

FOIA MARKER

**This is not a textual record. This is used as an
administrative marker by the William J. Clinton
Presidential Library Staff.**

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member:

Subseries:

OA/ID Number: 21064

FolderID:

Folder Title:

Botswana

Stack:

S

Row:

66

Section:

6

Shelf:

8

Position:

2

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. resume	John Lange (partial) (1 page)	nd	b(6)

COLLECTION:

Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 21064

FOLDER TITLE:

Botswana

2007-1550-F
kc1251

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

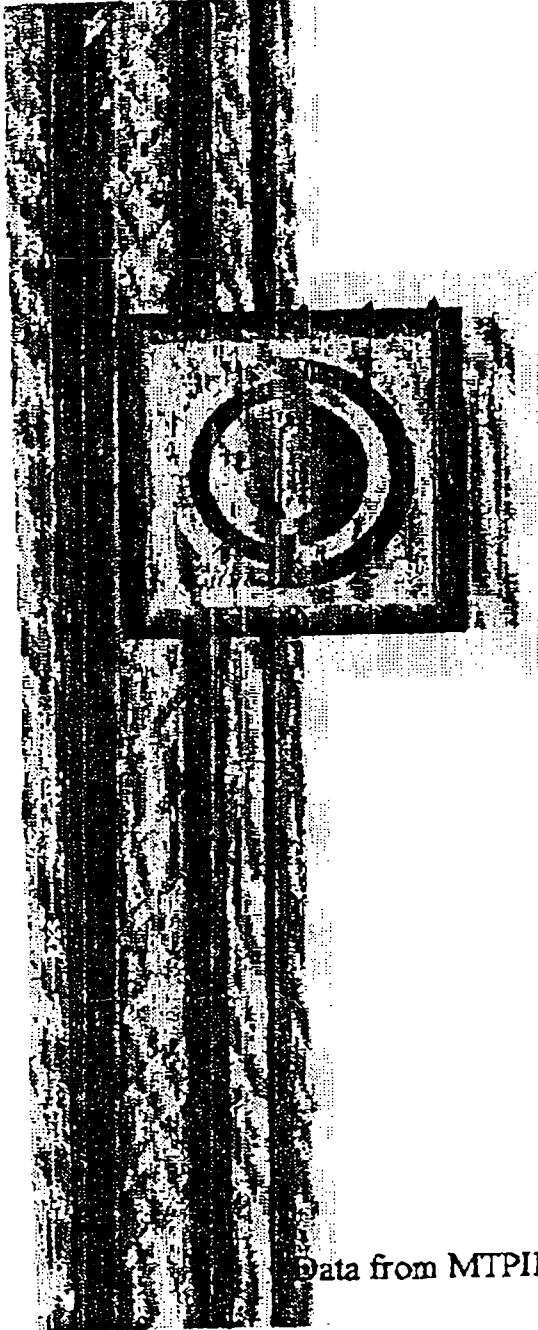
C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]



Status of HIV/AIDS in Botswana

Presented by Ambassador Archibald Mogwe
Thursday, July 29, 1999

Data from MTPII Report/related materials. Prepared by Sunnia Communications, LLC - S. Mogwe/R. Joynes



Botswana's Sustained Achievements in Health Care

Since independence in 1966, Botswana has rigorously and deliberately developed a National healthcare system that provides free access and quality care to all citizens of the Republic. "Except for a nominal consultation fee, primary health care services are substantially free and universally free for children , pregnant women and TB patients."1

Botswana's community health approach to healthcare delivery has produced a cost effective cadre of services including promotion of good health, family planning, prevention of disease, early detection, diagnosis, treatment, and rehabilitation. The remarkable achievements of the past two decades in health care are sadly being eroded by the HIV/AIDS epidemic in Botswana.

BOTSWANA'S POSITIVE HEALTHCARE SYSTEM INDICATORS

85% of the population within 15km of a health facility or services

76% within walking distance to a health facility

78% of women covered by antenatal care

Infant mortality rate per 1000 declined from 92 to 45

Immunizations

Fully immunized - TB	67%
----------------------	-----

Fully immunized - DPT	83%
-----------------------	-----

Fully immunized - Polio-	81%
--------------------------	-----

Fully immunized -Measles	82%
--------------------------	-----

Potable Water Supply

Urban	100%
-------	------

Urban Village	100%
---------------	------

Rural	53%
-------	-----

Data from MTPII Report/related materials. Prepared by Sunnia Communications, LLC - S. Mogwe/R.Joynes

HIV/AIDS Status Summary

The first case of AIDS in Botswana was identified in 1985. Two years after the diagnosis the government established the National AIDS Control Program to develop the framework for a national response to the crisis. Since the initial case the spread of HIV/AIDS, it is estimated that 25% of the adult population is living with HIV/AIDS. Listed below are percentages of population infected with the disease as of the end of 1997.

Population living with HIV/AIDS

Adults (15-49) 190,000

Women(15-49) 93,000

Children(0-15) 7,300

Estimated number of AIDS cases (since the initial case) 50,000

Estimated number of deaths due to AIDS 43,000

Estimated number of orphans 28,000

Critical Areas of the HIV/AIDS Epidemic

The ravage of HIV/AIDS in Botswana is hitting the adult population (age 15-49) most severely. These individuals comprise 45% of Botswana's estimated 1.5 million people. By all statistics this group is the most sexually active in the population and account for approximately 89% of reported HIV cases in the country. The rapidly increasing rate of infection in this population presents a most severe crisis on the country's future. As the death rates in this segment continue to increase the tremendous strides that Botswana has made in equitable allocation of health resources, sustained stability and growth both politically and economically, and the overall improvement in quality of life will be diminished. Listed below are three areas for immediate review.

- Increasing rate of new infections
- Delivery of care to AIDS victims
- Dilemma of Expensive drug treatments



Delivery of Care to AIDS Victims

Botswana is facing a dilemma in effectively managing the care of its AIDS victims. Minister Butale has stressed the need to strengthen Community Home Based Care for the over 7000 people with full blown AIDS, who occupied 60% of hospital beds in the country.

To effectively meet this challenge humanely, a coordinated Community Health Partnership needs to be implemented. Such a partnership would link Community Health Nurses, a strong professionally developed medical corp, the Home Base Care Workers, and the local health facility to more effectively meet the tremendous needs of those sent home to die.

- **Strengthen role of Community Health Nurses in management of the epidemic**
- **Effectively train Home Base Care Workers on proper and safe procedures for caring for the AIDS victims**
- **Provide access to medical technology and equipment to assist with the suffering and dying**



The Increasing Rate of New HIV Infection

It is estimated that by the turn of the century 332,000 Batswana will be infected with HIV. In order to stop the rapid spread of infection it is paramount that social and sexual behaviors be changed and a better understanding of the HIV/AIDS crisis must be developed throughout the nation. Although the urban areas have the higher numbers of HIV rates because of population size, Gaborone (39%), the most critical percentages are found in the mining region of Selibe Phikwe (50%) and Francistown (43%).

The mode of infection in Botswana is sexual. STDs (Sexually Transmitted Diseases) are a major public health problem in Botswana. The presence of STDs further predisposes individuals to HIV infection because of the failure to use safer sex practices such as condom use or the ultimate safe sex practice of abstinence. Sexual transmission of HIV is attributing to the increasing percentages of pregnant women with HIV and also transmission by multiple partners attributes to the spread of disease.

1998 Reports from the Ministry of Health's AIDS/STD Unit state that 61% of men with STD showed HIV seroprevalence.



The Dilemma of Expensive Drug Costs in the Treatment of HIV/AIDS

The problem with drug treatment therapy for Botswana and the other Southern African nations is cost and access to the drugs. At Western market prices of \$1000 per month, the multi-drug therapies are hopelessly out of the grasp of these countries where 90% of AIDS cases occur. Drug companies have left African markets out of their trade and distribution plans. Statistics show that less than 1% of AIDS drugs are sold in sub-Saharan Africa. This global disregard for human rights in Africa must be changed.

