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Acronyms

ACHAP	• African Comprehensive HIV/AIDS Partnerships
ACSM	• Advocacy Communication and Social Mobilisation
AIDS	• Acquired Immune Deficiency Syndrome
ARV	• Antiretroviral
BLA	• Botswana Libraries Association
BNLS	• Botswana National Library Services
BORNUS	• Botswana Retired Nurses Association
BSLA	• Building Strong Libraries Association
BTC	• Botswana Telecommunications Corporation
CDC	• Centre for Disease Control
CD4	• Cluster of Differentiation 4
CTP	• Cotrimoxazole Preventive Therapy
DHAPC	• Department of HIV/AIDS Prevention and Care
DHIS	• District Health Information Systems
DLIS	• Department of Library and Information Studies
DOT	• Directly Observed Treatment
GBC	• Global Business Council
HAART	• Highly Active Antiretroviral Therapy
HRDC	• Health Research and Development Committee
HIV	• Human Immunodeficiency Virus
ICASA	• International Conference on AIDS and Sexually Transmitted Infections in Africa
IT	• Information Technology
ICT	• Information Communications and Technology
ICDL	• International Computers Driving Licence
KAP	• Knowledge Attitudes and Practice
LAN	• Local Area Network
LIMSA	• Library and Information Management Students Association
MOVE	• Models for Optimizing the Volume and Efficiency of Male Circumcision Services
M&E	• Monitoring and Evaluation
MERD	• Monitoring Evaluation Research and Documentation
MSD	• Merck Sharp and Dome
MOH	• Ministry of Health
NACA	• National AIDS Coordinating Agency
PSI	• Population Services International
RMU	• Records Management Unit
SMC	• Safe Male Circumcision
UNAIDS	• United Nations Programme on HIV/AIDS
UNICEF	• United Nations Children's Fund
VCT	• Voluntary Counselling and Testing
VRRS	• Village Reading Rooms
WHO	• World Health Organisation
XPRES	• Xpert Package Rollout Evaluation Study



Chairpersons Foreword



JOY PHUMAPHI (ACHAP CHAIRPERSON)

ACHAP has closed a daunting chapter in its bludgeoning evolution and is well poised to meeting the challenges poised by a dynamic regional and global environment by opening an exciting new chapter in its continued development. This transformation in approach in part is necessitated by the vagrancies of the complex environment within which we live and operate, to further enable ACHAP to better leverage opportunities it has created. The sunset of TMCF funding in December 2014 represents an opportunity for ACHAP to refine its role further to enable a successful transition of ACHAP's current programs, so that the more experienced and invigorated ACHAP can harness and utilize knowledge it has generated in the area of HIV/AIDS, to improve programming and implementation in the region and around the continent given the myriad health challenges faced by our people.

The ACHAP we intend to create going forward is a cutting edge, catalytic and innovative organization that will support countries in the Eastern and Southern Africa region to optimize their responses to HIV/AIDS and other health challenges. As a mechanism for public-private partnerships, ACHAP intends to develop best practices in the health arena to enable innovative market-oriented interventions to transform government health responses. This is significant because ACHAP is committed to ensuring that yesterday's gains are not lost but increased, multiplied and sustained. Securing the healthy future for our region will mean ACHAP will remain committed to innovation, use of evidence based choices, making tough decisions, whilst stimulating and galvanizing action through strong partnerships including all stakeholders across the board.

This people centred approach includes Government's, communities and individuals to help overcome the bottlenecks which often strangle progress in combating efforts to reduce the disease burden on the continent. ACHAP will remain focused, strategic, systematic and uncompromising in its pursuit of measurable results. Despite the daunting task ahead we remain extremely proud that twelve years ago ACHAP developed and

implemented Africa's model programs, especially Antiretroviral Therapy (ART) and Prevention of Mother-to-Child Transmission (PMTCT). Thanks to ACHAP, Botswana has started to turn the corner on its HIV and AIDS epidemic. HIV infections have started to slow down and many people needing HIV treatment now have access to it. However, the challenge going forward lies in leveraging and harnessing these successes in a sustainable way through institutional strengthening initiatives at the national and regional levels.

Using regional health indicators and donor mapping tools, ACHAP has determined that Lesotho and Swaziland offer the best prospects for successful expansion in service provision in 2015. The markets are similar in size to Botswana and the HIV prevalence and nature of interventions are also comparable, and therefore market entry will be through existing HIV services. ACHAP believes there is a strong opportunity to enter these two markets as a regional expert in delivering successful HIV programs through Public Private Partnerships and have commenced discussions with key stakeholders.

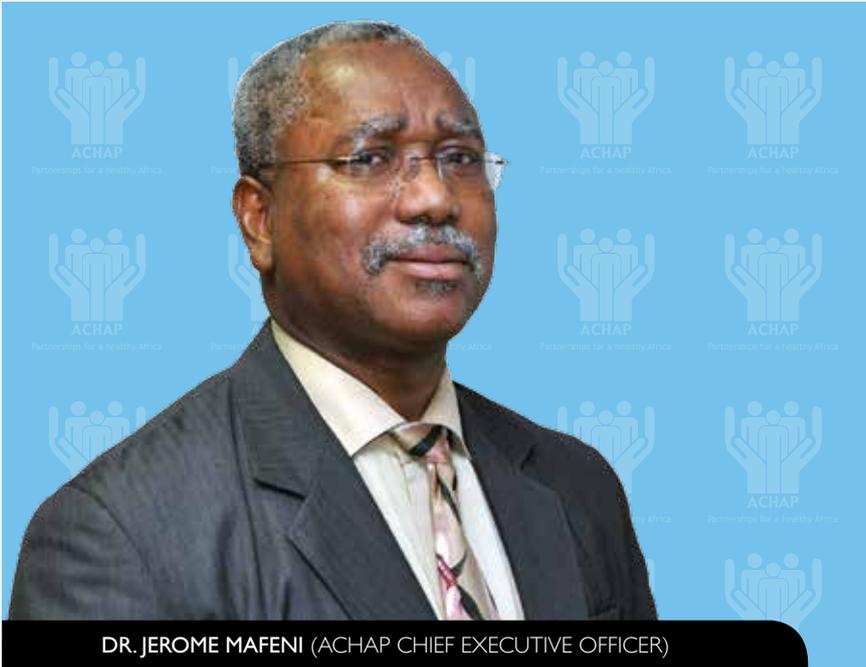
For the markets of Zimbabwe, Malawi, and Zambia the entry strategy is through existing HIV services. Once market entry has been gained in the HIV sector, ACHAP will seek to expand services into; Maternal and Child Health, Sexual and Reproductive Health, and Non-Communicable Diseases. Our track record in providing ARV's to 228,195 people in need shows that we have a well earned reputation for getting things done. We are confident the good work ACHAP has done with our key development partners and Government can inspire similar developments elsewhere in the region.

Thank you

MRS. JOY PHUMAPHI (CHAIRPERSON)



Chief Executive Officer's Preface



DR. JEROME MAFENI (ACHAP CHIEF EXECUTIVE OFFICER)

I am deeply humbled by the extraordinary strides we have achieved in fostering good relationships in support of good health outcomes in Botswana. The success we achieved in our work is best exemplified by prevention initiatives with partners within Government and in the community to promote Safe Male Circumcisions especially among young Batswana without undermining longstanding cultural norms.

ACHAP supported SMC's accounted for 35,507 circumcisions by December 31st 2013 which represented about 71 % of Botswana's annual national target. This is extraordinary. Our success in circumventing unnecessary excesses enabled ACHAP to further reduce cost per SMC to an average of USD\$98 in 2013 from USD\$179 in 2011. This is a remarkable feat because of the challenges encountered in many countries in the region especially because of challenges arising out of the limited access to financial resources following the global economic crises. ACHAP intends to break new ground in acting as a conduit for the development of working relationships between public and private partners, applying market-oriented approaches to public sector needs. ACHAP is in the process of identifying government needs and identifying private sector donors to support those needs, and catalyze and manage a Public Private Partnership (PPP) relationship.

We however are not complacent and will not allow ourselves to fall into the trap of celebrating the past. We are therefore currently in the process of expeditiously building a partnership that brings in outside resources to support national needs. The Madikwe Forum, comprising donor friends, Government officials and other stakeholders intend to build a dynamic and context sensitive organization, which responds to the health challenges faced by people in the region.

ACHAP typically envisages itself moving forward as a catalyst, innovator, and implementer of services. For example, if any Government in the region with the support of a private sector donor has an unmet need for technical innovation or implementation support in the health arena and not just HIV/AIDS, ACHAP intends to serve as the mechanism through which this takes place. As a proposal-driven organization, any role ACHAP plays will be time-delineated with an exit strategy.

In this way, ACHAP will be an implementer of health programs in some specific cases for specific times, but is not to be viewed as a long term implementation partner. ACHAP will no longer brand itself narrowly as only a program catalyst organization whose relevance is constrained to Botswana.

This new strategy recognizes that the strength of ACHAP rests on effectively applying private sector resources to address government and public sector programs by improving existing efficiencies and bolstering service delivery.

ACHAP intends to leverage knowledge generation and management generated in Botswana to improve health outcomes elsewhere on the continent.

The organization believes it can systematically harness its acquired strategic health information to develop appropriate best practices for outcome based program planning and implementation for benefit of stakeholders.

Thank you

DR. JEROME MAFENI (CEO)



Board of Directors



MRS. JOY PHUMAPHI
ACHAP Board Chairperson & Consultant



DR. JEROME MAFENI
ACHAP Chief Executive Officer



DR. LUKE NKINSI
Project Director



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Deputy Executive Director



HADDISTADESSE
Policy and External Relations
Officer, Global Development Policy
& Advocacy



ACHAP Management



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01. DR. JEROME MAFENI
Chief Executive Officer
02. DR. FRANK MWANGEMI
Executive Officer - Programmes
03. MR. BENSON CHOTA
Executive Officer - Operations
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Communication and Advocacy Manager
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Lead Technical Advisor
10. MS. RACHEL JACKSON
Grants Manager



ACHAP Program Highlights in 2013

- ACHAP supported SMC teams performed 35,507 circumcisions by December 31st 2013 which represented about 71 % of Botswana's Annual national target
- ACHAP's cost per SMC dropped to an average of USD\$98 in 2013 from USD\$179 in 2011.
- ACHAP completed a mapping exercise of catchment areas in districts to document the number of circumcised men and eligible uncircumcised men per village
- ACHAP successfully targeted 10,310 school boys for circumcision by 31st July 2013 in all 10 ACHAP supported districts countrywide in one month of school campaigns.
- SMC campaigns conducted by ACHAP show modern medical practices can successfully be blended with traditional practices with impressive results.
- HIV testing amongst TB patients in ACHAP supported districts is estimated at 99%.
- The 2013-2017 National TB Advocacy Communication and Social Mobilization Strategy and training curriculum for implementers was finalized in the year under review.
- In November 2013, 197,109 patients were on ARV treatment in the public sector with a combined cumulative total of 228,195 patients on ARV nationwide.
- The Treatment Optimization Pilot project (TOP) increased access to HCT services (over 60% new testers) and CD4 testing, with reduction in delays to ART initiation.
- The Sesigo project was launched in 2011 with 62 library staff qualifying for ICDL certification. Public training continues to take place at the public libraries, with 3578 trained during the reporting period bringing the total number of people trained to 59,867.



Executive Summary

During the financial period under review, a number of programs were successfully completed. A notable achievement of such an initiative was the execution of the Safe Male Circumcision (SMC) campaign, which successfully merged long standing traditional cultural practices with clinical medicine.

ACHAP supported circumcisions accounted for about 71% of the 2013 national target. This was possible because of smart partnerships developed by ACHAP with rural communities through traditional authorities and schools, where strong relationships with Parents Teacher's Associations (PTA) were nurtured, to solicit support of parents in persuading male children to circumcise.

The importance of nurturing this relationship was witnessed especially during school holidays with teachers in some schools volunteering to register students willing to be circumcised and submitting these lists to service delivery teams and ACHAP supported mobilizers.

Tremendous progress was also made in the implementation of TB and HIV collaboration and integrated services activities with access and utilization of TB/HIV services being expanded substantially throughout Botswana with almost 100 DOT coverage.

Another highlight in current financial year was the successful launch of the Treatment Optimization Pilot (TOP) Project in August 2013. It will attempt to provide catalytic support for the expansion of HIV counseling and testing services and strengthen linkages with post-test services.

Tutume was chosen to pilot the project because of the high burden of HIV in the area in the hope that lessons learnt can be developed into best practices for the benefit of communities in hard hit areas around the country.

There are a total of 228,195 patients on ARV treatment countrywide and a cumulative total of 23,103 patients who died on HAART since the inception of the program in 2002. The very high number of those on ARV treatment speaks volumes about the accessibility of ARV treatment support whilst the relatively low number of those dying shows how treatment support can prolong lives, if appropriate services are utilized.

Sesigo shifted into full gear during the financial year under consideration. A number of activities such as ICDL training, training of trainers, peer learning meetings and dissemination of final impact study results were carried out as the project moves into its final year of operation.

Knowledge generation, management and dissemination continue to remain a key foundational strength of ACHAP. The organization continues to harness its collection, management and utilization of strategic information to develop best practices for program planning and implementation for the benefit of all stakeholders.

Our capacity building capability is best reflected in the financial and human resource assistance ACHAP provided to the National AIDS Coordinating Agency (NACA) to undertake the fourth Botswana AIDS Impact Survey (BAIS IV), one of whose key objectives has been to provide current estimates of HIV prevalence and incidence amongst the population aged 6 weeks and above.

Health officials believe the survey will provide valuable information on full impact of behaviour change communication strategies on target audiences and facilitate gauging whether there is any empirical evidence to support the view that the myriad of HIV prevention interventions around the country can be regarded as successful.

Prevention

SAFE MALE CIRCUMCISION PROGRAM SUPPORT

Introduction

Safe Male Circumcision program is ACHAP flagship program, with support to the government being implemented in line with national protocols and guidelines. Application of field experiences and lessons learnt have continuously informed decisions made as regards the programmatic interventions being offered to the beneficiary communities. Different demand creation approaches have been tried in an effort to motivate eligible males to go for the service.

From contracting CBOs for demand creation to now contracting independent individual mobilisers who are directly compensated based on the clients who reach the service delivery sites. The beneficiary communities have been orientated and are now fully involved in encouraging their eligible males to for the services, there is increased visible ownership of the SMC program than before. There has been a shift from static to now outreach services provision, an effort to take services to the communities, this has generated better results and also further contributed to community participation and ownership of the program.

During the review period, the Ministry of health reviewed the National SMC targets from 100,000 to 50,000; however ACHAP exceeded its earlier commitment of contributing 26,700 of the national effort.

SMC PROGRAM PERFORMANCE - 2013

The application of the past experiences to SMC programme implementation by ACHAP teams over the years has progressively contributed to improved performance with regard to achieving set targets and reducing costs. The ACHAP performance has steadily been on the rise

since 2011 to the end of the current reporting period. During 2013, ACHAP's cost per SMC dropped to an average of USD 98 from USD 179 in 2011. The table below shows SMC programme costs over the last three years.

Table 1: SMC Cost and Performance Indicators

Budget year	2011 (Actual)	2012 (Actual)	2013 (Actual)
SMC Expenditure	\$2,307,097	\$3,899,324	\$3,494,160
SMCs Performed	12,861	25,505	35,507
Average Cost per SMC	\$179.39	\$152.88	\$ 98.4

During the 2013 reporting period ACHAP supported SMC teams performed 35,507 by December 31st 2013 (see figure 1 below), which represented about 71 % of the Annual national target and 133 % of the ACHAP 2013 target of 26,700 circumcisions. (see figure 2 below)

Figure 1 below shows performance by ACHAP teams since the programme started in January 2009 to 31st December 2013. The graph clearly demonstrates steady improvement in performance over the years, a key indicator of innovation and application of field experiences to programming.

