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Towards Improved Management of HIV Prevention Activities:

Practical Experiences from the Capable Partners (CAP) Botswana Project

Capacity Building Series

CAPABLE PARTNERS PROGRAM

Botswana

FHI 360

FHI 360 is a global development organisation with a rigorous, evidence-based approach. Our professional staff includes experts in health, nutrition, education, economic development, civil society, environment and research. FHI 360 operates from 60 offices with 4,400 staff in the United States and around the world.

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Capable Partners (CAP) project

Capable Partners is a USAID-funded project that supports the Botswana government's efforts to mitigate HIV. The CAP project promotes organisational development and capacity building through networking and technical support.

CAP partners with non-governmental organisations (NGOs), faith-based organisations (FBOs) and community-based organisations (CBOs) on HIV prevention services under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and Peace Corps engagement in PEPFAR programmes.

The CAP project also supports monitoring and evaluation of grantees and sub-grantees, routine training on HIV prevention interventions, and the development and dissemination of behaviour change tools. Strengthening communities towards sustainability is the over-riding goal of the CAP project.

Foreword

This publication is part of a *Capacity Building Series* documenting the experiences of the Capable Partners Botswana project in organisational development, and building the technical capacity of local civil society organisations in HIV Prevention, from 2008-2011. It is widely recognised that a strong civil society is essential for a successful and sustained response to the HIV and AIDS epidemic in Botswana. Much debate has taken place around the limited capacity of civil society in Botswana, and to date there have been only a few success stories. We are therefore pleased to introduce you to this *Capacity Building Series* which features real life experiences of civil society organisations in Botswana actively participating in their own capacity enhancement, and forging stronger and more effective organisations as a result. While the Capable Partners Botswana project contributed a solid capacity building model together with expert facilitation and tools, we believe it is the enthusiastic participation and ownership of the process by our local partners, which has been the most important ingredient for success.

As we look beyond the end of this project, we thank USAID for the opportunity to contribute to civil society strengthening in Botswana. We wish our partners and other civil society organisations every success in achieving their mandates, and hope this and other publications in the *Capacity Building Series* will prove useful in strengthening organisations, and, by doing so, improve the quality and sustainability of the response to the HIV and AIDS epidemic. Several individuals and institutions have contributed to the case studies, guidance and tools outlined in this and other documents in the series. Particular thanks is given to Digital Creations for their work in development of the publication. Also, we would like to thank Young Women's Friendly Centre (YWFC), and Botswana Christian AIDS Intervention (BOCAIP) for their participation in the development of the case studies. We thank all involved for their commitment and insights.

Mike Merrigan, Dr. PH
Chief of Party
FHI Development 360 Botswana

This Guideline has been made possible by the generous support of the American people through the United States Agency for International Development (USAID).

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMEST	African Methodist Episcopal Services Trust
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
BAIS	Botswana AIDS Impact Survey
BBCA	Botswana Business Coalition against HIV and AIDS
BCC	Behaviour Change Communication
BNAPS	Botswana National HIV and AIDS Prevention Support
BOCAIP	Botswana Christian AIDS Intervention Programme
BONEPWA	Botswana Network of People Living with HIV and AIDS
CAP	Capable Partners
CBO	Community-Based Organisation
CSO	Civil Society Organisation
DAC	District AIDS Coordinator
DBES	Department of Building and Engineering Services
DMSAC	District Multi-Sectoral AIDS Committee
DQA	Data Quality Audits
DSD	Delayed Sexual Debut
EFB	Evangelical Fellowship of Botswana
FBO	Faith-Based Organisation
GBV	Gender-Based Violence
GoB	Government of Botswana
HCT	HIV Counseling and Testing
HICD	Human and Institutional Development
HIV	Human Immunodeficiency Virus
HPP	Humana People to People
IEC	Information Education and Communication
KAP	Knowledge, Attitude and Practice
M&E	Monitoring and Evaluation
MCP	Multiple and Concurrent Sexual Partnerships
MoH	Ministry of Health
NACA	National AIDS Coordination Agency
NGI	Next Generation Indicators
NGO	Non-governmental Organisation
NPI	New Partners Initiative
NSF	National Strategic Framework for HIV and AIDS
OCA	Organisational Capacity Assessment
OD	Organisational Development
PLWH	People Living with HIV and AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PHDP	Positive Health Dignity and Prevention
PMTCT	Prevention of Mother to Child Transmission
RFP	Request for Proposals
RHAP	Regional HIV and AIDS Programme
RRAPS	Risk Reduction Assessment, Planning, and Support
RRT	Risk Reduction Tool
SADC	Southern African Development Community
SAHA-UB	Students against HIV and AIDS–University of Botswana
SMC	Safe Male Circumcision
SOPs	Standard Operating Procedures
STI	Sexually Transmitted Infection
TA	Technical Assistance
TLW	True Love Waits
ToT	Trainer of Trainers
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
YWFC	Young Women's Friendly Centre

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1 Background And Introduction

This publication documents the implementation process and experiences of the USAID-funded Capable Partners Botswana (CAP) capacity building project that supported a number of non-governmental organisations (NGOs) working in HIV prevention in Botswana from 2008–2011. The purpose of the project was to strengthen community-based responses to HIV prevention implemented by civil society organisations (CSOs), and help the organisations develop into strong and effective partners in the national HIV and AIDS response.

The CAP Project conceptual model, implementation processes, major activities, tools used and key results are outlined in this publication. Case studies and practical examples that capture personal experiences and community insights regarding HIV prevention have also been included. The process, findings, tools and results are of practical relevance to other organisations involved in capacity building or implementing community-based HIV prevention programmes in Botswana and beyond.

1.1 What is the Capable Partners (CAP) Botswana project?

On July 31, 2008, the Academy for Educational Development, now Family Health International (FHI 360) was awarded a USAID/RHAP Associate Cooperative Agreement for the Local Partners Capacity Building Programme to enhance the organisational development and sustainability of local non-governmental organisations (NGOs), faith-based organisations (FBOs), and community-based organisations (CBOs) implementing HIV prevention programmes in Botswana. All activities conducted under CAP are guided by the Botswana Partnership Framework for HIV and AIDS (2010–2014)—a collaboration between the Government of Botswana (GoB) and the United States Government (USG) through the President's Emergency Plan for AIDS Relief (PEPFAR). This supports the National Strategic Framework's (NSF II) focus on HIV Prevention, Capacity Building and Health Systems Strengthening, Strategic Information and Treatment and Care and Support as its main pillars.

By January 2011, CAP Botswana awarded 12 grants to local CSOs in 13 districts to support HIV and AIDS prevention activities. Seven of these grants are in their third year under CAP, two are new and three have been closed out. The project also provided technical assistance (TA) to strengthen the organisational and professional capacities of these local NGOs, FBOs and CBOs, and offered support to local CSOs through the Peace Corps Small Community Grants Progamme to design projects for funding and prepare grant applications, which resulted in 19 small grants.

Areas of intervention by CAP Botswana include: D'kar, Dukwi, Gaborone, Ghanzi, Goodhope, Lobatse, Kang, Kanye, Kasane, Mabutsane, Mahalapye, Masunga, Mochudi, Molepolole, Palapye, Rakops, Ramotswa, Selebi-Phikwe, Serowe, Tlokweng, Tsabong and Tutume.

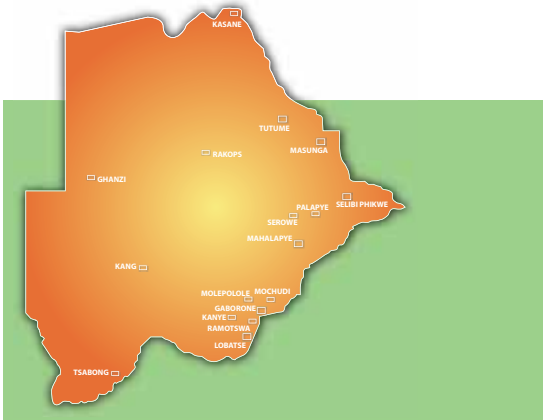


Figure 1. Map of Botswana showing CAP Project operational districts

'Prevention of new infections should be our priority number one, priority number two and priority number three.'

- Former President Festus Mogae

1.2 HIV prevention a priority

In building HIV prevention capacity in Botswana, the CAP Project is supporting the National AIDS Coordination Agency (NACA)'s focus on HIV prevention as the number one priority outlined in the second National Strategic Framework II for HIV and AIDS (2009-2016).

The implementation of the project has been guided by the National Operational Plan (NOP) for Scaling Up Prevention (NACA, 2008–2010) that emphasises the importance of capacity strengthening for effective implementation, as well as coordination and management of HIV prevention activities. Practical approaches to HIV prevention espoused through the NOP include the Thebe le Segai 'Shield and Spear' concepts, which work in harmony.

'The Minimum Package for Prevention acts as "The Shield" to protect the population from HIV, while strategic communication and community mobilisation act as the two blades of "The Spear" to thrust the package of prevention services forward, reaching the country and all levels of society within it.'

- National Operational Plan for Scaling Up HIV Prevention in Botswana (2008-2010)

The Minimum Package elements include prevention of sexual transmission of HIV, HIV counselling and testing, prevention of mother-to-child transmission (PMTCT) of HIV, prevention of sexually transmitted infections (STIs), and preventing blood borne transmission of HIV.

The CAP Project thus responds to the body of evidence presented on emergent HIV issues in Botswana, and complements the national strategy set out by the GoB.

NGOs supported by CAP Botswana

Year 1:

- African Methodist Episcopal Services Trust (AMEST)
- Botswana Christian AIDS Intervention Programme (BOCAIP)
- Evangelical Fellowship of Botswana (EFB)
- True Love Waits (TLW)
- Humana People to People (HPP)
- Young Women's Friendly Centre (YWFC)

Year 2:

- Botswana Network of People Living with HIV and AIDS (BONEPWA)
- Botswana Business Coalition Against HIV and AIDS (BBCA)
- Students Against HIV and AIDS (SAHA-UB)

2 HIV and AIDS in Botswana

2.1 What do we know about the HIV and AIDS epidemic in Botswana?

Even though HIV and AIDS has taken a tremendous toll across Africa, Botswana has been one of the hardest hit nations with an estimated national HIV prevalence of 17.6 percent (BAIS III, NACA 2008). The BAIS III (NACA 2008) results reveal a gender dimension to the epidemic with a higher HIV prevalence among women (20.4 percent) in comparison to men (14.2 percent). In 2009, UNAIDS estimated that 300,000 adults were living with HIV in Botswana, and with an HIV prevalence among 15- to 49-year-olds of 24.8 percent, Botswana has the second highest HIV prevalence in the world among this age group after Swaziland (http://www.avert.org/aids-botswana.htm).

A facilitator conducting a session.

HIV and AIDS has affected all areas of society. Life expectancy at birth fell from 65 years in 1990–1995 to less than 40 years in 2000–2005, a figure about 28 years lower than what it would have been without AIDS. Before the expansion of the national anti-retroviral therapy (ART) programme (known as MASA, a Setswana word meaning new dawn) the loss of adults at the prime of their lives had serious economic repercussions, leaving an estimated 93,000 single (loss of one parent) or double (loss of both parents) orphans. The hardships were exacerbated by the loss of income to households and rising expenditures because of funerals (http://www.avert.org/aids-botswana.htm).

In recent years, Botswana has made commendable achievements in its response to the epidemic, becoming the first African country to provide free of charge anti-retrovirals (ARVs) for people living with HIV and AIDS (PLWHA), with coverage levels now exceeding 90 percent of those in need. The success of this programme has been hailed as a best practice regionally and internationally. As has the prevention of mother-to-child transmission (PMTCT) programme, which now reaches over 95 percent of HIV positive pregnant women and new mothers, and is responsible for lowering HIV transmission to less than 4 percent in infants born to HIV positive mothers (Ministry of Health [MoH] 2010). There has been a similar scale up in access to HIV Counselling and Testing (HCT) services, with the proportion of individuals ever receiving a confidential and voluntary HIV test improving from around 26percent in 2004 to 56.4 percent in 2008 (BAIS III, NACA).

