

***Botswana Network on Ethics, Law and
HIV/AIDS (BONELA):***

Organisational Strategy 2013 - 2016

OUR VISION

Making human rights a reality in the response to HIV and AIDS epidemic in Botswana.

OUR MISSION

To promote a just and inclusive environment to prevent HIV infection and provide a greater quality of life for people affected by HIV and AIDS.

OUR STRATEGY

Aim 1 – Scaling up community response

To strengthen and scale-up a coordinated community response on health and human rights to maximise civil society impact on national HIV programming.

Aim 2 – Promote accountability

To increase accountability for health and human rights literacy among all stakeholders in the national HIV response

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BAIS	Botswana AIDS Impact Survey
BONELA	Botswana Network on Ethics, Law and HIV/AIDS
CSO	Civil Society Organisation
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IEC	Information, Education & Communication
LeGaBiBo	Lesbians Gays and Bisexuals of Botswana
LGBTI	Lesbians, Gays, Bisexuals, Trans-gendered and Inter-sexed
MARP	Most At Risk Populations
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
NACA	National AIDS Coordinating Agency
NGO	Non-Government Organisation
NSF	National Strategic Framework (I and II)
OSISA	Open Society Initiative for Southern Africa
OVC	Orphans and other Vulnerable Children
PEP	Post-Exposure Prophylaxis
PLWHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RHT	Routine HIV Testing
S&D	Stigma and Discrimination
SM	Sexual Minorities
SRH	Sexual Reproductive Health
SW	Sex Workers
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNHCR	United Nations High Commission for Refugees
WHO	World Health Organisation
WUSC	World University Services of Canada

EXECUTIVE SUMMARY

The Botswana Network on Ethics, Law and HIV/AIDS (BONELA) niche of focusing on the human rights of vulnerable and marginalised populations remains highly relevant and necessary in the response to HIV and AIDS in Botswana.

Since its formation in 2002, BONELA has advocated for a human rights approach to the national response to the HIV and AIDS pandemic. The organisation has made significant contributions to the development of policy and legislation, including the amended Employment and Public Service Acts, by lobbying for non-discriminatory practices in relation to health status and sexual orientation. The BONELA 2013-2016 Strategic Plan is aligned to the aspirations of Botswana's Vision 2016, the **Second Botswana National Strategic Framework for HIV & AIDS 2010-2016** (NSP 2010-2016), as well as the Millennium Development Goals. The strategy seeks to complement the HIV national response by addressing human rights and health related issues that specifically respond to the needs of vulnerable and marginalised populations.

Botswana's response to the HIV and AIDS epidemic can be seen in many respects as a model to be emulated by other nations; the health care system provides free anti-retroviral drugs to Botswana and the country has surpassed the prevention of mother-to-child treatment targets.

This notwithstanding, stigma and discrimination against people living with HIV (PLWHIV) continues to have detrimental effects on mitigating the impacts of HIV and is the greatest barrier to accessing prevention, treatment, care and support services. If a more conducive environment were created, more people would freely take up available life-saving services and live positively with the virus.

Furthermore, Botswana has made little progress in entrenching the rights of PLWHIV and other vulnerable and marginalised populations such as sex workers (SW) and men who have sex with men (MSM). The lack of protective legislation has led to frequent violation of rights. There are people being refused employment opportunities because of their HIV positive status and refugees and immigrants being denied antiretroviral drugs on the basis of their nationality.

The NSP 2010-2016 has also recognised women as most vulnerable to HIV and this is exacerbated by gender-based violence, lack of recognition of marital rape as well as lack of integration of HIV and other sexual and reproductive health services.

In this strategy, therefore, BONELA's vision and mission will be as follows with specific aims in place to address the issues outlined above:

OUR VISION

Making human rights a reality in the response to the HIV and AIDS epidemic in Botswana

BONELA will work tirelessly to create an enabling environment where people in Botswana most affected and vulnerable to HIV and AIDS have access to human rights knowledge, legal aid and a space to claim their rights and make better health choices.

OUR MISSION

To promote a just and inclusive environment to prevent HIV infection and provide a greater quality of life for people affected by HIV and AIDS

BONELA will facilitate the creation of an environment where Botswana's human rights and dignity are taken into account in policies, laws and practices.

AIM 1 – SCALING UP COMMUNITY RESPONSE

To strengthen and scale-up a coordinated community response on health and human rights to maximise civil society impact in the national HIV programming

We will expand and coordinate our network of CBOs, NGOs, the corporate sector and individuals across 16 out of 27 health districts in Botswana. Capacities of these organisations will be built/strengthened and these organisations mentored and monitored to engage in collaborative advocacy, to mainstream human rights and health issues in their interventions, to monitor health service provision within communities and to document human rights violations, such as being denied employment or access to anti-retroviral treatment (ART) due to assumed HIV positive status or treatment stock-outs.

We will also sub-grant to network member organisations to integrate rights-based health programmes that specifically respond to the needs of vulnerable and marginalised populations, including PLWHIV.

AIM 2 – PROMOTE ACCOUNTABILITY

To increase accountability for health and human rights literacy among all stakeholders in the national HIV response

BONELA focuses on advocacy for reform of policy, law and procedures to eliminate stigma and discrimination, and to enhance universal access to prevention, treatment, care and support services. To achieve reform in policies, laws and procedures, BONELA will continue to increase human rights and health literacy among all stakeholders, mainstream a human rights-based approach to health and HIV within the network, actively pursue strategic litigation of human rights violations, and engage with the government to build consensus on gender sensitive human rights, HIV, TB and related health issues.

OUR CORE VALUES

BONELA's work will be guided by a set of core values. These values are:

1. Botho

Literally translated as “humane behaviour”, Botho “defines a process for earning respect by first giving it, and gaining empowerment by empowering others. It encourages people to applaud rather than resent those who succeed. It disapproves of anti-social, disgraceful, inhuman and criminal behaviour, and encourages social justice for all.”

