Be Wise – Condomise
A study in Botswana on the spread of AIDS information and how the information is being received

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AIDS is a huge problem in the world and it is spreading rapidly, especially in Africa. Botswana is one of the world’s worst-hit countries, with over one-third of the inhabitants infected by HIV/AIDS. The measures that have been taken to stop the spread of AIDS are to inform and enlighten people on how the disease is spread and how to protect oneself.

The aim of this thesis is to investigate what different ways of informing people about AIDS different organisations make use of in Botswana. The thesis also addresses how some receivers of the AIDS information experience it. The receivers are limited to young women in Gaborone. The thesis is based on a MFS study carried out in Gaborone, Botswana. The study was conducted through interviews and observations.

The main question of the thesis is: Are the most common ways of spreading information about AIDS which the organisations we investigated in Botswana make use of also those which the young women appreciate most?

The thesis investigates both sides in the communication process, the transmitters of AIDS information and the receivers. It makes use of Jarlbro’s theory on health communication and Ross Todd’s theory on information utilisation to analyse the work of the different organisations and the interviews with the young women.

The result of the thesis is that the transmitters and the receivers do not always have the same perception of what are the best ways of informing people about AIDS. Mostly mass communication campaigns are being used, but young women prefer to be informed on a more personal level.
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1 Introduction

1.1 Background

In Sub-Saharan Africa the prevalence of AIDS—acquired immune deficiency syndrome—is greater than anywhere in the world. One out of ten people that have been infected with human immunodeficiency virus (HIV) live in Sub-Saharan Africa and 83% of the cases leading to death are found in the region, even though only one in ten of the inhabitants of the world live in Africa south of the Sahara (UN Office for the Co-ordination of Humanitarian Affairs 1998).

AIDS has now passed malaria as the largest disease-related cause of death in Africa. In Botswana, Namibia and Zimbabwe 25% of the inhabitants in the age group 15–49 have been infected with HIV/AIDS. Life expectancy has fallen from 70 years to only 40–45 years (Ohlsson 1999).

Jonathan Muganga writes in the book Information, Education and Communication (IEC) on AIDS in Uganda that, since there is no cure for AIDS, information, education and communication are still the only vaccine. The only way to stop the AIDS epidemic is to increase awareness about how infection occurs and then get people to change their behaviour (Muganga 1988).

We knew that AIDS was a major problem in Africa, but after reading things like this we realised that it is a much greater problem than we first thought. We decided that we wanted to investigate how this problem was being handled within the topic of information science. It is difficult to inform huge numbers of people. We wanted to know how this is being done, what different methods are being used and what the recipients of the information think about the information.

We chose Botswana because it is one of worse-hit countries in Africa (and the world) and also because we managed to make contact with Mrs Kerstin Jackson who agreed to be our supervisor and help us with our study. In November 2000 we were granted a Minor Field Study (MFS) scholarship from Sida (the Swedish International Development Agency) and on 1 March 2001 we left for Botswana. We spent two and a half months in Botswana, most of the time in Gaborone, the capital, where we conducted our study.

1.2 Problem demarcation

AIDS is a problem particularly in larger cities. We therefore chose to limit our study to Gaborone which, with nearly 200,000 inhabitants, is the largest metropolis in the country. We also wanted to limit the target group to the category “young women”, since these are an especially vulnerable group—a so-called “risk category” which requires extra information measures. We were aware that as a subject “young women” would not be a homogeneous group, but we did not know beforehand if we would have the possibility to refine our choices further.
As to the organisations we planned to visit, we intended to contrast a variety of different views. We hoped to talk to church organisations, more general NGOs (non-governmental organisations) and possibly also the Red Cross. We also wanted to visit schools and health clinics since these are important in the spread of AIDS information. We hoped to visit organisations of disparate character in order to see if they approach the problem in different ways and if they use different methods to spread information about AIDS. We also wanted to study a wider diversity of organisations as we expected they would reach young women in different environments and at different levels, which, we inferred, could be important in the way the information is received.

1.3 AIDS information and library and information science

How do we justify writing within the subject area of library and information science? To explain this we have used Lars Höglund’s Biblioteks- och informationsvetenskap som studie- och forskningsområde (“Library and information science as a field for study and research”). Höglund describes the field of library and information science as a broad and interdisciplinary field, which, among its other aspects, includes the mediation of information in different ways (Höglund 2000, p. 2).

Höglund shows how this field of study, because of its breadth, is connected to several other fields, e.g., communication (ibid., p. 2). In our study of AIDS information there is an important correlation between information and communication, as it directly concerns information exchange between transmitters and receivers. We also make use of communication theory in order to analyse some parts of our material. The subject of the thesis also has connections with health science.

According to Höglund, library and information science also concerns the ways in which information is constructed to fit the information-needs that exist in today’s societies. Enormous amounts of information are currently being produced, and within some areas there is too much. This leads to problems for the receivers who must sift through heaps of information in order to find the facts they require. There is a need, therefore, for people who can sort out the information and present it to the public in an appropriate way (ibid., p. 2).

Höglund further writes that as society evolves there will be an even greater need for information (ibid., p. 5). The production, distribution and use of information will become more important in every society, even in Botswana.

Within the field of library and information science more and more research is being done in which the user is placed in the centre. The users are in focus for different information services and their needs are fundamental. The availability of information affects the utilisation of that information (ibid., p. 12). Our study deals, among other things, with the receivers of AIDS information, what different needs they have, and what information is available to them.

Höglund writes that information can be seen as a resource in different contexts. It is a requirement for knowledge and it is also a requirement for the development of a society (ibid., p. 8). When it comes to AIDS it is also a prerequisite for survival.
1.4 Aim

Our purpose in this thesis was to study different ways of spreading information about AIDS that people and organisations in Botswana use and to find out what some of the recipients think of the information. We aimed to do this through talking to informants in different organisations, at schools and health clinics. To get a picture of the recipients of the information we chose to talk to young women.

1.5 Questions

Are the most common ways of spreading information about AIDS which the organisations we investigated in Botswana make use of also those which the young women appreciate most?

- Which ways of spreading information about AIDS do organisations use?
- What do the young women know about AIDS?
- In which ways do the young women want to be informed about AIDS?
- In which ways do the organisations think people want to be informed about AIDS?

1.6 The arrangement of this thesis

We have chosen to include a large and detailed descriptive part. That is because of the nature of our study. We made many observations of information during our stay in Botswana that we would like to share with the reader. We will try to give the reader a more holistic picture of the country, Botswana, both concerning the people and culture and concerning how they work with the AIDS problem there. We feel that it is important to give a thorough description of Botswana, how it has been affected by the AIDS problem, and how people can be expected to respond and react to the problem and information given to them. That is why, after the chapter on methods used (chapter 2) and an explanation of what AIDS is medically (chapter 3), we include a presentation of Botswana as a country and the AIDS situation there (chapter 4). After that we give an account of previous research and literature within the AIDS field, how to inform people about AIDS, the recipients of the information and the different organisations that work with AIDS information (chapter 5) and, finally, a chapter about communication (chapter 6). Here our two theoretical bases are presented—one theory about health communication by Gunilla Jarlbro, and a study by Ross Todd concerning young women’s use of information about heroin (section 6.3).

Chapter 7 then presents the results—both our own observations and the interviews. An analysis and a discussion of our work follow this. What conclusions we have made follow that. Finally, in chapter 10, we summarise the thesis.
2 Method

In this chapter we present the methods we have used in our study, the ways in which we have worked and the problems that arose during our work. In the last part of this chapter there is a list of abbreviations and terms used in the thesis.

2.1 Choice of method

We chose to do qualitative research. According to Idar Magne Holme and Bernt Solvang in their book Forskningsmetodik (“Research methodology”), the researcher should not concentrate on determining if the information has general validity. What is essential is rather that the researcher through different ways of collecting information can, on the one hand, gain a deeper understanding of the problem he or she is investigating, and on the other hand describe the entirety of the situation. This method relies on proximity to the source where the researcher receives his information (Holme and Solvang 1991, p. 14).

We chose the qualitative methods of interview and open observation because we wanted to get investigate thoroughly how different people and organisations work with the spread of information about AIDS and what they think is the best way to get messages out to the population. We did not want to draw any general conclusions; we wanted to describe a selection of how different organisations and people work in the dissemination of information about AIDS. We also wanted to examine what the young women think about the information they get.

Holme and Solvang see the strength of the qualitative interview as lying in the fact that the investigation situation is similar to an ordinary situation and a usual conversation. The researcher tries to allow the people in the investigation to influence the development of the conversation (ibid., p. 99). In connection with observation we carried out qualified interviews with the people involved in the dissemination of information and the recipients of the information. We talked to representatives of different projects and young women who have received information. We consider that this selection gives us a good insight into the ways in which information about AIDS is being disseminated in Botswana, and also what the receivers think about the information.

By means of open observation, by looking, listening and asking, the researcher can build an idea of what is going on with the people in the investigation (ibid., p. 122). Open observation means research where the subjects know and have accepted that they are being observed. Open observation is built on the groups’ acceptance of the researcher. As an observer the researcher should not be different from the group he or she is observing in behaviour, way of expressing oneself or dress. However, the researcher is not one of the group; instead he or she is expected to perform the activities required of an observer. The researcher can walk around and ask questions and look at the way things work in the group (ibid., pp. 111f). We used open observation in three different information sessions.
2.2 Selection of organisations and informants

According to Holme and Solvang the selection of people to investigate is a decisive part of the research. If the researcher gets the wrong people in the selection that can lead to the whole investigation becoming valueless, measured in terms of the aims the researcher had at the beginning. The selection should be made systematically from some consciously formulated criteria (ibid., p. 101). Our selection of organisations and informants that the investigation is based on was made with a view to getting a mixture of different organisations and informants.

The selection of schools for our informant interviews was made by simply visiting the two schools in our neighbourhood. Our supervisor, Mrs Jackson, also recommended that we visit the schools and was willing to contact the head teachers there, but we made the contacts ourselves. We were given assistance by the head teachers at the schools with the selection of the young women who took part in the interviews at the schools. We did, however, explain which age group we required. There was no possibility for us to control the actual selection of the young women.

We selected the 17-year-old girl to whom we have given the fictitious name Ann as an informant we made contact with on the basis of information from Mrs Jackson. We also interviewed Ann as a representative of the youth organisation PACT. This required two different interviews. The selection of the organisations was made after we had met Mrs Paivi Reay at UNAIDS. She had many names and telephone numbers to different organisations that she recommended. After we met her we chose to contact the organisations that we thought suited our investigation best. Our idea, when we chose the organisations to examine, was to get as large a spread as possible of the different types of work. We wanted to examine church organisations, NGOs, public institutions (e.g., libraries) and others. Some of the organisations that we chose to investigate we contacted through other organisations and even Mrs Jackson, because it was difficult for us to know what organisations that were active in Gaborone. Martyn Hammersley and Paul Atkinson give an account of this latter fact in their book *Ethnography: Principles in Practice*. They think that sometimes people select themselves or others for interviews. This can occur for different reasons. “Gatekeepers” or other powerful figures in the field sometimes attempt to select interviewees for the researcher (Hammersley and Atkinson 1983, p. 133). This may be done in good faith to facilitate the research, or it may be designed to control the findings. Sometimes it may even be necessary to negotiate with gatekeepers before one can contact the people one wants to interview. All of this can make it difficult for the researcher to choose the people to interview in an unknown setting (ibid., p. 134).

The representatives of the organisations we interviewed are not names, but we give the names of the organisations because we think it is important which types of organisations are providing information about AIDS.

2.3 Mode of procedure

We started our work about one year before we left for Botswana. We had some problems in getting in contact with someone in Botswana who could become our supervisor and help us with further contacts there. In September 2000 we came in contact with Mrs
Kerstin Jackson in Gaborone, who agreed to become our supervisor. Mrs Jackson has lived and worked in Botswana on and off since the beginning of the 1990s; three years ago she became a permanent resident. In Sweden Mrs Jackson worked for Utbildningsradion (Education Radio), and it was through her radio work that she came to work in Botswana. Today Mrs Jackson freelances and does radio programmes in Botswana, and sometimes does programmes for Utbildningsradion.

In October 2000 we got our MFS scholarship from Sida. Mrs Jackson helped us to get the official permission required so that we could gain access to all documents and persons we wanted to meet. We got the permission from Mrs Jackson on our first day in Botswana but did not have to show it to anybody, not even when we visited the organisation that had told Mrs Jackson we absolutely needed a permission to visit them!

In February 2001 we took part in a Sida course at Sandö in Kramfors. There we learned more about developing countries. On 1 March we travelled to Botswana. Mrs Jackson had told us before we left Sweden that it would be difficult to contact any organisations and informants before we were in Botswana.

We had no problems in getting interviews with representatives of the organisations. One problem was that we sometimes met people working at a somewhat higher level than we had first imagined. We did not always meet the actual disseminators of information. We also had a problem in getting hold of NACA (the National AIDS Co-ordinating Agency): we did not manage to contact anyone there who could give us an interview. There were also some problems due to misunderstandings and sickness. We had the opportunity to take part in only two information occasions. We could not attend an information session where we could interview both the informer and the receiver of information at the same time.

We had some problems in making contact with young women to interview. When we came to Botswana our idea was to interview one group of young women several different times—a reference group—and then to compare our results of the interviews with the theory of Ross Todd (of which we give an account in chapter 6). However, it was not so easy to find a reference group. Our supervisor, Mrs Jackson, told us to go to a school and ask if we could talk to some of their students but this meant that we got in contact with younger girls than we first had considered since the schools we visited were primary and secondary schools. After the first interview with four girls at the school we came to the conclusion that it would be difficult to do in-depth interviews. It was difficult to get the interviews to flow. We felt that it would not work better if we returned after a week. AIDS is a very delicate subject. It is acceptable to discuss AIDS on superficial level, but not to go into personal details. We therefore decided to do only one interview with each group of girls. Because we only interviewed the young women once the results that we have from our interviews with the young women are, therefore, more difficult to compare with Todd’s theory.

Another problem with the interviews was that the teachers attended them. This may have affected the students and the answers they gave us. But we did not feel that we were in a position to ask the teachers to leave. Therefore we can only hope that it did not affect the women too much.

We carried out the interviews with the young women at the schools in groups. Pål Repstad writes in his book *Närhet och distans* (“Nearness and distance”) that some-
times it can be good to do interviews in groups, e.g., when the respondents feel more safe than he or she would in individual interviews. One problem can be that only accepted and permissible attitudes will arise; another is that for group interviews to be successful the respondents have to feel safe with each other (Repstad 1999, p. 83). When we carried out the interviews with the young women we noticed that some of them talked more that others. For example, at the Primary School two of the girls were very quiet. When we tallied our results, we also did that in groups. It was very difficult for us to separate the young women from each other when we listened to the tape. When we present the interviews with the young women at some points we report what different women said. This we do with the parts of the interviews that we think are of especial interest.

We made notes as well as taping the interviews. After each interview we typed out the interviews as quickly as possible so that we would not forget any important parts. After the first interviews we observed that we had to change the questions slightly, but not to any great extent. We considered the interview technique to be difficult and we may not have been adequately prepared. Sometimes it was difficult to ask attendant questions and we discover now that there were some questions we forgot to ask. We will discuss this in the next chapter on the language situation.

Altogether we conducted 19 interviews and have chosen to include 14 of these. That we do not include all the interviews in the thesis is due to different reasons. The first interview we performed is not included because we do not think it gave us the facts that we require for this thesis. We think of it as a test interview. The second interview not included was with an insurance company, and did not produce any relevant facts for the thesis. The third interview we have dropped was with a woman at a diamond company, Debswana. We believe that she worked at a level too high for our needs; moreover she did not know what work the company was doing against HIV/AIDS. The fourth interview we have chosen not to use was with a man who works with AIDS at the University of Botswana. But he had another direction to his research which meant that it did not suit our thesis. The fifth and last interview not included was with a man at a counselling centre in a town outside Gaborone. The tape with the interview is still in Gaborone. A woman promised to help us to translate the interview, because some parts of it were in Setswana.

In the thesis we also include things we have heard and experienced in order to give a clearer, more holistic, picture of Botswana society.

The conclusions we drew as a result of the interviews and observations are presented in chapter 9, Discussion. We have done this because we think it more logical when we present our conclusions of the discussion.

2.4 The language situation

English is the official language of Botswana, and the medium of instruction from the fifth year of primary school. All the people in Gaborone we met spoke English. In the rural areas fewer speak English. The most common language is Tswana (or Setswana), a Bantu language in the Sotho-Tswana group, which is understood by over 90% of the population. It is the language of the dominant population group, the Tswana, and is used as a medium of instruction in early primary school (Swaney 1999, p. 436).
Since our aim was to conduct our study in Gaborone we did not need any interpreter. The representatives of the different organisations that we visited all spoke English; some of them were from the US, the UK or other English-speaking countries. All the representatives and the young women spoke English, but we felt that it was difficult to do the interviews in English. We consider interview technique in itself to be difficult and it is made worse when the interviews are not conducted in your native language. We found it difficult to ask attendant questions. Moreover it was sometimes difficult to understand what was said during the interviews, the dialect of the English language being different from what we are used to hearing, and it took some time to become familiar with it.

2.5 Analysis

To learn about how to do an analysis of qualitative methods we consulted two methods books, *Forskningsmetodik* by Holme and Solvang and *Närhet och distans* by Pål Repstad. In this section we describe the literature of analysis and then report on how we analysed our results.

The analysis of the information that qualitative interviews give is often both a time-consuming and a circumstantial process. Mainly this is because of the form that the information has. All structuring and organising of the information is made after the information is collected (Holme and Solvang 1997, p. 139). The first thing the researcher does in the analysis is to read the notes from the interviews and hopefully there he or she will find some entries for further analysis (Repstad 1999, p. 106).

Two types of text analysis can be distinguished—total analysis and partial analysis. Total analysis attempts to see the totality of the information collected. The basis for a partial analysis is the printed texts which include statements about some different facts, which are more or less tied to the facts that are in focus for the investigation (Holme and Solvang 1997, p. 141).

The relative emphasis on narrative accounts and theoretical interpretations can be different during different parts of the research (Repstad 1999, p. 96). There is no unbiased interpretation. The basis for the qualitative methods lies in getting the main figures in focus (ibid., p. 97).

Even in qualitative studies and evaluations there need to be a correlation between the theoretical perspective and empirical data. It may occur that the researcher discovers critical ideas of a certain theory, but the ideal is to relate to the theory (ibid., p. 98). In qualitative studies researchers are unwilling to try theories only to make them clear or to make them more or less reliable (ibid., p. 99). During the qualitative research process there is a continuous adjustment between empirical theory and data (ibid., p. 102).

When it comes to analysis of the interviews with representatives of the different organisations we went through the results and divided them according to Jarlbro’s model of health communication to see how the different organisations work in relation to the model. After that, we compared the organisations with each other to see how they work in relation to each other and in relation to Jarlbro’s model. With the interviews with the young women we compared them with Todd’s research on information
utilisation. Then we compared the analysis of the organisations and the analysis of the young women to try to draw conclusions in relation to our questions.

2.6 Literature studies

We did most of the literature studies before we travelled to Botswana. We read literature about AIDS in the world and especially in Southern Africa, about different ways of disseminating information and about how to prevent AIDS through information campaigns. We found considerable information about this and we had some problems in sifting out what was relevant for our study. However, we also had problems finding relevant literature about the recipients of information. It was also difficult to find literature by African authors: most of the literature is written in Sweden, the US or the UK.

We searched the library catalogues of the University College of Borås (Högskolan in Borås), Kristianstad University (Högskolan i Kristianstad), the University of Örebro, the Nordic Africa Institute (Nordiska Afrikainstitutet), and Sida’s Sandö library, and in Libris, the Internet and Artikelssök, among others. We also looked in the CINAHL database, which is a source of information for literature on nursing, allied health, biomedicine and health care. Other databases that we looked into include PubMed, which gets its data from the medical database MEDLINE; EBSCO host, from which we retrieved articles in full text; and African Women’s Bibliographic Database, in which we found many articles about Batswana women. Unfortunately the Högskolan i Borås library was unable to retrieve the articles for us.

In Botswana we searched for information in the National Library, but we did not find anything that was relevant to our study. After one interview we borrowed some papers. The material mostly included statistics about the numbers of AIDS-infected persons.

2.7 The title of the thesis

We have chosen the title Be Wise—Condomise: a Study in Botswana on the Spread of AIDS Information and How the Information is Received because we heard the slogan “Be wise—condomise” as radio advertising many times during our stay in Gaborone, and we think that is a good title for the thesis. Hopefully the title also gives the reader an indication of the substance of the thesis.

2.8 Abbreviations

AIDS – Acquired Immune Deficiency Syndrome

AIDS/STD Unit – The Primary Health Care Department in Botswana has several divisions. One of these is the AIDS/STD Unit

Batswana – people of Botswana
**BOCAIP**- Botswana Christian AIDS Intervention Programme - a church organisation in Botswana that works with information about HIV/AIDS

**BOTUSA**- a project between Botswana and US

**Catla** - Catla is a place in the villages where people gather on special occasions

**DFID** - Department for International Development (UK)

**HIV** – Human Immunodeficiency Virus

**MFS** – Minor Field Study

**NACA** – National AIDS Co-ordination Agency

**NGO** – Non-Governmental Organisation

**PACT** – Peer Education to Counselling Teenagers

**PSI** – Population Services International, who work with social marketing and communications for health

**Pula** - Name of the currency in Botswana

**Sida** – Swedish International Development Agency

**STD** – Sexually Transmitted Diseases

**Sub-Saharan Africa** – The part of Africa that is situated south of the Sahara desert

**TB** – Tuberculosis

**Tebelopele** – a testing and counselling centre in Gaborone, Botswana

**UN** - United Nations

**UNAIDS** - United Nations AIDS programme

**UNDP** - UN Development Programme

**WHO** – World Health Organization
3 AIDS

We start this chapter with a section on what AIDS and HIV are medically, what the symptoms are, treatment etc. This is basic to the thesis. To get these facts we used Collier’s Encyclopedia, and AIDS in Africa by Tony Barnett and Piers Blaikie. After that we examine why AIDS has spread so rapidly in Africa.

