Baseline Assessment - Botswana

Scaling up Programmes to Reduce Human Rights-Related Barriers to HIV Services

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The Global Fund

DISCLAIMER

Towards the operationalisation of Strategic Objective 3(a) of the Global Fund Strategy, *Investing to End Epidemics*, 2017-2022, this paper was commissioned by the Global Fund to Fight AIDS, TB and Malaria and presents, as a working document for reflection and discussion with country stakeholders and technical partners, findings of research relevant to reducing human rights-related barriers to HIV services and implementing a comprehensive programmatic response to such barriers in Botswana. The views expressed in the paper do not necessarily reflect the views of the Global Fund.

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LIST OF ACRONYMS

ACHAP	African Comprehensive HIV/AIDS Partnership
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral treatment
ARV	Antiretroviral medication
BONELA	Botswana Network of Ethics, Law and HIV/AIDS
BONEPWA+	Botswana Network of People Living with HIV and AIDS
CSO	Civil society organisation
FSW	Female sex worker
GBV	Gender-based violence
HCW	Health care worker
HIV	Human immunodeficiency virus
HTS	HIV testing services
IBBS	Integrated bio-behavioural surveillance
IDCC	Infectious Disease Care Clinic
IPV	Intimate partner violence
KP	Key population
KPI	Key performance indicator
LEA	Legal Environmental Assessment
LeGaBiBo	Lesbians Gays and Bisexuals of Botswana
LGBT	Lesbian, gay, bi-sexual, transgender
MOHW	Ministry of Health and Wellness
MSE	Mapping and size estimation
MSM	Men who have sex with men
NACA	National AIDS Coordinating Agency
NGO	Non-government organisation
NSF	National HIV and AIDS Response Strategic Framework
OSISA	Open Society Institute for Southern Africa
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PEP	Post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PR	Principal Recipient
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
SADC	Southern African Development Community
SALC	Southern African Litigation Centre
SRH	Sexual and reproductive health
STI	Sexually transmitted infections
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNHRC	United Nations Human Rights Council
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UPR	Universal Periodic Review
WHO	World Health Organisation

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Introduction

This report documents the results of a baseline assessment carried out in Botswana to support its efforts to scale up programs to reduce human-rights-related barriers to HIV services. Since the adoption of its new *Strategy 2017-2022: Investing to End Epidemics,* the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programmes to remove such barriers in national responses to HIV, TB and malaria (Global Fund, 2016a). While the Global Fund will support all countries to scale up programmes to remove barriers to HIV, TB and malaria services, it is providing intensive support in 20 countries in the context of its corporate Key Performance Indicator (KPI) 9: "*Reduce human rights barriers to services: # countries with comprehensive programs aimed at reducing human rights barriers to services in operation (Global Fund, 2016b).*" Based on criteria that included needs, opportunities, capacities and partnerships in the country, the Global Fund selected Botswana, with 19 other countries, for intensive support to scale up programmes to reduce barriers to services. This baseline assessment, focusing on HIV, is a component of the package of support the country will receive.

The objectives of the baseline assessment were to:

- Identify the key human-rights-related barriers to HV services in Botswana;
- Describe existing programmes to reduce such barriers;
- Indicate what a comprehensive response to existing barriers would comprise in terms of the types of programmes, their coverage and costs; and,
- Identify the opportunities to bring these to scale over the period of the Global Fund's 2017-2022 strategy.

Programs to remove human rights-related barriers to services are *comprehensive* when the *right programs* are implemented *for the right people* in *the right combination* at the *right level of investment* to effectively remove human rights-related barriers and increase access to HIV, TB and malaria services.[1]

The assessment took place between May and June 2018. It included a desk review, key informant interviews, and focus group discussions. It was conducted by the Health Economics and AIDS Research Division (HEARD) of the University of KwaZulu Natal under contract to the Global Fund.

[1] This definition of "comprehensiveness » for the purpose of GF Key Performance Indicator 9 was developed with the Global Fund Human Rights Monitoring and Evaluation Technical Working Group.

The specific populations or groups included in the assessment as most affected by human-rights-related barriers were identified by taking into account epidemiological evidence; Global Fund criteria and guidance; as well as what Botswana's *Third National Strategic Framework (NSF III) 2018/9-2022/23* identifies. Based on this analysis, the populations that were included in the assessment are shown in the table below:

Key populations	Vulnerable populations
▪ People living with HIV (PLHIV) ▪ Sex workers ▪ Gay, bisexual and other men-who-have- sex-with-men (MSM) ▪ Transgender people ▪ People who inject drugs (PWID) ▪ Prison inmates	▪ Adolescent girls/young women ▪ 'Non-citizens'—particularly refugees, asylum seekers, and undocumented foreigners

While these are not the only population groups that are prioritised in the national HIV responses in Botswana, they are those groups whose access to HIV services is ***most*** affected by human rights concerns.

Findings

Although Botswana continues to have one the highest HIV prevalence rates globally, at 26.3% for women and 17.6% for men in 2016, the country has continued to make significant progress in the management of its HIV epidemic. By the end of 2016, coverage of anti-retroviral therapy (ART) for all adults and children reached 83%; it was 93% for adult women, 72% for adult men, and 60% for children. At the same time prevention of mother-to-child transmission of HIV (PMTCT) coverage had exceeded 95%. Such progress was not equally shared across all groups most affected by the epidemic, however. Although available data is now more than five years old, it showed that in 2012 HIV prevalence for sex workers had reached as high as 68%, and for MSM as high as 26%. HIV prevalence data for other key or vulnerable populations, such as inmates or transgender people is still not available. Starting in 2015, there has been a considerable expansion of HIV programmes and services for sex workers, MSM and transgender women. However, there is still no comprehensive data on country-wide coverage and uptake of these programmes, although many participants in the assessment stated that it was continuing to improve.

While there is a generally favourable law and policy context for most aspects of the national HIV response, this is not the case for key populations. Criminal laws against same-sex sexual activity, sex work and drug use remain in place, hindering efforts to improve access and uptake of HIV programmes and to reduce HIV risk. These laws, along with problematic socio-cultural beliefs and practices, fuel high levels of stigma, discrimination, violence and abuse against MSM, sex workers and transgender people, along with the larger community of sexual minorities in the country. A policy requiring non-citizens, whether legally resident in the country or not, to pay for ART limits access to HIV treatment for those without the means to cover this cost (although other components of HIV services are available free of charge such as HIV testing and PMTCT services). Finally, despite concerted efforts on the part of government and other

stakeholders to change harmful, gender-related socio-cultural practices and beliefs, gender-based violence and other forms of gender-related discrimination persist across the country. These also affect members of key populations who endure stigma, discrimination and violence for being perceived to go against such norms.

In response to such challenges, efforts to identify and remove legal and human rights barriers to HIV services have been intensifying in Botswana. These include very specific projects as well as the growing number of key-population-focussed programmes that include human rights components. Some of these efforts are part of the regional, Global Fund-supported Removing Legal Barriers and KP REACH projects, particularly the recently completed Legal Environmental Assessment (LEA) which was an important resource for this baseline assessment. Others are supported through the United States President's Emergency Plan for AIDS Relief (PEPFAR).

There has also been strong engagement on the part of civil society, including key-population-led organizations and their allies, to identify and address human rights barriers to services. Expanding combination prevention interventions for MSM, sex workers and transgender people, for example, integrate human rights components in their design, such as stigma reduction and building personal pride and resilience, training for health care workers (HCWs), sensitization of police and local authorities, rights literacy and legal support, and comprehensive responses to support survivors of sexual violence.

Across all of these efforts, however, some challenges and gaps remain. Changes to the external environment, particularly removing punitive laws and strengthening legal protections against discrimination and violence, are not moving forward, and this alongside lack of progress on changing gender norms means that individuals are still reluctant to come forward to use available services, even when they are key-population-specific. One of the main reasons for such slow change is the lack of strong leadership and commitment on the part of government stakeholders to address and remove barriers, even within the Ministry of Health and Wellness (MOHW), which itself is reluctant to explicitly support key population concerns stating the limitations imposed by current laws. Other challenges include the lack of a central structure for coordinating human rights work in the context of HIV, duplication and fragmentation of existing efforts, and the lack of evaluation, meaning that many activities are simply repeated from year to year without sufficient attention to whether or not they are effective.

In taking all of these considerations into account, a number of actions are proposed that would comprise a more comprehensive and effective approach for addressing and removing the human rights barriers identified through the assessment. These address cross-cutting actions for overall strengthening of human rights work, as well as specific activities related to the main programmatic categories for effective responses to removing human rights barriers.

Cross-cutting actions

- **Establish a specific coordination mechanism for work to address and remove human rights barriers**. Ideally, this should be led by the National AIDS Coordinating Agency (NACA) with shared leadership from key population representatives, adolescent girls and young women, women's organization, and include multi-sectorial participation. The Legal Environmental Assessment Technical Working Group (LEA TWG) that has steered this baseline assessment could be restructured for this purpose rather than looking to establish a

new mechanism. Amongst other functions, the body could monitor and oversee the implementation of the 5-year comprehensive plan generated through this baseline process.

- **Address the gaps in data regarding uptake and retention in HIV services for key populations**. While these gaps persist, they will impede efforts to understand which approaches to removing barriers are more effective than others. This work should be a high priority and should be led by the MOHW and NACA with strong collaboration from partners such as the Global Fund, PEPFAR and UNAIDS. The country is not so large and the number of intervention not so great that a consolidated data set could not be generated to monitor what key-population-focussed programmes are collectively achieving.

- **Prioritise evaluation of programmes to reduce human rights barriers.** While it may be the case that many current efforts are able to achieve and sustain positive change in ways that the assessment did not capture, such things are currently neither documented nor shared. Better evidence is needed on which approaches are most effective for the Botswana context so that available technical and operational resources can be better aligned to what will increase momentum for change.

Reducing stigma and discrimination

- **Conduct a new Stigma Index Survey using the revised methodology that is more inclusive of key populations.**[2] The result of the process can then inform a coordinated action plan for reducing or eliminating what forms of HIV-related stigma and discrimination that remain.

- **Improve the technical capacity of NACA and the MOHW to take stronger action on reducing stigma and discrimination against key populations.** There are commitments to lead change within the NSF III but, in the experience of key population groups, such things have not led to concrete actions in the past. In addition to stronger action within their own institutions, NACA and MOHW should also prompt actions and accountabilities across other government stakeholders.

- **Sustain work using social media channels to publish and promote positive stories regarding key populations.** While it is important to highlight the challenges faced by key populations, it is equally important to show how these same constituencies make important contributions to the social-cultural and economic make-up of the country. Under the Global Fund-supported regional KP REACH project, local journalists were supported to write profiles of individuals from Botswana but they were not yet widely shared by the time of the assessment.[3] This work should be sustained and expanded.

- **Investigate reports of workplace discrimination against PLHIV and key populations and take appropriate action.** The multi—stakeholder consultations should determine roles, responsibilities and mechanism for receiving such reports, with due regard to confidentiality and privacy, and supporting individuals who have experienced discrimination to take effective action. This responsibility should also extend to working with relevant counterparts in government to investigate workplaces where discrimination is alleged to still be occurring and to support their owners to make appropriate changes.

[2] See Friedland, Sprague and Nyblade (2018).
[3] See, for example: https://kpreach.net/living-freely-pontsho-sekisang-tackles-stigma/

- **Continue work in communities to convene dialogues regarding diversity and inclusion, and equal access to health for all.** Key informants were of the view that this work at the community level was essential for increasing tolerance and acceptance of diversity as it provided opportunities for person-to-person sharing of experiences by key populations in their communities as well as opportunities for other community members to raise their questions and concerns.

- **Develop more focussed, community-level and peer-led interventions for transgender people, particularly transgender women.** This assessment and other sources have indicated that stigma, discrimination and violence experienced by transgender people are more severe than those faced by other key populations and that these problems are not being effectively addressed under broader approaches working with MSM, for example.

Training for HCW on human rights and medical ethics

- **Send a directive to all health facilities re-emphasising that the MOHW is required to offer patient-centred, non-discriminatory care to all individuals in need.** This should be done by the Minister or a relevant senior-level official. The wording of the directive should be supportive of HCWs and the critical roles they play but also be mindful of the need to ensure that all patients receive an appropriate standard of care.

- **Support the MOHW to increase the amount of training provided to HCWs, at both the pre-service and in-service stages, on the importance of medical ethics (particularly privacy and confidentiality), professionalism, and the rights and entitlements of patients to receive appropriate care.** The training should be conducted in a way that allows HCWs to express their concerns and to clarify their values, beliefs and practices regarding their role in the health care system. There should be a particular emphasis on clarifying patient confidentiality so as to prevent any disclosure of information to individuals outside the health care setting, including the police, unless a specific law or regulation provides for it.

- **Develop and implement minimum service packages for key populations that apply to the public health sector.** This is the responsibility of the MOHW which should receive any needed technical support to move it forward. Such packages will help to clarify for HCWs what services they are obliged to provide and, for key populations, what services they can expect to receive. NACA should facilitate the process to ensure that there is adequate involvement of key population representatives in the development of the packages.[4]

- **Support both PLHIV and other key-population-led networks to understand and use processes in the health sector to raise issues regarding the quality of care or the conduct of HCWs.** While there is an understandable reluctance on the part of individuals and communities to make formal complaints, there should be more opportunities for individuals to connect with CSOs and networks to engage with these processes and to use them for mutual problem-solving and collaboration.

Sensitisation of law-makers and law enforcement agents

[4] While the assessment was underway, UNFPA in Botswana was preparing to provide technical support for the development of the packages.

- **Scale up and consolidate work with traditional authorities into one, overall approach that works at community and institutional levels.** Both levels of intervention are important; however, more impact could be achieved through greater coordination. This could be done through Botswana Network on Ethics, Law and HIV/AIDS (BONELA), for example, whereby, in addition to continuing to support CSOs to conduct dialogues, it could be working directly with the *Ntlo ya Dikgosi* (the governing body for traditional Chiefs in Botswana) to guide it to put in place institutional mechanisms for supporting chiefs to acknowledge and champion diversity within their chiefdoms.

- **Strengthen coordination amongst CSOs working with the police, at local and national levels, in order to exert stronger pressure for an institutional commitment to changing police attitudes and practices towards key populations.** The Hands Off! Project has made an important step forward in gaining the commitment of the Botswana Police Service to implement training to eliminate violence against sex workers by its officers. This opportunity should be leveraged through a coordinated strategy to expand the commitment to protect and respect all key population groups.

- **Equip key-population-led networks and leaders, and their allies, with stronger technical capacities for political engagement and lobbying.** Significant law and policy change can only come about based on the political will of a majority of parliamentarians. More networks and individuals need to become engaged in these process to work with parliamentarians and to build a broader base of support for positive change.

- **Scale up work with parliamentarians, individually and through committees, to increase their knowledge about key population concerns gender, gender roles, concepts of manhood and masculinity, and their link to HIV, and to consolidate their commitment towards law and policy change.** Work currently done by BONELA and others should be sustained.

Legal literacy

- **Renew or revise the content of rights literacy materials to include new developments.** Revisions to legal literacy materials and approaches should address recent developments, particularly in the clearer articulation from the judiciary about the scope of the Constitution regarding sexual minorities. Revised rights literacy materials should 'translate' such developments in terms of what these mean for individuals.

- **Develop specific literacy materials on patient rights and appropriate complaints mechanisms within the health sector.** These materials should be available in all health facilities and should clearly articulate the law and policy frameworks that support non-discrimination in health care services as well as describe how individuals can receive support to use health-service-related complaints mechanisms.

HIV-related legal services

- **Sustain and scale up projects that employ members of key populations as paralegals in communities.** These individuals provide critical links between peers who experience legal and human rights violations and networks and services that are meant to assist them to seek redress.

- **Strengthen and scale up the creation of local networks between key populations, local authorities and CSOs to prevent legal and human rights violations and to support individuals when these things occur.** The Maun model, for example, should be documented and replicated.

- **Strengthen work with the Botswana Police Service to change police attitudes and practices that prevent individuals from obtain reports and filing cases.** This can be done as part of the planned interventions under the Hands Off! Project. The training should be expanded to include issues for MSM and transgender people.

- **Strengthen the capacity of Legal Aid Botswana to do more outreach in communities and to forge stronger links with key population groups to increase their utilisation of these services**. This is a resource that is infrequently used by individuals from key populations for fear of stigma and discrimination. Focussed outreach to key population networks in communities would address and resolve these fears.

Monitoring and reforming laws, regulations and policies

- **Incorporate the action plan to address the recommendations of the LEA in the 5-year plan for a comprehensive response.** The development of the LEA action plan has been provided for under the regional Global Fund grant on Removing Legal Barriers. Based on the results of this assessment, the action plan should prioritise the following key recommendations: reforming or repealing of laws that criminalise HIV transmission, sex work, and same-sex sexual activities; clarifying the law and policy requirements for government to provide HIV services for refugees and asylum seekers held in places of detention; amending laws regarding prisons to allow for condom distribution and other needed HIV prevention interventions; and, amending the HIV policy to allow legally resident non-citizens access to ART who cannot afford to pay for it themselves (using an appropriate means test, for example).

