Positive Health, Dignity, and Prevention in Botswana

Comparing national documents guiding the implementation PHDP with recommendations and guidance from key international public health organizations: a desk review

March 2015

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Tables

Acronyms

CSO	Civil Society Organization
DHAPC	Department of HIV/AIDS Prevention and Care
HTC	HIV Testing and Counseling
PHDP	Positive Health, Prevention, and Dignity
PLHIV	People Living with HIV
GNP+	Global Network of People Living with HIV
VTC	Voluntary Testing and Counseling
GIPA	Greater Involvement of People Living with HIV
M&E	Monitoring and evaluation
PMTCT	Prevention of mother-to-child transmission
RAG	Red, amber, green status
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS

Acknowledgements

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U91HA06801. The content and conclusions of this review are those of I-TECH Botswana and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Introduction

The first reported case of AIDS in Botswana was in 1985.[1] Over the next two decades, the epidemic progressed rapidly, resulting in a HIV prevalence rate which is currently among the highest in the world.[2] The national response to the HIV/AIDS epidemic has been multifaceted, with strong political support. In 2002, Botswana launched the first national antiretroviral therapy (ART) program in Africa at Princess Marina Hospital in the capital city of Gaborone. The ART program was rolled out to hospital facilities in Francistown, Maun, and Serowe later that same year. By the end of 2009, ART services were available countrywide.[3] In 2013, 87% of HIV-positive individuals estimated to be eligible for treatment had started ART.[4] Due to the success of the national ARV program, many people living with HIV (PLHIV) are living normal, productive lives engaging in social and sexual relationships.

Positive Health, Dignity, and Prevention (PHDP) is an HIV-prevention approach that focuses on interventions to help PLHIV protect themselves from HIV re-infection and other sexually transmitted infections (STIs), as well as to help them avoid infecting their partners with HIV.[5] In 2009, the Botswana Ministry of Health released a national strategy related to Positive Health, Dignity, and Prevention.[6] This was followed in 2010 by national implementations plans for both government facilities as well as civil society organizations.[7,8] Subsequently, a national training curricula was developed and piloted in 2014.[9] The Department of HIV/AIDS Prevention and Care's (DHAPC) (PHDP Unit has since been rolling-out trainings and support to nine health-districts throughout Botswana.

Objective

A desk review was conducted to compare the national documents guiding implementation of the PHDP program in Botswana with the recommendations and guidance from key international public health organizations in order to identify potential gaps.

Methods

A standardized desk review tool was developed to guide data abstraction. This can be found in Appendix 1. The tool was structured around the three strategic objectives guiding the PHDP program in Botswana. These are listed in Table 1. Specifically, the tool focused on systems level, service delivery level, and patient level objectives. The areas of interest for each level are defined below:

1. Systems Level: This focused on the human and organizational capacity to implement aspects of the PHDP program. Specifically, an assessment was made on whether the document provided information related to human and organizational capacity towards PHDP implementation. If so, a summary of the information was abstracted into the desk review tool

2. Service Delivery Level: This focused on the completeness and quality of the PHDP program components. If information related to the completeness and quality of PHDP programs was included in a document, a summary was abstracted.

3. Patient Level: This focused on risk reduction actions by PLHIVs. Specifically, information related to choices made by PLHIVs relative to PHDP were captured.

Within each level, information was abstracted related to goals and objectives, activities and processes, outcomes, and targets and indicators.

Table 1. Botswana PHDP Strategic Objectives

To enhance the institutional capacity at all levels for integration of PHDP services into existing prevention, treatment, care, and support programs.
To improve the quality of PHDP services.
To empower PLHIV to make and sustain effective choices that contribute to the reduction of HIV transmission and those that promote their wellbeing.

Characterization of the Botswana PHDP Program

The following four documents were reviewed to develop a comprehensive characterization of the Botswana PHDP program:

1. Positive Health, Dignity, and Prevention (PHDP) Strategy (2009-2016)[6]
2. National Positive Health, Dignity, and Prevention Implementation Plan, 2010-2016[7]
3. Positive Health, Dignity, and Prevention Implementation Plan for Civil Society Organization (2010-2016)[8]
4. Botswana Ministry of Health Positive Health, Dignity, and Prevention Curriculum[9]

Information was abstracted from each of these documents using the desk review tool. Each document was compared with the other three national documents to ensure alignment of information.

