people who indicated that they have never had sex. The denominator for the corrected version (24.0%) excludes people who did not answer the question as well as those who reported to have never had sex.

[4] In the 2010 report the indicator (81.1%) was calculated using the total number of people (aged 15-49) in the sample including those who did not answer the question as the denominator. The denominator also includes people who indicated that they have never had sex. The denominator for the corrected version (90.2%) excludes people who did not answer the question as well as those who reported to have never had sex.

[5] In the 2010 report the indicator (41.2%) was calculated using the total number of people (aged 15-49) in the sample including those who did not answer the questions as the denominator. The denominator for the corrected version (61.7%) excludes people who did not answer the question.

Target 1: Reduce sexual transmission of HIV by 50% by 2015

Indicators for the general population

INDICATOR 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 misconception about HIV transmission or prevention

The risk of contracting HIV infection is known to be driven by, among others, lack of comprehensive knowledge about the modes of HIV prevention and transmission. To address this problem, the the Government of Botswana and its partners have over the years developed and implemented a comprehensive behaviour change communication and media campaigns to provide young people with appropriate information and skills to make informed and responsible choices about sexual and reproductive health, including the prevention of HIV infection. The latest data used for the current reporting period is the 2008 Botswana AIDS Impact Survey (BAIS) III which showed that the percentage of young people aged 15-24 years who had comprehensive knowledge about HIV prevention stood at 43.7% in 2008. The aggressive efforts by both

INDICATOR 1.2: Percentage of young women and men who have had sexual intercourse before the age of 15

One of the critical objectives of the comprehensive behaviour change communication and media campaigns to providing young people with appropriate information and skills is to promote delayed age at sexual debut. Because there are no data for the current reporting period, the BAIS II showed that only 5.5 per cent of young women and men had sexual intercourse before they attained age 15.

INDICATOR 1.3: Percentage of adults 15-49 who have had sexual intercourse with more than one partner in the last 12 months

The National Strategic Framework for HIV and AIDS has identified multiple concurrent partnerships as one of the key drivers of HIV infection in the country. As such monitoring levels and trends in multiple concurrent partnerships is critical for monitoring HIV and AIDS. Evidence from BAIS III showed that 24 per cent of adults aged 15-49 years had sexual intercourse with more than one sexual partner in the last 12 months. In 2009, the Government of Botswana developed and implemented the National Multiple Concurrent Partnerships (MCP) Campaign to address MCP in all its forms, with a special focus on young women.

INDICATOR 1.4: Percentage of adults 15-49 who had more than one sexual partner in the last 12 months and who report the use of a condom during the last intercourse

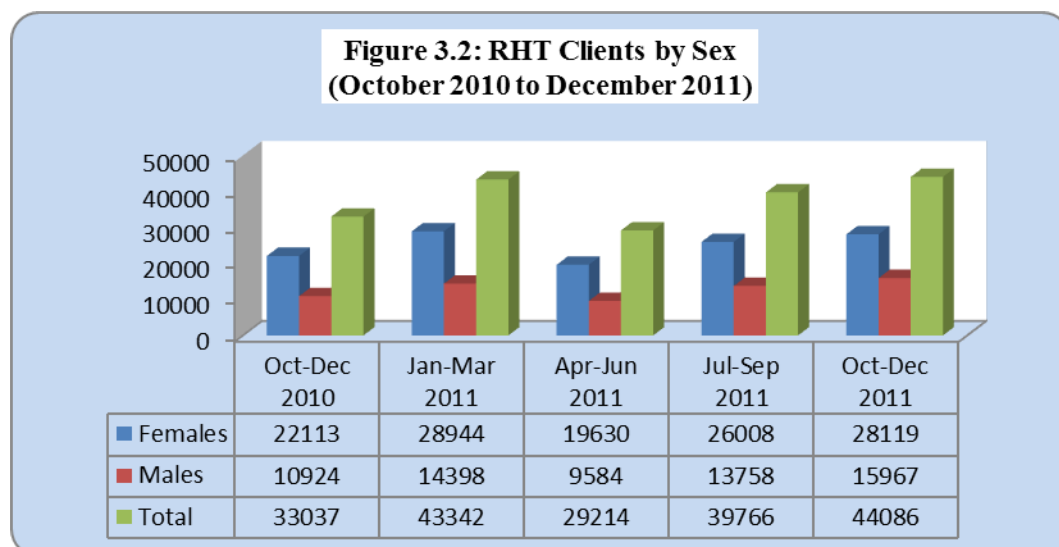
Part of the fight against HIV and AIDS includes the distribution of condoms (both male and females) with the hope that their uptake will increase. Various forms of distribution are used including all government health facilities, workplaces and non-traditional sites such as public toilets and hotels. BAIS III results indicated that 90.2% of adults 15-49 who had more than one sexual partner in the past 12 months reported using a condom during their last intercourse.

INDICATOR 1.5: Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results

Voluntary Counselling and Testing (VCT) for HIV is one of the strategies the Government of Botswana adopted to address HIV and AIDS epidemic. The introduction of VCT is premised on the assumption that once counselled and tested for HIV, the individual will evaluate their current level of HIV infection risk and they will have been provided with motivation and self-efficacy to avoid sexual risky behaviours, it will enhance safe sexual behaviour and lead to a lower risk of HIV infection. Routine HIV Testing is offered in all

government health facilities across the country and incorporates Voluntary Counselling and Testing (VCT) as one of its components.

In Botswana VCT is administered by four main service providers: Tebelopele (an NGO with a network of VCT centres in all the 24 health districts in the country); the Botswana Family Welfare Association (BOFWA); the Botswana Christian AIDS Intervention Programme (BOCAIP) and Routine HIV Testing (RHT).



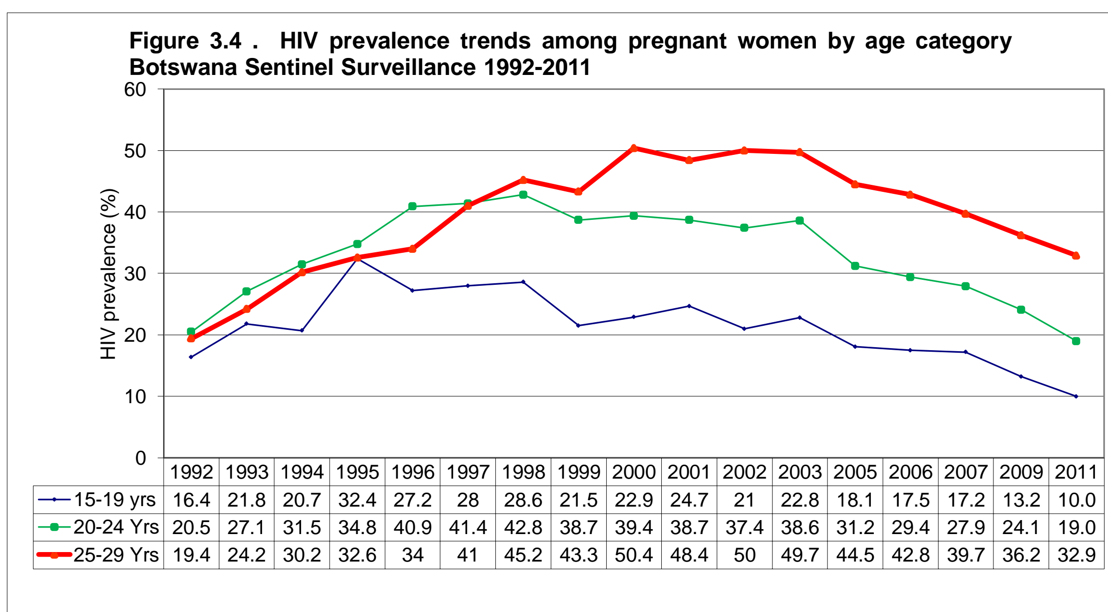
	Oct-Dec 2010	Jan-Mar 2011	Apr-Jun 2011	Jul-Sep 2011	Oct-Dec 2011
Females	22113	28944	19630	26008	28119
Males	10924	14398	9584	13758	15967
Total	33037	43342	29214	39766	44086

<u>Source</u>: Ministry of Health M&E Quarterly Report – (April to June 2011)

Figure 3.2 shows that clients receiving RHT were predominantly female. All the reports for the different quarters indicate that a smaller proportion of males compared to females access RHT services. Unlike RHT services which are provider-initiated, VCT services are voluntary.
13,355 clients turned up for VCT and 3,135 were offered RNT based on clinical suspicion, followed by 2,173 clients who turned up for PMTCT. 1,898 were further advised to undergo RHT since HIV testing is an entry point for Safe Male Circumcision (SMC).

INDICATOR 1.6: Percentage of young women aged 15-24 who are living with HIV

The BAIS III which was a population-based survey showed that 14.1 per cent of young women aged 15-24 were living with HIV. Data from sentinel surveillance surveys are used to track changes in the proportion of pregnant women living with HIV. Figure 3.1 shows that although the overall HIV prevalence remains high, there are notable overall declines in HIV prevalence among young people aged 15-24 years. HIV prevalence dropped from a high of 13.2% in 2009 to 10.0% in 2011 among the 15-19 year olds and from 24.1% in 2009 to 19.0% in 2011 among the 20-24 year olds. These declines have been maintained since 2005 and are likely to continue into the future.



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2005	2006	2007	2009	2011
15-19 yrs	16.4	21.8	20.7	32.4	27.2	28	28.6	21.5	22.9	24.7	21	22.8	18.1	17.5	17.2	13.2	10.0
20-24 Yrs	20.5	27.1	31.5	34.8	40.9	41.4	42.8	38.7	39.4	38.7	37.4	38.6	31.2	29.4	27.9	24.1	19.0
25-29 Yrs	19.4	24.2	30.2	32.6	34	41	45.2	43.3	50.4	48.4	50	49.7	44.5	42.8	39.7	36.2	32.9

Source: 2011 ANC Sentinel Surveillance Survey

Indicators for sex workers

INDICATOR 1.7: Percentage of sex workers reached with HIV prevention programmes

There are no data on this indicator. Mapping of key population is on-going

INDICATOR 1.8: Percentage of female and male sex workers reporting the use of a condom with their most recent client

There are no data on this indicator. Mapping of key population is on-going

INDICATOR 1.9: Percentage of sex workers who received an HIV test in the past 12 months and know their results

There are no data on this indicator. Mapping of key population is on-going

INDICATOR 1.10: Percentage of sex workers who are living with HIV

There are no data on this indicator. Mapping of key population is on-going

Indicators for men who have sex with men

INDICATOR 1.11: Percentage of men who have sex with men reached with HIV prevention programmes

There are no data on this indicator. Mapping of key population is on-going

INDICATOR 1.12: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

There are no data on this indicator. Mapping of key population is on-going

INDICATOR 1.13: Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results

There are no data on this indicator. Mapping of key population is on-going

INDICATOR 1.14: Percentage of men who have sex with men who are living with HIV

There are no data on this indicator. Mapping of key population is on-going

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

Indicators

INDICATOR 2.1: Number of syringes distributed per person who injects drugs per year by needle and syringe programmes

There are no data on this indicator. Mapping of key population is on-going

INDICATOR 2.2: Percentage of people who inject drugs who report the use of a condom at last sexual intercourse