2.2 The importance of HIV prevention and the 'drivers' of the epidemic

Despite these positive strides to mitigate the impact of HIV in Botswana, prevalence remains high among adults and HIV transmission continues to occur at an alarming rate. The primary mode of HIV transmission in this country is unprotected, heterosexual intercourse.

The NSF II and BAIS III outline key drivers of the epidemic, fuelling further HIV transmission.

Key drivers of HIV

I. Multiple and Concurrent Sexual Partnerships – This is derived from data which indicates that a significant proportion (11.2 percent, BAIS III) of both men and women in Botswana may have more than one sexual partner at the same time. Dense sexual networks resulting from overlapping sexual relationships are believed to facilitate faster HIV transmission and this is further complicated by inconsistent condom use during such relationships.

II. Male Circumcision – The BAIS III report indicates that only 11percent of the male population aged between 10 – 64 years have been circumcised. As an HIV prevention strategy, Male Circumcision needs to target increased numbers of HIV negative males. If done effectively, it reduces HIV transmission by 60 percent.

III. Adolescent and Inter-generational Sex – Inter-generational and age-disparate sexual relationships expose adolescents and young adults to partners who are more likely to be HIV positive because of their age and longer sexual history. According to the NSF II, adolescent girls are more at risk of HIV infection than boys, with levels of infection significantly higher up to the age of 24 years and beyond.

IV. Alcohol and High-Risk Sex – Evidence from prior research shows a strong linkage between excessive alcohol consumption and elevated risk of HIV infection. Misuse of alcohol and other recreational drugs have been linked to a number of social and health-related problems i.e. gender-based violence and risky sexual behaviour, including inconsistent and incorrect condom use.

V. Inconsistent Condom Use – Condoms remain highly effective prevention tools if used properly and consistently. Condom use to prevent HIV is most effective when it is part of a broader safer sexual behaviour package that includes sexual abstinence, non-penetrative sexual practices, and reduced numbers of sexual partners.

VI. Stigma and Discrimination – According to the National Operational Plan for Scaling up HIV Prevention (2008), stigma related to HIV keeps many people from accessing prevention, care and treatment interventions for HIV. Studies in Botswana have indicated that, in spite of the matured epidemic, stigma is still widespread. In addition to hindering effectiveness and coverage of HIV and AIDS programs, stigma and discrimination increase the vulnerability of particular groups in society, especially young women and girls.

VII. Gender Violence and Sexual Abuse – Women and girls are at greater risk of contracting HIV owing to gender inequities which increase their likelihood of exposure to violence and abuse. They may have very little say on matters regarding their reproductive health and sexual rights, including use of condoms and access to relevant sexual and reproductive health services.

Botswana has thus adopted a vision of zero new infections by 2016 and the NSF II places HIV prevention as the top priority in managing the HIV epidemic, supported by a multi-sectoral approach involving linkages with national plans and programs.

3 Capacity Building for HIV Prevention

The Human and Institutional Capacity Development (HICD) initiative has been developed by USAID as a framework for strengthening sustainable institutional capacities in development assistance. This model identifies the root causes of performance gaps in organisations, addresses these gaps through a wide array of performance solutions according to needs and performance factors and is characterised by a cyclical process of continuous performance improvement through the establishment of monitoring systems and flexible responses. This is achieved by providing methods and tools adapted from the field of human performance improvement.

3.1 The HICD model

As illustrated below in Figure 2, the HICD model engages a cyclical process that is premised on stakeholder participation and evidence-based planning.

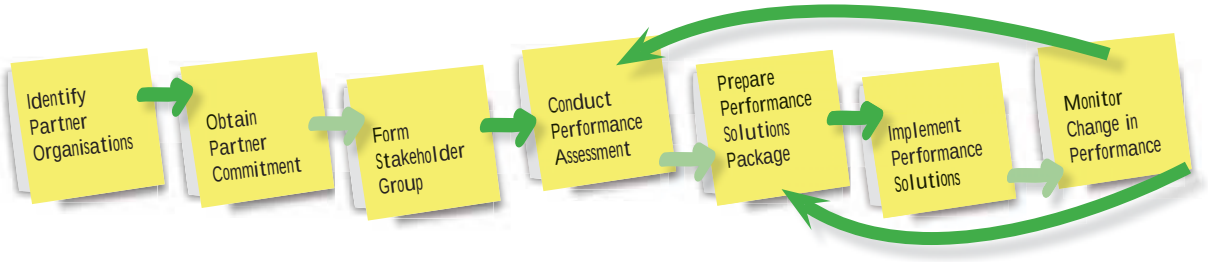


Figure 2. Human and Institutional Capacity Development (HICD) model
Source: Human and Institutional Capacity Development Handbook (a USAID model for Sustainable Performance Improvement) USAID October, 2010

The HICD logic is informed by the updated Behaviour Engineering Model , which shifts capacity building from primarily designing and providing formal training to stimulating organisation-wide change by actively involving partners in the design and implementation of organisational improvement.

Although it has been developed as a model for broad development assistance, the rationale and logic of this model are in line with the CAP Project focus, and especially relevant to developing institutional capacities for improved HIV prevention programming. As evidenced in the next section, the CAP Project builds on hallmarks of the HICD model. These are:

- HICD views organisations as adaptive systems
- HICD uses a systematic approach to analyse organisational performance
- HICD focuses on tangible, measurable performance improvement results

A successful HIV prevention capacity building programme must adapt approaches to suit the local context, ensure the involvement of relevant stakeholders, infuse best practices based on available evidence, and respond to an expressed need by implementing partners and their communities. Capacity building is a dynamic and iterative process intended to improve the skills of individuals, organisations and communities to enhance and sustain HIV prevention efforts. The methods include providing training, technical assistance and development activities to foster self-sufficiency and organisational capability, thus enabling partners to have a positive and sustained impact on HIV prevention processes, programmes and outcomes.

3.2 The CAP Project capacity building approach

HIV prevention activities can only achieve desired outcomes if implementing institutions are skilled and equipped with the appropriate tools and resources. The CAP model for capacity building follows a similar approach to the HICD model since it involves a cyclical process that includes assessment, prioritisation, planning and provision of technical assistance (TA).

CAP's capacity building approach involves regular assessments followed by tailored assistance including one-on-one mentoring, systems and tools development, supported by periodic monitoring and evaluation (M&E). Regular communication and close liaison with partners is a key feature of this approach.

As with the HICD model, CAP's capacity building model begins by conducting organisational capacity assessments, with qualitative and quantitative components. This facilitates objective, data-driven assessments that lays the foundation for gaining a shared understanding of interventions needed, capturing progress made and lessons learned.

In line with the HICD model, this assessment data is then used to prepare technical assistance plans with emphasis on areas where the organisation has scored the lowest and are thus viewed as high priorities for capacity building interventions. The focus of the CAP Project is to provide strong and consistent technical support for sustainability, and ensuring that TA reaches all levels of the organisation. Continuous assessments are carried out and the gathered data is used to refine technical assistance and identify new areas for development support and tailored assistance.

3.3 The CAP implementation process

Four important steps guided the CAP implementation process as illustrated in Figure 3 below:

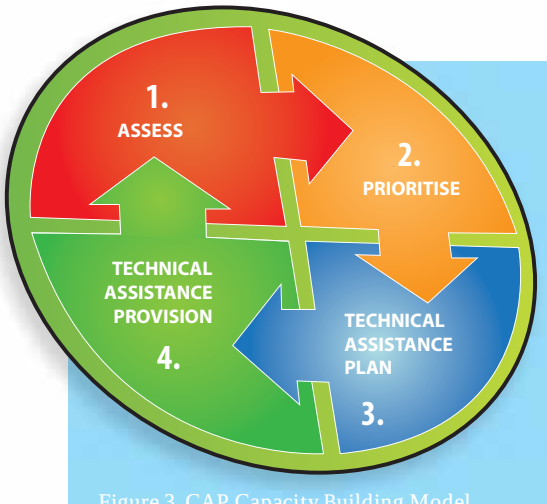


Figure 3. CAP Capacity Building Model
Source: CAP Botswana

Step 1: Undertake Capacity Assessment

Partner capacity assessments are conducted using a participatory methodology over a one-day period to gauge the partner's technical and organisational capacity, and on that basis, individual TA requirements are elaborated. Capacity assessments are guided by best practices and target all stakeholders involved in the organisations. The exercise enables organisations to determine existing capacity gaps based on national and international (e.g., PEPFAR) guidance norms, and plan appropriate TA measures.

Step 2: Prioritise Technical Assistance

It is important to note that not all gaps can be simultaneously addressed in TA provision, hence the need to prioritise some areas above others. Using a participatory prioritisation process and a specially designed tool, CAP prioritised TA together with partners based on meeting the most urgent needs of the organisation which also corresponded to the lowest scores on the assessment tool.

Step 3: Plan Technical Assistance

Development of TA plans is the next stage of the process. It is important to note that TA plans are determined by the prioritisation exercise. While developing plans, it is important to ensure that they are action-oriented and have specific target interventions to deal with organisational priorities for TA, roles and responsibilities, as well as expected deliverables.

Step 4: Provide Technical Assistance

Based on the results from the prioritisation exercise that outline areas requiring the most urgent attention, TA is provided. TA should be flexible and responsive to the immediate needs of the organisation. Technical Assistance is varied and can include customised training, in-depth, one-on-one mentoring, systems and tools development, direct meetings at least once a quarter for each partner, site visits to observe activities and discuss with stakeholders and beneficiaries benefits of projects in their areas and potential future needs or areas for support, phone calls and emails on a weekly basis.As part of the cyclical process outlined in Figure 3 above, this then leads to further capacity building and other assessments to evaluate the TA provided, as well as help identify new, emerging areas where TA is required.

Provide technical assistance through:

- Improving Planning Tools and Processes
- HIV Prevention Technical Support
- Improving Programme Management Tools and Processes, and Monitoring and Evaluation Technical Support

4 Implementation of the Technical Assistance Model for a Successful HIV Prevention Capacity Building Program

4.1 Undertake Initial Capacity Assessment

The beginning of every journey starts with knowing where you are, and where you want to go. Before embarking on actual capacity development and performance improvement activities, CAP took into account prior training and experience, learning style, access to technology and an objective assessment of individual and organisational capacities. Thus, the purpose of undertaking an initial capacity assessment is to determine the technical and institutional capacities of partner organisations as a basis for identifying appropriate technical and material assistance.

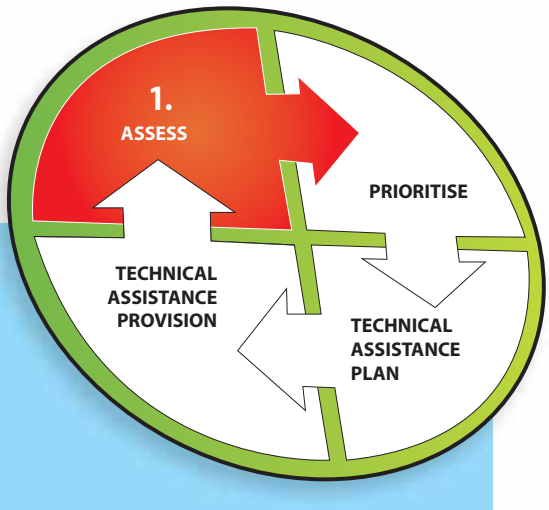
An organisational capacity assessment (OCA) tool was subsequently developed to help organisations create their own action plans and identify their specific technical and training needs. It also enabled partners to evaluate their progress and determine the level of maturity of their organisation.

By assessing systems and policies in place to enable organisations to fulfil their mandate, the capacity assessments helped CAP partners answer the following questions:

- Where are we now?
- Where do we want to be?

Organisational capacity assessments were introduced to measure CAP partners' capacity against established standards in a participatory manner. The assessments were conducted in September 2008 at baseline and then again in July 2010 to serve as a mid-point assessment for the three-year project. In the first year of implementation, the following assessments were conducted under the project: organisational capacity assessment (2008), training assessment (2008–2009) and a BCC assessment in 2009. The assessments focused on the following six key domains: monitoring and evaluation; finance; behaviour change communication; governance and leadership; human resources management; and sustainability.

