

Social Dimension of HIV/AIDS Information Education and Communication Programmes

Umunnakwe GC¹, Grand B² and Umunnakwe ACR^{2*}

¹University Library, Federal University of Technology Owerri, Nigeria

²Department of Library and Information Studies, University of Botswana, Gaborone, Botswana

***Corresponding author:** Umunnakwe ACR, Department of Library and Information Studies, University of Botswana, Gaborone, Botswana, Tel: +234.8063523076, E-mail: ansegert56@gmail.com

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Abstract

The research focused on social Dimension of HIV/AIDS Information Education and Communication Programme. The objective was to assess the extent to which mainstreaming business enterprises in Botswana incorporate staff members, staff member's families, hospitality guests as well as local residents in their workplace HIV/AIDS information education and communication programmes. The study adopted cross-sectional research design and explanatory sequential mixed methods approach. The sample comprised fifty (50) heads of HIV/AIDS programmes of hospitality facilities. Data was captured via questionnaires and face-to-face interviews. Analysis of variance (ANOVA) was used to check the individual as well as collective impact of inclusive target groups by mainstreaming organisations in the development of HIV/AIDS IEC policy. The study found that the incorporating of family members, local residents, guests/customers and facility's staff members' significantly will make for a robust HIV/AIDS IEC policy and programme implementation, since the significance value ($P < \text{value}$) 0.000 was less than 0.05. Also, the 2-tail t-test values for the variables were all above 0.05 implying that designing and implementation of HIV/AIDS IEC programmes for individual variables will not make for an effective HIV/AIDS IEC programme/policy. The study concludes that social dimension- holistic incorporation of target groups- holds the key to successful workplace HIV/AIDS IEC programme/policy implementation while cost, attitudinal behaviour of HIV/AIDS coordinators and lack of knowledge of role tasks constitute the constraints. The implication for practice is the need for hospitality facilities to incorporate all relevant stakeholders in their workplace HIV/AIDS IEC programmes. The policy implication calls for all stakeholders to liaise to develop a sector specific workplace HIV/AIDS IEC policy for the hospitality sector with specific reference to Botswana.

Keywords: Social Dimension; Information Education and Communication; HIV/AIDS; Workplace; Hospitality Facilities; Botswana

Introduction

Background to the study

Botswana is a Sub-Sahara African country with a population of about 2.1 million and is ranked the second highest HIV/AIDS prevalent countries in the world [1]. Botswana HIV and AIDS indicator reveals that the number of people living with HIV is 340,000 of which adults aged 15 years and above constitute 97%. The HIV incidence rate for the country stands at approximately 3%, while the prevalence rate is 18.5% [2]. The hospitality sector on which this study is skewed is a key sector of Botswana's economy; it employed about 70,000 jobs in 2014 and projected to rise to 89,000 jobs by 2024 [3]. Nevertheless, the sector is known to be more disproportionately vulnerable to HIV/AIDS transmission [4].

In response to the HIV/AIDS pandemic the Botswana government adopted the national HIV/AIDS strategic framework (NSF) [5]. The NSF stipulates among others the adoption of workplace HIV/AIDS Information, Education and Communication (IEC) programmes as a HIV/AIDS risky behaviour change interventions [6]. Considering the socio-economic impact of the pandemic as well as the national HIV/AIDS strategic framework demands, mainstreaming business enterprises in Botswana were required to adopt and implement workplace HIV/AIDS IEC programmes. Whereas business organisations have been implementing the programme, the social dimension of workplace HIV/AIDS IEC programmes (the target groups) have received little focus by researchers, hence, this study.

Literature Review

According to statistics, there were 36.7 million people living with HIV in 2016 [7]. Out of this number, 2.1 million were new

infections while 26 million (71.0%) are workers aged 15 to 49 [8]. This makes HIV/AIDS a workplace issue as it directly affects labour and productivity [9]. HIV/AIDS has equally been recorded to impact business enterprises adversely; which keeps increasing every year [8]. The consensus among researchers is that businesses are impacted in the areas of increased costs, declining productivity, profitability; reliability and re-investment [10].

