

**THE IMPACT OF HIV/AIDS ON THE SOCIO-ECONOMIC
ENVIRONMENT IN BOTSWANA WITH SPECIAL REFERENCE TO
TOURISM**

BY

LISBON SIMEON KETSHABILE

201062046

**RESEARCH THESIS SUBMITTED IN FULFILMENT OF THE
REQUIREMENTS FOR**

THE

D Tech: Tourism and Hospitality Management

IN THE

FACULTY OF BUSINESS

AT THE

CAPE PENINSULA UNIVERSITY OF TECHNOLOGY

SUPERVISOR: PROFESSOR IW FERREIRA

CAPE TOWN

DATE: 06 SEPTEMBER 2010

CONTENTS	PAGE
Declaration.....	ii
Abstract.....	iii
Dedication.....	V
Acknowledgements.....	Vi
Abbreviations and acronyms.....	Vii

CHAPTER 1

THE IMPACT OF HIV/AIDS ON THE SOCIOECONOMIC ENVIRONMENT IN BOTSWANA WITH SPECIAL REFERENCE TO TOURISM

1.2 Introduction	1
1.2 Problem statement and sub-problems	1
1.2.1 Sub-problem 1.....	2
1.2.2 Sub-problem 2.....	2
1.2.3 Sub-problem 2.....	2
1.2.4 Sub-problem 2.....	3
1.3 Research objectives.....	3
1.4 Key questions.....	3
1.5 Delimitation of the research.....	4
1.6 Rationale and justification of the study	4
1.7 Research methodology.....	4
1.7.1 Questionnaire.....	4
1.7.2 Literature search.....	5
1.7.3 Normative criteria.....	6
1.7.4 Description of the research population.....	6
1.7.5 Statistical analysis.....	6
1.7.6 Interpretation of the findings.....	6
1.8 Clarification of concepts.....	7
1.9 Preliminary list of sources.....	7
1.10 The structure of the thesis.....	7
Figure 1.1: Report structure.....	8

CHAPTER 2

THEORETICAL FRAMEWORK

2.1 Introduction.....	9
2.2 Adopted theories.....	9
Figure 2.1: Theoretical framework.....	10
Figure 2.2: Conceptual framework.....	13
2.3 Summary.....	14

CHAPTER 3

LITERATURE REVIEW

3.1 Introduction.....	15
3.2 Operation of terms in the study.....	15
3.3 General background of Botswana.....	16
Figure 3.1: Map of Botswana.....	17

3.3.1 Brief history of Botswana.....	17
3.3.2 An overview of the economy of Botswana.....	18
3.3.3 A synopsis of the economy of Botswana.....	18
Figure 3.2: Botswana’s major economic sectors.....	20
3.3.4 The education system.....	20
3.3.5 The economic growth.....	22
Table 3.1: Economic growth indicators.....	25
3.3.6 Trade and international relations.....	27
3.3.7 Investment environment in Botswana.....	29
Table 3.2: Investment environment in Botswana.....	31
3.4 Tourist attractions in Botswana.....	33
3.4.1 Tourism policy in Botswana.....	39
3.4.2 The contribution of tourism to the economy of Botswana.....	43
Table 3.3: Employment in accommodation.....	44
Table 3.4: Direct contribution of tourism to Botswana economy.....	44
Table 3.5: Tourist arrivals and growth rate.....	45
Table 3.6: Tourists’ expenditure.....	45
Table 3.7: Types of tourists’ expenditure.....	46
Table 3.8: Tourists’ purpose of visit and length of stay.....	47
Table 3.9: Tourism statistics.....	48
Table 3.10: Top ten tourist generating countries.....	48
Table 3.11: Tourist arrival from African countries.....	49
Table 3.12: Tourist arrivals from America.....	50
Table 3.13: Tourist arrivals from East Asia and Pacific.....	51
Table 3.14: Tourist arrivals from Europe.....	52
Table 3.15: Tourist arrivals from Middle East.....	53
Table 3.16: Tourist arrivals from South Asia.....	54
Table 3.17: Tourism statistics.....	55
Table 3.18: Tourist expenditure in Botswana by country of origin.....	56
Table 3.19: Botswana estimates and forecasts.....	58
Table 3.20: Road travel costs of tourists.....	60
Table 3.21: The air travel costs of tourists.....	61
Table 3.22: Revenue by type of fees.....	62
3.4.3 Community tourism.....	65
Figure 3.3: Factors affecting resident reactions to tourism.....	71
Figure 3.4: Community tourism development planning model.....	73
3.4.4 Sustainable tourism development.....	76
Table 3.23: Ownership of accommodation facilities in the Okavango Delta.....	88
Table 3.24: Ownership structure by category as at October 2008.....	89
3.4.5 Pro-poor tourism.....	91
3.5 An overview of the HIV/AIDS situation in Botswana.....	99
3.5.1 The HIV/AIDS situation in Botswana.....	99
Table 3.25: Number of people receiving art by year reported by the Botswana Ministry of Health.....	103
Table 3.26: Number of adults in need of art, 2008 – 2016.....	104
Table 3.27: Number of orphans by type in 2007.....	105
3.5.2 An overview of HIV/AIDS orphans in Botswana.....	108
Table 3.28: Botswana’s child and orphan HIV/AIDS policies.....	110
3.5.3 The impact of HIV/AIDS on the Botswana tourism sector.....	112

3.5.4 The socio-economic impact of HIV/AIDS in Botswana.....	114
3.5.5 Impact of HIV/AIDS on the image of the Botswana tourism.....	115
3.5.6 The Botswana HIV/AIDS policy.....	116
Figure 3.5: Integrated Botswana HIV/AIDS national strategic framework.....	118
3.5.7 The Botswana tourism sector's response to the impact of HIV/AIDS.....	130
3.6 General overview of HIV/AIDS in Africa and in the rest of the world.....	132
3.6.1 An overview of global HIV/AIDS situation.....	132
Table 3.29: Global HIV/AIDS estimates, end of 2008.....	133
Graph 3.1: Global HIV/AIDS trends.....	134
Table 3.30: Regional statistics for HIV & AIDS, end of 2008.....	135
Table 3.31: Global summary of the aids epidemic December 2005.....	136
Table 3.32: Regional HIV and AIDS statistics and features, 2003 and 2005.....	137
Table 3.33: Regional HIV statistics and features for women, 2003 and 2005.....	139
3.6.2 An overview of HIV/AIDS situation in Africa.....	140
Table 3.34: Women and HIV/AIDS in Africa.....	141
Table 3.35: Percentage of total population living with HIV/AIDS.....	142
3.6.3 An overview of HIV/AIDS orphans in Africa.....	144
3.6.4 An overview of HIV/AIDS situation in southern Africa.....	147
Table 3.36: Percentage HIV prevalence per country in a given period.....	150
Graph 3.2: HIV/AIDS prevalence among adults aged 15-49 in 1997.....	151
Graph 3.3: HIV/AIDS prevalence among adults aged 15-49 in 1999.....	152
Graph 3.4: HIV/AIDS prevalence among adults aged 15-49 in 2001.....	153
Graph 3.5: HIV/AIDS prevalence among women attending antenatal clinics in 2005.....	154
Table 3.37: People living with HIV/AIDS in southern Africa as of end of 2005....	156
Table 3.38: Percentage of total population living with HIV/AIDS for global top ten countries.....	157
3.6.5 An overview of the HIV/AIDS situation in South Africa.....	158
Table 3.39: Overview of HIV/AIDS in South Africa.....	163
Table 3.40: Profile of government efforts to combat aids.....	167
3.6.6 An overview of the HIV/AIDS situation in Namibia.....	170
3.6.7 An overview of the HIV/AIDS situation in Zimbabwe.....	174
3.7 The general socio-economic impact of HIV/AIDS.....	178
Figure 3.6: Vicious circle of HIV/AIDS.....	183
3.7.1 The impact of HIV/AIDS on economic growth.....	184
3.8 The impact of HIV/AIDS on the tourism sector in general.....	189
3.8.1 The impact of HIV/AIDS on the savings and investment.....	196
3.8.2 The impact of HIV/AIDS on tourism workforce.....	199
Table 3.41: Classification of tourism workforce.....	204
3.8.3 The loss of skilled workers.....	204
3.8.4 Training and recruitment costs.....	207
3.8.5 Impact of HIV/AIDS on tourism customer base.....	209
3.9 Summary.....	211

CHAPTER 4

RESEARCH METHODOLOGY

4.1 Introduction.....	213
Figure 4.1: Research methodology.....	214
4.2 Research problem.....	214
4.3 Research objectives.....	215
4.4 Literature review.....	215
4.5 Research variables.....	215
Figure 4.2: Research variables.....	217
4.6 Types of research.....	219
Figure 4.3: Types of research.....	220
4.6.1 Sampling.....	224
4.6.2 Data collection procedure.....	225
4.6.3 Data analysis.....	226
4.7 Summary.....	226

CHAPTER 5

EMPIRICAL SURVEY AND ANALYSIS OF RESULTS

5.1 Introduction.....	227
5.2. Contribution to research methods.....	227
5.3 Research limitations.....	228
5.4 Empirical survey and analysis of results.....	230
5.5 Sampling methods.....	230
Table 5.1: Number of respondents from various types of tourism organisations.....	231
Table 5.2: Respondents position in the organisation.....	232
Table 5.3: Respondents' nationality and educational level.....	233
Table 5.4: Respondents genders and age.....	234
Table: 5.5: Company location and HIV policy.....	235
Table 5.6: Organisational type and ownership.....	236
5.6 Reliability test and analysis.....	236
Table 5.7: Reliability test on the scale of tourism and HIV/AIDS in Botswana in general.....	237
Table 5.8: Reliability on the scale of tourism managers' perception on how host communities perceive tourism development, its benefits and its possible influence on the spread of HIV/AIDS.....	238
Table 5.9: reliability on the scale of the possible impact of HIV/AIDS on tourism businesses in Botswana.....	239
5.7 Key findings.....	240
Table 5.10: The percentage response on the perception of the tourism managers on the possible impact of HIV/AIDS on the Botswana tourism sector.....	240

Table 5.11: the average response on the perception of the tourism managers on the possible impact of HIV/AIDS on the Botswana tourism sector.....	242
Table 5.12: Perception of tourism managers on how host communities Perceive tourism development, its benefits and its possible influence on the spread of HIV/AIDS.....	244
Table 5.13: Perception of tourism managers on how host communities Perceive tourism development, its benefits and its possible influence on the spread of HIV/AIDS.....	245
Table 5.14: The perception of the tourism managers on the possible impact of HIV/AIDS on the Botswana tourism businesses.....	247
Table 5.15: The perception of the tourism managers on the possible impact of HIV/AIDS on the Botswana tourism businesses.....	248
Table 5.16: Difference in perception of HIV/AIDS by company HIV/AIDS policy.....	250
Table 5.17: Difference in perception in the possible impact of HIV/AIDS on the Botswana tourism, community perception on tourism in relation to the spread of HIV/AIDS, and the impact of HIV/AIDS on tourism businesses based on company size.....	251
Table 5.18: Difference in perception in the possible impact of HIV/AIDS on individual tourism business between small and medium size companies.....	253
Table 5.19: Difference in perception in the possible impact of HIV/AIDS on individual tourism business between medium and large companies.....	254
Table 5.20: Difference in perception in the possible impact of HIV/AIDS on individual tourism business between small and large companies.....	254
Table 5.21: Differences in perception of HIV/AIDS by length of business operation.....	255
Table 5.22: Difference in perception of HIV/AIDS by company owner.....	256
Table 5.23: Difference in perception of HIV/AIDS by company location.....	257
5.8 Summary.....	258

CHAPTER 6

RESULTS DISCUSSION

6.1 Introduction.....	259
6.2 Possible implications	259
6.3 Summary.....	270

CHAPTER 7

CONSTRUCTION OF A NORMATIVE MODEL

7.1 Introduction.....	271
7.2 Existing models in the fight against HIV/AIDS.....	271
Table 7.1: South Africa's HIV/AIDS model.....	271
7.3 Botswana's HIV/AIDS model.....	272
Figure 7.1: Integrated Botswana HIV/AIDS national strategic framework.....	274
7.4 Identified gaps within the existing models.....	277
7.5 Proposed model.....	278

Figure 7.2: Proposed normative model as a strategic approach in fighting the spread of HIV/AIDS.....	281
Figure 7.3: Vicious cycle of HIV/AIDS.....	284
7.6 Proposed Model’s recommendations.....	286

CHAPTER 8

CONCLUSION.....	288
8.1 recommendations.....	289
8.2 Research implication and recommendation for management and Government.....	290
8.3 Future research and directions.....	291
Bibliography.....	294
Annexure A: Map of Botswana.....	313
Annexure B: Global HIV/AIDS statistics.....	314
Annexure C: Research questionnaire.....	323

DECLARATION

I, Lisbon Simeon Ketshabile, declare that the contents of this thesis represent my own work, and that the thesis has not previously been submitted for academic examination towards any qualification. Furthermore, the facts and conclusions herein are my own and not of any other individual.

Signature: _____ Date _____

ABSTRACT

Purpose: Botswana is one of the countries with the highest HIV/AIDS prevalence rate in the world. This research aims to investigate the impact of HIV/AIDS on the socio-economic environment in Botswana with special reference to the country's tourism sector. Tourism plays a vital role in the economy of Botswana. It creates employment, earns foreign exchange, markets Botswana internationally, attracts foreign investments and contributes to Gross Domestic Products (GDP).

Methodology: This report explains the HIV/AIDS situation and policy framework relative to the tourism sector in Botswana and in selected African countries through conducting an extensive literature review and empirical surveys. This is a quantitative research in which non-probability method is used to identify the respondents. Here tourism general managers are identified and asked to identify their subordinates who are available and willing to participate in the survey by answering a self-administered questionnaire.

Findings: This study indicates that HIV/AIDS threatens the Botswana tourism and the viability of the socio-economic factors. In general, the Southern African region is experiencing the highest rate of HIV infection in the world. The infection rate is particularly high among the young people (aged 15 – 49). This age group constitutes people who are economically active, and a number of them work directly or indirectly in the tourism sector. HIV/AIDS kills the economically active population – people who hold the skills, do the work, pay taxes, raise children, vote in the elections, and provide leadership. HIV/AIDS results in increased mortality and morbidity rates, and it also results in increased health expenditure. It also results in increased poverty level in the country.

Practical implications: When observing the prevalence and impact of HIV/AIDS not only in the tourism sector but in general, it becomes evident that the fight against the disease should be a collaborative approach involving various sectors including tourism. Relying only on government and health sector to address the complex and systematic impact of HIV/AIDS cannot effectively combat the disease and its prevalence rate.

Originality/value: This report analyses HIV/AIDS situation in Botswana in a creative way, contributing to the understanding of its impacts on the socio-economic environment as well as identifying strategies that can be used in addressing the impacts. This research is important for public policy makers, government officials, and tourism role-players to be aware of implications HIV/AIDS has on the socio-economic environment and take them into consideration in the policy formulation and implementation, business strategies and processes. It is also imperative to academics who would like to expand their knowledge on HIV/AIDS.

Keywords: HIV/AIDS, Impact, Prevalence rate, Tourism sector.

DEDICATION

I would like to dedicate this dissertation to my wife, with love and sincere gratitude for the support she has given me during the study.

ACKNOWLEDGEMENTS

I would like to thank:

- My supervisor, Professor IW Ferreira, for his guidance, encouragement and support.
- City of Cape Town Department of Tourism for the valuable information they provided.
- My wife, for her love and patience.
- The CPUT library workers for their assistance.
- Dr. Magogwe for editing this thesis.
- Dr. N. Makgosa for her guidance in statistical analysis.
- Mrs C. Uys for her guidance on research questionnaire formulation and recommendations on the suitable statically analysis.
- The Office of Research and Development (ORD) in the University of Botswana for sponsoring this research.
- The Botswana's Ministry of Wildlife and Tourism for issuing a research permit for the study.
- Professor J. Saarinen for proof reading this report and comments he made.

ABBREVIATIONS AND ACRONYMS

AIDS: Acquired Immunodeficiency Syndrome.

ANC: Antenatal Clinics.

ART: Anti-Retroviral Treatment.

ARV: Antiretroviral.

ASSA: Actuarial Society of South Africa.

ATIC: AIDS Training and Information Centre.

BCI: Behavioural Change Interventions.

BEDIA: Botswana Export Development and Investment Authority.

BHRIMS: Botswana HIV/AIDS Response Information Management System.

BOCAIP: Botswana Christian AIDS Intervention Programme.

BOTUSA: Botswana-United States of America.

CAMPFIRE: Communal Areas Management Programmes for Indigenous Resources.

CITIES: Convention on International Trade in Endangered Species.

CSO: Central Statistics Office.

DMSAC: District Multi-Sectoral AIDS Committee.

DOH: Department of Health.

EA: Environmental Assessment.

GDP: Gross Domestic Products.

HAART: Highly Active Retroviral Therapy.

HATAB: Hospitality and Tourist Association of Botswana.

HIV: Human Immunodeficiency Virus.

HSRC: Human Science Research Council.

IEM: Integrated Environmental Management.

IDASA: Institute for Democracy in South Africa.

ILO: International Labour Organisation.

IMC: Inter-Ministerial Committee.

IPT: Isoniazid Prevention Therapy.

ITTT: Interim Tourism Task Team.

LAC: Legal Assistance Centre.

MEC: Members of the Executive Council.

NAC: National AIDS Council.

NACA: National AIDS Co-ordinating Agency.

NACOBTA: Namibia's Community-Based Tourism Association.

NACOSA: National AIDS Co-ordinating Committee of South Africa.

NAFT: National AIDS Trust Funds.

NEPAD: New Partnership for Africa's Development.

N.D.: Not Dated.

NGO: Non-governmental Organisations.

PAC: Provincial AIDS Council.

PLWA: People Living with AIDS.

PMTCT: Prevention of Mother-to-Child Transmission.

SATOUR: South African Tourism.

STD: Sexually Transmitted Diseases.

TAC: Treatment Action Campaign.

THETA: Tourism, Hospitality and Sport Education and Training Authority.

UNDP: United Nations Development Programmes.

UNICEF: United Nations International Children Funds.

US: United States.

VCT: Voluntary Counselling and Testing.

ZTA: Zimbabwean Tourism Authority.

ZTE: Zimbabwean Tourism Expo.

THE IMPACT OF HIV/AIDS ON THE SOCIOECONOMIC ENVIRONMENT IN BOTSWANA WITH SPECIAL REFERENCE TO TOURISM

CHAPTER 1

1.1 INTRODUCTION

Most research about HIV/AIDS in Botswana and in a number of Southern African countries is commissioned by governments and NGOs. It concentrates on social implication of HIV/AIDS such as death rate, poverty, mortality rates and morbidity. The research also focused on national issues such as GDP and economic development. Little research has been done on the impact of HIV/AIDS on businesses. This research therefore, contributes knowledge about the economic impact of HIV/AIDS on tourism. Specifically this study discusses the impact of HIV/AIDS on tourism sectors in Botswana and it recommends ways of addressing this problem. Based on a preliminary assessment of the impact, constraints and opportunities, the research explores the policy and programme elements of Government and tourism sector's response to the tragedy.

This research is based on three key objectives: Investigating the possible impact of HIV/AIDS on the Botswana tourism sector in general; the perception of tourism managers on how host communities perceive tourism development, its benefits and its possible influence on the spread of HIV/AIDS in their locations; and the possible impact of HIV/AIDS on the individual tourism businesses in Botswana.

1.2 PROBLEM STATEMENT AND SUB-PROBLEMS

HIV/AIDS negatively affects the Botswana's economic sectors including the country's tourism industry (Botswana's Ministry of Health, 2008: 24).

1.2.1 SUB-PROBLEM 1

According to the United Nations (2005: 21), Southern Africa is generally experiencing the highest rate of HIV infection in the world. The infection rate is particularly high among people aged between 15 and 49. This age group constitutes economically active people and a number of them work directly or indirectly in tourism sector. Sub-Saharan Africa is affected by the HIV/AIDS pandemic more than other parts of the world and a large number of people die from AIDS. Southern Africa consists of Botswana, South Africa, Namibia, Zambia, Angola, Zimbabwe, Mozambique, Lesotho, Swaziland, Malawi, Madagascar and Mauritius.

Ramsey, Hazoume and Chetty (2002: 2) indicate that the average life expectancy in many countries in the Sub-Saharan region has dropped from 62 years to 47 years due to HIV/AIDS. The average life expectancy is below 40 years in many countries with the highest HIV prevalence rate being in Botswana, Malawi, Mozambique and Swaziland (Ramsey *et al.*, 2002: 3).

1.2.2 SUB-PROBLEM 2

UNAIDS (2006: 17) indicates that reduced labour force and low productivity of Southern African countries has reduced government and private sector revenues including those in the tourism sector. In Botswana in particular, HIV/AIDS is reported to be high in areas in which tourism activities are taking place such as Kasane and Maun. The UNAIDS further indicates that a number of the Southern African countries spend between 20% and 90% of their health budgets fighting HIV/AIDS.

1.2.3 SUB-PROBLEM 3

The Botswana's Ministry of Health (2000:28) states that Botswana is confronted with many risks associated with the spread of HIV/AIDS. These include the migration of wage workers, alcohol abuse, deteriorating traditional family structures, denial and ignorance. Other risks include family and communal disruptions or transfers, poverty, low status of women, high proportion of single parents and early parentage. The average age of first sexual encounters in Botswana is 17 years, and this is linked to poverty and unemployment. Poverty and unemployment influence population migration of tourists and/or wage-workers both from neighbouring countries and of people from

other sectors within the country itself. According to the Botswana's Ministry of Health (2000), HIV/AIDS is also increased by a high rate of alcohol consumption and abuse among the young people in Botswana and in a number of Southern African countries. Alcohol abuse increases the chances of engaging in unprotected sex among the young people in Botswana.

1.2.4 SUB-PROBLEM 4

Medupe and Collins (2004: 2) indicate that Botswana has one of the highest HIV/AIDS rates in the world, and that 34% of the country's adult population is infected with HIV. In 2001, 50% of the natural deaths in Botswana were linked to AIDS.

1.3 RESEARCH OBJECTIVES

The main objectives of this research are:

- To investigate the possible impact of HIV/AIDS on Botswana tourism .
- To investigate the influence of tourism on the spread of HIV/AIDS.
- To investigate the impact of HIV/AIDS on individual tourism businesses in Botswana.
- To make necessary strategic recommendations on what can further be done to fight HIV/AIDS in the Botswana's tourism sector.
- To construct a normative model that can be used to minimise the spread of HIV/AIDS in Botswana and other African countries.

1.4 KEY QUESTIONS

- i. What is the impact of HIV/AIDS on the Botswana tourism?
- ii. How does tourism influence the spread of HIV/AIDS in communities in which tourism activities are taking place in Botswana?
- iii. What is the impact of HIV/AIDS on the tourism businesses in Botswana?
- iv. What do the Botswana tourism sector and government do about the HIV/AIDS dilemma and what are the chances of success?

1.5 DELIMITATION OF THE RESEARCH

Kaynak and Marandu (2006: 228) indicate that Botswana's tourism is predominantly located in the northwestern part. Wildlife is the main tourist attraction in Botswana and is concentrated in the Okavango Delta, which is the largest inland delta in the world. Tourism in Botswana is also concentrated in the Chobe-Kasane National Park, where Africa's big five wild animals (elephant, lion, buffalo, leopard, and rhino) are found in large numbers.

Data for this study was collected from the tourism companies in Okavango-Maun and Chobe-Kasane areas. Chobe and Maun are the major tourist destinations in Botswana and most of the tourism companies in the country are located in these areas.

1.6 RATIONALE AND JUSTIFICATION OF THE STUDY

This research contributes to the knowledge on the impact of HIV/AIDS on the tourism in Botswana. Most of the researches that have been conducted in Botswana generally focus on the impact of HIV/AIDS on the economy, but not specifically on the tourism sector. Most HIV/AIDS related researches in Botswana focus on agriculture, education and mining. No studies have been conducted on the impact of HIV/AIDS on the Botswana tourism sector. This research contributes to the understanding of the implications of HIV/AIDS on the Botswana tourism sector and recommends strategies that can be applied to address the problem. The research contributes to the knowledge that the impact of HIV/AIDS vary according to company size and length of business operation. This research is useful for tourism entrepreneurs, tourism policy makers, decision makers and tourism leaders, government officials within the tourism sector and the general communities.

1.7 RESEARCH METHODOLOGY

To achieve the aims of this study, a literature review and empirical surveys were conducted.

1.7.1 QUESTIONNAIRE

A questionnaire drafted by the researcher, supervisor and a registered statistician was used to collect data. The questionnaire was piloted before it could be used in the final research. The

questionnaire questions required the respondents to tick suitable answers using the Likert scale. The respondents chose between ‘Strongly Agree’, ‘Agree’, ‘Neutral’, ‘Disagree’ and ‘Strongly Disagree’ and according to a given statement.

The empirical survey was used to find out how much the tourism companies know about the socio-economic impact of HIV/AIDS in Botswana. The survey was also carried out to assess the level of awareness of the HIV/AIDS situation in Botswana in general, and to find out what is being done by both the Botswana tourism companies and government to curb the HIV/AIDS problems in the tourism sector. Non-probability sampling was used to select subjects for this study. As already indicated, the survey was conducted on the tourism businesses within Kasane and Maun, the major tourism destinations in Botswana. Kasane and Maun also have the highest HIV/AIDS prevalence rate in the Botswana (ACHAP, NACA & UNAIDS, 2008:13), hence the need to conduct such kind of research in these places. Tourism managers in Maun and Kasane were interviewed because they were expected to understand the implications of HIV/AIDS on their business. The general managers were approached and were asked to identify their subordinates in managerial positions.

1.7.2 LITERATURE SEARCH

The literature review was carried out to assess and describe the kind of studies that have been conducted on the impact of HIV/AIDS on tourism. The literature review was also done to evaluate the relationship between identified variables (diagnostic), and to identify strategic gaps that need special attention in combating HIV/AIDS in general. Relevant books were searched as well as journal articles, academic papers, official reports, government policies, such as legislation and subordinate legislation, minutes of meetings, official publications and other policy documents, newspaper articles, unpublished research and other applicable published and unpublished material related to both HIV/AIDS and tourism.

The literature indicates that HIV/AIDS negatively affects the Botswana’s tourism and other major economic sectors such as mining. AIDS deaths directly reduce the number of experienced workers including those in the tourism sector. Experienced workers are difficult to replace, and as a result the quality of service in a number of tourism companies in Botswana drops. The less experienced workers do not have necessary experience (Botswana’s Ministry of Wildlife &

Tourism, 2008: 65).

1.7.3 NORMATIVE CRITERIA

In constructing a normative model, the Botswana models and examples of successful models used by various countries have been extracted. These models were evaluated in relation to the research problem and were comprehensively analysed. These models are used in this research as guidelines for constructing a model that can be used to reduce the spread of HIV/AIDS in Botswana.

1.7.4 DESCRIPTION OF THE RESEARCH POPULATION

The research population in this study is divided into the following three categories: The total research population, which included people working in the Botswana tourism sector in Okavango/Maun and Chobe/Kasane areas; the target population, which included tourism managers and people working in senior positions in Kasane and Maun; and the total response population, which included 80 tourism managers in 18 tourism establishments in Kasane. However, only 71 of these responded.

1.7.5 STATISTICAL ANALYSIS

The researcher, the supervisor and a registered statistician determined the appropriate response percentage from the empirical data and transferred those values in a codified form to a computer database. The data was analysed and interpreted using various statistical methods and analytical measures such as Analysis Of Variance (ANOVA) and T-test.

1.7.6 INTERPRETATION OF THE FINDINGS

Empirical data has been analysed and interpreted using different analytical instruments such as tables, charts, and figures.

1.8 CLARIFICATION OF CONCEPTS

All concepts and items used such as abbreviations are clarified in a separate section in this report.

1.9 PRELIMINARY LIST OF SOURCES

The bibliography indicating literature reviewed is attached at the end of the final report.

1.10 THE STRUCTURE OF THE THESIS

The main sections of this report include the brief geography of Botswana, brief history of Botswana, problem statement and sub-problems, key questions, research objectives, delimitation of the research, research design/methodology, literature search, empirical survey, description of the research population, total possible research population, the target population, response, statistical analysis, construction of normative model, clarification of concepts and summary. See Figure 1.1 for a summary of this report.

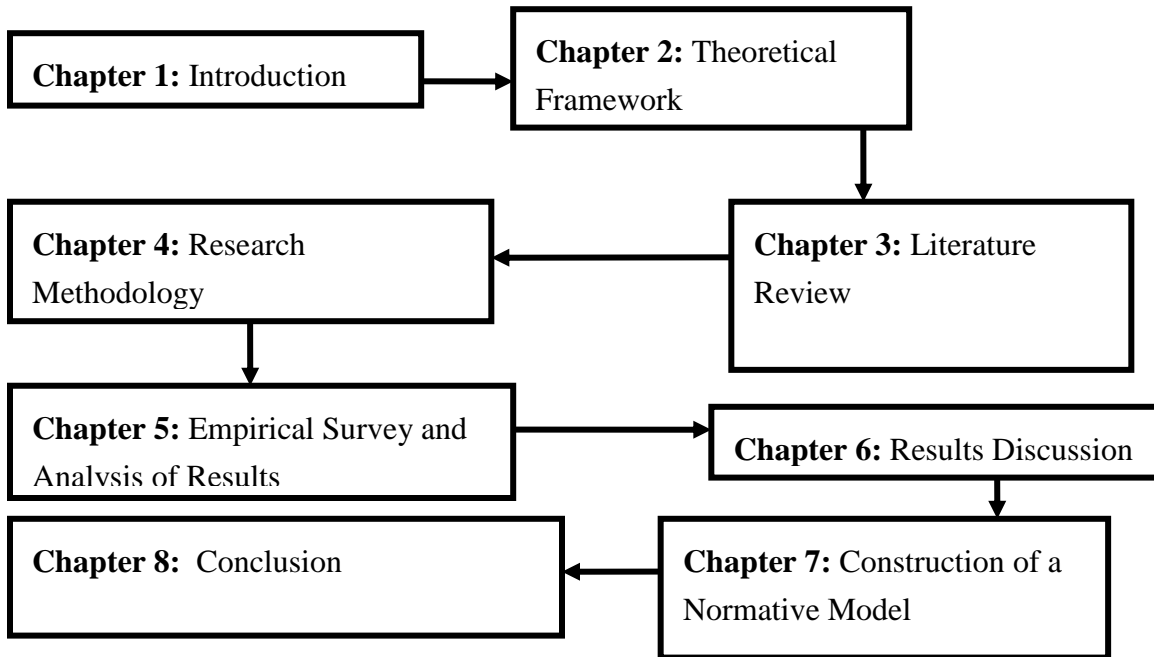


FIGURE 1.1: REPORT STRUCTURE

The following chapter focuses on the theoretical framework of the study.

CHAPTER 2

THEORETICAL FRAMEWORK

2.1 INTRODUCTION

This chapter focuses on the theoretical framework of the study. This research adopts various theories used in similar researches. Factors discussed in this chapter include adopted theories, conceptual framework, and a summary to the chapter.

2.2 ADOPTED THEORIES

This study adopted three types of theories that have been adopted by the previous researchers on tourism related fields. The theories are: Herzberg's Two-Factor theory of motivation used and tested empirically on seasonal workers in hospitality and tourism (Lundberg, Gudmundson & Anderson 2007); the Social Disruption Theory used in the study of crime in rural communities, (Park & Stokowski, 2008); and the Anthropological Theory, used in the study of understanding and addressing AIDS-related stigma on clinical practice in Haiti (Castro & Farmer, 2004). Figure 2.1 presents the theoretical framework for this study.

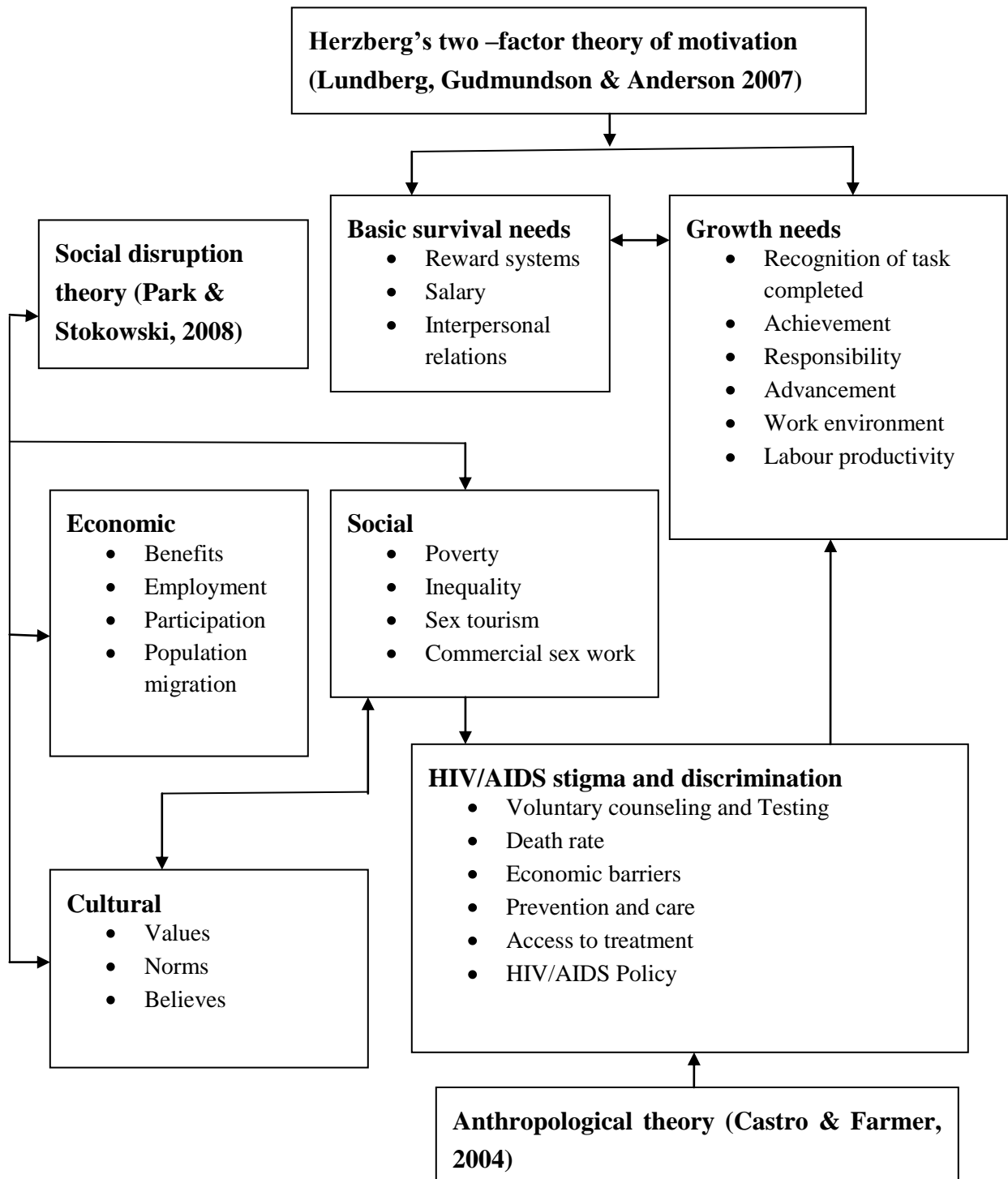


FIGURE 2.1: THEORETICAL FRAMEWORK

The Herzberg Two-factor Theory implies that people have two various types of needs and that various components of work situation satisfy or dissatisfy these needs (Wright, 1989: 37). This

theory specifies a relationship between two factors: basic survival needs and growth needs. To conceptualise both basic survival needs and growth needs, this study takes the approach in the study by Lundberg, Gudmundson & Anderson (2007) in which Herzberg's Two-Factor Theory of work motivation was tested empirically on seasonal workers in hospitality and tourism. The Herzberg's two-factor theory of work motivation also suggests that motivation is a fundamental aspect of the tourism and hospitality sector (Baum, 1999: 25; Lundberg, Gudmundson & Anderson, 2007: 890).

Various studies indicate that motivation plays an important role in the tourism and hospitality sector. Motivation is imperative for both tourist and tourism employees (Baum, 1999: 26). Tourists' perceived quality is often linked to employees' performance, which is also dependent largely on employees' motivation. Tourists would prefer to spend their money where they feel they get the value for their money in terms of service quality. Tourism employees on the other hand cannot be expected to do their best in providing quality service while they are demoralised. Motivated employees play an essential role in any organisation. This means that organisational management have the responsibility to motivate and to create conducive working environment for their employees. The motivational factors used by many tourism organisations include reward system, salary increase, interpersonal relationship, recognition of task completed, achievements, responsibilities, and conducive working environment.

However, this study adds the social aspects that affect the employees' motivation such as health. This study sought to find out whether HIV/AIDS affects tourism employees' motivation and commitment to their job. This is because HIV/AIDS generally demoralises infected and affected employees in the tourism sector. Besides, employees directly affected by HIV/AIDS are likely to be demoralised by the fact that their colleagues leave the job or often go on sick leave for a lengthy period or attend funerals frequently. This in return would affect service quality rendered to the tourists, which may result in concerned companies losing clients resulting from poor customer service (Parsons & Broadbrides, 2006: 66).

Anthropological Theory is based on certain circumstances and on empirical evidence supporting such circumstances (Appadurai, 1988: 16). This theory identifies the relationship between circumstances and variables within the environment. According to the Anthropological Theory, the evidence regarding a situation is largely influenced by specific variables. This study adopts the

Anthropological Theory and borrows from a study that used this theory to address the HIV/AIDS-related stigma in Haiti (Castro & Farmer, 2004: 53).

HIV/AIDS related stigma is often detrimental to strategies used in the fight against HIV/AIDS such as voluntary counselling and testing. Providing quality care to people living with HIV/AIDS is fundamental in reducing the HIV/AIDS stigma. There is a significant relationship between stigma, HIV/AIDS and poverty. People living in poorer developing countries are vulnerable to HIV/AIDS and often experience more HIV/AIDS stigma than those in developed countries. Fear, denial and stigma attached to HIV/AIDS may make many people hesitate to utilise voluntary counselling and to test their status (Castro & Farmer, 2004: 57).

The Social Disruption theory contends that disruption of both formal and informal tourism activities may deny the concerned population's freedom to exercise their rights and benefit from tourism (Park & Stokowski, 2008). This study borrows from the studies that have focused on social disruption theory in rural communities (Rephann, Dalton, Stair & Isserman, 1997: 43, & Park & Stokowski, 2008: 905).

Tourism contributes to the economy by creating employment, contributing to GDP, and alleviating poverty. However, tourism also has negative socioeconomic impacts on the lives of host communities in which tourism activities take place. In many occasions tourism planners and developers do not consult the host communities prior to developing the tourism sector in such communities (Long, 1996: 27 & Stokowski, 1996). Also, economic, social and cultural impacts of tourism to the host communities are often ignored and overlooked by many tourism planners particularly in rural areas. It is also worrying that not all communities benefit from tourism yet they all experience the cost.

Tourism also encourages commercial sex work and conflicts with the norms and values of the host communities. It is possible that commercial sex can contribute to the spread of HIV/AIDS. Tourism may bring urbanisation which may affect the social relationship and networks for the affected communities (England & Abrecht, 1984: 39).

Figure 2.2 presents the conceptual framework that summarises the impact of HIV/AIDS on the Botswana tourism sector. HIV/AIDS results in socioeconomic problems such as increased

poverty, increased number of orphans, population migration, early pregnancy, and increased dependence ratios resulting from high death rate. These problems negatively affect the tourism sector through staff turnover and low productivity.

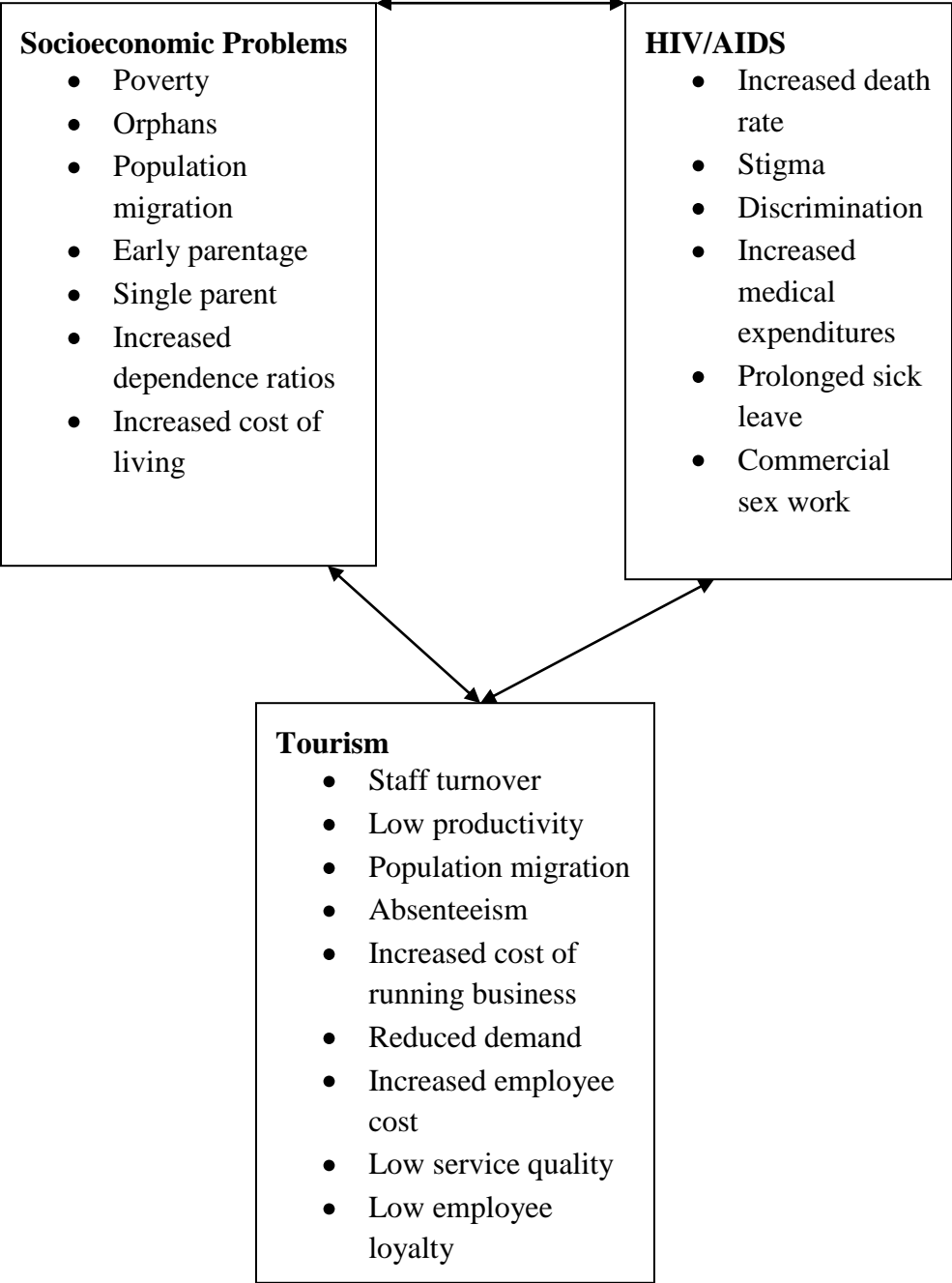


FIGURE 2.2: CONCEPTUAL FRAMEWORK

(Source: own concept based on information provided by Long, 1996 & Stokowski, 1996, & England & Abrecht, 1984)

2.3 SUMMARY

This chapter focused on the theoretical frame of this study. Factors discussed in this chapter include adopted theories, conceptual framework, and a summary to the chapter. The following chapter focuses on the literature review.

CHAPTER 3

LITERATURE REVIEW

3.1 INTRODUCTION

This chapter focuses on the general literature related to the impact of HIV/AIDS on the tourism sector and in general. Factors discussed in this chapter include operation of terms in the study, community tourism, sustainable tourism development, pro-poor tourism, the general socioeconomic impact of HIV/AIDS, the impact of HIV/AIDS on the economic growth, the impact of HIV/AIDS on the tourism sector, the impact of HIV/AIDS on the savings and investment, the impact of HIV/AIDS on tourism workforce, the loss of skilled workers, training and recruitment costs, impact of HIV/AIDS on tourism customer base, the overview of Botswana's economy, the Botswana formal education system, economic growth, major economic sectors, trading in Botswana and international relations, investment environment in Botswana, an overview of HIV/AIDS situation in Botswana, an overview of HIV/AIDS orphans in Botswana, the impact of HIV/AIDS on the Botswana tourism sector, the socioeconomic impact of HIV/AIDS in Botswana, impact of HIV/AIDS on the image of the Botswana tourism, the Botswana HIV/AIDS policy, and the Botswana tourism sector's response to the impact of HIV/AIDS, general overview of HIV/AIDS in Africa and in the rest of the world, and the general impact of HIV/AIDS, and the impact of HIV/AIDS in the tourism sector in general. Concluding remarks are also made at the end of the chapter.

3.2 OPERATION OF TERMS IN THE STUDY

Tourism is defined as "all travel with the exception of commuting" (Gunn, 1988: 1). It includes any activity concerned with temporary short-term movement of people to destinations outside the place where they normally live and work (Gunn, 1988: 1). Employment creation helps to fight poverty, which is one of the components contributing to the spread of HIV/AIDS particularly in rural areas.

Human Immunodeficiency Virus (HIV) is a complex virus that lowers the body's immunity and makes it vulnerable to disease. HIV develops into Acquired Immunodeficiency Syndrome (AIDS) when a person has developed a number of opportunistic illnesses such as pneumonia, tuberculosis, diarrhoea, skin rashes and sores. HIV positive people not using antiretroviral drugs (ARVs) normally die within ten years of contracting the virus. There is still no cure for the HIV/AIDS pandemic. HIV positive people who have not yet developed a full – blown AIDS look and feel healthy (Ramsey, Hazoume & Chetty, 2002: 2).

The HIV virus is carried in sperm, vaginal fluids, breast milk and blood. The most frequent way of transmitting HIV/AIDS is through vaginal, anal and oral sexual intercourse. The Virus can also be transmitted through breast feeding, blood transfusion, organ transplanting, or by sharing the needles or the razors with an HIV infected person (Ramsey *et al.*, 2002: 2).

3.3 GENERAL BACKGROUND OF BOTSWANA

Botswana is a landlocked country lying at the centre of the Southern African plateau. Four countries border Botswana: Namibia, South Africa, Zambia and Zimbabwe. Botswana is a transit country for truck drivers from South Africa, Zimbabwe, Zambia and Namibia. The prevalence rate of HIV/AIDS is also high in these countries. With a population of approximately 1.8 million and a total area of 582 000 square kilometres, Botswana is sparsely populated. Large parts of the country are sparsely inhabited due to the Kgalagadi (Kalahari) desert occupying 87% of the land. Most of the population live in the eastern part closer to the Zimbabwean border, where there is arable farming land and rainfall is relatively better when compared to the other parts of the country. Diamonds and tourism are important to the rapid economic growth of Botswana, but HIV/AIDS threatens these economic sectors (Botswana's Department of Tourism, 2008: 4).

Figure 3.1 below presents a map of Botswana depicting a number of tourist locations such as national parks, lakes, deserts, and the other physical features. The map also shows countries sharing borders with Botswana. Botswana's history has an influence on its economic situation.



FIGURE 3.1: MAP OF BOTSWANA

(Source: Shoortravel, 2008)

3.3.1 BRIEF HISTORY OF BOTSWANA

Botswana is also officially known as the Republic of Botswana (*Lefatshe la rona* in Setswana language) (Botswana’s Department of Tourism, 2008: 4). The people of Botswana are called Batswana (singular – Motswana), irrespective of their ethnic groups. Botswana was colonised by Britain, and at that time it was called Bechuanaland Protectorate. After independence on the 30 September 1966 Bechuanaland Protectorate became Botswana. The economy of Botswana, which is largely dependent on diamond mining, tourism and agriculture respectively, is closely tied to that of neighbouring South Africa. These two countries trade together and Botswana

imports most of the basic needs such as food and electricity from South Africa.

The Botswana's Department of Tourism (2008: 4) indicates that in the late nineteenth century conflict erupted between the Batswana settlers and the Ndebele tribes who migrated from the Kalahari Desert to Bechuanaland. Another conflict also broke up from the Boer settlers from the Transvaal. Due to these conflicts, on the 31 March 1885, Britain colonised and protected Bechuanaland. In June 1964, the then Batswana leaders Khama 111, Bathoen, and Sebele went to Britain to ask for liberation/independence from Britain, and Britain agreed to free the Bechuanaland Protectorate to become an independent state called Botswana. In 1965 Botswana became independent and the capital city, Mafikeng (located in South Africa), was moved to the now Botswana's capital city called Gaborone. On the 30 September 1966, Botswana held the first democratic elections. Sir Seretse Khama was elected the first President of Botswana, and he was subsequently elected two times before he died in 1980. After Seretse Khama's death in 1980, the then Vice President Sir Ketumile Masire became President until his retirement in 1998. Masire was succeeded by his vice Festus Mogae, who was democratically elected in 1999 and again in 2004. Before independence in 1966, Botswana was one of the poorest countries in the world, but it has since become one of the richest countries in Africa, with the fastest growing economy in the world (Botswana's Department of Tourism, 2008: 4).

3.3.2 AN OVERVIEW OF THE ECONOMY OF BOTSWANA

This section presents a synopsis of Botswana's economy, Botswana's formal education system, Botswana's economic growth, trade in Botswana, and the Botswana's investment environment.

3.3.3 A SYNOPSIS OF THE ECONOMY OF BOTSWANA

Botswana boasts one of the fastest growing economies in Africa, which largely depends on natural mineral resources and the tourism sector (Woods & Sekhwela, 2003: 76). Botswana leads the world in producing gem-quality diamonds accounting for one third of the annual Gross Domestic Product (GDP). Diamond mining also accounts for 60% of Botswana's mineral output. Botswana's tourist attractions include unspoilt vegetation and vast species of wild animals. Tourism also significantly contributes US\$240 million to the annual revenue of the government of Botswana. It also creates employment in the country (Mmopelwa, 2006: 117).

Mbendi (2007: 2) indicates that diamond mining, tourism and agriculture are the Botswana's major economic sectors, contributing significantly to the country's Gross Domestic Product and creating employment. Mbendi also indicates that diamond mining continues to be Botswana's major economic contributor, and that it accounts for one third of the country's GDP. Diamond mining in Botswana also accounts for 45% of government revenues and 75% of export earnings. Botswana is arguably the world's leading quality diamond producer, producing 29% of the world value and with the annual record amount of US\$ 5. 67 billion. Besides diamond mining, the other economic sector that plays a vital role in the economy of Botswana as already stated is the country's tourism sector.

Woods and Sekhwela (2006: 76) indicate that tourism plays a vital role in the economy of Botswana coming second after diamond. In 1997 tourism was reported to be contributing 3% of the Botswana's GDP. However, Woods and Sekhwela argue that most of the revenue generated from tourism in Botswana is not retained in the country due to the fact that most of the tourism companies are owned by foreign investors who take money to their countries of origin. Revenue generated from tourism provides little or to a certain extent no benefit to a number of poor communities living in remote rural areas in which tourism is taking place in the country.

Woods and Sekhwela (2006: 76) indicate that 50% of the Botswana population live in rural areas and rely on subsistence farming for their survival. However, agriculture in Botswana provides a small portion of food needs, and that it accounts for 2.8% of the Botswana's GDP primarily through beef export. Despite the fact that agriculture contributes less than 3% to the Botswana's GDP, it provides food for over 80% of the country's population living in rural areas. Majority of the Botswana population depends on subsistence agriculture and livestock production for their food. This clearly stipulates that mining, tourism and agriculture are the Botswana's top three key economic sectors.

Figure 3.2 depicts Botswana's major economic contributors. It is evident that mining leads the economic contributors in Botswana followed by tourism, and agriculture. However, these statistics presents the sectors' contribution based only on the country's GDP excluding other contributions such as employment creation. Based on the above figure, it becomes evident that in case any of the above economic sectors can be affected by the high HIV/AIDS prevalence rate in

the country, the Botswana's economy could be seriously affected. Both the Botswana's tourism and mining sectors are reported to be labour intensive, employing large numbers of migrant labours. However, this research focuses on the impact of HIV/AIDS on the Botswana's tourism sector. When observing both the contribution of tourism to the Botswana's GDP and its employment creation, it becomes evident that the impact of HIV/AIDS on this sector could jeopardise the country's economic growth. There is no doubt that mineral mining particularly diamond is the major economic contributor and the government actively promotes it. However, due to global economic crisis affecting the mining sectors of many countries in the world, the Botswana government promotes and is actively involved in the development of tourism.

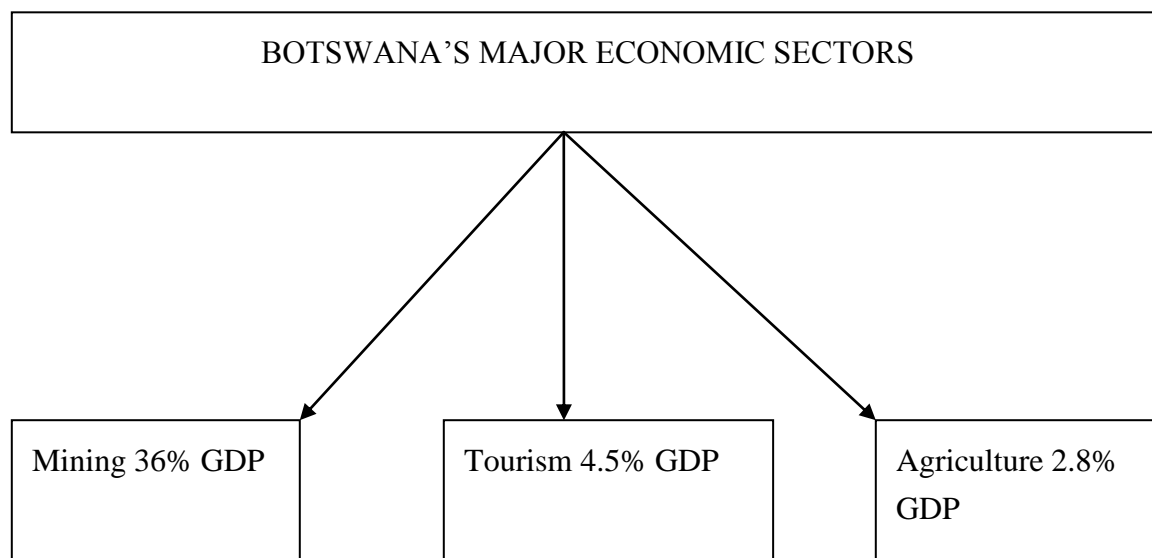


FIGURE 3.2: BOTSWANA'S MAJOR ECONOMIC SECTORS

(Source: Mbaiwa, 2005).

3.3.4 THE EDUCATION SYSTEM

Education contributes to the economic development of Botswana. The Government has made a significant effort in developing and improving education since independence in 1966. Before independence, Botswana had few university graduates and only a marginal percentage of the entire population had at least secondary school education (Bagwasi, 2005: 28). The discovery of

diamonds in 1967 resulted in the increase of university graduates in various sectors of the economy of Botswana. All Botswana citizens are guaranteed at least ten years of basic education from primary to junior secondary school. The Botswana basic education system consists of seven years of primary school; three years of junior secondary school; and two years of senior secondary school. Students automatically proceed from primary to junior secondary schools irrespective of whether they fail or not. Only those students who pass junior certificate with at least a second class can proceed to senior secondary school to do the Botswana General Certificate of Secondary Education (BGCSE). Students who do not meet the minimum requirements of entering senior secondary school apply to the technical colleges, and/or vocational schools. Students who pass BGCSE may either be admitted at the two Universities in Botswana provided they meet minimum requirement; or they may be sponsored by the Botswana government to study in foreign countries.

Besides formal education, the Botswana government is also committed to promoting and providing adult education and non-formal education to the citizens who do not manage to acquire formal education. Most adult learners play a vital role in generating income and contributing to the economic growth of their respective communities. This includes people who are working in the tourism sector. Botswana government also provides opportunities for non-formal basic education (NFBE) for both adults and youths. This out-of-school educational programme aims at providing learning opportunities outside of normal class situation for people who did not have access to formal education and for people who wish to further their formal education (Maruatona, 2007: 2).

The Botswana education system faces a number of socio-economic challenges. Primary schools do not have sufficient resources, and teachers are generally paid low salaries. There is a shortage of skilled educators in key subjects such as science and mathematics. These subjects are essential for the tourism sector because the sector needs accountants and environmental scientists for sustainable development.

Botswana is still faced with the challenges of shortage of skilled labour in various sectors of the economy including tourism. The shortage of skills is exacerbated by HIV/AIDS, which is killing many skilled people. The Botswana Government invests large amounts of money in education to diversify the economy and also to reduce dependence on foreign skilled workers (Botswana

Ministry of Education, 2003: 7). However, as already indicated, these efforts are defeated by the prevalence of HIV/AIDS, which, besides killing skilled labour, also forces the Government to divert funds to HIV/AIDS treatments. The Government of Botswana encourages the Botswana citizens to share the costs of educating their children. In January 2006, the Government reinstated school fees after two decades of free education. However, the Government still fully pays for scholarship and living expenditures for any Botswana citizen studying in a tertiary institution, either local or abroad in any field not offered locally such as medicine and tourism. The Government recognises that education significantly contributes to the country's economic growth.

3.3.5 THE ECONOMIC GROWTH

Botswana, like many other African countries, faces socio-economic problems such as poverty, high unemployment and disparity in income distribution. Siphambe (2004: 355) argues that assessing the performance of the economy in terms of growth alone does not give a true reflection of the country's performance. He argues that it is imperative to observe other socio-economic factors such as poverty, income distribution and general human development.

Mutula and Van Brakel (2007: 236) argue that Botswana experiences problems resulting from unemployment and poverty in spite of the fact that the economy of Botswana has grown significantly since independence in 1966. This is also despite the fact that Botswana's population is small and projected at only 1.8 million people. Poverty prevails more in rural areas and in areas where HIV/AIDS is more prevalent. However, it should be noted that statistical information on poverty in Botswana is scarce.

Even though poverty and unemployment remain a problem in Botswana, the proportion of the population in poverty dropped significantly between 1986 and 1994 (Botswana Institute of Development Policy Analysis (BIDPA), 1997: 22). The proportion of poor and very poor population dropped from 59% to 47%, and the proportion of poor households dropped from 49% to 38% during the same period. However, it is important to note that poverty reduction in Botswana is more significant in urban areas than in rural areas because there are more developments and formal job opportunities in the urban areas than in the rural areas. Poverty is increased by lack of formal sector jobs, low wages for those employed, and insufficient income-

generating options to supplement the wage income of the workers. However, there are success stories on the Botswana's initiatives to fight poverty through created educational opportunities.

The success stories in curbing poverty in Botswana are linked to a number of social indicators such as increased enrolment in both primary and secondary educational institutions. Due to increased investment in education, the adult literacy rates in Botswana has considerably increased, which gives the country a large supply of population that can be trained in various economic sectors including tourism. Investment in education attracts foreign investment. However, the quality of education requires immediate attention to make it more relevant to the economy of Botswana (Siphambe, 2004: 356). As already indicated, HIV/AIDS also threatens educational investment and labour availability in Botswana. But, the Government of Botswana provides anti-retroviral (ARV) drugs to the infected public for free, free condoms, and free education about HIV/AIDS.

In an attempt to reduce the level of poverty in Botswana the government encourages the development of small business enterprises including those in the tourism sector. Small business enterprises play a vital role in promoting economic and social development in Botswana. To promote the development of small business enterprises, the government of Botswana encourages investment in the Information and Communication Technologies (ICTs). This initiative also helps Botswana to diversify its economy, which is largely dependent on diamond mining. The major challenge facing the Botswana small business enterprises is the shortage of skilled human resources. This challenge is exacerbated by HIV/AIDS which kills many people possessing valuable skills.

Agriculture, one of the pillars of the economy of Botswana, has for many years experienced difficulties due to drought. However, during good rainy seasons, such as in 1966 and 1978, Botswana's cattle increased significantly. The other sector contributing significantly to the economy of Botswana is the country's tourism sector. Botswana's stable political environment contributes significantly to the development and growth of tourism in the country. Botswana is a peaceful and a democratic country and this attracts tourists and foreign investments in the country. Besides investment opportunities, Botswana has income distribution policies across various economic sectors such as agriculture and mining particularly in urban areas, which favour the low paid workers.

Colclough and McCarthy (2002: 17) argue that a number of rural areas in Botswana experience inequality of increased concentration of cattle ownership. However, the majority of people living in a number of rural areas in Botswana have equal access to the basic resources. To address inequality in rural areas, the Botswana government established Rural Development Programme (RDP) with the intention to develop infrastructure such as schools, clinics and water supplies to provide basic needs. These initiatives contribute to the Botswana economic success story.

Botswana like many other African countries is faced with challenges resulting from lack of formal employment opportunities. The challenges of unemployment are exacerbated by the fact that the agricultural sector for many years has been struck by drought and animal disease such as foot and mouth animal disease. Many people working in agriculture have lost their jobs. To address unemployment the government of Botswana promotes localisation of jobs where possible because employing expatriates is more expensive than employing locals. However, in cases where an expatriate possess scarce skills, an expatriate is given the job. Despite the challenges facing Botswana's agriculture, cattle farming is an important activity in the country and cattle farmers are highly subsidised by the government and they pay little tax. Besides mining and agriculture, the Botswana government promotes the tourism sector as an important economic activity. Tourism creates employment, contributes to the country's GDP and is one of the Botswana major foreign exchange earners.

