CHAPTER FOUR

Case study 1: Local councils in Botswana

KEY FINDINGS

- Despite a national policy and implementation framework that tasks public sector institutions with mitigating the effects of HIV/AIDS on their staff, local councils have yet to begin formalising an internal response to the epidemic.

- Although detailed human resource data could not be obtained, the age and gender profile of council employees suggests that staff are susceptible to contracting HIV.

- Managers report that attrition—in the form of employees taking sick leave and, to a lesser extent, dying—is on the increase. Most lower-level staff (74%) felt that absenteeism, illness, and retirement on medical grounds were problems in their organisation, while the same proportion felt that HIV/AIDS was a problem in their institution.

- The epidemic is increasing demand for services and hampering their supply. As implementers of the government's antiretroviral therapy (ART), VCT, tuberculosis and community home-based care programmes, the councils have had to take on additional functions and develop new competencies—often in the absence of sufficient human and financial resources. At the same time, the epidemic is exacerbating capacity constraints, resulting in delays and reduced professionalism.

- Despite recognising these problems, councils' focus is on addressing HIV/AIDS in the wider community. In the absence of clear guidelines, relatively little has been done to address the impact of HIV/AIDS on either staff or institutional effectiveness.

- None of the councils systematically gather information on either the HIV/AIDS prevalence levels within their workforces or the impact of the virus on their capacity to deliver. The Ministry of Local Government (MLG), however, is putting in place an information system which will require councils to periodically submit information on key human resource indicators for monitoring and evaluation purposes.

- None of the participating councils have an HIV/AIDS policy and lacked clear guidelines for managing HIV/AIDS in the workplace.

- It was also clear that the co-ordination of HIV/AIDS activities is not entrenched. Of the three councils, only Gaborone city council had established an HIV/AIDS co-ordinating structure, in the form of an HIV/AIDS co-ordinating committee. Guidelines are being developed to assist councils in forming such committees.

- None of the councils studied have an established budget for HIV/AIDS-oriented activities, although the MLG has recently instructed department heads to develop departmental HIV/AIDS budgets for the next six years.

- Both prevention and care and support programmes are limited and suffer from a lack of institutionalisation that is likely to severely undermine their sustainability.

- Like many public and private institutions in the region, managers have yet to begin conceptualising HIV/AIDS as an institutional issue with the potential to severely undermine service delivery, and none of the councils have explored any strategies to reduce the institutional impacts of the epidemic.

INTRODUCTION

As elsewhere in the world, the delivery of basic services in Botswana falls to the MLG and its implementing institutions. With the emergence of a severe HIV/AIDS epidemic in the last decade, local government institutions have also become increasingly responsible for implementing the government of Botswana's response to the epidemic.

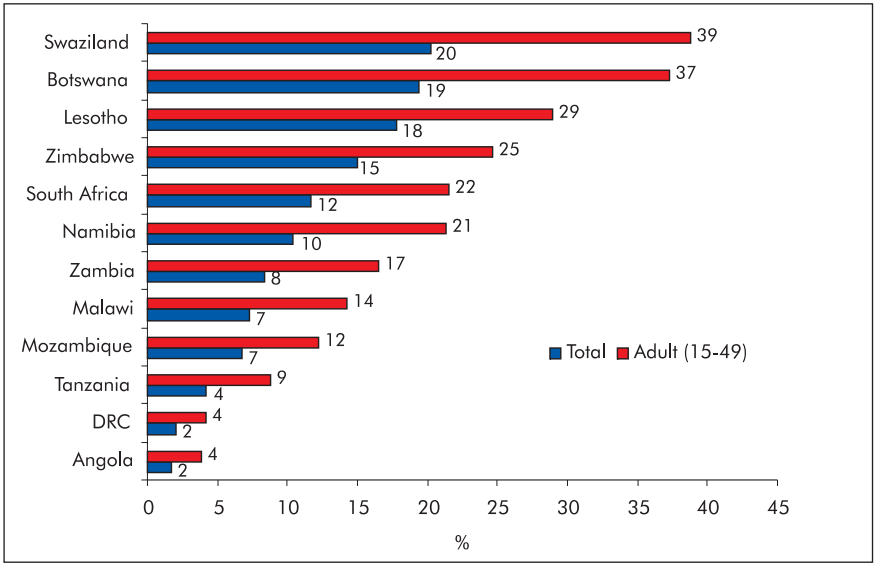
This case study examines the extent to which local government institutions—specifically three local councils—are in a position to mitigate the impact of HIV/AIDS on their staff and functioning. The study originally aimed to examine the state of the response in the MLG and—as the implementers of most of the ministry's policy—selected local councils. Unfortunately, owing to restructuring at the time of the study, researchers were unable to gain access to the ministry and had to focus their activities on three councils: Gaborone city council, Lobatse town council and Kgatleng district council.

By way of background, this chapter first briefly discusses the HIV/AIDS situation in Botswana, the national HIV/AIDS policy framework, and the institutional context in which the councils operate. It then goes on to explore the perceived impact of HIV/AIDS on the councils and the nature and extent of their response to the epidemic.