Figure 1 below Month by month Cumulative SMC performance

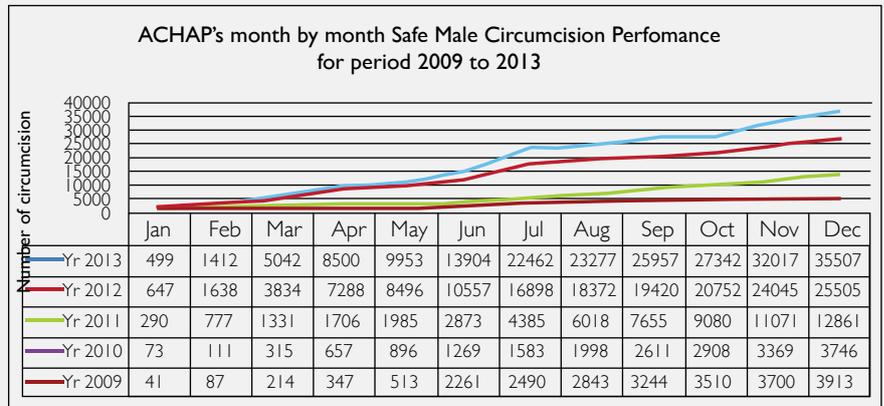
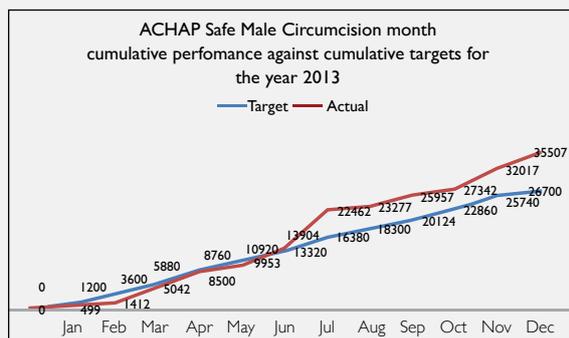


Figure 2 below shows ACHAP performance against monthly targets during 2013.





Prevention CONTINUED

CONTRIBUTING FACTORS TO IMPROVED PERFORMANCE

As presented in figure 2 above, SMC performance shows a sharp spike after the month of June 2013, with the month of July recording 8584 SMCs, the highest number of SMCs ever performed in a single month.

Factors attributed to this excellent performance include:

- Increased capacity at regional and district level to support and coordinate planning and implementation of programme activities.

ACHAP's operational re-structuring process was completed with two Regional Offices fully functional in Palapye and Gaborone headed by Regional Managers, support staff, transport and other logistical support. In addition, each of the ten ACHAP supported districts has a Programme Officer who provides technical and administrative support for SMC planning and implementation at district level. Each district has a service delivery clinical team that provides both static and outreach SMC services in the respective catchment area coordinated by the program officer. The Programme Officer also provides program management support to the team to ensure a flawless process of implementation, working closely with the DHMT and other stakeholders. This arrangement has provided effectiveness in program planning and execution thus contributing immensely to improved programme results at district level.

- Involvement of relevant community and district stakeholders in planning and implementation of activities including school campaigns. The engagement of Dikgosi, Village Development Committees and other village leaders contributed enormously to improved performance due to increased ownership of the SMC program by communities.
- Increased collaboration with and coordination by the Ministry of Health
- Active participation of SMC service delivery teams in community mobilisation for SMC
- Improved working relationships with the, Ministry of Education and Skills Development at district and national level presenting opportunities to reach schools and other institutions of learning
- Involvement of Parent-Teacher Associations in mobilising students for holiday SMC services
- Increased support from parents to have their children circumcised as part of the national effort to prevent HIV

Implementation of targeted SMC outreaches with support of community leaders and community based mobilisers

- Availability of supplies and other logistics to support campaigns and outreach services as well as continued partnership with volunteer mobilisers at village level.

DEMAND CREATION:

The art and science of motivating clients to make the decision to circumcise or take a health promoting action is a process that requires creativity and consistency. During the period under review, ACHAP promoted one of its Programme Officers to take on the role of a Demand Creation Technical Officer-SMC to provide technical support to the Programme Officers and mobilisers during planning and implementation of SMC demand creation activities. This officer works directly under the SMC manager who provided overall technical support.

A rapid gap analysis carried out in 2012 to assess the knowledge and skills levels of community mobilisers on SMC and explore barriers they experience in motivating clients for SMC was used to guide decisions on recruitment, training, deployment and remuneration of community mobilisers. A performance based remuneration strategy for community mobilisers was adopted to ensure consistency between inputs and outputs. IEC support materials including posters, brochures, water bottles, bags, pens and banners were produced in both English and Setswana to complement community based and school campaign efforts.

MAPPING OF CATCHMENT AREAS

A major activity carried out by ACHAP teams during 2013 was the mapping exercise of catchment areas by district to document the number of circumcised men and eligible uncircumcised men per village. ACHAP teams worked with District Health Management Teams (DHMTs) to define catchment areas within supported districts to determine populations of eligible men in order to plan for mobilization and provision of services. Working together with the Monitoring and Evaluation department, the number of eligible men per village for all ACHAP supported districts was documented. This



Prevention CONTINUED

effort enabled ACHAP teams working together with DHMTs and community leaders to strategically plan for client mobilization for SMC services. This approach also enabled the teams to identify champions within these catchment areas to play an advocacy role for the programme. Targeted outreaches were carried out guided by the mapping data.

PERFORMANCE BASED MOBILISATION STRATEGY

Independent mobilisers were engaged in defined catchment areas to intensify interpersonal communications at community and household level through door-to-door visits, group interaction and other community based opportunities. About 250 independent mobilizers were identified, trained and engaged to serve specific catchment areas across the ACHAP supported districts based on the mapping data. Each Independent mobiliser is remunerated based on the number of clients that reported to the service delivery point. The strategy of having independent mobilisers has assisted in identifying and retaining committed and respected individuals in different communities. These were supported by community leaders and SMC teams.

SCHOOL HOLIDAY SMC CAMPAIGNS

School holiday SMC campaigns have continued to provide opportunities to reach young school going eligible boys across the country. With the support of the Ministry of Education, Teachers and Parents, school holiday campaigns have continued to contribute the bulk of all circumcisions performed. During 2013 implementation period, deliberate efforts were made to address the key elements for campaign success- demand for eligible clients, space, supplies, and available service delivery in all supported catchment areas. The support counseling and guiding teachers have been very instrumental in motivating students, also parents' involvement has increased and many have come to facilities to consent for their children.

In an interview with one parent at the Boseja II Clinic, he said, "SMC is a good initiative because young boys and men are given healthy preventive measures to HIV/AIDS, STI's and personal hygiene". This parent, had accompanied his three sons to the clinic, and urged parents to act in a responsible way by being open to their children when it comes to sexual matters and instilling discipline in them. He added that children become curious as they grow, hence indulge in sexual relationships putting themselves at risk of contracting sexual transmitted diseases. He said teaching children about protection should be a priority in parenting.



Parents waiting to consent for their boys in Thamaga

As indicated, support from the Ministry of Education, School management teams and Parent Teacher Associations enabled ACHAPS teams to undertake highly successful school based mobilisation activities and motivate students to seek for circumcission. In some schools, teachers volunteered to register students willing to be circumcised and submit these lists to the service delivery teams and ACHAP supported mobilisers.



Nthwalang JSS students following an SMC mobilization session

OUTREACH AND MOBILE SMC SERVICES

The ACHAP team in collaboration with the Ministry of Health conducted mop-up mobile SMC services in Ghanzi, Bobirwa, Kasane, and Selibe-Phikwe districts using the Mobile Trucks (see photo below) procured by the Ministry of Health to facilitate access to services by rural remote populations and areas with limited space for service provision.

These services targeted mainly out of school men both in towns and rural remote areas. ACHAP teams provided support for client mobilization and provision of clinical services during this SMC teams developed outreach plans and worked with mobilisers and community leaders to motivate eligible men for SMC. This approach contributed significantly to reaching communities that would otherwise not be able to get to the health facilities. Over 60% of circumcisions done were through outreach services.



Prevention CONTINUED



SMC Mobile truck in Tsabong

SUPPLIES AND EQUIPMENT

With the support of the Ministry of Health through the Safe Male Circumcision Logistician, supplies were delivered on time to districts and health facilities. MOH procured some diathermy machines specifically for the mobile trucks and these were used by ACHAP teams during mobile and outreach services. ACHAP procured an additional five machines to complement the existing stock in health facilities and take care of increased outreach services.

HUMAN RESOURCE SUPPORT:

With a staff complement of one doctor, two nurses, two counsellors and a health care Auxiliary at each of the 10 SMC sites supported by ACHAP, 35, 496 circumcisions were performed during the year exceeding the annual target by 8796. However, these teams received supplementary support by locum Doctors, Nurses and Counsellors during school holiday campaigns to deal with the increased numbers of clients for SMC services. This approach to human resource support proved cost effective and contributed significantly to the achievement of the annual target.

The reduction of funding support by CDC to the SMC programme led to the termination of contracts of key personnel supporting the programme at national level. The SMC MOVE Manager, the SMC Logistician and the Monitoring

and Evaluation Officer who were funded by CDC through I-TECH lost their positions. ACHAP stepped in to temporarily fund the MOVE Manager Position while the MOH finds a lasting solution; the position will be supported till end of April 2014. A senior Programme Officer, Monitoring and evaluation was also recruited and seconded to the Ministry of Health to support the HIV/AIDS Department.

• LESSONS LEARNT:

Modern medical practices can successfully be blended with traditional practices with impressive results. The community in Digawana (a village in Lobatse) embraced both modern and traditional aspects of circumcision in a way that satisfies both contexts. The Digawana village chief, the Village Development Committee in collaboration with Junior secondary school staff and health workers organised a cultural day to take circumcised students through a traditional ceremony to recognise them in the community as having gone through the process of "Bogwera" and give them a name to their "Mopato" regiment. These students would have otherwise been circumcised through the traditional way in the bush to be recognised.



This process recognises that circumcision can be done in the modern facility followed by other traditional activities to fulfil the traditional requirements for "Bogwera".

This event was attended by the members of the community, parents and youth to witness the value of going through such a process and to honour their boys passing into a different stage of life.

ACHAP continues to engage communities to strengthen community ownership of programmes as they relate to their traditions and cultural practices.

- Early planning for School holiday SMC campaigns with all relevant stakeholders, yields very good results. This was demonstrated by the good results in the school holiday campaigns, enabling the teams surpass the set targets.
- Provision of locum services during campaigns enables the team to service the enhanced SMC demands during these periods.



Prevention CONTINUED



The women participating in the cultural ceremony in Digawana

CHALLENGES

While performance during the year was exceptionally great, there were a number of challenges that impacted negatively on performance, and these included:

- High attrition rate of community mobilisers leading to frequent recruitment and training of new and inexperienced mobilisers. This impacted on mobilisation efforts in some of the districts especially Boteti, Gaborone, Thamaga, Kanye and Tutume
- Deep rooted negative cultural beliefs about Male Circumcision in some districts like Boteti that took time to demystify and get community leaders and eligible men to support the programme. Key among these is the belief among women that when men are circumcised, their penises become smaller. This affected some young men from seeking the service in fear of having small penises.

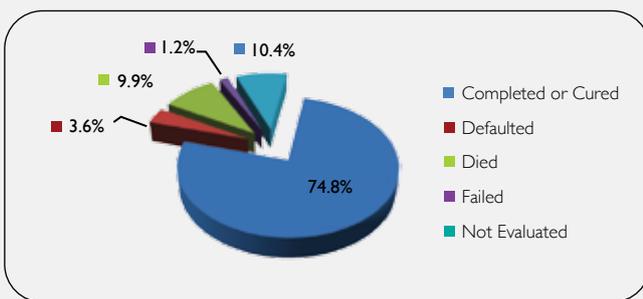
TB and TB/HIV Integration

Botswana is described as one of the high TB and HIV burden countries in sub-Saharan Africa; the high prevalence of HIV in the general population has been recognized as an important factor of the TB epidemic. The integration of TB and HIV services as outlined in the 2011 National TB/HIV Policy guidelines remains a priority result area in the period under review. There has been tremendous and notable progress made in the implementation of TB/HIV collaborative and integrated service activities, with access to and utilization of TB/HIV services being expanded substantially in the entire country with almost 100% DOT coverage. ACHAP support to the program has continued to focus on identified priority areas namely:

1. Coordination, governance and leadership
2. The scale up of TB/HIV collaborative and integrated services – intensive case finding, TB infection control and prevention, community TB/HIV care services, Early initiation of treatment for co-infected patients
3. Monitoring and Evaluation
4. Research and implementation science.

TB ACSM strategy implementation is being used as a platform of improving community participation and ownership hence improve case detection and promoting preventive interventions. The increased involvement of civil society in scaling up more patient centred community models of care is likely to further optimize treatment outcomes.

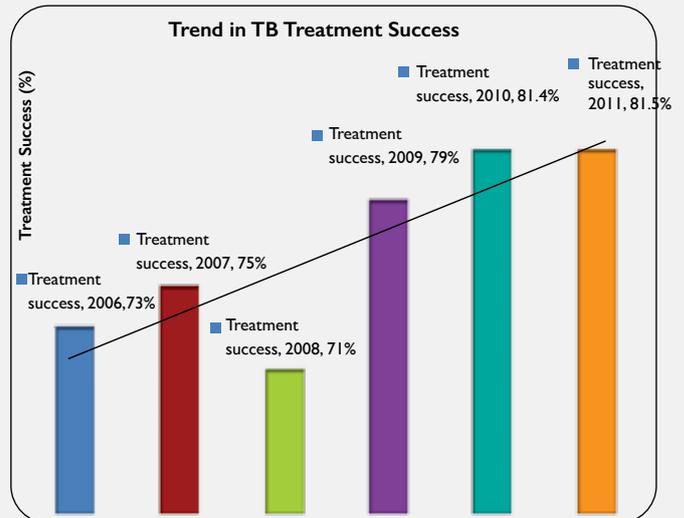
Progress in TB and TB/HIV collaborative activities
Figure 1: Showing Botswana TB treatment outcomes



(Source: BNTP annual report 2012)

The national treatment success rate (% of patients who completed treatment plus those completed with a negative bacteriology evidence) has slightly gone down from 81.5% to 74.8% against the 85% national target which has been greatly affected by the low (35.6%) cure rate. (BNTP annual report - 2012).

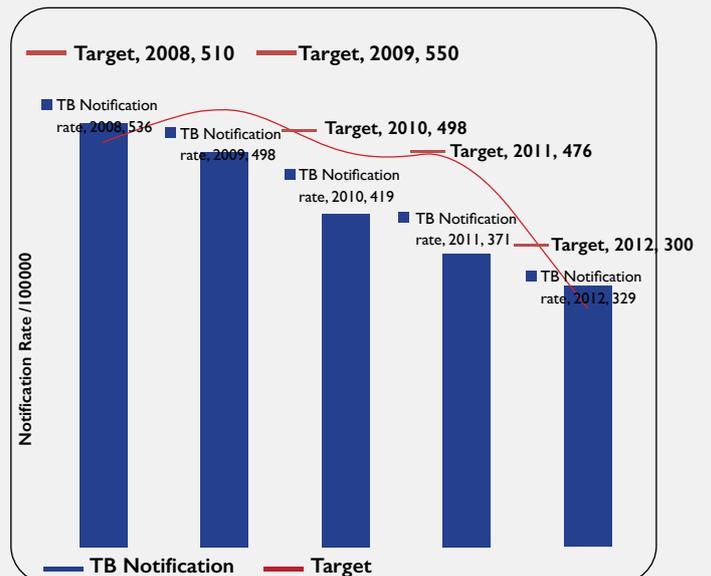
Figure 2: Showing the trend of the national TB treatment success rates



(Source: BNTP 2012 report)

The national TB incidence was estimated at 455 per 100 000 population in 2011, compared to 503 per 100,000 reported by WHO in 2010. This represents a 9.5% point decline. In 2012, 6,829 (331/100 000 population) new and retreatment cases were notified, compared to 7,706 (371/100 000 population) reported in 2011. This translates to 11% point decline in notification rate. The TB case detection rate remained unchanged, at 71% in 2011, compared to 70% the previous year.

