Republic of Botswana
Ministry of Local Government & Rural Development

Framework and Operational Guidelines for Community Capacity Enhancement through Community Conversations (CCE-CC)

February 2013

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# LIST OF ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>BAIS</td>
<td>Botswana AIDS Impact Survey</td>
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<tr>
<td>BOCOBONET</td>
<td>Botswana Community Based Organisations Network</td>
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<td>BOCAIP</td>
<td>Botswana Christian AIDS Intervention Programme</td>
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<td>BONASO</td>
<td>Botswana Network of AIDS Service Organisations</td>
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<td>BONELA</td>
<td>Botswana Network on Ethics, Law &amp; HIV/AIDS</td>
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<td>BONEPWA</td>
<td>Botswana Network for People Living With HIV/AIDS</td>
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<td>BOTUSA</td>
<td>Botswana USA Partnership</td>
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<tr>
<td>CCE</td>
<td>Community Capacity Enhancement</td>
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<td>CCs</td>
<td>Community Conversations</td>
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<td>CDO</td>
<td>Community Development Officer</td>
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<tr>
<td>CHBC</td>
<td>Community Home Based Care</td>
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<tr>
<td>CICE</td>
<td>Centre for In-service &amp; Continuing Education</td>
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<tr>
<td>DAC</td>
<td>District AIDS Coordinator</td>
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<tr>
<td>DHAPC</td>
<td>Department of HIV/AIDS Prevention &amp; Care</td>
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<td>DCS</td>
<td>Department of Clinical Services</td>
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<tr>
<td>DDC</td>
<td>District Development Committee</td>
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<tr>
<td>DET</td>
<td>District Extension Team</td>
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<tr>
<td>DHMTs</td>
<td>District Health Management Teams</td>
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<tr>
<td>DLGDP</td>
<td>Department of Local Government Development Planning</td>
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<tr>
<td>DMSAC</td>
<td>District Multi Sectoral AIDS Committee</td>
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<tr>
<td>DPHS</td>
<td>Department of Primary Healthcare Services</td>
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<tr>
<td>DPH</td>
<td>Department of Public Health</td>
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<tr>
<td>FWE</td>
<td>Family Welfare Educator</td>
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<tr>
<td>GOB</td>
<td>Government of Botswana</td>
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<tr>
<td>HEA</td>
<td>Health Education Assistant</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IHS</td>
<td>Institute of Health Sciences</td>
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<tr>
<td>MoESD</td>
<td>Ministry of Education and Skills Development</td>
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<td>MFDP</td>
<td>Ministry of Finance and Development Planning</td>
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<tr>
<td>Acronym</td>
<td>Full Name</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MLG&amp;RD</td>
<td>Ministry of Local Government &amp; Rural Development</td>
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<tr>
<td>MP</td>
<td>Member of Parliament</td>
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<tr>
<td>NAC</td>
<td>National AIDS Council</td>
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<td>NACA</td>
<td>National AIDS Coordinating Agency</td>
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<td>NASTAD</td>
<td>National Alliance of State &amp; Territorial AIDS Directors</td>
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<td>NCMS</td>
<td>National Community Mobilization Strategy</td>
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<td>NSF</td>
<td>National Strategic Framework</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PTA</td>
<td>Parents Teachers Association</td>
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<td>RDC</td>
<td>Rural Development Council</td>
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<td>RECC</td>
<td>Rural Extension Coordinating Committee</td>
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<tr>
<td>S&amp;CD</td>
<td>Social and Community Development</td>
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<tr>
<td>UDC</td>
<td>Urban Development Committee</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>VDC</td>
<td>Village Development Committee</td>
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<td>VET</td>
<td>Village Extension Team</td>
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<tr>
<td>VHC</td>
<td>Village Health Committee</td>
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<td>VMSAC</td>
<td>Village Multi-sectoral AIDS Committee</td>
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<tr>
<td>WET</td>
<td>Ward Extension Team</td>
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<tr>
<td>WDC</td>
<td>Ward Development Committee</td>
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FOREWORD

Botswana’s national response to HIV and AIDS is now guided by the second National Strategic Framework (NSF II) which runs from 2010 to 2016. The NSF II has identified four priority areas being; Prevention of New Infections, Systems Strengthening, Strategic Information Management, and Scaling-Up Treatment, Care and Support. The NSF II was informed by the realisation that through lifesaving initiatives such as provision of Anti-Retroviral Therapy (ARV) have guaranteed prolonged life for those infected, new HIV infections continue to occur across the population.

Realising the need for concerted efforts to curb the growth of new infection, the Government of Botswana developed a National Community Mobilization Strategy (NCMS) for HIV and AIDS which draws on the long-standing coping strategy that resonates with Batswana, being of self-reliance. The emphasis of the NCMS is on community involvement and participation in the national response to HIV and AIDS. The strategy borrows concepts from the Community Capacity Enhancement through Community Conversations (CCE-CC) methodology.

In 2004, the Ministry of Local Government with the assistance of UNDP introduced CCE-CC to help mobilise communities to participate in the HIV and AIDS response. CCE-CC is a participatory methodology that focuses on people and it empowers communities to identify HIV and AIDS related concerns through self-introspection and come up with solutions.

Consequently MLGRD in collaboration with the National Alliance of State and Territorial AIDS Directors (NASTAD) has developed a framework that will guide the implementation of CCE-CC. The CCE-CC framework recognises the critical role of various institutions and stakeholders and capitalizes on their natural responsibilities for leadership, coordination, partnership and cooperation in its implementation.

I therefore hope that the public sector, NGOs and CBOs will adopt and institutionalize CCE-CC as an effective and critical communication method to enhance programme uptake and sustainability.

B. Khumomathare
Permanent Secretary
Ministry of Local Government & Rural Development
ACKNOWLEDGEMENTS

The Ministry of Local Government would like to acknowledge and thank the National Alliance of State & Territorial AIDS Directors (NASTAD) for the technical and material support provided in the development of this framework that will guide the implementation of the Community Capacity Enhancement through Community Conversations (CCE-CC) in Botswana.

We would like to express our appreciation to Misters Besack Maphakwane & Malekantwa Mmapatsi who developed the framework and guidelines. Special thanks are extended to all members of the Technical Working Group who guided the entire process, as well as other stakeholders who provided useful input and guidance during the stakeholder workshop.

We are also greatly indebted to all those who agreed to be interviewed at various stages of this framework development, without whose input this document would not have been possible. These respondents include government officials, particularly in the Ministries of Health and Local Government, NACA as well as Non-Government Organisations and our development partners.

Finally, but not least our gratitude goes to the US-Government Centres for Disease Control and Prevention (CDC)/PEPFAR Botswana for their financial support.
EXECUTIVE SUMMARY

Over the last two decades, HIV and AIDS epidemic has dominated the health and the socio-economic development agenda in Botswana. Since 1987, almost two years after the first HIV case was diagnosed in the country, Botswana has devoted considerable resources for efforts to mitigate the spread of HIV and AIDS. The Government of Botswana (GOB) declared HIV and AIDS a national emergency and committed itself to a long-term response. This strong political will and commitment has strengthened the fight against HIV and AIDS in Botswana since the earliest stages of the epidemic. The national response was organized and guided by a series of plans, the most significant being the Medium Term Plan II (1997-2002), which was designed as an open “Multi-Sectoral Plan” which emphasized the importance of community leadership and participation in the national response. To this end, a variety of interventions and assistance programmes were designed and implemented at both the national and local levels.

Although much success was achieved through treatment and care of the infected, the rise in new infections remained a major challenge. It became clear that behavioural change was needed to curb the growing problem of increasing new infections. With the support of UNDP, the Community Capacity Enhancement through Community Conversation (CCE-CC)\(^1\) initiative was introduced in 2004. Since the successful pilot phase, CCEP was (and continues to be) implemented on a national scale through the Ministry of Local Government, in partnership with NACA, UNDP, PEPFAR and the U.S.-based organisation, the National Alliance of State & Territorial AIDS Directors (NASTAD).

Other countries have clearly documented the benefits of the CCE-CC strategy, and Botswana is keen to realize similar successes in its fight against HIV and AIDS. A framework that provides guidance on the implementation of CCE-CC in conjunction with the NCMS will allow for a more successful programme. The midterm evaluation of the National Strategy Framework (NSF) I, 2003-2009, identified weak community ownership and participation due to lack of meaningful community mobilization and engagement throughout the programming cycle as one key weakness (NACA, 2007).

Following the conclusion of the GOB/UNDP partnership, in 2010 NASTAD began provision of the much-needed funding for CCE-CC rollout from, and continues to fund the programme today. Although many other community mobilization strategies were implemented prior to CCE-CC, the latter’s success in other countries motivated Botswana to adopt and implement CCE-CC through the Department of Primary Health Care Services. The primary objective of the CCE-CC is to develop individual and community capacity to respond to the HIV/AIDS epidemic and understand how their interconnectedness and individual attitudes and practices influence the spread of the disease.

\(^{1}\) When this process was introduced by UNDP it was known as CCEP, but later changed to CCE-CC.
The development of the CCE-CC framework is therefore expected to provide a foundation for the achievement of meaningful community mobilization and engagement, which will inhibit the spread of HIV. The CCE-CC as a community mobilization tool also contributes to the National Community Mobilisation Strategy (NCMS). The NCMS was introduced in Botswana in 2011, and was intended to catalyse community involvement and participation in the effort to fight HIV infection. The NCMS and the CCE-CC framework are both in line with the national goal of achieving zero new infections by 2016.

The Botswana CCE-CC framework and operational guidelines were developed to guide effective implementation of the CCE-CC approach. This document is both an outline of the framework for CCE-CC in Botswana and a guideline for implementation of the framework. It provides the contextual background and history of community mobilization in Botswana, as well as a step-by-step methodology for implementation, training and resource mobilization and detailed outline of stakeholder roles and responsibilities. Strategies for monitoring and evaluation are also presented.
CHAPTER 1
RATIONAL FOR DEVELOPMENT OF A FRAMEWORK

The HIV and AIDS epidemic remains a major health and development challenge in Botswana. Results from the third Botswana AIDS Impact Survey (BAIS III of 2008) on the prevalence of HIV infection in Botswana estimated the prevalence rate of 17.6% compared to 17.1% that was estimated in the 2004 BIAS II. The results also showed that HIV prevalence increases sharply with age - peaking between the ages of 30-45 years.

