REPUBLIC OF BOTSWANA

MINISTRY OF LOCAL GOVERNMENT AND RURAL DEVELOPMENT

DMSAC

EVIDENCE BASED PLANNING TOOLKIT...

...with a Result Based Management (RBM) Focus

APRIL 2013

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The revision of the District Multi-sectoral AIDS Committee (DMSAC) Evidence-Based Planning Toolkit was made possible through funding from the President's Emergency Fund for AIDS Relief (PEPFAR) through the Centre for Disease Control (CDC/Botswana).

Technical support of this tool was provided to the Ministry of Local Government and Rural Development, HIV/AIDS Coordinating Division by the National Alliance of State and Territorial AIDS Directors.

NASTAD™
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

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LIST OF ACRONYMS / ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BAIS	Botswana AIDS Impact Survey
BHRIMS	Botswana HIV and AIDS Response Information Management System
CBO	Community Based Organization
DAC	District AIDS Coordinator
DMSAC	District Multi-Sectoral AIDS Committee
EBP	Evidence Based Planning
FBO	Faith Based Organization
GOB	Government of Botswana
HIV	Human Immune -deficiency Virus
M&E	Monitoring and Evaluation
MER	Monitoring, Evaluation and Reporting
MLG&RD	Ministry of Local Government and Rural Development
MOH	Ministry of Health
NACA	National AIDS Coordinating Agency
NASTAD	National Alliance of State and Territorial AIDS Directors
NDP	National Development Plan
NGO	Non-Governmental Organization
NOP	National Operational Plan
NSF	National Strategic Framework
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV and AIDS
RBM	Results Based Management
V/WMSAC	Village/Ward Multi-Sectoral AIDS Committee

ACKNOWLEDGEMENTS

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We would also like to express appreciation to the Reference group who guided the whole process as well as the National AIDS Coordinating Agency (NACA) for their unwavering support.

Gratitude also goes to District Multi-Sectoral AIDS Committees (DMSACs) in particular the District AIDS Coordinators (DACs) for their contribution at various stages of this document to make it a success.

EXECUTIVE SUMMARY

This latest District Multi-Sectoral AIDS Committee (DMSAC) Toolkit revision is a product of an informed series of progressive improvements based on evaluation recommendations as well as a critical review of relevant documents. It also includes feedback from the users, at district level, and other stakeholders, over a period of time, since 2004.

The Ministry of Local Government and Rural Development has, through partnership and support from the National AIDS Coordinating Agency (NACA) and the National Alliance of State and Territorial AIDS Directors (NASTAD), since 2004 been capacitating the District AIDS Coordinators (DACs) and DMSACs in the planning and implementation of the districts' HIV and AIDS response by applying the Evidence Based Planning Process (EBP). This approach to planning allows the districts to use data that is relevant to their district needs for HIV prevention, treatment, care and support services. The DMSAC Evidence-Based Planning (EBP) Toolkit was adopted by the Ministry of Local Government and Rural Development for use by the districts in 2007.

The EBP Toolkit has been designed to provide guidance to the DMSACs for developing their district comprehensive HIV and AIDS plans. In addition to the EBP, the Government of Botswana adopted a Results Based Management (RBM) approach to provide a coherent framework for accountability. RBM, as a performance management approach supports transition from an annual budget exercise to a strategy driven planning cycle, and from an internal management focus on inputs and outputs to an outward looking orientation centered on achieving results (outcomes and impact). This revised Toolkit, as outlined in this document, has further refined and improved on the linkages and use of the two approaches to ensure a more user friendly Toolkit, that is easier to use, and is more aligned to the National Operating Plan(NOP 2010-2016), especially with the monitoring and evaluation results framework.

The need and justification for revising the DMSAC Toolkit was informed by, among others, new evidence and emerging issues in the National HIV and AIDS Response, and the need to align the toolkit to the revised strategic imperatives and interrelated partnerships under which HIV and AIDS is implemented at District level. The 2009 evaluation of NASTAD's capacity building efforts in introducing EBP to MLG&RD and DMSACs (evaluation conducted by the University Research Co., LLC) found that, the strengths of the technical assistance efforts have been the provision of structure and focus, and encouragement for the use of evidence in the HIV and AIDS district planning process. The evaluation exercise nevertheless came up with a number of recommendations to strengthen the planning process and support the sustainability and expansion of EBP. These recommendations, alongside other observations, have indeed informed and guided the revisions and development of the revised Toolkit.

Towards this end, the revised DMSAC Toolkit has an evidence based-planning model that interfaces with results-based management. A number of documents have informed this Toolkit, including the National Development Plan (NDP 10), DMSAC Evidence based Planning Toolkit (2008), the National Strategic Framework II and Evaluation of the District and Community level EBP in Botswana Report (2010), DMSAC Communication

Strategy (2011), National Community Mobilization Strategy (2011), Handbook for Community Conversations (2004), the DMSAC and VMSAC/Ward Terms Of Reference (2006) and other relevant documents.

The revised Toolkit is therefore a product of input from the aforementioned sources and has been designed and packaged to be simpler, clearer and more user friendly to the District Planning Sub Committe

The above specified activities have resulted in the revised DMSAC Toolkit as outlined herein. The components containing various inputs and revisions are outlined in the following sections:

SECTION ONE

Provides an introduction to Evidence Based Planning which contains the critical logical questions that inform and define Evidence Based Planning.

SECTION TWO

Outlines the process of Evidence-Based Planning in six steps which include: Getting ready to plan; Evidence Gathering; Results Oriented Planning; Preparing the Plan; Planning for Implementation, Monitoring and Reporting; and Planning the Evaluation.

SECTION THREE

Outlines and explains the critical role of Monitoring, Reporting and Evaluation of the District Response in the overall context of National Operating Plan.

SECTION FOUR

Contains seven revised tools and templates which include: The DAC Activity Checklist; The District HIV and AIDS Profile – Data/information Form; The District Inventory Form; Detailed activity Proposal Template; Summary of Proposed Activities Template: Activity Monitoring and Reporting Form and the Activity Monitoring and Reporting Worksheet.

SECTION FIVE

Contains Reference Materials. These include: List of National Documents to guide the Planning and Implementation; A list of National NOP indicators to guide selection of District level Indicators and other relevant documents.

SECTION 01

Introduction to Evidence-Based Planning

PREAMBLE

The HIV and AIDS epidemic in Botswana has placed a heavy burden on families, communities and the government alike. The country is experiencing one of the most severe HIV and AIDS epidemics in the Southern Africa region. The 2008 Botswana AIDS Impact Survey (BAIS, 2008 III) estimated that HIV prevalence among the general population was at 17.6%, which translates to about 350, 000 people living with HIV infection. The prevalence is highest among pregnant women aged 30-34 years, with almost 50% of women in this age group being infected (BAIS III) . Botswana's national response to the HIV and AIDS epidemic has received the utmost political will and support. The national response to the fight against HIV and AIDS remains steadfast and unrelenting. This is reflected in national policies, strategies and commitment of resources. The national response is guided by national priorities and strategies, including the National Development Plan (NDP10), the National HIV and AIDS Strategic Framework (NSF II 2010-2016) and HIV and AIDS related goals as contained in the Nation's development blueprint, Vision 2016.

Furthermore, the country has continued to strengthen its efforts against HIV and AIDS by implementing a multi-sectoral approach. The multi-sectoral approach has demonstrated the need and value of engaging all stakeholders and the importance of decentralizing the response. The implementation of a multi-sectoral approach has been supported by district and community level structures via the District Multi-sectoral AIDS Committees (DMSACs) and the Village Multi-sectoral AIDS Committees (VMSACs). This approach has indeed brought many stakeholders together in the fight against HIV and AIDS. This approach has placed districts and sub districts at the center of the national response.

Since 2004, the Ministry of Local Government and Rural Development in collaboration with NACA and NASTAD has been capacitating the DMSACs in the planning and implementation of the districts' HIV and AIDS response by applying the Evidence Based Planning (EBP) approach. This approach to planning allows the districts to use data/information that is relevant to their district needs for HIV prevention and care services. Each district has a responsibility to plan and implement activities that will effectively address HIV and AIDS in their local communities. This is accomplished by developing comprehensive plans that are inclusive, effective, credible and aligned to the respective national strategic priorities.

In support of the district planning efforts, the first District Multi-Sectoral AIDS Committee (DMSAC) Planning Toolkit was put in place in 2005 and updated in 2008. In 2010, an evaluation of district level EBP for HIV prevention in Botswana was conducted , and its recommendations have informed a further revision of the Toolkit. Some of the key recommendations emanating from the evaluation were the need to strengthen the planning process and support the sustainability and expansion of EBP. As such, this Toolkit is informed by, among others, the 2010 evaluation and ensuing recommendations.

In addition to the EBP, the Government of Botswana adopted a Results Based Management (RBM) approach to provide a coherent framework for accountability. RBM, as a performance management approach, supports transition from an annual budget exercise to a strategy driven planning cycle, and from an internal management focus on inputs and outputs to an outward looking orientation, centered on achieving results (outcomes and impact).

WHAT IS EVIDENCE-BASED PLANNING?

Evidence based means that the best available data, information and knowledge are used to make decisions. Therefore, evidence-based planning is harnessing the knowledge gained from data and information and using it to optimize our planning process and improve results. It ensures that planned activities are linked to end results.

EVIDENCE-BASED PLANNING HELPS TO ENSURE THAT:

- The district's HIV and AIDS plan addresses the greatest needs for HIV prevention and care services in the district.
- Needs are determined by reviewing and assessing the HIV/AIDS situation in the district.
- The people of the district work together to set priorities for the coming years.
- The activities proposed are responsive to the identified priorities.
- The plan is comprehensive and provides guidance for various sectors and funding sources.
- It is an inclusive process.

WHY IS EVIDENCE BASED PLANNING IMPORTANT?

The district comprehensive plan is the DMSAC's most important management tool. It helps the DMSAC make sure that government funds, and funds from other sources are used in the best way possible in the district.

An evidence-based plan ensures that each district's plan addresses the specific situation and needs of people in that district. An evidence-based plan also assists the DMSAC to make sure that programs in the district are well coordinated. Resources may be wasted if services are not coordinated or if they duplicate each other. As such the DMSAC can use the planning process to improve coordination. Furthermore, an evidence-based comprehensive plan also assists the DMSAC to monitor what is being implemented in the district.

WHY HAVE AN EVIDENCE- BASED PLANNING TOOLKIT?

This Toolkit has been designed to provide guidance to the District AIDS coordinator (DAC), District Multi-Sectoral AIDS Committee (DMSAC) Chairs, and the DMSAC Planning Subcommittee members for developing their district's Comprehensive HIV and AIDS Plan. The Toolkit is intended to serve as a guide and therefore districts should feel free to adapt the proposed process to suit their own context and unique circumstances.

This Toolkit is guided by a Results Based Management (RBM) approach with the aim of improving service delivery, management effectiveness and accountability by outlining expected results, monitoring progress toward the achievement of expected results, and integrating lessons learned into evidence based planning and implementation.

The RBM system requires the DMSAC, its members and key stakeholders to carry out the following:

ARTICULATE THE GOAL: A clear goal is a critical starting point.

FORMULATE OBJECTIVES: Identify in clear, measurable terms the results being sought and develop a conceptual framework on how the results will be achieved.

IDENTIFY STRATEGIES AND ACTIONS: Determine strategies and well-articulated activities that are important in addressing the objectives and achieving the goal(s).

IDENTIFY INDICATORS: For each identified objective, specify what is to be measured along a scale or dimension which is the indicator.

SET TARGETS: For each indicator, specify the expected result to be achieved by certain timelines/ dates, which will be used to measure performance.

MONITOR RESULTS: Put in place a performance monitoring system to regularly collect data on actual results achieved versus expected results.

ANALYZE AND REPORT RESULTS: Compare actual results vis-à-vis the targets or use any other set criteria for measuring performance.

EVALUATE: Carry out evaluations to provide complementary information on performance not readily available from performance monitoring systems.Utilize performance information: Using information from performance monitoring and evaluation sources for internal management learning and decision-making, and for reporting to stakeholders on results achieved.

Evidence justifies why you are doing or implementing a given activity whereas RBM is an approach which systematically ensures that what you are planning to do and how you are going to do it, produces results that are measurable (RBM is results focused). This Toolkit therefore promotes the use of evidence (data, information and knowledge) to enhance the RBM approach.

HOW IS THE TOOLKIT ORGANIZED?

The toolkit is divided into five sections:

SECTION ONE: Introductory section to evidence-based planning.

SECTION TWO: The Planning Process: This is the heart of the Toolkit.

SECTION THREE: Monitoring, Reporting and Evaluation of the district response.

SECTION FOUR: This section contains tools/templates.

SECTION FIVE: This section concludes the Toolkit with reference materials and a listing of national documents to inform the planning and implementation process.