Figure 3: Trends in Botswana TB case notification rates per 100 000 2008 -2012



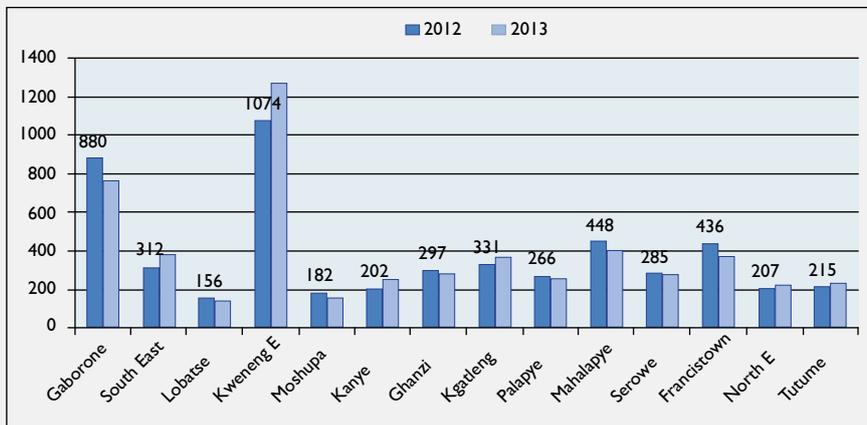
(Source: BNTP Annual report 2012)



TB and TB/HIV Integration CONTINUED

The observed reduction in TB notification rate trends and estimated incidences over the years is likely attributed to the universal access to ART services and aggressive TB interventions. As of November 2013, more than 98% of those patients in need of antiretroviral treatment were put on treatment. (MASA November Report 2013).

Figure 4: Showing TB Case registration in ACHAP supported districts 2012 & 2013



(Source: ACHAP TB/HIV database)

Out of 5291 TB cases registered in ACHAP supported districts in 2012, 4400 (83%) were new TB cases compared to 2013, where 5557 were registered in total and 4533 (82%) were new TB cases.

It should be noted that HIV testing amongst TB patients in supported districts has progressively increased and currently at 99% with insignificant increase in co-infection rate from 55% to 55.9% in 2013. The proportion of co-infected TB/HIV patients started on co-trimoxazole prophylaxis (CPT) has continued to inch towards universal access, as high 97% respectively in 2013. The notable decline in the national co-infection rate from the high of 64% in 2011 to 63% in 2012 demonstrates progress in the implementation of the TB/HIV collaborative and integrated service activities.

1. TB/HIV COORDINATION, GOVERNANCE AND LEADERSHIP

The active roles played by the National TB-HIV Advisory Committee, the national Technical working group and district TB/HIV committees during the reporting year, have contributed immensely with regard to reducing the burden of TB among people living with HIV and TB. The TB/HIV Technical Working Group (TWG) had up-scaled Gene X-pert® to 22 districts in the country to improve access to TB and drug resistant TB diagnostic equipment for improved TB treatment outcomes. The National TB /HIV committees revised the terms of reference for the district TB/HIV committees, evaluated the Intensified Case Finding screening and reporting tools, proposed critical indicators to track performance and reporting mechanism, conducted rapid assessment on Isoniazid Preventive Therapy (IPT) which was piloted in Kanye and Palapye from 2011 to 2012.



Picture 1: Kweneng East TB/HIV committee members in a scheduled quarterly meeting

All ACHAP supported districts have established functional TB/HIV coordinating structures at the district level. These have been supported to hold regular quarterly review meetings. While most are new, some have leveraged on existing establishments such as District Multi-Sectoral AIDS Committees (DMSACs). The committee spearhead the implementation of TB/HIV activities in the districts.

2. SCALING-UP TB/HIV COLLABORATIVE AND INTEGRATED SERVICES

There has been tremendous and notable progress made in the implementation of TB/HIV collaborative activities with the access to and utilization of TB-HIV services has being expanded substantially to all ACHAP supported health facilities. Periodically there is an effort to monitor and evaluate the implementation of these activities.



TB and TB/HIV Integration CONTINUED

Figure 5: TB/HIV indicator performance in ACHAP supported districts

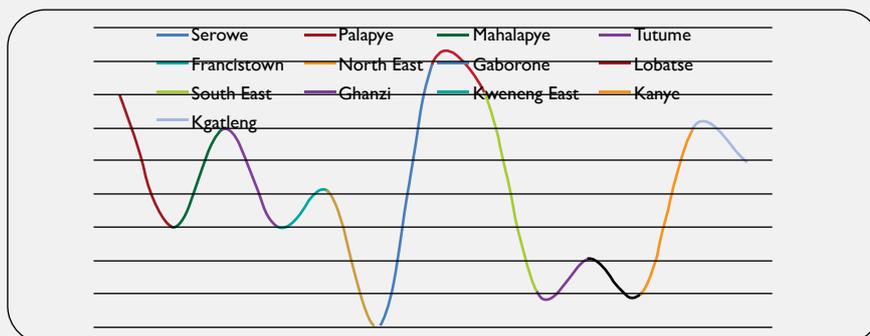
Indicators	ACHAP supported districts				National Coverage	
	2012		2013		2012	
	Target	Actual	Target	Actual	Target	Actual
Proportion of new TB patients	-	83.1%	-	81.5%	-	84.7%??
Proportion of TB patients tested for HIV	80%	98.4%	85%	99.0%	85%	86.9%
Co-infection rate	-	55%	-	56.5%	-	63%
Proportion of co-infected patients initiated on CPT	80%	95.4%	85%	96.9%	85%	90%
Proportion of TB patients enrolled on CTBC	50%	49.8%	60%	45.8%	75%	59%
% of new MDR/XDR TB cases	<2%	1.6%	<1%	0.8%	<2%	2.2%

A consistently high performance has been achieved in the area of HIV counselling and testing and Cotrimoxazole preventive therapy (CPT) which currently is at 99% and 97% respectively, with 56% co-infection rate in ACHAP supported districts compared to 63% for the national (2012). Consistent facility mentoring and supervision can be attributed the gains realized in the two years successively.

2.1 ACTIVE TB CASE FINDING AMONG HEALTH CARE WORKERS

The risk of transmission of Mycobacterium tuberculosis from patients to health-care workers (HCWs) seems as a neglected issue by most health care workers. Risk assessments conducted in supported districts have revealed that most health-care facilities are not infection control compliant; however there were efforts to strengthen workplace wellness to include among other things, periodic screening of health care workers in the health facilities. Out of the 236 health facilities visited, 53 health care workers were found to be having TB i.e. 49 susceptible TB, 3 Multiple-Drug Resistant (MDR-TB) and one (1) with Extensively drug resistant TB (XDR-TB) and all were started on treatment. Health care workers in supported districts are always encouraged to go for screening every 6 –months as per policy guidelines.

Figure 6: TB Screening among health care workers (Jan – Dec 2013) in supported districts



(Source: District Workplace wellness and individual facility screening reports)

2.2 INTENSIFIED TB CASE FINDING IN INFECTIOUS DISEASE CARE CLINIC (IDCC)

TB screening is an important “Stop TB” strategy geared towards improving the lives of PLWHA and reduces mortality. Interventions to detect TB promptly and to prevent TB among people living with HIV are gradually implemented in the IDCCs and started to gain momentum. A gap in accelerating Intensified Case finding has been bridged by the development and dissemination of the TB screening and reporting tool to all the districts. The expectation is that all People Living with HIV/AIDS periodically be screened for TB in order to initiate treatment early and contribute towards the reduction of TB mortality. While HIV fuels progression to active disease in people who are already infected with TB; TB is a major cause of morbidity and mortality among People Living with HIV (PLHIV).



TB and TB/HIV Integration CONTINUED

Figure 7: Showing TB Screening coverage among PLWHA in IDCCs 2013

Variables	Q1	Q2	Q3	Q4	Total	%
# of patients seen at IDCC	5469	13548	15669	16358	51044	-
# screened for TB	5469	12688	15074	13927	47158	92.3
# of TB suspects identified	22	299	287	192	800	1.6
# diagnosed with TB	2	54	65	136	257	32.1
# started on TB treatment	2	54	65	135	256	99.6

A total of 242 (92%) out of 263 targeted IDCC personnel and Lay counsellors have been oriented to screen patients for TB in the IDCCs. Currently out of a total of 800 (1.6%) TB suspects identified, 257 (32.1%) PLWHA in IDCCs have been diagnosed with TB, 256 (99.6%) started on TB treatment and 1 (0.4%) died before starting on treatment. ACHAP supported districts are some steps ahead with regard to TB screening in IDCCs using the newly disseminated intensified Case Finding (ICF) tool.

2.3. TB INFECTION CONTROL

ACHAP has continued to support the TB infection control officers seconded to the MOH. Much progress has been made to improve infection control practices through a series of regular risk assessments conducted during mentoring and support supervision visits to determine TB infection control best practices implemented at the facility level. Though all the 236 health facilities visited implement TB infection control; regular monitoring and coaching is essential to ensure quality services, ownership and sustainability.



Picture 2: North East district infection control team conducting risk assessment

All the ACHAP supported districts have TB infection control teams comprised of TB Focal persons, TB Coordinators, nurses, doctors, auxiliary staff etc. who are trained on principles of Infection control, coached on content specific health facility assessments and in crafting of Infection control site-specific plans for immediate implementation. Post-training mentorship from national level were encouraged the districts to independently conduct facility visits. Much improvement has been observed in all the visited health

facilities and districts where simple TB infection control measures are implemented though at different levels. These include opening of windows/doors, triaging patients, erecting coughing spots, utilization of outside waiting areas to reduce congestion within the facility to improve ventilation.

Picture 3 & 4: Outdoor waiting area and cough spot in one of the clinics in Francistown



2.3.1. RENOVATION OF IDCCs

A total of twenty four (24) targeted IDCCs have been installed with extractor and directional (propeller) fans to improve ventilation in the fourteen (14) ACHAP supported sites. Health care workers have been orientated on the advantages of using ventilators and their operation to ensure that they are effectively used to reach the intended purpose. The seating arrangements in consulting rooms have been assessed and rearranged to ensure free flow of air and reduce TB transmission in the health facilities. Simple measures such as opening doors and windows have been emphasized to improve the exchange of fresh and polluted air. There is still more that needs to be done including monitoring of health facilities in the implementation of TB infection control measures.

The directional fans were strategically located to ensure that air flows from the health care worker, to the patients and away through the window since the direction of air movement is very critical. The room with an open window and a fan will have a lower risk of TB-transmission.



TB and TB/HIV Integration CONTINUED

Picture 5: Clinicians checking whether the propeller (L) and extractor fans (R) are functional



Central ventilator system (extractor) at Broadhurst Traditional Area IDCC - Gaborone



3. TB ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION (ACSM) FOR TB CONTROL

The new 2013-2017 national TB Advocacy Communication and Social Mobilization Strategy and training curriculum for implementers was finalized in the year under review. The strategy was officially launched during the World TB day commemoration by His Excellency the Vice-President PH Kedikilwe. TB ACSM strategy focuses on informing, educating and engaging communities on TB issues with the aim of enlisting positive community responses towards TB prevention and control.

Figure 6: TB ACSM Training sessions for health care workers – August 2013



Following the development of the national TB ACSM strategy (2013-2017), ACHAP supported the development of the TB/HIV ACSM training curriculum for Training of Trainers. A total of 54/58 (93%) targeted TB Coordinators, Health Education Officers and Civil Society Organizations involved in TB/HIV activities have been trained on TB ACSM strategy in August 2013 for all ACHAP supported districts. The aim is to provide them with knowledge and skills to implement TB ACSM strategy interventions in their respective districts. The training has also strengthened the partnership amongst other health care providers (non-clinicians) and stakeholders as they formed teams in the districts and work together during the implementation of the identified activities. The districts have also been assisted to develop district implementation plans in line with the TB ACSM strategy and National TB control programme strategic plan.

The KAP study key findings and TB ACSM strategy (2013-2017) were disseminated to DHMT personnel, programme managers, service providers, TB focal persons and community leaders during the last quarter of 2013. The TB ACSM strategy once implemented is expected to help in improving TB case detection and treatment adherence by combating stigma and discrimination via increase understanding of TB, empowering individuals and communities. It will also assist to mobilize political commitment and resources for TB control, hence go a long way in sustaining the implementation of TB control activities in the districts and nationally.

The community leaders, traditional healers, faith healers and general community have been orientated on TB-ACSM strategy and community TB Care services in supported districts such as Ghanzi, Thamaga, Ramotswa, Lentsweletau and Serowe to strengthen good working relationship in the management of patients with the aim of improving TB treatment outcomes.



TB and TB/HIV Integration CONTINUED



Picture: Morama community during TB/HIV and TB ACSM campaign in Ghanzi district

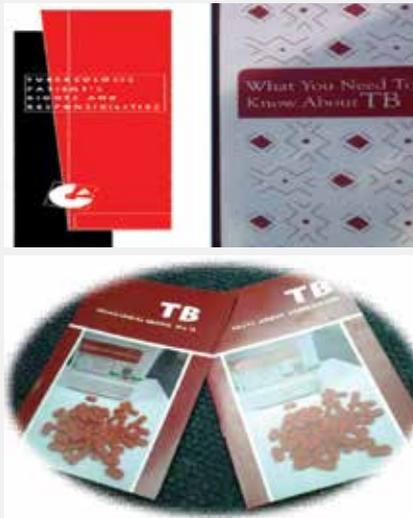
House to house and community campaigns have been conducted mainly to educate community on issues of household TB infection control. Ghanzi and Gaborone districts took a step further to engage TB and MDR-TB patients to participate as champions for the control of TB in some of their campaigns.

4. EMPOWERING COMMUNITIES THROUGH THE USE OF TB AND TB/HIV INFORMATION, EDUCATION AND COMMUNICATION (IEC) AND PROMOTIONAL MATERIAL

Communication prepares people for change, provides information on key areas and helps in decision-making. ACHAP supported the development and printing of content specific TB and TB/HIV Information Education and Communication and promotional material which was disseminated to all the supported districts for TB control activities. These materials were used during the World TB day, community campaigns and health education or talk sessions to individuals, families and community at large.

TB / HIV IEC & Promotional Materials

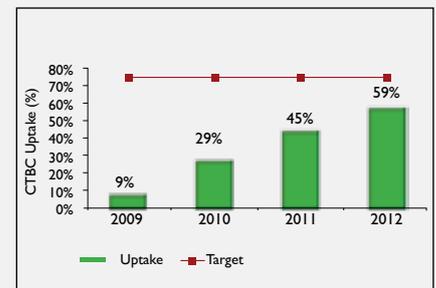
Caps, cooler bags, stationery sets, stickers, licence disck, carry bags



5. COMMUNITY TB CARE (CTBC) SERVICES

Community-based TB services include a range of activities contributing to TB casenotification, treatment adherence and improved TB outcomes through the execution of health promotion activities and demand creation for TB prevention and control in the community. TB patients are empowered to make informed choices of where they wish to be receiving their medication during their TB treatment until the end of the stipulated treatment duration. The observed gains in scale-up are largely attributed to contributions from Civil Society Organizations such as Botswana Retired Nurses Society (BORNUS) in 2011/2012 and BOCAIP in 2012/2013, through financial and technical support provided by ACHAP. Despite notable increase in CTBC uptake over the previous years, coverage remains way below the national target of 75%.

Figure 8: Trends in the national Community TB care uptake, 2009-2012



(Source: 11th Team TB/HIV district presentations May 2013)

BOCAIP has greatly contributed to the national TB Programme's goal of reducing the burden of TB in the community by making TB services accessible to individuals, families and communities. The primary aim of BOCAIP community TB care initiative was to influence community involvement and ownership in the fight against TB and HIV. Thirteen (13) Community TB Care Supporters were strategically placed in nine (9) wards in Francistown to ensure a balanced coverage with regard to patient support and workload.

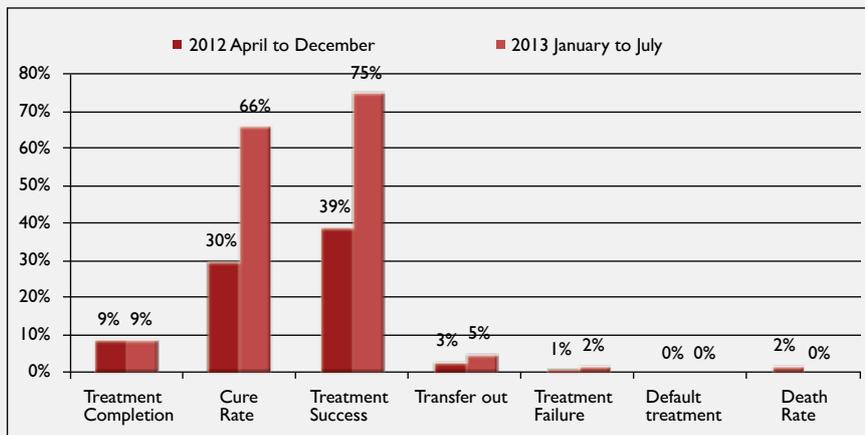


TB and TB/HIV Integration CONTINUED

5.1. BOCAIP COMMUNITY TB CARE PROGRAM

- BOCAIP was supported by ACHAP to implement community TB Care services in Francistown. Francistown district enrolled 290 (66.5%) TB patients into CTBC in 2012 out of 436 patients registered, this number increased to 200 (53.9%) in 2013 out of 371 patients registered against the consecutive annual national target of 75%.
- It should be remembered that there is a portion of TB patients in the facility who opted for facility DOT and those who were not eligible for CTBC due to social and medical reasons; habitual treatment interrupters or defaulters, TB patients receiving injectable TB treatment, those just started on TB treatment (below 8 weeks on treatment), treatment failures and children under 12 years of age.