Botswana has been making concerted efforts to impede the spread of HIV and mitigate the impact of AIDS since 1987, just two years after the first case of HIV was diagnosed. In 2003, the Government of Botswana (GOB) declared HIV and AIDS a national emergency and committed itself to a long-term response. A series of plans, most significantly the Medium Term Plan II (1997-2002), guides Botswana’s response, which emphasizes community leadership and participation.

Although a number of strategies (especially awareness campaigns) have been employed in Botswana to mobilize communities in response to HIV and AIDS, both at the district and national levels, these efforts have not had a significant impact on the reduction of HIV transmission. Persistent increases in new infections pointed to the need for a strategy to influence behavioural change to curb new infections. Community Capacity Enhancement through Community Conversations methodology was introduced in 2004 in five pilot districts in Botswana. This initiative is a methodology that targets hard-to-change behaviours by dealing with the underlying causes of HIV and AIDS, including power relations, gender issues, stigma and discrimination. The initiative focuses heavily on interactive dialogue about the epidemic’s deeper causes, community decision-making and action through a facilitated process. The CCE-CC approach is viewed as more promising than traditional programming that simply seeks to build knowledge and awareness.

Implementation of CCE-CC in Botswana was evaluated in 2009 after the GOB/UNDP partnership agreement was concluded. The evaluation found that CCE-CC had the potential to complement and strengthen a bottom-up planning approach in Botswana and that there was a need to expand it to all districts.

The evaluation of CCE-CC found that regular monitoring was necessary to build its sustainability and to facilitate its integration into the national, district, and village level HIV and AIDS efforts. The evaluation also showed that CCE-CC implementation was hindered by the lack of funds to support community initiatives, inadequate number of CCE focal persons, and limited support by District Multi-Sectoral AIDS Committees (DMSAC) and other district level structures. The assessment recommended that the implementation and popularisation of CCE-CC continue with the addition of clearer strategic guidance and management responsibilities as well as sufficient resources and training. (Development of a NCMS for Botswana, Background Report, Feb. 2011, P19).

It has been observed that community mobilization interventions have generally not been nationally standardized, which may decrease their effectiveness (National Community Mobilization Strategy, 2011). As a result, the National AIDS Coordinating Agency (NACA) developed a National Community Mobilization Strategy (NCMS) to coordinate national scale application, positioning community mobilization as the central intervention strategy at the individual, household and community levels. This National Community Mobilization Strategy identified CCE-CC as a key methodology for its interpretation and application since it

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1 Implemented through support from the United Nations Development Programme (UNDP) through its Leadership for Results Programme, CCEP was later changed to CCE-CC.
has been shown to be effective in mobilizing communities and positively impacting community norms and behaviours that drive the HIV and AIDS epidemic.

Since 2010, the Ministry of Local Government has been working to strengthen the application of the CCE-CC strategy with the assistance of the National Alliance of State and Territorial AIDS Directors (NASTAD). Some of the key goals of this collaboration are to:

- Identify and reinforce individual and community capacity to understand and reflect upon the nature and impact of the HIV and AIDS epidemic and then to initiate changes to respond effectively.
- Strengthen the capacity of individuals and organisations to facilitate local community responses to HIV and AIDS that integrate prevention, treatment, care and support.

Although the 2009 CCE-CC Evaluation Report identified a high level of support for the CCE-CC model, the evaluation and the CCE-CC Framework Consultancy have identified several challenges that require urgent attention in order to ensure the successful rollout and implementation of CCE-CC. Some of these challenges include:

- Ensuring programme sustainability
- Lack of clear roles and responsibilities
- Lack of dissemination and therefore inadequate buy-in of CCE-CC
- Dependence of CCE-CC on temporary staff, creating uncertainty about programme outlook and sustainability
- Community fatigue due to numerous programmes and initiatives
- Lack of continuous monitoring and evaluation of CCE-CC
- Erosion of the spirit of volunteerism amongst Batswana

**PURPOSE AND GAPS ADDRESSED BY THE FRAMEWORK**

The CCE Framework is expected to provide direction and structure for the achievement of meaningful community mobilization and engagement, which may result in a measurable reduction in the spread of HIV. Other important gaps that the CCE-CC Framework is expected to address are the following:

- Inadequate human and financial resources to sustain programme implementation and dissemination.
- Poor institutionalisation of CCE-CC across stakeholders, in particular within the public sector.
- Ineffective coordination and implementation structures for efficient and effective management and dissemination of CCE-CC to support cross-cutting HIV and AIDS interventions against further spread of the scourge.
- Inadequate buy-in mechanism(s) for the up-take of CCE-CC among other key stakeholders such as development partners, non-state actors, community based and private sector organizations.
- Insufficient technical and operational guidance for the implementation of Community Capacity Enhancement within the public sector as well as civil society organizations and training institutions.

By addressing these gaps and fully implementing CCE-CC throughout Botswana, it is envisaged that CCE-CC will enhance and deepen people’s participation in the various HIV and AIDS intervention measures and thereby mitigate the continued spread of the disease.
ORGANIZATION OF FRAMEWORK / GUIDELINES

Chapter 1  Introductory material with special coverage of factors that influenced CCE-CC launch in Botswana
Chapter 2  Highlights of community mobilisation in Botswana
Chapter 3  Description of the core elements of CCE-CC and conversation facilitation process
Chapter 4  Structures for institutionalisation of CCE-CC in Botswana and proposals for resource mobilization to support the approach
Chapter 5  A step-by-step framework for implementing CCE-CC
Chapter 6  A monitoring and evaluation matrix
CHAPTER 2

HIGHLIGHTS OF COMMUNITY MOBILISATION IN BOTSWANA

Community mobilization is a long-standing tradition in Botswana, symbolized through the Kgotla. The Kgotla is a place where communities gather to identify, address and resolve a range of issues that arise from communal living. The leadership of this forum has always been provided by the Kgosi. It was therefore logical that an approach such as CCE-CC be anchored into the Kgotla system.

The customary structures of the Kgotla system and chieftainship have existed since pre-colonial times. The Kgotla continues to survive and endure post-independence, although there have been changes to Kgotla status, powers and functions. However, one aspect of the Kgotla system, the key principle of community consultation, or therisanyo, has survived the turbulence of chieftainship evolution over the years. Communities are mobilized to the Kgotla for consultations on all manner of developmental and non-developmental issues, thus making this institution a major channel of communication between the government and its people. Thus, the cultural institution of the Kgotla is still considered critical in mobilizing communities in Botswana for all matters including health and overall socio-economic development.

The Community Mobilisation Model for Botswana has been heavily influenced by the Community Capacity Enhancement through Community Conversations, particularly the sequential steps of activities followed by that process:

1. **Pre-Assessment:** Collection of information about human, physical, and financial resources and a review of community strengths, weakness, opportunities and threats are done to measure the effectiveness and impact of the mobilization cycle.

2. **Building Relationships:** Creating rapport with members of the community for effective buy-in is important to create a relationship of trust and ownership in the process of community mobilization.

3. **Identification of Concerns:** Opportunities for community members to voice their concerns about the initiatives and community mobilisation processes are provided.

4. **Exploration:** This stage involves a critical review of the community’s concerns and coping strategies. This allows the community to identify underlying causes of persistent problems.

5. **Prioritizing and Planning:** Communities have finite resources to devote to major community problems. As a result, it is important that communities prioritize which problems are greatest and may be most effectively addressed with the available resources. The community may then outline plans to address the prioritized problems, and enlist the technical support of local governmental or non-governmental organizations.
6. **Initiating Action:** This involves the implementation of the prioritized actions.

7. **Maintaining Momentum:** Strong leadership within the community is necessary to preserve the momentum of the initiatives.

8. **Achieving Results:** In carefully outlining actions and initiatives that are plausible and realisable, benefits can accrue within the community. There may also be difficulty in achieving success, and strong will and desire must be used to overcome these obstacles.

9. **Reflection, Recognising, Celebrating:** This is an important stage in community mobilisation as it offers the opportunity for communities to assess their progress and the challenges that have arisen. Community mobilisation is a learning process where mistakes will inevitably be made, but must then be identified and corrected in order to progress. Achievements made, however little, should be celebrated as a step forward.

10. **Renewing the cycle:** Planning is imperative to a successful community mobilisation effort. In reviewing and revising the implementation plans, the community can move to greater heights of achievement.

As a process grounded in community mobilization and input, CCE-CC is a major tool for implementation of this National Community Mobilization Strategy. CCE-CC was introduced as a mode of community mobilization in Botswana in 2004. The CCE-CC community mobilization methodology aims at addressing the complex relationships between HIV and AIDS and poverty, and their combined impact on human development (UNDP 2005).

Through facilitated community conversations, CCE engages communities in participatory change and action-oriented strategies to transform local conditions that fuel HIV transmission, entrench poverty and ill-health, and impede human development. The CCE-CC implementation is currently supported through Ministry of Local Government & Rural Development (MLG&RD) in partnership with NACA and NASTAD.

Community mobilization has also been used successfully in Botswana to address other health and social development challenges. It has been employed in efforts to improve environmental health, to scale-up malaria prevention, and to engage adolescents and youth within the education sector.

**THE CHANGING CONTEXT FOR COMMUNITY MOBILIZATION**

The traditional structures of chieftainship remain the cornerstone of Botswana’s local governance system. Through the Kgotla system, Dikgosi facilitate the consultation processes on the formulation and implementation of public policies and district plans. The Government of Botswana (GOB) has recognized the importance of active participation and involvement of communities in development planning, demonstrating this commitment by decentralizing planning and development functions (Sharma 2004). Dikgosi can play an instrumental role in initiating social change by striking a healthy balance between tradition and modernity, especially in addressing emerging complex issues such as HIV and AIDS, through their pronouncements on some undesirable customs and harmful social behaviours.
From the Kgotla to Other Forums: As noted, community mobilization in Botswana is deeply embedded in the social and cultural traditions of the Kgotla system. However, as the country moved through successive stages of development, other forms of governance emerged as well. The new institutions established post-independence include decentralized structures such as District Councils and other departments for public service delivery.

