

Strengthening Community Health Systems for HIV Treatment, Support and Care: Old Naledi – Gaborone Botswana



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Cover photo: Thabo Seleke (November 2010- Old Naledi PRA research meeting) © University of Botswana, COBASYS 2010

1. Executive Summary

Rodney P et al (2010) stated that '*estimated worldwide deaths caused by HIV/AIDS total approximately 25 million. This epidemic has harmed the African continent in numerous ways and has profoundly changed its demographic profile*'. He further stated that HIV remains a global health problem, a threat to human health and development. Since 1983, it has caused an estimated 25 million deaths worldwide and has generated profound demographic changes in the most heavily affected countries (UNAIDS 2008). In countries most heavily affected, it has reduced life expectancy by more than twenty years, slowed economic growth, and deepened household poverty (UNAIDS 2008). In 2007 worldwide, the number of adults and children living with HIV was estimated at 33.2 million, including 2.5 million children (UNAIDS, 2007)" The disease is still considered an issue of national and international security. Available resources to prevent and treat it in developing countries have expanded more than fivefold since the Declaration of Commitment on HIV/AIDS, adopted by the United Nations General Assembly in 2001 (UNAIDS 2007; United Nations 2001), but the expansion has not been evenly distributed. Reports suggest that more needs to be accomplished

HIV/AIDS continues to be the biggest challenge faced by Botswana and the country is considered to have the highest percentage of individuals living with HIV/AIDS in the world. The 2008 Botswana Impact Survey III (BAIS III) data yielded a national prevalence rate of 17.6 percent, 20.4 percent females and 14.2 percent males. After more than 26 years of fighting HIV/AIDS, Botswana is still in a state of paralysis with the AIDS virus continuing as the deadliest enemy the country has ever faced. HIV/AIDS has to date claimed many lives in Botswana including the young and the old.

Former President Festus Mogae in 2000 declared HIV/AIDS a national emergency. This led to the development of a National Strategic Framework to turn the tide of the HIV/AIDS epidemic in Botswana. In 2001, the Government of Botswana (GOB) further introduced an ambitious treatment named Masa (New Dawn), a symbol of hope for those living with the virus. The Masa program provides free antiretroviral (ARV) drugs and counseling nation wide. Botswana government has also made administrative and organizational arrangements at the central and local government levels for the implementation of its policies and the fight against the scourge. These include creation of high level National Aids Council (NAC), National Aids Coordinating Agency (NACA), the Ministry of Health (MOH) and other ministries, private sector organizations have also made their contributions. The role of the community at the grassroots levels is being realized increasingly (Sharma K C, Seleke T.L 2009)

This study examined community response in HIV and AIDS treatment, care and support in Old Naledi, a high density suburb in Gaborone. It did that by identifying the factors that facilitate and block access to, use and effective coverage of services and responses to HIV treatment. This is done through a regional network for policy advocacy targeting vulnerable groups in east and southern Africa (ESA) and Europe with support from the European commission through the African Caribbean and Pacific (ACP) group of States. The Old Naledi Participatory Action Research on Community Based Systems in HIV/AIDS treatment (CoBaSys) was coordinated and implemented by the University of Botswana. The project strives to create a regional network for policy advocacy to empower communities to support anti-retroviral delivery programmes for patients with HIV/AIDS infection in ESA Countries targeting vulnerable groups. The project primarily focuses on building solid 'community based systems that support the HIV treatment to benefit most vulnerable social groups at primary care level. The learning and evidence from this tier of the health system within Old Naledi a high density area in Gaborone is collated, synthesized for national level advocacy and further integrated at regional level for global engagement

The study employed qualitative techniques using the Participatory Reflection and Action (PRA) approach with varying PRA tools to triangulate the methodologies and ensure validity and reliability of data. PRA tools were used primarily because they draw experience of direct actors and using collective validation to build shared knowledge and questions. It also exchanges information from participants experience and other sources to address identified questions and problems. The study units included Women, Youth and the elderly. Amongst these participants were social and community workers and the Chief and with only three men taking part. The study was carried out in Old Naledi, Gaborone (densely populated slum area within the city of Gaborone, growing because of rural- urban migration with an estimated population of close to 90 000 people). Extended focus group discussions were held on the 12 November 2010 and 26 November 2010.

This report presents findings of the participatory research carried out in Old Naledi of the CoBaSys. The research findings from the study established the following

- That although Old Naledi has several organizations as well as various social groups, churches and CBOs that assist in the fight against HIV and AIDS epidemic, it is still faced with a lot of challenges.
- The participants in Old Naledi suggested that Men do not actively take part in the fight against HIV and AIDS.
- That young people, children and women are the ones who are at greatest risk of infection.
- For the young girls, they stated sometimes they are forced into commercial and transactional sex in order to assist their mothers at home
- They also cited incidences where their mothers encourage them to engage in transactional sex especially with older men, 'the Sugar Daddies'
- The Research findings indicate that Old Naledi has a number of challenges such as high unemployment and lack of social and economic activities that could be tapped to facilitate an efficient HIV/AIDS treatment and support system at primary care level

This research identified recommendations that policy should consider in defining a comprehensive community based model for HIV treatment, support and care amongst PLWHA and those affected. These recommendations have been framed into three main health system domains for HIV treatment. These include the recommendations at community level, the frontline health system and interaction between community and the health system.

