BOTSWANA INSTITUTE FOR DEVELOPMENT POLICY ANALYSIS

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Report on the SADC HIV/AIDS and Governance Case Studies: Botswana

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Table of Contents

List of Abbreviations

ARVs:	Anti-retroviral drugs
BALA;	Botswana Association of Local Authorities
BIDPA:	Botswana Institute for Development Policy Analysis
BNSFHA:	Botswana National Strategic Framework on HIV/AIDS
CHBC:	Community Home Based Care
DMSAC:	District Multi Sectoral AIDS Committee
DLGSM:	Department of Local Government Service Management
GoB:	Government of Botswana
GCC:	Gaborone City Council
ISS:	Institute for Security Studies
KDC:	Kgatleng District Council
LTC:	Lobatse Town Council
MFDP:	Ministry of Finance and Development Planning
MLH:	Ministry of Labour and Home Affairs
MTP:	(I, II) Medium Term Plan
NAC:	National AIDS Council
NACA:	National AIDS Coordinating Agency
OVCPP:	Vulnerable Children Care Programme
PLWHA:	People Living With HIV/AIDS
PBRS:	Performance Based Reward System
PMTCT:	Prevention of Mother to Child Transmission
PSD:	Programme Support Document
SHHA:	Self Help Housing Agency

CHAPTER 1

1.1 Introduction

The Institute for Security Studies, (ISS) commissioned the Botswana Institute for Development Policy Analysis (BIDPA) to conduct a study on the Responses of the Public Sector to HIV/AIDS. This report is an assessment of the responses of the Gaborone City Council, Kgatleng District Council and Lobatse Town Council to the challenge of HIV/AIDS. The report examines the local government(s) activities, policies, structures and strategies of responding to the HIV/AIDS challenge as well as capacity constraints therein.

Councils as employers need to take the foremost role in responding to HIV/AIDS for their employees benefit. The other reason why councils are important in the national response to HIV/AIDS is they are in charge of most of the delivery of crucial services at local level and any change in their capacity could affect the delivery of such social and infrastructure services. Some of the statutory duties of the councils include the provision of:

- Primary health services
- Administration of primary education services
- Village water supply
- Waste management and sanitation services
- Construction and maintenance of rural roads
- Community and rural development
- Administration of Self Help Housing Agency (SHHA)
- Social welfare and,
- Labour intensive drought relief projects

This report follows the following format: Introduction, National Context, Institutional profile and context of each council, Impact of HIV/AIDS on the institution, the Extent of mitigating responses, and an Assessment of the effectiveness of the responses and Conclusions and recommendations

1.2 Aims of the Study

The aims of the study are to assess (i) the impact of HIV/AIDS on the local government service in Botswana, (ii) the ability of the councils to mitigate the impact of HIV/AIDS on the delivery of services by local government institutions and (iii) the ability of the councils to respond to the adverse effects of HIV/AIDS on their employees. The study attempts to achieve this aim through the following activities.

- Investigating where and how HIV/AIDS stands to impact most on institutions
- Investigating existing capacity and constraints to effective service delivery

- Investigating the extent to which institutions are able to implement appropriate mitigation strategies
- Investigating the extent to which such strategies have been implemented, and,
- Investigating facilitating factors, blockages, and constraints to implementation of the strategies

1.3 Methodology

In order to collect the information and data needed for the study, the research team followed a four pronged approach. First, the team interviewed members of the executive management of the councils; these included Chief Executive Officers and Heads of Departments on issues about what their departments were doing internally as a response to the HIV/AIDS challenge as well as the extent of the interventions. In total, twenty two interviews were conducted with executive staff members of the three councils. There was seven executive staff members interviewed in Kgatleng District Council, seven in Gaborone City Council and eight were interviewed from Lobatse Town Council.

The research team also interviewed one official from the Department of Local Government Management (DLGSM) which is the central government department in charge of personnel matters for local authorities, and the executive secretary of the Botswana Association of Local Authorities (BALA), which articulates the interests of local authorities[1].

Follow up interviews were conducted with the head of the National AIDS Coordinating Agency (NACA), members of the Ministry of Local Government AIDS Coordinating Unit as well as the HIV/AIDS Coordinator of the Ministry of Labour and Home Affairs.

The second aspect of the methodology involved circulating a self administered questionnaire among the general employees of the three councils. A total of sixty eight (68) of these were returned. This was done in order to cross-check the extent of agreement between executive management and the rest of the staff of the councils, in order to get an idea of whether the interventions employed by the councils are appreciated by all employees, who are the target group of the interventions.

[1] The BALA was formed in 1983 in order to strengthen decentralization initiatives in Botswana. It works among other things by promoting and strengthening local democracy, by providing advice and guidance to local authorities and through arranging training for councillors and officers to provide opportunities for discussing issues affecting Local Government. Information accessed at http://botswana.fes-international.de/Decentr.htm

The third aspect of the methodology involved collecting and collating personnel data. A questionnaire was distributed to the councils with the intention of gathering some human resources information on the councils dating back to over 5 years[2]. The data requested included:

- Number of official posts (over last 3 – 5 years)
- Number of these posts filled (over last 3 – 5 years)
- Demographic breakdown of staff (by age and gender)
- Number of staff in urban and rural locations
- Number of staff in each post by age and gender
- Number of deaths by post over last 3 – 5 years (where possible need to try and identify AIDS vs. non AIDS related)
- Number of retirements by post over last 3 – 5 years (need to distinguish between medical vs. old age retirement)

The fourth methodological tool used in the study involved inviting respondents of the study to a feedback workshop where they made comments on the draft report.

1.4 Limitations and Problems Encountered

1. The Department of Social Services in the Ministry of Local Government, which is the parent ministry, was originally targeted to be the central level agency to inform the study but did not have the data required for the study.

2. We encountered difficulties with the councils' data and information for the following reasons:

    - It was only two years ago that the councils were required by the DLGSM to compile staff lists. The staff lists provided did not have adequate information needed for the purposes of the study, for example, the Gaborone City Council does not have give information on gender, and the Lobatse Town Council's staff list does not give age of the staff members. However, lack of completeness of the councils' staff lists was the major impediment.
    - There is no reliable data required to give an understanding of staff movement, health and welfare. The data was inadequate at best, non-existent at worst for the years before year 2000.
    - Manpower planning figures at council level have not been kept in a systemized manner. It is only now that the DLGSM along with the councils are reconciling figures for staff establishment for the years prior to 2002/03.

[2] The personnel departments of the councils were meant to respond to this part of the study. Due to some of the shortcomings mentioned in the next section on Limitations and Problems Encountered, the same questionnaire was further administered to the DLGSM.

- There is generally a deficient personnel record keeping in the three targeted councils, for example, human resource databases are non-existent in all of the three councils

CHAPTER 2

2.1 National Context

Botswana has come to be one of the most affected countries in the world by HIV/AIDS. The government therefore responded by setting up institutions and policy mechanisms to mitigate the problem. The National Policy on HIV/AIDS is the government's major policy document on the national response. Besides the policy, there are numerous other initiatives which include policy statements, organizational entities and programmes that are aimed at prevention and mitigation. Added to that, Botswana's approach to management of HIV/AIDS has the benefit of devotion from the Office of the President with the president chairing the National AIDS Council (NAC).

2.2 The HIV/AIDS Situation in Botswana

On a per-capita basis, Botswana is the worlds' most affected nation as far as infection with the Human Immune- Deficiency Virus (HIV) is concerned (NACA, 2002, p ii) . This is the virus that causes AIDS. While Botswana's first known infection was discovered in 1985[3], Botswana has come to be the most affected country, leading the HIV/AIDS statistics in the world, with a sero-prevalence rate that now covers at least 36 percent of the adult population[4]. Since 1991 when sero-prevalence rates began to be systematically monitored, infection rates never declined in any consecutive years. Rather, the infections have been rising dramatically. A trend through the years shows growing rates of infection starting at 4.5%, in 1991 to 37.8% in 2002, without any decline in any consecutive years, but where the rates have tapered off somewhat after 2002[5].

Deaths due to HIV/AIDS in Botswana have risen. According to NACA (2001), crude mortality in Botswana has risen by 73.2% between 1995 and 1999 which is an increase of about 15%. HIV/AIDS meanwhile has been responsible for at least 20% of deaths by 1999. This is quite a big jump in causation since HIV/AIDS was the cause of only 10% of the deaths during the early stages of the epidemic in Botswana.

The factors that have led to the quick spread of infections in Botswana include; the high incidence of inter-generational sex, the low social status of women, the well developed road network and mobile population, ignorance and traditional myths about sex and the relatively high level of poverty, which constrains the choices that people can make, (UNDP, 2000).

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[3]Botswana's first case of HIV/AIDS was discovered in 1985, at least 4 years after AIDS was first recognized as a medical condition.

[4] UNDP 2000; p 9. Gaborone, Botswana

[5] AIDS/STD Unit: "Botswana Sentinel Surveillance Report, 2000" and NACA 2002.

2.3 *The HIV/AIDS National Policy Framework in Botswana*

Initially, public authorities in Botswana, as is perhaps the case in other parts of the world reacted to the HIV/AIDS pandemic as if it were entirely a medical problem. With the passing of time however, the response in Botswana became all-embracing, showing recognition of the problem as one with physiological, social, economic and cultural dimensions. Briefly, the problem and its impact are national and thus the response must be national in character.

