

**IMPLEMENTATION OF THE HIV/AIDS INTERVENTION
PROGRAMS IN BOTSWANA:**

**STRENGTHENING THE MANAGEMENT AND
PROGRAMMING CAPACITY OF THE DISTRICT MULTI
SECTORAL AIDS COMMITTEES**

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DECLARATION

I, Isaya Banda declare that the dissertation for the Masters Degree of Business Administration at the University of North West hereby submitted, has not previously been submitted by me for a degree at this or any other university, that it is my own work in design and execution that all materials contained herein have been duly acknowledged.

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AUGUST 2004

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I hope this research will contribute to the strengthening of the DMSACs and decentralized response through the development of intervention programmes that will substantially reduce the number of new infections in the districts.

ABSTRACT

This study sets out a detailed approach to responding to the HIV/AIDS situation in the Districts. The priority areas or targets of the response are derived from what has been learnt from the situation and the elements of the response to date. This study could be used by the management District Multi-Sectoral AIDS committees (DMSACS) to develop specific intervention programs and ensure effective implementation.

The priority areas for the response to HIV/AIDS in the districts are deemed to be:

- (1) behaviour change communication (BCC);
- (2) condom promotion and distribution;
- (3) sexual health education for the different social groups;
- (4) community mobilization and participation; and
- (5) training of personnel/community members at district level in the following areas:
community counselling, peer education and project management.

These priority areas can be regarded as the macro planning framework. Following from the priority areas, there are some key elements in need of response. These constitute the micro planning framework and for each there are a set of initiatives to meet their respective objective.

The first key element in need of response is men. The objective is to both increase awareness and improve the sexual knowledge of men so that they can be channeled in a positive manner toward behaviour which reduces the risk of HIV infection. Men deserve to be targeted for their own sake, for women's sake and for the health of their families and communities. The two initiatives proposed to meet the objective in this element are behaviour change communication campaigns, using traditional structures, non-governmental organisations and churches as the primary forums.

The second key element of the response pertains to women. Women are at greater risk than men in becoming infected with the HIV or sexually transmitted infections (STIs). At the same time, they have little or no control over how and when they have sex with their partners. They are perhaps the most vulnerable group in society. The objective here is to empower men while at the same time promoting gender awareness in behaviour change communication activities. Three initiatives are to be pursued in the context of this objective:

- (1) behaviour change communication campaigns to combat risk behaviour about HIV/AIDS, and other STIs, and to build safer norms through the specific gender awareness elements of those campaigns;
- (2) counselling services related to HIV/AIDS and other STIs as well as the associated promotion and distribution of condoms including the female condom;
- (3) development of income-generating schemes or the creation of opportunities for women to participate in such schemes.

The next key element relates to the youth. The youth, like women are also a very vulnerable group. They have high rates of teenage pregnancy and STIs infections as a result of unprotected sex. They face serious health risks due to limited factual information, too little guidance about social responsibility, and insufficient access to relevant health care. The objective is to reach out to young people to educate them about sexual health and their role in promoting safer sexual behaviour for themselves and their peers. The three initiatives for achieving this objective are:

- (1) design and implementation of in school and out of school sexual health education programmes
- (2) delivery of HIV and other STD health care services and counselling specifically for young people
- (3) promotion and distributions of male and female condoms in convenient places other than clinics and health posts.

The fourth key element in the response deals with orphans. The extended family system can no longer be seen as guaranteeing assistance to, orphans due, primarily, to the cost implications and some residual fear of the disease. The objective here is to develop cooperative efforts by all levels of government CBOs, NGOs and churches to provide assistance for subsistence health care, counseling, shelter, education and training and property inheritance.

The fifth key element in the response is the community at large. Since the contacting and spread of HIV/ AIDS has interdependent impacts which have multiplier effects on the community at large, it is necessary that steps be taken to involve and assist the community as a whole to mitigate the spread and impact of the disease. The objective is to both mobilize and empower the wider community to take actions to control the spread of HIV / AIDS and improve the quality of life of those affected. The only initiative required here is to facilitate grassroots participation in the development and implementation of appropriate elements of the response.

The other key elements pertain to develop human capital required to respond to this epidemic effectively. The human resources and equipment necessary to mount a credible response to the HIV/AIDS epidemic in districts is most inadequate. There does not exist a sufficient number of community counselors, peer educators and project managers nor staff at district level required for sustaining response activities. Consequently, the objective in this area is to both acquire and train personnel within the district councils and at community level.

The final element is ensuring that DAMSACs have a strengthened capacity for management and programming, which can only happen if District authorities develop specific project management, cost effective analysis tools and community counsellors in each District.

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CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Background

When AIDS emerged from the shadows two decades ago, few people could predict how the epidemic would evolve, and fewer still could describe with any certainty the best ways of combating it.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that in the year 2002, 3.1 million people died of AIDS. In addition in the same year, 42 million people were estimated to be infected with HIV. Despite anti-retroviral therapy, which reduced the number of deaths from AIDS in richer countries, this was a higher global total than in any year since the beginning of the epidemic. (Global AIDS Report 2000)

By the end of 2002, the epidemic had left behind a cumulative total of 14 million AIDS orphans (defined as those having lost their mother before the age of 15). Approximately half of all people who acquire HIV become infected before they turn 25 and typically die before their 35th birthday. Most have had children before they become infected and about 70% of children born to infected mothers will not, themselves, become infected. However, these children have an almost 100% chance of being orphaned. AIDS, therefore, is a unique disease as it has a major secondary effect as it impacts on the “bringing up” of children. The Global HIV/AIDS Report for 2000 states that, each day, 14,000 more people become infected with the HIV virus; half of them are between the ages of 15 and 24.

HIV/AIDS is rapidly reversing many of the social and economic gains won by developing countries over the past 50 years. AIDS is turning back the clock on development. In too many countries the gains in life expectancy won are being wiped out. Even in countries where prevention programmes have managed to cut the number of new infections to zero, deaths from those already infected will continue to mount for several years. (Global AIDS Report 2002)

1.1.2 The African Situation

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2002), HIV/AIDS is the leading infectious disease in the world, of the 42 million people infected at the end of 2002, 29.4 million live in sub-Saharan Africa. Of the 14 million children orphaned in 2002, 11 million of them are in sub-Saharan Africa. Yet sub-Saharan Africa contains only 11% of the world's population.

UNAIDS 2000 gives the following HIV Prevalence Rate in some sub-Saharan countries: Democratic Republic of Congo 4.9%, Nigeria 5.8%, Ethiopia 6.4%, Tanzania 7.8%, Côte d'Ivoire 9.7%, Cameroon 11.8%, Mozambique 13.0%, Kenya 15.0%, Malawi 15.0%, Zambia 21.5%, Lesotho 31.0%, Swaziland 33.4%, Zimbabwe 33.7% and Botswana has the highest of 35.4%.

AIDS is the worst infectious disease to hit Africa in recorded history. According to the World Bank, "deaths due to HIV/AIDS in Africa will soon surpass the 20 million Europeans killed by the plague epidemic of 1347-1351". In the past decade, 12 million people in sub-Saharan Africa have died of AIDS – one quarter being children. Each day, AIDS claims another 5 500 men, women and children. (In 1998 alone, AIDS accounted for 1,8 million deaths in sub-Saharan Africa, nearly double the one million deaths from malaria and eight times the 209 000 deaths from TB.)

In 2001, HIV/AIDS was the leading cause of death in Africa (*World Health Organization [WHO] 2001*), surpassing malaria, diarrhea, and acute respiratory diseases. In June 2001, a declaration of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS stated that "... Africa, in particular sub-Saharan Africa, is currently the worst-affected region, where HIV/AIDS is considered a state of emergency which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden".

The picture in Africa is mixed. The average adult prevalence rate is 8.4% but there is a wide range between countries and within countries. While North Africa is relatively free, sub-Saharan Africa is currently the epicentre of HIV and AIDS. Within sub-Saharan Africa, HIV/AIDS adult prevalence rates tend to be lower in Western Central Africa than in Eastern Southern Africa. "In West Africa, at least five countries (Burkina Faso, Ivory Coast, Nigeria, Togo and Cameroon) are experiencing serious epidemics, with adult HIV prevalence exceeding five percent." The countries in Eastern Southern Africa are

experiencing higher prevalence rates and therefore a greater urgency for action in terms of prevention and treatment programs. For example, Kenya (13.95 percent), Uganda (8.3 percent) and Zambia (19.95 percent) (*UNAIDS June 2000*) are countries where the USAID's rapid scale-up effort will significantly increase resources to combat HIV/AIDS in the next five years.

While HIV/AIDS is present throughout the population, youths and young women of childbearing age are of particular concern. UNAIDS estimates that 10.3 million people age 15-24 are living with HIV/AIDS and half of all new infections, more than 7,000 daily, are occurring among young people. Seventy percent of youths with HIV/AIDS live in sub-Saharan Africa. According to a study sponsored by Family Health International, half of all new infections are among 16-23 year-olds, and three-quarters of them are young girls and women (*Lamptey and Gayle 2001*). In some of the worst affected countries, adolescent girls are being infected at a rate five to six times higher than adolescent boys (*United Nations August 2001*). In South Africa, pregnant women in their 20s are the most affected group. By 1998, 21 percent of pregnant women under 20 were infected. In the country's Hlabisa District, 35 percent of pregnant women age 20-24 were infected, as were 23 percent of those age 15-19 (*U.S. Census Bureau June 2000*). This is because, despite differences in the growth and stage of the epidemic across the continent, the predominant pattern of transmission is similar in Eastern Southern Africa and Western Central Africa - older men infect younger women or girls. This means that strong prevention and treatment programs, especially aimed at young women of childbearing years and children, are urgently needed.

Other population surveys show that the infection levels in men are lower than in women in sub-Saharan Africa. On average, the 15 studies conducted in both rural and urban areas in nine different African countries suggest that between 12 and 13 African women are infected for every 10 African men. This implies that a future skewing of the demography of many African counties, with men outnumbering women, will occur.

1.1.3 African Nations' Responses to the Epidemic

The first cases of AIDS were diagnosed in a number of African countries during the period of 1983-1985. Diagnosis of AIDS cases was at first greeted with denial which induced complacency and outright indifference to the epidemic. There were also different responses from country to country and the diversity of the responses can only be understood from the perspective that Governments were doing so in a complex and dynamic socio-economic, political and cultural environment.

AIDS is only one of many problems being faced on the continent. It was within such an environment of suspicion, cynicism and declining economic performance that governments were responding to HIV/AIDS in Africa.

Caldwell (*Caldwell et al 1995*) suggests the following factors as being responsible for under- reaction to a problem of such severe consequence namely:

- (a) the fear of loss of tourist revenue if the disease is highly publicised
- (b) the lack of pressure from political leadership
- (c) the stigma associated with HIV/AIDS in the community.

These strategies soon became the template upon which National AIDS Programme (NAPs) in Africa were designed, implemented, monitored and evaluated.

During the past decade, African leaders were slow to recognize the problem of HIV/AIDS but now as the impact of AIDS continues to threaten African society African leaders are mounting a large-scale response to HIV/AIDS, targeting all sectors. More countries are openly discussing the problem, encouraging public dialogue, and debating national policy formulation for treatment in particular.

UNAIDS, United Nations Development programme, World Health Organisation and the European Commission, have provided financial and technical support focussing on blood safety and STD management as a way of preventing infection. In the case of Botswana, this included infrastructure development as well as capacity building at central government and district level in response to HIV prevention and care.

1.1.4 Botswana

Botswana is a landlocked country lying at the centre of the Southern African plateau. Four countries border Botswana: Namibia, South Africa, Zambia and Zimbabwe. With a population of approximately 1.7 million, and a total area of about 582 000 square kilometres, Botswana is a sparsely populated country. In 1991, it had a population density of 2.3 persons per square kilometre. Large parts of the country are sparsely inhabited due to the Kgalagadi (Kahalari) desert, which occupies approximately 87% of the land mass. The population is mainly concentrated along the eastern corridor, where there is arable land and rainfall is better. Botswana's population distribution is therefore skewed (*Botswana HIV/AIDS Second Medium Term Plan: MTP II 1997–2002*).

Road communication is well developed, and facilitates population movements within the country and between Botswana and neighbouring countries. Botswana's road infrastructure provides regional hub for movements of goods and services for her northern neighbours to South Africa and South African ports. Long distance truck driving, a common route for HIV infection transmission in many countries is a prominent feature of Botswana. (MTP11, 1997)

Botswana has one of the world's atypical settlement patterns. Traditionally, Botswana have three abodes: the village dwelling or homestead (often the principal home), the cattle post for cattle farming, and the lands area for arable farming. Some people have a fourth abode, an urban home. Rapid population movement revolves around these domains of abode in Botswana.

Botswana is among the few African countries classified as "Upper Middle Income" and between 1966 and 1991 its economy grew at an annual average rate of 13%. Mining, in particular diamond mining, has been the mainstay of the economy. In 1994/95 Botswana recorded a GNP of 12 177 million Pula and a per capita income (at current prices) of P8054. Although Botswana has one of the leading macro-economic and social indicators in the African region, poverty remains a major problem. The income gap between the poorest and the richest members of society in Botswana is high. The poorest, 40% of the population, get only 11.6% while the richest, 20%, get 59% (*MTPII 1997*).

The most recent available data show that 47% of the population live in poverty, 62% of these are in the rural areas while 38% are in urban areas. Female headed households form the majority of households living in poverty. The 1991 census data show that 47% of the households in Botswana are female headed and 52% of these are in rural areas. This level of poverty is likely to make most people living in the rural areas, and women in particular, vulnerable to HIV infection and less able to respond effectively to its consequences.

In common with other developing countries, Botswana has a young population structure. Data from the 1991 Census shows that approximately 29% of the population is below the age of fifteen. Forty-five percent of the population is aged between 15 and 49 years of age. This is the most sexually active section of the population and currently accounts for about 89% of the reported HIV cases in Botswana (*MTPH 1997*). People in this age group are also the most economically active and therefore very important contributors to the GDP.

Mobility between any of the three rural spheres of domicile and the rural areas is customary and frequent. It is therefore difficult to discern rural from urban people. The rapid interaction between various settlement types in Botswana may in large part explain the narrow gap between rural and urban HIV infection rates. The prevailing settlement patterns in Botswana may mean that a unified national response to the epidemic both in terms of prevention and mitigation may be more effective than one based on the urban/rural divide. The current HIV infection rates are largely concentrated in urban areas, but a high proportion of the rural population is also infected.

1.2 Statement of the Problem

Botswana has been documented as having the highest HIV infection rate in the world by UNAIDS. Despite having one of the best public health care systems in Africa, and a strong economic base, the Government's response to the pandemic has had minimal impact at district level. Botswana's implementation strategy of prevention and care is the operational model of UNAIDS which creates a centralized public health bureaucracy which, unfortunately, lacks active participation of communities in the planning and implementation of HIV/AIDS related programmes.

If Botswana has to attain its long term vision of an AIDS free generation by 2016, then concerted effort should be put in effective implementation of intervention programmes. ("By the year 2016, the spread of the HIV virus that causes AIDS will have stopped so that

there will be no new infections by the virus that year”: *Long Term Vision for Botswana 1997, p.9*)

1.3 Justification for this Study: To Examine Why is Botswana’s HIV/AIDS Related Programmes and Strategy Failing

Several approaches to prevention of HIV/AIDS were undertaken during the early stages of the epidemic in Botswana, but they have not reduced the numbers of people infected. The establishment of District Multi-Sectoral AIDS Committees was regarded as a new paradigm to strengthen the capacity of district authorities to efficiently manage and programme the HIV/AIDS intervention programmes.

The formation of the District Multi-Sectoral AIDS Committees is a variable strategy which can assist District authorities and communities to mitigate the impact of the epidemic and reduce new infections. So far, the twenty-four District Multi-Sectoral AIDS Committees currently operational, have made some head way in community mobilisation, orphan care and home based care. However, these DMSACs do not have the capacity to efficiently implement intervention programmes. Lack of strategic plans on development of human capital required to manage intervention programmes at grass root levels have hampered the twenty-four Districts from functioning effectively.

The multi-sectoral approach requires all the sectors to use their local knowledge to strategic advantage in the developing and implementation of prevention and care programmes. But public and professional concerns have observed there is a need for the District Multi-Sectoral AIDS Committees to formulate practical approaches to deal with the impact of intervention programmes. The District Multi-Sectoral AIDS Committees also need the right skills and strategic plans in order to provide guidance to all sectors involved at district level to enable them to respond effectively to this epidemic.

Guidelines on the functions and composition of DMSACs were drawn up by the Ministry of Health and the United Nations Development Programme. District authorities were not party to the initial stage of establishing these committees. This has contributed to operational and administrative problems faced by Districts. The lack of clear guidelines

specific to the needs of each District has resulted in instances where DMSACs failed to articulate and identify priority areas for prevention and mitigation responses.

It is crucial that District Multi-Sectoral AIDS Committees, have implementation plans which encourage development of human capital, skills development for managing the impact of intervention programmes and utilising structured methods for cost benefit analysis. Because resources are currently so constrained, it is imperative that available funds are spent for interventions that are cost-effective, i.e. interventions that avert a high number of HIV infections and treatment for those living with HIV/AIDS.

1.4 Significance of this Study

One aim of this study is to stimulate debate as to how District Multi-Sectoral AIDS Committees can assist to achieve Botswana's vision for 2016 by:

- ❖ Determining if human capital development and cost benefit analysis can be useful in enhancing the capacity of District Multi Sectoral AIDS Committees.
- ❖ Whether systematic programmes on human resources training and development should be a critical component of ensuring effective response and ownership of the intervention programmes.
- ❖ Motivate research units at the Ministry of Health and the University of Botswana to consider conducting research on the role and responsibilities of District Multi-Sectoral AIDS Committees.

While this study was underway the following two research questions were borne in mind:

1. Are the District Multi Sectoral Aids Committees (DMSAC) the only system that can drive district authorities and community leaders to implement intervention programmes that will ensure that Botswana experiences a reduced number of new infections?
2. Do the DMSACs do have a well established management and programming capacity to effectively implement intervention programmes?

1.5 Objectives of this Study

This study intends to assess the ability of the District Multi-Sectoral AIDS Committees to realistically program and implement the progression, and sustain the momentum, of the long term approach which is required to effectively and efficiently manage the HIV/AIDS Programmes at District level.

Systematic programmes, which focus on human resources training and development, should be a critical component of the intervention programmes to ensure effective response and ownership and this study will show that by developing human capital the capacity of District Multi Sectoral AIDS Committees will be enhanced.

The study will also discuss the utilization of cost benefit analysis models to ensure that funds are channelled to intervention projects which have the greatest impact.

To achieve this, the following will be undertaken:

- a) The role of District Multi-Sectoral AIDS committees will be examined to assess their effectiveness in the implementation of intervention programmes.
- b) It will be established whether the District Multi-Sectoral AIDS committees have played a key role in the national response of turning the pandemic around.
- c) Debate on the importance of strategic plans for development of human capital required to implement programmes at district level will be encouraged.

