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"Nurturing Enabling Environments for Culturally Appropriate HIV and AIDS Policies through Informed Public Dialogue the case of Botswana and Zambia" *****

by

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The opinions expressed in the present study are those of the author. They do not reflect nor commit UNESCO or its Member States.

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BACKGROUND

As part of UNESCO's strategy to respond to the global HIV and AIDS epidemic, the Culture, HIV and AIDS program works to support the development of culturally appropriate policies and programming that are gender-responsive, human-rights based and built on a thorough analysis of the cultural and social specificities of those communities concerned.

UNESCO's 'official' definition of culture as contained in the UNESCO Mexico City Declaration on Cultural Policies (1982) reads as following: *"a set of distinctive spiritual and material, intellectual and emotional characteristics which define a society or social group and in addition to the arts and letters, as encompassing ways of life and fundamental rights of the person, value systems, traditions and beliefs."*

Project that are labialized as "cultural approaches" needs to be tailored strategies grounded on the traditions, beliefs, values and practices specific to a particular group, that also mobilize the group's cultural resources and assets as a basis for social engagement and development.

Against this background, this docuemnt seeks *inter alia* to analyse some of the key factors that contribute to the creation of an "enabling environment" for culturally appropriate HIV and AIDS policies (i.e. a local context in which the conditions, factors, actors and dynamics required for the promotion and development of these policies are present).

Key factors that contribute to the creation of an enabling environment for the development of culturally appropriate responses to HIV and AIDS in sub-Saharan Africa, as well as concrete examples of good practices will be identified to that end. In this connection the role of Civil Society Organizations is key.

Civil societies comprise of civic and social organizations such as Non-governmental Organizations (NGOS), Community Based Organizations (CBOs), Faith Based Organizations (FBOs), trade unions, business and professional associations and groups, academic and research institutions, media, cultural and religious groups, cooperatives, among others. Civil societies in Africa tend to reflect the social and economic conditions and the particular historical and political circumstances of individual countries (Robinson and Friedman, 2005). Most Civil Society Organizations (CSOs) in Africa can be classified in various categories such as their organizational structures (formal, informal), their functional interest (development, policy advocacy, etc), their level of operation (local, regional, international, etc) and their funding sources (membership supported, locally financed and international donors). However, it is difficult to put a clear boundary among the categories as a single CSO can fall under more than two categories (ADB, 2001).

One of the most common categories of CSOs, which may fall under most of the above categories, are Non-Governmental Organisations (NGOs) that are associated with the International Development System. Often the term NGO has been used as a substitute for CSO. The African Development Bank described NGOs as visible, formally constituted, urban-based bodies that seek to provide goods and services to certain categories of people, or to advocate certain policies. They include (i) indigenous Non-Governmental Development Organizations (NGDOs); (ii) Organizations for domestic or regional issue-based advocacy NGOs (E.g. in regard to human

rights and gender); (iii) Knowledge based NGOs (e.g. research and policy analysis); (iv)International private aid agencies for development or humanitarian action (ADB, 2001).

Civil Society organizations contribute to development in many ways including (Malunga, 2006):

- Sensitization, awareness- raising and understanding of development policies, laws and regulatory institutions.
- Providing opportunities for stakeholders, particularly rural communities and marginalized groups, to communicate with governance institutions and elected representatives.
- Participate in discussions about development policy and implementation strategies. For example through lobbying and advocating for new perspectives, policies and methodologies of implementation.
- Giving feedback to citizens about what social and economic development decisions are being taken, by whom and from what options, on what grounds, with what expected results and with what resources to support implementation.
- Playing a crucial 'watchdog' role in monitoring the implementation and effects of national and international programs and policies. Through this, CSOs increase public accountability and promote e both democracy and development.

In spite of their great role in the society and some successes, there is general conclusion that there remain huge gaps between research and policy on HIV and AIDS in developing countries. This has devastating implications for human survival and quality of life as well as national development. Indeed, it is difficult to think of another pressing development challenge where research-policy gaps are so large (Court 2006).

I. HIV and AIDS in Sub-Saharan Africa

In this section we seek to contextualize the study by reviewing the HIV and AID situation in the Sub-Saharan Africa, Southern Africa region and in the two study countries: Botswana and Zambia. Sub-Saharan Africa is home to 23 million living with HIV – making it the most affected region by HIV in the world (UNAIDS, 2010). HIV is therefore a major public health and developmental challenge in this region. Despite reductions in the cost of HIV and AIDS drugs, millions of people affected by HIV and AIDS in most of the countries in this region do not have access to these life-saving drugs. HIV and AIDS therefore remain a major cause of morbidity and mortality in the countries in the region.

Southern Africa where Botswana and Zambia are located is perhaps the most affected region in the world as it is home to about a half of all the HIV and AIDS cases in the world. The region houses 11.3 million of all the PLWHA in the world (UNAIDS, 2010). The epidemic in this region is affecting individuals at all levels of society and is undermining most of the developmental gains that these countries have made in the recent past.

a) Zambia Country Profile

Zambia is a land-locked sub-Saharan country sharing boundaries with the Democratic Republic of Congo (DRC) and Tanzania in the North, Malawi and Mozambique in the East, Zimbabwe and Botswana in the South Namibia in the South West and Angola in the West. Zambia covers a land

area of 752,612 square kilometres which is about 2.5% of Africa. Administratively, the country is divided into nine provinces and 72 districts (CSO ***et al,*** 2009)

In 2010 the population of Zambia was estimated to be 13,460,305 and the population growth rate at 3.1%. The total birth rate estimated at 44.08, death rate 21.12, infant mortality rate 66.6, and total fertility rate 5.9 while life expectancy stood at 52.36 years.