At the village level, there are Village Health Committees (VHCs), Village Development Committees (VDCs), Village/Ward Multi-Sectoral AIDS Committees (V/WMSACs), Village Extension Teams (VETs) and Home-Based Care Committees. A variety of district oversight structures exist to coordinate these village/ward entities, such as the District Health Management Teams (DHMTs), District/Urban Committees (DMSAC), among others. Development Committees (DDCs/UDCs) Committees (DMSAC), among others.

With respect to HIV and AIDS, NACA provides the highest level of coordination and guidance for the national, district, and village level structures as well as for international partnerships, whilst the Department of Primary Health Care Services (DPHCS) at the MLG&RD is mandated to coordinate the HIV and AIDS district multi-sectoral response. Other important structures outside the government system that have potential for community mobilisation in Botswana through CCE-CC are religious groups (churches) and Civil Society Organisations. In order to combat the continued transmission of HIV, these organizations must be recognised and harnessed to help catalyse behavioural changes through CCE-CC.

NATIONAL PLANNING AND COORDINATION APPROACHES

An important and complimentary process underway in Botswana is Evidence Based Planning (EBP), which uses the best available data, information and knowledge to make decisions. It also harnesses the knowledge gained from data and information, and uses it to optimize planning processes and improve results. An evidence-based plan also assists the DMSAC to make sure that programmes in the district are well coordinated with each other and the data collected through CCE-CC facilitation process can form a good basis for situational analysis or environmental scan, as required by EBP.
In the context of CCE-CC, EBP is ideal as the two mutually reinforce each other. As the community go through CCs stages of decision-making, planning and taking action, the need for good data in planning and implementation is indispensable. Evidence Based Planning Process goes through six (6) steps:

1. Getting Ready to Plan
2. Evidence Gathering
3. Results Oriented Planning & Self-Assessment
4. Preparing the plan
5. Implementation, Monitoring & Reporting
6. Evaluation
7.

These steps are cyclical in the normal interactive planning process. EBP is an experiential learning based process. A compacted process is graphically represented below at Figure 1.

Figure 1: Evidence Based Planning PROCESS for DMSAC

CHAPTER 3

COMMUNITY CAPACITY ENHANCEMENT THROUGH COMMUNITY CONVERSATIONS (CCE-CC)

The CCE-CC is a community-based self-reflection intervention meant to raise awareness and stimulate action within communities. CCE-CC works by mobilizing communities to rise up to the challenges within the community and work together to address them. The approach is currently implemented by the Ministry of Local Government with the support of NASTAD to address the continued spread of HIV and AIDS and to deal with challenges arising from prevention efforts. Through the CCE-CC approach, communities and individuals recognize for themselves that some long-held values, traditions, and beliefs must change if the spread of HIV and AIDS is to be controlled. The approach enables communities to identify those behaviours and socio-cultural practices that need to change in order to control the epidemic.

The uniqueness of CCE-CC compared to other community mobilization strategies is that it goes beyond ‘awareness’ campaigns and offers a genuine space and platform for introspection by individuals and communities, hence its slogan: ‘The Answer Lies Within.’

OBJECTIVES OF CCE-CC

The CCE-CC aims to:

- Generate a deep understanding of the complex nature of the epidemic within individuals and communities, and to create the social cohesion necessary to create an environment for political, legal, and ethical change.
- Support the development of self-esteem, self-confidence, tolerance, trust, accountability, introspection, and self-management.
- Examine social contracts among various groups in the community – for example, between women and men, people living with HIV and those who have not been tested, the young and the old, the rich and poor – and to address girls’ vulnerability.
- Identify individuals within the community who possess leadership abilities and facilitation skills in Community Conversations to scale up the community response to HIV and related development issues.
- Bring the voices of people into the national response, and integrate community concerns and decisions into national and decentralized plans with the aim of linking resources to individual and collective needs.
- Strengthen the capacity of NGOs and community-based organizations to develop appropriate strategies for a response that prioritizes communities and individuals.

GUIDING PRINCIPLES

Community Capacity Enhancement through Community Conversations is a methodology based on the recognition that communities have the capacity to prevent the spread of HIV, care for those affected, change harmful attitudes and behaviours, and sustain hope in the midst of the epidemic. The methodology calls for local responses to be at the forefront of mitigating concerns of local communities. CCE-CC conversations use a participatory, team-based approach based on mutual learning, trust, and respect and are guided by the principles of sensitivity to local experiences, respect of human rights, gender sensitivity, and the belief in collective impact.
The CCE-CC approach uses a team of trained facilitators from inside or outside the community (but grounded in local reality) to drive the conversation. Through facilitated interaction, the conversations shift power relations, strengthen ownership and responsibility for change, and mobilize local capacity and resources. These resources may include material goods, social systems, time, social capital, skills, knowledge, values, tradition, etc. The conversations are designed to touch the soul of a community, catalysing transformation from the inside out.

The methodology translates the principle of participation into development practice by creating opportunities for people to understand, discuss, decide and act on issues affecting their lives. By bringing together men and women of different generations, it allows different perspectives to be heard and taken into account when decisions are made. It integrates the principles of diversity, respect of differences and non-discrimination into the tools and practices used to address issues critical to HIV and AIDS. These include issues related to stigma, discrimination and the violation of the rights and dignity of people living with HIV, along with issues related to voluntary counselling and testing, prevention of parent-to-child transmission, and access to treatment, including antiretroviral therapy.

At the same time, CCE-CC provides opportunities for authorities to listen to and understand community concerns and decisions in order to integrate them into national planning and implementation processes and provides NGOs, community-based organizations and faith-based organizations opportunities to reinforce social networks and coalitions. This helps to amplify community voices at various levels and support community responses to HIV and AIDS. Once begun, this process of knowledge transfer becomes self-propagating, from community to community, as well as among an ever-growing pool of skilled implementers and facilitators.
SCOPE AND APPROACH

The CCE-CC is comprised of a six-phase process: relationship building, identification of concerns, exploration of concerns, decision-making and planning, action (implementation), and reflection and review. A diagram of the process of facilitating community conversations is presented in Figure 2 on page 16. The central theme of the wheel is transformation, which takes place through the six steps outlined in the wheel. The idea of transformation is about actively pursuing the envisaged results with the belief that they will be realized. Transformation is the centre point upon which the six steps are based. In addition, the process encompasses the ideas of hope - the belief that things can be better, results - envisaging the desired outcome, and resonance - evoking or suggesting enduring images, memories or emotions.

The phases of the process are defined as follows:

1. **Relationship-Building**: This is a trust building phase between the facilitator and the community. A sense of understanding and mutual respect should develop between the facilitator and the community, as well as amongst the community members.

2. **Identification of Community Concerns**: This is the phase for identifying major problems and issues. Communities, not the facilitators, should identify their own concerns.

3. **Exploration of Community Concerns**: This phase allows for a thorough exploration of concerns raised. The purpose is to have a detailed understanding of the factors linked to the identified concerns.

4. **Decision-Making and Planning**: In this phase, decisions are made, based on the explored primary concerns and issues and community plans are developed.

5. **Action**: This is the implementation phase. Actions taken must reflect community consensus so that there can be ownership and willingness to carry through the decisions.

6. **Reflection and Review**: The community reviews and reflects on their own changes and the indicators of these changes. At each session, community members should also reflect on what needs to be done to continue to move forward and make progress.
EXPECTED OUTCOMES

Successfully executed community conversations are intended to change behaviours that are known to increase the risk of HIV infection and transmission. Successful implementation should result in increased number of community initiatives for prevention, home-based care, change in harmful traditional practices, reduction of stigma and discrimination, support for orphans, and voluntary counselling and testing.

Those affected by HIV and AIDS should be involved in the decision-making processes in the context of community-based HIV and AIDS interventions. This should result in decision-making that reflects the concerns of the individuals in the communities.

Familiarity with CCE-CC is also expected to lead to an increased number of NGOs and community-based organizations using Community Conversations to promote discussions and problem solving around other issues, including governance, health, the environment, agriculture and peace-building.
CHAPTER 4

PROPOSED STRUCTURES FOR CCE-CC IMPLEMENTATION AND COORDINATION

The Government of Botswana has established ministries, departments, local authorities and parastatals to oversee the planning and implementation of programmes and projects in order to deliver targeted services to communities around the country. In order to bring services closer to beneficiaries, provision of these services has been decentralised to the district and village levels. In recent years, the role of these organizations and institutions in the public sphere has expanded to address the HIV and AIDS epidemic. The incorporation of CCE-CC into existing institutions and organizations was seen as an effective way to make use of existing resources while simultaneously addressing the HIV and AIDS epidemic. In this way, the process of uptake and internalization of CCE-CC in Botswana will be greatly enhanced.

The key structures involved in the implementation and coordination of CCE-CC are described below.

As Figure 3 on page 19 demonstrates, specific core stakeholders inside and outside government form the multi-sectoral approach to the Botswana national response to HIV and AIDS challenge. This approach is cascaded to the district and village levels through structures such as DMSAC and VMSAC. Through the Ministry of Education, the intervention system is able to reach the youth who are found in majority at schools.

Figure 3: National AIDS Intervention System in Botswana
Source: DHAPC, Ministry of Health, 2011
OFFICE OF THE PRESIDENT

National AIDS Coordinating Agency (NACA)

This Agency serves as ‘supra-sectoral’ body that monitors and coordinates the implementation of the National AIDS Policy and programmes. NACA also advises the Botswana Government on policy and strategic adjustments that need to be made in the national response to HIV and AIDS.

The National AIDS Council (NAC) is the highest policy and decision-making body on all matters relating to the fight against HIV and AIDS in Botswana. The NAC is chaired by His Excellency the President, deputized by His Honour the Vice President. NACA serves as secretariat to NAC. Therefore, NACA’s connection to NAC places it in the best position of influence to marshal support for CCE implementation.

NACA drives and oversees the National Strategic Framework II that articulates a multi-sectoral response which emphasises conformity to the “Three Ones”:

- One national AIDS framework to coordinate all partners
- One national coordinating body
- One agreed country level monitoring and evaluation system

Through the National Community Mobilisation Strategy (NCMS), the role of NACA in ensuring domestication and implementation of CCE is considered critical. The NCMS itself is considered a government policy paper on community mobilization in the fight against HIV and AIDS. NACA ensures that all stakeholders comply with the NCMS framework.