Recommendations for community action

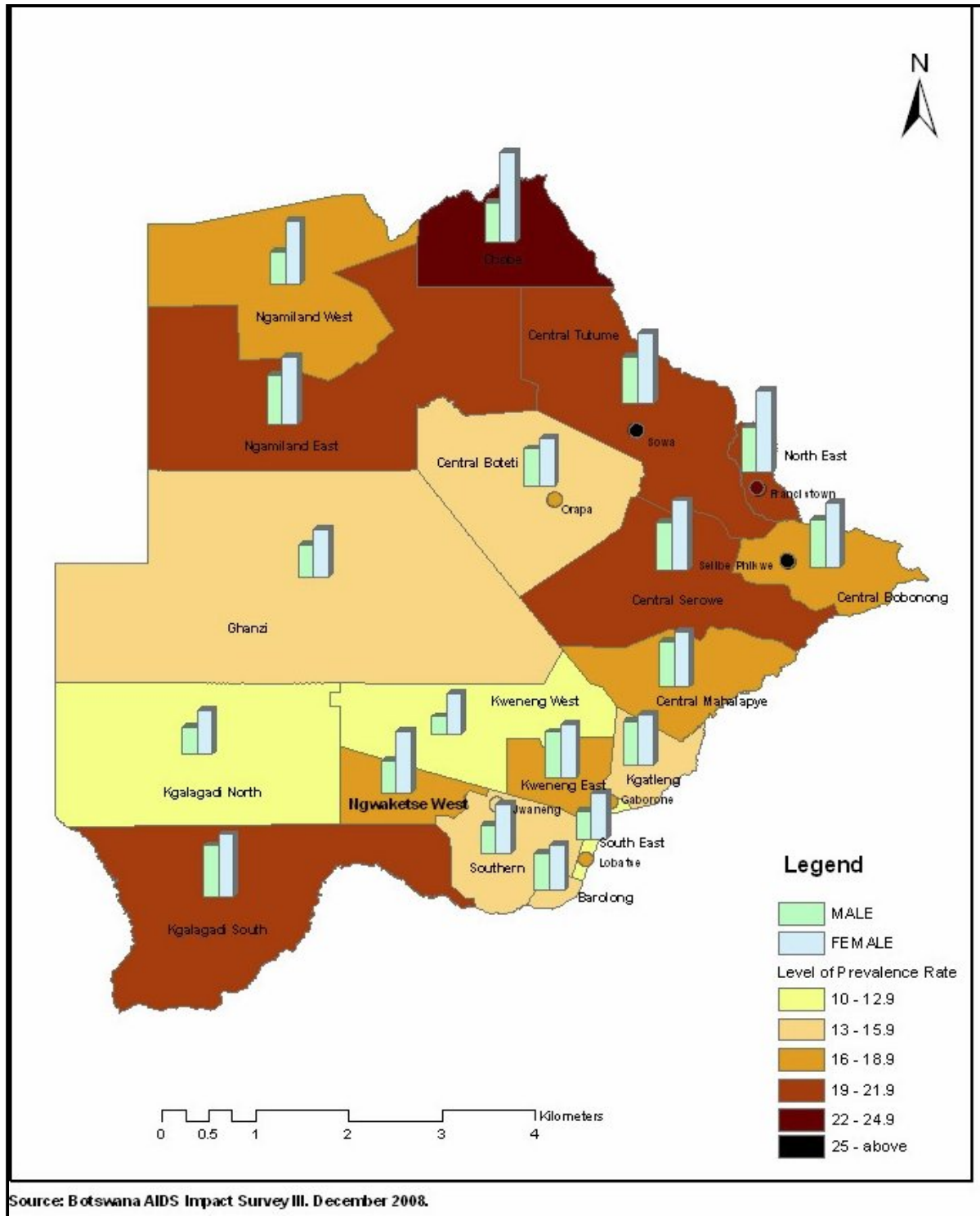
- Implement policy proposal to remove fees for primary care and monitor it regularly. This was observed mainly because citizens are required to pay P5.00 (US\$.71) in order to be assisted and in some instances if they fail to pay this fee, they are turned back home without being assisted.
- Improve resource allocation to health services, including vehicles for ambulatory services. This will ensure that patients are not transported in wheel barrows as it is sometimes the case.
- Ensure easy access and availability of ARVs in Old Naledi and avoid referrals to other clinics. Training of health workers to build trust and self esteem among PLWHA. The health workers should also be trained to ensure that they accept the people of Old Naledi and they do not look down upon them.
- The above is compounded by bad roads where in some extreme situations they have to transport patients to clinics in wheel barrows. They called for the procurement of an ambulance that will serve the entire community of Old Naledi.
- They also stated since ARV are collected very far, a CDC centre should be constructed in Old Naledi to enable patients not to travel long distances to access drugs. As a remedy, they also called for mobile clinic specifically for disbursing ARV drugs to PLWHA.

2. Background:

Mapping the prevalence at the district level is an attempt to portray the pattern of the pandemic nationally on the ground. Districts with relatively high prevalence rates are Selebi-Phikwe, Francistown, Sowa and Chobe, while Kweneng West, Kgalagadi North and South East

Fig. 1: Map – District Pattern of HIV Prevalence:

HIV/AIDS continues to be the biggest challenge faced by Botswana and the country is considered to have the highest number of individuals living with HIV/AIDS in the world. The



Source: Botswana AIDS Impact Survey III. December 2008.

2008 Botswana Impact Survey III (BAIS III) data yielded a national prevalence rate of 17.6 percent, 20.4 percent females and 14.2 percent males. After more than 26 years against HIV/AIDS, Botswana is still in a state of paralysis with the AIDS virus continuing as the deadliest enemy the country has ever faced. BIAS III (2009) reported that 23% men and 10.4% women had multiple partners and only 45.8% men and 34.6% women reported using condoms in a non – regular relationship. Against this background, the percentage of people who voluntarily tested in public facilities decreased by 2.4% between July, September, October and December 2010 quarters, 'The Mirror 24th February 2010.

The latest report on the performance of Botswana's National Aids Program (BNAP) in the quarter October – December 2010, released by the National Aids Council (NAC), has painted a gloomy picture. It notes that Botswana continues to be in a state of paralysis and still considered as the epicenter of the HIV and AIDS scourge in the Southern African Region. The report thus suggested that public education campaigns aimed at encouraging Batswana (people of Botswana) to engage in safe sexual behaviors and initiate volunteering counseling and testing is not bearing fruit. The report has further revealed that the number of first time testers at Tebelopele (Voluntary and Testing Centre) decreased by 4.1% and that the percentage of first time testers who tested HIV positive also increased by 0.4%, thus depicting the need for rigorous campaigns to promote safe sexual behaviors.

Botswana being the epicenter of the HIV/AIDS pandemic within the region tried to confront the problem with high degree of commitment. It thus developed a National Strategic Framework to turn the tide of the HIV/AIDS epidemic in Botswana. In 2001, the Government of Botswana (GOB) also introduced an ambitious treatment aptly named Masa (New Dawn), a symbol of hope for those living with the virus. The Masa program provides free antiretroviral (ARV) drugs and counseling nationwide. Similarly the Botswana Government introduced prevention of mother to child transmission (PMTCT), which has had remarkable results with positive increase in its uptake.

Botswana has developed a two tier system in terms of mainstreaming and fighting HIV and AIDS, i.e. At the Central Government level and District level. It has also at the same time developed institutional frameworks responsible for the successful implementation of government HIV and AIDS policies. This is in line with the World Bank Multi country HIV and AIDS programme (MAP) which was launched in September 2000. The overall development objective of MAP is to dramatically increase access to HIV and AIDS prevention, care, treatment programs, support to community organizations and the private sector, Sharma K and Seleke T L (2009)

In 2000, Botswana established NACA. This institution was primarily established to coordinate and ensure effective decentralization of HIV and AIDS policies and their implementation at district level. It also ensures that HIV and AIDS policies are integrated into district development plans coordinated by the Ministry of Local Government. NACA is also responsible for harmonizing the planning and implementation of all ministries and efforts of civil society organizations and private sector to ensure appropriate alignment with the vision and goals of the national response.

