



Republic of Botswana

THE SECOND BOTSWANA

**National Strategic Framework
for HIV and AIDS
2010-2016**



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The Second National Strategic Framework for HIV and AIDS: 2010-2016

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The National AIDS Coordinating Agency
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FOREWORD

As the period of the First National Strategic Framework (NSF I) draws to a close, the national response to HIV and AIDS has made some significant achievements in areas such as the national Antiretroviral Therapy Programme, the Prevention of Mother-to-Child Transmission Programme, and the care of our orphans and vulnerable children, to mention a few. However, in other areas the national response has not gained as much ground. For example, while beginning to move forward through the development of the *National Operational Plan for Scaling Up HIV Prevention in Botswana*, prevention efforts overall still lag behind. Similarly, the national response is hampered in a number of critical areas by capacity constraints. The health sector requires much greater attention to its capacity issues, while civil society and communities need to be strengthened and empowered to effectively play their role in the national response. In short, there are areas in our response to HIV and AIDS that need to be reviewed and refined so as to find ways in which they can be most effectively sustained over the long term, while others require more intensive focus and energy as well as greater resources in order to achieve greater success.

The Second National Strategic Framework for HIV and AIDS, 2010-2016, attempts to address two important areas. On the one hand, prioritizing those critical areas in which we must make substantial gains, while on the other, ensuring that the national response builds on its past successes to provide a firm foundation for future achievement. This framework serves as the roadmap for the national response over the next seven years and makes an important contribution to the successful implementation of the 10th National Development Plan and, ultimately, Vision 2016. It is a rallying call for all partners in the national response to align their efforts and to collectively push forward to the achievement of agreed outcomes. From the broad objectives and strategies outlined in the document, it is expected that stakeholders will be guided to produce specific, targeted and integrated plans where responsibility for performance is shared and accountability is confirmed. Streamlining our actions under this framework and toward a common purpose will make our national response more efficient and effective.

As we enter a new era of productivity and performance, Government is committed to addressing the priority areas outlined in this document. Based on the evidence, the NSF II priorities define the way forward for responding to the HIV and AIDS epidemic and tackling what remains a critical challenge to national development.



Hon. L. E. Motsumi

Minister for Presidential Affairs & Public Administration

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ACRONYMS AND ABBREVIATIONS

ACHAP	African Comprehensive HIV/AIDS Partnerships
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BAIS	Botswana AIDS Impact Survey
BBCA	Botswana Business Coalition against AIDS
BHRIMS	Botswana HIV/AIDS Response Information Management System
CHBC	Community Home-Based Care
CSO	Central Statistics Office
DMSAC	District Multi-Sectoral AIDS Committee
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immunodeficiency Virus
M&E	Monitoring and Evaluation
MARPS	Most At Risk Populations
MCP	Multiple and Concurrent Partnerships
MLG	Ministry of Local Government
MOH	Ministry of Health
MTR	Mid-Term Review
NAC	National AIDS Council
NACA	National AIDS Coordinating Agency
NGO	Non-governmental Organization
NSF	National Strategic Framework
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Programme for HIV/AIDS Relief
PEP	Post-exposure Prophylaxis
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
SADC	Southern Africa Development Community
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS

UNDP

United Nations Development Programme

UNFPA

United Nations Population Fund

UNGASS

United Nations General Assembly Special Session (on HIV/AIDS)

UNICEF

United Nations Children's Fund

VMSAC

Village Multi-Sectoral AIDS Committee

WHO

World Health Organization

ACKNOWLEDGEMENTS

There are many who have contributed to the development of this National Strategic Framework for HIV and AIDS, 2010-2016 (NSF II), by having generously shared their time, experience and thoughts about the way forward for the national response. The high-level Reference Group, established to oversee the development of the NSF, provided insight and policy guidance to ensure that the document had the best chance to speak to many audiences. Their comments and views were extremely important in helping to shape our thinking. A Technical Working Group was also established to more closely manage the process of developing the NSF II. Although its composition shifted over time, it was most often made up of committed individuals from NACA, the Ministries of Local Government and Health, the Botswana Business Coalition against AIDS (BBCA), UNICEF, UNFPA, UNDP, UNAIDS, WHO, the Botswana Network of People Living with AIDS (BONEPWA), the Botswana Network of AIDS Service Organizations (BONASO), the Botswana Christian AIDS Intervention Programmes, and the Botswana Network on Ethics, Law and Human Rights (BONELA). These individuals through their organisations have worked tirelessly to ensure the development of the National Strategic Framework and their efforts are greatly appreciated.

Both the content and direction of the Second National Strategic Framework were discussed extensively across all sectors and at all levels. First was a national workshop convened in September 2008 to hammer out rough priority areas. This was followed by numerous interactive consultations from the districts involving local government, Community Based Organizations (CBOs), traditional authorities and companies, and then carrying on with the youth, Civil Society, organized labour, the media, the Private Sector, the monitoring, evaluation and information management specialists throughout the country, and Ntlo ya Dikgosi (previously referred to as House of Chiefs) in the early months of 2009. We sincerely thank all those many hundreds of individuals that allowed us to consult with them on the development of this framework.

Special thanks go to our partners the African Comprehensive HIV/AIDS Partnerships (ACHAP), UNICEF, UNDP, UNAIDS and WHO for furnishing technical expertise and funding, as well as the many organizations that provided valuable and key contributions to successive drafts of the framework such as Population Services International (PSI), the Ministries of Local Government, Trade and Industry, and Health, BOTUSA/CDC, PEPFAR and Botswana Police Service. While the Second National Strategic Framework for HIV and AIDS, 2009-2016, represents the combined efforts and hard work of a number of dedicated individuals, there are in addition many within NACA that spearheaded its formulation and indeed deserves mention. The list is endless. That notwithstanding, special mention goes to Mr Peter Stegman, the NACA Strategic Planning Consultant for his commitment to the entire process.



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EXECUTIVE SUMMARY

The purpose of this document is to outline the national priorities for the national response to HIV and AIDS for the period 2010 to 2016. These priorities are based on the evidence accumulated locally and are augmented by international best practices. The overall philosophy behind the Second National Strategic Framework is one of prioritization, focus, and intensification. It is through collective and concentrated efforts around these priorities that we will be able to maximize the impact of the national response.

The process to develop this document was highly consultative, generating an in-depth picture of the epidemic and its response. The drivers of the epidemic, being verified through the consultation process and research, are generally understood to include: multiple and concurrent sexual partnerships; the low rates of male circumcision; adolescent and intergenerational sex; gender inequalities and violence; substance abuse, in particular alcohol; and stigma and discrimination. Despite some modest gains, significant gaps and challenges remain to be addressed or overcome. These main gaps and challenges include under funding of prevention; limited capacities for prevention as well as implementation and management; often competing communication strategies; weak community ownership and participation; insufficient targeting of prevention; prevention with positives; safe male circumcision; weak strategic information management; and insufficient scale up of treatment, care, and support.

Taking this situation as the starting point, the priority areas were built and refined through dialogue and inputs provided across sectors and at all levels of the national response. In order to maximize the impact over the next seven years, the following priority areas must be the focus of the national response:

Priority Area 1: Preventing New Infections

Priority Area 2: Systems Strengthening

Priority Area 3: Strategic Information Management

Priority Area 4: Scaling Up Treatment, Care and Support

The overall **Goal** of the national response is the **Prevention of New HIV Infection by 2016** and efforts in each of these priority areas are critical to achieving it. The Overall Strategic Objectives of the national response under the second National Strategic Framework for HIV and AIDS, 2010-2016 that make a contribution to the goal are:

1. To reduce the incidence of sexual transmission of HIV among females and males aged 10-49 years
2. To increase access to health care services for HIV prevention
3. To strengthen community and health systems capacity for Universal Access to quality, comprehensive and sustainable HIV and AIDS services
4. To effectively coordinate, harmonize and align stakeholder support to the national response at all levels
5. To strengthen and sustain political leadership and commitment on HIV and AIDS at all levels
6. To improve the ethical and legal environment to support the national response
7. To strengthen the information management system of the national response to enhance information sharing and utilisation
8. To increase access to HIV and AIDS comprehensive quality treatment, care and support services.

The NSF II is a forward looking document and frames the national response in terms of what it should look like by the year 2016. Thus, the Overall Strategic Outcomes for the period are:

1. Increased proportion of females and males aged 10-49 years practicing safer sexual behaviours.
2. Improved utilization of health care services for HIV prevention.
3. Communities empowered to effectively respond to HIV and AIDS.
4. Improved access to quality HIV and AIDS services.
5. Partners aligned to national priorities and held accountable.
6. National response adequately resourced
7. Ethical and legal environment for HIV and AIDS improved.
8. Increased availability of quality, comprehensive and harmonized information on the response to the epidemic.
9. Improved utilization of information by partners for policy development, advocacy and programming.
10. Improved basic and operational research, monitoring and evaluation of the HIV and AIDS response.
11. Improved access to comprehensive quality treatment, care and support services.

CHAPTER 1

BACKGROUND OF THE HIV AND AIDS EPIDEMIC AND NATIONAL RESPONSE

1.1 National Response Situation Assessment and Analysis

The HIV and AIDS epidemic represents the most critical development challenge in Botswana's history. Since the first reported case of HIV in 1985, Government declared HIV and AIDS a national emergency and committed itself to a long term response. There have been defined phases in the country's response that can be delineated according to the particular plans that have been developed to address the epidemic. The most noticeable of these phases include the 1987 – 1989 Short-Term Plan of Action; the 1989 – 1993 First Medium Term Plan; the 1997 – 2002 Second Medium Term Plan, a National HIV/AIDS Policy by 1993 and a National AIDS Council.

