Impact of HIV/AIDS in Botswana and on the Education Workforce.

Professor B. Motshegwa
Department of Political and Administrative Studies
University of Botswana

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Background

Botswana is a landlocked country between the countries of South Africa, Zimbabwe, Zambia and Namibia. It is about the size of France and is sparsely populated with 1.7 million people. The majority of the country is desert - Kalahari Desert and has the famous Okavango Delta. The country is democratically ruled with a stable political environment. It is one of the fastest developing economies in Africa and the world's largest exporter of gemstone diamonds. It has always depended on the export of beef, which is the second GDP earner since independence in 1966. Botswana has achieved success in developing education, health, transport, social and economic infrastructure. These are now threatened by HIV/AIDS.

The HIV/AIDS pandemic knows no boundaries. The Education workforce of administrators, teachers and support staff are some of those that can be termed the educated. In a preface to his book, Hope (1999) alleges that "in contrast to other causes of excess adult mortality rates in Africa, Aids does not spare the elites". This assertion has been proven in most Sub-Saharan Africa (SSA) countries where a lot of the working communities have been seriously affected.

The HIV/AIDS scourge has rampaged Sub Sahara Africa like uncontrollable veld fires. The most hard hit has been in the working sectors of our economies who have traditionally been the breadwinners for their families and relatives. According to Hope (1999) the epidemic has created a major public health crisis across the continent. HIV/AIDS is believed to be the leading cause of mortality in the ages between fifteen and forty-five in countries of Botswana, Malawi Uganda and Mozambique (Cohen 2002, Bennell 2002 and Brown 1996). Botswana, with a population of 1, 677, 302 million people, is the worst affected of these countries and has a large number – 19, 976 of the female workforce in the education sector alone while 19,983 females work in other various Departments as at September 2000. (Republic of Botswana, Labour Statistics 2000, April 2002) This is a cause for concern as the majority of the workers affected are women.

This paper will discuss the impact of HIV/AIDS in Botswana with particular reference to the education sector. HIV/AIDS has been treated as a health problem at its inception and the individual departments involvements rather came at a later stage when the Ministry of health alone could not handle the situation.

The Botswana AIDS impact Survey 2001 noted with concern that "the advent of HIV and AIDS has started to reverse the gains previously achieved through an effective health care system. HIV/AIDS has become the main killer disease in the country and Botswana is reported to be one of the most hard hit countries in the world"

The status of HIV/AIDS in Southern Africa

According to the statistics compiled by Aids Analysis Africa quoted by Mullins (2001), the pandemic in Southern Africa is the worst in the world.

Southern Africa still has the worst regional HIV/AIDS pandemic in the world

Overview: HIV prevalence rates at the end of December 1999					
Country	**National population**	**Adults and children living with HIV/AIDS**	**Adult HIV prevalence %**	**Aids Orphans**	**Aids deaths**
Botswana	1 5692 000	290 000	35.8	66 0000	24 000
Swaziland	981 000	130 000	25.25	12 000	7 100
Zimbabwe	11 509 000	1 500 000	25.06	900 000	160 000
Lesotho	2 108 000	240 000	23.57	35 000	16 000
Zambia	8 974 000	870 000	19.95	650 000	99 000
South Africa	39 796 000	4 200 000	19.94	420 000	250 000
Namibia	1 689 000	160 000	19.94	67 000	18 000
Malawi	10 674 000	800 000	15.96	390 000	70 000
Mozambique	19 222 000	1 200 000	13.22	310 000	98 000

(Source: Mullins (2001) quoted from Aids Analysis Africa, Vol. 11(5) March /Feb 2001)

Globally there are 42 million people living with HIV/AIDS virus and 29.4 million of these are in Sub-Saharan Africa. It was estimated that new infections in 2002 were 5 million and 29.4 million were from Sub- Saharan Africa. The estimated number of the newly infected adults and children was 3.5 million in Sub-Sahara Africa and deaths were estimated at 2.4 million. (UNAIDS/WHO 2002). Sub-Sahara Africa has over 70% of the global population of people infected with HIV/AIDS. Twenty one (21) of the most affected countries are in Africa. This paints a gloomy picture to the development of Africa as a whole but mainly in Sub-Saharan Africa. The majority of the infected and dying with the disease are the economically active in our societies – educated.