Characterization of International PHDP Guidance.

After characterizing the Botswana PHDP Program, comparisons were made with international guiding documents. Specifically, the following documents were reviewed:

1. Positive Health, Dignity, and Prevention: Policy Framework[10]
2. Positive Health, Dignity, and Prevention: Operational Guidelines[11]
3. PEPFAR Guidance for the Prevention of Sexually Transmitted HIV Infections[12]
4. Positive, Health, Dignity, and Prevention in Kenya.[13]

Compilation of Information

For each of the three levels assessed (systems, service delivery, and patient), a Red, Amber, Green (RAG) Status was generated to signify alignment (or lack thereof) with international guidance. A description of each status is included in Table 2. It is important to note that a 'Red' status does not necessarily signify a weakness in the program, but instead signifies where there are key differences.

Table 2. Description of Red, Amber, Green (RAG) Status

RAG Status	Status description
Red	Substantial differences between national documents and international guidance.
Amber	Slight differences between national document and international guidance.
Green	Close alignment between national documents and international guidance.

Results

Characterization of the Botswana PHDP Program

There were three key national policy documents used to describe the national PHDP program: the Botswana National Positive Health, Dignity, and Prevention Strategy (2009-2016),[6] the National Positive Health, Dignity, and Prevention Implementation Plan (2010-2016),[7] and the Positive Health, Dignity, and Prevention Implementation Plan for Civil Society Organizations (2010-2016).[8] Additionally, the national PHDP training curricula for health workers was reviewed.[9]

The four documents were generally well aligned with each other. The two Implementation plans provided more detail related to implementation than the national strategy document. The two Implementation plans were completely aligned and essentially parallel documents with one focusing on civil society organizations (CSOs) and the other focused on public service. The CSO document provided slightly more information about the PHDP minimum package than the other implementation plan.

Program Goal:

The goal of the PHDP program was the same in the national strategy and the national training curricula; but these differed slight with the goal in the two implementation plans. They were not, however, remarkably different. The program goals for the national documents are listed in Table 3. Also included in Table 3 is the goal delineated in the Policy Framework and Operational Guidelines released by UNAIDS and GNP+,[10,11] which cover similar constructs. **Given that the general philosophy of these goals are well-aligned, a "green" rating was assigned**.

Table 3. PHDP Program Goals listed in National and International Documents

Document	PHDP Program Goal
Botswana PHDP Strategy[6] and the Botswana PHDP training curricula[9]	"to contribute to the promotion of positive health and restore dignity of PLHIV and prevention of new HIV infection and impact related to HIV and AIDS among PLHIV"
Botswana PHDP Implementation Plans[7,8]	"to reduce new HIV infections, sexually transmitted infections and promote the well-being of PLWHAs [13]"
UNAIDS/GNP+ PHDP Policy Framework[10] and UNAIDS/GNP+ PHDP Operational Guidelines[11]	"to improve the dignity, quality and length of life of people living with HIV; which, in turn, will have a beneficial impact on partners, families, and communities, including reducing the likelihood of new infections"

Program Focus and Strategic Objectives:

The three national documents guiding the Botswana PHDP program[6-8] and the curricula[9] were completely aligned in terms of the strategic objectives. The three areas of focus for the Botswana PHDP program are 1) Institutional capacity and capability, 2) service delivery of integrated PHDP services, and 3) empowerment of PLHIV and their families. The three corresponding strategic objectives of the Botswana PHDP program are listed below:

1. To strengthen the institutional capacity at all levels for integration of PHDP into existing prevention, treatment, care, and support programs.
2. To improve the quality of service delivery by providing integrated and comprehensive PHDP services.
3. To empower PLHIV to make and sustain effective choices that reduce of HIV transmission.