- **Sustain efforts by civil society to support undocumented foreigners to access HIV services, particularly ART.** Since there is no requirement in law for the government to provide ART and HIV services free of charge to this group and it is unwilling to do so on humanitarian or public health grounds, the current efforts of civil society to support foreign sex workers, other undocumented migrants, and asylum seekers who have left their places of detention to access and remain on ART should be sustained and scaled up where needed.

- **Build the technical and operational capacities for more key-population-led networks and CSOs to participate in policy development and law reform processes.** Effective policy development and law reform requires strong technical skills for proposing policy options or the content of new legislation. It also requires capacity for negotiation and consistent participation and engagement over the longer term, something that CSOs and networks are rarely funded to achieve.

- **Create one monitoring and reporting mechanism for HIV-related human rights data.** Networks and CSOs should create one country-wide mechanism based, for example, on the REAct tool or other approaches in neighbouring countries (such as the web-based model use by the Love Not Hate Campaign in South Africa), to monitor and report on human

rights violations so that changes in the situation, either positive or negative, can be tracked and broadly communicated.[5]

Reducing Human Rights Barriers Based on Gender

- **Provide more training to HCWs, including those who are part of externally funded programmes for key populations, on recognising and responding to sexual violence and abuse, including intimate partner violence.** As the assessment has noted, there is great reluctance on the part of MSM, transgender people, or sex workers to disclose sexual violence and to seeking needed care, including important services such as post-exposyre prophylaxis (PEP). Equipping HCWs to be more aware and enabling would be an important step towards changing this situation.

- **Develop comprehensive referral networks to support individuals who experience sexual violence. While some implementers of key population programmes are doing this. it should become a routine component of all programming.** There should be a strong emphasis on psycho-social support, including referral for trauma counselling and other mental health interventions. Supporting access to justice should also be an important component of the referral system.

- **Strengthen efforts by key population networks and CSOs to make traditional authorities more active and accountable for confronting and changing harmful gender norms.** Such gender norms are too often sustained in communities because they form part of traditional identities and practices that many feel are being threatened by external influences.

Estimated Funding Needs to Implement the Comprehensive Approach

Using data collected from funders and implementers on current activities that address human rights barriers, the assessment estimated the amount of funding needed to implement the comprehensive response. The results are shown the table below:

Programme Areas		Year 1	Year 2	Year 3	Year 4	Year 5	Total
PA1	Stigma and discrimination reduction	828,658	353,251	438,352	291,423	565,810	2,477,495
PA2	Training for HCW on human rights and medical ethics	188,819	31,632	34,458	32,268	32,591	319,768
PA3	Sensitization of law-makers and law enforcement agents	728,620	88,597	67,846	124,506	69,210	1,078,779
PA4	Legal literacy	108,525	15,257	15,409	53,581	15,719	208,491
PA5	HIV-related legal services	289,743	309,955	313,055	370,895	319,347	1,602,996
PA6	Monitoring and reforming laws,	188,562	280,363	254,006	148,023	149,503	1,020,457

[5]See: http://www.lovenothate.org.za

	regulations and policies						
PA7	Reducing discrimination against women in the context of HIV	161,889	32,825	138,222	19,590	19,785	372,311
PA8	Other activities	106,161	113,823	163,142	116,111	215,850	715,088
Total		**2,600,977**	**1,225,704**	**1,424,491**	**1,156,397**	**1,387,815**	**7,795,385**

Over the 2018-2020, under its Global Fund programme, Botswana will have approximately US$2 million to invest in interventions to remove human rights barriers. Additional resources from Global Fund and PEPFAR will augment this through supporting integrated approaches to key population programming that include human rights components. Further resources may also be available from other partners, including UN agencies as well as bilateral donors.

Opportunities for scaling-up interventions

Botswana has reached a critical stage in its national HIV response where, at least for adults, it has reached or shortly will reach its fast-track targets for HIV diagnosis, treatment and viral suppression. Much of the gap that remains is no doubt related to the barriers for key populations that were identified through this assessment and through other similar efforts, such as the LEA and the Joint Global Fund/PEPFAR HIV Cascade Assessment for Key Populations, which stand in the way of further progress.

What is needed to move this work forward is a prioritized plan of action as well as a strong and committed coordinating body to lead and monitor progress. This assessment provides an outline for the plan and describes how such a coordinating entity could function. This larger plan should incorporate action planning for the LEA and be fully aligned to, if not enhance, what is contained in the NSF III. The larger challenge will be achieving effective leadership and coordination although there is currently willingness to empower the LEA TWG to reposition itself to play this role. New investments from the Global Fund and PEPFAR emphasising the need to scale up efforts to remove remaining barriers to HIV services create additional opportunities for the country.

1. INTRODUCTION

This report documents the results of a baseline assessment carried out in Botswana to support its efforts to scale up programs to reduce human-rights-related barriers to HIV services. Since the adoption of its new *Strategy 2017-2022: Investing to End Epidemics*, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programmes to remove such barriers in national responses to HIV, TB and malaria (Global Fund, 2016a). This effort is grounded in Strategic Objective 3 which commits the Global Fund to: "introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria service;" and, to "scale up programs to support women and girls, including programs to advance sexual and reproductive health and rights and investing to reduce health inequities, including gender-related disparities(ibid.)." The Global Fund has recognized that programmes to remove human rights and gender-related barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, Stop TB, PEPFAR and other bilateral agencies and donors to operationalize this Strategic Objective.

Though the Global Fund will support all countries to scale up programmes to remove barriers to health services. It is providing intensive support in 20 countries in the context of its corporate Key Performance Indicator (KPI) 9: "Reduce human rights barriers to services: # countries with comprehensive programs aimed at reducing human rights barriers to services in operation (Global Fund, 2016b)." This KPI measures, "the extent to which comprehensive programs are established to reduce human rights barriers to access with a focus on 15-20 priority countries." Based on criteria that included needs, opportunities, capacities and partnerships in the country, the Global Fund selected Botswana, with 19 other countries, for intensive support to scale up programmes to reduce barriers to services. The baseline assessment for Botswana, focusing on HIV, is a component of the package of intensive support the country will receive.

2. OBJECTIVES AND EXPECTED RESULTS

The objectives of the baseline assessment were to:

- Identify the key human rights barriers to HIV services in Botswana;
- Describe existing programs to reduce such barriers;
- Based on data concerning country realities, describe a comprehensive response to existing barriers in terms of the types of programs, their coverage and costs; and,
- Identify the opportunities to bring these to scale over the 5-year period of the Global Fund's 2017-2022 strategy.

Overall, the results of the assessment are meant to provide a baseline of the situation as of 2018 in Botswana. This effort will be followed up by similar assessments at mid- (2020) and end-points (2022) of the Global Fund's strategy in order to capture the impact of the scale up of programs to remove barriers in Botswana and in those other countries that are receiving similar support.

3. METHODOLOGY

The baseline assessment for Botswana was conducted between May and June 2018 according to the methodology described below.

3.1. Conceptual Framework

The conceptual framework that guided the assessment was based on the assumption that human rights barriers to full access to, uptake of and retention in HIV services exist in Botswana as in other countries regionally and globally. These barriers are experienced by certain key and vulnerable populations who are more vulnerable to and affected by HIV than other groups in the general population. It is also assumed that there are human rights and gender-related programme areas comprising several interventions and activities that are effective in removing these barriers, and if these interventions and activities are funded, implemented and taken to sufficient scale in the country, they will remove, or at least significantly reduce, these barriers.

Further, the removal of these barriers will increase access to, uptake of and retention in HIV services and thereby accelerate country progress towards national, regional and global targets to significantly reduce or to bring an end to the HIV epidemic. These efforts to remove barriers will also protect and enhance Global Fund investments and will strengthen health and community systems.

The assessment explored the following main program areas identified by UNAIDS and the Global Fund (UNAIDS, 2012; Global Fund, 2017a, b) by which to address and remove barriers:

- Stigma and discrimination reduction;
- Training for health care workers on human rights and medical ethics;
- Sensitization of law-makers and law enforcement agents;
- Legal literacy ("know your rights");
- HIV- related legal services;
- Monitoring and reforming laws, regulations and policies relating to HIV; and
- Reducing discrimination against women in the context of HIV.

Activities under these program areas can be integrated into ongoing HIV programs or can be implemented as stand-alone programs within the context of the national response. Programs to remove human rights-related barriers to services are *comprehensive* when the *right programs* are implemented *for the right people* in *the right combination* at the *right level of investment* to effectively remove human rights-related barriers and increase access to HIV, TB and malaria services.[6]

3.2. Key and Vulnerable Populations Included in the Assessment

The specific populations included in the assessment as most affected by human rights barriers were identified by taking into account those defined by Global Fund criteria as key and vulnerable populations for HIV; epidemiology; and, those which are included in national strategic documents, particularly Botswana's *Third National Strategic Framework (NSF III) 2018/9-2022/23* (Global Fund, 2013; Global Fund, 2017b; Ministry of Health and Wellness [MOHW] and National AIDS Coordinating Agency [NACA], 2017a).

Based on these criteria, the population groups considered as experiencing human rights-related barriers to HIV services in Botswana are shown in **Table 1**, below:

Table 1: Key and vulnerable populations for HIV included in the assessment

[6] This definition of "comprehensiveness » for the purpose of GF Key Performance Indicator 9 was developed with the Global Fund Human Rights Monitoring and Evaluation Technical Working Group.

Key populations	Vulnerable populations
▪ People living with HIV (PLHIV) ▪ Sex workers ▪ Gay, bisexual and other men-who-have- sex-with-men (MSM) ▪ Transgender people ▪ People who inject drugs (PWID) ▪ Prison inmates	▪ Adolescent girls/young women ▪ 'Non-citizens'—particularly refugees, asylum seekers, and undocumented foreigners.

Although people who inject drugs (PWID) are identified as a key population in Botswana, there is as yet no evidence about this group nor any services or links to this population, something that may in itself be a human rights barrier. Although issues for male or transgender sex workers were included in the assessment, to the extent that data were available, these groups are not yet recognised as key populations within the national HIV response. While the populations included in the assessment are not the only population groups that are prioritised under the national HIV response, they are, nevertheless, those groups whose access to HIV services is most affected by human rights-related barriers.

3.3. Data Collection and Analysis

Data collection and analysis involved the following steps:

- **Desk review**-- A comprehensive desk review was conducted of scholarly and grey literature sources describing the context for HIV in Botswana, sub-populations and groups most affected by the disease, human rights barriers to HIV services for these groups, and the country's efforts to address and remove these barriers. Sources for the review included peer-reviewed publications, national documents (plans, policies, strategies and progress reports), and other documents produced by the different stakeholders involved in efforts to address and remove barriers.

- **Development of fieldwork priorities and the fieldwork plan**-- Based on the results of the desk review, specific priorities for further data collection were defined. The desk review concluded that barriers to HIV were for the most part well documented for most groups included in the assessment. This allowed the fieldwork to focus more on current efforts to address those barriers, including their effectiveness, and on recommendations from stakeholders on how to achieve a more comprehensive approach that would ultimately remove as many barriers as possible. The fieldwork plan included key informant interviews (KIIs), round-table discussions, and focus group discussions (FGDs) with a full range of multi-sectoral partners, PLHIV, and representatives of other key or vulnerable population groups.

- **In-country data collection**--In-country data collection took place between 15 May and 1 June 2018. The Botswana Country Coordinating Mechanism (BCCM) Secretariat and the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) provided logistical support for

data collection. Inception meetings were convened to present the objectives of the baseline assessment and the data collection plan to the Legal Environment Assessment (LEA) Technical Working Group (TWG) and BCCM for their input and participation.

The key informants were drawn from the following locations: Gaborone and the surrounding area; Mahalapye; Palapye; Serowe; Serule; Selebi Phikwe; Letlhakane; Maun and the surrounding villages; Kasane and surrounding villages; Tutume; and, Francistown and the surrounding villages. Overall, 179 individuals representing 39 entities participated in the assessment. These included seven national non-governmental organisations (NGOs) and networks; 13 community-based organisations (CBOs); nine government ministries and agencies; nine multi-lateral and bilateral agencies; and one private practitioner. In addition to individual meetings and round-tables, 17 FGDs were convened with peer educators working with the different key and vulnerable population groups that were included in the assessment.

- **Collection of financial data--** The assessment identified investments in programmes to reduce human rights-related barriers, focussing on the calendar years of 2016 and 2017. Collection of financial data used a resource tracking tool that was either self-administered or applied as part of a site visit. Some of the data was then used to inform the costing of the comprehensive approach.

- **Data analysis** involved mainly thematic analysis of documents and interview notes according to the key themes and concepts set out in the conceptual framework.

The assessment was conducted by a team of five national consultants with support from the Project Leader and a costing expert from the Health Economics and AIDS Research Division (HEARD) of the University of KwaZulu Natal (UKZN). Ethics clearances were provided by Botswana's Health Research and Development Division of the MOHW, and the Biomedical Research Ethics Committee at UKZN.

4. FINDINGS

The findings for the baseline assessment are presented in the sections that follow. Current epidemiological data indicates that, although Botswana continues to make progress regarding its HIV epidemic in the general population, some key and vulnerable populations are still largely left behind. As the findings indicate, stigma, discrimination, punitive laws, and inadequate enforcement of protective laws make HIV prevention and support efforts challenging for sex workers; gay, bisexual and other MSM; transgender people; adolescent girls and young women; and certain groups of non-citizens, particularly refugees and undocumented foreigners.

However, the country is slowly increasing its efforts to remove these barriers. Some of these efforts include working with parliamentarians, the judiciary, the police and traditional leadership; legal services; strategic litigation; and a range of interventions to remove discrimination against women and problematic cultural norms. The assessment has also identified some promising human rights interventions that can be scaled up for the country to close the gap in increasing access to HIV services for key and vulnerable populations.

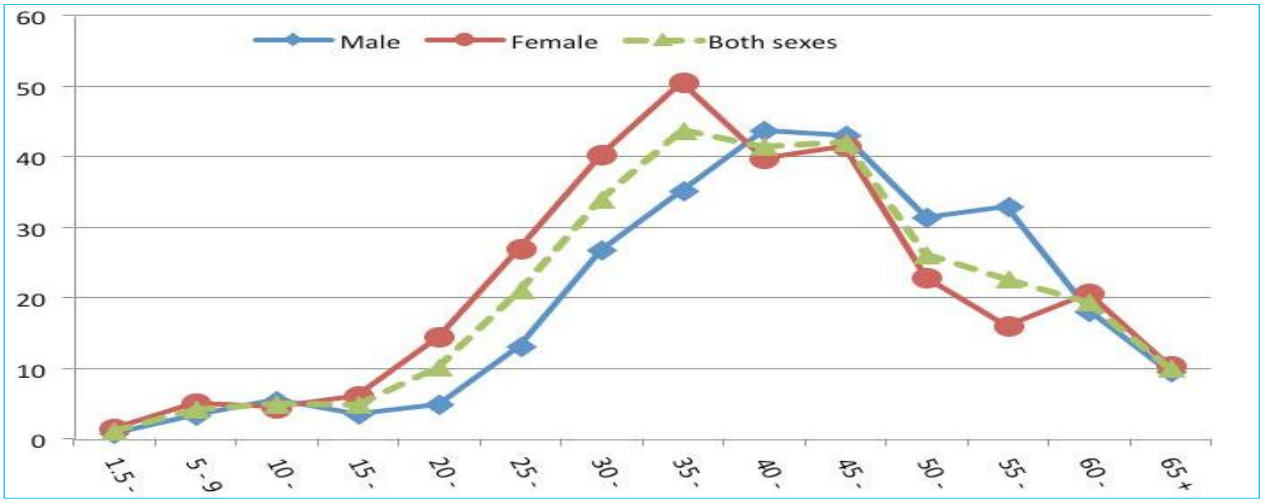
4.1.Prevalence of HIV amongst Key and Vulnerable populations

4.1.1. General Epidemiological Situation

According to the most recent data, in the year 2016, approximately 360,000 adults and children were living with HIV in Botswana out of a national population of 2 million (UNAIDS, 2016). Of all adult PLHIV, 57% were women and, of all PLHIV, just 3% were children under the age of 15 years. Also in 2016, adult HV prevalence was estimated at 26.3% for women and 17.6% for men. For younger females and males (15-24 years), it was 10.2% and 5.4%, respectively.

More comprehensive epidemiological data comes from 2013. It gives more detail regarding the age and gender disparities in HIV prevalence rates, as shown in **Figure 1**, below:

Figure 1: HIV prevalence by age and gender



Source: Statistics Botswana, 2013.