HIV/AIDS in Botswana

According to statistics, Botswana is the hardest hit country in Sub-Saharan Africa by the HIV/AIDS pandemic with 258 000 (PLWA Regional Estimates, 2002) of its people infected by the disease. The 2003 figures indicates that there are 300 000 people living with the HIV/AIDS virus in the country. This calls for organisations and the business community at large to be prepared and have mechanisms of how to deal with this epidemic (Motshegwa, 2002). The country has been guided by the National AIDS Control Programme and an emergency short term plan that was followed by the Medium Term Plan (MTP 1) (1989-1995) and the Medium Term Plan (MTP 2) (1997-2002). The two main goals of the second medium term are to:

- reduce HIV/AIDS infection and transmission and to reduce the impact of HIV/AIDS at the macro-economic, social, household, community and personal level. The goal emphasizes treatment, prevention and supportive strategies to deal with the pandemic.
- emphasize among others, strategies to address low productivity, high absenteeism, high employment, benefits, high labour replacement benefits shortage of skills and opportunistic infection epidemics at work.

The goals are supported by the National Policy on AIDS that was adopted in 1993 and the National Vision 2016 adopted in 1997. Vision 2016 Task Force (1997) observed that even if infection can be halted, the HIV/AIDS "will be with us for many years to come. The task of mitigating the effects of AIDS related illness must be given utmost priority throughout the health and education systems, though support for affected households, and through initiatives in the work place". Vision 2016 urges all business, enterprises and government " to set up schemes to educate their employees about the dangers of HIV and to promote safe practices. Benefits schemes, insurance, pension and medical aid schemes in the work place must be improved so that those who are suffering from AIDS related illnesses can continue to work productively for as long as possible, so that families and dependants are adequately cared for". (Presidential Task Force Group, 1997)

In his speech on the occasion of a Dinner in honor of Bristol Meyer Squibb Pharmaceutical Company on the 6th October 1999, His Excellency, The President of Botswana, Mr. Festus Mogae commented about the situation in Botswana by saying:

> "*Closer home here in Botswana the HIV/AIDS virus is currently having a devastating impact felt. The observed deaths are alarming. This is a telling fact that the scourge is taking its toll on the population. It is evident that the impact of the disease has permeated all sectors of the economy.*

Economic performance has been negatively affected. Increases in labour costs are inevitable as a result of this morbidity and regular absenteeism. The quality of the workforce is bound to deteriorate.

The most affected are the able bodied, economically active and the educated young. There has been a huge investment in the education of this cohort who are dying before they become productive and before we, as society can reap the benefits of such an investment. The positive social *indicators which have hitherto been the pride of Botswana, which are a result of reputable development planning and prudent resource management are now being reversed."* *http://www.securethefuture.com/program/data/10069.html*

Regardless of the earlier sentiments raised by our Head of State, who advocated for action and who showed political will, commitment and leadership, government only came up with the Policy on HIV/AIDS on the Workplace in July 2001 which was to be the guideline for the whole public service. This does not indicate government institutions did not make efforts before that as most of them used the 1993 National AIDS Policy as their guideline.

Executive management and the employees in government departments should devise strategies that counter the impact of HIV/AIDS at work. It is regrettable that after almost 20 years of the first HIV/AIDS case reported in Botswana, most companies and organisations still do not have policies and strategies in place of how to counteract the impact that HIV/AIDS will have or already has on their organisations. Some organizations (Debswana, Bank of Botswana, Botswana Defence Force, Botswana Police and others) in Botswana though have done a commendable job in the fight against the scourge and some have taken bold steps in that direction as early as the late 1980's.

