NATIONAL STRATEGY
for
BEHAVIOUR CHANGE INTERVENTIONS
and
COMMUNICATIONS
for
HIV and AIDS

April 2006
This national strategy is intended for Behaviour Change Interventions and Communications (BCIC) implementers within each of the national HIV and AIDS response structures outlined in the Botswana National Strategic Framework (NSF) for HIV/AIDS 2003-2009.

It is meant to guide planning, design, implementation and monitoring of BCIC activities in all sectors. It therefore does not prescribe actions for any pre-selected list of priority groups. Instead, it offers a generic framework for guidance that enables each sector or district or village to; among others:

- determine what behaviours or social change are needed
- target who to focus on in order to bring about the desired change
- select best strategies for motivating and supporting desired behaviours; and
- access ongoing and focused technical support for BCIC efforts

The strategy recognises that risk factors for HIV will differ with occupation, geographic location, gender and other socio-environmental dimensions. Because individual attributes and social environments differ; messages, communications channels and approaches to prevention will also differ. The National Strategy for BCIC aims to guide implementers in aligning programmatic responses to national priorities for HIV and AIDS. It also suggests stronger mechanisms for ongoing support and technical guidance. Implementers at district and community levels should use this strategy to plan interventions but may seek the requisite technical support where local capacity needs to be enhanced.

The strategy was developed in consultation with representatives from public sector, civil society organisations and other development partners.

More importantly, the Strategy has a critical role towards achieving the Botswana Vision 2016 goal of No New Infection. It is also pivotal in facilitating the Implementation of the recommendations of the National HIV Prevention Conference (2005) – Towards Zero New HIV infection: Zero Transmission and targets of Scaling up of Universal Access to HIV and AIDS Prevention, Treatment, Care and Support based on Brazzaville Commitment, and the Declaration of Commitment on HIV/AIDS.

It is hoped that this strategy will enable all sectors to be more focused and synergistic in consolidating prevention efforts to achieve long term sustainability of treatment, care and support. This strategy also suggests the priority areas for effective and innovative ways of utilizing available resources and offering HIV and AIDS services more widely to reach all communities across the country.

To this end, I would like to urge all stakeholders in the fight against HIV and AIDS to use this strategy in order to strengthen and accelerate the national response to the pandemic.

B. C. Molomo
National Coordinator
ACKNOWLEDGEMENT

The National Strategy for Behaviour Change Interventions and Communications for HIV and AIDS would not have been possible without the commitment, support and participation of many dedicated individuals from government, civil society networks and development partners who served on the Technical Working Group (TWG).

The development of this national guidance document was a several month undertaking which involved ongoing consultation with the TWG, NACA staff and behaviour change practitioners at national, district and community levels.

NACA would like to thank all those who gave their time and considered thought to shaping this document. That consultative process made this strategy a true reflection of the challenges the country faces today and opportunities available to meet them.

NACA also offers its thanks to SADC for its support and to the Academy for Educational Development (AED) for its technical assistance and guidance. This document would not have been possible without their support.
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<th>ACRONYMS</th>
<th>MEANING</th>
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<tbody>
<tr>
<td>ACU</td>
<td>AIDS Coordinating Unit</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>BAIS</td>
<td>Botswana AIDS Impact Survey</td>
</tr>
<tr>
<td>BCC</td>
<td>Behaviour Change Communications</td>
</tr>
<tr>
<td>BCIC</td>
<td>Behaviour Change Interventions and Communications Botswana HIV Response Information Management System</td>
</tr>
<tr>
<td>BHRIMS</td>
<td></td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based Organisation</td>
</tr>
<tr>
<td>CSW</td>
<td>Commercial Sex Worker</td>
</tr>
<tr>
<td>DMSAC</td>
<td>District Multi-sectoral AIDS Committee</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith-based Organisation</td>
</tr>
<tr>
<td>FDI</td>
<td>Foreign Direct Investment</td>
</tr>
<tr>
<td>FLE</td>
<td>Family Life Education</td>
</tr>
<tr>
<td>GEP</td>
<td>Gender Equity Promotion</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>HBC</td>
<td>Home-based Care</td>
</tr>
<tr>
<td>HCP</td>
<td>Health Care Providers</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IPT</td>
<td>Isoniazid Prevention Therapy</td>
</tr>
<tr>
<td>LSE</td>
<td>Life Skills Education</td>
</tr>
<tr>
<td>MAC</td>
<td>Ministry AIDS Coordinator Minimum District</td>
</tr>
<tr>
<td>MDP</td>
<td>Package for HIV/AIDS Response</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MIP</td>
<td>Minimum Internal Package</td>
</tr>
<tr>
<td>NACA</td>
<td>National AIDS Coordinating Agency</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental Organisation</td>
</tr>
<tr>
<td>NSF</td>
<td>National Strategic Framework for HIV/AIDS</td>
</tr>
<tr>
<td>OI</td>
<td>Opportunistic Infection</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<tr>
<td>PLWHA</td>
<td>People Living with HIV and AIDS</td>
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<tr>
<td>Acronym</td>
<td>Term</td>
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<td>---------</td>
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</tr>
<tr>
<td>PPP US$1</td>
<td>Equivalent purchasing power of US $1 in local economy</td>
</tr>
<tr>
<td>PWD</td>
<td>People with Disabilities</td>
</tr>
<tr>
<td>RHT</td>
<td>Routine HIV Testing</td>
</tr>
<tr>
<td>SAC</td>
<td>Sector AIDS Committee</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>THP</td>
<td>Traditional Health Practitioner</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV and AIDS</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>VMSAC</td>
<td>Village Multi-sectoral AIDS Committee</td>
</tr>
<tr>
<td>YSO</td>
<td>Youth Service Organisation</td>
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</tbody>
</table>
The National Strategy for Behaviour Change Interventions and Communications (BCIC) is a strategy for building Botswana’s capacity to stage more effective BCIC for HIV and AIDS. The Strategy is intended to guide BCIC implementers and planners within the national response structures. These are outlined in Table 1.

### TABLE 1: STRUCTURES FOR NATIONAL RESPONSE TO HIV/AIDS

<table>
<thead>
<tr>
<th>I. PUBLIC SECTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Ministries</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>II. CIVIL SOCIETY</td>
</tr>
<tr>
<td>Non-governmental Organisations – NGOs, CBOs, FBOs</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>III. PRIVATE SECTOR</td>
</tr>
<tr>
<td>For profit business and industry</td>
</tr>
<tr>
<td></td>
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<tr>
<td>IV. THE MEDIA</td>
</tr>
<tr>
<td></td>
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<tr>
<td>V. PARASTATALS</td>
</tr>
<tr>
<td></td>
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<tr>
<td>VI. DEVELOPMENT PARTNERS</td>
</tr>
</tbody>
</table>

The National BCIC Strategy builds on the National Strategic Framework for HIV/AIDS (NSF) — offering a structure for guiding BCIC activities in all sectors; identifying emerging issues and successful strategies; pointing out gaps in national response; and aligning overall efforts with national goals and priorities.

This Section provides background on national efforts to combat HIV and AIDS, and summarises the evolution in approaches to behaviour change. The rationale and guiding principles shaping this strategy are also discussed in Section 1.
1.1 BACKGROUND

Public health information, education and communications (IEC) have been utilised to create awareness around HIV and AIDS in Botswana for the past twenty years. IEC have contributed to the high levels of awareness and knowledge documented among people 10-64 years old:

- 92.7% of the population know about AIDS
- 72.6% know that condoms reduce the risk of HIV infection
- 71.1% women know that HIV transmission from mother to unborn child can be prevented

Despite these achievements, only 30.6% men and 37% women 15-49 demonstrated “sufficient knowledge” on HIV and AIDS for behaviour change. A quarter to one third of the population still harboured myths about HIV transmission and only 15.2% males and 22.1% females aged 15-24 met the UNAIDS standard on knowledge. Current IEC efforts have therefore not dispelled misconceptions about AIDS; neither has high levels of awareness been sufficient to motivate adoption of HIV-protective behaviours. HIV infection continues to outpace national efforts.

Programme experiences in HIV prevention over the last 20 years have documented effective approaches to motivating behaviour change. These approaches expand on public health tradition of IEC, adding to it knowledge from behavioural science and community development to more effectively motivate behaviour change. The resulting model—Behaviour Change Interventions and Communications (BCIC), is characterised by sustained audience-specific communications and programmes designed to inform and motivate, to build skills, confidence and social support for change. BCIC have become essential elements in the fight against HIV and AIDS.

The National HIV/AIDS Strategic Framework (NSF) 2003-2009 established clear goals and objectives for a national response. It also assigned responsibility for action across government, civil society, the private sector, media and development partners. The NSF urges the development of interventions built on behavioural research, audience segmentation and strategies with evidence of proven effectiveness for a stronger national response.

Within the national response structure, Sector AIDS Committees, (SAC) are charged with implementing a minimum internal package (MIP) of prescribed activities for employees and clients. Multi-sectoral AIDS Committees at district and village levels are charged with implementing AIDS response activities within each of their respective jurisdiction through the District Multi-sectoral AIDS Committees (DMSAC) and Village Multi-sectoral AIDS Committees (VMSAC). The decentralisation of national response imposed new mandates for behaviour change interventions and communications on all sectors; mandates for which some sectors are inadequately
prepared. Some did not have the requisite skills to deliver sound BCIC programmes and national systems for guiding and strengthening the response were not well developed. Decentralisation required increased levels of communication, coordination and technical support to harmonise an efficient overall effort.

To ensure efficiency in a decentralised effort, the NSF assigned to the National AIDS Coordinating Agency, (NACA), responsibilities for coordinating and supervising the national response. NACA is assigned responsibility for national planning, deployment of resources and technical inputs for producing a cogent, harmonised response aligned with the goals of the NSF. NACA is also charged with building each sector’s capacity for managing and implementing the national response and with tracking, monitoring and analysing implementation of the national response.

BCIC programmes are guided by the NSF whose goals, key objectives and priority populations are summarised in Table 2.

