

**PROCESS EVALUATION OF THE MULTIPLE CONCURRENT PARTNERSHIPS
“O ICHEKE, BREAK THE CHAIN” CAMPAIGN FOR HIV PREVENTION IN BOTSWANA
FROM 2009 - 2012**

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A mini- thesis submitted in partial fulfillment of the requirements for the degree of
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TEN KEYWORDS

Process Evaluation

Multiple concurrent partnerships (MCP)

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HIV and AIDS

Health communication

Communication theory

Behaviour change communication

Fidelity to an implementation plan

O Icheke



DECLARATION

I declare that “*Process Evaluation of the Multiple Concurrent Partnerships “O Icheke- Break the Chain “Campaign for HIV Prevention in Botswana from 2009 – 2012”*” is my own work, that it has not been submitted for any degree or examination in any other university, and that all sources I have used or quoted have been indicated and acknowledged by complete references.

Full name: Emmanuel Mafoko

Date: 21st May 2013

Signed.....



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ABSTRACT

PROCESS EVALUATION OF THE MULTIPLE CONCURRENT PARTNERSHIPS “O ICHEKE, BREAK THE CHAIN” CAMPAIGN FOR HIV PREVENTION IN BOTSWANA FROM 2009 - 2012

Botswana has the second highest HIV prevalence rate in Southern Africa, estimated at 17.6% for the total population (NACA, 2008). Despite a high level of awareness about ways of preventing HIV (82.4%), the rate of new infections is still high, suggesting that behaviour change remains a challenge (NACA, 2009). In response, the Government of Botswana launched a three year National Multiple Concurrent Partnership “O Icheke - Break the Chain” campaign in 2009 for the prevention of HIV infection.

The aim of this study was to conduct an evaluation of the campaign implementation between 2009 and 2012, taking account of its implementation plan. This qualitative evaluation study employed a descriptive study design focusing on whether the programme components were being implemented as planned and whether any issues that have arisen, require attention. Key Informant Interviews were conducted with a purposive sample of 12 respondents drawn from the study population of people who were directly involved with the campaign, and a documents review was also conducted.

Findings indicated that campaign activities were implemented according to the plan, except for the recruitment of campaign champions which was hampered by erratic funding. Findings also showed that support for district level implementation of campaign activities such as capacity building and advocacy was available but the campaign roll-out was affected by delayed funding. Strategies for development and distribution of materials were followed and materials development matched the specifications of the campaign in design, quality, messages and portability. Review of campaign

documents also attested to the fact that campaign design and planning were informed by behavioural theory and evidence based health communication programming. Gaps in monitoring and evaluation efforts were revealed and attributed to the absence of a Monitoring and Evaluation Officer. This hampered monitoring and reporting activities at national and district level.

In summary, factors which enhanced implementation were identified as strong stakeholder commitment, national reach and coverage, powerful branding, wide public debate and media coverage, while factors which hampered implementation were identified as erratic and delayed funding, organizational politics and conflicts, slow campaign roll-out to districts, weak and incapacitated local Community Based Organizations (CBOs) and inadequate monitoring and reporting activities at all levels. A number of recommendations were offered to improve implementation of campaigns, and opportunities for further research were proposed.

May 2013



DEFINITION OF TERMS

Process Evaluation: is the assessment of whether a program is delivered as planned. In the present context, process evaluation addresses questions concerning how well and under what conditions a mass media health communication campaign was implemented, and the size of the audience that is exposed to the message (Freimuth *et al*, 2000). Process evaluation is also synonymous with implementation evaluation.

Multiple Concurrent Partnerships (MCPs) are defined as two or more sexual partnerships that overlap in time increasing the risk of acquiring and transmitting Human Immune Virus (HIV), because each new partnership introduces a pathway for transmission.

Campaign: a campaign is an intervention that uses the media, messaging, and an organized set of communication activities to generate specific outcomes in a large number of individuals and in a specified period of time (Salama, 2011).

HIV and AIDS: HIV is a virus which is transmitted from an infected individual to an uninfected one through sexual intercourse (both vaginal, anal and oral), injecting drug use, infected blood products and mother-child transmission, resulting in weakening of the immune system and eventually causing the disease AIDS.

Health Communication: is the study and use of communication strategies to inform and influence individual and community decisions that enhance health (Centres for Disease Control (CDC), 2001).

Communication Theory: applying scientific methods, concepts and domains to the study of communication, as in the case of study of behaviour change resulting from exposure to a communication campaign (Finnegan, Jr, 2010).

Fidelity: the extent to which an intervention is delivered as planned. It represents the quality and integrity of the intervention as conceived by the developers. Fidelity is a function of intervention providers (Linnan and Steckler, 2002).

Behaviour Change Communication: is a research-based consultative process of addressing knowledge, attitudes and practices through identifying, analysing and segmenting audiences and participants in programmes by providing them with relevant information and motivation through well defined strategies, using an audience-appropriate mix of interpersonal, group and mass-media channels, including participatory methods (United Nations Childrens' Fund (UNICEF), 2005).

Interventions: in the context of HIV and AIDS, these are actions aimed at scaling up a comprehensive package of HIV prevention, treatment and care, and strengthening health care systems by government and implementing partners from various sectors (World Health Organization (WHO), 2009).

O Icheke: means “Check yourself” in literal meaning but in essence meaning “be cautious”; it is the brand identity and name of Botswana National Multiple Concurrent Partnership campaign.

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ACHAP	African Comprehensive HIV and AIDS Partnerships
ART	Anti- Retroviral Therapy
BAIS III	Botswana AIDS Impact Survey III
BCIC	Behaviour Change Intervention Communication
BOCAIP	Botswana Christian AIDS Intervention Program
BNAPS	Botswana National AIDS Prevention Support Project
CA	California
CDC	Centers for Disease Control
CSOs	Civil Society Organizations
DACs	District AIDS Coordinators
DHMTs	District Health Management Teams
GoB	Government of Botswana
FBOs	Faith Based Organizations
HIV	Human Immunodeficiency Virus
HRDC	Health Research and Development Committee
IBRD	International Bank of Reconstruction and Development
IEC	Information, Education and Communication
IPs	Implementing Partners
LTA	Lead Technical Agency
MCPs	Multiple Concurrent Partnerships
MOH	Ministry of Health
NACA	National AIDS Coordinating Agency
NAC	National AIDS Council
NOP	National Operational Plan
NGOs	Non-governmental Organizations
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
SADC	South African Development Community
PSI	Population Services International
TAC	Technical Advisory Committee

TRaC	Tracking Results Continuously
UNAIDS	United Nations Joint Program on AIDS
UNICEF	United Nations Children’s Emergency Fund.
USAID	United States Agency for International Development
UWC	University of Western Cape
VCT	Voluntary Counseling and Testing
VMSACs	Village Multi-sectoral AIDS Committees
WHO	World Health Organization
ZNFPC	Zimbabwe National Family Planning Council



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CHAPTER ONE- INTRODUCTION

1.1 Introduction

According to the United Nations Joint Program on AIDS (UNAIDS), the global HIV prevalence rate was estimated at 33.3 million people in 2010. In 2009, there were an estimated 2.6 million (2.3 million–2.8 million) people who became newly infected with HIV. This was nearly one fifth (19%) fewer than the 3.1 million (2.9 million–3.4 million) people newly infected in 1999 and more than one fifth (21%) fewer than the estimated 3.2 million in 1997, the year in which annual new infections reached peak. In 33 countries, the HIV prevalence has fallen by more than 25% between 2001 and 2009 and 22 of these countries are in Sub-Saharan Africa (UNAIDS, 2010). Despite the fact that prevalence is declining, there is an indication that the epidemic is not yet contained.

In sub-Saharan Africa, where the majority of new HIV infections continue to occur, an estimated 1.8 million people became infected in 2009 which is 400,000 fewer than the estimated 2.2 million people in sub-Saharan Africa newly infected with HIV in 2001 (UNAIDS, 2010). The HIV epidemics in sub-Saharan Africa vary considerably, with Southern Africa still the most severely affected. An estimated 11.3 million people were living with HIV in southern Africa in 2009, nearly one third (31%) more than the 8.6 million people living with HIV in the region a decade earlier (UNAIDS, 2010). Globally, 34% of people living with HIV in 2009 resided in 10 countries in Southern Africa; 31% of new HIV infections in the same year occurred in these 10 countries, as did 34% of all AIDS-related deaths. About 40% of all adult women with HIV live in Southern Africa (UNAIDS, 2010). According to UNAIDS (2010), the HIV incidence appears to have reached a peak in the mid-1990s, and there is evidence of declines in incidence in several countries in sub-Saharan Africa (UNAIDS, 2010). According to UNAIDS (2010), with an estimated 5.6 million people living with HIV in 2009, South Africa's epidemic remains the largest in the world. At an estimated 25.9% in 2009, Swaziland

has the highest adult HIV prevalence in the world (UNAIDS; 2010). However, in the Southern African region, the annual HIV incidence among 18-year olds declined sharply from 1.8% in 2005 to 0.8% in 2008, and among women 15–24 years old it dropped from 5.5% in 2003–2005 to 2.2% in 2005–2008 (UNAIDS, 2010). New indications show a slowing of HIV incidence amid some signs of a shift towards safe sex among young people (UNAIDS, 2010). In Zimbabwe, the main behavioural change appears to have been a reduction in the proportion of men with casual partners, while condom use with non regular partners has remained high since the late 1990s (UNAIDS, 2010). This decline reflected a combination of factors, including the impact of HIV prevention efforts and the natural course of HIV epidemics (UNAIDS, 2010).

Botswana is the country most severely affected by HIV/AIDS in the world, after Swaziland. The scale of the human cost of HIV/ AIDS is great. AIDS-attributed mortality in Botswana increased from 4 to 27 percent of all reported deaths between 1992 and 2003 and the national HIV prevalence rate among adults from 15–49 years is now estimated at 17.6 percent, and a total of 283,000 people, out of a population of more than 1.8 million, were living with HIV/AIDS in Botswana in 2008 (World Bank, 2010). The adjusted HIV prevalence in Botswana remains relatively high and it was estimated at 30.4% among pregnant women aged between 15 and 49 years (Ministry of Health, 2011). The 2011 sentinel survey indicates that most sites have infection rates of over 30 percent, with Bobirwa Sub-District recording the highest levels.

Table 1 show that the rural-urban differences have almost disappeared. This is an indication that the HIV virus is almost evenly distributed all over the country.

Table 1: HIV Sero-Prevalence among Pregnant Women: (MoH, 2011).

Sentinel site	HIV Prevalence (%)	Sample size
Bobirwa (rural)	41.8	363
Selibe Phikwe (urban)	41.2	288
Serowe/ Palapye (rural)	38.1	458
Chobe (rural)	37.1	143
Francistown (urban)	37	547
Mabutsane (rural)	36.7	95
Tutume (rural)	35.9	403
Kgatleng (rural)	34.5	330
Mahalapye (rural)	33.5	463
Kweneng West (rural)	33	157
Good Hope (rural)	30.8	194
Hukuntsi (rural)	30.5	118

Source: Department of HIV and AIDS Prevention and Care, Ministry of Health. *HIV Sentinel Surveillance Report 2011*

Key factors fuelling the HIV/AIDS epidemic in Botswana according to the World Bank (2010) included the incidence of multiple concurrent sexual partnerships, the incidence of unprotected sex and inter-generational sexual relationships, higher vulnerability among women, persistent inequality and poverty, and high levels of population mobility. The World Bank findings are also supported by the SADC Think Tank report which has identified leading key drivers of the epidemic as multiple concurrent partnerships (MCPs), intergenerational sex, alcohol abuse, and gender violence, low levels of condom use and low rates of medical male circumcision. The similarities of both reports is

that they have acknowledged MCPs and intergenerational sex as leading key drivers of the epidemic, while their difference lies in the fact that the SADC Think Tank report identified low rates of condom use and male circumcision as among the key drivers, while World Bank has identified structural factors such as poverty, gender inequality and population mobility as among the key drivers. The impact of the HIV/ AIDS epidemic in Botswana has already undermined the very significant socioeconomic development achievements realized over the past three decades (World Bank, 2010).

In response to the HIV and AIDS problem, the Government of Botswana made a strong commitment to provide care and support for those infected and affected by HIV/AIDS and to attempt to prevent further transmission of the virus through implementation of national HIV/AIDS prevention programs (NACA, 2008). As a result of that, positive trends have been registered regarding knowledge, attitudes, practices and behaviours (NACA, 2008). The BAIS III study of 2008 reported on knowledge of HIV and its risk factors. Results indicated that the percentage of young men and women aged 15-24 years who were knowledgeable about HIV transmission or prevention had on aggregate increased from just over 28% in 2004 (BAIS II) to 43% in 2008 (NACA, 2008). National AIDS Coordinating Agency (NACA) (2008) findings also showed that most respondents were relatively aware of risk factors for getting STIs and HIV, noting unprotected sex (97%) and having many sexual partners (98%) as key contributors.

1.2 PROBLEM STATEMENT

HIV/ AIDS prevalence continues to be high in Botswana, and is the second highest (17.6%) in Southern Africa, after Swaziland. Multiple concurrent sexual partnerships (MCPs), alcohol abuse, gender violence, intergenerational and transactional sex as well as low levels of safe male circumcision and inconsistent condom use have been identified as key drivers of the epidemic in Botswana (NACA, 2009) together with structural factors (World Bank 2010) The key drivers of the epidemic, as discussed in the previous section, have been found to be contributing to high rates of HIV infections not only in Botswana but in the whole Southern African region (Southern African Development Community (SADC), 2006). Despite high levels of awareness of HIV transmission routes and prevention methods, behaviour change with regard to risky sexual behaviours, such as multiple concurrent partnerships, is still a challenge.

The Government of Botswana therefore decided to embark on a HIV prevention campaign called “O Icheke - Break the Chain”, designed to address one of the key drivers - MCPs. The problem to be focused on in this study is that it is not known whether the “O Icheke - Break the Chain” campaign has been implemented in line with its plan. An implementation or process evaluation was designed to assess fidelity to the campaign implementation plan.

1.3 STUDY PURPOSE/ RATIONALE

It is important to reduce the spread of HIV in Botswana and the “O Icheke - Break the Chain” campaign on MCPs, which is part of Botswana Government’s investment in HIV prevention, was intended to make a contribution to this. Its potential impact depended in part on effective implementation. According to the campaign plan (NACA, 2009), monitoring of the national campaign plan was to be conducted on quarterly, semi-annual and annual bases, to gather sufficient information to measure implementation and achievement of objectives; it was planned for midterm

while an impact evaluation will be undertaken at the end of the campaign. A more detailed process evaluation of implementation of the campaign was not planned from the beginning, necessitating the important of conducting this study.

This is, therefore, a process or implementation evaluation which seeks to contribute to the body of knowledge with regard to implementation of HIV prevention campaigns and it is intended to ascertain whether the campaign is on the right track to impact on behaviours and whether there was a need to revise messaging strategy. It is therefore important to evaluate whether the implementation in the first three phases matched the implementation plan. This process evaluation is going to be complemented by the outcome evaluation which was carried out by Population Services International (PSI) at the end of 2012.



1.4 THESIS OUTLINE

Chapter 1: The chapter presents background on HIV and AIDS globally, and it explores the burden of HIV in Botswana; in addition, the problem statement and rationale for the study is presented.

Chapter 2: This chapter presents a literature review of multiple concurrent partnerships as a predisposing behaviour to HIV infections, MCP campaign interventions to date and communication campaigns as a method for addressing MCP behaviours.

Chapter 3: The research methodology section includes the rationale for conducting a process evaluation, a discussion of the study design, the study sample, the data collection process, the data analysis procedures, limitations and the ethical considerations of the study.

Chapter 4: In this chapter the findings from both Key Informants and Document Reviews are

presented.

Chapter 5: In this chapter a discussion of the relevant findings in relation to relevant literature will be presented.

Chapter 6: The conclusion, recommendations for theory and practices, and implications for future evaluation research will be offered.



CHAPTER TWO - LITERATURE REVIEW

2.1 Introduction

The first part of the review examines evidence on multiple and concurrent partnerships (MCPs) as a factor in HIV infection in the Southern African Region, drawing on findings generated by the SADC Think Tank Report of 2006 on HIV Prevention, as well as evidence from a study on MCPs in Botswana which was conducted by PSI in 2007. The review also covers some case studies of MCP campaigns implemented in countries in the region, such as South Africa, Swaziland and Uganda. This section concludes by detailing how the Botswana National “O Icheke - Break the Chain” MCP campaign was designed and planned.

The second part of it covers evidence about health communication campaign planning, design and execution. It also evaluates some evidence on health communication campaigns efficacy and effectiveness as well as their shortcomings. It also reviews theoretical underpinnings of communication and lastly elaborates on the value of process evaluation in health communication campaigns.

A comprehensive, detailed strategy to search for peer-reviewed journal articles, book chapters, research and evaluation reports, technical reports and conference papers relevant to this review was devised and undertaken. The intent was to locate all documents relevant to the evaluation study that were published from late 1987 through to 2011 on selected databases.. First, comprehensive searches of the Ebscohost, PsycINFO and Medline computerized databases were conducted. The following keywords were used in combination in the search: “HIV”, “AIDS”, “mass media”, “campaign”, “intervention”, “process evaluation”, “multiple concurrent partnerships”, “health communication”, “communication theory”, “behaviour change communication” and “social marketing.

In addition to the above mentioned process, various kinds of research papers on HIV and AIDS mass communication campaigns were searched online on Google scholar. The purpose undertaking such process was to supplement the electronic data bases searched and to identify other documents that were not included in them. All articles that were considered for inclusion in the whole search process had to meet the following criteria in order to be included in the review:

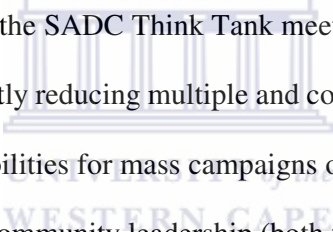
- (1) Published from 1987 to 2011;
- (2) Health communication had to be a central or significant component of the campaign process evaluation study;
- (3) As the focus was on HIV/ AIDS prevention campaigns, those campaigns that focused on increasing safer sexual behaviours, reduction of sexual partners, reducing risky sexual behaviours, condom use and encouraging HIV testing were included;
- (4) Studies had to provide empirical findings assessing the process of implementing health communication campaigns. This ensured higher-quality campaign evaluations and avoided the inclusion of abstracts where limited information about campaign design and evaluation is reported.

2.2 Regional Perspectives and Case Studies

One of the key drivers of the epidemic in southern Africa was identified as multiple concurrent partnerships by men and women (SADC, 2006). Male attitudes and behaviours, intergenerational sex, gender and sexual violence, stigma, lack of openness, untreated viral STIs and inconsistent condom use in long-term multiple and concurrent partnerships were also identified as significant contributing drivers of the epidemic (SADC, 2006). The SADC Think Tank findings are also supported by the World Bank report of 2011, which has also identified MCPs and intergenerational sex as key drivers of the epidemic. The World Bank report also identified other key underlying drivers of the epidemic as social and structural factors such as high population mobility, inequalities

of wealth, cultural factors and gender inequality that render young women especially vulnerable to HIV infection (World Bank, 2010).

It has been found out that multiple concurrent partnerships are not the outcome of any single phenomenon but have many different facets and underlying causes including and combining, deep-seated cultural traditions and modern phenomena (NACA, 2009). According to PSI (2007) these phenomena evolve from a typology of the different functions that additional partnerships (to the primary or first partnership during a given period) fulfil in people's lives. PSI (2007) has identified these typologies, as (1) avoiding enforced abstinence, (2) sexual variety, (3) material gain and (4) seeking a main partner.



One of the key recommendations of the SADC Think Tank meeting was for Southern African countries to work towards significantly reducing multiple and concurrent sexual partnerships for both men and women by exploring possibilities for mass campaigns or social movements. These should have strong political, religious and community leadership (both top down and bottom up) and use mass media to expose and discourage multiple partnerships as a threat to individual and public health (SADC, 2006).