Finally, it is hoped that this study will encourage/stimulate debates in regard to how DMSACs can develop, implement and sustain long term intervention strategies to achieve the goal of the “Long Term Vision for Botswana” and will encourage research units at the Ministry of Health and the University of Botswana to conduct research on the role and responsibilities of District Multi-Sectoral AIDS Committees.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

As there is limited literature on the establishment and management of District Multi Sectoral Aids Committees (DMSACs) the researcher has had to rely on only two publications, the Botswana HIV and AIDS Second Medium Term Plan, MTP II 1997 - 2000 and the Botswana Human Development Report 2000 for information related to District Multi-Sectoral AIDS Committees. (DMSACs)

2.2 Botswana HIV and AIDS Second Medium Term Plan, MTP II (1997-2002)

Since the establishment of the District Multi Sectoral Aids Committees in 1998, The Botswana HIV and AIDS Second Medium Term Plan, MTP II (1997-2002) has been used as a blue print for the management of HIV/AIDS intervention programmes at district level. The first case of AIDS in Botswana was identified in 1985 and in response, the Botswana Government set up a minimum programme in 1986 under the Epidemiology Unit of the Ministry of Health. The major focus of this programme was to screen blood and blood products as well as ensuring supply and use of disposable needles throughout the National Health Services. The Government also invited the World Health Organisation (WHO) to provide technical assistance in developing a National AIDS Control Programme (NACP) which resulted in the creation of an emergency Short Term Plan (STP) in 1987 covering the period 1987-1989.

It is clear from the initial response to the epidemic that the Botswana government used generic approaches rather than assessing what factors contributed to the rapid spread of the virus within the different social groups and communities.

2.2.1 Short Term Plan (STP) of 1987

The Short Term Plan (STP) of 1987 is silent on whether local responses and experiences should be used during the implementation of the short term plan. This is despite the fact

that countries such as Uganda had started recording a decline in the epidemic due to effective implementation of district response (*UNAIDS Best Practice 2000*.)

The STP's focus was to increase national public awareness of HIV and to provide training for health workers in AIDS clinical management. This emergency plan was followed by the first five-year Medium Term Plan (MTP I) covering 1989-1993, whose strategies were:

- Strengthening epidemiological surveillance activities;
- Prevention of sexual transmission of HIV;
- Prevention of HIV transmission through blood and blood products;
- Prevention of perinatal transmission;
- Strengthening diagnostic management and infection control; and
- Setting up systems for monitoring and evaluation.

According to the UNAIDS Policy Analysis Paper 2000, national evaluations of the Short Term Plan (STP) of 1987 do not show any impact that intervention strategies that were undertaken during this period had on the epidemic, or whether the objectives of these strategies were achieved. Cohen (2001) also asserts that efforts to strengthening the capacity of local response should be part of the intervention programmes to this epidemic.

The Government of Botswana has also taken some additional measures to respond to the epidemic. In 1993, a National AIDS Policy was prepared and adopted through a Presidential Directive. The policy provides a guide and framework for a National Multi-sectoral response to the HIV/AIDS epidemic (*the Botswana HIV and AIDS Second Medium Term Plan, MTP II, 1997-2002*).

2.2.2 Second Medium Term Plan MTP II 1997-2002

Building on the narrowly focussed MTP I, preparations for a more expansive MTP II process began in 1994. It was much more thorough and participatory, and it drew in some hitherto largely excluded stakeholders, amongst them NGOs and private firms. Covering the 1997 – 2002 period, the MTP II has two overriding goals:

- to reduce HIV infection and transmission, and
- to reduce the impact of HIV and AIDS at all levels of society.

The new MTP II is distinguished by its multi-sectoral approach and an evident commitment to redress many of the shortcomings that plagued the earlier response phases. Importantly, the plan recognizes gender inequality as a prime determinant of HIV transmission, although, as with other HIV and AIDS responses in the southern African region, men's roles and duties in achieving gender equality seem overlooked.

A very substantial part of the MTP II exercise has been devoted to the analysis of the country's situation in relation with the HIV/AIDS epidemic, including the response given to it. This has resulted in the identification of a number of determinants which influence the spread of the HIV, as well as of the impact of the epidemic at different levels of the society. (*UNAIDS Policy Analysis Paper 2000*)

The UNAIDS Policy Analysis Paper 2000, brings another dimension to the relevance of synergy in the planning process of the district response to the epidemic. Although the strategic plans for the HIV/AIDS at national level integrated a multi sectoral approach in its interventions there was lack of clear guide lines on how the different stakeholders were doing to actively in district initiatives.

MTP II recommends that District Multi Sectoral Aids Committees (DMSAC) are the only system that can assist district and community leaders to implement intervention programmes that will have more impact on this epidemic. However, the MTP II does not provide DMSAC with clear guidelines on how to manage intervention programmes.

Some topics that most often play a role in the spread of the HIV epidemic, and which might have to be considered in the study of the obstacles or opportunities, do not appear among those examined in MTPII, e.g. religion, political and legal issues including Human Rights issues, the country's communication system, etc. It is not clear whether they were not examined or on the contrary were assessed and found not relevant to the specific situation in Botswana. (*The Multi-sectoral response to HIV: What does it mean? United Nations Development Programme UNDP 2000.*)

Despite the considerable efforts put into the analysis of the country and epidemiological situation, no real priority setting was done among the identified needs. For example, the study of the social and cultural background and the patterns of the epidemic and its factors (contributing to the epidemic) could probably have more explicitly identified *youth* as the *top priority* for targeted action and further analysed the obstacles and opportunities surrounding this target group. (*UNAIDS Policy Analysis Paper 2000*)

The study of the factors contributing to the epidemic sometimes gives the impression that they issues specific to Botswana, however, these studies show a rather general set of factors that could almost be valid for about any country. Factors contributing to HIV/AIDS in Botswana are hardly mentioned (e.g. coercive and obligatory sex, alcohol and substance abuse, commercial sex workers etc.) or are even said to be of rather limited importance for Botswana, such as illiteracy.

The lack of analysis on local factors that contribute to the epidemic with special reference to Goal 1: Reduce HIV infection and transmission will make it difficult for government to take focused action on prevention of new infections.

According to UNAIDS Policy Analysis Paper 2000, the same question of generalisation and non-specificity (to the Botswana situation) could be raised in regard to the study of the impact, and more specifically, the opportunities identified there. For instance: the extraordinary opportunity provided by the Government wanting to integrate HIV/AIDS activities into the district plans and budgets of the various Sectors.

Methods used in MTP II are meant to provide a comprehensive and yet flexible set of strategies to minimise the transmission of the HIV in Botswana. These methods, however, present certain limitations:

- * MTP II has not addressed the local factors that contribute to the epidemic at district level and strategies planned on the basis of generalized factors have no priority setting at all.
- * Strategies and interventions supposed to deal with less important factors seemingly get the same attention as those dealing with top priority issues. In situations where resources are scarce, implementing low priority actions may have a very high opportunity cost, and could lead to essential issues not being addressed.
- * Obstacles to an expanded response do not seem to have been taken into account. For instance information education and communication (IEC) interventions are planned to address virtually all issues, **while the lack of behaviour change, in spite of extensive and long lasting IEC activities, casts some doubts on its efficiency.**

The planning of further investigations concerning the adequacy of IEC in the given context could have been very beneficial for many aspects of the HIV/AIDS district programmes in Botswana.

Opportunities for an expanded response, identified in the MTP II, are apparently under-utilised and there was no specific tools identified which could be used to ensure effective implementation. For example: no particular vehicle was identified or named for the implementation of specific actions, albeit policy development, institutional strengthening or service delivery, even if some of them have already been active in their field for many years. (*The Multi-sectoral response to HIV: What does it mean? United Nations Development Programm UNDP 2000*) It was mentioned that multi-sectoral actors may choose to intervene, but MTP II could have seized the opportunity by providing guidelines for a participatory planning process to obtain the direct involvement and commitment of almost all sectors, thereby increase their sense of ownership.

Access to education is said to be generally good in the country, but the only mention of the school system in the MTP II was for compulsory Family Life Education.

Since the desire expressed by the Government to integrate HIV/AIDS actions into the 8th National Development Plan was a unique opportunity to greatly improve the sustainability of the national response, (*Situational Response of HIV/AIDS, Kweneng District 2000*) a much more explicit mention of the integration of such activities in District Sectoral Programmes could have greatly facilitated further advocacy work.

However, defining the MTP II is a pronounced shift away from seeing HIV and AIDS as primarily a medical and health challenge, towards recognizing its profound social, economic and cultural dimensions. If translated into practice, it will mark a major break through in the fight against the epidemic.

2.3 The Botswana Human Development Report 2000

The Botswana Human Development Report 2000 (*BHDR 2000*) states that: “*achieving the Vision 2016 target of no new HIV infections by Year 2016 and the strategic goal of an AIDS-Free generation requires bold, innovative, well managed and well resourced*

policies and strategies. These in turn require an understanding of the factors that drive and sustain the HIV and AIDS epidemic. Only then can the requisite policies, strategies and actions be developed” (BHDR 2000:25). Such an exercise however, begins with the understanding that the magnitude and patterns of the epidemic depend fundamentally on at least three factors.

i The biological characteristics of HIV.

This information is essential for understanding the pathogenesis and infectiousness of the virus, which in turn influence its spread through a community. For instance, research has shown that while the dominant strain of the virus in Southern Africa is HIV 1, there are nine different sub types of HIV-1 found in the region. The dominant HIV-1 sub-type in Botswana is sub-type C.

ii The quality and reach of interventions.

Treatment and care for people living with HIV and AIDS are crucial and need to be attended with great enthusiasm. To this end, the requisite responses should be strong and relevant in content and reach people. Thus, *“prevention measures work best when they are comprehensive and sensitive to the needs of particular groups in society” (BHDR 2000:25).* In this regard, poor people, commercial sex workers and prisoners require the understanding and compassion of policy makers and society rather than being judged, blamed, ridiculed and marginalised. As Desmond Cohen (*Development and the HIV Epidemic, 2001*) explains, *“Impact is a function of how operable particular interventions are in given circumstances”*.

iii The social context, behavioural and attitudinal factors:

HIV and AIDS feed on deficiencies in the choices made by individuals, households, communities and leaders at all levels, in regard to both sexuality and the type of response to the epidemic. (*International HIV/AIDS Alliance, 2002*) These choices occur in complex political, social and economic contexts. They are shaped among others by: poverty and deprivation; unequal social relations; income inequality; the dynamics of the family unit and social structures; migration; religion; cultural value systems and sheer ignorance. (*BHDR 2000*)

The Botswana Human Development Report 2000 further points out that while we tend to speak of a Botswana HIV and AIDS epidemic, there are in fact several small epidemics that are propelled by different combinations of factors. It is therefore crucial that national-

level principles, policies and strategies are developed with an allowance for fine-tuning at the local level.

Cohen (2001) approaches the management of HIV/AIDS programmes from a local government perspective. He points out that whilst political leadership and commitment at the national level are widely regarded as cornerstones of success in tackling is increasingly turning to the local government context, noting that, certain national level imperatives apart, the delivery level of HIV/AIDS programmes is inevitably local. The capacity for national HIV/AIDS programmes to absorb funds depends on spending at local level.

The Urban Management Programme: Regional Office for Africa also locates the centrality of local response in the fight against HIV/AIDS, (*Commonwealth Regional Health Community Secretariat (CRHCS) 2001*) notes that a local government response should be two-fold. It should include action internally targeting local government employees and action externally targeting the wider community. The former should be in a workplace policy that must be built around the principles of equality and equity, non-discrimination, responsibility, inclusion and human dignity whereas the latter should be responsible for protecting and promoting the health of all citizens. Within the context of an HIV/AIDS epidemic, this responsibility broadens to encompass minimising the personal and social impact of HIV/AIDS, challenging discrimination against people living with HIV/AIDS and supporting the mobilisation of communities and community responses to the epidemic. Only at the central level is there a need for a strategic response framework. Attention increasingly being focused on local responses and to the decentralisation of national HIV/AIDS prevention, care and treatment plans

In examining the pattern of the epidemic, D. Low-Beer and R. L. Stoneburner (*Evidence of Distinctive Communication Channels Related to Population Level Behaviour Changes and HIV Prevalence Declines in Uganda, 2002*), discuss the strong effect of social behaviour on the spread of HIV (such as multiple sex partners, homosexuality, gender equality, female exploitation, poor sex education, traditional practices, the mobility of the population groups, migrant workers), an issue which must be addressed if the situation is to change.

According to Low-Beer and Stoneburner (2002) the challenge of HIV and AIDS requires openness about HIV and AIDS and unity of purpose in addressing it. It requires incentives for people to know their status and to bring infected and uninfected people together to

respond effectively to the epidemic. Thus, it requires responsibility at all levels such that people living with HIV and AIDS have a responsibility not to pass the virus onto others.

(It is worth pointing out here that while the condom is regarded as an effective preventive measure for those who choose to indulge in sex, it is by large still rejected by some religious denominations. (E. C. Green: *The Impact of Religious Organisations in Promoting HIV/AIDS prevention, 2001*). In addition, officialdom is hamstrung from taking preventive action by denials that rape and consensual sex occurs behind prison walls.)

The Botswana Human Development Report 2000 notes the importance of expanding the range and quality of services available to HIV-positive people and breaking down the stigma associated with HIV and AIDS is important since it will bring the HIV and AIDS epidemics into the open. However, getting to such a situation requires an intimate understanding of the forces behind the spread of HIV and AIDS. (*AIDS in Botswana, 2000*)

In recognizing the formidable task at hand, the painful reality is that the valiant response by the Government of Botswana and its partners has not prevented the epidemic from spinning almost out of control. This must be confronted as the ultimate indicator of success of any AIDS prevention programme is the extent to which infection rates have been reduced. About one-third of the adult population in Botswana is now estimated to be infected with HIV. The impact on human development is already distressing. In the next few years, as the HIV epidemic is overtaken by an AIDS epidemic, that impact will become devastating (*BHDR 2000*).

Like the global response, Botswana's response was fraught with denial and ignorance; hobbled by the belief that HIV and AIDS could be tackled like any other infectious disease and hampered by the inability to recognise and confront the structural determinants of the epidemic. Policy makers and public health officials tended to concentrate on the tip of the iceberg. The epidemic could be halted, they assumed, by informing people about HIV and AIDS, and by persuading them not to engage in unsafe sex. As a result, the social and economic factors that aid the spread of HIV were neglected. (*BHDR 2000*)

Sixteen years after the first case of HIV and AIDS in Botswana was diagnosed, the Revised Botswana National Policy on HIV and AIDS still put emphasis on education and information campaigns and other measures that address the immediate determinants of the epidemic. The policy does not adequately address the structural determinants of the epidemic, especially poverty. (*AIDS in Botswana 2002*) This is despite evidence from surveys as far back as 1993 indicating poverty as a factor in the spread of HIV. The policy therefore fell short by failing to appreciate the link between poverty and health and consequently failed to emphasise poverty reduction as an important contribution by the Ministry of Finance and Development Planning (MFDP) to the anti-HIV and AIDS initiative. But, as the UNDP report on Poverty and HIV and AIDS in sub-Saharan Africa 2002 notes: *“unless the realities of the lives of the poor are changed, they will persist with behaviours which expose them to HIV infection”*

An epidemiological approach to health and HIV and AIDS, which is the view now being recommended by the World Health Organisation, would emphasise poverty reduction as part of the long-term response. The long-term response is in essence the road to the Vision 2016 HIV and AIDS targets and the AIDS-Free generation (*BHDR 2000*).

According to UNAIDS Global Report 1999 estimates, approximately 98% of children below 15 years were HIV negative in Botswana. This represents an estimated 658,610 young Botswana who are not infected. This cohort represents Botswana's hope for an AIDS-Free generation.

HIV infections enter the cohort through inter-generational sex. In this way, the epidemic sustains itself from one generation to another. In both Lusaka and Kampala, early signs of lower HIV prevalence have been associated with changes in sexual behaviour in those aged 15 and below.

Already, anecdotal evidence suggests discernible change in sexual behaviour amongst teenagers. (*AIDS in Botswana 2002*) Response measures will be even more productive when more decisive action is taken against some of the structural determinants of the epidemic at local level. Campaigns against poverty and inequality, inter-generational sex, discrimination against women and homosexuals are tough but winnable. There is sufficient goodwill to build on. Efforts to generate more accurate data on the epidemic should be intensified to generate more knowledge about the epidemic and inform the fine-tuning of ongoing efforts (*BHDR 2000*)

Looking at the history of the fight against AIDS, the question arises why it has been so difficult to strengthen strategies for local response. The BHDR 2000 is an important document for providing suggestions of dealing with the epidemic in this decade. But, while the BHDR 2000 makes an attempt to recommend community involvement in responding to the epidemic *it fails to redefine the role of district multi-sectoral committees in ensuring the effective implementation of prevention, care treatment.*

The BHDR 2000 *does not provide* a coherent and consistent understanding of the issues, in particular of the systemic response at local level. Re-conceptualising the epidemic as a development issue – focusing on the interdependence of social and economic relationships at country, district, village and family levels – is a key step toward relevant and effective policies and programmes.

The causes of the epidemic have their origins in structural factors such as poverty and gender, and patterns of development. Unless these are addressed, the epidemic will thrive. There is now a good deal of experience of what can make a difference. The challenge is to take what is known and to transfer it, suitably adjusted to local conditions, but always ensuring that processes for policy and programme development are genuinely participative and inclusive. (*Cohen 2001*)

2.4 Other Related Publications

2.4.1 Impact of HIV on Universal and Equitable Service Delivery

The ILO (*Cohen 2002*) reports that although there have been several studies of the impact of HIV on specific sectors, such as education and health, there is as yet no general assessment of the impact on public services as a whole. The nearest there is to a comprehensive assessment is a study of the impact of HIV on Human Resources in Malawi. This study is important as an attempt to measure attrition of human capital across the public sector in a country experiencing a mature epidemic of HIV. Data showed that over the period 1990-2000 total annual attrition from all sources rose almost six times from 347 to over 2000. The average rate of attrition was 2.3%. The causes are complex, although one stands out in all of the organisations: death is the highest cause of attrition, varying between 40% and 58%. For the public service as a whole, mortality over the period has increased by a factor of 10, a situation due primarily to HIV. The high levels of mortality observed would not be present except under these conditions. The Malawi report

also concluded that all occupational categories experienced excess mortality, but that there were higher mortality rates among professional staff than among junior technical staff (*MIM/UNDP 2002*).

The conclusion of the Malawi report hints at implications for institutional knowledge and continuity:

The loss of experienced staff impacts negatively both on the coverage of service provision, through a reduction in the total number of staff, and on the quality of services, caused by the loss of skills and experience. Whereas the first (shortfall in the number of people) may be relatively easy to deal with, the second (loss of experience) amounts to a substantial organisational loss. Depending on which staff categories are most affected, certain organisational functions and capacities will be eroded, which will inevitably impact negatively on the core business of the organisation.

2.4.2 Projections of Loss of Public Sector Workers

Education and health are identified by the ILO (*Cohen 2002*) as two key sectors affected by HIV. Cohen points out that the effects on the sectors are complex, and that the interactions between sectors are only now beginning to be identified. Improvements in education and health are both seen as critical inputs for achieving sustainable development, but HIV is making it more difficult for countries to achieve their objectives in these sectors. Most households affected by HIV face deepening poverty, and part of their adjustment to this situation relates to decisions about school attendance, making it more difficult to achieve educational objectives in general, but especially in the case of the education of girls.