2. Integrity, accountability and transparency

We will conduct our business in a transparent manner, truthfully accounting to our stakeholders and partners.

3. Passion

We are driven in our work because we passionately believe in what we do and what we strive for: making human rights a reality in the response to the HIV and AIDS pandemic in Botswana.

BONELA also adheres to the following principles:

Human rights

We will address human rights in our HIV programming. Rights such as the right to information, the right to the highest attainable standard of health, the right to privacy, and the right to freedom of association must be protected and promoted in order for all members of society to meaningfully participate in community action on HIV. Those most at risk of HIV infection are often legally and socially marginalised (such as women, men who have sex with men, and sex workers) and the protection and promotion of their human rights is imperative for an effective HIV response.

Reducing stigma

We will work to reduce stigma through all our programming activities. Fear of social isolation, rejection or violence leads many people to hide their HIV status and prevents many more from getting tested or accessing information and services.

Greater involvement of people living with HIV (GIPA)

We are committed to meaningfully involving all vulnerable people, particularly those living with HIV, in all aspects of the response to the epidemic in Botswana.

We will support implementing NGOs and community-based organisations to ensure that all voices are heard, and that interventions are designed to identify and address inequalities such as those based on gender, wealth, age and perceived place in society. These unequal power relations have a significant impact upon individuals' vulnerability to HIV.

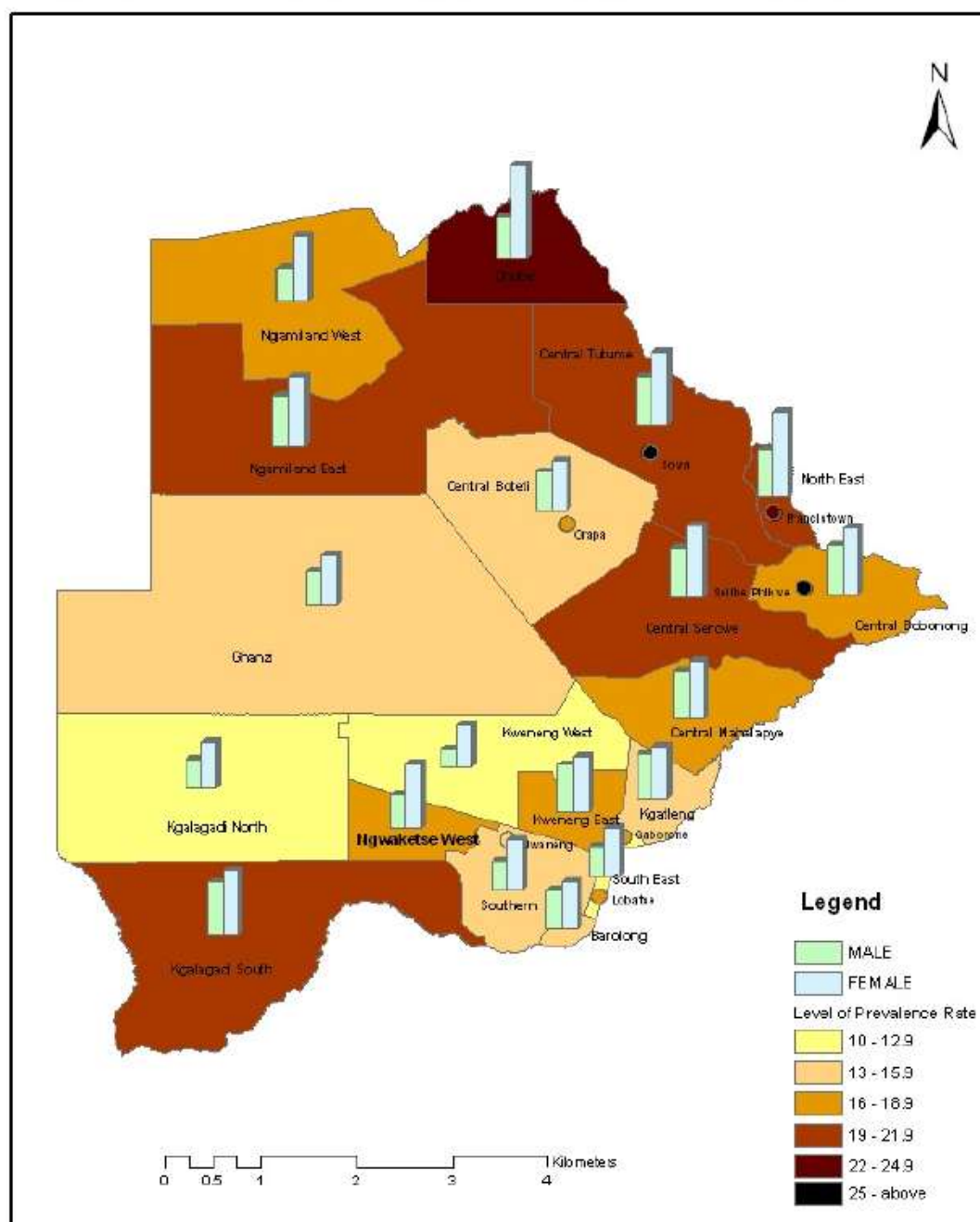
BOTSWANA: THE HIV EPIDEMIC AND BONELA'S ROLE

Botswana has a generalised epidemic, i.e. primarily driven by sexual behaviour in the general population (for a more complete review please refer to Annex 1).