MINISTRY OF HEALTH (MoH)

The Ministry of Health is responsible for the oversight of the health sector, including the provision of health care services. It is charged with the formulation of policies, standards, and norms for health services provision as well as the delivery of primary, secondary and tertiary health care.

As stated earlier, Botswana has adopted a decentralized system of services delivery. The District Health Management Teams (DHMTs) are decentralized structures of the Department of Clinical Services at MOH. Other departments such as the Department of Public Health (DPH) and the Department of HIV and AIDS Prevention and Care (DHAPC) operate at the local level through Clinical Services’ structures.

Role of NACA

- Provide leadership and coordination of the implementation of NCMS.
- Ensure synergy and alignment in the NCMS implementation and evaluation with other national HIV and AIDS strategies and programmes.
- Facilitate strategic partnership building and involvement of all key stakeholders in NCMS and CCE rollout and implementation.
- Mobilise resources.

Presently, His Excellency has delegated the NAC Chairmanship to the former President Mr. Festus G. Mogae.
Department of Public Health (DPH)

Public Health is about protecting and improving the health of the population through organised effort. The DPH is dedicated to the improvement of health and wellbeing of individuals throughout the country. The Department of Public Health has three core functions: assessment, policy development and assurance. Through assessment, the DPH assesses community health needs and investigates health hazards. The DPH advocates for and prioritizes community health needs through policy development. Through assurance, the DPH implements and evaluates programmes and informs the public. These mandates are carried out through the following divisions:

- Disease control
- Sexual Reproductive Health
- Child Health
- Environmental and Occupational Health
- Rehabilitation and Mental Health
- Health Promotion and Education
- Oral Health (now a unit under Health Promotion)
- Nutrition and Food Control
- Alcohol and Substance Abuse

The Department’s Health Promotion and Education Division has adopted a participatory communication approach called Participatory Hygiene and Sanitation Transformation (PHAST) to promote hygiene behaviour, sanitation improvements and community management of water. The main objective of the initiative is to empower communities to manage domestic water and control sanitation related diseases. The DPH has recently expanded the initiative to address other health problems, including nutrition education and malaria. PHAST shares similarities with CCE, and therefore this synergy is expected to help them adopt CCE to its programmes and thus help internalise CCE-CC.

The DPH is committed to providing comprehensive, preventive, curative, and rehabilitative health services consistent with community health needs. Therefore, the Department of Public Health is a candidate for institutionalization of CCE given the large role it plays in public education and mobilisation for health development. The department has a comparative advantage as it covers broader health issues along the health continuum.

Role of the Department of Public Health

- Assume leadership in CCE dissemination and facilitation because of its comparative advantage in information, education and communication (IEC).
- Adopt CCE in the implementation of public health and education programmes.
- Engage and mobilize stakeholders inside and outside government for CCE buy-in and implementation to fulfil its role as a leader in public education and mobilisation.
Department of HIV/AIDS Prevention and Care (DHAPC)

This department provides leadership in the provision of comprehensive HIV and AIDS services through policy and programme development related to the provision of prevention, treatment, care and support services for HIV and AIDS. Through the Preventative Division, DHAPC also develops behaviour change interventions, communications and community empowerment initiatives for HIV Prevention, treatment, care and support. DHAPC provides the following intervention programmes to promote HIV and AIDS Prevention, Care and Support:

- Counselling and Testing
- Behaviour Change, Intervention And Communications
- Workplace Wellness
- ARV Programme
- Prevention Of Mother To Child Transmission (PMTCT)
- Community Home Based Care (CHBC)
- NGO Support
- Safe Male Circumcision
- Kitso HIV/AIDS Training
- Sexually Transmitted Infections

The Department’s technical and institutional support for health related interventions to organizations, NGOs and CBOs, including Traditional Healers and People Living With HIV (PLWH), supports effective communication mobilization strategies such as CCE. This department is therefore capable of leading in CCE adoption and implementation.

Department of Clinical Services (DCS)

Since the government decision in April 2010 to relocate clinics from District Councils to the Ministry of Health, DCS has assumed the responsibility of overseeing all clinics throughout the country. However, DCS operates and manages clinics and health posts through the District Health Management Teams (DHMTs).

Role of DHAPC

- Model and endorse rollout of CCE-CC to increase uptake.
- Attend to the challenges communities identify as hampering the implementation of CCE-CC and develop strategies to address them.
- Ensure the DHAPC expertise on behaviour change is harnessed to complement the efforts of MLG and other stakeholders in CCE-CC rollout.
- Train CCE personnel in standards and protocols of HIV and AIDS programme delivery in order to reinforce implementation of CCE.
- Use its advocacy and community sensitisation skills to reinforce community mobilisation through CCE-CC.
**District Health Management Teams (DHMTs)**

Each health district has a leadership structure known as the DHMTs. The health service delivery institutions include hospitals, clinics and health posts. DHMTs are the core functionaries of the Clinical Services department at the district level. The DHMTs are responsible for overseeing both primary and hospital care in the districts (Referral Hospitals are exempted from DHMTs).

**MINISTRY OF LOCAL GOVERNMENT (MLG)**

The Ministry of Local Government (MLG) is one of the three core coordinating ministries in the Botswana government, along with the Office of the President and the Ministry of Finance and Development Planning. In particular, the MLG coordinates government programmes through the office of the District Commissioners at the local level. This also includes coordination of the district HIV and AIDS response through the DMSAC.

**Department of Primary Health Care Services (DPHS)**

The DPHS coordinates the district HIV and AIDS multi-sectoral response to ensure effective implementation of HIV and AIDS programmes that is in line with national strategic guidelines and policies. The Department of Primary Health Care operates with the following objectives: HIV/AIDS multi-sectoral coordination, workplace wellness support, and HIV mainstreaming.

The Department of Primary Health Care has seconded District AIDS Coordinators (DACs) to the office of the District Commissioner as focal points for HIV and AIDS matters. The DACs also serve as the Secretariat of the District Multi-Sectoral AIDS Committees (DMSAC) and oversee CCE activities at the District level.

**Role of Primary Health Care**

- Assume leadership role for the district level response of implementation and coordination of CCE.
- Ensure manpower provision and logistics support for effective CCE implementation and institutionalization at the local level, in order to mobilize communities.
- Mobilise government, non-state actors/civil society as well as private sector organisations for buy-in into the CCE approach to help achieve high levels of adoption.
- Engage local politicians, diKgosi and village development leadership in community mobilization and participation through CCE-CCs.
- Undertake training and management of core CCE personnel such as District AIDS Coordinators, Master Trainers, CCE Project Officers, Training of Trainers (TOTs) as well as community level Facilitators.
Role of Social & Community Development

- S&CD staff such as Community Development Officers (CDOs) must adopt and mobilise communities to work through CCE-CC principles to address community concerns.
- Adopt CCE-CC in on-going implementation of community development and social protection programmes.
- Play a major role as a lead department for community development through participatory approaches to promote and support the rollout and implementation of CCE at district and village levels, in collaboration with other stakeholders.
- Take part in the training and facilitation of CCE-CC, in collaboration with other stakeholders such as DAC, CCE Project Officers, Community Conversation Facilitators and DHMTs.
- Help Community Conversation Facilitators and Health Education Assistants popularize CCE-CC at the village level.
- Help to mobilize communities to perform conversations in areas where HEAS are not posted or there are no Community Conversation Facilitators.
- Help communities appreciate both the CCE-CC and sustainable livelihoods programmes.

Department of Social Services (DSS)

The DSS focuses on social protection intervention measures and community development. The former includes programmes targeting the vulnerable groups. Examples of such programmes are destitution, remote area development, old age pension, and WWII veteran allowances. The latter component includes capacity building through community mobilization and education, social justice, community governance and economic empowerment. Community mobilisation and education requires an understanding of socioeconomic dynamics and resource endowments at the community level. It employs targeted strategies to support marginalized groups, promote interaction between different socio-economic groups, and to facilitate the development of community action plans. Participatory methodologies are employed through other extension structures including VET, VDC, VHC and VMSAC to build capacity within communities in order to respond effectively to challenges such as HIV and AIDS. Community Development defines participatory development as a process by which individuals, groups and communities develop autonomy, allowing them to transition from passiveness and submission to negotiated action.

Because community development works through participatory methodologies, DSS is seen as a key stakeholder in the rollout and implementation of CCE.

At the district and village levels, the responsibility for execution of the numerous programmes described above lies with the District Councils through the Department of Social and Community Development (S&CD).

OTHER MINISTRIES

- Ministry Of Finance and Development Planning (MFDP)

The Ministry of Finance and Development Planning is responsible for the allocation of financial resources to government ministries, and for the coordination of planning and development implementation processes. It determines budgets for the execution of National Development Plans within each of the ministries. Within its portfolio of responsibility is the coordination of rural development through the Rural Development Council (RDC).
**Rural Extension Coordination Committee (RECC)**

This is an RDC sub-committee that receives extension programmes reports, and monitors and evaluates rural development plans and their implementation. It also makes recommendations to the RDC and responsible ministries. Within the rural extension and communications sub-sector, it promotes innovative ideas, advises policy formulation and implementation and generally promotes rural development.

Perhaps most importantly, the RECC provides guidance to district and village extension structures and acts as a liaison between the ministries and the districts on matters of extension strategy and community mobilization as a tool for service delivery and development.

Over the past decade, the RECC has led the institutionalization of Participatory Rural Appraisal (PRA) as part of the tool kit for extension workers. PRA is similar to CCE as they both focus on community mobilization for effective planning and implementation of development strategies and programmes. PRA and CCE are participatory methodologies that recognize and value the importance of local people and their knowledge in planning and implementing effective interventions.

The Government of Botswana has adopted self-reliance as one of the guiding principles of development. Community Capacity Enhancement through Community Conversation (CCE-CC) supports this principle by expanding people’s participation in local government and empowering them to take charge of their own situations. CCE-CC also endorses a philosophy similar to the participatory methodology used by the Rural Extension Coordinating Committee (RECC).

**Directorate of Public Service Management (DPSM)**

The major role of DPSM in the rollout and institutionalization of CCE is through manpower support. Furthermore, it is expected that closer collaboration with the Botswana Public Service College (BPSC) shall help create opportunities for expanded CCE-CC training and institutionalization.