Starting in adolescence (15 years), HIV prevalence increased significantly faster in females than in males, with the largest gap occurring at 35 years where it was 35% for males and 50% for females. Amongst the reasons put forward for this difference was the high frequency of gender-based violence (GBV) faced by women (Machisa and van Dorp, 2012). Gender-related vulnerabilities and human rights-related barriers to prevention, testing, treatment and care services need to be addressed to end the AIDS epidemic.

4.1.2. Prevalence of HIV for Key and Vulnerable populations

Epidemiological information regarding key populations comes only from 2012 and is found in an integrated bio-behavioural surveillance (IBBS) survey amongst female sex workers (FSW) and MSM conducted in three locations in the country: Gaborone, Kasane and Francistown (MOHW, 2013). Population size estimates are lacking, making it difficult to determine whether coverage with services is appropriate.

With regard to FSW, the study found an overall HIV prevalence rate of 61.9% amongst a sample of 947 women. In addition, more than 50% of women reported having had a sexually transmitted infection (STI) during the previous year. The prevalence of gonorrhoea and chlamydia were 10% or higher. A subsequent study in 2015 found that the risk of HIV infection increased with age (being 30-years-of-age or older); having been a sex worker for two or more years; and having sex

11 or more times per week (Aids Fonds, 2015b).[7] Some of the female sex workers in the study also reported challenges related to condom breakage and being paid or forced not to use condoms.

For MSM, the 2012 study found an HIV prevalence rate of 13.1% amongst the 454 respondents, ranging from 11.7% in Francistown to 25.9% in Kasane (MOHW, 2013; Tafuma et al., 2014). Regarding STI prevalence, 11.3% of study respondents had chlamydia at the time of the study, and 2.9% had gonorrhoea. One feature of the 2012 study was that it had a relatively young sample of MSM (mean age of 23 years; only two participants were older than 40 years) which meant that the estimates of HIV prevalence may not have been representative of the full population of MSM. For example, a study conducted in 2009 found an overall HIV prevalence rate of 19.7%, reaching as high as 46.7% amongst MSM above the age of 30 years (Zhan et al., 2016; UNAIDS, 2015).

The 2012 study found that a small proportion of MSM (7.8%) reported being engaged in sex work. Of all participants, most (71.5%) had a regular male partner; 49.3% reported having casual male partners; and 46.7% reported also having female partners. Amongst those who had female partners, 11% stated they had had sex with an FSW in the preceding six months; the highest proportion (26.8%) being MSM in the border town of Kasane (Tafuma et al., 2014). Nonetheless, the vast majority of MSM (almost 90%) who had female partners, including FSW, stated that they always used condoms. In contrast, only 66% of MSM reported always using condoms during anal sex with other men, though 84.3% reported they had used condoms during last anal sex.

Whilst there are civil society organisations (CSOs) currently implementing programmes for transgender people, at the time of the baseline assessment, there was no information on HIV prevalence or risk for this group. On the burden of HIV amongst people in prisons, an HIV prevalence of 14% was estimated in 2009 (MOHW and UNAIDS 2016). Aside from this, however there is no more current information available. In 2013, a sero-prevalence, knowledge and behavioural study was undertaken in selected Botswana prisons. However, the government has never released the results.

There is no information on HIV prevalence amongst PWID. Injection drug use is considered to be rare in Botswana (Selemogwe, Mphele, Manyanda, 2014). The sample for the 2012 IBBS study included two individuals (both FSW) who reported having injected drugs (MOHW, 2013). Similarly, only one person in the sample of 1,213 PLHIV who participated in the Stigma Index Survey reported having injected drugs (BONEPWA+, 2014). Finally, a number of sources mention vulnerable populations such as migrants, refugees and remote area dwellers, including the Basarwa (MOHW and NACA, 2017a; 2017b; MOHW and UNAIDS, 2016). However, there is no comprehensive information on the HIV burden amongst these populations.

4.2. Current Situation for Access and Uptake of HIV Services

Available data suggests that even though Botswana has made very substantial progress to provide HIV services and to encourage most PLHIV to use them, significant gaps remain for key populations. In 2016, coverage of ART for all adults and children had reached 83%; it was 93% for adult women, 72% for adult men, and 60% for children (MOHW and NACA, 2017a). An assessment undertaken in late 2015, covering 243 rural and peri-urban villages, found that, amongst the 12,610 participants, 29% (3,596) were PLHIV of whom

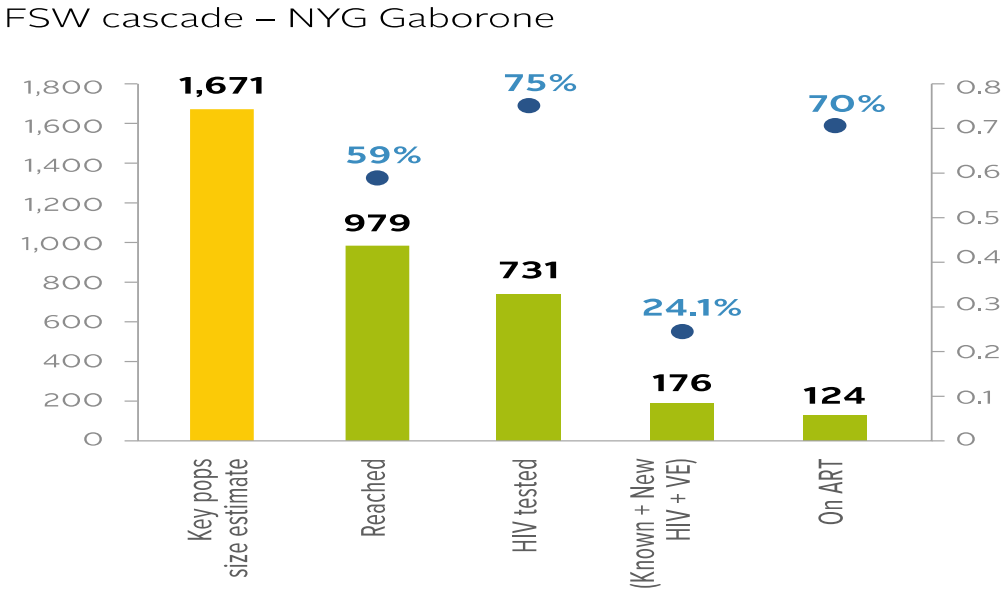
[7] The assessment included 545 sex workers of all genders. When asked about HIV status, 30% of respondents said they were HIV positive, 17% said they were HIV negative, 11% percent had never been tested, and 42% preferred not to disclose their status.

83% (2,995) knew their status, 87% (2,617) were receiving ART, and 96% (2,517) had achieved viral suppression (Gaolathe et al., 2016). In 2014, 98% of the PLHIV who participated in the Stigma Index Survey reported that their health was 'fine to excellent', and 95% were adhering to their treatment regimen (BONEPWA+, 2014). With regard to the PMTCT programme, in 2014, there were approximately 11,295 HIV positive pregnant women enrolled, amounting to a coverage of more than 95% (MOHW and NACA, 2017a). That year, the vertical HIV transmission rate was 1.8% (500 infants) down from 2.5% in 2013 (MOHW and UNAIDS, 2016).

Quantitative data on access to and uptake of HIV services for MSM and FSW is more than five years old and predates the significant expansion of HIV programmes for these groups that has taken place since the 2012 IBBS survey was conducted. For FSW, the study found that 88% of participants had pre vviously had an HIV test, 55% doing so within the past year (MOHW, 2013). Relatively few of those who had tested HIV-positive, however, stated they were receiving ART: 40% amongst both Batswana and Zimbabwean migrant sex workers (Merrigan et al., 2015). The 2015 assessment conducted by Aids Fonds found that only 55% of HIV-positive sex workers received regular HIV treatment.

Although the country does not have a nationally agreed upon minimum package of services for reaching key populations, the most recent Joint Global Fund/PEPFAR Key Population HIV Cascade Assessment report indicates that over 90% of the planned targets given by PEPFAR and Global Fund were attained (Global Fund and PEPFAR, 2017). The prescribed targets include social and behaviour change communication (SBCC) messages, distribution of condoms and lubricants, uptake of HIV testing services (HTS), and referrals for ART initiation. The report also showed that there was district and community-level ownership of the programs. It calculated an HIV cascade for FSW for one project in Gaborone which is shown in **Figure 2**, below.

Figure 2: HIV cascade for FSW in Gaborone

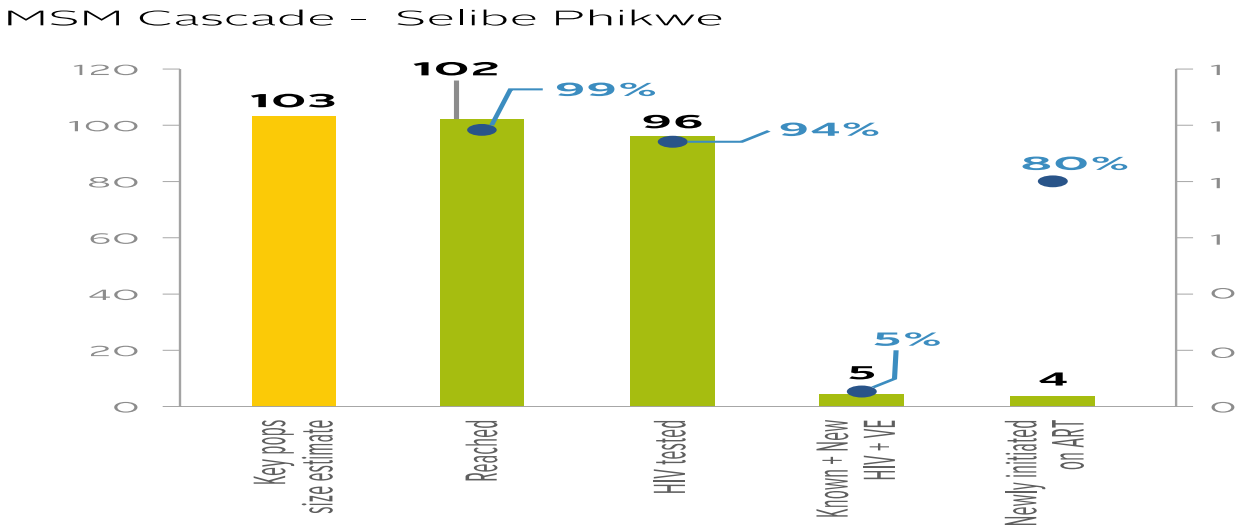


Source: Global Fund and PEPFAR, 2017

According to these data, programme coverage was 59% and, for FSW who were also PLHIV, ART coverage was 70%. The extent to which these figures represent the country-wide situation is not known, however.

For MSM, the 2012 IBBS study found that 76.2% of MSM participants had ever had an HIV test, and that 60.7% had been tested in the preceding six months (MOHW, 2013; Tafuma et al., 2014). Of the total study sample, a small proportion of participants (7.4%) self-disclosed their HIV status and an equally small proportion (13.1%) said they were receiving ART (ibid.). The extent to which this has changed, however, is not clearly known although, as is the case with sex workers, there has been significant expansion in MSM programmes since the study was conducted. The Global Fund/PEPFAR assessment in 2017 attempted to calculate an HIV cascade for MSM for one of the sites it included. The results are shown in **Figure 3**, below (Global Fund and PEPFAR, 2017).

Figure 3: HIV cascade for MSM in Selibe-Phikwe



Source: Global Fund and PEPFAR, 2017.

These figures clearly reflect the small scale of operations at the time of the assessment and likely cannot be understood to reflect the entire country. Elsewhere in the study report it is stated that uptake and retention in HIV programmes by MSM are lower than for FSW due to a number of factors which include: HIV-related stigma amongst MSM themselves; experiences of breach of confidentiality, including amongst peer educators; self-stigma and other mental health challenges; and, previous poor experiences in attempting to access services in public health facilities (Global Fund and PEPFAR, 2017). Finally, although current HIV treatment guidelines allow for the use of pre-exposure prophylaxis (PrEP), the reported noted that PrEP was not yet made available to MSM or FSW.

Available data suggests that, overall, there is relatively low use of HIV services by all adolescents. Notably, the MOHW and UNAIDS (2016) stated that:

> "Progress towards effective interventions to improve risk perception among non-infected adolescents, as well as specific programmes to address the particular needs of adolescence with acquired or prenatally transmitted HIV infection are not in place."

In 2016, only 41.1% of adolescents had ever been tested for HIV, and only 16.6% had been tested in the preceding twelve months. Furthermore, only 10% of boys and young men and 15% of girls and young women aged 15-24 knew their HIV status (NACA, 2017). There are apparent discrepancies in the official reports on the proportion and number of adolescents receiving ART. NACA (2017) reports that 90% of adolescent PLHIV were on ART in 2016. If the assertion is true, there would be 32,000-33,000 adolescents receiving treatment. However, this would mean that there was a rapid scaling up of treatment between 2013 and 2016 as figures for 2013 showed that only 9,900 adolescents PLHIV were on ART (MOHW and UNAIDS, 2016; NACA, 2017).

The government provides HIV and TB services for free to all citizens. IPT is not used in adult populations despite evidence and WHO recommendations for preventive treatment among certain adult patients. Although non-citizens can also use existing HIV and TB services they must pay for anti-retroviral medicines (ARVs). Currently, there are no comprehensive data on the extent to which non-citizens, some of whom are in the country illegally, cannot afford to buy ARVs. There are, however, a number of anecdotal accounts from CSOs working with such individuals that this is a significant barrier. Although the Botswana Prisons Service provides HIV and TB services in its facilities, including HTS and ART, until 2015, non-citizen inmates were also required to pay for ARVs. However, an August 2015 High Court ruling compelled the government to remove this requirement (BONELA and MOHW, 2017). Currently, condoms are still not part of the HIV prevention package in prisons.

Refugees and asylum seekers are required to stay in camps or other locations that the Government of Botswana designates. Those who are HIV-positive can receive ART services that are currently provided with support from PEPFAR although the Government of Botswana has committed to taking over this responsibility by April 2019. However, when individuals leave these areas, usually in search of employment since status determination can be a very lengthy process in the country, they, like other non-citizens, must pay for ARVs (BONELA and MOHW, 2017).

4.3. Relevant Features of the Country Context

The findings under this section describe the country context for work to address human rights-related barriers to HIV services in Botswana. This context includes law, policy and strategy issues as well as, more generally, the political and socio-cultural context for HIV and key populations. While key population groups and their human rights concerns are recognised in a number of key policy documents for HIV, the broader legal and socio-cultural context remains largely punitive for these groups and continues to impede the growing number of efforts to improve access and uptake of HIV services for them.

4.3.1. Legal Framework for the HIV Response

The legal context for HIV was recently mapped in the Global Fund-supported Legal Environmental Assessment (LEA) of which only main highlights are presented here (BONELA and MOHW, 2017). Botswana is a democratic, parliamentary republic that earned its independence in 1966. Although the country does not have a statutory entity for human rights, it nevertheless has a number of laws that protect the rights of all people from discrimination and promote access to health and other services. There are also a number of protective laws and legal mechanisms that support the rights of PLHIV and some groups that are vulnerable to or disproportionately impacted by HIV.

The amended *Public Health Act, No. 23 of 2013* covers a number of important issues that can support an effective national HIV response, including access to confidential testing for minors; prohibition of HIV testing in relation to employment; provision of pre-test information and counselling; protection of confidentiality; support for disclosure; and the regulation and quality of services and testing commodities (BONELA and MOHW, 2017). There are no specific provisions, however, that address the needs of key populations and, as discussed later in this analysis, the *Act* also contains highly problematic provisions regarding mandatory measures for HIV testing and disclosure.

Although same-sex sexual acts remain illegal in Botswana (see **Section 4.4.3**, below), the Botswana Court of Appeal recently stated in *Attorney General v Rammoge and 19 Others* that, "Members of the gay, lesbian and transgender community…form part of the rich diversity of any nation and are fully entitled in Botswana, as in any other progressive state, to the constitutional protection of their dignity (UNDP et al., 2018)." And, although there are equally no specific protections for transgender people, the High Court stated in *ND v Attorney General of Botswana* that, "…the State has a duty to uphold the fundamental human rights of every person and to promote tolerance, acceptance and diversity within our constitutional democracy. This includes taking all necessary legislative, administrative and other measures to ensure that procedures exist whereby all State-issued identity documents which indicate a person's gender/sex reflect the person's self-defined gender identity (ibid.)"

With regard to human rights and HIV, the country has a progressive law on employment. The *Employment Amendment Act of 2010* prohibits dismissal based on sexual orientation or HIV and also provides protection against discrimination for "any other reason which does not affect the employee's ability to perform that employee's duties under the contract of employment (BONELA and MOHW, 2017)." Botswana courts have protected the rights of PLHIV from unlawful HIV testing and disclosure in the workplace in a number of instances such as the case of *Diau v. BBS* and the case of *Attorney General of Botswana v. Unity Dow* (ibid.). There have been no cases to address discrimination on the basis of sexual orientation, however.

