

# BOTSWANA LEADS THE WAY

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From the brink of disaster  
towards an HIV-free future

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Republic of Botswana



MINISTRY of HEALTH  
REPUBLIC OF BOTSWANA



*Hand-made ribbon crafted by women of the Grow Program,  
a micro-savings initiative supported by PCI*

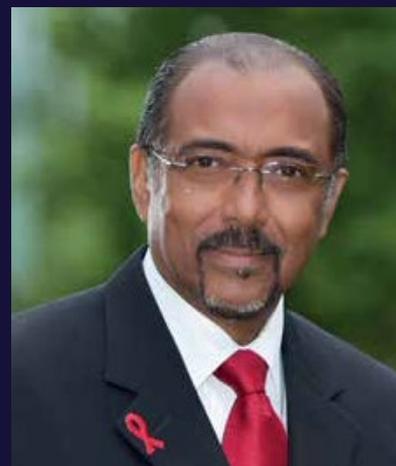


# BOTSWANA LEADS THE WAY

FROM THE BRINK OF DISASTER  
TOWARDS AN HIV-FREE FUTURE

# JOINT FOREWORD

MESSAGE FROM



Botswana has been at the forefront in responding to HIV in the world. The AIDS epidemic has deeply affected the country, caused suffering and needed to be responded to with unity and committed strength. Over the years, Botswana has proven leadership in responding to the disease in determined and innovative ways.

Today, having moved from the brink of disaster towards a future, where an HIV-free society is envisageable, it is time to tell the successful story which actually crossed generations as part of the global response and highlight our continued commitment to lead the way until the end of the AIDS epidemic in Botswana.

Botswana's successful response can be attributed to three major elements: leadership, partnership and innovation. It highlights not only the leadership at highest level, but also shows the contributions of strong, dedicated stakeholders and partners, and willingness to adopt the most recent scientific developments.

Botswana has adopted the UNAIDS fast-track targets towards meeting the Sustainable Development Goals and ending the AIDS epidemic by 2030, as evidenced by the launch of the Treat All Strategy on 3rd June 2016. Botswana is on track to meet the 90-90-90 treatment targets by 2020 with continued leadership support, partnership and innovations.

It is our pleasure to present to you this documentation of the Botswana successful story as a contribution to the global knowledge base on the response to HIV.

A white ink signature of Ms Dorcas Makgato, written in a stylized, cursive font.

**MS DORCAS MAKGATO**

**Minister of Health, Botswana**

A white ink signature of Mr Michel Sidibé, written in a stylized, cursive font.

**MR MICHEL SIDIBÉ**

**UNAIDS Executive Director**

# INTRODUCTION

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Botswana's first case of HIV was diagnosed in 1985. Since then the epidemic has posed countless challenges to this small nation of 1.7 million people. But even when the outlook seemed disastrous, the country has continued to respond with courage and dedication. Today Botswana's HIV response is recognized as a regional --and even global -- model of success. The secret of this achievement is down to three main ingredients: strong and dedicated leadership, creative and committed partnerships, and evidence-informed innovation.

This publication tells the remarkable story of Botswana's achievements in confronting the AIDS epidemic and its commitment to continue that struggle until full epidemic control is reached and all citizens are secure in a healthy future.

## **The early years**

Within two years of the first HIV diagnosis the Botswana government, with support from the World Health Organisation (WHO), had established a National AIDS Control Programme (NACP) and a solid plan<sup>1</sup> to increase public awareness and train health workers.

As the epidemic continued to expand, a specialized independent unit, the AIDS/STD Unit, was established within the Ministry of Health to coordinate the national programme. While early efforts had focussed on health-related issues such as blood safety and treatment of opportunistic diseases, subsequent national plans broadened their remit to cover the prevention of sexual transmission of HIV, as well as care and support for people infected and affected by HIV. Botswana pioneered a community home based care programme that provided services to chronically or terminally ill people, the majority of whom were living with HIV. At its peak, volunteers were caring for over 12,000 people in their homes and communities.

Despite these efforts, the epidemic took hold of the country and by 1993, more than half of all beds in the paediatric and medical wards of the two national referral hospitals were occupied by patients with HIV-related illnesses. By the mid-1990s the epidemic was taking its toll and tackling it had become a government priority.

In 1996, when the government published its broad national vision for the country's future (Vision 2016) it set a 20-year target of ending new HIV infections. To achieve this goal it was clear that a wide range of stakeholders would be required to work together in a concerted effort. In 1997 a national multisectoral plan was adopted to tackle HIV and AIDS. Led by the Ministry of Health, the plan included various government and non-governmental sectors and organisations: the scene was set for a comprehensive response.

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<sup>1</sup> See box Making a Plan for a more detailed description on the national plans.

# QUOTES

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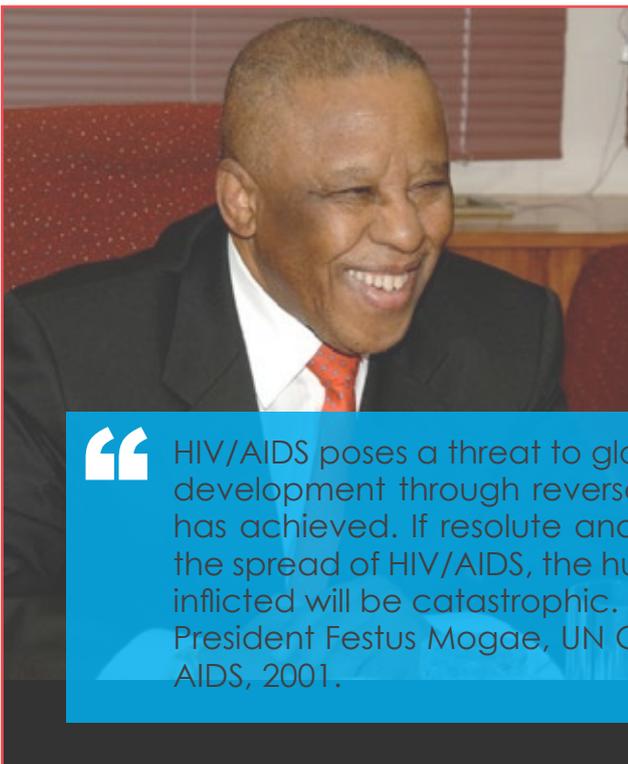
HIS EXCELLENCY  
THE PRESIDENT LIEUTENANT  
GENERAL DR. SERETSE KHAMA  
IAN KHAMA

*Treat All Launch, Oodi, 2016*

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“ The investment that we are making in the New HIV “Treat All” Strategy today is an investment in ensuring a healthy and disease free future for all Batswana – young and old.