Msimangira (2003: 8) points out that Botswana has profound democracy. Botswana has had democratic political and sound economic systems since independence in 1966. Botswana is arguably one of the richest countries in Africa. It has one of the world fastest growing per capita incomes. Botswana's per capita GDP is projected to be US\$11,200, and it has had over 9% of average economic growth per year since 1966. See table 3.1. Botswana is arguably the best African country in terms of credit rating, and it has a stockpile of foreign exchange reserve of more than US\$7 billion. Botswana's positive economic record is attributed to wise spending of money generated from diamond mining, which accounts for half of the country's government revenues. Besides this economic growth however, Botswana has significant problems of unemployment and poverty, particularly in rural areas.

TABLE 3.1: ECONOMIC GROWTH INDICATORS

ECONOMIC VARIABLES	VALUE INDICATOR
GDP Ranking	122 nd (2007)
GDP	US\$18.72 billion (2006)
GDP Growth	4.7% (2006)
GDP Per Capita Income	US\$11.400 (2006)
GDP by sector	Agriculture (2.4%), Mining (36%) and Tourism (4.5%) (2007)
Inflation	11.4% (2006)
People living below poverty line	30.3% (2006)
Unemployment rate	23.8% (2006)
Exports	US\$4.836 billion (2006)
Exports commodities	Diamond, copper, nickel, meat and textiles
Imports	US\$3.034 billion (2006)
Imports commodities	Foodstuffs, machinery, electrical goods, transport equipment, textiles, fuel and petroleum products, wood and paper products, metal and metal products
Government revenues	US\$4.256 billion (2006)
Government expenses	US\$3.968 billion (2006)

(Source: Compiled based on information provided by Msimangira, 2003 and Mutula and Van Brakel, 2007).

Table 3.1 above presents the economic growth indicators and the value added by various economic variables. The table indicates that Botswana is ranked number 122 in the world GDP, and that it has an annual GDP of US\$18.72 billion. Botswana has an annual GDP growth of 4.7% and per capita income of US\$11.400. Mining, Tourism and Agriculture, contribute 36%, 4.5% and 2.4% respectively to the GDP. It is also indicated on the table 2.1 that Botswana has inflation rate of 11.4% and that 30.3% of the country's population live below the international line of poverty (US\$1). The unemployment rate is 23.8%.

The export commodities listed in table 3.1, show that Botswana's economy depends largely on mineral exports. This implies that there is a need to diversify the country's economic contributors. In this regard, tourism has been identified as having the potential to diversify the economy of Botswana. The import commodities also indicate that Botswana depends heavily on foreign countries on numerous services. This explains why Botswana has high unemployment rate with a population of 1.8 million people. Botswana should start manufacturing its own products, especially foodstuff and electricity. The more the manufacturing factories the more unemployment and the reduction of poverty will be. Besides employment creation and poverty reduction, manufacturing may increase government revenues through exports and may reduce government expenditures through exports expenses.

Botswana's economic growth is hampered by the increasing health care expenditures. In 2002/2003 Botswana's economic growth was cut by 10%. Botswana is one of the countries hit hard by HIV/AIDS in the world, and the average life expectancy at birth in the country has dropped from 64 years since 1990 to 54 years. This is nearly half of the 59 – average of low income countries. Botswana and Swaziland are reported to be the Southern African countries whose population have the shortest average life span in the whole world attributed to HIV/AIDS. It is projected that one in three people in Botswana is HIV positive (Botswana's Ministry of health, 2000: 4). In realising the impact of HIV/AIDS on the economy, the Botswana government has introduced free antiretroviral (ARV) and Prevention of Mother to Child Transmission (PMTCT) programmes to curb the impact of HIV/AIDS on the country's economy.

The other serious challenge hampering the economic growth of Botswana is the high prevalence of HIV/AIDS. About 38% of the Botswana adult population are projected to be living with HIV/AIDS. HIV/AIDS is Botswana's major economic and social challenge. For example, in 2002/2003, health expenditure increased by 50%. It is worrying that the future economic implication of HIV/AIDS in Botswana is unpredictable.

The fact that the economy of Botswana is narrowly dependent on tourism and mineral mining is a challenge that needs to be addressed by diversifying the economic contributors. Botswana's economic growth does not benefit a number of the poor communities living in rural areas (Anon., 2007: 1-3). The other major challenge facing the country is the high level of unemployment,

which is exacerbated by lack of skills and experience particularly by people living in rural areas, and by the fact that the number of Botswana citizens working in foreign countries is decreasing. Employment creation process in Botswana is reported to be slow, with projections indicating it at only 1% in recent years. Botswana is reported to have unemployment rate of 21%., which shows a significant improvement when compared to 23.8% in 2006 (refer to table 3.1). Because of poverty and lack of employment opportunities, many people migrate from rural areas to urban areas with the hope that they may get jobs and improve their lives, but the remaining challenge facing a number of the immigrants is that they do not possess skills to earn employment. Population migration puts pressure on social and government services such as health and education. Poverty and population migration are closely linked factors, and are among the major factors contributing to the spread of HIV/AIDS in the country and in general.

Despite the identified challenges, the economy of Botswana continues to grow significantly and the tourism sector in particular is also significantly growing. Botswana's economic management and growth have set a good example that many African countries can learn from. Botswana, unlike many African countries, did not adopt the World Bank/International Monetary Fund because of the stable and growing economy, and the balance of payments surpluses (Siphambe, 2004: 353). Also, Botswana voluntarily adopted liberal policies from the beginning of the developmental strategies. Botswana's development approach is based on free enterprise and a market economy system. The National development plan stipulates that the Government should facilitate economic growth rather than actively participate in the economy. The Government should provide infrastructure, educate the nation, and establish policies to guide various economic sectors.

3.3.6 TRADE AND INTERNATIONAL RELATIONS

Mbendi (2007: 2) stipulates that Botswana, Lesotho, Swaziland, Namibia and South Africa are all members of the Southern African Customs Union (SACU). SACU collects levies, sales, and excise duties from all its member states and shares out proceeds according to each member's share of imports. SACU's secretariat is located in Windhoek, in Namibia. SACU member states strive for free trade arrangements with the United States of America (USA), and Botswana in particular strives for an Economic Partnership Agreement with the European Union. However, the government of Botswana protects major industries and follows the SACU's indications of the

infant industry clause. In this regard, SACU stipulations provide tariff protection by levying import duties on the member states. The purpose of this is to allow local sectors to compete effectively with the SACU. Botswana's main exports include diamonds, nickel, copper and beef. The major markets for these products are European Union (EU) and SACU member states. Botswana also imports products such as foodstuffs, machinery, and transport equipment, textiles and petroleum products. Both Botswana and South Africa are also the members of the World Trade Organisation (WTO), SADC, World Bank, and International Development Association (IDA).

The Southern African Development Community (SADC) headquarters is located Gaborone, the capital city of Botswana. SADC was established in 1980 to free regional economic development from the then apartheid South Africa. However, in 1994 the newly democratic South Africa became a member of SADC. SADC has the responsibility to sustain economic growth, development, and economic integration in Southern Africa. SADC's Trade Protocol, which was initiated on the 1st September 2000, encourages the abolition of all tariffs among the 11 SADC member states. This initiative is expected to give Botswana companies opportunities for free access to the major regional market. However, SADC has lost numerous opportunities for cooperation with the USA by failing to distance itself from undemocratic Mugabe government in Zimbabwe.

Mbendi further indicates that Botswana has been a member of the World Bank and the IDA since 1968. The World Bank assists Botswana with analytical and technical support concerning livestock and exports diversification, and also with the fight against HIV/AIDS. In 1979, Botswana also became a member of the International Finance Corporation (IFC) and in 1990 it also joined the Multilateral Investment Guaranteed (MIGA). To date, IFC has invested a total amount of US\$12.7 million in Botswana's tourism, financial markets, and mining sectors (Mbendi, 2007: 22). Although there is no investment made by MIGA in Botswana yet, Botswana has benefited from a couple of MIGA's technical assistance activities and the country participates in MIGA's annual African Mining Investment Symposium. The Botswana international relations and economic success is enhanced by the countries stability. These international relations and the Botswana's political stability contribute to the development of tourism in the country.

Mbendi (2007: 23) indicates that Botswana aims to integrate politics into the economic growth

within the Southern African region. Botswana strives to make SADC a functioning mechanism for economic growth and it also strives for Southern Africa self – policing in terms of preventive diplomacy, conflict resolution, and democratic governance. Through these efforts, Botswana has welcomed the post – apartheid South Africa a partner in these initiatives. Botswana participates on the African consensus on several major internal matters and is also a member of international organisations such as the United Nations (UN), the Commonwealth of Nations, and the African Union (AU). Botswana is also a member of the International Criminal Court with a Bilateral Immunity Agreement of protection for the United States of America’s Military.

3.3.7 INVESTMENT ENVIRONMENT IN BOTSWANA

Mogalakwe (2008: 422) stipulates that Botswana strives to diversify its economy from depending largely on mineral mining. During the periods 1998 and 1999 other economic sectors apart from mineral mining grew at 8.9%, partly offsetting a marginal 4.4% reduction in the mineral sector. The Botswana government encourages and welcomes foreign investors in varying economic sectors. Botswana does not have excessive foreign exchange controls, and the corporate tax rate in the country is 15%. Foreign ownership of companies is not restricted and as a result foreign investment has increased significantly in Botswana. For example, in the early 1990s, two American companies, Owens Corning and H.J. Heinz invested in production sectors in Botswana. In 1997, the St. Paul Group bought the Botswana Insurance, one of the country’s major short – term life insurance Service Company. The United States of America’s (USA) investments in Botswana are gradually increasing. Major USA investors in Botswana include Kentucky Fried Chicken (KFC) and Remax. The Botswana economic governance is the key component encouraging foreign investors in the country.

Mogalakwe (2008: 4427) indicates that Botswana has good economic governance. In 1994 the Transparency International ranked Botswana as Africa’s least corrupt nation, ahead of a number of European and selected Asian countries. The World Economic Forum also identifies Botswana as one of Africa’s most economically competitive countries. Botswana is also identified as the best credit risk country in Africa, and this positions Botswana on the same level or even above a number of countries in central Europe, East Asia, and Latin America. The credit rating record indicates that Botswana continues to be one of the best investment opportunities among the developing countries irrespective of some challenges such as small market size, high HIV/AIDS

prevalence rate, land locked location, and cumbersome bureaucratic economic operation systems. Because of the country's history and location, Botswana's economy has a strong link to that of South Africa. Botswana's currency (Pula), is one of the strongest currencies in Africa and is valued against the world strongest currencies that are weighed against the South African Rand. Botswana does not have restrictions on profits and direct investment repatriation. Foreign currency exchange controls were abolished in 1999, and in 2004 the Central Bank devaluated the Botswana currency (Pula) in order to maintain export competitiveness against the actual appreciation of the Pula. In May 2005, the Pula was further devaluated by 12%. Despite the strong currency and economic growth, Botswana imports most of its basic needs such as food and electricity from foreign countries. For example, Botswana imports 70% of its electricity from South Africa's Eskom, and 80% of local electricity production are located in one plant, Morupule Power Station. However, the investment policy permits investors, including those in the private sectors, to venture into various business opportunities including the tourism sector.

Matshediso (2005: 203) indicates that Botswana has established good environment for private sector investment in both minerals and other economic sectors. The government permits various economic activities provides a liberal exchange control system, which creates opportunities for free repatriation of dividends and profits without restrictions for importing goods and services. Botswana has established high levels of foreign exchange reserves. The government of Botswana encourages private sector investment, and it has low tax system and ensures macroeconomic stability. The private sector development is also encouraged through the investment incentive policies and infrastructure development. Generally, the Botswana's infrastructure is fairly developed, but there is still need for improvement especially in rural areas. One of the obstacles to business development in Botswana is the fact that the Botswana is land locked (far from the sea). The other area that needs to be addressed particularly by service providers such as restaurants is service quality, which is reported to be inadequate (Matshediso, 2005: 206). The Botswana Export Development and Investment Authority (BEDIA) has been established with the mandate to ensure quality service delivery by all service sectors in the country. Service quality is imperative in the tourism sector for the repeat business purposes. Quality service, diamond mining and investment welcoming investment policies can pay a vital role in Botswana's economic growth.

Matshediso (2005: 206) further argues that a combination of both good mineral potential and a

generally welcoming investment environment in Botswana give Botswana the opportunity to attract foreign investors and also to make money than majority of SADC countries. Botswana's mineral potentials and its democratic governance help its economy to grow significantly. Botswana is a peaceful country with a democratically elected government since independence in 1966. The Botswana government encourages the investment of foreign capital in employment creation by various sectors in the country. Both foreign and local companies in the country are given the same treatment, and the country's legislation discourages any form of discrimination. Table 3.2 below presents a summary of the investment environment in Botswana.

TABLE 3.2: INVESTMENT ENVIRONMENT IN BOTSWANA

CATEGORY	STATUS
Political Security Risks	Low insignificant (World Bank, 2004)
Corruption	Low (World Bank, 2004)
Mineral Potential	Good
Mineral Legislation and Ownership	Mining rights vested in state (Botswana's Ministry of Minerals, Energy and Water Resources, 2007)
Institutional Equity	15 – 35% (Matshediso, 2005)
Mining Policies and Licensing Procedures	Act of 1999 (Botswana's Ministry of Minerals, Energy and Water Resources, 2007)
Environmental Management	Act of 1976 (Botswana's Ministry of Minerals, Energy and Water Resources, 2007)
Fiscal Regime and Corporate Tax	25 – 35% (Matshediso, 2005)
Royalty	3 – 10% (Botswana's Ministry of Minerals, Energy and Water Resources, 2007)
Infrastructure	Fairly good (Matshediso, 2005)

(Source: Compiled based on information by World Bank, 2004, Matshediso, 2005, and Botswana's Ministry of Minerals, Energy and Water Resources, 2007).

Botswana has two types of tier system for company tax. Companies are legible to pay 35% of their taxable income but this is divided into two categories, company tax 25% of the taxable income, and an additional tax 10% of taxable income associated with withholding tax. Royalty is paid on construction, and it is 3% for industrial minerals, 5% for coal, 10% for precious stones, 5% for semi precious stones, 5% for precious metals, and 3% for any other minerals. Royalty is based on a percentage of the gross market value. Although there is a need for improvement, Botswana's infrastructure such as roads, railways and telecommunication system in most parts of the country is in an acceptable condition. Besides mineral mining investment, investment in the other economic sectors such as tourism is an important consideration by the Botswana government.

The Botswana Ministry of Wildlife and Tourism (2008: 1) indicates that the Botswana government encourages private investment in the country's tourism sector. The Botswana tourism policy encourages responsible tourism as a strategy to conserve the abundant wildlife and natural resources for the benefit of both current and future generations. It pays adequate attention in promoting and preserving both nature-based and community-based tourism. The Botswana economy, as already sated above, is largely dependent on diamond mining and agriculture, which cannot be predictable, but the country's tourism sector presents great hope for the future. The Botswana government considers tourism as a vital sector for the country's economic diversification. Tourism proves to be Botswana's key employment provider and is growing at an alarming rate. For example, the trade, hotels and restaurant sector have experienced more than 10% growth per annum over the past recent years. Private sector in general in Botswana has increased from P15 million to P500 million over the past ten years. Tourism investment in particular has tremendously increased from P12 million to P55 million (Botswana's Ministry of Wildlife and Tourism, 2008, 6).

The Tourism sector does not only encompass the management of hotels, game lodges, reservations and campsites but broadly includes related sectors such as safari operators, transport companies, air charter and car rental companies (Botswana Ministry of Wildlife and Tourism, 2008: 1). Tourism supports local arts and crafts and creates jobs for distant communities. The Botswana government effectively encourages investment in the tourism sector and in other

economic sectors through free enterprise policies. The Botswana Export Development and Investment Authority (BEDIA) actively markets Botswana as an excellent investment country. The Hotel and Tourism Association of Botswana (HATAB) encourages and promotes both foreign and local investment in the Botswana tourism sector. HATAB represents airlines, air charters, mobile safari operators, safari camps and lodges, hotel, ancillary services, restaurants, the Botswana wildlife management association and the Botswana community based network. Through HATAB's support for the abovementioned substructures, the Botswana tourism sector experiences significant growth.

In fostering professionalism and investment, Ministry of Wildlife and Tourism includes in its budget Tourism development Funds for the purpose of providing basic, intermediate and advanced training to tourism workers. The Botswana Wildlife Training Institute also provides training in various tourism fields. The Botswana government has allocated 39% of the land for the purpose of conservation and management of wildlife. Through these initiatives, the government aims to maximise both present and future investment in the Botswana tourism sector. The Botswana government through its policies focuses more on quality market with the intention to conserve the natural environment for both the present and future use than on mass market for short-term benefit. The government also encourages nature-based tourism in which private investors work in partnership with local communities to develop projects that benefit the local people. Through partnership, the Botswana government encourages investment that promotes sustainability and economic gain for all stakeholders including communities in which tourism is taking place (Botswana Ministry of Wildlife and Tourism, 2008: 2).

3.4 TOURIST ATTRACTIONS IN BOTSWANA

Botswana has vast natural resources such as minerals, large species of wild animals, natural vegetation, and a pristine inland delta that is unique (The Botswana's Ministry of Minerals, Energy and Water Resources, 2007: 18).

The Okavango is one of the largest inland river deltas in the world (Botswana's Department of Wildlife and Tourism, 2003: 10) This is a huge flood plain situated in Northern Botswana, and it has no natural outlets to the sea and is a vast eco-system covering 1500sq km of African

wilderness. Numerous safari camps within the swamps serve the visitors, providing for every need, making the region one of the prime safari destinations in Africa. The Okavango Marshlands are major tourist attractions in Botswana and most of the tourists who visit the country do not complete their visit without spending time in this pristine environment. For tourists to enjoy holiday for the tourists to the Delta, the need for a trained professional and experienced tourist guide is essential.

The Okavango Delta incorporates the Moremi Game Reserve, and is a unique African Wildlife paradise and one of the finest remaining wilderness areas in the world (Botswana's Department of Wildlife and Tourism, 2003: 14). Safari operators provide 4x4 open game viewing vehicles and 'Mokoro' (a flat bottomed wooden canoe) through the swamps and surrounding areas. Here professional guiding service is an important consideration. Pan, flood plains, reed banks, forests of giant acacia trees and mopane woodlands combine in an unsurpassed natural environment habitat for many wildlife species of Okavango.

A number of wildlife animals in the Okavango include lion, elephant, leopard, giraffe, hyena, kudu, roan, antelope, zebra, lechwe, hippo and crocodile, to name just the principal species. The Okavango can only be fully appreciated by arranging to stay at one of the many lodges situated deep within the swamps. The lodges in the swamps are fully equipped to cater for tourists needs including collection and return from and to Maun using the possible transport. Game rangers and other workers are professionals trained to provide the visitors with the comprehensive wilderness experience possible. Training of these workers is expensive and they are almost irreplaceable due to the high level of experience required. The Okavango is arguably the finest wildlife sanctuary in Africa protected and preserved for the benefit of both tourism and the people of Botswana.

The other attraction according to the Department of Wildlife and Tourism is the Tsodilo Hills located south of Shakawe village in the western part of Botswana. These majestic quartzite hills rise 420 metres above the surrounding country and, and remarkably, are the highest point in Botswana at an elevation of 1394 metres (Botswana's Department of Wildlife and Tourism 2003: 16). The hills feature over 500 individual San rock art sites, which support the spiritual and historical significance of these enigmatic hills through the ages. The Hambukushu and San people who live at the base of these hills provide guiding information to the visitors. About 150km south of Tsodilo Hills is where the range of Aha Hills is found, which is located in one of

the most remote corners of Botswana against the Namibian Border.

The other key tourist attraction in Botswana is the Chobe National Park located in the northern region of the country, and is wildlife wilderness area, which is 11000sq km in size and offers enormous wildlife diversity. The Chobe and Savute Rivers attract huge concentrations of game, particularly elephant and lion in a number of the highest densities in Africa, and is a source of water for the Chobe Region (Botswana's Department of Wildlife and Tourism, 2003: 17). In the far north, near the border town of Kasane, the Chobe River is a popular tourism centre for game viewing by either riverboat or game viewing vehicle. The tourist guides in the region provide professional guiding services to the visitors. There are a number of lodges that offer accommodation services to the visitors. Few examples of the lodges in the region include Chobe Safari Lodge, Chobe Game Lodge, Kubu Lodge and Toro Lodge. The Chobe is made up of four distinct regions, namely: Savute, Serondela, Linyanti and Chobe River Frontage.

Savute is located 180km north of Maun in the western section of Chobe. Covering 5000sq km, Savute is Africa's most densely populated predator area, also hosting the greatest concentration of plain antelope, zebra and wildebeest in the Southern Africa (Botswana Department of Wildlife and Tourism, 2001: 8). There are also 350 recorded bird species, and is home to the most diverse landscapes in the country. Savute is renowned for its magnificent lions and the spectacular annual summer migrations of plain game.

Serondela is a popular tourist destination along Chobe River. This area offers wildlife viewing and photo opportunities. Serondela is famous for the large number of elephants, which form one of Africa's last remaining great herds. Exciting safari experiences can be explored from the land, in special viewing vehicles or from the river in the cruise boats. Tourist guides lead the excursions.

Linyanti, north of Savute, is a nature-wooded area with river frontage of the swamps. Although fairly small, this is one of the most attractive areas in the park. The short trip of swampy river frontage is similar to the Okavango's permanent waterways with papyrus-lined lagoons, extensive reed banks and tall canopies of trees. The principal attraction to this pristine region includes the diverse wildlife of Linyanti. Many natural observing points overlooking the river provide photographic opportunities. Birds-life is plentiful and the sunset is attractive.

Most camps in the Chobe operate their own air services from Maun direct to the destinations. Accommodation is provided in either tented or permanent camps. All offer full meals, accommodation and game viewing drives as part of the overall package. The Chobe Region offers variety of unusual adventure activities. For example, apart from the usual game viewing by either river craft (Mokoro) or special game-viewing vehicle, elephant back safaris and horseback rides are arranged into special designated game areas. Game rangers take groups to the wildlife in the most natural and undisturbed surroundings.

Besides Chobe and the Okavango Delta, the other key tourist attraction in Botswana is the Kalahari area. The Kalahari is situated across the western reaches of Botswana and occupies over half of the land area of the country. The Kalahari is one of the greatest ecological treasures and wilderness areas of the world (Johnson, 2001: 14). The Kalahari is protected by its sheer size and the scarcity of surface water, and has remained unspoilt by encroaching pressures of civilization. The vastness of the semi-desert landscape, the wildlife, the reptiles and the insects, each living a life of interdependence in this arid land, is the key attraction to the visitors. The attractiveness of the Kalahari lies in its remoteness, the wilderness, the harsh, landscape, the great sky and the silence of this pristine African eco-system.

Johnson further stipulates that there are three principal conservation regions located within the greater Kalahari region, namely: The Central Kalahari Game Reserve, the Khutse Game Reserve in the central region and the Kgalagadi Transfrontier Park in the extreme south west corner of Botswana. The reserve is remote and by its nature, even attractive to the visitors who want to escape into the desert wilderness of Botswana. The suitable mode of transport used is the four wheel drive vehicle. Game viewing is abundant, especially at the many drinking points. The entire principal desert is renowned for vast species of wildlife including lion, leopard, giraffe, wildebeest, hyena, and gemsbok, along with many small species. Bird viewing is an added attraction, particularly the many raptor species, which can be observed and easily photographed in the open country.

The Kgalagadi Transfrontier Park, which shares a common border with South Africa, is managed through a joint transfrontier management venture between the two countries. The Kgalagadi Transfrontier Park offers breathtaking landscapes of rolling grasslands, strangely shaped, ever

shifting distinctively coloured sand dunes with a scattering of indigenous trees and shrubs. The park conserves a wide variety of desert game such as hartebeest, eland, springbok and gemsbok. Another fascinating attraction is the Khutse Game Reserve which shares a common northern boundary with the Central Kalahari Game Reserve. However, there are no fences dividing the two reserves and game species are generally common to both.

The Makgadikgadi and Nxai Pan National Parks are famous salt pans of the north central Botswana, and are the largest such pans in the world. These pans were formed millions of years ago when a huge lake covered the entire region. The area is remote, even by Botswana standards and herein lies the attraction. The pans are filled by seasonal rains and are the feeding and breeding grounds for huge flocks of greater flamingos, pelicans and other water-bird species.

The above information indicates that the key tourist attraction in Botswana is wildlife. For tourists to enjoy the experience of the Botswana tourism the guidance of professional tour guides is essential. Quality service needs to complement the wildlife experiences. In case the key personnel such as professional guides are threatened by HIV/AIDS, the quality of service rendered to the tourists could be affected. This research is therefore, aimed at investigating the possible impact of HIV/AIDS on the Botswana's tourism sector

The nature based tourism in Botswana presents the potential for tourism in contributing to the country's economy. This means that the government of Botswana through tourism policy can utilise the tourism potential to fight poverty particularly in rural areas in which tourism activities are located. Poverty alleviation in return, may mitigate the spread of HIV/AIDS. This means that the Botswana tourism policy should be focused at promoting tourism that enhances the quality of life for residents living in areas in which tourism activities are taking place and in general. Tourism policy is also an essential tool in guiding how tourism can be managed and sustained.

Within the vicinity of Gaborone is a variety of wildlife species in their natural habitat in Mokolodi Nature Reserve and the Gaborone Game Reserve. These attractions are part of eco-tourism, which needs a professional guide to explain them to the tourists. Training of these professional guides is expensive and time consuming. Botswana also has a number of unique world-class attractions. One of the attractions in the capital city Gaborone include the Botswana National Assembly located in a tranquil garden setting close to the city centre. Also close by is

the National Museum and Art Gallery situated in the Independent Avenue and which houses a fine ethnographic collection and serves as the centre for ethnographic and botanical research. The modern art gallery, attached to the museum is an important window for the display, development and upliftment of Botswana arts.

It is further indicated by the Botswana's Department of Wildlife & Tourism that Botswana art has become more diverse in the wake of globalization; Local artists face an interesting challenge to introduce the uniqueness and vibrancy of their arts and crafts to a wide international audience. These attractions need more attention to be marketed worldwide, but HIV/AIDS draws more attention and funds than the development of art, and a number of artists die of the pandemic, thus the Botswana art is deteriorating (Botswana's Department of Wildlife and Tourism, 2001: 4).

Botswana is also known for its traditional crafts of which the most famous is probably the basketry practiced by the many regional groups offering individualistic design and patterns. Traditionally, such crafts as pottery and basketry were produced for utilitarian purposes and materials were generally selected from available natural resources. Designs are passed down through generations and today there is a need to preserve these skills in the face of the social dynamics of an ever-changing society. The threat posed by HIV/AIDS is a possible factor that could destroy these skills. But these collections need an experienced person to explain them to the tourists (Botswana. Wildlife & Tourism Department, 2001: 5). The other key tourist attraction in the country is the Okavango Delta.

This study recognises the importance of environment as an integral part of tourism development and attractions. Environment does not only refer to natural environment but also to human environment. South African Tourism formally known as SATOUR (1991: 1) indicates that the environment is viewed within its broadest sense to include the natural, historical and cultural heritage as well as the lifestyles, values and traditions of all the people of the entire Southern African region and in general These elements constitute the primary resource base for the Botswana tourism in general and its global uniqueness is of considerable significance. The Southern African tourism sector and the environment have a strong relationship and depend on one another. Whilst the environment is the primary resource base for tourism, tourism in return provides a primary means through which an economic return can be generated from the environment. Tourism is a dynamic activity that is constantly changing to cater for new and

changing needs. The same can be said of the Botswana tourism sector, which is entering a particular dynamic yet complex and demanding period, especially with the prevalence of HIV/AIDS pandemic and its dramatic spread in the country. This requires flexibility to adjust to change.

3.4.1 TOURISM POLICY IN BOTSWANA

The government of Botswana realizes and acknowledges the contribution of tourism to the country's economy and formulates policies that create a viable environment for foreign exchange earnings and government revenues. The government of Botswana and its policies encourage foreign investment and strive to make conditions more conducive to investors. The government encourages the development of tourism in rural areas so as to create employment and raise income for public servants within the tourism sector in rural areas in order to reduce urban drift. The government also improves the quality of national life by providing education and recreational opportunities with the intention to project a favourable national image to the outside world. In addition, it emphasizes the need to ensure that tourist activities are carried out in an ecologically sustainable manner. The government is also keen to encourage private investment in the tourism sector. Botswana's tourism policy is set out to stimulate sustainable management and utilization of the country's diverse wildlife and natural beauty so that it can be preserved for future generations. Particular emphasis is placed on the sustainability of eco-tourism, which is spearheaded by the Botswana government in conjunction with local communities (Botswana's Ministry of Environment, Wildlife and Tourism, 2003: 10).

The government of Botswana is dedicated to developing tourism and recently incorporated the Department of Tourism and the Department of Wildlife and National Parks into the Ministry of Environment, Wildlife and Tourism. Such an initiative indicates that the Botswana tourism is still in its growing stage. The government also established the Botswana Tourism Board in 2003. The Department of Tourism and the Department of Wildlife and National Parks focus on legislation and policy, while the Botswana Tourism Board concentrates on product development and marketing (Kaynak & Marandu, 2006: 227).

The Botswana tourism policy encourages responsible tourism that avoids damaging the environment for the benefit of both the present and future generations. The government

encourages high-cost, low-volume tourism (Kaynak & Marandu, 2006: 228). This type of tourism discourages camping but encourages tourists to lodge in permanent accommodation like lodges and hotel. The high-cost low-volume strategy encourages sustainable tourism and environmental protection. However, it is worth pointing out that the high-cost-low-volume tourism may also deprive local poorer people the opportunities to participate in tourism activities in favour of the rich people. Local communities should be supported to participate in tourism activities both as entrepreneurs and tourists. This is particularly important in the face of global economic recession.

The government of Botswana is committed to responsible tourism and actively markets Botswana as the responsible tourism destination. The government provides incentives to responsible tourism providers by purchasing services from them only.

The international organizations and agencies are also encouraged to practice responsible tourism, and the government of Botswana accords them preferential access to national marketing funds. The government also encourages partnership between the tourism private sector and the local communities. The private sector is sensitized to the importance of involving communities in the development of responsible tourism, and both local and international media are used to recognize and promote establishments that take actions to become socially and environmentally responsible (Kaynak & Marandu, 2006: 228).

However, there are criticisms by a number of communities in Botswana that there is no enough consultation in terms of policy framework (Kaynak & Marandu, 2006: 229). Most of the tourism companies in Botswana are foreign owned and a number of communities, particularly around the Okavango Delta, argue that they do not benefit from Botswana's tourism (Mbaiwa, 2005: 216). To avoid these criticisms, the government of Botswana should adopt the South African policy framework. South Africa is number one tourist generating country for Botswana. For example, 407 247 tourists came from South Africa in 2004 (Botswana's Department of Tourism Research and Statistics, 2005: 41).

Tourism policy formulation in South Africa is not carried out in isolation but is integrated into other processes (South Africa's Department of Environmental Affairs and Tourism, 1996: 6). For example, in October 1994, the then Minister of Environmental Affairs and Tourism appointed the Interim Tourism Task Team (ITTT) and gave it the responsibility to draft a tourism

discussion paper as a direction for a future national tourism policy. In September 1995, the ITTT drafted a Tourism Green Paper that represented the business sector, labour movement, provincial governments, community organizations and the national government. The Green Paper was distributed nation-wide for comment, and it was later forwarded to the European Union for technical assistance and for developing it into a White Paper. As a follow up, in 1995 international tourism specialists were appointed by the European Union to develop the White Paper and to encourage participation by all. Stakeholders' participation in tourism is fundamental not only in enhancing benefits to the communities but also in the fight against poverty and the spread of HIV/AIDS.

Tourism proves to be one of the most important economic activities in developing countries. This means that the sector needs to be developed in a responsible and sustainable manner. The concept of Responsible Tourism should be the key guiding principle for tourism development (South Africa's Department of Environmental Affairs and Tourism, 1996:10). Responsible tourism encourages a proactive approach of developing, marketing, and managing the tourism sector in a responsible manner in order to develop a competitive advantage. Responsible tourism implies accountability to the environment through the promotion of balanced and sustainable tourism and focuses on the development of environmentally based tourism activities. In practicing responsible tourism, the researcher recommends that the concept should not be limited to natural environmental aspects, but should also consider socioeconomic factors that can directly or indirectly affect tourism development such as HIV/AIDS.

In addressing socioeconomic problems, both the government and tourism business sectors should work with the local communities that are in close proximity to the tourism activities and attractions through the development of sensible economic linkages and continuous consultation. This implies the responsibility to respect, invest and develop local cultures and protect them from over-commercialization and over exploitation. In achieving such initiatives, local communities should be largely and actively involved in tourism, to exercise sustainable development and to ensure the safety and security of the tourists. This would also apply to the Botswana tourism, in which the tourist attractions are in close proximity to many local communities. The other consideration is that a number of people living within the proximity in which tourism activities are taking place such as the Okavango Delta and Chobe are also reported to be living in poverty (Mbaiwa, 2005: 217). This means that involving poorer communities to enhance their benefits

from tourism is imperative in the fight against poverty. Responsible tourism also implies the responsibility of both employers and employees in the tourism sector both to one another and to the visitors. As a hallmark of the new tourism, responsible tourism also implies responsible government as well as the responsibility of the visitors themselves to observe the norms and practices of the country, particularly in respect of the physical and cultural environments (South Africa's Department of Environmental Affairs and Tourism, 1996:13).

The White Paper depicts the following important key elements of responsible tourism:

- Use of local resources in a responsible manner.
- Avoid littering and over-consumption.
- Maintain and motivate natural, economic social and cultural diversity.
- Consult the local community in planning and decision-making.
- Evaluate environmental, social and economic impacts as a prerequisite to developing tourism.
- Recognize the environment and benefits of communities in tourism.
- Monitor impacts of tourism and ensure transparency on information available.
- Encourage full responsibility, respect to the local, natural and cultural environments when marketing tourism.

Based on the above information, it is clear that responsible tourism has emerged as the most appropriate guideline for Botswana tourism development because it recognises the responsibility of the government and the private sector. Responsible tourism is a new concept that Botswana has adopted and takes to the marketplace, and it gives the country the opportunity to be a leader in the new tourism. It gives Botswana a chance to define global practice in responsible tourism and set the standard for the rest of the world to follow, rather than follow the initiatives that others have developed. Responsible tourism as already indicated above implies involving proactive participation and involvement by all stakeholders like the private sector, government, local communities, consumers, non-governmental organisations (NGOs), the media and the general employees. It is an absolute necessity for Botswana as an emerging and a new successful international competitor to follow the concept of responsible tourism.

3.4.2 THE CONTRIBUTION OF TOURISM TO THE ECONOMY OF BOTSWANA

Tourism is regarded as one of the three principal pillars of the economic success of Botswana. (Botswana's Department of Wildlife and Tourism, 2001: 4). It helps to diversify Botswana's economy that is largely dependent on diamonds. Tourism contributes 5% to Botswana's GDP and it also creates jobs for poor people in rural areas, where other sources of formal employment are scarce.

Kaynak and Marandu (2006:228) indicate that tourism promotes the image of Botswana to the outside world. Botswana has attracted important people like Bill Clinton in 1998, and George W. Bush in 2003 by her strong economy, low crime rate and stable democracy. The other event that contributed to the positive image of Botswana is the election of Mpule Kwelagobe (a Botswana citizen) as Miss Universe in 1999.

Botswana's rich cultural and historical heritage and abundant wildlife resources provide opportunities for investment in the tourism sector. Global statistics continue to record a good growth in tourist arrival in the country. Tourist arrival in Botswana rose from 571,931 in 1979 to 923,132 in 2001. This together with the tourism sector's multiplier effect and increased local participation provides the potential to diversify the economy from reliance on other sectors. The government of Botswana through the Department of Tourism has established a one-stop service centre, The Botswana Export Development and Investment Authority (BEDIA) to expedite processing of licenses, and permits (Botswana's Department of Tourism Research and Statistics, 2004). Opportunities have been created in eco-tourism and man-made attractions.

As already indicated, tourism is one of Botswana's most important economic activities. Of all subsectors of the tourism businesses in Botswana, accommodation creates most of employment. Every room in all accommodation establishments is projected to be creating 0.6 jobs, and more than half (53%) of all jobs in accommodation establishments are occupied by female Botswana citizens (Botswana Department of Tourism, 2009). This could be attributed to the fact that usually more women do housekeeping jobs than men in Botswana. See table 3.3.

TABLE 3.3: EMPLOYMENT IN ACCOMMODATION

Employees Per Room	0.6
Employee Distribution	Percentage
Male Batswana	40
Female Batswana	53
Male Foreign	4
Female Foreign	3
Total	100

(Source: Botswana Department of Tourism, 2009).

About 57% of the people working in the accommodation establishments in Botswana are the citizens of Botswana. The fact that the accommodation sector in Botswana is dominated by female also shows the significant role played by females in the country's tourism sector. The worrying factor is that females in Botswana in general are among the population group vulnerable to HIV/AIDS. This means that the continued spread of HIV/AIDS could have negative impact on the Botswana tourism sector in future. In general, the hotel and restaurant sectors alone create 11000 tourism jobs in Botswana (Botswana Department of Tourism 2009).

Besides employment, tourism brings a significant amount of revenue to Botswana. See table 3.4 below.

TABLE 3.4: DIRECT CONTRIBUTION OF TOURISM TO BOTSWANA ECONOMY

Gross Foreign Exchange Earnings	P3 billion
Tourism Value Added	P1.9 billion
Tourism GDP	3.4%

(Source: Botswana Department of Tourism, 2009).

The number of tourists visiting tourist attractions in Botswana is growing. The total number of

tourists visiting Botswana is projected at 2.1 million. More than 420 000 tourists visit Botswana for leisure/holiday (Botswana Department of Tourism, 2009). Table 3.5 below presents the number of tourists arriving in Botswana and the growth rate of the arrivals between 2001 and 2008.

TABLE 3.5: TOURIST ARRIVALS AND GROWTH RATE

Year	Arrivals	Growth rate (%)
2001	1.193.399	
2002	1.273.814	67
2003	1.404.985	10.4
2004	1.522.847	8.3
2005	1.675.132	10
2006	1.842.645	10
2007	1.990.056	8
2008	2.131.149	7.1
Average		8.6

(Source: Botswana Department of Tourism, 2009).

The arrival of tourists in Botswana is growing at an average rate of 8.6%. The continued growth indicates that Botswana is recognised by many tourists as a growing tourism destination.

Tourists do not just visit Botswana's tourists' attractions but also spend money at their various destinations. Table 3.6 below shows tourists' expenditure in Botswana.

TABLE 3.6: TOURISTS' EXPENDITURE

Year	Spend/Night (P)	Total Spend (Pm)	Growth rate (%)
2001	264	1.928	
2002	317	2.815	19.3
2003	314	1.815	- 21.1

2004	225	1.642	- 9.5
2005	274	2.433	48.2
2006	266	2.858	17.5
2007	321	3.283	14.9
2008	241	4.098	24.8
Average			11.4

(Source: Botswana Department of Tourism, 2009).

The average growth rate of tourist expenditure in Botswana is significant (11.4%). This growth rate shows that tourism continues to be one of the Botswana important economic activities. The total tourism expenditure in Botswana in general is projected to be more than P4 billion, with an average expenditure per night of P341.00.

Tourism expenditure in Botswana can also be classified according to types of expenditure. See table 3.7 below. Accommodation and shopping dominate all the tourism expenditures in Botswana and they are the key tourism contributors to the economy of Botswana. Almost half (46%) of tourists in Botswana prefer to stay in lodges. The fact that shopping dominates all tourists' expenditures indicates that tourism makes significant indirect contribution to host communities. This is because when tourists buy from local shops, employment and entrepreneurial opportunities are created for host communities. More employment opportunities are critical in combating the spread of HIV/AIDS through poverty alleviation.

TABLE 3.7: TYPES OF TOURISTS EXPENDITURE

Type of Spend	P (m)	Percentage
Accommodation	811.3	19.8
Meals/Drinks	386.7	9.4
Transport	460.8	11.2
Recreation	108.2	2.6
Shopping	1.536.8	37.5
Other	794.3	19.4

Total **4.098.1** **100**

(Source: Botswana Department of Tourism, 2009).

Leisure/holiday tourists in particular accounted for 20% of all tourists in Botswana in 2008, and on average they stay 6.6 nights. Besides, leisure/holiday tourists visit Botswana for various purposes and their length of stay also varies according to the purpose of visit. Table 3.8 below shows tourists' purpose of visit and length of stay.

TABLE 3.8: TOURISTS' PURPOSE OF VISIT AND LENGTH OF STAY

Purpose of Visit	Tourists	Length of stay (nights)
Leisure/Holiday	420.836	6.6
VFR	594.384	9
Business	121.858	4.2
Transit	278.107	2
Other	715.972	6.8
Total	2.131.149	

Source: Botswana Department of Tourism (2009).

Tourists who visit friends and relatives (VFR) dominate other purposes of visit in terms of length of stay (9). However, it is difficult to project how much tourists visiting friends and relatives spend on places visited. Leisure/holiday tourists accounted for 33% of all tourist expenditure in Botswana in 2008. Specifically, shopping accounted for 37.5% (1.5 billion) of all tourists' expenditure in Botswana in 2008, and accommodation accounted for more than 19.8% (0.8 billion) in the country for the same year (Botswana Department of Tourism, 2009).

Tourism in Botswana is diverse and it attracts visitors from various parts of the world both locally and internationally. Botswana's Department of Tourism Research and Statistics Section (2004) published the following tourism statistics in the country:

TABLE 3.9: TOURISM STATISTICS

International Tourists/year:	2000	2001	2002
Total tourists	1 103 796	1 048 845	1 036 558
Leisure	316 847	306 980	197 219
Business	143 304	132 012	146 437
Average nights per visitor:			
All visitors	9.8	10.3	8.2
Leisure			6.6
Business			4.2
Tourism Expenditure US\$ million	313	300	309
Tourism contribution to GDP (%)	4.5	4.8	5

TABLE 3.10: TOP TEN TOURIST GENERATING COUNTRIES

Country/year	2001	2002
South Africa	478 044	407 247
Zimbabwe	319 174	401 424
Zambia	36 681	44 644
Namibia	36 681	34 814
United States of America	21 971	15 238
United Kingdom	19 283	18 077
Germany	8 875	8 640
Netherlands	6 030	5 161
Australia	5 756	5 488
France	4 358	3 679

Tourist arrival in Botswana in 2001 totalled 1.4 million, a growth of 80% since 1995, but the target is 10% growth per annum by 2020 (Botswana's Department of Tourism, 2004: 10). The

possible threat to this target is the HIV/AIDS pandemic. Estimates by the Department of Tourism are that tourism is contributing 4.5% to Botswana's GDP. Based on the latest figures available, the tourism sector brings in an annual foreign exchange worth P500 million, the tourists spend P1.1 billion, and government benefits by P320 million. Putting this into context, the GDP in fiscal 2001/2002 is projected at P 32 billion: mining contributes a direct 35% and indirectly much more, manufacturing a second engine growth – 4.4 percent. As indicated in statistics above, most of the tourists visiting Botswana come from South Africa, Zimbabwe, Zambia, Namibia, the United States of America and the United Kingdom.

The growth of tourism as a tourist destination is significant and the country continues to attract many tourists from various parts of the world. The Botswana department of Tourism further presents the following tourists statistics of tourist's arrival in Botswana in 2004 from various countries and regions. See table 3.10. This is the latest statistic that the country has.

TABLE 3.11: TOURIST ARRIVAL FROM AFRICAN COUNTRIES

Country	Leisure/Holiday	Business	VFR	Other	Total
Angola	50	10	40	250	350
Botswana	0	0	0	0	0
Comoros	0	0	0	0	0
Djibouti	10	0	0	0	10
Ethiopia	100	30	30	85	245
Ghana	40	60	90	220	410
Kenya	380	120	500	910	1,910
Lesotho	1,153	203	1,401	2,717	5,474
Madagascar	0	0	10	40	50
Malawi	200	190	1,070	1,649	3,109
Mauritius	110	61	140	170	481
Mozambique	153	110	100	252	615
Namibia	2,376	901	5,922	48,343	57,542
Nigeria	31	10	60	61	162
South Africa	115,045	56,863	99,233	355,066	626,207

Sudan	10	0	0	0	10
Swaziland	1,222	443	1,111	2,135	4,911
Seychelles	10	0	0	10	20
Tanzania	252	171	521	643	1,587
Uganda	60	10	290	290	650
Zaire	10	0	20	30	60
Zambia	2,516	1,480	9,646	58,850	72,492
Zimbabwe	65,779	11,629	330,091	168,829	576,328
Other Africa	81	111	30	280	502
Total	189,588	72,402	450,305	640,830	1,353,125

(Source: Botswana Department of Tourism, 2008)

Table 3.11 above presents the statistics of tourists who visit Botswana from other African countries based on the purpose of visit. It is evident on the table that most of tourists visiting Botswana from African countries on all purpose of visit categories are from South Africa.

Table 3.12 presents the statistics of tourists visiting Botswana from America. It is indicated in the table that USA is the leading country in terms of tourists visiting Botswana from America followed by Canada. This shows how important are these countries are to the Botswana tourism sector bearing in mind that USA is one of the countries that have strong economy in the world. In terms of foreign exchange, USA has stronger currency (US\$) than that of Botswana (Pula), which is vital important for Botswana tourism to capitalise on this market.

TABLE 3.12: TOURIST ARRIVALS FROM AMERICA

Country	Leisure/Holiday	Business	VFR	Other	Total
Canada	1,526	61	327	897	2,811
USA	7,938	304	1,012	8,416	17,670
Other	232	0	50	260	542
Total	9,696	365	1,389	9,573	21,023

Source: Botswana Department of Tourism (2008)

Table 3.13 presents the tourists' statistics visiting Botswana from East Asian and Pacific. It is indicated in the table that most of the tourist visiting Botswana from East Asia and Pacific are from Australia.

TABLE 3.13: TOURIST ARRIVALS FROM EAST ASIA AND PACIFIC

Country	Leisure/Holiday	Business	VFR	Other	Total
Australia	2,878	261	254	2,202	5,595
China	350	50	100	562	1,062
Hong Kong	120	0	30	80	230
Iran	0	0	0	0	0
Japan	1,172	21	10	1,315	2,518
Malaysia	130	20	0	30	180
New Zealand	518	10	90	763	1,381
Singapore	102	10	20	30	162
Taiwan	60	0	0	70	130
Other Asia	220	0	40	330	590
Total	5,550	372	544	5,382	11,884

Source: Botswana Department of Tourism (2008)

Table 3.14 presents the statistics for tourists visiting Botswana from European countries. It is indicated in the table that majority of tourists visiting Botswana from Europe are from United Kingdom (UK).

Table 3.14: TOURIST ARRIVALS FROM EUROPE

Country	Leisure/Holiday	Business	VFR	Other	Total
Austria	533	0	11	386	930
Belgium	919	30	50	787	1,786
Czech Republic	266	10	20	272	568
Denmark	431	70	12	392	905
Finland	162	30	0	71	263
France	2,034	84	120	1,751	3,989
Germany	4,354	70	348	4,913	9,685
Greece	23	0	0	40	63
Ireland	579	20	0	236	945
Israel	101	2	70	51	172
Italy	1,697	40	110	1,389	3,196
Netherlands	2,591	40	30	2,188	4,929
Norway	531	50	20	240	671
Poland	100	0	10	60	180
Portugal	270	0	0	160	440
Russia	124	11	10	250	385
Spain	1,320	40	90	586	1,956
Sweden	546	60	73	348	1,044
Switzerland	1,121	31	73	621	1,846
UK	13,843	933	2,473	6,820	24,069
Yugoslavia	60	20	40	50	170
Other Europe	60	10	20	150	240
Total	31,485	1,569	3,617	21,761	58,432

Source: Botswana Department of Tourism (2008)

Table 3.15: presents the statistics for tourists visiting Botswana from Middle East. However, this

statistic does not reflect all the countries in the Middle East because it states only one country, Iraq. The researcher wonders why the Botswana Department of Tourism chose only Iraq in the Middle East. It is amazing that only one country has been chosen in this region because no tourists are registered from Iraq. The basis for the selection criteria is not clearly stipulated. The researcher therefore, recommends that more research should be conducted to find out why Botswana does not have any tourists coming from Middle East. More marketing strategies should be done do attract tourists from the Middle East. This will help the country to diversify its tourism market and to also further diversify the economy in the phase of global economic recession.

TABLE 3.15: TOURIST ARRIVALS FROM MIDDLE EAST

Country		Business	VFR	Other	Total
Iraq	0	0	0	0	0
Total	0	0	0	0	0

(Source: Botswana Department of Tourism, 2008)

Table 3.16 presents the statistic for tourists visiting Botswana from South Asia. It is indicated in the table that most of the tourists visiting Botswana from South Asia are from India. The worrying factor is how the high prevalence of HIV/AIDS in India may affect those tourists visiting Botswana from India. This is because India is one of the countries in the world with the highest HIV/AIDS prevalence rate (World Health Organisation, 2004: 17). The concerning factor is the fact that HIV/AIDS is closely linked to poverty, and people living in poverty are not expected to participate in tourism activities due to the fact that tourism is an optional activity that needs disposable income.

TABLE 3.16: TOURIST ARRIVALS FROM SOUTH ASIA

Country	Leisure/Holiday	Business	VFR	Other	Total
Bangladesh	30	30	20	30	110
India	310	70	560	751	1,691
Pakistan	120	10	40	150	320
Sri Lanka	40	0	10	52	102
Total	500	110	630	983	2,223

(Source: Botswana Department of Tourism, 2008)

The above tourism statistics presented by the Botswana's Department of Tourism show that tourism in Botswana is growing. This shows that tourism is ideal sector in diversifying the economy of Botswana in the face of global economic recession affecting the mining sector. Although the contribution of tourists to the economy of Botswana vary according to the tourist generating countries, the tourism contribution to the economy of Botswana in general is significant. The other area of concern is to investigate how much is the impact of HIV/AIDS on the Botswana tourism sector, particularly with increased poverty among highly affected communities, hence the need to conduct this study. Despite anticipated challenges that could be affecting the Botswana tourism, tourism statistics indicate that the number of tourist arrival in Botswana over number of years is growing. The following table depicts the projected growth of tourist arrival in Botswana from 2001 to 2006.

Table 3.17 presents the growth of tourism over a number of years. Based on the table, the Botswana tourism sector is growing and its contribution to the country's economy is significant. However, the contribution made by tourists to the economy of Botswana varies according to countries in which tourists come from. Although most of the tourists visiting Botswana in general come from South Africa, their contribution in terms of expenditure is relatively lower than that of tourists from a number of developed countries. The table below presents the tourists' expenditures in Botswana by country of origin based on various tourism services.

TABLE 3.17: TOURISM STATISTICS

Year	Tourist Arrival	Exp (Million)	Avg spend per day	Room Occu Rate (%)	Bed Occu Rate (%)	Length of Stay nights	Avg Room (Persons)	No. of Rooms	No. of Beds
2001	1193399	1928	264	24.6	18.8	2.5	1.5	3100	6200
2002	1273814	2301	317	24.1	18.0	1.6	1.4	3350	6450
2003	1405985	1815	314	30.5	26.7	2.0	1.7	3589	6646
2004	1522847	1642	225	35.5	32.0	2.7	1.7	4050	7800
2005	1675132	2433	274	41.5	36.0	2.5	1.7	4795	8040
2006	1759000	2481	266	54.4	43.9	2.1	1.6	4895	8612
2007								4832	8509
2008								4966	8716

(Source: Botswana Department of Tourism, 2008)

Table 3.18 presents tourist expenditure in Botswana on various service variables. The service variables used in the table include accommodation (acco), food and drink, transport (trans), recreation (rec), shopping (shop), and any other service that tourists may request. The other variables used to measure tourists' expenditure indicated in the table include expenditure per person, average stay in terms of nights, and average expenditure per day for each and every country stated in the above table. The table depicts that accommodation such as hotels and lodges presents relatively higher tourists' expenditure than any other service variable. In general, the tourist expenditure further emphasises the importance of tourism to the economy of Botswana. Tourist arrivals and expenditure also show that tourism has the potential not only to diversify the economy of Botswana but also to mitigate socioeconomic challenges such as the spread of HIV/AIDS through poverty alleviation. The tourist statistics and expenditure indicated in the above tables indicated that tourism has the potential for both entrepreneurship and employment opportunities for people living in Botswana particularly those living poverty.

TABLE 3.18: TOURIST EXPENDITURE IN BOTSWANA BY COUNTRY OF ORIGIN

Country of Origin	Acco %	Food & Drink %	Trans %	Rec %	Shop %	Other %	Total %	Spend /person (Pula)	Avg Stay/ nights	Avg spend per day
RSA	33.7	13.0	5.2	8.5	8.1	31.7	100.0	649	3.4	191
Zimbabwe	6.5	5.7	3.5	2.8	56.1	25.5	100.0	345	5.5	63
UK	40.3	8.6	7.6	10.8	5.6	27.3	100.0	2520	6.2	406
Germany	26.1	9.1	8.0	8.7	9.7	38.5	100.0	2165	7.7	281
USA	46.6	10.1	11.9	11.6	5.1	14.8	100.0	3070	10.4	295
Australia	25.9	12.9	9.8	24.6	10.6	16.0	100.0	2180	10.2	214
France	42.2	4.0	15.2	16.0	8.0	14.8	100.0	4710	8.4	561
Canada	40.8	15.4	10.3	20.7	5.7	7.1	100.0	3870	16.8	230
Namibia	37.7	19.1	9.0	12.9	5.3	16.1	100.0	1146	4.9	234
Switzerland	6.2	4.2	3.7	7.5	2.4	76.0	100.0	6712	10.8	621
Other	30.7	13.9	8.6	14.5	11.1	21.3	100.0	1760	8.4	133
Total	29.8	10.8	7.2	10.2	15.8	26.3	100.0	869	8.2	107

(Source: Botswana Department of Tourism, 2008)

The abundant wildlife in Botswana provides both direct and indirect employment opportunities for people living in Botswana. Direct tourism employment includes people working in tourism businesses and companies that deal directly with tourists such as hotels, lodges, airlines, shops, attractions, conservation areas, airports, banks, reception workers, waiters, chefs, housekeeping, game rangers, cleaners, tourism managers, reservationists, drivers, maintenance staff, cabin attendants, pilot, ground workers, and administrative workers. In direct employment include people in other sectors providing services to the tourism sector such as suppliers of food and fish produce, furniture, fittings, vehicles and vehicle parts, construction materials, equipment, technology, fuel maintenance and cleaning materials, and craft and curios (UNWTO & Botswana Department of Tourism, 2008: 3).

Besides direct and indirect employment created by tourism, income generated from tourism can be invested in other service sectors such as health. The contribution of tourism to the economy indicates that when tourism is negatively affected by pandemic such as HIV/AIDS, many other sectors may also be indirectly affected. This study therefore aims to investigate the impact of HIV/AIDS on the Botswana tourism sector, which is one of the economic sectors of the country with great entrepreneurial opportunities. The area of focus is on tourism businesses. Business opportunities in tourism include operation of bed and breakfast, guest houses, restaurants, and transport services. Tourism also provides local suppliers with the opportunity to supply their goods to local tourism enterprises (UNWTO & Botswana's Department of Tourism, 2008: 4). Services and entrepreneurial opportunities created by tourism further create employment opportunities that can assist the country in the fight against poverty and HIV/AIDS.

The employment created by tourism in Botswana is significant in both private and public sectors. For example, Tour Operators in particular employ a large number of people who receive wages, benefits and tips amounting to over P4 443 000 annually (Botswana's Department of Tourism Research and Statistics, 2004: 12). Among the people employed by the tour operators are both locals and foreigners. Hotels and associated industries also employ large number of workers both directly and indirectly to provide services and facilities to eco-tourism. Employment indicates an average of 7.7 dependants per person employed. This is a clear indication that people who are employed in the Botswana tourism sector support a large number of population, which may directly or indirectly mitigate poverty level in affected rural areas of the country.

In general, the tourism sector is labour intensive, which makes the sector to employ large number of people across the full employment spectrum. The sector accounts for 8.3% of global employment (WTTC, 2007: 26). In Botswana in particular, tourism creates 58, 780 jobs, which is 10.6% of total employment in the country. It is also projected by WTTC that by the year 2017 tourism would create 78, 540 jobs, which is equivalent to 13.1% of the total employment. The contribution of tourism to the economy of Botswana is significant, and the sector continues to create jobs. The table below presents the projected tourism and its contribution to the Botswana's economy.

Table 3.19 presents the projected potential of tourism in contributing to the Botswana's economy. It is indicated in table 3.19 that tourism is an important economic activity and has the potential

for future growth. The contribution of tourism to the Botswana's GDP and employment creation is significant.

TABLE 3.19: BOTSWANA ESTIMATES AND FORECASTS

	2007			2017		
	P mn	% of Tot	Growth	P mn	% of Tot	Growth
Personal Travel & Tourism	1,823	10.7	5.4	4,126	10.9	3.7
Business Travel	721	-	8.3	1,566	-	3.3
Government Expenditures	792	6.1	5.1	1,899	6.3	4.3
Capital Investment	596	5.4	8.6	1,559	6.5	5.2
Visitor Exports	5,893	13.1	8.1	16,094	14.1	5.7
Other exports	148	0.3	6.3	299	0.3	2.6
Travel & Tourism demand	9,973	-	7.3	25,544	-	5.0
Travel & Tourism Industry GDP	2,995	4.3	5.3	8,749	5.4	6.7
Travel & Tourism Economy GDP	6,787	9.7	7.4	18,819	11.6	5.8
Travel & Tourism Industry Employment	23	4.2	3.8	31	5.1	2.9
Travel & Tourism Economy Employment	59	10.6	2.9	79	13.1	3.0

(Source: WTTC, 2007)

As already indicated in this study, tourism is an important economic sector for Botswana. Tourism makes a significant contribution to the Botswana's GDP. Direct tourism consumption

contributes 3.4% to the Botswana GDP (UNWTO & Botswana Department of Tourism, 2008: 2). The combination of both direct and indirect contribution of tourism to the Botswana's GDP ranges between 4.2% and 6.0%. This contribution is imperative for employment creation. Direct and indirect employment created by tourism in Botswana is projected at a range of between 22 000 and 32 000 (Botswana's Department of Tourism, 2007:3). Besides employment creation, tourism also plays a fundamental role in its contribution to the Botswana's exports. Tourism exports are projected at P796 million, which is 53% of the total Botswana's exports. This makes the Botswana tourism sector the country's second largest exporter after diamonds, which makes P12479 million.

Tourism provides key social and economic opportunities for Botswana and it has a potential to enhance developments in particularly in rural areas where most poor communities live. As already indicated, tourism also has the potential to diversify the economy and address socioeconomic challenges such as poverty.

As already been stated, tourism contributes significantly to the Botswana's economy, coming second after diamond mining and is growing at a high rate. Tourism in Botswana contributes over 3.8% to the country's gross domestic product (GDP). The Okavango Delta is the biggest tourist attraction in the country, and this resulted in the establishment of community-based tourism project (Mmopelwa & Blignaut, 2006:113). The community-based tourism in the delta creates employment opportunities for people living in rural areas of Okavango and in general. What make the Okavango Delta fascinating to the tourists are its dry land, island fringe, and wetland habitat and vast wildlife species like big game, birds, fish and reptiles.

The government of Botswana recognises and acknowledges the delta's contribution to the country's economy, and use this as an opportunity to diversify the country's economy, which largely depends on mineral mining. This initiative is imperative because the government has realised that depending only on minerals may jeopardise the country's economy due to the fact that the minerals may be exhausted at a certain stage. The other concern by the Botswana government is environmental protection, and this is due to the fact that the wetlands are under enormous pressure resulting from damage. The damage is due to the fact that the wetlands economic value is widely underappreciated. Lack of wetlands economic appreciation is attributed to the fact that they are generally regarded as wastelands, and due to insufficient marketing

(Mmopelwa & Blignaut, 2006:113). This means that more work need to be done to market and protect the wetlands in Botswana by both the government and communities collectively. The contribution of tourism to the country’s economy depends on the mode of transport used by tourists. In most cases, tourists who travel by air spend more on transportation than those who travel by road such as tourists visiting the Okavango Delta from South Africa and the Botswana neighbouring states.

Many tourists visiting the Okavango Delta and other tourist destinations in Botswana in general from Southern Africa are travelling by road. Most tourists (95%) visiting Botswana from South Africa travel by road to Maun, and only 5% of the tourists from South Africa use air transport when visiting Botswana (Mmopelwa & Blignaut, 2006: 118). The travel expense for the tourists travelling by road is estimated based on general expenses like fuel costs and food expense, the same way it is done for the citizens. Although it is difficult to quantify the contribution of tourists travelling by road to the economy of Botswana, road travellers make significant contribution to the economy, thus contribution to poverty alleviation. For the tourists who travel by air transport, the expenses are calculated based on the return ticket of P2211.00 (Botswana currency) between Maun and Johannesburg looking at the number of tourists. Table 3.20 below stipulates the projected road travel costs of tourists in the northern part of Botswana in 2003.

