



1. Demographic and socioeconomic data

| | Date | Estimate | Source |
|--|------|----------|----------------|
| Total population (millions) | 2004 | 1.8 | United Nations |
| Population in urban areas (%) | 2003 | 51.3 | United Nations |
| Life expectancy at birth (years) | 2002 | 40.4 | WHO |
| Gross domestic product per capita (US\$) | 2001 | 2872 | United Nations |
| Government budget spent on health care (%) | 2001 | 7.6 | WHO |
| Per capita expenditure on health (US\$) | 2001 | 190 | WHO |
| Human Development Index | 2001 | 0.614 | UNDP |

3. Situation analysis

- Epidemic level and trend and gender data.** In 2001, the median HIV prevalence among antenatal clinic attendees tested in 22 health districts was 36.3%. HIV prevalence among antenatal clinic attendees increased rapidly from 18.1% in 1992 to 32.4% in 1995 and 38.5% in 2000 and declined slightly in 2001. Major urban areas in Botswana include Gaborone, Francistown and Selebi-Phikwe. The HIV prevalence increased from 14.9% in 1992 to 39.1% in 2001 in Gaborone and from 23.7% in 1992 to 44.9% in 2001 in Francistown. Sites outside the major urban areas are also experiencing increasing HIV infection trends. In 2001, median HIV prevalence in areas outside the major urban areas was 38.6%.
- Major vulnerable and affected groups.** People 15–19 and 20–24 years old exhibit high and increasing HIV infection trends. HIV prevalence at all sites increased from 16.4% in 1992 to 24.1% in 2001 among those 15–19 years old and from 20.5% in 1992 to 39.5% in 2001 among those 20–24 years old. HIV prevalence rates peaked among the 25– to 29-year-old antenatal clinic attendees at 50.4% in 2000 and declined to 48.4% in 2001.
- Policy on HIV testing and treatment.** Routine HIV testing started in early 2004. Sixteen voluntary counselling and testing centres have been established countrywide in collaboration with BOTUSA (a collaboration between the government and the United States Centers for Disease Control and Prevention). Botswana was one of the first countries in Africa to establish a national antiretroviral therapy programme. The implementation of antiretroviral therapy started in one centre in 2001 and has since been expanded to eight sites. The provision of antiretroviral therapy free of charge positively influenced the demand for voluntary counselling and testing.

2. HIV indicators

| | Date | Estimate | Source |
|--|-----------|-----------------|------------|
| Adult prevalence of HIV/AIDS (15–49 years) | 2003 | 35.5–39.1% | WHO/UNAIDS |
| Estimated number of people living with HIV/AIDS (0–49 years) | 2003 | 330 000–380 000 | WHO/UNAIDS |
| Cumulative number of reported AIDS cases | 2001 | 10 178 | WHO/UNAIDS |
| Reported number of people receiving antiretroviral therapy (15–49 years) | June 2004 | 18 000 | WHO |
| Estimated total number needing antiretroviral therapy in 2005 | 2003 | 60 000 | WHO/UNAIDS |
| HIV testing and counselling sites: number of sites | | not available | |
| HIV testing and counselling sites: number of people tested at all sites | | not available | |
| Prevalence of HIV among adults with tuberculosis (15–49 years) | 2002 | 79% | WHO |

- Antiretroviral therapy: first-line drug regimen, cost per person per year.** The starting regimen for adult men, women with no reasonable risk of pregnancy and children older than five years is: zidovudine + lamivudine + efavirenz. The starting regimen for pregnant women or women likely to become pregnant and for children younger than five years is zidovudine + lamivudine + nevirapine. The government is currently funding the procurement of antiretroviral drugs. Antiretroviral therapy is provided free of charge in the public sector.
- Assessment of overall health sector response and capacity.** There is a high level of political commitment. Botswana is among the 19 African countries that have established a National AIDS Council chaired by the head of state to take charge of a multisectoral response to AIDS. Various factors are identified as obstacles to an effective health sector response to rapid scaling up and decentralization of antiretroviral therapy, particularly: the fragmentation of HIV/AIDS programmes and interventions.
- Critical issues and major challenges.** A lack of human resources has been identified as the most significant constraint to scaling up antiretroviral therapy. Issues affecting staffing levels include a government freeze on creating new posts to prevent future budget deficits. Other major challenges to scaling up antiretroviral therapy include policy-related issues such as whether nurses should be authorized to initiate treatment, the use of generic drugs, strengthening public-private partnerships, ensuring fairness and equity in providing antiretroviral therapy services and reducing sociocultural effects and stigma.

4. Resource requirements and funds committed for scaling up antiretroviral therapy in 2004–2005

- WHO estimates that the total funding required to support scaling up antiretroviral therapy to reach the WHO “3 by 5” treatment target of 30 000 by the end of 2005 is between US\$ 97 million and US\$ 101 million.
- The national antiretroviral therapy programme is funded by the government in collaboration with the African Comprehensive HIV/AIDS Partnerships (ACHAP) and a few other development partners. ACHAP is funded by the Bill & Melinda Gates Foundation with a US\$ 50 million contribution over a five-year period, to be matched by pharmaceutical manufacturer Merck & Co., Inc. and The Merck Company Foundation, whose contributions will include antiretroviral medicines.
- Botswana submitted a successful Round 2 proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria with two-year approved funding of US\$ 18.6 million focused on training, strengthening treatment, care and support activities, scaling up prevention programmes and reducing stigma and discrimination. An estimated US\$ 3.2 million of this is expected to be available for scaling up antiretroviral therapy.
- The United States President's Emergency Plan for AIDS Relief is expected to contribute about US\$ 36 million for scaling up antiretroviral therapy in Botswana.
- Taking into account the funds committed to date to support scaling up antiretroviral therapy, WHO estimates that the total funding gap for Botswana to reach 30 000 people by the end of 2005 is between US\$ 38 million and US\$ 42 million.