The main programmatic components included in the Policy Framework and Operational Guidelines released by UNAIDS and GNP+[10,11] are listed below;

1. Empowerment
2. Gender Equality
3. Health Promotion and Access
4. Human Rights
5. Preventing New Infections
6. Sexual And Reproductive Health and Rights
7. Social and Economic Support
8. Measuring Impact

The objectives from the UNAIDS and GNP+ documents[10,11] are listed below:

1. Increasing access to, and understanding of, evidence-informed, human-rights-based policies and programs that support individuals living with HIV to make choices that address their needs and allow them to live healthy lives free from stigma and discrimination.
2. Scaling-up and supporting existing HIV counselling and testing, care, support, treatment, and prevention programs that are community owned and led, and increasing access to rights-based health services including sexual and reproductive health.
3. Scaling-up and supporting literacy programs in health, treatment, prevention, human rights and the law, and ensuring that human rights are promoted and implemented through relevant programs and protections.
4. Ensuring that undiagnosed and diagnosed people living with HIV, along with their partners and communities, are included in HIV-prevention programs that highlight shared responsibility regardless of known or perceived HIV status and have opportunities for, rather than barriers to, empowering themselves and their sexual partner(s).
5. Scaling-up and supporting social capital programs that focus on community-driven, sustainable responses to HIV by investing in community development, networking, capacity building, and resources for people living with HIV organizations and networks.

The program focus and strategic objectives for the Botswana PHDP program were very general, while those provided by UNAIDS were more specific. **Direct comparison was challenging given the differences in specificity, therefore a color-rating of "yellow" was assigned.**

General Activities

The Botswana PHDP Implementation Plans[7,8] outlined eight general activities across the three focus areas of the program. These are listed in Table 4 along with more specific corresponding activities.

Table 5 presents PHDP activities suggested by UNAIDS and GNP+ in the Operational Guidelines.[11]

Table 4. General activities to be conducted as part of the Botswana PHDP Program

Botswana PHDP Focus Area	Corresponding General and Specific Activities[7,8]
Institutional capacity and capability	**1. Develop policy guidelines for PHDP integration into existing programs.** o Review policy guidelines and advocate for changes to incorporate PHDP into existing policies and national frameworks. o Develop and disseminate a plan to integrate PHDP into existing services. o Train service providers on the revised sexual and reproductive health (SRH), STI, tuberculosis (TB), mental health, infection control, behaviour change information and communication (BCIC), HIV Testing and Counselling (HTC), and treatment guidelines. **2. Build the capacity and capability of institutions and organizations at all levels to deliver integrated quality PHDP services.** o Assess and build capacity and capability of public, private, and civil society organizations in PHDP implementation. o Document and share best practices and experiences on PHDP interventions. **3. Strengthen linkages, networking, and coordination of PHDP services.** o Establish areas of linkages and collaboration. o Improve access to services for PLHIV in remote areas.
Service delivery of integrated PHDP services	**4. Implement effective BCIC strategies targeting PLHIV.** o Develop target specific BCIC strategies targeting PLHIV. **5. Improve the quality of services to PLHIV.** o Train service providers on the minimum package for PHDP. o Train counsellors on special PLHIV groups (couple, positive with dignity (PWD), discordant couples).
Empowerment of PLHIV and their families	**6. To strengthen risk reduction behaviour among PLHIV.** o Improve knowledge on risk reduction behaviors among PLHIV. o Provide ongoing quality post-test and supportive counselling to PLHIV. **7. Create a supportive environment for PLHIV to adopt and sustain positive living.** o Establish/renovate PLHIV resource centres for positive living. Information. o Train support groups and community based organization on positive living.

	○ Establish two national 24hour toll-free call-in help centres for PLHIV. ○ Conduct annual stigma reduction activities. ○ Enhance involvement and full participation of PLHIV in all sectors. ○ Promote gender equality among PLHIV and their partners. **8. Strengthen economic and livelihood of PLHIV and their families.** ○ Support PLHIV with livelihood projects. ○ Equip 300 PLHIV with survival skills. ○ Train 240 PLHIV members with entrepreneurship skills. ○ Provide 50 small grants to 50 PLHIV support groups annually. ○ Crate opportunities of vocational training for youth living with HIV. ○ Create pubic private partnerships. ○ Provide implementation grants to ten CSOs and ten support groups per health district.

