REPORT OF THE TERMINAL EVALUATION

PSD (1997 – 2002)

10TH DECEMBER 2002

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ABBREVIATIONS

ACHAP **African Comprehensive HIV/AIDS Partnership**

ACS	**Assistant Council Secretary**
ACU	**AIDS Coordinating Unit**
AIDS	**Acquired Immune deficiency syndrome**
ARV	**Antiretroviral (drugs)**
ASU	**AIDS STD Unit**
AYA	**African Youth Alliance**
BCC	**Behaviour Change Communication**
BDF	**Botswana Defence Force**
BOFWA	**Botswana Family Welfare Association**
BONASO	**Botswana Network of AIDS service organisation**
BONELA	**Botswana Network for Ethics and Law**
BONEPWA	**Botswana Network of People living with HIV/AIDS**
BPF	**Botswana Police Force**
BOTUSA	**Botswana United States of America**
CBO	**Community Based Organizations**
CDC	**Centre for Disease Control**
CEYOHO	**Coping Centre for Youth of Hope**
CHBC	**Community Home Based Care**
COCEPWA	**Coping Centre for People With HIV/AIDS**
CSW	**Commercial Sex Worker**
DAC	**District AIDS Coordinator**
DAO	**District Administration Officer**
DC	**District Commissioner**
DO	**District Officer**
DHT	**District Health Team**
DMSAC	**District Multi-sectoral AIDS committees**
DOT	**Directly Observed Therapy**
DPSM	**Directorate of Public Service Management**
GOB	**Government of Botswana**
HIV	**Human Immunodeficiency Virus**
IEC	**Information Education and Communication**
IGA	**Income Generating Activities**
IPT	**Isoniazid Prophylactic Treatment**
MIS	**Management Information System**
M&E	**Monitoring and Evaluation**
MLG	**Ministry of Local Government**
MLHA	**Ministry of Labour and Home Affairs**
MOH	**Ministry of Health**
MTP II	**Medium Term Plan II**
NAC	**National AIDS Council**
NACA	**National AIDS Coordinating Agency**
NDP	**National Development Plan**
NGO	**Non Governmental Organization**
PLWHA	**People Living With HIV/AIDS**
PSD	**Program Support Document**
PMTCT	**Prevention of Mother To Child Transmission**
SIDA	**Swedish International Development Agency**
TA	**Technical Assistance**
TB	**Tuberculosis**
TCM	**Total Community Mobilisation**

TOF	**Training of Facilitators**
TOT	**Training of Trainers**
TPR	**Tripartite Program Review**
UN	**United Nations**
UNDP	**United Nations Development Program**
UNFPA	**United Nations Fund for Population Assistance**
UNGASS	**United Nations General Assembly Special Session**
UNHCR	**United Nations High Commission for Refugees**
UNICEF	**United Nations Children's Fund**
UNV	**United Nations Volunteers**
VCT	**Voluntary Counselling and Testing**
VMSAC	**Village Multi-sectoral AIDS Committees**
WHO	**World Health Organisation**
YWCA	**Young Women Christian Association**

A GLOSSARY OF TERMS

HIV/AIDS COMPLIANT CENTRES: Institutions meeting requirements based on the criteria set for "HIV/AIDS risk management" .

HIV/AIDS COMPLIANCE CERTIFICATION: A process by which an institution is certified on accreditation as an "HIV/AIDS risk management centre".

MANAGEMENT OF THE HIV/AIDS RISK: Implementing policies, procedures, standards, or specific strategies and services to address a range of HIV/AIDS related risks at different points within the life cycle, for

prevention, reduction of transmission and mitigation of impact, at the personal, family, household and community levels.

***MAINSTREAMING OF THE MANAGEMENT OF THE HIV/AIDS RISK*:**	Integrating activities for the "management of the HIV/AIDS risk" in the mandates, programmes, and interventions by sectors, CBOs or institutions.
UNIVERSAL TESTING AND COUNSELLING:	A national service made available and accessible to "individuals as a human right, based on the individual`s right-to-know own serostatus, in order for them to take appropriate action on, prevention, early detection, reduction of HIV transmission, seeking counseling and other services relevant to managing the "HIV/AIDS risk based on **public health principles** and the individuals social responsibility.
PROGRAMME SUPPORT DOCUMENT ***(PSD):***	Refers to GOB/UNDP Partnership.
YOUTH FRIENDLY VOLUNTARY COUNSELLING AND TESTING CENTRES OR SERVICES:	Refers to Voluntary Counseling and Testing Services made readily accessible and acceptable to adolescents and youth in centres, health, leisure and recreational facilities including employment settings.

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The Evaluation Team

Dr. V. Ngcongco
Mr. M. Motsemme
Ms. G.M. Moalosi
Ms. E. Koko
Mr. D. Ngele
Dr. G. Rae

EXECUTIVE SUMMARY

The executive summary presents the synopsis of the main report of the terminal evaluation of the Programme Support Document (PSD) 1997 – 2002, which was designed to support the implementation of the Medium Term Plan II (1997 – 2000) multi-sectoral National AIDS Programme. The Botswana National Policy on HIV/AIDS, which was revised in 1998, directed that all sectors, public or private, mainstream HIV/AIDS activities and issues in their mandates. The PSD provided support to the mainstreaming process.

The overall objective of the terminal evaluation was to assess the extent to which the objectives of the PSD had been achieved, as well as the impact of the PSD on the National Programme, objectives and goals. The evaluation was conducted between 19th August and 18th November 2002, by a team of five consultants, and a short term international public health consultant.

The layout of the report is in the following order:

Background and Context of the Programme Support Document. II. An Overview of the Review Process, followed by: 1. Main Findings. 2. General Discussions. 3. Recommendations. 4. Strategic Approaches. 5. Issues for Consideration. 6. Future Directions. 7. Conclusions and Annexes.

The Background and Context of the PSD outlines the situation and trends of the epidemic in Botswana in terms of the prevalence of HIV transmission, and the impact of the epidemic as depicted by the morbidity and mortality trends, including increased number of orphaned children as a consequence of the epidemic. Surveillance data is presented in graphs and maps displaying all districts. Information based on the latest survey of districts published by NACA in the latest Technical Report of 2001 is also presented, to provide the latest information on the situation.

The context of the PSD, its focus, targets and three-pronged strategy is discussed briefly. The three-pronged strategy consists of policy development, institutional strengthening and service delivery. At the national level the target areas are NACA, 10 sectors, 4 disciplined forces and 3 networks or Civil Society organisations, as well as sixteen District Multi-sectoral AIDS Committees, all of which have established Village Multi-sectoral AIDS Committees or Village AIDS Committees, at the local level. The PSD strategy aimed at capacity development for a multi-sectoral response to the epidemic, as well as for promoting mainstreaming of HIV/AIDS activities and issues in the sectors. The PSD is a joint initiative by the Government and UNDP. The purpose and objectives of the terminal evaluation are outlined in the Terms of Reference listed in Annex I.

The terminal evaluation was guided by the terms of reference, as well as by the broad-based framework and a set of data collection tools developed by the evaluation team.

The evaluation used qualitative research methods for data collection and analysis. Group interviews, focussed discussions, individual interviews, document review and site visits were used to collect data at all levels.

The Main Findings of the evaluation include the highlights, achievements, constraints and gaps identified at the national and district levels, specifically among the District Multi-sectoral AIDS Committees. The PSD project seems to be the most comprehensive, integrated and multi-pronged programme on HIV/AIDS between GOB, UNDP and SIDA as it fully translated the objectives of MTP II into a coherent set of interventions which heightened the national response, and the appreciation of the impact of the epidemic on the national development and the quality of life of

Batswana. Progress was observed in all target areas, and the process of mainstreaming was gaining some ground in the response. Progress made in policy development, institutional strengthening for service delivery was evident. Capacity development of sectors and DMSACs through training and technical assistance had occurred to some extent, as was evidenced by outputs observed at all levels. Peer education and counselling, including condom use, care and support has become the main content of workplace programmes. UNDP played a catalytic role in supporting structures, partnerships and alliances for the response. UNDP also provided technical leadership and advocacy for promoting action at household levels while catalysing community mobilisation through capacity building. The implementation capacity of sectors, DMSACs, networks and disciplined forces has been reasonably enhanced, and the mainstreaming of the HIV/AIDS risk management in the mandates of sectors is beginning to take root although at varying degrees and rates.

Constraints and implementation gaps were observed at all levels. Less than average performance was observed in areas of capacity development and policy development, including mainstreaming in some sectors, networks, disciplined forces and NACA. While most sectors have shown progress in the area of service delivery, very few have demonstrated capacity for "managing the HIV/AIDS risk" in a meaningful and comprehensive manner. Most sectors and disciplined forces have not yet developed the skills for prevention, reduction of transmission, and human transformation through BCC for the adoption of appropriate behaviours and seeking services needed for the response. This has largely been the main weakness in the "management of HIV/AIDS risk", in all target areas.

- **The main recommendations** are concerned with:

    - Consolidating the achievements and gains made in PSD (1997-2002), bridging the implementation gaps, reducing some constraints, scaling up best practice in areas where interventions were likely to make significant impact.

    - Introducing new thinking for improved performance in the area of prevention and reduction of transmission, especially with respect to making the "management of the HIV/AIDS risk" the centre piece of the mainstreaming process, as well as the rallying point for the response. Equally, recommendations on the development of policies and focused strategies to support "new thinking" were outlined. Strategies like Universal Testing were also seen as critical to both prevention and the reduction of transmission as it is believed that knowing one's status should lead to appropriate and timely action irrespective of the serostatus. Approaches aimed at facilitating access to relevant services, in a timely manner are presented as recommendations; with a view to social marketing the advantages and benefits of "knowing" in order to make informed decisions for appropriate action.

    - The recommendations also support the development of a successor PSD project to facilitate the implementation of strategies based on new thinking for maximum returns in the area of prevention and reduction of HIV transmission, including timely access to a variety of treatment options where necessary. Also, the PSD II is recommended to ensure that the management of the HIV/AIDS risk is anchored at the household and community levels for an enhanced response.

- **Strategic approaches** to implementing the recommendations, as well as to addressing challenges presented by the epidemic, are proposed for use in PSD II. Likewise, strategic entry points to operationalising new concepts as part of expanding the response are outlined. The establishment of strategic partnerships and forging of alliances is considered critical to success

of PSD II, thus the government and UNDP are urged to embrace international agencies, NGOs, the private, formal and informal sectors in the response.

- **Issues for consideration by key actors**, especially in the planning and implementation of PSD II, are raised to facilitate a useful debate on important issues considered crucial to the successful implementation of interventions envisaged in PSD II. Districts that may require individualised approaches to capacity development and service delivery are cited, and attention is drawn to the need to address their special circumstances accordingly, to ensure maximum impact.

- **Future Directions**, are suggested with a view to stimulating thinking on how best the existing target areas, and additional areas, might be addressed from a programmatic point of view in the light of a number of diverse factors prevailing in the key target areas. This strategic thinking is considered essential to the operational planning process for PSD II in the near future.

- **The appropriateness, efficiency and effectiveness** of PSD in the context of MTP II and the mainstreaming process are discussed. Likewise, the best practice experiences and lessons learned are discussed briefly. Programme developments arising from the findings of the socio-economic studies, in particular the study on the impact of HIV/AIDS on education, are noted and supported. Similarly the success stories from some DMSACs are recognised.

- Some suggestions on the scope of PSD II are put forward, especially given the proposed expansion of the scope of PSD II. UNDP is being encouraged to use its advocacy role, mandate and comparative advantage to ensure that crosscutting issues such as poverty reduction, gender and environment are integrated at all levels of programme development.

- **Opportunities and risks to PSD II** are outlined and discussed to stimulate strategic thinking ahead of the actual design and planning of PSD II, to ensure that PSD II operational plans are able to pre-empt future pitfalls and outline strategies to prevent these in a timeous and efficient manner.

- **A schematic presentation of the suggested programme components or building blocks** for PSD II is presented for discussion. (See Appendix I). It is proposed that PSD II should build on the present **PSD**, articulate the programme strategies clearly, present these in a coherent manner, and develop main areas. Consolidation of the multisectoral approach and the mainstreaming process should cut across all target areas. Gender development, poverty reduction, human development and human rights should all be integrated as crosscutting issues. Partnerships and alliances, resource mobilisation including provision of technical assistance, collaborative action and support to programme areas should be part and parcel of the new PSD programme.

- Appendix I contains Suggested Building Blocks for PSD II.

- Appendix II contains a Summary of the Financial Support to PSD (1997 – 2002).

- Annexes I, II, III and IV contains the Terms of Reference for the Evaluation, list of names of persons contacted, schedule of visits, and documents reviewed, respectively.

BACKGROUND AND CONTEXT OF THE PROGRAMME SUPPORT DOCUMENT (PSD) (1997 – 2002)

Current Status of the Epidemic in Botswana

More than 95% of all HIV-positive people live in the developing world, which also accounts for an estimated 95% of all deaths due to AIDS. HIV infection is particularly high in sub-Saharan Africa. In 1999 it was estimated that 70% of the global population of PLWA lived in the region. Furthermore some 11.5 million people in sub-Saharan Africa have died of AIDS. Botswana, Namibia, Swaziland, Zambia and Zimbabwe are the worst affected countries in the region, with HIV prevalence rates of between 20 and 36% in the 15-49 age group.

Figure 1 shows HIV prevalence rates for Botswana in relation to Southern Afri

Since the first reported case of AIDS in Botswana in 1985 HIV has spread rapidly. It is estimated that between 28% (AIDS/STD Unit) and 36% (UNAIDS) of the country's sexually active population is HIV-positive. Sentinel surveillance has been carried out in antenatal clinics since 1992 and the resulting data has been used to produce estimates. Antenatal clinics (ANC) are surveyed annually in Gaborone and Francistown. In other selected sites, clinics are surveyed every other year. The surveys cover pregnant women attending antenatal clinics, and men with STDs[1].
The following figures and maps show trends in HIV prevalence among pregnant women in Botswana between 1993 – 2001, district specific HIV prevalence for all pregnant women and teenagers (15 – 19 years) as well as estimated HIV infection for adult males and females (15 – 49 years)[2].

[1] Botswana Human Development Report 2002
[2] The National AIDS Coordinating Agency Technical Report 2001

About 85% persons are being infected everyday and one in 8 infants are being infected at birth.

The impact of HIV/AIDS is also visible in the socio-economic dimensions of the society. In the next 8 years in 2010, the current orphan population, which is 65,000, is expected to rise to between 159,000 and 214,000 and the rise in the number of widows and widowers is unprecedented. The widows and orphan issue is shifting the burden of dependency to just a handful of elderly people and a small population of young breadwinners. This has adversely disrupted the social fabric and the traditional support network of the extended family system.

Under the most likely scenario considered, HIV/AIDS reduced the growth rate of GDP by 1.5% so that after 25 years the economy will be 31% smaller than would otherwise have been.[3]

The overall government expenditure will be reduced by 20% because of reduced revenues, the government's commitment to ARV therapy, other health care needs, and skills training to compensate for the loss of an educated workforce.

HIV/AIDS resulted in the significant reversal of the development achievement Botswana had registered in the last 40 years of its independence. Key development indicators like infant mortality and life expectancy have considerably deteriorated. Infant mortality is projected to increase from 57 to 60 per 1,000 live births. The overall life expectancy has dropped from 67 years before the epidemic to 55.6 today.[4]
All these are viewed in the context of a small population of approximately 1.7m (2001 census data), which is likely to decline given the worst-case scenario.

The figure below makes comparison of HIV related deaths and other non-neonatal hospital deaths.

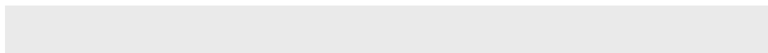
[3] Macro economic Impact of HIV/AIDS in Botswana – BIDPA 2000
[4] Central Statistics Office Census Data 2001

Figure 2: Trends in Inpatient Deaths ages 15-44

Source: Health Statistics Unit, MOH 1998

HIV/AIDS is now the commonest condition associated with all deaths. Figure 2 illustrates the projected AIDS cases and deaths in Botswana by year. The projections are from 2001 to 2009.

Figure 3: Projected AIDS cases and AIDS deaths in Botswana by year.



Projections of the impact of HIV/AIDS deaths and illness indicate that the total population growth rate will decline rapidly, only in the best case scenario will remain positive (at 0.2%) by 2010.

These estimates show that the epidemic has reached crisis proportions. In order to reverse the tide created by the epidemic, Government of Botswana and its partners has put in place structures for the national response. The political will is very high and it is used to mobilise the needed funds to fight the epidemic. Currently government finances about 80% of the national HIV/AIDS programmes[5]. The Government established the National AIDS Council, which is chaired by the President to oversee the implementation of the national response programmes. The Government also established the Parliamentary Select Committee on HIV/AIDS and the National AIDS Co-ordinating Agency to co-ordinate the national response.

The Medium Term Plan II (MTP II) strategic plan 1997 – 2002 was developed to set the agenda for multi-sectoral response for HIV/AIDS. It had two major objectives (i) preventing the transmission of HIV and (ii) mitigating the impact of the epidemic.

The Government of Botswana/UNDP Programme Support Document (1997 – 2000 which was later extended to December 2002) operationalised MTP II. The PSD was developed as a multi-pronged programme that would strengthen NACA, strengthen the central and district level institutional capacity for implementing the multi-sectoral MTP II. The strengthening of the capacity of the Disciplined Forces for a national response to the epidemic, as well as the institutional arrangements and capacity of civil society organisations has been an important function of the programme. The programme in line with MTP II has also focussed on strengthening the districts' capacity for promoting the response through the formation of the District multi-sectoral AIDS Committees and Village multi-sectoral AIDS Committees in the PSD target districts.

The overall expected result is the reduction of the transmission of HIV/AIDS and the mitigation of its socio-economic impact. **Vision 2016 advocates for an AIDS free Generation in Botswana**. This is the ultimate national vision and is contained in the *Botswana Human Development Report 2000 - Towards an AIDS Free Generation.* The human development report is a useful advocacy tool and source of information for both the Government of Botswana and non-government institutions. The report is anchored on Botswana's vision of no new HIV infections by 2016 and seeks to focus policy on the window of opportunity presented by young Batswana aged below 15 years. Within this cohort, it was identified that HIV prevalence rates are very low; less than 2% compared to about 30% in the 15-49 age group. The central message, around which extensive consensus has been built, is that this cohort has to be saved from the dangers posed by intergenerational sex; that extraordinary measures need to be taken to equip them to avoid infection with HIV. Abridged versions of the report, in both Setswana and English, have been produced for use as supplementary material in primary and secondary schools. The report also provided a platform for discussion of sensitive issues such as commercial sex, sex in prisons and the need for condom distribution in prisons, and homosexual practices. These debates may not have been resolved as the report suggested but there is growing realisation that radical shifts in the approach to these issues are essential. The report gave needed impetus to the discussion on Anti-Retroviral Therapy and provided a bigger platform for discussion.

An AIDS free generation has the probability to reverse the socio-economic losses recorded and anticipated. The actions to fulfil this vision will include intensification of efforts that have already begun; some of these are in the process of implementation as part of the PSD initiatives.

HIV is sexually transmitted, in order to make any meaningful reduction two approaches should be: either the enforcement of total abstinence or safer sexual practice. Total abstinence is unrealistic and a pipe dream, and

[5] Botswana Human Development Report 2002

not an option for the majority or a national program. It may also not be in the interest of progeny of the human species. To attain an effective culture of safe sex individuals must turn inwardly to themselves and institutionalise discipline and sexual self-accountability through universal Voluntary Counselling and Testing (VTC). To accelerate the attainment of these universal VCT very effective and innovative techniques will have to be developed and applied.

The purpose of the initial actions was to build the foundation for effective action at the household level, which is the most critical point for behaviour change.

The Context of the PSD

The Medium Term Plan II (1997 – 2002) provided guidance to all partners for addressing the epidemic which had become the greatest threat to the development efforts of the country. Through the MTP II document, policy development, institutional strengthening and service delivery were identified as effective strategies to prevent the spread and mitigate the impact of HIV/AIDS. UNDP's focus in promoting the response aimed at strategic policy development, and institutional strengthening at the national level in order to guide the response at the district and community level. The UNDPs strategic position continued to target critical elements considered essential to co-ordinating and directing the implementation of MTP II. This was to be achieved through the development and implementation of GOB/UNDP programme known as the PSD, which was developed in 1997. The Ministry of Health through the AIDS/STD/UNIT was designated the executing agency of the PSD programme, and the Ministry of Finance and Development Planning was charged with the channeling of funds to the executing agency.

At the initial phase of the PSD 1997 – 1999, 5 Ministries, 10 Districts, 3 Disciplined Forces and 3 Civil Society Organisations were targeted, and in March 2000, the Tripartite Programme Review (TRP) approved the extension of the PSD to 2002 based on the findings and recommendations of the Mid-Term evaluation a PSD conducted in 1999 through the Project Support Document Addendum : 2000 – 2002 the modus operandi of the PSD was outlined further.

The extension entailed the increase of Ministries to 10, that of Districts to 16, and the inclusion of the Botswana Local Police in the Disciplined Forces.

Overall the direct recipients of the programme support document included, the general population and PLWHA, institutions both at national and district levels responding to the epidemic including the NGO and CBO's. The strengthening of the multisectoral response at the district and community level would also benefit the rural community with special attention given to women, children, youth and other vulnerable groups in the community.

The Purpose and Objectives of the Terminal Evaluation of the PSD (1997 – 2002)

The **overall objective** of the terminal evaluation was to assess the extent to which the PSD has supported the AIDS Programme in the implementation of the Multisectoral MTP II (1997 – 2002) and the mainstreaming of HIV/AIDS in line with the National Policy on HIV/AIDS revised in 1998.

The **specific objectives** of the terminal evaluation were to:

- ❖ Assess the extent to which the three-pronged strategy consisting of policy development, institutional strengthening and services delivery had been operationalised at the national district levels.
- ❖ Assess programme performance in terms of efficiency and effectiveness.
- ❖ Assess the extent to which the decentralisation process has taken stock and the effectiveness of the multisectoral response at the district level.
- ❖ Assess the efficiency of the delivery of inputs and the results of the impact achieved.

- Assess the capacity of the Government and other institutions in executing and implementing the programme.

- Assess the strengths and weaknesses of the implementation process and various outputs.

- Document lessons learned and the best practice experiences that are emerging within UNDP supported activities.

- Assess the extend to which the mainstreaming process has occurred at the national and district levels in line with the National Policy on HIV/AIDS.

- Assess the catalytic role of UNDP and the relevance of the PSD.

- Assess the interrelatedness of the PSD to the national programme strategies.

- Assess the impact of the UNV programme support to capacity building and transfer of skills and experiences from the region.

- Come up with concrete recommendations geared towards the successor programme.

Overview of the PSD

The Government of Botswana and UNDP project, known as the Programme Support Document (PSD)[6] to the National AIDS Programme was implemented between 1997 and 2002. The Programme has a three-pronged strategy consisting of **policy development**, **institutional strengthening** and **service delivery**. Capacity building, training and research were considered key agents to supporting or driving the process towards the achievement of the development objective. This was done through the target outputs in the five project areas namely, the central and, district levels, civil society organizations, disciplined forces and strengthening of institutions to conduct applied research studies relevant to policy and programming in HIV/AIDS. Funding, administrative, and operational services were provided to support the implementation process during the five-year period.

Technical assistance was provided through short and long term placement of consultants and international UNVs to the central, district, and community levels. The initial program, which was to end in 1999, was extended from 2000 to December 2002 through the PSD Addendum 2000 – 2002. The Tripartite Program Review (TPR), held in March 2000, approved the PSD Addendum. With the extension of the PSD, support was provided to increase sectors from five to ten and districts from ten to sixteen.

[6] Program Support Number BOT /96/001, 1997-2002

II. OVERVIEW OF THE REVIEW PROCESS

The terminal evaluation was conducted from August 19 to November 2002. The evaluation team consisted of six members: Dr. V. Ngcongco, Ms. G.M. Moalosi, Mr. M. Motsemme – consultants, Ms. E. Koko – Health Officer - IEC (ASU), Mr. D. Ngele – Director (BONEPWA) and Dr. G. Rae - Public Health Specialist who joined the team during the 4th week of the evaluation. The evaluation process was guided by a set of Terms of Reference, the development objectives, the goals of MTP 11 and the core mandate of the PSD, which was to support the implementation of the multi-sectoral second Mid Term Review (MTP 11) (1997 – 2002).

The first week was used to assist the team of national consultants to understand the task of the evaluation and to develop shared understanding and appreciation of the notions of a multi-sectoral approach, and HIV/AIDS mainstreaming. A resource person, Dr Roland Msiska, provided the orientation. Models of evaluation were shared and a framework for evaluation of the PSD was discussed and agreed upon. The processes of mainstreaming were discussed including an analysis of approaches and issues considered important to the evaluation process.

Methodology

The evaluation used qualitative research approaches such as: Group discussions, Review of documents and Field visits, individual and group interviews.

A broad-based framework was developed as a data collection tool for the evaluation. Tools were developed for each target area (National Sectors, Disciplined Forces and Civil Society organisations). The data collection tools were used as a guide for data collection, discussion and consolidation of findings. Various documents on the project, including reports and records from target areas were reviewed. Discussions with key informant individuals involved in the project including local level community leaders enriched the information base. The criteria used for the selection of the districts and the sectors was as follows: early beginners, late beginners, good performers, average performers and below average. The Disciplined Forces and the Networks were all visited, and data was collected.

The selected districts were Chobe, Gaborone, Lobatse, Kgatleng, Kweneng East, Kgalagadi South and Serowe/Palapye. The selected sectors were, the Directorate of Public Service Management (DPSM), the National AIDS Coordinating Agency (NACA), Ministries of Health including the AIDS/STD Unit, Local Government, Labour and Home Affairs, Finance and Development Planning. Site visits provided an opportunity for more in-depth discussions and exchange of ideas and opinions. In almost all the districts visited except two, an opportunity to seat in a regular DMSAC meeting was availed to the evaluation team. This provided an opportunity for interaction with the DMSAC members. Interviews and discussions with representatives of the Ministries of Education, Trade, Industry and Tourism were held.

The catalytic role of UNDP and the relevance of PSD to the National Program on AIDS including MTP II, (1997 – 2002), was assessed. The overall mandate of UNDP for human resource and sustainable development and its interface with the management of the HIV/AIDS risk was also analysed. The link between the Declarations of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS (June 2001) where the benchmark targets were set, and the development objective of the PSD, the goals of the MTP II and the Strategic Plan III draft goals and objectives were assessed.

1. MAIN FINDINGS

These are presented as, main achievements and information on best practice experience, constraints and gaps.

1.1 Achievements, Constraints, Gaps and Recommendations

A. National Level - Ministries

- ***Achievements***

  - Ministries are at different levels of development in as far as progress made in the areas of mainstreaming the "management of the HIV/AIDS risk" in their mandate. Progress has been made by most ministries in the areas of implementing workplace programmes on HIV/AIDS IEC, peer education and counselling, condom use and education including care and social support to PLWHA and the affected. Some ministries have developed HIV/AIDS policies for their sectors, while others are in the process of identifying areas requiring policy development.

  - In the area of institutional strengthening, AIDS co-ordinating committees, focal persons and AIDS, co-ordinators are in place. In almost all the ministries reviewed except one, the AIDS Committees were functional. The ministries had all managed to encourage their sector personnel at the district level, to participate fully in the multisectoral response through the District Multisectoral AIDS Committee. This was evidenced by their involvement in HIV/AIDS activities implemented at both the district and local levels, as well as by the extensive intersectoral collaboration.