HIV/AIDS IN BOTSWANA

Botswana has some of the highest rates of HIV/AIDS prevalence in the world. UNAIDS estimates that at present some 350,000 people are

Figure 4: HIV/AIDS prevalence in the 12 continental SADC states (2003)

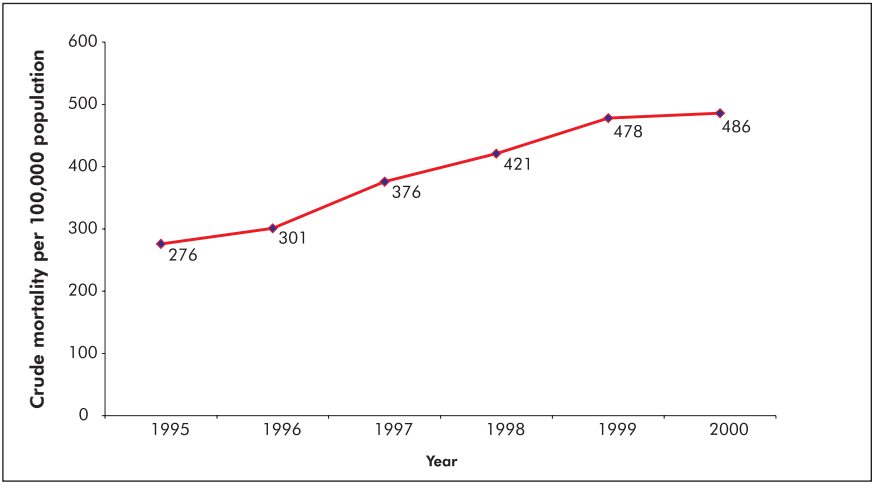


Source: UNAIDS/UNICEF/WHO, 2004

living with HIV/AIDS in Botswana.[45] In absolute numbers, this is less than some of Botswana's more populated neighbours, but equates to roughly 19% of the total population—giving Botswana the second highest levels of per capita prevalence globally, after Swaziland. Not surprisingly, Botswana also has one of the highest proportions of adults living with HIV/AIDS, with UNAIDS further estimating that approximately 37% of all adults between the ages of 15 and 49 are living with HIV/AIDS (Figure 4).[46] Sentinel site survey data gathered from pregnant women attending antenatal clinics between 2000 and 2003 indicates that prevalence rates are highest among women between the ages of 25 and 29.[47] Data gathered from VCT centres in 2003 also indicates that women are likely to contract HIV at a younger age than men. This data shows that prevalence among those seeking treatment is highest in women between the ages of 25 and 35, and in men between the ages of 30 and 49.[48]

Sentinel site prevalence surveillance amongst pregnant women shows that prevalence levels in Botswana have increased over the past decade, from approximately 18% in 1992 to 39% in 2000 and 36% in 2001, with few differences between urban and rural areas. Evidence from the most recent round of data collection, however, suggests that prevalence may be beginning to level off, with the data suggesting that prevalence

Figure 5: Crude mortality per 100,000 people in Botswana (1995–2000)



Source: National AIDS Co-ordinating Agency, 2003

across the 22 sentinel surveillance sites has remained fairly stable over the last three years.[49]

Death rates, on the other hand, seem to be increasing. UNAIDS calculates that 33,000 men, women, and children died of AIDS in 2003, up from an estimated 26,000 in 2001.[50] Analysis by the Botswana National HIV/AIDS Co-ordinating Agency (NACA) also suggests a gradual increase in mortality.

This analysis does not, unfortunately, extend to the present but, as shown in Figure 5, suggests that crude mortality rates increased by roughly 73% between 1995 and 2000. This translates into an annual increase of 15%, up, they argue, from approximately 10% in the early stages of the epidemic.[51]

THE NATIONAL RESPONSE TO HIV/AIDS

HIV/AIDS has been prioritised as a national emergency by the government of Botswana and for many years has received the attention and support of the president and his cabinet. The government's stance is encapsulated in the opening pages of the Botswana National Policy on HIV/AIDS, where it is argued that:

> HIV/AIDS is one of the most important current global socio-economic and development problems … The range and projected magnitude of [the] socio-economic impact of HIV/AIDS indicate that the epidemic should now be regarded as a national crisis and receive from each government ministry, and sector of society, the attention that such a crisis deserves.[52]

THE NATIONAL POLICY FRAMEWORK

Botswana is a signatory to the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS and has endorsed a range of regional declarations and commitments. The latter, which was signed by 189 countries in 2001, serves as a benchmark for global action. It aims to mobilise both political and financial support for a response to HIV/AIDS at all levels. Key goals include:

- improving global, regional, sub-regional, and national leadership on HIV/AIDS;
- strengthening prevention and care and support activities;

- putting in place measures to alleviate the social and economic impacts of the epidemic;
- upholding human rights; and
- better protecting vulnerable groups such as women and children orphaned by AIDS.

The document is non-binding but, by establishing specific, time-bound targets, it puts pressure on signatories to accelerate programme implementation. Participating countries are expected to submit yearly progress reports to the UN, using indicators established by UNAIDS.

The National Policy on HIV/AIDS is the government's main policy statement on HIV/AIDS. This document, which came into effect in 1993, has evolved significantly since the government's first policy statement in 1987. Like many other countries, this has involved a shift from viewing HIV/AIDS as a purely medical problem to seeing it as a far-reaching issue with physiological, social, economic, and cultural dimensions. This, in turn, has seen the national response move from a clinical and health-oriented response—under the gambit of the Ministry of Health (MoH)—to a co-ordinated, multi-sectoral effort involving all government institutions. The objectives of the policy include:

- preventing and reducing transmission of HIV and other STIs;
- reducing the personal and social consequences of HIV/AIDS and STIs;
- reducing their socio-economic consequences; and
- mobilising all sectors and communities for HIV/AIDS prevention and care.