Table 5. General PHDP activities outlined in the UNAIDS/ GNP+ Policy Framework

UNAID/ GNP+ PHDP Program Components	Corresponding General Activities
Empowerment	• Meaningful involvement of PLHIV. • **Education and literacy.** • Capacity building for organizations and networks of PLHIV.
Gender Equality	• Gender-based violence prevention and management. • Constructive engagement of men in reproductive and sexual health. • Appropriate health services for women living with HIV, including, but not limited to, prevention of vertical transmission of HIV. • Legal advocacy and activism for women's rights. • **Legal advocacy and activism for rights for men who have sex with men, and for lesbian, gay, bisexual, transgender, and intersex people.** • Economic empowerment of women. • Education. • Support for caregivers. • Social empowerment, including equality in decision-making and negotiating skills.
Health Promotion And Access	• Knowledge of HIV status under conditions of informed consent, confidentiality, and good counselling. • **Treatment and care access, availability, sustainability, and quality assurance.** • **Psychosocial well-being services access, availability, sustainability, and quality assurance.**
Human Rights	• Confidentiality of HIV-positive status. • Conditions for safe, voluntary, and beneficial disclosure. • Respect for individual autonomy. • Establishment of an enabling environment, including protective laws.
Preventing New Infections	• Access and availability of tools and technologies that help prevent sexual HIV transmission. • Access and availability of services that help prevent vertical transmission. • **Access to evidence-informed harm reduction for people who use drugs, including opiate substitution therapy.** • Serodiscordant couples counselling (including partner and couples testing).

	• Prevention, screening and treatment of sexually transmitted infections, including viral hepatitis.
Sexual And Reproductive Health And Rights	• Sexual health and well-being. • Reproductive health. • Sexual and reproductive health, rights advocacy and funding.
Social And Economic Support	• Food and water security. • Social and economic support for caregivers. • Access to financial services • Employment of people living with HIV • Health and social protection for children and adolescents living with HIV
Measuring Impact	• Indicators designed to interface with key national and international indicators

(Note: Bolded text designates areas not covered in the Botswana PHDP Program)

Several of the activity areas suggested in the UNAIDS Policy Framework and Operational Guidelines (Table 5) are not addressed in the national PHDP documents from Botswana. These include education and literacy (Empowerment), legal advocacy and activism for rights for men who have sex with men, and for lesbian, gay, bisexual, transgender, and intersex people (Gender Equality), quality assurance of treatment, care, and psychosocial well-being services (Health Promotion and Access), and access to harm reduction interventions for drug users. Furthermore, Human Rights is not directly mentioned in the Botswana PHDP Strategy or Implementation Plans.

'Measuring Impact" is not directly covered within the general activities of the Botswana PHDP program. However, Monitoring and Evaluation (M&E) is discussed in the Botswana PHDP Implementation Plans and the national strategy included a section highlighting the importance of M&E to the program. Additionally, the Implementation Plans delineate a set of ten core programmatic indicators for the program. Finally, activities such as evaluating existing policies and guidelines are well-embedded in the Botswana PHDP documents.

A "red" color rating was assigned to related activities since the following were not addressed by within the Botswana PHDP program: education and literacy to empower PLWHIV; legal advocacy and activism for gay and lesbian populations; quality assurance of treatment, care, and psychosocial well-being services; and human rights. Harm reduction interventions are unlikely to be an important need in Botswana.

PHDP Minimum Package

As outlined in the Implementation Plan for CSOs,[8] the PHDP minimum package is described in Table 6. The UNAIDS/GNP+ documents did not include recommendations or guidance directly related to the minimum package of PHDP services. However, the PEPFAR Guidance for the Prevention of Sexually Transmitted HIV Infection[12] presents a minimum set of PHDP services and messages. Several aspects of care from the PEPFAR

document are not included in the Botswana PHDP minimum package, such as assessment and treatment for opportunistic infection, referral systems, risk assessment including alcohol use, provision of condoms and lubricant at all care and treatment encounters, and prioritization of HIV-infected individuals in serodiscorant couples. However, opportunistic infection, referral systems, and condom provision are mentioned in the sub-activities of the Implementation plans.[7,8] They are also well covered in the Botswana PHDP Training Curricula for Health Workers.[9] **This aspect was assigned a "green" rating.**