Importantly, improvements in education have been seen as essential for reducing HIV transmission, as the risk factors faced by young people are in part the outcome of low levels of literacy impeding access to information. Similarly, HIV and AIDS have direct and indirect effects on the healthiness of populations. Functioning health care systems are essential to the diagnosis and treatment of infection, but the HIV epidemic not only raises

the demands on health systems, but simultaneously erodes their capacity to provide services.

Projections of percentage losses of education and health workers are fraught with difficulty. There are demographic and aggregation problems in making projections, and the results are uncertain. The World Bank, while acknowledging these drawbacks, makes gloomy projections for SSA: it projects falls in the primary school age population by 2010 of 24% (Zimbabwe), 20% (Zambia), 14% (Kenya), 12% (Uganda). The losses of teachers due to HIV between 2000 and 2010 for the same countries are estimated annually at 2.1%, 1.7%, 1.4% and 0.5%, respectively, which are cumulatively very substantial losses (*World Bank 2002*).

UNECA (2000) presents reports from Kenya (teacher deaths rising from 450 in 1995 to 1,500 in 1999), Cote d'Ivoire (reported to be losing teachers at the rate of five per teaching day, 900-1,000 per year, but unclear if this attrition is due to mortality or other factors), Zambia ('severe losses' among trainee teachers), Congo (schools closing due to death of teachers from AIDS).

Cohen (2002) states that there have so far been studies of the effects of the HIV epidemic on primary and secondary education in three countries; Malawi, Uganda and Botswana. There is a consolidated report of the three countries, *The Bennell Report*, comprising the most detailed analysis of impact yet produced. Its overall conclusion is that 200,000 teachers, 9.4% of the total employed in 1999, could die of AIDS-related illnesses by 2009. The projection is based on three key assumptions (teachers have the same age- and HIV-profiles as the rest of the population, the 1999 adult HIV prevalence rates in each country will not increase, and teachers are unable to access lifelong antiretroviral drugs). In the view of the ILO (*Cohen 2002:15*) some of the assumptions are overly optimistic, and the real outcomes therefore likely to be considerably more adverse.

Cohen (2002:16) points out that there are major gaps in knowledge about the education sector in the context of HIV; lack of firm data on absenteeism, organizational capacity loss through mortality of senior teachers, teacher trainers and administrators, and school drop-out rates and their relationship to household poverty. In terms of the health sector, he notes that there are very few comprehensive analyses of the effect of the epidemic. One of the few is a study of Botswana, which concludes that 17-32% of its health workers were infected in 1999, and 28-41% could potentially be infected by 2005. Evidence from

elsewhere in Sub-Saharan Africa (SSA) suggests that likely magnitude of the effect of HIV on human resources in the health sector will be immense. A study by WHO in Zambia in the early-mid 1990s concluded that 40% of health sector staff were infected with HIV. Cohen contends that there is no evidence that any country has begun to comprehensively address the human resource planning issues raised by the HIV epidemic, and no evidence that there is capacity either domestically or externally to meet the needs for critical skills and training.

Comparative figures for other regions are not available. For example, as is widely known, the Chinese government officially denied its HIV problem for years, and discouraged accurate monitoring and independent surveillance. The government has also considered the number of infected people in China to be a politically charged topic, with a great deal of national reputation riding on statistics. For these reasons, reliable statistics on the current state of the HIV epidemic in China are difficult to obtain, and therefore future projections extremely difficult to make (*Bates, 2002*). Similarly, in Russia and India, statistics for the seroprevalence of HIV are rather unreliable; in Russia, medical authorities have registered 200,000 HIV-positive patients, but US intelligence suggests the figure stands at one to two million. In India, UNAIDS suggests that there are four million people infected, but the Health Minister warns that the figure may be higher (*Eberstadt, 2002*); this figure is currently a source of dispute. The HIV epidemics in Russia, China and India are far newer than those in SSA, and for reasons of the relative youth of the epidemic, and the problems of estimating prevalence, systematic analyses of projections of long-term effects on services, revenues and so on have not yet been developed.

The effects of sickness, low morale and absenteeism on service delivery is difficult to quantify. Cohen (2002) argues that the costs of the HIV epidemic are not confined to estimates of lost output due to early mortality, although these are clearly very important. There are other costs that are also significant: those due to absenteeism both directly due to illness, and indirectly caused by funeral attendance, caring for sick relatives, disruption of the flow of work and so on. These are estimated in the Malawi report (MIM/UNDP 2002), and found to be 'very significant'. The report notes that policies with respect to sick leave and more general absenteeism are not being observed in Malawi, and that urgent reform is required if the public service is to continue to function. This is a symptom of the Commissioned Desk Based Research slowness of reaction by Malawi Ministries to this attrition, ongoing for over a decade.

Many posts have remained vacant for long periods, and overall vacancy rates are at extremely high levels: 58% in Education and 52% in Water Development (*Cohen 2002:10*). In all ministries, it was found that the vacancy rate is higher in rural than in urban areas, implying that service delivery may be worse in the former. Costs attached to these issues are directly experienced in the budgets of the various ministries; funeral costs, recruitment and training costs for new staff etc. Although low morale is mentioned widely as a result of HIV attrition, there are very few studies which address this issue and which are able to attribute effects to perceived 'low morale'.

HIV and the 'brain drain'

The 'brain drain' is particularly acute in SSA, and while there is little empirical evidence pointing to HIV as a cause of emigration (although many anecdotal references), there is work which identifies the brain drain as a factor compounding the problem of HIV in country. In particular, trained medical staff are among those commonly leaving SSA countries with high seroprevalence rates, for work in other African countries, or further afield. This is a particular problem in South Africa and Zambia. According to DENOSA, 300 trained nurses leave South Africa each month. A vicious cycle has developed in that the nurses remaining in the public service are required to deal with a heavier workload. The flight of specialised skills could have a devastating effect on the quality of care for the terminally ill, especially HIV patients. One of the worst examples of the regional brain drain cited by the IDR is Zambia, where the number of doctors has fallen dramatically, attributed to the brain drain. Zambian doctors have migrated to Europe, the United States and neighbouring Botswana, lured by higher salaries. (*GlobalEyes 9.3.02*).

HIV-driven changes in demand for public services

Just as projections of mortality and prevalence of HIV are difficult to make, extending these to suggest the effect on public services is also extremely difficult. It is particularly difficult to identify changes in demand for public services which are the result of changes in household structure or demography, rather than of high prevalence. It is generally accepted that demand for health services will increase, but there are complex issues here about the precise nature of care required, which bear some relation to changing household structures. Conversely, the provision of Anti-retro Viral treatment actually reduces the demand on health services, as people are not as sick. A report on the impact of HIV in Botswana (*BIDPA, 2000*) states that the degree to which AIDS patients' treatment is split

between hospital-based and home-based care is one of the factors which will determine health spending. Home-based care would require a household structure with a care-giver in the home, and therefore it might be argued that demand for hospital-based care will increase as households become more fragmented (single-parent, grandparents as guardians and so on).

The *Bennell Report, 2001* on education, reviewing trends of mortality and student enrolment, concludes that the net impact in Malawi, Kenya, Uganda, Botswana, Zambia and Zimbabwe will be that reduced demand for teachers will outweigh the increase in AIDS-related mortality over the next decade. Somewhat perversely, therefore, the HIV epidemic will make it easier to reduce student-teacher ratios and meet Education for All targets. However, this conclusion is in opposition to that of *Kelly (2000, for UNESCO)* who concluded that high rates of AIDS-related mortality may raise demand for new college educated graduates above the supply, this prolonging the dependence of schools on unqualified teachers.

2.4.3 Long-term Effects of Absenteeism from Education.

There does not seem to be research yet available which seeks to project levels of literacy given children's absenteeism from school due to the effects of HIV, or how this anticipated change in literacy levels will affect skills in the longer term.

While it is naturally assumed that attending school has a positive effect on the education of children, research has shown that the school environment can place children at risk of infection. *Badcock-Walters 2002*, argues that the assumption that interactive, high-risk sexual activity between learners does not take place in primary education may be badly misplaced. This is because the age-profile of learners in this sector does not necessarily coincide with what might be expected. Over-age learners are a common feature of the school system from the first year. Therefore, the 'age of innocence' may be circumscribed by peer pressure, behaviour examples and actions of over-aged learners in the classroom, and their appropriately-aged peers. School data for South Africa show this trend. UNECA echoes this concern, adding that many school children are in danger of sexual harassment from teachers and that schools commonly do little to help pupils develop the appropriate behaviour patterns for the responsible management of their sexuality (*UNECA 2000*).

2.4.4 Implications for Effective pro-Poor Policies and Revenue Collection

Projections of the impact of HIV on government revenue and expenditure.

It is important to state at the outset that the impact of HIV on revenue and macroeconomics will be very different for highly populated countries (China, India, Indonesia, Russia) when compared to the smaller countries of SSA, and to understand that there are therefore difficulties in comparing statistics.

It is widely acknowledged that HIV will have an effect on government revenue and expenditure, both in terms of increasing expenditure on services due to higher costs of recruitment, training, sick pay, etc., and reducing revenue, due to economic impact. However, there are very few firm projections of the scale, magnitude and impact of these anticipated changes, and the few which do exist tend to focus on Southern Africa. (CRHCS 2001)

Greener (undated) argues that HIV will have direct effects on some key areas of government spending, most obviously the health budget. There will also be a range of indirect effects arising from aggregate economic impacts, and increase in poverty. These can be expected to reduce the ability of governments to raise tax revenues (since these depend on the size of the economy), while increasing demands on government expenditure, including poverty alleviation measures. Although there may be some savings, Greener continues, arising from reduced population growth, he expects HIV to exacerbate the pressure for deficit spending by government. It will also distort development spending on other areas, since it will be necessary to use valuable resources in a 'defensive' or socially unproductive way. In addition, he expects the distortions that HIV causes in the labour market to put more pressure on government in its regulatory role (for example the issuing of licences and work permits).

A country study of Botswana (*BIDPA, 2000*) gives more projections of projected government expenditure. It is anticipated that in Botswana employment costs will increase as a result of the projected increase in skilled labour costs, since government is a major employer of skilled labour. This effect is estimated at 2.3% of the total recurrent budget after 10 years. The pension liability of government is projected to fall, as a result of earlier mortality of the workforce, but the saving will be small, predicted at 0.6% of the total

recurrent budget. Training and recruitment costs will increase, but this will also be a small expense, amounting to 0.3% of the total recurrent budget after 10 years. Health spending is expected to increase dramatically, but unpredictably, anticipated to increase total recurrent spending by anywhere between 3% and 12% over 10 years. Population projections of lower numbers of school-age children suggest a saving in education costs translating to 1.5% of the total recurrent budget. Increased poverty due to HIV is projected to lead to increased poverty alleviation expenditure, increasing total recurrent spending by 3-4% after 10 years. Added together, these various changes in expenditure amount to a 7-18% increase in 10 years time.

However, the study projected that government revenue would fall. Mineral revenue was seen as unlikely to be affected by HIV (although mining revenue is expected to fall elsewhere because of labour problems, especially in South Africa), but other sources are expected to decline. Botswana's GDP is projected to be 20% smaller than the 'no-AIDS' situation after 10 years, which means that revenues from income and sales taxes will be lower, and resulting deficit pressure will mean that interest from the Bank of Botswana will be lower. This amounts to a projected fall of 10% in government revenues after 10 years. Botswana's overall projection is that expenditure will be in deficit for other reasons in 10 years time, and that additional pressure caused by HIV will make the overall deficit unsustainable. (*Botswana Institute for Development Policy Analysis, (BIDP) 2000: Macroeconomic Impacts of the HIV/AIDS Epidemic in Botswana, Final Report May 2000*)

2.4.5 Labour Force Issues

The impact of HIV on public sector labour is closely related to its effect on the labour market as a whole. The ILO Programme on HIV and the World of Work reported in June 2002 that HIV has become a major threat to employment objectives and labour market efficiency in all sectors (public, private and informal). The loss of workers and workdays due to AIDS-related illnesses or the demands of caring can result in significant decline in productivity, loss of earning and attrition in skills and experience. HIV is also changing the age and gender distribution of the work force, and increasing the number of women, children and the elderly facing economic uncertainty. The vulnerability of women to infection, as compared with men, increases gender inequalities.

The most obvious effect of HIV on the labour force from which the public sector draws its employees is on the numbers of people of working age and the effect on the structure of the working population. The majority of those who die from AIDS are adults in their productive and reproductive prime. Therefore, the effect of HIV on the labour force is more severe than that on the population as a whole. The loss of people of working age, particularly those over the age of thirty-five, with proportions of men and women varying according to age group, drastically increases the dependency ratio and has profound implications for all employment sectors. This effect has been greatest in SSA. Within this region, the highest rate of infection is in Southern Africa (UNAIDS estimates of adult infection rate in this region in 2000 were: Botswana 36%; Zimbabwe and Swaziland 25%, South Africa and Zambia 20%, cf. 8.4% in SSA in general, and a world figure of 1.2%). (CRHCS 2001)

ILO expects that in 29 SSA countries the number of male and female labour force participants will be 12% and 10% smaller respectively by 2020 than in the absence of HIV; in the eight SSA countries with the highest prevalence rates (Botswana, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa and Zimbabwe) the projected cuts are higher still – 19% for men, and 18% for women (Lisk, 2002:5)

Lisk (2002, for the ILO) reports that the early loss of qualified employees in the public sector will result in a decline in the quality of public services, and countries will find it hard to replace highly-trained public servants such as doctors and teachers. In addition, because of greater employment security in the public sector, the costs of absenteeism will be higher than in the private sector. Current ILO estimates suggest that some SSA countries will lose between one quarter and one third of their skilled and educated population. This will result in a decline in productivity and the effectiveness of public administration (Lisk 2002:6).

ILO research suggests that amongst the workers at special risk in SSA (including groups such as sex workers, and migrant workers) is the unexpected group of males with higher levels of education, such as teachers and middle/senior civil servants. ILO suggests that their apparently higher than average risk of contracting HIV may be partly related to mobility, but also reflects their higher disposable income and, perhaps, resulting increased propensity for casual sex (Lisk 2002:9).

Research in Botswana and other African country's points towards the same set of factors propelling the epidemic

2.4.6 Success Stories; Uganda, Thailand and Senegal

The International Coalition on AIDS and Development (ICAD), 2000, discusses the problems of analysing success stories. They write that three examples are commonly quoted as successes; Uganda, Senegal, Thailand and Brazil. In 1986, Ugandan President Museveni publicly acknowledged the country's AIDS problem and established the Uganda AIDS Commission. In Senegal, the government responded early to promote extensive NGO activity, and in Thailand, lobbying led to the 1991 nationwide programme.

More recently, Brazil now leads the developing world in the provision of anti-retroviral drugs (ARVs), with a government policy of universal access.

In each country, strong political commitment is cited as a factor in its response.

The key factors for success seem to be:

- political commitment
- multi-sectoral response
- community involvement

Political commitment is difficult to measure. ICAD suggest the following indicators:

- Budget allocations to prevention and care
- Measures of AIDS programme activity (based on a questionnaire to key informants)
- Indicators of compliance with the International Guidelines on HIV and Human Rights.

Difficulties in measuring commitment means that it is very difficult to know whether efforts to increase political commitment have any impact on the AIDS epidemic.

ICAD concludes that although there appears to be widespread agreement that political commitment is an important factor in the successful response to HIV, it remains an elusive concept. It is unclear whether a focus on greater political commitment alone will have a significant impact on the course of the pandemic. It also ignores the reasons why government leaders act, or fail to act, on HIV.

A paper co-authored by Dr Coll Seck of Senegal (*Piot & Coll Seck 2001*) argues for the primacy of political commitment: Firstly, political leadership is required at all levels to marshal the necessary commitment and resources for the social mobilization on which response to HIV must be built. Secondly, responses to the epidemic need to be conceptualised as multi-sectoral tasks and not confined to the health sector. Thirdly, national coordination is required, and fourth, responses are successful when people living with HIV (PLWA) are centrally involved in the effort. Lastly, successful responses to the epidemic have their roots in communities. Piot and Coll Seck 2001, argue that the common experience of 'success story' countries is that risks cannot be reduced in isolation. Where responses have been successful, they contend, they have built wide community support, given 'target' groups the driving role in designing and delivering change, and participating in changing the social environment. This 'expanded response', they concede, has been criticized as insufficiently prioritised, not focused on outcomes and lacking in emphasis on sustained behaviour change. However, they argue that evidence from those national and local responses to HIV in which sustained drops in HIV incidence have been observed, or where low incidence has been maintained despite surrounding trends, shows that success has been achieved where the response is based on a broad social mobilization, accompanied by clear deliverables.

2.4.7 'Success Stories'

Uganda

The World Health Organisation *'Health a Key to Prosperity'* 2001, states that Uganda's success in reducing high HIV infection rates is the result of high-level political commitment to HIV prevention and care, involving a wide range of partners and all sectors of society. Same-day results for HIV tests and social marketing of condoms and self-treatment kits for sexually transmitted infections, backed up by sex education programmes, have helped reduce very high HIV infection rates. It says that success in reducing the prevalence of HIV in Uganda is the result of a broad-based national effort backed up by firm political commitment, including the personal involvement of the head of state, President Yoweri Museveni. From the outset, the government involved religious and traditional leaders, community groups, NGOs, and all sectors of society, forging a consensus around the need to contain the escalating spread of HIV and provide care and support for those affected.

S. Okware, A. Opio, J. Musinguzi and P. Waibale “*Fighting HIV/AIDS: Is Success Possible?*” 2001, argue that Uganda’s experience suggests that a multipronged prevention and control strategy can significantly influence behaviour and dent prevalence as well as incidence rates. Early recognition of the problem is necessary, and it must be followed by the construction of comprehensive frameworks for intervention.

However, despite being widely regarded by the international community as having very successfully lowered the rates of HIV, an article in *The Lancet*, 2002 questioned the basis for the Ugandan claim of success, saying that it has rarely been investigated, and that rates of seroprevalence, rather than rates of infection each year, were often quoted, distorting the picture.

Thailand

Janjaroen and Khamman (2002) describe Thailand’s response to HIV as one of the most successful. The country’s pro-active, multi-sectoral prevention and care efforts have led to risk reduction and reduced incidences of HIV. The Thai experience, they contend, demonstrates that institutional and traditional approaches can be employed together with efforts to empower individuals, families and communities to protect and care for themselves to develop an effective national response. In analysing Thailand’s success, Janjaroen and Khamman suggest that a number of lessons can be learned from it: the principal lesson being that the commitment of national leaders at the highest levels is required for effective action. Other lessons are that social capital and civil society need to play a significant role; effective programmes, often based on pilot schemes, lead to effective outcomes; a people-centred approach to programme development should be adopted; prevention works best when targeted at vulnerable groups, and HIV response must be linked to development programmes and to national and provincial level planning. One much vaunted policy in Thailand was 100% condom use in brothels.

Senegal

Senegal is one of the countries cited as an example in the struggle against AIDS in Africa. Since its first confirmed case in 1986, prevalence rates of HIV amongst adults have been kept at between 1.77 and 1.74%. Eighty thousand adults are infected, out of a population of 9 million. The reasons for this relative success are: Senegal’s early response to the disease, vigorous preventative action, care of AIDS patients and the mobilization of people at all levels, including teachers, soldiers, women, religious leaders and NGOs. Democracy and press freedom facilitated open discussion and information dissemination.

