BOTSWANA

PEPFAR GENDER ANALYSIS

IRENE RAMATALA
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SEPTEMBER 2016

USAID FROM THE AMERICAN PEOPLE

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CONTENTS

ABBREVIATIONS

ALHIV	adolescents living with HIV
APC	Advancing Partners and Communities
APR	Annual Program Results
ART	antiretroviral therapy
ARV	antiretroviral
BAIS	Botswana AIDS Impact Survey
BOFWA	Botswana Family Welfare Association
BPS	Botswana Police Service
BYRBSS	Botswana Youth Risk Behavioral Surveillance Survey
CBO	community-based organization
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
COP	Country Operations Plan
DCM	Deputy Chief of Mission
FGD	focus group discussion
FSW	female sex worker
FY	fiscal year
GA	gender analysis
GBV	gender-based violence
GBVRSP	Gender-Based Violence Referral Information System Project
GeAD	Gender Affairs Department
GNP	gross national product
GOB	Government of Botswana
HR	human resource
HTC	HIV testing and counseling
IDCC	infectious disease care clinic
IDU	injection drug user
IP	implementing partner
IPV	intimate partner violence
KI	key informant
KII	key informant interview
KP	key population
LCI	Local Capacity Initiative
LGBTI	lesbian, gay, bisexual, transgendered, intersex
M&E	monitoring and evaluation
MCP	multiple concurrent partnerships
MER	monitoring, evaluation, and reporting
MoESD	Ministry of Education and Skills Development
MOH	Ministry of Health
MSM	men who have sex with men
NAC	National AIDS Council
NACA	National AIDS Coordinating Agency
OVC	orphans and vulnerable children
PEP	post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PCI	Project Concern International

PCV	Peace Corps volunteer
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PrEP	pre-exposure prophylaxis
SI	strategic information
SOP	standard operating procedures
SRH	sexual and reproductive health
SSI	Stepping Stones International (based in Mochudi, Kgatleng, Botswana)
STI	sexually transmitted infection
TA	technical assistance
TB	tuberculosis
TWG	technical working group
WAR	WoMen Against Rape
VACS	Violence Against Children Survey
VMMC	voluntary medical male circumcision

1. BACKGROUND

In 2014, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) required that all country teams conduct a gender analysis (GA) of their respective HIV epidemics and country responses. The aim of the GA was to identify gender-related factors in current programming that pose barriers to preventing new HIV infections, accessing testing services, starting antiretroviral therapy (ART), and adhering to treatment protocols.[1] Guidance published by the PEPFAR Gender and Adolescent Girls Technical Working Group (TWG) outlined the expectations for the GA process, which included focusing on the sociocultural gender norms, inequities, and inequalities that put people at risk for HIV transmission and influence their ability to access and adhere to treatment.[2]

It has long been recognized that gender inequality exacerbates a range of negative health outcomes in varying contexts around the world. More recently, gender inequalities, and gender-based violence (GBV) in particular, have been recognized as major drivers of the HIV epidemic worldwide. In 2011, UNAIDS added a gender indicator to its global reporting systems for countries for the first time since these commitments began with the UNGASS in 2001.[3] Therefore, undertaking gender analyses to identify gender-related factors and barriers in countries has been recognized as critical to controlling the epidemic. The GA process mandated by PEPFAR in each of its funded countries was to yield a set of pragmatic recommendations that could be employed to strengthen the PEPFAR response in countries. In this way, the gender analyses will help facilitate the achievement of the 2020 global goal of the 90-90-90: 90 percent of people living with HIV knowing their status, 90 percent of people diagnosed with HIV will receive sustained ART, and 90 percent of people being treated will have viral suppression.[4] The gender staff of the Botswana USAID Mission requested that MEASURE Evaluation collaborate with them on the PEPFAR GA.

Document Organization

The methods employed in this GA are described in Part 2. Part 3 of the report, Findings on Gender and HIV in Botswana, is categorized into the following nine subareas: (i) HIV prevalence, risk, and service utilization; (ii) gender norms (beliefs, access to and control over resources, decision-making); (iii) economic vulnerability; (iv) GBV; (v) stigma & discrimination; (vi) youth; (vii) key populations (KPs); (viii) laws & policies; and(ix) community resilience and media engagement. The recommendations in Part 4 stem directly from the analyses of the three sources of data used in the GA: the literature review, existing quantitative data, and primary collection of qualitative data. After a

[1] U.S. President's Emergency Plan for AIDS Relief (PEPFAR). (2014, March). *PEPFAR: Addressing gender and HIV/AIDS*. Washington, DC: PEPFAR, U.S. Department of State. Retrieved from http://www.pepfar.gov/press/223084.htm

[2] PEPFAR Gender and Adolescent Girls Technical Working Group. (2015). *PEPFAR gender analysis: Key principles and minimum standards: 2015*. Washington, DC: U.S. Department of State.

[3] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2012). *Global AIDS response progress reporting: monitoring the 2011 political declaration on HIV AIDS: guidelines on construction of core indicators: 2012 reporting*. Geneva: UNAIDS. Retrieved from http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/document/2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf/.

[4] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2014). 90-90-90: An ambitious treatment target to help end the AIDS epidemic. Retrieved from http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf

short section of overarching ones, the remaining recommendations are organized into the same nine subareas as the key findings.

Six annexes follow the report. Annex 1 comprises the references consulted. Annex 2 presents the quantitative tables and figures that were derived from published reports. Annex 3A is a description of the qualitative respondents, and Annex 3B presents the qualitative tools. Annex 4 is the summary of the qualitative results, presented in table format. Annex 5 is a table of Botswana gender-related laws and policies. Annex 6 is a summary table of Botswana PEPFAR GBV programming.

2. GENDER ANALYSIS METHOD

Information was gathered from a variety of sources to conduct the GA. The GA began with a desk review of published literature, reports and program documents.[5] Quantitative data were derived from reports based on surveys conducted in Botswana pertaining to HIV, gender, and GBV and from the PEPFAR Monitoring, Evaluation and Reporting (MER) system. Qualitative data were collected from stakeholders and program beneficiaries in March 2016, by MEASURE Evaluation staff and a local consultant.

Literature Review

A comprehensive literature review was conducted to explore: (1) the HIV epidemic in Botswana; (2) gender and the risk for infection, access to services, and adherence to treatment; (3) gender-based violence (GBV); and (4) policy environment. Literature searches were conducted using PubMed, Popline, Google Scholar, and the Google search engine for Government of Botswana (GOB) and other documents online. The National HIV and AIDS Response Gender Assessment Report, conducted in 2014,[6] was one of the key documents for the literature review. The analysis of the literature focused on the remaining gaps to answer critical questions about how to strengthen prevention of and response to GBV and HIV. These gaps included gender norms pertaining to gender roles/acceptable behavior, decision-making power, and several issues around GBV. The qualitative interview tools were developed to gather information from stakeholders on these outstanding areas.

PEPFAR Program Portfolio Review

The Annual Program Results (APR) for 2015 were reviewed and presented, including (1) sex-disaggregated data, where available; (2) program approaches and strategies; and (3) the extent to which programs reached their target populations, addressed gender dynamics, and addressed structural barriers (such as policies, stigma & discrimination). The programs reviewed included HIV counseling and testing (HTC), care and support, tuberculosis (TB), orphans and vulnerable children (OVC), Gender & GBV, KPs, and treatment. The Gender Cascade was populated using selected indicators from programs. Changes from New Generation Indicators (NGI) to the MER disaggregation presented a challenge for comparing patterns and trends over time, except for the HTC and treatment indicators. Many of the other indicators were not disaggregated by age and sex for previous years.

Botswana's comprehensive GBV portfolio was reviewed to establish the current status of each program. Some of the activities in the portfolio include the Violence Against Children Survey (VACS), the development and piloting of the GBV referral system, and the development of and training on standard operating procedures (SOPs) that define how to handle a GBV case for all GBV service providers. SOPs were developed within the Ministry of Health, the Department of Social Protection, Botswana Police Service and the Ministry of Education.

[5] See Annex 1 for the full list of references consulted.

[6] Government of Botswana (GOB). (2015). *National HIV and AIDS response, gender assessment report, October 2014*. Gaborone: GOB, National AIDS Coordinating Agency, Joint United Nations Programme on HIV/AIDS.

Qualitative Data Collection

Qualitative data were collected in March 2016 to explore the gaps identified from the literature review, and to add context for better understanding of the quantitative data. Interviews were conducted with 22 key informants from a range of implementing organizations. These included community-based organizations (CBOs), defined as any Botswana-based nongovernmental organization (NGO); other NGOs, defined as agencies based abroad with local branches in the country; GOB actors within several ministries; and local/traditional political authorities.

Focus group discussions (FGDs) were held with six gatherings of program beneficiaries in different communities. A total of 27 people participated in these six groups. These included a group of men and boys from the Otse Youth group, adult men and women receiving services from Hope Worldwide, a group of adult women from the Mochudi community who have worked with Stepping Stones International (SSI), a group of youth from SSI, a group of HIV-positive women, and a group of people from the lesbian, gay, bisexual, transgendered, intersex (LGBTI) community.

The qualitative data provide an in-depth understanding of gender norms in the context of GBV, HIV service provision, decision-making, and culturally sensitive ways of addressing gender-related barriers. The information to collect was organized around results of the literature review and topics identified in the PEPFAR GA guidance:

- GBV as a cross-cutting concern
- Key gender norms, attitudes and beliefs including: Access to and control over resources, power and decision-making patterns (within couples and households in particular), gender-related stigma and discrimination as a cross-cutting concern
- Legal-policy environment and policy implementation
- Community engagement/voice

3. FINDINGS ON GENDER AND HIV IN BOTSWANA

Country Demographic Context

In 2014, Botswana had an estimated population of 2.0 million people. Life expectancy at birth was 66.8 years for females and 62.1 years for males. Mean years of schooling among females was 8.7 years, as compared with 9.1 years among males. Fewer women (73.6%) had some secondary education when compared with men (77.9%), and men had higher labor force participation (81.6%) than women (71.9%).[7] The estimated population of adolescents ages 10–19 in 2013 was 440,000, comprising 22 percent of the total population of Botswana.[8]

Botswana has made notable progress in health over the last two decades. The total fertility rate in 2013 was estimated at a low of 2.6 children per woman,[9] a drop from 5.0 in 1998.[10] The maternal mortality ratio of 360 deaths per 100,000 live births in 1990 declined to 170 deaths per 100,000 live births in 2013. The estimated number of deaths due to AIDS declined dramatically from 1056.4 deaths per 100,000 population in 2000, to 205.6 deaths per 100,000 population in 2012. The estimated deaths due to TB in HIV-negative people also declined from 57 deaths per 100,000 population in 2000 to 22 in 2013.[11]

While significant progress has been made in many areas, HIV prevalence remains high, and testing, treatment, and adherence targets are not being met. Awareness around GBV has been building around the country in recent years as a result of many local campaigns, but an overall strategy to reduce incidence, increase service utilization and monitor and evaluate prevention and response at the national level is still lacking. The qualitative analyses show that HIV-related stigma, particularly self-stigma, is still very problematic for the general population, and is especially the case for key populations with regard to accessing any HIV service.

(i) Patterns of HIV Prevalence, Risk, and Service Utilization

Botswana's HIV epidemic is generalized, with more females infected than males across age, urban/rural residence, and geographic region. The only exception to this pattern is for people ages 40–60, where a slightly higher proportion of males than females are infected (Figure 1, Annex 2). In 2013, overall HIV prevalence for the country was 18.5 percent, with 20.8 percent of females versus 15.6 percent of males infected. It is worth noting that these proportions were almost completely reversed in 2004, meaning that the epidemic in Botswana has feminized over time as it has in other countries of sub-Saharan Africa.[12]

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[7] United Nations Development Programme (UNDP). (2015) Work for human development: Briefing note for countries on the 2015 Human Development Report: Botswana. *UNDP Human Development Report 2015*. New York: UNDP.
[8] United Nations Children's Fund (UNICEF). (2015). Adolescent assessment and decision-makers tool (AADM). In *Strengthening the adolescent component of national HIV programmes through country assessments* (pp. 08–16). New York: UNICEF.
[9] World Health Organization (WHO). (2015, January). *Botswana: WHO statistical profile.* Geneva: WHO. Retrieved from http://www.who.int/gho/countries/bwa.pdf/.
[10] Botswana demographic and health survey 1998: Summary report. Columbia, MD: IRD/Macro Systems. Retrieved from https://dhsprogram.com/pubs/pdf/SR2/SR2.pdf/.
[11] World Health Organization (WHO). (2015, January). *Botswana: WHO statistical profile.* Geneva: WHO. Retrieved from http://www.who.int/gho/countries/bwa.pdf/.
[12] Government of Botswana (GOB). (2013). *Botswana AIDS impact survey IV (BAIS IV 2013): Summary results.* Gaborone: Statistics Botswana, GOB. Retrieved from: http://www.cso.gov.bw/images/aids_summary.pdf/.

Figure 1 (Annex 2) shows the proportion of females and males infected by age, in 2013. The proportions of infected boys and girls were about equal until age 10, when the prevalence curve for girls began to rise sharply. Between ages 15–30, the proportion of females infected with the virus was more than double that of males, with a peak of 50.6 percent of females ages 30–35 infected. Males became infected later in life than females in general. Among males, prevalence peaked at age 40-44 (43.8%), and the proportion of men infected was somewhat higher than women until age 60 and above.

In 2013, prevalence was higher in cities (19.5%) and towns (21.6%) than in rural areas (17.4%), and varied considerably by region. Table 1 (Annex 2) shows the prevalence rates per district of the country. Female prevalence was higher than male prevalence in every district. The highest rates were observed in Selibe Phikwe at 27.5 percent (29.3% female, 25.4% male) and the lowest in Kgalagadi South at 11.1 percent; here, the rate for females was double the rate of males (15.0% and 7.1%, respectively).[13]

Knowledge about HIV

Risky behavior can reflect lack of knowledge, lack of motivation to apply one's knowledge (e.g., due to cultural norms that support other behaviors) or strong competing factors such as fear of consequences to apply one's knowledge (e.g., due to GBV). The Botswana AIDS Impact Survey IV (BAIS IV, 2013) recorded a small gender gap in knowledge of AIDS among young people (15–24 years) that shifted over time. In 2013, only 47.9 percent of young people demonstrated comprehensive knowledge of HIV (correctly identifying ways HIV can be transmitted and rejecting major misconceptions about HIV), a rise of only five percentage points from 2008. In 2013, a slightly lower proportion of females (45.9%) demonstrated comprehensive knowledge compared with males (47.1%). In the previous two surveys, the proportion of females demonstrating HIV knowledge was slightly higher than the proportion of males.[14] The low percentage of young people demonstrating knowledge about HIV is very worrisome given the likelihood of infection at these ages.

Sexual Behavior Patterns

In 2013, the proportions of all females (87.7%) and males (89.7%) who reported using a condom at the last intercourse were high. More concerning were the lower proportions of people who consistently used a condom with nonregular partners: 65.2 percent of -24 year olds stated that they used condoms consistently, compared with only 30.5 percent of people age 25 and above.[15] There was a decrease in condom use among sexually active young people ages 15–24 between the last two surveys, from 78.4 percent in 2008 to 65.2 percent in 2013 and a similar decline among all respondents who reported having more than one partner, from 90.2 percent in 2008 to 81.9 percent in 2013.[16] This

[13] Government of Botswana (GOB). (2013). *Botswana AIDS impact survey IV (BAIS IV 2013): Summary results.* Gaborone: Statistics Botswana, GOB. Retrieved from: http://www.cso.gov.bw/images/aids_summary.pdf/.
[14] Government of Botswana (GOB). (2013). *Botswana AIDS impact survey IV (BAIS IV 2013): Summary results.* Gaborone: Statistics Botswana, GOB. Retrieved from: http://www.cso.gov.bw/images/aids_summary.pdf/.
[15] Government of Botswana (GOB). (2013). *Botswana AIDS impact survey IV (BAIS IV 2013): Summary results.* Gaborone: Statistics Botswana, GOB. Retrieved from: http://www.cso.gov.bw/images/aids_summary.pdf/.
[16] Government of Botswana (GOB). (2009, November). *Botswana AIDS impact survey III, statistical report, 2009*. Gaborone: Central Statistics Office, GOB. Retrieved from http://catalog.ihsn.org/index.php/catalog/2045/; GOB. (2013). *Botswana AIDS Impact Survey IV (BAIS IV 2013): Summary Results.* Gaborone: Statistics Botswana, GOB. Retrieved from: http://www.cso.gov.bw/images/aids_summary.pdf/.

trend in condom use, low levels of HIV knowledge among young people, and the incidence of transactional sex for income, gifts, or favors, were identified as potential drivers of the current epidemic.[17]

Both quantitative and qualitative data suggest that males are more likely than females to have multiple and concurrent sexual partners. In one study, 33 percent of males and 17 percent of females reported having more than one partner in the past 12 months. The same pattern held for concurrent partners—25 percent of men and 12 percent of women reported having more than one partner.[18] In 2013, the percentage of all women and men who had multiple sexual partners in the last 12 months (prior to the BAIS IV survey) was 15.8 percent, an increase from 11.2 percent in 2008.[19]

Many gender-related domains associated with the risk of HIV emerged from the qualitative analyses. These results will be discussed in detail below under their relevant sections. They include gender norms about traditions, beliefs, gender roles, and household decision-making (including sexual negotiation power). Other gender-related areas were economic vulnerability leading to early marriage and transactional sex, fear of GBV as a result of refusing sex, insisting on condom use, or disclosing a positive HIV status, and stigma and discrimination.[20]

HIV and Health Service Utilization

The National HIV and gender response is multisectoral and decentralized, with gender and human rights treated as cross-cutting issues. In principle, the national response targets all people, including KPs and vulnerable groups, such as women, girls, migrant workers, the elderly and people with disability. However, not all groups are equally reached by services.[21]

There are many structures within communities to help achieve epidemic control. These include the Village Multi Sectoral AIDS Committee, Village Development Committee, health facilities (hospitals, clinics, health outposts), and CBOs. All of these services work to increase the quality of life for those living in the community. Organizations and committees host events, for example on World AIDS Day and World TB Day, to increase awareness about important health issues. Schools often work with CBOs to provide life skills lessons to students on topics such as HIV prevention, dealing with stigma and discrimination, GBV, and drug use. Health facilities provide education and treatment for sexually transmitted infections (STIs), HIV, TB, etc. Most health facilities have a Youth Friendly Nurse or Clinic that works with adolescents to help prevent HIV infection, or to help youth who have HIV to understand more about the virus, deal with stigma and discrimination, and learn how to live positively. In addition to the work at the community level, the District Multi Sectoral AIDS Committee coordinates and provides funding for CBOs carrying out HIV/AIDS activities in the community.

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[17] Strengthening the adolescent component of national HIV programmes through country assessments in Botswana: SBOZA RE MMOGO! (2015, June). Unpublished preliminary report of rapid assessment, June 2015.

[18] Gourvenec, D., Taruberekera, N., Mochaka, O., & Kasper, T. (2007, December). *Multiple concurrent partnerships among men and women aged 15-34 in Botswana: Baseline study, December 2007*. Gaborone: PSI Botswana.

[19] Government of Botswana (GOB). (2013). *Botswana AIDS impact survey IV (BAIS IV 2013): Summary results.* Gaborone: Statistics Botswana, GOB. Retrieved from: http://www.cso.gov.bw/images/aids_summary.pdf/.

[20] Annex 4

[21] Government of Botswana (GOB). (2013). *Botswana AIDS impact survey IV (BAIS IV 2013): Summary results.* Gaborone: Statistics Botswana, GOB. Retrieved from: http://www.cso.gov.bw/images/aids_summary.pdf/.

Overall, the proportion of people 15–49 years old who received HIV counseling and testing in the last 12 months and knew their results improved from 2008 (41.2%) to 2013 (63.7%).[22] However, the proportion of males being tested went down in the same period. Table 1 (Annex 2) summarizes testing numbers annually, between 2013 and 2015. Over these three years, a larger proportion of those ages 15 and above that received HTC and knew their results were female versus male. Among people tested who were ages 15 and above in 2015, 53.5 percent were female; in 2013, 50.5 percent were female. This decrease in the proportion of males versus females tested is seen clearly in Figure 2 (Annex 2).

Table 3 (Annex 2) shows that in 2013 among people ages 15 and above with advanced HIV infection who were receiving ART, 57.7 percent were female (42.3% were male). As with testing, the number of individuals reached in 2014 and 2015 was lower overall than in 2013. In the latter two years, there were slightly more males than females reached. Figure 3 depicts the clinical cascade for 2015, showing differences in the number of people diagnosed, linked to care, currently on ART and virally suppressed, for males and females. As noted, more women than men were diagnosed, which fits with the epidemiological pattern of the country, but under 20 percent of women and less than 5 percent of the men diagnosed were linked to care. Also disturbing is that the number of men currently on ART/virally suppressed in 2015 was slightly larger than the number of women, indicating that many women are not accessing services after diagnosis.