The process was undertaken through interactive discussions between organisational leadership and staff members, complemented by interviews with key informants and reference to organisational documents. Results from the assessment were reviewed and discussed with stakeholders in the relevant organisation.



BEHAVIOUR CHANGE COMMUNICATION (BCC) PROGRAMMING						
NO.	QUESTION	SOURCE OF VERIFICATION	POSSIBLE POINTS	YR 1 POINTS AWARDED	COMMENTS YR1	YR2 POINTS AWARDED
BCC PROGRAMMIMG						
Program Approach and Strategy						
1.	Do you have copies of the following (eg, National Strategic Framework II, National Prevention Plan)?	Plans	1			
2.	Are your projects aligned to these documents?	Explain understanding	1			
3.	Are your projects aligned to the PEPFAR BCC Prevention Guidelines?		1			
4.	Is there a BCC strategy or plan for the organisation?	Sample strategy	1			
5.	Do interventions use participatory and interactive methods?	Describe methods	1			
6.	Are the specific behaviours that are targeted understood by the managements?	Describe drivers of epidemic	1			
7.	Are the specific behaviours being targeted understood by staff/implementers?	Ask about integration into	1			
8.	Do you undertake community mapping to distinguish areas of coverage per implementer, location of target venues and referral places, and locate other groups undertaking similar or complimentary work in the areas or with the populations with whom you work?	Community map	1			
9.	Are number of intended sessions clearly defined to clarify programmatic completion/reach?	Documentation	1			
10.	Do you involve members of the target population/ beneficiaries in program planning and/or implementation? (needs assessment)	Explain process, copy of assessment/report	1			
11.	Are HIV prevention projects based on a BCC theory?	State theory(ies) an explain application to project	1			

Figure 4. BCC capacity assessment
Source: CAP Botswana

Part of the BCC assessment component of the OCA tool is illustrated in Figure 4, which gauges the adequacy of an organisation's HIV prevention strategy. The assessment criteria reflect on the key principles of effective BCC programme design and implementation. Thus, a key tenet for assessment, for example, is ensuring that the project is aligned to national evidence and strategies as reflected in BAIS III and the NOP for HIV prevention. Furthermore, as part of this component, organisation are assessed in terms of alignment to standards outlined in PEPFAR HIV prevention and monitoring and reporting guidelines. The assessment also goes beyond design and strategy issues to examine implementation and management practices, including project coverage, volunteer management and community/stakeholder networking.

On the basis of requested information, a possible score is allocated for each response. This will be calculated into an overall score for analysis. A score will be generated for each section (e.g., BCC), as well as overall, and for each subsection (e.g., referral systems, within the BCC component). Using a standard tool in this manner permits an analysis of progress over time, as well as comparisons between partners, which highlight the need for more intensive TA.

Success elements and lessons learned

The OCA tool provided a useful starting point for articulating the capacity building and training needs of CAP partner organisations, thereby helping place them on course to reach their full potential. The tool's systematic approach helps organisations to assess existing capacity vis-à-vis best practice standards of capacity to support the implementation of quality HIV prevention programming and services.

The OCA process fosters leadership and provides direction to the organisation, with a high level of involvement of all stakeholders in the capacity assessment process, allowing for valuable introspection about goals, capacity and strategic direction, both realised and unrealised.

The OCA tool has been described as a good practice by stakeholders. After presenting the tool to the National AIDS Coordinating Agency (NACA)–World Bank–Botswana National HIV/AIDS Prevention Support (BNAPS) project team, it was compressed and adopted for wider use.

Key revisions to the OCA tool were made in Year 2 (June 2010) to allow for more objective and measurable results. Sources of verification were added to create a more realistic picture of capacity per domain; and a participatory prioritisation exercise was conducted for increased ownership and involvement of CAP partners in organisational development (OD) activities and deliverables. There are plans for a final OCA in September 2011. The following were important learning points for CAP from the baseline OCA are in Table 1.

WHAT WE OBSERVED	HOW WE RESPONDED
Some questions were subjective i.e. Do you deliver quality HIV prevention programs? This made it difficult to ensure objectivity of responses.	Technical support was provided to partners in developing more specific and objectively verifiable indicators. The tool was updated for the mid-point capacity assessment with this in mind.
There was limited verification of responses, and some of the scores appeared much higher than they should have been.	Sources of verification were identified and added for the mid-point assessment to provide a more realistic picture of an organisation's systems per domain.
There were limited prioritisation exercises.	A participatory prioritisation exercise was undertaken to increase ownership of this process.

Table 1. OCA revisions

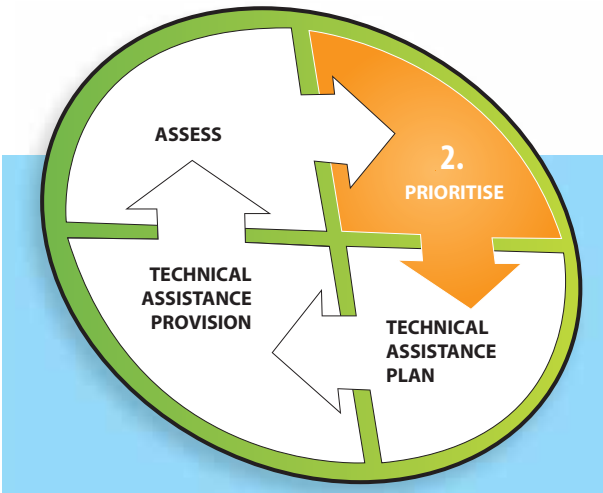
4.2 Prioritise Technical Assistance

Although it is useful and even important to address every gap identified during the capacity assessment exercise, time and resource limitations mean that some prioritisation has to occur. CAP thus led partners through a prioritisation exercise to highlight critical areas for TA to be addressed in TA plans. This was achieved by reviewing the scores from the capacity assessment exercise, then working with partners to prioritise gaps in different domains assessed on a case-by-case basis.

Some of the common gaps identified across partners included:

- limited capacity to receive and manage funds
- limited ability to deliver quality technical programme
- inadequate performance management systems
- poorly functioning linkages with other implementing partners and community stakeholders.

Through a participatory approach, managers from each partner organisation were actively involved in ranking priority areas for TA. A prioritisation tool was adopted for the process that helped match low scores in the capacity assessment to key priorities as viewed by partner managers, and offered practical questions that helped to guide the prioritisation.



Overview of prioritisation exercise

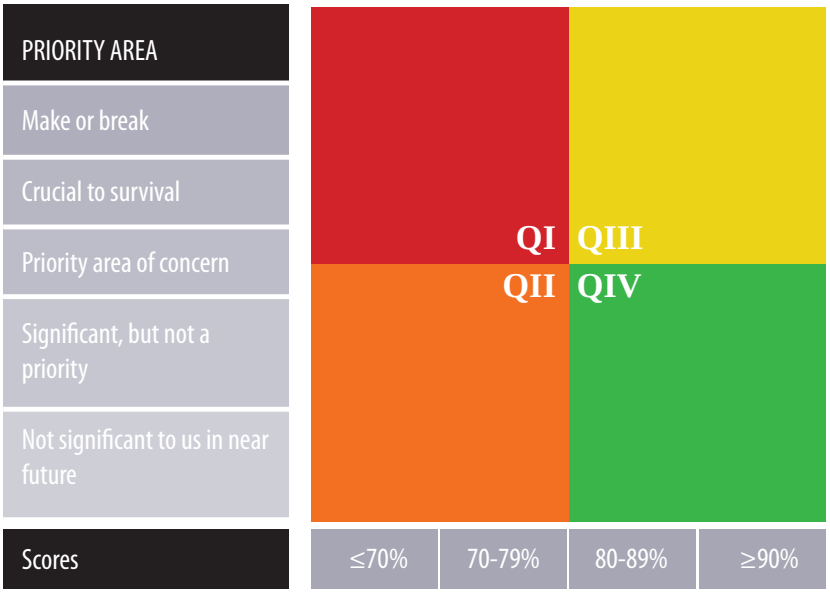


Figure 5. CAP prioritisation matrix for technical assistance

The prioritisation matrix in Figure 5 above helped partners and the CAP team identify priority needs by matching scores from the OCA with specific priority levels. In this instance, scores of below 80 percent for an assessment area reflected the weakest systems and processes within a particular organisational domain. Issues with this score then fit into Quadrant I or Quadrant II, depending on the level of priority assigned to this issue (under Priority Area in Figure 5). Issues that are seen as lowest priority to address are those in QIV, which represents issues which scored high in the capacity assessment, and are not seen as a priority as this time.

The four quadrants in the matrix can be summarized as follows:

QI: The highest priority issues to address since they scored lowest on the assessment tool and were viewed as 'make or break' or 'crucial to survival' by the partner.

QII: Issues that scored low on the assessment tool but are not seen as 'make or break' or 'critical to survival', hence are still important, however, slightly lower priorities than QI.

QIII: Issues that scored high on the assessment tool but are still seen as 'make or break' or 'critical to survival', hence are still important, however, slightly lower priorities than QI.

QIV: Issues that scored highy on the assessment tool and are seen as either 'not a priority' or 'not significant to us in the near future'. Issues in this quadrant are the lowest priority and hence least likely to be included in the TA plan.

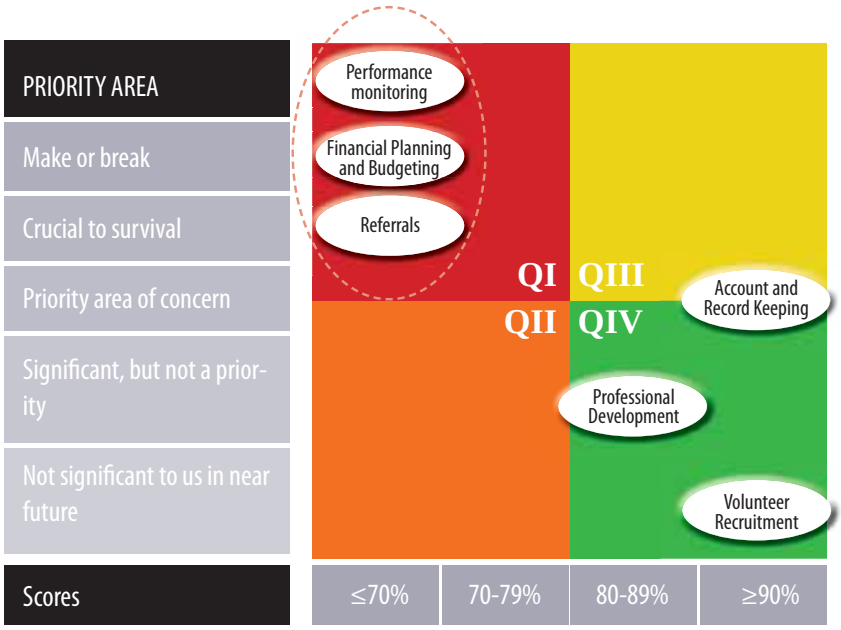


Figure 6. Prioritisation Exercise - True Love Waits

From Figure 6 above, it can be seen that the key priority areas (Q1) for True Love Waits included performance monitoring, financial planning and budgeting as well as referrals, while professional development, accounting and volunteer recruitment were factored in for QIV. The issues in QI formed the basis for the subsequent TA plan.

Success elements and lessons learned

- *Participation is key to prioritising TA interventions*

  The participatory nature of this exercise has resulted in the outcomes and subsequent TA plans being shared and owned by the partners themselves. This increases the legitimacy of the TA and the likelihood that it will be effective.

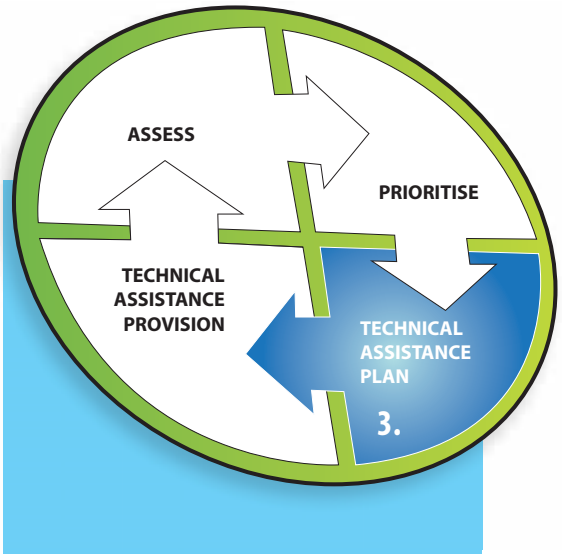
- *Prioritisation does not mean discarding what is not deemed urgent but rather prioritising TA on the basis of available resources and actual need.*

  Although it is useful to address every gap identified in the project, be mindful that not all identified gaps are of equal priority. The scores alone do not communicate the relative importance of the issue so ranking is important for ensuring that critical and fundamental needs are met first.