More than a decade ahead of the discovery of the first AIDS case, the Senegal government had initiated a screening system for blood donations, and there was a programme against sexually transmitted disease, which targeted sex workers. There was trust between medical experts and government officials, and budgetary resources were allocated to tackle the problem of HIV. In 1988, health officials targeted women and young people, particularly students, raising awareness of these groups, which in turn helped raise awareness among vulnerable groups such as migrant and sex workers. Senegal was also among the first African countries to take advantage of access to anti-retroviral drugs. According to the report of the United Nations Economic Commission for Africa (UNECA) 2000, *“The Leadership Challenge and the Way Forward”* the key aspects of Senegal’s approach to tackling HIV were:

- A National Committee to fight AIDS was launched by medical experts and government officials in October 1986.
- Peer education; knowledgeable young people talking to others at community level (sports clubs, cultural associations etc.)
- Religious leaders; both Muslim and Christian authorities have been active, organising multi-faith events to disseminate information aimed at changing behaviour.
- Acknowledging cultural practices; many cultural practices prevalent in Senegal enabled religious and cultural leaders to give advice about how best to protect oneself against infection.
- Awareness among the military; Army soldiers are Senegal’s biggest consumers of condoms, and army generals receive training about AIDS from military doctors. While on missions, soldiers are educated about the disease and receive condoms. They also undergo examinations and screening.

In none of the ‘success stories’ detailed above has the initial trigger for high-level political commitment been explicitly identified. *ICAD (2000)* writes that although political commitment has been identified as crucial in achieving progress, few ways have been identified to directly achieve it. In other words, although we can observe the effect of political commitment, the reason why the commitment was there at all is seldom obvious. In one example of political commitment in Zambia, President Kaunda opened international conferences on AIDS – his commitment is seen to stem from his having lost a son to HIV. However, in other accounts of less successful governments, such as China,

an unwillingness to admit that HIV was a problem, or even that it was a condition present at all in the country, stalled official moves towards tackling the problem. In China, this reluctance stemmed from Chinese officialdom's initial dismissal of HIV as a 'Western' problem (*Bates 2002*). In a toolkit produced by the *Policy Project*, *Goliber (2000)* states that political commitment 'is often underscored by an accurate understanding of the crisis dimensions of HIV...'. Availability of information, or willingness to believe that information and act upon it, might therefore be an important factor.

2.4.8 Effects of HIV on Macroeconomic Stability

The International Crisis Group (ICG) 2001 report states in the opinion of the United States National Intelligence Council that in Africa's worst-hit countries HIV has already reduced GDP by 1%. In South Africa, the World Bank estimates that GDP will be 17% lower by 2010 than it would have been without the HIV epidemic. Countries below the 20% seroprevalence level are also thought to face macroeconomic problems. ICG reports various projections that Botswana's economy may shrink by 30% by 2010 as a result of HIV, that Kenya's GDP may be 14.5% smaller in 2005 than it otherwise would have been, and that the combined effects of TB and HIV in Russia could cost 1% of its GDP by 2005.

HIV's effects on labour force have been documented previously, but the impact of these changes on private industry is critical to macroeconomic impact. Key sectors in SSA economies are affected by HIV, notably agriculture, mining and transport. In South Africa in particular, mining is of central importance for revenue, and here and elsewhere, mining is a key source of foreign exchange. HIV affects business investment; as revenues and savings shrink due to reduced workforce productivity and rising costs, the ability to invest is diminished. HIV in Russia threatens to exacerbate the current economic crisis through its impact on the working age population. In China, it is feared that were the HIV epidemic to worsen, the economy could face an intensifying slowdown, along with a reversal of the gains made in reducing poverty over the past several decades. However, a study carried out by NCAIDS (Beijing) 2002 concluded that in a worst-case scenario, the AIDS impact on GDP growth would cause a decline of 0.03%.

Eberstadt 2002 in "The Future of AIDS Foreign Affairs" projects the effects on macroeconomic stability in Russia, India and China. He uses a model based on the World Bank's data for national life expectancy and output per member of the potential

workforce, amending these figures with simulations of life expectancy and work force size based on US Census data, according to three different levels of anticipated HIV epidemic, and amends these projections according to three different levels of severity of HIV epidemic. Using his 'health-based productivity' model, he predicts that Russia's output will be radically reduced under even nascent epidemic conditions, and that in a concentrated epidemic, output could be lower in 2025 than it was in 2000. For India, he projects that a nascent epidemic could depress output by 40%, and an concentrated one could mean that output per worker could be no higher in 2025 than it is today.

In a recent paper written for the IMF: "*Modeling the Macroeconomic Impact of HIV/AIDS*" by M. Haacker 2002, two main arguments are questioned. Firstly, most of the economies worst affected by HIV are characterised by high rates of unemployment or a high share of the working population in the informal sector. He reports that various authors have argued that 'per capita output might actually rise as workers involved in low productivity activities fill the vacancies created by AIDS in the more productive formal sector'. However, he writes, this does not necessarily follow, as higher costs or a decline in the supply of skilled workers would also result in a decline in the demand for unskilled workers in the formal sector. Secondly, he states that in most studies on the impact of HIV on economic growth or per capita income, the negative impact of declines in productivity or the supply of human capital is at least partially offset by an increase in the (physical) labour-capital ratio. Aggregate changes in savings rates appear to be relatively small, and the steady state capital-labour ratio rises as the growth rate of the working population declines. However, he argues, a significant increase in the rate of return to capital, and the assumption that this would not affect investment behaviour is questionable.

Haacker (2002) examines two methods of modelling the macroeconomic impact of HIV; a dual economy model and a one-sector neoclassical growth model. He finds that it is not possible to confirm the hypothesis that HIV results in a decline in unemployment rates, and therefore on per-capita output. HIV affects both the supply and demand for workers in the formal sector, and the net effect, he says, is ambiguous. He concludes that the lower the level of foreign assets held by a country, or the higher the external debt, the larger will be the adverse effect of HIV. In the context of SSA, this is particularly relevant for highly-indebted low-income countries and Haacker therefore concludes that any macroeconomic assessment of the impact of HIV should include an analysis of the implications for the sustainability of external debt.

4.9 HIV, Voice and Marginalisation

HIV/AIDS exacerbates, and is in turn exacerbated by political and social exclusion. Politically and socially marginalised people including women, migrant workers and sex workers are relatively vulnerable to HIV infection for a number of reasons, including having relatively restricted access to user-friendly health services, public health information and access to justice (e.g. protection against economic or sexual exploitation). People affected by HIV are in turn subject to further stigmatisation. Once infected, already-marginalised people are poorly placed to protect their rights.

Suggestions from lessons learned from ‘success stories’ of tackling HIV include the importance of an inclusive strategy, based on broad social mobilization. There is a growing literature covering the concept of responding to HIV by involving those most affected. International HIV Alliance (2002) argues that global experience has shown that involving those most affected strengthens the effectiveness of responses to HIV. In relation to HIV programming, this includes involvement in analysing their own vulnerability and risk, in designing projects and in making decisions about interventions.

2.4.10 The Role of Locally Based Inter-personal Strategies in Behaviour Change?

For a long time, William Schramm’s *Mass Media and National Development: The Role of Information in the Developing Societies*, published in 1964, has been the “blueprint” for development communication. The expansion of mass media and the increased flow of information has been seen as widening the horizons of the poor, raising personal aspirations, enlisting support for national policy, and focusing attention on social development.

The media creates an information climate in which development is stimulated and communications technology is an important tool for the nation’s social and economic development: “the task of the media of information and the ‘new media’ of education is to speed and ease the long, slow social transformation required for economic development, and, in particular, to speed and smooth the task of mobilizing human resources behind the national effort” (*Schramm 1964: 27*).

By providing individuals with a glimpse of “developed” society and the inspiration for attaining this new way of life, the media enhances the sense of empathy necessary for spurring economic growth. The mass media is involved in two important aspects of social development: it infuses or instils the modern ethos or “mobile personality” based on notions of empathy and it is the “mobility multiplier” (*Schramm 1964*). Geographical mobility is no longer necessarily the key to economic growth, the media is seen as providing a kind of “virtual” mobility.

Mediated experience through mass communications is seen as providing the means for an individual to “see himself in the other fellow’s situation.’ He is the type of person who becomes ‘the cash customer, the radio listener, the voter’ who accepts and advocates change.” (*Schramm 1946: 46, quoting Lerner*). According to Lerner, information flow plants the seed of change and modernisation: “the process of modernisation begins when something stimulates the peasant to want to be a free holding farmer, the farmer’s son to want to learn reading so he can work in town, the farmer’s wife to stop bearing children, the farmer’s daughter to want to dress and do her hair” Schramm 1964: 44).

The media is seen as raising the motivation for achievement. Katz and Lazarsfeld, 1995, bring another dimension to the analysis of mass communications. They emphasise interpersonal relations as integral to looking at the media’s ability to change opinions and attitudes. In their “two-step flow of communication,” the first step constitutes the information flow from the media to the opinion leaders, the second step is the transfer of ideas from the leaders to the less “active” sections of the population. Interpersonal networks are linked to mass media networks through “primary groups” (community leaders, etc.).

According to this scheme, influential individuals have a high persuasive power in their interventions between the media and the resulting opinions and decisions held by the general public. Social stratification plays an important role in channelling communications flow and interpersonal relations in the channel between mass media and the audience. All interpersonal relationships are potential “networks of communication.”

It is clear that interpersonal communication is necessary for the media to have any kind of “effect”. The diffusion of ideas, information, and values which the mass media broadcasts and publishes is extremely important but in terms of changing behaviour, interpersonal

contact is a key. Furthermore, even mass media enthusiasts highlight the need for local networks of interpersonal relations to mobilise the themes presented in the mass media.

Intervention programmes developed and implemented by the District Multi-Sectoral AIDS Committees should have a strong component on interpersonal communication targeting different social groups. Findings from both the surveys and the observational studies indicate that in most respects, mass communications are far less important sources of information and influence than interpersonal communication. With respect to AIDS, this type of communication is especially important due to the particularly personal and sensitive issues involved.

The “mass media” is assumed to instil the unified “masses” with information. As Hartmann et al. discuss, development discourse has often treated people as a singular collective entity, or if there is a differentiation, it is articulated as the urban versus the rural. The assumption being that there is harmony of interests among the rural population; whereas village society is highly differentiated and conflicts of interests are prevalent. The use of mass media for development has often oversimplified the concept of the “mass” public.

While the mass media may be gradually changing people’s perceptions of gender, responsibility, and sexuality, locally based interpersonal strategies are a necessary immediate response to HIV/AIDS. With the present mass media AIDS campaigning, priority is given to awareness and information -- this does not necessarily lead to behavioural change.

Strategies focussing on enhancing motivation for condom use, utilising interpersonal means and community participation, is the most “effective” way of preventing the spread of HIV at district level. **District Multi-Sectoral AIDS committees** are the only coherent structure that can ensure that locally based interpersonal strategies are implemented.

2.4.11 The Value of Cost-effectiveness Analysis in Guiding Policy Processes.

According to Kahn J. G. and Marseille E., “*Fighting Global AIDS 2001: The Value of Cost-effectiveness*”, cost-effectiveness analysis can guide the policy process in several specific ways.

First, because it is ultimately about choosing among alternatives, cost-effectiveness analysis requires a clear description of all relevant policy options.

Second, cost-effectiveness analyses take perspective into account. A programme that may not be cost saving nor even cost-effective to a particular governmental agency may none-the-less be desirable from a societal perspective.

Kahn and Marseille state the measure of efficiency used in cost-effectiveness analyses is the cost-effectiveness ratio, which is the ratio of programme costs to a health-related outcome such as lives saved, life-years saved, or cases of HIV prevented:

$$\text{Cost-effectiveness ratio} = \frac{(\text{Cost of programme} - \text{medical and other costs saved})}{\text{Health benefits}}$$

The numerator equals the cost of delivering the intervention minus the medical costs saved by preventing the transmission of HIV and other economic benefits of prevention.

The smaller the cost-effectiveness ratio, the more economically efficient the programme.

Third, the importance of politics in HIV does not preclude a role for cost-effectiveness analysis, but instead means that such appraisals must be compelling enough to influence a process with many actors and aims.

Assessing Cost-Effectiveness Analyses.

The results of cost-effectiveness analyses are driven mainly by the assumptions that underlie them, such as intervention effectiveness or baseline HIV incidences. A jaundiced extension of this truism is that one can therefore use cost-effectiveness analyses to argue anything. The best protection against the manipulation of cost-effectiveness analyses is complete and clear presentation. Although this section cannot inventory all the elements of a good cost-effectiveness analysis, nor all of the pitfalls that may snare the unwary consumer of economic appraisals, there are a few general principles.

The first and most important is "No black boxes". In other words, all the key assumptions that drive the analysis--or, anticipating the consumer, *that might be expected to do so*--should be clearly identified and justified. These include both modelling assumptions that determine how inputs are related mathematically to produce the final cost-effectiveness

ratio, and data assumptions concerning the estimated value of those inputs. A convincing rationale should be presented for each. Consumers should ask, "Are they appropriate for the setting? Are they thoroughly examined in the sensitivity analyses where the effect of changed assumptions on results is studied? Are the estimates derived from reliable sources?"

A second rule is "Note the perspective". This means being aware of the level (e.g., an individual clinic, agency, national government, society as a whole) at which costs and benefits are being accounted. This should be made explicit, but often is not. The consumer should ask, "Is the analytic perspective appropriate to the policy question being addressed? How might a different perspective change the results?" Cost-effective interventions, except those that are also cost saving, still require a net increase in funds. An analysis that assesses only the financial effects on a health care agency or clinic may conclude that a given intervention is un-affordable. This could happen, for example, if averted future medical care costs do not accrue to the implementing agency. However, from the perspective of a higher level of government that does receive the savings in medical cost, the intervention could be cost-effective or even cost saving.

A third rule is, "Confront the uncertainties". A good cost-effectiveness analysis presents the results of a "base case" analysis that incorporates the best estimates for each input. These findings are then supplemented by extensive use of sensitivity analyses, which explore how variations in the value of key inputs affect the results. The sensitivity analyses are very useful in determining the range of circumstances in which a given intervention is likely to be cost-effective.

A final rule could be called, "Compared to what?" A cost-effectiveness ratio is strictly a relative measure.

The finding that an intervention is cost-effective simply means that one can expect as much or more health benefits from spending a given amount of money on that intervention, as on alternative uses of the same money in that setting.

Cost-effectiveness analysis offers a critically important perspective for decision-makers seeking the largest health impact for limited HIV prevention dollars. There is also ample evidence of the cost-effectiveness of a wide range of HIV prevention interventions. New spending on these interventions, particularly if targeted to high-risk groups and implemented as early as possible in the local development of the epidemic, is capable of

producing dramatic reductions in HIV incidences. These programmes achieve important health benefits and in some cases even save money, which may be used for other aspects of HIV prevention and care. These findings should be carefully considered and incorporated into the HIV prevention planning process and programme priority setting of each affected country.

2.6 SUMMARY

This review has looked at specific issues regarding HIV and governance, and has drawn together findings from research from donors, NGOs and academics from a wide variety of studies at different scales.

There is a notable absence of specific information on the management of the District Multi-sectoral AIDS Committees. In particular as to how the AIDS Committees can develop intervention programmes which can have an impact on HIV/AIDS prevalence at both the District and community levels. Therefore one of the main conclusions to be drawn is that as there is insufficient data and information to provide guideline on how to manage HIV/AIDS intervention programmes in Districts this provides an opportunity for further research into finding the best methods for managing DMSACs.

CHAPTER 3

THEORETICAL PERSPECTIVE

3.1 Other Countries Initiatives on HIV

Information in this chapter is based on Uganda's experiences. Uganda's success story is as a result of the programming focusing on District initiatives. Apart from ensuring better planning for prevention programmes the Uganda AIDS Commission provide a blue print for district initiatives, which have contributed to the reduction in the number of new HIV infections.

3.1.1 Uganda's Initiative

The District Response Initiative on HIV/AIDS (DRI) was initiated by the Uganda AIDS Commission (UAC) with technical and financial support of UNAIDS and implemented by UNICEF in its 31 districts of focus in August 2003. (District Response Initiatives Uganda AIDS Commission 2003) The DRI aims to work toward AIDS-competent districts and communities. Within the DRI framework, the Action Research aims at documenting HIV/AIDS best practices in Ugandan communities in order to support a strengthened local response and enhance AIDS-competence, thus technically supporting the DRI.

The DRI Action Research covered 10 districts in Uganda, namely Arua, Busia, Kabarole, Kalangala, Kibaale, Mbarara, Moroto, Ntungamo, Pallisa and Rakai and was funded by Pfizer foundation, with technical support from a steering committee composed of UNICEF, UAC and UNAIDS among other partners.

The Department of Social Work and Social Administration was selected to implement the research together with 10 District Study teams, which were selected by the districts and supported by SWSA.

The Rakai HIV/AIDS Strategy 2003, mentions a study which used participatory research and learning methods to generate descriptive and analytical case studies and general findings mainly from focus group discussions, key informant interviews and relevant documents. (*Rakai: HIV/AIDS Strategy 2003/4 – 2005/6*) Using a cross-sectional survey design, quantitative data were collected from 1 640 respondents (ranging in age from 15 to

49 years) to validate the qualitative data. Based on the conceptual framework, five main areas of action were identified: coordination and management, prevention and control, treatment, care and support and mitigation.

The multi-sectional approach adopted in Uganda is a liberal policy, which gives a wide range of actors an opportunity to take part in planning and implementation of HIV/AIDS activities thus creating a wider scope for individuals to be served. Decentralization has resulted in an increased interest of actors to directly focus their HIV/AIDS interventions at lower government levels.

Cross community information sharing and central level sharing of information is limited. Resource mobilization is mainly project specific. Applying other resources to HIV/AIDS activities through mainstreaming is almost non-existent.

District Local Governments do commit resources to HIV/AIDS activities but these may not be availed for implementation due to other competing priorities and changes in the resource flow. Whereas the concept of multi-sectoral planning is being appreciated and applied in districts, M&E for HIV/AIDS is not well developed especially in directorates other than health. (*Rakai HIV/AIDS Strategy 2003*)

The research results indicate that the focus of Government, NGOs and donor agencies has largely been in the areas of prevention and treatment, leaving affected families and communities to struggle with the care, support and mitigation. Moreover, the various actors pursue different, sometimes conflicting objectives, often leaving communities confused. A few isolated cases show evidence of enhanced networking in lower levels and among implementing partners. The absence of planned interaction between most actors results in cases of disjointed service delivery in some

The nature and level of sensitization about HIV/AIDS achieved in the national response constitute a major landmark in the history of Uganda. Widespread sensitization about HIV/AIDS has universalized awareness and perception of risk among the people. For the moment, openness, advocacy and publicity from national to district and lower levels have created a big impact in the lives of people. Doubtless, individuals, families, communities, and institutions at all levels of society have responded to the epidemic; effectiveness of their response aside. (*District Response Initiatives Uganda AIDS Commission 2003*) While correct knowledge about key aspects of HIV/AIDS is almost universal, reference was made to Information Communication and Education (IEC) fatigue, urging for new

ways to package prevention messages especially for young people. Innovation is also required in rethinking the IEC strategy to raise risk perception and scale-up further behaviour change as well as to provide information on specific topics necessary for the actual adoption of an approach. This needs to be done in partnership with the targeted groups in the design and implementation of both messages as well as interventions.