Minister Butale remarked in a press conference in March 1999 at the announcement of availability of the drug AZT to pregnant women prior to birth that without the assistance of UNICEF the country cannot afford this therapy and other HIV drugs because of the astronomical costs. "The total cost of these drugs for the number of HIV infected persons calculated to be in the region of P12 billion per annum." BOPA

AIDS AWARENESS AND KNOWLEDGE AMONG BOTSWANA WOMEN: IMPLICATIONS FOR PREVENTION PROGRAMS

Kathleen F. Norr, PhD

University of Illinois at Chicago, Chicago, Illinois, USA

Sheila D. Tlou, BSN, PhD

University of Botswana, Gaborone, Botswana

Beverly J. McElmurry, EdD, FAAN

University of Illinois at Chicago, Chicago, Illinois, USA

In-depth interviews with 56 urban women in Botswana revealed high levels of AIDS awareness and high reliance on mass media information. Many of the women expressed confusion about AIDS as an illness, that is, its symptoms and the latent period. Nearly all of the women were aware that the virus that leads to AIDS is sexually transmitted and believed that condoms are effective for prevention. However, one third had incorrect knowledge about transmission, lacking a full understanding of sexual transmission and believing that transmission can occur through casual contact. Two thirds believed they were at risk for getting AIDS, usually because they did not trust their partners and lacked control over their partners' behaviors. More than half of the women said they had changed their behaviors to prevent AIDS. Thirty-six said they had only one partner, but only 11 said they used condoms or would do so with a future partner. The women's responses provide important information on gaps in AIDS knowledge that need to be addressed in AIDS prevention.

In this qualitative study, we investigated AIDS awareness and knowledge among urban women in Botswana. Surveys have found relatively high levels of AIDS knowledge in Africa. However, people may have erroneous beliefs or gaps in their knowledge that do not appear in quantitative studies. In-depth interviews permit the exploration of the full

Received 21 February 1995; accepted 28 September 1995.

Funding for this project was provided by the National Institute on Aging and the U.S. Agency for International Development through Family Health International.

Address correspondence to Kathleen Norr, Maternal-Child Department, UIC College of Nursing (M/C 802), 845 South Damen Avenue, Chicago, IL 60612-7350 USA.

extent of a person's understanding of AIDS. Such information is especially critical for women, because many cultural, social, and economic barriers hinder women's access to AIDS information as well as their ability to implement suggested preventive strategies (Gupta & Weiss, 1993). In this article, we report the results of the first in-depth exploration of AIDS awareness and knowledge among urban women in southern Africa.

BACKGROUND

AIDS Knowledge in Africa

The AIDS epidemic is in its second decade in Africa. News of the epidemic and prevention information have been widely disseminated by radio and newspapers. The mass media, particularly radio stations, have been identified as primary information sources about AIDS in Burkina-Faso, Ghana, Nigeria, Zaire, and Zimbabwe (Asindi et al., 1992; Bertrand et al., 1991b, 1992; Caprara et al., 1993; Ndlovu & Sihlangu, 1992; Neequaya et al., 1991; Sicard et al., 1992). AIDS awareness and knowledge surveys have been conducted among the general population in Ghana (Neequaye et al., 1991), the Ivory Coast (Caprara et al., 1993; Yelibi et al., 1993), Uganda (Konde-Lule et al., 1993), Zaire (Bertrand et al., 1991a, 1991b, 1992), and Zimbabwe (Moyo et al., 1993; Wilson et al., 1991); among women only in Kenya (Garland et al., 1993), South Africa (Govender et al., 1992), Rwanda (Lindan et al., 1991), Uganda (McGrath et al., 1993), and Zaire (Bertrand et al., 1992); among students in Kenya (Sindiga & Lukhando, 1993), Nigeria (Asindi et al., 1992; Odebiyi, 1992), Tanzania (Ndeki et al., 1994), Uganda (Lule & Gruer, 1991), and Zimbabwe (Ndlovu & Sihlangu, 1992; Wilson et al., 1991); among health care workers in Nairobi and Kenya (Rogstad et al., 1993); and among long-distance truck drivers in Kenya (Bwayo et al., 1991). All surveys have found high levels of knowledge, especially about the basic fact that AIDS is spread by heterosexual contact. Knowledge is more widespread in urban than in rural areas (Bertrand et al., 1991a; Caprara et al., 1993), and higher knowledge is associated with higher education (Garland et al., 1993; Yelibi et al., 1993), male gender (Bertrand et al., 1991a; Lule & Gruer, 1991; Wilson et al., 1991), and younger age (Bertrand et al., 1992; Yelibi et al., 1993).

Knowledge gaps and false beliefs are also documented. Apathy, fatalism, and underestimation of personal risk are common (Bertrand et al., 1991a; Sindiga & Lukhando, 1993). The persistent belief that transmission can occur through casual contact was found in 25% or more of the people surveyed in all but three studies. In the Ivory Coast, some

people confuse AIDS with a traditional disease or witchcraft (Caprara et al., 1991; Yelibi et al., 1993). Lack of understanding of AIDS as a disease and negative attitudes toward persons with AIDS have frequently been reported (Asindi et al., 1992; Bertrand et al., 1991b; Govender et al., 1992; Lindan et al., 1991; Ndeki et al., 1994; Yelibi et al., 1993). Disbelief in the effectiveness of condoms has been found among the general population (Asindi et al., 1992; Caprara et al., 1993; Govender et al., 1992; Lule & Gruer, 1991; Odebiyi, 1992; Wilson et al., 1991; Yelibi et al., 1993) and even among health care workers in Kenya (Rogstad et al., 1993).

Women and AIDS in Botswana

HIV infection has spread rapidly in Botswana; the Ministry of Health has estimated that about 10% of the total population is HIV positive (Update on the status of HIV/AIDS in Botswana, 1994). As a result, vigorous mass media campaigns on AIDS prevention are currently underway, better quality condoms are available for free, sex education programs are offered in the schools (Adeyemi & Tabulawa, 1993), and free AIDS testing and counseling services are available. AIDS has been mistaken for traditional illnesses in several African countries. In Botswana, AIDS is sometimes confused with *boswagadi*, a traditional illness and treatment previously described by Ingstad (1990). Some people believe that AIDS is actually *boswagadi* and is caused by the failure of the modern generation to observe traditional treatment and the taboos of sexual abstinence.

The second Botswana Family Health Survey (BFHS-II), a national study of women in their childbearing years conducted in 1988, revealed that 96% of urban women and 85% of rural women said they had heard about AIDS (Ministry of Health, 1990). Younger and more educated women were most likely to have heard about AIDS. Of those who had heard about AIDS, 75% named multiple partners as a route of transmission. However, women also gave evidence that they believed transmission could occur through casual contact. For example, more than half thought that someone who shared food with a person with AIDS was at high risk.

The Need for Qualitative Studies

In Botswana and other African countries, the erroneous beliefs about AIDS and gaps in AIDS knowledge that have been identified need to be better understood if programs to address them are to be developed. However, few qualitative studies of AIDS knowledge have been conducted in

Africa or other regions. In two qualitative studies in Botswana and South Africa, some traditional healers said they believed that AIDS is a traditional disease or is curable by traditional methods (Abdool Karim, 1993; Ingstad, 1990). Nicoll et al. (1993) discussed reasons for the persistence of these incorrect beliefs about AIDS among lay health care providers in Tanzania, but their discussion was anecdotal, and not based on systematic interviews. Using in-depth interviews in Uganda, McGrath et al. (1993) found that specific traditional beliefs had little negative impact on AIDS prevention but that the cultural norm that permits men to have more than one partner reduced women's control over their own risk of AIDS. To date, no in-depth study of women's AIDS awareness and knowledge has been conducted in any country in southern Africa.

METHOD

Using a naturalistic inquiry perspective (Lincoln & Guba, 1985), we conducted in-depth interviews with 56 women in Botswana to determine their awareness and knowledge of AIDS and their prevention behaviors for the purpose of developing a community-based peer group intervention (Norr et al., 1992). According to Lincoln and Guba (1985), naturalistic inquiry assumes that there are "multiple constructed realities that can be studied only holistically" (p. 37). In this study, we wanted to understand the ways urban women in Botswana understand AIDS in their social context. We used purposive sampling in neighborhoods with different income levels to ensure the inclusion of women representative of a wide range of demographic and socioeconomic features. We interviewed 13 women in working-class neighborhoods and 13 women in middle-class neighborhoods. To reach women with high status, we drew up a list and randomly selected 8 women from it. To reach younger women, we interviewed 4 teenagers recruited in secondary schools, 5 adolescent school dropouts recruited from neighborhood gathering places, and 9 university students. Finally, we interviewed 4 low-income women living in a periurban village to include the views of at least a few women from outside the city.