Most relevant to the study, the policy tasks all public and private sector institutions with developing and implementing their own HIV/AIDS prevention activities with, where necessary, the technical assistance of the MoH. Specifically, government ministries are required to:

- develop relevant policy guidelines for HIV/AIDS prevention to guide the implementation of activities at the central, district, and local levels;

- plan for, and allocate resources to, the implementation of HIV/AIDS prevention activities among staff and target members of the public;

- consider the potential impact of all programmes on the spread of HIV and take steps to minimise the possible transmission of the virus; and

- implement, co-ordinate and monitor HIV/AIDS prevention activities.[53]

IMPLEMENTATION

Implementation of the National Policy is driven by the National Strategic Framework on HIV/AIDS (NSF) 2003–2009.[54] The NSF aims to provide the guidance necessary for ministries, sectors, and districts to achieve the goals of the national response to HIV/AIDS. It clarifies the roles and responsibilities of all institutions involved in implementing the response and establishes how the various administrative and functionary tiers of government—ministries, departments, and districts—should develop internal and external responses to the epidemic. It also establishes particular roles and areas of intervention for public, private, and non-governmental institutions.

Most pertinent to this study, the MLG—through its primary organs of implementation, the councils—is made responsible for providing care and support services to children and families affected by HIV/AIDS through community home-based care (CHBC), orphaned and vulnerable children (OVC) programmes, and mainstreaming HIV/AIDS into district development plans. The ministry is also required to oversee the implementation of district level responses (see Box 5, over page).

The national response is supported by the National AIDS Council (NAC), which is chaired by the president of Botswana, and is co-ordinated by the NACA. The NACA constitutes the secretariat of the NAC and provides the link between policymakers and programme implementers.[55] Its purpose is to develop and refine the government's HIV/AIDS strategy and to assist other ministries and sectors in developing their own HIV/AIDS prevention and care activities. In an arrangement that shows significant political will on the part of Botswana's government, NACA falls under the Office of the President. Unlike many similar bodies, it brings together representatives from the key public sector institutions, such as the Directorate of Public Service Management (DPSM) and the MoH, other government institutions, the private sector, and non-governmental and community-based organisations.[56]

Botswana receives considerable assistance in implementing its response from a number of external players. One of the major external organisations is African Comprehensive AIDS Partnerships (ACHAP). This is a collaborative project between the government of Botswana, the Bill and Melinda Gates Foundation, and the Merck Company

Box 5: Implementation of the district-level response

UNDER the framework established by the NSF, district-level actors—including central government departments, local authorities, non-governmental organisations, and the private sector—have a key role to play in mitigating the impacts of HIV/AIDS, as "the district level is where the National Strategic Framework for HIV/AIDS is translated … into operational programmes and activities". District multi-sectoral AIDS committees (DMSACs) are tasked with managing and co-ordinating district-level responses.

These are, as their name suggests, multi-sectoral committees consisting of high-ranking district officials, including the chairperson of the local council or mayor, district parliamentary representatives, and district-level representatives from the MLG's departments of social welfare, education, health, labour, and agriculture.Their key functions are to:

- articulate priority areas of the response at district level;
- translate national response strategies to district-level ones;
- liaise with the NACA on issues of institutional capacity-strengthening at the district level; and
- mobilise resources for implementation of activities by the various district-level actors, including public and non-governmental institutions.

The MLG, through district AIDS co-ordinators (DACs), provides the secretariat for the local DMSAC and plays a key role in developing, facilitating, and monitoring district-level responses. The NSF stipulates that DMSACs perform a management role. Implementation of DMSAC activities thus generally also falls to the MLG and, as the primary bodies responsible for service delivery at the local level, district, city, and town councils.

Foundation. It aims to assist the government in decreasing HIV incidence and increasing diagnosis and treatment of the virus by improving prevention programmes, access to health care, patient management, and treatment infrastructure.[57] Other important players include the Department for International Development of the government of the United Kingdom (DFID), the Swedish International Development Agency (SIDA), and the United Nations Development Programme (UNDP), who support a range of prevention and care activities.

PROGRAMMES

The government of Botswana was one of the first to roll out a national prevention-of-mother-to-child transmission (PMTCT) programme. The

programme was established in 1999 and provides counselling and testing for pregnant mothers, as well as short courses of antiretroviral therapy to help prevent transmission of HIV from mothers to their infant children. Since 2000 the government has also offered VCT through its public health-care system. VCT facilities have been established at 16 sites—one in each of Botswana's districts. Mobile testing centres have been developed for remote areas. In collaboration with ACHAP, the government has put in place a pioneering HIV/AIDS treatment and management programme, which aims to eventually provide free, universal antiretroviral therapy for all HIV-positive Batswana requiring treatment.

The national antiretroviral therapy programme was initiated in February 2002 at the Princess Marina Hospital in Gaborone, from where it was extended to other regional sites such as Francistown, Maun, and Serowe. Since then, it has provided drugs to approximately 17,372 people at 18 sites across Botswana, and was expected to enrol a further 20,000 to 22,000 people by the end of 2004.[58]

All three programmes, and the antiretroviral programme in particular, have been hampered by high levels of stigma and denial, which have resulted in relatively small numbers of people coming forward for VCT[59]—the entry point for both treatment and PMTCT activities. Despite recruiting widely in the region, they have also been constrained by staff shortages and, in the case of the antiretroviral therapy programme, backlogs in the system created by an enormous demand for treatment.[60]

At least one aspect of this problem may soon be eased with the government's introduction of routine testing for patients attending public health facilities. This initiative, announced by President Mogae in October 2003, aims to encourage people to undergo voluntary testing as part of health checkups in both public and private clinics.[61] It has also been suggested that government may soon require students applying for scholarships to undergo HIV testing. While some analysts believe that this testing will be used to determine eligibility for these grants, the government maintains that it will simply be a mechanism to get more people into the treatment system.[62] It is unclear, however, what implications such moves will have for the blockages that exist in the system, or whether there are plans to alleviate the staff shortages that underlie these backlogs.