However, both Short-Term Plan and the First Medium Term Plans were largely strong clinical responses to the HIV and AIDS situation, while public awareness and information campaigns lacked sufficient quality and coverage. The development of the second Medium Term Plan for 1997 – 2002 recognised the need to go beyond the limitations inherent in the previous plans by providing a platform for a multi-sectoral national response. It also established the coordination structures such as the National AIDS Council (NAC), National AIDS Coordinating Agency (NACA), District Multi-sectoral AIDS Committees (DMSACs) and Village Multi-sectoral AIDS Committees (VMSACs). Significant programmes such as the ARV Therapy, the home-based care and the orphans and vulnerable children were launched as part of the national response to mitigate the impact of the HIV and AIDS epidemic. HIV voluntary counselling and testing was introduced, and the first Botswana AIDS Impact Survey (BAIS I) was conducted in 2001.

Building on the lessons learnt from the implementation of the MTP II, the First National Strategic Framework for HIV and AIDS (NSF I) was developed for 2003-2009. The NSF I addressed the weaknesses that were becoming evident in national responses across Africa, such as lack of focused and coordinated implementation, weak management of the national response, inadequate legislative and policy environment, and insufficient strategic guidance for implementing sectors. It was deliberately aligned with the Ninth National Development Plan (NDP9) in order to emphasize the longer-term development aspects of the epidemic and to promote mainstreaming of HIV and AIDS into national development planning and budgeting processes.

Most importantly, the NSF I articulated agreed response strategies for emerging areas of national concern. It also provided guidance to Ministries, districts, NGOs, and the Private Sector to enable them work in a collaborative manner toward achievement of the intended goal of the National Response: *to eliminate the incidence of HIV and reduce the impact of AIDS in Botswana.*

Overall, Botswana has made significant gains in addressing the HIV and AIDS epidemic. These are especially in the area of clinical prevention, where access to mother-to-child prevention services is about 97%, access to ART services is unequalled by any African standards. Although remarkable successes have been achieved, there are areas of the national response that require deliberate actions to be taken to address them. The recommendations of the mid-term review of

the NSF I (NACA, 2007) have identified the need to focus on the prevention of new HIV infections as a key priority.

1.2 Key Drivers of the Epidemic

The HIV and AIDS epidemic in Botswana is generally driven through sexual transmission. It is recognised that no one prevention effort holds the key to stemming HIV infection, and that programmes must necessarily be made up of a combination of approaches including biomedical, behavioural and community, and be tailored to a specific context. Behaviour change has been recognised as the only long term solution to the prevention of the HIV and AIDS epidemic. The prevention interventions that have arguably the greatest potential for impact on the epidemic include those that address cultural, structural and institutional determinants of vulnerability. While they may require significantly more time to register impact, HIV cannot be successfully contained or reversed without them. Behavioural change, in this context, primarily involves sexual behaviour change and behaviour change relating to stigma and discrimination.

1.2.1. Multiple and Concurrent Sexual Partnerships

Multiple and concurrent sexual partnerships have become an increasingly important focus of prevention efforts in Botswana's national response. It has been observed that, in general, both men and women in Africa may often have more than one sexual partner, simultaneously, that may overlap for months or even years (Halperin & Epstein, 2004).

There are two important drivers of HIV infection within the context of multiple concurrent sexual partnerships. The first is the elevated risk that each of the members of any given group of sexual partners, what is called a sexual network, is exposed to over time. As one person may have two to three sexual partners, so too could each of those partners have sexual relations with two or three additional people. Thus, a single individual may be linked to a large number of unknown sexual "partners". While many of these partnerships are largely long term, relationships may, and often do change. With each new sexual partner added to the network, the risk to every member is elevated due to the fact that individual infectivity during the first few weeks or months after initial infection is much higher owing to the amount of virus in one's body. Thus, as soon as one person in the network is infected, the risk to all others is especially high (Halperin & Epstein, 2004)

The second major driver has to do with the level of condom use within the context of multiple concurrent sexual partnerships. In concurrent sexual partnerships, individuals may start out using a condom, but abandon the practice after a "sense of commitment and trust" has been established (Halperin & Epstein, 2004; SADC, 2006).

1.2.2. Adolescent and Inter-generational Sex

Adolescent sexual activity is recognised as an important driver of new HIV infections. The 2006 sero-prevalence study of pregnant mothers confirmed that about 55% of the total population was initiated to sexual intercourse by 19 years of age and around 8% have had sex by age 15. Adolescent girls are more at risk of HIV infection than boys. For example, infections are three times higher for girls than for boys aged 15 – 19 years; and are significantly higher at every other age group up 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 risk factor.

Studies have shown that some of the major factors that appear to drive intergenerational sexual relationships are monetary gain and material support. 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. This serves to underscore how important it is for the national response to seriously address issues of adolescent and intergenerational sex, and multiple concurrent sexual partnerships among youth, especially young women and their older partners.

1.2.3. Alcohol and High-Risk Sex

The association between alcohol and the risk of contracting HIV has been a concern in Botswana for a number of years. Several studies undertaken over the last few years have highlighted the importance of the strong linkage between alcohol consumption and elevated risk of HIV infection. Existing reports indicate that alcohol accounts for about 95% of all recreational substance use in the country. Furthermore, 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 behaviours such as multiple sexual partners, unprotected sex, and sex with high risk partners, and non-adherence to treatment for AIDS and TB for both men and women. The 2008-2010 National Operational Plan for Scaling up Prevention also points to the significance of the relationship between the misuse or abuse of alcohol and other substances, and the risk of HIV infection.

1.2.4. Stigma and Discrimination

Stigma and associated discrimination are socially embedded phenomena that impact negatively on the national response as they collude to constrain the coverage and effectiveness of HIV and AIDS interventions and increase the vulnerabilities of particular groups in society. Stigma and discrimination operate at the surface of human interaction, and have become accepted elements of public health theory and practice. Beneath this surface, however, are the complex social realities and beliefs surrounding illness and disease, prevailing social inequalities and societal power structures that are much more difficult to conceptualize and articulate.

Stigma and discrimination severely constrain the ability to maximize the impact of many interventions by reinforcing existing negative social constructs, norms and practices that further disadvantage and marginalize groups of people, reducing their overall integration into the national response. They limit the delivery of, and access to relevant services thereby increasing the risk and vulnerability to HIV infection. It is a broad concern that must go beyond the current focus on societal attitudes towards people living with HIV and AIDS.

While there is limited Botswana-specific data on the extent of stigma and discrimination against children, and little research has been done regarding their short and long term effect on child welfare and development, global and regional evidence can be used to gain a better understanding of the situation as it may pertain to Botswana. More research is also needed on the negative impact of stigma and discrimination against most-at-risk populations since they seem to erect and reinforce social barriers that inhibit their health seeking behaviours.

1.2.5. Gender Violence and Sexual Abuse

The status of women, especially adolescent girls, is one of the most powerful drivers of the AIDS epidemic. Women are often caught within a vicious set of circumstances. As they tend to have little power over their own bodies, they are put at risk by a combination of tacit social acceptance of male partners having more than one sexual relationship, inability to negotiate condom use, and sexual exploitation, especially among younger girls. Thus, socially as well as biologically, they

are more susceptible to HIV infection. There is also growing evidence in the region on gender violence, sexual abuse and how they could be associated with risk to HIV infections. If the national response does not begin to deal effectively with this larger reality experienced by women and girls, it cannot hope to achieve the goal of preventing new infections by 2016.

1.3. Analysis of Gaps and Challenges

In spite of the attention and focus given to both behavioural and clinical HIV prevention in the national response, many significant gaps and challenges remain to be addressed or overcome. These main gaps and challenges include the following.

1.3.1. Under-funding of HIV Prevention

Mobilizing sufficient resources for enhanced prevention programming in the context of the present global financial crisis and the need to maintain, or increase, current investment levels for the national ARV Therapy programme is a considerable challenge. The costs of the ARV Therapy programme continue to be high and, while this is an issue of national concern, there is general consensus that prevention efforts overall are under-funded and will require well targeted infusions of resources. Investments in the national response from both national and international sources, for both treatment and prevention, will have to be increased and streamlined. This reality must be understood in the context of the long term commitments to treatment being ultimately unsustainable without a commensurate commitment to effective prevention. Only through a critical focus on infection reduction over the next few years can the national response hope to ensure that ARV Therapy programme remains economically and socially sustainable.

1.3.2. Limited Capacities for Prevention

Disparity in levels of funding for both treatment and prevention is due to lack of capacity for HIV prevention. Most institutions and organizations have neither the technical ability and experience, nor the absorptive capacity to develop, implement and sustain large scale prevention initiatives. Capacity to undertake proven prevention programmes or to develop innovative and targeted initiatives is a crucial gap in the ability of the national response to move ahead with an effective prevention agenda.

1.3.3. Competing Communication Strategies

While the 2008-2010 National Operational Plan for Scaling up Prevention made some important strides in putting together and managing a coordinated communications strategy have been made, more work remains to be done in this area. National prevention efforts cover a wide range of issues and must target ever more specific audiences on a number of different levels and using a variety of channels over time. To this add the number and mix of implementing institutions, and the communications landscape for prevention becomes complex and cumbersome, with different messages often competing for the same audience. Obviously, to be effective, such a system requires planning, significant coordination, collaboration and a high level of sophistication. As the National Operational Plan for Scaling up Prevention (NACA, 2008) says, "without a shared plan and vision, national and district communication efforts will remain weak and disjointed."

1.3.4. Weak Community Ownership and Participation

Insufficient local level ownership and participation contributes significantly to the present limited capacity for the development and implementation of response programmes. Contrary to historical precedents in which communities such as community schools, the Brigade movement, community development trusts, among others, organized themselves to address what they have

identified as important needs; it has been observed that community structures in Botswana have tended to play a rather minor role in the current response to the epidemic. Whether local social organizations, traditional authorities, cooperatives, commercial associations, local trusts or other community based organizations, the overall level of community ownership and participation is not at a level to maximize impact. Research in this area is an important gap that must be filled to enhance large scale, sustainable prevention efforts.