To date, a large portion of the PEPFAR Botswana treatment portfolio has focused on technical assistance (TA). For 2014, results reflected in the cascade for "treatment current" (technical assistance) show that more women than men were reached, which is consistent with past years. The 2015 TA results were not available when this report was being written, as the partner was just starting a new agreement.

HIV services, and health services in general, reach more women than men. The PEPFAR APR 2015 recorded fewer men reached by HTC, gender norms activities, priority prevention, and family-based programs such as OVC. The gender-related barriers associated with access to and utilization of services identified by the United Nations (UNAIDS) gender analysis include those mentioned above—stigma, GBV, harmful social norms, lack of access to money and other resources, issues of gender identity, sexual orientation, marital status, disability, and power relations between men and women.[23] KIIs and FGDs observed similar gender-related barriers, as noted below:[24]

- The notion of "being strong" is a defining aspect of masculinity in this part of Botswana. Seeking treatment, for HIV—or anything else—implies that they are/may be sick, which itself is associated with a notion of weakness and being in need of assistance. Being sick and asking for help diminishes a man's masculinity, inviting ridicule.
- HIV is still highly stigmatized in Botswana, and people do not want their positive status known. The set-up of the infectious disease care clinic (IDCC) in health facilities obliges people to wait in a public place designated for infectious disease treatment—i.e., you are probably if you are in that area. Due to the self-stigma around a positive status, people do not

[22] Government of Botswana (GOB). (2009, November). *Botswana AIDS impact survey III, Statistical report, 2009*. Gaborone: Central Statistics Office, GOB. Retrieved from http://catalog.ihsn.org/index.php/catalog/2045/.
[23] Government of Botswana (GOB) & United Nations, Botswana. (2009). *Situational analysis on gender-based violence in Botswana.* Gaborone: United Nations, Botswana.
[24] Annex 4.

want to be seen there. This was mentioned about men in particular. People also stated that if they have the means, they travel to facilities away from their home area so they would not be recognized.

- Alcohol was mentioned as a major problem in many contexts, and one that affects men more than women. Many sources stated that men and boys in particular drink heavily, which creates several problems. Alcohol interferes with HIV treatment, so they will be told not to drink (and they do not want to stop drinking); they will not come into services because they are too drunk; if they are on medication, they forget to take it.
- The behavior of health practitioners can encourage or discourage people from seeking and adhering to treatment. One group mentioned a particular health worker in their area who was so good with his clients that they were motivated to return for treatment. He used a sense of humor and treated people with respect. Another group mentioned being very embarrassed by health practitioners who were judgmental, asking questions such as, "Your last test was negative. What did you do to need a repeat one?"
- Many informants stated that these barriers were more difficult for men and boys to overcome. Women and girls were described as stronger than men and boys with regard to facing social pressures. People explained that they are socialized from childhood to bear hardship and abuse, and were therefore more likely be successful in seeking and adhering to ART.

(ii) Gender Norms: Beliefs, Access to, and Control over Resources and Decision Making

Gender norms play a critical role in women and girls' vulnerability to both HIV & GBV. Traditionally, girls in Botswana have been raised to believe that they should be subservient to men; boys are raised to believe that they have power and control over girls and women. Girls and women are generally conditioned to believe that their natural sphere of influence is inside the home, whereas power and decision-making outside the household and in public life belongs to men and boys. When a girl is married, she is told that she is obligated to obey her husband, is the junior partner, and that being beaten by a man is a normal part of marriage, even an expression of love. Although household social dynamics are slowly changing, these norms still directly influence GBV and HIV by reinforcing gender inequalities.[25]

Norms that result in power imbalances translate into risks for HIV. Even when they know that their partner has an STI or is sleeping with other women, women are often unable to negotiate safe sex, including the use of condoms or refusing to have sex. Women and girls are vulnerable to agreeing to have sex in return for favors or gifts.[26] For example, one recent study showed that 53 percent of women had unprotected sex because their partners refused to use condoms; 78.5 percent of the women in that study believed that a woman should obey her husband and 36.5 percent believed that a woman cannot refuse to have sex with her husband for any reason.[27] On the other hand, an

[25] Annex 4.
[26] Government of Botswana (GOB) & United Nations, Botswana. (2009). *Situational analysis on gender based violence in Botswana.* Gaborone: United Nations, Botswana.
[27] Underwood, C. & Schwandt, H. (2015, July). Community support and adolescent girls' vulnerability to HIV/AIDS: Evidence from Botswana, Malawi, and Mozambique. *Int Q Community Health Educ*, 35(4): 317-334.

intervention in schools aimed at empowering girls had an important influence over girls' ability to refuse sex and thus reduce their risk of exposure to HIV.[28]

A study among women living with HIV in Botswana showed that the concept of womanhood is synonymous with motherhood, and that women are expected to have sex in order to please a partner. A positive HIV status creates a barrier to fulfilling these expectations because women are anxious about revealing their status, or infecting their partner. The sense of pride and dignity that usually accompanies being pregnant is diminished by the fear of passing HIV to an unborn child. Shame and stigma play large roles in creating these negative conceptions, and possibly block women from seeking treatment.[29]

Gender norms also influence the risk of HIV for men and boys. As noted above, norms around masculinity and what it means to be a man create barriers to testing and treatment for men and boys. The widening gap between the proportions of women relative to men who completed gender norm interventions from 2014–2015 is therefore worrisome. Though many more people were reached overall, the proportions of males relative to females decreased markedly, from 46 percent versus 54 percent in 2014, respectively, to 39 percent males versus 61 percent females in 2015.[30] In 2015, 9,349 women ages 25 and over were reached by a gender norms intervention, compared with only 5,077 men. Among youth, the figures were a little closer, but many more girls were reached than boys. Specifically, among 15–19 year olds, 1,658 girls were reached compared with only 1,253 boys.[31]

In sum, the traditional patriarchal nature of Botswana society is still strongly felt. Although social dynamics are changing, these pervasive norms reinforce gender inequality and contribute to the risk of GBV and HIV.[32] Almost all KIs and the majority of people participating in FGDs stated that girls are still socialized to be submissive to men and to believe they are the junior partners in marriage, meaning they should not speak up for themselves. For example, people stated that wives are not expected to question husbands about where they have been, or what they do with their money. This existing gender power imbalance translates into less autonomy and household decision-making power for women relative to men,[33] including little sexual negotiation power.[34]

Within this context, HIV-positive women are afraid to disclose their HIV status to their male partners because they know they will be blamed. They fear rejection and repercussions, including GBV. Other findings from the qualitative data around norms were: [35]

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[28] Underwood, C. & Schwandt, H. (2015, July). Community support and adolescent girls' vulnerability to HIV/AIDS: Evidence from Botswana, Malawi, and Mozambique. *Int Q Community Health Educ*, 35(4): 317-334.
[29] Schaan, MM, M Taylor, N Gunggisa and R Marlink. 2015. Personal views about womanhood amongst women living with HIV in Botswana. *Cult Health Sex*, 18(2):171-83.
[30] Annex 2, Table 6.
[31] United States President's Emergency Plan for AIDS Relief. *(2015) PEPFAR gender clinical cascade*. Washington, DC: U.S. Department of State.
[32] Government of Botswana (GOB). (2009, November). *Botswana AIDS impact survey III, statistical report, 2009*. Gaborone: Central Statistics Office, GOB. Retrieved from http://catalog.ihsn.org/index.php/catalog/2045/.
[33] Annex 4.
[34] Government of Botswana (GOB). (2014, March). *Botswana 2013 Global AIDS response report: Progress report of the national response to the 2011 Declaration of Commitments on HIV and AIDS*. Gaborone: National AIDS Coordinating Agency (NACA).
[35] Annex 4.

- There is a double standard around multiple partners: The acceptance that men have multiple partners has been long rooted in Botswana society. There are several well-known colloquial expressions and phrases used for this established pattern, such as "small houses," "the right of a bull to enter a kraal," a man is an "axe," and so on. These idioms portray men in a positive light, whereas women with multiple partners are considered "very bad people."

- Gender norms place women and girls at risk for intergenerational and transactional sex: Low income women and girls are more likely to engage in transactional sex than those better off. Gifts such as cell phones, clothing, etc. are exchanged for sex. Women may have sex with superiors at work to get a raise or a better job.

- A few people mentioned a new trend of older, wealthy women picking up young boys and offering them money and gifts for sex.

- On a positive note, programs are successfully transforming gender norms:

    - Girls' empowerment in schools has been integrated into teacher training in order to implement the program. Teachers were thus exposed to the norm-transforming interventions. Now both female teachers and students are challenging traditional roles with new choices.

    - The program, *Men in the Kitchen*, teaches boys traditionally "female chores" by getting them together in a fun peer environment to do them with older male mentors. Performing these tasks in this manner changes the way men and boys feel about the work and themselves: boys begin challenging old gender norms.
    - Gender sensitization trainings in schools have taken place in the Gender Affairs Department's (GeAD) pilot districts for a GBV referral system. Schools also host gender transformative career talks and recruitment fairs, aimed at reducing gender parity in traditionally gendered fields.[36]

[36] United Nations (UN) Botswana. (n.d.). *United Nations Joint Programme of Support to End Gender-Based Violence in Botswana: 2015–2016*. Gaborone: UN Botswana.

USAID Mission employees marching against GBV as part of the 16 Days campaign against GBV activities.
Photo: Douglas Seremane, December 2013

(iii) Economic Vulnerability

According to the 2011 Household Income and Expenditure Survey, women are often unemployed in the formal sector, are overrepresented in marginal employment sectors, or else do unpaid work. This employment inequality leaves both women and female-headed households more at risk for poverty and economic marginalization than men and male headed-households. This plays out in household poverty statistics: 46 percent female-headed households compared with 27 percent of male ones were living in poverty. In a list of economic activities surveyed, male headed households were more likely to be engaged in a broader range of them than female headed ones. Males are also more likely to have higher levels of education than females in Botswana. More males than females finished secondary and university education. In sum, relative to men, women are less employed, less highly educated and less economically active. [37] The educational disadvantage and lower chance of gaining

Boy Scout Troop graduating from the Gender & HIV module and receiving badges from J.O. Smith, representing U.S. Ambassador Gavin.
Photo: Baoki Ditau

[37] Statistics Botswana. (2014). *Population and Housing Census 2011: Analytical report*. Gaborone: Statistics Botswana. Retrieved from: http://www.cso.gov.bw/images/analytical_report.pdf.

higher paying employment are risk factors for poverty. Poverty, combined with gender norms supporting inequality, can cause people to engage in risky behaviors to earn money, including transactional sex and multiple concurrent partners (MCP).

Deputy Chief of Mission Michael Murphy launching a GBV program at Botswana Christian AIDS Intervention Programme (BOCAIP), a nongovernmental organization. Photo: Douglas Seremane, November 2014

Girls and women in particular become economically vulnerable for many reasons, including dropping out of school early due to pregnancy (though it is legal for girls to be in school when pregnant, and they can return after giving birth) and having to care for younger family members if one or both parents are absent. Men's economic advantage fuels gender inequality in that their better access to and control over economic resources reinforces gender power differentials. Many respondents in the qualitative interviews said that men are still considered to be the primary family breadwinners, earning and/or controlling most or all household income. Women often lose control over their possessions after marriage, and inheritance laws can be abused when husbands die.[38]

As noted, economic vulnerability is also tied directly to transactional sex—according to qualitative respondents, females are more likely than males to engage in transactional sex. The majority of the people involved exchange sex for gifts, money or favors. The partner accepting the payment or favors are usually in a vulnerable position, where he/she is less likely to be able to negotiate for safe sex and in particular the use of condoms.

(iv) Gender-Based Violence

Following the global pattern, GBV is a major factor driving the HIV epidemic in Botswana. There are many direct and indirect factors that put people at risk for HIV if they are vulnerable to or have experienced GBV. This has been demonstrated by research for almost two decades.[39] As one example of how this takes place, violence in a relationship results in the inability of the abused person to make decisions regarding his/her sexual and reproductive health, such as negotiating for condom use during sex.

Botswana suffers from very high levels of GBV. In the 2012 GBV Indicators study, 67 percent of women interviewed reported experiencing some form of GBV in their lives, with 62 percent reporting intimate partner violence (IPV) in their lifetimes. Over a third of women (39%) reported experiencing IPV in the past 12 months, while 28 percent of men reported perpetrating IPV in the past 12 months.[40] Another study in Botswana found that less than a quarter of women who experienced IPV in the last 12 months reported it to the police. Among the types of IPV reported to the police, physical

[38] Annex 4.

[39] Maman, S., J Campbell, M Sweat, A Gielen. (2000). The intersections of HIV and violence: Directions for future research and interventions. *Social Science and Medicine*, (50): 459–478.

[40] Machisa, M. & van Dorp, R. (2012). *The gender-based violence indicators study: Botswana.* Gaborone: Ministry of Labour and Home Affairs, Women's Affairs Department, Government of Botswana and Gender Links. See Annex 1 for a table of full results.

violence constituted the vast majority of cases; verbal, sexual and emotional IPV reports were about 1/5 the number of physical violence. Economic violence constituted the least number of cases.[41] It was estimated that up to 2 percent of lost productivity in Southern Africa is due to GBV, and that a third of women who experience GBV have to take time off work because they need to recover from injuries.[42]

Adolescent girls and young women are particularly vulnerable to GBV. The BAIS IV showed that 24.8 percent of females reporting early sexual debut stated that they did not give consent at the time of intercourse, and 3.1 percent of women ages 15–49 reported having sex without giving consent in the last 12 months. Further, cultural norms contribute to the risk of GBV. In Ngamiland, girls are at higher risk for defilement than elsewhere because of community norms around the power of older male relatives.[43] One study reported a strong link between GBV and HIV, noting that women who are emotionally abused are 52 percent more likely to be infected than those who are not.[44]

According to the Botswana GBV indicators study:[45]

- 20.3 percent of women who were sexually abused by their partners tested HIV-positive
- 15 percent of the women who were sexually abused by nonpartners tested HIV-positive
- 53 percent of the GBV survivors who experienced GBV in the last 12 months suspected that their partners were having sex with someone else, increasing the risk of HIV transmission
- Child abuse was reported/observed as a key factor influencing GBV
    - 66 percent of male perpetrators experienced child abuse themselves; 24 percent experienced child sexual abuse
    - 19.6 percent of women survivors experienced child sexual abuse themselves
    - 56 percent of women survivors witnessed their mothers being abused

Added to this, the GOB/UN situational analysis noted that 23 percent of pregnant women reported experiencing violence during pregnancy.

Table 8 in Annex 2 shows the distribution of women experiencing IPV and men perpetrating it, both for ever in a lifetime, and recently (during the past 12 months before the survey). Age, education, and to some extent, employment, are all associated with ever or recently experienced IPV. Education does not appear to offer a protective effect, as a large proportion of more highly educated women experienced IPV relative to those without high school education. However, this could be due to a bias in reporting, where more educated women interpret GBV as something they should report, compared with those who are less educated who may regard it as a normal part of life. Women between the ages of 18-44 reported experiencing the most IPV. The male perpetrators followed the same patterns noted.

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[41] Government of Botswana (GOB). (2014, March). *Botswana 2013 global AIDS response report: Progress report of the national response to the 2011 Declaration of Commitments on HIV and AIDS*. Gaborone: National AIDS Coordinating Agency (NACA).
[42] Botswana Council of NGOs (BOCONGO). Southern African Development Community (SADC) Gender Protocol 2015: Barometer Botswana. Genderlinks for Equality and Justice. Retrieved from http://genderlinks.org.za/programme-web-menu/publications/sadc-gender-protocol-2015-barometer-botswana-2015-06-25/.
[43] Government of Botswana (GOB). (2013). *Botswana AIDS impact survey IV (BAIS IV 2013): Summary results.* Gaborone: Statistics Botswana, GOB. Retrieved from: http://www.cso.gov.bw/images/aids_summary.pdf/.
[44] GOB. (2014, March). *Botswana 2013 Global AIDS response report: Progress report of the national response to the 2011 Declaration of Commitments on HIV and AIDS*. Gaborone: National AIDS Coordinating Agency (NACA).
[45] Machisa, M. & van Dorp, R. (2012). *The gender-based violence indicators study: Botswana.* Gaborone: Ministry of Labour and Home Affairs, Women's Affairs Department, Government of Botswana and Gender Links.

The GBV indicators study reported a range of attitudes on gender norms, some of which were incongruous. For example, while over 80 percent of men and women interviewed agreed that people should be treated the same whether they are male and female, 88.9 percent of men and 78.5 percent of women stated that wives should obey their husbands. Yet, only 28.4 percent of women and 54.3 percent of men agreed that husbands should have the final say in all family matters. The same disparity was observed when asking people what their community believes about the same issues.[46] This indicates that ideas are definitely changing, but pragmatically, things are slower to transform.

Attitudes pertaining to conjugal rights demonstrated a more consistent pattern, with women espousing less traditional attitudes than men. In answer to whether it was possible for a woman to be raped by her husband, 54.3 percent of women and 48.8 percent of men agreed that it was. Under 50 percent of women and men agreed that a woman cannot refuse sex from her husband; 22.7 percent of women and 44.7 percent of men agreed that if *lobola* (bride price) has been paid, the wife belongs to the husband.[47] The GBV law in Botswana does not cover marital rape as a crime.[48]

While GBV is mainly experienced by women and children, men are also susceptible. Accurate levels of GBV are difficult to obtain for women; it has long been recognized that GBV is underreported due to stigma, fear and other factors.[49] However this problem is even more acute for men, due to the norms around what it means to be a man. One set of FGD respondents said that men who are raped are unlikely to report to authorities because they are apt to be ridiculed, instead of being taken seriously.[50]

GBV services in Botswana are delivered by an array of providers who are currently connected by an informal referral system. Skills and training around handling a GBV case varied considerably both within and across agencies providing GBV services. Recently, PEPFAR implemented an intervention of developing SOPs with four GOB sectors that provide care and support for GBV survivors, Health, Education, Police, and Social Work. These SOPs are now being implemented. Previous to this, few agencies were identifying cases and delivering services aligned with standardized protocols.[51]

A few CBOs provide services to GBV survivors such as temporary shelter, provision of legal aid, HIV testing, psychosocial support, family-centered trauma counselling, and referral for treatment, including post-exposure prophylaxis (PEP). Over one-third of respondents in both KIIs and FGDs stated that GBV services were fragmented, in need of organization and linkages.[52] To that end, the GOB is collaborating with USAID and MEASURE Evaluation in piloting a new electronic GBV referral system based on mobile technology.

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[46] Machisa, M. & van Dorp, R. (2012). *The gender-based violence indicators study: Botswana*. Gaborone: Ministry of Labour and Home Affairs, Women's Affairs Department, Government of Botswana and Gender Links.
[47] Machisa, M. & van Dorp, R. (2012). *The gender-based violence indicators study: Botswana*. Gaborone: Ministry of Labour and Home Affairs, Women's Affairs Department, Government of Botswana and Gender Links.
[48] Government of Botswana (GOB). (n.d.). Botswana e-Laws website, Botswana Penal Code. Retrieved from http://www.elaws.gov.bw/default.php?UID=602/.
[49] Palmero, T., Bleck J., & A Peterman, A. (2013, December 12). Tip of the iceberg: Reporting and gender-based violence in developing countries. *Am J Epidemiol.* Retrieved from http://aje.oxfordjournals.org/content/early/2013/12/12/aje.kwt295.full.pdf+html/.
[50] Annex 4.
[51] MEASURE Evaluation conducted informational interviews with GBV service providers in 2014 as part of its work on the GBV Referral System Project (GBVRSP), a pilot referral system in two areas of Botswana, and found that both government and NGO providers had no standard operating procedures.
[52] Annex 4.

Females accounted for the larger part of the proportions of young people (ages 15–24) receiving post-GBV care (Annex 2, Table 7) in 2014 and this differenced increased in 2015. Among the total number of men and women receiving post GBV care, the vast majority (76 percent) were female, and the difference remained the same for both years. This gender gap exists because GBV is high among women nationally (67 percent) and the two shelters providing post GBV care services provide shelter for women and girls only; boys are admitted only if they are below age 13. Some men who receive counseling are partners of GBV survivors as well as men who experience violence themselves.

There were no data available for measuring coverage of pre-exposure prophylaxis (PrEP). There is no National Program in Botswana for PrEP, but there is one for PEP. No data were available for the use or coverage of PEP because PEP is distributed by health facilities, and currently there is no tracking system for this type of referral. The country does not have any prevention interventions targeting adolescents who inject drugs.