  - With respect to capacity development of personnel in various sectors, training, workshops, seminars and study tours were undertaken except for one ministry where it was indicated that the process was about to begin. Peer educators and counsellors were trained with support from the AIDS/STD/UNIT (ASU), the Population Service International (PSI) and the Institute of Development Management (IDM).

- ***Constraints Implementation Gaps and Recommendations***

  - While some progress has been made some constraints were observed, and these were mainly related to the inadequate capacity of some ministries in interpreting the concept of mainstreaming as well as their inability to fully incorporate the "management of the HIV/AIDS risk" into their mandates. Similarly most ministries did not have the technical capacity to promote behaviour change in a significant manner. Issues of mitigating the impact of the epidemic seemed to receive priority over those of prevention and the reduction of sexual transmission. Furthermore, departments and divisions within ministries were not collaborating effectively in the planning and implementation of HIV/AIDS activities. Networking has not really been addressed.

- Recommendations to ministries/sectors are concerned with strengthening the capacity of ministries/sectors for policy development and mainstreaming the "management of the HIV/AIDS risk" into their mandates, using their comparative advantage to facilitate the multisectoral response envisaged in MTP II. In addition the recommendations aim at strengthening the institutional capacity to sustain and enhance the gains and achievements realised during PSD (1997 – 2002).

National AIDS Coordinating Agency (NACA)

- The PSD supported the establishment of the National AIDS Co-ordination Agency in 2000 for the management of the multisectoral response to the epidemic, as well as for co-ordinating, monitoring and the evaluating the national AIDS Programme including the development of policies to enhance the mainstreaming process at all levels.

- Technical assistance was provided to support the co-ordination role of NACA by UNDP through PSD, while the government, WHO, UNICEF and CDC- BOTUSA also provided technical support by making available short-term and long-term consultants from time to time.

- ***Achievements***

    - Technical assistance has been provided through PSD in the development of the strategic planning process and this has resulted in the development of the Strategic Plan III 2003 – 2008.

    - NACA has functioned as the Secretariat to the National AIDS Council and co-ordinates the work of the sectoral committees on HIV/AIDS.

    - NACA has developed a National IEC strategy on HIV/AIDS with participation by various stakeholders, similarly an IEC Technical Committee has been established and is functional.

- ***Constraints, and Implementation Gaps***

    - The agency is constrained by shortage in human resources at all levels as such it has not been able to carry out its functions as required. Similarly the organisational needs for technical support were not elaborated fully when the agency was established.

    - NACA relies heavily on short and long term international consultants to do the basic programme planning, monitoring and evaluation and there is hardly any skills transfer as NACA does not have the national counterparts to understudy the consultants. Similarly NACA as an agency does not have the capacity to supervise or backstop the consultants nor to follow up their recommendations in an effective and significant manner.

    - While it was planned that the responsibility for the execution of the PSD would finally be handed over to NACA when it came to being, this occurred before NACA was ready to

assume the responsibility administratively and technically. As such, NACA has not yet put in place the necessary institutional arrangements to support PSD.

- ***Recommendations***

  - It is proposed that consultations between the Office of the President, the Directorate of Public Service Management and NACA on all matters pertaining to fulfilling the requirements and needs of the Agency should begin as a matter of urgency.

  - NACA should be supported to carryout its coordinative, monitoring and evaluation role.

Directorate of Public Service Management

The evaluation team met with four members of the Social Rehabilitation Unit of the Directorate of Public Service Management (DPSM) charged with responsibility for mainstreaming HIV/AIDS activities and issues within DPSM as well in Human Resource Management departments or divisions of the entire public sector. The DPSM is one of the first group of sectors targeted for PSD support at the start of the initiative in 1997. Support to DPSM has thus been provided for almost five years on a continuous basis, however DPSM has never had technical assistance channelled to it on a long term and consistent basis.

Achievements

Achievements are categorized under policy development, institutional strengthening and service delivery based on the three pronged strategy of the PSD for capacity development at the rational and district levels.

Policy Development

- The Directorate of Public Service management has developed a “Code of Conduct on HIV/AIDS in the Workplace” for use by the entire public service.
- The Directorate of Public Service Management distributed 25,000 copies to all Ministry departments and divisions of human resource management in the entire public service.
- The Code of Conduct on HIV/AIDS in the workplace addresses critical issues outlined in the National HIV/AIDS Policy for Botswana such as; discrimination associated with HIV/AIDS, and the rights of employers and employees in the work-place. It further articulates the public service position, practices and responsibilities with regard to officers who are infected or affected by HIV/AIDS.
- The Code of Conduct has not yet been discussed with the Teaching Services Management (TSM) and the Unified Local Government Service Management (ULGSM) to ensure that these two institutions which are responsible for a large group of human resources adhere to the specifications of the Code of Conduct on HIV/AIDS in the work-place.

Institutional Strengthening

- The Directorate of Public Service Management has established AIDS Co-ordinators positions within the Public Sector and nine positions have been filled. The positions are at a high level of decision making, and should enhance the place or position of HIV/AIDS activities in ministries.

- The Social Rehabilitation Unit is providing the appropriate orientation to human resource management on issues of HIV/AIDS prevention, care and support, upholding the rights of employers, and sustaining their well-being in line with its mandate within the Directorate of Public Service Management.

Capacity Building

- DPSM has established an AIDS Committee to spearhead all activities for the prevention of HIV/AIDS and mitigation of the impact of HIV/AIDS. Similarly the committee is also charged with responsibility to plan and implement HIV/AIDS awareness creation activities within the sectors.

- The Committee has trained peer educators and counsellors within DPSM. Similarly a video set equipment has been bought to facilitate exchange of information, education and communication on HIV/AIDS to officers, in an effective manner.

- Administrative and senior management staff have been sensitized to issues of HIV/AIDS and their implications for human resource management.

- It became apparent during the discussion that the Social Rehabilitation Unit was initially introduced to HIV/AIDS IEC by the AIDS/STD/UNIT prior to the implementation of PSD.

- Some members of the committee participated at a seminar organised through the African Comprehensive Program on HIV/AIDS (ACHAP) on the leadership model. The Social Rehabilitation Unit has networked with workplace programmes in institutions such as the AIDS/STD/UNIT, the Community Health Science Unit, and the Voluntary Counselling Testing Centre for the implementation of training workshops.

Constraints

- The team did not become aware of the components of PSD and the support that was available through PSD early enough, although they were aware of MTP II and the National Policy on HIV/AIDS much earlier. Similarly the team had not availed itself of PSD support that would have assisted to develop the Code of Conduct, and be able to interpret and disseminate it with confidence.

- The DPSM team did not have the capacity to influence Human Resource Department divisions or units within the Public Sector on issues of HIV/AIDS at the workplace as well as on the use of the Code of Conduct on HIV/AIDS in the workplace. They felt inadequate to do this. By the same token they had not reached out to the Unified Local Government Management Services and the

Teaching Service Management on the use of the Code of Conduct in their workplaces, although they had distributed the copies to them.

Implementation Gaps

- The Social Rehabilitation Unit does not have the capacity to meet the demand for support by the various departments or divisions of human resource management on the implementation of the Code of Conduct.

- DPSM does not have the capacity and resources to support sectors to mainstream HIV/AIDS issues in their human resources management policies, plans and activities.

- The Social Rehabilitation Unit does not have the tools nor the expertise to monitor and evaluate progress made towards mainstreaming of HIV/AIDS activities and issues of human resource management policies, plans and activities

- The Social Rehabilitation Unit has not had the technical support of an international UNV, similarly no Technical Assistance had been provided to DPSM on a short or long term basis. The team is highly motivated but lacks the requisite skills to make any significant impact.

Recommendations

The DPSM should be supported to launch the "Code of Conduct on HIV/AIDS" in a systematic and efficient manner to ensure the use of the code by all sectors.

- The DPSM should be assisted to address the 'Management of the HIV/AIDS risk' as a continuum, by addressing prevention, reduction of sexual transmission, including care and support issues taking into consideration the circumstances of the workforce in various sectors.

- The Directorate of Public Service Management's capacity to provide leadership to other sectors for the maintenance of productivity levels in the public sector through the "management of the HIV/AIDS risk" and the mainstreaming of HIV/AIDS services by all sectors should be raised. To this end, technical assistance on HIV/AIDS and human resource management should be provided to the Social Rehabilitation Unit as well as to the executive levels of personnel in the Directorate of Public Services Management, as a whole.

- The entire DPSM (departments, divisions and units) should be targeted with much more focused institutional strengthening and capacity building activities to accelerate and consolidate the process of mainstreaming the management of the HIV/AIDS risk throughout the DPSM, and other sectors.

- The Director of Public Service Management should in addition to the "Code of Conduct on HIV/AIDS", be assisted to develop tangible policies on the "Management of the HIV/AIDS risk" in the work place, well beyond work place services such as IEC, condom use and education. Guidelines, standards and procedures for monitoring adherence to such policies by all departments, for human resource management institutions should be developed.

- Periodic reviews, should be undertaken in all sectors to assess the extent and progress made by various sectors and institutions towards mainstreaming the management of the HIV/AIDS risk in a comprehensive manner.

- PSD should provide technical assistance in the development of a relevant and appropriate Management Information System (MIS) to enable the Human Resource Management departments, and divisions to have a reliable basis for anticipating the HIV/AIDS risk among their human resources and to develop an effective strategy for the management of the HIV/AIDS risk.

- The DPSM should be supported through training, capacity building and long term technical assistance to develop Trainers of Trainers, and Trained Facilitators who will build strong teams of trainers at all levels to facilitate the implementation of meaningful HIV/AIDS programmes for human resources at all levels, and in all sectors.

- Guidance should be provided to sectors on approaches to developing human resource management policies that will enable sectors to pre-empt the human resource effects and impact of HIV/AIDS on the work force.

- The Social Rehabilitation Unit would like more support from NACA as they believe this contact is essential to their operations and responsibility. This should be facilitated as soon as possible.

Ministry of Education

The Ministry of Education was only included in the PSD in 2000 and experienced some difficulties in accessing funding owing to delays in the disbursement of funds. The department of Pre-Service and in-Service Education for Teacher Training Development has however registered some modest success and made some gains.

Policy development

The Ministry of Education is yet to develop its policy on HIV/AIDS addressing the management of HIV/AIDS risks in the entire sector as a workplace, the risks facing pupils in school and at home, as well as in communities. The ministry will require technical assistance to carryout its tasks.

Institutional Strengthening

- The Department of Pre-Service and In-Service Teacher Training Development was the first to appoint a full time AIDS Coordinator and to establish an HIV/AIDS Committee. The committee outlined a clear and comprehensive work plan, which detailed objectives, activities, key indicators etc.

- A work place programme was established and the team was sensitized and trained on aspects of HIV prevention, sexuality issues, counseling, and condom education. The aim was to raise the

teachers' level of competence in HIV/AIDS education, counseling etc. so that the teachers could incorporate HIV/AIDS in the curricula.

- Teachers in the districts were sensitized to the challenges of managing the HIV/AIDS risk.

Capacity building

- Ancillary staff were trained as Peer Educators and Peer Counselors. Similarly 12 Officers were trained for 12 weeks as HIV/AIDS Counselors to enable them to develop workplace programmes in their workplaces.

- A framework for mainstreaming HIV/AIDS in pre-service education is in place.

Applied Socio-economic Research

The impact study on the Education Sector was instrumental in highlighting the critical role of teachers, parents and young people in the management of the HIV/AIDS risk at all levels of the growth and development of children. The study also drew the attention of authorities to the school population characteristics that were to be observed as a result of the impact of the epidemic, and further emphasized the human resource gaps that were likely to occur as a result of the different levels of understanding of teachers.

Implementation Gaps

- A number of gaps have been observed in the implementation of the programme. The Pre-Service curriculum does not address issues of sexuality and HIV/AIDS management.

- The pay structure for education officers is not attractive and this has resulted in the migration of education officers to other fields of work. This has adversely affected continuity and quality of the programme implementation.

- The integration of HIV/AIDS in the curriculum and syllabus has been achieved but as teachers do not have skills to handle the content and process of instruction on sexuality, the actual implementation of the programme has stalled.

- Monitoring systems are not in place.

- Overall, the human resource base for the programme implementation, monitoring and evaluation is inadequate both in numbers and skills level.

Main Recommendations

It is recommended that PSD provide technical assistance to the department and that the department should be consulted in the recruitment and selection of any form of technical assistance. The support should be skill based and reflect a high level of technical competence.

Technical assistance for training of trainers should be provided under the project as part of capacity building. The experts should have expertise in the relevant training methodologies.

Technical assistance should be provided to the Education Centres and particular attention should be given to life skills education.

The scope of PSD II should be expanded to support professional teacher education and the department of Vocational Education and Training.

A "management of the HIV/AIDS risk" training programme should be developed and implemented targeting specific age groups of pupils in school, homes and the community. Sensitization of parents to the "management of the HIV/AIDS risk" should also be conducted.

Partnership between UNFPA, MOE, and BOTUSA, the European Union and SIDA should be continued and new areas of collaboration with the PSD should be explored.

- Pupils sensitized to HIV/AIDS issues should be used as vehicles for behaviour change among peers and in the community. New thinking should be factored into schools for the "management of the HIV/AIDS risk". The main target should be the elimination of HIV transmission by 2016.

- Monitoring systems and tools should be developed and used.

Overall recommendations

The Ministry of Education is very large and an in-depth understanding of how and where to channel the support is critical to the effectiveness of any support or technical assistance provided to the Ministry both as a work place and as a centre for human resource development. The following are the overall recommendations for the education sector:

- UNDP and partners within PSD should support the in-service teacher training and development through training, capacity building and empowerment of teachers for sexuality education, reproductive health, and life skills initially, and the mainstreaming of strategies and interventions for the management of HIV/AIDS risk in the curriculum and instructional process.

- UNDP and partners should use the 14 Education Centres as a springboard for launching Teacher Training and Parent Education including the youth development and empowerment programmes. Remote areas like Kasane, Kang. Gantsi, Maun, and Tsabong have education and youth centres, Tsabong and Kang have started projects on Parent Education in collaboration with the YWCA. An alliance with UNFPA-AYA, UNICEF and the DMSAC's should expand the PSD influence in the areas of parent education, teacher training, youth development and empowerment.

- The PSD II project should use the youth development and education centres as strategic entry points for the implementation of income generation and poverty reduction projects to improve the quality of life and well being of youth. The youth centres should also be equipped to serve as multipurpose centres for the human, personal and social development of young people. It is only when the young people are such empowered that it will make sense to them to adhere to issues of

safe sex as they would not be driven by hunger and lack of support to engage in unsafe sexual practices.

- PSD should explore approaches to providing training in IEC and community mobilsation to youth out of school to promote prevention, reduction of sexually transmitted infection, including HIV infection as well as to support care, counseling and social support services provided to people living with HIV/AIDS and their families. This may also be used as an employment opportunity for young people, while they actively promote prevention and positive living.

- The PSD should consider the schools and youth centres as important environments for promoting behaviour change communication, gender sensitive HIV/AIDS risk management, information, education and communication including community mobilisation. The centres should support the DMSAC's in community mobilisation and advocacy for behaviour change among youth.

- Strong linkages should be established between the Teacher Capacity Building initiative, the Teacher Training Colleges, the Parent Education Programme, and functional literacy programmes implemented by Adult Education Assistants in households and communities, for maximum effect.

- PSD to spearhead consultations between MOE/MLG/MOH and partners on developing a comprehensive national programme that takes into consideration the physical, mental, and emotional health and human development of orphans along the life cycle, and their individual circumstances, and the risks to HIV/AIDS.

Ministry of Finance and Development Planning

The Ministry was one of the four sectors at national level initially targeted by the PSD. This was particularly because its revenue and expenditure functions would be affected by low productivity levels and additional expenditures incurred as a result of the HIV/AIDS epidemic.

It was observed that the implementation of PSD activities had not occurred for various reasons. The ministry had not really benefited from the PSD in terms of mainstreaming the "management of the HIV/AIDS risk". The HIV/AIDS activities were coordinated by an officer at the level of Deputy Director, but due to commitment to other duties HIV/AIDS activities were not fully elaborated, organised nor implemented.

The ministry stated that it was beginning to organise itself for action and indicated that it needed support.

Recommendations

- Technical assistance for institutional strengthening to ensure that the ministry addresses and effects modalities for operationalising the concept of mainstreaming HIV/AIDS interventions within the ministry departments.

- Technical assistance should be provided to assist the ministry to implement work place programmes on HIV/AIDS, IEC, training and capacity development.

- Establishment of an AIDS Coordinating Committee to spearhead mainstreaming of HIV/AIDS risk management at the work place, should be given priority.

- Technical assistance should be provided to develop policy and procedures essential to incorporating the "management of the HIV/AIDS risk" in national development planning.

- Provision of technical assistance for the development of a monitoring and evaluation, Management Information System (MIS) should be a priority.

Ministry of Health

The Ministry of Health has provided support, through the AIDS/STD Unit (ASU) as the main government organ for technical assistance, training, institutional strengthening and capacity building to sectors at all levels, including Disciplined Forces, BONASO and organisations of People Living With HIV/AIDS. The Ministry of Health, through ASU, played a major role in enhancing the potential of PSD, by assisting sectors to incorporate the HIV/AIDS issues in their mandates using their comparative advantage.

Policy Development

- Through ASU, PSD has facilitated the operationilisation of the 2nd Medium Term Plan (MTP II) which advocated the multi-sectoral approach to the response.

- The macro- and micro-economic impact studies have provided a basis for the development of a policy framework for the introduction of Antiretroviral (ARV) therapy, and the development of Policy framework on orphans.

- The MOH recognises the need for the review of the National Policy on HIV/AIDS to broaden the health sector response in the light of new thinking and emerging issues.

Institutional Strengthening

- ASU has supported the initial establishment of the Networks, namely BONASO, BONEPWA and BONELA. Prior to BONEPWA being registered as an NGO in 2000, the Network was coordinated by ASU.

- ASU also played a major role in supporting those districts under the PSD to establish DMSACs including the implementation of their programmes.

- ASU has been involved as the technical arm of the PSD, as well as the point of reference for the approval and funding of the DMSACs, NGOs, and CBOs activities within the PSD, until end of 2001.

- The staff of ASU was responsible for the initial training of the 10 focal ministries on the aspects of PSD, and the training of Focal Persons and sector AIDS Committees, including the Disciplined Forces.

- ASU also played a role in the strengthening of the institutional capacity of public and private sectors, Disciplined Forces and the Civil Societies, for the development of their workplace programmes.

Capacity Building

- The PSD Coordinator at ASU in collaboration with UNDP HIV/AIDS Programme Officer had the oversight for the implementation, follow up, monitoring and support to programmes.

- 7 UNVs, a secretary, a data clerk, a driver and a planning officer were provided to ASU through the PSD. Through the UNVs provided to CHBC, counselling, and social mobilisation, and to the networks, NGOs and support groups of PLWHA, ASU was able to reach out to ministry departments, disciplined forces, networks, and support groups with training, capacity building and institutional strengthening for service delivery.

- Through counselling, the ASU assisted and supported the PLWHA to reveal their status and assisted them to cope with the consequences, and develop healthy coping mechanisms.

- ASU strengthened the capacity of the sectors, districts, disciplined forces and civil societies through training of peer educators and peer counsellors, as well as by mobilising technical assistance through PSD.

Service Delivery

- The UNVs, in collaboration with CHBC coordinators, nurses and social workers developed a number of innovations in the area of information and AIDS counselling centres such as the Light and Courage Centre, the House of Hope and the Maun Day Care Counselling Centre. These innovations triggered off other modalities of day care, hospices, respite and orphan care centres.

- The result of the collaboration between ASU, as the technical arm of the Ministry of Health, the clinics, the public health nurses and members of the DHT, was consensus building on the impact of the epidemic, sensitisation, IEC, service delivery including CHBC and orphan care.

Constraints

- The Ministry of Health was not targeted by the PSD as the sector. There is no evidence of the extent to which the health sector has mainstreamed the HIV/AIDS response.

- The Ministry has not been able to cater for its own workplace needs, but concentrated on developing and supporting other sectors. There has been no real mainstreaming of HIV/AIDS activities at the sector, departments, institutions and division levels.

- The UNVs were caught up in the work of ASU, and they did not have counterparts attached to them for skills transfer, thus the opportunity to exploit their expertise in areas such as mainstreaming was missed.

- The inadequate capacity of the DHT to provide technical leadership for mainstreaming seemed to compromise the scope and the quality of the health sector response at the district, community and local level.

- While ARV, IPT, PMTCT have been initiated by the Ministry of Health, efforts to mainstream these activities to other areas of the ministry have yet to begin.

- The transition from ASU to NACA has slowed down ASU's operations. Likewise, issues of role clarity with regard to ASU and NACA have compromised progress in some way.

Recommendations

- The Ministry should be targeted fully by PSD II. To this end technical assistance and support should be provided at all levels to enable the ASU to fulfil its mandate for the Health sector response to the epidemic, and to mainstreaming of HIV/AIDS initiatives in all the departments.

- The ministry should be supported to provide technical leadership in the management of HIV/AIDS risk, and to reduce transmission of HIV and the impact of HIV/AIDS at all levels.

- The staff of ASU and other departments of the Ministry Health should receive appropriate training, technical assistance, and support for capacity building to mainstream the HIV/AIDS response in all the sector departments.

- New thinking and emerging issues in HIV/AIDS should be exploited to commission the review of the National Policy on HIV/AIDS to address the mainstreaming of the HIV/AIDS risk throughout the health sector at all levels.

- There is need to strengthen the DHTs through training in mainstreaming HIV/AIDS and the supervision of activities for promoting the health sector response.

Ministry of Labour and Home Affairs

This is a very large ministry, with diverse functions. The ministry consists of thirteen departments. Its functions include, among others labour and administration, correctional and rehabilitative services, sports, youth and gender affairs. To this end the ministry has a critical role to play in the prevention of the spread and mitigation of the impact of the epidemic.

The ministry is one of the first four that were targeted by PSD as it was destined to play a critical role in the response.

- ***Achievements***

Policy issues

- The sector has draft policy that addresses specific issues related to HIV/AIDS within the sector; the draft is in line with the National AIDS Policy. The recent appointment of a National AIDS Coordinator and the decision to appoint officers in charge (focal persons) in different departments of the sector, should further strengthen the sector.

- There is a document developed by consultants on mainstreaming.

Institutional Capacity

- Technical assistance through PSD was provided to the sector to conduct a situational analysis. The appointment of focal person within the different departments enhanced the concept of mainstreaming. The departments are beginning to recognise the need to network.

Capacity building

- The sector conducted a series of sensitisation activities on HIV/AIDS for staff members, through workshops, short talks by experts, and monthly meetings etc. They have also involved PLWA in the sensitization programme. They have developed relevant IEC materials and each department has a workplace programme.

- Training of peer educators and counsellors was conducted by a professional body.

- PLWHA have also been involved in sensitisation training programmes.

- Relevant IEC materials have been developed to suit the work place within various departments.

- Some procedures to meet the needs of PLWHA have been developed internally.

Constraints and Implementation Gaps

- Late disbursement of funds.

- Inadequate guidance especially to departments such as Women, Youth, Gender etc

- Districts are sometimes discouraged as they have to wait a long time for the approval of funds.

- The full time AIDS Coordinator has recently been appointed, as such the Ministry has not had any leadership prior to this.

- There does not seem to be adequate networking between the departments on HIV/AIDS programming despite the fact that key departments like Women, Youth, Sports, Labour and Immigration have so much to collaborate and network on.

Recommendations

- Technical assistance should be provided to finalise the policy on HIV/AIDS in the sector, as well as for programme development.

- Renew programme support for mainstreaming to facilitate the implementation process within the sector.

- Conduct a focused needs analysis and assessment to identify priorities and gaps.

- The sector should address the reduction of transmission, as well as approaches to reducing the factors that fuel the epidemic.

- Networking and joint programming between and among departments should be pursued as a matter of urgency.

- MLHA should forge meaningful alliances with key Women, Youth, Men and Workers Organisations including Networks and Disciplined Forces on issues of "Managing the HIV/AIDS risk".

Ministry of Local Government

Introduction

The Ministry of Local Government was targeted for institutional strengthening with emphasis on the mainstreaming of HIV/AIDS programme into their mandates and comparative advantage much more fully between 2000 and 2002. Earlier on the main emphasis was on the districts which fall directly under the ministry of Local Government.

- To this end, the establishment of DMSACs and VMSACs or VACS, the development and strengthening of Community Home Based Care services in the districts, and the organization of services for orphan care mainly through the Social and Community Development (S and CD) were the most prominent developments of the time.
- At the Ministry headquarters level, institutional strengthening activities consisted of:

    - the establishment of departmental and ministerial AIDS Committees;

    - Identification of focal points for HIV/AIDS;

    - The establishment of IEC, condom education and condom use, provision of condoms, peer education and peer counselling training initiatives; and

    - Workplace programmes.

These were supported by ASU within PSD, as well as by organizations such as Population Service International (PSI).

- Technical assistance was provided through the PSD to MLG over time and the need for the development of a capacity within MLG to fully address the objective and functions of mainstreaming HIV/AIDS into its mandate at the national, district and local levels was recognised.

Main Achievements

The Ministry of Local Government has undergone an internal reorganization to enable it to address the following:

Policy Development Related Issues

- An AIDS Coordinating Unit (ACU) has been formally established and staffed. Its roles and responsibilities have been fully established, and an organisational structure to support the process is in place. The ACU has assumed responsibility for district planning and the mainstreaming process, the provision and coordination of CHBC and Orphan Care services at district level. Training, monitoring and evaluation of HIV/AIDS activities and functions have also been made the responsibility of the ACU.

- District AIDS Coordinators have been appointed in all the districts in the PSD project sites as well as in other districts, as a matter of policy.

- Steps to develop an integrated CHBC and Orphan Care Programme have been taken, and a number of capacity building initiatives towards this have been effected.

- Plans to integrate the mainstreaming of HIV/AIDS in all district development plans and projects have been elaborated, and an initial training activity towards this has taken place.

- Plans and procedures to anchor HIV/AIDS prevention, reduction, care and social support at the household and community levels are being outlined.

- A system and plan for monitoring and evaluation at the district and local levels has been elaborated, and mid-level staff have been sensitised to the process.

Capacity Building

- Through technical assistance provided under PSD, between 2000 and 2001 two consultancy reports provided the direction and impetus for strengthening the capacity of MLG to respond to both the mainstreaming and decentralization requirements of MTP II 1997-2002. Through technical assistance provided by the UNDP Regional HIV/AIDS advisor in the form of workshops, and consultations, the MLG has been assisted to develop capacity for implementing the mainstreaming process, service delivery, coordination, monitoring and evaluation.

- Training workshops for service delivery, monitoring and evaluation have been conducted for district level leaders and other groups involved in the provision and management of CHBC and Orphan Care. Most of these initiatives have been supported technically through the services of an international consultancy team with back-up support from the Institute of Development Management (IDM). The Swedish International Development Agency (SIDA), a partner to GOB on the PSD, provided the funding for the initial training and other capacity development initiatives.

- The Ministry of Local Government headquarters level personnel have increased their understanding of the mainstreaming process as well as their functions, responsibilities and tasks for managing the district level response. Conceptually there seems to be a shared understanding of how MLG should organize itself to fulfil this responsibility.

Institutional Strengthening

Both the policy changes, new institutional arrangements, and the capacity development initiatives, have contributed to the strengthening of MLG for promoting the response, as well as towards the sustainability of the mainstreaming and decentralization of HIV/AIDS activities. The AIDS Committees and co-ordinators at the Ministry and departmental levels have proved to be valuable structures in the response at the national level.