1.3.5. Insufficient Targeting of Prevention

The identification of specific groups and their unique profile and specialized needs, remains an important gap in the design of prevention interventions. Programme development at present relies largely on fairly simple demographic categorizations based on gender, age, and occupation. The challenge is to develop a deeper and more intimate understanding of the variation and complexity that underlies our current conceptualization of who makes up the audience or market for prevention interventions. It is critical to diversify prevention approaches or products to cater for multiple wide-ranging needs.

1.3.6. Inadequate Generation and Utilization of Local Research

Underlying many strategic and operational deficiencies in the prevention response has been the limited generation and use of appropriate socio-cultural research to inform the development of prevention approaches tailored to the specific needs and circumstances of various target groups. While the drivers of the epidemic in the sub-region are generally understood it is the more specific local social and cultural nuances and structural factors that have not received the needed investigation. Even where research has been undertaken, it is often not widely disseminated, analysed, or applied within the framework of prevention programming.

1.3.7. Safe Male Circumcision

Discussions around the potential of male circumcision to prevent HIV infection actually began in the mid to late 1980s. The efficacy in averting HIV infection through safe male circumcision has been demonstrated conclusively. The national response must therefore articulate male circumcision as one of the proven methods of HIV prevention as an *'add-on'* strategy. Creative solutions and mechanisms need to be put in place to ensure that the national response can capitalize on and sustain the potential that safe male circumcision offers.

1.3.8. Prevention with Positives

An area of weakness in prevention efforts under the first National Strategic Framework was the inadequate attention given to prevention for HIV-positive individuals. Although substantial and important resources were committed to treatment, care and support of people living with HIV, they were rarely targeting prevention with positives. While Botswana-specific research in this area has not yet been undertaken, attention on and interest in Prevention with Positives has been growing. Drawing on studies and experience from elsewhere, however, will enable the national response to elevate the strategic position of Prevention with Positives and give it the significant boost it requires to maximize its potential impact.

1.3.9. Inadequate Capacity for Implementation and Management

While some gains have obviously been made in developing the capacity of the nation to respond to HIV and AIDS, much still remains to be done. There are evident weaknesses and gaps in national capacity that were either not addressed or received only minimal attention over the course of implementation of the NSF I. Training tends to be biased toward costly in-service, rather than quality pre-service programmes. Such programmes disrupt normal service delivery

by requiring staff to be away from post for prolonged periods of time, with no retention assessment to ensure that participants have learned the material thoroughly.

The skills and experience of communities at the local level are not being mobilized or used effectively. Communities across the country have assets and expertise that can be brought to bear in the design and implementation of HIV and AIDS related interventions. This is being increasingly recognized as a fundamental gap in the national response and was highlighted in both the Mid-Term Review (NACA, 2007) and the National Operational Plan for Scaling Up Prevention (NACA, 2008). Communities are seen as holding out a great deal of potential but the centralized structures and processes inherent in the national response do not allow for the adequate integration of local level counterparts.

Another capacity limitation is the ethical and legislative environment for the national response. While this was already recognized as a weak area during the development of NSF I, very little was done throughout its implementation to strengthen it. Some ground work had been done through a review of the existing policies and legislation related to HIV and AIDS, to provide some strategic direction. Despite this, few public sector institutions took up the challenge. Underlying this gap in the ethical and legislative environment is the shortage of strong leadership for HIV and AIDS across sectors. Leaders find ways and means of maximizing stakeholder contributions to achieve crucial results. Without them the national response has a challenge to move policy and advocate for legislation and new programmatic directions.

Systems for coordination of the multi-sectoral national response are a further area of concern. This includes both stakeholder coordination, across sectors and at all levels, and financial coordination. Coordinating structures have been put in place, and are generally well attended. However, aside from platforms for meeting and information sharing, they tend not to have specific and well understood functions that they perform within the context of coordination.

1.3.10. Strategic Information Management

Since the development of the NSF I, and throughout its implementation, gaps have emerged and areas requiring strengthening have been identified. The indicators that were contained within the NSF I were often not properly defined, with limited descriptions of outcome and impact indicators and no output indicators. There was no composite Monitoring and Evaluation (M&E) framework in the Botswana HIV Response Information Management System (BHRIMS) plan developed from the NSF and incorporating UNGASS indicators. There was also a paucity of qualitative indicators. It is important that the national response be in a position to regularly monitor “contextual factors” that may have a significant influence on programme implementation. This requires clear guidance on the collection and use of both qualitative and quantitative data. The need for promoting information sharing, dissemination and documentation were also not adequately addressed in NSF I, nor was the strategic direction on research as a source of acquiring strategic information well identified.

Other gaps identified include the lack of integration of M&E into planning processes and serious challenges with skills in M&E. Skills for monitoring programme performance remain rather limited especially with regards to analysis of data. Similarly, reporting systems that were put in place are not well integrated for verification of data and assessment of data quality in the monitoring of programmes at all levels of the response. There is also inadequate baseline information, which is partly the reason why there is a lack of evaluation of programmes in the response to provide details of actual success and achievement of objectives. Most of the reviews

conducted are process oriented and thus cannot measure efficiency, effectiveness, relevance and impact. Similarly, reporting systems that were put in place are not well integrated for verification of data and assessment of data quality in monitoring of programmes at all levels of the national response.

There has also been limited production of social science research in the country. The focus for HIV and AIDS research has been in other areas. Thus, while the country has benefited from a number of clinical trials that have been conducted, there have been few ethnographic studies, for instance, that help determine the most at risk groups or help determine the drivers of the epidemic. Additional constraints in the area of research for the national response include the limited research capacity to address local needs, exacerbated by delays that are often experienced in the efficient and timely ethical reviews of research proposals, and the rather limited funding available for research in social science and related aspects of HIV and AIDS. These limitations are further exacerbated by the lack of a dedicated HIV and AIDS research coordinating body to systematically guide and manage research undertakings across sectors.

Monitoring, evaluation and research currently seem to occupy a largely sub-ordinate position within the national response, being treated as add-ons or after-thoughts, rather than being an integral part. As a result, resources for their implementation and management are very often insufficient. Innovative information technology that could be developed and used, including advanced networks for data collection and information sharing, are currently unavailable. Acquisition of such tools is generally done in a less than systematic way across sectors, often at greater costs. Without the essential integration of monitoring, evaluation and research, and the necessary investment of resources, the response will always lag behind what is being demanded from it – it will always lack the capacity to cope.

1.3.11. Scaling up Treatment, Care and Support

In order to enhance and improve effectiveness and sustainability of the national response, there are a number of on-going interventions generated in NSF I, and assessed during the mid-term review, that require focused attention within the scope of the NSF II. The ARV Therapy programme represents an outstanding commitment to the people of Botswana and significant achievements have been gained in terms of scale of the programme, coverage, and positive impacts at both micro and macro- levels. The programme embodies a moral imperative and obligation for its continuance over the next seven years of the implementation of the national response. The ARV Therapy programme cannot be sustained indefinitely, given the cost implications if treatment is not combined with prevention and efficiency measures. Increasing the treatment threshold from a CD4 count of 200 to 250 has, of course, increased the number of persons eligible for treatment. Elevating the threshold still further, to a CD4 count of 350, as the upper threshold being recommended by WHO (2006), would substantially increase the number of persons in need of treatment, as well as the overall costs of the ARV Therapy programme.

While adherence in Botswana generally remains high, there is still cause for concern as issues such as pill fatigue, alcohol, and accessibility due to geographical distance have emerged as key constraints. Better adherence rates mean fewer instances of resistance and the need for more expensive treatment including using second line drugs. Advances in testing infants have introduced a new cadre into HIV and AIDS treatment and care. From infancy to adolescence, this population segment grows up with a different set of needs to those of adults on treatment. As a child transitions out of the monitoring and tracking carried out through the PMTCT programme

and into the system for the ARV Therapy programme, a number of them fall through the cracks and are lost to consistent follow up, and thus fall prey to adverse drug side effects, and resistance.

There is no one integrated patient tracking system for the different programmes delivering HIV and AIDS services. This presents numerous complexities and obstacles to patient monitoring and follow up in Botswana's highly mobile society.

The orphans and vulnerable children (OVC) programme's emphasis on the provision of material and medical assistance to OVC during the preceding years has taken precedence over other aspects of support such as behavioural interventions, child welfare monitoring and, importantly, psychosocial support. There is the need to further articulate the programme and expand its scope to cover orphans and vulnerable children and to strengthen the social welfare and protection systems within a family-centred social development framework. There is therefore a need to establish and strengthen coordination monitoring and evaluation, and mechanisms within the framework of the Children's Act of 2009.

Due to the paradigm shift of HIV and AIDS being treated as more of chronic condition than an incurable, infectious emergency, the Community Home Based Care programme is in a state of transition having to redefine itself for the future. The growing medical complications that have arisen due to years of ARV Therapy, such as cancer, heart disease, diabetes, among others, have brought into stark relief the need for a change in direction for the CHBC programme and to have sufficient capacities to address these complications.

The fourth priority area is made up of what has been termed the scaling up of treatment, care and support. These are programmes and initiatives that have been running relatively successfully and there is general agreement regarding the need for them to be maintained throughout the implementation of the NSF II. These are areas to which the country has made a commitment and from which national attention cannot be diverted. This priority area is slightly different in character relative to the others as it is focusing primarily on the refinement and improvement of existing programmes, which are already having an impact, rather than the introduction of strategic areas that are largely new or have received only limited exposure in the past.

2.3 Guiding Principles of the National Response to HIV and AIDS

The NSF II is underpinned by a number of basic guiding principles that are drawn from international best practice and reflect the country's unique social context. In order to make this framework real, these principles are aligned to and reflect VISION 2016, the nation's developmental vision.