THE INSTITUTIONAL CONTEXT

Local authorities, in the form of district, city, and town councils, are significant public sector employers, employing approximately one third

of all Botswana's civil servants (25,072 out of a total establishment of 77,277 in 2002/2003). There are currently 15 councils, of which six are urban and nine are rural. These councils are tasked with providing basic services, such as primary health care, social services, and water and sanitation. Under the current policy framework, local government institutions are also required to play a leading role in both mobilising communities and other sectors to respond to the epidemic at the local and district levels and implementing HIV/AIDS prevention and care activities, including support for individuals and families infected with and affected by HIV/AIDS.

Local councils are thus required to respond to HIV/AIDS as the local-level representatives of both the state and employers. In their role as agents of development, planning, and implementation, councils are required to mitigate the impacts of the epidemic on members of the public and are increasingly being called upon to allocate personnel and money to HIV/AIDS-related activities. Thus, for example, the 1999/2000 Establishment Register for Botswana Local Authorities allocated personnel to all councils, creating new posts in order to help "implement and sustain the CHBC programme for AIDS patients".[63] As employers, they are required to take the lead in preventing HIV transmission among their workers and mitigating the impact of the virus on their staff.

As with most other local authorities in the region, however, councils are generally under-resourced when compared with central government agencies.[64] Their personnel are not as well trained as their central-level colleagues, budgets are regularly limited, and the combination of human and financial constraints often leaves councils severely lacking in implementation capacity. In the context of the epidemic, local councils' resources are likely to be spread even more thinly; as will be discussed in the next section, it seems that councils have sometimes had to redirect some of their personnel towards caring for those infected with and affected by the virus. As noted by a respondent from one council's department of social welfare:

> All programmes mushrooming from government are given to councils and most land in this department. Unfortunately they do not come with corresponding resources, especially personnel. In other instances we see resources being diverted to departments that are not as fully involved in the programme as us, for instance, CHBC finances are sent to the health department, while the same department pushes clients to our department.

THE IMPACT OF HIV/AIDS

Determining the impact of HIV/AIDS on Gaborone city council, Lobatse town council, and Kgatleng district council was difficult. All three councils lacked human resource databases, and poor human resource record keeping meant that researchers were unable to obtain reliable information on attrition levels and trends over the past five years. Manpower planning figures have not been kept in a systematised manner either. The Department of Local Government Service Management (DLGSM) and its councils are currently in the process of reconciling their staffing figures, but at present data is incomplete for the period prior to 2002. This made it impossible to accurately quantify the potential susceptibility of council employees to HIV/AIDS or if and how HIV/AIDS may be impacting on attrition levels within the three institutions. Despite these limitations, the information collected from the in-depth interviews and the self-administered questionnaires provides some indication of the susceptibility and vulnerability of the councils to HIV/AIDS.

SUSCEPTIBILITY TO INFECTION

The limited demographic data that could be collected shows that the bulk of the three councils' employees are relatively young—between the ages of 25 and 35—and that women outnumber men. As already mentioned, both Botswana's antenatal clinic surveillance and testing data recorded the highest levels of age-specific prevalence among women in this age band, which, without considering confounding factors such as education level or socio-economic status, broadly suggests that prevalence may be high. Other characteristics of councils' workforce may also suggest a certain susceptibility to infection. It is clear from the interviews, for instance, that the councils employ large numbers of lower-skilled, 'industrial class' workers, who generally have lower levels of education—a widely acknowledged risk factor for HIV/AIDS. The work in particular institutions, such as departments of health, may also expose employees to occupational risk of exposure.

THE IMPACT OF HIV/AIDS ON ATTRITION

Virtually all of the management staff interviewed felt that attrition—in the form of employees taking sick leave and, to a lesser extent, staff dying—is on the increase. The head of the department of architecture

and buildings at Gaborone city council, for instance, estimated that as many as 10% of his staff are on sick leave in any given week, while the principal environmental officer reported that as many as a third of the department's 500 employees may be absent at a given time. In terms of death-related attrition, the head of social and community development estimated that ten of his approximately 117 employees had died in the past two years, while the chief engineer in the engineering department maintained that at least two staff members die in an average month.

Gaborone city council reported particularly high levels of illness. The City Clerk attributed this to the good medical facilities in the city, arguing that many employees from rural councils request to be transferred to Gaborone, where they can receive better health care (and given that the national antiretroviral therapy programme was first rolled out in Gaborone, quite possibly access to previously limited antiretroviral drugs). This has resulted in staff loses in rural councils and the Gaborone council having to function with above average numbers of sick staff. The City Clerk's concerns were confirmed by a representative of the DLGSM, who noted that the department had received complaints from the City Clerk about exceptionally high rates of attrition.

These arguments are supported by the data collected from the self-administered questionnaires distributed to less senior staff. When asked whether they felt that absenteeism, illness, and retirement on medical grounds were problems in their organisation, almost three quarters of respondents (74.1%) felt that they were. The same proportion felt that HIV/AIDS was a problem in their institution. On the positive side, such findings indicate very high levels of awareness about HIV/AIDS, which, while not necessarily indicative of safer behaviour, may reduce the susceptibility of councils to the virus.