Botswana has a supportive legal and regulatory framework for the provision of most HIV services in prisons (BONELA and MOHW, 2017). Both the Prisons Act and the Prison Regulations require the Botswana Prisons Service to provide health services for inmates and to routinely monitor health-related conditions in all facilities. Policies and guidelines for HIV and TB also stipulate what services must be provided. However, because sexual activity remains illegal under the Prisons Act, these services do not extend to the provision of condoms.

In the case of GBV, the *Domestic Violence Act of 2008* provides protection against physical, sexual, emotional, economic and other abuse and harassment committed by intimate partners, family members and cohabitants (BONELA and MOHW, 2017). The *Act* also protects victims of domestic violence through an application of an interim order, a restraining order, a tenancy order or an occupancy order. Botswana has also enacted laws that protect children, adolescents and youth on issues of violence and harmful practices. These include laws establishing the age of legal capacity for consenting to sexual activity and for access to health services (18 years in both cases for both males and females); and providing for access to support services for orphans, vulnerable children, children with disabilities and refugee children (ibid).

4.3.2. Policies Addressing the Provision of HIV services

The country has national policies and strategic plans that provide an enabling environment for the provision of HIV services. The *Botswana National Policy on HIV and AIDS* has guided the national HIV response in Botswana for some years (NACA, 2012). With regards to human rights, the policy makes strong commitments to non-discrimination as well as to the principles of informed consent, privacy and confidentiality in the provision of HIV services. However, key populations are not mentioned in the document and, under the section addressing HIV treatment, there is the following statement that, "Every person in Botswana shall not be discriminated against in terms of access to health services. That notwithstanding, the Government may confer preferential treatment on its citizens (ibid)."

In addition to the policy, the NSF III recognises the need to address all forms of stigma, discrimination and violence that impede the implementation of effective interventions and that increase the vulnerabilities of particular groups in society (MOHW and NACA, 2017a). It calls for the "full implementation and enforcement of all existing protective laws and strengthening of access to justice and law enforcement" for key populations in order to eliminate stigma, discrimination and violence and to improve access to and utilisation of HIV services (ibid). At the time of this assessment, the operational plan for the NSF III was still in draft form and thus the specific actions to be taken to fulfil these commitments were not yet finalised (MOHW and NACA, 2017b).

In spite of these efforts to create an enabling environment through enacting progressive laws and drafting supportive policies, in practice some key and vulnerable populations continue to face challenges to protect themselves from HIV and to access needed services. These are described in the next section.

4.4. Human Rights-related Barriers to HIV services

The findings in this section consolidate information derived from the desk review as well as the fieldwork. They illustrate that, with regard to HIV services, there are significant human rights barriers to HIV services for gay men and other MSM, sex workers, transgender people, prisoners, and undocumented foreigners.

4.4.1. Stigma, discrimination and violence

Key informants and focus group participants interviewed indicated that stigma and discrimination against PLHIV and other key and vulnerable populations remains prevalent in Botswana, although they vary among these groups, including in how they affect access to HIV services. For example, the PLHIV Stigma Index Survey, carried out in 2013, found that only 10% of study participants had experienced external stigma, such as gossip and verbal insults, and that

only 5% experienced exclusion from social gatherings (BONEPWA+, 2014). However, according to key informants, there are still challenges for some PLHIV to come forward to be diagnosed and to access HIV treatment, largely as a result of self-stigma. They noted that, although stigma at community and family level is no longer as prevalent as it was, there are still some instances that may not deter PLHIV from accessing services but do affect their quality of life. For example, in Letlhakane, key informants noted that HIV-positive women in the community were sometimes labelled as sex workers and were said to be servicing men in the nearby mines. Living with HIV still has negative moral and cultural connotations, something that has been difficult for the country to permanently overcome.

Some key informants noted that there were still challenges for some PLHIV in workplaces. These concerned access to HIV services whereby, for example, some employers would not allow sufficient time for PLHIV to attend appointments or would refuse such requests. As a result, PLHIV would go to great lengths to hide their HIV status. The examples given were largely from small-scale retail businesses, although the supermarket chain Choppies was also mentioned. Other concerns involved PLHIV working in remote lodges whereby, although legally mandated to do so under Section 125 of the Employment Act, employers did not provide for the health of their employees by, for example, providing transport or other assistance for attending medical appointments.

There are more serious issues for key populations who continue to endure a heavy burden of dual stigma. According to key informants, **sex workers** continue to be blamed for being HIV-positive, bringing this on themselves as a result of their 'immoral' and criminal behaviour. These same informants described how, at community level, sex workers are rejected by family members, and the community at large, and are even condemned by cultural and religious leaders. The rejection extends to their children who are bullied and stigmatised. These observations were similar to the findings of an assessment conducted by Aids Fonds in 2015 which found that most participants experienced high levels of social stigma and discrimination, and that there were high levels of violence, including beatings, theft and rape (Aids Fonds, 2015). The main perpetrators were clients and the police, although sex workers were sometimes violent towards each other. Sixty-six percent of participants in this study experienced violence in the past year.

Stigma, discrimination and violence against **gay men and other MSM** are also widespread in Botswana. Criminalisation and other negative social-cultural and religious attitudes and beliefs fuel this situation. Key informants and focus group participants described how gay men and other MSM, and the wider group of sexual minorities, continue to endure challenges within their families and local communities, which include verbal and physical abuse, sexual violence, and threats of blackmail and exposure (UNDP et al., 2018; Zhan et al., 2016).

With regards to public attitudes towards sexual minorities, according to a 2015 survey, 60% of respondents would not accept to have 'homosexuals' living next to them. However, the fact that 40% did not feel this way placed Botswana amongst the more tolerant countries in the region where homosexuality remained criminalised (Dulani, Sambo, Dionne, 2016; Rakgoasi and Keetile, 2016). Some key informants and focus group participants spoke about how things are beginning to change in the country in large part due to the sustained efforts of key population communities themselves to earn recognition, such as through the recent court decisions already noted in this analysis. Some recent studies have also documented these early signs of improvement (Muzenda, 2017; Global Fund and PEPFAR, 2017; UNHRC, 2017).

Stigma, discrimination and violence against transgender people, particularly **transgender women**, have been reported. A recently concluded mapping and size estimation study found that

many transgender women experienced constant stigma, discrimination, and harassment in their families and communities, the impact of which included mental health problems, including thoughts of suicide, poor educational outcomes, poverty, unemployment, and social marginalisation (MOHW and ACHAP, 2017). High levels of physical and sexual violence and abuse have also been documented (UNDP et al., 2018). As a result, many individuals have legitimate fears of being seen in public spaces, including health facilities.

There is limited information on stigma, discrimination or violence regarding the other groups included in this assessment. Refugees and asylum seekers, for example, have recently raised public concern about the conditions within which they are currently held and the discriminatory and abusive treatment they experience.[8] The government has denied these claims.

4.4.2.Stigma and Discrimination in Health Services

Neither the desk review nor the field work found any substantial evidence of generalized HIV-related stigma and discrimination in the provision of health services in Botswana. Some informants spoke about how having separate facilities for HIV treatment (the Infectious Disease Care Clinics) had the effect of involuntarily disclosing someone's status as they were seen coming and going from these venues. This was not said to be a substantial barrier to access or retention in services. Challenges were much more significant for key populations, however.

With regard to **sex workers**, such issues are well documented and were confirmed during the fieldwork. Key informants and focus group participants all described how sex workers continue to endure stigma and discrimination from HCWs in public facilities. This includes being denied access to lubricants, post-exposure prophylaxis (PEP) and condoms. They can also be ridiculed by HCWs for the frequency of their visits and can have their confidentiality breached when they are gossiped about by the staff. The Hands Off! assessment made similar findings as illustrated in the following comment by a FSW from Gaborone: "I have a dress that shows my hips and I once wore it to a clinic in the morning. The nurse called some nurses and said to them, 'This one is selling her body.' She asked me why I was wearing this dress and I told her it's because I want to wear it and she said never come here wearing a dress like that. I told her I want to wear it, can you please just help me with prevention injection and nothing else (Aids Fonds, 2015b)."

For MSM and transgender women, the situation is similar. Key informants and focus group participants from across the country gave accounts of how these groups face significant difficulties to use health services because of what they experience from HCWs. This echoes similar findings from two recent studies (Southern African Litigation Centre [SALC], 2016; UNDP et al., 2018). There were numerous accounts of how individuals would simply avoid public health facilities, even at the cost of their own health, rather than have negative and demeaning experiences with HCWs. As a result of the recent expansion of health interventions for key populations in some parts of the county, which include components of training and sensitisation for HCWs, it was noted that the frequency of such experiences was declining for some individuals (Botswana Centre for Human Rights et al., 2017; Global Fund and PEPFAR, 2017; MOHW and ACHAP 2017; Muzenda, 2017). In places where these programmes did not operate, however, no change was occurring.

Key informants gave some accounts of different groups of **'non-citizens'**, such as undocumented foreign migrants, having negative experiences when accessing HIV services. HCWs cannot or do

[8] See: https://www.dailymaverick.co.za/article/2018-01-08-botswana-asylum-seekers-accuse-prison-officials-of-ill-treatment-and-sexual-assault/#.Ws8_TS97HUo

not provide assistance. These issues instil fear amongst those seeking services. Finally, key informants also gave some accounts of adolescents and young people facing challenges as they seek HIV and other sexual and reproductive health services. It was said in one focus group discussion (Kasane) that some parents would ask auxiliary staff at facilities to inform them if their children were seen using HIV or other services.

4.4.3. Punitive laws, policies and practices

Although the Constitution of Botswana articulates a commitment to human rights for all citizens, certain key and vulnerable populations experience punitive laws, policies and practices that effectively deny these rights. Punitive laws that limit access and uptake of HIV services for these groups include the following:

- Criminalization of HIV non-disclosure, exposure and transmission deters people from seeking to get tested and know their HIV status.

- For **MSM** (as well as for lesbians and transgender people), Section 164, 165 and 167 of the *Penal Code* criminalise sexual relations between persons of the same sex (BONELA and MOHW, 2017). The sections specifically refer to sexual conduct between same sex persons as "offences against the order of nature". While there have been very few criminal prosecutions under these provisions, the possibility of prosecution continues to be a major source of threat and intimidation for sexual minorities in the country (UNDP et al., 2018).[9] As the assessment was being conducted, LeGaBiBo lodged a constitutional challenge calling for the law to be repealed.

- For **sex workers**, Sections 149 and 155-158 of the *Penal Code* criminalize sex work, including purchasing sexual services, living off the proceeds of prostitution, and brothel-keeping. Section 179 covers "idle and disorderly persons" and includes "a common prostitute" in this category. There is a large body of evidence on the serious, negative impacts of this law, and key informants and focus group participants only confirmed these many findings. The impacts include arbitrary arrest and detention, physical and sexual violence and abuse, bribery and extortion, and ridicule and public exposure. There were a number of accounts of how police officers in communities would harass and arrest women for 'loitering' or being a 'common nuisance,' for their appearances, or for simply being in a location where sex workers were usually found. Condoms were also confiscated as evidence that women were sex workers. There were rarely any formal cases launched when sex workers were arrested. Foreign migrant sex workers were more vulnerable to such abuses and feared deportation.

- For **drug users**, the *Drugs and Related Substances Act* prohibits the use, possession and sale of "habit- forming" drugs. There is no further definition of what drugs this includes. As already noted, the country is still working to understand drug use in the context of HIV so it is not known at this time how this law affects access to HIV services.

- The *Public Health Act* contains highly problematic provisions regarding the use of **mandatory measures** for HIV testing and disclosure of HIV status to others by HCWs (sexual partners of newly diagnosed PLHIV, for example, where an individual has not done it on his or her own). The *Act* also addresses situations where a PLHIV

[9] Although the use of this language has become rare, as recently as 2016 a Magistrate in Gaborone at the Village Magistrate Court issued a conviction on these grounds. The individual was, however, pardoned shortly afterwards. The case was, unfortunately, not officially reported; nor was it appealed.

"knowingly or recklessly places another person at risk of becoming infected with HIV." In such instances, a court can order mandatory treatment or counselling, or that an individual be detained for a maximum period of 28 days. There are no written accounts of whether or not any of these provisions have been used (Sarumi and Strode, 2015). There was a clear consensus amongst key informants that these provisions were both unnecessary and potentially harmful in perpetuating HIV-related stigma.

Finally, it is worth noting that, under the *Refugee Act*, **asylum seekers** may be kept in a prison pending a determination of their status or pending deportation (BONELA and MOHW, 2017). These individuals and their families are currently held at the Francistown Centre for Illegal Immigrants under prison conditions, some for long periods of time well beyond the maximum of 28 days stipulated under the law. Other prisoners are also housed at the centre. In 2017, approximately 170 asylum seekers sought the assistance of the court to address the harsh conditions at the centre, which included the absence of schools for children and inadequate health services, including HIV services (Konopo and Ntibinyane, 2017). The petitioners lost their case but the court did confirm the centre's status as prison bringing with it the obligation to provide health services, including HIV and TB services, to all detainees as would be the case for other inmates in other facilities. The attempt of some NGOs such as BONELA to monitor this, however, have not been successful and no access to the centre by such entities is currently allowed.

4.4.4. Gender-related Barriers

Although a full assessment of gender-related barriers to HIV services was not part of the scope of this effort, both the desk review and the fieldwork did identify a number of gender-related concerns. These include cultural beliefs and practices, gender-related stigma regarding HIV, and rigid gender norms that, amongst other negative impacts, contribute to GBV.

For example, key informants and focus group participants in the Maun region, Francistown and Kasane spoke about how traditional beliefs and customary practices perpetuate gender inequality and violence against women. Some of these key informants described how men in rural areas rely on traditional medicines to 'heal' their HIV and, afterwards, considering themselves no longer HIV-positive, are no longer willing to use condoms. Men still carry the burden of self-stigma, which can inhibit their access to HIV services and fuels discrimination against their partners who are HIV-positive.

Aside from the field work, other sources have shown that women in Botswana are generally still considered to be morally responsible for HIV. A gender analysis of the HIV response in Botswana conducted in 2016 highlighted the following (Ramatla, Bloom, Machao, 2016):

- Rates of GBV, including intimate partner violence (IPV), are high in Botswana. In 2012, 67.3% of women reported experiencing some form of GBV, and 44.4% of men reported having perpetrated violence against women (Women's Affairs Department and Gender Links, 2012). Furthermore, 28% of the survey respondents reported experiencing IPV in the preceding year, whilst 62% had experienced it at some point in their lives. There are no more recent data to know whether, given expanded efforts to transform gender norms and to protect women and girls, the situation has changed (see **Section 4.5.9**, below).

- Gender norms play a significant role in driving stigma, discrimination and violence against key populations, particularly sex workers, MSM and transgender people. Individuals who challenge norms of masculinity, particularly 'feminine' gay men, transgender women and lesbians, are at high risk of violence and abuse.

- For some women living with HIV, stigma and violence surrounding disclosure to partners, and challenges negotiating condom use and having children continue to arise. Finally, some women living with HIV also experience stigma from HCW, particularly regarding contraception.

The fieldwork further highlighted that there is still an entrenched belief that 'good young girls' do not engage in sexual intercourse. This, along with parental consent requirement for adolescents below the age of 18, inhibits them from accessing HIV and other sexual and reproductive health (SRH) services. Finally, both the LEA and the gender analysis address the dual legal system in Botswana, particularly the aspect of the use of customary laws that, in many instances, can privilege men over women in circumstances involving marriage, children, inheritance, and property rights. How this affects access to HIV services, however, was not specifically addressed in either analysis.

4.4.5. Other barriers

Although poverty and socio-economic inequality remain cross-cutting concerns for the country, neither the desk review nor the fieldwork revealed substantial barriers in this regard for access to HIV services. One issue that was raised was the fact that ART is provided only in designated referral hospitals across the country, meaning that some PLHIV may face high transport costs to attend monthly appointments. While community-based delivery of ART and longer dispensing periods (three months versus one month) are being implemented, they are not yet instituted country-wide. There were related issues for key populations. MSM or transgender people who are excluded from their families and communities experience high levels of poverty which, if they are HIV-positive, affects their ability to access and remain on ART. Further, as many individuals will prefer to use key-population-friendly services, there can be additional transport costs when they are not available locally. At the time of the assessment, one PEPFAR-supported clinic was closing due to changes in funding agreements and focus group participants who were peer educators spoke about how individuals were planning to travel as far as Gaborone to receive services rather than use their local public health facilities.

4.5. Efforts to Address and Remove Barriers to HIV services

4.5.1. Overview

Efforts to identify and remove legal and human rights barriers to HIV services have been intensifying in Botswana, given the relevant provisions in the national legal and policy framework, and efforts of government and communities as well as other civil society organizations. Some of these efforts are part of the regional Global Fund-supported Removing Legal Barriers and KP REACH projects while other are funded under direct Global Fund grants to Botswana. PEPFAR is also a main contributor.