While rigorous IEC supports a delayed onset of sexual intercourse and abstinence, research results indicate that the Abstinence, Be Faithful, Condom (ABC) model truly contributed to the Ugandan success in the prevention of HIV/AIDS. A marked effort to be faithful once married is shown as well as the use of condoms particularly in non-marital, non-cohabiting sexual relationships. However, there are challenges to the adoption and consistent use of any of the elements of the ABC - model. In practice, individuals use the responses concurrently, sequentially, but at some times finding it difficult to apply any of the three. Beyond the ABC - model, the Action Research findings point to other efforts that are important in preventing the spread of HIV/AIDS, such as the recognition and gradual phasing out of harmful cultural practices such as widow inheritance, wife sharing, and spontaneous sex during cultural rituals. A significant group of people has embraced Voluntary Counselling and Testing (VCT) and taken steps to live positively or adopt preventive practices. (Piot & Coll Seck 2001, *International Response to the HIV/AIDS Epidemic: Planning for Success.*) However, coverage of VCT is low and in the absence of treatment for OI's and availability of Ant-Retro Viral drugs (ARV's), the usefulness of testing is not clear to all. The same challenges apply to Prevention of Mother to Child HIV Transmission services (PMTCT). Improved access to VCT services in communities can stimulate people to seek for HIV tests and, as resulting from the individual risk assessment included in the Voluntary Counselling and Testing protocol register, positive behavioral change.

The AIDS competence assessment exposes wide variations in service delivery across communities and districts in Uganda. A number of deserving communities particularly in the East and North-East are not reached by major interventions such as IEC, VCT, treatment, and care and support services. (*Uganda AIDS Commission 2003*) This also explains differential progress made in addressing HIV/AIDS in various districts and thus their level of AIDS competence. These variations across districts, local communities and groups and individuals provide an opportunity to scale up knowledge management both horizontally as well as vertically; to compare their different levels of AIDS competence, share information, experiences, and contexts that are important for enhancing their

competence, and learn. It also provides an opportunity for districts and lower levels to demand for a more coordinated approach to service delivery.

Resource mobilization for HIV/AIDS activities is mainly project specific, while District Local Governments commit limited resources to HIV/AIDS activities that might not be availed for implementation due to the many competing priorities and changes in the resource flow. Whereas the concept of multi-sectoral planning is being appreciated and applied in districts, Monitoring and Evaluation (M&E) for HIV/AIDS is not well developed especially for directorates other than health.

Uganda's response to the HIV/AIDS epidemic was timely, characterized by high-level political interest in addressing the epidemic. The enthusiasm shown by H.E the President has since grown, spreading to leaders at districts and lower levels in the country and even beyond the borders, to leaders throughout the world. With the support of bilateral and multilateral agencies, local and international NGOs, academic and research institutions, financial institutions, cultural and religious leaders/institutions, and receptive communities, the Government has been able to put in place the infrastructure, a conducive and supportive environment necessary to address the medical, and to a smaller extent, economic, material and psychosocial burdens/challenges that come with HIV/AIDS. (*Rakai HIV/AIDS Strategy 2003*)

The contribution of all types of services to the national response is clear and visible. The synergy of these efforts is what is needed to meet the challenge of a devastating disease. However, Uganda is a nation of 56 unique districts each of which operates with semi-autonomous powers for administration, planning and technical support to service delivery.

There are lessons to be learnt from the Uganda decentralized level approach by the management of DMSACs. In Uganda the planned service delivery takes place at community level with the support of the district authorities. (*Uganda AIDS Commission 2003*) Key issues in project management such as capacity to implement programs, bottlenecks in channeling funds, personnel management and priority resource allocation are adequately addressed by district administration. Ownership and accountability for outputs by communities and local leaders is fully appreciated and realized. Generally, the decentralized system is appreciated in contributing to improvements in service delivery through increased community participation and better supervision, this creates an enabling

environment for developing the capacity of districts and secondly to manage and scale up the services and best practices in their response.

3.2 Findings of Behaviour Change in Eastern and Southern Africa

Changes in age of sexual debut, casual and commercial sex trends, partner reduction, and condom use all appear to have played key roles in the continuing declines. Although it is known that HIV knowledge, risk perception, and risk avoidance options can ultimately lead to reduced HIV incidence, there is a complex set of epidemiological, socio-cultural, political, and other elements that likely affected the course of the epidemic in Uganda. Many of these elements appear to be absent or less significant in other African countries that have not yet seen significant seroprevalence declines, such as Zimbabwe, South Africa, Botswana, Kenya, and Malawi. (*International HIV/AIDS Alliance, 2002*)

Findings include:

- Regarding prevalence, estimates are that national HIV prevalence peaked at around 15 per cent in 1991, and fell to 5 per cent as of 2001.
- High-level political support fostered a multi-sectoral response, prioritising and enlisting a wide variety of national participants in the “war” against HIV/AIDS.
- Behaviour Change Communication (BCC) interventions reached not only the general population, but also key target groups including female sex workers and their clients, soldiers, fishermen, long-distance drivers, traders, bar girls, police, and students, without creating a highly stigmatising climate.
- Early and significant mobilisation of Ugandan religious leaders and organisations resulted in their active participation in AIDS education and prevention activities.
- The most important determinant of the reduction in HIV incidence in Uganda appears to be networks and a decrease in multiple sexual partnerships. Condom promotion was not an especially dominant element in Uganda’s earlier response to AIDS. However, in more recent years, increased condom use has contributed to the decline in prevalence. (*Rakai HIV/AIDS Strategy 2003*)

- The effect of HIV prevention interventions in Uganda during the past decade appears to have had a similar impact as a potential medical vaccine of 80 per cent efficacy.

In considering whether this success in Uganda could be replicated elsewhere, the following points are relevant:

- Many elements of Uganda's response, such as high-level political support, decentralised planning, and multi-sectoral responses, do not affect HIV infection rates directly.
- The historical and socio-cultural context, various interventions and other factors are complex and may be unique to Uganda, and it is unclear to what extent this success can be replicated elsewhere.
- However, recent seroprevalence and behavioural survey data among youth in Zambia indicate that a Uganda-like success story may be in the making there, too.

3.3 Summary

Experience in Uganda and in other countries that have achieved some success suggests that a comprehensive behaviour change-based strategy, ideally involving high level political commitment and a diverse spectrum of community-based participation, may be the most effective prevention approach.

District initiatives in Uganda have integrated all sectors and ensured that AIDS Competence assessments are conducted in each district. These initiatives can play a key role in motivating the behaviour of individuals within their areas. DMSACS could implement intervention programmes that will address factors that spread the virus at district or community level and in the process develop programmes on behaviour change that will have an impact on men, women and the youth.

There are lessons to be learnt from the Ugandan initiatives by Botswana on how members of the community could be encouraged to become involved in district initiatives.

CHAPTER 4

RESEARCH DESIGN AND METHODOLOGY

4.1 Research Design

The research design looks at the methods, procedures, sampling techniques and instrumentation used in the research. It also encompasses data collection, data analysis and problems or limitations encountered in the collection of data.

The study was done in the following districts and sub districts: Gaborone, Kgatleng, Kweneng, Palapye, Francistown, Kgatleng, Kasane, Maun, Lobatse and Kanye.

The study is both descriptive and analytical. The use of observation enabled me to critically analyse some activities district multi-sectoral AIDS Committees. I also chose the descriptive research design because the design is associated with the questionnaire which involved the use of structured interviews.

4.1.1 Sources of Information Used as Input in Construction of the Research Design

Information was collected from a wide variety of sources. Both primary and secondary data were sourced. The researcher used the Ministry of Health, research department at the Ministry of Local Government, District Councils, resource centers and University Library, National Institute of Research (University of Botswana). Unpublished thesis and articles were used for secondary data. Primary data was obtained through the use of the interviews and participant observation where I held informal discussions with the respondents.

The following were also used as sources of information for the design of this study:

- Selected 10 key informants in charge of the HIV/AIDS programmes in the DMSAC;
- Activity reports of DMSAC's;
- The limited existing literature;
- Official government reports; and
- Reports of relevant United Nations agencies.

4.2 Sampling Techniques

4.2.1 Research Tool

The research tool utilized in this study is a questionnaire consisting of open ended questions. This process facilitates active participation of each coordinator of DMSAC who answered the questionnaire.

Participant observation and a structured interview schedule were used to collect primary data. I visited the ten district multi-sectoral AIDS committees to discuss the selection of the key respondents. A structured questionnaire/interview administered by the researcher was found to be appropriate because respondents had a heavy workload and therefore, the researcher had to be there to interview and record the answers. The other advantage was that the researcher was there to clarify some ambiguous questions and was also able to complete the task on time.

4.2.2 Data Collection

The interview schedule was administered to one set of respondents. The interview schedule was aimed at collecting factual data on the organisation structure and roles of district multi-sectoral AIDS committees and to study the attitudes and opinions held by respondents regarding their duties as district coordinators. Informal discussions were held with some members of the district multi-sectoral committees to get explanations for certain activities done by their communities. A combination of structured and unstructured interviews and participant observation were found to have provided reliable data.

The sample size of the study was ten (10). Ten out of twenty four districts were used in the study as they were the first to set up District Multi-Sectoral AIDS Committees, and they reflect a similar pattern as to how all the committees conduct their business. Questionnaires were issued to the co-ordinators from the 10 DMSACs and the results obtained from the answers were used to ascertain whether the DMSACs have the skills, strategies and capacity to achieve their aim of successfully implementing the Government HIV/AIDS policies and programmes at District level.

The study has employed a non-probability/availability sampling procedure which involves the first available, appropriate sampling units within the total population of coordinators for DMSAC in the ten districts. This can be viewed as the total population of active DMSAC members in each district.

4.3 Methodology

This study is based on a *qualitative* methodology, as described by Morse (1992) and Kim (1993). The questionnaire has been developed and administered to the 10 coordinators of each the 10 District Multi-Sectoral AIDS Committees (DMSAC) involved in this study. Co-ordinators in the District Multi-Sectoral AIDS Committees have, over the last five years, provided leadership in the implementation of HIV/AIDS programmes in the districts. Interview material has been subjected to *narrative analysis* (using techniques suggested by Reissman (1993) in order that the underlying themes can be identified. The researcher has also tapped on his experiential knowledge.

The choice of a qualitative approach is dependent upon the questions, which were asked from the target group. Therefore to get a meaningful insight into and from the data the questionnaires were structured to ascertain the opinions of the co-ordinators on the most important issues which affect their capability to function effectively.

In order to fulfil the overall objectives of this research report, the following areas have been considered when designing the questionnaire: policy, function, planning, financial and human resources.

Broad stakeholder participation in the ten districts involved in the research: Consultation with local stakeholders and service providers helped to identify what the key areas of investigation should be. At the same time, local capacity was improved by drawing on local expertise for consultation, data generation, and analysis of results.

Advocacy: The results from the research programme will provide the evidence needed to advocate for sustainable interventions that improve the capacity of DMSACs. This will be especially pertinent for effective implementation of intervention programmes.

Programme implementation: The researcher, in collaboration with key local stakeholders (district AIDS coordinators) will be able to **identify feasible interventions and best practices** needed for district planners or decision makers to implement the identified interventions and other recommended strategies.

Feasibility of project and research methodology: The participatory research methodology employed “enables local people to share, enhance and analyse their

situation, to plan and to act'. It supports decentralised planning and more democratic decision-making, as well as placing value on social diversity, sustainability, enhance community participation and empowerment.

4.3.1 Units of Investigation

Units of investigation are the actual entities (objects, people, or events) that are under investigation. In this study, the units of investigation are the 10 members from each of ten districts involved in this research.

Under the current national strategy to prevent and mitigate the impact of HIV/AIDS in the district, members of the DMSAC have been given the mandate by the Central Government to implement programmes.

Each of these members has been given a questionnaire to complete in order to get a professional point of view of experience and recommendations as how to improve the implementation of programmes.

4.3.2 Data Analysis and Interpretation Procedure

The data was analysed quantitatively and qualitatively. The qualitative analysis in this study involves the presentation of data in a thematic form, i.e. data was organised around common themes. Qualitative analysis also involved discussion of data from the interview schedule and the researcher's point of view.

4.4 Limitations of the Study

The concept for DMSAC was developed in Botswana by officials in the Ministry of Health and The United Nations Development programme. The concept was not replicated from any of the countries that have experienced a mature epidemic and as a result there is very limited research material on their implementation and success. Uganda that uses a similar model has not institutionalized management structures but has instead integrated all AIDS related activities in the different departments. Botswana has a unique system and this provides the researcher with very limited qualitative and quantitative research material to use.

CHAPTER 5

RESULTS AND COMMENTS FROM THE SURVEY

5.1 District Multi-Sectoral AIDS Committee – DMSAC

Tools were administered to 10 District Multi-Sectoral AIDS Committee members during the study. Interviews were also conducted with task force members of DMSAC. Their understanding of the DMSAC responsibilities is:

1. Involvement of different sectors/stakeholders in the community in response to programmes on AIDS epidemic.
2. Intersectoral approach to HIV/AIDS problem in order to expand and vary intervention methods or approaches for maxim benefits of all stakeholders.
3. Participation of different sectors and stakeholders through information sharing, consultation, cooperation and co-ordination of multi-sectoral response structure and programme for common courses.

Generally the District Multi-Sectoral AIDS Committees have been able to mobilize the community and resources so that they can implement intervention programs. However, 80% of those interviewed indicated that lack of training on planning, implementation, management and monitoring skills have hampered the implementation of effective strategies.

5.2 Respondents Comments Derived from Questionnaires:

Eighty five percent (85%) of those interviewed showed a lack of clear terms of reference and funding procedures is another setback for the DMSAC. The generic terms of reference in MTP II 1997-2002 have not been used as a guideline to develop terms of reference which are relevant to the district. This has contributed to the poor attendance to the meetings and commitment to implementation of projects. Composition of DMSAC does

not include all the stakeholders in the district. Government departments are not represented resulting in the situation where there are no on-going programs on prevention and care for civil servants. Although a large sum of money has been on a number of projects initiated by DMSAC there are no indicators to show the impact of these interventions.

5.3 Conclusions Derived from Analysis of Data.

Limited donor funds therefore cost effectiveness is important. The programmes must have a major impact and Districts have to implement stringent cost restrictions.

Build a team for each district. Workshop multi skilling techniques. Management and Programming skills are needed at District level to empower the Aids co-ordinators and other district offices to provide leadership for District initiatives.

District AIDS co-ordinators: view that strengthening management and programming capacity at District level is crucial if Botswana is to effectively respond to this epidemic. However, there is an urgent need to consider providing specific training workshop programmes that will deal with Human Capital Development and tools for cost effective analysis.

5.4 The Gaps in Prevention, Care and Support within DMSAC from the SWOT Analysis (Strengths, Weaknesses, Opportunities and Threats) Table 1.

The use of generic terms of reference which are outlined in MTP II affects the operations of DMSAC because they are binding.

Composition of DMSAC does not represent all the stakeholders in the district. Membership should also include those who have the authority to drive the projects. {representatives from informal sector} ?

Procedures for funding projects and flow of funds from the central government needs to be clarified.

Members of DMSAC need to use the strength of their sectors to respond to HIV/AIDS.

The DMSAC has not exploited the capacity of community counseling in dealing with stigma, and strengthening STD treatment and prevention, MTCT, TB and HIV/AIDS Care, support and prevention.

Failure to establish an information management system that will capture information on training for HIV/AIDS related issues in order to ensure that the problem on capacity building within the district is sustainable.

There is a need to address the issue of training on project management, which includes planning, on-going monitoring, management and evaluation has been overlooked although such training would improve the functions and effectiveness of HIV/AIDS projects.

5.5 The Needs of the DMSAC include:

- funding
- training
- advocacy
- materials (transport and other logistics)
- staffing

5.6 During the year 2000 DMSAC achieved the following:

- Improved capacity building
- Improved Community Based Organisations (CBOs) and community AIDS programmes
- HIV/AIDS IEC dissemination

Improved Home-Based Care services and referrals

- Improved networking among cooperative partners within and outside the District
- Improved participation of political leadership.

Table 1: SWOT ANALYSIS OF THE TEN DISTRICT MULTI-SECTORAL AIDS COMMITTEES

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
DMSACs were setup in 1998 AIDS Coordinators & Secretary to the DMSAC Plans and budgets are developed through participatory process. Developed plans to support wards AIDS committees Awareness creation workshops on HIV/AIDS prevention, home based care and counselling Mobilised traditional and spiritual healers for focused action on HIV/AIDS prevention and care Reasonable level of political and district management support Growing participation of NGOs and CBOs including religious groups	Prioritising in planning for prevention programs Lack of gender sensitivity in developing programs for prevention and care No district based Information, Education and Communication strategy No clear recruitment plans for DMSAC membership Non availability of strategy for community mobilisation Failure of using generic terms in MTP 1997 – 2002 to develop district based terms of reference. Failure to develop tools for monitoring and evaluation of impact of several workshops and training Records on the number of people who have been involved in HIV/AIDS training activities not available. Critical areas for capacity building not addressed (e.g. community counselling). Politicians (MPs & Counsellors) are not actively involved in HIV/AIDS related activities Clear guidelines for the AIDS co-ordinators on the areas of technical support that the UNV should be providing to DMSAC. Lack of on-going training on project management for the International UNV by UNDP	HIV/AIDS related studies and research (e.g. Situational Analysis and MTCT sponsored by Harvard AIDS Institute) have also been conducted in the districts in the last few years Students from Institute of Health Science could be involved in providing clinical care during the period of their studies, while students from Colleges of Education could be mobilised to train community counsellors Business community in the ten districts is committed to active participation in HIV/AIDS activities (District Home Based Care Committee has the support and participation of both Government and Private Sector) On-going training and capacity building for prevention and capacity building in community based preventive counselling, Voluntary testing and Counselling, and home based care.	Lack of co-ordinating desk for HIV related activities within the district could result in a situation where the districts could be overloaded with studies, research and intervention programmes. Lack of monitoring tools by DHT and DMSAC to show efficacy of syndromic approach and trends in HIV within the districts could affect the capacity to respond to the epidemic with focused action. Non availability of specialised health providers who are responsible for STDs management. Non existence of co-ordinated approach by HBC and TB programme. No guidelines for members of DMSAC for reporting and follow-up action on district activities to their sectors. Senior Officers in Government and Private Sector do not attend meetings regularly.

CHAPTER 6

DISCUSSION, SOLUTIONS, CONCLUSIONS AND RECOMMENDATIONS.