There are many challenges to preventing and controlling GBV. For example, there no system to monitor compliance with existing policies and laws, inadequate human resource capacity to deliver comprehensive services, including legal recourse, and insufficient funding to thoroughly address GBV. These issues, combined with cultural norms and the economic dependence by women and children on men, make women and girls more vulnerable to GBV, especially in rural areas. Most cases of violence go unreported due to fear of further violence. In some instances, GBV cases have been dismissed due to lack of sufficient evidence, despite violence having taken place.[53] An assessment of adolescents and HIV identified several gaps in prevention of GBV among young people, including conflicting laws, varying cultural norms, lack of youth-friendly services as well as knowledge about available services, and no access to financial support:[54]

GA qualitative data indicated that Botswana faces many challenges to effectively prevent and control GBV, as expressed below by various respondents:[55]

- Women are now taking on nontraditional roles and responsibilities and are changing at a faster rate than men are. As a result, many men view women's new independence as a threat to their traditional control and power in relationships. This creates a potential risk for GBV.
- Sero-discordant couples are at high risk for GBV for several reasons. If the woman is negative, the notion of a man's conjugal rights makes it difficult to counsel couples. On the other hand, if she is positive, she will be at risk for getting evicted from the house, beaten, and ostracized by her family and community.
- Alcohol was mentioned as factor influencing the risk of several types of GBV. Women who become drunk may be taken advantage of by men. Men who drink excessively may lose control of themselves and beat their wives. Later, alcohol is used an excuse: "I was drunk. So I beat her." [56]

[53] Government of Botswana (GOB). (2015). *National HIV and AIDS response, gender assessment report, October 2014.* Gaborone: GOB, National AIDS Coordinating Agency, Joint United Nations Programme on HIV/AIDS.
[54] Strengthening the adolescent component of national HIV programmes through country assessments in Botswana: SBOZA RE MMOGO! (2015, June). Unpublished preliminary report of rapid assessment, June 2015.
[55] Annex 4.
[56] Annex 4.

- The quality of GBV survivor services is often questionable. GBV survivors are made to stand in long lines to receive services, and then may not what they need. Added to this is the sometimes unsupportive and judgmental attitudes of police, health practitioners and other service providers. These quality of care issues further traumatize GBV survivors who choose to report, and serve to discourage others from coming forward in the first place.
- There is a lack of accountability and supervision in various sectors to effectively combat noncompliance with existing GBV-related policies and laws.
- Most GBV cases go unreported, due to fear of further violence or loss of economic support from the perpetrator.
- Information gaps exist pertaining to GBV: KPs, including transsexuals, have not been reached by GBV awareness campaigns. In these communities, the extent and patterns of GBV are not known.

The United Nations Joint Gender Program holds promise for preventing and responding to GBV in Botswana. The program proposes to support the establishment of a youth advisory committee, training youth, and leveraging the use of social media platforms to respond to GBV. It will also disaggregate youth data by sex (something observed in the PEPFAR indicators as lacking), and engage in other efforts to strengthen monitoring and evaluation (M&E).[57] The report goes on to mention many M&E activities based on a centralized, national GBV surveillance system, but with no specific plans for that system's development. The UN group has not yet coordinated with the new GBV Referral Information System Project (GBVRSP), which is being piloted in two areas of the country for GBV referrals. This system was designed with the ability to expand to a national-level GBV information system. The UN group does not mention how another system would be set up or where it would be housed. Thus, at present, a national-level system does not seem realistic. For example, section 3.1 of the document states, "routine GBV data collection incorporated into pre-existing HIV structures…GBV incorporated as a thematic focus area in the next HIV and AIDS National Strategic Framework."[58] Incorporating information into an existing data system is complex. Data collection and reporting have their own streams, and the report never specifies where or how the data will be collected or by whom they will be reported.

The PEPFAR B team has implemented a comprehensive portfolio of programming. Some activities aim to build the capacity of the GOB and its partners to prevent and respond to GBV and include:

- Working with American International Health Alliance to roll out already existing MOH Protocols and Services Standards for Prevention and Management of GBV for Health Care Providers. This involved the development of a training curriculum and materials to support the dissemination and training plan for the roll-out of GBV services nationwide. Because the prevention and response to GBV involves multiple sectors, the training materials will be used by health care workers in collaboration with social workers, police, and NGO service providers. The content covers screening, case management, case reporting, and collecting

[57] United Nations (UN) Botswana. (n.d.). *United Nations Joint Programme of Support to End Gender-Based Violence in Botswana: 2015–2016*. Gaborone: UN Botswana

[58] United Nations (UN) Botswana. (n.d.). *United Nations Joint Programme of Support to End Gender-Based Violence in Botswana: 2015–2016*. Gaborone: UN Botswana, p. 17.

evidence. These trainings are ongoing, with over 90 health care providers trained in five districts so far.

- Working with Management Sciences for Health to develop SOPs for Botswana Police Services, the Department of Social Protection and the Ministry of Education. The draft SOPs are currently being piloted in Maun/Shorobe and Mochudi/Artesia as part of the collaboration with MEASURE Evaluation to implement the GBVRSP.

- Working with CBOs who are implementing community outreach engagement activities in various districts. These activities are aimed at raising awareness, encouraging communities to take action against GBV, and addressing cultural norms. For example, cultural dialogues at the traditional tribal authority (kgotla), advocacy activities with traditional leaders, individual and small group interventions with men, women, out of school youth, churches, and gender and GBV focused life skills sessions with in-school youth. CBO partners use interactive evidence-based approaches including: (1) *In Her Shoes,* an interactive exercise designed to allow women and men the opportunity to walk "in the shoes" of women experiencing violence; (2) *SASA!,* a methodology that can be used to address the link between violence against women and HIV; (3) *Go Girls!* project manuals and materials designed to identify and reduce girls' vulnerability to HIV*;* 3) *Engaging Boys and Men in Gender Transformation's Group Education Manual*, to help men explore gender socialization and its impact on HIV prevention and care; (4) and the *One Man Can* action kit, with resources to help men act on their concerns about GBV.

- Peace Corps volunteers facilitating Girls Leading Our World camps in various schools across the country.

Other PEPFAR B activities aim to expand existing GBV services, such as supporting the only two shelters to expand the provision of post GBV services in Botswana. Kagisano Women's Shelter in Gaborone serves clients in the southern part of the country. Women Against Rape (WAR) in Maun serves survivors from the northern part of the country. These shelters provide shelter counseling, legal aid, and art therapy for young survivors. They also provide referrals for HIV/AIDS testing, STI screening and PEP. GBV survivors are assigned case managers who remain with them at health facilities and the police to ensure they receive the required services. Their activities also include community outreach, advocacy, and training of service providers.

J.O. Smith and Kgosi Mosadi Sebogo at the national launch of 16 Days, a cultural dialogue organized by Gender Affairs in partnership with the USAID Mission in Botswana and Bamalete traditional leaders.

Photo: Baoki Ditau

PEPFAR B also supports research activities and is implementing the VACS, working closely Department of Social Protection and the CDC/Atlanta Division of Violence Prevention. The VACS will elucidate issues of sexual and other violence experienced by children and can provide the critical information and momentum to implement needed policies and programs, as has taken place in other countries. The Botswana study is

unique since it includes HIV testing. Data collection is scheduled for 2016.

(v) Stigma and Discrimination

Despite policy and programmatic strategies aimed at reducing HIV-related stigma and discrimination, high levels of both persist in Botswana. Unfortunately, trends seem to be worsening, as the proportion of people expressing accepting attitudes towards people living with HIV (PLHIV) dropped from 64.8 percent in 2008 to 23.8 percent in 2013.[59] In the 2013 BAIS study, men and young people (age 15–24) were more likely to express stigma than women. External stigma was lower, at 13 percent, compared with internal stigma,[60] which was reported by 20 percent of respondents.[61] The GA qualitative results suggest that these estimates are very low.

Stigma is a key underlying factor exacerbating HIV risk and increasing barriers to testing, treatment, and adherence. In the view of the majority of people interviewed for the GA, being HIV-positive is still very shameful. Respondents concurred that self-stigma was the worst—people's fears of what family and community would say or do. Stigma around HIV intensifies the inequities already experienced by women, children and KPs as part of normal life. In the stigma assessment among LGBTI, 14 percent reported being denied health care services; only 25 percent reported disclosing their sexual orientation to healthcare providers, while 20.5 percent of the respondents reported being afraid to seek services due to fear of stigma.[62]

Main findings from the qualitative research about the effects of HIV stigma are:[63]

- People fear knowing and/or sharing their status within families and communities. This means that people cannot enlist the help and support of family members or spouses; adherence without such support is likely to fail.
- Parents are reluctant to disclose their child's HIV-positive status to them before adolescence, resulting in several negative effects, including:
    - Teens infect one another because they are unaware of their status.
    - Anger, blame, and resentment are expressed towards parents when the child finally finds out.
    - Teens stop taking their medications once they find out, because they are confused and angry.
- Women are more likely than men to endure the stigma of possible exposure from seeking and adhering to treatment, because (1) they are motivated to save themselves in order to care for

[59] Government of Botswana (GOB). (2009, November). *Botswana AIDS impact survey III, statistical report, 2009*. Gaborone: Central Statistics Office, GOB. Retrieved from http://catalog.ihsn.org/index.php/catalog/2045/. GOB. (2013). *Botswana AIDS impact survey IV (BAIS IV 2013): Summary results*. Gaborone: Statistics Botswana, GOB. Retrieved from: http://www.cso.gov.bw/images/aids_summary.pdf/.

[60] External stigma refers to behaviors enacted or demonstrated by people towards a person (with HIV, for example) based on fear or judgements about something "different"; internal stigma refers to what people perceive about how they are being treated—for example, fear of community judgment (whether or not it is actually taking place).

[61] Government of Botswana (GOB). (2015). *National HIV and AIDS response, gender assessment report, October 2014*. Gaborone: GOB, National AIDS Coordinating Agency, Joint United Nations Programme on HIV/AIDS (UNAIDS).

[62] LEGBIBO. (n.d.). *LGBTI Health and wellness needs assessment in three locations in Botswana*. LEGBIBO.

[63] Annex 4.

their families, and (2) the inequities they bear as females are similar to the experience of stigma associated with HIV (i.e., they are used to dealing with these feelings).

(vi) Youth

Young people are clearly at risk for HIV in Botswana. The last two BAIS reports showed that although the proportion of 15–24 year olds who reported having multiple partners fell from 5.5 percent in 2008 to 4.6 percent in 2013, consistent condom use with nonregular partners among sexually active young people was 65.2 percent in 2013, down from 78.4 percent in 2008. Among in-school youth surveyed in 2012, 19.1 percent reported having sexual intercourse before age 13, with 13.5 percent having partners at least five years older than they were. Additionally, the first act of sexual intercourse was associated with several risky behaviors: 12.8 percent stated that it was nonconsensual, 20.1 percent exchanged sex for money, and 16.6 percent reported using alcohol.[64]

According to the 2013 BAIS study, HIV prevalence among adolescents (ages 15–19) was double for girls (6.2%) compared with boys (3.6%). Among people 20–24 years old, HIV prevalence for females (14%) was estimated at almost three times higher than for males (5%).[65] Another study suggests that knowledge of HIV among all youth is low. Among girls ages 15–19, 56 percent demonstrated comprehensive knowledge of HIV compared with 52 percent of boys of the same age group. Among young adolescents (10–14 years), rates were even lower, at only 24 percent and 22 percent of girls and boys, respectively.[66]

Tables 4 and 5, and Figure 4 in Annex 2, present PEPFAR data on HTC and treatment for youth. The proportion of those ages 15–24 reached by HTC who were girls versus boys was much larger, especially in 2015, when almost double the number reached were girls. The numbers for youth under 15 years of age seem incorrect for 2013, but even in this age group many more girls than boys were tested and knew their results. Figure 4 depicts the continuing gender gap over the years, though it closed somewhat for 2015. Disaggregated statistics for treatment in youth were only available for 2015 (Table 5, Annex 2). Here as well, a notably larger proportion of those ages 15–24 that were treated were girls relative to boys.

A rapid assessment on OVC was conducted in 2015 by USAID/Botswana in PEPFAR districts, based on group interviews and with key informants from each district (e.g. health care providers, S&CD, teachers, the police among others). The interviews consistently highlighted issues of early sexual debut, teen pregnancy and STIs, rape/defilement, transactional sex and identified some important gaps in HIV service access for young people. For example, in addition to youth having misconceptions about condoms, they are not available at school. The Ministry of Education and Skills Development (MOESD) encourages abstinence and promotes use of condoms, but condoms cannot be distributed in schools. Teenage pregnancy and the need for adolescent girls to work were cited as reasons for not staying in school (either temporarily or fully dropping out). Access to health services designed

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[64] Government of Botswana (GOB). (2012). *First Botswana Youth Risk Behavioural Surveillance Survey, 2012*. Gaborone: Ministry of Education and Skills Development (MOSED), GOB.

[65] Government of Botswana (GOB). (2013). *Botswana AIDS Impact Survey IV (BAIS IV 2013): Summary Results*. Gaborone: Statistics Botswana, GOB. Retrieved from: http://www.cso.gov.bw/images/aids_summary.pdf/; see Annex 2 for more results.

[66] Strengthening the adolescent component of national HIV programmes through country assessments in Botswana: SBOZA RE MMOGO! (2015, June). Unpublished preliminary report of rapid assessment, June 2015.

specifically for youth is limited. Also, HIV testing hours are inconvenient for many youth, and parental consent is needed. Children on antiretroviral (ARV) drugs cannot easily hide their status from peers and teachers, and external stigma is high from both groups, making it very difficult for children to want to take their medications. OVC may be at even higher risk for negative outcomes than other children. Assessment respondents cited specific examples of neglect, rape and incest, and verbal abuse leading to low self-esteem, and exploitation of boys for child labor among OVC. [67]

Knowledge about HIV

In 2013 only 47 percent of youth ages 15–24 correctly identified ways of preventing sexual transmission of HIV. A slightly larger proportion of girls ages 15–19 (56%) demonstrated comprehensive knowledge of HIV, compared with boys of the same age group (52%). To demonstrate comprehensive knowledge, the respondent must correctly answer a number of questions regarding the transmission and prevention of HIV. The low rates of comprehensive knowledge among young adolescents (10-14 years), estimated at 24 percent and 22 percent among girls and boys, respectively, are very worrisome. The last two waves of the BAIS showed that condom use among adolescents with nonregular partners has fallen.[68]

Sexual Behavior Patterns

Among youth (15–24), the proportion that reported having multiple partners within the previous 12 months was considerably lower than for all BAIS IV respondents (at 4.6%, down from 5.5% in 2008). The number of young women and men (ages 15–24) with multiple partners decreased from 5.5 percent in 2008 to 4.6 percent in 2013.[69] However, in 2013, consistent condom use among nonregular partners among sexually active young people ages 15–24 was reported at 65.2 percent, down from 78.4 percent in 2008.[70]

Anecdotal information suggests that inter-generational sex is prevalent between young girls and men who are 10 years older. HIV prevalence among adolescents is estimated to be much higher for girls (6.2%) than boys (3.6%) age 15–19 years. The BAIS III noted that 76.3 percent (78.2% females and 74.1% males) of respondents reported that it is acceptable for a woman to obtain male condoms.[71]

The results from the 2012 Botswana Youth Risk Behavioral Surveillance Survey (BYBSS) provides an indication of risky behaviors among the subgroup of in-school youth. Specifically, 19.1 percent

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[67] Segwabe, M., Segametsi D., S., Lynne Gaffikin, L., & and Yamba, B. (2015) *Orphans and vulnerable children 2015: Botswana priority districts–July 2015*. SADC Gender Protocol 2015 Barometer–Botswana 2015. Gaborone: Botswana Council of NGOs.

[68] Strengthening the adolescent component of national HIV programmes through country assessments in Botswana: SBOZA RE MMOGO! (2015, June). Unpublished preliminary report of rapid assessment, June 2015.

[69] Government of Botswana (GOB). (2013). *Botswana AIDS impact survey IV (BAIS IV 2013): Summary results.* Gaborone: Statistics Botswana, GOB. Retrieved from: http://www.cso.gov.bw/images/aids_summary.pdf/.

[70] Machisa, M. & van Dorp, R. (2012). *The gender-based violence indicators study: Botswana*. Gaborone: Ministry of Labour and Home Affairs, Women's Affairs Department, Government of Botswana and Gender Links.

[71] Government of Botswana (GOB). (2015). *National HIV and AIDS response, gender assessment report, October 2014.* Gaborone: GOB, National AIDS Coordinating Agency, the Joint United Nations Programme on HIV/AIDS (UNAIDS.

reported having had sexual intercourse before the age of 13; 13.5 percent reported having had sexual intercourse for the first time with a person at least 5 years older than they were.[72]

These statistics corroborate the qualitative findings of USAID Botswana's 2015 OVC rapid needs assessment. Relevant recommendations in the report focus on youth friendly services. The only mention of anything specifically related to gender—although all of these issues are strongly impacted by gender inequality—is family planning to be promoted among girls. Also, teenage pregnancy and the need for adolescent girls to work were cited as reasons for not staying in school. Other report recommendations include life negotiation skills and facilitated peer-to-peer community conversations. The assessment identified the following barriers to service access for young people:[73]

- HTC: delinked management information systems, age of consent (16), multiple protocols, high staff turnover, inconvenient service hours, and negative attitudes among health workers.
- ART: forced disclosure at school, stigma/discrimination, lack of trained staff, stockouts at facilities, misconceptions about the side effects of ARVs, poor adherence due to fatigue, high patient burden, lack of trained staff.
- Condoms: myths and misconceptions related to use, stockouts at facilities, lack of availability at schools and juvenile centers.

These findings echoed similar themes about the difficult for youth to access HIV testing and treatment services:[74]

- Parental consent for HIV testing is needed for children under age 16, meaning children are put into a position of having to disclose their sexual activity to parents. Parental consent is not necessary for HIV treatment.
- Boys are afraid to test, and like adult men, use their partners as a "yardstick" for their HIV status. In other words, when partner's get tested, boys (and men) believe that their test reflects their own status—and so they do not bother to get tested themselves.
- Both testing and treatment service hours coincide with the school day. Teachers are supposed to facilitate treatment for HIV-positive students, but this means that students have to disclose their status to teachers. Barriers to doing this come from parents who do not want anyone to know their child's status, and to the stigma associated with revealing your own status. As is the case with adults, girls are more likely to reveal their status to teachers than boys are.
- Youth may know about condoms but they do not know how to use them. Since the MoESD does not allow condom distribution at school as part of their HIV interventions, youth are not trained on how to use condoms.
- If someone is on treatment, it is very hard to hide their HIV status from others, because of the need for support, such as eating a meal on time. The stigma associated with disclosing status leads to difficulty in staying on treatment.
- Several suggestions were made to increase the use of HIV services among youth:

[72] Government of Botswana (GOB). (2012). *First Botswana youth risk behavioural surveillance survey, 2012*. Gaborone: Ministry of Education and Skills Development (MOSED), GOB.
[73] Strengthening the adolescent component of national HIV programmes through country assessments in Botswana: SBOZA RE MMOGO! (2015, June). Unpublished preliminary report of rapid assessment, June 2015.
[74] Annex 4.

- Engaging youth friendly services and practitioners will ensure that youth feel comfortable in the facility.
- Youth friendly clinics could be open after school hours to encourage people to go without having to disclose their status to teachers and others at school.
- Adding some form of youth-friendly entertainment (like electronic games) in waiting areas would provide incentives for youth to seek treatment.

Although only 64 percent of sexually active adolescents ages 15–19 have been tested for HIV, ART coverage for adolescents ages 10–19 is very high at 90 percent, compared with young adults at only 50 percent. This indicates that adherence and retention in programs as adolescents move into their 20s poses a challenge. ART rates among pregnant adolescents is higher, at 95 percent. Viral suppression among HIV-positive adolescents is estimated at 92 percent, but no sex-disaggregated data was available for this indicator.[75]

For girls and boys passing from childhood to adolescence, there is a formidable challenge in the lack of access to adequate sexual and reproductive health (SRH) services, information, and mentorship from parents. The norms around discussing sexuality and related topics prevent parents from talking about these topics with their children, especially in rural settings. These norms leave children and young adolescents vulnerable to HIV.

One common observation in OVC-related programming, across all the districts examined in the assessment, is that M&E is fairly weak. Strengthening M&E would provide a good opportunity for directing attention to gender.[76] For example, in Lobatse, challenges under ART for adolescents include stigma and discrimination; adolescents do not want to be singled out. Important questions to ask are: Is this effect the same for girls and boys? Is stigma for one or the other worse or better? Do boys react in the same way as girls? Are the ways for addressing this the same for both boys and girls? The next assessment of this type need to have a gender-focus in order for those questions to be addressed.