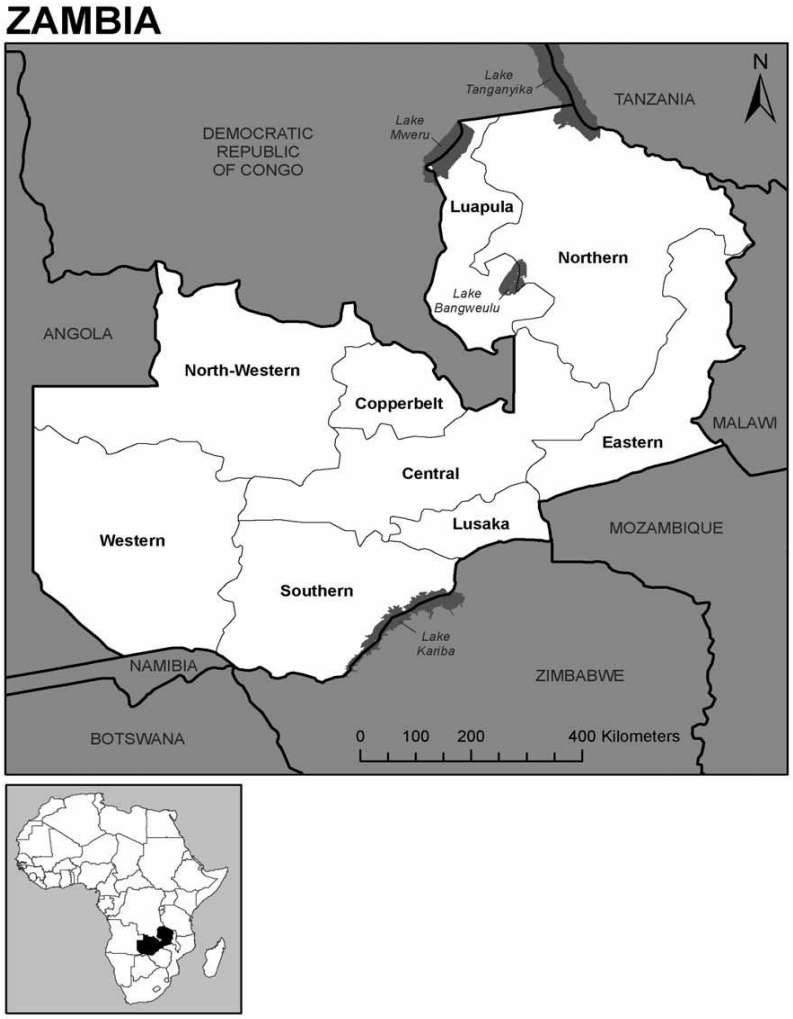


Fig. 1: Map of Zambia: adopted from CSO *et al* (2009) The Zambia Demographic and Health Survey 2007

Zambia is one of the sub-Saharan African countries worst affected by the HIV and AIDS pandemic. According to the last Zambia Demographic and Health Survey 2007, the adult HIV prevalence rate was 14%. 2009 estimates indicate an adult prevalence rate of 13.5%. Among women aged 15-49, the HIV prevalence rate was 16%, while among men aged 15-49 the HIV prevalence rate was 12%. HIV prevalence in urban areas is twice as high as in rural areas, 20 and

10%, respectively. Among women aged 15-49, the HIV prevalence rate in urban areas is more than twice as high as in rural areas (23 and 11%, respectively). For men the prevalence rates are 16% in urban and 9% in rural areas (CSO *et al*, 2009).

Among women, HIV prevalence is 26% in the 30-34 age group, which is four times the rate among women aged 15-19 (6%) and more than twice the rate observed among women age 45-49(12%). For men, the prevalence increases sharply from 4% among men aged 15-19 to 24% for age 40-44, and it drops thereafter to 19%, (CSO *et al***,** 2009).

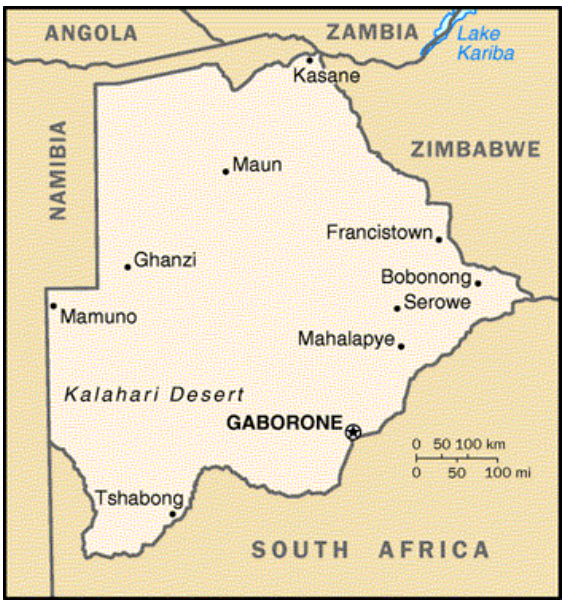
b) Botswana Country Profile

Botswana is a land-locked semi-arid country that covers an area of 582,000 kilometres squared. It borders Zambia to the North, Zimbabwe to the North East, South Africa to the South and Namibia to the West.

The 2006 Botswana Demographic Survey projected the population would reach 1.8 million in 2008 up from the 1,773, 210 in 2006. July 2011 estimates indicate that this population will rise to 2,065,398. The population growth rate is at 1.65%. The age structure estimates show that persons between 0-14 years represent 33.9%, 15-64 years 62.2% while 65 and above represent 3.9% of the total population.