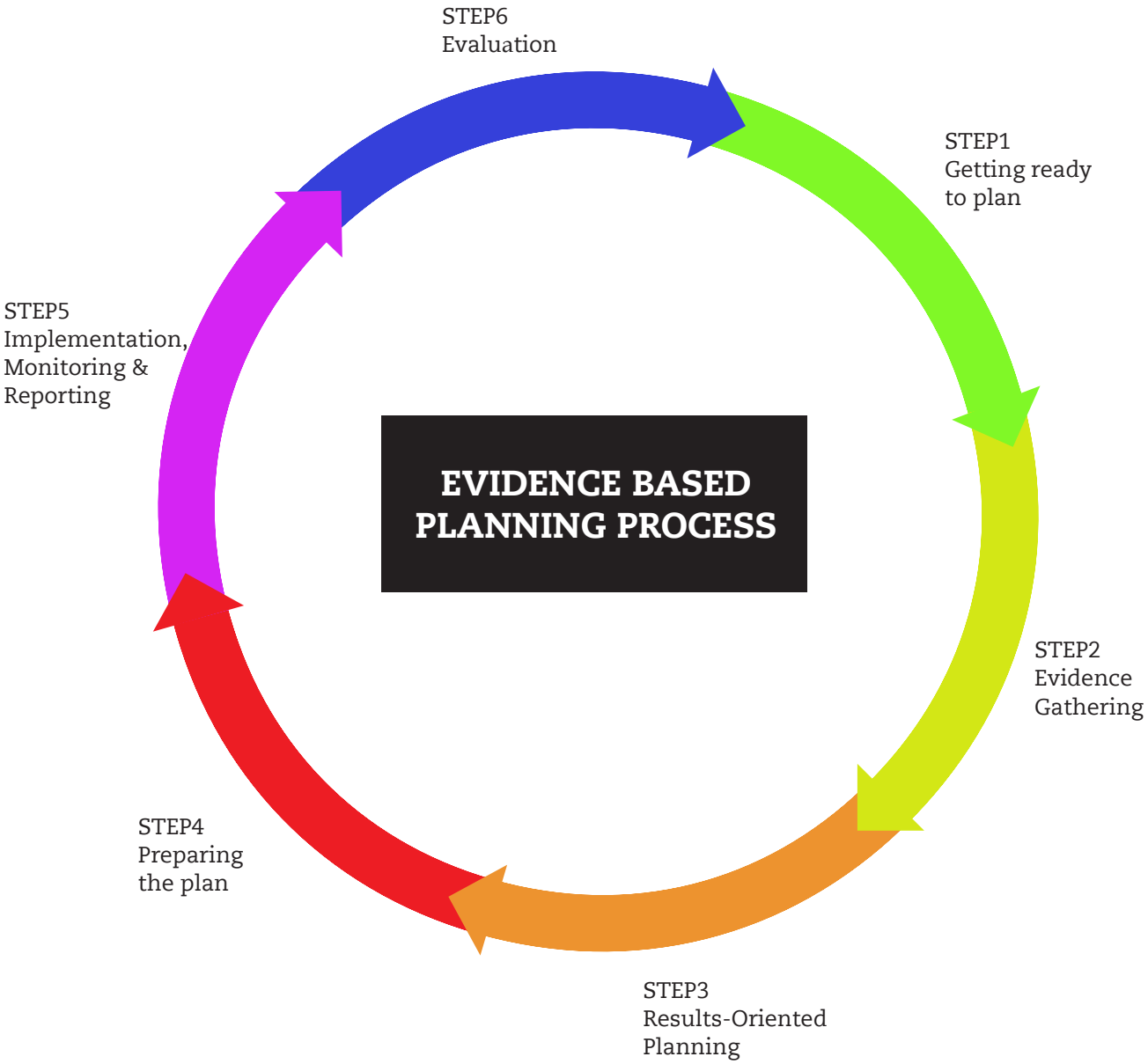
SECTION 02

Process in Evidence-Based Planning

PROCESS IN EVIDENCE-BASED PLANNING

The evidence-based planning process in this toolkit has six important steps to be followed. These steps are inter-related and are like “building blocks”, and must be followed in a stepwise manner in-order to complete the Plan. These steps are illustrated in the diagram below:

EVIDENCE BASED PLANNING PROCESS



STEP ONE
GETTING READY TO PLAN

It is important to prepare well for any planning process. Planning should not be seen as something you do before you start the real work, but as part of "the real work" itself. It takes up time, energy and other resources. It plays a crucial role in laying the basis for effective on-going thinking, action and achievement. Therefore, the DMSAC members should never under-estimate the amount of time and commitment necessary for effective planning. Effective planning requires a major commitment from all the DMSAC members and all other stakeholders whose participation is necessary to enable successful planning, implementation and monitoring. To get ready for the planning process, the DMSAC should "plan to plan". While a number of issues must be addressed in assessing readiness, the determination essentially comes down to whether the DMSAC and its members are committed to the effort. Once a DMSAC determines that it is indeed ready to begin the planning process, it must perform the three tasks listed below in order to pave way for an organized process.

In Step One, the DAC takes the lead role in ensuring that planning process is well executed and completed.

The DAC office serving as the DMSAC Secretariat will take the lead role in ensuring that the entire planning process is successfully completed.

TASK 1 :

ESTABLISH A PLANNING SUB-COMMITTEE

The DAC and DMSAC should ensure they select members for the Planning Sub-Committee who have the knowledge, skills and experience to lead the planning process. They should also ensure that membership to this committee is representative. This committee should be comprised of 15-20 people with representation from:

- DAC Office
- DHMT
- S&CD
- Representation from the NGOs/CBOs/FBOs
- PLHIV
- Private Sector
- Representation from other sectors i.e. , youth, men etc.
- Community leadership
- Other stakeholders as may be deemed necessary

The DMSAC should ensure that adequate involvement and participation takes place. The DMSAC must actively build commitment to the planning process so that stakeholders are willing to give the time, energy and resources necessary for effective planning.

When planning, it is important for the DMSAC to get input from everyone who will be responsible for implementing parts of the plan, along with representatives from groups who will be affected by the plan. Those who are responsible for reviewing and authorizing the plan should also be involved.

TASK 2:

REVIEW AND ESTABLISH ROLES AND RESPONSIBILITIES

The functions of the DMSAC are spelt out in the "Terms of Reference for the DMSAC and VMSAC, Ministry of Local Government March 2006" document. Drawing on that document, it is important to establish the roles of all the key persons or stakeholders who will be involved in the planning process. Some key roles are outlined below and the DMSAC is at liberty to review and add some roles as deemed necessary.

A) THE DMSAC

- Coordinates the planning process.
- Ensures that the required resources for the planning process are available.
- Ensures that the Planning Sub-Committee is representative and members have the requisite skills and experience to perform their planning role.
- Ensures that key stakeholders are engaged and involved in the planning process.
- Signs off the Comprehensive HIV and AIDS District Plan.

B) THE DMSAC PLANNING SUB-COMMITTEE

This committee is put in place by the DMSAC Chair and the DAC. This committee:

- Identifies required resources for the planning process.
- Draws the detailed planning process timelines and deliverables.
- Collects, collates and analyses data on the HIV and AIDS Situation.
- Identify priority issues/needs and activities to be addressed in the plan.
- Develops the plan.

C) THE DISTRICT AIDS COORDINATOR

- Facilitates the planning process and its successful completion.
- Works with the DMSAC's Planning Sub-Committee to ensure the development of a Comprehensive HIV and AIDS Plan document.

- Submits the plan, with the DMSAC's consent, to the Ministry of Local Government and Rural Development.
- Sets the broad planning process timelines and key deliverables.
- Engages key stakeholders in the planning process.

D) DISTRICT'S MONITORING & EVALUATION (M&E) OFFICER

The M&E Officer must be a member of the DMSAC Planning Sub-Committee.

He/she is engaged as follows:

- Identifies appropriate data and information to be utilized during the planning process.
- Ensures that the selected M&E indicators are relevant, applicable and aligned to NSF II-NOP (2012-2016).
- Leads the process of setting targets and determining baseline data.
- Provides guidance in the development of the district M&E Plan.

E) IMPLEMENTING PARTNERS

- Ensure representation in the planning process.
- Review and update their organizational profile.
- Prepare and submit their proposals to the DMSAC Planning Sub-Committee.

F) MINISTRY OF LOCAL GOVERNMENT AND RURAL DEVELOPMENT

- Provides overall oversight and technical support to the planning process.
- Reviews and approves the Comprehensive HIV and AIDS district plans.
- Provides overall oversight in the implementation of district plans.

G) OTHER STAKEHOLDERS

- Provide technical support/assistance to the DMSAC and the DAC.

TASK 3:

IDENTIFY SPECIFIC ISSUES THAT THE PLANNING PROCESS SHOULD ADDRESS.

The scope of issues to discuss and agree upon includes:

- How much time should be given to each step?
- How much time and other resources will be needed for the whole planning process?
- Is more information needed on past experience, achievements or the situation we are hoping to influence before we start the planning and, if so, who will get it, how will they get it, where and from whom?
- How important is the involvement of key stakeholders to the successful implementation of our plans?
- How important is it that each main stakeholder group understands and agrees to the planning decisions?
- How important and/or influetial is each main stakeholder group? Whose needs, interests and concerns should be prioritized in the planning process?
- How useful or essential would their involvement be at each step in the planning process?
- What kind of involvement will be adequate for each key stakeholder in each step of the process?
- How will we get the commitment to the planning process we need from each key stakeholder?
- How should each stakeholder be prepared so that they can participate efectively? What information will they need beforehand?
- Who will facilitate each session? Who will keep and circulate a record of discussions and decisions reached?
- What other tasks need to be done, by whom and by when (organizing venues, food, transport etc.)?
- What other resources will be required (flip charts, overhead projectors, and paper, admin support for contacting people and circulating records of discussions etc.)?
- When will the planning begin and what target dates should we set for the completion of each step?

KEY NOTE

Section Four of this Toolkit contains a checklist of proposed timelines for a 3-year plan Tool # 1 and Tool # 2 is a checklist to be used for the annual planning process.

Once you have made these decisions, built a commitment to participate and prepared everyone who should participate to do so effectively; you are now ready to start the actual planning process.

Output under Step One:

Schedules on the planning process with clear timelines and persons responsible

STEP TWO
EVIDENCE GATHERING

This is a very important step since evidence-based planning is dependent on available data, information and knowledge on HIV and AIDS in your district. Therefore, it is paramount to be up to-date with the current situation in your district. This is accomplished by gathering the information for two documents: (i) the District Profile and (ii) the District Services Inventory. These documents will provide important information for the Planning Sub-Committee to use in Step Three.

I. THE DISTRICT PROFILE

The District Profile is designed to answer the question, "What is the current HIV and AIDS situation in our district and why is it so?". The Profile presents the basic facts and information on HIV and AIDS within the district, and helps to identify issues that need to be addressed. Furthermore, the gathered data/information will promote good decision making.

In describing your district, it is important to answer the following questions:

- What is the current HIV and AIDS situation?
- Do we understand the major risk factors of HIV infection in our district?
- Are our HIV and AIDS strategies and activities well aligned to the national frameworks?
- What have we done so far to address HIV and AIDS in our district?
- What have we done well?
- What have we not done so well?
- Do we have indicators for measuring our work?
- How useful have the M&E indicators been?
- Did we monitor our activities well?
- How can we improve?
- Any lessons learned?

The Planning Sub-Committee should first and foremost determine the type of data/information required for the planning process and thereafter identify possible data sources containing the required HIV and AIDS data and information in the district. The Planning Sub-Committee should endeavour to gather both quantitative and qualitative data. A majority of the required data for planning can be extrapolated from secondary sources. For purposes of acquiring more qualitative data (if needed to fill in certain gaps or to know other factors contributing to the observed HIV and AIDS situation in the district), the Planning Sub-Committee may decide to conduct key informant interviews and focus group discussions.

Under this step the following tasks should be performed:

TASK 1:

COMMUNITY CONSULTATIONS

In gathering information for the district profile, one of the key tasks to perform is to ensure that community views on HIV and AIDS are taken into account. The Planning Sub-Committee will use information from the on-going community conversations to inform the district profile. The community conversations provide a platform for discussing HIV and AIDS issues affecting their district. Community conversations generate information regarding the communities' issues in HIV and AIDS. Community conversations are one of the methodologies used in Community Capacity Enhancement (CCE) strategies. Community conversations can be conducted in various places i.e. kgotla, community social halls, schools, health facilities, churches, sports grounds etc.The community conversation reports will generate qualitative information on HIV and AIDS and this information will be analyzed by the Planning-Sub Committee. At the end of this task the Planning-Sub Committee will incorporate the key findings into the district profile.

TASK 2:

COLLECT DISTRICT HIV AND AIDS STATISTICS / INFORMATION

Under this task the Planning Sub-Committee will gather data / information from secondary sources and analyze them in readiness for incorporation in the "District Profile".

TASK 3:

PREPARE THE DISTRICT PROFILE

The district profile contains six sections:

3.1: DISTRICT OVERVIEW

The Overview section of the district's profile should be a concise description, highlighting the geographical coverage, demographics, socio-economic factors and those characteristics that have a bearing on HIV transmission or the effective delivery of AIDS-related services. Every district is unique, and has unique characteristics that are important to their HIV and AIDS situation and response. Therefore, in outlining the District Overview, select what is important and bear in mind that content quality and quantity must be balanced against the needs and expectations of the district response.

3.2: HIV AND AIDS SITUATION IN THE DISTRICT

This section should be informative and reflective of the current HIV and AIDS situation in the district. The following information should be captured:

- Brief overview on the national response.
- Overview of the HIV and AIDS Situation in the district (This should include the major risk factors of HIV infection in the district).
- District achievements on HIV and AIDS (based on set district objectives and targets) and its contribution to the national response.
- HIV and AIDS data /information.

3.3: LESSONS LEARNED IN THE DISTRICT ON HIV AND AIDS PROGRAMMING.