- **Multi-sectoralism.** HIV and AIDS are a complex and multi-dimensional problem. Multi-sectoral involvement is therefore essential to national, district, and community responses to HIV and AIDS.
- **Human rights.** The national response upholds individual and human rights by promoting the dignity, non-discrimination and welfare of all people, whether infected or affected by HIV and AIDS and ensuring equal access to health and social support services regardless of race, creed, religious or political affiliation, sexual orientation or socio-economic status.
- **Improvement and innovation.** Improvement of HIV programmes, taking into account lessons learned at the national, regional and/or global level should be a continuous process. The framework recognizes the dynamism and fast pace of the epidemic and the global response to it and endeavours to adopt a flexibility and adaptation to change.
- **Specificity and focus.** In all efforts to combat HIV and AIDS, the socioeconomic and cultural context of the country should be born in mind. Mass media should be utilized in a positive manner to create and promote awareness on HIV and AIDS in the population as a mean of change in behaviour.
- **Community involvement.** Communities are the focus of efforts to curb the epidemic and they must be empowered to take control over and improve their own health.
- **Evidence informed responses.** Evidence forms the foundation for programme and policy development and is, therefore, a critical component in the shaping of the future national response to HIV and AIDS.
- **Gender sensitivity.** In view of the fact that the HIV and AIDS epidemic has been feminised, it is very important to recognise, based on evidences, the peculiarity and uniqueness of addressing the national response based on the analysis of the different needs of women and men, girls and boys.

2.4 Purpose and Goal of NSF II

The purpose and goal of the Second National Strategic Framework for HIV and AIDS, 2010-2016 are aligned to and support the implementation of other guiding documents for the nation's development including the 10th National Development Plan and Vision 2016:

The overall **Goal** of the national response is the **Prevention of New HIV Infection by 2016**

2.4.1. Overall Strategic Objectives

1. To reduce the incidence of sexual transmission of HIV among females and males aged 10-49 years
2. To increase access to health care services for HIV prevention
3. To strengthen community and health systems capacity for the provision of quality, comprehensive and sustainable HIV and AIDS services
4. To effectively coordinate, harmonize and align stakeholder support to the national response at all levels
5. To sustain and strengthen political leadership and commitment on HIV and AIDS at all levels
6. To improve the ethical and legal environment towards universal access for HIV and AIDS services
7. To strengthen the information management system of the national response to enhance information sharing and utilisation for evidence based planning
8. To increase access to HIV and AIDS comprehensive quality treatment, care and support services.

2.4.2. Overall Strategic Outcomes

1. Increased proportion of females and males aged 10-49 years practicing safer sexual behaviours
2. Improved utilization of health care services for HIV prevention
3. Communities empowered to effectively respond to HIV and AIDS
4. Improved access to quality HIV and AIDS services
5. Partners aligned to national priorities and held accountable
6. National response adequately resourced
7. Ethical and legal environment for HIV and AIDS improved
8. Increased availability of quality, comprehensive and harmonized information on the response to the epidemic
9. Improved utilization of information by partners for policy development, advocacy and programming
10. Improved basic and operational research, monitoring and evaluation of the HIV and AIDS response
11. Improved access to comprehensive quality treatment, care and support services

CHAPTER 3

PRIORITIZATION OF THE NATIONAL RESPONSE

3.0. Introduction

This chapter focuses on providing more details on the strategic objectives, outcomes and implementation strategies of the four national priorities that form the core of the national response for the next seven years. The four priorities are (1) preventing new HIV infections, (2) system strengthening, (3) strategic information management, and (4) scaling up treatment of treatment, care and support. Specific details relating the strategic objectives, outcomes and strategies to indicators, targets and means of verification are to be found in the Annex¹ of the NSF II. It also draws attention to the need to watch potential advances and future directions in HIV prevention.

3.1. PRIORITY 1: Preventing New HIV Infections

3.1.1. Introduction and Overview

Relative to the global progress made in providing access to treatment, prevention efforts have generally lagged behind with little direct evidence to suggest many major accomplishments in specific areas. In fact, such has been the overwhelming global concentration on treatment related issues that prevention appears to have largely lost its way, raising genuine concerns that it may be falling off the international AIDS agenda (Piot, 2006).

While evidence is frequently sketchy, there is a growing body of knowledge regarding the dynamics and determinants of HIV transmission; hence efforts should be directed to initiatives such as 'Know Your Epidemic' and 'Mode of Transmission'. Prevention planning, however, still appears to remain largely unresponsive and misaligned to this information. As a result, programming seems to be embedded within what have become fairly standardized formulas like condom use for the sexually active population, abstinence for the youth, universal precautions and blood safety measures. What is needed is a prioritized and cost effective mix of interventions that address what is known about the local epidemic, while continuing to build and improve the evidence base that is necessary to refine, reinforce and maximize prevention programming over time (Merson et al, 2008; UNAIDS, 2005).

Despite its relative relegation in the national response, Botswana's investments in prevention may be registering some beneficial results. Recent evidence suggests that the 'wave' of the epidemic is moving and is cresting in the older age groups. This is perhaps not surprising as more and more people are being kept alive through the ARV Therapy programme. However, it may also indicate that the national response is having a positive preventative effect on the younger age groups as evidenced by lower overall prevalence rates in the 15-30 year age groups.

While understanding that no one prevention effort holds the key to stemming HIV infection, in the absence of a vaccine, behaviour change is the only long term solution to the problem of the HIV and AIDS epidemic. The prevention interventions that have arguably the greatest potential for impact on the epidemic include those that address cultural, structural and institutional determinants of vulnerability. While they may require significantly more time to register impact,

¹ National Strategic Logical Framework

HIV cannot be successfully contained or reversed without them, as the factors that drive vulnerability will remain (UNAIDS, 2005). The process of behaviour change, which can be defined as adopting and maintaining positive health behaviours or discarding harmful ones is a critical factor in reducing new HIV infections by 2016. However, despite the programmes that have been put into place aimed at promoting behavioural change, efforts appear to have yielded few of the desired results (UNAIDS, 2007; MOH, 2006), indicating the need for a more focused approach, looking at the particular profiles of specific target groups, and delivery within locality specific contexts. Another important strategic pillar for preventing HIV transmission is *Clinical Prevention* delivered through health services.

3.1.2. Strategic Objectives

1. To reduce the incidence of sexual transmission of HIV among females and males aged 10-49 years
2. To increase access to health care services for HIV prevention

3.1.3. Strategic Outcomes

- 1.1. Increased proportion of females and males aged 10-49 years practicing safer sexual behaviour
- 1.2. Improved utilisation of health care services for HIV prevention
- 1.3.

3.1.4. Implementation Strategies

In order to achieve the outcomes outlined above for behaviour change and clinical prevention, the following strategies will have to be put in place,

1. Scale up interventions for reduction of multiple and concurrent sexual partnerships (MCP)
2. Strengthen comprehensive condom programming
3. Scale up national communication programmes for HIV prevention
4. Strengthen linkages between HIV prevention and alcohol and substance abuse interventions
5. Strengthen interventions to address age-disparate sex
6. Scale up comprehensive gender-sensitive HIV and AIDS knowledge, life skills and abstinence programmes
7. Increase demand and provision of quality HIV Testing and Counselling services
8. Increase demand and access to quality safe male circumcision services for HIV-negative males at all levels
9. Promote prevention with and among HIV positive persons
10. Scale up universal HAART for all pregnant HIV positive women
11. Increase access to HIV prevention services for MARPs and hard to reach populations
12. Scale-up the provision of PEP services

3.2. PRIORITY 2: Systems Strengthening

3.2.1. Introduction and Overview

Health outcomes are unacceptably low across much of the developing world, and the persistence of deep inequities in health status is a problem from which no country in the world is exempt. At the centre of this human crisis is a failure of health and community systems. The problem is getting drugs, vaccines, information and other forms of prevention, care or treatment – on time, reliably, in sufficient quantity and at reasonable cost – to those who need them. In many countries the systems needed to do this are on the point of collapse, or are accessible only to particular groups in the population. Failing or inadequate health and community systems are one of the main obstacles to scaling-up HIV and AIDS services. Worldwide there is widespread acceptance of the basic premise that only through building and strengthening health and community systems will it be possible to secure better health outcomes.

Health and community system consist of all organizations, people and actions whose *primary intent* is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation. It includes inter-sectoral action by health staff, for example, encouraging the Ministry of Education and Skills Development to promote female education, a well known determinant of better health.

In Botswana, 95% of the population lives within 8 km radius of a health facility (CSO, 2007). Public Sector is the predominant provider of health care services in Botswana with more than 80% of the people receiving care from public facilities and programmes (CSO, 2006). Although these facilities should be enough to provide optimal services for the population, several factors affect access and quality. Some of these factors include availability, skills and motivation of health workers, drug procurement and distribution systems, access – especially financial access, management and co-ordination of services, and fragmented information, monitoring and evaluation systems.

In the previous National Strategic Framework (NSF I) there was a lack of comprehensive programme of action to fully exploit community level capacities for effective service delivery to achieve better outcomes in the national response, hence the need for community systems strengthening. This is increasingly being recognized as a fundamental gap in the national response and was highlighted in both the Mid-Term Review (NACA, 2007) and the *National Operational Plan for Scaling up Prevention* (NACA, 2008).

In many countries, laws, policies, and regulations have contributed towards the development of a supportive environment for HIV prevention, care and support. But even in places where supportive policies and legislation exists, nonexistent or weak enforcement of these laws may facilitate the perpetuation of stigma and discrimination and limit the general success of the response to HIV and AIDS. A supportive environment for HIV should be created through legal and policy action to facilitate achievement of desired outcomes.

National governments have the mandate to direct policy, provide resources, and offer leadership at a scale that will arrest and turn back the epidemic. In the last national strategic framework considerable progress was achieved in terms of leadership commitment particularly at the

political level. However in light of the global challenges, such as the economic crisis and the ever growing needs in HIV it is still critical to sustain such levels of political commitment. It would also be important to further strong leadership advocacy and capacity building at community and district levels.