In response to that call, several countries in the Southern African region have implemented innovative health communication campaigns to educate people about multiple concurrent partnerships. Apart from the Botswana National MCP "O Icheke - Break the Chain" campaign, other promising MCP campaigns in Africa are the "Scrutinize" Campaign in South Africa, the "Secret Lovers" (Amakhwapeni) campaign in Swaziland and "Zero Grazing" in Uganda.

In South Africa, the evidence based MCP Campaign called Scrutinize, was conceived to include a combination of multi-media approaches, combining an advertising campaign with popular multilevel communication activities that spoke directly to youth in communities and on university campuses (Spina, 2009). Scrutinize has since become a popular slogan among young people and in 2009 it won the Khuza Award, South Africa's biggest competition for communications marketed towards youth (Spina, 2009).

In Swaziland an MCP campaign known as Makhwapheni (The Secret Lovers) was launched in 2006 as the country's first national media effort to focus on the HIV risk of multiple and concurrent sexual partnerships (MCP). The Makhwapheni campaign was evaluated through the assistance of USAID and the overall results showed that 86 percent of respondents had heard of the campaign and understood the key campaign message (Spina, 2009).

Key findings from the recent 2009 Panos East African study of the Ugandan MCP Zero Grazing campaign reported on the effectiveness of the campaign and suggested the following key points and recommendations: "...(1) that messages about MCP are ineffective unless they address issues of domestic violence and stigma related to condom use and HIV testing; (2) MCP communication should be integrated with prevention strategies rather than as stand-alone and separate campaigns; (3) The findings revealed that most MCP messages are not reaching rural communities in language and formats which can be easily understood by illiterate communities; (4) The findings also revealed a gap in research work on MCPs and suggested that more of it is needed to understand community perceptions and the complex social and structural drivers of HIV, including culture, masculinity and gender, with particular reference to MCPs" (Panos East African Study Report, 2009. P4).

2.3 National “O Icheke- Break the Chain” MCP Campaign

2.3.1 *Why the need for the campaign?*

A recent Population Services International (PSI) study of 2010 revealed that the rate of MCPs in Botswana is 17.5%, with both men and women practicing them. This was also supported by Carter *et al* (2007) who observed that although multiple concurrent partnerships should not be confused with culturally permitted polygamy, multiple concurrent partnerships are a tolerated pattern of sexual relationship in Botswana. This is evident in the Setswana saying, with reference to men, *"a bull cannot be contained in a single kraal"*, meaning *"...a man is at liberty to have as many partners as he wishes"* (Carter *et al*, 2007).

According to PSI (2007), key informants consulted during the “O Icheke - Break the Chain” campaign development believed that the most frequent type of MCPs occur between older, wealthier men and younger women motivated by sexual variety and material gain respectively. Although the phenomenon of older women seeking to have relationships with younger men seemed to be on the increase, it was still considered much less common than relationships between older men and younger women (PSI, 2007). Young women receive gifts from older men such as cell phones, cars, groceries, clothes and eating out at expensive food outlets and more seriously they also get financial favours for unprotected sex (PSI, 2007). Most young women in Botswana are unemployed and under employed; they are mostly found to work in informal businesses such as hair salons, restaurants, bars and retail stores. Disparities in income levels, unemployment and underemployment status of young women in Botswana places them at the risk of HIV infection because they cannot negotiate safe sex (PSI, 2007).

Evidence suggests that young men indulge in MCPs to seek additional partnerships for sexual variety. These may be one-offs; ‘no-strings attached’ relationships or just-for-fun casual partners, or relationships with sidekicks, ‘small houses’ also known as ‘Ma14’ or ‘14 year olds’ (NACA, 2009 and PSI, 2009). Ma 14 is street jargon for young girls who have just graduated from adolescence. There is also a cultural belief among elderly men that sleeping with those young girls purifies the blood and cleanses diseases. Finally, men and women looking for a serious or stable relationship (i.e. a primary partner) may go through a number of short-term partners while they are looking for permanent ones, resulting in them practising MCPs (NACA, 2009 and PSI, 2009).

2.3.2 The Campaign Project Overview

In response to the issue of MCPs, the Government of Botswana developed the National Operational Plan for Scaling Up HIV Prevention (2008–2010), which gave birth to the National Multiple Concurrent Partnership (MCP) “O Icheke - Break the Chain” campaign (meaning *Check yourself and Break the Chain*). The “O Icheke - Break the Chain” campaign was launched in 2009, as a high-profile, national, multi-year behaviour change campaign that focuses specifically on the acknowledged drivers of the epidemic, initially targeting MCPs. The campaign was planned to last for three years, from 2009 to 2012.

The National AIDS Coordinating Agency (NACA) was mandated to provide leadership, while PSI in collaboration with local NGOs implemented campaign activities for “O Icheke - Break the Chain”. The campaign was created as an initiative focused on a common set of target populations, behaviours, and behavioural drivers with a shared set of messages supported by sustained political leadership (Lillie, 2010). The campaign’s main objectives were to reduce the percentage of people who are engaged in multiple concurrent partnership practices as well as to reduce the rate of new infections.

A campaign plan was developed, articulating the time frame, common objectives, activities such as mass media and interpersonal communication, dissemination of messages through information, education and communication (IEC) materials and resources for implementation of a genuinely national and multi-sectoral effort to address MCP and achieve Botswana's Vision 2016 goal of zero new infections (NACA, 2009) (*Refer to Annex: 1*). The process of developing the campaign plan was designed as a multi-sectoral one, involving national and district level policy-makers, managers and implementers from across the public, private sector and civil society (NACA, 2009) (*Refer to Annex 3*).

Interventions for Phases I and II included dissemination of information, education and communication (IEC) materials in the form of billboards, radio and television spots, leaflets, pamphlets, brochures and posters. Some promotional materials such as cups, umbrella and caps were also distributed to support community-based activities (NACA, 2009). Phase III of the campaign focused on community-level reinforcement activities through one-on-one sessions, group discussions, dramas, testimonials by People Living with HIV/AIDS (PLWHA), community and church events, youth clubs at schools, and poetry/music groups (NACA, 2009). Activities which were planned to be implemented at national and district level were a mass media campaign, kombi advertising, print and electronic (radio, television) and community interpersonal communication interventions.

At national level, it was planned that a campaign coordinating unit be established in the Behaviour Change Information and Communication (BCIC) division of NACA and to be staffed by personnel on secondment from PSI, the campaign Technical Lead Agency. The campaign coordinating unit was proposed to comprise the following staff members; National Campaign Coordinator, two

National Campaign Support Officers, District Support Officers and Monitoring and Evaluation Officer (NACA, 2009).

Oversight for implementation of the campaign at national level was mandated to the National HIV Prevention Technical Advisory Committee (TAC) (NACA, 2009). The campaign coordinating unit was scheduled to report its progress regularly to the National HIV Prevention Technical Advisory Committee (TAC) and other relevant structures (NACA, 2009). An MCP campaign sub-committee was planned to be constituted to oversee implementation of the campaign on a regular basis.

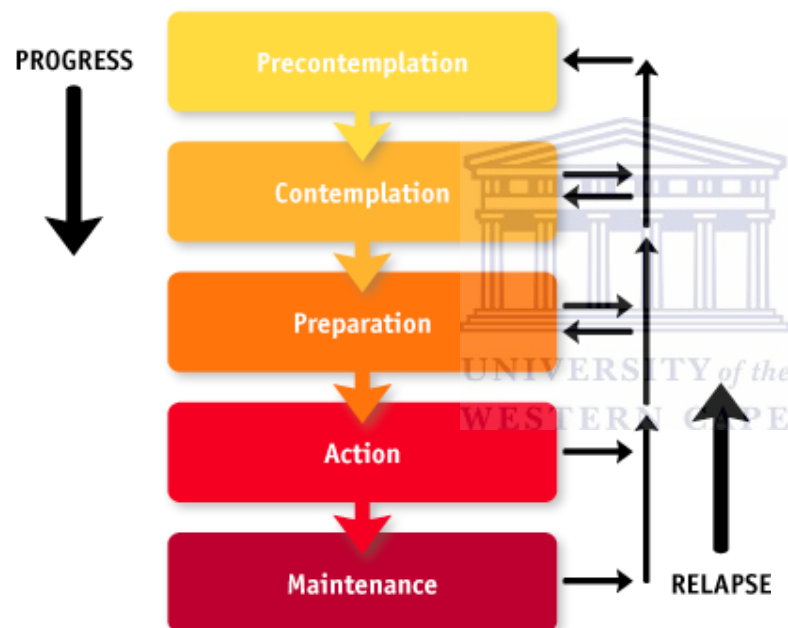
2.3.3 Evidence Upon which the Campaign was Designed

Substantial evidence was also drawn from the National Strategic Framework (NSF II) for HIV and AIDS Response, which identified MCPs as a priority for HIV prevention. MCPs were also identified as a priority in the National Operational Plan for Scaling Up Prevention in Botswana and the goal and the objectives of the campaign were aligned to that National Operational Plan (NACA, 2009). According to the National Campaign Implementation Plan (2009), the process of designing the campaign plan drew on a set of key studies. These quantitative studies have yielded high estimates of the proportion of people who are engaged in MCPs, in between 1 in 5, and 1 in 3 sexually active Botswana men and women respectively have reported that they are personally engaged in MCPs (NACA, 2009). The most consistent demographic difference in MCPs relates to gender, with men being more likely than women to report being in concurrent partnerships (NACA, 2009). Some studies also show that youth, those living in rural areas, and those educated above primary level are most likely to be engaged in MCPs (NACA, 2009).

2.3.4 Application of the Trans-theoretical Model (Stages of Change Model)

According to the National MCP Campaign Plan (2009), the development of the campaign was based on the Trans-theoretical Model, also known as Stages of Change Model. The Stages of Change explains the process of incremental behaviour change, from having no intentions to changing, to maintaining safer behaviours, and it is based on five stages, which are: Pre-contemplation, Contemplation, Preparation, Action and Maintenance (NACA, 2009).

Figure 1: Trans-theoretical Model (Prochaska and DiClemente, 1983)



The campaign’s approach to behaviour change was based on the premise that sustained behaviour change can only be achieved if there is a desire to change within the individual and if there is an enabling environment for adopting and maintaining new behaviours (NACA, 2009). To create desire to desist from MCPs within individuals, the campaign adopted a consumer-centred approach that would not simply tell women and men to ‘do this’ or ‘don’t do that’ (NACA, 2009). Target audiences were offered clear alternatives to their current behaviours, and these alternatives were to

be promoted, or positioned, by means of benefits that were relevant, attractive and important to people's lives (NACA, 2009). At the same time, the campaign was designed to shift perceptions of the risks and costs of MCPs, so that people's evaluation of the costs and benefits of multiple partners alters, and the benefits of sticking to one partner outweigh those of having more than one partner (NACA, 2009). To create an enabling environment for adoption and maintenance of new behaviours, the campaign focused on the values and norms that shape target groups' lives (NACA, 2009).

2.3.5 Audience Segmentation and Message Targeting

The campaign focused particularly on young women between 18 and 24 years (an age group when young women typically have sex for the first time and young men aged 25 to 35 (an age group when young men are typically moving into the workforce for the first time and have sustainable disposable income) (NACA, 2009). However, a general message was also targeted towards older men engaged in cross-generational and transactional sexual partnerships.

Another priority for the campaign messaging was to address the problem of inter-generational sex involving older men who use their status to have sex with vulnerable young girls, who feel pressured to consent (NACA, 2009). The campaign was designed to combine approaches that create individual desire to adopt and maintain safe behaviour and those that create enabling environments for sustained behaviour change (NACA, 2009). The intention of consumer-centred messaging was to promote the relevant benefits of behaviour change and to shift the values and norms that shape target groups' lives so that they felt supported to avoid having multiple concurrent partnerships rather than encouraged to do so (NACA, 2009).

2.3.6 Resources Mobilization for the Campaign

According to the review of campaign documents, resources for the implementation of the campaign plan were mobilized through a partnership framework between NACA, the Government of Botswana, the African Comprehensive HIV/ AIDS Partnership (ACHAP) and Bill and Melinda Gates Foundation; in addition, some resources were allocated from the President's Emergency Plan for AIDS Relief (PEPFAR) through a Center for Disease Control Cooperative Agreement funding mechanism (NACA, 2009). Population Services International (PSI) was contracted by CDC through PEPFAR support to be a Technical Lead Agency for the campaign so that it could drive the planning, design, implementation process, monitoring and evaluation. PSI is also an organization that has extensive expertise in health communication campaigns and social marketing (NACA, 2009).

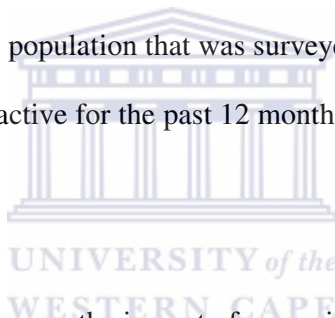
Other resources were mobilized through the Botswana National AIDS Prevention Support project (BNAPS) World Bank loan, amounting to United States \$ 50 million for a five year period to support local NGOs to implement HIV prevention programs. The annual budget for implementing the National "O Icheke" MCP campaign was Botswana Pula (BW P 2 500, 000. 00), equivalent to United States Dollars (US \$ 330,000.00) and the bulk of the campaign budget went to mass media, television and radio and civil society organizations implementing the campaign at local level (NACA, 2009).

2.3.7 Research, Monitoring and Evaluation

As articulated in the campaign plan (NACA; 2009), the concept of MCP encompasses a number of discrete behaviours with a variety of motivations; understanding these phenomena was critical to designing successful interventions. According to the campaign plan (NACA, 2009), four types of research were included in the research agenda for MCPs, which were as follows: a quantitative survey that measured the extent of MCPs, a qualitative study envisioned to provide a perspectives on

the phenomena of MCPs, operational research was to be conducted to identify ways to improve the efficiency and effectiveness of programmatic interventions, and to assess the costs and cost-efficiency of the campaign as well as modelling work that characterises the nature and density of the sexual networks in Botswana.

In addition to the four types of research studies outlined above, NACA and its partners developed a monitoring, research, and evaluation plan for the MCP campaign in August 2009 (NACA 2009). Population Services International (PSI) in collaboration with Centres for Disease Control (CDC) and National AIDS Coordinating Agency (NACA) conducted a national cross-sectional survey in 2011, to measure some levels of campaign impact. The survey used a two-stage random sampling technique to select the 1 237 sample population that was surveyed. Men and women aged between 18-35 years and who were sexually active for the past 12 months and residing in the area for the past 12 months answered questionnaires.

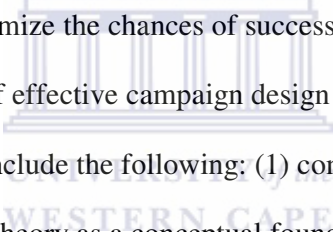


The purpose of the survey was to measure the impact of campaign exposure effects through matching statistically equivalent groups of exposed and non-exposed individuals. The findings of the evaluation revealed that there was no evidence that the campaign succeeded in reducing concurrent partnerships, however, campaign exposure was associated with risk reduction behaviours, namely more consistent condom use, greater HIV testing, greater confidence in condoms as an HIV risk avoidance strategy (PSI, NACA & CDC, 2011).

2.4 Evidence about Health Communication Campaigns: Planning, Design and Execution

Noar, Palmgreen, Chabot, Dobransky, and Zimmerman (2009), suggested that in order to improve the way public health practitioners implement health communication campaigns successfully, efforts should be made to understand better the most efficient and effective methods for carrying out such

campaigns. They noted that health communication researchers have presented recommendations for how HIV/AIDS campaigns should be carried out. They suggest that effective HIV/ AIDS prevention campaigns must begin with careful planning in which campaign goals are determined, the target audience's specific needs and orientations examined, and the target audience segmented into homogeneous groups. They also recommended that the communication strategy should be carefully analyzed to identify accessible and effective communication channels, design campaign messages, and test these messages for use with target audiences. Earlier, Maibach *et al*, (1993) also suggested that campaign outcomes must be carefully evaluated so that the influences of the campaign on health behaviours and directions of future risk prevention and health communication efforts can be identified.



Noar *et al* (2009) stated that to maximize the chances of success, HIV/ AIDS campaigns should adhere to well-accepted principles of effective campaign design and evaluation. Specific principles as articulated by Noar *et al* (2009) include the following: (1) conducting formative research on and about the target audience; (2) using theory as a conceptual foundation; (3) segmenting one's audience into meaningful subgroups; (4) using a message design approach that is targeted to the audience segment(s); (5) utilizing effective channels widely viewed by and persuasive with the target audience; (6) conducting process evaluation and ensuring high message exposure; and (7) using a sensitive outcome evaluation design that reduces threats to internal validity and allows causal inferences about campaign impact to be made. In a 2006 publication, he specified the following principles to guide the design of health communication campaigns.

Table 3: Major principles to be followed in campaign design for health communication campaigns (Noar, 2006)

Summary of major principles of effective campaign design applied to health communication campaigns	
Principle	Description
<i>Conduct formative research</i>	With the target audience to clearly understand the behaviour and the problem area; pre-test messages with target audience to be sure they are both appropriate and effective.
<i>Use theory</i>	As a conceptual foundation to the campaign; theory will suggest important determinants around which to develop messages, and will help ensure that campaign messages guide individuals through the process of attitude and or behaviour change.
<i>Segment audience</i>	Into meaningful subgroups based on important characteristics such as demographic variables, risk characteristics, experience with the behaviour, personality characteristics.
<i>Message design approach and targeting</i>	Targeted to and likely to be effective with the audience segment; develop novel and creative messages; design messages that will spark interpersonal discussions and may persuade individuals important to the target audience (e.g., influencers).
<i>Place messages in channels</i>	Widely viewed by the target audience; strategically position campaign messages within the selected channels.
<i>Conduct process evaluation</i>	Including monitoring and collecting of data on implementation of campaign activities; ensure high message exposure among members of the target audience, including both reach and frequency.
<i>Use a sensitive outcome evaluation design</i>	That reduces threats to internal validity and permits firm causal conclusions about the campaign's influence on attitudes and behaviours to be made.

Earlier Francis, Pirkis, Dunt, Blood and Davis (2002) stated that contemporary thinking on health communication campaign design also suggested that in order for a communication campaign to be successful, an evidence based process should evolve based on stakeholder participation and an understanding of a given public health challenge being tackled. A number of design and planning components were also considered essential. Concept formulation was an integral component of the campaign development process, and there should be widespread exposure to campaign messages (Francis *et al*, 2002). Campaign appeals that are socially distant from audiences are generally ineffective, and messages promoting prevention are less likely to be successful than those with immediate positive consequences (Francis *et al*, 2002). Francis *et al* (2002) also argued that research should focus not only on summative evaluation, which measures campaign outcomes, but also on process.



2.5 Underpinnings of Health Communication Theory

According to Rimer and Glanz (2005: 29) communication theory explores “...who says what, in which channels, to whom, and with what effects”. Creating messages that attempt to reach larger numbers of individuals can range from the simple dissemination of a pamphlet to the complex production and delivery of a series of television broadcasts that are supported by an interactive website and phone-in resource. The communications medium is used by health educators primarily to inform the public of health compromising and health protecting behaviour, to influence attitudes, perceptions and beliefs, to prompt action and to describe services of a preventive nature that are available (Office of Cancer Communications, 2001).

Bernhardt (2004: 2051) defines public health communications as the: “...scientific development, strategic dissemination, and critical evaluation of relevant, accurate, accessible, and understandable health information, communicated to and from intended audiences to advance the health of the

public”. He argues that public health communications should represent an ecological perspective and foster multilevel strategies, such as tailored messages at the individual level, targeted messages at the group level, social marketing at the community level, media advocacy at the policy level, and mass media campaigns at the population level (Bernhardt, 2004). Freimuth and Quinn (2004: 2053) also indicated that “...without supports in the social and physical environment, however, health communications alone may not be enough to sustain individual-level behaviour changes, may not be effective for relaying complex health messages, and cannot compensate for lack of access to health care or healthy environments”.