TABLE 3.20: ROAD TRAVEL COSTS OF TOURISTS

Type of tourist	Total number of tourists	Number of tourists based on assumptions	Number of vehicles	Return distance travelled (km)	Rate used (pula/km)	Cost of travel (pula)	Cost of travel (US\$)
Local (Maun)	-	268	54	200	1.3a	13932	2843
Residents and other local tourists	6717	13166	2634	1596	3	3069664	626365
South	24456	12228	2446	2250	7	3425678	699610

Africans							
International	49090	49090	9818	200	3	2533044	516868
Overseas							
Total	73546	74752	14952	4246	17	9042318	1845686

a = mileage rate for tarred road

b = mileage rate for gravel road

(Source: Northern Parks and Reserves Visitor Statistics Annual Report, 2003).

The international tourists who visit Botswana travel by air transport from either Johannesburg in South Africa, Victoria Falls in Zimbabwe, or Windhoek in Namibia. This is because the airports in Botswana are not big enough to accommodate the big air crafts. International tourists are described by Mmopelwa and Blignaut as foreign visitors from countries other than South Africa. The travel expenses of the international tourists is projected to be P2115.00 per person (P is an abbreviation for Pula, which is Botswana's currency). This amount is calculated by multiplying the average cost of return air ticket from each of the above departure airports by the number of tourists (Mmopelwa & Blignau, 2006:121).

TABLE 3.21: THE AIR TRAVEL COSTS OF TOURISTS

Type of tourist	Number of tourists	Cost of return air ticket (Pula)	Travel cost (Pula)	Travel cost (US\$)
South Africa	306	2211	676 566	138 053.29
International	24 545	2115	51 912	10 592 781.33
Total	24 851		52 589 241	10 730 834.62

(Source: Northern Parks and Reserves Visitor Statistics Annual Report, 2003).

It is indicated in the table 3.21 that a total of 24 851 of both South African and international

tourists visiting the northern part of Botswana account for air travel costs amounting to P52 589 241 (US\$10 730 834.62). Although this statistics compose of only the northern part of Botswana, there is no doubt that tourism contributes significantly to the economy of Botswana. It is therefore imperative for the Botswana government to construct large airports so that big aircrafts like jets can land directly in the country instead of visitors having to go to South Africa, Zimbabwe and Namibia before visiting Botswana. This will help to increase the contribution of tourism to the Botswana economy through extra charges like landing and departure fees and increased number of overseas tourists. The other point that the Botswana tourism sector should consider is to market the country's tourism locally, and to encourage local people to utilise the tourism facilities available in the country. This will help the country to diversify the Botswana's tourism market instead of depending largely on South Africans and international tourists.

The other sub-sectors of the Botswana tourism that contribute significantly to the country's economy are accommodation and vehicle admission. Accommodation (camping) costs are calculated by multiplying the total number of tourists by the nights spent, which is then multiplied by the average camping charges per person per night (Mmopelwa & Blignau, 2006:118). The camping charges are as follows; P5.00 for the Botswana citizens, P15.00 for the residents and P20.00 for non-residents. Admission fees into the park are P30.00 for Botswana citizens, P40.00 residents and P50.00 for non-residents.

TABLE 3.22: REVENUE BY TYPE OF FEES

Type of fee	Revenue generated (Pula)	Revenue generated (US\$)	% contribution
Entry	5 495 723.50	1 121 402.38	78.26
Camping	539 774.50	110 140.99	7.69
Vehicle	488 110.00	99 598.85	6.95
Boat	240.00	48.97	0.0034
Aircraft	34 050.00	6 947.90	0.48
PARRO	464 730.00	94 828.16	7.62
Total	7 022 628.00	1 432 967.00	100.00

Source: Northern Parks and Reserves Visitor Statistics Annual Report (2003).

The other contributors to the Botswana tourism include vehicle charges, aircraft, and Parks Reserve Reservation Office (PARRO). Vehicles are charged according to their weights and whether they are registered in Botswana or not. The vehicle contribution is projected based on the total number of vehicles per day, which is multiplied by the amount charged as per vehicle weight. Vehicles registered in Botswana weighing below 3 500kg are charged P10.00, and those between the weight of 3 500kg and 7 000kg are charged P500.00. Vehicles weighing more than 7 000kg are charged P800.00. Vehicles that are not registered in Botswana weighing below 3 500kg are charged P50.00, and those weighing between 3 500kg and 7 000kg are charged P1 000.00, whilst those vehicles weighing more than 7 000kg are charged P1 500.00. All these charges indicate the significant contribution of tourism to Botswana's economy (Mmopelwa & Blignaut, 2006: 122).

The results in the table 3.22 above indicate that entry fee contributes 78.26% to the tourism in the northern part of Botswana. Camping contributes 7.69%, vehicle 6.95%, boat 0.0034%, aircraft 0.48%, and Parks Reserve Reservation Office (PARRO) contributes 7.62%. The total amount generated from the variable indicated in the table 2.5 above is P7 022 628.00 (US\$ 1 432 967.00). From the results indicated in the table, it is evident that tourism plays a major role in the Botswana's economy.

Besides positive contribution of tourism to the Botswana's economy, it also has negative social implications. Tourists are people on vacation and their cultures and behaviour may vary from that of the communities visited. This in number of occasions results in conflicts between tourists and locals. The worst conflicting scenario is sex tourism (commercial sex work), which is in contradiction with communities' social values and expectations in Botswana. This is a serious problem in the country due to the fact that Botswana is one of the countries with the highest rate of HIV infection in the world (UNDP, 2000: 23). The other problem is that a number local people in the country perceive tourism as an activity that does not contribute anything positive to their lives but exploiting their environment (Mbaiwa, 2005: 215). What contributes to this perception is the fact that most of the tourism companies in Botswana are owned and managed by the white foreigners who buy and possess land, and the general workers like porters and waiters are the poor local people who possess no formal training. The country is also facing challenges resulting

from illegal activities such as poaching and trophy smuggling that take place in the camps. The social problem exacerbating the resentment by selected local communities living in areas where tourism activities are taking place is the fact that selected safari camp operators portray discriminatory behaviour by denying the local people access to their camps. Tourism should enhance host community access and economic benefits so that the fight against HIV/AIDS through poverty alleviation can produce needed results.

Based on the above information, it is evident that tourism does not only make a positive contribution to the Botswana's economy but also has a number of negative social implications. It is therefore, imperative for the Botswana government and other stakeholders to engage in educational activities and policy framework to guide both tourists and local people to respect and accept each other. Activities like sex tourism and commercial sex workers should be forbidden in Botswana, bearing in mind that the country is faced with high HIV/AIDS infection rate. It can be indicated in the brochures given to the tourists when entering the country that visitors are welcome in the country, but any risky behaviour like sex tourism by visitors and locals is unacceptable. The general public should be encouraged to participate in tourism activities in the country, and the entrepreneurs on the other hand, should also be encouraged to respect and accept the locals. The entrepreneurs need the support from the local communities to run their businesses, and local communities should acknowledge the contribution of tourism to Botswana's economy. The local investors need to be educated that tourism is like any other business which has nothing to do with race or nationality, and they need to invest in tourism businesses in the country. By having citizens of Botswana investing in tourism will maximise citizen economic empowerment, and it will help to retain money in the country, rather than having foreign entrepreneurs taking the money outside the country.

The other important consideration is that the government of Botswana and the general public should refrain from selling the land to the foreigners. Selling land to the foreigners may later result in political problems that attract the attention of media worldwide when the land needs to be repossessed for the citizens. The land should be treated as an asset belonging to the country's citizens. Botswana should observe and learn from problems faced by Zimbabwe and South Africa in land redistribution process. In maximising the benefits of tourism to the Botswana economy, community tourism should be promoted in which host communities are encouraged to participate in tourism activities.

3.4.3 COMMUNITY TOURISM

Tourism has the potential to influence the lifestyles of the communities in which tourism activities are taking place (Sparks, 2007: 1180). In managing and developing tourism destinations, stakeholders such as local communities and educational institutions should be involved. Educational institutions play an important role in conducting research so that tourism economic benefits can be enjoyed in a sustainable manner.

Boxil (2003: 148) indicates that tourism is one of the economic sectors that have the potential to enhance development in many developing countries such as Botswana. In reaping the benefits of tourism, developing countries need to encourage development of tourism policy that does not violate local communities' way of living and that engages local communities in tourism activities that benefit them psychologically, economically and intellectually. Tourism should be developed in a sustainable manner without damaging the ecological system. Both cultural and social conflicts that result from mass tourism should be observed. Tourism policy makers should devise policies that encourage sustainability on local communities' cultures and ecological systems. In terms of cultural development, countries can focus on both local and international languages, and can also promote festival type of tourism so that they can cover various cultural aspects of a country.

Boxill (2003:149) advises that festival type of tourism should be adequately managed to avoid commercialisation of sensitive aspects of people's cultures. In preserving community cultural aspects, the festival may be linked to educational institutions so that professional advice and decisions can be made. Instead of developing tourism from individual country, tourism development should be collaborative efforts of different countries in a region and stakeholders such as local communities should be involved.

However, communities should not only participate in tourism development, but they should be able to control tourism activities taking place in their communities through cooperative ventures. Tourism organisations need to have tourism policies that prevent communities' exploitation by both tourists and investors. Community members should also be trained in tourism management and entrepreneurial skills. Community training in tourism related skills is an important initiative because it helps local communities to participate in tourism not just as a pull of cheap labour but

also as entrepreneurs. Tourism development is accompanied by various changes that need close monitoring so that lives and values of the local communities cannot be violated. For example, activities such as sex tourism and prostitution should be closely monitored, particularly in the face of HIV/AIDS. Community leaders in developing countries should be actively involved in the development of tourism in their respective communities (Boxill, 2003: 150).

Boxill (2005:150) argues that tourism is an important economic sector, and its development needs careful management, monitoring and administration. Tourism development should not be a sole responsibility of governments or investors, but it should be a collaborative responsibility of local communities and other stakeholders. Tourism cannot successfully develop in an environment that is full of uncertainty such as high crime, poor management and planning, and insufficient support from local communities. All stakeholders such as local communities should feel that they own tourism in their communities and that tourism is beneficial to them. Their cultural pride and values should be recognised and respected.

Guest host interaction should be adequately managed to foster understanding of cultural differences. Cultural tourism promotes interaction between host communities and visitors (Moulin, 2007: 35). This creates experience and enhances quality of life for local people. The development of cultural tourism provides the basis for caring for the history and heritage for both the visitors and host communities. Cultural tourism provides opportunities for local communities to participate in tourism activities taking place in their communities and also to interact with visitors in an innovative way. Cultural tourism encompasses both tangible and intangible aspects of life such as landscape, festivities, games and traditions. In promoting cultural tourism, it is imperative to view environment as an attractive element that attracts tourists to select a particular tourism destinations, and that encourages tourists to stay at a chosen destination.

Place, space and landscape are also integral components of cultural heritage tourism. Place does not refer only to physical structures, but it also refers to physiological and interactional concepts (Moulin, 2007: 36). Communities can derive meaningful concepts of social relationship from place. The meaning of a place is an experience derived from physical and social contacts between space based on individual perceptions, previous experience and acquired knowledge. Landscape is associated with the environment and the expression of cultural values, social attributes, and is also linked to decisions made by people over lengthy period of time. For cultural tourists to

appreciate places and landscape, they need to view landscape as an important aspect of cultural tourism development. Communities involved in cultural tourism development on the other hand, should acknowledge and encourage quality of a place. The focus of enhancing the experience of both visitors and host communities creates the basis of planning and developing of sites and community values.

Moulin (2007: 38) indicates that tourists can influence the cultural values of the host communities. Tourism brings about changes such as the design and planning of tourist attractions, facilities as well as advertising and promotional campaigns. Community tourism therefore, should be developed based on local communities' attributes, unique quality of the place so that local communities' way of life cannot be exploited. In developing cultural tourism, the emphasis should be placed on preserving quality of life and customs of local communities and maintain them against the pressures of changes attributed to tourism. Culture is a dynamic aspect of community life, and it contributes both past and present values of life. Cultural tourism development and practices create platform for an evolutionary change and it shapes both the presents and future aspects of community life. Involving communities in development of cultural tourism is imperative not only for the sake of tourism development but also for conserving cultural aspects and authenticity. Tourism planners should work closely with local communities in the process of developing cultural tourism. The planning process should consider economic socio-cultural and environmental aspects, which are essential factors in tourism. The planning process needs adequate resource assessment so that sustainable cultural tourism can be developed. Sustainable development should also include discovering and conserving social and cultural aspects, heritage sites, and lifestyles of host communities. Host communities' lifestyles and culture presents the basis for young people's guidance in how they handle and manage their lives. Cultural tourism also has the potential to contribute to the economy of the host communities, thus reducing the spread of HIV/AIDS through poverty mitigation. This means that cultural conservation through practices such as carrying capacity is imperative.

The concept of carrying capacity should be practiced so that the negative impacts of cultural tourism development can be minimised. This may also enhance quality of service provided to the cultural tourists. Both tourists and host communities should enjoy informative quality experience that enhances quality of life. For host communities, cultural tourism development should reflect their way of living and communities should feel they are represented by cultural tourism taking

place in their respective communities. However, the host communities should be aware of influences and challenges brought by tourism to their respective communities. Respecting community cultural aspects, way of life, values and norms is an essential aspect for cultural tourism development and for the sustainable tourism development in general (Moulin, 2007: 39).

Tourism plays a significant role in the economies of many countries in the world. It creates employment and contributes to various countries' GDP. However, tourism has both positive and negative impacts on the communities in which it is taking place. Many governments and communities recognise and strive to optimise the economic contribution of tourism to an extent that the social and environmental impacts of tourism are ignored (Faulkner & Tideswell, 1997: 3). This needs adequate attention so that both natural environment and social aspects of the host communities cannot be compromised for the sake of economic benefits. This means that the concept of sustainable development should be utilised so that the current generation can continue to reap the benefits of tourism without jeopardising the benefits of the future generations from tourism. Studies conducted in Australia indicate that monitoring community reaction is an essential strategy in urban planning and tourism development and management mechanisms. Most of the inbound tourists in Australia are from nearby Asian countries and economic development in those countries is a catalyst for discretionary travel. The cultural aspects and languages that are different from those of host communities often results in increased mixed reactions among the host communities. The increased number of inbound tourists put pressure on both social and natural environmental components.

Faulkner and Tideswell (1997: 3) argue that the literature on the social impact of tourism in communities is generally not substantial. Little research has been conducted on the socioeconomic impact of tourism on host communities, and most of the studies conducted in many developing countries focus on environmental and cultural impacts. One of the social implications of tourism in host communities includes its influence on the spread of HIV/AIDS, particularly through activities such as sex tourism and organised prostitution (Forsythe, 1999: 5). In addressing the social impact of tourism, tourism planners need to consider the intrinsic and extrinsic dimensions of the community tourism development interface. The extrinsic dimension refers to the features of the host destination and its role in tourism development, and intrinsic dimension refers to the characteristics of the host community members. These include community involvement in tourism socio-economic activities, and the distance between host

community and tourism activities.

Community reactions on the impact of tourism pass through various sequential stages. An initial euphoria is followed by apathy, irritation, and antagonism. There is a strong relationship between this sequence of reaction, which also depends on the stages of destination life-cycles such as exploration, involvement, development, consolidation, stagnation, and decline or rejuvenation. These stages have different impacts on host communities according to the stages in which tourism in a particular destination is growing or changing. This also indicates that community reaction to development is dependent on the stage of tourism and the community reaction can also influence the progression of stages. Communities can either encourage or discourage the development of tourism in their areas as a tourist's destination (Faulkner & Tideswell, 1997: 6).

Different attitudes and perceptions towards tourists by people within host communities are influenced by the type of tourists visiting those communities. The community reaction towards tourism depends on factors such as the degree to which the host population and tourists vary from each other in terms of race, cultural factors and socioeconomic status (Forsythe, Husban & De Lister, 1998: 279). The other factors influencing the local communities' reaction towards tourists include the influx of tourists, overcrowding, and congestion. The other important aspects influencing the host communities' attitude towards development is the degree of which the community is involved in tourism. The relationship between host communities, and tourists is also determined by balance between costs and benefits of tourism on both guests and residents. Many studies conducted in various communities indicate that residents who are dependent on tourism for their livelihood often accept the negative impact of tourism and encourage its development (Faulkner & Tideswell, 1997: 7).

When tourism activities are located outside the residential area, there is often less tourism disputes and the host communities accept and encourage tourism (Faulkner & Tideswell, 1997: 8). Community members living next to the tourism activities and depending on tourism often accept the development of tourism. Most of the studies conducted in various countries do not cover the socio-demographic features of host communities and variation in perception of tourism (Faulkner & Tideswell, 1997: 8). Generally, the negative impacts of tourism are expected to be more significant at a mature state of tourism development in which there is a high ratio of international tourists on a seasonal basis. Destinations at an early stage of tourism development

dominated by domestic visitors and low seasonality are expected to draw positive community response to tourism development. As already indicated, response to the tourism development is determined by the degree of community involvement in tourism. Host community members whose employment is dependent upon tourism often support development of tourism and accept its impacts. Residents who are not involved in tourism may negatively react to tourism development depending on how far the tourism activities are from host communities. For migrants, their reaction depends on their motivation for migration and involvement in tourism, and for long term residents their reaction depends on their involvement and location of tourism activities from their area.

The study conducted in the Gold Coast region of Australia provides a good example of how communities may react to tourism development. The Gold Coast is renowned for classic beach-side resorts. The Gold Coast is a mature tourist destination and attracts a large number of international tourists and investors. It has a range of community tourism impacts. For example, the rapid population growth in the area results in a tension between urban and tourism developmental imperatives, which does not only impacts on tourism but also other impacts of urban development linked to tourism (Faulkner & Tideswell, 1997: 11).

Figure 3.3 depicts various factors influencing resident reaction to tourism development. It shows that residents often prefer low seasonality tourism due to its low tourist ratio. Communities often support tourism development that is attracts domestic markets. On the other hand, host communities do not prefer tourism that is at its mature stage of development due to the influx of international tourists who visit the area on a seasonal basis (Faulkner & Tideswell, 1997: 20). However, as already indicated, the community reaction to tourism development often depends on the degree of their involvement in tourism and residential proximity to tourism activities. The other determinant factor to the community perception of tourism is the period of residence. The reaction of residents who recently migrated to the community depends on their motivation for migrating and the degree of involvement in tourism development in their areas.

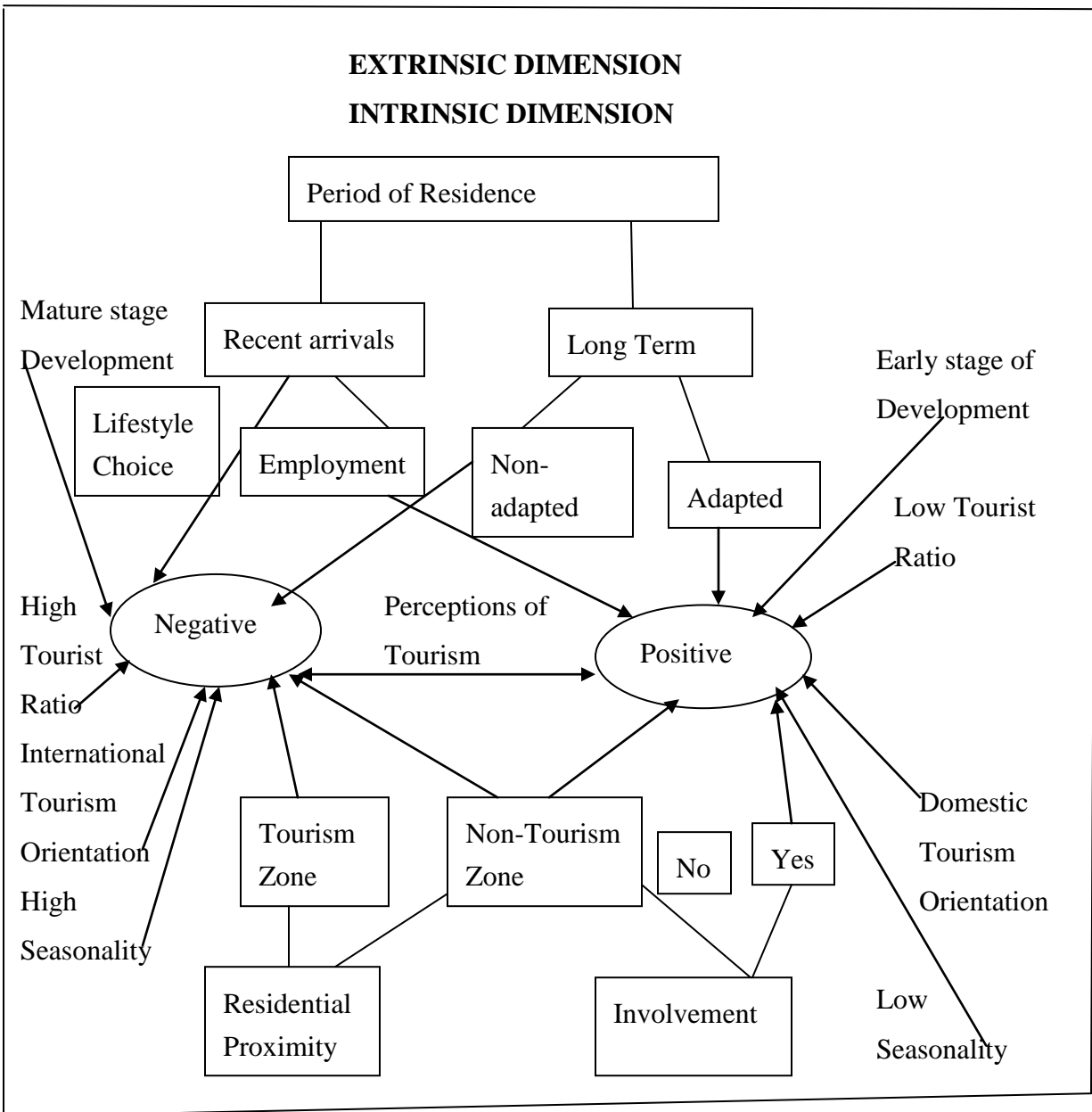


FIGURE 3.3: FACTORS AFFECTING RESIDENT REACTIONS TO TOURISM

Source: Faulkner & Tideswell (1997)

Studies conducted in the Gold Coast indicate that tourism has negative impacts such as noise and congestion, increased cost of living, queuing at service facilities, and litter and damage to the natural environment. Besides negative impacts, tourism plays a vital role in the lives of host communities because it enhances their quality of life and creates employment opportunities for them. Tourism enhances the quality of host communities through increased types of and standards of recreation, shopping and service facilities. Besides employment opportunities,

tourism develops infrastructure and superstructure, improves the appearance and amenity of the area and also increases the level of local pride.

Considering both positive and negative impacts of tourism, it is complicated to conclude that host communities are expected to react negatively or positively to tourism development in their area because it depends on communities' involvement in tourism and also on economic benefits such as employment, economic benefits and improved quality of life. However, the negative socio-cultural impacts of tourism may not be accepted by various communities. In the Gold Coast in particular, tourism is viewed by communities as an important economic activity, but its negative impacts such as cultural erosion are of a minor concern. Residents in the Gold Coast are divided because a number of residents feel that cultural stereotype linked to tourism undermines their own cultural aspects (Faulkner & Tideswell, 1997: 20).

Reid, Mair and George (2004: 623) argue that the studies on the involvement of general communities in the tourism planning process are insufficient. It is imperative for the host communities to effectively participate in the planning of tourism activities in their areas so that poverty alleviation can be a collaborative effort. In a number of occasions, community recreations grow enormously to an extent that outsiders dominate local residents or even change and influence the nature of the event. In planning tourism related activities, tourism-oriented communities should plan their tourism activities more systematically according to residents' attitudes and perceptions about tourism development at the outset. The fundamental point is to get local community residents involved in the development process. This means that tourism, particularly in rural areas, should be inclusive and encourage meaningful public participation. This is because lack a of resident participation opportunities in tourism development within their communities may lead to negative residents' perceptions of tourism development, and it can lead to tourist dissatisfaction and ultimately reduced visitation. Public in tourism development planning is not only important for community support, but is also essential for sustainable tourism development. The following figure presents a model for community tourism development planning.

The model in the figure 3.4 provides a framework focusing on local community participation. It indicates that leadership in the form of a catalyst is an essential aspect in the tourism planning and development process. The model depicts that it is imperative to raise community awareness

on tourism development issues, and identify community values that may be in contradiction with certain tourism activities such as sex tourism. Community values are an important consideration and should provide guidelines for organisational structure, product development and marketing for tourism activities. Planning tourism activities should be collaborative efforts of all concerned stakeholders, and it requires regular monitoring and evaluation so that tensions that may rise between host communities and tourism developers due to negative impacts of tourism, can be avoided. This strategy is also essential in enhancing the potential of tourism in mitigating socioeconomic challenges facing communities such as poverty and prostitution, which may also help in fighting the spread of HIV/AIDS in communities.

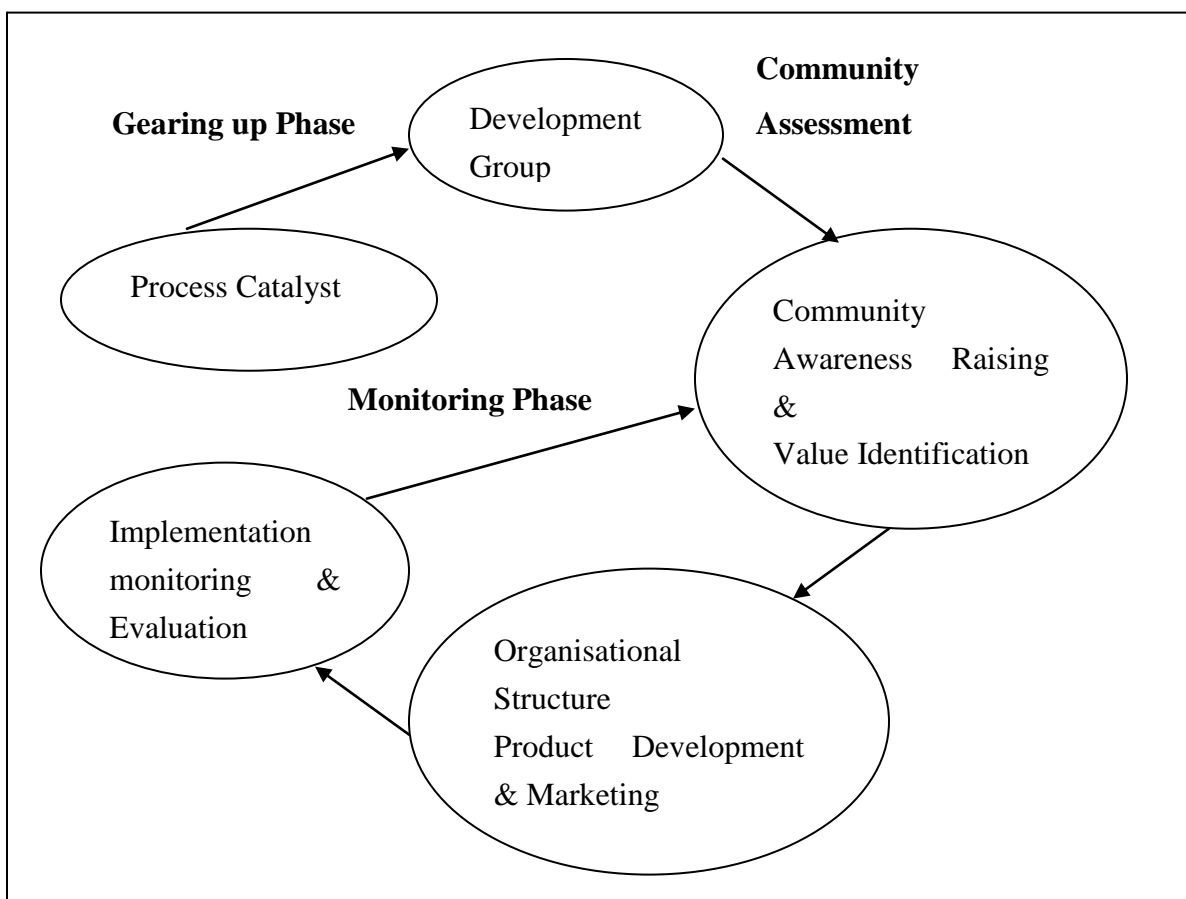


FIGURE 3.4: COMMUNITY TOURISM DEVELOPMENT PLANNING MODEL

(Source: Reid *et al.*, 2004)

The key challenge facing a number of tourism planners and developers particularly in developing tourism destinations is the initiation of a community-wide interaction. Community interaction is

an essential aspect of successful tourism planning procedures in mitigating tensions that may rise between foreign tourists, investors and host communities and to gain residents' support on tourism development in their communities. However, residents who do not directly experience negative impact of tourism often find it difficult to visualise challenges and impacts that unplanned tourism development may have on their everyday life (Reid *et al.*, 2004: 627). Failure to involve host communities in decision making pertaining to tourism activities taking place in their areas often results in tensions between tourism businesses and host communities. There may be tensions among community members who prefer niche-tourism and those who prefer mass tourism. The other challenge facing developing countries such as Botswana is the fact that tourism planning and development are often centrally organised and controlled, which is a complex practice for an ordinary community member. Community members who are not involved in public decision making may feel that their ideas are not considered important, and they may perceive tourism to be destructive to their lives.

Coate and Handmer (2006: 135) indicate that community building and sustainability processes should involve the concerned communities. In developing countries in particular, there is usually a high proportion of labour force engaging in the informal economy including those in the tourism sector. In addressing socioeconomic problems such as poverty and unemployment, it is imperative to the local economy so that the livelihood of those affected can be improved. This is because the economy does not only involve formal activities but it also involves informal activities. The informal tourism activities are of paramount importance in supporting livelihoods of many people in developing countries, and are an important poverty alleviation activity. Informal activities comprise privately owned tourism businesses that are usually not registered with government and other regulatory authorities. People involved in the informal sector do not only own businesses but are also important to those who are employed by informal tourism enterprises.

Occupations and businesses in which informal employees often engage in include fisheries, touts, mobile hawkers, taxi drivers, masseurs, beach based beauty therapists, sex workers, carpenters, garden workers and fishmongers (Coate & Handmer, 2006: 138). In general, informal businesses operate in a small scale and are labour intensive with low skilled labour force in which skills have been acquired outside formal education systems. This sector has high competition due to limited barriers to entry. The informal sectors such as those in tourism play a vital role in the economy of

many developing countries such as Botswana. In Thailand for example, the informal sector is a key contributor to the country's economy in which many people in the country derive their income from the informal enterprises such as those in the tourism sector. A number of developing countries such as those in the Southern Africa face socioeconomic challenges such as lack of employment opportunities to an extent that their citizens rely on governments and international communities such as United Nations for their livelihoods. People are usually vulnerable to natural disasters such as Tsunami and HIV/AIDS are those living in poverty.

It is therefore, imperative for the local community groups to participate in local government decisions and public policy-making in mitigating any challenges facing the communities. In mitigating the impacts of any disasters such as poverty and HIV/AIDS in developing countries, NGOs often play a vital role, particularly when working with local communities. It is therefore imperative to involve local communities from grass root levels in any recovery and development plans. The initial process of integrating local communities in recovery plans should be coupled with detailed socio-economic needs assessments so that marginalised communities cannot be left out (Coate & Handmer, 2006: 140).

Coate and Handmer (2006: 140) argue that for any recovery plan to be successful, communities from grass-root level from various sectors should participate. It is also imperative for governments, NGOs and business communities to work collaboratively in mitigating any disastrous situation facing communities or a country. The local NGOs often have great knowledge of how vulnerable the local communities are to the prevailing socioeconomic challenges and they can make sure that stakeholders in the local communities participate in strategic planning for problem mitigation. Studies conducted in the Northern Thailand on Tsunami disaster recovery plans conclude that the collaborative model involving all stakeholders including marginalised communities is cost effective. This is because it gives communities the opportunity to participate in the recovery strategies and to rebuild themselves and cope with the situations. Community participation is also imperative because it helps the marginalised communities such as AIDS orphans to be able to deal with trauma. Disasters such as tsunamis and HIV/AIDS destroy the development that a country has achieved in the past years, and may cause stress and shocks that may be difficult to cope with particularly by affected communities. Examples of shocks include inequality and intensified poverty levels (Bernett, Whiteside & Desmond, 2001: 166)

Coate and Handmer (2006: 142) further argue that development alone cannot make people less vulnerable to a problem, but individuals, communities and countries should participate in problem solving. This indicates that in mitigating any problem affecting societies, it is imperative for NGOs, government authorities, businesses and local communities to work collaboratively. It is important for the recovery strategies to work within established social patterns and norms to ensure that various economic sectors work hand-in-hand. For example, in the Southern Thailand area, the emphasis was based on both tourism and fishing sectors. These two sectors have potential to fight socioeconomic problems such as poverty. Sustainability of both tourism and fishing sectors in Southern Thailand is the fundamental focus forming the basis for the objectives of livelihood for local communities. The initiatives in the Southern Thailand is a collaborative approach involving the United Nations, Food and Agricultural Organisation (FAO) together with NGOs such as the Catholic Agency for Overseas Aid and Development, and Rotary International who provides support such as fishing boats and nets (Coate & Handmer, 2006: 142). This also provides a good example of sustainable development principles in which various stakeholders are involved in various developmental activities.

3.4.4 SUSTAINABLE TOURISM DEVELOPMENT

Byrd (2007: 6) indicates that sustainability is an essential concept in tourism planning and development, and that the success of sustainable tourism development depends largely on the stakeholders' involvement in tourism planning. Sustainable tourism refers to the process in which tourism resources are utilised to benefit the present tourists and communities without jeopardising the benefits of the future tourists and communities from tourism. This indicates that sound planning in tourism development is imperative. Failure to plan tourism activities may damage the key tourism resources such as economic, environmental, and social aspects of the community. Also, for tourism development to be successful, planning and management are the key considerations. The fundamental aspect to the success and implementation of sustainable tourism development is the stakeholders' support. Stakeholders refer to any group or individuals who can influence or be influenced by tourism development such as general citizens, entrepreneurs, and community leaders. The problem facing tourism development in many developing tourism destinations such as Botswana is that decisions regarding tourism development are usually made from the top instead of involving communities from grassroots

level. Such decisions often fail to attract the concerned communities' support and are often perceived by local communities as not representing community interests and ideas.

Byrd (2007: 7) argues that for sustainable tourism development to be successful, it should take stakeholders interests into consideration. To be regarded as a stakeholder, a group or individuals should have a legitimate interest in the development of tourism in their areas. The stakeholders should also show interest in tourism organisations. This means that stakeholders should actively participate in influencing the directions of the organisation they are interested in. It is therefore, imperative for all stakeholders' interests to be identified. Although not all stakeholders should be equally involved in the public decision-making process, all stakeholders' interests in tourism should be identified during tourism development planning process. Failure to identify stakeholders' interests may lead to failure of tourism development in an area, especially in circumstances in which the stakeholders whose interests are not considered are those for influential stakeholders.

Various key groups of people and individuals in the community should be identified and important tourism issues should be discussed with them. From the discussion, stakeholders should be given the opportunity to state their views on the development of tourism in their community. The stakeholders' participation should be on-going and stakeholders should know that their views have the potential to influence important decisions not only at the initial stages of tourism planning but throughout the entire tourism planning and management process. Stakeholders' involvement in tourism planning should be based on fairness, efficiency, knowledge, wisdom and stability. The participation should be fair in the sense that all stakeholders' interests are taken into consideration and they and they should feel that decisions made are also fair. Fairness enhances stakeholders support for the decision made regarding tourism development. Although stakeholders may be convinced that tourism development process is fair, the development process needs to be efficient and the decisions made should be based on available information (Byrd, 2007: 9).

Byrd (2007: 9) emphasises that tourism development should be planned and managed in a way that it meets the needs of the present generations without compromising the needs of the future generations. Tourism should be planned and developed taking natural environmental concepts, social concepts, and economic concepts into consideration. Tourism should enhance the quality

of life of the host communities, and the planning process should have a social structure that resolves any form of conflict attributed to tourism and affecting tourism development.

The World Tourism Organisation (WTO) (1998: 21) describes sustainable tourism development as the tourism that satisfies the needs of the current tourists and host communities while conserving and enhancing opportunities for the future. This emphasises sound management of all tourism resources in a way that economic, social, and aesthetic needs can be satisfied while maintaining cultural integrity, important ecology process, biological diversity, and life support systems. WTO's definition of sustainable tourism development focuses on both the present and future tourists and the host communities. The process of sustainable tourism development considers satisfaction of the present tourists, future tourists, present host communities, and future host communities.

The present host communities encompasses all groups that live within areas in which tourism activities are taking place such as residents, business owners, and government officials. However, changes brought by tourism, often impact more on host communities than on any other group because host communities use most of the tourism resources for their livelihood and they are present in the location in which tourism is taking place on a longer term basis. The present tourism development in a host community influences the community support for future tourism development and it plays an important role in the host community's interaction with tourists. The host community support for tourism development and their interactions with the visitors are essential considerations because it determines success or failure of tourism development in a particular tourism destination (Byrd, 2007: 11).

Nyberg (2001: 54) indicates that Destination 21 is a national eco-label for tourism destinations that aims at assisting destinations to achieve the concept of sustainable development based on the national and local sustainability objectives. The concept of sustainable tourism development is in contradiction with various agreements on sustainable development such as those established through the Brundtland report and a number of United Nations (UN) documents promoting massive developments. In 1997, the World Tourism Organisation, the World Travel and Tourism Council and the Earth Council established Agenda 21 for the Travel and Tourism Sector, and Denmark established a framework for a national Agenda 21 for tourist destinations, which is known as Destination 21. Destination 21 is a national initiative and is linked to Agenda 21 vision

and objectives. This initiative strives to address variations between the concepts of sustainable tourism development and sustainable development. Destination 21 focuses on the environmental, socio-cultural and economic basic dimensions. This initiative views tourism as an integrative activity in which the key aspects of management include a holistic approach focussing on future and equitable developmental opportunities (Nyberg, 2001: 54)

The aim of the Danish government and the national tourist organisation was to establish Destination 21 and to empower the Danish tourism, and to enhance its competitiveness in the international market. This initiative has eight sustainability objectives focussing on knowledge, evaluation of natural resources, socio-cultural and economic factors of the tourism destination. The objectives include the strategies encouraging collaboration between the local stakeholders to ensure that all parties of the local communities are represented. The second objective focuses on building competence and spread messages about sustainable tourism development principles and practices among organisations that are taking part in the process. The information about Destination 21 is disseminated to the local politicians, local residents, and to the visiting tourists regarding the economic, social, and environmental aspects. The local authorities play a vital role in protection of the natural and cultural environmental factors, and the local cultures are made stronger through social and cultural tourism development. The local Agenda 21 principles emphasise environmental management aiming at mitigating excessive resource use and pollution. The development of tourism should create economic benefits and employment opportunities for the hosting communities through sustainable tourism activities and business opportunities (Nyberg, 2001: 56).

Nyberg (2001: 56) argues that sustainable development and sustainable tourism development are not always compatible concepts. There are various tourism concepts that are not sustainable in nature, particularly with adverse competition between tourism sectors and other economic sectors sharing similar resources. For example, the purpose of Destination 21 concept is to strengthen Denmark's international competitive advantage as a tourist destination, and it focuses more on the development of tourism than on conserving the local tourism-resource-base. This argument presents a conflict between the concept of sustainable development and sustainable tourism development in a local community. This also provides a distinction between eco-centrism and techno-centrism as variations towards sustainability. The eco-centrism focuses on strategies that encourage the sound management of natural and human resources, and techno-centrism focuses

on utilising and exploiting natural resources in enhancing development for social and economic benefits (Nyberg (2001: 58). In this regard, Destination 21 supports techno-centrism concept, and Agenda 21 is in support of eco-centrism concept.

Choi and Sirakaya (2006: 1274) indicate that the concepts of globalisation, capitalism, population migration, and advanced transportation and communication technology fuel the development of tourism into one of the largest sectors in the world. However, the challenge facing many developing tourism destinations is to balance between developments and also adhere to the concept of sustainable development.

Choi and Sirakaya (2006: 1275) argue that the fact that many tourism businesses are small in size, raises serious challenges when it comes to implementation and monitoring sustainable tourism development, particularly at local levels. Consequently, many developing countries find it difficult to have sound national policies and strategies on sustainable development and its implementation. Many developing countries do not have management strategies or indicators that are essential for systemic tracking and monitoring socio-economic and political changes in communities. Indicator studies in tourism are minimal despite the fact that WTO and other organisations are making tremendous efforts to establish them. In tracking and addressing the impacts of tourism in various communities, it is important to base indicators on policy relevance, analytical, soundness, and measurability. The indicators should be used in various situations, particularly at local levels where the impact of tourism is often significant.

Sustainable development for community tourism should be focused at enhancing quality of life for the local residents by creating economic benefits, protecting the natural and manmade environmental factors, and providing training opportunities for residents working in tourism so that tourists can receive quality services and experience. Sustainable community tourism should also provide long term economic benefits to both local residents and businesses alike. However, economic benefits should not compromise sustainability of natural and socio-cultural environmental aspects of the host destination. Community stakeholders such as governments, tourists, host communities, tour operators and other tourism related businesses should take the responsibility to ensure that tourism is conducted in an ethical manner. Public decision-making and developmental planning procedures need to be collaborative efforts of various stakeholders at all levels of planning and policy formulation, and this should include government, NGOs, local

residents, the tourism sector and professionals in a form of partnership. The focus should also be on what type of tourism development is suitable for a particular community (Choi & Sirakaya, 2006: 1275).

Community leaders and planners should take the initiative to educate residents, tourists and other stakeholders on the planning and conservation of community tourism resources. Sustainable community tourism consists of ecological, social economic, political, cultural, and technological aspects at the international, national, regional, and local community levels. It is to ensure that economic benefits from tourism are equally distributed throughout the community. Sustainable community tourism requires that socio-cultural sustainability should respect social integrity and social capital for the community culture so that community residents can control their lives. Sustainable development is a political aspect, which means that in achieving sound sustainable community tourism, community's political system and power distribution are imperatives. Governments in most developing countries often control the development of tourism and local community residents are often ignored in the Public decision-making process. Sustainable community tourism needs local residents to play an active role in the public decision-making process (Choi & Sirakaya, 2006: 1276).

Most of the political challenges detrimental to profound sustainable community tourism include lack of stakeholder collaboration or community participation, lack of community leadership, poor policy systems, the roles of NGOs that are not clearly defined, and the displacement of residents and the excessiveness of eternal control of tourism development by private foreign investors. Technological development in transportation, information and communication dramatically influence the growth of modern tourism, which also attract foreign investors in many developing countries. Technological development creates communication networks that assist stakeholders to share information through mechanisms such as e-mail, world-wide-web, e-commerce, and the internet. In achieving sound sustainable community tourism, scientific knowledge and technological advancements are imperative (Choi & Sirakaya, 2006: 1276).

Most of the strategies on sustainable development in many developing countries do not include tourism. Many studies indicate that there is little effort made to monitor and measure sustainable community tourism development in various developing tourism destinations. Monitoring and evaluation are the essential strategies to predict both present and future tourism development and

its impact. Monitoring and evaluation are the last procedures in the planning process, and they are conducted simultaneously with the implementation of the planned tourism development. Failure to establish sustainable tourism policies and evaluation at an initial stage may result in failure to identify and mitigate negative impacts of tourism. It is imperative to identify important indicators that can assist in avoiding risks associated with poorly planned tourism development (Manning, 1999: 180).

The complexity of interrelationships of tourism systems requires sustainable indicators for community tourism development to be varied from traditional indicators. Sustainable tourism strategic planning should incorporate ways and means to establish relevant policies and suitable decision making procedures at all levels of government. Sustainable tourism involves various stakeholders, which means that the political support in terms of rules and regulations at national and regional levels are important. The process of utilising and evaluating sustainability indicators should be transparent so that participation of all stakeholders, including the host communities, can be enhanced. This means that stakeholders should be given the opportunity to give direction for both current and future community tourism development (Choi & Sirakaya, 2006: 1278).

Ryan (2002: 17) indicates that tourism is a complex business consisting of components such as transport, attractions, accommodation and technologies. As part of the tourism network, tourists wish to get away from their everyday lives. They wish to escape from routines of family, homes and work to see various places, to meet people and to experience new behaviour. The core complexity of the modern tourism is determined by an individual's experience of the place and the interaction that an individual has with the location, local community members, other tourists and tourism employees within the visited place. Tourists influence the people they interact with at the tourists' destination, such as other tourists, intermediaries between tourists and environment, workers such as tourist guides, accommodation providers, interpreters, bus drivers, and entertainers. Tourists also interact with people not directly involved or employed by the tourism sector but residing in the destination area and those living outside of the destination area but having accountable for the development of the particular destination such as government employees and tourist agencies.

Tourists and the authorities who give permission for tourism development should be adequately responsible. This leaves government agencies forced to devise management policies that control

access, permission control and zoning. Government agencies, particularly in a number of developing countries, often dictate which locations are allowed to have tourism development, which also determines jobs and incomes that tourism generates. These policies often deprive communities whose locations are not identified as suitable for tourism development economic opportunities derived from tourism. Communities that are denied tourism opportunities are often the economically marginalised, and they often perpetually suffer a loss of economic opportunities that tourism possesses. This often results in people particularly young community members having to migrate to other areas in search of employment opportunities (Ryan, 2002: 18).

Both tourists and tourism organisations should observe and respect the host communities' values and norms. This can be done by discouraging activities such as sex tourism and organised prostitution, as well as enhancing safety and security of tourists. Organised sex tourism may increase HIV/AIDS, which may destroy tourism in return. Social tourism development should be sensitive to the impact it has on host communities. Tourism in general has several social impacts in communities in which it is taking place. For example, a study conducted in the Spanish hotel sector on Costa Brava indicates that tourism development in that area attracts migrant female workers as housemaids and receptionists. The majority of the migrant workers are young ladies who have responsibility to take care of their families. The Spanish tourism and the hotel sector change the role of females in this part of the Spanish society. Besides having to take responsibility for taking care of their respective families, females often engage in activities like sex tourism which also expose them to diseases such as HIV/AIDS and other sexually transmitted illnesses. WTO clearly stipulates that activities such as sex tourism are prohibited because they relate to the abuse of the children. The issue of social equity makes it difficult to foster sustainable tourism (Ryan, 2002: 22).

Sustainable tourism is often perceived as a conservation of the cultural or physical environment, but it does not cover the social inequality. Consideration should be given to poor regions that do not have sufficient economic, educational or social opportunities. Also there should be balance between the potential for economic growth for the poor and the concept of sustainable development that emphasises the protection of the natural resources. Host communities should be involved in an equitable manner in any tourism development taking place in their respective communities. Tourism should not be perceived as creating low skill jobs. Tourism companies that provide poor skills, often offer poor quality service and are less likely to survive tough

competition. It is imperative to be proactive in planning the new tourism. Communities need to identify their vision before any developmental proposals can be developed, and planning should be a continuous process that is conducted in a collaborative manner (Ryan, 2002: 24).

Responsible tourism requires philosophical and moral beliefs fundamental to promoting the ethical values common to humanity. These are tolerance and respect and respect for the diversity of religions. Stakeholders and tourists need to respect the social and cultural freedoms of the host communities. Communities should respect the needs of the tourists who visit their community (Ryan, 2002: 24).

Holden (2003: 94) argues that the concept of ethics within the tourism sector of many developing countries has not been receiving attention up until the early 1990s. Consequently, the studies conducted in tourism ethic are insufficient. Ethics should provide guidelines for human conduct and interaction. Tourism activities such as sex tourism, the displacement of local people from their land for tourism development purposes, and lack of access for resources such as water by host communities, raise serious ethical concern. Many studies and planners in a number of developing countries often focus on the impacts of tourism on natural environment and not much attention is focused on the socioeconomic impacts of tourism. The general environmental ethics are important considerations in determining the relationships between human and nature, also among human beings themselves.

Failure to comply with ethical requirements may cost tourism because the environment may lose its quality. The economic development of tourism destinations often influences decisions that comprise ethical issues. The need for sustainable tourism adhering to a code of ethics is imperative particularly in developing countries. It is often assumed by many tourism planners that local communities in tourism destinations are willing to employ conservation ethics to the environment that surrounds them. It is also believed that local communities who are involved in tourism planning and development would support the nature conservation concept. The concept of tourism ethics is more complex than it appears to be, and is one of the fundamental considerations in sustainable tourism development (Holden, 2003: 104).

Mbaiwa (2005: 203) argues that development of tourism in most of the developing countries does not comply with the principles of sustainable tourism development. In the Okavango Delta in

Botswana, for example, the tourism sector satisfies the needs of foreign tourists from developed countries and is dominated by foreign safari companies. The tourism sector in the Okavango Delta does not show concern for the socio-cultural, economic and environmental imperatives of the host communities. Local companies and investors in the Okavango Delta are often marginalised by tourism planners, and there is significant leakages and repatriation of tourism revenue from Botswana to developed nations. Tourism in the Okavango Delta fails to promote rural development and reduce poverty, and it does not observe policies aiming at protecting the delta as a natural ecosystem (Mbaiwa, 2005: 204). It is essential for tourism to be planned and developed in a way that satisfies the needs of both tourists and tour operators without compromising the socio-cultural, economic, and environmental qualities of both host communities and countries.

Generally, tourism plays a vital role in contributing to the economy of many countries in the world. The development of international tourism is influenced by higher standards of living in and sophisticated modes of travel in developing countries.

The development of tourism in the Okavango Delta should be sustained to maintain long term viability of good quality natural and human resources. The Okavango Delta in particular, is not only an area of rich ecotourism such as wildlife, but is also home to more than 122 000 people. More than 90% of the people living in the Okavango Delta area directly or indirectly depend on natural resources for their livelihoods. Sustainable development in the area needs to focus at enhancement of quality of life for communities living in the Okavango Delta area, tourists' satisfaction, and conservation of both natural and socio-cultural components. This is because poorly planned tourism development can destroy itself by damaging the environment that attracts tourists to a destination (Mbaiwa, 2005: 208).

Achieving sustainable tourism development in developing countries and tourism destinations like the Okavango Delta in particular is complicated due to the international context in which tourism is occurring, the number and characteristics of tourists visiting the tourist destination, and the characteristics of the host communities. Most of the tourists visiting the Okavango Delta are from developed countries such as North America, Europe, Australia and New Zealand. The main mode of transport used by tourists visiting the area is by airplane. Botswana does not have an international airline operating between Botswana and developed countries, and tourists visiting

Botswana use foreign-owned airlines such as South African Airways, British Airways, Lufthansa and Royal Dutch KLM, but these airlines have to fly to Johannesburg in South Africa where tourists can connect with Air Botswana to Maun. Foreign-owned airlines operating in developing destinations can influence the number of tourists visiting the concerned destinations through marketing strategies such as discounted seats. However, Air Botswana lacks such competitive advantage, and it does not have power to control or influence the number and types of tourists visiting the Okavango Delta. The fact that Botswana relies on foreign airlines for tourists visiting the Okavango Delta means that the country is losing important revenues because payments for transport arrangements are managed in foreign countries (Mbaiwa, 2005: 209).

Besides the foreign control of the airlines industry for tourists visiting the Okavango Delta, foreign tourism companies also operate charter aircrafts that transport tourists from Maun Airport to different lodges and camps in the Okavango Delta. Maun Airport is the Botswana's centre for arrival and departure for international tourists from developed countries. This clearly indicates that foreign companies dominate and control the air transport sector in the Okavango Delta. This also means that the tourism sector in the Okavango Delta is designed to meet the interests of foreign tourists and companies only. Barriers to entry into the air transport by local investors are high, resulting in marginal economic benefits from the air transport sector by the local economy. The economic benefits accrue to the local economy are generally limited to employment and fees such as landing and parking paid to the Department of Civil Aviation in Botswana. This shows that the transport sector in the Okavango Delta does not provide equal access and benefits to all stakeholders such as local investors (Mbaiwa, 2005: 209).

Besides air transportation, the other key sector in the tourism industry that attracts many investors in the Okavango Delta is the accommodation or hotel sector. The accommodation and hotel sector in the Okavango Delta is also dominated by international companies and investors. This also means that most of the economic benefits generated by accommodation sector in the delta do not accrue to local companies and investors. Consequently, local communities do not have control over local resources, which often results in negative long term impacts of tourism. Local residents are often displaced and their environment or residential areas are converted to accommodation facilities owned by foreign investors. Consequently, many residents in the Okavango Delta are under the impression that the wetland has been taken away from them by the Botswana Government and given to the international tour operators. This results in many local

residents and a number of Botswana citizens in general perceiving tourism as the sector belonging to foreign companies and investors, and as a sector that exploits their resources without providing any benefits to them. This perception is exacerbated by the fact that local communities are not consulted and involved in decision making and planning for resource use in their areas. Excluding local communities in tourism planning and public decision-making is against the concept of sustainable development which emphasises participation by all stakeholders in decision making on utilisation of natural resources (Mbaiwa, 2005: 211).

Mbaiwa (2005: 211) further argues that the domination of the tourism sector by foreign companies in the Okavango Delta is not a unique practice, but is a common phenomenon in many developing countries. For example, the development of the tourism sector in Turkey during the 1990s resulted in the tourism in that country dominated by international companies, which displaced local investors. Similar experience occurs in the Caribbean, in which a foreign dominated tourism sector results in marginal contribution to the economic benefits of the Caribbean countries.

This further marginalises local investors and does not provide access for local communities' participation in tourism activities, which also does not support the concept of sustainable tourism development (Mbaiwa, 2005: 212). For example, major safari or tourism companies operating in the Okavango Delta have their headquarters in places such as New York, Houston, Berlin, London, Tshwane, Johannesburg and Sydney. This results in payment transactions taking place in foreign countries. Worse more, payments for accommodation facilities in the Okavango Delta are done outside Botswana in headquarters of concerned foreign companies. Most of the foreign tourism companies operating in the Okavango Delta have supply offices in Maun, but those offices do not handle bookings or payments but they only receive tourists and pass them to lodges and camps in the Okavango Delta. The fact that a number of foreign companies operating in the Okavango Delta have their headquarters in developed countries gives them a competitive advantage over the emerging local tourism company in Botswana. This is because most of the foreign tourism companies have direct sales and marketing links in developed countries, which help them to successfully market their tourism services using extensive advertising. Consequently, local companies in Botswana and the Okavango Delta face tremendous challenges in penetrating and competing with foreign companies.

Foreign ownership of accommodation establishments in the Okavango Delta dominates organisations owned by citizens. The increasing number of accommodation establishments in the delta has implications on the waste management. As accommodation in the delta increases, the number of visitors also increases. The worrying factor is that there is no balances in establishments' ownership because the economic benefits accrue to host communities are minimal. The increased number of visitors results in negative impacts such as increased garbage and overcrowding of airstrips used by charter aircrafts that fly tourists between camps and Maun airport. Aircrafts produce noise that disturbs wild animals. The development of tourism facilities in the Okavango is done without adhering to Environmental Impact Assessment (EIA) principles, and the concept of carrying capacity is often ignored by the developers in the delta (Mbaiwa, 2005: 214). The environmental conservation policies such as High-Cost-Low-Volume that Botswana adopted in 1990 are often ignored by tourism developers in the Okavango Delta. The policies emphasises on the environmental conservation of the Okavango Delta through ecotourism practice as opposed to mass tourism. It requires licences that limit the number of camps and lodges as well as the number of beds per establishment. However, this policy requirement is not enforced and there is no adequate monitoring of development activities. Consequently, a number of safari operators expand their establishments beyond required capacity, which has implications on socioeconomic and environmental impacts in the delta. This in return has the potential to destroy the environment tourists are paying for, which may increase the poverty level in host communities, resulting in an increase in the spread of HIV/AIDS.

TABLE 3.23: OWNERSHIP OF ACCOMMODATION FACILITIES IN THE OKAVANGO DELTA

Ownership of tourism facilities	Frequency	Percentage
Citizen owned	12	18.5
Jointly owned	18	27.7
Non-citizen owned	35	53.8
Total	65	100

(Source: Mbaiwa, 2005)

Contrary to the accommodation facilities' ownership in the Okavango Delta, the Botswana tourism is generally dominated by Botswana citizens. Table 3.24 below presents the ownership structure of tourism establishments in Botswana in general.

The table presents that most of the tourism establishments in Botswana in general are owned by Botswana citizens. Ownership of tourism establishments by Botswana citizens is imperative for the country to fight the spread of HIV/AIDS through poverty alleviation. However, ownership of accommodation establishments in the Okavango Delta is dominated by non-citizens of Botswana (Mbaiwa, 2005: 212). This aspect needs further investigation because the Okavango Delta is the key tourist attraction in Botswana. Opportunities therefore need to be created for local communities and Botswana citizens to participate in the tourism activities taking place in the Okavango Delta.

TABLE 3.24: OWNERSHIP STRUCTURE BY CATEGORY AS ON OCTOBER 2008

Ownership Structure	2001	2002	2003	2004	2005	2006	2007	2008
Citizen	141	178	202	225	223	254	290	304
Joint Venture	110	116	135	138	129	129	132	137
Non – Citizen	140	14	168	179	170	177	177	178
Total	391	442	505	542	522	560	599	619

(Source: Botswana's Department of Tourism, 2008)

Generally, many people in developing countries live in poverty, and they do not have sufficient capital to capitalise the potential economic benefits that tourism has in the same way that international companies from developed countries do. This in return, as already indicated above, results in many tourism destinations such as the Okavango Delta dominated by foreign companies. This also results in promotion and development of enclave tourism, in which tourism is concentrated in remote destinations whereby types of establishments and their physical location do not consider the needs and expectations of local communities. The worrying factor is that services available at tourism facilities such as in the Okavango Delta are expensive for the host communities, and the foreign currency generated makes only marginal contribution to the

economy of the region. The enclave tourism do not support poverty alleviation systems in host communities because it results in poor employment opportunities for local communities, and repatriation of revenue to developed countries (Mbaiwa, 2005: 215).

Insufficient skills and experience by local people results in poorly paying employment opportunities for the Botswana and many developing countries' tourism sector. There are low skilled and poorly remunerated jobs in the Okavango Delta (Mbaiwa, 2005: 216). Employment opportunities for locals in the delta are limited to manual labours, drivers, maids, cleaners, night watchmen, gatekeepers, and cooks. Such jobs attract unskilled labour and pay relatively lower salaries when compared to the skilled management positions often occupied by foreign employees. Mbaiwa (2005, 216) further projects that 62% of the junior tourism employees in the Okavango Delta earn salaries below P900.00 per month and two thirds of the Botswana citizens working in tourism – related jobs in Maun are paid less than P954.78 (\$190.96) per month. The average salary for citizen employees in Botswana in general is P600.00 per month but for foreign employees is P5000.00 per month. This presents a significant salary variation between Botswana citizens and expatriates, and the gap becomes wider when considering benefits and allowances accrue to foreign employees.

The problem of low paying jobs for local tourism employees in the Okavango Delta is not a unique practice in Botswana but is also a common practice in a number of countries such as in Asia, Latin America, and other parts of Africa. For example, in St Lucia, situated in the Caribbean, 90% of managers in the hotel and restaurant sectors are foreigners and they earn average salaries that are significantly higher than those of local employees. In the Middle East, in Turkey in particular, the domination of the tourism sector by international companies is reported to be a source of cheap labour by local communities who are occupying low paying positions. Lower salaries paid to local employees as opposed to those of their foreign counterparts often results in resentments and hostility from citizens towards foreign employees and their companies, and it worsen the poverty situation in the concerned areas (Mbaiwa, 2005: 217).

Sustainable tourism development requires that local people should participate and benefit from tourism activities taking place in their areas (Mbaiwa, 2005: 219). Generally, the tourism sector in the Southern African region is large, but many people in most countries in the region are reported to be living in extreme poverty. Poverty alleviation is not a priority of the tourism

agenda in many Southern African countries. In the Okavango Delta, which is the Botswana's key tourism destination, poverty among local communities is reported to be significant. Most people living in the Okavango area are living in extreme poverty. However, the poverty situation in the Okavango area is not a unique case in Botswana because it is reported that 70% of the poor families in the country in general are living in rural areas. In the Okavango Delta in particular, poverty is exacerbated by enclave tourism and limited opportunities for local people to participate in tourism and other economic activities. Insufficient employment opportunities in the Okavango region in general increase the vulnerability of the local people to poverty. The worrying factor is that poverty is one of the key factors influencing the spread of HIV/AIDS and the Okavango region is reported to be one of the regions with the highest HIV/AIDS prevalence in Botswana (Mbaiwa, 2005: 219). The income generated from enclave tourism in the delta does not benefit local communities, and the fact that local communities do not participate in the planning of tourism and that tourism in the delta does not significantly support poverty alleviation mechanisms means that tourism in the Okavango Delta does not comply with the all requirements of sustainable tourism development.

Mbaiwa (2005: 220) extends arguments that community-based tourism in the Okavango Delta presents passive community participation. It is therefore, imperative for communities to engage in small scale tourism projects so that they can enhance their active participation in the tourism activities. Examples of small scale tourism projects that communities can participate on would include leatherworks, curio shops, campsites, community tour operators, cultural tourism activities, and music. This may empower the communities with relevant experience and boost their confidence in operating larger projects. Community-based tourism is an important tool in fighting poverty not only in the Okavango Delta but in general. Community tourism may also play a vital role in conserving the environment because economic benefits may motivate local people to protect the environment for their continued socioeconomic benefits such as poverty alleviation.

3.4.5 PRO-POOR TOURISM

Torres and Momsen (2004: 296) define pro-poor tourism as tourism that contributes benefits to people who are living in poverty. As already indicated, tourism has economic benefit. Pro-poor tourism extends beyond community tourism because it aims at creating opportunities for people

living in poverty at all levels and scales of operations.