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prevention of HIV infection</td>
<td>▪ Increase HIV prevention knowledge …</td>
</tr>
<tr>
<td></td>
<td>▪ increase adoption of key HIV prevention behaviours among the sexually active population …</td>
</tr>
<tr>
<td></td>
<td>▪ decrease HIV transmission from HIV+ mothers to their newborns …</td>
</tr>
<tr>
<td></td>
<td>▪ decrease STI prevalence …</td>
</tr>
<tr>
<td></td>
<td>▪ decrease HIV incidence among sexually active population …</td>
</tr>
<tr>
<td>2. Provision of treatment, care and support</td>
<td>▪ increase PLWHA on ARV returning to work …</td>
</tr>
<tr>
<td></td>
<td>▪ decrease the incidence of TB among HIV+ patients …</td>
</tr>
<tr>
<td></td>
<td>▪ increase the number of skilled health workers providing accurate diagnosis and treatment of opportunistic infections (OI) …</td>
</tr>
<tr>
<td>3. Strengthened management of national response to HIV and AIDS</td>
<td>▪ decrease HIV prevalence in transfused blood in the country …</td>
</tr>
<tr>
<td></td>
<td>▪ decrease incidence of TB among PLWHA …</td>
</tr>
<tr>
<td></td>
<td>▪ strengthen effective partnerships for HIV and AIDS response at all levels</td>
</tr>
<tr>
<td></td>
<td>▪ strengthen capacity to implement HIV and AIDS response at various levels and sectors</td>
</tr>
<tr>
<td></td>
<td>▪ implement NSF minimum HIV and AIDS response package within all sectors …</td>
</tr>
<tr>
<td>4. Mitigation of psycho-social and economic impact of HIV and AIDS</td>
<td>▪ increase number of households with registered orphans receiving support …</td>
</tr>
<tr>
<td></td>
<td>▪ reduce absenteeism and illness in labour force …</td>
</tr>
</tbody>
</table>
TABLE 2: GOALS and OBJECTIVES ESTABLISHED BY THE NSF

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Creation of a legal and ethical environment to support NSF</td>
<td>▪ ensure supportive, human rights-based, ethical and legal environment that conforms to international standards …</td>
</tr>
<tr>
<td></td>
<td>▪ reduce impact of HIV and AIDS on the economy …</td>
</tr>
</tbody>
</table>

PRIORITY POPULATIONS

The NFS recognised as priority populations for attention:
- women
- children and youth
- orphans
- mobile populations
- the poor
- PLWHA

Since the formulation of the NSF, other populations have also been prioritised for special attention:
- people with disabilities
- THP
- CBH providers
- couples
- men
- CSW
- HCP

1.2 EVOLUTION OF APPROACHES TO BEHAVIOUR CHANGE

Behaviour change is the process of adopting and maintaining positive health behaviours or discarding harmful ones. Activities which focus on information, education and communications as the primary means of motivating positive health behaviours are generally referred to as information, education and communications (IEC). The underlying assumption of IEC is that awareness and knowledge leads to positive action.

Approaches to influencing health behaviours have moved beyond IEC to employ targeted psychological positioning of information accompanied by activities like:
- skills building to enable enactment of the desired behaviour
- marketing designed to induce changes in socio-cultural values and norms favourable to the adoption and reinforcement of desired behaviours

Strategies that employ demographically targeted communications aimed at motivating behaviour change are called behaviour change communications (BCC). When other dimensions like skills building and social support for motivating and enabling change are combined with BCC, the overall effort is called behaviour change interventions and communications.
The underlying assumptions of BCIC are that:

1. **individuals act in relation to their social environment based on their own perception and/or experience of rewards associated with specific behaviours**, e.g. —males believe or have experienced greater respect through the exercise of force so they behave aggressively

2. **behaviours require the physical and emotional capacity to act and these capacities can be learned through education, modelling and guided practice**, e.g. —driving a car requires the physical ability to control a car and the confidence to make quick decisions in a changing environment, these skills may be acquired through driving school, observation of other drivers and supervised practice

3. **individuals can be motivated and equipped to engage in specific behaviours**, e.g. advertising, interpersonal communications, availability of appropriate safety gear and experienced guides can motivate some people to bungee jump or negotiate dangerous rapids successfully

The effectiveness of BCIC will depend, in large part, on the degree to which interventions succeed in:

- **communicating** accurate and relevant information about how to prevent HIV infection and delay the onset of AIDS in a manner that is easily understood and emotionally comfortable to the intended audience
- **stimulating community response** — community initiated activities including advocacy
- **building capacity of communities** to provide environments conducive to HIV prevention, treatment and related care
- **motivating** individual desire to adopt behaviours that protect self and others from HIV infection and related illnesses
- **enabling** individuals with the skills for performing HIV-protective behaviours both in sexual relations and in the provision of care for PLWHA
- **creating an institutional culture** that relies on evidence-based planning

Experience suggests that the integration of these elements in BCIC programmes should improve their effectiveness in promoting behaviours that prevent the transmission of HIV and lessens its impact on those who are infected or affected.
1.3 RATIONALE FOR NATIONAL BCIC STRATEGY

Botswana’s national response has not yet realised its key objectives. Behaviour change interventions are struggling to motivate the behaviours and social norms needed for achieving zero new infections. In addition, new challenges threaten to roll back gains in prevention.

Analysis of the current response shows that many interventions are neither focused on specific risk conditions or risk behaviours; nor do they target discrete subsets of the population. In addition, the technical capacity of designated staff to analyse local contexts and recognise gaps in response is constrained by the lack of the required competencies for the task. This situation has weakened the effectiveness of BCIC in supporting HIV prevention, treatment, care and support.

In the absence of behaviour change new HIV infections will continue and “treatment programmes will become overwhelmed and unsustainable.”

BCIC has also been undermined by weaknesses in organisational structures to support and coordinate programme responses. BCIC programme efforts need to be improved but systems for guidance...
and coordination also need to be strengthened to better support national goals and priorities. This National Strategy for BCIC has been developed to address both of these gaps.

### 1.4 GUIDING PRINCIPLES FOR BCIC

The goal of the National BCIC Strategy is therefore to provide a framework for guiding sectors in their development and implementation of effective BCIC that respond to national goals and priorities.

The National BCIC Strategy is guided by the principles of effective HIV prevention articulated by the UNAIDS:

1. BCIC should be evidence-based, informed by what is known and proven to be effective.
2. BCIC should involve PLWHA in all stages of programme planning.
3. BCIC should be tailored to address the specific needs and challenges of the communities and risk groups the intervention is designed for and should adapt as conditions change.
4. BCIC should be planned with communities for whom they are intended and should employ approaches that are culturally and linguistically appropriate for those communities.
5. BCIC should facilitate policy, institutional practices, and changes in the sociocultural environment to decrease vulnerability to infection and enable behaviour change.
6. BCIC should be comprehensive in scope, addressing the full range of available options in prevention, treatment, care and support.
7. BCIC should integrate HIV prevention across the continuum of care, strategically reinforcing prevention in treatment, care and support settings.
8. BCIC should be a sustained, long-term effort, recognising that results will only be seen in the long run.
HIV infection is influenced by environmental, institutional and personal factors. Patterns of infection and the underlying causes are dynamic and complex. The fact that HIV transmission involves sexual intercourse adds yet another layer of complexity in the search for solutions. While there is no cure for HIV and AIDS, there are some factors that can be targeted to reduce the risks of infection.

This section provides an overview of key factors linked to HIV in Botswana. It is organised around three clusters of determinants — those derived from Botswana’s socioeconomic and sociocultural environment, its institutional practices and individual behaviours that present opportunities for infection.

### 2.1 CONTEXTUAL FACTORS

#### 2.1.1 Economic Factors: In 2004, the Botswana AIDS Impact Survey (BAIS) estimated unemployment at 24.6% and showed young adults with the highest rates of unemployment.\(^{10}\)

Women as a group were less likely to be employed than men and as the majority population, also head a majority of households with dependent children.\(^{11}\) Half of all households headed by women fall below the poverty line.\(^{12}\)

Economic factors hence increase vulnerability to HIV infection and intensify impact at all levels. For example, poverty...
being one of the attributes of economic factors:
■ reduces investments in human development
■ limits employment opportunities and protection for workers
■ restricts provision of essential health and social services for prevention, treatment, care and support for HIV and AIDS

Poverty also makes households more vulnerable to HIV infection. At the household level, poverty:
■ weakens a family’s ability to provide for basic needs
■ reduces access to healthcare and other life enhancing services
■ increases victimisation from discrimination, marginalisation and exploitation on multiple fronts
■ forces the poor in relationships of dependency and submission that increases vulnerability to HIV

HIV thrives in environments where access to economic opportunities and basic services are compromised.

2.1.2 Culture and New Norms. There are features of traditional and modern culture that heighten vulnerability to HIV. These include:
■ the focus of sex in modern culture
■ the use of sexual relationships for obtaining the symbols of modern living such as expensive cars.
■ Mobility through village homestead, cattle post and urban residences that increases the chance of having multiple sexual partnerships

■ the practice of sending children to live with relatives – about one third (33.6%) of children 0-18 years live with neither biological parent.¹³
■ practices related to caring for the sick with out protective materials against infection
■ treatment prescribed by traditional health practitioners and self medication from over-the-counter supplements sometimes contradict HIV-prevention practices and ARV regimens
■ some beliefs – 20% of young people aged 10-24 years believed that HIV can be cured by having sex with a virgin¹⁴ and 28% of the population surveyed in 2004¹⁵ believed that witchcraft was a factor in HIV and AIDS.

2.1.3 Sexuality. Human sexuality and norms around sexual conduct are at the heart of the epidemic. Sexual behaviours acquire different meanings in different socio-economic and cultural contexts. Yet there is a reluctance to address sexuality holistically and in a forthright manner. Many adults believe that sexuality education before puberty encourages early sexual experimentation.¹⁶ Yet only 40% of parents reported speaking with their own teenagers about sex.¹⁷ Less than 20% of children 10-14 years reported ever talking with an adult about sexuality.¹⁸

Environments in which sexuality education occurs are not adequately supportive. However, most believe that sexual intercourse is required as a proof of love or cultural identity, modernity,
masculinity, femininity, etc.; making everyone more vulnerable to infection.