(vii) Key Populations

The majority of African states, their governments, and individual citizens are largely intolerant of homosexuality and associated behavior. This generalization is supported by statistics from the 2016 Afrobarometer report, which polled 33 countries across the continent and concluded that, on average, 78 percent of respondents would "strongly dislike" or "somewhat dislike" having a homosexual neighbor. However, when disaggregated by region, Southern Africa appeared to be the most tolerant, with the majority of citizens in South Africa, Mozambique, and Namibia not opposed to homosexuals. In Botswana, the proportion reporting tolerance was and 43 percent. Statistics also indicated a greater degree of tolerance in younger (18–35 years old), more highly educated (post-secondary) Africans

[75] Strengthening the adolescent component of national HIV programmes through country assessments in Botswana: SBOZA RE MMOGO! (2015, June). Unpublished preliminary report of rapid assessment, June 2015.
[76] Segwabe, M., Segametsi D., S., Lynne Gaffikin, L., & and Yamba, B. (2015) *Orphans and vulnerable children 2015: Botswana priority districts–July 2015*. SADC Gender Protocol 2015 Barometer–Botswana 2015. Gaborone: Botswana Council of NGOs.

when compared with their older counterparts. This suggests that Africa may become progressively less homophobic over time.[77]

Botswana was ranked highly in the Afrobarometer tolerance index, but it differs significantly from its regional neighbors, South Africa and Mozambique, in the fact that homosexuality is not constitutionally decriminalized. Currently, the Penal Code of Botswana Chapter 8:01, Section 164 (a) holds that, "any person who…has carnal knowledge of any person against the order of nature…is guilty of an offence and is liable to imprisonment for a term not exceeding seven years." Originally addressing homosexual men, the statute was amended in 1998 to criminalize female-to-female sex as well.[78] In his statement on the ruling of Utjiwa Kanane v The State Appellate Court, Justice Tebbutt JP took the view that, "gay men and women did not…represent a group or class which had been shown to require protection under the Constitution." In writing for the African Human Rights Law Journal, University of Botswana law professor EK Quansah concludes, "the executive's attitude to same-sex relationship is, at best, one waiting to be shaped by majority sentiments of the people of Botswana and, at worst, one of denial — such relationships do not exist in Botswana."[79]

Botswana has not clearly defined who constitutes KPs. In the absence of a national definition of KPs, this GA adopted the global definition that includes sex workers, men having sex with other men (MSM), Injecting Drug Users (IDUs), and prison inmates. In addition, transgender people were also included in the definition, as required by the UNAIDS Gender Assessment Tool. Existing policies have not specifically addressed the needs of KPs. Punitive legal practices still exist – sex work, and as indicated above, MSMs—are both considered illegal practices. While there is no written policy, some services such as condoms are not freely available in prisons.[80]

The provisions of the Constitution and the National Policy on HIV and AIDS are intended to protect the rights of all people, including KPs, from any form of stigmatization, discrimination, and abuse of their basic rights. Botswana does not have any specific law that protects the rights of KPs, but rather treats them as part of the general population. The Constitution is silent on discrimination on the basis of gender identity and/or sexual orientation. Gender identity and sexual orientation are not criminal offenses in of themselves, but the act of engaging in sexual activity within these relationships is criminalized. Sex work is illegal in Botswana. These laws make it difficult for MSM and FSWs to freely access and utilize essential services. Sex workers are often arrested and charged with other laws, despite the provisions of the CEDAW. The Constitution specifically prohibits anyone from benefiting from the proceeds of prostitution.

Despite relatively high tolerance rates, the pervasive thought by conservative and ultra-religious Batswana (people of Botswana) is that homosexuality is a criminal and immoral act, eroding the traditional fabric of society and breaking down conventional family structure. Further, these effects on traditional society exacerbate the spread of HIV, child abuse, and overall deviant behavior. Others see it as a conscious lifestyle choice.[81] What is apparent, however, is that "the well-being of LGBT persons

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[77] Dulani, B., Sambo, G., & Dionne, K. Y. (2016, March). Afrobarometer Round 6, Dispatch 74, March 1, 2016.
[78] Kedikilwe, R. (2011, November). Where morality and homosexuality cross paths. *Sunday Standard*, November 17, 2011.
[79] Quansah, E. K. (2004). Same-sex relationships in Botswana: Current perspectives and future prospects. *African Human Rights Law Journal* , 4(2): 201–217. Retrieved from http://www.ahrlj.up.ac.za/quansah-e-k/.
[80] Government of Botswana (GOB). (2015). *National HIV and AIDS response, gender assessment report, October 2014.* Gaborone: GOB, National AIDS Coordinating Agency, Joint United Nations Programme on HIV/AIDS.
[81] Kedikilwe, R. (2011, November). Where morality and homosexuality cross paths. *Sunday Standard*, November 17, 2011.

in Botswana has only been minimally researched and documented"[82] and there are no "dedicated government expenditures funding evidence-based and targeted…programs for MSM."[83]

Lesbians, Gays & Bisexuals of Botswana (LEGABIBO) is the only LGBTI organization in country. Until March of this year, 2016, LEGABIBO was refused registration as a society, with the GOB, on the grounds that the rights of LGBTI were not recognized by the Constitution of Botswana. The ruling stated that the objectives of LEGABIBO were not compatible with "peace, welfare and good order in Botswana." In March, 2016, the Supreme Court overruled the government's decision to refuse registration of the organization on the basis that there was no specific legislation to prohibit anyone from being homosexual, and that "fundamental rights are to be enjoyed by every person and to deny this, is denying an individual's human dignity." [84]

In 2013 LEGABIBO conducted a needs assessment. Despite countrywide programs to combat social and human rights injustice, the study found that LGBTI faced ridicule, stigma, disenfranchisement and criminal charges in Botswana.[85] In addition to social stigma, LGBTI face discrimination in healthcare settings which impede their access to services. A 2015 study concluded that Botswana health policies and guidelines do not address the challenges they face. This was particularly true with reference to HIV prevention, and awareness raising.[86] Moreover, access to health care is hindered by an unwillingness to disclose sexual orientation to health care providers and fear of seeking health services. In Botswana, less than 25 percent of LGBTI disclosed their sexual orientation to health workers, and over 20.5 percent admitted being afraid to seek health services. As a consequence, "these structural barriers…limit the efficacy of any interventions targeting individual level determinants of HIV transmission among MSM and must arguably, be mitigated to effectively decrease HIV incidence."[87] In light of existing research, while progress has been made to recognize and address the needs of the LGBTI community in Botswana, overall patterns continue to impede targeted interventions within this key population.

Violence is another overarching consequence of discrimination against the LGBTI community. The LEGBIBO needs assessment cited instances of intimate partner violence among LGBTI and the prevailing fear of reporting, due to stigma and discrimination from authorities. Of the 23.8 percent of respondents in 2013 who disclosed that there had been physical violence in their relationships, 53.8 percent said they reported to police but were not taken seriously.[88] Furthermore, according to another study, 29.1 percent of LGBTI Batswana admitted being afraid to walk in their community, 26.5 percent said they had been blackmailed because of their sexuality, and 11.4 percent reported being raped by

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[82] LEGBIBO. (July 25, 2013). *LGBTI health and wellness needs assessment in three locations in Botswana*. LEGBIBO.
[83] Baral, S., Trapence, G., Motimedi, F., Umar, E., Iipinge, S., Dausab, F., & Chris Beyrer, F. (2009). HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PLoS One*, 4(3): 34997.
[84] Southern African Litigation Centre. (2016, March 16). *Ground-breaking judgment by Botswana Court of Appeal on freedom of association and LGBTI rights*. News release. Retrieved from https://legabibo.wordpress.com/2016/03/16/press-release-groundbreaking-judgment-by-botswana-court-of-appeal-on-freedom-of-association-and-lgbti-rights/.
[85] LEGBIBO. (2013, July 25). *LGBTI health and wellness needs assessment in three locations in Botswana*. LEGBIBO.
[86] Kwele, Bachidzi and Anna Mmolai-Chalmers. (2015, March 25). "Report on baseline study on human rights, HIV-related stigma and discrimination among key populations." Unpublished.
[87] Baral, S., Trapence, G., Motimedi, F., Umar, E., Iipinge, S., Dausab, F., & Chris Beyrer, F. (2009). HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PLoS One*, 4(3): 34997.
[88] LEGBIBO. (2013, July 25). *LGBTI health and wellness needs assessment in three locations in Botswana*. LEGBIBO.

another man.[89] Additionally, the LEGABIBO noted that LBT women in schools faced discrimination and violence such as bullying, verbal, sexual and physical abuse, adversely affecting their access to education. As "the number of gay people who have come out in the open about their sexual orientation has risen…acts of violence and hate crimes against them have likewise risen."[90]

An important USAID/Botswana partner that will be contributing to community mobilization and capacity-building of providers, caregivers and decision-makers, is Linkages Across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES). LINKAGES is set-up to implement a set of interventions that will reduce HIV transmission among the KPs including MSM and FSWs. Specifically, it aims to i) increase access to and availability of quality comprehensive HIV prevention, care, and treatment services, across the continuum of care for KPs; ii) increase demand for and uptake of comprehensive HIV prevention, treatment, care and support services through self-advocacy, and KP community agency; and iii) address stigma, and discrimination that impede access to quality services by KPs. The project will operate in four PEPFAR sites, including Selebi-Phikwe given its high HIV prevalence among KPs, overlapping with APC and USAID/ASSIST in the Greater Gaborone cluster.

The US-CDC Botswana is currently implementing an HIV service delivery project for KPs in a fifth PEPFAR site (Kasane, in Chobe district. A number of CDC partners are providing technical assistance at the facility level to help achieve the UNAIDS 90-90-90. Both CDC and USAID are helping to coordinate efforts at the district level with the DMSAC, DAC and DHMT structures.

The BYBSS (2012) found that HIV prevalence among FSWs was 61.9 percent, higher than in any other KP. Prevalence among MSM was 9.2 percent. Treatment coverage among FSW was only 24 percent compared to 66 percent of women in the general population.[91] FSWs are also at very high risk for both physical and sexual GBV because of the nature of their occupation and related gender-power dynamics. Clients can beat and or rape them under various circumstances. FSWs and other KPs experiencing GBV cannot report to the police because of the illegal context of their behavior. The police focus on the legal aspect of *their* behavior, rather than the crime that was committed against them. Other services, such as clinics, are not set up to deal with FSWs and practitioners may treat them rudely, expressing judgements about who they are.[92] Transgender people experience even worse situations.

All of the issues described pertaining to stigma, gender norms, and beliefs are exacerbated for KPs because of the burden of societal stigma based on who they are (LGBTI) or what they do (sex workers). Issues identified in the qualitative data include:[93]

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[89] Baral, S., Trapence, G., Motimedi, F., Umar, E., Iipinge, S., Dausab, F., & Chris Beyrer, F. (2009). HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PLoS One*, 4(3): 34997.

[90] Kedikilwe, R. (2011, November). Where morality and homosexuality cross paths. *Sunday Standard*, November 17, 2011.

[91] Government of Botswana (GOB). (2013). *Botswana AIDS impact survey IV (BAIS IV 2013): Summary results.* Gaborone: Statistics Botswana, GOB. Retrieved from: http://www.cso.gov.bw/images/aids_summary.pdf/.

[92] Annex 4.

[93] Annex 4.

- Transsexuals (males to females) who have experienced GBV have nowhere to go, since their body appears male. The shelter will not take them for fear of threatening the female residents.
- Alcohol is a major problem among these KPs. Alcohol is consumed at parties that take place often within this community.
- KPs already suffer from societal stigma—to come forward for testing and treatment is another added layer of potential shame and harassment—and most will choose not to go to general clinics.
- Health care workers reinforce societal stigma and often behave rudely to KPs.
- All the gender norms that apply to heterosexual relationships apply to LGBTI as well, particularly with regard to GBV. There are no services set up to deal with KPs within the GBV service system.

(viii) Law and Policy

Botswana has policies and laws that articulate equal access to health services for both sexes, as well as a very comprehensive GBV law. The Constitution and the National Policy on HIV and AIDS outlaw all forms of discrimination and stigmatization including those associated with HIV and AIDS.[94]

According to the Africa Gender and Development Index - Botswana report (2012), women represent a small number of the members of the three political houses, i.e., Parliament, Cabinet, and House of Chiefs. Despite being few in Parliament, women seem to be playing a key role in influencing decisions, policies and legislations.[95] The multisectoral and decentralized strategy of the national response has provided meaningful opportunities for the participation and engagement with many and diverse stakeholders at national, sectoral, district and community levels. Stakeholders participate in the design and planning, M&E, and implementation of the national response through the National AIDS Council (NAC), the Global Fund Country Coordinating Committee (CCM), the District and Village Multisectoral AIDS Committees (DMSAC/VMSAC), the NAC sector coordinating committees, and technical working groups.[96] Despite good policies, however, many barriers exist that inhibit equal access.

Although all forms of GBV are outlawed, the laws of Botswana are silent on sexual violence within marriage, and/or cohabiting relations under customary law. There is a need to continue to work towards harmonizing policies and minimizing contradictions between customary law and common law. Dissemination of all these policies is a challenge; in some instances service providers do not know the provisions or have no access to copies of the policies relevant to their sectors.

Botswana enacted the Domestic Violence Act (No. 10 of 2008) to provide protection to survivors of domestic violence. The Act defines domestic violence as "any controlling or abusive behavior that

[94] See Annex 5 for a table of laws and policies that pertain to gender equality.

[95] United Nations Development Programme (UNDP). (2015). Work for human development: Briefing note for countries on the 2015 Human Development Report: Botswana. *UNDP Human Development Report 2015*. Retrieved from http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/BWA.pdf/.

[96] Government of Botswana. National HIV and AIDS response, gender assessment report, October 2014. Gaborone: GOB, National AIDS Coordinating Agency, Joint United Nations Programme on HIV/AIDS.

harms the health or safety of the applicant" and lists the types of abuse, such as physical, sexual or emotional, economic, etc. The Act also deals with the jurisdiction of the courts; describes how an "applicant" (i.e., "any person who alleges to have been subjected to an act of domestic violence") can lodge an application for an order by the court; explains how documents are served to the "respondent" (i.e., "any person who is or has been in a domestic relationship with the applicant and against whom the applicant seeks to obtain or has obtained an order under this Act"); and identifies the nature of proceedings in a domestic violence case.[97]

The Children's Act has defined children as those under age 18. As children, they are expected to abstain from sex, despite the fact that young people between 10-17 years are sexually active. Available evidence also indicates that children as young as 11 years old are known to have given birth. The Children's Act also prohibits early or forced child marriages. However, under customary law, children as young as age 16 are known to have been married. Under Customary law, polygamous marriages are not illegal in Botswana. Many women associate such marriages with MCP that put them at risk of HIV infection. Botswana does not collect data specifically on unintended pregnancies. Pregnancies among adolescents are considered as unintended or unplanned.

The Penal Code (1998) criminalizes the transmission of HIV by a person if s/he knows her/his HIV status. The revision of the Penal Code focused mainly around sexual abuse, including rape. Although the Penal Code is gender-neutral, in the event a woman rapes a man or transmits HIV while knowing her HIV-positive status, the legal sanction is not clear. Other legal and Policy instruments have been established to protect women, girls, men and boys and KPs affected by HIV & AIDS including, The Drug Control Act prohibiting the use of intoxicating drugs, The National Health Policy (2011) and the policy guidelines and service standards on SRH provide access to SRH by all people.

Attention to adolescent service access also unveiled some additional needs. Government Stakeholders noted a fragmentation of adolescent programming, that government departments worked in silos, and that they were not necessarily familiar with adolescent issues. There is an urgent need to better understand the situation pertaining to adolescents, to address legislation relating to homosexuality, and sex work. Further clarification is required regarding the age of consent for service delivery for adolescents, in particular HTC, as well as sexual and reproductive health services, including contraceptives. There was no uniform understanding of the current policy among technical partners on this issue, indicating a need for explicit communication and clarification among decision makers, service providers, adolescents, and the community at large.[98]

In the absence of a National Gender and Development Policy, strategic orientation of the national Gender and HIV and AIDS response is compromised. Coordination has increasingly become complex and to some degree fragmented.

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[97] Immigration and Refugee Board of Canada. 2011. Botswana: Domestic violence, including legislation, state protection, recourse and services available to victims (2007–February 2011). Retrieved from http://www.refworld.org/docid/4dbe8bc52.html.

[98] Strengthening adolescent component of national HIV programmes through country assessments in Botswana: SBOZA RE MMOGO! (2015, June). Unpublished preliminary report of rapid assessment, June 2015.

(ix) Community Resilience and Media Engagement

Engagement in Community and Public Life

Botswana is moving towards implementation of a Test and Treat strategy, beginning April, 2016. In preparation, the Ministry of Health (MOH) developed a task force with a number of subcommittees, including one dedicated to community involvement. The overarching purpose of that subcommittee is to facilitate the establishment of "community health systems" to help achieve the Test and Treat targets of 90-90-90 by March 2017. Relevant strategies include i) plans to mobilize the community and ii) addressing critical enablers and barriers, specifically, stigma and discrimination, gender inequality and violence, sociocultural barriers and key populations.[99]

The community involvement subcommittee, of which USAID is a member, is identifying and prioritizing community-based services to test and link people to treatment, retain them in treatment, and support people with HIV. This will inform the development of recommendations to shift health facility-level work to communities to address bottlenecks, as well as a minimum package of services available at the community level (considering the community as an extension of the health facility). The subcommittee has identified existing community structures (VMSAC, VDC, VHC, AND CHW) that all have a potential role to play at this level.

Complementary to this, the National AIDS Coordinating Agency (NACA) is supporting an initiative called Communities Acting Together to Control HIV (CATCH). CATCH reflects a bottom-up approach to help bring community voices into the planning process and encourage community participation in the county's response to HIV/AIDS, operating through the dikgosi, (traditional village leaders). A key goal of CATCH is to build community agency: strengthen self-esteem, self-confidence, self-management, accountability, tolerance and trust. This will help address HIV related stigma and discrimination in their communities, leading to a positive impact on the epidemic. The main HIV/AIDS related goal of CATCH is contributing to zero new infections in their respective communities[100]

Increasing community competency to identify and lead interventions is pivotal to the above strategy. This includes gathering, analyzing, and acting on data to inform the selection of interventions at the community level. Operationalizing the CATCH approach involves dialoguing with community members to elicit their issues, concerns, and suggestions. In addition, it encompasses strengthening the capacity of local NGOs and various community-based structures, including CHWs and support groups to address them.

USAID/Botswana has been a key player in conceptualizing CATCH, and supporting its implementation at the community level, as well as complementary structures at higher levels. Initial support was provided by FHI 360, through its Maatla Project; ongoing support is being provided by FHI 360's Advancing Partners and Communities (APC) project as well as USAID's Applying Science to Strengthen and Improve Systems (ASSIST) project. FHI360 is USAID/Botswana's key community implementing partner, working in eight PEPFAR districts to increase utilization of integrated community-based services. This supports the first 90 objectives, and also improves linkages to care, and ART/TB adherence and retention in support of the second and third 90's (APC PMP draft framework, August 2015). Through its on-the-ground subpartners in these priority districts, APC is training men and women to provide testing, retention/adherence, and GBV care and services at the community level, linked to services at the facility level, and in coordination with relevant structures at the district and national levels. USAID/ASSIST is applying quality improvement (QI) methodologies at the local level,

[99] *Terms of reference for the community test & treat thematic group – final draft.* (2016, February). Unpublished report.
[100] Gopinath, C. Y. (2016, February). *Changing the ground*. Paper presented as CATCH consultancy final presentation.

through community QI teams, including representatives from various community structures (schools, VACs, etc.), APC subpartners, health facilities and others, with active involvement of the kgosi. They are helping to form teams, identify key issues on which the community can focus, develop strategies to systematically address the issues, set specific objectives for improvement, and ways to document and actively monitor progress towards achievement. In addition to their specific PMP objectives, the two projects are contributing to CATCH objectives in overlapping districts and communities. Collectively, all the initiatives are helping to mobilize and build the capacity of community men and women to function as care providers, caregivers, and decision-makers.

Engagement in Media

Traditional media platforms, such as radio and television, continue to be utilized in Botswana to sensitize a wide audience on targeted issues such as GBV, and stigma and discrimination. In recent years, however, these platforms have been largely enhanced by increased use of social media sites such as Facebook, Twitter, YouTube, and blogs, both professional and personal. Individuals and organizations are targeting a younger and more diverse clientele by employing a combination of media outlets. For example, internet campaigns such as One Billion Rising introduced the hash tag #botswanarises, and encouraged people countrywide to stand up against GBV. Coverage of events and the corresponding social media campaign was detailed in articles for the *Daily News* and *All Africa*, BTV and RB1. Similar forums were used for International Women's Day, International Men's Day, and 16 Days of Activism Against Gender-Based Violence (16 Days). During the 16 Days campaign, U.S. Ambassador to Botswana, Mr. Earl Miller, joined radio hosts at Duma FM and RB2 to discuss the U.S. government's current efforts to address GBV in the country.[101]

One organization, Gender Links for Equality and Justice, is working with media houses throughout Botswana to increase gender mainstreaming and gender policy in their media programming. As part of the Gender and Media project, Gender Links has garnered a commitment from the various media stations that "all their messages in various forms are gender aware, and that through the station, audiences will become gender aware through education and information."[102]

As such, Duma FM has committed to at least one weekly program covering gender-related issues, and guaranteed all productions will carry gender-sensitive language and challenge existing stereotypes. Likewise, Gabz FM used their platform to voice support for the signing and adoption of the SADC protocol by the government of Botswana and opened up a forum for women's advocacy groups to speak out on the issue. Similarly, The Voice launched a gender aware HIV and AIDS newsroom policy and has been one of the first media houses to bring the subject of HIV and AIDS out for public discussion. It has also dedicated sections of the paper to issues directly affecting women.[103]

In addition to national media campaigns, organizations utilize the various media platforms for localized outreach, addressing stigma, discrimination, and gender norms. Men and Boys for Gender Equality (MBGE), for example, uses an integrated media approach, incorporating social media, radio, and TV.

