A TECHNICAL ASSESSMENT OF THE BOTSWANA HIV/ AIDS PREVENTION PROJECT

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SWDS

Social Welfare and Development Services (Pty) Ltd

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LIST OF ABBREVIATIONS

AED	Academy for Educational Development
AIDS	Aquired Immune Deficiency Syndrome
AWP	AIDS in the Workplace Project
BDF	Botswana Defence Force
BFTU	Botswana Federation of Trade Unions
BOCCIM	The Botswana Confederation of Commerce, Industry and Manpower
CDC	Centers for Disease Control
DPSM	Directorate of Public Service Management
GOB	Government of Botswana
HIV	Human Immune Deficiency Virus
IDM	Institute of Development Management
IEC	Information, Education & Communication
MLGLH	Ministry of Local Government, Land & Housing
MoH	Minsitry of Health
NACP	National AIDS Control Programme
NGO	Non Governmental Organisation
NORAD	Norwegan Development Organisation
OHU	Occupational Health Unit
STD	Sexually Transmitted Disease
UB	University of Botswana
UK	United Kingdom
ULGS	Unified Local Government Service
UNICEF	United Nations Childrens Fund
UNDP	United Nations Development Programme
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organisation

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FOREWORD AND ACKNOWLEDGEMENTS

This report presents the findings of the Technical Assessment of the Botswana HIV/AIDS Prevention Project.
The Assessment was conducted between August 10th and 25th 1992 by a combined team of Botswana based and external consultants.
The report considers the project's development, current status and sustainability in the future. A variety of recommendations are offered to help to build upon an admirable foundation.

Many different individuals and organisations have contributed to this assessment. In the companies, organisations and the BDF, special thanks must go to the working group members and the coordinators who so willingly devoted their time and energy to the task.
Special acknowledgements go to the Ministry of Health and especially to the Community Health Services Division and the Aids in the Workplace Project Coordinator for commitment and energy, advice and assistance throughout this assessment.

This thanks extends to the Assessment Reference Group which guided the progress of the work and offered comments and suggestions on the final draft report.

The assessment was funded by U.S.A.I.D.

While gratefully acknowledging the support and assistance of so many individuals and organisations, the views expressed in this report remain those of the assessment team and do not necessarily reflect those of the Ministry of Health or the Government of Botswana, the companies and organisations participating, nor USAID.

Eva Procek
Team Leader

September 1992

EXECUTIVE SUMMARY

This summary presents a brief overview of the major issues raised in each section of the assessment.

Introduction

The Assessment Team consider The Botswana HIV/AIDS Prevention project an unequivocal success as judged by the strength of support for the programme and the extent of its implementation in all of the participating companies and organisations. This is not to say that it is does not have some major weaknesses which need to be addressed. Also the mechanisms required for institutionalisation and sustainability of the programme are clear, practical and attainable even given the inevitable resource constraints.

1. Context of HIV/AIDS in Botswana

Botswana has an integrated primary health care system and no specialised clinics for STD treatment therefore it is not easy to calculate the STD incidence rate However HIV sentinel surveillance took place from 3 February - April 30th1992 at 4 sites in Botswana with results indicating that one in four adults of sexually active age in Francistown and one in six of sexually active age in Gaborone may have HIV.

2. Project Activities

The basic guiding principle of the AIDS in the Workplace Project is that the workplace is a convenient, effective and regular location to reach many men and women of strategic importance to business and society.

Further, that the strategy of peer education is appropriate and effective in this context.

A review of the project indicates that all of the organisations selected have established programmes at their workplace - they have selected coordinators who have been trained and who have selected and trained a number of peer educators. They too have conducted a variety of educational activities for and with their coworkers, with the exception of one or two companies which adopted different patterns

Two study tours were undertaken, one highly effective tour of Zimbabwe and one judged as much less so to USA.

3. The Workplaces

Each workplace' s pattern of project implementation is decribed and recommendations made to improve effectiveness.

The major strengths identified are the commitment and energy of the workplace implementers and the fact that they are continuing to sustain and develop the programme.

The major weaknessess identified concern the lack of strategic planning, the need for closer and more visible involvement of the very top managers and the lack of monitoring and evaluation procedures

The peer educators are the most recent stratum of the project and they are clearly still "feeling their way". In some contexts they are facing real difficulties in gaining access to their peers for educational activities.

4. Materials

A variety of materials have been produced and are being used as an integral part of the project - posters, guides and a brochure. Many of these were produced under immense pressure and remain in draft form. Almost all require revision and reformatting to make them more 'user friendly' and attractive.

It is recommended that an information pack be available to interested companies from the Occupational Health Unit and this should be finalised as a matter of urgency.

5.The Occupational Health Unit

The Occupational Health Unit has taken major responsiblity for planning, coordinating, materials production, training and motivation for the project and has fulfilled these tasks with energy, enthusiasm and skill. It is recommended that the programme remain here with increased staff and with a.'ditional training and support.

Some of the current Unit activities should be contracted out to non - governmental organisations and companies.

6.The Working Group

This Group has functioned as the key support and communications network for the project and has acted as advisory and consultative body to the development of the project. It depends upon the coordinating services of the Occupational Health Unit. It is recommended that the group continue but reconsitituted as an Advisory Board with clear Terms of Reference.

7. Insitutionalisation and Sustainability of the Project

The future of the programme and its expansion require that it should

continue to be housed in a strengthened Occupational Health Unit which has some clearly formulated goals for the programme and an attractive information pack available to interested companies at low or no cost. There is a need for positive action to be taken in terms of programme monitoring and quality control
Advocacy must be sought and coordinated from the highest levels of all the organisations involved
Each company must put in place a strategic plan detailing clearly how, when and where peer education is to take place.
Future financing will depend upon a continuing partnership between the companies and the Ministry of Health (with donor support) with the small companies depending heavily - services to this group should be made available at little or no cost. The larger companies are already making significant financial contributions to their own programmes and indicate a willingness to continue.
The programme should now be expanded to other companies.

8.Impact of Project Efforts to date and Baseline Data for Future Impact Evaluation

STD data are probably the best proxy measure of project impact but unfortunately, data is scanty. Organisations with medical facilities report a decline in STD rates [eg BDF Francistown reports approximately 20% decline] but these are not accurate.
The project is clearly associated with greater knowledge about AIDS and increased demand for and uptake of condoms.
It is recommended that the national STD reporting and surveillance be improved and that organisations with medical facilities track STD trends more closely.
Those organisations without medical facilities should use a simple evaluation survey

9.Additional Recommendations concerning Activities Outside the Project

The workplace based project should be combined with intensive targetted intervention among "high risk" groups within the community. Peer education led community outreach is suggested, especially in Selibi - Phikwe and Orapa. These are seen as being most appropriately conducted through the Local Authorities.

SUMMARY OF RECOMMENDATIONS

Introduction

The MoH/USAID pilot AIDS in the Workplace prevention project is an unequivocal success as witnessed by the number of other companies and workplaces either setting up their own programmes or coming forward to join this programme. Given the high rates of HIV + in Botswana it is a moral imperative for businesses that the project should be sustained and supported in the future. A remarkable feature of the project is the degree of cooperation which exists between all the participating agencies - within the Ministry of Health, between the Ministry of Health and the Red Cross, between the Occupational Health Unit and the companies and within the participating companies. It is clear that trust and confidence exist.

It is within this extremely positive context that the following recommendations are made.

They are organised into broad groups - Minstry of Health and the Occupational Health Unit, Materials, Project Implementation in Companies, Working Group, Financing of the Programme, General

Ministry of Health

1.The Occupational Health Unit of the Ministry of Health should continue to house the programme and provide its coordination and management

2. The current draft policy on AIDS is an excellent document which should be speedily formalised and circulated

3.A mechanism should be established for top level advocacy of the project to top level management in the companies ie from the highest level in the Ministry of Health to the highest level in companies

4. A Clear management structure should be formalised to ensure coordination and communication between OHU& NACP and OHU and community AIDS programmes.This would include clear role definitions for NACP and OHU and other involved organisations

5. The Ministry of Health should support the project with a minimum of 2 full time members of staff - the current Programme Coordinator and a second member of staff who should be specially selected for his/her workplace experience and interest in AIDS

6.The Ministry of Health should support the project with earmarked secretarial and transport services

7. Communications channels between the NACP Manager and the Director of BOCCIM should be formalised for effective advocacy and programme promotion

8. The Ministry should strive to improve STD reporting and surveillance

9 Additional training should be arranged for OHU staff - this could include visits to community projects in Zimbabwe, the Red Cross Workplace training programme (USA), course/s at Toulane (USA), AIDS Programme Management Training (Institute of Tropical Medicine, Antwerp), workplace programme visits in USA & UK, and training in sociology of the workplace.

10 The OHU should formulate some clear general goals for the programme

- to add a minimum of 20 new workplaces t the programme each year

- each worker in each workplace will know the basic route of transmission, primary preventive strategies and ways in which HIV is not transmitted

- programme seeks to reduce casual sexual partners by 20% each year

- programme seeks to increase condom use by 100% in the first year and 50% in the second year

11.The OHU should develop criteria for excellence of peer educators and training programmes which incorporate minimum standards

12. Weekly monitoring by peer educators should be initiated by coordinatorsand consolidated into monthly forms.
The OHU should compile the coordinators monthly forms into a quarterly activity form report for general circulation

Materials

13. Materials production should be contracted out to a private contractor

14. Revision of existing programme training materials should be completed immediately by a Botswana resident organisation - ideally before the next phase of the programme.

Recommended revisions:

Coordinators guide

- reformatting in larger type
- emphasising most important information
- printed in smaller more accessible sections
- each section printed in a different colour
- attractive packaging
- inclusion of pictures and photographs where relevant
- inclusion of table of contents
- inclusion of simple checklists
- production of critical information on one sheet which could be easily copied
- more stress on process of peer education
- expanded list of resources to include addresses and telephone numbers
- inclusion of sources of advocacy with top management
- more emphasis on the planning phase of programme development

Managers Guide

- inclusion of sections on policy implementation, listening skills, basic adult education , how to support peer educators and how to implement employee education
- heavy emphasis should be placed on making time and space available for peer educators to conduct peer education

Peer Educators Handbook

- reformatted with checklists, fact sheets and clear examples of which topics are most important
- include case studies from coordinators manual
- include safer sex negotiation

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- include some of the following:
    - active listening skills
    - accessing time and space for peer education
    - materials and tools available
    - what should be communicated
        - basic facts about AIDS and HIV
        - how AIDS can be prevented
        - why there is no risk of spread from casual touch
        - how to respond to a co worker with HIV/AIDS
        - company benefits regarding HIV/AIDS
        - confidentiality and privacy issues
        - where to go in the company for help
        - additional community resources and confidential information sources
        - how co workers can talk to family members

<u>Brochure</u>

Produce an additional colourful brochure for a lower reading age and highlighting illustrations

<u>Posters</u>

- more posters to be made available
- other posters produced (up to 12)

<u>Video</u>

Production of a Setwana Botswana based video on AIDS is vital - this should be contracted out to a private company

15 The proposed information pack should be finalised and made available to companies at low or no cost through the BHC. It should include

- Principles/ Policy for the Workplace
- clear guidelines for planning and setting up a workplace based programme
    - planning should include a management plan for condom supply and distribution
- revised training materials
- contact persons, addresses and telephone numbers
- clear statement of programme goals
- clear statement of programme objectives (see Appendix 8.5 for an example of 'Strategic [illegible] Objectives')
- clear statement of the roles and responsibilities of all parties
- clear information about training

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16. The relationship between the NACP Materials Development Unit the Health Education Unit and the GHHE should be strengthened

17. Materials should be updated at regular intervals
18. A video recorder and tapes loan programme should established (possibly with donor assistance)

19. Materials development to be secondary to and supportive of face to face dialogue in small groups and participative rather than didactic

Working group

20. The Working Group should be reconstituted as the Advisory Board for Workplace Aids Education Programme- for advice and policy formulation
- Membership be reviewed to include representatives from other strategic sectors eg Information, Commerce and Industry , MHGL, H & DPSM
There should be sub groups dealing with specific issues

21. The Advisory Board should have detailed Terms of Reference which should be drawn up by the current Working Group

21 A Subsidiary Working Group or Groups should of programme implementers should be formed regionally as the programme expands
- the AWP coordinator should be a member of and coordinate all such groups

Project Implementation

Study Tours
22. Future study trips to USA should be undertaken only by staff involved directly in programme implementation and should include visits to AIDS in the Workplace Programmes in US companies

23. Future study trips to Zimbabwe should be undertaken, perhaps by middle management as they are directly involved in programme implementation. These may need to be grant aided.

24. Visits from business leaders outside Botswana to the Botswana programme should not be encouraged at this stage as the programme is

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still in its infancy.

BOCCIM

25. An advocacy group should be formed consisting of the Director of BOCCIM, the Permanent Secretary of the Ministry of Health and one or two leaders of industry to give the highest possible level of leadership and support to the AIDS in the Workplace programme

26. BOCCIM should continue to play a key advocacy role in the programme

27. BOCCIM should organise a seminar/ workshop for its members on 'The Economic Impace of AIDS at the Workplace in the 1990s', to be addressed by a health economist.

BFTU

28. BFTU should focus its efforts on AIDS Education and Prevention work in their consitutuent unions as the organisation has unique insight into and experience of their circumstances

29. The proposed AIDS in the Workplace Programme should be closely coordinated with the programme activities of the OHU

Companies (general recommendations)

30. Top management should give direct and visible support to the AIDS in the Workplace programme in their company (ie Chief Executive Officers, Managing Directors or General Managers) through briefings and circulars

32. Monitoring and quality control systems should be operationalised Individual Peer Educator Monitoring Forms should be compiled by the coordinator into Monthly AIDS Education Forms, the results of which should be widely disseminated throughout the company.
Quality control should always be supportive not punitive

33.Each company to put in place a stategic plan which would clearly detail when, where and how Aids education is to take place, and wherever possible make funds available

AIDS Training Plans should be produced by each company - produced jointly by the coordinator and a senior personnel manager after detailed

workplace consultations especially with supervisors to ensure that each worker receives AIDS education on a regular basis.

This plan should include a plan for the when, where and how of condom supply and distribution

34. Coordinators training should place more emphasis on programme planning and implementation, monitoring and evaluation, and educational and counselling techniques

35. Peer educators should be selected with great care

36. Peer educators' training should be more intensive and should emphasise STD/HIV facts, organising and leading meetings, communications techniques and basic adult education. This training should be practical, job related and supported by close field supervision.

37. Each coordinator should identify what motivates peer educators and as far as possible ensure that these incentives are provided. Sources of motivation may include access to training, occupational privileges, greater visibility and status at work and opportunity to be of service to others.

38. Peer educators should be involved in distributing condoms and materials as this enhances their visibility and importance

39. When more peer educators are recruited the coordinators should foster supportive groups which entails providing opportunities for the group to meet, discussing and planning activities with peer eductors and including them in programme review and evaluation.

Financing

40.The Ministry of Health should continue to fund a minimum of 2 posts for the AIDS in the Workplace programme plus earmarked secretarial and transport support

41.The training of coordinators (& peer educators where appropriate) should be contracted out to a non governmental organisation using donor funding (if possible)

42.The Centre for Continuing Education at University of Botswana and

other appropriate bodies should be invited to prepare proposals for coordinator and peer educator training

43. Small businesses will depend heavily upon OHU - services should be available at minimum or no cost

44 Large companies should be able to provide time, space and facilities for AWP education This should include:

- purchasing training and materials for training of coordinators

- supporting coordinators to attend coordinators meetings and workshops

- contributing (as appropriate) to community outreach programmes and medical care

45 Small companies should provide time, space and motivation

46. An AIDS in the Workplace Fund should be set up by companies - the management of this and the mechanisms for disbursements from it to be determined by the Aids in the Workplace Advisory Group

Future Impact Evaluation

47. Companies with health centres should track STD trends more closely

48. Simple evaluation surveys should be undertaken by all companies which examine :

exposure to programme activities
AIDS knowledge
risk perception
reported sex behaviour
reported condom use

General

49..Workplace education should concentrate on face to face interaction and small group particpatory methods.

50. Advocacy of the programme to be shared between BOCCIM, BFTU and OHU

51.The programme should be expanded to other businesses throughout the country

52. Another project should be established to expand the AIDS in the Workplace Programme to central and local government through the involvement of DPSM and ULGS

54. Community peer education programmes in the major urban and semi urban areas should play an important role in complementing and reinforcing the workplace programmes. These are recommended as an urgent priority.

METHODOLOGY

Team Composition

Social Welfare and Development Services (Pty) Ltd (SWDS), Francistown, Botswana was contracted by USAID to provide two consultants and to provide evaluation support The third and fourth members were external consultants contracted by USAID to work in collaboration with the local company.The Field work for the Assessment was conducted between August 10th - 25th 1992.

The 4 consultants :

Mr Taka Mudariki	Centre for Continuing Education, University of Botswana, Francistown, Botswana
Dr Eva Procek	Social Welfare & Development Services Francistown, Botswana
Dr David Wilson	Department of Psychology, University of Zimbabwe, Harare, Zimbabwe
Dr Margaret Scarlett	Centers for Disease Control, Altlanta, USA

This team structure was intended to optimise the technical resources available for the assessment by combining in - depth knowledge of the programme environment through the local company with expertise gained through substantial experience with peer education for AIDS prevention elsewhere in Africa and extensive experience of workplace based AIDS prevention programmes in the USA and elsewhere.
It was anticipated that this collaboration would assist to strengthn capacity and capability to implement future AIDS - related activites locally.