In carrying out all its activities and functions it directly reports to National AIDS Council (NAC) which is chaired by the State President. NAC has a wide representation from other stake holders such as the private sector, public sector, NGO's, civil society and the legislature. Its primary role is to serve as the highest organ to monitor and coordinate the implementation of the national aids policy and programmes that are developed by NACA and other relevant stakeholders.

Realizing the need and significance of decentralization, the government has organized administrative machinery at the district levels in the country. District Multi Sectoral AIDS committees (DMSAC) in collaboration with the District Development Committees (DDCs) are the pivotal organs at the district level for giving leadership to and coordinating all HIV-AIDS related activities at these levels. DMSAC, like the DDC, is an inter-departmental and multi-sectoral body consisting of representatives of different governmental, non-governmental and civil society organizations operating at the district level. It includes members from organizations such as District Councils, Tribal Administration, Land Boards, Community Based organization and government departments operating at district level and District Commissioner's office. DMSAC functions as the voice of the people at the local level and manages inputs facilitating the development of multi- sectoral HIV and AIDS action plans. DMSAC are housed under the Ministry of Local Government and are served by District AIDS coordinators, who are chairpersons of DMSAC. They also act as secretariat to the DMSAC. District Aid Coordinators are expected to play a key role in the development, facilitation and monitoring of the district response and work in close co-operation with all relevant stakeholders to ensure the effective contribution of the district to the overall national response. They are primarily the eyes and the ears of central government at the district level. The Ministry of Local Government works in collaboration with NACA to ensure that annual multi-sectoral planning is undertaken. It also facilitates the provision of technical assistance for the planning and management of local response.

Non Governmental Organizations (NGO's), Community Based Organizations (CBO's), Civil Society and the Private sector are also considered as active partners in the fight against the HIV-AIDS at national and local levels. For strengthening its effectiveness, the private sector has formed Botswana Business Coalition on AIDS (BBCA). This was established in 1994, using the best practice models from Global Business Coalition (GBC) on AIDS. This coalition coordinates HIV and AIDS interventions in the work place from the different private sector organizations. Private sector organizations have come up with work place interventions in educating and sensitizing their employees about the disease; in accessing existing government HIV and AIDS services; in assisting the government and partners in reaching more people; and in increasing up take levels for their services. The private sector is also addressing the issues of stigma and discrimination of employees infected with the virus. As Aids is destroying work force, productivity is declining and absenteeism is increasing, the private sector has to complement and supplement the government effort.

Civil Society organizations are also major partners in the fight against the HIV/AIDS pandemic as stated above. They have formed several networks such as Botswana Network of AIDS Service Organizations (BONASO), Botswana Net work on Ethics, Law and HIV and AIDS (BONELA), Botswana Christian AIDS Intervention Programme (BOCAIP) to support and promote coordination among them. All these NGO's play an advocacy role in terms of the fight against the pandemic in Botswana.

They help in facilitating community interactions, distributing resources such as condoms, changing social attitudes, and representing public interest in policy matters. They play a significant role in contributing to devising of innovative strategies, complimenting government's efforts in social mobilization, confronting difficult issues such as those related to sexuality, stigma, discrimination, human rights and access to treatment. These organizations also work with community based organizations that often have relationships with the locals in an effective way to lessen the impact of the epidemic on individuals and families, etc.

Aims of CoBaSys programme of work:

The PRA research in Old Naledi was conducted in the context of CoBaSys main objectives of empowering communities, generating evidence and sharing the learning with communities

through action research to promote local stakeholder advocacy towards national policies on HIV treatment, support and care at community level. Broadly, the COBASYS work will demonstrate mutual interests in the scientific cooperation on HIV AIDS at Euro –African Level through shared learning and understanding on HIV AIDS treatment systems at the primary care level of the Health system, Thus the action research conducted the high density neighborhood of Old Naledi in Gaborone explored the factors that facilitate and block access to, use and effective coverage of services and responses to HIV, and identified relevant and effective approaches to building community systems for responding to HIV/AIDS and services that support these systems.

Within the overall framework of the research programme, Old Naledi research aimed to:

- 1) Map the social economic differentials within the communities that affect risk and vulnerability to HIV and AIDS, and that may have an impact on uptake of available services for prevention, treatment and care of AIDS
- 2) Using this, identify the nature of the epidemic in the community in terms of risk groups and environments, the public health stage and burdens of the epidemic and discuss the nature of the responses needed for key social groups.
- 3) Map the resources, institutions and actors available at community and primary care level to respond to the epidemic.
- 4) Identify for key social groups the priority social and economic determinants at individual, household, community and system level that facilitate and block availability, access, acceptability, uptake, quality of care in and adherence to the resources above for prevention, treatment and care for HIV and AIDs (including community knowledge on social rights)
- 5) Review the evidence to assess the opportunities and mechanisms to enhance facilitators and overcome priority blocks to availability, access, acceptability, uptake, quality of care in and adherence to services: (e.g. opinion leader and health worker attitudes and practices; communication processes and skills, mechanisms for social dialogue and communication; resource transfers, service organization and so on)
- 6) Identify strategies for strengthening these opportunities and mechanisms as recommended by communities, health authorities, opinion leaders and key stakeholders, the actions that can be taken in the medium and long term.

3. Methods:

The study employed qualitative techniques with varying Participatory Reflection and Action (PRA) tools to triangulate the methodology and ensure validity and reliability of data. The study units included women, men, youth, elderly, social and community development workers; home based care volunteers as well as the chief of the area. The study was carried out in Old Naledi

The research started with a review of existing literature as well as the prevailing framework on HIV/AIDS in Botswana, regionally and worldwide.

A PRA study protocol used in the research was developed; peer reviewed and pretested prior to implementation (Machingura F et al 2010). The protocol was co-authored by Machingura F, Loewenson R and Kaim B from TARSC and peer reviewed by PRA experts, University of Manchester, University of Eduardo Mondlane, University of Namibia, University of Botswana, University of Modena, University of Helsinki, REACH trust Malawi and by the University of Zimbabwe. The tools were pre-tested in Goromonzi district by the researchers with a sample of 30 community members representing the target social groups. Researchers were trained over a 3-day regional training workshop in April 2010 (Harare) on participatory methods for community based systems in HIV treatment –‘*Strengthening capacities for qualitative research using PRA approaches*’ run by TARSC (TARSC 2010).