Figure 9: BOCAIP Community TB care Treatment outcomes



Death rate is high at 4 (3.7%), in relation to the number of patients enrolled during the period under review and national target of <5%. A high proportion of patients got transferred out 7(6.4%) without being evaluated (an area, which needs to be improved). It is also worth noting that treatment failure remained at 1.8% for the entire reporting period with zero treatment defaulters. The effectiveness of every community TB care programme mainly depends on how the community articulates the information given during empowerment sessions. A total of 4103 people, 228 families and 174 community leaders were reached through door-to-door visits, community health talk sessions and TB/HIV campaign including in schools and work places.

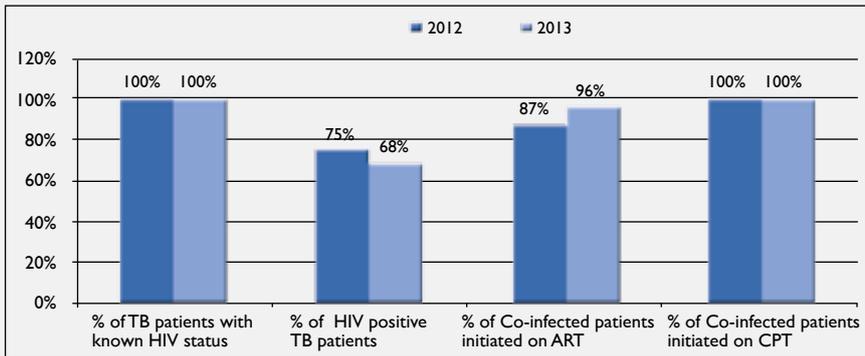
5.3. BOCAIP COMMUNITY TB CARE AND TB/HIV COLLABORATION

Notable strides in BOCAIP CTBC cannot go unnoticed, where HIV testing among TB patients has been registered at the highs of 100% (90% target) for consecutive years (2012 and 2013) with reduction in co-infection rate from 75% (2012) to 68% (2013); ART initiation among patients co-infected increased from 87% to 96% (85% target) and CPT initiation among co-infected TB/HIV patients stood at 100% (90% target) for the two consecutive years. All current BOCAIP TB/HIV collaboration coverages had exceeded the national targets for all the basic indicators.



TB and TB/HIV Integration CONTINUED

Figure 10: Showing BOCAIP performance of basic TB/HIV indicators



Community volunteers are better placed to help identify people with symptoms of TB and link them to services, based on this understanding they were engaged in actively searching for TB cases in the community through the use of the symptom-screening tool, with suspects being referred to the facility for further TB investigation, diagnosed and initiation of treatment. During the year under review TB Case finding was conducted periodically, 246 people were screened for TB, 35 (14.2%) TB suspects were identified out of all the screened cases, 5 (14.2%) cases were diagnosed with active and were all put on treatment.

6. TB/HIV MENTORING AND SUPPORT SUPERVISION (MSS)

ACHAP continued to mentor health care providers in all the supported districts on clinical care of TB patients, implementation of TB infection control and TB data management throughout the period under review.

Figure 11: Districts visited during MSS per quarter in 2013

Districts	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Francistown				
Gaborone				
Ghanzi				
Kanye				
Kgatleng				
Kweneng East				
Lobatse				
Mahalapye				
Moshupa				
Serowe				
North East				
Tutume				
Palapye				
South East				
% districts visited	7/14 (50%)	13/14 (92.8%)	13/14 (92.8%)	9/14 (64.2%)

A total of 42 (75%) visits out of 56 targeted were conducted to the 14 supported districts. A total of 281(100.3%) out of 280 health facilities targeted were visited where on site practical coaching and end of visit feedback provided to district managers and service providers. This also provided an opportunity to do chart reviews and reflect on the quality of record keeping. Engaging district managers and district TB infection control teams during district mentoring and support visits, facility risk assessments and feedback meetings proved a promising best practice, in ensuring district ownership in institutionalizing implementation of TB and TB/HIV interventions.

Research and implementation of science

Evaluation of the Community Tuberculosis Care (CTBC) services is a collaborative effort with the Botswana National TB program (BNTP). The aim of this evaluation is to determine the extent to which the different approaches to CTBC in Botswana have contributed to the attainment of TB control outcomes and to recommend an appropriate CTBC approach to be scaled up.

Specifically the objectives of this evaluation are:

1. To determine the programmatic efficiency of each of the CTBC approaches employed in Botswana
2. To measure the effectiveness of CTBC approaches implemented in Botswana
3. To establish the acceptability of each of the various CTBC approaches implemented in Botswana
4. To establish the sustainability of each CTBC approach
5. Document lessons learnt best and promising practices from the implementation of CTBC since 2010.



TB and TB/HIV Integration CONTINUED

During the year under review, the evaluation protocol was developed and received ethical approval from the HRDC. Field work for the study was conducted over a period of 21 days starting on the 11th November 2013. Data management and Analysis are still ongoing and the preliminary results are expected end April 2014.

Lessons learnt, best and promising practices from the districts

- Sensitization of traditional and faith healers on basic TB information including patient referral system ensure timely referral by traditional healers hence improve TB treatment outcomes.
- Livelihood empowerment through income generation initiatives for people affected by TB and/or HIV are a potentially sustainable intervention, likely to positively impact the socio-economic status of intended beneficiaries.
- The sustained scale up of community models of care through increased engagement of civil society empower TB patients and affected communities to meaningfully participate and contribute to TB prevention and control.
- Engaging district level managers in championing the cause of TB Infection control is critical to ensuring district ownership and for institutionalization of best practices.

Best and promising practices in the districts





Treatment Program Support

INTRODUCTION:

ACHAP has been part of the MASA support since its inception in 2002, since then the ART sites have been rolled out in a phased manner and by November 2013, 34 ART sites and 524 satellite clinics across the country were dispensing ARVs. By end of November 2013, 197,109 patients were on treatment in the public sector, of which 63% were females. Children aged under 13 years accounted for 4% (7,953) of the public sector patients. A further 14,901 patients were treated by the private sector under the Government's Out-sourcing Program. Another 16,185 patients were being treated in the private sector of the country by the Medical Aid Schemes and Work-place Programs. This gives a total of 228,195 patients currently receiving HAART in Botswana. There were 1,644 new clients started on HAART in the public sector this month of which 79.8% were initiated in clinics. A cumulative total of 23,103 patients died while on HAART since the inception of the ARV program in 2002.

I. Merck ARV Medicine donation

ACHAP has continued to be the channel for Merck ARV donation to the government of Botswana. The agreed medicine transition has been on schedule with Merck providing 75% Atripla national needs and 100% Raltegravir including buffer stocks for Effervirenze in 2013. This will be scaled down further to 40% Atripla by 2014.

TREATMENT OPTIMIZATION PILOT PROJECT

The Treatment Optimization Pilot project (TOP) is an initiative of the African Comprehensive HIV/AIDS Partnerships (ACHAP), and the Ministry of Health (MoH) of Botswana aimed at catalyzing optimal access to ARV treatment services in Tutume district. Tutume was chosen because of the high HIV/AIDS burden in the area with a prevalence of about 21%.

Project Goal:

Is to contribute to the reduction of HIV transmission and AIDS related deaths in Botswana through catalytic support to enhance treatment access for eligible patients currently not receiving it; using point-of-care CD4 testing, and enhancing access to community based HIV testing.

Project objectives:

- i. To provide catalytic support for the expansion of HIV counselling and testing services and strengthen linkages with post test services.
- ii. To facilitate creation of demand and expansion of access to quality HIV/AIDS treatment services and through catalytic support, for reduction of treatment initiation delays by the use of point-of-care CD4 count testing services in 4 facilities.
- iii. To demonstrate the added value of point of care CD4 testing; tracking length of time to initiation of treatment, proportion of patients initiated on treatment; cost of provision of this diagnostic approach.
- iv. To build on existing treatment investments and achievements
- v. To generate and share innovations on the programme with national and international audiences.

PILOT PROJECT IMPLEMENTATION:

Project start-up activities

The project started in earnest in August 2013, with the deployment of a dedicated project team. This was followed by a series of community sensitization meetings, targeting the Village Chiefs (Di Kgosi), Village Development Committee (VDC) Chairpersons, Home-based Care (HBC) Chairpersons, Health Education Assistants (HEAs), youth representatives and Spiritual Leaders. Eight meetings, attended by over 150 community leaders were conducted to sensitize them about the project and solicit their support during project implementation.

They were very enthusiastic about the project and have helped the team to convene Kgotla meetings where community dialogues on HIV/AIDS, HIV testing and ART are done, including provision of HCT and point-of-care CD4 testing. They have also provided support in the identification of community mobilizers for the project. Currently, project data is being keyed in, after which preliminary analysis will be done to establish the impact of the point-of-care CD4 instruments.

Current Status of the Project

The Project has a staff complement of 15 staff including the Project Coordinator, Project Officer, 10 Lay Counsellors, 2 Data Clerks and 1 Cleaner. The Project Office is housed within the Tutume District Health Management Team (DHMT) Office, further enhancing the ownership by the district. The office is fully furnished with chairs and desks, laptop computers for the staff as well as a multi-purpose colour printer and access to internet through internet modems. Each Clinic site develops a monthly work plan, detailing the activities to be implemented in their community. This is forwarded to the Project Coordinator, who consolidates and harmonizes it and the project core team is then able to monitor and support the planned activities by site.



Treatment Program Support CONTINUED

Demand Creation

At the core of project implementation is enhanced mobilization of communities for HIV counseling and testing leading to early detection and treatment of eligible patients through point-of-care testing and diagnosis.

The following core activities have characterized the shape of the project:

- Door-to-door home-based HIV counseling and testing
- Work-place based HIV counselling and testing and CD4 testing targeting mines, brick-laying factories, schools and brigades, water utilities staff, land boards, Police barracks etc
- Community-based HCT Outreaches at Mobile Stops, health posts, cattle posts within the district
- Point-of-care CD4 testing and linkage to care through referral for ART initiation and management of opportunistic infections
- Referral for Safe male circumcision services and cervical cancer screening
- TB Screening for those who are HIV positive
- Demand creation for HCT and CD4 testing through health talks, Road shows featuring prominent artists, conducting community dialogues at Kgotla meetings, as well as use of IEC materials (T-shirts and Sun-Hats), and Jam sessions.
- Moonlight HIV testing in villages and at road shows /jam sessions



Lay Counselor providing CD4 testing services at Malelejwe Cattle Post, Dukwi

A total of 31 Community mobilizers were deployed to work closely with 10 Lay Counsellors in scaling up community mobilization for HCT and point-of-care CD4 testing.

Service Delivery

Ten (10) PIMA CD4 Machines, procured by ACHAP from ALERE Company in South Africa were deployed in 2 phases. The first phase covered Maitengwe, Mokgoro and Matsitama Clinics, while the second phase covered Nata, Sebina and Nkange clinics scattered across Tutume District.



Lay Counselor prepares for an outreach at Lepache Settlement

The PIMA CD4 Machines were validated against the FACS Calibur CD4 machine at Tutume Primary Hospital, as the instrument of reference. Findings from the laboratory validation showed that there were no statistically significant differences in the CD4+ T cell counts obtained using the PIMA instrument using capillary blood and those observed using FACS Calibur and venous blood. However, the difference tended to be significant at CD4+ T cell counts greater than 350 cell / μ l (-21.2 (95% CI -45.3, +2.9)) whereby the PIMA machines gave slightly lower values than the FACS Calibur machine.



Treatment Program Support CONTINUED

Monitoring and Evaluation of Project activities

The project has a robust M&E system of recording and reporting that entails the use of the National HCT Register, as well as Point-of-Care CD4 registers and ART initiation form specially designed for this purpose by the ACHAP M&E department. A tool for collecting data on community outreach activities, specifically door-to-door testing, road shows and mobile outreaches has also been developed and is being used.

These tools are filled manually by the Lay Counsellors. The data is then entered into a CsPro® database by a team of 2 data clerks. The data is backed up on a daily basis on a central server at the ACHAP head office through Teamviewer®. Lay Counsellors report to the Project Coordinator on a weekly basis. Reports are consolidated and weekly updates generated and sent to the ACHAP Executive Officer Programs and the Technical Working Group at Ministry of Health by the Project Coordinator.

A Technical Working Group meeting is held monthly at the Ministry of health to review project performance and progress. This meeting is attended by ACHAP, BHP and MoH technical staff. Similarly, a weekly program review meeting is organized by the ACHAP head office, which the Project Coordinator participates via teleconference. Quarterly project review meetings involving the DHMT and site managers are conducted to assess project progress and chart a way forward.

Monthly mentoring visits are conducted by a team of Laboratory Master Trainers from Botswana Harvard Partnership.

Summary Project Outputs as at 31st December 2013

CLINIC	HCT done	Number HIV Positive	POC CD4 Tests done
Maitengwe	828	77	483
Matsitama	920	54	263
Mokgoro	635	38	288
Sebina	1496	159	481
Nkange	1141	80	330
Nata	988	66	638
Totals	6008	474	2483



Picture 3: Kgosi Ndzonga of Nkange Village gives remarks at a Road show

Key Achievements of the Treatment Optimization Pilot

- Increased evidence of community ownership and involvement in the project
- Reduction in stigma and increased acceptability to HIV testing and CD4 testing
- Increased access to HCT services (over 60% are new testers) and CD4 testing, with evidence of reduction in delays to ART initiation.
- Increased number of people who are enrolling on ART treatment.
- Increased knowledge among community members about HIV/AIDS and health-related issues
- Increased community awareness about HIV/AIDS related issues
- It has provided opportunities for scaling up safe male circumcision (SMC). Those who test negative (and those positive but eligible by CD4) are referred for SMC. Females are being referred for cervical cancer screening.
- There is TB screening for every individual who tests HIV positive and linkage to care and treat. Hence broader health benefits for the individual and the community.



Treatment Program Support CONTINUED



Counselor conducts Moonlight testing at Sebina



Demand Creation for HCT at a Road show in Sebina

Opportunities:

The project presents an opportunity for integrating HIV with other non-communicable diseases, in an effort to reduce morbidity and mortality with further improvement of the quality of life. The patients have been requesting for assessments on hypertension and diabetes for instance to mention a few.

Challenges encountered

- Inadequate supplies of HIV test kits and lancets as well as related consumable supplies. These are procured through the Central Medical Stores by the Laboratory Manager at Tutume Primary Hospital. The increased demand for HIV testing has significantly increased the need for test kits.
- Inadequate of transport at clinics to conduct regular outreaches.
- Vast geographical distances between households complicates door-to-door testing
- Staff Retention: Lay Counsellors that are already trained in the use of PIMA CD4 machines have become very marketable to the partners in the same core business.
- Short battery life of 4-5 hours for some of the PIMA machines against the manufacturer guarantee of 8 hours.



Treatment Optimization Pilot Project

The department supported the development of the monitoring and evaluation system for this project including: definition of indicators and targets, development of data collection tools, and development of a data management system.

Monitoring and Evaluation Support to the Ministry of Health of Botswana

During the course of the year, the department continued providing technical support to the MOH and NACA through its active participation in the following monitoring and evaluation related Technical Working Groups (TWG):

Technical Working Group	Description
SMC Monitoring and Evaluation (MOH)	This is a group composed of partners that are involved in SMC. Its mandate is to provide technical advice in matters relating to monitoring and evaluation of SMC programme.
Monitoring and Evaluation (MOH)	This is a broader TWG housed under the Department of policy, planning, monitoring and evaluation of the MOH, chaired by the chief health officer M&E. Its mandate is to provide technical support to all M&E issues for the MOH.
NACA	This is a group established to provide technical support to NACA in the development of strategic plans and NOPs, the setting of national targets for HIV interventions, the development of district plans. It has several subdivisions (e.g. research).
National surveillance (MOH)	This group was established to provide technical support to the MOH regarding national surveillance. It is chaired by MOH DHAPC
PrePex	This is a short term group established to guide and oversee the studies related with the piloting and scaling of the PrePex device for male circumcision.