Constraints and Implementation Gaps

- Although the period 2000 – 2002 has seen significant development in the Ministry of Local Government in some areas, constraints in the national system in general, and to some extent the ministry of Local Government itself were observed.

    - The scope and diversity of roles, functions and responsibilities, require a high level or organisation.

    - The MLG is a large and diverse entity which offers a wide range of mixed services, provided by various parent ministries that have structures and personnel at the district, sub-district and local levels. The planning, supervision, coordination, monitoring and evaluation of the mainstreaming process as well as the quality of the HIV/AIDS risk management is going to be a challenge, and the training required may be well beyond the technical resources available.

- Inadequate human resources to manage and sustain the process, especially at the household and local levels.

- The staff shortages affecting the efficiency of the services throughout the country remain a problem. Similarly both the HIV/AIDS work and the decentralization process require an initial investment in time, people and skills. The current human resource base may not facilitate the process as efficiently as desired.

- The capacity of the newly established AIDS –Coordinating Unit (ACU) is inadequate for its functions, responsibilities and tasks.

    - The Unit as of now, does not have adequate human resources and capacity to pursue its objectives and tasks in an efficient and effective manner especially given the scope and complexity of what it has set itself to do. Without an injection of more technical personnel the few, may be bogged down and overstretched.

- Inadequate numbers of personnel with the requisite skills for IEC, BCC and social mobilization essential to the response.

    - The lack of personnel with requisite skills for IEC, as well as for promoting behaviour change through social mobilization and social marketing of selected strategies for reducing transmission remains a major constraint to the response.

- Inadequate development of formal networking and collaboration initiatives between sectors, CBOs and NGOs with communities involved in HIV/AIDS activities.

- While priorities had been identified through the studies conducted prior to the implementation of PSD, some districts did not seem to have used the data as a basis for intervention development, their plans are not based on evidence.

- Inadequate use of the findings of the 6 Socio-Economic Impact studies in determining policy related and other programme development priorities, at all levels. The follow-up of recommendations and use of findings from these studies was probably hampered by; the level at which the dissemination of the findings and recommendations of the studies were disseminated, and secondly by inadequate capacity to follow-up the recommendations in an efficient and purposeful manner. An appropriate strategy for dissemination of study results has not been elaborated.

- Inadequate training and capacity building for monitoring and evaluation of services provided at district and local levels, it was therefore not possible to assess the progress made.

    - An integrated approach to training for CHBC and Orphan Care has only recently been introduced, and has yet to be operationalised at local levels.

- Inadequate appreciation and articulation of the roles of international UNVs in some districts resulting in role conflict in some settings, compromised the capacity development initiatives in some instances, especially where the UNVs did not have counterparts.

    - In some districts, UNVs worked without national counterparts and therefore worked more closely with the administration and technical committees of the DMSACS while they continued to network with various sectors within DMSACS.

- At the district level, there seemed to be several factors which were reported to have contributed to the delays in the actual disbursement of funds. These were seen as the cause of bottle-necks.

Recommendations

- The Ministry of Local Government suggested that DMSAC plans be synchronised with the district development plans for mainstreaming HIV/AIDS at the district levels, so that planners also mainstreamed these into their district plans. The evaluation team while appreciating this notion however cautions against denuding the DMSAC plans of their 'community driven' and 'locally inspired response' in the process. The empowerment of DMSACs can only promote ownership of the response at this level where it can make significant impacts.

- The Ministry of Local Government should consider creative approaches to motivating the DMSACs towards pursuing comprehensive public health driven, and human rights based approaches to the "management of the HIV/AIDS risk" at the personal, family, household and community levels.

- The Ministry of Local Government should explore approaches to emphasise the critical roles of the household, schools, the Kgotla, faith-based groups and traditional community systems, in promoting prevention and behaviour change communication for the reduction and elimination of the sexual transmission of HIV.

- The Ministry of Local Government, Teaching Service Management (TSM) and the entire Department of Local Government Service Management (DLGSM) should redefine the scope of their roles and responsibility, in developing and implementing HIV/AIDS risk management compliant policies, services and human resources development plans.

- MLG should be assisted to support initiatives to strengthen IEC and BCC programmes as an approach to the anchorage of HIV/AIDS activities at the household and community levels.

- Technical assistance should be channelled to the DMSACs, some sectors and institutions such as youth centres, CHBC, Orphan Care, CBOs, Disciplined Forces, Support groups etc., where they are likely to make a significant impact.

- MLG should be assisted to target the capacity development of DMSACs, partners as an approach to promoting action at the sector, household and community levels for the management of the HIV/AIDS risk at these levels.

- The Ministry of Local Government's capacity to develop the DMSACs to implement their co-ordination, training, monitoring and evaluation responsibilities should be enhanced as a matter of urgency during PSD II.

- The Ministry of Local Government should be assisted through PSD to conduct a needs analysis and assessment of the types and levels of human resource mix required to meet its target for the anchorage of the management of the HV/AIDS risk at the household and community levels. Similarly the training modalities most suited to the development of the requisite skills for this process should be explored, developed and implemented.

- MLG should be assisted to develop a plan of action to implement selected recommendations aimed at sustaining the gains and achievements realised thus far, especially with regard to the DMSACs, and partners within the 16 districts.

- MLG should be assisted to identify the nature of international and national technical assistance and UNV assistance required to develop the next 8 districts likely to be included in PSD II 2003 – 2007.

- Capacity development among the Civil Society Organisations BONASO, BONELA, BONEPWA should be undertaken to ensure that the networks impact at the local level, through their affiliated CBOs and support groups.

- Technical assistance including international UNV support should be channelled to each of the following service areas, the CHBC and Orphan Care, the Social Welfare Department and the Social and Community Development Services. Consultation and consensus on the details of the technical assistance and UNV support is considered important.

- The current PSD assistance to the monitoring and evaluation section of ACU should be continued.

- ACU should support the process for the integration of the work of both the District AIDS Co-ordinator and UNVs into the work of the District Commissioner so that they service the District Commissioner on HIV/AIDS for the empowerment of the DMSACs.

Ministry of Trade, Industry

The Ministry was included in the PSD following the extension of the programme to increase areas of coverage from 5 to 10 ministries. The Ministry has been concerned that the HIV/AIDS epidemic posed a big threat to the country's tourist industry. As the sector responsible for trade and industry development the ministry plays a key role in facilitating the process of generating and sustaining productive employment. The strategy employed by the ministry is to empower private sector and ensure their growth and development. To this end the ministry is well placed to play the essential role in motivating the business sector response to HIV/AIDS.

Policy Development

- The Ministry has developed policy guidelines on the prevention of HIV/AIDS at the workplace, and for addressing the impact of the epidemic on the sector programmes.

- The Ministry participates at the National AIDS Council through the Sector Committee for Trade, Industry and Tourism, whose overall purpose is to "stimulate, guide, develop and coordinate the trade and commerce sectors' response to HIV/AIDS on behalf of the NAC."

Institutional Strengthening

- An HIV/AIDS Coordinating Unit (HACU) has been established in order to consolidate and strengthen the HIV/AIDS initiatives within the ministry, and to make sure that the interventions undertaken by the ministry within the context of the response, are coordinated amongst the various departments.

- The HIV/AIDS Coordinator was appointed to the position in September 2002.

- All the departments are encouraged to sensitise the staff and make them aware of the dangers that may be encountered if HIV/AIDS is not addressed seriously.

- Smaller committees, headed by Department Heads, have been established at the departmental level to address related issues, and are encouraged to give the necessary support to the infected and affected members of staff.

Capacity Building

- Departments held weekly prayers to reach out to, and to support the infected and affected members of staff. The sessions are also used to address pertinent HIV/AIDS issues and initiatives.

- Distribution of Information, Education and Communication materials, as well as presentation of video shows on HIV/AIDS prevention and other related matters is carried out in divisions within departments.

- Sensitisation and awareness workshops to address HIV/AIDS issues have been organised for district workers in the Department of Tourism from time to time.

- The Ministry Management Department organises bi-weekly informal meetings where issues relating to prevention, care, and support are discussed. Similarly the impact of HIV/AIDS is also discussed.

Service Delivery

- The Ministry provides support and guidance to the private sector to enable the sector to identify the appropriate approaches to addressing the epidemic.

- Distribution of condoms, and display of posters depicting HIV/AIDS messages in selected places where members of staff and visitors to the ministry may easily access them.

- As an undertaking to support those members of staff who are very sick a special fund, to which members voluntarily make contributions of Pula Five (P5.00), has been established.

Constraints and Implementation Gaps

The following have been identified as issues that adversely impact on the ministry's efforts towards the response:

- There has been no focal unit to guide the HIV/AIDS initiatives in the ministry; the activities undertaken differ from one department to another and are carried out on an ad hoc basis. There is no policy framework to guide HIV/AIDS activities carried out by departments.

- HIV/AIDS activities are carried out on a voluntary basis and are not considered priority. These are also not mainstreamed.

- The staff members volunteering to coordinate the HIV/AIDS initiatives in the ministry do not have the requisite knowledge and skills to effectively address the responsibility.

- Inadequacy of IEC materials, and other related equipment that could be used to expand awareness activities limits the scope of activities that could be implemented to fight the epidemic.

- Establishments such as hotels, motels, and lodges play a significant role in the promotion of tourism in Botswana, an industry viewed as a major contributor to the economy. Most of these facilities, particularly in the Chobe and Okavango areas, have not started to address HIV/AIDS at the workplace and among their families.

Recommendations

- The Ministry should, in line with its vision, commit itself to look at new approaches to carrying out its mandate, and using its comparative advantage to address the epidemic.

- Appropriate action should be taken to strengthen the capacity of HACU to spearhead the coordination of the HIV/AIDS initiatives to ensure that the ministry addresses the response effectively.

- Technical assistance should be sought to address training, capacity building and institutional strengthening within the ministry to help raise the level of awareness among the work force.

- Initiatives carried out by the ministry should move from the current concentration to condom education and distribution to a focused approach to strengthening and mainstreaming of HIV/AIDS in the activities of the ministry at all levels.

- The ministry should hasten to encourage and assist the private sector into developing their own policies and guidelines for addressing the HIV/AIDS response. In addition, the ministry should develop standards and procedures to monitor performance in the management of the HIV/AIDS risk at the workplace for all hotels, motels etc.

- Hotels and other such facilities particularly those catering for the tourist industry, should be specifically targeted with capacity development and training for the prevention of HIV transmission, reduction of the spread of the epidemic, protection of the employees and families.

- "Managing the HIV/AIDS risk" should be operationalised at all levels, and activities should be well defined.

- **Civil Society Organisation/Networks**

  The concept of Networks for People Living with HIV and AIDS (PLWHA) was developed at the start of the project in 1997, but it was not until the period following upon the Midterm review, June 1999, that the two networks, BONELA and BONEPWA were formed as Networks for People Living with HIV and AIDS. The Botswana Network for AIDS Services Organisations (BONASO) had been formed much earlier on to facilitate the co-ordination of the work of AIDS service organisations.

  The PSD (Bot/96/001) focused on the strengthening of BONASO, and the establishment of BONELA and BONEPWA. Much progress has been made between 2000 and 2002 November in terms of setting up BONELA and BONEPWA, strengthening the institutions, as well as capacitating them to advocate for the human rights of PLWHA including the development of approaches to meeting their physical, socio-economic, emotional and personal growth needs for an improved quality of life. BONELA and BONEPWA have to some extent provided a forum through which PLWHA and their support groups can mobilise support in a collective and strategic manner. The Botswana AIDS Service Organisation established much earlier than the establishment of the PSD, was included as the third civil society organisation to be strengthened during MTP II 1997 – 2002 through the GOB and UNDP PSD initiative.

  Achievements

  The three Networks BONASO, BONELA and BONEPWA have all made some progress towards policy development, institutional strengthening and facilitating service delivery to PLWHA and the affected. Some technical assistance through consultants and UNV support has been provided to BONASO, BONELA AND BONEPWA on a small scale. All three Networks have participated in discussions related to policy analysis and review especially with respect to the human rights of PLWHA. Similarly the two Networks, BONELA and BONEPWA have advocated for the development of programmes to meet the physical, psychological and social needs of PLWHA and those affected. They have collaborated with various government institutions, the private and informal sectors to mobilize support on behalf of their members and support groups. With motivation from BONEPWA, some support groups such as COCEPWA, CEYOHO and Nkaikela are providing HIV/AIDS counselling service for prevention reduction of sexual transmission, including care and support to PLWHA and the affected.

- ***Constraints, Implementation Gaps and Recommendations***

  The main constraints to the efficiency and effectiveness of the Networks has largely been in the areas of human resource shortages, institutional capacity and the provision of technical assistance to the Networks on a consistent and dependable basis. This has slowed down their development and efficiency in terms of realising their planned targets. Generally their capacity to respond to the needs of their membership is inadequate. An appropriate resource mobilisation strategy for the Networks has yet to be developed.

  Recommendations in this area are primarily focussed on the strengthening of the organisations in a comprehensive and coherent manner. The strategy for enhancing the efficiency and effectiveness of the Networks should address institutional strengthening provision of needed human, financial, material and technical resources, and capacity development as a matter of urgency. Similarly the three Networks should be assisted to collaborate, network and reinforce one another taking into consideration their mandates and comparative advantage. Effort should be made to enhance their capacity to reach out to the grass-root levels. They should be targeted with training in techniques and methodologies for addressing and combating stigma. Similarly they should be empowered to spearhead activities for managing the HIV/AIDS risk among the members their families and others.

Botswana Network of AIDS Service Organisation (BONASO)

The Botswana Network of AIDS Service Organisation (BONASO) which was already existing was strengthened during PSD. The planning process of BONASO was informed by the Medium Term Plan II (MTP II). The PSD kick started the activities of the network and enabled it to provide greater support to its members than before. The network has 55 members and a Directory of Member Organisation has been developed for ease of reference and collaboration between members.

BONASO mobilizes technical support to meet the needs of its members from the AIDS/STD Unit in the Ministry of Health, internal and external sources, and also by using some of its members with the relevant expertise.

The network has strengthened some CBOs such as the Holy Cross Hospice and to a large extent the Ghetto Artist and Reetsanang Community Group.

Some progress has been observed in the way the network has responded to supporting its members in the response with regard to addressing policy related issues, institutional strengthening and capacity building.

Policy Related

BONASO is a member of the National AIDS Council (NAC) and as such plays an advocacy role on behalf of its members. As a member of NAC, BONASO participates in advising the Government on policy and strategic adjustments that may be required in the national response in relation to prevention and mitigation programme and strategies. The network also advocates for the effective involvement of all

NGOs and CBOs in the implementation of the programmes and strategies for the prevention of HIV and the mitigation of the impact at various levels of society.

Institutional Strengthening

- The mainstreaming of HIV/AIDS into the mandates of member organisations is in place as the network is about organizations whose mandate is HIV/AIDS.
- A UNV Advisor was appointed in 2000 and the individual provided much needed support in skills building and on the job training of members.
- BONASO has assisted its members in programme design, including resource mobilization.
- BONASO also produces an annual newsletter to disseminate network news and views on HIV/AIDS.
- PSD has mobilized resources from other partners and agencies to support the running costs of BONASO.
- BONASO has established a resource centre for long life learning of all its members.

Capacity Building

- A number of workshops were conducted for members to build their capacity to respond to the fight against the epidemic.
- There has been an increase in the involvement of NGOs, CBOs and Support groups in the fight against the epidemic, and prior to Annual General Meetings, members share experiences.
- Linkage with other civil society organizations is maintained through quarterly meetings between BONASO, BONELA and BONEPWA.

Service Delivery

- Support groups of PLWHA are providing services to individuals, families and communities with the objective of raising HIV/AIDS awareness, help fight the stigma and help members access services such as PMTCT, IPT and ARVs.

Implementation Gaps

- Collaboration between BONASO member organizations and the disciplined forces is very minimal.
- Monitoring and evaluation of member programmes is not in place.

- The presence of NGOs and CBOs is lacking at the grass roots level. There is a great need to strengthen the NGOs sector at the district and community level in order to prompt the trickling down effect of programmes to the grassroots.

Recommendations

- BONASO, as an umbrella body for NGOs and CBOs providing HIV/AIDS services, needs to encourage its members to overcome stigma, denial and break the culture of silence in the society. Stigma is believed to be preventing access to HIV/AIDS services such as VCT, PMTCT, IPT and ARVS.

- Provide technical assistance for institutional strengthening to enable BONASO to meet the individual needs of its member organisations and CBOs.

- Strengthen partnerships and joint programming with other networks for maximum impact at the district and community level.

Capacity Building

- Strengthen BONASO's capacity with skills to support is members to mobilise communities to seek and access services and support.

- Facilitate the development of training programmes in leadership, organisational development and monitoring to enable BONASO to be responsive to the needs of its members.

- Provide support to BONASO for the documentation of best practice experiences and lessons learned on living positively and contributing towards the reduction of stigma.

- Provide technical assistance to BONASO in programme development for family and community based approaches to community and household empowerment, through social marketing to improve the uptake of VCT, HIV/AIDS related programmes and other health programmes.

- Provide technical assistance to BONASO in the use of participatory approaches to addressing household and communities for empowerment in the management of the HIV/AIDS risk.

- Provide technical assistance for the development of comprehensive advocacy strategies to promote an enabling environment for addressing poverty reduction, gender issues, and human development.

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

BONELA is a network that deals with legal and human rights issues in HIV/AIDS, and was established through PSD. Its core mandate is to ensure that human rights issues are integrated within individual organizations, communities and services. The main areas of focus are advocacy, lobbying for human rights, training and education, litigation and research.

Achievements

Policy Development

- The establishment of a registered network on HIV/AIDS legal issues.

- The establishment of an interim board whose members are drawn from Institute of Management and development (IDM), and the University of Botswana (UB).

- Establishment of legal and ethical sector within the National AIDS Council (NAC).

- Supported the development of the employment equality act, which will be related to the Labour Act (In collaboration with Labour and ILO).

- The Botswana Network on Ethics, Law and HIV/AIDS (BONELA) is the secretariat of the sector on Ethics, Law and Human rights within the National AIDS council (NAC).

Institutional Strengthening

- A Co-ordinator has been appointed.

- An Interim Board is in place.

- Linkages with other networks have been established.

- The notion of a legal Fraternity i.e. bringing Judges and Magistrates together in the area of HIV/AIDS legal issues has been developed and accepted.

- The organization has developed a strong professional standing and has also established effective collaboration with recognized professional bodies.

- Financial support has been provided to BONELA.

Capacity Building

- Conducted public talks on HIV/AIDS and human rights.

- Conducting talks at different tertiary institutions to sensitize them on the issues of HIV/AIDS and human rights. (For both academic and non-academic staff).

- Organized workshops with the Botswana Federation of Trade Union (BFTU) to sensitize the workers on the issues of HIV/AIDS and human rights.

- Community mobilization on the issues of HIV/AIDS and human rights.

- Ability to involve others and tactics in advocacy and community mobilisation has been developed.
- A training of trainers' workshop on HIV/AIDS legal and human rights has been conducted.
- Participated in the Inter district training on HIV/AIDS legal and human rights.
- The organization has attained high level of understanding of HIV/AIDS legal and human rights issues.

Constraints, and Implementation Gaps

- Lack of managerial and administrative support.
- Inadequate capacity, human, material and other resources.
- Delays experienced in processing documents in government institutions owing to its status.
- No technical assistance is available for BONELA.

Recommendations

- Strengthen partnerships and joint programming between BONELA and other networks for maximum impact at the district and grass root level.
- Provide technical assistance to promote advocacy for human rights for people living with HIV/AIDS at all levels.
- Facilitate the development of training programmes in leadership, organisational development and monitoring to enable BONELA to be responsive to the needs of PLWHA.
- Provide support to BONELA for the documentation of best practice experiences and lessons learned in advocacy for human rights for PLWHA.
- Provide assistance to BONELA to encourage other networks to incorporate human rights issues into their programmes.
- Strengthen the capacity of BONELA to work directly with CBOs and support groups at local level on the application of human rights concepts at the household and community levels.

Botswana Network of People Living With HIV/AIDS (BONEPWA)

BONEPWA is a national NGO network formed by and for those people living with HIV/AIDS in Botswana. It was founded in 2000 driven by the need to provide leadership and a common forum for

concerted advocacy efforts to provide a united voice for PLWHA through their support groups. It was established through PSD (1997 – 2000).

Institutional Strengthening

- A Board has been established, and is functional. Various support groups have membership on the Board.
- BONEPWA has supported the development of support groups nationally and has carried out advocacy functions for ethical and human rights and greater involvement of people living with AIDS. Similarly the network has been involved in resource mobilisation for members of the network.
- The Network has established linkages with civil societies, i.e. Botswana Defence Force and Botswana Council of NGOs (BOCONGO), and procedures for collaboration have been established.
- Advocacy activities for assuring the rights of PLWHA have been initiated at the national level. The Network has been involved in resource mobilisation for members of the network to promote positive living and their well being.

Capacity Building

- Sensitisation and training seminars including workshops to promote HIV/AIDS awareness have been instituted, and training of peer educators and counsellors effected.
- Study tours, including exchange programmes, have been arranged with different districts and internationally to exchange information on best practice and lessons learned.

Service Delivery

- The establishment of networks and support groups for people living with HIV/AIDS (BONELA, BONEPWA, COCEPWA) has greatly contributed to legitimising their existence and reducing stigma. This has also strengthened their involvement in the fight against HIV/AIDS. This arrangement is a best practice that can be emulated and replicated elsewhere.
- BONEPWA has supported training for caregivers at the Loratong Centre of the Holy Cross Hospice, which was conducted in collaboration with the staff of the Loratong Centre.
- The network has produced a newsletter
- Sensitisation seminars have been set up in various communities in the country and these have motivated PLWHAs to form support groups.

Constraints and Implementation Gaps

- Inadequate support for the development of a logical plan of operation at all levels.

- Inadequate technical assistance provided for the development of strategies for meeting the learning and development needs of emerging support groups at the district and local levels.

- Inadequate human resources for the administration and management of BONEPWA as an organisation.

- Inadequate technical capacity within BONEPWA for providing leadership to various groups of PLWHA.

- Lack of a clear national programme for the development of PLWHA.

- Inadequate expertise within BONEPWA for supporting other networks.

Recommendations

- Conduct focused needs analysis and assessment of gaps and priorities prior to the design of the successor project; to facilitate evidence based program interventions.

- Provide technical assistance for institutional strengthening to enable the network to meet the individual needs of support groups, CBOs and NGOs within their networks.

- Strengthen the network's capacity with skills essential to mobilising communities to seek and access services and support.

- Facilitate the development of training programs in leadership, organisational development and mentoring, to enable the network to be responsive to the needs of their members.

- Provide support to the network for the documentation of best practice experiences and lessons learned on living positively and contributing towards the reduction of stigma.

- Provide technical assistance to the network in the development of participatory methodologies to household and communities for empowerment in the management of the HIV/AIDS risk.

- Provide technical assistance to the network for the development of comprehensive advocacy strategies to promote an enabling environment for addressing poverty reduction interventions, gender issues, and human development.

- Establish strong partnerships and alliances with in- and out-of-school youth groups to campaign for behaviour change for addressing the biological, socio-economic and cultural factors that fuel sexual transmission of STIs/HIV among young people.

Disciplined Forces

The disciplined forces namely, Botswana Defence Force (BDF), Botswana Police, Local Police, Prisons and Rehabilitation Services have made some progress towards policy development institutional strengthening and services delivery with respect to the mainstreaming of HIV/AIDS.

All except the Local Police who are late starters, have developed policies to support the implementation and integration of HIV/AIDS activities in their mandates. Similarly all four disciplined forces have implemented activities and developed structures for institutional strengthening and service delivery.

They have all established AIDS Committees, appointed focal persons or co-ordinators and outlined procedures for their operations within each force. They have trained peer educators and HIV/AIDS counsellors, and established points for condom distribution, and education on consistent use of condoms. Similarly services for HIV/AIDS prevention, care and social support are being provided to PLWHA within the forces. The Botswana Police College and the Botswana Defence Force are integrating HIV/AIDS in their basic training programmes. The Botswana Police College has recently completed its integrated curriculum on HIV/AIDS which has been made possible through support from the PSD.

- ***Constraints Implementation Gaps***

  While the disciplined forces have made some progress towards the implementation of the mainstreaming process some constraints, which have impeded the implementation process were encountered. The disciplined forces do not have capacity to provide adequate training to their members owing to a lack of HIV/AIDS trained trainers within the forces. Similarly they do not seem to reach out to their neighbourhoods in a significant manner. The other constraint that negatively affects their implementation capacity is the extent and frequency of staff movements on transfers from one district to the other. This has been reported to have a disruptive effect on training programmes and other capacity building initiatives by the forces. The other area of weakness has been the inability of the forces to collaborate effectively among themselves despite their similar circumstances, and problems. This has adversely impacted on the sharing of information on best practice experiences and lessons learned. They have also not been able to collaborate with civil society.

  The potential of the disciplined forces in promoting the Management of the HIV/AIDS risk as a large, organised and extensively widespread group, has not been fully exploited at all levels

- ***Recommendations***

  Recommendations in this area focus on mobilising technical assistance and UNV support to all four disciplined forces to strengthen their capacity for "managing the HIV/AIDS risk" at the personal, household and community levels. Recommendations also focus on enhancing their capacity to collaborate, network and reach out to the community levels.

Botswana Defence Force (BDF)

The BDF, like the Botswana Police and the Prison and Rehabilitation Services were included as one of the four disciplined forces targeted by the PSD in 1997 for capacity development through policy development, institutional strengthening and service delivery.

The BDF has made some modest progress towards raising awareness on HIV/AIDS issues in general as well as on addressing the vulnerability of its members and families to the epidemic. The BDF showed a lot of enthusiasm and interest in the PSD activities. During the first two years of the PSD (1997 – 1999) an extensive situation and response analysis was conducted, and a number of programme implementation recommendations were put forward. The findings and recommendations were largely used as the basis for drawing up the work-plans of the BDF.

Capacity Building

- The BDF developed and implemented IEC, AIDS awareness, HIV prevention and reduction of sexual transmission, activities including condom use and education services with support from the AIDS/STD/UNIT initially.

- With support from the AIDS/STD/UNIT and the Institute of Development Management, the BDF was assisted to develop peer educators and peer counsellors who provided services through their 27 security units in the work place.

- The Directorate of Social Welfare Services established in 1997, and supported by the AIDS Co-ordinating committee has the main responsibility for facilitating the implementation of the HIV/AIDS activities in the entire army.

- Army workshop engineers carry out HIV/AIDS activities and participate in the provision of HBC services to the infected and affected.

- Peer educators and counsellors provide training in districts within the structures of BDF, at this level.

Institutional Strengthening

- The existence of the Directorate of Social Welfare Services within BDF has provided a stable base for the management and provision of HIV/AIDS services in BDF, as well as for addressing HIV/AIDS issues.

- The AIDS Co-ordinating Committee established through PSD support has provided both guidance and support to the work of the HIV/AIDS working committees in the security units.

- Through the PSD, the BDF has been supported to acquire equipment to enable the military to expand its IEC programme activities. Computers, printers and TV sets have been purchased for use in the development and dissemination of IEC materials.

- The BDF has developed IEC materials and posters on HIV prevention which derive their messages from the mandate and basic concepts underpinning the responsibility of BDF in 'defending', 'protecting' and strengthening the country, as well as 'fighting HIV/AIDS as an enemy', including being a "force for change" through its leadership in the "fight against the epidemic". The IEC materials show ingenuity in mainstreaming HIV/AIDS issues in the basic principles of the army's mandate.