Current 2011 estimates indicate that Botswana's birth rate stands at 22.31, death rate at 10.57, infant mortality rate at 11.4, total fertility rate at 2.5. Life expectancy at birth increased from 55.5 years in 1971 to 65.3 years in 1991 and decreased to 54.4 years in 2006 as a result of HIV and AIDS. Estimates show that this will increase to 58.05 by July 2011, a factor attributed to increased interventions on HIV and AIDS. (Demographic Health Survey 2006, CIA world fact book demographic statistics 2011).

Fig 2: Map of Botswana



Botswana is one of the African countries that continue to bear the global burden of HIV and AIDS. 2009 estimates show an HIV adult prevalence rate of 24.8%. The 2008 Botswana AIDS Impact Survey (BAIS) estimated that 17.6 %, (about 320,000 persons) of the population aged 18 months and above was HIV positive in that year. The corresponding figure in the 2004 BAIS was 17.1% (Botswana Country progress Report 2010), indicating an increase, though minimal, in the number of HIV and AIDS positive people. 2009 estimates indicate that there were 5,800 deaths from HIV and AIDS.

The 2009 HIV and AIDS Sentinel Surveillance show that HIV prevalence among pregnant women aged 15-49 years has consistently remained at around 33% since 2005. Statistical evidence from the BAIS and Sentinel
Surveillance indicates that HIV prevalence among young people aged 15-24 years has been declining consistently since 2001. BAIS 2008 shows that females have a higher HIV prevalence, estimated to be
20.4% compared to 14.2 % for males.

c) Responses to HIV and AIDS in Zambia

1. National Response to HIV and AIDS

Zambia is among the world's poorest countries worst hit by the HIV/AIDS scourge. The first AIDS case was reported in 1984. According to the 2009 AIDS epidemic update, new HIV infections have been reduced by 17% over the past eight years and Zambia has made significant efforts towards the fight against HIV and AIDS although adult HIV prevalence still stands at 16% (UNAIDS 2009).

Given the potentially devastating impact of HIV and AIDS on social, economic, and cultural life of the country, the Government of Zambia through the Ministry of Health gave top priority to the development and implementation of HIV prevention and control strategies, care and support through the provision of free Antiretroviral Therapy, and strengthening of Voluntary Counselling and Testing (VCT) and Home Based Care (HBC) programs. Progress made includes scale up of anti-retroviral treatment to reach more than 149,000 people, however this represents only 51% of women and men in need, and much more remains to be done to scale up all aspects of the HIV response. Only about 14,000 are receiving ART and an estimated 200,000 persons need HIV treatment including ART. The country is deeply affected by HIV and continues to face serious challenges in addressing the epidemic, including gender inequality and other drivers that enhance vulnerability (Government of the Republic of Zambia, 2008).

In 1986, Zambia created the National AIDS Surveillance Committee and National AIDS Prevention and Control Program to coordinate HIV and AIDS related activities. Constraints to the government's response through the late 1990s included lack of high-level political commitment, strategic management of the HIV/AIDS program, analysis of HIV/AIDS in the context of macroeconomic or gender policy, programs tailored to different populations, implementation evaluation, and intra-governmental collaboration (WHO 2005).

The new millennium saw renewed governments efforts towards the fight against HIV and AIDS. In 2002, the government of Zambia established the National HIV/AIDS/STI/TB Council (NAC)

to be responsible for national and technical leadership, strategic management, and effective coordination of all government and civil (multi-sectoral) interventions. NAC is also responsible for guiding the implementation of the national HIV and AIDS strategic framework (2006-2010). The framework recognises key roles for civil society in all areas of the national response from prevention, treatment, care and support, impact mitigation, mainstreaming and decentralisation, to monitoring and evaluation, coordination and advocacy (NAC, 2006). In 2004, the then President of Zambia Mr. Mwanawasa declared HIV and AIDS a national emergency and started rolling out free antiretroviral treatment to Zambians. Zambia has since made significant attempts at combating HIV and AIDS including, establishing a high-level cabinet committee on HIV/AIDS to provide policy direction and regularly report to the cabinet on HIV/AIDS issues. Zambia has also developed various policies, planning frameworks, guidelines and protocols to guide the national response. A national HIV and AIDS/STI/TB policy (2005) is in place. In addition, Zambia has been expanding voluntary counselling and testing, providing antiretroviral therapy, developing home-based care, managing opportunistic infections, strengthening laboratory capacity, ensuring blood safety, managing sexually transmitted infections and encouraging behaviour change (WHO, 2005).

Zambia launched its PMTCT Initiative in 1999 and has also developed national guidelines for ART and established nine provincial treatment centres to provide ART to 10,000 people. Owing to the increase in the number of orphans and OVC, the Zambian government has launched the Social Welfare Scheme, and is seeking to establish effective legislation with regard to children, youth, and HIV/AIDS. Zambia developed the Code of Ethics and Practice for Counselling to establish standards of competence and conduct for counsellors, trainers, and supervisors. The code is reinforced through the more detailed Guidelines on HIV/AIDS Counselling in Zambia, produced by the Ministry of Health in 2000 (Garbus, 2003)

2. Civil Society Response to HIV and AIDS

The role of CSO in the national response to HIV and AIDS is well articulated in the Zambia National HIV and AIDS Strategic Framework 2006-2010 (see NAC, 2006). CSOs involved in the HIV response are far from homogeneous and range from umbrella organisations to grassroots associations. Civil society is seen as being able to achieve results in areas inaccessible to government. It is also recognized as an important service provider, especially for interventions relating to HIV prevention, treatment, care, and support and impact mitigation. Civil society is seen as critical in ensuring that the perspectives of non-state actors are heard, and for promoting full country ownership. It also plays a significant role in strengthening the multi-sectoral HIV response. CSOs have demonstrated an important role in facilitating community mobilisation, social accountability, advocacy, policy dialogue, mainstreaming, capacity building and information/skills exchange (UNAIDS 2006). Notably, the expanding roles of civil society beyond HIV service delivery parallels the development of contemporary "good governance" approaches (Corella *et al.* 2006) and illustrates that CSOs can have a particular role in facilitating linkages between HIV responses, health care and social development in general (Kruse 2002).