6.1 The Prevalence of HIV/AIDS in Botswana

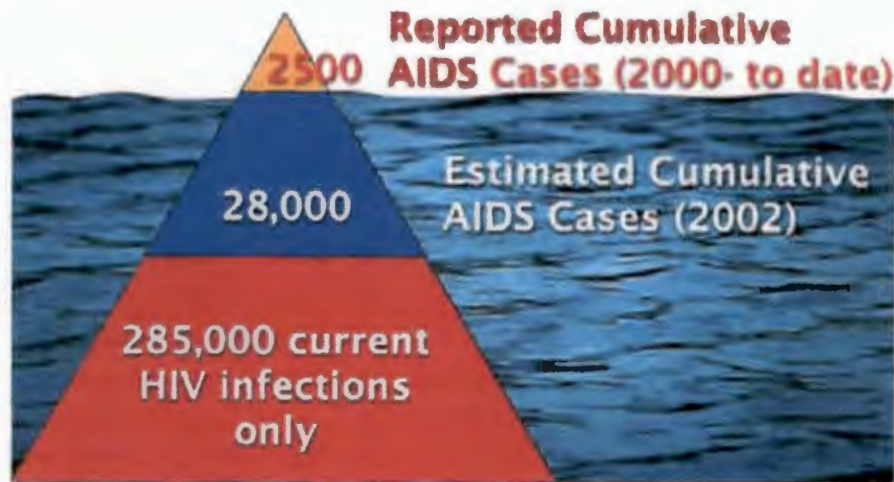


Fig. 1 HIV/AIDS Pyramid in Botswana

Source: *AIDS IN BOTSWANA, 2002*

Botswana is sitting with a “hidden epidemic” as the true number of AIDS cases is not known. As seen in the pyramid in Fig. 3 the orange tip shows 2 500 AIDS cases have been reported between 2000 – 2002 but an estimated 28 000 adults and children had developed it by the end of 2002 (blue) while the red portion indicates that an estimated 285 000 people are infected with HIV and as yet have not developed AIDS. (Many may not even show symptoms and know that they are infected.)

Facts in Brief: (*Status of the 2002 National Response to the UNGASS Declaration of Commitment on HIV/AIDS.*)

- More than one in three Botswana between 15 and 49 are HIV+
- An estimated 320 000 Botswana are living with HIV (0 – 64 + years)
- An estimated cumulative 138 000 Botswana have died of AIDS by 2002; an additional 263 000 are likely to die by 2010 in the absence of ARV treatment.

The percentage of 15 – 49 year olds antenatal attendees infected with HIV (prevalence) increased from 13.8% in 1992 to 35.4% in 2002 and there is considerable variation across districts as can be seen in Fig. 4 below.

Estimated HIV infected adults 15-49 years in Botswana, 2002

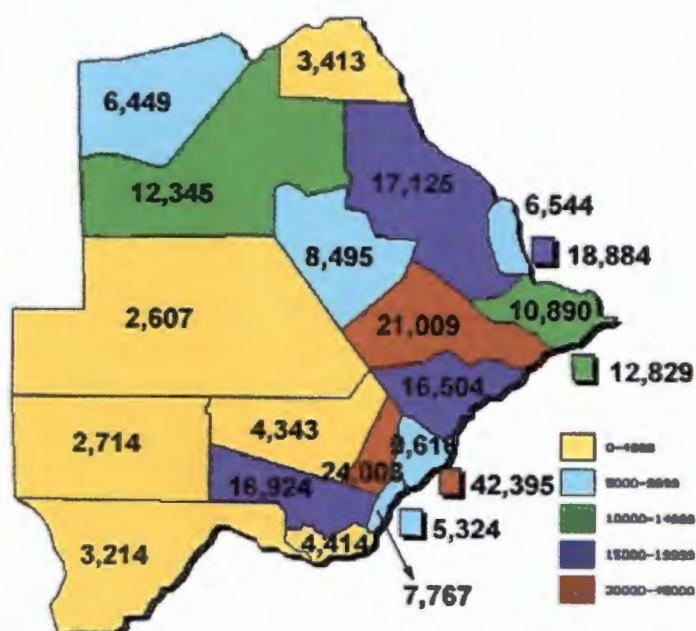


Fig. 2. Geographical Distribution of Prevalence Rate of HIV in Botswana.

Source: *Status of the 2002 National Response to the UNGASS Declaration of Commitment on HIV/AIDS.*

The geographical pattern of HIV may be directly related to the existence of truck routes and mining activities. For example in major mining districts like Selebi Phikwe the prevalence of HIV is over 50% among adults aged 15 – 49 years.

Many cities and towns in Botswana serve as transit and resting points for long distance truckers en-route to neighbouring countries.

The previously predominantly higher prevalence rates in the urban areas is also changing, as recent surveys indicate that infection rates are increasing at a higher rate in rural areas.

The highest HIV prevalence rate is consistently in the 25 – 29 year age group in which prevalence has been at 50% for the past 3 years. The lowest rates are among women aged

15 –19 years. However, by far the most worrying trend is significantly higher HIV prevalence rate among young women than men of similar age. (See Fig. 5 below.)

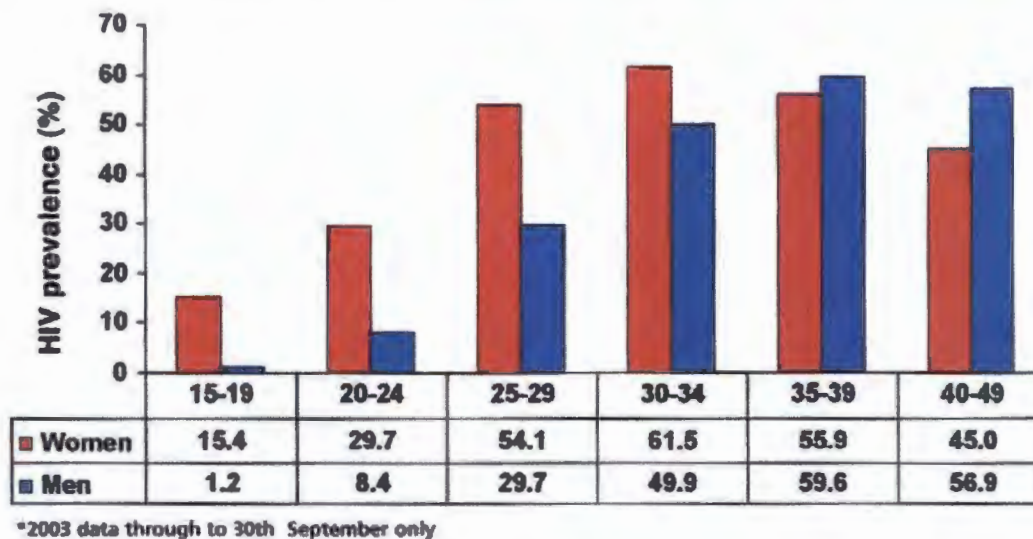


Fig. 3 HIV Prevalence by Age Group Among Men and Women Aged 15 –19. Tebelopele VCT Centres, 2003.

Source: *Botswana 2003 Second Generation HIV/AIDS Surveillance*

However men have higher prevalence in the older age groups. A similar pattern is seen among those who have developed AIDS. (See Fig. 5 below.)

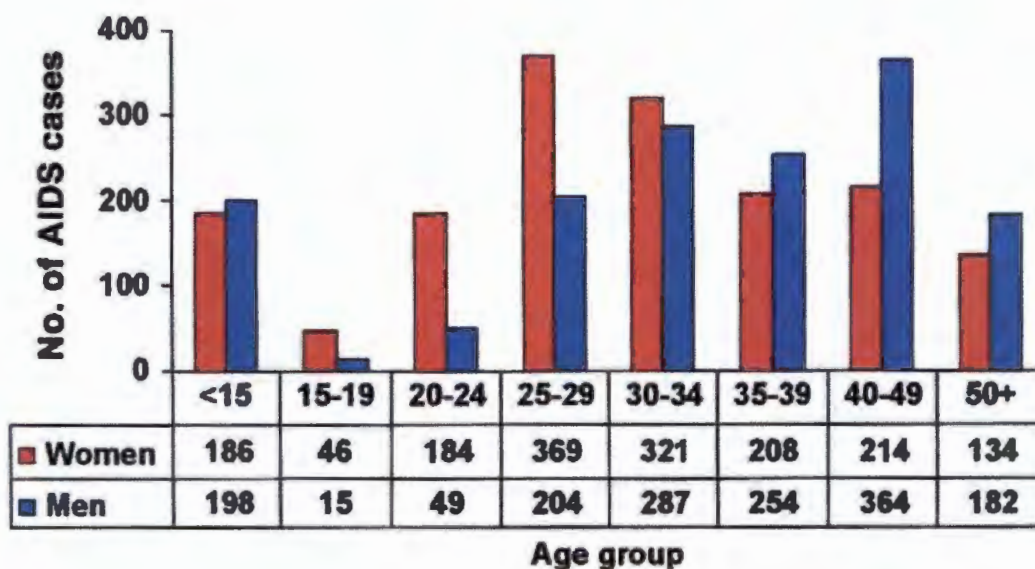


Fig 4. Distribution of Reported AIDS Cases by Age, 2000 – 2003.

Source: *Botswana 2003 Second Generation HIV/AIDS Surveillance*

It can be observed that as persons in the 25 –34 age group constitute the most productive age group of any nation and as they are the worst affected by HIV/AIDS there is going to be a depletion of the work force. In fact, this has already occurred in the some sectors such as mining, agriculture and education.

The high level of HIV infection in the most sexually active age group will certainly reverse the gains that Botswana made in the past two decades in child health indicators. Between 1971 and 1991, infant mortality rate per 1000 declined from 92 to 45, while under five mortality rate fell from 151 to 56 over the same period.

Life expectancy in Botswana increased from 55.5 to 61.7 between 1971 and 1991. The significant gains made so far in life expectancy are also under threat from the scale of the HIV epidemic. Although exact figures are currently not available the average life expectancy of Batswana has decreased significantly in the last 10 years and the most pessimistic estimate so far (supplied by UNAIDS and US Bureau of Census) suggests that life expectancy in Botswana could drop to 29 years by 2010.

However there is evidence that HIV prevalence is slowing down, particularly among the 14 –19 age group. (See Fig. 7 below.)

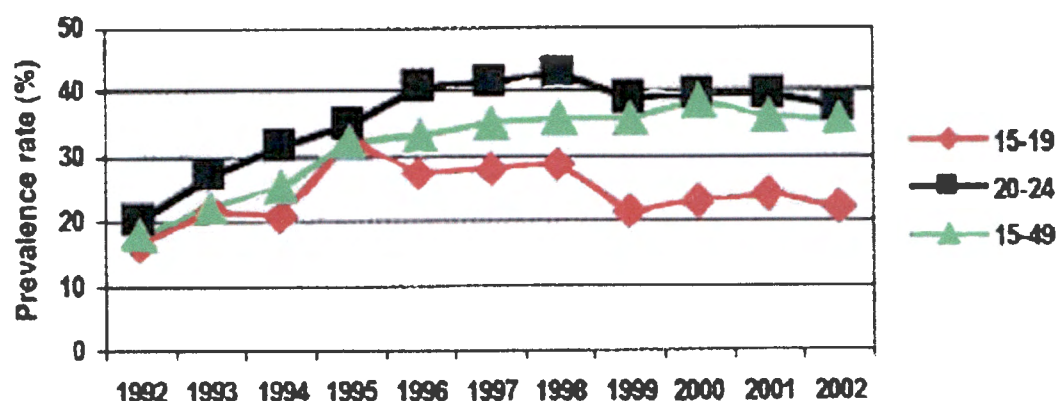


Fig. 5 Trends in HIV Prevalence by Age Group 1992 – 2002

Source: 2002 *Second Generation HIV Surveillance Report*

6.1.1 The Origins of the National AIDS Programme

Typically the Government response to HIV/AIDS in Africa has consisted of policies, strategies, goals and delivery mechanisms which embody what is now called National AIDS prevention programmes (NAP).

Through a series of well-coordinated policies, management instruments supplemented by technical visits by Botswana and United Nations health officials, National AIDS Programmes were established to consolidate these efforts by UNAIDS strategy for HIV/AIDS prevention and care which had the following components:

- (a) prevention of infection with HIV
- (b) reducing the personal and social impact of HIV infection
- (c) mobilizing and unifying national and international efforts against AIDS

6.1.2 Botswana Government's Response to the Epidemic.

There is a high level of political and economic commitment by the government of Botswana. Botswana is among the 19 African nations that have established National Aids Councils or commissions personally chaired by the Head of State to take charge of a multi-sectoral response to AIDS.

Two years after the first case was diagnosed, Botswana initiated the following:

- a) Set up the National AIDS Control Programme.
- b) Developed an emergency one year response plan called the Short Term Plan (STP).
- c) Developed a broad based five year First Medium Term Plan I.

Followed by:

- d) Botswana HIV/AIDS second Medium Term Plan MTP II 1997 – 2002.

Among the most important government initiatives were the formulation and adoption through a Presidential Directive of a National Policy on HIV/AIDS in 1993. This policy articulated government's concern about the epidemic and its consequences for the development of the country. The Government also recognised that political commitment, openness about the disease and its consequences, community participation, prevention, care and support, are essential at the district level.

6.1.3 The National Policy on HIV/AIDS

The National Policy on HIV/AIDS takes the form of a multi-sectoral framework. The main component is the District Multi-Sectoral AIDS Committees which were set up in 1998.

The multi-sectoral approach is the most effective answer to fighting the spread of HIV and dealing with its consequences because it ensures that all sectors determine how to

strategically respond to the HIV epidemic and can contribute to various issues such as how the epidemic is likely to affect their own sectors' plans, objectives and goals in the future. Particularly important is the involvement of district authorities and communities in mobilising all sectors into developing strategic plans which can focus on district multi sectoral response.

6.1.4 District Multi-Sectoral AIDS Committees

The districts and communities are part of the national response structures, as out-lined in MTP II (*Botswana HIV/AIDS Second Medium Term Plan, MTP II 1997–2002*). The implementation of the MTP II resulted in decentralisation of HIV/AIDS prevention and care programmes to the district, sub-district and community levels as the District Multi-Sectoral AIDS Committees (DMSAC) are now responsible for the coordination and promotion of the implementation of response programmes and strategies at the district and sub-district level. Technical committees in the various DMSACs have the task of providing each District with leadership and technical support during the implementation of intervention programmes.

DMSACs functions are to:

- a) Articulate and identify priority areas for prevention and mitigation responses at district and sub-district levels
- b) Translate national response programmes and strategies annually into plans of action and projects at district and sub-district levels.
- c) Co-ordinate and supervise implementation of MTP II programmes, projects and strategies at district and sub-district levels.
- d) Monitor and evaluate MTP II activities of the various district and sub-district organizations.

These committees also have the responsibility to liaise with National AIDS Coordination Agency (NACA) on issues of strengthening institutional capacity at district and sub-district levels and mobilise resources for implementation of activities of various institutions, NGOs and CBOs at district and sub-district levels.

6.1.5 Composition of Multi-Sectoral AIDS Committees

The district commissioner and council secretary are co-chairpersons, at district level, while the district officer and assistant council secretary are co-chairpersons, at Sub-District level.

Other members included in the committees are the chief or his representative, principle or senior district medical officers and matrons. There two members of the district council – reflecting gender balance Heads of Departments of Agriculture, Education, Health, Labour and Social Welfare, Planning Officers or District Officers.

Officials from Police and Prisons; two representatives of prominent NGOs operating in the district/sub-district; two prominent citizens in the district – reflecting gender balance and the chairman of the Land board, are also members of the committee.

6.2 District Guiding Principles and Organisational Framework

The district guiding principles are derived from the National AIDS Coordinating Programme (NACP). As such, it falls into the category of national priorities with local strategies. The goals of the NACP are the prevention of further spread of HIV transmission and the reduction of the HIV/AIDS impact at the individual, family and societal levels. The Multi-Sectoral National Council (NAC) is the highest national body that advises government on all matters of policy in relation to HIV/AIDS in Botswana. NAC is charged with the responsibility to coordinate, oversee, and monitor the implementation programmes and strategies of the national response to the HIV epidemic and the AIDS scourge.

The districts and committees part of the national response structures during MTPII (1997-2002). The implementation of MTPII is based on decentralization to the district, sub-district and community levels with sufficient attention being paid to gender, geographical representation, cultural and religious diversity, variety of expertise and key stakeholders, including the youth and PLHA (People Living with AIDS), in the policy and implementation organs. All districts and sub-districts are to establish Multi-sectoral AIDS Committees to coordinate and promote the implementation response programmes and strategies at their district and sub-district levels. The district and sub-district Multi-Sectoral AIDS Committees are to instruct the Village Extension Teams and Village Development Committees to establish Village AIDS Committees. The composition and functions of Village AIDS Committees are to be determined at the district and sub-district levels. The NACP is responsible for strengthening district level capacity for effective information, education and communication (IEC).

6.3 Discussion

6.3.1 Exploiting Proven Prevention HIV Strategies

The world knows much about how to prevent HIV transmission, and both developed and developing strategies can have a major impact. This blueprint for action by *the Global HIV Prevention Working Group Report 2002*, provides a road map for rapidly scaling up prevention programmes to contain and ultimately reverse the AIDS epidemic.

The report provides effective models for HIV prevention interventions, identifies obstacles to quickly expanding prevention programmes, and makes specific recommendations to prevent millions of infections this decade. The sense of inevitability about HIV/AIDS ignores not only the extraordinary resources at the world's disposal but also the fact that our knowledge of effective prevention strategies has grown substantially in recent years. Extensive scientific research has identified effective prevention interventions for all routes of HIV transmissions.

Effective HIV prevention involves a carefully planned combination of these interventions, reinforced by public policies to combat the social factors that facilitate HIV transmission. Just as combination antiretroviral therapy slows HIV replication by attacking the virus from multiple angles, effective prevention strategies must be integrated to address the many behavioural and biomedical susceptibilities of individuals and communities. Given the over-whelming evidence demonstrating what works to prevent HIV transmission, the biggest challenge is to scale up effective prevention models to reach millions more people at risk. However, a number of obstacles stand in the way of bringing prevention programmes to scale.

The Working Group makes the following recommendations to expand HIV prevention to reach all those at risk, and help prevent millions of new infections this decade:

- Substantially increase and sustain prevention funding
- Build capacity and scale up proven prevention strategies
- Encourage vocal political leadership
- Use prevention resources more strategically
- Expand access to key prevention tools
- Accelerate research into new prevention technologies
- Confront social factors that facilitate the spread of HIV

Interest has been growing in the ABC approach to sexual behaviour change to prevent HIV, especially for generalized, high prevalence epidemics. (*Partner Reduction in HIV Prevention: The Neglected Middle Child of ABC*. 2003, James D. Shelton¹, Daniel T. Halperin¹, Vinand Nantulya², Malcolm Potts³, Helene D. Gayle⁴, K. K. Holmes Affiliation.) In this approach A stands for “Abstinence” or delay of sexual activity, especially among youth. B literally stands for “Be faithful” - but importantly also includes partner reduction for those having multiple partners. C represents “Condom” use, especially for higher-risk sex. In the often dialectical discourse surrounding AIDS prevention, some voices have stressed A, whereas others have concentrated on C. However, B has been something of a neglected middle child of behaviour change efforts, and could, in fact, become the centerpiece of a unifying, evidence-based ABC approach. Based on the available evidence, fidelity and partner reduction deserve considerably more attention than they have heretofore received in either research or programs for STD/HIV prevention. We need to develop rigorously evaluated best practices on how to promote B and apply them in conjunction with other ongoing behaviour change efforts. Rather than expending energy debating the merits of A versus C, the international health community should unite around the common ground of a balanced ABC approach, tailored to the local epidemiological and socio-cultural contexts. In this way we can build on the partner reduction and other behavioural changes that are already happening, and help reverse the tide of AIDS.