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FESTUS G. MOGAE FORMER  
PRESIDENT OF THE REPUBLIC  
OF BOTSWANA AND CHAIRMAN  
OF THE CHAMPIONS OF THE HIV  
FREE GENERATION

*Gaborone, 2007*

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“ HIV/AIDS poses a threat to global security, peace as well as sustained development through reversal of development gains that the world has achieved. If resolute and concerted action is not taken against the spread of HIV/AIDS, the human death toll and suffering that will be inflicted will be catastrophic.  
President Festus Mogae, UN General Assembly Special Session on HIV AIDS, 2001.

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# LEADERSHIP

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**Mopaki Kotsi, *Break the chain*, 2011**

Nna le seabe HIV/AIDS Art Awareness Programme is led by the Ministry of Youth, Sports and Culture. The programme meaning 'You have a role to play' in Setswana, involves local artists in the fight against HIV and is held annually.

In 2000 Botswana's HIV epidemic entered the world stage when it was declared a national emergency, a crisis of the first magnitude. The shocking statistics were repeated in headlines everywhere -- 36.2% of all adults HIV positive! Life expectancy to plummet to 49 years! The then president, His Excellency Festus Mogae, led the country's commitment to deal with the crisis.

The epidemic had already been a priority for the government for more than a decade, but by the turn of the millennium prevention programmes were still not optimal and HIV prevalence had reached an unacceptable level. What worried the Cabinet almost as much as the terrifying figures and projections was the macro-economic impact of AIDS on the country. A report commissioned by the Ministry of Finance and Development Planning estimated that the economy would shrink by one quarter in 25 years. The AIDS epidemic was threatening to reverse all development goals.

# Leadership at the highest level

This urgent and unacceptable situation catalysed Botswana's political commitment and its remarkable national response that continues to the present day. Political leaders have shown a personal dedication to establishing, strengthening and leading the country's HIV response. Some key events include:

- **1999** : A Presidential Cabinet Directive establishes the National AIDS Council (NAC) to coordinate the national response. It is chaired by President Mogae and situated in the Office of the State President.
- **2001** : President Mogae addresses the United Nations General Assembly on HIV/AIDS.
- **2008** : President Mogae is appointed as the Chair of the "Champions of the HIV free Generation", which gathers influential public figures to advance the AIDS agenda in the region and beyond.
- **2009** : The Parliamentary Portfolio Committee on Health and HIV/AIDS is established, playing a critical role in overseeing and guiding on HIV initiatives nationally.
- **2014**: President Lieutenant General Dr. Seretse Khama Ian Khama pledges to eradicate Mother to Child Transmission.
- **2015** : Vice President Mokgweetsi Masisi takes over the Chair of the National AIDS Council.
- **2015** : the Mayor of Gaborone champions the city initiative to promoting HIV testing ("the first 90").
- **2016**: President Lieutenant General Dr. Seretse Khama Ian Khama launches the Treat All Strategy.

## Building the response

While presidents and politicians have played a visible and important public role, they have also been pivotal in building and leading the structures necessary for a robust, coordinated response.

Central to this has been the National AIDS Council (NAC), the multisectoral body leading the national effort, and its secretariat, the National AIDS Coordinating Authority (NACA). While the Ministry of Health has played a leading role in the health response, the work of other government departments has been critical. Civil society and the private sector are also active members of the NAC, whose activities are coordinated by NACA. The focus is on planning, prevention, community support and monitoring and evaluation.

By 2002 all of Botswana's 27 districts had established District Multi-Sectoral AIDS Committees (DMSAC). This multi-sectoral, localized approach has provided a platform to discuss and coordinate issues at district level and therefore improve programme implementation across the country.

Alongside the development of effective coordination structures, successive national HIV plans have matured in complexity and sophistication. In 2003 a new National Strategic Framework (NSF I, 2003-2009) addressed coordination and management issues and was the first to be aligned to the national development plan.

NSF I explored new ways of thinking and combined the lessons from both Botswana's experience and the international situation to provide a more robust framework aimed at effective implementation. This refined and targeted approach -- including mainstreaming HIV into various government programmes -- gave additional strength to the national HIV response. In 2010 the second National Strategic Framework, NSF II provided a complete roadmap to an integrated multisectoral response.

The multisectoral plans gave government ministries, civil society organisations and other key actors clear roles and responsibilities to take the lead in their areas of work. For example:

- **Ministry of Local Government and Rural Development (MoLGRD)** : managing district coordination and the programme to support orphans and vulnerable children.
- **Ministry of Education and Skills Development (MoESD)** : mainstreaming HIV into the curriculum and promoting life skills training.
- **Ministry of Youth, Sport and Culture (MoYSC)** : integrating HIV into youth activities.
- **Botswana Defence Force** : promoting HIV counselling and testing, condom use and safe male circumcision.
- **Ministry of Labour and Home Affairs (MoLHA)** : supporting HIV workplace policies, addressing gender based violence and support for the men's sector.

In 2015 NACA was placed under the Ministry of Health. This was part of a wider rationalization of Government portfolios aimed at maximizing resources, improving organizational efficiency and strengthening collaboration.

## MAKING A PLAN

1985	National Minimum Programme	National plans focus on clinical aspects of HIV.
1987-1989	Emergency Short term Plan	National plans focus on clinical aspects of HIV.
1989-1993	Medium Term Plan I (MTP I)	Plan expands to include prevention, care and support
1997-2002	Medium Term Plan II (MTP II)	Shift to seeing HIV as a development issue. First fully multisectoral plan.
2003-2009	National Strategic Framework I (NSFI)	Multisectoral plan assigns roles and responsibilities to all stakeholders.
2009-2016	National Strategic Framework II (NSF II)	Plan focuses and intensifies activities. HIV prevention a key priority.

## Programmatic leadership

The keen leadership of Botswana's HIV response has ensured that the country has benefitted from international evidence and best practice. Botswana has been an early adopter and regional leader in many programmatic areas, particularly in its

national rollout of programmes that in many other countries existed initially as pilots. Highlights here include:

- **1995** : Implementation of a national home based care programme;
- **1999** : Launch of a plan of action to meet basic needs and provide psychosocial support for orphans and vulnerable children;
- **2000** : Rollout of a national programme to prevent the transmission of HIV from mother to child (PMTCT);
- **2002** : Launch of a national antiretroviral therapy (ART) programme;
- **2015** : Launch of the national Option B+ Programme; and
- **2016** : Adoption of the Treat All Strategy to provide ART to all people living with HIV, regardless of HIV status.

## Financial commitment

The Government of Botswana has followed through its political commitment with generous and consistent funding for HIV and AIDS programming. Between 2003 and 2015 the total estimated expenditure on HIV and AIDS from the Government of Botswana was around 17.19 billion BWP (2.42 billion USD at nominal exchange rate from the Bank of Botswana).

The bulk of the funding, over 60%, for Botswana's HIV response, comes from the government, rather than donors -- making Botswana one of only three African countries whose domestic spending on HIV exceeds funding from other sources.