3.4: CHALLENGES FACED IN THE FIGHT AGAINST HIV AND AIDS IN THE DISTRICT (This section should include possible solutions on the identified challenges).

3.5: RESEARCH/ SURVEY FINDINGS AND RECOMMENDATIONS ON HIV AND AIDS IN THE DISTRICT. (This section include information obtained through community conversations)

3.6 DISTRICT RESOURCES

The purpose of the Summary of District Resources section is to provide an overview of how the district is currently organised to contribute to the national HIV and AIDS response. Using information from the District Service Inventory Tool # 4 (Section 4) and other sources, this section should provide a summary of:

- Outline of available resources (Manpower, Equipment and Funds)for HIV and AIDS programming in the district.
- Location, structure and resources of the DAC office/DMSAC.
- Location of villages with active VMSACs.
- Number, types and locations of health care facilities.
- Involvement of CBOs, NGOs, and FBOs in providing HIV and AIDS-related services.
- Sector involvement in HIV and AIDS-related services.
- Significant target groups that are underserved and/or types of services that are unavailable.
- Brief description on how the available resources have contributed to the district HIV and AIDS Response.

KEY NOTE:

Tools have been made available in Section Four of this Toolkit to assist you in completing the District HIV and AIDS Profile form Tool #3.

2. THE DISTRICT SERVICES INVENTORY

The District Services Inventory is a listing of all the organizations within the district that are currently involved in HIV and AIDS interventions. The Inventory is a useful tool in identifying service gaps and in clarifying the question, "What are we currently doing and whom in our district is addressing the HIV/AIDS situation?"

The DAC plays a facilitative role in the preparation of the District Services Inventory and promotes participation of stakeholders.The DAC should also ensure that the data provided is complete and accurate

The Inventory is also important in terms of identifying what more can be done to accelerate the achievement of objectives and to better address HIV related issues in the district. The preparation of the District Services Inventory should be facilitated by the DAC. It is recommended that the DAC present findings /achievements for the previous year and to receive feedback for incorporation for the new plan from the stakeholders. This step is crucial in ensuring involvement and ownership of the emerging Plan. Furthermore, this gives all the stakeholders an opportunity to reflect on their previous achievements, lessons learned and challenges going forward.

3. THE DISTRICT INVENTORY DATA FORM

The inventory format should include the following information:

- Name of organization
- Contact person/title
- Phone/fax numbers and email address, if available
- Postal address and physical address, if different
- Type of organization
- Services offered
- Target group

It is important for the DAC to confirm that the information provided is complete and accurate. It is also important for the DAC to continuously review and maintain an up-to date inventory.There are many methods or ways of gathering new information or updating the District Services Inventory. These methods include: visiting each organization; making telephone calls; mailing out the inventory data form and/or circulating the inventory at meetings that the organizations attend.

The Planning Committee should analyse the inventory and identify gaps including services not available in the District, geographical reach population not reached.

KEY NOTE:

A format of the District Services Inventory is contained in Section Four (Tool #4) of the Toolkit. This format is available as a Microsoft Word template and the template and instructions for completing it are available at the DAC offices.

Output under Step Two:
A District Profile and District Services Inventory

STEP THREE
RESULTS-ORIENTED PLANNING

Evidence-based planning uses the evidence i.e. data, information and knowledge as the foundation for deciding what should be done. Under this step the Planning Sub-Committee should review the data, information and key issues/fndings in the District Profile and the District Services Inventory. The review exercise will provide an opportunity for the Planning Sub-Committee to prioritize key issues for incorporation in the "Plan Document" and its implementation. Based on the District Overview and the HIV and AIDS Data, the Key Findings and Issues for intervention section identifies the issues that are important to consider in setting priorities and planning activities.

Therefore this part should outline the findings/issuses in the district that need to be addressed. The findings/ issues should be listed under the four categories as reflected in the National Operational Plan for NSF II, namely:

PRIORITY AREA 1: Preventing new infections
PRIORITY AREA 2: Systems strengthening
PRIORITY AREA 3: Strategic Information Management
PRIORITY AREA 4: Scaling up treatment, care and support

This is accomplished by completing the following tasks:

TASK 1:
ISSUE ANALYSIS

This task lays the basis for the prioritization process. Building a deeper understanding of the situation, problems and issues in the district is critical. Furthermore, it leads to a shared understanding, good decision making and commitment.

Therefore, the goal of Issue Analysis is for the Planning Sub-committee to re-examine and analyze the findings and issues identified in the District Profile and the District Services Inventory and thereafter itemize all important issues facing the district related to HIV and AIDS. Key questions one should ask include:

Is the data and information gathered complete, accurate and reliable? Are the findings and identified issues relevant to our target community/population?

To facilitate the issue analysis, it is recommended that the Planning Sub-committee holds a one day workshop with all the key stakeholders to discuss and review all the itemized issues. Issues should be recorded in readiness for prioritization. Below is an "Issue Identification Worksheet" to be used in selecting key issues in your district.

WORKSHEET # 1: ISSUE IDENTIFICATION

WHAT ARE THE KEY HIV AND AIDS ISSUES IN YOUR DISTRICT (THESE SHOULD BE BASED ON THE DISTRICT PROFILE)	WHY ARE THEY ISSUES?
1	
2	
3	
4	
5	
6	

Issues / Gaps/ Challenges may include for example;

- Essential services that need to be maintained.
- Services that are not being adequately addressed.
- Populations that aren't being sufficitly reached.
- Needs that aren't being fully met.

TASK 2:

PRIORITY SETTING

The "Issue Analysis" process will generate a lengthy list of important issues and concerns. However, due to limited resources not everything can be addressed at once. The goal of Priority Setting is therefore to select from the list those issues (5-6) and concerns that are most critical. The priority setting needs to be very transparent and objective. Given the fact that this is an EBP process, one clear way of determing the highest priorities is by examining the evidence (available data and information). The Planning Sub-Committee should critically interrogate each issue using the questions under each worksheet:

Depending on the evidence given in support to the above guiding questions, the Planning Sub-committee can proceed to prioritize the problems to be addressed.

Prioritization is an exercise which allows the district to attend to issues which truly need attention. Therefore, evidence based planning will allow the district to assess issues and make decisions based on facts.

Worksheets must be completed by the Planning Committee Members individually

WORKSHEET 2A

PRIORITY ISSUES	PREVALENCE (BASED ON EVIDENCE)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

HOW TO RANK

A) PREVALENCE OF AN ISSUE

WORKSHEET 2B

	POINTS
Prevalence 40 and above%	10
Prevalence between 20-39%	8
Prevalence between 10-19%	6
Prevalence between 5 - 9%	4
Below 5%	2

B) IMPORTANT ISSUES

Using the scoring scale below, each of the priority issues based on

WORKSHEET 2C

ISSUES	SOMEHOW IMPORTANT (1 POINT)	IMPORTANT (3 POINTS)	MOST IMPORTANT(5 POINTS)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

- How does this problem affect our district response?
- What can our district realistically expect to achieve in addressing this problem?
- Is the identified problem aligned to the National Strategic Framework and its Operational Plan
- Can the district realistically hope to make a significant contribution to the national response by addressing this problem?
- What experience does the district have so far that is relevant to this problem or issue and what can the district learn from it?
- What resources and capacity are available inside and outside the district to address this problem?

C) CRITICAL ISSUES

Based on the prevalence ranking of the issue, determine the most critical issue in the district.

WORKSHEET 2D

ISSUES	IMPORTANT BUT NOT CRITICAL (1 POINT)	IMPORTANT AND CRITICAL (3 POINTS)	IMPORTANT AND MOST CRITICAL (5 POINTS)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

The sum of the prevalence, importance and critical issues should clearly determine the priority issues to be addressed.

- Is it a major problem faced by our target community/population? If so how and to what extent?
- How critical is it that we address this problem? What will go wrong if we do not address it?

D) LIST OF PRIORITY ISSUES (5-6)

WORKSHEET 2E

1
2
3
4
5
6

TASK 3:

DEFINING A GOAL (S)

Having agreed on the highest priority problems/issues, the next task for the Planning Sub-Committee is to define what should be accomplished by the district. This would require the Planning Sub-Committee to fomulate a goal or two for their district.

WHAT IS A GOAL?

A goal is a clear statement of the future situation you would like to see. It may sound obvious, but if you don't have an end-point in mind you'll never get there. Deciding on a goal is important because this tells you what change in people's lives you hope to contribute to. Goals are usually longer-term aims that your district cannot hope to bring about alone but will make a significant contribution to. Goals are also the final basis on which you evaluate what you have achieved.

Examples

Once you know what the goal is, you need to decide what needs to happen to achieve it. In this task you will use your district profile analysis to decide:

- What is the future situation you want to see in your district?
- What do you want to achieve (as a district) that will make the most significat contribution to achieving your desired situation?

After articulating a goal, it is important to ask yourself these questions:

Is it:

- Appropriate for our district
- Realistic
- Attainable
- In line /contributing to the national HIV and AIDS response

It is important to remember that you are making choices when you decide on a goal. These choices need to be strategic (carefully selected from the alternatives as the most useful), as they will affect all of your further planning. They also need to be as clear as possible so that they are a record of agreement that can guide your further decisions and actions, and be used as a basis for assessing what you are achieving as a district. In task 4 below, you will be deciding on specific objectives that will enable you to achieve your goal(s).

TASK 4:

DEFINING OBJECTIVES:

Having articulated your goal(s), the next thing is to formulate the objectives. Objectives provide focus on actions that are directed towards addressing your problems/issues. The objectives will help the district to define what results they want to see?

WHAT IS AN OBJECTIVE?

An objectives is a specific statement that supports the goal and it relates directly to the goal. It says what you are going to do, but not how you are going to accomplish your goals.

Objectives should be "SMART" as explained below:

SPECIFIC – What result do you want to occur, and for what target group?
MEASURABLE – Is there a way to measure whether you are meeting the objectives or not?
ACHIEVABLE - Is the objective feasible with the resources that are available?
RELEVANT – Will the objective help to solve an important issue?
TIME-BOUND – By when will the objective be accomplished?

WHILE ARTICULATING THE OBJECTIVES, KEEP IN MIND THE FOLLOWING QUESTIONS:

- What specific results are needed to achieve your goal?
- Can the district realistically achieve these results? If not, can the district improve its capacity to achieve them by, for example, building alliances and improving its capacity? Does the district need to set objectives to take account of these things? (If the district can't improve its capacity to achieve the results that are necessary to achieve the goal, it will need to go back and make its goal more realistic.)
- Do the causes of the identified problems/issues give an idea of what must change in order to achieve the goal?
- Is it possible to make the district's objectives more specific by stating by when they should be achieved, who should benefit, how many or much must be achieved and how well?

The Planning Subcommittee should define, for each priority issue, one or more objectives to be accomplished. Basically the task is to take the statement of the problem (the issue) and transform it into an action statement that describes a solution. The District Profile should be used to set realistic and measurable targets for all its objectives. For example, if a high priority issue is "High incidence of mother-to-child transmission of HIV", An objective may read as follows:

By 2013, reduce mother-to-child transmission rate of HIV in Kgaolong from the current 9% to 6%
Or
To reduce mother to child transmission rate of HIV in Kgaolong from the current 9% to 6% by end of December 2013.

An example on "How to draft a SMART Objective" is indicated below.

DRAFTING AN OBJECTIVE	
Which area/aspect of change in your district do you want to address?	Teenage Pregnancy
What is the current rate of teenage pregnancy in your district?	35%
What do you want to do?	Reduce teenage pregnancies by 5%
Who is your target population?	Young girls aged 13-19 years
Where do you want to see the change?	In Kgaolong district
When do you want to see the change (Time Frame)?	By 2014
Based on the above, your objective may read as follows:To reduce teenage pregnancies among young girls aged 13-19 years in Kgaolong district from 35% to 30% by the end of 2014	

Once you have SMART and agreed objectives, you are now ready to develop the strategies and actions (activities) that the district will implement to achieve its objectives and long term goal (s). Therefore the goal (s) and objectives are the foundations of this process. The Planning Sub-Committee will need to decide on the best strategies and actions for achieving each objective.

TASK 5:

DETERMINING THE STRATEGIES

This task requires that the Planning Sub-Committee (in small groups) identifies and selects the best ways (strategies) of achieving the district objectives. The key thing is to ensure that appropriate strategies are identified. The Planning Sub-Committee members should take into consideration any current successful strategies that ought to be continued along with new approaches.

WHAT IS A STRATEGY?

A Strategy is the choice we make about the best approach to getting something done. This is a very important task. It enables us to avoid just assuming that there is a right way of getting something done and forces us to look at alternatives that we may not have considered properly before. This is very important if you want to find new and more effective ways of doing things. Just doing things the way you always do them, may not be strategic. You won't know unless you deliberately think of other options and test them out with open minds. The biggest mistakes and waste in development work are made by organizations that do not keep testing their thinking to come up with better and more relevant strategies.

Examples

In this task, the Planning Sub-Committee will need to apply their deeper understanding of the district HIV and AIDS priorities to decide:

- The alternative ways one could use to achieve each objective.
- The criteria one will use to assess each strategy (e.g. relevance, realistic etc.) in order to choose the most effective and realistic alternative.
  (More guidance on examples of characteristics of effective strategies and promising prevetion strategies is contained in Section 6 of the Toolkit)
- Based on criteria, the most efective strategy for achieving each objective.
- Conditions will need to exist for one to efectively implement each strategy.
- Resources that will be needed for this strategy.
- Whether the strategy realistic and practical?