Workplace HIV/AIDS IEC is a behaviour change intervention (BCI) tailored to the needs of the workforce aimed at creating awareness and increased knowledge, which, motivates recipients to adopt better health measures that help reduce risk behaviours and vulnerability to HIV [11]. The programme aims at promoting and sustaining individual, organisational and societal norms and cultures and galvanizing them towards appropriate positive behaviours [12]. The overall objective of the programme is to increase reach and greater awareness which results in beneficiaries making informed decisions towards behaviour change [13]. The areas of focus of workplace HIV/AIDS IEC programmes include HIV/AIDS information awareness, Voluntary counselling and testing (VCT), Mother-to-child transmission of AIDS (PMTCT) and Safe-male-circumcision (SMC).

Relevance of Target Groups in Workplace HIV/AIDS IEC

The health status of a staff or any member of the staff's family, especially with regards to HIV/AIDS infection, affects his/her productivity at work. Likewise, high HIV/AIDS prevalence in a locality has the tendency to affect its potential as a destination of choice by tourists as well as endanger the health and wellbeing of the general society, which may lead to loss of market, low productivity and profitability on the part of business organisations. Risky behaviours and un-protected sexual relationships within a business operating environment exposes business organisations, staff members' and staff members' families, as well as local residents and tourists/guests to further risk of HIV infection, thus heightening the spread of the disease [14].

In line with basic communication principle, a well packaged message- barring communication barriers- will still be ineffective if the information communicated is not targeted at the right audience. Thus, the importance of ILO recommendation #200 on HIV/AIDS IEC and the place of work which prescribed target groups for workplace HIV/AIDS IEC for mainstreaming business organisations. The target groups include: staff members, staff members' families, guests/customers and local residents of the business operating environment. Incorporating all relevant stakeholder in the HIV/AIDS IEC programme enhances reach and knowledge about the pandemic; thus, helping them to moderate their behaviours [15]. There is the need therefore, for staff members, staff members' families, guests/customers and local residents of the business operating environment to be regularly reminded/educated about the dangers any risky sexual behaviours and or other poor approaches to the pandemic poses to themselves, the environment, and the business organizations in particular as well as the nation in general [16].

Statement of the Problem

An all-inclusive health education is a sine-quo-non for efficient health programme delivery. It is therefore imperative that workplace HIV/AIDS IEC programme of mainstreaming business enterprises should incorporate staff member's families and local residents of the business operating area, in addition to staff members as well as guests [17]. However, studies have shown that most business organisations do not implement the programme at all, some implement the programme by targeting only their staff members; others target guests/customers only, while local residents and staff members' families are in most cases left out. What is the state of affairs with regards to mainstreaming business enterprises in Botswana formed the bases for this study.

Study Objectives

The main objective of study was to assess the extent to which hospitality facilities in Botswana incorporate requisite target groups in their workplace HIV/AIDS information education and communication programmes. The specific objectives of study were (a) to determine the effect of incorporating staff member's families as part of the target groups of the HIV/AIDS IEC programme of hospitality facilities in Botswana; (b) to analyze the extent to which local residents are part of the target groups of the HIV/AIDS IEC programme of hospitality facilities in Botswana; (c) to find out the effect of incorporating staff members as part of the target groups of HIV/AIDS IEC programme of hospitality facilities in Botswana; (d) to analyze the extent to which guests/customers are part of the target groups of the HIV/AIDS IEC programme of hospitality facilities in Botswana; and (e) to establish the collective effect of main streaming all target groups on workplace HIV/AIDS IEC policy by hospitality facilities in Botswana.

Methods

The study adopted a cross sectional research design while the approach was the explanatory sequential mixed methods (ESMM).

Sample, Selection and Procedures

The sample comprised 51 hospitality facilities in greater Gaborone, Botswana. The sample frame was through list submitted by the department of tourism. Due to the manageable number of facilities the study adopted the census survey. The hospitality facilities were represented by HIV and AIDS Coordinators. The respondents, selected via purposive sampling were from guest-houses (24), lodges and camp sites (13), and hotels and motels (13) as well as self-catering establishment group (1).