Element	Figures	Sources of data
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Population size	2 million people	Population census; CSO 2011
HIV Prevalence Rate	17.6%	3 rd Botswana AIDS Impact Survey (BAIS); 2008
HIV prevalence among pregnant women	30.4%	ANC Sentinel Surveillance Survey; 2011
HIV Incident Rate	2.7%	ANC Sentinel Surveillance Survey; 2011
Number of people living with HIV	350,000	EPP Spectrum; MASA 2011
Number of people on ARVs (ART)	178,684	EPP Spectrum; MASA 2011
Number of HIV+ in need of ART	185,963	EPP Spectrum; MASA 2011
ART Coverage	96.1%	EPP Spectrum; MASA 2011
Age cohort mostly affected by HIV	15-49years	3 rd Botswana AIDS Impact Survey (BAIS); 2008
Geographical areas mostly affected	See map below	3 rd Botswana AIDS Impact Survey (BAIS); 2008

Map: Estimated HIV Prevalence Rates Among Botswana Population Aged 18 Months and Above by District and Gender. (3rd Botswana AIDS Impact Survey (BAIS); 2008)

ESTIMATED HIV PREVALENCE RATES AMONG BOTSWANA POPULATION AGED 18 MONTHS AND ABOVE BY DISTRICT AND GENDER



Source: Botswana AIDS Impact Survey III, December 2008.

Botswana is ranked as one of nine Southern African countries where more than 10% of the population is infected with HIV. The NSF II notes that Botswana has a generalised heterogeneous and hyperendemic HIV epidemic with a prevalence rate of 17.6% among the generalized population. UNAIDS estimates 23.9% of adults 15 to 49 years of age are HIV positive¹, and despite recent surveys suggesting that the HIV prevalence in Botswana may have reached a plateau with the rate of new infections possibly slowing, the country

¹UNAIDS / NACA, Botswana Country Report 2010, pg. 23

continues to face enormous challenges in dealing with the multiple impacts of the epidemic. Approximately 17.6% of the population aged 18 months and above is HIV positive. The corresponding prevalence figure in the 2004 Botswana AIDS Impact Survey II was 17.1%.

The focus of BONELA's interventions is to protect and advocate for the rights of vulnerable and marginalised populations, vulnerabilities that are based on health and socio-economic status, geographical area, gender, sexual orientation and identity. These marginalised populations have been identified as the most at-risk communities in the HIV and AIDS epidemic globally, where it is acknowledged that their quality of life in terms of broad health, social, and economic needs demand that HIV prevention and treatment efforts are built taking these into account.

Although Botswana is often cited as having one of the best health care systems in the region, the NSF II 2 states that stigma and discrimination continues to be one of the key drivers of the epidemic, presenting barriers to accessing services, particularly for vulnerable and marginalised populations. In this regard, BONELA will contribute towards stigma reduction in the national response to HIV by advocating for an enabling policy and legal environment.

Other health issues related to HIV

To ensure an improved response to all aspects of HIV (prevention, treatment, care and support) it is critical that strong linkages are made with the health sector. Access to appropriate barrier methods for HIV prevention; work to counter stigma and discrimination among policy makers and health service providers; interventions to focus on gender violence and sexual abuse as well as sexual and reproductive health rights and tuberculosis, are all examples of issues linked to HIV that could exacerbate morbidity if not integrated into the response. According to the Linking HIV and Sexual and Reproductive Health Rights in Southern Africa Report (2012)³, integration is undermined by an inappropriate policy and legal environment for key populations (KP), under-resourced interventions, stigma and discrimination and the unavailability of services to respond to gender-based violence. Although underlying determinants of HIV have been acknowledged, they are not properly integrated into the HIV prevention, treatment, care and support services.

There are other broad health conditions that also burden HIV infection, such as cancer, diabetes and hypertension. The Botswana National TB Evaluation Report of 2009⁴ showed TB is the number one threat to PLWHIV. Botswana has a co-infection rate estimated at 60–80%, with an estimated death rate of 60% among PLWHIV. TB/HIV integration has been poorly implemented; services have not been integrated and a community TB care model has not been rolled out, with a TB policy (defined within the Public Health act) that continues to discriminate against TB/MDR/XDR patients.

Women living with HIV continue to face stigma and discrimination related to accessing sexual reproductive health services and particularly when seeking maternal care services⁵. Although there has been a shift in mindsets, male involvement and participation in family

² www.bbca.org.bw/Botswana%20Nat%20Strat%20Fram%202010.pdf

³ Linking HIV and Sexual and Reproductive Health Rights in Southern Africa, 2012 report. Ministry of Health

⁴ Botswana National TB Evaluation Report of 2009

⁵ Linking HIV and Sexual and Reproductive Health Rights in Southern Africa, 2012 report

planning and childcare remains very low⁶, making women carry the responsibility of prevention, treatment, care and support, especially in the rural areas.

Moreover, access to voluntary counselling and testing (VCT) for youth is limited by the age at which they do not require parental consent (18 years), yet evidence has shown that sexual debut takes place below this age. This makes it very difficult for those under this age, to seek voluntary testing and counselling. The “one-size-fits-all” model to HIV prevention, treatment, care and support has further marginalised groups such as sexual minorities, prisoners and migrant workers.

This strategy will thus guide evidence-based collaborative advocacy on human rights, health and HIV through a coordinated community driven response. The strategy will also guide organisational systems for efficiency and effectiveness.

Alignment to national and international priorities

BONELA’s work is aligned to the aspirations of two crucial national strategy documents: A Framework for a Long Term Vision for Botswana (commonly known as Vision 2016) and the National Strategic Framework II (NSF II). Vision 2016 calls for a tolerant, healthy, just and caring society by 2016⁷, values that inform this strategy document.

The BONELA strategy is also aligned to NSF II priority areas to create a supportive environment for HIV prevention and care, so that communities are able to prevent new HIV infections and address the key drivers of HIV and AIDS, including stigma and discrimination, in order to achieve zero new HIV infections by the year 2016⁸.

BONELA’s human rights work is also guided by existing international instruments, declarations, protocols and treaties for human rights and health, including the Global Millennium Development Goals. As a member of the International HIV/AIDS Alliance (IHAA), BONELA is also aligned with its strategy and code of conduct.