- The BDF has also spearheaded the preparations for two consecutive "World AIDS Day Commemoration events".

- Currently the BDF ***chairs*** the Men sex and AIDS sector programme committee.

- The basic institutional arrangements within BDF are strong and augur well for capturing the target audience; being an army of about ± 25,000 and their families which are spread all over the country. This arrangement has a potential to reach not only the army and their families but also the neighbourhood, and in this way expand the response.

Constraints and Implementation Gaps

- The army's enthusiasm and capacity does not seem to have grown much given the rate at which the BDF's uptake of PSD initiatives had occurred earlier on. While the evaluation team may have gained more insight into the functioning of the AIDS Co-ordinating Committee if it had met with committee, evidence on the ground did not quite reflect intensive action and concrete plans for the future, although there was interest in HIV/AIDS.
- BDF has not had technical assistance provided to the force for strengthening the capacity to train its own peer educators and counsellors within their institutions. Similarly they do not have a trainer of trainers cadre that can continue to provide on site training to keep up the skills of peer educators and counsellors. This is a major constraint to capacity building.

- BDF has not really begun to network with other forces and civil society organizations in a meaningful manner. Not much support has been provided to BDF to explore ways to achieve networking with other forces nor with civil society organizations. As such, cross fertilization between BDF, the Police and Prisons on best practice experiences with respect to mainstreaming HIV/AIDS and expanding the response has not yet begun in any significant manner.

- The BDF clinic does not seem to be fully integrated in the response.

- The MIS has not yet been set up in a meaningful and usable manner, this seems an area of great need in the army.
- No operational research seems to be going on in BDF at this point in time.

Recommendations

- Long term technical assistance should be made available to BDF in a manner that would be acceptable to the top executive and membership of the army.

- A needs analysis and assessment of the priorities, needs and gaps in the mainstreaming of HIV/AIDS within BDF at the national and district levels should be undertaken as a matter of urgency to facilitate the development of a much more focused strategy for managing the HIV/AIDS risk at all levels of the army.

- The BDF should be assisted to develop a strong pre-service programme on HIV/AIDS to facilitate its integration into the entire basic training of the BDF personnel. Similarly intensive in-service training should be conducted.

- BDF should be assisted to develop their own trainers of trainers so that they may undertake their own training and thus increase the numbers of peer counsellors and educators within BDF, and sustain the capacity of those trained through continous training.

- Support should be provided for the development of the BDF's Management Information System (MIS), and this should be designed in a meaningful and relevant manner to meet the BDF's needs.

- BDF should be assisted to develop skills for networking and joint programming with other disciplined forces and civil society.

- Some effort should be made to motivate the AIDS Co-ordinating Committee at the headquarters of BDF, through training, capacity development, encouragement and support.

Botswana Police

The Botswana Police Force, one of the Disciplined Forces, was targeted by the PSD in 1997. The Police were targeted to strengthen the HIV/AIDS prevention and care services. It was also planned to promote collaboration and joint programme planning between forces in the fight against HIV/AIDS. Owing to logistics and the nature of their operations, the differences between the forces, joint programming was not pursued, and the forces agreed to function individually and meet to share experiences only.

Policy Development

- The Police are in the process of developing policy and would require technical assistance in the exercise which they have found to be a challenge.

Institutional Capacity Strengthening

- The PSD has supported the Police Department to be more multi-sectoral in their approach to their work.

- The HIV/AIDS Advisory Committee, made up of members from various Divisions of the Police Force, is in place and is actively addressing issues concerning the epidemic.

- Monitoring and evaluation is in the form of quarterly reports from Branch Commanders to the Commissioner, and this has helped them to make informed contributions to NDP IX. The Police believe that their objectives have been incorporated in the HIV/AIDS Chapter in NDP IX.

- Station Commanders participate in the DMSAC and feel that they are part of DMSAC activities.

- Partnerships have been broached with the civil society organisations, schools and communities. Strong and active collaboration with NGOs and CBOs has been established.

Capacity Building

- Senior officers and the management team have been sensitised to ensure mainstreaming through the cadres.

- Peer educators and counsellors have been trained and are distributed to provide the necessary services, where needed.

- IEC materials have been developed, and these include AIDS ribbons, posters and are in circulation. A column on HIV/AIDS is included in the Police magazine.

- Consultants have been engaged and are working on the HIV/AIDS curriculum for incorporation into the training programme, the first draft of the curriculum is complete and is currently being reviewed.

Constraints and Implementation Gaps

- The delay in the disbursement of funds hinders implementation of planned programmes.

- Some components of PSD are difficult to implement, such as the policy development aspect as the sector did not have technical assistance in the area.

- The capacity for programme development, documentation and monitoring was reported to be inadequate, and this was evident.

Recommendations

- There is a need for a UNV to provide technical support and capacity building, and a full time AIDS Coordinator. Furthermore, Technical assistance in policy development, as well as in training of officers in operations should be provided.

- A Training of Trainers programme should be set up so as to increase and sustain the capacity building process.

- Training of more peer educators and counsellors, as the number of Peer Educators and Counsellors is not sufficient to meet the requirements of police for IEC and Counselling should be organised.

- Study tours to areas that have progressed to expose personnel to new ideas for capacity development.

- Provide technical assistance for the development of capacity to facilitate the establishment of an appropriate management information system (MIS).

- Provide technical assistance for the implementation a focused needs analysis and assessment of gaps and priorities in the Police force, to facilitate the development of evidence-based programme.

- The Police, as a vulnerable group due to the nature of their work, should be provided with technical assistance to strengthen interventions that will empower them to use innovative approaches to the reduction of HIV infection through behaviour change

Botswana Local Police

The Botswana Local Police were included later in the PSD. The programme started mid 2001 as an educational programme aimed at sensitizing the entire local police community to the impact of the HIV/AIDS epidemic. The programme was intended to benefit persons whose practices and behaviours put them at risk to HIV. The objective was to disseminate information and provide counselling to members of the Local Police service. The programme also aims at behaviour change in order to prevent new infections with HIV.

Although the programme is still new, a lot of enthusiasm was observed among the police. Some impressive achievements were noted in the area of institutional strengthening and capacity building. Efforts to involve local police families and the community in service areas were also observed. The police were also capitalising on their proximity to households and communities by supporting CHBC activities.

Policy Development

- The AIDS Coordinating Committee was fully established at the Local Police Headquarters in Gaborone.

- The District AIDS Coordinating Committees in various districts were established to collaborate with the DMSACs.

- The HIV/AIDS programme targeting the Local Police community targeting officers and their families was developed and was in place.

Institutional Strengthening

- Thirty-seven peer educators and 37 peer counsellors have been trained and are functional.

- Men, sex and AIDS committees have been established among local police. These committees are actively involved in sensitizing men on issues of sexuality and prevention of HIV transmission. They also encourage men to be involved in HIV/AIDS programmes.

- Sensitisation of Senior Officers to discourage discrimination tendencies towards the infected has been carried out through workshops.

- An awareness workshop for AIDS Coordinating Committee was conducted, as part of strengthening the committee.

- Plans to form AIDS committee at the training college are at the advanced stage.

- District reports are submitted to the HQ Coordinating Committee for compilation, as well as for soliciting funds for HIV/AIDS activities.

- Follow-up of training activities is conducted by the Coordinating Committee to assess progress and evaluate the result of the training.

- Focal persons are in place in the districts, and participate fully in the DMSAC activities, while collaborating with sectors at the local level.

Capacity Building

- Training of Trainers was conducted for 37 educators from 19 districts. These were expected to conduct training for local police officers on HIV/AIDS prevention care and support at the workplace as well as in the communities.

- Training in HIV/AIDS awareness for members of Local Police from 19 districts was also conducted.

- HIV/AIDS IEC Training materials were distributed for use by local police.

- Plans to train AIDS Counsellors are at an advanced stage, and the training should begin early next year.

Service Delivery

- Peer education on reduction of transmission including condom distribution is being provided by local police at the work place and to families of officers.

- IEC on HIV/AIDS is provided to communities by officers on patrol and other community based duties

Implementation Gaps

The following gaps have been observed in the implementation of the programme.

- The local police have yet to develop a policy on HIV/AIDS to address the current issues in HIV/AIDS and introduce new thinking on “the management of the HIV/AIDS risk”.

- Monitoring tools are not yet in place as the local police do not have the capacity to develop the tools.

- Partnerships with other disciplined forces NGOs and CBOs have not yet been developed, as such networking has not occurred.

- Inadequate supply of protective clothing such as gloves for handling the ‘wounded’ especially those involved in road traffic accidents.

- The programme experiences shortage of trained peer educators and peer counsellors as their numbers are limited.

- Inadequate transport for the distribution of IEC materials and behaviour change messages especially to remote areas was observed. Police in remote areas are therefore deprived of the valuable information.

Recommendations

Policy related

- A policy to be developed to address the management of the HIV/AIDS risk in the local police department of the Tribal Administration.

- Advocacy for a shift toward the anchorage and concentration of HIV/AIDS prevention, reduction of HIV transmission care and support to the households and community level for maximum impact, by the local police in villages and kgotlas based on guidelines.

- Strengthening the mainstreaming of HIV/AIDS in the mandate of the local police activities and service delivery.

Institutional Strengthening

- Provide technical assistance for the implementation of focused needs analysis and assessment of gaps and priorities in the local police service.

- Provide technical assistance to the local police services to ensure mainstreaming of the management of the HIV/AIDS risk within the mandate of local police.

Capacity Building

- Support capacity development in the use of effective communication and networking processes between the local police and other disciplined forces as well as with the civil society organisations to expand the response.

- Strengthen the design and development of IEC interventions to enhance the effectiveness of the initiatives and interventions of the local police, targeting the reduction of the sexual transmission of HIV at the household and community levels.

- Develop an appropriate monitoring system to assess progress towards the management of the HIV/AIDS risk.

- Develop partnerships with other disciplined forces, NGOs and CBOs for the provision of HIV/AIDS reduction services.

- Provide support for provision of protective clothing for the effective use of universal precautions by local police for the prevention of HIV transmission resulting from blood-borne infection.

- Train more peer educators and peer counsellors to enhance service provision.

Service delivery

- Strengthen the institution capacity of local police institutions for service delivery.

Botswana Prisons and Rehabilitation Services

Botswana Prisons and Rehabilitation Services Department has made good progress, and the areas of policy development, institutional strengthening, capacity building and service delivery have been satisfactorily covered.

Policy Development

- The Prisons Department has drawn up a policy addressing HIV/AIDS issues in the force, and require technical assistance to finalise the document.

- A Focal Point Person has been appointed at the national level. An AIDS Co-ordination Unit has been established.

- Terminally ill patients requiring Home Based Care are released from prison to be taken care of by their families, and may only return when their condition has improved.

Institutional Strengthening

- The PSD has strengthened the Prisons Department's resolve to motivate members to take interest in HIV/AIDS, and has enhanced their full participation in the response.

- The Divisional Commanders, who are AIDS District coordinators, assist the stations to come up with programme plans, which are compiled and passed on to Headquarters for final processing, and recommendation for funding.

- The Commanders and Station Commanders participate in the DMSACs activities at the districts level.

- There are plans to incorporate HIV/AIDS in the training programmes conducted in the training college of prison officers.

- The Department collaborates with other sectors such as Labour, Youth, Sports and Recreation and Men's sector on HIV/AIDS prevention activities from time to time.

Capacity Building

- Sensitisation training seminars and workshops to promote HIV/AIDS awareness have been conducted, and peer educators (59) and peer counsellors (60) have been trained. The level of awareness has been raised.

- The Occupational Health and Safety programme has prepared the staff for dealing with HIV/AIDS concerns. The Department has introduced "AIDS pouches", containing First Aid equipment for use in emergency situation. The pouches are carried by officers on their bodies when on duty and are used as required.

Service Delivery

- The Department participates in community based care activities, such as Home Based Care, including the family care and support of People Living with HIV/AIDS and the care of orphans.

- PSD has contributed towards reducing denial, secrecy and stigma in the prisons. A number of officers and inmates have come forward for Voluntary Testing and Counselling. Between January 2002 and July 2002, 235 people were offered counselling and 204 opted for voluntary testing. HIV positive people were referred for treatment, and follow-up care.

- Condom education and supply of condoms to officers and their families, has been established as a service in the prisons. Prisoners are given condoms on their release from prison.

- IEC materials conveying HIV/AIDS messages, in the form of desk calendars, diaries, posters and AIDS ribbons have been produced and distributed for use in training.

Constraints

- There were no mechanisms in place for supervision, monitoring and evaluation of counsellors activities. As such, the quality of counselling provided is unknown.

- The PSD does not cover the inmates as a target group. This is considered a disadvantage by the prison executive.

Recommendations

- A focused needs analysis and assessment of the gaps and priorities should be conducted to determine technical assistance needed in the Department to expand the programme and identify approaches to redirecting some strategies for maximum impact.

- HIV/AIDS should be incorporated in the curriculum at the training college for prison officers.

- There is need to set up a Training of Trainers programme to increase the training capacity and sustain the momentum.

- Technical assistance for the development or establishment of an appropriate management information system (MIS) for use in prisons should be provided.

- Technical assistance for the implementation a focused needs analysis and assessment of gaps to identify priorities and gaps should be provided.

- Provide technical assistance directly to the Prisons Department to implement mainstreaming of the Management of the HIV/AIDS risk within the Department.

B. District Level

Achievements

The concept of multi-sectorality has been understood and has been implemented throughout the PSD targeted districts. DMSACs have been formally established in these districts, and they are engaged in the planning, implementation, monitoring and coordination of the HIV/AIDS response. There is evidence of joint planning and implementation, collaboration and increased partnerships among sectors. Progress was observed in the areas of institutional strengthening, capacity building and service delivery in all the target districts.

- **Institutional Capacity Strengthening** is evidenced by appointment of full-time technical support personnel. District AIDS Coordinators and the UNV District AIDS Advisors. In most districts, the international UNVs have counterparts, and skill transfer is apparent. A positive working relationship has been established between UNVs and partners.

- A high level of awareness has been established, and a positive change has been observed in the response by the private sector, where formulation of workplace policies, and programmes for promoting the response, are in progress. Counselling and Support Centres supported by government, faith based organisations and civil societies, offer supportive counselling to the infected and affected, as well as through outreach services. The Centres provide various forms of counselling. This development has contributed to the reduction of stigma at the household and local levels.

- Community mobilisation towards the development of Village Multi-sectoral AIDS Committees has been noted in several villages, while in some districts the VMSACs are in the process of being established. There is notable support to, and involvement of NGOs, CBOs and other groups in the fight against the epidemic. Support groups of PLWHA have been formed and are enjoying the support of the DMSACS.

- Sensitisation of communities has been instituted through training, seminars and workshops to promote HIV/AIDS awareness. Appropriate education for promoting safer sexual behaviours for the control of the HIV and other STIs has been provided and supported by community groups. Furthermore, study tours and exchange programmes have been arranged to different districts and internationally for DMSAC members to enable them learn from local and international best practice experiences. Production of IEC materials in the form of posters displaying HIV/AIDS messages targeting different groups within the community and the general population such as youth, PLWHA, women, and the community at large, has continued.

Constraints and Implementation Gaps

- While numerous achievements have been experienced since the commencement of the PSD project, there were, however, some constraints and gaps, inherent in the National AIDS Control Programme, which need immediate attention if the project is to contribute fully to the goals set for the reduction of HIV, and mitigation of its impact.

- Inadequate capacity of technical committees to provide support to the DMSACs has inhibited the DMSACs from providing adequate support to sectors and CBOs for prevention, care and support activities, as part of "managing the HIV/AIDS risk". Similarly the concept of mainstreaming HIV/AIDS has not been clearly understood nor fully operationalised by Technical committees, hence their inability to provide the needed support.

- Reports from many districts indicate that full participation by all members at the DMSAC meetings is not regular. The exact cause of this irregularity may be related to lack of clarity on lines of authority and accountability. Lack of transport was observed as contributory to poor supervision and continuous support of the VMSACs by the DMSACs, as the distance between villages was formidable, and unmanageable without transportation.

- The DMSACs do not have adequate back-up support for IEC from the DHTs. This has been a missing link in the response at all levels of the management of the HIV/AIDS threat. At all levels of operation organisations do not routinely use operations research as a tool for decision-making and intervention development for programme implementation.

Recommendations

- The recommendations are intended for PSD II to focus on the strengthening of technical assistance to DMSACs, for the anchorage and concentration of the HIV/AIDS risk management to the household and community levels for maximum effectiveness, provision of targeted technical assistance to the DMSACS, sectors, CBOs, and technical committees, to empower them in IEC approaches for the reduction of the HIV transmission through behaviour change communication, and other strategies to address vulnerable groups, including strengthening the institutional and technical capacity of the DMSACs to coordinate and monitor for the management of HIV/AIDS risk at the community and household levels, as well as strengthening the training methodologies on TOTs.

- Recommendations also focus on the provision of technical assistance to the DHTs for improved leadership in the management of HIV/AIDS risk at the district level to meet the demand at the household level and to facilitate improved service delivery in the following areas: HBC, IPT, VCT, PMTCT, and ARV services as well as reducing and finally eliminating HIV transmission by 2016.

Chobe Sub-District

The Chobe District has the potential to promote the response at the district and local levels. Similarly, because of its geographical location, and its attraction to tourists and other migrants, it can also serve as a major gateway to increased transmission of sexually transmitted infections (STIs), including HIV. The vulnerability of this area to HIV/AIDS is reflected in the 2001 sentinel surveillance.

Institutional Capacity Strengthening

- The Technical Committee, supported by UNV, was in place and responsible for and played the leading role in HIV/AIDS activities.

- The UNV provided technical support to the DMSAC and generated the concept of community participation through the formation of the Village AIDS Committee, such as at Kavimba.

- Formation of AIDS Committees in various sectors in the District ensures that various departments in the districts participate actively in the response activities

- The establishment of a community based counselling centre (Pakalemasa), for people affected by HIV/AIDS, providing counselling services, and care for orphans, for which a shelter has been secured through the DMSAC.

- There are plans to establish a Resource centre at the Hospital, and a multi-purpose hall in Kasane to cater for recreational facilities and activities.

- Tebelopele Voluntary Counselling and Testing Centre has recently been opened in Kasane.

Capacity Building

- Village Health Committees, which have been converted to Village AIDS Committees (VAC), provide home-based care to the terminally ill patients who have been discharged from the hospital.

- Workshops have been conducted for VAC members, addressing the issues of cultural sensitivity and HIV/AIDS. The committee members in turn, trained community members on issues pertaining to HIV/AIDS.

- Peer Educators and counsellors have been trained and are servicing the work places.

- The community has been sensitised and awareness created. Some communities have set up services and projects for addressing HIV/AIDS problems in the villages.

- The district, in collaboration with the CHBC and Orphan care team has trained 10 CHBC volunteers per village to ensure continued care, community mobilisation and empowerment in the area of HIV/AIDS.

Service Delivery

- Prevention activities such as condom education and distribution, as well as information materials in the form of posters and leaflets are available, and are accessible to community groups.

- The district has trained volunteers in Home based care and the volunteers are assisting in taking care of patients discharged from hospital to be cared at home.

- The centre is run by supportive staff of lay counsellors. The counsellors visit the orphans at their homes from time to time.

- The various sectors engage in fund raising activities, embark on income generating activities and engage in raising vegetable gardens. The proceeds from these activities are donated to HBC patients, orphans and PLWHA.

Constraints and Implementation Gaps

- The main draw back to the positive response to the epidemic is lack of commitment to HIV/AIDS activities.

- All the work carried out the DMSAC in the entire multisectoral response is positively supported by other sectors such as S&CD, while the DHT is seen as not providing any support and thus rather hampering progress.

- The Secretariat of DMSAC is not fully involved. There is generally a lack of commitment from sectors represented in the DMSAC. Workers pay more attention to their work mandate, and HIV/AIDS issues become secondary to them.

- No supportive materials are available and mainstreaming of HIV/AIDS is still a problem.

- No guidance is being provided to DMSAC by the technical committee.

- Lack of recreational facilities for the youth in surrounding villages has contributed to migration of young people from villages to places like Kasane, the only township in the area.

- The VCT Centre recently opened in Kasane is not being fully utilitised despite the encouragement by DMSAC to communities to use the facility.

Recommendations

- The current initiatives should be analysed and assessed for their usefulness and adequacy in terms of reducing the spread of the epidemic and its impacts. Gaps and priorities should be identified, and a much more focused and intensive approach to the development of a multisectoral program should be adopted. Implementation for outcome-based results should take centre stage in the response.

- Adolescent, Youth, and Young adults have to be empowered through Information, Education and Communication, Services and condom use education and training whenever they are. To this end, the service delivery of the Youth component of the PSD II initiative has to be elaborated fully.

- The newly established Voluntary Counselling and Testing Centre in Kasane should be assisted to identify approaches to spreading its influence to other areas such as schools, hotels, workplaces and youth centres as part of popularising prevention and, behaviour change communication (BCC).

- As the CHBC strategy seems to have provided a convergent point for sectoral collaboration in the care and support of PLWA and their families, strategies to use CHBC as an entry point for prevention. Condom use, IEC, Counselling and behaviour change should also be implemented within CHBC services. This approach should maximize the scope and impact of the District Health Team (DHT), on the quality of services provided to the household and community.

- The District Health Team should be empowered to enable it to play a visible leadership role in matters pertaining to health care and development within the DMSAC.

- Direct support should be provided to the sectors on selected HIV/AIDS aspects such as community education, strengthening linkages including community education, It is strongly recommended that community based initiatives should be reviewed with a view to finding ways to fine-tuning community driven initiatives.

- Supervision support to the local communities which is currently inadequate, should be strengthened, in a systematic manner for performance improvement and sustained action.

- Support to the development of proposals by CBOs to solicit technical assistance and funds for the planning and implementation of initiatives, including the scaling up of best practices at the community level, should be provided.

- Districts or sub -districts level multisectoral committees which have committed to promoting the response should be trained and provided with support on a consistent basis to raise their capacity for guiding others.

- Training in leadership and organizational development should be provided to different levels of AIDS committees in a much more focused and consistent manner.

  - The DHT, as the team expected to provide technical support to the DMSAC, should provide the needed support and direction for the response.

  - The VMSAC should be accorded all the necessary support and the members encouraged to achieve their objectives towards the management of HIV/AIDS concerns e.g. the Kavimba community must be provided with the products necessary to promote and sustain their income generating projects.

  - Promote partnerships in the development of projects that cater for health and the quality of life across life span.

Gaborone District

Gaborone is one of the districts included in the PSD following the approval by the Tripartite Programme Review, March 2000 to extend the programme to December 2002. The Gaborone DMSAC was included in the PSD in 2001. The District Commissioner believes that the PSD has assisted tremendously.

Institutional Strengthening

- The DMSAC structures have been established, and are now functional though a lot needs to be done in order to achieve the objectives of MTP II(1997 – 2002).

- The UNV AIDS Advisor and the District AIDS Coordinator support the DMSAC Secretariat, and the provision of the UNV has facilitated the formation of linkages between the DMSAC and various sectors.

- A technical Committee is in place to advise the DMSAC and facilitate coordination of HIV/AIDS activities amongst stakeholders

Capacity Building

- Sensitisation seminars have been arranged targeting a wide variety of people in the district, including members of the DMSAC and NGOs.

- Study tours and visits have been organised around and outside the district to share experiences and learn from existing best practices and experiences.

Service Delivery

- The services provided by the DMSAC include: Home Based Care, Counseling and Orphan Care, and IEC on aspects of HIV/AIDS risk management.

- The DMSAC has assisted Holy Cross Hospice with funds for a sensitisation workshop. The Hospice is working with the terminally ill patients, and providing assistance and care, as well as running a Day Care Centre for orphans.

- The DMSAC also has availed funds to the National Youth Centre and facilitated the promotion of HIV/AIDS awareness among the youth.

Constraints and Implementation Gaps

- The district capacity to handle the HIV/AIDS risk management remains very low, as such, the achievements accomplished have not made any significant impact on the HIV/AIDS situation.

- The numbers of individuals, groups, families and communities requiring prevention and behaviour change communication, including counseling, care and support is well beyond the service delivery capacity of sectors and CBOs.

- The DC's office does not have the technical competence required to provide informed counsel, guidance and support to the sectors, as the staff complement is low, and there is no administration officer to service PSD.

- The lack of role clarity, of the various co-ordination groups namely ACU, NACA and MLG is affecting the functioning of the DMSAC.

- The disappearance of ASU from the scene, which Unit had previously provided technical assistance and support, has compounded the confusion, according to the Gaborone DMSAC.

- The absorption capacity within the district is low, as the implementation capacity is low.

- The problem of shortage of transport has impacted negatively on the work of the UNV, as far as reaching out is concerned.

- The overload on the DC's office has made it difficult for the DC to provide the desired support to the PSD implementation process.

- The disbursement of funds is slow and this has a negative effect on the rate of implementation.

- Engaging the DHT in a meaningful manner has been difficult. The DMSAC has the comparative advantage of the DHT, but this capacity has not really been brought to bear on the work of the DMSAC in any significant manner.

Recommendations

- The PSD should continue as a fully fledged programme after December 2002, and the UNV support should continue as the Gaborone DMSAC has a lot of catching up to do especially considering the late inclusion of the district in the PSD.

- Capacity Building should be considered a priority in every way. A much more focused training is needed. More counselors are needed. CHBC and orphan care should be strengthened further.

- Increased participation by the DHT is critical especially given the developments in the ARV Therapy in CBHC.

- The PSD should commission a focused needs analysis and assessment of the gaps and priorities for programme intervention, with respect to the HIV/AIDS risk management at the district and local level. It is necessary to find out what strengths, weaknesses and opportunities are inherent in the district for managing the HIV/AIDS risk.

- Support should be provided to the DMSAC and the DHT to promote participation by sectors, civil society and support groups in activities designed to ensure the continuum of care to patients on ARV therapy, IPT, DOTS, PMTCT and other treatment options.

- The DMSAC's learning and training needs for managing the multi-sectoral process should be assessed to facilitate the development of a meaningful capacity building programme.

- Reorientation and sensitisation programmes for the various groups and levels of DHT and clinic staff should be planned and implemented as a matter of urgency to facilitate the uptake of important programme activities for the management of the HIV/AIDS risk.

- The Gaborone District as a whole requires a shift towards integrated community-based approaches for addressing the epidemic.

Kgalagadi South Sub-District

The Tsabong DMSAC was constituted formally in August 2000 and is therefore a late starter. Operations towards support to the National AIDS Programme began mid 2001. The evaluation team had the opportunity to sit in at a formal meeting of the DMSAC held on the 26 September 2002, where an

overview of the Kgalagadi South District Multi-sectoral AIDS activities was made available to the Evaluation Team. The Evaluation Team was informed that the DMSAC had identified four main areas for strategic interventions. These were listed as: Advocacy, IEC, Capacity building, Public and Private Sector response including Community Home based Care.

Policy

- The DMSAC has been established in accordance with the guidelines set out in MTPII.

- Meetings are being held monthly.

- A Technical Committee has been formed and has been tasked to monitor and evaluate progress made by the DMSAC, appraise departmental proposals, support the preparation of the annual budget as well as to compile quarterly reports.

- Three sub-committees, one for planning, a second one for fundraising and a third one for publicity and awareness, have been formed.

Institutional Strengthening

- A functional, technical committee and 3 sub committees have been formed

- Advocacy for enhancement of participation by councillors in HIV/AIDS work has been pursued in the form of consensus building workshops.