The interview guide included topics we believed were important to understand in order to develop an AIDS prevention intervention sensitive to the context of urban women's lives. Questions and suggested probes included how women first learned about AIDS; their sources of information; their beliefs about what AIDS is, how it is transmitted, and how it can be prevented; their assessment of their AIDS risk; and any changes in their own AIDS behavior. Other sections of the interview explored how women learned about sex and their experiences with condom use. (The interview guide is available upon request.)

Two female nursing students at the University of Botswana who had

clinical experience in discussing intimate sexual matters with women conducted the interviews. They attended a weeklong training conducted by an anthropologist with extensive field experience in Botswana. The course provided intensive training in interviewing techniques, including establishment of rapport, nondirective probing, and discussion of sensitive topics. After in-class training, the two interviewers conducted taped practice interviews and received individual feedback. We evaluated the adequacy of their preparation by listening to their practice interviews. The interviews occurred in English or Tsetswana, according to the interviewee's preference. Only 2 of the interviewees were willing to be tape-recorded, so the interviewers took detailed notes during and immediately after the interviews. The Tsetswana interviews were translated into English by the interviewer and then reviewed for accuracy. The transcribed interviews were coded and analyzed with the help of Ethnograph, qualitative data analysis software (Siedel et al., 1988). We categorized each participant's level of overall AIDS knowledge by reading the entire interview, not just specific questions, such as how AIDS is spread, because the women often indicated misunderstandings about AIDS in responding to other questions.

The background characteristics of the sample are summarized in Table 1. Our relatively large sample size permitted us to include women at all socioeconomic levels and in a wide variety of relationships. However, our sample was entirely urban in a predominantly rural country. Compared with the BFHS-II (Ministry of Health, 1990) and the Botswana 1991 census, our study included more educated women with high-level occupations and fewer adolescents.

RESULTS

Awareness of AIDS

Most of the women were aware that AIDS is a serious health problem. Forty-one of the 56 women interviewed mentioned that AIDS was a deadly and/or incurable disease. As one woman put it, "AIDS is a dangerous disease which does not have a cure." Only 4 women expressed disbelief about AIDS. When discussing AIDS, many women conveyed anxiety or discomfort in their body language and tone, as well as silence and nervous laughter. Seven persons explicitly discussed their concern that AIDS is spreading rapidly in Botswana. As one woman said, "I want to say that if AIDS is spreading so much I believe almost everybody will have it because people are still promiscuous. Teenagers still do it left and right without condoms." Eight women expressed a sense of despair or hopelessness about AIDS. A young teacher said, "We are aware that there is AIDS but I told myself that we should give up. As the disease

Table 1. Background characteristics

Characteristic	n	%
Age		
Under 20	9	16
20-29	26	46
30+	21	38
Education		
Primary school or less	13	23
Some secondary school	18	32
Secondary school or more	25	45
Occupation		
Unemployed	6	11
Homemaker	6	11
Student		
Secondary	4	9
University	9	16
Manual labor	9	16
Clerical and sales	4	7
Professional/managerial	18	32
Partner status		
Single, no current partner	15	27
Single, with boyfriend	18	32
Cohabiting	6	11
Married	17	30
Number of children		
None	19	34
1 or 2	28	50
3 or more	9	16

has attacked there is nothing we can do." Eight women said they knew someone who had AIDS, and an additional 10 said they had heard rumors that someone they knew had AIDS but they did not know this for certain.

AIDS as a Disease

The women were not well informed about AIDS as an illness. Only one person, a 17-year-old secondary school student, clearly mentioned the latent period between infection with the HIV virus and the development of symptoms. However, many women indicated at least some awareness that they might not be able to recognize a person infected with the virus. For example, a university student asked, "Is it true that

one can have AIDS but without symptoms?" Only 9 women accurately described the signs and symptoms of AIDS. Many women asked about the signs, symptoms, and treatment of AIDS. One homemaker said, "I would like to know what an AIDS patient looks like. How can you tell that you have AIDS as a person? What are the signs and symptoms and how do we cure AIDS?" Several women had heard about links between AIDS and other sexually transmitted diseases and tuberculosis, but they did not understand these relationships clearly. An accountant said, "We hear that people who have TB get AIDS. We hear that people who have VD do not get AIDS. So I would like you to clarify that for me." There is still a great deal of uncertainty about treatments and possible cures. One university student asked, "If somebody is aware that they have AIDS, is there any treatment or any assurance that can be made for such a person to live a normal life—like before he had AIDS?" The issue of whether persons with AIDS should be isolated has been controversial in many countries. Some women advocated isolation or publication of persons' HIV status, but others mentioned the harm that negative attitudes bring. One woman said,

I'm a bit concerned about AIDS victims in Botswana. They are identified at the hospitals, they go home, and why can't they be isolated somehow? I have heard about where a patient has AIDS and their families are not told. This causes fear in people.

Sources of AIDS Information

Fifty of the 56 women said they first learned about AIDS from mass media, primarily the radio. Other sources mentioned were the clinic or hospital ($n = 11$); pamphlets and/or posters ($n = 7$); and meetings, workshops, or lectures ($n = 8$). Five of the younger women said they had learned about AIDS in school. Twenty mentioned friends, family, or other informal contacts as sources of information.

Most of the women believed their sources of information were reliable. Thirty-two women said they believed mass media sources were reliable. As one teacher said,

I believe in the radio and papers because they come through the health workers with the aim of informing the nation, unlike my schoolmates who may talk of AIDS but not being sure of what it is. They might not believe AIDS exists.

Five women stated that they believed no source: 4 of these 5 women questioned the existence of AIDS, and the fifth said that "all sources are exaggerated." Several women commented on the type of presentation

they found helpful. A teacher said, "I believe most in what I hear from organizations like the Red Cross because they explain at length about it." Two women mentioned the importance of visual presentations, because "posters . . . make you see what is involved."

AIDS Transmission

Twenty-five of the 56 women had extensive and accurate knowledge about HIV transmission, correctly citing sexual transmission and at least one other mode of transmission and not mentioning any incorrect ones. As one university student replied, "It is also transmitted through blood transfusions. It is transmitted through the placental route." Twelve additional women appropriately named sexual transmission as the way AIDS is spread and did not express any incorrect beliefs about how AIDS is spread, although they did not mention any other ways AIDS can be spread. As one woman with only primary school education said, "People contract AIDS through sexual intercourse. I do not know any other ways a person can contract AIDS." All of these women understood the process of sexual transmission of the virus. A single woman explained, "If a man or woman has many partners, during sexual intercourse the fluid of nature that we exchange can lead to one getting AIDS if the other partner has AIDS."

Nineteen women expressed incorrect beliefs about AIDS. Four of them questioned or flatly denied the existence of AIDS. One homemaker with a primary school education said, "I heard [about AIDS] from the nurse . . . but I don't think there is AIDS. I want to see an AIDS patient before I can believe." Said another,

I still don't believe there is AIDS because if it is, the White people could be fighting the disease, at least coming up with a cure for AIDS victims. We know well enough that they have found cures for other diseases.

Interestingly, all 4 of these women also said AIDS was caused by sexual intercourse and/or multiple partners. All were able to correctly state all the messages that had been given in the mass media campaigns against AIDS, but they were not fully convinced that AIDS exists or exists in Botswana.

Seven women held incorrect beliefs regarding the mechanism of sexual transmission that may reflect traditional beliefs that equate AIDS with *boswagadi*. Only one, a woman with no formal education, clearly labeled AIDS as *boswagadi*. She stated, "I heard AIDS is caused by women who have lost their husbands who do not get traditional treatment and start sleeping around, giving people AIDS." However, all 7 women explained the risk of AIDS from sexual relations as stemming from the mixing of

body fluids of multiple partners, not the transmission of a specific organism that may or may not be present in a particular individual. As one said, "If, say, you have four people you have sex with, they have different kinds of body fluids and different germs, so when they meet they cause AIDS." They did not seem to be aware that even a single act of unprotected intercourse can put a woman at risk if her partner is HIV positive, whereas intercourse with many HIV-negative partners will not cause HIV infection.