⁶ Ibid

⁷ A Framework for a Long Term Vision for Botswana; August 1996

⁸ Botswana National Strategic Framework, page 24

BONELA STRATEGY 2013-2016

VISION

Making human rights a reality in the response to the HIV and AIDS epidemic in Botswana

BONELA will work tirelessly to create an enabling environment where people in Botswana most affected and vulnerable to HIV and AIDS have access to human rights knowledge, legal aid and a space to claim their rights and make better health choices. We will facilitate the creation of an environment where Botswana's human rights and dignity are taken into account in policies, laws and practices. To accomplish this, BONELA will strengthen and coordinate a body of civil society organisations that will collaboratively be the voice of marginalised groups.

MISSION

To promote a just and inclusive environment to prevent HIV infection and provide a greater quality of life for people affected by HIV and AIDS.

AIM 1: SCALING UP COMMUNITY RESPONSE

To strengthen and scale-up a coordinated community response on health and human rights to maximise civil society impact on national HIV programming

The BONELA Network

From humble beginnings back in 2002, BONELA is today working in six health districts (out of 27 nationwide) and has 20 member organisations across the country. We see the expansion of our network and increasing engagement of civil society in HIV and human rights issues as a key priority. By positioning BONELA as a network with national coverage we believe we can: maximize our collective efforts and impact to ensure a coordinated response to HIV and human rights issues, increase the weight we can bring by working together, and facilitate learning and sharing ideas across the network between experts, civil society organisations (CSOs) and affected populations. During the period of this strategy (2013-2016) we aim to expand to 16 districts and have at least 32 member organisations by 2016. We will expand progressively year on year, adding two or three districts per year, identifying and working either with existing organisations or, in districts without CSOs, helping activists to mobilise and organise, including supporting the registration of new entities where appropriate.

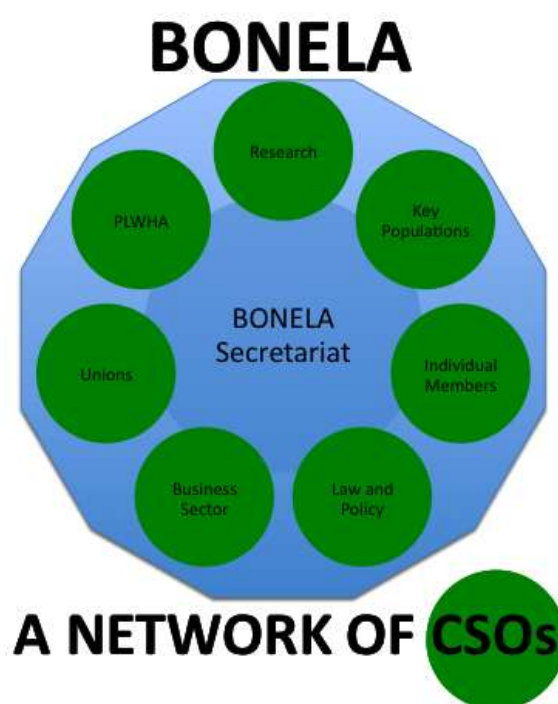
Developing a national network allows for effective identification of issues to be addressed and enhances support to community groups. A network facilitates dialogue among members on pertinent constitutional, strategic, programmatic and operational issues. The BONELA Secretariat will coordinate and manage the network operations and processes, as well as facilitating opportunities for sharing learning and good practices between members, taking advantage of emerging new technologies where appropriate and making accessible to members. BONELA's expanded network will also provide a forum for awareness raising and greater engagement of civil society by bringing together the combined weight of members in collaborative advocacy efforts such as advocacy for the provision of ART for foreign prison inmates or access to health insurance for employees in the informal sector. To guide this work, members will jointly develop and implement an advocacy strategy, which will include a key communications component.

Strengthening the network happens both through increasing network membership but also by strengthening members' capacities. BONELA will conduct CSO assessments, helping

CSOs put together and implement development plans, working with members to address gaps and weaknesses. Sharing good practices and learning is a key part of this work.

BONELA does not work alone, but has a number of strategic partnerships with regional and international organisations that support BONELA to achieve its objectives, with these partners providing technical capacity-building guidance to BONELA and its Secretariat. Among other partnerships, BONELA is a member of the International HIV/AIDS Alliance and has been a regional partner of Aids Rights Alliance of Southern Africa (ARASA) since 2007. These partnerships are important for BONELA and we aim to take advantage of them in order to help us to help the network, to share and exchange lessons and best practices and strengthen capacities. We will look to develop further partnerships where appropriate.

Figure 1: Concept Representation of the BONELA Network



AIM 1 Objectives

BONELA will:

- a. Expand and formalise the network for national coverage;
- b. Strengthen capacities of PLWHIV, key populations network members to mainstream a human rights focus throughout their work;
- c. Facilitate learning and exchange of best practices within the network;
- d. Strengthen the technical capacity of BONELA through alliances with collaborating partners, and
- e. Undertake collaborative advocacy through the network on issues of gender, human rights, health, HIV and vulnerable and marginalised populations for policy and law reform.

Case Study #1: Advocating for the Inclusion of Sexual Minorities



BONELA lobbies and advocates for inclusion of sexual minorities in HIV/STI interventions, and raises awareness on LGBTI issues. We support Lesbians, Gays and Bisexuals of Botswana (LeGaBiBo), an LGBTI organisation that has been denied registration. We provide them with *nesting* which refers to housing the organization while also providing mentoring and technical support.

Targets for 2016:

- People in 16 districts reached with human rights, health and HIV interventions by 2016;
- 32 organisations of PLWHIV and marginalised populations with increased knowledge of and mainstreaming rights, health and HIV interventions by 2016, and
- A minimum of five long-term collaborative advocacy initiatives for policy and law reform on human rights, health and HIV issues.