3.1 Acquired Immune Deficiency Syndrome

According to Frederick and Marta Siegal in the article “Acquired Immune Deficiency Syndrome” in Collier’s Encyclopedia, AIDS is a human viral disease that ravages the immune system, undermining the body’s capacity to defend itself against certain microbial organisms. It usually leads to death from multiple infections or other disturbances in an individual’s natural defences. Once such disturbances are manifested, the disease becomes fatal, this may occur within a few months or up to several years from the time of onset (Siegal and Siegal 1996, p. 87).

Barnett and Blaikie write in AIDS in Africa that AIDS was first identified in 1980 among homosexual men and injection drug users in New York and California. Shortly after its detection in the United States, evidence grew of epidemics in Sub-Saharan Africa and Haiti. Several years after its appearance, AIDS had become a worldwide epidemic, or pandemic, affecting people in virtually all nations. In Africa, the disease has been spreading heterosexually from the outset. The rapidity of its spread can be partly explained by the lack of health resources, poor general health, and long periods of social unrest (Barnett and Blaikie 1992, p. 2).

AIDS is the end-stage of a chronic infection with Human Immunodeficiency Virus. The virus destroys the body’s defence mechanisms. HIV is a slow-acting virus able to reproduce itself using genetic material from the cells of its host. It can lie dormant for many years, enabling infections but allowing people to appear healthy. This aspect of the disease means that many people may be infected before medical, social and political responses can be mobilised. The virus opens the way for other infections that do kill, as the body’s ability to muster its defences decreases. The virus is fragile. It cannot live for very long outside the human body and passes from person to person via the medium of body fluids such as blood, semen and vaginal secretion (ibid., p. 3).

When HIV first infects someone there can be an acute onset of fever, rash and meningitis. Later during the incubation period of AIDS, swollen lymph nodes commonly develop, reflecting activity of HIV in those tissues of the immune system. The diseases associated with AIDS itself can develop only when the immune system has sustained a certain degree of damage. Tuberculosis can become an opportunistic infection relatively early in the immune decline of patients infected with HIV (Siegal and Siegal 1996, p. 88).

HIV infection is generally confirmed by laboratory tests that detect antibodies in the blood that react with HIV. No curative therapy exists at present, but several antiviral drugs appear to mitigate or delay certain aspects of the disease process (ibid., p. 88).
At present, efforts to prevent the further spread of AIDS focus on the dissemination of knowledge about how the virus is spread and in convincing people to avoid exposure. Some riskful behaviour that accelerates the spread of AIDS through populations has long been identified, but education has proved insufficient to stop the AIDS pandemic (ibid., p. 88). Research into vaccines against AIDS has advanced substantially, but efforts to design and produce a universally effective vaccine have not met with success so far. One of the most important obstacles is inherent in the AIDS virus itself: by its fiendish ability to mutate, it has so far managed to frustrate human efforts to develop an effective vaccine or curative drug (ibid., p. 88).

The solution to the AIDS problem will come from medical science, but the effects of the disease will be felt by individuals, communities and societies for years to come. In the absence of a cure or a vaccine, millions of individuals will die. The importance of writing about Africa is that the disease is spreading very rapidly there in impoverished communities which depend on human labour for survival and where at national level countries are so poor that resources for dealing with the care of the sick and dying and the orphans are already extremely scarce (Barnett and Blaikie 1992, p. 5).

Certain things are clear about AIDS. It is a disease that can affect anybody. It is not especially a disease of gays, black people or of intravenous drug users (ibid., p. 3).

### 3.1.1 Summary

AIDS ravages the immune system and usually leads to death. AIDS is the end stage of a chronic HIV infection. HIV is transmitted through body fluids such as blood, semen and vaginal secretion. Today there is no vaccine.

### 3.2 AIDS spread quickly in Africa

Because we were studying Africa we were interested in why AIDS is so prevalent in Africa and why it spreads so fast. To learn about this we studied literature that discusses the differences between the spread of AIDS in Africa and in Europe, and factors that influence the spread of the sickness in Africa.

Benedict N. Chin in her book *AIDS and AIDS Prevention in Africa* thinks that the three most common ways in which people become infected by AIDS in Sub-Saharan Africa are:
- heterosexual intercourse
- transmission from mother to child
- blood transfusion (Chin 1998, p. 5).

According to Ann-Charlotte Ek in her book *Kenyanska aidsdiskurser* (“Kenyan AIDS discourses”) this is different from the case in Europe: sexual practices are different in Africa. Here different factors play a role (Ek 1999, p. 6). In *Preventing and Mitigating AIDS in Sub-Saharan Africa* the editors, Barney Cohen and James Trussell, write that the social, cultural and economic factors that affect the size and form of the AIDS epidemic in Sub-Saharan Africa are:
- the age and sex composition of the population
• patterns of sex roles and expectations within the society
• inequality between the sexes and power
• the sexual availability of young girls and the acceptance of great age differences between sexual partners
• rapid urbanisation with high unemployment
• poverty
• the great extent of sexual exchange caused by women’s limited capacity to earn money themselves
• lack of access to medical aid, especially for treatment of sexually transmitted diseases (STD)

(Cohen and Trussell 1996, p. 4).

Carl-Johan Birkoff and Johan Körner write in *AIDS Education Through Drama* that studies carried out among married men in Africa show that not many bother to protect themselves. Many of the men said that they never used condoms. Another reason why the disease is spreading so rapidly in Africa is the mobility of the population, with broken family relations. Extra-marital relations are very common. These relations exist especially among migrant workers, men who work away from home (Birkoff and Körner 1994, pp. 11f). It is also common to exchange sex for money or material things. This is not always considered to be prostitution. Many women who live apart from their husbands or are legally divorced have sexual relations in return for money and things to supplement their low income and to support the family (ibid., 1994, p. 13).

*Aids i Afrika* (“AIDS in Africa”) Mai Palmberg writes that one important goal has been to try and change men’s view of their sexual roles. The more wives or girlfriends a man has the higher status he will have; a woman is a part of his property (Palmberg 1993, p. 166). Benedict N. Chin writes that with that attitude women have seldom any say in sexual decisions. AIDS prevention programmes will not accomplish much without first dramatically reducing the inequality between the sexes.

Different types of interventions are:

• health education
• counselling
• peer education
• broadcast strategies (for example, the mass media, theatre, pamphlets, radio)


### 3.2.1 Summary

Among the reasons why AIDS is spreading so fast in Africa are: (a) the mobility of the population, with broken family relations; (b) the fact that sexual practice is different from what it is, for instance, in Europe; (c) it is common practice to exchange sex for money or material things, which is not always regarded as prostitution. The widespread AIDS epidemic in Africa is the result of social, cultural and economic factors. One important goal is to change men’s sexual attitudes. For this to be realised the genders have to become more equal. Different examples of interventions are health education, and peer education.
4 Botswana

In this chapter we present some general facts about Botswana; history, the people, language etc. There is also a section about AIDS in Botswana, and the problems that exist in relation to the epidemic. To get the facts about Botswana we consulted two books, *Botswana* by Alan Brough, and *Zimbabwe, Botswana and Namibia* by Deanna Swaney.

(Source: CIA World fact book 2000)

4.1 History of Botswana

The earliest modern inhabitants of Botswana were the San (Bushmen). They have lived an almost unchanged lifestyle in the country since the Middle Stone Age. In the early 1980s the last wandering family groups were unwillingly brought into the “civilised” world. The San were peace-loving people who lived in harmony with nature, but not so the more dominant socially organised Bantu tribes that migrated into the subcontinent from the Congo Basin about 1,500 years ago (Brough 1997, pp. 14 f).

The first socially stratified Bantu “chiefdoms” with a distinct class structure emerged in Botswana 1,000 years ago near Palaye, and by AD1,200 a second, greater power had developed. Following centuries of tribal nomads endlessly splitting and reforming into different groups, almost all the fertile land in Southern Africa was occupied by the early 19th century. As a result people became competitive, vying for the natural wealth that
the land had to offer. Social unrest, tribal tension and chaos heightened by the growing ivory and slave trades ushered in a particularly violent and destructive period in Botswana’s history (ibid., pp. 14 f).

In 1885, as a result of conflict with the Boers across the border in the Transvaal, the Tswana chiefs appealed to Britain for protection, and the Bechuanaland Protectorate was proclaimed. In 1895 Britain incorporated the southern part of the territory, including the capital, Mafeking, into the Cape Colony. This saved the country from the Boers. The protectorate status was to remain until full independence in 1966 and brought with it a long period of “peaceful neglect” which was characterised by little development, but also by few of the colonial impositions suffered by all other countries in Southern and Central Africa (ibid., p. 17).

When British rule had been firmly established, the chiefs more or less accepted the fact that their tribal rites, traditions and lifestyles would be forever altered by the influences of Christianity and Western technology. A capital was established at Mafeking, in South Africa. Bechuanaland Protectorate was one of the few countries in the world to have its capital outside its national boundaries (Swaney 1999, p. 417).

Indicative of the lack of interest shown in the Bechuanaland Protectorate by the British, the colony was administered from Mafeking. In the early 1960s Gaborone was selected as the site of the new capital and frenetic construction began immediately. In 1965 the protectorate was granted internal self-government. The birth of the Republic of Botswana and full independence came on 30 September 1966, under the leadership of Sir Seretse Khama (ibid., p. 418).

4.2 Botswana today

4.2.1 Geography and climate

Botswana is one of the world’s most thinly populated countries, with less than 3 people per km$^2$ (Brough 1997 p. 5). Located in the centre of Southern Africa and covering an area of 581,730 km$^2$, Botswana is a landlocked country. To the west and north lie Namibia and the Caprivi Strip, which runs along the top of Botswana, to the south South Africa and to the east Zimbabwe. Botswana is dry and prone to drought (Brough 1997, p. 6).

There is considerable variation in the seasons and climatic conditions in Botswana. There are generally two seasons—summer, which lasts from October to April, and winter, which is slightly shorter, from May to September (ibid., p. 7).

4.2.2 Population

The largest tribal group in Botswana is the original Tswana tribe, comprising almost 50% of the population, followed by the Bakalanga people (Brough 1997, p. 25).
4.2.3 Language

English is the official language of Botswana and the medium of instruction from the fifth year of primary school. The most common language is Tswana (or Setswana), a Bantu language in the Sotho-Tswana group, which is understood by over 90% of the population. It is the language of the dominant population group, the Tswana, and is used as a medium of instruction in early primary school (Swaney 1999, p. 436).

4.2.4 The schools, literacy and libraries

The colonial government did not give priority to the health and education of the Batswana, and five years after independence the literacy rate was still below 15%. Over the next 10 years, however, profits from diamond mining became available and the government used them to step up its primary education programmes (Central Intelligence Agency 2001). Today’s primary education offers seven years of basic instruction. Children may enter “Standard 1” in the January following their sixth birthday. Secondary education in Botswana consists of three years of junior secondary education and two years of senior secondary education (Government of Botswana Web Site 2001). Approximately 97% of Botswana’s primary school-aged children—both boys and girls—now attend school. Currently, however, only 33% of the population have access to a full secondary education. In rural areas, only 7–9 years of schooling are available locally (Swaney 1999, p. 433). In 1995 the literacy rate was 69.8% (Central Intelligence Agency 2001).

The Botswana National Library Service is located in Gaborone. Its goal is to provide information to all Batswana nationwide no hyphen by means of an efficient and effective library service. The National Library provides Public Library Services, Educational Library Services, Special Library Services and Services for the Disabled (Republic of Botswana – The National Library Service 2001).

4.2.5 Religion

Christianity is now the official religion in Botswana and certainly the strongest. A variety of different faiths are also practised. Certain traditional beliefs have been incorporated into modern Christianity. David Livingstone brought Christianity into Botswana, in the middle of the 19th century. There is also a strong Muslim community in Botswana (Brough 1997, p. 28).

4.2.6 Gaborone

Botswana’s capital is Gaborone, one of Africa’s fastest-growing cities. It has seen phenomenal growth. From being an obscure village in the early 1960s, it became home to more than 160,000 people in only 30 years. Gaborone has neither a long history nor an established traditional African character, as certain other African cities such as Nairobi and Dar Es Salaam do. It does provide the facilities people expect to find in any modern city (ibid., p. 31).
4.2.7 Social structure

Since independence the Botswana Democratic Party (BDP) has governed the country. The British system of parliamentary rule and democracy was inherited by the Botswana government and, under the inspired leadership of Sir Seretse Khama, Botswana was one of the few countries in Africa to choose democracy over socialism at independence. The head of the state is the president, currently Festus Mogae. The president is elected to serve a term of five years by the 34-member National Assembly of Parliament, which holds legislative powers and includes the 15 cabinet ministers. The House of Chiefs is made up of 15 chiefs and tribal representatives whose function is to advise the National Assembly on proposed laws relating to land usage as well as social and traditional customs (ibid., p. 20).

4.2.8 Economy

The degree of Botswana’s success is reflected in the fact that for the first 20 years since independence it enjoyed the highest growth rate of gross national product (GNP) per capita in the world. The pula is Africa’s strongest currency, making Botswana’s economic outlook fairly good (Swaney 1999, p. 428). The reason for this phenomenal growth was the comparative lack of development at independence in 1966 and the discovery of diamonds in 1967 (Brough 1997, p. 22).

By value, Botswana is the largest diamond producer in the world. Diamonds have accounted for approximately 80% of Botswana’s total export earnings (ibid., p. 21). Tourism is a significant foreign exchange earner for Botswana with estimated annual earnings in excess of US$50 million. It is still a major growth industry (ibid., p. 22).

4.3 AIDS in Botswana

The first HIV/AIDS cases in Botswana were diagnosed in 1986. Since then the spread of the disease has been rapid compared to most other countries. The epidemic is now widespread all over the country and the HIV/AIDS situation is extremely serious. The official figure for the incidence of HIV in the 15–49 age group is 25%. This would mean a total of 210,000 HIV-infected persons in the population today, with an estimated 100 new cases added every day (UNAIDS 2000).

Life expectancy is expected to decrease and return to the 1955 figures of 43 years, the 1990 figure having been 61 years. One group which is severely affected is young women, who will not live long enough to bear many children or who may give birth to children already infected by HIV/AIDS (ibid.).

HIV/AIDS is a major challenge to development in Botswana. The epidemic is challenging otherwise positive development gains made in the last decades and is already having a severe social, economic, political and cultural impact in the entire society. There is an urgent need to lift the HIV/AIDS issue from a health issue to a much wider multi-sectoral context (ibid.).
Jan-Olof Morfeldt and Birgitta Rubenson write in *HIV/AIDS in Botswana* that the difference between the prevalence of AIDS in rural and urban areas is no longer significant, even if the sparsely populated western areas of the country are less affected then the eastern. The highest figures are found among men coming for STD treatment (60%), and pregnant women (41%) in Francistown (Morfeldt and Rubenson 1999, p. 5).

The Ministry of Health in Botswana works with HIV/AIDS through the Botswana AIDS/STD Unit by using several monitoring tools. The AIDS/STD Unit holds many different events to inform people about HIV/AIDS, for instance, World AIDS Day and Youth against AIDS (Botswana AIDS/STD Unit 2001).

### 4.3.1 Women and AIDS in Botswana

According to Gwen Lesedeti in her article, “HIV/AIDS and the status of women in Botswana”, women are most affected because they constitute the majority of the poor and the poorly educated. More women of low economic status are being diagnosed with and are dying of AIDS. AIDS affects every aspect of women’s lives whether they themselves or other members of their families are infected. Factors that put women at higher risk of infection include biological and social factors. Biologically, women are more vulnerable to HIV/AIDS than men because infection is much more concentrated in vaginal fluids. Women are at even greater risk because they tend to have sexual relationships with men who may have several partners and are more likely to be carriers of HIV/AIDS. The impact of HIV/AIDS on women is also more severe because of the multiple roles women play in the family as well as in society as a whole. They often combine the role of family care with that of breadwinner (Lesedeti 1999, p. 48).

Botswana is unusual in that girls are more literate and account for a higher proportion of primary school students than boys. There are gender imbalances at the secondary and higher levels of education. A significant number of females also drop out of school due to pregnancy, which prevents them from acquiring sufficient skills and training to qualify for better-paid jobs (ibid., p. 51).

Much of the inequality faced by women in Botswana can be attributed to traditional cultural values, which still have a very strong influence on women’s behaviour. In modern Botswana it is deemed acceptable for men to have more than one sexual partner. Men always dominate these relationships and women feel compelled to give in to their demands. In these relationships women have little power, for example, in determining whether condoms should be used. The cultural situation therefore makes women even more vulnerable to the risk of being infected by the HIV/AIDS virus (ibid., pp. 52f).

### 4.3.2 Social, economic and political consequences of the epidemic

In this section, when appropriate, we describe our own observations about everyday life in Botswana and share facts that we received from people we have met. Our literature source is Morfeldt and Rubenson’s study, *HIV/AIDS in Botswana*.

Large numbers in the population already feel the social consequences of the epidemic. Traditionally funerals are held at weekends to enable relatives and friends to gather.
With the increasing numbers of AIDS-related deaths many funerals are now being held during the weekdays, which means that many cannot attend. If people do attend the funerals, this will effect work productivity because they have to take both days and hours off (Morfeldt and Rubenson 1999, p. 6). Our supervisor, Mrs Jackson, told us that this has been a great problem for the families of the deceased. Funerals are expensive and all the people who come to the funeral must be served food. This is financially devastating for many families.

The high number of orphaned children is another consequence of HIV/AIDS, and will be an enormous burden on society with great social consequences. The estimated number of children who have lost their mother or both parents to AIDS while under the age of 15 since the beginning of the epidemic is 66,000 (UNAIDS 2000). Botswana has traditionally had a very mobile population. People move between the home village, the cattle post and the lands (Morfeldt and Rubenson 1999, p. 6).

We observed the latter. It is easy to travel, the roads are new and very good, it is cheap to go by bus and tours are frequent. It is very easy to take the bus and you get where you are going fast (we know, because we travelled considerably by means of local buses which were often crowded). We also saw many expensive new cars, and one man told us that it is easy to get bank loans to buy a car.

In contrast to many other African countries, Botswana has a good and stable economy, with a sizeable foreign reserve. The main source of income is the diamond mines, which account for 80% of the export revenues. This dependence on one sector does make the economy vulnerable to fluctuations of world prices etc. Even if only a small portion of the population works in the diamond industry, a manpower loss of 20–40% due to HIV/AIDS will have a clear impact on production capacity (ibid., p. 7). The representative at UNAIDS told us that Debswana, the diamond company in Botswana, hired two people for every job because of AIDS.

Considering the economic situation in the country, it is paradoxical that around 47% of the population live below the poverty line. This in itself is an important contributing factor to the rapid spread of the infection. If no radical change in economic policy is introduced this inequality will grow as a consequence of HIV/AIDS. The official figures on unemployment are also alarmingly high—an estimated 21%, especially among young people (ibid., p. 7).

The strong position of the ruling party (BDP) makes it possible for the government to formulate and implement its political priorities and measures, especially in a sensitive issue such as HIV/AIDS. Botswana, as a small country with a sizeable foreign reserve, has a stable democratic government, good communications, well-developed school and health services, and unique capabilities to fight the HIV epidemic. If this opportunity is missed the effects on the economy, the population and the development gains will be enormous (ibid., p. 7).

There are various factors that can help explain the HIV/AIDS situation in Botswana and why the spread of the virus continues at such speed. The most complex and profound is the sociocultural structure, with high mobility, disintegrating family structures and a strong male influence over sexual behaviour (ibid., p. 8).
One problem, stressed by Mai Palmberg in Aids i Afrika, is the connection between alcohol and AIDS. Heavy consumption of alcohol affects the production of T cells in the body, which weakens the body’s immune defence. But the most important effect of alcohol is at the social level. Alcohol weakens the ability to use sound judgement and may put people in high-risk situations, where they do not use condoms regardless of knowing about the risks of HIV transmission. Where condoms are used, alcohol may reduce the chance of their being used properly, thus destroying the protection effect. Men usually do not drink together with their wives, so the wives stay at home when their husbands go to the beer hall. It is usually not socially accepted for married women to drink beer. The men get drunk, meet other women, and get into situations and behave in ways they probably would not if sober (Palmberg 1993, p. 55).

One person told us that alcohol is a huge problem for the HIV/AIDS situation in Botswana. According to this person liquor is very cheap in Botswana, and we saw a lot of liquor stores everywhere along the roads and in the city. In the rural areas there are small bars where people brew their own beer. We visited one of these small bars. The majority of people in the bar were men. They sat outside on wooden benches drinking home-brewed beer from Tetra Pak containers.
5 Previous literature

In this chapter we discuss the literature that we consider relevant to our thesis. We aim to show the reader a relevant selection of what is written about information and communication about AIDS, different ways of disseminating information about AIDS and organisations that spread information about AIDS. Before each section we have an introduction to tell the reader what is discussed and why we think it is relevant. At the end of each section we summarise the literature that we have discussed in that section.

5.1 Definitions of information

We also want to define the term “information”. Lars Höglund writes in Biblioteks- och informationsvetenskap som studie- och forskningsområde that today there are many definitions of the term. In practice words like “data”, “information” and “knowledge” are used in ways which overlap (Höglund 2000, pp. 7f).

To get one of these definitions we read Information and Information Systems by Michael Buckland. He says that there are four aspects of the term “information”:

1. **Information-as-thing**, is exemplified by books, documents and recorded knowledge and how knowledge can be represented in text and numbers.
2. **Information processing** is how information-as-thing can be rewritten to a new form, e.g., word-processing text can produce a Web page.

The other two aspects are the most important in user studies:

3. **Information-as-process** is the process whereby someone is informed about something.
4. **Information—as-knowledge** is knowledge or facts that are the ground when someone is being informed (Buckland 1991, pp. 6ff).

In the thesis we use the term “information” in the different senses that Buckland gives, i.e., information-as-a-thing and as something that presupposes a change in the person who use information.