There are no data on this indicator. Mapping of key population is on-going

INDICATOR 2.3: Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected

There are no data on this indicator. Mapping of key population is on-going

INDICATOR 2.4: Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results

There are no data on this indicator. Mapping of key population is on-going

INDICATOR 2.5: Percentage of people who inject drugs who are living with HIV

There are no data on this indicator. Mapping of key population is on-going

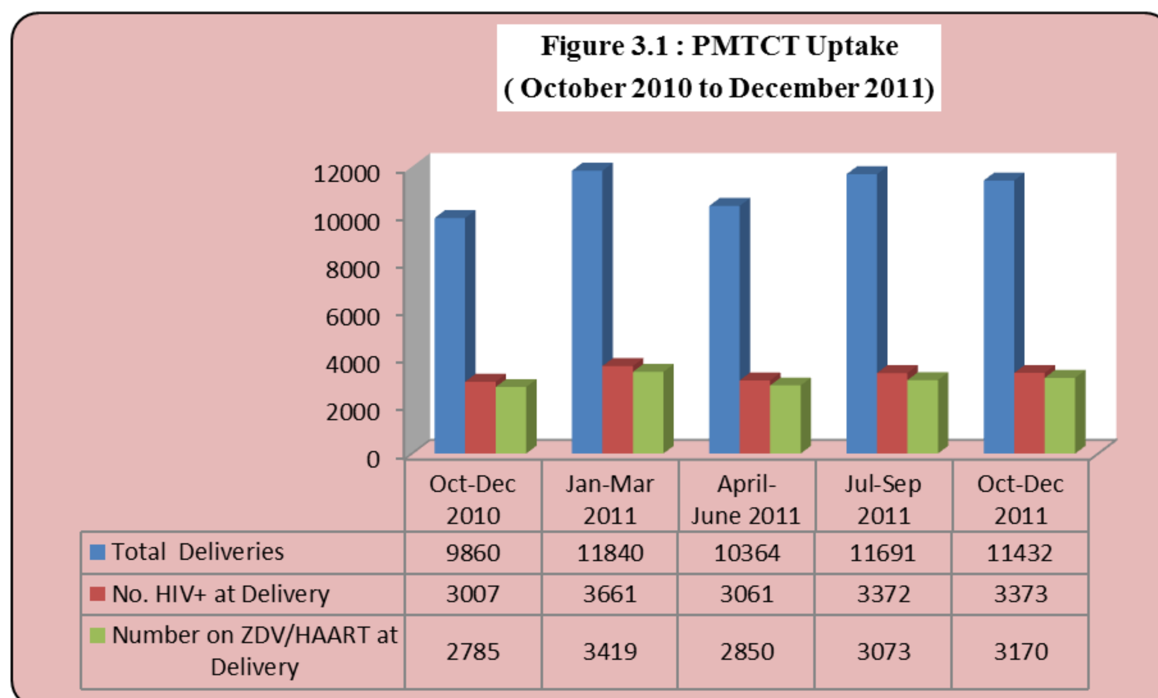
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS- related maternal deaths

Indicators

INDICATOR 3.1: Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission

The Prevention of Mother-to-Child Transmission (PMTCT) programme was launched in 1999 with a view to prevent transmission of HIV to unborn babies from their infected mothers. Pregnant women presenting at antenatal care services (ANC) are offered HIV testing and those testing HIV positive are persuaded to enrol in the programme. The PMTCT programme in Botswana has been heralded as a success story because it has reduced mother to child transmission of HIV from 20-40% in 2001 to around 4% in 2008/09.

According to data from the Ministry of Health, PMTCT uptake has increased from 27% in 2002 to 94% in 2011. Figure 3.1X below shows the uptake during the reporting period of 2010-2011.



	Oct-Dec 2010	Jan-Mar 2011	April-June 2011	Jul-Sep 2011	Oct-Dec 2011
Total Deliveries	9860	11840	10364	11691	11432
No. HIV+ at Delivery	3007	3661	3061	3372	3373
Number on ZDV/HAART at Delivery	2785	3419	2850	3073	3170

Source: Ministry of Health M&E Quarterly Report – (October to December 2011)

The percentage of infants born from HIV positive mothers testing HIV positive at 6 weeks has remained constant at 2% for the previous and current quarters, an indication that PMTCT programme is successfully reducing HIV infection.

INDICATOR 3.2: Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth

The percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth was reported as 45.9 per cent according to data from programme statistics.

INDICATOR 3.3: Mother-to-child transmission of HIV (modelled)

Data from programme data showed that mother-to-child transmission of HIV was 3.6 per cent in 2011.

Target 4: Half 15 million people living with HIV on antiretroviral treatment by 2015

Indicators

INDICATOR 4.1: Percentage of eligible adults and children currently receiving antiretroviral therapy

Botswana was the first African country to implement a free national antiretroviral therapy (ART) programme. Treatment for HIV is now available in 30 hospitals and 130 satellite clinics countrywide. Since 2010, Botswana has maintained more than 90% of HIV infected pregnant women received PMTCT services. In 2011, the total number of patients receiving highly active antiretroviral treatment (HAART) was 178,684, translating to 96.1% of the projected 185,963 adults and children in need of ART at the need of 2011 (see Table 3.1). According to the MOH October to December 2011 quarterly report, a cumulative total of 19,350 patients died while on HAART since the inception of the programme in 2002.

Table 3.1: ART Uptake

Date of Reporting	Estimated number of people in need of ART	Cumulative number of patients on ART	Coverage (%)
End of December 2009	157,127	139,643	88.9%
End of March 2010	160,500	145,413	90.6%
End of June 2010	163,872	151,695	92.6%
End of September 2010	167,245	156,916	93.8%
End of December 2010	170,617	161,219	94.5%
End of March 2011	174,454	164,559	94.3%
End of June 2011	178,290	168,140	94.3%
End of September 2011	182,127	172,920	94.9%
End of December 2011	185,963	178,684	96.1%

Source: Ministry of Health M&E Quarterly Report – (October to December 2011)

It is noteworthy that the distribution of ART clients is concentrated in cities and urban areas. It should also be noted that the public sector carries the bulk of the total number of people on treatment at 82.7%, followed by those outsourced to the private sector at 9.1% and the remaining 8.2% are directly enrolled under the private sector.

INDICATOR 4.2: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

The percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy stood at 95 per cent in 2011.

Target 5: Reduce tuberculosis deaths in the people living with HIV by 50 per cent by 2015

Indicators

INDICATOR 5.1: Percentage of estimated HIV- positive incident TB cases that received treatment for both TB and HIV

Tuberculosis (TB) related morbidity and mortality have increased significantly since 1990. Before then, Botswana was on course to eradicate TB mainly because of an accessible publicly funded and administered TB programme. The strong association of the resurgence of TB with HIV and AIDS is now a central front in Botswana's quest to contain TB. The integration of TB into the HIV and AIDS response is an imperative for the containment of the former. Therefore in order to eradicate TB, Botswana must overcome HIV and AIDS. However this indicator has no data for its estimation.

Target 6: Reach a significant level of annual global expenditure (US$ 22-24 billion) in low and middle income countries

Indicators

INDICATOR 6.1: Domestic and international AIDS spending by categories financing sources

There are no new data on this indicator. However, using the National Health Accounts of 2009/2010 yielded a figure of US$147.2 million.

Target 7: Critical enablers and synergic with development sectors

Indicators

INDICATOR 7.1: National Commitments and Policy Instruments (NCPI) (Prevention, treatment, care, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)

The data on this indicator are presented in Annex 2.

INDICATOR 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

Data on the 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 are unavailable. However, a proxy for this indicator is the prevalence of intimate partner violence experienced by women in the past 12 months which indicate 28.9 per cent. A noteworthy point is that the results came from a sample of both men and women aged 18 years and above and not 15-49 years as required by UNAIDS.

INDICATOR 7.3: Current school attendance among orphans and among non-orphans aged 10-14

Orphanhood is more often than not associated with increased non-attendance of school and increased drop-out rate for those attending school. As a result of this, monitoring the extent to which support programmes succeed in securing educational opportunities of orphans is imperative. There are no data on this indicator.

INDICATOR 7.4: Proportion of the poorest households who received external economic support in the past 3 months

There are no data for the calculation of this indicator.

6 Trend analysis on key National Commitments and Policy Index since 2003

This section of the report describes progress made in policy/strategy development and implementation and trend analysis on the key NCPI data since 2003. The most notable strategy development appears to have appeared during the reporting period of 200-2007 with the recommendation for the second NSF to include most-at-risk populations, especially those that had traditionally been excluded by national interventions. One of the most notable achievements with regards to most at risk populations is the open discussions and debates on MARPS by parliamentarians and the public at large. This is a breakthrough as this has previously been a taboo to openly discuss some key populations such as sex workers, same sex relationships.

Year GAPS AND SUBSEQUENT IMPROVEMENTS NOTED IN NCPI SURVEYS

Area: Policy/Strategy Development and Implementation

2003: **1**. Only general non-discriminatory provision in the constitution

2. Non-discrimination laws for women and youth

3. General policy to ensure equal access to prevention and care for most-at-risk is implied in the HIV/AIDS Policy. It includes women, youth and orphans and vulnerable children but not sex workers, men who have sex with men (MSM) and prisoners.

2005: **1**. National Strategic Framework for HIV/AIDS (NSF) does not address migration issues

2. No policy for most-at-risk populations, other than work done by NGOs for sex workers

2007: **1**. Recommendations made for expansion of NSF to address most-at-risk target groups, covering workplace, schools, prisons and cross-cutting issues of poverty, human rights, stigma & discrimination; people living with HIV/AIDS (PLWHA) involvement and gender.

2. NSF has an operational plan with goals, budget and an M&E framework

3. Development partner plans & programmes are aligned with the NSF

4. Improvement in the use of impact study results on informing socio-economic planning & resource allocation decisions

5. Universal access commitments have been included in the NSF, operational plan and budget

6. Country has developed a health system strengthening plan

7. Lacking policy or strategy to address intravenous drug use (IDU) in prevention

2009: **1**. The development of the **National Operational Plan for Scaling-up Prevention** 2008-2010 in 2008 whose aim was to present an aggressive prevention

implementation programme that will fill the gaps in current programming and intensify, unify and scale-up the response. This Plan ensures that resources are allocated to interventions with the greatest potential impact for preventing new HIV infections

2. The new **National Guidelines for HIV Testing and Counselling** 2009 aimed at showing the procedural and operational requirements for both Voluntary Counselling and Testing and Routine HIV Testing.

2011: **1**. Ministry of Health initiated a **Situational Analysis of Most-At-Risk Populations** in Botswana

2. NSF-II has a **National Operational Plan** with goals and an **M&E** Plan with indicators

3. The **ART Treatment Guidelines** 2012 have been revised to increase the minimum CD4 count from <250 to <350

4. A **National Capacity Building Strategic Framework for Botswana HIV and AIDS Service Organizations** has been developed with a view to provide a framework that will ensure a coordinated civil society organization response, and will enable civil society to become an effective stakeholder and contributor in the provision of comprehensive and quality prevention, treatment, care and support services.