Expanding combination prevention interventions for MSM, sex workers and transgender people, for example, integrate human rights components in their design, such as stigma reduction and building personal pride and resilience; training for HCWs; sensitization of police and local authorities; rights literacy and legal support; and comprehensive responses to support survivors

of sexual violence. There has also been strong engagement on the part of civil society, including key-population-led organizations and their allies, to identify and address human rights barriers to services.

Across all of these efforts, however, some challenges continue to arise. Changes to the external environment, particularly removing punitive laws and strengthening legal protections against discrimination and violence, are not moving forward meaning that individuals are still reluctant to come forward to use available services, even when they are key population specific. One of the main reasons for such slow change is the lack of strong leadership and commitment on the part of the government to address and remove barriers, even within the MOHW which itself is reluctant to explicitly support key population concerns, citing the limitations imposed by current laws. Other challenges include the lack of a central structure for coordinating human rights work in the context of HIV; duplication and fragmentation of existing efforts; and, the lack of evaluation meaning that many activities are simply repeated without sufficient attention as to whether or not they are effective.

In taking all of these items into account, a number of specific actions are proposed that would comprise a more comprehensive and effective approach for addressing and removing the barriers identified through the assessment. The remaining discussion begins by describing cross-cutting approaches that integrate human rights components before addressing each of the seven main programme areas.

4.5.2. Integrated Approaches

Interventions that integrate components for removing human rights barriers to HIV services have included the following:

- ACHAP, as a Global Fund Principal Recipient (PR), engaged Tebelopele Voluntary Counselling and Testing Services as a Sub-Recipient (SR) to deliver combination prevention programmes for sex workers in eight districts (Greater Francistown, Tutume, Palapye, Okavango, Boteti, Serowe, Ngamiland and Kweneng West). Combination prevention includes condom and lubricant distribution, HIV testing, counselling and referral for STI screening, and referral for ART. Programme components addressing human rights concerns includes weekly empowerment groups for stigma reduction and resilience, amongst other needs; training of HCWs on stigma reduction in service provision; legal literacy; proactive work with the police and other local authorities to accept and not interfere with the programme; and, advocacy for Zambian and Zimbabwean sex workers to be able to receive services. Peer educators who participated in the baseline assessment spoke about how, in their view, the project had reduced stigma in health facilities and the level of police abuse against sex workers while at the same time empowering women with knowledge about their health and rights. There was concern, however, about the project coming to an end and how much positive progress would be sustained.[10]

- Similarly, ACHAP engaged BONELA to implement combination prevention interventions for MSM and transgender women in seven districts (Palapye, Francistown, Serowe, Selebi-Phikwe, Tutume, Boteti and Ngamiland). The combination prevention package was the same as for the sex worker intervention; so too were the programme components addressing human rights barriers. Peer educators for the project also participated in the assessment. They noted that self-stigma and fear of being identified as MSM continued to keep individuals away from

[10] See: http://www.tebelopele.org.bw/?page_id=81

services, two issues the project was not effectively addressing.[11]

- ACHAP is also the PR for Botswana for regional Removing Legal Barriers project. It has similarly engaged BONELA as the main implementer of funded activities. This programme of work cuts across many areas of human rights programming, including stigma and discrimination reduction; interventions for HCW to reduce stigma and discrimination in service provision; training and sensitisation for law makers and law enforcement agents; legal literacy; law and policy reform; and, improving access to justice.[12] The LEA was a component of this project.

- BONELA itself undertakes a comprehensive range of programmes from local to national levels to 'promote, protect and fulfil' the legal and human rights of key populations, including for access to HIV services. In 2015 alone, for example, these included interventions for stigma and discrimination reduction; legal and human rights literacy; provision of legal services; maintaining a database of legal and human rights abuses; strategic litigation; advocacy for law and policy change; and capacity-building for CSOs and other entities on human rights (BONELA, 2016).

- BONEPWA+, as the national network of PLHIV, has in the recent past implemented a number of programmes that address human rights issues. These included support groups for, amongst other things, dealing with stigma and discrimination, including self-stigma, and legal and human rights literacy. BONEPWA+ is also active as the public face of PLHIV country-wide. Its members participate in a range of public fora from the national to the local community levels to address stigma and discrimination, and to improve knowledge and understanding regarding the legal and human rights of PLHIV.[13]

- A number of local key-population-led organisations also undertake human-rights related activities that are integrated within their broader SRH programmes. These are LeGaBiBo, Rainbow Identity Association (transgender and intersex people), Pilot Mathambo Centre for Men's Health (MSM and male sex workers), and Men for Health and Gender Justice (gay men and other MSM). Under the Bridging the Gaps programme, these groups are supported to undertake community mobilisation and empowerment interventions for stigma reduction and resilience; to work with traditional and religious leaders in communities; to sensitise HCWs on provision of stigma-free services to key populations; and to improve their organisational capacities for advocacy and engagement. These activities are integrated with other programme components supporting service provision for HIV and other SRH needs.[14]

- Sisonke Botswana is a sex-worker-led, national network for sex workers of all genders. Integrated within its combination prevention interventions are components of stigma reduction and resilience, legal and human rights literacy, access to legal services, and support and referral for survivors of physical or sexual violence.[15]

- Botswana Family Welfare Association (BOFWA), which amongst other activities provides SRH services, is the lead implementer for the three-year Advocacy, Communication and Social Mobilisation (ACSM) project supported by PEPFAR. In addition to supporting HIV and SRH

[11] See: http://www.achap.org/global_fund_three.php
[12] See: http://www.achap.org/rlb.php
[13] See: http://www.bonepwa.org.bw/home/
[14] See: https://www.hivgaps.org/projects/lesbian-gay-bisexual-and-transgender-projects/lgbt-project-botswana/
[15] See: http://www.nswp.org/members/africa/sisonke-botswana

services for sex workers and MSM, the project has a focus on creating enabling environments using diverse communication strategies that have the objective of changing knowledge and attitudes of different national and community level stakeholders. These include opinion leaders, service providers, and community leaders and others.

Taken together, all of these efforts give the impression of a comprehensive response to human rights-related barriers to HIV services as most of the UNAIDS-defined programme areas are covered in some way. There appears to be a contradiction, however, between what organisation say they are implemented and the findings of this assessment which describe a number of ongoing barriers and challenges for key populations to access HIV services. When asked about this, key informants gave the following explanations:

- Interventions focus at the local level, particularly policing units or health facilities, for example, and when individuals who have been sensitised or trained leave their posts as a result of rotation, progress is lost.

- There is a very low level of institutional commitment to change in regards to key populations, particularly the Botswana Police Services or amongst the bodies that govern health care professionals, particularly nurses. As already noted, the MOHW itself has been reluctant to make institution-wide commitments to address stigma and discrimination against key populations in public health facilities.

- No evaluations have been done by implementers to measure what works, particularly how efforts to remove barriers have increased uptake of HIV programmes. Although during the assessment key informants shared some success stories of local level changes--certain health facilities becoming more key-population-friendly, policing units changing their practices, or communities becoming more accepting--there was no information shared about more systematic efforts to identify best-practices and to seek to replicated them country-wide.

- All of the activities described in this section are externally funded and, for the most part, operate outside of the public health system, posing challenges in ensuring sustainability. There has been slow movement at best by the MOHW to integrate services for key populations within public health facilities, except for those that are included within these externally funded projects. And while the presence of these externally funded projects has helped to establish trust with local key population groups, such as sex workers or MSM, to persuade them to use the facilities the project supports, once the project ends, old fears return for individuals that HCW will revert to previous stigmatising and discriminatory practices.

- The legal context of criminalisation and the corresponding absence of protective laws, policies and effective mechanisms for redress for key populations continues to limit what progress can be made as, on the one hand, it provides reasons for individuals such as the police or HCWs not to change attitudes and practices, and, on the other, it creates reluctance and fear on the part of these individuals to participate in programmes or to use services.

- Finally, while some entities have forged effective partnerships amongst each other for collaboration, ACHAP and BONELA, for example, there is no overarching coordination mechanism for human-rights-related work in the context of HIV. There is, as a result, no platform for exchange between stakeholders on what works for removing barriers, how much collective progress is being made, and which approaches should be prioritised for country-wide expansion and additional resource mobilisation.

To address these challenges in order to accelerate progress towards removing human rights-related barriers, a more comprehensive, cross-cutting approach should contain the following:

- **Establish a specific coordination mechanism for work to address and remove human rights barriers**. Ideally, this should be led by NACA with shared leadership from key population representatives, adolescent girls and young women, women's organization, and include multi-sectorial participation. The LEA TWG (discussed further in **Section 4.5.8**, below) that has steered this baseline assessment could be restructured for this purpose rather than looking to establish a new mechanism. Amongst other functions, the bod could monitor and oversee the implementation of the 5-year comprehensive plan generated through this baseline process.

- **Address the gaps in data regarding uptake and retention in HIV services for key populations**. These gaps were described in **Section 4.2**, above, and include among others, key populations size estimates, age and gender-disaggregated data on epidemiology and access to services for all key populations. While they persist they will impede efforts to understand which approaches to removing barriers are more effective than others. This work should be a high priority and should be led by the MOHW and NACA with strong collaboration from partners such as PEPFAR and UNAIDS. The country is not so large and the number of interventions not so great that a consolidate data set could not be generated to monitor what key-population-focussed programmes are collectively achieving.

- **Prioritise evaluation of programmes to reduce human rights barriers.** While it may be the case that many current efforts are able to achieve and sustain positive change in ways that the assessment did not capture, such things are currently neither documented nor shared. The endline evaluation of the regional Removing Legal Barriers project could be shaped to address some of these gaps. Better evidence is needed on which approaches are most effective for the Botswana context so that available technical and operational resources can be better aligned to what will increase momentum for change.

More details on efforts to remove human rights barriers according to the seven main programme areas are given in the sections that follow.

4.5.3. Stigma and discrimination reduction

There are some interventions in Botswana that are focussing on reducing HIV-related stigma amongst PLHIV, particularly self-stigma and its influence on retention for HIV treatment. From 2016 to 2017, BONEPWA received support from NACA to implement the Positive Health and Dignity (PHD) project in eight of the country's 17 districts where there were higher numbers of PLHIV. The programme components included finding and supporting PLHIV who had stopped treatment largely because of challenges of self-stigma. Further, the PHD approach is a component of the PEPFAR-funded "Treat All Project", which is implemented in six priority districts. This component includes addressing internalised stigma through peer counselling for self-acceptance and for building personal resilience.

Across all efforts to reduce stigma and discrimination, including those described in the previous section, some gaps and challenges remain. These include:

- There is a lack of consensus across stakeholders on the extent to which generalised HIV-related stigma is still present in Botswana and what is required to address it. Quantitative data is out of date and there is a high degree of complacency amongst some stakeholders who believe that stigma reduction is no longer a main priority.

- Efforts to identify and address self-stigma, and to understand its longer-term implications for PLHIV, have been episodic and based largely on the PHD approach which is not implemented on a country-wide basis.

- There are no clear institutional-level commitments, on the part of the MOHW or other government entities, for example, to reduce stigma and discrimination against key populations. This work relies solely on the efforts of civil society and although there are many successes in communities, progress is eroded by turnover and the lack of higher level commitments and accountabilities to end discrimination against these groups.

- Stigma reduction interventions led by key population constituencies in communities do not follow common approaches and sometimes duplicate each other. Rarely within programme designs are there processes for measuring change.

- There is an absence of specific stigma reduction interventions for transgender people with many making the assumption that transgender women, for example, are covered under interventions addressing stigma and violence against MSM.

A comprehensive approach to reducing stigma and discrimination against PLHIV and key populations should include the following:

- **Conduct a new Stigma Index Survey using the revised methodology that is more inclusive of key populations.**[16] The results of the survey can then inform a coordinated action plan for reducing or eliminating forms of HIV-related stigma and discrimination that remain.

- **Improve the technical capacity of NACA and the MOHW to take stronger coordinated action on reducing all forms of HIV-related stigma and discrimination, including stigma and discrimination against key populations.** There are commitments to lead change within the NSF III but, in the experience of key population groups, such things have not led to concrete actions in the past. In addition to stronger action within their own institutions, NACA and MOHW should also prompt actions and accountabilities across other government stakeholders, as well as greater coordination among stakeholders' actions.

- **Sustain work using social media channels to publish and promote positive stories regarding key populations.** While it is important to highlight the challenges faced by key populations, it is equally important to show how these same groups make important contributions to the social-cultural and economic make-up of the country. Under the Global Fund-supported regional KP REACH project, local journalists were supported to write profiles of individuals from Botswana but they were not yet widely shared by the time of the assessment.[17] This work should be sustained and expanded.

- **Investigate reports of workplace discrimination against PLHIV and key populations and take appropriate action.** The multi—stakeholder consultations should determine roles, responsibilities and mechanism for receiving such reports, with due regard for confidentiality and privacy, and supporting PLHIV who have experienced discrimination to take effective action. This responsibility should also extend to working with relevant

[16] See Friedland, Sprague and Nyblade (2018).
[17] See, for example: https://kpreach.net/living-freely-pontsho-sekisang-tackles-stigma/

counterparts in government to investigate workplaces where discrimination is alleged to still be occurring and to support their owners to make appropriate changes.

- **Continue work in communities to convene dialogues regarding diversity and inclusion, and equal health for all.** Key informants were of the view that this work at the community level was essential for increasing tolerance and acceptance of diversity as it provided opportunities for person-to-person sharing of experiences by key populations in their communities as well as opportunities for other community members to raise their questions and concerns. Such work at community level must follow common effective approaches while allowing for contextualization, must be coordinated, and must document approaches and successes.

- **Develop more focussed, community-level and peer-led interventions for transgender people, particularly transgender women.** This assessment and other sources have indicated that stigma, discrimination and violence experienced by transgender people are more severe than those faced by other key populations and that these problems are not being effectively addressed under broader approaches working with MSM, for example.

4.5.4. Training for health care workers on human rights and medical ethics

Training and monitoring of HCWs is the responsibility of the MOHW in partnership with the country's training institutions and the governing bodies for health professions. With specific regard to HIV, in 2016 the MOHW released new HIV treatment guidelines to support the roll-out of the 'Treat All' approach (MOHW, 2016). In the introductory section, the guidelines state the importance of providing all services based on principles of human rights and medical ethics. The guidelines also address provision of PrEP to MSM and sex workers, amongst other groups (however, this is not yet implemented in the country). The MOHW, with support from partners, leads the training of HCWs on the implementation of the new guidelines.

As already noted, the ACSM project led by BOFWA has a component of conducting trainings and values clarification interventions for the HCWs linked to their service delivery programmes. There is work by other key-population-led entities, such as LeGaBiBo, Pilot Mathambo Centre for Men's Health, and Rainbow Identity Association, amongst others, to sensitise and equip HCWs for non-discriminatory, non-judgemental service provision. These activities take place in specific districts with specific health facilities, however, and do not as yet amount to country-wide reach.

Clearly, as the results of this assessment show, there are still gaps in this work as many individuals from key population groups continue to have negative experiences. These challenges include:

- **The commitment on the part of the MOHW to address the challenges for HCWs to provide stigma-free services for key populations is not strong.** There is still both a lack of clarity and a lack of consensus on the role of the MOHW to insist upon the provision of non-judgemental and non-stigmatising services by all HCWs and to enforce accountabilities for professionalism and ethics. There is a prevailing view that 'we treat everyone the same' and that problems are the fault of key populations themselves who are said to expect 'preferential treatment' or to misunderstand how HCWs do their work in facilities.

- **A patient-centred, rights-based approach to the provision of health services is still relatively unknown amongst HCWs or, at least, rarely practiced.** Two important reasons for this are the above-noted lack of high-level commitment on the part of

the MOHW to this approach, as well as the lack of adequate emphasis and re-emphasis on its importance in both pre-service and in-service training programmes.

- **In the absence of such strong institutional commitment, key-population-led efforts to work with individuals and facilities have limited effects.** This is particularly true in the context of constant rotation of HCWs in public facilities. Also, these efforts can never reach all HCWs nor can they strengthen institutional accountabilities for appropriate care.

A more comprehensive approach to improving the practice of patient-centred, rights-based approaches to the provision of all health care services should include the following:

- **Send a directive to all health facilities re-emphasising that the MOHW is required to offer patient-centred, confidential, rights-based non-discriminatory care to all individuals in need.** This should be done by the Minister or a relevant senior-level official. The wording of the directive should be supportive of HCWs and the critical roles they play but also be mindful of the need to ensure that all patients receive an appropriate standard of care. HCW need to be capacitated to be able to apply the directive in practice.

- **Support the MOHW to increase the amount of training provided to HCWs, at both the pre-service and in-service stages, on the importance of medical ethics (particularly privacy and confidentiality), professionalism, and the rights and entitlements of all patients to receive appropriate care.** The training should be conducted in a way that allows HCWs to express their concerns and to clarify their values, beliefs and practices regarding their role in the health care system. There should be a particular emphasis on clarifying patient confidentiality so as to prevent any disclosure of information to individuals outside the health care setting, including the police, unless a specific law or regulation provides for it. As one-off trainings are not effective, such capacity building needs to be institutionalized in the current pre-service and in-service education, provided regularly and apply both institution-led and key population-led training delivery modalities.