5.2 Information and communication about AIDS

Because our thesis is about AIDS information we are interested in why AIDS information is used. We are also interested in how information about AIDS should be designed and what the creator of the information should think about when creating the information. In this section we examine the literature that discusses this.

Birkoff and Körner write in AIDS Education Through Drama that, since it is impossible to stop or cure AIDS medically, information and education about how to protect oneself are the only alternative to reduce its spread. Thus AIDS is not only a medical problem but also a problem of communication. Large social and cultural differences in a society make it difficult for the state to find effective channels of communication. The trans-
mitter of the message must, for example, be trustworthy and the message presented in an attractive form so that the receiver can take it in (Birkoff and Körner 1994, pp. 1 and 19).

Gunilla Krantz in her book *The Role of Woman’s Groups in Health Promotion, Health Care and Social Support in Relation to the HIV/AIDS Epidemic* believes that, since almost all transmission is a consequence of prior sexual transmission, programmes should also be directed at preventing sexual transmission. Studies have shown that over 40% of the girls in Africa have their sexual début before the age of 14. In order to affect norms and values in the future society, therefore, information and education should also—or especially—be offered to young women in school. But this will be difficult since less than half of children between the ages of 6 and 20 go to school. A way therefore has to be found to spread information to these out-of-school children (Krantz 1994, p. 5).

Further on Krantz writes that in Africa AIDS interplays with other sociocultural and socio-economic factors (ibid., p. 6). The thing programmes should try to effect is sexuality, since this is the cause. To be able to change this you have to have:

- **Knowledge:** To be able to make well-founded decisions about their sexual activity, people have to have knowledge. Examples of necessary knowledge are information on how AIDS is transmitted, how to protect oneself, how one’s own body works and what consequences the infection will cause. It is usually around these questions that information and education are concentrated (ibid., p. 6).

- **Rationality:** In connection with AIDS is it a rational action to use a condom? It will cause difficulties in getting pregnant, while not using a condom is a rational act, culturally, in that you should show trust in your partner. These norms are part of rational action (ibid., p. 7).

The environment in which information is disseminated in the Third World involves very different conditions and problems from those we have in the West. For example:

- infrastructure is often deficient
- people have relatively limited reading ability
- women hold a limited position of power (ibid., p. 25).

According to Krantz it is also necessary to look at how information is interpreted according to the sociocultural norms that exist in the country (ibid., p. 25). Even if the development of a modern society is far advanced, the norms of the traditional cultures still influence the understanding of reality (ibid., p. 61). Knowledge about AIDS can be presented but the problem lies in how it is interpreted and incorporated into the dominating sociocultural norms and practices (ibid., p. 88).

In *Preventing and Mitigating AIDS in Sub-Saharan Africa* the editors consider that denial, fear, external pressure, social and sexual norms, other priorities or simple economics can prevent people from adopting a healthier lifestyle. Interventions must be culturally correct and relevant locally. They must reflect the social context within which they work. They should be developed with a clear idea of the target group and types of behaviour to be changed. In Sub-Saharan Africa there is an urgent need to develop interventions to reach women and young people with prevention messages. The basic principles for a successful programme include the following:

- learning and adapting to local circumstances
• ensuring the participation of the society
• ensuring the participation of the target group
• identifying efficient strategies and messages
(Cohen and Trussell 1996, p. 9).

According to Palmberg in *Aids i Afrika* it can be difficult to get general participation that affects people’s sexual behaviour. Many await instead for a cure through effective vaccine or medical treatment (Palmberg 1993, p. 93).

Birkoff and Körner in *AIDS Education Through Drama* think that information itself cannot be expected to change patterns of sexual relations that have their roots in the social and cultural norms existing in Sub-Saharan Africa. Changes in behaviour are dependent on a number economic, political, cultural and sex-related questions. A change to safer sexual behaviour will therefore demand a deep-rooted social change, which cannot be accomplished over night (Birkoff and Körner 1994, p. 16).

Bernard W. Lukenbill writes in his book, *AIDS and HIV Programs and Services for Libraries*, that in modern society information is power. Those who have access to information are better able to deal with problems and to survive. They can define problems and see alternatives (Lukenbill 1994, p. 37). Lukenbill also thinks that information cannot just focus on the epidemiological aspects of HIV; it must also be effective, personal and work directly for change of values and attitudes as well as behaviour (ibid., p. 62).

In *Aids i Afrika* Palmberg also writes that health education has always been in focus in the fight against AIDS. Personal communication between people is much more important than messages through the mass media, which do not have any great effect on behaviour. Among preventive measures one should focus on the use of condoms as a short-term solution and behavioural changes as a more long-term solution (Palmberg 1993, p. 94).

According to Lukenbill text and pictures can be easy to use but hard to interpret. This can be because of many different factors. A reader can, for example, lack the necessary background knowledge within the subject or language skills (Lukenbill 1994, p. 51). Palmberg writes that almost everywhere in Africa today posters against AIDS can be seen on health clinic walls. Pictorial language is also a language to learn, and ignorance about how pictorial language works in different environments can make posters a far more difficult means of communication than one would first imagine (Palmberg 1993, p. 171).

Ann-Charlotte Ek writes in *Kenyanska aidsdiskurser* that studies which have evaluated the Danish Government’s AIDS campaign point to the importance of formulating the message clearly without any unnecessary paraphrasing. The need for direct communication applies to all messages about AIDS. Often the information does say that you should use condoms, but it does not say why, or in what ways they are protective. In public conversation about AIDS it becomes clear that it is still difficult to talk about sexuality. The informant leaves it to the listener to form his own picture, which can lead to a lack of understanding in making the connection between sexual intercourse and the protection offered by condoms (Ek 1999, pp. 54–56).
Ruth Nduati and Wambui Kiai discuss information and communication about AIDS in their book *Communicating with Adolescents about AIDS*. They believe the media have played a major role in increasing awareness about AIDS and in people’s paying attention to information about AIDS. The media can be described as a medium or channel that is used to inform or communicate safe information. Such a channel can be formal, for example, newspapers or radio, or informal, for example, drama, posters or interpersonal interaction. The choice of channel can depend on factors such as the purpose of the communication or the nature of the message. The media have been found to be most efficient in increasing awareness about AIDS (Nduati and Kiai 1997, p. 79).

### 5.2.1 Summary

Because there is no vaccine or treatment against AIDS, communication and information are the only alternatives to reduce the spread of AIDS. For this communication and information to be effective, there cannot be too great a sociocultural distance between the transmitters and the receivers. Denial, fear etc. are factors that can lead to people dismissing messages about AIDS, and this is something that has to be changed. Because in the majority of cases infection occurs through sexual contact there have to be programmes that concern the prevention of sexual transmission, but it is difficult to change people’s sexual behaviour. Many children in Africa do not go to school and there has to be a way to get information to these children also. Information about AIDS must be effective, personal etc. There is a huge need for interpersonal communication. The pictorial language of posters, for example, must be easy to understand so that the messages cannot be misconstrued. The message in the information is also important. The media play a major role in the dissemination of information about AIDS.

### 5.3 The receivers of information

We did not find much literature about women as receivers of AIDS information. We identified two articles, the first about Botswana women and the other about women in the whole of Africa.

The first article is *AIDS Awareness and Knowledge among Botswana Women: Implications for Prevention Programs* by McElmurry, Norr and Tlou. They investigated AIDS awareness and knowledge among urban women in Botswana. They write that earlier studies have shown that knowledge about AIDS is more widespread in urban areas than in rural areas. Knowledge gaps and false beliefs are also documented. Lack of an understanding of AIDS as a disease and negative attitudes toward persons with AIDS have frequently been reported (McElmurry, Norr and Tlou 1995, pp. 133f).

In Botswana many mass media campaigns on AIDS prevention are currently under way, better quality condoms are available free, and sex education programmes are offered in the schools (ibid., p. 135).

Questions and suggested topics for investigation included: how women first learned about AIDS; their sources of information; and their beliefs about what AIDS is, how it is transmitted, and how it can be prevented (ibid., p. 136). Most of the women in the study were aware that AIDS is a serious health problem, but they were not well
informed about AIDS as an illness. Fifty out of 56 women said they first heard about AIDS from the mass media, primarily the radio. Other sources were the clinic or hospital; pamphlets and/or posters; and meetings, workshops or lectures. Most of the women believed their sources were reliable. Half of the women said they believed mass media sources were reliable (ibid., pp. 137–139).

These women had a high awareness of preventive measures. When asked how people can protect themselves from AIDS, 52 of the 56 women especially mentioned condoms, 39 mentioned partner education or sticking to one partner, and 38 mentioned both condoms and reducing the number of your partners. Sixteen pointed out that those condoms could prevent AIDS only if they are used effectively (ibid., p. 141).

The women mentioned numerous barriers to making behavioural changes for themselves and others. One theme was the lack of urgency in Botswana regarding AIDS. Sexual infidelity and the sexual double standard were mentioned as barriers to both partner reduction and condom use. Several expressed concern about asking a regular partner to use condoms (ibid., 142).

About two-thirds of the women believed they could be at risk of contracting AIDS. Fifteen women of the 56 said they were not at risk. Thirty-three of the women said they had made changes in their behaviour to keep themselves from getting AIDS. Having only one sexual partner was the most frequent preventive action taken. Only 11 women said they used condoms for AIDS prevention or would do so when they had a partner. Just two explicitly mentioned both having only one partner and using condoms. Only two mentioned talking to their partner about the risk of AIDS (ibid., pp. 142–144).

Intensive mass media campaigns have succeeded in communicating AIDS prevention responses to most women in Botswana. The women in this study often repeated verbatim catch phrases such as “Stick to one partner”. However, continued discussion often revealed a lack of understanding of the full meaning of these catch phrases. About one-third of the 56 women interviewed had knowledge gaps regarding AIDS transmission. Less educated women were less informed.

The two most common misunderstandings the authors found among these women in Botswana need to be addressed in future programmes. The first is a persistent fear of contracting AIDS through casual contact. Belief in casual transmission appears to be related both to lack of knowledge about AIDS as an illness and to the negative emotions and stereotypes surrounding AIDS and persons with AIDS. Women who believed that transmission could occur through casual contact have little reason to make the changes in sexual behaviour that would protect them against sexual transmission. Second, many women also lack understanding of the mechanism of transmission during sexual intercourse. This misunderstanding may be reinforced by traditional beliefs about boswagadi\(^1\) (ibid., pp. 144f).

These women also discussed one major AIDS prevention issue that women face which is not well addressed in current programmes in Africa. Many women can choose monogamy for themselves, but they are not able to be confident about their partners’

\(^1\) Boswagadi is a traditional illness and some people believe that AIDS is actually boswagadi and is caused by the failure of the modern generation to observe traditional treatments and the taboos of sexual abstinence (McElmurry, Norr and Tlou 1996, p. 135).
behaviour. This dilemma cannot be overcome simply by recommending continuous condom use, because many married women want to have children (ibid., p. 145).

The other article we read is by Lesedeti, about women’s knowledge about AIDS, their information needs and how they acquire this information. Lesedeti writes that most HIV/AIDS prevention programmes attempt to persuade people to change their sexual behaviour. The representatives for the programmes assume that men and women can be given information, which will lead them to make rational decisions to practise safer sex and then to implement those decisions. However, they often fail to recognise the difficulties facing women who attempt to do this. Since women do not use condoms, they must persuade men to do so, which can be extremely difficult. However, it has been found that giving women more information about HIV transmission and about the use of condoms results in an increased use of condoms. A peer education programme support model for HIV prevention was initiated in 1990 through the Botswana Council of Women. The aim of the programme was to ensure safer sex practices. An evaluation was done three years later. There was increased condom use in all types of relationships, although married women found it more difficult to introduce condom use (Lesedeti 1999, pp. 53f).

5.3.1 Summary

Not much research is being done on women’s knowledge of AIDS and what they think about the information they receive. In the studies that have been done it has become clear that women know that AIDS is a huge health problem, but they are not well informed about AIDS. Most women first heard about AIDS from the mass media, chiefly the radio, but also posters and pamphlets at clinics and hospitals. They had a high level of awareness of preventive measures but mentioned numerous barriers to making changes for themselves and others. Thirty-three out of 56 women who were the subject of one study said they had made changes in their behaviour to keep themselves from getting AIDS. One major difficulty with HIV/AIDS information programmes which encourage people to change their sexual behaviour and use condoms is that women have to exhort their men to use condoms; this can be a big problem. However, researchers have discovered that informing women about condoms has result in a higher level of condom use.

5.4 Women-men and condoms

To understand the AIDS problems in Africa we studied literature about the problems between women and men, and of condom use in Africa. Condoms are a major part of the discussion about HIV/AIDS. Here we report the discussion in *AIDS in Africa*.

Condoms and condom use are among the most difficult areas of any programme designed to slow down the spread of AIDS. Cultural attitudes, particularly among men, may make these solutions very difficult to accept. They are seen as wasting time, wasting sperm, etc. Religious objections to condoms are also important. But perhaps the greatest difficulty with condom use has to do with poverty and the fact that their use is dependent upon male cooperation. Crowded living conditions, the lack of running water and the cost of the condoms themselves all present obstacles to their acceptance (Barnett...
and Blaikie 1992, p. 160). Women in particular confront the difficult task of persuading their husbands or partners use condoms in situations where women’s economic dependence upon men is high and acceptance of men having multiple sexual partners is the norm for many women. It is the millions of individual decisions which will decide the effectiveness of programmes to promote condom use (ibid., p. 162).

Poor younger women in very poor parts of the country are vulnerable to the blandishments of older men who can offer them financial rewards as well as emotional and sexual support. The problem is not restricted to younger unmarried women. Women who are married or in long-term relationships are also very vulnerable; for them saying “no” is not easy, nor does it fit the traditional expectations of men and women in their relationships (ibid., p. 164).

5.4.1 Summary

There are many problems with condom use. In poor countries there is the problem of money: people do not prioritise condoms when they need things as basic as water. There is also a problem in that men do not want to use condoms and women cannot say no to their husbands.

5.5 Different ways to disseminate information about AIDS

Because we are interested in how different organisations are disseminating information about AIDS we include a section concerning this. In this section we present that part of the literature that we think is relevant.

Afrikagrupporna (the Swedish African Support Groups) work with different projects in Africa concerning AIDS information. Marja Wolpher has put together their experiences in a text available on the Internet, Afrikagrupporna erfarenheter av arbete med HIV/AIDS frågor (“The Swedish African support groups’ experience of work on HIV-AIDS issues”). Wolpher writes that theatre is one method of conveying information which has been shown to be an important, especially when attempting to reach people who cannot read. It can reach a large audience and touch them deeply. Radio too is a good way to convey information (Wolpher 1999, p. 4). The people active in the project have noticed that the sensitive message about AIDS reaches a larger audience and is received more actively when it is conveyed with a local connection. The members of the theatre group are chosen locally and know about local events and traditions that are important for the audience (ibid., p. 5). The plays are performed in the local language so that everyone in the audience can understand the message and immediate problems in the community can be made clear (ibid., p. 6).

Mai Palmberg has written about theatre in Aids i Afrika. According to her African theatre is built on body language, dance and music, and in giving full expression. The dance is a language itself. The motions show the life, the relationships between people, and their attitudes towards one another. African audiences engage loudly in the production. People who can neither read nor write can still take in the message (Palmberg 1993, p. 198).
Palmberg also writes that there is a great need for interpersonal, oral communication. One good way is to educate cab drivers in an area where they gather together, so that they can teach their colleagues (ibid., p. 164). Further Palmberg writes that in South Africa some AIDS information work has been conducted through the bush radio. To use medicine men as a resource in information campaigns about AIDS also can be a way to get knowledge to the people, since they have the trust of the local societies. That the information is in the local language and comes from a local person is important. There is a need for group pressure to change people’s behaviour. Information given only through posters etc. will not lead to any long-term changes in sexual behaviour, which is a long-term goal in the fight against AIDS. If the information, on the other hand, comes from several directions and in several different ways the chances are greater that programmes will succeed, especially if the person conveying the message is someone the people look up to (ibid., pp. 10f).

Ek writes about radio in her book *Kenyanska aidsdiskurser*. In Kenya there has been a concentration on radio broadcasts in local languages, which has a positive information effect, but Ek considers an overemphasis on radio lectures to be detrimental to personal immediate communication, which has been given much too minor a role (Ek 1999, p. 37). Lukenbill in *AIDS and HIV Programs and Services for Libraries* writes that it is more difficult to present information in written form than orally, when women are able to ask questions and receive repetition. This points to a need for both repetition of information and a dialogue with well-informed people if information is to be readily apprehended and correctly interpreted (Lukenbill 1994, p. 48).

Further on Lukenbill writes that art, as a tool of information, can be an efficient method of getting attention for AIDS, especially when it is created by people who have personal experience of the disease. Art has been shown to be an efficient way to present to people many other publications on AIDS (ibid., p. 60).

The workplace has a central role in people’s lives, and making AIDS information available at the workplace can help in the fight against the disease (ibid., p. 62).

According to the authors of *Interventions to Prevent HIV Risk Behaviour*, efficient primary prevention programmes must be created in order to stop the further spread of AIDS. It is also necessary to help people maintain the changes in behaviour that reduce the risk of infection with HIV and STD. People have to be made to understand that they are vulnerable to HIV/STD if they are not careful and if they do nothing to change their situation (for example, by using condoms). Face-to-face programmes can also be run to increase individuals’ knowledge about AIDS. This increases the understanding of the personal risk of getting HIV/STD and increases the motivation for behavioural change. Knowledge that increases self-discipline must be taught. All preventive measures aim to change behaviour on an individual level. Efficient measures have been developed which concentrate on the individuals, on peers and on families on a community level. To involve the sexual partner can increase the efficiency of individual intervention programmes, and measures taken in family situations can reduce risk behaviour among both parents and children (*Interventions to Prevent HIV Risk Behaviours: based on an NIH Consensus Development Conference 1997*, pp. 2f).
5.5.1 Summary

There are many different ways of disseminating information about AIDS today in Africa. According to the literature theatre is one good way because it involves people locally and includes body language, music, dance etc. Radio is also a powerful medium and again it is important to use the local language and local people to get the messages across. It is important that information comes by several different methods and from people the receivers look up to. Interpersonal communication is thought by most authors to be the best way to get information out. Oral information is also effective when people can ask questions and receive repetition. AIDS information in the workplace is effective and art can also be used as an information tool.

5.6 Organisations that disseminate information about AIDS

In this section we aim to give a picture of the different organisations that are working to disseminate information about AIDS.

In Uganda it has been realised that the Ministry of Health cannot alone cope with the struggle against AIDS, and the responsibility has therefore been given to a committee that is directly supported by the president. To get to the root of a problem, for example, unemployment, alcoholism or divorce, you must involve all sectors of society, including the ministries (Palmberg 1993, p. 92). There is no lack of will or of knowledge in disseminating information about AIDS. However, there is a huge lack of money and of educated personnel. Nor do foreign donors always have the same opinion as the Ministry of Health as to where resources should be allotted (ibid., pp. 184f).

Lukenbill writes in AIDS and HIV Programs and Services for Libraries that churches and other religious organisations have shown hesitation and sometimes even hostility about taking an active role in the AIDS crisis. Among the problems that can arise, for example, is the Catholic Church’s opposition to the use of condoms. It recommends that couples should confine themselves to one partner. Many people have great trust in their priest and if he says that they should not use condoms many of them will not do so. This is precisely the opposite of what many organisations are working for (Lukenbill 1994, p. 63).

Palmgren’s AIDS i Africa reports that WHO has identified AIDS as a severe threat to humanity and started a special programme against the disease. Many international organisations have also created their own institutions to combat the disease, and most countries have special AIDS programmes. WHO has offered help to the countries in Africa for establishing special programmes in their ministries of health to fight AIDS. The ministry of education in a number of countries has started to introduce programmes of education for family planning and information about AIDS, but the subject is rather sensitive (Palmberg 1993, p. 91).

There are many volunteer groups (often women’s groups) which have health-related activities, such as care and social support for people with AIDS and their families, care of orphans etc. These voluntary women’s groups can be of help in the prevention of HIV/AIDS. They can become the link between the rural people and national AIDS programmes (Krantz 1994, p. 73). One organisation among schoolboys and schoolgirls
has had great success in Zambia—anti-AIDS clubs. Members promise to abstain from sex until they marry and to fight discrimination of those already infected and sick from AIDS. The campaign has many members and the idea is spreading to other countries (Palmberg 1993, p. 91).

Marja Wolpher writes in _Afrikagruppernas erfarenheter av arbete med HIV/AIDS frågor_ that according to UNDP (the UN Development Programme) the problems of AIDS have been tackled best in those countries where there has been a political commitment as well as cooperation between several ministries. In Mozambique the Ministry of Health coordinates the country’s AIDS effort, concentrating on prevention (Wolpher 1999, p. 2).

5.6.1 Summary

Many different organisations are working to disseminate information about AIDS. The Ministry of Health in Uganda has involved all ministries and other sectors to get to the root of the problem. Churches and other religious communities also work with the spread of AIDS information. WHO and voluntary groups work with AIDS information in different ways. One kind of organisation in Zambia is the anti-AIDS clubs in schools. This campaign has won many members. Afrikagrupperna also have many different projects about AIDS in Africa.
6 Theory

We have chosen two theories. The first is a model of communication (figure 6.1) from a health communication perspective, which we have studied with the help of Gunilla Jarlbro’s book *Hälso/kommunikation: en introduktion* (“Health communication: an introduction”). Our purpose is to put the different organisations into the model and scrutinise how the organisations we have investigated work in relation to it. We are also going to analyse and discuss the theories Jarlbro describes about health campaigns, community intervention and so on to spread health messages.

Since Jarlbro’s book focuses mainly on the transmitter of information, we have also chosen to use a study by Ross Todd, *Utilization of Heroin Information by Adolescent Girls in Australia* to scrutinise young women’s use of information and see if their views and thoughts square with the organisations’ work. We also analyse our observations through Jarlbro’s model of health communication.