2.1.4 Gender Inequality. Gender inequality remains a contributing factor for women’s and men’s vulnerability to HIV. Male dominance in sexual decision making and violence against women and girls contribute directly to women’s higher levels of HIV infection at earlier ages. Women also suffer a disproportionate burden of care and support for people infected and affected by HIV and AIDS. Gender norms around help seeking behaviours have also fuelled underutilisation of needed prevention, treatment and support services by men.

2.1.5 Intergenerational Sex. Sexual relations between older men and younger women are believed to explain the high rates of infection seen in young women. Intergenerational sex also involves older women and younger men. Many of these relationships are predatory—older, better resourced men or women preying on sexually naïve or economically dependent girls. Intergenerational sex involves family members as well and may account for a significant portion of first time sexual intercourse among very young girls.

2.1.6 Population Mobility. Internal population movement in Botswana is fuelled by the search for economic opportunities, rotation of civil servants and the traditional land tenure system. Almost half the population spent at least one month away from their place of residence in 2004. In addition, as a hub for regional transport, there is high population flow from neighbouring countries. The transit of people through these areas creates sexual dynamics that contribute to the higher rates of HIV infection found in communities along these routes.

2.1.7 Stigma. The fear or experience of rejection and exclusion continue to inhibit prevention, testing and treatment. Fear of victimisation keeps people from confirming their HIV status, from accessing information and services for opportunistic infections and from accepting prophylaxis to prevent transmission from mother to child. Stigma also prevents utilisation of treatment, care and support services that can prolong health.

2.1.8 Emerging Concerns. Antiretroviral therapies (ARV) have recovered health and lowered viral loads among PLWHA. Sometimes, lowered or undetectable viral loads are mistaken as cure. These factors have led to the resumption of unprotected sexual activity. HIV discordance exists within 22%-33% of couples who have tested. Failure to practice safe sex consistently within these unions places the negative partner at high risk of infection. Hence, HIV transmission within discordant unions and re-infection among PLWHA constitute new areas of concern. This holds true among HIV positive mothers who already know their status and/or are on treatment and get pregnant.
2.2 INSTITUTIONAL FACTORS

The persistence of high rates of HIV infections is also linked to institutional practices. Given the broad mandate to action in the NSF, institutions must be a part of the solution. However, a range of organisational, resource and policy challenges get in the way of optimal support to prevention.

2.2.1 Human Resources Gaps. HIV/AIDS response institutions suffer chronic shortages in staffing and deficits in important technical areas related to BCIC. Key positions in health, education, research and other areas go vacant. Monitoring reports on the national response show the public sector operating with 40% of required staff for HIV and AIDS activities and equally critical, operating with 25% or less of required personnel for core business. Civil society operates with close to 50% of required staff in place. The resulting pressure on existing staff compromises their ability to perform effectively in core areas of responsibility, and in providing meaningful support for HIV prevention. The HIV and AIDS response effort is therefore weakened by the inability of national institutions to maintain an appropriately skilled response team in sufficient numbers for meeting HIV prevention, care and support needs at all levels.

2.2.2 Inadequate Operating Systems. Many public sector and civil society agencies begin programmes lacking necessary inputs for efficient functioning. It is not unusual to find systems for guiding, tracking and monitoring interventions being constructed well after start-up. Implementation begins without clarity on objectives, stakeholder involvement or baseline data. In addition to the guess work around programme design and key inputs for operations are sometimes missing. Appropriately skilled personnel, adequate staffing, reporting structures, relevant policies, agreements on terms of collaboration among partners are not always in place. It is also not uncommon to find systems for data management and communications within core team and across partners not formalised. These situations pose formidable challenges to staging a coherent response to HIV. Systems inadequacies result from human and financial resource constraint as well as poor planning. Coordination across sectors and between levels seems sporadic and activity-specific. Other ways in which institutional practices undermine effective prevention include:

- investing in interventions that do not adequately focus on principles of behaviour change
- providing prevention, treatment and care services with little or no linkages across services and provider agencies to reinforce prevention and facilitate continuity of care
- fragmenting delivery of complementary prevention services
- absence of or disregard for policy instruments guiding human rights-based response to HIV and AIDS
- operating staff not fully informed of laws and policy governing HIV and AIDS response within their
sectors or their absence.
- maintaining practices which reinforce gender stereotypes and gender inequality
- deployment of employees to posts away from their homes and family life.

## 2.3 INDIVIDUAL RISK BEHAVIOURS

Individual behaviours are shaped and supported within a broader socio-cultural and socioeconomic environment. Unprotected sex in relationships characterised by socioeconomic power, with multiple concurrent partners continue to drive the epidemic. They are the primary determinants of the epidemic in Botswana.

Sentinel surveillance and population-based surveys describe the persistence of risk behaviours. Key indicators include:

- age of first sex
- multiple concurrent sex partners
- condom use
- alcohol use and unprotected sex
- help seeking around STI
- voluntary counselling and testing

### 2.3.1 Age of First Sex


Median age of sexual debut had indeed improved to 18 years for females and 19 for males. However, a larger proportion of 15-19 year olds (6.8%) reported ‘having had sex’ in 2004 than in 2001.

BAIS II showed knowledge about AIDS decreased between 2001 and 2004. In 2001, about a third of males and 40% of females 15-24 years old provided correct responses to five questions about HIV and AIDS. In 2004, only 28% females and 18% males 15-24 year old gave correct answers to the same five questions. Further, for both surveys, young people were more likely to have correct responses than the general population and females were more likely to have correct information than males.

### 2.3.2 Multiple Sex Partner and Condom Use

Survey findings showed a significant reduction in the proportion of the population having more than one sex partner as well as the proportion engaging in unprotected sex with a non-regular partner(s).

Over half of males and females surveyed reported having more than one sexual partner (BAIS 2004). In 2004, 8.3% males and 3.4% females reported having more than one sexual partner. Multiple sex partnering was halved for
both males and females 15-24 years old but males remain twice more likely than females to have more than one partner. Condom use with non-regular partner increased dramatically among youth 15-24 years though less so for the general population. However, about 22% males and 31% females persist in unprotected sex with non-regular partners. Among youth 15-24 years, 12% males and 25% females continue to report more than one partner.

2.3.3 Alcohol and Unprotected Sex. The use of recreational drugs and their impact on sexual conduct has become an area of increasing concern. Alcohol use among young men was monitored in 2001 and among young people in 2004. Fifteen percent of young men, 15-24 years, reported unprotected sex after alcohol consumption in 2004. This represents an increase over 2001 levels of 5 percentage points. In 2004, 10.9% of female in this cohorts reported unprotected sex with alcohol consumption as well.

2.3.4 Sexually Transmitted Infections. Data on STI prevalence are incomplete and dated, despite the role of STI in facilitating HIV infection. The Central Statistics Office reported declining incidents of sexually transmitted infections between 1999 and 2001. However, 57% of 10-64 year olds surveyed in 2004 reported symptoms of STI in the 12 months preceding the interview. 81% percent of these sought treatment from a health worker and 19% sought treatment from Traditional Healers. Alarmingly, 9% of respondents who reported symptoms of STI said they continued having unprotected sex while on treatment.

2.3.5 HIV Testing. VCT increased dramatically with the scaling up of opportunities to test and expanded access to treatment. VCT in the general population more than doubled for females between 2001 and 2004. For males, testing increased from 18% to 24%. Twelve percent of males and 32% females 15-24 have been tested. Routine testing has produced similar outcomes with 5-6 thousand tests per month reported for 2004 and a doubling of that rate of acceptance for 2005. As the epidemic changes, new areas for attention emerge. One such area covers the ways in which PLWHA pose new challenges in the control of HIV and AIDS.

2.3.6 Risk Behaviours among HIV.

Data on the magnitude of risk taking among PLWHA do not exist. However there are indications that for some
once health status improves sexual activity resumes unprotected and with concurrent partners. There are also reports of discontinuation of ARVs with reduction in viral load. These behaviours present grave risk of continued transmission, re-infection and drug resistance.

Special attention is needed to support discordant couples in preventing infection of the HIV negative partner.

The increase in VCT is very encouraging as testing presents real opportunities for prevention education, risk management and early treatment.

Likewise achievements in partner reduction and condom use with non-regular partners are positive steps in reducing HIV infection. However, the misconceptions about AIDS that have taken hold, emerging trends around high risk sex under the influence of recreational drugs and the increasing proportion of 10-14 year olds reporting sexual initiation create expanded opportunities for infection. Patterns of increased condom use with non-regular partners are not convincing indicators of preventive behaviour. Self-reports of consistent condom use may in fact reflect individual perceptions rather than actual practice.

Given the continued high prevalence of HIV, there is need for much greater strides in prevention behaviours, particularly among children, adolescents, and other segments of the population facing greater vulnerability.

Sentinel surveillance data from 2001-2003 show continued increase in HIV prevalence. Current patterns of HIV prevalence show continued higher vulnerability for females and adults 25-39 years old, women in cohabiting, non-marital relationships and women with lower levels of education.

Gender inequality, poverty, population mobility, and unequal access to jobs continue to reinforce vulnerability.
The national response recognises the power of BCIC to motivate HIV-protective behaviours. BCIC is also an essential component of treatment programmes and initiatives for impact mitigation. About two-thirds of industries have instituted communications for HIV and AIDS complemented by print and radio campaigns at national level to motivate prevention. Public schools have instituted Life Skills Education (LSE) and increasing numbers of faith-based organisations and cultural institutions have joined the national response. However, the adoption and maintenance of HIV-preventive behaviours rests not only on multisectoral involvement but on the capacity to these response organisations to:

- sustain well designed, targeted BCIC
- influence the development of supportive social norms
- be provided direction and technical support for contributing effectively to the fight against HIV and AIDS

Section 3 outlines the National Strategy for strengthening BCIC. This strategy is informed by an analysis of BCIC performance against national targets established in the NSF. It takes into account, gaps in current BCIC response and emerging areas of vulnerability for Batswana. The strategy provides a common framework to be used by all sectors and focuses on three important areas:

1. building capacity for sound BCIC among implementers in HIV and AIDS response structures
2. strengthening systems for supervision and guidance within HIV and AIDS response structures including NACA
3. providing tailored technical assistance to address specific BCIC challenges

This three-pronged approach is described, followed by an overview of BCIC performance in supporting the national response. Section 3 concludes with a discussion of challenges to effective BCIC and recommendations on priority areas for BCIC.
3.1 GOAL AND OBJECTIVES

Goal

The goal of the National BCIC Strategy is to improve the effectiveness of BCIC efforts in motivating behaviours that prevent HIV infection and support treatment, care and support for people affected.