Artists at work during the 2014 workshop of the Nna le seabe HIV/AIDS Art Awareness Programme.



90-90-90 Mayors Test Drive, 2015, Gaborone.

# QUOTES



Vice President Mokgweetsi Masisi having an HIV test in Tonota village, Central District, 2015, during the World AIDS Day Commemorations.



“Home-based care is taking us back to the root of human coexistence. It reminds us that we all have the responsibility to one another. If we hold hands through this tragedy...we will be able to retain our humanity and will come out of this epidemic as a stronger community.

MRS JOY PHUMAPHI, MINISTER OF HEALTH, 1999,  
BOTSWANA.



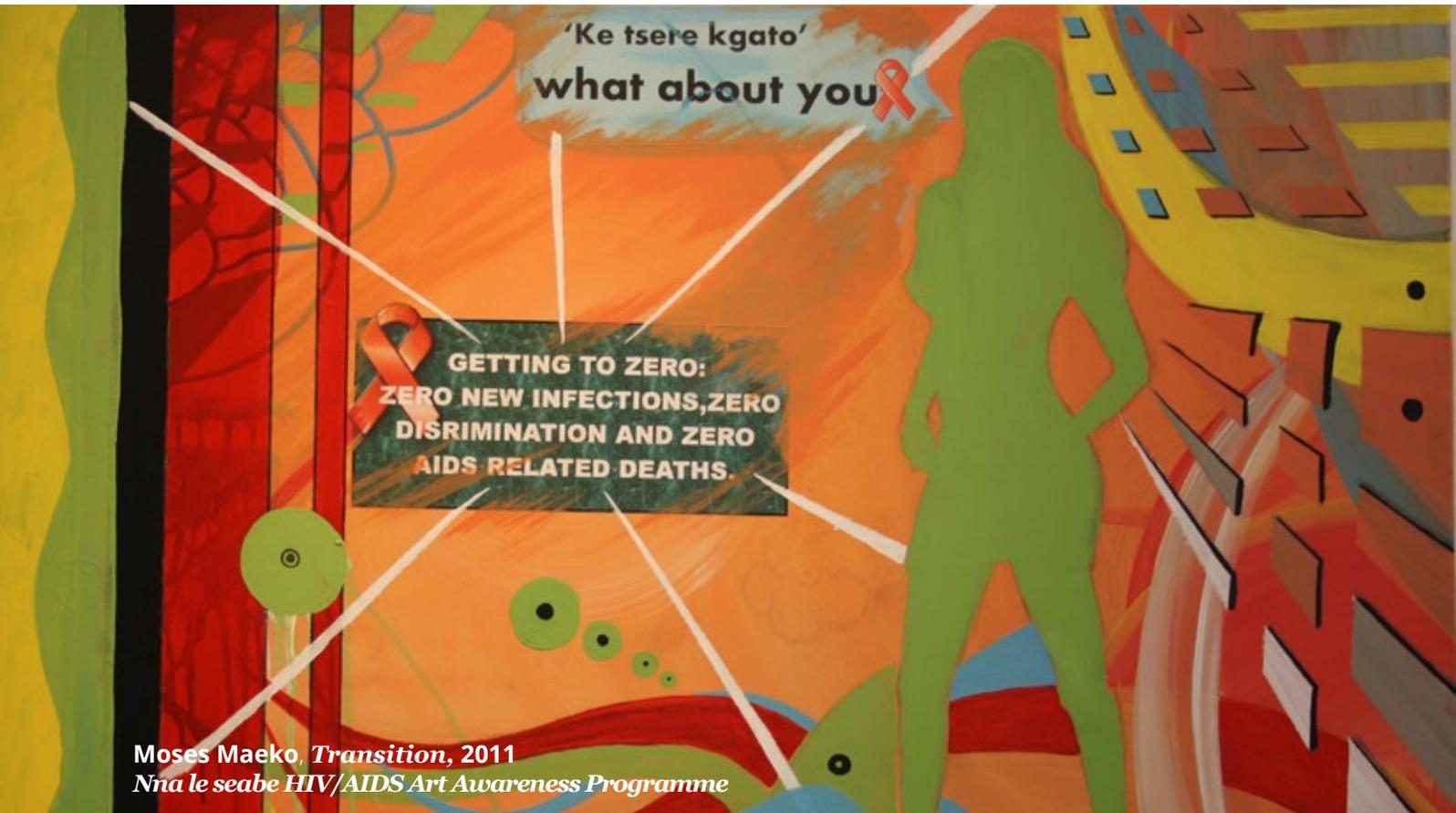
## TOGETHER AGAINST HIV & AIDS



LET'S GET  
TESTED

Poster promoting HIV testing, featuring members of the Parliamentary Portfolio Committee on Health and HIV/AIDS, (l - r) Hon. Gilbert Mangole, Hon. Billy Buti, Hon. Mohammed Khan, and Hon. Sethomo Lelatisitswe.

# PARTNERSHIPS



Moses Maeko, *Transition*, 2011  
Nna le seabe HIV/AIDS Art Awareness Programme

From the start, Botswana has been a model of best practice in partnerships for the HIV response. The NACA and government departments have provided leadership and worked with a wide range of development partners, academic institutions, private sector actors and civil society organizations to develop and implement HIV and AIDS programmes.

The full list of partners is too long to document here. Highlights include:

- **BHP, 1996** : The Botswana-Harvard Partnership (BHP) had an initial focus on locally relevant HIV research. Highlights included the building of an HIV Clinical Reference Laboratory in 2001, the first of its kind in Africa. BHP also collaborated with the Ministry of Health to develop the KITSO AIDS training programme for Botswana's health care professionals and supported a number of important research studies (see research section below).
- **ACHAP, 2000** : The Government of Botswana, the pharmaceutical company Merck and the Gates Foundation launched the African Comprehensive HIV/AIDS Partnership (ACHAP) to fund and develop the first national antiretroviral therapy programme on the African continent. ACHAP has also supported the work of civil society organisations, the training of health workers and other programmes such as Safe Male Circumcision. A cost-effectiveness study<sup>2</sup> of the ACHAP programme estimated that the ART programme saved 165,000 lives, and together with the male circumcision programme, averted 114,000 new infections.

- **BOTUSA, 2002** : The BOTUSA Project is a collaboration between the Government of Botswana and the US Centers for Disease Control and Prevention (CDC). It has provided technical assistance, funding and implementation support for a wide range of prevention, treatment, care and support programmes. In its early years it was instrumental in expanding HIV testing and PMTCT services with focus on early-infant diagnosis (EID). This partnership led to the creation of Tebelopele, which runs voluntary counselling and testing centres.
- **Secure the Future, 2003** : The Bristol-Myers Squibb Foundation provided funding for the Botswana-Baylor Children's Center of Excellence in 2003.
- **PEPFAR, 2004** : Since its inception the United States President's Emergency Plan for AIDS Relief has delivered more than 706 million USD in health assistance. It has developed a wide range of partnerships<sup>3</sup> to support capacity building, HIV prevention and treatment. Priorities include technical and financial assistance for PMTCT and Option B+; HTC, STI programmes; palliative care; expanding safe medical circumcision; combination prevention; improving TB services; TB/HIV integration; building capacity to respond to gender-based violence; and prevention programmes and surveys for key populations.
- **Associated Fund Administrators (AFA), 2005** : The Government entered into a novel partnership with private sector doctors to ease congestion in the health facilities. This public-private partnership (PPP) was managed by AFA, the body that administers medical aid schemes, and lasted two years during which time it treated over 6,000 people. (6.8% of the national total at that time).