Finally, 8 women expressed other misunderstandings about HIV transmission. Four of these respondents plus 3 of the women who held traditional beliefs explicitly mentioned casual contact as a source of HIV infection. One respondent stated, "One gets AIDS from sexual intercourse [and you] can get it from toilet seats. Also, you can get it from the kitchen utensils." The other 4 knew that AIDS is spread through sexual contact and multiple partners, but they could not provide a detailed explanation of how AIDS could be contracted sexually.

It has been found that accurate knowledge of AIDS is related to educational level, but there are women with inaccurate knowledge at all levels of education. Of the 25 women who had at least a secondary school certificate, 23 had accurate AIDS knowledge. Half of the women who had some secondary school education had accurate AIDS knowledge. Among those still in school, all of the 9 university students and 3 of the 4 secondary school students had accurate knowledge. Of the 13 women who had a primary school education or less, only 5 had accurate knowledge. Two had inaccurate knowledge related to traditional beliefs, 4 had other types of incorrect knowledge, and 2 denied that AIDS was a problem. Age and other background factors did not relate to accuracy of knowledge.

Knowledge of Preventive Measures

The women had a high level of awareness of preventive measures. When asked how people can protect themselves from AIDS, 52 of the 56 women specifically mentioned condoms, 39 mentioned partner reduction or sticking to one partner, and 38 mentioned both condoms and partner reduction. One clerical worker who had a boyfriend replied, "They must stick to one partner. They must use a condom." Nine specifically mentioned abstinence. As one woman put it, "They are advised to abstain; condoms will not help."

Sixteen women pointed out that condoms can prevent AIDS only if they are used effectively. One woman stated, "If a condom cannot protect you 100% against pregnancy, it cannot protect you 100% from AIDS." Two women thought condoms cannot prevent AIDS because you could

get AIDS from casual contact and a condom is not able to prevent this. As one woman put it, "I personally don't believe it, because if a person breathes onto you when he has AIDS you will get it."

Only 6 women discussed other preventive measures, including the use of gloves when working with blood, the possible benefits of spermicide with condoms, or avoidance of sharing hypodermic needles and razor blades. One woman with a university education said, "Condoms if they don't burst. Gloves for people who handle AIDS patients. Making sure to use sterile needles." Two women cited not sharing toothbrushes. One married woman in her 30s said, "I would love to see people being allowed to go to the hospital before they decide to have a child to be tested to see if they have AIDS or not."

Barriers to Prevention

The women mentioned numerous barriers to making behavioral changes for themselves and others. One theme was the lack of urgency in Botswana regarding AIDS. As one woman put it, "People do not protect themselves at all because most of the people believe there is no such thing as AIDS." Sexual infidelity and the sexual double standard were mentioned as barriers to both partner reduction and condom use. One university student said, "We do not trust each other, so 'stick to one partner' doesn't work well." A woman with a boyfriend said, "Our problem in Botswana is that our men like keeping many women as partners." Several expressed concern about asking a regular partner to use condoms, saying, for example, "Since you think you trust your partner, it makes it difficult." Still others mentioned problems with using condoms, such as a lack of sensation; men's general dislike of condoms; or possible holes, leaks, or other problems. Some women said they fear men may deliberately subvert condom use. As one woman said, "I have to make sure . . . that they do not make holes in the condom."

Personal Risk of AIDS

About two thirds (39 of 56) of the women believed they could be at risk of contracting AIDS. Fifteen women said they were not at risk. Two said they did not know whether they were at risk, and one refused to answer. Of the women who thought they were at risk, 21 believed that although they could control their own behavior, they were at risk because of their partners' behavior. As a woman who lived with her partner put it, "I can stick to my boyfriend but he might not stick to me, so he can get AIDS from other girlfriends and I will also get it." A married woman whose husband worked in another city said, "I cannot say I can't get AIDS as I don't

think I trust my husband 100%." Concern about misplaced trust was also expressed.

Five women said they were at risk because it was hard for both men and women to practice monogamy. As a single university student put it, "I might be tempted and have another boyfriend who might have AIDS. My partner may also be tempted . . . and this is risky behavior which might result in our getting AIDS." Eight women who felt at risk stated that anyone could get AIDS. One woman pointed out, "The way it is said to be spreading, nobody is excluded." Only 4 women expressed concern about personal risk from non-sexual transmission, including casual contact and risk from work at the hospital.

Of the 15 women who believed they were not at risk, 7 said it was because they had only one sexual partner. Three of these women qualified their answer by mentioning that they could be at risk from their partner. As one said, "I can't get AIDS because I only have one partner, unless it's him who cheats on me." Two women practiced abstinence, although one expressed uncertainty about whether she might be at risk if she does have a boyfriend.

Changes in Personal Behavior

Thirty-three of the 56 women said they had made changes in their behavior to keep themselves from getting AIDS, and 23 said they had not made changes. However, the types of behaviors discussed turned out to be more important than whether they said they had changed. Of the women who had always had only one partner, some said they had not changed their sexual practices and others said they had, sometimes adding that this was not really a change.

Having only one sexual partner was the most frequent preventive action taken, mentioned by a total of 36 women. Twenty-six women who had made changes said that they had stuck to one partner since AIDS became known. As one married woman whose husband worked in a different town said, "Since I heard about AIDS I have changed my behavior. I used to have many secret partners, but now I have stopped." Four of the 26 women mentioned that they had had only one partner before concern about AIDS arose. Nine additional women said they had always had only one partner. As one woman put it, "I have not changed any behavior. I have been sticking to one partner all my life."

Only 11 women said they used condoms for AIDS prevention or would do so when they had a partner. Just 2 women explicitly mentioned both having only one partner and using condoms. As one woman currently without a partner said, "If I get a boyfriend I will use condoms. I have changed my behavior—I think having one partner is the right thing to

do. I also have to use a condom with that one partner." Five of the 11 women said they currently used condoms. Three women said they had been using them before AIDS became known (and had not changed), and 1 woman said that she had not changed her behavior because her partner always bought and used condoms. Two additional women currently without partners said they would use a condom with a new partner. Two women mentioned that they did not use condoms all the time (e.g., "I sometimes use a condom").

Only 2 women mentioned talking to their partner about the risk of AIDS. Said one, "I have one partner and I talk strongly with my husband concerning AIDS and his unnecessary movements." Two women claimed to be especially particular in choosing their sexual partners. Four women said they were abstaining from sex. One of these women made it clear that this was a deliberate choice. The others said they were between partners or had not yet had a partner.

A nurse stated that she took protective measures such as being careful of needle pricks while working in the hospital. Three women mentioned getting tested for HIV infection. One said, "I frequently go to the clinic to be checked over and give blood to be tested for HIV."

Accurate knowledge about AIDS transmission did not relate to the use of more effective protective behaviors. Of the 37 women with accurate knowledge, 5 were using condoms or practicing abstinence, 25 reported having only one partner, and 6 had made no change. Of the 19 women who had some inaccurate knowledge, 5 were currently using condoms or practicing abstinence, 10 were sticking to one partner, and 4 had not made any effective change. Although more women with accurate knowledge than women with inaccurate knowledge reported making behavior changes, most were relying solely on sticking to one partner, not the more effective means of condom use or abstinence. Neither did prevention behaviors relate to demographic factors.

DISCUSSION

Intensive mass media campaigns have succeeded in communicating AIDS prevention responses to most women in Botswana. The women in our study often repeated verbatim catchphrases such as "Stick to one partner." However, continued discussion often revealed a lack of understanding of the full meaning of these catchphrases. About a third of the 56 women interviewed had knowledge gaps regarding AIDS transmission. Less educated women were less informed. Because our purposive sample had proportionally fewer women with low education than the general population contains, the overall proportion of urban women with significant AIDS knowledge gaps is probably higher than one third.

The two most common misunderstandings we found among these women in Botswana need to be addressed in future programs. The first is 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 believe that transmission can occur through casual contact have little reason to make the changes in sexual behavior that would protect them against sexual transmission. Many women also lack an understanding of the mechanism of transmission during sexual intercourse. This misunderstanding may be reinforced by traditional beliefs about *boswagadi*.

These women also discussed a major AIDS prevention issue that women face that is not well addressed in current programs in Africa. Many women can implement monogamy for themselves, but they are not able to be confident about their partners' behaviors. This dilemma cannot be overcome simply by recommending continuous condom use, because many married women want to have children. Moreover, many of the issues related to partner trust can also act as barriers to condom use in committed relationships. Women need practical strategies to help them negotiate for safer sex and to evaluate whether and when they can rely on their partner to be trustworthy. Many women have a sense of despair and high anxiety about AIDS. Their inability to control their partner's sexual behaviors, misunderstanding about AIDS as an illness, and groundless fears of getting AIDS through casual contact all contribute to anxiety and hopelessness. Strong negative emotions can interfere with the ability to practice AIDS prevention.