Objectives:

1. establish key principles of BCIC in the design, implementation, monitoring and evaluation of BCIC for HIV prevention; treatment, care, support and impact mitigation
2. strengthen institutional systems for guidance, coordination and alignment of BCIC efforts with national priorities
3. provide tailored technical assistance to address specific challenges faced by BCIC implementers in the field

3.2 STRENGTHENING BCIC: A THREE PRONGED APPROACH

The power of BCIC to motivate the adoption of HIV-protective behaviours is widely recognised. BCIC also contributes to positive outcomes in programmes for treatment, care and impact mitigation. Experience with BCIC for HIV prevention in diverse settings has shown that key elements of successful interventions include:

- increasing people’s ability to communicate effectively about sex
- increasing people’s condom use skills
- personalising risk of infection
- making risk avoidance a social norm
- providing social reinforcement and support for sustaining risk reduction
- changing policy, institutions, social norms and cultural practices that influence individual risk behaviours

Decentralisation of interventions for BCIC requires diffusion of the necessary knowledge and skills to deliver behaviour change interventions with these elements. Also required are:

- a common framework for all sectors
- institutional systems for supervising and guiding BCIC efforts
- technical support for improving BCIC programme efficiency
- partnerships for sustaining a comprehensive response
3.2.1 CAPACITY BUILDING FOR BCIC

The first prong of the National Strategy for BCIC attends to capacity building for designated BCIC implementers within the various HIV and AIDS response structures:

- Programme Coordinators
- Sector HIV/AIDS Focal Point Persons
- Community Health Workers
- Community Organisers
- PLWHA
- Media
- Programme Officers
- Religious Leaders
- Social Welfare Coordinators
- Teachers
- Youth Workers

NACA is the assigned organ for “ensuring that curriculum for programmes at each level meet the prioritised needs of the response.”

Using the curriculum designed for BCIC in 2004, National Master Trainers, a cadre of trainers who will be expected to train other trainers and implementers, will be trained and deployed to build capacity throughout the HIV and AIDS response structures. Capacity building will focus on the following areas:

- patterns and trends in HIV and AIDS
- principles of behaviour change
- community engagement for social change
- communications planning
- programme planning
- monitoring and evaluation
- gender equity promotion
- participatory research
- forging partnerships for sustained action
3.2.1.1 Trends in HIV and AIDS. Since 1992, systems for monitoring the epidemic have been in place. These include sentinel surveillance of pregnant women in public antenatal care (ANC) facilities and population-based AIDS impact surveys. An appreciation of patterns and trends within targeted groups is an important element of BCIC planning since these are significant for determining segmentation and BCIC focus.

3.2.1.2 Principles of Behaviour Change. BCIC implementers also need to understand how to motivate the adoption of HIV-protective behaviours –behaviours which sometimes defy prevailing social norms. For example, BCIC promoting abstinence among secondary school learners cannot rely on classroom presentations alone. To be effective, abstinence promotion programmes will also need to include activities that influence:

FIG. 8: A 3-Pronged Approach to Strengthening BCIC

- **CAPACITY BUILDING**
  - trends in HIV and AIDS
  - principles of behaviour change
  - community engagement
  - communications planning
  - programme planning
  - monitoring and evaluation

- **GUIDANCE FOR BCIC**
  - feedback from M&E
  - information management
  - communications

- **TECHNICAL SUPPORT**
  - for improved effectiveness of BCIC
  - for policy development
  - for resource mobilisation
  - for forging partnerships to sustain the effort

- **STRONGER BCIC PROGRAMMES**
  - implementers have requisite knowledge and skills
  - vulnerabilities and risk behaviours identified with community affected
  - KAP relevant to risk behaviours established
  - behaviour change/social change objectives defined with community
  - target audiences defined & segmented as needed
  - communication strategy determined with community
  - social norms influenced to lessen vulnerability & reinforce protective behaviours
  - strategies informed by research and lessons from the field
  - advocacy for policies and institutional practices to facilitate desired behaviours
  - M and E processes determined
  - feedback mechanisms in place for continuous improvement
  - partnerships in place for comprehensive response

NATIONAL STRATEGY FOR BCIC
- attitudes about having sex and its associated rewards
- perceptions about social, emotional and physical risks involved with abstaining from sex
- perceptions about peer behaviour and expectations around abstinence
- social skills to negotiate abstinence
- self-confidence about being able to abstain

3.2.1.3 Community Engagement. The effectiveness of the abstinence programme referenced above will also depend on the school’s capacity to engage the broader community in creating a climate in which:

- policies that prohibit sexual harassment and statutory rape by teachers and community members are enforced
- learners receive positive social reinforcement for remaining abstinent

For BCIC implementers, community engagement means working with the community to identify factors that pose HIV risks as well as factors that protect against HIV. Engagement entails ongoing dialogue with the community and the sharing of skills and resources needed for creating/reinforcing conditions that support HIV prevention, treatment, care and support.

3.2.1.4 Communications Planning. Communications planning refers to all the tasks that should be undertaken for designing comprehensive behaviour change interventions. It is based on having relevant information for:

- determining the specific groups of people on which BCIC efforts should focus to be most effective
- determining what target group(s) know, feel and do relevant to HIV risk and the environmental factors that influence their vulnerability to HIV
- establishing behavioural objectives for target audience(s) – defining the behaviours needed to stay HIV negative and what the target group needs to know, feel and do in order to achieve those behaviours
- developing a communications strategy – using information about the target group to develop audience-specific messages, build skills and create social supports for behaviour change
- determining the most appropriate and effective media for conveying those messages

Communications planning also involves pre-testing materials and methodologies for effectiveness with intended groups. Finally, communications planning includes monitoring and evaluation – keeping track of activities undertaken, their effect on the behaviours sought and their impact on HIV infection, treatment, care and support.

3.2.1.5 Programme Planning. BCIC programmes need to be planned in a within the larger cycle of programme planning to ensure that each BCIC effort is based on reliable data, careful analysis and well defined goals and objectives. Programme planning begins with situational analysis of the workplace, the village, the school – to ensure that the circumstances most relevant to the problem, as well as potential opportunities for mitigating that problem are addressed. This initial step helps implementers know how and
what their intervention can contribute towards a solution. Having well defined, locale specific goals and objectives make BCIC more manageable.

For example, a goal of the NSF and Vision 2016 is no new HIV infection by 2016. The goal of a workplace programme however, may be to reduce the rate of transmission from infected employees to their uninfected partners. Having specific, measurable objectives for BCIC provides structure for guiding implementation and management of the effort.

Other area for attention in programme planning is laying the groundwork for sustained programme effort beyond the specific project timeframe. This type of forward thinking needs to be built into planning.

3.2.1.6 Monitoring and Evaluation. Monitoring and evaluation is an integral part of programme planning. These are the processes through which information about programme activities and achievements are gained. For example, one objective of school-based LSE might be to enable all participating learners to negotiate abstinence until graduation. Through monitoring, the quality of programme inputs, the adequacy of coverage and barriers encountered are assessed. Evaluation demonstrates the impact LSE—whether those learners who were exposed to the intervention were indeed able to negotiate abstinence successfully until graduation. Together monitoring and evaluation let implementers know what is being done, how well it is being done and if the BCIC programme achieved what it set out to do.

3.2.1.7 Participatory Research Tools. Research plays an important role in every phase of BCIC programming. National and district level information on HIV infection should be complemented by target group specific research. Not all research requires complex technical activities although all require precision in executing standardised steps. Research methods which involve targeted groups are important for programme development.

3.2.1.8 Gender Equity Promotion. Strengthening BCIC also requires competences for gender equity promotion. Efforts that seek to prevent HIV and mitigate its impact must also address inequality in women’s and men’s access to and control over resources for HIV prevention, treatment, care and support. GEP in BCIC programme planning entails:

- analysis of power dynamics in male-female relationships that put women and men at risk for infection
- integrating strategies to alter those dynamics in BCIC programme design
- addressing institutional barriers to gender equity

3.2.1.9 Partnerships for Sustained Action. Interventions and communications for behaviour change require a range of communication vehicles and supportive services that are difficult to find in one response agency. Partnerships across agencies enable a broader range of supports for the differing needs of the target audience. For example, while schools provide LSE, community based youth service organisations or even commercial establishments can provide the same information and support for youth who are not in school. Similarly, sexual health
services can be provided through public health facilities, NGOs/CBOs, workplace programmes and private sector.

Building BCIC competences at all levels across sectors will strengthen the effectiveness of national response in motivating behaviour change.

3.2.2 GUIDANCE FOR BCIC

The second prong in the National Strategy for BCIC attends to strengthening systems for ongoing guidance and support. These include structures and routines for:

- communications and coordination
- information management
- monitoring and evaluation

NACA is assigned responsibility for coordination and management of the national response however each of the response structures also needs to have systems in place for managing implementation and monitoring of its own effort.

Monitoring and Evaluation. Behaviour change activities are monitored at national level through reporting to NACA and project specific assessments. Independent assessments are not systematically shared with NACA. Similarly, the circulation of findings from national surveys and impact assessments is limited to central bodies. Feedback derived from monitoring data, research findings and guidance derived from both does not occur routinely at national, district or community levels. BCIC implementers need timely feedback and guidance on their specific efforts. Programmes also need to understand if and how their efforts contribute to the national response.

Priority Areas for Attention:

1. build capacity of response organisations for monitoring and evaluating BCIC efforts and reporting back to community
2. instituting tighter follow-up and reinforcements for national implementing and research agencies to submit monitoring and evaluation data routinely to NACA
3. conduct operations research to identify and document effective models for BCIC
4. institute feedback system for BCIC response structures that summarises overall findings, highlights developments of relevance and profiles lessons from the field.