How often do people need to hear a message before it influences their beliefs or behaviour? This depends on several factors: characteristics of target audiences (e.g. their readiness for change, the ways they process information), the complexity of the health issue, the presence of competing messages and the nature of the health message influence the relationship between exposure to a health message and an outcome effect (Rimer and Glanz, 2005). Repeated exposure to a message, especially when it is delivered through multiple channels, may intensify its impact on audience members (Freimuth and Quinn, 2004).

2.6 Differing Positions on Effectiveness and Efficacy

Health communication campaigns have formed an important strategy for health promotion and education since the 1940s yet substantial discourse surrounds the efficacy of these campaigns. The influential synthesis of health communication research by Rogers and Storey (1987) is a point of reference. Rogers and Storey (1987) noted that there is evidence that health communication campaigns can be effective under certain conditions for specific audiences, but that accumulation of campaign experience over years suggests many failures and unrealistic expectations about outcomes. In their literature review, Rogers and Storey (1987) documented the history of communication

campaigns and offered a set of generalizations based on campaign research and evaluation. Much of the contemporary research on health campaigns hinges on their generalizations.

Rogers and Storey (1987) summarized the current views on campaign efficacy over the years, recounting three eras of effects. The first, the era of nominal effects, which reached its climax in the 1940s and 1950s and was characterized by studies that refuted the idea that mass media could directly and consistently affect the behaviour of individuals. During the second era which followed in the 1960s and 1970s, it was believed that campaigns could succeed if they were designed and conducted in more strategic ways. These strategies included the use of formative evaluation, audience segmentation, interpersonal communication networks, and the setting of more reasonable campaign goals. Contemporary campaign research has reached a more balanced view of effects as evidenced in the title Rogers and Storey (1987).



Two well-known articles which offered pessimistic and optimistic positions about the effectiveness of communication campaigns were “Some reasons why communication campaign fails” or some reasons why communication campaigns fail” by Hyman and Shetesley (1947) and the response by Mendelssohn (1973) two and half decades later entitled “Some reasons why communication campaigns can succeed”. Hyman and Shetesley (1947) argued that health communications are largely impotent for purposes they are designed for and that their impact on behaviour is often limited. On the more positive side, Mendelssohn (1973) holds the view that communication campaigns are potentially influential, especially if there are properly designed and their effects are sensitively measured and interpreted.

There is no universal consensus that health communication campaigns can be effective at all. According to Lehmann (2007: 36) quoting Snyder (2003) "...the effectiveness of communication campaign remains controversial, and many believe that the best is interpersonal communication through professional health staff". However, Atkin (2001) has also noted that evidence related to communication campaigns suggests that widespread exposure to campaign messages is necessary for the success of a campaign, and that the mass media component in particular plays a key role in creating awareness and knowledge, in stimulating interpersonal communication, and in encouraging individuals to participate in the campaign activities.

Several evaluation studies in Botswana regarding campaigns have basically been based on measuring success in terms of outcomes and impact and as thus neglecting inputs and process. This concern is supported by Hannan (2009: 153) who stated that the majority of evaluation studies which have been conducted worldwide have basically focused on the following criteria: "...(1) Message exposure level; (2) Comprehension and acceptance level (3) coverage level (4) Retention level as well as (5) Attitude Change level".

In responding to the above gaps in evaluating health communication campaigns, Bauman (2000) offered a set of guidelines which he characterized as precepts and principles for campaign designers and planners. These are focused on best practices and grounded in both campaign experience and evaluations mass media health campaigns. His guidelines, or precepts and principles, include the following: (1) formative research should be integral component of the campaign development, (2) Process evaluation is essential as it involves critical assessment of each part of the campaign's implementation, providing essential data on message production and dissemination, and audiences' responses, (3) Development of appropriate outcomes is essential, (4) Summative and process evaluation as measurement of carefully defined outcomes is essential, (5) Research designs should

include adequate resources and methods to achieve useful campaign evaluation, and (6) Effective health communication campaigns need to be disseminated to other stakeholders to enable others to learn from campaign success and failures.

2.7 Conclusion

In conclusion, the first part of literature review has revealed that MCPs are a factor in HIV infection in the Southern African region, drawing from several study findings on MCPs. The review also covered some successful case studies of MCP campaigns implemented in other countries in the region.

The second part focused on literature concerning effective health communication campaigns and identified the following stages to be followed in order to conduct a successful health communication campaign; (1) Formative Research, (2) Use of Theory (3) Segmentation and Audience Analysis (4) Message Tailoring (5) Process evaluation and (7) Outcome evaluation.

The importance of applying theory in health communication campaigns was examined as a spring board for understanding the complexity of human behaviour and communication approaches which should be applied in planning and design of campaigns. The review concluded with a discussion of the value of process evaluation as a means of improving and sustaining successful health communication campaigns as it helps in identifying key components of an intervention that are effective, as well as for whom the intervention is effective, under what conditions the intervention is effective and the challenges thereof.

CHAPTER THREE – METHODOLOGY

3.1 Introduction

Traditionally, evaluations of health communication campaigns have focused on initial recall and recognition by target groups or programme outcomes. However, it is increasingly acknowledged that it is not possible to assess campaign effects without information on programme implementation (Freimuth *et al.*, 2001), which can be undertaken through process evaluation. In this regard, process evaluation of the “O Icheke” campaign development and implementation was carried out utilising a qualitative research approach.

This chapter outlines the study aim and objectives for conducting the process evaluation of the “O Icheke” - Break the Chain campaign before describing the methods that were used for conducting the evaluation, the study design, study population, sampling procedure, sample size, data collection methods, data management and analysis, rigor and ethical considerations for protection of human subjects and study limitations.

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3.2 Study Aim and Objectives

3.2.1 Aim

To evaluate the implementation process of phases I to III of the Botswana National Multiple Concurrent Partnerships “O Icheke” Campaign for the prevention of HIV infections between 2009 and 2012.

3.2.2 Objectives

The objectives of this study were:

- a) To assess whether campaign activities including national sensitisation were implemented according to the plan.
- b) To determine whether the strategies for development and distribution of materials were followed and to assess whether they matched specifications of the campaign in design, quality, messages and portability.
- c) To assess whether interim monitoring and reporting have been undertaken, whether problems have been identified and recommendations acted upon.
- d) To identify factors that helped or hindered the implementation of the campaign.

3.3 Study Methods

This process evaluation study employed a qualitative research approach. This was considered appropriate for evaluating a program such as the “O Icheke” campaign which was being implemented for the first time in a new setting and has a unique potential outcome; it was also being implemented in an unpredictable environment (Albright, Howard-Pitney, Roberts, and Zicarelli, 1998). Another advantage of choosing qualitative research is that it is conducted in a natural setting involving a process of building a complex and holistic picture of the phenomenon of interest which it was hoped would complement the log frame monitoring process represented in Appendix 1. It was hoped that findings might be more personalised, more authentic and grounded in the Botswana context. Categories of interest emerged from study participants and patterns were then extracted to help explain the phenomenon of interest. These categories and patterns were later compared with information from project documents and the “O Icheke” implementation plan.

Mixed methods, which are a combination of applying qualitative and quantitative techniques, were not used because of the institutional requirement to work within one methodological tradition in a mini-thesis.

3.4 Study Design

A descriptive study design was used for this National “O Icheke – Break the Chain” Multiple Concurrent Partnerships campaign process evaluation study. This study design allowed for in-depth interviewing with key informants by asking them open-ended questions. Study subjects were asked to describe the fidelity of implementation to the plan of the “O Icheke” campaign as well as factors which aided implementation and those that hindered it. The study design also allowed the researcher to identify common themes emerging from the respondents.

This study design assisted in showing whether the “O Icheke” campaign has been implemented as planned, and it studied the process that was followed in implementing it; it provided feedback about the campaign diffusion strategy, the materials that were developed and the distribution process in relation to campaign goals, objectives and plans. This also included enquiry as to whether timelines were followed and milestones achieved, whether output and coverage related targets were met, and whether the quality, timing and quantity of campaign resources and products was achieved.

The evaluation identified challenges that have arisen during the implementation process and how the campaign implementation design matched up to the best practice in HIV prevention campaigns as identified through the literature review. This evaluation also documented campaign inputs and processes related to the design of the program and the context in which phases I to III of the campaign were delivered. Once reported, this may allow opportunities for improvement, realignment or modification for subsequent phases IV to VI. Such an evaluation may also inform the design and

planning of other health campaigns of a similar nature.

3.5 The Value of Process Evaluation

Process evaluation is the focus of this study, so the rationale for its use is of particular relevance and significance, because it justifies why it is an imperative for health communication campaigns.

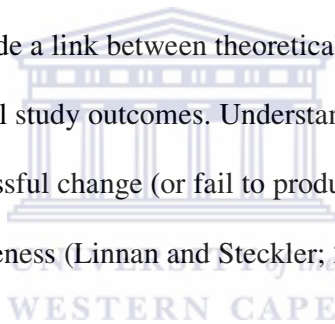
According to Linnan and Steckler (2002), improving and sustaining successful public health interventions depends heavily on the ability to identify key components of an intervention that are effective, to identify for whom the intervention is effective, and to identify under what conditions the intervention is effective. In order to advance the understanding of how to design, plan, implement and evaluate health communication interventions, public health practitioners should learn a great deal more about health communication intervention successes and failures, and process evaluation efforts can assist in making these discoveries (Linnan and Steckler, 2002).

Linnan and Steckler (2002) noted that in the last decade, the literature on process evaluation related to public health interventions had grown considerably. In the late 1990s and in early 2000s, there has been an explosion in the number of published studies which include extensive process evaluation components (Linnan and Steckler, 2002). These authors (2002) also observed that there are several explanations for this noticeable increase in the use of process evaluation, attributing it to the fact that social and behavioural interventions have become increasingly complex, making it important for researchers to know the extent to which all intervention components are actually implemented.

Another plausible explanation for the reasons why process evaluation efforts have proliferated, as observed by Linnan and Steckler (2002), is the need to identify ways to explain why certain results were achieved. Specifically, when interventions lead to significant outcomes, it is important to understand which components of the intervention contributed to the success. Linnan and Steckler

(2002), quoting Fisher (1995) and Susser (1995), on similar lines, state that when large sums of taxpayer money are allocated to conduct multilevel community trials and the primary outcomes are insignificant (or the magnitude of the effect is small), there is an increased demand among researchers, funders, and members of the general public to understand why these interventions did not produce their intended effect. Linnan and Steckler (2002) concluded that process evaluation can help explain positive, modest, and insignificant results.

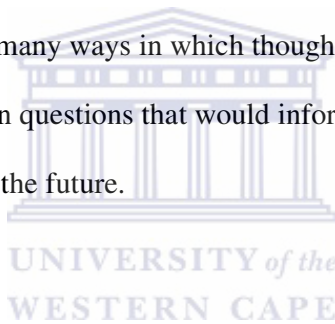
Process evaluation also provides important links to understanding and improving theory-informed campaigns. Because more programs are developing theory-informed interventions, there is a greater need to understand which theoretical constructs make a difference (Glanz, Lewis and Rimer, 1997). Process evaluation efforts can provide a link between theoretical constructs thought to be essential for intervention success and the final study outcomes. Understanding the mechanisms for how and why these constructs produce successful change (or fail to produce change) is key to refining theory and improving intervention effectiveness (Linnan and Steckler; 2002).



According to Linnan and Steckler (2002), process evaluation efforts also help us understand the relationships among selected intervention or program components. Process evaluation can help disentangle the effects of each method singly, and clarify the possible interactions that can occur to produce a synergistic effect. Few studies have attempted to reach a consensus on intervention effectiveness, to explore which program components have been more or less effective within a comprehensive process evaluation effort (Karachi, Abbott, Catalano, Haggerty, and Fleming, 1999). Assessing the quality and accuracy of the health communication intervention delivered to program participants can also be achieved with process evaluation, which is another reason why these studies have proliferated. Linnan and Steckler (2002) also contend that increasingly, funders and program participants at all levels want assurances that the intervention being delivered is of a high quality and

is highly accurate. In addition, attention to the cost-effectiveness of interventions is an increasingly important component of intervention planning and evaluation. Process evaluation efforts can assist with each of these requirements (Linnan and Steckler, 2002).

Finally, a further reason for the rise in the use of process evaluation is the increasing recognition of the value of qualitative research methods (Linnan and Steckler; 2002). Process evaluation frequently uses both quantitative and qualitative methods. Integrating different methods such as qualitative and quantitative methods yields rich detail about study outcomes that neither method could achieve alone (Tashakkori and Teddlie, 1998; Steckler *et al*, 1992). Linnan and Steckler (2002) concluded that the increase in published literature on process evaluation results reflects the complexity of contemporary public health interventions, and the many ways in which thoughtful, comprehensive process evaluation efforts could shed light on questions that would inform improvements in theory, intervention design, and methods in the future.



3.6 Study Population

When choosing interviewees, the researcher considered a sample that best represented the diverse implementation stakeholders and opinions of those stakeholders. The study population for this evaluation study was people who have been instrumental in conceptualizing and implementing the campaign to date. It was drawn from those involved in the initial planning process and implementation of the Campaign through their membership of the National Technical Advisory Committee on HIV prevention, which provided oversight of the development and implementation. The people included were campaign planners, coordinators, implementing partners, sponsors and development partners.

3.7 Nature of the Sample and Sampling Procedure

The evaluation study employed non-probability purposive sampling as appropriate to qualitative research. The aim of this sampling procedure was to select information rich cases for in-depth study to examine meanings, interpretations, processes and theory. This sample was drawn from organizations which are members of the National Advisory Committee on HIV prevention who are directly involved with the implementation of the Campaign and therefore understand it very well. Heads of implementing organizations were approached and requested to identify a suitable officer who was involved in the campaign from initial planning stage to date, to participate in the study. The researcher consulted leaders of participating organizations on selecting participants. Those organizations which have a higher stake in the campaign were asked to contribute more than one participant. The sample included people at national and district levels. The criteria for sampling included among others:

- All members of the sample should have been involved in the campaign throughout phase I to III.
- At national level, seven (7) people from primary stakeholders, who represented key roles at this level were invited to participate; these were members of the national coordinating unit within NACA, PSI staff members responsible for the campaign, one (1) member of the Technical Advisory Committee (TAC) from ACHAP, and PEPFAR/ CDC staff members who were responsible for technical assistance and oversight.
- At District level, five (5) people were invited as follows:
One member of the District AIDS Coordinating Unit; Three members of the District Campaign Teams with differing roles; One member from the District Multi-sectoral AIDS Committee (DMSAC) representing a local implementing Community Based Organization (CBO).

Table 4: Interview sample

KEY INFORMANT AT NATIONAL LEVEL			KEY INFORMANTS AT DISTRICT LEVEL		
Name of Organization	Type of Organization	No of Participants	Name of Organization	Type of Organization	No of Participants
NACA	Coordination	3	Kgatleg District	Implementation	1
Population Services International (PSI)	Implementation & Technical Lead Agency	2	Gaborone District	Implementation	2
President 's Emergency Plan for AIDS Relief (PEPFAR) and Centers for Disease Control (CDC)	Technical Assistance & Funding	1	Lobatse District	Implementation	1
African Comprehensive HIV/ AIDS Partnerships (ACHAP)	Funding	1	Botswana Christian AIDS Intervention Program (BOCAIP)	Implementation	1
Sub-totals	4	7	4		5
TOTAL SAMPLE	12				

Initially, it was planned that a sample of 15 respondents would be interviewed but only 12 respondents were available and agreed to be interviewed.

3.8 Sample Size

Fifteen (15) respondents were initially sampled to represent key roles and characteristics of the general population from which it was selected. Therefore, in working with a small sample size, it was important to ensure that the stakeholders interviewed provided information for purposes of achieving the study goal and objectives. Due to logistical challenges and time constraints only 12 respondents were interviewed. Most of the respondents were either on work-related field trips or

busy with other official engagements and that resulted in the data collection phase taking more time than initially anticipated. However, the data collection from the 12 respondents was judged to have achieved data saturation on the basis that no new observations were emerging from the later interviews.

3.9 Data Collection Methods

3.9.1 Key Informant Interviews

In-depth interviewing was conducted with the selected respondents to explore their perspectives on the “O Icheke” campaign as well as to solicit their experiences and expectations related to the campaign and their thoughts concerning campaign operations, processes, and outcomes. The purpose of the interviews was to collect information from people who were involved from conception and through the implementation of the phases of the campaign. The interview guide was tried out with two conveniently available people from the study population to practice the process and consider whether any modifications may be required in the areas of questioning. Following this process, minor modification were made in the interview guide to make it more practical and user friendly. *(Refer to Annex: 8: Final Interview Guide).*

Interviewing Process

Individual interviews were conducted in English and were recorded and transcribed fully. The researcher also took shorthand notes during the interviews to record important points which fed into the analysis process. Initially the interviews were planned to take about 45 minutes but as the researcher mastered the skill of conducting in-depth interviews and having gained confidence in asking questions, they only took on average 35 minutes.

During the interview the following process was followed;

- a. The purpose of the interview, why the stakeholder had been chosen, and the expected duration of the interview was explained
- b. Informed consent of the interviewee was sought, written and orally.
- c. The researcher and the interviewee signed two copies of the consent letter and each one retained a copy. .
- d. The researcher re-explained the purpose of the interview, why the stakeholder had been chosen, expected duration of the interview and how the information would be kept confidential.
- e. The researcher audio recorded the proceedings of the interview but also took notes of some important points raised during the interview.
- f. The interview responses were cleaned through re-listening of audio tapes and later transcribed. Key themes were identified during data transcription.
- g. Following the interview, the researcher verified some aspect of the responses which were not clear with the respondents.

Limitations of the Study

During the interviews, it became evident that not all the participants were involved throughout the campaign cycle. This was not ascertained before the interviews. While some were knowledgeable about the planning and design stage, others were more knowledgeable about the implementation, monitoring and evaluation phases. Despite disparities of participants' knowledge level regarding the campaign, the researcher was able to tease out common trends, similarities and inferences from respondents which actually formed the basis of thematic analysis. Because some people who were interviewed were people holding senior positions, they had constrained time for data collection because either they were not available during the scheduled time for interviews or they were simply

engaged in other official duties. Several of the key people in senior positions frequently postponed the date and time for data collection and this resulted in delays in data collection.

Another shortcoming of the data collection process was issuing the interview guide to respondents prior to the interview. This resulted in respondents having pre-prepared answers drawn from campaign documentation. This was done to save time as most of the respondents were senior officers who communicated that they had little time for interviews and would prefer to have the interview guide in advance so that they could be familiar with questions, and able to answer them appropriately. As a result, some of their responses sounded like captions from documents such as reports.

3.9.2 Documents Review

Document review was employed as an additional technique of data collection. Document review is a procedure of analysing or evaluating documents both printed and electronic (Bowen, 2009). Like other analytical methods in qualitative research, document analysis requires that data be examined and interpreted to gain a better understanding of meanings and gain empirical insights. For this purpose, primary sources or documents developed for the campaign were selected, while secondary sources in the sense of articles about the campaign have been confined to the literature review.

Campaign documents such as field support reports, quarterly, semi and annual performance reports from 2009 to 2012, as well as Information, Education and Communication (IEC) materials containing text and images, developed without the researcher's intervention, were reviewed. These documents were provided on request, by people who were interviewed; others were sourced from NACA and PSI Program Officers. The analytical procedure entailed finding, selecting, appraising and synthesizing data contained in documents.

This desktop review of campaign records was carried out through reading sections of the documents that were relevant to the evaluation objectives. It constituted a form of triangulation, in the light of the outcomes of the key informants' interviews, to identify comments that support or invalidate the information generated from the interviews. These records were not available as part of literature review but were available as part of findings.

3.10 Data Management and Analysis

Responses from key informants' interviews from both audio recordings and shorthand notes were fully transcribed. Where transcriptions were not clear, they were checked by re-listening to audio tapes to achieve clarity.

The data was first organized into emergent thematic categories which were based on the study objectives. Data were then further coded within the broad themes resulting in the identification of sub-themes. The thematic categories helped to shape later data collection. The interview guide contained some probes which also helped in shaping thematic areas. The data analysis process was considered complete once saturation of new insights has been achieved (Gifford, 1998).