Once the Planning Sub-committee has agreed that the selected strategies are realistic and effective for achieving each of the objectives, the final task will be to develop the "Activities" which will lead to achieving the objectives.

NOTE:
Some sort of baseline (usually the end targets from the previous year and any new surveillance findings or newly completed surveys within the district or that have included the district) may have a bearing on new strategies to address emerging issues.

TASK 6:

ACTIVITIES

This task determines what activities or actions are to be carried out and by whom, under each objective. This step involves detailed planning about the activities that will be implemented to achieve the objectives. The Planning Sub-Committee will determine the following:

- What major activities will be needed to implement each objective?
- Are the activities relevant, sufficiant and effective for producing desired results?
- Who will be responsible?
- By when should activities be completed?
- What deadlines should be set?
- What specific resources will be needed for the activities required to achieve each objective?

ACTIVITIES:
Actions taken or work performed through which inputs, such as funds, technical assistance and other types of resources are mobilized to produce specific results

The Activity Worksheet # 3 below should be used to draw out a list of activities with their assumptions under each priority area.

WORKSHEET # 3: ACTIVITIES AND ASSUMPTIONS

PRIORITY AREA: PRIORITY ISSUE:		
OBJECTIVES	ACTIVITIES	ASSUMPTIONS(EXAMPLES OF ASSUMPTIONS INCLUDE: AVAILABILITY OF ADEQUATE RESOURCES, ADEQUATE CAPACITY& CAPABILITY ETC.)
Objective 1:		
Objective 2:		

TASK 7:

IDENTIFYING/FORMULATING M&E INDICATORS

Under this task, the Planning Sub-Committee will need to set the milestones, targets and indicators for measuring their activities, objectives and goals. The set indicators will be guided by the current NOP M&E Plan. A list of the M&E indicators are contained in Section Five of this Toolkit. Under this task it is important to understand the following:What criteria or indicators will the district use to monitor the progress of its activities and evaluation of its achievements in relation to set goal (s) and objectives?

- How will the district monitor progress and evaluate its achievements?
- Where and from whom will the district get the information needed (data sources)?
- Who will be involved in monitoring progress and evaluating achievements?
- How will the district collect the information needed (data collection methods)?
- How will the data be analyzed?
- How will the data be stored?
- How will the information be disseminated?

PROCESS OF SELECTING INDICATORS

The selection of indicators should be participatory, involving not only the Planning Sub-Committee, but also representatives from the implementing partners and other stakeholders. Participation in the indicator selection process will result in obtaining consensus and ownership. Given that the responsibility for data collection will often fall on the implementing partners, gaining their involvement and agreement at this stage is crucial.

The Planning sub-Committee should review the national level indicators that are relevant and applicable to the district's priority areas and generate a list of possible indicators for each desired objective or result. The initial list of indicators should be as inclusive as possible and aligned to the national level indicators. It should also incorporate the views and perspectives of all stakeholders. The next task is to review each indicator against a checklist of criteria for judging its appropriateness and application. The final step is to select the "best" indicators; this will form an optimum set that will measure the intended results in the district.

The number of indicators selected to track each objective or result should be limited to the bare minimum needed to represent the most basic and important dimensions of the district's response. There should be a mix between quantitative and qualitative indicators. At the end of the exercise, the Planning Sub-Committee will need to have determined the inputs, outputs and outcomes indicators for measuring the district response.

An *indicator,* simply put, is a sign that can be measured to show progress or change towards reaching a defined destination/objective.

Indicators are not designed to explain why a situation has changed or has failed to change – they are designed simply to measure the change. They can be constructed from qualitative or quantitative data according to the type of variable one is interested in tracking.Inputs: the financial, human, material, technological and information resources used for the development intervention.

OUTPUT INDICATOR: Number of health facilities providing PMTCT services
OUTPUT INDICATOR: Number of women enrolled on PMTCT
OUTCOME INDICATOR: Number of infants born HIV negative by HIV positive mothers

OUTPUTS: The products and services which result from the completion of activities within a development intervention.

OUTCOMES: The intended or achieved short-term and medium-term effects of an intervention's outputs, usually requiring the collective effort of partners. Outcomes represent changes in development conditions which occur between the completion of outputs and the achievement of impact.

QUANTITATIVE INDICATORS: Are objectively or independently verifiable numbers or ratios, such as number of people trained; percentage of people living with HIV enrolled in the Home Based Care program etc.

QUALITATIVE INDICATORS: Are subjective descriptions or categories, such as type of services offered to PLHIV; beneficiaries' assessment of the quality of services offered; or simply a narrative describing change.

EXAMPLE OF INDICATOR:

OBJECTIVE: By 2013, reduce mother-to-child transmission rate of HIV rate in Kgaolong district from the current 9% to 6%

TASK 8:

SETTING TARGETS

Once indicators have been identified and selected, the task is to set targets. Targets will help to orient the DMSAC and its implementing partners to the activities to be completed and motivate them to do their best to ensure that the targets are met. The set targets will serve as guideposts for assessing whether progress is being made and help determine if implementation of planned activities is on schedule.

The DAC should ensure that baseline data if available is determined

A target is a specific value to be accomplished within a given timeframe. It is a reference point or standard against which progress or achievements can be assessed. These values are expected at various points-in-time over the implementation of your district plan.
Targets represent commitments signifying what one intends to achieve in concrete terms, and become the standards against which to assess performance or degree of success. Monitoring and analysis of results then becomes a process of gathering data at periodic intervals and examining actual progress achieved vis-à-vis the set targets.

It is important that the DAC and the Planning Sub-Committee establish baseline values which measure conditions at the beginning of implementation of the planned interventions. This will assist in setting realistic targets for achievement within the constraints of resources and time available.

If targets are unrealistically high and unattainable, confidence and credibility will suffer, and may even result in hiding or distortion of the data. It is difficult if not impossible to set reasonable targets without baseline data. Baselines may be established using existing secondary data sources. A setting indicators and targets worksheet (Worksheet # 4) should guide this exercise.

WORKSHEET #4: SETTING INDICATORS, TARGETS AND EXPECTED RESULTS

Priority Area:

Priority Issue # 1:

Objective 1:

Expected Result:

	BASELINE		TARGETS	
		YEAR 1	YEAR 2	YEAR 3
Indicator				

TASK 9:

DETERMINING WHO WILL IMPLEMENT THE DISTRICT ACTIVITIES

At this stage, the Planning Sub-Committee and the DAC will determine which sectors are best suited to implement the identified activities. This will be guided by the core mandate of the various sectors and their comparative advantages. Given the increasing number of CSOs requiring government resources versus limited resources, allocation to the civil society sector will need to be transparent and credible. This will entail a competitive process.

SELECTION OF CIVIL SOCIETY ORGANIZATIONS

The Civil Society Organizations (NGOs, CBOs and FBOs) will in some cases be selected through a competitive process. Based on the district's priority areas, a call for proposals will be made and a Technical Review Committee will be constituted by the DAC to evaluate the proposals. In a competitive process, consideration should be given to the following:

- Their skills and expertise in that priority area
- Their capacity and capability to produce results
- Previous track record on performance

Where a competitive process has not been followed capacity building is built into project implementation.

In addition to the submission of proposals, the CSOs will need to furnish the DMSAC with the following information:

- Certificate of Registration
- Names of the Board of Directors or Trustees
- Service delivery areas
- Target Population
- List the current projects
- Geographical Coverage
- Project Targets
- Other sources of funding

Selected CSOs will be given annual performance based contracts. Performance reviews will be done every six months by the DAC and MLG&RD. Once all the 9 tasks have been successfully completed, the Sub-Planning Committee and the DAC are now ready to draft the Plan.

Outputs under Step Three:
District Priorities, Goal (s), Objectives, and Strategies, Key Activities, Indicators, Baseline values (where applicable), Targets and sector activities/proposals

STEP FOUR
PREPARING THE PLAN

At this point, stakeholders and the DMSAC Planning Sub-Committee have: identified the district's issues; selected the key priorities; formulated the goal(s), objectives for addressing the goal; selected strategies to achieve the objectives and activities for implementation. It is now time to bring all this work together into the district's Comprehensive HIV and AIDS Plan in readiness for submission and approval by the MLG&RD. The tasks involved are:

TASK 1:

GATHER DETAILED ACTIVITY PROPOSALS FROM IMPLEMENTING PARTNERS AND/OR SECTORS

Using the list of activities developed by the Planning Sub-Committee, the DAC should collaborate with the sector or implementors that will carry out each activity to develop a more detailed implementation proposal. In addition to these proposed activities, there may also be other HIV and AIDS activity plans that have been developed by various sectors. These plans should be collected and submitted as an attachment to the Comprehensive HIV and AIDS Plan. The Detailed Activity Proposal Form can be found in Section Four Tool # 5.

TASK 2:

COMPLETE THE SUMMARY OF PROPOSED ACTIVITIES FORM

The Planning Sub-Committee will need to review and transfer the information contained in the Detailed Activity Proposal forms to the 3 year plan or the annual plan (whichever is appropriate). The information contained in Tool # 6 or 7 will be used to allocate funds to the district and for monitoring and evaluation purposes. It is, therefore very important to ensure that it is complete and accurate.

TASK 3:

ORGANIZE THE DMSAC COMPREHENSIVE HIV AND AIDS PLAN DOCUMENT

The final plan document should contain the following sections:

i. Title Page including the name of your district and the plan period
ii. An Executive Summary briefly describing the planning process, key findings, and total funds requested
iii. District Profile
iv. District Services Inventory
v. A Summary of Priorities, that includes identified district's issues, and the evidence of prioritisation of issues
vi. Completed Summary of Proposed Activities form
vii. M&E indicators congruent corresponding to the proposed activities.

TASK 4:

SUBMIT THE PLAN

Prior to submitting the completed district Plan, a DMSAC meeting should be share the Plan with all the relevant stakeholders. This is very important in ensuring that no major stakeholder was left out and no major activity was overlooked and to ensure ownership and buy in of stakeholders.

The DAC is responsible for submitting the District's Plan electronically and in Print to the DPHCS

After the Planning Sub-Committee has presented the Comprehensive HIV and AIDS Plan to the DMSAC and other stakeholders, the plan is adjusted as per the review comments. Thereafter, it is for the DMSAC Chair to sign off and the DAC to submit the district's Plan electronically and in print to the AIDS Coordination Division at the MLG&RD.

Outputs under Step Four:
A Comprehensive District HIV and AIDS Plan

STEP FIVE
PLANNING FOR IMPLEMENTATION, MONITORING AND REPORTING

PLAN FOR IMPLEMENTATION

To a large extent, the success of this step is dependent on how well step one-four were managed. This step of the planning cycle is really about making sure the activities are implemented in an organised and co-ordinated manner, and that there is regular monitoring, project adjustments, and problem solving.

Implementation is where all the hard work of the DMSAC members begins to bear fruit in the form of activities and services that improve people's lives. It is where everyone works together to achieve the district's needs for prevention, care, treatment, and support. The main work of carrying out the planned activities is done by the Implementing Partners; however, the DAC Office and the DMSAC members also have an important role in this process. All three groups must work in partnership in order for activities to be implemented effectively. Working together creates a strong fabric within the district. The respective roles of the DAC, the DMSAC and the Implementing Partners are illustrated below:

ROLE OF THE DMSAC

- Create linkages among implementing partners.
- Assist implementers in procuring or obtaining materials to complete activities.
- Solve problems that are delaying or weakening implementation of planned activities.
- Participate, when appropriate, in planned activities.
- Ensure that district priorities are met.

ROLE OF IMPLEMENTING PARTNERS

- Prepare before the funds arrive in order to avoid implementation delays.
- Ensure that all necessary materials and arrangements are in place for implementation.
- If implementation difficulties occur, communicate these to the DAC Office.
- Share workplan with the DAC office.
- Submit progress report to DAC office.
- Request help from the DAC Office when needed.

ROLE OF THE DAC OFFICE

- Remind implementing partners of targets, schedules, and expectations.
- Assist implementers to procure or obtain materials to complete activities.
- Provide quality controls to ensure activities are effective at meeting objectives.
- Consolidate district progress report.
- Update DMSAC on implementation progress.

It is therefore important for the DAC and the Planning Sub-Committee to develop a detailed implementation Plan. The detailed implementation plan will serve as important roadmap to track the timelines and achievements of the district activities.

PLAN FOR MONITORING

Monitoring is an essential component of any Plan. The implementation of the district activities needs to be monitored to ensure that planned activities are implemented and are on schedule. Monitoring is essentially ensuring that data and information is collected and analyzed to strengthen evidence based implementation.

WHAT IS MONITORING?

Monitoring can be described as the systematic and continuous process of collecting and analyzing data about the progress of any activity or work towards achieving a defined target.

Why is it important to monitor our activities during implementation?

- To keep an eye on progress towards objectives
- To reduce wasted time and resources both in the project implementation and in the monitoring process
- To quickly identify and solve problems
- To gauge if allocated funds are adequate to carry out planned activities
- To allow greater transparency for beneficiaies and stakeholders
- To meet the needs and conditions of the funding requirement

Therefore Monitoring helps to answer important questions, such as:

- How are we doing?
- What activities have taken place and what still remains to be done?
- Are budgets adequate to carry out planned activities?
- How well are we meeting the objectives we set forth in the DMSAC Comprehensive HIV and AIDS Plan?