These feedback processes should require response agencies to engage their respective communities in processing findings as well as interrogating confounders or new trends documented. The monitoring feedback loop should also activate alerts for technical support.

Information Management. Systems for collecting and storing information for management decisions vary according to sectors and levels of response. Population level indicators for monitoring key behaviours are delineated in national guidance documents however; data collection does not always reflect these. Essential information is scattered across many systems. Many BCIC programmes develop interventions without the benefit of relevant data. Where information is collected, storage does not always allow for easy retrieval and broad access. BCIC efforts need support in instituting and utilising technologically appropriate management
information systems. At national level, NACA is charged with collecting and analysing information on the national response and feeding the findings back to the district and Ministries for BCIC planning. NACA’s web site and resource centre can be enhanced to better meet this need. Information relevant to BCIC planning should be made available and accessible through NACA’s web site and resource collection.

**Priority Areas for Attention:**
1. harmonise collection of data relevant to national response
2. provide support to national implementers for improved compliance with reporting
3. create a central repository of relevant data for common access
4. expand NACA website functions to provide access to data collected
5. create directory of HIV and AIDS services by district and post for public access

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### Communications and Coordination

Systems for communications and coordination are also needed within BCIC response structures for:
- establishing national, district and local for BCIC networks
- providing guidance, coordination and routine feedback from monitoring reports
- identifying gaps in BCIC efforts and emerging trends
- sharing research, best practice and
resources across levels and sectors involved in the national response. Internet and intranet can be upgraded to facilitate systems-wide, interactive communication and direct access to data bases. Where communities lack access to these electronic networks, paper distribution can be facilitated by sector HIV and AIDS coordinators at district level so that every response organisation is catered for. Communications networks and processes should be monitored to assess utility and efficiency at each level of response.

**Priority Areas for Attention:**
1. establishing BCIC networking at all levels
2. upgrading NACA’s website to enable access to quality data
3. formalising communication strategy for BCIC structures

### 3.2.3 TECHNICAL SUPPORT FOR BCIC

The third prong in this strategy is the provision of technical assistance for strengthening BCIC efforts at all levels of national response. Monitoring activities at national, sector and local levels will uncover some of the areas in which technical assistance is needed. When that happens, NACA can initiate or can be called on to facilitate technical assistance to specific efforts, e.g.:

- identifying potential sources of funding for local response
- enabling access to operational resources like equipment

### Priority Areas for Attention:
1. research to inform prevention programmes for HIV+ individuals
2. research to better understand motivators and barriers to condom use
3. analysis of BCIC coverage to identify gaps
4. research to inform development of partnerships for sustained response

### 3.3 OVERVIEW OF BCIC PERFORMANCE AGAINST NATIONAL TARGETS

Behaviour change interventions and communications have contributed to increased adoption of HIV-protective practices. Batswana have increased condom use and reduced the numbers of concurrent sexual partners. BCIC have also contributed to increased VCT and RHT. More Batswana know their HIV status and have accessed treatment, care and support services.
Despite these achievements, knowledge about HIV and AIDS deteriorated, many Batswana are not aware of priority interventions and support for PLWHA lag behind current demand. There is also slow adoption of important HIV-protective behaviours like abstinence among youth. Among the key HIV-risk behaviours the nation must continue to address and address more effectively are:

<table>
<thead>
<tr>
<th>Early sexual debut</th>
<th>Unprotected sex</th>
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<tbody>
<tr>
<td>Multiple concurrent sexual partners</td>
<td>Ignorance of HIV status</td>
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The following section assesses progress more systematically, using some of the indicators and targets set in the NSF.

3.3.1 Prevention

3.3.1.1. Overview of Progress in Meeting Prevention Targets

| ✓ indicates achievements | ✗ indicates shortfall in meeting target | ? indicates no data available to assess progress |

- ✓ HIV contamination of blood products eliminated
- ✓ proportion of sexually active Batswana with more than one sex partner declined
- ✓ condom use with non-regular partners increased
- ✓ prevalence of gonorrhoea, syphilis and chancroid decreased among FP clients.
- ✓ 86.9% of HIV+ women giving birth received ARV prophylaxis in 2005
- ✓ VCT increased to 23.9% among males and 38.4% among females
- ✗ 28.1% of youth 15-24 demonstrated correct knowledge of HIV and AIDS in 2004, less than the proportion of youth who did so in 2001.
- ✗ Median age of first sex was estimated at 18 years in 2004. The 80% virginity among youth 18 years old target could not be confirmed. However, data showed a higher proportion of 10-14 year olds reporting sexual initiation in 2004 than in 2001.
- ✗ Alcohol consumption and unprotected sex persists and at higher levels in 2004 than in 2001.
- ✗ Prevalence of herpes simplex virus (HSV) increased among FP clients.
- ✗ Only 77.9% of new ANC clients opted to test.
- ✗ 6.3% children 18 months to 4 years and 6% 5-9 year olds tested HIV+ in 2004.
- ✗ HIV prevalence among 15-19 year olds was reported 6.6 in 2004, slightly higher than prevalence for the same cohort in 2001.
- ✗ 23.1% 15-19 year olds using
public facilities for ANC tested HIV.

3.3.1.2 Challenges

1. A big challenge for BCIC is the promotion of a comprehensive approach to prevention and the formation of effective partnerships to do so. Comprehensive prevention communicates a full range of options for preventing HIV infection. Experience has shown that prevention efforts which present all effective approaches, in ways that are appropriate and accessible to the target audience, work.

2. BCIC planners are challenged to keep track of factors fuelling the epidemic. Assumptions on which programmes are built need to be tested and changes in the dynamics that influence behaviours need to be reflected in BCIC.

3. Prevention for positives has emerged as a new challenge to prevention efforts. As treatment improves physical and emotional health of PLWH, the resumption of sexual activities prevents renewed risk of transmission and reinfection.

4. A fourth challenge is the mobilisation of communities for meaningful participation in ongoing research, planning and social change.

5. Finally, BCIC which motivate males to protect themselves and their partners from HIV infection remain a formidable challenge.

3.3.1.3 Strategies for Strengthening Prevention

- Expand targeted BCIC aimed at reducing concurrent sexual partnerships, normalising VCT, supporting couples with disclosure and enabling broader access to prevention services for PLWH and general population.
- Implement targeted educational campaigns to eliminate misconceptions about HIV, AIDS, alcohol and sex.
- Strengthen and expand Life Skills Education (LSE) in schools and community programmes for youth.
- Integrate BCIC for prevention in treatment and care settings.
- Strengthen & expand partnerships for wider coverage and more comprehensive BCIC.
- Develop BCIC for enhancing parent-child communications around sexuality and HIV risk behaviours.
- Expand gender sensitive BCIC for motivating increased HIV testing, partner reduction and fidelity among males and females.
- Expand support for community mobilisation around HIV prevention and gender equality.
- Enhance community capacity to sustain prevention effort beyond the life span of projects.
Expand opportunities for group testing and cohort support for remaining HIV.

Review and revise policies that contradict a human rights approach to national response, including restrictions on young people’s access to VCT and SRH services.

### 3.3.1.4 Priority Areas of Focus for Prevention

<table>
<thead>
<tr>
<th>PRIORITY AREAS</th>
<th>STRATEGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BUILDING PARTNERSHIPS FOR</strong></td>
<td>- recruit and train community institutions to provide or support access to a comprehensive range of coordinated and complementary HIV interventions</td>
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<tr>
<td><strong>COMPREHENSIVE COVERAGE</strong></td>
<td>- engage communities in the creation of social norms supportive of HIV-protective behaviours</td>
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<td></td>
<td>- build capacity of traditional health practitioners (THP) and PLWHA to support prevention</td>
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<td></td>
<td>- strengthen referral networks between THP and health facilities</td>
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<td></td>
<td>- build capacity for BCIC for PWD within these partnerships</td>
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<tr>
<td><strong>STRENGTHENING WORKPLACE</strong></td>
<td>- link workplace initiatives to health care services for HIV prevention, treatment, care and support</td>
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<tr>
<td><strong>PROGRAMMES</strong></td>
<td>- create opportunities for peer support in maintaining healthy, low-risk lifestyles in workplace programmes</td>
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<td></td>
<td>- institute workplace programmes for health sector personnel</td>
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<tr>
<td></td>
<td>- integrate communications on community supports, rights, universal precautions, post exposure prophylaxis (PEP) and management of HIV contaminated waste products in workplace programmes</td>
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<tr>
<td><strong>PREVENTION IN TREATMENT &amp;</strong></td>
<td>- integrate prevention education and support into clinical care and home based support</td>
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<tr>
<td><strong>CARE SETTINGS</strong></td>
<td>- create medical network to ensure PEP coverage for rape survivors</td>
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<tr>
<td></td>
<td>- expand HIV prevention services (universal precautions, post exposure prophylaxis (PEP) and management of HIV contaminated waste products) in treatment and care settings</td>
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<tr>
<td><strong>PREVENTION WITH POSITIVES</strong></td>
<td>- expand BCIC aimed at prevention for positives</td>
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<td></td>
<td>- expand support and support groups for treatment adherence and positive living</td>
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<td></td>
<td>- expand involvement of PLWHA in counselling and psychosocial support for pregnant HIV+ women</td>
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<tr>
<td>PRIORITY AREAS</td>
<td>STRATEGIES</td>
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</tbody>
</table>
| GENDER EQUITY PROMOTION  | ■ mobilise sector and community leaders to intensify promotion of shared responsibility for HIV prevention among men  
                            ■ enhance capacity of response agencies to integrate gender analysis and gender equity promotion in BCIC  
                            ■ empower women to assert themselves in sexual decision making and socialise men to share power in that arena  
                            ■ advocate for dismantling of customary practices which disadvantage widows and children |
| HIV TESTING              | ■ expand and target marketing of VCT services with special attention to males, couples and adolescents  
                            ■ expand BCIC aimed at making HIV testing the norm for couples before they introduce sex into the relationship  
                            ■ create peer networks for group testing and support for remaining HIV negative  
                            ■ expand mobile VCT and SRH services for commercial sex workers, mobile and hard to reach populations  
                            ■ improve counselling for RT to ensure informed consent |
| CHILDREN & YOUTH         | ■ enhance comprehensive, developmentally appropriate LSE with integrated HIV and AIDS in all educational institutions and youth service organisations (YSO)  
                            ■ enhance LSE skills of people who work with children & youth  
                            ■ improve youth access to gender-sensitive, youth friendly SRH services  
                            ■ build parents’ skills for communicating with children on sexuality and HIV prevention  
                            ■ mobilise cultural & religious institutions to create structures for reinforcing delayed sexual debut and youth development  
                            ■ integrate abstinence options in all HIV prevention efforts  
                            ■ expand youth access to quality recreation and youth development programmes  
                            ■ advocate for harmonisation of legal and policy instruments to enable greater access to VCT for young people  
                            ■ educate communities on laws protecting minors from sexual exploitation and abuse and enforce those laws |
| SEXUAL PARTNER REDUCTION | ■ develop BCIC to promote faithfulness to one sexual partner  
                            ■ develop BCIC aimed at reducing the number of sexual partners  
                            ■ mobilise community institutions to reinforce social norms supportive of faithfulness to one partner and reform norms fuelling the epidemic |
<table>
<thead>
<tr>
<th>PRIORITY AREAS</th>
<th>STRATEGIES</th>
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</table>
| **CONDOM USE** | - expand targeted social marketing, distribution and support for use of male and female condoms  
- build capacity of females to negotiate partner/client acceptance use of condoms or initiate discrete use of female condom  
- expand peer and clinical counselling support for couples on condom use, with special attention to discordant couples and PLWH  
- advocate for condom availability in prisons & same-sex facilities  
- expand condom distribution in motels, hotels, high transit areas, construction and trade industries |
| **MANAGEMENT OF STI** | - build capacity of health care personnel to effectively treat STIs  
- equip staff and health facilities to implement more effective diagnostic protocols in the management of reoccurring, non-responsive STI  
- motivate observance of patient rights, including confidentiality, among health care personnel  
- expand public education on STI targeting rural communities, men and groups with low levels of formal education  
- implement gender equitable strategies for promoting greater males utilisation of SRH services |
| **PMTCT** | - implement gender sensitive strategies to encourage males’ attendance at ANC with partners  
- improve counselling on PMTCT for expectant women who test positive and their partners  
- stage targeted awareness campaigns on PMTCT services, particularly in communities with demonstrated low levels of awareness  
- encourage testing before delivery for women who refused RT  
- strengthen and expand community support networks for HIV+ couples in PMTCT programmes  
- reinforce social norms for parenting responsibly  
- expand involvement of PLWHA in counselling and psychosocial support for pregnant HIV+ women |
### 3.3.2 Treatment, Care and Support