Ashley, Boyd and Goodwin (2000: 1) argue that tourism policy in most developing countries has not considered poverty alleviation as a priority. The main focus of tourism development and policy is on economic benefits, environmental protection and cultural aspects at national levels. The impact of tourism on poor people requires pro-poor tourism to be the central focus tourism policy. Participation by people living in poverty and the benefits they accrue depend on various key factors such as the type of tourism taking place in communities, tourism policies, land tenure, type of tourist clients, access to capital by local community members, and training.

Tourism in general has the potential to positively change the lives of the poor. The tourism as private sector in many developing countries however, does not consider poverty alleviation as a priority, and this could be due to lack of emphasis on pro-poor tourism by the tourism policy in many developing countries. The world has adopted the International Development Target that aims at having no people living in extreme poverty by 2015 (Whiteside, 2002: 326). To achieve this target, all stakeholders and countries ought to promote pro-poor tourism. Governments and donors in many countries promote tourism private sector investment, macroeconomic growth and foreign exchange earnings and opportunities for the poor are often not prioritised. The focus of most international donors is on infrastructure development, investment in tourism and attracting international tourists. This approach is similar to that of sustainable tourism development (Whiteside, 2002: 327).

The focus of sustainable tourism development is on environmental and cultural protection, but not much is said about the impact of tourism on people living in poverty. The challenge facing many governments and donors particularly in developing countries such as Botswana is to develop tourism activities that enhance significant economic contribution of tourism to the lives of people living in poverty. Studies conducted in India, Indonesia, Namibia, Nepal, Philippines, Uganda, Zambia and Zimbabwe indicate the need for such initiatives (Bernett, Whiteside & Desmond, 2001: 259). However, the challenge facing many developing countries is the fact that tourism is a complex economic sector dominated by private and international investors, which give many governments in developing countries limited influence on the sector. The fact that tourism activities often take place in communities where poor people live, provide potential opportunities for poverty alleviation because poor people can sell their goods and services to the

tourists. Tourism also has the potential to diversify the host country's economy, and it can foster development in poor and marginalised communities. Remote areas in particular attract tourists because they are often rich in cultural aspects, wildlife and unspoilt landscape. However, overemphasis of tourism economic benefits without good management and plan often results in unwanted costs (Ashley *et al.*, 2000: 2).

As already indicated, poor communities can benefit from involvement in the tourism activities taking place in their respective communities. However, community participation in tourism activities is influenced by various complex factors such as gender, livelihoods, tourism policy and tourism market segments. Studies conducted in Bolivia and a number of Muslim countries reveal that a percentage of tourism jobs occupied by women varies from over 60% to under 10% respectively (Sjoberg & Du Guerny, 1993: 1029). The fact that tourism is a service sector with high proportion of low skilled domestic type of work make the sector to be accessible to women. In a number of occasions, women participate in informal tourism activities such as hawking.

The potential for tourism to contribute to the lives of poor people in general is hampered by the fact that tourism particularly in developing countries is owned and controlled by foreign companies and investors from developed countries, which results in leakages of money to foreign developed countries. Studies conducted in various developing countries indicate that an average of 55% of tourism income remains outside the destination countries, rising to 75% in particular destinations like Gambia and Commonwealth Caribbean. Leakages of tourism revenue in most developing countries often occurs due to the fact that tourism often relies on expatriates' skills, sophisticated products, repatriation of profits by investors and company owners, and other services based in the originating countries (Khalifah, Hamzah, Dahlan & Kachik, 2006: 132). However, the fundamental consideration should be not on how much money stays in the destination country, but on how much is spent on improving the lives of poor people in host communities (Khalifah *et al.*, 2006: 132).

Poverty alleviation is an important initiative in the fight against the spread of HIV/AIDS, and it has the potential to minimise population migration. Tourism opportunities for the poor people who migrate to tourism destinations in many developing countries are hindered by factors such as bureaucracy, lack of transport, and social networks. In situations where the land is privately owned by the members of the host communities, local residents are less likely to be moved out,

but they often sell the land to foreign investors. Consequently, the local residents often end up as tourism employees rather than owners or decision makers. Land ownership has the potential to empower the poor and give opportunities to negotiate and reap benefits from tourism. In cases where the poor do not have the backbone to negotiate with tourism entrepreneurs or company owners, government authorities can mediate on the best interest of the poor communities. The challenges facing poor communities include tourism regulations such as those encompassing formal qualifications of employees, and the fact that service standards are often focused on formal sectors, which often victimise the poor (Khalifah *et al.*, 2006: 136).

The benefits of tourism to the poor depend on the type of tourists visiting and their interaction with and their usage of the community tourism facilities. For example, budget and independent tourists such as backpackers often use the cheaper guest house than luxury tourists' accommodation. Budget and independent tourists also use accommodation such as home-stay and use transport and catering services provided by local people. They usually stay for longer periods than group tourists and they often interact with local economy, but they are often price conscious (Khalifah *et al.*, 2006: 137).

Nature based tourists such as eco-tourists do not create more opportunities for the poor compared to mass tourism. Mass tourism is largely competitive, and often dominated by big suppliers who are less concerned about the destination, and who are unlikely to use services provided by local suppliers. However, mass tourism creates significant employment opportunities and its negative impacts are less likely to spread beyond localities. The informal sector, which is often ignored by tourism planners provides tremendous opportunities for small scale enterprises for the poor. For example, at the Bay Cray, Ha Long Bay in Vietnam, most families are reported to have private hotels, and local participation in tourism activities is projected at above 70% of the population. Besides people operating hotel and restaurants businesses, many local women in Vietnam operate noodle stalls and many women and children operate vendors. Community members who own boats or motorbikes hire them out to the visitors (Schilcher, 2007: 167).

Although the contribution of tourism to the livelihood of local communities cannot only be assessed based on paid jobs, the most notable contribution or benefit of tourism to the host communities is cash income. Despite the fact that most of the jobs created by tourism often present low pay, it also provides opportunities for local people to sell goods or engage on casual

labour such as selling food, crafts and guide services (Schilcher, 2007: 182). Income from tourism can also be derived from locally-owned businesses. Casual activities such as guiding work are often perceived as high status and generate high income for communities in many developing countries. Studies conducted in Kenya and Namibia indicate that income generated from casual guide work can be equivalent to that of most paid jobs, and it has potential to sustain the livelihoods of many families (Schilcher, 2007: 185). This kind of tourism activity is significant for community members who do not have alternative means of generating income but it is difficult to manage (Schilcher, 2007: 186).

Tourism has both negative and positive economic impacts on the host communities. The negative economic impacts include inflation, dominance by foreigners, and in-migration, which reduces benefits for poor host communities who often have to share the benefits with the migrants. Poorly managed tourism activities can deny local communities access to natural resources and it can disrupt social network such as cultural pride and socio-cultural intrusion by tourists. The other notable impact of tourism is sexual exploitation that often affects poorer women, girls and young men in particularly in poor developing destinations. On the positive side, tourism generates revenue that can be invested to enhance basic needs and social developments such as education and development of infrastructure. However, negative and positive impacts of tourism differ significantly according to various circumstances, among different people and over time, and the extent to which local assets are able to influence the planning process. The impacts of tourism on communities often vary between men and women. Women are more vulnerable to the negative impacts of tourism through activities involving sexual exploitation than men (Ashley *et al.*, 2000: 5).

The impacts of tourism relating to in-migrant depends on whether the migrants are poorer groups, willing to work for lower salaries to mitigate desperate situations from their place of origin, or they are skilled entrepreneurs taking up opportunities that local have not explored (Ashley *et al.*, 2000: 6). The fact that tourism policies in many developing countries are not focused on pro-poor tourism means that the strategies addressing the poverty impact of tourism should differ from that of commercial, environmental, or ethical considerations. Pro-poor tourism needs proactive and strategic interventions that create access and economic participation and that mitigate barriers that poor people face in participating in tourism activities. Besides reducing barriers to participation on tourism activities by poor communities, minimising cultural disruption of

tourism on host communities is also imperative. The fundamental consideration is to enhance participation by the communities in decision making and planning tourism activities so that they can influence tourism development in their localities (Ashley *et al.*, 2000: 6).

Torres and Momsen (2004: 294) indicate that the rapid growth of tourism in developing countries needs integration of pro-poor tourism into the international tourism and aids agendas. Tourism is an integral sector of economic development initiative in many developing countries. As already indicated, tourism has the potential to generate foreign exchange revenue, attract foreign investment, increase tax incomes, and create employment opportunities. For many years, tourism has been focused primarily on generating macroeconomic growth and private sector profit. The concept of poverty alleviation is generally not considered by tourism agendas of many developing countries and international development agencies. This can be partly linked to the fact that tourism activities are often associated with negative social and environmental impacts such as control by foreign investors, leakages and expatriation of profits, and the fact that most of the tourists visiting developing countries are rich people from developed countries and they often do not have interest in visiting poor communities. The other area of concern is that tourism particularly in developing countries results in unequal dependency ratio, and it fosters inequitable socioeconomic and spatial development (Torres and Momsen, 2004: 294)

The concept of growth of a transnational system and globalisation fuels the spread of tourism worldwide, contributing significantly to most poor developing countries. This means that the emphasis should be on pro-poor approaches involving the whole spectrum of the private sector, community, public joint ventures, and public sector infrastructure investment. The other important initiative is to link tourism demand for food to local agricultural production so that local agricultural production can also be enhanced. Linking agriculture and tourism is imperative because it can channel tourism sector benefits to farmers so that economic leakages can be reduced. Agriculture is the key livelihood of many host communities in most areas in which pro-poor development strategies are focused. The pro-poor approaches for international community aim at reducing the proportion of people living in extreme poverty by 50% by 2015. This Millennium Development Goals support the pro-poor approaches to fight poverty and hunger worldwide. This dedication to pro-poor approach, together with the emphasis on developing sustainable livelihood strategies supports pro-poor Tourism initiatives (Torres & Momsen, 2004: 296).

Torres and Momsen (2004: 297) argue that tourism has more potential to curb poverty than other economic sectors. Tourism has the advantage of attracting clients (tourists) to the communities in which tourism activities are taking place, which creates opportunities for linkages and access for poor people to sell their goods and services to the tourists. Tourism has the opportunity to create employment and income earnings for women than other economic sectors because it is labour intensive. Tourism has the potential to diversify the economy of the destination in which tourism activities are taking place, and it also has the potential to create participation opportunities for poor people who often operate informal activities. Tourism in return largely depends on the natural environment and this gives the host communities the opportunity to obtain equity in joint venture partnership. Besides employment and business opportunities, people living in poverty can also benefit from tourism activities through improved infrastructure, security communications, community development and local pride. As already indicated, the other benefits of tourism to the poor include generating government revenues that may be invested in other socioeconomic activities such as education and health. Torres and Momsen (2004: 296) further argue that despite the fact that benefits for the international development agencies, national governments, and local communities to encourage pro-poor tourism are significant, the motivation for the private sector tourism companies to adopt pro-poor tourism initiatives is often not clearly stipulated.

Poverty alleviation strategies are imperative because poverty is the key threat to peace, security, democracy, human rights and the environment. The fact that poverty is one of the key factors influencing the spread of HIV/AIDS means that combating the spread of HIV/AIDS should start with poverty alleviation. In achieving pro-poor tourism approach, tourism companies need to work in harmony with the host communities. The growing social consciousness among tourists means that tourism companies should exhibit social responsibilities. The challenge however is that it is complicated for tourism companies to reach the poorest segments of societies. The pro-poor tourism strategies in most developing countries often provide minimal economic benefits to the poorest members of the host communities. This situation is exacerbated by the fact that tourism in most developing countries is controlled by foreign corporations. Participation by the poor in tourism activities is also hampered by the fact that most of the people in poorer communities lack education and training required in tourism, lack of economic and social capital, and the fact that the tourism sector general requires high quality standards (Torres & Momsen, 2004: 298).

In fostering the potential of tourism in achieving the fight against poverty tourism needs to be integrated with agricultural activities. Many developing countries with rapid growth of tourism also experience significant growth of agricultural activities. Agriculture is the key livelihood of many poorer communities. It is therefore, imperative for pro-poor tourism approaches to be closely linked to agriculture. Tourism has the potential to be a catalyst for agricultural development through backwards linkages that provide farmers within the host communities to sell food to the tourism sector as well as to the host communities. However, tourism and agriculture often compete for the key resources such as land and labour, which means that failure to plan and manage such competition, may result in negative impacts on these key economic sectors and ultimately increase the poverty levels on host communities (Torres & Momsen, 2004: 299).

The linkages of pro-poor tourism and agriculture cannot automatically occur, but they need active facilitation (Torres & Momsen, 2004: 299). Understanding the relationship between tourism and agriculture is imperative for the success of pro-poor tourism objectives of minimising negative impacts while maximising net benefits for people living in poverty. It is also important to understand the impacts of tourism activities on local agriculture because farming, fishing and animal husbandry are the key livelihood activities for many people in most developing countries. Negative impacts of pro-poor tourism in local agriculture may include depriving agriculture resources such as land and water for the benefit of tourism, competition for time between tourism and agriculture, and diverting from sustainable farming concept so that production for tourism can be increased. Besides the negative impacts, linking tourism and agriculture may play the vital role enhancing pro-poor tourism strategies.

Encouraging agricultural production for the benefit of tourism also provides opportunities for the poor to enhance their skills without changing their economic livelihood approaches, lifestyles and tradition. Enhancing access to credits, markets, training and private sector joint venture give farmers opportunities to supply tourism with fresh crop products. Besides generating income from agriculture, stimulating agriculture for tourism can achieve the pro-poor tourism objective enhancing the quality of life for people living in poverty through employment creation, which may also strengthen rural communities by minimising population migration particularly by young people who often leave rural areas to seek employment in urban areas. Linking tourism and

agriculture may also balance development in tourism destinations, and it may create opportunities for tourism destinations to retain tourism benefits through reduced leakages often occurring through foreign imports of agricultural products. However, enclave tourism impose great challenges to pro-poor tourism because it is attributed to the negative economic, social and environmental impacts, and is also associated with linkages to the local economy (Torres & Momsen, 2004: 302). Mass tourism presents both positive and negative on the lives of poor people living rural areas of many developing countries. Producing food for large tourism destinations by agriculture is one of the key strategic approaches that can integrate poverty alleviation into mass tourism initiatives.

For tourism to continue to benefit the communities in which activities are taking place, a sustainable tourism development concept is imperative. Sustainable tourism development concept is a tourism development concept that promotes the benefit of the current generation from tourism development without compromising the opportunities of the future generations from benefitting from tourism. Sustainable development and sustainable tourism development concepts are the fundamental concepts in poverty alleviation strategies.

3.5 AN OVERVIEW OF THE HIV/AIDS SITUATION IN BOTSWANA

This section focuses on an overview of the HIV/AIDS situation and its economic impacts in Botswana. Factors discussed in this section include the HIV/AIDS situation in Botswana, an overview of HIV/AIDS orphans in Botswana, the impact of HIV/AIDS on the Botswana tourism sector, the socioeconomic impact of HIV/AIDS in Botswana, impact of HIV/AIDS on the image of the Botswana tourism, the Botswana HIV/AIDS policy, and the Botswana tourism sector's response to the impact of HIV/AIDS.

3.5.1 THE HIV/AIDS SITUATION IN BOTSWANA

Botswana is among the countries experiencing the severest HIV/AIDS infection rate in the world (UNAIDS, 2006: 1). Botswana has 270, 000 people living with HIV/AIDS out of a population of about 1.8 million. The adult HIV prevalence rate in Botswana is estimated to be 24.1%, the second highest in the world after Swaziland. Life expectancy at birth in Botswana dropped from

65 years in 1990 – 1995 to 40 years. It is reported that 120, 000 children in Botswana have lost at least one of their parents to HIV/AIDS and that there are 65, 000 HIV/AIDS orphans.

Research shows that Botswana has the second highest HIV/AIDS prevalence rate in the whole world, next to Swaziland (Letamo, 2003: 347). It is reported that 36.2% of the pregnant women attending antenatal clinics in Botswana are HIV positive. One of the big challenges facing Botswana is the stigmatisation and discrimination against people living with HIV/AIDS. A number of people are afraid to be identified as HIV positive to the extent that they do not go for voluntary counselling and testing. Others do not accept their HIV status and live in denial.

The first HIV/AIDS case in Botswana was reported in 1985 (Botswana Ministry of State President National AIDS Coordinating Agency, 2005: 8). HIV/AIDS is spreading fast despite the fact that the government of Botswana is working hard to educate people about the disease. The 2004 Botswana HIV Sentinel Survey by the Botswana Ministry of Health reveals that 35.4% of the pregnant women aged 15 -49 attending Antenatal Clinics are HIV positive.

The high percentage of HIV positive pregnant women in the country shows that the battle against the spread of HIV/AIDS in Botswana is far from won and this means that much work needs to be done to curb the spread of HIV/AIDS. It is imperative to spread the message and educational programmes to the schools, and that could be done by introducing HIV/AIDS as a subject in the syllabus. This will help to educate young people about HIV/AIDS, and discourage them from engaging in sexual activities at an early age.

Many young people in Botswana become sexually active at an average age of 17.5 years, while the average age at first marriage is 19.0 years. The average age at first birth in Botswana is 18.6 years (Letamo, 2003: 348). Gender inequality, sexual exploitative relationship between older men and teenage girls, rape and other forms of violence against women also increase the spread of HIV/AIDS. Younger ladies are often sexually exploited by older men because they are often submissive and unable to negotiate protected sex with them. Older men usually have more money and more power over the younger ladies. Unemployment and poverty contribute to the spread of HIV/AIDS. This suggests that the spread of HIV/AIDS could be mitigated by poverty alleviation.

The above information suggests that much work needs to be done to fight any behaviour or

activity contributing to the spread of HIV/AIDS in Botswana. The researcher recommends that gender equality and women economic empowerment should be more aggressively promoted. Employing women in high positions that pay good salaries could be used as a strategy to empower women.

Failing to protect teenagers from HIV/AIDS and teenage pregnancy jeopardises the future economic growth of Botswana because teenagers are the future leaders of Botswana. Therefore, the researcher recommends that a law should be put up to protect all children in Botswana to punish older persons engaging in sex with teenagers. Schoolgirls falling pregnant drop out from school and later become unemployed. As already indicated, unemployment contributes to poverty and to the spread of HIV/AIDS in Botswana.

According to ACHAP, NACA and UNAIDS (2008:7), the prevalence of HIV/AIDS in Botswana significantly declined from 37.4% in 2003 to 32.4% in 2006. HIV/AIDS has also declined among 15 -19 ages and 20 – 24 age groups. In 2004 the Botswana AIDS Impact Surveys (BAIS) reported 17.1% HIV/AIDS cases. It is also reported that 91780 (81.2%) of the 113 000 HIV positive people were treated for HIV/AIDS in 2007 in Botswana. This includes 74 273 people in the public health sector, 7 993 people out-sourced to the private sector and 9 514 who are enrolled directly in the private sector. The Sentinel Surveillance among pregnant women aged 15 – 49 indicates a decline from 33.4% in 2005 and 32.4% in 2006.

ACHAP, NACA and UNAIDS (2008:13) further indicate that the prevalence of HIV/AIDS in Botswana varies according to different districts/regions in the country. Generally, the HIV/AIDS prevalence rate, among the total population of women in the reproductive age group of 15 – 49 years is projected to be 32.4%. Chobe District in particular, is projected to have HIV/AIDS prevalence rate of 42%, which is the highest in Botswana, and Kgalagadi District records the HIV/AIDS prevalence rate of 19.1%. Generally, the prevalence of HIV/AIDS in Botswana is reported to be high in the northern and eastern parts of the country. To be specific, Ngamiland (Maun) is reported to have the HIV/AIDS prevalence rate of 35.4%, Selibe-Phikwe 41.1% and Chobe/Kasane 42%. Chobe/Kasane and Ngamiland/Maun Districts are the key tourism destinations in Botswana, hence the need to investigate the impact of HIV/AIDS on the tourism sector within these districts. In generally, pregnant women attending antenatal clinics in various regions in Botswana, both in rural and urban areas, presents similar HIV/AIDS results, with rural

areas recording 34.6% and 33.9% for urban areas in 2006.

The Botswana national HIV/AIDS prevalence rate among adults aged 15 – 49 shows a decline from 27% in 2001 to 23% in 2007 (NACA & ACHAP, 2008: 3). However, as indicated, the HIV/AIDS prevalence decline in Botswana differs according to various locations, with a slight decline in urban areas and constant decline in rural areas. The number of new infections among adults aged 15 years and above in the 1990s peaked at 33 000, the period during which Botswana experienced dramatic spread of HIV/AIDS. With the Botswana government efforts in combating HIV/AIDS this figure declined to 18 000 in 2007, which is almost half of the prevalence in 1990s. The annual newly infected population aged 15 – 49 peaked to 5% in 1995, but declined 2.4% in 2007. In 1999 the number of babies born with HIV/AIDS infection in the country reached a peak of 4 600, but with the inception of prevention of mother to child treatment (PMTCT), the new infections significantly declined to 890 in 2007. The introduction of ART has also significantly reduced death rate in Botswana.

The number of people in need of ART rapidly increases every year and this includes both adults and children. The projected number of children in need of ARV in Botswana is just over 7500. The introduction of ART and PMTCT programs has significantly reduced the number of AIDS deaths. However, the challenge facing Botswana is to continue to provide ARV and PMTCT programs and also to mitigate the number of new infections. The Botswana HIV/AIDS treatment program (ART) coverage is one of the highest in the world (NACA & ACHAP, 2008: 13). The program covers both adults and children. Table 3.25 presents the projected number of people on HIV/AIDS treatment over a period of 6 years.

NACA and ACHAP (2008: 14) claim that the annual HIV/AIDS-related death rate is determined by the rate of annual HIV/AIDS infection in the previous years, the rate of progression from infection to death, and the spread and effectiveness of the HIV/AIDS treatment programs. It is projected that the median period from infection to AIDS death without ART is 11 years. ART increases life span of people on treatment, and it creates 91% survival for first year of taking treatment and 99% in every subsequent year.

TABLE 3. 25: NUMBER OF PEOPLE RECEIVING ART BY YEAR REPORTED BY THE BOTSWANA MINISTRY OF HEALTH

Year	Adults Receiving ART	Children Receiving ART	Children Receiving Co-trimoxazole
2000	932		
2001	1 865		
2002	2 811		
2003	10 346		
2004	31 449	2 142	5 475
2005	51 661	3 503	8 115
2006	81 874	5 564	8 830
2007	85 497	7 435	9 858

(Source: NACA and ACHAP, 2008)

Table 3.26 presents the projected number of people in need of ART in 2008 – 2016 in Botswana. It is indicated in the table that the number of people in need of ART in 2008 and 2016 is expected to grow. This could mean that HIV/AIDS is expected to spread in the country. The growing number of people in need of ART may have negative impacts on the country's economy and developments due to the fact that increased number of people in need of ART means that more money should be spent on buying the HIV/AIDS drugs such as ARV (NACA & ACHAP, 2008: 18). ART are expensive and more money from the government annual budget may be consumed by HIV/AIDS treatment. The number of people in need of ART in Botswana each year is reported to be increasing, and it is projected that the number will continue to grow in the next years. The table below presents the projected number people in need of ART between 2008 and 2016 in Botswana.

TABLE 3.26: NUMBER OF ADULTS IN NEED OF ART, 2008 - 2016

Year	2008	2009	2010	2011	2012	2013	2014	2015	2016
Number of adults in need of ART	137000	153000	167000	178000	186000	193000	198000	203000	207000
Number of Children needing ART	8000	8700	9200	10000	10800	11600	12300	12900	13500

(Source: NACA & ACHAP, 2008)

Table 3.27 presents the number of HIV/AIDS by type. Maternal orphans refer to orphans aged 18 years and below who have lost their mothers, and paternal orphans refer to the children who lost their fathers. Double orphans refer to children who have lost both parents, and are also referred to as maternal and paternal orphans. The total number of orphans is calculated by adding both maternal and paternal orphans and then subtracting the double orphans. Failure to take adequate action to raise orphans and provide educational opportunities may result in concerned orphans being destitute, which may make them more vulnerable to HIV/AIDS. Orphans who grow in poverty may be forced to migrate to urban areas. HIV/AIDS generally increases adult death rates, which also increases the number of orphans in the country (NACA & ACHAP, 2008: 18). The table below presents the number of orphans by type.

TABLE 3.27: NUMBER OF ORPHANS BY TYPE IN 2007

Maternal Orphans	
AIDS	65 100
Non-AIDS	15 700
Total	80 800
Paternal Orphans	
AIDS	53 500
Non-AIDS	25 900
Total	79 400
Double Orphans	
AIDS	31 900
Non-AIDS	1 700
Total	33 600
All AIDS Orphans	89 700
Total Orphans	125 700

(Source: NACA & ACHAP, 2008)

In addressing the spread of HIV/AIDS, variables such as poverty and population migration should be taken into consideration. A high HIV/AIDS infection in Botswana is attributed to both internal and external population migration (Letamo, 2003: 347). One example of population is that of truck drivers across Botswana borders from other countries such as South Africa, Zambia, and Zimbabwe etc. Population migration has an influence on people's health and to a certain extent contributes to the spread of HIV/AIDS in the country. As a matter of fact, observations in Kasane/Kazungula by both the researcher and the community are that many truck drivers who cross the Botswana border across the Chobe River at Kazungula often spend weeks queuing to cross to Zambia. A number of girls see truck drivers in the area as an opportunity to make money through commercial sex work. The other population migration that is a cause for concern is labour migration. During labour migration, there is social interaction including sexual intercourse among migrant workers. A number of the migrant workers are married and in most case

preventive measures like condoms are not used during sexual intercourse. These workers may be infected with HIV/AIDS and later go back to their families and infect their spouses with HIV. This is relevant to the Botswana tourism sector because tourist attractions in the country are located in rural areas such as Chobe, Maun and the Okavango Delta. This means that most of the tourism employees often migrate from homes in pursuit of employment in locations in which tourist attractions are located. Unprotected sex as already indicated, is the primary mode of transmitting HIV/AIDS and other sexually transmitted diseases (STDs). A number of people tend to ignore the use of preventive measures like condoms irrespective of education programs about HIV/AIDS, its transmission methods and impacts. It is evident that places in which major projects and developments are taking place in Botswana do attract large numbers of migrant workers, and are reported to have relatively high HIV/AIDS infection rates when compared to places where there are fewer developmental projects.

Based on the above information, it is evident that population migration contributes to the spread of HIV/AIDS in Botswana. Providing condoms to migrant workers within the areas in which major developmental projects are taking place is not good enough to curb the spread of HIV/AIDS in these areas because a number of people are ignorant about using condoms. Many migrant workers like those in the tourism and mining sectors spend lengthy periods away from their families. For example, tourism in Botswana is concentrated in remote areas in the northwest part of the country. This means that people working in the tourism organisations spend time away from their families.

It is evident that labour migration and the time the migrant labour spend away from their families are among the variables contributing to the spread of HIV/AIDS in Botswana. The researcher therefore recommends that the Botswana government and companies should create opportunities for married migrant workers to stay and work closer to their spouses. This can be done by encouraging married couples to transfer to the institutions closer to where their spouses are working so that they can either live together or be able to visit each other on a regular basis. This strategy can be implemented in Botswana because the Government is the country's main employer. This strategy could be suitable for the tourism sector because the sector is concentrated in certain areas of the country, and attracts large number of migrant workers. This shows that failure to address HIV/AIDS problems by tourist enterprises, including those in the private sector, may result in the damage on the Botswana tourism sector. Negative impacts of HIV/AIDS on the

Botswana tourism sector may also negatively impact on the economy bearing in mind the fact that tourism plays a significant role in the country's economy.

HIV/AIDS negatively affects Botswana by reversing the socio-economic achievements acquired over the years since its independence in 1966. The high rate of HIV/AIDS leads to an increased morbidity and mortality rate in the country. The current infants mortality rate (IMR) and under five mortality rate (U5MR) in Botswana are 57 and 75 per 100 live births respectively (Botswana Ministry of Health, 2000: 17). The effect of adult mortality rate resulting from HIV/AIDS is that a number of families in the country are losing their breadwinners, thus increasing household dependence ratio in the country. Besides loss of breadwinners by a number of families vulnerable to HIV/AIDS, a number of people living with HIV/AIDS in Botswana face the challenges of discrimination and stigmatisation.

Letamo (2003: 348) indicates that many people living with HIV/AIDS in Botswana are often stigmatised irrespective of how they contacted the disease. A number of HIV/AIDS patients experience violence, harassment, and feel rejected by the communities. This often occurs in cases when married couples happen to be HIV positive. A number of family members either from the husband or wife's side often accuse the partner from bride/bridegroom of bringing AIDS virus into the family of the infected couples. The worst scenario occurs when one of the couple dies. The deceased's family may reject and accuse the remaining partner of causing the person's death. In a number of occasions, individuals blame each other on witchcraft. Denial, fear and lack of knowledge about how HIV/AIDS is transmitted are among the factors contributing to the discrimination of people living with HIV/AIDS by a number of community members. The Botswana HIV/AIDS policy forbids discrimination against people living with HIV/AIDS. Many communities in Botswana associate HIV/AIDS with social attitudes resulting from deviant behaviour, which is viewed as an individual's responsibility or lack of it. There is also a belief by a number of religious people that contracting HIV/AIDS is a punishment for wrong doings. Religious people generally believe that 'sex before marriage is a sin'. This is sometimes wrongly interpreted and results in discriminatory problems in the country. A number of people living with HIV/AIDS in the country feel rejected by their religious groups, and they feel that they are identified as sinners who contracted HIV/AIDS through morally unsanctioned behaviour.

Discrimination against people living with HIV/AIDS can cause depression to the infected people.

It is therefore imperative for communities including religious people, to be educated on how HIV/AIDS can be contracted. The belief that 'sex before marriage is a sin' is a good practice encouraging young people to stay away from sexual activities but it should be carefully interpreted to avoid any discriminatory messages against people living with HIV/AIDS. Communities need to be educated to treat HIV/AIDS like any other illness, and that not all people living with HIV/AIDS contracted it through immoral behaviour. Discrimination against people living with HIV/AIDS may result in many people not willing to go for voluntary HIV counselling and testing. All people living with HIV/AIDS should be treated with love and care irrespective of how they contracted the disease.

Discrimination against people living with or suspected of living with HIV/AIDS is wrong and is an ineffective public health measure. The government of Botswana's Vision 2016 encourages and emphasises a compassionate, just and caring country. In order to achieve this goal, stigma and discrimination against people living with HIV/AIDS should be abolished and strict actions should be taken against any person discriminating against an HIV/AIDS patient.

The information provided by Uhegbu and Okereke (2006: 35) indicates that gender inequality contributes to the spread of HIV/AIDS particularly among women and children. The researcher therefore recommends that the African countries including Botswana should conduct research on gender inequality and provide mechanisms to protect women and children who are often the victims. Women play a vital role in the economy of any country. They raise children and in a number of occasions women provide home-based care for people living with HIV/AIDS. It is imperative to give women formal education and open economic opportunities equal to that of men. This can be done by diversifying developmental projects to the rural areas of all the African countries. The important developments should include formal educational opportunities, infrastructure and equal employment opportunities. This strategy may reduce poverty and level of prostitution, and it may also minimise the spread of HIV/AIDS. Women should not be used as domestic labourers, but should be seen as valuable assets for any country. Besides their economic role, women also play a vital role of raising HIV/AIDS orphans.

3.5.2 AN OVERVIEW OF HIV/AIDS ORPHANS IN BOTSWANA

In Botswana, a number of households with HIV/AIDS orphans experience financial difficulties

because of the support they give to orphans. Families that take care of a couple of orphans or sick adults in the country and orphans at the same time are reported to be the most struck by both financial challenges and poverty. A number of orphans, particularly those from poorer families, do not receive sufficient care because a number of caregivers often go to work and do not give sufficient time to the orphans. They fail to provide orphans with adequate care such as basic health services and emotional support. In a number of occasions, orphan caregivers who have other dependants have no sufficient time to focus on individual orphans' needs than caregivers without other dependents (Miller, Gruskin, Subramanian, Heymann, 2007: 2478).

The Central Statistics Office (2005: 56) indicates that two thirds of the families in Botswana have at least one adult suffering from HIV/AIDS related illness, and that one third of the families in the country have one or more orphans. Many orphans in Botswana are reported to be facing discrimination because they are suspected of living with HIV/AIDS. Such orphaned may be given relatively lower health care or in worst situations given insufficient food than other children. Research conducted in Uganda indicates that in most cases orphans do not receive equal vaccination and vitamin A compared to non-orphans (Deininger, Garcia and Subbarao, 2003: 1205). In Kenya, research shows that children orphaned for at least more than one year are most likely to be stunted growth and vulnerable to illness such as diarrhea. This indicates that health care is one of the utmost important considerations in caring for children. Community-based care is an important practice in any society, but only 2% of the caregivers in Botswana get help from community volunteers (Miller *et al.*, 2007: 2478).

Miller *et al.* (2007: 2478) argues that Botswana has a relatively stronger child health policy system when compared to a number of other Sub-Saharan countries. The Botswana child health policy encourages adequate health care to children, provides nutritional supplements, and also encourages caregivers to give social welfare support to orphaned and vulnerable children. However, it is reported that only one third of the caregivers in Botswana receive the requisite government support. This indicates that there is no balance between child health policy formulation and implementation in Botswana. Therefore, the government of Botswana should devise strategies to ensure child health policy control and implementation in the country. Policy implementation process should be monitored to ensure that it reaches the communities in need and also to protect the children from the impact of HIV/AIDS such as being exposed to sexual risky behaviour and poverty.

Table 3.28 presents the Botswana’s child and orphan policies. It is indicated in the table that Botswana’s National Programme of Action for Children (1999 – 2003) focuses on health programme for all children. The National Health Policy of 1995 forbids all health expenses for all children under the age of 13 years. The government of Botswana strives to provide basic needs and care to orphans in the country, and the country’s Destitute Policy of 1980 requires the Social Welfare Division to identify, register and support orphans in the country. The National Orphan Care Programme of 1999 encourages all the stakeholders to provide material support such as food and clothing to all orphans in the country, and the Family Care Model controls and coordinates all programmes and services provided by government to orphans. Botswana also has HIV/AIDS prevention and treatment policies such as Prevention of Mother to Child Transmission (PMTCT), which provides free counselling and HIV testing to pregnant women in the country. The Botswana National antiretroviral (ARV) Roll Out also known as MASA was established in 2002 and it aims to provide ARV to all HIV positive and legible citizens.

TABLE 3.28: BOTSWANA’S CHILD AND ORPHAN HIV/AIDS POLICIES

Target and policy	Aims
<i>All children</i>	
National Programme of Action for Children (1993 – 2003)	Establishes health programmes
National Health Policy (1995)	Eliminates fees for children under age of 13 years
<i>Orphan care</i>	
Destitute Policy (1980)	Mandates that the Social Welfare Divisions identifies, registers and support orphans
National Orphan Care Programme (1999)	Provides material support to orphans
Family Care Model	Coordinates all programmes and services
<i>HIV/AIDS prevention and treatment policies</i>	
Prevention of Mother to Child Transmission (PMCT)	Establishes free counselling and HIV prophylaxis

MASA National ARV Roll Out (2002)	Provide free ARV
National Strategic Framework for AIDS 2003 – 2009	Prioritises prevention, treatment, and support for orphan households

(Source: Miller *et al.*, 2007).

Table 3.28 also shows that Botswana’s child and orphan HIV/AIDS policies aim at mitigating the spread of HIV/AIDS. This shows that the Botswana government understands the economic impact of HIV/AIDS in the country and is committed to fight the disease. However, the remaining challenge is to ensure that all the stakeholders implement the policies and structures according to the aims and objectives, and include the country’s tourism sector. Without sound actions in addressing the continued spread of HIV/AIDS, the number of orphans is likely to escalate.

UNICEF (2004: 63) indicates that 20% of children aged 0 – 4 years in Botswana have lost at least one of the parents linked to HIV/AIDS, and that 11% of the children aged 5 years have also lost one parent. This is a problem facing a number of Sub-Saharan African countries and it is projected that 88% of the orphans in the region are between the age of 5 and 17 years. UNICEF further indicates that 66% of the orphans in Botswana are cared for by their grandparents who in a number of cases, live in poor families. A number of orphans also live in families with high dependency ratios and with generally uneducated and unemployed household heads. This usually results in orphans being stigmatised due to a lack of education and knowledge on matters surrounding HIV/AIDS by a number of caregivers.

Miller *et al.* (2007: 2483) argue that in Botswana orphaned children between the ages of 0 – 4 years generally experience poor health conditions. Orphans relatively live in poorer conditions than non-orphans, and poverty directly affects both the growth rate and health of a child. HIV/AIDS has an adverse socioeconomic impact in Botswana, but the government of Botswana finds it difficult to identify the highest impact intervention due to limited information available on orphan-based disparities. The Botswana government have devised policies with the intention to reduce the socioeconomic impact of HIV/AIDS through health and social services such as free antiretroviral treatment (ART), healthcare, nutritional supports, and social welfare assistance. However, Botswana’s HIV/AIDS policy is faced with challenges when it comes to its

implementation. The challenges include lack of health human resource capacity, inadequate financial budget, and underdeveloped infrastructure. The other challenge facing the country is the fact that the number of people in need of ART is dramatically increasing, which results in a number of orphans and HIV/AIDS patients not having access to health and social services. The increase of HIV/AIDS patients in need of ART in the country makes it difficult for the Botswana government to meet its national health and development objectives for children.

In Botswana, the financial budget allocated for implementation of the orphans' policies is not sufficient to cover the actual costs. For example, the orphaned and vulnerable children related budget in Botswana for the year 2007 was projected to be US\$31 million whereas only US\$5 million was budgeted. Botswana also gets financial support from the international communities to fight HIV/AIDS, but it is reported that little has been done to support orphaned and vulnerable children plans in the country. As a result, in 2003, 96% of the donors' funds amount of US\$9 million given to the country was allocated to generally combating HIV/AIDS in the country, and only US\$3.7 million (4%) of the amount was allocated to orphaned and vulnerable children. In reality, support for the public systems and families that care for orphans in Botswana is significantly insufficient irrespective of the international donors' commitments (Miller *et al.*, 2484).

3.5.3 THE IMPACT OF HIV/AIDS ON THE BOTSWANA TOURISM SECTOR

Botswana and the entire Southern African Region is confronted with many risk factors associated with the spread of HIV/AIDS, which include the migratory pattern of wage workers, alcohol abuse, deterioration of traditional family structures that used to reinforce morality, denial and ignorance. Other susceptibility factors are family and communal disruption (transfers), poverty, low status of women, high proportion of single parents and early parentage. The average age of first sexual encounters in Botswana is 17 years (Botswana's Ministry of Health, 2000:28).

Tourists, people from other sectors and wage-workers migrate within Botswana and between Botswana and neighbouring countries. With this high rate of movement of both workers and tourists, there is social interaction, which includes sexual activities and unprotected sex practised. The other contributing factor to the HIV/AIDS prevalence according to the Botswana Ministry of Health (2000) is a high rate of alcohol consumption and abuse among the young people in

Botswana and in a number of Southern African countries. The influence of alcohol leads to a risk of engaging in unprotected sex among the young people in Botswana, which in most cases creates high chances of spreading HIV/AIDS.

A number of people are ignorant of the educational activities about AIDS, and do not take precautions like use of condoms. Due to paid jobs and demand for jobs in different areas of the country and the entire Southern African Region, most workers get transferred to faraway places and spend more time away from their family members. This factor contributes to the spread of HIV/AIDS among married people, especially if either the husband or wife engages in unprotected sex with an HIV positive person and later infects his/her partner. There is the problem of poverty in Botswana and other Southern African countries, especially in a number of the rural areas, which causes people, especially young female people, to engage in sexual activities with the hope that they will get money in return. This spreads HIV/AIDS, especially in circumstances in which preventive measures such as condoms are not used (Botswana's Ministry of Health, 2000:28).

The impact of HIV/AIDS is felt across various economic sectors in Botswana including tourism. For example, it is reported that a high incidence of morbidity and mortality among teachers limits the teaching hours, and it results in poor quality teaching. A number of school children may fall ill or leave school because they have to take care of their families. Children who remain in schools may have their learning ability affected psychologically when they see their colleagues and teachers suffering from HIV/AIDS. HIV/AIDS also threatens the economy of Botswana through its impact on the general workforce including people working in the tourism sector. The majority of the workforce across various sectors in Botswana consists of sexually active young people. Because of HIV/AIDS the number and quality of population available to work in the Botswana tourism and other economic sectors is expected to shrink over the next 5 – 10 years. This may increase poverty and also affect essential services in Botswana. Botswana may fail to attract important international investors because of lack of quality human resources (NACA, 2002: 14).

3.5.4 THE SOCIO-ECONOMIC IMPACT OF HIV/AIDS IN BOTSWANA

UNDP (2006: 14) indicates that HIV/AIDS has various macroeconomic impacts in Botswana. HIV/AIDS negatively affects Botswana's GDP, average incomes, savings and investments and employment. HIV/AIDS significantly affects a number of households in Botswana through increased poverty and it negatively affects income distribution. HIV/AIDS also directly increases morbidity and mortality rates. Increased morbidity affects productivity because a number of infected and affected workers including tourism workers often take time off duty either on sick leave or to look after family members who are infected with the disease. Low productivity may also result from employees who are demoralised by illness or by their health status.

HIV/AIDS also increases expenditure for government and the private sector. Replacing sick workers also increases recruitment and training expenses. Increased expenditures and low savings reduce investment attributed to lower expected profits (UNDP, 2006: 14). HIV/AIDS reduces the population growth rate through increased death rate (mortality). Increased mortality reduces labour force, which also changes the age structure and reduces the availability and productivity of experienced labour force. The negative impacts of HIV/AIDS on the population also affects GDP and on the size, skills, structure and productivity of employees including those in the tourism sector.

Despite the impacts of HIV/AIDS, the Botswana GDP indicates positive growth. The economy continues to grow although it does so slowly. Slow economic growth affects consumption demand, which indicates that HIV/AIDS may have a negative impact on various organisations' local markets. HIV/AIDS reduces population growth in Botswana through the increased death rate and lower birth rate. Mortality across all age groups in Botswana is significantly increasing and life expectancy is dramatically dropping. It is projected that by 2010, life expectancy in Botswana could drop to 29 years (NACA, 2002: 13). The other problem is the increasing number of HIV/AIDS-related orphans in Botswana. NACA (2002: 13) projects that Botswana has 78 000 orphans and that by 2010 over 20% of all children will be orphans. The worrying factor is that the extended family taking care of orphans are the grandparents, and many orphans may have no one to take care of them once the old people die.

NACA identified other factors that influence the spread of HIV/AIDS in Botswana. These

include stigma and denial, socio-cultural factors, socio-economic factors and demographic mobility. The 2001 sentinel surveillance report projected that 36% of adults in Botswana live with HIV/AIDS (NACA, 2002: 15). However, the report indicates that these people are not aware that they are living with the disease. This is because of the stigma and denial associated with HIV/AIDS. Stigma and denial make people uncomfortable, fuel the infection rate and minimises the ability of people infected to cope and live with the disease.

Women are traditionally expected to be submissive to men and therefore are denied the ability to negotiate safer sex. Such tradition and customs may expose women to HIV/AIDS. Many women in Botswana lack economic power to the extent that they are dependent on their male counterparts. Alcohol abuse also increases the spread of HIV/AIDS especially among young people. Shortage of personal income also makes poor young ladies resort to the risky commercial sex. However, people with money are also at risk because they buy sex. Various researches conducted in Botswana indicate that most of the young girls sleep with men possessing ‘three Cs’ (cash, car and cellular phones). Poverty also significantly contributes to the spread of HIV/AIDS in Botswana. Research shows that 48% of households in Botswana live below the poverty datum line, and that in rural areas in particular, over 55% of the population is living in poverty (NACA, 2002: 15).

The poverty level in rural areas influences population migration from rural areas to urban areas and across the borders. The level of urbanisation in Botswana grows at an alarming rate. However, most of the people migrate to urban areas temporarily and eventually return to rural areas. This population movement often results in young school children spending more time alone as parents move to and from farms and cattle posts. As a result, young girls engage in risky sexual behaviour resulting from insufficient parental guidance (NACA, 2002: 14).

3.5.5 IMPACT OF HIV/AIDS ON THE IMAGE OF THE BOTSWANA TOURISM

The image of the Botswana Tourism Sector is threatened by the prevalence of HIV/AIDS. HIV/AIDS claims the lives of the skilled people working in the tourism industry, resulting in poor service rendered to clients. The goals and objectives of the Department of Tourism in Botswana include competing internationally for the global market, but HIV/AIDS reduces competitiveness of the industry as the skilled and experienced people die due to the pandemic.

The sector is operating with the young unskilled workers who in most cases offer low quality service to the clients (Botswana Guardian Friday 27 2004: 18).

A number of tourism organisations face serious problems due to the high prevalence of HIV/AIDS in Botswana (Anon, 2004: 13). They speculate that a number of tourists may not feel comfortable to eat food from hotels where workers like chefs, waitresses and waiters are perceived to be suffering from HIV/AIDS. The fact that Botswana is reported to be one of the countries with the highest prevalence of HIV/AIDS in the world, may damage the image of the country's tourism sector. The word of mouth marketing strategy that the country relies on could be damaged by the poor service rendered by the young less, experienced workers who work in the sector.

HIV/AIDS impacts negatively on the Botswana tourism sector by killing the experienced and skilled tourism workers. A number of organisations are reported to have problems of poor quality service rendered because they operate with young inexperienced workers. Many tourism organisations in Botswana experience high costs resulting from continuous employment and regular interviews as a process to replace the lost employees due to HIV/AIDS. Many key people within the tourism sector in the country are lost to HIV/AIDS. In response to the epidemic, a number of organisations train two or more people in one position so that in case one dies, they can have a replacement. This is costly because training more people means more expenses. The government of Botswana on the other hand, sends large numbers of students to foreign countries for training (Botswana Guardian Friday 27 2004: 18).

3.5.6 THE BOTSWANA HIV/AIDS POLICY

The Botswana National AIDS Coordinating Agency (NACA) (2002: 6) indicates that Botswana's National HIV/AIDS Strategic Framework 2003 – 2009 is an initiative by the Botswana government in combating HIV/AIDS in the country. The strategic framework is based on the experience and lessons that the Botswana government learnt both in the country and internationally regarding the impact and complications of HIV/AIDS. This initiative is imperative for Botswana to adequately fight HIV/AIDS and mitigate its adverse impacts. However, the Botswana HIV/AIDS Strategic Framework can also be applied in other African countries and internationally. The aims of the Botswana National Strategic Framework (NSF) include

distributing educational programmes concerning HIV/AIDS in line with Botswana's Vision 2016, which stipulates that Botswana should be free from new HIV/AIDS infection by the year 2016. The NSF also provides guidance to various ministries, NGOs and the private sector and it encourages a synergistic approach in curbing HIV/AIDS in Botswana. Although the Botswana's vision 2016 states that the country strives to be free from new HIV/AIDS infection by 2016, the spread of the virus in the country continues to increase, which may make this objective impossible.

NACA (2002: 10) indicates that the government of Botswana has declared HIV/AIDS a national emergency and that it is essential to fight the adverse impacts of HIV/AIDS collaboratively. HIV/AIDS is not the only health challenge facing Botswana but is the most serious threat to both current and future socio-economic progress of the country. HIV/AIDS is a complex disease that needs sound leadership and strategic national response involving stakeholders. The lessons learnt by the Botswana about HIV/AIDS show that it is imperative to engage in a collaborative approach to fight the disease. It is essential to be flexible in fighting HIV/AIDS so that both micro and macro changes within the society regarding HIV/AIDS can be identified and accommodated. However, one key aspect to the Botswana HIV/AIDS Strategic Framework that needs adequate attention is its implementation (NACA, 2002: 11). Strategic implementation and monitoring are the key considerations that determine the success or failure of the NSF. Monitoring and information system facilitating management decision making is also the key component for successful NSF implementation.

Figure 3.5 depicts the comprehensive HIV/AIDS National Strategic Framework for Botswana and the implementation and monitoring process. The implementation of NSF by the Botswana government is a comprehensive and integrated approach. Botswana's NSF formulation and implementation is based on various policies and assessments. The community response is imperative and is evaluated based on the feasibility of the plan, and all decisions made are based on strategic information management. An informed decision forms the basis for the government to establish and implement the NSF.

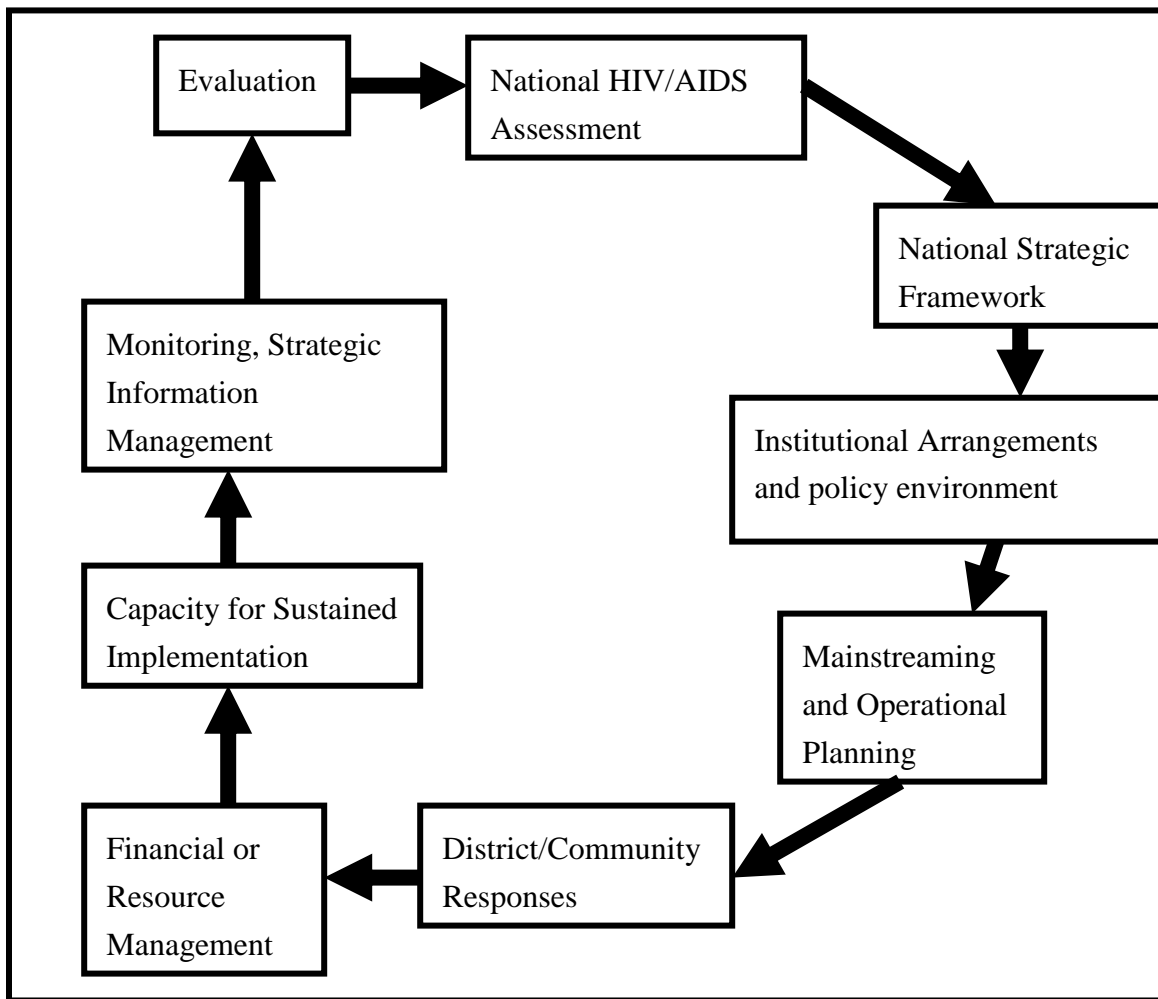


FIGURE 3.5: INTEGRATED BOTSWANA HIV/AIDS NATIONAL STRATEGIC FRAMEWORK

(Source: NACA, 2002)

Nagelkerk, Jha, Devlas, Korenromp, Moses, Blachard and Plummer (2002: 1) argue that depending on how the ARV treatment is utilised and focused, 25 – 100% of HIV positive people would be resistant to the treatment after three years of taking it. They also argue that HIV/AIDS is generally difficult to control in a number of Sub-Saharan African countries. In Botswana, for example, one in three adults is projected to be HIV positive. In Asia, the prevalence of HIV/AIDS in most countries except Thailand is reported to be increasing steadily. The country reported to be most vulnerable to HIV/AIDS in Asia is India. Interventions to control HIV/AIDS are essential in Botswana, particularly among female sex workers. They should be encouraged to use preventive measures such as condoms and other safer sex practices. Commercial female sex

workers constitute a population group reported to be most vulnerable to HIV/AIDS. However, data with regards to commercial sex working in Botswana is limited, but research conducted in most African countries indicate that unsafe commercial sex work contributes to the spread of HIV/AIDS. The other treatment intervention that needs adequate attention is the prevention of mother-to-child HIV transmission coupled with avoidance of breastfeeding, particularly among HIV positive mothers.

In Botswana, where HIV/AIDS prevalence rate is reported to be high, no huge increase is projected. The continued spread of HIV/AIDS shows that the general use of preventive measures is low in Botswana. Therefore, there is need for a focused intervention to minimise HIV/AIDS transmission (Nagelkerk *et al.*, 2002: 3).

It is projected that at least 90% of all pregnant women in Botswana attend antenatal clinics, (Nagelkerk *et al.*, 2002: 8). Besides encouraging people to practice safer sex, Botswana provides highly active retroviral therapy (HAART) to people living with HIV/AIDS. Although its long-term impact cannot be predicted, HAART reaps positive results on the mortality of people infected with HIV/AIDS in Botswana. The worrying factor is that it is projected that many AIDS patients may develop resistance to HAART after many years of taking it. HAART does not cure HIV/AIDS but may prolong the life expectancy of a person living with HIV/AIDS. The other challenge facing Botswana is that many HIV/AIDS patients are also likely to suffer from TB, an illness closely linked to HIV/AIDS. To fight HIV/AIDS, it is imperative to combine various types of interventions. For example, the HIV/AIDS education campaign can be used concurrently with focused female commercial sex workers programme, sexually transmitted infection (STIs) treatment, and prevention of mother-to-child transmission programme. Failure to explore possible strategies that can minimise the spread and impact of HIV/AIDS can threaten the future of Botswana.

Ngwenya and Kgathi (2006: 670) indicate that HIV/AIDS threatens many households in Ngamiland and the rest of Botswana. In Botswana, the HIV/AIDS prevalence rates are reported to be high in the sub-districts of Ngami (34%) and Okavango (41%). The Okavango area is the major tourist destination in Botswana, and it is reported that HIV/AIDS affects general developments including those of tourism in the region. Due to the continuous spread and impact of HIV/AIDS, the government of Botswana has established home-based care programmes in

various parts of the country as an initiative to encourage share of responsibilities in caring for HIV/AIDS patients between government and communities. HIV/AIDS is not only a health problem, but it is also a socio-economic, cultural and human rights issue. This suggests that strategies to fight HIV/AIDS should be the collaborative efforts between various sectors of developing societies.

The health care systems in Botswana cannot effectively deal with the continuous growing number of HIV/AIDS patients who suffer from the illness for a long time (Ngwenya & Kgathi, 2006: 671). To address this challenge, in 1999 the Botswana Ministry of Health established the community home-based care (CHBC) programme as a strategy to reduce the pressure of hospitalised HIV/AIDS patients in public hospitals. In April 2005, the CHBC in Ngamiland was reported to have 1369 HIV/AIDS patients (North West District Council Annual Report, 2005: 14). Under the CHBC programme, hospitals delegate the HIV/AIDS patients' medical supervision to the family members. The purpose of the CHBC is also to encourage families to take ownership of caring for patients (World Health Organisation, 2002: 13). The Botswana CHBC programme is not only focused on HIV/AIDS patients but on people suffering from other illnesses such as cancer and sugar diabetes. Besides medical treatment, CHBC patients need sufficient nutritional food on a continuous basis.

The government of Botswana aims to prevent HIV/AIDS and to provide financial support to foster implementation, monitoring and evaluation by establishing management strategies of HIV/AIDS (UNDP, 2000: 21). The Botswana's response to HIV/AIDS has gone through three various stages (Noble, 2007:1). The first stage was established between 1987 and 1989 and focused primarily on screening blood to reduce the risks of HIV transmission through blood transfusion. The second stage established between 1989 and 1997 includes the first Botswana's Medium Term Plan (MTP), which involves the introduction of HIV/AIDS information, communication and education programmes from a narrow perspective. The third stage established in 1997 includes education, prevention, comprehensive care, and provision of antiretroviral (ARV) treatment.

The Botswana's Ministry of Health (2003: 8) states that the Botswana HIV/AIDS policy is structured on Vision 2016, which stipulates that by 2016 there will be an AIDS free generation in Botswana. The stakeholders in different sectors in Botswana show strong commitment in

combating HIV/AIDS. The Office of the President of Botswana is taking the lead in fighting the pandemic by providing adequate financial resources and the support of the development partners to contain the HIV/AIDS pandemic.

Noble (2007: 1) indicates that the government of Botswana uses the following strategies to combat HIV/AIDS:

- Public education and awareness
- Education for young people
- Condom distribution and education
- Targeting of highly mobile populations
- Improvement of blood safety
- Prevention of mother-to-child HIV transmission (MTCT)

Noble (2007:2) points out that the Botswana's HIV/AIDS public education and awareness has previously encouraged people to either abstain, be faithful or to use condoms whenever having sex. Botswana has taken a further step countrywide by introducing billboards and posters with the messages encouraging people to practice safe sex, but it is uncertain how effective the educational messages are when looking at the new HIV infection rate in the country. Besides the billboards and posters, there is a radio drama programme known as Makgabaneneg, which is focusing on culturally specific HIV/AIDS-related matters to encourage sexual behavioural change in the country.

The government of Botswana, through the Youth Health Organisation (YOHO), educates young people on how to prevent HIV infection. YOHO is a non-governmental organisation that is run by youth in Botswana. YOHO is working closely with the Ministry of Education to provide school-based learning programmes that consist of Botswana-specific HIV/AIDS materials for students. The Ministry of Education and the United Nations Development Programme (UNDP) established the teacher-capacity building programme in collaboration with the government of Brazil supported by African Comprehensive HIV/AIDS Partnerships (ACHAP). The aim of the teacher-capacity building programme is to enhance the teachers' understanding of HIV/AIDS and also abolish the stigma resulting from misconceptions and cultural beliefs about sex and sexuality. As part of this initiative, primary and secondary schools in Botswana have been given televisions, video recorders, satellite dishes and decoders, and an interactive HIV/AIDS

educational programme known as Talk Back which is broadcasted by the Botswana Television (BTV) two times a week.

The government of Botswana encourages the public through social marketing and subsidisation programmes to use condoms whenever having sex. In 1993 the Population Service International (PSI) introduced the male condom (Lovers Plus), and in 2002 the female condom (Care) in Botswana. To promote the use of condoms in Botswana, PSI uses peer education programme, which is often implemented on special occasions such as fairs and festivals, and also in various strategic places like shopping malls, workplaces and bars. The government, through the technical and financial support from ACHAP, provides free condoms to the public throughout the country.

Noble (2007:3) argues that the highly mobile population like migrant workers are most likely to be vulnerable to HIV/AIDS. To address this problem, the government of Botswana, together with American Agencies, National AIDS Co-ordinating Agency (NACA), African Comprehensive HIV/AIDS Partnership (ACHAP) and other stakeholders, introduced prevention programmes linked to the corridors of the Hope project. This project is used by a number of other African countries. This programme targets the highly mobile population throughout the country, and it focuses on providing treatment for sexually transmitted infection as well as encouraging people to practice safe sex by using preventive measures such as condoms.

The Ministry of Health in Botswana, the Safe Blood for Africa Foundation and other stakeholders, through the financial support from ACHAP and PERFAR, have improved the safety of blood transfusion in Botswana by introducing 'Pledge 25'. Through Pledge 25, young people in Botswana are encouraged to donate blood at least 25 times during their lifetimes. The government of Botswana through the Ministry of Health provides the Prevention of Mother-to-Child Treatment (PMTCT) to pregnant women who are also HIV positive. HIV positive mothers who decide not to breastfeed their babies are also given free infant food (formula) for a period of one year from the time the baby is born. Besides pregnant women, the general public in Botswana is encouraged to go for voluntary HIV/AIDS counselling and testing.

Noble (2007: 5) indicates that voluntary HIV/AIDS counselling and testing (VCT) plays a major role in HIV-related prevention and care in Botswana. Noble (2007: 6) also argues that Botswana is the first country in Africa to introduce a national policy of routinely providing an HIV test at

clinics. The routine HIV testing in Botswana helps the country to strengthen its HIV prevention programmes, and it also reduces the workload in hospitals by making it easier for the general public to access treatment provided in various clinics at early stages of illness. The Botswana national antiretroviral treatment is formally known as MASA, the Setswana word for 'dawn'. MASA provides treatment for over 84, 000 people, and through this initiative, death and mortality rates for young people in Botswana have been reduced. The Botswana treatment programme (MASA) has trained and deployed health professionals who are working in various clinics situated in various areas of the country. The other initiative that Botswana is using in fighting HIV/AIDS in the country is the clinical preceptor-ship programme. Through this programme, the Botswana's Ministry of Health regularly works with the specialist medical doctors from the United States of America (USA) and Europe, who provide training to Botswana's health workers for a period of three months. The Botswana government also encourages and pays private doctors to conduct an HIV test and provide treatments where possible, particularly to people who find it difficult to access treatment through public clinics like those who live in rural areas.