The following table shows how the methodology was staged in the protocol for each objective of the research

Table 1: Staging of Methodology and how each of the aims was addressed

Objective	Method
Map the social economic differentials within the communities that affect risk and vulnerability to HIV and AIDS, and that may have an impact on uptake of available services for prevention, treatment and care of AIDS	Social mapping Map interview Discussion
Using this, identify the nature of the epidemic in the community in terms of risk groups and environments, the public health stage and burdens of the epidemic and discuss the nature of the responses needed for key social groups.	Stepwise diagram and Focus Group Discussion (use FGD guide)
Identify for key social groups the priority social and economic determinants at individual household, community and system level that facilitate and block availability, access, acceptability, uptake, quality of care in and adherence to the resources for prevention, treatment and care for HIV and AIDs (including community knowledge on social rights)	Problem Tree Discussion
Map the resources, institutions and actors available at community and primary care level to respond to the Epidemic.	Stakeholder analysis Plenary roundtable Community roundtable
Review the evidence to assess the opportunities and mechanisms to enhance facilitators and overcome priority Blocks to access.	Leaping blocks Market place Discussion
Identify strategies for strengthening these opportunities and mechanisms as recommended by communities, health authorities, opinion leaders and key stakeholders, the actions that can be taken in the medium and long term for these strategies and the progress markers for these actions	Margolis Wheel Spider Web Discussion

(Refer to Loewenson R et al 2006, Loewenson R et al 2007, Loewenson et al 2008, Loewenson et al 2009 and Machingura F et al 2010 – **CoBaSys PRA Research Protocol**) for further reading on tools used.

The PRA research meeting participants were drawn from members of Old Naledi Community, community development workers, home based care givers, youth representatives, support groups and local leadership (Chief). This group constituted a total of 36 participants from Old Naledi. The research team comprised of the Coordinator and research manager as well as three research assistants.

Site Selection, Community Mobilization, and Planning the Research Meeting:

The PRA research was conducted in Old Naledi, a high density suburb in Gaborone, with an estimated population of 90 000. Old Naledi was selected as area of research for the following reasons:

- It is a densely populated with high number of people who have come to the city from their rural areas with the hope of finding employment. These people end up residing in Old Naledi because it offers the cheapest accommodation in the City.
- Old Naledi is a slum area located within the City of Gaborone and as such facilitated regular visits, monitoring and communication feedback for the study.
- Because of its location, it provides easy access for the target groups especially those living with HIV and AIDS. It also facilitated the identification of support groups and those involved in HIV prevention, treatment and care.

The research began with preparations for the PRA meetings as early as June 2010 immediately after the research permit was given by the Government of Botswana. This was done by issuing out invitation letters to the various organs and stakeholders as well as working hand in hand with Community Development officers. The invitation letters introduced the CoBaSys project and its intended objectives and aims. An extensive preparation of the meeting was done with the Old Naledi Chief as well as the community development workers and support groups. A tentative date and venue of the meeting was indicated in the invitation letters and times of the PRA meeting. Regular visits and updates were made to Old Naledi from June 2010 up to the time the meetings were eventually held in November 2010.

Introduction to the PRA Research Meeting:

The PRA meetings were held in Old Naledi Township on the 12th and 26th November 2010 (two days are hardly adequate for the study protocol) . There were a total of 36 delegates, including 25 women, 9 youths and 3 Men These delegates included two community development workers, and Old Naledi Chief. The participants were broken into three groups and each group was given a name, i.e. Kutlwano Focus Group, Masa Group (with three men participating) and the Lesedi Youth Group. The research team welcomed the delegates and participants introduced themselves. Old Naledi Chief officially opened the meeting and formally introduced CoBaSys in Old Naledi. The area MP, the three Old Naledi Councilors, Old Naledi Station Commander and health workers were invited but they could not attend due to other engagements although they expressed their interest.

4. Findings of the PRA Research:

4.1 Mapping social and economic differentials in Old Naledi

Participants discussed how the socio-economic differentials may have an impact on uptake of available services for HIV/AIDS. Participants were divided into groups according to gender and age and drew a map of their community on flip charts, mentioning the main features such as roads, hospitals, churches, sources of waters, markets, schools, shops, rail way line, children's play ground, public toilets, police station traditional healers, Kgotla and community centre.

“A community system is the total of all the organizations, local government structures, civil society organizations, institutions and resources whose primary purpose is to improve health at primary care level. The community system draws organizations into a broader primary care based service provision network structure for improved service delivery into the wider health system. The primary care level is the first level of care in the health system, it is the lowest tier where people are and where need is greatest” (Machingura F. et al 2010).

The groups identified the following main features in their social maps

- Social services, particularly schools, clinic, churches, police station, traditional healer's kgotla, NGOs and social services.

and transport. There is also no motivational support such as small fees to encourage them to participate in such activities.

The few that are in the fore front include Home Based Care (HBC), People Living with HIV/AIDS (PLWHA) and the Youths.

There are no social groups for men and because of that men by and large do not actively participate even in health committees. There are however, Non Governmental Organizations that offer support to Old Naledi residents among others Kgothatso, Holy Cross Hospice and Save our souls (SOS). The support they offer includes counseling services and provision of cooked meals and food baskets to HBC and for people living with HIV/AIDS. However these services are not adequate and consistent as people benefiting from them continue to seek the same services from GCC to supplement their diet.

Old Naledi is divided into three respective areas being Naledi South, North and Central and has an estimated population of about 90 000. It also has only one health services centre (clinic) that serves the entire community of Old Naledi. The clinic is manned by only one Doctor who is not resident there and only comes two times a week at specific times. As a result of this there are long queues and poses a challenge in that some resident of Old Naledi end up going to other health facilities that are far away. The clinic provides Voluntary Counseling and Testing (VCT) services and Prevention of Mother to Child Transmission (PMTCT) services. However, the clinic does not carry out CD4 count. Patients are referred to other clinics such as Bontleng clinic (about 3km away); Block 9 clinic (about 5km) and Village Clinic (about 4km). Others are referred to Princess Marina Referral Hospital (about 7km). The greatest challenge faced by the patients on referral is that some do not even bother to go at all, due to lack of transport fares (high for many of them) and there are no other supporting mechanisms to enable them to reach there. At times they are turned away for failing to produce their national identity cards, which prevent access to health services and care. Some faith based organizations as well as traditional doctors/healers do not allow their members to be enrolled on Anti Retroviral Treatment (ART). As a result of such objections some people abandon treatment which ultimately affects their adherence levels. Men also do not actively participate in various committees that focus on health issues and HIV/AIDS.

One of the major issues affecting Old Naledi residents in terms of adherence as well as access to treatment and care is the lack of support from their employers. Old Naledi is located adjacent to an Industrial site. As a result of this some employees end up being reluctant to go for routine check ups or to collect their treatment drugs out of fear of losing their jobs.