AIM 2: PROMOTING ACCOUNTABILITY

To increase accountability for health and human rights literacy among all stakeholders in the national HIV response

In the past few years BONELA has worked with its existing membership to increase health and human rights literacy among community members, network members and policy members to promote accountability for policies and service delivery. As new members in new health districts join the network in the coming years, BONELA will work with them providing support, guidance and training, organising community dialogues, legal outreach and comprehensive communications (including taking advantage of emerging new technologies such as mobile phone and internet technologies) in order to help them position themselves within the human rights environment.

Case Study #2: Providing free legal aid for HIV discrimination cases



In 2010 Obakeng Madubela (left), a 35 year-old woman, successfully sued another woman for invading her privacy by publicly disclosing her HIV status. Represented by BONELA, Obakeng was awarded US\$1,000 in damages. This is one example of the many stigma and discrimination cases that BONELA has handled through free legal aid services enabling access to justice.

In Botswana, BONELA is well-known for providing legal aid: in 2012 it provided legal aid to over 700 people, negotiating settlements out of court as well as helping individuals mount full-scale legal cases. In addition, every day it provides ad hoc legal advice via a telephone line. The organisation will document human rights violations through a variety of means, including monitoring the ongoing provision of legal aid, mounting specific strategic litigation cases and carrying out a number of pieces of research. All these approaches will gather evidence to support advocacy actions aimed to bring about policy and law reform on issues of human rights, health and HIV. This will include making policy submissions where appropriate. BONELA will also scale up its involvement in existing policy meetings at both district and national levels and will initiate additional fora where needed, bringing together key stakeholders.

Case Study #3: Sex workers' rights are human rights



March 3rd marks International Sex Workers' rights day. In 2012 BONELA, in partnership with sex worker organisation Sisonke Botswana, commemorated the day with a first ever sex workers march in Botswana under the theme 'Sex workers' rights = Human Rights'. During

the commemoration, sex workers publicly came out and identified themselves as sex workers. They shared their experiences of violence through personal narratives that revealed challenges regarding violations of their human rights which include extortion of sex workers' goods and money by clients and law enforcers.

One woman's account: My life

My name is Malebogo. I am a young woman of 23 years of age. I am a Motswana and I live in a town called Francistown. Due to unemployment I turned myself to selling my body as my source of income. In doing that I met lots and lots of challenges. In some cases I got arrested and I had to pay the police officers with sex to avoid being charged. There was a time I met a man, we agreed on a price and he took me to his house. He used me the whole night, insulting, beating, and forcing me to perform all such nasty [acts]... When I refused he would beat me more. In the morning he asked me to leave his house without even any cab money. He told me that sluts don't deserve to be treated nice because they are not people. I went home hurt and I knew that if I went to the police or hospital I was going to be humiliated because those people hate us.

AIM 2 Objectives

BONELA will:

1. Work through BONELA network members to increase human rights and health literacy among community members and policy makers;
2. Engage in existing policy meetings and create fora for civil society to come together with key stakeholders to increase opportunities for dialogue and joint action on human rights, health and HIV issues;
3. Engage with key policy makers for policy and law reform;
4. Conduct strategic litigation on human rights violations using legal aid evidence to achieve policy and law reform;
5. Collect evidence on human rights violations in Botswana through research, policy analysis, media, legal aid provision and community monitoring to inform advocacy for policy and law reform, and
6. Ensure that communities have access to relevant, updated and appropriate information on human rights, health and HIV.

Targets for 2016

- All stakeholders in 16 districts have increased access to information regarding their human rights, health and HIV.
- 10 advocacy fora held in 16 districts engaging civil society with key stakeholders and 4 national fora organised.
- 15 policy submissions for policy and law reform developed and submitted.
- Four strategic litigation cases used for policy and law reform.
- 1500 people accessing legal aid services.
- Evidence from four research initiatives, monthly media monitoring and quarterly community monitoring on human rights violations used to inform advocacy for legal and policy reform by 2016.

- One mid-term review and one final evaluation conducted documenting BONELA's contribution to the realisation of human rights in Botswana by 2016.

Case Study #4: Working with communities to address TB/HIV co-infections



Through public campaigns and forums, BONELA raises awareness and understanding around TB/HIV co-infection and advocates for integration of TB/HIV interventions. In 2010, BONELA initiated a 'TB Buddy' pilot project in two health districts. Using incentivized TB-Buddies who provided one-on-one Directly Observed Treatment (DOT) support to individual TB patients, the project demonstrated an improvement on treatment completion and cure rates, reduced defaulting, and strengthened the performance of Community TB Care.

RESOURCING THE STRATEGY

This strategy is ambitious and in order to bring about the vision that it presents, BONELA needs to focus on mobilising more resources. This section of the strategy focuses on how BONELA will both diversify and increase our resource base.

We define sustainability as the ability to:

- Maintain our core structure and capacity, regardless of the ebb and flow of project and programme funding;
- Mobilise resources in diverse ways from national, regional and international sources, appropriate to the context in which we work and therefore reducing our dependence on any one single funder. We particularly look to develop a balance of public and private partnerships, given the volatility of international aid spending and the opportunities we see within the region to partner with the private sector;

- Develop project proposals for a range of donors, either independently or in collaboration with partners;
- Independently and reliably manage the implementation and oversight of projects and programmes.

To this effect, a key first step will be to work with the support of an expert in resource mobilisation to develop a comprehensive resource mobilisation strategy, which will incorporate a range of innovative and forward-looking approaches to diversify and sustain our income. This may include exploiting fundraising opportunities offered through social networking and mobile telephones, accessing lottery funding in Botswana, and selling advertising space in our publications or other initiatives. We will also seek to capitalize upon our expertise in the provision of training and legal services and intend to create a commercial business arm that will administer these services.

In July 2011 one of BONELA's donors, Schorer Sticking, donated funds to buy a plot of land. In the coming years BONELA will seek partners to work with us to construct a building on this plot, which can be rented out, providing a reliable, long-term income to sustain the work of BONELA and its secretariat.