Systems for coordination of the multi-sectoral national response are a further area of concern. This includes both stakeholder coordination, across sectors and at all levels, and financial coordination. Although structures have been put in place, and are generally well attended, they are often seen as more form over function. Stakeholder coordination structures, for example, are most often platforms for information sharing rather than effective means of harmonisation and alignment.

The focus of this priority area is strengthening health and community systems for improved provision of and access to HIV and AIDS services through building the capacity of institutions, structures and creation of an enabling policy and legal environment. Based on this, the strategic objectives outcomes and strategies outlined below have been prioritised.

3.2.2. Strategic Objectives

1. To strengthen community and health systems capacity for Universal Access to quality, comprehensive and sustainable HIV and AIDS services
2. To effectively coordinate, harmonize and align partner support to the national response at all levels
3. To strengthen and sustain leadership and commitment on HIV and AIDS at all levels
4. To improve the ethical and legal environment for the national response

3.2.3. Strategic Outcomes

1. Communities empowered to effectively respond to HIV and AIDS
2. Improved access to quality HIV and AIDS services
3. Partners aligned to national priorities and held accountable
4. National response adequately resourced
5. Ethical and legal environment for HIV and AIDS improved

3.2.4. Implementation strategies

1. Improve competencies, skills and retention of human resources for the national response at all levels
2. Increase resources to strengthen community and health infrastructure, equipment and systems²
3. Improve linkages and referrals between health and community structures
4. Strengthen integration of TB, STI, SRH and HIV and AIDS services
5. Expand Private Public Partnership for improved service delivery
6. Strengthen existing coordination mechanisms and structures for programme alignment, accountability and partner engagement at all levels
7. Mobilize and maximize utilization of available resources for scale up of national response
8. Develop a system for the engagement and management of technical assistance at all levels
9. Develop mechanisms for evidence informed advocacy to sustain leadership and political commitment

² Information, financial, programme, procurement and supply chain management

10. Advocate for the development, review, enactment of appropriate HIV and AIDS related policies and legislation
11. Strengthen participation of civic bodies and communities in the development of appropriate HIV and AIDS related policies and legislations
12. Mainstream HIV and AIDS into sector policies and strategies
13. Build capacity to address HIV and AIDS stigma and discrimination

3.3. PRIORITY 3: Strategic Information Management

3.3.1. Introduction and Overview

This section outlines outcomes and strategies for managing strategic information in NSF II. These strategies will build on the Botswana HIV and AIDS response information management system (BHRIMS) which was established in 2001 to monitor and evaluate the implementation of the multi-sectoral response to HIV and AIDS. The vision and goal of BHRIMS is to develop a sustainable national multi-level monitoring and evaluation infrastructure using a multi-sectoral approach in order to provide high quality. It also aims at fostering an environment for data sharing and utilization in policy formulation and review, and programme development (NACA, 2002). Besides providing information for national policy formulation and planning purposes, BHRIMS enables Botswana to fulfil her commitment to international conventions and declarations on the HIV and AIDS epidemic such as UNGASS and Millennium Development Goals.

ANC surveillance survey which started in 1992 has been conducted annually with all districts included in the survey since 2001. However from 2009 onwards it will be conducted on a bi-annual basis. In spite of these efforts there are still critical gaps regarding capacity, coordination and linkages among research institutions. There is no policy framework on dissemination and sharing of information at national, district and community levels.

HIV and AIDS related search is coordinated by the Ministry of Health. However Population based surveys such as Botswana AIDS Impact Surveys (BAIS) are coordinated by NACA in collaboration with Central Statistics Office (CSO). It is in this respect that coordination of research in HIV and AIDS is fragmented. During NSF II, research will be integrated in the planning processes in order to enhance availability of evidence for improved programming and coordination.

Evaluation of the national response will be a periodic assessment of accomplishments and challenges encountered while implementing NSF II and will be integrated in the programme planning processes of all interventions. In addition, it is envisaged that the design of all interventions will be guided by evidence. Evaluation in this context is viewed as part of the continuum for improving the quality of the national response.

Continuous monitoring of the national response is vital to ensure periodic assessment of status of implementation of interventions as well as trends in programme performance overtime. In the context of the national response to HIV and AIDS, two broad monitoring systems are essential: programme activity monitoring, and monitoring of finances.

In NSF II knowledge management at all levels will be enhanced to ensure appropriate channelling of information to different segments of the audience for effective use. It is crucial,

therefore, that the national response sets up clear strategies and structures so that each of the various elements of knowledge can be captured, collated, organized and packaged, as a prerequisite for its dissemination to stakeholders. Currently there is no clear and consistent strategy on knowledge management or strategic information management.

3.3.2. Strategic Objective

To strengthen the information management system of the national response to enhance information sharing and utilisation for evidence based planning

3.3.3. Strategic Outcomes

1. Increased availability of quality, comprehensive and harmonized information on the response to the epidemic
2. Improved utilization of information by stakeholders for policy development advocacy and intervention design
3. Improved basic and operational research, monitoring and evaluation of the HIV and AIDS response

3.3.4. Implementation Strategies

1. Build capacity in information management at all levels of the national response³
2. Provide quality, comprehensive and harmonized information to inform the national response
3. Strengthen coordination, collaboration, information sharing and promote utilization among partners
4. Integrate research and evaluation recommendations for programming
5. Promote and build capacity for quality research
6. Establish information, knowledge management⁴ and dissemination platforms
7. Develop and implement policy guidelines regarding data and information protection

³ IT infrastructure development, retention, certification, accreditation and skills for oversight responsibilities

⁴ Note of knowledge management

3.4. PRIORITY 4: Scaling Up Treatment, Care and Support

3.4.1 Rationale and Overview

This section pays attention to existing and ongoing programmes to which the nation has committed itself, and which have achieved various degrees of success over the course of the implementation of NSF I. They have become an important part of the national response and are a priority in the sense that they need not only to be maintained over the next seven years, but action must be taken to fine-tune them and scale them up. These include integrated HIV/TB/SRH services, adolescent HIV and AIDS services, universal HAART, CHBC services and OVC programmes.

At present, there are no fully integrated HIV/TB/SRH services for HIV patients co-infected with TB or vice versa. This lack of integration presents a barrier to access comprehensive services, patient monitoring and follow up in Botswana's highly mobile society. There is therefore need to offer fully integrated HIV/TB/SRH services.

As a child transitions out of the monitoring and tracking carried out through the PMTCT programme and into the system for the ARV Therapy programme, it may be that a number of them fall through the cracks and are lost to consistent follow up. HIV and AIDS services for adolescents and children have become a critical part of this priority since failure to scale up these services will lead to non-adherence and possible drug side effects and resistance.

The orphans and vulnerable children (OVC) programme's fundamental emphasis on the provision of material and medical assistance to OVC during the preceding years has taken precedence over other aspects such as behavioural interventions, child welfare monitoring and, importantly, psychosocial support. There is the need to further articulate the programme and expand the scope of programming to include social welfare and social protection systems within a family centred social development framework.

3.4.2 Strategic Objective

To increase access⁵ to HIV/AIDS comprehensive quality treatment, care and support services.

3.4.3. Strategic Outcome

1. Improved access to comprehensive quality treatment care and support services

3.4.4. Implementation Strategies

1. Strengthen integration of HIV/TB/SRH services at all levels
2. Scale up children and adolescent HIV and AIDS treatment, care and support services
3. Strengthen capacity of CHBC service providers to deliver comprehensive quality services
4. Strengthen coordination mechanisms and a comprehensive family-centred plan of action for the protection, care and support of OVC and their care-givers

⁵ Access as defined by UNGASS and contextualized

3.5. POTENTIAL ADVANCES AND FUTURE DIRECTIONS

As a matter of urgent consideration, there is the need to rapidly identify and reapply new knowledge and appropriate technologies such that successes and best practice models documented in different parts of the country and internationally are widely disseminated to allow for adaptation and reapplication. This effort is to position the nation proactively to ensure prompt access to relevant new technologies important for the prevention of HIV infection. Some of these advances will be in the areas of HIV vaccine, microbicides, treatment for HIV and concurrent infections, and “test and treat” interventions.

In addition, the national response must prepare for the rising trend of complications that arise from treatment regimens and other interventions. A growing number of medical complications have been observed in a number of patients after years of ARV Therapy. Such conditions include cancer, heart disease, and diabetes, among others. While maintaining the priority focus on addressing HIV infection and the treatment of AIDS, concurrent programmes must be put in place for capacity building to deal with the increasing disease burden over the implementation of the NSF II.

CHAPTER 4

ROLES AND RESPONSIBILITIES

4.1 Introduction

Roles and responsibilities for implementing the priority areas of the National Strategic Framework are based on institutional mandates. All stakeholders will operate within the ambit of their mandates in creating enabling environment for the realization of the goal, objectives, outcome and strategies as outlined in this National Strategic Framework. Specific roles and responsibilities will be outlined in the National Operational Plan, which will be developed to as a complementing document to the NSF II.

4.2 Public Sector

Public sector institutions generally drive and manage the national response. The Public Sector's role is a critical one, from establishing clear priorities, to ensuring broad, multi-sectoral participation through Joint Planning and Reviews. In the absence of such Public Sector support, developing high impact initiatives around key priorities is likely to stall.

4.2.1 National AIDS Council (NAC)

As the highest coordinating body in the National Response, NAC must be in the position of overall authority. It must be the voice of NAC that articulates the national priorities that are to be addressed and to assure accountability of stakeholders for performance and progress. The major roles and responsibilities of the NAC include:

- Receiving and appraising quarterly progress reports from the monitoring of the joint operational plan.
- Holding leadership accountable for performance against set results and recommend remedial actions where progress is constrained.
- Ensuring adherence to established joint review schedule and assess results.
- Endorsing mid-plan shifts in planned activities or the incorporation of new technologies or methodologies for plan implementation.