Women in Old Naledi are also vulnerable mainly as a result of lack of income as well as lack of access to and control over resources. This vulnerability has contributed to some women resorting to transactional sex as well as trading as commercial sex workers. Because of high unemployment in the area, some women resort to selling traditional illicit brews as a way to raise money to enable them to feed their households. They are also vulnerable in most cases due to the role they have to play as caregivers as well as doing household chores. Women also stated that it is very rare for them to ask a man to use a condom even when they know their partner has multiple sexual relationships. They stated that it is very rare to hear a woman telling a man to use a condom and to insist on him always putting it on. They further stated that in some cases even if you refuse, they can get beaten and in some cases their arms being twisted to squeeze them in submission.

Thus, although economic issues influence power relations between men and women in relationships, it is evident that there are more complexities than issues such as socialization and assertive demands for safer sex coming from partners coming into play.

Men are equally affected by the high unemployment situation and those that are employed are in the low income groups. This affects family set up in that; women would desert their men or tend to engage in multiple concurrent partners as a way to raise extra income for themselves. Men who work as night watch men are also faced with greater challenges in that while they are at work, their women bring men in the house who assume the role of a lover or even a husband. This has led to cases of passion killings being reported from Old Naledi, where men have killed their lovers out of jealousy that they had cheated on them.

The youth on their part, noted that there is rampant unprotected sexual intercourse amongst themselves. They also stated that the greatest challenge that they are faced with in terms of their relationships with their female peers is that they have to compete with older affluent men. Because of their financial position these older men entice young girls into sexual relationships and to engage in transactional sex. They also stated that their mothers end up tolerating their relationships with older men for as long as they benefit financially, the mothers turn a blind eye to such activities or condone or in some cases even encourage them. In worst case scenarios mothers vacate their rooms for the older men to have sex with their daughters (young girls). The youths stated that some parents even go to the extent of urging their daughters to indulge in transactional sex (survival sex) and cross- generational sex (sex with old men – nearly the age of their fathers) in order to meet the basic needs. The other contributing factor is that the girls engage in transactional and cross generational sex because they aim to live or experience a lifestyle that is far above the economic means of average community members. It is not just because they are not able to meet their basic needs for survival.. It is about maintaining fancy city life style which most of them cannot afford. So they seek and look out for men who can give them money to satisfy their needs. Therefore, the priority for these girls/women is not protection, but appearance which gives them a higher status in the community

The discussion during the PRA meetings confirmed that many young people have adequate information on the dynamics of HIV/AIDS, especially on the modes of transmission and means of prevention of HIV infection. Most of them do have enough knowledge to start embracing safer sexual behavior. However, the young people have not yet developed the capacity in terms of appropriate attitudes and life skills to use the information for HIV prevention. It emerged that the young people have a lot of information on HIV/AIDS and sexually transmitted infections. They know the basics that they need to know. The problem is that they do not know how to handle it in their daily lives. They do not know how to handle this information to help them stay safe from sexually transmitted infections.

Young men also state that as a result of stiff competition they face from older women and their peers having no time for them, they resort to Sugar mummies as well. Thus communication and issues of conflict management skills seem to be a problem in relationships involving young people, who even adopt riskier strategies due to friction in their relationships.

For their part HBC complained about lack of facilities such as protective clothing and monetary incentives as care givers.

4.2. Priority socio-economic determinants that facilitate and block health service coverage.

Participants defined the major health needs in their social groups using the ranking and scoring Participatory tool. They did this in groups divided by gender and age and one other group with community development workers and distributed seeds against the health problems they felt needed greatest attention. The total seeds for each problem were used to determine the three top health priorities. This was done to identify the priority social and economic determinants at individual household, community and system level that facilitate and block availability, access, acceptability, uptake, quality of care in and adherence to the resources for prevention, treatment and care for HIV and AIDS.

Women highlighted unemployment, gender inequality and non activism of men on health issues as their most serious problems in that order. Women highlighted that their vulnerability is founded on their lack of access to and control over resources, household chores and child care responsibilities. They stated that because there is high unemployment with little economic activity in Old Naledi they end up having to resort to other means of raising household income such as brewing illicit alcohol beverages. They also stated that the biggest needs at community level that relate to HIV were on gender related barriers and men's non participation on HIV and AIDS related issues. They cited lack of support systems such as an ambulance in Old Naledi that can ferry patients to the clinic and that they have to travel long distances on referrals.

The men who participated in the PRA highlighted unemployment and low paying work as their priority needs respectively. They stated that lack of unemployment amongst men living with HIV and AIDS causes economic pressure at household level leading to stress and low self esteem associated with their inability to look after their families. Men at the same time are also not at the forefront on the fight against HIV and AIDS. They mainly rely on information from their spouses and partners. They stated that most men do not test for HIV/AIDS and only ascertain their HIV and AIDS status after their partners have tested. They stated that men in general often find it difficult to talk openly about sex and to reveal their status. Men are also affected by the high unemployment rate and some who are employed receive low wages. Because men are traditionally seen as the providers, and they believe that they must fulfill this role, many of them react negatively if they cannot find work or if they are unable to provide for their family.

The Youth on the other hand noted that unprotected sexual intercourse was rife and common. They stated that in some cases they are lured by older men to have sexual relationships and the main motivating factor being finance. They also highlighted lack of care and attention paid to the young people by adults and that in some cases their parents encourage them to have sexual relationships with older men for financial gain. This they said actually exposes them to risky sexual behaviors and they end up having unprotected sex with the older men. The youths also stated that in some instances some of them quit schools and have children in order to benefit from the social welfare programmes and some said that they do so to work in the lowly paying 'Ipelegeng Scheme' (Government drought relief scheme). The youths suggested that educational campaigns on HIV and AIDS must be strengthened and that there should be open discussions with parents, community leaders and other relevant stakeholders. They stated that they are generally shy to ask for provision of condoms and suggested that condoms should be easily accessible.

Although health workers did not participate in the PRA, the participants highlighted that addressing shortage of staff, operational hours, need for mobile clinic or hospice to provide ARVs in Old Naledi, and were their priority needs. Shortage of health workers and only one Medical Doctor manning the clinic poses a great challenge in terms of accessibility to health services and systems to the people of Old Naledi. They stated that to avoid long queues they have to wake up as early as 3am in order to go to the clinic. However, waking up such early is not a guarantee that one would be assisted on time. Home Based Care on their part

stated that because they do not have adequate facilities for handling patients with HIV and AIDS they may be exposed to contracting the disease. They suggested that they must be provided with proper equipment and facilities that will not expose them to the danger of contracting the disease when handling and dealing with terminally ill patients and those living with HIV and AIDS.