2.3.1 The evolution of the National Response

Botswana's major official reaction to HIV/AIDS began in 1987, with the formulation of the country's Short Term Plan. The plan's implementation period lasted between 1987 and 1988. The plan's stated objectives were to:

- Strengthen the epidemiological surveillance activities
- Prevent sexual transmission of HIV
- Strengthen the diagnostic management and control practices

One of the criticisms of the STP was that it was highly restricted in scope and focus. While it focused on training public health workers on clinical management of HIV/AIDS as well as boosting public awareness about HIV/AIDS, the public awareness campaigns and information campaigns lacked sufficient quality and coverage (UNDP, 2000, P41). This was probably due to the then insufficient knowledge about the disease as well as the then smaller amounts of public funding allocated to fighting HIV/IDS.

2.3.2 First Medium Term Plan (MTP I), 1989-1997

In 1989 government came up with a document called the Medium Term Plan, which had the following three objectives:

- Prevent and reduce HIV transmission Botswana
- Reduce morbidity and mortality associated with HIV infection and AIDS
- Reduce the social and economic impact associated with HIV and AIDS

The major challenges of MTP I related to the lack of involving other partners such as ministries, donors' local government institutions and civil society organizations into the response. The rising levels of infection nationally meant that the Ministry of Health, which then was the national focal point of the response to HIV/AIDS, was not coping with the challenge.

Following on the review of this plan, some changes were introduced into the national response to HIV/AIDS. These changes, premised on the multi-sectoral response as evinced by the National Policy on HIV/AIDS augmented the institutional framework in the country that was to be tasked with leading the national response to HIV/AIDS.

2.3.3 The Botswana National Policy on HIV/AIDS

The policy came in 1993, as a more comprehensive response to an epidemic that was far-reaching in its consequences than first recognized. While the policy had some of the main objectives of the National AIDS Strategy as found in the MTP I, it aiso had a provision to mobilize communities and other sectors of the economy towards campaigning against HIV/AIDS. The policy's call for a multi-sectoral approach to prevention and mitigation of the epidemic is an innovation that has chailenged all in society to take a part in prevention and mitigation. Government and private sector organizations are actively between themselves forming alliances for prevention and mitigation while also having internal programmes for such. While it is a totally different question as to how well the policy is being implemented, it is a good base to build on for the national effort.

2.4 Current Responses: Medium Term Plan 11 and After

The national response is guided by the Botswana National Strategic Framework for HIV/AIDS of 2003-2009. The framework came about after the revision of the second Medium Term Plan (MTP II), which like BNSFHA follows government's six yearly national development plans. One of the findings of the BNSFHA on the review of the MTPII is that the MTPII went a long way to establish crucial institutions that are now at the forefront of leading the national response. The following are the institutions and strategies that were set up during the MTP II phase.

2.5 The Institutional Framework

The National AIDS Council (NAC) is the foremost advisory body to government on matters related to HIV/AIDS. The NAC is chaired by the President of Botswana with the Minister of Health as the deputy chair. It has oversight of the national response to HIV/AIDS as well as the major coordinating duties. The functions and responsibilities of the NAC are:

- Monitoring and coordination of implementation of programmes
- Ensuring effective monitoring and evaluation of programmes
- Ensuring of periodic review of MTP II and the National Policy on HIV/AIDS
- Strengthening capacity of implementation in relation to implementing MTP II objectives
- Commissioning of research studies

2.5.1 National AIDS Coordinating Agency (NACA)

NACA is the secretariat of the NAC. Organizationally, NACA is under the Office of the President, reflecting the urgency of the state's response to HIV/AIDS. Some of the functions of NACA are:

- Policy and programme development
- Strengthening of institutional level at national, district and community levels
- Monitoring and evaluation of programmes and strategies at various levels

- Resource mobilization for implementation of programmes at all levels

2.5.2 The Ministry of Health (MoH)

Being the ministry in charge of public health issues, the ministry is the lead implementing organization in matters related to mitigation of HIV/AIDS. The MoH runs most of the public health infrastructure ranging from the country's major hospitals to the clinics in the country. Included among these are the country's major hospitals, like the Princess Marina Hospital in Gaborone and the Francistown based Nyangabgwe Hospital. The ministry is also the major employer of most career health personnel whose expertise is crucial to the care and treatment aspects of the national response to HIV/AIDS.

2.6 Involvement of External Agencies

Government's HIV/AIDS policy recognizes the necessity of mobilizing the entire society for activities related to prevention, care and mitigation of HIV/AIDS. In this regard, Botswana has attracted a number of external players who have come in to the HIV/AIDS response with different mandates. As coordinator of the national response, NACA is also in charge of coordinating the activities of these. Some of the major external organizations involved in the national response in Botswana and what they do in the national response are presented below (BNSFHA 2003)

2.6.1 African Comprehensive AIDS Partnerships (ACHAP):

ACHAP is involved in several facets of the national response including: the Safe Blood Project, Behaviour Change Communication Strategy Project, Condom Marketing and Distribution, Anti-retroviral programme infrastructure development, anti-retroviral programme implementation project and scaling up of laboratory capacity in Botswana

2.6.2 Department for International Development of the government of the United Kingdom of Great Britain (DFID)

DfID is involved in several activities including: Sexually Transmitted disease management, condom accessibility, behaviour communication and small grant schemes

2.6.3 Swedish International Development Agency (SIDA)

SIDA is involved in the support of Adolescent Reproductive Health

2.6.4 United Nations Development Programme (UNDP)

The United Nations Development Programme is involved in projects spanning prevention and care. Some of the specific activities include: assistance with the establishment of the National HIV/AIDS helpline through the National AIDS programme and support to NACA on the implementation of the Information, Education and Communication project. On care related activities, the UNDP supports the PLWHA (people living with HIV/AIDS) through its programme PSD.

2.7 *Some Programmatic Responses to HIV/AIDS*

Government, sometimes in partnership with external agencies has come up with several programmes as a way of responding to the HIV/AIDS challenge. Some of these programmes such as the National Anti-retroviral Programme were pioneering in nature. This programme came about at a time when most sub-Saharan African governments were complaining about costs of such therapies or else questioning the viability of such undertakings.

2.7.1 National Anti-Retroviral Programme

In order to mitigate the physiological, psychological, social and economic effects of HIV/AIDS on the country's PLWHA, Government of Botswana (GoB), made a commitment to provide free antiretroviral drugs, (ARVs) to the country's more than 300 000 HIV positive citizens if their viral load necessitated that[6]. The access to ARVs is not only free, it is universal. Despite this, only 9,000 of an estimated 300,000 HIV positive people in Botswana have enrolled for the national ARV programme.

The uptake of the drugs has been hampered by the lack of testing by citizens because in order for one to access the drugs, they not only have to be proven to be HIV positive, their CD4 count also has to be of the level that allows them to access ARVs. The fear of stigmatization is the problem suspected to lead to reluctance to test by many in Botswana. The government has introduced routine testing for patients attending public health facilities as a way of encouraging enrolment in the ARV program[7]. However, such patients have to give their consent to such testing.

2.7.2 Prevention of Mother to Child Transmission

Botswana has embarked on a supply of medications aimed at preventing the mother to child transmission of HIV. Pregnant women with HIV can enrol into a free programme of using medication that can help prevent their unborn children from contracting HIV. Since one of the common modes of transmission of HIV is through the passing of the virus from the mother to the child during pregnancy, this is an important intervention in preventing the spread of HIV.

Since 1992, Botswana has been monitoring the prevalence and infection rates of HIV through sentinel surveys of women attending ante-natal clinics. Results of these surveys are extrapolated to give an indication of the prevalence rates nationally, (NACA and others, 2003, p 1). The women thus tested however retain the right to be told their HIV status.

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[6] Agence France Presse, Botswana to provide free AIDS drugs; S. Africa maintains "no". Accessed at URL: http://www.aegis.com/news/afp/

[7] : Routine HIV Testing Initiative in Botswana Aims To Get More People Into Treatment Program Accessed at: http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=1&DR_ID=20767

2.8 *Macro Issues Relating to Public Sector Context*

In Botswana, the public sector consists of ministries of government, parastatal organizations, the Teaching Service Management, the Directorate of Local Government Service Management. The central government aspect of the public sector has a manpower establishment that grew in size from 72803 posts in 1997 to a total of 77277 posts in 2002/03. This represents an annual increase of 1.3% in the sector attributable to pressures due to an increase in projects, underestimation of manpower plans by departments, accommodation of returning graduates and new posts created in the ministries due to Organization and Management reviews.

CHAPTER 3

3. Institutional Profile and Context of the specific Institution

The Institutional Context of Local Government in Botswana

District and Town Councils which are referred to as local government are part of the service delivery system in Botswana. Currently, there are 15 councils in Botswana. Of these, there are six urban councils and nine rural councils. The councils are in charge of service delivery and represent the geographical spread of service provision across the country. The District Councils Act of 1965 is the enabling legislation that establishes District Councils, while the Town Councils Act of 1965 establishes the urban councils.

While government is committed to effective service provision, the councils in Botswana continue to show many of the afflictions demonstrated by the councils in the rest of Africa. Compared to central government agencies, the councils are under-resourced, both in terms of human and financial resources (BIDPA, 2001, Picard, 1987).

