

Empowering older women in AIDS prevention: the case of Botswana

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Abstract

This article describes the preliminary results of a peer education programme for AIDS prevention and care among older women in Botswana. A culturally-sensitive programme was developed based on the findings of a qualitative study that revealed older women's knowledge and beliefs about HIV/AIDS. These findings indicated that older women have been marginalized by public-health messages on AIDS prevention, thus making them vulnerable to HIV infection. Through peer education, older women were empowered to prevent HIV infection to themselves, and within their families and communities. They also learnt about the care of people who have AIDS. The result of the peer education programme indicates that older women, as respected members of the community, are an important resource in HIV/AIDS prevention and control.

Introduction

AIDS is a global health problem that threatens the lives of millions of men, women and children as well as the economic and social development of whole regions. The United Nations (1996) estimates that as of July 1996, 27.9 million people worldwide have been infected with HIV since the beginning of the pandemic in the early 1980s. Of these, 19 million (65 %) are in sub-Saharan Africa (World Health Organization, 1993).

Over the last decade, AIDS has slowly spread south from its sub-Saharan epicentre in Uganda. The rate of infection is now very high in Zimbabwe, Zambia and Tanzania. In the past several years, there has been a rapid explosion of the infection in Botswana and South Africa, areas relatively free of AIDS only a few years ago.

The AIDS pandemic in Botswana

The Republic of Botswana, located in Southern Africa, has a population of 1.5 million. Since independence, Botswana has achieved a stable democratic government and substantial improvement in its economic level, and health and educational systems. The per capita income of US\$2 600 is one of the highest in sub-Saharan Africa (World Bank, 1993). Botswana has worked to implement a primary health-care delivery system, and approximately 90 % of the population now lives within walking distance (10 km) of a health facility. The overall mortality rate is now 9.7 per 1 000, life expectancy is 66 years, and the infant mortality rate has fallen from over 100 per 1 000 in 1971 to 32 in 1994 (Ministry of Finance and Development Planning, 1991). Botswana has made major

gains in economic growth, health and education since independence, but these gains are now seriously threatened by the AIDS epidemic.

The first case of AIDS in Botswana was diagnosed in 1985. Since this person was a non-citizen, the authorities seemed reluctant to accept the existence of HIV/AIDS and blamed it on foreigners and "immoral people." The general feeling was that "AIDS is a disease of homosexuals and it cannot be a problem since there are no homosexuals in Botswana" (MacDonald, 1996: 1325). In 1990, however, tests of blood donors found HIV seropositivity rates of 5-7 % among donors in urban areas and 1-2 % in the rural areas. (Ministry of Health, 1991). As in the remainder of sub-Saharan Africa, heterosexual transmission is the major route of AIDS infection.

Since 1990, HIV infection has spread rapidly in Botswana and has now reached alarming rates. In 1995 the Fourth HIV Sentinel Surveillance of 2 990 pregnant women in three urban and three rural areas found HIV prevalence rates of 19 - 39 %. In the same survey, between 12 and 50 % of men with sexually-transmitted diseases were found to be HIV positive, which reaffirms that Botswana is now one of the countries worst hit by HIV/AIDS in Africa. (Ministry of Health, 1995). Rural areas seem to have a lower prevalence than urban areas but the difference is small and narrowing. A pattern of frequent movement from the countryside to the city and back again, and from garden lands to cattle posts in rural areas, promotes rapid dissemination of the infection into rural areas. By 1997, if the epidemic continues at its present rate, a cumulative total of 155 000 persons will have HIV infection and over 27 000 persons will have AIDS. In a country of only 1.5 million persons, this poses an enormous economic and social burden (Wathne & Moeti, 1993).

AIDS and Botswana women

My interest in the role of older Botswana women in the prevention and control of HIV/AIDS arose out of the success of the Women and AIDS Prevention Project which had been carried out since 1992 and which had already reached more than 2 000 women of reproductive age (Norr, Tlou & McElmurry, 1993). Older women aged 50-60 years were chosen as a target group for the following reasons:

- (1) **They are sexual beings.** HIV can be acquired at any age and older people become infected in the same ways that younger people do. Contrary to the belief or stereotype that older people are not sexually active, a study of elderly people at village level in Botswana (Ingstad, Bruun, Tlou & Sandberg, 1992) found that 54 % of the

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elderly men and 30 % of the elderly women over age 60 were sexually active. Those women who claimed to be no longer sexually active gave reasons such as loss of interest or death of a spouse.