- The DMSAC has conducted several activities to focus on challenges involved in controlling the epidemic, preventing new infectious and promoting behavioural change.

- Collaboration between the DMSAC and BOTUSA has resulted in the establishment of a Voluntary Counselling and Testing Centre in Tsabong.

- An old building donated by the District Commissioner has been refurbished into a centre for VCT with financial support from BOTUSA.

- The culture and youth office has been supported to purchase TVs, scanners and overhead projectors, including an internet modem for Kgalagadi South and North offices for the dissemination of information on ASRH, prevention of HIV and other STIs, as well as to promote healthy sexual behaviours among youth.

- Partnership between the YWCA and the DMSAC on bridging the gaps in information between parents and youth, as well as for developing approaches to parent education are in the process of being established.

- Partnership between sectors, pastors, BOCAIP and other groups have been established through DMSAC.

- Networking between the sectors, disciplined forces and CBOs has been established at both the district and community levels. This is evidenced by the joint efforts between the Agriculture and the Department of Supply, and Prisons and Rehabilitation Services who produce green vegetables to provide to PLWHA and their families. CBOs and the CHBC teams work collaboratively to ensure that the needs of patients and families for a nutritious diet are met.

- All sectors participating in the DMSAC activities have established AIDS Committees, and some have identified HIV/AIDS focal persons in their own settings. The committees are actively promoting the response in their individual areas.

- A District AIDS Advisor/international UNV and a district AIDS Co-ordinator are in place, and are reported to be working well together.

- Team building activities are continuing at the district and local levels.

- Strong collaboration exists between the DMSAC and the DHT.

Capacity Building

- All heads of departments in the districts have been trained in HIV/AIDS prevention and care issues, and have also been equipped with information to enable them to appreciate the impact of HIV/AIDS on young girls, women, men and youth and the society as a whole.

- Prison officers and prisoners have been sensitized to issues that fuel the epidemic amongst prisons, prisoners and their families.

- Youth (out of school) have been trained in the management of adolescent sexuality and on how HIV/AIDS can be spread among youth. A competition was launched to encourage youth to produce art work that depicts ways and ideas for the prevention and control of HIV and other STIs among young people. It is hoped to use the art work and ideas depicted to produce appropriate and relevant IEC materials.

- Sensitisation workshops on HIV/AIDS and development were conducted at the district level.

- Sensitisation of sectors on the Public Service Code of Conduct was conducted through workshops and the following sectors and disciplined forces were included in these workshops.

    - District Administration
    - Consumer Affairs
    - Labour
    - Immigration
    - National Registration/civil registration
    - Revenue
    - BDF
    - Botswana Police and Local Police
    - The Department of Non-Formal Education

- An HIV/AIDS Awareness Festival was held in Tsabong with the aim of educating the local community.

- DMSAC technical teams conducted training workshops on HIV/AIDS for prison officers and prisoners.

- Two workshops were held for the Carers of Orphans

- Local Police were sensitized through training on the impact of HIV/AIDS on society. Similarly a workshop for the Association of Pastors against HIV/AIDS on advocacy was conducted. The Village Development Committee was also trained in approaches to advocacy and planning.

- A TOTs workshop on HIV/AIDS and development for the Departmental Heads of Disciplined Forces on how to conduct HIV/AIDS prevention and IEC campaigns for maximum effect on the community was conducted.

- A Mini Research Centre has been established at the Tsabong National Library and a wide range of HIVAIDS and reproductive health materials have been made available to the centre.

- The DMSAC plans to build its capacity by establishing alliances with the Kgomotso Counseling and Centre, the YWCA, Anti-AIDS Parent Education Project. It is hoped to target peer education in senior secondary schools as well as to out of school youth groups.

Constraints and Implementation Gaps

- The Kgalagadi South has only a few CBOs and international NGOs who are actively involved in development and HIV/AIDS activities in general. This is a major constraint to youth development and social mobilisation.

- Youth, in and out of school, have not been adequately targeted with development and recreational activities in any significant manner, as such, HIV/AIDS prevention and the reduction of the sexual transmission of HIV and other STIs is not part of a coherent youth development agenda.

- The DMSAC has not had a focused situation and response analysis done yet, as such, none of its plans are based on locally derived information. This has also affected their priority setting and intervention development capacity as they have no basis for planning.

- The Youth Centre/Education Centre is searching for ways of harnessing young people in HIV/AIDS activities as they can play an important role in mobilizing others for involvement in the response. As there is no real ‘youth development programme,’ IEC, counselling, condom use and education activities are not easy to organize on their own.

- Most out-of-school youth have no skills. They are not in a position to be gainfully employed in formal and informal sectors. This lack of vocational skills makes it difficult to mobilize them around some of the income generation activities that are likely to help them earn a living.

- The absence of recreational and leisure programmes is not helping the situation in any way. Commercial sex work and smoking are the main leisure outlets available to the youth in Kgalagadi.

- Prevention and reduction of sexual transmission programme initiatives are at a rudimentary stage and the newly established DMSAC has yet to develop the capacity to design and develop the appropriate plans and interventions to address this aspect of HIV/AIDS.

- The Tsabong DMSAC is highly committed to the response but does not have the experience and technical capacity to analyze its needs for technical assistance, especially in areas such as IEC, prevention, BCC and intervention development for social mobilisation.

- The UNV Advisor is highly motivated, and focused but needs more inputs and guidance in aspects of capacity development, programme development and training.

- Patients discharged to CHBC are generally very ill and almost ready to die. This raises questions as to the quality of clinical care provided to patients with HIV/AIDS related conditions in hospitals and the quality of pre-discharge assessment and procedures for the continuum of care from institutions to the homes.'

- The Kgomotso Counselling Centre under BOCAIP, the Youth Education Centre and the YWCA have not been provided with the requisite skills for social mobilization, parent education and counselling to enable them to adequately promote the response.

Recommendations

- More CBOs and international NGOs should be persuaded to set up programmes in the Kgalagadi South to further strengthen the response.

- The government in collaboration with the private sector and international agencies, the UN Family and other groups should develop a multi-facetted youth development programme which will be organised around the "Management of the HIV/AIDS risk" among adolescents, youth and young adults.

- Tsabong or the entire Kgalagadi South should have a focused needs analysis and assessment study conducted to identify priority areas, gaps and requirements for programme development. This is an urgent need in this area.

- The youth education centres should be reviewed with a view to identify their needs for programme design and intervention development, including the technical assistance needed to enhance their capacity for the implementation of HIV/AIDS activities.

- Vocational training should be reviewed in Tsabong to ensure that youth completing from secondary education can be gainfully employed afterwards. Similarly, the youth centre staff should be empowered to negotiate with the private and informal sectors for the creation of employment opportunities to absorb young people.

- Technical assistance should be channelled to the DMSAC participants to support sectors in the planning and implementation of programme interventions for the reduction of the transmission of HIV and other STI. Similarly support should be provided to sectors, CBOs, disciplined forces and others on aspects of IEC and BCC for the reduction of the transmission of HIV and other sexually transmitted infections at the household and community levels.

- Support should be provided to primary hospitals and CHBC on the quality of care provided to PLWHA in institutions prior to discharge to CHBC.

- Multipurpose youth centres which offer recreation and leisure programmes which incorporate the management of the HIV/AIDS risk, and interventions for the reduction of social maladies such as commercial sex work, smoking and alcohol abuse should be established.

- Overall, the Tsabong DMSAC and partners should be targeted with a series of capacity development initiatives as part of strengthening and widening the response at the household and community levels.

  PSD II should support the work of the DMSAC in a proactive and focused manner. Poverty reduction initiatives should be part of the youth multipurpose centre development programmes.

Kgatleng District

Kgatleng DMSAC was established in 1999 primarily to develop, coordinate, monitor and facilitate the implementation of HIV/AIDS prevention, care and support activities in the District. Although the DMSAC was established in 1999 the UNV was placed only in the last quarter of 2001 and the DMSAC annual plan was developed for 2002. The evaluation team had the opportunity to attend the full DMSAC meeting and listen to experiences of managing HIV/AIDS Programme by sectors.

Institutional Strengthening

- Technical assistance was provided in the form of 2 UNVs, one a local and the other an international. Both were placed during the last quarter of 2001. The placement of UNVs was part of the strategy to develop a decentralised response to HIV/AIDS in Botswana by building capacity to develop and implement HIV/AIDS prevention, care and support programmes. The contract for the international UNV had ended and he was no longer in the district. The District AIDS Coordinator was also posted to Kgatleng in 2002.

- The annual work plan has been developed for 2002 and five DMSAC sub-committees have been formed. The sub-committees are still not fully functional and are therefore in the process of formulating their activity plans.

- To date, 19 VMSACS have been formed and arrangements to conduct orientation workshops for them are underway. Training of VMSACS is planned during the last quarter of 2002.

Capacity Building

- A number of workshops were conducted in the district aimed at strengthening the capacity of the DMSAC members and stakeholders to develop, implement, monitor and evaluate HIV/AIDS intervention programmes. DMSAC members and stakeholders were trained in the following areas:

    - HIV and development to strengthen stakeholders capacity to initiate and implement HIV/AIDS prevention, care and support programmes.

    - Partnership building to assist participants to identify areas of partnership and develop networking mechanisms.

- Study tour to Palapye and Mahalapye was undertaken by DMSAC members in order to learn from other well established and functional DMSACS. This provided an opportunity for members to learn from the experience of districts which started implementing the HIV/AIDS programs earlier.

- CBOs in the district are sensitized to participate in HIV/AIDS activities. There is a functional men, sex and AIDS committee with women in its secretariat and is active in mobilizing the community to participate in HIV/AIDS programs. The CBO also undertakes fund-raising activities to support CHBC programme.

- The Bakgatla Bolokang Matshelo CHBC support group undertook a study tour to Light and Courage centre and Tshireletso Centres in Francistown in May 2002. The purpose of the study tour was to learn the management of adult and Orphan Day Care Centres in order to establish one in Mochudi. The CBO has a large plot and hopes to expand its income generating activities as well, but requires assistance. The project proposal for the establishment of the proposed Day Care Centre has been prepared and submitted to NACA for funding.

Service Delivery

- A DMSAC open day was organised and held on the 4th of September 2002 to reach out and sensitise the larger community in the district about HIV/AIDS and the interventions towards the response.

- Information on the 2001national surveillance report was disseminated to the community during the open day to highlight the HIV/AIDS impact.

- The District Commissioner officially launched the DMSAC fund to sensitize the community to mobilise local resources to fight the epidemic.

- The sectors were encouraged to mobilise resources to support HIV/AIDS prevention, care and support programmes.

Constraints and Implementation Gaps

- Late disbursement of funds was experienced in the district, thus delaying the implementation of planned activities. For example funds for the first quarter 2002 (Jan – March) were disbursed at the end of March 2002 effectively meaning that activities for that quarter could not be implemented as planned.

- Inconsistent and irregular attendance of DMSAC meetings by some members was experienced. Mechanisms for addressing this problem have not been developed. At present, there are no set guidelines or procedures to enforce attendance. The members remain accountable to their sectors.

- Unsatisfactory participation by most DMSAC members at sub-committee meeting. The reason for this poor attendance of sub-committee meeting is also not clearly understood. It is believed that it is linked to the same reason for poor attendance of DMSAC meetings.

- HIV/AIDS prevention interventions fall far below the required levels for addressing the magnitude, and the scope of sexual transmission and the seriousness of the problem in the district.

Recommendations

In order to address some of the identified implementation gaps and to point the way forward for PSD II the following recommendations were made. The recommendations are presented under Policy, Institutional Strengthening, Capacity Building and Service Delivery for improved performance during the PSD II.

- Provide technical assistance to guide the DMSAC in the development of policies on the following areas:

- the management HIV/AIDS risk

- the development of district focused activities and

- monitoring adherence to mainstreaming of HIV/AIDS by sectors and civil society organisation.

- The recent arrangement by NACA to release funds on half-yearly basis is a welcome move and should be continued, as this will ensure that programmes are implemented timeously.

- Strengthen the co-ordinating and monitoring role of the DMSAC by retaining both the local UNV and the District AIDS Coordinator in post, considering the fact that Kgatleng was included late in the PSD and the district has a lot of catching up to do.

- Assist the DMSAC to develop a comprehensive programme for the reduction of the sexual transmission of HIV and other STIs.

- Develop a comprehensive program for monitoring progress towards the reduction of the sexual transmission of HIV.

- Heads of sectors at ministerial level should ensure that their departments at the district level are fully represented, regularly at DMSAC meetings.

- Heads of sectors at ministerial level should ensure that sectoral HIV/AIDS programmes are developed and implemented at district level and subsequently reported on at DMSAC meetings. This should help sectors appreciate the fact that they are equally accountable to their parent ministries as well as to the DMSAC.

- Establish strong partnerships and alliances with youth groups in the district, in and out of school, including CBOs to campaign for behaviour change and address the biological, socio-economic and cultural factors that fuel sexual transmission of STIs and HIV among young people.

- Strengthen the DMSAC towards the anchorage and concentration of the HIV/AIDS risk management to the household and community levels for maximum effectiveness using the kgotla as a unit for action.

- Provide targeted technical assistance to the DMSAC, sectors, CBOs , and technical committee to empower them in IEC approaches for the reduction of the HIV transmission through behaviour change communication and other strategies for addressing vulnerable groups.

- Strengthen the institutional and technical capacity of the DMSAC to monitor services for the management of HIV/AIDS risk at the community and household levels.

- Strengthen the design and development of IEC interventions to enhance the effectiveness of the initiatives and interventions of VMSACs, targeting the reduction of the sexual transmission of HIV, at community and household levels.

- Provide technical assistance to the DHT for improved leadership in the management of HIV/AIDS risk at the district level to meet the demand at household level.

- Provide support to the DMSAC to facilitate improved services delivery in the following areas: IPT, VCT, PMTCT, CHBC and ARVs at the household level.

- Provide technical assistance to improve the quality of services provided in the proposed Bakgatla Bolokang Matshelo Day Care Centre.

Kweneng East Sub-District

Kweneng East District Multi-sectoral Committee was formed in 1998. The DMSAC has a number of sectors, institutions and community leaders who have membership in the committee. While most programmes covering HIV/AIDS prevention, care and support, including orphan care had already been initiated through the DHT and ASU, the PSD initiative consolidated these into a multi-sectoral response through the application of good strategies adopted by the DMSAC. The District AIDS Advisor recognised the existence of partners who were already on board with regard to HIV/AIDS prevention, care and support and collaborated with them in addition to carrying out the PSD specific activities.

Policy Development

- The DMSAC, is chaired by the District Commissioner, and as the pivotal point coordinating HIV/AIDS issues, it addresses the multi-sectoral approach through the active participation of various sectors.

Institutional Strengthening

- The DMSAC has mobilised various sectors very well towards promoting a multi-sectoral response.

- The technical support has been accorded to the DMSAC by the AIDS Coordinator and UNVs The AIDS Coordinator and the UNV serve as the Secretariat and this has brought positive results to the DMSAC

- The DHT's leadership in Condom Education, HBC, PMTCT and mobilising AIDS Committees has provided anchorage for other sectors' involvement in the response.

- There are 19 VACs active in the district. Workshops have been planned to train traditional healers in HIV/AIDS awareness, and as influential members of the community, they are encouraged to open up and to serve in the VHCs and VACs.

Capacity Building

- At the time of the evaluation a workshop was going on at the Molepolole stadium at which AIDS Coordinators from various sectors were participating.

- Consultation among and between sectors has been maximised through the DMSAC forum e.g. participation in the DMSAC by the Agriculture and the Water Affairs sectors has promoted collaboration between the two sectors in food production for use by patients in CBHC.

- Workshops have been implemented to train peer educators and peer counsellors in various sectors, and these have raised the level of awareness and sensitisation, which undertaking has led to positive change of attitude and behaviour.

- The Youth are targeted through programmes to develop entrepreneurial skills to encourage them to be involved in income generating projects. Seminars, workshops and rallies addressing HIV/AIDS sensitisation and awareness about the response towards the epidemic have been implemented.

- Prison officers and inmates were coming forward for voluntary testing and counselling, and some with suspicions clinical symptoms were submitting themselves for pre-test and post-test counselling.

- The community has been mobilised and sensitised, as VDC members to, serve in the various committees in the villages as caregivers. CHBC has managed to forge alliance with Traditional

Healers in care and support. Traditional healers in the four villages of Gabane, Kopong, Metsimotlhaba and Mogoditshane have formed health committees.

Service Delivery

- Many DMSAC member sectors have developed vegetable gardens to support Home Based Care programmes and PLWA. Several sectors are involved in fund raising activities and income generation initiatives with the proceeds from these projects being donated to CHBC and Orphan Care programmes. Four bicycles have been donated to CHBC, and the (IHS) students participate in outreach activities into the community.

- Encouragement towards positive living and support for the people living with HIV/AIDS (PLWHA) has been noted as a member of the *Boipoloko Support Group* participated in the meeting and reportedly participates in the DMSAC activities. Participation in income generation projects, with proceeds contributed to Home Based Care and Orphan Care.

- Condom education and promotion are ongoing and positive change of attitude and behaviour has been observed. Extension workers going on field trips always ask for condoms. A condom slogan has been developed at the Department of Youth and Culture: "Collect me, I am here", and appear to have popularised condom use among the youth.

Constraints and Implementation Gaps

- There was lack of skills in supervision, monitoring and evaluation of programmes, and there are difficulties in reaching and mobilising the smaller communities. The DHT did not seem to be providing adequate technical support to the DMSAC activities.

- Shortage of human resource in the DMSAC resulted in inadequate supervision and support to villages to promote community action. This was further compounded by lack of transportation for follow up and outreach, and this has impacted adversely on the response.

- The DMSAC are uncertain about the roles of NACA, ACU and AIDS/STD Unit, and how they are expected to relate to these three institutions.

- Though IEC is considered critical to promoting Behaviour Change Communication, and the need is recognised countrywide, not much effort seem to be made to increase the numbers of IEC officers.

- There were no intensive programmes aimed at developing capacity for research. Whereas research was key to the intervention development, it was not being exploited enough.

Recommendations

- Provision of technical assistance to the DHT for improved leadership in the management of the HIV/AIDS risk in the district to meet the demand at the household level.

- Strengthen the technical capacity of the DHT in the implementation, monitoring and reduction of transmission of HIV interventions, including the care of patients on ARV at the household.

- Provide targeted technical assistance to the DMSAC to empower it in IEC approaches for the reduction of HIV transmission through behaviour change communication for addressing vulnerable groups.

- Incorporate HIV/AIDS and health education in learning programmes of the training institutions to enhance awareness.

- Strengthen the training methodologies on HIV/AIDS to focus on effective skills for human development and community leadership through development of appropriately trained TOTs.

Lobatse District

The Lobatse District Multisectoral AIDS Committee was formed in 1998 in line with MTP II (1997 – 2002) guidelines advocating for a wider representation. The DMSAC became an expanded version of the Lobatse District HIV/AIDS Co-ordinating body formed in 1994.

The DMSAC seems to have managed to involve various groups of stakeholders, and therefore has a fairly diverse and vibrant membership. In their own words the LDMSAC stated that the PSD had empowered them.

Policy Development

- The DMSAC has been fully established in line with MTP II 1997 – 2002.

- A decision to have, a technical committee, an IEC training and co-ordinating committee, and a Community Home Based Care Co-ordinating Committee was taken.

- Each sector represented in the DMSAC had formed an AIDS Committee in their own parent sector areas, and they had designated a co-ordinator or focal point.

- Work plans were being developed and submitted through the DMSAC as specified by the PSD.

- Workplace programmes for service delivery, IEC, condom use and condom education, including training in peer education and counselling have been developed as stipulated in the PSD.

- The Botswana Meat Commission and Lobatse Clay Works have formulated HIV/AIDS policies in the workplace.

- The Athlone Hospital had formed an AIDS committee in line with the requirements of PSD.

- As part of the policy guiding the use of UNVs Lobatse DMSAC had appointed a District Coordinator who is currently a counterpart to the international UNV.

Institutional Strengthening

- The District Multisectoral Committee has been fully established with a wide and diverse membership.

- Village AIDS Multisectoral Committees and 11 Wards AIDS Committees have been formed.

- DMSAC activities and decisions have been decentralised to sectors.

- Functional focal persons, AIDS Coordinators and AIDS Committees have been formed in sectors, public and private, as well as in CBOs and institutions.

- DMSAC monthly meetings are being used as a forum for follow-up, exchange of information and supervision support.

- A culture of reporting on achievements, progress, gaps, limitations and problems encountered during the process of implementation has been adopted as routine by the DMSAC.

- The private sector, CBOs , and support groups have been fully integrated into the DMSAC.

- Partnership between the workplace, CBOs and NGOs have been established in selected areas.

- Progress has been made towards the expansion and strengthening of CHBC and orphan care progress, and effort to strengthen both programmes is being made.

- Based on the results of the situation analysis conducted in 1999 the DMSAC outlined seven areas of focus and identified 5 priority areas.

- Groups of PLWA have been integrated into the DMSAC development plans and are being encouraged to work within the mainstream of DMSAC plans while they are also being assisted to pursue their mandates.

Capacity Building

- Training in peer education, counselling, condom use for youth and young adults is mainly being conducted by BOFWA, while the workplace training programmes are being provided by the technical committees of the DMSAC and in other instances by BOCAIP.

- IEC materials targeting different vulnerable groups have been developed for use.

- Targeted study tours to other districts to exchange information on best practice, lessons learned and experiences have been undertaken.

- Educational programmes for promoting safer sexual behaviours for the prevention, reduction and control of HIV transmission and other STIs have been developed.

- Several workshops and seminars have been conducted to raise awareness on various aspects of the epidemic, and a number have been sensitized and trained.

- A Health Resource Centre had been established within Athlone Hospital for both training, service delivery and the follow up of clients. The Centre fulfils four main functions, education and counselling of clients and families, serves as a resource and training centre, and a family support and continuum of care centre. The Athlone Hospital in Lobatse with support from the DMSAC has trained 120 HIV/AIDS trainers to raise the capacity of the institution for providing the continuum of care to patients on ARV Therapy who invariably always came back to Athlone for management, care and support as soon as they as they were released from the ARV centre in Gaborone.

- UNV support was reported to have had a significant impact on institutional strengthening, capacity development and resource mobilisation.

Service Delivery

Services were primarily provided as workplace programmes by various sectors.

The Bosele Group a support group formed by PLWA, has mobilised themselves to support counselling at the household and local levels, on adherence to ARV, IPT and PMTCT treatment options and they are in the process of developing a project proposal for funding of these activities. The group plans to organise themselves as a force to combat stigma.

Constraints and Implementation Gaps

- The composition of the DMSAC as outlined in MTP II was reported to be limiting and self defeating in some ways as heads of departments were hardly available to attend the monthly meetings, and some had not truly come to regard the mainstreaming of HIV/AIDS as a priority information.

- The flow from the ministerial levels, to the district and local levels is reported to be 'weak', and this was considered an impediment to programme implementation.

- The DMSAC has yet to establish an effective supervision, monitoring and evaluation system.

- Most groups within sectors, institutions and CBOs, lack the skills essential to promoting the implementation of the mainstreaming process beyond IEC and peer counselling activities.

- Generally networking and joint programming between and among sectors as well as between CBOs and sectors has been inadequate at both the national and district levels.

- Inadequate numbers of fully trained personnel and trainers of trainers (TOTs) in the areas of counselling and IEC. Similarly the area of HIV/AIDS counselling has not been fully developed in terms of both the content and process of counselling.

- Technical support to newly established support groups such as the Bosele group is grossly inadequate although moral support provided is in itself adequate. As such, they are not in a position to provide the education and focussed support to young people who have been successfully persuaded to reveal their status, and are battling the emotional and social effects of having gone public.

- Inadequate technical assistance and support has been provided to the staff of the Health Resource Centre as it is assumed that they are self-sufficient, capable and informed. Their own learning needs, as well as their needs for counselling and coping with the challenges in their work, has not been assessed and targeted with efficient interventions.

- Inadequate exposure of the staff in the Health Resource Centre to educational and other staff development opportunities available in the region and internationally.

- The AIDS Committees in most sectors, and institutions are working closely together but do not seem to reach out much outside their own areas inspite of the apparent inclusiveness and collaboration spirit that is reported to be prevailing among the groups.

- Although almost all the DMSAC participants expressed concern over the vulnerability of adolescents, youth and young adults, only a few members and groups seemed to have focused their interventions on this group. There seems to be a lot of dependence on BOFWA's leadership and effectiveness in this area. Sexual transmission of HIV was seen as a critical area of need in this district yet the coverage with youth activities was inadequate in HIV/AIDS work.

- Inadequate information available on the quality of information, HIV/AIDS awareness, education and counselling services provided in the newly established AIDS information, counselling, care and support centres, including the Health Resource Centres.

- Inadequate approaches to establishing efficient procedures to scaling up best practice initiatives as part of expanding and accelerating the response within and outside the districts.

- Inadequate operationalisation of the concept of mainstreaming by sectors, institutions and CBOs at the local levels.

- Inadequate implementation capacity among CBOs and NGOs especially at the Tsholofelo Counselling Centre which could do a lot if its capacity were to be developed further.

- Delays in disbursement of funds to the district from NACA was cited as an impediment to the implementation process.

Recommendations

- The DMSAC should be entrenched as a policy requirement. Procedures and guidelines for full participation by members at the monthly meetings should be outlined clearly as part of policy.

- Mainstreaming should be defined beyond integration of general HIV/AIDS activities to include clear tasks aimed at the "management of the HIV/AIDS' risk.

- Appropriate intervention programmes on IEC, counselling and BCC targeting the reduction of the sexual transmission of HIV and other STIs for the control of the epidemic, should be implemented as a priority for this district. Similarly as there is much progress made in CHBC and orphan care, these programmes should also be used as an entry point to prevention.

- Local NGOs and CBOs should be assisted through institutional strengthening and capacity development initiatives to enhance the quality and scope of their activities for maximum impact at the household and community levels.

- Technical support should be provided to the small support groups of PLWHA to build their skills in the areas of peer counselling and psychosocial support, to enable groups like Bosele to provide the necessary guidance and counselling to their members.

- The technical assistance required by the Lobatse Health Resource Centre should be assessed in order to strengthen their own skills in counselling as well as for the provision of the continuum of care of PLWHA and their families. Similarly the staff needs for training, and emotional support should be assessed and support should be provided as needed.

- The various AIDS committees should be assisted to develop appropriate networking and joint programming skills and techniques to facilitate outreach to the household, community and district levels with much more effective programmes.

- The DMSAC should be assisted to motivate their technical committee and the IEC Committee to encourage the sectors, CBOs, and institutions to address prevention, the reduction of sexual transmission and other STIs among adolescents, youth and young adults as a matter of urgency. Similarly programmes for prevention and reduction of sexual transmission of HIV and other STI's targeting vulnerable groups should be expanded and elaborated clearly by all parties.

- The newly established AIDS information and counselling services including the Health Resource Centre should be assessed to identify priorities and areas to be strengthened. Similarly best practice experiences should be replicated for the expansion of the response.

- The concept of mainstreaming should be operationalised at all levels and should be seen as an active process for managing the HIV/AIDS risk at all levels and at all points of the life cycle, taking into consideration the personal, socio-economic and social circumstances of individual groups.

- The composition of the DMSAC should be reviewed with the full involvement of the DMSACS membership.

- The leadership role of the DMSAC in promoting the response at the district level should continue, and the technical committees of the DMSAC should be strengthened.