**CIVIL SOCIETY**

Given that the government of Botswana promotes an all-inclusive, pluralistic and participatory approach to development, non-state actors including Non-Governmental Organizations, Community Based Organizations and the Business Community are also involved in the discussions. Major development partners for Botswana have generally been active in the areas of HIV and AIDS and TB.
Volunteerism in CCE-CC Implementation

The spirit of volunteerism in Botswana has a long-standing history. Self-help programmes, or Ipelegeng, have long been a part of Botswana’s culture. Prior to independence, DiKgosi mobilised communities to undertake projects such as the construction of schools.

When CCEP was introduced in Botswana in 2004, the programme was maintained and sustained through locally recruited participants. At the time, the need for full-time facilitators was met on a temporary basis by locally appointed United Nations Volunteers (UNV), but resource constraints constrained this programme (SACI/UNDP 2005). Competition from similar programmes with incentives for volunteers decreased volunteer interest. Despite these limitations in volunteerism in Botswana, it is still believed that volunteerism can and should play a role in CCE-CC rollout and implementation. Small allowances would likely support the Community Facilitators.

Role of Volunteers

- Complement government resources and sustain CCE-CC over the long-term.
- Engage in on-going community-to-community exchange initiatives to sustain CCE-CC.
- Develop leadership skills by becoming Community Conversation Facilitators (CCFs) and thereby help grow, catalyse and sustain CCE-CC.
- Diffuse ideas on the best practices for effective prevention of the spread of HIV and AIDS.

Note: Volunteers will be funded through Ipelegeng.

A major limitation to volunteerism in Botswana is the lack of a policy framework on volunteerism. Such a policy would help guide implementation and utilisation of volunteers in Botswana.
Civil Society Organizations (CSO)

Civil Society Organisations (CSO) includes NGOs, CBOs and Faith Based Organisations or FBOs. The partnership between CSOs/NGOs and government is long-standing and has made a meaningful contribution to the overall socio-economic development of Botswana. This partnership permeates all public sectors, including the health sector. The NGOs tend to take a more flexible approach to community-based initiatives, perhaps filling a void left by the more structured governmental initiatives. Like government, NGOs often use participatory methodologies for the purpose of community mobilisation. The partnership between the government and NGOs is therefore an effective platform for the implementation of CCE-CC. CSO/NGOs are one of the lead players in the rollout and implementation of CCE-CC because they are already community based organisations that thrive on mobilisation and participation of communities for effective programmes delivery.

CCE NATIONAL COORDINATION BODY

CCE-CC National Steering Committee

Botswana has also emphasized the connection between Evidence Based Planning⁶ and Community Capacity Enhancement Programme through Community Conversations. The former is a participatory planning methodology while the latter is a participatory implementation process. Not only are both of these programmes participatory, but they also both aim at deepening impact. As a result, Botswana has determined that they both must be implemented by the same structure of coordination (i.e., the DDC and DMSAC), and it is considered logical for the same national structure to assume the role of Steering Committee for CCE-CC. The key stakeholder membership⁷ of the Steering Committee and their roles are defined as follows:

<table>
<thead>
<tr>
<th>CCE-CC National Steering Committee Membership</th>
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<tbody>
<tr>
<td><strong>Chairperson:</strong> National AIDS Coordinating Agency</td>
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<tr>
<td><strong>Deputy Chair:</strong> Ministry of Health</td>
</tr>
<tr>
<td><strong>Secretariat:</strong> Ministry of Local Government &amp; Rural Development (DPHCS).</td>
</tr>
<tr>
<td><strong>Members:</strong></td>
</tr>
<tr>
<td>Ministry of Labour and Home Affairs</td>
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<tr>
<td>Ministry of Agriculture</td>
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<tr>
<td>Ministry of Education and Skills Development</td>
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<tr>
<td>Ministry of Youth, Sports and Culture</td>
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<tr>
<td>Ministry of Finance and Development Planning</td>
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<tr>
<td>Representatives of Non-State Actors/NGOs</td>
</tr>
<tr>
<td>Development Assistance Partners</td>
</tr>
<tr>
<td>Ministry of Local Government &amp; Rural Development</td>
</tr>
</tbody>
</table>

⁶ See chapter 2 Overview for details on Evidence Based Planning
⁷ It is proposed that Directors delegate fairly senior officials as appropriate, to ensure synergy between policy and implementation, since efforts at this level focus on programmes while also providing the necessary guidance and support on the ground.
The mandate of the National Steering Committee shall be to:

- Promote community mobilization across the country
- Oversee CCE-CC implementation, institutionalization and uptake at all levels of national, district and village
- Advocate for CCE-CC institutionalization in government, non-state actors/civil organisations, private sector as well as development assistance partners
- Mobilize resources to support the NCMS strategy as well as CCE-CC implementation
- Engage civil society organizations at all levels to support and participate in the implementation of the strategy as well as CCE-CC implementation
- Facilitate streamlined and integrated coordination and implementation mechanisms for NCMS and CCE-CC
- Provide strategic guidance and support
- Assure on-going alignment of national strategy implementation with other health and development strategies, in particular the NSF II
- Guide the development and implementation of an impact measurement system and an operational research strategy.

**DISTRICT LEVEL**

In an attempt to expedite the process of rural development, the Government of Botswana also took a deliberate decision to establish various committees at the district and village level. Some of these are:

- District/Urban Development Committees (DDCs/UDCs)
- District Multi-sectoral AIDS Committee (DMSAC)
- Village Multi-sectoral AIDS Committee (VMSAC)
- Village Health Committee (VHC)
- Village Development Committees (VDCs)

These committees are expected to inform the work of the Rural Development Council (RDC), National AIDS Council, NACA and all other national coordination structures. Institutionalization of Community Capacity Enhancement Programme must be carried out by programmes in all public, non-state and community-based entities as part of their work with and within the communities. Thus the incorporation of CCE into these structures is indispensable to the overall strategy of sustainable community mobilisation.
DISTRICT/URBAN DEVELOPMENT COMMITTEE (DDC/UDC)

These committees operate under the Chairpersonship of the District Commissioner, or in some cases the Deputy District Commissioner. The DDC and the UDC are the most significant organisation at the district level for the coordination of development activities. The DDC/UDC provides strategic leadership in the coordination of all development activities at the district level.

The committees are comprised of heads of departments of line ministries at the district level. This includes the directors of para-statal structures, NGOs and private sector representatives. The heads of departments or Sector representatives consult with their respective sectors prior to and after each DDC/UDC to update them on pertinent issues arising from their sectoral reports. The DC/DDC has the authority to invite any person or institution to the DDC/UDC to contribute to the discussions.

Role of DDC

- Provide overall monitoring and guidance on CCE implementation through District Extension Team (DET) & DMSAC operations. The DET is a sub-committee of DDC and is constituted by all heads of extension departments at the district level.
- Focus on CCE-CC as it relates to all other multi-stakeholder programmes (DET) and on implementation in the health sector, particularly HIV and AIDS (DMSAC).

DISTRICT MULTI-SECTORAL AIDS COMMITTEE (DMSAC)

DMSAC is the multi-sectoral body for coordinating the district response to the HIV and AIDS epidemic. This includes the planning of HIV and AIDS activities and the monitoring and evaluation at the district level. It is comprised of representatives from all the government sectors as well as representatives from the civil society.

Role of DMSAC

- Monitoring of CCE implementation.
- Oversight of CCE implementation.
- Refining the skill base of CCE operatives.
- Advocacy for adoption of CCE in community mobilization in the fight against HIV/AIDS.
- Providing linkages between the districts, villages and national structures in CCE implementation.
- Resource mobilisation.

TECHNICAL ADVISORY COMMITTEE (TAC)

The TAC provides technical advice to the DMSAC on HIV/AIDS issues, facilitates the EBP process and serves as a district steering committee for CCE.

Role of TAC

- Provide overall oversight of quality CCE–CC implementation on behalf of DMSAC.
- Monitor and evaluate CCE–CC initiatives and advise DMSAC.
- Advocate for use of CCE–CC as an approach to promote community participation in the district HIV and AIDS response.
- Link EBP and CCE–CC (ensures appropriate use of CCs to address issues identified through EBP process, and inclusion of activities emanating from CCs into the district EBP).
THE DISTRICT HEALTH MANAGEMENT TEAM

The department of Clinical Services is capable of implementing CCE-CC through the DHMT structure throughout the districts. DHMTs are the frontline operatives of the health sector at the local and village levels where there is a high level of interaction with communities at hospitals, clinics and health posts. Through the use of CCE-CC approach, DHMTs are better placed to mobilize communities for their full participation and implementation of the numerous health sector intervention programmes.

Role of DHMTs

- As the lead personnel in health education matters at the district level, DHMTs must assume the lead role of CCE dissemination, facilitation and implementation.
- The District Health Education Officer is also expected to play a major role in capacity building, training and resource mobilization and provision for effective CCE implementation in collaboration with other key CCE drivers such as CCE Project Officer, DAC and DMSAC.
- Responsibility for CCE-CC dissemination, facilitation and implementation at the village levels will be assigned to health education assistants at clinics, in close collaboration with other stakeholders such as VMSAC, CCE Facilitators, Village Health Committees, Village Development Committees and Village Extension Team members. This cadre must be fully trained in CCE-CC to assume permanent facilitation responsibilities at village levels. This will help minimize dependence on facilitators that fall outside permanent employment of government, who contribute to high attrition levels of facilitators for the CCE.
- Provide regular reporting linkages on CCE to the Director of Clinical Services at the Ministry of Health.

VILLAGE LEVEL

The District Multi-Sectoral AIDS Committee is replicated at the Village level with the Village Multi-Sectoral AIDS Committees. The functions of VMSAC are the same as those of DMSAC, except that the focus is at the village level.

VILLAGE/WARD MULTI-SECTORAL AIDS COMMITTEE (V/WMSAC)

The V/WMSAC is the driving force behind the planning, coordination and monitoring of HIV and AIDS activities at village/ward level. It is the voice of advocacy for the community in matters relating to stigma and discrimination of PLWHA and other barriers that impede the HIV and AIDS response. It also mobilises resources to strengthen community capacity on HIV and AIDS responses at the local level. It is comprised of representatives from Tribal Administration, NGOs, CBOs, Parents Teachers Association (PTAs), VDCs/WDCs, VET, Farmers’ Committee, Traditional Healers’ Association, AIDS Support Groups, CHBC, VHC, Business Community, Men Sector and Councillors. The chairperson and deputy are chosen by consensus of the committee members (District Planning Handbook, 2007).