CSOs were among the first to respond to the HIV pandemic, with community level initiatives being set up as early as 1986. There has since, been a tremendous increase in the number of civil society organisations (CSOs) working on HIV in Zambia. The most rapid increases have occurred since 1999 (Birdsall & Kelly 2007). Zambia's civil society is vibrant and active (Corella et al 2006). This expansion of capacity in the civil society sector represents an important opportunity as Zambia moves forward towards universal access. It is recognised that ambitious HIV targets will only be reached through partnership building between the public, civil society and private sectors. At the same time the rapid growth and diversity of the civil society sector represents an increasing challenge for the coordination of an effective response by the NAC (Mundy *et al, 2008)*. According to Hachonda (2004), civil societies have been the leading force in the Zambian response and in efforts to mitigate the impact of HIV/AIDS in the country. CSOs were pioneers in providing care and support over a long period, which has included peer support networks, home-based care, post-testing clubs, networks of people living with HIV and AIDS (PLWHA), OVC facilities and programs, the hospice movement, all of which have been initiated by CSOs with little or no government support. Though the situation is changing, with government accessing more external resources, CSOs are still the main pillar of HIV/AIDS-related care and support. By 2004, there were about 600 non-governmental organisations (NGOs) in Zambia, over half of these rural-based and about a quarter of them working in the HIV/AIDS arena. Civil society has played a pivotal role in mobilising both government and communities to act to alleviate developmental challenges, by being on the cutting edge of innovations, and has contributed greatly to the fight against HIV/AIDS, being well-positioned to reach even the less accessible areas of the country. About 75% of CSOs working on HIV and AIDS are local organisations , with over 22% having a religious affiliation, while international NGOs constitute around 20% of the whole (Birdsall and Kelly, 2007). There are national and district interfaith HIV/AIDS working groups to sensitize religious leaders and train clergy and lay religious leaders in counselling and supporting communities. Many church leaders appear to be recognizing that they need to play a greater role in HIV/AIDS prevention and care. However, some still object to HIV prevention messages that include mention of condoms.

Some traditional leaders have played a critical role in HIV and AIDS prevention. Chiefs have been particularly instrumental in the Southern Province in modifying sexual cleansing practices. Traditional healers are represented on the National HIV/AIDS/STD/TB Council. Guidelines for conducting research on herbal remedies have been developed. Zambian NGOs, particularly those related to religious organizations, took the lead on home based care (HBC) and developed a variety of approaches, many of which serve as best practice for other countries. Government has played a very limited role in HBC provision. In 2002 there were over 50 HBC programs in Zambia, primarily found in urban areas and covering at most 20 percent of people living with HIV and AIDS (PWHA). Demand for HBC is enormous, and programs are overwhelmed (Garbus, 2003). This calls for greater government involvement in provision of home based care.

Since 2004, the NAC has made significant progress in the inclusion and representation of civil society in governance and coordination structures for the HIV response. Civil society representation in the Council's structure is now firmly established, as is civil society representation in the Country Coordinating Mechanism (CCM) for the GFATM, for which the NAC provides secretariat support. There is also strong civil society participation in the NAC's technical 'Theme' Groups (which monitor progress in implementing the NASF), as well as in the HIV and AIDS Sector Advisory Group (which monitors progress in implementing the Fifth National Development Plan or FNDP) and the Partnership Forum (a high-level forum for

information exchange, cross-sectoral dialogue and advocacy). In addition, the NAC has been working systematically with key civil society structures (such as network and umbrella organisations, FBOs and gender groups) and constituencies (such as PLHAs, youth and people with disabilities) to strengthen mechanisms for self-coordination, consultation and information/ data exchange at national and decentralised levels (Mundy *et al, 2008).*

The NAC considers the benefits of strong partnerships with CSOs to be:

- maximising sectoral comparative advantage
- maximising efficient, effective, equitable and improved distribution of resources (human, as well as financial resources)
- Improved outreach, coverage and inclusivity – including identification and addressing of gaps
- harnessing creativity, flexibility, complementarity, effective communication channels and networks; traditional knowledge and expertise
- Improved transparency, accountability, grassroots and community-based monitoring, consultation, participation and "buy-in"
- Provision of comprehensive, flexible, responsive, targeted and culturally sensitive services.

There has been an increasing consensus among several stakeholders that the response to HIV/AIDS requires not only a multi-sectoral approach but also a multi-stakeholder approach to ensure that responses produce results that are both significant and tangible. The Government of Zambia has therefore encouraged several stakeholders to operate around this theme and still strives to provide an enabling environment for CSO operations.

d) Response to HIV and AIDS in Botswana

1. National Response to HIV and AIDS

The first case of HIV and AIDS in Botswana was reported in 1985. However, by close of 2009 the country had an estimated 300,000 people living with HIV. With a national population of just below two million and an estimated adult HIV prevalence of 23.9%, Botswana becomes the second highly affected country by HIV after Swaziland. HIV and AIDS has had a devastating impact on Botswana. The loss of adults in their productive years has serious adverse economic implications as families are being pushed into poverty through the costs of HIV and AIDS medical care, loss of income, burials and funerals. The economic output of Botswana has been reduced by the loss of workers and skills or as more workers are taken ill with HIV and AIDS related illnesses. The loss of adults to AIDS has also significantly increased the population of orphans and vulnerable children in Botswana. An estimated 95,000 children in Botswana have lost at least one parent to the epidemic.