#### 3.3.2.1 Progress in Meeting Treatment, Care and Support Targets

- ✓ indicates achievements  
- ✗ indicates shortfall in meeting target  
- ? indicates no data available to assess progress

- ✓ By the end of March 2005, 89.5% of persons who met the criteria for treatment were enrolled.\(^{37}\)

- ✓ In March 2004, 65% of households meeting the established criteria received some form of support.\(^{38}\)

- ✓ Capacity for syndromic management of sexually transmitted infections improved with the training of 575 health providers since 2003.\(^{39}\)

- ✓ Capacity of health sector to manage OI improved with the training of 554 health providers between 2002 and 2003.\(^{40}\)

- ✓ Home-based care has identified 5,672 orphans and potential orphans thus far. BAIS II identified a total of 110,916 children who lost one parent and 23,316 who lost both.

- ✗ 87% of communities polled in
BAIS I reported AIDS as their major health problem yet in 2004 only half reported awareness of ART.41

Less than half Batswana are aware of support for PLWHA and only four out of ten know about IPT.42

The impact of treatment on HIV bed occupancy and PLWHA productivity are unknown.

Patterns in access to ARVs could not be determined since data was not disaggregated.

BAIS attributed 34.2% of deaths to TB in 2004.43 Available data on IPT uptake did not address its impact on HIV/TB co-infection.

3.3.2.2 Challenges

1. Expanded access to treatment has brought to the fore, a number of challenges. The first of these is the necessity to strengthen prevention behaviours among PLWHA on HAART, particularly discordant couples. This includes support for disclosure.

2. Infants at risk of infection through maternal transmission and children living with HIV pose special challenges for treatment, care and support. Parents and infants need psychosocial and economic supports to maintain alternative breast feeding practices, to adhere to ARV prophylaxis and to attend clinic visits for monitoring the HIV status of their child. Further, as treatment prolong the lives of children with HIV, parents, teachers and the community at large need to be equipped to provide appropriately for their physical and emotional needs.

3. Treatment literacy, i.e., knowledge of HIV progression to AIDS, medications and treatment options for PLWHA, how they work, work, where and how to access them, side effects and their management, prevention of drug resistance, etc., needs to be improved among healthcare personnel, PLWHA, their families and home-based caregivers. Treatment preparedness and wellness management are also needed. These gaps impact adherence negatively.

4. Stigma undermines treatment adherence for PLWHA and inhibits the expansion of care and support services. PLWHA are fearful that maintaining treatment schedules will attract negative attention when they resume normal activities and either shy away from re-entry to productive lives or compromise treatment regimen to avoid notice. Care givers are also affected. Sometimes they are cut off from the vital support of relatives and friends.

5. Finally, the over reliance on females for care and support limits expansion of these services and denies PLWHA the potential advantage male involvement could bring to the field. Males, in turn, who have more leisure time and financial resources, miss another opportunity to contribute positively to the response by extending care and support.
3.3.2.3 Strategies for Strengthening Treatment, Care and Support

- Expand buddy systems for treatment adherence, to support HIV+ parents in protecting infants from infection and caregivers for dependent children and adults.
- Integrate couples counselling in ANC. Counselling provided couples should focus on testing, disclosure, prevention for couples, treatment and care of HIV+ mother and infant.
- Expand BCIC campaigns to promote awareness of PMTCT, ART and IPT treatment programmes in ways that reach communities on the periphery.

3.3.2.4 Priority Areas of Focus for Treatment, Care & Support

<table>
<thead>
<tr>
<th>PRIORITY AREAS</th>
<th>STRATEGIES</th>
</tr>
</thead>
</table>
| AWARENESS OF TREATMENT AND CARE INTERVENTIONS | ■ expand awareness campaigns for PMTCT, IPT & HAART targeting groups with low rates of participation and communities with low rates of awareness  
■ enlist & train community institutions on promoting HIV and AIDS related services  
■ increase public education on HIV, pregnancy and HAART  
■ integrate GEP in BCIC for treatment services  
■ integrate HAART, IPT, PMTCT counselling in SRH, ANC, TB services |
### National Strategy for BCIC

#### Treatment Literacy
- Expand awareness campaigns on HAART, HIV progression & sources of treatment for general public.
- Implement awareness campaign on patent rights.
- Train PLWHA and caregivers on positive living, disease progression, recommended medical procedures, treatment regimens and human rights.
- Improve access to information on treatment options through targeted communications, including communications for people with disabilities.

#### Treatment Access
- Promote greater awareness of treatment services – HAART, IPT, PMTCT and how to access them.
- Expand service points for treatment to ensure equity in access to treatment.
- Improve reliability of health system and adequacy of trained personnel to support treatment of OI and other HIV and AIDS related conditions.
- Address negative attitudes of health workers & observance of protocols for ensuring confidentiality.

#### Couples Counselling
- Expand small group, interpersonal education, counselling and skills building to strengthen partner reduction, fidelity and other prevention behaviours among couples.
- Expand BCIC to support disclosure of HIV status.
- Integrate GEP in counselling to motivate shared responsibility for HIV prevention, treatment and care.
- Engage community in the creation of social norms that support faithfulness to one sexual partner.

#### Treatment Preparedness, Adherence and Wellness Management
- Expand buddy system to support treatment preparedness and adherence with special attention to males, pregnant women and caregivers to dependent PLWHA.
- Integrate prevention education & skills building into all treatment and wellness management programmes.
- Mobilise male sector to support other men in treatment adherence and prevention.
- Engage community in addressing stigma and discrimination and in creating a supportive environment for treatment access and adherence.
- Expand involvement of PLWH to provide interpersonal support to peers in treatment preparedness, adherence and wellness management.
### ORPHANS AND VULNERABLE CHILDREN

- expand community support structures like day care centres, group homes, supervised recreational facilities
- strengthen capacity of indigenous community structures to identify and provide protection, care and support to children made vulnerable by HIV and AIDS
- expand community-based networks to support children in need and ensure continuity of care
- implement developmentally appropriate treatment literacy for children & youth
- enhance coping skills of OVC and care givers with special attention to child-headed households and families headed by the elderly

### CARE FOR PLWHA

- mobilise community to expand the pool of caregivers for children and adults living with HIV and AIDS
- integrate gender sensitive approaches to recruitment efforts to increase male participation in care giving
- recruit and train CBO and traditional institutions to provide counselling, nursing care and support for meeting psychological, spiritual, economic and legal needs
- create of community networks to ensure continuity of care
- provide AIDS care training that reinforces treatment literacy, palliative care, universal precautions and human rights
- increase registration of households eligible for home-based care and provision of support to those households
- increase community-centred provision of nutritional support to families in need

## 3.3.3 Impact Mitigation

The impact of HIV and AIDS in terms of lost skills and lost productivity has been documented in many studies on the various sectors and the nation at large. For example, UNDP assessment of the impact of HIV and AIDS on the education sector suggests that if teachers have the same health risk as Batswana with the same age and gender profile, it is possible that half of all teachers could be infected. These losses filter down to households, snatching not just income, but parents from children and safety nets from communities across Botswana.
3.3.3.1 Progress in Meeting Impact Mitigation Targets

✓ indicates achievements  ✗ indicates shortfall in meeting target
? indicates no data available to assess progress

✓ orphans were as likely to be in school as children with living biological parents

✓ 89% households with orphans received assistance in 2004, 44% report monthly food parcels; 40% school fees

? Achievements in the other measures selected to assess impact mitigation were difficult to assess. For example, increased employment of people with HIV is difficult to ascertain without careful tracking, particularly when employment in the informal sector is high. Illness-related absenteeism poses similar challenges. Ministries reported more than 50% of all benefit time used was claimed for illnesses. However sick time may be used for care of others as well as self and is not beyond abuse.