4.3 Plan Technical Assistance

After identifying capacity and resource gaps, the next step is to develop an outcome-based plan for capacity building. The plan is a logical follow on from identified and priority gaps, and includes next steps such as what needs to be done, by whom, the appropriate timelines for completion and finally, expected 'tangible' results. Thus, the objective of the planning process is to document the practical steps that should be followed in the provision of TA to address gaps identified during the capacity assessment exercise.

Individual technical assistance plans were developed for each partner organisation using a common template. Having outcome-focused plans was important because it attached a particular, foreseeable result to specified actions, responsibilities and timelines. As illustrated in Table 2, the plan for Evangelical Fellowship of Botswana (EFB) included tangible results in monitoring and evaluation, governance, finance and management and human resources.



PROGRAM AREA	PROGRAM GAP	ACTIVITY NAME	DELIVERABLE	RESPONSIBILTY	ESTIMATED COMPLETION DATE
Monitoring and Evaluation	No staff members assigned full-time to M&E	Hire M&E staff	M&E staff	EFB, other donors	30/3/2009
Governance	Board lacks relevant skills to support the organisation	Board governance training	Board members with relevant skills to support the organisation	FHI 360, EFB	15-18/7/2009
	No leadership succession plan	Develop a leadership succession plan	Leadership succession plan	EFB	16/5/2009
Financial Resources	No sustainability plan	Sustainability training (proposal writing etc)	Sustainability plan	FHI 360, EFB	30/8/2009
	Organisation has never been audited	Audit	Audit report	EFB, external comsultant	16/10/2009
Management and HR	No staff dedicated to HR	Hire HR staff	HR staff	EFB	15/9/2009
	HR policy in place, but has gaps	Review HR policy	Revised HR policy	FHI 360, EFB	30/6/2009
	No performance based staff appraisal & salary review system	Develop staff performance review tool (FHI 360 can supply sample)	Staff appraisal review tool utilised	FHI 360, EFB	30/6/2009
	No professional development programme for staff	Carry out needs analysis & develop staff development programme	Staff development programme	EFB	20/11/2009
	Meetings not minuted and not followed through	Appoint secretary at every meeting to take minutes, with action items	Minutes of meetings and feedback on action items	EFB	Commenced 30/4/2009
	No risk management	Develop risk management plan	Risk management plan	EFB	10/12/2009

Table 2. Sample technical assistance plan developed for Evangelical Fellowship of Botswana (EFB)

Success elements and lessons learned

The planning process created a means of participating in a dialogue to reach agreement with partners on the nature of capacity building required as well as the sequencing of activities, thereby laying the groundwork for an effective working relationship.

CAP partner Young Women's Friendly Centre (YWFC) found the planning process useful, since they gained a better understanding of the need for a systematic process to guide organisational development. A YWFC officer described the usefulness and merit of the new financial budgeting system—one of the first activities in their plan:

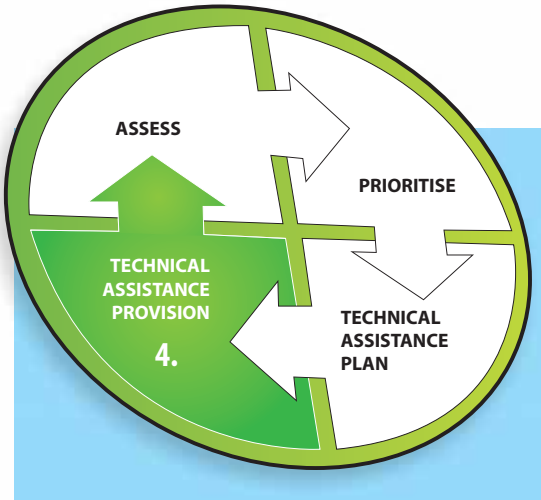
'We had no formalised budgeting systems in place. We knew there was a need for certain HIV prevention activities, for example, but did not know how to clearly budget for them, causing some challenges in implementation. We have learned the importance of budgeting for HIV prevention activities and now have historical financial information that we use when we submit our budgets to potential donors.'

YWFC team

For the successful implementation of capacity building plans, it is important to take into account the available resources and ensure that the set timelines are practical and achievable. The technical assistance plan needs to be complemented with a detailed budget so that partners know in advance what can be covered financially, and whether additional resources have to be mobilised.

4.4 Provision of Technical Assistance

This stage is the most important since it describes the implementation of technical assistance through the CAP Project. As outlined earlier, TA was provided through a number of different mechanisms—formal training, mentoring, system and tools development. It was characterised by regular two-way communication and was refined and improved based on partner and beneficiary feedback.



4.4a: Improving Planning Tools and Processes

The first area CAP partners received assistance in involved improving their ability to plan evidence-based and effective programmes.

> *'The CAP Project has taught us about HIV prevention and increased our understanding of behaviour change communication.'*
>
> - YWFC Project Officer

i. Evidence-based training

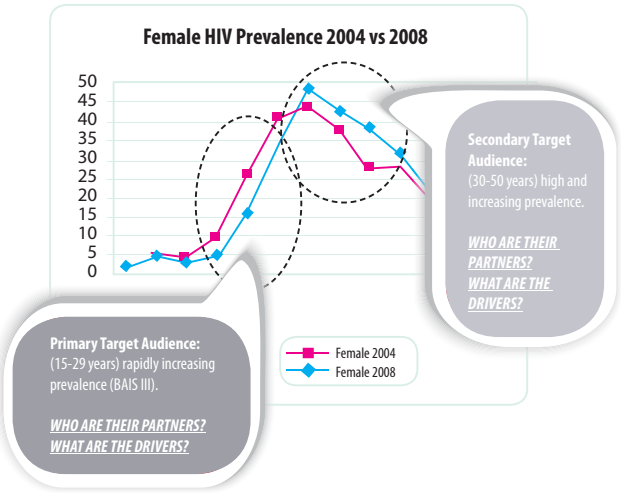


Figure 7. YWFC target group selection based on BAIS III

In August 2009, a workshop on Evidence-Based Programming was held where partners learned how to improve the design of HIV prevention activities through alignment with evidence and programme design skills. Through the detailed integration of evidence-based planning, CAP partners successfully incorporated national data and evidence contained in the BAIS III, NSF II and NOP in their programmeme design and targeting.

Following this training, YWFC strengthened its programme design through use of BAIS III data in appropriate target population selection and segmentation. YWFC has as its primary target group young women aged between 15 and 29 years old. Figure 7 below outlines how they designed an appropriate BCC intervention based on this audience segmentation.

ii. Community Mapping

Community mapping was introduced to improve the planning and implementation of HIV prevention activities in partner community settings. Maps were developed by each partner organisation which included the following:

- Areas of implementation, roads and other landmarks
- Key outreach sites including schools, churches, bars and other places where community members gather
- Other implementing partners
- Referral sources and service providers
- Assigning responsible implementation areas for each community outreach worker
- Mapping areas already covered by each community outreach worker.

Community mapping exercises have helped CAP partners reduce the duplication of efforts in HIV prevention programming by dividing up the area among the implementation team, and also maximising coverage of the population. Community mapping has also helped identify different service providers offering complementary services and strengthening relationships through a network of services.

Fig 8. A community map

iii. Community Outreach Worker Implementation Plans

Since CAP-supported BCC projects rely on community outreach workers who received a stipend for conducting community outreach, systems for managing these community outreach workers were not as well developed as they might be for staff. An important area for TA in project planning, therefore, and a tool used in conjunction with community maps was the volunteer implementation plan. These were clearly defined plans using a common template developed by partners to guide each individual on how to effectively reach out to their target audience each month. Each individual's plan typically answered five questions regarding their work for the coming month, namely 'who', 'what', 'when', 'where', and 'how'? These plans also helped partners set monthly targets for volunteers. An excerpt from a typical monthly plan is included below in Table 3 .

Name of Peer Educator: KABO THIPE
Implementation Village: HUKUNTSI
Responsible Ward (s): SEMELE, RANATA
Name of Supervisor: BOITUMELO THUTO
Monthly Target: 150

WEEK	DATE	WARD	TYPE OF VENUE	NAME OF VENUE	CLASS/GRADE/ GROUP	COMMUNICATION GUIDE	TARGET
1	2 March	Ranata	Bar/Shebeen	Lotlamoreng Bar	N/A	Alcohol	15
	4 March	Semele	School	Hukuntsi Senior Secondary	7A	Delayed Sexual Debut	30
2	10 March	Ranata	School	Hukuntsi Senior Secondary	7B	Delayed Sexual Debut	30
	11 March	Semele	Church	Semele Roman Catholic Church	Youth Choir (aged 20-30	MCP	15
	12 March	Ranata	Church	Semele ZCC	Women's Group	Gender Based Violence	15
3	16 March	Semele	School	Hukuntsi Senior Secondary	7C	Delayed Sexual Debut	30
	17 March	Semele	School	Hukuntsi Senior Secondary	7D	Delayed Sexual Debut	30
4	22 March	Boipelo	Workplace	Water Utilities	Management Body	MCP	10
	23 March	Boipelo	Workplace	DHT	Lay Counsellors	MCP	10
	24 March	Boipelo	Workplace	Landlord	Drivers	MCP	10
Total							**210**

Table 3. Sample Peer Educator Implementation Plan, TLW

Devising volunteer implementation plans relied on good community maps. The maps helped demarcate different areas for implementation, so community outreach workers could be assigned to maximise coverage and avoid duplication. The use of volunteer implementation plans has helped CAP partners to:

- Plan and document individual peer educator coverage
- Match implementation areas with hotspots identified on the community map
- Monitor where each volunteer would be at any given time
- Segment the community into different catchment areas without overlapping implementers;
- Identify which Communication Guide (see Section 4B iv) will be used to ensure appropriate message delivery to appropriate target audience
- Outline intended targets

4.4.b HIV Prevention Technical Support

Based on findings from the initial BCC assessment (January 2009), the OCA and subsequent assessments, the CAP team designed a comprehensive programme of HIV prevention technical support. Trainings were a key component of the CAP capacity building approach, thus workshops were conducted to address key gaps identified through capacity assessments and process reviews. The training sessions were practical and action-orientated, and used various participatory approaches to enable partners to 'hit the ground running' when it came to implementation. The trainings were enhanced by the development of complementary systems and tools, including extensive pre-testing by partners in their community settings.

i. Tailored training programmes, following from initial assessment

After the initial round of CAP assessments and planning exercises, tailored training programmes were designed to build the capacity of partners in HIV prevention. The training programmes were geared to improving partners' technical knowledge and skills, and enhancing their ability to contribute to lasting solutions through a more sustainable HIV prevention response.

Facilitators from the YWFC in Mahalapye at a debriefing session.

In January 2009, a BCC assessment was conducted to help identify CAP partners' capacity in BCC as well as understand behaviour change principles and elements involved in effective programming. The BCC assessment identified a number of limitations.