4.3. Underlying, intermediate and immediate causes of health needs

Social Group	Underlying Causes	Immediate Causes?
Women	Policy and planning	<ul style="list-style-type: none"> • One Clinic • One Doctor • Clinic located in Naledi North and therefore situated very far • Over Crowding at Naledi Clinic
Elderly	Policy and planning not pro-poor	<ul style="list-style-type: none"> • No cooperation between HBC and clinic. • limited operational Hours for the clinic • Increase staff • Lack of transport • Lack of care to the sick by family members. • Shortage of tests kits
Youth	<ul style="list-style-type: none"> • Stigma • Discrimination 	<ul style="list-style-type: none"> • .ARV accessed outside Old Naledi • Delayed Health Attention • No ambulance • Alcohol abuse amongst youth as a way to turn away from harsh realities of life.
Community Dev Officers	<ul style="list-style-type: none"> • Referrals too far from the clinic • Shortage of staff and no pharmacists • Sanitation very poor and some tenants rent out homes to tents even though they know the conditions are not health friendly. 	<ul style="list-style-type: none"> • Adherence declines as patients may feel lazy or reluctant to go and take drugs. • Transport fares are high for some of them as they are so poor and unemployment. • Burden created on Community Development Officers (CDO). In some cases patients die and create problems for CDO as they have to identify patient's relatives.



Participant presenting results from group discussions-Old Naledi

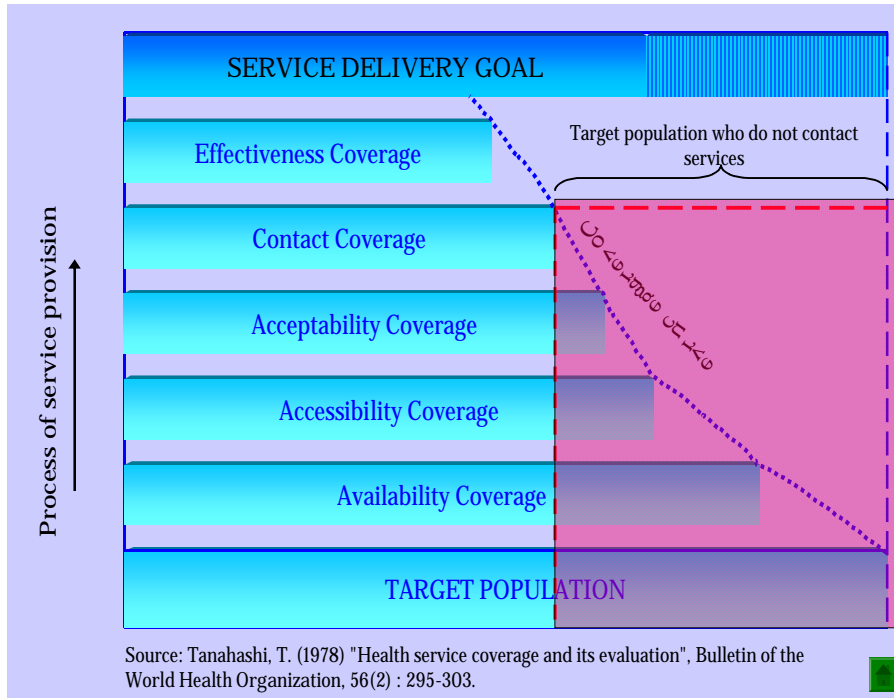
.Social Group	Problems	Solutions
Women	<ul style="list-style-type: none"> • One Clinic & One Doctor 	<ul style="list-style-type: none"> • Introduction of a mobile clinic and expansion of existing clinic. • Increased health personnel. • Increased Operational Hours
Elderly	<ul style="list-style-type: none"> • Shortage of tests kits and protective gloves 	<ul style="list-style-type: none"> • Provision of test kits and protective gloves
Youth	<ul style="list-style-type: none"> • ARV accessed outside Old Naledi. • No ambulance • Alcohol Abuse 	<ul style="list-style-type: none"> • Introduction of hospice and ensure that ARVs are at least provided for in Old Naledi. • Provision of an ambulance • Awareness, counseling and educational campaigns should be provided.
Community Development Officers	<ul style="list-style-type: none"> • Referrals too far. • Shortage of staff and no pharmacist 	<ul style="list-style-type: none"> • ARVs should be provided in Old Naledi and mobile facility be provided to help mitigate the problem. • Increased staff personnel and pharmacist.

Community action to address causes of priority health problems

Field Intervention	Means of Community Support.
Community Support to Home Based Care	<ul style="list-style-type: none"> • Care to people living with HIV and AIDS must be over emphasized. The participants had stated that often times there are lack of care of PLWHA by family members. • Because there is lack of care for PLWHA patients at home are often compelled to await the help of HBC members and if they are not checked by HBC, they skip taking medication. The family members need to behave more responsibility, • HBC must be assisted with the provision of gloves, as well as allocation of a piece of land for gardening. HBC must also be assisted by family members and they must not leave everything as the responsibility of HBC in providing care to PWLHA • Provision of vegetables to HBC so that they can give to PLWHA. HBC does not have a garden and rely on hand out from SOS that they pass on to PLWHA. • Support in identifying ill people and encouraging them to visit the clinic. • Cooperation between HBC and the clinic
Community support to Community Development Officers	<ul style="list-style-type: none"> • Identification of families and landlords must know their tenants. • Encouragement of men to take part in social groups and should work closely with Community Development Officers. Encouragement of back yard gardens. • Regular communication through different forums such as Kgotla, VDCs, and HBC should be encouraged.

4.4. HIV/AIDS responses for key social groups in health services coverage.

We understand Health service coverage as “the extent to which services reach out to communities needing it. In this context it is the extent to which health services reach out to communities affected and living with HIV including some vulnerable groups and other social groups in similar social networks. It also addresses how communities interact with the services provided by community health systems and the wider health systems in terms of



access, provision and uptake of HIV treatment, support, prevention and care services. Services will include those provided by health care systems, those demanded by communities, resources generated for health, financing of health systems and stewardship” (Machingura et al 2010)

Figure 3: Tanahashi model of health care coverage

To identify the nature of the epidemic in the

community in terms of risk groups and environments, the public health stage and burdens of the epidemic and discuss the nature of the response needed for key social groups the Tanahashi model was used. Tanahashi (1978) provided a concept of coverage that helps to understand the level at which inequalities in peoples’ contact with health care may arise. Tanahashi provides for five domains for this (See Figure 3):

Three social groups each identified a service where resources were available but were the social group faced challenges in accessibility, acceptability of those resources up to the point of contact and effective coverage. All the social groups noted that HIV treatment systems and services were available, however there were challenges associated with accessibility, acceptability, utilizations that did not translate to effective coverage.

Tanahashi model was used to qualitatively interrogate the health service coverage in terms of HIV treatment in Kariba district. The tool was designed to enable communities to express coverage of HIV treatment relative to need of the population requiring treatment who have used the service. Importantly the qualitative component of the provision of care is what the Tanahashi model interrogates. Reasons for flaws in availability, accessibility, acceptability, contact and effective coverage were identified and possible solutions were discussed, including recommendations on how to strengthen the community based system on HIV treatment. The five domains of coverage were expressed in terms of availability, accessibility, acceptability, contact and effective coverage as outlined below.