COMMUNICATION AND ADVOCACY

Technical Working Group	Description
I. Botswana HIV/AIDS toolkit	<p>This work group is hosted by NACA. It is an online repository of HIV and AIDS information resources that informs and empowers policy makers, program managers and health service providers with evidence-based information. The TWG is responsible for the following:</p> <ul style="list-style-type: none"> • Providing technical leadership in conceptualizing and developing the eToolkit • Establishing criteria for inclusion of resources • Ensuring that tasks are completed in a timely manner • Reviewing the eToolkit in preparation for its launch • Working with K4Health on promoting the eToolkit • Soliciting feedback from in-country stakeholders • Overseeing content updates



Treatment Optimization Pilot Project

CONTINUED

PROGRAMMES

Technical Working Group	Description
1. SMC Governance Board	This board brings together all the key SMC partners, provides strategic guidance to the implementation of the program. It meets fortnightly.
2. TB/ HIV	It provides technical guidance and support in the implementation of TB/HIV collaborative and integration services. It meets quarterly
3. Gene-Xpert scale up	It provides technical and program support in the roll-out of the Gene- Xpert instruments nationally.
4. ARV Costing and Forecasting	It support the forecasting for the national ARV needs and costs for the medicines, regularly takes inventory of the ARV medicines stock levels at the Central medical stores. It meets monthly.
Global fund	A group of partners involved in the implementation of the global fund priority programmes of HIV, TB and malaria. This is the group involved in providing technical guidance in writing proposals and technical assistance to the implementation of supported programs.
1. The National HIV Prevention	It is hosted by NACA to provide guidance and technical support for the design, implementation and monitoring of HIV Prevention interventions in the country. The TWG meets quarterly or as need arises
2. The National SMC Implementers	It is hosted by the Ministry of Health. The group receives reviews and provides technical input into the implementation approaches for the SMC programme. The group makes recommendations to the SMC MOVE Board for approval of strategic implementation approaches.

OPERATIONS

Technical Working Group	Description
1. The Investment Case Technical Working Group for Botswana.	To understand the HIV epidemic in Botswana, the current resources and utilization, and how the national program can work differently to achieve more with fewer resources.

CEO

Technical Working Group	Description
1. Country Coordinating Mechanism (CCM) Botswana for the Global Fund for HIV/AIDS, TB and Malaria	Multisectoral leadership forum made up of public and private sector representatives including persons living with and affected by the three disease conditions that takes decisions on areas of priority for Global Fund applications, selection of Principal and Sub-Recipients for grant implementation, oversight of grants, and consensus building and harmonization of grants with existing national programs.



Treatment Optimization Pilot Project CONTINUED

CEO continued

2. Botswana Health Partners Forum	Multisectoral leadership forum made up of public and private sector representatives co-chaired and led by the Ministry of Health that takes decisions on areas of priority for Botswana's health system including consensus building and harmonization of various health initiatives for greater efficiency.
3. NACA Joint Oversight Committee	The purpose of the Joint Oversight Committee is to oversee development, implementation and review of the National Operational Plan for HIV/AIDS, including the integrated Monitoring and Evaluation Plan and budget.
4. Madikwe Forum	Multisectoral leadership forum made up of Government of Botswana public sector representatives led by their Permanent Secretaries and Co-chaired by the Permanent Secretary of the Ministry of Finance and the ACHAP Board Chairperson, with the remaining membership being ACHAP Board and Management that meets periodically to review progress being made on the Public-Private Partnership between ACHAP and the GOB, setting policy tone and direction and assisting with resolving implementation bottlenecks and assuring government support and ownership for programs.
5. HIV/AIDS Partnership Forum	Multisectoral leadership forum of HIV/AIDS stakeholders made up of public and private sector representatives including persons living with and affected by HIV/AIDS that provides leadership on governance and policy directions, strategy and technical issues, and harmonization of program implementation activities by various actors with priorities of the national HIV/AIDS response.
6. NACA Technical Planning Group-I	The Technical Planning Group is established to develop a NOP for the strategic priority area to which it is assigned, as well as accompanying integrated M&E plans and budgets. It will continue its work through the implementation, monitoring and review of the specific plans in order to assist with continuous refinement and accountability.
7. SMC Governance Forum	Forum of Safe Male Circumcision implementers in Botswana led by the Director of the Department of HIV/AIDS in the Ministry of Health that meets twice a month to review high-level issues related to SMC implementation, resolve implementation bottlenecks, and set policy direction for harmonized program implementation.
8. TB/HIV-AIDS Advisory Committee	To provide policy guidance to the national TB/HIV response in Botswana; in line with the national TB/HIV policy guiding principles. To advocate and mobilize for adequate resources for TB/HIV program implementation. To provide oversight to the TB/HIV Technical Working Group. Membership of the national TB/HIV Advisory Committee will constitute representation at Directorship level from Government Departments, Technical Agencies, Civil Society Organizations, Private Sector and Academic institutions.



Treatment Optimization Pilot Project CONTINUED

In addition to the participation of its core professional staff in technical working groups, the department has also seconded one staff member to support monitoring and evaluation activities in the MOH specifically in the SMC and the HIV / ART programs.

Since the second semester of 2013, the department has been actively involved in the process of revising the figures of antiretroviral therapy coverage for the country. The MOH, in collaboration with partners including ACHAP, has undertaken two lines of work as part of this process. The first one is the conduction of a nation-wide ARV data audit to verify the numbers of patients currently receiving ART, and the second one is the updating of the projections of population in need of ART. The former was initiated early in November with the training of ARV site managers and other relevant personnel to implement aggregated data collection to determine the total numbers of patients active in treatment and registered in the program. It is planned that the audit be completed by April 2014. Regarding projections, also during November, the MOH initiated the process of updating them using the software SPECTRUM. The process implies the triangulation of different sources of data and the revision of several assumptions that serve as inputs for the projections.

MONITORING AND EVALUATION SUPPORT TO THE NATIONAL AIDS COORDINATING AGENCY – NACA

Botswana AIDS Impact Survey (BAIS IV)

ACHAP supported the National AIDS Coordinating Agency (NACA) in conducting the fourth Botswana AIDS Impact Survey (BAIS IV), both technically and financially. ACHAP is a member of both the reference and the technical working groups for this survey. In addition, ACHAP provided financial support for the tests required for estimation of HIV incidence.

One of the key objectives of BAIS is to provide current national estimates of HIV prevalence and incidence among the population aged 6 weeks and above. The survey also provides critical information regarding HIV related knowledge and behaviour and coverage of HIV prevention interventions at the population level.

Monitoring and Evaluation support to implementing partners

Support was provided to Community-based Organizations (CBO's) that were subcontracted by ACHAP to create demand for SMC services in 2012. The support provided included review of submitted proposals, development of indicators, setting of targets, and reporting of performance among others. The support continued during the implementation of the performance-based contracts for SMC demand creation. Similar support was also provided to BOCAIP to implement the community TB care initiative supported by ACHAP.

ACHAP'S INTERNAL MONITORING AND EVALUATION

Institutional Performance Dashboard

Early in 2013, the department developed an Institutional Performance Dashboard. The dashboard facilitates the tracking of performance and progress towards achieving

defined targets for all ACHAP programs and departments.

ACHAP Internal Databases and SharePoint reporting system

Two key developments regarding data storage and management took place in 2013: the establishment of a system of databases for long-term data capture and storage, and the deployment of a reporting module denominated SharePoint. This reporting module allows the data in ACHAP databases to be displayed as dashboard graphs on the ACHAP intranet. The information is automatically updated as more data are captured into the databases.

Monthly Progress Update for ACHAP Board of Directors

Reports that update ACHAP'S Board about the performance of the programs on a monthly basis were introduced early in 2013. The objective of these reports is to frequently inform the members of ACHAP Board of Directors about the progress toward programmatic targets and objectives. These frequent updates facilitate supervision and guidance.

RESEARCH

The activities related with research that were conducted during 2013 were varied and included the development of research protocols for several projects, the conduction of field work for data collection, and the dissemination of studies completed previously. An important focus has been operational research, with the objective of generating knowledge that contributes to improve the coverage, effectiveness and efficiency of programs, and supports the decision and policy making processes.



Treatment Optimization Pilot Project CONTINUED

During 2013, the department initiated the evaluation of Community Tuberculosis Care (CTBC) and the evaluation of the SMC demand creation approaches; it participated in the PrePex acceptability and safety study, and presented findings from the evaluation of the SMC short-term communication strategy and the “Co-Creation” model design to support HIV prevention for females in the 17th ICASA conference. In addition, manuscripts presenting findings from the “Models of Care” study and the evaluation of the SMC short-term communication strategy were published in peer reviewed journals.

Evaluation Of Community Tb Care Approaches

This is a collaborative project with the National TB program of the MOH. The overall objective of the project is to evaluate the effectiveness, acceptability and sustainability of the approaches for care of TB in the community that have been used in the country: NGO / CBO managed Porta-Cabins, NGO / CBO organized community volunteers, Home-based care (HBC) managed by the government, Family / Guardian / “Buddy” treatment supporters, Institution (workplace / school) - based treatment supporters, Community-based TB promoters / treatment supporters.

The evaluation has several components: a retrospective cohort study was designed for the evaluation of effectiveness, and qualitative methods (focus groups discussions and key informant interviews) targeting different participants in the health care system (from treatment supporters to programs managers and decision makers) and stakeholders (from patients to community leaders) were used to assess acceptability, challenges and lessons. Fieldwork for data collection was completed in 2013 covering 9 districts and 201 health care facilities. Data analysis and reporting of results will take place during the first quarter of 2014.

Evaluation of SMC demand creation approaches

Under the methodological guidance of the department, this evaluation is implemented through a consultancy contract with *iTalk*. The overall objective of the project is to evaluate the effectiveness and efficiency and to document processes, challenges and lessons of the three approaches that ACHAP has used for the creation of demand for SMC: CBO / NGO mobilization, CBO / NGO managed MOH / ACHAP trained mobilizers, and ACHAP directly managed mobilizers with performance-based payment. During the second semester of 2013, the protocol for the project was developed and data collection and analysis are planned for the first quarter of 2014.

The evaluation will have two major components: one focusing on the implementers of demand creation activities – mainly of qualitative nature-, and the other focusing on the beneficiaries -recipients of them, using both qualitative and quantitative methods. The implementer’s evaluation component will use documentation methods, in depth interviews with key programme personnel, and cost-effectiveness analyses. The recipient’s evaluation will use a case-control design as the quantitative method, and focus groups discussions with circumcised and uncircumcised males and their sexual partners as the qualitative methodology.

PrePex™ device acceptability study

This is a collaborative effort between the MOH, CDC, ACHAP and JHPIEGO. This study will provide evidence about the safety and acceptability of PrePex™ circumcision device in Botswana.

PrePEX is a nonsurgical device that can be applied by mid-level providers to perform safe male circumcision in a non-sterile setting. It is expected that its use will help to overcome some of the challenges associated with the large scale implementation of surgical SMC for HIV prevention such as shortage of human resources, cost of surgical procedure, time to achieve expected coverage, and to address some of the concerns of the population such as pain, complications, recovery time, etc. Enrolment of the 805 participants required for the study was completed by the end of September 2013. Completion of data analysis and reporting of findings are expected early in 2014.

Dissemination of Research Findings

During the 17th International Conference on AIDS and STIs in Africa – ICASA- that took place in South Africa, ACHAP shared with the scientific, program implementation and HIV affected communities findings from two studies.

From the evaluation of the SMC short-term communication strategy implemented in collaboration with the MOH, the presentation highlighted the positive association between knowledge of SMC and circumcision status, and the finding that although acceptability of SMC among men in Botswana remains high, fear for pain, complications or deaths, lack of time, and inadequate information on SMC constitute the main barriers to be circumcised.



Treatment Optimization Pilot Project CONTINUED

From the “Co-Creation” model design to support HIV prevention for young, at risk females in Botswana, a project implemented with idea couture, the presentation emphasized that HIV transmission in and around Gaborone is a complex behavioural issue that is shaped by shifting cultural values and beliefs surrounding sex and sexuality; that there are complex needs surrounding intimate relationships, sexual health knowledge, transactional sex, coercive sex and rape and most importantly that messaging focusing on prevention should address that complexity. In addition, there is an opportunity for condoms to be repositioned as a desirable mode of prevention and protection. The prevention communications practice should be evolving and be rooted in contemporary Batswana culture.



Knowledge Generation, Management and Dissemination

MONITORING AND EVALUATION (M&E)

In the year 2013, the Monitoring, Evaluation and Research department initiated several activities to improve the collection, management and utilization of strategic information, and the identification and sharing of best practices within ACHAP and its partners, with the overall objective of strengthening program planning, development and implementation to achieve expected coverage, effectiveness and efficiency in service delivery.

MONITORING AND EVALUATION OF ACHAP PROGRAMS

Safe Male Circumcision (SMC) Program

To strengthen the monitoring and evaluation system for the SMC program with the aim of improving its capacity to generate timely, complete, reliable and correct information, the department undertook several activities such as: revision or development of standard operating procedures for data collection; revision or development of data collection tools such as the demand creation register and summary sheets; mentoring and training of personnel in clinical sites and data verification visits. The aim of the visits was not only to monitor data quality periodically and systematically, but also to support and mentor the teams in the field on the procedures for appropriate recording and reporting, and on the importance of high quality data for monitoring progress in implementation and evaluating programmatic outcomes. Furthermore, in one of the districts the department supported the training of health officers from clinics and health posts on the identification of adverse events, and appropriate reporting in post operation registers.

In order to facilitate efficient collection, management and reporting of data on demand creation for SMC, the department has also developed a database, which is now functional.

In its effort to contribute to appropriate and efficient program planning at the central and peripheral levels with the mapping of populations eligible for SMC, the department generated calculated numbers of the "pools" of eligible males for circumcision at the district and village levels for all the SMC sites that are supported by ACHAP. Generating these figures required the triangulation of several sources of data such as census, HIV epidemiologic data (BAIS), and SMC performance data. These figures are updated on a regular basis, and help the teams in the field to plan outreach and campaign activities in a more targeted form.

TB/ HIV SERVICE INTEGRATION

The department also supported the generation and timely reporting of TB and TB / HIV integration program data from the 14 districts supported by ACHAP. The department developed a TB/ HIV database to capture monthly aggregated data and followed-up the submission of monthly reports by the districts.

Furthermore, the department provided technical support to NGOs sub granted by ACHAP to implement community-based TB/HIV care, in particular to BOCAIP. The department provided support for the monitoring and evaluation of the project in the following areas: definition of indicators and targets, analysis of project outcomes, cohort analysis and end of project evaluation.



Communications and Advocacy CONTINUED

STAKEHOLDER ENGAGEMENT AND ACHAP VISIBILITY

CEO Introductory meetings

The Communications and Advocacy department led in arranging introductory meetings for the CEO with various stakeholders upon his arrival in January 2013. The stakeholder engagement meetings that were a part of Dr Jerome Mafeni introduction to Botswana's HIV/AIDS community commenced the week of the 21 January 2013 and ended in March 2013. He was accompanied by ACHAP's team; Chief Operations Officer, Director Programmes, and an officer from the Communications and Advocacy Department.

The key purpose of the meetings was to introduce ACHAP's CEO, discuss the organization's programme of implementation while also touching on the organization's strategy moving forward. The stakeholders targeted were; a mix of Governance structured (selected Board and Madikwe Forum members), Development Partners currently working with ACHAP, UN Agencies, friends of ACHAP and blue chip corporate sector.



ACHAP management meets ministry of local government & rural development



Dr. Jerome Mafeni meeting with Dr. Gang Sung UNAIDS Country Representative

CEO OPERATIONAL AREA VISITS

Following courtesy calls to stakeholders, Dr Mafeni, accompanied by a group of ACHAP delegation visited Operational Areas on the 7th March 2013 starting with Gaborone, followed by Molepolole, Palapye to end in Francistown. The purpose of the visits was mainly to introduce himself to ACHAP staff on the field, meet community leaders and for him to appreciate what the teams do on the field. During his visits, he met District Health Management Teams, SMC teams and Xprese Study Sites to discuss the SMC programme, HIV/TB initiatives, community mobilization and school campaign initiatives among other things.