6.1 Health communication

Jarlbro’s focus is on health campaigns, especially on HIV/AIDS campaigns in Sweden. We are conscious of the differences between Sweden and Botswana, but we think the problems Jarlbro describes, such as social divisions, exist all over the world.

Jarlbro discusses the possibility of communicating about such a delicate subject as HIV/AIDS. Moreover, she discusses the possibility of getting people to change more or less established patterns of behaviour through communication (Jarlbro 1999, p. 7). For the population to take in a health message (in our case HIV/AIDS) it is not enough that individual doctors or other persons think it is important: there also have to be the necessary channels and resources, and for that there has to be a political will to deal with the problem and an administration to handle it (ibid., p. 8).

6.1.1 The process of communication

There are some elements that always exist in the process of communication:

- **The transmitter** – someone who wants to say something
- **The message** – which the transmitter sends through a medium
- **The receiver** – one person, or several people, who react to the message.

The receiver’s reaction can be passed back to the transmitter and that is called feedback (ibid., p. 14). John Fiske explains the term feedback in his book *Kommunikationsteorier* (“Theories of communication”). Feedback assists the transmitter by helping him to fit the message to the receiver’s needs and responses. It also helps the receiver by allowing him to feel that he is participating in the communication. The transmitter takes on board the receiver’s reaction and makes the receiver more willing to accept the message. Feedback is used to make the transfer of the message more effective (Fiske 1997, pp. 37f). The model we use also includes the term “feed forward”. Jarlbro does not explain the term, but *Kommunikation - teorin i praktiken* (“Communication: theory in practice”)
by Lars Palm and Sven Windahl offers a definition. The term “feed forward” means that the transmitter gets knowledge about the receiver before the communication starts. The more the transmitter knows about the receiver, the more she or he can adjust or adapt to the receiver (Palm and Windahl 1989, p. 12).

Definitions of communication presume that there should be reciprocity between the transmitter and the receiver in the process of communication. Jarlbro emphasises that the problem with health communication is that transmitter and receiver are in different “sociocultural rooms”. She believes that this makes the decoding and construing of messages more difficult. The social distance between the transmitter and the receiver can sometimes lead directly to messages being misconstrued (Jarlbro 1999, p. 15).

6.1.2 Health campaigns

In health campaigns transmitters have begun to use commercial marketing. This sometimes causes problems because transmitters use simple solutions, for instance, “use a condom to stop AIDS”. One problem is that transmitters, instead of exhorting people to go and buy something, are in the case of AIDS information campaigns trying to prevent people from doing something (ibid., pp. 18f).

Effective health campaigns:
- use several different types of media—radio, television and pamphlets
- combine mass communication with interpersonal communication, for example, small group activities
- have a specific target group
- provide constant repetition of simple message
- advocate the positive aspects of a behavioural change rather than the negative effects of wrong behaviour
- give directions as to how to act to avoid the problem arising, if the transmitter uses messages that include terror and fear
- appeal to authorities (ibid., p. 21).

Communication researchers today agree that campaigns, i.e., mass communication efforts such as advertising, are most effective when it comes to making people aware of a problem. Campaigns can also be functional when it comes to stimulating interpersonal
communication. They are thought to be less important when it comes to bringing about long-term changes in people’s attitudes and behaviour. Interpersonal communication is often more effective than mass communication in bringing about a behavioural change on the part of the receivers (ibid., p. 28).

### 6.1.3 Community intervention

Community intervention strategies are preferred in affecting long-term attitudes or effecting behavioural changes. Briefly this means that transmitters make use of the existing formal and informal groups in the community at the same time as they seek to create new groups that can contribute to the project’s fulfilling its goal. Grass-roots activities are a constant element in all forms of community intervention. Another important factor is that the project leadership has a good knowledge of the society where the intervention takes place and that they create good relations with authorities, social workers and possible key personnel in existing organisations (ibid., p. 39).

### 6.1.4 Target groups

All health communication campaigns should be managed through a realistic and detailed picture of the target group. This is important because the transmitter needs to convey the right message, and argument, through the right channels for the target group (ibid., p. 61).

### 6.1.5 Transmitter

The transmitter can be the person who creates the content of the message or the person who conveys the message. In many health campaigns medical expertise is responsible for the content, but it is not evident that medical expertise should convey the message. Sometimes there is a risk in using authorities, and other adults, as transmitters, for example, when the target group is young people who belong to different risk categories. One effect of using the wrong transmitter can be that the person can become a negative transmitter. The solution, when it is impossible to use authorities or other adults as transmitters, is to use what is called peer education. Peers are supposed to have a huge measure of cultural competence. The peer educator is expected to know what norms, values and attitudes the target group has (ibid., pp. 67f).

### 6.1.6 Message

There is no answer to the question whether transmitters should use matter-of-fact or emotional messages. Some researchers think that the use of too much fear can lead to denial. This can occur when there is a lack of direction in the message about how the receiver should react to avoid the problem (ibid., p. 81).

When the transmitter formulates a message, she or he has to take into consideration the fact that different target groups have different relations to the subject. For some target groups the transmitters have to focus attention on a complex of problems (ibid., p. 83).
6.1.7 Media

The choice of medium in a communication activity obviously depends on the transmitter, what the message is, who the target group is and what the subject is. Different media have different qualities and their appropriateness depends on which communication activities are of immediate importance (ibid., p. 91). If transmitters put their messages on huge billboards and placards, where these are common, there is a risk of saturation, with the consequence that the target group does not see any messages at all. When the transmitters choose media they have to consider that different media have different credibility for different target groups (ibid., p. 92).

6.1.8 Evaluation

It is important to evaluate preventive efforts according to the goal that has been formulated in a communication project (ibid., p. 97). There are two types of evaluation: Process evaluation: the transmitters study which activities have been accomplished in the project and whether these are appropriate in relation to the project’s goal and target groups. Effect evaluation: the transmitter studies the results of the project. Did the project reach the goal intended and is it possible to find measurable data in the target group? (ibid., p. 98).

6.2 Reflections

This section describes the ways in which we plan to use Jarlbro’s theory about health communication in the analysis. These reflections can help us in getting an answer to our main question.

Jarlbro enumerates some things that an effective health campaign should include. Furthermore she says that interpersonal communication is more effective than mass communication in changing people’s behaviour. In the analysis chapter (chapter 8) we scrutinise the different organisations that we have interviewed to see if they make use of the different ways Jarlbro mentions for disseminating information. We also scrutinise the organisations to see if they made use of commercial marketing.

Jarlbro considers that community intervention is important in making health campaigns as effective as possible. We believe this is especially important in countries where, as in Botswana, there are many international organisations at work; if the organisations do not work together with the people in the society, the people may not listen to them. In the analysis of the results of the interviews we will examine the organisations’ use of community intervention.

Jarlbro writes that feed forward is a good thing to use because the organisations get a better picture of what the receivers already know and what they want to know. For feed forward to be effective, the organisations need to have a clear picture of who the receivers are and which special needs they have. We will ask which target groups the organisations have and whether the organisations made use of feed forward.
According to Jarlbro, it can be somewhat unclear who the transmitters are. They can be medical experts, adults or different kinds of authority. Jarlbro also says that sometimes peers are the transmitters of the information because they are expected to know what attitudes and values the receivers have. In the analysis we investigate who the transmitters are and who the young women think they should be.

Jarlbro writes about the use of scare tactics. She reports that some researchers think that too much terror can lead to denial. For scaremongering to be effective, it has to be coupled to information about how to avoid the problem. We will investigate if any of the organisations we have interviewed use scaremongering tactics and whether we can observe any scaremongering.

According to Jarlbro, when the transmitter formulates the message, he has to take into consideration what the target group is. We investigate in the analysis whether the organisations send different information to different target groups.

There are several different ways to spread information about HIV/AIDS. Jarlbro mentions some of them, and says that the transmitter’s choice of medium depends on what the target group is. We will investigate which different methods the organisations in our study use and whether they know which media the target group prefers.

Jarlbro also says that there can be too much information, and that this can be a problem. Through observations we will investigate whether too much information is being given out in Botswana and in which ways the information is used, for instance, if there is information about how to avoid the problem.

Something that Jarlbro believes is important is that the organisations that work with health communication should evaluate their work to see if they lead to their stated goals, and in which ways they can work better. We investigate the organisations in our study to see if they do any kind of evaluation.

6.3 Information utilisation

The other theory we have used is a study by Todd, *Utilization of Heroin Information by Adolescent Girls in Australia*. We think his study suits our subject field well. We have not carried out our study in the same way as Todd did his. Todd interviewed his subjects on three different occasions; we have interviewed our subjects only once. In spite of this, we feel that we can use Todd’s results and compare them to the results of our interviews, since both his study and ours are about information utilisation.

Todd’s study investigates how older adolescents cognitively utilise information on the drug heroin. With a small group of four girls in their final year of secondary education, the study sought to:

- establish the perceived effects of exposure to information
- establish how the perceived effects are associated with changes in the girls’ knowledge structure
- establish any patterns in relation to changes in knowledge structures and perceived effects.
In his study, Todd gave information about drugs to the girls on three occasions, and after each he interviewed the girls and observed how their knowledge had changed. Five types of effect of the information were identified. The girls:

- got a complete picture
- got a changed picture
- got a clearer picture
- got a verified picture
- got a position in the picture (Todd 1999, p. 10).

The study of information utilisation is an active area of academic investigation in information science that has emerged from several different traditions, including the sociology of knowledge, applied social science research and organisational change. The literature as a whole conveys the sense that information utilisation is all about people and information coming together: it is about people doing something with information that they have sought and gathered themselves or that was provided for them by someone else (ibid., p. 11).

Todd’s study sought to investigate the cognitive construction of adolescents when they were exposed to information about the drug, from the perspective of the adolescents.

The five types of effect:

**Getting a complete picture** is a process of creating new knowledge and a link to remember old knowledge.

**Getting a changed picture**. The girls had a change of perception: they gained new facts that showed that their old knowledge was wrong. The girls took away facts that were incorrect and replaced them with new facts.

**Getting a clearer picture**. The information shed light on their ideas so that the ideas could be seen with greater understanding and clarity.

**Getting a verified picture**. The girls used information to confirm aspects of their existing knowledge.

**Getting a position in the picture**. The information made it possible for the girls to establish an understanding of the problem and confirm a change in attitude.

### 6.3.1 Todd’s conclusion and discussion

The types of effect identified in Todd’s study provide an alternative set of categories of desired outcomes, which could be built into information systems as a central design characteristic. The findings of the study suggest a design approach of matching user-defined cognitive effects with pictures of particular resources (ibid., p. 22).

The girls commented on the central role of visual media in determining their existing knowledge of heroin, and made many references to television images of drug addicts they had seen (ibid., p. 21).
The implication is not that adolescents should be swamped with facts about drugs, as is often the case, in the hope that providing the general facts might provide the needed pictures or cognitive effects. Information providers need to focus on desired cognitive effects to understand how they can best meet the specific needs of each person (ibid., p. 21). Traditionally the role of the information professional has been conceived in terms of matching people to specific resources. The types of information utilisation identified in Todd’s study could provide a new way of looking at the form of dialogue between the information user and the information professional (ibid., p. 22). The findings also have implications for teachers in designing and carrying out classroom instruction, particularly relating to drug education. By understanding how cognitive changes occur in relation to the stream of information that is provided to adolescents, practising teachers can design better instructions to support the pictures (ibid., p. 22).

Todd’s study also raises some suggestions concerning the distribution of information about drugs, whether through government drug awareness services, the media, school education campaigns or citizens groups. Often drug awareness campaigns and education programmes express the idea that simply by making the information available, and often with graphic depictions of the serious consequences of drug abuse, they can convert the existing drug problems of adolescents into non-problems (ibid., p. 22).

The study shows that no matter how forceful or reliable information might be in the minds of others, no matter how useful someone else might think the information is, these qualities do not guarantee that adolescents will receive and use it (ibid., p. 22). It suggests that by matching the choice of information with a perception of where the adolescents are in their personnel and social experiences and in their physiological development the information may be used more effectively and integrated more significantly into their existing knowledge (ibid., p. 22).

### 6.4 Reflections

Todd found five different types of effects of the information provided. We are aware that it can be difficult for us to place the young women we interviewed in the different stages, because we have not done our interviews in the same manner as Todd. We will, however, try to do this.

In Todd’s study, the young women liked visual media best. We will investigate what kinds of information the young women in our research have access to and which ways of getting information they prefer.

Through Todd’s study we found a new way of looking at the form of dialogue between the user of information and the information professional. We will investigate the possibility of a dialogue between the organisations and the young women in our research.

Todd says that there are no guarantees that the adolescents approve of the information, even if others assume they do. We will investigate how the young women think the transmitter of the AIDS information should be.

Todd’s study shows that the choice of information depends on where the adolescents are in their personnel and social experiences. We will investigate if the young women in our study get information that suits them through a sociocultural perspective.
7 Presentation of results

In the first section of this chapter, Observations, we put together some of what we observed and got to know in Botswana—observations that have to do with AIDS. Here we also present the meeting with the AIDS club. We then divide the interviews with the different organisations into groups according to how they conduct their work and what institution they belong to. We start with Church groups, move on to international organisations and national organisations, and end with the youth organisations. We group the interviews in this way because we think this will make it easier to read and to see more clearly what sort of organisations they are. We also make use of this grouping later on in the discussion to make it easier to compare and discuss them. The interviews with the receivers are presented last.

7.1 The observations

7.1.1 Video at the public library

Every Wednesday at about 5 p.m. the library staff showed a video about AIDS at the Public Library in Gaborone. We visited one of these sessions. The video was shown in the reference room. There were about 20 people there when they started showing the video. We estimated that all the viewers were under 25 years of age, some of them even wore school uniforms. There were about as many boys as girls. The librarian placed us at the very front. We felt as if the librarian were showing the video only to us. Sitting in the front we could not observe the onlookers as well as we had hoped. The whole thing felt very artificial. It felt as if we were a huge intrusion. The room was very quiet and we felt as if the librarian disturbed the young people when they were studying. Not one of the viewers seemed to be very excited at having to watch a video; they looked troubled. Some of them left the room even before the librarian started showing the video, and before the video was finished about half of the onlookers had left the room.

The video they showed when we visited the library was a new video. It was produced and shot in Botswana, in the Setswana language, so we did not understand what was said. But just by watching it, we seemed to see that it was trying to frighten people—what Jarlbro called scaremongering. There were very horrible pictures of people with STD and AIDS.

The television set was very small, so the people in the back cannot have seen much. The picture was also of very poor quality, and in black and white.

After the show the librarian asked the onlookers some questions but no one bothered to answer, so the librarian did it. The librarian then asked if someone there could lead a prayer, so a girl said a prayer for the victims of AIDS. It seemed as though the students were thinking that they had been forced to watch the video and that they now wanted to go back to their studies.
7.1.2 Lovers Plus session by PSI

Lovers Plus was a condom brand that was marketed and distributed by PSI. To promote the condom, and to make a contribution to the struggle against AIDS, PSI among other things held sessions in public areas to make people aware of AIDS and to promote condom use. We observed one of these sessions in Gaborone. (PSI and its work are described more thoroughly on page 56.)

The Lovers Plus session took place at the main mall in Gaborone. Loud music was playing long before the session started. It was heard all over the mall and caught people’s attention. In the meantime PSI was putting up large tents. Then at about four o’clock the session started and people started gathering. Everything was said in Setswana, though, so we can only describe what we saw. There was some sort of competition: people in the audience could win a tee-shirt if they for example could put a condom on a stick, tell something about AIDS or dance on the stage. Beside the tent there was a condom demonstration, a young girl showed condoms to a bunch of men. There was also some sort of a raffle. The performance was not crowded, but people came and went throughout. During the session much music was played and the whole performance was a “show” the whole time, not a boring lecture about AIDS.

7.1.3 The AIDS club at the Primary School

When we conducted the interview at the Primary School (see page 61) they asked us if we wanted to come back the following week when the schools AIDS club had a meeting. We therefore returned the following Wednesday. We were told that the school had many different clubs and that the AIDS club was especially popular. The meeting with the club was held outside in the schoolyard, after school had finished for the day. All the children were already gathered when we arrived. We were seated in front of all the pupils. We introduced ourselves briefly and then the pupils stood up and said their names and which standard they were in. There were about 30 pupils, most of them girls. They were in standards five, six and seven, most of them in standard seven. Two teachers also attended the meeting.

They told us they usually have different activities concerning AIDS at the meetings. Sometimes they had discussions, when they argued the pros or cons of some aspect of the AIDS issue. At the meeting we observed the students were given the opportunity to ask questions. One girl led the meeting. She started by asking the others questions about AIDS, which she had prepared prior to the meeting and written down. Many of the pupils were given the opportunity to answer, which they did by raising their hand. The questions she was asking them were, for instance, “What is AIDS?”, “How can one get AIDS?”, “How long have you known about HIV/AIDS?” and “How can you avoid this AIDS disease?”. We recognised some of the questions from the interview we had conducted with the four girls at the school the week before. The four girls we had then interviewed also attended the meeting with the AIDS club. The girl leading the meeting was one of those we had interviewed.

Mostly the pupils handled the meeting on their own: the two teachers were there for support only. By the end of the meeting the teachers had become more involved and helped in answering and also in asking questions.
When the girl who was leading the meeting had asked all her questions anyone could ask questions of the others. Some of the questions were, “Where does AIDS come from?” and “Where does HIV come from?”. Some of the pupils answered several of the questions and seemed very involved, while others did not seem to care so much. Some of the younger boys sat in the back doing other things and giggling.

We did not think that the answers given to the questions were always altogether correct. We reacted to the fact that the teachers did not then intervene. The teachers even seemed to give a wrong answer at one point. It seemed that they did not want to go into the depths of the problem of how AIDS is being spread. They seemed to want an easy way out and not really to go into sex instruction. Or perhaps they did not know themselves. For example, on the questions where HIV comes from the answer was sexually transmitted diseases. All the questions and answers were very superficial, and they seemed to have been talking about this many times before.

7.1.4 General impressions and observations

We had no problem getting interviews. It was acceptable to talk about AIDS as long as it was in general terms. Not one of the people we met ever talked about AIDS on a personal basis, and still they say that everybody in Botswana has someone in the family that has died from AIDS or is infected with AIDS. One woman took us to visit her brother. He was very sick and had tuberculosis (TB); she did not mention anything about AIDS. (He died just before we left Botswana.) Another woman was at a funeral one day and at a wedding the day after but she never talked about anyone in her family being infected with AIDS. Still we felt that she was very open with us and talked about everything. We got to know her well during our stay in Botswana. The last week when we visited our supervisor Kerstin Jackson together we came to talk about AIDS and then she told us that she had attended the funeral of a man who had died from AIDS and that more in his family were sick.

We did not see condoms being sold at many places. The grocery store we went to did not sell condoms, at least we could not see them anywhere. In the pharmacy we could not see them either: they were probably kept behind the counter, so that people had to ask for them. You could find condoms at the petrol stations, at least at the BP filling stations. We did not visit that many petrol stations but we saw one that sold Lovers Plus condoms. (On Lovers Plus condoms see section 7.2.4.2 below.) One day PSI handed out free Lovers Plus condoms at the main mall. At the library you could get condoms. They were placed in the reference room, very visibly.

There were both private clinics and public clinics, located together with the district councils. We visited three of the public clinics. In the clinics people could find information in the form of posters on the walls about AIDS/HIV and STD. We saw posters about Tebelopele (a testing and counselling centre in Gaborone, further described in section 7.2.4.2) and others with horrible pictures and photographs of people with STD. The information at the clinics we visited was both in English and Setswana. One poster said: “It is tough to were condom” (sic). There were also pamphlets that the visitors could take home with them. These were in Setswana and were like a comic strip. But we could not see any condoms there, at least not on open display. We visited three clinics.
and did not see any condoms. In *Choose Life* (see page 51) they say that people can get free condoms at the clinics.

In Gaborone and along the roads we saw quantities of posters and huge placards. Often small posters were pasted up on the garbage bins around town. At the bus shelters you could also see posters about AIDS. NACA had many posters at the bus stations and there was also a huge yellow poster promoting TebeloPele. Along the roads, when we were travelling outside Gaborone, we also saw huge placards, one that we often read: “Avoiding AIDS is as easy as…Abstain, Be faithful and Condomize” etc. The yellow poster promoting TebeloPele we also saw everywhere.

### 7.2 The interviews

#### 7.2.1 The Church

**7.2.1.1 BOCAIP – Botswana Christian AIDS Intervention Programme**

Interview with a representative of the Mennoite Central Committee

The representative told us that the Mennoite Central Committee (MCC) is a church-based relief and development agency from North America. BOCAIP was founded in 1997. It was based on community grass-roots initiatives by individuals and on church-based groups and churches which were interested in responding to AIDS in a community-integrated way, not as individuals, each with their own little programme, but cooperating with others. The basis for BOCAIP’s work is training for counselling work with people infected with and affected by AIDS, seen from a Christian perspective. The representative at MCC said that Botswana is a very religious country and most people are members of a church even if they are not closely involved.

According to the representative at MCC the people of Botswana did not respond well to the epidemic in 1996. Then President Masire challenged the church to become involved and actually brought in people from Uganda to try and see how this response could be broadened, and it was out of that initiative that BOCAIP was started. Today BOCAIP has five centres in Botswana.

The representative at MCC said that BOCAIP is being very strongly challenged by the Ministry of Health, by the AIDS/STD Unit and by other agencies to expand its work. This is because the counselling offered by hospitals, clinics and testing centres is a start but it is not enough. Usually the hospitals etc. only do pre- and post-test counselling if a person has chosen to go for an AIDS test and then the patient is dropped, whether the test is negative or positive. BOCAIP’s support and counselling of the client are ongoing. They do not stop when the client dies: the counsellors continue their relationship with the family, particularly if children are left. When one partner dies and the other is already sick, the children’s situation is almost as bad, if not worse, because they have to care for the sick parent.

BOCAIP has training for its counsellors. It now has two Batswana trainers and will hopefully bring on board more trainers as the need continues to increase. Some of the
trainers are assigned to clinics and then work with clients referred by nurses in the clinics. BOCAIP also tries to form an ongoing relationship with the community.