5. The development of the **National Condom Marketing Strategy and Implementation Plan**

Year GAPS AND SUBSEQUENT IMPROVEMENTS NOTED IN NCPI SURVEYS

Area: Human Rights

2003: **1**. Generic provision for ethical research of HIV/AIDS in National Health Policy, Public Health Act, National HIV/AIDS Policy

2005: **1**. Only general non-discriminatory provision in the constitution, none specific to gender, health status or other grounds

2. Non-discrimination laws for only women and youth

3. Laws and regulations exist that present obstacles to effective HIV prevention and care for most-at-risk populations

4. General policy to ensure equal access to prevention and care for most-at-risk is implied in the HIV/AIDS Policy and would not include sex workers, MSM and prisoners

5. HIV screening policy exists for expatriates seeking employment and renewal of contracts

6. Draft ethical research policy for HIV/AIDS exists

7. Lack of data collection on human rights and HIV/AIDS

8. No independent national institutions for protection of human rights

9. Lacking focal points within government to monitor HIV-related human rights abuses

10. No indicators or benchmarks to measure compliance of human rights standards

2007: **1**. Absence of legislation that protects PLWHA – however legislative review completed to address some of the pertinent issues

2. Lack of legislation to protect most-at-risk groups (other than women; however these do not protect against marital rape)

3. Laws exist that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk groups

4. Gaps exist in service delivery for most-at-risk populations

5. Lack of human rights monitoring and enforcement mechanisms

6. NSFII increased recognition of many most-at-risk populations

2009: **1**. Laws exist that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk groups

2. Immigrants have no access to free ARV treatment and all other diseases

3. No HIV specific laws regulating the private sector employment

4. The law criminates sex work and men who have sex with other men (MSM)

5. People who are HIV+ are criminalized in case of rape case. People who are HIV+ get steeper sentences for rape compared to other people

6. The introduction of **Domestic Violence Act No. 10 of 2008** which protects women in domestic relationships and also seeks to provide survivors of domestic violence with protection. Because of this Act, it is now possible to act on cases or threats of domestic violence

7. The introduction of the **Public Service Act of 2008** which protects employees from discriminatory treatment or prejudice because of their HIV status. As such employees will not be denied promotions or opportunities for further education because they are HIV infected.

2011: **1**. Laws exist that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk groups

2. Although the **2010 Draft National Policy on HIV and AIDS** stipulates that there should be no mandatory pre-employment testing of citizens of Botswana unless when circumstances demand like the disciplined forces, it is silent on expatriates

3. The **2010 Draft National Policy on HIV and AIDS** was not presented to Members of Parliament for approval in 2011 because of pressure from BONELA who raised an objection that the Policy is not based on human rights approach because it excludes most-at-risk populations such sex workers, gays, lesbians, bisexuals, transgendered and intersexed persons. Criminalization of homosexuals (same sex-sex and sex work), ARV provision programme policy excludes migrants, foreign prison inmates, refugees present obstacles to prevention, treatment, care and

support for key populations. Criminalization fuels negative public attitudes/ stigma and discrimination which contribute to low uptake of services by MARPS.

4. There has been no deliberate promulgation of specific laws or specific provisions within existing statutes to address HIV related discrimination.

5. The ARV program guidelines exclude all foreigners (even those in genuine need) access to free ARV treatment, e.g. prison inmates and refuges.

7 BEST PRACTICES

7.1 Introduction

The purpose of this section is to share lessons learned from one or more of the key areas such as political leadership; a supportive policy environment; scale-up of effective prevention programmes; scale-up of care, treatment and/or support programmes; monitoring and evaluation; capacity building; and infrastructure development.

7.2 Best practices

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

In 1999, the Government of Botswana piloted the Prevention of Mother-to-Child Transmission Programme in the two cities of the country, namely, Francistown and Gaborone. Botswana has a successful PMTCT programme where

This is a best practice example with respect to programme coverage (about 95% of women in need) and impact with HIV transmission rates below 4% and perhaps below 2%. Access to the programme is free, and there is an effort also for the provision of early infant diagnosis with PCR enabling better HIV outcomes for those children who are infected. The programme has been sustained mainly with domestic resources over a period of a decade.

One of the challenges is ensuring optimal infant feeding practices as one of the concerns Botswana has currently is a higher than expected infant and under five mortality rate (as reported in the 2010 MDG report). Research conducted locally has shown that children who are breast fed appear to have lower mortality rates than those who are formula fed, with higher rates due to causes of death other than HIV/AIDS (diarrhoeal diseases). Implementation of the infant formula feeding policy where parents are to be given the appropriate choices that meet their own needs is a challenge.

7.2.2 Routine HIV Testing (Provider-initiated testing)

Routine HIV Testing is still a best practice example in that this practice has greatly increased the probability of HIV testing being discussed and provided during clinical encounters, contributing since 2004 to significant increases in uptake of ARV treatment and PMTCT services. Amongst the challenges is verification of the data which has previously suggested that over 90% of people offered a test in such clinical services accept it – thus improving access to treatment and preventions services. Monitoring of the service through research/periodic surveys may be necessary to ensure service quality related to counselling and also ensuring that the encounter does not suggest limitation of patient choice or coercion.

As appropriate it needs to be emphasised that the provision of these services has required significant investment necessitated by the very severe nature of the epidemic in Botswana on Botswana's most productive age groups and the dire socio-economic consequences on not putting in place effective interventions. While the treatment programme has required investment of huge resources economic studies suggest that the economic impact of not intervening would have been greater than the cost of providing an effective treatment programme.

7.2.3 Antiretroviral Therapy

The Botswana ARV programme is still a best practice example as it provides access to treatment to over 90% of people in need (95%) by the current criteria and to keep up to date with current WHO recommendations treatment eligibility criteria are being changed to CD4 350 in line with the revised WHO eligibility criteria. The majority of people in need of treatment are able to access it free of charge.

While the programme has the potential to be more cost effective and there are opportunities to improve efficiencies, the programme has continued to provide access to those who need it because the country has made a conscious effort to ensure that treatment is made available not only in hospitals but in primary care settings and now about 225 clinics offer access to treatment in all districts across the country (in addition to the 32 main treatment sites).

The programme also has sustained a high treatment adherence rate (estimated at over 90%) though verification of this figure may be necessary. It is however known that the rate of progression from 1st to 2nd line treatment remains low with over 90% of patients still on first line treatment even after 10 years of the programmes existence. Such low rates of migration to second line treatment are a reflection of high adherence rates.

While there are opportunities for improved efficiencies there is evidence that the programme has significantly reduced morbidity and mortality (due to the high coverage rates with effective treatment) with estimates that between 2002 and 2007 HIV/AIDS mortality rates were almost halved.

Sustainability of the programme is a significant challenge as the number of people on treatment increases significantly on yearly basis and the programme does receive external donor support. However despite this challenge, since about 60%+ of the costs of the programme are met with domestic resources this does improve prospects for long term sustainability compared to many programmes in resource poor settings where the programme is mostly supported with external resources.

7.2.4 National Orphan Care Programme

The programme was started in 1999 to provide food baskets, psychological counselling and to facilitate the waiving of school fees for orphans. This programme is regarded as the model in Africa.

Despite being a best practice, the programme has some challenges. One such challenge is that the programme emphasizes material provision for orphans at the expense of psychosocial support. Another challenge is that at the age of 18 orphans exit the programme is regarded as low because usually these children exit without the necessary survival skills. Thus the absence of an exit strategy for orphans when they reach age 18 results in these children facing life-long hardships. One other challenge is that Botswana uses a different definition from that of the UN making comparisons difficult.

8. MAJOR CHALLENGES AND REMEDIAL ACTIONS

8.1 Introduction

This section presents the challenges reported in the 2010 report and reports on the progress made regarding each identified challenge. Challenges encountered in the current reporting period and proposed remedial actions to address the challenges are also captured.

8.2 Progress made on key challenges reported in the 2010 Country Progress Report

SECTOR	Progress since 2010
Public Sector	
• Reduced budget allocations and expenditure as a result of the global economic crisis • Behaviour-focussed interventions have been given less attention than the biomedical interventions • Low level of leadership commitment at district and community to national level	• Still a challenge and development partners have reduced funding. • HIV Prevention strategies developed, (Community mobilization strategy) • Community mobilization strategy
Civil Society Organizations	
• Inadequate financial and technical support as well as lack of capacity to mobilize resources for sustainability of their programme • Reduced financial support from donors due to the global economic crisis • High turnover of employees • Increased workload and fatigue for national partners as a result of different donor programmatic and financial requirements	• Inadequate financial and technical support remain a challenge today • The financial situation has not improved due to the continuing global economic hardships • High turnover of staff remains a challenge
Private Sector	
• Lack of capacity to mobilize resources • Sustainability of BBCA	•
Development Partners	
• Financial challenges mainly due to the global economic crisis which has	• The financial situation has not improved due to the continuing

led to reduced development partners' support • High turnover of staff in projects supported by development partners • Poor clarity of roles and responsibilities among stakeholders which often leads to duplication of efforts • Weak coordination among partners which adversely affect input of development partners • Bureaucratic procedures of different organizations which often result in delays in the disbursement of funds	global economic hardships • High turnover of staff remains a challenge • Poor clarity of roles and responsibilities is still a challenge • Role clarity has improved with more joint planning activities and has reduced duplication of efforts and has led to more efficiency in the use of resources

8.3 Challenges faced throughout the reporting period (2010-2011) that hindered the national response and the proposed remedial actions

Challenges in the current reporting period	Proposed remedial actions
Public Sector	
• Inadequate of skilled human resource • Inadequate infrastructure (ICT, equipment, transport to aid provision of health care services, clinic structures) • Inadequate data on MARPS	• Strengthen/support the continued development of the Medical school • Continue task shifting • Scale up training and in-service training • Recruit skilled human resource • Refer to remedial action for finance • Collect baseline data on MARPS
Civil Society Organizations	
• Donor fatigue and the fact that Botswana is classified as middle income country , has left a lot of CSO without a choice, but to close shop • Lack of funds have resulted in CSO's having to amend their mandates so as to get funding as per donor dictates • The desire to keep afloat by lots of CSOs causes them to apply for more funding than they can utilise hence issues of absorptive capacity coming into play • Some CSOs' lack of experience in proposal writing has disadvantaged	• The government should have set aside budget for CSOs and identify one principal recipient who can help administer the funds to other CSOs while at the same time capacity building them on financial management. • Those issuing Request for Applications should go a step further to verify what CSOs do on the ground so as to properly rationalise CSO funding • Government grants instead of depending on donors • To have long term funding that is consistent to benefit the community

them from being funded, and yet they are excellent at implementation. On the other hand some briefcase CSOs who are good in proposal writing and not good on the ground have won funding hence crippling CSO work	and contribute to prevention, treatment, care and support • Use bottom to top approach in involving the community and stakeholders • There should be a revamp of the HIV and AIDS national response by some innovative strategy
Development Partners	
• In addition to the global economic crisis, there are new and emerging/competing priorities which are diverting funds away from HIV and AIDS such as war and global warming • Botswana's middle income status is presenting challenges because it is not considered a priority in terms of needs • High staff turnover which leads to high demands on training • Coordination and harmonization remain a challenge • Role clarity also remains a challenge	• Leverage resources where available • Focus on sustainability plans i.e. partners are moving towards providing technical assistance and building capacity rather than funds • Involve communities to take ownership of the response • Encourage Public Private Partnerships to finance the response. The national response has been largely government funded and it is high time the private sector responds to social responsibility • Provide incentives that are not necessarily monetary, including recognition • Improve documentation of processes • Professional staff development activities is required • There is need to continue strengthening coordination • Role clarity has improved with more joint planning activities and has reduced duplication of efforts and has led to more efficiency in the use of resources

9. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

9.1 Introduction

The multi-sectoral nature of the epidemic requires all relevant stakeholders to make their fair share of the contribution towards the fight against the epidemic. Even though Botswana government provides the largest share of funding for HIV and AIDS activities in the country, development partners are important players in the national response to the epidemic.