4.2.2. National AIDS Coordinating Agency (NACA)

As the Secretariat to the National AIDS Council, NACA has the responsibility of overseeing the day-to-day management of implementation of the NSF II and the development of the National Operational Plan that will define specifically the activity outlines for the national priorities, coverage and specific roles of all stakeholders. Specific responsibilities include:

- Developing strategic direction for the national response and oversee the monitoring program implementation.
- Managing the development and implementation of a national HIV/AIDS research agenda.
- Overseeing financial monitoring, mobilize alternative resources and make recommendations on appropriate allocations per priority.
- Managing the multi-sectoral Joint Planning and Review process.
- Facilitating reporting to the NAC on a quarterly basis.
- Managing and communicate HIV and AIDS knowledge gathered through reviews, monitoring and research.

4.2.3. District Multi-sectoral AIDS Committees (DMSACs)

The DMSACs coordinates all responses at the local level by managing the planning and implementation of local initiatives and integrating vertical, sector-based plans into the national priorities. Responsibilities over the course of implementation of the NSF II may include:

- Managing local participation in a peer review mechanisms to assist with the development and review of the Joint National Operational Plan.
- Facilitating the mobilization of local level structures and groups across sectors for implementation of the national response.
- Ensuring dissemination and awareness of HIV and AIDS-related policies, technical guidelines, protocols and research for maintaining standards of service.
- Monitoring programme and policy implementation and financial utilization at the district level and ensure quality of data collection and processing at the local level.
- Supporting the development of implementation of research and surveillance activities on priority issues.

4.2.4. Ministry of Health

As one of the primary implementers of the national response, the Ministry manages and implements many of the major clinical/biomedical programmes. One of its continuing roles is to ensure that the health sector is optimized so as to maximize the impact of the national response and other specific roles and responsibilities as will be outline in the National Operational Plan. Over the course of the NSF II, some of the specific responsibilities of the MOH may include:

- Developing and strengthen guidelines and protocols for service outreach and mobile services for key health sector activities.
- Continuing to provide technical support to other stakeholders in the development and implementation of planned health sector-related activities.
- Strengthening monitoring, surveillance, clinical trials and health research activities.
- Testing, adapting and adopting new and alternative technologies for the delivery of prevention, treatment, and care services.
- Strengthen the Ministry's leadership role in the advocacy for and the development of HIV and AIDS related policy and legislation.

4.2.5. Ministry of Local Government

The MLG shares responsibility with the MOH to link the central and local levels of the national response and manages the Orphan Care and the Community Home Based Care programmes. These roles will continue and in addition, the Ministry's specific responsibilities include:

- Identifying and mobilization of community structures in support of HIV and AIDS planning and programme implementation.
- Facilitating financial and programme monitoring and evaluation.
- Facilitating the identification and undertaking of research at the local level.
- Coordinating local level knowledge management and information dissemination.
- Strengthening the role of the DMSAC and the office of the DAC.

4.2.6. Ministry of Presidential Affairs and Public Administration

As a large Ministry it undertakes many important functions of Government including being NACA's parent Ministry. Its primary role is one of creating and maintaining a supportive environment in which an effective national response can be implemented. Within the scope of its responsibilities the Office of the President, the Directorate of Public Service Management, and the Attorney General's Chambers role may include:

- Strengthening and supporting the National AIDS Coordinating Agency.
- Engaging the Strategic Office to act as a key driver of mainstreaming HIV and AIDS to ensure linkage with NDP 10 implementation coordination and monitoring.
- Mainstreaming HIV and AIDS into the management of the public service.
- Assessing and enhancing the capacity of the public service to respond to HIV and AIDS.
- Monitoring the implementation of HIV and AIDS related policies and administrative instruments within the public service.
- Developing model public sector wide workplace programmes that meet international standards and best practice.
- Providing the necessary legal guidance to public sector institutions in the mainstreaming of HIV and AIDS into the review of existing, and the development of new Government policies.
- Promoting awareness of the policy and legal issues surrounding HIV and AIDS through legal education programmes throughout the public service.

4.2.7. Ministry of Finance and Development Planning

The Ministry has an important position in the national response, ensuring that appropriate levels of funding are mobilised and available for implementation. Specific responsibilities of the MFDP may include:

- Supporting Joint Planning and Review methodology under Results-Based Management.
- Supporting cost-benefit analyses of major programmes within the national response and implementing agreed recommendations.
- Adopting flexible funding ceilings so that funds mobilized for the national response are seen as additional as opposed to alternative.
- Agreeing to longer term financial horizons for the national response to HIV and AIDS allowing for the tentative earmarking of funds for the two year activity period of the plans especially for priority areas of NSF II.

4.2.8. Ministry of Labour and Home Affairs

The Ministry is the lead in many key areas that impinge on the national response to HIV and AIDS. These include portfolio responsibilities for labour, women, immigration, prisons, company registration, etc. Additionally, with a number of cross-cutting portfolio responsibilities, it is in a position to make important programmatic and sectoral linkages that will strengthen implementation and maximize impact. Some of the specific responsibilities of the Ministry may include:

- Strengthening the Ministry's leadership role in advocating for HIV and AIDS relevant policies and legislation addressing key sectors and populations.
- Supporting the development of HIV and AIDS related research that will aid programming.
- Supporting the strengthening of civil society through re-engineered processes for the formal registration of community and faith based non-governmental organizations.

- Developing the Ministry's capacity and role in monitoring the status of the epidemic in specific areas of its mandate, especially the Most at-risk Populations.

4.2.9. Ministry of Education and Skills Development

The need for reaching ever younger populations with prevention messages is clear, and the Ministry is positioned to make this happen. Education is a powerful socializing tool that can promote those behavioural attributes that may have a protective effect on many individuals. Additionally, schools are important local level structures within the community to input into plan development and local implementation. Some of the specific responsibilities of the Ministry include:

- Reviewing and revise current pedagogical methods to promote behaviour change.
- Strengthening the Ministry's leadership role in the development of the policy environment dealing with HIV and education policy.
- Developing schools as platforms for the delivery of local level, context specific HIV education programmes.
- Supporting the establishment and undertaking of key research topics especially using expertise within the University of Botswana and other local and international tertiary institutions.
- Strengthening HIV and AIDS related curriculum into all levels and institutions.

4.2.10. Ministry of Youth, Sports and Culture

This Ministry established during the implementation of the NSF I, shares many of the key advantages as the Ministry of Education and Skills Development in being able to reach the important youth segment of the population. With such a broad and cross-cutting mandate, the Ministry can cultivate linkages between and across sectors to ensure that issues regarding the youth (particularly the out-of-school) are mainstreamed. Additionally, it can use the medium of sports as well as bringing elements of national cultures to bear on key issues related to the response. Specific responsibilities may include:

- Adapting cultural stories for disseminating HIV prevention and AIDS care and treatment messages for specific target audiences.
- Developing sports and culture oriented youth centres to reach at risk youth populations with appropriate messages and services.
- Utilizing national and local sports teams to contribute to and facilitate the implementation of national response programming.
- Providing technical expertise and resources for the development of culturally relevant HIV and AIDS related materials of other stakeholders.
- Developing HIV and AIDS programmes specifically targeting out-of-school and unemployed youth.
- Coordinating and expand implementation of planned activities through youth centred civil society organizations, especially at the local level.
- Strengthening the Ministry's leadership role in the advocacy for and the development of HIV and AIDS related policy and legislation for the youth.
- Mainstreaming HIV and AIDS into girl child and boy child programmes.

4.2.11. Ministry of Trade and Industry

As one of the key ministries concerned with the economic growth and diversification of the country, HIV and AIDS and its impacts on the economy must be an important focus. Being responsible for imports and trade, the Ministry plays a key role in securing access to essential commodities for all areas of the national response. Providing these commodities on preferential terms should be a central feature of MTT's involvement. Additionally, throughout the NSF I period the Ministry's responsibilities were mainly focused on policy and legislation. This attention should continue during the NSF II period. Specific responsibilities may include:

- Integrating HIV and AIDS into policy and legislative instruments, such as the Trade and Liquor Act, the Industrial Development Policy and the Small, Medium and Micro Enterprise Policy.
- Improve regulation of the granting of liquor licenses.
- Promote the development of appropriate HIV and AIDS policies in the private sector, especially amongst those that do business with Government.
- Assist and support efforts to promote cost effectiveness in procurement of vital HIV and AIDS related commodities.

4.2.12. Ministry of Transport and Communications

Government infrastructural development projects continue to be one of the mainstays of the local economy with millions of Pula being invested in road works, civic buildings and utilities. Several major infrastructural development projects have been slated for the NDP 10 period, up to 2016, and will have an influence on the implementation of plans under the NSF II. Given the impact such projects have on elevating the risk of spreading HIV infection, with a significant role to play in the management of this development, the Ministry should keep the response to HIV and AIDS very much in focus as these projects are being planned and implemented.

- Integrating internet and mobile telephony into programme design and implementation.
- Promote the development and devote specific television air time to shows related to the HIV and AIDS response.
- Provide leadership in advocating policy development and legislation that promote the expansion and utilization of communications technologies for the national response.
- Facilitate the linkage of various HIV and AIDS related programmes through communications technologies, e.g. call-in information and referral services.

4.2.13. All Ministries and Departments.

Without being specifically mentioned here, all Ministries and Departments within the Government have a role to play in the national response that is largely executed through the mainstreaming of HIV and AIDS into each Ministry or Department's internal, or workplace domain and the external domain. Specific responsibilities for all Ministries and Departments should include:

- Developing and implement HIV and AIDS specific workplace interventions.
- Ensuring integration of HIV and AIDS into policies and administrative procedures.
- Monitoring implementation of mainstreaming.
- Undertaking research and segment both institutional personnel and clientele.
- Where appropriate, developing HIV and AIDS related interventions aligned to the institutional mandate, capacity and scope of operations that target specified client segments,

or develop business strategies or modify current business practices so that they meet the changing needs of identified client segments.