The Terms of Reference for the Technical Assessment are found in Appendix 1.

Primary issues of focus were identified for each team member but the consultants worked concurrently and in close collaboration with other team members.A sample of the different focuses of interest of the consultants within a single company can be found in Appendix 2.

Dr Eva Procek was designated Team Leader , a joint decision between SWDS, USAID and the Ministry of Health, to coordinate collaboration between team members, and to ensure consistency of findings and recommendations.
The external consultants remained in Botswana until the final draft report was completed.

The Assessment Team worked very closely with the Project Officer at USAID and the Project Coordinator at OHU and through them to the Assessment Reference Group.

Methods and Procedures

Data was collected through document review, key informant interviews, systems review and site visits. Visits were made to all the companies participating in the project, 3 BDF camps [Gaborone, Selebi - Phikwe and Francistown], Debswana, Orapa, the Red Cross in Gaborone and Francistown and the Ministries of Health & Labour In addition ,visits were made to Rotary Club meetings in Gaborone and Francistown
The Literature Review, list of documents reviewed, the persons interviewed and the assessment programme can be found in Appendixes 3,4, 5 & 6.respectively

CONTEXT OF STD/HIV IN BOTSWANA

Botswana's population is 1.3 million of which 48% are under 15 years of age and 83% live in rural areas.

Botswana's reporting system does not easily lend itself to calculation to the STD incidence rate as STD services are part of an integrated Primary Health Care Service, but STD are clearly common.

In 1989, 145,000 persons attending out patient clinics were diagnosed as having an STD. Since many present more than once for each episode, this does not represent the annual number of episodes. However if each person presents three times per episode, then 8.5% of sexually active adults (aged 15 - 49) had an STD episode in 1989. If the average STD presentation per episode is two then the rate was 12.7%.

AIDS was first reported in Botswana in 1985. As of June 1992, 350 cases had been reported to the Ministry of Health, but computer models suggest that 2,400 people in Botswana may have AIDS.

From February 3 - April 30th 1992 sentinel surveillance took place among antenatal women and male STD patients at four sites in Botswana. The results are presented below

Site	**Context**	**Antenatal Women HIV Prevalence**	**Male STD Patients HIV Prevalence**
Gaborone	Urban	14.9% (N= 841)	21.8% (N=385)
Francistown	Urban	23.7% (N= 796)	-
Maun	Semi - Urban	12.7% (N= 299)	-
Mahalapye	Semi - Urban	-	23.2% (N=168)
Total	Mixed	18.1% (N=1936)	22.2% (N=553)

Thus, one in four adults of sexually active age in Francistown and one in six of sexually active age in Gaborone may have HIV.
Nationwide, the Ministry of Health estimate that 28,000 to 40,000 Batwana may have HIV. HIV infection is highest among men aged 30 - 34 and women aged 20 - 24

Comparison of the sentinel surveillance with earlier, non standardised surveys suggests that HIV seroprevalence may have doubled from early 1991 - early 1992.

The epidemiology of HIV in rural areas, where most Batswana live, is unclear
However, the high prevalence in Maun indicates that HIV is not confined to the large urban areas. Several factors have contributed to rapid HIV transmission in Botswana, including high levels of other STD, rapid urbanisation, disproportionate numbers of single men in such mining towns as Orapa and Selibi - Phikwe, high mobility, work - related family separation, the proximity of much of the population to rail, road and trade routes to Zimbabwe and Zambia, social and economic vulnerability of women and low rates of condom use.

PROJECT ACTIVITIES AND IMPLEMENTATION I

Introduction

Project achievements to date include:

1. Two study tours were undertaken
- one group visited the USA to make contact with agencies involved in AIDS Policy formulation and technical assistance and the second, a group of business leaders, visited Zimbabwe on an observational tour to get first hand experience of AIDS education at the workplace.

2. An Aids in the Workplace Task Force was formed and continues to function

3. The Aids in the Workplace Coordinator has a strong organisational base and support within the Ministry of Health

4. There is a functioning Working Group for the Aids in the Workplace project

5. Materials for both managers, coordinators and peer educators have been produced although they are still in draft form and require revision and finalising

6. Two posters have been produced

7. A total of nine coordinators have been trained from the companies and organisations selected to participate in the pilot project

8. All of the organisations selected have established programmes at their workplaces .
Each workplace has its own unique pattern of operation and relationships which have shaped the way in which the project is implemented.

Guiding Principles

A review of different health education paradigms indicates three dominant models:

> the behaviour change model which seeks to improve health by changing peoples' behaviour
> the self - empowerment model which attempts to improve health by developing peoples' ability to understand and control their health status to whatever extent is possible in their circumstances
> the collective action model which is concerned to improve health by changing environmental, social and economic factors through community involvement and action.

The HIV/AIDS Prevention in the Workplace Project currently operates from within the first two of these paradymes -

> "Health Education is any combination of learning activities that encourage voluntary adaptation in human behaviour which will promote health, prevent disease and help recovery and rehabilitation. People should be helped and encouraged to understand health problems and choose the most appropriate solutions for themselves"
> [Coordinators Guide pg 22]

The project operates with the assumptions that prevention of HIV infection can be effected through education, that the workplace is an effective site for education, and that peer education is the most appropriate structuring prinicipie for this preventive education

> "Many lessons have been learned from previous and ongoing HIV/AIDS prevention programs and can be summarized as:
>
> Programme planners and educators must understand and relate to the identified audience. (e.g. local language)
>
> Personal communication by trained peers is the key factor in re - inforcing more generalised educational efforts. While general education and information campaigns provide knowledge, behaviour modification requires more.
>
> Effective prevention programs must be based on giving answers to specific problems (e.g. negotiating skills)

Extensive and continual monitoring and evaluation is an essential component of any prevention programme

HIV/AIDS prevention is forever. Thus, prevention programs and education messages must be understood as continual effort and not as a one time project.

The goal is to reduce risk behaviour and to decrease the transmission of HIV."
[Coordinators Guide Pg 15]

Further, the elements of a Workplace HIV/AIDS Prevention Programme are detailed

"1. The major issues of prevention in Botswana relate to sexual behaviour

2.Sexual transmission of HIV is reduced by changing sexual behaviour, condom use, STD diagnosis and treatment and HIV diagnosis

3. Regardless of the preventive efforts some employees or their family members will become infected with HIV and progressively develop AIDS. Their needs are for supportive regulations and services"
[A Management Guide Section VI]

"The most economically productive segment of the work force is the population most threatened by HIV/AIDS. These are men and women between the ages of 20 and 49 years. This makes the workplace a particularly effective place to implement HIV/AIDS programmes because many people can conveniently be reached and because particular relations typical of work settings create pressure for behavioural change among work peers.....
THE WORKPLACE IS A CONVENIENT, EFFECTIVE AND REGULAR LOCATION TO REACH MANY MEN AND WOMEN OF STRATEGIC IMPORTANCE TO BUSINESS AND SOCIETY"
[A Management Guide Section IV]

Stated Project Goals and Objectives

"1.To strengthen the capacity of the Occupational Health Unit of the Ministry of Health and Botswana Defence Force to develop and conduct HIV/AIDS prevention activities in the workplace.

2.To develop an HIV/AIDS training program suitable for use in a variety of workplace settings throughout Botswana

3.To facilitate the establishment of a long - term relationship between representatives of the MOH, BDF and Botswana's NGO community and professionals from the university and health sectors in the US who are working in the area of HIV/AIDS prevention and health education.

4. To develop a program which can be shown to provide economic benefit to businesses and which businesses will therefore be willing to provide the costs of continued HIV related training and health education of its workers"
[Project Agreement USAID & GOB]

The Occupational Health Unit of Ministry of Health also framed its own objectives

Long Term Objectives

1.To control and prevent HIV infection among workers in Botswana
2.To reduce the sickness, absence and mortality rates due to HIV infection/AIDS at the workplace
3.To reduce the social and economic impact of HIV infection and AIDS at the workplace

General Objectives

1.To raise AIDS awareness among workers through various activities
2.To set up workplace AIDS education programmes for workers in conjunction with primary health care systems
3.To conscientise workers of the effects of high risk behaviour and its relation to AIDS
4.To promote safe sexual behaviour among workers through promotion of condom usage
5.To provide accurate updated information on HIV infection to all workers and their families [Internal MoH document]

Brief background to and development of the project

August 1990
The Agreement was signed

U.S.A.I.D and the Ministry of Finance & Development Planning signed the agreement for project No 698 - 0474 - 38
"To assist the Government of Botswana to strengthen the effectiveness and efficiency of its HIV/AIDS related activities through establishing more effective HIV prevention programs in the workplace"
The project was originally funded for one year at a cost of US$ 100,000 but was extended for a further 1 year until July 1992 and then again until November 1992

November 1990
The Manager of the National Aids Control Programme in the Ministry of Health instigated the programme and the Occupational Health Unit was identified as the organisational base for the project. A key worker, a family nurse practitioner, was nominated the Aids in the Workplace Project Coordinator
Intitial contact with companies was made by the NACP Manager

The NACP Manager contacted BOCCIM with some suggestions of companies and BOCCIM in turn contacted a variety of companies with details of the proposed project.
The Occupational Health Unit already had extensive contacts with a variety of companies through their family planning projects and other workplace activities.

A trip to USA was undertaken - the Aids in the Workplace Project Coordinator in the Occupational Health Unit was nominated as the Ministry of Health representative - the other members were representives of the NGOs (the Red Cross), the BFTU and the BDF.

January 1991
The Task force was formed

The US trip members were consituted into a Task Force which worked with the NACP Manager to draw up a programme for a team of consultants, identified by USAID, to assist in setting up the Botswana project and to develop materials.
A schedule was produced and the companies' involvement was confirmed.

May 1991
A Team of 3 consultants assisted with programme planning and materials production
The project was publically launched in one day seminar

A team of 3 consultants was identified by U.S.A.I.D. and 2 of them arrived together (1 from Kenya, designated the team leader and 1 from Zimbabwe)
whilst the third (from Zambia) arrived one week later
A comprehensive programme of visits to all the companies identified for the project was made by the 2 consultants who in turn briefed the third member of the team

A one day seminar to launch the project was attended by the Permanent Secretary in the Ministry of Health, general and personnel managers from invited companies, representives from BOCCIM and from a variety of organisations involved in funding or supporting AIDS related activities in Botswana [UNDP, UNICEF, WHO, NORAD, USAID]

After two weeks of team activity two of the consultants left and only one remained to produce the draft training manual for the company coordinators.

June 1991
The Aids in the Workplace Coordinators were selected by companies
The Working group was formed
The first training workshop for coordinators was held

The 5 Companies involved were:

Company	Number of employees	Male	Female
Algo Industries	655	173	482
Kgalagadi Breweries (Gab)	578	470	108
Gaborone Sun	469	240	229
BCL Selibi Phikwe	5138	5017	121
Botswana Defence Force	not available		

plus BOCCIM and BFTU.
A sixth company MANICA FREIGHT contacted the Occupational Health Unit and requested to participate in the project
Each company identified one or more coordinators (based on their own criteria)

A Working Group was formed of the Personnel Managers of these Companies, representatives of BOCCIM, BFTU and the BDF and key officials from the Ministries of Health and Labour & Home Affairs. This working group was seen as the potential backbone of the project both in its current phase and for the future.

The first 3 day training seminar for coordinators was conducted by the consultant team.The schedule was not entirely clear and some participants expressed confusion at the end of the training.
After the first seminar MANICA withdrew from the project.

The team of consultants, working under extreme time constraints left with the training manual in draft form, the posters yet to be completed (one for women workers and one for men workers) and the other materials (a general brochure for workplace distribution, a peer educators handbook and 2 manuals - one for managers and one for coordinators) still on the drawing board.

June/July 1991
The posters and brochure were completed
One consultant returned to work on materials production and the posters and brochure were completed.

August 1991
Zimbabwe trip undertaken by leaders of industry

A three day trip to Zimbabwe was organised for selected influential business leaders in Botswana to expose them to aids education and prevention activities.

September 1991
The Handbook & Managers manual were completed
The second training workshop for coordinators was conducted
The handbook and managers manual were completed by one consultant who also assisted in a second training workshop for coordinators. This was designed to reinforce knowledge but in some cases coordinators had changed and this was their first training.
This workshop appears to have marked a transition in the confidence of the coordinators and their 'ownership of the project and its programmes'
Each coordinator constructed his her own work plan at the end of the workshop and left to put this plan into action.

By the time the remaining consultant left, the revised manual was available, the posters were ready and the managers manual produced.

November 1991 - January 1992
A working definition of `peer educator' was established and the deadline of the end of February set for peer educator training to be completed
Peer educators received training

The Task Force held meetings with the coordinators in November and again in January 1992 to plan the selection and training of peer educators
An agreed working definition of `peer educator' was established; it was agreed that peer educator training would last 3 - 5 days and selection of peer educators to be based on the coordinators' personal experience and knowledge of the specific workplace and personnel. The numbers of peer educators and their distribution in the work place was to be decided by the coordinators in the light of their own specific circumstances.

A deadline was set for the end of February 1992 for peer educators to have been trained by the coordinators.
The materials were all supplied by the Ministry of Health
This training was undertaken with the following exceptions :
1.MANICA had already withdrawn from the project
2.ALGO had problems with a venue for training the peer educators and eventually the training was conducted by members of the Task Force in in OHU premises and at their expense.
3.GABORONE SUN - the coordinator, also the company training officer decided against the peer education approach as AIDS education was already being implemented

February 1992
Peer educators operational

The peer educators began to initiate educational activities with their peers (small group and large group discussions, individual question and answer sessions, question boxes etc)

March 1992
Follow up of peer educators by theTask Force
The Task Force visited all the coordinators and peer educators and spent a full day in each workplace with them

The parties and groups involved in the the project are:

1. **USAID &The Ministry of Finance & Development Planning**

2. **The Ministry of Health**
   Head of Community Health Services
   Manager of National Aids Control Programme
   Head of the Occupational Health Unit
   AIDS in the Workplace Project Coordinator, OHU

3. **The Task Force**
   - 4 members (who visisted USA) -
   AIDS in the Workplace Project Coordinator
   Representative of the Red Cross (representing NGOs)
   Representative of BDF
   Representative of BFTU

4 **The Working group**
   Personnel managers or training managers of all 5 companies - report progress in their companies and financial issues
   Manager National Aids Control Programme- information on NACP
   Head of Occupational Health Unit- clinical aspects of HIV/AIDS
   Head of Community Health Services - liason with Ministry of Health
   Rep of BFTU - union and advocacy issues
   Rep of BOCCIM - companies and industry
   USAID - financial issues
   Project coordinator
   BDF doctor
   Chief Factories Inspector
   The working group is understood to act as the major planning force and to provide the `backbone' for the future development of the programme

5. **The Coordinators group**

Regular meetings are held between the AWP Coordinator and the coordinators which are rotated between the companies with each company providing a venue, tea, lunch and where possible accomodation Where this pattern poses difficulties the Occupational Health Unit fills the breach

PROJECT ACTIVITIES AND IMPLEMENTATION II

THE STUDY TOURS

Two study tours were undertaken as part of the AWP pilot project - one to USA and the second to Zimbabwe

1. THE USA TRIP

U.S.A.I.D financed 4 people to visit the United States in November 1990 with the stated purpose of providing a 2 week orientation for assisting in the development of an AWP programme in Botswana.
The participants were:

- the Aids in the Workplace Coordinator , OHU respresenting Minstry of Health
- a representative from the Botswana Red Cross
- a representative of the Botswana Federation of Trade Unions and
- a family nurse practitioner, representative from the Botswana Defence Force

This group was identified as being the possible instigator of the Botswana Aids in the Workplace programme and did in fact go on to form the AWP Task Force.

Programme
Visits were undertaken to Walter Reed Hospital in Bethesda, Maryland, the National Institute of Health, a Public Health Research Facility not currently involved in Aids in the Workplace; AIDSCOM of the Academy for Educational Development (AED), as well as AIDSTECH and the various communication arms of John Hopkins University. A trip to New Orleans included a visit to a prosititute prevention programme.

Overview
A review of the trip report from the Aids in the Workplace coordintor revealed that the US trip was of limited value as the Botswana project was only at the initial stages of development and the coordinator's experience was extremeley limited, making it difficult to 'ask the right questions' .
No meetings were scheduled with US businesses which had workplace AIDS education programmes.
Also none of the US contractors visited were known for AIDS in the workplace activities. Since 1990, AED has provided technical assistance to Uganda (March 1992). This assistance included evaluation of the the peer educator workplace programme and the workplace video ,"It"s Not Easy"

Conclusion

The relevance of the U.S.A. was extremely limited for the AIDS in the Workplace programme. The 2 week trip did not provide orientation as no US based businesses with AIDS in the workplace programmes were included. Neither the persons travelling nor the actual meetings were significant from the standpoint of AWC progamme implementation. According to several of the participants, the U.S. meetings were seen as offering information which was too general and not specific to the workplace.