Students at Mosu queuing up for the SMC service



Serowe SMC team during school campaign



Communications and Advocacy CONTINUED



Dr Mafeni meeting with the Letlhakane DHMT

During visits some challenges were presented by field staff these included; low turn up of clients, low HIV testing among males (13 - 49) and lack of transport among others. Dr Mafeni urged Operational Area teams to initiate new demand creation approaches to increase numbers. He said using the same approaches over extended periods could be the cause of a low turn up of clients. He appreciated the good works relationship between ACHAP and DHMTs. Teams were urged to increase their performance before end of 2014 in order to achieve maximum results.

MEDIA ENGAGEMENT

As part of media engagement, introductory meetings were arranged for the CEO to host various media houses also with the view to form strategic partnerships. These media entities varied from the private sector and government. The CEO from the press; Sunday Standard/Telegraph, Weekend Post, Mmegi, Botswana Guardian/Midweek Sun, Daily News. From the electronic media the CEO met with Yarona FM and Gabz FM. It was proposed at these meetings that ACHAP can act be subject matter/content specialist to journalists and help journalists in finding human interests stories.

ACHAP Media briefing



ACHAP CEO, Board Chairperson and NACA National Coordinator

A media briefing was held on the 29th August 2013 whose objective was to forge working relations with the media and brief them about the organisation's transition. The briefing was addressed by the ACHAP Board of Directors chairperson Mrs Joy Phumaphi accompanied by the CEO, Dr Jerome Mafeni and NACA's National Coordinator Mr Richard Matlhare who represented Madikwe Forum.

ACHAP's past success in supporting Botswana Government was highlighted. These successes include completion of treatment and care programs, providing assistance in infrastructural development, training health care workers, provision of equipment, drugs and systems strengthening. The board chairperson also informed the media about the focus shift in 2010 to support for prevention of new HIV infections. The support provided to the Ministry of Health includes strengthening TB/HIV and taking on the Safe Male Circumcision (SMC).

Adding his voice Dr. Mafeni said the organization will robustly go into Phase III by being a catalytic and innovative institution that will support countries in Africa to optimise their responses to HIV/AIDS and other health challenges.

Dr Mafeni said ACHAP has done exceptionally well in the past programmes to put the country on themap and this shows that the organisation can grow beyond the borders of Botswana.

For his part, Mr Richard Matlhare revealed that Madikwe forum was established to provide strategic guidance to the implementation of ACHAP supported programmes initiatives and to ensure transparency in the achievement of mutual goals of the Botswana government and ACHAP. He said advocacy and support for SMC has been provided through Madikwe forum by removing obstacles that may exist.



Communications and Advocacy CONTINUED

The ACHAP Board Chairperson Mrs Joy Phumaphi applauded all young men who have gone for SMC to protect themselves, their partners and the community from the spread of the virus. She called them warriors and heroes in the fight against HIV/AIDS Botswana. She also thanked approximately 20 journalist that attended the briefing at the Madikwe boardroom.

University of Cincinnati College of Medicine Visit

The University Of Cincinnati College Of Medicine delegation led by Associate Professor Jason Blackard on the 2nd May 2013 visited ACHAP as part of their experiential tour. This visit to Botswana was facilitated by among others the Ambassador of Botswana in the US Ms TebeleloSeretse, who is also the University's alumni. The purpose of the experiential tour was to give students first-hand experience of the health sector on HIV/AIDS, TB and Malaria in South Africa and Botswana.



1. A traditional doctor demonstrating how they decipher with their bones



2. Students listening to presentations

When welcoming them, Dr Jerome Mafeni, thanked the delegation for choosing ACHAP as one of the institutions to visit in the country. He said ACHAP is a good Public Private Partnership model in health sector and encouraged the participants to have an interactive discussion during the session. Director of Programmes, Dr Frank Mwangemi gave an overview of ACHAP's work in Botswana and the general statistics on HIV/AIDS and TB. Also present at the meeting was the Botswana Dingaka Association team whose Chairperson, Mr. Banyatsi Setilo, indicated that traditional doctors have always been viewed with suspicion and called "witchdoctors" which is not true. Setilo acknowledged that in the past they thought of HIV/AIDS as boswagadi (disease one gets after being widowed) because the bones they used to diagnose those infected had no appreciation of HIV/AIDS. He said through attending training workshops organized by MoH, they have started to use gloves and other sterile objects, as well as encourage their clients to use condoms. Setilo mentioned that the traditional healers have also started working with various institutions to do research on the medicinal value of their herbs.

House of Hope mini-bus donation ceremony

The African Comprehensive HIV/AIDS Partnerships (ACHAP) officially handed over the House of Hope Mini Bus that has been donated by The Merck Company Foundation / MSD. The House of Hope is a day-care centre that provides support to orphans and vulnerable children (OVCs) and their caregivers, funded by a variety of sources, including the Botswana Government, international donors, corporate sponsors and private donors. ACHAP built the Day Care Centre facilities for the House of Hope and has

provided other support including funding to support personnel costs through a one-time grant from MSD and programmatic and financial assistance since 2007 and through PCI since 2009. The Day Care Centre opened its doors in 1999.

Speaking an event held on the 15 May 2013 held at Palapye, ACHAP CEO, Dr Jerome Mafeni said, "ACHAP is proud to be part of the significant achievements Botswana has made in what has been an exemplary HIV response. Botswana has established a very effective ARV treatment programme, and a highly successful PMTCT programme both of which have amongst the highest coverage and access rates in Sub Saharan Africa at over 90%." Mafeni thanked the House of Hope and PCI for the strong partnership in supporting the Orphan and Vulnerable Children (OVC) national programme through the House of Hope Day Care Centre. He also praised the leadership of the House of Hope, the Palapye Community and the Palapye private sector for ensuring that the House of Hope continues to provide such benevolent and needy services to the young ones of our Country. More information on ACHAP's work with House of Hope can be found in the Grants Management section.



CEO, MSD representative and House of Hope Board Chairperson at the ceremony



Communications and Advocacy CONTINUED

Mmathete launches SMC site

The Gaborone Operational Area team in collaboration with Good Hope District Health Management Team launched Mmathete SMC site at an event held on the 22 March 2013 at Mmathete Junior Secondary School. The launch also coincided with the start of the SMC pre campaign activities in the District.



Performing artist Jonny Mokhalip performing at Mmathete



Mmathete CJSS students during the launch of SMC site

Speaking at the launch the SMC National Coordinator Mr. Conrad Ntsuape said the goal of the National Strategy for Safe Male Circumcision is to contribute to the reduction of HIV infection rates by scaling up Safe Male Circumcision throughout the country, to reach a prevalence rate of 80% (480 000) among 0 – 49 years old HIV – negative males by 2016. He emphasized that SMC does not in any way, mean that one is no longer at risk of being infected but that the youth must continue to practice ABC (abstain, be faithful, proper and consistent condom use)

The ACHAP Director Communications & Advocacy, Mrs Shungu Phillips – Malikongwa, praised the community and school leadership of Mmathete for their commitment and the efforts made in contributing to strategies to reduce the HIV transmission among Batswana. Also present at the event was Johnny Mokhali and his wife who shared with the crowd why he decided to undergo circumcision. The village chief thanked the audience, ACHAP and MoH for their efforts in his closing remarks.

Theory of Change Strategy Workshop

The theory of change was held on the 23rd February 2013 at Grand Palm Hotel, the workshop whose purpose was for the ACHAP Board, the Madikwe Forum, and the CEO to have a common consensus on the way forward and clear terms of reference to prepare ACHAP to be ready for Phase III. Specifically,

1. Answer critical questions that will guide the strategic direction for Phase III
2. Create a change-oriented roadmap for transitioning from Phase II to ACHAP Phase III
3. Develop recommendations to present to the Madikwe Forum on April 4th

Rationale for the Theory of Change Workshop

Advances in medical science and technologies are rapidly changing the course of diseases and global epidemics such as HIV and AIDS; and the way national governments, global and regional partners respond to them. What has been consistent in this regard is the central role of strong political commitments at national, regional and global level to ensure increased resources and their effective use to assure attainment of sustainable outcomes. Consequently, new infections have started to slow down in some countries and many people needing treatment now have access to it. In many countries HIV incidence and mortality has declined significantly. However, the challenge going forward is in leveraging and harnessing these successes in a sustainable way through systems and institutional strengthening initiatives at regional and national level. The need for this is shaping the strategic discourse around investing for results, integrating programmes for effectiveness and improving value for money through improved programme efficiencies.



Communications and Advocacy CONTINUED

The changing HIV and AIDS landscape has an effect on how technical partnerships are organised to respond to the systemic needs and demands. Catalytic thinking and innovative partnerships will define the agility and responsiveness of support to national governments and regional organisations. This is made urgent in the wake of the economic crisis, resulting in the decline in global resources to support national or regional interventions.

Many organisations, including national institutions, are at a crossroads in determining their own strategic niche based on the rapidly changing environment and their perceived comparative advantages. ACHAP is among those organisations. After 12 years of active engagement in the national HIV and AIDS response in Botswana, ACHAP must reposition itself for the future. It is for this reason that the Board of Directors has commissioned the development of a strategic plan.

SUPPORT TO SMC

A Successful Safe Male Circumcision School Campaign

The June/July 2013 School campaign was the most successful SMC campaign in Botswana. The school holiday campaign that started on the 24th June 2013 targeting 10310 school going boys to be circumcised by the 31st July 2013 in all 10 ACHAP supported districts. The national results were in excess of 14,000 while the ACHAP contribution in the national effort is in excess of 11,000. Preparation was key to the success of this campaign. ACHAP teams started preparatory activities in early May 2013 carefully applying valuable lessons learnt from the past.

Difference approaches were employed such as at Digawana village where circumcised boys were welcome in a traditional manner of well newly graduated initiates. The boys were clad in traditional wear and went the kgotla where they were welcomed by the traditional leadership. The ceremony attracted many uncircumcised young men who registered in the good numbers. The ceremony was a joint activity between the DHMT, the school and Digawana traditional leadership.



Nthwalang CJSS students at the initiation ceremony



Traditional leaders attending the ceremony at the kgotla

Within the first week, about 3100 males had been offered SMC services, and the numbers continued to increase each week contrary to previous campaigns where numbers reduced drastically after the first week.

During the campaign clinical teams working with schools, parents and students ensured consent forms were signed and HIV testing was done on time. Transport was provided for students to the service points. Students were also provided with snacks as they waited for their turn to be served. The service teams consisting of 1 medical officer (doctor), 3 nurses, 1 HCA adopted a healthy competitive mood to serve about 40-50 clients per day.



Communications and Advocacy CONTINUED

CONFERENCES AND EXHIBITIONS

BOCCIM Northern Trade Fair

ACHAP participated in the 19th BOCCIM Northern Trade Fair held in Francistown from the 29 May to 02 June 2013. The fair was officially opened by Mr Paul Taylor, Botswana Telecommunications Chief Executive Officer under the theme, "Unlocking Opportunities "To Successful Citizen Participation In The Economy Of Botswana". Mr. Taylor indicated that the theme recognizes the private sector's pivotal role in driving the economy. Speaking at the Fair he said, "through working together in the form of Private Public Partnerships, significant opportunities can be delivered and significant needs met." He urged the private sector to work closely with all stakeholders so that it becomes quicker and easier to establish and operate in Botswana.



The ACHAP stall was among the over 180 exhibitors set up in the marquee and over of 220 visitors for the duration of the fair. Most enquiries were about Safe Male Circumcision (SMC) and in particular the PrePrex circumcision device that was being piloted at the time. About 30 young men aged between 13 and 25 years registered to circumcise in the upcoming campaign.

International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA).

ACHAP participated at the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) was held in Cape Town - South Africa at the Cape Town International Convention Centre (CTICC) from 07 – 11 December 2013. The conference theme "Now More Than Ever: Targeting Zero" was derived from the UNAIDS' vision of striving for "Zero new HIV infections, Zero discrimination, Zero AIDS-related deaths", and also highlighting the need to "now more than ever" maintain the commitment to ensure access to treatment for everyone in Africa irrespective of their ability to pay for such treatment. ICASA 2013 was an opportunity for the international community and all Africans to join efforts in committing to achieving an AIDS-free Africa which attracted about 10 000 of the world's leading scientists, policy makers, activists, PLHIV, government leaders – as well as a number of heads of state and civil society representatives.

The conference objectives were to; serve as an advocacy platform to mobilise African leaders, partners and the community to increase ownership, commitment and support to the AIDS response, mobilise support to scale up evidence-based responses to HIV/AIDS/STIs/TB and Malaria in order to achieve the MDGs to name a few.

The conference was co - chaired by Professor Robert Soudre, the President of the Society for AIDS in Africa (SAA) and Professor Ian Sanne, the CEO of Right to Care an

Associate Professor of Internal Medicine at the University of the Witwatersrand. The ACHAP was led by the CEO.

ACHAP had presented three abstracts, two of which were successful. The two successful abstracts were, Communication Interventions - SMC Motivators and Associated Factors that was accepted for an oral presentation by the M & E Specialist Mr. Lesego Busang. The other successful abstract: "Co-Creation" Model Design To Draw Out Cultural Insights With At-risk Populations To Support Development Of A New HIV Prevention Campaign Targeting Young, At-risk Females In Botswana was accepted for a poster display. The Communications and Advocacy department also distributed over sixty information packs that had the 2013 Annual Report and important information on ACHAP.

INFORMATION TECHNOLOGY

In addition to providing end-user and network support that assist ACHAP staff in fulfilling their many responsibilities, IT plays a critical role of technical support for ACHAP Programmatic objectives. In 2013, this support included:

- Advice and training for sub-award organizations in purchasing and maintaining IT equipment
- Improve access to information and support external communication activities
- Technically supporting all ACHAP departments
- Review and advice on vendor selection in technical projects
- Support in managing IT related consultancies for systems development and maintenance.



Communications and Advocacy CONTINUED

Discontinuation of Frame Relay

- The frame relay which linked the Head Office in Gaborone and its two regional offices, that is, Francistown and Palapye offices was discontinued. The frame relay allowed direct access of data and resources from both Palapye and Francistown. Having cut the frame relay, both offices reverted to using the single direct phone lines from BTC as compared to the previous use of VOIP (Voice over Internet Protocol) phones, which supported access of data in the network. There is also an Orange livebox at the Palapyeoffice, which is used for accessing the internet. It was suggested that VPN (Virtual Private Network) be implemented so that staff members could have access to some of the resources at the Head Office.
- Internet modems (dongles) from Orange were introduced to assist users in accessing the internet and ACHAP email. The internet dongles enabled staff members to communicate with the rest of staff in different areas.

IT also assisted with the provision of printing facilities at the Treatment Optimization office in Tutume, including provision of internet modems for accessing the internet. Installation of phone and fax lines in all ACHAP operational areas is to be completed by BTC. The assistance is also extended to operational sites both in the North and South Regions with the provision of printing facilities to help in day-to-day business.

In 2014, a major goal of IT is to support improved personnel performance by building technical capacity among staff and facilitate the development of the ACHAP extranet, which will enhance communication and access to information on ACHAP activities.



Business Development

With the expiration of the Bill & Melinda Gates Foundation grant in 2013 and the winding down of the Merck Foundation support by December 2014, ACHAP has stepped up its focus on Business Development and Resource Mobilisation.

In September 2013 ACHAP's Business Development efforts were bolstered by the recruitment of a Business Development Director, supported by the Grants Manager and Business Development Assistant, additional targeted support has been delivered through an organization restructured which has enabled the management team to devote more time and resources to pursuing new business opportunities.

2013 saw the commencement of a series of Business Planning initiatives as ACHAP continued to redefine itself as an organization capable of implementing programmes across Southern Africa in a wider health arena.

The resulting Business Plan which will guide the organization in 2014 and beyond, will enable ACHAP to leverage its core capabilities in continuing to support the Government of Botswana in HIV interventions, but at the same time enable the organization to build a franchise partnership network throughout the region to support implementation of HIV, MCH, and SRH programming.

ACHAP increased engagement throughout 2013 with the Private Sector in Botswana, to build on established and new relationships and explore innovative funding mechanisms that meet the objectives of all stakeholders, but ultimately serve to improve the health outcomes for all Botswana.