Impact of HIV/AIDS in Botswana

The demographic impact

By 1999 more than 240 000 people in Botswana had already lost their lives due to the HIV/AIDS pandemic. Aids is currently "erasing the decades of progress in life expectancy" according to UNAIDS fact Sheet. (Fact Sheet UNAIDS on global Impact of HIV/AIDS, July 2002 compiled by the US Embassy on Tokyo, Japan). The average life expectancy in Botswana has dramatically dropped from 67 years to 47 years. Infant mortality is projected to rise from 90 in 2000 to 98 in 2005. Crude birth rate are projected to fall by 22% in 2010 but this is said to fall by as much as 32% due to HIV/AIDS. The hardest hit are the children and young people between the ages of 15-49. Currently according to the national Aids

Coordinating Agency (NACA), it is estimated that 300 000 people in a population of 1, 677, 302 million (Population and housing census 2001) are living with HIV/AIDS. According to Tlou (2002) "about 20-50% of pregnant women in our cities, towns, and villages are HIV positive and have great chances of passing the infection to their children in utero, during birth and through breast feeding"

Devastating economic impact

It is projected that the country will have 32% less growth by the year 2021 and Government expenditure would have risen by 20%. The overall impact on the economy is due to loss of – skilled labour, training costs and re-employing workers. Most government institutions are now recording low productivity due to absenteeism from attending funerals, caring for others, illness during which additional workload on other staff or work simply isn't done. There have been some allegations that some offices in the rural areas had to be closed because people who staffed such offices were either sick or dead which means 'organizational memory' is lost. Temporary staff may need to be recruited and trained to keep organisations running and avoid loss of production. Lisk (2002) who studied the labour market and employment implications of HIV/AIDS observed that " the loss of workers and workdays due to AIDS – related illnesses or the demands of caring can results in significant declines in productivity, loss of earning , and attrition in skills and experience" Lisk also maintains that "the early loss of qualified employees in the public sector will result in a decline in the quality of the public services, and countries will find it hard to replace the highly trained public servants such as doctors and teachers who fall victim to HIV/AIDS".

The impact on the households

HIV/AIDS pushes households deeper into poverty as households lose their breadwinner, livelihoods are compromised and savings are consumed by the cost of health care and funerals. (Cohen 2001, Mullins 2002, Lisk 2002, Aventin and Huard 1997). There is pressure on the extended family system due to loss of income, increased health care expenditure, decreased agricultural production, increased dependency ratio - up to 4 additional persons requiring support in the poorest households. The current estimates of 65 000 orphans will increase by 2010. Death results in permanent loss of income, funeral and mourning expenses.

The fact that sick people cannot do most of their normal work, Mullins (2002) contends that " …these activities are either dropped, or taken by someone else. This leads to a burden of shift of activities, with even more taken by women and girls, in addition to normal duties." These sentiments are also echoed by Tlou (2002) who emphasizes that girl children have been most severely affected by

HIV/AIDS in their "families as they normally are the only ones left to care for the sick or raise orphaned siblings. Many had to drop out of school because of their new roles, for those who are able to stay on in school, their performance in class usually declines due to lack of time for studying". This situation is highly prevalent in Botswana and some is research needed in this area as it undermines the girl child's opportunities for their own development for the rest of their lives leading to potential delinquents or future prostitutes as a survival mechanism. Therefore, HIV/AIDS has a profound impact on growth and poverty.

The impact on the health sector

The health sector in Botswana has been put under a lot of strain. According to Cohen (2002), " Botswana has the highest recorded prevalence of HIV of any country with an estimated 36.5 per cent of the adults infected infection rate with an estimated". In 2000, the government of Botswana commissioned a report on the Impact of HIV/AIDS in the Health Sector. Some of the major conclusions were that HIV/AIDS "will create a massive need to be met by the health system but will also reduce the capacity of the health system to respond to this need". The demand for health care services is expanding and more health care personnel are being affected by HIV/AIDS. The health sector, like any sector in government, "was to experience the full force of the epidemic either in terms of infection levels among employees or AIDS cases and deaths". The health system cannot cope with the epidemic due to low capacity to provide services for which it has been established. It cannot adjust and/or even respond to current and future problems posed by HIV/AIDS. The costs to the health sector will dramatically increase and these include government contribution to private insurance, retirement and deaths benefits, housing benefits, car allowances/ loans and salary advances and medical costs.