Recommendations for Future Trips

1. USAID and others should carefully consider the value of funding any future US trips not directly related to AIDS in the workplace programme implementation

2. A future trip is recommended for staff involved directly in the implementation of the AWP programme.
Participants should include a representative of BOCCIM, the current AWC programme coordinator and the materials development and production staff of the Ministry of Health

3. Future activities should include review of U.S. produced materials for adaptation by a Botswana based company or educational resource

4 Any future U.S. trip should include actual AWC programmes in companies such as Digital in Boston, Massachusetts and Levi Strauss in San Francisco.
Other suggestions include:

> **the American Federation of Labour - Congress of Industrial Organisations to determine international efforts regarding AIDS**
>
> **3 day workplace AIDS education training offered by the American Red Cross**
>
> **a review of the policies and activities of the National Leadership Coalitition on AIDS, a U.S. business coalition group with representatives from business, labour and the non - profit sector**

Centers for Disease Control (CDC) technical assistance
- the Director of Corporate Relations, National AIDS Information and Education Program, and
- other relevant CDC resources including :
the health economist working on the cost of AIDS to businesses,
the CDC Business Responds to Aids Resource Service at the Library of Business Resources and
materials available from the CDC National AIDS Clearinghouse in Rockville Maryland

If possible this visit should cooincide with the lauch of the CDC workplace materials 'Business Responds to AIDS' on December 1st 1992

2. THE ZIMBABWE TRIP

This trip was undertaken by 5 participants with the express purpose of exposing private sector leader to the AIDS education and prevention activities being undertaken by their counterparts in Zimbabwe.

The participants were:
Manager of the National Aids Control Programme
USAID Project Officer
General Manager of Kgalagadi Management Services
a representative of the Botswana Diamond Valuing Company and
a representative from Debswana Orapa

The specific objectives of the trip were:
- to show business leader the impact of AIDS at the workplace as perceived by their Zimbabwean counterparts
- to motivate the Botswana private sector to initiate and undertake similar projects at their own workplaces
- to ensure that the companies represented, amongst the largest employers in Botswana, start such education programmes

The Programme

The delegation visited the following organisations:

The Confederation of Zimbabwean Industries

Old Mutual (Insurance Company)

Anglo - American

David Whitehead (Textile Company)

University of Zimbabwe

Peter McKenzie (Commercial Farmers Union)

The National Aids Control Programme

During these meetings and discussions the delegation was exposed to diffent models of intervention which included condom distribution, education through drama performances at the workplace, peer education, use of comic books with AIDS information, a peer education project with commercial sex workers and their clients and alternative income generating projects for commercial sex workers

Overview

Several of the participants agreed that the trip had been very fruitful indeed and had provided the following lessons:

the commitment of top management is critical to the recipients of any AIDS education programme (At Anglo - American the Group Personnel Manager is directly involved in the organisation of the project)

the business community has an important role to play in the fight against AIDS at the workplace

Businesses need to include the impact of AIDS in their strategic plans

AIDS has serious social and economic impact on the performance of an enterprise (eg increased insurance premiums, medical bills and loss of skilled manpower)

Conclusion

The trip assisted the delegates to gain insight into the scope and implications of the AIDS epidemic and inspired business leaders to do something in Botswana. All of the companies represented have started AIDS education programmes.

Learning by seeing is a valuable strategy for convincing business leaders.

Recommendations

1. Future trips should be undertaken, perhaps for middle management as they are directly invovled in programme implementation These may need to be grant aided.

2. Visits from business leaders outside Botswana to the Botswana programme should not be encouraged at this stage as the programme is still in its infancy. In 1 - 2 years time the situation may be appropriate for such visits.

BOTSWANA CONFEDERATION OF COMMERCE, INDUSTRY AND MANPOWER (BOCCIM)

BOCCIM was instrumental in initiating the project and has representation on the Working Group.

1.BOCCIM's membership comprises 48% firms classified as 'micro' (ie 0 - 10 employees), 29% small (11 - 25 employees), 12.6% large (101 - 1000 employees) and 1.4% very large (1001 + employees).
It is an influential organisation and all the companies in the project looked to it for programme advocacy and support.
Discussions with Secretariat officials revealed that the organisation is committed to the project and is prepared to actively encourage its members to take part in AIDS awareness and prevention programmes.

Suggestions
Secretariat officials suggested that an effective approach to AIDS education in the workplace is to target each industry in order to tailor the programme to the specific workplace culture. The following Industries or Organsiations were identified: -

The Retail Trade
Manufacturing Industry
Transportation
Tourism
Construction
Local Government
Directorate of Public Service Management

The following strategies were suggested to insitutionalise the programme:

Include AIDS education in every BOCCIM Training Course
Develop policy guidelines for its members once a National Policy is in place
Organise a private sector conference on "Economic and Social Impact of AIDS on Industry and Commerce"
Include AIDS briefings and information on the AWP project in the BOCCIM Newsletter
Increased involvement of BFTU in AIDS awareness and prevention campaigns

Conclusion

BOCCIM has a major advocacy role to play in the AWP project although there is no clear organisational base from which this can operate as there is no Health and Safety Committee within the current BOCCIM structure
Companies look to BOCCIM for leadership and guidance and in relation to AWP they are looking to the Directorate.

Recommendations

1. That an Advocacy Group be formed consisting of the Director of BOCCIM, the Permanent Secretary of the Ministry of Health and one or two leaders of industry to give the highest possible level of leadership and support for the AIDS in the Workplace Programme

2. THE BOCCIM 2ND PRIVATE SECTOR CONFERENCE

Another avenue of BOCCIM involvement was the agreement to give time to the Manager of the National Aids Control Programme to address the delegates attending the BOCCIM 2nd Private Sector Conference held in Francistown in September 1991
The NACP Manager gave an unprogrammed presentation on the possible impact of AIDS on the workforce, especially skilled personnel. Although the presentation was brief and there was insufficient time for questions and answers many business leaders acknowledged this to be their first briefing on the subject by a professional.

Conclusion

The presentation made a significant impact upon the Conference as measured by the inclusion of the following AIDS related issues in the recommendations of the published Conference Proceedings :

> "The private sector should play a signficant role in AIDS prevention and control for the workforce and BOCCIM
>
> The private sector should play a leading role in mobilising financial resources from the private sector to support AIDS prevention programmes for under - resoureed small

companies

Employers should integrate AIDS education into existing training courses including induction, health and safety, management etc.

Employers should establish company based sustainable AIDS education programmes including appointing peer educators who will function with technical support from the health sector"
[Proceedings of the Second Private Sector Conference 2 - 4 September 1991, Francistown Botswana]

Some companies have taken up these recommendations and have spontaneously integrated AIDS education into induction and other training courses - BCL and Anglo American provide illustrations.

Recommendations

1. Further presentations to the private sector and other BOCCIM events should be made

2. These presentations should be planned and placed on the agenda with sufficient time for questions and answers

3. The presentations should be specifically tailored to the topic of the event and to the interests of companies and the private sector

4. BOCCIM should organise a seminar/workshop for its members on
'The Economic Impact of AIDS at the Workplace in 1990s' to be addressed by a health economist. Other appropriate organisations should be invited such as BFTU and service clubs such as Rotary, Round Table and Lions

BOTSWANA FEDERATION OF TRADE UNIONS (BFTU)

The trade unions see AIDS education as an important aspect of workers education and incorporate it in all their monthly educational programmes.
One of the BFTU Education Officers undertook the USA study tour, is a key member of the Project Task Force and trained as an AWP coordinator

Project implemention

Two strategies are being pursued :-

All Unions are being encouraged to establish Education and Health and Safety Committees which would be responsible for promoting AIDS prevention programmes

Donor assistance has been sought to set up a workplace based AIDS education programme using the peer education model and the OHU materials - several companies have been targeted.

Recommendations

1. BFTU should focus their efforts on AIDS Education and prevention work in each of their consituent unions as BFTU has unique insight into and experience of their circumstances

2. The proposed AWP programme to be undertaken in selected companies should be closely coordinated with the programme activities of the OHU.

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PROJECT ACTIVITIES AND IMPLEMENTATION IN THE COMPANIES

KGALAGADI BREWERIES (PTY) LTD GABORONE

KBL is a large employer with a total work force of 850 - 518 in Gaborone and the remainder spread among the various depots in the country.
The company does not have any medical personnel
The company forms part of a larger group - Kgalagadi Management Services whose General Manger undertook the Zimbabwe study tour

Company Policy
The company has no specific policy on HIV AIDS
It is anxious to contribute to the national prevention programme and sees its role as disseminating information on AIDS and creating the time and space necessary for AIDS education. There is no specific budget for AIDS education and funds currently come from the training budget.
The Company provides condoms (both distributed through the Ministry of Health and privately purchased)

The Coordinator -The training manager was selected as the AWP Coordinator

The Peer Educators - 2 Peer Educators were selected by the coordinator for their approachability and communications skills. However, the coordinator is concerned at their literacy level and hopes to select additional peer educators from a higher level in the company hierarchy.
(from the Engineering, Quality Control, Finance and Packaging Works Councils and from the Health & Safety Committees)

Programme Operation -the nature of the plant makes it difficult to get people together without disruption to production. Most of the talks and demonstrations take place at lunch time in the canteens where workers gather to play cards or on the rare occasion of a shut down of the plant In Segwana, the peer educator meets her peers once every two weeks.
A nurse has been brought in, on occasion to give extra training

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The company would also like to see the Botswana Beverages and Allied Workers Union revived so that it could also play a key role in AIDS education.
Condoms are available either on request or at the canteen and pub.

Problems and Suggestions
The nature of the plant makes it difficult to get people together and some sections of the workplace are very noisy thus making informal discussion difficult
The coordinator is concerned with the effectiveness of the current peer educators
The coordinator strongly advocates the need for a company nurse
The need for a summary of the Manual and Brochure to facilitate easy reading in both English and Setswana

Conclusion
The programme has taken root in the company and is being endorsed by senior management
The peer educators are still in a process of flux and require more training
Little direct education of the workforce has yet taken place
The monitoring and quality control aspects of the programme are still in their infancy.

Recommendations

1. The supervisors should be more directly involved in the planning and implementation of the programme

2. A project training plan should be developed

3. Workers should be released in small groups from each section in order to ensure that all workers are exposed to AIDS education with minimium disruption

4. Special playing cards should be developed with AIDS messages on them as playing cards is a daily favoured past time.

ALGO INDUSTRIES

This textiles company has recently drastically reduced its workforce from 655 to 125 and displays a general lack of resources
The company employs a nurse who is also the AWP coordinator

Company Policy
The company has no specific policy on HIV/AIDS
The company has very limited resources to support the programme but does allow the coordinator to operate the project and has transferred a retrenched worker to her department to act as a health assistant.
The Personnel Manger is a member of the AWP Working Group

The Coordinator
The company nurse was selected as the AWP coordinator

The Peer Educators
Originally 7 peer educators were selected by the supervisors, the key communication links between workers and management in this company, but only 2 remain after the retrenchment of almost 75% of the staff. Both of these are young women who have completed Form 2.
Because of limited company resources the peer educators were trained by the Task Force members

Programme Operation
The nature of production makes it difficult to get people together and educational activities take place during lunch time.
The coordinators medical post is full of posters and information about HIV/AIDS, many procured through her individual resourcefulness and she conducts informal discussions with her patients. She was particularly aware of the signficance of STD in this context. She also conducts some HIV counselling and had kept some monitoring information
Condoms are available from the health post and training in their use given regularly.
It was noted that condom use had risen sharply to approx 400 per month (no base line available) and the nurse remarked on an apparent reduction in STD.

Problems and Suggestions

There are little time and space for AIDS education and no training aids available - no video or overhead projector

The peer educators and health assistant all felt that they should get paid for doing AIDS education

The company has found it difficult to find finance for the coordinators travel expenses to attend coordinators meetings and clearly has not been able to reciprocate in the rotating system of hosting meetings

Conclusion

AIDS education is largely being resourced and conducted as part of the medical service provided by the company. The peer education component is rather weak with little monitoring or quality control.

Recommendations

1. A training plan for AIDS education should be planned by senior management, the supervisors and the AWP coordinator to ensure that time is available for each worker to receive AIDS education on a regular basis

2. A budget for AIDS education should be drawn up in order to clarify the extent of the resource shortfalls.

3. The company should be one of those to benefit from the development of a training aids library (where a video and OHP could be available on loan for specific training days and activities)

MANICA (BOTSWANA) PTY LTD

Manica employs 107 people and requested involvement in the pilot project.
The Botswana company is part of an international group which had already initiated AIDS education.
The company decided not to follow the peer education approach and eventually effectively withdrew from the project although AIDS education continues.
There is no company medical facility

Company Policy
The company had no specific HIV/AIDS policy although it was dealing on ad hoc basis with various related issues - for example the question of HIV testing for insurance purposes and for recruitment into senior management posts; company medical expenses in treating workers who are HIV+
The company provided condoms to its workers, some provided by MoH but because of complaints about their quality management purchased expensive ones.

Programme implemenation
The General Manager (post currently not filled) included an AIDS briefing and update in his monthly briefings to the workforce. It was felt that this was adequate for the company to fulfil its social responsiblity of bringing information to the attention of the workers. Any behaviour change was understood to rest squarely with the workers themselves as individuals.
In addition to the briefings, inserts were placed in drivers subsistence pay packets warning of the dangers of AIDS and posters and cartoons were pinned on public notice boards
Condoms are distributed through the Health and Safety Kit which is refilled every Friday. They are part of the First Aid budget.

Problems and Suggestions
The company expressed a need for more visual display materials of all kinds - posters, brochures etc.

Conclusion
The company has its own 'in house' style of AIDS briefings which satisfies its own limited goals. It would be unrealistic to expect that these alone could have any marked impact on behaviour as there is almost no possibility of asking questions or sharing fears.

Recommendations

1. Other information should be available to workers about where they might find out more or have their questions answered.

THE GABORONE SUN

This Gaborone based hotel which is part of the Sun International Group employs 469 people.

Company Policy
Sun International Head Office in Johannesburg decided to undertake an AIDS awareness campaign in all its hotels, including those in Botswana. In 1989 the Training Manager at the Gaborone Sun attended a course at The Insitute of Medical Research in South Africa.
Later that same year the AIDS awareness campaign was adopted as an integral part of the orientation programme for new employees.
The company has no specific HIV/AIDS policy
The Botswana company has contributed time and space for AIDS education and hospitality for coordinators meetings.

The Coordinator
The Training Manager was selected as the AWP coordinator because of his previour training and involvement in AIDS education with employees.

Programme Implementation
The Coordinator was already undertaking an AIDS awareness programme as part of the induction process for all new employees.This extended to students and others on industrial placements It was concluded that the peer educator model was not appropriate to the company circumstances.
The Training Manager conducted a series of AIDS education sessions for existing hotel staff to ensure that all staff had received some education and included an AIDS education component in other training courses.
The current pattern therefore is that AIDS education is included in induction, as part of other training courses and ad hoc refresher sessions are held when possible.

There is no separate training plan for AIDS education.
Condom vending machines are placed in some of the public toilets.

Problems and Suggestions

No problems were presented but several suggestions offered:
That the company was prepared to consider including its subcontracting companies in its AIDS education sessions where appropriate and where it would not strain or exploit the existing manpower resources
That a clear partnership with government was envisioned in which a clear policy on AIDS would guide private sector initiatives.

Conclusion

This company provided a different model of AIDS education which may need to be more closely examined for its possible general relevance to the hotel industry
The induction process for new employees can be a confusing and stressful time and may not be an ideal time for retention of AIDS related information
The opportunity for asking questions, sharing fears and discussing personal relational issues may be constrained in the contexts currently being utilised.

Recommendations

1. Emphasis should be placed on an AIDS training plan which reinforces on a regular basis the information received in the induction process and during other training sessions

2. The reinforcing training should be undertaken in small groups where there is an opportunity for frank and open discussion of the personal and relational aspects of HIV/AIDS. Attention should given to creating the conditions for this openness (especially in situations where older, non literate women may be receiving training from a powerful, high status, male training manager)

THE BOTSWANA DEFENCE FORCE

The Botswana Defence Force has taken a very active part in the AWP project. One representative undertook the USA study tour but was then sent for further training and another officer took over as member of the Project Task Force
Both of these officers are medical personnel.

Senior management gives unqualified support to the project - time, space, and transport and subsistence allowances to attend meetings

Project Implementation

3 bases were visited - Gaborone, Selibi Phikwe and Francistown

GABORONE

22 peer educators have been trained many of whom are troop leaders, chosen because of their closeness to the men both on patrol and on the base.
AIDS education takes place during regular briefing sessions and has been integrated into other regular army training courses.
Condoms are made available through medical facilities, at the gates and in rest rooms.

Problems and Suggestions
Because of the command structure peer educators need to be of equal rank for effective communications; junior officers cannot easily discuss AIDS related issues with their seniors.
It was found that the soldiers responded more readily to an emphasis upon STD prevention - something much more tangible and immediate to their experience than HIV/AIDS which still remains abstract
Condom distribution is being extended to the local bars and night clubs.and senior officers are concerned about alcohol abuse and its implications for rational sexual decision making.

SELIBE - PHIKWE

There are 2 coordinators and 7 peer educators
Initially the programme was controlled by the Coordinator from the Francistown base who subsequently appointed 2 adjutants to

act as coordinators.
AIDS education is integrated in all training courses and at morning parades. Troop leaders conduct AIDS education programmes with their units during field trips. The coordinator visits the men in the field one every two months and checks on the progress of the peer educators and the knowledge level of the men.

Problems and Suggestions
1.Materials are limited and requests were made for video material in particular

2. Phikwe poses certain special problems in that soldiers are sharing a relatively small pool of female contacts with men from BCL mine
It was recognised that there is an urgent need for a community based AIDS education programme targetting female school leavers, school girls, young working girls and the out of town 'month end' visitors

Recommendation
1. The Local Authorities should be contacted in order to initiate a community based outreach AIDS education programme as a matter of urgency

FRANCISTOWN

There is one recently appointed coordinator who has not received any training to date and 13 peer educators.
Project implementation is very similar to other camps - AIDS education is integrated into training courses and during briefings when the troops are on patrol duties.
Selected cartoons are photocopied and displayed in public places.