It would be erroneous to assume that older individuals who are sexually active are in long-term mutually monogamous relationships because quite often they are not. In fact one of the identified beliefs among the elderly villagers was the concept of *go itlhatswa madi*, i.e. "rejuvenating oneself by having sex with a younger person." Although most of the women claimed not to indulge in such sexual relationships, they nevertheless believed that some of their peers do so. Such practice could speed up the transmission of HIV from a higher-risk group (young adults) to a lower-risk group (older adults).

- (2) **They can be a great resource in HIV/AIDS prevention and control.** Women in Botswana, like women throughout the world, are a key to family and community health because of their vital roles as mothers, health-care providers and decision makers in the home and related areas. They are traditionally the custodians of health care in their communities. As mothers-in-law and grandmothers, they are the major decision makers and educators on matters pertaining to the health of the family. A survey of village primary-school and secondary-school youths' perceptions of older people revealed that the elderly are seen as an important source of advice and pertinent information on matters concerning proper manners and sexual behaviour (Tlou, 1994). It is also worth pointing out that most older women, including those in rural areas, belong to women's organizations such as the YWCA, Girl Guides, Emang Basadi and the Botswana Council of Women. These organizations are an important source for positive change in Botswana society and overall improvement in the quality of life.
- (3) **They are the major carers of people with AIDS.** As more people become ill as a result of HIV infection, the health-care delivery system is unable to cope with the provision of care to people with AIDS. In most urban hospitals in Botswana, about 30-50 % of the beds are occupied by patients with AIDS-related illnesses and the situation is getting worse. The Ministry of Health is in the process of integrating community-based AIDS care into the existing health-care system by training health-care workers, establishing a supervisory system and a referral network, and supporting families in the care of people with AIDS. What this means is that the major burden of care will be on middle-aged women and older women who, in most instances, have missed out in HIV/AIDS educational messages of "stick to one partner" and have limited knowledge about the provision of care in the home.

All these practical considerations pointed to a need for a special pilot programme on peer education for older women and for it to be implemented in a rural village. For logistical reasons a village was chosen that was close to the capital city of Gaborone.

Development of the intervention

The research leading to this intervention was a phase of the Women and AIDS Prevention Programme sponsored by the Botswana Ministry of Health and the European Union. The original project (1991-95) among childbearing-age women was sponsored by USAID and the US National Institute of Aging.

I conducted the initial qualitative interviews with older women to identify their knowledge, experiences and attitudes regarding HIV/AIDS. Twenty-four interviews were conducted in a Setswana language using a convenience sample of older persons in the area who agreed to participate. The interview guide included open-ended questions on knowledge and beliefs about AIDS, sex practices, and experience in caring for people with HIV/AIDS. The findings from these interviews were used to design and evaluate the intervention, i.e. peer education on HIV/AIDS.

Pre- and post-intervention surveys using a structured questionnaire were carried out to determine the effectiveness of the intervention. These questionnaires were self-administered in the case of literate older people, or administered by trained research assistants who participated in many similar in-depth interviews. Nurse-students and clinic staff participated as facilitators at the peer group sessions.

Knowledge and concern about AIDS

Although public-health campaigns have created a high level of concern in the general population about AIDS as a societal problem, older people seem to have been excluded. Studies (Norr, Tlou & Norr, 1993) show that over 90 % of the population is able to give correct answers about HIV/AIDS transmission and safer sex but a major problem is still the application of knowledge through responsible sexual behaviour. For older people, the in-depth interviews were very helpful in planning the intervention programme. Some of the findings that were unique to this group of older women were:

- Beliefs about AIDS were rooted in cultural perceptions of disease being a result of breaking taboos, in this case a breaking of sexual taboos relating to widowhood, or *boswagadi*.
- *Boswagadi* is a state of widowhood whereby after the death of a spouse, the remaining spouse has to undergo ritual cleansing and observe several taboos, the major one being sexual abstinence for a period of a year. The purpose of these rituals is to dissolve the physical and spiritual unity between the living and the dead spouse that was established at marriage and at subsequent births of children. At the end of a year, only a traditional doctor can perform the purification rituals and declare that the widow(er) can now live as a single person, i.e. have sexual relations, marry, etc. It is believed that failure to observe the rituals and abstinence can result in disease and ultimate death of the widow(er), or any person who has sex with him/her. The term *boswagadi* is also used to name the disease resulting from failure to observe the prescribed rituals.

All the older women believed that AIDS is not a new disease but an epidemic of *boswagadi* brought about by young "modern" people who refuse to observe the sexual taboos and end up spreading the disease whose symptoms are the same as those attributed to AIDS, i.e. loss of weight, diarrhoea, swollen limbs, multiple infections, etc.

Knowledge about AIDS among the older women was also limited because the information campaigns of the Ministry of Health had been based mainly on the use of visual (billboards, posters, bumper stickers) and auditory (radio, public lectures) media. The women most often cited the radio as their source of information on AIDS. Very few women mentioned newspapers or posters, which are mainly in English.

To determine the extent to which messages on posters and billboards reach older women, the women were all

- shown a popular message on a billboard which reads "Avoiding AIDS is as easy as A, B, C, ... Abstain, Be

faithful, Condomise." Only three women were able to explain in Setswana what the message was about. Some of the women were not even aware that this was a message on AIDS; and

- shown a bumpersticker which has a man and a woman smiling, standing side by side with an upright, waist-high smiling condom between them. The English text under the picture was "Condoms: a smart choice against AIDS." When asked to explain what the sticker was about only three older women were able to correctly explain the picture and the message. The others gave partially correct answers but half the women could only utter statements such as "I see a man, a woman and a child," "a man, a woman and a ghost," "a couple next to a covered tree stump [*sesana*]." None understood the message conveyed on the sticker.

This finding clearly showed that older men and women, most of whom (78 %) are literate in Setswana, have been marginalized when it comes to government messages on HIV/AIDS and the limited extent to which these messages might influence preventive or caring behaviour among older women. The intervention therefore had to be designed to include more detailed and individualized discussion of HIV/AIDS, including a clarification of myths and traditional perceptions about the disease.

The intervention

Based on the results of the qualitative interviews, a culturally-sensitive peer education intervention for AIDS prevention, care and control was developed for older women in Botswana. The intervention is currently being evaluated for effectiveness and possible utilization in other parts of the country, as part of a multisectoral strategy to reduce the impact of HIV/AIDS in Botswana.

Rationale

The choice of the peer education/support model used for the intervention was influenced by its known effectiveness in other countries and in intervention projects in which the researchers have been involved. At the core of the peer education model is the development of small groups for education and support led by trained group leaders from the community. Peer groups are effective interventions because they can provide information, support and social learning, and promote behavioural changes in group members. The group can begin to question prevailing norms and structures that support harmful behaviours and to develop new group norms supporting positive behavioural changes. Kelly and St Lawrence (1990) identify two strategies to alter AIDS-related behaviours as specially promising: redefining group norms to encourage behavioural changes to reduce HIV transmission; and helping individuals to acquire and use the behavioural skills and resources needed for risk education. The peer group provides an opportunity for both of these important changes to occur.

In the United States, peer groups and/or peer leaders have achieved positive behavioural changes for individual homosexual men and their communities (Kelly & St Lawrence, 1991, 1992) and for intravenous drug users in treatment (Magura, Siddiqui, Shapiro *et al.*, 1991). Forty-five peer education programmes for commercial sex workers in developing countries have had a positive impact, increasing condom use by as much as 81 % (Ferencic, Alexander, Slutkin & Lamptey, 1991). In a well controlled study, Magura *et al.* (1991) found that a peer-group intervention was more effective in promoting behavioural change than a didactic

learning session for persons in methadone treatment, although both interventions increased knowledge. The peer-group model is an effective strategy for AIDS prevention for women because it provides a context for overcoming cultural barriers and developing group norms supporting behavioural change (Norr, Tlou & McElmurry, 1993).