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[101] Botswana United States Embassy Facebook page. Retrieved from https://www.facebook.com/U.S.EmbassyGaborone/.

[102] Gender Links Botswana. (n.d.). Retrieved from http://genderlinks.org.za/what-we-do/governance/centres-of-excellence-for-gender-mainstreaming/botswana/.

[103] Gender Links Botswana. (n.d.). Retrieved from http://genderlinks.org.za/what-we-do/governance/centres-of-excellence-for-gender-mainstreaming/botswana/.

The organization's social media platform (Facebook and Twitter) is used to determine which issues the public would like to see discussed on radio and television, and creates a forum for further dialogue after the programs. The radio and TV programs highlight male involvement in reducing GBV, sexual reproductive health for men, and harmful gender norms. They also include referrals to the MBGE offices for further assistance, counseling, and linkages to relevant service providers.

Like outreach, media is used as a powerful tool for activists in Botswana. In March 2016, LEGABIBO invited local and international media to join them at the courthouse for the important ruling in *Attorney General v. Thuto Rammoge.,* a controversial case determining whether the organization could legally register in Botswana. They also organized a web campaign, inviting stakeholders, partners, activists, and media to use the #LEGABIBOregistration when tweeting about the case.[104] Similarly, at a press conference, Kagiso Ntime, President of Botswana National Front Youth League, called on young people to take to popular media sites like YouTube, Facebook, Skype and Twitter to criticize government tactics in subduing a student-led protest.[105]

Mixed media is an efficient and effective tool for the use of government, civil society, and individuals in sensitizing communities across a wide range of locations and demographics. The different platforms complement one another and help reach a much broader target audience on a variety of issues related to culture and gender norms. In sum, mixed media holds great potential for impacting the gender effects on the HIV epidemic.

[104] Lesbians, Gays, & Bisexuals of Botswana (LEGABIBO). (n.d.). Retrieved from https://legabibo.wordpress.com/.
[105] Moeng, G. (2011, May 19). Youth to use social media to relate Botswana's problems. Mmegionline. Retrieved from http://www.mmegi.bw/index.php?sid=1&aid=941&dir=2011/May/Thursday19/.

4. RECOMMENDATIONS

This section has been divided into two parts: (1) Broad, overarching recommendations resulting from the analysis for consideration at the national level, and (2) PEPFAR-specific recommendations which are narrower in focus, and represent ongoing or potential contribution from PEPFAR investments. Please note that not all of the recommendations will be addressed in COP 16; PEPFAR Botswana will continue to program based on these recommendations in the coming years.

Overarching Recommendations for Consideration by National–Level Organizations

- Laws, policies, and practices should be aligned across ministries and public/private services to help ensure that the rights of girls, women, boys, and men are respected and enforced vis-à-vis access to services, anti-discrimination, GBV prevention and treatment.
- Leadership, mid-level management, and employees across ministries and departments—including the MOH, GeAD, MoESD, NACA, and Botswana Police Services— should all be engaged to address gender and equity support on multiple fronts.
- A GOB intra-governmental effort should: support girls, boys, women, men, KPs, and transgender people; combat discrimination and inequalities; and strengthen linkages between the Women's Sector, Men's Sector, NACA, and the MOH.
- A national GBV information system should be developed, incorporating data from all programmatic sectors to allow for evidence-based policy and programmatic decision making.
- The national M&E system should mainstream the use of gender-sensitive indicators as part of the national multi-sectoral HIV and AIDS response.
- Capacitating key duty bearers, such as community leaders (chiefs), law enforcement officers, and judiciary officers, will strengthen national capacity to address gender inequalities and GBV, including IPV.
- Interventions aimed at addressing alcohol abuse should be increased, as it is cited both as a contributing factor to GBV and as a barrier to adherence to HIV treatment.
- Youth-friendly health services are needed with operating hours that can accommodate adolescents' schedules and staff who are sensitive to the specific needs of adolescents.

Prioritized Recommendations for PEPFAR Investment Health Services

- Design, implement, and monitor innovative ways to increase uptake of HTC among men (e.g., through sports, work place programs, and campaigns). HTC partners Tebelopele and FHI 360 are currently programming to address this recommendation.
- Target sexual partners of voluntary medical male circumcision (VMMC) clients to encourage their partners to circumcise, thereby increasing uptake of VMMC services. Jhpiego and team will include the role of partners in demand-creation activities and materials. Women will be encouraged to promote VMMC among their partners, sons, and friends.
- Provide capacity building and training on gender norms, stigma, human rights, and GBV to service providers.
    - The PEPFAR Botswana treatment program is mostly TA. Therefore, it is critical to include modules on the above topics in the trainings for clinical workers, both GOB and those supported by the PEPFAR implementing partners. University of Maryland and ITECH will train facilities in priority districts. APC and the Botswana Family Welfare Association (BOFWA) will also work with community-based service providers to deliver this training. APC plays a critical role in sensitizing communities and community volunteers on these issues.
- Incorporate GBV as a topic for partners in PMTCT programs. Intensify male involvement in family planning. To address this in COP 16, the prevention of mother-to-child transmission (PMTCT) team

will work with MOH to revise the training curriculum to include gender and GBV. The team will incorporate gender, GBV, and human rights modules and provide training for service providers.

Transforming Gender Norms

- Support activities that can transform gender norms related to men's perception of illness and disease in order to encourage them to seek and stay in treatment.
  - Programs tailored around men's/boys' motivations—like sports clubs—can help change their perceptions about seeking treatment.
  - Other examples are One Man Can, Men Engage, and Boy Scouts.
- Support programs like Men in the Kitchen to change male perceptions of gender roles.
- Support community projects that aim to modify community norms and increase support for girls and women to be able to refuse sex. PEPFAR B will address this recommendation by expanding the current activities.
  - Examples of such projects include theatre groups, Sky Girls movement, PACT clubs, out of school youth groups and several USG-supported mentoring programs.
- Provide support to school-based strategies that have proven successful in changing norms.
  - Gender sensitization trainings in schools have taken place in the districts in which GeAD is piloting a GBV referral system.
  - Schools have hosted gender-transformative career talks and recruitment fairs aimed at reducing gender parity in traditionally gendered fields.

Economic Vulnerability

- Support programs that provide women and girls with sources of low-risk income.
  - Scale up livelihood activities in supported sites to reduce young women and girls' economic vulnerability to GBV, HIV, and transactional and intergenerational sex.
- Provide life skills training to girls to help counteract their lower than average educational attainment level.
- PEPFAR B is currently implementing livelihood activities like GROW, Aflateen, and a youth employment program. In COP 16 these initiatives will be intensified by increasing the number of youth targeted, partnering with more vocational schools for training.

Gender-Based Violence

- Address the fragmented service provision of post-GBV care.
  - Build linkages between government facilities/sectors and NGOs to enhance GBV care-related coordination.
  - Expand the GBV referral system pilot taking place in Mochudi and Maun.
  - In larger areas, like Gaborone and Francistown, One Stop Centers for survivors of GBV should be considered.
- Support GBV training for school teachers and a standardized curriculum such as the "Life Skills" curriculum, to span all grades.
- Support training and roll-out of SOPs for the MOESD (in which PEPFAR B has already made an investment by developing the SOPs).
- Address the vulnerabilities of adolescent girls and young women via increased community mobilization, working with families, communities, and traditional leaders. This will build on the current CATCH efforts and implementation of the SASA! model.
- Incorporate results of the Violence Against Children Survey (VACS) to better inform future GBV prevention activities for adolescents and youth.

Stigma

Addressing stigma among people living with HIV is currently supported through FHI 360's community care activities implemented by the APC project. LGBTI-related stigma is addressed as part of the KP program through LINKAGES and the Local Capacity Initiative (LCI).

- Develop a comprehensive strategy to decrease HIV stigma towards PLHIV and key populations.
  - Target men with human rights and sexual diversity information.
  - Raise awareness among communities.
  - Support door-to-door testing and treatment-related interventions in order to ensure that people do not feel singled out and also so they can establish a relationship with care providers, making them more likely to seek services.

Youth

Current investments in youth activities implemented by both Peace Corps Volunteers and FHI 360 (APC) focus on enhancing the communication, risk assessment, and negation skills among youth in partnership with community leaders for sustainability. The following recommendations will be implemented in COP 16 through integration into the existing programs.

- Design, implement, and monitor innovative ways to increase uptake of HTC among youth (e.g., sports, Shuga, campaigns).
- Design, implement/integrate, and monitor innovative ways to address transactional sex among youth.
- Leverage proven approaches for OVC programming, such as the family-centered model implemented by PCI, to help identify and link those eligible for treatment services among OVC and their families, for example Journey of Life.
- Strengthen/scale up programs for adolescents, like Teen Clubs, to improve adherence among adolescents and youth.

Key Populations

In terms of LGBTI, PEPFAR B implements activities for FSWs and MSM only; however the advocacy and enabling environment efforts for these two KPs can benefit the whole LGBTI community. All the recommendations below will be implemented through the current PEPFAR B activities—LCI and LINKAGES.

- Integrate GBV and interventions to address alcohol abuse into KP programs.
- Advocate for KP-friendly services. Currently the GOB is more willing to accommodate sex workers than MSM and the rest of the LGBTI community.
- Assist communities and support groups to reach out and offer psychosocial support to PLHIV, including KPs, in order to enhance their uptake of treatment and improve adherence.
- Strengthen civil society and communities' ability to advocate for LGBTI rights.
  - Strengthen human rights education/legal literacy, particularly among KP, PLHIV, and civil society, to be able to demand their rights and seek redress, where applicable.

Policy

In terms of policy, those pertaining to GBV and KP are the priority for the PEPFAR B health diplomacy agenda. Due to funding limitations, only the first two recommendations below will be implemented in COP 16:

- Provide capacity building and training on gender norms, stigma, human rights, and GBV to service providers.

- Work with traditional leaders (Kgosi) so they can address GBV and gender issues that affect the transmission and acquisition of HIV and the uptake of services among their community members through various means, including using Kgotla meetings to disseminate policies.
- Support the dissemination of existing laws, such as the GBV Act, Children's Act, etc., as universal knowledge about them is lacking.
- Advocate at the highest level in each sector for these policies to be enforced/implemented and institutionalized.
- Promote harmonization on HIV issues between common and traditional law through training and roundtables with law enforcement, traditional leaders, and members of parliament (e.g., "tshenyo" versus maintenance). GBV and KP policy advocacy should be included in the agenda for health diplomacy.

ANNEX 1. REFERENCES

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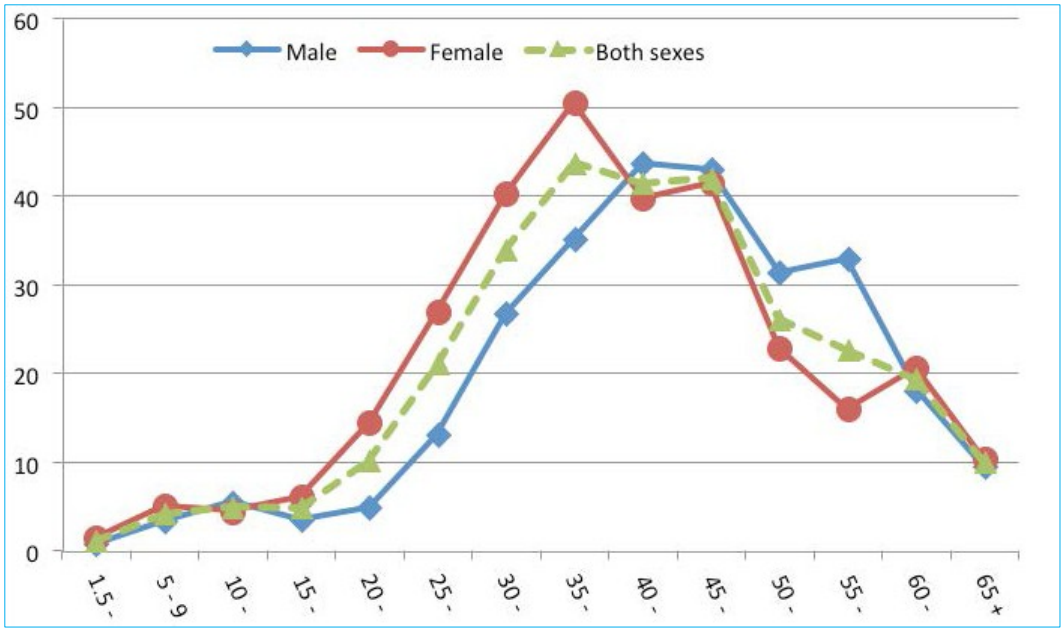
ANNEX 2. QUANTITATIVE DATA TABLES AND FIGURES

Figure 1. HIV prevalence in Botswana by age and sex, 2013



Source: BIAS IV, summary results, 2013

Table 1. HIV prevalence rate by district

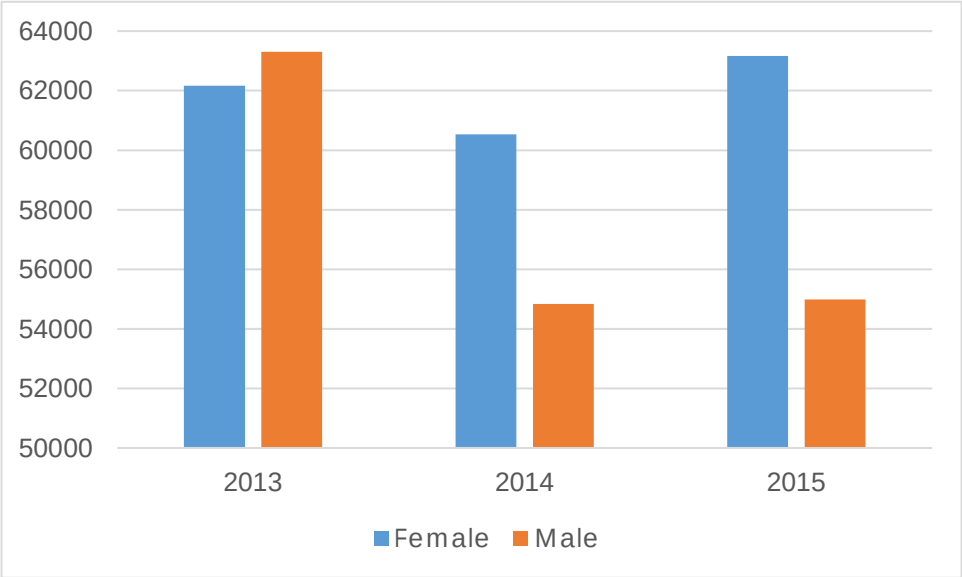
District	Male	Female	Total population
Gaborone	*13.4*	*19.8*	*17*
Francistown	*20.7*	*27.5*	*24.3*
Lobatse	*13.4*	*20*	*17.2*
Selebi-Phikwe	*25.4*	*29.3*	*27.5*
Orapa	*9.9*	*20.2*	*15.6*
Jwaneng	*8.5*	*16.7*	*12.8*
Sowa	*13.3*	*26.5*	*19.8*
Southern	*10.6*	*12.8*	*11.8*
Barolong	*8.9*	*25.7*	*20.3*
Ngwaketse West	*10.9*	*24.5*	*18.8*
Southeast	*19*	*14.6*	*16.6*
Kweneng East	*20.2*	*22.1*	*21.5*
Kweneng West	*7*	*16.1*	*11.8*
Kgatleng	*15.6*	*23.8*	*19.9*
Central-Serowe	*16.4*	*17.8*	*17.1*
Central-Mahalapye	*20.1*	*25.9*	*23.1*
Central-Bobonong	*15.3*	*22*	*19.3*
Central-Boteti	*15.5*	*25.5*	*20.3*
Central-Tutume	*14.1*	*21.5*	*18.2*
Northeast	*13*	*20.4*	*17.7*
Ngamiland South	*13.3*	*17.2*	*15.2*
Ngamiland North	*10.6*	*15.4*	*13.5*
Chobe	*16.5*	*18.9*	*17.7*
Ghanzi	*14.6*	*19.9*	*17.1*
Kgalagadi South	*7.1*	*15*	*11.1*
Kgalagadi North	*18.2*	*18.1*	*18.1*
Total Population	***15.6***	***20.8***	***18.5***

Source: BIAS IV, summary results, 2013

Table 2. Number and proportion of people ages 15 years and above who received HIV testing and counseling (HTC) and received their test results, by sex[106]

	April 2013		April 2014		April 2015	
	Number reached	Proportion	Number reached	Proportion	Number reached	Proportion
Women	62,163	50.5%	60,529	52.5%	63,167	53.5%
Men	63,302	49.5%	54,833	47.5%	54,988	46.5%

Figure 2. Number of adults 15 years of age and older who were counseled and tested for HIV, and who received their results



Source: PEPFAR Gender Cascade

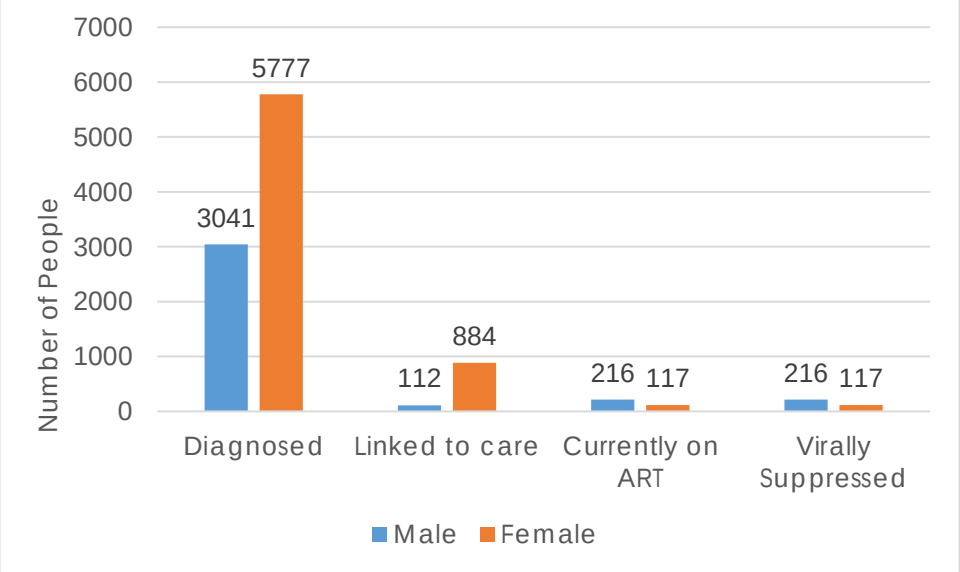
Table 3. Number and proportion of adults ages 15 years and older with advanced HIV infection who are receiving antiretroviral therapy[107]

Population	April 2013		April 2014		April 2015	
	Number reached	Proportion	Number reached	Proportion	Number reached	Proportion
All Females	3243	57.7%	1315	49.9%	1343	47.3%
All Males	2377	42.3%	1322	50.1%	1496	52.7%

[106] PEPFAR Gender Clinical Cascade, 2015

[107] PEPFAR Gender Clinical Cascade, 2015

Figure 3. PEPFAR clinical cascade for FY 2015



Source: PEPFAR Gender Clinical Cascade, 2015

Table 4. Number and proportion of youth who received HTC and received their test results, by sex.[108]

Population	April 2013		April 2014		April 2015	
	Number reached	Proportion	Number reached	Proportion	Number reached	Proportion
Girls 15–24			21,214	59.4%	25,741	63.6%
Boys 15–24			14,526	40.6%	14,741	36.4%
Girls <15	4658	83.6%	794	63.9%	415	51.8%
Boys <15	917	16.4%	448	36.1%	386	48.2%

[108] PEPFAR Gender Clinical Cascade, 2015

Figure 4. Number of children under 15 years of age who were counseled and tested for HIV, and who received their results