BOCAIP offers orphan care at two centres. One is primarily for children of pre-school age. They are finding that teenagers, particularly when the last remaining parent has died, will be forced to leave school to care for their younger siblings, who are not yet in school. In Maun they have a day-care centre for those children whose siblings have become the head of the household.

BOCAIP offers outreach and education in the community, material assistance in emergency situations, youth work and support groups to people living with AIDS. According to the representative at MCC, BOCAIP is trying to expand in all different ways.

The representative at MCC said that BOCAIP has applied for funding through Barclays Bank to train counsellors in better outreach. They go to schools, businesses, workplaces, churches, youth groups and community meetings. Outreach workers go to the main catla (which is a place where people gather for special gathering; each member of the community is required to be there), or they are invited, but they also send out invitations. BOCAIP counsellors have had meetings with a dozen headmasters in Lobatse. They have also met with headmasters in Juweni, where the diamond mine is located, to get outreach workers placed as educators in the schools.

The health resource centre at the hospital in Lobatse is the centre where people with AIDS come for testing and counselling, through the hospital. There they can get information about AIDS and about other health matters—STD, TB, malaria and cancer. A team of hospital staff works there as well as social workers and nurses.

According to the representative at MCC, BOCAIP has some written information but does not have enough material. Much of the written material is not in Setswana and is hard to get. There is no adequate distribution centre. The representative at MCC tried to supply the centres, but if they go to a school with 200 children they require a lot of material. They do not have a central resource centre, except in Lobatse.

The representative at MCC believed that they had seen results. They did quarterly reports. This had been done for all of their work for the last quarter of 2000 and included statistics, etc.

### 7.2.1.2 Keletso Counselling Centre

Interview with a counsellor at the Keletso Counselling Centre

The Keletso Counselling Centre is one of the BOCAIP centres working with HIV at the grass-roots level. Keletso was initiated by a united Christian front; it was a response to the ever-increasing number of HIV-infected and -affected people. The centre exists to help meet the needs of people in Molepolole and surrounding areas arising from the AIDS pandemic. Keletso has a team of qualified counsellors and volunteer counsellors who have all completed an extensive training programme in counselling through BOCAIP.
According to the representative at Keletso the centre performs all types of counselling marriage counselling, relationships counselling and family counselling. They make house calls and they have a support group for people living with AIDS. Keletso also has education and outreach programmes in which they visit schools, workplaces, churches—anywhere there are people. They also have an orphan care centre for children who have lost their parents.

A man who worked at the centre earlier implemented a model called “listen, learn and live” to make people listen to the information, learn the facts, use the information they had received and heard, and make a change in their lives, but he had left and they had not been able to keep this programme going.

The outreach programme that Keletso is running is not a one-off initiative, but is ongoing. During the interview the representative at Keletso said that: “If we just go once, there is no change”. The counsellors talk about HIV/AIDS, show pictures and cards, show a video and remind the audience of what was said the last time. The counsellor talks about changes in behaviour. In schools Keletso counsellors meet large groups of up to 40 children. In workplaces and other places they have small groups which makes discussion possible.

The representative at Keletso said that the centre has different videos depending on the group. They have noticed that young people like video best; it is something they can see, visual; the representative believed that just talking in schools is no good.

Keletso does not encourage condom use as many other organisations do. They encourage abstinence, especially in young people. According to the representative at Keletso this is difficult. Older people say this way is best for younger people, while the young people think it is impossible.

The information is given in both English and Setswana, depending on the group. Keletso uses both written and oral information, but mostly oral. The representative at Keletso thought people appreciated receiving some written information, but the centre cannot produce large amounts of material.

With the counselling the representative at Keletso said that they had seen results because people come to the centre, or come to tell them they have a client.

According to the representative at Keletso the centre has many difficulties. For example, hospitals do not refer clients to the centre. This is a great problem. Another problem is trying to clarify all the misunderstandings people have about sex, HIV/AIDS etc.

7.2.1.3 The Methodist Church and Botswana National Youth Council

Interview with a reverend at the Methodist Church, who also was a representative of the Botswana National Youth Council

The reverend said that as a church the Methodists are still divided over the issues of HIV/AIDS. At the beginning of the pandemic in the early 1990s, some people in the church were saying that it was “the wages of sin”, but the reverend has always said that
it is a problem in the material world and you need to find some common ground to fight it.

Some people in the church believe that abstinence is the only solution. The reverend understood that abstinence is important, but he said you also have to ask yourself “…but how many of the people abstain?”. He believed that you should give the people information so that those who want to abstain can abstain and those who are not able to abstain are able to protect themselves and have safer sex. The Methodist Church has more and more come to accept this position, the reverend said. “Yes, we would like people to abstain, but when people are not abstaining then they must have a choice and that choice is a condom.” This was a difficult choice for the churches in the beginning but now they more and more have accepted the use of condoms. The reverend also offered condoms to his congregation by placing them in the toilet.

The reverend believed that the major problem in Botswana is the issue of sexuality. People have tended to avoid from it, but now it is central in any teaching they do, both cultural and in schools, and even in the church. He believed that the church has stigmatised sex, so that when the pandemic began it was as if the disease had arisen to punish people. But it is not so, the reverend said: it is people who lack information. The church therefore wants to change their approach to issues of sexuality and deal with them pragmatically. They want to pass on information, to be able to socialise children over the years. As a church he believed they have to take serious views. So now they pass the message on. Some of the messages came from NGOs. They support a peer approach to counselling by young teenagers. The teenagers talk to each other in the church. The reverend believed that peers can understand each other on a different level.

The reverend said that among male partners the Methodist Church is urging faithfulness in marriage. He also said that: “In case you are not faithful or do not know your partners’ status, even in marriage then you should use a condom”. This is the message the Methodist Church has now to pass on. It is an area that the church has not really worked in. The Methodist Church has a programme called Botswana Christian AIDS Intervention Programme, where all churches come together to try and offer relief. “For now the solution is prevention, to raise a new generation as a nation” said the reverend. He thought it was important to be aware that the spread of HIV/AIDS in Botswana was quite different from in other countries in Africa because of the level of development in the country in that mobility is very high (you can move from one corner of the country to another in one afternoon). This is the main difference from other, less developed countries in Africa, where the pandemic seems to be centralised in large cities and towns. Botswana also has a very small population, only 1.5 million people, the reverend explained. The other thing is the nature of Batswana society. This entailed working in a large city, but coming from a village, to which people return, where their chattels are kept and where their crops are. According to the reverend that circle is a part of the AIDS problem.

Other churches in Botswana do not have the same view about AIDS, according to the reverend. He said that some churches are not open-minded and that some people even say the victims should be allowed to die. Some churches are still conservative. The reverend said that they cannot be—there is a problem, a crisis that they need to deal with. He said that he is not proud of himself; the church seems not to be dealing with the issues and has to start now with social support, health education etc. “Sometimes we
get hung up on issues of morality for yesterday…and the theological solutions to problems yesterday are not the same today”, he said.

The reverend was also the executive director of the Botswana National Youth Council, which is a coordinating council for about 50 organisations. He oversaw the activity of the young people. The council also tries to help governmental hospitals and other establishments to be sensitive to people. According to the reverend there is still a problem with awareness. A person cannot go into a clinic and receive good service; if he or she asks for a condom, for example, they are then asked what they want it for.

The Botswana National Youth Council does a lot of IEC—information, education and communication—work. It also increases the capacity of district and village young people’s councils to deal with HIV. The reverend said that they have to respond to the community and they want solutions to come from the people in the community: “We do not want to impose on them”.

Even if people knew how AIDS was transmitted then there were other issues that played a role—issues of income, poverty, recreation and entertainment. The reverend believed that Botswana needs to offer alternatives to young people in the fields of recreation and entertainment. When they do not have alternatives they more easily turn to alcohol and then to sex, because they lack other forms of recreation. Botswana needs to offer recreation and entertainment to young people. The main difficulties are due to the fact that it is behavioural changes that are on the line. The reverend believed that what remains for the country to do is to induce behavioural change. It is difficult but it is possible; but it is a process that takes a long time. It requires more information and more empowerment—to be able to say no. It is also an issue of gender: women need to be empowered to be able to say no.

7.2.2 International organisations

7.2.2.1 UNAIDS

Interview with a representative of UNAIDS

UNAIDS is UN programme on HIV/AIDS. It is spread across seven agencies—UNDP, WHO (the World Health Organisation), UNICEF (UN Children’s Emergency Fund), UNFPA (the UN Population Fund), UNESCO (the United Nations Educational, Scientific and Cultural Organisation), the World Bank, and now the UN Drug Control Programme. In some areas in the world drugs are spreading HIV. UNAIDS changes its staff (personnel deployment) from one country to another.

UNAIDS in Botswana looks very much at the management of HIV/AIDS. It provides guidance and support to the national AIDS programmes, helping them to create more effective and stronger programmes. UNAIDS works with, and through, its key national partners—both government and civil society organisations—to empower Botswana to deal with the HIV/AIDS epidemic effectively and in ways that are appropriate in the national context. It held a workshop in February 2001 with a project at the University of Botswana. It also has a youth project focusing on behavioural change and is looking at ways of facilitating behavioural change during the HIV epidemic. UNAIDS is not going
to accomplish this, but its strategies are to mobilise the resources for doing so. UNAIDS works closely with the young people. The representative at UNAIDS thought that was important to involve them.

UNAIDS has many strategies, but the key strategy is defence. It also has considerable information exchange. The representative at UNAIDS said that:

Last week for example, two weeks ago, Debswana came up with a new policy where they require all companies who are attending with them, who have contracts from them, to be eligible, they must have AIDS-programs. AIDS programmes that reach stated standards. That we thought was really ground breaking so we got commission from them, and immediately sent a copy of the policy to Geneva, and Geneva in turn has sent it around to all the different countries, so we do a lot of information exchange.

The representative at UNAIDS thought it was too soon for UNAIDS to see any results. The epidemic is still continuing. The results UNAIDS actually can see are that more programmes are being set up, and the representative could see better management in some areas. The methodology is also beginning to develop. UNAIDS has very much been facilitating the introduction of behaviour change methodology. It needs to target not only the persons in immediate danger but also the community. It wants to make safer sex a norm and to make condoms readily available.

People walk into a pharmacy and buy it, and they have to ask for it, because there are so many taboos, that it is not out in show, you cannot just pick it up. So, now you have to go to somebody who you probably know, and say “May I have a condom, please?” “You, what do you want a condom for? I am going to tell your mother.”

According to the representative at UNAIDS one problem that UNAIDS has is that it is working with and through all the UN agencies. AIDS is a priority at UNAIDS, but not in the other agencies.

7.2.2.2 The BOTUSA Project

Interview with a representative of the BOTUSA Project

BOTUSA is a cooperative effort between the Ministry of Health and the US Centre for Disease Control and Prevention. It was established in February 1995. Its goal is to generate information to improve TB and HIV control in Botswana and it works in collaboration with the Botswana National Tuberculosis Programme (BNTP). The BOTUSA Project has now $8 million entailed specifically for HIV/AIDS programmes and a budget of $1 million for research.

The representative of BOTUSA had noticed that there is a good deal of ignorance about HIV/AIDS in Botswana. There is a high level of understanding, but also many misconceptions, which can sometimes stand in the way of behavioural change. 30% of the population believe that if you donate blood you get HIV: people die because they cannot get blood transfusions. The representative of BOTUSA thought that:

Alcohol is a big problem. It is very cheap, it is very available, and alcohol reduces resistance to sexual activity. It has made people inattentive to safe sex. Mobility is also a big factor, probably one of the biggest factors to explain the huge magnitude of the epidemic. People have a lot of mixing partners. Another issue is just the status of women in the society. For cultural reason they cannot say no to their husbands.
Condoms need to be a big aspect of HIV prevention, but they are not widely available. Young people cannot go to a clinic and ask for a condom, because legally you cannot have sex until you are 16. Interviews have been done with HIV-positive people about their last ten encounters and only 24% used condoms in all of those sexual contacts.

According to the BOTUSA representative, the problem in Botswana is that culture makes AIDS a secret: people cannot tell someone that they have HIV. There are actually people who consider the pandemic to be an emergency—for instance, the Minister of Health—but it is too late to declare a state of emergency now. One hundred people per day are being infected. Probably less than 5% of the population know their own HIV status. The BOTUSA representative said that: “I think the emphasis now needs to be on getting information to the individual, not just to the mass media, because that does not seem to influence behaviour very well”.

BOTUSA’s biggest form of assistance is in stabilising, counselling and the testing centre called Tebelopele (which means “to look into the future”). This was started last April, and there should be, by end of the year 2001, some 15 centres. BOTUSA provides condoms at Tebelopele. As far as spreading information is concerned, BOTUSA also has a separate activity with PSI. It does the marketing for Tebelopele, creates posters and sends out information on the radio. BOTUSA also sponsors a campaign called Total Community Mobilisation, TCM. Workers go door to door and educate the public, both in English and Setswana. Basically BOTUSA has printed materials, face-to-face drama, radio (radio messengers and radio drama) and video.

According to the representative of BOTUSA, radio is a powerful medium in getting information out. BOTUSA used the local radio station when it opened a centre in the north of Botswana, and attracted many clients. Batswana listen to the radio a great deal. Drama is also an extremely effective medium. There are a couple of drama groups in Gaborone. BOTUSA is sponsoring the theatre group Reetsanang. It is also in the process of starting a radio drama following a model from Tanzania which is quite effective in displaying disordered behaviour. The drama is an ongoing series, not just a one-off show, which is important. A major study was done the year 2000 to produce a better understanding of what Batswana know about AIDS and what they think about it in a cultural perspective. The report has been drafted.

BOTUSA also places televisions and video players in several hundred clinics around the country. So far there is nothing in the way of VCRs in the clinics.

The BOTUSA representative thought that it was best to have someone from Botswana to get the information out and to get the message in the right format. BOTUSA has a Batswana employed who has been encouraged by its education and communications activities.

BOTUSA has only seen small results as it started only last year. The representative of BOTUSA said that: “In terms of interest for testing we see results”. When BOTUSA opened a centre in Francistown the Minister of Health opened it and then went for public test together with her husband.

The representative for BOTUSA thought it is too early, too premature, to say that it has made an impact. It may have done so at the individual level, but not for the country as a whole.
The final words of the interview were: “It is a catastrophe, an emergency”.

7.2.2.3 DFID – Department for International Development

Interview with a representative of DFID

DFID is the British ministry responsible for overseas aid. The representative told us that DFID has a special project working with and through regional offices in Pretoria covering Botswana, Namibia, Lesotho, Swaziland and South Africa. The programme has a budget of £14 million per year.

The representative at DFID said that:

The private sector in Botswana is becoming increasingly concerned about HIV/AIDS. People like BP, the banks, diamond mines are all formulating their own policies on how to deal with HIV/AIDS in the workplaces, and in some places they are deliberately employing two people for every job on the basis that sooner or later somebody will have to leave. You cannot change people’s attitudes overnight. It is a slow process.

DFID publishes the magazine *Choose Life* in consultation with many people—the church, teachers, youth groups, parents, NGOs and so on. The representative at DFID felt that there was mild resentment across the four smaller countries (Botswana, Namibia, Lesotho and Swaziland) at having something very South African shown to them. With every issue DFID goes through a consultation process to put together a magazine that will reflect local feelings, local values, local trends and so on. DFID did a pilot test in some districts in Botswana, both urban and rural, before it published the magazine and specifically asked children what they thought about the magazine. There was some criticism and some positive comments. According to DFID they took all of this in, thought about it and changed the publication. Some of the parts in the magazine were in English and some in Setswana. The key part was in Setswana. DFID wanted both an English version and a version in Setswana, but did not have funds. There has been a roadshow going around the country advertising *Choose Life*, as has the radio, the press etc.

The DFID representative said that the idea behind the magazine was to place a copy in the hands of every person between the ages of 12 to 18 in Botswana. DFID used Ministry of Education channels to get it to schools and other channels. DFID targets both young women and men.

According to the representative at DFID some of the teachers in the schools do not want to pass out the magazine at all: some are keen to use it but do not want to let it out of the classroom, want to keep it as a textbook. DFID thinks that the whole tone of the magazine is positive: it is not a negative message along the lines of “Do not do this, do not do that”.

DFID also has plans to launch a much bigger programme across Botswana. The aim of that programme will be to help strengthen existing national AIDS programmes, to support condom social marketing, and to help NGO and community groups who are dealing with HIV/AIDS. The Ministry of Education is becoming increasingly concerned with the impact of HIV/AIDS on manpower planning—teachers dying, children dying,
people in the ministry dying. Another project is to produce a study on how to mitigate the ineffable effects that HIV/AIDS has on the workforce.

DFID is to launch a second magazine aimed at a younger audience, 8–12 years old. The whole issue there is prevention, trying to stop the next generation from contracting AIDS. DFID hopes to make children aware, to make them change their behaviour.

The representative at DFID thought that young people were positive towards the magazine. The young people know it is a real problem and they feel more comfortable talking about it than the older generation did. According to the DFID representative, messages that have come from the top, from educators, ministers and the president have lauded their effort. AIDS has to be talked about, for behavioural changes to be achieved. It is a slow process to make middle-aged people change their attitudes.

The representative at DFID said that: “If the young people feel it is just another lesson they do not listen. But young people feel that here they are being asked to participate in something that relates to their age group, that uses the language they use, and that it is a topic related a lot of time by people in their age group”.

7.2.3 National Organisations

7.2.3.1 Reetsanang Association of community drama groups

Interview with two representatives for Reetsanang

Reetsanang was founded in 1986. It is a non-profit-making membership community theatre organisation whose mission is to promote and develop the use of community theatre as a medium of participatory, dialogical and horizontal development communication and education with and within both urban and rural communities whose voices, skills, expertise, knowledge and energies are necessary in the overall development of Botswana, and to promote cross-cultural communication within multi-ethnic countries and between peoples of different countries.

According to the representatives for Reetsanang the organisation has a membership of about 2,500 theatre artists, who constitute the current Reetsanang member group and operate in various communities throughout the country. Two types of theatre groups constitute the membership of Reetsanang: out-of-school groups, which are made up of both unemployed and employed young people and adults, and in-school groups, which are mainly made up of students with teachers acting as advisers.

Reetsanang has prioritised HIV as an issue of national concern. To start an HIV education programme it looks basically at the government’s role and the incidence and prevalence of the epidemic. It is alarming, and Reetsanang wanted to produce a programme which would involve young people, both in school and out of school, old people, men and women—particularly women. The representatives thought that most of the men are working; it is only the women who are at home. These are the groups Reetsanang wants to engage. The group, which is mobilising the women, organises them and educates them to respond correctly and effectively.
The representatives for Reetsanang told us that in some schools there are school drama clubs. Every year Reetsanang has training workshops for schools on the use of theatre and acting skills.

Community members come to Reetsanang and ask it to do a workshop. Reetsanang then goes throughout the community, working together with community members. The group travels to a district and holds a workshop for two or three days. Local health facilities are also involved in the programmes. On the first day of the workshop there are meetings and discussions about HIV/AIDS. One person will speak in the language specific to the area, a person who knows both Setswana and the local language, e.g., the Bushmen language. After that there are group discussions, each group taking a particular subject, such as HIV and women or HIV and men. The representatives for Reetsanang thought the subject has to be made real in order to be felt, which is why they bring in community members. A story is created—a story that should offer a possible solution to the local problems. Members of the community do the acting. The show is in the main _catla_. After the play there are discussions about what occurred in the play. Reetsanang engages community members so that the audience can identify and they know that “that is my neighbour, and that problem is affecting me”, the representatives for Reetsanang said. Usually they give three performances, on different subjects—HIV and women, HIV and young people, HIV/AIDS and home-based care and so on.

The representatives for Reetsanang said that after that particular activity there has to be a theatre group in the village, formed of the people who participated in the HIV workshop. After the workshop Reetsanang goes back to the community to see what they are doing, in a continuing effort of education about the problem of HIV/AIDS.

The representatives for Reetsanang had noticed that in remote areas Reetsanang has received a good response. In the remote areas there is only a small part of its activity is concerned with HIV/AIDS.

A big problem for Reetsanang is money. Last year it had numerous programmes. Now it has to set limits. When people ask it to perform a play, often the group has to say no. Reetsanang has tried to talk to the BOTUSA Project. BOTUSA has the management of specific programmes, but it is difficult to do programmes without money. Reetsanang receives support from an organisation based in the Netherlands, but its ended in September 2001. Sida rejected an application for support in December 2001.

The representatives of Reetsanang thought that one problem for the whole HIV/AIDS issue is that as many condoms as possible have to be provided, but they said that the Christian organisations do not accept condoms. It is a continuing debate.

### 7.2.3.2 Botswana National Library Services

Interview with a librarian at the Botswana National Library Services

The librarian at the Botswana National Library Services told us that in the libraries they have many books, many titles, and some simplified readers on the AIDS topic. Every local title that is published on HIV/AIDS is acquired. International texts and books that are of interest are also acquired. All libraries now buy many videos. In Botswana the public libraries do not buy their own books. They can select titles, but purchasing is
centralised. The public libraries buy videos and posters. “Just by posters and books and videos people are being informed and empowered” the librarian said.

Every Wednesday at 16.30 a video is shown at the Gaborone Public Library about HIV/AIDS. Everybody who wants can come and watch. It is a pilot project which the library hopes will be passed on to all the other libraries. It has had the video for about a year and a half. It is shown to a “captive audience”, that is, in the reference room, but the staff also send notices about the video to all schools nearby and ask the schools to pass on the message to their staff and students. According to the librarian at the Botswana National Library Services it is mostly young people who come to see the videos. They do not have many different videos or a large variety. They have four main videos and others that they borrow. Recently the department bought many new videos, but they have only just started going through them. Recently a video was produced locally, shot in Botswana.

The librarian said that the information is mostly of general nature. But one of the four main videos that are shown is especially for young people—cartoons. That video is about an elephant and his friends. Elephants are supposed to be wise.