Aims and objectives

The major goals of the peer education/peer support intervention are twofold:

- (1) **To train older women as trainers of other older women.** The aim is to empower older women with knowledge about HIV/AIDS, communication skills, and knowledge about gender issues and HIV/AIDS, and to promote assertiveness in negotiating for safer sex with their partners. Older women discuss their rights as human beings, issues and practices within their culture that could predispose their age group to HIV/AIDS, their entitlements to healthy sexual life-styles, and how to speak up and say "no" to unsafe sexual practices.
- (2) **To train older women as community resources for younger women and people with HIV/AIDS.** The aim is to empower older women with knowledge about physical and psychological care of a person with HIV/AIDS, how and where to mobilize resources, e.g. where to seek help from a clinic nurse or a social worker on matters of social welfare, and to communicate with younger women and men such as sons and daughters-in-law, grandsons and granddaughters in matters relating to sexuality in the era of HIV/AIDS. This means re-educating family members and neighbours on gender issues, cultural practices, etc.

The objectives of the pilot intervention are that older women will:

- (a) Increase their knowledge and concern about HIV/AIDS for themselves and their offspring, including how AIDS is different from *boswagadi*, i.e. the latter can be cured but not the former.
- (b) Know the basic facts about HIV/AIDS transmission and how to prevent its spread through safer sex. Prevention of *boswagadi* is the same as that of HIV/AIDS.
- (c) Identify sociocultural factors in women's lives that increase their risk of contracting HIV/AIDS and other sexually-transmitted diseases (STDs).
- (d) Identify barriers to safer sex for women and strategies to overcome these barriers.
- (e) Develop a plan for personal safety from AIDS and other STDs.
- (f) Participate in at least one formal or informal activity to help prevent HIV/AIDS among younger men and women. These persons may be family members, friends, relatives or other community members.

Establishment of peer groups

A meeting of all older women in the village who were between the ages of 55 and 65 years and were not employed full time was called with the help of the clinic nurse and the Family Welfare Educator. The venue was the village clinic, which is centrally located. The turn-up was very good, mainly because the women had been told that the researchers would be giving feedback on the findings of the qualitative interviews which almost everyone knew about. Sixty-one of the expected hundred or so older women turned up.

The researcher, with the help and co-operation of the clinic staff and community health nurse-students, met the women, discussed the findings of the qualitative study, and explained the aims and objectives of the subsequent intervention. All the women were interested in participating in the intervention. They were asked to choose ten peer leaders, each of whose responsibility would be to later lead a support/education group of eight to 15 members at her home or a convenient location. It was emphasized that refreshments for group members and any training materials would be provided by the project. For easy communication, only those women who could read and write in Setswana were chosen as group leaders.

Peer-leader training

The training of peer leaders took three full days. The content covered was dictated by the objectives and a modified Setswana version of the "Women and AIDS" prevention project peer-education manual was used. The various teaching strategies that were employed included:

- (a) Group discussions.
- (b) Assertiveness training, using role play – especially on safer sex negotiation with an emphasis on communication skills.
- (c) Quizzes, and the use of pamphlets and pictures to later communicate with those who cannot read or write Setswana.
- (d) Demonstrations, e.g. a hands-on condom exercise for each participant using wooden dildoes and condoms.
- (e) Video shows to assist them with negotiation skills and to give them the real picture of AIDS. This was helpful as most of the participants have never seen someone with AIDS. A major limitation of the videos, however, is that they are all in English and thus call for participants who are literate in both Setswana and English. Some of the group leaders were only literate in Setswana and could only get partial messages. These leaders were later reluctant to show videos during their peer-group sessions at home but were helped by community nurse-students in related shows and discussions thereof.
- (f) Physical care of a person with HIV/AIDS, which emphasized observation of the universal precautions in caring.
- (g) Resources that are available in clinics and other agencies to help in caring for people with AIDS, e.g. the provision of gloves and supplementary foods.