BONELA has a range of on-going and valued strategic partnerships: with Aids Rights Alliance of Southern Africa (ARASA) who builds BONELA's technical support around TB, HIV and human rights; with International HIV/AIDS Alliance, we have access to their technical hub, resources, organisational development and learning exchange; with Open Society Initiative of Southern Africa (OSISA), technical support for organisational development, and access to resources; Africa Sex Workers' Alliance (ASWA) offers technical support for Sisonke, a sex worker organisation; and with World University of Services of Canada (WUSC) which offers technical support around organisational development. These partners support BONELA not only in successfully securing funding, but also through offering technical support and building our core capacity. Over the course of this strategic period we aim to strengthen these partnerships and will look to enhance them where appropriate.

Resource Mobilisation Objectives:

1. Develop and implement a resource mobilisation strategy (or business plan) that is focused on raising funds to support the implementation of the BONELA Strategy 2013-2016, both for network members and for the Secretariat. This business plan will look to take advantage of opportunities to partner with both public and private entities and will include setting ambitious yet achievable annual resource mobilisation targets.
 - Together with network members, develop a resource mobilisation strategy.
 - Develop a multi-year implementation plan and annual action plans.
2. Diversify BONELA's funding sources, including engaging with the private sector through public-private partnerships that can assure the core costs of the organisation in the future.
 - Start implementing the business plan developed in objective one.
 - Identify (public-private) partners to fund the development of the BONELA plot of land and work with us to rent out the building.
 - Look for opportunities to market and sell BONELA's expertise, particularly legal and training services.
 - Establish a business arm to support BONELA and its beneficiaries. This will administer the provision of training and other services.
 - Seek accreditation of BONELA's training services through the Botswana Training Authority (BOTA) to be able to sell training services to individuals and corporates.

3. Position BONELA to access national, regional and international resources through strategic partnerships.
 - Continue to work together with existing partners, looking to consolidate and maintain these relationships.
 - Identify new potential partners and donors (both institutions and donors) in order to support our expanded work.
 - Identify friends of BONELA to mobilise funding on behalf of the organisation (locally and internationally), including exploring the possibility offered through creating long-term legacies.

ORGANISATIONAL EFFECTIVENESS

This section of our strategy focuses on work we need to engage in to ensure that BONELA has the governance, human resources, financial and programme management capacity it requires to achieve the goals set-out in this strategy and support and serve the network to achieve the goals and objectives described in this strategy.

For this, building and consolidating the strengths and capacities of the BONELA Secretariat is key so that it is well placed to support the BONELA network and able to deliver on this strategy. After several years of rapid growth, 2011-12 were difficult years for us and like many other organisations in Southern Africa focusing on HIV and AIDS, we were obliged to cut jobs as our funding base declined. Following the downsizing, the BONELA Secretariat needs to re-structure itself so that it has the skills and capacities that are required to deliver the priorities defined in this strategy.

The first step in this process is to carry out a full organisational audit and develop an appropriate core organisational structure, one that can grow or shrink in response to changing funding patterns, while retaining the key expertise required to support the network. A focus on building the BONELA Secretariat's own organisational capacity so that it is able to deliver capacity building to its membership will be important, as well as reviewing and updating all organisational policies.

We also intend to improve our monitoring and evaluation capacity so that we can clearly demonstrate the impact that the work of BONELA is having. As part of this, we will fully institute the International HIV/AIDS Alliance's Monitoring and Reporting System (MRS) to enable reliable, consistent, results-based reporting.

For a network such as ours, exploiting the opportunities that information technology offers us both to connect with our members (and allow them to connect with each other) as well as to raise awareness, campaign and lobby is vital. At the same time we are aware that many of our members may not have the level of connectivity that they require to function effectively. Carrying out an assessment of members' information technology needs will help us to identify key gaps and start to address them through our programmes, as well as giving us the basis to put together a communication strategy to support our members.

Finally, we remain committed to ensuring that we maintain the highest governance standards. Our board meets quarterly, convenes annual general meetings (AGMs) bringing together our entire membership, and undertakes annual reviews of its own performance in order to hold itself to account. In the years of this strategy the board will orient its work around leading the organisation to deliver its strategic objectives. Additionally it will convene a network forum every two years following the AGM, in order to evaluate achievements and guide the advocacy agenda for the subsequent years.

Organisational development priorities for BONELA therefore include:

- In 2013, conducting a full organisational skills audit and use the findings to put in place a new organisational structure for the BONELA Secretariat that will serve us in the following years;
- Developing and implementing an organisational capacity development plan. This will include reviewing and updating all BONELA policies (including policies relating to financial management, volunteer management, information technology, administration and communications), job descriptions and reviewing the salary structure of the Secretariat;
- Continually improving our monitoring and evaluation processes in order to develop better means of measurement, piloting new community-friendly methods, and sharing these with stakeholders. We also intend to fully adopt the International HIV/AIDS Alliance MRS system;
- After carrying out an assessment of the IT needs of both BONELA's network members and its Secretariat, developing and implementing an IT strategy and action plan to address key fundamental IT gaps;
- Developing and implementing a network communication strategy (linked to the IT strategy), to improve communications with network members and within the BONELA secretariat; and
- Convening a network forum every two years following the AGM, in order to evaluate achievements and guide the advocacy agenda for subsequent years.

To maximise organisational effectiveness we will additionally:

- Adhere to the Code of Good Practice for NGOs Responding to HIV, and model best practices with organisational development practices and systems;
- Adhere to good finance, human resource, governance and security practices, and
- Take a community-appropriate approach – we will act as a conduit between national and local, policy and practice, and as custodians of information and civil society.

IMPLEMENTING THE STRATEGY

The implementation of this Strategy will require on-going collaboration, commitment, and leadership, as well as adequate funding and support. Close working relationships with specific stakeholders such as the International HIV/AIDS Alliance Secretariat, partner organisations, the Government of Botswana, National Commission for HIV/AIDS, and the donor community will be crucial to realise the results of the strategy.