Table 6. Botswana PHDP Minimum Package

	Health Facility Level	CSO Level
Psychosocial Support Services	• May include emotional, material, spiritual, support counselling.	• All elements to be included: emotional, material, spiritual, life skills, support counselling to PLHIV and their caregivers.
HIV Testing and Counselling	• Counselling and testing services • Disclosure • Partner notification • Discordant couple counselling	• Counselling and testing services • Disclosure • Partner notification, • Discordant couple counselling
ART Services	• ART provision • Treatment literacy • ARV adherence	• Treatment literacy • ARV adherence
Prophylaxis	• Cotrimoxazole Prophylaxis	• Treatment literacy
STI Management	• STI screening and treatment	• Prevention education • Treatment literacy and adherence
TB testing and treatment	• Prevention education • Screening and treatment • Partner notification	• Prevention education • Treatment literacy and adherence • Community DOT
PMTCT	• Treatment • Adherence and treatment literacy • Counselling and testing • Paediatric treatment • Infant feeding	• Education and support services for PMTCT • Community mobilization for male involvement in PMTCT • Peer mothers and fathers • Education on infant feeding and food preparation
Condom Promotion	• Education and promotion of correct consistent use of condoms • Avail and distribute condoms	• Education and promotion of correct consistent use of condoms • Avail and distribute condoms
SRH Services	• Family planning provision and counselling • Safe motherhood • Adolescent SRH • Cervical cancer screening • ANC and PNC • Education and Information	• Education and Information • Counselling • Adolescent SRH • Cervical cancer screening • ANC and PNC •
BCIC Interventions	• Promotes behaviors such as reducing risk of HIV transmission, VCT and CHCT, HIV status disclosure, prevention of unwanted pregnancies, adherence, reduction of sexual partners, seeking health care early, and seeking psychological support	• Promotes behaviors such as reducing risk of HIV transmission, VCT and CHCT, HIV status disclosure, prevention of unwanted pregnancies, adherence, reduction of sexual partners, seeking health care early, and seeking psychological support

Targets and Indicators

Table 7 contains a list of additional indicators listed in the two Implementation Plans for the Botswana program.[7,8] The two Botswana PHDP Implementation Plans[7,8] included a set of ten core indicators for PHDP monitoring and evaluation. These are listed below:

1. **Institutional capacity and capability**
    i. Enhanced capacity and capacity to deliver integrated and comprehensive PHDP services.
2. **Service delivery of integrated PHDP services**
    ii. Improved access to quality services delivery to PLHIV.
    iii. Increased number of people who test for HIV.
    iv. Increased % of PLHIV practicing safer sex practices.
    v. % of PLHIV who access integrated and comprehensive services.
    vi. Reduction in STI cases among PLHIV.
3. **Empowerment of PLHIV and their families**
    vii. Reduced stigma and discrimination.
    viii. % of PLHIV with improved household livelihoods.
    ix. % of PLHIV empowered to make and sustain choices that reduce HIV transmission.
    x. Reduced HIV transmission.

There were no indicators suggested by PEPFAR specifically for the monitoring of PHDP programmatic activities. The UNAIDS Policy Framework[10] does not include indicators, but it recommends that M&E indicators cover the following areas:

- Stakeholder knowledge of Positive Health, Dignity, and Prevention framework/operational guidelines;
- Policy dialogue;
- Integration and services;
- People living with HIV involvement and leadership;
- Quality of programmes and services;
- Health outcomes;
- Prevention of new infections; and
- Human rights, stigma, and discrimination.

The UNAIDS/GNP+ PHDP Operational Guidelines[11] does include a list of suggested indicators. Many of these indicators are aligned with the Global AIDS Response Progress Report (GARPR)'s use of the following outcome and impact.

- % of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy. (Impact, GARPR)
- Recommended development of indicator(s) to assess quality assurance and improvement of health services for PLHIV (outcome).
- % of young women and men aged 15–24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject the major misconceptions about HIV transmission. (Coverage, GARPR)

- # of syringes distributed per person who injects drugs per year by needle and syringe programmes. (Outcome, GARPR)
- % of adults aged 15–49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse. (Outcome, GARPR)
- % of sex workers reporting the use of a condom with their most recent client. (Outcome, GARPR)
- % of people who inject drugs who report the use of a condom at last sexual intercourse. (Outcome, GARPR)
- % of people who inject drugs who reported using sterile injecting equipment the last time they injected. (Outcome, GARPR)
- % of PLHIV who used a condom at last sex (of those who are currently sexually active). (Outcome GNP+ Positive Health, Dignity and Prevention Questionaire)
- % of PLHIV who have not had an STI since being diagnosed HIV-positive (of those who are currently sexually active). (Outcome, Global Fund HIV)
- % of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission. (Coverage, GARPR)
- % of PLHIV who have been denied sexual and reproductive health services because of their HIV status. (Outcome, PLHIV Stigma Index)
- % of PLHIV who have ever taken positive action to respond to gender-related negative situation (filed complaint, sought help, etc.). (Outcome, GNP+ Positive Health, Dignity and Prevention Questionnaire)
- % of PLHIV who have never experienced negative situation (including abuse, denial of support, etc) after HIV diagnosis because of their gender. (Outcome, GNP+ Positive Health, Dignity and Prevention Questionnaire)
- % of PLHIV who never experienced any discriminatory experience in the past 12 months. (Outcome, GNP+ Positive Health, Dignity and Prevention Questionnaire)