Problems and Suggestions
The peer educators suggested that they should have T shirts with AIDS messages to wear during their AIDS education sessions.
They also requested more posters and materials generally.
Several expressed concern at their inadequacy in dealing with the relational aspects of AIDS education, especially the whole question of negotiating safer sexual practices with partners.

Recommendations

1. Coordinators and peer educators should have training in talking about sexuality and negotiating sex..This should also include some personal awareness and sensitivity training.

General Conclusions

The pattern of project implementation was very similar in the three camps although the quality and sensitivity of the peer educators varied considerably. Only in Gaborone was there any discussion with the men and their general level of understanding of AIDS related issues was poor (based on the kinds of information they sought from the team).

There was general agreement that an approach which focused on STD was more productive as this was real and tangible to the men whereas there was still a high level of denial of the existence of AIDS.

BCL - SELEBI PHIKWE

BCL is a copper nickel mine which employs over 5,000 people. The project started at the Mine Hospital and then extended to all the departments.

Company policy

The company is concerned about the need to maintain a healthy work force both within the mine and outside. The problem of AIDS is taken very seriously expecially its potential impact on the supply of skilled labour and localisation.

The company has no written policy but follows the provisions of the Labour Act as regards termination of employment in the event of sickness and inability to work.

The company has an intensive educational programme concerned with mine safety which is well resourced in terms of training aids and these are availabe to the AWP project. The mine also installed videos at key locations to assist with the education effort.

The company distributes condoms through the hospital and clinics at the shafts and because all the employees and their families use the mine hospital it is relatively easy to monitor STD and HIV infection rates.

Project implementation

The AIDS education is undertaken by peer educators who are elected representatives of Workers Committees representing the following departments:

Medical
Underground
Administration
Concentrator
Personnel and Housing
The Laboratory
Loss Control

Underground crew bosses have a waiting place where they give safety talks and it is hoped to train 180 of them to act as peer educators to cover all the workers in the underground department.

All first aid courses now include information on AIDS and over 1000 people are trained annually.

All induction programmes also include AIDS information

Video machines are placed in the change rooms and show AIDS education material
The company is considering organising a seminar on AIDS for Union Brach Officials in order to ensure that that AIDS message comes from as many sources as possible.

Probems and suggestions
Because of the production process there is a lack of time for AIDS education and meetings - on average the peer educators had met his/ her group only once or twice since they were appointed. Likewise the coordinator had only managed to meet the peer educators twice since January.
Materials in Setswana are required and attention must be given to the fact that a significant proportion of the workforce are illiterate. Alcohol abuse was cited as a major problem, especially at month end.

Selibi Phikwe is a mining town with more men that women and tends to attract women from other areas, especially at pay time. There is a tendency for the men to share the available women increasing dramatically the risk of HIV infection.The women also tend to be sexual partners for the soldiers at the Selibi - Phikwe base.
A community programme is strongly requested. The Mine is already represented on the District Aids Committee and this presents a unique opportunity for the Mine to be involved in a community outreach programme.

Given that approximately 40% of the workforce is illiterate there is an expressed need for an integrated educational programme including literacy,family planning, economic literacy and health & AIDS education

The peer educators would like to have refresher courses and more training materials including a Setwana, Botswana based video. They also want a closer involvement of the supervisors as they play a key role in motivating the workers under their supervision and they are gatekeepers in terms of releasing workers for AIDS education activities

Conclusion

The project in BCL is well established and well supported although it is still in its infancy and lacks a clear AWP training plan.

BCL is in a unique position to undertake an intensive sustained campaign which could cover all its employees and most of their dependents since it has its own hospital and medical staff, and has a substantial influence on the social and economic activities of the town.

Recommendations

1. An Aids in the Workplace training plan should be produced which indicates how and when workers are to receive AIDS education from the peer educators.
This plan should also inlcude follow up by the coordinator

2.Through the District Aids Committee and Health Team a community outreach programme should be mounted as a matter of urgency.

DE BEERS BOTWANA MINING COMPANY (PTY) LTD - ORAPA

This company is only just entering the Aids in the Workplace Project as such.
In the mid 1990s an AIDS Action Committee and AIDS Education Programme started at the Orapa Mine Hospital (which also serves as a referral hospital for the local area).This was a community based programme financed by the Hospital. and with one of the Hospital staff nominated the AIDS Coordinator.
The Committee comprises representative from the Hospital. Personnel, Public Relations. Engineering. Loss Control and Schools, the Church and contractors.
The AIDS Coordinator has been giving talks to the miners and Orapa contractors and has worked with the following departments:

First Aid
Fire
Security
The Training Centre
Personnel and
Loss Control.

Thus far the Hospital has been the prime moving force in the programme and now the Company is looking to broaden the base of involvement.

Several of the hospital and mine nurses have received training througth the Ministry of Health as AIDS counsellors and this group has been nominated to be trained in the AWP project.The Mine is funding this and a private training company has been approached
This extension of AIDS education is strongly supported by senior management and adequate training facilities exist. The general manager expressed his willingness to launch the programme.

<u>Problems and suggestions</u>
The Hospital is very concerned at the increase in the number of HIV + school children and highlights the need for work in the schools as part of the community inititative
The situation is similar to Selibe - Phikwe with a large population of men sharing a small pool of female contacts. Mine management is looking towards a partnership with government whereby the mine funds activities within its boundaries and the government funds the wider community initiatives.

Conclusion

There is a great deal of energy and enthusiasm for the programme but this has largely been generated from the Hospital. It is vital that senior management are seen to be committed to the programme and that other non medical personnel become key partners in the programme.

Recommendations

1. The trained AWP staff should train non medical peer educators

2. Senior management should be seen to be actively involved in the programme - this would lend great weight to the programme

3. The community outreach programme should be initiated as a matter of urgency, through the Local Authorities

SUMMARY OF PROJECT IMPLEMENTATION AT THE WORKPLACES

Conclusions

Some general conclusions can be made about workplace implementation.

1. There is a clear difference between service and production industries in their capacity to release workers for AIDS education and different plans are required for each.
Many companies get around this problem by
- using lunch breaks and free time
- including AIDS education in other activities ie in induction, during briefings and parades and during other training activities.

2. All companies have an ongoing programme in place but in most cases this is in its infancy and has not yet reached the majority of the workforce

3. The systems and procedures for monitoring the frequency, extent and quality of AIDS education are weak and urgently need strengthening
There is little evidence of accurate and consistent record keeping on any aspect of the project.

4. All the companies make condoms available to the workforce either by placing them in toilets, recreation and changing rooms or distribute them through peer educators or medical facilities
No organisation reported serious problems with securing condoms for distribution but there were universal complaints about their poor quality

5. There is a conspicuous absence of poster coverage in the companies visited - one large company had only 1 poster and others had none at all.

6. There is a general shortage of accessible materials for peer educators to use for training especially simple pictorial handouts and brochures in Setswana

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7. There is wide disparity in the availability of financial and material resources for training

8. The presence or absence of a company medical facility was a significant factor is the shape taken by the project
Where there was a company hospital, clinic or nurse there tended to be a relative distancing by senior management from involvement in the project (eg Orapa, AFGRO)

On the other hand these organisations were able to closely monitor the impact of condom distribution on STD and provided HIV counselling

9. BCL and ORAPA have very close contact with their employees since they provide not only employment and medical care but also housing and recreation facilities for their employees and their legal dependants. This places them in a unique position for the integration of AIDS education efforts.

Recommendations

1. Top management should give direct and visible support to the AWP programme in their company (Managing Director or Chief Executive Officer)

2. Peer educators should receive more and regular training This should include sexuality and negotiating safer sex

3. Monitoring and quality control systems should be operationalised

4. AIDS training plans should be produced for each company - to be produced jointly by the coordinator and a senior personnel manager after detailed workplace consultations especially with supervisors
to ensure that each worker receives AIDS education on a regular basis

5. Budgets for AIDS education should be drawn up

6. Training should be face to face and interactive wherever possible to supplement information giving in didactic situations

7. Since adequate time and space are often a constraint in businesses the OHU should stress several alternative approaches for employee education

1. including AIDS information as routine part of employee induction

2.offering 1 or 2 hour seminars with basic facts about HIV infection and AIDS, with much time for questions and answers
The level of the seminar should match the knowledge level of the participants. Participation from the top leadership in such seminars should be sought

3. Distributing payroll inserts and brochures on HIV and AIDS prevention for employees and their families

4. Presenting HIV and AIDS prevention videos.

COORDINATORS

The effectiveness of tiered education and the dilution factor involved in training are significant concerns. By tiered education is meant that coordinators teach managers and peer educators who in turn teach the employees. This means that the burden of all company education rests with the coordinator.
The coordinators are critical for programme implementation and how they are supported is a crucial issue.

Selection of coordinators

Almost all the coordinators were selected on their basis of their existing position in the organisation and the perceptions of senior executives about the 'appropriate organisational location' of AIDS education..
In two companies the training managers were selected (AIDS education being understood as another aspect of training), a further two companies selected personnel officers(AWP being understood to be a personnel issue), BOCCIM selected the senior industrial relations officer, BFTU selected an Education Officer and the remaining companies selected medical personnel (the company nurse and a doctor in the company hospital where AIDS education understood as part of general health care)
These selections have strategic outcomes for project implementation. It seemed that where responsibility was vested with medical personnel, senior management and administrative personnel were somewhat distanced from the programme - particularly so where medical responsibility had been vested in a junior member of staff.
The seniority of the coordinator in the organisation was also crucial in terms of gaining active senior management support and involvement - where the coordinator is relatively junior effective communications with decision makers is impeded.

Knowledge of AIDS issues

There was a variety of skill levels and understanding of HIV issues. Medical staff coordinators had a high degree of medical information and basic knowledge but more limited knowledge of health promotion and adult education techniques
Non medical coordinators, especially the training and education personnel were very capable trainers but their comfort levels with sexuality and medical issues varied.

Communications skills

Coordinators often had excellent to good communications with peer educators. However access to the highest level of management was not always gained althougth there was clear recognition that top management could give the "green light" to time and space for employee edcuation

Role within the company

Some coordinators did not always understand or accept that it was their responsiblity to encourage peer educators in their task or to monitor and evaluate the training the peer educators were conducting
The coordinator could rarely state how many educational sessions had been held, of what type and to how many employees; nor did they know about condom supply and distribution.
The use of a monitoring form would go a long way to rectifying this situation.

Coordinators' network

A vital ingredient in the current success of the project is the regular pattern of coordinators' meetings.These are rotated between the companies, resources permitting, and provide an invaluable forum for sharing information and gaining support.

Recommendations

1. Where the coordinator is selected from the company's medical facility, a member of senior management (eg training manager or personnel manager) should be selected to work with him/her.

2. Coordinators' training should place more emphasis on programme planning and implementation, monitoring and evaluation

3. Additional written materials, posters and videos should be supplied to coordinators one a quarterly basis if possible from the Occupational Health Unit.

PEER EDUCATORS

The team met peer educators from BCL, BDF and Kgalagadi Breweries and attended a general AIDS meeting with soldiers from the BDF

The entire workplace programme is young and peer education is clearly in its infancy. The process of selection of peer educators was guided by the deliberations of the Coordinator's group in January 1992 where the following were agreed:

- a working definition of 'peer educator'

"A member of the workforce who is selected by workmates to educate others, the selection being based on the characteristics of a peer educator"

- the characteristics of a peer educator

"Leadership qualities
Good communications skills
Knowledgeable
Credibility and Consistency
Confidence
Competence"

- the process of selection

"selection to be coordinated by the coordinator based on the above characteristics"

- the roles of a peer educator

"- assist the coordinator to monitor the programme including gathering of information for recommendations
- give basic support and refer for counselling
- organise discussions for HIV/AIDS related issues
- identify resource people
- act as a link beteen peers and coordinators"

Selection of peer educators

The general pattern in almost all the workplaces is selection by the coordinator based on the criteria outlined above. Workers committees existed only in BCL and here they selected their own peer educators - this is a reflectionof the lack of structured workers organisations in most of the workplaces.

In all the companies visited the peer educators were well accepted by the workforce and committed to their tasks.

Review of the Effectiveness of the Peer Educators

The following comments must not obscure the remarkable fact that peer education had been adopted as a strategy in several of Botswana's largest workplaces and that peer educators have been selected and trained and are conducting shopfloor education

Knowledge of AIDS issues

The peer educators had received basic information about AIDS facts but were not confident about their material - they had very limited grasp of the biomedical aspects of HIV, knew very little about STD and could not resoundingly dispel fears about the casual transmission of HIV.

Their training had been too short and was not supported by adequate readable materials - simple clear brief materials in Setwana are not available to them.

In addition, they have received limited follow - up or further support.

Communications skills

The peer educators communications skills are vitiatied by limited communications training, especially practical training and the absence of supervision and guidance when holding AIDS meetings. Most education offered, within group contexts is didactic and prescriptive.

In view of evidence indicating the superiority of particpatory, interactive methods of health education, it is important for future training and field supervision to develop peer educators' capacity to use participatory methods

Role within the company

Their understanding of their role within the company as peer educators varied but was generally limited and few knew how to place AIDS activities into the workplace. A management plan, which specificies how and where peer educators will conduct AIDS education is urgently needed.

Numbers of Peer Educators

The peer educators lack confidence, especially when educating people of superior rank or education. An effective way of promoting confidence is to foster a cohesive, supportive peer educator group, but currently there are too few peer educators for this.

Recommendations

The following recommendations are offered in the hope that they may help to build upon an admirable foundation.

1. Selection of peer educators

Selection of peer educators requires great care - they must be effective communicators and acceptable to workers.
It is suggested that the following steps should be taken when selecting peer educators:

> **1The coordinator should meet with workers to explain the importance of AIDS, the initiation of a workplace programme, the selection of peer education as a strategy and the need for capable, committed, trusted peer educators**
>
> **2. Either ask workers to choose peer educators who they trust to represent them or consult with them about individuals being considered by management as peer educators**
>
> **3. If employees are uncertain about a selection, do not rush it. Give them time to think about their choice, then meet them later in the week.**
>
> **4.When potential peer educators are chosen, the coordinator should meet with them to explain what will be involved. Emphasize that they do not have to become peer educators and that they are free to withdraw without stigma. If they are interested, invite them to attend AIDS training.**
>
> **5. After they have had an opportunity to see what is involved and when they have shown sustained commitment to peer education invite them to become formal peer educators**

2. Training of Peer Educators and Others

Dilution of training is a major impediment to effective peer education.

At each level there should be more training:

1.The Occupational Health Unit should have more training in

the theory and practice of training
in planning and management of peer education
in participative approaches to health education
in industrial sociology and workplace dynamics and communications

2. The coordinators should have more training in

STD/HIV facts
educational and counselling techniques
strategic plan development for peer education in each workplace

3. The peer educators need intensive training in

STD/HIV facts
organising and leading meetings
communications techniques
basic adult education

This training should be practical, directly job - related and supported by close field supervision

4. Both coordinators and peer educators should have frequent refresher training

3. Strategic Plan for Peer Education

Few organisations had brought all the relevant departments together to identify opportunities to schedule AIDS education at work.

1. Each company should produce a strategic plan for peer education to schedule AIDS education at work - specifying exactly where, when and how often peer educators can receive training or conduct AIDS education
Without this peer education will remain confined to the fringes of company life.

4. Motivation of Peer Educators

No programme which ignores the motivation of peer educators can be sustained

1. Each coordinator should identify what motivates peer educators and as far as possible ensure that these incentives are provided. Sources of motivation may include access to training, occupational privileges, greater visibility and status at work and opportunity to be of service to others.

5. Peer Educators and the Distribution of Condoms and Materials

1. Peer educators should be involved in distributing condoms and materials as this enhances their visibility and importance.

Peer Educator Groups

One of the greatest sources of confidence and encouragement to peer educators is membership of a cohesive, motivated group. Currently there are too few peer educators to form such groups.

1. When more peer educators are recruited, the coordinators should foster supportive groups which entials providing opportunities for the group to meet, discussing and planning activities with peer educators and including them in programme review and evaluation

7. Monitoring Peer Education

Programme monitoring is necessary for many reasons not least of which is that it helps to motivate peer educators. They are unlikely to sustain instensive activity if their efforts are not recognised, praised and rewarded.

1. Monitoring should occur weekly and should include:

- **the number of meetings held**
- **men and women reached**
- **number of condoms and materials distributed**

A sample individual peer educator monitoring form , with explanatory notes is included as Appendix 9

2. Individual Peer Educator Monitoring forms should be compiled by the coordinator into Monthly AIDS Education Forms, the results of which should be widely disseminated throughout the company.
A sample possible Monthly AIDS Education Form with notes is included.as Appendix 10

3. Meetings should be audited by the coordinator to ensure quality control in respect of dissemination of correct information by appropriate educational techniques.
For example meetings would fail to meet quality control audits if incorrect information was given, if the audience was too large or disruptive or if a peer educator were inaudible, uncertain or unduly prescriptive.

4. Quality control should never be punitive but rather supportive, designed entirely to help develop the skills of peer educators.

8. Networks of Coordinators and Peer Educators

Wherever possible coordinators and peer educators from different branches or companies should be given opportunities to meet, to exchange information and to observe each other conducting meetings.