Successful implementation assumes that the political, economic and security situation in the country remains stable and that infrastructure development, which is already taking place, opens access to more remote and underserved communities. BONELA is determined to work closely with all partners to achieve its vision of a healthy Botswana free of HIV.

GLOSSARY

Capacity building: The process of enabling people, groups or organisations to build their knowledge, skills and resources, in order to undertake activities more effectively.

Civil society: The wide range of organisations and bodies that are not under direct government control and have a range of useful functions in support of a country's citizens. Broadly civil society includes community organisations, NGOs, private sector bodies and businesses. They can act as advocates and critics of government, mobilise communities and help shape policy. They can also provide health, social or economic support and services that complement, provide alternatives to, or fill gaps in government provision.

Community: 'Community' has no single or fixed definition; rather communities consist of people who are connected to each other in distinct and varied ways. Community members may live in the same area or they may instead be connected by shared experiences, challenges, interests, living situations, culture, religion, identity or values. Communities are both diverse and dynamic, and one person may be part of more than one community.

Community Systems Strengthening: CSS is a framework for the provision of HIV and broader health responses at the community level and a key element of the wider Health System Strengthening (HSS) framework. CSS develops the role of community-based organisations in the design, delivery, monitoring and evaluation of services and activities related to the prevention, treatment, care and support of people living with and affected by the major health challenges. The CSS framework highlights five key building blocks for community systems to function well: sustainable resources; quality programmes, activities and services; functioning community networks; linkages & partnerships; leadership and governance, and enabling environments for rights and equity of access.

Health Systems Strengthening: The HSS framework supports the building of sustainable public health systems.

Key populations: Key populations are groups that are at higher risk of being infected or affected by HIV, who play a key role in how HIV spreads, and whose involvement is vital for an effective and sustainable response to HIV. Key populations vary according to the local context but include vulnerable and marginalised groups such as people living with HIV, their partners and families, people who sell or buy sex, men who have sex with men, people who use drugs, orphans and other vulnerable children, migrants and displaced people, and prisoners.

Linking Organisation: The International HIV/AIDS Alliance is a partnership of strong, independent, national Linking Organisations with good international connections, supported by an international secretariat. Where no local organisations exist and where a speedy response is paramount, the Alliance Secretariat has set up its own country offices as interim Linking Organisations.

Livelihoods: Livelihoods are made up of the means and activities needed for sustainable living, which can cope with the stresses and shocks of unforeseen and unavoidable events. Securing livelihoods for people living with and affected by HIV is particularly important as HIV increases their economic, social and physical vulnerability.

Stakeholder: A person, group, or organisation that has a direct or indirect stake in an organisation because it can affect or be affected by the organisation's actions, objectives, and policies.

ANNEX 1 – Socio-Economic and HIV Context in Botswana

Socio-economic and Political Context

Since independence, Botswana has had uninterrupted civilian leadership, and significant capital investment has created one of the most dynamic economies in Africa. However, at 26.2%⁹ the country has high rates of unemployment and 49.4% of the population lives below the poverty datum line.

Botswana is a multi-party democracy consisting of the executive, legislature and judiciary structures. The country has held general elections consistently since independence in 1966, with the Botswana Democratic Party remaining in power since then. The President is both the head of state and head of government. There is little understanding of human rights, democratic principles and processes by the general public and how elected politicians can be held accountable.

Currently the government spends approximately 6% of Gross Domestic Product (GDP) on health¹⁰. Although Botswana is one of the few African countries that met the 15% quota towards health, the recent global financial crisis, which affected the diamond industry, has put a strain on the national economy and expenditure targeted towards the HIV/AIDS response. In addition, with Botswana moving into the category of a middle-income country, donor funding has decreased.

Botswana are a proud nation who have maintained their traditional values and conservative culture. Botswana's society is mainly patriarchal although the civil Marital Power Act of 2004, which gave husbands absolute powers over wives, has been abolished. Due to cultural and economic gender inequality, women are disempowered to negotiate safe sex. Women have a higher rate of unemployment than men. According to the Botswana AIDS Impact Survey III (BAIS III)¹¹ unemployment rates are 21.9% for men and for 31.2% women, with female unemployment being higher in rural settings, where there are higher levels of poverty¹². Gender inequality with respect to wages is also very high, with Botswana women earning 58% of wages earned by their male counterparts¹³.

Gender-based violence has been identified as one of the key drivers of HIV/AIDS in the second National Strategic Framework. Sexual Reproductive Health (SRH) for women living with HIV has been effectively dealt with at national level, owing, in part, to BONELA's efforts. However, there is need to intensify monitoring and to focus on SRH for other MARPs, such as sex workers, and LBT women. Currently the government provides post-exposure prophylaxis (PEP) in cases of abuse and rape. In addition, the government has passed the Domestic Violence Act, in an effort to decrease this type of violence. However, it is noted that the legislation does not acknowledge rape in marriage. This omission potentially exposes women to HIV infection and limits their right to justice.

In spite of the above socio-cultural issues, a lot has been achieved since 2007 and anecdotal evidence further suggests a shift in attitudes and mindsets amongst the urban general public towards sexual minorities. For example, the former President of Botswana, Mr Festus Mogae has openly called for non-discrimination of sexual minorities.

⁹ 2008 Botswana AIDS Impact Survey: Stastical Report (BAIS III), National Aids Coordinating Agency (Botswana).

¹⁰ WHOSIS. (2010). World Health Statistics 2010. (http://www.who.int/entity/whosis/whostat/EN_WHS10_Full.pdf). Accessed, 27th September, 2010.

¹¹ 2008 Botswana AIDS Impact Survey: Stastical Report (BAIS III), National Aids Coordinating Agency (Botswana).

¹² Ibid, Preliminary Results: BAIS III. May, 2009.