Noble (2007:9) recommends that other African countries should use the example of the Botswana's national HIV/AIDS treatment strategy as a guideline to fight HIV/AIDS in their countries. He further recommends that African countries should use their public health facilities to provide antiretroviral treatment to the public instead of depending on localised projects run by foreign aid workers or researchers. The Botswana government demonstrates high political commitment in combating HIV/AIDS by paying almost all of the HIV/AIDS treatment costs in the country, while other stakeholders give support by providing laboratory equipment, staff training or patient monitoring services.

Noble (2007:3) indicates that the government of Botswana established the National AIDS Co-ordinating Agency (NACA) in 1999. The responsibilities of NACA include mobilising and coordinating various sectors' response to HIV/AIDS in the country. NACA reports directly to the National AIDS Council, which is led by the Office of the President of Botswana and it has representatives from 17 sectors including civil society and both public and private sectors. In 2002, Botswana became the first African country to provide antiretroviral (ARV) to the needy citizens. The ARV treatment programme initially focused on certain areas of the country but rapidly expanded throughout the whole country. Also in 2002, Botswana's first antiretroviral

(ARV) clinic was established at Princess Marina Hospital, which is located in the country's capital city, Gaborone. In the same year, the government of Botswana, in collaboration with a number of doctors and nurses from Chelsea and Westminster hospital in London, established the second ARV clinic in Francistown, the Botswana's second city. ARV treatment is given to people with either HIV/AIDS related illness such as Tuberculosis (TB), Kaposi's Sarcoma or chronic diarrhoea, or with a CD4 cell count below 200. CD4 cell, also known as T cells, are immune cells attacked by the virus.

The other initiative by the Botswana government is the introduction of African Comprehensive HIV/AIDS Partnerships (ACHAP) and the Botswana-USA (BOTUSA) projects in the country. Through these projects, Botswana gets financial support from international donors. ACHAP was established in July 2000 and is a collaborative effort of the Botswana government, Bill and Melinda Gates Foundation and Merck Company Foundation. ACHAP is committed to supporting the Botswana's strategic response to HIV/AIDS until 2009 (Botswana's Ministry of Health, 2007: 3). The introduction of BOTUSA is a comprehensive work of the United States of America and the Botswana government, and it aims to combat both HIV/AIDS and TB in Botswana. BOTUSA is part of the Botswana's President's Emergency Plan for AIDS Relief (PEPFAR). During the year 2006, PEPFAR contributed US\$55 million to HIV/AIDS programmes in Botswana. The Botswana government on the other hand is reported to be spending about US\$ 150 million on HIV/AIDS related treatment per annum, which is 6% of the national budget.

The amount of money spent on HIV/AIDS as indicated in the above paragraph, is evidence that HIV/AIDS has negative economic impacts on Botswana. It becomes significant that the fight against HIV/AIDS cannot be done in isolation but as a collective effort from different organisations and countries. It is therefore imperative for Botswana government to work with other governments from other neighbouring states in fighting against HIV/AIDS. This is an important consideration due to the fact that the spread of HIV/AIDS is linked to both internal and external population migration across the borders of Botswana and her neighbouring states.

Botswana's Ministry of State President National AIDS Coordinating Agency (NACA) (2003: 14) stipulates that the Botswana National AIDS Policy was developed and adopted in 1993 and later revised in 1998. This is a guideline and a framework for a National and Multi-Sectoral Response to the HIV/AIDS. In 1994 the Botswana government in collaboration with a number of

stakeholders who had previously been excluded from HIV/AIDS strategic planning established the second Medium Term Plan (MTP 11), which was revised in 1997. The goals and objectives of the plan include identifying the strategic approach so that the response to HIV in the country can be expanded. To ensure effectiveness of the implementation of the national response and to achieve its goals and objectives, various structures have been established in the country. The examples of the structures include the National AIDS Council (NAC), Parliamentary Select Committee of Health, Ministry of Local Government and District Multi-Sectoral AIDS Committees (DMSAC).

The Botswana government is responding effectively to the HIV/AIDS epidemic and works hard to fight the disease. The country's Vision 2016 states that Botswana strives towards an HIV/AIDS-free generation by the year 2016 in terms of new infection. The government departments in different ministries show dedication in fighting the HIV/AIDS pandemic. The national policies and strategies like the Botswana HIV/AIDS Response Information Management System (BHRIMS) are in place to fight the HIV/AIDS pandemic (Botswana. Ministry of Health, 2003: 5).

The objectives of the Botswana HIV/AIDS Response Information Management System (BHRIMS) include the development of the needed infrastructure to monitor and evaluate the implementation of the National Strategic Plan. The specific objectives of the Botswana National HIV/AIDS strategy include the establishment of the Botswana HIV/AIDS Response Information Management System (BHRIMS) infrastructure, to develop national core performance indicators, to build and strengthen the human resource capacity for the BHRIMS, to harmonize national data collection tools, to improve management and utilisation in the whole country, to develop the HIV/AIDS information management system, and to mobilise adequate resources for the implementation of the BHRIMS (UNDP, 2000: 28).

The interest and value for the monitoring and evaluation of the Botswana National HIV/AIDS Response is driven internally by the government of Botswana, based on the intensity of the national response and the need to identify the lessons to be learnt on the interventions. The Botswana government carries out a nation-wide assessment on a regular basis to identify the needs and capacities of the existing monitoring and evaluation system in the country. This assessment also helps the government to identify the strengths and weaknesses of the national

response to HIV/AIDS, and the assessment's findings are used as inputs for the comprehensive national monitoring and evaluation plan. The aims of the monitoring and evaluation are: to identify the existing monitoring and evaluation infrastructure in the country, to have a clear overview of the Botswana HIV/AIDS monitoring and evaluation response, to use the findings of the baseline data to develop a comprehensive and sustainable Botswana HIV/AIDS response information management system, and to develop technical assistance and capacity building Action Plan to fight the epidemic (Botswana's Ministry of Health, 2003: 17).

The Botswana Ministry of Health (2003: 18) further indicates that in order to achieve the above goals and objectives, government officials within the Botswana Ministry of Health should regularly review the available literature on issues concerning HIV/AIDS, observe existing infrastructure and systems, pay regular visits to the districts within the country, and hold consultative meetings with stakeholders on a regular basis. The literature review is to be conducted to identify existing monitoring and evaluation approaches, to assess the availability of human resources, to identify opportunities, and to identify constraints that may exist. Stakeholder meetings and interviews help to examine the desires, perceptions and aspirations among the stakeholders of existing monitoring and evaluation systems in the country. The key stakeholders consulted include the National AIDS Co-ordinating Agency (NACA), Ministry of Health and Local Government, key programmes, major partnership projects, civil society organisations, and the private sector.

The stakeholders give their support to the concept of the Botswana HIV/AIDS Response Information Management System as a universal approach. The stakeholders are also committed to incorporate a monitoring and evaluation system into their programmes. For example, the Botswana Ministries of Agriculture and Education has established basic HIV/AIDS monitoring and evaluation infrastructure within their departments. These ministries have also developed guidelines to facilitate and serve as a springboard for the development of a national monitoring system. The Botswana Christian AIDS Intervention Programme (BOCAIP) and Botswana-USA (BOTUSA) have strategic plans that incorporate HIV/AIDS monitoring and evaluation systems. The Botswana Ministry of Health, together with the stakeholders, indicate that this is an on-going process, and the National AIDS Co-ordinating Agency (NACA) is in the process of developing a new strategic plan to guide the national HIV/AIDS response and at the same time is developing Monitoring and Evaluation Plan. The Ministries of Local Government and

Agriculture integrate HIV/AIDS awareness activities into their existing Strategic Plans and Monitoring and Evaluation Systems (Botswana's Ministry of Health, 2003: 22). The worrying factor however is that not much is said about the private sector such as those in tourism when it comes to minimise HIV/AIDS.

The Botswana Ministry of Health also indicates that there is a wide dissemination of specific monitoring and evaluation findings in the country. Sentinel Surveillance data coordinated by National AIDS Co-ordinating Agency (NACA) in collaboration with both the Ministry of Health and the Ministry of Local Government is disseminated nation-wide to the various ministries, sectors, districts, programmes, and to the international community on an annual basis as a way of creating awareness. The aim of the government of Botswana together with the stakeholders is to develop the suitable infrastructure to monitor and evaluate the National Response based on the National Strategic Plan (2003 – 2009). The National Strategic Plan encourages the general public to go for HIV voluntary counselling and testing, and it develops and implements segmented, actionable behavioural change interventions which identify the unsafe practices that put people at risks of acquiring HIV/AIDS. The use of both male and female condoms in Botswana is encouraged by increasing the supply channels free of charge, improved access, and through sustained education for both genders (Botswana's Ministry of Health, 2003: 24).

The Botswana Government encourages the communities to identify and take action on issues contributing to the spread of HIV/AIDS in the country like alcohol abuse and unprotected sex, especially among the young people. Alcohol abuse and unprotected sex practices are the most identified factors contributing to the spread of HIV/AIDS not only in Botswana but in general. The Botswana government encourages cultural and Behavioural Change Interventions (BCI) at national and district levels to address vulnerable groups particularly in terms of sex, gender relations and alcohol abuse. The government also strives to eradicate discrimination and stigmatisation in both private and public sectors. The Botswana Government provides HIV/AIDS treatment like Anti Retroviral Treatment (ART) and Isoniazid Prevention Therapy (IPT) free of charge to the people who are HIV positive and certified to take the treatment. Pregnant women who are also HIV positive and their families are encouraged by the government of Botswana to use the Prevention of Mother to Child Transmission (PMTCT) programme, which is provided by the government free of charge, and care is given to people living with HIV/AIDS (PLWHA) throughout the country (Botswana's Ministry of Health, 2003: 27).

However, the Botswana's HIV/AIDS treatment campaign does not cover a number of rural areas in the country due to the fact that the infrastructure in many rural areas in the country is poorer than those in urban areas (Noble, 2007:4). The other challenge with regards to treatment in rural areas is that HIV/AIDS increases the demand for additional infrastructure like testing centres and storage facilities, and it increases the need for trained medical personnel, who are also wiped away by the disease. Many HIV/AIDS patients in rural areas where treatment is accessible are illiterate and find it difficult to understand the significance of taking the complex HIV/AIDS treatment daily for the rest of their lives. One of the challenges is that it is difficult to control and ensure that HIV/AIDS patients who are on HIV/AIDS treatment programme stick to the treatment as prescribed by doctors. A number of the HIV/AIDS patients develop resistance to the antiretroviral treatment, which forces the government to look for alternative treatment, and it is quite complicated and expensive. In most cases, parents die and leave AIDS orphans with the grandparents who are pensioners, and in a number of cases pensioners find it difficult to take care of the children due to old age and poverty. There is also a shortage of skilled health workers to facilitate the ARV treatment outside the health clinics, and a number of the skilled health workers leaves the country and go overseas for better paying jobs. This leaves the country with no choice but to recruit health workers from poorer African countries, which is also complicated. The other major challenge facing Botswana is the increasing number of new HIV/AIDS infection accompanied by ignorance and denial.

The challenges facing the Botswana's HIV/AIDS treatment campaign means that the antiretroviral treatment alone is not good enough to help the country to win the battle against the devastating HIV/AIDS infection rate in the country. The Botswana's long-term vision is to have HIV/AIDS free nation by 2016, when the country will be celebrating 50 years of democracy. This will be difficult to achieve without a heavy and comprehensive HIV prevention framework involving the government, private sectors such as those in tourism, stakeholders and communities at large. It is imperative to build infrastructure like testing centres in rural areas so that the rest of the country can be covered by the treatment campaign. The Botswana government in collaboration with the stakeholders should train people who will facilitate and coordinate the treatment programme in rural areas, and who will make sure that HIV/AIDS patients take the treatment according to the doctor's prescription. These trained people could be deployed in various communities in all the regions of the country and given the mandate to check regularly

and ensure that HIV/AIDS patients within specific communities do take treatment. This strategy may also assist pensioners who take care of HIV/AIDS patients.

The Botswana government should pay health workers such as medical doctors good salaries and improve their working conditions to motivate them not to leave the country for better paying jobs in foreign countries. Health is an important sector in the country; therefore, it is important to keep health workers happy so that the skills could be retained in the country. By retaining the skilled health workers who are also citizens of Botswana in the country could solve the problem of shortage of skilled health workers in Botswana, and it could reduce the costs of training people who eventually migrate to foreign countries for better paying jobs. The other important factor that should be taken into consideration is that health workers who are also Botswana citizens understand the cultures and languages spoken by the local people in the country, which makes it easier for them to communicate and facilitate the HIV/AIDS treatment campaign. This is an important consideration in rural areas where a number of people are not educated and cannot speak English or any foreign language except Setswana and their local tribal languages, which could make it difficult for foreign health workers to communicate and facilitate HIV/AIDS treatment within those communities.

Although this study is focused on Botswana, it is imperative to evaluate HIV/AIDS response strategies in the countries that share borders with Botswana. The reason for this is that population migration has an influence on the spread of HIV/AIDS, and Botswana and the neighbouring states experience high population migration across their borders. HIV/AIDS is also reported to be high in Southern Africa, with Botswana and the neighbouring states being among the countries with the highest HIV/AIDS infection rate in the world. The Botswana strategies on the fight against HIV/AIDS involve selected government ministries and departments but the private sector such as tourism does not make significant contribution in the fight against HIV/AIDS. The following section discusses how the tourism sector in Botswana in general responds to the impact of HIV/AIDS.

3.5.7 THE BOTSWANA TOURISM SECTOR'S RESPONSE TO THE IMPACT OF HIV/AIDS

Preece and Ntseane (2004: 5) advance arguments indicating that a number of organisations including those in the tourism sector in Botswana do not incorporate HIV/AIDS education into their strategic plans. However, there are various educational and counselling programmes available in selected companies, but many companies in the country including those in the tourism sector do not actively engage in the fight against HIV/AIDS in workplace, but rely on government policies and strategies. This is because a number of companies lack awareness about the possible action they can take to fight HIV/AIDS among their employees. Preece and Ntseane (2004: 6) also emphasise that the Botswana HIV/AIDS and prevention policies should be integrative and actively involve communities in formulating and implementing HIV/AIDS policies. The other variable that needs adequate attention is gender inequality both at workplace and in general, and specific area that needs to be addressed is the cultural position of women that often expose them to HIV/AIDS. Many companies' HIV/AIDS information, education and communication (IEC) strategies in Botswana in general do not address gender inequality and the general needs of both women and young people regarding HIV/AIDS at the workplace. Slow behavioural change in the country indicates that adequate attention should be paid in addressing social and cultural contexts both at the workplace and in general.

USAIDS (2005: 3) indicates that the response to the impact of HIV/AIDS by many companies in Botswana differs from sector to sector. For example, the mining sector is generally unique in its operation, therefore, its utilisation of employees varies from other economic sectors such as tourism. However, both mining and tourism sectors operate in a global market earmarked with intensified competition. The mining sector in particular, depends on employees' productivity, which is threatened by HIV/AIDS. Tourism on the other hand, depends on quality service rendered to clients, and HIV/AIDS affects the service quality by killing experienced and skilled workers. Both tourism and mining workers are vulnerable to HIV/AIDS because of conditions of their work and lifestyles. The working stations of these two sectors in Botswana are often located in remote areas. A number of working stations in both tourism and mining in Botswana often present unpleasant working and living conditions, with limited opportunities for leisure, which often encourage a number of workers to engage in risky behaviour. A number of workers in remote areas in Botswana do not have access to adequate HIV/AIDS educational information.

The fact that most of workers in both tourism and mining sectors are migrants contributes to a lack of opportunities for social support and health care for these employees, and a number of employees feel they do not have control over their lives. The bad working and living conditions in remote areas influence a number of employees to engage in sexual activities and alcohol abuse, which make them more vulnerable to HIV/AIDS.

Based on the information above, it becomes evident that workplace-based HIV/AIDS education programmes in a number of companies in Botswana do not take social and psychological aspects into consideration. HIV/AIDS programmes at the workplace need to address social and psychological pressures resulting from HIV/AIDS. Companies including tourism should take responsibility to protect and support their employees against risk situations resulting from poor or unhealthy working and living environments. However, Botswana and a number of other African countries in general have policies encouraging companies to support employees and to create conducive working environment.

Besides providing workplace-based HIV/AIDS education, the other challenge that needs to be addressed is the fact that a number of workers in the Botswana tourism sector are migrants living away from their families. In addressing this challenge, it is recommended that companies should encourage and create opportunities for migrant workers to bring their families or spouses to live with them. This strategy could help companies to protect their employees, particularly married couples and it may also minimise costs resulting from HIV/AIDS treatment. It is also imperative for senior management in the tourism sector and in general to play an active leadership role in monitoring and implementation of HIV/AIDS-related educational programmes at the workplace. The focus of workplace education should be at behavioural change and utilisation of preventive measures such as condoms.

There is a strong link between the spread of HIV/AIDS and other sexual transmitted infections (STIs), which suggests that the general health care for workers is imperative to reduce the spread of HIV/AIDS and other illness (USAIDS, 2005: 4). An example of an illness closely linked to HIV/AIDS is TB, which often develops in HIV positive people and failure to take effective measures may result in TB spreading fast to the general population. USAIDS also argues that proactive treatment of employees can prolong their working periods and prevent early termination of employment, which may also mitigate loss of benefits. This strategy may benefit

the employees and their families, the company may also retain skills and experience, and may also benefit the country in general. Conducting regular counselling with employees living with HIV/AIDS is imperative, and HIV positive employees should be encouraged to continue working without fear of job insecurity when they disclose their status. Workers need to be trained in various company operations to equip them with multiple skills. In monitoring and managing HIV/AIDS at workplace, companies should have information on the employee profile such as age, gender, qualifications, job categories, costs of employment both direct and illness related costs, and worker health and access to health services. This can help companies to determine employment costs, project the impact of ill-health, and to evaluate the effectiveness of prevention intervention.

In conclusion, most of the tourism companies in Botswana particularly in the private sector do not take in the fight against the spread and impact of HIV/AIDS on tourism businesses. This is because most of the tourism companies in the country do not incorporate HIV/AIDS policy as part of their daily business operation. The fight against HIV/AIDS is left to be the state government's responsibility.

3.6 GENERAL OVERVIEW OF HIV/AIDS IN AFRICA AND IN THE REST OF THE WORLD

This SECTION presents a general overview of HIV/AIDS in the Africa and the world at large. Factors discussed in this SECTION include an overview of global HIV/AIDS situation, an overview of HIV/AIDS situation in Africa, an overview of HIV/AIDS orphan in Africa, and an overview of HIV/AIDS situation in Southern Africa.

3.6.1 AN OVERVIEW OF GLOBAL HIV/AIDS SITUATION

The impact of HIV/AIDS is escalating and many people across the world are losing their lives to HIV/AIDS. It is projected that more than 25 million people in the world have died of HIV/AIDS related illnesses since 1991, and that Africa has more than 14 million AIDS orphans (UNAIDS, 2009: 1). UNAIDS estimations show that women account for 50% of the adult population living with HIV/AIDS in the world. In developing countries, 9.5 million HIV/AIDS positive people

need treatment, but only 4 million (42%) of these people actually get the treatment. Table 3.29 presents the projected number of people living with HIV/AIDS globally.

Table 3.29 presents the total number of people living with HIV/AIDS as at the end of 2008. It is projected that 33.4 million people in the world are living with HIV/AIDS. The continued spread of HIV/AIDS has negative impacts on various economic sectors including tourism. Despite the fact that many countries have made efforts in educating people about HIV/AIDS, the disease is still spreading at an alarming rate. The Graph 3.1 also presents the HIV/AIDS trends over various years.

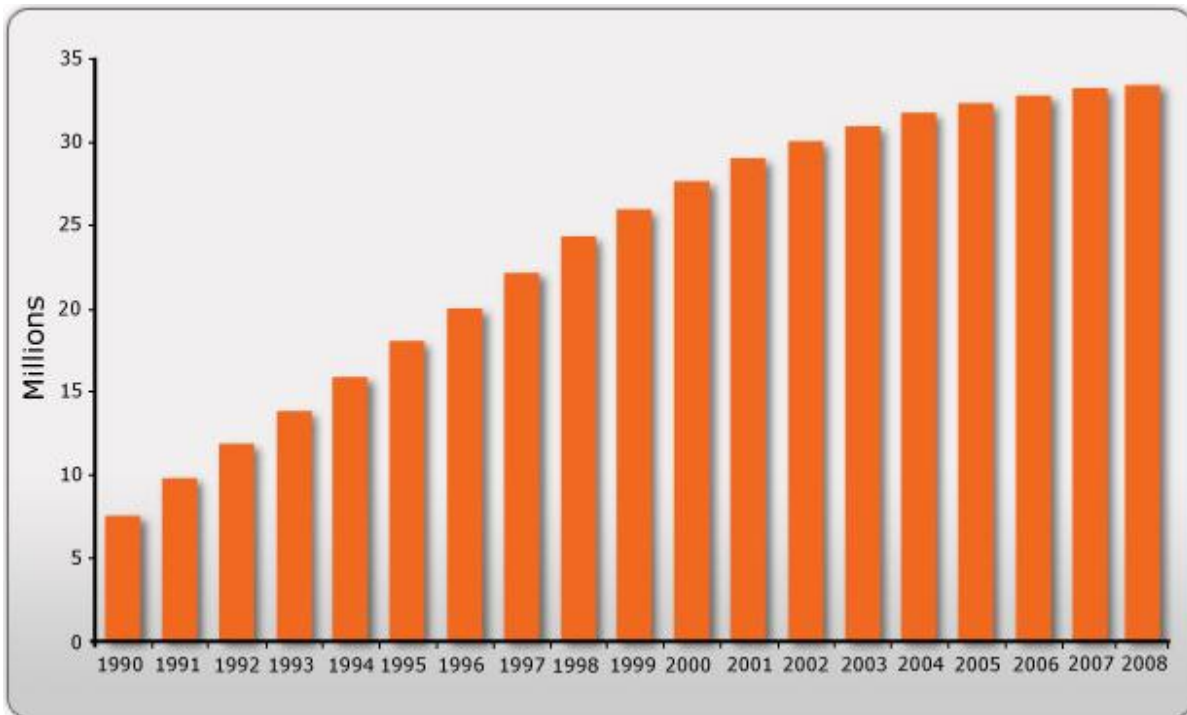
TABLE 3.29: GLOBAL HIV/AIDS ESTIMATES, END OF 2008

	Estimate	Range
People living with HIV/AIDS in 2008	33.4 million	31.1-35.8 million
Adults living with HIV/AIDS in 2008	31.3 million	29.2-33.7 million
Women living with HIV/AIDS in 2008	15.7 million	14.2-17.2 million
Children living with HIV/AIDS in 2008	2.1 million	1.2-2.9 million
People newly infected with HIV in 2008	2.7 million	2.4-3.0 million
Children newly infected with HIV in 2008	0.43 million	0.24-0.61 million
AIDS deaths in 2008	2.0 million	1.7-2.4 million

(Source: UNAIDS, 2009)

Graph 3.1 depicts the increase in HIV/AIDS between 1990 and 2008. The graph shows that HIV/AIDS continues to spread in the world. The number of people projected to be living with HIV/AIDS increased from 8 million in 1990 to 33 million in 2008. UNAIDS (2009: 3) also projects that 67% of the world population living with HIV/AIDS is in Sub-Saharan Africa. Botswana is one of the countries in the Sub-Saharan Africa with the highest HIV/AIDS prevalence rate, hence the need to conduct this research in the country to investigate the impact of the disease on the country's tourism sector.

GRAPH 3.1: GLOBAL HIV/AIDS TRENDS



(Source: UNAIDS, 2009)

The socio-economic impact of HIV/AIDS varies from region to region. Sub-Saharan Africa is the most affected region in the world (Ramsey *et al.*, 2002: 3). In 2001, 2.3 million Africans died of AIDS. In the same year, 3.4 million people in the region were diagnosed with HIV/AIDS. To date, over 28.1 million people in Africa are reported to be HIV positive. The most vulnerable people are young women.

Due to HIV/AIDS, the average life expectancy in Sub-Saharan Africa has dropped from 62 years to 47 years. In the countries with the highest HIV prevalence rate in the region like Botswana, Malawi, Mozambique and Swaziland, the average life expectancy is below 40 years (Ramsey *et al.*, 2002: 3).

Sub-Saharan Africa also accounts for the highest death rates than any other region in the world. High death rate is expected to reduce population in the region and often leads to social problems such as poverty and high orphanage, which directly or indirectly affect the tourism sector of countries vulnerable to HIV/AIDS. This is because the population that dies of HIV/AIDS constitutes both current and potential tourism clients and investors. High infection and death rate means that more money and time is spent on medication and funerals than on developing tourism

and other economic sectors. The prevalence of HIV/AIDS also varies according to various regions of the world. Table 3.30 presents the prevalence of HIV/AIDS according to various regions of the world.

TABLE 3.30: REGIONAL STATISTICS FOR HIV & AIDS, END OF 2008

Region	Adults & children living with HIV/AIDS	Adults & children newly infected	Adult prevalence*	Deaths of adults & children
Sub-Saharan Africa	22.4 million	1.9 million	5.2%	1.4 million
North Africa & Middle East	310,000	35,000	0.2%	20,000
South and South-East Asia	3.8 million	280,000	0.3%	270,000
East Asia	850,000	75,000	<0.1%	59,000
Oceania	59,000	3900	0.3%	2,000
Latin America	2.0 million	170,000	0.6%	77,000
Caribbean	240,000	20,000	1.0%	12,000
Eastern Europe & Central Asia	1.5 million	110,000	0.7%	87,000
North America	1.4 million	55,000	0.4%	25,000
Western & Central Europe	850,000	30,000	0.3%	13,000
Global Total	33.4 million	2.7 million	0.8%	2.0 million

(Source: UNAIDS, 2009)

Table 3.31 shows that out of 38 million adults living with HIV/AIDS, 17.5 million people are women. Women and children combined constitute more than 19.5 million of the total population projected to be living with HIV/AIDS in the world. This indicates that women and children are more vulnerable to HIV/AIDS. It is worrying that HIV/AIDS poses a serious threat to women who play a vital role in societies by raising children. HIV/AIDS kills 3.1 million people and more than a million of these people are children. The prevalence of HIV/AIDS varies according to different regions in the world. Table 3.3 further presents the global summary of HIV/AIDS and its impact on death rate.

TABLE 3.31: GLOBAL SUMMARY OF THE AIDS EPIDEMIC DECEMBER 2005

Number of people living with HIV in 2005		
	Total	40.3 million
	Adults	38 million
	Women	17.5 million
	Children under 15 years	2.3 million
People newly infected with HIV in 2005		
	Total	4.9 million
	Adults	4.2 million
	Children under 15 years	700 000
AIDS deaths in 2005		
	Total	3.1 million
	Adults	2.6 million
	Children under 15 years	570 000

(Source: UNAIDS & WHO, 2005)

Table 3.32 presents the projected HIV/AIDS statistics in various regions in the world between 2003 and 2005.

TABLE 3.32: REGIONAL HIV AND AIDS STATISTICS AND FEATURES, 2003 AND 2005

	Adults and children living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)	Adults and children deaths due to AIDS
Sub-Saharan Africa				
2005	25.8 million	3.2 million	7.2	2.4 million
2003	24.9 million	3 million	7.3	2.1 million
North Africa and Middle East				
2005	510 000	67 000	0.2	58 000
2003	500 000	62 000	0.2	55 000
South and South-East of Asia				
2005	7.4 million	990 000	0.7	480 000
2003	6.5 million	840 000	0.6	390 000
East Asia				
2005	870 000	140 000	0.1	41 000
2003	690 000	100 000	0.1	22 000
Oceania				
2005	74 000	8 200	0.5	3 600
2003	63 000	8 900	0.4	2 000
Latin America				
2005	1.8 million	200 000	0.6	66 000
2003	1.6 million	170 000	0.6	59 000
Caribbean				
2005	300 000	30 000	1.6	24 000

2003	300 000	29 000	1.6	24 000
Eastern Europe and Central Asia				
2005	1.6 million	270 000	0.9	62 000
2003	1.2 million	270 000	0.7	36 000
Western and Central Europe				
2005	720 000	22 000	0.3	12 000
2003	700 000	20 000	0.3	12 000
North America				
2005	1.2 million	43 000	0.7	18 000
2003	1.1 million	43 000	0.7	18 000
Total				
2005	40.3 million	4.9 million	1.1	3.1 million
2003	37.5 million	4.6 million	1.1	2.8 million

(Source: UNAIDS & WHO, 2005)

Table 3.33 indicates that women in general are vulnerable to HIV/AIDS. Within Sub-Saharan Africa Southern African countries are the most hit-hard by HIV/AIDS. For example, it is projected that the prevalence rate among pregnant women in Botswana, Lesotho, Namibia, South Africa, Swaziland and Zimbabwe exceed 20% (UNAIDS & WHO, 2005: 4). Studies conducted by various researchers indicate that the Sub-Saharan Africa is vulnerable to HIV/AIDS.

TABLE 3.33: REGIONAL HIV STATISTICS AND FEATURES FOR WOMEN, 2003 AND 2005

		Number of women (15-49) living with HIV	Adults (15-49) living with HIV who are women (%)
Sub-Saharan Africa	2005	13.5 million	57
	2003	13.1 million	57
North Africa and Middle East			
East	2005	220 000	47
	2003	230 000	50
South and South-East Asia	2005	1.9	26
	2003	1.6	25
East Asia	2005	160 000	18
	2003	120 000	17
Oceania	2005	39 000	55
	2003	27 000	44
Latin America	2005	580 000	32
	2003	510 000	32
Caribbean	2005	140 000	50
	2003	140 000	50
Eastern Europe and Central Asia			
Central Asia	2005	440 000	28
	2003	310 000	26
Western and Central Europe			
Europe	2005	190 000	27
	2003	180 000	27
North America	2005	300 000	25
	2003	270 000	25
Total	2005	17.5 million	46
	2003	16.5 million	47

(Source: UNAIDS & WHO, 2005)

3.6.2 AN OVERVIEW OF HIV/AIDS SITUATION IN AFRICA

Women's HIV/AIDS prevalence in Africa in general is in a devastating situation (Uhegbu & Okereke, 2006: 37). The HIV/AIDS infection rate among African women in a number of African countries is high and is increasing at an alarming rate. A number of health experts in Nigeria for example project that at least one Nigerian gets infected with HIV/AIDS every minute of the day, and that 518400 people in the country get infected every 12 months, in which women are dominating. Various researches show that 55% of adults living with HIV/AIDS in Africa are women. The African women and girls at the age of 15 to 24 are the most vulnerable to HIV/AIDS.

It is projected that an overall 33.6 million people in Africa are infected with HIV/AIDS, and that 14.8 million of these people are women. The fact that women are more vulnerable to HIV/AIDS than men is a cause for concern. This causes concern because women play a vital role in communities by raising children and doing domestic work within the tourism establishments. It is worse when single mothers die of HIV/AIDS related illness and leave orphans without anybody to take care of them. In such situations, a number of the HIV/AIDS orphans eventually get exposed to risky behaviour. In general, Africa is projected to be having more than 5 hundred thousand children under the age of 15 years living with HIV/AIDS. It is also projected that most of the children living with HIV/AIDS acquired it from their mothers either through breastfeeding or during birth.

Table 3.34 presents the statistics provided by the World Health Organisation (WHO) (2004) on women and HIV/AIDS in Africa.

TABLE 3.34: WOMEN AND HIV/AIDS IN AFRICA

Overall HIV/AIDS infection rate in Africa	HIV/AIDS Infection among women in Africa
A total of 33.6 million people are living with HIV/AIDS	14.8 million women in are living with HIV/AIDS
5 million adults are newly infected (1999)	2.3 million women are newly infected
2.1 million people die of HIV/AIDS (19990)	1.1 million women die of HIV/AIDS
For every 10 infected African men	There are at least 12 to 13 infected women
5 hundred thousand children under the age of 15 in Africa live with HIV/AIDS	Most of the children living with HIV/AIDS got it from their mothers

(Source: own table based on information provided by WHO, 2004. and Uhegbu and Okereke, 2006).

Table 3.35 presents the percentage of the total population living with HIV/AIDS in various African countries. The total percentage population living with HIV/AIDS in Botswana is relatively high when compared to a number of other countries in Africa. The table also shows that African countries are leading in the total percentage of HIV/AIDSs. This could be because of the movement of people across these countries' borders. Although Southern African region records the highest prevalence rate of HIV/AIDS in the World, it is not the only region affected by the disease, but other regions in Africa in general are facing high prevalence rate of the pandemic. Many studies reveal that the Southern African countries including Botswana present the highest percentage of the total population living with HIV/AIDS (Globastat, 2005: 2).

TABLE 3.35: PERCENTAGE OF TOTAL POPULATION LIVING WITH HIV/AIDS

World rank	Country name	% of total population
1	Botswana	18.284%
2	Zimbabwe	13.198%
3	Swaziland	11.772%
4	Lesotho	11.024%
5	South Africa	9.636%
6	Zambia	8.905%
7	Namibia	8.900%
8	Djibouti	8.031%
9	Malawi	7.584%
10	Kenya	6.826%

(Source: Globastat, 2005).

In 2001, many countries in Southern and Eastern Africa were reported to have HIV/AIDS prevalence rate exceeding 30% of their adult population between the ages of 15 – 29, meaning that 1 out of 3 people is HIV positive. The prevention responses in a number of countries in Africa are fruitful. The slowing down of the HIV prevalence in Uganda is continuing and the antenatal clinics in urban areas indicate that HIV prevalence in the country dropped from 29.5% in 1992 to 11.25% in 2000 (Ramsey *et al.*, 2002: 3).

In West Africa, the HIV/AIDS cases were reported much later than in the East and Southern Africa, and five West African countries (Burkina Faso, Cote d'Ivoire, Nigeria, Togo and Cameroon) show a national adult HIV prevalence rate of 5%. This means that 1 person out of 20 people is projected to be HIV positive. In Senegal, the HIV/AIDS prevalence rates have been kept down by persistent political support and leadership, and by integrated prevention strategies.

Majority of people vulnerable to HIV/AIDS in Africa in general are the young people who participate in economic activities including tourism. Most of the young adults in rural areas of a number of African countries lack the knowledge and understanding of the HIV/AIDS pandemic.

The studies conducted by UNICEF indicate that 70% of the young girls aged 15 – 19 in Somalia, over 40% in Guinea – Bissau and in Sierra Leone had never heard of HIV/AIDS. The studies also indicate that more than 40% of young girls in Kenya and Tanzania have no clue on how the HIV/AIDS virus is transmitted. The studies carried in South Africa indicate that more than 95% of the South Africans have a clear understanding of how the HIV/AIDS pandemic is transmitted and that there is no cure for this pandemic. Knowledge and awareness is the key to effective HIV/AIDS prevention strategies. By the end of 2000, 12.1 million children in Africa had lost their mothers or both parents to HIV/AIDS pandemic. In a number of the African countries with the highest HIV/AIDS prevalence rates, many babies are born with the HIV/AIDS virus and the child mortality rates are rising at an alarming rate. For example, 70% of the deaths of the children under the age of five in Zimbabwe are caused by the HIV/AIDS pandemic (Ramsey et al., 2002: 4).

It is projected that 36.1 million people worldwide are living with HIV/AIDS, and that 71% of these people infected with HIV/AIDS globally are from the Sub-Saharan Africa (Agbola, Damoense & Saini, 2004: 721 – 731). South Africa is one of the countries that experienced fastest spread of HIV/AIDS over the number of years. For example, in 1996, 2 million people were projected to be living with HIV/AIDS in the country, but by 2001 the figure had increased to 4 million. It is projected that more than 500 000 people in the country have been killed by HIV/AIDS-related illness in the past few years, and it is further projected that by the year 2015 the number of people who are killed by HIV/AIDS in South Africa will increase by a factor of 20 to more than 10 million deaths. By the year 2008, life expectancy in South Africa is expected to drop from 65 years to 40 years (FAO, 2001: 5).

The other population group vulnerable to HIV/AIDS are the immigrants. For example, HIV/AIDS prevalence rate is reported to be high along channels such as truck routes and areas with high population migration, thus posing serious threats to villages and towns in which trucks drive or in which there is high population migration (Villarreal, 2006: 197). There is no exception to the major tourist destination where there is high population migration from both clients and workers. The HIV/AIDS prevalence rate in rural areas of many African countries is exacerbated by the fact that a number people migrate to urban areas for employment opportunities and later return to rural areas when they are infected with the disease. Unlike in urban areas, most rural areas in a number of African countries like Botswana do not have adequate HIV/AIDS

information and health services, and a number people who live in rural areas are more less likely to know how to protect themselves against the HIV/AIDS infection, and when they fall ill, they may not have relatively good health services available in the cities. HIV/AIDS general poses more threats in rural areas than in urban areas. Tourist destinations in most African countries are located in rural areas. HIV/AIDS is therefore, expected to have impact on tourism particularly in rural areas, hence the need to conduct this research in Chobe and Maun.

3.6.3 AN OVERVIEW OF HIV/AIDS ORPHANS IN AFRICA

The African continent is generally faced with a challenge of having many children who are living with HIV/AIDS. The continent has over 1900 children who get infected with HIV from their mothers daily (Dabis & Ekpini, 2002: 209). Africa is generally faced with 25% to 45% risk of mother-to-mother HIV/AIDS transmission, but the prevention programmes in a number of countries in the continent reaches only 3% of women living with HIV/AIDS. Dabis and Ekpini (2002) further project that 35 to 59% of children infected with HIV/AIDS in Africa die within a period of two years of their lives, and that the number of HIV/AIDS-related orphans in the continent is increasing at an alarming rate. At least 28.1 million people in Africa are projected to be living with HIV/AIDS, and 2.4 million of these people are children. Health systems in a number of African countries do not have adequate resources such as finance to implement prevention of mother-to-child programmes. However, selected countries in the continent such as Botswana get political, technical and financial support from international communities. It is projected that 90% of children either infected or affected by HIV/AIDS in the Sub-Saharan Africa have access to prevention of mother-to-child transmission programmes and care but at small scale.

Dabis and Ekpini (2002: 2100) further argue that 95% of children living with HIV/AIDS got it from their mothers. They also argue that children in the Southern African region have a shorter life expectancy than their grandparents. In Zimbabwe, 70% of deaths in children under the age of five years are linked to HIV/AIDS. Mortality rate in the country is projected at 26 to 45% at first birth and 35 to 59% at two years. Historically, high numbers of orphans in Africa in general were resulting from war, famine or some diseases, but HIV/AIDS is the leading contributor to high number of orphans in Africa. More than 15.6 million children in the world are reported to have lost either one or both parents attributed to HIV/AIDS. Africa is projected to be having 12.1

million orphans and this number is expected to increase when observing the increased HIV/AIDS prevalence rates in the continent. It is further estimated that 9% of children under the age of 15 years in Africa will be orphans by the end of 2010. Without amicable strategic solutions by either parents or caregivers, orphans are likely to suffer from lack of basic needs such as educational opportunities, nutrition, shelter, health care, and sufficient growth and development. Taking care of orphans in general is imperative for future development of tourism in African countries because children including orphans represent the population group that constitutes future tourism leaders. Taking care of orphans is imperative for future development of tourism in African countries and the rest of the world because children including orphans constitute future tourism leaders.

Community-based care for families and children and children affected by HIV/AIDS is the fundamental strategic care. However, the tradition of orphans and widows being adopted into the extended family structure is not commonly practiced in a number of African countries. The information on models to provide care for orphaned and vulnerable children in the African continent is limited. However, the analysis of various strategies for caring for children orphaned by HIV/AIDS and other vulnerable children in South Africa shows that community care is more cost-effective than residential care. Residential care is reported to be less cost-effective in countries with high number of orphans such as Zimbabwe, where less than 4000 out of projected 800 000 orphans are accommodated in the country's 45 registered residential care institutions (Dabis & Ekpini, 2002: 2101).

Botswana has one of the world's highest numbers of HIV/AIDS orphans. HIV/AIDS affects child health throughout Botswana, and it is the leading cause of child mortality in the country, resulting in high numbers of orphans. It is also indicated that only 85% HIV/AIDS patients legible to take antiretroviral treatment (ART) in Botswana are receiving it. The remaining challenges include shortage of manpower to implement the ART programme and make it accessible by all HIV/AIDS patients in the country. The other major challenge facing the ART programme in the country is the fact that a number of HIV/AIDS patients experience side effects linked to the treatment. However, the Botswana ART programme is expected to address the problem of HIV/AIDS mortality and also to minimise the cases of newly orphaned children in the country (UNICEF, 2004: 50).

UNICEF (2004: 50) indicates that 20% of children in Botswana are orphans, and that by the year 2010 40% of the children will be orphans. UNICEF further indicates that 77% of orphans in Botswana is linked directly to HIV/AIDS deaths of parents. UNICEF defines an orphan as a child under the age of 18 whose one or both parents have died. Maternal and paternal orphans are the children who have lost at least one of the parents, and double orphans are the children who have lost both parents. UNICEF advances argument that a number of orphans face difficulties resulting from the fact that either their parents or caregivers are also HIV/AIDS patients. Orphans and vulnerable children (OVC) relatively face more health and financial challenges when compared to non-orphans. In a number of cases many OVCs do not receive adequate care, they are cared for by poor parents, do not always have access to public services, and are often stigmatised.

UNDP (2003: 1) argues that since the evolution of HIV/AIDS in the early 1980s, both infant and child mortality rates in Botswana increased dramatically. Since the year 1999, the infant mortality in the country increased from 39 to 82 infants/1000, and children mortality also increased from 48 to 112 children/1000 in the same period. This has increased the number of orphans and vulnerable children in Botswana. HIV/AIDS does not only affect Botswana but the rest of Southern African region and in general, and both poverty and HIV/AIDS increase the infant and child mortality in the Southern African region. Both infant and child mortality rates are likely to negatively affect the Botswana's and other Southern African tourism sector, particularly countries that are vulnerable to HIV/AIDS.

The rate of mother-to-child transmission (MTCT) is generally projected to be 25 to 45% in the Sub-Saharan Africa, and orphans aged 0 – 4 years in the region are said to be facing relatively greater HIV/AIDS challenges than their non-orphans counterparts (Dabis & Ekpini, 2002: 2097). Without HIV/AIDS treatment interventions, it is projected that an HIV positive child can live up to an average of two years. Since the year 2005, 80% of the children born with HIV/AIDS in Botswana have access to ART, whereas in a number other Sub-Saharan countries only 7% of the children living with HIV/AIDS receive the treatment. However, it remains uncertain what impact an ART will have on infant and child mortality rates in the country.

Generally, many orphaned and vulnerable children in a number of African countries experience health difficulties because they live in poverty. For example, research conducted in Tanzania and Uganda shows that children from poorer families cared for by uneducated caregivers face more

difficulties than those from wealthier families cared for by educated caregivers (Miller, Gruskin, Subramanian & Heymann, 2007: 2478).

3.6.4 AN OVERVIEW OF HIV/AIDS SITUATION IN SOUTHERN AFRICA

HIV/AIDS is significantly having a negative impact on tourism in Southern Africa. According to the United Nations Organisation (2005: 22), the Southern African Region in general is experiencing one of the severest HIV/AIDS pandemics on the African continent. According to the organization the pandemic began to spread in Southern Africa during the 1980s. In the 1990s, HIV prevalence increased dramatically in a number of countries in the region. The report also indicates that since the survey of HIV prevalence among pregnant women attending antenatal clinics was conducted in the 1990s, prevalence has climbed by 25% to 45% in selected countries within the Southern African Region. Indications are that the severity of the pandemic in urban and rural areas in Southern Africa is quite similar, unlike in many other parts of Africa.

According to the United Nations International Children Fund (UNICEF) annual report on the progress of nations (2007: 18), it is increasingly evident that HIV/AIDS has a major effect in Southern Africa. There is no doubt that overall infection rates in the region are high and increasing. Some countries in the region, like Botswana, are reported to have an HIV infection rate of 18.284% of the entire population, and it is expected that this will increase to a peak of 30% or perhaps even higher. According to the report, infection rates among specific sub-groups of the adult population are higher, with sentinel surveys of pregnant women in the region showing an infection rate of 40-50% in a number of countries within the Southern African Region. The same pattern could be true of the region's tourism sector.

HIV/AIDS affects Southern Africa extensively in many different ways and eventually results in death. Demographically, a sharp rise in the mortality rate causes life expectancy to fall and also reduces the population growth rate. Socially, illness and death are devastating and costly.. The income for households with AIDS patients reduces when breadwinners become sick and die, and the expenditure on medical and related costs increases. The impact of HIV/AIDS is more significant on economic growth, per capita incomes, savings, investments and the labour force (UNICEF 2004: 18).

The UNICEF report further stipulates that HIV/AIDS has a negative impact on the Southern African economy, the workforce, business, and individual workers and their families. HIV/AIDS is a threat to enterprise performance. The world of work is affected by increasing costs due to health care, absenteeism, burial fees, recruitment, training and re-training costs. HIV/AIDS disrupts the performance of the formal and the informal sectors and small and medium enterprises including those in the tourism sector. Other manifestations are low productivity, depleted human capital, challenged social security systems and threatened occupational safety and health, especially among certain groups at risk such as migrant workers and their communities and workers in the medical, tourism, mining, and transport sectors. Overall, there could be a reduction of growth and productivity without rapid measures to prevent the impact of HIV/AIDS in the Southern African tourism sectors. This is relevant to the Botswana tourism sector.

HIV/AIDS is the leading cause of death for many young people in many Southern African countries. This creates problems for the remaining parents who take the responsibility of caring for the large numbers of orphans with little or no income at all. The scarcity of HIV/AIDS data in rural areas of a number of Southern African countries means that little could be known about how citizens respond to and cope with the pandemic. Within the tourism sector in Botswana for example, no research has been conducted to find out the possible impact of HIV/AIDS on tourism businesses, hence the need for this research. People's perceptions and experience in the Southern African region vary in important ways from what the objective data leads them to expect. HIV/AIDS is a family problem in Southern African communities. Due to the high rate of poverty and high rate of unemployment, many communities within a number of Southern African countries are concerned with getting income, feeding their families, protecting themselves from crime and insecurity, and obtaining basic health care more than with being saved from HIV/AIDS (Whiteside, Mattes, William & Manning, 2002: 2).

As already indicated in this study, HIV/AIDS is a complex issue and its epidemiological data is composed of two important concepts; incidence and prevalence. Incidence is the number of people who are newly infected over a certain period of time, whereas Prevalence is the exact population that is infected (Whiteside *et al.* (2002: 4). The prevalence rate refers to the proportion of the population that exhibits the disease at a certain period, or in simpler terms, the average over a period of time. Both incidence and prevalence concepts are used in Southern Africa as key statistics for tracking the course of the HIV/AIDS pandemic in the region. The incidence data is

used to measure the spread of the HIV/AIDS pandemic and the impacts of prevention efforts. For people to know their HIV status, they need to be tested through the sample of their blood.

The testing of HIV/AIDS as indicated above is conducted through a blood sample, and the testing of the entire population is not feasible or justifiable, hence HIV epidemiological data is based on sample surveys of specific sub-groups. Although the Southern African Region is the most vulnerable to HIV/AIDS in the world, various countries in the region experience the prevalence of HIV/AIDS differently. For example, the HIV prevalence rates among adults (aged 15 – 49) in Botswana is 38.8% and 15% in Malawi (UNAIDS, 2001). This UNAIDS report is based on seven Southern African countries. The report also stipulates that the prevalence rates are steeply rising in a number of Southern African countries, particularly Lesotho and Zimbabwe, but stabilising in other countries. This stability of HIV prevalence in a number of the Southern African countries is due to increased AIDS death rates. The incidence of AIDS illness and deaths in Southern Africa continues to rise irrespective of HIV prevalence stabilisation or declines (Whiteside *et al.*, 2002: 8).

Many countries in Southern Africa did not monitor the HIV/AIDS pandemic until recently, which results in a scarcity of data for earlier years (UNAIDS, 2006: 28). The HIV prevalence in the Southern African Region is further illustrated by the graphs below. The three graphs are composed of a randomly picked sample of four Southern African countries, which were used to represent the region in 1997, 1999 and in 2001. These graphs are used to indicate the percentage HIV/AIDS prevalence among adults aged 15–49 years for the three indicated periods. The fourth graph indicates the percentage of HIV/AIDS prevalence rates among pregnant women attending antenatal clinics in 2005 in the four Southern African countries sharing the border with Botswana. The purpose of studying these countries is to observe how the prevalence of HIV/AIDS has increased in Botswana relative to other Southern African countries over the years. Table 3.36 presents percentage HIV prevalence per country based on countries vulnerable to the disease between the period of 1997 and 2001.

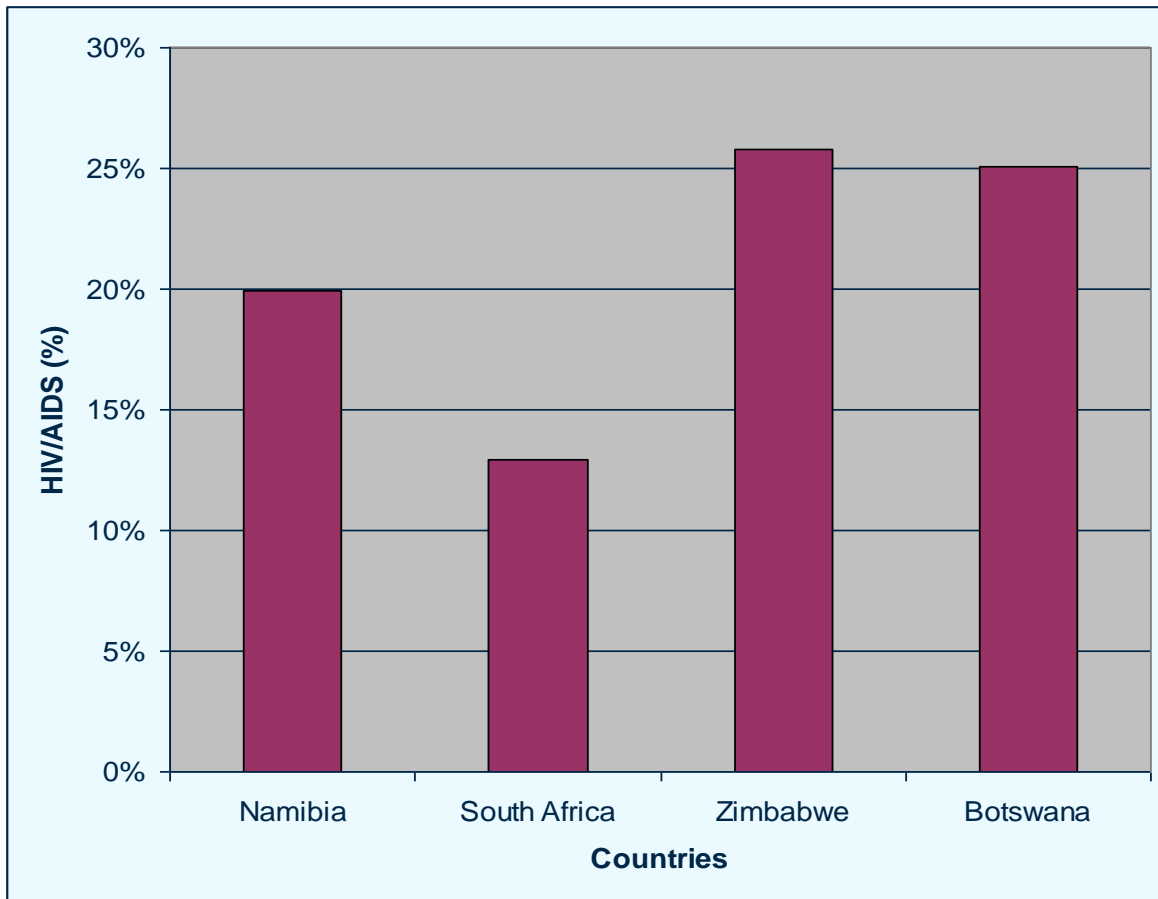
TABLE 3.36: PERCENTAGE HIV PREVALENCE PER COUNTRY IN A GIVEN PERIOD

COUNTRIES	1997	1999	2001
Lesotho	8.4	23.6	31.0
Malawi	14.9	16.0	15.0
Namibia	19.9	19.5	22.5
South Africa	12.9	19.9	20.1
Zambia	19.1	20.0	21.5
Zimbabwe	25.8	25.1	33.7
Botswana	25.1	35.8	38.8

(Source: UNAIDS, 2006)

Graph 3.2 indicates that in 1997 Namibia had 19.9% HIV/AIDS prevalence among adults aged 15–49. South Africa had 12.9%, Zimbabwe 25.8%, and Botswana 25.1% for the same period.

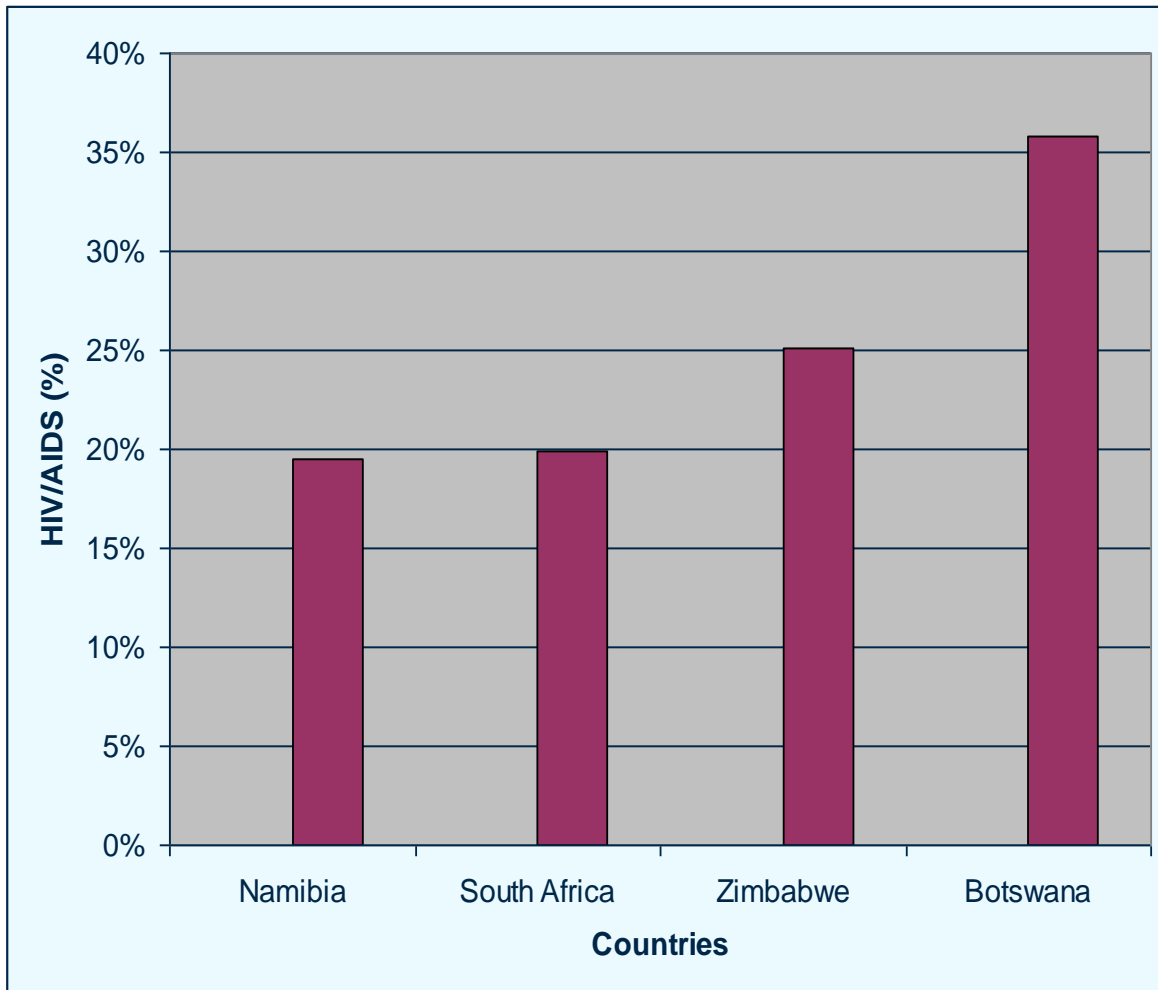
GRAPH 3.2: HIV/AIDS PREVALENCE AMONG ADULTS AGED 15-49 IN 1997



(Source: UNAIDS, 2006)

Graph 3.2 indicates that Namibia had a 19.5% HIV/AIDS prevalence rate among adults aged 15–49 in 1999. This shows that there was little improvement from the 19.9% of 1997 (see graph 3.2). South Africa had a 19.9% HIV/AIDS prevalence rate among adults aged 15–49 in 1999, and this indicates that the situation was becoming worse when compared to the 12.9% of 1997. The graph shows that Zimbabwe had a 25.1% HIV/AIDS prevalence rate among adults aged 15–49 years, and this indicates that there was improvement when compared to the 25.8% of 1997. Botswana had 35.8% HIV/AIDS prevalence among the adults aged 15–49 years in 1999, and this indicates a rapid growth and a worse situation in the country when compared to the 25.1% of 1997 (see graph 3.2).

GRAPH 3.3: HIV/AIDS PREVALENCE AMONG ADULTS AGED 15-49 IN 1999

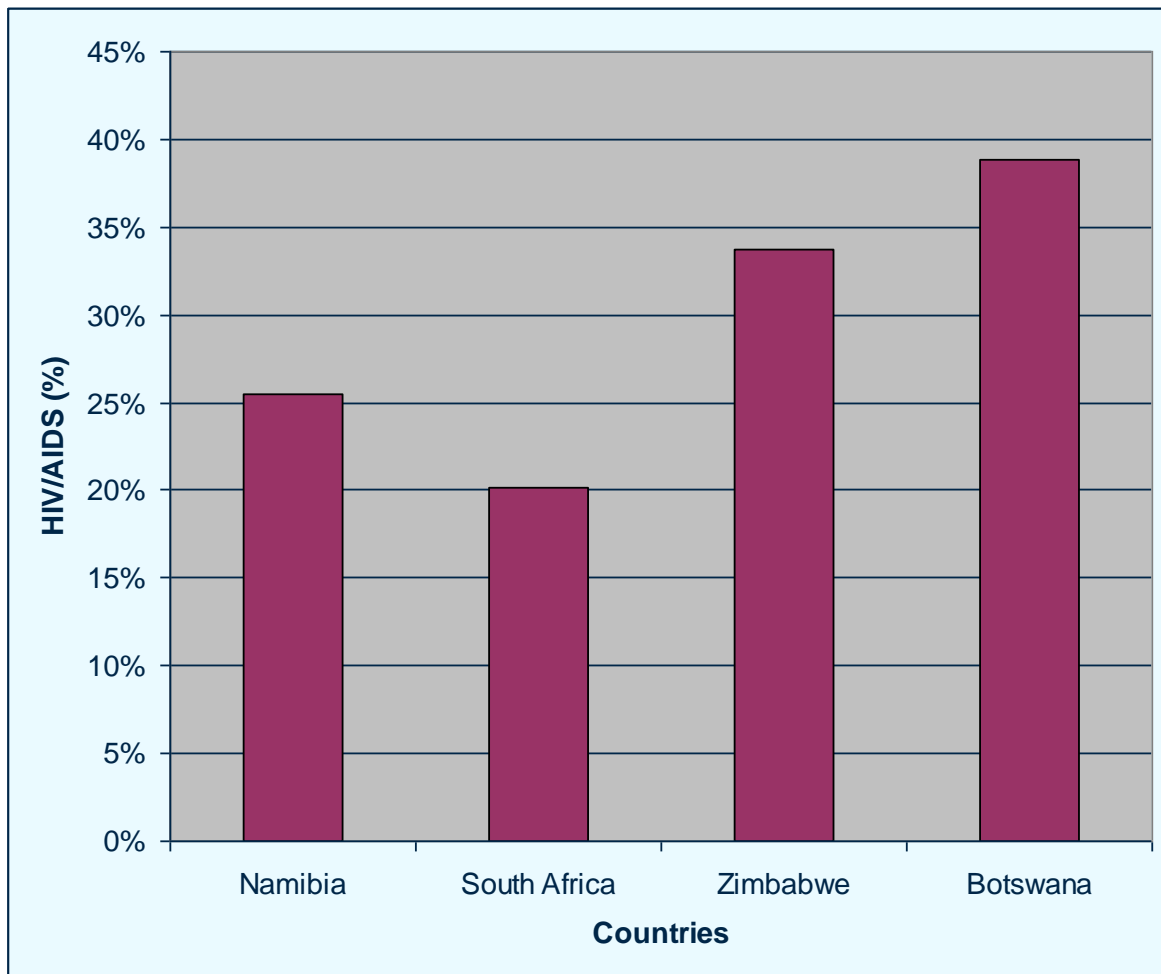


(Source: UNAIDS, 2006)

Graph 3.4 shows that in 2001 the situation was becoming bad in Namibia with a 25.5% HIV/AIDS prevalence rate among adults aged 15 – 49 years, worse when compared to 1997 and 1999. South Africa had 20.1%, which indicates worse results when compared to 12.9% in 1997 and 19.9% in 1999 (see graph 3.2 & 3.3). The graph indicates that in 2001 Zimbabwe had 33.7% HIV/AIDS among adults aged 15 – 49 years, and this shows the worst recorded when compared to 25.8% in 1997 and 25.1% in 1999. In Botswana, the graph shows that the HIV/AIDS prevalence among adults aged 15 – 49 years dramatically rose to 38.8% 2001 and this shows a worse situation in the country when compared to 25.1% in 1997 and 35.8% in 1999. The

worrying factor is that the age group vulnerable to HIV/AIDS in all the countries constitutes people at their productive ages, and this is the age group working for the tourism sector. This shows continued spread of HIV/AIDS could have more threats on the future of the tourism sector of Botswana and other southern African countries.