**Private sector partners** have played a crucial role in mainstreaming HIV/AIDS into workplace policies and practices. Over the years around 1,500 companies were involved in increasing access to HIV prevention, treatment and care, covering a population of over 27,000 employees and contributing about 2.3% of the total HIV and AIDS country expenditure. For example Debswana, the diamond mining company owned by the Government of Botswana and De Beers, was one of the early public-private partnerships in the HIV response and has provided HIV counselling and education programmes for its employees since the late 1980s. Debswana also offers antiretroviral therapy to all HIV-positive employees and their partners.

“ We see before us the most dramatic experiment on the continent. If it succeeds, it will give heart to absolutely every country worldwide.

STEPHEN LEWIS, UN ENVOY TO AFRICA, 2001, ON ACHAP

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<sup>2</sup> Economic and social impact assessment, 13 years. Futures, 2014.

<sup>3</sup> PEPFAR service delivery partners include CDC, USAID, Peace Corps and Department of Defense .

# QUOTES



FESTUS G. MOGAE FORMER  
PRESIDENT OF THE  
REPUBLIC OF BOTSWANA  
AND BILL GATES

*Gaborone, 2003*

“ Botswana's provision of free antiretroviral treatment to its citizens has become a model for the rest of Africa, and frankly for the world.  
US AMBASSADOR TO BOTSWANA, EARL MILLER, MARCH 2015



In October 2006, Professor Sheila Tlou, Botswana Minister of Health, Ambassador Mark Dybul and Dr. Kent Hill, Assistant Administrator, Bureau for Global Health, USAID visited Mater Spei (Mother of Hope), a co-educational high school administered by the Catholic Vicariate of Francistown. Mater Spei was one of the pilot schools for the new PEPFAR-supported Life Skills Materials Curriculum developed to support HIV/AIDS education in schools.



Participants at the 26th National Business Conference held in Francistown, 2012, where a Private Sector Declaration of Commitment was developed.

(l - r) Mr Kabelo Ebineng (Private Sector), Mr Richard K Matlhare (NACA), Ms Rachel Jackson (Private Sector), Mr Frank Phatshwane (Private Sector), Ms Mellisa Godwaldt (WUSC), Ms Irene Maina (UNAIDS), Mr Bonnet Mkhweli (NACA), Mr Joseph Kefas (NACA)

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# Multilateral partnerships

Multilateral partnerships have been pivotal in the Botswana's HIV response. From the start of the epidemic WHO provided technical support for the development of the national coordinating structures and plans. UNAIDS has also provided policy, M&E and technical support. Other multilateral support includes UNDP on the economic impact study; UNFPA on condom promotion and SRH/HIV linkages; UNICEF on PMTCT, youth prevention and care; UNESCO on HIV in the education sector; World Bank and European Union on health system strengthening and civil society support; ILO on HIV/AIDS Workplace Education and UNHCR on HIV prevention and care programme in the Dukwi Refugee Camp.

# Civil society partners

Community based organisations (CBOs), faith based organisations (FBOs) and other civil society groups (CSOs) have provided essential support for the HIV response in Botswana, mobilising communities to take up HIV services as well as implementing programmes. With their affiliates and associated organisations they currently number around 300 institutions. The CSO network is coordinated by an umbrella organisation, the Botswana Network of AIDS Service Organisations (BONASO), which also provides communication support.

Many of these organisations receive funding from the government of Botswana via the NACA as well as from development partners. Key services supported by civil society organisations include:

- **Community Home Based Care Programme (CHBC)** : CHBC was based on the strong cultural values of the family in Botswana in caring for terminally ill family members. Communities themselves were engaged to provide care -- over 6,000 volunteers from 300 CSOs have been the backbone of the government's CHBC programme across all health districts. Services include comprehensive care, material and psychosocial support, care-giver training and much, much more.
- **PLHIV services** : The network BONEPWA+ coordinates a range of organisations providing care and support for people living with HIV. The Centre for youth and Hope (CEYOHO) was one of the earliest of these groups assisting young people to overcome stigma and discrimination.
- **Peer counselling** : Botswana Young Women's Christian Association pioneered the Peer Approach To Counselling by Teens (PACT) in 1990 as a strategy to promote dialogue on adolescent sexual and reproductive health. The programme builds youth leadership and capacity to withstand social ills such as HIV, gender-based violence, drug and alcohol abuse.

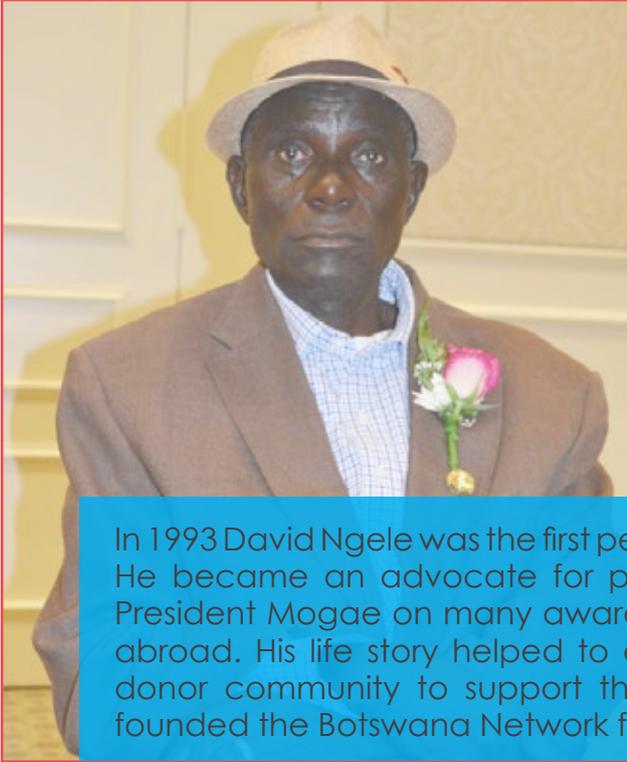
- **HIV Counselling and testing** : Tebelopele has provided confidential HIV testing since 2000. From a single facility it has expanded to 16 stand-alone centres and 26 mobile stations. The centres also promote community awareness on the importance of knowing one's status. Other NGOs, such as the Botswana Christian AIDS Intervention Program (BOCAIP) and the Botswana Family Welfare Association (BOFWA), also provide HIV testing services.
- **Youth-friendly services** : BOFWA is one of the leading organisations providing sexual and reproductive health services and advocacy for young people. The African Youth Alliance project also facilitated the engagement of youth and pioneered the establishment of youth-friendly services at national and district levels. In less than two years, Young Love, a youth-led programme to raise awareness on Sugar Daddy among teens, has reached about 35,000 adolescents in Botswana through trained volunteers.
- **Community outreach** : The government has always regarded community engagement activities as integral to the HIV response and has therefore provided funding for various projects, such as through Humana People to People (HPP). Peace Corps, with more than 2,500 volunteers over the past five decades, has worked with the government to strengthen community outreach of clinics in rural areas and other district activities.
- **Human rights** : Organisations such as the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) have played an important advocacy and watchdog role.
- **Faith-based response** : The Faith Based Organization (FBO) Strategy (2011-2016) was developed by all FBOs in the country and was aimed at coordinating targeted HIV prevention, care and support initiatives in the country. The Botswana Council Of Churches has also facilitated the engagement of the Church in the response through the establishment of the Ministers' Fraternity.
- **Key populations** : A range of CSOs and international NGOs are working to address the needs of key populations, including sex workers and MSM.