- **Develop and implement minimum service packages for key populations that apply to the public health sector.** This is the responsibility of the MOHW which should receive any needed technical support to move it forward. Such packages will help to clarify for HCWs what services they are obliged to provide and, for key populations, what services they can expect to receive. NACA should facilitate the process to ensure that there is adequate involvement of key population representatives in the development of the packages.[18]

- **Support both PLHIV and other key-population-led networks to understand and use processes to raise issues regarding the quality of care or the conduct of HCWs.** While there is an understandable reluctance on the part of individuals and communities to make formal complaints, there should be more opportunities for individuals to connect with CSOs and networks to engage with these processes and to use them for mutual problem-solving and collaboration.

[18] While the assessment was underway, UNFPA in Botswana was preparing to provide technical support for the development of the packages.

4.5.5. Sensitisation of law-makers and law enforcement agents

'Law-makers' in Botswana include not only parliamentarians or the justice sector, but also local traditional structures led by *dikgosi* of chiefs who continue to have a strong influence over the daily lives of much of the population. Investing in their capacity is therefore critical. A number of assessment participants stressed the need for HIV programs to be guided and led or owned through such structures and processes.

Key-population-led groups are doing work at this level and those involved describe how some communities are beginning to become at least more tolerant if not exactly fully embracing of diversity. While some traditional leaders, village development structures, church leaders and local politicians are changing their beliefs and practices regarding key populations in their midst, this progress depends largely on individual willingness to change and, in some cases, can easily be reversed when there is turnover of members in these structures (see also Muzanda, 2017).

One approach was said to be stronger than others which were the community dialogues convened by *dikgosi* with the support Rainbow Identity Association and Men for Health and Gender Justice. The dialogues take place as part of *kgotlas*, or local community meetings, which are traditionally used as places to raise community concerns for discussion and resolution through consensus under the guidance of the chief. The point of these dialogues is to, on the one hand, raise issues of diversity and to share some of the negative experiences of stigma, discrimination and exclusion individuals endure because of their sexual orientation or gender identity, and, on the other, to provide an opportunity for community members to raise questions and issues regarding tolerance and acceptance, many of which arise due to lack of knowledge or understanding (McAllister, 2015; Muzanda, 2017).

Key informants noted that there has been less success working with religious leaders who also wield strong influence over community norms and behaviours. While, for example, the Botswana Council of Churches has voiced support for respecting and protecting individuals, churches leaders from other institutions have firmly condemned this position, the most vocal of these being the Evangelical Fellowship of Botswana (Muzanda, 2017). Nevertheless, key informants did state that as part of their community level work, some individual church leaders were becoming more tolerant and accepting, albeit in mostly discrete ways, of the diverse individuals within their congregations and surrounding communities.

Another approach being implemented by BOFWA and its partners involves intervening with district level structures, such as Technical Advisory Committees and District Multi-Sectoral AIDS Committees, to have stronger technical capacity regarding key population programming and to play a role in creating and sustaining enabling environments. Different sectors are represented on the Committees, including local law and justice sectors as well as local cultural and religious institutions.

As noted above, there is also work by national networks and CSOs with parliamentarians, judicial officers, and the police. BONELA has been leading much of this work over the years and, under the Removing Legal Barriers project in particular, this work has recently expanded. Work with the judiciary has involved sessions on human rights law, including its application and interpretation in the context of HIV and key populations, a topic that is not adequately covered in legal education in the country or in the training of the judiciary. Key informants viewed recent court rulings on sexual orientation and gender identity, highlighted previously, as one indication of the success of these efforts.

Through the Hands Off! Project, BONELA and Sisonke Botswana will receive support to develop training manuals for police on working with sex workers (Aids Fonds, 2015a). The manuals will be an adaption of materials developed for use with the South African Police Service. The training is meant to be done with the Botswana Police Service and other related law enforcement agencies such as the Botswana Defence Force. It is also worth noting that, in its recent Universal Periodic Review submission, the Government of Botswana stated that it has provided general human rights training to the police. However, this assessment captured no additional details about the activity and some key informants disputed this assertion (Botswana Centre for Human Rights et al., 2017; UNHRC, 2017).

Finally, a number of partners are working with the Botswana Prison Services, including Prison Fellowship Botswana, Alpha Botswana, Botswana Red Cross Society, Tebelopele, and Botswana Christian AIDS Intervention Programme. These efforts are largely focussed on supporting the provision of services, such as HIV education and HTS. They also support released prisoners with their transition back to communities, including those on HIV treatment. No information was available however, on the extent to which these groups address human rights concerns.

Across all of these efforts, however, there are some important gaps:

- **Similar to work with HCWs, the lack of institutional commitment to address stigma, discrimination and abuse against key populations means that efforts by CSOs that work with individuals at community level have limited impact.** This is particularly true for work with police, for example, where individual officers are sometimes conflicted in their roles. While they appreciate the training they receive and understand the importance of change, they must still work within a structure that enforces laws, including criminal provisions against sexual minorities, sex workers or drug users. The senior leadership of the Botswana Police Service has yet to give any indication of willingness to provide institutional support for changes in police practices.

- **While parliamentarians are willing to hear and be sensitised on key population concerns in the context of HIV, particularly the Parliamentary Committee on HIV and Health, there is not the same willingness to take action.** Too often the criminal laws are raised by legislators as an impediment (excuse?) in the way of showing more leadership to remove human rights barriers to HIV programmes.

- **Institutions supporting traditional and religious leadership structures are resistant to change.** As described above, local chiefs or religious leaders are amendable to change but, for example, the governing body of chiefs, the *Ntlo ya Dikgosi*, has, as yet, expressed no public support for key population concerns.

- **Government institutions are similarly resistant to change, even in the face of court rulings that require them to do so.** For example, despite the court ruling that the

refusal to register a legitimately constituted organisation such as LeGaBiBo was a violation of the constitutionally guaranteed right of freedom of association, the Ministry of Justice is still considering requests on a case-by-case basis and suggesting that other organisations should also seek court orders.

- **Due largely to inadequate funding, community level interventions have been episodic and limited in geographic scope.** Also there has been a tendency to repeat approaches, such as community dialogues, based on available funding rather than to evolve towards higher-level and more complex interventions to encourage institutional change.

- **There is very little political engagement beyond educational sessions with parliamentarians, for example**. While these efforts have their value, advocacy for more comprehensive law and policy change, including decriminalisation, cannot be effective without more direct political engagement by key population groups and their allies from the constituency to the national levels.

A more comprehensive approach to achieve sustained change across the law and justice sectors, and amongst traditional and religious leaders, should include the following:

- **Consolidate work with traditional authorities into one, overall approach that works at community and institutional levels.** Both levels of intervention are important; however, more impact could be achieved through greater coordination. This could be done through BONELA, for example, whereby, in addition to continuing to support CSOs to conduct dialogues, it could be working directly with the *Ntlo ya Dikgosi* to guide it to put in place institutional mechanisms for supporting chiefs to acknowledge and champion diversity within their chiefdoms.

- **Strengthen coordination amongst CSOs working with the police, at local and national levels, in order to exert stronger pressure for an institutional commitment to changing police attitudes and practices towards key populations.** The Hands Off! Project has made an important step forward in gaining the commitment of the Botswana Police Service to implement training to eliminate violence against sex workers by its officers. This opportunity should be leveraged through a coordinated strategy to expand the commitment to protect and respect all key population groups.

- **Equip key-population-led networks and leaders, and their allies, with stronger technical capacities for political engagement and lobbying.** Significant law and policy change can only come about based on the political will of a majority of parliamentarians. More networks and individuals need to become engaged in these process to work with parliamentarians and to build a broader base of support for positive change.

- **Scale up work with parliamentarians, individually and through committees, to increase their knowledge about key population concerns, gender, gender roles, concepts of manhood and masculinity, and their link to HIV, and to consolidate their commitment towards law and policy change.** Work currently done by BONELA and others should be sustained.

4.5.6. Legal and Human Rights Literacy

There have been a number of efforts to improve legal literacy amongst PLHIV and other key and vulnerable populations. Some of these efforts are also combined with the provision of legal

services or support for individuals to access legal services elsewhere. Most organisations working with key populations in the context of HIV have at some point and in different ways encouraged individuals to know more about their legal and human rights despite the limitations in the country to being able to act on this knowledge. Much of this work has been described above as part of integrated approaches to the provision of HIV and SRH services or through the PHD approach.

In addition to working with key populations directly, BONELA has used the media to create broader awareness of key population issues, including legal and human rights concerns. The aim of this approach has been to encourage more informed public dialogue and to build a broader base of support across the general population for stronger protections for key populations as well as for law and policy reform. The organisation has also used social media platforms to reach across key population groups with messaging and other content to build knowledge and confidence regarding human rights and opportunities for seeking legal redress.

The Botswana Centre for Human Rights (Ditshwanelo) is another organisation that implements programmes addressing key populations, HIV and human rights in the context of its broader human rights mandate. In addition to human rights literacy work, the organisation also supports paralegals for general human rights work which can also include HIV-related claims.

The assessment identified some gaps and challenges for this work which included the following:

- **Despite knowing about legal and human rights, many individuals are reluctant to claim these rights for fear of exposure or reprisal in their communities.** Raising claims means identifying as MSM, a transgender person or being a sex worker and, in the eyes of many, this risk is too great in comparison to seeking support to defend their legal or human rights. This observation also holds true for PLHIV who experience discrimination in employment. Although many know that it is illegal, the prospect of job loss prevents them from taking action to protect themselves.

- **Opportunities to act on knowledge about legal or human rights are limited.** There continue to be numerous accounts of abuse by the police and other relevant authorities when sex workers or MSM, for example, attempt to lodge complaints or open cases. In addition to the non-recognition of rights around sexual orientation or gender identity in Botswana (despite recent progressive court rulings) there are no formal mechanisms for lodging human rights complaints.

- **Not all key population groups are equally empowered to claim rights once they become aware of them.** The assessment found more examples of success amongst sex workers, for example, than amongst MSM, transgender people or foreign migrants.

A more comprehensive approach to improving and sustaining legal literacy should include the following:

- **Renew or revise the content of rights literacy materials to include new developments.** Revisions to legal literacy materials and approaches should address recent developments, particularly the clearer articulation from the judiciary about the scope of the Constitution regarding sexual minorities. Revised rights literacy materials should 'translate' such developments in terms of what these mean for individuals.

- **Develop specific literacy materials on patient rights and appropriate complaints mechanisms for the health sector.** These materials should be available in all health

facilities and should clearly articulate the law and policy frameworks that support non-discrimination in health care services as well as describe how individuals can receive support to use complaints mechanisms (see SALC, 2016).

4.5.7. HIV-related legal services

A number of organisations work to provide legal support, including direct legal services or referral; support to access legal services provided by others, such as the Botswana Legal Aid programme; and, deployment of paralegals in communities. These are implemented either as part of integrated programming, as already described, or as specific programmes or services.

As a recent example of this latter approach, through the Removing Legal Barriers project, BONELA has been promoting access to justice through supporting paralegals and referrals for legal services.[19] This includes supporting individuals to use the Legal Aid programme as well as to access a referral network of lawyers. The programme is advertised through various media platforms including social media, radio and newspapers. BONELA also serves as the referral point for other projects that have access to justice as a component to their service packages.

Several key informants spoke about the important work of paralegals such as those employed through Sisonke Botswana. These women are sex workers or former sex workers. They are known and trusted by their peers and have their own experiences of the different types of legal problems sex workers face. With their knowledge and skills as paralegals, they can advise and motivate their peers to pursue their legal rights, they can also mediate between sex workers and the police to limit or prevent abuse. In Maun district, for example, the local paralegals have helped to create links between sex worker networks, Women Against Rape, health facilities and the police in order to have a rapid respond mechanism for sex workers faced with violence or threats of violence.

Key informants also spoke about the critical importance of 'safe spaces' that are maintained by CSOs in communities for key populations. These are important meeting points where individuals can report legal and human rights violations to paralegals and peers, can be informed about seeking redress, and can be supported to engage with these processes.

One key limitation of this work, however, has been low utilisation of legal services and other mechanisms for legal redress for the many similar reasons noted in the previous section regarding legal and human rights literacy interventions. Many individuals remain reluctant to come forward since filing a case can require having a police report, for example, and this raises too many risks, including discrimination, abuse and retaliation, as well as the possibility of further criminal charges if cases involve MSM, transgender people or sex workers.

A more comprehensive approach to improving both provision and use of HIV-related legal services should include the following:

- **Sustain and scale up projects that employ members of key populations as paralegals in communities.** These individuals provide critical links between peers who experience legal and human rights violations and networks and services that are meant to assist them to seek redress.

[19] A recent change in policy brought about by the Law Society requires individuals to use private lawyers and no longer allows CSOs like BONELA to provide these services directly.

- **Strengthen and scale up the creation of local networks between key populations, local authorities and CSOs to prevent legal and human rights violations and to support individuals when these things occur.** The Maun model, for example, should be documented and replicated.

- **Strengthen work with the Botswana Police Service to change police attitudes and practices that prevent individuals from obtain reports and filing cases.** This can be done as part of the planned interventions under the Hands Off! Project. The training should be expanded to include issues for MSM and transgender people.

- **Strengthen the capacity of Legal Aid Botswana to do more outreach in communities and to forge stronger links with key population groups to increase their utilisation of these services**. This is a resource that is infrequently used by individuals from key populations for fear of stigma and discrimination. Focussed outreach to key populations in communities would address and resolve these fears.

4.5.8.Monitoring and Reforming Laws, Regulations and Policies

As described throughout the assessment, civil society is actively involved in monitoring laws and policies and in pushing for law and policy reform in Botswana. In the context of HIV, BONELA, Ditshwanelo and key-population-led organisations such as LeGaBiBo are the leaders in this area. Their successful use of strategic litigation to win claims on behalf of the LGBT community, foreign prisoners and transgender people was highlighted previously in this report.

The LEA and the similar work by BOFWA on law, policy and structural barriers for key populations has strengthened the work of organisations like BONELA for evidence-based advocacy for policy and legislative reforms. A new report on the impacts of criminalisation on the LGBT community in Botswana has a similar aim of increasing the body of evidence for accelerating change (UNDP et al., 2018).

As this assessment was being completed, BONELA was drafting a number of policy briefs for different recipients, including parliamentarians, the *Ntlo ya Dikgosi*, the MOHW and NACA based on the LEA and the work of BOFWA. In addition, the LEA TWG was preparing to convene stakeholders to develop an action plan and political engagement strategy to address the recommendations of the LEA report.

As noted throughout this assessment, a number of CSOs monitor human rights trends and periodically publish the results. This work includes support for the implementation of the REAct tool as well as work by BONELA to maintain a database of human rights violations. It also includes work to prepare UPR submissions as was the case for the country's most recent reporting cycle (Botswana Centre for Human Rights et al., 2017; UNHRC, 2017).

However, despite these effort, some serious challenges remain in the way of achieving significant change. These include:

- **There is continued reluctance or resistance on the part of the government to support or encourage law reform projects.** This was noted in the LEA itself, and confirmed through the assessment, (BONELA and MOHW, 2017; see also Botswana Centre for Human Rights et al., 2017).

- **This reluctance is contributing to a widening gap between CSOs and government on the need for urgent change, even for policies that the NSF identifies as needing change.** Some key informants spoke about a growing 'stand-off' including within national coordinating mechanisms for the HIV response. As a result, important priorities such as improving protections for key populations to support greater access to HIV services, as well as longer term goals such as decriminalisation, are not being addressed by the response. Although these priorities are included within the NSF III and are part of the recommendations of the LEA, confidence is waning amongst some stakeholders that this will lead to concrete action and measurable change.

- **There is a reluctance on the part of government to be transparent about and accountable for human rights obligations.** While key informants raised this concern regarding HIV services for prisoners and for refugees and asylum seekers, this challenge is broader and is part of a general situation that has been raised by other human rights groups including DITSHWANELO (Botswana Centre for Human Rights et al., 2017).

- **Work to monitor and report on human rights trends is not consolidated and not consistent, largely due to funding and sustainability challenges.** Recently released reports by Aidsfonds and UNDP, for example, that attempt to quantify the extent of current challenges were possible as a result of projects and not through a routine process of monitoring and reporting, despite the effort of BONELA and others to maintain such a system.

- **Not enough key-population-led networks and CSOs are engaged in policy development or law reform processes.** This work has often been left to BONELA which has sometimes been side-lined as a 'single issue' entity focussed on 'special rights' for criminalised populations. It is important for more key population leaders to join this effort and not to expect that government alone has the technical skills or the basic knowledge to draft new policies or laws on their own.