The data collection procedure comprised recruitment of hospitality facilities. The process involved physical visits by researchers to hospitality facilities. The researchers used the telephone directory to obtain the telephone numbers of most facilities; thereafter,

visits were made to the facilities; in some cases, phone calls were made to them for directions. Staff of other hospitality facilities was also used to get direction to some facilities whose addresses were not very clear.

At each facility, the researchers explained the mission and purpose of the research, what the hospitality facilities, the government and Botswana public stood to benefit from the study. The researchers supported their request for participation of hospitality facilities with letter of permission to conduct the research from the Ministry of Environment, Wildlife and Tourism (Botswana). The management of facilities were equally assured that the findings from the study would be made available through appropriate organs and that there would be no risk to their organizations or the key informants as a person for participating in the study. Thereafter, the prospective facility's chief executive was formerly requested to support the research. All but one prospective hospitality facility chief executive accepted their organisations' participation in the research.

After the facility management's consent, they were requested to permit their HIV/AIDS IEC programmes coordinators to participate as key informants for the study. The permissions were granted. All the HIV/AIDS coordinators whose facility's management had agreed to support the study also consented to be part of the study as key informants. The informants were informed that the study required signing of consent form and could involve face-to-face interviews if necessary.

The research consent form was read and discussed with each key informant. The consent form covered items such as: introduction, names of researchers, purpose of study, issue of non-risk to informants, benefits of the study and assurance of confidentiality. It also covered the provisions that participation in the study was purely out of the informant's free will, and how the results of the study would be disseminated. Each informant was requested to sign the consent form. However, in many facilities, verbal acceptance to participate was accepted in place of a signed consent form.

The loyalty of key informants was retained firstly by moral-suasion (considering HIV/AIDS situation in Botswana). Secondly, the researchers exchanged mobile cell phone numbers with them to enable further communication; this helped both sides to keep constant communication open, and enabled re-scheduling of appointments until the questionnaires were completed and collected and interviews conducted. Because the administration of data capturing instruments were based on appointments, majority of the questionnaires were answered while the researcher waited, while a few were collected a day or two after.

Data Collection Instrument and Measurement

The quantitative data was collected using the structured questionnaires. This was chosen because of its ease of administration among respondents with busy schedules [17]. The face validity of the instrument was established by experts from the relevant fields- Library and Information Studies and HIV/AIDS monitoring and evaluation section of the Ministry of Health (MoH). The construct validity was established through pilot study. The 5-point measuring scale (strongly agree, agree, neutral, disagree and strongly disagree) was the bases for measurement of responses.

Fifty-one (51) questionnaires were administered to heads of HIV/AIDS programme of the selected hospitality facilities, by hand delivery. The period between administration and collection of completed questionnaire was seven (7) days. The response rate was 98%.

SPSS version 21 was employed for processing the data. Descriptive statistics was used to capture the distribution of categories of hospitality facilities. Frequency, and percentages, was used to capture levels of respondents' responses to all the variables using the 5-point measuring scale. Standard deviations (SD), Mean ranking and inferential statistics were used to make meaningful conclusions based on the findings. Mean Ranking of ± 3 was set as acceptance criteria. Analysis of variance (ANOVA) was used to check the individual as well as collective impact of inclusive target groups by mainstreaming organisations in the development of HIV/AIDS IEC policy.

The qualitative data was captured via face-to-face interviews. In most facilities, interview sessions were conducted in the HIV/AIDS Coordinators' office, while a few were done in the facility's board rooms. To avoid interruptions in the course of interviews, the informants agreed to place sticker with inscription "interview in session" on the doors leading to the office/boardroom. The interviews were recorded on participants' approval, using the researcher's "Samsung Class S4 Cell phone voice recorder". Responses were transcribed and coded into appropriate variables/question areas. The following were the findings.

Results

Facility Categories	1-5 years		6 - 10 years		Above 10 years		Total	
	N	%	N	%	N	%	N	%
Hotels and Motels	10	20	1	2	10	20	21	42
Guest House	3	6	7	14	6	12	16	32
Lodge/Camping	4	8	5	10	3	6	12	24
Self-Catering Establishment	0	0	0	0	1	2	1	2
Total	17	34	13	26	20	40	50	100

Table 1: Hospitality Facilities by Category and Years of Operation

Table 1 revealed that hospitality facilities who participated are made up of hotels/motels (42.0%), guesthouses (32.0%), lodges/camp-sites (24.0%) and self-catering establishments (2.0%). The finding also revealed that 20 facilities (40.0%) have been in operation for over 10 years, 17 (34.0%) have operated for less than 5 years while 13 (26.0%) have operated for 6 to 10 years.