The women we interviewed also suggested reasons for optimism regarding AIDS prevention. Urban women in Botswana have great concern about AIDS and a high level of trust in mass media messages, especially government-sponsored radio broadcasts about AIDS. It is also a good sign that so many women are aware that lack of trust is a barrier to AIDS prevention for them. Awareness of barriers is an essential prerequisite for overcoming them.

The findings from this study may be relevant for other African countries. Nearly all the surveys conducted in Africa have shown higher levels of incorrect beliefs about transmission through casual contact than understanding about sexual transmission. However, the degree to which the persisting beliefs that transmission can occur through casual contact poses a barrier to changing behaviors to reduce sexual transmission has not been widely recognized. Nicoll et al. (1993) argued that many incorrect beliefs about AIDS meet psychological needs, including providing a rationale for not changing behaviors that cannot be easily altered. The concerns about their lack of control over partner behavior raised by women in

Botswana are very similar to those raised by Ugandan women (McGrath et al., 1993).

That the women we interviewed displayed a high level of knowledge about sexual transmission of HIV infection does not mean that developers of prevention programs can safely ignore issues of knowledge. Simple surveys can give planners misleadingly optimistic assessments of people's knowledge, perhaps analogous to the student who can pass a short-answer quiz but cannot provide a full explanation of the subject when questioned further. Detailed and individualized instruction and discussion are needed to help women gain a better understanding of sexual transmission and to dispel fears of transmission through casual contact. Program developers need to address the negative emotions of anxiety and despair. Once these knowledge gaps are addressed, staff can help women work through the many complex issues, such as partner trust, that they must resolve to practice safer sex.

REFERENCES

- Abdool Karim, S. S. (1993). Traditional healers and AIDS prevention. *South African Medical Journal*, 83, 423-425.
- Adeyemi, M. B., & Tabulawa, R. (1993). AIDS and related issues—The views of junior secondary teachers in Botswana. *Educational Studies*, 19, 227-234.
- Asindi, A. A., Ibia, E. O., & Young, M. U. (1992). Acquired immunodeficiency syndrome—education exposure, knowledge and attitude of Nigerian adolescents in Calabar. *Annals of Tropical Paediatrics*, 12, 397-402.
- Bertrand, J. T., Brown, L. F., Kinzonzi, M., Mansilu, M., & Djunghu, B. (1992). AIDS knowledge in 3 sites in Bas-Zaire. *AIDS Education and Prevention*, 4, 251-266.
- Bertrand, J. T., Makani, B., Djunghu, B., & Niewembo, K. L. (1991a). Sexual behavior and condom use in 10 sites of Zaire. *Journal of Sex Research*, 28, 347-364.
- Bertrand, J. T., Makani, B., Hassig, S. E., Niewembo, K. L., Djunghu, B., Muanda, M., & Chirhamolekwa, C. (1991b). AIDS-related knowledge, sexual behavior, and condom use among men and women in Kinshasa, Zaire. *American Journal of Public Health*, 81, 53-58.
- Bwayo, J. J., Mutere, A. N., Omari, M. A., Kriess, J. K., Jaoko, W., Sekkade-Kigundu, C., & Plummer, F. A. (1991). Long distance truck drivers. 2: Knowledge and attitudes concerning sexually transmitted diseases and sexual behavior. *East African Medical Journal*, 68, 714-719.
- Caprara, A., Seri, D., De Gregorio, G. C., Parenzi, A., Salazar, C. M., & Goze, T. (1993). The perception of AIDS in the Bete and Baoule of the Ivory Coast. *Social Science and Medicine*, 36, 1220-1235.
- Garland, M., Maggwa, B. N., Mati, J. K., Kihoro, J., Mbugua, S., Achola, P., & Hunter, D. J. (1993). Knowledge of AIDS and other sexually transmitted diseases among women attending a family planning clinic in Nairobi, Kenya. *American Journal of Preventive Medicine*, 9, 1-5.
- Govender, V., Bhana, R., Pillay, A., Padayachee, G. N., & De Beer, M. (1992). Percep-

- tions and knowledge about AIDS among family planning clinic attenders in Johannesburg. *South African Medical Journal*, 81(18), 71-74.
- Gupta, G. R., & Weiss, E. (1993). Women's lives and sex: Implications for AIDS prevention. *Culture, Medicine and Psychiatry*, 17, 399-412.
- Ingstad, B. (1990). The cultural construction of AIDS and its consequences for prevention in Botswana. *Medical Anthropology Quarterly*, 4, 28-37.
- Konde-Lule, J. K., Musagara, M., & Musgrave, S. (1993). Focus group interviews about AIDS in Rakai district of Uganda. *Social Science and Medicine*, 37, 679-684.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Lindan, C., Allen, S., Carael, M., Nsengumuremyi, F., Van de Perre, P., & Serufilira, A. (1991). Knowledge, attitudes, and perceived risk of AIDS among urban Rwandan women: Relationship to HIV infection and behavior change. *AIDS*, 5, 993-1002.
- Lule, G. S., & Gruer, I. D. (1991). Sexual behavior and use of the condom among Ugandan students. *AIDS Care*, 3, 11-19.
- McGrath, J. W., Rwabukawli, C. B., Schumann, D. A., Pearson-Marks, J., Nakayiwa, S., Namande, B., Nakayobe, L., & Muksa, R. (1993). Anthropology and AIDS: The cultural context of sexual risk behavior among urban Baganda women in Kampala, Uganda. *Social Science and Medicine*, 36, 429-439.
- Ministry of Health. (1990). *Botswana Family Health Survey (BFHS-II)*. Gaborone, Botswana: Government Printer.
- Moyo, I. M., Low, A., Ray, C. S., Katsumbe, T. M., Chisvo, D., Mbengeranwa, O. L., & Gumbo, N. (1993). Knowledge and attitudes on AIDS relevant for the establishment of community care in the city of Harare. *Central African Journal of Medicine*, 39(3), 45-49.
- Ndeki, S. S., Klepp, K. I., & Mliga, G. R. (1994). Knowledge, perceived risk of AIDS and sexual behavior among primary school children in 2 areas of Tanzania. *Health Education Research*, 9, 133-138.
- Ndlovu, R. J., & Sihlangu, R. H. (1992). Preferred sources of information on AIDS among high school students from selected schools in Zimbabwe. *Journal of Advanced Nursing*, 17, 507-513.
- Neequaye, A. R., Neequaye, J. E., & Biggar, R. J. (1991). Factors that could influence the spread of AIDS in Ghana, West Africa: Knowledge of AIDS, sexual behavior, prostitution, and traditional medical practices. *Journal of Acquired Immune Deficiency Syndrome*, 4, 914-919.
- Nicoll, A., Laukamm-Joston, U., Mwizarubi, B., Mauala, C., Mkuye, M., Nyembela, G., & Grosskurth, H. (1993). Lay health beliefs concerning HIV and AIDS—a barrier for control programmes. *AIDS Care*, 5, 231-241.
- Norr, K. F., McElmurry, B. J., Moeti, M., & Tlou, S. D. (1992). AIDS prevention for women—a community-based approach. *Nursing Outlook*, 40, 250-256.
- Odebiyi, A. J. (1992, April). Conception of AIDS and its prevention among students in a Nigerian university. *Journal of the Royal Society of Health*, pp. 59-63.
- Rogstad, K. E., Tesfaledet, G., Abdullah, M. S., & Ahmedjushuf, I. H. (1993). Knowledge of HIV transmission and risk behavior in Kenyan health care workers. *International Journal of STD and AIDS*, 4, 200-203.
- Sicard, J. M., Kanon, S., Ouedraogo, L. A., & Chiron, J. P. (1992). Evaluation of sexual behavior and knowledge of AIDS among secondary school students in Burkina-Faso. *Annales de la Societe Belge de Medicine Tropicale*, 72, 63-72.