- Organisations did not utilise formal behaviour change theories to guide and inform their programme planning and design.
- There was limited utilisation of existing studies or additional collection of information about target populations and determinants/ dynamics of behaviour to inform programme and design and planning.
- There is limited involvement of stakeholders during planning.
- Partners did not have a strategy for setting clear behavioural targets.
- There was minimal periodic review of BCC messages, materials and approaches.
- Messages were mixed (cover several topics or drivers of the epidemic each time) and usually not supported by IEC/BCC materials.
- Apart from low allowances, most organisations did not have a retention strategy for community outreach workers and staff.
- There was no formal supervision process or tools used to guide supervisory visits.
- There is was no formal ongoing assessment BCC competencies of staff.
- Most organisations focused solely on their primary target populations and often failed to ensure that communication interventions reached secondary target populations including sexual partners and peers.

ii. BCC Basics Workshop

In response to the BCC assessment, a workshop was held in March 2009 to disseminate the results of the BCC assessment, to provide a theoretical basis for behaviour change programmes, to assist partners in the development of BCC objectives, and to review and improve messages and programming with grounding in theory. Social mapping exercises were also conducted to understand the different influences on high risk behaviour, and how partners can better address the context of risk within their communities.

iii. BCC It's About Change Workshop

A follow-on BCC workshop was held in October 2009 and provided orientation and practical training for partners on the fundamentals of BCC. It also identified key tools or strategies that could be utilised to improve BCC approaches, and participants reviewed initial drafts of communication guides addressing key drivers of the HIV epidemic (outlined in 4.4biv. on page 24). During the second year of funding for CAP partners a Request for Proposal (RFP) was designed to spark innovative programme design. Based on the RFP core areas of BCC identified gaps needed to be addressed in the submitted proposal for funding including:

- Systematic collection and use of data to inform programme planning and design
- Active participation and involvement of stakeholders during planning
- Improved strategies for setting clear behavioural targets
- Regular review of BCC messages, materials and approaches Segmenting audiences and targeting messages appropriately
- Specific messages that focused on the key drivers of the epidemic
- Communication interventions to influence not only the primary target audience but also their partners and peer groups

A third training (BCC ToT) was held in February 2010 (covered in 4.4ci.), where further opportunities were taken to improve the communication guides covering key drivers of the epidemic and formulating activities to accompany each guide. Participants were taught how to train their implementers on BCC and developed sample agendas for the training, including training materials.

iv. Communication Guide Development

Based on findings from the initial BCC assessment and the first round of process evaluations undertaken in 2009, a range of HIV Prevention Communication Guides were developed. The need arose in response to the finding that messages were mixed (covering several topics or drivers of the epidemic each time) and usually not supported by IEC/BCC materials.

A total of nine guides were designed, tested and revised to meet user needs. The Guides were developed with input from the MoH and NACA to support good quality HIV prevention communication and were based on PEPFAR guidelines, evidence-based strategies and adult learning methods. Produced in English and Setswana, they are user-friendly and include a facilitator's guide, case studies, role plays and audience feedback.

The HIV prevention guides are in line with the NSF II, covering key drivers of the epidemic such as Alcohol and HIV, Condom Use, Cross-Generational Sex, Delayed Sexual Debut (DSD), Gender-Based Violence (GBV). Multiple Concurrent Partnerships (MCP), Positive Health, Dignity and Prevention (PHDP), Relationship Enrichment, and Safe Male Circumcision (SMC).

> *They teach us that we should learn to control our feelings and not have them controlling us. Every time they talk to us, they make us think outside the box'.*
> - Student from Lobatse Senior School (AMEST awareness sessions participant).

The content of these guidelines have been revised and re-adapted extensively on the basis of comments and suggestions from implementing partners and target group members participating in field pre-tests. The 'final products' reflect the inputs from a wide variety of stakeholders and beneficiaries.

v. Individual Risk Reduction Assessment Planning and Support (RRAPS)

Since communication guides were designed primarily with small group sessions in mind, a high-level USAID TA visit indicated the need for additional interventions to boost the intensity and effectiveness of the communications approach. In response, the individual RRAPS tool was developed, which is composed of a tool together with an easy-to-use guide for partner volunteers and staff. It is essentially a case management approach starting with recruiting and engaging a client in one-on-one risk assessments, and then follow-on support for on risk reduction. Initially, the client's knowledge, attitudes and behaviours are assessed. Based on responses garnered, a customised risk reduction plan is drawn up, and if necessary, referrals for required services such as voluntary counselling and testing (VCT) and SMC are also made.

The client's efforts at implementing the risk reduction plan are outlined in a personal Goal Card (Figure 9), and this is periodically monitored and reviewed by the facilitator during follow-up sessions.

The RRAPS tool accompanies the communication guides for one-on-one follow-ups and repeat contacts. Using the guides, individuals can be referred from group sessions to more intensive individual-level support using the tool. All materials used are in line with PEPFAR Next Generation Indicators (NGIs). Additionally, they support linkages with national programmes and initiatives, and provide opportunities for referrals to other prevention services in the district.

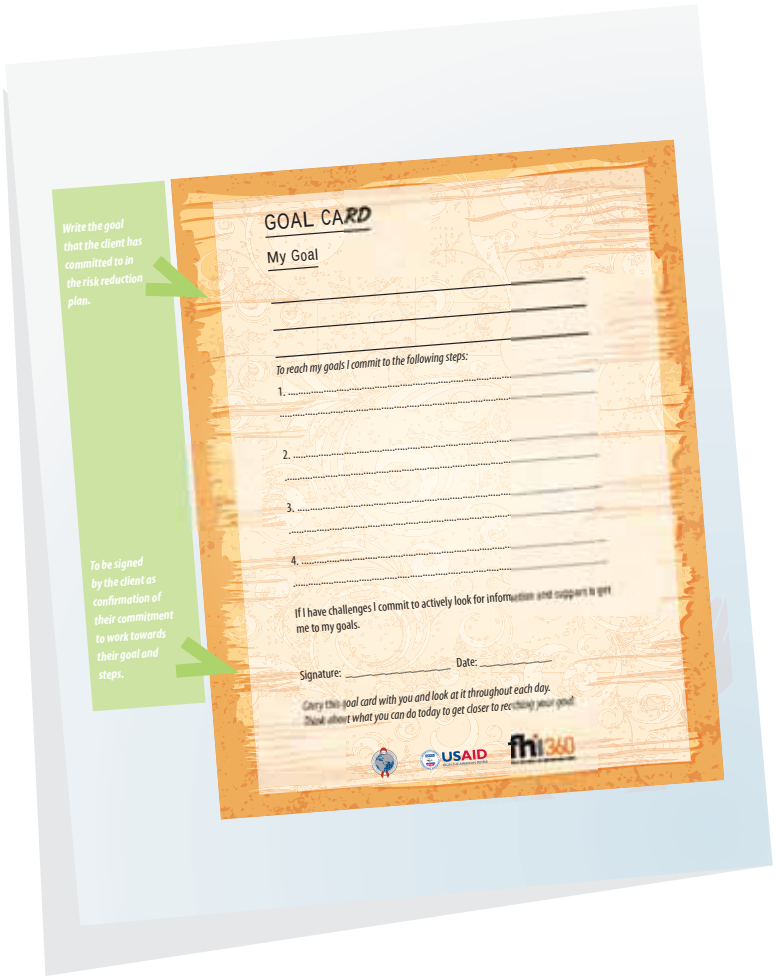


Figure 9. Goal Card for risk reduction

Pilot testing for the RRAPS tool was done extensively, allowing partners the opportunity to network with other service providers and increase referrals within their respective districts. On the basis of findings from the pilot test, minor revisions were made and a training curriculum developed for implementers together with a Standard Operating Procedures (SOPs) manual. Subsequently, the tool has been rolled out to CAP partners and supported by close monitoring and supervision.

The SOPs manual for RRAPS accompanies the Risk Reduction Tool and outlines the process for providing in-depth, personalised support to implementers in various community settings to promote behaviour change in relation to the key drivers of the epidemic. It has been developed as a 'how-to' manual for risk reduction in the community and covers steps from identifying and engaging clients through to supervision, and adhering to the monitoring and reporting tools and processes.

Feedback from the early usage of the RRAPS tool has been promising since it permits high-quality and tailored one-on-one contacts with individuals in confidential settings. Moreover, its linkage with national programmes and initiatives, and the option of providing referrals to other prevention services, makes it a tool that can be used to help meet a greater variety of HIV-related and sexual health needs across the population.

CAP presented the revised version of RRAPS tool to the MoH's HIV Prevention Technical Advisory Committee. Members of the committee felt the tool filled an important gap in the national prevention programming portfolio and called for its further review with consideration for adoption by other units in the MoH following guidance from the BCIC technical working group.

CASE STUDY 1:
RELATIONSHIP ENRICHMENT

Upholding family values and making right choices

The Botswana Christian AIDS Intervention Programme (BOCAIP) runs the community-friendly Lesedi Counseling Centre in Kanye village, a bustling and vibrant locale. With a population of 44,716 (GeoNames database, 2010) Kanye has earned the moniker 'major village,' one of 26 such villages in the country.

Today Kanye—89 km southwest of Gaborone—is at the forefront of BOCAIP's efforts at empowering communities on the dangers and risks of HIV, mainly alcohol and substance abuse, early sexual debut, gender-based violence, and multiple and concurrent partnerships. The community-friendly Lesedi Counselling Centre in Kanye is managed by Josephine, an affable, middle-aged woman, supported by a team of 13 approachable staffers and knowledgeable volunteer couples. The underlying emphasis of the centre is to sensitise the local community about safe sexual practices, marriage and relationships in a thoughtful yet honest manner.

The latter led to the initiation of marriage enrichment sessions in 2008 as part of the ongoing HIV workplace policy for the Department of Building and Engineering Services (DBES) under the purview of the Ministry of Infrastructure, Science and Technology.

According to a staff member, this male-dominated department had an alarmingly high HIV infection rate because of mandatory prolonged work-related tours in other areas. He admitted, 'There were lots of trips and too many girlfriends along the way'.

Clad in a ubiquitous black suit, the welcoming Pastor Paul Tsisti is the designated peer educator at the relationship enrichment sessions at DBES since 2008. Having received training on the Risk Reduction

Participants at a marriage enrichment seminar in Kanye sharing their experiences.

Participants at a marriage enrichment seminar in Kanye sharing their experiences.

Assessment Planning and Support (RRAPS) tool and accompanying Communication Guides, Pastor Paul conducts marriage enrichment sessions with groups of 15 employees. Following the same format, each session starts with an opening prayer. The attendees—largely male, though wives of employees are free to attend—are encouraged to talk candidly about their marital and extra-marital relationships. Pastor Paul steers the discussion to the impact of HIV on a married couple. The atmosphere is conducive to debate with no hint of reprisals, discrimination or condemnation.

The 45-minute session discusses cultural norms, prevailing sexual practices, fidelity, condom usage and multiple and concurrent sexual partners, ending with practical strategies to reduce HIV transmission. The men are encouraged to be forthright about the challenges and temptations they face as well as their strategies to overcome these, and the resultant positive impact this has on their relationships and well-being.

The communication tool on relationship enrichment comprises a guide, facilitator's notes and activities linked to the central theme. During the session, various relationship-related themes are explored, including trust, fidelity, cultural and social beliefs that endorse a man's right to have sex against a woman's will, negotiating safe sex, financial issues and gender inequality that hampers a woman's ability to seek health services.

Though the Relationship Enrichment communication guide is still at an early stage, participants are unanimous about its uplifting and educational aspects. While the impact of the relationship enrichment initiative has not been quantified yet, the community's appreciation is tangible. A DBES employee said, 'The marriage enrichment sessions have taught me the importance of upholding family values and making the right choices. Wrong choices and giving in to temptation can increase the risk of contracting HIV, and now I can discuss these issues with my wife freely, and we can move forward as partners'.

Another employee in his early 30s admitted that until he attended the session, he had believed that sex in marriage was a man's undeniable conjugal right. 'However, I now realize that a woman has the right to refuse sex, and her feelings should be respected'.

Meanwhile, the relationship enrichment module has spurred many cohabiting couples to legalise their union and helped warring spouses to settle their disputes amicably. One male participant said, 'I am 39 and have lived with a woman since 1993. We have four children. The relationship enrichment sessions have helped me to openly express myself. I now understand and appreciate the value of a happy relationship and am proud to use my salary to support my family'. More importantly he admitted that the session had helped him comprehend the necessity of fidelity and consistent condom use to protect his wife and himself from HIV.

The programme has cut through impregnable taboos and awkward silences, bringing hitherto unmentionable subjects into the open. As an older participant explained, 'Sex is part and parcel of marriage. This has been a wonderful opportunity to talk about something we have never dared to before'.

The absence of quantitative outcome data notwithstanding, the initial signs are favourable. At least five cohabiting couples have legalised their union and many more plan to follow suit. Moreover, lines of communication have been established and several participants have come forward to testify on the programme's efficacy at different forums and stakeholder meetings.