GRAPH 3.4: HIV/AIDS PREVALENCE AMONG ADULTS AGED 15-49 IN 2001

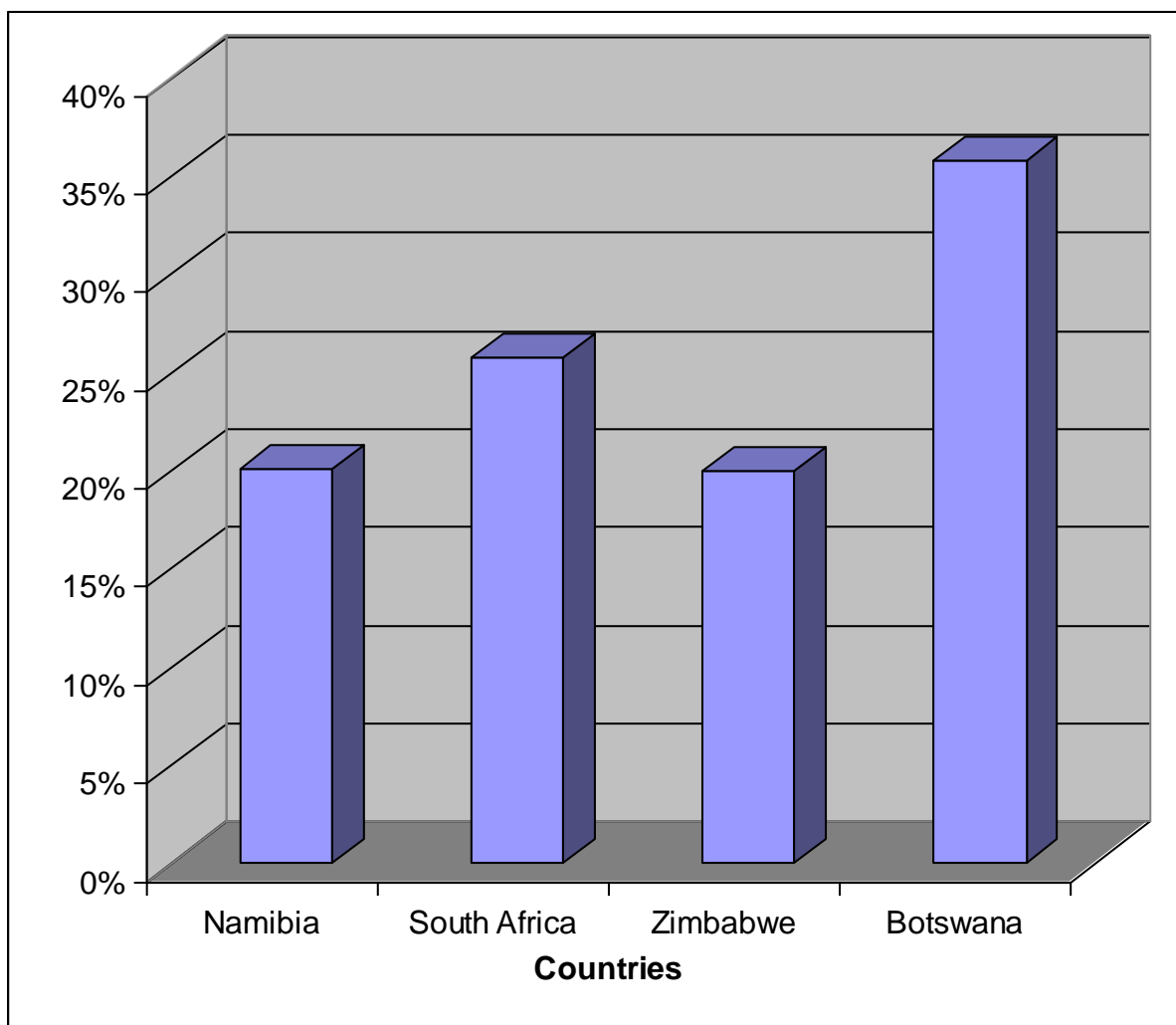


(Source: UNAIDS, 2006)

Graph 4.5 indicates that 20.1% of pregnant women attending ante-natal clinics in Namibia in 2005 were HIV positive. South Africa had 25.8%, Zimbabwe 20.0%, and Botswana 35.8% in the same year. Almost all graphs depicts that Botswana is leading in all categories of HIV/AIDS prevalence rates, hence the needs to conduct this research to find out the possible socioeconomic

implications of HIV/AIDS in the country particularly on the tourism sector, which is the second economic contributor in Botswana.

GRAPH 3.5: HIV/AIDS PREVALENCE AMONG WOMEN ATTENDING ANTENATAL CLINICS IN 2005



(Source: UNAIDS, 2006)

The above graphs also indicate that countries in Southern Africa are in different stages in terms of the HIV/AIDS pandemic situation. In South Africa the HIV/AIDS pandemic was first reported in the late 1980s, while in Botswana it was a few years later. HIV/AIDS pandemic cases in the other countries in northern part of Southern Africa were reported earlier in the 1980s. The

Southern African countries indicated in the graphs have differently shaped pandemics. For example, in Zimbabwe the HIV/AIDS pandemic rose gradually through the 1980s and early 1990s, while in Botswana the pandemic begun later but rose much more rapidly and to a higher overall level. These differences indicate the way Southern African countries experience the HIV/AIDS pandemic. In Zimbabwe, Namibia and Malawi the HIV prevalence has prevailed for a long time, and people within these countries have had a long time to become aware of HI/AIDS and to experience the pandemic first-hand (Whiteside *et al.*, 2002: 10).

In Lesotho and South Africa the HIV/AIDS pandemic started later than in most Southern African countries but has spread more rapidly. This is an area that also needs further research to find out the reason for rapid spread of HIV/AIDS in such countries. The fast rate at which the HIV/AIDS pandemic spread in Southern Africa relates to the state between HIV/AIDS infection and AIDS-related illness and death. For example, in Botswana in the mid-1990s, the ante-natal clinics reported that the HIV/AIDS prevalence had already reached 30%, but the level of illness and death was determined by the prevalence 5–8 years earlier. These differences lead to ignorance and denial in Southern Africa, the region in which HIV pandemic is spreading at a fast rate (Whiteside *et al.*, 2002: 10).

By observing the current prevalence rates and the period in which the HIV/AIDS have been reported in Botswana and a number of other Southern African countries, the indication is that there is less severe pandemics in Zambia, Zimbabwe and Malawi compared to the fast-spreading pandemic in South Africa, Lesotho and Namibia. Botswana has the highest percentage per population of HIV/AIDS prevalence rate when compared to the other Southern African countries presented in the above graphs. The HIV/AIDS prevalence in Zimbabwe is rising more rapidly than previously projected. In South Africa, the highest prevalence rates are among women between the ages of 20 and 29. The entire population-based surveys indicate that HIV prevalence in South Africa among men increases at an older age, in their mid-to-late thirties (Whiteside *et al.*, 2002: 11).

The problems with HIV data is that it is difficult to collect information about the exact number of AIDS patients or those who died from HIV/AIDS related illness. Little is known of the total number of deaths caused by HIV/AIDS in most Southern African countries due to the fact that AIDS deaths are not registered (Whiteside *et al.*, 2002: 12). Unlike a number of other Southern

African countries, South Africa has the registration systems of death in general, but the vital statistics of both births and deaths indicate only 80% of the total deaths occurring in the country, which does not give accurate causes of death. HIV/AIDS is a sensitive issue and most people do not want to reveal that their family members died of the pandemic.

Besides the fact that young people in Southern Africa are the most vulnerable to the HIV/AIDS pandemic, different ethnic groups in the region also experience varying HIV/AIDS prevalence rates. In South Africa for example, there are significant differences in terms of demographic category, with 42% of the black South Africans showing that they are affected by HIV/AIDS, 16% whites, 9% coloureds, and 3% Indians being affected by HIV/AIDS. The other indication is that 20% of the black South Africans are personally exposed to AIDS deaths, compared to 6% whites, 4% coloureds, and 2% Indians. The fact that HIV/AIDS is a sensitive issue makes many people to be secretive about any person who is either ill or die of HIV/AIDS related illness. Unlike in most countries in Southern Africa, Zambians and Malawians openly admit personal or family experience with AIDS pandemic. For example, 82% of Zambians and 65% Malawians annually attend religious gatherings out of the normal church services to discuss the HIV/AIDS pandemic, unlike in any other Southern African country (Whiteside *et al.*, 2002: 18).

UNAIDS (2005) reveals the following HIV/AIDS statistics for the top ten Southern African countries:

TABLE 3.37: PEOPLE LIVING WITH HIV/AIDS IN SOUTHERN AFRICA AS OF END OF 2005

COUNTRY	NUMBER OF PEOPLE LIVING WITH HIV
South Africa	5, 300, 000
Zimbabwe	1, 800, 000
Mozambique	1, 300, 000
Zambia	920, 000
Malawi	900, 000
Botswana	350, 000

Lesotho	320, 000
Angola	240, 000
Swaziland	220, 000
Namibia	210, 000

(Source: UNAIDS, 2005).

The global statistics of total people living with HIV/AIDS as indicated by UNAIDS as for end of 2005 is 40, 300, 000.

Globastat (2005) reveals the following statistics based on percentage of total population living with HIV/AIDS:

TABLE 3.38: PERCENTAGE OF TOTAL POPULATION LIVING WITH HIV/AIDS FOR GLOBAL TOP TEN COUNTRIES

COUNTRY	% OF TOTAL POPULATION LIVING WITH HIV/AIDS
Botswana	18. 284%
Zimbabwe	13. 198%
Swaziland	11. 772%
Lesotho	11. 024%
South Africa	9. 636%
Zambia	8. 905%
Namibia	8. 900%
Djibouti	8. 031%
Malawi	7. 584%
Kenya	6. 826%

(Source: Globastat, 2005).

Globastat (2005) indicates that HIV/AIDS negatively affects a number of Southern African

countries by reversing the socio-economic achievements they have made over the past years. HIV/AIDS results in an increased morbidity and mortality rates in a number of Southern African countries. For example, in Botswana the infant mortality rate (IMR) under five mortality rates (U5MR) are 57 and 75 per 100 births respectively. The effect of the adult mortality rate due to HIV/AIDS is that a number of families in Southern Africa are losing their breadwinners, thus increasing the household dependence ratio in the region.

The above part of the research focused broadly on the HIV/AIDS situation in selected Southern African countries and in selected other African countries in general. The following part of this study focuses on the HIV/AIDS situation in countries that share borders with Botswana. The purpose of this section is to evaluate HIV/AIDS situation and how other countries sharing borders with Botswana deal with the HIV/AIDS problem.

3.6.5 AN OVERVIEW OF THE HIV/AIDS SITUATION IN SOUTH AFRICA

Agbola *et al.* (2004: 722) indicate that the South African government response to HIV/AIDS include establishment of the country's AIDS Unit and the national Advisory Group, which was established in 1988. HIV/AIDS was first reported in South Africa in the mid 1980s. The duties of the AIDS Unit include creating HIV/AIDS awareness, making preventive measures such as condoms accessible to the community, surveillance surveys, and helping non-governmental organisations (NGOs) with finance. The National Advisory Group helps the government on HIV/AIDS policy matters. Also in 1988, the South African government established the country's HIV/AIDS Training Information and Counselling Centres (ATICC) in big cities. The main responsibilities of ATICC include arranging for educators and counsellors for HIV/AIDS, testing and support services for people infected with HIV/AIDS. In 1992, the South African government established a committee with the mandate to review the situation of HIV/AIDS in the country. Based on the committee's review and recommendations, the National AIDS Plan was established in 1994 and officially launched in 2000 under the National AIDS Strategic Plan. The aims of South African HIV/AIDS Strategic Plan include mitigating the new HIV infection and to control the impact of HIV/AIDS in communities. The focus of the Strategic Plan is on HIV/AIDS prevention, treatment, care and support, human and legal rights, and monitoring research and surveillance. Despite the fact that the South African HIV/AIDS Strategic Plan has significant progress, it is criticised for lack of focus area, and for not having coordination and monitoring

strategies.

The impact of HIV/AIDS on the South African economy is reported to be significant. For example, in the 1990s, the country's HIV/AIDS programme costs were relatively low when compared to the country's total health costs and total government costs. The country's health budget has since increased and is projected at 11% of the overall government budget. It is projected that the South African government expenditures on health and social services could dramatically increase over the coming years due to the high spread of HIV/AIDS in the country. The Public health sector in South Africa and Botswana is significantly subsidised to more than 80% of the country's population, and this put pressure on government's resources. In responding to the spread and impact of HIV/AIDS on the economy, the South African government invest large amount of money in its health sector to combat HIV/AIDS. For instance, in 2005 the government's health budget was reported to be R38.7 billion and 4.6% of (R1.8 billion) was dedicated to fight HIV/AIDS. Linked to HIV/AIDS is Tuberculosis (TB), and it is projected that the area with 40 to 50% of TB patients is also likely to have high HIV/AIDS prevalence rate (Agbola *et al.*, 2004: 723).

Maher (2003: 177) argues that although National Tuberculosis programmes (NTPs) in a number of countries are often focused on encouraging access to effective TB care through government health sectors, most NTPs encourage access to TB care through various health service providers such as those in communities. He also adds that it is imperative to encourage the general community to participate in fighting HIV/AIDS as part of NTP activities, particularly in the Sub-Saharan Africa where HIV/AIDS is reported to influence the spread of TB. It is reported that the spread of TB in the Sub-Saharan region is enormous and it makes it difficult for governments to cope with the illness through government health service, hence the encouragement of community participation. The worst TB situations are reported in countries that have high prevalence of HIV/AIDS. In acknowledging the significance of community participation in TB care, particularly in countries vulnerable to both TB and HIV/AIDS, the World Health Organisation (WHO) established "Community TB Care in Africa". Researchers for this project met in Zimbabwe in 2000 to discuss both the results and policy guidelines. The focus of WHO's initiatives in evaluating and encouraging community participation in TB care is in the Sub-Saharan Africa, the region most struck by HIV/AIDS in the world. However, this initiative and policy framework are not exclusive to the Sub-Saharan region but can be applied in other parts of

the world in general. As already stated, Botswana and South Africa are among the countries most struck by HIV/AIDS in the southern African region. These two countries share borders, which mean that it is important for them to work together in combating HIV/AIDS.

Focusing on South Africa, it is reported that the South African government's budget for the National HIV/AIDS Programme aims at minimising the impact of HIV/AIDS particularly in poorer communities in rural areas. The South African government supports children and youth vulnerable to HIV/AIDS, through child support fund. The country also has also funding for life-skill programmes in schools, which aims at providing education and training for both learners and educators. The other HIV/AIDS programmes also accessible to the general public in South Africa include voluntary counselling and HIV testing, and prevention of mother-to-child transmission. Care and support programmes such as home-based care, step-down care, and community-based support and care are also available in the country. The success stories of Uganda and Thailand indicate that high level of political commitment and governmental support is important to mitigate the spread of HIV/AIDS (Agbola *et al.*, 2004: 723). Agbola *et al.*, also emphasised the need for both political commitment and collaborative efforts in fighting HIV/AIDS in South Africa by government, non-governmental organisations, religious groups, local communities, and people living with HIV/AIDS. Similar approaches can be suitable for Botswana.

Strode and Grant (2004: 7) argue that South Africa, like other developing countries, has experienced the HIV/AIDS epidemic for more than 20 years. The antenatal clinic survey conducted by the South African Department of Health in 2000 indicates that 25.2% of pregnant women attending antenatal clinics in the country are HIV positive and 20% of adults aged 15–49 years are infected with the HIV/AIDS virus. They further argue that the South African political response to HIV/AIDS has been characterised with inconsistencies, absurdities and good practice.

The denial approach to HIV/AIDS existence was summed up in 1998 by the then deputy president Thabo Mbeki who became the centre of controversies. For many years a number of South Africans did not take HIV/AIDS seriously and they were under the impression that the pandemic problem was just a speculation. Both the apartheid and the post apartheid governments did not initially respond to HIV/AIDS pandemic effectively. The poor response to the HIV/AIDS pandemic by the apartheid government was due to a lack of political commitment, and the post apartheid government in 1994 became more concerned with restructuring and developing new

policies and programmes (Strode & Grant, 2004: 7).

The South African response to HIV/AIDS has been for a lengthy period marked with denial. Strode and Grant indicate that hundreds and thousands of South Africans lose their lives due to HIV/AIDS every year, and 1 million South Africans died in 2003 due to the pandemic, but the country lacks the political courage to fight the pandemic. The confusion around the government's HIV/AIDS policy fails programmes on various levels. For example, the Treatment Action Campaign (TAC) indicates that they cannot provide training in all of the hospitals they have aimed for in the utilisation of Nevirapine for preventing transmission of HIV from pregnant women to their unborn babies, and a number of hospitals indicate that they are afraid that working with the TAC they may result in them losing their government funding. The total costs for the national provincial health care in 2000 were R31.966 billion, R33.835 billion in 2001 and R34.026 billion in 2002. The AIDS Budget Unit of the Institute for Democracy in Africa (IDASA) conducted a study which reveals that despite the fact that overall health care remains consistent, the actual expenses on provincial HIV/AIDS conditional grant has increased from R18 million in 2000, to R97.207 million in 2001, to R341.939 in 2002 (Strode & Grant, 2004: 9).

The South African government allocated R2.1 billion over a period of three years to fight the HIV/AIDS pandemic. The country's anti-retroviral programme is the largest public health intervention of its nature that the world has ever experienced. Strode and Grant indicate that in 2004 there were 350 000 people on the anti-retroviral (ARV) programme worldwide, and 100 000 of these people were reported to be in Brazil. The South African government's rollout programme has over 53 000 people on the ARV programme and 1.4 million people are projected to be on the programme by the end of 2007. This results in levelling of criticism at the state health sector for taking long in implementing the rollout of the ARV programme. South African communities were quiet about HIV/AIDS during the first 15 years of which the HIV/AIDS was reported in the country. Gradually, communities are more mobilised around HIV/AIDS issues, and levels of openness are increasing and many people contribute to the fight against the HIV/AIDS pandemic by encouraging their family members to utilise the Voluntary Counselling and Testing programmes (Strode & Grant, 2004: 9).

Berman, Tempest and Morton (2006: 1) argue that the evidence does not support the South African government claims that the country's HIV/AIDS programme and policies in combating

the HIV/AIDS pandemic are the best in the world. The increasing HIV/AIDS prevalence rate and the alarming death rate indicate that the struggle for fighting HIV/AIDS is far from won. Poverty alleviation and HIV prevention should be given high attention in the fight against the HIV/AIDS pandemic. South Africa is facing one of the severest HIV/AIDS infection rates in the world, with 5.5 million people estimated to be living with HIV/AIDS (Berman *et al.*, 2006). The World Health Organisation predicts that when compare all countries in the Sub-Saharan Africa, South Africa has the highest HIV pandemic increasing rate.

In responding to the above statement, in 2006 the then South African President Mr Thabo Mbeki, as cited by Berman *et at.* (2006: 1), argued that he works in the Presidency on a daily-basis and no one indicates the alarming deaths rate linked to HIV/AIDS. Contrary to this argument, Mr Joel Netshitenze and the Reverent Frank Chikane state in a report published by the presidency that the HIV/AIDS pandemic's dreadful impact is beginning to show its significance in both morbidity and mortality rates. The latest predictions indicate that by July 2006, 2.2 millions South Africans would have died of HIV/AIDS. In response to this, the South African government has established a large scale of antiretroviral (ARV) treatment strategy, and the latest predictions state that 134 473 South Africans are registered on public sector ARV treatment. In addition to this figure, 80 000 patients are projected to be on ARV treatment in the private and NGO sectors (Berman *et al.*, 2006: 1).

It is significant that figures for the public sector comprise the patients who are registered to receive ARV, and do not involve those who are infected but not taking the treatment. The Actuarial Society of South Africa predicts that there are more than 500 000 adults in the country who need ARV treatment but do not get it. The health minister emphasised in the budget speech in May 2006 that infant and under-five mortality rates have dropped since 1998, but the latest indications by Statistics South Africa are that there is a 73% increase in the number of deaths in the 0-5 age group between 1997 and 2004. The death rate among the 30-35 age groups of those who have developed full blown AIDS has increased by 207% per annum. These statistics indicate that South Africa is in the grip of the HIV/AIDS pandemic. The further prediction by Statistics South Africa is that by the year 2011 more people will die of AIDS in South Africa than of all other causes of death put together.

TABLE 3.39: OVERVIEW OF HIV/AIDS IN SOUTH AFRICA

	NUMBER		SOURCE
Present number of HIV infections (2006)	High	5 500 000	USAIDS
	Low	5 372 474	ASSA 2003 (2005)
Number of people on HAART (2006)	Public	134 473	Department of Health
	Private	80 000	Department of Health
HIV infection rate (2005)	High	10.80%	Human Science Research
	Low	9.80%	Statistics South Africa
HIV infection rate by 2025 (2006)	High	18.00%	Metropolitan Life
	Low	7.00%	Metropolitan Life
Life expectancy at birth in 2025 (2006)	Worst	50 years	Metropolitan Life
	Best	59 years	Metropolitan Life
HIV + pregnant women visiting antenatal clinics (2004)	High	29.50%	Metropolitan Life
	Low	27.30%	Actuarial Society of South Africa
AIDS deaths proportional to total deaths (2005)	High	57.20%	Metropolitan Life
	Low	45.40%	Actuarial Society of South Africa
AIDS orphans currently living (2006)	High	1 200 000	UNAIDS
	Low	1 100 000	UNICEF (2004)
Child-headed households	High	719 000	HSRC (2004)
	Low	236 000	Census (2001)
Numbers of orphans (2010)	High	1 950 000	UNICEF (2002)
	Low	1 704 000	UNICEF (2002)
Workforce & AIDS (2005)		18.80%	ASSA 2003 (2005)
Shrinkage of labour force (2015)	High	25.30%	UNAIDS (2004)
	Low	23.50%	UNAIDS (2004).

(Source: Marco MacFarlane, 2006).

The table 3.39 above presents high and low predictions for the HIV/AIDS figures because most of the data is based on statistical modelling. The UNAIDS indicates in the table that 5 500 000

people in South Africans are living with the HIV/AIDS pandemic. The Actuarial Society of South Africa (2005) stipulates in table 3.11 that the low HIV prevalence rate in 2006 is 5 372 474 in the country. The South African Department of Health (2006) indicates that there are 134 473 AIDS patients on ARV treatment in public clinics, and 80 000 patients are in the private clinics in the country.

The South African Human Science Research Council indicates in table 3.11 that the high HIV infection rate in 2005 was 10.80%, and Statistics South Africa indicates that the low HIV infection rate in 2005 was 9.80%. It is also indicated in the table that Metropolitan Life (2006) projected that the high HIV infection rate by the year 2025 would be 18.00%, and low projection rate would be 7.00%. Metropolitan Life further projected that the worst life expectancy at birth in 2025 would be 50 years and the best life expectancy for the year 2025 would be 59 years.

The National HIV prevalence Survey (2004) indicates in table 3.11 that the high level of HIV prevalence rate among pregnant women visiting the antenatal clinics is 29.5%. The Actuarial Society of South Africa (2004) also indicates that the low HIV prevalence rate among pregnant women visiting the antenatal clinics is 27.30%.

Metropolitan Life (2005) states that the high AIDS death as a proportion of total deaths in South Africa is 57.20%, and the Actuarial Society of South Africa indicates a low death rate of 45.40%. The UNAIDS (2006) indicates that the high number of AIDS orphans Living in South Africa is 1 200 000, and the UNICEF indicates the low number of 1 100 000 AIDS orphans.

It is also indicated in the table 3.11 by the Human Science Research Council (2004) that the high number of children who head households in South Africa is 719 000, and the Population Census (2001) indicates that the low number of children heading the households is 236 000. The UNICEF (2004) predicts that by the year 2010 the high number of AIDS orphans would be 1 950 000 and the low for the AIDS orphans in the year 2010 would be 1 704 220. The Actuarial Society of South Africa (2005) indicates that the HIV/AIDS infection among the workforce in 2005 was 18.8%. The UNAIDS projects that the high shrinkage of the labour force would be 25.30% by the year 2015, and the low shrinkage rate would be 23.50% in the year 2015.

Moodley (2006: 15) indicates that South African companies show the commitment in fighting the

pandemic by investing on HIV/AIDS treatment programmes for their workers as the high costs of ignoring the epidemic begin to be experienced. Selected companies including tourism lose between R1.8 billion and R2.2 billion annually due to staff absenteeism related to the HIV/AIDS pandemic. In fighting the spread and impact of HIV/AIDS, education and treatment are both critically important in South Africa and other Southern African countries including Botswana because a number of companies including those in the tourism sector particularly in South Africa experience up to a 30% HIV/AIDS prevalence rate among their employees. Many of the South African companies have moved beyond prevention programmes to an extent of introducing and supplementing antiretroviral (ARV) treatment programmes.

The other strategy in the fight against HIV/AIDS that tourism companies in general could use is to provide ARV treatment, which involves the employer funding and delivering the treatment at facilities on site. Mining house Anglo American uses this model and in 2005, it indicated that 34 000 of its 145 000 employees were HIV positive, with 9 000 in need of the treatment (Moodley, 2006: 15). The HIV/AIDS prevalence rates are general high in the mining sector with Botswana's Debswana indicating a 35% prevalence rate among the employees, and Old Mutual indicating the lowest rate of 5%. A number of companies including those in the tourism sector are facing the pressure of increased absenteeism and high staff turnover due to the rapid spread of HIV/AIDS (Moodley, 2006: 15).

The Grant Thornton International Business Owners in 2006 conducted an HIV/AIDS survey of the companies with 50 to 250 employees, and the survey results indicate that many companies lose up to 23 of their employees due HIV/AIDS-related diseases within a period of two years. South Africa is estimated to be losing up to R12 billion a year due to workers absenteeism with between R1.8 billion and R2.2 billion being directly associated with HIV/AIDS. In responding to this, a number of South African companies are more determined to subsidise treatment for their employees because the average annual costs of treating an employee infected with HIV/AIDS has declined significantly from R48 000 in 1998 to less than R10 000 a year. The study carried out at the Helen Joseph HIV Clinic, funded by the President's Emergency Plan for International Development indicates that the cost of successfully treating a person with HIV/AIDS is R7 285 per annum. The advantage of ARV treatment is that it prevents the cost of not intervening from outweighing the costs of developing strategies and programmes to address the pandemic (Moodley, 2006: 15).

Caelers (2006: 3) stipulates that the available HIV/AIDS data shows that ANTI-AIDS drugs help people living with the disease to live for 13 more years. The data from the United States indicates that people who started therapy in 2003 are expected to live more than 13 years longer than if they had been diagnosed in 1988. The US data sponsored by the National Institute of Allergy and Infectious Diseases, which is based in the United States of America and being part of the National Institute of Health (NIH) measure the survival benefits of HIV therapies and come up with the above conclusion. Caelers also indicates that HIV therapies are effective and this is clarified by the period of use of anti-retroviral therapy which provided years of increased life to a number of Americans who have been diagnosed with HIV/AIDS since 1989.

HIV therapies transform the HIV/AIDS from a rapidly fatal disease into a medical controllable condition (Caelers, 2006: 3). However, these survival benefits are only available to people who know that they have been infected with HIV/AIDS and are certified by doctors to use the treatment. The worrying factor is that most people in South Africa and other Southern African countries like Botswana start the treatment when their body's ability to fight the disease (CD4 counts) is lower than the recommended measure (200) and when they are already ill (Caelers, 2006: 3).

People who start taking anti-retroviral treatment when their CD4 are very low tend to have a poor prognosis. The 13 years average life extension include both adherent and poorly-adherent patients, and the people with poor prognosis may dramatically bring this figure down. The patients presenting with AIDS at higher CD4 cell counts have a significant gain in years of survival. There are survival benefits that are gained globally through continued expansion of access to the HIV/AIDS treatments. South Africa and a number of other Southern African countries including Botswana are faced with a challenge to motivate everyone to get tested before they feel ill (Caelers, 2006: 3).

TABLE 3.40: PROFILE OF GOVERNMENT EFFORTS TO COMBAT AIDS

Expenditure	R30 million (1994)	R3 billion (2006)
Condom distribution	270 million (2003)	346 million(2004)
Female condom distribution	1.3 million (2003)	2.6 million (2004)
Access to condoms	97%	
Public HIV/AIDS service points	123	
Public ARV distribution points	199	
People on public ARV treatment	130 000	
People on private ARV treatment	80 000	
People accessing nutritional support	329 000	
Public VCT sites	1 500 (2002/03)	3 700 (2004/05)
Number of people counselled	691 000 (2003/04)	1.3 m (2004/05)
Prevention of mother-to-child facilities	2 500	
Health professionals recruited	1 060	
Health professionals trained on HIV	7 600	
Community caregivers trained on HIV	61 000	
Awareness about HIV/AIDS	92% - 98%	

(Source: Actuarial Society of South Africa, 2004)

Table 3.40 above indicates that in 1994 the South African government spent R30 million in fighting the HIV/AIDS pandemic, and in 2006 the government budgeted R3 billion to fight the pandemic. In 2003, it is indicated in the table that 270 million condoms were distributed to the public, and in 2004 346 million condoms were distributed throughout the country. In 2003, 1.3 million female condoms were distributed nation-wide, and in 2004 the government distributed 2.6 million female condoms. This is an indication that the demand for the use of condoms was high among female South Africans. It is also indicated in the table that 97% of the people in South Africa have access to condoms, and that there are 231 public HIV/AIDS service points in the country. South Africa has 199 public antiretroviral (ARV) distribution points that are open and accessible to the population.

It is also stipulated in the table that there are 130 000 AIDS patients on public sector ARV treatment, and 80 000 AIDS patients are on private sector ARV treatment. A total of 329 people in the country have access to the nutritional support services. During the period between 2002 and 2003, 1 500 public voluntary counselling and testing (VCT) sites were established in the country, and during the period 2004/2005, the government of South Africa established a total of 3 700 voluntary counselling and testing sites. The other indication in the table is that between the period 2003 and 2004, 691 000 people in South Africa used the voluntary counselling and testing services, and in 2004/2005, 1.3 million people in the country were voluntarily counselled and tested for HIV/AIDS.

It is further indicated in table 3.40 that 2 500 prevention of mother-to-child transmission facilities have been established in the country, and there are 1 060 health professionals recruited. There are 7 600 health professionals trained specifically on HIV/AIDS programmes, and 61 000 people have been trained on HIV/AIDS community care-giving programmes. It is also stipulated in table 3.12 that 92% to 98% of people in South Africa are aware of the HIV/AIDS pandemic and the way in which HIV virus is being transmitted. All the above initiatives indicate that HIV/AIDS has significant economic impact.

Strode and Grant (2004: 12) argue that the national and provincial efforts to address HIV/AIDS by the apartheid government were not good enough, and it failed the national institutions and there was no national HIV/AIDS strategy. The first comprehensive national AIDS plan was established by the National AIDS Co-ordinating Committee of South Africa (NACOSA). This plan was developed outside the government concern through a full consultative process between the African National Congress (ANC) members before it became the ruling party in government. The NACOSA Plan indicates that it is imperative that South Africa's response to HIV/AIDS should be based on the principles of inter-sectoral partnerships and it is the responsibility of all the sectors including tourism. The aim of NACOSA is to mobilise and unify provincial, international and local resources. These initiatives and collaborative efforts by South Africa is an example that Botswana tourism and other economic sectors can follow bearing in mind that South Africa and Botswana share borders and the prevalence rate of HIV/AIDS in these countries is reported to be high.

The post-apartheid government in South Africa adopted the NACOSA Plan as the national HIV/AIDS strategy in July 1999 and empowered the Directorate of HIV/AIDS and sexually transmitted diseases (STD) in the Department of Health (DOH) to ensure a comprehensive implementation process. However, the institutional mechanisms to harness political commitment in the country are ineffective, and there are criticisms that the implementation is slow and focused narrowly on the health sector in the government other than in other sectors. The other concern is that there is a lack of co-ordination at various levels, and the conflicts between sectors are not managed and controlled (Strode & Grant, 2004: 12).

The National Review indicates that the established recommendations to resolve the institutional arrangements regarding the response to HIV/AIDS are that the political leaders should shift the accountability of fighting HIV/AIDS from the Ministry of Health to an individual person in a wider perspective, secondly, the inter-departmental and inter-sectoral responses to the HIV/AIDS pandemic need to be strengthened. The Inter-ministerial Committee (IMC) on HIV/AIDS has been established to facilitate the development of political commitment to deal with the epidemic. The South African government established the 2000 – 2005 HIV/AIDS Strategic Plan to guide the country's response to the HIV/AIDS pandemic by both the public and private sectors. The aim of this Strategic Plan is to guide the sectors in developing their own strategic and operational plans which in return assist the nation to establish a peaceful, efficient and effective response to HIV/AIDS (Strode & Grant, 2004: 13).

South Africa's 2000–2005 HIV/AIDS Strategic Plan was established in July 1999 after reviewing the existing HIV/AIDS prevention, treatment and care strategies by the participants. The 2000–2005 HIV/AIDS Strategic Plan was established through a comprehensive approach which involved faith-based organisations, people living with AIDS (PLWA), human rights organisations, academic institutions, the civil–military alliance, the media, organised labour, organised sports, organised businesses, insurance companies, women's organisations, youth organisations, international donor organisations, health professionals and health consulting organisations, political parties and affected government departments. The worrying factor is that the tourism sector does not appear among the sectors that were involved in South Africa's 2000 – 2005 HIV/AIDS strategic plan. However, the consensus was reached and a committee was established and given the mandate to develop a five–year HIV/AIDS/STDs Strategic Plan. The existing goals and objectives were reviewed and the set priority areas include prevention,

treatment, care and support, legal and human rights, and monitoring, research and evaluation (Strode & Grant 2004: 13).

The HIV/AIDS policy formulation process in South Africa is an integrated framework which involves a number of sectors like the traditional leaders, faith-based organisations and the private sectors to get their views and to enhance active participation. In September 1999, the Minister of Health together with the nine provincial Members of the Executive Council (MEC) for Health reviewed the policy priority areas. In October 1999 a two-day National AIDS meeting was organised by the Ministry of Health in which AIDS Co-ordinators, the National Department of Health, Directorate of HIV/AIDS/STDs, representative of the AIDS Training and Information Centre (ATIC) and representatives of various organisations discussed progress of the establishment of the five-year HIV/AIDS Strategic Plan. The goals and objectives of the plan were also established. In January 2000 the final 2000–2005 HIV/AIDS Strategic plan was established and finalised. The fundamental guiding principle for the 2000–2005 HIV/AIDS Strategic Plan is the fact that all sectors of government and other stakeholders in civic society should take part in fighting the HIV/AIDS pandemic to reduce the infection rate and HIV/AIDS impacts on both families and communities (Strode & Grant, 2004: 14).

The South African 2000–2005 HIV/AIDS Strategic Plan emphasises that every province must have its own Provincial AIDS Council (PAC), and this idea is supported and stressed by the cabinet. The Provincial AIDS Councils are accountable for co-ordinating the provincial multi-sectoral approach with a specific focus on districts, municipalities and communities. The responsibilities of the Provincial AIDS Councils include providing guidance and to establish a Provincial AIDS Plan which is in line with the 2000–2005 National HIV/AIDS Strategic Plan, to facilitate partnership responses among government sectors, sectors of civic society and local government departments, to evaluate the implementation of the provincial AIDS Plan and to give advices to the Provincial Cabinet on issues associated with HIV/AIDS, but in this regard the final decision on health aspects is made by the Provincial Cabinet (Strode & Grant, 2004: 16).

3.6.6 AN OVERVIEW OF THE HIV/AIDS SITUATION IN NAMIBIA

The Namibia government established the country's national HIV/AIDS policy in August 2003. The HIV/AIDS policy formulation in Namibia is a collaborative effort by the AIDS law unit of

the Legal Assistance Centre (LAC), Non-government Organisations (NGOs), and the stakeholders from the legal, social and community sectors. Namibia's Ministry of Health and Social Services spearhead the HIV/AIDS policy formulation process in the country and the LAC carries the mandate to draft it (AfroAIDSinfo, 2005: 28). The first Namibia's national AIDS policy was established in 2003, but there were a number of HIV/AIDS national strategic plans prior to the period. In the same year, the third medium-term plan was introduced and was planned to be used until 2009. The drafted policy aims at providing prevention and treatment, care and support for people living with HIV/AIDS, creating an enabling environment, reducing the impacts, and managing and monitoring the disease strategies.

The framework to establish a sound National HIV/AIDS policy in Namibia is a multi-sectoral approach. This involves partnership between government and affected stakeholders, the private sector, community-based and nongovernmental organisations, trade unions, religious groups, and people living with HIV/AIDS. The government of Namibia allocates 2% of the entire national budget to HIV/AIDS related practices, and it also encourages local authorities to allocate 2% of their annual budget for HIV/AIDS activities and also to include these activities into their key daily business operation activities. The other recommendation is that the monthly grants allocated to AIDS orphans should be paid out along with the monthly government pensions to ensure that grants actually reach them. Pensioners who look after their own grandchildren are indicated (AfroAIDSinfo, 2005: 31). Just like in South Africa, it is not clear in Namibia's strategic plan on the fight against HIV/AIDS what the tourism sector is particularly doing in combating HIV/AIDS.

The general public is encouraged to participate and contribute to the activities that combat HIV/AIDS in the country. For example, Helga Huses, an HIV/AIDS patient in Namibia operates a self-help project known as Family Hope Sanctuary which is based in the Katukura Township on the western outskirts of Windhoek. Helga Huses is one of the first people to receive antiretroviral (ARV) in Namibia, and publicly confirms that the treatment works and that it helped her. Her community-based organisation was established in 2004, and it is composed of 82 people, 78 women and four men. This project provides home-based care to people diagnosed with HIV/AIDS, and it also provides education facilities to people who cannot read or write. This project has 40 children from the neighbourhood between the ages of 7 and 15 who are studying subjects including arithmetic. Local-based organisations like butcheries, diary companies and

shops in the central business district of Windhoek donate food to this project, and the UNAIDS also donates funds to cover part of the costs of running the organisation (AfroAIDSinfo, 2005: 33).

The challenge facing many Southern African countries including Botswana is the fact that many people particularly in rural areas live in poverty in which there is also a problem of shortage of food. Food is of utmost importance to people who take ARV treatment, and HIV/AIDS patients should not take ARV treatment on empty stomachs because it may cause stomach upsets that may result in a weak body system (AfroAIDSinfo, 2005: 35). For example, Huses disclosed that five people in her organisation died due to poor nutrition that resulted in body weakening and eventual death. Food security is a daily basic need that should be part of the overall strategy to fight HIV/AIDS. The Namibian ARV programme meets its target, and the UN Secretary General's report to the General Assembly on HIV/AIDS in 2005 indicated that Namibia is one of the three African countries in which over 25% of people certified to use ARV treatment actual receive it. The other two African countries are Uganda and Botswana. Namibia begun offering ARV to the AIDS patients in August 2003 and by June 2004 there were 17, 000 patients on the treatment from both the public and private sector in the country. The projected number of Namibians in need of ARV treatment is 56, 000. The European Union provides funds for Namibia's AIDS policy process.

United Nations' Department of Economic and Social Affairs (2004: 1) indicates that the government of Namibia is committed to combating the HIV/AIDS pandemic in the country. From 28 to 30 January 2004 the Government of Namibia in collaboration with the United Nations Department of Economic and Social Affairs held an HIV/AIDS policy formulation workshop. The aim of the workshop was to bring together government representatives, non-governmental organisations and HIV/AIDS practitioners from different countries within the Southern African Region to discuss the impact of HIV/AIDS on families within the region, and also to assess both communities and family reaction to the pandemic. The contribution towards the establishment of a strategic policy framework to assist governments to strengthen the capacity of families and family networks to cope with HIV/AIDS was also made. A participant from Eastern Europe was present as one of workshop delegations to make comparison at the level of experience across various regions.

Besides delegations from within Namibia, international delegations came from other countries including Lesotho, Mozambique, South Africa, Swaziland, Ukraine, Zambia and Zimbabwe. Issues discussed during the workshop included the impacts of HIV/AIDS on family and family networks, the generational responsibilities, and the related social interaction aspects. The strategies to reduce the HIV/AIDS impacts on various societies and families were identified, and the existing policies and programmes were reviewed to assess how they meet the needs of families affected by HIV/AIDS at various stages. The policy framework and recommendations for addressing family problems and involving intergenerational roles in HIV/AIDS policies and strategies were identified, and further capacity building imperatives and understanding gaps for evaluation activities were established (United Nations. Department of Economic & Social Affairs, 2004: 2).

HIV/AIDS also hinders progress in terms of development strategies, future planning and the country's vision of political, social and economic stability. In response to the situation, the government of Namibia is making efforts to fight HIV/AIDS as an urgent issue of its Second National Development Plan. Namibia's future national vision, Vision 2030, stipulates that the government of Namibia's main focus is on the well being of all its citizens and residents, and to strengthen family units. The government of Namibia addresses HIV/AIDS not just as a health issue, but a development, economic, security and human rights issue. The impacts of HIV/AIDS are diverse and overlapping, and these include the reduction of life expectancy and workforce, and loss of earnings. HIV/AIDS reduces the production capabilities for the families, and it also reduces the workforce productivity, and would include workers in the tourism sector. It seriously disrupts family structures and functions by killing the parents, leaving orphans who are cared for by relatives and in most cases the grandparents (The United Nations. Department of Economic & Social Affairs, 2004: 2).

Many families not only in Namibia but in many African countries in general suffer due to stigmatisation, discrimination and economic insecurity as a result of HIV/AIDS. The most vulnerable group to the HIV/AIDS pandemic are young people, and half of the projected 6, 000 daily infected people in Namibia are the youth. This in return affects the adults because most of the people who die of AIDS are the young parents, who leave orphans with grandparents with a challenge to care for orphaned children. Namibia's HIV/AIDS policy encourages and assists government and civil society to formulate and implement policies and programmes that support

and protect families and the family network (The United Nations' Department of Economic & Social Affairs, 2004: 10).

The Namibia's HIV/AIDS policy stipulates that all family members should have access to the information concerning testing, counselling and protection, and it emphasises that HIV/AIDS awareness information should be made clear to the public. Stigmatisation and discrimination against HIV positive people are discouraged, and the legislation that is discriminatory against people living with HIV/AIDS have been reviewed. The Namibian policy also stresses that all policies and programmes must support care for the children orphaned by HIV/AIDS and the legal rights and protection for these children should be clarified (The United Nations' Department of Economic & Social Affairs, 2004: 10)

3.6.7 AN OVERVIEW OF THE HIV/AIDS SITUATION IN ZIMBABWE

As already indicated, the Southern African region is the region most struck by HIV/AIDS and Botswana and its neighbouring states are reported to have high HIV/AIDS prevalence rates. For example, Zimbabwe had a 34% of adult HIV/AIDS prevalence rate by the end of 2001, compared to an estimated 25% two years earlier (USAID, 2002: 1). USAID further argues that Zimbabwe is one of the countries most vulnerable to the HIV/AIDS pandemic in Sub – Saharan Africa. By the end of the year 2001, 2 million adults in Zimbabwe were reported to be living with the HIV/AIDS pandemic, with women comprising 60% of the HIV/AIDS cases in the country. Zimbabwe's life expectancy is projected to drop to 35 years by 2010, compared to 66 years in 1997. The death rate in the country is expected to increase by more than 200% as a result of HIV/AIDS, compared to 1990. In the year 2000, the HIV/AIDS prevalence among women attending the antenatal clinics in the cities was projected at 31.1% and the median prevalence for men patients attending the Sexual Transmitted Infection (STI) clinics in the cities were projected at 71.1% in 1995. The median prevalence for female sex workers in the big towns and cities in 1995 was 86%.

The number of HIV/AIDS cases among women in Zimbabwe increases from the ages between 20 and 29 years, and 15% of the children under the age of 5 years in the country are reported to be living with HIV/AIDS. The government of Zimbabwe in collaboration with the US Centre for Disease Control and Prevention together with donors have established and are implementing a

comprehensive prevention of Mother-To-Child Transmission (MTCT) program. In the year 2001, USAID projected that Zimbabwe had over 780, 000 AIDS orphans under the age of 15 years. Among the 15–24 years age group, HIV/AIDS prevalence for females in the country is 2.6 times more than that of males. The age and gender distribution of HIV/AIDS cases in Zimbabwe indicates that most of the HIV/AIDS transmission is from older men to young women. Zimbabwe was the first country in Southern Africa to introduce female condoms in 1997. In response to the HIV/AIDS pandemic situation in the country, the government of Zimbabwe has established the National Strategic framework on HIV/AIDS, the National AIDS Policy, the National AIDS Council (NAC), and has introduced an AIDS Levy to generate essential resources to support HIV/AIDS intervention (USAID, 2002: 2). However, the escalating HIV/AIDS prevalence rate in Zimbabwe could also be a result of the economic situation in the country.

The establishment of the Zimbabwean National AIDS Council (NAC) was not done in isolation but is a comprehensive effort by the Ministry of Health, representatives from government departments, non-governmental organisations (NGOs), faith-based groups, the private sector, and the media. Zimbabwe's HIV/AIDS National Strategic Framework was approved by NAC in May 2000, and it aims at prevention and care for people living with HIV/AIDS in the country. A number of organisations like churches, women's groups, and NGOs take part in the fight against the HIV/AIDS pandemic in the country. In 2001, USAID donated \$6.4 million to Zimbabwe's HIV/AIDS prevention and care programme, which is more than \$5 million than what the organisation donated to the country in 2000. The USAID objective is to achieve behaviour change through improving accessibility to quality services, specifically in voluntary counselling and testing (VCT), communication interventions, and an improved capacity for public institutions, non-governmental organisations (NGOs), and communities to establish effective care programmes for orphans and people affected by HIV/AIDS (USAID, 2002: 2).

This strategy makes a tremendous contribution towards the HIV/AIDS awareness campaign, and studies indicate that 98% of Zimbabwe's population is aware of the HIV/AIDS pandemic. The negative factor is that even if people are aware of the HIV/AIDS pandemic, they do not all change their risky behaviour. USAID has established the initiatives to identify sustainable, and suitable Zimbabwe community programmes to help orphans and children affected by HIV/AIDS, and to initiate economic opportunities for young people affected by the pandemic. USAID also encourages a wide community-based condom distribution, selling and supply channels and use of

condoms in a sustainable manner (USAID, 2002: 3).

USAID/Zimbabwe is working hard and encourages the local NGOs and faith-based organisations to give support to the establishment of an informed HIV/AIDS policy in the public sector. In the year 1999, the centre for Voluntary Counselling and Testing was established in Zimbabwe, and by the year 2001 more than 50, 000 people used it, which was more than the projected 42% expected. Most of the people who use VCT in the country are the young generation and couples. Between the year 1999 and 2000, 10 VCT clinics were developed at strategic locations across the country. USAID encourages individuals and couples to know their HIV status and use the service available and change their risky behaviour (USAID, 2002: 3).

Zimbabwe faces numerous challenges in dealing with the HIV/AIDS pandemic. For example, due to financial constraints and political instability in the country, the Health Department is failing to cope with the HIV/AIDS situation. The other challenge is that despite the HIV/AIDS awareness campaign, sustained changes in risky sexual behaviour among the public, the government is not meeting its objectives. HIV/AIDS is characterised by a stigma attached to it, and most people do not want to accept and disclose their family members who die of HIV/AIDS. The gender inequality issue in Zimbabwe results in a number of women being exposed to HIV/AIDS risky situations, which make them more vulnerable to the pandemic than men (USAID, 2002: 3).

Felicity, Lydia, Sekai, & Hatendi (2001: 1) carried out a study to assess the levels of awareness on the 1999 HIV/AIDS National Policy and on the National AIDS Council Funds by civil society and also to assess the implementation strategies. Felicity *et al.* indicate that the government of Zimbabwe established a National HIV/AIDS Policy in December 1999 with the intention of establishing guidelines for all programmes designated to fight the HIV/AIDS pandemic in the country. A number of NGOs in the country argue that Zimbabwe's policy document does not meet its objectives due to the fact that HIV/AIDS continues to spread at an alarming rate in the country. In addition to the National AIDS Trust, in 1999 the government of Zimbabwe introduced the AIDS Levy that is managed by the National AIDS Council Board reporting directly to the Ministry of Health and Child Welfare. The centralised control of this AIDS levy and inadequate awareness among the people of Zimbabwe make access to these public funds difficult. There is limited information with regard to the level of awareness and implementation

of the Public of Zimbabwe's HIV/AIDS National Policy and available National AIDS Trust Funds (NATF).

The National AIDS Council leads the implementation of the Zimbabwe's National AIDS Policy, and the National AIDS Council Board controls the funding system. The Council established the structures at the national, provincial and district levels for the development of a convenient operational atmosphere for the HIV/AIDS multi-sectoral approach. These structures suffer the criticism of not working in consultation with all civil society representatives. Policy awareness and accessibility in Zimbabwe is generally limited and varied among different NGOs.

The Zimbabwean HIV/AIDS policy contains weak points and its dissemination and distribution strategies are inadequate. NGOs implement HIV/AIDS prevention, care, and control eradication activities irrespective of the limited awareness information by the government HIV/AIDS policy. The government of Zimbabwe considers its policy to be an important document and a milestone in combating the HIV/AIDS pandemic, but there is criticism that little is done by the government to create awareness and to encourage the use of the policy concepts by the general public (Felicity *et al.*, 2001: 2).

There is a lack of capacity in civil societies involved in the fight against HIV/AIDS programmes, and only the traditional health associated NGOs implement the policy, although in a fragmented way. There are individuals and institutional capabilities and resources available among the non-traditional HIV/AIDS civil society development programme implementers. This means that there is a need to increase mainstreaming and incorporation of HIV/AIDS in existing development programmes in the country. There is a lack of maximum consultation and involvement of civil society on the approach to strategic policy planning, formulation, implementation, monitoring and evaluation in the country. The civil society policy ownership is lacking, and the responsibilities and accountabilities of NGOs on policy implementation is not clearly stipulated, hence the poor participation in an on-going district policy implementation planning process (Felicity *et al.*, 2001: 2).

There is also a lack of essential law enforcement in the policy implementation process. The accessibility to the National AIDS Trust Funds by a number of NGOs is minimal. This can reportedly be attributed to a number of reasons including a shortage of necessary information

with regards to fund operation systems. The other reasons indicated are that most of the NGOs mainly rely on donors and do not consider the national funding to be a necessity. NGOs are not members of the District AIDS Action Committee and have little or no participation in the District Planning forum, and also in areas that are generally considered for accessing funds. The general overall administration and management of funds are aspects of concern (Felicity *et al.*, 2001: 5). The above section covered the HIV/AIDS policy in countries sharing borders with Botswana. The following section covers the HIV/AIDS policy in Botswana.

3.7 THE GENERAL SOCIO-ECONOMIC IMPACT OF HIV/AIDS

The adversity of HIV/AIDS impact is generally determined by the severity of infection rate in the population of a given country (Villarreal, 2006: 197). This is an important argument by Villarreal and it can be used to assess the socio-economic impact of HI/AIDS in different countries. HIV/AIDS and its socio-economic impact is a gradual process, and its impacts are usually felt at the population level when more people get infected and eventually die. The intensity of HIV/AIDS usually varies in time, but high death rates can be projected at 5 to 10 years of its spread in the country, but it depends on individual's nutritional level. Death is one of the major impact indicators, but prior to death, there are other impact indicators such as body weakness, inability to work hard, but this is also determined by other factors such as medical and nutritional levels. Impoverishment is another HIV/AIDS impact, and it begins at the time of reduced work capability. The other general HIV/AIDS socio-economic impact is the high number of orphans, especially when both parents die and leave children behind (Piot, Bartos, Ghys, Walker & Schwartlander, 2001: 967).

The impact of HIV/AIDS is systematic in such a way that it affects all societies and economic factors at various levels. When one sector of the economy and society is affected, the other sectors are also likely to be affected either directly or indirectly (Dixon & MacDonald, 2002: 235). The HIV/AIDS is usually evident at various levels such as individuals, households, communities, and nationals. This means that the fight against HIV/AIDS cannot be the sole responsibility of governments or Ministries of Health, but it should be collaborative efforts by various economic sectors including those in tourism sector. The major HIV/AIDS impact is the loss of people in their productive ages, which usually results in loss of income, experience, skills

and household productivity. It also affects service provision, company productivity and leadership both at community and national levels. HIV/AIDS also reduces economic growth of most countries reported to be having high infection rate (Villarreal, 2006: 199).

Many economic sectors and governments are losing large numbers of their employees to HIV/AIDS. For example, 58% of employees who die in Kenya's Ministry of Agriculture are projected to be killed by HIV/AIDS. It is also indicated that 16% of Agricultural workers in Malawi are infected with HIV/AIDS. Agriculture, mining and tourism are the economic sectors most vulnerable to HIV/AIDS because of mobility of their workers (Villarreal, 2006: 199). Much impact may be expected in the tourism sector due to both workers and customer mobility. HIV/AIDS generally affects various economic sectors in a number of African countries. For instance, in 1998 Zambia was reported to have lost 1 300 teachers to HIV/AIDS, which is equivalent to a third of the country's total graduate teachers per year. HIV/AIDS also reduces the country's investment in training, education, staff development, and it increases staff turnover (Topouzis, 1998: 2). This affects the service quality provided by many economic sectors because it is impossible to replace the experience of the deceased employees.

The social impact of HIV/AIDS in many countries is significant, and providing HIV/AIDS treatment for people who are infected is expensive. For example, many developing countries find it difficult to cope with the costs of HIV/AIDS treatment. HIV/AIDS also reduces most governments' economic investment in major economic sectors including those in tourism. It is also projected that the costs of providing HIV/AIDS treatment will reach a pick of more than 30% of the Ministry of Health's budget in Ethiopia, 50% in Kenya and 60% in Zimbabwe by the year 2014. The other costs expected to rise at a great rate, particularly in countries with high prevalence rate such as Botswana and South Africa, is the cost of caring for orphans and poor families (Topouzis, 1998: 2).

HIV/AIDS reduces productivity and labour supply, and also influences population migration especially from rural areas to urban areas due to its increased levels of poverty (Villarreal, 2006: 200). It also increases households' expenditures such as funeral and medical expenses. Increased households' expenditures such as funeral and medical expenses have indirect impact on the tourism sector because tourists often participate in tourism activities at their disposable time using their disposable income. Increased expenditure therefore reduces disposable income.

HIV/AIDS also hampers rural development by killing skilled and experienced people in rural areas including people working in the tourism sector. HIV/AIDS has a direct impact on the lives of people living in rural areas because it reduces productivity in subsistence farming, which is a source of living for many people living in rural areas of most African countries. This is because when people are sick may not be able to work in the farms, and a number of the people who are not infected spend time caring for their infected family members instead of working in the farms. The HIV/AIDS problem and its impact on the community often results in child labour particularly among children who remain custodian of their young brothers and sisters and those who remain with their grandparents (Villarreal, 2006: 200).

Children, particularly girls, in selected African countries are often forced to drop out of schools and assist in the families in taking care of HIV/AIDS patients. Thus, these children are denied the opportunities to have education and a successful future. Although this may seem not to have immediate impact on tourism, it may have significant implication in future because these children are the future tourism developers, public policy makers and managers. Denying the children the opportunity to study, increases the level of poverty in a number of communities, which means that more money will be used to provide care for poor communities instead of developing tourism and related economic activities. Many households in a number of African countries lose their savings and remain with no choice but to ask help from either relatives or to borrow money or even sell their valuables assets to sustain their living (Villarreal, 2006: 200). Many people are forced to migrate to urban areas to look for formal employment, which further exacerbates the spread of HIV/AIDS. In situations in which the breadwinner dies, the dependency ratio and poverty in many households increase (Villarreal, 2006: 200).

HIV/AIDS leads to poverty, poverty results in poor nutrition and poor health, which results in many people becoming vulnerable to HIV/AIDS. This situation is evident in poor rural areas where most people do not have adequate access to medical services. The other factors influencing the spread of HIV/AIDS in many counties are wars and political instability, which are often accompanied by sexual violence, rape, and displacement of population, thus increasing poverty (Villarreal, 2006: 202). A good example is the political situation in Zimbabwe in which large numbers of people have migrated to other countries such as Botswana and South Africa (Villarreal, 2006: 203). HIV/AIDS affects both the amount and quality of food production, and it also affects all people irrespective of income or educational level, but the poorer people in

communities are more affected than the richer people. Poverty creates a risk environment that influences the spread of HIV/AIDS because it is associated with low levels of human capital, population migration, insufficient assets and gender inequality in access to resources. HIV/AIDS in return exacerbates poverty levels, particularly in rural areas in which most poor people in many African countries live (Villarreal, 2006: 200).

Arndt and Lewis (2000: 13) and Lisk (2002: 14) indicate that HIV/AIDS affects the gross domestic products (GDP) in a number of countries in Southern Africa through its impact on tourism labour supply, savings, and through reduction in the productivity. However, HIV/AIDS does not only affect the Southern African tourism sector, but affects other sectors in general. Moreover, poverty in Southern Africa and in other parts of Africa is likely to increase as a result of the continuous spreading of the HIV virus on the continent (Arndt and Lewis, 2000: 13 & Lisk, 2002: 14).

HIV/AIDS creates a vicious cycle by reducing economic growth, which leads to increased poverty, which in turn, results in the rapid spread of HIV/AIDS due to reduced household income and nutrition. In addition to these impacts, the HIV/AIDS pandemic results in income inequality by increasing the supply price of scarce tourism skilled labour, which results in higher wages of skilled workers when compared to the wages of unskilled labour.

HIV/AIDS affects development progress at various levels and throughout societies. For example, Africa is burdened by large socioeconomic difficulties and poverty, and the HIV/AIDS pandemic threatens human welfare and social stability. HIV/AIDS is the largest obstacle to the implementation of the African Renaissance through structures like NEPAD. The poverty rate in a number of Southern African countries is high, and three quarters of the Africans live on less than US\$ 2 a day (Ramsey, Hazoume & Chetty, 2002: 4). The most destructive impact of HIV/AIDS in Sub-Saharan Africa is its contribution to poverty by increasing the vicious cycle of poverty already prevailing in the region, and it increases forms of social inequality (Ramsey *et al.* 2002: 4).

Generally, people who suffer the severest impact of HIV/AIDS are those living in poverty (Ramsey *et al.* 2002: 4). The fact that HIV/AIDS kills family breadwinners and the young adults who have the potential to be breadwinners, means that most households become poorer and

fragmented as children are sent away to be looked after by relatives, or they become heads of families at a young age. Supporting these children with basic needs like food, shelter and education in the face of a disintegrating traditional family network and deteriorating government services and resources is a great challenge. For example, in Uganda, 25% of families take care of an AIDS orphan, and this stretches family resources (Ramsey *et al.* 2002: 4).

Caring for the AIDS patients is a challenging task for the families that have small or tight financial budgets. For example, in urban areas in Cote d'Ivoire, education investment dropped by half, food consumption dropped by 41% per capita income and health care expenses are more than four times in families that have an AIDS patient (Ramsey *et al.*, 2004). In Rwanda, the annual per capita health care expenses for families that have an AIDS patient is US\$63 compared to average families in which health care expenses is US\$20 (Ramsey *et al.* 2002: 4).

Figure 3.6 depicts the relationship between HIV/AIDS, poverty and population migration. HIV/AIDS and poverty directly influence each other. The more HIV/AIDS spread in the community, the more poverty levels grow, and the more people become poor the more they become vulnerable to HIV/AIDS. Poverty has direct influence on population migration, which results in further spread of HIV/AIDS. This means that fighting HIV/AIDS cannot be done in isolation, but it should be a systematic approach that addresses poverty, population migration and HIV/AIDS simultaneously.