- Siedel, J., Kjolseth, R., & Seymour, E. (1988). *The ethnograph* [Computer program]. Corvallis, OR: Qualis Research Associates.
- Sindiga, I., & Lukhando, M. (1993). Kenyan university students' views on AIDS. *East African Medical Journal*, 70, 713-716.
- Update on the status of HIV/AIDS in Botswana. (1994, July 1). *The Guardian*, p. 1.
- Wilson, D., Dubley, I., Msimanga, S., & Lavelle, L. (1991). Psychosocial predictors of reported HIV-preventive behavior change among adults in Bulawayo, Zimbabwe. *Central African Journal of Medicine*, 37(7), 196-202.
- Yelib, S., Valenti, P., Volpe, C., Caprara, A., Dedy, S., & Tape, G. (1993). Sociocultural aspects of AIDS in an urban peripheral area of Abidjan (Cote-d'Ivoire). *AIDS Care*, 5, 187-197.



Embassy of the United States of America

Gaborone, Botswana
May 16, 2000

Ms. Sandra L. Thurman
Director
Office of National AIDS Policy
The White House
Washington, D.C. 20500

Dear Sandy:

I would like to express sincere appreciation for your participation in the U.S.-SADC Forum in Maputo.

Southern Africa, as you well know, has the highest HIV infection rates in the world. It therefore was very important for the forum participants -- a dozen SADC ministers and numerous senior officials -- to learn about the necessity of a multi-sectoral approach in combating the epidemic and about possibilities for U.S.-SADC cooperation on HIV/AIDS strategies. Your announcement that the President had signed an Executive Order for a new AIDS drug policy the previous day was a very helpful intervention. Drug policy is a subject that resonates in this region; I later was asked (by South African television) about the same issue at a post-Forum news conference in Gaborone and was able to quote from the White House announcement. We will be actively following up in the region on the HIV/AIDS items in the Forum communique by working through both the SADC Secretariat in Gaborone and the Health Sector Coordinating Unit in Pretoria.

Botswana and its neighbors are close to the epicenter of the HIV/AIDS epidemic, and I would like to repeat my suggestion that you make a trip through this region at some point during the year. We would be very pleased to arrange a series of high-profile meetings for you in Gaborone.

Thanks again for all of your efforts, and I hope to get a chance to see you again soon.

Sincerely,

A handwritten signature in black ink, appearing to read "John E. Lange".

John E. Lange
Ambassador
Special Representative to the
Southern African Development Community

Encl: US-SADC Forum communique

COMMUNIQUE

SECOND SADC-US FORUM MAPUTO, MOZAMBIQUE 11 MAY, 2000

1. The Second Southern African Development Community (SADC) – United States (U.S.) Forum was held in Maputo, Mozambique on May 10-11, 2000. The Forum was opened by His Excellency Joaquim Chissano, President of Mozambique and also Chairperson of SADC, who described the Forum as a shining example of partnership between the United States and SADC. President Chissano pointed out that the Forum should not be used only as a platform to review progress but to deepen dialogue and co-operation between SADC and the United States. He emphasized the importance of translating the objectives of the Forum into concrete actions that will enhance the welfare of the people of SADC and the United States.
2. In his introductory statement, Deputy Secretary of State Strobe Talbott, and the leader of the U.S. Delegation, reiterated the U.S. government's commitment to co-operate with SADC in particular and Africa in general. Deputy Secretary of State Talbott stressed the importance of progress in four key areas to be addressed: promoting SADC's regional economic integration, strengthening the region's ability to address security challenges, tackling the scourge of HIV/AIDS, and building the capacity to prepare for and manage disasters.
3. The forum was also attended by Ministers, Deputy Ministers, and senior officials from all fourteen SADC member states, senior officials from nine U.S. government agencies, representatives from the Association of SADC National Chambers of Commerce and Industry and from the newly formed U.S.-SADC Business Council.
4. The second SADC-U.S. Forum strengthened the foundation laid at the first Forum in deepening co-operation and broadening engagement between SADC and the United States. It addressed a broad range of political, social and economic issues of common interest.

Economic Working Group

5. The Forum discussed the multilateral trading system, Africa Growth and Opportunity Act, U.S./SADC Trade and Investment Framework Agreement and the role of the private sector. The Forum also discussed the ACP-EU post-Lome agreement and reviewed the state of regional integration in SADC.
6. The Forum reaffirmed the important role regional integration plays in attracting new investment and improving economic development. It applauded the entry into force of the SADC Trade Protocol in January, 2000 after very intensive negotiations which took into consideration the specificities of member states. The Forum also noted with satisfaction the preparatory activities that have been agreed upon to launch the implementation of the Trade Protocol on 1st September 2000. The United States reiterated its willingness to assist SADC in implementing its free trade area.
7. The U.S. delegation noted that its experiences with the North American Free Trade Agreement (NAFTA) have been "win-win" situations despite differing levels of development as is the case among SADC member states. The Forum recognized the importance of creating an environment to enhance the intra-regional trade, to attract investment and create new jobs and economic growth across southern Africa. To that effect, the United States agreed to extend financial support for a period of two years for the hiring of a regional trade expert by the SADC Secretariat and offered to provide technical assistance in areas such as rules of origin, product standards, customs harmonization and dispute settlement. The United States committed to fund seminars on WTO issues and will continue to assist with streamlining border crossing procedures. The United States also agreed to SADC's request to provide support to the technical working groups responsible for ensuring implementation of the Trade Protocol at the national level.
8. The Forum focused on the urgency of putting in place policies that attract both foreign and domestic investment needed to create employment opportunities and generate economic growth and prosperity. The Forum agreed that negotiation of a regional Trade and Investment Framework Agreement (TIFA) between the United States and SADC should be expedited.

The Forum agreed that upon completion of the TIFA, the first meeting of its Trade and Investment Council should explore other possible agreements to reduce trade barriers to U.S.-SADC commerce and resolve any trade disputes amicably.

9. The Forum recognized the need to embrace all stakeholders. To this effect, the Forum agreed that the SADC Secretariat and the United States should cooperate in arranging a meeting with private sector representatives to ensure the effective implementation of a SADC free trade area.
10. The United States expressed its deep appreciation of SADC countries' support for the Africa Growth and Opportunity Act, (AGOA). The Forum agreed that AGOA was a significant breakthrough in U.S.-African relations and that it provides the freest access to U.S. markets short of a free trade agreement. The bill will eliminate quotas on textiles and apparel for eligible sub-Saharan countries. The United States postulated that these trade preferences would be a strong incentive to new investment in the region. SADC expressed the wish for more information about the Act, particularly the eligibility requirements.
11. The Forum welcomed the successful conclusion of the new ACP-EU Partnership Agreement. On the request for a WTO waiver for the continuation of non-reciprocal trade preferences for African, Caribbean, and Pacific (ACP) countries in the post-Lome period, the United States agreed in principle to support the waiver.
12. On the next WTO round, SADC made a detailed presentation of its position. The United States emphasized the potential role biotechnology can play in ensuring food security in the SADC region and called for the rules governing trade in biotechnology to be based on sound scientific knowledge. The Forum called for the elimination of trade distorting agricultural export subsidies but recognized the need to take into account the specificities of each country, especially small, vulnerable and net food importing countries in the negotiations on agriculture. The Forum called for increased market access.

13. The Forum welcomed the constructive suggestions offered by the Association of SADC National Chambers of Commerce and Industry and the U.S.-SADC Business Council for enhancing both the further economic integration of SADC and the growth of trade and investment links between SADC and the United States. The two business groups agreed to maintain a dialogue among themselves on the issues raised at the Forum with a view to informing the United States and SADC governments of additional steps needed to improve the climate for increased trade and investment.

Political Roundtable

14. On the political front, the Forum considered the regional political situation, specifically in the Democratic Republic of Congo, Angola and Lesotho. The Roundtable touched on conflict resolution and management, the problem of refugees and small arms, democracy, good governance and the rule of law.
15. The Forum confirmed the need for political stability and security in Southern Africa as a prerequisite for economic growth and prosperity in the region.
16. On the DRC, the Forum expressed strong support for the efforts of SADC leaders, the OAU and the UN to support urgently implementation of the peace process agreed at Lusaka in July 1999. The Roundtable welcomed the parties' renewed commitment to the cease-fire agreement signed in April 2000. The Forum recognised the importance of launching the Inter-Congolese National Dialogue, and expressed its strong support for the facilitation of this dialogue by Sir Ketumile Masire. The Forum also recognized the importance of the Joint Military Commission (JMC) of the Lusaka peace process and called for support to the JMC for it to perform its function in order to allow for an orderly withdrawal of foreign troops from the DRC territory as specified in the Lusaka Ceasefire Agreement.
17. On Angola, the Forum agreed that the rebel forces under the command of Jonas Savimbi continue to constitute the principal obstacle to peace. It expressed strong support for the recent UN Security Council resolution on enforcement of UN sanctions

against UNITA and agreed on the need for strengthening mechanisms for the enforcement of sanctions. The Forum called upon the UN to speedily take follow-up actions emanating from the Fowler Report. The Forum pledged to do more to strengthen policing of trafficking in illicit diamonds, noting the importance of making a clear distinction between legitimately produced diamonds and illicit diamonds.