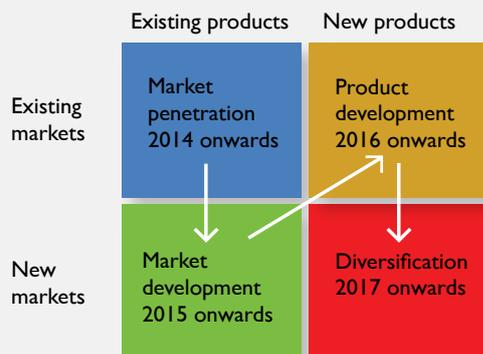
In addition to engaging with the Private Sector, ACHAP continue to target multiple funding streams from; the Government of Botswana, bi-lateral and multi-lateral donors, international foundations, research institutions, and through partnerships with other implementers.

In the Business Development arena, 2013 was a year of organizational planning and restructuring for ACHAP, whilst at the same time ensuring the organization was able to meet, and in many cases, exceed its project deliverables. 2014 promises to be a very exciting year for the organisation, as it uses its unique implementation capacity, business processes, and institutional skills and knowledge, to secure new funding in preparation for the roll out of new health programmes in 2015.

BUSINESS PLAN HIGHLIGHTS

Guided by a market and needs analysis for the Southern African region, and a review of current and forecast health trends, ACHAP determined where the organization is best placed to enhance national health outcomes.

ACHAP have determined a growth strategy for new services and markets, which can be well illustrated using the following 'Ansoff matrix'



2014 onwards ACHAP will focus on penetrating their existing market in Botswana, with existing HIV services.

2015 onwards, ACHAP will leverage their HIV expertise to enter new markets with existing HIV products and services.

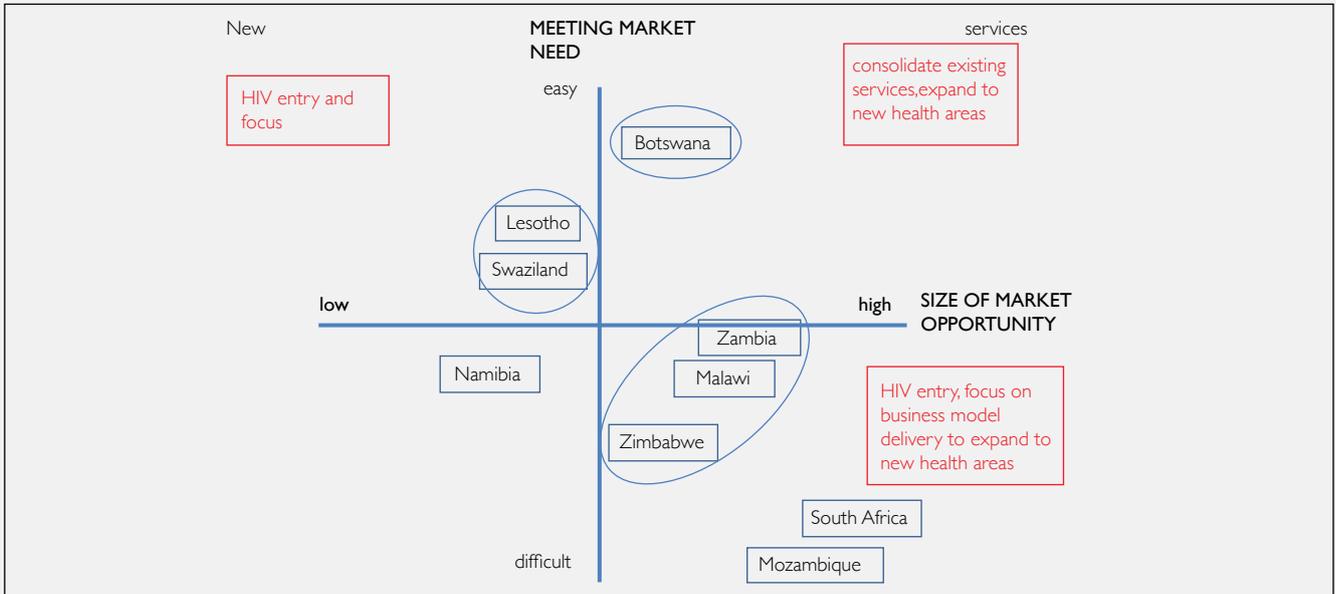
2016 onwards, ACHAP will introduce new products and services to Botswana. 2017 onwards, ACHAP will introduce new products and services to new markets.

New markets

Given the complexities of entering new markets, a franchising model whereby ACHAP will form partnerships with existing implementers to deliver ACHAP services is the preferred route of entry into new markets. ACHAP will become a 'parent' organization, offering operational, financial, HR, and legal support to country franchises. It is planned to launch two franchise operations in 2015, one of these, ACHAP Botswana, has already been registered.

In 2014 ACHAP will continue engaging not only with potential donors but with potential partners. Using regional health trend indicators, ACHAP have determined their focus markets as below:

Business Development CONTINUED



Products and services

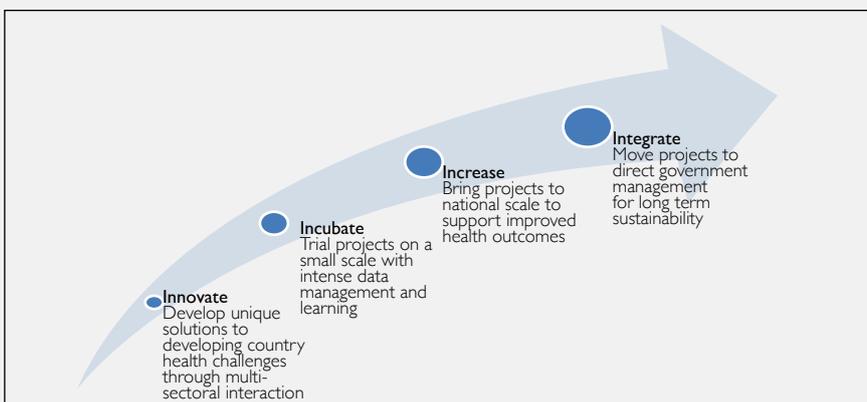
ACHAP acknowledges that its core area of expertise is the HIV sector in Botswana, and its growth strategy takes into account that the organisation will continue to implement and grow its HIV treatment and prevention activities in Botswana.

Using regional health indicators and donor mapping tools, ACHAP have determined that Lesotho and Swaziland offer the best prospects for successful expansion in service provision in 2015. The markets are similar in size to Botswana and the HIV prevalence and nature of interventions are also comparable, and therefore market entry will be through existing HIV services. ACHAP believes there is a strong opportunity to enter these two markets as a regional expert in delivering successful HIV programmes through Public Private Partnerships and have commenced discussions with key stakeholders.

For the markets of Zimbabwe, Malawi, and Zambia the entry strategy is through existing HIV services. Once market entry has been gained in the HIV sector, ACHAP will seek to expand services into; Maternal and Child Health, Sexual and Reproductive Health, and Non-Communicable Diseases.

4i Business Model

What sets ACHAP apart is that they are an African born NGO with the capacity and systems to implement health programming on an international scale. ACHAP's proven 4i Business Model is relevant for implementing current HIV programming, but will also be utilized to deliver other health programmes. It is by using this model that ACHAP is able to deliver; cost effective, high impact, locally relevant programmes at a large scale.





Grants Management

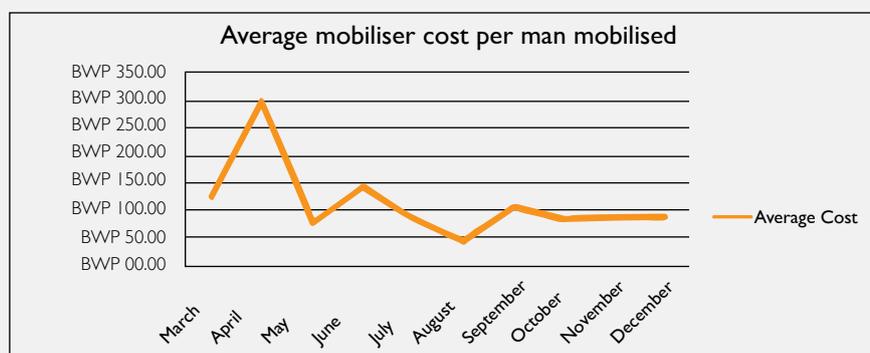
2013 marked a year of growth and significant accomplishment for the Grants Management Team. With a continued focus on supporting internal capacity and programmatic accomplishment, the Grants Management unit also played a significant role in Business Development activities in line with their traditional role of Funder Management. In 2013, Grants Management promoted two interns to full time staff these being the Grants Management Assistant and Business Development Assistant. Along with the promotions, the officers took on additional responsibility including background research and literature reviews for potential funding opportunities, increased interaction and administration responsibilities for vendor relationships and an active role in concept development for innovative funding activities.

Managing Electronic Payments

Grants Management continued to manage electronic payments for Safe Male Circumcision mobilisers through a platform developed by the Orange Mobile company, Orange Money. This system has assisted ACHAP to provide volunteer mobilisers with commission based incentives, using the number of actual SMCs provided to determine their allowance. The low administrative overhead of the Orange Money system means that data from the field can be translated into mobile payments in a time efficient manner. In addition to the continued administration of the Orange Money Platform, Grants Management worked with the Programme Team to identify a number of process improvements to support a more satisfactory system, these improvements were implemented in May 2013 including;

- Moving to internally managed registration of mobilisers for the Orange Money Platform,
- Standardising the use of Orange Money in all areas and creating a suitable system to use the platform in areas without Orange Network,
- Creating a schedule for payment request receipt and fund transfer,
- Standardising payment amounts,
- Standardising payment request forms to reduce likelihood of errors and delays in fund transfers.

The implementation of this has led to reduced costs from an average P298 in mobiliser payments per man circumcised in April 2013 to P84 by July 2013.



Turnaround times for the average time for payment receipt was also significantly reduced from up to 8 days from request to payment in Q1 2013 to less than 3 days in Q4 2013.

In addition to the improvements to the Orange Money based platform, Grants Management has coordinated trials of other potential products and platforms to support mobiliser payments including pilots with Standard Chartered and Banc ABC. In 2014, Grants Management will look at how these platforms can be used to further improve mobiliser payments and support other business needs.

Sub Award Management and Capacity Building

A core responsibility for the Grants Management team is supporting the effective management of sub-awards. In 2013, this work included the finalisation of a number of policies to support a clear, consistent and coherent process for managing the development of proposals, the development of contracts, review of programmatic and financial reports and close-out of sub-awards. In addition, Grants Management joined with Programmes and Monitoring Evaluation Research and Development departments to support improved reporting, requests and internal monitoring of sub-awards. This included development of cost value measures for regular reporting, guidance on improving request information and work on internal dashboards for sub-awards.

Grants Management supported the management of four sub-awards in 2013 being:

Botswana Harvard Partnerships (BHP) Treatment Optimisation CD4 Pilot Support

To pilot the optimization of HIV treatment by increasing the availability of CD4 testing services through the use of a POC analyzer at selected healthcare facilities in Tutume sub-district in the north east of Botswana



Grants Management CONTINUED

Botswana Christian AIDS Intervention Programme (BOCAIP) TB Community Care Project

To support a demonstration project for Community TB Care in Francistown using TB Care Supporters to link health facilities and patients, administer directly observed treatment in homes and the community, hold educational and counselling sessions, trace treatment interrupters and sensitize the community.

Additional information on the BHP and BOCAIP projects can be found in the Programmes Report.

House of Hope (HOH) General Operating Support – Merck Grant

Management of an award by the Merck Company Foundation to support a child care centre focused on orphans, vulnerable children (OVC) and their caregivers. The project's goal was to promote healthy childhood and to help local communities in Palapye to cope with the crisis of orphans and vulnerable children by providing training in early childhood development and to enhance the capacity of the community in providing quality care to all the children in House of Hope care, also to identify available resources within the community to support children and their families.

The HOH grant was scaled down from 2012, with final sustainability related funding to be released early in 2014. In 2013 the grant supported the purchase of a combi to support centre activities and transport to the centre for youth. The availability of a combi serves as an important resource for OVC as well as a draw for fee paying students which provide an important source of funding for the centre, information regarding ACHAP's participation in the combi handover ceremony can be found in the Communications & Advocacy section of this report.

ARV Donation Programme

In 2013 Grants Management continued assistance of the ARV Donation Programme. Twenty thirteen marked a year of continued improvement in logistics management for the drug donation programme, with ACHAP supporting the process for communicating required drug amounts and supporting the purchase of generic Atripla. More information on the ARV donation programme can be found in the Programmes Report. In addition Grants Management supported the annual drug donation audit and tracked improvement against the audit recommendations. This has seen an improvement in the internal controls at the Government Central Medical Stores on quality assurance, storage and distribution of ARVs to all government, mission and mine health facilities and non-government organizations in Botswana.

As part of this work the Grants Management Officer collaborated with the Programmes and DREAM team to participate in the National Drug Forecasting Technical Working Groups.

Business Development Support

The Business Development Unit was staffed in mid 2013, Grants Management served as the coordinator for funding requests and opportunities prior to the establishment

of the unit and continues to collaborate with Business Development in researching potential opportunities, providing literature reviews and background information, and developing concept notes, proposals and budgets for funding opportunities. A full report on the year's business development activities can be found in the Business Development Section of this Report.

Grants Management also took an active role in researching innovative financing mechanisms and served as a participant on the National Private Sector Funding Technical Working Group.



People and Growth

ORGANIZATIONAL EFFECTIVENESS

Recruitment of Strategic Positions

As the organisation transitions and moves forward, key Strategic positions have been filled in order to move the organization into the new era. These include:

Position	Name of person appointed to the position
Chief Executive Officer	Dr. Jerome Onome Mafeni
Executive Officer Programs	Dr Frank Mwangemi
Director Business Development	Mr Nick Brealey
Director Monitoring, Research and Evaluation	Dr Juliana Cuervo-Rojas
Lead Technical Advisor	Mr Benjamin Binagwa
Regional Manager North	Mr Blessed Monyatsi
Regional Manager South	Ms Elizabeth Moshi
Compliance Officer	Ms Sarah Malefo
Communications & Advocacy Manager	Ms Mable Bolele
Health Economist	Mr. Ivor Williams
Programme Coordinator – Treatment Optimization	Dr Kenneth Mugisha

POLICIES AND PROCEDURES

The Human Resources and Administration Department conducted a Human Resources policy audit to guide policy revisions and development to ensure that ACHAP has:

Robust and innovative human resource systems, procedures and practices which are compliant with relevant statutes;

Fair, inclusive and transparent policies in order to maintain good employer-employee relationships, and Policies that contribute to improved staff productivity, motivation, and morale.

A formative and summative evaluation of the drafts was achieved through consultative meetings held with staff in both North and South Regions. The policies were subsequently approved by the ACHAP Board of Directors at the August 2013 Board of Directors meeting and will be launched and rolled out to staff in March 2014.

STAFF PERFORMANCE RECOGNITION PROGRAM

Our STAR Performers for Year 2013

ACHAP prides its self in being a high performance organization. The organization stresses teamwork and commitment to ACHAP objectives while still encouraging

individual achievement and creativity. Employee surveys consistently show that employees want more than a salary from their jobs—they want to feel safe, secure and appreciated at work. It is in this spirit that ACHAP continues to publicly recognize its high performers through the STAR Performer Awards program. By publicly recognizing STAR performers the organization hopes to provide employees with:

- A clarification of what behaviors and outcomes are valued by the organization.
- Motivation to improve and maintain their performance.
- Appreciation for their efforts

All teams participate in the exercise by nominating a member of their team to be considered for the STAR performer Award through a secret ballot. The nomination is done strictly by the team members and not the supervisor or manager. The results are validated using the Performance Management System, that is, the winner must also have been rated at “meets or exceeds expectations” on the two most recent performance appraisals.



People and Growth CONTINUED

Our STAR Performers for 2013 are:

Name	Position Held
Lesego Busang	Monitoring and Evaluation Specialist
Moreri Mokgadi	Technical Officer Demand Creation
Susan Molatlhegi	Human Resources Assistant
Julias Maposa	Finance Assistant
Rachel Jackson	Grants Manager
Karabo Malao	Driver/Messenger
Ikothaeng Letang	Cleaner Safe Male Circumcision Site- Block 8 Clinic- Gaborone
Caroline Ramotsoko	Safe Male Circumcision Nurse - Emmanuel Centre- Ramotswa
Edmond Koboyankwe	Safe Male Circumcision Nurse – Kanye Main Clinic- Kanye
Sefania Salepito	Safe Male Circumcision Nurse – Kediretswa Clinic- Palapye
Bernadinah Moatshe	Safe Male Circumcision Nurse –Thamaga- Clinic- Thamaga
Glaudiah Maja	Health Care Assistant- Goodhope Hospital- Goodhope
Tidimalo Ngwakomonnye	Health Care Assistant- Area W Clinic -Francistown
Shirley Segajane	Health Care Assistant- Sekgoma Memorial Hospital- Serowe
Botshelo Moitoi	Health Care Assistant- Letlhakane Primary Hospital- Letlhakane
Kagiso Maphondo	Lay Counsellor- Thini Clinic - Tutume

Pay for performance

The organization implemented a Performance Incentive Bonus Scheme for the Safe male Circumcision Field teams and support staff working directly with the teams as a way of communicating to the teams that as an organization we have noticed their efforts. The organization provides cash bonuses to performing teams each quarter and is shared equally by the team regardless of position or level.