MATERIALS AND COMPANY PROGRAMMES

1. MATERIALS DEVELOPMENT

The following materials were developed:

1. A Poster (men)
2. A Poster (women)
3. A Management Guide
4. A Programme Coordinators Guide
5. A Peer educators Handbook
6. An AIDS in the Workplace brochure

Other materials used in both training and implementation include condoms, both free ones available from the Minstry of Health and higher quality one purchased from vendors and a few anatomic models. The video "It's Not Easy", a Ugandan AIDS in the Workplace video is used by many workplaces as part of training.

Chronology of Materials Development

In May 1991 three consultants assisted in programme planning and materials devlopment - one, the nominated team leader from Kenya, one from Zambia and one from Zimbabwe.
By June 1991, the posters and brochures were completed and printed in final form.
By September 1991 the peer educators handbook, managers and coordinators guides were completed and printed as drafts.

Materials were reviewed by the Task Force, the Working Group and in some of the training sessions and modified accordingly.

Other Available Materials

Other materials are available, but these have not been systematically diverted to the AIDS in the workplace project. The team did not review all the general information material which could be used with employees.
There are three general informational booklets produced in collaboration with the Botswana Red Cross and published by Macmillan Botswana. These materials are written in both Setswana and English, the type is bold and the information is included in simple story format. The material appeared to be attractive and easily understood.

There is currently no established mechanism for regular updating of materials.

Overview

The materials developed are comprehensive in scope and range and are good especially considering the time and budget constraints involved in writing and producing them.
They contain a great deal of factual information about HIV and AIDS. In particular, the Aids in the Workplace brochure is good, with pictures for condom use and how AIDS is not transmitted. It contains both English and Setswana.
The guides and the handbook are currently in draft form.

Recommendations for further revision

1. Any materials developed should be secondary and supportive of face to face dialogue in small groups (less than 20) - future revisions should support a conversational or dialogue type approach for health promotion in the workplace.

2. With the notable exception of the posters all the materials are printed in small black and white type. The materials should be reformatted with different type for easy reading and reference with emphasis on the most important information.

3. The materials should be printed in smaller, more easily manageable and digestible parts. This would eliminate the need for repetition of information and allow those persons, particularly those with knowledge about medical issues to familiarise themselves with areas beyond their expertise. The parts should be printed in different colours and attractively packaged as a set.

2. THE POSTERS

The posters appeared in almost all the workplaces. They are attractive and eye catching.Several coordinators noted the need for additional and different posters. Some critical comments were received from coordinators about the inclusion of certain categories of workers depicted in the posters and about the separation of the sexes.

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3. THE PROGRAMME COORDINATORS GUIDE

1. With the exception of the case studies, the approach used in the manual is didactic.

2. It is not clear from the manual how top management can be encouraged to support AIDS education. This is a critical issue.

3. There is little guidance on the process and content of policy formulation.

4. There is little guidance on the planning and implementation of programmes.

Suggestions

It is recognised that there are many competing business issues both in space, time and finances for coordinators - the following suggestions are intended to make the guide as simple and easy to use as possible.

1. The case studies are excellent and could be used for the development of additional materials such as posters or brochures or video vignettes. Simple illustrations could be added using Botswana identified persons or simple actor photographs. They could be used as the basis for group discussions.

2. Possible resources could be suggested for coordinators in soliciting support from top management. The Working Group could function as a strong advocate for top management.

3. A simple policy statement, such as the 10 Principles for the Workplace (see Appendix 8.1) could be very useful. In addition a compilation of sample policies, including the draft policy from the Ministry of Health would be useful.

4. The following check list may prove useful to assist coordinators with programme planning and implementation.

The Planning Phase:

1. Identify leader(s) or champions in the company.
2. Get support from top leadership.
3. Develop peer educators for a committee of those those with interest and good communications skills.

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4. Develop and talk about the company's policy on HIV and AIDS, emphasising confidentiality
5. Create a plan of action, a timetable and assign tasks. Include communication plan
6. Use a monthly activity report or develop a survey or other evaluation method

The Implementation Phase:

1. Identify community contacts for resources and referrals
2. Identify resources for the organisation
3. Identify and obtain training materials that are appropriate to the culture and literacy of the employees
4. Train peer educators and fill out monthly activity sheets
5. Implement employee training
6. Implement communications strategy with supportive materials
7. Implement evaluation
8. Determine the next steps

How condoms are to be provided and distributed should also be included in the initial planning process

Recommendations

1. The guide should be condensed and reformatted.

2. A Table of Contents, some simple checklists and more emphasis on planning and programme implementation should be included

3. Critical information should be highlighted - this would make the manual more useful as a reference

4. Critical information should be condensed into a single page as a fact sheet. Such a sheet could be easily photocopied or printed as a handout for smal group peer education sessions (See Appendix 8.2)

5. The planning phase of developing the programme should be strengthened - planning should include policy development, condoms and programme implementation

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6. The Ministry of Health should finalise and circulate its excellent draft policy on AIDS - this would be extremely helpful to businesses which are looking to government for leadership.

7. The list of resources should be expanded to include phone numbers and addresses. Sources of advocacy with top management and sample letter from top management should be included (See Appendix 8.3 for sample)

4. THE MANAGERS GUIDE

Overall the guide has many of the didactic issues necessary to management. It lacks sections on policy implementation, listening skills, basic adult education issues, how to support peer educators and how to implement employee education. Only Part I is available which suggests that additional sections were under consideration.
There is a good discussion of cost and policy implications

Suggestions
Costs might also include a section on cost estimates to businesses in Botswana as well as model Botswana policies from businesses.

Recommendations
1. Heavy emphasis should be placed on providing time and space for peer educators to provide employee education

5. THE PEER EDUCATORS HANDBOOK (ENGLISH ONLY)

The Handbook is the most problematic of all the materials reviewed. It is in draft form, it is long and contains many complicated topics.

Recommendations

1. It should be reformatted with checklists, fact sheets and clear examples of which topics are most important.

2. The case studies from the coordinators manual should be part of this handbook

3. Information should be included on ways in which peer educators can provide employee education.

4. There should be a Setswana version of the Handbook.

5. The Peer Educators Handbook should be rewritten to include some basics such as:

1. **Active Listening Skills**
2. **Accessing Time and Space for Peer Education**
3. **Materials and Tools available**
4. **What should be communicated**
   a. **Basic facts about AIDS and HIV**
   b. **How AIDS can be prevented**
   c. **Why there is no risk of spread from casual touch**
   d. **How to respond to a co worker with HIV/AIDS**
   e. **Company benefits regarding HIV/AIDS**
   f. **Confidentiality and privacy issues**
   g. **Where to go inside the company for help**
   h. **Additional community resources and confidential information sources**
   i. **How co workers can talk to family members**

6. THE AIDS IN THE WORKPLACE BROCHURE

This is clear and factual but a little long, perhaps because the English and Setswana versions are contained in the same document.

Suggestion
It might be useful to produce a four colour brochure with a lower reading level and highlighting the illustrations.

7. ADDITIONAL GENERAL RECOMMENDATIONS

1. In addition to policy finalisation the Ministry of Health should recommend the benefits from developing a workplace HIV and AIDS program
[A comprehensive program might include:

1. **Workplace policy**
2. **Training for managers, supervisors and union leaders**
3. **Peer training, with peers used as ongoing resources for employees**

4. Employee education
5. Family education
6. Community involvement|

2. The relationship between the NACP materials development unit and the OHU should be strengthened.

3. All existing materials, including that used for employees, should be reviewed by a group of Boswana based persons, to be established by the Working Group.

4.The review group should make recommendations for additional materials needed such as a sample policy for businesses (see Appendix 8 for suggestion for inclusions in workplace policy)

5. Any revisions should include a less didactic approach because with existing time and space constraints actual peer education is likely to occur in less formal and structured settings

6..Any materials distributed should be

1. Easy to use with a table of contents

2. Employee information should include a choice of materials for low literacy use by peer educators; some of these should be developed in Setswana.

This should include materials with few words and many pictures to convey information quickly and simply.

Some possible ideas:

a wallet sized condom card

a simple pay packet insert

several posters - to keep the information fresh and to be use as part of a peer education session. The posters would then serve as reinforcement

7.Peer educators and employees should be included in the review of existing materials and in the design and development of new materials

8. Existing materials should be reviewed for availability

9. Materials should be laid out as part of an attractive package which is made availabe to businesses at low or no cost

10. Materials should include a list of available resources and a number to call for more information. If possible the additional programme staff member would include this as part of routine duties

11. Materials should be updated on a routine basis.

12. The refinement and reformatting of current materials and their development and updating should be contracted out to one or more Botswana based companies
Funding for this should be provided by donor agencies if possible.

13. Videos
While the Ugandan film is good, it is an AIDS film performed by actors and based in Uganda. Many comments were heard about the need for a video that is a Batswana documentary.
Problems with permission from family members to show an existing Botswanan video were noted.
Strong consideration should be given to the development of a new video.

14. Also a library of audio visual material should be developed in the OHU

15. A video loan programme should be established particularly for small businesses where there is no access to video equipment

THE OCCUPATIONAL HEALTH UNIT

The Occupational Health Unit is a unit of The Community Health Division of the Ministry of Health (see organisation chart in Appendix 7).This is a small unit with a total of 8 professional staff [A Doctor, Family Nurse Practitioner & Aids in the Workplace Coordinator, Matron of Occupational Health, Health Inspector, Nutritionist/Health Educator, Health Assistant and 2 Sisters conducting Family Planning in the Workplace] and access to poole secretarial and tranport support. The Unit has extensive contacts with workplaces and the Manager of the National Aids Control Programme [NACP] identified it as the most appropriate 'home' for the workplace based AIDS programme.For some time however the NACP Manager continued to be the contact person between Ministry of Health and USAID and attended all the decision making meetings whilst AWP coordinator in the Occupational Health Unit was the nominated implementer of the programme. This led to a lack of clarity and failure of communications which was eventually resolved by making the Occupational Health Unit and the AWP coordinator the executive and managerial locus of the Aids in the Workplace project.
This lack of clarity also extended to the funding arrangements between USAID and MoH.

Since then planning, coordination, materials production ,training and motivation for the project have come from within the Occupational Health Unit This has been a successful location - due in part to the existing good relations with industry and BDF , to the private sectors perception of the role of government in AIDS prevention and to the outstaning qualities of the project coordinator.

The programme was initiated in the OHU, initial research conducted materials produced, coordinators trained (with the assistance of external consultants and latterly single handed), and support and coordination provided - but the actual putting in place of the specific programme in the workplace left to the individual companies.
The balance of responsibilities and effort in this partnership has varied from workplace to workplace - with ALGO relying extensively upon OHU and the Task Force for all aspects of the programme to DEBSWANA initiating and implementing most aspects of their own programme (training of AIDS counsellors has been conducted by Ministry of Health and condoms are supplied through central medical supplies)

It would seem that many of the smaller companies will continue to rely heavily upon the OHU for all aspects of the programme. Others will depend selectively.

Relationships

Thus far the OHU has worked relatively closely with Botswana Red Cross. One member of the Red Cross staff has worked part time with the OHU since the projects inception on a "loan" arrangment . She is a central part of the Task Force and a member of the working group and is currently spearheading the extension of the workplace programme to Francistown.
It is clear that other relationships need to be forged and specific tasks and responsibilities possibly contracted out

The relations with NACP are close but without any clear structure - both are in the Community Health Division of MoH and both report formally to the quarterly Division meetings. However most the of communication is informal between the Aids in the Workplace coordintor and the Manager of NACP- thus far the arrangement has worked successfully but this mechanism may be strained if the programme is extended. A clear management structure is required The National Commitee has played a significant supportive, advisory role to the workplace project but the major impetus and drive has clearly come from within Occupational Health itself.

The team considered the possibility of the AIDS in the Workplace programme being subsumed within the NACP for clarity of objective setting and implementation, access to expertise (eg r terials production) and clear coordination and consolidation of effort and possible future financing. (particularly in view of imminent formation of a sepate AIDS unit)
On balance it was felt that the programme should remain with Occupational Health because of its special understanding of and relations with the workplace and its acceptability and familiarity to industry - AIDS being seen as part of the overall brief for health and safety at work
However to repeat a clear mangerial structure is required .

However it is clear the occupational sphere links with other economic and social spheres and the effective negotiation of AIDS education at those boundaries requires close liason with the NACP. For example in the special cases of BCL & BDF in Selibi Phikwe there are high

concentrations of single male workers interacting sexually with a relatively small population of women in recognised high risk situations the workplace effort must be augmented with a project for women. The mechanism for translating these requirements into practical programmes must be clear and direct

Conclusion

The Occupational Health Unit is the best place from which to continue the expanded programme. This will require a minimum of one extra staff member, recruited from within the Ministry of Health, to work exclusively with the programme.

The team considered the current relationship with the Red Cross and concluded that this could not provide the consistency and reliability required.

The Unit staff require additional training and updating – a trip to Zimbabwe is highly recommended to visit both workplace and community initiatives.

Recomendations

1. The programme should remain with the Occupational Health Unit

2. The programme should have 2 full time members of staff supported with its own secretarial support.

3..That an information and materials pack be available in OHU for any interested company
- with clear guidelines for setting up the programme
- with revised training materials
- with contact persons and numbers
- with examples of workplace patterns
- with clear information about arranging training
- with clear and concise statements of tasks and objectives of all parties (senior management, personnel staff, coordinators and peer educators)

The existing training materials would form the basis of this pack but revised in a more accessible and appealing format

4. Materials revision and development should be contracted out to private enterprise

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- the revision of the current training materials should be completed immediately by a local team (materials need to be edited, reformatted into separate manageable parts, illustrations and photodocumentary material added to make the materials attractive and readable. Some separate single picture leaflets produced for distribution to workers)
Ideally this should be completed before the next phase of the training of coordinators and peer educators

5. Training of the coordinators should also be contracted out several possiblities were considered using the following criteria:
- expertise and experience in training
- expertise and experience in health education and health education training
- flexibility and responsiveness
- country wide cover
- national visibility and acceptability to business
- economy
- ability to provide follow up
- ability to continue to develop materials and upgrade training;

The Centre for Continuing Education,UB , IDM, the Red Cross and private training organisations were considered. The team concluded that UB offered the widest range of advantages on the above criteria. but this issue should be given detailed consideration by the Working Group.

6. Coordination, support and information giving, liason with NACP and community projects, monitoring and evaluation should remain the responsibilities of OHU

7. Advocacy of the AIDS in the workplace programme should be shared between OHU, BOCCIM, BFTU and other appropriate organisations (eg Chambers of Commerce and Service Clubs)

8. Additional training should be provided for OHU staff.

THE WORKING GROUP

The working group is an advisory and consultative group composed largely of personnel managers and officers in the companies engaged in the pilot project. They belonged to the intitial group invited by the NACP to the launch of the Aids in the Workplace project addressed by the Permanent Secretary of The Ministry of Health in May 1991
Many companies sent along their General Managers and Personnel Officers. The latter group comprised the core of the The Working group
This group provides an organisational network for information sharing , support, programme monitoring and expansion
The current membership comprises:

The Personnel Manager Kgalagadi Breweries, Gaborone

The BCL Representative in Gaborone, BCL

The Training Manager Gaborone Sun, Gaborone

The Personnel Manager, ALGO INDUSTRIES, Gaborone

The Personnel Manager, MANICA, Gaborone

The Medical Officer, BDF, Gaborone

The Senior Industrial Relations Officer, BOCCIM

The Chief Factories Inspector, Ministry of Labour and Home Affairs

The Head of the Occupational Health Unit, Ministry of Health

The Manager of the National Aids Control Programme, MoH

The Head of the Community Health Services Division, MoH

The AIDS in the Workplace project coordinator, MoH

The AIDS Educator and Counsellor, Botswana Red Cross

The Project Officer, U.S.A.I.D

To some extent tasks have ben divided between the members as follows:

Personnel managers

- to liase with coordinators and resolve problems and issues with management concerning support to the projec
- inform the group on the progress on peer educators

The Manager of the National Aids Control Programme

- to brief the group on policy issues and new developments regarding HIV/AIDS in workplaces
- to promote project sustainability through financial support and conduct HIV surveillance in workplaces

The Head of the Occupational Health Unit

- is responsible for technical issues concerning management of AIDS cases, support of HIV + people in the workplaces and workers who have AIDS cases at home

The Medical Officer, BDF

- to monitorof HIV/AIDS in the BDF
- to update the group on AIDS related activities in the BDF

The Senior Industrial Relations Officer ,BOCCIM

- to liase between the working group and BOCCIM

The Project Officer,USAID

- to give periodic briefings on financial and other related matters

The AIDS in the Workplace project coordinator, OHU

- to coordinatethe activities of the group

The Head of the CHSD

- to act as the contact person between the Ministry of Health and the Working Group

The Training Manager, Gaborone Sun

- to liase with the hotel industry and be a facilitor for programme expansion

The Working Group was instrumental in the preparation and refinement of the training manuals and materials and has made a consistent central contribution to the development of the project.

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It provides a forum for sharing and support which is invaluable.

It is clear that the group requires the ongoing services of the OHU coordinator who provides the lynch pin for the successful operation of the group.

The future role of the group
This is a group with actual concrete experience of promoting workplace programmes and is a source of information and support to its own consituents and to other companies joining the scheme.

Recommendations
1.The Working Group should continue to perform the tasks already outlined

2.The current working group should be reconsitituted as the Advisory Board for the Workplace Aids Education Programme - for advice and policy formulation. The current membership should be reviewed to include representatives from other key sectors This board should have sub groups dealing with specific issues.

3.The Advisory Board should have detailed Terms of Reference which should be drawn up by the current Working Group

4.A subsidiary Working Group or Groups to be formed regionally of programme implementers
The Coordinator should be a member of all such subsidiary groups to provide continuity and organisational backup.