Additionally, UNAIDS/GNP+ PHDP Operational Guidelines[11] contains a list of tools that can be helpful in monitoring of PHDP programs. These included the People Living with HIV Stigma Index,[14] the Greater Involvement of People Living with HIV/AIDS (GIPA) Report Card,[15] the Global Criminalization Scan,[16] Human Rights Count!,[17] Global Database on HIV-Specific Travel and Residence Restriction,[18] and the Treatment Monitoring and Advocacy Project.[19] Those documents were used in an assessment conducted in Kenya to identify barriers to PHDP implementation.[13]

In terms of alignment between the indicators listed in the Botswana-specific documents and those suggested by UNAIDS/GNP+, there was little overlap. One indictor in the Botswana documents, % of person ages 15-49 years who have tested with the last 12 months and know their HIV status, was included in the UNAIDS/GNP+ Operational Guidelines, but UNAIDS/GNP+ suggest that it is expanded to also include, men-who-have-sex- with- men, intravenous drug users, and sex workers. Additionally, "% of HIV positive pregnant women accessing Universal HAART" was very similar to one of the indicators recommended by UNAIDS/GNP+.[11] **Given the lack of alignment between indicators listed in the Botswana PHDP documents and those suggested by UNAIDS/GNP+, a red color was assigned.**

While the objective of this desk review was not to evaluate the quality of the Botswana PHDP program, it is worth noting that the minimum set of indicators delineated in the Botswana PHDP Implementation Plans lack specificity and are not time bound. The measurability of many of these indicators will be difficult. While the indicators in the PHDP Strategy were, in some cases, more specific; they also were not time bound and may be challenging to measure. Attention to the development of a full M&E plan for the PHDP program is warranted.

Table 7. Outcome and impact indicators identified in the national documents

PHDP Strategy (2009-2016)[6]	PHDP Implementation Plans, 2010-2016[7]
Institutional capacity and capability	
• # of PLHIV receiving both prevention and care services from health facilities. • # of PLHIV receiving health facility based peer educators support. • # of PLHIV who received counselling services from treatment and care settings. • # of PLHIV referred by health facilities to CSOs for psychosocial support. • # PLHIV receiving PHDP services. • # CSO staff trained on project management. • # PLHIV who received condoms from CSOs. • # PLHIV referred from CSOs to health facilities. • # PLHIV received PHDP services from new support groups/CSOs. • # CSOs with and using PHDP monitoring tools. • # PLHIV receiving # of minimum PHDP packages from new CSOs. • # PLHIV receiving services after regular working times. • # PLHIV receiving services from additional staff.	• # of supportive policies and legislations reviewed and/or enacted. • Meaningful participation of civic bodies in the review and /or development of policies. • Stigma and discrimination index. • % of health facilities providing quality and cost effective services. • % of persons aged 15-49 years who have tested within the last 12 months and know their status. . • % of program M&E systems aligned to the national M&E framework. • Timely and consisted delivery of quality partner reports. • % of community structures providing quality and cost effective services. • % of health facilities providing quality and cost effective services. • # of dissemination forums at all levels. • % of partners guided by the national HIV and AIDS response information in the development of their programs.
Service delivery of integrated PHDP services	
• # PLHIV reporting practicing safer sexual behaviors. • % PLHIV with relevant knowledge on correct methods of HIV prevention. • # PLHIV who received supportive counselling according to guidelines. • # PLHIV who know their status. • # Organization providing counselling that are using monitoring tools. • # PLHIV screened for STIs. • # PLHIV diagnosed and treated for STIs. • # partners of PLHIV with STIs who were traced and treated for STIS. • # PLHIV receiving integrated HIV/SRH services. • # reduction of unwanted pregnancies among PLHIV. • # PLHIV receiving prevention from clinical settings. • # PLHIV adolescents receiving PHDP services. • # PLHIV who received condoms from clinical settings. • # health facilities monitoring PHDP. • # PLHIV educated on nutrition. • # PLHIV receiving good nutrition. • # adult PHIV who received supportive counselling. • # adolescent PLHIV who received supportive counselling.	• Improved access to quality services delivery to PLHIV. • Increased number of people who test for HIV. • Increased % of PLHIV practicing safer sex practices. • % of PLHIV who access integrated and comprehensive services. • Reduction in STI cases among PLHIV. • **% of person ages 15-49 years who have tested with the last 12 months and know their HIV status.** • **% of HIV positive pregnant women accessing Universal HAART.** • % VCT clients who access HTC as couples. • Timely and consistent delivery of quality partners reports. • % of HIV+ persons accessing integrated HIV/TB/SRH services. • % of children and adolescents accessing a package of HIV and AIDS treatment, care, and support. • % of population in need who access comprehensive quality community home based care (CHBC) services.