The respondents' gender revealed that 62.0% (31/50) are female and 38.0% (19/50) are male. Out of the 21 respondents employed in the hotels/motels category 24.0% (12/50) are female while 18.0% (9/50) are male. Out of the sixteen (16) respondents from the guesthouses, 20.0% (10/50) are female and 12.0% (6/50) male. The 12 respondents from the lodges/camp-sites comprised of 8 female (16.0%) while 4 (8.0%) are male. One respondent was from the self-catering establishment, who was a female (Table 2).

The educational attainment of respondents revealed that 50.0% (25/50) had bachelors' (First degree), 34.0% (17/50) had diploma certificates; 10.0% (5/50) had postgraduate degrees while 6.0% (3/50) had Cambridge certificates. The age range of respondents showed that 74.0% (37/50) are between 21 and 40 years; 22.0% (11/50) were between 41 and 60 years while 4.0% (2/50) are above 60 years (Table 2).

(a) Respondents by Hospitality Facility Category and Gender (N =50)						
Hospitality category	Female		Male		Total	
	N	%	N	%	N	%
Hotel/ Motel	12	24	9	18	21	42
Guest House	10	20	6	12	16	32
Lodge/Camping Site	8	16	4	8	12	24
Self-Catering Establishment	1	2	0	0	1	2
Total	31	62	19	38	50	100
(b) Respondents by Highest Educational Attainment and Gender (N =50)						
Highest Educational Attainments	Female		Male		Total	
	N	%	N	%	N	%
Post graduate degree	2	4	3	6	5	10
First degree	17	34	8	16	25	50
Diploma certificate	9	18	8	16	17	34
Cambridge certificate	3	6	0	0	3	6
Total	31	62	19	38	50	100
(c) Respondents by Age and Gender (N =50)						
	Female		Male		Total	
	N	%	N	%	N	%
Between 21 and 41yrs	22	44	15	30	37	74
Between 41 and 60yrs	7	14	4	8	11	22
Above 60yrs	2	4	-	-	2	4
Total	31	62	19	38	50	100

Table 2: Personal Data of Respondents

Table 3 measured the target groups of HIV/AIDS IEC programme. The finding revealed that 98.0% (49) of respondents indicated that staff members and guests are the target groups/beneficiaries of the HIV/AIDS IEC programme, neutral was 0% (0), 2.0% (1) disagreed; with a Mean Rank of 4.28 and SD ± 60.11 . Fifty-two percent (26/50) of respondents disagreed that staff members families were beneficiaries of HIV/AIDS IEC programme, 2.0% (1/50) was neutral, while 46.0% (23/50) agreed that staff member families are among the target groups of HIV/AIDS IEC programme, with a Mean rank of 3.12 and SD ± 30.90 . The findings also revealed that 76.0% (39/50) disagreed that local residents were part of the HIV/AIDS IEC programme target groups, 4.0% (2/50) were neutral, while 20.0% (10/50) agreed. The Mean rank was 2.38 and SD ± 21.82 .

Measurement items	Strongly disagree (%) 1	Disagree (%) 2	Neutral (%) 3	Agree (%) 4	Strongly agree (%) 5	S.D(\pm)	MEAN RANK
Your organization's workplace HIV/AIDS IEC programme include staff members only?	1 (2)	0 (0)	0 (0)	32 (64)	17 (34)	60.11	4.28
Your organization's workplace HIV/AIDS IEC programme include guests/customers?	1 (2)	0 (0)	0 (0)	32 (64)	17 (34)	60.11	4.28