3.3.3.2 Challenges

1. In an economy where a quarter of the work force is officially unemployed and a third employed in the informal sector⁴⁶ employment of PLWH experiencing any signs of illness will be difficult.

2. Children experiencing long term illness and loss of parent(s) need special psychological, economic and social support. Providing these supports in an already under-resourced education system remains a challenge.

3. Chronic poverty make mitigation more complex than the provision of food baskets and school fees. Education increases the likelihood of good health and economic self sufficiency but children in poor communities have little access to productive assets. Only about 50% of junior high school graduates go on to senior high school⁴⁷ with or without parental support. Securing positive futures for all children remain a big challenge.

4. Monitoring of the indicators selected to measure impact mitigation may prove too difficult an undertaking with present human and data management resources.
3.3.3.3 Strategies for Strengthening Impact Mitigation

- Advocate for increased, long term investments in sustainable development so that communities are in a better position to be self-sufficient.
- Develop livelihood programmes for PLWHA and unemployed youth.
- Stimulate development of community-owned gardens to supplement nutrition needs of families in need.
- Support community-initiated solutions to meeting the needs of people affected by HIV and AIDS.
- Review and reform customary law that deny women and children the right to inherit property and other assets.
- Empower communities to review practices that render widows and children destitute when a spouse dies. Rekindle that spirit of Botho articulated in Vision 2016.
- Ensure that people with disabilities have access to interventions for mitigating the impact of HIV and AIDS.
- Increase legal literacy around the rights of workers, PLWHA, women and children and around recourse when those rights are violated.
- Expand opportunities for psychosocial supports for children and their caregivers at community level, including structured recreation and counselling.

3.3.3.4 Priority Areas of Focus for Impact Mitigation

<table>
<thead>
<tr>
<th>PRIORITY AREAS</th>
<th>STRATEGIES</th>
</tr>
</thead>
</table>
| COMMUNITY DEVELOPMENT        | - develop the consciousness, skills, capabilities and systems to enable communities and their indigenous institutions to contribute to mitigating the impact of HIV and AIDS  
- improve access to information, skills, capital and technologies that can enhance community development and economic self sufficiency  
- facilitate meaningful partnerships across communities, CBOs and donor agencies for impact mitigation  
- advocate for greater flexibility in funding for local initiatives and create mechanisms for better management of small grants to local initiatives  |
| CHILD DEVELOPMENT           | - mobilise increased investment in community based services for children and youth development  
- ensure children's rights to protection from neglect, exploitation and abuse  
- create opportunities for continued education, internships employment and quality recreation  
- integrate life skills and income generation in programmes for youth development  |
3.3.4 Creating an Enabling Legal Environment

The national composite policy index used to assess progress in development of policies and strategies that support a strong national response to HIV and AIDS measures adequacy of national strategic planning, comprehensiveness of BCIC promoting prevention and the degree to which a supportive, human rights-based, ethical and legal environment that conforms to international standards has been created. The creation of an enabling legal environment, in turn, is measured through:

- the enactment of laws and regulations that protect people living with HIV and AIDS from discrimination
- the creation of policies that ensure women and men equal access to services for prevention and care
- the creation of policies to ensure proper review and approval of research protocols involving human subjects

Botswana’s progress on this index is discussed below in Section 3.3.4.1.

3.3.4.1 Progress in Creating an Enabling Environment

In 2002, Botswana met only one of these conditions –ethical review of research involving humans. It has since succeeded in the development of policies that mainstreamed HIV/AIDS concerns into strategic planning at national and district levels. In 2004, a review of all laws, regulations and policies having a bearing on HIV and AIDS was undertaken. The review analysed guidance documents for their compatibility with human rights instruments to which Botswana is signatory. It also assessed legal options for dealing with HIV and AIDS within a human rights framework.

Neither the constitution nor law prohibits discrimination by private persons or entities. In the absence of laws, cultural practices that discriminate against women continue to heightened women and girls vulnerability to HIV and AIDS. For example customary law gives men the right to ‘chastise’ their wives; confers ‘marital power’ which contravenes women’s right to bodily integrity, property and economic opportunities.

Likewise, discrimination against persons with HIV and AIDS is not restrained by laws but by conscience. For example, employers do not have statutory obligation to not disclose health information on employees, neither is there statutory prohibition against pre-employment testing. “Employers have the common right to demand pre-employment testing.”

Contradictions in legal statutes on age of consent create differential access to prevention services. For example, differing definitions of age of majority inhibits youth access to VCT but not to alcohol consumption.
There is however, no contradiction between a human rights approach to HIV and AIDS and public health. “Promoting human rights helps ensure a more effective HIV prevention programme.”

There is need to support legal review for the amendment and harmonisation of laws to protect vulnerable populations, and advocacy to create a more enabling legal environment for the HIV and AIDS response.

3.3.4.2 Challenges

1. Issues of law and policy are not generally accessible to the lay public. The common lack of familiarity with what is considered a specialty field makes it difficult to engage a broad cross-section of Batswana in changing this situation.

2. The review of laws and policies, and their implications for the national response to HIV and AIDS will require time and resources of an already over-burdened legal system. Alleviating backlogs within the legal system and freeing personnel to address these issues remains a formidable challenge.

3. Customary law provides rulings on many civil matters related to family and marital conduct. Many of these have a direct bearing on the position of women and children in relation to men. Male privilege is engrained in culture and customary law, a condition that renders women and children more vulnerable to exploitation. The necessity for change in this area, without weakening the integrity of tradition and customs as a whole, will require careful negotiations and full the participation of the community.

4. Finally, people with disabilities are amongst the most marginalised in the society. For them, concerns around rights and entitlements are generally relegated to survival needs and their dependency on others makes them more vulnerable to exploitation and neglect. Policies and the policing of those are needed to ensure that people with disabilities can access information and services for HIV prevention, treatment, care and support. Further, policies are needed to protect disabled persons from sexual exploitation and neglect in institutional or community-centred care settings.

3.3.4.3 Strategies for Creating a More Enabling Environment

- Complete interrogation of findings from the constitutional review process already undertaken.

- Draft legislative changes to give effect to recommendations for mainstreaming human rights into Botswana’s legal environment for HIV and AIDS.

- Develop policy for children and HIV/AIDS that addresses sexual abuse of children and strengthens children’s rights to SRH information and care.

- Engage traditional leaders who administer and enforce customary law and community representatives in dialogue around needed reforms.
### 3.3.4.4 Priority Areas of Focus for a More Enabling Environment

<table>
<thead>
<tr>
<th>PRIORITY AREAS</th>
<th>STRATEGIES</th>
</tr>
</thead>
</table>
| **LEGAL LITERACY**   | - train local cadres to conduct legal education at the workplace and in the community on the human rights, the rights of workers, women and children, related laws and options for legal recourse  
                        - implement legal literacy campaigns in a range channels accessible to people with low levels of literacy, limited English and Setswana proficiency and people who are visually or hearing impaired.  
                        - implement legal literacy campaigns for all segments of the community, with special attention to groups whose rights are most frequently abridged –the poor, illiterates, minority ethnic groups, PWD, sex workers, etc.  
                        - sensitise traditional leaders to and the ways in which customary laws impact equality in the community  
                        - promote education on patients’ rights in relation to confidentiality and RT |
| **POLICY**           | - develop policy for children and HIV/AIDS that addresses sexual abuse of children and strengthens children’s rights to SRH information and services.  
                        - harmonise policies with conflicting authority for age of consent  
                        - review the criminalisation of commercial sex work, and potential advantage for prevention if this area of work were regulated instead  
                        - revise policy on distribution of condoms in prison and rehabilitation centres  
                        - review and develop policy for ensuring that information and services for HIV prevention, care and support are made accessible to people with disabilities |
Behaviour Change Interventions and Communications programmes are fundamental to the national response. By knowing more about what behaviours and social change are needed for respective communities and what BCIC strategies work, more effective programmes can be staged to realise national goals for HIV prevention, treatment, care and support. Monitoring and evaluation (M&E) show if and how BCIC programmes are working. Together, they measure programme achievements and provide valuable information on how programmes interact with other events and forces at implementation level. M & E allow managers and staff to assess the quality of their activities and services and the extent to which BCIC is reaching its intended audience. Monitoring and Evaluation:

- support strategic planning
- help organisations prioritise resource allocation
- improve information for advocacy and fund-raising
- provide motivation for staff
- provide evidence for the effectiveness of BCIC program approaches

M&E findings, when shared, can help the community and other stakeholders understand what the program is doing, how well it is meeting its objectives and whether there are critical needs inhibiting progress. They identify approaches worth replicating or scaling up. Sharing results contributes to the body of knowledge on best practices that can strengthen national response. M&E also uncovers unmet needs and barriers to programme success and can be used to lobby for policy or legislative changes.

In the case of the National Strategy for BCIC for HIV and AIDS, monitoring and evaluation is intended to assess:

- implementation
- the capacity of BCIC implementers
- systems developed for communication and coordination as well as
- impact of the strategy on aligning BCIC to national priorities
- impact of resulting BCIC initiatives on indicators specified in the NSF

Section 4 describes the monitoring and evaluation plan for the National Strategy for BCIC.
4.1 MONITORING THE NATIONAL STRATEGY FOR BCIC

Monitoring and evaluation of the National Strategy for BCIC will be focused on the degree to which:

1. the strategy has been implemented as designed
2. the capacity of BCIC implementers has been built to integrate principles of behaviour change in programmes for HIV prevention, treatment, care and support—the quality and effectiveness of the processes involved
3. systems developed for communication, coordination have succeeded in guiding BCIC efforts as well as
4. the overall impact of the BCIC strategy on guiding sectors in their development of programme activities aligned to national priorities

5. the overall impact of resulting BCIC initiatives on population level indicators specified in the NSF

The following monitoring plan is based on a three year action plan. Thereafter the strategy will be evaluated and, if useful, extended to coincide with the next NSF for HIV and AIDS. Implementation of the BCIC strategy will depend on the participation of all response structures and the strength of the systems designed for coordination. In both areas, the employment of sufficient, appropriately skilled, dedicated staff is absolutely essential.