• # couple PLHIV who receive couple counselling. • # PLHIV with disability who received supportive counselling. • # PLHIV who know the status. • # service providers trained on integrated HIV/SRH services. • # PLHIV receiving integrated PHDP services.	
Empowerment of PLHIV and their families	
• % PLHIV reporting to have knowledge on risk behaviors. • # PLHIV receiving education from trained peer educators. • % of sexually active PLHIV reporting consistent and correct use of condoms. • % PLHIV reporting practicing safer sexual behaviors. • # PLHIV receiving counselling services from trained peer educators. • % PLHIV reporting disclosure to their partners. • % PLHIV adhering to treatment. • % PLHIV reporting positive living. • % PLHIV disclosed to the public. • # PLHIV disclosed to the public who report feeling participating in HIV and AIDS activities. • # PLHIV support groups with minimum standard of organizational management. • % PLHIV support groups involved in policy analysis and public dialogue on policy issues on advocacy activities. • # PLHIV attended national conference. • # PLHIV attended international conferences. • # people trained on stigma reduction activities. • # people reached with stigma reduction messages. • # people participated in community dialogues. • # PLHIV support groups that conducted community dialog on HIV and AIDS related stigma. • # stigma reduction campaigns conducted. • # CSOs involved in stigma reduction activities. • # PLHIV organization using training guidelines. • # PLHIV with income generating activities. • # PLHIV receiving support for poverty reduction. • % eligible PLHIV receiving food baskets. • % eligible PLHIV educated on HIV and nutrition. • % PLHIV who received information, education, and communication (IEC) materials on nutrition. • % eligible PLHIV counselled on nutrition.	

• # PLHIV households with nutrition projects.	

(Note: Bolded text indicates that similar indicators were proposed by UNAIDS/GNP+[11])

Conclusions

The goal of the Botswana PHDP program was well-aligned with the philosophy set forth by UNAIDS. The program focus and strategic objectives for the Botswana PHDP program were very general, while those provided by UNAIDS were more specific, which made direct comparison a challenge. The following activities, which are suggested by UNAIDS/GNP+, were not addressed by the Botswana PHDP program: education and literacy to empower PLWHIV; legal advocacy and activism for gay and lesbian populations; quality assurance of treatment, care, and psychosocial well-being services; and human rights. The minimum package of PHDP services to be offered in Botswana was well-aligned with that proposed by PEPFAR. There was a substantial lack of alignment between indicators listed in the Botswana PHDP documents and those suggested by UNAIDS/GNP+. Attention to the development of a full M&E plan for the PHDP program is warranted. Table 8 highlights the alignment and RAG color rating.

Table 8. Botswana alignment to international guidance across areas

PHDP Program	Alignment with international guidance and/or recommendations	RAG Color Rating
Goals	The goal of the Botswana PHDP program was well-aligned with the philosophy set forth by UNAIDS.	Green
Program Focus and Strategic Objectives	The program focus and strategic objectives for the Botswana PHDP program were very general, while those provided by UNAIDS were more specific. Direct comparison was challenging.	No color assigned
Activities	The following were not addressed by the Botswana PHDP program: education and literacy to empower PLHIV; legal advocacy and activism for gay and lesbian populations; quality assurance of treatment, care, and psychosocial well-being services; and human rights.	Red
PHDP Minimum Package	The minimum package of PHDP services to be offered in Botswana was well-aligned with that proposed by PEPFAR	Green
Indicators	There was a lack of alignment between indicators listed in the Botswana PHDP documents and those suggested by UNAIDS/GNP+.	Red