4.4c Improving Programme Management Tools and Processes

In any comprehensive approach to addressing capacity gaps in HIV prevention programmes, specific tools are required to support individuals, organisations, and communities in managing their activities. The second phase of the CAP Project thus focused on management training together with implementing systems and tools to better support quality HIV prevention programming. Below is a description of these initiatives.

i. BCC Trainers of Trainers (ToT) workshop

This ToT workshop focused on introducing key management tools for HIV prevention. It also imparted information on the BCC minimum package for HIV prevention; explored communication skills; and data verification. Detailed implementation plans as well as supervision and reporting procedures were introduced, as well as the following tools:

- Volunteer management strategy and tools
- Supervisory checklist to guide supervisory visits
- Job descriptions for staff and community outreach workers
- Ongoing assessments of staff BCC competencies

The ToT workshop recognised partners for their outstanding efforts in HIV prevention through certificates and awards for organisations making effective use of CAP processes and tools. Some of the tools introduced in the training are explained in more detail below.

ii. Routine Field Supervision and Supervisory Checklist

The purpose of routine field supervision is for supervisors to support implementers to adhere to good BCC practices and ongoing professional development. The process involves observing interpersonal communication and completing an assessment tool. The supervisor gives a score for each assessment criterion based on how well the implementer performed, and notes general observations. Feedback is then provided, including outlining observed strengths, areas requiring improvement and recommendations. On the next observed visit, the supervisor checks to see if the recommendations have been implemented from the previous visit.

Supervisory checklists were introduced as a quality management tool for field supervisors to strengthen BCC interventions. The main purpose is to help improve the performance of facilitators in the field and identify future training needs and support where necessary. The system was designed so that each implementer receives a supervisory visit on a quarterly basis. After the tools are filled out, scores are sent to the CAP team, together with other reports on a monthly basis.

OBSERVATIONS

Questions	SCORE 0	1	2	3	Observations
1. Did the facilitator explain the purpose of the activity/exercise?					
2. Did the facilitator build rapport and connect with the audience, eye contact?					
3. Did the facilitator demonstrate good listening skills?					
4. Did the facilitator ensure that everyone could hear him/her?					
5. Did the facilitator retain the audience's attention/interest?					
6. Did the facilitator use communication aides according to standards, e.g. flip charts, picture codes, discussion guides?					
7. Was correct factual information disseminated?					
8. Did the facilitator assess the audience's utilisation of any key referral services, e.g., counseling and testing, sexually transmitted infections (STIs), safe male circumcision, family planning?					
9. Did the facilitator refer the person(s) to other services as needed, and were referral tools used for this purpose?					
10. Did the facilitator create an environment safe for learning/sharing? (minimal outside interference/disturbance)					
11. Was the facilitator able to deal with troublemakers, talkers, bored participants?					
12. Did the facilitator avoid lecturing the participants?					
13. Did the facilitator thank participants?					
14. Did the facilitator make a plan for follow up?					
TOTAL					

FEEDBACK PLAN

Strengths	Areas for Improvement	Recommendations

Figure 10. Supervisory checklist

iii. Quarterly performance review meetings

Performance review meetings were introduced in July 2010 as a performance management mechanism that involved reviewing performance together with partner managers and their team members, reflecting on progress towards targets, successes, and challenges encountered. These forums have proved to be a useful learning process, beginning with the presentation of data, followed by discussions centred on stimulating performance improvements, organisational development issues, and stakeholder relations.

In the first round of meetings the CAP team prepared the data presentation for discussion with partners. The second and subsequent rounds of meetings involved partners preparing and presenting their own data to the CAP team and stakeholders. Stakeholders invited to these meetings include representatives from the District Multi-Sectoral AIDS Committee (DMSAC), clinic staff, school staff, District Education Officers, church leaders, di-kgosi (traditional leaders) and other CSOs.

These meetings presented excellent opportunities for partners to improve their capacity in data analysis and use together with garnering feedback and inputs from stakeholders and other beneficiaries. They have also been good opportunities for mobilising support for the partners within each district by raising awareness of their achievements, and forming stronger linkages with stakeholders and district authorities.

iv. Monthly supervision meetings, data analysis and feedback

Monthly supervision meetings offer CAP partners an opportunity for all community outreach workers to gather with their supervisors to evaluate the previous month's work plan, formulate the next month's plan, and discuss the successes and challenges during the month. Typically, all volunteers gather for the meetings that commence with a mini-training session lasting 15 minutes. This provides an opportunity for refresher training on a particular topic to support programming. Managers from partner organisations then analyse the performance of the whole team, followed by discussions regarding key activities that have been conducted. Time is then allocated for challenges encountered in the field; and participants then share success stories.

Agenda

Sample agenda developed for partners was as follows:

Agenda Item	Time
Date	
Attendees	
Mini training: Opportunity to provide implementers with new knowledge or skills to help effectively conduct HIV prevention activities	15 minutes
Updates: List out name of person/village of responsibility and major activities accomplished challenges, success stories, etc.	30 minutes
Update by management, field visit feedback	15 minutes
Internal performance data review	15 minutes
Field officer of the month	5 minutes
Internal data audit: Submission of monthly M&E reports and one-on one coaching to verify and correct reports	60 minutes
Key action items for next meeting	10 minutes
Total	2 hours 30 minutes

4.4d. Monitoring and Evaluation Technical Support

Monitoring and evaluation (M&E) is critical for decision-making and represents a common capacity gap among CSOs in Botswana. Strengthening M&E capacity has thus been a key component of the CAP Project, and partners have been provided with technical support primarily in the following areas:

i. Data Collection and Data Quality System and Tools

One of the first areas of M&E technical assistance was in the development of user-friendly and streamlined data collection tools. Designed with PEPFAR minimum standards in mind, and based on health informatics principles that value simple tabulation and transference of data, new HIV prevention tools were introduced to partners in October 2009. Special attention was paid to strengthen partner reporting skills and capabilities to ensure they apply M&E tools effectively to inform HIV prevention programming.

At the same time, data quality checklists were designed that match the HIV prevention tools, and a system for the regular internal and external verification of data was established among partners. The flowchart below shows the new tools introduced together with responsible individuals for data collection, reporting, and relevant timelines.

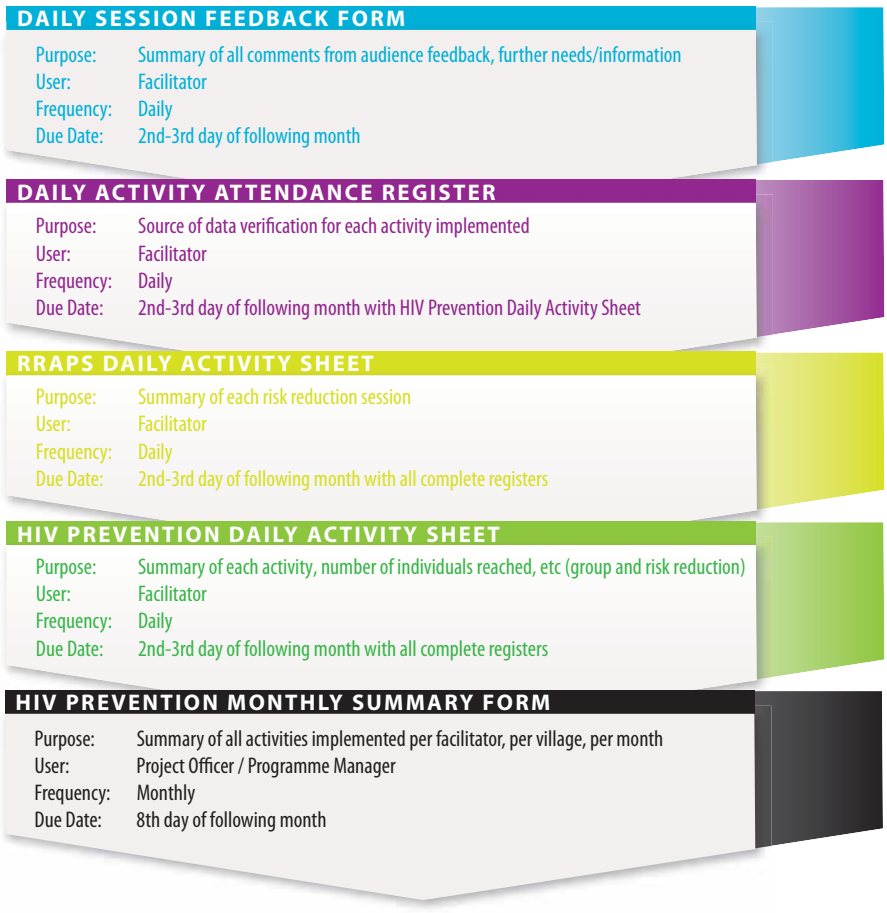


Figure 11. CAP M&E tools and flow chart

ii. Process evaluations

Process evaluations were introduced in 2009 to assess how programmes were being implemented with a view to improving organisational systems, procedures and the effectiveness of programmes. A two-day rapid protocol was developed with methods including: data qauality audits (DQAs); focus group discussions (FGDs) with staff, beneficiaries and stakeholders; key informant interviews, observation of communications quality, and a simple, anonymous Knowledge, Attitude, and Practice (KAP) survey for beneficiaries and implementors.

Below is an excerpt from the stakeholder FGD guide:

- What do you believe are some of the key problems in your community that contribute to HIV transmission?
- What organisations/programmes currently exist in your community to address HIV issues? (Note to facilitator: Have the respondents specify type of programme, target population, location of services).
- Which problems do (insert name of organisation) address through their project? What behaviour, attitudes, groups do they specifically address?
- Have you ever attended one of their activities/interventions?
- What is your opinion of (insert name of organisation) HIV prevention programme?
- Do you believe that (insert name of organisation) are adequately addressing these problems? What are the strengths of these programmes/services? How can they be improved?
- What are the key venues where (insert name of organisation) should be offering services (schools, NGOs/CBOs/FBOs, health setting)?
- Do you feel that you are adequately informed about (organisation's) activites?
- Do you have any other suggestions for organisation X which would enable them to improve their programme?

Key findings from the initial process evaluation suggested that not all drivers of the HIV epidemic were being adequately addressed, including alcohol use, cross-generational sex, transactional sex and multiple and concurrent sexual partnerships (MCP). These findings, together with those from the earlier BCC assessment, stimulated the development of the aforementioned communication guides and RRAPS tool. The process evaluations also improved relationships between organisations and stakeholders within districts, and led to a better understanding of programming processes.

In 2010 it was determined that as part of capacity building, partners—rather than the CAP team—would take the lead in conducting their own process evaluations. Process evaluation training was held in September 2010 to enable participants to understand concepts, principles and processes of evaluating HIV and AIDS programmes, and how to conduct effective process evaluations. The training also imparted knowledge and skills in using appropriate methods and tools for data collection, as well as emphasising the use and dissemination of evaluation findings and lessons learned.

As a result of the training and close monitoring and support, all partners successfully led their own process evaluations in 2010. The CAP team contracted a consultant to support each partner's process evaluations, including being present for the field work, and helping with data analysis and report writing. Some of these skills require further development at partner level—particularly as far as analysing the results are concerned and ensuring they guide future programme developments.

iii. Strengthening M&E systems through use of the OCA

The M&E section of the OCA tool provided a basis for assessing organisational capacity in M&E and planning systemic improvements. On the basis of defined criteria, the OCA enabled organisations to realistically assess processes, systems and the overall performance of their M&E system. Subsequently, the OCA scores in this area helped partners to identify their key gaps and prioritise areas for assistance. As a result, the follow on OCA assessment recorded significant improvement in overall M&E capacity of partners across the board. The overall score (all partners combined) for the M&E component of the assessment improved from 31 percent at the baseline stage to 79 percent in Year 2. Individual progress at partner level is outlined in Figure 12 below.