SETTINGS/FORUMS FOR CCE-CC

Apart from the Kgotla, there are various other forums and settings for CCE-CC rollout, including churches, beer halls/Shebeens, sports forums, youth forums, schools and other settings (e.g., Metshelo, baby showers).

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8 Cases have been reported around the country where the shebeen-queens close for an hour or so to ensure participation of her patrons in CCs. This is the context in which the shebeen is cited as alternative and potential forum for CCE rollout.
CCE-CC RESOURCING

DEPARTMENT OF PRIMARY HEALTH CARE SERVICES:

This is the focal point for the district multi-sectoral response in the country and should be in the forefront of CCE implementation in the fight against HIV and AIDS transmission. The Department is already undertaking this leadership role, especially at the local level. What is required is a consolidation of all CCE personnel through the creation of permanent posts for CCE-CC staff at a departmental level.

DEPARTMENT OF HIV AND AIDS PREVENTION AND CARE:

This department is the focal point for all Clinical HIV and AIDS programmes. The Department should adopt CCE-CC fully, train all programme leaders in CCE-CC and ensure its adoption for effective community mobilization in all HIV and AIDS programmes in the country through District Health Management Teams (DHMTs) and DMSAC.

DEPARTMENT OF PUBLIC HEALTH:

This Department is charged with the responsibility to coordinate all public health programmes. This Department is a focal point for Health Education. The Department already implements one participatory methodology called PHAST for sanitation programme. CCE-CC as a communications methodology should be adopted here and funding should be sought through the normal recurrent budgeting process to facilitate the national rollout of CCE-CC. Resources should be provided to enable District Health Officers and Health Education Assistants to implement and sustain CCE-CC at the District and Village levels.

DEPARTMENT OF LOCAL GOVERNMENT DEVELOPMENT PLANNING (DLGDP):

This Department is expected to embrace CCE in order to mainstream its components into district level planning, in particular community participation and enhancement of bottom-up planning. The potential for DLGDP to assist with funding for CCE support may be explored through programmes such as Ipelegeng. Although in principle CCE facilitation is based on the spirit of volunteerism, in reality this is difficult to sustain. The potential for utilization of Ipelegeng programme funding will therefore help sustain CCE as will provide income earning opportunities for youths and other community members.

DONOR SUPPORT AND RESOURCE MOBILIZATION:

International Partners and Donors should continue to support CCE-CC in order to make meaningful a contribution to the reduction of new HIV and AIDS infections, as per objectives of the 2nd Botswana National Strategic Framework on HIV and AIDS (2010-2016). The NACA and MLG should continue to flag CCE-CC as the ultimate methodology to advance the NCMS agenda.
The system for implementation of CCE-CC is depicted in Figure 4 summarising the relationships between health policy, HIV and AIDS prevention and care, and mechanism for implementation of CCE-CC. The system shows tiers of governance starting from the centre at national to district and village levels, where CCE-CC implementation takes place. Furthermore, the above figure depicts coordinated multi-level and multi-sectoral system that easily lends itself to assume the role of CCE coordination.
CHAPTER 5

CCE-CC IMPLEMENTATION FRAMEWORK

In order to implement CCE-CC most effectively, the following Step-by-Step Approach is necessary to ensure standardization, direction and coordination of efforts among the various stakeholders:

1. Conduct Enrolment and Facilitate Buy-In
2. Build and Develop Capacity
3. Convene Conversations
4. Document Approach
5. On-site Support
6. Share Knowledge

The steps are presented in the chronological manner in which they must be executed and are further described below.

Step-by-Step Approach

1. CONDUCT ENROLMENT

This is a process of ensuring buy-in, stakeholder mobilization, sustainable relationships and momentum at all levels of national, district community leadership, and civil society and private sector organizations. There are numerous stakeholders in Botswana directly and indirectly involved in HIV and AIDS care, support and prevention. These are key stakeholders in the implementation and sustainability of CCE approach. It is therefore important to identify these at the start of implementation and ensure their buy-in. In the context of Botswana these stakeholders are classified and identified as follows:

At the National Level:

- Parliament, Ntlo Ya Dikgosi, Ministries, departments and committees (Ministries of Health, Local Government, Office of the President – NACA; Departments of Primary Health Care, CCE Implementation Steering Committee).
- Civil Society Organisations/Non-government organizations and development assistance partners
- Private Sector organisations (i.e., BOCCIM)
At the District Level:

- District/Local Authorities (Councils, District Administration, Tribal Administration). Buy-in of councillors and dikgosi is important to ensure community mobilisation through community leadership
- District level central government departments
- Committees for the coordination of HIV and AIDS programmes and intervention measures (DMSAC, DDC, DET)
- Non-government organizations representatives

At the Village Level:

- Headmen, Councillors
- Extension staff aligned to health and HIV and AIDS intervention measures and programmes
- Committees (VMSAC, Village Extension Teams, Village Health Committees and Village Development Committees)
- Non-government organizations village level representatives

Facilitate Buy-In:

There are many ways to facilitate buy-in of CCE-CC from public sector, donor agencies, development partners, private sector and civic organisations, including the following:

- Develop an advocacy strategy to mobilize, launch and brand CCE to private sector organizations such as BOCCIM. For example, the business community may donate food rations to CCs groups and volunteer facilitators as motivation or reward for their community work.
- Train civic, NGO and CBO organizations such as BOCONGO, BONEPWA, BOCOBONET and BONASO on the principles of CCE in order to enhance networking. This is important because these organizations are potential implementing partners and have expressed their willingness and readiness to be part of the CCE initiative. Furthermore, the participation of these partners in CCE training and dissemination may help change their mind-set for approaching communities towards one of genuine collaboration and community participation.
- Urge development assistance partners to strive for a balance between promoting their interests and those of the beneficiaries. This is consistent with motivating communities towards the CCE philosophy, ‘The Answer Lies Within.’
- Align donor partners to the CCE methodology to mitigate any confusion resulting from different community mobilization methodologies. A good alignment of the activities of development partners to goals, strategies and objectives of government policies and the national and district development plans will greatly enhance the partnership between government and non-state actors.
- Ensure the government recognizes partners’ input and role. The government must be reciprocal and consider non-state actors as equals in this partnership.

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9 BOCONGO = Botswana Council of Non-Governmental Organizations’ BOCOBONET = Botswana Community Based Organizations Network; BONASO = Botswana Network of AIDS Service Organizations.
2. DEVELOP AND BUILD CAPACITY

This stage entails transferring CCE-CC skills, concepts and tools and improving HIV/AIDS understanding at the individual, community and organizational levels, as well as stimulating group dynamics and partnerships and the Community Conversations methodology and the implementation of this approach.

This stage also involves the organization and execution of the CCE training and dissemination. This may occur at the national, district and at village levels. These preparations are predominantly logistical, involving the establishment of budgets for workshops, workshop venues that are accessible to participants and local communities as well allowing for fieldwork during training sessions. The participants are drawn from the communities, local authorities and other stakeholders such as non-state actors and field officials of various ministries and departments.

❖ TRAIN TRAINERS: The capacity building sessions are held at two levels. One level is skills building for trainer of trainers (ToTs) and the other level is skills-building for community facilitators.

❖ MASTER TRAINERS: All stakeholder institutions should identify staff members who are at the supervisory level and have good communication skills to be trained as master trainers. It is important to enlist personnel at the supervisory level because they are already familiar with how their system works and they can provide mentorship.

❖ TRAINERS OF TRAINERS (TOT’s): The trainers should be personnel as well but based at the National and District levels.

❖ COMMUNITY CONVERSATION FACILITATORS:
A Community Conversations facilitator should preferably be a member of that particular community who is knowledgeable in the culture and language of the community and the HIV/AIDS issues impacting it and who shows commitment in working with the community, as well as upholding the belief that communities have the capacity to identify needed changes and own and share these changes.

❖ INVOLVE TRAINING INSTITUTIONS: Institutions that already train extension workers as part of their core mandate should be approached to incorporate CCE-CC training into their curriculum. This will help to strengthen domestication and adapt UNDP Manual to the Botswana environment. These institutions are the following:

* Institute of Health Sciences (IHS)
* University Botswana’s Centre for Continuing Education,
* Botswana College of Agriculture’s CICE
* IDM, Civil Service College, BNPC
Lead Personnel in CCE-CC Implementation

There are several personnel with chief roles in CCE-CC implementation, including Master Trainers, Trainer of Trainers, CCE-CC Programme Officers and CC Facilitators. Their relationships and hierarchy are outlined in Figure 6 and their roles are detailed below. In addition, a detailed outline of the roles and responsibilities all stakeholders involved in CCE-CC implementation and their Terms of Reference can be found in Annex 1.

Role of CCE Master Trainers

- Develop, customize or adjust training content and schedule in close collaboration with MLG, MoH and other key stakeholders
- Provide technical assistance and support (mentoring and coaching) to the district Project Officers and TOTs
- Serve as a national resource for training on CCE-CC; support districts in training TOTs and CC facilitators under MLG guidance
- Bring to the notice of MLG any improvement/refinement needed in CCE-CC manual as well as the CCE-CC delivery mechanism (implementation)
- Conduct training in CCE-CC using methods and tools in accordance with the standardized programme, practices and standards
- Submit training reports indicating information on participants, summary of the content covered and outcomes-challenges/issues to be addressed
- Conduct CCs as well as providing support to facilitators in CCs execution
Role of DAC:

- Ensure capacity building for TOTs and CCFs
- Provide overall oversight and technical support for quality CCE-CC implementation
- Facilitate continuous stakeholder relationship
- Ensure that CCE is a standing agenda item for TAC meetings
- DACs are pivotal in ensuring not only CCE-CC implementation, but also linking it to Evidence-Based Planning

Role of CCE-CC Programme Officers:

- Coordinate CCE-CC at the district level
- Supervise TOTs and CCE-CC facilitators
- Provide technical expertise to communities once initiatives are identified
- Serves as community liaison on matters relating to CCE-CC
- Compile monthly reports
- Convene TOTs and CCF meetings
- Facilitate CCs

Role of CCE Trainers of Trainers (TOTs):

- Assist in the identification and training of CCE-CC facilitators
- Facilitate Community Conversations
- Support Community Facilitators
- Attend district level CCE-CC Committee (i.e., TAC)

Role of CC Facilitators:

- Mobilise communities for CCE-CC
- Facilitate CCE-CCs
- Serve as community liaison on matters relating to CCE-CC
- Drive community initiatives
- Ensure quality documentation during CCE-CC

3. CONVENE COMMUNITY CONVERSATIONS

An important part of CCE-CC is the process of facilitation. Facilitation refers to the simplification of CCE-CC in such a manner that it is easy to understand and apply. In this regard, the carrying out of facilitation must be done by skilled and trained facilitators. For example, during Community Conversations, a skilled facilitator ensures that all the views and perspectives of participants are heard equally and without prejudice. CCE-CC approaches HIV and AIDS challenges with a community-driven mind-set, through which each individual – rich, poor, young or old – identifying, exploring and making decisions about what social changes are needed. This inclusive process requires the respect, recognition and acceptance of differences, and strengthens the community or group’s social capital.
The communities may decide how many conversations to convene per village, per month, however the frequency should be reasonable to maintain the momentum and continuity. This is important to achieve in order to progress and accelerate implementation of CCE-CC. However, it is acknowledged that in some instances the process of facilitation and conversations themselves may take longer than anticipated and make this target unachievable.