6.4 Solutions

DMSAC should consider developing their own terms of reference which will address the needs of the district. Such as:

- ❖ Guidelines on procedures for funding should be developed by DMSAC and distributed to all the stakeholders.
- ❖ District based team which should include planners should be considered for monitoring projects activities.
- ❖ Developing HIV/AIDS information management systems in order to monitor initiatives on capacity building.
- ❖ Project management training for all managers representing stakeholders within the district.

The multi-sectoral approach adopted in Botswana is a liberal policy, which gives a wide range of role players an opportunity to take part in planning and implementation of HIV/AIDS activities thus creating a wider scope for individuals to be served. Decentralization within the districts could result in increased interest of actors to directly focus their HIV/AIDS interventions at community levels. Cross community information sharing and central level sharing of information is limited. Resource mobilization is mainly project specific. (Uganda AIDS 2003 Commission.) Applying other resources to HIV/AIDS activities through mainstreaming is should be encouraged in all districts in order to strengthen DMSACs. Enough manpower should be committed at District level in order to ensure effective implementation of programmes. Whereas the concept of multi-sectoral planning is being appreciated and applied in districts, monitoring and evaluation for HIV/AIDS is not well developed. Well defined indicators should be developed within the monitoring and evaluation systems in order to generate information needed for decision making.

Traditionally, monitoring and evaluation have been perceived as forms of control mainly because their objectives were not clearly articulated and understood. Thus, the learning aspect of monitoring and evaluation needs to be stressed along with the role that these functions play in decision-making and accountability. (United Nations Development Programme, 2000.) In the context of district response, the contribution of learning to the building of capacity within each DMSACs to improve management of intervention programmes should be emphasised.

Thus, evaluation can be considered as part of an ongoing learning process, through which people will find the solutions to specific problems relating to implementation of programmes. This summarised in the diagram below. Evaluation occurs when people:

- consider what is needed in the current situation
- reflect on what has happened so far
- collect data to check whether their initial impressions are accurate
- analyse that data
- use the data to decide how a situation has changed, or what actions should happen next.

6.4.1 A Circle of Learning: the General Processes of Learning

Some possible uses of evaluation

Within the learning cycle, what is the particular role of evaluation? This depends on what is considered most important to learn at any stage of the process. The United Nations Development Programme UNDP (*UNDP: Evaluating HIV and Development: Guidelines and Suggestions - Evaluating HIV and AIDS: Why capacity development is central to assessing performance, 2000*) suggests that three interrelated dimensions of programmes and projects must be assessed as the substantive focus of monitoring and evaluation: **relevance**, **performance** and **success**. The handbook suggests the following considerations for each of these areas of focus:

Relevance

Is the programme or project valid and pertinent?

- Development issues, problems and priorities at the district and community/village levels
- Target groups
- Direct beneficiaries

Performance

What progress is being made by the programme or project relative to its objectives?

- Effectiveness
- Efficiency
- Timelines of inputs and results

Success

What has the programme or project done to bring about change?

- Impact
- Sustainability
- Contribution to capacity development

UNDP: Evaluating HIV and Development: Guidelines and Suggestions - Evaluating HIV and AIDS: Why capacity development is central to assessing performance, 2000

6.4.2 In order for the DMSACS to respond to the epidemic they should go through a Strategic planning process. Strategic planning for responding to the HIV/AIDS epidemic entails the development of cost-effective strategies to prevent the spread and mitigate the impact of HIV/AIDS. The goal is to reduce the number of new infections of HIV and the consequences of AIDS. In other words, to move towards a situation where HIV spreads less rapidly and has fewer negative consequences for those infected their families, and the society at large.

Such strategic planning is based on situations which are different according to the population group addressed, and which may change rapidly over time. It therefore means devising strategies relevant to concrete situations, flexible enough to be adapted when that situation changes, and realistically & taking available resources into account. A strategy is a formulated or thought out means of moving from a current situation to a stated goal; either in one bold step or through a series of successive steps.

The strategic planning process encompasses: the answer to three questions:

- (1) what is the HIV/AIDS situation in the district;
- (2) what has been the response so far;
- (3) what should be done about it in the future.

6.4.3 Priority Areas and Broad Strategies

The priority of targets of the response derived from what has been learnt from the situation and the elements of the response to date. The following elements of the response are necessary and should therefore be implemented.

i Behaviour Change Communication

These need to be more frequent and more tightly focused on all segments of society. Health professionals, politicians (national and local) men's and women's activists need to be solicited to lend assistance in trying to influence community receptivity to this and other response elements. In addition, other respected community figures, such as traditional leaders, religious leaders and teachers and should be drafted into the **behaviour change communication** campaign structure. If the communities are not regularly or properly informed and educated on the perils of HIV/AIDS, then there can be no sustained progress toward the reduction of the spread of HIV and the mitigation of the impact of HIV/AIDS.

ii Condom Promotion and Distribution

Condoms represent the only barrier method known to prevent the transmission of HIV during penetrative sexual intercourse. Consequently, encouraging and supporting the use of good quality condoms has to be a basic strategy for any HIV prevention programme. Successful and effective condom programmes ensure that condoms are available and affordable to users. Convenient places and methods, other than clinics and health posts need to be found for men, women and youths to access condoms.

iii Sexual Reproductive Health Education

Sexual debut for most young people in the districts occurs primarily during their pre-teen and early teenage years. Young people who are sexually-active are generally not in a stable sexual relationship and may have frequent changes of partner. They are often ignorant of the health risks of sexual behaviour. In addition, they are sensitive to peer pressures to engage in unprotected sex and some are sexually exploited by adults. Educating adolescents on contraception, HIV/AIDS and other STIs prevention has to be made an integral part of their activities. This is not only necessary on its own merits but also due to the fact that parents, although keen to help their children, still do not communicate adequately with them about sex. Many parents feel inadequate to the task despite the fact that the youth have been crying for their parents to communicate with, and guide, them on matters related to sexual health. *(A Situation Analysis of HIV/AIDS, Kweneng District, Botswana Government, 2000, Unpublished Report)*

Thus, we have a situation in which people are beginning their sexual lives as youngsters and have a reasonable turnover of partners once they do; there is a demonstrated risk in terms of unwanted outcomes (pregnancy, HIV/AIDS and other STIs infections) and parents are concerned but unprepared for intervention. However, the international evidence indicates that education prior to sexual initiation is most efficient in terms of reducing teenage pregnancy and STIs infection. The need for formalized provision of education about sexual health and its potential consequences for young people is therefore apparent.

At the same time, young people can be a positive asset in helping prevent HIV and STIs. As they are still developing behaviour and experimenting in sexual matters they can adopt safer practices from the outset - or switch to them - more easily than adults. Their attitudes are also usually less rigid and they tend to have less entrenched taboos. They can exert a strong influence on one another. This can be negative, by encouraging: each other to engage in risky behaviours, but equally, it can be channeled positively in AIDS education

programmes to spread messages on what is safe and what is not with respect to AIDS. Peer-based AIDS education is known to be more effective than education developed and delivered by other "external" agents, especially in remote communities suspicious of government programmes.

Young people also have great energy and commitment. Since they have had less time to develop prejudices young people can also learn to adopt non-discriminatory behaviour and attitudes towards people with HIV/AIDS far more easily than adults can. Given the vulnerability of young people in all the districts to HIV and other STIs, more needs to be done to help them protect themselves. Leaving education matters relating to sexuality to parents alone is a haphazard policy which is doomed to failure for reasons stated before. Community based organisations must take on this task.

Cross-cultural studies have shown that good sexual health education among adolescents does not lead to increased sexual activity but on the contrary, delays the age of first sexual intercourse. Similar studies have also confirmed that when the same adolescents become sexually active, they tend to avoid risky sexual behaviour. (D. Cohen, 2001: *Development and the HIV Epidemic: Strengthening Multi-Sectoral Programmes*) Since young people are a huge asset to society and represent the future, it is worth investing in them to help bring the overall HIV epidemic under control in the districts.

iv Community Mobilization and Participation

Community mobilization and participation (CMP) is required to ensure grassroots input in response development and implementation. For any community-based service delivery programme to be successful, it must have the active support and participation of the affected community in the decision-making process bearing upon the delivery and distribution of that service.

For this study, community is defined as a group of people who have something in common and will act together in their common interest. In the districts, many people belong to a number of different communities, such as their village, the people they work with or their religious group, for example.

CMP has always played a major role in the global response to HIV/AIDS. As a matter of fact, in many countries such as Uganda for example, (*International HIV/AIDS Alliance, 2002*) CMP came before the official national response. It has proved essential to many

components of a successful response particularly with respect to empowerment capacity-building, and effectiveness. CMP, as a scale of both reference and intervention is a crucial concept in AIDS prevention. Its basic principle revolves around the ability of a community to say: "We did it ourselves".

If people in the various villages are to take initiative, be creative, learn and assume responsibility for not contracting HIV/AIDS, they must actively participate in the development and implementation of the response. This requires building into policies and programmes features which enable and facilitate CMP. Community mobilization and participation in response to AIDS is occurring in many countries and has been shown to be an effective way to change attitudes and behaviour within communities, to provide care and treatment to community members, and to design and implement prevention programmes that have a lasting impact.

In sum, the experiences of CMP and lessons learned in their development of prevention programmes highlight four key elements of the process.

First: participation can increase the likelihood of action through community members becoming involved in activities. This involvement may be in the development of ideas, designing an approach or participation in the implementation of community programmes.

Second: Within communities there are already existing resources that can be used to develop programmes and promote change. In the districts these resources include local organizations and groups that play a key role in mobilizing change, as well as political and religious leaders.

Third: the involvement of people most affected by HIV/AIDS, including those who are infected can add significant impetus to change as the community rallies to provide support reflecting the usual communitarian spirit.

Fourth: CMP eventually leads to empowerment by providing communities with the ability to take control of a situation and a sense of knowing what to do to reduce vulnerability to HIV infection.

v Resource Availability

The availability of resources is an often overlooked priority area in the development of response strategies for dealing with HIV/AIDS because the emphasis tends to be on the

health aspects of the disease rather than on a multi-sectoral approach. Yet at the same time, resources are an essential component of any multi-sectoral effort to successfully respond to the AIDS epidemic. Without adequate and appropriate resources, the best thought out strategic plan is doomed to failure.

In most districts, human resources (informed, knowledgeable, and skilful people with respect to HIV/ AIDS) are required to act as catalysts in the implementation of the various elements of the response. Ensuring the development and acquisition of such human resources must be a part of the basic strategy. Moreover, until there is a cure for AIDS responding to the epidemic in a strategic way will require an on-going process of resource availability to build institutional capacity; acquire and maintain knowledge and skills.

6.4.4 Elements in Need of Response

The previous section identified and discussed the priority areas and broad strategies for the strategic plan. It can be regarded as the macro planning framework for the HIV/AIDS response in the Districts. This section discusses the key elements in need of response, including the specific objectives and associated strategies for each. It can be regarded as the micro planning framework.

i Men

Men are much more dominant in the rural and remote areas than they are in the urban areas of Botswana. For purely socio-cultural reasons, men engage in multi-partner sex and maintain extensive sexual networks. They are regarded and they accept themselves, as being more knowledgeable than women about sex and sexuality even though that may not be the case. Men also determine whether or not condoms are used during sexual intercourse. (*A Situation Analysis of HIV/AIDS, Kweneng District, Botswana Government, 2000, Unpublished Report.*)

The objective is to both increase awareness and improve the Sexual knowledge of men so that they can be channeled in a positive manner toward behaviour which reduces the risk of HIV infection. Targeting men is a winning strategy for addressing the HIV/AIDS problem. With HIV now spreading faster among women than among men in Kweneng West, the AIDS epidemic has focused attention on the health consequences of men's sexual behaviour. Men deserve to be targeted for their own sake, for women's sake and for the health of their families and communities.

Conversely, neglecting men and their sexual health is a losing strategy with adverse consequences for men, women, families, and society at large. Consequently, there are opportunities for men -as individuals, family members, community leaders, and policy-makers, for example -to promote better sexual health for all. Men can help slow the spread of HIV/AIDS and other STIs the districts. As HIV/AIDS continues to spread in all the districts, along with an increase in some other STIs, the need for men to practice safer sexual behaviour is becoming ever more urgent. Above all, men need to use condoms correctly and consistently and to limit their number of sexual partners.

The steps toward meeting the ultimate objective of behaviour change in men, as spelled out above, are shown in **Table 2**. These steps are generalized, it should be noted, because they apply equally to the discussions which follow below on women, youth, and the community at large.

Accomplishing the outcomes from these steps and, hence, meeting the objective, requires the pursuit of two initiatives. The first initiative is to use traditional leaders, sport, pubs and churches much more frequently as the primary forums, through which men are reached, for affecting the BCC campaigns. Traditional leaders have historically, been regarded as the reliable channel through which to reach members of the community. Churches can also play a similar role. The second initiative pertains to the promotion and distribution of condoms. Clinics and health posts do not currently provide the level of convenience that is desired by men for consistently obtaining condoms. Consequently, condoms need to be made available via outreach services using natural and popular points of congregation such as workplaces and bars. Men are comfortable in their natural environments and form a ready audience. Partnerships that can enhance the success of the foregoing initiatives - by providing human material resources are NGOs, government departments, district authorities and churches. A sustained and sustainable effort to target men, as per the objective previously outlined, will require that such partnerships be established in all the districts. (*A Situation Analysis of HIV/AIDS, Kweneng District, Botswana Government, 2000, Unpublished Report.*)

ii Women

Due to the dominance of men, as well as socio-cultural norms, women are at a particular disadvantage in all the districts. The majority of female-headed households are economically inactive and therefore extremely poor. For almost every indicator there is considerable gender inequality. Women are also prevented from acquiring and exhibiting knowledge about sexuality and reproductive health for purely socio-cultural reasons. A woman who is poor and uninformed about sexuality and reproductive health will find it much more difficult to insist that her partner abstain from sex with others or use a condom. At the same time, research shows that the risk of becoming infected with HIV during unprotected vaginal intercourse is as much as 2-4 times higher for women than men. Women are also more vulnerable to other sexually transmitted diseases. Moreover, the presence of untreated STIs, in either partner, multiplies the risk of HIV transmission by up to ten-fold.

Table 2: Steps and Outcomes of Sexual Behaviour Change (men)

Steps	Outcomes
Knowledge	• Recalls Sexual Health Messages • Understand What Messages Mean
Approval	• Responds Favorably to Sexual Health Messages • Discusses Messages or issues With Family Members and Friends • Thinks Family Members, Friends and Community Approve of Practice • Approves of Practice
Intention	• Recognises That Specific Sexual Health Practices Can Meet a Personal Need • Intends to Practice What has been Learned
Practice	• Visits Providers of Information and Sexual Health Services • Practice Safe Sexual Behaviours
Advocacy	• Experiences and Knowledges Benefits of Practice • Advocates Such Practices to Others

Source: Table 2 & 3 - A Situation Analysis of HIV/AIDS, Kweneng District, Botswana Government 2000 (Unpublished Report)

Table 3: Steps and Outcomes in the Empowerment of Women to Combat HIV/AIDS

Steps	Outcomes
Combat Ignorance	• Improved Access to Information About the Female Body • Improved Access to Information/Education About HIV/AIDS and Other STDs • Acquisition of Skills to Say No to Unwanted/Unsafe Sex
Provide Women-Friendly Services	• Improved Access to Health Care • Improved Access to HIV/STD Prevention and Care Services • Expanded Access to Counselling Services • Promotion and Distribution of the Female Condoms
Build Safer Norms	• Sustainable Support for Groups and Organisations Challenging Risk Behavioural Traditions • Education of Men and Boys to Respect Women, to Engage in Responsible Sexual Behaviour and to Share the Responsibility for Protecting Their Partners and Themselves from HIV and Other STDs
Reinforce Women's Economic Independence	• Improved Opportunities to Participate in Income-Generating Activities to Reduce Economic Dependence on Men

Lacking economic resources of their own, fearful of abandonment or violence on the part of their male partners, and willingly compliant with gender norms, women have little or no control over how and when they have sex and, hence, over their risk of becoming infected with HIV. This is the meaning of vulnerability.

The objective in this key area is to empower women while at the same time promoting gender awareness in BCC activities. The basic steps in the empowerment of women are shown in **Table 3**. To accomplish the specific outcomes of the objective, there are three initiatives to be pursued. The first is the tried and proven BCC campaigns to combat ignorance about reproductive health, HIV/AIDS, and other STIs, and to build safer norms through the specific gender awareness elements of those campaigns.

The second is an expansion of health care and community counselling services related to HIV/AIDS and other STIs as well as the associated promotion and distribution of condoms including the female condom. The third and final initiative here is the development of income-generating schemes or, at the minimum, the opportunities for women to participate in such schemes.

iii Youth

The youth are among the most vulnerable to HIV/AIDS and other STIs. They engage in unprotected sex and this results in high rates of teenage pregnancy and STD infections. As they mature and become more sexually active these young people face increasingly more serious health risks. They face these risks with too little factual information, too little guidance about sexual responsibility, and insufficient access to relevant health care. Meeting the diverse health needs of these young adults challenges parents, communities, health care providers, and educators.

The help that young adults need to avoid health risks can vary. Some young people may not yet be sexually active. They need support and skills to postpone starting sex. Some suffer, or have suffered, from sexual abuse. They need protection and care. Many start sex before marriage, and many others change sexual partners several times before they marry. They all need help to abstain from sex or use condoms to prevent pregnancy and the contracting or spread of HIV and other STIs. The objective here is to reach out to young people to educate them about sexual health and their role in promoting safer sexual behaviour for themselves and their peers.

The steps toward meeting this objective are as follows:

- (1) Involve parents and local leaders in developing Behaviour Change programs for the youth
- (2) Enlist young adults in programme design and delivery.
- (3) Provide training on life skills to avoid risks.
- (4) Link information and advice to health care services such as condom distribution

The first key initiative for achieving the objective, through the above steps is the design and implementation of in school and out of school youth sexual health education with a strong HIV/AIDS component. To win public support, programmes must work within community norms. However, at the same time, such programmes must advocate new social norms that protect the health of young adults.

Sexual health education programmes (sometimes referred to as family life education programmes (FLE) in some parts of the world) may encourage abstinence, teach reproductive health and physiology, build skills in avoiding risks, reduce behavioural patterns relating to the risk of HIV/AIDS, and inculcate respect for the rights, wishes, and concerns of others, including the use of condoms for HIV and other STIs protection and of contraceptives to avoid unwanted pregnancies.

iv The Community at Large

Men, women, the youth, and orphans are representative groups of the society. At the same time, they collectively comprise the community at large. Since the contracting and spreading of HIV/AIDS has interdependent impacts which have multiplier effects on that same community at large, it is necessary that steps be taken to involve and assist the community as a whole to mitigate the spread and impact of the disease. In other words, the objective is to both mobilize and empower the wider community to take actions to control the spread of HIV/AIDS and improve the quality of life of those affected.

There is one key initiative required to achieve the objective. That is to facilitate grassroots participation in the development and implementation of appropriate elements of the response. This targeting would allow for the creation of greater awareness of individual and collective vulnerability to HIV/AIDS; motivation to do something about that

vulnerability; and collective cooperation to improve the situation of those community members most seriously affected by the disease through activities such as social support to orphans and home based care to households with people living with HIV/AIDS, for example.