THE IMPACT OF HIV/AIDS ON CAPACITY AND DEMAND

Despite recognising attrition as a problem in their institutions, most managers were reluctant to overtly link HIV/AIDS to high levels of attrition, arguing that it was difficult to know for certain whether a person's illness was caused by AIDS. This could have been a subtle effort to protect those suspected of being HIV-positive, or denial, or simply a failure to make the connection between AIDS and attrition in the face of more obvious constraints. The data suggests that the latter may be the case.

The findings show that, although concerned about the impact of epidemic, most saw it as only one of several factors affecting the demand

for and supply of services. Many viewed issues such as population growth, political demands, limited human and financial resources, and weak human resource management as more immediately pertinent to service delivery than HIV/AIDS. Only managers from institutions directly involved in responding to the epidemic, such as departments of health and social and community services, consistently saw the virus as a significant feature of their service delivery landscape. This is probably because such personnel are confronted by the realities of the epidemic through their day-to-day work, making the links between HIV/AIDS, capacity and service delivery easier to see.

When asked whether HIV/AIDS was impacting on service delivery, most staff felt that it was impacting on both the demand for services and the capacity of councils to supply such services. As shown in Figures 6 and 7, the majority (74%) of those who completed a self-administered questionnaire felt that HIV/AIDS was having a moderate to large impact on demand for services, with most of these (45%) of the opinion that HIV/AIDS was having a large impact on demand. A slightly smaller, but still significant, proportion felt that HIV/AIDS was impacting on the ability of councils to supply services, with fractionally under two thirds (65%) of respondents stating that HIV/AIDS was having a moderate or large impact on supply.

In terms of demand, the epidemic has resulted in councils having to take on additional functions. As already noted, the HIV/AIDS epidemic

Figure 6: Impact of HIV/AIDS on demand for services (local councils, Botswana)

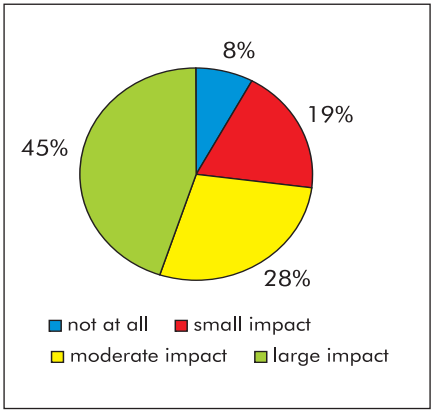
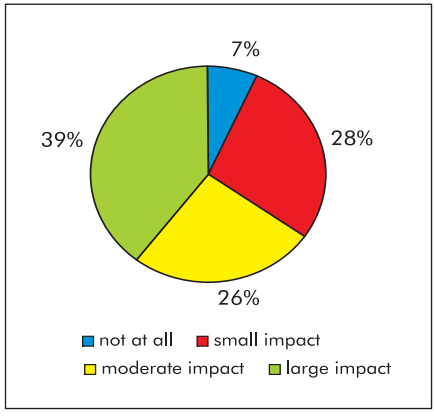


Figure 7: Impact of HIV/AIDS on supply of services (local councils, Botswana)



has resulted in councils being allocated new responsibilities, which include implementing the government's CHBC programme, the OVC care programme, the antiretroviral therapy programme, and the PMTCT programme. These added functions have required these departments not only to establish new posts, but also to develop new competencies, and seem to have left them feeling overstretched. As argued by a senior manager in Lobatse town council:

> Our clinics do not have enough space, especially consulting rooms. This is manifested in the long queues. We, as suppliers of a service, feel we are not giving our clients enough care because due to the numbers we serve we are forced to just dish out tablets. Also, our department is responsible for the many recently introduced programmes such as [the] PMTCT, antiretroviral [programme] and we can't do all these at the same time.

The need for biomedical expertise, in particular, has proved difficult owing to the relative scarcity of scientifically trained individuals. Despite actively recruiting in Botswana and the region, councils have found it difficult to find suitably qualified personnel, and many of the additional posts created by central government to address these new responsibilities have not been filled.

On the supply side, managers argued that high levels of illness may be contributing to lower levels of effectiveness. While cautioning that it is impossible to isolate the effects of HIV/AIDS compared with other factors such as low pay, low staff morale, a lack of training opportunities, and the loss of employees to other sectors (including central government and the private sector, which have better conditions of service), they felt that ill health is reducing capacity within departments, as people miss work, work fewer hours, or need to be reassigned to 'light duty' as a result of poor health. Such losses are exacerbating existing shortages and have resulted in other staff having to take on more work. In this respect, two thirds (66%) of the respondents to the self-administered questionnaire reported that they had had to do additional work or had been unable to perform their duties as a result of someone being absent or ill. Staff losses have also resulted in delays and, in some cases, reduced professionalism. The head of social and community development in Gaborone, for example, noted that his employees sometimes make appointments with their clients and then fail to honour these appointments because of sickness.

Box 6: Comparative data from eThekwini municipality, South Africa

IN 2002, the Centre for Social Science Research (CSSR) and the Health Economics and HIV/AIDS Research Division (HEARD) conducted a study into how HIV/AIDS is affecting local-level democracy, in the form of eThekwini municipality in KwaZulu-Natal province, South Africa. This province is widely acknowledged as one of the areas hardest hit by epidemic and has consistently registered the highest levels of antenatal prevalence in the country. In 2002, for example, 37% of women attending antenatal clinics in the province tested positive for HIV, well above the national average of 27%. The study collected quantitative and qualitative data on the ways in which the epidemic may be affecting demand for services and the ability of the departments of cemeteries and crematoria, housing, fire and emergency services, and electricity to supply such services.