4. DOCUMENT CCE-CC IMPLEMENTATION

Each step of the CCE-CC process must be accompanied by a verbatim report. Where possible; photos, maps and other community designated illustrations such as songs and play-drama are used to document CCE-CC. The choice of the type of documentation must reflect community preferences. Documentation is an on-going part of this approach that provides information on activities, outcomes, decisions and changes, outputs such as community maps and schedules.

5. ON-SITE SUPPORT

Once started, Community Conversations is an on-going process that requires continuous support to sustain the momentum towards achieving CCE-CC results. It is the duty of the DAC office to provide regular onsite support at least on a monthly-basis (this can be varied according to the demands on the ground).

Through this support, the Master Trainers will be able to:
* Reflect with the facilitators on the community capacity and their own concerns relating to HIV and AIDS.
* Review with facilitators the skills and tools acquired in the training.
* Explore with community members and facilitators the process dynamics of Community Conversations.
* Identify other health and social development issues that have emerged as a result of Community Conversations.
* Meet with various stakeholders on issues raised and decisions taken during Community Conversations.
6. SHARE KNOWLEDGE

During implementation of CCE-CC, Community-To-Community Exchange visits will be organized as part of learning and transfer process at the village level. Small teams from a community CC team will go from one implementation point to another to share, observe and transfer knowledge, know-how and experiences. These visits are not evaluative, but are tools for strengthening the process and skills of facilitators as well as encouraging communities in their efforts.

At the national level, an Annual Conference should be held to share experiences with CCE-CC implementation across the country. The participants should be drawn from all communities and organizations that have been implementing the CCE-CC approach. The conference will provide the opportunity for stocktaking, setting up direction for scaling up and the expansion of partnerships. The overall documentation of the approach across the country shall be consolidated and presented at the gathering.

In addition to the national conference, initial conferences could be held at district and regional levels as build-up to the national one. This should be based on a competitive system with reward mechanisms for the three stages. The reward will go to the best Community Conversation group with the best initiatives and actions plan. This competitive system is expected to motivate participating communities around the country to do best, thus catalysing CCE-CC rollout, adoption and implementation.
CHAPTER 6
MONITORING AND EVALUATION

To realize the maximum benefits from CCE-CC, there is a need for closer monitoring and evaluation of the methodology. As the goal is to effect behavioural change, monitoring needs to focus on whether the approach is yielding the expected benefits. The programme needs to come up with appropriate indicators to be used for monitoring and evaluation. A concerted monitoring would help in identifying and prioritizing gaps where immediate attention is needed. The monitoring and evaluation component of this approach is expected to achieve the following:

- To establish a programme database of all conversations
- To support conversation groups
- To document programme successes and challenges
- To showcase a consolidated effort of all CCE-CC activities across the country
- To determine the contribution of identified factors in the spread and reduction of HIV and AIDS

The monitoring and evaluation should take place at different levels. At community level, where CC’s are conducted, there should be continuous monitoring of the CC’s as the process unfolds. This starts with continuous documentation of community conversations as they unfold. Whilst there will be differences per conversations, the monitoring need to be as standardized as possible to permit for easy district level and national level reporting.

As the overall objective is to have an impact at individual and community level, measurable achievements need to be realized here for the programme to bear fruits.

There will also be quarterly district level and national level monitoring of the CC’S activities. This monitoring will concentrate more on the process and administration of the approach and will be followed on an annual basis by a behavioural survey that checks on any changes in the customary norms of the community.

For effective monitoring and evaluation, discussion group facilitators will play an active role in collating CC’s activities. They will work closely with Health Education Assistants and other local organizations in the respective communities. At the district level, AIDS Coordinators will be responsible for overseeing monitoring and evaluation. The CCE-CC Officers will take responsibility for the district behavioural survey that maps the programme outcome. For all these levels, a clear systematic and largely standardized method and indicators is needed.

For an effective and efficient monitoring and evaluation system, all the necessary levels need to be capacitated to perform optimally. All stakeholders in the CCE-CC processes need to be trained in monitoring and evaluation that emphasizes standardized recording, data collecting and reporting.

There is need for clarity of roles as several stakeholders are involved in the community mobilization process and in particular with the CCE-CC process. These stakeholders include; Ministry of Health, Ministry of Local Government, National AIDS Coordinating Agency, Community-Based Organizations, District Multi-Sectoral AIDS Committee, Village Multi-Sectoral AIDS Committee and others.

The annual evaluations are strategic in showing the effectiveness of CCE-CC as they map the outcome of the programme. They will need to be corroborated through a larger national survey in the form of the periodic Botswana AIDS Impact Survey.
MONITORING CCE OUTCOMES

There is need to devise easy and user-friendly methods and indicators for tracking behavioural change. The methods and indicators need to be aligned across conversations and communities to permit them to feed on each other for a broader and more consolidated impact measurement while still allowing for case specific diversity. Communities must relate to impact measurement and appreciate the benefits accruing from such measurement. Those working on impact tracking must adopt a bottom-up approach where communities at all levels drive inquiry and can immediately realize the benefit of pursuing such an approach. This must be an on-going effort that will not overwhelm and burn-out implementers. The successes realised through these efforts serve as motivation to deal with other concerns.

**Table 1: Monitoring Programme**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Target Group</th>
<th>Output</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship building</td>
<td>Facilitator, Community</td>
<td>Relationship built</td>
<td>Enhanced participation</td>
</tr>
<tr>
<td>Identification of problem issues</td>
<td>Facilitator, Community, Civic society</td>
<td>Identified and prioritized issues</td>
<td>Problems identified</td>
</tr>
<tr>
<td>Further exploration of factors driving identified problems</td>
<td>Facilitator, Community, Civic society</td>
<td>Underlying factors identified</td>
<td>Enhanced participation</td>
</tr>
<tr>
<td>Prioritization of problems</td>
<td>Facilitator, Community, Civic society</td>
<td>Priorities set</td>
<td>Enhanced participation</td>
</tr>
<tr>
<td>Implementing the prioritized actions</td>
<td>Facilitator, Community, Civic society, MLG, MOH, NACA, etc.</td>
<td>Actions implemented Momentum maintained</td>
<td>Enhanced participation</td>
</tr>
<tr>
<td>Maintaining momentum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reviewing and learning from experiences starting new CCs</td>
<td>Facilitator, Community, Civic society</td>
<td>Reviewed conversations New CC cycles</td>
<td>Active participation Behaviour change</td>
</tr>
<tr>
<td>Objective</td>
<td>Activities</td>
<td>Output</td>
<td>Indicator</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>To involve relevant stakeholders at national, district and village levels</td>
<td>Re-launch Enrolment of various stakeholders</td>
<td>Stakeholder Buy-in</td>
<td>No. enrolled</td>
</tr>
<tr>
<td>To train Master Trainers and Community Facilitators</td>
<td>Training</td>
<td>Trainers and facilitators</td>
<td>No. trained</td>
</tr>
<tr>
<td>To align CCE with other interventions used by civic society</td>
<td>Identification of other complementary interventions</td>
<td>Alignment</td>
<td>No. of interventions</td>
</tr>
<tr>
<td>To facilitate Community Conversations</td>
<td>Initiation of CC’s operating</td>
<td>Open discussion</td>
<td>No. CCs operating</td>
</tr>
<tr>
<td>To host community to community conversations</td>
<td>Annual community to community conversations</td>
<td>Exchange visits Shared</td>
<td>No. of exchanges</td>
</tr>
<tr>
<td>To host annual consultative national conference</td>
<td>Annual CCE-Pitso</td>
<td>Standardisation issues identified</td>
<td>Pitso undertaken</td>
</tr>
</tbody>
</table>
Programme Monitoring

- Regular and continuous CC data capturing
- The monitoring need to be as standardized as possible to permit for ease of district level and national level reporting.
- There will also be quarterly district level and national level monitoring of the CC’s activities.
- An annual behavioural survey that checks on any changes in the customary norms of the community.
- At district level District AIDS Coordinators will have the responsibility of district level monitoring and evaluation.
- The CCE-CC Officers will review the survey reports and take responsibility for the district behavioural survey that maps the programme outcome.