9.2 Challenges in 2010 and progress made

The 2010 UNGASS Progress Report highlighted several challenges. The following challenges were highlighted in the progress report:

- Financial challenges (mainly due to the global economic crisis) which affected development partners' support to government and civil society organizations;
- High turnover of staff in projects that were supported by development partners;
- Poor clarity of roles and responsibilities among stakeholders which often leads to duplication of efforts;
- Weak coordination among partners which adversely affect input of development partners; and
- Bureaucratic procedures of different organizations which often result in delays in the disbursement of funds

9.3 Current challenges and remedial actions that need to be taken by development partners to ensure achievement of targets

Development partners have reported numerous challenges that they encountered during the current reporting period and proposed a set of remedial actions that are needed to address the identified challenges.

9.3.1 Funding

In addition to the global economic crisis there are new and emerging/ competing priorities which are diverting funds away from HIV and AIDS such as war and global warming. Another challenge is that many donor agencies have pull out of the country to focus on poorer countries because Botswana has been classified as an upper middle income country. This has resulted in critical shortages of finances and skilled human resources in many areas of need.

In order to address the funding challenge, development partners are urged to leverage resources where available. Because development partners are moving more towards providing technical assistance and building capacity rather than providing funds, there is a need to focus on sustainability plans i.e. develop plans of how existing programmes can continue undertaking their activities without donor support. Another option available is to

involve communities to take ownership of the response. This option will allow communities to seek alternative ways of resource-mobilizing so as to address the national response to HIV and AIDS.

Because the national response has largely been government funded, it would be important going forward to engage the private sector to contribute in financing of the response beyond corporate social responsibility and identify and implement resource mobilization activities. In addition strengthening Public Private Partnerships in programme delivery for sustainability will be important for the national response.

Development partners should communicate funding situation timeously (partner funding to gradually decrease over the next 5 years) to ensure a smooth transmission from international funding to government.

9.3.2 High Staff Turnover

Another challenge still facing the development partners is the high turnover of staff in projects that they support. This challenge has been articulated in previous UNGASS reports and the situation has not improved up-to-date. The problem of high staff turnover leads to high demands on training.

To overcome the above stated challenges, several initiatives have been proposed. One such remedial action proposed is the provision of incentives to staff that are not necessarily monetary, even recognition is enough. Another suggested remedial action is that of professional staff development activities.

9.3.3 Coordination and Harmonization

Harmonization and coordination of development partners' support and of different stakeholders to ensure maximum impact of the multi-sectoral response remains a challenge. To remedy this situation, there is need to continue to strengthen coordination, joint planning and performance management within the national response for effective utilization of resources. The NOP provides a platform for achieving joint planning and the structures that have been set up for NOP development and implementation oversight need to be strengthened and supported and their effectiveness reviewed regularly.

9.3.4 Role Clarity

Poor clarity of roles and responsibilities among stakeholders which often leads to duplication of efforts remains a challenge. However, this area has improved with more joint planning activities and there is less duplication and more efficiency in the use of resources. The Joint Oversight Committee oversees development, implementation and review of the National Operational plan. Activities are prioritized and funding is based on programmes that show results, therefore improved management of resources.

UN conducts joint planning with the Government of Botswana through the initiative of "delivering as one UN" since 2010. The initiative removes the need for developing separate Country Programme Action Plans (CPAP) for UNFPA, UNICEF and UNDP and is aligned

to the Governments priorities. It ensures faster and more effective development operations and accelerates progress to achieve the Millennium Development Goals. In short, it is a UN development system that delivers more and better for the poorest and most disadvantaged in Botswana.

10. MONITORING AND EVALUATION ENVIRONMENT

10.1 Overview of the current monitoring and evaluation system

A strong Monitoring and Evaluation system is essential for a coherent and integrated HIV and AIDS response, accountability for resources, assessment of effectiveness, efficiency and sustainability of programmes and improvement of quality of service. The National HIV and AIDS Monitoring and Evaluation Plan 2012-2016 is designed to guide the response to HIV and AIDS with essential information on core indicators that measure the effectiveness of the national response to HIV and AIDS. Botswana subscribes to the principle of the "three ones" as an overarching framework of coordination where a well-defined Monitoring and Evaluation (M & E) system is key. The current M & E Plan development was guided by the National Operational Plan (NOP) for National Strategic Framework for HIV and AIDS (NSF) II during the 2010-2016.

10.2 Challenges faced in the implementation of a comprehensive M&E system

The two evaluations – one conducted in 2005 and another in 2007 – reached the same conclusions on the achievements made by BHRIMS in meeting its objectives. However, some challenges were highlighted as follows:

- Many stakeholders did not share a common understanding around BHRIMS and its objectives. Part of this problem was related to inadequate M&E expertise
- There was inadequate capacity in management and coordination of M&E
- There were multiple and fragmented reporting system. Given the multiplicity, feedback in the data flow was not optimal. Data quality was a serious problem at all levels
- There was weak coordination in updating of national indicators and revision of tools
- There is too much dependence on international partners for funding & technical assistance
- Lack of electronic M&E system and database is a challenge
- Inadequate data from private sector & community initiatives
- Inadequate funding for evaluation and operational research
- M&E Strategy has not been translated into a costed Operational Plan
- Lack of reporting on outcome/impact indicators
- Inadequate M&E training institutions in the country

10.3 Remedial actions planned to overcome the challenges

In order to address the above mentioned problems, a number of remedial actions have been proposed by the current National M&E Plan 2012-2016. The remedial actions proposed for addressing the above-stated challenges are as follows:

- There should be an increase in the number of trained M&E officers throughout the HIV and AIDS response management structure

- M&E must be a recognized career with a clear professional growth pathway
- An M&E module should be integrated in the social sciences first degree curriculum
- National indicators, reporting guidelines and tools should be reviewed annually and aligned to NOP
- Conduct Joint annual M&E plan development
- Advocate for visionary leadership, political will and resource commitment to drive M&E
- Develop an M&E communication and advocacy strategy
- Develop an indicator definition, reporting guide and tools
- Align data flow and reporting channels
- Interface web-based data transfer systems
- Improve human resource capacity for survey management and advanced data analysis
- Include special population groups in surveys and surveillance
- Develop national guidelines for routine data quality audits
- Track results of data quality improvement by facility, programmes and districts over time and use the information to improve programme performance
- Advocate for adequate financial resources for research and evaluation
- Advocate for the establishment of an independent national research council
- Promote research and evaluation in the country

10.4 Highlight the need for M&E technical assistance and capacity-building

Although the demand for trained M&E officers exists, M&E is not yet a recognized career with a clear professional growth pathway. The setting up of a post-graduate training programme in M&E at the University of Botswana would need technical assistance and capacity-building of staff at the university to run the programme effectively.

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ANNEXES

ANNEX 1: List of participants at the National Consensus Building Workshop

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ANNEX 2: National Commitments and Policy Instrument (NCPI) 2012

COUNTRY:

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

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Postal address: ____

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Tel: ____

Fax: ____

E-mail: ____

Date of submission: ____

Instructions

The following instrument measures progress in the development and implementation of national HIV policies, strategies and laws. **It is an integral part of the core indicators and is to be completed and submitted as part of the 2012 Country Progress Report**.

This fifth version of the NCPI and the first revised version since the tool changed the name to National Commitments and Policy Instrument (NCPI), instead of the earlier National Composite and Policy Index (NCPI) has been updated to reflect new HIV programmatic guidance and to be consistent with the new 2011 Political Declaration on HIV/AIDS. Additional guidance has been included to increase validity of the responses and comparability across different countries. The majority of questions are identical to the 2005, 2007 and 2009 NCPI to allow for trend analyses. Countries are strongly advised to conduct a trend analysis and include a description of progress made in (a) policy, strategy and law development and (b) implementation of these in support of the country's HIV response. Comments on the agreements or discrepancies between overlapping questions in Parts A and B should also be included as well as a trend analysis on the key NCPI data since 2003, where available[30].

I. STRUCTURE OF THE QUESTIONNAIRE

The NCPI is divided into **two parts**, (the different sections under part A and part B have been slightly reorganized since last reporting round).

Part A to be administered to government officials.

Part A covers:

I. Strategic plan
II. Political support and leadership
III. Human Rights
IV. Prevention
V. Treatment, care and support
VI. Monitoring and evaluation

Part B to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations.

Part B covers:

I. Civil Society involvement
II. Political support and leadership
III. Human rights
IV. Prevention
V. Treatment, care and support

Some questions occur in both Part A and Part B to ensure that the views of both the national government and nongovernmental respondents, whether in agreement or not, are obtained.

For questions that pertain to key populations at higher risk for HIV (heretofore referred to as "key populations" and other vulnerable populations, the following definition is applied: Key populations are defined as **most at risk for HIV (heretofore referred to as "key populations")** within a defined epidemiological context, that have significantly higher levels of risk of acquiring and transmitting HIV, and with higher rates of mortality and/or morbidity; access or uptake of relevant services is often significantly lower than the rest of the population. Depending on the disease and the country context, some population groups may require explicit attention (for example, people who inject drugs, sex workers, and men who have sex

30 Compare NCPI in Guidelines on construction of core indicators, UNAIDS 2003, 2005, 2007, 2009 respectively, for selecting questions for which trends can be calculated.

with men). Other populations that may be vulnerable to HIV are women and girls; transgender persons; clients of sex workers; prisoners; refugees, migrants or internally displaced populations; people living with HIV; adolescents, and young people; vulnerable children and orphans; people with disabilities, ethnic minorities; people in low-income groups; people living in rural or geographically isolated settings or other group(s) specific to the country context.

It is important to submit a fully completed NCPI. Please check the relevant standardized responses as well as provide further information in the open text boxes where requested. This will facilitate a better understanding of the current country situation, provide examples of good practice for others to learn from, and pin-point some issues for further improvement. NCPI responses reflect the overall policy, strategy, legal and programme implementation environment of the HIV response. The open text boxes provide an opportunity to comment on anything that is perceived to be important but insufficiently captured by the standardized questions (e.g. important sub-national variations; the level of implementation of laws, policies or regulations; explanatory notes; comments on data sources etc). In general, draft strategies, policies, or laws are not considered 'in existence' (i.e. there is no opportunity yet to expect their influence on programme implementation) so questions about whether such a document exists should be answered with 'no'. It would, however, be useful to state that such documents are in draft form and any specifics about them in the relevant open text box.

The overall responsibility for collating and submitting the information requested in the NCPI lies with the national government, through officials from the National AIDS Committee (NAC) (or equivalent).

II. PROPOSED STEPS FOR DATA GATHERING AND DATA VALIDATION

The NCPI is ideally completed in the last 6 months before submission (i.e. between October 2011 and March 2012 for the 2012 reporting round). As a variety of stakeholders need to be consulted, it is important to allow adequate time for the data gathering and data consolidation process.