According to the librarian at the Botswana National Library Services the people who watch the video are often shocked. The librarian has had some people coming up to talk to her after the video.

The Botswana National Library Service arranges workshops for teachers. In most of their workshop programmes they put HIV/AIDS into the programme.

7.2.3.3 National Library headquarters

Interview with the AIDS coordinator at the National Library headquarters

The National Library headquarters has its own AIDS programme for the staff. Every Wednesday morning they have a meeting or they invite somebody to come and talk about AIDS issues. Once, for instance, someone who talked about testing was invited. Another week a pastor was invited, to present the issue from a Christian perspective. There has also been a debate on abstinence. The meeting is held every week, but it is very brief—about 15–20 minutes.

The government decided to do something with the issue of HIV/AIDS in the workplace, the AIDS coordinator told us. About four ministries together with UNDP came together. A fund, which had been put together by UNDP and the four ministries, will be used to pilot the project on HIV/AIDS in the workplace. They are supposed to initiate some educational programmes to try to stop the spread of HIV/AIDS in the workplace. The role of the workplace coordinator is basically to organise activities that will help raise awareness among colleagues. Currently the programmes that they have at the National Library Services are on a weekly basis. They meet just before they start work. It is basically a prayer meeting but also a chance to share information. The meetings are very short—15–20 minutes, but sometimes longer. They also distribute condoms, but not on a person-to-person basis. They put them in the toilets, so people can get them there.
According to the AIDS coordinator the organisation has had a number of resource people, normally specialists invited from outside, for instance, a lecturer from the University of Botswana Department of Adult Education who is well versed in HIV/AIDS issues. He is an adult educator; his perspective is from the social point of view. They have also had people from the church.

The ministries are composed of 13 departments, and among these is the HIV/AIDS Committee which the AIDS coordinator at the National Library headquarters chairs. It is made up of representatives from all these departments. Each of them is supposed to have an HIV/AIDS Committee, which should be chaired by the director of the department to emphasise the seriousness of the activity. This arrangement is supposed to function also in the districts, which have the same committees at district level. In the future they hope to work on this.

7.2.4 Youth organisations

7.2.4.1 PACT—Peer Education to Counselling Teenagers

Interview with a 17-year old girl whom we here call Ann

Ann told us that PACT is a youth programme which helps young people by providing information to a group so that they can then go and teach about youth problems on a peer-to-peer basis. Initially it was formed to reduce teenage pregnancy and to deal with problems of drugs and alcohol.

According to Ann they were first called “The teenagers’ YWCA”—Young Women’s Christian Association teenagers—but then in 1991 they formed this PACT group. The main body is the YWCA. PACT has an office at the YWCA in Gaborone, and also a large Gaborone PACT group. Different PACT groups connect together into one body, and they all get together every month for meetings.

Ann told us that PACT has training and workshops, for about a week, and they do a community diagnosis, which is a kind of research. Through the community diagnosis PACT learns exactly what is going on in the community and which places to target. PACT also holds sessions, conferences and talk shows, and uses other different methods of attracting young people. It has workshops when there is a need for workshops.

PACT does not deal with adults: they focus on peers, Ann said. That is why it is called peer approach: young people spread the information to their peers. “In the Botswana society it is very difficult to talk to your parents about such things. That is why PACT is there. People can talk to their peers about everything. For example, sexual matters”.

Ann said that:

Sometimes you can find, if you go to a primary school and ask them where a child comes from. One possibility: the child comes from the banks of a river, the child comes from a helicopter, the mother buys them from the hospital. If children are told exactly where they come from, if they are told the truth, if the parents do not feel too shy to talk, I think that is the best thing to do.

PACT provides mostly oral information, but they also have pamphlets. Ann thought drama was the best way of educating people. People like to sit watching and laughing
and having fun. Having fun and learning at the same time is the best way to educate. Sometime PACT has a “PACT day” in which all the young people get together and have a fun day. They have a talk show, they get pamphlets out, there are competitions where they ask questions about AIDS. Young people learn in order to get something, and what they also get is information. At the same time they are having fun. The young people have to go around asking questions to get the answers. They learn, but they do not notice that. And they have fun at the same time.

Ann thought that PACT had seen some results from their work. For example, when PACT started at Maru-a-pula (a private school in Gaborone) they had about 42 students dropping out with teenage pregnancies. The following year this was reduced to 20, the next year to only three.

Ann thought that: “There has always been that gap between the parents and the children. In this country, it is a part of the culture. PACT is meant to break this gap, but it is very difficult”.

7.2.4.2 PSI—Population Services International

Interview with a representative for PSI

PSI is a non-profit-making NGO. Its main purpose is to market social products, such as health products, as well as family planning. It is currently operating in 50 countries worldwide, mostly Third World countries. Its first project was launched in 1993 and was called Lovers Plus, the representative told us. Currently PSI also has two other projects running—Choose Life and Tebelopele.

Lovers Plus
PSI markets and distributes the Lovers Plus condom in Botswana. It has developed material for Lovers Plus (promotional material such as tee-shirts, banners, and brochures). One of its promotions for Lovers Plus is called “Once in a lifetime”. This is a competition and aimed to encourage the consumers to buy Lovers Plus condoms. PSI gives away things such as a week at a resort, bicycles, caps and tee-shirts to attract people to enter the competition. The Lovers Plus condoms are sold in kiosks and tuck shops (the little shops in residential areas) and in clubs, bars and supermarkets. People can go out at any time and buy a Lovers Plus. PSI is trying to educate people about correct behaviour, and also gives instruction on how to use the condoms correctly.

Besides handing out the pamphlets, brochures and so on mentioned above PSI also does peer education, the representative at PSI told us: a group of young people go out into a mall area and do condom demonstrations and talk about AIDS and STD. During the sessions PSI tries to entertain and educate at the same time. To do that it usually uses music and drama groups or does some sketches. PSI does role-play to keep the crowd interested as well as to educate them.

To promote Lovers Plus, PSI also has a radio programme for one hour every Friday, the representative told us. Usually it is live and like a talk show. PSI sometimes invites “keyholders”, specialists in the field that we are talking about, so that they can answer
questions and give their opinion on the issue. PSI tries to be as controversial as possible so as to get two sides of the story.

PSI is also trying to involve parents. By doing so it hopes to get them to encourage their children to go out and get the booklet and win prizes. This is mainly so as to make the programmes a family thing. The parents should also learn that it is time they start talking to their children.

PSI usually has a session around midday, when it knows it will get a large crowd of people. PSI then goes out with a team, a group of educators. They set up and begin to play music. People start coming to hear more, to find out what PSI is talking about and ask them questions on AIDS, STD, condom use and the effectiveness of condoms. PSI may have a role-play drama—to demonstrate one of the scenarios, on how to negotiate safe sex or avoid teenage pregnancy. PSI tries to add more flavour by using a drama group to do an AIDS sketch for about 10 minutes, but the main goal is to get the message out to the people.

According to the representative at PSI the Lovers Plus condom is quite a popular brand now. Because PSI is doing social marketing they sell Lovers Plus for quite a substantial price, 2 pula.

**Tebelopele**
Recently PSI started a relationship with CDC, the Centre of Disease Control, and BOTUSA. PSI handles the marketing and communications work for Voluntary Consulting and Testing Centres—called Tebelopele in Setswana. With Tebelopele PSI does printing, advertising and newspaper advertising and produces bumper stickers, brochures and so on. With these advertisements PSI is trying to encourage people to go and get tested in order to know their HIV status and to tell them that the test is confidential, anonymous and fast, with same-day results. The advertising also shows people exactly where the centres are located. Currently they have four centres (in Gaborone, Francistown, Maun and Selibwe-Pikwe). Usually advertisements for Tebelopele are to be found in most workplaces, one in English and one in Setswana.

**Choose life**
PSI has done the research and is now doing the distribution for a magazine entitled *Choose Life*. This is done in cooperation with an NGO in South Africa and the project is founded by DFID. For the whole of February 2001 PSI had a team out all over Botswana, travelling, going to schools, handing out the magazine and educating the teenagers. The magazine was for 12- to 18-year-olds. PSI educates teenagers on the problems teenagers usually have—pregnancy, relationships, love, condom use and so on. There are many young people who do have finished school in Botswana and PSI has tried to distribute the booklets to them through BP filling stations. PSI normally goes out to the filling stations and holds sessions. It then has young people talk about the issues and provides entertainment as well.

PSI also does workplace education, when it is invited by various organisations to come and educate their staff members. It usually starts by assessing the knowledge of the staff, and can then design an education module depending on the assessment. Then PSI moves into training.
PSI has printed 400,000 copies of *Choose Life*, which is about the number of teenagers in Botswana, so that every teenager can have a copy of the magazine. According to the representative at PSI, PSI has had some problems with *Choose Life* in the schools. One problem is that some teachers in the schools do not give them to the students. They keep them and use them as a teacher’s aid, without the children actually getting to look at them. This allows the teachers to choose what they want to talk to the children about. Another problem is that PSI has heard that teachers, mostly in the Catholic schools, have torn out the page with the condom demonstration. The representative of PSI thought that it was difficult to convince the Catholics that sex education is essential, especially if you talk about contraception, because this is not an accepted part of the Catholic religion, in which sex is not allowed until you are married. Still, young people have sex at an early age and that is one reason for publishing *Choose Life*. Many young people get the wrong information from their parents. They believe that if they drink Coke after unprotected sex they will not get pregnant, or if they take laxatives they will not get pregnant or not get AIDS. If they have sex standing up they will not get pregnant. PSI is trying to clarify these messages and act as an adviser, a source of information. Usually in African culture it is not very easy for a young person to talk to his or her parents about sex issues and other such problems, the representative at PSI said. PSI tries to serve as a stepping-stone for the young to get the right, correct information.

Before the campaign with *Choose Life*, research is being done, the representative at PSI told us. *Choose Life* has been developed from a South African publication. PSI is therefore drawing up its own edition based on the South African magazine. To create a Botswana edition it first does research. There is also research done to develop a local Tebelopele.

DFID only recently launched *Choose Life*, but, according to the representative at PSI, it believes that young people are reading the booklets. This conclusion is drawn especially from the number of entry forms that it has got back, and the feedback it gets has also been quite good. At a later stage some research should be done to find out how informed the young people now are.

PSI’s peer education activity has been going on since 1994. PSI is a young organisation. Most of the participants are in the same age group as the PSI representative we spoke to or younger. This is because it is easier for the young to get the message across, especially to their peers, who are the majority of the sexually active population. But this does not mean that PSI limits its activities to young people. It also gives talks to older people. Sometimes older people may wonder “Why is this young girl telling me about sex?” But they actually manage to get the message across.

### 7.2.5 The users

#### 7.2.5.1 17-year-old woman

Interview with “Ann”

Ann lives in Gaborone and goes to high school at the private school Maru-a-Pula. This is the second of two interviews we conducted with her, this time as a representative young woman in Botswana.
Ann said she was about nine years old when she first heard about AIDS. She heard about it in school. Ann told us young people obtain information about HIV/AIDS mostly from school, but also from radio and television. There are posters on HIV everywhere. Ann said that she and her friends can discuss AIDS with their teachers, but not all the teachers are very open in talking about sex and AIDS.

Ann thought the information she receives in school is quite good. According to her, school is the best way to inform young people. The young people do not have a choice, they have to listen, and they know they are going to be tested. Ann thought there is a risk that AIDS may become “just a boring subject”. The young people need a new approach to it. Ann said that:

The best thing is if the first person gives a speech on AIDS, and the second person dramatises on AIDS, and the third person passes out posters on AIDS and pamphlets. That is three different ways to give knowledge on the same thing. That will keep us interested.

Today it is mostly speakers who present information. Ann said that teachers in private schools are being taught through training. In Ann’s school, Maru-a-pula, they have professional teachers. The teachers know what they are talking about.

Ann thought Choose Life is a very good magazine. The people in it are young and they are local, which is very important. She gets the magazine in her school. Ann thought it is a good way to inform young people.

Ann thought abstinence is the most important way to stop the spread of HIV, but it is very difficult to tell people to abstain.

According to Ann it is important that people, like the president, talk about AIDS: people listen to that.

7.2.5.2 The Junior Secondary School

Interview with four young women (one 15, the others 14 years old)

We first met with the head teacher and a teacher at the school in the morning. They asked us to come back in the afternoon because they would then have picked out four young women for us to interview. We conducted the interview outside in the schoolyard. For about half of the interview two teachers also sat there listening.

What the four young women knew about AIDS in general was that there was no cure. They said that it is easily transmitted, mostly through sexual intercourse, but you can also get AIDS from sharing needles, by transmission from mother to child, and through blood transfusions. They do not believe you can get AIDS from mosquito bites or kissing.

On the question of when they first heard about AIDS they answered a little differently. One young woman said she heard about AIDS 10 years ago, and it was her father who told her. One young woman did not hear about AIDS until she came to school and went in standard five.
The young women said that the teachers at school talk with them about AIDS in school. They talk a lot about it during science lessons, but also during guidance lessons and moral lessons, the young women pointed out.

According to the young women the people who had informed them about AIDS had been of all kinds, all ages from adults to younger people/peers. But they said that they preferred to have adult inform them about AIDS: they thought adults were more trustworthy.

The young women told us the information they had received had been mainly oral: they had not been given any written information. However, they also said that in some of their schoolbooks they can read about AIDS and that there are posters all over. They preferred someone to talk to them about AIDS instead of reading about it in a magazine. They thought that sitting and talking about it has the best effect on them. They talk about AIDS especially in school because sometimes they believe that it can be a sensitive subject to talk with their parents about. One young woman said:

…most of the time our parents are dedicated to our culture and it is considered taboo to talk about these kinds of things, so it is very rare to find a parent who can talk to a child about this topic. Most of the time, in the rural areas you find that most people do not know about this disease: some just like to ignore it. They do not want to know about it and some do not know it at all, they do not know about the disease, they do not know anything and when you talk to them about it is something new to them. They do not know what you are talking about even though you try to explain.

They thought that the information that they have got about AIDS has affected them positively. But one young woman said that she does not think that the information had affected her.

The young women thought that the AIDS issue is very open in Gaborone; at least students are very open about this topic.

It is not only the teachers that tell them about AIDS. They also sit and discussing it among their friends. They said that they can sit and discuss AIDS without the teachers during lunchtime.

All the young women thought it was very good to learn about AIDS in school. They believed that school is the best place to talk about it and get information about AIDS because there are so many people from different places. They also felt that they can share information with each other in school.

The young women believed that most of the time the information that they get is targeted them as young people. They said that there is very little which is merely general and that most of the time AIDS information is directed to them as young children.

They had all seen the magazine Choose Life. They thought it had a very positive effect because the publisher is trying to be realistic, and that this helped young people to get to know about the whole AIDS epidemic. They thought the magazine helps and does not think it produces any negative effect. They believe that their parents think it has a very negative effect, that there are more negative points than positive, but they themselves thought it is very positive and that the magazine is just trying to tell the young about AIDS. However, although they thought it is a very good magazine, they did not think
they had learned a lot from it. They believed they knew most of what it contained already.

One young woman said that you have to realise how important it is to talk about AIDS, it is good to talk about it. They others agreed but one young woman said:

…it is good to talk about it with our parents, you know Batswana parents they are very sensitive when it comes to things like this. Like take me for example. Whenever I talk to my mother about it she is so uncomfortable talking about it. She does not, she just tells me “Those things, keep them to you. Do not talk about it”. It is like if I talk about it, it does something to her which she does not like. Most of the times if I try to talk about like sex she does not want me to talk about it. Sometimes she says you are too young, yet I tell her even us as young people we have to know about these things, we really need to know about them, you should not keep it a secret. Because at our age I think it is time to know about AIDS, sexually transmitted diseases and also sex in general. But she is very uncomfortable talking about it and I know other parents they do feel uncomfortable when their children want to talk about it. It is very rare to find that parents talk about it. Very few parents do talk about it.

One young woman said that her father had told her about AIDS, but he worked at the AIDS/STD Unit so she got to know about it at an early age. She said that they usually come together as a family and talk about these things. She said that it affects us even though it does not infect us. She also thought that AIDS was the most important thing to talk to your children about, otherwise you are not a responsible parent. Another young woman said that she got her aunt to talk to her about AIDS, because her aunt worked at the Ministry of Health. So when her aunt came back from some conference she said she told her what she had learnt there.

On the question whether all the information they got and all they had leant would cause them to do something, to use a condom, they laughed and said “of course”.

7.2.5.3 The Primary School

Interview with four girls, 13 years old

The teachers here also picked out the girls we interviewed. The interview was conducted in the teacher’s room and two teachers accompanied us during the entire interview.

When we asked the four girls what they knew about AIDS, they said that it is a killer disease. All four used the words “killer disease” and repeated them frequently. They also told us that they knew there was no cure and that many people are losing their lives because of it. Therefore you must protect yourself to avoid getting it.

They said that the teachers at their school talk about it all the time, mostly during science lessons. After getting knowledge about sexually transmitted diseases from their teacher they talk about AIDS among themselves. Even during other subjects in school they talk about AIDS. They also felt that they could ask the teachers anything, and if the teacher knows the answer they will give it. They not only talked about it but also read about AIDS in their books and they have many pamphlets about AIDS in their classrooms. These pamphlets are not only for school, but are free to take home, if the pupils want to. Another source of information about AIDS is videos. They could not watch videos in school, so they sometimes went to the family centre to watch them. The videos have been about people affected with AIDS and how they lived.
The girls said that they all felt that they can talk to their parents about AIDS. One said that she could talk very openly to her mother about AIDS: her mother gave her advice on what to do and what not to do. They also talk to their friends about the disease and believed that it is easier to talk to their friends than to their parents: they felt that they can be more open. They also shared information about AIDS with their friends. Sometimes it was easier to talk to their friends, especially when they could not talk to their parents.

On the question of where they first heard about AIDS they answered somewhat differently. One girl had heard about AIDS for the first time from the teachers in school, another heard it on the television and one heard it from her mother.

The girls said that the information that is given to them is mostly in English. The teachers try to speak Setswana for those who do not understand English. The girls also said that in the classroom there are pamphlets in both English and Setswana.

The girls said they best like it when their teacher tells them about HIV/AIDS, and when they can ask questions. According to the girls they talk about AIDS in school sometimes, but not on a regular basis. Some of the students are members of the AIDS club that they have in the school and there, of course, they talk about it all the time. The AIDS club is voluntary, but they said that it is very popular to be in the AIDS club. A teacher is the leader of the club. She provides the club with some books and pamphlets.

They had all seen Choose Life. They thought the magazine is horrible and frightening but they thought it could be good for those who cannot talk to adults; at least there they can read about the disease. The girls got the magazine from friends, not from the teacher. They also told us that they can bring books to school and present them to their classes, after which everyone can read them.
8 Analysis

In the following analysis we first of all compare our research with the theories of Jarlbro and Todd described above. First we compare the work of the different organisations with the model of communication to see how this can be interpreted. After that we look at the interviews with the users and try to see them through Todd’s theory of information utilisation. We also, where appropriate, compare the results of our interviews with the previous literature we have read. We have described the work of the organisations and now analyse it in detail and compare them, because the thesis may be used in Botswana. At the end we present a table to help the reader.

8.1 Transmitter, message, media and receivers

8.1.1 The Church

We carried out three interviews with representatives of church organisations—BOCAIP (the representatives for MCC and the Keletso Counselling Centre) and a representative for the Methodist Church.

Transmitter: The transmitters that BOCAIP uses were the counsellors at the centre. All the personnel had to go through a programme of training.

The transmitter of AIDS information in the Methodist Church was the reverend, and sometimes the church had peer counselling. Jarlbro indicates that sometimes the best transmitter could be a peer. Then both the transmitter and the receiver are on the same level; they understand each other much better (Jarlbro 1999, pp. 67f).

Message: BOCAIP was a transmitter with a Christian perspective on AIDS and how to try to prevent it. BOCAIP encouraged abstinence to prevent AIDS, but did not encourage condom use.

The reverend also had a Christian perspective on AIDS and wanted to send the message that abstinence was important, but he also believed that there had to be an alternative to abstinence, and that was to promote condom use. He also pointed out that only a small number of the churches in Botswana thought as he did.

Media: BOCAIP transmitted mostly oral information as they felt that they did not have the resources to hand out written material, although people often wanted to have some information to take home. BOCAIP had videos that they showed when they visited schools, and pictures. They had information in both English and Setswana. Jarlbro writes that it is very important to repeat the messages; the representative at the Keletso Counselling Centre also thought so and said that this was why they visited schools on a regular basis (ibid., p. 21). The representative also said that it was necessary to vary the media so as not to lose the receivers’ interest. This is also discussed in Aids i Afrika: Mai Palmberg
writes that the chance to get people to change their behaviour is much greater if the message comes from different directions (Palmberg 1993, p. 10). Jarlbro also says that interpersonal communication is better than mass communication (Jarlbro 1999, p. 28). BOCAIP made use of both. They also had specially designed information for when they visit schools—information that was especially developed for that target group.

The medium the reverend used to spread the message about HIV/AIDS in his congregation was the spoken word, in the church. We did not find out if the church had any written information to offer the people.

**Receivers:** BOCAIP’s receivers were mostly schools but they also visited places of work. They had different media depending upon the target group. This was something that Jarlbro pointed out as important (ibid., p. 91).

The Methodist Church receivers were the people of the congregation.

Lukenbill in his book *AIDS and HIV Programs and Services for Libraries* says that one problem with the Catholic Church is that it does not encourage people to use condoms, and people often listen to the church (Lukenbill 1994, p. 63). The Methodist Church took a daring stand against AIDS, which other churches needed to emulate. As the representative at MCC said, the Batswana are very Christian people, and it is therefore even more important for the church to make an effort and help people, because they listen to what it says. It is a very important authority and has the power to make people change their behaviour. Jarlbro says that it is important to make use of the authorities in the society (Jarlbro 1999, p. 21). If the church, then, does not want to spread the message about AIDS this is very destructive, as people may listen more to the church than to other informers. The representative at the Keletso Counselling Centre even felt it was very difficult to only promote abstinence. Was it not better then to encourage abstinence but also offer condoms as an alternative?