Group training

The peer-leader training was carried out in February 1996. So far, due to limited funding and other commitments of the ploughing and harvesting seasons, only six of the ten peer leaders have completed a training session with their members and there are altogether sixty-seven such members with ages ranging from 48 to 62 years.

All the groups met at a group leader's home on a Saturday or Sunday afternoon, so as not to clash with funerals and church worship which are normally held in the morning. Most of the groups met every week and therefore took about two months to complete their discussion/learning activities, while others took up to three months.

The sessions themselves were designed to last for two hours, but all the groups have taken up to three and a half hours depending on the level of interest in a particular topic or activity.

The group leaders are supported by community nurse-students as part of their clinical nursing practicum. Two nurse-students were assigned to each group. Their major role was to help the group leaders to clarify some of the concepts, give the groups the stationery and materials needed, assist in showing and explaining the videos, attend some of the sessions, co-ordinate group reports and process recordings, and collect and process data. In short, the nurse-students were the actual support systems for group leaders, which was a learning experience for them in this unique aspect of community health nursing.

Evaluation and follow-up

The preliminary results indicate that the peer education model may be used to raise the awareness of older women regarding HIV/AIDS prevention for themselves, their families, and their communities. The evaluation used a baseline and a post-test for the intervention groups (N = 50), as well as details of post-group community activities aimed at HIV/AIDS prevention and care.

Knowledge about HIV/AIDS

A total of ten questions that have clear correct answers about AIDS transmission and safer sex were asked. The results suggest that there has been a general increase in knowledge as a result of the intervention. Specific items where the scores after the intervention were high include AIDS is caused by a germ, AIDS is not a traditional disease (*boswagadi*), AIDS cannot be cured, and AIDS cannot be transmitted through the use of public toilets, handshaking, sharing utensils or mosquito bites. Knowledge of STD symptoms also increased for the post-intervention groups.

When asked what behavioural changes would help to avoid contracting AIDS, the post-intervention groups mentioned more correct safer-sex practices. For example, the proportion mentioning condom use increased from 32 % at pre-intervention to 92 % after the intervention. Even the attitudes towards condoms became more positive. Initially, all the women were reluctant to learn about condom use because they perceived themselves to be less vulnerable to HIV infection and therefore "it would be a waste of time to know something we will not use." However, as the training sessions progressed more women became eager to learn for themselves and to teach younger male and female family members. All of them could correctly demonstrate the proper use and disposal of condoms.

Safer-sex practices for themselves

Of the fifty women interviewed, 26 (52 %) were married. The remainder were widowed (22 %), divorced (10 %) or never married (16 %). To determine the practice of safer sex, each woman was asked which of the following relationships she had: husband, live-in partner, regular boyfriend, casual boyfriend and "one-night stands." For each type of relationship the women were asked how often (always, sometimes, never) they had used condoms during the past two months. None of the women reported having casual boyfriends and "one-night stands." They all stated that "only the youth of nowadays have those type of relationships." It is interesting to note that 14 (28 %) women were celibate, most of them widows.

Initially very few women had ever used condoms, let alone talked to their partners about them. The peer-group intervention enabled more women (64 %) to discuss AIDS and its implications with their husbands, live-in partners and regular boyfriends. There was also an increase (38 %) in the number of women using condoms, but only with boyfriends and partners that one has reason to believe were "having affairs

with other women." The issue of trust in a relationship still prevents many women from negotiating the use of condoms.

Encouragement of safer sex for others

The participants in the intervention have also shown impressive increases in their promotion of safer sex for others, an important goal of the programme. The women were asked whether in the past three months they had talked about AIDS to other people, discussed six AIDS-related topics, and participated in any type of AIDS prevention activities. The women who had received the intervention were more likely than the pre-intervention groups to have talked to their partners, female relatives, daughter or son, co-workers and neighbours. For example, the proportion who had talked to a male or female relative increased from 12 to 70 %. Among all the relatives, the only category that no woman had talked to was the son-in-law. He, more than anyone else, seems to command a lot more reverence and respect and is seen to be almost infallible. As one older woman put it, "He is your daughter's guardian, how can you possibly talk to him about sexual matters?" One hopes that since these sons-in-law are sons elsewhere, their own mothers would talk to them.