Tasks to be performed include:

TASK 1:

DETERMINING THE MONITORING SYSTEM

The DAC and the District M&E Officer should facilitate a meeting with implementing partners in putting a district monitoring system in place. A "Monitoring System" is a way of organizing your monitoring work so that it is less time consuming and easy to implement. A monitoring system will clarify the following:

- Which monitoring tools will be used?
- Who will facilitate the monitoring?
- Who will be involved /contact person from each implementing partner?
- How frequently should reporting be done? (i.e . monthly, quarterly, semi-annually or annually)
- How will the information be recorded?
- Who will analyze the data at regular intervals?
- How will the records/data be kept?

Monitoring systems vary in sophistication from a piece of paper and some note books or files, to electronic filling systems and databases. The most important thing is not how sophisticated the system is, but whether the information is collected, reviewed systematically and used. Try to only collect information that you will be able to learn from and/or that which is required.

TASK 2:

COLLECT AND COMPILE INFORMATION ABOUT ON-GOING AND COMPLETED ACTIVITIES

It is important to collect information continuously, not just at the end of the year. The DAC should make certain that every Implementing Partner knows when and how they are to report back about their completed activities.

Monitoring and evaluation is important for spiraling upward in evidence based planning

Activity Monitoring Form Tool # 8 and 9 have been included in Section Four of this Toolkit. Sample formats of a log-frame for a 3-year Plan and an annual plan are also included (Tool # 6 and 7 respectively)

Each implementer must complete the Activity Monitoring form and submit it to the DAC Office as per agreed reporting timelines (i.e. monthly, quarterly, semi-annually and annually).

TASK 3:

DATA ANALYSIS AND REPORT CONSOLIDATION

The submitted activity reports and data will be consolidated and analyzed. It is important that gathered data and information is complete and accurate before consolidating the findings into one district Activity Monitoring Report.

TASK 4:

DISSEMINATION OF FINDINGS OF THE DISTRICT ACTIVITY MONITORING

The DAC should put systems in place to ensure that the Activity Monitoring report is shared with the DMSAC and all key stakeholders at all levels e.g. MLG&RD and all implementing partners at the district level on a regular basis. Sharing the reports will serve as an opportunity to discuss the effectiveness of activities in achieving objectives, to note promising strategies that are working well and should be expanded, and to identify solutions to common challenges that are barriers to successful implementation. This progress review will provide valuable insights to incorporate into implementation and the next planning process.

Outputs under Step Five:

A detailed implementation plan, Monitoring and Reporting Plan &Tools

STEP 6:
PLAN FOR EVALUATION

This step involves planning how the DMSAC will evaluate its achievements and determine what has been successfully achieved or not and why on an annual basis. The Planning Sub-Committee should determine how evaluation will be conducted (i.e. internally, externally or both). Evaluation examines the effectiveness of what is being done. There are two types of evaluations, namely; process evaluation, which measures progress towards achieving set objectives; and summative evaluation which measures the outcomes and impact of the project/programs, based on the end of district targets. A range of methods and tools will be used to conduct on-going assessments of the district's response to the epidemic.

WHAT IS EVALUATION?

Evaluation is a careful assessment of the extent to which a project is achieving or has achieved its stated outcome goals. In evaluating programs the following key questions are asked:

WHAT HAVE WE ACHIEVED ?

What outcome/impact have we made?

What lessons were learned?

It is important to clearly define why you are doing your evaluation. Evaluations can be carried out for a range of reasons and it is important to be clear about exactly why you are undertaking yours.Purposes may include one or more of the following:

- To report achievements
- To review appropriateness of strategies to achieve set objectives
- To contribute to evidence about what works
- To inform strategic planning
- To argue for project expansion
- To improve project delivery
- To analyze funding distribution and impact
- To argue for program funding

Programs that desire to "do well" must also know "how well" they have met their goals.

The Sub-Planning Committee should put an evaluation plan in place. An evaluation plan will assist the DMSAC to focus on the most important questions/issues to address during the evaluation, to determine the timelines, sources of information and methodology. Once you have made these decisions, you have completed the planning process. Now, all that is needed is to summarize your plan in a neat, clear, easy-to-use form so that it is a useful record and guide for all those who will play a part in implementing it successfully.

Output under Step Six:
An Evaluation Plan

SECTION 03

Monitoring, Reporting & Evaluating the District Response

MONITORING, EVALUATING & REPORTING THE DISTRICT RESPONSE

Monitoring, Reporting and Evaluation (MRE) for the district response to the epidemic must be aligned to NSFs and provide timely reports on their interventions, their performance; ensure optimum use of available resources and improve programmatic decision making. In addition, MER must provide information to other key stakeholders regarding progress and accomplishments; help disseminate knowledge of lessons learned and best practices; and strengthen their capacity to effectively carry out their MRE functions, while ensuring compliance and alignment to BHRIMS and related indicators framework.

It is important for the implementers to track their performance and understand how their interventions contribute to the district response which in turn contributes to the National Response. The use of data and other evidence to inform sound decision making is essential. As such, MRE system should be designed to track processes, activities and ensuing results (outputs and outcomes). To achieve this, both qualitative and quantitative data will be collected. Simplified data collection forms and tools will be used to ensure gathering and presentation of information is done in a concise manner. A detailed M&E plan should be in place which includes a comprehensive results framework, complete with indicators, targets, data sources, collection methods, baseline data (where available), and schedule for periodic assessments, surveys and evaluations. The district should identify its data dissemination strategies to ensure that information is not only available and accurate, but also disseminated to the appropriate stakeholders in a timely manner. Focus should be put on district's level data dissemination and use to assure that district's specific data is not only reported to the national level, but is also disseminated locally to local HIV stakeholders and used in local decision making and planning.

Monitoring implementation of activities should be done in close collaboration with implementing partners. Monitoring will include regular supervisory support visits, internal monthly meetings to review progress and quarterly review meetings with partners. Regular reviews of output and outcome data will constitute part of the on-going monitoring process.

Activity reporting will be carried out regularly, based on agreed timelines. At a minimum, reports will be generated on quarterly, semi-annual and annual basis. The reporting formats will be agreed upon by implementing partners and other key stakeholders. The activity reports will focus on progress towards achieving the agreed benchmarks and performance indicators, status of activities and outputs, a comparison of actual versus planned accomplishments (as indicated in the implementers' individual work plans). The financial reports will track expenditures against budget line items. For internal purposes, financial reporting will be on a monthly basis. The DAC will be responsible for collating and submitting reports. Therefore all implementing partners will report their activities to the DAC.

The District will rely on existing data sources for baseline purposes. These include BAIS reports, surveillance reports, documents and statistics from the MOH, MLG, NACA and other research or survey conducted by

other stakeholders. All district data will be analyzed and disaggregated by gender, age and district and other parameters as will be appropriate.

In concluding this section on monitoring, reporting and evaluation, it is important to note that, MRE plays a key role in achieving meaningful coordination of the district response.
Coordination of the district should be linked to the national response so as to ensure that all HIV and AIDS interventions in the country are harmonized and aligned with national priorities and strategies, in keeping with the Three Ones principles, namely; One National coordinating body, One National strategy, One National M&E framework.

SECTION 04

Tools/
Templates

TOOL # 1

EVIDENCE-BASED PLANNING PROCESS:

DAC ACTIVITY CHECKLIST FOR A 3 YEAR PLAN

ACTIVITY	TASKS TO BE PERFORMED	MONTH
STEP ONE: Getting Ready to Plan	■ Establish the planning Sub-Committee ■ Review, Adapt or Establish Roles and Responsibilities ■ Identify specific issues that the planning process should address	April
STEP TWO: Evidence Gathering	■ Update the District Profile ■ Update the Services Inventory	April
STEP THREE: Results-Oriented Planning	■ Issue Analysis ■ Priority Setting ■ Defining a Goal (s) ■ Defining Objectives ■ Identifying Strategies ■ Determining the key Activities ■ Identifying/Formulating M&E Indicators ■ Setting Targets	April – May
STEP FOUR: Preparing the Plan	■ Gather detailed activity proposals from implementing partners and/or sectors ■ Complete the Summary of Proposed Activities form ■ Organize the DMSAC Comprehensive HIV/AIDS Plan ■ Submit the Plan	June
STEP FIVE: Plan for Implementation, Monitoring & Reporting	■ Develop an Implementation Plan ■ Determine the Monitoring System ■ Collect and Compile Information about ongoing and completed activities ■ Data Analysis	January – February
STEP SIX: Plan for Evaluation Implementation, Monitoring and Reporting of Planned Activities	■ Develop an Evaluation Plan ■ Implement Activities as per approved work plan ■ Gather and compile information about completed activities ■ Review and Assess the implementation data ■ Update DMSAC on implementation progress	Starts in April

TOOL # 2

EVIDENCE-BASED PLANNING PROCESS:

DAC ACTIVITY CHECKLIST FOR ANNUAL PLANNING

ACTIVITY	TASKS TO BE PERFORMED	MONTH
Evaluate the Previous Year Activities and accomplishments	Determining how well the district has done in terms of:- ■ Implementing its activities-meeting its targets ■ Achieving expected results ■ Absorptive capacity: (did we spend the allocated resources as per the budget) Challenges/obstacles encountered during implementation	April
Develop the next year's annual plan	Extrapolate year 1 activities, targets and expected results from the 3 year plan and draft the district's annual plan. Based on the evaluation, determine what activities need to be continued and to what extent; those that need to be modified or redirected and new activities drawn from the 3 year plan ■ Update the district inventory ■ Produce the annual plan	May – June
Implementation, Monitoring and reporting of Planned Activities	■ Implement activities as per approved work plan ■ Gather and compile information about completed activities ■ Review and assess the implementation data ■ Update DMSAC on implementation progress	Starts in April

PERFORMANCE REVIEW: at an interval of six months (during the 2nd quarter TAC meeting) carryout a performance review of the district based on the indicators, targets, timelines, and absorptive capacity.

TOOL #: 3
DISTRICT HIV AND AIDS PROFILE

I). BACKGROUND INFORMATION /INTRODUCTION

This section should focus on district geographical

II). SOCIAL-CULTURAL AND ECONOMIC ISSUES IN THE DISTRICT

This section should focus on socio-cultural and socio-economic factors and other determinants that have a bearing on HIV and AIDS. Focus on factors that place men, women, boys, and girls at higher risk of HIV infection and more vulnerable and susceptible to the AIDS pandemic

III). DEMOGRAPHICS

Population	Number of males	% of males	Number of females	% of females	Total – Both sexes	% - Both sexes
Age Group						
0-4						
5-9						
10-14						
15-19						
20-24						
25-29						
30-34						
35-39						
40-44						
45-49						
50-54						
55-59						
60-64						
65-69						
70-74						
75-79						
80-84						
85-89						
90-94						
95 and above						
Total Population						
Data Source:						

IV) HIV PREVALENCE

Target

Age Group	Males tested	% of males HIV+	Females tested	% of females HIV+	Total tested both sexes	% of HIV+ for both sexes
0-4						
5-9						
10-14						
15-19						
20-24						
25-29						
30-34						
35-39						
40-44						
45-49						
50-54						
55-59						
60-64						
65 and above						
Data Source:						

V). HIV COUNSELING AND TESTING

Target

A). GENERAL POPULATION

	Males	Females	Total for both sexes
Persons aged 15-49 tested for HIV			
Persons aged 15-49 found to be HIV Positive			
Data Source:			

B). COUPLE TESTING

Target

	Number
Couples tested for HIV	
Couples found to be HIV positive	
Couples found to be HIV negative	
Discordant couples	
Data Source:	

VI). SAFE MALE CIRCUMCISION

Target

Age Group	Number Circumcised	Booked	Counselled
0-4			
5-9			
10-14			
15-19			
20-24			
25-29			
30-34			
35-39			
40-44			
45-49			
50-54			
55-59			
60-64			
Total			
Data Source:			

VII). PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)

A) MOTHERS

Target

Mothers	Total	%
New ANC Clients		
New ANC Clients under age of 20		
Women tested for HIV		
% of Women tested for HIV		
Number of women who tested HIV positive		
ANC Prevalence rate		
Women registering with known HIV positive status		
Women registering with known HIV negative status		
Number of HIV positive women attending ANC offered Triple ARV Prophylaxis (TAP)		
Number of HIV positive women offered PMTCT excluding TAP		
Number of HIV positive women using exclusive breastfeeding		
Number of HIV positive mothers		
Percentage of HIV positive mothers using exclusive breastfeeding		
Partners tested		
Data Sources:		

NB:
% of Women tested for HIV = women tested / total new ANC Clients
ANC Prevalence rate= Women tested HIV positive / Women tested for HIV
Percentage of HIV positive mothers using exclusive breastfeeding = Number of HIV positive mothers using exclusive breastfeeding / HIV positive mothers

B) NEWBORNS

Target

Newborns (Neonates)	Total
Number of neonates tested for HIV	
Number of neonates with HIV positive result	
Number of neonates with HIV negative result	
Number of neonates born HIV- and sero-converted	
MTCT prevalence rate	
Data sources:	

MTCT prevalence rate = Number of neonates with HIV positive result / Number of neonates tested for HIV

VIII). TEENAGE PREGNANCY

Target

Teenage Pregnancies	≤ 14 years	Aged 15-19 years	Total	%
New ANC Clients				
Tested for HIV				
% tested for HIV				
Tested HIV positive				
Prevalence rate among Teenage ANC clients				
Data Sources:				

% of tested for HIV = Tested for HIV / total new teenage ANC Clients
ANC Prevalence rate= Teenagers ANC clients tested HIV positive / Teenage ANC clients tested for HIV