### 8.1.2 International organisations

We talked to three different international organisations—BOTUSA, DFID and UNAIDS. They use three different ways of spreading information about AIDS. UNAIDS is a special organisation and does not fit Jarlbro’s model. We therefore analyse the results of the interviews with UNAIDS after BOTUSA and DFID.

BOTUSA has several different projects, but we have chosen only to look at Tebelopele, which is their biggest project. DFID’s largest project is the magazine *Choose Life*. They both collaborate with local Batswana organisations.

**Transmitter:** The main publisher of the magazine *Choose Life* is DFID, but it started the magazine together with churches, schools, teachers, youth groups, parents, NGOs and others. It was originally a magazine from South Africa, which was adapted for Botswana. Jarlbro says that it is important that the transmitter and the receiver are in the same “sociocultural room” (ibid., p. 15). DFID had avoided this problem by creating a magazine especially for Botswana. Birkoff and Körner also say that large social and cultural differences between the transmitter and the receivers of
information make it difficult to find effective ways of getting information out (Birkoff and Körner 1994, pp. 18f).

The transmitters of the Tebelopele project were different. On the one hand counsellors were the direct transmitters, while on the other hand PSI did the marketing and spread information about Tebelopele to the people. According to Jarlbro it is good to use authorities to get a message out (Jarlbro 1999, p. 21). BOTUSA made use of this in inviting the Minister of Health to open one of its centres and then be tested, from which it received a very good response. Palmberg also states that the chance of reaching people improves if the person who sends the message is someone people look up to (Palmberg 1993, pp. 10f). Jarlbro writes that political will has to be present in order to solve the problem of HIV/AIDS (Jarlbro 1999, p. 9). We think this shows the importance of people in power also acknowledging the AIDS epidemic, showing that they also are at risk and setting a good example by being tested themselves. They show that everybody needs to do his or her part. This was what the Minister of Health was doing in Botswana.

**Message:**
With the Tebelopele project BOTUSA wanted to convince people to go and be tested and get to know their HIV status. In connection with the testing it offered counselling: the representative of BOTUSA believed that the information now had to provided be on an individual basis since the mass media did not seem to work. This is similar to what Palmberg writes in *Aids i Afrika*—that personal communication is better and more effective that mass communication when it comes to giving people information about behavioural change (Palmberg 1993, p. 94).

DFID wanted to enlighten people about AIDS, what it was, how you can protect yourself and so on. Krantz says that people need knowledge to be able to make well-founded decisions about their sexual activity. People need information like how AIDS is transmitted, how to protect oneself etc. (Krantz 1994, p. 7). This was something DFID was working for.

**Media:**
To encourage people to visit its centres, BOTUSA used different media to get its messages out, mostly posters and advertising in newspapers. Jarlbro thinks this is the best way to get messages out (Jarlbro 1999, p. 21).

DFID got its message out through *Choose Life*. Birkoff and Körner write in their book that the messages need to be presented in an attractive form, so that the receiver can take them in (Birkoff and Körner 1994, p. 17). DFID tries to work in this way.

**receivers:**
The receivers BOTUSA wanted to reach with Tebelopele were all Batswana.

The receivers DFID had in mind when starting *Choose Life* were 12- to 18-year-old Batswana boys and young women. We think it is very important that *Choose Life* has a specific target group. None of the other organisations we interviewed had such a specific target group. The
advantage of this is that the information is adapted and designed especially for that group’s needs and wishes. This will give them a better chance of influencing the receivers of the information and making a difference, because the receivers may feel that the information is produced especially for them; they recognise themselves in the message. If DFID had not remade the South African magazine this could possibly have resulted in what Jarlbro calls a negative transmitter. The young people would probably not have bothered to read it as it did not show any regard for them, but was rather designed for young people in South Africa (Jarlbro 1999, pp. 67f).

UNAIDS mobilised resources and supported national AIDS programmes. It had a special programme for young people. The message UNAIDS promoted was to make safe sex a norm in Botswana society. Several authors have written about this in the literature, e.g., Krantz, who writes that the knowledge about AIDS can be there, but the problem lies in how it is interpreted in the sociocultural norms of the country (Krantz 1994, p. 25). The representative at UNAIDS said that if everybody did something it then became natural. It did not help to only change people; the whole society must change. However, she also talked about the difficulty of changing people’s behaviour. She also mentioned the problem of getting condoms: one could not just go and buy them off the shelf: they must be requested, she said.

UNAIDS did not work with spreading information, but gave grants of resources and money to the national AIDS programmes carrying out the work. It is therefore difficult to analyse and discuss its work in relation to Jarlbro. However, we agree with the representative at UNAIDS that it is important to make safe sex a norm.

8.1.3 National organisation

We interviewed two national organisations, Reetsanang and the National Library and its headquarters.

Transmitter: Reetsanang made use of what Jarlbro calls community interventions: it worked through the society, which knew the inhabitants, what they needed and which AIDS interventions could make an impact in their society. Reetsanang even went so far as to involve members of the community in AIDS education: they decided what problems they wanted to address and passed this on to the rest of the community. By doing this, the receivers themselves were involved in the whole process: the information was not forced on them. The receivers could themselves decide what they needed to know more about and what was important to pass on to others. In Preventing and Mitigating AIDS in Sub-Saharan Africa the editors write that interventions against AIDS must be culturally correct and locally relevant (Cohen and Trussell 1996, p. 9).

The transmitters of information presented at the libraries were different organisations that placed brochures and pamphlets there. The library staff were also transmitters of some information.
Both Reetsanang and the libraries encouraged abstinence and condom use. They recommended that people learn to take care of themselves.

Reetsanang made use of drama to make people aware and make them learn more about AIDS. In *Aids i Afrika* Palmberg says that drama is an especially good way of informing people about AIDS because it involves a large audience and has local connections (Palmberg 1993, p. 198). On the whole Reetsanang’s way of working agreed with what we have read in the literature about drama and AIDS. We think that drama is a very good way of educating people about AIDS, especially because of the local connection, which people can relate to, and the fact that the drama group is run by Batswana. It is not a foreign organisation. In the drama people can relate to the everyday life they know and learn how they can deal with that. Continuing the work is something that Jarlbro points out as important (Jarlbro 1999, p. 21). Reetsanang tries to do this by forming a local drama workshop. If this works we would consider it a wonderful idea, which avoids losing what has been accomplished. Birkoff and Körner also think that big social and cultural differences can be a problem for the communication about AIDS (Birkoff and Körner 1994, pp. 18f).

The libraries in Botswana try to get the message about AIDS out to the public through books, posters and videos. When we visited the library we noticed many posters and pamphlets but we did not see many books about AIDS. When we visited the library to watch the video we felt that people were merely annoyed at being forced to watch a video. We think this can be what Jarlbro calls a negative transmitter—that you get the wrong effect when you use a wrong transmitter (Jarlbro 1999, pp. 67f). If a person does not want to listen, they may be given the wrong impression about AIDS information, that it is something that is being forced on to them and that they then do not want anything to do with it. In this case they do not listen to the message. The video also used scare tactics. The pictures were very horrible. Jarlbro says that if scaremongering is being used then you also have to enlighten people about how to avoid the problem, but she also says that too much can lead to denial (ibid., p. 81). We also think there can be a risk with the video shown at the library because there was no discussion afterwards.

The receivers that Reetsanang aimed to reach out to were women in particular but also young people as a whole. We think it is more difficult for Reetsanang to have a specific target group, because all the members of the community are in the audience.

The information the library provided was mostly of a general nature and not very concentrated on any special group in the society. This was so even though the librarian at the Botswana National Library Services said it was mostly young people who visited the library.
8.1.4 Youth organisations

The two youth organisations we visited were PACT and PSI. They were run by young people and concentrated on young people in the whole of Botswana. PSI had three projects, Tebelopele, Choose Life and Lovers Plus. As we have discussed Tebelopele and Choose Life already we look only at Lovers Plus here.

Transmitter: In PACT it was the young people working for PACT who were the transmitters of the information.

The transmitters in PSI were the personnel who worked there, who were all young people.

Message: PACT’s message was that young people should try to abstain until they get married but if that is not possible to abstain they should use condoms. Krantz writes that people have to have a rationale for their actions and with AIDS that it is a rational action to use a condom, although this can be difficult (Krantz 1994, p. 7).

The message of Lovers Plus was “use a condom”.

Media: The medium PACT uses was mostly oral communication but they also distributed pamphlets.

PSI made use of many different media. They handed out tee-shirts, had radio programmes, banners and drama, and sold condoms. The personnel at PSI led a radio programme once a week and put up posters around town at different times. The organisation held a competition to entice people to come. They also had programmes at, for example the mall, where they made use of peer education, and workplace education to reach other groups. According to Jarlbro it is good to use different media to carry out an effective health campaign (Jarlbro 1999, p. 21).

Receivers: PACT’s receivers were young people. PSI directed its attention to all age groups, young as well as old.

The personnel at PSI said that Lovers Plus condoms could be bought everywhere, but we could not see them anywhere. We think they condoms must be available to be bought everywhere. There was also the problem of embarrassment while buying condoms. We can compare this with our own experiences here in Sweden. People in Sweden may consider themselves to be very open-minded, and perhaps they ask themselves why people in Botswana do not just go out and buy condoms, but on reflection we know many people who find it somewhat embarrassing to buy them. In Sweden this problem can be avoided as people can buy condoms through a mail order firm. The condoms are then delivered in a parcel which does not show what it contains.

We feel that condoms should be sponsored so that they could be handed out free of charge, and possibly placed in places where people can just take one without anyone seeing them. They should especially be found at clinics, on open display: people should not have to ask for them. In AIDS in Africa Barnett and Blaikie write that one of the
greatest difficulties with buying condoms is poverty, and that their use depends on male cooperation (Barnett and Blaikie 1992, p. 160). They also write that it is hard for women to say no to their partners and that this does not fit the traditional expectations of men, or women, in their relationships (ibid., p. 164).

8.2 Effects, feedback and feed forward

By making an evaluation and by investigating the effects and the results which the organisations see in their work, they get feedback from the receivers. Jarlbro says that evaluation is important (Jarlbro 1999, p. 98). Feedback assists the transmitter in suiting the message to the receiver’s needs. Response and feedback are used to make the transfer of the message more effective. Another way for the organisations to suit the information to the receivers is to do a feed forward. The more the transmitter knows about the receiver, the more he can adapt the message to the receiver.

We have tried to give an account of both the effects of the programmes and the feedback they have generated as we feel that feedback is a result of these effects.

8.2.1 The Church

Effects: The results/effects BOCAIP had seen were that it had noticed a greater interest in HIV/AIDS in the centres. As an evaluation BOCAIP made a quarterly report, which included statistics. Jarlbro thinks it is important that the transmitters evaluate their work to investigate if what they are doing is in accordance to their goals (ibid., p. 98). BOCAIP was the only organisation that we interviewed in our research that made an exhaustive evaluation. This was something we thought more organisations should do to make their work more effective.

The result the reverend had seen was that people in the Methodist Church could talk a little more openly about AIDS.

Feed forward: None of the church organisations that we interviewed made use of feed forward. We think this was not good, as it then was difficult for them to create information that suited the receivers of the information.

8.2.2 International organisations

Effects: DFID thought it was too soon to see any effects of the magazine, but the large number of entry forms it had received implied that people were reading the magazine.

BOTUSA only started slightly over a year ago so did not believe it could see any results yet, but it had seen direct results after using radio advertising when opening a new centre in the north of Botswana.
The result UNAIDS had seen in Botswana was that more AIDS programmes had started. UNAIDS worked very much on getting the different AIDS programmes and authorities in society to collaborate.

**Feed forward:** DFID did quite a lot of research (feed forward) before starting *Choose Life*. Jarlbro emphasises the importance of feed forward, as the information needs to be adapted to the receiver, to the special “sociocultural room” of different groups in the society (ibid., p. 15). Birkoff and Körner also say that it can be difficult to find effective channels to get out information about AIDS because there can be large social and cultural differences between the transmitters and the receivers (Birkoff and Körner 1994, pp. 18f). By using feed forward DFID can avoid this.

### 8.2.3 National organisations

**Effects:** The librarian showed a video at the library once a week and had received positive responses from that—positive in the sense of awakening an interest: people had been shocked and came to talk to her.

Reetsanang did not get any feedback, nor did it do any evaluation of their work, but it felt it had received positive responses from the remote areas and it is often asked to come and hold workshops. The point it tried to make was that the community should continue what Reetsanang initiated. There should be a drama group in the community that continued spreading information about AIDS. Reetsanang made a follow-up visit to see how the work was proceeding.

**Feed forward:** None of the national organisations we interviewed made use of feed forward.

### 8.2.4 Youth organisations

**Effects:** The people at PACT had seen some results, for instance, at Maru-a-pula school, where the number of pregnancies has gone down since PACT started. We think it is very important to do some kind of evaluation, because even if the organisations do hear positive or negative comments from people they still have to do an evaluation themselves. It is crucial for continuing their work that the transmitter knows what kind of information the receivers want and what kind of information affects the receivers. There is no point in informing people if they do not like the information. The feedback from an old information campaign is a sort of feed forward for future campaigns!

The feedback PSI got was that it could see that Lovers Plus had become a very popular brand.

**Feed forward:** PACT made use of feed forward and called it community diagnosis. PACT then looked at where they should take measures and what type of
measures. We think it is very important to find out what knowledge the receivers already have and what they want to know more about before informing people. It is important to build on the receivers’ already existing knowledge. Todd writes about how different steps or effects in the information can work a change in the receiver. It is the organisations’ job to give the receivers different information in order to gain a deeper understanding and see things more clearly. In the literature we have read a good deal about this. Krantz says that people need knowledge about AIDS if they are to be able to change their behaviour (Krantz 1994, p. 7).

PSI had not used any feed forward.

8.3 Tables

We have described and analysed the work of the organisations in the form of tables, a sort of key map.

8.3.1 Table 1 The communication process

<table>
<thead>
<tr>
<th>Church</th>
<th>Transmitter</th>
<th>Message</th>
<th>Media</th>
<th>Receiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOCAIP and Keletso</td>
<td>Counsellors</td>
<td>Christian perspective. Abstinence, not condoms</td>
<td>Mostly oral information, some videos and pictures</td>
<td>Mostly schools, also workplaces</td>
</tr>
<tr>
<td>Methodist Church</td>
<td>Reverend, peers</td>
<td>Christian perspective. Abstinence, but condoms as an alternative</td>
<td>Oral information</td>
<td>The people of the congregation</td>
</tr>
</tbody>
</table>

**International organisations**

<table>
<thead>
<tr>
<th>UNAIDS</th>
<th>The national AIDS programs</th>
<th>To make safer sex a norm in the Botswana society</th>
<th>They gave money to the national AIDS programs</th>
<th>All Batswana</th>
</tr>
</thead>
<tbody>
<tr>
<td>The BOTUSA Project</td>
<td>Tebelopele</td>
<td>Offer testing and counselling - know your status. Safe sex</td>
<td>Mostly posters and advertising in newspapers</td>
<td>All Batswana</td>
</tr>
<tr>
<td>DFID</td>
<td>The magazine Choose Life</td>
<td>Enlighten people about AIDS. Safe sex</td>
<td>Magazine</td>
<td>12-18 years old Batswana</td>
</tr>
</tbody>
</table>

**National organisations**

<table>
<thead>
<tr>
<th>Reetsanang</th>
<th>The community members</th>
<th>Abstinence and condom use</th>
<th>Drama</th>
<th>Young people, especially women</th>
</tr>
</thead>
<tbody>
<tr>
<td>The libraries</td>
<td>The personnel at the libraries</td>
<td>Abstinence and condom use</td>
<td>Books, posters and videos</td>
<td>All Batswana</td>
</tr>
<tr>
<td>Youth organisations</td>
<td>Transmitter</td>
<td>Message</td>
<td>Media</td>
<td>Receiver</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------</td>
<td>---------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td>PACT</td>
<td>The youth working for PACT</td>
<td>Try to abstain, otherwise condom</td>
<td>Oral information and pamphlets</td>
<td>Youth</td>
</tr>
<tr>
<td>PSI</td>
<td>The personnel at PSI, mostly young people</td>
<td>&quot;Use condoms&quot;</td>
<td>T-shirts, radio programs, drama, posters, offering condoms etc.</td>
<td>All Batswana</td>
</tr>
</tbody>
</table>

8.3.2 Table 2 Effects and feed forward

<table>
<thead>
<tr>
<th>Church</th>
<th>Effects</th>
<th>Feed forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOCAIP and Keletso</td>
<td>Greater interest on HIV/AIDS in the centres</td>
<td>No feed forward</td>
</tr>
<tr>
<td>Methodist Church</td>
<td>People in the church now talk a little more openly about AIDS</td>
<td>No feed forward</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>International organisations</th>
<th>Effects</th>
<th>Feed forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNAIDS</td>
<td>More AIDS programs had started in Botswana.</td>
<td>No feed forward</td>
</tr>
<tr>
<td>The BOTUSA Project</td>
<td>To soon to see any results</td>
<td>No feed forward</td>
</tr>
<tr>
<td>DFID</td>
<td>To soon to see any results</td>
<td>Research among 12-18 years old before they printed the magazine.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National organisations</th>
<th>Effects</th>
<th>Feed forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reetsanang</td>
<td>No responses, but good responses from the remote areas.</td>
<td>No feed forward</td>
</tr>
<tr>
<td>The libraries</td>
<td>Positive responses from the videostapes.</td>
<td>No feed forward</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Youth organisations</th>
<th>Effects</th>
<th>Feed forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>PACT</td>
<td>Pregnancies had gone down e.g. at Maru-a-pula</td>
<td>Community diagnosis</td>
</tr>
<tr>
<td>PSI</td>
<td>The Lovers Plus condom had become a very popular brand</td>
<td>No feed forward</td>
</tr>
</tbody>
</table>
8.3.3 Table 3 Different messages about sex

To show how the organisations and their messages about sex relate to one another, we have ranged the organisations on a spectrum according to the different messages they advocate, those who advocate abstinence at the left end and those who advocate condom use at the right end.

8.4 Users

In this section we try to compare Ross Todd’s theory with our interviews with the young women at the Junior Secondary School and the Primary School, the interview with Ann and the observation at the AIDS club. We try to analyse the young women’s knowledge of AIDS in relation to Ross Todd’s study.

The four young women at the Junior Secondary School seemed to have a rather good picture of AIDS. At least they seemed to be very sure about their knowledge and we understood this to mean they knew a lot. If we match this with the five types of effect that Todd could see from his interviews we would place them at the stage that Todd called “getting a clearer picture” (Todd 1999, p. 11). We gained this impression from our observations during the interview as the young women looked only at us during the interview, although their teacher sat there. They seemed to be very relaxed when they talked to us and did not seem to be especially shy.

The four girls at the Primary School seemed to know about AIDS but not as much as the young women at the Junior Secondary School. They repeated the same verbal expression several times and they often looked at the teachers, perhaps to get support or to see that they were giving us the “right answers”. We would therefore like to place them in Todd’s first stage, which is “getting a complete picture” (ibid., p. 11). We think they needed a lot of new knowledge to be able to stand on their own feet and think for themselves. Their answers sounded monotonous, as though they only were repeating what their teachers had told them, without thinking of what they were saying. We believe that they did not understand the information that they had been given. Of course they were young and would be learning considerably more in the years ahead, but they have to have a good foundation to stand on; they must get the right knowledge even though they are young. We did not think they were too young to really get to know what AIDS is, how it is spread and so on. They did not seem to have been given any sex instruction or the correct information about how AIDS is being spread.

When we visited the Primary School, especially when their AIDS club had a meeting, we noticed that the pupils did not have the correct information. After hearing their questions at the meeting, the answers they gave one another and the answers the teacher gave we did not think that they were given the correct information on how AIDS is
being spread. Even if we observed just the one meeting and did not interview any of the pupils, we would place them in the first group in Todd’s study (ibid., p. 11). The pupils had some knowledge, but not enough to create new knowledge; Todd explains that you have to have a certain amount of basic knowledge to be able to create new knowledge while still remembering the old knowledge. As we said above, the pupils did not seem to have the correct knowledge and seemed only to repeat phrases that they had learnt from their teacher; they did not really understand the knowledge that they were repeating. Krantz says in her book that people need knowledge about AIDS to be able to change their behaviour (Krantz 1994, p. 7). By her estimation it would be a real problem that the children did not seem to have more knowledge about AIDS.

When interviewing Ann we felt that she knew a good deal about AIDS—much more than we did. We would like to place her in the type “getting a position in a picture” (Todd 1999, p. 11). As Todd describes this type, she has formed her own opinion and has made a stand. She had such a strong opinion that she decided to join a youth organisation that works to educate other young people about AIDS (PACT).

Todd talks about the use of different media, and the girls he interviewed liked visual media (ibid., p. 21). He also said that the information and the form in which it is presented must be approved of by the receivers: it does not matter what the transmitter imagines to be the best method (ibid., p. 22). Birkoff and Körner also say that problems can arise if there are cultural and social differences between the transmitter and the receiver (Birkoff and Körner 1994, pp. 18f). We asked the young women we interviewed in what form they wanted the information to be presented. Best of all they liked a transmitter who was an adult. This was just the opposite of the girls in Todd’s study, who liked visual media best. The young women at both the Junior Secondary School and the Primary School thought that it was best when their teachers informed them about AIDS and when they could ask questions. Todd mentions in his study that dialogue is a new and positive way of educating people about AIDS (ibid., p. 22). Lukenbill also writes that oral information is good in that people can ask questions and create a dialogue (Lukenbill 1994, p. 48). All the young women interviewed liked sitting and talking about AIDS best—having a small discussion.