CCE-CCs in Session
### ANNEX 1: STAKEHOLDER ROLES AND RESPONSIBILITIES IN CCE IMPLEMENTATION

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Roles and Responsibilities</th>
</tr>
</thead>
</table>
| National AIDS Coordinating Agency (NACA), OP | ❖ Provide leadership and coordination of the implementation of NCMS  
❖ Ensure synergy and alignment in the NCMS implementation and evaluation with other national HIV and AIDS strategies and programmes  
❖ Facilitate building of strategic partnerships as well as involvement of all key stakeholders in NCMS and CCE-CC rollout and implementation |
| Department of Primary HealthCare Services (DPHC), MLG | ❖ Assume leadership role for the district level response regarding implementation and coordination of CCE-CC. This is done in close cooperation with HIV/AIDS Prevention and Care as well as Public Health departments of the Ministry of Health  
❖ Ensure manpower provision and logistics support for effective CCE-CC implementation and institutionalization at the local level, in order to mobilize communities in the fight against HIV/AIDS transmission  
❖ Mobilise government, non-state actors/civil as well as private sector organisations for buy-in into the CCE-CC approach and help achieve high levels of its adoption in the communities  
❖ Mobilise local politicians, dikgosi and village development leadership to help in community mobilization and participation through CCE-CCs  
❖ Undertake training and management of core CCE-CC personnel such as District AIDS Coordinators, Master Trainers, CCE-CC Project Officers, Training of Trainers (TOTs) as well as community level Facilitators |
| Department of HIV and AIDS Prevention and Care (DHAPC), MoH | ❖ Because CCE-CC is an effective community mobilization tool, its adoption by DPH in the rollout of these programmes is expected to yield positive results in terms of increased uptake.  
❖ Through facilitation of Community Conversations (CCs), communities shall be given the opportunity to introspect on these intervention measures and identify challenges hampering their implementation and how these can be addressed  
❖ The experience of DHAPC in behaviour change must be harnessed to complement the efforts of MLG and other stakeholders in CCE rollout  
❖ DHAPC shall train CCE-CC personnel in standards and protocols of HIV and AIDS programme delivery in order reinforce implementation of CCE-CC  
❖ DHAPC through its advocacy and community sensitisation skills shall reinforce community mobilisation through CCE-CC |
| Department of Public Health (DPH), MoH | ✤ Assume leadership in CCE-CC dissemination and facilitation because of its comparative advantage in information, education and communication (IEC)  
✤ Because of CCE-CC strength as a community mobilization tool, the department has adopted CCE-CC in the implementation of public health and education programmes  
✤ As a leader in public education and mobilisation, the department must engage and mobilize stakeholders inside and outside government for CCE-CC buy-in and implementation |
| Department of Clinical Services (DCS), MoH | ✤ The District Health Education Officer as the lead officer in health education matters at the district must assume the role of CCE-CC dissemination, facilitation and implementation. The District Health Education Officer is also expected to play a major role in terms of capacity building, training and resource mobilization and provision for effective CCE-CC implementation at the district level. This will be done in collaboration with other key CCE-CC drivers such as CCE-CC Project Officers, DAC and DMSAC  
✤ Health Education Assistants at Clinics to be assigned responsibility for CCE-CC dissemination, facilitation and implementation at the village levels. This will be done in close collaboration with other stakeholders such as VMSAC, CCE-CC Facilitators, Village Health Committees, Village Development Committees and Village Extension Team members  
✤ This cadre, whose primary responsibility is public health education, must be fully trained in CCE-CC to assume permanent responsibilities of facilitator role at village levels. This will help minimize dependence on facilitators that fall outside permanent employment of government, who therefore contribute to high attrition levels of facilitators for the CCE-CC  
✤ DHMT to provide regular reporting linkage on CCE-CC to the Clinical Services at the Ministry of Health |
| Department of Local Government Development Planning (DLGDP), MLG | ✤ Mainstream CCE-CC methodology into the district and village level development planning process and thus entrench the beneficial principles of CCE-CC methodology  
✤ Through Ipelegeng programme, this department may provide potential to fund and support Community Conversations efforts in order to sustain interest of communities in CCE-CC |
| Social and Community Development (Councils) | ✤ At the village level, Community Development Officer (CDOs) must adopt and mobilise communities to work through CCE-CC principles to address community concerns, including HIV and AIDS spread  
✤ Because CCE-CC is a participatory methodology for community mobilisation and development, DSS is expected to adopt CCE-CC in its on-going implementation of its various programmes  
✤ As a lead department in matters of community development through participatory approaches, S&CD is also expected to assume leadership, in collaboration with other stakeholders, to promote and support the rollout and implementation of CCE-CC at district and village levels  
✤ Council based staff of S&CD (CDOs) are also expected to take part in the training and facilitation of CCE-CC in collaboration with other stakeholders such as DAC, CCE-CC Project Officers, Community Conversation Facilitators, DHMTs |
| National Steering Committee | To promote community mobilization across the country  
To oversee CCE-CC implementation, institutionalization and uptake at all levels of national, district and village  
To play advocacy role for CCE-CC institutionalization in government, non-state actors/civil organisations, private sector as well as development assistance partners  
To mobilize resources to support the NCMS strategy as well as CCE-CC implementation;  
To mobilize and engage civil society organizations at all levels to support and participate in the implementation of the strategy as well as CCE-CC implementation  
To facilitate streamlined and integrated coordination and implementation mechanisms for NCMS and CCE-CC  
To provide strategic guidance and support  
To assure ongoing alignment of national strategy implementation with other health and development strategies, in particular the NSF II  
To guide the development and implementation of an impact measurement system and an operational research strategy |
| Rural Extension Coordinating Committee (RECC), Rural Development Council, MFDP | RECC to assume government-wide advocacy role of CCE-CC adoption as a major extension tool for community mobilization. This will also raise the uptake of CCE-CC across other sectors apart from HIV and AIDS programme implementation. As CCE profile rises, CCE-CC will catch the attention of decision makers and thus attract further resource support and adoption  
Through the RECC Training sub-committee, a programme for training of CCE-CC master trainers across government wide extension service should be formulated and adopted  
In collaboration with key stakeholders, RECC is expected to identify suitable pre and in-service training institutions and agencies for CCE-CC institutionalisation and training across government extension machinery |
| District Development Committee (DDC) | Because the DDC oversees all development programmes at the district level, it is well positioned to provide overall monitoring and guidance on CCE-CC implementation  
The DDC will undertake this role through District Extension Team (DET) & DMSAC operations. The DET is a sub-committee of DDC and is constituted by all heads of extension departments at the district level  
Promote multi-stakeholder approach to HIV and AIDS |
| **District Multi-sectoral AIDS Committee (DMSAC)** | - Monitoring of CCE-CC implementation  
- Oversight of CCE-CC implementation  
- Refining the skill base of CCE-CC operatives  
- Advocacy role for adoption of CCE-CC for community mobilization in the fight against HIV/AIDS  
- Provide linkage between the districts, villages and the national structures in CCE-CC implementation  
- Promote multi-stakeholder approach to the fight against HIV and AIDS |
| **District Health Management Teams (DHMTs)** | - See Department of Clinical Services above |
| **District Extension Teams (DETs)** | - Complement DMSAC efforts through CCE-CC focus on non health sector adoption of CCE-CC process  
- Advocate and adopt CCE-CC methodology to reinforce existing participatory approaches for community mobilisation  
- Report to DDC on progress relating to CCE-CC implementation |
| **Village Multisectoral AIDS Committee (VMASC)** | - This is the driving force of planning, coordinating and monitoring of HIV and AIDS activities at village/ward level  
- It is the voice of advocacy for the community in matters such as those of stigma and discrimination of PLWH and other barriers that impede the HIV and AIDS response  
- It also mobilises resources to strengthen community capacity on HIV and AIDS responses at the local level |
| **Village Extension Teams (VETs)** | - Complement efforts of VMSAC and VHC to mobilise communities toward CCE-CC  
- Advocate for and adopt CCE-CC as one of the major community consultation and mobilisation tool |
| **Village Leadership (Kgosi, MP, Councillor & VDC)** | - Advocate for CCE-CC adoption as an effective community mobilisation tool for all development effort, including steps to reduce HIV and AIDS spread  
- Provide leadership for CCE-CC buy-in among their communities in an objective and non-partisan context  
- Provide encouragement and support for community participation in development through CCE-CC |
<table>
<thead>
<tr>
<th>Civil Society Organisation/NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ CSOs/NGOs are one of the lead players in the rollout and implementation of CCE-CC because they are already community-based organisations that thrive on mobilisation and participation of communities for effective programmes delivery</td>
</tr>
<tr>
<td>❖ CSOs/NGOs must participate in the training and facilitation of Community Conversations in collaboration with other stakeholders</td>
</tr>
<tr>
<td>❖ Because of the flexibility and focus on niche communities by NGOs, they are expected to effectively rollout CCE-CC to remote communities</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Donor Assistance Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ Financial resources mobilisation and support to various CCE-CC activities</td>
</tr>
<tr>
<td>❖ Provision of technical assistance for the support of all CCE-CC initiatives</td>
</tr>
<tr>
<td>❖ Sponsor capacity-building needs for sustainable CCE-CC rollout and implementation</td>
</tr>
<tr>
<td>❖ Provide opportunities for international networking and exchange of experiences on CCE matters</td>
</tr>
</tbody>
</table>
ANNEX 2: REFERENCES

Government of Botswana

Ministry of Finance and Development Planning
National Development Plan (2010)

Ministry of Local Government
District Planning Handbook 2011 (Unpublished)
DMSAC Communication Strategy (2011)

Ministry of Health
Botswana Medium Term Plan II (1997-2002)
DHAPC, Ministry of Health (2011)

NACA

Others

NASTAD
Evidence Based Planning Toolkit (2012)

Other Countries
National social mobilization strategies and implementation and training manuals of other countries in the region

UNDP
Community Capacity Enhancement Strategy Note (2005)
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>M. Balosang</td>
<td>Executive Director</td>
<td>NASTAD</td>
</tr>
<tr>
<td>E. M. Gower</td>
<td>Planning and CCE Manager</td>
<td>NASTAD</td>
</tr>
<tr>
<td>S. Ludick</td>
<td>Director</td>
<td>DPHS, MLG</td>
</tr>
<tr>
<td>K. Maapatsane</td>
<td>Chief Health Officer</td>
<td>DPHCS, MLG</td>
</tr>
<tr>
<td>K. Kgwaraga</td>
<td>Principal Programme Officer</td>
<td>DPHCS, MLG</td>
</tr>
<tr>
<td>R. M. Radibe</td>
<td>Acting Director</td>
<td>Social Services, MLG</td>
</tr>
<tr>
<td>R. Dimbungu</td>
<td>Chief Economist</td>
<td>NACA</td>
</tr>
<tr>
<td>P. Chibatamoto</td>
<td>National AIDS Advisor</td>
<td>NACA</td>
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<tr>
<td>CC. Nfila</td>
<td>Chief Health Officer</td>
<td>DCS, MoH</td>
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<td>S. Sebetso</td>
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<td>M. Galeemelwe</td>
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