3.11 Measures of Rigor

3.11.1 Reflexivity

Reflexivity was employed as a means to continuously recognise the researcher's role in the research activities. Reflexivity it is argued, ensures that a researcher is cognizant of the state of his/her on-going relationships with participants, and how this might be influencing the outcomes of a study (Watt, 2007). During this study, the researcher noticed an uneasy awareness of the authority and power he was perceived to have as researcher as well as a Chief Information, Education and

Communications Officer within National AIDS Coordinating Agency (NACA), an organization responsible for the implementation of the campaign. By virtue of being Head of Communication Campaigns within NACA, the researcher participated in quarterly campaign meetings and used this space to reflect and debrief with team members. In addition to that, through the literature review and writing process, the researcher was conscious of his own memories of past involvement with the campaign, having been part of its conception, planning and the oversight of its initial funding mechanism from United States Government as well as a technical advisor to the campaign. This required the researcher to remain vigilant in prioritising the responses of study participants, and setting aside his own to such an extent as was possible. This close relationship with the campaign was therefore potentially an advantage and a limitation of the study.

Reflexivity was achieved through documenting and articulating the researcher's personal views and insights regarding the phenomenon explored. This was done to ensure that personal values and perceptions of the researcher do not compromise the quality of the study. In this study, two tools, drawn from Hutchinson (1986), were used to limit the influence of pre-existing constructions on participants: (a) a post comment interview sheet and (b) a personal journal. During the research process, the post comment interview sheet was used to note aspects of the interview data that provided excitement or surprise; the researcher also kept a personal journal to record his views about the phenomena (Hutchinson, 1986). Both these tools assisted in achieving reflexivity to maintain distinction between personal values and those of the study.

3.11.2 Triangulation

Triangulation was another method that was used for increasing trustworthiness of findings and this was done through deliberately seeking evidence from a wide range of sources and comparing findings from those different sources. For example, feedback from key informant's interviews was

compared with the information obtained from document reviews of campaign records such as field support visit reports, minutes of campaign monthly meetings, quarterly and annual performance reports, as well as Information, Education and Communication (IEC) materials. Interview transcripts which were not quite clear were sent back to those who were interviewed to verify with them certain aspect of the interview responses which were not clear. The results of this triangulation process are presented in Chapter 4

3.12 Ethical Issues

After the protocol was approved by the University of Western Cape (UWC) Ethics Committee, it was presented to the National Health Research and Development Committee (HRDC) of Botswana, which is situated at Ministry of Health. Data collection was undertaken after clearance by the HRDC in accordance with the International Health Research Ethical Standards as prescribed by Helsinki Declaration of 2002. To ensure that the study was ethically sound and that it safeguarded the dignity, rights, safety and well-being of respondents, the following principles were applied:

- a. Autonomy: respect the rights of the individual
- b. Beneficence – doing good
- c. Non-maleficence: not doing harm
- d. Justice – particularly equity

The following important ethical issues were taken into consideration before, during and after interviewing process.

(i) Consent

Before data collection, participants were sent a letter explaining the purpose and process of the evaluation study, requesting their participation and assuring them of confidentiality and anonymity. Every participant who participated had freely consented to participation, without being coerced or

unfairly pressurized. Participants were well-informed about what participation entails, and reassured that declining will not affect them in any way. Participants were informed that they can withdraw from the study at any time if they feel like doing so.

Participants were also given copies of the ethics committee's approval letters from both the HRDC and the UWC ethics authorities for reference to assure them of the credibility of the evaluation study. Participants were also informed that the study posed no physical harm or threats to them. Participants were free to agree or refuse to take part in the study. Participants who agreed to participate were issued with a Participant Consent Form to sign to confirm their agreement to participate.

(ii) Confidentiality

Participants were given code numbers to protect their identities and to ensure their anonymity. Digital Recorder and transcripts were kept in a lockable cabinet so that they were not easily accessible to third parties. Participants were assured of confidentiality and that their identities were anonymous and confidential. Participants were also informed that the study findings were not meant to be linked to them as individuals. Participants were assured that interview conversations will only be listened to by the researcher and thereafter destroyed.

3.13 Conclusion

This chapter has outlined the study aim and objectives for conducting the process evaluation of the “O Icheke” - Break the Chain campaign and provide description of the methods that were used for conducting the evaluation, as well as the study design, study population, sampling procedure, sample size, data collection methods, data management and analysis, rigor and ethical considerations for protection of human subjects and study limitations. The next chapter presents the findings of the study from both participants' interviews and document analysis.

CHAPTER FOUR - FINDINGS

4.1 Introduction

In this chapter the findings of the evaluation study will be discussed. This discussion will take the following format:

- i. Firstly, the findings from key informant interviews will be presented according to the study objectives, as per the interview guide. The objectives were:
 1. To assess whether campaign activities including national sensitisation were implemented according to plan.
 2. To determine whether the strategies for development and distribution of materials were followed and to assess whether they matched specifications of the campaign in design, quality, messages and portability.
 3. To assess whether interim monitoring and reporting have been undertaken, whether problems have been identified and recommendations acted upon.
 4. To identify factors that helped or hindered the implementation of the campaign.
- ii. Secondly the findings of the documents analysis will be briefly presented in the same format.

4.2 Findings of the Key Informant Interviews

In this section, the findings from key informant interviews will be presented.

4.2.1 Fidelity to the Campaign Design and Planning Process

This section present themes pertaining to fidelity to design and planning process of the campaign: the following emergent themes will be covered; a consultative and participatory process, campaign hinged on evidence, awareness of the stages of change model, state of resources for the campaign, successful and high quality campaign, “O Icheke” brand recognition, sensitization efforts, implementation scenario at national level as well as district level co-ordination and implementation.

A Consultative and Participatory Process

Some respondents were involved in the planning and the design of the campaign while others were not; there were also some who did not participate in the initial stage but were knowledgeable about the planning and design process that took place. According to respondents who participated at the planning stage, the process of developing the campaign was a multi-sectoral one involving private sector, civil society and public sector from national to district levels.

One participant elaborated on the planning process by stating that:

“... The campaign planning process was done in an impeccable way because it was a consultative and collaborative process, involving a wide spectrum of stakeholders. We attended a national campaign consultative planning workshop which was attended by all stakeholders, from district level to the national level”. PE. N1.

A number of the respondents who participated from the initial phase of campaign development noted that during the design stage of the campaign, a transparent and open approach was achieved to accommodate the views and contribution of other stakeholders. This suggests a participatory process either at design stage or the sharing of information relating to its design.

A Campaign Hinged on Evidence

A number of respondents who participated during the development stage of the campaign also observed that conception of the campaign goal and objectives was informed by available evidence from studies which were conducted locally and regionally, as well as drawing from Botswana HIV and AIDS strategic documents such as National Strategic Framework II (2009) and the National Operational Plan for Scaling Up HIV Prevention in Botswana (2010).

One respondent mentioned that:

“... a number of documents were referred to during the campaign design stage; among them were the SADC Think Tank Report, the National Strategic Plan II as well as NOP for Scaling Up Prevention in Botswana”. PE. N11.

Respondents also alluded to the fact that substantial evidence was drawn from the PSI study (2009) which identified MCP as equally a common practice among women and men in Botswana. As lead technical agency for the campaign development, PSI was tasked with a mandate to carry out a consultative and evidence-based approach to developing the campaign. One participant observed that:

“... A qualitative assessment conducted by PSI served as the basis for the development of campaign material which showed people who are practicing MCP and why they are practicing it”. PE. N9.

Awareness of the Stages of Change Model

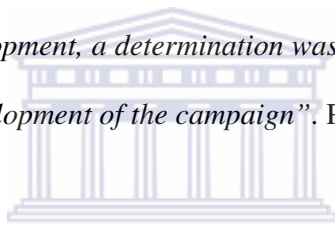
A number of the respondents from the initial phase of campaign development were aware of the use of the Stages of Change Model, which was introduced to them by PSI during the design stage:

“... In designing the campaign, behaviour change theory was used to determine different stages in which people are in regarding their understanding of MCP issues. For example

some people (community members) felt there is nothing wrong with engaging on MCP as it is a social norm, while others understood it as a predisposing factor to HIV infection”. PE. N2.

“... There was sufficient evidence that people are in different stages of readiness with regard to given behaviours. Different persuasive strategies are called for in the different stages of change. It is important to determine which stage your client or audience is in before developing a campaign”. PE. N11.

“... During campaign development, a determination was made about which stage the target audience was in before development of the campaign”. PE. N4.



This kind of response demonstrated that respondents showed understanding of how different persuasive strategies were called for in the different stages of change and they were well versed in behaviour change related theory, which suggests that they were aware of the underpinning framework for the campaign as explained by the Stages of Change model at section 2.3.4.

State of Resources for the Campaign

According to a number of study participants, financial resources for the implementation of the campaign plan were mobilized through a partnership framework between NACA, the Government of Botswana and the African Comprehensive HIV and AIDS Partnership (ACHAP), to support implementation at national level. They also stated that some financial resources were received from the President’s Emergency Plan for AIDS Relief (PEPFAR) through a Center for Disease Control (CDC) Cooperative Agreement funding mechanism, to support implementation at district level,

through assistance to local Implementing Partners (IPs). Population Services International (PSI) was contracted by CDC through PEPFAR support to be a Technical Lead Agency to lead the planning, design and implementation of the campaign.

“ ... The government of Botswana also supported the campaign through its normal budgetary allocations for prevention programs, under the Recurrent Budget Allocations”

stated one of the respondents. PE. N4.

“... the campaign was budgeted within the NACA IEC Vote which catered for all production of IEC materials, including campaigns”. PE. N4.

Some participants who were interviewed observed that despite very good financial planning for the campaign at the beginning, the repercussions of the economic crisis of 2009 and 2010 resulted in the deterioration of the fiscal position of Botswana's HIV and AIDS response resources, hence negatively impacting on the delivery of campaign activities including sensitization efforts.

The “O Icheke” brand was widely recognized

According to study participants, the branding process was actually carried out according to the plan. The campaign brand “O Icheke” was an action slogan that was used on all campaign materials and signage throughout the duration of the campaign, acting as a unifying theme and message.

One study participant observed that:

“...The “O Icheke” brand was widely recognized by all stakeholders and the general public as the brand awareness was initially done during the teaser phase of the campaign and that created public debate as people discussed how they know the Break the Chain campaign. The

campaign also got wide coverage by local media houses, newspapers, radio stations and television, through talk shows and news articles”. PE. N5.

Sensitization Efforts

Sensitization is reported to have been implemented successfully and this is well articulated by the following study participants quoted below:

“... National sensitization was a success because it started at national level with Heads of Departments, CEOs, Program Officers and key Response Sectors and buy-in from stakeholders was achieved through sensitization efforts. To build on momentum and interest created, sensitization then followed capacity-building of implementing partners through training them on MCP campaign”. PE. N9.

Another respondent stated that:

“... Although national sensitization efforts were largely successful due to the fact that there was a national rollout plan that was implemented to cascade from national level, to district and to local community level, there were challenges that were experienced such as erratic funding because sometimes funds were released very late and planned sensitization workshops had to be delayed or cancelled. Due to challenges of erratic funding flows it was not possible to reach out to other target audiences such as Traditional Health Practitioners (THPs)”. PE. N12.

Another respondent mentioned that:

“... Initially it was planned that the campaign sensitization and promotion efforts be driven by Campaign Champions but that was not achieved because there were no funds to undertake it. There was some kind of resistance from other organizations and individuals who felt that

MCP messaging was just too explicit and derogatory, this resulted in some of them not buying-in into the campaign. Political support was not enough because political leaders at all levels were not much engaged in sensitizing the public about the dangers of MCP”. PE.

N6.

Implementation at National Level

Interviewees reported that all major project activities planned at national level were implemented according to the National MCP Plan (2009), except staff attrition of monitoring and evaluation officers . According to a number of participants, local CBOs were identified in the districts and were contracted to serve as Implementing Partners (IPs) of the campaign at district level.

One participant who worked at the national level stated that:

“... PSI in collaboration with NACA trained all implementing partners across all districts on “O Icheke” messaging, project management, finance and monitoring and evaluation so that they can confidently implement a successful campaign. Activities which were implemented at national level were: mass media campaign- kombi adverting, Go girls program, print and electronic (radio, TV) and community interpersonal communications”. PE. N7.

Another participant also stated that:

“.. Major project activities implemented at national level were mass media campaigns (print, TV, and radio, advocacy and sensitization, production and distribution of IEC materials, information and educational tools for one-on-one, small group and community settings, mainstreaming of MCP messages into other HIV and AIDS programs, i.e. PMTCT, ARV, HCT and SMC. capacity building through training of IPs as well as interpersonal communication intervention through peer education and peer counseling and monitoring and evaluation”. PE. N2.

A number of study participants also noted that PSI as the lead technical agency was able to execute its mandate according to the plan, despite challenges arising from delayed project funding and government bureaucratic decision-making.

One participant mentioned that:

“... This PSI provided technical assistance across the various dimensions of the campaign, and with specific responsibilities for development of messages that can be used by the range of partners involved in the campaign, in order to ensure that consistent messaging is used throughout the country”. PE. N3.

Reflecting on the state of staffing for the campaign and how it has affected the campaign implementation, a number of study participants made observations that the campaign implementation was affected by staffing attrition in the form of resignation of key staff members such as the National Campaign Coordinator, who resigned in 2010, the Monitoring and Evaluation Officer who left in late 2009, and one District Support Officer who left in 2011.

One participant summarized the reasons for staffing attrition by saying that:

“... Reasons for staffing attrition were that people are always seeking greener pastures and good rewarding jobs. Again, authorities did not make any efforts to replace resigned staff and this was said to be attributed to inconsistent funding mechanism. This staffing situation left the coordinating unit operating with the National Campaign Support Officer, who acted as National Campaign Coordinator and only one District Support Officer. This staffing situation affected the delivery of the campaign activities both at national level and district level. As a result, the monitoring and evaluation component also suffered because there was no coordinator to do it”. PE. N2.

Embedding District Level Co-ordination and Implementation

The structure of management and coordination at the district level was similar to the structure at the national level (*Refer to Annex 4*). The Office of the District AIDS Coordinator (DAC) was responsible for the overall leadership for the campaign at the district level. According to the campaign plan (2009), it was by design that there were no full-time MCP campaign personnel at district level, because it was agreed from the planning stage that District AIDS Coordinators (DACs) should identify key personnel such as the Health Education Officer, Monitoring and Evaluation Officer, Assistant DAC and Peace Corps Volunteers who then dedicated a proportion of their time to the campaign and formed a district campaign coordination team.

Participants also stated that the district campaign team was led by the district campaign coordinator who was nominated from the district campaign team. The work of these teams was supported by existing structures such as the IEC Technical Working Groups of the District Multi-Sectoral HIV/AIDS Committee (*Refer to Annex 4*). The teams were also responsible for mobilizing Village Multi-sectoral HIV/AIDS Committees (VMSACs) and Village Health Committees.

The district campaign coordinators were responsible for monthly progress reports to the national campaign coordinating unit through the Ministry of Local Government. Once nominated, district campaign coordinators attended a national capacity building training workshop on the MCP messaging and campaign delivery. District campaign coordinators also received support from the national campaign coordinating unit to sensitize key district stakeholders and develop district campaign rollout plans.

One respondent observed that:

“... the motivation of the district campaign coordinators was a key to the campaign’s success and the national campaign coordinating unit also played a critical role by ensuring that the

district coordinators are capacitated to have all the tools and resources for successful implementation of the campaign. Access to the resources was key and non-monetary recognition ensured ownership of the campaign by district coordinators". PE. N6.

4.2.3 Strategies for Campaign Material Development and Delivery

This section presents findings pertaining to the strategies for development and distribution of materials as well as specifications of the campaign in design, quality, messages and portability. The following emergent themes are covered by this section; message tailoring and the use of mass media, high standard quality materials and district input to the material development process.

Message Tailoring and the Use of Mass Media

Regarding tailoring of messages to the target audiences, a number of key informants who participated in the campaign material development stage stated that they followed an audience segmentation process in order to gain a better understanding of the campaign audience, based on their preferences, needs, demographics, health behaviours, media interests and other characteristics. This information allowed the Design and Planning Team to better predict behaviours and develop messages that appealed to the audiences, using the channels and vehicles that would reach them. Participants noted that audience analysis consisted of the gathering, interpretation and application of demographic, behavioural, and psychographic information related to audiences of interest. According to study participants, early campaign messages focused on increasing knowledge about how and why MCP increases HIV transmission, increasing individual risk perception around MCP. Subsequently, the campaign also focused on the values and norms that cause people to engage in MCP and, how to create new values and norms that discourage MCP.

"... Messages were regularly reviewed and where possible changed to keep the campaign

fresh and make sure the messages keep pace with target audiences' changing attitudes". PE. N4.

A number of key informants stated that different messages were created for different target audiences, but observed that most materials were produced in English language when some large section of the community preferred the materials to be produced in the local language Setswana.

With regard to the successful messaging and the use of mass media, participants stated that a range of interpersonal, community and media channels were used to disseminate campaign messages. These, according to participants, included among others, above line mass media such as bill boards, television and radio and below the line media such as print materials as well as interpersonal communication interventions.

This is illustrated in the following participant responses:

"... Private companies and government institutions such as DEBSWANA Diamond Company and Botswana Police were approached to rollout MCP messages through the interpersonal channels at their disposal. District Multi-Sectoral AIDS Committees (DMSACs) and other grant-makers were allocated budgets to fund CBOs and community theatre groups who were implementing grassroots projects focused specifically on MCP. Through both media channels and IEC materials for grassroots interventions, the campaign used stories, drama, discussion and other inter-active methodologies to stimulate debate of key issues and audience generated solutions". PE. N6.

And:

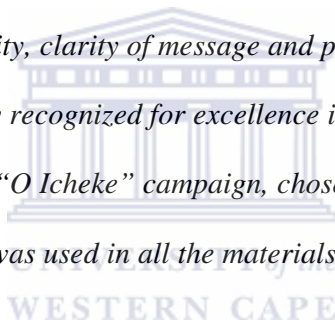
"... Media and community level interventions complemented each other, with media channels being used as a catalyst for community level debate, key questions arising at the community

level were captured in national media commentary and local solutions and successes being celebrated in the media. The campaign also engaged artists such as musicians like “VS” who sings the “O Icheke” song, comedians, poets and theatre actors whose media give them the freedom to expose secrets and taboos in a creative and non-threatening manner, and equip them with the information they need to incorporate MCP themes into their acts. PE. N3.

High Standard Quality Materials

On issues relating to the quality of materials produced, a number of participants observed that the materials which were produced for “O Icheke” Campaign were by any standard of high quality, as explained as follows:

“... The design, layout, quality, clarity of message and portability materials were of a higher standard, since PSI is widely recognized for excellence in social marketing and branding. The campaign was branded “O Icheke” campaign, chosen after a wide consultation with stakeholders and the brand was used in all the materials”. PE. N1.



With regard to the quantity of materials which were produced for the “O Icheke” campaign, participants were asked if there were enough to cover the target audience. They stated that generally materials were enough except that there were no Setswana versions which were most preferred in rural areas, and none were developed for people with disabilities.

One respondent summarized that:

“... Generally the materials were enough. However there was an over production of flipcharts and less production of leaflets. Materials were mostly in English language and there were no materials developed for people with disabilities. Mostly the target groups were covered through radio and television and that was also supplemented with community outreach activities as well as interpersonal communication interventions”. PE. N11.

District Input to Material Development Process

With regard to participation of target groups and district representatives in the materials development process, some of the study participants gave the following perspective:

“... Districts’ involvement was achieved through the technical working group of which districts were represented, while target audiences participated at the pre-testing stage. The Ministry of Local Government as a member of the TWG also ensured that districts made some inputs in the development of the materials. Target groups participated in the materials development process at a stage of pre-testing. The feedback that was drawn from pretesting was used to further improve on the quality of the materials”. PE. N6.