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INSTITUTIONALISATION AND SUSTAINABILITY OF THE PROJECT

To successfully institutionalise the project the following issues need to be addressed:

Ministry of Health

All of the organisations contacted regarded the OHU as the natural home of the project and look to it as the source of information guidance and materials for AWP education. OHU has the confidence of the business organisations and should continue to play the central role in coordination and management of the AWP programme.

Recommendations

1. To enable the OHU to continue and expand the programme the Ministry of Health should fund 2 full time positions and provide earmarked secretarial and other support. The current AIDS in the Workplace coordinator should continue and another staff member should be specially selected or identified [selection to be based on relevant experience, personality, interest in occupational health and AIDS]

2. Additional training should be provided for OHU which could include :

- visits to Zimbabwe especially community outreach projects in Bulawayo
- the Red Cross Aids in the Workplace training programme (works USA)
- course/s at Toulane USA
- AIDS Programme Management course at Institute of Tropical Medicine, Antwerp
- workplace programme visits in USA & UK
  (it would appear that the Botswana Aids in the Workplace project is in the forefront of workplace based programmes in Africa)
- training in the sociology of the workplace
- training in participatory, interactive methods of adult education

The OHU has no clearly defined terms of reference or goals which can be easily and coherently communicated to interested companies or to provide the basis for objective monitoring and evaluation

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3. The Occupational Health Unit should frame some simple goals . For example:

* to add a minimum of 20 new workplaces to the programme each year

* each worker in each workplace will know the basic modes of transmission, primary preventive strategies and ways in which HIV is not transmitted

* programme seeks to reduce casual sexual partners by 20% each year

* programme seeks to increase condom use by 100% in the first year and 50% in the second year

One of the major weaknesses of the programme is the lack of monitoring and quality control

4.The OHU should take positive action in terms of quality control - establish criteria for excellence for peer educators and monitor/ moderate training to ensure that it meets minimum standards. This would be assisted by the establishment of a weekly monitoring system to be used by peer educators with the weekly returns being compiled into monthly activity forms by coordinators and into quarterly reports by OHU (sample forms in APPENDIX 9 & 10)

5. OHU, with donor assistance should urgently finalise the proposed information pack and make it available to companies at low or no cost

6. The terms of reference of NACP and OHU should be clarified and some formal mechanism established for effective coordination of their respective efforts.

All the senior officials interviewed were firmly of the opinion that it is the Governments responsibility to develop policy and to issue guidelines.

7. The Ministry of Health Policy on AIDS is an excellent document which should be formalised and circulated as soon as possible.

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8. The OHU together with the Department of Labour should draft a workplace policy (Appendix 8.1. gives a sample policy)

Relationship with BOCCIM

A mechanism is required for ensuring top level Ministerial advocacy of the AWP programme with leaders of business and industry.

There is also a need for formalisation of channels of communication between the Manager of NAWP and the Director of BOCCIM for advocacy and promotion of the programme. The involvement and commitment of the President of BOCCIM is also sought.

It is suggested that a high level seminar for BOCCIM members be organised with a health economist presenting information on the financial aspects of AIDS

The establishment of a Health & Safety Unit within the BOCCIM Secretariat would provide a natural structural home for all aspects of Occupational Health including the Aids Prevention Programme

Companies

There is an urgent need for the AWP programme to be visibly supported by the leaders of industry and business. The General Manager, managing director or chief Executive Officer need to be actively encouraged to support the programme through briefings and circulars, or messages for example on International AIDS Day Dec 1st.

Recommendations

1. Each company should put in place a strategic plan which will clearly detail how, when and where AIDS education is to take place and wherever possible to make funds available (the focus must be on face to face interactive education in small groups)

An AWP management plan including monitoring, evaluation and carefully planned training and retraining cycles is likely to ensure that the programme develops from needs within the organisation.

2. Each company should develop its own strategic condom plan.

Condom demand and supply should be constantly assessed in terms of availability and accessibility. Care need to be taken about where, when and how condoms are to be made available to the entire workforce

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The organisational structure of each company needs to be carefully considered to determine the best location for the programme - it would seem that where the AWP programme is located in a medical facility top management withdraws from active involvement. The combination of the Personnel and Training Dept with a medical facility would seem to offer the most advantages. The AWP is not exclusively medical in orientation - it involves almost all aspects of human relations.
It is also important that the programme is perceived as being targetted at the entire workforce and not exclusively those on the shop floor.

The success of the programme also critically depends upon the support of the workers and wherever possible workers representative structures should be used as the basis from which to launch and implement the programme. The involvement of workers in the selection of peer educators is vitally important.
Given that the country is shifting to collective bargaining the structures for collective bargaining could be utilised by each enterprise in promoting aids education.

The Working Group

The current working group appears to have little real authority or influence and needs to be reconstituted as a Board with clear terms of reference.

Financing

Ministry of Health

The Ministry of Health is currently providing the major part of the funding required for the project. This will continue in the future although the funding demands should not increase dramatically with the expansion of the programme once the initial capital expenditure is invested.

Recommendations

1. The Ministry should continue to fund a minimum of 2 posts for the AWP together with earmarked secretarial support (currently the OHU uses pool secretarial and transport support)

2. The training of coordinators (& peer educators where appropriate) should be contracted out to a Botswana resident non governmental organisation using donor funding (if possible)

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3. The training pack should be finalised - this too to be contracted out to a
Botswana resident non governmental organisation/s (using donor funding if possible)
4. The training pack should be made available to businesses at low or no cost through the OHU.

Companies

Recommendations

1. Small companies will depend heavily on OHU - services to this group should be available at minimum or no cost. They can provide time, space and incentives

Large companies have already shown their willingness to provide time, space, & audiovisual aids for the AWP project. One or two have also offered to include small companies or their contractors in their programmes if the logistics allow
They could
- purchase training and the materials for the training of coordinators
- support coordinators to attend coordinators group meetings and workshops
- contribute to community outreach programmes and medical care for dependants
- contribute to care programmes

2. The larger companies should be encouraged to contribute to an Aids in the Workplace Fund to be managed by the Advisory Board.

Summary
The project is very successful and the mechanisms required for insitutionalisation and sustainability are clear, practical and attainable. The AWP programme does not stand in isolation - the workplace is one ingredient of community and in certain specific situations the programme will not succeed without a corresponding community based programme (eg Selibi Phikwe and Orapa)

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IMPACT OF PROJECT EFFORTS TO DATE AND BASELINE DATA FOR FUTURE IMPACT EVALUATION

STD data are probably the best proxy measure of programme impact. However, the absence of STD monitoring in the health care system and the absence of health centres in most workplaces make STD trends extremely difficult to measure.

The BDF in Francistown reported an approximately 20% decline in STD rates, but it is not clear whether or how much of this may be attributable to soldiers seeking care elsewhere or to reduced recreational income as a result of drought.

What seems clear is that the programme is associated with greater knowledge of AIDS, heightened perception of vulnerability to AIDS and increased demand for and uptake of condoms.

There is an urgent need for Botswana as a nation to improve its STD reporting and surveillance. From the standpoint of this programme, an evaluation system is of urgent priority.

Recommendations

1. Those organisations which have health centres, such as BCL,BDF and DEBSWANA ORAPA should track STD trends more closely

2. Most companies have no access to STD data, so a simple evaluation survey should be used examining

- **exposure to programme activities**
- **AIDS knowledge**
- **risk perception**
- **reported sex behaviour and**
- **reported condom use**

A possible survey form is attached [Appendix 11]

If administered before project inception and at regular, perhaps six monthly intervals throughout the programme, this instrument would permit tracking of trends in sex behaviour and condom use. In addition, it may be helpful to analyse reduction in casual sex and increased condom use as a function of exposure to programme activities.

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ADDITIONAL RECOMMENDATIONS: CONCERNING ACTIVITIES OUTSIDE THE PROJECT

The workplace project must continue to be a pillar of AIDS prevention activities in Botswana.

However, there is a growing consensus that every possible channel must be used to reach people and sexual partners. There is a major role for community - level interventions targetting "high risk" groups (including prostitutes, their clients, male and female STD patients and single, mobile men and women). Mathematical models strongly support targetted interventions. When the effects over 10 years of preventing a single case of HIV among vulnerable groups and among the general population are modelled, the former is estimated to avert approximately 10 times as many infections. However, given recent evidence that up to one in four adults of sexually active age in Francistown and one in six sexually active adults in Gaborone may have HIV, an exclusive emphasis on "primary risk groups" may omit large secondary risk groups who have already been substantially exposed to HIV. It is thus important to combine intensive targetted intervention among high risk groups with community - wide outreach and mobilisation.

Peer education led community outreach

This may be done by recruiting members of vulnerable groups to serve as peer educators and condom distributors, first to their immediate peers and then to the larger community. The philosophy of peer education led outreach is to take AIDS education to situations where men and women at "high risk" of HIV infection gather, to places where people feel relaxed and attentive. Here peer educators conduct intensive interpersonal education in their social and geographic networks. In addition, they can help to organise and conduct public meetings. These may be held at convenient times, before patrons are drunk, in bars, hotels, beergardens and shebeens, and aimed primarily at men. Similarly, home - based meetings may be held at convenient times during the day, aimed primarily at women. Meetings for both sexes may be held in marketplaces, bus stops and other public places.

Such community programmes combining targetted intervention with community - wide outreach have been initiated in 6 Zimbabwean cities: Bulawayo, Gwera, Mutare, Masvingo, Shurugwi and Kariba.

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Recent evaluations of these interventions suggests that properly designed and managed community peer education programmes can achieve widespread coverage and impact with great economy.

For $ 85,000 the combined programmes:

held 12 865 community meeting attended by 1.03 million people
distributed 5.74 million condoms

One completed study and other provisional data indicate promising programme coverage and impact: over 80% of a sample of 705 prostitutes had attended community AIDS meetings and 83% had been taught by a peer educator and of these over 90% had recieved condoms from the project.
The percentage reporting condom use with last client rose from 18% before the programme to 66% two years later. Reported condom use was strongly related to programme exposure

27% of those who had attended 0 meetings
46% of those who had attended 1 meeting
74% of those who had attended 2 - 4 meetings and
80% of those who had attended 5 or more meetings
reported using condoms with their last client.
[Nyathi, Wilson, Lamson, Foster, Dawka et al
Community Interventions in Zimbabwe: Analysis of Multi - Site Replication]

Where gaps in coverage were identified, they could be clearly traced to geographic gaps in the location of peer educators or community meetings.
This underscores the importance of rigorous mapping, strategic geographic planning and constant review of peer education, community meetings and condom promotion in relation to geographic coverage plans.
The strong linear relation between number of exposures to education and reported condom use affirms the importance of intensive, recurrent programming with continual follow up.

Many towns in Botswana are small, compact and secure, which greatly assists community outreach work. Community interventions could easily be mounted in such "total environments" as Selebi - Phikwe and Orapa and would be quite feasible in both Francistown and Gaborone

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A community intervention programme should have the following components:

- identification of implementing partners

- reconnaissance and mapping of intervention site

- training of outreach coordinator

- recruitment, selection and training of peer educators

- community outreach spearheaded by peer educators

- improved STD services, to reduce presence of STD pathogens especially among "high risk groups". This includes improved partner notification, free, accessible, sympathetic voluntary STD screening among prostitutes, recruitment of women for STD screening and care

- evaluation of programme activities, coverage and impact

Recommendations

1. Community peer education programmes in the major urban areas should play an important role in complementing and reinforcing workplace programmes .
These are recommended as an urgent priority

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APPENDIX L

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TERMS OF REFERENCE OF THE TECHNICAL ASSESSMENT

"The consultant team will consider each of the following issues and address its importance to the overall project goals, successes and failures regarding the project activities to date, and recommendations as to how it should be addressed in future related activities.

1) The role of the Occupational Health Unit in promoting and implementing HIV - related activities in the workplace throughout Botswana. The relationship of the occupational health unit in conducting HIV related activities vis a vis the NACP

2) Review the activities of the working group and consider how it can best be utilised in future efforts

3) Review method(s) of developing materials and company programs By whom and how were the materials and company programs developed and tested; what safeguards are built into the company programs to ensure that correct information is being communicated; what materials are available from other sources which could be incorporated into the project; how will the messages be periodically updated given "new discoveries" and to prevent general boredom concerning the issue; what revisions are required to existing materials to make them more effective

4) Review the effectiveness of company coordinators including:

* Their understanding of HIV - AIDS - related issues
* Their understanding of their role within the company as AIDS coordinator
* Their communication skills to management and workers in both formal (workshops) and informal settings
* Effectiveness of materials used

5) Review the effectiveness of the peer educators including:

* Their understanding of HIV - AIDS - related issues
* Their understanding of their role within the company as AIDS peer educators
* Their communication skills to management and workers in both formal (workshops) and informal settings
* Effectiveness of materials used

6) Review the method of selection of AIDS coordinators by the individual companies and of the peer educators by the AIDS coordinators

7) Based on anecdotal information and focus group discussions, assess what impact has occurred through the project efforts on behaviour modification of the target audience

8) Relevance of US trip: whether additional trips should be sponsored and if so, who should attend, how should be modified etc

9) Relevance of the Zimbabwe trip for senior business leaders, whether additional trips should be sponsored and if so how could they be modified. Should business leaders from other countries be brought to Botswana to observe ongoing activities

10) Effectiveness of the HIV/AIDS presentation made to BOCCIM whether additional presentations should be planned and if so how modified

11) Determine methods by which these project activities can be expanded to include additional workplaces with particular emphasis on issues concerning financing of activities, institutionalisation and sustainability. Identify proper roles and activities for the public and the private sector regarding promoting these activities as well as implementing HIV/AIDS - prevention programmes. Determine why some companies who began participation stopped and why some companies who were contacted chose not to participate. Assess the potential role of unions in both advocacy and worker education and mobilization efforts

12) Determine base line data that should be collected in order to conduct a future impact evaluation and plan the scope of that evaluation.

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APPENDIX 12

SAMPLE OF DIFFERENT FOCUS OF INTEREST OF THE CONSULTANTS

INDUSTRY	TECHNICAL INSTITUTIONAL FM & MS	HCWP	HCDW
General manger General profile of company - size, activities unions etc	General views on programme esp future organisation and financing		Attitude towards HIV issues generally Has programme made any difference to him and his senior colleagues
Personnel Manager (member of working group)	1 management a 2 workers roles in programme 3 general thoughts about the programme institutionalisation of the programme 4 communication structures within the company 5 View of management on the specific benefits to them of the programme 6 Policies on management of HIV 7. Opinions on impact of programme and any behaviour change in the workforce 8. Availability of condoms 9. Any counselling role for him or anyone else in the workplace 10 what resources are made available by management for the programme	1 How were coordinators selected - what criteria were used and who determined what they should be 2 Review functioning of working group - its effectiveness and his role in it How could it be improved Is it the future backbone of the programme 3. General understanding of HIV issues and attitudes 4 Views of role of Occupational Health Unit and National Aids Control Programme	1. Management review of the effectiveness of the coordinators 2. Communications between management and coordinator 3. Management view of effectiveness of peer educators and their communication skills (with workers and with coordinators) 4 General effectiveness and appropriateness of the programme for the specific workplace

Coordinator - general questions about organisation of the peer educators	1. How can programme be sustained in the future 2. Coordinators support network 3. Views on respective roles of management, workers, unions and govt 4. Views on future financing of programme 5. Any change in the relations between you and management as a result of this programme 6. Accessibility of information and materials for training for yourself, the peer educators and the workers (eg where are brochures kept etc)	1. View on roles and contributions of COHI and NACP 2. How were you selected to be a coordinator and how did you feel about it 3. How did you select your peer educators 4. Do they share any characteristics 5. What is their general educational level 6. How is peer education conducted 7. How well does the peer education approach work in your workplace 8. Could any other approach work as well or better	1. Views on effectiveness of coordinators training and the training materials available for working with 2. Cultural relevance and pertinence 3. How was your programme developed how much was your own input 4. Ideas about any alternative strategies or approaches 5. Any need for revisions in the materials 6. Understanding of HIV issues and communication skills 7. Understanding of role in the programme and in the company and feelings about those 8. Self reported level of skill and confidence and further learning requirements or other requirements

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Workers general issues how many are to be considered in what groups do they fall etc possiblity of group discussion	1 Is this programme valuable and what is best form of delivery for the future 2 How do you receive information 3 respective roles of unions, company, management, nurses, community organisations etc for the future 4 Who should pay 5 What happens to a person found to be HIV + here - how are they treated by management and by their fellow workers 6. How should the company treat someone who is HIV +	Have your view on these issues changed Are you talking with your friends or family about HIV issues	Understanding of AIDS related issues Understanding of managing medical, cultural and practical Are your rights of [illegible] assessed Changes in ideas and behaviour – what has influenced your mind

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Key

TM	Mr Taka Mudariki
MS	Dr Margaret Scarlett
IEC	Information, Education, Communication
EP	Dr Eva Procek
DW	Dr David Wilson

APPENDIX 3

LITERATURE REVIEW

1 General References on HIV/AIDS in Botswana

Ahmed G & Brumborg H (1988)
'Knowledge, Attitudes, Prevalence and Prospects of Aids in Botswana'
Paper presented at the Annual meeting of the Population Association of America, New Orleans, April 17th 1988
This survey concluded that the population in Botswana is fairly well informed about AIDS but that few people realised the high risk of personally becoming infected

Ahmed G & Shastri G N (1989)
'People's Fear of Catching AIDS in Botswana : What are they doing to prevent it in the Society ?'
Paper presented to the Annual Conference of the International Union for the Scientific Study of Population, New Delhi 1989

Magami E T (1988)
'AIDS in Botswana'
Paper presented at the First National Workshop on AIDS, Francistown, Botswana 21 - 26 February 1988

Ingstad Bedicte (1989)
'The Cultural Construction of AIDS and Its Consequences for Prevention in Botswana'
Medical Anthropology Quarterly 1989 pgs 28 -40
A description of how traditional Tswana healers perceive AIDS and classify it either as a "Tswana disease" or a "modern disease" , and the consequences of these categorisations for preventing the spread of HIV and the possible role of healers.