- i. Are the care resources (infrastructure, drugs, personnel) available, and for whom? termed **availability coverage**.
- ii. Are these resources accessible, and for whom? This is termed **accessibility coverage**. There may be physical or financial barriers to access.
- iii. Are the resources / services acceptable to the population, and for whom? This is termed **acceptability coverage**. This includes social, cultural and perception financial barriers to using services.
- iv. Are people making contact with the services, and who?, termed **contact coverage**, or utilisation, and finally
- v. **Effective coverage**, or what share of the population in need of an intervention effectively receive that intervention? This does not include the health impact of the intervention, but does include successful and complete compliance with the entire intervention, whether treatment, maternal health services etc.

Participants noted that the greatest challenge that they are faced with in terms of all the above is the issue of accessibility. That although Old Naledi is overly populated, the clinic is manned by only one doctor with no physician and patients have to travel long distances to other clinics on referral. The question of availability as well as contact coverage then arises.

The first level of health service provision in Old Naledi township is the clinic. The clinic has different units ranging from out patient ward, testing centre and maternity ward. Patients are tested at Old Naledi clinic and after having followed all the necessary processes and procedures such as pre test counseling, there are other steps involved such as CD4 counts and these are undertaken elsewhere. Home based care participants stated that although they are responsible for assisting people living with HIV and AIDS, there are no linkages between HBC at clinics and HBC housed at Social and Community Development Department at local government level. This they stated contributes to friction and conflict the end result being lack of support.

4.5. Community Systems and Mechanisms for Referral network in HIV treatment

In this context of community based systems in HIV treatment, 'a referral is the process by which immediate client needs for comprehensive HIV care and supportive services are assessed and clients are helped to gain access to services, such as setting up appointments or giving directions to facilities. Referral should also include reasonable follow-up efforts to facilitate contact between service providers and to solicit clients' feedback on satisfaction with services.(Family Health International 2005).

The discussions highlighted that health service provision is integrative, characterized by, for Example ART programmes have been integrated with VCT, PMTCT and Male circumcision Programmes.

The first point of testing for CD4 is done and carried out at the Old Naledi clinic. After that patients are referred to other clinics in order to be enrolled in ART. Such services are provided and carried at by other clinics, such as Bontleng clinic, Block 9 and Princess Marimah Referral Hospital. The ANC programme assumes the lead in making referrals to other clinical service providers in Gaborone. However, there is no formal mechanism for follow up on the patients to determine if the need has been satisfied, i.e. if the patients that have tested positive have been enrolled on ART or not. There is also no follow up on the patients themselves and determine as to whether they have gone and consulted the referral network system.

As a result of the above, the participants recommended that Old Naledi clinic should be a one stop shop with all the facilities on site to avoid referrals. They recommended for the establishment of the CDC centre, as is the case through out the country where all the

services are provided. In doing so, follow ups on patients can easily be made and can also help address the issue of accessibility. Thus

Community health system should make integration of the referral network a central principle to help PLWHA, family support, Home Based care givers, Village Health workers, and HIV AIDS support groups. These groups should obtain information and access services on health to facilitate their active participation in decisions affecting their lives and to promote social acceptance and respect for those living with HIV and those caring for HIV-infected persons.

4.6. Community Systems and Mechanisms for Clinical Mentoring in HIV treatment

“Clinical mentoring is a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes in HIV treatment. Expertise in managing antiretroviral therapy and opportunistic infections is often not found on the district management team in programmes that are starting to scale up HIV treatment. A clinical mentor in the antiretroviral therapy context is a clinician with substantial expertise in antiretroviral therapy and opportunistic infections who can provide ongoing mentoring to less-experienced HIV clinical providers by responding to questions, reviewing clinical cases, providing feedback and assisting in case management. This mentoring occurs during site visits as well as via ongoing phone and e-mail consultation. Clinical mentoring is critical to building successful district networks of trained health care workers for HIV care and treatment in resource-constrained settings.” Machingura F et al 2010)

Although health workers failed to make it at the PRA meetings, the participants who attended stated that there were no experienced practicing clinicians with strong teaching skills and with time to mentor less experienced health workers in the administration of HIV treatment and management of AIDS based at the Old Naledi clinic. They also emphasized the need for training for Home Based Care givers in order to enable them to handle PLWHA.

4.7. Organization of Primary Care Patient flow approaches in HIV treatment

Understanding of Patient flows within Health facilities provides an in-depth appreciation of flaws that exist within health facilities for delivering HIV treatment.

These flaws were observed to resonate with long waiting times. The participants stated that because there is only one clinic in Old Naledi, they have to wake up as early as 3am to avoid long queues. However, such was not a guarantee and in that even when the clinic start its operations at 730am, they end be served around 12noon or even after wards. Thus the patients spend long hours waiting for service. The participants also stated that there is severe shortage of staff and that the clinic is manned by only one doctor who comes only at certain times. These waiting hours are often characterized by patients with empty stomachs, frustrated and angry for slow service and in some instances patients out of frustration end up returning home even before been served.

Another barrier that participants talked about was the porter camps where counseling and CD4 count are being undertaken. It is detached from the Main clinic building and there is often some stigma attached to it. As a result of this, patients end up felling shy to visit the facility because it is just in the open space with no confidentiality.

4.8. Mapping community resources, institutions and actors that respond to HIV AIDS

The participants stated that although there are CBOs and NGOs working with the community in terms of addressing HIV and AIDS, most of such institutions are only visible during the HIV and AIDS commemoration day. They are also only visible when they want to carry out research studies and on matters that they are only interested in. There is also a vacuum in

terms of vertical and horizontal linkages and these defeats the multi sectoral approach to HIV and AIDS. The participants also highlighted instance of duplication of efforts and roles especially with regard to Home Based Care and its relationship with the Community Development Workers and the District Health Team (Clinic). Such duplication creates conflict amongst the two institutions. There was also lack of commitment on the part of health workers and other extension workers working with Old Naledi Community and they often look down to the members of the community as inferior.

As recommendation the participants suggested that the extension workers and the different stake holders working in Old Naledi should work closely with the Old Naledi Community and must not only see and use them as a subject of research. They also stated that there should be clear and sound coordination that provide horizontal and vertical linkages between the districts and the national level.

4.9. Strengthening communication opportunities for health workers and communities.

Health workers act as a bridge between health system and community in providing HIV treatment and care. Knowledge, capacity and communication skills of the workers are key to both their own confidence and building trust within communities. This is thus, fundamental for the success of the health system. Engaging communities and workers in building systems that are capable to manage HIV treatment at community level demands a system that recognizes effective health worker-patient interaction.