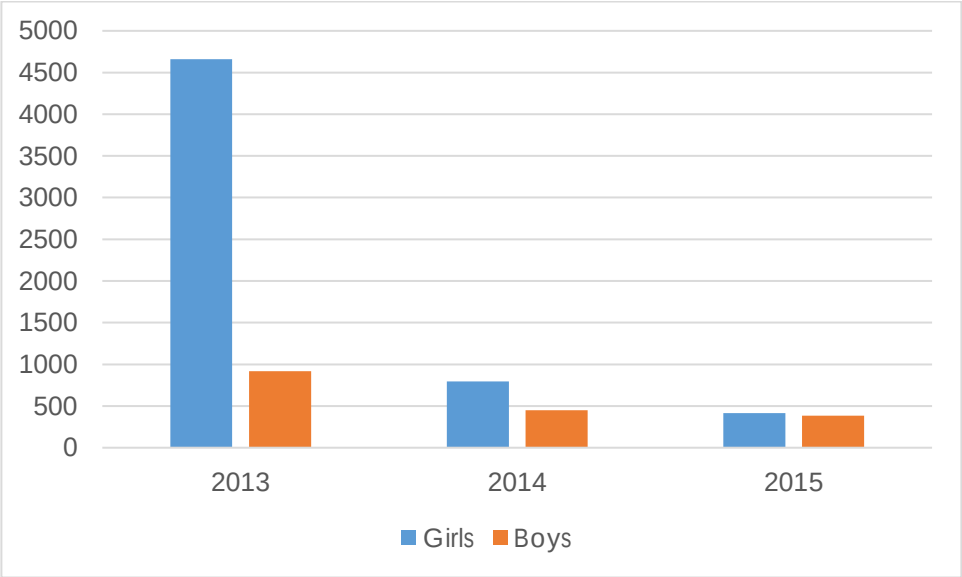


Table 5. Number and proportion of youth ages 15–24 years and older with advanced HIV infection who are receiving antiretroviral therapy[109]

Population	April 2013		April 2014		April 2015	
	Number reached	Proportion	Number reached	Proportion	Number reached	Proportion
Females 15–24					631	54%
Males 15-–24					543	46%

[109] PEPFAR Gender Clinical Cascade, 2015

Table 6. People who completed a gender norms intervention in the context of HIV and AIDS which meet the minimum criteria[110]

Population	April 2014		April 2015	
	Number reached	Proportion	Number reached	Proportion
Females 15–24			3,655	59%
Males 15–24			2,549	41%
All Females	886	54%	15,827	61%
All Males	751	46%	9934	39%

Table 7. People receiving post-GBV care[111]

Population	April 2014		April 2015	
	Number reached	Proportion	Number reached	Proportion
Females 15–24	25	69%	160	75%
Males 15–24	11	31%	53	25%
All Females	330	76%	1134	76%
All Males	107	24%	359	24%

[110] PEPFAR Gender Clinical Cascade, 2015

[111] PEPFAR Gender Clinical Cascade, 2015

Table 8. Proportions of people who have ever and recently (within the past 12 months) experienced intimate partner violence (IPV), 2012[112]

Characteristics		Ever experienced IPV		Experienced IPV in the past 12 months	
Age		**% Female survivors**	**% Males perpetrating**	**% Female survivors**	**% Males perpetrating**
	18–29	65.7	52.8	39.4	28.5
	30–44	65.7	48.6	30.8	26.0
	45+	54.3	38.5	9.2	8.1
Education					
	High School incomplete	60.7	42.3	24.4	17.5
	High School plus	65.8	54.7	35.8	29.2
Worked past 12 months					
	No	60.7	42.3	24.4	17.5
	Yes	65.8	54.7	35.8	29.2

[112] Government of Botswana, The Gender Based Violence Indicator Study Botswana, 2012

ANNEX 3A. DESCRIPTION OF QUALITATIVE RESPONDENTS

Interview organization codes:	CBO: local CBO/NGO, NGO: foreign NGO, POL: local/traditional political authorities (Kgosi, VDC), GOV: GOB sector, FGD=focus group discussions with community members		
Organization name	**Code**	**GBV/gender programming**	**Mission/programmatic aims**
Botswana Christian AIDS Intervention Programme	CBO_1	Faith-Based organization	Prevention, care and support, and advancement of Christian values to girls and boys, women and men infected and affected by HIV
Kagisano Women's Shelter Gaborone	CBO_2	GBV-Based program	Focuses on GBV and includes an OVC and gender program
BONEPWA	CBO_3	Gender norms/GBV	Implements HIV-positive health and dignity program, looking at issues affecting people living with HIV/AIDS. Prevention, care and support services for people living with HIV
Rainbow Identity	CBO_4	LGBTI	Works to create a society that recognizes, respects, protects and values the rights of the transgender and intersex community in Botswana; Supports transgender and intersex individuals by providing a safe space to debrief and share necessary information with one another
Humana People to People	CBO_5	Developed a gender focused program	Ensures that ART reaches the population, meeting children's needs. Makgabaneng program partnership to broadcast about HIV, abuse, gender, and other social issues that promote HIV spread. PEPFAR-funded HIV program to implement testing in rural centers. They currently have three sites in the South East, Goodhope, Kanye, and Moshupa areas. The program includes HIV testing and gender issues.
Project Concern International (PCI)	CBO_6	Gender integrated in all programs	Provides comprehensive support to OVC and their families through providing service packages, working with communities, strengthening CBO, and selected government departments—PCI implements OVC and gender activities
Men & Boys for Gender Equality	CBO_7	Gender programming	Ensures male involvement around issues of men care, involves mostly training; They have embarked on a campaign against street harassment (social campaign) with PCI through PEPFAR and are focused on GBV and children's rights.

Tebelopele	CBO_8	Gender programming	Provides immediate; confidential; and high-quality voluntary HIV counseling, testing, and referral services throughout Botswana
Voices of Women	CBO_9	Gender programming	Over the years they have been carrying out community conversations and initiating linkages, referrals, and counselling.
House of Men Theater Group	CBO_10	Youth and gender programming	The youth group initially started as a drama group. The government got interested in what they did and used them to pass messages; therefore, they embarked on an HIV/AIDS edutainment mission and trained school kids through edutainment for peer education within the school.
Silence Kills	CBO_11	Gender programming	HIV prevention services and support groups—this organization provides testing, counseling, and rehabilitation for alcohol abusers and sex workers. They work with communities, stakeholders, and gate keepers (consulting them first)—now, only in Phikwe; previously, in a few other regions.
FHI 360	NGO_1	Incorporates gender issues	Community-based services: HIV prevention, care, and treatment [including key population (KP) and GBV programs]—works with local CBOs
University of Pennsylvania	NGO_2		TA for in-service training of healthcare providers in Botswana in the management of HIV/AIDS and HIV/TB co-infection
Hope Worldwide	NGO_3	Referral tools, advocate for affected participants	The organization is run along Christian principles and exists to serve the poor and vulnerable with a special focus on vulnerable children (including orphans) and HIV prevention. HOPE Worldwide Botswana has a head office in Gaborone and a field office in Molepolole covering the Kweneng East District.
Red Cross Botswana	NGO_4	GBV programming via the United Nations High Commissioner for Refugees (UNHCR)	HIV treatment, care, and support services in the Dukwi refugee camp
Village District Committee Molepolole	POL_1	None specifically	Local political leadership (village parliament) in the Ward of Boswelakoko, Molepolole—they oversee the development of the village the health of the people as well as their well-being and ensure cleanliness in the village. They are partners with the home-based care, PTA, and youth committees that arrange sporting events and visit the elderly. They work closely with the chiefs.
Kgotla, Lekgwapheng	POL_2	None specifically	Traditional legal branch

Ministry of Education and Skills Development	GOV_1	HIV education in schools	Overarching view of HIV/AIDS component in schools
Ministry of Education and Skills Development	GOV_2	Gender in curriculum	Works on curriculum for schools, guidance, teachers, etc.
Men's Sector, NACA	GOV_3	Gender in programs	Running a program under SWONKE (menEngage) for men to challenge gender norms
District AIDS Coordinator, Mahalapye subdistrict	GOV_4	Incorporates gender programming and works with NGOs focused on gender	They are the coordinator for HIV and AIDS activities in the district—working closely with the NGO in the district funded by PEPFAR and other CBO, which do lot of ground work. They also get reports from NGO reporting on HIV issues, and they then submit them to the Ministry of Health. Most of the NGO they work with, and that are funded by PEPFAR, are members of DMSAC (the District Multi Sectorial AIDS Committee) and TEC.
Ministry of Health	GOV_5	GBV programming	Male involvement, SRH, and health sector response to GBV
Department of Social Protection	GOV_6	GBV programming	
Men & Boys Otse Youth Group (Otse village)	FGD_1		Village outside Mahalapye
Hope Worldwide	FGD_2		In Molepolole
Stepping Stones International	FGD_3		In Mochudi, these are the "aunties"/community leaders.
BONEPWA	FGD_4		PLWHA Mahalapye
SSI young men	FGD_5		Mochudi.
Lesbians, Gays, & Bisexuals of Botswana (LEGABIBO)	FGD_6		Gaborone

ANNEX 3B. QUALITATIVE INTERVIEW TOOLS

Key Informant Discussion Guide

Informant's Name: _____

Position/Title: _____

Organization: _____

Date: _____

Introduction: Hello, my/our name is _____ and I am working with MEASURE Evaluation. We are conducting a gender analysis of HIV programs in Botswana. We are interviewing PEPFAR staff, implementing partners, and HIV stakeholders to learn more about how gender is being addressed in the HIV epidemic in Botswana. We would like to interview you to learn your perspective on this topic.

Your responses will be kept confidential. Any information gathered in this interview will be de-identified and combined with other findings, so that your responses are unidentifiable. Your participation in this interview is completely voluntary and you may stop at any time, with no penalty. We expect this interview to take 45 minutes. Is it okay for me to start?

To begin, let me explain what we mean when we say "gender issues" in some of our questions. Gender issues will be used to refer to the disparities and constraints created by the unequal roles and opportunities that shape the lives of women/girls, men/boys, MSM and transgender persons; these issues vary in diverse cultural contexts. Gender issues also include stigma, discrimination and other issues affecting people because of their gender or sexual orientation, including issues related to key populations. Key populations (also referred to as most-at-risk populations) are people who inject drugs, men who have sex with men (MSM), transgender persons, and sex workers.

Questions (and probes if necessary) Italics to be read; **text in bold is for organization**
Probes to be read in bold italic if interviewee does not cover it (if it applies to the context)

DISCUSSION QUESTIONS

Part I: Background

What is your role or relationship with PEPFAR?

Does you program include gender issues in any way? Please describe:

Please describe any programs you are involved in that incorporate GBV

Part II: Gender norms related to the RISK of HIV infection and transmission (i.e., testing, exposure)

Can you please describe any observations you have about the roles, or beliefs about the roles, of men and women in your program area or target population, that are related to the risk of infection/transmission?

Probes

- ***Community beliefs and customs including***
- ***Level of autonomy and economic security***

- ***Education for girls compared with boys***
- ***Early marriage/choice in marriage***
- ***Stigma and discrimination***
- ***GBV***
- ***Violence against key populations (SW, MSM, transgender)***
- ***Other barriers to testing for women, men, girls, and boys***
- ***Barriers to access of general healthcare facilities and services for men and boys***

Part III: Gender norms that affect people's ability to ACCESS HIV services (i.e., testing, starting HAART)

Can you please describe any observations you have about the roles, or beliefs about the roles, of men and women in your program area or target population, that are related to the ability to access HIV services?

Probes

- ***Community beliefs and customs including***
- ***Level of autonomy and economic security***
- ***Education for girls compared with boys***
- ***Early marriage/choice in marriage***
- ***Stigma and discrimination***
- ***GBV***
- ***Violence against key populations (SW, MSM, transgender)***
- ***Other barriers to VCT for women, men, girls, and boys***
- ***Barriers to access of general health care facilities and services for men and boys***

Part IV: Gender norms that impact efforts to achieve EPIDEMIC CONTROL (i.e., adherence, viral suppression)

Can you please describe any observations you have about the roles, or beliefs about the roles, of men and women in your program area or target population, that are related to continuing treatment/ adherence?

Probes:

- ***Community beliefs and customs including***
- ***Level of autonomy and economic security***
- ***Education for girls compared with boys***
- ***Early marriage/choice in marriage***
- ***Stigma and discrimination***
- ***GBV***
- ***Violence against key populations (SW, MSM, transgender)***
- ***Other barriers to testing for women, men, girls, and boys***
- ***Barriers to access of general health care facilities and services for men and boys***

Part V: Pertaining to recommendations for PEPFAR on gender and HIV for the Country Operational Plan (some of these will apply to certain key informants [KIs], others will not)

Please share your thoughts on gender issues around community involvement and clinical programs:

- ***PEPFAR HIV programs involving women and children***
- ***Barriers or challenges that the PEPFAR HIV programs have experienced (public or private health clinics***
- ***Existing screening processes: when screening is complete, what is the referral process? (probe for existing services and/or potentially harmful negative attitudes, i.e. ,stigma within service provision)***
- ***How do services to deal with cases of SGBV (post-exposure prophylaxis [PEP] kits provision to survivors)?***

Please share your thoughts on gender issues around counseling and testing:

- ***Experiences your organization encounters in its VCT programs, and addressing violence (specify types of violence)***
- ***Specific challenges faced by your VCT program/strategies to address them***
- ***Alternative approaches that could successfully address violence in the local context of HIV testing and counseling***
- ***What types of counselling does your organization provide? (Probe for couples counselling, mediated disclosure, serodiscordant couples)***
    - ***For serodiscordant couples: do you think mediation helps to lessen the impact of negative outcomes?***
- ***Is couples counseling feasible with the rapid expansion of HIV services (that PEPFAR is moving toward)?***
- ***Plans for capacity building for counselors to address violence***

Please share your thoughts on gender issues around existing activities:

How is gender-related HIV information (including GBV), policy and action shared between your organization and the Government of Botswana?

How do you promote gender equality, or ensure your services reach women, men, boys, and girls?

Probes:

- ***Working with men and boys***
- ***Community based interventions, e.g., Stepping Stones***
- ***Working with the police***
- ***Working with advocacy groups or CSOs***
- ***Capacity building, skills training, promoting economic activities***
- ***Information on laws and rights***
- ***Keeping girls in school***

Part VI: M&E

What gender and GBV data do you collect?

Do you have any comments on the current gender indicators that you are collecting for PEPFAR?

Do your current program indicators align with the GOB HIV program indicators?

Please tell me if there are other indicators for which you collect data that are not required by PEPFAR.

Wrap up:

If you had three wishes that you would like to see happen that would help PEPFAR-funded organizations reach more men, women and children to invite them in for HIV testing, what would they be? (It can be anything!)

Did I miss anything or is there anything else you would like to tell me before we close?

Focus Group Discussion Guide

Group participants:

Associated organization:

Date:

Introduction: Hello, our names are _____ and we are working with MEASURE Evaluation. We are exploring how gender roles—what it means to be a man or woman, boy or girl—affect the risk of HIV, and access to testing and treatment for HIV in Botswana. We are holding this group to learn your views on this topic, so that we can improve HIV programming in Botswana.

Your responses will be kept confidential. Any information gathered in this group will not list any names, and will be combined with other findings, so that your responses will not be recognizable by anyone.

Your participation in this interview is completely voluntary and you may stop at any time, with no penalty. We expect this interview to take an hour. Is it okay for me to start?

To begin, let me explain what we mean when we say "gender issues" in some of our questions. Gender issues will be used to mean the disparities and constraints created by the unequal roles and opportunities that shape the lives of women/girls, men/boys, MSM and transgender persons. Gender issues also include stigma, discrimination and other issues affecting people because of their gender or sexual orientation

Questions (and probes if necessary) Italics to be read; **text in bold is for organization**

Probes to be read in bold italic if interviewee does not cover it (if it applies to the context)

DISCUSSION QUESTIONS FOR EVERY GROUP

Introductions

*Let's with introductions. Please tell us your first name, the last grade you completed in school (***for youth:** *and your age)*

Part I: Gender Norms and Practices:

How do you think men and women interact together in daily life? Tell me about the roles of men and women in your community.

Probes

- ***Changing beliefs and customs in society***
- ***Violence against women…themes (fear, types of abuses occurring, acceptability)***
- ***Early marriage***
- ***Lack of autonomy and economic security***

What do you think about communication in sexual relationship?

Probe

- ***Is it okay for both men & women buy condoms and ask their partners to use them during sex? Why, why not?***

Does transactional sex—either paying for sex or having sex for something in exchange—occur in your district?

How about sex between younger people and people much older than them?

Probe:

- ***Describe the patterns—trends over time***
- ***Reasons behind this patterns described***

How do people react to someone who has HIV in your community?

Probes

- ***Stigma and discrimination: e.g., blamed for bringing HIV into the family***
- ***Describe what it is like for a person in your community to access health care or medicine for HIV.***
- ***Barriers witnessed in access to services – e.g., culture of silence, child rearing responsibilities***
- ***Barriers to men and boys for access to health facilities and services***

What happens when you walk into your local health facility, when you need health care, and you go to the reception window? What happens next? **(The process, attitude of service providers etc.)**

Part II: Exploring barriers to voluntary counseling and testing [VCT]/counseling and testing (C&T)

Describe HIV testing in your community.

Do you think people in general are willing to take an HIV test? Why/why not?

Do you think it is easier for younger or older people to access testing and services? Why or why not?

How is partner/couples testing in your community? Do you think people feel comfortable in disclosing their status to their partner? Why/why not?

Part III: Treatment and adherence

Have you heard that it is difficult for some people to start ARVs?

Have you heard that it is difficult for some people to stay on ARVs?

Who do you think it is most difficult for, women or men? Why?

Do you think it is easier or more difficult for younger or older people to continue to stay on ARVs? Why?

What do you think are some solutions to support women, men, boys, and girls to staying on treatment?

WRAP-UP FOR ALL GROUPS EXCEPT HIV-POSITIVE ONES:

- *If you had three wishes that you would like to see happen that would improve your ability to access HIV services, what would they be? (It can be anything!)*
- *Is there anything else you would like to tell me before we close?*

CONTINUED DISCUSSION QUESTIONS, FOR HIV-POSITIVE GROUPS ONLY

Barriers to C&T

How willing are/were you to take an HIV test?

Probe

- ***How long did it take you to decide to take one?***
- ***What made you hesitate to take a test?***
- ***How old were you when you took your first test?***
- ***Why did you decide to take one?***

Have you disclosed your status with anyone?

- ***With whom?***

- ***If not, would you like to disclose to anyone?***
- ***To whom would you disclose?***

Barriers to Adherence:

Are you currently on HIV treatment/ARVs?

If Yes:

- ***How long have you been taking them?***
- ***When you received a positive test result, was it difficult for you to begin treatment?***
- ***Why or why not?***

What prevents you from taking your ARVs?

What would help you stay on treatment? In other words, what would make it easier, more possible?

Do you partake any support group? If yes, how supportive is the group?

Are your peers supportive?