4.3 Private Sector

The involvement of the Private Sector in the national response to HIV and AIDS has not been realised to its fullest potential. The NSF I involved the private sector only peripherally and made no significant efforts to cultivate a potentially powerful partner in the national response. Despite this the private sector did move forward, responding to HIV and AIDS through implementation of the Minimum Implementation Package (MIP), which provided direction for establishing or strengthening workplace programmes. Strengthening their participation in the national response offers an opportunity to tap into Private Sector expertise and other resources in new ways. Specific responsibilities for the Private Sector may include:

- Applying Private Sector tools and techniques such as market segmentation and product or service research, and branding.
- Undertaking mainstreaming of HIV/AIDS into the internal and external domains of private sector enterprises and, through partnerships and experience sharing, in the public sector as well.
- Utilizing private sector products, logistical networks, and advertising channels to support implementation of HIV and AIDS plans.
- Supporting the national monitoring and evaluation system by supplying private sector tools information and sharing best practices.
- Mobilizing additional resources for planned activities, including the financing of events and research.
- Providing mentoring to other private sector companies in terms of responding to the epidemic.

4.4 Civil Society

Civil Society, used here to denote community, religious and other non-governmental organisations, is a key partner in the response to HIV/AIDS. Civil Society has grown and has played an increasingly important role in the expansion of programmes through outreach and targeting marginalized populations such as sex workers, people with disabilities, sexual minorities, and displaced persons. Additionally, their programmes are often well received by target populations due to their civic, rather than governmental, nature. By adding their multiple points of interface with specific target groups, Civil Society can expand the capacity of initiatives to address issues on many different fronts. The responsibilities of Civil Society may include:

- Identifying and assisting community organizations and structures to mobilize human, financial and material resources.
- Participating in local level peer review mechanisms to assist with the development and review of the Joint National Operational Plan.
- Strengthening Civil Society's leadership role in advocacy and lobbying activities.
- Supporting the development of a national HIV and AIDS research and evaluation agenda and participate in their implementation.
- Promoting the development of local level support groups and networks.
- Improving coordination among Civil Society Organizations at all levels, and between Civil Society and other stakeholders in the national response.

- Expanding the current role in the provision of HIV and AIDS related services.
- Strengthening local level programmatic monitoring and ensure quality data gathering, analysis and utilization.

4.5 Development Partners

Development partners are key collaborators in Botswana's national response to the HIV epidemic. They are instrumental in providing necessary inputs, in terms of financial resources, technical expertise and material supplies in the fight against the epidemic. It is envisaged that throughout NSF-II this partnership would continue to promote the effective implementation of the national response. Through their involvement in jointly developing and reviewing operational plans, Development Partners will bring global experience to bear while defining their specific contributions to the national response. Some specific responsibilities of Development Partners may include:

- Supporting information exchange through participation in coordinating structures and facilitating international exchange visits.
- Channelling assistance through a single entry point for HIV/AIDS interventions in the country to avoid duplication and ensure sustainability of services.
- Ensuring, within the context of their existing agreements, adaptability to respond to emerging priorities and specific intervention areas.
- Assisting the development of review of joint operational plans through global experience, knowledge and information exchange.
- Enhancing support by rationalizing and streamlining reporting, and planning periods with national standards and strengthening inter-organization or inter-agency coordination.

4.6 The Media

The Media is a powerful and influential force in determining the public's perceptions of life in our rapidly transforming society. The many channels of media have a critical influence on our behaviours, inclinations and preferences. In this era of abundant and instant information, one cannot deny the public agenda-setting role of the media. It has long been recognised that the mandate of the media includes stimulating debate, advocacy and helping to re-invigorate the sense of community and voluntarism in the face of the epidemic. Ultimately, the media can do a great deal to develop public ownership of the national response. They are, therefore, significant agents of change. Over the course of the NSF I, the media has developed an increasingly sharper focus on addressing HIV and AIDS. It has developed policies and codes of conduct relating to the management of HIV and AIDS and its reportage. Working both collectively and individually, they have put together numerous publications, radio and television programmes, and have trained personnel in areas related to HIV and AIDS. These efforts will continue throughout the NSF II, in addition to other responsibilities which may include:

- Advocating for alternative channels of resources that will enable the media to play an innovative and consistent role in the national response.
- Providing support to research, monitoring and evaluation through dissemination of results and findings to enhance public awareness and understanding of priority HIV and AIDS related issues.
- Enhancing the participation of all media channels in the national response through integrated cross-sectoral communications activities.
- Strengthening media HIV and AIDS capacity through period training and international media exchange programmes.

- Providing active advocacy support for key strategic HIV/AIDS issues.
- Developing a systematic, collaborative programme for media editors covering journalism theory, ethics and practice with expert sessions on various HIV and AIDS related topics.
- Mobilize and galvanize communities for greater participation in HIV and AIDS planning, research, implementation, evaluation and documentation.

4.7 Organised Labour

Organised Labour has a unique role to play in the fight against HIV and AIDS especially as it affects their members in the workplace. Historically, organized labour has been somewhat overlooked in the fight against HIV and AIDS, perhaps due to misconceptions around Labour itself, which should be seen as an organized entity in and of itself, rather than as a function under the auspices of any ministry. In particular, Labour's participation in the development of the first National Strategic Framework 2003-2009 was rather limited. Labour has long recognized that the national response to HIV and AIDS is not just about health, but obviously involves important human resource issues in which the labour movement must play a role. Further, Labour is well positioned to advocate for legislation and the protection of fundamental rights within the world of work. Additionally, Labour offers the national response an entry point to assist with the establishment and maintenance of workplace wellness programmes. Under the NSF II, Labour can have a voice in setting the tone and direction of the national response for the next seven years. Some specific responsibilities of Labour may include:

- Participating in the development and implementation of Joint Planning and Review processes for the National Operational Plan.
- Ensuring the dissemination and understanding of relevant policies, guidelines, codes of conduct among workers.
- Developing and implementing specific programme components for labour, in partnership with employers, for labour members both inside and outside the workplace.
- Strengthen Labour's integration within national and sub-national coordinating structures.
- Strengthening Labour's leadership role in advocating for advances in labour law and policy development, especially in terms of linking HIV and many other areas including poverty, gender, and the world of work.
- Developing strategies to link workers with a range of HIV and AIDS related services for prevention, treatment, care and support.

4.8. Guidelines for deriving operational plans

This Second National Strategic Framework will be accompanied by a National Operation Plan (NOP) that will address each of the priority areas and provide more details on the broad projects and activity outlines, implementation roles and responsibilities, costs, and monitoring plan. These plans will drawn up jointly from the strategies outlined within this document and establish milestones to be achieved during the intervening period in order to realize the purpose and goal of the overall national response.

In order to derive operational plans all stakeholders will start from the NSF objectives and outcomes to which they are most related and find the strategies and activities which their key institutions both public and private are programmed to implement. The Strategic Logical Framework included in the NSF II, will provide guidance with regards to outcomes and targets. In the event that a sector does not find any strategy relevant to it in the NSF, it should initiate dialogue with NACA so that its views can be accommodated in the NSF during the midterm

review. Similarly all donor supported activities and programmes must indicate the objectives, strategies and activities⁶ of the NSF to which they are contributing.

Joint Planning begins to move the national response in Botswana from one involving multiple sectors, to one being multi-sectoral and collaborative. While there is intrinsic value in the mobilisation of all sectors in the response, it is of greater importance that these sectors work together to collectively address critical issues and achieve maximum impact. Joint planning achieves this by providing a methodology to practically apply a multi-sectoral approach, whereby sectors can address, in a concerted and organised way, the achievement of results in specific priority areas. Joint Planning clarifies the strategic linkages and common milestones toward which all sectors will collectively work.

Reorienting the national response using results-based Joint Planning is not meant as an immediate substitute for action already being undertaken by the various stakeholders; it is understood that institutional alignment and the balancing and merger of relative planning cycles is a time consuming process that will have to be worked toward over the implementation of the NSF. However, the effort is intended to strengthen and align, over time, the way in which the national response is implemented. It represents an important and critically needed intensification of efforts providing a realistic means of ensuring that concrete, measurable and concerted progress is made in crucial areas of national concern.

It will be remembered that one of the important focal areas for the NSF II is empowering and mobilizing communities for greater action in the national response. One of the ways in which this can be realized is through ensuring participation in the development of the NOP. Following what was done through the National Strategic Framework development process, local level representatives may be co-opted into the actual development, and what has been deliberated at the central level will be communicated to the local level for peer review and feedback. Local level information will be used to verify national level perceptions and provide guidance for further implementation of the initiative, or the development of additional initiatives. This cycle of interaction will greatly assist with securing the necessary local level input and buy-in for the implementation toward and monitoring of results.

While at the public policy level, this NSF attempts to steer the response toward greater reliance on evidence and results, it is through Joint Planning and Review that the national response will achieve greater focus. Reviewing performance, programmatically and financially, in the achievement of agreed results is a way of promoting a learning culture where results become increasingly focused and defined based on a broader and deeper knowledge base, which in turn support the development of better programmes to actually achieve the expected results.