Treat All pre-launch walk, June 2016, Oodi Botswana.

# QUOTES

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DAVID NGELE

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In 1993 David Ngele was the first person to publically disclose his HIV status. He became an advocate for people living with HIV, accompanying President Mogae on many awareness-raising missions in Botswana and abroad. His life story helped to educate the public and catalyse the donor community to support the national HIV response. Ngele later founded the Botswana Network for People Living with HIV (BONEPWA+).



Miss Stigma-free pageant, Fancistown, 2008. The pageant is staged annually by the Centre for Youth of Hope (CEYOHO), which provides care and support to young people living with HIV. Their main aim is to address stigma and discrimination against PLHIV.

# HISTORICAL JOURNEY – STRATEGIC AI



## PHASE 1

Multise

HIV/AIDS as a health issue(1985-1996)

First case of HIV in Botswana

Medium Term Plan I

First Motswana discloses HIV status

Medium Term Plan II

Botswana Cabinet to declare AIDS epidemic as a national emergency & PMTCT launched

1985

1987

1989

1992

1993

1995

1997

1999

2000

2001

National AIDS Control Programme & Short Term Plan

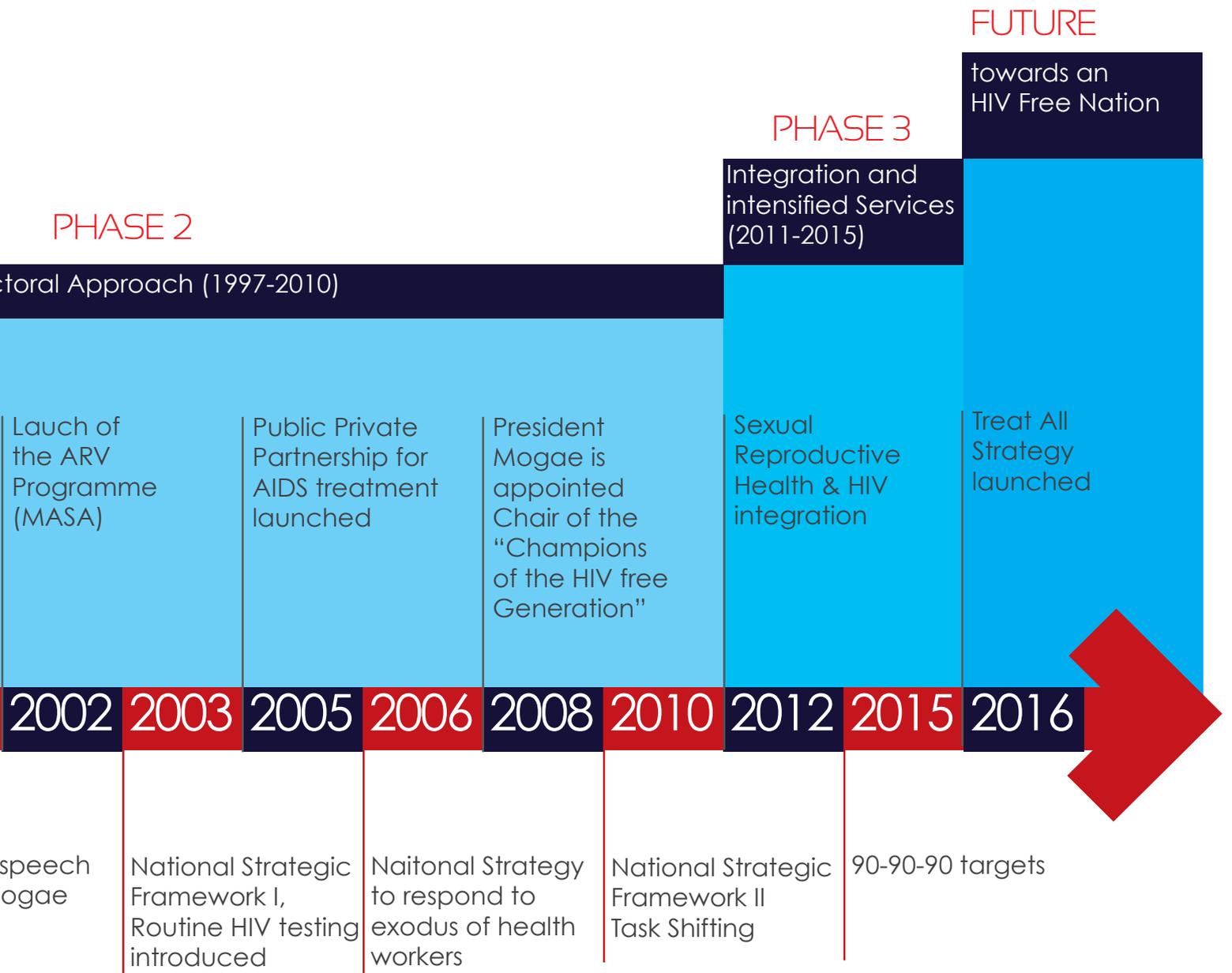
AIDS/STD Unit (ASU) established

Community Home-based Care Programme

National AIDS Council(NAC) and National AIDS Coordinating Agency(NACA) established, Short Term Plan of Action on Care of Orphans

UNGASS By H.E. M

# AND PROGRAMMATIC DEVELOPMENTS



# INNOVATIONS

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Tshepo Salobati, *Zero infection*, 2014  
*Nna le seabe HIV/AIDS Art Awareness Programme*

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# Saving babies - preventing mother to-child transmission (PMTCT)

In 1998 an estimated 40% of babies born to HIV-positive mothers in Botswana became infected with HIV -- a toll of around 7,000 to 9,000 babies a year. This was leading to very high levels of child mortality and at this time 70% of paediatric hospital deaths were HIV-related.