The study found evidence that HIV/AIDS will significantly affect the public's demand for particular types of services. The department of cemeteries and crematoria, for example, may already be seeing the effects of HIV/AIDS. Its burial statistics for 2001 and 2002 showed that more people between the ages of 26 and 50 were buried or cremated in the municipality than any other age group, when one would usually expect death rates to be highest among the very young or the very old. Using these statistics, projections suggested that the number of burials and cremations would rise steadily from roughly 14,000 in 2001 to a high of approximately 25,000 in 2009. The department already faces a severe shortage of burial space. Unless current campaigns to encourage cremation instead of burial bear fruit, or the municipality experiences significant demographic change, it will probably run out of burial space in its existing cemeteries within the next ten years.

Departments were also found to be vulnerable to the impact of HIV/AIDS, and managers expected that employee absenteeism and turnover would have a direct and substantial impact on service provision. In addition, evidence showed that, although the perceived impact of HIV/AIDS on operational effectiveness varied between departments, AIDS-related absenteeism and turnover were already on the rise in several departments.

The departments of fire and emergency services and housing were found to be particularly at risk. In the department of fire and emergency services, this was due to the demographic characteristics of its employees and vulnerabilities associated with its work and institutional context. Employees were mostly from a demographic group—young, single men with a risk-taking ethos—that is highly susceptible to HIV infection. The department was also understaffed and overburdened, and relied heavily on on-the-job training and experience gained over time, which made it highly vulnerable to employee absenteeism and turnover. In the department of housing, managers reported that after registering for a housing subsidy, AIDS-affected clients frequently died or disappeared before receiving the title to their home, complicating the department's task of delivering housing to qualifying families.

Source: R Manning, 2003

THE RESPONSE TO HIV/AIDS

In adherence to the national policy framework, most government ministries in Botswana have either put in place or are in the process of developing formalised responses to the epidemic (Box 7). The MLG is still in the process of developing its HIV/AIDS workplace policy but,

Box 7: Public sector responses in Botswana

ACCORDING to the NSF, at least nine of Botswana's 14 ministries have developed, or are in the process of developing, HIV/AIDS workplace policies—although it notes that many of the policies developed to date need revision to incorporate recent conceptual developments and interventions. A number of institutions have taken these policies one step further and developed HIV/AIDS-oriented strategic frameworks and medium-term plans.

Most ministries have also appointed HIV/AIDS co-ordinators, although many co-ordinating structures are still finding their feet and need to be adequately staffed and provided with clear and specific terms of reference.

The process of mainstreaming HIV/AIDS at ministry level was initiated in 1999, although most ministries and sectors have only recently embarked on such processes as part of government's most recent national development plan. It is hoped, however, that ministries will soon be in a position to develop annual HIV/AIDS action plans that address the impact of HIV/AIDS on their workplaces and external service provision areas.

Most ministries appear to have started a workplace programme, although these vary considerably in terms of the range of issues covered and the services provided. The most common activities include behavioural change initiatives, peer education, and condom distribution. Only a minority of ministries have instituted a care and support programme to provide medical, social, and economic support for those infected with and affected by HIV/AIDS. Overall, the NSF identifies a number of important gaps in the public sector response:

- Co-operation and co-ordination between the various ministries and institutions is often inadequate and public institutions generally fail to form linkages with existing services and resources, such as counsellors, HIV-testing facilities, and treatment.
- Existing responses are frequently generalised and fail to target vulnerable groups or high-risk activities.
- Only a limited number of studies have been undertaken to establish prevailing attitudes and behaviour, and available information is not used to inform HIV/AIDS programming.
- Mechanisms for monitoring HIV and its impacts are largely lacking.
- Information sharing amongst the various sectors and the NACA is limited.

Source: National AIDS Co-ordinating Agency, 2003

despite not having a tailored policy framework to guide its response, has begun to mainstream HIV/AIDS into its internal and external activities by incorporating HIV/AIDS alleviation strategies into its developmental planning. It has also established a 'caring for us' programme within the ministry itself.[65]

The research suggests that councils are further behind in this process and have yet to begin formalising a response to the epidemic. It is clear that, although HIV/AIDS is viewed as a problem, councils lack clear guidelines on how to manage HIV/AIDS in the workplace. As with many institutions worldwide, the emphasis is very much on addressing HIV/AIDS in the wider community. In the absence of clear guidelines, relatively little has been done to address the impact of HIV/AIDS on either staff or institutional effectiveness. The information also suggests that, despite central government's emphasis on mainstreaming HIV/AIDS, this process is still in its early stages and has yet to reach the point where doing something about HIV/AIDS is part of everyday functioning. This is not unique to Botswana. Mainstreaming is universally difficult to implement, and Botswana should be commended for prioritising and attempting to mainstream HIV/AIDS in the way that it has done.

RESEARCH INTO THE EXTENT AND IMPACT OF HIV/AIDS

As already discussed, none of the councils systematically gathered information on HIV/AIDS prevalence levels in their workforces, or the impact of the virus on their capacity to deliver. This may be changing, however. The MLG, with the assistance of its human resources department, is putting in place an information system which will require councils to periodically submit information on key human resource indicators to the ministry for monitoring and evaluation purposes, including levels of sick leave, death, and absenteeism.