Measurement items	Strongly disagree (%) 1	Disagree (%) 2	Neutral (%) 3	Agree (%) 4	Strongly agree (%) 5	S.D(±)	MEAN RANK
Your organization's workplace HIV/AIDS IEC programme targets Staff members' families?	7 (14)	19 (38)	1 (2)	7 (14)	16 (32)	30.90	3.12
Your organization's workplace HIV/AIDS IEC programme targets local residents of the operating community?	11 (22)	27 (54)	2 (4)	2 (4)	8 (16)	21.82	2.38
Your hospitality facility has HIV/AIDS IEC programme policy?	17 (34)	16 (32)	2 (4)	3 (6)	12 (24)	7.11	2.74

Table 3: Target Groups/Beneficiaries HIV/AIDS IEC Programmes (n = 50)

The implementation of workplace HIV/AIDS IEC programme was also assessed with respect to existence of HIV/AIDS IEC policy. The finding revealed that 66.0% (33/50) of respondents disagreed with respect to the existence of HIV/AIDS IEC policy, 4.0% (2/50) were neutral, while 30.0% (15/50) agreed; S.D was ± 7.11 and Mean Rank of 2.54 (Table 3).

Some aspects of the findings from the quantitative data was followed up in face-to-face interviews. Respondents' were asked to state what could be the reason for not incorporating staff-members families and local residents of their operating communities. The findings revealed that cost considerations, inadequate knowledge of the role hospitality facilities are to play in workplace HIV/AIDS IEC programme implementation and attitudinal behaviour of some of the respondents were responsible for not incorporating staff-members families and local residents of their operating communities in the workplace HIV/AIDS IEC programmes. A respondent stated:

"We have not considered staff families and local residents because of cost; it would add extra financial burden on our meagre sources"

Another respondent indicated:

"I do not think it is our duty; it is an individual's private and personal business"

Yet, other respondents posited:

"There is already plenty of HIV/AIDS education being provided by government and NGOs everywhere; individuals should avail themselves that information"

Another interview respondent stated:

"The government and other agencies are already doing a lot of education out there. For now, we are focusing on our staff"

The general perception of the interview informants with regards to non-existence of HIV/AIDS IEC policy at almost all the facilities was lack of human resource capacity.

ANOVA

The analysis of variance tool was used to determine the effect of incorporating staff member's families, staff members, guests/customers and local residents as part of the target groups of the HIV/AIDS IEC programme/policy of hospitality facilities in Botswana as well as to establish the collective effect of main streaming all target groups on workplace HIV/AIDS IEC policy by hospitality facilities in Botswana. IEC Policy was the dependent variable while local residents, staff members' families and guests/customers were the independent variables.

The regression analysis of the collective effect of including all target groups on workplace HIV/AIDS IEC programme/policy by hospitality facilities in Botswana showed a great level of significance at .000 (Table 4). The effect of individual target groups on the programmes/policies was analyzed. The finding is as shown in Table 5. The effect of including staff members' family only posted a level of significance of .154 that of guest and customers was .463 while that of local residents only was .060.

Model	Sum of Squares	df	Mean Square	F	Sig.	
1	Regression	80.944	3	26.981	11.214	.000 ^b
	Residual	110.676	46	2.406		
	Total	191.620	49			

Table 4: ANOVA

Dependent Variable: IEC policy/programme

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	
	B	Std. Error	Beta			
1	(Constant)	-2.097	1.685		-1.245	.219
	Staff_members family	.715	.494	.243	1.448	.154
	Guests_Customers	.187	.252	.146	.741	.463
	Local_Residents	.501	.260	.335	1.929	.060

Table 5: Coefficients and T-Statistics

Discussion

As per ILO (2010) recommendation, workplace HIV/AIDS IEC programme of business enterprises requires that it be encapsulated in a HIV/AIDS IEC policy. The policy is the wheel that should drive the programme delivery. In the absence of policy as discovered by this study, even if the programed seems to be achieving some positive results, it is only momentary. The programme cannot be properly monitored or evaluated and its sustainability cannot be guaranteed as it is subject to the personal will of the chief executive or the HIV/AIDS Coordinator. The policy should specify the target groups for the programme and how they are to be incorporated and the methodology to be adopted.