Following a successful PMTCT trial in Thailand, the Botswana Minister of Health, with the support of UNICEF, immediately established a task force to pilot the feasibility of a national PMTCT programme -- the first such programme in Africa. One year later the programme was being piloted in Gaborone and Francistown and by 2001 it was rolled out to the whole country.

Initially uptake was slow, but programme innovations such as routine HIV testing<sup>4</sup> and the inclusion of lay counsellors led to rapid improvement in the uptake of PMTCT services. By the end of 2015, it was estimated that the MTCT rate had declined from 40% to 2%. The PMTCT programme was strengthened further when Botswana adopted the Option B+ protocol, which provides life-long treatment for pregnant and breast-feeding women with HIV.

Botswana's PMTCT programme has resulted in an 89% decline of new infections among children (0-15 years old) between 2000 and 2014. This programme is now widely acknowledged as being one of the most effective in low- and middle-income countries.

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<sup>4</sup> see p14 for Opt-out testing strategy

# Saving children - excellence in paediatric care

The Botswana-Baylor Children's Clinical Center of Excellence was the first centre on the African continent to provide and supervise care and treatment and cater for HIV positive children and their families. Within three years the centre had placed more children on ART than any other clinic in the world. By January 2015, as a result of the successful PMTCT programme, there were few HIV-positive infants in the centre and the majority of patients were adolescents.

Highlights of the centre's work include:

- The Paediatric Infectious Diseases Clinic, which provides comprehensive care to children as well as mentoring health professionals;
- The Challenge Clinic for young patients who are failing treatment;
- The Adolescent Program with clubs and activities to support HIV-positive teens; and
- A paediatric TB/HIV project that has made important advances in the diagnosis of TB in children.

The Baylor International Pediatric AIDS Initiative (BIPAI) has also played an important role in training and mentoring of health workers and has produced path-breaking research into paediatric AIDS.

## A new dawn – a national antiretroviral therapy programme

In the year 2000 the Botswana government began discussing a bold new strategy to save lives: a national antiretroviral therapy programme (ART). This programme was named Masa, meaning 'new dawn' in Setswana.

The magnitude of this undertaking can only be understood by revisiting the global context for treatment at that time. Although high-income countries had been providing antiretroviral therapy since 1996, it was expensive and complex to administer. The drugs alone cost over 15,000 USD per person per year. While activists worldwide were demanding access to the drugs, the global consensus was that ART was neither affordable nor feasible in low- and middle-income countries.

Undaunted, the ACHAP partnership forged ahead with the plan. By 2001 a feasibility study had provided a complete understanding of both the need and the resources required for a national programme. Initial figures suggested a latent demand of 110,000 people, estimated to rise to 260,000 by 2005.

By January 2002 the programme was launched at the first site and by July four public hospitals were offering free treatment to selected groups of patients most in need. By the end of 2004 all 29 hospitals and their satellite clinics were offering ART services free of charge.

Initially enrolment was lower than expected and people presented for treatment when they were already very ill, with low CD4 counts. To increase enrolment, in 2003 the government changed the testing guidelines: now people would no longer need to volunteer for testing, but everyone visiting a health facility would be routinely tested unless they actively decided to opt out. Opt-out or routine testing was tried in several hospitals and high acceptance meant that it could be implemented nationally.

The new testing strategy led to increased enrolment into both PMTCT and treatment programmes. It also influenced WHO's global guidelines on provider-initiated counselling and testing which were published four years later.

Another innovative aspect of Masa was the use of viral load testing, right from the start of the Botswana treatment programme. This close monitoring of viral suppression, which has only recently been employed in low- and middle-income countries, has contributed to the good treatment outcomes of the Botswana programme.

Strengthening human resources for health was an essential component of the Masa programme. The KITSO Programme (Knowledge, Innovation, Training Shall Overcome), which was established in 2000, trained over 10,000 health workers in its first two years. A clinical preceptorship programme was also developed which brought HIV specialists from the US and Europe to Botswana to provide hands-on training to local medical staff.

From 2005 the MASA programme went into a phase of rapid scale-up and decentralization. ART services were rolled out to all clinics and even health posts. The ART guidelines were reviewed on a regular basis, increasing eligibility and improving the drug regimens in line with global guidelines. In 2012 Masa was one of the first African programmes to adopt the single pill fixed-dose combination drug.

By 2012 treatment was available at all health facilities across the country. By 2015, 96%<sup>5</sup> of those eligible, for treatment at CD4 350 -- or 62% of all estimated people living with HIV-- were receiving free treatment. A comprehensive evaluation concluded that it was a programme with good clinical outcomes that were improving as the programme matured. By June 2015, there were 261,922 adults and children on ART.

Recent estimates suggest that the country is already on track to achieve the 90-90-90 treatment targets. A study published in *The Lancet*, based on an ongoing combination prevention trial<sup>6</sup> showed that, **in the 30 communities of the project sites, 83% of HIV-positive people knew their status, 87% were on treatment and 96% were virologically suppressed.**

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<sup>5</sup> Investment case.

<sup>6</sup> Gaolathe et al. 90-90-90 antiretroviral therapy and virological suppression goals: a population-based survey. *The Lancet*. March 23, 2016. [http://dx.doi.org/10.1016/S2352-3018\(16\)00037-0](http://dx.doi.org/10.1016/S2352-3018(16)00037-0)



Botswana's Permanent Secretary in the Ministry of Health, Shenaaz El-Halabi, receives nine Gene Xpert instruments from US Deputy Chief of Mission Timothy Smith, in 2015. The Gene Xpert instruments enable more advanced TB diagnostic testing.

## Task shifting to strengthen HIV services

As the Masa and PMTCT programmes expanded, new strategies were needed to meet the shortage of doctors to initiate new patients onto ARVs. In response Botswana began investigating the national rollout of task shifting, a strategy that had been recommended by the WHO only one year earlier.

In 2006, after negotiations between the MoH, MoLGRD and the Nurses Association, it was decided that nurses would be trained to prescribe and dispense ARVs to stable patients. With support from PEPFAR and BHP two training programmes were developed and nurses began taking on some of the tasks formerly done by doctors. By 2016, nurse prescribers and dispensers have become the backbone of the ART programme in clinics and health posts.

## Integrating HIV and health services

The Botswana Ministry of Health has long recognized that the integration of HIV treatment, care and support into routine health services is essential to maximize human and financial resources. For patients, particularly those in remote rural areas, being able to access a range of services in one facility saves the time and expense of multiple journeys and appointments.

Integrating HIV and TB services has been underway since the development of the TB/HIV Policy Guidelines in 2011. Implementation is through the support of the TB/HIV Coordination Committees in districts.