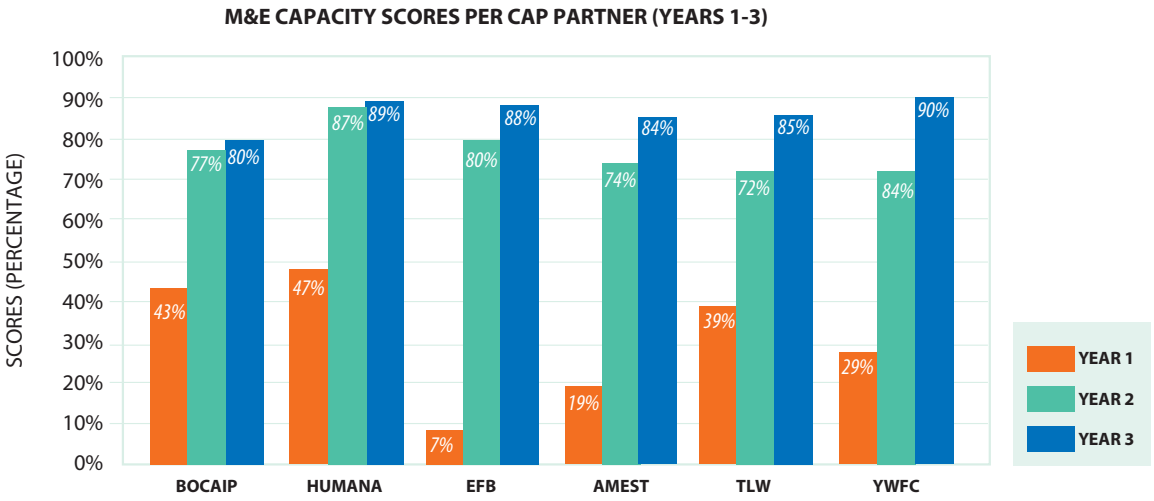


Figure 12. Organisational M&E Capacity Scores (Years 1-3)

Changes in M&E systems and processes that help explain the improvement in the OCA scores between Year 1 and Year 3 included developments such as target setting exercises integrated during programme design; improved M&E and DQA tools with written instructions in the form of an SOP; the introduction of internal performance management meetings on a monthly basis; and increased analysis and use of data through quarterly stakeholder meetings.

iv. Checklist of CAP tools and processes

4.4a. Improving Planning

- ☑ Evidence-based training
- ☑ Community Mapping
- ☑ Volunteer Implementation Plan

4.4b. HIV Prevention Technical Support

- ☑ Communication Guides
- ☑ Tailored Training
- ☑ RRAPS Tool

4.4c. Programme Management Tools

- ☑ Routine Field Supervision
- ☑ Supervisory Checklists
- ☑ Quarterly Performance Review Meetings
- ☑ Monthly Supervision Meetings

4.4d. M&E Technical Support

- ☑ Data Quality Audits
- ☑ Recording and reporting formats
- ☑ Process Evaluations

5 Results of the CAP Project

Major results of the CAP Project over the three-year phase were evident from all partners in the areas of improved institutional capacity, programme quality, HIV prevention coverage, and cost.

5.1. Overall capacity improvements of CAP partners

Clearly, the CAP Project has made significant strides towards strengthening organisational capacity of partners. A partner-specific analysis indicates that between baseline - Year 1 (2008) and final - Year 3 (2011) capacity assessments, capacity scores improved for all partners and across all domains assessed. HPP realised a significant increase in overall organisational capacity from 65 percent in Year 1 to 88 percent in Year 3. BOCAIP and YWFC also made significant improvements in capacity from 57 percent and 33 percent in Year 1 to 76 percent and 75 percent respectively in Year 3. A key factor explaining the improvements in institutional capacity is the committed engagement of partners in this programme of multi-faceted capacity building and technical assistance.

Figure 13. Overall capacity improvements of CAP partners

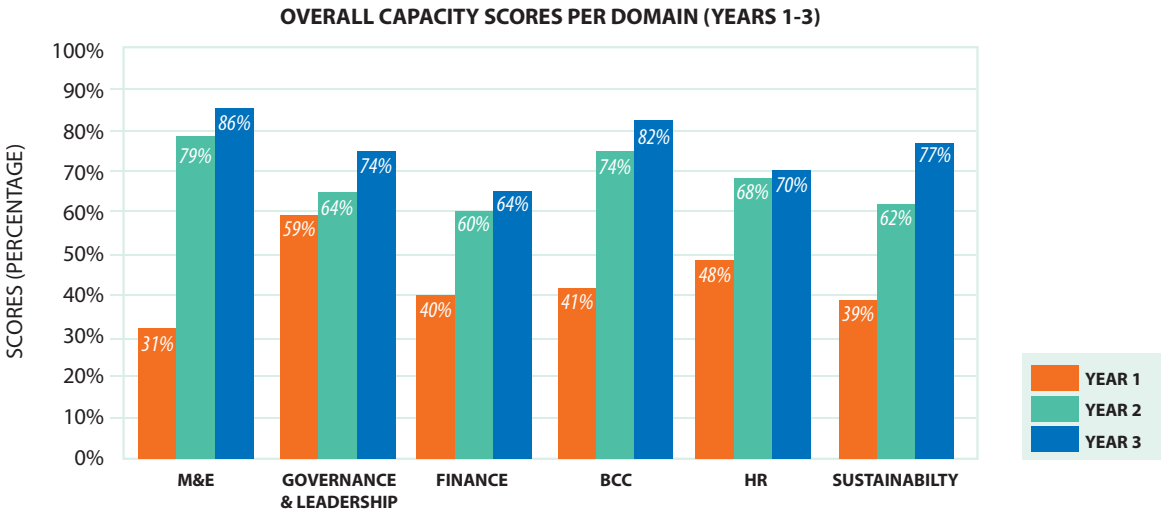


Figure 14. Overall capacity scores per organisational domain (Years 1-3)

5.2. Increase in project coverage

A milestone for the CAP Project has been a significant increase in project coverage, with more than 150,000 individuals reached through community outreach to promote HIV prevention as of June 2011.

As illustrated in Figure 15 below, CAP partners reached over three times as many people with HIV prevention interpersonal communication in Year 2 and 3 compared to the first operational year and coverage improvements have been observed among all partners.

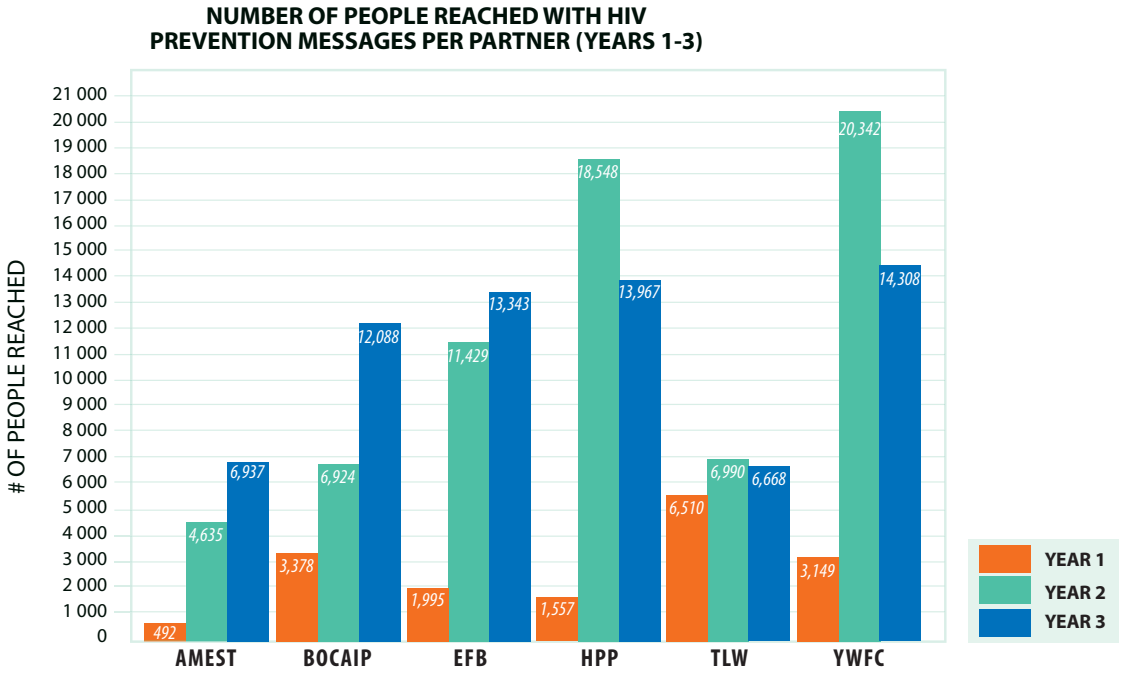


Figure 15. Total number of people reached per CAP Partner (Years 1-3)

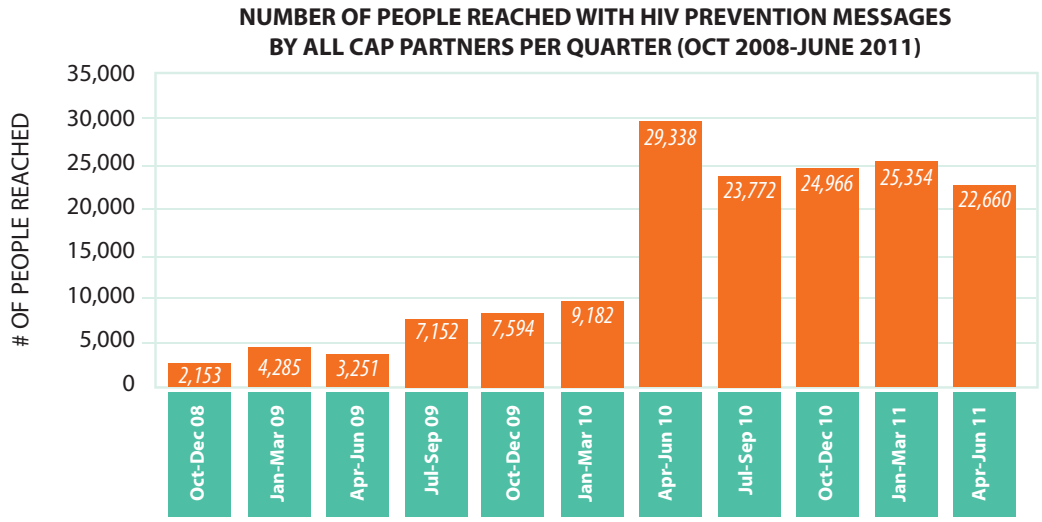


Figure 16. CAP Project coverage (Oct 2008–Jun 2011)

The increased coverage can largely be attributed to the efforts of CAP partners that use the new performance management systems outlined in this document. Other changes included an expansion of sites within districts, which occurred around March 2010.

Encouragingly, partners have been able to sustain this much higher level of performance since then.

5.3. Improved quality of BCC delivery

Reaching more people is only significant if the efforts of implementers are effective in stimulating sustainable behaviour change. Although reliable outcome data linked to these specific interventions are lacking, it can be concluded that not only have partners reached more individuals with HIV prevention communication, but the quality of this communication has also improved. Communication guides specific to the drivers of the epidemic are now in use and implementers are able to meet minimum PEPFAR standards during each session because of upgrading the content of education combined with skills building, role plays and other adult learning techniques. The introduction of the individual-focused RRAPS tool and SOP improved linkages with complementary services, and with a number of activities aimed at stimulating behaviour change, implementers are now significantly better equipped to empower beneficiaries within their communities with the necessary knowledge, skills and support to make healthy decisions on matters relating to sex and sexuality.

Another perspective on quality comes from the partner-administered Supervisory Checklist. The checklist, as explained in an earlier section, involves supervisors rating implementers on factors such as two-way communication, delivering messages accurately and in a way that engages the audience, as well as actively seeking feedback and making necessary referrals, to name a few. An analysis of scores from the Supervisory Checklist administered by partners shows an improving trend in the quality of communication delivery, with scores increasing from 73 percent in the last quarter of 2009 to 82 percent during the period July 2011 to September 2011.