The HIV/AIDS Challenge for Local Authorities

HIV/AIDS brings to the local government structures an added burden of new services, demands on their budgets and their human resources. The rise in number of orphans and PLWHA who will need medical attention at the council run primary health facilities are two of the examples of how HIV/AIDS brings on added demands to the councils. Ultimately there are added demands on the councils' service delivery capacity. Local government personnel as the agents of development planning and implementation need to be healthy to give sufficient service. As such, another way in which the pandemic would affect the councils is by the negative consequences of poor health that will lead to poor output at work.

To date however, there is no comprehensive study of how HIV/AIDS will affect local government agencies. It is certain though that certain adjustment have had to be made as a direct result of HIV/AIDS. One such adjustment is the call for more capacity to take care of the burgeoning number of orphans due to HIV/AIDS.

For instance, the 1999/2000 Establishment Register for Botswana Local Authorities allocated personnel to all the councils, creating new posts in order to help "implement and sustain the Community Home Based Care (CHBC) Programme for AIDS patients". The establishment register also makes the promise that "the distribution of coordinators will follow" (GoB, 1999, p 155).

The councils in Botswana are a crucial link in the state's objectives of bringing social, economic and infrastructure development to the population. Councils are

important for two primary reasons in so far as the national response to HIV/AIDS is concerned: as employers, they have the duty of taking the lead in HIV prevention and mitigation for their employees. Councils as employers have to create a favourable working environment that addresses the issue of risk and vulnerability of employees to HIV/AIDS. When these are met, employees are better placed to address the mandate of the councils. Various policy documents on HIV/AIDS in Botswana emphasize that the challenge of HIV/AIDS in Botswana necessitates a multi-sectoral approach to national response, and since organizations are at the forefront of this response, employers like local governments are important parts of the strategy, (MoH 1993, UNDP, 2000).

The health of their employees who are the agents of development activities is of importance to the rural and urban populations who look up to the councils for the delivery of services. Capacity for mitigation therefore becomes very important if the personnel of the councils are to be functional and bring about the much needed service delivery. It is also the case in Botswana that the councils are among the major players for the district level HIV/AIDS response. It is therefore important that capacity for response is built within the council for them to be effective as role players and leaders in district level response.

It is however widely accepted that local governments' programmes in general are under funded; their personnel are not as well trained compared to their central level colleagues and councils severely lack for implementation capacity; (Phirinyane and Kaboyakgosi, 2001, p 8). Where such bottlenecks transcend into personnel matters, as in the prevention and mitigation of HIV/AIDS, it can have reverberating effects which include poor service delivery.

With the mandate for governing at a local level, councils have had to redirect some of their manpower, towards the caring of orphans due to HIV/AIDS. For instance, with the realization that most hospitals are now overwhelmed with patients in Botswana, community home based care has been encouraged by government as a way to alleviate the patient load at the hospitals. Councils therefore have to assign some of their nurses to CHBC. Essentially, because they are closer to the majority of the people, councils are being called upon to extend their meagre resources to caring and mitigation as is the case in the orphans programme and the CHBC.

In total, local governments employ 25072 people in the first quarter of 2004. Of all these, 22% come from the three councils of Gaborone, Kgatleng and Lobatse. Gaborone employs 3262 people; Lobatse employs 1023 while the Kgatleng District Council employs 1249 people. These totals include both permanent and pensionable staff as well as industrial class staff.

Of the three local governments, Gaborone is the largest, in terms of population size, with a total of 186,007 people counted as living in Gaborone or its surroundings in 2001 census. There were 91,823 males and 94,184 females. The

Lobatse Town Council, which is one of the oldest local authorities in Botswana, had a total of 29,689 people in 2001. 14,202 of them were males while 15487 were females. The Kgatleng District had a population of 73,507 people in 2001. Males accounted for 35725 while females were 37,782. It can be surmised therefore that there were more females than there were males living in the three local authorities in 2001. In total, there were 290,000 people living in the three local government jurisdictions, making over about a third of the total national population.

The Botswana National Strategic Framework for HIV/AIDS (BNSFHA) recognizes the importance of councils in the coordination of the district level response. However, it also gives credence to the criticism mentioned above; basically that capacity to implement programmes is somewhat lower in the councils, as evidenced by poor coordination of activities. Of the three councils, the area under the jurisdiction of Gaborone City Council was the highest hit in terms of sero-prevalence. Gaborone had prevalence of 38.3% of the population, which is slightly above the national average of 38.5%, Lobatse has a sero-prevalence rate of 34.6%, and Kgatleng had prevalence rates of 30.9%. All the jurisdictions have functional DMSACs in their respective jurisdictions.

CHAPTER 4

4.0 Impact of HIV/AIDS on Local Authorities

The United Nations Joint Programme on AIDS, UNAIDS presents HIV/AIDS as a human security threat in that it adds to the strain on state institutions and resources, causes provision of essential services to falter (damaging the state's legitimacy), leaves orphans vulnerable to different circumstances including being lured into the military in conflict situations, and has a potential impact on the rule of law due to attrition rates among staff serving in justice institutions[8]. Thus, HIV/AIDS poses a threat to governments' capacity to enhance socio economic development as it, among other problems, reduces productivity and quality of services provided by government. By causing provision of essential services to falter and damaging the state's legitimacy, HIV/AIDS "can contribute to social disruption and perhaps civil unrest, which invariably hurts the most vulnerable sections of society" (ibid).

In this chapter the study assesses the impact of HIV/AIDS in Gaborone City Council, Lobatse Town Council and Kgatleng District Council. The assessment of HIV/AIDS in councils sought to answer five major questions, namely; whether attrition (deaths, retirements, absenteeism, sick leave, etc) has increased over the past few years; to establish the impact of HIV/AIDS on the demand for services; to establish the impact of attrition on the ability to supply services; whether employees see HIV/AIDS as a problem to their institution; and lastly, to identify who the interviewees see as particular groups exposed to contracting HIV and the reasons for that.

Answers to the questions presented above were gathered through face to face interviews with Heads of Departments of the various councils, as well as Chief Executive Officers and their deputies, and leaders of agencies directly dealing with Local Authorities in issues related to personnel management, capacity building or HIV/AIDS. These include the Botswana Association of Local Authorities and the Department of Local Government Service Management. We also circulated a self administered questionnaire was circulated among employees of these councils. These are employees who are not in executive management (i.e. not Heads of Departments nor Chief Executive Officers).

4.1 Attrition

Attrition is a loss of employees in an organization through resignation, retirement, death, morbidity, ill health and absenteeism for reasons other than annual leave[9]. Attrition is not always a result of HIV/AIDS. However, it is believed that an increase

[8] UNAIDS Fact Sheet 2002

[9] ISS (2003) HIV/AIDS and Attrition: Assessing the impact on the Safety, Security & Access to Justice Sector in Malawi and Developing Appropriate Mitigation Strategies.

in the rate of infections and in the number of people living with HIV/AIDS has a great potential to increase and dominate causes of attrition. HIV/AIDS related attrition is mainly evident through increased ill health, absenteeism due to sick leave[10] and funeral attendance and death (ibid).

One way of measuring HIV/AIDS related attrition is to measure HIV/AIDS – related mortality, HIV/AIDS related absenteeism and sick leave. Data obtained from DLGSM on the three measures is limited. It gives the number of deaths and retirements by post in the selected councils only from 1999 to 2003. Because the DLGSM did not compile such data on them, this data does not include the industrial class workers who are perceived as the most affected by the majority of Heads of Department who were interviewed. The industrial class workers may even account for the majority of councils' employees. Table 1 below shows the different attrition rates by type on in the three councils.

Table 1: Attrition by death in the three councils: 1999-2003

NUMBER OF DEATHS BY COUNCIL:1999-2003						
	1999	2000	2001	2002	2003	Total
Council						
Lobatse	1	1	3	1	2	8
Gaborone	5	10	3	5	0	23
Kgatleng	4	2	2	0	2	10
Grand total						41

Of the three councils under review, the GCC is the one with most deaths. It is however difficult to say what percentage of the staff has died over the last 5 years because of the issue of non-presence of complete staff lists for the councils.

Table 1a: Attrition by retirement in the three councils: 1999-2003

Number of Retirements by Council 1999-2003						
Council	1999	2000	2001	2002	2003	Total
Lobatse	1	1	1	0	4	7
Gaborone	4	6	9	5	3	27
Kgatleng	6	7	4	3	1	21
Total						55

Tables 1 and 1a both prepared by Ms. R.C. Tema-Department of Local Government Service Management
Note: These deaths and retirements are only for the permanent and pensionable staff; hence they exclude industrial class workers.

Like Table 1 above, Table 1a does not give conclusive evidence on the situation of attrition due to retirement in the three councils for the years 1999-2003. This is

[10] Authors addition

basically because it gives details on retirement strictly due to old age. Data was not available on early retirements either due to illness or any other reasons or according to staff categories.

To have conclusive evidence of the rates of attrition at council level would require the availability of quantitative data on the number of deaths, sick leave and absenteeism over a period of time from these councils. Attempts were made to get this information but it has become clear that poor record keeping as well as failure to specifically follow and measure HIV/AIDS related attrition in these institutions have made the task of measuring the trends in attrition very difficult. For example, Table 1 above gives attrition by death and retirements from the period 1999-2003. However, the table fails in that it does not give attrition by death and retirements in relation to age and gender.

In order to compensate for this inadequacy in data, the study employed a qualitative measure and asked those in executive management positions in the councils if they have noticed an increase in attrition due to HIV/AIDS. This is in essence more of a perception question since disclosure of HIV/AIDS as a course for attrition is the prerogative of the employees. However, executive management are best suited to respond since they are in charge of personnel issues and councils management as a whole. The research therefore adopted the qualitative measure and used responses from interviews with management teams in these institutions and agencies, as well as data from self administered questionnaires.