Plans to integrate sexual reproductive health (SRH) and HIV services began in 2008 with an assessment of linkages between the two systems. Emerging from this assessment, a pilot was tested in three districts over a two-year period. The Linkages project, which is supported by development partners<sup>7</sup>, looks at different integration models

and gauges their acceptability and success. The results of the pilot showed a large increase in the percentage of people accessing dual services. The development of the Integrated SRH/HIV curriculum was a highlight of this initiative.

Ambitious plans are also underway to create “Speciality Centres” that will provide decentralized advanced care for HIV, TB, SRH, cervical cancer screening, paediatric care, PMTCT, NCDs such as hypertension and diabetes, and psychosocial support. These sites will also care for HIV/TB patients who are failing treatment.



Condomize! A mobile campaign led by the Ministry of Health and supported by UNFPA has travelled over 2000kms across the country since 2014. It targets young people aged 15-24 years, promoting correct and consistent condom use. Condoms are distributed and children and young people, especially males, are trained and educated.

## Reaching youth, empowering communities

While the numbers of new HIV infections in Botswana have declined over the years, there are worrying signs that HIV prevention efforts are not succeeding. An analysis of HIV prevalence data<sup>7</sup> by cohorts (age groups) between 2004 and 2013 shows that all of the youngest cohorts had either doubled or tripled their HIV prevalence over about ten years.

This situation has called for a revitalisation of prevention efforts. New ideas and programmes are being tested that aim to empower young people and communities, and escalate HIV prevention.

- **Comprehensive sexuality education** : In December 2013, Botswana was one of 21 countries in Eastern and Southern Africa to sign a Ministerial commitment on comprehensive sexuality education (CSE) and sexual and reproductive health

<sup>7</sup> These include EU, SIDA, UNFPA and UNAIDS

<sup>8</sup> from the BAIS surveys

services for adolescents and young people. This has catalysed efforts to meet CSE commitments: CSE teacher training has been strengthened and 100% of Botswana's schools now offer life-skills based HIV and sexuality education.

- **Youth empowerment** : Tweende or "Let's Go" is a youth empowerment programme offering a range of skills to improve the employment opportunities of vulnerable youth.
- **Community empowerment** : Building on the experiences of past projects<sup>9</sup> a novel approach to community empowerment is being piloted in the South East district. Communities Acting Together to control HIV (CATCH) uses a model whereby communities, through their traditional leaders or DiKgosi, identify key challenges in their areas and come up with their own initiatives and solutions. This participatory, "bottom-up" approach promotes community ownership and has reached over 10,000 individuals. It has facilitated the establishment of various community actions such as HIV testing days and awareness raising sessions by community groups at schools on topics such as alcohol and drug abuse or teenage pregnancies.
- **Understanding key populations** : In 2012 Botswana conducted its first survey of female sex workers and men who have sex with men. It estimated the size, HIV/STI prevalence, risks and needs of these populations in the three urban centres of Gaborone, Francistown and Kasane<sup>10</sup> . The survey found that HIV prevalence among female sex workers and men who have sex with men was 61.9% and 13.1%



CATCH meeting. Community members drawing their common vision of an HIV-free community (Otse, Botswana, September 2015)

“ If each of Botswana's community leaders could be empowered to eliminate new HIV cases in their jurisdiction, the country would reach zero new infections...”

GRACE MUZILA, NATIONAL COORDINATOR, NACA, 2014, ON CATCH

”

<sup>9</sup> These include Total Community Mobilization (TCM) and Community Capacity Enhancement Program (CCEP)

<sup>10</sup> Mapping, Size Estimation & Behavioral and Biological Surveillance Survey of HIV/STI Among Select High-Risk Sub-Populations in Botswana (BBSS).

respectively. These findings prompted the Government to introduce new guidelines for treating female sex workers who from 2015 have been offered treatment regardless of CD4 count.

## Research and Evaluation

Botswana's HIV response has been the subject matter of a large number of studies and research papers that have influenced global thinking on HIV services in resource-constrained countries. Some highlights include:

- **PMTCT** : The MASHI and Mmabana studies in Botswana (BHP) provided critical evidence on infant feeding that informed PMTCT protocols in Botswana and globally.
- **TB prophylaxis** : The first ever isoniazid prophylaxis (IPT) study was conducted in 2000 in three health districts in Botswana. This led to the collaboration between the Government and CDC for national scale-up, and also contributed to strengthening the relationship between TB and HIV services.
- **Household Surveys** : Since 2001 regular<sup>11</sup> large scale AIDS impact surveys have been conducted at household level. The Botswana AIDS Impact Survey (BAIS) methodology has improved over time, for example shifting from manual to electronic data collection and data entry.
- **PrEP evaluation** : The TDF2 study, conducted by Botswana MoH and CDC found that oral pre-exposure prophylaxis reduced the risk of acquiring HIV by roughly 63%. This study has contributed to global guidelines on oral PrEP.
- **Combination Prevention** : The Botswana Combination Prevention Project (BCPP) is an operational research project that is being conducted by the Botswana MoH, the BHP and other partners. The ongoing study will determine whether an enhanced combination prevention package, including treatment as prevention, will result in declining HIV incidence at population level over a three-year period, and will be cost-effective.
- **Integrated evaluation** : An evaluation of the Sexual and Reproductive Health/ PMTCT/ Maternal, Neonatal and Child Health programmes in 2015 was led by the MoH. This was an important effort to integrate the evaluation of inter-related programmes instead of running vertical evaluations.
- **New approach for HIV testing services** : A new HIV Testing Service (HTS) strategy is being developed according to the most recent WHO guidelines. It is based on most efficient and appropriate approaches to the provision of HTS in Botswana. This may include broadened and innovative approaches such as self-testing and community testing.
- **Structural interventions** : INSTRUCT<sup>12</sup> is a cluster randomized controlled trial of a package of structural interventions for HIV prevention, especially targeting young women. Undertaken by a collaboration between NACA and CIET (a research NGO), it refocuses government structural support programmes to make them more accessible to youth.

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<sup>11</sup> 2001, 2004, 2008 and 2013.

<sup>12</sup> Interministerial National Structural Intervention Trial, 2014-2018.

# The Investment Case

In 2014 NACA embarked on a comprehensive review of Botswana's HIV response aimed at optimizing programming and costs. The Investment Case was developed with participation of representatives of MoH and MoLGRD, research institutions, development partners and civil society, with support from UNAIDS. It analyzed trends and gaps in HIV planning, programme implementation and funding and made recommendations for future work. The process embraced the National Treatment Guidelines Committee's recommendation of adopting Treat All strategy<sup>13</sup> using dolutegrevir as 1st line ARV.

The Investment Case identified five priority areas for Botswana's HIV response:

- HIV prevention for youth;
- Improving monitoring and evaluation and supply chain management;
- Integration of health services and maintaining clinical care excellence;
- HIV testing, tracking and engagement in care; and
- Community engagement and empowerment.