“... District people were involved through representation by MLG and Ministry of Health’s DHMTs. Some people from the districts participated during the campaign design and planning stage and also during pre-testing of materials”. PE. N1.

“...District people and representatives of the target audience participated during the brand selection as well as pre-testing of materials”. PE. N5.

“... The process of developing campaign materials was overseen by TWG which was made of highly experienced individuals in the area of IEC/ BCC programs”, noted the another participant. PE. N8.

4.2.4 Monitoring, Evaluation and Reporting Framework

This section presents findings on objective three on monitoring, evaluation and reporting and the following emergent issues from study participants are being presented to highlight responses on whether interim monitoring and reporting activities were undertaken and whether problems in the campaign have been identified and whether recommendations were acted upon. The issues are as follows: fidelity to the monitoring plan; monitoring and evaluation staffing situation; and evaluation research, respectively.

Fidelity to the Campaign Monitoring Plan

According to the campaign plan (2009), monitoring of the national campaign plan was envisaged to be conducted on quarterly, semi-annual and annual basis. A monitoring plan developed to address two key objectives: (1) to gather sufficient information to measure campaign implementation achievement of objectives and inform ongoing campaign planning; and (2) to minimize the administrative burden to implementers of mainstreaming MCP messages in their ongoing activities. Campaign monitoring at district level was designed to be integrated into existing mechanisms to the maximum extent possible, with the desire to reduce the imposition on district personnel (NACA, 2009).

Quarterly monitoring was conducted to measure the extent to which the campaign rollout schedule was being followed and focused on process indicators relating to implementation of district campaign plans, distribution of I.E.C materials, placement of media communications and disbursement of funds. Semi-annual campaign reports were compiled by the national campaign coordinator, who documented successes, lessons learned and recommendations from districts and implementing partners for improving the rollout.

On the fidelity to the campaign plan, study participants differed. Some reported that the campaign

monitoring plan was adhered to, while others said it was not implemented due to some challenges with staffing for monitoring and evaluation. The following illustrate their responses:

“...monitoring and evaluation plan was not adequately implemented due to the fact an officer who was responsible for M & E decided to resign his post before the end of first year”. PE. N3.

“... Implementation went well during the first of the campaign but suffered draw back in 2010 where there was shortage of fund”. PE. N8.

Monitoring and Evaluation Staffing Situation

Most study participants reported that the monitoring and evaluation staffing situation was a challenge for the campaign due to staff attrition:

One participant stated that:

“...Initially an M and E officer was hired to oversee both the plan and the M and E component of the campaign but later left the job in the middle of campaign implementation. This eventually led to the M and E function of the campaign weakened as there was no one solely responsible for M and E activities. Campaign Coordinator then combined his coordination function with that of M and E”. PE. N2.

Another one noted that:

“... The resignation of the Monitoring and Evaluation Officer affected the monitoring of the campaign at national level resulted in over-burdening of the National Campaign Coordinator with additional responsibilities, to such an extent that he was not able to discharge his coordination duties properly and the situation was not helped by the fact the vacancy was not

filled up". PE. N8.

Evaluation Research

According to some respondents Population Services International (PSI) supplemented ongoing monitoring and evaluation activities by conducting an annual quantitative study called the TRac Survey which measured changes in behaviours and individual behavioural drivers as well as exposure to different MCP message sources and how norms about MCP and other key campaign themes were changing as the campaign rolled out. This is the study that is used by implementing partners and other stakeholders to track trends, patterns in behaviours and norms about MCP.

One participant stated that:

"...Implementation Plan was initially adhered to but with challenges regarding funding in the second and third phases, some of the campaign activities were not implemented according to the plan. Monitoring was conducted through support visits to districts to monitor implementing partners. Regular quarterly reports were written to track how the campaign is progressing. This included NACA Quarterly Review Report and NACA Annual Report, as well as PEPFAR semi-annual and quarterly reports. PSI has recently conducted an impact evaluation to determine if at all the campaign managed to change people 's behaviours". PE. N2.

4.2.5 Factors Facilitating Successful Implementation of the Campaign

This section presents findings pertaining to Objective 4 which are organised under the following themes, identified as; stakeholder commitment, the use of theory to inform design, the power of branding, high quality materials, strong national and community leadership, achievement of national coverage and reach, as well as wide public discourse and mass media coverage. The following themes are being reported here because they are thought to be factors which have facilitated

successful implementation of the campaign. In responding to this question and the following respondents repeated some earlier responses.

Stakeholder Commitment at All Levels

According to study participants, there was a lot of stakeholder buy-in at all levels - national, district and community level and at the national level, there was thorough consultation and good coordination. There was also a campaign development workshop in which district people were bought along.

As one of the study respondent stated:

“... A strong stakeholder commitment during planning, designing and deciding about messages, execution of the entire campaign, different level of collaboration that were required for the campaign to pull together was done in admirable style”. PE. N2.

Another study participant stated:

“... Ongoing collaboration across multiple sectors was done in an impeccable fashion during implementation phases of the campaign”. PE. N6.

A further participant stated that the campaign was a success because:

“... MCP although not a new campaign it was a fresh approach to tackling HIV prevention, radical from traditional HIV prevention interventions and that stimulated the interest and the buy-in of political, cultural and religious leadership”. PE. N8.

A Strong Evidence Based Approach

Participants highlighted the strong evidence base upon which the campaign was planned. The following respondents reported the below perspectives:

“... There was sufficient evidence provided by PSI and other local researchers on MCP in Botswana, which informed material development and messaging.” PE. N10.

“...Evidence which was used to develop materials was drawn from PSI MCP study; the study informed the type of materials to be developed and also the target audiences to be reached with those messages. Stages of Change Model were used to development campaign materials for use at different stages of the campaign”. PE. N2.

“... There were studies which were referred to which indicated the magnitude of MCP in Botswana and why people engage in such practices”. PE. N2.

“... A lot of data was referred to and evidence was drawn from the following documents, which have a lot of information about MCP; PSI TRac Survey, SADC Regional – Think Tank Meeting Report, Soul City Mega-Country Evaluation, MCP Evaluation Report and the Botswana AIDS Impact Survey (BIAS 3). PE. N1.

The Use of Theory to Inform Design

Most key informants suggested that the campaign was successful because of its theoretical underpinning in behavioural theory. Participants only mentioned stages of change theory as the one that was applied when designing the campaign. The use of theory as a conceptual foundation for the design of the campaign helped uncover important determinants around which to develop messages, for each target audience as well as ensure that campaign messages guide individuals through the process of attitude and behaviour change.

One study participants pointed that:

“... In design the campaign behaviour change theory was used to determine different stages which people are in regarding their understanding of MCP issues. Quoting the preliminary research, for example some people felt that there is nothing wrong with engaging on MCP as it is a social norm, while others understood it as a predisposing factor to HIV infection”. PE. N2.

The Power of Branding

The “O Icheke” Campaign had a powerful brand identity agreed upon after a wide consultation with the target group and stakeholders. *(Details are provided in 4.2.2 part on branding).*

Some respondents noted:

“... The “O Icheke” brand was widely recognized by all stakeholders and the general public as the brand awareness was initially done during the teaser face of the campaign and that created public debate as people discussed how they know the Break the Chain campaign. The campaign also got wide coverage by local media houses, newspapers, radio stations and television, through talk shows and news articles”. PE. N5.

“...The design, layout, quality, clarity of message and portability materials were of a higher standards, since PSI is widely recognized for excellence in social marketing and branding. The campaign was branded “O Icheke” campaign, chosen after a wide consultation with stakeholders and the brand was used in all the materials”. PE. N2.

“... The “O Icheke” Campaign was one of the best campaigns Botswana has ever implemented for HIV prevention. As studies have shown, most prevention efforts were implemented in past were of small-scale and fragmented. However, the “O Icheke” campaign was a success due to that fact that it had a national coverage and reach”. PE. N1.



FIGURE 2: The campaign brand “O Icheke” in English and Setswana language

High Quality Materials Based on High Levels of Consultation

The success of the “O Icheke” campaign depended heavily on the quality of its IEC materials and mass media products. According to participants, the materials were of high quality in terms of visual aesthetics and clarity of messages and very appealing to the target audiences.

One participant summarized the above notion by stating that;

“...Every brochure, billboard, poster, radio and television clips or other pieces of IEC materials was a product of a well thought decision, supported by research, to deal with specific MCP concern and to be well received and persuasive among target audiences”. PE.

N4.



FIGURE 3: One of the Campaign Billboards featuring the “O Icheke” brand

Strong National and Community Leadership

According to study participants, the involvement of national leadership in the campaign ensured the success of the campaign as issues of MCP dominated public discourse and debate as well as media. The following study participants attributed this by stating that:

“... factors that contributed to the success of the campaign were the buy in of national and community leaders as well as other stakeholders at all levels - national, district and community level and this was achieved through consultation, collaboration during planning across multiple sectors and well strong coordination”. PE. N1.

“...The national launch was a very good success, initially it was planned to be launched by the President or the Minister responsible for HIV/AIDS in the Office of the President but they were held up with other official duties, and hence it was then launched by the Speaker of National Assembly. The launch also gained a lot of publicity by media houses”. PE. N4.

“...Community leadership involvement was very critical in the success of the campaign because Chiefs and Councillors were very supportive of the campaign and always talked about it whenever they addressed community meetings”. PE. N7.

Achievement of national coverage and reach

Findings from study participants showed that “O Icheke” had a national coverage and reach and that it was Botswana’s first ever campaign to achieve such. Stressing the importance of reach and coverage for the campaign, one of the participants stated that:

“... The “O Icheke” campaign was one of the best campaigns Botswana has ever implemented for HIV prevention. As studies have shown, most prevention efforts were

implemented in past were of small-scale and fragmented. However, the “O Icheke” campaign was a success due to that fact that it had a national coverage and reach”. PE. N1.

“...to achieve coverage and reach, activities which were implemented at national level were mass media campaign thorough radio and television. There was also a radio serial drama called Makgabaneng which was broadcasted on Radio Botswana, the drama covered issues of MCP in the storyline. In 2010, again, there was a television drama called Morwalela which was broadcasted on Botswana Television, it also covered MCP issues and it was very popular”. PE. N10.

Wide Public Discourse and Media Coverage

The “O Icheke” Campaign was a success story because it received wide publicity and media coverage. After the launch of the Campaign, there was wide coverage of the issue of MCP by media houses including newspapers, radio and television broadcasters. There were numerous radio call-in programs, where people called in to express their views about MCP and how they perceive it as a risk factor for HIV infection. Furthermore, in support of the campaign, PSI with assistance from PEPFAR launched an eight (8) episode television drama. (See Annex 4). The television drama which was called “Morwalela” (*meaning flooding in Setswana language*) was broadcasted in 2010 to educate people about the risks associated with practicing MCP (Refer to Annex 4). NACA in collaboration with the National Assembly (Parliament), also conducted a nation-wide Public Hearing Dialogue (Kgotla Meetings) to stimulate national debate about MCP throughout the general population.

One participant reported that:

“... one factor that was very important during implementation was that a youth group of AIDS Activists from a local village of Gweta in the northern part of country created an

independent “O Icheke” Facebook page, to encourage others to reduce multiple and concurrent partnerships. The Facebook was a platform for young people around the country to engage in an easy way to discuss a sensitive issue of MCP”. PE. N7.

4.2.6 Factors Hindering Implementation of the Campaign

This section presents the findings pertaining to factors hindering implementation of the campaign with the following emergent sub-themes: inadequate resources and erratic funding, lack of funds to sponsor campaign ambassadors, organizational politics, lack of a well laid down materials development and distribution plan, slow campaign roll-out to districts, inadequate support to local implementing partners and inadequate monitoring and evaluation efforts.

Inadequate Resources and Erratic Funding

Most participants stated that erratic funding was a major hindrance to the success of the “O Icheke” campaign; they attributed this to delayed funding or funds not coming at the right time for implementing time conscious campaign activities as well as reduced funding at some instances.

A Key Informant noted that:

“... Extensive delays were experienced with regards to the release of funds from development partners, CDC/ PEPFAR and Government of Botswana. Sometimes bureaucracy in decision-making regarding funding and funding restrictions imposed by development partners hindered implementation of the campaign” PE. N10.

Another Key Informant alluded to the fact that:

“... Initially, when the campaign plan was hatched a well balanced campaign budget was formulated, inclusive of all activities deemed necessary for the campaign to be successful but the cost of the campaign was by far exceeded available resources but NACA was able to

source funding from the BNAPS Project, which was inadequate to meet the originally budget amount”. PE. N4.

Lack of Funds to Sponsor Campaign Ambassadors

Initially, during the planning process, it was agreed that a team of campaign ambassadors be constituted to become the campaign’s public face and drive both sensitization and community mobilization efforts. The ambassadors were envisaged to be men and women of integrity who were supposed to be role models to the target audiences. They were supposed to practise what they preach in order to drive the message home. Even though sensitization and community mobilization efforts were generally implemented successfully, the campaign suffered from lack of public figures with whom the campaign could be associated. This was largely attributed to some inadequate funding to sponsor recruitment of ambassadors and their initiatives as well as perception from others who felt the campaign was to some extent negative and critical.

One participant noted that:

“... Initially it was planned that the campaign sensitization and promotion efforts be driven by campaign champions but that was not achieved because there were no funds to undertake it. There were some kind of resistance from other organizations and individuals who felt that MCP messaging was just too explicit and derogatory, this resulted in some of them not buying-in into the campaign. PE. N6.

Organizational Politics: MOH versus NACA

During initial planning stage of the campaign, various government agencies and other implementing partners were tasked with different aspects of “O Icheke” campaign. The Ministry of Health (MOH) and NACA each had key roles in the campaign. NACA initiated the “O Icheke” campaign and was responsible for coordinating stakeholders for implementation. NACA carried out advocacy activities,

conducted training, and provided necessary funding while the Ministry of Health role was to oversee mainstreaming MCP into the health sector programs, such as couples testing, VCT, ART, and PMTCT. According to study participants, there was organizational politics of coordination and implementation between NACA and Ministry of Health which hampered successful implementation of the campaign:

NACA officials and other stakeholders stated that the MOH was invited to participate in the campaign from the start and had a representative at the initial meetings. Nevertheless, Ministry of Health still thought of the “O Icheke” campaign as a NACA initiative and felt left out of it.

Another key informant corroborated this by stating that:

“...One of the core activities of the campaign was to integrate MCP messages into other HIV and AIDS prevention programs for which the MOH holds responsibility but to a certain extent, the institutional politics and rivalry between NACA and the Ministry of Health had hindered mainstreaming of MCP messages into other national programs”. PE.N2

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Lack of Materials Development and Distribution Plan

The findings of this study indicate that although generally enough materials were developed and distributed to the target audiences, there was lack of a well laid down material development and distribution plan. This is attributed to the fact that respondents reported over-supply of some IEC materials while others were not adequate for the target audience. Respondents also observed that most materials were developed in English language with less in Setswana language. There were no materials which were developed for special population groups like people with disabilities.

One participant observed that:

“...Generally the materials were enough. However there was an over production of flipcharts and less production of leaflets. Materials were mostly in English language and there was no materials developed for people with disabilities”. PE. N2.

Slow Campaign Roll-out to the Districts

The majority of informants reported that by early 2010, most community level campaign activities had taken place in the majority of districts, implemented both by local CBOs and through the district structures. Key informants at the district level felt that the implementation of community-based or interpersonal interventions at the local level was slow. They attributed the slow campaign roll-out to delays in release of funds, identifying local Implementing Partners and bureaucratic process of distributing funds and planning and launching campaign at district level.

One participant stated that:

“...Generally I can say yes. Campaign activities were implemented successfully despite disruptions caused by delayed funding and inadequate funding for district and community level activities”. PE. N7.

Inadequate Support to Local Implementing Partners

Most of the respondents felt that the implementation of community-based or interpersonal interventions at the local level was slow. Many study participants concurred that most implementing partners did not have the capacity to carry out their activities due to shortage of funding during later stages of campaign implementation.

“... Am not aware of any action taken to address the situation because what I know is that the situation of lack of funds was never addressed and PSI ended not renewing some contracts with local CBOs due to lack of funds”. PE. NO 6.

“... Implementing partners were not very much competent to deliver campaign messages to the communities despite having been trained to do so. Peer educators were not supported by their employers to deliver the campaign messages at their respective work places and as thus negatively impacting on roll-out of the campaign at the district level”. PE. N4

Inadequate Monitoring and Evaluation

An Officer who was hired to oversee monitoring and evaluation activities at a national level left the job some few months into the implementation phase, so monitoring activities at national level suffered because of this loss. The responsibility of monitoring and evaluation was placed on the National Campaign Coordinator, who was overwhelmed, according to one participant, and thus monitoring and evaluation efforts suffered. The Monitoring and Evaluation Officer was not replaced when he left. Monitoring at the district level was also seen as a challenge to many organizations.

It was narrated well by one participant that:

“...Yes, the campaigns have implementation plan and a monitoring and evaluation framework. Initially an M and E officer was hired to oversee both the plan and the M and E component of the campaign but later left the job in the middle of campaign implementation. This eventually led to the M and E function of the campaign weakened as there was no one solely responsible for M and E activities. Campaign Coordinator then combined his coordination function with that of M and E”. PE. N6.

“... Reasons for staffing attrition were that people are always seeking greener pastures and good rewarding jobs. Again, authorities did not make any efforts to replace resigned staff and this was said to be attributed to inconsistent funding mechanism”. PE. N6.

4.3 Findings from Document Review

In this section, findings from document review will be presented according to the study objectives, stated at the beginning of the chapter.

The documents that were reviewed were: National MCP Quarterly Reports from 3rd Quarter of 2009 to 4th Quarter of 2012 (NACA, 2009-2012), National MCP Campaign Plan (2009- 2012), National MCP Campaign Monitoring and Evaluation Plan (2009- 2012), National MCP Campaign Performance Log-frame (2009- 2012) and National MCP Campaign I.E.C Materials Package (2011) as well as Field Support and Monitoring Reports (2009-2012). These types of materials were sourced from NACA and PSI's institutional records and were provided by program officers.

4.2.1 Fidelity to the Campaign Implementation Plan

This section presents findings of the document review pertaining to objective number one, which is to assess whether campaign activities including national sensitization were implemented according to the plan. These included among others major campaign milestones such as planning and consultations, national sensitization and leadership mobilization, engagement of campaign champions, campaign branding and district support.

Planning and Consultations

According to the campaign a report, the National “O Icheke” campaign was conceived out of the National Strategic Framework (NSF II) and the National Operational Plan for Scaling Up HIV Prevention in Botswana (NACA & PSI, 2009-2012). The Government of Botswana then called for support from development partners to assist technically and with resources to implement a national campaign focusing on MCP (NACA & PSI, 2009-2012). PSI was contracted by PEPFAR through Centres for Disease Control to lead the process of designing the campaign.

In 2007, PSI conducted a TRaC (Tracking Results Continuously) survey of MCP in Botswana and presented its findings to the first consultative and planning workshop for MCP campaign, which was held in 2008 (NACA & PSI, 2009-2012). The planning and consultation workshop was attended by stakeholders from public and private sectors and civil society as well as development partners. The workshop came up with recommendations on how the envisaged MCP campaign should look (NACA & PSI, 2009-2012). One of the outcomes of the workshop was the establishment of a Technical Advisory Committee made up of various stakeholders mandated to oversee the campaign development and implementation (NACA & PSI, 2009-2012).

National Sensitization and Leadership Mobilization

According to the campaign quarterly program reports (NACA & PSI, 2009- 2012), the national sensitization starting with national launching of the campaign was achieved according to the plan in quarter 1 of 2009. This was followed by sensitization of implementing partners, which was accomplished according to the plan in quarters 1 and 2 of 2009. Sensitization of national and local leadership was planned to be conducted in quarters 1 and 2 of 2009, but was delayed and ended up being implemented during quarters 3 and 4 of 2009. However, sensitization of leadership continued through the second year of the campaign as part of regular briefing of leaders on the overall National HIV and AIDS Response (NACA & PSI, 2009- 2012).