Success, as perceived by the participants, has been regularly documented through personal interviews with some women, or the information that the women voluntarily give the programme implementors. Most of the women see the group sessions and involvement in the project as the only activity that is fully relaxing and enjoyable. An older woman captured it all when she stated that "the kinds of chores that we have to do can be very tiring and monotonous. It really helps if once a week you can meet other women just to relax, laugh, talk about sex and act silly. It brings back an aspect of the good old days when we had no aged parents and grandchildren to take care of."

Indeed, the high overall retention rate (80-90 %) indicates that most of the participants see the programme as being successful and want to be part of it for a long time to come. Even those who had to leave the sessions because of an engagement in weeding and harvesting grain have vowed to resume the sessions as soon as the harvesting season is over.

In addition, the women and their peer-group leaders have continued to engage in community activities after the completion of their sessions. They have initiated some AIDS prevention activities for their communities. For example, at *kgotla* (village meetings) some of the women have had the bravery to talk about AIDS in the community and what can be done to prevent it and to help care for people with AIDS. These talks have been well accepted even though the particular village meetings were on topics that had very little to do with HIV/AIDS.

Probable reasons for the success of the intervention are mostly due to intrinsic rather than observable or measurable factors. First, the participants chose their own group leaders. This gave them a feeling that they "own" the project and led them to make efforts to ensure its success. The participants also made their own decisions on the times, venues and refreshments to be served at their group sessions. For some women those are the only major decisions which they have ever made in their lives. The latter is especially true in the case of women without children, since infertile women are often stigmatized and their decision-making arena is limited – in contrast to older women who, as mothers-in-law and grandmothers, are major decision makers and educators regarding family health.

Second, the subject matter was interesting. These are people who have, at one time or the other, wanted to talk about aspects of their sexual lives but were somewhat inhibited by

their culture. An opportunity to talk about any aspect of sexuality with their peers was in itself a motivator. Indeed, all of their sessions took a lot more than the planned two hours and, even then, most participants felt that the time was still too short.

Lastly, the training gave the group leaders (and later the group members) referent power, which is power that derives from having more knowledge than others, or being expert at something. This referent power was demonstrated by most members as they volunteered to teach about HIV/AIDS to other people and other women's organizations, serve as members of village health committees, talk at *kgotla* meetings, and join the newly-formed Botswana chapter of the Society for Women and AIDS in Africa (SWAABO).

Problems encountered have been very few and are usually financial rather than personal or logistical. A minor problem has been attrition from groups due to other responsibilities such as ploughing and harvesting. Similar training in the future will have to take these seasons into account to avoid a conflict of interests. A major problem is financial. Although the intervention is very cheap and costs about US\$10 a woman, funding such an undertaking continues to be a problem because donors are prepared to fund only activities but not staff to co-ordinate such activities. This poses a problem of continuity and expansion from one village to other villages in the country. Donors are also reluctant to donate vehicles, so the problem of transportation will be a major obstacle to AIDS prevention among older women in other areas, including remote areas of Botswana.

Conclusion: the importance of empowerment of older women

Knowledge is power. The empowerment of older women through education, specifically peer education, is important for AIDS prevention. First, older women are able to apply the new knowledge to prevent their own infection with HIV/AIDS. This is an area that has been neglected because of an incorrect assumption that older people are not at risk of HIV/AIDS since they are not sexually active. Second, the more knowledgeable and empowered older women mobilize and support other women in AIDS prevention. Thus they are important health resources because they educate families, neighbours and communities in HIV/AIDS prevention and care. This is what empowerment is all about: women being empowered to empower others and to further develop their leadership skills in the community.

In this pilot project, one of the many lessons learned is that older women in Botswana do have strong motivation to prevent HIV/AIDS transmission for themselves, their families, and their communities, especially adolescents. When these older women are helped to become knowledgeable about HIV/AIDS and its prevention, when they learn how to discuss and negotiate with others and to support each other in their endeavours, they become effective leaders and decision makers in their families and communities. Thus AIDS prevention programmes led by older women can help to reduce the impact of HIV/AIDS on the nation of Botswana and at the same time empower the women in their daily lives.

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