IX). TREATMENT

A) SEXUALLY TRANSMITTED INFECTIONS (STIS)

Target

STIs	Males	Females	Total	% Males	% Females
STI cases for the current year					
STI cases for last year					
STI cases for the year before last					
Data sources:					

B) ARV TREATMENT

ARV Therapy	Males	Females	Total	% Males	% Females
Persons eligible for ARV treatment					
Persons who started on ARVs this year					
Persons currently taking ARVs (cumulative)					
Persons on 2nd line ARV Regimen					
Persons on 3rd line ARV regimen					
Persons lost to follow up in the current year					
Percentage of adherence to HAART					
Data Sources:					

C) TUBERCULOSIS

TB	Males	Females	Total	% Males	% Females
New TB cases					
TB patients tested for HIV					
TB patients found to be HIV positive					
Number of patients placed on treatment					
Data Sources:					

X). CARE AND SUPPORT

A) COMMUNITY HOME BASED CARE

CHBC	Males	Females	Total	% Males	% Females
Persons currently registered for CHBC					
CHBC clients who are HIV positive					
CHBC clients receiving Psycho-social support					
Number of CHBC clients who graduated from the program this current year					
Data Sources:					

B) ORPHANS AND VULNERABLE CHILDREN

OVC	Males	Females	Total	% Males	% Females
Number of registered orphans					
Number of vulnerable children registered					
Number of registered orphans receiving Psychosocial Support					
Number of Vulnerable children registered receiving Psychosocial Support					
Number of orphans who graduated from the orphan care this current year					
Data Sources:					

TOOL # 4
DISTRICT SERVICES INVENTORY FORM

Key Target Group		Others (specify)w			
		PLHIV			
		General community			
		Women			
		Men			
		In school youth			
		OVC			
Activities/ Services					
Postal Address/Location					
Contact Person					
Type	PRIVATE SECTOR				
	CIVIL SOCIETY ORGANISATION	CBO			
		FBO			
		NGO			
	GOVERNMENT				
Organization					

TOOL # 5
DETAILED ACTIVITY PROPOSAL TOOL

NSF Priority Area:
Priority Issue:
Result:
Activity:
Target Group:
Lead sector or organisation (Sector, CBO, FBO, NGO or other groups responsible for implementing the programme)
In which quarter(s) will the activity occur? ☐ Apr-Jun ☐ Jul-Sep ☐ Jan-Mar
Contact person and phone number (Individuals responsible for the project who can be contacted with question
Description of how the activity will be carried out
Anticipated outputs (what measurable results are expected to occur?)
Project memorandum information (Detailed budget information about costs necessary to do the activity) Example ■ Tea – P420 (P7 for 10 people for 6 sessions) ■ Printed material – P60 (P10 for 6 people) ■ Telephone charges to coordinate group – P600 ■ Trained facilitator – P1800 (P300 each session for 6 sessions) ■ Promotional
Source of funds (example: NACA, ACHAP)

TOOL # 6
3 –YEAR PLAN

NSF Priority Area:								
NSF Outcome Result:								
Priority Issue:								
Results		**Activities**	**Lead Body**	**Budget breakdown**	**Cost/Budget**			**Source of Funding**
Outcome Result	**Output Result**				Year 1	Year 2	Year 3	
	Output Results 1	**Activity 1**						
		Activity 2						
		Activity 3						
	Output Results 2	**Activity 1**						
		Activity 2						
		Activity 3						
	Output Results 3	**Activity 1**						
		Activity 2						
		Activity 3						
			Sub total					
			Total					

TOOL # 6

3 –YEAR PLAN (A COMPLETED THREE YEAR PLAN TOOL)

NSF Priority Area:								
NSF Outcome Result:								
Priority Issue:								
Results		**Activities**	**Lead Body**	**Budget breakdown**	**Cost/Budget**			**Source of Funding**
Outcome Result	**Output Result**				Year 1	Year 2	Year 3	
Reduced mother to child transmission from 9% to 6% by 2015 in Gaborone	**Output Results 1** Increased PMTCT uptake from 87% to 90% by 2014	**Activity 1** Conduct CC on PMTCT	CCE Facilitator	n/a	0	0	0	n/a
		Activity 2 Conduct health talks on PMTCT at facilities	HEA	Flip charts, meeting refreshment Markers, Transport	P500	P500	P500	DMSAC
		Activity 3						
	Output Results 2 Increased testing of infants for HIV from 50% to 95%	**Activity 1** Procurement of additional test kits	Pharmacy Technician		n/a	n/a	n/a	MoH
		Activity 2 Training of lay counselors on testing	PMTCT Coordinator	Flip charts, meeting refreshment Markers, Transport	P2000	P2000	P1500	MoH DMSAC
		Activity 3 Health talks delivered during ANC attendance by HEAs	PMTCT Coordinator & HEO	Flip charts, Markers	P300	P300	P200	MoH DMSAC
	Output Results 3	**Activity 1**						
		Activity 2						
		Activity 3						
			Sub total		P2300	P2300	P2200	
			Total		P7300			

TOOL #7
ANNUAL PLAN

NSF Priority Area:										
NSF Outcome Result:										
Priority Issue:										
Results		**Activities**	**Lead Body**	**Implementation**				**Budget Breakdown**	**Total Budget**	**Source of Funding**
Outcome Result	**Output Result**			Q1	Q2	Q3	Q4			
	Output Results 1	**Activity 1**								
		Activity 2								
		Activity 3								
	Output Results 2	**Activity 1**								
		Activity 2								
		Activity 3								
	Output Results 3	**Activity 1**								
		Activity 2								
		Activity 3								
			Total Budget							

TOOL #8

ACTIVITY MONITORING TOOL (To be completed by Implementing Partner)

NAME OF ORGANIZATION:

REPORTING QUARTER:

NSF Priority Area:						
NSF Outcome Result:						
Priority Issue:						
Activity	**Target Group**	**Expected Output/Result**	**Actual Output/Result**	**Total Budget**	**Expenditure**	**Remarks/Comments**
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Challenges Encountered:

Other Comments and Ideas for Future Strengthening:

TOOL #9

ACTIVITY MONITORING TOOL (To be completed by DAC)

NAME OF DISTRICT:

REPORTING QUARTER:

NSF Priority Area:							
NSF Outcome Result:							
Priority Issue:							
Activity	**Target Group**	**Organization & Contact Person**	**Expected Output/ Result**	**Actual Output/ Result**	**Total Budget**	**Expenditure**	**Remarks/ Comments**
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

SECTION 05

Reference Materials

NATIONAL DOCUMENTS TO GUIDE HIV AND AIDS PROGRAMMING

BELOW ARE SOME O THE POLICIES AND TECHNICAL GUIDELINES FOR REFERENCE

INSTRUMENT	TYPE OF INSTRUMENT	RISK FACTORS OR DRIVERS INSTRUMENT IS RESPONDING TO	YEAR	SOURCE
Constitution of Botswana	Law	Structural Drivers (human rights, right to health, discrimination)		**AG's Office**
Public Service Act Section 7 (e)	Law	Stigma and Discrimination	2008	**AG's Office DPSM**
Domestic Violence Act No.10	Law	Domestic and Gender Based Violence	2008	**AG's Office MLHA-WAD**
The National HIV and AIDS Policy (revised)	Policy	Overarching	2010	**NACA, MoH**
The National Operational Plan for NSF II: 2012-2016	Plan	Overarching	2012	**NACA**
The Second NationalStrategic Framework 2010-2016	Plan	Overarching	2010	**NACA**
The National Operational Plan for Scaling up Prevention 2008-2010		Overarching	2008	NACA
Prevention of Mother to Child Transmission Guidelines	Guidelines	Mother to Child Transmission	2005	MoH
Behaviour Change Interventions & Communication Strategy: 2006-2009	Strategy	Individual Risk Factors	2006	MoH
National Guidelines for HIV Testing and Counselling	Guidelines	Knowledge of sero-status	2009	MoH
National Multiple Concurrent Partnership Campaign Roll out Strategy	Strategy	Multiple Concurrent Partners	2009	NACA
Safe Male Circumci-sion Strategy	Strategy	Male Circumcision	2009	MoH
The National PHDP Strategy (2009-2016)	Strategy	Positive Health Dignity and Prevention	2009	MoH
The HIV and AIDS Health Sector Strat-egy (2010-2016)	Strategy		2010	MoH
The National PHDP Implementation Plan (2010-2016	Plan	Positive Health Dignity and Prevention	2010	MoH
The CSO PHDP Operational Plan (2010-2016)	Plan	Positive Health Dig-nity and Prevention	2010	MoH, BONEPWA+BONASO
The CSO PHDP Operational Plan (2010-2016)	Plan	Positive Health Dignity and Prevention	2010	MoH, BONEPWA+BONASO

II. TREATMENT, CARE AND SUPPORT SERVICESBELOW IS A LIST OF SOME KEY DOCUMENTS THAT INFORM AND GUIDE PROVISION OF TREATMENT, CARE AND SUPPORT SERVICES

INSTRUMENT	TYPE OF INSTRUMENT	RISK FACTORS OR DRIV-ERS INSTRUMENT IS RESPONDING TO	YEAR	SOURCE
Constitution of Botswana	Law	Structural Drivers (human rights, right to health, dis-crimination)		MoH NACA
The National HIV and AIDS Policy (revised)	Policy	Overarching	2010	MLG-DSS
The Children's Act	Law	Orphans and Vulnerable Children	2009	MLG-DSS
Children in Need of Care	Regulations	Orphans and Vul-nerable Children	2010	NACA
The Second National Strategic Framework :2010-2016	Strategic Frame-work	Overarching	2008	MoH
The National Tuberculosis Control Programme: 2008-2012	Strategic Plan	Control and Management of TB	2008	MoH
The Revised ARV Treat-ment Guidelines	Guidelines	Care and Treatment	2008	MoH
Palliative Care Guidelines	Guidelines	Care and Support		MoH
Community Home Based Care Guide-lines	Guidelines	Care and Support		MLG-DSS
National Guidelines on the Care and Support of Orphans and Vulnerable Children	Guidelines	Orphans and Vulnerable Children	2008	MLG-DSS
National Monitor-ing and Evaluation Framework	Framework	Orphans and Vulnerable Children	2008	MoH
The National PHDP Strategy (2009-2016)	Strategy	Positive Health Dignity and Prevention	2009	MoH
The HIV and AIDS Health Sector Strategy (2010-2016)	Strategy	Positive Health Dignity and Prevention	2010	MoH
The National PHDP Imple-mentation Plan (2010-2016)	Plan	Positive Health Dignity and Prevention	2010	MoH
The CSO PHDP Opera-tional Plan (2010-2016)	Plan	Positive Health Dignity and Prevention	2010	MoH, BONEPWA+BONASO
The CSO PHDP Opera-tional Plan (2010-2016)	Plan	Positive Health Dignity and Prevention	2010	MoH, BONEPWA+BONASO

THE NOP RESULTS FRAMEWORK: 2012-2016

NOP	RESULTS	FRAMEWORK
IMPACT RESULTS	**OUTCOME RESULTS**	**OUTPUT RESULTS**
PRIORITY 1: PREVENTION OF NEW HIV INFECTIONS		
[a] Annual HIV incidence is reduced from 2.9% in 2010 to less than 1% by 2016	[1] Increased proportion of males and females aged 10-49 practicing safe sexual behaviour	[1.1] % of service providers im-plementing a minimum package of services for key affected popu-lations by 2016
		[1.2] People aged 10-49 years reached with anti-MCP messages increased by 20%by 2016
		[1.3] People aged 15 – 49 years who received HIV test and know their status increased from 41%(2008) to 50% in 2012, to 60% by 2016
		[1.4] Male and female condom distribution increased from 29 million to 32,7 million for male condom and Y% to X % for female condom by 2016
		[1.5] People aged 10 – 49 years reached with anti – alcohol and substance abuse messages in-creased by X% by 2016
	[2] Improve utilization of health care services for HIV prevention	[1.6] People aged 10 – 49 years reached with intergenerational sex messages increased by X% by 2016
		[2.1] HIV negative males aged 10 – 49 years reached with SMC services increased from 11%, to 80% by 2016
		[2.2] PLHIVs involvement in pre-vention interventions strengthened
		[2.3] 100% increased coverage of STI treatment for people present-ing with STIs
		[2.4] 100% donated blood units are screened for transfusion trans-missible infections using national screening guidelines and main-tained at that level by 2016
		[2.5] HIV positive pregnant wom-en accessing PMTCT services in-creased from X% to 100% by 2016
		[2.6] Provision of HIV DNA PCR testing scaled up to 100%
		[2.7] Improved capacity to man-age PEP services in the workplace and communities
		[2.8] Community awareness of PEP for rape survivors and gender based violence increased
PRIORITY 2: SYSTEMS STRENGTHENING		
[b] 80% of stakeholders that have expressed satisfaction with the level and type of HIV and AIDS services provided at various level	[3] Communities (CBO, NGO/FBO) empowered to effectively respond to HIV and AIDS	[3.1] CSO competency in delivery of HIV and AIDS services increased from 40% in 2011 to 70% in 2013 and 100% by 2016.
		[3.2] CSOs coordinating struc-tures participating in programme Planning cycle increased from 40% in 2011 to 70% in 2013 and 100% by 2016
		[3.3] 80% of needs-based fund-ing requirements for CSOs met by 2016
	[4] Improved access to quality HIV and AIDS services [improved capacity to ensure universal to HIV and AIDS services]	[4.1] Proportion of skilled health sector workforce increased to 80% 2016
		[4.2] Proportion of skilled social welfare workforce increased from XX to YY by 2016
		[4.4] % of institutions (health facilities) with capacity for sup-ply chain management increased from XX to 100% by 2016
		[4.5] Organisations implementing the workplace programme as per the national standard increased from XX to 100% by 2016
		[4.6] Organisations with approved development projects main-streaming HIV and AIDS to the national standards increased from 60% to 100% by 2016
		[4.7] Health facilities with ad-equate capacity to provide in-tegrated HIV and AIDS services increased from XX to 100% by 2016