THE POLICY FRAMEWORK FOR DEALING WITH HIV/AIDS

Despite the decentralisation of responsibility stipulated in the national policy on HIV/AIDS, respondents agreed that little progress had been made in institutionalising a response to the epidemic. None of the participating councils had an HIV/AIDS policy and thus lacked clear guidelines for managing HIV/AIDS in the workplace.[66] There would seem to be a number of reasons for councils having not yet developed HIV/AIDS policies, including:

- *Capacity constraints:* The research suggests a perceived lack of capacity at many levels of government to draft appropriate workplace policies. In two of the councils, in particular, respondents felt that an HIV/AIDS co-ordinator should be responsible for drafting a workplace policy and attributed the lack of capacity to the absence of such co-ordinators.

- *A perceived lack of need for a policy:* Managers rely heavily on the national policy framework and many felt that its comprehensiveness made an institutional-level policy unnecessary. This is problematic because, while national policies give direction to institutional-level responses, workplace-specific policies are needed to address the specific needs of each working environment. They outline the activities to be pursued in a particular setting and are a key ingredient of any meaningful response.

- *Confusion of district-level initiatives with internally focused activities:* Linked to the above was a lack of distinction between what is being done by the councils at district level and what is being done to mitigate the impact of HIV/AIDS on councils themselves. As noted earlier, councils play an active role in implementing the government's response to HIV/AIDS at district level, and are responsible for implementing a range of programmes aimed at alleviating the impact of HIV/AIDS on Botswana's citizens. These external, district-level responses are evidently often confused with internal policies, with both managers and their staff reporting on council-level workplace policies that do not, in fact, exist.

The perceived lack of need for a policy, and the blurring of internal and external activities, seem part of a larger perception of councils as service providers rather than employers. Despite the national policy framework, managers argued that a council's primary mandate is to serve its constituents and that, in the context of often limited human, technical, and financial capital, available resources are focused on service delivery.

THE CO-ORDINATION OF HIV/AIDS ACTIVITIES

It was also clear that the co-ordination of HIV/AIDS activities is not entrenched. Of the three councils, only Gaborone city council had established an HIV/AIDS co-ordinating structure, in the form of an

HIV/AIDS co-ordinating committee. According to the City Clerk, however, this committee has been poorly co-ordinated and has been largely ineffective. Similarly, only Gaborone city council had a senior-level HIV/AIDS co-ordinator, who, according to the City Clerk, had been recently recruited to improve the effectiveness of HIV/AIDS-related activities carried out in the council.

In the case of Lobatse town council, the local DMSAC is housed within the council, but it does not itself have any structures to co-ordinate its own activities. This committee is co-ordinated by a senior health education officer, who acts as the council's *de facto* HIV/AIDS co-ordinator.

The lack of dedicated co-ordinating structures and personnel was in part attributed to the lack of distinction between internal, staff-oriented activities and those targeting communities. As argued by a matron in one of the councils, the involvement of the councils in home-based care and HIV/AIDS-related programmes at district level has given management and employees the impression that something is being done about HIV/AIDS in their councils.

It was also suggested that the failure to formalise responses may sometimes be due to a lack of will on the part of senior personnel to implement a comprehensive response. Respondents involved in health functions, in particular, felt that employees and management are often not interested in dealing with HIV/AIDS and tend to relegate HIV/AIDS issues to the department of health. Others pointed to limited success in mainstreaming HIV/AIDS.

This situation may be about to change—at least in part. It emerged from the feedback workshop that the DLGSM, which is responsible for the provision and management of human resources for the local councils, has asked councils to form internal HIV/AIDS committees and is currently developing guidelines to assist them in forming such committees. These will apparently direct councils on issues such as:

- the duties and responsibilities of committees;
- the duties and responsibilities of individual staff members with regard to the committees; and
- the external resources and linkages that they can tap into.

This development is encouraging, as many similar programmes have failed owing to both a lack of clarity about who is responsible for activities and a lack of resources.

BUDGETING FOR HIV/AIDS ACTIVITIES

None of the councils studied had an established budget for HIV/AIDS-oriented activities, although the MLG has recently instructed department heads to develop departmental HIV/AIDS budgets for the next six years. In line with government's district-oriented approach to combating HIV/AIDS, internally and externally oriented activities—including the resources necessary for the implementation of national programmes—are all currently funded through the DMSACs.

Under this system, councils submit proposals to their local DMSAC detailing the activities they wish to undertake. Once approved by the DMSAC, these proposals are routed through the MLG's HIV/AIDS Co-ordinating Unit to the NACA for review. Once cleared by the NACA, the proposals are forwarded to the Ministry for Finance and Development Planning (MFDP), who disburse the necessary funds to the councils.

This system is designed to provide oversight over local-level initiatives, but has sometimes resulted in delays, especially because all districts are required to submit their proposals before they are forwarded to the MFDP.

Channelling funding through district co-ordinating structures may also feed into the predominantly external focus of HIV/AIDS activities highlighted above, as the DMSAC's focus is primarily on community-oriented initiatives. This is an issue that needs some attention as the DMSACs will continue to drive district-level activities, although the implications of the new six-year planning cycle for the current funding system are unclear.

WORKPLACE HIV/AIDS PREVENTION PROGRAMMES

All three councils conducted HIV/AIDS prevention activities of some kind, although the absence of efficient co-ordination means that activities occur on the initiative of particular people and are often relatively *ad hoc* in nature. This reliance on individuals severely compromises the sustainability of these activities, which are likely to cease if those driving their implementation become ill, die or leave the organisation. It is thus vital that initiatives be institutionalised, so that programmes can continue even when key people are no longer present.