The bonus is calculated at two levels; a bonus is paid for achievement of 91% to 100% of target, recognizing the significant effort that must be made in order to achieve the full target and a higher bonus is paid for each SMC over 100% of target. The higher bonus rate is to encourage performance above the annual target and, it is envisaged that if the 100% of target is achieved, it will begin to reduce the average cost per SMC.

The performance targets are based on quarterly Safe Male Circumcision objective targets.

On boarding for newly appointed Board members

The Human Resources and Administration Department coordinated an event to on-

board the new ACHAP board members. The orientation was designed to help the board members get to work quickly and confidently, shorten the learning curve, get the relationship off to a good start and speed-up how soon we receive invaluable advice about issues facing our organization.

The event included a range of topics related to ACHAP's governance, current ownership arrangements and future plans. A resource speaker from PricewaterhouseCoopers provided a brief review of governance.

Interns

ACHAP is increasingly engaging interns through the Internship Program for entry level positions. This approach not only reduces the average cost per staff member but also provides valuable on-the-job experience for talented young persons who are experiencing difficulty in entering the Botswana job market. At the end of 2013 ACHAP had engaged six (7) interns to support Information Technology, Monitoring & Evaluation, Programmes, Business Development and Communications and Advocacy. Since 2010 ACHAP has engaged twenty two (22) interns of which nineteen (19) were absorbed.

OPERATIONAL EFFECTIVENESS

Fleet management

In an effort to promote operational effectiveness the organization invested in a Vehicle Tracking and Fuel Management System.

Staff Separations- Chief Operations Officer

Mr Arthur William Mooney separated from ACHAP at the end of his contract. Mr Art Mooney joined ACHAP in January 2011



ACHAP 2013 Financial Report

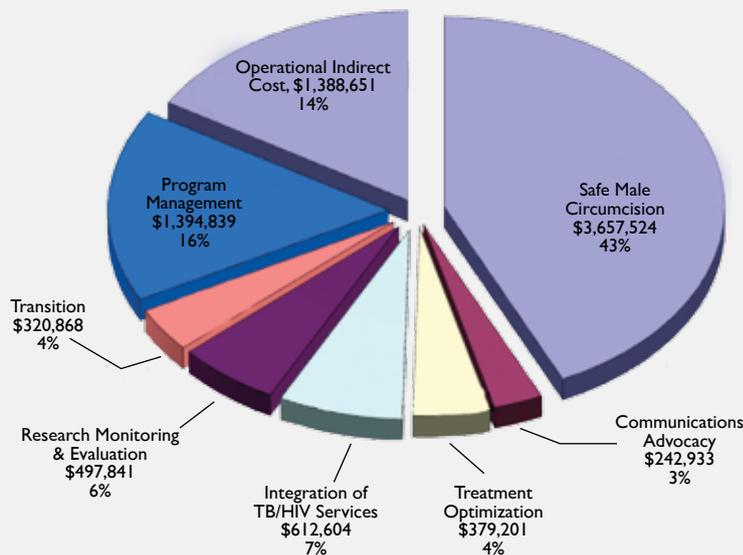
FINANCIAL COMMITMENTS AT 31 DECEMBER 2013

In the period under review, ACHAP activities were funded by grants from The Bill & Melinda Gates Foundation and The Merck Company Foundation. The Merck Company Foundation grant of US\$26.559 million over five years continues until 31st December 2014. The BMGF grant was valued at \$15 million for three years ended 14th September 2012. ACHAP was awarded a no-cost extension to utilise the balance of US\$1.6 million, which was carried over to fund the SMC objective activities. These funds were fully utilised by August 2013.

Implementation of the Phase II activities started on the 1st January 2010. The grant income is used to support the development and implementation of strategic HIV/AIDS initiatives through the provision of human resources, technical support, procurement of supplies and financial resources to fund deserving projects in Government and Civil Society. Programs supported by the Organisation are funded in line with the ACHAP's six Strategic Focus Areas at national and operational area levels.

YEAR 2013 GRANT ALLOCATION:

During the budget year ended 31 December 2013 the budget amounted to a total of US \$8, 639,617. The funds were utilized as allocated to the strategic focus areas and management costs as indicated in the chart below.



As shown by the chart above, a large portion (43%) of the organizational funds were used on the Safe Male Circumcision (SMC) and supported human resource, Information Education Communication (IEC) materials and SMC demand creation activities. Demand creation activities were undertaken at the Operational areas. The independent ACHAP Operational area offices supported district interventions for agreed activities. This approach worked well with oversight from the Head Office Programs team who approved all major transactions. SMC is the major prevention strategy implemented by ACHAP in the second phase hence the higher budget share when compared with other

programs. SMC numbers performed for the year 2013 exceeded the targets set. ACHAP continued to seek ways of "doing more with less" in order to heighten cost efficiency and continue achieving the Organizational objectives.

Funds amounting to US \$2.8 million were used for program management and operational indirect costs. Expenditure incurred related to human resource, travel and structures that supports and provides technical succour to program implementation in order to continue achieving the set targets and the Organizational mandate.

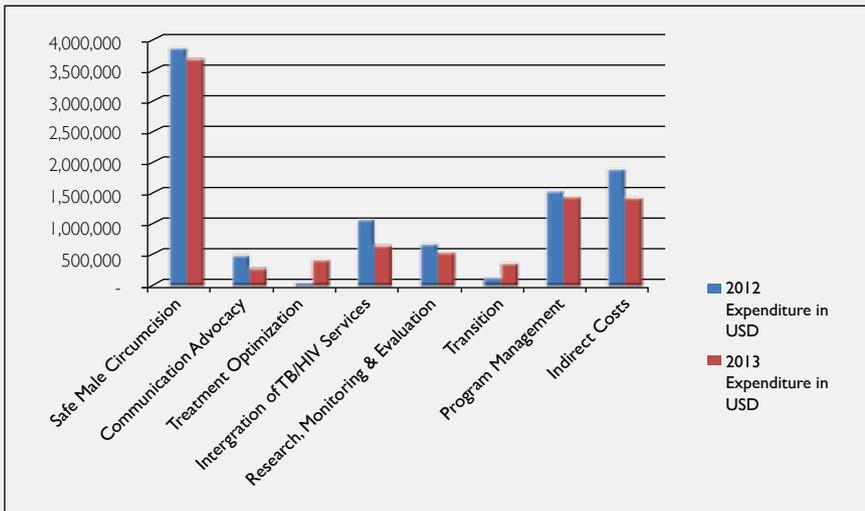
A significant amount of the year 2013 grant funds (US \$1.3 million) went into the Integration of TB/HIV Services, Transition and Treatment Optimization programs. The program objectives were to increase enrolment of TB patients, increase treatment rates and ensure sustainability of programs respectively.

The total expenditure for the period ended 31 December 2013 amounted to US \$8,494,459 compared to US \$9,378,000 in year 2012. This shows a 9.4% reduction in Organizational costs.



ACHAP 2013 Financial Report CONTINUED

2013 EXPENDITURE VS 2012



The table above illustrates a reduction in expenditure in all Organizational programs in year 2013.

In 2009 ACHAP was awarded a grant valued at \$4,750,000, to support the Botswana component of the Bill & Melinda Gates Foundation global libraries program. The utilization of the grant was originally expected to complete by 30 June 2013 but a no cost extension to 31 March 2014 was issued to utilize the balance of funds. The table below depicts the Sesigo expenditure up to the period ended 31 December 2013.

	Year 2009	Year 2010	Year 2011	Year 2012	Year 2013	Cumulative Spending	Five Year Grant Amount in USD	Unobligated funds as at 31/12/2013
Project Expenditure in USD	250,169	960,450	977,326	1,190,004	891,271	4,269,220	4,750,000	480,780

MEDICINE DONATION

In addition to The Merck Company Foundation financial support to ACHAP, Merck & Co.Inc., will continue donating selected anti-retroviral medicines to the Government of Botswana to 31st December 2014. In 2012, Merck elected to provide funding for the purchase of generic Atripla, rather than supply their branded product. The funds are disbursed to ACHAP, which procures the generic ARVs for delivery to the Central Medical Stores. The value of the medicines donation to the national ARV program for the year ended 31st December 2013 was approximately US \$13.8 million, while medicines with a value of US\$25 million were donated in year 2012. The cumulative cost of medicines donated by the Merck Company Foundation since 2001 is US \$153.8 million.



Sesigo Project

The Sesigo project reached full transition mode by officially handing it over to the Botswana National Library Service (BNLS) and the Ministry of Youth, Sport and Culture (MYSC) in August 2013. This ceremony marked the end of the project phase and a move into a full program within the public library system. Before then the normal project activities such as ICDL training, training of trainers, peer learning meetings and dissemination of final impact study results were carried out. ICDL training took place at 26 libraries. The seven BNLS staff who underwent the Training of Trainers course at Basago University College sat for the examinations with six of them successfully completing the course. A two-day peer learning meeting was organised for library staff to provide those implementing innovation projects to showcase and share their experiences with other librarians. The results of the final impact study were disseminated through a drama series aired on national radio and a summarized version of the findings as an insert in two nationally distributed newspapers.

Implementation of the innovation projects at ten (10) public libraries gathered momentum by mobilising stakeholders mobilisation and implementing planned project activities. Project mentors conducted site visits to the respective projects to provide guidance and support to the implementation teams. The project will be reviewed and evaluated through the help of BIDPA in both January and March 2014.

Training and Capacity Building

The training contractor provided ICDL training to 26 libraries which were not previously covered. In this period 26 libraries and 62 library staff were trained in ICDL to bring the total number of libraries and staff trained to 55 and 288 respectively. Thirty three (33) of these library staff wrote examinations and passed and thus qualified for ICDL. In total 62 library staff have qualified for ICDL certification comprising of 42 non-professional and 20 professional staff. Public training continues to take place at the public libraries; during the reporting period 3578 were training bringing the total number of people trained to 59867 since the beginning of the project. This is 50% more than the projected 40000 people who were to be trained/assisted in the use of technology.

The project held a peer learning workshop attracting 2 people each from 34 libraries and 6 village reading rooms, BNLS management, University of Botswana department of library and information studies, 2 delegates from the National Library of South Africa and one from the Global Libraries project in Poland. The workshop presented a platform for the innovators to share their projects with participants. Additionally, other librarians running projects but not amongst the ten sponsored innovation projects had the opportunity to share these as well, giving a snapshot of the initiatives that take place at Botswana public libraries. A site visit was organised to Moreomaoto community library which is hosting a very successful early childhood education project.

The South African delegates discussed about their programs. The presenter from National Library South Africa discussed the programs at their libraries, their partnerships with the local companies and the community. The other presenter from South Africa was more on the technical side, discussing their infrastructure rollout to support the libraries, their challenges and how they mitigate them. The presenter from Poland gave

the polish background, their programs and finished by showing the similarity in challenges faced by Botswana and Poland.

Advocacy and Communications

The Sesigo project was officially handed over to the BNLS at a closing ceremony on 1 August 2013. The official closing and handing over of the project to government was performed by the Minister of Youth, Sport and Culture, Honourable Shaw Kgathi. The event was graced by about 150 key stakeholders most of whom were instrumental in its implementation. Dignitaries included the Permanent Secretary in the Ministry of Youth, Sport and Culture as well as Deputy Permanent Secretaries from the same ministry as well as Directors from departments of Youth, Archives, Museum, and Sports as well as CEO's and Managing Directors from private companies and non-governmental organisations (NGOs). Also addressing the audience in absentia (through a video) was Ms Deborah Jacobs, the Global Libraries Director at the Bill & Melinda Gates Foundation. The event also saw 15 of 35 library staff who had passed International Computer Driving Licence (ICDL) being awarded their certificates. The fifteen were deliberately chosen to encourage other library officers. These were from the lowest cadres of the library structure (cleaners, gatekeepers and library clerks) and had all surpassed the ICDL pass mark of 75%.

Having been handed over the Sesigo project, the BNLS continued with implementing advocacy and communications activities at both national and local levels. The acting publicity librarian coordinated a radio presentation show called Makgabaneng extra which gave an opportunity to BNLS management, librarians and library users to share



Sesigo Project CONTINUED

impacts of Sesigo project. Library management shared about library services including Sesigo, with a focus on the results of the last impact study and also got an opportunity to hear and respond to users's feedback. Two Librarians also participated, giving their own personal experiences of how the project impacted on their work and personal lives. Lastly, library users who benefitted from the use of computers and Internet in public libraries interacted and shared their experiences with listeners across the country. A total of three shows were held. In addition, A drama based on the results of the Sesigo final impact study was aired on national radio once a week over a period of 12 weeks. Five mini launches of the Sesigo project were held in Kgatleng village reading rooms at Bokaa, Oodi, Modipane, Mmathubudukwane and Morwa. These were coordinated by the library staff and village development committees. The launches got publicity in both print media and the national television. More libraries continue to conduct library events including IT graduations for community members who successfully completed training. These events attracted local leadership and members of parliament and in some villages libraries have secured donations during the ceremonial activities. Tonota public library received 15 additional computers and Bokaa reading room got 3 additional computers.

This period saw the completion and opening of another community library built by the Robert and Sarah Rothschild Foundation in Sebina. The library is yet to be officially opened but has however been opened to the public for use. Six (6) of the seven selected BNLS trainers passed their final training of trainers examinations and are now expected to acquire full accreditation from Botswana Training Authority. The remaining trainer is expected to graduate in 2014. The Sesigo project thus leaves behind a group of soon to be accredited trainers who will coordinate BNLS training activities in advocacy, ICT and monitoring and evaluation. The seven trainers held a meeting with BNLS management to agree on a training plan as well as agree on conditions of their training.

Impact assessment

The results of the final impact assessment study were used for advocacy in a number of ways namely the development of an impact video which was shared with the stakeholders at the Sesigo project closing ceremony in August 2013. The video was also put in memory sticks and shared with those who attended the ceremony. It was further uploaded to Youtube (www.youtube.com/watch?v=fwtLYWqxMBo) to further expand access to others. A radio drama based on the findings was also aired on national radio once a week for 12 weeks. A brief summary of the final impact study findings was drafted and put inside two weekly newspapers which are distributed nationally in September 2013.

Innovation fund Project

Implementation of the innovation projects at ten (10) public libraries gathered momentum by mobilising stakeholders mobilisation and implementing planned project activities. Project mentors conducted site visits to the respective projects to provide guidance and support to the implementation teams. The project will be reviewed and evaluated through the help of BIDPA in both January and March 2014.

As part of enhancing project implementation and building capacity for the project innovators, the ten project innovators together with their partners, project mentors and

some members of the BNLS management team, a total of 46 people, were in August sponsored for a five-day benchmarking exercise to South Africa. Split into 3 groups, they visited libraries in Kwazulu Natal (Durban and Pietermaritzburg), Gauteng (Pretoria and Johannesburg) and Western Cape (Cape Town).

A two day peer learning meeting (PLM) was held in the last week of August 2013 with 100 participants including the BNLS management team, heads of stations of all public libraries, project innovators, University of Botswana department of library and information studies representatives from the National Library of South Africa and Poland global libraries project. The PLM afforded the project innovators an opportunity to share their experiences with the participants as they implemented their projects which they showcased through poster sessions and breakaway sessions.

The international presenters from South Africa and Poland shared with the participants about the library environment in their respective countries.. An opportunity was also afforded to the two Botswana INELI (International Network of Emerging Library Innovators) to share their experiences as they connect with their counterparts internationally to implement new ideas and services and learning from each other. The participants also further toured the Moreomaoto community library to experience their early childhood programme in action. Following the PLM, the BNLS and the Ministry worked to hold the first ever library summit in November with the highlight being innovative programming at libraries.