Ann thought it is especially valuable to be able to educate people about AIDS in school. We think that one reason why it is good to talk about AIDS in school is that it is neutral ground, away from the family. But the situation depends very much on the teacher, on whether or not the pupils feel that they can talk openly about AIDS. According to Palmberg it is beneficial if the information comes from someone people esteem (Palmberg 1993, pp. 10f). The young women at the Junior Secondary School and the Primary School also thought that one of the best places to get to know about AIDS was in school. Todd says that it is important that the teachers have the knowledge (in our case about HIV/AIDS) and that they know how the pupils receive the information (ibid., p. 22). After the interview at the Primary School the teacher asked us if we knew where she could learn more about HIV/AIDS and how she should teach the subject. She did not think she knew enough.

Some of the young women interviewed said that they could talk about AIDS at home with their parents, and that they first heard about the disease from their parents. Some of them could not talk to their parents, but to some other relative, such as an aunt. One young woman said that her mother absolutely could not talk about AIDS. This was
something many people have told us. It was often very difficult to talk about AIDS between parent and child.

Ann thought it was very important that people such as the president talked about AIDS because she was convinced that young people listen to authorities. Jarlbro also thinks this is important in an effective health campaign (Jarlbro 1999, p. 21).

We asked the young women what they thought about Choose Life. Since we had met the originator of the magazine, and had heard what they had been thinking while making it and how they thought it was received, we thought it would be interesting to hear what the young women thought of it. The four young women at the Junior Secondary School liked the magazine and they thought it had a positive effect, but some of their teachers thought it had a negative effect on their pupils. However, the young women did not think they had learnt anything from the magazine; they knew everything already. Ann also liked it. She thought it was a good magazine as it has a local connection and that it showed young people from Botswana in it. The four girls at the Primary School, on the other hand, did not like the magazine at all—they thought it was frightening and horrible—but they thought it could be worthwhile for those who cannot talk to adults about AIDS. According to Birkoff and Körner it is important that the message is presented in an attractive form, so that the receiver can take it in (Birkoff and Körner 1994, p. 17).
9 Discussion

In this chapter we discuss what we found out in the analysis of the interviews, both with the organisations and with the receivers of information about AIDS. We discuss the differences we found between how the organisations work and how the young women experience the information they have received about AIDS. To do this we use some of the steps in Jarlbro’s model, namely: transmitter, message, media, receivers’ effects, feedback and feed forward. We do this to show more clearly what both the transmitters and the receivers think about the information.

9.1 Transmitter

Who the transmitters were differed some between the organisations, for example, BOCAIP used their counsellors, the transmitters of Reetsanang’s messages were the members of the community and PACT had peer counselling. Something that we found when we analysed our material was that several of the organisations thought that young people preferred other young people as transmitters, that they paid more attention to their peers and gained more knowledge from the information given them by their peers. Jarlbro also writes about this: she says that using adult transmitters can cause a problem (Jarlbro 1999, pp. 67f). This does not fit in with what the young women in our research told us. The receivers we talked to considered it best for the transmitter be an adult because they placed more trust in adults. Birkoff and Körner say in AIDS Education Through Drama that the transmitter of the message must be someone accepted to be dependable (Birkoff and Körner 1994, p. 19). Palmberg writes that the transmitter of the information should be a person that people admire (Palmberg 1993, pp. 10f).

Jarlbro and the transmitters thus have different ideas from the young receivers we talked to about who should inform young people about AIDS; it is important that the transmitter is a trustworthy person that people can look up to. We think this shows the importance of doing evaluation or feed forward. We believe that more work is required of an organisation when it comes to investigating who the transmitter of the information should be. We have only talked to a few receivers and we believe that the peer approach can sometimes be the best way of informing young people, but this should be investigated before the communication starts, so that the organisations get the right transmitter for the target group/receivers.

9.2 Message

The messages the organisations used when spreading information about AIDS varied between the organisations. They even differed within the different types of organisations. BOCAIP, for instance, only recommended abstinence, while the reverend thought that if people could not abstain, condom use was an alternative. Others, like Lovers Plus, only gave information about condoms. Most of the organisations recommended both abstinence and condom use. Of course the best and safest way to avoid AIDS was abstinence, but if that was not possible there had to be an alternative. Otherwise young people would ignore the risk and not even bother to use condoms. We felt that this was something BOCAIP should think about. We believe it can be difficult
for the receivers if the different organisations informing them about HIV/AIDS have different messages. According to Krantz people need information on how HIV is transmitted, how to protect oneself etc. (Krantz 1994, p. 7). We believe that if people get this knowledge they can make their own decisions about using condoms or abstaining from sex.

One very important question is how the information should be adapted to the target groups it aims to reach. Jarlbro writes how important this is (Jarlbro 1999, p. 83). But almost all the information we came across was of general nature. This could cause a problem, a negative force in the process of educating people. Different groups of receivers have different information needs because their lifestyles are not the same. There is a big difference between a grown man and a young girl. We do not believe that they can be given the same information regarding AIDS and how to protect themselves. In the book *Preventing and Mitigating in Sub-Saharan Africa*, the editors write that interventions must be culturally correct and relevant locally (Cohen and Trussell 1996, p. 9). This shows that it is important to create information that suits the different groups in the society.

9.3 Media

There were many different approaches to the question which media should be used to spread information. Many organisations made use of oral information which could lead to discussions about HIV/AIDS in, for instance, the workplace and schools. This is what Lukenbill writes about in *AIDS and HIV Programs and Services for Libraries*. Lukenbill says that oral information is useful, because people can discuss the subject and they have a dialogue with the transmitters of the information (Lukenbill 1994, p. 48). Some of the organisations we interviewed did not think they had enough money to hand out written information. That was a problem because it was important for people to be able to take information home with them and read it, think about it, and discuss it with friends and family.

We have read a good many positive comments about theatre as one way of informing people about AIDS. According to Palmberg, theatre is a good way to get information out: African theatre is built on body language dance and music. People who can neither read nor write can still take in the message (Palmberg 1993, p. 198). Only one of the organisations that we visited—Reetsanang—used theatre, and they were burdened with financial problems. Because of this, unfortunately, we could not go with them and observe how they worked. However, of the young women we interviewed only Ann thought that theatre was one of the best ways of informing people about AIDS. The other young women did not even mention theatre. We believe that the way Reetsanang works in the towns and villages, involving all the people, is a very effective method of informing people about AIDS. The whole community attends the theatre and learns as a group what needs to be done. Marja Wolpher writes that the members of the theatre groups often are chosen locally; they know what local events and traditions are important to the people in the audience (Wolpher 1999, p. 5).

Many of the organisations explained their interpretation of what young people consider to be the best way of getting information, but this did not agree with what the young women told us. Some of the representatives of the organisations said that young people liked visual media and preferred an environment in which something was happening.
However, the young women said that oral information was the best method and they
liked to sit and discuss what they had learned. Most thought that receiving information
in the school was best. According to Palmberg there is an organisation in Zambia,
among schoolboys and girls, an Anti-AIDS club. As members of the organisation, the
young people promised to abstain from sex until they got married and to fight
discrimination against those already infected and sick from AIDS (Palmberg 1993, p.
91). The AIDS club we visited in Botswana could be one type of anti-AIDS clubs.

One problem we encountered was that the teachers did not have enough knowledge
about AIDS, as one of them told us; they wanted to know more when teaching about it.
We noticed that the young women were not given correct information, which is a
problem that must be addressed. In order for the teacher to teach they must possess
knowledge about the disease. We believe that teachers, and the school, are one of the
best “media” for informing young people about AIDS. Todd writes in his study that
teachers can design better information if they understand how changes happen in
relation to the stream of information that is provided to young people (Todd 1999, p.
22).

### 9.4 Receivers

During the analysis we have observed that some, actually most, of the organisations do
not have any clearly defined target group. It is only DFID that definitely says that their
principal target group for Choose Life is young people in Botswana aged between 12
and 18. The youth organisation PACT addresses its work to “young people” vaguely
defined; other organisations do not have any designated target groups. However, Jarlbro
says that it is important to have a specific target group to create information that suits
that group (Jarlbro 1999, p. 61). We also think that this is important, although we
understand that it can be difficult for BOTUSA, for example, to create information
about Tebelopele that suits the entire population. According to Birkoff and Körner it is
essential that messages be presented in an attractive form in order for the receivers to
take them in (Birkoff and Körner 1994, p. 17).

### 9.5 Effects and feedback

Some of the organisations considered that it was too early for them to observe any
results of their work, because it was only recently begun. The only organisation that did
a close evaluation of its work was BOCAIP. According to Jarlbro it is essential for
organisations to do continuous evaluations (Jarlbro 1999, p. 98). Our opinion is that
more of the organisations should do evaluations in order to assess the effects of their
work, so as to improve their information even more. Evaluations can be both time-
consuming and resource-consuming, but we consider them to be necessary. There is no
point in giving information to people if it is designed in a way that means the people
cannot take it in.

The librarian at the Botswana National Library Services told us that they got feedback
from some of the people who have watched the video in the library. They wanted to
discuss the movie. Even the youth organisation Lovers Plus got feedback, as their
Lovers Plus condom had become a very popular product. This was one kind of feed-
back. But we think that especially the library should do a more thorough evaluation to discover what it could improve. These types of feedback were not organised, they just happen.

When it came to the young women, their knowledge about AIDS differed somewhat from one to another, and so did the effect that the information had had on them. We could not, on the basis of our research alone, say that the information had produced any effects on the young women, but we did observe some differences between them when guided by the Ross Todd’s research. One effect that came out strongly at one of the schools we visited was that the young women looked to their teacher whenever they answered our questions, and that they often repeated pat phrases. On the other hand Ann had considerable knowledge about AIDS, and this information had affected her so strongly that she was now active in PACT. McElmurry, Norr and Tlou write in their study about AIDS knowledge and awareness among women in Botswana that the women in their study often repeated catch phrases but discussions often revealed a lack of understanding of the full meaning of the phrases (McElmurry, Norr and Tlou 1996, pp. 144f). This is what we observed at the Primary School.

Something that we thought was very interesting was the young women’s reaction to Choose Life. When we interviewed DFID, who publish the magazine, they said that the tone in the magazine was positive. When we asked the girls at the Primary School for their opinion, they answered that they thought it was scary and they did not like it at all. However, the other young women we talked to liked it, even though they believed they already knew all the facts it contained. They did not seem to be overwhelmed by what they saw. It did not have any noticeable effect on them. Nduati and Kiai mention in their book Communicating with Adolescents about AIDS that the media play an important role in increasing awareness about AIDS and that care must be taken in forming that information (Nduati and Kiai, 1997, p. 79). Even if DFID had made use of feed forward, the young women did not think the magazine was especially good.

9.6 Feed forward

DFID carried out a wide-ranging feed forward survey before they started Choose Life because they wanted to know what young people aged 12–18 in Botswana wanted to know about AIDS. Even PACT made use of one sort of feed forward which they called community diagnosis. Palm and Windahl explain the term feed forward in their book Kommunikation – teorin i praktiken: the transmitter establishes knowledge about the receiver before the communication starts. The more the transmitter knows about the receiver, the more he can adapt to the receiver (Palm and Windahl 1989, p. 12). Only DFID and PACT made use of feed forward to gather knowledge about what the target group already knew, what they wanted to know, in what form they wanted the information and so on. We think it is very important that more organisations make use of feed forward in order for the information to be improved and made better suited for the receivers. Otherwise the transmitter of the information can become what Jarlbro calls a negative transmitter (Jarlbro 1999, pp. 67f). This means the organisations have the information but present it in a way this is not suitable for the receiver. This can produce the opposite effect on the receiver from what the transmitter intended.
10 Conclusion

In this section we report on the conclusions we can draw as related to the main question of this paper. We are conscious that we cannot draw any general conclusions, but we intend to explain the conclusions we have discovered in the material. The main question is:

Are the most common ways of spreading information about AIDS which the organisations we investigated in Botswana make use of also those which the young women appreciate most?

Several of the organisations we talked to assumed that young people approved best of receiving information from their peers, but the young women we interviewed preferred to be informed by an adult, for instance, in school by a teacher. The organisations also explained their interpretation of what young people consider the best way of getting information, but this did not agree with what the young women told us.

The messages the organisations presented varied between the organisations and even within the different types of organisations. Some organisations recommended abstinence only while one organisation advocated condom use only. Most of the organisations recommended both abstinence and the use of condoms.

Many different media were used to spread information. Many of the organisations we interviewed made use of oral information, and others used peer teaching, magazines, counselling, drama, posters etc. Several of the organisations used mass communication campaigns. The young women we interviewed preferred oral information, so that they could discuss it. Many of the writers we discussed above pointed out the importance of discussion. This was also shown by the fact that organisations like BOCAIP and Tebelopele made use of counselling in some form.

If you look at which media are being used in relation to the type of organisation that is disseminating information, our results, as is shown in table 8.3.1, are that the organisations which have had a little more money, for example, the international organisations, often spread their messages through written material. The national organisations, such as BOCAIP and Reetsanang, have to make use of oral information because of lack of money. PSI is sponsored from abroad and makes use of both written and oral information, but mostly written material. If we compare this to what the young women preferred, it was not written information but rather oral, personal information. Another advantage with oral information is that it can reach more people, even those who cannot read (the literacy in Botswana is about 70%).

The young women’s knowledge about AIDS varied, but they all knew something. All had heard about AIDS. One major problem which we discovered was that one of the teachers did not think she had enough knowledge about AIDS to educate her pupils, and some of the young women we interviewed had not received correct information from their teacher.
We believe that more organisations have to make use of feed forward and evaluation in their work to suit the receivers’ needs. Only two of the organisations we interviewed made use of feed forward, and only one made a close evaluation of its work.

Thus, in some ways the most common methods of spreading information about AIDS that organisations used were those most appreciated by the receivers; but in other ways the organisations did not know what kind of information the receivers wanted to have. Through the use of feed forward, and by making evaluations of their work, organisations can gain knowledge about the receivers of their information which will enable them to generate better and more effective communication with the receivers. As it is today, most of the organisations do not make use of feed forward. Information has to suit the needs of the receivers.
11 Summary

In the introduction we presented the background to the emergence and preparation of this thesis. AIDS has now passed malaria as the greatest disease-related cause of death in Africa. In Botswana, Namibia and Zimbabwe AIDS or HIV have hit 25% of the population in the age group 15–49. Life expectancy has fallen from 70 to only 40–45 years of age.

As there is no cure for AIDS, information, education and communication are still the only vaccine. We decided that we wanted to investigate how this problem was being handled within the subject information science. This thesis was conducted as a Minor Field Study (sponsored by Sida) in Botswana.

We chose Botswana because it is one of worst-hit countries in Africa, and the world, and also because we managed to get in contact with Mrs Kerstin Jackson who agreed to be our supervisor and help us with our study. On 1 March 2001 we left for Botswana. We spent two and a half months in Botswana, most of the time in Gaborone, the capital, where we conducted our study. The study was based on interviews conducted in Gaborone with different organisations that work to spread information about AIDS. Interviews were also done with receivers of the information, in particular young women.

The purpose of this thesis is to study some of the different ways of spreading information about AIDS that people and organisations in Botswana use and to find out what some of the receivers think about this information. This has been done by means of talking to informants at different organisations, schools and health clinics. To get a picture of the receivers of the information we chose to talk to young women.

Our main question is:

Are the most common ways of spreading information about AIDS which the organisations we investigated in Botswana make use of also those which the young women appreciate most?

To answer our main question we composed several questions, both for the organisations and for the young women:

- Which ways of spreading information about AIDS do organisations use?
- What do the young women know about AIDS?
- In which ways do the young women want to be informed about AIDS?
- In which ways do the organisations think people want to be informed about AIDS?

The method we chose for the study was qualitative interviews and observations. We interviewed representatives from different organisations and young women. The organisations we talked to have been divided into four groups; church organisations, international organisations, national organisations and youth organisations. The young women we interviewed were 13–17 years old. One problem that we encountered was that we could not take part at any of the occasions when information was presented, and because of this we could not observe the work in progress or conduct interviews with the receivers who were present. This was due to different reasons, misunderstandings among others.
To give the readers a picture of Botswana, we have a chapter in the thesis in which we give general facts about Botswana, such as its history, population, economy, social structure and so on. In that chapter we also have a section on AIDS in Botswana. The AIDS situation in Botswana is a little different from that in many other African countries because Botswana has a sound and stable economy, and the leaders are aware of the epidemic. The AIDS epidemic has affected the entire community and large numbers of the population feel the social consequences of this. In this chapter we also have a section about women and AIDS in Botswana. One problem in Botswana is that men dominate relationships and it is acceptable for men to have more than one sexual partner.

We found considerable literature about AIDS and AIDS information and so on, and we have made a selection of the literature that we think is most relevant for this thesis. In the literature we learned that there is a huge need for information and communication about HIV/AIDS, and that the AIDS situation in Africa is different from that in, for instance, Europe. In Africa HIV/AIDS is, in most cases, heterosexually transmitted. One reason why HIV/AIDS is transmitted so rapidly in Africa is the mobility of the population and to male sex roles. The more wives and girlfriends a man has the better status he will gain, while “his” woman is seen as a part of his property. Condoms also need to be available everywhere. But while some people do not have money to buy condoms, another problem is that their use is dependent on male cooperation. A study done in Botswana about AIDS awareness and knowledge among urban women in Botswana shows that women have some knowledge about the infection, but there is a lack of complete understanding and there are some misunderstandings. There are many different ways to get information out to the population, one method is through theatre; another is by distributing brochures, pamphlets, posters etc. Some of the authors of the literature that we have discussed say that interpersonal communication is very valuable, even better than the mass media. Many different organisations work with AIDS information in Africa—the Ministry of Health in Uganda, the churches, NGOs etc.

We decided to base our work on two different theories. The first is one about health communication developed by Gunilla Jarlbro. It explains how organisations working with health campaigns should work, what they should think about and so on. In her book Jarlbro presents a model, a common model, of communication, and describes the different parts of the model; transmitter, message, media, receiver, effect, feed forward and feedback. All these parts have to exist in order to develop effective health communication. The other theory is that of Ross Todd and deals with young women’s information utilisation concerning heroin. Todd gave information about drugs to selected girls three times and after each information opportunity he interviewed the girls and observed how their knowledge had changed. He found five different types of effects of the information. Our thought, when we went to Botswana, was to create a reference group of young women, do perhaps three interviews with them, and then compare our results with Todd’s. In fact it proved too difficult for us to create a reference group. Because of this, we did only one interview each with a select group of young women.

Altogether we conducted 19 interviews and we have chosen to show 14 of these. We did interviews with three church organisations, three international organisations, three national organisations and two youth organisations. We did three interviews with different young women, two of these with groups of four young women. We have chosen not to show all the interviews for different reasons. We concluded that three of
the interviews were not relevant to our subject; the tape with one of the interviews is still in Botswana awaiting translation; and the first interview we accomplished did not produce all the facts we required. In this thesis we also include material that we have heard and experienced in order to show a holistic picture of the Botswana society.

The organisations we talked to were of different types and had different messages to present about AIDS. There were some differences between the organisations in the different groups, and even within the groups. Some of the organisations (two church organisations) encourage abstinence. Others recommend both abstinence and the use of condoms, while one organisation advocates condom use only.

The organisations also made use of different ways of spreading information about HIV/AIDS. One organisation we talked to was a theatre group, others presented mostly oral information, others had both written and oral information, while still others made use of video. Several of the organisations thought that young people preferred to be informed by other young people and that young people preferred visual media.

The young women we talked to had different levels of knowledge about AIDS. One of them had a very high level of knowledge and was active in a youth organisation that worked with AIDS information. The young women at the schools seemed to have less knowledge and they repeated several pat phrases repeatedly. Most of the young women preferred to have an adult talk with them about AIDS, but they also liked to talk about it with their friends. Some of the young women preferred oral information and being able to discuss HIV/AIDS, but one young woman thought theatre was a good way to inform young people about the disease.

The conclusions we have drawn are that in some ways the most common methods of spreading information about AIDS that the organisations we investigated use are the ones most appreciated by the receivers; but in some ways the organisations do not know what kinds of information the receivers wish to have. For example, the young women preferred an adult as transmitter of the information, but the organisations thought that young people preferred peers to be the transmitters. We think that through the use of “feed forward” and by doing evaluations of their work the organisations can gather knowledge about the receivers, and in that way institute a better and more effective communication with them.
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The Junior Secondary School
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BOCAIP – Botswana Christian AIDS Intervention Programme

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UNAIDS

2001-03-27
Keletso Counselling Centre

2001-03-28
The Primary School
Interview with four young women 13 years old

2001-03-29
PACT - Peer Education to Counselling Teenagers

2001-03-29
Interview with a 17 years old girl

2001-04-02
Botswana National Library Services

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Interview with AIDS coordinator at National Library headquarters

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2001-04-04
The AIDS club at the Primary School
12.2 Observations

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### 12.4 Web resources

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13 Appendixes

13.1 Interview manuals

13.1.1 Questionnaire for transmitters

Is there a problem in openly discussing issues such as sex and AIDS in Botswana?

How do you conduct your work?

In which form is the information presented?

What strategies have been used?

Is the information given of general nature or does it target special groups in the society?

What do you think is appealing to young women/people?

How do you look at the group “young women”?

Can you get knowledge about what they already know and what they want to know more about?

How is the information received? (What does the information lead to?) (Evaluations?)

What do you hope to accomplish?

Have you seen any results of your work?

Are there any difficulties that have arisen concerning your work? Lessons that will be useful for future work?

Which source would you consider best to learn about intimate issues? (written, oral etc why?)

13.1.2 Questionnaire for receivers

Name, age
Where do you live?

What do you know about AIDS?

Who told you that?

Do the teachers here in school talk to you about AIDS?
Can you ask the teachers questions about AIDS?

What do the teachers tell you about AIDS?

Can you read about AIDS in your school-books?

Have you watched any videos about AIDS?

Have you got any written information that you could take with you home?

Do you talk to your parents about sex and AIDS?

Do you talk about AIDS with your friends? (when teachers are not there)

Had you heard about AIDS before the teachers told you about it?

Do you understand the written information about AIDS?

Is the information in Setswana or English?

When you are taught about AIDS which way do you like the best?
- read about it
- teachers talk about it
- watch video
- maybe something else

Have you seen the magazine Choose Life?