5. Antiretroviral therapy coverage

- Botswana's total treatment need for 2005 is estimated to be 60 000 people, and the WHO “3 by 5” treatment target is 30 000 for the end of 2005 (based on 50% of need).
- The government has declared a national treatment target of 55 000 by 2005.
- An estimated 18 000 people are currently receiving therapy; 12 000 are enrolled in public health facilities (under MASA – the national antiretroviral therapy programme) and about 6000 through the private health sector.

6. Implementation partners involved in scaling up antiretroviral therapy

- *Leadership and management.* The National AIDS Council coordinates the multi-sectoral response to HIV/AIDS. The secretariat of the National AIDS Council is the National AIDS Coordinating Agency. The National AIDS Council has representatives from 17 sectors including civil society, the private sector and the public sector. Other coordinating mechanisms include the National HIV/AIDS Partnership Forum, chaired by the National AIDS Coordinating Agency; and the HIV/AIDS Donor Coordination Forum, chaired by the Ministry of Finance and Development Planning. The government has also established HIV/AIDS sector committees in all ministries aimed at mainstreaming HIV/AIDS into sector plans and programmes. The Ministry of Local Government coordinates the district response centrally. The AIDS Department of the Ministry of Health plays the role of sector leadership, formulating policy, strategic planning, developing programmes, technical support and implementation in selected areas. WHO supports the AIDS Department in coordinating and harmonizing the work of all stakeholders.
- *Antiretroviral therapy service delivery.* The Government introduced highly active antiretroviral therapy on a nationwide scale in 2001. The implementation started in one centre, Princess Marina Hospital, and has since expanded to eight additional sites. The African Comprehensive HIV/AIDS Partnerships (ACHAP), funded by the Bill & Melinda Gates Foundation, Merck & Co., Inc. and The Merck Company Foundation, has been responsible for coordinating and financially supporting the antiretroviral therapy programme since inception. It has provided critical human resources and facilitated and supported the development of needed space in a number of treatment sites. It has also supported the development of information, education and communication activities for antiretroviral therapy, a system for tracking patients on treatment and monitoring of the programme. It has also provided support for logistics, medicines and other supplies. Other major partners supporting the antiretroviral therapy programme in Botswana include the United States President's Emergency Plan for AIDS Relief and the United States Centers for Disease Control and Prevention. The Baylor Center of Excellence is promoting comprehensive HIV/AIDS family care and support. The Botswana–Baylor partnership includes work on antiretroviral therapy for children and women and family care in general. The Botswana–Harvard Partnership provides assistance in laboratory services. BOTUSA is contributing to HIV testing and counselling activities. WHO is supporting activities related to assessment and planning for human resources for scaling up.

- *Community mobilization.* Over the years, civil society involvement in HIV/AIDS in Botswana has focused on prevention and on basic care for affected and infected victims. Several nongovernmental organizations operate in Botswana together with faith-based organizations. The most common community-based organizations involved in HIV/AIDS work are church organizations and women's groups. Village health committees are also reported to be very active in HIV/AIDS in many areas. The First Coping Center for People Living with HIV/AIDS, which began in Gaborone as a private initiative, has been expanded to six centres operating countrywide. The main challenge faced by nongovernmental organizations and community-based organizations is the scarcity of available funding.
- *Strategic information.* The Ministry of Health provides leadership and coordination in monitoring and evaluation, surveillance, patient tracking, operational research and information management activities. Supporting agencies include the Ministry of Local Government, the Botswana–Harvard Partnership and WHO.

7. WHO support for scaling up antiretroviral therapy

WHO's response so far

- Conducting a WHO scoping mission to Botswana in March 2004 to assess the situation and identify opportunities and challenges for scaling up antiretroviral therapy and areas for WHO support
- Monitoring the development of a national operational plan for scaling up antiretroviral therapy
- Assessing the human resource situation for scaling up antiretroviral therapy

Key areas for WHO support in the future

- Establishing a subregional “3 by 5” team for Botswana, Lesotho and Swaziland
- Supporting the strengthening of Ministry of Health planning and coordination mechanisms
- Supporting the review and update of regulations and policies on the role of nurses and midwives in delivering antiretroviral therapy
- Supporting the review and update of policies and legislation on issues related to the TRIPS Agreement and generic antiretroviral drugs
- Supporting the strengthening of the monitoring and evaluation system in accordance with scaling up antiretroviral therapy, including work on indicators for tuberculosis, HIV/AIDS care, preventing mother-to-child transmission and testing and counselling
- Supporting the development of treatment literacy to ensure community involvement

Staffing input for scaling up antiretroviral therapy and accelerating prevention

- Current WHO Country Office staff responsible for HIV/AIDS and sexually transmitted infections include one National Programme Officer for HIV/AIDS. Recruitment of a subregional “3 by 5” officer (for Botswana, Lesotho and Swaziland) is currently underway.
- Additional staffing needs identified include one National Programme Officer and one medical officer for antiretroviral therapy.

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This country profile was developed in collaboration with national authorities, the WHO Country Office for Botswana and the WHO Regional Office for Africa.