- The DMSAC should be invited to some of the national planning process meetings where policy and strategic issues on promoting the response are being discussed. Similarly the DMSAC should be invited to participate in capacity development workshops and meetings at the regional and international levels, to broaden their view on the epidemic.

- The partnerships between VMSAC, Ward AIDS Committees and CBOs which are in the process of being formed should be strengthened, as part of promoting the anchorage of the response at the household and community levels.

- PSD II should focus on supporting the strengthening of the quality of the initiatives, and continue to build capacity for sustained action.

Serowe/Palapye Sub-District

Serowe/Palapye has been one of the areas where the DMSAC has been successful and functioning well. The VMSACs have been established in all the 44 villages of the Sub-district. There has been a strong partnership with the private sector in the sub-district. The Botswana Power Corporation though not supported financially by the DMSAC, has played a leadership role in participating in DMSAC activities. It participates in one of the DMSAC Technical Committees and the General manager is the current chairman of the Board of Governors for the House of Hope. Serowe/Palapye is one of the areas where collaboration between the DMSAC, the private sector, NGOs and CBOs is visible and is successful.

Some progress has been observed in Palapye in the way the Sub-district responded to the HIV/AIDS epidemic with regard to activities implemented to address policy related issues and policy development, institutional strengthening and capacity building.

Policy development

- The Botswana Power Corporation (BPC) has been mandated by the DMSAC to lead in the AIDS at-the-Workplace for the private sector. BPC then takes a leadership role in arranging AIDS at-the-workplace meetings for the private sector in the sub-district. An opportunity is taken by the corporation to also share its experiences at these meetings.

- BPC has a Policy on HIV/AIDS dating back to 1991 which is currently being reviewed. The review will incorporate current issues such as treatment for opportunistic infections, ARV and the right of employees to know their HIV serostatus through the universal testing and counseling for better management of HIV/AIDS risk and human resource management.

Institutional Strengthening

- Technical assistance is available in the form of a local UNV and the AIDS Coordinator for the sub-district. The presence of technical assistance in the sub-district has spearheaded the implementation of planned HIV/AIDS activities in all the 44 villages.

- Communities have been sensitised on HIV/AIDS issues and awareness has increased. It was noted that the level of awareness is high. All sectors have been sensitised and in turn sensitise their staff and communities they serve. Even the private sector - BPC has community outreach services and is planning to put up a Resource Centre which will either be placed in the community or be made accessible for the community as well.

- Generally, the staff at the Rural Administration Centre has been sentisised and participates in the AIDS at-the-Workplace activities.

- The Village Multisectoral AIDS Committees have been formed in all the villages in the Sub-district.

Capacity building

- Peer educators and peer counselors have been trained and are functional in most sectors.

- Various programmes addressing the response to the epidemic in the sub-district such as CHBC, Orphan care, and information dissemination are in place.

- Communities have been mobilised to form organisations to address HIV/AIDS and its impact on vulnerable group. Several organisations such as Itsoseng Banana, Tsaya Kgato have been formed and the House of Hope is currently being expanded in order to respond to the increasing demand for its services.

- Sensitisation workshops for various groups have been conducted and awareness on HIV/AIDS has been increased.

- Partnership has been formed between the DMSAC and other organisations such as TCM and BPC. TCM is an NGO which is involved in community mobilisation against HIV/AIDS. It is working at household level and has a potential for influencing behaviour change at the individual level.

- BPC is involved in the HIV/AIDS activities in the Sub-district. It participates in the Technical committee of the DMSAC and the general manager is currently the chairman of the Board of Governors of the House of Hope.

Constraints and Implementation Gaps

Although notable achievements have been made in the sub-district, several constraints and gaps have also been observed which need attention in order to reduce HIV transmission and mitigate its impact in the

sub-district. These are divided into two main groups those inherent in the National AIDS Control programme and the general gaps in the sub-district.

- Many sectors participating in the DMSAC did not seem to regard HIV/AIDS work as a priority. Activities within sector mandates seemed to take precedence over attendance of DMSAC meetings. Active participation was noted where the Head of the section took keen interest in HIV/AIDS issues.

- Low implementation of planned activities was noted as attributed to lack of capacity at sector level. At the district level, sectors were entrusted with a number of responsibilities that demanded attention often at the same time.

- The DHT did not seem to be taking an active part in the provision of technical support to the DMSAC in IEC and general public health issues. Although the DHT is the secretariat of the DMSAC it did not appear to be the driving force for DMASC meetings either.

- Orphan care services such as House of Hope were found to be available only in Palapye. These services were therefore inaccessible to other villages in the sub-district. There is an apparent absence of NGOs and CBOs working in HIV/AIDS in most villages in the Sub-district. These are concentrated in the major centres such as Palapye and Serowe. The presence of these organisations in other villages in the sub-district may result in better outreach to orphans, affected children and PLWAs.

- Orphans were found to be abused by relatives, where in some cases their property was taken away from them. In the same way, they were stigmatized at school which adversely affected their performance.

- Currently, ARV is provided only in Sekgoma Memorial Hospital in Serowe and some patients from other villages in the sub-district access this service. There is no follow up of such patients by the hospital and also no arrangements are made to monitor such patients in the referring health facilities.

- The quality of services at the House of Hope in Palapye was found to be low. Also the services provided did not cover all aspects of child development. Services such as psychosocial support, child counseling for traumatised children, child health, child growth and development which are very important were found missing.

- Enthusiasm in many VMSACs seemed to have gone down, and many of them are inactive due to lack of supervision by the DMSAC. This is alluded to lack of transport for the UNV and the District AIDS Coordinator to cover all the 44 villages for supervision. The AIDS Coordinators share transport with the rest of District Administration or District Council and it has proven to be very difficult to share transport when going on different supervisory trips. Another problem is that the District AIDS Coordinator covers more than one DMSAC and supervision for double catchment area becomes impossible.

Recommendations

- Technical support should be provided at the sector level in order to improve the implementation of planned activities.

- DHT should be supported in order to improve its capacity to provide technical support to the DMSAC.

- A review of the existing HIV/AIDS prevention programme should be undertaken in order to assess its effectiveness and effective communication strategies for behaviour change should be developed.

- The private sector initiatives at BPC should be supported. Technical assistance should be provided for policy review as well as for conducting the planned "blanket anonymous stratified HIV testing" for all workers.

- Issues of poverty and the health of vulnerable groups should be addressed and these should include empowerment of women and youth. Capacity to access the existing poverty alleviation programmes should be developed. Youth friendly services should also be developed in the sub-district. It is recommended these issues be addressed through partnership with the UN family and other development partners.

- The current HIV/AIDS prevention programme should be reviewed in order to assess its effectiveness and effective BCC strategies should be developed.

- Stigma towards orphans at school as well as issues of orphan protection from abuse by relatives should be addressed.

- Partnership with NGOs and CBOs working in HIV/AIDS should be encouraged and they should also be encouraged to expand their services to other villages in the sub-district.

- The services at the House of Hope in Palapye should be improved in order to provide quality care. Comprehensive orphan care services should be provided including psychosocial support, child counseling for traumatised children, child health as well as child growth and development.

- Orphan care services such as those provided at the House of Hope should be expanded to other villages in the sub-district. This is beyond the capacity of the DMSAC and should be included in the district development plan.

- Patient management protocols should be developed for follow up of patients on ARV in areas where the programme is accessible from long distance.

- The DMSAC should be supported with transport in order to enable the UNV and the District AIDS Coordinator to support the VMSACs. This could be done through supporting DHT and a flexible transport sharing arrangement be made for the AIDS Coordinators.

1.2 EMERGING BEST PRACTICE AND INTERVENTIONS

The five years of PSD program implementation has brought with it some best practice experiences and lessons learned that can be shared with countries elsewhere and be used to scale up selected program areas. A selection of what is considered best practice is described below as "targeted" and "emergent" as the program was evolving.

1.2.1 Targeted:

The five impact studies, done through PSD, have facilitated the development of a policy analysis dialogue among public and private sectors on the reduction of HIV/ prevalence and mitigation of the impact of HIV/AIDS:

- The Establishment of the DMSACS in the district as an instrument for a multi-sectoral approach in the response to HIV/AIDS. This has demonstrated the feasibility of joint planning and operations. All agencies involved in HIV/AIDS activities in the district work within DMSACs. The PSD has developed the DMSAC innovation into a reality that has gone beyond expectation. This experience should be documented for possible replication in other countries.

- The development of Networks and the support group organisations for people living with HIV/AIDS, namely: BONELA, BONEPWA, CEYOHO and COCEPWA respectively, have greatly contributed to legitimising the existence of PLWHA and reducing the stigma associated with HIV/AIDS. This has also strengthened their involvement in the fight against HIV/AIDS. This arrangement is a best practice that can be emulated and replicated elsewhere.

- The PSD approach has accelerated the involvement of civil society organizations and the private sector in the fight against HIV/AIDS. The Botswana Power Corporation (BPC) in Serowe/Palapye district through its participation in the DMSAC technical committee has developed IEC materials, which are being used by partners. The BPC also chairs the Board of Governors of the House of Hope an orphan care community initiative.

- The intensive use of peer education, which has been built into programmes, has greatly improved the effectiveness of programmes. This is an innovation that is being replicated nationally.

1.2.2 Emergent:

- The emergent best practices include, the House of Hope in Serowe/Palapye and the Light and Courage Centre in Francistown, which cater for orphans and PLWHA, respectively. Both these institutions act as day care and drop in centres, and provide care, counselling and outreach services. There are also centres for the continuum of care, which also serve as respite centres, as well as centres for family and group counselling.

- The PSD has stimulated some humanitarian initiatives for supporting the infected and affected at the national, district and local levels. People are organizing themselves to contribute resources e.g. charity boxes for public financial contributions to both orphans and PLWHA. The combined effort in the development of vegetable gardens to support patients on HBC is a rapidly developing undertaking, which has attracted wide participation from public, private and informal sectors. The interesting aspect of this innovation is the inter-sectoral collaboration that is evident at the community level.

- The mainstreaming of HIV/AIDS by institutions has also stimulated the development of an increasing concern for the care of the infected and affected in the workplace. It has been observed among the disciplined forces and other sectors that the infected are assigned lighter duties taking into consideration their needs and well being. In other instances they were conveniently moved to work near their homes.

- The establishment of AIDS Information and Counselling Centres and Health Resource Centres has been stimulated by the PSD. This innovation is currently being replicated in public and private institutions, including the formal sector.

- **The development of the Nkaikela Project**

"Since 1998, a *small group of Commercial Sex Workers (CSWs) in Nkaikela Ward in Tlokweng serving truck drivers were mobilized for the prevention of STIs and HIV. This became known as Nkaikela youth project. The Project received funding from through the South East DMSAC for workshops and training in IEC, Counselling, Condom promotion and STI treatment and prevention. UNDP supported the mobilization of funds from the MAC Foundation for the salary of the Coordinator. The CSWs are involved in IGA, consisting of gardening, running a Kiosk and Candle Making. The program is also supporting VCT activities around the area and carry out extensive peer education. The CSWs are involved in outreach activities visiting other "Hot Spots" around Tlokweng.The project has been replicated in Mahalapye, where training has begun. The strategy being used is peer education. The Nkaikela Project is now seeking ways of training the truckers as trainers and service providers. The project group recognizes the importance of developing young girls as Trainers of Trainers (TOTs) to sustain the initiatives beyond the life of the project. The University of Botswana HIV/AIDS Project in Francistown, is seeking collaboration with this project and plans are to reach out to the truckers with the essential HIV/AIDS services package, and identify those who are motivated to train others. These will be trained as trainers of trainers for service delivery among truck drivers.*

1.3 UNDP's CATALYTIC ROLE AND THE RELEVANCE OF THE PSD

- UNDP has played a catalytic role in supporting the establishment of structures, partnerships and alliances essential to the implementation of the Medium Term Plan II multi-sectoral strategy. The initial Program Support Document and the Project Support Document Addendum have been instrumental in ensuring that UNDP's central mandate to promote human development is pursued.

- At the national level, UNDP has provided technical leadership and advocacy for policy analysis to promote the process of organizational, community, household and individual

behaviour change for the response. Political, technical, economic and social inputs have been mobilized and brought to bear on the management of the HIV/AIDS risk.

- **The Programme Support Document and the Project Document Addendum**

  In line with UNDP's mandate, the PSD has fully supported activities which:

  i) ***Catalyse*** processes for community and national mobilization through capacity development at these levels;

  ii) ***Create*** supportive ethical, legal and human rights based environments through the and capacity development of civil society groups such as the Botswana National AIDS Service Organisations (BONASO), the Botswana Network for Ethics and Law (BONELA) and the Botswana Network for People Living with AIDS (BONEPWA);

  iii) ***Are gender-sensitive***; In 1997, UNDP and GOB through the PSD, supported the development of the Botswana National Gender Framework which was launched by the President in 1998. In June 2001 the Women's Affairs Department in collaboration with the Commonwealth Secretariat through PSD, conducted a workshop during which consultations on Mainstreaming Gender in HIV/AIDS were held. This has since been followed by the June 2002 Conference, which was dedicated to Mainstreaming Gender in HIV/AIDS. The Women's Affairs department in collaboration with the Commonwealth Secretariat has developed "**A Step by Step Guide to Gender Mainstreaming".** Currently three modules on **Mainstreaming Gender in HIV/AIDS** are being developed.

  iv) ***Are based*** on approaches to development of practices that empower people to take charge of their own well being, drawing down on local resources and building on local knowledge and value system. The District Multisectoral AIDS Committees, Village Multisectoral AIDS Committees, Support groups of People Living With AIDS, Faith Based Organizations, extension groups from various sectors, including women and youth groups have been capacitated and supported to develop and implement their indigenous strategies some of which have been documented as best practice. Replication of these innovations has attracted support from other development partners, locally and internationally.

  The Government of Botswana already has a Policy on Women and Development and has appointed focal points for Gender Mainstreaming in seven ministries. This should further enhance the Mainstreaming of Gender in HIV/AIDS at the national, districts and local levels.

Mainstreaming the Management of HIV/AIDS Risk in the Mandate of different Sectors.

- The PSD has played a major role in supporting the public sector ministries, namely: the Office of the President and its departments of Information and Broadcasting and the Directorate of Public

Service Management to play their role in the mainstreaming of HIV/AIDS risk issues in their core mandates, including the overall functions of human resource management for sustainable development. The Ministries of Finance, Education, Labour and Home Affairs, Local Government, Health and others, including parastatals, private sector and NGOs, and CBO's have been assisted to play their roles in mainstreaming HIV/AIDS in their mandates, and comparative advantage as outlined in the Botswana National Policy on HIV/AIDS. The Ministries of Industry, Wildlife and Tourism, and Works and Communication were also assisted through PSD to establish institutional arrangements essential to promoting a multisectoral response and the mainstreaming of HIV/AIDS risk management in their core mandates.

Enhancing the Scope and Implementation of HIV Prevention Interventions

- The PSD partnership has supported the broadening of the scope and implementation of the prevention program by the public sector at the national, district and community levels. The sectors included in PSD have, through the technical assistance and support provided, been capacitated to implement prevention activities as follows; information, education and communication, counselling, education on condom use, provision of condoms, early detection, diagnosis, treatment and control of STIs. These have formed the basic package of prevention services provided in the work place programs.

  The PSD is in line with the objectives and the two over-arching goals of prevention, care and support of the MTP II. The PSD also addresses the key elements of the Declaration of Commitment on HIV/AIDS, set out at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) June 2001, at which a series of benchmark targets were adopted in the fight against the epidemic. The declarations on the reduction of HIV transmission among young people, should through partnerships formed through PSD become a reality.

Forging Alliances with the Private Sector for Human Resources

The PSD has catalysed processes at the national, institutional and community levels for the formation of alliances with the private sector through the DMSACS as an approach to mobilizing efforts to respond to the human resource management challenges, resulting from the impacts of HIV and AIDS on human resources. The need to preserve human resources is recognized by all sectors. In most workplaces **PLWHA are assigned lighter duties and usually posted nearer to their families in consideration of their needs.** Not only have the sectors increased the workplace prevention, care and support interventions, alliances between the public and private sectors and medical insurance institutions have resulted in the development of schemes to anticipate the effects of the epidemic on human resource at the workplace. UNDP through its strategic partnerships with the Government, Private sector, Parastatal and selected Medical Insurance groups has provided support in the search for ways of supporting Governments aspirations towards making ARV therapy and other treatment options available and accessible to Botswana. In April 2002 UNDP/Botswana in collaboration with UNAIDS, WHO and other partners provided technical assistance to Botswana in the preparation of the Government's proposal to the Global Fund for TB, Malaria and HIV/AIDS. This affirms commitment to the UNGASS Declarations by way of maximizing partnerships for human development in Botswana.

Policy Development and Capacity Building for Program Development

The widely publicised *Botswana Human Development Report 2000 - Towards an AIDS Free Generation,* has proved to be a useful advocacy tool and source of information for both the Government of Botswana and non-government institutions. The report is anchored on Botswana's Vision of no new HIV infections by 2016, and seeks to focus policy on the window of opportunity presented by young Batswana aged below 15 years. Within this cohort, HIV prevalence rates are very low; less than 2% compared to about 30% in the 15-49 age group. The central message, around which extensive consensus has been built, is that this cohort has to be saved from the dangers posed by intergenerational sex; that extraordinary measures need to be taken to equip them to avoid infection with HIV.

Abridged versions of the report, in both Setswana and English, were produced for use as supplementary material in primary and secondary schools. The report also provided a platform for discussion of sensitive issues such as commercial sex, sex in prisons, homosexual practices, and the need for condom education and distribution in prisons. These debates may not have been resolved as the report suggested but there is growing realisation that radical shifts in the approach to these issues are essential. The report also provided the impetus to the discussion on Anti-Retroviral Therapy and provided a bigger platform for discussion.

The Impact studies conducted between 1998 and 2002 through PSD have provided the first set of socio-economic analysis studies that can be used as a sound basis for the development of evidence-based policies, and programs for the management of the HIV/AIDS risk at the national, and district levels. The results, findings and recommendations from these studies have been used for advocacy, and resource mobilization at all the national and international levels.

The Monitoring and Evaluation Framework for the PSD

The Monitoring and Evaluation Framework for the PSD outlined the monitoring activities as follows: quarterly financial reports with precise dates, monitoring visits, and audit, mid-term evaluation, tripartite report, annual programme report meetings, terminal report and a terminal TPR. This process has facilitated the tracking of the progress and identification of priority areas of focus. The Monitoring and Evaluation process has also enabled the government, NACA, the Ministry of Health, the Ministry of Local Government, UNDP and other stakeholders to have oversight on the programme implementation process.

To date, the PSD has been the most integrated, and comprehensive, multi-pronged programme between the government of Botswana and UNDP. The Government of Botswana has provided 75% of the funding towards the implementation of the PSD, and has ensured that the project has the relevant administrative, management, technical and back-up services needed to support a project of this nature and size.

2. DISCUSSION

In the national response to HIV/AIDS, the PSD project remains the most comprehensive, integrated and multi-pronged program, between the Government of Botswana, UNDP, UNAIDS and SIDA. During the

life of the project, UNDP and the Government provided exemplary leadership to the response. This leadership has managed to translate the objectives of the MTP II into a concerted and effective set of actions which resulted in a number of impressive achievements.

There has been a rapid rise in the National consciousness and knowledge about the reality of HIV/AIDS and its health and socio-economic consequences. Similarly, establishment of an effective, political and technical infrastructure for initiating and rolling out the national response has been realised. This infrastructure is providing the basis for a sustainable future in the response at the National, District, Community and household levels.

Instruments for the development of an effective institutional policy have been initiated for a sustainable response. As a result future policies will be based on detailed institutional analysis of the HIV/AIDS risk, and strategies that are most likely to have maximum impact.

Infrastructure for institutional development for mainstreaming the HIV/AIDS response into all the targeted areas have been established. The process of mainstreaming of the HIV/AIDS response is currently being anchored. Some degree of progress has been made toward the implementation of the mainstreaming. According to the assessment of the evaluation team, the mainstreaming objective is at various stages of implementation. This reflects steady progress and a defined path towards full mainstreaming. This should contribute to an effective and continuing HIV/AIDS response.

Multi-sectorality has been achieved especially at the district and local levels. Collaboration between sectors at the district level has been observed in joint action towards the response. Action using comparative advantage in supporting other sectors to realise their objectives has been observed. For example, Department of Prisons and Rehabilitation has used its expertise in gardening to support other sectors to develop vegetable gardens for the support of CHBC and PLWHA. At the national level this has yet to be realised.

The foundation for all areas of the response has been laid through progress made in institutional capacity development. Capacity has been developed through establishing and making operational the aspects of the HIV/AIDS risk management in 10 ministries, 16 districts, 3 civil society organisations and all the 4 disciplined forces. The progress towards institutionalising the response at the community level has begun in earnest and will be consolidated during the successor project. The appointment of AIDS coordinators in the targeted ministries, the establishment of the ACU in the Ministry of Local Government, and the making the DMSACS function under the chairmanship of the District Commissioners/Council Chief Executives and the appointment of the District AIDS Coordinators (DAC) has given great impetus to the capacity development intentions of the MTP II, though the PSD project. The contribution through the training of peer educators, counsellors and the implementation of the IEC has secured the future of the program for sustainability. Plans are afoot to fully integrate concepts of Behaviour Change Communication (BCC), community mobilization and leadership in the IEC training modules, during PSD II.

HIV/AIDS service delivery strategy has been established at all targeted areas. Condoms have been made available and distributed at all levels targeted institutions. The demand for condoms has intensified and people openly request for them.

Individual and group IEC has begun in all public, private and informal sectors included in PS; and in-house counselling at the workplace has been initiated in targeted ministries and districts.

Support groups of PLWHA have been formed throughout Botswana as an off shoot of the Networks for PLWHA established through the PSD. The support groups are providing counselling to individuals and families for positive living, as well as to women on the Prevention of Mother-To-Child Transmission (PMTCT) programme. Furthermore, the involvement of PLWHA at all levels has been very high. Service delivery by support groups has been observed in many districts; similarly effort to support orphans has increased.

PSD has stimulated the establishment of AIDS Information and Counselling Centres and Health Resource Centres. This innovation is currently been replicated in public and private institutions, as well as in the formal and informal sectors.

3. RECOMMENDATIONS

This section outlines the main recommendations, the specific and general recommendations for improved performance, expansion of programme interventions as well as for ensuring sustainability of PSD II planned initiatives and interventions.

3.1 MAIN RECOMMENDATIONS

3.1.1 The Main Recommendations are concerned with:

- Extension of PSD to March 2003, and setting the agenda for laying the foundation for PSD II (2003 – 2007)

- The development of a successor project –PSD II, including an outline of the proposed building blocks, renewing the UNV project from 2003 – 2007, and recruiting UNVs for all districts, selected sectors, and all three Networks, including four Disciplined Forces.

- Introducing new thinking and interventions through PSD II to ensure that the programme is in line with the national objectives of reducing and finally eliminating HIV infection set out in the draft Strategic Plan III and the Vision 2016 target of “no new infections resulting from HIV”.

- Outlining strategies for targeting various vulnerable groups along the life cycle by: age, sex, occupation, social orientation, socio-economic status and socio-cultural extraction.

- Advocating for a shift toward the anchorage and concentration of HIV/AIDS interventions (prevention, reduction of HIV transmission, care and social support) to the household and community levels for maximum effect, and impact, using the Kgotla as an important unit for action.

- Strengthening the mainstreaming of HIV/AIDS in the mandates, activities and service delivery policies of sectors; public, private and informal, including district and local levels.

- Making the "Management of the HIV/AIDS risk" the rallying point for the response.

- Employing strategies to reach large numbers of community groups as well as approaches that have the potential to make a significant impact on the reduction of the transmission of HIV and other STIs with a view to eliminating the transmission in the very near future.

3.1.2 Make Universal HIV/AIDS Testing the mainstay and entry point for the national and institutional response. Consultations on this will be needed to share perceptions and control for sensitivities fears, and to provide for an analysis of the proposed strategies including the personal and social benefits of taking such action.

3.1.3 Initiate a consultative process to review the current National HIVAIDS Policy to incorporate new thinking and emerging issues particularly the concept of Universal Testing and Counselling as the entry point to institutional, community and household HIV/AIDS risk management programmes.

3.1.4 Make the "Management of the HIV/AIDS risk" the rallying point for the response through the following policy interventions:

- Establish universal multi purpose testing centres.
- Establish VCT compliant centres within existing services.
- Spearhead effort to make VCTs youth friendly at all levels.
- Building Youth leadership for the "Management of the HIV/AIDS risk".

3.1.5 PSD II to spearhead the implementation of policy related interventions on the establishment of HIV/AIDS compliant centres, institutions, facilities, schools, organisations, etc.

- Facilitate multilevel consultation processes essential to securing consensus on criteria for HIV/AIDS risk management compliant centres and to this end, support the process for determining:

    - HIV/AIDS risk management compliance certification requirements.
    - Procedures for supporting the development of HIV/AIDS risk management compliant facilities.
    - The content and context of the HIV/AIDS risk management compliant services.

3.1.6 Support the development of a national consultative process for monitoring and supporting adherence to mainstreaming the "management of the HIV/AIDS risk" at all levels.

3.1.7 Support the development of policies, standards and procedures for monitoring adherence to workplace performance on the management of the HIV/AIDS risk.

3.1.8 Support the documentation of current best practice experience and lessons learned from selected workplaces and medical insurance companies that have embarked on clear programmes for mainstreaming the management of the HIV/AIDS risk in their mandates through **policy shifts and innovations**.

3.1.9 PSD II to emphasise joint programming and dialogue by all stakeholders through: multi-level consultations on the recommendations on the **critical building blocks for PSD II**.

3.1.10 PSD II to continue to provide technical assistance to the Advisory Committees of NAC and the Select Parliamentary Committee on HIV/AIDS to enable these important bodies to fully address the management of the HIV/AIDS risk issues, and the changing needs of Batswana, through policy analysis and policy development.

3.1.11 Support to strengthening the role of NACA as an organ for spearheading the coordination of policy related efforts and responses aimed at accelerating and expanding the response.

3.1.12 Strengthen the technical capacity of DHTs for leadership in the planning and implementation of the public health management; approach to the prevention and control of HIV/AIDS, including the treatment, care and support interventions at the district and household levels.

3.1.13 Continue to support deliberate efforts aimed at promoting greater involvement of people living with HIV/AIDS (PLWHA) and Networks in the main stream of policy, and programme development decisions and interventions.

3.1.14 Target the Ministry of Health for capacity development, policy and institutional strengthening to mainstream the Management of HIV/AIDS risk in its mandate at all levels taking into consideration its comparative advantage in Public Health.

3.1.15 PSD II should support all its target areas to use the operational research as a tool for decision making and programme development at the national district and local levels.

3.2 SPECIFIC RECOMMENDATIONS

The specific recommendations are outlined under Policy, Institutional Strengthening, Capacity Building, and Service Delivery for improved performance in the 5 target areas.

Policy related

Specific policies are to be developed around the "Management of the HIV/AIDS risk" at all levels, as a standard rule.

The PSD is to spearhead the development and ***institutionalisation of "HIV/AIDS risk management" compliant policies*** for all sectors and organisations to achieve the following:

- Management of HIV/AIDS risk at all levels.
- Development of standards and procedures on the reduction of HIV/AIDS transmission.

- Provision of technical guidance to the Advisory Committees on the National AIDS Council (NAC), Parliament Select Committees on aspects of the Management of the HIV/AIDS risk nationally.

- The monitoring of adherence to mainstreaming of HIV/AIDS by sectors and organisation.