Key indicators of progress in implementation of the BCIC strategy are highlighted below under each of the three objectives and goal already reflected in Section 3.

### Objective 1: Capacity Building for BCIC Implementers

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>WHO</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. staff for coordinating capacity building activities in place</td>
<td>NACA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. 40 Master Trainers trained</td>
<td>NACA</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>3. 300 personnel trained in BCIC</td>
<td>NACA, SECTORS</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4. trained BCIC implementers in 100% response sectors</td>
<td>SECTORS</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>5. 75% BCIC interventions reflect principles of behaviour change &amp; BCIC planning</td>
<td>SECTORS, NACA</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>6. 75% BCIC interventions address one or more priority areas in strategy</td>
<td>NACA, SECTORS</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>7. interpersonal channel of communications integrated in 90% BCIC activities</td>
<td>SECTORS</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

MONITORING AND EVALUATION
### Objective 2: Institutional Systems Strengthening

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>WHO</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. staff designated to facilitate coordination, communications and technical support</td>
<td>NACA</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. systems for communications and coordination of BCIC operationalised</td>
<td>NACA SE Cors</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. feedback provided on programme performance, including data reporting</td>
<td>NACA SE Cors</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4. feedback integrated into program implementation</td>
<td>SE Cors</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5. systems to support monitoring and reporting implemented according to plan</td>
<td>SE Cors</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>6. distribution of quarterly report summaries institutionalised</td>
<td>NACA DMS AC</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>7. feedback &amp; guidance for BCIC efforts provided where indicated</td>
<td>NACA SE Cors</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>8. lessons learned documented and distributed</td>
<td>NACA DMS AC</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>9. info on new resources distributed through formal distribution points</td>
<td>NACA DMS AC</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>10. HIV and AIDS data &amp; resource materials housed in NACA resource centre</td>
<td>NACA SE Cors</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>11. HIV and AIDS data &amp; resource materials posted on NACA website</td>
<td>NACA</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Objective 3: Technical Assistance for BCIC Implementers

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>WHO</th>
<th>TARGETS</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. technical assistance provided in response to programme requests</td>
<td>NACA</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2. technical assistance initiated on the basis on quarterly reports</td>
<td>NACA</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3. BCIC programme adjusted to reflect TA</td>
<td>SECTORS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Goal: Improved Effectiveness of BCIC Response

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>WHO</th>
<th>TARGETS</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. achievement of behavioural objectives sought in BCIC</td>
<td>SECTORS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2. achievement of behaviour change targets established in NSF</td>
<td>SECTORS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

4.2 MONITORING AND EVALUATION FOR BCIC

4.2.1 Recommendations for Monitoring and Evaluating BCIC Programmes

BCIC programmes face tough challenges in monitoring and evaluation, particularly when programmes lack human and financial resources for core services. Below are suggestions from practitioners in the field on how to approach M&E.

**Monitor what your system is set up to deliver.** Base your M&E effort on the knowledge and behaviours your BCIC aims to change and the processes assumed to influence those changes. Basing M&E on these indicators helps document how programs are working and, if they are successful, aids in their replication and adaptation.

Assess working assumptions about the factors that influence behavioural outcomes. Assess what is believed about the influences assumed to affect behavioural outcomes. Increased understanding of the assumptions on which BCIC are built will strengthen programme choices.

**Test and document the elements that contribute to programme effectiveness.** A number of elements contribute to programme effectiveness, e. g:

- staff expertise
- message content
- mode of communications
define your objectives realistically and provide enough time to measure changes. ensure that objectives clearly state the outcomes BCIC are expected to produce and budget sufficient time before attempting to measure expected outcomes.

use a combined qualitative and quantitative approach. Qualitative methods can be used to assess social and cultural contexts as well as inform areas of inquiry for quantitative assessments. Qualitative data can also be used to interpret the findings of quantitative surveys and may reveal program results not discovered through quantitative methods.

quantitative methods ensure standardised data collection over time and enable definitive measurement of changes in outcomes that can be generalized to the larger population. they can also be used to show that changes are due to your program activities.

use monitoring and process data to support impact evaluation. conducting outcome and impact evaluations requires resources and time, and even those that are well-designed may not show conclusive results. using monitoring and process evaluation data can strengthen the results of outcome and impact evaluations. the information collected through monitoring and process evaluation will also help build the case that the changes were a result of your program, even if an impact evaluation is not feasible. documenting factors such as service utilisation, programme participation and effect of programme strategies will strengthen the case that your program produced the desired outcomes.

engage in a genuine participatory process. evaluation that engages and involves stakeholders and staff is more likely to produce reactions that are critical and honest than those conducted exclusively by external experts. a participatory process also encourages the community and staff to utilize the information from evaluations and own evaluation results. giving community the opportunity to discuss and analyze their concerns, and to suggest and enact solutions, may also increase effectiveness of BCIC in reaching their behavioural objectives.

ensure that your data collection effort addresses ethical concerns. professional standards of conduct as well as moral principles and values should be exercised in monitoring and evaluation.

be creative in assessing sensitive areas. asking questions of a sensitive nature, while difficult, can be done successfully in many different settings. first, get support from a broad range of community stakeholders. second, obtain the necessary consents, particularly for minors. third, employ “skip patterns” to avoid explicit questions on sexual practices if youth who have not had sex are involved.

monitoring and evaluation

reach and frequency of message
community involvement

use M&E to establish which elements work and the conditions under which they work.
Learn by trial and error. Some areas of assessment require learning by trial and error. For example, we are learning that we can ask questions about sexual behaviour even in settings with very traditional values. Who asks the questions, how we ask the questions, or the place in which we ask the questions may need to be modified in each setting. Build on what is works as more systematic approaches to monitoring and evaluation get developed.

Limit evaluation costs when possible. Outcome and impact evaluation can be costly, however there are ways for pro-
grams to limit costs and still produce valid results. For example, an evaluation can examine only those outcomes most important to your program. Measuring outcomes that require less costly data collection methods or utilise existing data can also reduce costs. Training and utilising staff to conduct some parts of the evaluation may be feasible for some programs. A sound sampling strategy can help you limit the amount of data collected without compromising the validity of your evaluation results.

4.2.2 Features of Good M&E for BCIC

Monitoring and evaluation can provide valuable insights for improving BCIC performance and for maintaining excellence in efforts. Whether programmes are based at the workplace, in community settings or attached to a larger national effort, systems for M&E can be designed to provide the information needed to guide programme staff. Features of good monitoring and evaluation practices for BCIC programmes are described in Table 3.

<table>
<thead>
<tr>
<th>TABLE 3: Features of Good Monitoring &amp; Evaluation Practices for BCIC</th>
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</thead>
<tbody>
<tr>
<td><strong>ORGANISATIONAL</strong></td>
</tr>
<tr>
<td>M&amp;E functions established within BCIC programme activities</td>
</tr>
<tr>
<td>systems indicators for BCIC performance established</td>
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<tr>
<td>adequate budget provided for M&amp;E activities</td>
</tr>
<tr>
<td>formal M&amp;E link with NACA (BHRIMS) established</td>
</tr>
<tr>
<td>data processing, statistical and BCIC expertise available for M&amp;E</td>
</tr>
<tr>
<td>M&amp;E data dissemination plan established</td>
</tr>
<tr>
<td><strong>PROGRAMME DESIGN</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>DATA COLLECTION AND ANALYSIS</strong></td>
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<td></td>
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<tr>
<td><strong>DATA DISSEMINATION</strong></td>
</tr>
</tbody>
</table>
## TECHNICAL WORKING GROUP MEMBERS

1. Richard K. Matlhare  
   NACA
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   NACA
3. Bekure. Hawaz  
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   NACA
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   DPAC - MOH
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   DPAC - MOH
8. B.L. Shah,  
   DPAC - MOH
9. Elizabeth Koko  
   DPAC - MOH
10. Oemetse.S. Nkoane  
    MOE
11. Kushata Mosienyane  
    MLHA
12. Boitumelo. Motshidisi  
    MWT
13. Kedibonye D. Macha  
    MLG
14. Joan Sullivan  
    ACHAP
15. Irene Marina  
    UNAIDS
16. Rosemond O. Khumi  
    UNICEF
17. Liydia Seeletso  
    BOTUSA
18. P. M. Shrestha  
    BONEPWA
19. Bagaisi Phaphe  
    BONASO
20. Irene Kwape  
    BOCAIP
21. Tinah Molatlhegi  
    BNYC
22. Lorato Mothusi  
    YOHO
23. Dimakasso Toitoi  
    MTI
(Endnotes)


2 This indicator combines UNAIDS Knowledge Indicator Number 1 and 2 which assessed both knowledge of factors that reduce risk of HIV transmission and misconceptions about AIDS. See BAIS 1& II.

3 *Botswana AIDS Impact Survey II*, op. cit.


6 ibid. For a complete description of the objectives and targets set, see pp 23-30


10 BAIS II reported unemployment rates of 60% among youth 15-19 and 45.6% among young adults 20-24 in 2003.


13 BAIS II, op. cit.


15 BAIS II, op. cit.

16 MOH, op. cit.

17 ibid.

18 ibid.

19 BAIS II, op. cit.

20 There is no hard data on this indicator for Botswana. Discussions at the Zero Transmission Conference in Francistown (20-22 September, 2005) suggested that there is discordance in HIV status in 22-30% of couples testing.


22 BHRIMS op. cit.

23 The underlying assumption is that first sex experiences are personal choices and not the result of rape. This needs further investigation.

24 BAIS I, op. cit.


26 BAIS II op. cit.

Data for this assessment were drawn primarily from BAIS II. Data from other sources are referenced.


MOH, This figure represents the numbers of trainers trained, data on actual numbers of providers trained are not available.

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NACA, UNICEF. Botswana HIV Response Information management System (BHRIMS), May 2003


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