Almost all the executive management staff interviewed stated that attrition has increased over the last few years. In Gaborone alone, all the interviewees agree that attrition has increased significantly. The City Clerk reported that due to good medical facilities in the city, a lot of employees in rural councils prefer to be transferred to Gaborone. This has resulted in a complicated situation, with the council having to operate with lots of sick people. The representative of the Department of Local Government Service Management concurs with this view and states that they have even received complaints from the City Clerk on the matter. By implication, neither the GCC nor the other councils who lose employees to GCC end up benefiting from the situation. Those councils other than GCC whose employees transfer to Gaborone for reasons of wanting to be near better medical facilities end up losing employees, while the GCC ends up with staff members who are operating at below full potential due to illness.

From the interviews, it appears that the most commonly reported types of attrition are absenteeism and sick leave. In the department of Architecture and Buildings at Gaborone City Council for instance, the Head of Department estimates that on a given week at least 10% of staff are on sick leave. The Principal Environmental Officer reports that though his department has a total of 500 employees, approximately 35% to 40% of these employees are not necessarily on duty on any given day but in clinics and at home because they are sick. The head of Social and

Community Development stated that in the past two years his department lost at least ten people to death and currently they are nursing a good number and absenteeism is quite high[11]. The Engineering department is experiencing almost a similar problem and the Chief Engineer reports that death has increased in his department and they lose at least two people to death every month.

Attrition is not the only manner in which the councils could feel the impact of HIV/AIDS. The other impact of HIV/AIDS on the councils could be financial. This is bound to be felt more on the long-term investments that councils make on behalf of their employees: pension funds. In Botswana since 2000, all employees of the public service are required to contribute to a public officer's pension scheme. The essence of pension funds in the public service is that they are premised on the expectation of each employee contributing to the fund for about 25-30 years of employment. The scheme entitles employees to 20% of their salary upon retirement. Government contributes 15% while the employees contribute 5%. Early exits and resultant withdrawals mean that the funds which depend on long-term investments are faced with the challenge of early withdrawals and hence interfering with the maturing process of the investments.

Another manner in which the public service will be impacted financially is through the granting of leave. According to the General Orders Governing Conditions of Service of the Public Service of the Republic of Botswana (1996)[12], civil servants (a category which includes local and central government employees) are entitled to leave in the following conditions and extents. In any period that an employee may on medical grounds seek to be away from work, the following apply:

- Up top six months on full pay
- Any vacation that the employee has to his credit
- Followed by up to six months on half pay

The General Orders however do have some exceptions to the above stated rules such as the following:

- Officers are not eligible to sick leave prior to their retirement
- Sick leave applies strictly to the officers. It may not be requested for purpose of attending to family members illness

The General Orders also have a provision that covers employees who are new in the service and might not have accumulated the requisite 6 months. This dispensation is referred to as Special Leave and it is granted to officers who have no leave due to them or where such leave is insufficient to cover the period requested.

[11] In the years 2002, 2003, the S&CD had about 117 staff posts established for permanent and pensionable staff. On this information, and assuming that the department had a 100% establishment, ten people dying would constitute about 17% of the staff. However, the head of S&CD has pointed out that

[12] This document sets out the basic principles of public service and acts as a guidance manual for officers, both in their relationship with other colleagues and with the client public, (General Orders, 1996, p3).

However, certain conditions apply in this case, such as the fact that if such leave exceeds 10 days (including weekends), then it is treated as unpaid leave. This means that the officer concerned is not remunerated for the days of absence. Such leave does not count in the officers' favour calculation of pension and gratuity.

In Kgatleng District Council, five of the seven Heads of Departments interviewed stated that there has been a significant increase in attrition. In Lobatse, the Town Clerk stated that absenteeism is chronic. In this Council, the Heads of Department report more increases in absenteeism and sick leave. Only in the department of Environmental Health did the Head of Department report deaths, and stated that her department lost only six employees in 2003 even though she cannot attribute any of the deaths to HIV/AIDS due to the limitations placed on reporting causes of deaths. This figure makes for seven (7) percent of the total (83) number of employees in that department for the year 2003-2004.

Interviews were supplemented by a self administered questionnaire circulated among the general staff members so as to compare the perceptions of the general staff membership to that of the executive management of the respective councils. Results from this process show that overall, in all the surveyed local government institutions; attrition is perceived as a problem by staff members of the councils.

Overall, 75% of the respondents indicated that attrition was a problem for their local government. However, 21% of the respondents felt it was not a problem, while 4% indicated that they did not know. The responses differed by personnel cadre. In the management cadre 80% of those who responded thought that attrition is a problem. This compares with the 81% of the administrative cadre who responded. However, the technical cadre responded evenly in both respects with 43% of the technical cadre who responded indicating that attrition was a problem while another 43% also thought it was not. The rest of the staff (14%) thought it was not a problem.

To shed more light on whether HIV/AIDS was indeed a problem, a question was posed to the respondents: "did you have to do additional work due to the absence of a workmate?" This question can be used to substantiate claims that absenteeism is a problem. Where employees have to stand in for others due to extended absenteeism it can be inferred that HIV/AIDS is a problem. However such inferences can only be indicative.

Overall, 65% of the respondents indicated that they have had to stand in for a colleague due to absence. For lack of substantive reasons for the cause of absenteeism, though, the reasons could include resignations, illness, vacancies due to transfer which were not filled on time and retirements among other reasons and not necessarily HIV/AIDS.

In the management cadre, 50% of those who responded indicated that they to stand in for an absent colleague as were 66% of administrative staff and 71% of the technical cadre. The emerging picture here is that the different staff cadres have experienced attrition levels to differing degrees, and that there are differing demands on the need to cover up for absentee employees. For instance, the technical department appear to be requiring their employees to stand in for absent colleague (at 71%), signalling perhaps both the specialized nature of the job and the high rate of attrition therein.

It is thus apparent that if attrition is to be measured by the indicator of the number of employees who had to temporarily stand in for others, then the situation is quite severe, judging from the 65% of employees who had to stand in for colleagues.

4.2 Impact of HIV/AIDS Related Attrition on the Demand for Services

The impact of HIV/AIDS can be felt in two ways by organizations. First, the HIV/AIDS epidemic adds more responsibilities to councils through a number of new programmes such as Prevention of Mother to Child Transmission, Orphan and Vulnerable Children Care Program , Provision of Anti Retroviral Drugs in clinics, Community Home Based Care Programmes and provision of counselling to the HIV/AIDS infected and affected to name a few. However, one has to note that this affects mainly two departments, namely the Department of Health and Social and Community Development. This in essence is an increase in the demand for services provided by councils. See table 2 below showing responses by general staff members on the perceived impact of HIV/AIDS on the demand for the services provided by the three councils.

Table 2: Perceptions on the impact of HIV/AIDS on the demand for services by general staff members

Impact of HIV/AIDS	Percentage
No impact	8.8
Small impact	17.6
Moderate impact	26.5
Large impact	41.2
No response	5.9
Total	100

Overall, about 85% of employees which is a considerable majority of council employees feel that HIV/AIDS has a small to a large impact on the demand of the services of the councils. Only about 9% feel it has no impact while abut 6% had no response to the question. The employees however differed only on the extent of perceived impact[13].

[13] The figure 85% is found by adding the percentages of employees who rated the impact of HIV/AIDS in the "small impact", "moderate impact" and "large impact" categories.

These responses are quite in consonance with what has happened at council level in the response to HIV/AIDS. Due to HIV/AIDS, new mandates were added to the council's responsibilities. For instance, the 1999 Establishment Register for Local Authorities created new posts for different staff categories to assign them to the Community Home Based Care Programme. Other programs which have led to the establishment of new posts and oftentimes requiring new competencies include the Orphan and Vulnerable Children Care Programme (OVCP), the Prevention of Mother to Child Transmission (PMTCT) program and the Tuberculosis (T.B.) prevention programme. In exception of the OVCP which is a social welfare function, the competencies required for the other programmes such as PMTCT, ARV program or the T.B. programme are in the scientific/medical professions. Botswana has always had scarcity of human resources in this fields and it is highly likely that the situation would have been made worse by the human resource demands due to HIV/AIDS.

With the new programmes as evidence, it is definite that HIV/AIDS has added some new dimensions to the demands for the services of the councils. From the perspectives of the councils, some of the programmes such as PMTCT as directed from the centre have not been supported adequately with personnel allocations. This suggests that the posts recommended in the Establishment Register or at least a sizeable portion of them have not been met.

A major constraint in proving this issue is the lack of conclusive data. However as Table 2 above shows, the majority of non-executive management staff in the councils feels that the new demands for new services do definitely have an impact on the capacity of the councils to deliver. This is not surprising in that the councils, as indeed Botswana as a whole has always experienced difficulties in recruiting personnel in the science/medical professions. The demand for new services has definitely exceeded the supply of personnel required to carry out such tasks.

HIV/AIDS also affects councils' human resources who are essentially the providers of the services demanded by the public through ill health. Since HIV/AIDS related attrition and the demand for services are reported to be on the increase in the councils, then the employees are vulnerable. An issue of interest therefore is whether these institutions will be able to cope based on the circumstances that obtain. Table 3 in the next section shows the responses on the perceived impact of HIV/AIDS on the ability to provide services.