1. **Designate two technical coordinators (one for part A; one for part B)**

   Technical coordinators should be given responsibility to undertake the desk review, to carry out interviews as needed, to bring together relevant stakeholders, and to facilitate collating and consolidating the NCPI data. Preferably, the technical coordinator for Part A is from the NAC (or equivalent) and for Part B is a person outside the government. They should ideally have understanding of the national policy and legal environment, a monitoring and evaluation background, and knowledge of the main actors in the national HIV response.

2. **Agree with stakeholders on the NCPI data gathering and validation process**

   Accurate completion of the NCPI requires the involvement of a range of stakeholders including representatives of a variety of civil society organizations. It is strongly recommended to organize an initial workshop with key stakeholders to agree on the NCPI data-gathering process including relevant documents for desk review, organizational representatives to be interviewed, the process to be used for determining final responses, and the timeline.

3. **Obtain data**

   The submitted NCPI data should represent the most recent stock-taking of the policy, strategic and legal environment. As the process involves a range of stakeholders and data need to be consolidated before official submission to UNAIDS, it is important to allow adequate time for completion.

   Each section should include completion of the following tasks:

   (i). Desk review of relevant documents.

   If not already the case, it is useful to collate all key documents (i.e. policies, strategies, laws, guidelines, reports etc) related to the HIV response in one place which allows easy access by all stakeholders (such as a website).This will not only facilitate validation of NCPI responses but, even more importantly, increase awareness about and encourage use over time of these important documents in the implementation of the national HIV response.

(ii). Interviewing (or other ways of obtaining the information efficiently) key people most knowledgeable about the specific topic including, but not restricted to the following:

- For Strategic Plan and Political Support sections: the Director or Deputy Director of the National AIDS Programme or National AIDS Committee (or equivalent), the Heads of the AIDS Programme at provincial and at district levels (or equivalent decentralised levels).
- For Monitoring and Evaluation section: Officers of the National AIDS Committee (or equivalent), Ministry of Health, HIV focal points of other ministries, the national monitoring and evaluation technical working group.
- For Human Rights questions: Ministry of Justice officials and human rights commissioners for questions in Part A; representatives of human rights and other civil society organizations, including representatives from networks of people living with HIV and from key populations and other vulnerable sub-populations , and legal aid centres/institutions working in the area of HIV for questions in Part B.
- For Civil Society Participation section: key representatives of major civil society organizations working in the area of HIV. These specifically include representatives from networks of people living with HIV and from key populations and other vulnerable sub-populations.
- For Prevention and Treatment, Care and Support sections: Ministries and major implementing agencies/organizations in those areas, including nongovernmental organizations and networks of people living with HIV.

  Note that interviewees are requested to provide responses as representatives of their institutions or constituencies, not their own personal views.

4. Validate, analyse and interpret data

Once the NCPI is fully completed, the technical coordinators need to carefully review all responses to determine if additional consultations or review of more documents are needed.

It is important to analyse the data for each of the NCPI sections and include a write-up in the Country Progress Report in terms of progress made in policy/strategy development and implementation of programmes to tackle the country's HIV epidemic. Comments on the agreements/discrepancies between overlapping questions in Part A and Part B should also be included, as well as a trend analysis on the key NCPI data since 2003, where available.

It is strongly recommended to organize a final workshop with key stakeholders to present, discuss and validate the NCPI responses and the write-up of the findings before official submission. It is expected that representatives from civil society organizations working in the area of HIV are invited to participate. These specifically include representatives from networks of people living with HIV and from key populations and other vulnerable sub-populations. It is also important that persons with gender expertise and expertise with other key populations be involved in the review and validation process. Ideally, the workshop would review the results from the last reporting round highlighting changes since that time and focus on validation of the NCPI data. Agreement on the final NCPI data does not require that discrepancies, if any, between overlapping questions in Part A and Part B be reconciled; it simply means that when there are different perspectives, that Part A respondents agree on their responses, Part B respondents agree on their responses, and that both are submitted. If there are no established mechanisms in place, the workshop can also provide an opportunity to discuss further collaboration between relevant stakeholders to address key gaps identified through the NCPI process.

5. Enter and submit data

Submit the final NCPI data before 31 March 2012, using the dedicated software provided on the Global AIDS Progress reporting website (www.unaids.org/AIDSReporting). If this is not possible, an electronic version of the completed questionnaire should be submitted as an appendix to the Country Progress Report before 15 March 2012 to allow time for the manual entry of data in Geneva.

National Commitments and Policy Instrument (NCPI)

Data Gathering and validation process

Describe the process used for NCPI data gathering and validation:

The process began with a presentation of an Inception Report by the consultant to the Technical Working Group. The presentation mainly focused on the proposed approach to the process, particularly the methods of data collection (document and literature review; key informant interviews, and stakeholder group meetings), as well as on agreeing on a feasible work-plan.

The document and literature review was done concurrently with the data collection over a period of three weeks. Thereafter the consultant synthesized the data and wrote the different sections of the report. Focus group discussions were organized with three groups, namely, government officials; civil society organizations; and development partners with a view facilitate the filling in of the NCPI document. The draft generated from the focus group discussions was presented at a national consensus building workshop held on the 22nd March 2012. The workshop—attended by a wide range of representatives from the different partners in the national response (see list in Annex A)—enabled partners to review each section of the report and to provide feedback and any outstanding or additional information. In order to validate the report, government officials formed a group to review the responses that they earlier provided either as individuals or groups of NCPI Part A. Development partners and representatives of civil society organizations were grouped together to review and agree on the responses of the NCPI Part B. Each group nominated a representative who then presented the responses on behalf of each group. After the workshop the consultant incorporated all comments and additional data into a final draft which was submitted to NACA for

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:

Overall the responses were unanimous in that they were not major disagreements between various stakeholders and as such the responses presented largely represent the general view of all the stakeholders.

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

NCPI Respondents

*[Indicate information for **all** whose responses were compiled to fill out (parts of) the NCPI in the below table; add as many rows as needed]*

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

Organization	Names/Positions	Respondents to Part A [indicate which parts each respondent was queried on]					
		A.I	A.II	A.III	A.IV	A.V	A.VI
National AIDS Coordinating Agency	Richard Matlhare	√	√				
Ministry of Health	Sheila D. Lesotlho				√	√	
Ministry of Health	Elizabeth Koko				√	√	
Ministry of Foreign Affairs & international Cooperation	Bella E. Mosime				√	√	
Ministry of Finance and Development Planning	Dineo Champane				√	√	
Madirelo Training & Testing Center	Permlar Morolong				√	√	
Ombudsman	Koziba Chibona				√	√	
Ministry of Health	Taurayi A.Tafuma				√	√	
National AIDS Coordinating Agency	Nonofo E. Leteane				√	√	
Ministry of Health	Marina Anderson				√	√	
Department of Public Service Management	Monametsi C. Moncho				√	√	
National AIDS Coordinating Agency	Alla T. Moyo				√	√	
Ministry of Local Government	Ella M. Matshidiso				√	√	
Madirelo Training & Testing Center	Eric K. Mosothwane				√	√	
Ministry of Health	Maureen M. Mpho				√	√	
Botswana Police Service	Bojelo Ratsatsi				√	√	
Botswana Prison Service	Montle Ponatshego				√	√	
Ministry of Health	Koona Keapoletswe				√	√	
Ministry of Health	Penny S. Makuruetsa				√	√	
Ministry of Health	Elsie B. Hulela				√	√	
Ministry of Health	Dinah Ramaabye				√	√	√
Ministry Of Sports Youth And Culture	Chedza Motsie				√	√	

Ministry of Local Government	Steven Ludick				√	√	
Ministry Transport & Communication	Simon T. Seisa				√	√	
Department of Public Service Management	Elson Malowa				√	√	
Department of Public Service Management	Ntwala P. Mouti				√	√	
Ministry of Education & Skills Development	Oletsositse M. Mogwe				√	√	
Ministry Transport & Communication	Kgannang W. Sebego				√	√	
Ministry of Health	Tim Chadborn				√	√	√
National AIDS Coordinating Agency	Diana Meswele			√			
Botswana Police	Ms. B. Ratsatsi						√
ITECH	Ms. B.W. Sento						√
UNAIDS	Mr. E. K. Baingana						√
BBCA	Mr. F. Phatshwane						√
Makgabaneng	T, Burn						√

Add details for all respondents.

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

Organization	Names/Positions	Respondents to Part B [indicate which parts each respondent was queried on]				
		B.I	B.II	B.III	B.IV	B.V
Botswana Christian AIDS Intervention Programme	I. Kwape	√	√		√	√
Botswana Christian AIDS Intervention Programme	T. Monametsi	√	√		√	√
Botswana Network of People Living with HIV/AIDS	D. Ngele	√	√	√	√	√
Botswana Network of People Living with HIV/AIDS	K. Kelebemang	√	√	√	√	√
Botswana Network of AIDS Service Organizations	O. Motsumi	√	√		√	√
Botswana Family Welfare Association	K. Poloko	√	√		√	√
Botswana Network on Ethics, Law and AIDS	U. Ndadi	√	√	√	√	√

Botswana Network on Ethics, Law and AIDS	L. Scheffers	√	√	√	√	√

Add details for all respondents.

National Commitments and Policy Instrument (NCPI)

Part A

[to be administered to government officials]

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes	No

IF YES, what was the period covered *[write in]*: **Second National Strategic Framework for 2010 -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 is prioritized (4 priority areas) ▪ The second National Strategic Framework for 2010 – 2016 is being accompanied by a costed National Operational Plan and a Monitoring and Evaluation Plan. This is the first time Botswana has developed a costed National Operation Plan that is aligned to National Strategic Framework. The National Operation Plan 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?

Name of government ministries or agencies *[write in]*: **National AIDS Coordinating Agency**

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

SECTORS	Included in Strategy		Earmarked Budget	
Education	Yes	No	Yes	No
Health	Yes	No	Yes	No
Labour	Yes	No	Yes	No
Military/Police	Yes	No	Yes	No
Transportation	Yes	No	Yes	No
Women	Yes	No	Yes	No
Young People	Yes	No	Yes	No

Other: Other Government Ministries, Non Governmental Organisations	**Yes**	No	**Yes**	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		
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[31]	Yes	No
SETTINGS		
Prisons	Yes	No
Schools	Yes	No
Workplace	Yes	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	Yes	No
Gender empowerment and/or gender equality	Yes	No
HIV and poverty	Yes	No
Human rights protection	Yes	No
Involvement of people living with HIV	Yes	No

IF NO, explain how key populations were identified?

31 Other specific vulnerable populations other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners and refugees)

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

KEY POPULATIONS
▪ Men who have sex with men ▪ Migrants/mobile populations ▪ Orphans and other vulnerable children ▪ People with disabilities ▪ Sex workers ▪ Women and girls ▪ Young women/young men ▪ Adolescents

1.5. Does the multisectoral strategy include an operational plan?

Yes	No

1.6. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?	**Yes**	No	
b) Clear targets or milestones?	**Yes**	No	
c) Detailed costs for each programmatic area?	**Yes**	No	
d) An indication of funding sources to support programme implementation?	Yes	**No**	
e) A monitoring and evaluation framework?	**Yes**	No	

1.7. Has the country ensured "full involvement and participation" of civil society[32] in the development of the multisectoral strategy?