Botswana has been very proactive in dealing with the problem of HIV and AIDS. The government has demonstrated a high level of political commitment to addressing HIV and AIDS and seeks to see an end to new infections by 2016. The national response to HIV and AIDS began with the establishment of the National AIDS Control Program and the development of Short Term Plan (1987-1989) in 1987 and a Medium Term Plan in 1989. The Short term plan focused on creating public awareness of HIV and training of health workers in AIDS and clinical management including diagnoses while the Medium Term Plan I (1989-1993) focused on epidemiology and surveillance, prevention strategies (behaviour change, blood and blood safety, PMTCT, diagnoses and infection control), clinical management, and monitoring and evaluation.

In 1989, the HIV testing and Counselling (HTC) program was established under the Ministry of Health and in 1993, Botswana developed the National Policy on HIV/AIDS. The National AIDS Coordinating Agency (NACA) was formed in 1999 and given responsibility developing and coordinating a multi-sectoral national response to HIV and AIDS. NACA developed the Medium Term Plan II which adopted a multi-sectoral and participatory approach which also saw HIV and AIDS being treated as a developmental rather than just a medical challenge. The Medium Term Plan II was reviewed in 2002 and the results informed the development of the National Strategic Framework for HIV/AIDS (NSF) (2003-2009), by highlighting strengths to build on and weakness to address. The goals of the NSF (2003-2009) were:

(1) Prevention of HIV infection
(2) Provision of Care and Support
(3) Strengthened Management of the National Response to HIV/AIDS
(4) Psycho-social and Economic Impact Mitigation and,
(5) Provision of a strengthened Legal and Ethical Environment (Botswana Country Progress Report 2008).

Botswana also established a National AIDS Council (NAC) chaired by the president to take responsibility for a multi-sectoral response to AIDS. The National AIDS Coordinating Agency established in 1999 provides technical support to the NAC and coordinates the national multi-sectoral response. NAC has representatives from across the society including the public and private sectors, and civil society. In 2001, there was a major shift in policy, with Botswana becoming the first African country to introduce free ARV treatment to its population. The state was willing to recognize the problem of HIV and use its resources in attempts to tackle it. Botswana began providing anti-retroviral treatment in 2002 in Gaborone. A national Emergency Operational Plan for scaling up anti-retroviral therapy in 2004-2005 was developed to guide the roll out of treatment in the public sector. The success of this treatment program made Botswana an example for other African nations to follow. Yet even though it has achieved universal treatment access (that is at least 80% of those who need HIV treatment are receiving it), the country continues to suffer greatly from AIDS (WHO, 2006).

The Botswana enjoys strong political commitment which has led to the integration of HIV and AIDS into national planning and budgeting. In 2009 Botswana completed its second National Strategic Framework, NSFII (2010-2016) to guide its national response towards achieving the country's goal of 'prevention of new infections by 2016'.

The implementation of the National response to the HIV and AIDS epidemic through the National Strategic Framework (NSF) is managed by the Botswana HIV and AIDS Response Information

Management System (BHRIMS). BHRIMS was developed in 2001 and its goal is to reduce the spread of HIV and mitigate its impact through effective and efficient monitoring and evaluation of the national multi-sectoral HIV and AIDS response (Republic of Botswana, 2002:90).

The 2003-2009 National Strategic Framework document outlines the objectives of the BHRIMS as follows:

1. To establish a monitoring and evaluation infrastructure
2. To support the storage and analysis of all available HIV and AIDS data at different levels in the country
3. To improve the accessibility of HIV and AIDS information and data
4. To increase the utilisation of available reports and data for action
5. To maintain institutional memory of the National HIV and AIDS response

BHRIMS is in the process of developing a national research agenda for HIV/AIDS interventions in line with the key goals of the national response as spelt out in the National Strategic Framework 2003-2009. The Southern African Development Community (SADC) has come on board so as to ensure that the process benefits from and inform similar exercises regionally. Despite the successes of BHRIMS, it faces certain challenges particularly, disharmony within the national Monitoring and Evaluation system and absence of a consistent and reliable information dissemination system.

2. Civil Society Response to HIV and AIDS

The Civil Society Organizations (CSOs) commonly known as Health Service Support Network complements the government in health service delivery and are the major stakeholders in implementation of HIV and AIDS programs.

In Botswana the involvement of CSOs in HIV and AIDS response became more visible in the early 1990s when the HIV and AIDS epidemic levels rose thus overwhelming the capacity of the public sector to deliver services to all people in need. In 1995, the government adopted community home based care program as a strategy to ensure continuity of care and support to PLWHA and other chronically ill patients and to educate communities on HIV and AIDS. Family and community mobilization strategy was adapted as one of the major community home based care (CHBC) program interventions. This strategy was successful as there has been positive community response. Communities responded by forming community based organisations (VHCs, CHBC committees, Support groups for people living with HIV and AIDS, community based organisations (CBOs), Faith based organisations (FBOs) and Non-governmental organisations (NGOs). To date there are more than 300 Local CSOs involved in CHBC program (DHAPC, 2009).