4.3 Impact of Attrition the Ability to Supply Services

In this section, the study reports on the impact of HIV/AIDS related attrition on service delivery. Specifically, the study investigated the impact of this form of attrition on the ability of these councils to supply services they are responsible for. Two sets of information gathered are used, namely, information from interviews

with Heads of Departments and information from general staff membership gathered through self administered questionnaires.

From the interviews conducted with the executive management of the councils, the impact of HIV/AIDS related attrition is perceived as negatively affecting the three councils. In section 4.1 and 4.2 we have observed from responses that attrition has been increasing in these councils. Mainly, it is reported that there is significant increase in absenteeism and sick leave. From the respondents' perspectives, these increases in attrition have led to the following:

Low productivity levels in almost all departments in all the councils resulting from such problems as absenteeism, people working few hours, while others are on light duty (redeployed to less demanding tasks for health reasons) and hence being unable to do the duties they were employed to do. However, it is important to point out that the perceived productivity decline cannot be attributed to any single factor, iet alone HIV/AIDS because other issues such as low pay, low staff morale, perceived slow training opportunities and losing employees to other sectors of the economy including central government could be contributors.

Some of the councils departments are overwhelmed with responsibilities because while some of their employees are unable to perform their duties without being compromised by serious health problems, those without ailment are left with the burden of doing the work of others, hence probably causing stress due to being overworked.

There is poor service delivery because of delays due to shortage of readily available staff. Where service is provided in some instances, it is delayed and of poor quality. As an example, the Head of Department of Social and Community Development in Gaborone reports that at times, his employees make appointments with their clients and then fail to honour these appointments because of sickness.

Table 3: Perceptions on the impact of HIV/AIDS on the ability to provide services by general staff members.

Impact of HIV/AIDS	Percentage
No impact	8.8
Small impact	25
Moderate impact	23.5
Large impact	36.8
Don't know	5.9
Total	100

From table 3 above, only about 9% of the general staff respondents' believe that HIV/AIDS will not have any impact on the councils' ability to provide services. The rest of the respondents, save for 5.9 who stated they "don't know" felt that it will have an impact. However, the perceptions on the magnitude of the problem varied

across the different staff categories. About 37% felt HIV/AIDS will have a large impact on the councils' ability to deliver services. Still among the general staff respondents, 24% thought such impact will be moderate while a slightly higher number, 25% thought there will be a small impact on the councils' ability to provide services due to HIV/AIDS.

From the foregoing, it shows that the general staff members as do the executive management members are in agreement that HIV/AIDS has an impact on the councils' ability to supply services.

4.3 Perceptions on Particular Groups Exposed to Contracting HIV

A question was asked those to members of executive management teams and representatives of agencies relating to the groups that are exposed to contracting HIV/AIDS and why. Responses to this question point to a number of groups that are seen as the most vulnerable. This information could help in assisting authorities target the most vulnerable groups in the councils by developing more relevant interventions.

From the interviews, there emerges a general consensus that industrial class workers are particularly exposed for the following reasons; they have low levels of educational attainment, which in turn means their level of understanding on a lot of things in general, and HIV/AIDS in particular could be low. In Botswana, this could be particularly true as levels of HIV infection have been found to be inversely proportional to educational attainment, where the higher the educational attainment of a social group, the lower the risk of infection, (NACA, CDC and ASU, 2002). Their low incomes status also means they are unable to meet their basic needs hence indulging in activities that could compromise their health, low levels of hygiene, low levels of nutritional status and high indulgence in alcohol among other factors mentioned. Other groups that were deemed as exposed groups include health workers due to the nature of their work; the youth because they are sexually active and over indulge in alcohol consumption and lastly drivers due to the nature of their work that requite frequent trips.

Despite the perceived risk factors of the employees mentioned here, there was no notable targeted intervention by management to meet the specific needs of the employees who are perceived to be overexposed, meaning that whatever measures exist are not institutionalized, nor tailored to the needs of those perceived to be highly exposed to infection as a result of their work commitments.

CHAPTER 5

5.0 The Councils' Mitigating Responses

This chapter details responses by the three councils in the management of the HIV/AIDS challenge in the local authorities' institutions in the study. It focuses on six (6) specific issues. In section 5.1 the study deals with issues of HIV/AIDS policy framework. In particular, the study sought to find out if these institutions concerned have a specific organizational HIV/AIDS policy or document outlining how the organization deals with and manages HIV/AIDS. Section 5.2 deals with the question of the institutional structures designed specifically for coordinating activities. The study sought to find out what these structures, (if any exist), actually do in so far as HIV/AIDS is concerned, their reporting mechanisms as well as the powers they have. Sections 5.3 and 5.4 of this chapter assess the existing HIV/AIDS Prevention, Care and Support programmes and their activities respectively, and who is responsible for their implementation, their target groups and the extent to which these programmes have been implemented. Section 5.5 deals with the important issue of HIV/AIDS budget. Section 5.6 deals with issues of management of attrition in the councils.

District Multi-Sectoral AIDS Committee (DMSAC)

The DMSAC is a district level organization that coordinates HIV/AIDS activities. Its functions are to:

- Articulate priority areas of the response at district level
- Translate national response strategies to district level ones
- Liaise with NACA on issues of institutional capacity strengthening at district level
- Mobilize resources for implementation of activities by the various district levels in all sectors of the economy including public, and non-governmental

The other duties of the DMSAC include facilitating the development of a multi-sectoral annual HIV/AIDS Action Plan, supporting local level capacity building for implementation and coordinating strategic implementation partnerships across sectors. The work of DMSAC is largely at district level in nature and scope. Through DMSAC, all districts and sub districts have developed district missions and actions for the next six (6) years.

Composition of the DMSAC and its Relationship to the Councils

The composition of the DMSAC gives an obvious indicator of the influence that the structure is meant to have. The DMSAC is made up of all high ranking district officials, including the Members of Parliament for the district. The composition of the DMSAC includes:

- District Commissioner and Council Secretary (co-chairpersons)
- Members of Parliament in the District
- Council Chairperson or Mayors
- Principal District Medical Officers (secretaries)
- Heads of Department of social welfare, education, health, labour, agriculture
- Private Sector and Non Governmental Organisations

A point to make about the councils as they relate to the DMSAC is that councils are the service providing bodies at a local/district level and as mentioned in the introductory chapter; their mandate covers health, education, major infrastructural works and other important functions. Because of that, the majority of the activities that are initiated by the DMSAC are implemented by the councils. For instance, such activities as PMTCT and Orphan Care are carried out by the DMSAC. This also means that programs like PMTCT which are implemented by the councils are budgeted for as part of the DMSAC activities, where the councils are however the mandated implementing organs.

Overall, it appears possible that councils end up with a situation where, for their status as implementers of government programs at local level, implement nationally determined programs, to which they could have had little or no input at conceptual stages. Their situation of having no policies, programs nor strategies aimed specifically at alleviating the HIV/AIDS situation on their own employees is attributed by councils to this latter role of being implementers; in other words, the councils are so dedicated to improving the lives of the average citizens that they do not have time to come up with strategies of lessening exposure to and impact of HIV/AIDS on their own employees in the workplace.

5.1 Institutional Policy Framework for Dealing with HIV/AIDS

This study investigated whether Gaborone City Council, Lobatse Town Council and Kgatleng District Council have institutional HIV/AIDS policies or documents outlining how HIV/AIDS is dealt with and managed. It also examined if the document (s), if any, are known and accessible to all the employees, and lastly, the study investigated the extent of implementation of the policy if it existed. All the interviewees and those responding to the self administered questionnaire were asked to respond to these questions.

From interviews with Executive Management Teams of the three councils the study found that despite the existence of the national policy for HIV/AIDS, district level strategies such as the Medium Term Strategic Actions and structures like the DMSAC, none of the participating councils has developed its own workplace policy for managing HIV/AIDS. In Gaborone for instance, it is expected to be developed soon. In Lobatse meanwhile, those interviewed made a lot of reference to the national policy framework but this framework is not specific in so far as managing HIV/AIDS in the workplace is concerned. The existence of an institutional policy

framework does not only show the seriousness accorded to dealing with this epidemic (as was stated by the Deputy Council Secretary in Kgatleng District Council), but also serves as a guide to dealing with issues of attrition such as perpetual absenteeism and continued sick leave.

While the existence of a national framework as a guide is commendable, it is however flawed since it does not give specific guidelines on how to deal with HIV/AIDS in the workplace. It appears that the lack of a workplace policy at council level could be attributable to any one or all of the following reasons:

- Capacity constraints to draft the policies
- Perceptions of the lack of necessity of one, relying on the national policy
- Confusion of the national policy with local initiatives internal to the councils

While management teams from all the participating councils state that they do not have institutional policies designed for dealing with HIV/AIDS, it is inaccurate to state that nothing is happening in these institutions concerning HIV/AIDS mitigation. It is clear that both the national and district policy frameworks somewhat influence what obtains in these councils through NACA and DMSAC. This means that implementation of these policies runs across almost all institutions at local level including councils. This explains to an extent, the apparent confusion among the general members of staff. From our analysis of their responses, there are significant numbers of them who state that these organizations have an HIV/AIDS policy document and that they have actually seen it. See table 4 "Knowledge of existence of a policy document by general staff membership" below.