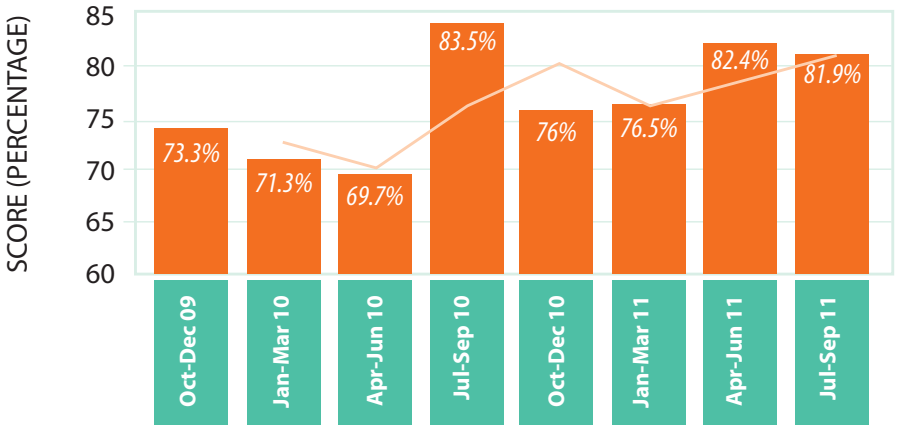


Figure 17. CAP Project supervisory checklist scores and trendline (Oct 2009-Sept 2011)

Furthermore, OCA results have also revealed that partners' capacity in the delivery of BCC has significantly improved. Scores on the BCC domain increased from 41 percent in Year 1, 74 percent in Year 2 and 82 percent in Year 3. This change can be attributed to improved alignment to national priorities and PEPFAR BCC minimum requirements; improved evidence-based planning and programme design-use; use of the communication guides that focused on the key HIV drivers as outlined in NSF II; and increased feedback from beneficiaries. Partners were also better able to segment their audiences and target messages.

This measure of quality has been complemented by feedback from the target groups that indicate that targeted BCC has helped transform lives by placing community members in a better position to make informed decisions on matters related to safer sex and sexuality. The following case study shows how implementers are working to facilitate behaviour change.

CASE STUDY 2: COMMUNITY OUTREACH

Peer Education to Explain the Benefits of Delayed Sexual Debut

Her beguiling smile and easy demeanour makes it easy for adolescents in Kanye to confide in her about their sexual attitudes and practices. At 18, Taetso's contribution as a peer educator at the Seepapitso Secondary School in the busy 'village' of Kanye in southern Botswana is invaluable, given that the country has high HIV infection rates and young people are at high risk.

Recent data from an FHI 360 study in Selebi-Phikwe and Bobirwa Districts, with Tebelopele, indicated that individuals initiating sex before the age of 15 were more affected by HIV than those who debut sexual activity at a later stage. Age disparate relationships are quite common in Botswana, and the higher HIV prevalence among young women compared to young men is thought to be partly related to relationships with older men, among whom HIV is more prevalent. An important dimension here is that adolescent girls are more prone to HIV infection than boys owing to permissive cultural norms and economic pressures.

Taetso's forthcoming attitude makes her the ideal role model for other adolescents to emulate and discuss issues pertaining to sex. There is ample evidence to suggest that given the right cues and information about contracting HIV and its fallouts can encourage youth to defer the age at which they first have sex and prevent them from making wrong choices and indulging in unsafe sexual practices.

Such peer educators have assumed a vital role in Botswana's response to HIV and AIDS. A 2010 UNAIDS and NACA Botswana report highlight the need to educate and empower younger women in the country about unsafe sex and provide them with life skills, HIV education and information. School and community-based learning about HIV and AIDS by way of youth centres or clubs can go a long way in empowering young people to avoid risky behaviours and realise the importance of seeking out HIV prevention services. Already, the initiative has started making inroads into the minds and hearts of youth. The BAIS III (NACA) shows that the percentage of young women under 15 who engaged in sex was cut in half from 7 percent in 2004 to 3.5 percent in 2008. Furthermore, HIV prevalence decreased among 15- to 19-year-olds during the same time from 6.6 percent to 3.7 percent.

Taetso kicks off sessions with a combination of topical questions and answers, lively role-plays and games all geared towards providing workable strategies to avoid adolescent sex and delay the onset of sex. 'Before these sessions, we had a real fear of AIDS. We thought it was a curse that destroyed homes. We have seen it break up families, kill our teachers, parents and loved ones. So many children are orphans today and have to fend for themselves,' says Taetso as she sits among her friends

Students at Seepapitso Secondary School explaining how their education on DSD has benefited them.

Students at Seepapitso Secondary School posing for pictures.

and fellow-members of her school Peer Education Club against HIV. Since 2008 under the CAP Project, the Botswana Christian AIDS Intervention Programme (BOCAIP), has introduced age-appropriate HIV prevention interventions at this secondary school and six other primary schools in Kanye using the communication guides on delayed sexual debut (DSD).

The DSD guide is a comprehensive behaviour change communication tool that targets youth and adolescents, educating them on the link between early sexual debut and HIV. This methodology works to encourage and empower the young, especially women, to delay the onset of sexual activity. The project stakeholders maintain that core interventions to prevent new infections among adolescents and young people can be effective only when used as part of a combination of preventive approaches, including behavioural, health and environmental components. BOCAIP has embodied this methodology for over a year now by sharing accurate information using relevant tools, providing information and access to health care services, safe practices and condoms, in the non-threatening, supportive environment of schools and peers. So far, the guides have been introduced in 17 villages and 12 schools in Botswana.

The educational group sessions have been an eye-opener for participants, providing much food for thought. It has exposed them to a realm of knowledge and energy, and empowered them with tools and strategies to deal with potentially detrimental situations. Many youth admit that they look forward to the sessions because it gives them the opportunity to express their innermost dilemmas and experiences. As 17-year-old Thlamamo confides, 'The sessions teach us skills that help us take care of ourselves. I especially like the game, Resisting Temptation, because it teaches me how to communicate effectively and say 'no' when I do not want to indulge in risky sexual behaviour'. He says his friend and he often share tips and other useful information to friends who are not part of their club.

Their new-found exuberance and optimism is palpable: 'We are young people and have a promising future. We love this approach that allows us to ensure we enjoy healthy lives. It is now fashionable to say no to sex and stay safe,' says a confident Taetso.

Since schools, youth clubs, camps, teachers, families and local leaders play pivotal roles in HIV prevention by cultivating 'safer' attitudes and behavioural norms among the youth, BOCAIP continues to involve all these stakeholders.

5.4. Reduction in cost per person reached through BCC

A notable achievement of the CAP Project has been improving coverage without significant increases in cost. Adoption of cost-efficient implementation strategies has seen a 73 percent decline in cost per person reached achieved between 2009 and 2010. In monetary terms, this meant a reduction from 278 Pula per person reached in 2009 to 76 Pula per person reached in 2010. This demonstrates that partners are now making much more out of their limited financial resources, which occurred as outlined in the previous section, without detriment to the quality of services provided.

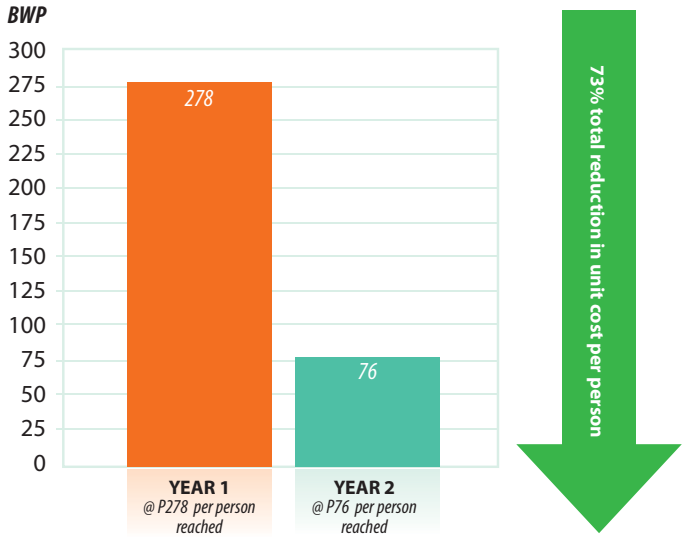


Figure 18. Cost per person reached for the CAP Project (Botswana Pula)

5.5. Expansion of funding base

An overarching goal of the CAP Project has been to enhance sustainability of programmes offered by partners through diversification of funding sources, increasing demand for technical expertise and services offered by partners, and improving the integration of partner programmes into district and national plans. On the basis of the aforementioned components, OCA assessments have revealed an overall increase in sustainability capacity from 39 percent to 62 percent in Year 1 and Year 2 respectively.

Through training on evidence-based programme design, partner capacity to request and secure additional funding has been strengthened. Results show that partners were able to diversify funding sources as evidenced by an increase of 178 percent in the number of funding partners in Year 2.

6 Conclusion

Botswana is currently facing an uncertain future with respect to the level of funding for HIV and AIDS programmes, and there are similar concerns internationally after it was revealed that global HIV and AIDS funds decreased for the first time in more than a decade in 2010 (Kaiser Foundation and UNAIDS 2011). This is occurring against a background in Botswana where CSOs are widely perceived as not fulfilling their potential as partners to government in the national response, and communications approaches aimed at facilitating behaviour change for reduced HIV transmission are being called into question because of limited evidence of their effectiveness. At the same time international experience indicates that a sustainable and effective HIV prevention response requires community-driven responses working in concert with government, and facilitated by a strong civil society.

Throughout this publication, we have striven to share the experiences of the CAP project, as well as describe the key elements of a successful capacity building programme for CSOs that implement community-based HIV prevention activities in Botswana. There has been no attempt to contribute to the evidence base on effective interventions or better position the contribution of civil society within the national response; the CAP programme rather has sought to work with a group of partners to upgrade the quality and effectiveness of their activities, while at the same time strengthening their organisations, so they are better positioned to fulfil their mandates and make a significant public health impact by reducing HIV infections in Botswana.

Over time, the capacities required by civil society will change. However, the generic capacity building model presented here is robust and should continue to stay relevant even though certain tools may become obsolete. The important take-home messages in this document include evidence that CSOs in Botswana are active partners in improving their own capacity, that these improvements can be measured and can result in noticeable changes in their communities, and that effective capacity building partnerships with international organisations (in the form of the CAP project) are achievable through a good collaborative model, high-quality TA and close partnerships. Evidence for the 'effectiveness' of this partnership presented include improvements in coverage, capacity, quality and unit-cost of partner programmes.

Although no outcomes such as reduced HIV transmission in target communities have been presented, it is expected that the improvements in HIV prevention communication design, implementation and management will contribute to these desired outcomes. As study designs able to attribute outcomes to certain initiatives are currently complex to design and expensive to implement, the CAP programme has looked more towards process measures and outputs, together with locally available evidence, including beneficiary, implementer and stakeholder feedback, for development and validation of the model and tools.

Partners have not only upgraded their technical approach and ability to have an impact on HIV transmission in their communities, but they have also used community-centred approaches to improve the integration of their efforts with other HIV prevention initiatives. As such, partners are now more visible stakeholders in the community response and have new relationships with law enforcement agencies, government departments beyond the MoH, the education sector, social services, and faith-based movements as part of a network of services.

Although sustainability is an elusive concept for organisations, community capacity can be sustainably enhanced, and through the CAP project over 100 implementers (identified as potential champions for HIV prevention within their communities) have been trained and supported over the last three years and will remain behind after the project ends, representing a sustainable enhancement to the capacity of communities to understand the epidemic and respond.

Capacity building is a cyclical process that requires continual assessment, learning and improvement. CAP partners have demonstrated substantial improvements in performance because of their active participation in the design and delivery of technical support, including the new systems and management tools described here. It is this active participation; together with commitment to learn from beneficiaries; willingness to test, learn and adapt, and willingness to strengthen partnerships for more effectiveness— rather than the tools themselves—that are the key ingredients in this success.

Future models for civil society strengthening need to move beyond capacity building of small groups of organisations to models that can be taken to scale cost effectively and involve national CSO coordination structures. Organisations that should attract more funding within a national response (and hence have greater likelihood of sustainability) are those that can perform their work better, more cost effectively, and with more impact than their competitors. The CAP project has a number of partners who have demonstrated the flexibility, commitment and capability to evolve in this direction over the past three years, and hence should now be seen as reliable partners in the current national response, as well as good prospects for the future.

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