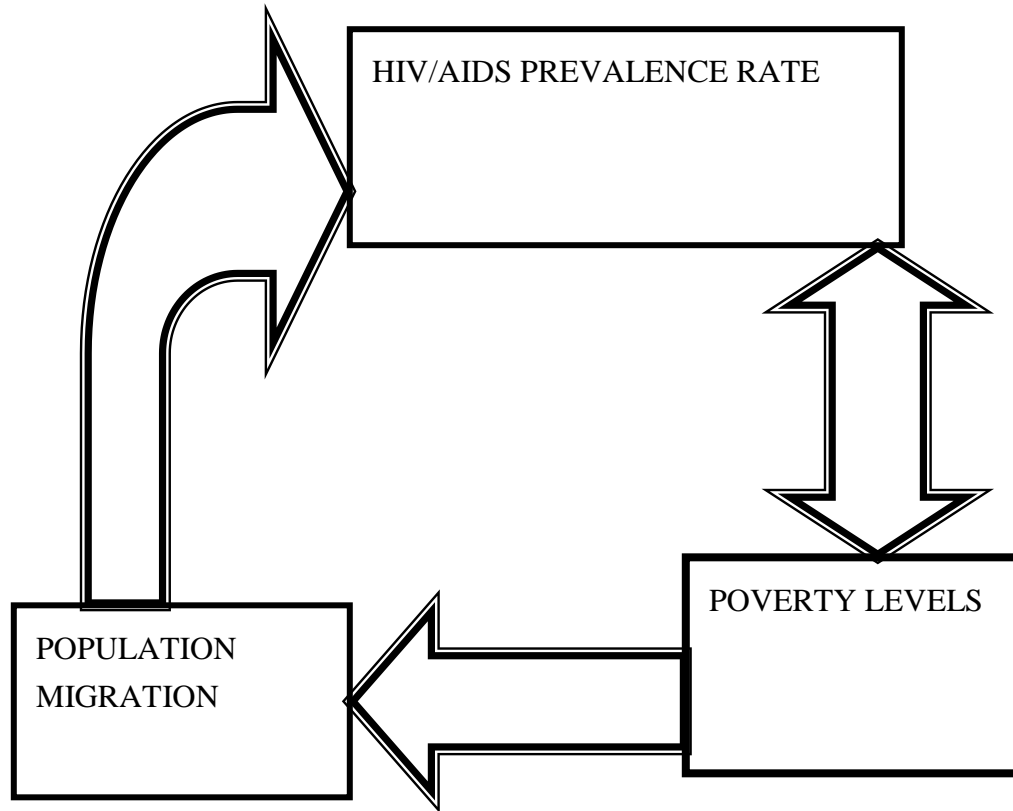


FIGURE 3.6: VICIOUS CIRCLE OF HIV/AIDS

(Source: own figure based on information provided by Ramsey *et al.*, 2002)

Besides population migration and poverty, the other variable that needs to be addressed adequately is gender inequality. Gender inequality is one of the factors influencing the spread of HIV/AIDS in a number of African countries. In a number of occasions, access to productive resources such as land, credit, education, training and technology in a number of African countries is largely dependent on gender lines, with men having more access to these services than women (Villarreal, 2006: 202). HIV/AIDS exacerbates the existing gender inequality in African rural communities in which women have access to basic resources only after they get married. Traditionally, a selected African cultures depict that when a married African man died, the wife could marry the deceased husband's brother so that she could continue having access to resources, but due to HIV/AIDS, the traditional practice have withered away. Lack of ownership of valuable resources and high poverty levels force a number of African women to send their children away from home to look for means of survival such as casual employment. This in

numerous occasions exposes the children to risky behaviour, particularly girls who may engage in occasional sex for money as commercial sex workers. In a number of African countries, HIV/AIDS infection rates are reported to be three to five times higher under younger women than younger men. HIV/AIDS affects the main factors of economic growth such as physical, human and social capital, and it affects development of many countries (Villarreal, 2006: 203).

HIV/AIDS has adverse impacts on labour supply and productivity for the economic sectors including tourism, and it increases unbearable medical and funeral costs in many African societies. Poor productivity results in reduced investments and savings opportunities in major economic sectors such as agriculture and tourism, which also result in reduced GDP for severely affected countries such as South Africa, Botswana and a number of other African countries (Agbola, Damoense & Saini, 2004: 724). HIV/AIDS reduces population growth, diverts household spending patterns towards health and related costs, and it forces most governments in many African countries such as South Africa to spend more money on health, education and social services. Agriculture and service sectors such as tourism are the most vulnerable to HIV/AIDS in a number of developing countries because they are labour intensive. This is because HIV/AIDS reduces the skilled workers available to work and develop these sectors. It also causes food insecurity by killing people who work in agriculture to produce food, particularly subsistence farming. When an elderly person becomes sick or dies of HIV/AIDS, the households usually suffer because children may not be able to work or cultivate the land to produce food for the family. The situation is worse in a number of rural areas in a number of African countries where many people are poor and cannot afford to buy food. The worst scenario occurs when the family has to care for both orphans and HIV/AIDS patients concurrently.

3.7.1 THE IMPACT OF HIV/AIDS ON ECONOMIC GROWTH

HIV/AIDS significantly affects economic growth of Botswana and many other African countries. Besides the fact that the South African history of racial discrimination delayed the country's entry onto the world stage in various economic activities including tourism, HIV/AIDS is one of the key problems threatening the progress in the development of the tourism sector in South Africa. HIV/AIDS also limits the benefits that the tourism sector would provide economically and socially (World Travel and Tourism Council, 2002: 41). However, the future prospects of the South African tourism sector appear to be positive. There is a widespread recognition, although

somewhat more realistic and projection, of the tourism contribution and potential contribution to the regional economy, and more importantly, during the challenges of global economic recession. Among the identified constraints prohibiting the contribution of tourism to the South African economy as already stated is the HIV/AIDS pandemic. HIV/AIDS affects the South African economy by killing the economical active age groups. Among the people killed by HIV/AIDS in South Africa are the skilled tourism workers who are difficult to replace.

The relationship between HIV/AIDS and the costs and revenue of employers has rarely been examined systematically to date (Namibia's Tourism Board, 2004: 27). Moreover, little data is available on how HIV/AIDS affects micro and small formal and informal tourism enterprises. Overall, there could be a reduction in profits if tourism companies in Namibia and in a number of Southern African countries do not take measures to prevent the impact of HIV/AIDS.

However, tourism employers are unlikely to be affected significantly by HIV/AIDS where those tourism employees who have to leave the tourism companies can be replaced without loss of productivity. This may happen in countries with high employment and underemployment rates. In view of the expected impact of HIV/AIDS on the composition of the available tourism workforce, there is likely to be a mismatch of human resources and tourism labour requirements in terms of qualifications, training and experience. Other significant impacts include a loss of tourism markets where the purchasing power of the population declines.

The most terrific impact of HIV/AIDS is in lives lost. Another impact felt mostly by those not infected, is economic. Predicting the impact of the disease, especially in Southern African feeble economies, is an inappropriate practice even by the economic standards due to the fact that AIDS is more vulnerable in areas where data are least accurate. The pandemic depresses the Sub-Saharan Africa's annual GDP growth rate by 0.8 percentage points (South Africa's Department of Economic Development and Tourism, 2004: 82).

Many Southern African countries which have more than one-fifth of adults with HIV/AIDS, the GDP impact points is estimated to be 2.6%. Besides mining and tourism, the South African Economy also relies on farming, and due to the fact that women have the highest incidence of AIDS, food security becomes a problem in the region because women are more involved in agriculture and households than men. HIV infection implicates that other diseases spread faster,

and AIDS patients are normally too weak to work effectively. The Southern African Region's food shortage in 2002 was due to the fact that many young adults were too sick to work or to travel for help (South Africa's Department of Economic Development & Tourism, 2004: 82).

The impact of HIV/AIDS on the economic growth of many African countries is expected to be worse in future when considering the continued spread of the disease in the continent. For example HIV/AIDS is expected to reduce the South Africa's economic growth by 4.4% by between 0,38 and 0,46 percentage points by 2020 (Kahn (2006:1). This projection is made by the Bureau for Economic Research at the University of Stellenbosch. However, the HIV/AIDS implication depends on the number of people infected with the disease. This impact is not as serious as the World Bank projected in its report in 2003, that South Africa is faced with extreme economic decline if it does not deal with HIV/AIDS effectively. The UNAIDS report indicates that South Africa has 5.5 million people living with HIV/AIDS, and is the second highest in the world after India.

HIV/AIDS would have a negative effect on economic growth with no treatment scenario. Without AIDS treatment, the South African rate of gross domestic product (GDP) growth may fall from an estimated average of 4.4% over the period 2000 – 2020 to 4%. The study projects per capita GDP of about 8% higher in real terms, as population declines outweighs negatively on the real GDP. Providing 50% AIDS coverage may bring down the pandemic's impact on economic growth by 17%, from an estimated impact of -0, 46 percentage points to -0, 38 percentage points. The effects of the pandemic would most likely be experienced after 2010 (Kahn, 2006: 3).

Focussing on various economic sectors such as tourism, the semiskilled and the unskilled workers are the most vulnerable to HIV/AIDS. However, the semiskilled workers can be replaced comparatively easily from the large pool of population, which means that the economic impacts would be less felt than predicted by various studies that involved full employment (Kahn, 2006:3). In the past, most studies had often ignored the contribution made by the health services' expenditure to the GDP, and this resulted in overly optimistic projections. As already indicated, Botswana is one of the countries with highest prevalence of HIV/AIDS in the world, and the impact of the disease across various economic sectors in the country is significant.

HIV/AIDS negatively affects both labour and productivity of many companies in Botswana and

in other African countries. The two major factors that affect most companies' productivity are illness and death of employees and their family members. When employees are sick, they often take prolonged sick leave. This includes permissible sick leave and annual leave before they become seriously sick to an extent that they cannot work anymore. A number of companies including those in the tourism sector face problems of unauthorised absenteeism among a number of employees resulting from illness. In cases where the job is insecure or threatened by regular sick leave, many employees after exhausting their leave days, may continue to work even if they are not feeling well, which affects their productivity (USAIDS, 2005: 1). The other impact of HIV/AIDS that affects productivity in a number of companies in Botswana and in general is the fact that employees who may be either seriously ill or die, need to be replaced, which is time consuming and lowers productivity during the new employees training and adaptation to the company.

Besides the fact that a number of employees get sick and go for a leave for a lengthy period, a number of employees often request for compassionate leave to care for their family members who are suffering from HIV/AIDS-related illness. The other significant impact of HIV/AIDS across various economic factors including tourism is the time spent by employees on funerals of families, friends or colleagues. Bearing in mind that many economic sectors such as tourism and mining depend largely on migrant labours, it is hard to imagine how much time is spent by employees travelling long distance to their homes or colleagues' homes to attend funerals. Labour replacement as indicated in the above paragraph is a complex issue because it depends on various aspects such as labour intensiveness of a particular sector, the levels of skills need to be replaced, and the availability of skilled labour. Tourism skills in many African countries including Botswana are scarce, and when skilled workers within the sector fall sick or die, it often takes time to replace them. The other worrying factor is that experience is of utmost important in economic development of any country, and in case the company loses experienced workers it becomes difficult or impossible to replace their experience. The loss of a key worker does not only affect productivity, but it also affect the remaining workers' morale, increases workload, and may creates discrimination and confusion about HIV/AIDS resulting from fear of being infected. A number of employees are sensitive that they do not feel comfortable to work with a colleague who is or suspected of being HIV positive (USAIDS, 2005: 3).

HIV positive workers who work under strenuous conditions such as in mining usually develops

into illness faster than workers who work under more relaxed environment. The development of HIV into a fully blown AIDS does not only affect the individual worker but also lowers productivity. For example, it is projected that in South Africa companies that have HIV/AIDS prevalence rate of 10% of their workers could have their productivity reduced by 2.5%. Many companies in the country face problems arising from increased workers benefits such as payroll costs. However, in situations where the company pays salaries and workers make their own provision for basic services such as medical care, pensions, insurance and housing or rely on government for such services, then the impact of HIV/AIDS on the company payroll is not heavily felt. The major concern however is that the costs of such basic services are increasing with the spread of HIV/AIDS, and in the long term the government may remain with no choice but to increase taxes to cover the costs. It is a common practice for many companies to subsidise basic benefits such as medical care, pension, insurance, housing and funeral cover to their workers in senior positions. In case of mining sector, these benefits are often provided to a large number of employees, particularly in mines located in rural areas (USAIDS, 2005: 3).

The reduction in the growth of the labour force and declining productivity among Southern African countries results in low government revenues from both individuals and enterprises. For example, Botswana government expenditure is expected to shrink by more than 20% the next twenty years due to the damage of the revenue sources in the country such as tourism (UNAIDS, 2003: 17). At the same time, the costs of fighting the HIV/AIDS pandemic in the country are high due to the fact that more people are infected. The UNAIDS also indicates that a number of the Southern African countries spend between 20% and 90% of their health budgets in fighting HIV/AIDS.

HIV/AIDS generally has a significant impact across all economic sectors. For example, the research conducted in South African mines indicates that more 60% of the mines surveyed experience low profit attributed to HIV/AIDS (Reuters, 2004: 1). It is also projected that 50% of manufacturers in the country are experiencing both low profits and labour productivity, and that a number of South African companies in general face challenges linked to HIV/AIDS. When comparing the impact of HIV/AIDS across various South African economic sectors, mining and manufacturing are the most vulnerable, especially from the production perspective. HIV/AIDS prevalence in a number of mining companies increases production costs, and it is also projected that one in three of mineworkers are HIV positive. HIV/AIDS also has significant impact on a

number of financial services companies' target market. This is because HIV/AIDS does not only slow the growth in consumer markets, but increases non-profitable loans as people including clients get sick and die. However, other economic sectors such as retail, wholesale, motor trade and building and construction in South Africa experience relatively lower impact on profitability, but the impact within these sectors could be severe in future. Problems such as high staff absenteeism forces companies such as those in mining and manufacturing to invest in technology like machinery to divert from depending on labour. Contrary to other economic sectors, the tourism sector cannot substitute labour for machinery. There is a significant need for face to face service provision in the tourism sector. Reuters also argues that across various sectors of the economy only a few companies make effort to fight HIV/AIDS, but many companies rely on government.

3.8 THE IMPACT OF HIV/AIDS ON THE TOURISM SECTOR IN GENERAL

As already stated in this research, the impact of HIV/AIDS on the economy is also significant in the tourism sector of various Southern African countries including Botswana and South Africa. The HIV/AIDS pandemic in South Africa is felt by most companies' managers directly in the workplace. This includes companies in the tourism sector. For example, Fedics, South Africa's largest black-owned outsourced caterer is one of the few South African tourism companies that admit the adverse impact of the HIV/AIDS pandemic. This company has taken steps towards educating its employees on how to limit the chances of contracting the HIV virus, and how to live with the virus and to cope with difficulties associated with it (World Travel & Tourism Council, 2002: 44).

Fedics has realised that, by effectively taking an early action to fight AIDS, it can save its employees and revenue lost through medical and treatment costs. Besides Fedics being committed to educate its employees about HIV/AIDS, it has also adopted a positive and proactive approach through an effective HIV/AIDS management strategy. The strategic approach of this company includes its HIV/AIDS policy that acknowledges the sensitivity and complexity of the HIV/AIDS pandemic, which cuts across all economic, gender and race barriers (World Travel & Tourism Council, 2002: 43). However, the greatest challenge is to identify the secrecy and non-

disclosure of HIV/AIDS due to the stigma and discrimination attached to it.

The Fedics Group encourages a non-discriminatory working environment by enhancing a code of conduct, confidentiality and disclosure around HIV testing. The approach applied by this company shows that South African tourism companies and in general cannot avoid HIV/AIDS, but they can manage its impact. This concept is the driving force behind Fedics' strategy to face the challenges posed by the HIV/AIDS pandemic. The Fedics' strategy is not just a moral concept, but a survival concept that can be applicable to a number of tourism companies in South Africa (World Travel & Tourism Council, 2002: 45). The researcher therefore recommends that the Botswana tourism companies should adopt the strategy used by Fedics in coping with the impact of HIV/AIDS on their businesses.

Without necessary steps taken, there is no doubt that HIV/AIDS will have a serious impact on the Botswana economy and its people. Travel and tourism companies and stakeholders in the country are encouraged to adopt a proactive strategic approach in addressing the impact of HIV/AIDS (World Travel & Tourism Council, 2002: 33). The tourism companies are also encouraged to work together to devise strategies to combat the HIV/AIDS pandemic. This approach can save a large percentage of their employees and mitigate the impact of HIV/AIDS on their businesses.

The worrying factor is that many tourism companies in Botswana and in a number of Southern African countries also vulnerable to HIV/AIDS do not take actions to fight the spread and impacts of HIV/AIDS on their businesses. For example, a study conducted on selected South African tourism and hospitality companies indicates that 75% of the companies surveyed do not take measures to manage HIV/AIDS in their companies (Tourism, Hospitality and Sport Education and Training (THETA), 2003: 4). However, 2% of the managing directors of the surveyed companies take steps in managing HIV/AIDS at workplace. It is also indicated by THETA that 93% of companies surveyed do not have HIV/AIDS policy. The problem of not taking active role to fight the spread and impact of HIV/AIDS among tourism companies could be also a common practice in Botswana and this research aims at investigating measures taken by tourism business in mitigating the spread and impact of HIV/AIDS on Botswana tourism businesses.

THETA (2003: 5) indicates that 64% of the surveyed organisations are concerned about the

impacts of HIV/AIDS on their businesses, whereas 36% of the surveyed companies indicated that HIV/AIDS will not affect their businesses. The other area of concern by THETA is that a number of tourists engage in risky behaviour like not using preventive measures and alcohol abuse when they travel than when they are at home. The international studies as indicated by THETA, state that there is high sexual interaction among tourists and tourism/hospitality workers. The other area which needs attention is the fact that sex tourism is perceived as spreading HIV/AIDS.

It is imperative for tourism companies to use voluntary counselling and testing as a tool in fighting HIV/AIDS. Voluntary counselling and testing is imperative because it helps the workers to know their HIV status so that they can change lifestyle and make the right choices about their lives (THETA, 2003: 28). THETA further encouraged the companies to have voluntary counselling and testing programs or to organise transport to the testing centre for workers, indicating that this will motivate workers to go for voluntary counselling and testing. This strategy is relevant to Botswana because as already stated, Botswana is one of the country with the highest HIV/AIDS prevalence rate in the world and the country's tourism sector contributes significantly to the country's economy by employing a large number of people, making the sector to be labour intensive.

The other important consideration in the fight against HIV/AIDS is the political support. This means that the fight against HIV/AIDS should be a collaborative effort of the governments, public tourism entities, tourism businesses in the private sector and the public in general (World Travel and Tourism, 2002: 44). Communities should also play active roles in the fight against HIV/AIDS and mitigate any factors contributing to the spread of the disease such as gender inequality and domestic violence.

Studies conducted in Zimbabwe show that the risk of contracting HIV/AIDS and other sexually transmitted diseases (STD) by a number of married women in the country is linked to domestic violence (Over, 2001: 51). There is also a problem of gender inequality in terms of access to the labour market in tourism and other sectors. Over (2001: 51) also argues that migration and tourism could be among the factors that contribute to the spread of HIV in Zimbabwe. This is because most of the tourism workers migrate from their homes and stay away from their families for a long time. However, migration alone is not a risk factor, but risks are determined by the way these workers conduct themselves when they are away from home, the living conditions for the

migrants host destinations, and the differential HIV/AIDS levels between the destination and the place of origin.

Migration and tourism-related movements indirectly contribute to the spread of the HIV/AIDS pandemic among the tourism workers in Zimbabwe through social interaction channels with other people from other countries affected by HIV/AIDS. However, this study does not provide the statistics on correlation between tourism and migration. The spread of HIV/AIDS among the tourism workers in Zimbabwe affects the economy of the country by lowering productivity. Most companies report that their major problems are workers absenteeism and prolonged sick leave, which reduce their profits. The other argument by Over is that the negative influence of tourism on the spread of HIV/AIDS is justified by the economic benefits the sector has. Both migration and tourism are important aspects of the economy. As already stated in this research, the group most vulnerable to HIV/AIDS among the tourism workers in Zimbabwe are women (Over, 2001: 52).

There are several mechanisms by which HIV/AIDS affects macroeconomic performance in Zimbabwe and in the Southern Africa region at large. HIV/AIDS deaths lead directly to a reduction in the number of tourism workers available in their productive ages (Namibia's Ministry of Environment and Tourism, 1994: 22). The high death rates lead to experienced tourism workers replaced by younger, less experienced persons, which results in reduction on productivity. An experienced worker is difficult to replace, and the loss of experienced employees often negatively affects the service quality rendered to clients such as tourists. Southern African countries that face a shortage of skills in tourism sector like Botswana are expected to face severe HIV/AIDS challenges.

A shortage of skilled workers leads to higher production costs and a loss of international competitiveness (Botswana's Department of Tourism 2003: 23). The market for tourism is globally focused and Botswana operates its tourism business under the World Tourism Organisation standards to compete globally. Due to the prevalence of HIV/AIDS, the Botswana Tourism sector's service quality and productivity may deteriorate especially in cases in which skilled workers are lost to HIV/AIDS. To compete internationally, skilled workers are essential so that quality service can be provided.

Botswana and a number of other Southern African countries are experiencing lower government revenues and reduced private savings because of greater health care costs and loss of income for workers, which lead to slower employment creation in the formal sector, particularly capital intensive opportunities. As a result, a number of workers are pushed into lower paying jobs in the informal sector. The Government of Botswana spends over P10 million on HIV/AIDS drugs per annum. This affects the productivity and economy of the country because of the shift from developing and marketing tourism to the fight against HIV/AIDS (Botswana's Ministry of Health, 2005: 26).

The Botswana tourism sector particularly the private tourism companies is facing high expenditures resulting from the monitoring of high risk groups, the establishment of prevention strategies, and the provision of health care and welfare for the infected and affected tourism workers. The Botswana Ministry of Health in collaboration with a selected tourism companies both in private and public sectors have established home-based care programmes for workers suffering from HIV/AIDS (Nagelkerk, Jha, De Vlas, Korenromp, Moses, Blanehard & Plumber, 2002: 93). This results in low productivity in the tourism sector because more money is spent on AIDS patients than on the development of tourism. The Botswana tourism sector experiences increased pressure on the social security system, including life insurance and pension funds, which are important sources of capital for both government and the private sector. A number of tourism organisations in Botswana encourage their workers to go for voluntary HIV/AIDS testing, and also encourage those who are HIV positive to take AIDS drugs like ARV, which are provided by the government of Botswana free of charge.

The macroeconomic impact of HIV/AIDS is a sensitive issue as to about how HIV/AIDS affect savings and investment rates, and whether HIV/AIDS affects the educated and experienced tourism employees more than others. Studies in Tanzania, Cameroon, Zambia, Swaziland, Kenya, Botswana and other Sub-Saharan African countries indicate that the rate of economic growth in Southern Africa is reduced by as much as 25% over a 20 year period as a result of the HIV/AIDS pandemic (MacFarlan, Maitland Segherri & Silvia, 2001: 18, Botswana Harvard International 2003: 27). Most of the countries in the Sub-Saharan region depend on tourism for their economy, and this region is the most struck by HIV/AIDS in the world. The World Health Organisation's statistics (2004) shows that Botswana is one of the countries with the highest HIV/AIDS prevalence rate in the whole world. Among this population are people working in the tourism

sector, which clearly shows that HIV/AIDS poses threats to Botswana and the entire Southern Africa Tourism sector.

The high prevalence of HIV/AIDS and its continued spread means that a lot need to be done in the fight against the disease. People need to be educated about the disease and encouraged to be actively involved in strategies aiming at minimising its spread. The number of tourism employees lost to AIDS could rise from 40% to 50% of the tourism workforce in a number of companies in Botswana in the next 10 years (Botswana's Department of Tourism Research and Statistics, 2003: 31). According to the Department, HIV/AIDS is already adding between 2% and 6% to salary bills.

It is indicated by the Botswana's Department of Tourism that most of the tourism companies in the country are suffering from HIV/AIDS-induced absenteeism, a decline in the skilled workforce, fall in productivity, increased sickness payments and rising employee benefits costs. The cost of standard forms of benefit like death or disability benefits or a spouse's pension is also expected to double in next five to ten years.

The costs of tourism employment are likely to rise as a result of HIV/AIDS (Botswana. Department of Tourism Research & Statistics 2004: 38). Government is the major employer in many sectors including tourism sector in Botswana. The analysis by the Department of Tourism indicates that HIV/AIDS exacerbates the shortage of tourism skilled labour, leading to an increase in the wages of skilled workers. The Botswana Department of Tourism also depicts that the employment costs of government on tourism are between 36% and 40% of the annual budget. The extent to which it would be affected depends on the proportion of the wage bill paid to skilled workers. The proportion of the tourism skilled workers according to the Department of Tourism in the overall labour force is approximately 20%. Government employs a higher proportion of skilled workers than in the labour force as a whole. The Botswana Department of Tourism indicates that 27% of tourism workers in both the government and private sectors are classified as skilled. It is also indicated that the skilled workers' salaries are on average 2.5 times higher than that of unskilled workers' salaries. With the persistence of HIV/AIDS, this is expected to rise.

HIV/AIDS-related illness and deaths of tourism workers affect employers both by increasing

their costs and reducing revenues. The Department of Tourism in Botswana indicates that employers in the tourism sector spend a lot of money in areas like health care, burial, training and recruitment to replace the sick or dead employees. The process of recruitment and training is costly and time consuming. Revenues are decreased in a number of the tourism organisations because of absenteeism due to illness or attendance of funerals, as well as taking care of the family members who are sick. This is a serious problem because the productive employees spend most of the time off duty attending funerals or taking care of family members who are ill of HIV/AIDS. In a number of cases a number of tourism organisations lose their experienced key workers, who are difficult and to a certain extent impossible to replace. Labour turnover experienced by many tourism organisations leads to employment of less experienced and therefore less productive tourism workforce. This in return results in poor quality service rendered by the affected tourism organisations (Botswana. Department of Tourism Research & Statistics 2004: 38).

The Botswana Human Capital Corporation (2003: 29) in collaboration with the Department of Tourism in Botswana depict that besides the costs of general health care, tourism employers in Botswana are most concerned about HIV/AIDS because there is no simple solution they can buy off the shelf for the pandemic of HIV/AIDS. Furthermore, Human Capital Corporation indicates that the employer is exposed to the legislation placing restrictions on the scope and funding of occupational health care in Botswana and in general. For example the company cannot impose compulsory testing for HIV. The codes of legislation are clear: obligatory testing for HIV constitutes a breach of confidence and can lead to unfair discrimination, with consequences under the Botswana Labour Relations Act. Based on the legislation, the employers are omitted from pre-testing the potential employees during employment process. This poses some problems to the organisations and employers since the chances of employing people who are HIV positive in a country with high prevalence of HIV/AIDS are high.

Botswana's Department of Tourism Research and Statistic Section (2003: 34) indicate that managing risks is an important consideration by most of the tourism companies in Botswana and the entire Southern Africa. A number of tourism employers are providing a funding mechanism for engaging with experienced medical people in Botswana. Individual employees are encouraged to go to the doctors and testing centres to be tested for HIV and the organisations ensure that the medical aid pays, in case of private doctors consulted. The organisations

encourage the employees to register with an AIDS programme, in the event of a positive diagnosis, so that the disease can be managed. Several medical Aids in Botswana are offering this service.

3.8.1 THE IMPACT OF HIV/AIDS ON THE SAVINGS AND INVESTMENT

The impact of HIV/AIDS on the economy such as its impact on the medical expenses also affects the savings both for individuals and businesses. For example, Zimbabwe is faced with the problem of a fall in both domestic and external savings, and investments and physical capital are reduced by factors related to HIV/AIDS. This affects most of the Southern African tourism because there is little or no disposable income for the people to spend on tourism. For example, studies on the macro-economic of HIV/AIDS in Malawi and South Africa reveal that the annual GDP growth rates in these two countries could drop by 1% to 2% points attributed to HIV/AIDS. This indicates that failure to take the appropriate measures to mitigate the impact of HIV/AIDS, may result in a number of countries in Southern Africa encountering serious macro-economic instability and difficulties in future. This could have an adverse impact on investment due to loss of confidence by investors not only in tourism but in general (Lisk, 2002: 11). Reduced savings directly affects investments in small-scale tourism businesses, which are livelihood for many people in Southern Africa.

Majority of people in Sub-Saharan Africa make their living through small-scale or home-based businesses in both the informal and formal sectors (Ramsey *et al.*, 2002: 5). HIV/AIDS has an enormous impact on small businesses including those in tourism sector due to the fact that a number of entrepreneurs either become ill with AIDS themselves or have to take care of their family members who are suffering from HIV/AIDS, and spend plenty of time away from their work, and also spending a lot of money on medical expenses. The risks of business failure and loss of living assets become much higher in these situations.

HIV/AIDS shifts the responsibility of caring for the families to the less productive grandparents who have little or no resources. HIV/AIDS disrupts budgeting and spending plans and makes saving difficult or impossible, because a lot of money is spent on health care, traditional ceremonies and funeral expenditures than on tourism activities (South Africa's Department of Economic Development and Tourism, 2004: 82). On average, the AIDS patients get too sick to

work for six months before death, and the costs of care increase. For example, one third of 1,000 South African companies in 2003 reported that HIV/AIDS had damaged their profit, but it does not cause a run-up in wages in terms of making labour more scarce. The problems encountered include absenteeism due to sickness or attending funerals, workers moral becomes low, jobs go unfilled, and training costs increase. All these variables have direct impact on the investment particularly on countries facing the severe HIV/AIDS prevalence like Botswana.

HIV/AIDS is threatening direct foreign investment in Botswana, “AIDS is definitely one of the factor inhibiting foreign investment – on top of all the structural issues”, said the then Vice President of the Republic of Botswana, Sir Seretse Khama Ian Khama (2003), in a business interview (Anon., 2003 :7). Foreign investment in Botswana is based on the tourism sector. According to the then Vice President of the Republic of Botswana, a number of foreign investors hesitate to invest in Botswana attributed to the HIV/AIDS pandemic. The image of the Botswana Tourism is suffering due to the prevalence of HIV/AIDS. HIV is a double bind for tourism employers and their organisations. The increasing number of ill tourism workers, whose health deteriorates, pushes health care costs high and productivity down.

The Botswana Department of Tourism (2003:21) also states that a number of tourism organisations in Botswana face a problem of over-spending due to the workers who become too sick to work but still have a contract binding the organisation to pay them. This is a challenge because the organisation seeks for a replacement for a sick worker, and will be paying both the sick worker and the one replacing him/her. As a result, the organisation is losing a lot of money.

The Botswana Ministry of Environment, Wildlife and Tourism (2003: 43) states that Botswana’s rich cultural and historical heritage, and abundant wildlife resources provide opportunities for investment in the tourism industry, but HIV/AIDS threatens this investment. However, the government of Botswana encourages the foreign investors to invest on Botswana’s tourism sector. HIV/AIDS threatens the Botswana Tourism sector because it results on investment losses (UNDP, 2000: 22). For example, HIV/AIDS causes a shortage of tourism skilled labour, which results in high wages and rising labour costs such as recruitment and training costs, and due to deaths of skilled workers. In response to the HIV/AIDS problem a number of firms decide to adopt more capital-intensive production techniques, which in most cases causes the rate of investment in physical capital to arise.

Higher tourism labour costs cause the overall profitability of tourism investment to fall, which causes a reduction in tourism investment. Due to the high prevalence of HIV/AIDS in the country, investment in tourism is reduced because firms revise downwards their projections of future demand in line with lower projected Gross Domestic Product (GDP) growth rates. Investment is also strongly influenced by the degree of uncertainty or risk in an economy. Tourism contributes to the economy of Botswana, but HIV/AIDS add to the level of uncertainty in the country's economy by impacting negatively on the sector. Tourism organisations in Botswana are unsure as to whether they will be able to secure the necessary supplies of tourism skilled labour in order to maintain production, given that HIV/AIDS is anticipated to reduce tourism skilled labour supplies in future (UNDP, 2000: 23).

The changes in the level of savings impacts on investment because investment can only be made if there is sufficient amount in savings. Many African countries including Botswana are typically characterised by a shortage of domestic savings and hence a dependence upon foreign savings or capital inflows to finance investment (UNDP, 2000: 43). A reduction in the rate of domestic savings in most of Southern African countries therefore causes overall tourism investment to fall, as access to foreign savings is often highly constrained. Due to high rate of HIV/AIDS prevalence in Southern Africa, and the fact that the costs of dealing with HIV/AIDS are financed from savings, the overall rate of savings and investment deteriorates. Indeed, reduced tourism investment due to reduced savings is the main channel through which HIV/AIDS has a negative impact on the economy of Botswana and the entire Southern African Region and tourism sector in particular.

Botswana's Department of Tourism in (2003: 43) expressed concern about the impact of HIV/AIDS on the rate of growth of tourism consumption expenditure in the country. The department indicates that the tourism growth rate is becoming lower and lower due to HIV/AIDS. HIV/AIDS causes reduction in the population growth rate and in Gross Domestic Product (GDP). Over 70% of death cases in Botswana are caused by HIV/AIDS related diseases and the country is facing a problem of taking care of orphans that result from HIV/AIDS (Botswana's Ministry of Health, 2002).

High death resulting from HIV/AIDS also directly affects the tourism sector through reduced

local market. The impact of HIV/AIDS on demand for tourism in the country is significant since the disease is claiming a high percentage of lives. This in return affects the tourism demand because the people who die of AIDS include the market for tourism. Reduction on the population is a reduction on the tourism market, which also results in lower growth in demand. A number of people spend more money on caring for the orphans left by family members who died of HIV/AIDS. This results in a low demand for tourism because of low disposable income available to spend on tourism. Another concern according to the Ministry of Health is that a number of the orphans are HIV positive, and they need more care and expenses are accumulated. This results in a fall in tourism demand because people do not have both money and time to spend on tourism activities.

The Botswana Central Statistics Office (CSO) (2000: 28) projects that the rate of population growth in Botswana over the next 25 years could fall from 2.8% a year to 0.9% a year under the AIDS scenario. Based on this prediction, it becomes clear that the demand for tourism in the country will deteriorate since the population growth is falling. The Central Statistics Office also indicates that there is a reduction in GDP growth from 4% without AIDS to 2-3% with AIDS. Based on this information, it is evident that tourism consumption growth rates will be much lower in the future as a result of AIDS as compared to the present and the past years. The reduced population growth also affects both availability and quality of tourism workforce.

3.8.2 THE IMPACT OF HIV/AIDS ON TOURISM WORKFORCE

The most significant impact of HIV/AIDS on the general labour is on population growth. This impact has been greatly felt by a number of countries in Sub-Saharan Africa (UNAIDS, 2003: 280). Within this region as already stated in this research, the highest rate of HIV/AIDS is in Southern Africa. The UNAIDS projects that about 36% of the adult population in Botswana, 25% in Zimbabwe and Swaziland, and 20% in South Africa and in Zambia are infected with the HIV virus. This is compared with the HIV/AIDS prevalence rate of 8.4% for Sub-Saharan Africa and 1.2% for the world as a whole. The life expectancy is projected to drop from 60 years to 30 years by 2010 in the seriously affected countries, and the rate of population growth is expected to drop among most of the Southern African countries.

In countries with a higher HIV/AIDS prevalence rate, the impact is expected to be greater than in

countries with lower HIV/AIDS prevalence rate. For example, the Zimbabwean population is projected to be 20% lower than without AIDS by the year 2020 (UNAIDS, 2002: 13). These projections and the available evidence on the impact of HIV/AIDS indicate that the economic and social impact of HIV/AIDS will rise, and cause more damage, especially by killing the young people at their productive ages. This includes workers in the tourism sector.

The impact of HIV/AIDS on the general population structure is a reflection of what damage may be expected in the labour force. Most of the people who die of HIV/AIDS-related illness in Southern Africa in general are the adults in their productive, sexual and reproductive prime. In 1999, 80% of the newly infected people in Rwanda, Tanzania, Uganda and Zimbabwe were between the age of 20 and 49 years (Lisk, 2002: 10). For this reason, the impact of HIV/AIDS on the labour force is even more serious than its impact on the general population. For example, it is projected that by 2020 the Botswana population will be dominated by the old (above 60 years) and the young (under 15 years) people. The loss of young people in their working age, especially those who are between the age of 20 and 49 years, enormously increase the dependency ratio and also affects the work force of a number of economic sectors including tourism.

The population group at risk is the commercial sex workers. Commercial sex workers are more vulnerable to HIV/AIDS than any other workers, and 80% of the commercial sex workers in most areas are HIV positive (Lisk, 2002: 8). In generally, workers who work far away from their homes and in separation with their family members like the long distance truck drivers, train crews, sailors, mining, construction, seasonal workers in agriculture and tourism are particularly vulnerable to the HIV infection. This is because a number of these people engage in commercial sex activities without taking preventive measures. This in return, results in these people being infected with the HIV virus and who later spread the virus to their spouses and to the general public who engage in sexual intercourse with them without using preventive measures.

HIV/AIDS affects many Southern African tourism companies and in general through long and frequent labour absenteeism, lower labour productivity and higher employee benefits (Ellis & Terwin, 2004: 30). These factors have the largest impact on the production side of companies that have been affected by HIV/AIDS. For example, between 60% and 70% of the mining companies and about 50% of the manufacturing companies in South Africa indicate that HIV/AIDS reduces their labour productivity and increases absenteeism among their employees and it leads to higher

employee benefit costs. This could have a similar impact on the tourism companies. A number of companies indicate that the pandemic leads to higher labour turnover rates, lost experience and skills and higher recruitment and training costs. Most South African companies including those in the tourism sector strive to retain their skilled workers, but semi-skilled workers are often casually employed and are likely to move from one area to another to find work.

More than 16% of the South African companies indicated that HIV/AIDS disrupts the supply of goods and services to their customers (Ellis & Terwin, 2004: 36). For most of the companies to meet the supply timeline and volumes and to ensure their ultimate survival, they should find strategies to come to grips with the adverse implications of the pandemic. HIV/AIDS affects companies' employment decision in diverse ways. As already indicated above, lower labour productivity, prolonged absenteeism and high employee benefits and other HIV/AIDS related costs force a number of companies to invest on technology, machinery or equipment in order to shift their dependence from labour. For most of the companies within the service sector like those in tourism sector, appoint and train two employees for the same position (work shadowing) to compensate for the impacts of HIV/AIDS on labour productivity, absenteeism and mortality (Ellis & Terwin, 2004: 37).

Ellis and Terwin (2004: 44) state that 24% of small companies in South Africa indicate that HIV/AIDS increases their demand for labour, and the medium and large companies indicate 40% and 51% respectively. Most large companies experience lower labour productivity or increased absenteeism and higher labour turnover rates due to HIV/AIDS than the smaller companies. This in return affects the service quality rendered to their customers. The large companies realise that their production and service quality may be negatively affected if they do not employ more workers to compensate for the adverse impacts of HIV/AIDS.

HIV/AIDS has now become the leading cause of death in Botswana and in many African countries, with three in five deaths being attributed to HIV/AIDS (Botswana's Ministry of Health 2008: 22). The expectations of life at birth in African countries that are seriously affected have declined by seven years on average and by as much as twenty years in the most severe cases.

The World Health Organisation's report (2005: 28) indicates that in South Africa, Botswana, Namibia, Zambia and Zimbabwe, the life expectancy at birth in 2000-2005 is reported to be

between 20 and 29 years lower than it would have been in the absence of HIV/AIDS. The population in these countries is expected to be 20% smaller than it would have been by the year 2015. However, because of the high fertility levels, the population will still continue to grow. There is an average interval of nine to eleven years between HIV infections and full-blown AIDS.

The Botswana Tourism sector was reported to have high HIV/AIDS prevalence among the tourism workers in 2002, and the estimation in mid 2003 by the Department of Tourism was 15%, or 5% fewer than it would have been without the impact of HIV/AIDS. By the year 2015 the total percentage is expected to reach 30% or 10% lower than it would have been without AIDS (Botswana's Department of Tourism, 2004: 23).

The impact of HIV/AIDS on the Botswana Tourism productivity in general is obviously negative, but what is difficult to determine is the magnitude of that impact. As the disease develops workers suffer from progressively more illness, before they eventually die (UNDP, 2000: 18). HIV/AIDS affects most companies' productivity because workers take time off work because they become ill, and a number of employees' work rate drops because of illness and depression. A number of tourism organisations experience a problem of absenteeism because workers are either sick or attending funerals of family members who die of AIDS related illnesses. Working days are lost because a number of employees take time off to look after their sick relatives and family members attributed to HIV/AIDS. Essentially, all of these effects reduce the supply of tourism labour, and increases its costs.

As already stated in this research, the other channel through which HIV/AIDS affects productivity is through the disruptive effects, which results in frequent replacement of workers. Even if tourism workers who fall sick can be replaced, their replacement does not immediately reach the same levels of productivity (Botswana's Department of Tourism 2004: 25). This effect is more pronounced in Botswana and the entire Southern African tourism sector because on-the-job learning and experience is important. It is difficult or even impossible to replace a highly qualified and experienced worker after he/she dies. This is costly because a lot of time and money is spent in recruitment and training of new workers. As a result, a number of tourism companies in Botswana operate with unqualified workers, which lead to low productivity and poor service rendered.

While the general channels from HIV/AIDS infection to low productivity can be described in detail, quantifying the productivity impact is much more difficult. A lot of information is available about the general level of HIV prevalence in Botswana, but less information is available about prevalence rates in different sections of the tourism labour force.

Botswana's Ministry of Health (2000: 17) states that Botswana has reasonable good data on overall prevalence rate and on prevalence by age group. There is data on prevalence rates by geographical locations, derived from testing centres in different towns, but even this does not provide reliable information on differences in urban and rural prevalence rates as many of those tested in urban centres are drawn from surrounding rural areas.

The Botswana Tourism Sector is characterised by a shortage of skilled workers, and the high HIV infection rates in the country in general exacerbates the skills shortage with potentially adverse effects on economic output and growth (Botswana's Department of Tourism 2003: 13). The extent to which HIV/AIDS affects the tourism labour force depends on the response of firms and the government. At the same time, Botswana is characterised by extensive employment, and hence large proportion of the unskilled tourism labour force has a marginal productivity that is close to zero. HIV/AIDS infection amongst this segment of the tourism labour force is more likely to reduce the unemployment rate.

Besides a lack of information on prevalence rates in different segments of the tourism labour force, there is also uncertainty on surrounding the impact of HIV/AIDS infection on the productivity of those tourism workers who are infected. The impact depends partly on the duration of the disease. However, developed countries have relatively extensive information on the impact of HIV/AIDS on productivity than developing countries where the incubation period could be shorter (Botswana Harvard International, 2003: 23). In situation in which an HIV patient has to lose 250 days of work between infection and death for example, the productivity loss of 20% is expected in case the period from infection to death is 5 years, but only 10% of the period in 10 years (on the basis of 250 working days a year).

TABLE 3.41: CLASSIFICATION OF TOURISM WORKFORCE

SKILLED	UNSKILLED
Administrators and General Managers	Clerks
Professional Tourist Guides	Receptionists
Marketing Managers	Cleaners
Technicians	Drivers
Chefs	Gardeners

(Source: Botswana's Ministry of Environment, Wildlife and Tourism, 2003).

3.8.3 THE LOSS OF SKILLED WORKERS

Over (2001: 53) indicates that HIV/AIDS affects the tourism of any country with high prevalence rate by disrupting the human resources available in the country. The human resources of a country are provided by the size and quality of its labour force, and HIV/AIDS affects both. HIV/AIDS affects the size and productivity of the tourism labour force because of mortality and morbidity. Tourism employees who die of HIV/AIDS-related illness do not only represent losses in productivity, but also losses in terms of knowledge and experience they possess.

HIV/AIDS negatively affects tourism workforce in many Southern African countries. For example, the High morbidity among the tourism sector in Zimbabwe reduces the country's tourism labour productivity, for example, a number of companies in the tourism sector are reported to have a high rate of staff turnover, high health costs and the need to educate their employees about the pandemic and preventive measures. HIV/AIDS also poses a threat on the future human capital in the country (Over, 2001: 53). The high death rate in Zimbabwe means that the country is faced with an increased number of AIDS orphans who are less likely to fully develop their physical and intellectual capabilities due to poverty. This in return may affect the future prospective of the country's tourism and other sectors.

Lisk (2002: 8) indicates that most of the people struck by HIV/AIDS in Namibia are between the age of 15 and 49. A number of these people within these age ranges work in the tourism sector.

The impact of HIV/AIDS is significant not only on tourism workers and their families, but on general enterprises and on national economy. HIV/AIDS has become a major threat to employment objectives and to the labour market efficiency in Namibia. The loss of tourism workers and work-days linked to HIV/AIDS-related illness and the cost of taking care of the ill workers and their families all contribute to low productivity, loss of earnings, and loss of skills and experience in a number of tourism companies in the country.

HIV/AIDS changes the age and gender distribution of tourism labour force, and increases the number of women, children and elderly people who face the economic challenges. A number of the tourism companies in Namibia employ young people who do not have the experience, and other companies employ old people who are not active to work. The impact of HIV/AIDS on employment and on the labour market is a major concern for the International Labour Organisation (Lisk, 2002: 8). Another major concern by the International Labour Organisation is the discrimination against workers and people who are infected with the HIV virus at the work place.

Ramsey *et al.* (200: 5) argue that the majority of African countries have a small number of skilled workforce to manage the economy and to provide services to the public both in the government and private sectors. In a number of African countries, health, education, police and army are the government sectors most struck by HIV/AIDS pandemic. The countries with a high HIV/AIDS prevalence rate are losing their skilled workers to HIV/AIDS. In the year 2000, 12% of educators in South Africa were projected to be HIV positive and in Botswana 4% of children had lost a school teacher to AIDS. In Zambia, death among health workers has increased 13 folds between 1980 and 1990 as a result of the HIV/AIDS pandemic. The loss of skilled workers greatly reduces the quality of basic services that the government can provide and its contribution to the rising costs of accessing infrastructure, increasing the cycle of poverty in areas affected by the AIDS pandemic. It is also difficult and expensive to replace these skilled employees who die of AIDS.

HIV/AIDS lowers the average age of the tourism labour force due to the impact in Botswana. Even assuming the same labour force participation rates, the median age of the labour force would be reduced by as much as two years by the year 2020, implying an increasing proportion of younger age group in the tourism labour force and other sectors in general (Botswana's Department of Tourism Research and Statistics, 2004: 33).

Little is known of the impact of HIV/AIDS on the quality of the labour force in terms of education, training and experiences. However, it is probable that HIV/AIDS will have a severe impact on these factors, particularly in view of the effect of HIV/AIDS on the education sector, in selected Southern African countries, where it is reducing the number of teachers and tourism trainers like lecturers, and leading to a rise in early school drop-out rates for students whose parents die of AIDS. This results in low number of tourism-trained people in the Southern African countries. HIV/AIDS is therefore likely to have profound effects, not only on the size, but also on the composition and quality of the tourism labour force in Botswana and the entire Southern Africa (Botswana. Department of Tourism 2004: 26).

The Department of Tourism in Botswana further indicates that a number of tourism organisations in Botswana experience the problem of losing a number of their key workers. In view of these factors, many companies have already begun to hire or train two or three employees for the same position. This is done in fear that employees in key positions may be lost due HIV/AIDS. A number of tourism organisations in Botswana replace their loss of key employees by importing tourism labour from South Africa and other neighbouring countries, at the risk of creating a bigger immigrant sub-population, which is often more vulnerable to HIV/AIDS infection.

HIV/AIDS has led to increased demands for spending for health and social welfare, and the costs of insurance benefits for households, companies and government have increased. Many organisations have reported a doubling of medical expenses over a five-year period; while tourism employees who fall ill have to divert their savings into their medical care. Greater claims are being made on group life insurance and health schemes (Botswana's Ministry of Health, 2003:17).

South African tourism companies and multinationals provide anti-retroviral drugs to infected employees. Distributing these drugs safely is expensive, and the alternative is to let workers fall sick and die. South African government started providing anti-AIDS drugs like antiretroviral (ARV) to the general public in 2004 but at a few dozen public clinics. The South African government predicts that HIV/AIDS may reduce a small percentage point off the annual GDP growth. It is expensive to treat sick doctors, accountants, civil servants and the general skilled workers, but it is cheaper than waiting for a new generation because a number of them are AIDS

orphans and do not have education and training skills. HIV/AIDS drugs do not cure the pandemic but lessen its impact (South Africa. Department of Economic Development and Tourism, 2004: 83).

3.8.4 TRAINING AND RECRUITMENT COSTS

The fact that HIV/AIDS kills many people and results in many tourism employees having to leave their jobs leaves many tourism companies with no options but to recruit and train new employees. HIV/AIDS kills young working adults, and this generally affects the Botswana and other African economy and productivity. The specific impacts on the business depends on the benefit package offered by the individual companies to their employees but it involves: absenteeism, hiring replacement workers, costs of treatment and funerals, reduced productivity, retraining of workers and providing family pensions. The study of 15 companies in Ethiopia over a five-year period indicates that 53% of all illness among workers is AIDS related (Ramsey *et al.*, 2002: 5). In Zimbabwe, the law was passed that funerals should only be held on weekends as the large number of funerals is intruding the economic activities.

The Botswana Tourism Sector faces costs arising from the AIDS related mortality, and the loss of trained worker who are expensive and difficult to replace. It is difficult and expensive for a number of organisations to replace an experienced person in case of death. Projections by the National Development Plan in collaboration with the Department of Tourism (2003) are that adult mortality (age 15-49) might increase by as much as 40 deaths per thousands adults per annum. This will lead to an increase in training costs since the skills imported would be lost. Both the Government and private sectors need to train more than the usual number of people in order to compensate for those who die either during their training, or during their period of service following the training, when the skills are being put to use. This increases the costs as excess people are trained as part of contingency plan.

The amount of extra training required depends upon the length of the training course, and the length of time for which the government or the private tourism organisation would expect to benefit from the skills provided. The aims and objectives of the Botswana Tourism Sector are to provide quality service to the clients and compete globally, which require proper training in excellent schools. For example, the Department of Tourism indicates that a first degree course

lasting four years might be expected to be followed by four years of service by employee concerned. This is a total of eight years. The number of people dying of AIDS over an eight year period is compounded – and amounts to about 220 per thousands (Botswana National Development Plan 2003: 31).

Training and recruitment cost as a result of HIV/AIDS does not only affect the Botswana tourism sector but a number of other Southern African countries. For example, the concern for the Namibian Tourism Board includes the costs of new recruitments which are projected that 15 new recruits per 1000 employees per year would be expected as a result of HIV/AIDS related cases. The total costs of this extra recruitment excluding training are not expected to be sufficiently large to justify an independent estimate. The problem facing many tourism organisations in Namibia with regard to new recruits is the fact that new recruits tend to be less productive when they start to work, so there is a hidden cost in inefficiency resulting from an increased staff turnover. Operating the tourism business with new and inexperienced employee often results in poor service rendered by organisations and lack of competitiveness in the global market by the Namibia Tourism Sector. This could be the same case with a number of Southern African countries (Namibia. Tourism Board, 2004: 21).

The effects on the individual tourism organisation depend upon the degree of employment of skilled workers. This could be expected to have the greatest impact on the bigger tourism organisations, which are major skilled workers' employers. The other impact pointed out by the Namibian Tourism Board is the fact that there is an increase in death benefits and funeral expenses facing the tourism sector both in the government and private sectors. This results from an increased mortality rate among employees. This could however be significantly offset by savings in pension costs resulting for the earlier mortality of employees.

The Botswana National Development Plan projections (2003: 33) indicated that pension liabilities are expected to be about 9.8% of the bill for personnel emoluments, or about 3.7% of the recruitment budget. This poses problems to a number of tourism organisations in the country and the entire Southern African Region, especially the small organisations that are still at their infancy stage. It is further indicated that the savings only apply under the present defined benefit schemes. In responding to this problem, a number of organisation including government departments work in collaboration with insurance companies providing the annuity in the short

term, and encourage employees to have life insurance. The fact that HIV/AIDS is the leading cause of death in the general population means that it also has impact on the tourism customer base.

3.8.5 IMPACT OF HIV/AIDS ON TOURISM CUSTOMER BASE

The HIV/AIDS problem in Botswana is forcing tour operators to restructure their businesses and expand into new markets because their local market base is shrinking (Botswana's Department of Research and Statistics, 2008: 27). Tour operators targeting lower-income emerging market consumers are most at risk in the face of increasing AIDS deaths, which will cut population forecast to 1.3 million by 2010 instead of the 2 million projected by population census (2001) under a non-AIDS scenario.

Besides the impact of HIV/AIDS on the population growth in general, the HIV/AIDS pandemic is expected to reduce Botswana's GDP growth rates by an average of 0.5% to 0.6% a year over the next 10 years (HATAB, 2004: 14). Other figures put the expected GDP reduction as high as 1.7% a year.

HATAB, which owns a significant share of Botswana's tourism, is reducing its risk profile by extending the tourism business market from areas of high HIV/AIDS prevalence like the Sub-Saharan region to other global market. HIV/AIDS also influences HATAB's decision to create additional income streams such as its joint venture with the Department of Wildlife, Department of Customs and the 2003 formulation of Botswana Ministry of Tourism. The Association's strategy is based on a study commissioned a few years ago. The study highlighted the HATAB specific costs effects, such as a 65% decline in operating profit for selected tourism organisations stemming from payroll increases due to AIDS (HATAB, 2004: 14).

The impact of HIV/AIDS on the tourism sector is also significant on the reduced customer base. Significant shift in the customer base is on the age profile. It is projected that HIV/AIDS would have reduced the tourism target market by 21.8% in the year 2015 (HATAB, 2004: 17). Early reaction to these projected trends will safeguard Botswana and the other affected Southern African countries' tourism value in a struggling market.

The Botswana tourism market is both local and internationally based, and with the prevalence of HIV/AIDS, the country is likely to lose a high percentage of the market especially in countries in which individuals cannot afford antiretroviral drug. This means that the tourism market in the country could be deteriorating because individuals who should participate on tourism activities as clients would have to support families and orphans. Many people in foreign countries face internal cost problems such as training and health insurance. People in Botswana are the exception to the problem because the Government of Botswana through the Ministry of Health offers antiretroviral drug free of charge to the public.

Ellis and Terwin (2004: 44) state that most South African companies indicate that the HIV/AIDS pandemic has had little impact on the demand for their products and services. Most of the companies have not conducted any research to establish the impact of HIV/AIDS on their consumer base or target market. It is also indicated by many companies that HIV/AIDS does not adversely affect the decision to invest in South Africa. HIV/AIDS puts profitability under pressure, not only because of its induced cost increase, but because it reduces the size of a company's target market and therefore reduces sales when compared to a non-AIDS scenario. A number of companies in Kwazulu-Natal and Gauteng indicate that HIV/AIDS imposes high threats on their profits. HIV/AIDS does not only affect the profitability and tourism customer base but it also affects the image of the tourism sector in the country through its negative impact on the service quality.

Despite the fact that HIV/AIDS affects the viability of the communities it attacks, it is possible to mitigate its spread, and there are success stories reported in selected African countries and in general (Villarreal, 2006: 205). For example, it is reported that the HIV/AIDS prevalence rate in Uganda dramatically increased during the 1990s with a projected 15% of the country's population infected. In fighting the spread of HIV/AIDS, Uganda engaged in a massive collaborative strategy such as mobilising communities and working closely with people infected with HIV/AIDS, innovative communication techniques, and collectively fighting discrimination against people living with HIV/AIDS. Through this strategy, the country saw tremendous reduction of HIV/AIDS new infection rate. The other country that successfully applied extensive strategy similar to that of Uganda is Thailand. Both Uganda and Thailand governments are reported to have relatively managed to reduce the HIV/AIDS infection rate in their countries than most of the countries because they were proactive by engaging all the sectors and communities to

fight the spread of HIV/AIDS collectively (Villarreal, 2006: 205).

The success stories of Uganda and Thailand indicate that HIV/AIDS needs not be a death sentence in communities and that with the collaborative efforts the spread of HIV/AIDS can be reduced. This also shows that to fight HIV/AIDS, the systematic strategic approach is essential. The researcher therefore recommends that the Botswana major economic sectors such as mining, tourism, agriculture and community in general should work together in fighting the spread of HIV/AIDS and its socio-economic impact in the country. This is because a systematic approach may help the government and a number of major economic sectors to be proactive rather than to be reactive in fighting the spread of HIV/AIDS. This means that both the Botswana government and general communities need to work closely in combating HIV/AIDS. The tourism sector including the tourism businesses in the private sector should play an active role in fighting HIV/AIDS. Benchmarking the strategies used by other countries such as those sharing borders with Botswana is also imperative.

3.9 SUMMARY

This chapter focused on the general literature related to the impact of HIV/AIDS on the tourism sector. Factors discussed in this chapter included operation of terms in the study, community tourism, sustainable tourism development, pro-poor tourism, and the general socioeconomic impact of HIV/AIDS. The other factors discussed in this chapter the impact of HIV/AIDS on the economic growth, the impact of HIV/AIDS on the tourism sector, the impact of HIV/AIDS on the savings and investment. The impact of HIV/AIDS on tourism workforces, the loss of skilled workers, training and recruitment costs, and impact of HIV/AIDS on tourism customer base were also discussed in this chapter. Also discussed in this chapter include the overview of Botswana's economy, the Botswana formal education system, economic growth, major economic sectors, trading in Botswana and international relations, investment environment in Botswana, an overview of HIV/AIDS situation in Botswana. An overview of HIV/AIDS orphans in Botswana, the impact of HIV/AIDS on the Botswana tourism sector, the socioeconomic impact of HIV/AIDS in Botswana, impact of HIV/AIDS on the image of the Botswana tourism, the Botswana HIV/AIDS policy, and the Botswana tourism sector's response to the impact of HIV/AIDS, general overview of HIV/AIDS in Africa and in the rest of the world, and the

general impact of HIV/AIDS, and the impact of HIV/AIDS in the tourism sector in general are among factors discussed in this chapter.

Botswana boasts one of the fastest economic growths in Africa, and the country's economy is largely dependent on natural mineral resources and its booming tourism sector. The Botswana's economy is faced with challenges such as poverty, which leads to population migration putting pressure on social services such as health care, and the high prevalence of HIV/AIDS. Botswana's economy needs to be diversified from depending largely on mineral mining. The prevalence rate of HIV/AIDS in various regions and countries is high and escalating. The Southern African region is the most vulnerable to the disease. Strategic HIV/AIDS interventions in various countries as indicated in chapter 3 do not include the private sectors in the tourism sector. This research, though focusing on Botswana, recommends ways in which the tourism companies particularly in the private sector can get involved in the fight against HIV/AIDS.

The following chapter focuses on the research methodology used in this study.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 INTRODUCTION

Research can be categorised under the following four types: reporting, description, explanation and prediction. Research involves the application of scientific methods in generating relevant information to solve an existing or anticipated problem (Emory & Cooper, 1991: 14; Welman & Kruger, 2001: 2).

Research involves formulating a hypothesis, collecting and analysing information to conclude whether the formulated hypothesis holds the truth. Besides finding the truth about the formulated hypothesis, research is often conducted to make suggestions in solving a particular problem. A hypothesis refers to a possible answer and possible correlation between two or more components that needs to be evaluated (Welman & Kruger, 2001: 11). A hypothesis is a possible answer to a research problem and questions that the researcher should investigate.

In conducting this research, an extensive literature review on the socio-economic impact of HIV/AIDS in Botswana was conducted.

Factors covered in this chapter include the research problem, research objectives, literature review, research variables, types of research and research methods. Figure 4.1 below depicts factors covered in this chapter.

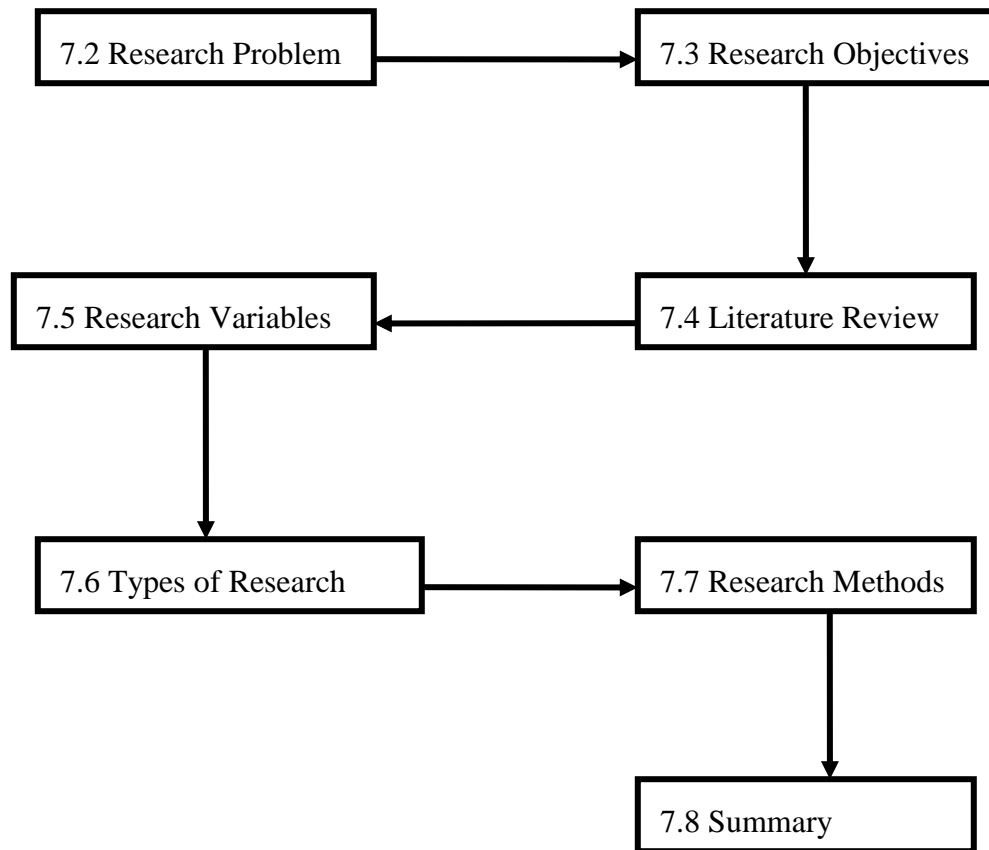


FIGURE 4.1: RESEARCH METHODOLOGY

4.2 RESEARCH PROBLEM

As already indicated in this thesis, a social research project should aim at addressing a particular research problem (Blaikie, 2003: 11; Cooper & Schindler, 2003: 5; Welman & Kruger, 2001: 11). For the research problem to be amicably addressed, the research key questions and objectives should be clearly stipulated so that scientific methods can be used to investigate the research problem focusing on research questions and objectives. The research questions and objectives should lay a foundation for the scientific research. The purpose of the scientific research is to increase the knowledge essential to strategically solve certain problems.

4.3 RESEARCH OBJECTIVES

It is imperative for the researchers to indicate the research objectives before attempting to analyse and solve the research problem (Blaikie, 2003: 10).