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Rao K.V. & Letamo G. (1992)
'Knowledge and Perception of AIDS in Africa - A Case Study of Botswana'
Paper presented at the Population Association of America meetings
Denver April 30 - May 2 1992

National Aids Control Programme, Ministry of Health Botswana
'Report on the First HIV Sentinel Surveillance in Botswana'
July 1992

WORK PLACE BASED HIV AIDS RELATED ACTIVITIES

Barr J.K., Waring J.M. & Warshaw L.J. (1992)
'Knowledge and Attitudes about AIDS among Corporate and Public Service Employees'
American Journal of Public Health 1992 82: 225 - 228
Work site comparisons show that where educational programmes are minimal employees know less about HIV transmission and hold more negative attitudes. The study concludes that comprehensive workplace AIDS education can reinforce workers knowledge about HIV transmission thereby fostering more favourable views towards coworkers with AIDS

Barr J.K., Warshaw L.J. & Waring J.M. (1991)
'Employee Sources of AIDS Information: The Workplace as a Promising Educational Setting'
Journal of Occupational Medicine 1991 33: 143 - 147

Herold D.M. (1988)
"Employees' Reactions to AIDS in the Workplace"
Presented at meeting of the Academy of Management - Anaheim California
August 1988

Best Available Copy

Herold D.M. (1989)
'AIDS in the Workplace: what Georgia workers are thinking'
Presented at conferece on managing AIDS in the workplace, Georgia Institute of Technology, Atlanta January 1989

McCombie S (1992)
'Evaluation of a Workplace based Peer Education Program designed to prevent AIDS in Uganda. Preliminary report'
A.I.D. contract No.I Dpl: 5972 - Z - 00 - 7070 - 00

Occupational Health Unit, Ministry of Health, Botswana (1991)
'AIDS Awareness in the Workplace in Botswana. A review of a preliminary study'

Centers for Disease Control, Commission of the European Communities, International Labour Office, United Nations Educational, Scientific and Cultural Organisation (UNESCO) and the World Health Organisation 1990
'AIDS and the Workplace. Summary of Conference Proceedings'
Conference held in Paris April 25 - 26 1990

COMMUNITY INTERVENTION

Nyathi B, Wilson D, Lamson N, Foster G, Dakwa F et al
'Community Interventions in Zimbabwe: Analysis of a Multi - Site Replication'

Wilson D
'Provisional Rapid Assessment Guidelines for Prostitute Interventions in Sub - Saharan Africa'

Wilson D, Mavesere D, Hood R, Simunyu E, Zenda et al
Behavioural Research to Develop Interventions among Prostitutes and Clients in Zimbabwe'
[The above are all papers of the Dept of Psychology, University of Zimbabwe].

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PAGE 81 WAS NOT USED

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APPENDIX 4
DOCUMENTS CONSULTED

Minutes of the Working Group meetings
November 1991 - August 1992

Limited Scope Grant Project Agreement between
USAID and Government of Botswana
'HIV/AIDS Prevention - Botswana'

AIDS IN THE WORKPLACE - BOTSWANA
Revised Framework and Schedule
June 1 - Sept 30 1991

Draft Policy on HIV/AIDS, Ministry of Health

AIDS AT THE WORKPLACE
Internal OHU paper

Report on AIDS EDUCATION IN THE WORKPLACE CO-ORDINATORS SEMINAR
Gaborone 3 - 7 May 1991

Report on Training of Trainers Seminar for AIDS AT THE WORKPLACE
Gaborone 21 - 25 October 1991

Report on AIDS/HIV IN THE WORKPLACE
compilation of activities in workplaces
(no date)

Report on the First HIV Sentinel Surveillance in Botswana
NACP July 1992

Report on a USA Trip
Project Coordinator, OHU
(no date)

HIV/AIDS PREVENTION IN THE WORKPLACE
PART I - A MANAGEMENT GUIDE
June 1991

Best Available Copy

HIV/AIDS PREVENTION IN THE WORKPLACE
PART II – A PROGRAMME COORDINATOR'S GUIDE
October 1994

A PEER EDUCATORS HANDBOOK ON AIDS PREVENTION AND SUPPORT IN THE WORKPLACE
(no date)

Linda Pfotenhauer in collaboration with the Botswana Red Cross Society
REGRETS
TWO BROTHERS
THE LETTER
Macmillan Botswana 1980

Best Available Copy

APPENDIX 5.

THE SCHEDULE

Monday August 10th		Meeting with Project Coordinator Collection of documents and discussion Preparation of consultants briefings
Tuesday August 11th		Arrival of External Consultants
	9.00am	General Manager Khaladi Management Services [Harare trip]
	10.00am	Gaborone Rep BCL Gaborone [working group member]
	2.45pm	Meet at USAID
	3.00pm	Deputy Permanent Secretary Ministry of Health
Wednesday Aug 12th		
	9.00am	Briefing for team at **USAID**
	3.00pm	**BOCCIM** Deputy Director & Senior Industrial Relations Officer
Thurday August 13th		
	8.00am	Head of **Community Health Div. MoH** [working group member] **Occupational Health Unit. MoH**
	11.30am	**Chief Factories Inspector** Ministry of Labour & Home Affairs [working group member]
	2.00pm	**BFTU (Botswana Federation of Trade Unions)**
	3.30pm	**MANICA**
Friday August 14th		**KGALAGADI BREWERIES**

9.00am	
Saturday August 15th	Discussions and progress report (further discussions as appropriate)
Monday August 17th 9.00am	**ALGO INDUSTRIES**
3.00pm	AWP Project Coordinator
Tuesday August 18th 9.00am	**BDF, GABORONE**
Wednes August 19th 9.00am	**GABORONE SUN**
pm	Travel to Selibi - Phikwe
Thursday August 20th 7.30am	**BCL**
Friday August 21st 9.00am	**BDF, SELIBI - PHIKWE**
pm	Travel to Francistown
Saturday Aug 22nd	**BDF, FRANCISTOWN**
Monday August 24th	**DE BEERS BOTSWANA ORAPA**
Tuesday August 25th	**BOTSWANA RED CROSS** **Rotary Club of Francistown**
Wed 26th - Thurs 27th	Preparation of draft final report
Friday August 28th	Submission of draft final report Departure of external consultants
Friday Sept 4th	Comments on draft final report
Friday Sept 11th	Submission of final report

APPENDIX 6.
PERSONS INTERVIEWED

Ministry of Health

Mrs Mandeva	Head of Community Health Services Division
Dr Moeti	National AIDS Control Programme Manager
Dr Gyi	Head of Occupational Health Unit
Mrs Tembo	Family Nurse Practitioner & Coordinator Of AIDS in the Workplace Project

the

BOCCIM

Mr Dewah	Deputy Director
Mr Robi	Senior Industrial Relations Officer

BFTU

Mr Masunga	Executive Secretary
Mr Marambo	Education Officer (ILO)
Mr Mangena	Education Officer & AIDS in the Worplace Coordinator

Ministry of Labour & Home Affairs

Mr Taolo	Chief Factories Inspector

Botswana Red Cross

Ms Thupayagale	Secretary General
Ms Letsididi	AIDS Educator and Counsellor

U.S.A.I.D

Mr Stewart	Project Officer

Companies

MANICA

Mr Monyatsi	Personnel Manager

BCL LTD

Mr Mmopi	BCL Representative in Gaborone
Mr Obuseng	The Personnel Manager
Mr Bryant	Chief Loss Control Officer
Mr Rabai	Assistant Personnel Manager
Mr Habangana	Personnel Officer and AIDS in the Workplace coordinator
Mr Kumila	Former AIDS in the Workplace coordinator
Dr Ramondo	Chief Medical Officer
5 peer educators	

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ALGO INDUSTRIES

Mr Ratsatsi	Personnel Manger
Mrs Nkacha	Nurse & AIDS in the Workplace Coordinator
Mr Stephens	Health Assistant
2 peer educators	

KGALAGADI BREWERIES

Mr Lekalake	General Manager, Kgalagadi Management Services
Mr Matlhaku	Personnel Manager
Ms Matome	Training Manager and AIDS in the Workplace Coordinator
2 peer educators	

SUN INTERNATIONAL - GABORONE SUN

Mr Contini	General Manager
Mr Gudu	Training Manager and AIDS in the Workplace coordinator

BOTSWANA DEFENCE FORCE, GABORONE

Captain Mabena	Chief Medical Officer
Captain Ovuyu	Family Nurse Practitioner
Captain Letsholathebe	AIDS in the Workplace coordinator
Major Mosinyini	AIDS in the Workplace coordinator
Lt. Kgomo	
Brigadier Fisher	
40 soldiers in a general meeting	

BOTWANA DEFENCE FORCE, SELEBI PHIKWE

Lt Mngqibisa	AIDS in the Workplace Coordinator
Captain Macheng	AIDS in the Workplace Coordinator
2 peer educators	

BOTSWANA DEFENCE FORCE, FRANCISTOWN

Major Mualefhe	AIDS in the Workplace Coordinator
8 peer educators	

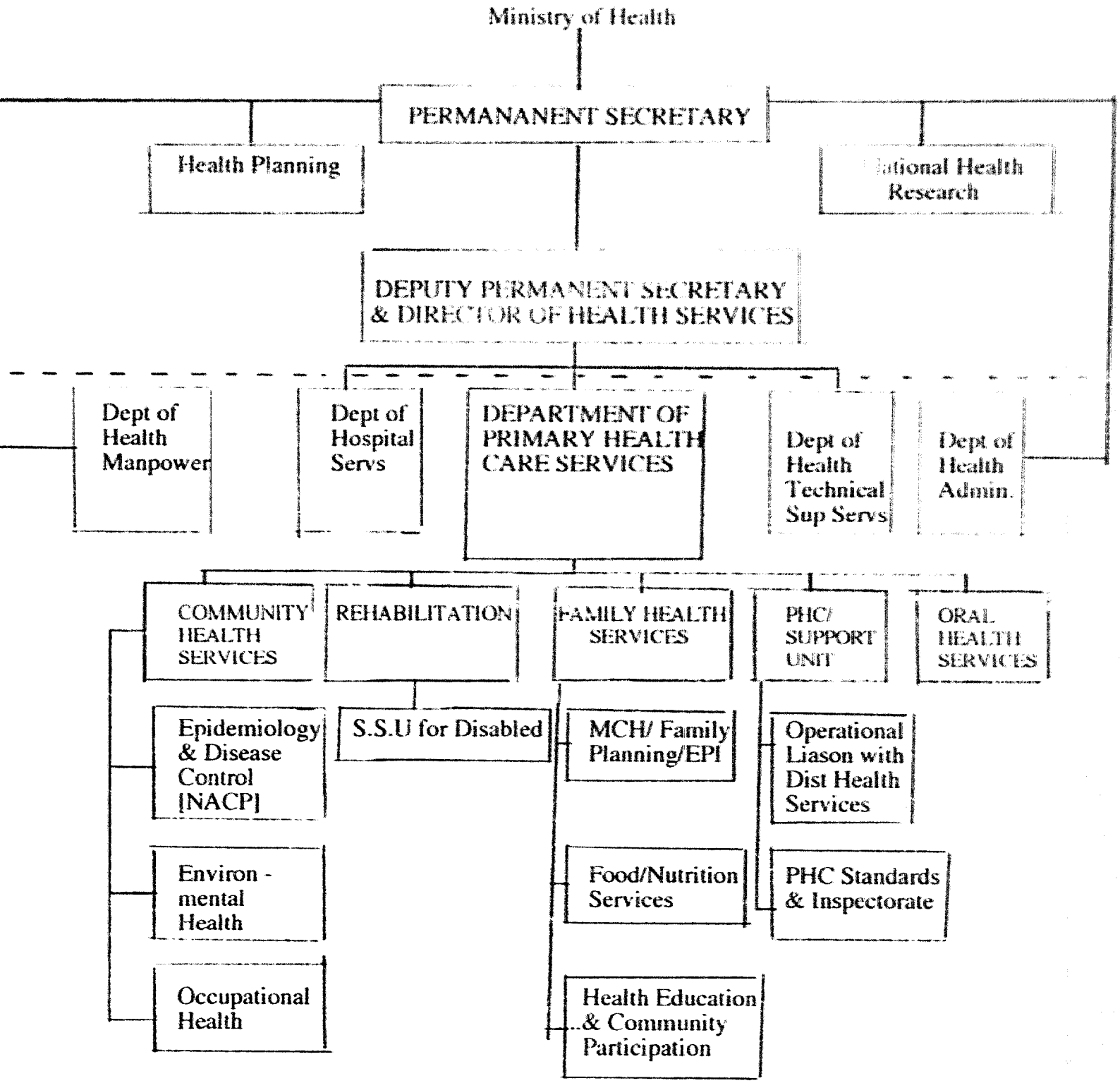
ROTARY CLUB OF FRANCISTOWN

Mr G Oosthuizen	Acting President & President Elect
30 club members and guests	

DE BEERS BOTSWANA MINING COMPANY - ORAPA

Dr Gulubane	Dentist and Chair of Orapa AIDS Action Comm.
Mrs Masole	Nurse & AIDS Coordinator
Mr Lesothi	Social Worker
Dr Tsie	Doctor and AIDS in the Workplace organiser
Dr Pauli	Chief Medical Officer
Mr Wittet	General Manager
Mr Matlhapaphiri	Assistant Personnel Manager
	Community Nurse

APPENDIX 7
ORGANISATION OF DEPARTMENT OF PRIMARY HEALTH CARE SERVICES



APPENDIX 8

EXTRACTS FROM 'BUSINESS RESPONDS TO AIDS'

Centers for Disease Control
U.S. Dept of Health and Human Services

1. Sample Policy for the Workplace

2. Facts About AIDS

3. Example of Suuport and Communication from the Top

4. Action Plans by Strategy

5. Stategies by Objectives

6. HIV / AIDS Program Checklist

Sample Policy: The 10 Principles for the Workplace

1. People with AIDS or HIV (Human Immunodeficiency Virus) infection are entitled to the same rights and opportunities as people with other serious or life threatening illnesses.

2. Employment policies must, at a minimum, comply with federal, state and local laws and regulations.

3. Employment policies should be based on the scientific and epidemiological evidence that people with AIDS or HIV infection do not pose a risk of transmission of the virus to co-workers through ordinary workplace contact.

4. The highest levels of management and union leadership should unequivocally endorse nondiscriminatory employment policies and educational programs about AIDS.

5. Employers and unions should communicate their support of these policies to workers in simple, clear and unambiguous terms.

6. Employers should provide employees with sensitive, accurate and up-to-date education about risk reduction in their personal lives.

7. Employers have a duty to protect the confidentiality of employees' medical information.

8. To prevent work disruption and rejection by co-workers of an employee with AIDS or HIV infection, employers and unions should undertake education for all employees before such an incident occurs and as needed thereafter.

9. Employers should not require HIV screening as part of pre-employment or general workplace physical examinations.

10. In those special occupational settings where there may be a potential risk of exposure to HIV (for example, in health care, where workers may be exposed to blood or blood products), employers should provide specific, ongoing education and training, as well as the necessary equipment, to reinforce appropriate infection control procedures and ensure that they are implemented.

If your organization wishes to endorse the Ten Principles, write to:

The National Leadership Coalition on AIDS
1730 M Street, NW, Suite 905
Washington, D. C. 20036

Developed by
The Citizens Commission on AIDS
of New York City and Northern New Jersey

Facts About AIDS

What Is AIDS?

AIDS means Acquired Immunodeficiency Syndrome. It is caused by the Human Immunodeficiency Virus, or HIV. HIV attacks the immuno system and reduces a person's ability to resist infections and diseases.

- There are already about 1 million Americans infected with HIV, and about 50,000 more become infected each year.
- Fewer than half of those infected know they are infected, but they can still infect others.
- Most people infected with HIV do not show any symptoms of disease for many years after infection.
- HIV infection itself does not affect one's ability to do his/her job.
- There is no risk to co-workers or the public from casual contact with an HIV-infected person.

How Is HIV Transmitted?

HIV can be transmitted:

- By having sexual intercourse (vaginal, anal, or oral) with a man or woman who is infected with the virus
- By sharing needles or syringes with someone who is infected with the virus
- From an HIV-infected woman to her child during pregnancy or childbirth or through breast-feeding
- From transplanted tissue or organs or from HIV-infected blood, blood products, or plasma. (This has been very rare since 1985, when blood centers across the nation were required to begin screening all donated blood for HIV.)

How Is HIV *NOT* Transmitted?

HIV does not just happen. You cannot simply "catch" it like cold or flu viruses. You cannot become infected with HIV from air, food, water, insects, or animals or from a handshake, sneeze, hug, or other casual contact, or even from sharing cups and dishes, tools, telephones, computer keyboards, bathroom facilities, or drinking fountains.