The partnerships needed to effect this initiative have to be established with traditional leaders, Village Multi-Sectoral HIV/AIDS Committees, Village Extension Teams, Village Development Committees, religious organisations and NGOs.

v Stigmatisation

Current education campaigns have not been successful in de-stigmatising AIDS. AIDS is associated with unacceptable behaviour particularly promiscuity and unfaithfulness. The stigma attached to the epidemic currently passes as a patient's right to confidentiality. Confidentiality is observed even by the public sector responsible for the educational campaigns.

6.3.5 Appropriateness of the District's Response Strategies

The preceding discussion is based on the various response strategies to the HIV/AIDS epidemic in the districts. Existing response strategies in the districts under this study are riddled with numerous gaps. This study examines gaps in the public sector responses, then move on to gaps that pertain to the private sector, NGOs and CBOs response strategies.

i Gaps in Public Sector Response Strategies: Structural Level

Gaps in public sector response occur at two levels- there are gaps that are of a structural nature and those which want of a better term could be dubbed operational. Their terms structural and operational emanate from the MTP II conceptual model on the determinants of HIV/AIDS spread in Botswana.

ii Absence of a Stratified Response to the Epidemic

The primary defect in public sector's current response strategies is that they are not premised on the stratified or layered understanding the determinants of the HIV infection in Botswana. The strategies concentrate almost exclusively on addressing the immediate determinants, which in this case revolved around unprotected penetrative sex. Thus despite the recognition in the MTP II of the complex and over determined nature of the factors behind the spread of the epidemic. extant response strategies have not interpreted this as to meaningfully translate it into complex and broad based response to the epidemic.

Respondents in the ten districts involved in the study indicate that unemployment, poverty gender inequalities as well as the erosion of cultural norms and values are factors in the spread of the epidemic.

Two related factors could possibly explain this serious defect- first, the manner in which causality in development is usually understood in Botswana and, secondly, the initial sectoral approach to the epidemic- thus- the treatment of AIDS as a health issue.

Observant analysts of Botswana's development strategies in general will have noted the scant attention paid to structural factors in explaining the country's development condition. The tendency is to concentrate on more empirical and immediate factors either facilitating or impeding the country's development efforts. The approach could be said to be basically atomistic as opposed to being holistic. For example, in trying to understand and plan for the urbanisation processes in the country, very little attempts are made to understand this within the context of the country's position in the global economy. Despite all this, mention is often made to globalisation processes and the need for the country to prepare itself for competition in a global economy. Despite such pronouncements such terms are never operationalised and therefore made part of a possible explanation of the country's development status, and at the same time, part of a search for alternative development models. As the reading of any of the country's development documents- from the National Development Plan through district Development Plans down to Settlement Plans- urban plans, would reveal, at best. Structural factors could be ideologically motivated in that it serves to divert attention away from structural defects which, if addressed could result in major changes within the status quo. Analysis that attempts to highlight structural determinants or social phenomenon, are currently the preserve of academics hence when it comes to implementation is done mainly by public sector bodies. The response to HIV/AIDS epidemic in the ten districts has not escaped this defect - those preparing the MTP II have identified the structural factors in the spread of the epidemic - those responsible for implementation have chosen to concentrate on the immediate factors.

Turning to the second interpretation the focus on immediate determinants of the spread of HIV/AIDS could be viewed as emanating from the initial tendency to treat AIDS as a health issue. Viewed as such the epidemic required health solution and therefore it was proper for the health personnel to concentrate on unprotected sex- the immediate factor in the spread of the epidemic. Ideally, the advent of the multi-sectoral approach should go a long way in dispelling the perception of AIDS as a health issue.

As reflected in their plan of action the DMSAC's response has not transcended the limitation discussed above. The approach focuses almost exclusively on immediate determinants of the epidemic. One would have expected that the bringing together of economists-(Council Planning Officers District Officer Development) Agricultural specialists (Regional .Agricultural Officer), sociologists (social and community development staff) political scientists and administrators (District Officer Administration) and others, would have brought about a multi-disciplinary understanding of the AIDS epidemic in the district Thus the economist would focus for example on poverty alleviation measures while the sociologist focuses on community mobilisation leaving the political scientist to identify political barriers and possibilities for the adopted strategies. For their part the health profession would focus on public education on the dangers of unprotected sex. It would appear that currently, all the above expertise has been brought together to focus on how unprotected sex could be avoided. The contention is that roles within the multi-sectoral approach should be clearly defined should be based on strength of each actor – whether in public sector.

DMSAC's observed:

"if an officer is required to complete a report for submission to his or her superior and there is a scheduled DMSAC meeting, it is only natural for the officer in question to attend to the former first. That is what the officer is employed to do in the first place! His or her appraisal and therefore progress is measured not by participation in the DMSAC but how well he executes his duties as per the job description"

At issue here is the commitment of the officer to the DMSAC and its activities. The committee's activities are hampered by problems that include lack of capacity, and well defined roles of each member in responding to the epidemic at district level. The argument advanced so far is that the current status of the DMSACs within the district's institutional set up significantly hampers the activities of the committee. Consequently, measures aimed "at addressing the HIV AIDS epidemic in the district are not accorded the attention they deserve.

iii Gaps at the Operation Level

Under response strategies it was argued that the district health teams (DHT) were currently responsible for most of the district's public sector response to the epidemic. Their strategies include educational campaigns aimed at awareness raising. There are two major

defects within the DHT response strategies to the HIV/AIDS epidemic- campaign seem to be targeted at easily available groups- those who visit the health facilities and secondly those in educational institutions-primary and secondary schools. Consequently, it does appear that the message is not reaching some sections of the district's population.

Despite concerted efforts by the health personnel at disseminating information on HIV/AIDS it is apparent that behaviour change has not been adequately addressed in the Districts. As illustrated in this example: AIDS coordinators in the ten districts could not find the link between behaviour change and awareness creation. The issue of whether basic knowledge on HIV/AIDS could encourage behaviour change was debated at length. There is a general consensus among AIDS coordinators that the current educational and awareness campaign does not provide individuals with enough skills for behaviour change.

6.4. Cost-Effectiveness Analysis

Cost-effectiveness analysis tools can ensure proper allocation of AIDS/HIV funds and assist DMSAC's to be more focused in planning and implementing intervention programmes which will have an impact on this epidemic. On the other hand, Cost-Effectiveness Analysis for HIV/AIDS programmes ensures priority setting and help DMSAC's to save financial resources in the process.

6.4.1 Why Cost-Effectiveness Analysis?

Despite the widely acknowledged severity of the HIV crisis in Botswana, resources available to combat the epidemic are severely limited. The combined contribution of official international aid for HIV prevention and care and funds, committed by the Botswana Government at district level are well below the required amount needed to stem the pandemic.

Since resources are currently so constrained, it is imperative that available funds are spent for interventions that are cost-effective, i.e. interventions that avert a high number of HIV infections compared with alternative uses of the funds. Over time, cost-effectiveness information can also support the rational allocation of resources as funding is scaled up to more closely match real need.

By increasing the likelihood that new funds will be spent efficiently, cost-effectiveness analyses may also strengthen the political will to commit these funds. (*Ref: Kahn J. G.,*

Cost-effectiveness analysis can guide the policy process in several specific ways:

First, because it is ultimately about choosing among alternatives, cost-effectiveness analysis requires a clear description of all relevant policy options. Such an inventory of options is otherwise rarely made. Defining the desired outcome (e.g. reduction in HIV incidence in a particular population) can stimulate new thinking about the best means to achieve this end. It can also help to crystallize the most policy-relevant assessment of intervention data, for example: "How much behavior change must a program deliver to be worthwhile?"

Second, cost-effectiveness analyses take perspective into account. A program that may not be cost saving nor even cost-effective to a particular governmental agency may nonetheless be desirable from a societal perspective. This shifts the terms of the policy debate away from narrow fiscal effect on a particular governmental entity and toward a broader assessment of societal good, including possible savings to the national budget. In this way, cost-effectiveness analysis can move politically moribund alternatives onto the active agenda.

Third, the importance of politics in HIV does not preclude a role for cost-effectiveness analysis, but instead means that such appraisals must be compelling enough to influence a process with many actors and aims. Credible cost-effectiveness analyses can thus be a means of political persuasion. Rather than supporting a policy decision merely because it appears to be effective or because it enjoys broad political support, systematic analysis pushes another and perhaps more useful question to the fore: Is it the best use of available resources?

Cost-effectiveness analysis cannot and should not substitute for the political process. Nevertheless, cost-effectiveness information can focus the attention of decision-makers on the interventions with real potential to contain the epidemic and to aid in setting priorities within a reduced menu of options. Credible cost-effectiveness analysis can do this by providing needed information to decision-makers who are already disposed to focus on interventions that can make a difference. Where this political consensus has not been achieved, cost-effectiveness analysis can bolster the arguments of those advocating less popular but more cost-effective strategies. Although political processes, not economic appraisals, determine policy, cost-effectiveness analysis can help shape the political agenda.

The failure to pursue rational resource allocation can only be at the peril of overspending scarce prevention Botswana Pula on less effective programmes, and underspending on more effective ones. Ultimately these missed opportunities mean lost lives. Rather than focussing on interventions that are most likely to be effective and cost-effective, governments and donor agencies support programmes that are politically popular and uncontroversial. Almost by definition, these exclude strategies focused on high-risk groups such as sex workers, the youth, mobile workers and school children.

Focussing on such groups can pave the way for encouraging prevention and promoting abstinence among people in each district. Recognizing the need for a scaled-up response, the Botswana government and its cooperating partners have supported "multi-sectoral" or "expanded" programmes intended to increase the political and economic resources available to fight the epidemic. But these efforts too often end up spreading funds over a wide range of programmes with little focus. Also, because they are multi-sectoral, they bring agencies into the AIDS arena that may have little relevant experience or competence. The result again is a lack of priority setting.

The use of Cost-Effectiveness Analysis can assist DMSAC's to be more focused in planning and implementing intervention programmes that will have an impact on this epidemic. On the other hand, Cost-Effectiveness Analysis for HIV/AIDS programmes ensures priority setting and help DMSAC's to save financial resources in the process

Even with optimistic estimates of increases in global funding for HIV/AIDS, the task of controlling the epidemic remains daunting. Regardless of the infusion of new resources, little gain will be realized if they are used inefficiently. Thus, it is imperative that DMSAC's use available funds on interventions that are cost-effective and that information on cost-effectiveness help guide resource allocation as funding is scaled up to more closely match real needs.

6.5 DMSAC's

The HIV/AIDS pandemic has given urgency to the need for developing human capital, particularly in high prevalence countries such as Botswana. If intervention programmes are to be implemented effectively in each district in Botswana, then developing human capital should be top on the agenda of district planners.

6.5.1 Developing Human Capital in Order to Sustain DMSAC's

Developing Human capital involves the development of human skills capacity, and the effective use of managerial, professional and technical staff, and volunteers. It includes identifying the right people to be trained; developing and delivering training strategies that are responsive to the needs of the target audience; providing an appropriate learning environment for training and education; ensuring in-service/field supervision for continued skills transfer; and, especially in the case of HIV/AIDS, longer term mentoring for directional, emotional and moral support.

According to United Nations Development Programme (UNDP) - *Evaluating HIV and Development: Guidelines and Suggestions, published in September 2001*, capacity is the ability of individuals and organisations to perform functions effectively, efficiently and sustainably. The term "capacity development" is preferred to "capacity building"; while capacity strengthening is important so are the retention of existing capacity, improvements in the way in which existing capacity is being utilised, and the retrieval of capacity which has been eroded or lost.

The Guidelines and Suggestions also stated that capacity development does NOT take place only through the training of additional staff or the creation of new organisations, but requires an enabling environment to ensure that people are used effectively, are retained within organisations and structures that need their inputs, and are motivated to perform their tasks.

6.5.2 Conclusions Drawn from the Losses of Human Resources which are Critical for Management of DMSAC's

Most obvious are the losses of human capital due to the epidemic – skilled, educated, and unskilled men and women, in the districts are dying. One important issue is how to sustain management of DMSAC's in circumstances of high morbidity and mortality. District authorities in Botswana have to deal with how HIV/AIDS prevention and care programmes and projects should be managed.

It follows that capacity development strategies have to address the maintenance of the needed human resources for the implementation of intervention programmes.

DMSAC's should ensure that programme managers of all projects and programmes develop a capacity development strategy and be evaluated on the basis of whether they address the key issues that this involves. Central to evaluation of the project or programme is whether in the formulation of a capacity development strategy. A capacity assessment can help the districts to make contingency plans for management of human capital.

A capacity assessment involves an analysis of capacity issues such as:

- ❖ **The task network:** a mapping of the array of organisations engaged in the performance of the function in question and the inter-organisational relationships involved. The network will generally include non-government as well as government organisations, users as well as providers of services, training institutions, and relationships with regional and overseas institutions. The assessment would examine the extent to which interactions among organisations constrain or enhance the capacity to undertake activities and achieve objectives.
- ❖ **The organisation and its management:** the organisational structure, corporate culture, management systems and processes that affect the recruitment, utilisation, recognition, motivation and retention of staff.
- ❖ **The availability of human resources:** the quantity and quality of personnel available to the organisation, the quality of training available and provided, the degree to which existing human resources are utilised effectively, and likely constraints on the future availability of essential human resources.

On the basis of a capacity assessment it is possible to examine the strengths and weaknesses of the existing arrangements for undertaking the project or programme, the reasons for weaknesses in existing capacity and why these have persisted over time, and the factors which are undermining existing capacity such as losses of skilled labour due to HIV-related mortality. Such an assessment would also generate insights into past failures and successes in regard to capacity strengthening and how to build on the latter in implementing activities.

6.5.3 The Main Areas of Focus of Capacity Development Strategies in the Light of the Capacity Assessment

These might include at each level the following:

- ❖ **The overall context:** sustained investment in human resource development, the strengthening of institutions that mediate and prevent social conflict and build social

capital, increased participation of communities in the design and implementation of development programmes, and mechanisms for ensuring that public policy and programmes are delivered in ways that are efficient and respond to the needs of sustainable development.

- ❖ Capacity development in the circumstances of the HIV epidemic is both significantly more difficult to achieve and is critical to the successful outcome of projects and programmes. (United Nations Development Programme (UNDP) - *Evaluating HIV and Development: Guidelines and Suggestions: September 2001*)

It is important for DMSAC's to focus on measuring the extent to which projects and programmes at the design stage take account of the many ways in which the HIV epidemic undermines capacity in all of its dimensions, both directly and indirectly, and respond to this challenge in ways that lead to effective outcomes.

6.6 Conclusions

In responding to HIV/AIDS, a number of social, economic or political enabling factors and constraining factors are at play. Communities draw lessons from their observations and actions thereby generating new knowledge. Lessons learned in countries that have experienced mature epidemics need to be shared within and across communities. The AIDS competence model that has been used in Uganda to strengthen district response could be used by DMSACs in Botswana during the strategic planning process for developing intervention programmes. AIDS competence is defined as:

- Ability of society to accept and recognize the reality of HIV/AIDS
- Ability of society to assess the effects of AIDS on its members, and
- Ability to take action to prevent the spread of HIV, maintain and improve quality of lives of People living with AIDS, families affected by AIDS, and the community at large.

Components of aids competence include internalization of safe sexual behaviors, attitudes and values. Translation of these and knowledge about HIV/AIDS prevention into practice, Acquisition of specialized skills to avoid being infected, Appreciation of the consequences of infection and development of coping capacities. The assessment of AIDS competence

requires interaction with the community members to establish their ability to recognize the problem, analyze and take action as response to the epidemic.

The AIDS Competence criteria developed for each district and the self assessment of competence at validation provide an important entry point for thinking through modalities for scaling up the response and incorporating knowledge management and programming (creation, sharing and adaptation) within the framework of decentralization. The competence measurement criteria should be further operationalised to generate a tool with specific objectively verifiable indicators and outputs to monitor progress or lack of it, based on the local understanding of competence.

DMSACs, village development committees, CBOs and NGOs and even individuals should also be able to compare their different levels of AIDS competence, share information, experiences, and contexts that are important for enhancing their competence. At a broader level, the National AIDS Coordinating Agency as a center for planning and capacity building could have the opportunity to reflect on the AIDS competence exhibited by communities to begin a process of action learning (fact finding, reflection and action)

The AIDS Competence criteria gives communities in each district the opportunity to demand for a balanced and coordinated approach to service delivery in line with their capacities that are clearly informed by their genuine priorities as actors and beneficiaries. Finally, there is a need for better data within each DMSAC to help develop management and programming capacity at district level, to judge the most effective interventions, and to help decision-makers decide between competing priorities.

6.7 Recommendations

1. The Ministry of Local Government should strengthen and improve district capacity for coordination and mobilization of resources for HIV/AIDS □
2. District authorities should enhance technical, political commitment and leadership for HIV/AIDS in the DMSACs
3. District authorities should strengthen planning and management of HIV/AIDS activities within DMSACs.
4. DMSACs should ensure that interventions respond to the priorities of communities in a coherent and comprehensive way by offering a balanced package of prevention, treatment, care and support and mitigation activities.
5. DMSACS should empower communities so that they can be able to guide the implementation of intervention programmes
6. DMSACs should develop a tool for surveillance AIDS Competence Assessment systems.

ANNEXURE A

QUESTIONNAIRE

District Multi-Sectoral AIDS Committees (DMSAC)

To be administered to District AIDS Coordinators of the 10 DMSAC's)

A: Name of interviewer/s:

B: Name of interviewee:

C: Name of interviewee:

D: Contact address of interviewee:

1.1 What is your understanding of the multi sectoral concept?

1.2 In your understanding, what are the functions of the DMSAC?

1.3 Please describe the structure of DMSAC in your district?

1.4 Is the current structure working? Yes

No

1.5 If no, how do you think the existing structure could be improved?

1.6 What do you see as your DMSAC's main responsibilities with respect to comprehensive HIV/AIDS care and prevention, support

1.7 From your opinion as a member of DMSAC, are you carrying out your roles effectively? If no, why?

1.8 What are the priority areas that your DMSAC is focusing on in your district's prevention, care and support activities?

1.9 Is the DMSAC involved in policy formulation ?

1.10 Does the DMSAC have an annual work-plan? Who was involved in developing the plan?

1.11 How do you monitor the DMSAC activities?

1.12 Do you think DMSACs can contribute to the national response of turning the epidemic around?

1.13 In your opinion, what were the achievements of DMSAC in the past year?

1.14 Do you think specific training programmes for human capital development and cost-effective analysis could enhance management and programming capacity of DMSACs?

1.15 Funding sources for the DMSAC during the past year (For Planning Officers)

Please indicate if the DMSAC received funding from any of the resources in the table below

Funding Agent	Yes	No	Total Amount
Central Government			
Council			
Local Fund raising			
Local Donations			
International donors			
Other (Specify)			
Total			

DMSAC BUDGET (FOR PLANNERS)

1.15.1 Did the DMSAC have a budget for its activities during the previous year

Yes No Not sure

1.15.2 Are the district activities being funded

Yes No

1.15.3 Do the amounts meet the needs of DMSAC?

Yes No

1.15.4 Describe the process of funding from:

a) Central government and other sources to the DMSAC

b) DMSAC to stakeholders in the district

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