		[5]	Partners aligned to national priorities and are accountable for their use of resources and perfor-mance	[5.1] 100% of Implementing part-ners programmes aligned to NSF II-NOP results by 2016
				[5.2] National, District and Local levels coordination structures supported to provide effective and effcient coordination of the national response by 20162016
		[6]	National response adequately resourced	[6.1] NOP financial resource needs mobilised by 2016
				[6.2] 100% of Coordination struc-tures reporting financial perfor-mance by 2016
		[7]	Ethical and legal environment for HIV and AIDS improved	[7.1] % of strategic partners hav-ing adequate technical capacity to participate in the development of appropriate policies and legis-lation [11]
				[7.2] Number of policies that have mainstreamed HIV & AIDS by 2016
	PRIORITY 3: STRATEGIC INFORMATION MANAGE-MENT			
[c]	Stakeholders who have used evidence to plan for the national multi-sectoral HIV and AIDS re-sponse by 2016	[8]	Increased availability of quality, comprehensive, and harmonized information on the response	[8.1] A functional national M&E system by 2012
				[8.2] 100% NAC sectors aligned to the national M&E system by 2016
				[8.3] Strategic Information dis-seminated to all stakeholders by 2016.
				[8.4] 100% national HIV and AIDS interventions are based on evi-dence by 2016
				[8.5] Research agenda imple-mented
	PRIORITY 4: TREAT-MENT, CARE AND SUP-PORT			
[d]	Adults and children with HIV still alive and known to be on treatment more than five (5) years after the ini-tiation of ART is in-creased from X in 2010 to 95% by 2016 (disaggregated by gender (female, male) and age (<15, 15+)	[9]	Improve access to comprehen-sive quality treatment, care and support services.	[9.1] Patients tested positive as-sessed for ART eligibility within two weeks increased from 25% in 2010 to 50% by 2013 and 75% by 2016
				[9.2] Eligible patients promptly initiated on HAART in public facili-ties in accordance with the Na-tional ARV Treatment Guidelines in-creased from 96.2% in 2010 to 98% by 2013 and 100% by 2016
				[9.3] Registered HIV infected pa-tients not yet eligible for HAART receiving clinical monitoring ac-cording to national ARV treat-ment guidelines increased from 35% in 2010 to 65% by 2013 and 80% by 2016
				[9.4] HIV registered infants who receive CTX prophylaxis according to national guidelines increased from 50% in 2009 to 75% in 2013 and to 90% by 2016
				[9.5] Registered children who receive CTX prophylaxis according to national guidelines increased from 50% in 2009 to 75% in 2013 and to 85% by 2016
				[9.6] Registered adults who re-ceive CTX prophylaxis according to national guidelines increased from 75% in 2009 to 85% in 2013 and to 95% by 2016
				[9.7] Approved health facilities prescribing and dispensing ART increased from 70% in Sept 2010 to 85% by 2013 and 100% by 2016
				[9.8] Children on HAART receiving clinical monitoring according to national ARV treatment guide-lines increased from 75% in 2010 to 85% by 2013 and 95% by 2016
				[9.9] Adults on HAART receiving clinical monitoring according to national ARV treatment guide-lines increased from 75% in 2010 to 85% by 2013 and 95% by 2016
				[9.10] Women and men aged 15 years and above eligible for HAART who are receiving it in-creased from 93.7% in Sept 2010 to 97% by 2013 and 100% by 2016

		[9.11]	Children aged 0-14 years & adolescents eligible for HAART (according to the national guide-lines) who are receiving it in-creased from 95.2% in Sept 2010 to 98% by 2013 and 100% by 2016
		[9.12]	HIV patients routinely screened for TB at every visit in-creased from 25% in 2010 to 60% by 2013 and 85% by 2016
		[9.13]	HIV/TB co-infected patients eligible for HAART according to national guidelines initiated on HAART increased from 75% in 2010 to 85% by 2013 and 95% by 2016
		[9.14]	HIV+ female patients screened for cervical cancer annu-ally increased from 20% in 2010 to 45% by 2013 and 75% by 2016
		[9.15]	CHBC-registered patients receiving comprehensive quality health services increased from 92.0% in 2010 to 96.0% by 2013 and 100% by 2016
		[9.16]	CHBC-registered patients receiving comprehensive qual-ity social services increased from XX% in 2010 to YY% by 2013 and ZZ% by 2016
		[9.17]	Registered HIV+ patients receiving psychosocial support services increased from XX% in 2010 to YY% by 2013 and ZZ% by 2016
		[9.18]	Registered OVC receiving basic services increased from 48,7% in 2010 to 90% by 2013 and 95% by 2016
		[9.19]	OVC graduates aged 18-21 years receiving appropriate ser-vices increased from 15% in 2010 to 40% by 2013 and 80% by 2016

SECTION 06

Promising Practices in Prevention: Guidance for More Effective Programmes

GUIDANCE FOR MORE EFFECTIVE PROGRAMMES

The fundamental focus of the National Response is on prevention. Without prevention, Botswana has a grim future where trends in infection, death, and decline in socio-economic development continue. Prevention is about changing societal behaviours in terms of sex, and also those contributory behaviours such as stigmatisation, gender inequality, and other social relations that underpin our actions.
- The National HIV/AIDS Strategic Framework 2003-2009, p.32

INTRODUCTION

Prevention is the first priority of Botswana's National Response to HIV/AIDS. The National Strategic Framework calls for prevention activities at all levels directed at achieving the following impacts:

- Increase in HIV prevention knowledge of people aged 15-49
- Adoption of HIV prevention behaviours of people aged 15-49
- Reduction of infants born to HIV infected mothers who are infected at 18 months
- Decrease in the HIV incidence among the sexually active population
- Decrease in the STI prevalence among the sexually active population

The development of strong and effective prevention programmes is critically important for changing the course of the AIDS epidemic in Botswana. It is essential that sectors and organisations at all levels work in concert to create a network of prevention activities throughout the country.

Research has shown that there are approaches that, when utilised, can help improve the effectiveness of prevention programming. The purpose of this document is to provide DACs, DMSACs and Implementing Partners with guidance to help strengthen prevention programmes at the district level.

PART ONE: UNDERSTANDING BEHAVIOUR CHANGE

Preventing the spread of HIV requires behaviour change. The goal of prevention activities is to get people to adopt new behaviours.

To want to change their behaviour, people must see the desired change as important and possible. The Health Belief Model (Rosenstock, Strecher and Becker, 1994) helps us to understand what particularly motivates people to make behavioural changes when faced with a health threat.

The Health Belief Model identifies six key concepts that motivate people to take healthy action. By addressing these concepts, prevention efforts can help to increase people's sense of motivation.

THE HEALTH BELIEF MODEL

HEALTH BELIEF MODEL CONCEPTS	DEFINITION	HOW PREVENTION PROGRAMMES CAN ADDRESS
Perceived Susceptibility	A person's perception of his/her risk of getting a condition I believe that my behaviour puts me at risk of acquiring HIV.	■ Define population(s) at risk and their risk levels ■ Help people understand their behaviours that lead to personal risk ■ Heighten perceived susceptibility if too low
Perceived Severity	A person's perception of how serious the condition and its consequences are Acquiring HIV would have serious consequences for me and my family.	■ Specify and describe consequences of the risk and the condition
Perceived Benefits	A person's belief in the effectiveness of the strategies designed to reduce the threat I know of effective ways to prevent myself from contracting HIV.	■ Define action to take — how, where, when ■ Clarify the positive effects to expected ■ Describe evidence of effectiveness
Perceived Barriers	A person's sense of the potential negative consequences that might result from taking particular health actions I believe I can handle any conflicts or problems that might result from making changes in my behaviour	■ Identify and reduce barriers through reassurance, incentives, and assistance
Cues to Action	Events, either internal (e.g., physical symptoms of a health condition) or environmental (e.g., community campaign) that motivate people to take action I receive messages from my environment that support my behaviour change goals.	■ Provide how-to information ■ Promote awareness ■ Provide reminders
Self-Efficacy	A person's confidence that he or she can successfully do the behaviours required for the desired outcome I feel that I can successfully perform the actions required for the new behaviour.	■ Provide training, guidance, and positive reinforcement

Adapted from "Health Belief Model (detailed)." Retrieved 12 Feb 2008, from The Communication Initiative Network.
Website: www.comminit.com/en/node/27093

People generally do not make big behavioural changes instantly. Rather, they typically go through a process of more gradual change over time.

THE STAGES OF CHANGE MODEL

(Prochaska, DiClemente and Norcross, 1992) helps us to understand the steps people are likely to go through in making changes. Recognising this, prevention efforts should provide support to people at each of these various steps

THE STAGES OF CHANGE MODEL

STAGES OF CHANGE CONCEPT	DEFINITION	HOW PREVENTION PROGRAMMES CAN ADDRESS
Pre-Contemplation	Individual is unaware of the problem, hasn't thought about change. Example: No consideration of using condoms	Increase awareness of need for change, personalise information on risks and benefits
Contemplation	Individual recognises the problem and is seriously thinking about changing. Example: Understands the need to use condoms	Motivate, encourage to make specific plans
Preparation	Individual recognises the problem and intends to change the behaviour within the next month. Some behaviour change efforts may be reported, such as inconsistent condom usage. However, the defined behaviour change criterion has not been reached (i.e., consistent condom usage). Example: Thinking about trying to use condoms	Assist in developing concrete action
Action	Individual has enacted consistent behaviour change (i.e., consistent condom usage) for less than six months. Example: Has begun to use condoms on a regular basis	Assist with feedback, problem solving, social support, reinforcement
Maintenance	Individual maintains new behaviour for six months or more. Example: Is always using condoms	Assist in coping, reminders, finding alternatives, avoiding slips/relapses
Relapse	Individual resumes old behaviour. Example: Slipping-up with respect to condom use	Assist in restoring motivation, removing barriers, developing better coping strategies

Adapted from "Health Belief Model (detailed)." The Communication Initiative Network.
Website: http://www.comminit.com/en/node/27168

PART TWO: CHARACTERISTICS OF EFFECTIVE PREVENTION STRATEGIES

As we work to prevent the spread of HIV by getting people to change their behaviours, there are a number of personal, social, and environmental factors (determinants) that can help or hinder our efforts. These include:

- **KNOWLEDGE –** people's awareness of the facts about HIV, its transmission, and its impacts
- **ATTITUDES AND MOTIVATION –** one's feeling about how important it is to take action and one's ability to do so
- **SKILLS –** knowing specifically what to do, when to do it, and how to do it to avoid risk
- **COMMUNITY NORMS –** prevalent attitudes, beliefs and practices related to HIV and HIV risk-reduction approaches
- **ACCESS TO RESOURCES –** people's ability to obtain the information, services and supplies necessary to reduce their risk of HIV transmission

The chart on the following page summarises how these determinants can work for or against positive change, and identifies some of types of prevention strategies that can help to address each determinant.

In addition, research has shown some types of prevention activities to be more effective than others in terms of producing behaviour change:

- **PROGRAMMES THAT ADDRESS MULTIPLE DETERMINANTS OF BEHAVIOUR** are more effective than those that address only one.
- **PROGRAMMES THAT UTILISE A STRUCTURED APPROACH OR CURRICULUM** are more effective than those without a well-defined format.
- **PROGRAMMES INVOLVING MULTIPLE CONTACTS WITH THE SAME PARTICIPANTS** are more effective than one-time only workshops.
- **PROGRAMMES DEVELOPED IN COLLABORATION WITH THE TARGET GROUP** are more effective than programmes developed without their involvement.
- **INTERACTIVE ACTIVITIES** are more effective than those that are aimed at information-giving alone.

Our success in moving people towards healthier behaviours will be determined by how well these factors are addressed. It should be noted that most highly effective prevention strategies address many of these factors simultaneously.