According to the BNSFHA, the Ministry of Local Government through its primary organs of implementation, the councils, is "responsible for providing care and support services to families affected by HIV/AIDS, ensuring needs of orphans, vulnerable children through Community Home Based Care (CHBC) and Orphans and Vulnerable Children (OVCP) Programmes and also mainstreaming HIV/AIDS into District Development Plans.

While the BNSFHA allocates the said work to the Ministry of Local Government, the primary implementing organizations at that level are the councils since they are the ones with the mandate, technical know-how, organization and budget at district level as well as infrastructure to carry out these tasks.

Table 4: Knowledge of existence of a policy document by general staff membership

HIV/AIDS Policy	Yes (%)	No (%)	Don't know (%)
Existence of policy document	51.5	30.9	16.2
Seen policy document	38.3	52.9	2.9
Has the policy been disseminated	25	42.6	5.9
Has the policy been implemented	36.8	19.1	27.9

With the knowledge that the councils do not have a policy document, the one plausible interpretation for employees saying they have actually seen one in so large numbers is that most of them probably mistake the national policy document to be the same as their respective councils'. Similarly, a significant number (25%) say that actually the policy has been implemented. If this is meant to say that they know that some type of programme aimed at alleviating HIV/AIDS has been implemented, then this is consistent with the notion that though the councils lack workplace policy documents on HIV/AIDS per-se, that is not to say they do not have anything in place, however ad-hoc to address the situation.

With regard to creating formal internal structures, policies and strategies to address the HIV/AIDS situation, there is an admission that not much has been done in that direction by the councils. Councils cite the fact that they are service oriented organizations, whose primary mandate is to serve their constituents. However, the DLGSM are currently discussing draft guidelines which will be sent to the councils to give indicators on how to form internal HIV/AIDS committees. These will apparently guide the councils on some of the following:

- Duties and responsibilities of the committees
- Duties and responsibilities of individual staff members with regard to the functions in the committees
- External linkages for the committees

Together with the DLGSM, the councils are also in a process of formalising the modalities through which the councils will submit periodic data to the ministry on human resource matters. This data will give indicators of the well-being of the staff members. The data will be expected to include information on all types of leave taken, including sick leave and absenteeism for monitoring and evaluation purposes.

Possible Way Forward For the Councils: An Example from the Ministry Of Labour and Home Affairs

While the councils have not come up with their own formal policies, strategies and structures for mitigating HIV/AIDS in the workplace, an example of such a response from the Ministry of Labour and Home Affairs in Botswana (MLH) is presented in the box below.

Response to HIV/AIDS in the workplace: A case study from the Ministry of Labour and Home Affairs

The objectives of the HIV/AIDS Committee of the ministry (the committee was founded in 1998) include development of the HIV/AIDS workplace policy which as stated above is in draft stage, provision of supportive counselling for the affected and infected workers, management and mitigation of the impact of HIV/AIDS at work as well as promotion of confidentiality and elimination of stigma and discrimination related to HIV/AIDS. Among its achievements, the ministry points out to the formation of the Ministerial AIDS Advisory Committee (MAAC), the training of about 14 HIV/AIDS Counsellors as well as training 14 HIV/AIDS Peer Educators.

The Ministry of Labour and Home Affairs is one of the Government of Botswana ministries with an HIV/AIDS coordinator. To date, the ministry has a draft policy on HIV/AIDS in the Workplace. It covers among others, Rights and Responsibilities of employees and the employer, Prevention, Treatment, Care and Support, Occupational Benefits and Compensation, Risk Management, First Aid and Compensation. What is interesting about the policy is also that the ministry does not duplicate some of the nationally existing programmes; instead it works to complement them. For instance, on Treatment, Care and Support, the policy statement points out that the ministry will "create a conducive environment that will encourage HIV-infected employees and their dependents to voluntarily submit to public assistance programmes such as the PMTCT, Voluntary Counselling and Testing, Antiretroviral therapy, CHBC, TB Treatment and the Orphan Care Programmes.

As part of their drive to raise awareness and reduce stigma related to HIV/AIDS, the ministry also recently held a voluntary HIV testing campaign. As part of the day's activities, there were testimonies from two citizens, not employees of the ministry though, living with HIV/AIDS on how to live positively with HIV. However, the main achievement of the day was that about 25 employees of the ministry were mobilized to test themselves for HIV. 320 had actually indicated willingness to test, but due to staff constraints by the testing centre professionals and also that it takes longer to counsel a person coming to test, only the 25 mentioned were able to test.

Sources: Interview with **K. Mosienyane** (HIV/AIDS Coordinator, MLH): the **Botswana Guardian** February 27th 2004, **MLH Workplace Programme**, MLH **(Draft) Policy on HIV/AIDS in the Workplace**

5.2 HIV/AIDS Coordination at institutional level

Mitigating responses of HIV/AIDS also requires that institutions develop policies, strategies and structures to specifically deal with HIV/AIDS issues. It was therefore the intention of the study to investigate the existence of such structures in the three councils. This sub-section is therefore an analysis of responses on the question on whether the councils have a structure or individuals responsible for coordinating HIV/AIDS related activities within the institutions, and what these individuals, if any, do and lastly where they report to.

In the previous subsection, we indicated that there are national and district structures designed specifically to address the HIV/AIDS epidemic. Care must be taken to avoid confusing these structures with what this study intended to find out. We must treat these structures as separate from the institutional ones for the simple reason that the two aforementioned structures prominent at local level; national and

district level structures in existence have a scope not specific to the council as a workplace.

This study found out that though Gaborone City Council does have an HIV/AIDS committee, the committee is not well coordinated according to the city clerk. As a result, the committee has not been effective and hence the recent recruitment of an HIV/AIDS Coordinator. It is envisaged that the coordinator will be the focal person for HIV/AIDS related activities at council's level, thus his or her duties will be to coordinate the activities of the committees as well as giving regular updates to the council secretary. The office of the HIV/AIDS Coordinator is new and evolving. One of the responsibilities of the Coordinator is the development of an HIV/AIDS Policy in the workplace. Even though we report of an existing structure, it is important to note that there is confusion with a lot of employees who confuse the national and district structures with the institutional structures.

In Lobatse and Kgatleng there are no institutional structures set up to deal with HIV/AIDS related responses in the workplace. The Lobatse Town Clerk stated that there is a structure existing in the council even though it is not strictly internal. The structure, though located inside the council is meant to be a liaison structure, linking the council's DMSAC representatives with the DMSAC. The Council has an AIDS Committee coordinated by the Senior Health Education Officer. While the committee has trained two HIV/AIDS Coordinators, who are responsible for training their colleagues on HIV/AIDS response related issues, some in the management team state that it is difficult to tell what its mandate is. The committee reports to the Town Clerk, who then reports to the DMSAC. The absence of a structure however does not stop departments to develop their own at departmental structures. It has emerged that most of departments have developed their own structures at departmental level as an initiative of the heads of department. For instance, the department of Environmental Health has a compulsory meeting every Friday where they invite outsiders to address its employees on HIV/AIDS issues.

The absence of institutional structures is partly due to the existence of district level structures which are housed and implemented through these councils, meaning, as stated earlier that the DMSAC, is only but a coordinating agency at local level, where the councils are the primary agencies of program implementation. The Health Department in these institutions is responsible for among other things, primary health and health programmes that are directly a result of HIV/AIDS such as Home Based Care, HIVAIDS, Prevention of Mother to Child Transmission (PMTCT) and others. According to the matron in Kgatleng District Council, these responsibilities have given management and employees the impression that something is being done in their councils. It is also important to note the responses from the two matrons interviewed, who agree that councils' employees and management do not seem interested in dealing with HIV/AIDS issues resulting in a situation where everything that needs to be done is delegated to the health department. In the perspectives of the matrons, this, to an extent shows that the

attitude of employers and employees, that of viewing HIV/AIDS as an entirely health matter rather than a disease with deep socio-economic and political implication has not changed.

5.3 HIV/AIDS Prevention Programmes

One of the major emphases on dealing with the HIV/AIDS epidemic in Botswana is prevention of new infections. To this end, a number of prevention programmes and activities have been implemented both at national and district level. In this sub section we are responding to the broad question which asked respondents to whether their institutions have any kind of workplace programmes that deal with preventing HIV/AIDS. Specifically, the study wanted to find out the key activities of such a programme if it exist; who is responsible for implementing the programme; the group targeted by this programme; and lastly, the extent to which the programme has been implemented.

From interviews with the management teams of the councils, the study found out that all these councils are engaged in some form of HIV/AIDS prevention activities. Prevention activities are varied ranging from condom distribution, workshops where presentations on prevention are made, HIV/AIDS rallies and distribution of information pamphlets and brochures. However, the most common activity taking place is condom distribution, with condoms being placed in both male and female toilets. Interestingly, going for HIV tests features in the activities under prevention, as some among the executive management respondents believe knowing ones status, especially if they are HIV negative encourages one to remain negative. Those that test positive are encouraged to avoid infecting those closer to them. During HIV/AIDS workshops and seminars, employees are always encouraged to avoid contracting HIV/AIDS.

Responses from the general staff membership show that in relation to prevention of HIV/AIDS there is more emphasis on condom distribution. See table 5 below.