Using a PRA tool- Margolis Wheel to determine the issues that patients face and those that health workers face that affects their interaction, quite a number of factors were exposed. However, what the health workers face in their interaction with patients was not discussed, since they did not participate in the PRA, despite having been invited to take part.

For their part the participants cited long distances to the Old Naledi Clinic. They also cited long waiting times and stated that the dispensary is not manned by qualified personnel and in some instances nurses become in charge of disbursing drugs (Not necessarily ARVs). They also stated that the health workers in some instances look down up them and become arrogant in serving them by referring to them as people from 'Ditakana' (slumps). The participants also talked about the referral system where ARVs are not disbursed at the Old Naledi clinic and hence have to travel long distances to other clinics, where they are also ridiculed and stigmatized as people from Ditakaneng (slumps). As a solution they stated that government should consider expanding the existing health facility with a CDC centre to avoid transfers and referrals.

5. Discussion

The research findings indicate that Old Naledi has high unemployment and lack of social and economic activities that could be tapped into to facilitate an efficient HIV/AIDS treatment and support system at primary care level. There are also no major economic incentives to work and most of those that are working are low income earners. There is also lack of vibrant social activities mainly due to lack of motivational resources to encourage participation.

Old Naledi is faced with challenges that relate to access, availability and accessibility that prevent effective coverage. There is only one clinic in Old Naledi that caters for the entire community and the clinic is manned by only one Doctor with no CDC. The clinic provides Voluntary Counseling and Testing (VCT) services and Prevention of Mother to Child Transmission (PMTCT) services as well as maternity services. Old Naledi does not administer CD4 counts as these are done on referrals.

There is also problem faced by the various social groups in Old Naledi such as women, youth, men and the elderly. For their part women in Old Naledi are vulnerable mainly as a result of lack of income as well as lack of access to and control over resources. This vulnerability has contributed to some women resorting to transactional sex as well as engaging in the brewing and selling of illicit brews as a way to raise household income. According to Old Naledi women, it is very rare for them to ask a man to use a condom even when they know their partner has multiple sexual relationships. As a result of this, it becomes difficult for them to insist on men to use a condom.

According to Men in Old Naledi, they are equally affected by the high unemployment situation and those that are employed are in the low income groups. This they stated their affects family set ups in that; women would desert their men or tend to engage in multiple concurrent partners as a way to raise extra income.

The youth on their part, noted that there is rampant unprotected sexual intercourse amongst them. They also stated that the greatest challenge that they are faced with in terms of their relationships with their female peers is that they have to compete with older affluent men. The youths stated that some parents even go to the extent of urging their daughters to indulge in transactional sex (survival sex) and cross- generational sex (sex with old men – nearly the age of their fathers) in order to meet the basic needs. The other contributing factor is that the girls engage in transactional and cross generational sex because they aim to live or experience a lifestyle that is far above the economic means of average community members than because they lack basic needs. It is about maintaining fancy city life style which most of them cannot afford. So they seek out men who can provide these needs.

6. Recommendations and Conclusion

6.1. Recommendations for Community Action

The Community participants recommended for the extension of clinic operational (24 hours a day) including operations during weekends. The participants stated in the focus groups discussions that the clinic does not open on weekends and that it closes at 1630hours from Monday to Friday and hence why they came up with such a recommendation. They also recommended for the construction of a hospice where People Living with HIV and Aids can be assisted and taken care of. They suggested that because currently there are no such facilities and that they only take CD4 counts at the Old Naledi clinic and are then referred to other health facilities in order to be enrolled on ART when their CD4 count has reached the recommended amount. Further, they recommended that community campaigns on education and adherence to treatment as well as elimination of stigma and discrimination related to HIV and AIDS should be reinforced through the ministry of Health. .

6.2 The Frontline Health System

Although the health professionals did not attend and did not participate in the PRA after having been invited to, some of the issues pertaining to the frontline health system raised in the meeting include:

- Implement policy proposal to remove fees for primary care and monitor it regularly. This was observed mainly because citizens are required to pay P5.00 (US\$.71) in order to be assisted and in some instances if they fail to pay this fee, they are turned back home without being assisted.
- Improve resource allocation to health services, including vehicles for ambulatory services. This will ensure that patients are not transported in wheel barrows as it is sometimes the case in Old Naledi
- Ensure easy access and availability of ARVs in Old Naledi and avoid referrals to other clinics.

- Training of health workers to build trust and self esteem among PLWHA. The health workers should also be trained to ensure that they accept the people of Old Naledi and they do not look down upon them.

6.3 The Interaction between Community and Health Systems

Old Naledi is over crowded with an average household having about fifteen people. As a result of this they are prone to different ailments and diseases. For instance there has been high number of Multi Drug Resistance TB (MDR). They also recommended for the construction or expansion of the current clinic since it is serving so many people offering few services. They also called for employment of more doctors in order to assist in this serious problem they are currently faced with this currently there is only one medical doctor assigned to Old Naledi clinic.

- Given that the clinic is far and accessibility is not easy and the problem is compounded by bad roads where in some extreme situations they have to transport patients to clinics in wheel barrows. They called for the procurement of an ambulance that will serve the entire community of Old Naledi. Furthermore, since ARV are collected very far, participants recommended that a CDC centre should be constructed in Old Naledi to enable patients not to travel long distances to access drugs. As a remedy, they also called for mobile clinic specifically for disbursing ARV drugs to PLWHA.
- Home Based care givers should be provided with gloves and other protective clothing when dealing with patients. Incentives such as monthly allowances can be used for transportation and buying of food on their visits to patients. Participants called for some of assistance from the community leaders and government to provide them with pieces of land on which they can grow vegetables allow them carry such an activity.

7. Appendices

7.1. Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
AR	Anti-Retroviral Treatment
BOCAIP	Botswana business coalition on HIV/AIDS
BCL	Bamangwato Concession Limited
BONASO	Botswana Network of AIDS Services Organizations
BONELA	Botswana Network of Ethics Law and HIV/AIDS
CBOs	Community Based Organizations
CDC	Centre for Disease Control
DDC	District Development Committee
DMSAC	District Multi Sectoral HIV/AIDS Action Committee
GBCA	Global Business Coalition on AIDS
GoB	Government of Botswana
CoBaSys	Community Based Systems in HIV treatment
HBC	Home Based Care
HIV	Human Immunodeficiency Syndrome
MAP	Multi Country HIV/AIDS program
NAC	National Aids Council
NACA	National Aids Coordinating Agency
NGO	Non Governmental Organization
PLWHA	People Living with HIV AIDS
PMTCT	Prevention of Mother to Child Transmission
PRA	Participatory Reflection and Action
TARSC	Training and Research Support Centre
UNAIDS	Joint United Nations Programme on AIDS

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