- Establishment of VCT compliant services within existing structures.

- Development of comprehensive social marketing of the BCC process at all levels.

- Investing in human resource through **Universal Testing**, Counselling, treatment and care and the development of ***incentive packages*** to support initiative for the relevant continuum of care.

- Advocating for stigma reduction, and the combating of stigma.

- Setting of standards and requirements for the reduction of HIV sexual transmission, programmes and intervention and to monitor adherence to the standards.

- Development of policies and procedures to guide and monitor the implementation of the mainstreaming process at all levels.

- Development of procedures to guide consultations on the development of a Policy on **Universal Testing**, counselling and support, treatment and care, as a system for the continuum of care.

- Establishment of **Certified** HIV/AIDS risk management compliant centres at all levels.

- Provision of support to DMSACs for the development of district and household focused HIV/AIDS risk management activities.

- Provision of continued guidance to DMSACs on inter-sectoral collaboration.

- Making VCT Youth friendly in schools, multipurpose centres, health and employment settings.

Institutional Strengthening

- PSD II to provide technical assistance to the Government of Botswana (GOB) on the structuring, organization and staff requirements of NACA to enable the agency to fulfil its mandate and responsibilities.

- UNDP should play a key role in mobilising the UN–Family and other development partners to strengthen the institutional capacity of NACA.

- PSD to provide technical assistance in the mainstreaming of programmes and activities for the "Management of the HIV/AIDS risk" by sectors, DMSACs, disciplined forces and networks at all levels.

- UNDP through PSD II to use its catalytic role to strengthen all sectors including the Ministry of Health, to enable them to efficiently mainstream the "management of the HIV/AIDS risk" through their mandates and comparative advantage at all levels.

- Develop the institutional integrity and capacity of sectors and networks to conduct focused analyses and assessments, in order to identify policy related factors that are likely to enhance the implementation of precise activities for the reduction of the sexual transmission of HIV and other STIs.

- Provide technical assistance to each disciplined force for conducting focused needs analysis and assessment within their forces to identify gaps and priorities for the effective mainstreaming of HIV/AIDS risk management plans, programmes and interventions by each force.

- Channel technical assistance directly to each disciplined force, to enable them to develop the managerial capacity to sustain gains made thus far towards the response. Similarly, ensure that technical assistance is provided for the establishment of an efficient Management Information System (MIS) for use by all disciplined forces.

- Establish strong partnerships and alliances with youth groups in an out of school to campaign for behaviour change for addressing the biological, socio-economic and cultural factors that fuel sexual transmission of STIs/HIV among young people.

- Develop a focused strategy for PSD II that will facilitate the development of interventions for anchoring the "management of the HIV/AIDS risk" at the household and community levels.

Capacity Building

The overall intention of these recommendations is to sharpen the focus on activities that reduce the sexual transmission of HIV and other STI's.

- Provide technical assistance and support for mainstreaming the management of the HIV/AIDS risk in the policies, plans and program activities at all levels.

- Strengthen capacity for the planning and implementation of comprehensive IEC, counselling and BCC, on sexual transmission reduction, including treatment and care programmes as required.

- Strengthen capacity of existing Voluntary, Counselling and Testing Centres and the proposed **VCT compliant services** in approved establishments.

- Enhance the existing AIDS committees and other structures to facilitate mainstreaming of activities through social mobilization and social and marketing within the workplace.

- Develop a comprehensive monitoring program for assessing progress towards the reduction of the sexual transmission of HIV, and other STIs.

- Enhance the use of quality training methodologies, and participatory approaches to problem analysis and evaluation at the household and community levels.

- Strengthen the IEC component of HIV/AIDS to incorporate strategies and interventions to reducing and combating stigma.

- Facilitate the development of training programs on leadership, organisational development and mentoring, to enable the networks and disciplined forces to be responsive to the needs of their members.

- Provide support to networks for the documentation of best practice experiences and lessons learned on living positively and contributing towards the reduction of stigma.

- Provide technical assistance to networks on programme development for family and community-based approaches to community and household empowerment, to promote the uptake of HIV/AIDS and health related programs. Provision of guidance on ethical and legal issues should be an integral part of the program.

- Provide support for the development and use of effective communication between the individual forces as well as with civil society organisations.

- Strengthen the technical capacity of the DMSACs for enhancing the effectiveness of the initiatives by DMSACs for reducing the transmission of HIV at the household and community levels.

- Raise the capacity of the DMSAC sectors, CBOs, and technical committees to empower them in the use of BCC approaches for the reduction of HIV transmission among vulnerable groups.

- Raise the technical leadership of DHTs for monitoring the quality of care provided to HIV/AIDS patients discharged from the Primary hospitals to CHBC.

- Provide technical assistance to the networks for the development of comprehensive advocacy strategies for promoting an enabling environment for implementing community-based poverty reduction interventions and to address gender issues.

- Provide technical assistance to the DHTs for improved leadership in the management of HIV/AIDS risk at the district level to meet the demand at the household level.

- Raise the technical capacity of the DHTs for monitoring the quality of services provided to HIV/AIDS patients in district and primary hospitals through implementation of discharge standards for effective continuum of care.

- Strengthen the technical capacity of the DHTs for leadership in the implementation, monitoring and evaluation of the reduction of sexual transmission of HIV interventions, including the care of patients receiving ARVs at the household level.

- Support should be provided to DMSACs for planning, monitoring and coordinating the work of sectors, CBOs and others working through the DMSACs through technical assistance and UNV support to District AIDS coordinators.

- The DMSACs should be assisted to explore the TCM model for its appropriateness and utility for anchoring the response at the household level, and the extent to which the model may be improved for the efficient dissemination of messages essential to the "Management of the HIV/AIDS risk".

Service Delivery

- Channel focused institutional strengthening and capacity building resources to selected sectors that have the potential to have maximum effect and impact on reducing the sexual transmission of HIV i.e. Youth sector, PLWHAs, and the Disciplined Forces.

- Provide support to sectors, CBOs and networks within the DMSACs to facilitate improved service delivery in the following areas: IPT, VCT, PMTCT, CHBC and ARVs at the household level.

- Provide technical assistance to improve the quality of services provided in a number of centres, established as a result of PSD such as: IEC and Counselling, and Health Resource Centres, Day Care Centres, Respite Centres and other emergent community based facilities.

3.3 General Recommendations

- Institutionalise programs for capacity building within sectors, districts and communities by ensuring availability of a **critical mass** of TOTs in each sector, organization, or district for the management of the HIV/AIDS risk.

- Establish strategic partnerships between sectors, the UN-Family, Civil Society and private sector, for joint consultation and planning on critical issues related to the management of the HIV/AIDS risk.

- Develop linkages with existing education, training, service delivery and research institutions to facilitate the integration of the management of the HIV/AIDS risk information in education, training, research and service delivery.

- Forge alliances and partnerships for consultation on critical human resources development strategies and modalities to anticipate the effects of the epidemic on the human resources.

- Develop innovative funding modalities to facilitate access by community based groups and other small support groups involved in developing "community solutions to the management of the HIV/AIDS risk" at the household and community level, through the DMSACs.

- Outline modalities for channelling money directly to the sectors participating in the response at the district and local levels through the DMSACs.

- Determine a clear strategy for strengthening the capacity of the DMSACs for monitoring, co-ordinating and supervising the implementation of HIV/AIDS planned activities at the local and district levels.

- Outline general procedures for simplifying and facilitating the entire financing to CBOs which can be acceptable to and usable by all stake holders.

- Strengthen NACA's capacity to manage the funding process for funds placed under their control in a manner that is likely to facilitate efficient and effective use at the district and local levels.

- The Government and UNDP should explore modalities to expanding the numbers of Family Welfare Educators, and other community based caregivers who can further strengthen the social mobilisation and Behaviour Change Communication (BCC) activities for the "Management of the HIV/AIDS risk" at the household and local levels. Similarly consultations between PSD and TCM on how the scope and quality of TCM social mobilisation initiatives may be enhanced further.

- The choice of people assigned to work at the household and local level should be reconsidered to make sure that they fit in with the social environment or able to adapt to the needs and aspirations of local communities.

- Priority sectors requiring technical assistance should be determined at the start of PSD. It is expected that MOE, MOH, MLHA, DPSM, MTI and MFDP including networks, disciplined forces and the S&CD will be considered for the support.

4. STRATEGIC APPROACHES

- Developing a shared vision on the implementation of policies aimed at reducing the transmission of HIV in line with the targets of Vision 2016.

- Development of strategic partnerships between and among UN agencies and development partners for technical assistance in programme design, implementation and evaluation based on their mandates and comparative advantage.

- Forging alliances with the Public and Private Sector, Civil Societies, International partners and institutions to supplement national efforts for contingency planning to anticipate future requirements and demands for continued provision of ARV therapy and other treatment options.

- Exploring efforts aimed at enhancing the technical capacity of the DMSACs for providing leadership for multi-sectoral action in a coherent and enhanced manner.
- Channelling technical assistance where it is needed most to ensure targeted action at district, community and local levels.

- Identifying the most appropriate mix of human resources with the necessary, gender sensitive and culturally relevant skills for promoting the response at the household level.

- Building consensus for a shared vision and joint partnership for programme development to address the challenges in a strategic, targeted and coherent manner. Similarly determine strategic entry points and programmes for anchoring PSD interventions at the household and local levels.
- Developing linkages with the existing education, training, service delivery and research institutions to facilitate the integration of HIV/AIDS risk management information in education, training and service delivery.
- Establishing partnerships with departments and institutions at the national, district and community levels to promote collaboration in policy analysis and development including contingency planning.
- Designing programmes with in-built M&E and supervision systems for quality assurance and quality improvement, respectively, as well as to ensure sustainability of programmes.
- Disciplined forces should be targeted with much more precise capacity building, training, institutional strengthening and well planned service delivery programmes tailored to their needs, strengths, limitations, HIV/AIDS risks, taking into consideration their vulnerability, opportunities and workplace environments.

5. ISSUES FOR CONSIDERATION

- UNDP/GOB should address institutions for education, training and development as critical areas for human resources development, management and sustainable development. These institutions produce large numbers of human resources annually. The government should ensure that the educational centres are HIV/AIDS risk management compliant.

- UNDP and the Government of Botswana and other partners should **Jointly Consider Playing** a much more comprehensive advocacy role and approach to the development of a national orphan care programme in line with the wider goal of human resource development management and sustainable development within the benchmark targets outlined in UNGASS June 2001.

- **The PSD Partnership may have to Consider its Approach to Selebi-Phikwe** and the Bobirwa Sub-District villages of Bobonong, Mmadinare, Sefhophe and Tsetsejwe, given the high prevalence of HIV infection in these areas, and other factors e.g. mining, population mobility, and the current levels of HIV/AIDS related morbidity and mortality in villages.

- **Hukuntsi, Kang, Tsabong and Ghantsi** are least impact areas, and the population migration and other life styles render these areas highly vulnerable to HIV/AIDS and other factors fuelling the epidemic. Consideration of aggressive, and strategic approaches to the development of interventions in these areas seems a priority.

- Consider approaches to assisting community based groups, and families to develop innovative approaches to communicating HIV/AIDS prevention, care and support information at the household and local levels.

- Kasane being on a trucking route which links with Mahalapye, Palapye, Francistown, Nata, Pandamatenga and similarly, Ghantsi also being on the trucking route extending from Jwaneng, Kang and Tsabong may all require a re-thinking of strategies.

- The results of the latest National Surveillance (2001) and their implications for priority setting and Programme Development, should take centre stage in determining approaches to reducing the sexual transmission of HIV and other STIs.

- The extent and expediency with which UNDP/GOB will respond to the findings, recommendations and issues outlined in the evaluation will be critical to the management of the HIV/AIDS risk in Botswana and to the contribution of PSD II, as well as to NDP 9 (draft) and Vision 2016.

- Some thought should also be given to reviving high level and community dialogue on the use of evidence-based information to map out a prevention and reduction strategy in a much more profound manner especially with respect to the social marketing of the strategy and interventions at the local levels.

6. FUTURE DIRECTIONS

6.1 PSD II should continue to provide support to the 16 districts, bearing in mind that the districts are at different levels of development with respect to the potential and strengths of the DMSACs in the response, including their different circumstances.

6.2. The PSD should consider its approach to the eight remaining districts and decide how to channel their support to these districts to strengthen the capacity of the DMSACs.

6.3 PSD II should continue support as for PSD I but concentrate effort to the household level, by promoting reduction of the HIV sexual transmission, behaviour change communication, use of participatory approaches to the identification and solution of HIV/AIDS related problems. Youth development, and the reduction of poverty at the household levels must be seen as important issues for consideration, as these are intertwined in sexual transmission.

6.4 Reactivating VMSACs should be given priority, during PSD II, as these are likely to provide the impetus for the anchorage of the HIV/AIDS prevention, reduction of sexual transmission, care and social support activities at the household and community levels.

7. CONCLUSIONS

PSD has achieved its overall objective in the context of the two goals of the MTP II for prevention, care and the mitigation of the impact of HIV/AIDS. The three intended strategies have been realised to the optimum level within the limits of what has been feasible given the constraints identified by the evaluation team. All areas namely Ministries, DMSACs, Disciplined Forces and Civil Society have been targeted with the deliberate strategies outlined in the PSD and the Addendum Document. Some new strategies such as the establishment of new community based AIDS Information and Counselling Centres, or Health Resources Centres, Day Care Counselling and support centres and variations of Orphan Care centres and homes, have emerged as direct offshoots of the PSD. Similarly strong community leadership and inter-sectoral collaboration has emerged at the household and community levels although these developments had not necessarily been outlined as deliberate strategies within PSD.

Partnerships between the public, private and the informal sectors have emerged as a valuable strategy for exchange of information, resource mobilisation and skills transfer among the parties. The results of the impact studies, specifically the study on the impact of HIV/AIDS on education have had far reaching implications on the recognition of the importance of teacher capacity building for promoting the management of the HIV/AIDS risk at the primary, secondary and tertiary education levels. Teacher Capacity Building has thus emerged as a companion strategy to the management of the HIV/AIDS risk in the various stages of child education and development, including the stages of puberty, adolescence and youth.

Not only have the DMSACs been successful in promoting the multi-sectorsal response in the 16 Districts, they have also promoted greater involvement of PLWA, thus contributing to the reduction of stigma, and the mobilisation of resources in support of PLWHA. The DMSACs have succeeded in making the response everybody's business, and have therefore decentralised and demystified the response in every way.

7.1 The Scope of PSD II

- The Evaluation Team firmly believes that PSD II should intensify support to the 16 districts bearing in mind that the districts are at different levels of development both in terms of achievements and the stages at which they were incorporated in the PSD. Similarly, the eight remaining districts should be included among the districts to be strengthened during the life of PSD II, so that all 24 districts are supported to further expand the national response. A focused approach should be used in targeting the 24 districts taking into consideration their vulnerability to HIV/AIDS, and other risk factors inherent in the populations within districts.

- The Evaluation Team is of the opinion that UNDP through its advocacy role, its position and mandate on human resource development within the UN system, should assist DMSACs, VMSACs, Disciplined Forces, Ministries, Civil Society, the Private and informal sectors to accelerate efforts aimed at reducing the sexual transmission of HIV among teenagers, adolescents, youth and young adults. In addition, UNDP should use its comparative advantage to ensure that, **poverty reduction, gender environment, and youth empowerment** strategies are integrated as crossing cutting issues in prevention and control interventions at the national, district, community and household levels. The evaluation team also believes that in line with UNDP's wider mandate

of promoting human development as well as protecting the human rights of all individuals to security, and survival, PSD II should also provide technical support to the Government of Botswana, Civil Society, the private and informal sectors in the development of Orphan care and support programmes that have a strong child and human development component which incorporates the elements of physical, intellectual and emotional development of children, teens and adolescents.

- **Building Blocks for PSD II**

In addition to the 4 PSD I strategies, the following strategic areas should be included:

(i) Social mobilisation
(ii) Mainstreaming the management of the HIV/AIS risk
(iii) Teacher Capacity Building, and
(iv) Advocacy for partnerships to address; Gender and Youth Development, Poverty Reduction and Orphan Care.

Expanding target areas to include 4 more Ministries, 8 more districts (see map below) and possibly the Botswana Christian Council to target Refugees or displaced people.

Consolidating the multi-sectoral response at all levels and anchoring the mainstreaming process at the district and household levels.

Integrating interventions on Gender Development, Poverty Reduction, Human Development and Human Rights as cross-cutting issues in HIV/AIDS risk management.

Building partnerships and forging alliances with public, private and informal sectors for the reduction of sexual transmission of HIV, and the mitigation of impact.

Collaboration in the delivery of prevention, care and support services at the district, community and household levels, including support for joint programming in selected areas. (See Appendix I).

- **Resource Mobilisation Strategy for PSD II**

The Government of Botswana should continue to mobilise funds for PSD II, and the partnership with UNDP should be maintained**.** UNDP should continue to maintain its mandate to mobilise funds and support from UN agencies, other local and international development partners, and to manage such.

The UNV support modality should be seen as part of the Resource Mobilisation strategy and should be continued and expanded, as this will ensure the cost effective provision of experts for the project. Similarly the use of national advisors as counterparts to the international UNVs to ensure skills transfer and sustainability of the programme, should continue.

7.2 Opportunities for the PSD II

There exist a number of opportunities for the implementation of the PSD II interventions during NDP 9, similarly the strategic areas outlined in the Strategic Plan III (zero draft), are areas that PSD has already been co-operating in at the district and community levels, especially in Community Home Base Care, IEC, condom use and education, food provision to the households, including orphan care, income generation activities and support to PLWA. The PSD II components, strategies and interventions will add value to these initiatives and strengthen the linkages.

- The current efforts by MLG to strengthen mainstreaming in District planning through the use of organisation development, co-ordination and monitoring activities, including innovative approaches to service delivery in the areas of CHBC and Orphan Care, should provide an opportunity to PSD II for the anchorage of its proposed prevention, care and support interventions at the households and community levels.

- PSD II will be developed at a time when the national monitoring systems are being developed for the national and district levels. This will provide an opportunity for the articulation of qualitative and quantitative monitoring indicators for PSD II. Similarly the implementation of PSD II will coincide with the implementation of NDP 9 and this should contribute to the development of partnerships, and the formation of alliances between districts and communities, as well as among various community based actors. This should enhance synergy, and joint programming especially at the local levels.

- **The Ministries** have begun to address the issues of mainstreaming in earnest, and are redefining their roles, functions and responsibilities in managing the HIV/AIDS risk and its impacts. The PSD II strategy will capitalise on these developments by providing the technical assistance and

support, through further institutional strengthening, capacity building, policy development for improved service delivery, and the anchorage of the management of the HIV/AIDS risk at the household levels with an emphasis on reducing vulnerability to HIV sexual transmission.

- The UN Family and other development partners through the UN Theme group on HIV/AIDS are considered partners in the response and have won the confidence of the Government of Botswana in this respect.

- Among the PSD I operational guidelines, provision of technical support and guidance to the National AIDS Council (NAC) and the select committees of parliament on HIV/AIDS, in addition to strengthening NACA was listed as one of the key activities or functions of the PSD. The evaluation team has reason to believe that this function or activity will be pursued in earnest during the planning of PSD II as well as during the implementation of PSD II in 2003.

- The decentralisation of HIV/AIDS management interventions to districts and local levels has taken root throughout Botswana, especially in the 16 PSD districts. This development has laid the ground for the implementation of a much more community and household focused PSD II, which should be in place by the first half of the year 2003. It is therefore hoped that all things being equal, the PSD II elements, strategies and interventions will be gradually worked into the NDP 10 national HIV/AIDS strategy with technical assistance, guidance and support from the UN family, development partners including regional and international groups.

- Best Practices and lessons learned by different sectors in the Management of HIV/AIDS in the workplaces such as Debswana, Kgalagadi Breweries and Water Utilities Corporation, and others, should provide examples for action.

- The 1997 – 2002 National AIDS Programme activities were guided by a National Policy on HIV/AIDS and the goals and objectives of the Medium Term Plan II. Mainstreaming of HIV/AIDS in the mandates of sectors, and promoting the implementation of a multisectoral response to the epidemic became the two main strategies to be pursued at the national and district levels.

- The proposed PSD II 2003 – 2007 therefore is likely to be implemented in a much more enabling environment as a number of new strategies towards prevention, reduction of the sexual transmission of HIV and the mitigation of the impact of the epidemic are being implemented. A few examples of these developments are listed below:

    - The Botswana Training Authority (BOTA) the accrediting body for training institutions has agreed to assume responsibility for mainstreaming HIV/AIDS in Vocational Education and training in an effort to “Manage the HIV/AIDS risk”.

    - BOTA plans to forge alliances with “Civil Societies” (some of which have been beneficiaries and partners in PSD 1997 – 2002). BOTA has also been involved with stakeholders like the AIDS/STD/UNIT of the Ministry of Health, and the National AIDS Co-ordinating Agency, to think up strategies which are most applicable in Vocational Education and Training.

  - The Botswana Quality Assurance has taken steps to address the spread of HIV/AIDS in order to implement strategies aimed at sustaining quality productivity levels in various industries.

  - The Banks in commemorating the World AIDS Day made a joint commitment to mobilise their forces to confront what is clearly a formidable common enemy which threatens to undermine the entire economy and all development achieved to date.

- The District Multisectoral AIDS Committee established through MTP II have lived up to the expectation of promoting and co-ordinating the multisectoral response at the district and local level. The DMSACs have provided the forum and platform for joint action by sectors, CBO's and informal community groups, the private sector and international organisations. Partnerships and alliances have been established to address the challenge posed by the epidemic.

- More and more people, sectors and community groups have begun to realise the implications of the persistently high prevalence of HIV transmission in the districts throughout the country, on the lives of Batswana and the national development. More and more people and community groups are clamouring for much more 'focused' and 'efficient' strategies and policies for the reduction or even elimination of the sexual transmission of HIV.

- The proposed PSD II offers the opportunity for the development of such strategies, policies and procedures through selected recommendations some of which are listed below:

  - "Making the Management of the HIV/AIDS risk" the "mainstay of response".

  - Introducing 'Universal Testing and Counselling' on "an individual, human rights-need-to-know" basis as the entry point to prevention, reduction of transmission, care and support service, at their place of choice. This approach also offers an opportunity for early detection and timely management of any form of the HIV/AIDS risk. The approach also provides a 'lifeline' to both the infected and affected along a continuum of care. It is in the light of this notion that the proposed PSD II recommends that the existing facilities should offer services for Voluntary Testing and Counselling to ensure access coverage.

- The proposed PSD II is designed to address the urgent national need to ensure an "AIDS free generation by 2016". It is thus recommended that "Youth-Friendly Voluntary Counselling Testing Centres be introduced in existing multi purpose, educational, recreational and reproductive health facilities and outlets frequented by youth.

  - Ensuring that multi purpose youth facilities and outlets are both "HIV/AIDS risk Management Compliant" and "Youth Friendly" is an approach that the PSD in collaboration with partners consider to have the potential to make a significant impact on reducing and finally eliminating new infectious resulting from HIV by 2016.

- The PSD proposes the strengthening of partnerships and forging of alliances for comprehensive youth development as an approach to assisting young people to access services aimed at

"managing the HIV/AIDS risks" in the wider context of their needs for healthy living and an improved quality of life. The opportunity to realise this, does exist as there are a number of actors collaborating with health, youth sectors, NGOs and international agencies in this venture. Similarly the private sector is also involved in projects that motivate young people to engage in activities that are likely to improve their quality of life.

7.3 Risks or Threats to PSD

The absence of an adequate infrastructure for the efficient implementation of PSD II within the NACA will be a risk or threat to the planning, implementation and the efficient oversight for the PSD II. NACA is grossly under resourced both in numbers and capacity, and is certainly not geared for the challenge that PSD II is likely to present. NACA does have a division for programme planning and implementation, however the operations of the PSD II have to be steered by an individual within the programme planning division. A project coordinator who will be full time on this position will have to be found. It is hoped that an effective project coordinator with the appropriate interpersonal and technical skills and relevant experience that fits the PSD II approach and style will be appointed. Without support from a competent and technically sound person, PSD II will not achieve its objectives and may not contribute to the overall objectives of the Strategic Plan III and the overall goals of NDP 9.

- Support to DMSACS through technical assistance; long and short-term, should be provided to enhance the performance of DMSACS and VMSACS. Without this support, the gains made during the PSD are likely to be reversed. This is bound to compromise the efficiency and effectiveness of the PSD II and pose a threat to the sustainability of the National AIDS programme in general.

- Should the required funding, technical assistance and UNV support, not be made available to the PSD II project, achievements secured during (1997 – 2002) will not be sustained and the objectives of PSD II will not be achieved. The multi-sectoral response and the modest achievements in some selected aspects of the mainstreaming process will not be consolidated further.

- Should the adverse factors such as; gross shortage of human resources at the community and local levels, low implementation capacity, and inadequate performance management, intervene the PSD II implementation will also be affected.

- Another threat to the PSD may result from the failure to build consensus between key partners in the National AIDS programmes on the critical role of the PSD II project. Partnerships between the PSD and the UN family including other development partners will be needed if the PSD II project is to succeed. If this does not occur, efforts towards the management of the HIV/AIDS risk, will not take off.

- Should the roles of ACU and NACA not be clarified, the DMSACS will not see any added value in the new arrangement, and this may be more disruptive than synergistic.

- Should the support required to move the process forward and maintain the momentum not be provided, PSD II will not have a solid foundation and structure to meet the challenge ahead.

- Should new thinking on issues such as, making the management of the HIV/AIDS risk the mainstay of the response, making VCTs youth friendly, making existing facilities and centres, “HIV/AIDS compliant” including introducing the principle of Universal Testing and Counselling Services on an individual human rights based-need-to-know basis, not be taken up in PSD II, then the target for an AIDS free generation by 2016 will be beyond reach.