Active involvement	Moderate involvement	No involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organised:
Consultations were held with all groups of civil society (National and International NGOs, CBOs, Labor, Private sector, FBOs and People Living with HIV) during the development of both Strategic Plan and Operation Plan. They are also members of the Technical Working Groups, National AIDS Council and Joint Oversight Committee monitoring the implementation.

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

32 Civil society includes among others: networks and organisations of people living with HIV,women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes	No	N/A

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners	Yes, some partners	No	N/A

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

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes	No	N/A

2.1. IF YES, is support for HIV integrated in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/UN Development Assistance Framework	**Yes**	No	N/A
National Development Plan	**Yes**	No	N/A
Poverty Reduction Strategy	**Yes**	No	N/A
Sector-wide approach	Yes	No	**N/A**

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)			
HIV impact alleviation	**Yes**	No	N/A
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	**Yes**	No	N/A
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	**Yes**	No	N/A
Reduction of stigma and discrimination	**Yes**	No	N/A
Treatment, care, and support (including social security or other schemes)	**Yes**	No	N/A

Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No	N/A
Other[write in below]:	Yes	No	N/A

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

Yes	No	N/A

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 strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes	No

5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS? [33]

Yes	No

5.1. Have the national strategy and national HIV budget been revised accordingly?

Yes	No

5.2. 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

5.3. Is HIV programme coverage being monitored?

Yes	No

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

Yes	No

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

Yes	No

33 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, A/RES/65/277, 10 June 2011

IF YES, for which population groups?
▪ Orphans and other vulnerable children ▪ People with disabilities ▪ Women and girls ▪ Children ▪ Adolescents ▪ Young women/young men ▪ Men ▪ Pregnant women
Briefly explain how this information is used:
▪ The information is used for program planning, policy formulation, resource allocation

(c) Is coverage monitored by geographical area?

Yes	No

IF YES, at which geographical levels (provincial, district, other)?
▪ District and sub-district level
Briefly explain how this information is used:
▪ The districts (through District Multisectoral AIDS Coordinating Committees) use evidence based information for writing proposals on a yearly basis (Annual Work Plans). The funding is then given to districts on the basis of their submissions. ▪ Targeted program planning

5.4. Has the country developed 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:
The country has a Health Sector Strategic Plan that is aligned to the National Strategic Plan for HIV and AIDS; with focus on the priority areas concerned. The health system has been impacted as a result of the approach of integrating health issues, including HIV. The government has also adopted the new CD4 count of 350 for pregnant women. . This has impacted on the laboratory issues, training of staff and mobilization of communities.

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 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	**8**	9	10

Since 2009, what have been key achievements in this area:

- Effective Joint planning, budgeting and monitoring of the implementation of interventions
- Adoption of the High political declaration resolutions made in 2011
- Development of the strategy to eliminate Mother to Child Transmission
- Development of the SMC National Operational Plan
- Development of the National HIV and AIDS Research Agenda
- Adoption and implementation of MOVE strategy for Safe Male Circumcision
- Costed National Operation Plan and Monitoring and Evaluation Plan developed
- Adoption of the new CD4 count of 350 and provision of Triple ARV Prophylaxis for HIV infected pregnant women
- Integration of HIV and sexual reproductive health services
- Adoption of the Country Ownership Initiative
- Identification of options for sustainable financing
- Collaborative costing and forecasting of ARVs
- Implementation of TB/HIV collaborative activities (3Is)
- TB/HIV operational guidelines developed

What challenges remain in this area:

- Domestic revenue decline resulting in a reduced budget for HIV
- Donor funding is scaling down resulting in increased financial burden for government
- Mobilization of sufficient resources to achieve national targets
- Skilled human resource and infrastructure
- Legal environment barriers for effective program planning and implementation

II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about HIV/AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

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	No

B. Other high officials at sub-national level

Yes	No

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?

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

Yes	No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
▪ Chairman of National AIDS Council (former Head of State) has supported the revision of the National HIV and AIDS Policy to incorporate issues that affect MARPS ▪ The Head of State, Vice President and other high ranking government officials officiated at World AIDS Day commemorations

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

Yes	No

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

2.1. IF YES:

IF YES, does the national multisectoral HIV coordination body:		
Have terms of reference?	**Yes**	No
Have active government leadership and participation?	**Yes**	No
Have an official chair person?	Yes	No
IF YES, what is his/her name and position title? **F. G. Mogae Former President**		
Have a defined membership?	**Yes**	No
IF YES, how many members?36 members		
Include civil society representatives?	**Yes**	No
IF YES, how many? 10 members		
Include people living with HIV?	**Yes**	No
IF YES, how many? BONEPWA +		
Include the private sector?	**Yes**	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	**Yes**	No

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

Yes	No	N/A

IF YES, briefly describe the main achievements:
▪ The Joint Oversight Committee and Partnership Forum, that comprises of all stake holders and manages the national response, have agreed on priority areas described in the National Strategic Framework. Duplication of effort has been minimized. ▪ The districts (through District Multisectoral AIDS Coordinating Committees) enable interaction between government, civil society organizations and the private sector in implementing HIV strategies/programmes
What challenges remain in this area:

- Donors are scaling down, and hence the need to identify sustainable solutions
- Inadequate private sector involvement

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

3.3%

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**	No
Coordination with other implementing partners	**Yes**	No
Information on priority needs	**Yes**	No
Procurement and distribution of medications or other supplies		**No**
Technical guidance	**Yes**	No
Other [write in below]:	**Yes**	No
Operational costs including wages and salaries	**Yes**	No

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

Yes	No

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

Yes	No

IF YES, name and describe how the policies / laws were amended
1. Wider consultative process with stakeholders, ie. Government, CSO's, private sector 2. Consultations with the National AIDS Council 3. Cabinet Approval 4. Tabling before parliament for debate and approval
Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:
The laws are still under review.

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 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	7	**8**	9	10

Since 2009, what have been key achievements in this area:
▪ Government supports 70% of the national HIV response ▪ 8% of the state presidency development budget is allocated to HIV ▪ Former Head of state still actively involved in the response ▪ There is an active Parliamentary AIDS Committee ▪ The Vice President, 3 Ministers, a Member of parliament are NAC Members. His Excellency the President is the stewardship of the national response.
What challenges remain in this area:
▪ Delays in creating a supportive legal environment ▪ Cascading of political support

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? Circle yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS and VULNERABLE GROUPS		
People living with HIV	**Yes**	No
Men who have sex with men	Yes	**No**
Migrants/mobile populations	Yes	**No**
Orphans and other vulnerable children	**Yes**	No
People with disabilities	Yes	**No**
People who inject drugs	Yes	**No**
Prison inmates	Yes	**No**
Sex workers	Yes	**No**
Transgendered people	Yes	**No**
Women and girls	**Yes**	No
Young women/young men	**Yes**	No
Other specific vulnerable subpopulations *[write in]*:	Yes	**No**
Refugees and foreign prison inmates		**No**

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

Yes	No

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

Constitution of Botswana (Bill of Rights) section 3-19 provides for the protection of fundamental rights and freedom 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.

Briefly explain what mechanisms are in place to ensure these laws are implemented:
There has been no deliberate promulgation of specific laws or specific provisions within existing statutes to address HIV related discrimination.

Briefly comment on the degree to which they are currently implemented:
The courts (of Law) have progressively interpreted the constitution to address (to a limited extent), HIV related stigma and discrimination. However, this depends on the attitude and awareness of the individual judiciary officer. It is not a deliberate Government measure to address discrimination related to HIV and AIDS.

2. ***Does the country have laws, regulations or policies that present obstacles[34] to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?***

Yes	No

IF YES, for which key populations and vulnerable groups?		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations[35][write in below]:	Yes	No
Criminalization of homosexuals (same sex-sex and sex work), ARV provision programme policy excludes migrants, foreign prison inmates, refugees.		

34 These are not necessarily HIV-specific policies or laws. They include policies, laws or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: “laws that criminalize same sex relationships”, “laws that criminalize possession of condoms or drug paraphernalia”; “loitering laws”; “laws that preclude importation of generic medicines”; “policies that preclude distribution or possession of condoms in prisons”; “policies that preclude non-citizens from accessing ART”; “criminalization of HIV transmission and exposure”, “inheritance laws/rights for women”, “laws that prohibit provision of sexual and reproductive health information and services to young people”, etc.

35 Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

Briefly describe the content of these laws, regulations or policies:
▪ 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 if guilty of an offence. ▪ Prison health policy prohibits availing condoms to inmates ▪ National ART guidelines prescribes access of free ART to citizens only
Briefly comment on how they pose barriers:
▪ Difficult for government to develop policing provisions/ programmes targeting or aimed at improving access to needs specific services for most at risk/ vulnerable populations. ▪ Criminalization fuels negative public attitudes/ stigma and discrimination which contribute to low uptake of services by MARPS. ▪ The ARV program guidelines exclude all foreigners (even those in genuine need) access to free ARV treatment, e.g. prison inmates and refuges.

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	No

IF YES, what key messages are explicitly promoted?		
Abstain from injecting drugs	Yes	No
Avoid commercial sex	Yes	No
Avoid inter-generational sex	Yes	No
Be faithful	Yes	No
Be sexually abstinent	Yes	No
Delay sexual debut	Yes	No
Engage in safe(r) sex	Yes	No
Fight against violence against women	Yes	No
Greater acceptance and involvement of people living with HIV	Yes	No
Greater involvement of men in reproductive health programmes	Yes	No
Know your HIV status	Yes	No
Males to get circumcised under medical supervision	Yes	No
Prevent mother-to-child transmission of HIV	Yes	No
Promote greater equality between men and women	Yes	No
Reduce the number of sexual partners	Yes	No
Use clean needles and syringes	Yes	No
Use condoms consistently	Yes	No
Other [write in below]:	Yes	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	No

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

Yes	No

2.1.

Is HIV education part of the curriculum in:		
Primary schools?	**Yes**	No
Secondary schools?	**Yes**	No
Teacher training?	**Yes**	No

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?