Workplace HIV/AIDS IEC programme aims at reaching the widest audience. According to ILO, these include the staff members and their families, hospitality facility guests as well as the local residents of the main-streaming business enterprise's operating areas. As it were, if only a minority is availed the information- staff members and guests only-, to the exclusion of local residents as well as staff member families', this leaves a gap that could aid the continued spread of the virus, thus, threatening the achievement of the desired programme objective.

The study found that majority (76.0%) of hospitality facilities target staff members and guests only (Mean Rank of 4.28 and SD ± 60.11); whereas, 52.0% and 76.0 of facilities respectively do not include staff members' families and local residents as part of their target groups. This finding was corroborated by Bergstrom and Liljeqvist (2010) who found that informant organisations neither included staff members' families nor the residents of the local community as part of their target groups [18]. Not incorporating these two classes of target groups runs contrary to ILO policy on workplace HIV/AIDS and world of work, and the ILO recommendations No. 200, as well as the Botswana revised national policy on HIV/AIDS which provides that they should be included. The fact that a substantial percentage (48.0% and 24.0% respectively) of the facilities does not incorporate staff members' families and local residents in their programmes is therefore a potential call for action by all stakeholders [19,20].

Although some hospitality facilities argued that they are mainly profit maximizing organisations and should not be burdened with such extra cost, however, the consequences of non-inclusiveness of target groups as seen in table 5 in their IEC programmes pose more danger to the businesses themselves. Among these could be the exacerbation of the spread of the disease within hospitality facilities operating environment which affects the locality's rating as a destination of choice. On another hand, the sicknesses of staff members' may turn around to hurt the hospitality business through man-hours lost on staff hospital visits to see their relatives and or taking care of them. In an environment of high HIV/AIDS prevalence as have been found to exist in Botswana, neglecting to incorporate staff member's families and local residents by hospitality facilities is like turning a blind eye to its future business survival. The consequences of neglecting to include staff members' families and local residents in their programmes could endanger the future of hospitality business in the country [21-24].

A critical aspect of the findings of this study deals with the reasons behind the non-inclusiveness of all relevant target audience. These are cost considerations, inadequate knowledge of the role hospitality facilities should play in workplace HIV/AIDS IEC programme implementation and individual attitudes of HIV/AIDS Coordinators. Of the aforementioned reasons, the study considers "inadequate knowledge of the role hospitality facilities should play in workplace HIV/AIDS IEC programme implementation" most remarkable. The Issue of cost and attitudinal behaviour seem to flow from this, in the absence of HIV/AIDS IEC policy [25-28]. A general adage postulates that "knowledge is power"; there is therefore urgent need for this gap to be addressed while hospitality facilities should do well to check the attitudinal behaviours of their HIV/AIDS Coordinators.

Conclusion

On the bases of the findings, this study concludes as follows: that social dimension- holistic incorporation of all target groups by main streaming hospitality facilities- holds the key to any successful workplace HIV/AIDS IEC programme/policy implementation; that cost, attitudinal behaviour of HIV/AIDS coordinators and lack of knowledge of role tasks on the part of hospitality facilities constitute the main constraints to effective workplace HIV/AIDS IEC programme/policy implementation.

Implication for Practice

The hospitality facilities need to urgently incorporate its staff members' families and local residents in their workplace HIV/AIDS IEC programmes to achieve the key objective of workplace HIV/AIDS IEC programme as well as safeguard the future of the hospitality sector.

The Ministry of Environment Wildlife and Tourism (MEW&T), need to intensify oversight functions to the hospitality facilities to ensure compliance with the Botswana national workplace HIV/AIDS IEC policy.

Implication for Policy

Considering the importance of policy in health programmes delivery, there is need for Ministry of Environment Wildlife and Tourism (MEW&T), the National AIDS Coordinating Agency (NACA) and Ministry of Health (MoH) to liaise with other relevant stakeholders to develop sector specific workplace HIV/AIDS IEC policy for the hospitality sector in Botswana.

Recommendation

This study was localised to Greater Gaborone area. The recommendation is that similar research be conducted in other districts of Botswana and or nationally for a nationwide view of the target groups of workplace HIV/AIDS IEC programmes of hospitality facilities in Botswana.

Limitation of Study

The major limitation of this study was its being limited to Greater Gaborone City area.

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