Campaign Champions

The reports indicate that recruitment of campaign ambassadors was planned to be achieved in the first quarter of 2009 but was unsuccessful due to inadequate resources as well as logistical challenges of coming up with a criteria for recruiting them. Campaigns champions was an idea originated by planning and consultation workshop participants who were mandated with coming up with initiatives to promote safer sexual practices as well as discourage MCP practices among people (NACA & PSI,

2009- 2012). They were expected to carry out educational sessions in schools, workplaces, public places and address community meeting in both rural and urban areas (NACA & PSI, 2009- 2012). Campaign champions were envisaged to become the campaign's public face and brand managers as well (NACA & PSI, 2009- 2012).

Branding the Campaign

The initial stage of materials development was campaign branding and development of sensitization materials; these activities were successfully accomplished during the first year of the campaign, according to the plan (NACA & PSI, 2009- 2012). The branding package included information about the logo and templates (colors, fonts, designs) that were used in all materials, including media, sensitization packs and communications tools and all Information, Education and Communication (IEC) and promotional materials that were produced. These materials included print materials (newspapers, flipcharts, leaflets), electronic media (television spots, radio spots, jingles and social media), campaign signage (banners, posters, billboards) as well as promotional material such as pens, t-shirts, umbrellas, cups and computer mouse pads, car license discs and caps (NACA & PSI, 2009- 2012). The brand was also used in information and educational tools for one-on-one, small group and community settings (NACA & PSI, 2009- 2012).

District Support

Most of the campaign activities planned for district support were scheduled to be implemented during the first to third quarters of the first year of the campaign but were postponed due to delays caused by late arrival of funds. Activities earmarked for district support were, however, implemented from the fourth quarter of first year to the second quarter of second year (NACA & PSI, 2009- 2012). These activities started with sensitization of community leaders and district partners, and then followed by sensitization of DMSACs.

The second major activities in support of districts were the establishment of district MCP campaign teams, which was followed by training of districts campaign coordinators (NACA & PSI, 2009-2012). NACA and PSI supported district campaign teams to develop their respective district specific campaign plans (NACA & PSI, 2009- 2012). NACA and PSI also assisted districts to select key local NGOs to serve as implementing partners of the campaign at local level (NACA & PSI, 2009- 2012). This activity was then followed by training of local implementing partners to build their capacity and competences to implement the campaign successfully. Local implementing partners were trained on “O Icheke” MCP messaging, project management, financial management, monitoring and evaluation (NACA & PSI, 2009- 2012).

4.2.2 Strategies for Material Development and Distribution

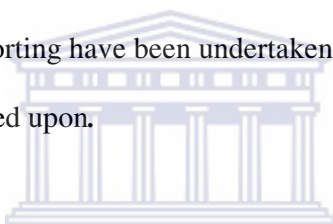
The section presents the findings of the document review as pertaining to objective two; which seeks to determine whether the strategies for development and distribution of materials were followed and to assess whether they matched specifications of the campaign in design, quality, messages and portability.

According to document reviews, development of materials for the first phase of the campaign, also known as the “Teaser Phase”, was achieved on schedule according to the plan (NACA & PSI, 2009-2012). The Teaser Phase which stimulated public debate with its message of “*Who is in your sexual network*” was scheduled to run for one month but because of its popularity in engaging the public it was extended to run for six months. Billboards were placed from second quarter of 2009 up to second quarter of the following year, however, there were no billboard placements for extended periods due to lack of funds caused by the financial crisis of 2009/ 2010 (NACA & PSI, 2009- 2012). The billboards were only placed back during the third quarter of 2011.

Print materials were developed and printed on time except that in 2010 there was chronic shortage of materials due to shortage of funds, as funds tended to arrive late for planned activities. Second and third phase materials were produced in the second quarter of 2011. Although television and radio reached many people as per monitoring reports (NACA & PSI, 2009-2012), these media were also affected by funding shortages due to the 2009-2010 financial crisis. However, the reports indicate that initial broadcasting of both TV and radio was achieved on schedule for the first phase of the campaign until second quarter of 2010 (NACA & PSI, 2009- 2012).

4.2.3 Monitoring, Reporting and Evaluation

These section present findings from the review for objective number three; which seeks to assess whether interim monitoring and reporting have been undertaken, whether problems have been identified and recommendations acted upon.



Research, Monitoring and Evaluation

NACA, PSI and implementing partners developed a monitoring, research and evaluation plan in August 2009. The plan articulated the exploration of MCPs in Botswana through the use of quantitative, qualitative and ethnographic study methods as well as network modeling to understand how concurrency fuelled HIV infections_(NACA & PSI, 2009- 2012). A national Monitoring and Evaluation Officer was also recruited to be responsible for documenting the implementation and success of the campaign against its performance indicators; however, the officer decided to resign his post during first year of the campaign and was never replaced (NACA & PSI, 2009- 2012).

According to the reports, a campaign baseline study was not conducted but some information on MCPs in Botswana was available from PSI's Tracking Result Continuously (TRaC) study of 2007 (NACA & PSI, 2009- 2012). A mid-term evaluation of the campaign was planned for 2010 but was

never achieved due to shortage of funds, lack of time and expertise to conduct it. At the end of 2011, PSI conducted an impact evaluation of the campaign on the exposure effects on MCP behaviours. The findings of the evaluation revealed that there was no evidence that the campaign succeeded in reducing concurrent partnerships, however, campaign exposure was associated with other risk reduction behaviours, namely more consistent condom use, greater HIV testing, greater confidence in condoms as an HIV risk avoidance strategy (PSI, NACA & CDC; 2012).

4.2.4 Factors which aided successful implementation of the campaign and those that hindered it.

This section presents findings pertaining to Objective 4, which assessed factors which aided successful implementation of the campaign and those that hindered it.

Factors which aided successful implementation

According to document reviews (PSI, NACA & CDC; 2012), factors which contributed to successful implementation of the campaign were, among others, a strong commitment by all stakeholders during planning, designing and message development and execution of the entire campaign. This commitment resulted in stakeholder buy-in, responsibility and ownership of the campaign.

The campaign design was hinged on strong evidence. Document review (NACA, 2009) findings indicate that several studies were referred to and various local studies that were conducted on the issue of MCP were also used to inform the campaign design. Key strategic documents of the Botswana National HIV and AIDS response were also referred and this included among others: Botswana National Strategic Framework for HIV and AIDS, Botswana AIDS Impact Survey III (2008) and the National Operational Plan for Scaling HIV Prevention in Botswana (2008) among others.

The reviews indicate that the campaign was successful because of the quality of “O Icheke” messages which were consistent with international standard as messages, were clear, simple, specific, factual, appropriate, timely and relevant and driven by channels which were appropriate, relevant, accessible, except mass media such television, radio and billboards which were found to be expensive (NACA, 2009-2012) and (ZNFPC, 1998).

The brand “O Icheke” was also found to be a success factor for the campaign as it increased visibility and ownership of the campaign (NACA, 2009-2012). The brand was conceived from a local popular song which discourages MCP and was well accepted as a local product with a local feel. The success of the “O Icheke” campaign depended heavily on the quality of its IEC and mass media products. The success and the impact of campaign materials emanated from the understanding of the target audiences by the material design team.



The findings from document analysis revealed that strong involvement of implementing partners, and many organizations at all levels (national, district, and local) ensured that the campaign became an exemplary multilevel communication initiative. Monitoring reports (PSI, 2009) and the TRac survey (2009) indicated that the campaign’s reach and coverage was excellent and was visible in most urban and peri-urban areas and this was attributed to efforts of the majority of Community Based Organizations who were implementing the campaign at district level (NACA & PSI, 2009-2012).

According to the campaign plan “O Icheke” campaign was a success story because it built on a strong evidence base, and the national leadership was highly supportive of the ongoing collection of data and this was also attested by Lillie (2010). The use of Stages of Change Model (Prochaska *et al*; 1983), to inform campaign design and material development also ensured that the campaign was

strategically positioned to reach all the targeted audiences.

The “O Icheke” campaign was a success story because it received wide publicity and media coverage. After the launch of the campaign, there was a wide coverage of the issue of MCP by media houses; both newspapers, radio and television broadcasters (NACA & PSI, 2009-2012). The “O Icheke” campaign has given people an easier way to talk about a difficult topic (NACA & PSI, 2009-2012).

Factors hindering the implementation of the campaign

According to reports (NACA & PSI, 2009- 2012), factors hindering implementation of the campaign were identified as follows; inadequate funding of some of the core activities of the campaign such as mass media (television and radio), as well as delayed release of funds, which resulted in some key campaign activities not being implemented on time. Lack of recruitment of campaign ambassadors was also identified as a factor which contributed to the failure to sustain community sensitization and mobilization beyond mass media as well as hampering efforts to provide role models for the campaign.

The reports (NACA & PSI, 2009- 2012) indicate that district support was delayed due to delays experienced in funding, resulting in some planned activities not being implemented. This situation also contributed to failure in rolling out to other districts on time. The reports (NACA & PSI, 2009-2012), pointed out that even though a monitoring and evaluation plan was in place, it was never implemented accordingly due to the resignation of the national monitoring and evaluation officer; this contributed to poor monitoring of the campaign from district level to the national level.

4.4 Conclusion

In conclusion, this chapter presented study findings from both participants’ interviews and document

analysis according to the study objectives as per the interview guide. The chapter covered fidelity to the implementation plan, strategies for material development and distribution research, monitoring and evaluation as well as findings on factors which have contributed to success of the campaign and those who have hindered it.



CHAPTER FIVE – DISCUSSION

5.1 Introduction

In this chapter, the findings from participant interviews and documentary analysis will be triangulated. The discussion will also provide general comments about the campaign in relation to the literature review and key issues that have emerged from the analysis of interviews and documents, forming the basis of recommendations in the next chapter.

5.2 Planning, Basis and Process

As described in Chapter Two, the campaign was based upon evidence from various studies that were conducted on the issue of MCPs: these were, among others, the PSI TRaC Survey of 2007, the SADC Think Tank Report (2006), the Botswana AIDS Impact Survey III (2008), the National Operational Plan for Scaling HIV Prevention in Botswana (2008) and the Soul City Mega-Country Evaluation Study on MCP (2009). This was reflected in the documentary analysis, especially the policy context of the campaign implementation plan (NACA, 2009) and also supported by a number of participants who observed that conception of the campaign goal and objectives were informed by available evidence from local and regional studies.

The campaign design was not only based on evidence about the MCP issue in Botswana, but also structured in terms of Prochaska and Diclemente's (1983) Stages of Change model, as reflected in the campaign plan (NACA,2009), which proposed three implementation phases. The findings revealed that many of the participants were well aware of this, and were impressed by the use of a theoretical basis for the campaign. They were evidently adequately informed of the campaign's basis, and in many instances were included in the campaign rationale and design discussions from the start. This suggests the campaign designers' commitment to inclusiveness and buy-in from an early stage. In one instance, however, a participant from the Ministry of Health described a feeling of

exclusion from the initial discussions and asserted that this led to poor mainstreaming of the campaign messaging in some national HIV prevention programs.

The perception of NACA officials and other stakeholders was that the Ministry of Health was invited to participate in the campaign from the start and had a representative at the initial meetings.

Nevertheless, some representatives of the Ministry of Health still thought of the O Icheke campaign as a NACA initiative, and felt left out of it.

5.3. Leadership and Sensitization

Both participant findings and document reviews attest that leadership and thorough sensitization of key stakeholders were important ingredients in ensuring the success of the campaign. Analysis of the NACA and PSI reports of 2009-2012 confirmed that the sensitization of implementing partners, and national and local leadership had been accomplished by the 4th quarter of 2009, although slightly later than planned; furthermore, the document review confirmed that the leadership was kept informed through the second year of the implementation of the campaign.

The national campaign performance log frame also shows that sensitization efforts were implemented according to the plan at both national and district level. However, although generally findings from both study participants and document reviews suggest that sensitization efforts went well, there were some participants who referred to the impact of erratic funding, causing delays in the sensitization workshops. This led to the exclusion of, for example, Traditional Health Practitioners. Furthermore, the plan that Campaign Champions should drive sensitization efforts was undermined by funding shortages. It was suggested that Campaign Champions may have been able to counter negative responses to the MCP messages, which were in some quarters felt to be “*too explicit and derogatory*”.

5.4 Strong Support Structure

According to the study findings from both key informants and document review (NACA 2009-2012), PSI in collaboration with NACA provided districts and implementing CBOs with capacity building support on “O Icheke” messaging, project management, finance and monitoring and evaluation so that they could confidently implement a successful campaign. At national level, there were two (2) District Support Officers and a Monitoring and Evaluation Officer employed to support implementation of the campaign in districts. Efforts to support districts to implement the campaign were through the Ministry of Local Government.

PSI and NACA started district support by working with the Ministry of Local Government to identify district campaign coordinators who were then trained on the MCP messaging and campaign delivery (NACA, 2009-2012). District campaign coordinators also received support from the national campaign coordinating unit to sensitize key district stakeholders and develop district campaign rollout plans (NACA, 2009-2012). It was also found that the motivation of the district campaign coordinators was key to the campaign’s success. The national campaign coordinating unit also played a critical role by ensuring that the district coordinators had all the support they needed to effectively implement the campaign at district level. This finding emerged more strongly from document review.

5.5 Rolling Out the Campaign

According to both sets of findings, major project activities implemented at national level were the mass media campaign (print, TV, and radio), advocacy, sensitization and production and distribution of IEC materials; these included information and educational tools for one-on-one, small group and community settings. Ongoing capacity building was conducted through training of Implementing Partners, as well as interpersonal communication interventions through peer education and peer

counselling.

Study findings from interviews and document review indicate that the campaign was generally rolled out according to plan despite the fact that, at national level, disruption in funding flow resulted in delayed implementation of mass media for some campaign phases. The campaign received positive endorsement from a participant as “one of the best campaigns ever in Botswana...” (PE. N1), because of its national coverage, its scale and because, in contrast to earlier campaigns which had been fragmented, it was integrated in overall HIV prevention messaging.

However, both document review (NACA 2009-12) and interview findings revealed that in spite of support given by the national coordinating office to districts, rollout of the campaign was weakened by slow or inadequate funding for implementing community-based or interpersonal interventions at the local level. Interview findings showed that most implementing partners could not carry out their activities due to shortages of funding during the later stages of campaign implementation.

Both sets of findings showed that some implementing partners were not sufficiently competent to deliver campaign messages to the communities, despite having been trained to do so (NACA, 2009-2012). They also indicated that peer educators were not supported by their employers to deliver campaign messages at their respective work places and this negatively impacted on roll-out of the campaign at the district level (NACA, 2009-2012).

Staff attrition also negatively affected campaign rollout because officers working in the campaign’s monitoring and evaluation section left the campaign for better jobs. For example, the Monitoring and Evaluation Officer left the campaign in late 2009, the National Campaign Coordinator resigned his post in 2010 and one District Support Officer left the job in 2011. A participant also noted that

efforts were not made to replace staff who had resigned.

5.6 Campaign Content Development and Material Distribution

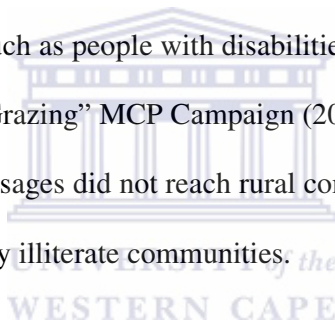
The findings from both interviews and document reviews indicate that strategies for development and distribution of materials were followed and matched the specifications of the campaign very well in design, quality, messages and portability. The findings also revealed that “science and art were combined” (NACA and PSI, 2009) in developing concepts for materials, messages, stories and participatory processes. For example, the campaign was branded “O Icheke” Break the Chain campaign”, a brand which was chosen after a wide consultation with stakeholders and audiences. There was also a systematic process involved in material development which included pretesting and revision based on feedback. Both sets of findings showed that conceptualization of the campaign emphasized maximum participation of both campaign implementers and audiences, from development to implementation stage. This was in line with Noar *et al*'s 2009 research-based assertion that in order to develop effective communications, participation and involvement of both campaign developers and beneficiaries is very important.

The messages themselves were reportedly found to be clear, simple, specific, factual, appropriate, timely and relevant (NACA, 2009-2012; ZNFPC, 1998). Both sets of findings indicated that the channels for communicating messages were also appropriate, relevant and accessible, with the exception of mass media such as television, radio and billboards, which were found to be expensive (NACA, 2009-2012).

Both document reviews and participant interviews attested that PSI's materials development methodology was used and that it was a methodology based on the international best practice method known as the Delta Health Communication Methodology (PSI, 2009; NACA, 2009-2012). Delta is

used to develop communication programs addressing a wide range of topics such as encouraging safer sexual behaviour to prevent HIV transmission, promoting child survival, reducing maternal mortality, increasing contraceptive prevalence, preventing infectious diseases, or promoting environmental health (PSI, 2009).

The findings from interviews and documents indicated that although materials were of high quality, and appropriate channels were used, the materials distribution plan did not cater for issues of supply and demand. Some materials were found to be in abundance while others were limited in quantity. Moreover, most materials were found to be in English language with only a limited number in Setswana language (NACA, 2009-2012). Both findings also reveal that there were no materials developed for special populations such as people with disabilities. Similarly, the Panos Evaluation study findings of Uganda 's "Zero Grazing" MCP Campaign (2009) highlighted in the literature review revealed that most MCP messages did not reach rural communities in language and formats which could be easily understood by illiterate communities.



5.7 Research, Monitoring and Evaluation

Findings from document analysis (PSI, 2009; NACA & PSI, 2009-2012) and participant interviews indicated that a monitoring and evaluation framework was developed and four types of research were included in the research agenda for MCP, to further explore the issues of MCP as a pre-disposing factor to HIV infections. These were aimed at identifying ways to improve the efficiency and effectiveness of programmatic interventions, and to assess the costs and cost-efficiency of the campaign.

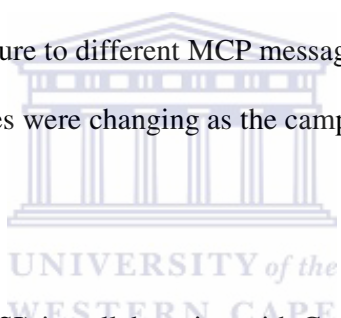
The current research findings suggest that a campaign baseline study was not conducted, although other studies were referred to, providing reasonable data for comparison. For example, a Population Services International (PSI) study of 2010 was used which revealed that the rate of MCPs in Botswana was 17.5%, with both men and women practicing them. This was supported generally by Carter *et al* (2007) who observed that multiple concurrent partnerships are a tolerated pattern of sexual relationship in Botswana. Since more was known about the problem, potential solution and intended audience, the findings indicated that planners reported that there was no need to conduct formative research before taking the next planning steps.

Participant interviews and document analysis showed that monitoring of the national campaign plan was conducted regularly, but that some of the recommendations from the monitoring, such as the improvement of the funding streams, were not acted upon. In cases where some peer educators were identified as having challenges, a twinning arrangement was made with other districts which were doing very well in terms of campaign implementation, for them to learn lessons on improving their campaign delivery at their respective districts. In workplaces some peer educators were not supported by their management to implement the campaign in their respective work places. (NACA & PSI, 2009-2012).

On the basis of both sets of findings, a quarterly monitoring exercise was conducted to measure the extent to which the campaign rollout schedule was being followed. It focused on process indicators relating to implementation of district campaign plans, distribution of I.E.C materials, placement of media communications and disbursement of funds. Semi-annual campaign reports were compiled by the national campaign coordinator, who documented successes, lessons learned and recommendations from districts and implementing partners for improving the rollout. In addition to monitoring, plans were drawn for campaign evaluation measures to determine how well the

campaign achieved its objectives. These were to be achieved through PSI's TRaC Survey which measures campaign success in terms of reach and recall, including the effects of different activities on different audiences.