Yes	No

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

Yes	No

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

Yes	No

Briefly describe the content of this policy or strategy:
National Operational Plan of the National Strategic Framework II ▪ The NOP indicates that NSF II has identified addressing prevention, care and support for most at risk populations' as one of the critical areas for the national 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 most at risk populations (MARPS) and other vulnerable groups. ▪ Communities will be adequately mobilised and specific interventions will be designed and implemented 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 populations and elements are included in the policy/strategy

	IDU[36]	MSM[37]	Sex workers	Customers of Sex Workers	Prison inmates	Other populations[38] *[write in]*
Condom promotion			y	y		
Drug substitution therapy						
HIV testing and counseling			y			
Needle & syringe exchange						
Reproductive health, including sexually transmitted infections prevention and treatment						
Stigma and discrimination reduction		y				
Targeted information on risk reduction and HIV education		y	y			
Vulnerability reduction (e.g. 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 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
Services for Most at Risk populations: PMTCT Avaialbility of Councelling and testing services Prevention services for long distance truck drivers
What challenges remain in this area:
Mapping and size estimation of MARPS and developing targeted interventions for specif groups

36 IDU = People who inject drugs

37 MSM = men who have sex with men

38 Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

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

Yes	No

IF YES, **how were these specific needs determined?**
▪ Research surveys/studies ▪ Assessments/Evaluations ▪ Community consultations ▪ (Routine) Program Data

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

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Harm reduction for people who inject drugs	1	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counseling	1	2	3	4	N/A
IEC[39] on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination reduction	1	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
Prevention for people living with HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
School-based HIV education for young people	1	2	3	4	N/A
Universal precautions in health care settings	1	2	3	4	N/A
Other*[write in]*:	1	2	3	4	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 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

39 IEC = information, education, communication.

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	No
Yes	No

If YES, Briefly identify the elements and what has been prioritized:
▪ Treatment eligibility criteria ▪ Nutrition for PLWH ▪ Palliative care ▪ Psycho social and economic support ▪ TB/HIV collaboration ▪ CHBC ▪ STI management ▪ Management and treatment of Opportunistic infections ▪ SRH/HIV integration ▪ Pediatric Care and Support

Briefly identify how HIV treatment, care and support services are being scaled-up?
▪ Decentralization of services ▪ Financial support ▪ Human capacity building ▪ Advocacy, community mobilization and advertising ▪ Coordination and leadership ▪ M&E ▪ Research

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	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3	**4**	N/A
ART for TB patients	1	2	**3**	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	**4**	N/A
Early infant diagnosis	1	2	**3**	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	**2**	3	4	N/A
HIV testing and counselling for people with TB	1	2	**3**	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	**2**	3	4	N/A
Nutritional care	1	2	3	**4**	N/A
Paediatric AIDS treatment	1	2	3	**4**	N/A

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Post-delivery ART provision to women	1	2	3	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	N/A
Psychosocial support for people living with HIV and their families	1	2	3	4	N/A
Sexually transmitted infection management	1	2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	N/A
TB preventive therapy for people living with HIV	1	2	3	4	N/A
TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-related infections	1	2	3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

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

Yes	No

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

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

Yes	No	N/A

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	No	N/A

IF YES, for which commodities?
▪ ARV ▪ Condoms

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 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	**9**	10

Since 2009, what have been key achievements in this area:
▪ ART coverage 95% ▪ PMTCT uptake 93% (women who need treatment/prophylaxis get it) ▪ Survival rate ▪ Low resistance ▪ Continuation on first line therapy ▪ Decentralization of services (ARV clinic roll out, lab services, pharmacy services) ▪ Low rate of absenteeism at the work place
What challenges remain in this area:
▪ 6-7% of women that are not captured for PMTCT (locating them is a challenge) ▪ Improved timeliness of Early infant diagnosis and referral to treatment services ▪ Adherence issues ▪ Late presentation for treatment ▪ Sustainability of programs (financial) ▪ Shortage of skilled human resource and infrastructure ▪ Inadequate SRH/STI/TB/HIV integration

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

Yes	No	N/A

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

Yes	No

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

Yes	No

6.3. ***IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?***

Yes	No

6.4. ***IF YES***, what percentage of orphans and vulnerable children is being reached?

100%

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 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	7	**8**	9	10

Since 2009, what have been key achievements in this area:
What challenges remain in this area:

VI. MONITORING AND EVALUATION

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

Yes	In Progress	No

Briefly describe any challenges in development or implementation:
• Plan available but not disseminated it • Harmonization of indicators • Inadequate guidance on indicators capturing community/civil society activities • Lack of baseline and target for new indicators

1.1. IF YES, years covered [write in]: *2012-2016*

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 partner	No	N/A

Briefly describe what the issues are:
• Alignment was guided by NSF-II and NOP which were developed in 2010. Even though the NOP is for 2012 because of the revised costing, it has been used prior to 2012. • Some partners align their indicators to donor requirements and not necessarily to national M&E requirements

2. Does the national Monitoring and Evaluation plan include?

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

A data analysis strategy	Yes	**No**
A data dissemination and use strategy	Yes	**No**
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)	**Yes**	No
Guidelines on tools for data collection	**Yes**	No

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

Yes	In Progress	No

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

1 %

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

Yes	In Progress	No

Briefly describe any obstacles:

- Shortage of staff
- Shortage of M&E skilled staff (Most staff members are new)
- Retention of staff presents a challenge
- Inadequate opportunities for postgraduate training in M&E

4.1. Where is the national M&E Unit based?

In the Ministry of Health?	Yes	**No**
In the National HIV Commission (or equivalent)?	**Yes**	No
Elsewhere *[write in]*?	Yes	No

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

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
Permanent Staff [Add as many as needed]			
Manager, Research, Monitoring & Evaluation	√		2011
Chief Research Officer I × 2	√		2009
Principal Research Officer I	√		2009
Research Officer I	√		2011
Research Officer II × 2	√		2007
Assistant Research Officer	√		2003
Data Clerk	√		2001

	Fulltime	Part time	Since when?
Temporary Staff [Add as many as needed]			

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	No

Briefly describe the data-sharing mechanisms:
• All ministries and NGOs report to NACA quarterly for inclusion in the national AIDS report • NGOs report through their umbrella organizations
What are the major challenges in this area:
• Non-affiliation of some NGOs to the umbrella body • Inadequate coordination and adherence to reporting mechanisms • Lack of electronic reporting system and central database • There is multiple and fragmented reporting systems • Weak coordination in updating of national indicators and revisions of tools • Feedback is not optimal • Data quality is a problem at all levels

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

Yes	No

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

Yes	**No**

IF YES, briefly describe the national database and who manages it.
Program data are deposited into an excel spreadsheet and updated on a quarterly basis. There is need for development of more robust database at national level.

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?

6.2. Is there a functional Health Information System[40]?

At national level	**Yes**	No
At subnational level	**Yes**	No
IF YES, at what level(s)? *[write in]* • *National and district levels* • *The system is mostly paper based but it is being upgraded to electronic system*		

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

Yes	No

40 Such as regularly reporting data from health facilities which are aggregated at district level and sent to national level; data are analysed and used at different levels)?

8. How are M&E data used?

For programme improvement?	**Yes**	No
In developing / revising the national HIV response?	**Yes**	No
For resource allocation?	**Yes**	No
Other *[write in]*: Local quality improvement activities (Facility & District level)	Yes	No

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

- Some of information is used for advocacy e.g. BONELA PRISM survey results used to advocate for inclusion of MARPs issues in the National AIDS Policy
- PMTCT data have been used as evidence for retesting of pregnant and testing infants
- Safe Male Circumcision data used to shift towards Model of Optimizing Volume and Efficiency (MOVE) Strategy
- ARV & PMTCT data used for evidence-based adoption of WHO guidelines on initiation of ART & triple ARV prophylaxis
-

Challenges

- Lack of reporting on outcome/impact indicators

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

At national level?	**Yes**	No
IF YES, what was the number trained: 119		
At sub-national level?	Yes	**No**
IF YES, what was the number trained:22		
At service delivery level including civil society?87	Yes	**No**
IF YES, how many?		

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

Yes	No

IF YES, describe what types of activities
• Data quality workshops conducted for district data quality teams • Retention& absorption of seconded M&E staff • Coaching M&E officers & health facility staff on data flows and reporting tools

10. 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 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
• M&E Plan was developed & some sector plans aligned with it • Revision of indicators of NOP • Improved availability of data for national planning and policy development (SPECTRUM (AIM & GOALS) MODES OF TRANSMISSION) • Implementation of behavioural surveys e.g. MARPs, HIV in prisons, BAIS-IV, alcohol & HIV, • District-specific research to capacitate districts on how to conduct research • Revision and development of tools for many health sector programmes • Retention& absorption of seconded M&E staff • Research agenda for HIV/AIDS • Evaluation of programmes (ARV, IPT, MCP) • NHARSOC • Prevention Response and Modes of transmission analysis
What challenges remain in this area:
• Fragmented reporting system • Inadequate feedback and dissemination • Inadequate data quality • Dependence on international partners for funding & technical assistance &Lack of capacity • Lack of electronic M&E system and database • Inadequate data from private sector & community initiatives • Inadequate funding for evaluation and operational research • M&E Strategy has not been translated into an costed Operational Plan

Yes In Progress No

National Commitments and Policy Instrument (NCPI)

Part B

[to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

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 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:
Strengths: Civil society organizations continue to play a critical role in strengthening the political commitment of top leaders and national strategy formulation through their involvement/in membership of national task forces or committees. Through these memberships, CSOs are engaged in policy formulations. Involvement in NSF II and NOP. Challenges; • CSOs are also represented at national committee such as NAC however Fragmentation of CSO weakens the CSO's voice, this impacts negatively on Advocacy. • CSOs need to interact with the Parliamentarians Committee on HIV/AIDS • No coordinating body for CSOs.

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:
Strengths: • CSOs are mostly involved in planning meetings and have been involved in the costing of NOP in 2011. CSOs submit their budgets to NACA. • CSOs were heavily involved in the HIV/AIDS Strategic Plan Challenges; • CSOs are not involved in the budgeting process due to the most part shortage of human resources. • There is need for an active umbrella body where CSOs could be contributing inputs for presentation to national fora

41 Civil society includes among others: networks and organisations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

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

b. The national HIV budget?

LOW					HIGH
0	1	2	3	**4**	5

c. The national HIV reports?

LOW					HIGH
0	1	2	3	**4**	5

Comments and examples:

Strengths:

- The development of National Strategy for Civil Society involved CSOs
- CSOs receive bridge funding & free supply of test kits from government

Challenges:

- While the HIV/AIDS Strategy recognizes the role played by CSOs there is very limited support for the work carried out by CSOs in relation to HIV/AIDS. The funds made available do not help build sustainable CSOs.
- CSOs lack capacity to access money through proposals.
- Sector reports not shared at NAC.
- There is no feedback mechanism for those who do not attend NAC

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?

LOW					HIGH
0	1	2	3	**4**	5

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

LOW					HIGH
0	1	2	3	**4**	5

c. Participate in using data for decision-making?

LOW					HIGH
0	1	2	**3**	4	5

Comments and examples:
Strengths: • CSOs participate in work groups and committees in M&E • Data has been used by CSOs such as BONELA to help with some policy issues (eg commercial sexwork and msm in the HIV Policy) • CSOs are involved in the drafting of proposals such as the Global fund Challenges: • Although government receive reports from CSOs there is little feedback to help CSOs to make informed decisions • Advocacy is not funded at all the levels even though it is a step after the evidence provided by the data • Need to improve the bottom up strategy as this is where we are still weak.

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

LOW					HIGH
0	1	2	3	**4**	5

Comments and examples:
Challenges: • Although almost all CSOs are represented, their level of participation differ e.g. people living with disability are not currently actively participating in the HIV/AIDS discourses

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?

LOW					HIGH
0	1	**2**	3	4	5

b. Adequate technical support to implement its HIV activities?

LOW					HIGH
0	1	2	**3**	4	5

Comments and examples:
Strengths Development partners are providing technical support. Challenges: CSOs would like to do activities such as advocacy, ethics and legal issues.

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	<25%	25-50%	**51–75%**	>75%
Men who have sex with men	**<25%**	25-50%	51–75%	>75%
People who inject drugs	**<25%**	25-50%	51–75%	>75%
Sex workers	**<25%**	25-50%	51–75%	>75%
Transgendered people	**<25%**	25-50%	51–75%	>75%
Testing and Counselling	<25%	25-50%	**51–75%**	>75%
Reduction of Stigma and Discrimination	<25%	25-50%	**51–75%**	>75%
Clinical services (ART/OI)*	**<25%**	25-50%	51–75%	>75%
Home-based care	<25%	25-50%	51–75%	**>75%**
Programmes for OVC**	<25%	25-50%	**51–75%**	>75%

**ART = Antiretroviral Therapy; OI=Opportunistic infections*
***OVC = Orphans and other vulnerable children*

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 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	**7**	8	9	10

Since 2009, what have been key achievements in this area:
• The development of Capacity Building Strategy for CSOs 2010-2016 • The Capacity Building Project for CSOs conceived • MARPS Health Sector Operational Framework – Developed in Collaboration with MOH, WHO, CSO.
What challenges remain in this area:
• Capacity-building of CBOs is also a challenge • Civil society in Botswana is still relatively young, inexperienced, and grossly under resourced both financially and in human capital.