APPENDIX I

SUGGESTED BUILDING BLOCKS FOR THE PSD II

Building Partnerships and Alliances with the Public, Private and Informal Sectors for HIV Infection Transmission Reduction	*Resource Mobilisation including Provision of Technical Assistance to target areas.*	*Collaboration in the Delivery of Prevention, Care and Social Support at the District, Community and Household levels*	*Support to Programme Development in Selected Areas*

INTEGRATION OF GENDER DEVELOPMENT, POVERTY REDUCTION, HUMAN DEVELOPMENT AND HUMAN RIGHTS, AS CROSS CUTTING ISSUES IN HIV/AIDS

ANCHORING THE MAINSTREAMING PROCESS AT THE NATIONAL, DISTRICT, COMMUNITY AND HOUSEHOLD LEVELS

CONSOLIDATING THE MULTISECTORAL RESPONSE AT ALL LEVELS

	TARGET AREAS			
ALL 14 MINISTRIES AND THEIR DEPARTMENTS	*23 DMSACS IN 23 DISTRICTS AND MAIN INSTITUTIONS FOR HRD*	*3 NETWORKS AND SUPPORT GROUPS OF PLWA*	*4 DISCIPLINED FORCES*	*BOTSWANA CHRISTIAN COUNCIL FOR REFUGEES*

POLICY DEVELOPMENT	*INSTITUTIONAL STRENGTHENING*	*CAPACITY DEVELOPMENT*	*SERVICE DELIVERY*	*SOCIAL MOBILISATION*	*MAINSTREAMING HIV/AIDS RISKS MANAGEMENT*	*ADVOCACY*	*TEACHER CAPACITY BUILDING*

STRATEGY LEVEL

APPENDIX II

The Summary of the Financial Support to the PSD Program in US Dollars:

The breakdown of the financial expenditure in covering the project period is presented in the Table below:

Expenditure description	**Total**	**1997-200**	**2001**	**2002**
PERSONELL COSTS				
International consultants	834,883	104,551	357,064	373.268
Administrative support	516,689	96,770	114,880	304,989
UN Volunteers	2,217,657	1,136,525	531,132	550,000
Monitoring and evaluation	349,243	115,335	98,973	134,935
Mission costs	39,697	28,197	8,212	3,288
National consultants	1,105,731	500,680	220,575	384,476
PROJECT PERSONELL TOTAL	5,063,850	1,982,058	1,330,836	1,750,956
CONTRACTS				
Printing	200,300	99,244	101,056	101,056
Management	10,000			111,056
SUBCONTRACTS TOTAL	210,300		99,244	111,056
TRAINING				
Central Level	1,922,170	1,44,497	212,691	264,982
District	729,758	71,119	353,639	300,000
CSOs	175,476	55,863	49,613	70,000
Disciplined forces	252,478	82,477	61,935	108,066
Applied research	56,031	5,251	40,056	10,724
Behavioural project	20,000		17,063	2,937
Prior years adjustment	-445,010	-265,955	-179,055	
In-service training	4005	4005		
TRAINING TOTAL	2,709,908	1,397,257	555,942	756,709
EQUIPMENT				
Equipment component	634,782	341,480	163,302	130,000
EQUIPMENT TOTAL	634,782	341,480	163,302	130,000
MISCELLENEOUS				
Reporting costs	128,354	70,614	46,658	11,082
Sundries	139,432	69,884	31,792	37,756
MISCELENOUS TOTAL	267,786	140,498	78,450	48,838
MICRO-CAPITAL GRANTS				
Microgrants	227,388	19,838	107,550	100,000
MICROCAPITAL GRANTS TOTAL	227,388	19,838	107,550	100,000
Micro Grants Total	227,388	19,838	107,550	100,00
	227,388	19,838	107,550	100,00
MISCELENEOUS				
Exchange differential	70,997		40,997	30,000
MISCELENEOUS TOTAL	70,997		40,997	30,000
BUDGET TOTAL	**9,185,011**	**3,881,131**	**2,376,321**	**2,927,559**

Total Program Allocation	9,437,071.00
Expenditures as at 30/09/2002	- 7,923,582.00
Available	1,513,489.00

Year	Expenditure	TRAC	Gov't CS	Other
1997	446,572.00	200,271.00	246,301.00	
1998	737,093.00	196,994.00	540,099.00	
1999	616,038.00	103,796.00	512,242.00	
2000	2,212,867.00	105,411.00	2,016,956.00	90,500.00
2001	2,376,321.00	137,672.00	2,038,649.00	200,000.00
2002	**1,534,691.00**		**1,534,691.00**	
	7,923,582.00	**744,144.00**	**6,888,938.00**	**290,500.00**

Budgeted amount for 2002	2,927,559.00
Expenditures to date are	-1,534,691.00
Available	1,392,868.00
Planned activities	**- 400,000.00**
Balance	992,868.00

The analysis of this financial expenditure indicates that the money has been use to support what it was intended for. The program has had the capacity to spend the finances allocated to various expenditure areas. The expenditure has been concurrent with the stated allocation and within the expected periods. This balance can be spent on the outstanding activities, cost of extension and the outlined priority areas identified in the evaluation.

NOTE

TRAC refers to UNDP core funds
Gov’t CS refers to Government cost sharing

ANNEX I

TERMS OF REFERENCE FOR THE TERMINAL EVALUATION OF BOT/96/001 PROGRAMME

BACKGROUND

The UNDP HIV/AIDS program support to the Botswana Government started in 1997 and was developed inline with the National Policy on HIVIAIDS and the Second Medium Term Plan (MTPll) for HIV and AIDS. MTPII proposes a three-pronged strategy to curb the spread of HIV/AIDS and concurrently mitigate its impact. The three-pronged strategies are: - policy development, institutional strengthening and service delivery. In line with its mandate UNDP is supporting upstream policy interventions and institutional capacity building for the management of the HIV and AIDS epidemic.

The program initially ran from 1997- 2000 and implementing partners in the program were:

National level: Ministry of Agriculture, Ministry of Finance and Development Planning, Ministry of Health, Ministry of Labour and Home Affairs and The Directorate of Public service Management.

District Level: North East (Masunga), Ghanzi, Francistown, Lobatse, Letlhakeng, Maun, Kweneng East, Serowe/Palapye, South East and Kasane.

Disciplined Forces: Police Service, Botswana Defence Force, Department of Prisons and Rehabilitation.

Civil Society Organisations: Botswana Network of AIDS Service Organizations (BONASO), Botswana Network of People Living With HIV/AIDS+ (BONEPWA+) and Botswana Network on Ethics, Law, Human Rights and HIV/AIDS (BONELA).

The programme has five major targets:

National Level: To strengthen capacity of ministries in mainstreaming HIV / AIDS into their programmes and planning as stipulated in the MTP II. Also that there is sensitisation and periodic updating of policy makers on issues of HIV and Development.

District Level: To improve and strengthen district and sub-district level capacities to develop and manage (co-ordinate, implement, monitor and evaluate) the HIV/AIDS Programme.

Applied Research: Support the development of applied socio economic research.

Civil Society: To strengthen the capacity of NGO's, CBO's for effective participation in

response to HIV/AIDS.

Disciplined Forces: To strengthen the HIV/AIDS prevention and care services in the disciplined forces. Also promoting civil military partnerships in the fight against the epidemic.

Mid term evaluation of the program in 1999 identified several achievements some of which are among others, that the programme should increase its outreach from 10 to 16 Districts; 5 to 10 Ministries and also include Local Police among the Disciplined Forces. Based on these recommendations the Tripartite Programme Review of March 2002, approved the extension of the Programme for two more years 2000 – 2002.

National Level: Ministry of Industry, Trade, Wildlife and Tourism, Department of Information and Broadcasting, Ministry of works, Transport and Communication, Ministry of Local Government and Ministry of Education.

District Level: Selibe Phikwe, Mahalapye, Tsabong, Kgatleng, Gaborone and Kanye.

Management Arrangements

The Ministry of Health - AIDS/STD Unit is the executing Agency. UNDP has offered technical support through a UNV Specialist and contracted other personnel to support the programme under the management of the Chief Health Officer. The Ministry of Finance and Development Planning is responsible for channelling funds to the executing agency under the normal procedures for the National Execution Modalities of UNDP. Funds are advanced on a quarterly basis.

The direct support of the selected activities by UNDP is provided upon request from the Executing Agency. This may be done through the written request by the ASU. It is the responsibility of the latter to facilitate of funding and technical support from other agencies, departments and organisations that have comparative advantage in particular areas.

Funding

The programme is funded on a cost sharing arrangement among the following partners: - Botswana Government, UNAIDS, SIDA and UNDP. It is national executed programme, through the Ministry of Health and National AIDS Coordinating Agency (NACA).

OBJECTIVES OF THE EVALUATION

The terminal evaluation of the programme was approved by the TPR held on the 17th September 2001. In line with the UNDP programming approach, the evaluation will focus on the following areas:

- Assess whether the capacity building components within the programme were

achieved.

- Assess programme performance in terms of efficiency and effectiveness.

- Document lessons learned and the best practices that are emerging within the UNDP supported activities.

- Assess the programme and determine its impact, on the National Response.

- Identify and determine lessons learned on management capacity of multi sectoral programme.

- Assess the impact of the UNV programme support to capacity building and transfer of skills and experiences from the regions.

- Assess the extent to which the decentralisation process has taken stock and effectiveness of the multi sectoral response at the district level.

- Assess the catalytic role of UNDP in the coordination of UN system response to the HIV/AIDS epidemic.

- Assess the extent to which UNDP has tapped into the resource mobilisation potential available in the country to fund the HIV activities in the context of this programme.

- Assess and identify programme partnerships strengths and effectiveness for enhancing the national multi -sectoral response.

- Come up with concrete recommendations geared towards the successor programme.

- Assess the inter- relatedness of the PSD to the national programme strategies.

SCOPE OF THE EVALUATION

The evaluation will cover all the five components of the programme. The evaluation will involve travelling to all the sixteen districts.

ISSUES TO BE ADDRESSED BY THE EVALUATION

The evaluation will focus on: -

- Comparative advantage of UNDP vis-à-vis other donors

- The flexibility of the programme in responding to emerging needs

- The strengths and weaknesses of the implementation process and the various outputs

- The capacity of the Government and other institutions in executing and implementing the programme.

- The efficiency of the delivery of inputs and the results of the impact achieved.

- Assessing the linkages between and among the targets of the programme BOT/96/001 and how they complement the National AIDS Programme.

PRODUCTS EXPECTED FROM THE EVALUATION

- The evaluation mission will produce a report detailing the extent to which objectives of the programme have been met and drawing any lessons learned based on the implementation of the programme.

- The report will also make recommendations on the areas of focus for the successor programme.

- Furthermore the report will recommend the appropriate resource mobilisation strategy for the successor programme.

- Finally the report will recommend actions on the design of the successor programme in terms of its main thrust, execution modality and implementation and management arrangements.

METHODOLOGY OR EVALUATION APPROACH

The evaluation should be retrospective and should explore how the programme has enhanced the multi-sectoral response and capacity building in all the implementing partners. In relation to retrospective the evaluation should take a serious reflection on what impact the programme has had. The nature of the assignment will necessitate the utilisation of both qualitative and quantitative methods. A desk review of relevant documents will be undertaken. Questionnaires, complemented by selected field visits, interviews and focus group discussion will be used to obtain the views of key persons in the programme.

COMPOSITION OF THE EVALUATION TEAM

An independent team of Gender balanced consultants will undertake the evaluation. The team will be composed of five members as follows: -

- One Government representative with background in Public Health to be identified by NACA and ASU.

- One Government representative from MFDP, to be identified by MFDP.
- One Government representative from MLG, to be identified by MLG.
- One International consultant with background in Public Health and experience in programme evaluation who will be the team leader, to be recruited by UNDP.
- One NGO beneficiary (PLWHA) representative to be identified jointly by UNDP, NACA and ASU.

All the representatives except the NGO representatives should have experience in programme evaluation. The representatives should not be involved directly in the execution or implementation of the programme.

IMPLEMENTATION PLAN

The Government of Botswana and UNDP will coordinate the evaluation process. A reference group will oversee the evaluation process. However, UNDP will manage the evaluation.

DURATION

The evaluation will take eight weeks.

PROPOSED SCHEDULE

DATE	ACTIVITY
1ST July to 30th July 2002	Recruitment of the Team
1st to 5th August 2002	Desk Review
8th August 2002	Submission of Inception Report
11th August 2002	Reference Group Meeting
15th August to 2nd September 2002	Field Visits
9th September 2002	Submission of Draft Report
19th September 2002	Reference Group Meeting to Review Reports
26th September 2002	Submission of Final Report

CONSULTATION IN THE FIELD

The team will:
Maintain a close liaison with UNDP Resident Representative in Gaborone and the National AIDS Coordinating Agency. Although the mission should feel free to discuss with the authorities concerned any matters relevant to the assignment, it is not authorized to make any commitment on behalf of Government of Botswana and UNDP.

ANNEX II

LIST OF PEOPLE CONTACTED

UNDP

Mrs Comfort Tetteh, Ag Res., Rep.
Mr R. Moaneng, Ass Res. Rep.
Lydia Matebesi, NPO
Dorothy Tlagae, Programme Associate
Rose Mandevu, Programme Officer TCB
Sennye Obuseng, National Economist
Valencia Mogegeh, Gender Policy Adviser
Andreas Sieren, UNV PO

UNAIDS

Dr K. Ampomah, CPA

NACA

Dr B. Khan, Coordinator
Mrs Monica Tselayakgosi, Programmes
Dr Fiona Percy, Policy Adviser (UNDP)
Bontsi Monare, Programme Assistant
Thangathurai Subramanyam, UNV
Tommy Nkanane, Data Clerk

MINISTRY OF HEALTH

Dr P. Mazonde, Director of Health Services
Mr L. T. Lesetedi, Assistant Director, PHC Department

AIDS/STD Unit

Ms K. Molosiwa, Ag Head of Division
T. Kejelepula
M. Balang
B. Mudanga

DPSM

M. Ramotshabi, Assistant Director
M. Pelaelo, Senior Assistant Director
M. B. C. Makati, Social Rehabilitation Officer

C. M. Masoba, Senior Personnel Officer

MINISTRY OF EDUCATION

Mrs O. Nkwane

MINISTRY OF FINANCE AND DEVLOPMENT PLANNING

Mrs B. Molosiwa, Secretary for Economic Affairs
Grace Muzila
B. Mooketsi

MINISTRY OF LABOUR & HOME AFFAIRS

K. Mosienyane, HIV/AIDS Coordinator
M. Mosele, Immigration Department (FP)
P. A. Mokgete, Senior Registration Officer
Salalenna G. G. Phaladi, National Museum, Monuments and Art Gallery

MINISTRY OF TRADE AND INDUSTRY

Mr L. Dimbungu, Principal Industrial Officer

PRIVATE SECTOR

Mrs Tsetsele Fantan, Debswana

MINISTRY OF LOCAL GOVERNMENT

Mr B. Sentle, DPS

AIDS COORDINATING UNIT

Dr G. P. Obita, Unit Head
Dr Paolo Craviolatti, Policy Adviser
Dr San San Myint, Policy Adviser (UNDP)
Mrs N. Mabua,Policy Advisor, CHBC
Ms Dudu Macha, US, Policy Advisor
Mr Peter Makhala, Dept of Social Welfare

DISCIPLINED FORCES

BOTSWANA DEFENCE FORCE

Lt Ditsela
Ms Batlang
2nd Lt Tiroyamodimo

BOTSWANA LOCAL POLICE

Moses Mhateng
Kesolofetse Setlhong

BOTSWANA POLICE

Mr K. L. Gabaake, Coordinator
B. Ratsatsi
M. Tshwaane
P. Monareng
Mrs. Rauwe
Mr. Mojabe
Mr. Monekwe
Mr. Mack
Ms. Nkau

BOTSWANA PRISONS AND REHABILITATION SERVICES

Mrs L. N. Semelamela, Focal Person
Ms E. Balang
Mr E. Tsimako

CIVIL SOCIETIES/NETWORKS

Mr. J. Mafusire, BONEPWA
Mr. Westgard, Total Community Mobilisation (TCM)
Anneke Visser, COCEPWA
Christine Stegling, Director, BONELA
Mr Daniel Motsatsing, Dierctor, BONASO
Stephen Ssebaggala, UNV BONASO

ARV PROGRAMME

Dr Ernest Dacko

ACHAP

Mrs L. Mpotokwane

UNVs (ASU)

Grace Karugaba
Michael Kiwombojjo
Fortune Chibamba

KGALAGADI SOUTH DMSAC (TSABONG)

Valela David, Council Secretary, DMSAC Chairperson
Olebogeng Mogajane, Tribal Admin
Nomphelo Obuseng, Chief supply Officer
Obusitswe Mariping, DAO No.9 Botswana Police
Mompati Mowoggwe, Officer in charge, DRTS
Kedibonye Toto Inspector, Local Police
Masego Ngwato, Land Board, Tel: 6540253
Susan T. Motsamai, AIO**,** Integrated Field Services
Bayei Motsamai, Tsabong Prison
Amos Ramokate, Wildlife Dept
Vivian Makuku, AEA, Non-Formal Education
Allan Mbuya, Tsabong Primary Hospital
Malebogo N. Lekoko, Trade & Consumer Affairs
Keolopile Moapare, Culture and Youth
Isaac Koogotsistse, Elections
Selina Sethibang, DHT
Mabebe Ralekgobo, DHT
Judith Thobane, Food Resources Division
Oratile K. Maswe, Meteorological services
Ajelitha Sampson, Tsabong Primary School
One P. Tapologo, BOCAIP
Rev. J. Jagtet, Lekgotla la Baruti

CHOBE DMSAC (KASANE)

C. T. T. Magowe District Commissioner, DMSAC Chairperson
M. B. Othomile, Wildlife
P.O. Jeremiah, PAO
Tjazha Lekone, ACS
W. Chimiri, Culture & Youth, Box 338 Kasane
A.M Shamukuni, Roads, Box 12 Kasane
O.G. Morale, Customs, Box 211 Kasane
M. S. Setlhare, OC Local Police, Box 343 Kasane
L.A. Masole, DLO, Box 57 Kasane
B. Masonya, Cooperatives, Box 222 Kasane

P. Tsebekgele, DABS, Box 14 Kasane
P. Radithupa, DEMS, Box 101 Kasane
C. Nfila, DCA, Box 349, Kasane
O.J. Mlalazi, SAEA Non Formal
Dr. G. Mwaipopo, PMO Kasane Hospital
L.D. Mogaetsho, Animal Production
B. Mapholo, Prisons Dept Kasane
V.O. Jonas, Dept Road Transport & Safety
Lulu N. Dipao, Panda Met. Services
Kgomotso Masole, Revenue Accountant General
G.G. Mbaiwa, MET. Services
D. Serero, ASO II Forestry CP&F
M. Chilimba, DOA
B. Dikgobe, Education
K. M. Chingabe, Police
J. P. Mazhani, Police
M. Mothomogolo, Immigration
K. K. Inko, Water Affairs
M. Tirelo, Kasane Primary School
M. Chalashika, Prisons
W. Chimiri Culture & Youth
L. N. Dipao, Meteorology
M. Ranko Kasane, Public Library
C. D. Magodu, IFS
B. Mookiemang, Supply
Phenyoyaone K. Dithobolo, Labour
E. Pelaelo, WildlifeKavimba

KAVIMBA VMSAC

Mr Masul,e Chief
Masego Tirelo, Kasane Primary School
W. Chimiu, Culture and Youth
H. Chika, Kavimba CHBC
P. Sumbikani, Police Officer
C. Simasiku, Police Officer

GABORONE DMSAC

Mr Kgosikhumo Gofhamodimo, District Commissioner, DMSAC Chairperson
Mrs Susan Mpe, CEO Botswana National Youth Council, DMSAC Dep Chair
Dr D. K. B. Malauka, PHS Gaborone DHT
Elizabeth Musoke, UNV AIDS Adviser

HOLY CROSS HOSPICE

Ms P. Maputle
Mrs P. Matome
Mrs Mangate

KGATLENG DMSAC

Mr W. S. Ongadile, District Commissioner, DMSAC Chairperson
D.M. Ramagaga, Regional In-service Coordinator
M.Molomo, Council Chairperson
P. Mphoeng, OC Local Police
George D. Thwane, Chairperson Men Sex & AIDS
G.G Tahla, Station Manager DWA
M. Barwabatsela, Principal Education Educator
M.V. Temane, Principal Education Officer
O. Phele, Pastor
A.E Van As, Member of youth for Christ Botswana
T. E. Mphothwe, Snr Admin Officer Land Board
A.J. Maswabi, Ass Information Officer
F.J. Orman, Local Police
Linchwe, BBM Chairperson
S.D Makgatlhe, BBM Member
L. O. Mariri, AIDS advisor
Dr. G.G. Mbugua, Public Health Specialist, DHT
Gase Kedikilwe, DCHN
Irene S. Lebekwe, CHBC Coordinator
S.K Thathau , Ministers Fraternal
David O. Modisagape, Council secretary
V.K. Morebodi, NS, DHT

OODI VILLAGE EXTENSION TEAM

Boselo C. Ongadile, VET Chairperson
Margaret M. Chinya, DNFE, VET Secretary
Idah M. Koboyankwe PFWE
Nketso M. Raphutshe Police
Boikhutso J. Modise Police
Bertha Mogopodi, Driver

KWENENG EAST DMSAC (MOLEPOLOLE)

Mr B. Seitshiro, District Commissioner, DMSAC Chairperson

Laughter S. Kopi, Umbrella VDC
Grade Imoh, UNV AIDS Advisor
Sarah Seabelo, Boipoloko Group
Sheila O. Mokgwathi, SYO
Gloria Thagane, SAE, Non Formal Education
Mmonemang Matsebe, SIA BOPA
Masego Mogwera, Bookkeeping Officer, Crop Production & Forestry
B.M. Mosienyane, SWO, S&CD
J.N. Mazonde, Lecturer, IHS
Dikaelo J. Molatole, Education Officer, Molepolole Education Centre
O. Wakitso Matenanga, STO, Water Affairs
Dr. E.B. Ebyengonzi, CMO, Thamaga Primary Hospital
Olebogeng Tshedi, CHBC Coordinator, DHT
Ernest Molale, ASP, Prisons
Dr Moses K. Galakpai Public Health Specialist, DHT

LOBATSE DMSAC

Mr J. Nsala, Town Clerk, DMSAC Chairperson
Mr. B. Gaseitsiwe, Mayor
Dr S. Lanje, DMO Lobatse DHT
Dr Than Myint, UNV AIDS Adviser
S. Khubile, National UNV AIDS Adviser
Ms. R. Motlhagodi, District AIDS Coordinator
Ms. B. Sethibang, Tsholofelo Counseling and Support Centre
Mr. Matlhabaphiri, Lobatse Clay Works
Full DMSAC Membership
Bosele Support Group

ATHLONE HOSPITAL

Dr M. B. Mohammed, Chief Medical Officer
William Bapasi, Health Resource Centre
Winnie Metsing, OT, Health Resource Centre
Letsema Proctor, Health Resource Centre
Dorothy Keokgale, Health Resource Centre
C. Chepete,
Josephine Moabankwe,

SEROWE/PALAPYE DMSAC

Mr Letsholo, Assistant Council Secretary, DMSAC Co-Chairperson
Mr Changu Gulubane, District Officer, DMSAC Co-Chairperson
David Sediadie, National UNV AIDS Adviser
Mr Mokwaledi Mokwena, UNV House of Hope
BPC AIDS Coordination Committee
TCM Palapye

SEKGOMA MEMORIAL HOSPITAL

Dr P. F. Mwala, Chief Medical Officer
Mrs L. Mooketsi, Nursing Superintendent

ANNEX III

DOCUMENTS REVIEWED

1. Adupa R. L., 1999: *Mainstreaming HIV/AIDS in the Ministry of Local Government: Operational Plan January 2000 – December 2001.*

2. Adupa R. L., 2000: *Ministry of Local Government HIV/AIDS Prevention and Control: Management and Coordination Arrangements.*

3. Agelton P. and Parker R., (UNAIDS) 2002: *A Conceptual Framework and Basis for Action, HIV Stigma and Discrimination.*

4. Annan J. S. and Stegman P. M., 2000: *Mainstreaming HIV/AIDS into the Ministry of Labour and Home Affairs: A Situation/Response Analysis & Operational Guidelines.*

5. BONEPWA, 2001: *Annual Report, 2001 – 2002.*

6. Development Management Associates Consultants, 2001: *Ministry of Trade, Industry, Wildlife & Tourism: HIV/AIDS Coordination Unit.*

7. Development Management Associates Consultants, 2001: *Ministry of Trade, Industry, Wildlife & Tourism: HIV/AIDS HIV/AIDS Policy Guidelines.*

8. Development Management Associates Consultants, 2001: *National AIDS Council: Trade, Industry and Tourism Sector Committee: Mandate and Operational Agenda.*

9. GOB, UNDP, 2000: *An Impact Assessment of HIV/AIDS on Current and Future Population Characteristics and Demographics in Botswana.*

10. Government of Botswana, ASU (MOH), 1998: *Botswana National Policy on HIV/AIDS (Revised Version).*

11. Government of Botswana, NACA, 2001: *Botswana 2001 HIV Sero-prevalence Sentinel Survey Among Pregnant Women and Men With Sexually Transmitted Infections.*

12. Government of Botswana, National AIDS Control Programme (NACP 38), 1997: *Botswana HIV/AIDS Second Medium Term Plan (NTP II).*

13. Kempe H. and Gaborone S., 1999 (UNDP): HIV/AIDS in Botswana: A Situational and Response Analysis of the Town of Lobatse.

14. Kempe H. and Gaborone S., 2001: Botswana HIV/AIDS Strategic Planning for the Town of Lobatse.

15. Kinghorn A. Et al., 2001: *The Impact of HIV/AIDS on Education in Botswana.*

16. Molebatsi C. and Mguni B., 1999: *Kweneng East District Plan on HIV/AIDS: A Situational Analysis and Response Analysis.*

17. NACA, 2002: *Ntwa e Bolotse.*

18. UNDP, 2000: *Botswana Human Development Report 2000: Towards AN AIDS-Free Generation.*

19. UNDP, 1997: *The Mid-Term Evaluation Report of Programme (BOT/96/001): Support to the National AIDS Programme Conducted 17 May - 10 June 1999.*

20. UNDP and GOB ASU 2000: *A Report on the Monitoring Visits to the Districts, BOT/96/001 Support to the National AIDS Programme.*

21. UNDP and GOB, 1997: *Programme Support Document (BOT/96/001).*

22. UNDP and GOB, 2000: *Programme Support Document (BOT/96/001) Addendum.*

23. UNDP, GOB, and SIDA, (Oakwood Consultants), 2000: *HIV and AIDS Best Practices: The Experiences From Botswana.*

ANNEX IV

SCHEDULE OF VISITS FOR THE EVALUATION

PLACE	**DATE**	**TIME**
	MINISTRIES	
DPSM	04/09/02	8.30 AM
MLHA	04/09/02	14.00 HOURS
MLG	05/09/02	14.00 HOURS
MLG (PS/DPS)	06/09/02	8.30 AM (Tentative)
MOH	06/09/02	10.00 -12.30
MOE	10/09/02	14.00 HOURS
MFDP	12/09/02	8.30 AM
MTIWT	11/09/02	14.00 HOURS
	DISCIPLINED FORCES	
BDF	09/09/02	14.00 HOURS
BOTSWANA POLICE	10/09/02	8.30 AM
PRISONS	10/09/02	14.00 HOURS
LOCAL POLICE	11/09/02	8.30 AM
	DISTRICTS	
GABORONE	11/09/02	CONFIRMED
LOBATSE	13/09/02	CONFIRMED
MOLEPOLOLE	16/09/02	CONFIRMED
MOCHUDI	17/09/02	
SEROWE/PALAPYE	18/09/02	CONFIRMED
KASANE	23/09/02	CONFIRMED
TSABONG	26/09/02	

NGO`S

BONEPWA, BONASO & BONELA 09/09/02

NAME	DATE	TIME
Mr. R. Moaneng	07/10/02	09.00 hours
Mrs. C. Tetteh (UNDP)	08/10/02 (confirmed)	14.30 hours
Mrs. R.O. Mandevu (UNDP)	08/10/02	11.00 hours
Mrs. L. Matebesi (UNDP)	08/10/02 (confirmed)	09.00 hours
Ms. D. Tlagae (UNDP)	08/10/02 (confirmed)	10.00 hours
MS. K. Molosiwa (ASU)	10/10/02	08.30 hours
S.M. Chaba (UNFPA)	Will be out of the country until 21/10/02	
Tommy/Tanga (PSD Staff)	10/10/02 (confirmed)	10.30 hours
M.O.H. (Mr. Lesetedi)		
M.L.G. (Mrs. Mabua)	14/10/02 (confirmed)	14.00 hours
M.O.E.		
DC – GABORONE	10/10/02	09.00 hours
MTI/WT		
COCEPWA	07/10/02 (confirmed)	11.00 hours
CEYOHO (Ms. Basha)	10/10/02 (confirmed)	14.00 hours
NACA		
MOCHUDI (DC`S OFFICE)	09/10/02 (confirmed)	08.30 hours
BONEPWA		
BOTUSA		