⁶ As will be found in the National Operation Plan to be developed

ANNEX 1: National Strategic Logical Framework for the NSF II 2010-2016

GOAL	Objectively Verifiable Indicator (OVI)	Target	Baseline	Means of Verification (MOV)	Assumptions
Prevent new HIV infection by 2016	<ul style="list-style-type: none"> HIV incidence rate 	1.4% (2008 baseline – 2.9%)	<ul style="list-style-type: none"> (Proxy) BAIS III (2008) 11.2% BAIS III (2008) 39.6% BAIS III (2008) 42.1% (for 15-24 year olds) BAIS III (2008) 62.9% 	<ul style="list-style-type: none"> BAIS report Sentinel surveillance reports 	
<p>PRIORITY 1: Preventing New HIV Infection</p> <p>Strategic Objectives:</p> <p>(1) To reduce the incidence of sexual transmission of HIV among females and males aged 10-49 years</p> <p>(2) To increase access to health care services for HIV prevention</p>					
OUTCOMES					
1.1. Increased proportion of females and males aged 10 – 49 practicing safer sexual behaviour	<p>Objectively Verifiable Indicator</p> <ul style="list-style-type: none"> Proportion of males and females who engage in MCP Proportion of people aged 15-49 years who always use condoms with non-regular partners in the last 12 months Proportion of young people aged 10 – 24 years who correctly identify ways of preventing sexual transmission of HIV Proportion of persons, 15-49 years, who were drunk before their last sexual intercourse and used a condom 	<p>Target</p> <ul style="list-style-type: none"> 5.6% 60% 65% 75% 		<p>Means of Verification</p> <ul style="list-style-type: none"> BAIS report BAIS report BAIS report BAIS report 	
1.2. Improved utilisation of health care services for HIV prevention	<ul style="list-style-type: none"> Proportion of persons aged 15-49 years who have tested within the last 12 months and know their HIV status Proportion of VCT clients who access HCT as couples Proportion of 0-49 year old HIV-negative males circumcised in health facilities Proportion of HIV positive pregnant women accessing Universal HAART Proportion of MARPS¹ utilizing HIV Prevention services 	<p>Target</p> <ul style="list-style-type: none"> 60% 30% 80% 90% TBD 	<ul style="list-style-type: none"> BIAS III (2008) 41.2% (Proxy) Tobeloapele (2008) 8% (Proxy) BAIS III (2008) 11.2% (for all males) (Proxy) PMTCT (2009) 28% NO BASELINE² 	<ul style="list-style-type: none"> BAIS report NAC Reports BAIS report, Programme reports MoH/ NAC reports 	

1 Current MOH definition includes: sex workers, truck drivers, seasonal farm workers, and construction workers but can be expanded

2 Where no baseline is indicated, these are to be conducted in 2010

PRIORITY 2: Systems Strengthening

Strategic Objectives:

- (1) To strengthen community and health systems capacity for Universal Access to quality, comprehensive and sustainable HIV and AIDS services
- (2) To effectively coordinate, harmonize and align stakeholder support to the national response at all levels
- (3) To sustain and strengthen political leadership and commitment on HIV and AIDS at all levels
- (4) To improve the ethical and legal environment for the national response

OUTCOMES	Objectively Verifiable Indicator	Target	Baseline	Means of Verification
2.3.1 Communities empowered to effectively respond to HIV and AIDS	<ul style="list-style-type: none"> ● Proportion of community structures³ providing quality and cost-effective services 	<ul style="list-style-type: none"> ● 70% 	<ul style="list-style-type: none"> ● (Proxy) BAIS II (2004) 37%⁴ 	<ul style="list-style-type: none"> ● Surveys ● District reports
2.3.2. Improved access to quality HIV and AIDS services	<ul style="list-style-type: none"> ● Proportion of health facilities providing quality and cost-effective services 	<ul style="list-style-type: none"> ● TBD 	<ul style="list-style-type: none"> ● NO BASELINE 	<ul style="list-style-type: none"> ● Surveys ● Program reports
2.4.1 Partners aligned to national priorities and held accountable	<ul style="list-style-type: none"> ● Proportion of partners aligned to national priorities and strategies 	<ul style="list-style-type: none"> ● 100% 	<ul style="list-style-type: none"> ● NO BASELINE 	<ul style="list-style-type: none"> ● NASA reports ● Surveys ● Programme reports
2.5.1 National response adequately resourced	<ul style="list-style-type: none"> ● Improved resource/budgetary allocation for the national response 	<ul style="list-style-type: none"> ● TBD 	<ul style="list-style-type: none"> ● NO BASELINE 	<ul style="list-style-type: none"> ● NASA reports
2.6.1 Ethical and legal environment for HIV and AIDS improved	<ul style="list-style-type: none"> ● Number of supportive policies and legislations reviewed and/or enacted ● Meaningful⁵ participation of civic bodies in the review and/or development of policies ● Stigma and discrimination index⁶ 	<ul style="list-style-type: none"> ● TBD 	<ul style="list-style-type: none"> ● NO BASELINE 	<ul style="list-style-type: none"> ● Policies and legislations
		<ul style="list-style-type: none"> ● 100% 	<ul style="list-style-type: none"> ● NO BASELINE 	<ul style="list-style-type: none"> ● Surveys
		<ul style="list-style-type: none"> ● TBD 	<ul style="list-style-type: none"> ● NO BASELINE 	<ul style="list-style-type: none"> ● Surveys

3 VMSAC, CBOs, FBOs, PTAs and other local structures (e.g. burial societies, co-ops, etc.)

4 Percentage of people surveyed who “participated” in HIV prevention campaigns

5 To be defined

6 Index to be defined

PRIORITY 3: Strategic Information Management

Strategic Objective:

To strengthen the information management system of the national response to enhance information sharing and utilisation for evidence based planning

OUTCOMES	Objectively Verifiable Indicator	Target	Baseline	Means of Verification
3.7.1: Increased availability of quality, comprehensive and harmonized information on the response to the epidemic.	<ul style="list-style-type: none"> Proportion of programme M&E systems aligned to the National M&E framework Timely and consistent delivery of quality partners reports Proportion of HIV and AIDS budget allocated to M&E 	<ul style="list-style-type: none"> 90% Quarterly 10% 	<ul style="list-style-type: none"> NO BASELINE NO BASELINE NO BASELINE 	<ul style="list-style-type: none"> Prog. M&E plans; reports Prog. M&E plans and reports Nat. Op. Plan
3.7.2 Improved utilization of information by partners for policy development, advocacy and programming	<ul style="list-style-type: none"> Number of dissemination forums at all levels Proportion of partners guided by the national HIV and AIDS response information in the development of their programmes 	<ul style="list-style-type: none"> TBD 100% 	<ul style="list-style-type: none"> NO BASELINE NO BASELINE 	<ul style="list-style-type: none"> Dissemination Strategy⁷ Surveys
3.7.3 Improved basic and operational research, monitoring and evaluation of the HIV and AIDS response	<ul style="list-style-type: none"> Proportion of programmes informed by evaluation findings Proportion of approved evaluation recommendations implemented Proportion of HIV and AIDS related research proposals approved by the relevant authority Proportion of approved HIV and AIDS related research completed 	<ul style="list-style-type: none"> 90% 90% 95% 90% 	<ul style="list-style-type: none"> NO BASELINE NO BASELINE NO BASELINE NO BASELINE 	<ul style="list-style-type: none"> Programme reports Compendium of conducted research Performance Index

⁷ To be developed in 2010

PRIORITY 4: Scaling Up Treatment, Care and Support

Strategic Objective:

To increase access⁸ to HIV/AIDS comprehensive quality treatment, care and support services.

OUTCOME	Objectively Verifiable Indicator	Target	Baseline	Means of Verification
4.8.1. Improved access to comprehensive quality treatment care and support services	<ul style="list-style-type: none"> ● Proportion of HIV+ persons accessing integrated HIV/TB/SRH services ● Proportion of HIV+ children and adolescents accessing a package of HIV/AIDS treatment, care and support⁹ ● Proportion of population in need who access comprehensive quality CHBC services ● Percentage of households with OVC receiving free basic external support for care and support in the last 12 months 	<ul style="list-style-type: none"> ● 80% ● 90% ● 80% ● 70% 	<ul style="list-style-type: none"> ● VCT (2009) 63% ● Baylor (2009) 22% ● (Proxy) BAIS III (2008) 49% of households ● BAIS III (2008) 31.2% 	<ul style="list-style-type: none"> ● MOH/NAC report; ● MoH BNTP report ● MoH/NAC report ● BAIS report; NAC report ● BAIS report

⁸ Access as defined by UNGASS and contextualised

⁹ A package has been developed and piloted allowing for the measurement of all three elements as a single deliverable

REFERENCES

1. CSO (2006). *Access to Health Services in Botswana*, Statistical Brief No. 2007/4, Gaborone: Government of Botswana.
2. CSO (2006). *Botswana Demographic Health Survey*. Gaborone: Government of Botswana.
3. Halperin, D. & Epstein, H. (2004). "Concurrent sexual partnerships help to explain Africa's high HIV prevalence: implications for prevention." *Lancet* 364(9428): 4-6.
4. Merson, M., Padian, N., Coates, T., Rao Gupta, G., Bertozzi, S., Piot, P., Mane, P. & Bartos, M. (2008). "Combination HIV prevention." *Lancet*, 372 (9652): 1805-1806.
5. Ministry of Health, (2006). *Behaviour Change Interventions & Communication Strategy for the Health Sector – 2006-2009*. Gaborone: Government of Botswana.
6. National AIDS Coordinating Agency (2002). *BHRIMS Report of Assessment of Needs and Capabilities for Monitoring and Evaluation in Botswana*. Gaborone: Government of Botswana.
7. National AIDS Coordinating Agency (2007). *The Mid-Term Review of the Botswana National Strategic Framework for HIV/AIDS 2003-2009: On the Road to Vision 2016*. Gaborone: Government of Botswana.
8. National AIDS Coordinating Agency (2008). *National Operational Plan for Scaling Up HIV Prevention in Botswana: 2008-2010*. Gaborone: Government of Botswana.
9. Piot, P. (2006). "AIDS: from crisis management to sustained strategic response". *Lancet* 368 (9534): 526-530.
10. Southern African Development Community (2006). *Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa: Report*, Gaborone: SADC Secretariat.
11. UNAIDS (2005) *Intensifying HIV Prevention: a UNAIDS Policy Position Paper*, Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS.
12. UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: Joint United Nations Programme on HIV/AIDS.
13. WHO (2006). *Scaling up antiretroviral therapy in resource-limited settings: treatment guidelines for a public health approach 2006 revision*. Geneva, Switzerland: World Health Organization.



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