Table 5: Prevention activities undertaken

Prevention Activity	Percentage
Condom distribution	45.6
Workshop on HIV/AIDS	29.4
Presentation on HIV/AIDS	16.2
Distribution of brochures/pamphlets	4.4
HIV/AIDS awareness drives/rallies	1.5
No activity undertaken	2.9

Condom distribution is the most commonly occurring of the above activities. In each of the councils, condoms are placed in the toilets (both male and female) so that employees can pick them as and when they need them. The councils have different people for ensuring constant supply: the personnel offices make requests for the councils from the district health offices which are then distributed to the

various council departments. Employees' responsibilities are to report when the supply runs out anytime in the councils.

The workshops on HIV/AIDS and presentations happen less in the councils for the reason that they demand more time of the employees. It was reported though that the workshops and presentations are presented in such a manner that they target different groups. For instance, the drivers who do a lot of travelling and thus could be exposed to risk are reported to be some of the groups which are targeted more through these. However, all groups can make an application to the DMSAC (through the council) for funding for any of the activities. In a given year, the various groups of employees have up to two workshops.

The other activities such as distribution of brochures happen at different paces and frequencies. In the Gaborone clinics, the brochures for PMTCT are given out at the clinics freely. Pregnant women going for their first ante-natal visits are given these. There are also posters posted on the walls on the same subjects. Otherwise, the public at large get these mostly when there are activities such as National AIDS Day, PMTCT Awareness drives. In other words, such times when the brochures are distributed are to the general public are linked to specific activities/themes coming mainly from the nationally determined campaigns.

From table 5 above, it appears that the councils are very strong on prevention as witnessed by condom distribution 46% and presentation on preventing HIV/AIDS (16%). Together, both activities were recognized as existing by 62% of the employees. A good sign though is that only 2.9% of the employees thought that nothing was done in relation to prevention. Knowing that preventative measures are the best way to stay away from infection, the council's strategies are commendable, more so because of the diversity of the programmes shown above.

5.4 HIV/AIDS Care and Support Programmes

Based on the rate of infection in Botswana over the past years and responses from interviews with management teams of the councils on the impact of HIV/AIDS in these institutions, one is of the view that there is a need to carefully look into issues of HIV/AIDS Care and Support Programmes with a view to strengthen them so as to make them responsive to the potentially rising needs of employees due to illness. The previous chapter shows that attrition in councils has increased, and that a good number of employees are on sick leave. On the other hand one has to take note of the fact that these councils are still expected to deliver as per their mandates despite the obvious stress placed on employees due to illness.

A key question that has to be asked in relation to these issues therefore is; what are councils doing in relation to their sick employees? To respond to this question, the study investigated the existence of workplace programmes that deal with caring for or supporting their employees with HIV/AIDS. In specific terms, the study sought to

identify the key activities of the programme; those responsible for their implementation; and the extent to which the programme has been implemented.

Activities under the care and support programme include but are not limited to the following; voluntary counselling and testing, support counselling, provision of treatment, activities to reduce stigma, compassionate leave for people with HIV/AIDS. These are activities that were investigated in this study through a self administered questionnaire. Table 6 below shows the most common activities in the three councils.

As for the management teams, we asked if their institutions have a workplace programme that deals with caring for and supporting people with HIV. This was an open ended question and as a result a number of activities have been cited. One major finding of this study relating to provision of care and support programme is emphasis made on knowledge of one's HIV status. Most of management team members believe that an effective programme would be dependent on this information since in order for people to access the nationally provided ARVs and the attendant counselling on time, knowing one's status early is prerequisite. It was suggested by many respondents that rather than absenting oneself due to ill health, one could talk to his or her supervisor and confide their problem so that appropriate action can be taken. It is however important to note that not many people would declare their status, thereby making intervention strategies even more difficult. While no studies have been carried pout as to why people do not test for HIV, most suggestions point out that the fear of stigmatization once it becomes known that a person has HIV.

In Gaborone City Council for instance the following activities are undertaken; encouraging people to go for HIV/AIDS test and counselling, home visitation by colleagues including Head of Department, some departments such as the Environmental Department at the Gaborone City Council have a daily prayer every morning in all their depots because they believe that can go a long way in raising the level of awareness about HIV/AIDS. They also encourage employees to enrol in the Anti Retroviral Programme, and unfortunately two of their employees died while in the enrolment process. According to the City Engineer, in their department they emphasize that it is important not to pressurize sick employees to deliver as much as when they were healthy, and while this impacts on their ability to deliver effectively and efficiently, they have to be seen to be compassionate by their employees. He cited that some of their employees can only afford to work for two to three hours in a day instead of the stipulated eight. Compassion is therefore important but one has to note applying this kind of 'policy' is at the sole prerogative of the head of department.

In Lobatse, there is more emphasis and faith on the spiritual kind of support. The Council employees are encouraged to attend the daily morning session where prayers are held for the infected and the affected. They also encourage home

visitations for the sick. The department of Environmental Health however, has its own complimentary programme which entails a departmental meeting every Friday where among others things, they encourage staff to test for HIV and also inform them about existing programmes that could assist them in case they are HIV positive such as the provision of AR Vs. The Head of this department has indicated that as a result of these meetings, a number of employees have confided to them about their HIV status.

From the interviews we conducted, it appears that the home visits are properly targeted not to interfere with the work schedules of the employees. Firstly, the visits are not compulsory as they are conducted by heads of departments, as and when their schedules allow. In this sense, the councils do not lose lots of working time to visits.
About 30% of the general staff membership either did not know about the existence of the treatment programmes or thought that none existed. Table 6 below shows the response to the question on knowledge of the existence of care and support programmes based at the councils.

Table 6: Knowledge of council based care and support programmes by general staff membership

Care & Support Programmes	Percentage
No programme	17.6
Voluntary Counselling	35.3
Support Counselling	29.4
Provision of treatment	1.5
Don't know	11.8

A few clarifications about the above table are in order. The voluntary counselling, support counselling and provision of treatment alluded to above are not provided by the councils to service their employees needs as the councils do not as yet have such strategies. Rather, these come about as part of the councils implementation of their mandate as determined by the national government to alleviate the HIV/AIDS situation in their jurisdictions. Such efforts take place in the government clinics, which are run by the Ministry of Local Government through the councils in the entire country.

The implementation of the national anti-retroviral program began in four sites in Botswana. These were Gaborone, Serowe, Francistown and Maun. Rolling out the program entails not only delivering ARV capsules/tablets to those who need them. Other prerequisites include training the counsellors and establishing laboratory capacity for testing.

The national ARV programme is still on schedule as planned. In 2003, six more clinics were opened in other centres of Molepolole, Jwaneng, Kanye, Mahalapye, Tutume and Orapa. By the end of fiscal year 2004/05, the project anticipates the establishment of ten more sites in the country. Thus, one challenge to the program

is that the roll-out, though it was planned as such, was made to begin from certain areas (strategically central to serve the whole country), and slowly reach other areas. Another of the challenges though is the lack of capacity, demonstrated through poor NGO capacity, shortages of trained personnel, poor project management skills and lack of qualified counsellors, all which are national in character and scope. In places where it is fully operational, the programme offers pre-test and post counselling, testing for HIV antibodies as well as viral load tests.

From table 6 above a considerably high number 29.5% do not know about the existence of a programme. Thus this means that employees do not know about the existence of programmes either because they are not aggressively marketed (consider the 64.7% who know about voluntary counselling and support counselling) or perhaps because there is little interest on the part of employees or perhaps, due to the lack of existence of policies on HIV/AIDS, such activities are not necessarily linked to HIV/AIDS interventions.

HIV/AIDS Budget

Effective management of HIV/AIDS requires adequate financial resources. The study investigated four critical questions relating to HIV/AIDS budgets in the three councils. Specific questions that were asked in relation to the budget issue included the following; how much money does the budget (if there is any) consist of, and what proportion of the councils' total budget is it? From what sources does this money come from? What are conditions associated with accessing this budget? And lastly, how easy is it to access or use the money?

Only members of Management Teams in the three councils responded to these questions. The reason for this is that only executive management personnel are better placed to be knowledgeable about budgetary matters where such undertakings are in place.

From the interviews, it emerges that none of these institutions has a specific institutional HIV/AIDS budget for activities such as the employing of HIV coordinators in the councils and prevention activities targeted specifically at council employees. However, we noted that in Lobatse reference was made to a savingram from the Ministry of Local Government which had just been circulated instructing all Heads of Departments to develop HIV/AIDS departmental budgets for the next six years. This development could be indicative of movements towards instituting internal measures aimed at alleviating the HIV/AIDS situation in an approach internal to the councils. The process of developing the budgets was ongoing during the interviews. The Lobatse Town Clerk and the Head of Department of Social and Community Development intimated that their activities have all along been funded by DMSAC. This is not surprising bearing in mind the fact that even the policy framework and prevention activities in these councils are mainly trickling down from DMASC.

After interviewing the Ministry of Local Government HIV/AIDS Coordinating Unit, it emerges that the reason why it might appear that the councils do not have "HIV/AIDS" specific budgets is due to a national attempt to mainstream HIV/AIDS into development planning in the country. Budgeting that includes mitigating HIV/AIDS has to be all inclusive so as to include HIV/AIDS in the entire development planning process and not simply target HIV/AIDS, a factor that might make the disease appear to be out of the confines of the development discourse. For instance, mitigation programs which the councils perform as part of the national response such as PMTCT, Orphan Care Program and the provision of ARVs and related costs such as transportation, human resource development, procurement of medical supplies and other expenses related to mitigation of HIV/AIDS are included in budgets that are presented to NACA. This means that it is very unlikely to have a budget with the appearance of HIV mitigation though money will certainly be allocated for such activities.