Botswana Network of Aids Service Organization (BONASO) is the umbrella body for all the organizations involved in health and HIV and AIDS response. Other key local NGO Networks involved in coordinating HIV and AIDS response include, Botswana network of people living with HIV and AIDS (BONEPWA), Botswana Network of Ethics Law and HIV and AIDS (BONELA), Botswana Christian Aids Intervention Program (BOCAIP), Botswana Business Coalition on AIDS (BBCA), and Youth Health Organization (YOHO) among many others. The civil society organizations also include

institutions, international organizations, researchers, and individuals. These CSOs provide strategic opportunities to increase access to services and geographical coverage of services; they reach marginalized vulnerable and underserved community groups with ease. These CSO have an added advantage of adopting community-based interventions thus facilitating community empowerment, participation and ownership of the HIV and AIDS epidemic. CSOs provide range of services either as stand alone or integrated services depending on organization's capability and comparative advantage. Some of the services they provide include: community mobilization, distribution of health commodities such as condoms, bed nets,0 community TB DOTS, monitoring and advocacy for quality of health services, dissemination of health promotion messages, including dissemination HIV prevention messages, provision of spiritual /pastoral care, mobilizing material and financial support, training home based care caregivers, provision of palliative care to CHBC patients and their families (DHAPC, 2009).

Despite efforts by government and civil society, Botswana still faces challenges in: reliance on facility HIV testing; low acceptability of abstinence; inconsistent condom use; limited targeting of high risk populations; repeat enrolment in Preventing Mother to Child Transmission of HIV (PMTCT); non-adherence to treatment; OVCs, HBC, Counselling and psycho-social support and; reliance on volunteers by many key HIV and AIDS programs which impedes sustainability of programs (Government of Botswana, 2008).

II. Good practices that contribute to creating an enabling environment for the development of culturally appropriate responses to HIV and AIDS

In the following section, we intend to demonstrate how good practices can contribute to the creation of an enabling environment for the development of culturally appropriate responses to HIV and AIDS**.** A case study can be defined as a method of empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used (Yin, 1984: 23).

Case studies are useful in illuminating our understanding of a complex issue or object. Case studies emphasize detailed contextual analysis of a limited number of events or conditions and their relationships. In particular, case studies are used to examine contemporary real-life situations and provide the basis for the application of ideas and extension of methods.

The three case studies we use to illustrate how good practices can contribute to the creation of an enabling environment for the development of culturally appropriate responses to HIV and AIDS are: the Kgotla system in Botswana, the Churches Health Association of Zambia and the Stepping Stone project in Botswana.

1. Case study one: Kgotla System in Botswana

Fig 4: The Kgotla as an avenue for HIV and AIDS Dialogue in Botswana

A Kgotla, (a loan word in Botswana English from Setswana, meaning court) is a public meeting or a community law court headed by a chief or headman found in every Botswana village. This pre- independence form of governance was hierarchically organized with the kgosi's kgotla being the central one. Below this were a number of wards (dikgotla). The Kgotla was an institution that served as a forum for policy formulation, decisions including political and economic developmental activities and judiciary on litigations. Advisers mostly from royal relatives assisted the chiefs of the kgotla. These institutions still play a vital role in the present form of government. All matters affecting a community, be they social, economic, health, discipline, land disputes are discussed and decisions arrived at by consensus. Anyone is allowed to speak, and no one may interrupt while someone is speaking. Gender and age are of no consequence - each voice whether male or female, adult or child will be heard. The underlying principle in the Kgotla is that: *"Every Motswana in every district, in every village, community cries and he/she is heard through the Kgotla system".* The custom of allowing everyone their full say is carried over into meetings of all kinds, from discussing a bill to a staff briefing. Kgotla is also a speaker's forum; it takes the form of Parliament on the national level. The Kgotla is a traditional concept unique to Botswana and makes Botswana Africa's cradle of democracy.

A Kgotla

In addition to a Kgotla being a place where local voices are heard, this traditional structure has helped a lot in terms of HIV and AIDS education, sensitization and research because it is used for community mobilization. Home Based care programs go through the Kgotla chiefs who are also the cultural gatekeepers and people easily relate to the Kgotla (see also Piwane, 2010).

Success factors

The Kgotla chiefs, as community gatekeepers, recognize the impact of HIV and AIDS and hence are willing to work with organizations in intervention activities including community mobilization. The Kgotla is not only seen as the court or arbitration place, it is also the place for socialization and cultural activities and hence this provides a forum for easy accessibility of the community for education and sensitization on HIV and AIDS.

Challenges

The Kgotla system is increasingly being seen and challenged by some people as a traditional system that is in conflict with modernity and this may affect attendance levels.

The Kgotla represents the best example of some good practices that contribute to the creation of an enabling environment for the development of culturally appropriate responses to HIV and AIDS. The Kgotla being a place for socialization and cultural activities, it provides a forum for easy accessibility of the community for education and sensitization on HIV and AIDS.

2. Case study two: one: Traditional Health Practitioners Association of Zambia

Fig 5 : Traditional Health Practitioners Association of Zambia (THPAZ)

Research suggests that some 80% of people in developing nations, particularly in sub-Saharan Africa, seek the aid of traditional healers as their primary source of care. They are consulted, not only because they are closer and more affordable than their modern-trained counterparts, but also because they are embedded, extensively and firmly, within the culture. Traditional healers are highly respected and widely consulted by communities in spite of their low levels of education and training. In Zambia, traditional healers operate under the umbrella body, the Traditional Health Practitioners Association of Zambia (THPAZ). The Association collaborates with various organizations and institutions to bridge health gaps in Zambia.

Under the Zambia Integrated Health Program (ZIHP), The Ministry of Health IN Zambia has developed an innovative collaborative program with the 50,000 member strong Traditional Health Practitioner's Association of Zambia (THPAZ) for increasing access to health services for rural communities in Zambia. This followed research results by Zambia AIDS Law Research and Advocacy Network (ZARAN) that showed that at least 60 percent of the country's populations were receiving some or all of their medical care from traditional health practitioners across the country. Yet, few attempts had been made by the Zambian government and other policy makers to actively engage these traditional healers in Zambia's response to HIV and AIDS.