DETERMINANTS OF BEHAVIOUR CHANGE

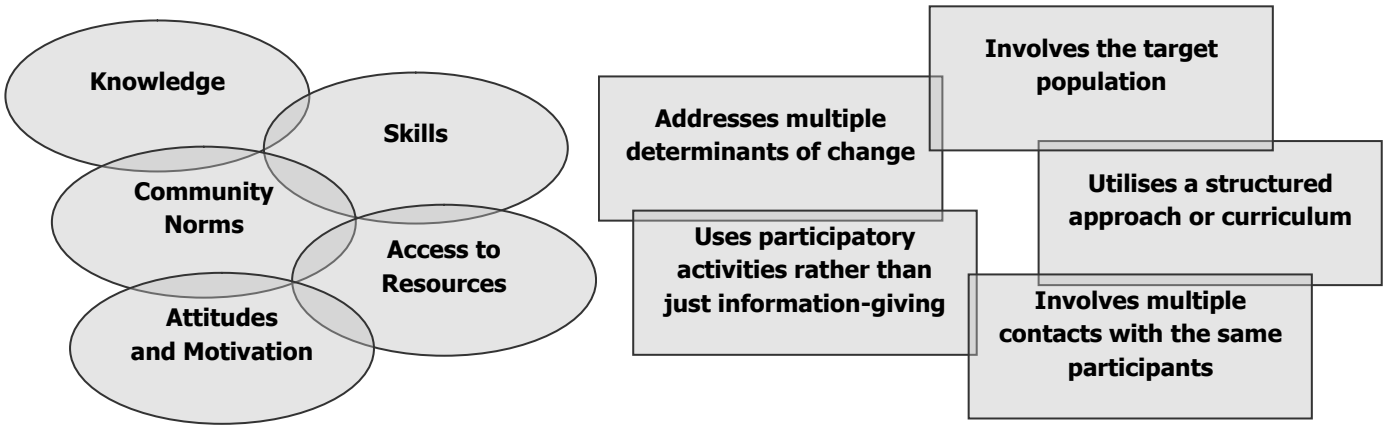
	Detrimental	Helpful	Useful types of interventions
Knowledge	■ Not having basic knowledge about HIV transmission and consequences ■ Believing myths about causes and prevention	■ Having accurate knowledge about what HIV is, how it is transmitted, and its impact on individuals, families, and the community	■ HIV education in schools ■ Community fairs/events ■ Media campaigns
Attitudes and Motivation	■ Feeling that "this has nothing to do with me" ■ Engaging in risky behaviours and not perceiving any need to change ■ Engaging in risky behaviours and feeling too ashamed to admit it ■ Feeling that "it makes no difference what I do" ■	■ Perceiving HIV as: a) having severe consequences; b) that you personally are at risk; and c) that you are capable of doing what's necessary to avoid risk	Peer outreach/story-telling ■ Promoting abstinence as an option ■ Information and activities in "natural community" settings (churches, kgotla, etc.) ■ PLWHA activism ■ Activities in high-risk settings (STI & VMC clinics, shabeens) ■ Messages delivered by local opinion leaders (kgosi, traditional healers, athletes, media figures)
Skills	■ Not feeling able to say no to sex ■ Not knowing how to use condoms properly ■ Not being able to get partner's cooperation to use safe sex practices	■ Girls and women feeling able to refuse undesired/ unprotected sex ■ Knowing how and feeling comfortable using condoms ■ Sexual partners being able to talk honestly about risk and actions for risk reduction ■ Sex workers and clientele taking preventive measures	■ Teaching how to use condoms ■ Teaching life skills to youth ■ Modelling positive behaviours through edutainment ■ Teaching communication and relationship skills to women ■ Educating PLWHA about risk reduction strategies
Community Norms	■ Generally-held beliefs and practices that promote unsafe behaviours ■ Generally-held beliefs and practices that make it difficult or unacceptable to practice risk-reduction behaviours ■ Generally-held beliefs and practices that stigmatise PLWHA	■ Community encourages/ supports adoption of risk-reduction behaviours ■ Community holds risky behaviour unacceptable ■ Community accepts and supports PLWHA	■ Public dialogue about risks, consequences, and strategies ■ Recruitment of community norm-setters /opinion leaders as champions of the cause ■ Creating attractive cultural heroes who exemplify new way of thinking ■ Stigma reduction programmes ■ Activities to improve the status of at-risk people ■ Involvement of PLWHA in programme planning and design

Access to Resources	■ Resources (information, condoms, pre-natal care, ARVs, etc.) not being available at all ■ People not being able to get to where resources are ■ People not being able to afford resources People feeling uncomfortable about accessing resources	■ Having services and supplies available to and used by populations in need	■ Condom distribution ■ PMTCT programmes Community mobilisation to build stronger service networks Referral programmes to help people obtain services Programmes that help people gain employment and income Media campaigns about where to obtain condoms

PART THREE: INTERVENTION IDEAS

This section contains some examples of promising prevention strategies that have been implemented in Botswana and other places. They are presented here to stimulate your ideas to develop new and better prevention activities in your district.

As you review these strategies, you will notice that a single strategy often will touch on many of the determinants of behaviour change and also contain some or all of the features of effective prevention programmes:



These examples are just a few of many proven and promising HIV/AIDS prevention programmes that are currently available.

EXAMPLE #1: WORKING IN PARTNERSHIP WITH TRADITIONAL HEALERS

Training traditional healers as educators and counsellors to disseminate information on HIV and sexually transmitted infections in their communities and to their peers

In much of sub-Saharan Africa, a high percentage of people make use of traditional healers' services in both rural and urban areas. Traditional healers tend to be the first 'professionals' consulted by people with a sexually transmitted disease, including HIV. Healers are more easily accessible geographically and provide a culturally accepted treatment. They have credibility, acceptance and respect among the population they serve, and thus form a critical part of the health-care delivery system.

Leaders in one community in South Africa identified local traditional healers as having an important role to play in strengthening their response to the AIDS epidemic. In response to their request, community service providers and medical doctors began working in partnership with the local traditional healers on HIV prevention projects.

Over a two year period, a group of around 16-20 healers attended a monthly one-day workshop where they learnt about HIV transmission, prevention, treatment and care. Discussions took place around traditional and cultural sexual practices that could prevent HIV transmission and safer sexual practices involving more than just condoms.

Herbal treatments were debated alongside other traditional medicines used by the healers. Guest speakers were invited to talk about the use of medicinal plants and the healers, who were invited to attend a course at a medicinal plant nursery, later established a medicinal plant garden.

Through the regular meetings, the healers have established an informal support network and rely on each other for referral and resources. Increasingly, ways are being found to stimulate both referral networking with the formal health sector and with the traditional healers.

The ripples of the healers' work have become increasingly widespread and more and more people are requesting HIV testing, counselling and support through the healers.

Source: UNAIDS website www.unaids.org - Feature Story 07 February 2007
Additional information: Collaborating with Traditional Healers for HIV Prevention and Care in sub-Saharan Africa: suggestions for Programme Managers and Field Workers (UNAIDS Best Practice Collection, 2006). Available at http://data.unaids.org/Publications/IRC-pub07/JC967-TradHealers_en.pdf

EXAMPLE #2: STEPPING STONES

An award-winning training package on HIV/AIDS, gender issues, communication and relationship skills for people of all ages

Stepping Stones is a life skills training package in gender, HIV, communication and relationship skills. Developed for use in communities throughout sub-Saharan Africa.

The Stepping Stones package is designed to enable women, men and young people of all ages to explore their social, sexual and psychological needs, to analyse the communication blocks they face, and to practise different ways of addressing their relationships. Workshops aim to enable individuals, their peers and their communities to change their behaviour - individually and together - through the "stepping stones" which the various sessions provide.

Most sessions are designed for people in small groups of 10-20, of their own gender and age. Occasional sessions bring everyone together. It has been used successfully with groups of HIV positive people and with groups of people who are HIV-free or who do not know their status. The whole package is based on a human-rights based approach, assuming that we all share certain challenges in our lives, which the package aims to help us address.

- All sessions use a participatory approach of adult learning through shared discussions.
- Exercises are all based on people's own experiences, and role play and drawing exercises enable everyone to take part. No literacy is needed.
- Participants discuss their experiences, act them out, analyse them, consider alternative outcomes, and then rehearse these together in a safe, supportive group.
- People feel safe because most sessions take place in groups of their own gender and age.
- Though designed with HIV/AIDS in mind, the package covers many related topics such as gender violence and alcohol use.

Stepping Stones is designed for use by a team of skilled people -- ideally two male, two female -- who work with peer groups of community members. Experienced trainers should be able to use the material straight away. Less experienced trainers may need a training course to help them start to use it.

Source: Strategies for Hope website - www.stratshope.org/t-training.htm

EXAMPLE #3: YOUTH-FRIENDLY CLINIC SERVICES

Improving young people's access to and the quality of reproductive health services

Youth-Friendly Services (YFS) are services that attract youth, meet a variety of young people's needs comfortably and responsively, and succeed in retaining them for continuous care.

In 2000 Pathfinder International launched The African Youth Alliance programme (AYA) to develop YFS clinics in Botswana and three other African countries. AYA/Pathfinder sought to address the factors that hinder young people from seeking sexual and reproductive health (SRH) services and to improve the overall quality of services.

What makes services youth-friendly? Pathfinder developed a list of the key elements, categorised into essential and supportive elements as shown in the following chart.

ESSENTIAL	Supportive
▪ Convenient open hours	▪ Youth input/feedback to operations
▪ Privacy ensured	▪ Accessible location
▪ Competent staff	▪ Publicity for YFS
▪ Respect for youth	▪ Comfortable setting
▪ Minimum package of services available	▪ Peer providers/counsellors available
▪ Sufficient supply of commodities and drugs	▪ Educational materials available
▪ Range of family planning methods offered	▪ Delay of blood test and pelvic exam, if possible
▪ Emphasis on dual protection/condoms	▪ Partners welcomed and served
▪ Referrals available	▪ Non-medical staff oriented
▪ Young adolescents (12-15) are served	▪ Provision of additional educational opportunities
▪ Confidentiality ensured	▪ Outreach services available
▪ Waiting time not excessive	
▪ Affordable fees	
▪ Separate space and/or hours for youth	

Based on their experience in Botswana, AYA/Pathfinder made the following suggestions for helping clinics increase access to and improve the quality of their youth services:

- Make facility hours more convenient for young people by staying open beyond 4:30 p.m., possibly by staggering service providers' working hours.
- Conduct outreach through community-based health workers or through community-based sites and organisations that are linked, and able to refer, to the clinic.
- Set up alternative service delivery channels such as pharmacies and consider non-traditional condom distributors.
- Initiate services that cater to the needs of young men.
- Encourage younger adolescents (ages 12-15) to visit the clinics for information and services by improving provider attitudes and biases to serving this group of young people.
- Place more emphasis on dual protection and condoms. Protection against pregnancy, STIs, and HIV needs to be discussed with each client regardless of presenting conditions, especially when young people come in for minor ailments, and condoms need to be made easily available.
- Ensure that there are enough BCC materials available at the clinics for clients.
- Include youth in designing, monitoring, and evaluating youth services (e.g. village health committee involvement in facility assessments, adding suggestion boxes to clinics, etc.)

Source: Youth-Friendly Services: Botswana End of Programme Evaluation Report (African Youth Alliance/AYA - December 2005). Available at www.pathfind.org/site/DocServer/BT_YFS_report_FINAL.pdf?docID=5141

Additional information: Department of Public Health (Reproductive Health Services Division). Ministry of Health, Government Enclave. Tel: 3170585

EXAMPLE #4: COMMUNITY CAPACITY ENHANCEMENT PROGRAMME (CCEP)

Engaging communities in open discussions on issues of sexuality and HIV/AIDS

This programme was developed by the United Nations Development Projects and has been implemented in many African countries. In Botswana, the Ministry of Local Government's Department of Primary Health Care Services is coordinating implementation of this project.

CCEP is based on the recognition that communities have the capacity to prevent, care, change and sustain hope in the midst of the HIV/AIDS epidemic. The CCEP process creates opportunities for people to understand, discuss, decide and act on issues affecting their lives. It is led by either a United Nations Volunteers or a trained community member. Facilitators are expected to engage communities in open discussions at the kgotla or in other appropriate settings on issues of sexuality and HIV/AIDS. CCEP targets behaviour change while seeking solutions that are based on the community's concerns, opinions, and ideas.

This programme is designed to involve communities in addressing local norms associated with HIV/AIDS. The facilitators are put through a rigorous training programme and provided with a facilitation guide that emphasising a series of steps that must be taken in the proper order for a successful CCEP meeting to have occurred. The CCEP meeting will most likely not be a single event, but will be a series to meetings that each focus on different parts of the process. This process works on developing problem solving and empowerment skills for community members and is intended to fully address issues of community norms. As communities meet to discuss issues, the norms that underlay issues are brought to the surface and examined as a part of the decision making process.

Source: Community Capacity Enhancement in response to HIV/AIDS, A Handbook for Community Conversations produced by UNDP-BDP HIV/AIDS Group, Leadership for Results Programme, October 2004

Additional information: Department of Primary Health Care Services, Ministry of Local Government & rural development; Tel: 3998800

EXAMPLE #5: LIFE SKILLS PROGRAMME

Teaching communication and decision-making skills to help youth and other vulnerable groups avoid contracting HIV

The Life Skills programme is a comprehensive behaviour change approach that concentrates on developing the skills needed for life, such as communication and critical thinking. Additionally, it addresses the important related issues of empowering girls and guiding boys towards new values. The Life Skills approach is completely interactive, using role plays, games, puzzles, group discussions, and a variety of other innovative teaching techniques to keep the participant wholly involved in the sessions.

The manual consists of over 50 different lesson ideas that you can use with any group: anti-AIDS clubs, girls clubs, boys clubs, youth clubs, women's groups, and so forth. The manual is written with a strong bias towards youth work and health issues. These lessons are quite easy to adapt to any age and other topics. In addition to the lesson plans, some lessons learned regarding peer education are included, as are some sample schedules, and tips to facilitators.

The Curriculum Development & Evaluation Department has also developed a Lifelihood Skills Manual that has been used by Civil Society Organisations with impressive results.

Additional information: Life Skills Manual (Peace Corps Centre for Field Assistance and Applied Research - 2001.) Available at www.peacecorps.gov
Curriculum Development & Evaluation Department (Guidance), Ministry of Education & Skills Development. Tel: 3952990/3655400

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