Like many public institutions in Botswana and elsewhere, activities most often take the form of distributing condoms and, to a lesser extent, education-oriented strategies such as workshops and presentations, and the distribution of pamphlets and brochures.[67]

Table 2: Percentage of respondents reporting specific prevention activities (local councils, Botswana)

Activity	Percentage
Distribution of condoms	94.1
Workshops on prevention issues	20.2
Presentations on prevention issues	20.2
Distribution of information materials	19.7
HIV/AIDS awareness drives/rallies	11.6
No activities undertaken	2.9

These trends are supported by the results from the self-administered questionnaires. As shown in Table 2, virtually all respondents reported that condoms are distributed in their workplace, while approximately one fifth recalled workshops or presentations on prevention issues, or the distribution of education materials. No mention was made of peer education strategies.

In line with good practice elsewhere, managers reported that condoms are placed in both male and female toilets. It was noted, however, that the centralisation of supply means that it often takes a while to replenish stocks when they run out, and some councils have not distributed condoms for quite some time.[68] This is typical of many condom distribution programmes globally. It was also evident that it was up to employees to report when the supply of condoms runs low, which may reduce the consistency of supply if staff are embarrassed to come forward.

It was argued that although some department heads regularly invite speakers to address their staff on issues of prevention and VCT, workshops and presentations are generally held only once or twice a year, as they demand more time of employees. These often target groups of employees, such as drivers, who are perceived to be at particular risk of contracting HIV.

This may be a positive characteristic, as one of the chief failings of many such activities is that they are overly generalised and do not target particularly high-risk groups. However, it is clear that all employees are at risk of contracting HIV/AIDS and activities must also involve those perceived to be at lower risk, including middle and senior management.

Other activities, such as the distribution of pamphlets and other materials, happen on an *ad hoc* basis and are often linked to nationally directed events or campaigns.

WORKPLACE CARE AND SUPPORT PROGRAMMES

As noted in the previous chapter, effective care and support programmes generally aim to protect the health of HIV-positive employees—by providing treatment for opportunistic infections and, where possible, antiretroviral therapy—and provide psychosocial support to those infected with and affected by HIV/AIDS. It may be argued that the rollout of VCT and comprehensive treatment through the public health care system in Botswana reduce the responsibilities of government institutions such as the councils. However, while they need not provide pre- and post-test counselling or treatment, good practice suggests that they still have a responsibility to refer staff to appropriate counselling and testing facilities, and to provide on-going counselling and other forms of social support.

As with many other government institutions in Botswana, however, the extent of such activities is relatively limited. Managers believed that the successful prevention and management of HIV/AIDS in the workplace is dependent on employees knowing their status and have encouraged staff to undergo VCT. Other activities were carried out on an *ad hoc* basis and the scope and nature of the support provided was again dependent on the attitudes and commitment of individual managers.

In Gaborone city council, for example, heads of departments reported that, schedule allowing, they visited ill staff in their homes. The department of environmental health reported holding daily prayer meetings in all their depots, while the City Engineer reported that his department tended to be lenient towards ill staff by allowing them to work fewer hours than their healthy colleagues. Lobatse town council also encouraged daily prayer sessions, where staff prayed for infected and affected colleagues, and conducted after-hours visits to the sick. Its department of environmental health held weekly departmental meetings where they not only encourage staff to undergo testing but also inform them about national initiatives and programmes, such as the national antiretroviral therapy programme and the CHBC programme, aimed at assisting people infected and affected by HIV/AIDS.

These efforts are commendable, but do not constitute a comprehensive care and support programme. Like the prevention activities discussed above, a failure to institutionalise responses is likely to undermine their sustainability. It is thus vital that the councils put in place formal, unified care and support mechanisms that can continue in the absence of specific individuals.

STRATEGIES TO MANAGE THE INSTITUTIONAL IMPACTS OF HIV/AIDS

Despite managers' concerns over the impact of HIV/AIDS on their staff, none of the councils had explored any strategies to reduce the institutional impacts of HIV/AIDS. Like many public and private institutions in the region, managers had yet to begin conceptualising HIV/AIDS as an institutional issue with the potential to severely affect their ability to fulfil their mandate, and attrition tended to be dealt with by either replacing staff or moving personnel around to fill serious gaps in capacity. In line with a national move towards the privatisation of less specialised government functions, the councils increasingly outsource some of their responsibilities, including some repair and maintenance work, sanitation, and procurement for the OVC care programmes.

As discussed in the previous chapter, none of these responses is ideal. While they may provide short-term solutions to the problem of attrition, they may prove unsustainable in the long term—either because they rely on there being a large pool of skilled, healthy, and interested individuals from which to draw staff in the future or, in the case of outsourcing, because they shift the burden of responsibility without addressing underlying issues of susceptibility and vulnerability. They also do little to address issues such as the loss of institutional memory and experience, which require the development of non-replacement strategies that develop and preserve knowledge and networks.

The findings of the study suggest that the development, sharing, and preservation of knowledge and experience are still relatively weak. Like many other civil services in the region, Botswana's public institutions are often characterised by poor record keeping and communication within entities, and the councils conform to this trend. There are few mechanisms in place to manage and preserve knowledge or cope with the organisational effects of high rates of attrition. Those activities that do occur again tend to do so on the initiative of particular individuals, as opposed to being part of the organisational culture.

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