The modelling showed that between 2015 and 2030 the Treat All Strategy could lead to a decrease of 105,891 new infections, enabling Botswana to be among the first countries in the world to eliminate AIDS by 2030.

The Investment Case economic analysis also showed that Treat All will be more cost-efficient than the current scenario of treating people at CD4 350 -- or even the scenario of expanding eligibility to CD4 500. Although Test and Treat will create a funding gap, this gap will decline after 2018 due to efficiency gains plus the savings from infections and illnesses averted. In contrast to the other scenarios where it keeps on increasing – and from the mid-2020s onwards, the Treat All scenario has the smallest financing gap of all of the three scenarios. Clearly this is a case where



Testing Campaign in Maun, November 2014. As part of the combined effort of Botswana, South Africa and Tanzania to win a place in the Guinness Book of Records for achieving the greatest number of people tested for HIV in 8 hours. Botswana outperformed its partners by conducting more than half the of the 4,367 tests.

<sup>13</sup> Treat All requires that all HIV-positive people are put on treatment regardless of CD4 count.

# QUOTES



*Picture showing GAOLATLHE KALANKE and her family, from the publication 'Faces of an AIDS - free Generation in Eastern and Southern Africa', UNAIDS, 2015.*

“

Now young women in my community understand more about HIV than I did when I was their age. They are free to ask questions and talk about their sexuality and HIV. With the new generation of strong young women, I am so confident that we can make sure that no baby is born with HIV in my community.

GAOLATLHE KALANKE, HIV-POSITIVE BENEFICIARY OF THE BOTSWANA PMTCT PROGRAMME, 2015

”



Masa, the Government of Botswana Programme to provide free ARV therapy to all Botswana returned hope to thousands. Masa, a Setswana word meaning 'new dawn', heralds the rising of a dawn over Botswana's struggle against HIV/AIDS.

# TOWARDS THE FUTURE - ENDING

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# AIDS BY 2030

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Botswana has made astounding achievements in tackling its HIV epidemic. From a period of funerals every weekend, the nation has recovered from mourning to face a bright future. Not only have lives been saved and illness cured, Botswana is recognized as the African model for best practice in so many aspects of the HIV response.

But there is still a way to go before Botswana can meet the goal of ending AIDS by 2030. The need to reduce new HIV infections while expanding treatment are interrelated challenges that will require even greater political commitment, expanded partnerships and programmatic innovations than we have seen to date. In the current climate of global economic crisis declining domestic and donor funding will pose constraints on the ambitious new programmes needed to end AIDS.

The Government of Botswana and partners are working to tackle these challenges head-on.

## Stepping up prevention

Botswana's Investment Case analysis showed that a Treat All approach, with expanded prevention programming, has the potential to lead to epidemic control by 2020. But for Treat All to reduce HIV incidence at population level there is a lot more work to be done. Challenges include improving adherence and changing risky behaviour. The findings of the combination prevention study (BCCP) will be used to strengthen prevention programming.

## Strengthening the health system

The "ending AIDS" agenda requires the strengthening of all health system building blocks. This includes a more robust health information system; strengthened procurement and supply chain management; and renewed service delivery models, including service delivery at community level. One area in which progress has already been made is in the integration of HIV and sexual and reproductive health services, which is being rolled out nationally.

## Meeting the funding challenge

Finding the additional resources to increase prevention and expand treatment will be an ongoing challenge. Different approaches to increasing domestic funding, such as maximising usage of alcohol and tobacco levies, are also under discussion.

Strong and continued government commitment, support from development partners and the private sector, and increasing efficiency gains are all expected to provide the resources needed to sustain quality programmes.

The 2016 award from the Global Fund is a positive development. This funding of 27million USD is the first substantive Global Fund HIV grant since 2004 and will be managed by MoH and ACHAP for prevention, treatment and TB/HIV co-infection. A good performance in the implementation of these programmes is expected to attract more resources from the Global Fund in the future.

## Healthy and disease-free future

The Botswana Government is committed to meeting future challenges, with the help of partners and the mobilisation of ordinary citizens, and will continue to lead the HIV response and end AIDS by 2030.

In June 2016 Botswana was among the first African countries to adopt the Treat All Strategy. In announcing this watershed moment for ending AIDS, the President said; "My message is simple: I encourage everyone to test to know their HIV status. Let us, together put a final end to AIDS in Botswana," he said" If you are HIV positive, do not despair but rather take action immediately to start ART so that you never let HIV destroy your chances of living a healthier and positive life, raising healthy children and families well into your eighties and nineties. "

With this move, Botswana has once more proven its commitment to ending AIDS through clear and visible leadership, upholding of important partnerships and integrating of newest findings and innovation.



It is imperative that we leave no stone unturned in coming up with interventions that will make a difference.

HIS EXCELLENCY THE PRESIDENT LIEUTENANT GENERAL DR. SERETSE KHAMA IAN KHAMA, WORLD AIDS DAY, 2013



# QUOTES



HONORABLE MINISTER OF  
HEALTH MS DORCAS MAKGATO,

*Treat All Launch, Oodi, 2016*

“ From the reporting of the first AIDS case to date, it has been a long and tough journey. But, we are gratified that with strong political commitment, dedicated leadership, committed partners, a committed health workforce and supportive communities, we stand today to proudly declare that our human spirit and resolve have overcome the formidable threat HIV/AIDS posed to our very existence. ”



from middle to right: HIS EXCELLENCY THE PRESIDENT LIEUTENANT GENERAL DR. SERETSE KHAMA IAN KHAM, MOKGWEETSI MASISI, VICE-PRESIDENT OF BOTSWANA, EARL MILLER, US AMBASSADOR TO BOTSWANA, SHEILA TLOU, DIRECTOR, UNAIDS REGIONAL SUPPORT TEAM FOR EASTERN AND SOUTHERN AFRICA AND SHENAAZ EL-HALABI , PERMANENT SECRETARY IN THE MINISTRY OF HEALTH

Treat All launch, Oodi, 2016

# ACHIEVEMENTS AT A GLANCE

THEN 2010	NOW 2015	FUTURE (2020)
HIV INCIDENCE		
1.4%	1.2%	0.8%
NEW HIV INFECTIONS		
14,920	11,700	4,600
ANNUAL AIDS-RELATED DEATHS		
8,700	5,500	2,300

*from Investment Case Modelling 2016*

THEN 1999	NOW 2015	FUTURE (2020)
MOTHER TO CHILD HIV TRANSMISSION RATE		
40%	1.5% *	<1%
Botswana launches first national programme in Africa	100% national facilities offering PMTCT	100%

*\* PMTCT Programme Data*



Traditional Dance Group, World AIDS Day 2012, Mogoditshane



BOTSWANA LEADS THE WAY

*From the brink of disaster towards an hiv-free future*