WRAP-UP FOR HIV-POSITIVE GROUPS:

- *If you had three wishes that you would like to see happen that would improve your ability to access HIV services, what would they be? (It can be anything!)*
- *Is there anything else you would like to tell me before we close?*

ANNEX 4: SUMMARY OF QUALITATIVE ANALYSES USING THE GAIM TOOL

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations
Gender-Based violence (GBV)		

1. What cultural and social factors contribute to GBV?	• When **women become economically independent**, men start to feel out of control and use violence to control (NGO_3, FGD_5)
	• When **women are unfaithful** men resort to GBV, when men unfaithful it is their right (CBO_5)
	• **GBV risk key for power dynamics**—men have decision-making power and can beat them without question, as long as the marks do not show Men need to beat their wives is encouraged in folklore and socialization—for both women and men (NGO_3, CBO_6,CBO_7)
	• **Kids brought up in violent homes** tend to be violent themselves as adults. There is still **corporal punishment in schools** and homes (GOV_1)
	• Little community understanding of GBV, very few women report it (CBO_5)
	• **Alcohol: Women go to bars and shebeens** and are taken advantage of in their drunken state—they consent to having sex once and when they refuse a second time GBV ensures girls/women swear and drink and men hit them in response (POL_2) **Alcohol** tied into GBV: use it as an excuse—I was drunk, therefore I beat her; also results in rape (CBO_6, FGD_3)
	• **Sero-discordant couples** are at great risk for GBV. Many times male is positive and female is negative, so we counsel about when and how sex should be done. Male thinks he has the right since he paid the bride price; women can be chased away if woman is positive and man is negative (CBO_8, CBO_9, FGD_4)
	• **Men beat up their women to show love** and these norms are enforced by women at the time of marriage—friends and relatives will tell the women to tolerate violence, part of life, etc. (COS_1,CBO_4, GOV_4, FGD_6)
	• **Defilement:**
	  ◦ High rates take place within families—man can be a breadwinner or relative, girl cannot say anything about it and families not willing to report it (CBO_1,CBO_9, GOV_3, GOV_4)
	  ◦ Tradition that uncles will sleep with nieces when woman is unavailable, child must respect wishes, believed that women age more rapidly than men; a lot of defilement within families with younger girls and older men (CBO_5, CBO_9, GOV_1, GOV_2, GOV_4)
	  ◦ Cases of children being abused by pastors in churches, but it is kept secret. (CBO_1)
	• **Notions of masculinity** work against men in GBV. When men report rape they are ridiculed, women get service. GBV takes place against younger unmarried men (CBO_4, CBO_10, FGD_1, FGD_5, GOV_6)
	• **Women who spend too much time out** HIV+ women risk GBV because they spend time in support groups, husbands wonder where they are (CBO_3)
	• **Economic vulnerability** increases risk of GBV for women (CBO_5)
		• In TB screening (mentoring program), GBV screening could be part of it—integrate into MD mentoring program (NGO_2)
		• A one-stop center for women who have experienced GBV and need HIV services (and everything else) (CBO_2)
		• A need for GBV survivors to get preferential treatment so they do not have to wait in line. They need to be seen quickly (CBO_2)
		• **HIV counselors and service providers** do not have GBV training and need that in order to service these people. They need training (CBO_2, CBO_8, NGO_2)
		• Committees in villages with paralegals and others trained to attend to issues of HIV and GBV within the village set up to ensure continuity of care (CBO_5, CBO_8)
		• Legal actors need to be sensitized about LGBTI. The legal case becomes about a person's identity instead of about the crime of GBV (CBO_4)
		• Need a shelter for transgender people, but since it is such a small community, security is an issue. They all date each other, so likely that

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations
2. Is there a difference in rural and urban environments?	• **Regional differences** based on how conservative communities are: in Phikwe GBV very common, a very conservative area (CBO_5)	perpetrators will know where their abused partners are (CBO_4) • Funding needed to capacitate staff on GBV issues of transgender and sexual minorities (CBO_4) • **Need national GBV data system** that crosses sectors. One sector doesn't inform another—for GBV /HIV decreased, need national M&E system (CBO_6, CBO_7) • **Service provision** for GBV needs to be organized and scaled up (NGO_1, CBO_8, NGO_1, GOV_2, GOV_4, FGD_4) • **Need GBV training for teachers** in school, a good package like the Life Skills one to diffuse throughout the span of school years and curriculum (GOV_2) • **Need GBV training** through health facilities—practitioners and others (GOV_5) • **More couples education needed** around testing and disclosing status to avoid GBV—especially in discordant couples (CBO_8) • **Funding** should be specific from PEPFAR to target GBV and give **straight to the organizations working on it**, or nothing will get done. (GOV_3) • **Need for a study on GBV** in schools—there has not been one so far. To scope the situation out in order to intervene, and to identify perpetrators and how to deal with the situation (GOV_1, CBO_010) • **Media does not help GBV**: says: person killed, etc. Nothing about
3. Are there gaps on information related to GBV?	• **KEY POPS** dearth of studies (CBO_4) • **There is very little GBV information in school** curriculums for learners. Some guidance teachers are trained, others are not. Some put GBV as a component of compulsory sex education, some do not, or as part of moral education. (GOV_2) • **Marital rape,** which is not covered by law (GOV_5)	
4. What aspects of GBV are specific for key populations for HIV (sex workers, transgendered persons, and men who have sex with men)	• **KEY POPS:** • **Transgender people are left out of service provision for GBV** because women's shelter will not take a transgender man or woman—because they don't appear as men or women. So there are no GBV services for trans/intersex (CBO_4) • **Gender norms behind GBV still the same for gay/transgender** whoever is id as male—transgender women will even say they need their partners (transgender men) to beat them (CBO_4, FGD_6) • **FSWs at very high risk** for GBV. If they decide they do not want to have sex with a client and he forces her, sometimes has to travel far for work and then walk home in the dark and get raped. If clients won't pay. (CBO_11) • **Harder for FSWs to seek services**—cannot report the rape to the police because they will start focusing on why they were doing something illegal instead of the crime that took place. Services are not prepared to deal with them. In their area they have a very good network. (CBO_11) • In the gay community GBV is kept secret because the victim will think if they report it they will have to deal with **what people think of their sexual orientation.**	
5. Are there gaps in health and other services for GBV that would improve the overall response to HIV?	• **GBV services are fragmented**. We need something to bridge the sectors for these women who need care in all of them. Poor referral services. Sexual violence cases are referred to clinics, but cases are not followed through (CBO_2,, CBO_3, CBO_4, CBO_5, CBO_11, GOV_2, FGD_5) • **Women do not receive good care when they come for services**—they have to wait, and sometimes don't get the relevant service (CBO_5, CBO_7). **Attitude of health service providers and police are** often unsupportive and people know that so they do not come forward willingly—they blame the victim (CBO_5) • **GBV is not integrated** into current health programs and people are not trained (GOV_5)	
6. How does GBV act as a barrier to access to testing, treatment & retention?	• **Fear of GBV** will prevent **people from getting tested or disclosing**; because they cannot disclose, difficult to obtain and then maintain treatment if they have to hide the meds. They will be blamed for bringing HIV into the house (NGO_3, CBO_1, CBO_2, CBO_6, CBO_8, GOV_3 FGD_3, GOV_6) • **Women fear disclosing status and sometimes hide their meds in the field** so their men do not find out—hard to adhere that way because need to access clinic once a month, need to be able to cook and take medicine. When they test and come back positive they get beaten for bringing HIV in the home (CBO_2, CBO_6, CBO_9). Also true for refugees (NGO_4)	

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations
		transforming norms, that gender violence is bad, etc. (CBO_9) • **Shelters/safe spaces are needed** in local places. (CBO_1, CBO_7, CBO_9) • **Improve care and support for adolescent refugees** (NGO_4) • **Services for FSWs (KPs)** should be housed in places that are prepared to deal with their special needs—including training for staff of their programs, and housing on-site psychologists, and making sure that they receive appropriate services when they have to be referred. (CBO-11) • **We mentor TB health practitioners—can sensitize to gender & GBV** in training (NGO_2)
Economic vulnerability		
1. **What economic factors increase vulnerability of girls and women?**	• **Men are breadwinners and given that women cannot ask** about their income; this happens at all socioeconomic levels, and this is how men control women; men have better-paying jobs and have power as a result (NGO_3, GOV_4, FGD_3, FGD_5) • **Girls drop out of school pregnant** after exchanging sex for money or gifts so are not as able to seek employment later (NGO_3) • **Transactional sex because girls/women need or want resources:** o **Parents away working for a long time leaving care of family in hands of girls**—mainly falls to girl child, She needs money to fend for family so has intergenerational sex (CBO_3) o **Girls want things** like cell phones, etc. Economically disadvantaged ones want to keep up with peers o Go up to the ferry crossing in Kasane because they know they can get money from men for sex there (GOV_1, CBO_7, GOV_2) o **In poor houses women use their sexuality to generate income**—expectations for girls/young women to do this more than boys (CBO_2) o Even **in the work place women will exchange sex** with a male superior to get a better job (CBO_5) o Women go **into sex work** because they need the money for their families. Many of them are married or have regular partners who do not know they make extra income this way. (CSP_11)	• Need a **study to explore income and intergenerational sex** (GOV_2)

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations
	• **Women lose control over her possessions upon marriage** "in community of property" law. Men hold onto their property and income (women's as well as their own) (CBO_5) • **Women will not report GBV** to save their financial support from men (CBO_5)	
2. What economic factors limit access of women and girls to health services?	• **Poor women** cannot adhere—meds are free, food is not (CBO_9, CBO_11) • **Poor women have less time to go to the clinic** (CBO_9,)	
Stigma and discrimination		

1. How do stigma and social prejudices affect risk? Access to and retention in services for men, women, as well as girls and boys? Key populations?	• **Kids do not want others to see** them taking medication at school, do not know if there is a difference between boys and girls (CBO_2)
	• Early in the epidemic people would **share their survivor stories, but now people are reluctant** to do so because of stigma. (CBO_3)
	• **Prevents people from testing and knowing their status** early—lack of knowledge about advantages of knowing your status early and benefits of early treatment (CBO_6)
	• **People pass comments about HIV+** (FGD_5)
	• **Prevents adherence**
	  • because couples do not support each other—men could be taking meds and wife doesn't know, so cannot make the effort to cook on time, etc. (CBO_6)
	  • at festive times they will not take meds because they don't want others seeing (GOV_4)
	• **Regional differences** In Ghanzi the more conservative residents will not disclose their status, so they will not come forward to test, will not seek treatment, or stay on treatment.
	• **Parents will not disclose to their children** that the child is HIV-positive, for protection, or other reasons—they just see to it they take the medication. (CBO_1, CBO_5, CBO_8, GOV_6). This results in
	  • **Teens infecting one another** because they do not know their status (CBO_5, CBO_6)
	  • **Lack of socialization** because parents will not let children go away to relatives or on trips (CBO-6)
	  • **Blaming the parents and anger among** adolescents (CBO_6, GOV_1, GOV_2, FGD_5) Some teens resort to revenge mentality and rape younger relatives, nothing you can do to stop them, they cannot accept their status, some stop taking medication (FGD_3, GOV_6)
	• **Parents don't want to disclose child's status to teachers** because some teachers have disclosed status to others. **Lack of support in school—**caregiver does not tell teacher, and OVC or child does not get the support of the teacher (GOV_2,CBO_6)
		• **Anti-stigma campaigns** are needed so that LGBTI are not shunned within communities (CBO_4)
		  • **Decrease stigma among health service providers** for people in general & KP (NGO_2, CBO_4)
		  • **Within communities** (CBO_9)
		• **Door-to-door testing and treatment**
		  • **Will decrease stigma** on all levels. People will feel freer and not singled out. They will also establish a relationship with care providers and be more likely to come forward for services. Enrollment and meds at home too—community-based dist. (CBO_5, CBO_9)

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations

	• **Risk to infants—**women are afraid to exclusively breastfeed (mixed feeding is norm) or not breastfeed at all because people will know she is HIV-positive (CBO_1,CBO_8)
	• **Less than before** but some people still affected (FGD_3)
	• **Women can bear stigma better than men** and are thus more open to **services** because they have been socialized to bear discrimination as part of their role—men brought up to be strong, but young girls/women do better than older ones (CBO_8, GOV_4, NGO_1)
	• **Gender activists** are labeled negatively and considered HIV-positive when they try to work (FGD_1)
	• **Couple testing** not popular because people have multiple partners and don't want to go with more than one to the clinic (FGD_3)
	• **Positive people** are abused instead of supported by family (FGD_4)
	• **Not included in social events** community functions—PLWA are verbally abused. (FGD_4)
	• **KEY POPS:**
	  • **Stigma so heavy with transgender** population; add HIV and it becomes very difficult to deal with people; do not want to come forward for testing because of the way they are dealt with (CBO_4)
	  • **General stigma** intensifies for KP (NGO_1)
		• **Ensure that people in remote areas can continue treatment**. Traveling far once a month is hard (FGD?_1)
		• **Encourage parents to disclose children's status to them early**—they don't always take it well but they do better (CBO_5)

1. How does discrimination affect risk? Access to and retention in services?
• **For women and girls?**
• **For key populations?**
	• **I=Infectious disease care clinics (IDCC) at facilities:**
	  • People **in small communities do not want to take treatment** where they live, because they do not want to be known, so they have to travel out, access transport, etc. (CBO_3, FGD_3)
	  • **Adherence**: People do not want to return because if they see them going every month people will know they are HIV-positive (CBO_8, CBO_9, FGD_4)
	• **Medication makes a certain noise** when the bottle is shaken, so people start leaving their meds at home because they don't want people to know (CBO_9, FGD_3, GOV_6)
	• **KEY POPS**
	  • **When transgender people walk into services**, administrative personnel won't let them in because they don't appear as women, but their body is one—like for Pap smear (CBO_4)
	  • **Stigma from healthcare workers** (CBO_5, CBO_4, NGO_2)
	• **Stigma from healthcare workers** prevents people from accessing them in the first place
	• **Adherence takes support**—if you cannot disclose to teachers, family, spouse, chances of adhering very low (CBO_6, FGD_3)
	• **Women will fight through the stigma** because they want to remain healthy to take care of families, men do not have this motivation (CBO_8)
	• **No couples testing because of stigma between couples (FGD_1)**	

1. How does internal stigma (self-stigma) affect risk taking and	• **People are more likely to self-stigmatize than the community does**, blocks them from seeking treatment where they are known or will be seen (CBO_, CBO_5, NGO_1) • Those without support cannot disclose, they are afraid (CBO_8) • **Males test less than females** because they don't want to accept themselves or their status, but more recently numbers have been better. (POL_1)	

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations
access to and retention in services? **2. For men and boys?** **3. For key populations?**	• They don't want to be seen in the IDCC (GOV_3) • They'll take their wife's pill (FGD_3) • Boys are more secretive and do not want anyone to know they are on treatment, so staying on is harder for them—girls will seek out support (GOV_2) • **Men will go late to IDCC** when they are really sick and desperate because they do not want to be seen. (CBO_8) • **LGBTI** really suffer because is it out of cultural bounds here (FGD_4) • **Sex work** is not considered work. Women not treated well by service providers and it is hard for them to come forth because they know they will be treated badly. (CBO_11) • **People are afraid to be seen taking ARVs** so they fall off. • **Youth** sometimes do not want treatment—parents feel hurt and under pressure, but they don't want to be seen taking it (FGD_5) • **There is a lot of stigma in gay communities if you are HIV-positive** because we tend to remove ourselves from issues instead of facing them. You double the stigma if you are HIV-positive and gay (FGD_6).	
1-Stigma and refugees	• Lots of **difficulty in reaching** the population because of stigma—they come at night when no one can see. (NGO_4) • **Women who are not supposed to be breastfeeding** do it when they get back home because of stigma—they don't want to be singled out. (NGO_4)	
Beliefs and traditions		
1. How do gender norms influence sexual behavior and how does this relate to HIV transmission?	• **Women socialized to be submissive to men:** (GOV_4, GOV_5, FGD_4, CBO_8, FGD_6) • **Man treats woman like a child** has control over her (FGD_4) • **Women cannot speak up for themselves** (FGD_4) • **Women cannot question men** about whereabouts (if they have relations with someone) and cannot refuse sex for any reason (NGO_3, GOV_4, GOV_6) • **Men head of the family and leader in all family issues but will work together with women** nowadays—he just needs his love and respect. Men will help in the household now (FGD_2, FGD_6, GOV_6) • **Fearing the male figure has decreased**, couples discuss issues including sex (FGD_2) • **Men bring status to the household** but don't do anything else in the house (FGD_3) • **Men are shocked to see empowered women** so women are changing but men are not. Used to be accepted for women to be submissive and men dominant, but now things are changing, with technology and changing roles—but men do not accept that. They become threatened (FGD_5)	• **PEPFAR withdrew its funding for gender activities** and so is not getting information on harmful norms anymore (CBO_3) • Should consider **Botswana-specific research on norms** and how to change them. Has not been an in-depth look at how gender factors affect HIV in Botswana (CBO_2, CBO_3) • **Life skills training** will counteract lower educational level of girls (CBO_3)

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations

	• **Women cannot negotiate safer sex** meaning they cannot refuse sex, ask for condom use or anything else because of the power imbalance Men will not use condoms (NGO_3, CBO_5, CBO_7, GOV_2, FGD_1, FGD_2).
	• **Men are the ones to initiate sex and condom use** so it is hard for a woman to ask (CBO-1, FGD_6)
	• **Parents want their children married with kids** without any regard to what kind of man they are with—focus is on children and marriage (GOV_6)
	• **Youth more open communication between boys and girl about sex** and other things is more common today (FGD_2, FGD_3, FGD_5)
	• **Men migrate** for work and leave women in care of male relatives who sleep with them (NGO_3)
	• **Postpartum prohibition on sex:** Men should not have sex with their wives for six months after birth so satisfy themselves elsewhere (NGO_3)
	• **Men have multiple partners (MPs):** Long history of acceptance. Thus the term "small houses" referring to partners outside the main relationship; "Man is an axe"—something to be borrowed and passed around to plow field (sex other women), "right of a bull to enter any Kraal" same thing; men with MPs are viewed in a positive light, given names like "player"—not at all derogative. One primary partner and others. This norm is reflected to **youth** and is perpetuated (CBO_2, CBO_5, CBO_6, CBO_7, GOV_3, GOV_4, CBO_9, NGO_30, FGD_2, FGD_3)
	• **Women with multiple partners** are not accepted, portrayed as very bad people, negative, deserving anything they get (NGO_3, CBO_7, GOV_3, GOV_4)
	• **Early marriage** isn't considered as such by people doing it, they are viewed positively in society; older men take girls as young as 13 in some areas (CBO_2, CBO_7). Also true for Somali refugees, they are very secretive about it—older men arrange these marriages (NGO_4). Parents will consent to early marriage because rich man will support her and give them money—they have been taken out of poverty—girl does not have a choice (FGD_11).
	• **Intergenerational marriage,** younger girls marrying men way older than them and have no power to negotiate anything (sex or otherwise). Marriage is very valued—so if the father will marry the pregnant girl, big relief no matter what the age (CBO_3, CBO_6).
	• **Forced marriage** in hard to reach areas—by custom, so nothing is done about it; women in these marriages have no control over sexual (or any other) negotiation (CBO_3, CBO_5, CBO_6).
	• **Intergenerational and transactional sex**
	  • For gifts, like cell phones, good clothing, etc., especially economically disadvantaged girls (GOV_5)
	  • Parents will not confront girls who come home late with gifts or money—nor will they question who is sleeping at the house. Families want the income (FGD_1, FGD_4).
	  • Men within village leave their families for younger girls. Young girls date older men. Women have no power in these relationships because of age and sex. Men lure the girls with money, provide income "for your mother" (FGD_1, FGD_4, FGD_5, GOV_5).
	  • Women get jobs quicker when they have sex for the job (FGD_2).
		• **Education should target specific vulnerability**, not only gender but social exclusion; people with different socioeconomic backgrounds need different education (CBO_2)
		• **Gender issues should be funded directly, not hidden in existing activities.** If more was specifically known to PEPFAR about gender issues and HIV, we would get more funding for them. They directly drive the epidemic (CBO_5)
		• **Men and boys need to be empowered** to say no to sex—not just girls. Gender work needs to reach out to men and boys to change their norms (CBO_7;) **Empower boys and men.** Need to bring the boy child on board with empowerment and reach out to parents. Need whole community involved (GOV_2, NGO_1) **One Man Can program puts boys** into situations where they are doing things like washing dishes, clothes, caring for children, and other things that make them see they can participate—and this changed the way they act and feel. (GOV_3)
		• **Youth:** New approaches are needed in schools to transform harmful norms: involving peer to peer interventions. (GOV_2)
		• **Gender norms of health service providers** needs to be changed—men wanted to be treated as

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations
	• Retired women look for young boys—and young boys have sex to get money from the older women, a trend today (FGD_2, FGD_4, FGD_6). • Older men do not want to use condoms, they have power over the younger women, also economic imbalance (FGD_4). • A lot of this in refugees too (integrational) (NGO_4). • Sometimes girl is too young to have the kids, so she enters into financially beneficial relationship with an older man, leaves kids at home, so she can obtain income for family. Or girl is a dropout and cannot make money in a job so makes money by doing sex work (FGD_4, FGD_5). • **School dropout**: Girls drop out of school because of teen pregnancy, boys drop out because they need income (GOV_1). • **Boys do not take advice** on drinking HIV or anything else. Young boys at risk through their constant partying and use of **alcohol** and drugs, and their refusal to listen to advice. They walk away if you try to give advice (POL_1, FGD_1). • **Alcohol and substance abuse** contributes among **youth**. They have parties where they switch sex partners like dance partners, men go to bars looking for sexual partners (GOV_1, CBO_1, CBO_7). • There is **no condom use** among **youth** (GOV_1). • **Condom** not using one is a sign of love and trust (FGD_1, FGD_3). • Okay for **women to carry condoms** in their bag, can get into a situation when you need it. You should carry condoms with you; virus has caused people to want to carry protection (FGD_2, FGD_3). Married women stigmatized for carrying condoms—only okay for unmarried (FGD_5). • When women buy **condoms** people look at her like she really loves sex, partner could view it as women are unfaithful (FGD_4). • **Youth** don't know how to use condoms. • **Raising children** falls to women, many times as single parents. Men abandon them—so men are always making it to the top and women are economically disadvantaged because they have to take care of their kids (FGD_11). • **Conjugal rights—**male feels he has paid the bride price and has the right to sex, regardless of what he does/risk, women's economic dependence on men creates this feeling of rights as well. (CBO_6, GOV_4) • **Women engage in unsafe practices to please men** like using things to tighten their vaginas, which can tear the vaginal wall (GOV_4). • **Gender roles are defined in society** when women do masculine things she is laughed at, and we don't do feminine things for the same reason we don't want to get laughed at (FGD_1). • **Transforming gender norms** • **Training among teachers and empowerment of girls** with the life skills curriculum has transformed norms among teachers and (female) learners. Girls are now pursuing topics like math and science which previously they would not have—female teachers and their female students are becoming empowered. This focus on female empowerment in schools through teachers and students has been very powerful for transforming norms. (GOV_2)	men, not motherly matrons (NGO_2) • **Condom use** should be both men's and women's responsibility—but need education in village for that. Both sexes should be sure to have condoms on them (FGD_1)

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations
	• **Men in the kitchen**—teaching them household chores, etc.—letting the do the job in order to change the norms. One Man Can program (GOV_3). • **Men and boys especially in female-headed households** when they need to help taught men to be more involved in parenting and childrearing (CBO_7,FGD_2, FGD_5).	