Members of the District Health Management Team and staff of local health centre now work with traditional healers participate in educating the public on matters relating to: HIV/AIDS, malaria, tuberculosis, child health and nutrition, while also helping local communities identify cases that needed timely referrals to health clinics. ZIHP has supported the development of a national training manual for practicing traditional healers -- the first of its kind to be sanctioned by the Central Board of Health and the THPAZ -- which is now available for nationwide use. The tension, suspicion and mistrust that characterized relationships between medical practitioners and traditional healers have now disappeared as the two teams of traditional healers and health centre staff serves the same communities. Unlike in the past, traditional healers are now able to:

- Distribute and demonstrate proper use of condoms to prevent HIV and AIDS in their communities
- Distribute and demonstrate use of oral rehydration salts
- Keep record of community health activities that they send to the local health centers monthly while the health centres provide quarterly reports to the District Health Management Team

- Are able to share health education messages and assists health clinic staff with their public health campaigns
- Mobilize other traditional healers and communities to discuss HIV and AIDS and other health problems in the community.

With this program, ZIHP is helping to fulfil the Government of Zambia's vision of bringing services as close to the community as possible. This initiative not only provides community health practitioners with technical information that has potential to reduce mortality, but also builds trust between the traditional healers and health centre workers, strengthening the social capital of cooperation in the rural areas.

Impact:

- Through herbal treatment from traditional herbalists, PLWHA have experienced reduced discomfort from opportunistic infections, and an improved quality of life. They have been able to successfully treat some of the common infections, and to improve their nutrition.
- Traditional healers have broadened their knowledge on treatment of HIV/AIDS related infections, use of appropriate dosages, length of treatment and the importance of nutrition on managing HIV/AIDS. They also gained new skills related to record keeping and their ability to collaborate with "Western" health workers was been profoundly enhanced.
- The home care approach developed by ZIHP is being adapted and adopted in other countries such as Tanzania. .

Advantages of involving traditional healers

- Traditional healers are able to successfully communicate prevention messages in local languages and in ways congruent with local customs and traditions.
- Working with traditional healers promotes understanding among the research community and biomedical practitioners on the local belief systems and practices, including what significance these practices have in local terms and how to communicate for behaviour change.
- Working with traditional healers allows for wider dissemination and local acceptability of HIV preventive education and practices.
- Traditional healers can assist in the treatment of opportunistic infections and providing care to people affected by HIV/AIDS in resource limited settings
- Traditional healers can promote cross referencing of patients by referring patients to modern health system and vice versa - a system built on mutual respect and which can greatly benefit the population.
- Well trained training traditional healers can help reduce HIV transmission by changing risky traditional treatment practices such as making incisions with contaminated equipment or using one razor blade for a number of patients.

Traditional medicine and traditional healers are important indigenous cultural resources. While traditional medicines may not provide a cure for HIV, they can be useful resources in providing both psychological and physical relief to persons living with HIV and AIDS. Local medicine is easily available, accessible, acceptable, and affordable. Recognizing the importance of traditional

healers will go a long way in strengthening the national capacity for HIV and AIDS prevention, treatment, care and support in Zambia as in many other countries.

3. Case study Three: Stepping Stones Project in Botswana

Fig. 6 : Stepping Stones

Stepping Stones is a life skills training package in gender, HIV and AIDS, sexual and reproductive health, communication and relationship skills. The training package was developed for use in communities throughout sub-Saharan Africa and Asia. In Botswana, it is being disseminated through BONASO. The Stepping Stones package is designed to enable women, men and young people of all ages to explore their social, sexual and psychological needs, to analyse the communication blocks they face, and to practise different ways of addressing their relationships. It is an effective community-based approach to HIV prevention that can improve relationships between men and women, promote gender equality, and create an enabling environment for sexual and reproductive wellbeing.

The training package is based on a human-rights based approach, assuming that people share certain challenges in their lives, which the package aims to help address.

Trainings are carried out through workshop groups of about 10-20 people, both HIV positive and negative, of the same age and gender. The groups share experiences and perform role plays based on those experiences, analyse them and consider alternative outcomes. The homogenous groups are occasionally brought together to share experiences.

Results

The trainings have led to increases in the following:

- Knowledge of gender, HIV and AIDS and sexual and reproductive health issues.
- Communication skills and enhanced discussion HIV and AIDS and other sexual issues.
- Gender, inter-generational and peer relationships.
- Practice of safer sex.
- Income-generating activities.
- Sharing of knowledge with other community members
- Trust within peer groups and helping older and younger men to explore their own attitudes, behavior and vulnerability in ways they feel comfortable with.
- Enabling men to hear the perceptions of women and to consider the impact of their attitudes and behaviors on the situation of women.
- Trained skilled male facilitators.
- Positive peer and community pressure for behavior change.

Success factors

The effectiveness of Stepping Stones is based on the process, approach and activities employed.

- Working in peer groups divided by age and gender enables the groups of older and younger men and women to explore their experiences and seek for solutions for their age-gender groups.
- Workshops encourage participation by all members through discussion and role plays. This enhances respect for other persons and genders and encourages free participation in other community activities
- Groups encourage free discussion on sexual and reproductive wellbeing, including contraception, STI and HIV, infertility, communication, gender and sexual relations, the

household economy.
- The separate groups are brought together to share experiences, ideas and solve problems together. This encourages recognition of the equal value and contribution of other groups in the community.
- The workshops encourage participation of couples and other family members. This helps to improve gender and inter-generational relationships.