What has emerged concerning funding for HIV/AIDS is that the councils are requested to write their proposals for funding, which they then submit to their respective DMSACs. Thereafter the proposals are routed to the MLG HIV/AIDS Coordinating Unit[14], which then sends them to NACA after review. After their own scrutiny, NACA sends them to the MFDP.

It however emerged that sometimes there could be delays in the funding of the projects as requested by the councils emanating from the fact that the proposals have to undergo lots of bureaucratic checks (from council-DMSAC-NACA-MFDP) before funding allocations are made. Further delays in the process are added by the practice of having to await all districts to submit their proposals before they are all finally submitted to MFDP. All this means that districts that submit earlier often feel punished by the delays caused by late submission by other districts.

5.6 Policy Framework for Managing Attrition

In this subsection we investigate whether the three councils have a policy framework for managing the impact of attrition. A number of questions were posed to the respondents relating to this subject, such as whether there are information sharing practices, shadowing of employees in key posts, multi-skilling of employees and training plans. Care must be taken here because some of these practices have been practiced before the HIV/AIDS problem in the institutions, but the study seeks

[14] The Ministry AIDS Coordinating Unit has several roles to play in the Ministry's response. They include planning, monitoring and evaluation (PM&E), counseling and other related activities and functions. It is staffed by the AIDS Coordinator and personnel responsible for the functions mentioned above such as PM&E. As a ministerial unit in the ministry responsible for the councils, the MLG-MAC is responsible for coordinating the activities of the councils and by extension the implementation activities of the DMSAC since the councils are the major implementing organs of the DMSACs. It manages the linkage between the (national) HIV/AIDS plan and the multi-sectoral district-level HIV/AIDS plans.

to find out if there are deliberate policies for managing the impact of attrition resulting from the HIV/AIDS pandemic.

It emerges from the interviews that there are no deliberate policy guidelines for managing the impact of attrition on the functioning of these institutions. As stated by the Lobatse Town Clerk, there is a provision to employ people on temporary basis, but that depends both on whether they suit the needs of the councils and on the level of skill required for the post. A different picture though emerges, when talking to Heads of Departments, whose preferred solution is to move their people around if and when they are faced with serious problems of attrition. This seems quite widespread from responses of the general staff membership. See table 7 below that demonstrates the employees' response to the question on their readiness to take up duties other than those they were trained for.

Table 7: Levels of ability to respond to attrition by employee cadre and job type

Type of activity for managing attrition	Yes	No	Don't know
Whether the org. encourages employees to do jobs outside their trained areas	63.2	30.9	4.4
Whether if administrative level is absent from work others can step in	89.7	4.4	5.9
Whether if technical level is absent from work others can step in	77.9	5.9	13.2
Whether if management level is absent from work others can step in	86.8	7.4	4.4

From table 7 above, it appears that most employees have indeed, at one point or other in their tenure at the local government institutions been encouraged to do duties other than those for which they were trained. Overall, 63% of the employees who responded indicated that they had been called on to do jobs outside of their areas of competence.

In the various staff categories, 90% of management staff was called on to do so while 64% of the professional level carder had the experience. However, the technical cadres do not get opportunities to do work outside their competencies as compared to the other cadres as only 53% of technical staff indicated that they had not had an opportunity to do jobs outside areas for which they were trained. This is perhaps due to their job requirements that are more specialized in nature.

It is worth noting though that the above measures have always been part and parcel of the councils and did not come about directly as a response to HIV/AIDS. Another such response mechanism which could lessen the strain on the councils due to HIV/AIDS related attrition is outsourcing or contracting out of jobs done by the councils. While this is done as part of the councils in carrying out the privatization policy, it would go some way in reducing possible strain o the council human resources, at a cost iess than that incurred by the councils.

CHAPTER 6

6.1 Conclusions

From the discussions with the respondents of the study we conclude that:

- Botswana's response to the HIV/AIDS epidemic is national in character and scope; hence there is a sound policy and institutional framework that is evident at national district level. However, councils as employers do not have HIV/AIDS specific policies.

- In relation to the need by councils of HIV/AIDS workplace programmes, the following issues emerged:

  - Councils have delayed developing their workplace programmes due to the fact that they are service organizations. As a result, they are mostly focused on serving the needs of their clients which often take priority over other internal initiatives.

  - Councils are unanimous in the need for own workplace HIV/AIDS policies. They pointed out that these policies would be tailored to reflect the specific situations facing the councils such as the different social amenities, for example, hospitals in the geographical jurisdictions of the various councils.

  - However, the view of NACA was that perhaps there could be too much duplication if each council was to run its own internal policy. NACA pointed out that the national policy framework gives good guidance, including for instance, the need for non-discriminatory hiring policies.

  - While councils also pointed out to their need for HIV/AIDS coordinators, NACA's view was that due to the prevailing budgetary constraints and vacancy freezes at national level, the district HIV/AIDS coordinator might probably be utilized to include (internal) council needs.

- Councils continue to serve as vehicles for district development. For this reason, their existence plays a
  very important role in the development of lives of citizens hence they are must be seen as relevant and crucial.

- HIV/AIDS has certainly added to the councils responsibilities. The introduction of new programmes such as Anti-Retro-viral drugs, Prevention of Mother to Child Transmission, and the Orphans Programme are some of the additional responsibilities.

- It is difficult to measure the impact of HIV/AIDS related attrition in the three councils targeted for this study for a number of reasons. Firstly, poor keeping of personnel related information in the councils makes it difficult to measure the impact of HIV/AIDS in the councils. Secondly, these institutions have not yet started measuring HIV/AIDS related attrition. However, interview accounts with executive management in the councils indicate that there is an increase in the number of deaths and absenteeism due to illness in the councils. It is not conclusive though that HIV/AIDS is the cause for this rise. The increase in attrition is reportedly impacting on the councils' ability to supply services.

- The three targeted councils do not have internal workplace policies for managing the HIV/AIDS responses. Most of the activities being undertaken come from the national and district level campaigns through NACA and DMSAC. However, in relation to prevention, some activities are undertaken, especially condom distribution. Care and support is ad-hoc as it appears these are dependent on the head of any given department, who can encourage staff to visit sick employees and encourage staff to go for HIV/AIDS testing. Other than that, employees depend on national initiatives.

- The three targeted councils do not have budgets specifically for HIV/AIDS activities. However, they are in the process of developing six year budgets, with each department being encouraged to submit a departmental budget.

- The lack of existence of policy documents in the councils does not mean that there are no initiatives to mitigate HIV/AIDS at council level. Such programmes exist, though in a disjointed, uncoordinated fashion and the scope of activities in the programme is defined by the leaders at council's level; for instance, some council emphasize spirituality in their programmes where prayers are held daily at work.

- While respondents in executive management point out those industrial class employees are more exposed to HIV/AIDS, the councils have not developed specific mechanisms to deal with the specific challenges facing such employees.

- There are no policies specifically designed to manage HIV/AIDS related attrition. However, these councils have initiatives such as development of training plans but these were not developed in response to the challenge of HIV/AIDS. Rather, they came about as normal councils human resource management exercise.

6.2 *Recommendations*

- There is need for institutional specific HIV/AIDS policies in these councils.

- HIV/AIDS prevention campaigns in the councils must take into account the different needs of their employees due to the diversity of their employees.

- It appears that the councils have always had some measures of managing attrition. While this is commendable, the councils must be assisted to institutionalize some of these approaches to be more beneficial as mitigating strategies against HIV/AIDS.

- With the computerization of human resource departments process ongoing, we recommend that the process be finalized and that councils use a standardized system that will be able to track relevant human resources data

- The HIV/AIDS committees as they exist in the councils need to be strengthened, by allowing them to meet regularly.

- The post of council HIV/AIDS coordinator must be created and filled for all the councils. An alternative however is for the councils themselves to take own initiative in filling the posts where resources permit, as happened at GCC.

- With the above recommendation in mind, councils, as must all other institutions, mainstream HIV/AIDS in their development planning activities. However, care must be taken not to make HIV/AIDS a "special case" in a way that will further propagate the stigma attached to it as an intractable social problem. Some of the ways recommended by the stakeholders, including the HIV/AIDS Coordinating Unit at the MLG include:

    - Set up Employee Assistance Programmes (EAP) in the councils which will also include HIV/AIDS counselling. This will help people to access help easier, unlike when one might shy away from visiting the HIV/AIDS counselling services because it is obvious when they visit such offices why they are going there for HIV/AIDS related matters which might detain people from accessing necessary help

    - Councils could also broaden the mainstreaming exercise through attaching delivery on HIV/AIDS part of public sector reforms such as the Performance Based Reward System (PBRS). For instance managers can be rewarded on how well they implement HIV prevention programmes.

    - Broaden the target of the HIV/AIDS prevention programmes by involving the families of the employees of the councils. For instance, a male

employee could be encouraged to inform his wife/partner of the PMTCT programme being run by the councils. Another example is to encourage employees to teach their own teenage children about condom use where possible.

- Where possible, the transfer policies of the local government service must ensure that spouses of the people within the service must be transferred together to similar locations

- In order to increase the involvement o f males in the response to HIV/AIDS, the councils workplace programmes on HIV/AIDS must encompass sexual harassment clauses, and have equal numbers of males involved in activities such as counselling

- Local governments need to be involved in planning activities such as doing the needs assessments for their own HIV/AIDS response strategies. Central government's role therefore will be to support this.

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