- **The policy of requiring all non-citizens to pay for ART is eroding the public health benefits of full access to treatment for all PLHIV as, according to key informants, a growing number of these individuals cannot afford this cost.** Such individuals include non-citizens with legal status in the country as well as undocumented foreign migrants. A new approach is needed that balances the issues of affordability and government responsibilities to support the integrity of its HIV programmes with the regional reality of continuous migration due to economic reasons as well as war and conflict.

To address these challenges, a more comprehensive approach to monitoring and encouraging law and policy reform should include the following:

- **Incorporate the action plan to address the recommendations of the LEA in the 5-year plan for a comprehensive response.** The development of the LEA action plan has already provided for under the Removing Legal Barriers project. Based on the results of *this* assessment, the action plan should prioritise the following main recommendations: reforming or repealing of laws that criminalise HIV transmission, sex work, and same-sex sexual activities; clarifying the law and policy requirements for government to provide HIV services for refugees and asylum seekers held in places of detention; amending laws regarding prisons to allow for condom distribution and other needed HIV prevention interventions; and, amending the HIV policy to allow legally resident non-citizens access to ART who cannot afford to pay for it themselves (using an appropriate means test, for example).

- **Sustain efforts by civil society to support undocumented foreigners to access HIV services, particularly ART.** Since there is no requirement in law for the government to provide ART and HIV services free of charge to this group and it is unwilling to do so on humanitarian or public health grounds, the current efforts of civil society to support foreign sex workers, other undocumented migrants, and asylum seekers who have left their places of detention to access and remain on ART should be sustained and scaled up where needed.

- **Build the technical and operational capacities for more key-population-led networks and CSOs to participate in policy development and law reform processes.** Effective policy development and law reform requires strong technical skills for proposing policy options or the content of new legislation. It also requires capacity for negotiation and consistent participation and engagement over the longer term, something that CSOs and networks are rarely funded to achieve.

- **Create one monitoring and reporting mechanism for HIV-related human rights data.** Networks and CSOs should create one country-wide mechanism based, for example, on the REAct tool or other approaches in neighbouring countries (such as the web-based model use by the Love Not Hate Campaign in South Africa), to monitor and report on human rights violations so that changes in the situation, either positive or negative, can be tracked and broadly communicated.[20]

4.5.9. Reducing HIV-related Discrimination Against Women

There are a number of interventions being implemented by a range of stakeholders, including government, addressing different aspects of HIV-related discrimination against women. These receive Global Fund support as well as funding from other partners, such as PEPFAR and UN agencies. They also receive government support. Most of these efforts are part of **broader, cross-cutting programmes addressing barriers related to gender, both those that increase HIV risk as well as those that inhibit access to services**. These programmes include interventions in schools and communities to challenge and transform gender norms, such as girls' empowerment programmes, gender sensitisation training, and interventions with men and boys to understand and transform traditional notions of masculinity. These projects include In Her Shoes, SASA, Go Girls!, and Men in the Kitchen, amongst others.

Other interventions include **comprehensive responses to GBV prevention and support**, such as the development and roll-out of protocols and standard operating procedures (SOPs) for prevention and management of GBV; development of SOPs for Botswana Police Services; and support for CSOs to deliver comprehensive services packages, including two shelters which provide HIV counselling and testing, PEP, referral for HIV treatment, legal support, and psycho-social support, amongst other services.

As this assessment and other similar work has highlighted, however, progress to effectively reduce and reverse gender-based vulnerability in the context of HIV, including factors that limit access to services, still have some distance to cover before such efforts can become fully effective. Challenging and transforming gender norms that harm women and girls as well as constrain men and boys is a long term and complex effort. Within the context of this assessment, the following were identified as actions to be taken to add to these broader approaches.

[20] See: http://www.lovenothate.org.za

- **Provide more training to HCWs, including those who are part of externally funded programmes for key populations, on recognising and responding to sexual violence and abuse, including intimate partner violence.** As the assessment has noted, there is great reluctance on the part of MSM, transgender people, or sex workers to disclose sexual violence and to seek needed care, including important services such as PEP. Equipping HCWs to be more aware and enabling would be an important step towards changing this situation.

- **Develop comprehensive referral networks to support individuals who experience sexual violence.** While some implementers of key population programmes are doing this, it should become a routine component of all programming. There should be a strong emphasis on psycho-social support, including referral for trauma counselling and other mental health interventions. Supporting access to justice should also be an important component of the referral system (see Mosenge at al. (2018) for an example of such networks in Cameroon).

- **Strengthen efforts by key population networks and CSOs to make traditional authorities more active and accountable for confronting and changing harmful gender norms.** Such gender norms are too often sustained in communities because they form part of traditional identities and practices that many feel are being threatened by external influences.

5. FUNDING FOR PROGRAMMES TO REMOVE BARRIERS TO HIV SERVICES

The compilation of information on current funding for programmes to remove human rights-related barriers involved collecting data from both funders and implementers. The findings are presented below starting with information on expenditures before considering funding and funding sources.

The available data showed that, between 2016 and 2017, a total of US$3,222,867 was spent on human rights-related programmes as show in **Table 2**, below.

Table 2: Spending by Programme Area (2016 -2017)

Programme Area	2016 US$	2017 US$	Total US$
Stigma and discrimination reduction for key populations	29,738	-	29,738
Training for health care workers on human rights and medical ethics related to HIV	-	7,432	7,432
Sensitization of law-makers and law enforcement agents	42,473	52,730	95,203
Legal literacy	67,468	114,681	182,150
HIV-related legal services	104,188	52,596	156,784
Monitoring and reforming laws, regulations and policies relating to HIV	68,224	27,820	96,044
Reducing discrimination against women in the context of HIV	1,319,543	418,843	1,738,386
Integrated approaches	306,334	610,797	917,131
TOTAL	**1,937,968**	**1,284,899**	**3,222,868**

Most of the identified expenditure, 54%, was for programmes aimed at reducing discrimination against women in the context of HIV. The main projects were the Advancing Partners and

Communities (APC) project implemented through FHI360, and the OVC and Gender project implemented through Project Concern International, both of which were funded by USAID. The next largest expenditure for a single programme, at 28%, was for the PEPFAR-funded ACSM project that integrated human rights components and amounted to US$245,046 and US$345,414 in 2016 and 2017, respectively.

Other identified expenditures were more modest, largely as a result of the fact that, as described in **Section 4.5**, above, many of these activities were implemented as part of broader programmes. The reflected amounts are for those areas where implementers could identify specific expenditures. The large drop in funding for programmes addressing discrimination against women between the two years was due to the fact that funding for the OVC and Gender project ended.

Table 3, below, shows the amounts of funds that, according to the main funders, were available for programmes to reduce human rights barriers.

Table 3: Main funders of human rights programmes (2016-2017)

Funder	2016 US$	2017 US$	Total US$
Global Fund	420,924	395,000	815,924
COC Netherlands	63,859	61,362	125,221
FELM	77,281	-	77,281
Aids Fonds	78,200	142,484	220,684
ARASA	-	20,004	20,004
PEPFAR	1,583,145	539,817	2,122,962
TOTAL	**2,223,409**	**1,158,667**	**3,382,076**

FELM=Evangelical Lutheran Church of Finland.

According to these results, PEPFAR and the Global Fund provided 72% and 16% respectively of the resources available between 2016 and 2017. However, it should be noted that PEPFAR support was for a broadly integrated programme and this may distort the results of the analysis whereby other funding was more specifically focussed on human rights work. For all amounts, it was not possible to determine how these resources were divided between the different human rights programme areas.

6. Projection of Funding Needs for Comprehensive Programmes to Remove Barriers

The final component of the assessment was to estimate the five year cost of implementing the comprehensive approach as outlined in **Section 4.5**. A high level summary is shown in **Table 4**, below. The detailed activities are described in **Annex A** and the detailed costing is included in **Annex B**.

Table 4: Estimated funding needs 2018-2022 (US$)

Programme Areas		Year 1	Year 2	Year 3	Year 4	Year 5	Total
PA1	Stigma and discrimination reduction	828,658	353,251	438,352	291,423	565,810	2,477,495
PA 2	Training for HCW on human rights and medical ethics	188,819	31,632	34,458	32,268	32,591	319,768
PA 3	Sensitization of law-makers and law enforcement agents	728,620	88,597	67,846	124,506	69,210	1,078,779
PA 4	Legal literacy	108,525	15,257	15,409	53,581	15,719	208,491
PA 5	HIV-related legal services	289,743	309,955	313,055	370,895	319,347	1,602,996
PA 6	Monitoring and reforming laws, regulations and policies	188,562	280,363	254,006	148,023	149,503	1,020,457
PA7	Reducing discrimination against women in the context of HIV	161,889	32,825	138,222	19,590	19,785	372,311
PA 8	Other activities	106,161	113,823	163,142	116,111	215,850	715,088
Total		**2,600,977**	**1,225,704**	**1,424,491**	**1,156,397**	**1,387,815**	**7,795,385**

The main cost items under PA1 is the recruitment, training and deployment of peer educators and paralegals as well as the implementation of a new PLHIV Stigma Index Survey in Years 1 and 5. The main cost item under PA6 is the establishment of a national, CSO-led observatory to collect data and issue reports on human rights barriers faced by key populations. Under PA7, the main cost items address increasing the capacity of CSOs and HCWs to recognise and respond to physical and sexual violence against key populations. Under PA8, the main cost items are repeating the baseline assessment at the mid- and end-points of the five-year plan as well as supporting evaluations of the different interventions included in the plan to address human rights barriers.

7. OPPORTUNITIES TO SCALE UP INTERVENTIONS

Botswana has reached a critical stage in its national HIV response where, at least for adults, it has reached or shortly will reach its fast-track targets for HIV diagnosis, treatment and viral suppression. Much of the gap that remains is no doubt related to the barriers for key populations

that were identified through this assessment and through other similar efforts, which stand in the way of further progress. Much of this work has also identified needed solutions.

What is needed to move this work forward is a prioritized plan of action as well as a strong and committed coordinating body to lead and monitor progress. This assessment has provided an outline for the plan and describe how such a coordinating entity could function. This larger plan should incorporate action planning for the LEA and be fully aligned, if not enhance, what is contained in the NSF III. The broader challenge will be achieving effective leadership and coordination although there is currently willingness to empower the LEA TWG to reposition itself to play this role. New investments from the Global Fund and PEPFAR emphasising the need to scale up efforts to remove remaining barriers to HIV services create additional opportunities for the country.

8. LIMITATIONS

The assessment encountered some limitations:

- Some important stakeholders were not able to participate in data collection due to competing priorities. These included some government representatives, from the BPS and the Botswana Prisons Service, for example, and as a result the analysis of some issues may not be as comprehensive as it my otherwise have been. These gaps can be addressed as the report is shared and these and other stakeholders have opportunities to strengthen the analysis.

- There were challenges to convince some stakeholders regarding the merits of the assessment since it was perceived as too closely duplicating the LEA, the HIV treatment and care cascade assessment or the more recent UNDP assessment on the impacts of criminalisation. This was unfortunate; however, the assessment team did their best to explain how this initiative was more comprehensive than these other efforts and would incorporate their findings and recommendations to the extent that they were relevant.

- There were some specific limitations and challenges to the collection of financial data:
  - It appeared that a number of organisations felt that the information requested was too sensitive to share even though it was indicated in the invitation messages that the data would be consolidated and anonymised.
  - Many human rights interventions are not funded or implemented as separate activities and, in many cases, there was not a sufficient level of detail to identify human-rights-specific expenditures or funding amounts from the data that was shared with the assessment team.

- Finally, as the analysis has noted in several places, there is a large gap in current and comprehensive quantitative data on a number of the human rights barriers identified by the assessment. As a result, there may be an over-reliance on individual or anecdotal accounts or perspectives which may not, in some cases, be an accurate reflection of an overall, country-wide situation.

9. NEXT STEPS

This baseline assessment will be used as the basis for dialogue and action with country stakeholders, technical partners and other donors to scale up comprehensive programs to remove human rights barriers to HIV services in Botswana. Towards this end, the Global Fund will arrange a multi-stakeholder meeting in the coming months in order to share the assessment results for consideration and discussion towards using existing opportunities to include and expand programs to remove barriers to services. Depending on the country's status in the funding cycle, these opportunities might comprise matching fund applications, funding proposal development, grant negotiation, grant implementation and reprogramming.

The Global Fund will also use the assessment as a basis to support country partners to develop a 5-year plan to move from the current level of programming to remove barriers towards the achievement of a fully comprehensive approach. In this 5-year plan, it is envisioned that the country will set priorities as well as engage other donors to fully fund the comprehensive programmes involved. Finally, in order to build the evidence base regarding programmes to reduce barriers to HIV and TB services, the Global Fund will commission follow up studies at mid- and end-points of the 2017-2022 strategy to assess the impact on access to HIV and TB services of the expanded programmes put in place under the 5-year plan.

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ANNEX A: COMPREHENSIVE PROGRAMMES TO REDUCE HUMAN RIGHTS BARRIERS TO HIV SERVICES

Programme Area	Ref.	Activity	Sub-activity	Implementing Partners	Assumptions	5 Year Amount (US$)
1. Stigma and discrimination reduction	1,1	Conduct a PLHIV Stigma Survey	Revise PLHIV Stigma Survey tools and methodology to include components of MSM, LGBT and sex workers.	Ethics, Law and Human Rights Sector (ELHRS) Secretariat	Year 1	**15 965**
			Conduct a PLHIV Stigma Survey across all key and vulnerable population groups (MSM, LGBT, sex workers and PLHIV)		Year 1 and year 5	**402 375**
			Prepare and disseminate findings.		Workshops in Year 1 and Year 5	**54 371**
	1,2	Develop a national action plan to reduce stigma and discrimination against all key and vulnerable population groups	Based on the Stigma Survey results and other relevant surveys, develop affirmative action protocol on meaningful involvement of all key and vulnerable population groups in the delivery of HIV-related services.	Ethics, Law and Human Rights Sector (ELHRS) Secretariat	TA (40 days)	**20 965**
			Based on the results of the Stigma Survey and other relevant surveys, conduct annual joint national review and planning meetings with strong participation of PLHIV, MSM, LGBT and sex workers.		1 meeting every year (30 pax)	**49 550**
	1,3	Build partnerships with traditional and religious leaders to address socio-cultural and religious drivers of HIV related stigma and discrimination against key and vulnerable populations	Involve the traditional and religious leaders in national dialogue, implementation and provision of services ranging from HIV prevention to supporting MSM, LGBT and sex workers.	Local level CSOs	2 workshop (one for traditional and the other for religious) per year with national cultural and religious institutions	**13 056**
	1,4	Conduct conversations on cultural and religious based settings for reducing HIV related stigma and discrimination among MSM, LGBT and sex workers.	Recruit peer educators and paralegals	Local level CSOs	2-5 peer educators/paralegals per district	**824 369**
			Train peer educators and paralegals on human rights		Training workshops	**107 501**
			Conversations in 30 districts (1 per quarter) every year.		Travel and subsistence allowances for the peer educators/paralegals	**104 251**
			Print material for use during community conversations		Make a provision for printing of brochures and leaflets	**10 595**

	1,5	Scale up interventions to reduce internal stigma	Review and strengthen guideline and tools to manage internal stigma among MSM, LGBT and FSW	National NGOs and Local level CSOs	TA for 20 days	**10 965**
			Train Peer Educators on use of the tools and guidelines to reduce internal stigma among MSM, LGBT and FSW		Train 5 people per district, I year 1 and year 3	**135 727**
	1,6	Revise HIV workplace policies and programs with a strong focus on employment related stigma in the context of MSM, LGBT and PLHIV.	Revise and validate the workplace policies and programs	Botswana Business Coalition on AIDS (BBCA)	TA (40 days)	**20 965**
	1,7	Sensitise labour sector on employment related stigma and discrimination in the context of MSM, LGBT and PLHIV.	Train representatives of trade unions on revised HIV policies and programs	BBCA	Workshop for 1 day for 30 people every year	**6 528**
	1,8	Sensitise private sector employers on employment related stigma and discrimination in the context of MSM, LGBT and PLHIV	Train Private Sector Forums (employers) on employment related stigma and discrimination in the context of MSM, LGBT and PLHIV	BBCA	One day workshops for 10 Private Sector Forums (employers) across the country	**25 983**
	1,9	Train private sector peer educators to implement revised workplace policies and programs on employment related stigma and discrimination in the context of MSM, LGBT and PLHIV	Train private sector peer educators (through the Peer Educator Forums) on employment related stigma and discrimination in the context of MSM, LGBT and PLHIV	BBCA	Three days training workshops for 10 Private Sector Peer Educators Forums (employees) across the country	**135 049**
	1.10	Support workplace interventions on stigma and discrimination reduction among MSM, LGBT and PLHIV.	Conduct workplace conversations on stigma and discrimination reduction among MSM, LGBT and PLHIV	BBCA	Cost to company and managed by Company Health Workplace Committees	**-**
			Mentor Peer Educators on implementation of HIV workplace policies and programs		Travel and accommodation for 5 people from BBCA, BB, NACA, MOHW and Ministry of Labour	**56 185**
	1.11	Share positive stories on social media regarding MSM, LGBT and Sex Workers	Develop content on positive stories regarding MSM, LGBT and sex workers and train selected members of MSM, LGBT and Sex Worker networks	National NGOs and Local level CSOs	TA to develop content and train	**16 558**
			Train selected members of MSM, LGBT and Sex Worker networks on management of human rights content and management of social media platforms for publishing and promoting positive stories regarding key populations		Costs of the workshops for training of 5 national networks (Yr 1 and Yr 3)	**3 264**