Lack of a Monitoring and Evaluation Officer at national level did however affect monitoring of the campaign at national level and was identified as a major challenge for the campaign (NACA & PSI, 2009-2012). A process evaluation was not conducted as was planned earlier which runs counter to Noar *et al's* recommendation for implementing a successful campaign (2009). However, to supplement ongoing monitoring and evaluation activities, PSI also conducted the annual quantitative study called the TRaC Survey, through which they measured changes in behaviours and individual behavioural drivers as well as exposure to different MCP message sources, and how norms about MCP and other key campaign themes were changing as the campaign rolled out (NACA & PSI, 2009-2012).



Population Services International (PSI) in collaboration with Centers for Disease Control (CDC) and National AIDS Coordinating Agency (NACA) conducted a national cross-sectional survey in 2011. The findings of the evaluation revealed that there was no evidence that the campaign succeeded in reducing concurrent partnerships, although campaign exposure was associated with risk reduction behaviours, namely more consistent condom use and greater HIV testing (PSI, NACA & CDC, 2012). Results of the study (PSI, 2012) indicated that stand-alone campaigns on concurrency were not sufficient to change behaviours, given the evident confidence in condom use to mitigate risk. Given the entrenched and social acceptance of multiple and concurrent partnerships, one campaign may not be sufficient in duration or intensity of exposure to change these behaviours (PSI, NACA & CDC, 2012). This was also corroborated by the Panos study (2009) which recommended that MCP communication should be integrated with prevention strategies rather than as standalone and separate

campaigns.

5.8 Factors which Contributed to the Campaign

This section discusses findings drawn from both document reviews and participant interviews on factors which have contributed to the success of the campaign and those which have hindered it.

5.8.1 Factors which contributed to the campaign's success

Regarding factors which contributed to successful implementation of the campaign, the findings indicate that one of the factors was a strong commitment by all stakeholders during planning, designing, message development and to a lesser extent execution of the campaign. This commitment resulted in stakeholder buy-in, responsibility and ownership of the campaign.

The campaign was also reported to be successful because its design hinged on strong evidence, a likely factor for its success. The findings indicate that several studies were referred to and various local studies that were conducted on the issue of MCP were also used to inform the campaign design. Key strategic documents of the Botswana National HIV and AIDS response were also referred to and this included among others: Botswana National Strategic Framework for HIV and AIDS, Botswana AIDS Impact Survey III (2008) and the National Operational Plan for Scaling HIV Prevention in Botswana (2008).

The campaign was also thought to be successful because of the quality of “O Icheke” messages which were consistent with international standards for messages, i.e. clear, simple, specific, factual, appropriate, timely and relevant. Furthermore, the media employed to disseminate messages were appropriate, relevant, accessible, except mass media such television, radio and billboards which were found to be expensive (NACA, 2009-2012; ZNFPC, 1998). A strategies health communication plan

that focuses on specific change objectives, audiences, messages and media was implemented and concepts, messages, materials, and media strategies were tested to ensure appropriateness, relevance and quality of messages (NACA, 2009).

The brand, “O Icheke” was also found to be a success factor for the campaign, as it increased visibility and ownership of the campaign (NACA, 2009-2012). According to study findings, the branding process was actually carried out according to the plan. The campaign brand “O Icheke” was an action slogan that was used on all campaign materials and signage throughout the duration of the campaign, acting as a unifying theme and message. The brand was conceived from a local popular song discouraging MCPs, and according to document evidence and participant interviews, the brand was well accepted as a local product with a local feel.

The success of the O Icheke campaign depended heavily on the quality of its IEC and mass media products. According to study findings, the materials were reported to be of high quality in terms of visual aesthetics and clarity of messages and very appealing to the target audiences. The success and the impact of campaign materials emanated from the understanding of the target audiences by the material design team. A number of study participants were positive when it came to the level of consultation in relation to IEC materials design.

The findings from both document analysis and study participants also revealed that excitement among various implementing partners, and many organizations at all levels (national, district, and local) ensured that the campaign became an exemplary multilevel communication initiative, a factor which was also endorsed by NACA (2009-2012). The NACA/PSI Report (2009-2012) notes that the campaign’s reach and coverage was excellent and was visible in most urban and peri-urban areas: this was attributed to efforts of many community based organizations who were implementing the

campaign at district level (NACA & PSI, 2009-2012).

The findings suggested that coordination by the national government under the auspices of the National AIDS Coordinating Agency and not by an international donor was also a factor for success. The use of the Stages of Change Model (Prochaska *et al*, 1983) to inform campaign design and material development also ensured that the campaign was better positioned to appeal to targeted audiences.

According to the findings, another factor that contributed to the successful of implementation of the campaign was the national coverage and reach (NACA & PSI, 2009-2012). Part of this success was attributed to its multifaceted character, of having multi-level interventions (national, district, local, and clinical), implemented by numerous stakeholders through existing structures such as the District AIDS Coordinating Offices (NACA & PSI, 2009-2012).

O Icheke campaign was also successful because it received wide publicity and media coverage: after launching the campaign, there was wide coverage of the issue of MCP by media houses including newspapers, radio and television broadcasters (NACA & PSI, 2009-2012). The campaign was also successful because of the support it got from Makgabaneng Radio Serial Drama and Morwalela Television Drama, which proved to be popular among the target audience (NACA & PSI, 2009-2012) (*Refer to Annex: 4*). One of the indicators of success cited by the NACA/PSI Report (2009-2012) was that it gave people an easier way to talk about a difficult topic.

5.8.2 Factors which hindered implementation of the campaign

The findings also pointed to a number of factors which were considered as a hindrance to the implementation of the campaign: among others, erratic funding was repeatedly cited as a major hindrance to the success of the O Icheke campaign. These extensive delays were experienced with regard to the release of funds from development partners, namely CDC/ PEPFAR and the Government of Botswana (NACA & PSI, 2009-2012). These challenges took the form of delayed funding or funds not coming at the right time for implementing time-conscious campaign activities; this stifled implementation of various planned campaign activities.

According to the findings, organizational politics between the Ministry of Health and NACA also contributed to failure of some of the planned campaign activities such as mainstreaming of MCP messages in other prevention programs implemented by the Ministry of Health. While the roles of both NACA and the Ministry of Health were clearly articulated at the initial planning stage of the campaign, key personnel from the Ministry of Health (MOH) held the view that they were left out of the initial campaign process; they criticized NACA for bringing them into the campaign at a later stage than the other secondary stakeholders.

Regarding support to districts to implement the campaign, findings show that district implementation was also affected by erratic funding which also cascaded to affecting implementation of community-based or interpersonal interventions at the local level (NACA, 2009-2012). Findings suggest that though district support activities were implemented, such as offering training in financial management, campaign delivery, project management and monitoring and evaluation, most implementing partners were not sufficiently competent to deliver campaign messages to the communities despite having been trained to do so (NACA, 2009-2012).

A summary table of the challenges has been included as Annex 9 and illustrates the sources of these findings.

5.9 Conclusion

In this chapter, the data from interviews and document review has been triangulated. It has also compared the study outcomes with the campaign implementation plan to reveal the course of and extent of implementation as planned. General comments on the campaign have been made, followed by discussion of key issues that emerged from the data collection process, as well as a discussion of factors contributing to the success of the campaign and those that did not. In the final chapter, conclusions are drawn, limitations discussed and recommendations are offered.



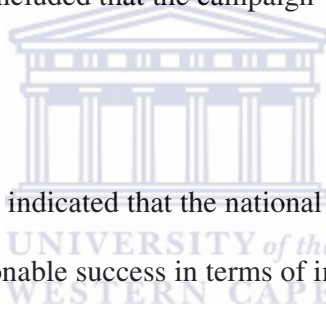
CHAPTER SIX - CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

In this chapter conclusions will be drawn, study limitations will be discussed and recommendations for improving the practice of implementing health communication campaigns will be offered; in addition, implications for future research will be proposed.

6.2 Conclusions

It is evident from this study, that planning of the O Icheke Campaign design, implementation, and material development and distribution was based on behavioural theory and evidence based programming. It can therefore be concluded that the campaign was grounded in strong evidence derived foundations.



The process evaluation findings also indicated that the national “O Icheke” Multiple and Concurrent Partnership Campaign enjoyed reasonable success in terms of implementation of planned activities, despite the challenges that were encountered. These findings demonstrate that “O Icheke campaign activities unfolded in the main according to the plan, particularly in the earlier phases one and two. As time passed and funding delays emerged, which coincided with campaign activities further from the national level or centre, district level campaign roll-out was affected. In contrast, national level activities such as development and distribution of materials were followed, and were reported as of international standard and quality.

Factors which enhanced implementation were identified as strong stakeholder commitment, broad national reach and coverage, and importantly wide public debate and media coverage. Factors which hampered implementation were identified as primarily erratic and delayed funding, slow campaign roll-out to districts, organizational politics and conflicts, insufficient capacity and skills by some

implementing partners to implement the campaign, and inadequate monitoring and reporting activities at all levels.

The value of this evaluation study is to contribute to the body of knowledge on improving and sustaining health communication campaigns. It has drawn attention to the effect of certain process or implementation factors on this campaign, and hopefully contributed an understanding of the importance of including a process evaluation in the course of an intervention.

6.3 Recommendations

This study was a process evaluation of the implementation process of phases I to III of the Botswana National Multiple Concurrent Partnerships “O Icheke” Campaign between 2009 and 2012. In the course of the evaluation, factors that enhanced or hindered the implementation process were identified. This was not an evaluation of the effectiveness of the campaign, so no recommendations on the overall effectiveness of the campaign can be made and caution must be taken when interpreting the results.

The positive evaluation points made in the course of this study serve, however, to endorse the strengths of this campaign, which could be seen as recommendations along with those which follow. Despite the restricted nature of the study design and the limitations of the data collected, there are a number of recommendations which are proposed to inform improvements to future implementation processes of national health communication campaigns, in terms of planning and practices. These improvements may serve to contribute to planning and implementation of future campaigns of this nature.

The recommendations are as follows:

6.3.1 Planning, basis and process

The findings indicated that key primary stakeholders were properly involved in the campaign planning and design stage: it is therefore recommended that for a campaign to achieve success, primary key stakeholders should be involved from the onset so that they can “own” the campaign and drive its delivery at all levels. Primary stakeholders are here defined as those who will be driving planning, coordination and implementation at national level, those who will be responsible for resources for the campaign as well as those who will be responsible for delivery at district and local level.

Although the findings indicate that an evidence planning approach was utilized, they also suggest that a formative study was not conducted to inform planning as per standard norms in campaign development. A formative study seems to be an important process in planning a campaign of this magnitude because it is more focused, it tests processes at a smaller scale and also involves the target audience in identifying key problems before campaign planning. This was emphasized in Noar *et al's* (2006) assertion that prior to a campaign, a formative study should be conducted with the target audience to clearly understand the behaviour and the problem area and to pre-test messages and processes with the target audience to be sure they are both appropriate and effective.

It is therefore recommended that, depending on scale, a formative study be conducted prior to campaign implementation, so that its findings can serve as evidence for planning purposes.

6.2.2. Leadership and mobilization

Findings from this study indicate that lack of funding for campaign champions hampered opportunities for role modelling and leadership roles. They were supposed to have been “the face of the campaign”, providing it with a public face driving the MCP messages, as well as sensitizing and mobilizing communities to own the campaign. Because funding prevented this intervention, it is recommended that this strategy be explored in future interventions and that their contributions to the campaign are assessed.

6.2.3 Funding

From the study findings, it is recommended that planning should match financial resources which should be both readily available for implementation of campaign activities and must come at the right time for planned activities. Financial flows should be maintained to keep pace with implementation of the campaign. Funding streams and mechanisms should be set up in such a way that there are no delays in disbursement of funds. Funding levels should be maintained such that they meet requirements of planned activities. Campaign implementation is time sensitive, and delayed funding causes a lot of disruption in the way the campaign implementation phases are rolled out. It should also be recognized that factors outside local control can impact on funding. This is the case with dealing with funding from outside government funding mechanisms; plans could also be developed to identify less critical expenditures should this occur.

6.2.4 Financial Planning

Additionally as part of the campaign implementation plan, within a financial plan, it should be specified when the funds will be available for implementation, over what period they will be utilized and how much will be used for various components of the campaign. The implementation plan,

should also articulate stakeholders' roles and responsibilities regarding disbursement, utilization and accountability pertaining to funding.

6.2.5 Stakeholder engagement

It is very critical to actively involve all key stakeholders in the life cycle of the campaign, from the initial planning and design stage up to implementation and evaluation stage. This should entail stakeholder participation in the initial brainstorming sessions, to actual planning and implementation. It is recommended that involvement of all key players - national, district, international and local partners - be achieved to ensure overall success, as the success of national campaigns hinges on their active participation, support, and ownership. It is also noted that higher levels of government should communicate institutional involvement down the line to implementers so that they are aware of this involvement from the earliest stages, even if it is not possible to involve them all at the outset.

6.2.6 Stakeholder role clarity

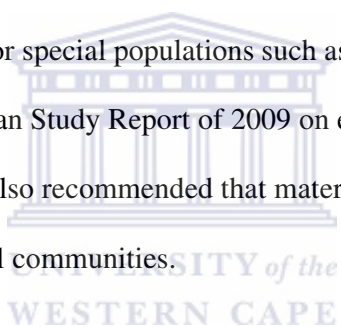
From the study findings, it recommended that at the planning and design stage of the campaign stakeholder roles and responsibilities should be clarified to ensure that all key stakeholders are aware of them before implementation. This is equally important to achieve the objective of collective buy-in and ownership by various key players. Stakeholder role clarity is also important in ensuring that organizational politics are avoided.

The roles of key campaign players, more especially within government ministries and departments, should be continuously clarified and strengthened to develop a more constructive partnership in the campaign. The relationship between key government entities is essential for the successful district-level roll-out of the campaign. Ministry of Local Government and Rural Development should have

been be involved at an earlier stage of the campaign so that issues pertaining to implementation of the campaign at district and community level could have been addressed at a planning stage.

6.2.7 Content and material development

Findings show that there was no detailed distribution plan for materials. Some materials were over supplied while others were always in shortage. There were no materials produced for special populations such as people with disabilities. Most materials were found to be in English language with only a limited number in Setswana language. It is therefore recommended that during planning phase, a material distribution plan be developed before implementation and adequate materials should be developed in local language which is understood by many people. It is also recommended that special materials be produced for special populations such as people living with disabilities. This is also in line with Panos East African Study Report of 2009 on evaluation of the “Zero Grazing” MCP Campaign in Uganda, which also recommended that materials should be produced in a language mostly understood by local communities.



It is also recommended that a more thorough pre-testing of materials be undertaken before mass production, to ensure that materials are understood by the target audience and also to determine acceptability; whether the materials are offensive or not and whether they are culturally accepted or not. Pre-testing may also help determine familiarity and relevance of the materials; to check whether the problem known and relevant to the target audience. Pre-testing may also help with issues of appropriate language for the target group as well as also considerations for production of materials for special populations such as people with disabilities.

6.2. 7 Human resources for monitoring and evaluation

According to study findings, management of the campaign was marred by human resources challenges arising from attrition of staff working on the campaign's monitoring and evaluation area. It is therefore recommended that for a campaign to be successful it should be well staffed by qualified and experienced evaluation officers and plans should be in place to retain them. Plans should also be in place to replace those who have resigned within a short period of time so that implementation is not affected.

Monitoring and evaluation form a critical component of tracking campaign success or failure: therefore it is important that there should be dedicated staff for monitoring and evaluation at both national and district level and efforts should be put in place to replace them quickly.

6.2.9 Supporting implementation at district and local levels

The findings indicate that district support was not sufficient due to limited funding and also that implementing partners were struggling to implement the campaign at local level due to limited funding and lack of capacity to implement planned campaign activities. It is against this background that it is recommended that strong support should be given to implementing partners operating at district and local level and that such support should come in the form of resources, technical assistance and capacity building.

6.4 Implication for Future Research

Improving and sustaining successful health communication campaigns relies increasingly on the ability to identify the key components of an intervention that are effective, to identify for whom the intervention is effective, and to identify under what conditions the intervention is effective (Linnan & Steckler, 2002). It is therefore upon this notion that a recommendation is made that a process

evaluation be undertaken at district level amongst those who participated or felt excluded, and to determine how the campaign implementation could have been improved. Furthermore, it would be of interest to implement the use of community champions in future campaigns and to investigate their contributions to achievements.



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ANNEXURES

Annex 1: National “O Icheke” Multiple Concurrent Partnerships Campaign Plan

2009- 2012

ACTIVITY	Pre-Launch	YEAR 1 Apr09-Mar10				YEAR 2 Apr10-Mar11				YEAR 3 Apr11-Mar12				Responsible
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
National Sensitization														
Presentation to National AIDS Council, Parliament and Ntlo Ya Dikgosi (House of Traditional Leaders)		X	X											Campaign Team
Sensitization Meetings with Partners	X	X				X				X				Coordinator
National Campaign Launch	X													Campaign Team
District Support														
Train District Campaign Coordinators		X				X				X				Coordinator
Sensitization Meetings with DMSACs		X	X	X										Campaign Team
Establish District MCP Campaigns Teams		X	X	X										Campaign Team
Presentation to Community Leaders and district partners		X	X	X										Campaign Team
Development of District Campaign Plans		X	X	X										Campaign Team
Material Development														
Develop Campaign branding and sensitization Materials	X													Lead Technical Agency
Develop Phase I Materials and Media	X													Lead Technical Agency
Develop			X	X		X	X		X					Lead

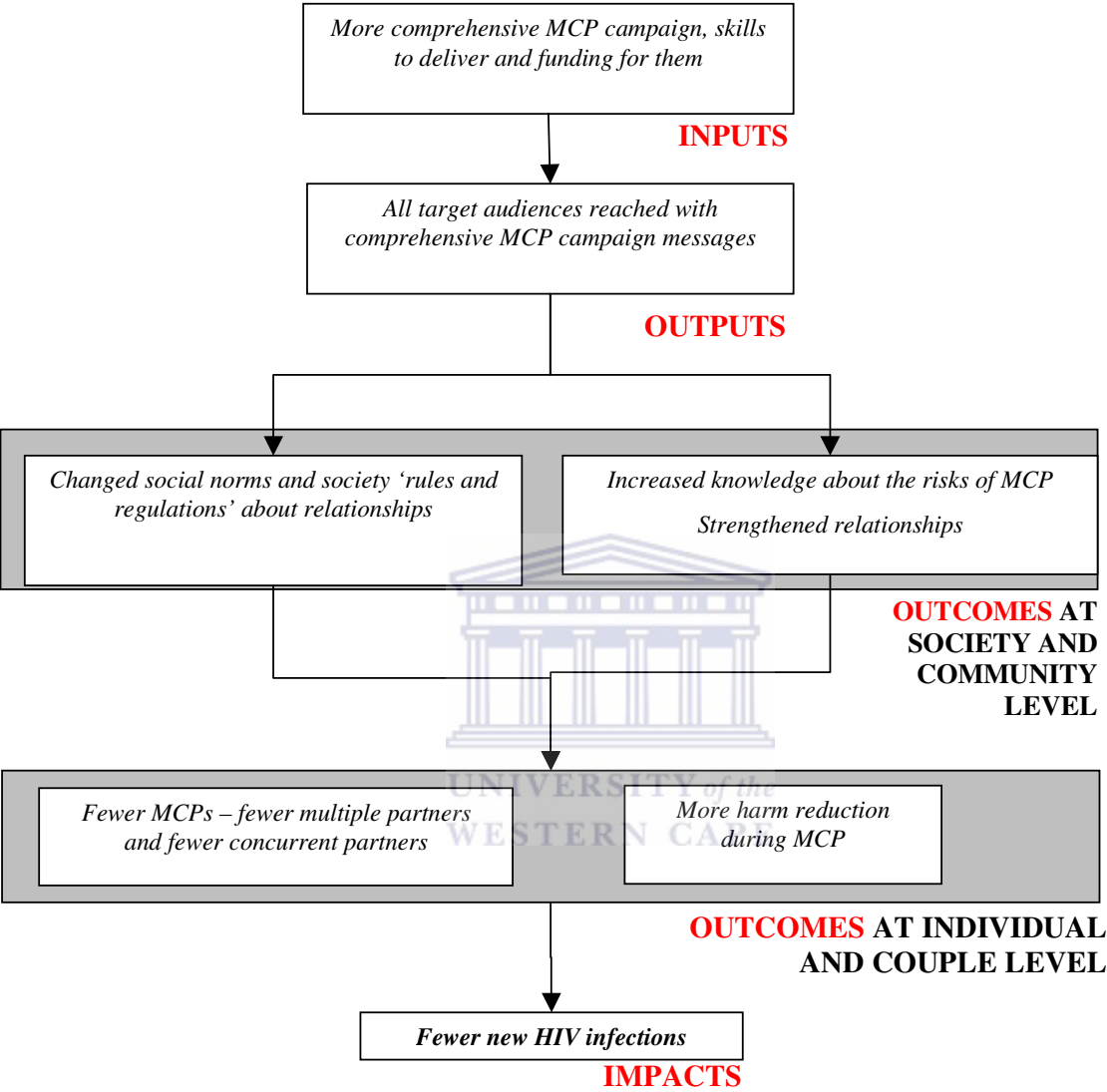
subsequent phases of materials and media														Technical Agency
Distribute Campaign Materials		X		X		X		X		X		X		Coordinator
Air Media Communications		X	X	X	X	X	X	X	X	X	X	x	x	Lead Technical Agency
Monitoring and Evaluation														
Disseminate monitoring tools to partners		X												Coordinator
Collate quarterly district and sector reports		X	X	X	X	X	X	X	X	X	X	X	X	Coordinator
Regular Partner and district support visits		X	X	X	X	X	X	X	X	X	X	X	X	Coordinator
Semi-annual campaign reports				X		X		X		X		X		Coordinator
Annual quantitative and qualitative studies				X				X						Lead Technical Agency
Mid-Term Campaign Review								X						Campaign Team
End of Campaign Evaluation							X	X				X	X	External Evaluator