Other stakeholders like trade unions and other organisations (civil society and private organisations) have not been mobilized in response to AIDS. There is also no consistent workplace programmes as noted above that "The public Service Code of Conduct on HIV/AIDS in the Workplace" came into effect in 2001. The capacity of the health sector has also been exacerbated by the brain-drain that occurred in the health sector in the late 1990's where most nursing staff left the health sector to go and work abroad where conditions and pay were better.

Overall quality of health care is reduced in that there is shortage of hospital beds and people have to be admitted only in the latter stages of the illness reducing their recovery chances.

HIV/AIDS in the Ministry of Education (MoE) – Botswana

The ministry of education started to address the epidemic in 1998 after the release of the Policy on HIV/AIDS Education. This does not, in any way suggest that no effort was undertaken by the Ministry before that as for most part ministries and departments depended on the 1993 National Policy in AIDS. The ministry policy referred to above, concentrated on curbing spread of the HIV/AIDS by addressing HIV/AIDS in its education programmes and at the work place. The policy guidelines are as follows:

1. HIV/AIDS education must be integrated into the curriculum and should be made compulsory at all levels of education:
   a) primary schools,
   b) secondary schools,
   c) teacher training institutions and all other tertiary institutions,
   d) non-formal education programmes.
   e) vocational education and training institutions
2. The content, methodology and strategies used to impart HIV/AIDS education should be adapted to the age and maturity of the students.
3. It is the responsibility of all staff involved in Education to participate in HIV/AIDS education since the disease has social, economic, scientific, demographic and moral implications. This staff includes education officers, principals and headmasters, teachers, lecturers and instructors in all subject areas and boarding staff.
4. In-service courses on HIV/AIDS education and strategies to disseminate this information should be developed and implemented by the Ministry of Education staff listed in paragraph 3.
5. An in-service curriculum and a plan for its implementation will be developed in consultation with the Ministry of Health, and in particular through its National AIDS Control Programme, and other concerned ministries and organisations with experience in this area.
6. Counselling for AIDS prevention and AIDS related social problems should be a component of the training programme for Guidance and Counselling teachers.
7. Schools, in co-operation with the local health authorities, should involve the Parents Teachers Association and the community in

AIDS education. There should be links between the school and the local community on this issue.

8. HIV/AIDS awareness programmes for all Ministry of Education employees with will be developed and implemented, in consultation with the National AIDS Control Programme.
9. Students, trainees, staff and all Ministry of Education employees with HIV/AIDS or from families with infected members should not be discriminated against and should remain in school/college for as long as their health permits, and should be referred for support and care to appropriate institutions as need arises.

(Source: Ministry of Education Policy on HIV/AIDS, 1998)

With this policy in place the MoE was in a better position to address HIV/AIDS both at the school level and in the workplace. In 2001, International Education in collaboration with The World Health Organization, organized a workshop on School health and HIV/AIDS and STI Prevention in Southern Africa whose objectives were to enable teacher trade union leaders, their constituency and teachers to:

- Acquire the skills they need to avoid HIV/STI, help other avoid infections, reduce related discriminations and confront stigma related to the HIV infection in the education system.
- Advocate implementation of effective HIV prevention programmes in unions, schools and communities.
- Implement interactive learning experiences to help young people acquire the skills they need to avoid HIV/STI and reduce related discrimination.
- Help schools focus resources on implementing four components of an effective school health programme as called for in FRESH: school health policies, skill-based health education, safer water and sanitation, as first steps in creating a healthy school environment, and school health services and
- Finalize the project proposals on school health and HIV/STI prevention in Southern Africa

This workshop was one of the initiatives to deal directly with the problem of HIV/AIDS with the involvement of the stakeholders. As already alluded to before, HIV/AIDS in Botswana at first was taken as a health problem until it was realized

that the infection rate was increasing and most governments departments were beginning to feel the impact of it.