18. With regard to Lesotho, the Forum agreed on the need for a peaceful resolution to the constitutional crisis. It commended the Government of Lesotho for pursuing an inclusive political solution despite its clear mandate in the free and fair May 1998 elections and noted that elections will be held between April and May 2001.
19. The Forum recognized the importance of effective regional cooperation in dealing with regional conflicts and SADC described its regional defense and security structures. The United States outlined its experiences in other parts of the world with regional security arrangements. The United States stressed that its ability to assist effectively in regional conflict prevention, management and resolution depends to a great extent on the existence and effectiveness of regional organizations. SADC welcomed the U.S. offer to fund a seminar on conflict prevention and management in Cape Town at the Center for Conflict Resolution and to fund training in early-warning and conflict prevention by the Washington-based Fund for Peace. The Forum noted the approval of the African Center for Strategic Studies (ACSS) seminar to be held in Gaborone in July 2000.
20. On the refugee issue, the Forum agreed that refugees in Africa should receive the same support as refugees elsewhere and also stressed the importance of addressing the root causes of refugee movements in the region: armed conflicts. The U.S. noted that security and access are key prerequisites for providing refugees with support. The Forum also noted the ongoing U.S. contribution to the protection, care and maintenance of refugees in the SADC region. The United States expressed its willingness to make its migration program resources more accessible and relevant to SADC Member States.

21. SADC reported on its efforts to formulate and implement a regional conventional arms policy, including small arms. The United States urged the conclusion this year of the UN Protocol on Small Arms. The United States and SADC agreed to undertake annual working consultations on ways to address the problem of small arms and light weapons. SADC welcomed the U.S. offer to send technical assistance teams for exchanges of views on surplus weapons and excess stockpiles. The United States suggested to undertake a joint U.S.-SADC communiqué by foreign ministers on the margins of the 2000 United Nations General Assembly meeting which will address adherence to UN sanctions and restraint in the sale of conventional arms.
22. The Forum welcomed the SADC Region's continued consolidation of a culture of democracy, good governance and the rule of law. In particular, the Forum noted that Botswana, Malawi, Mozambique, Namibia and South Africa successfully held elections in 1999 and Zimbabwe held a constitutional referendum in February 2000. Continued assistance is needed, however, to improve election administration and processes.
23. The Forum noted that efforts are underway to uphold the rule of law by strengthening police and judicial structures and by adhering to national constitutions. In addition, watchdog institutions continue to be created to defend human rights.
24. The Forum observed that in terms of civil and political rights, freedom of the press must be upheld.
25. Consensus emerged that all coups are anathema. The Forum noted SADC's leadership role in the campaign to exclude the participation of governments that had come to power through military coups or unconstitutional means in OAU meetings and unequivocally confirmed support for this principle.
26. The Forum reaffirmed its acceptance of the Global Coalition for Africa's 25 Principles Against Corruption and noted that SADC Member States have established various institutions to combat corruption, including offices of ombudspersons and anti-corruption commissions. The Forum welcomed U.S. support for anti-corruption initiatives in the region.

27. The Forum welcomed Zimbabwe's frank and detailed historical overview of the land issue in that country. The U.S. Government affirmed the importance of land reform in Zimbabwe and reiterated its willingness in principle to provide technical assistance to help Zimbabwe to resolve this issue quickly and in a manner that is consistent with the principles agreed to at the September 1998 Land Reform Conference.
28. The Forum recognized the continuing threat to lives and economic development in SADC countries posed by land mines. The Forum commends the ongoing SADC initiatives, which, inter alia, focus on the ability of the affected member states to establish sustainable demining capabilities. SADC welcomed U.S. efforts in several member states to assist with mine awareness, detection and removal. The Forum welcomed the planned visit of a U.S. humanitarian demining assessment team later in 2000 to evaluate Zambia's land mine removal requirements. The United States agreed to strive to meet Mozambique's request for demining technology and to prioritize equipment needs.
29. The Forum agreed that crime, small arms and narcotics trafficking, and terrorism are all major threats in southern Africa and agreed that effective border controls are essential to combating these regional problems. SADC noted the bilateral efforts of the United States and Botswana, in consultation with SARPCCO, to establish an International Law Enforcement Academy (ILEA) in Botswana and recognized that it could make a major contribution toward fulfilling the training needs of SADC member state law enforcement agencies. The United States agreed to provide assistance to the SADC region for a border control project and training on combating small arms trafficking.
30. The Forum expressed its firm support for the completion by the end of 2000 of the Convention Against Transnational Organized Crime and its Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children. The United States and SADC also expressed support for the Protocol against Illicit Manufacturing of and Trafficking in Firearms, their Parts and Components and Ammunition as mandated by UN General Assembly Resolutions 53/11 and 53/114.

HIV/AIDS:

31. The Forum recognized HIV/AIDS as a threat to regional and international security as well as a major development challenge in the region. It focused particularly on the impact of HIV/AIDS on SADC, and highlighted the importance of pursuing multi-sectoral approaches to contain the spread of HIV/AIDS. SADC welcomed the U.S. announcement of the \$15 million "Project Storm Warning," a sub-regional development assistance program that focuses on combating HIV/AIDS transmission along major transportation corridors. The Forum reviewed the social, economic, political and security aspects of HIV/AIDS as well as the dual strategy, the elements of which are prevention and care for the affected. The United States announced formally the \$35 million Leadership and Investment in Fighting an Epidemic (LIFE) Initiative for southern Africa. SADC expressed concern at the high cost of HIV/AIDS drugs. They called upon the U.S. government to use its influence to make patenting laws more flexible for drugs to be manufactured cheaper within the region and to support research programs. The United States announced that President Clinton had signed an Executive Order on May 10 intended to help make AIDS-related drugs and medical technology more accessible and affordable in sub-Saharan Africa.

Regional Disaster Preparedness and Management:

32. The Forum expressed deep sadness at the terrible human and economic suffering, particularly in Mozambique, as a result of the recent natural flooding. It commended the response of SADC member states as well as of the United States and the international community to this disaster. The Forum reiterated the need to establish a mechanism for co-ordinated disaster preparedness and management in the SADC region. This mechanism would also be responsible for mobilizing resources that would be used to obviate the effects of disasters whenever they occur. To this effect, the U.S. government agreed to make an initial contribution of US\$200,000 to kickstart the development of a formal mechanism for disaster preparedness at the SADC Secretariat. Though floods were the latest disaster to befall the southern Africa region, the area is prone to other natural disasters. The Forum also discussed issues of regional water management and food security. It welcomed the

U.S. offer to assist in the strengthening of SADC and member states disaster management organizations, to provide technical assistance for enhancing the region's water management capabilities, and to help organize a regional disaster management seminar

Conclusion:

33. The Forum agreed to maintain the momentum gathered by the two Fora by making follow-ups to ensure that projects are implemented. To this end, the Forum recognized the importance of meeting annually at a mutually agreed time and place to pursue issues of mutual interest and importance to SADC and to the United States. It called upon the U.S. Special Representative to SADC and the Executive Secretary of SADC to convene meetings of the U.S.-SADC Forum Steering Committee made up of representatives from the United States, the SADC Secretariat, the SADC troika and other southern African institutions as appropriate to provide coordinated follow-up on actions agreed at the first and second SADC-US Fora. This Steering Committee will meet before the August 2000 SADC Summit and will be responsible for ensuring the execution of follow-on projects and for evaluating their effectiveness, as well as developing an agenda for the next Forum, which participants recommended be held in Washington, D.C., in the second half of 2001.
34. The Forum thanked the Government and the people of the Republic of Mozambique for their generous hospitality. It expressed appreciation for the excellent facilities made available that indeed contributed to the successful deliberations. The Forum also thanked ministers and their delegations from the SADC region, the SADC Secretariat for its tireless efforts, the U.S. Deputy Secretary of State and his delegation, the U.S. Special Representative to SADC, and representatives from the business communities for their invaluable commitment and contribution to the success of the Forum.