Completed

Ongoing

Stalled

Annex 2: National MCP Campaign Monitoring and Evaluation Framework & Results Chain



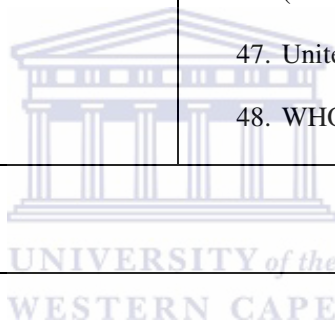
Annex 3: Partners in the development of the National MCP Campaign Plan (NACA, 2009)

The following organizations took part in the development of the National MCP Campaign Plan

TYPE OF ORGANIZATIONS	LIST OF ORGANIZATIONS PER TYPE
National Government	<ol style="list-style-type: none"> 1. National AIDS Coordinating Agency (NACA) 2. Ministries of Health 3. Department of Women's Affairs 4. Ministry of Education and Skills Development 5. Ministry of Labour and Home Affairs 6. Ministry of Local Government 7. Ministry of Youth, Sports and Culture 8. Office of the Ombudsman 9. Radio Botswana 10. Men Sector (Police, Prisons) 11. Central Transport Organization
Local Government	<ol style="list-style-type: none"> 12. Ghanzi Tribal Administration 13. Ghanzi adolescent sexual and reproductive health clinic 14. Ghanzi District AIDS Coordinator's (DAC) Office 15. Maun District Multi Sectoral AIDS Committee (DMSAC) and District AIDS Coordinator's Office
International Non- Governmental Orgnaizations	<ol style="list-style-type: none"> 16. Pathfinder International

	<p>17. Population Services International (PSI)</p> <p>18. Johns Hopkins University</p> <p>19. Humana People to People</p> <p>20. Family Health International (FHI)</p>
<p>Local Non- Governmental Organizations</p>	<p>21. Makgabaneng</p> <p>22. Tebelopele</p> <p>23. Botswana Network of Ethics and Law and HIV/AIDS (BONELA)</p> <p>24. Botswana Network of People With AIDS (BONEPWA)</p> <p>25. Botswana Christian AIDS Intervention Project (BOCAIP)</p> <p>26. Botswana Couples Forum</p> <p>27. Botswana National Youth Council</p> <p>28. Maun Tribal Administration</p> <p>29. Botswana Council of Churches</p> <p>30. Love Botswana</p> <p>31. Women Against Rape (WAR)</p> <p>32. Selebi Phikwe District AIDS Coordinator's Office</p> <p>33. Selebi Phikwe Positive Living Helper Cells (PLHC) Support Group</p> <p>34. Ministers Fraternal</p> <p>35. Selebe Phikwe Secondary School</p> <p>36. Botshabelo Customary Court</p> <p>37. Kuru Trust</p> <p>38. Evangelical Fellowship of Botswana (EFB)</p>

	<p>39. Botswana Family Welfare Association (BOFWA)</p> <p>40. True Love Waits</p> <p>41. Ghanzi Christian AIDS Committee</p>
Private Sector	<p>42. BCL Mine</p> <p>43. Botswana Business Coalition on AIDS</p> <p>44. University of Botswana</p>
International Development Partners	<p>45. African Comprehensive HIV/AIDS Partnerships (ACHAP)</p> <p>46. Botswana/ United States of America Project (BOTUSA)</p> <p>47. United Nations Children's Fund (UNICEF),</p> <p>48. WHO</p>



Annex 4: MCP TELEVISION DRAMA- A SUCCESS STORY- Changing Perceptions of Batswana: Understanding the Impact of “Morwalela”



Mma Segolame Mokone is guidance and counselling teacher at a Letlole Mosielele Junior Secondary school in Thamaga. Her job is to talk to students about a range of issues that they may be affected by; such as alcohol abuse, gender-based violence and high risk sexual behaviours. Segolame encourages students to identify the links between the subject being discussed in the classroom and their own experiences and perceptions. One such way of stimulating discussion is through the use of visual media.

One day Segolame asked her class to present on pertinent issues such as alcohol or multiple concurrent partnerships and one group of students chose to present on *Morwalela*, a TV series developed by PSI Botswana that weaves a number of key themes such as high risk sexual behaviours such as multiple concurrent partnerships (MCP) and alcohol abuse into its storylines with an overall goal of reducing HIV incidence in Botswana.

Segolame’s idea of using *Morwalela* as the focus of her lessons has been very successful. For one of her students, 15 year old **Thuto**, the discussions have had a big impact. *“I learned that if you are a man you should be responsible and take care of your family and make sure that your behaviour does not put them at risk. John Kenosi was very irresponsible because he slept around and ended up infecting his wife with HIV, he was also a leader and he should have behaved in an exemplary*

manner but he did not, this might end up leading to kids who look up to him thinking that his behaviour is okay when it is not,” she says. It is widely recognized that there is a strong correlation between the misuse of alcohol and the number of social and health-related problems, such as risky sexual behaviours, intimate partner violence. Another student from Segolame’s class, 14 year old **Sandra**, said that Morwalela taught her that *“if you find yourself in overwhelming trouble like Lebo who was HIV positive and had lost a son to AIDS, you do not drown your problems in alcohol you should instead look for counselling.*

It’s not just Segolame’s students that have been impacted by *Morwalela*. PSI has also heard from other such groups and individuals who have been impacted by *Morwalela*. For Eddie Monnaathare 18 years old, *Morwalela* helped him change his stance on having a relationship with a person living with HIV. Eddie said Justice and Mpho’s discordant storyline helped him realise that although it’s a big step to take, it can be done. *“As long as you have a strong support system and you both agree on a plan of how you will take care of yourselves to avoid the one person infecting another, I can do it,”* According to Eddie he always thought that it is wrong to have a relationship with someone living with HIV because infection to the other partner was guaranteed. *“Justice and Mpho made it look so easy for me and it is no longer such a big deal for me.”*

Morwalela’s two month run on BTV in April and May of 2010 generated a positive reaction from Batswana. The creation of a Facebook page has enabled PSI to receive feedback and spark discussions over the topics addressed in each episode. This is the first time Facebook has been used in this way in Botswana to great success – the *Morwalela* pages now have more than 5,000 fans and friends. Reruns started in July 2010 in a different timeslot on BTV in the hopes of reaching a larger audience. *“When will there be a second season?”* is a question asked by many of the fans on Facebook and by Segolame’s students.

Botswana currently faces one of the worst HIV/AIDS epidemics in the world with **17.6%** of the general population infected with HIV, translating as one **in four** Batswana between the ages of 15 and 49 living with HIV. *Morwalela* represents an innovative and pioneering approach to HIV-related behaviour change communications in Botswana. The TV series was written by local writers – Wame Molefhe and Lauri Kubuitsile and has a predominantly Batswana cast and crew. Filmed entirely in Setswana, the cast portray characters living in a small fictional village called Morwalela, in Botswana. They are faced with the same difficult decisions as many Batswana and show the impact of their choices on their lives and the lives of loved ones. The series illustrates many of the issues

around HIV-transmission such as the emotional and health risks of multiple concurrent partners, the dangers of excessive drinking, the value and need of HIV-testing, the importance of condom use and the importance of honest communication. It also highlights the importance of healthy living and the necessity for HIV positive individuals to commit to their anti-retroviral (ARV) drug regime in order to remain healthy.

Success stories such as this can be found across Botswana. *Morwalela's* national reach has helped raise awareness of key issues that affect the wellbeing of the people of Botswana.

For more information, please contact Botho Tlhobogang, PSI/B Corporate Affairs Coordinator: Botho.Tlhobogang@psi.co.bw. For more information on PSI/Botswana online, please go to www.psi.org/botswana and for more information on Morwalela, please visit www.facebook.com/morwalela



Annex 5: Participant Information Sheet



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 2809, Fax: 27 21-959 2872

Project Title: *Process Evaluation of the Multiple Concurrent Partnerships O Icheke Campaign for HIV Prevention in Botswana from 2009 - 2012*

Dear Study Participant,

I am a student studying at the University of Western Cape. I am planning to conduct an Implementation or Process Evaluation of the Multiple Concurrent Partnerships “O Icheke” Campaign for HIV Prevention in Botswana.

What is this study about?

This is a MPH Mini-thesis project being conducted by myself, Emmanuel Mafoko. I am inviting you to participate in this research project because you have been identified as knowledgeable and experienced and a stakeholder in the National Multiple Concurrent Partnership Campaign. The purpose of this research project is to evaluate the implementation of the Multiple Concurrent Partnerships “O Icheke” Campaign for HIV Prevention in Botswana.

What will I be asked to do if I agree to participate?

You will be asked questions about your experiences of implementing the “O Icheke” Campaign.

How the study will be done?

This study aims to assess phases I, II and III of the National MCP “O Icheke Campaign”. It will be carried out through interviews with informants who have played key roles and through an analysis of Campaign documentation.

What are the issues that will be discussed in the interview?

The interviews will focus on your views on the following key areas:

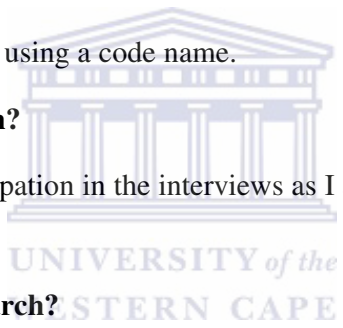
- Actions aimed at national sensitisation.
- Steps to achieve district support.
- The strategy for development and distribution of materials.
- Monitoring and reporting.
- Factors that helped or hindered the implementation of the Campaign.

Would my participation in this study be kept confidential?

- All personal information will be kept confidential. To help protect your anonymity, I will not share any information regarding your identity with anyone.
- Your organization’s name will not be identified.
- Your recorded responses will not be attributed to you as individual and they will only be listened to by the researcher and destroyed thereafter.
- Any quotations from interviews which are included in the final report will be anonymised.
- Your responses will be recorded using a code name.

What are the risks of this research?

No risks are anticipated from participation in the interviews as I am not asking participants to disclose any sensitive information.



What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator to make recommendations on how to improve the implementation of the National Multiple Concurrent Partnerships Campaign in order to achieve its intended goal of changing people’s behaviours to practice safe sex and prevent HIV infections. Findings will be reported to NACA so that they can be drawn on? where appropriate to do so. In the future, other people might benefit from this evaluation through improved understanding of how HIV prevention campaigns of this nature can influence social norms and behaviours for the prevention of HIV/AIDS.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Emmanuel Mafoko, a student at the School of Public Health at the University of the Western Cape. If you have any questions about the research study itself, please contact me at *P/ Bag 00463, Gaborone, Botswana*; E mail: emafoko@gov.bw.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Ms L Alexander

School of Public Health

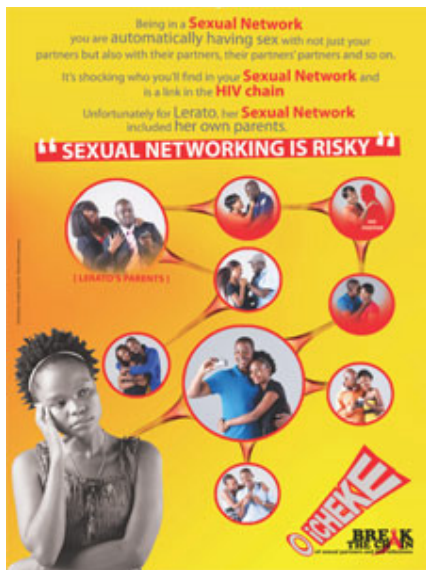
University of the Western Cape

Private Bag X17, Bellville 7535

This research was approved by the University of the Western Cape's Senate Research Committee and Ethics Committee on 13th April 2012.



Annex 6: National “O Icheke- Break the Chain” Multiple Concurrent Partnerships Campaign
 - **Sample of Information, Education and Communication (IEC) materials: Print, Mass Media, Interpersonal Communication and Social Media**



Poster



Bill board



Bill board



Social Media



Interpersonal Communication (IPC)

Annex 7: Informed Consent Form



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 2809, Fax: 27 21-959 2872

**Title of Research Project: *Process Evaluation of the Multiple Concurrent Partnerships
O Icheke Campaign for HIV Prevention in Botswana from 2009 – 2012***

This study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name
Participant's signature
Participant's code name
Date



The researcher agrees to the following:

- To keep all personal information confidential.
- To help protect your anonymity, I will not share any information regarding your identity with anyone.
- Not to disclose the organization's name where I work.
- Your recorded responses will not be attributed to you as individual and they will only be listened to by the researcher and destroyed thereafter.
- Any quotations from interviews which are included in the final report will be anonymised.
- Your responses will be recorded using a code name.

Researcher's name

Researcher's signature

Date

Your participation is greatly appreciated. Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact my supervisor:

Supervisor: Lucy Alexander (Ms)

University of the Western Cape

Private Bag X17, Bellville 7535

Tel: (021) 959-2809/2782; Cell: +27 83 564 4519; Fax: (021) 959- 2872

Email:lalexander@uwc.ac.za



Annex 8: Final Interview Guide

TITLE: <i>Process Evaluation of the Multiple Concurrent Partnerships O Icheke Campaign for HIV Prevention in Botswana from 2009 – 2012</i>	
Role of organization in the Campaign:	
Participant's place of work:	
Code name:	
Date:	
FINAL INTERVIEW GUIDE	
<p>1. To assess whether Campaign activities including national sensitisation were implemented according to the plan.</p>	<p style="text-align: center;">What was the plan?</p> <p>1. Describe the process that was entailed in the development of the campaign? N/A</p> <p>Prompts;</p> <ul style="list-style-type: none"> • How did you conceive the goal and objectives of the campaign? • Was there sufficient evidence informing the campaign design? • What concepts and theory were drawn on in designing the campaign? • Did members of the target populations take part in the design and planning process of the campaign? • How was the programme designed to address the different reasons between men and women for practicing MCP? • How did you mobilize resources for implementation of the campaign? • What can you tell me about the national launch? • What were your assumptions about national sensitization at the design stage?

	<ul style="list-style-type: none"> • Did anything facilitate or hamper national sensitization?
<p>2. To determine whether the strategies for development and distribution of materials were followed and to assess whether they matched specifications of the Campaign in design, quality, messages and portability.</p>	<p>2. Can you tell me about what you know about the campaign materials (what materials were produced, who was involved and the process of development)</p> <p>Prompts:</p> <ul style="list-style-type: none"> • What kind of materials were developed and produced for the campaign? • Who was responsible for material development? (District people – did you have any involvement?) • Was any evidence on communication material drawn on in developing the materials? • Did the designers follow a material development process when developing materials? • Did the target group take part in the materials development process? • Can you comment on the materials e.g.; design, layout, quality, clarity of message and portability? • Were materials enough to cover the intended target groups?
<p>3. To assess whether interim monitoring and reporting have been undertaken, whether problems have been identified and recommendations acted upon.</p>	<p>4. Did the campaign have an implementation plan and a monitoring and evaluation framework?</p> <p>Prompts:</p> <ul style="list-style-type: none"> • If Yes. Were these activities carried out? • If yes. What challenges were in the monitoring activities? • Were any actions taken to address the problems? • Were any recommendations made from the monitoring – were these acted on?

<p>4. To identify factors that helped or hindered the implementation of the Campaign</p>	<p>Were you part of the design team and can you tell me a little about this? (If you weren't involved what do you know about the design?)</p> <p>Objective 5: Questions.</p> <ul style="list-style-type: none"> • What were the factors helping or hindering the implementation of the campaign • What were factors which were hindering implementation?
<p>5. Can you provide me with any documentation related to the campaign?</p>	<ul style="list-style-type: none"> • Both electronically or hard copies?



Annex 9: Areas of the National “O Icheke” MCP Campaign accessed by process evaluation and implementation challenges experienced

CRITICAL CAMPAIGN ACTIVITIES	ASSESSED IN THIS RESEARCH	IMPLEMENTATION CHALLENGES EXPERIENCES BY THE CAMPAIGN	
		Participants	Documents Reviews
Planning, Basis and Process	Yes	Both: <ol style="list-style-type: none"> 1. Although the campaign drew evidence from related MCP studies, a formative study was not conducted to inform the campaign from the initial stage. 2. Lack of involvement of Ministry of Health as a key stakeholders affected campaign delivery and mainstreaming of MCP in key programs. 	
Leadership and Sensitization	Yes	Participants only: <ol style="list-style-type: none"> 1. Sensitization at district and community level hampered by erratic funding of the campaign. 2. Lack of funding for campaign champions also affected sensitization activities which they were suppose to conduct. 3. Some influential people such as traditional health practitioners were not covered by sensitization efforts 	
Management and Coordination	Yes	Both: <ol style="list-style-type: none"> 1. Management of the campaign was marred by human resources challenges arising from staff attrition working on the campaign’s monitoring and evaluation area. 	
Rolling out the Campaign	Yes	Both: <ol style="list-style-type: none"> 1. At national level, disruption in funding flow resulted in delayed implementation of mass media for some campaign phases. 2. Implementation of community-based or interpersonal interventions at the local level was slow due to inadequate funding. 3. Most implementing partners did not have the 	

		<p>capacity to carry out their activities due to shortage of funding.</p> <ol style="list-style-type: none"> 4. Staff attrition was also a factor which challenged implementation. 5. Some implementing partners were not very competent to deliver campaign messages to the communities. 6. Peer educators were not supported by their employers to deliver the campaign messages at their respective work places and as thus negatively impacted on roll-out of the campaign at the district level.
Content Development	Yes	<p>Both:</p> <ol style="list-style-type: none"> 1. There was no distribution plan for materials; other were over supplied while others were always in shortage. 2. No materials were produced or special populations such as people with disabilities. 3. Most materials were found to be in English language with only a limited number in Setswana language.
Research	Yes	<p>Both:</p> <ol style="list-style-type: none"> 1. The current research findings suggest that the campaign baseline study was not conducted as per standard norm in campaign development process.
Monitoring and Evaluation	Yes	<p>Both:</p> <ol style="list-style-type: none"> 1. Recommendations of the monitoring such as the improvement of the funding streams were not acted upon. 2. Lack of a Monitoring and Evaluation Officer at national level also affected monitoring of the campaign at national level and was identified as a major challenge for the campaign. 3. A process evaluation was not conducted as was planned.



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WESTERN CAPE