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	No

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

Strengths:

- PLWA sit in reference committees that are tasked with developing regulations and strategies for supporting PLWAs specific intervention programmes

Challenges:

Key populations such as sex workers and men who have sex with other men are not covered because they are viewed to operate outside the legal framework.

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**	No
Men who have sex with men	Yes	**No**
Migrants/mobile populations	Yes	**No**
Orphans and other vulnerable children	**Yes**	No
People with disabilities	**Yes**	No
People who inject drugs	Yes	**No**
Prison inmates	Yes	**No**
Sex workers	Yes	**No**
Transgendered people	Yes	**No**
Women and girls	**Yes**	No
Young women/young men	**Yes**	No
Other specific vulnerable subpopulations *[write in]*:	**Yes**	No

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

Yes	No

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:
The constitution under the Bill of Rights provides for non-discrimination. The Employment Act (Amendment of 2012) provides for non-discrimination on the basis of health status. The country has a hybrid of laws that protect from discrimination, for example the common law.
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
There is access to the courts of justice, but not for all as some courts are inaccessible to indigent people and those in remote areas. There is general access to political redress, the policing services, social services and some free legal aid through partnerships with government and the civil society.
Briefly comment on the degree to which they are currently implemented:
• There is limited human rights and legal literacy across all levels of society. • Limited access to free legal services by middle income and indigent groups because of exorbitant legal fees charged by private law firms • There is no systematic follow-up and address of cases to their logical conclusion despite the reporting mechanisms such as police of political accessibility • Personnel dealing with cases of human rights violations have insufficient skills of the subject as they have little or no training.

2. Does the country have laws, regulations or policies that present obstacles[42] to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes	No

42 These are not necessarily HIV-specific policies or laws. They include policies, laws, or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: "laws that criminalize same sex relationships", "laws that criminalize possession of condoms or drug paraphernalia"; "loitering laws"; "laws that preclude importation of generic medicines"; "policies that preclude distribution or possession of condoms in prisons"; "policies that preclude non-citizens from accessing ART"; "criminalization of HIV transmission and exposure", "inheritance laws/rights for women", "laws that prohibit provision of sexual and reproductive health information and services to young people", etc

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	**No**
Men who have sex with men	**Yes**	No
Migrants/mobile populations	**Yes**	No
Orphans and other vulnerable children	Yes	**No**
People with disabilities	Yes	**No**
People who inject drugs	**Yes**	No
Prison inmates	**Yes**	No
Sex workers	**Yes**	No
Transgendered people	**Yes**	No
Women and girls	Yes	**No**
Young women/young men	Yes	**No**
Other specific vulnerable populations[43] *[write in]*:	Yes	No

Briefly describe the content of these laws, regulations or policies:
• Policies preventing distribution of condoms in Prisons • Policies denying free ARVs for foreign prisoners and immigrants • Non-recognition of marital rape • Laws criminalizing LGBTI • Restrictive access to PEP • Poor enforcement of laws protecting children from incest and defilement.
Briefly comment on how they pose barriers:
• Admission of sex work is against the law. As such sex workers cannot disclose their activity to health care providers, implying that they make not get appropriate health care service • Because the nature of sex work is such that one may have sex with multiple partners, experience of repeated STIs is heightened and partner tracing becomes problematic • Homosexuals cannot disclose sex and anal STIs making the provision of preventive measures in place difficult • Prison inmates have no access to condoms because it is illegal to provide them in prisons but inmates receive treatment • Immigrants have no access to free ARV treatment and other diseases

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	No

43 Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

Briefly describe the content of the policy, law or regulation and the populations included.
• Gender Based Violence law • Domestic Violence Act which regulates relationships in families • Marital

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

Yes	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
NSF II and NOP. The pending national HIV/AIDS Policy is still under review

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	No

IF YES, briefly describe this mechanism:
• Police • Ombudsman • Documented cases of discrimination through the Legal AID programme

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	
Antiretroviral treatment	Yes	No	**Yes**	No	Yes	No
HIV prevention services[44]	**Yes**	No	Yes	No	Yes	No
HIV-related care and support interventions	**Yes**	No	Yes	No	Yes	No

If applicable, which populations have been identified as priority, and for which services?
Only citizens and non-citizen spouses legally married to citizens may access free-of-charge ART

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	No

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	No

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	**No**

IF YES, Briefly describe the content of this policy/strategy and the populations included:
Strategy for ensuring equal access for certain vulnerable sub-populations is still at the level of development. Affected sub-populations include lesbians, MSM, sex workers, transgender, intersexes, etc.

44 Such as blood safety, condom promotion, harm reduction for people who inject drugs, HIV prevention for out-of-school young people, HIV prevention in the workplace, HIV testing and counseling, IEC on risk reduction, IEC on stigma and discrimination reduction, prevention of mother- to-child transmission of HIV, commissioners

prevention for people living with HIV, reproductive health services including sexually transmitted infections prevention and treatment, risk reduction for intimate partners of key populations, risk reduction for men who have sex with men, risk reduction for sex workers, school-based HIV education for young people, universal precautions in health care settings.

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?

Yes	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	**No**

IF YE,S briefly describe the content of the policy or law:

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	**No**

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

Yes	**No**

IF YES on any of the above questions, describe some examples:
An indicator has been developed in the NOP which is still to be followed.

commissioners

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)[45]?

Yes	No

b. Programmes for members of the judiciary and law enforcement[46] on HIV and human rights issues that may come up in the context of their work?

Yes	No

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

a. Legal aid systems for HIV casework

Yes	No

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

Yes	No

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

Yes	No

IF YES, what types of programmes?		
Programmes for health care workers	Yes	No
Programmes for the media	Yes	No
Programmes in the work place	Yes	No
Other *[write in]*:	Yes	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 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

45 Including, for example, Know-your-rights campaigns – campaigns that empower those affected by HIV to know their rights and the laws in context of the epidemic (see UNAIDS Guidance Note: Addressing HIV-related law at National Level, Working Paper, 30 April 2008)

46 Including, for example, judges, magistrates, prosecutors, police, human rights commissioners and employment tribunal/ labour court judges or commissioners

Since 2009, what have been key achievements in this area:
• Ethics & Law on HIV/AIDS Office in NACA • Sensitization of Judiciary & Law Enforcement Officers • Media Forum with CSOs to discuss HIV & human rights issues • CSOs represented in NAC • Advocacy on HIV/AIDS revised to include human rights issues & MARPs • BONELA presentations at NAC raise awareness about human rights issues
What challenges remain in this area:
• Lack of independent human rights commission • Same-sex individuals still not recognized • Lack of advocacy skills among NGOs

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 2011?

Very Poor										Excellent
0	1	2	3	4	5	**6**	7	8	9	10

Since 2009, what have been key achievements in this area:
• Addressing legislators about HIV/AIDS matters • NSF II and NOP have human rights issues and indicators • MOH is conducting MARPs Situational Analysis study • MARPs Strategy developed by MOH & presented & approved by NAC • CCM developed LGBTI proposal to World Bank
What challenges remain in this area:
• Cultural barriers/attitudes towards MARPs • Human rights issues not considered a priority (not at par with prevention, treatment & care) • Commercial sex clients are not targeted. Focus is only on sex workers • Policy is not conducive to the provision of services to commercial sex workers • Policies for migrants still a problem

IV. PREVENTION

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

Yes	No

IF YES, how were these specific needs determined?
• HIV prevention has been identified as the priority number one in the national response. The country has identified the need to treat key populations as a group that needs special attention if the country is to achieve zero new HIV infections by 2016. In view of this, government has taken an initiative to know the size of the key populations, the specific behaviors associated with these groups, the geographical locations, etc • Prison study just approved.

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

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	**4**	N/A
Condom promotion	1	2	3	**4**	N/A
Harm reduction for people who inject drugs	**1**	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	**4**	N/A
HIV prevention in the workplace	1	2	3	**4**	N/A
HIV testing and counseling	1	2	3	**4**	N/A
IEC[47] on risk reduction	1	2	**3**	4	N/A
IEC on stigma and discrimination reduction	1	2	**3**	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	**4**	N/A

47 IEC = information, education, communication

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Prevention for people living with HIV	1	2	3	**4**	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	**3**	4	N/A
Risk reduction for intimate partners of key populations	1	**2**	3	4	N/A
Risk reduction for men who have sex with men	1	**2**	3	4	N/A
Risk reduction for sex workers	1	**2**	3	4	N/A
School-based HIV education for young people	1	2	3	**4**	N/A
Universal precautions in health care settings	1	2	3	**4**	N/A
Other*[write in]*:	1	2	3	4	N/A

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 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	**7**	8	9	10

Since 2009, what have been key achievements in this area:
Systems in place: • Prevention strategy • Condom strategy • MARPS operational plan • SMC/MOVE strategy • MCP strategy • PHDP strategy
What challenges remain in this area:
• MARPS strategy

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	No

IF YES, Briefly identify the elements and what has been prioritized:
• CD4 count threshold changed from <250 to <350 • PMTCT • OVC food basket increased for patients with low CD4 count • HCT • ART • Adherence counseling • IEC treatment literacy • Treatment monitoring • Nutritional assessment • Psychosocial support
Briefly identify how HIV treatment, care and support services are being scaled-up?

1.1. ***To what extent have the following HIV treatment, care and support services been imple- mented?***

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3	4	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	N/A
HIV testing and counselling for people with TB	1	2	3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	N/A
Nutritional care	1	2	3	4	N/A
Paediatric AIDS treatment	1	2	3	4	N/A
Post-delivery ART provision to women	1	2	3	4	N/A

V. TREATMENT, CARE AND SUPPORT

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	**4**	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	**4**	N/A
Psychosocial support for people living with HIV and their families	1	2	**3**	4	N/A
Sexually transmitted infection management	1	2	**3**	4	N/A
TB infection control in HIV treatment and care facilities	1	**2**	3	4	N/A
TB preventive therapy for people living with HIV	1	2	**3**	4	N/A
TB screening for people living with HIV	1	2	**3**	4	N/A
Treatment of common HIV-related infections	1	2	3	**4**	N/A
Other*[write in]*:	1	2	3	4	N/A

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 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	**8**	9	10

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	No

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

Yes	No

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

Yes	No

2.3 . IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

2.4. IF YES, what percentage of orphans and vulnerable children is being reached?

%

3. 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 2011?

Very Poor										Excellent
0	1	2	3	4	5	**6**	7	8	9	10

Since 2009, what have been key achievements in this area:
• National Plan on OVC 2010-2016 • Increased political commitment to the plight of orphans
What challenges remain in this area:
• Increased budget even though orphans are weaned at age of 18 • OVCs who are weaned from the programme are not given life skills even after they no longer receive food baskets • Vulnerability of OVC as they grow old