¹³ UNDP. Human Development Reports. (<http://hdr.undp.org/en/reports/global/hdr2009/>), 2009. Accessed 27th September, 2010

According to police records there is a significant increase in child sexual abuse such as incest and defilement. Stigma and discrimination towards children/adolescents who are living with disabilities, LGBTI and those living with HIV is still prevalent.

In Botswana prisons, anecdotal evidence points to HIV transmission through voluntary and involuntary sexual activities. However, there is no access to barrier methods for prisoners and no access to treatment for foreign inmates.

Botswana ARV policy does not include non-nationals, that is, refugees and migrants in the treatment programme.

Sex work is illegal in Botswana hence there is insufficient data about the issue. However, several studies conducted in the region suggest very high HIV prevalence rates in this group, some estimates being as high as 69%. Research suggests that sex work is a critical node in the spread of the epidemic. Stigma and discrimination at the hands of health service providers and harassment by the police fuel the risk of HIV transmission as they limit the chances of sex workers' consistent access to prevention services.

The Constitution of Botswana, which is the foundation of laws in the country, was written at Independence in 1966 and has not been reviewed since then to accommodate emerging socio-cultural issues such as diversity amongst people. Whilst it recognizes certain civic rights, it does not protect the right to health, a prerogative in the era of HIV/AIDS and other diseases, as well as their determinants.

HIV in Botswana

Botswana has a generalized heterogeneous and hyper-endemic HIV epidemic with a prevalence rate of 17.6% among the generalized population¹⁴. UNAIDS estimates 23.9% of adults 15 to 49 years of age are HIV positive, but recent surveys show the rate of new infections could be slowing. Despite evidence that the HIV prevalence in Botswana has reached a plateau, the country continues to face enormous challenges in dealing with the multiple impacts of the epidemic. Approximately 17.6% of the population aged 18 months and above is HIV positive¹⁵. The corresponding prevalence figure in the 2004 BAIS II was 17.1%. Prevalence in both urban and rural areas decreased between 2001 and 2006, according to UNAIDS, and the percentage of 20- to 24-year-old antenatal clinic attendees who were HIV-infected fell from 38.6% in 2003 to 24.3% in 2009. As services for the prevention of mother-to-child transmission of HIV (PMTCT) have been brought to scale there has been a steady decline in the proportion of infants born to HIV positive mothers who are infected, with the proportion decreasing from 20.7% in 2003 to 3.8% in 2007¹⁶.

The Government has implemented some of Africa's most progressive and comprehensive programs for dealing with the epidemic. Of note: the MASA program launched in 2002, which provides free ARV treatment to all citizens (it has reached 95% of those who need it); the prevention of mother-to-child transmission (PMTCT) program (launched in 2000); the routine HIV testing (RHT) program (launched in 2004), and more recently, the National Orphan Care Program. In addition, the Government has also invested significant resources in building infrastructure, setting up hospitals, clinics, health posts and mobile clinics, to improve access to health services for the majority of the population. In 2007, 89% of Botswana lived within an 8 km radius of a health facility¹⁷.

¹⁴ NSF II, pg. 9.

¹⁵ From the 2008 Botswana AIDS Impact Survey III Results (BAIS), Stats Release, pg. 16.

¹⁶ UNAIDS / NACA, Botswana Country Report 2010, pg. 29.

¹⁷ Central Statistics Office, Stats Brief: Access to Health Services in Botswana. Gaborone, Botswana. August 2007.

As noted by UNAIDS, the government demonstrated strong political will in funding these and other initiatives¹⁸. However, such levels of funding will not be sustainable in the long-term. Recognising this, the Botswana government has set the ambitious Vision 2016 goal of zero transmission by the year 2016, with a focus on prevention¹⁹.

Despite these ongoing efforts, findings from the second and third Botswana AIDS Impact Surveys (BAIS II and III) show that HIV prevalence from 2004 to 2008 has shown a slight increase (17.1% to 17.6%)²⁰. In addition, incidence in 2008 was 2.89%²¹. These statistics indicate that the national approach may be too broad and needs to be refined and targeted, as suggested in the mid-term review of the first National Strategic Framework for HIV and AIDS (NSF I)²².

The Government of Botswana has helped to ensure that the national response to HIV prevention was inclusive of civil society organisations (CSOs), to the extent that these organisations sit in all national structures of the National Strategic Framework (NSF). In addition, a strategy to strengthen the capacities of CSOs to effectively respond is being developed under the auspices of the National AIDS Coordinating Agency (NACA).

The *National Strategic Framework 2011-2016* identifies five key drivers of the epidemic that still present major obstacles to preventing new HIV infections: (i) multiple and concurrent sexual partnerships; (ii) adolescent and inter-generational sex; (iii) alcohol and high risk sex; (iv) stigma and discrimination, and (v) gender violence and sexual abuse. Stigma and discrimination in relation to people living with HIV has been a significant and enduring challenge since the origin of the epidemic. Although Botswana society has begun to engage in discussions on the rights of MARPs in HIV and AIDS interventions, shifts in perceptions and behaviour have been insignificant. The underlying drivers of the epidemic, most of which relate to relations and interrelations surrounding MARPs have remained insufficiently addressed.

18 UNAIDS & NACA. (2010). *Progress Report on the National Response to the 2001 Declaration of Commitment on HIV and AIDS: Botswana Country Report 2010*. Gaborone, Botswana.

19 National AIDS Coordinating Agency. (2010). *Second National Strategic Framework for HIV and AIDS 2010-2016*. Gaborone. Botswana.

20 Stats Brief: Preliminary Results, Botswana AIDS Impact Survey III, 2008. Central Statistics Office. May 2009.

21 Ibid, Preliminary Results: BAIS III. May, 2009.

22 National AIDS Coordinating Agency. (2003). *National Strategic Framework of Botswana for HIV/AIDS, 2003-2009*. Gaborone, Botswana. Gaborone, Botswana.