Challenges

In spite of the achievements of the stepping stones training program, it continues to face challenges with regard to:
- Low attendance levels by men
- Managing conflict and embarrassment between peer groups during joint meetings
- Encouraging participation to people who may be shy to speak
- Some men are resistant to female participation in the trainings

The Stepping Stone program is another good example of practices that contribute to the creation of an enabling environment for the development of culturally appropriate responses to HIV and AIDS because it complements local cultural practices especially as it relates to communication. It encourages all people to participate in HIV and AIDS discussions and to share their experiences and takes into account the gender and age factor, and this way it builds on existing local customs, beliefs and practices.
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III. RECOMMENDATIONS

1. Many CSOs work individually, hardly consulting or collaborating with each other, and duplicating efforts in the same field and communities. This limits their influence on policy making. There is, therefore, need for sustained collaborative efforts. This collaboration would also ensure adequate information sharing and documentation of good practices to enhanced impact on community and policy, mobilization of resources, greater recognition and legitimacy, better influence on the way governments work.

2. Interactive, authentic partnerships among CSOs and public institutions are required for sustainable impact on HIV and AIDS interventions. Governments should invest in the capacity of the civil society to provide effective, locally legitimate evidence-based research information on HIV policy formulation and implementation.

3. Both countries do not have an approved national HIV and AIDS research agenda. The lack of a policy framework on HIV and AIDS research means that research is fragmented and the national bodies have no way of harnessing research conducted at the local level which is critical for decision making. A research framework would improve linkages and relations between CSOs and HIV and AIDS national bodies thus ensuring an effective mechanism for evidence-based research and data collection.

4. There is need for CSOs and researchers to diversify and use multiple methods of research communication to ensure that they reach the public and policy makers as widely as possible. This could be done through disseminating reports, policy briefs, all-inclusive stake-holder workshops, community dialogues, and use of both print and electronic media for a research project. This also ensures public participation for impact on policy making.

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Annex 1: List of Persons Interviewed in Botswana

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- Ms Sibusisiwe Butale, Program officer, Botswana Council of Non-Governmental Organizations (BOCONGO)
- Ms Mabel Rammekwa, Secretary General, Botswana Red Cross Society
- Mr. Boga Fidzani, Senior Monitoring and Evaluation Consultant (BNAPS), National AIDS Coordinator Agency, Botswana
- Dr. Keitseope Nthomang, Senior Lecturer, Social Work Department, University of Botswana
- Dr. Alfonse Mulumba, Program Officer, Southern African Development Community (SADC)
- Dr. Banyana Madi-Segwagwe, Program Officer, Southern African Development Community (SADC)
- Ms. Margaret Tebogo, Program Officer, Botswana Network of People Living with HIV and AIDS
- Mr. Zogani Kraai, Program Officer, Botswana Network of People Living with HIV and AIDS
- Nthabiseng Nkwe, Project Coordinator, Botswana Network on Ethics, Law and HIV and AIDS (BONELA)
- Ms. Roos Van Dorp, Program Assistant, Botswana Association of Local Authorities (BALA)
- Daniel Motsatsing, Executive Director, Botswana Network of AIDS Service Organizations (BONASO)
- Ms Irene Maina, Social Mobilization Advisor, UNAIDS Country Office, Gaborone

Annex II: List of Persons Interviewed in Zambia

- Ms. Doreen Mainza Shempala, Senior Program Officer (HIV), Churches Health Association of Zambia
- Prof. Michael Kelly, Independent Consultant and Catholic Priest
- Mr. Crispin Sapele, Monitoring and Evaluation Advisor COMETS - COMETS PROJECT CHAMP
- Ms. Rosanna Price-Nyendwa, Chief of Party COMETS - COMETS PROJECT CHAMP

- Mr. Rudo Phiri Mumba, Lecturer/ Researcher, University of Zambia, (Department of Development Studies, School of Humanities and Social Sciences)

- Harrison Musonda, Program Officer (AIDS), Churches Health Association of Zambia

- Mumba Moonga Hangoma, Lecturer, Researcher and Consultant, University Of Zambia (Department of Development Studies, School of Humanities and Social Sciences)

- Mr. Nicholas Shiliya, Monitoring and Evaluation Director, Society for Family Health, Zambia

- Ms Rosemary Kabwe, Health Programs Manager, Churches Health Association of Zambia

- Dr. Bona Chitah, Department of Economics, University of Zambia

LIST OF ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
BBCA	Botswana Business Coalition on AIDS
BHRIMS	Botswana HIV and AIDS Response Information Systems
BOCAIP	Botswana Christian AIDS Intervention Program
BONASO	Botswana Network of AIDS Service Organizations
BONELA	Botswana Network of Ethics Law and HIV and AIDS
BONEPWA	Botswana Network of people living with HIV and AIDS
CSO	Civil Society organization
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
DMSAs	District Multi-sectoral HIV and AIDS Committees
FBO	Faith Based Organization
FNDP	Fifth National Development Plan
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
NAC	National HIV/AIDS/STI/TB Council
NACA	National AIDS Coordinating Agency
NASF	National AIDS Strategic Framework
NGO	Non-Governmental Organization
NSF	National Strategic Framework for HIV and AIDS
OVC	Orphaned and Vulnerable Children
PMTCT	Preventing Mother to Child Transmission of HIV
PLWAs	People Living With HIN and AIDS
SADC	Southern African Development Community
STI	Sexually Transmitted Illnesses
TB	Tuberculosis
UNAIDS	Joint United Nations Program for HIV and AIDS
UNESCO	United Nations, Educational, Scientific, and Cultural Organization
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization
YOHO	Youth Health Organization