References

1. Republic of Botswana. *Botswana national policy on HIV/AIDS, 17th November 1993.*Gaborone: Ministry of Health AIDS/STD Unit; 1993.
2. Joint United Nations Programme on HIV/AIDS., World Health Organization. Report on the global HIV/AIDS epidemic 2008. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS) : World Health Organization (WHO); 2008.
3. African Comprehensive HIV/AIDS Partnerships (ACHAP). *The Frontline in the War Against HIV/AIDS in Botswana: Case Studies from the African Comprehensive HIV/AIDS Partnerships (ACHAP).* Gaborone, Botswana2002.
4. UNAIDS. *Report on the Global AIDS Epidemic.* 2013.
5. Botswana Ministry of Health. *National HIV Prevention Plan* 2009.
6. Botswana Ministry of Health. *Botswana National Positive Health, Dignity and Prevention (PHDP) Strategy (2009-2016).* 2009.
7. Botswana Ministry of Health. *National Positive Health, Digniy and Prevention Implementation Plan 2010 - 2016.* 2010.
8. Botswana Ministry of Health. *Positive Health, Dignity and Prevention Implementation Plan for Civil Society Organizations (2010 - 2016).* 2010.
9. Botswana Ministry of Health. *Positive Health, Dignity, and Prevention Training Curricula for Health Workers.* 2014.
10. UNAIDS, GNP+. *Positive Health, Dignity, and Prevention: Policy Framework.* Geneva: UNAIDS;2013.
11. UNAIDS, GNP+. *Positive Health, Dignity, and Prevention: Operational Guidelines.* Geneva: UNAIDS;2013.
12. PEPFAR. *Guidance for the Prevention of Secually Transmitted HIV Infections.* 2011.
13. National Empowerment Network of People Living with HIV and AIDS in Kenya (NEPHAK). *Positive, Health, Dignity, and Prevention in Kenya.* Nairobi, Kenya: NEPHAK,;2012.
14. UNAIDS, GNP+. http://www.stigmaindex.org/. Accessed 27 March, 2015.
15. GNP+. GIPA Report Card. http://www.gnpplus.net/about-gnp/areas-work/gipa/.
16. GNP+. The Global Criminalization Scan. http://criminalisation.gnpplus.net/v.
17. GNP+. Human Rights Count! http://www.gnpplus.net/resources/human-rights-count-key-findings-from-the-pilot-studies-in-kenya-nigeria-and-zambia/.
18. Global Database on HIV-Specific Travel http://napwha.org.au/organisation/global-database-hiv-specific-travel-and-residence-restrictions. Accessed 27 March, 2015.
19. International Treatment Preparedness Coalition (ITCP). Treatment Monitoring and Advocacy Project. http://www.itpcglobal.org/treatment-monitoring-advocacy-project.

Appendix 1. PHDP Desk Review Tool

PHDP
DESK REVIEW TOOL

DOCUMENT TITLE: _____
DOCUMENT CODE: _____
DATE DOCUMENT CREATED: _____
REVIEW DATE: _____
NAME OF REVIEWER: _____
PURPOSE OF THE DOCUMENT: _____

Systems Level: human and organizational capacity to implement PHDP
Does the document provide information related to human and organizational capacity towards PHDP implementation?

Human and organizational capacity	specified Yes / No	If yes, give a brief description of the findings from the document.
Goals or objectives		
Activities and processes		
Outputs, outcomes		
Targets or indicators		
Training materials		
Other: (Specify) _____		

Service delivery: completeness and quality of PHDP programs
Does the document provide information related to the completeness and quality of PHDP programs?

Service delivery	specified Yes / No	If yes, give a brief description of the findings from the document.
Goals or objectives		
Activities and processes		
Outputs, outcomes		
Targets or indicators		
Training materials		
Other: (Specify) _____		

Uptake of services: risk reduction actions by PLHWAs
Does the document provide information related choice made by PLWHAs relative to PHDP

Uptake of services	specified Yes / No	If yes, give a brief description of the findings from the document.
Goals or objectives		
Activities and processes		
Outputs or outcomes		
Targets or indicators		
Training materials		
Other: (Specify) _____		