The impact of HIV/AIDS on the Education workforce

The disastrous impact of HIV/AIDS on the education sector included but not exclusively limited to the following problems: illness and deaths, the use of resources, the absenteeism of teachers/ administrators, shortage of qualified teachers, labour stress, stress in the workplace and in decreasing the quality of education. Most of these problems relate to teachers as it has already been indicated that they are the majority not only in the Ministry of Education but also in government totaling 30 606 in a public service that had 83 662 employees by September 2000 (Government of Botswana, Labour Statistics 2000). Teacher mortality rates in Botswana according to Bennell (2003) were lower than the mortality rates of the semi-unskilled public sector workers in 2000. The media estimated that in 2002, 1 in 3 teachers were dying of HIV/AIDS virus but this is not well supported by research, which shows that in Botswana, where the prevalence is the highest in the world, only 0.5% of the teachers died in 2002. The number of teachers taking Anti-Retroviral drugs in Botswana increased from 62 in 1999 to 474 in April 2002 representing only 2% of the total in post. Mortality rates at the University of Botswana have been increasing over time among the academic and the junior support staff and the most affected of these two groups is the lower socio-economic group.

There is the contention that the country has lost many teachers in the primary education sector than in the secondary and the tertiary education sectors. This was confirmed by the Department of Vocational, Education and Training, HIV/AIDS Coordinator, who alluded the high prevalence in primary school teachers to the following: the fact that they are not assertive, the majority are young and sexually active, clinics where they could get things like condoms are far from their work stations, and that the majority are not empowered. He saw the impact of HIV/AIDS in the number of increased deaths, loss of skills, declining morale, low performance among ill employees, absenteeism, people falling ill, those on training extending their training due to illness and that the young women were the most affected. As a result of this, colleges' staff had to be reshuffled, temporary teachers employed, retraining of staff necessary, as

teachers are subject specialists and an increase in the recruitment costs. He however observed that the Ministry Head Quarters was giving HIV a low priority, as a result of managers believing that "HIV/AIDS was not their problem". This is rather a disturbing attitude shown by the education management in the midst of the high of HIV/AIDS prevalence in the country.

Many teachers are infected or affected, and some are taking care of children affected by AIDS as well as sick relatives resulting in emotional breakdown and burnout according to Tlou(2001).

Factors that contribute to the spread of HIV/AIDS in the education workforce.

Other factors that have been cited as putting the education employees at risk of infection by Coombe (2002) are: because of their relative affluence, mobility and status in the community (in rural areas many women from the same community would go out with one teacher), their expectations of sexual 'bonuses' in lieu of better conditions of services and circumstances that separate them from their families as the Botswana Government Transfer Policy requires employees to be transferred to any part of the country with out their spouses.

Collaboration efforts

Government is implementing the Teacher Capacity Programme (TCP), which is a partnership with African Comprehensive HIV and AIDS Partnership (ACHAP), the Botswana Government and the Government of Brazil. Through this project Botswana will have teachers who are knowledgeable, just, compassionate, caring and emphatic enough to participate in fighting the stigma and discrimination surrounding the epidemic and to ensuring sustainable solutions for the problem. The teachers will also be in a position to talk to students about sex and sexuality comfortably in the classroom.

Government of Botswana's response to HIV/AIDS

The government's response to HIV/AIDS started as early as 1993 when the National Aids Council was formed. This resulted in the formation of the National

AIDS Coordinating Agency (NACA) whose mandate is to coordinate the expanded multisectoral response through:

- Policy and programme development
- Coordination and support implementation of programmes by various stakeholders
- Monitoring and evaluation of the national response and
- Mobilization of resources for implementing the response with stakeholders.

Other efforts by government included response in the form of prevention, links, treatment, care and support .

Prevention

In this response government has aggressively embarked on information education and communication, condom distribution, prevention of mother to child transmission (MTCT), treatment of sexually transmitted disease and recently the vaccine trials.