2. What difference do men and women have in terms of decision-making power ?	• **Girls socialized to believe men are superior and decision makers**
	  • Patriarchal society
	  • Men have authority over decision making in house and control over property (CBO_3, CBO_5, CBO_8, GOV_3, GOV_4, NGO_1, NGO_30, FGD_3).
	• **Women have less autonomy** because they have very little knowledge (CBO_5).
	• **Women share power with men** and even discuss HIV (also then says men blame women for HIV) (FGD_2).
	• **Sex workers are trained to negotiate condom** use in their programs, but clients may not accept. Many times they do because of education and knowledge that HIV is common. Sometimes they have no negotiation power (CBO_11).	

3. What social factors, beliefs and traditions/ patterns increase vulnerability, affect risk, access to and retention in services for women and girls?	• **Women take TX in secret, they fear** violence if they **disclose** their status, even though they know men have multiple partners, they are trapped by male dominance in the relationship (CBO_2, NGO_30, FGD 2). • **Religious/more traditional people** don't tend to take meds since they believe they will be healed; churches preach healing and do not support the use of ARVs and this influences people to think they don't need them (POL_1, GOV-5). • **Mostly female students who care for HIV-positive** person in family, so they gain more knowledge and experience on HIV/AIDS. Girls take up testing more than boys. (GOV_1) • **Women are busy** and do more work than men, so may miss their time to go back to the clinic. (GOV_3) • **Women better at adhering** because they want to care for their kids/families. (FGD_3)	

4. What social factors, beliefs and traditions/ patterns increase vulnerability, affect risk, access to and retention in services for	• **Men are socialized/ raised to be strong not to talk about issues/do not want to be seen as weak, thus tend not to test or access treatment** (CBO_2, CBO_7, CBO_8, GOV_3, GOV_4, GOV_5, CBO_9, NGO_30)
	  • Believe the virus will not affect them
	  • Worry about what people would say if they access services, they cannot take that kind of social pressure, being called a "sissy"
	  • Accessing services will diminish their masculinity and make them be perceived as weak
	  • Raised to make it to the top and get money and women
	  • Fear a positive status so they do not test
	  • Need partners to support them and push them to take meds, cook for them, but this is contrary to idea you are supposed to stand strong on your own	

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations
men and boys?	• Regional differences: men in Ghanzi test and disclose more freely, take care of their families, men in Phikwe are more conservative and reserved, less family support (CBO_5) • They believe more in traditional medicine so will not take ARVs (FGD_3) • **Men do not make time** for accessing and adhering to treatment, they complain that going to the clinic is time-consuming (CBO_3) • **Men are more likely to default** • throw away their pills once they feel better (CBO_3, POL_1, POL_2, NGO_30) • pill fatigue affects men more than women because not as resilient (GOV_4) • **Men do not access services until they are sick and have a hard time accepting their status**—they don't pay attention to the counseling when they are tested; also take their wives' pills. (CBO_3, CBO_7, CBO_9, FGD_2, FGD_4)) • **Men look at physical signs and use women as yardsticks to know status** so do not test themselves to see that they are sick rather than access services, so will blame women, also use their women to test their own status—assume women's result is their result, get to know their status when women are pregnant because she goes onto PMTCT. This applies to **youth** as well. Men are afraid to test. (NGO_3,CBO_2, CBO_8, CBO_9, GOV_3, GOV_4, NGO_30, FGD_1, FGD_2, FGD_4)) • **Men blame women** for infecting their children (CBO_2). • **HIV-positive men do not come to support groups**—only access services for condoms. (CBO_3)	
5. What social factors, beliefs and traditions increase vulnerability, risk for key populations and refugees? Influence access to and uptake of services?	• **Refugees** cannot work so there is a lot of idle time—sex is a leisure activity for them (NGO_4). • HIV comes from sexual relationships outside the camp—since they know who has the virus in this small community and they avoid those people. • **Refugee** men's uptake of services is very low—they do not test or come for treatment (NGO_4). • Considered sinful to be sex workers. Hard for them to come forward because they are doing something illegal. **Alcohol** abuse is very common, and so they may know their status and begin meds, but medication should not be taken with drinking and they forget the meds and default. (CBO_11) • **Intergenerational sex** takes place among gay people because they need funding for their activities—they like to have fun. (FGD_6)	
Health services		
1. Is there a difference in the use of health services for men and women?	• **Alcohol**—and substance abuse—boys/men do not go to services, neglect themselves, and they neglect treatment. Men and boys tend not to follow through on treatment because they are brought up with habits that don't foster making that kind of effort, alcohol use also; also true among **refugees.** People want to keep taking drugs and alcohol rather than go on treatment (NGO_4) (GOV_1, GOV_3, CBO_6, NGO_30, FGD_1, FGD_2, CBO_3, POL_2, FGD_5). • **Alcohol and substance abuse** cuts across the 90-90-90 (GOV_5) •	• Need to get **services in hard-to-reach areas** (CBO_3) • **Bring the health services to women and girls** and they will use them (NGO_3)

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations
2. What factors limit access to health services for women, or girls?	• **Parental consent** is needed for testing kids under 16 (GOV_1, GOV_2). • **Distance:** Women do better in general but in hard-to-reach areas it is harder for them (GOV_4). • **Female nurses and doctors have attitude** and don't dress "decently"—Males nurses and doctors are nicer and better. Female SPs call their friends into an examining room and talk on the phone while attending you, no confidentiality. Patients are sometimes abused (FGD_2).	• **Rape should be treated as a priority condition,** affected people not made to wait for services (CBO_5) • **Sensitize and train all health staff** especially admin about LGBTI so they are treated well and dealt with appropriately from the time they walk in the door. (CBO_4, GOV_3) • **BOFWA needs more training on transgender and intersex.** Ongoing training and desensitization (CBO_4) • **Make one-stop-shops to pull men into services,** they can get everything they need in one place (CBO_7) • **Testing**: Permanent testing facility in the form of a tent could be erected in the Kgotla so that testing services are easy to reach by the community (POL_2) • **IDCC needs to be considered**—plays into stigma, people do not want to be seen using these services (CBO_8, GOV_2, FGD_3, see notes above, lots) • **Gov't facilities do not work with NGOs and this is a problem**—need a linkage (NGO_3) • **Intensify partners around PMTCT of refugees** to improve adherence in that program (NGO_4) • **Sensitivity training** for health practitioners for KPs (CBO_11) • **Long waits for service** try to rectify that, but put in some form of entertainment so that people

3. What factors limit access to health services for men and boys?	• **Service provider norms around gender and stigma**
	  • **"Motherly"** nurses turn men off, who want to be perceived as strong, don't want that kind of care (NGO_2)
	  • **Can be very rude—**for HIV-positive person this is heavy (FGD_5)
	  • **Asked what people did to need repeat test** which turned people off from coming to test again (FGD_5).
	• **Easier for girls to access** testing than for boys
	  • They have to tell their teachers, since testing places are only open during school hours, and girls are more open. Treatment patterns the same—guidance teachers facilitate student health care—teachers are required to give student notes, etc. Boys less willing to tell their teachers (GOV_2, CBO_9, FGD_5))
	• **Infectious disease care clinics set up:** Special section in health facilities, people do not want to be seen standing there, because it is for HIV treatment. Testing is different—here you are definitely positive so it is different (CBO_8, FGD_4).
	• **Health practitioner's behavior can enhance care**: Men feel comfortable with the local nurse because he jokes with them and makes everyone feel welcome. If people miss their medication there is no judgement, just counsels and gives more meds. Urges them to come back (FGD_1).	

4. What factors limit access or use of services for key populations?	• **Service provider norms around gender and stigma** (NGO_2, CBO_4, CBO_11, GOV_3)
	  • When transsexuals present for treatment, sometimes they are refused care because SPs are prejudiced against them and act nasty.
	  • There is a lack of classification for them—only male and female.
	  • Norms around "acting like a man" would turn them off (NGO-2, CBO_4).
	  • Stigma around LGBTI blocks people from coming in for services-know they will be nasty to them, to shame them etc.
	• **For transgender**—you must show an ID to get services, sex will be listed as one thing, but you appear as another—they won't let you in, think you have stolen the ID (CBO_4).
	• **Transgender** access youth-friendly services (BOFA) (CBO_4).
	• **Refugee cultural difference:** No problem in enrolling Namibians and Zambian women in testing, Somalis do not come. **Men do not come** in the same proportions within all their country populations at the camp (NGO_4).
	• Service providers are not trained to deal with FSWs nicely and they will abuse them (CBO_11).
	• **People in same sex relationships tend not to test a lot and use their partners** to know status. (FGD_6)
	• **Due to the double stigma for HIV-positive gay people,** it is hard for them to use health services (FGD_6).	

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations
		waiting could do something, especially games for youth. • **Service provider should not care who sleeps with whom**—this is a person and they should service them (GOV_3)
5. How is the country mobilizing to build the capacity of women and men as health care providers, caregivers, and decision-makers throughout the health system from the community to the national level?	• **LGBTI just sued government and won**—to be recognized. Until now very vulnerable because they were not recognized under the constitution—but not being LGBTI illegal, just the act. (CBO_4, GOV_3)	• **Transgender not part of MSM/WSW**, **need better language** for sexual minorities (CBO_4) • **Transgender people do not have anything they can use for protection** for their body parts, condoms are not designed for their use (CBO_4)
6. What factors related to health and prevention services influence risk of transmission in KP?	• **No information available on how hormones** taken by transgender people affect HIV treatment and vice-versa (CBO_4) • **Refugee men are mobile, so adherence is difficult**. They are not allowed to work locally, so they leave to find work (NGO_4).	
Policy issues		
How were gender disparities and inequities taken into	• **In Botswana it is not illegal to be gay, or transsexual**—the "unnatural act" is illegal and you have to be caught in the act. But police consider that you are confessing to this act if you report a crime (like GBV).	• **Harmonization over HIV issues between common and traditional law:** For example, when girl gets pregnant, in customary law the man can just be charged

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations
account in the development of policy		"tshenyo" pregnancy damages, leave the girl and move on. In common law he'd be charged maintenance through life. Can cause difficulties in gender-related issues because of the way the two systems differently deal with them (e.g., pregnancy damages). Conjugal rights: traditionally women cannot refuse sex for any reason, but it does not apply to the current context because men do not get tested (CBO_6)
What issues related to gender need to be kept in mind in PEPFAR programming and priority-setting?	• **Transgender people are left out of interventions**—MSM do not cover them. (CBO_4) • **The stand of the Ministry of Education and Skills Development** is that during sex educations condoms can be talked about, but they will **not distribute condoms** in school, because it is not the job of the MoESD—it belongs to the MoH, but they do not distribute them either. (GOV_1)	• **Law enforcement and awareness of existing laws: GBV Act, Children's Act,** etc. are not enforced, nor is there knowledge about them. (CBO_6) • **The government has to really enforce the law in not discriminating against LGBTI** in order to help key pops. They must be provided service without any harassment—sensitivity to practitioners, informing people of law and educating them.
Community resilience		
Community involvement in reducing vulnerability and ad risk to HIV transmission and increase access to/use of health services?	• Support if the community helps get through infection and treatment (CBO_4, GOV-2, GOV_3, NGO_3, FGD_2).	• **Find out what community needs are**. Emphasis on numbers precludes that (number of hours, number of people) (CBO_5)**; Focus groups and discussions in the community** about HIV, real education (FGD_2); In villages, could have **health days to encourage conversations about HIV**—if people would talk to each other things between men and

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations
		women, would **decrease stigma** and testing and treatment would increase. Would unify the village and encourage support. (FGD_1) • PEPFAR does not believe in **media campaigns, but in communities** they would help raise awareness about GBV and GBV services (CBO_2) • **Involve traditional leaders-**likely to be able to intervene best on gender issues and GBV that is affecting risk of HIV and uptake of services (CBO_5) • **Community needs to be involved** to intervene in GBV, to create safe spaces, referral system, services—GBV is multisectoral so everyone needs to be involved to succeed involved; treat GBV like HIV (CBO_6, GOV_2)
M&E		
Comments about data collection for PEPFAR and others	• **Collect info on GBV even though not required for PEPFAR (CBO_3).** • **No studies on HIV prevalence or rate of new infections among transgender people—**too small a community so we have no idea what rate is infection in this group **(CBO_4)** • **Get rid of the targets**—they restrict our ability to make a real difference because we need to reach numbers of people with a certain number of hours, not go in depth with fewer people (NGO_3). • Need **Botswana-context indicators** that will help programs make decisions—not global indicators (CBO_2). • **Gender indicators would lead to implementation of activities** to generate required data like # mentors trained in gender, GBV screening. Need for more gender indicators and on GBV (NGO_2, CBO_3). • Focus on 90-90-90 is on numbers, not on getting real progress made (NGO_1).	• **PEPFAR indicators are very limiting**—and do not include the types of GBV like child marriage, intergenerational marriage etc. (CBO_2)
General recommendations for PEPFAR		
	• Transgender people are a small community, PEPFAR will not invest—cannot collect stats, etc.; transgender people are **left out of interventions**, the other key pops are different. (CBO_4) • Funded **gender training for mentors** (NGO_2). • Wish they put **more support into gender programming and reporting** (CBO_3).	

Gender Analysis Questions	Stakeholder Answers	Stakeholder-Stated Needs & Recommendations
	• **Gender should mean men and boys** as well as women/girls, include transgender and intersex; GeAD targets women and girls (CBO_4, NGO_1). • **Schools**: **circles of support.** When a child is at risk, program brought together practitioners from different sectors to support the child. Helped children get the comprehensive care they needed for HIV or risk of HIV (GOV_1). • **Cannot address the recommendations of the BYRBSS**. The youth study was great but nothing is happening with the results. We need action on the recommendations (GOV_1, GOV_2). • **If climate change isn't dealt with all the work on women's empowerment** will regress—women's income, collecting things from nature, etc., dependent on rain and regular seasons (CBO_6). • **Botswana needs to take gender as seriously as other issues**—gov't needs to make a commitment—GeAD located in a Ministry that houses things that have nothing to do with it and there is no priority or support. No Ministry of Gender here (CBO_6). • **Using media—widespread public campaigns** that spread education. Still a lot of misinformation CBO_7). • Make programs that men will love to get them in—like sporting programs and educational camps for boys and girls (CBO_7). • **Need training and curriculum development like the life skills—in GBV for skills**. Give us the TA and we can do it. (GOV_2) • **PEPFAR should be specific about funding for LGBTI—**and say these funds can only be used to target these pops if you really want to help them—not give gov't a choice if they want those funds (GOV_3). • Intensify efforts to **bring stakeholders together to share challenges and opportunities**—periodic regular meetings (GOV_3). • **Funding for** organizations who are following through—**organizations actually doing the work** (NGO_30). • Special program for **grassroots organizations targeting youth** boys and girls, especially wat the school level. They are still young and we can influence them (GOV_3). • **Education should be taken to social groups**—schools, churches, and to the people doing the actual work instead of taking officers into workshops (GOV_4). • **Ongoing CBT for funded organizations** (NGO_3). • A lot of sexual activity takes place among **refugees because they are stuck in camp and not allowed to work**, they need something to do—but non-starter with the government (NGO_4). • **Educations in camps about HIV** (NGO_4). • **Have meetings at the work place to open up these issues (HIV status disclosure**). People need to know how important it is to disclose. (FGD_2, FGD_3) • Need **more programs for sex workers and other key pops** like Silence Kills (CBO_11). • If we **ignore key pops** we will never end the epidemic (CBO_11). • **Sustainability** a huge problem for (KP) programs—funded through one NGO, then stop, then another…discontinuity hurts overall program. (CBO_11) • **Involve youth** in spreading education/information about HIV, others seem tired; social media campaigns f=targeted at youth would work (FGD_5). • **Balance current over-focus on treatment with prevention** (GOV_5). • **Gap in research on early marriage in Botswana** (GOV_6). • **Programs for kids to empower them and communicate sensitive issues to adults** so they can disclose defilement and report (GOV_6).	

ANNEX 5. BOTSWANA & INTERNATIONAL LEGAL AND POLICY INSTRUMENTS RELATED TO GENDER EQUALITY

Policy/Law	Year	Gender-Related Key Provision
Constitution of Botswana	1965	**The constitution entitles equal fundamental rights and freedoms irrespective of sex, hence is said to recognize the equality of both sexes under the law. Botswana has a dual legal system; common law and customary law exist side by side. Customary law is enforced by tribal structures and customary courts. As a result, societal discrimination against women persists in practice—particularly in rural areas and in relation to restrictions on women's property rights and economic opportunities.**
Policy on Women in Development	1995	**The policy addresses the broader sociocultural, economic, health, and political gender dimensions, ranging from women's and girls' rights and economic empowerment to social protection.**
CEDAW	1996	**The convention calls for the elimination of all forms of discrimination against women. Botswana ratified CEDAW without reservations in 1996 but has not yet fully domesticated its provisions. Implementation of some of the components is ongoing.**
Vision 2016	1997	**Vision 2016 commits Botswana to provide equitable access to HIV and AIDS services by all people.**
Penal Code	1998	**The code was amended in 2004 to include a gender-neutral definition of rape.**
Marriage Act	2001	**This act prohibits marriage below the age of 18 for anyone; and those above 18 but below 21 must have parental consent.**
National Policy on HIV and AIDS	Revised 2012	**The policy commits Botswana to ensure equitable access and utilization of HIV and AIDS service. The policy lacks specific guidelines on gender and key populations.**
Public Service Act	2008	**This act criminalizes any form of sexual abuse in the public service.**

Domestic Violence Act[113]	2008	**The act criminalizes any form of gender-based violence, including child abuse.**
SADC Protocol on Gender and Development	2008	This protocol calls for promotion and implementation of strategies that improve gender equality between males and females in all spheres of society and levels of socioeconomic and political development (not yet ratified).
Children's Act	2009	**The act provides for the promotion and protection of the rights of children. It does not make any clear reference to the differential impact of specific circumstances on the male or female child. The act provides guidance for the provision of care and support for OVC.**
NDP 10 (National Development Plan	2009	**Key objectives of the plan are promoting gender equality and the empowerment of women. Gender is treated as a cross- cutting strategy, and the plan anticipated that service providers would mainstream a gender dimension in service delivery, planning, and implementation of development projects.**
Inheritance Act		**The law is largely biased towards inheritance by men.**
Gender and Development Strategy	**2012**	**The strategy promotes equitable distribution of services, protection, and respect of gender-related human rights.**

[113] Botswana enacted the Domestic Violence Act (No. 10 of 2008) to provide protection to survivors of domestic violence. The Act defines domestic violence as "any controlling or abusive behavior that harms the health or safety of the applicant" and lists the types of abuse, such as physical, sexual, emotional, economic, etc. The act also deals with the jurisdiction of the courts; describes how an "applicant" (i.e., "any person who alleges to have been subjected to an act of domestic violence") can lodge an application for an order by the court; explains how documents are served to the "respondent" (i.e., "any person who is or has been in a domestic relationship with the applicant and against whom the applicant seeks to obtain or has obtained an order under this Act"); and identifies the nature of proceedings in a domestic violence case.

ANNEX 6. SUMMARY UPDATES ON CURRENT GBV ACTIVITIES

PEPFAR Botswana has a comprehensive GBV program which aims to build capacity of the GOB, implementing partners and communities to prevent and respond to GBV. There is a dedicated gender specialist responsible for overseeing the portfolio and providing TA across agencies. There is an interagency technical working group (TWG) and also a 16 Days Committee, which is chaired by the DCM. Below is the summary of our progress so far.

Activity	Status	Implementing Partner	Agency
Violence Against Children Survey (VAC)	Ongoing—training is scheduled for April, and we anticipate results by the end of the FY.	GOB	CDC
GBV referral system	Ongoing—this system developed, trainings which were then conducted, and we anticipate the first report on data flow through the system by December.	MEASURE Evaluation	USAID
Rollout of the MOH SOP	Ongoing—training material was developed, piloted, and finalized. Four trainings have been conducted so far, reaching over 153 health workers.	American Health Alliance	CDC
Integration of gender and GBV in HTC	Completed—protocols were revised, training was conducted, and mentoring from the gender advisor and Liverpool VTCT was continued for eight months.	Tebelopele	CDC
Gender norms activities	Ongoing through different tools, including SASA, In her Shoes, One Man Can, and 16 Days campaigns.	FHI 360, PCI, Peace Corps	USAID and Peace Corps
Development of the SOP for BPS, DSP, and MOESD	Ongoing—SOP were developed and are being piloted at GBV referral system pilot sites, and we anticipate finalizing them by the end of the year.	MEASURE Evaluation	USAID
Operations research	Ongoing as part of the pilot	MEASURE Evaluation	USAID
Provision of post-GBV care	Ongoing	FHI 360 and PCI (through the shelters)	USAID

BOTSWANA

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