	1.12	Programme Management and Monitoring & Evaluation	Programme Management and M&E	Ethics, Law and Human Rights Sector (ELHRS) Secretariat	23% of programme costs	**463 271**
						-
2. Training for health care workers on human rights and medical ethics	2,1	Review the code of conduct for health workers in addressing human rights in the context of impact of HIV on MSM, LGBT and sex workers.	Recruit consultant to review the code of conduct for health workers in addressing human rights in the context of impact of HIV on MSM, LGBT and FSW	Ministry of Health and Wellness (MOHW)	TA for 20 days	**10 965**
			Disseminate the revised Code of Conduct to Health Workers for awareness		No cost. Disseminated during the routine meetings	-
	2,2	Revise and display the charter on patients' rights and obligations in all health care settings (in English and Setswana).	Recruit consultant to review the charter on patients' rights and obligations in all health care settings	Ministry of Health and Wellness (MOHW)	TA costs (year 1) - 20 days	**10 965**
			Print the charter in Setswana and English		5000 posters printed	**4 281**
	2,3	Ensure the importance of patient-centred, non-discriminatory care to all individuals in need (particularly MSM, LGBT, FSW and adolescent girls) is a permanent agenda item on the DHMT meetings .	Hold regular DHMT meetings	Ministry of Health and Wellness (MOHW)	Non-cost item. This should be a regular agenda items in the existing DHMT meetings.	-
	2,4	Scale up sustained partnerships between DHMTs and CSOs monitor to ensure alignment of patient charter with delivery of health services	Hold meeting between DHMTs and CSOs	ELHRS	Discussions during regular DHMTs/ CSO meetings	-
	2,5	Scale up the BOFWA led ACSM project in conducting trainings and values clarification interventions for the HCWs in all health facilities linked to their service delivery programmes with emphasis on patient-centred, non-discriminatory care to all individuals in need (particularly MSM, LGBT, sex workers and adolescents).	Train HCW at the district level (10 per district each year)	BOFWA	Workshop costs	**65 282**
	2,6	Re-inforce health care workers commitment to patient ethics and respect for diversity	Revise the pre-service training curricula to strengthen the MSM, LGBT and FSW components	Ministry of Health and	TA costs (year 1) - 40 days	**20 965**

			Orient course instructors in all health training institutions on the revised curricula.	Wellness (MOHW)	Train 20 course instructors per year, from all health training activities. Once a year. MOH provides training.	**60 323**
	2,7	Monitor frequency of the stigma and discrimination in health facilities across MSM, LGBT and sex workers.	Develop a tool to gather/collect data on stigma and discrimination experienced at health facilities	National NGOs and Local level CSOs	TA to develop tool and train Peer Educators on the use of the tool	**15 965**
			Print the tool to gather/collect data on stigma and discrimination experienced at health facilities		It costs $10 to print the tool and the user guide	**4 040**
			Train Peer Educators on the use of the tool		Workshop costs for the Peer Educators	**67 188**
			Set-up reporting mechanisms		Reporting mechanism designed by TA as part of the development of the tools	**-**
	2,8	Programme Management and Monitoring & Evaluation	Programme Management and M&E	ELHRS	23% of programme costs	**59 794**
						-
3. Sensitisation of law-makers and law enforcement agents	3,1	Engage all traditional leaders in communities for acceptance of key populations and respect for diversity.	Conduct training of trainers (TOTs) of members of House of Chiefs (Ntlo Ya Dikgosi) on human rights and engagement of MSM, LGBT and FSW in the context of HIV	National NGOs and local level CSOs	Workshop costs	**4 352**
			Develop program of action for supporting key populations		TA for 20 days	**22 262**
			Support traditional leaders at the *Kgotla* in facilitating discussions and negotiations among community members in addressing practices that impede access to services by MSM, LGBT and FSW		Peer educators from different implementers to support the traditional leaders during discussion sessions at the kgotla meetings	**-**
	3,2	Engage more members of parliament to suppport law reform	Provide technical assistance to support parliamentary committee on health and HIV on lobbying for law reform regarging human rights of key populations	Ministry of Defence, Justice and Security	TA for 20 days	**10 965**
			Conduct regular breakfast sessions on HIV and human rights		Cost of breakfast meeting one a year for 20 people	**2 140**

	3,3	Increase skills of Ministers to address human rights and HIV.	Organise inter-ministerial meetings on human rights and HIV	Ministry of Defence, Justice and Security	One meeting year (for one day for 50 people including PSs)	**10 880**
	3,4	Conduct a professional development session with the judiciary.	Train the judiciary on Human rights and HIV	Ministry of Defence, Justice and Security	One day session for 30 people every year	**6 528**
	3,5	Train Magistrates on himan rights and HIV.	Develop a training program for magistrates	Ministry of Defence, Justice and Security	TA for 30 days	**32 414**
			Train Magistrates on human rights and engagement of MSM, LGBT and FSW in the context of HIV		Workshop every year (30 people every year) for 1 day	**6 528**
	3,6	Strengthen the institutional commitment of the Botswana Police Services to good policing practice and respect for human rights and diversity.	Develop program on good policing services	Ministry of Defence, Justice and Security	TA for 30 days in year 1 and revise in year 4	**495 401**
			Orient the executive management of the Botswana Police Service on human rights and engagement of FSW in the context of HIV		Workshop in year 1 and year 3 for 1 day for 30 people	**6 528**
			Review the BPS client charter for police in addressing human rights in the context of FSW		TA costs (year 1) - 40 days	**20 965**
			Print and display the BPS client charter on human rights and obligations charters in all police posts		5000 copies. Displayed in Police Stations	**4 281**
			Train police officers on human rights approach to working with clients		Train 30 per district every year (16 police districts in the country)	**83 964**
	3,7	Support Botswana Police Services (BPS) to end abuses against sex workers.	Adapt the South African Police Service training manuals for BPS	Ministry of Defence, Justice and Security	TA to adapt the manual, workshop to validate	**16 125**
			Print the training manuals		Printing of manuals	**25 685**
			Revise the pre-service police training curricula to incorporate the human rights component regarding FSW, LGBT and MSM		TA costs (year 1) - 40 days	**20 965**
			Train course instructors in the police training college on the revised curricula.		Assume 30 instructors in Year 2 and Year 4	**2 611**
			Train in-service police officials on human rights and engagement of key and vulnerable populations in the context of HIV		Train 30 per district every year (16 police districts in the country)	**104 451**
	3,8	Programme Management and Monitoring & Evaluation	Programme Management and M&E	ELHRS	23% of programme costs	**201 723**
						-

4. Legal and Human Rights Literacy	4,1	Conduct conversations on cultural and religious based settings on human rights for MSM, LGBT and sex workers.	Hold sensitization meetings with the community and Key populations	National NGOs	To be facilitated by paralegals	**69 501**
	4,2	Revise legal literacy programmes to incorporate new developments for MSM, LGBT and PLHIV in the context of HIV.	Engage consultant to revise legal literacy materials	Legal AID Botswana and National NGOs	TA for 30 days	**15 965**
			Train paralegals on using the rights literacy materials on PLHIV (including MSM, LGBT)		Covered as part of trainings in Activity 5.1	
			Print revised legal literacy materials on PLHIV (including MSM, LGBT)		Printing in year 1 and year 4 (provide USD10K each year)	**20 303**
	4,3	Revise legal literacy programmes to incorporate new developments for sex workers in line with police training manual	Engage consultant to revise legal literacy materials	Legal AID Botswana and National NGOs	TA for 30 days	**15 965**
			Train paralegals on using the rights literacy materials on FSWs		Part of the training content in 4.1 above	**-**
			Print revised legal literacy materials on FSWs		Printing in year 1 and year 4 (provide USD10K each year)	**20 303**
	4.4	Equip key population groups with the skills to use health care complaints mechanisms.	Engage consultant to develop use guidelines	Legal AID Botswana and National NGOs	TA 30 days	**15 965**
			Print material and disseminate in hospitals		Printing in year 1 and year 4 (provide USD10K each year)	**20 303**
			Launch the guideline		Hold 10 one day meetings for 20 people each	**4 196**
			Train paralegals on the revised guidelines		Part of the training content in 4.1 above	**-**
			Hold sensitisation meetings in hospitals between HCW and Key populations		Covered as part of trainings in Activity 5.1	**-**
	4,5	Programme Management and Monitoring & Evaluation	Programme Management and M&E	ELHRS	23% of programme costs	**25 990**
						-
5. HIV-related legal services	5,1	Recruit, train and deploy paralegals in communities	Recruit paralegals	Legal AID Botswana and National NGOs	2 paralegals per district	**1 190 755**
			Train paralegals on using the rights literacy materials on PLHIV (including MSM, LGBT, FSW) and on skills to use health care complaints mechanisms		5 days training (in year 1 and year 4)	**107 810**
	5,2	Scale up rapid response mechanisms to address issues of violence against key populations.	Identify focal point person	Legal Aid Botswana	Identify persons already working within the establishments	**-**
			Set up toll free and SMS services with Legal Aid Botswana for increased access of legal services by MSM, LGBT and FSW		provision of mobile phones for paralegals	**4 720**

			Provide airtime to the paralegals		provision of mobile airtime	**121 627**
			Train community implementers to include issues for MSM and transgender people.		Issues of MSM to be included in the overall training of Community facilitators	**-**
	5,3	Improve services of Legal Aid Botswana to work with LGBT and sex workers in communities.	Train Legal Aid Botswana on addressing HIV and human rights issues of key populations	Legal Aid Botswana	Training for 30 people for 1 day	**1 280**
			Mentor outreach workers on delivery of HIV and Human rights issues for key populations		A liaison person housed at Legal Aid Botswana will provide mentorship to outreach workers	**18 728**
			Conduct awareness campaigns on the mechanisms for provision of legal services including services for MSM, LGBT and FSW in all districts		cost for media (newspapers, TV and Radio) announcements, pamphlets, and mobile sms.	**94 622**
	5,4	Conduct professional development sessions with private legal practitioners on HIV and human rights issues for key populations	Train members of the Law Society on human rights and engagement of MSM, LGBT and FSW in the context of HIV	National NGOs and local level CSOs	Workshop every year (30 people every year) for 1 day	**6 528**
		Programme Management and Monitoring & Evaluation	Programme Management and M&E	ELHRS	23% of programme costs	**56 926**
						-
6. Monitoring and Reforming Laws, Regulations and Policies	6,1	Amend Penal Code Sections 149; 155; 158; 179 and 182 to prevent victimization, societal marginalization, police harassment and blackmail of sex workers as per the LEA recommendations	Lobby parliament to understand impact of criminalization of aspects of sex work	National NGOs and local level CSOs	Breakfast meetings	**3 391**
	6,2	Amend Penal Code Sections 164; 165 and 167 which prohibits unnatural offenses, indecent practices and carnal knowledge against the order of nature in the context of MSM and LGBT as per LEA recommendations.	Lobby parliament to understand impact of the current Penal Code sections	National NGOs and local level CSOs	Breakfast meetings	**-**
	6,3	Support strategic litigation for the purposes of law and policy reform.	Provide grants for strategic litigation on select cases	National NGOs and local level CSOs	Annual grants of $50K per years	**255 050**

	6,4	Provide core skills to representatives from key population networks for collaborative engagement in policy development and law reform processes.	Engage a consultant to develop/adapt training materials	National NGOs and local level CSOs	TA, 30 days	**15 965**
			Engage regional partners (ARASA, KELIN, SALC) to provide the training	National NGOs and local level CSOs	One national workshop for 5 days for 25 participants done in years 1 and 3.	**44 695**
	6,5	Revise the government policy on access to ARVs for non-citizens.	Engage a technical consultant to develop a policy options paper.	NACA	TA, 30 days	**16 125**
			Conduct consultations regarding the policy options		one national and two regional (northern and southern) workshops - 1 day resident workshop	**29 433**
			Develop a new draft policy.		TA 30 days	**16 125**
			Convene stakeholders for validation.		30 people	**-**
			Print and disseminate the policy		Print 1000 copies	**10 595**
			Undertake a media campaign to create awareness about the policy		Media campaign in the year policy is approved and the next (20 per month)	**94 300**
	6,6	Establish on national observatory to monitor human rights trends for key populations (based in a national CSO).	Establish the observatory	National NGOs	programme officer 0.5FTE, data analyst 0.5FTE	**217 141**
			Develop a web-based platform for reporting.		TA (40 days)	**20 965**
			Train peer educators to promote the observatory and to encourage reporting		One day training	**6 463**
			Conduct field missions to monitor and investigate trends and issues		Costed as part of programme management and M&E	**-**
			Compile and disseminate annual reports.		Printing of annual reports (100 per year, from year 2)	**4 302**
			Conduct media campaigns based on reports.		3 full months of campaign each year after the report (30 campaigns a month)	**95 090**
	6,7	Programme Management and Monitoring & Evaluation	Programme Management and M&E	ELHRS	23% of programme costs	**190 817**
						-
7. Reducing HIV-related	7,1	Adapt, print and disseminate a protocol for standard operating procedures (SOPs) for prevention and management of GBV against	Engage consultant to adapt the protocol	Ministry of Nationality, Immigration	TA for 20 days	**10 965**
			Printing the SOPs		cost printing 1000	**10 490**

Discrimination Against Women		sex workers, LGBT, and women living with HIV.		and Gender affairs		
	7,2	Train peer educators and health workers in CSOs serving key populations on the protocol.	Train peer educators and health workers in CSOs serving key populations on the protocol	Ministry of Nationality, Immigration and Gender affairs	2 day workshops peer educators plus other officers in year 1 and year 3 (5 workshops of 40 people each)	**180 970**
	7,3	Train police officers and traditional leaders on recognizing and responding to sexual violence and abuse, including intimate partner violence.	Train police officers and traditional leaders on recognizing and responding to sexual violence and abuse, including intimate partner violence amongst FSW, transgender women and women living with HIV.		1 day workshops x 4 regions x 30 pax in year 1 and year 3	**10 341**
	7,4	Train Peer Educators on providing psychosocial support to sex workers, LGBT and women living with HIV who are survivors of sexual violence and abuse, including intimate partner violence.	Train Peer Educators on providing psychosocial support to FSW, lesbian, bisexual and transgender women, as well as women living with HIV who are survivors of sexual violence and abuse, including intimate partner violence	Ministry of Nationality, Immigration and Gender affairs	Part of the training content in 7.2 above	-
	7,5	Establish rapid response and referral networks for responding to violence against key populations based on the WAR model.	Include FSW, lesbian, bisexual and transgender women, as well as women living with HIV into protocols of a comprehensive referral system for access to HIV services	Ministry of Nationality, Immigration and Gender affairs	TA for 20 days	**11 075**
	7,6	Incorporate components addressing gender-based violence against key population in the 16 days of activism programme.	Include FSW, lesbian, bisexual and transgender women, as well as women living with HIV into the campaigns	Ministry of Nationality, Immigration and Gender affairs	Advert (radio, TV and newspaper) - 5 per month	**78 852**
	7,7	Programme Management and Monitoring & Evaluation	Programme Management and M&E	ELHRS	23% of programme costs	**69 619**
8. Relevant activities but which cannot be classified elsewhere	8,1	Conduct mid and end-term baseline assessment to monitor progress on reducing human rights barriers.	Conduct mid-term and end of term evaluations (including the impact of behaviour change interventions among the general population on the rights of MSM, LGBT and sex workers)	ELHRS	TA	**143 695**
	8,2	Conduct project evaluations for human rights interventions	Conduct one small evaluation in year 2 and 4	ELHRS	$25K per evaluation	**51 008**
			Conduct one large evaluation in year 5		$50K per evaluation	**52 030**
	8,3	Improve the technical capacity of MOHW/NACA to take stronger action on reducing stigma and discrimination against all key and vulnerable populations	Resuscitate the National AIDS Council (NAC) Ethics, Law and Human Rights Sector (ELHRS) Secretariat with guidance from the LEA TWG	ELHRS	Review terms of reference and strategic plan	**15 965**
			Capacitate the NAC ELHRS Secretariat		Recruit the ELHRS secretariat	**434 283**

					Orientation and training of the Secretariat	**5 050**
			Bi-annual meetings of a reference group (a revamped LEA TWG)		30 people for 1 day meeting	**13 056**