Links

Links have been formed with voluntary counseling and testing centers like Tebelopele Voluntary and Counselling Centres. Other links are with the Total Community Mobilsation (TCM) organisations. The biggest problem with these efforts is that the majority of the counseling and testing centres and the total community mobilisation units are based either in cities, towns and big villages while the majority of people live in the rural areas and do not benefits on their services frequently. Tebelopele Counselling and Testing Centre is trying by all means to reach all people in the country in that they have mobile units that visit villages and offer their services there. Other organisations still need a lot of funds for them to be able to expand to rural areas.

Treatment, care and support.

This has been in the form prevention of TB, treatment of opportunistic infections, provision of antiretroviral therapy, community home based care, orphan care and support and the formation of People Living With HIV/AIDS (PLWHA) groups.

Botswana's Partners

The overall aim of partnership is to strengthen Botswana's response to the epidemic. Partners working with us include: public-private partnership, public-public partnership, multilateral partnerships and bilateral partnerships. These

partnerships are crucial for sustaining and ultimately winning the war against the epidemic.

1. African Comprehensive HIV/AIDS Partnerships (ACHAP)

ACHAP is collaboration between the government of Botswana, The Bill and Melinda Gates Foundation and the Merck Company Foundation/Merck and Co., Inc., to prevent ant treat HIV/AIDS in Botswana. The main objective of ACHAP, established in 2000, is to support governments effort to decrease the incidence of HIV and significantly increase the rate of diagnosis and the treatment of the disease, by rapidly advancing prevention programmes, healthcare access, patient management and treatment of HIV/AIDS. The partners have dedicated $100 million over 5 years towards the project. Merck & co., Inc., is also donating two anti-retroviral medicines for appropriate treatment programmes developed by the Government of Botswana for the duration of the initiative. The programmes supported by ACHAP include: The establishment Coping Centres for People Living With HIV/AIDS (COCEPWA), Support for the Botswana Christian AIDS Intervention Programme(BOCAIP), technical and monetary support of Masa, the governments national anti-retroviral (ARV) progamme and grants issued to small , community based programmes.

2. *Botswana-Harvard AIDS Institute Partnership (HAI) Collaborative activities*.

The Botswana-Harvard AIDS Institute Partnership include the following programmes Mashi: reduction of mother-to-infant transmission, Tshepho: treatment of HIV infected patients, Maiteko a Tshireletso: development and testing of vaccines and Kitso: Education for treatment, Research, and Prevention of HIV/AIDS.

3. Centres for Disease Control (CDC) and Prevention

Merck also helps Botswana improve health care infrastructure to facilitate HIV/AIDS treatment. Infectious Disease Control Centres have opened in Gaborone Maun, Serowe, Selebi-Phikwe, and Mahalapye and Francistown. The centers in Kasane and Molepolole are schedules to open before the end of 2003.

4. Secure the Future (Bristol Meyer Squibb)

The partnership gives support to the Botswana Reference Laboratory and to the centre for pediatric treatment. The also support the NGO's by funding different projects.

Conclusion

Botswana is a country besieged by the HIV/AIDS epidemic and all efforts must be geared towards the eradication of the disease. This calls for the stakeholders in the private sector, non-governmental organisations and the international community to join hands to fight the war against HIV/AIDS. The education sector like any sector of the economy in Botswana has been severely affected and preventive measures have to be vigorously put in place like HIV/AIDS education, distribution of condoms, counseling, caring and being empathic to the sick. (a caring nation according to our Vision 2016). The loss of employees in the public sector can cause some disturbances in the workflow, training, recruitment, costs to medication, pension and many more undesirable consequences. The already deficit government budget are overstressed by the advent of HIV/AIDS.

Funding is also critical to ensure that services reach all the intended beneficiaries instead of being accessible to people in towns and big villages. More testing centres are needed; more ARV drugs needed and also the distribution of condoms must be expanded beyond the existing parameters.

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