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

April 2000 VOL 6 NO 4

JOURNAL

OF THE INTERNATIONAL ASSOCIATION
OF PHYSICIANS IN AIDS CARE

AIDS in Botswana
David Hilmers

**Advice for travelers to the 13th
International Conference on AIDS**
*Nigar Kirmani and
William Powderly*

Global forum on bioethics



batling complacency
advancing commitment

Socio-Economic Data:

Total population (thousands), 1997	1,518	UNPOP
% of population urbanized, 1996	63	UNPOP
Annual population growth rate, 1980-95	3.3	UNPOP
Infant mortality rate (per 1,000 live births), 1996	40	UNICEF/UNPOP
Maternal mortality rate (per 100,000 births), 1990	250	WHO/UNICEF
Life expectancy, 1996	52	UNPOP
Adult literacy rate, 1995	M 81, F60	UNESCO
Per capita GNP (US\$), 1995	3,020	World Bank
Human Poverty Index Value (HPI)	22.9	UNDP

Status of the Epidemic:

Prevalence – Year	Trend
25.1 – 97	Growth, with most sites reporting over 30% prevalence.

National Response:**National AIDS Programme**

- The National AIDS Programme is under the Ministry of Health and designated as AIDS/STD Unit. Since December 1999, a National AIDS Coordinating Agency has been established under the President's office. A coordinator who will be at the level of Permanent Secretary will chair it.

Strategic Planning

- A Botswana HIV and AIDS Second Medium Term Plan (MTP II 1997-2000) has been developed to provide guidelines for all key players and stakeholders.
- An Operational plan for the period 1999-2000 has been extracted from MTP II 1997-2000.

Political Commitment

- A National AIDS Council has been established, which will be chaired by the President. The Vice President will be the Deputy Chairman.

Multisectoral Involvement

- A National AIDS Policy adopted in 1993 provides a guide and framework for a National Multisectoral response to the HIV/AIDS epidemic.
- The Private sector, NGOs, Religious organisations, and community based organisations are all actively involved.

UN Support:

UN Theme Group on HIV/AIDS:

Chair: WHO Representative

Members: UNDP, WHO, UNFPA, UNICEF

The Theme Group is very active. Chair rotates. As a good example of UN collaboration, UN Theme Group conducted joint programme review and joint planning with the Government.

Support from UN System Agencies for HIV/AIDS activities in 1998-99:

Organization	Amount US\$
UNAIDS	140,000
Total	140,000

BOTSWANA**07/01/00****Socio-Economic Data:**

Total population (thousands), 1997	1,518	UNPOP
% of population urbanized, 1996	63	UNPOP
Annual population growth rate, 1980-95	3.3	UNPOP
Infant mortality rate (per 1,000 live births), 1996	40	UNICEF/UNPOP
Maternal mortality rate (per 100,000 births), 1990	250	WHO/UNICEF
Life expectancy, 1996	52	UNPOP
Adult literacy rate, 1995	M 81, F60	UNESCO
Per capita GNP (US\$), 1995	3,020	World Bank
Human Poverty Index Value (HPI)	22.9	UNDP

Status of the Epidemic:

Prevalence – Year	Trend
25.1 – 97	Growth, with most sites reporting over 30% prevalence.

National Response:**National AIDS Programme**

- The National AIDS Programme is under the Ministry of Health and designated as AIDS/STD Unit. Since December 1999, a National AIDS Coordinating Agency has been established under the President's office. A coordinator who will be at the level of Permanent Secretary will chair it.

Strategic Planning

- A Botswana HIV and AIDS Second Medium Term Plan (MTP II 1997-2000) has been developed to provide guidelines for all key players and stakeholders.
- An Operational plan for the period 1999-2000 has been extracted from MTP II 1997-2000.

Political Commitment

- A National AIDS Council has been established, which will be chaired by the President. The Vice President will be the Deputy Chairman.

Multisectoral Involvement

- A National AIDS Policy adopted in 1993 provides a guide and framework for a National Multisectoral response to the HIV/AIDS epidemic.
- The Private sector, NGOs, Religious organisations, and community based organisations are all actively involved.

UN Support:

UN Theme Group on HIV/AIDS:

Chair: WHO Representative

Members: UNDP, WHO, UNFPA, UNICEF

The Theme Group is very active. Chair rotates. As a good example of UN collaboration, UN Theme Group conducted joint programme review and joint planning with the Government.

Support from UN System Agencies for HIV/AIDS activities in 1998-99:

Organization	Amount US\$
UNAIDS	140,000
Total	140,000

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
--------------------------	---------------	------	-------------

001. resume	John Lange (partial) (1 page)	nd	b(6)
-------------	-------------------------------	----	------

COLLECTION:

Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 21064

FOLDER TITLE:

Botswana

2007-1550-F
kc1251

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[0017]

Botswana

BIOGRAPHIC SUMMARY
(Highlights)

NAME: John E. Lange

POSITION FOR WHICH CONSIDERED: Ambassador to the Republic of Botswana

PRESENT POSITION: Deputy Chief of Mission, American Embassy, Dar es Salaam, Tanzania

FOREIGN SERVICE GRADE: Career Member of the Senior Foreign Service, Class of Counselor

LEGAL RESIDENCE: Wisconsin

OFFICE ADDRESS: American Embassy Dar es Salaam
Department of State
Washington, D.C. 20521-2140

DATE/PLACE OF BIRTH:

(b)(6)

HOME ADDRESS: Vienna, Virginia

MARITAL STATUS: Married

NAME OF SPOUSE: Alejandra Macias Lange

NAMES OF CHILDREN: Julia Alejandra Lange

EDUCATION: M.S., (distinguish graduate)
National War College, National Defense University, Washington, D.C., 1996
J.D., (cum laude) University of Wisconsin, Madison, Wisconsin, 1975
B.A., (with distinction), University of Wisconsin, Madison, Wisconsin, 1971

MILITARY SERVICE: None

FOREIGN LANGUAGES: French (good), Spanish (good)

WORK EXPERIENCE:
1997-Present
Deputy Chief of Mission, American Embassy, Dar es Salaam, Tanzania

1996-1997	Deputy Director, Office of East African Affairs, Bureau of African Affairs, Department of State
1995-1996	Student, National War College, National Defense University, Fort McNair, Washington, D.C.
1991-1995	Officer/Counselor, Refugee and Migration Affairs, U.S. Mission to International Organizations, Geneva, Switzerland
1989-1991	Administrative Officer, American Embassy, Lome, Togo
1988-1989	Special Assistant, Under Secretary for Management, Department of State
1987-1988	Management Analyst, Office of Management Operations, Department of State
1985-1986	Staff Assistant, Bureau of Inter-American Affairs, Department of State
1983-1985	Budget and Fiscal Officer, American Embassy, Paris, France
1981-1983	Consular Officer, American Embassy, Mexico City, Mexico
Mar 1981-Nov 1981	Junior Officer Training, Department of State
1976-1981	Deputy Vice President and Director of Field Development, United Nations Association of the USA, New York, New York
Mar 1976-Jun 1976	Attorney at Law, Delbert D. Smith Law Offices, Madison, Wisconsin

HONORS/AWARDS:

Department of State Distinguished Honor Award, 1999
Group Award for Heroism, American Embassy Dar es Salaam, 1998
Higgins Award for Excellence in Writing, National War College, 1996
Department of State Superior Honor Award, 1995 and 1986

PUBLICATIONS:

"Dar es Salaam: Confronting the Crisis," State Magazine, Department of State, Oct. 1998
"Civilian-Military Cooperation and Humanitarian Assistance: Lessons

from Rwanda," Parameters-US Army
War College Quarterly, summer
1998

"Conventional Wisdom," Foreign
Service Journal, American
Foreign Service Association,
June 1989

**ORGANIZATIONAL
AFFILIATIONS:**

State Bar of Wisconsin
American Society of International
Law
American Foreign Service
Association
United Nations Association of the
USA
National War College Alumni
Association
Wisconsin Alumni Association

January 1999