Example of Support and Communication from the Top
(Letter from the President of the New York Public Library to All Staff)

The New York Public Library

Fifth Avenue and 42nd Street, New York, New York 10018

President and Chief Executive Officer

August 5, 1987

Dear Staff Member:

Over the past months intense media attention and public concern have made everyone increasingly aware of the impact of AIDS (Acquired Immune Deficiency Syndrome) on our lives. The dimensions of human and personal tragedy of this epidemic have touched us all. In light of this, I feel it is important that the Library, both as a major employer and as a source of information to the New York population, review with our staff this issue, in particular, and our guidelines generally on life-threatening illnesses.

The two underlying objectives of the Library as a concerned employer in addressing the issue are to ensure a safe healthy environment for all our staff and patrons, and to prohibit all forms of arbitrary discrimination against anyone of our colleagues who may be suffering from a life-threatening illness. Based upon current medical research persons with AIDS do not present a health risk to others in the work place under normal working conditions. As long as staff members suffering from life-threatening illnesses continue to meet acceptable performance standards and medical evidence indicates that their condition is not a threat to themselves or others, managers should ensure that they continue to be treated in the same manner as other staff.

As a major source of information to the people of New York City, the Library has a special obligation. One third of all AIDS cases in the United States have been diagnosed here. It is therefore critically important that we make available accurate and up-to-date information about the disease, its medical advances and its prevention. With this in mind, the Library has helped to spearhead the distribution of material on AIDS, and extensive information is available to the public in all of our branches and in the Economic and Public Affairs Division of the Central Research Library. The enclosed brochure is a synopsis of AIDS information developed for distribution in the workplace.

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So that the Library can respond to the needs and concerns of our staff regarding AIDS, we have developed a questionnaire to be published in Staff News next week. From your input on this, we will be better able to determine the focus of further updates. In addition, the Human Resources Department has already prepared a resource and referral guide for staff members. This will be distributed to all units and is available directly from the Benefits Office, whose staff members can also give consultation on how best to manage health, leave and other benefit matters.

Knowledge of the disease and practices that will prevent its transmission is the only known way, at present, of stemming this epidemic. Each one of us therefore has a particular responsibility to educate ourselves, our families, our friends and the public we serve about AIDS, so that we may do our part to combat this deadly disease.

Sincerely,

Vartan Gregorian

Vartan Gregorian

Action Plans By Strategy

Strategy I:

Assist corporate America in defining terms and developing guidelines for a comprehensive workplace "model" response to HIV and AIDS designed to reach all employees and in implementing and replicating that model.

- Determine barriers to implementing program:
  - -Lack of materials on policy (including Americans with Disabilities Act) and on supervisory and employee education.
  - -Lack of known technical assistance.
  - -Lack of data on costs of HIV to businesses (insurance, litigation).
  - -Easy access to materials, technical assistance, and training.
  - -Fear of impact to company's bottom line and to its reputation for association with HIV issue.
  - -Lack of CEO leadership on the HIV/AIDS issue.

- Provide solutions to overcome barriers:
  - -Identify or develop materials.
  - -Establish appropriate referral systems for technical assistance.
  - -Provide access to resources, technical assistance, and training through Business Responds to AIDS Resource Service in the CDC National AIDS Clearinghouse.
  - -Establish an IPA with a health economist to understand and document HIV costs to business.
  - -Stimulate and increase leadership with a specific marketing campaign to CEOs and other leaders of corporate America.
  - -Evaluate efforts.

- Outline with business and labor organizations and experts components of effective HIV comprehensive workplace programs:
  - -Business and health organizations and associations (National Leadership Coalition on AIDS; New York and Washington Business Groups on Health; American Red Cross; U.S. Departments of Labor and Commerce, and Small Business Administration).
  - -Companies with programs (Levi Strauss, Digital Electronics Corporation, Polaroid, Harbor Sweets, Tusco Manufacturing).
  - -Unions (American Federation of Labor-Congress of Industrial Organizations George Meany Center; American Federation of State, County and Municipal Employees; and Service Employees International Union).
  - -Workplace education experts (Alan Emery, Ph.D.; John Bunker, Sc.D.; William McHugh, Ph.D.; Hazel Witte, J.D.; Barney Singer, J.D.; Erline Belton).

STRATEGIES BY OBJECTIVES

Objective 1: By December 1995, increase by 5 percent the percentage of employees who report that their employer has ever provided workplace-based HIV prevention education programs (of at least approximately 1 hour) for their employees and/or their families (Baseline unknown). Strategies: I, II, III, IV, V, VI

Objective 2: By December 1995, increase by 5 percent the percentage of employees who have ever participated in a workplace-based HIV prevention education program sponsored by their employer (of at least approximately 1 hour). (Baseline unknown). Strategies: I, IV,

Objective 3: By December 1995, increase by 5 percent the percentage of employees who are aware of written policies by their employer that prohibit discrimination or job loss for employees who are HIV positive or who are perceived to be HIV positive. (Baseline unknown.) Strategies: I, IV

Objective 4: By December 1995, increase by 5 percent the number of employees who participate in HIV related prevention education or service activities. For the purposes of this objective, these include participating in an AIDS walk-a-thon; working (volunteering) in an AIDS community organization; initiating AIDS education in their church, local school, civic or social organization; becoming an American Red Cross volunteer for HIV AIDS education, contributing financially to an AIDS organization or activity; or other (to be specified by employee). (Baseline unknown.) Strategies: I, IV

Objective 5: By December 1995, increase by 5 percent the number of employees who report (a) an AIDS activity sponsored by their employer or union; or (b) that their company contributes to HIV activities. (Baseline unknown). Strategies: I, IV

Objective 6: By December 1995, 50,000 companies will have requested and received BRTA materials. Of those, 5 percent (2,000 companies) will have adopted and implemented all 5 components of BRTA (HIV written policies, HIV supervisory training, employee and family education, employee volunteerism, and corporate community service. (Baseline 0% in 1992.) Strategies: I, II, III, IV, V, VI

HIV/AIDS Program Checklist

The following checklist might be useful to an organization as it begins to formulate its AIDS education program. The order of the steps may vary from one program to another:

Planning Phase

1. Identify leader(s) or champion(s).
2. Get support from top leadership.
3. Develop a committee or team.
4. Involve labor unions.
5. Develop and articulate the organization's policy/ guidelines on AIDS, emphasizing confidentiality and non-discrimination.
6. Create a plan of action and a timetable, and assign tasks.
7. Develop a communication plan.
8. Develop a survey or other evaluation method.

Implementation/ Training Phase

1. Identify community contacts for resources and referrals.
2. Identify resources within the organization.
3. Identify and obtain training materials that are appropriate to the culture and literacy level of employees.
4. Implement management/union stewards training.
5. Implement employee training.
6. Implement communications strategy.
7. Implement evaluation.
8. Determine the next steps.

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APPENDIX 9

THE WEEKLY PEER EDUCATORS FORM
and notes on its use

USING THE WEEKLY PEER EDUCATION FORM

1. At the top, record your company, your department, the data of the week ending on Sunday, then your name and signature.

2. There is space to record two AM meetings and two PM GROUP meetings. If you hold more GROUP meetings, use an extra Peer Educator Monitoring Form.

3. For each day of the week record your GROUP meetings.

4. Next to time, record when the meeting started and finished.

5. Next to site, record the specific place where the meeting was held. Don't just put the name of the company, put the exact department and place where the meeting was held.

6. Next to group, write down who the group was: eg Production, Distribution, Personnel, Administration or Security.

7. Next to men, write down the total number of men attending.

8. Next to women, write down the total number of women attending.

9. Next to condoms, write down the total number of condoms you distributed at each meeting.

10. Next to materials, write down the total number of educational materials you distributed at each meeting.

11. The last box is to record your informal 1-on-1 AIDS education activities. In the boxes next to 1-on-1, record the number of men reached 1-on-1, the number of women reached 1-on-1, the number of condoms distributed in 1-on-1 activities and the number of educational materials distributed in 1-on-1 activities.

WEEKLY PEER EDUCATION FORM

Meetings	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
1st AM							
Time							
Site							
Group							
Men							
Women							
Condoms							
Material							
2nd AM							
Time							
Site							
Group							
Men							
Women							
Condoms							
Material							
1st PM							
Time							
Site							
Group							
Men							
Women							
Condoms							
Material							
2nd PM							
Time							
Site							
Group							
Men							
Women							
Condoms							
Material							

1-on-1 activities	Men	Women	Condoms	Materials

APPENDIX 10

THE MONTHLY AIDS ACTIVITY FORM
and notes on its use

USING THE MONTHLY AIDS ACTIVITY FORM

1. At the top, record the company name, month and year.

2. In the next box, summarize activities by department.

3. Under the heading Number of Meetings Held, simply record the number of meetings held in each department over the last month.

4. Under the heading Number of Condoms Distributed, simply record the number of condoms (a) given and (b) sold in each department over the last month.

5. Under the heading Number of Educational Materials Supplied, simply record the number of (a) posters (b) brochures and (c) other materials supplied in each department over the last month.

6. Under the heading Number of Employees Contacted Supplied, simply record the number of (a) men and (b) women contacted in each department over the last month.

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7. In the box entitled Training Sessions Held, you report the training acvitities held to train AIDS educators over the last month. Record the type of session (eg introductory AIDS information, advanced AIDS information, counselling techniques, programme

management), the category of participants (e.g. managers, coordinators, peer educators), the number of sessions held, including length of each session and the number of participants trained.

8. In the box entitled Managers, Coordinators and Peer Educators, you simply report the number of (a) managers (b) coordinators and (c) peer educators who have been (a) selected and (b) trained to date. You also record the number of each category who are estimated to be active on the project.

9. In the box titled STD Data, you record whatever STD data are available for your company.

10. The second page is for qualitative assessment. Your present, in narrative form, your impressions of (a) project successes over the past month (b) problems experienced over the past month and (c) recommendations for improving the project.

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MONTHLY AIDS ACTIVITY FORM

Company _____ Month _____ Year _____

Education and Condom Distribution

Department	Number of Meetings Held	Number of Condoms Distributed		Number of Educational Materials Supplied			Number of Employees Contacted	
		Free	Sold	Posters	Brochures	Other	Male	Female
Production								
Administration								
Personnel								
Marketing								
Distribution								
Security								
Other Departments								
Other Departments								
Other Companies								
Other Companies								

Training Sessions Held			
Type of Session	Category of Participants	Number of Sessions	Number of Participants

Managers, Coordinators and Peer Educators			
	Number of Educators Selected	Number of Educators Trained	Number of Educators Active
Managers			
Coordinators			
Peer Educators			

STD DATA

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QUALITATIVE ASSESSMENT

Major successes or achievements in previous month	
Major problems experienced in previous month	
Recommendations to improve programme	

Name _____ Position _____ Signature _____ Date _____

APPENDIX II

THE BOTSWANA WORKPLACE SURVEY FORM

and notes on its use.

USING THE BOTSWANA WORKPLACE SURVEY FORM

1. The Botswana Workplace Survey Form is designed to be administered to employees by a trained interviewee who **DOES NOT KNOW ANY OF THE EMPLOYEES.** This is extremely important, as employees would be reluctant to provide extremely personal information to anyone they know. The interviewee should be carefully trained to administer the survey properly and should practice using the survey under careful supervision.

2. The interviewer must be trained not to disclose any interview information to anybody.

3. The survey should if possible be administered every 6 months.

4. It should also be administered to a random sample, randomly drawn each time the survey is used. A random sample may be drawn in several ways. The company could draw a random selection of names from a register of all employees. Alternatively, employees could be called together and a random sample selected.

5. It is very important that all employees understand that the sample is chosen randomly and that all employees stand an equal chance of selection. All employees must understand that their participation is strictly voluntary and that no-one will object if they

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decline to participate. They must also understand the exercise is absolutely anonymous and that no attempt will ever be made to establish the identity of any interviewee.

6. The sample size will vary according to the size of the company. The following approximate rule of thumb is suggested:

Under 50 employees	10 - 20 respondents
50 - 100 employees	20 - 40 respondents
100 - 500 employees	40 - 100 respondents
Above 500 employees	100 - 200 respondents

7. The data should then be analyzed. Simple frequency and distribution data may be compiled by hand. However, if computer facilities are available, crosstabulations may be useful. In either case, it is important to produce simple graphs, initially depicting sexual behaviour at the outset of the programme and thereafter illustrating exposure to education, trends of behaviour change over time and sexual behaviour in relation to the number of AIDS activities attended. The latter may be compiled into a useful table.

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	0 meetings attended	1-2 meetings attended	3-4 meetings attended	5+ meetings attended
Number of casual partners in last 3 months				
% using condoms with last casual partner				

This simple table helps to show whether one's activities bear any relation to fewer casual sexual partners or to increased condom use with casual partners.

8. Finally, it is important to disseminate this information, in graph form, to both managers and employees. If correctly used, results may serve as a form of advocacy for the programme and as a source of motivation for sustained behaviour change.

BOTSWANA WORKPLACE SURVEY

Interviewer_____ Date today_____

Company_____ Department_____

Sex of interviewee [BY APPEARANCE]_____

The answers to this health survey will be used to develop health programs that might help you. Some of the questions are personal, but necessary in order to get important information. Your answers will be completely confidential. Please make every effort to answer each question as honestly as possible. The interview should take about 15 minutes. Please ask me if you have any questions.

1. What year were you born in?_____

2. How many years of education have you completed?_____

3. What is your main job?_____

4. What is your marital status?
   Married_____
   Divorced_____
   Widowed_____
   Nevermarried_____

5 How long have you worked at this company?
   Don't work at this company_____
   Under 3 months_____
   3 months to under 1 year_____
   More than 1 year_____

6. The next few questions are important. They are about AIDS. Have you ever heard about AIDS?
   Yes_____ No_____ [IF NO, SKIP TO 21]

7. Can you get the AIDS virus from having sexual intercourse?
   Yes_____ No_____ Not sure_____

8. Can you get AIDS by having sex with a person who looks healthy?
   Yes_____ No_____ Not sure_____

9. Can you reduce the risk of AIDS by having one faithful sexual partner who is also faithful to you?
   Yes_____ No_____ Not sure_____

10. Do know what a condom is? [SHOW CONDOM]
   No____ [IF NO, SKIP TO 11]
   Yes___ (IF YES) a. Can condoms reduce the risk of getting AIDS?
   Yes_____ No_____ Not sure_____

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11. Can a pregnant woman give AIDS to her baby?

Yes_____No_____Not sure_____

12. Is there a cure for AIDS?

Yes_____No_____Not sure_____

13. Can you get AIDS by working next to a person who has AIDS?

Yes_____No_____Not sure_____

15. Do you think there is a risk that you may get AIDS? Would you say there is:

No risk____ Little risk_____ Big risk____

16. Have you ever attended an AIDS education meeting in this workplace?

No_____**[IF NO, SKIP TO 17]**

Yes_____**(IF YES)**

a. How many AIDS education meetings have you attended in this workplace in the past six months?

1 2 3 4 5 6 7 8 9 10+

b. In the past six months, have you got any condoms at an AIDS education meeting held in this workplace?

Yes_____No_____

c. When was the last meeting you attended in this workplace?

_____

Month Year

17. Have you ever attended an AIDS education meeting in this workplace?

No_____**[IF NO, SKIP TO 18]**

Yes_____**(IF YES)**

a. How many AIDS education meetings have you attended in this workplace in the past six months?

1 2 3 4 5 6 7 8 9 10+

b. In the past six months, have you got any condoms at an AIDS education meeting held in this workplace?

Yes_____No_____

c. When was the last meeting you attended in this workplace?

_____

Month Year

18. Have you ever heard about AIDS from a peer educator from this workplace?

No_____[IF NO, SKIP TO 19]

Yes_____(IF YES)

a. How many times have you talked about AIDS with a peer educator from this workplace?

1 2 3 4 5 6 7 8 9 10

b. In the past six months, have you got any condoms from a peer educator from this workplace?

Yes_____No_____

c. When was the last time you talked about AIDS with a peer educator from this workplace?

_____

Month Year

19. Have you ever heard about AIDS from a peer educator from this workplace?

No_____[IF NO, SKIP TO 20]

Yes_____(IF YES)

a. How many times have you talked about AIDS with a peer educator outside this workplace?

1 2 3 4 5 6 7 8 9 10

b. In the past six months, have you got any condoms from a peer educator outside this workplace?

Yes_____No_____

c. When was the last time you talked about AIDS with a peer educator from this workplace?

_____

Month Year

20. Have you seen any of the following in the last six months?

a. AIDS video Yes_____No_____

b. AIDS drama Yes_____No_____

c. AIDS brochure Yes_____No_____

d. Other Yes_____No_____

(Specify) _____

It is important to ask these personal questions about your sexual life. Remember we do not know your name. Please try to answer as honestly and accurately as possible. Your answers are confidential.

21. Do you have a steady sexual partner, such as a spouse or steady boyfriend /girlfriend?

Yes _____ No _____

22. **[IF YES]** In the last three months, have you had sexual intercourse with your steady partner?

Yes _____ No _____

23. **[IF YES]** Did you use a condom the last time you had sex with your steady partner?

Yes _____ No _____

24. **[IF YES]** In the last three months, how many times did you use a condom with your steady partner?

Would you say it was:

Never _____
Less than half the time _____
About half the time _____
More than half the time _____
(but not always)
Always _____

25. In the last 3 months, did you have sex with a casual partner?

Yes _____ No _____

[IF NO END HERE AND THANK INTERVIEWEE]

26. In the last three months, how many casual partners did you have sex with?

27. Did you use a condom with your last casual sexual parnter?

Yes _____ No _____

28. In the last three months, how often did you use a condom for casual sex?

Never _____
Less than half the time _____
About half the time _____
More than half the time _____
(but not always)
Always _____