The general aim of research is to find out answers to key questions using scientific process and measures, and also to discover the facts that may not be known by the researcher and community (Kothari, 1990: 2). However, each research serves a unique purpose.

4.4 LITERATURE REVIEW

The purpose of reviewing literature is to identify gaps in previously researched problems so that the new research can fill those gaps. Literature review is imperative because it indicates to the researcher how much is known about the problem. However, literature review should be relevant to the topic and problem researched. In conducting this research, an extensive literature review including study of relevant books, journal articles, academic papers, official reports, government policy such as HIV/AIDS legislation and subordinate legislation, official publications and other policy documents and unpublished materials were used.

4.5 RESEARCH VARIABLES

McBurney (1994: 63) defines variables as measurable characteristics of research phenomena. It is imperative for the researcher to identify the research variables before commencing with research so that the research can be focused on specific aspects of the research problem. In conducting a scientific research, the relationship between research variables should be identified and assessed. Variables are linked to the available literature or theory regarding the research problem. The relationship between research variables is an important consideration to prove or disprove the viability of certain theory that stimulates or motivate the researcher to conduct the research.

It is imperative for scientific researchers to understand different features associated with research variables so that formidable research can be conducted (Welman & Kruger, 2001: 13). In scientific research, variables are usually classified as either dependent or independent variables.

The dependent variable refers to the variable that is used to measure the response of the research subject. Dependent variables depend or are often influenced by independent variables. Independent variables are variables that stimulate or influence changes in the status of dependent variables. In scientific research, the independent variable is regarded as cause, and dependent variable is regarded as an effect. Research variables can also be distinguished as either quantitative or categorical variables. A quantitative variable is a variable that differs in terms of quantity or amount, and a categorical variable is a variable that differs in terms of classification or quality (McBurney, 1994: 64).

For the purpose of this research, the research objects refers to the individual stakeholders in the Botswana's tourism sector and the extent to which they are affected by HIV/AIDS. This also refers to the way the Botswana socio-economic environment is affected by HIV/AIDS in general. A number of variables contributing to the spread of HIV/AIDS in Botswana have been identified in this research. These variables include ignorance, gender inequality, poverty, and population migration. The other variable affecting the Botswana's tourism sector is workers' absenteeism, which results from the impact of HIV/AIDS and population migration.

Poverty influences the spread of HIV/AIDS particularly among young ladies through activities such as commercial sex work. It is reported that a number of young ladies particularly in selected rural areas of Botswana and a number of African countries are not given adequate formal education opportunities given to their male counterparts by their parents. This in return creates unemployment because these ladies do not have the necessary skills to acquire employment in formal sectors. Unemployment also exacerbates levels of poverty in selected societies in Botswana and in a number of African countries. It is reported that a number of unemployed young ladies often engage in either relationships with older men or in worst scenarios, they engage in commercial sex work as a desperate measure to fight poverty, and this exposes young ladies to HIV/AIDS.

Gender inequality is reported to be a problem in selected communities in Botswana and a number of African countries. In selected societies in Botswana and a number of African countries, women and children particularly girls often do domestic work and do not have formal education opportunities available to men. Women rarely occupy senior management positions available to men. This is relevant to the Botswana tourism sector which is also located in remote areas such as

the Okavango Delta. The other variable contributing to the spread of HIV/AIDS in Botswana is the fact that a number of people are reluctant to change their risky sexual behaviour irrespective of efforts made by the Botswana government in educating its population about the disease.

The other challenge facing Botswana and a number of African countries in fighting the spread of HIV/AIDS is population migration. An example of population migration that puts pressure on Botswana and her neighbouring states such as South Africa is that of people migrating from Zimbabwe as a result of poverty and political instability in the country. The researcher does not say people from Zimbabwe are spreading HIV/AIDS, but the population migration itself has an influence on the spread of HIV/AIDS because during population migration people interact and socialise including engaging in sexual intercourse. When preventive measures such as the use of condoms are not applied during sexual intercourse, there is a high risk of contracting and spreading HIV/AIDS. This is relevant to the Botswana’s tourism sector because a number of tourism workers in the country are migrants from different parts of the country and across the borders. The worrying factor is that a number of migrant tourism workers in Botswana are married people who leave their spouses at home, and when they get ill or go on leave, they may infect their spouse, which gradually exacerbates the spread of the disease in the community. The purpose of this research is therefore to explore possible strategies to address gaps indicated by these variables.

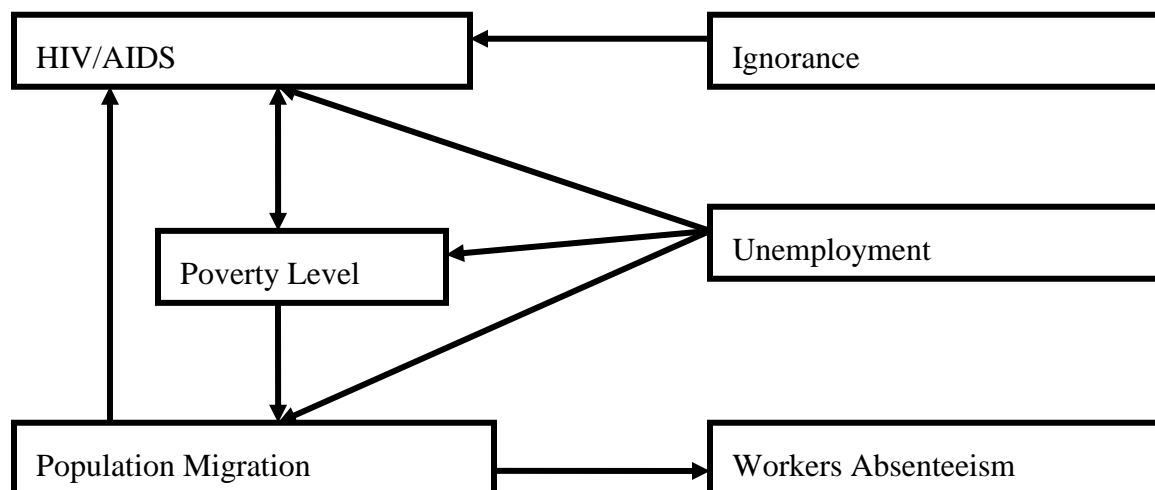


FIGURE 4.2: RESEARCH VARIABLES

(Source: compiled based on information provided by Botswana’s Ministry of Health, 2008, Botswana’s Department of Tourism, 2009).

For the purpose of this research, the abovementioned variables are categorised into independent and dependent variables. In this research, HIV/AIDS is categorised as an independent variable because the disease itself is natural and because it influences other variables such as poverty level, population migration and tourism workers' absenteeism. However, the spread of HIV/AIDS is categorised as a dependent variable because it depends on the other variables such as ignorance, gender inequality and population migration. HIV/AIDS increases the level of poverty in society through various mechanisms such as killing family breadwinners. Poverty in return influences population migration, which contributes to the spread of HIV/AIDS. In this research, population migration is divided into two categories, namely; people who migrate from across the borders of Botswana from neighbouring countries and abroad, and people who migrate from various parts of the country to look for employment in sectors such as tourism. In this circumstance, population migration and poverty are dependent variable because they are both affected by the spread of HIV/AIDS. The more HIV/AIDS spread in communities, the more people become poor, and the more people become poor, the more they disperse, which also exacerbates the spread of HIV/AIDS.

Ignorance and gender inequality are categorised as independent variable because they are not influenced by any of the identified variable in figure 4.2. One of the major impacts of HIV/AIDS on the Botswana tourism is workers absenteeism, which affects a number of companies' productivity. Worker absenteeism is influenced by the fact that most of the people working in the Botswana's tourism sector are migrants. In case of illness or a funeral of a family member or colleague, affected migrant workers spend long time out of work because they have to travel long distances back to their homes. In this regards, workers' absenteeism is a dependent variable because it is influenced by migrant workers' distance from home, illness and death rate resulting from HIV/AIDS. HIV/AIDS threatens the economy of Botswana by killing people working in the tourism sector and other major economic sectors such as mining. This research focused on the impact of HIV/AIDS on the Botswana tourism sector by investigating variables stipulated by figure 4.2 above.

4.6 TYPES OF RESEARCH

The various scientific research types often used in the business environment include: reporting study, descriptive study, explanatory study and predictive study (Cooper & Schindler, 2003: 10). These types are compared two at a time. Reporting study implies that the researcher only indicates a brief summary of collected data for the purpose of statistics (Cooper & Schindler, 2003: 10).

A descriptive study refers to the research that intends to provide comprehensive answers to the research questions based on the research problem and sub-problems. It generates data, identifies variables and evaluates the implication of the findings. The descriptive method also gives the researcher the opportunity to evaluate variables regardless of the research circumstance or environment (Mitchell & Jolley, 1992: 413). This method can be applied without having to manipulate the research variables. With descriptive research method, the researcher is able to identify the relationship between various research variables. This research method is suitable for this research because it evaluates the relationship between identified variables in relation to the spread of HIV/AIDS in Botswana and its socio-economic impact on the country's tourism sector.

This research is also an action research because it encourages innovation based on the quality and reliability of data it generates (Somekh, 2006: 18). Action research encourages changes in the society and is an essential research methodology for this research because it supports systemic changes, which is vital important in fighting the spread of HIV/AIDS in Botswana. Systemic change or approach implies that individual and groups should work together either as socio-cultural, political or as economic structures (Somekh, 2006: 19). This method is relevant to this research because the fight against the spread and impact of HIV/AIDS is a complex issue that requires a systemic approach involving various economic sectors and communities. Part of this research included an experiment that tests the viability of the proposed strategies (normative model) of fighting the spread of HIV/AIDS in the Botswana tourism sector.

Explanatory research on the other hand states the research situation and gives reasons why the research problem prevails. The research that evaluates the relationship between various variables is known as correlation study (Cooper & Schindler, 2003: 11). Before any conclusion can be

made, the research hypothesis should be tested against literature and empirical survey results.

Predictive study is based on available literature or theory and it gives an explanation of a situation based on future projections. The researcher using this type of research attempts to gain control over a situation through application of certain scenarios and projected outcomes.

Kothari (1990: 3) identifies and compares various types of research as shown in figure 4.3 below:

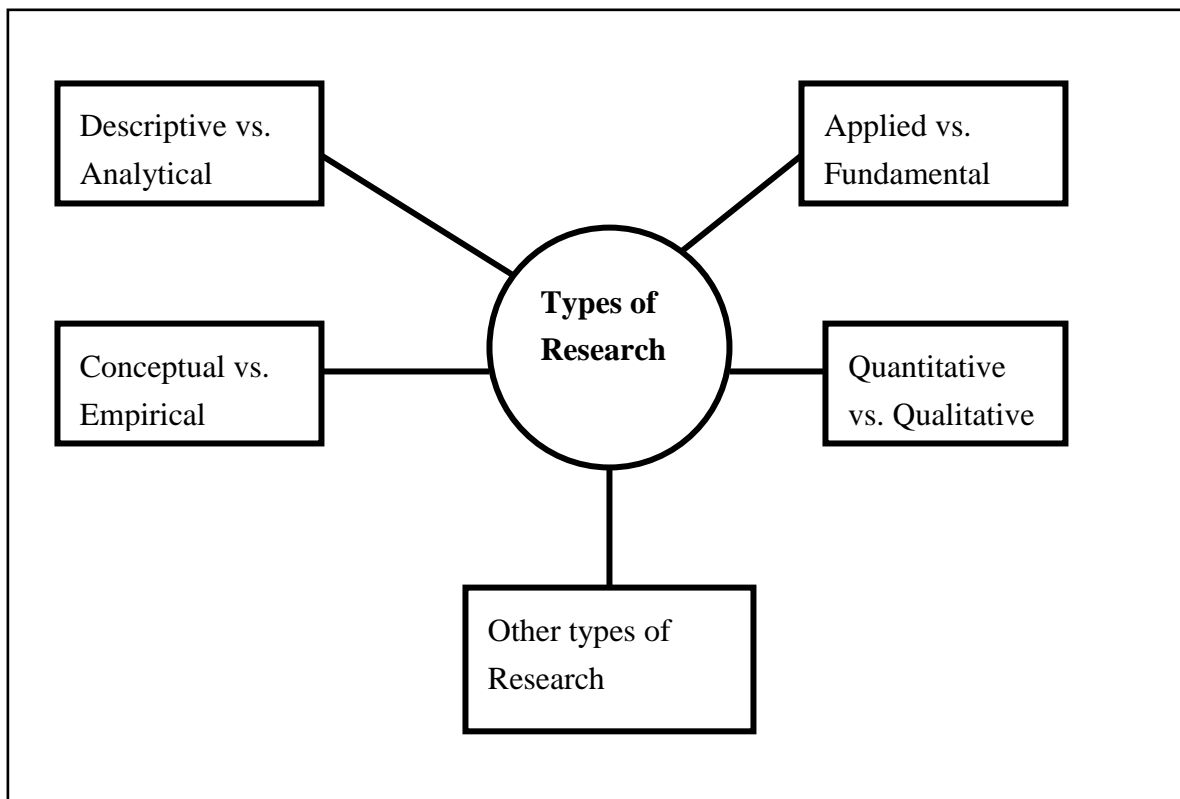


FIGURE 4.3: TYPES OF RESEARCH

Descriptive research involves surveys and obtaining the facts of various types related to the research problem. As already indicated by Cooper and Schindler (2003:11) in the above section, the purpose of descriptive research is to explain a particular situation or research problem as it exists. In case of both social science and business research, descriptive research is referred to as Ex post facto research. In a descriptive research the researcher cannot control the research variables, but can only report on the existing problem. However, the researcher can identify the causes of the research problem.

The analytical research on the other hand requires the researcher to analyse and critical evaluate the research problem based on the available data (Kothari, 1990: 3).

The scientific research can either be applied (action) or fundamental (basic) in nature. In conducting a scientific research, the researcher can either use quantitative or qualitative research type or methods. Quantitative research refers to the research that is focused on figures or quantity, and qualitative research focuses on quality. In qualitative research, interviews are often used as a mechanism to find out reasons and individuals' views on why certain things happen in a particular way or why people portray certain behaviour (Kothari, 1990: 13). Qualitative research type is suitable when the intention of the researcher is to get people's attitude or their views on the research problem or topic. Qualitative research is essential for the research aiming at discovering and analysing various components that stimulate or influence population behaviour. The scientific research can be classified as field-setting research, laboratory research or simulation research, depending on the environment in which it is taking place. The scientific research is often classified as exploratory or formalised format. The aim of exploratory research is to establish the research hypothesis but formalised research aims to test the research hypothesis. The purpose of the scientific research is usual to make certain decisions and conclusions. In conducting a conclusion-related research, the researcher should identify the research problem and investigate it. The decision-based research is often used for the purpose of making certain decisions but the researcher is limited in terms of how the research should be conducted.

In scientific research, descriptive and diagnostic research methods usually have similar characteristics and are often put under the same category (Kothari, 1990: 47). Both descriptive and diagnostic research methods require the researcher to clearly define what is measured based on the population sample and suitable methods of data collection.

The research approaches that are often used in scientific research are quantitative approach and qualitative approach. Qualitative approach is based on getting and assessing population views, attitudes, opinions and behaviour. The main focus of qualitative approach is on individual' impression, and information gathered through this research approach is usually not quantifiable because it is based on quality or views not on quantity. The technique often used in conducting

research using qualitative approach is the focus group interviews, projective techniques and depth interviews (Kothari, 1990: 6). Quantitative approach, as already indicated above, implies the researcher gathering and analysing information based on quantity or numbers. Quantitative research is also referred to as inferential, experimental and simulation approach to research. The aim of inferential approach in scientific research is to establish a data base in which features or relationship of population can be inferred. This is often done through survey research in which a sample of population is questioned or observed to identify certain behaviour. Experimental approach is conducted in such a way that the researcher has control over variables, and in simulation approach the researcher can create a research situation or circumstance and gather the needed information based on the research environment or situation. This allows an observation of the changing behaviour of a system under controlled situations. Simulation approach is imperative in constructing normative models for understanding future situations.

Applied research focuses on identifying a solution to the existing research problem facing the society or business sectors. Applied research refers to the researches focusing on identifying social and economic trends that have an impact on a certain society or sector (Kothari, 1990: 4). This research type is suitable to this current research because it investigates the impact of HIV/AIDS on the Botswana tourism sector. Contrary to the applied research, fundamental research focuses on compiling theory about the problem but not on providing solution to the research problem. In summary, the focal point of applied research is to come up with solution to an existing problem, whereas fundamental research aims at expanding the existing scientific knowledge through information gathering.

Research can also be either conceptual or empirical. Conceptual research refers to the research associated with abstract views or theory. It is often used by researchers to establish new concepts or to describe an existing concept. Contrary to conceptual research, empirical research is dependent on experience or observation of the situation but not on theory. It is based on data collected, and conclusions are often made according to verification which is based on observation or experiment. In conducting empirical research, it is imperative for the researcher to gather the necessary facts regarding the research hypothesis and use the facts to test the research hypothesis (Kothari, 1990: 4). Empirical research is also essential in identifying and analysing the relationship between various research variables.

Figure 4.3 also refers to the types of research that vary according to any of the above research types. Other types of research are often based on various factors such as aims of research, duration of research the environment or circumstances in which the research is taking place, and any other influential components. Based on time factor, research can be classified as either one-time research or longitudinal research. One-time research refers to the research that is conducted at one time-period and longitudinal research refers to the research that is conducted several times-periods (Kothari, 1990: 5).

Research can also be identified as clinical or diagnostic research, and this refers to the research that follows case-study methods or detailed process to identify the core causal relations. Such researches often go deep into the cause of the research problem using small samples in gathering detailed information (Kothari, 1990: 5)

After considering various types of research, the researcher selected descriptive, applied research and quantitative approach. Descriptive research is suitable for this research because the primary objective of this study is to describe the HIV situation and its impact on the socio-economic environment in Botswana with special reference to tourism. Descriptive research should include surveys and fact finding process of various types (Kothari, 1990: 3). Descriptive research helps the researcher to describe prevailing circumstances. As already stated above, descriptive research is used in this research to describe the HIV/AIDS situation in Botswana and its impact on the country's tourism sector and in general. The method used to gather information in this research is survey questionnaires. The limitation facing the researcher using descriptive research is the fact that the researcher has no control over the variables, but can only report what is happening. The research problem and topic together with the nature or type of research prove that it is imperative to use applied research so that recommendations in solving the impact of HIV/AIDS in the Botswana tourism sector can be made profoundly. This is an applied research because of its conclusions and recommended solutions. This is also an applied research because it aims not only at describing the socio-economic impact of HIV/AIDS but also at coming up with a number of strategic recommendations suitable to solve the spread of HIV/AIDS in the Botswana's tourism sector.

This is a quantitative research because it is based on the quantity or numbers of respondents who answer the questionnaire in a particular way. This research uses questionnaires drafted by the

researcher in conjunction with the supervisor and registered statistician.

Quantitative research questionnaire requires respondents to choose the answer they find suitable to the question and the analysis of quantitative research is based on the number of people who answered a question in a particular way.

Non-probability (snowballing) sampling method was used to identify respondents in their respective organisations and departments.

Besides this research being descriptive in nature, it is also a diagnostic research.

4.6.1 SAMPLING

To draw a meaningful sample for this study, general managers/ Chief Executive Officers (CEOs) in tourism companies were approached and asked to make referral (snowballing sampling) of possible respondents to the confidential questionnaire. This is called snowballing sampling. Thus non-probability sampling procedure was applied in this study. The reason for choosing non-probability method as opposed to probability sampling method is that generally, there is no sampling frame or list of managers in Botswana in which the names of possible respondents can be drawn. The other reason is due to the fact that HIV/AIDS is a sensitive issue, and the respondents may feel uncomfortable to respond to HIV/AIDS related questionnaire from a stranger. The respondents may feel more comfortable when asked by their managers/CEOs to respond to the questionnaire.

Tourism managers who participated in the research survey were derived according to their various departments in their respective organisations irrespective of their gender. There are a total of 69 registered tourism organisations in Kasane and a total of 172 registered tourism organisations in Maun. This research targeted all tourism managers from all registered tourism organisations in both Kasane and Maun. The target number of respondents was 167, and this is the total number of tourism managers who indicated that they were willing and had time to participate in this research from both Kasane and Maun. The reason for targeting this sample size is the fact the HIV/AIDS is a sensitive issue, which means that people may be reluctant to respond to the questionnaire and that only those tourism managers who showed interest and had

time to answer the questionnaire from their respective organisations and departments, were given the questionnaire. The other reason is that tourism in Botswana is still at its development stage and the tourism managers are expected to be few. The reason for working with tourism managers or departmental heads instead of the general tourism workers is because tourism managers are expected to have better understanding of the impact of HIV/AIDS on tourism than general employees. Working with tourism managers such as heads of departments is imperative because these individuals have high level of expertise and experience in tourism and a number of them are involved in daily running of tourism businesses. This also helped the researcher to generate quality data that could be analysed and utilised to come up with a report indicating the possible strategies in combating the spread of HIV/AIDS and its impact on the Botswana tourism sector.

4.6.2 DATA COLLECTION PROCEDURE

Before commencing the survey, permission was asked from tourism managers to find out whether they were willing to participate in the research or not, and only managers willing to participate in the research were given the questionnaire. This was a self administered questionnaire. General Managers/CEOs were also asked to identify and ask their subordinates in managerial positions who had time and who were willing to participate in the research. The general managers/CEOs and their subordinates who indicated that they have time and were willing to participate in the research were given the questionnaire to answer on their own. This data collection method helped to ensure that the questionnaires were answered by intended people, and also prevented unnecessary personal relation or influence that could have occurred during face-to-face interview.

Considering that this study is quantitatively designed, the questions asked in the questionnaire required the respondents to tick the answer they think is suitable to a particular question. Respondents were given options such as (strongly agree, agree, neutral, disagree and strongly disagree) and they chose options according to a given statement (question).

This research gave priority to respect respondents' rights to privacy, morals and values, their social and psychological welfare. Risks usually associated with this type of research include distress, guilt, anger or fear of disclosure of health status, particularly by respondents who are HIV positive. The other risks associated with this research include discrimination, stigmatisation

and loss of employment especially if they revealed the number of employees suffering or died as a consequence of HIV/AIDS in their organisations.

To avoid the abovementioned risks, this research did not ask any personal and embarrassing questions. No questions regarding individual health status, number of people living with HIV/AIDS in an organisation or number of people who died of HIV/AIDS were asked in this research. Tourism managers who participated in the survey were treated with respect and remained anonymous. The names of the respondents and their organisations were not mentioned in results analysis. The questions asked are based (workers absenteeism, low productivity, poverty, service quality) but not on individual organisations. This is imperative to protect the privacy and rights of the respondents and their respective organisations. This process together with the aims of this research is indicated in the covering letter accompanying the research questionnaire.

4.6.3 DATA ANALYSIS

In analysing the survey results, descriptive statistics in the form of frequencies and averages have been used. The summated (Likert scale) was used in analysing data according to measurement items. This means that the results have been analysed using statistical methods based on the percentages of respondents who answered a question in a particular way. The statistical methods used in this research included frequencies, cross tabulation, T-tests, ANOVA and Cronbach's Alpha.

4.7 SUMMARY

The above chapter covers the research methodology and methods used in conducting both literature review and empirical research. Factors covered in this chapter included the research problem, research objectives, literature review, research variables, types of research, and research methods.

The following chapter covers the actual empirical research and analysis of results.

CHAPTER 5

EMPIRICAL SURVEY AND ANALYSIS OF RESULTS

5.1 INTRODUCTION

This chapter presents the research results. The results are presented using various statistical presentations such as tables according to the key objectives of the research. Factors covered in this research include contribution to research methods, research limitations, empirical survey and analysis of results, sampling methods, reliability test and analysis, key findings, and concluding remarks are made at the end of the chapter.

5.2. CONTRIBUTION TO RESEARCH METHODS

The sampling method used in identifying the respondents in this research is non-probability (snowballing) method. The target group in this research are the tourism managers in Kasane and Maun. The tourism managers from various tourism companies from both Kasane and Maun were approached and the purpose of the research was discussed with them. They were then asked to identify and ask their subordinates, also in managerial positions who were willing to participate in this research. The purpose of using this method was because HIV/AIDS is a sensitive issue and generating information from people who do not know one as a researcher about HIV/AIDS could be more difficult than when they are asked by their managers. However, the researcher is aware that this method could lead to tourism managers who are not willing to participate in the research to participate just because the manager is forcing them. To address this problem, the researcher made it clear to the general managers and CEOs that the participants were not going to be forced to participate in this research, and that those who voluntarily participated in the research were going to be anonymous.

The popular sampling method used by many people in conducting research is probability method (e.g. Pansiri, 2006 & Ketshabile, 2007). Approaching general managers and company CEOs who then identify their subordinates also generates quick response. This sampling method also helped

to obtain quality data because the questions were answered by the people who were identified by the researcher instead of any one person answering it. Self-administered questionnaires also help the respondents to have enough time to read and understand the questions and give true reflection of their perceptions on the measurement items without the interference of the researcher that often occurs in face to face interviews. In a face to face interview, the respondent may feel intimidated and give quick answers just to finish the interview and the interviewer may influence the response.

The results were statistically analysed using descriptive statistics, which is the statistical analysis often used in research in the tourism field. Before the analysis was conducted, Cronbach's Alpha was used to test reliability of the measurement scale that was used. The measurement scale used in this research is the Likert Scale, and respondents were given five options (strongly agree, agree, neutral, disagree and strongly disagree). The results of the reliability test that was conducted indicate that the scale used in this research is reliable. More statistical tests were conducted using ANOVA to find out whether the impact of HIV/AIDS on the individual tourism businesses vary according to company size, length of business operation, ownership, and location. In cases in which the differences according to the above variables were significant, T-tests were conducted to further explore the differences.

5.3 RESEARCH LIMITATIONS

Before the research results are presented, the limitations of this research are identified.

To start with, since only 89% of the intended population of the tourism managers actually responded to the survey questionnaire, one has to consider that there may be selection bias in the sample. A selection bias would have occurred if the tourism companies and the actual population that participated in the survey in the two areas in which the research was conducted, were significantly different from the population that decided not to respond. For example, if the population sample that responded are more concerned about the impact of HIV/AIDS, are more likely to have conducted research on the impact of HIV/AIDS or they are more likely to have experienced adverse impacts as a result of the disease, they would have reported different impacts of HIV/AIDS compared to those that did not respond to the questionnaire. If this was the case,

the research results would not be a true reflection of the impact of HIV/AIDS on the Botswana tourism sector.

In order to avoid a selection bias and to ensure the integrity of the results, tourism managers who participated in this research were encouraged to complete the questionnaire even if they thought that HIV/AIDS has had no impact on their tourism businesses. Respondents were also given the option to choose 'neutral' on the measurement items listed in the questionnaire.

The response rates within the tourism companies selected in the two areas in which the research was conducted are lower than what was aimed for because a number of tourism managers cited lack of time as a reason for not answering the questionnaire. Besides time constraints, this lower response rate can in all likelihood be attributed to the fact that the HIV/AIDS and the disease itself is a sensitive issue especially to infected people. The research results derived from the tourism companies, whose managers participated on this research within the two areas in which the research was conducted did not differ significantly among the respondents. These factors all support the fact that a selection bias did not occur.

The second limitation of this research that requires consideration is the fact that most questions in this research tested the perceptions of the tourism managers and CEOs who participated in this research rather than the statistical core data-like statistics. Since most of the tourism companies, within the two areas in which the research was conducted, have not conducted research to investigate the impact of HIV/AIDS on their businesses, it is unlikely that many tourism companies would be able to quantify the impacts of HIV/AIDS on various aspects of their businesses. The fact that most business decisions are often influenced by the perceptions of managers, directors and company CEOs, the subjectivity of their views does not invalidate the results of this research but it enhances the quality of data collected given the participants' levels of expertise.

The other limitation is that, the research did not cover all the tourism companies in Botswana, therefore, results cannot be generalised to every individual tourism company in the country. The reason why this research could not cover all tourism companies in Botswana is due to lack of funds and time.

5.4 EMPIRICAL SURVEY AND ANALYSIS OF RESULTS

In conducting the field research as already stated in this thesis, a self-administered questionnaire was given to tourism managers in various tourism establishments in Kasane and Maun. The research was conducted in 241 registered tourism companies based in Kasane and Maun.

Kasane and Maun as already indicated in this research are the key tourism destinations in Botswana and tourism and these two destinations and Botswana in general, still in development stage.

5.5 SAMPLING METHODS

The general population targeted by this research are people in the management working in various tourism organisations in both Kasane and Maun. Kasane and Maun are also among the areas most struck by HIV/AIDS in Botswana. This also gives a reason why empirical research presents the number of tourism managers who answered the questionnaire from various types of tourism organisations within the two areas in which the research was conducted.

Table 5.1 shows the number of tourism managers who participated in this research at two locations in which the research was conducted based on the type of registered tourism organisation in which the respondents came from. 69 registered tourism businesses in Kasane and 80 managers indicated that they were willing to participate on this research, and the researcher therefore issued 80 questionnaires to managers who indicated that they were willing to answer the questionnaire. Out of the 80 managers who were targeted by this research in Kasane, 73 responses were obtained. The same approach was used in Maun in which all the registered tourism businesses were included in the research. People who participated in the research included the general managers, financial managers, human resources managers and any other individuals in managerial positions such as company Chief Executive Managers, section heads and supervisors.

In Maun, there are 172 registered tourism companies. In conducting this research, 87 tourism

managers from their respective organisations indicated that they were willing to participate in this research and 87 questionnaires were then distributed among various tourism companies in the area including the Okavango Delta. Out of the 87 targeted tourism managers who had shown interest in participating in this research, 76 responses were obtained. The number of tourism managers is smaller than expected because the selected tourism managers and CEOs for certain reasons were not willing to participate in this research.

The total number of questionnaires that were given to tourism managers within the two areas in which the research was conducted is 167, and out of 167 questionnaires, 149 responses were obtained. This means that 18 tourism managers did not complete and return the questionnaires. A number of tourism managers who did not complete and return the research questionnaires cited shortage of time resulting from busy schedules from their respective organisations as the main constraint that contributed to their failure to honour their agreement that they would answer the questionnaires.

TABLE 5.1: NUMBER OF RESPONDENTS FROM VARIOUS TYPES OF TOURISM ORGANISATIONS

	Location			
	Kasane: number of registered tourism organisation	number of tourism managers who answered the questionnaire in Kasane	Maun: number of registered tourism organisation	number of tourism managers who answered the questionnaire in Maun
Hotel	0	0	13	12
Lodge/Camp	28	59	64	52
Guesthouse	2	0	4	1
Other (mobile safaris)	39	14	91	11
Total	69	73	172	76

Table 5.2 shows respondents' position in their respective organisations. Although the specified positions in the table includes General Managers, Food and beverage Managers, and Human Resources Managers, most of the respondents fall under the category 'other'. This is because most of the respondents are the company owners who indicate that they are either the Chief Executive Officers (CEO) or Managing Directors (MD). In addition to these individuals, a number of respondents indicated that they were section heads. Although all individuals participated in the research were managers from various tourism organisations, different organisations have different names for their various departmental managerial positions, hence the category 'other' dominate variables within the respondents position. The fact that tourism in Botswana is still in its development stage also means that most of the people own and manage their own business as CEOs and Managing Directors.

TABLE 5.2: RESPONDENTS POSITION IN THE ORGANISATION

Position	Number	Percentage
General Managers	17	12
Food and Beverage Managers	6	4
Human Resources Managers	4	3
Other (CEO and MD)	117	81
Total	144	100

Most of the tourism managers who participated in this research are Botswana citizens in their young ages and these are the people who are active at work. Majority of the respondents have at least basic educational qualification.

Table 5.3 shows both the respondents' nationality and educational level. This question aims to establish the active roles played by Botswana citizens as opposed to non-Botswana citizens against their highest educational levels. Most of the tourism managers who participated in the research have certificate/diploma as their highest educational level. Few respondents had both undergraduate and postgraduate degrees. Fewer respondents had either primary or other qualifications such as professional qualification. Tourism managers were selected irrespective of

their gender and age. The following table presents the respondents gender and age.

TABLE 5.3: RESPONDENTS' NATIONALITY AND EDUCATIONAL LEVEL

	Number	Percentage
Respondents' Nationality		
Botswana Citizen	124	85
Non-Botswana Citizen	22	15
Total	146	100
Respondents' Highest Educational Level		
Primary	3	2
Secondary	37	25
Certificate/Diploma	77	53
Undergraduate Degree	18	12
Post graduate Degree	9	6
Other	3	2
Total	147	100

Table 5.4 shows the respondents' gender and age. It is indicated in the table that most of the tourism managers who participated in the research are females. This shows that women play an active role in the development and management of tourism in Botswana. It is also indicated in table 5.4 that most of the tourism managers who participated in the research ranged between the ages of 20 and 39 years. This is the age group that is economic active and as already stated in this research, this is the age group vulnerable to HIV/AIDS in Botswana (UNDP, 2006).

TABLE 5.4: RESPONDENTS GENDERS AND AGE

Respondents' Gender	Number	Percentage
Male	61	41
Female	87	59
Total	148	100
Respondents' Age		
Under 20 years	1	1
20 – 29 years	56	38
30 – 39 years	63	43
40 – 49 years	17	11
50 – 59 years	9	6
60 years and above	2	1
Total	148	100

The following table 5.5 presents the number of tourism companies that have HIV policy among the companies in which the research was conducted located in the two areas.

It shows the location of the companies that participated in the research. More companies who participated in the research are in Maun. This is because Maun has more tourism companies than Kasane. It is also indicated in table 5.5 that most of the tourism companies that participated in the research have HIV/AIDS policies. However, as indicated in table 5.5, the number of tourism companies indicating that they do not have HIV/AIDS policy is 46%, which is high bearing in mind the seriousness and the high prevalence rate on HIV/AIDS in Botswana. This shows that more work needs to be done to encourage tourism companies to fight the impact of HIV/AIDS. The following table presents the type of ownership of the tourism organisations in which the research was conducted.

TABLE: 5.5: COMPANY LOCATION AND HIV POLICY

	Number	Percentage
Location		
Kasane	72	48
Maun	77	52
Total	149	100
HIV POLICY		
Yes	75	54
No	63	46
Total	138	100

Table 5.6 depicts the type and ownership of tourism organisations that participated in the research. Most of the tourism organisations in which research was conducted are owned by the Botswana citizens either as sole owners or as partners with non-citizens. To be more specific, both hotels and lodges/camp in which tourism managers came from are owned as partnership between Botswana citizens and non-Botswana citizens (80% and 35% respectively). Only one of the tourism managers came from a guest house and the guest house owned by a Botswana citizen. This is because according to the Botswana tourism policy, guesthouses can only be owned by Botswana citizens because they are categorised as small scale tourism businesses. Most (45%) of the mobile safaris companies from which the tourism managers come from are owned by non-Botswana citizens. These results indicate that tourism indeed plays an important role in the lives of many citizens of Botswana by creating both employment and entrepreneurial opportunities. These results also vary with many studies indicating that the Botswana tourism sector is generally dominated by expatriates.

TABLE 5.6: ORGANISATIONAL TYPE AND OWNERSHIP

Type of Tourism Organisation	Organisational Ownership			Total
	A Botswana Citizen	A Non-Botswana Citizen	A Partnership between a Botswana citizen and a non-Botswana citizen	
Hotel	1 (10%)	1 (10%)	8 (80%)	10 (100%)
Lodge/Camp	44 (44%)	21 (21%)	35 (35%)	100 (100%)
Guesthouse	1 (100%)	-	-	1 (100%)
Other (Mobile Safari companies)	5 (25%)	9 (45%)	6 (30%)	20 (100%)
Total	51 (39%)	31 (24%)	49 (37%)	131 (100%)

5.6 RELIABILITY TEST AND ANALYSIS

Initially, before running an analysis related to addressing objectives in this research, a reliability test was prepared on three scales namely; tourism and HIV/AIDS in Botswana, tourism and communities relative to HIV/AIDS and the impact of HIV/AIDS on the tourism businesses. Cronbach's Alpha was used in conducting the reliability test and the results show a high reliability as follows; tourism and HIV/AIDS in Botswana in general: $\alpha = .84$; tourism and communities relative to HIV/AIDS: $\alpha = .70$, and the impact of HIV/AIDS on the tourism businesses: $\alpha = .90$. The following tables 5.7, 5.8 and 5.9 present the results for reliability tests for scales 1, 2 and 3. The tables depict the results for the scale reliability tests conducted on the three measurement scales based on the research objectives. The purpose of the reliability tests is to test the reliability of the measurement scales that were used in this research. In general, the results show that the scales are reliable because they present results not far from positive (0.84). However, the only item that presents negative results is the last measurement item on scale 1. This does not mean that the item is not reliable but it is a result of the way in which the question is structured. The following section addresses the research objectives based on how the participants responded on each measurement scale.

TABLE 5.7: RELIABILITY TEST ON THE SCALE OF TOURISM AND HIV/AIDS IN BOTSWANA IN GENERAL (CRONBACH ALPHA = 0.84)

Measurement Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Tourism is one of Botswana's important economic activities	.206	.840
Botswana is one of the countries in the world with highest rate of HIV/AIDS infection	.295	.838
HIV/AIDS increases the levels of poverty in a number of rural areas in Botswana	.452	.832
Botswana tourism is losing experienced workers to HIV/AIDS	.434	.833
Botswana tourism sector is seriously threatened by HIV/AIDS in future	.602	.825
Gender inequality contributes to the spread of HIV/AIDS in Botswana	.419	.833
Government should do more to address HIV/AIDS problems	.251	.839
Prospective domestic tourism demand in Botswana is threatened by the HIV/AIDS	.602	.826
HIV/AIDS threatens new investments in the tourism private sector	.616	.825
HIV/AIDS increases health expenditure on individuals, and tourism business	.435	.833
HIV/AIDS problem reduces individual's savings due to medical expenses	.520	.829
HIV/AIDS reduces the government investment in tourism public sector	.521	.829
Tourism organizations often discuss HIV/AIDS problems among themselves	.168	.844
HIV/AIDS increases the growth rate of average incomes	.287	.839
HIV/AIDS problem results in lower population growth	.318	.837
Tourism companies are not doing much in fighting the impact of HIV/AIDS in their organization	.143	.846
HIV/AIDS problem is expected to become much worse in future	.388	.834
Quality of service is affected by the HIV/AIDS problem	.593	.825
Alcohol abuse influence the spread of HIV/AIDS in Botswana	.416	.835

IV/AIDS increases the costs of running tourism businesses	.474	.831
Tourism organisation experience low labour productivity resulting from HIV/AIDS	.627	.824
HIV/AIDS is a serious problem for tourism industry	.500	.830
Tourism business community in Botswana often discusses the HIV/AIDS problem with the local community members	-.105	.854

TABLE 5.8: RELIABILITY ON THE SCALE OF TOURISM MANAGERS' PERCEPTION ON HOW HOST COMMUNITIES PERCEIVE TOURISM DEVELOPMENT, ITS BENEFITS AND ITS POSSIBLE INFLUENCE ON THE SPREAD OF HIV/AIDS (CRONBACH ALPHA = 0.84)

Measurement Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Tourism creates employment in our location	.046	.711
Tourism motivates host communities to be more conscious of the need to maintain and improve the appearance of the area	.105	.713
Development of tourism facilities has generally improved the appearance of the area	.180	.704
Tourism contributes to the conservation of the environment as a national asset	.114	.709
Tourism development brings facilities that improve quality of life of residents.	.124	.711
Economic benefits of tourism to the communities are overrated	.326	.689
Tourism benefits only a small proportion of the community members	.321	.691
Tourism contributes to the spread of HIV/AIDS in your location	.535	.656
Tourism increases social cultural problems such as commercial sex workers	.533	.657
Tourists are often an intrusion on communities' lifestyles	.433	.674
Tourism results in damage to the natural environment	.475	.668

Tourism increases the cost of living in host communities	.410	.677
Further tourism development will disadvantage the community	.422	.677
Host community should be involved and work closely with business community in tourism development	.172	.705

TABLE 5.9: RELIABILITY ON THE SCALE OF THE POSSIBLE IMPACT OF HIV/AIDS ON TOURISM BUSINESSES IN BOTSWANA (CRONBACH ALPHA = 0.84)

Measurement Items	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
HIV/AIDS problem directly affects the daily running of our business	.712	.893
HIV/AIDS results in increased employee costs for us	.654	.895
Quality of our service is affected by the HIV/AIDS problem	.758	.892
Organisation experienced high labour turnover rates attributed to HIV/AIDS	.669	.895
Workers go on sick leave for lengthy periods	.790	.890
Tourism workers loyalty and commitment to their job is negatively affected by the HIV/AIDS	.663	.895
Cost of business operations have increased because of the need to replace workers who are absent due to illness	.807	.890
Organisation experienced employment (recruiting and training) costs resulting from the loss of employees due to HIV/AIDS	.836	.889
HIV/AIDS affects workers relationship to each other by creating discrimination against those living with the disease	.549	.899
We often discuss HIV/AIDS problems in our meetings	.192	.911
Tourism results in increased commercial sex work in our region	.225	.910
Sex tourism is a common practice in our area	.110	.913
Our organisation work closely with the local community members in fighting the spread of HIV/AIDS	.290	.908

A number of our workers have gone on early retirement on medical grounds	.714	.894
HIV/AIDS reduces infected employees efficiency on their job	.647	.896
HIV/AIDS is a serious problem for our business.	.725	.893

5.7 KEY FINDINGS

In addressing the key research objectives, the respondents were given a self-administered questionnaire to give their perception based on the experience and expertise on the possible impact of HIV/AIDS on the Botswana tourism in general, how host communities perceive tourism development in relation to the prevalence of HIV/AIDS, and the possible impact of HIV/AIDS on the individual tourism businesses in Botswana.

Table 5.10 shows the percentage response. Table 5.10 also presents the actual number of people who answered each measurement item.

TABLE 5.10: THE PERCENTAGE RESPONSE ON THE PERCEPTION OF THE TOURISM MANAGERS ON THE POSSIBLE IMPACT OF HIV/AIDS ON THE BOTSWANA TOURISM SECTOR (TOTAL RESPONDENTS: N =149)

Measurement items	Strongly Agree (%)	Agree (%)	Not agree nor disagree (%)	Disagree (%)	Strongly Disagree (%)	Total % (N)
Tourism is one of Botswana's most important economic activities.	83	17	0	0	0	100 (149)
Botswana is one of the countries in the world with the highest rate of HIV/AIDS infection.	31	53	6	9	1	100 (149)
HIV/AIDS increases the levels of poverty in a number of rural areas in Botswana.	47	34	11	4	4	100 (144)
Botswana tourism sector is losing experienced workers to HIV/AIDS.	32	34	22	7	5	100 (148)
Botswana tourism sector is seriously threatened by HIV/AIDS in future.	27	41	13	13	6	100 (147)
Gender inequality contributes to the spread of HIV/AIDS in Botswana.	28	33	21	12	6	100 (145)
Government should do more to address HIV/AIDS problems.	51	29	14	3	3	100 (148)

Prospective domestic tourism demand in Botswana is threatened by the HIV/AIDS.	14	44	23	18	1	100 (148)
HIV/AIDS threatens new investment in the tourism private sector.	18	34	24	21	3	100 (147)
HIV/AIDS increases health expenditure on individuals, and tourism businesses.	32	43	16	6	3	100 (143)
HIV/AIDS problem reduces individual's savings due to medical expenses.	33	36	12	15	4	100 (147)
HIV/AIDS reduces the government investment in tourism public sector.	25	34	22	17	2	100 (143)
Tourism organisations often discuss HIV/AIDS problems among themselves.	23	33	24	13	7	100 (144)
HIV/AIDS increases the growth rate of average income incomes.	16	18	35	25	6	100 (142)
The HIV/AIDS problem results in lower population growth.	43	35	14	7	1	100 (148)
Tourism companies are not doing much in fighting the impact of HIV/AIDS in their organisations.	16	24	24	22	14	100 (146)
The HIV/AIDS problem is expected to become much worse in future.	17	21	33	25	4	100 (146)
Quality of service in general is affected by the HIV/AIDS problem.	21	35	19	20	6	100 (145)
Alcohol abuse influences the spread of HIV/AIDS in Botswana.	62	29	5	3	1	100 (148)
HIV/AIDS increases the costs of running tourism businesses.	16	33	26	20	5	100 (148)
Tourism organisations experience low labour productivity resulting from HIV/AIDS.	20	35	21	18	6	100 (147)
HIV/AIDS is a serious problem for tourism industry.	31	37	18	10	4	100 (141)
Tourism business community in Botswana often discusses the HIV/AIDS problem with the local community members.	18	37	21	20	5	100 (137)

Table 5.11 presents the perception of tourism managers who participated on the research on the possible impact of HIV/AIDS on the Botswana tourism sector. On average, most respondents confirm that HIV/AIDS has negative impacts on the Botswana tourism sector. All tourism managers who participated on the research indicated that tourism is one of the Botswana's most important economic activities (see tables 5.9 and 5.10). Most respondents agree with the statements indicating that Botswana is one of the countries with the highest prevalence of HIV/AIDS, and that HIV/AIDS affects the country's tourism sector through its negative effects on experienced workers within the sector.

On average, most respondents agree that the increased death rate resulting from HIV/AIDS related illness also threatens both the Botswana prospective domestic tourism demand and tourism investment both in public and private sectors. HIV/AIDS results in reduced individual savings through its increased medical expenses. HIV/AIDS also results in increased growth rate of average income for key tourism employees who remain with the companies. The companies that experience severe HIV/AIDS prevalence rate among their employees also experience poor quality service, which also affects the daily running of tourism business. Besides its impacts on the service quality, most respondents indicated that HIV/AIDS also results in low labour productivity particularly for tourism companies that experience its adverse impacts. On average, many respondents agreed with the statement indicating that HIV/AIDS results in lower population growth than in no-AIDS scenario. Reduced population growth affects both availability and quality of tourism workforce and it also reduces tourism local market.

TABLE 5.11: THE AVERAGE RESPONSE ON THE PERCEPTION OF THE TOURISM MANAGERS ON THE POSSIBLE IMPACT OF HIV/AIDS ON THE BOTSWANA TOURISM SECTOR (TOTAL RESPONDENTS: N =149)

Descriptive Statistics					
Measurement Items	N	Mini mum	Maxi mum	Mean	Standard Deviation
Tourism is one of Botswana's important economic activities.	149	1	2	1.17	.375
Botswana is one of the countries in the world with highest rate of HIV/AIDS infection.	149	1	5	1.97	.918
HIV/AIDS increases the levels of poverty in a number of rural areas in Botswana.	144	1	5	1.85	1.051
Botswana tourism is losing experienced workers to HIV/AIDS.	148	1	5	2.18	1.113
Botswana tourism sector is seriously threatened by HIV/AIDS in future.	147	1	5	2.24	1.144
Gender inequality contributes to the spread of HIV/AIDS in Botswana.	145	1	5	2.36	1.182
Government should do more to address HIV/AIDS problems.	148	1	5	1.77	.990
Prospective domestic tourism demand in Botswana is threatened by the HIV/AIDS.	147	1	5	2.50	.989
HIV/AIDS threatens new investments in the tourism private sector.	147	1	5	2.56	1.099

HIV/AIDS increases health expenditure on individuals, and tourism business.	143	1	5	2.02	.968
HIV/AIDS problem reduces individual's savings due to medical expenses.	147	1	5	2.23	1.194
HIV/AIDS reduces the government investment in tourism public sector.	143	1	5	2.36	1.098
Tourism organisations often discuss HIV/AIDS problems among themselves.	144	1	5	2.49	1.194
HIV/AIDS increases the growth rate of average incomes.	142	1	5	2.87	1.150
HIV/AIDS problem results in lower population growth.	148	1	5	1.89	.977
Tourism companies are not doing much in fighting the impact of HIV/AIDS in their organisation.	146	1	5	2.95	1.294
HIV/AIDS problem is expected to become much worse in future.	146	1	5	2.79	1.128
Quality of service is affected by the HIV/AIDS problem.	145	1	5	2.54	1.184
Alcohol abuse influence the spread of HIV/AIDS in Botswana.	148	1	5	1.52	.804
HIV/AIDS increases the costs of running tourism businesses.	148	1	5	2.65	1.118
Tourism organisation experience low labour productivity resulting from HIV/AIDS.	147	1	5	2.54	1.178
HIV/AIDS is a serious problem for tourism industry.	141	1	5	2.19	1.114
Tourism business community in Botswana often discusses the HIV/AIDS problem with the local community members.	137	1	5	2.58	1.142
Valid N (listwise)	108				

Note: 1=Strongly agree, 2=Agree, 3=Neither agree nor disagree, 4=Disagree and 5= Strongly disagree

Table 5.12 presents the percentage response of the tourism managers on how host communities perceive tourism development in relation to its possible influence on the spread of HIV/AIDS. The also presents the actual number of people who answered each measurement item. Table 5.13 presents the average response of tourism managers who answered the questionnaire.

TABLE 5.12: PERCEPTION OF TOURISM MANAGERS ON HOW HOST COMMUNITIES PERCEIVE TOURISM DEVELOPMENT, ITS BENEFITS AND ITS POSSIBLE INFLUENCE ON THE SPREAD OF HIV/AIDS (TOTAL RESPONDENTS: N =149)

Measurement items	Strongly Agree (%)	Agree (%)	Not agree nor disagree (%)	Disagree (%)	Strongly Disagree (%)	Total % (N)
Tourism creates employment in our location.	82	16	2	0	0	100 (148)
Tourism motivates host communities to be more conscious of the need to maintain and improve the appearance of the area.	55	28	10	5	2	100 (148)
Development of tourism facilities has generally improved the appearance of the area.	47	39	10	3	1	100 (148)
Tourism contributes to the conservation of the environment as a national asset.	63	26	9	1	1	100 (145)
Tourism development brings facilities that improve the quality of life of residents.	55	31	8	5	1	100 (147)
Economic benefits of tourism to the communities are overrated.	18	36	29	13	4	100 (143)
Tourism benefits only a small proportion of the community members.	14	19	27	27	13	100 (146)
Tourism contributes to the spread of HIV/AIDS in your location.	12	17	20	26	25	100 (148)
Tourism increases social cultural problems such as commercial sex work.	12	20	22	26	20	100 (146)
Tourists are often an intrusion on communities' lifestyles.	13	15	25	30	17	100 (144)
Tourism results in damage to the natural environment.	8	17	21	34	20	100 (148)
Tourism increases the cost of living in host communities.	20	25	19	23	13	100 (145)
Further tourism development will disadvantage the community.	3	10	16	40	31	100 (148)
Host community should be involved and work closely with business community in tourism development.	53	38	3	5	1	100 (148)

TABLE 5.13: PERCEPTION OF TOURISM MANAGERS ON HOW HOST COMMUNITIES PERCEIVE TOURISM DEVELOPMENT, ITS BENEFITS AND ITS POSSIBLE INFLUENCE ON THE SPREAD OF HIV/AIDS (TOTAL RESPONDENTS: N =149)

Descriptive Statistics					
Measurement Items	N	Mini mum	Maxi mum	Mean	Standard. Deviation
Tourism creates employment in our location	148	1	3	1.19	.426
Tourism motivates host communities to be more conscious of the need to maintain and improve the appearance of the area	148	1	5	1.70	.951
Development of tourism facilities has generally improved the appearance of the area	148	1	5	1.74	.868
Tourism contributes to the conservation of the environment as a national asset	145	1	5	1.50	.774
Tourism development brings facilities that improve quality of life of residents	147	1	5	1.69	.935
Economic benefits of tourism to the communities are overrated	143	1	5	2.50	1.061
Tourism benefits only a small proportion of the community members	146	1	5	3.05	1.250
Tourism contributes to the spread of HIV/AIDS in your location	148	1	5	3.35	1.345
Tourism increases social cultural problems such as commercial sex workers	146	1	5	3.22	1.300
Tourists are often an intrusion on communities' lifestyles	144	1	5	3.23	1.267
Tourism results in damage to the natural environment	148	1	5	3.41	1.211
Tourism increases the cost of living in host communities	145	1	5	2.83	1.339
Further tourism development will disadvantage the community	148	1	5	3.86	1.069
Host community should be involved and work closely with business community in tourism development	148	1	5	1.64	.865
Valid N (listwise)	132				

Note: 1= Strongly agree, 2 = Agree, 3 = Neither agree nor disagree, 4 = Disagree and 5 = Strongly disagree

On average (1.19), most of the respondents strongly agree with the statement indicating that tourism creates employment in their respective locations and that it also motivates the host communities to be more conscious of the need to maintain and improve the appearance of the area. Many respondents also agreed that tourism contributes to the conservation of the environment and it also brings facilities that improve quality of life for host communities.

However, on average (3.05), many respondents disagreed with the statement indicating that economic benefits of tourism to the communities are overrated and that tourism benefits only a small proportion of the community members. The respondents also disagreed with statements indicating that tourism contributes to the spread of HIV/AIDS and it increases the socio-cultural problems such as commercial sex work. Most respondents do not view tourism as intrusion on host community lifestyle. However, most respondents agree with the statement indicating that tourism increases the cost of living for host communities. This is because prices of basic needs such as food and clothes in tourism destinations are relatively higher than in places that are not tourism destinations. Despite the increased cost of living for host communities, most respondents disagree with the statement indicating that further tourism development will disadvantage the host community. On average, most of the respondents strongly agree with the statement indicating that host communities should be involved and work closely with tourism business community for tourism development.

Table 5.14 presents the percentage response of the tourism managers who answered the questionnaire based on the perception of tourism managers on the possible impact of HIV/AIDS on individual tourism businesses. It also presents the actual number of people who answered each measurement item.

TABLE 5.14: THE PERCEPTION OF THE TOURISM MANAGERS ON THE POSSIBLE IMPACT OF HIV/AIDS ON THE BOTSWANA TOURISM BUSINESSES (TOTAL RESPONDENTS: N =149)

Measurement items	Strongly agree (%)	Agree (%)	Neither agree nor disagree (%)	Disagree (%)	Strongly Disagree (%)	Total % (N)
The HIV/AIDS problem directly affects the daily running of our business.	17	30	17	28	8	100 (148)
HIV/AIDS results in increased employee costs for us.	13	28	25	23	11	100 (146)
Quality of our service is affected by the HIV/AIDS problem.	14	24	26	25	11	100 (147)
Organisation experience high labour turnover rates attributed to HIV/AIDS.	9	21	28	30	12	100 (144)
Workers go on sick leave for lengthy periods.	14	19	20	31	16	100 (147)
Tourism workers' loyalty and commitment to their job is negatively affected by the HIV/AIDS.	12	28	27	24	9	100 (145)
Cost of business operations have increased because of the need to replace workers who are absent due to illness.	14	28	19	25	14	100 (148)
Organisation experience employment (recruiting and training) costs resulting from the loss of employees due to HIV/AIDS.	14	18	23	29	16	100 (147)
HIV/AIDS affects workers relationship to each other by creating discrimination against those living with the disease.	12	16	22	30	20	100 (146)
We often discuss HIV/AIDS problems in our meetings.	23	36	13	21	7	100 (146)
Tourism results in increased commercial sex work in our region.	14	18	20	28	20	100 (146)
Sex tourism is a common practice in our area.	8	13	23	28	28	100 (144)
Our organisation work closely with the local community members in fighting the spread of HIV/AIDS.	27	34	15	16	8	100 (146)
A number of our workers have gone on early retirement on medical grounds.	8	8	22	37	25	100 (146)
HIV/AIDS reduces infected tourism employees' efficiency on their job.	12	31	25	22	10	100 (142)
HIV/AIDS is a serious problem for our business.	19	17	28	23	13	100 (145)

Tables 5.14 and 5.15 present the perception of the tourism managers who participated on the research regarding the possible impact of HIV/AIDS on the Botswana tourism businesses. On average, most of the respondents agree with the statement indicating that the HIV/AIDS problem directly affects the daily running of their businesses. This is because HIV/AIDS results in workers absenteeism. This in return affects the quality of service rendered to the tourists. However, most of the respondents disagreed with the statements indicating that tourism organisations experience high labour turnover rates as a result of HIV/AIDS and that tourism employees often go on sick leave for a lengthy period.

TABLE 5.15: THE PERCEPTION OF THE TOURISM MANAGERS ON THE POSSIBLE IMPACT OF HIV/AIDS ON THE BOTSWANA TOURISM BUSINESSES (TOTAL RESPONDENTS: N =149)

Descriptive Statistics					
Measurement Items	N	Mini mum	Maxi mum	Mean	Standard. Deviation
HIV/AIDS problem directly affects the daily running of our business.	148	1	5	2.80	1.244
HIV/AIDS results in increased employee costs for us.	146	1	5	2.92	.223
Quality of our service is affected by the HIV/AIDS problem.	147	1	5	2.97	1.227
Organisation experience high labour turnover rates attributed to HIV/AIDS.	144	1	5	3.15	1.155
Workers go on sick leave for lengthy periods	147	1	5	3.17	1.295
Tourism workers loyalty and commitment to their job is negatively affected by the HIV/AIDS	145	1	5	2.88	1.152
Cost of business operations have increased because of the need to replace workers who are absent due to illness.	148	1	5	2.97	1.285
Organisation experienced employment (recruiting and training) costs resulting from the loss of employees due to HIV/AIDS.	147	1	5	3.17	1.284
HIV/AIDS affects workers relationship to each other by creating discrimination against those living with the disease.	146	1	5	3.32	1.286

We often discuss HIV/AIDS problems in our meetings.	146	1	5	2.53	1.244
Tourism results in increased commercial sex work in our region.	146	1	5	3.23	1.328
Sex tourism is a common practice in our area	144	1	5	3.56	1.244
Our organisation work closely with the local community members in fighting the spread of HIV/AIDS.	146	1	5	2.44	1.254
A number of our workers have gone on early retirement on medical grounds.	146	1	5	3.62	1.182
HIV/AIDS reduces infected employees efficiency on their job.	142	1	5	2.87	1.184
HIV/AIDS is a serious problem for our business.	145	1	5	2.93	1.305
Valid N (listwise)	127				

Note: 1= Strongly agree, 2 = Agree, 3 = Neither agree nor disagree, 4 = Disagree and 5 = Strongly disagree

On average, most of the respondents agreed that HIV/AIDS results in increased business operations due to the need to replace tourism workers who are absent due to illness. Most of respondents also agreed that HIV/AIDS affects tourism workers' loyalty and commitment to their job. However, most of the respondents disagreed with the statement indicating that HIV/AIDS affects tourism workers' relationship to each other by creating discrimination against workers who are living with the disease. Majority of the respondents indicated that their organisations do not experience severe employment costs resulting from recruiting and training costs as a result of HIV/AIDS. On average, respondents also disagree with the statements indicating that tourism results in increased commercial sex work in their region.

Besides the primary objectives mentioned above, further statistical analysis was conducted to further explore the possibility that the socioeconomic impacts of HIV/AIDS on the tourism sector in Botswana could also be influenced by other variables such as company size and length of business operation. The other objectives included investigate whether the tourism companies that have HIV/AIDS policy experience the impact of HIV/AIDS more than those that do not have HIV/AIDS policy, and also to find out whether the companies owned by Botswana citizens differ

with those owned by non-Botswana citizens in terms of having HIV/AIDS policy. Table 5.16 presents the difference in respondents' perceptions of HIV/AIDS by company HIV/AIDS policy.

Table 5.16 presents the perceptions of tourism managers on the possible impact of HIV/AIDS on the Botswana tourism in general, community perception on tourism development, its benefits and its possible influence on the spread of HIV/AIDS, and on the possible impact of HIV/AIDS on individual tourism businesses in Botswana based on whether the tourism companies in which the respondents come from has HIV/AIDS policy or not. The perceptions of tourism managers in companies that have HIV/AIDS policy do not significantly vary from companies that do not have HIV/AIDS policy. However, the perception of tourism managers who participated in the research regarding the impact of HIV/AIDS on the individual tourism businesses in Botswana only vary significantly at the 0.1 level of significance, between companies that have an HIV/AIDS policy and those that do not have HIV/AIDS policy.

TABLE 5.16: DIFFERENCE IN PERCEPTION OF HIV/AIDS BY COMPANY HIV/AIDS POLICY

Perception	Yes	No	t-value	p-value
	Mean (SD)	Mean (SD)		
The possible impact of HIV/AIDS on the Botswana tourism sector in general	2.23 (.57)	2.30 (.46)	.83	.41
Host community perception on the tourism development, its benefits and possible influence on the spread of HIV/AIDS	2.46 (.54)	2.53 (.54)	0.83	.41
The possible impact of HIV/AIDS on tourism businesses in Botswana	2.94 (.82)	3.18 (.81)	-1.70	.09

These p-values show significance.

On average, tourism managers who participated in the research from tourism companies indicating that they do not have HIV/AIDS policy disagree that HIV/AIDS has negative impacts on their respective businesses. In contrast, tourism managers who participated in the research from tourism companies that have HIV/AIDS policy agree that HIV/AIDS has negative impacts

on their businesses. This shows that tourism companies that have experienced the impact of HIV/AIDS are more concerned with fighting the disease than companies that do not experience the impact of HIV/AIDS.

An ANOVA was conducted to find out whether the respondents' perceptions on the impact of HIV/AIDS on the Botswana tourism sector vary according to company size. For the purpose of this research, the company size is determined by their number of employees. The categories used in this research are: small company (1-25 employees), medium size company (26-49), and large company (50 or more employees). This is the standard category in Botswana (Hilton, Mokobi & Sprokel, 2006: 3).

TABLE 5.17: DIFFERENCE IN PERCEPTION IN THE POSSIBLE IMPACT OF HIV/AIDS ON THE BOTSWANA TOURISM, COMMUNITY PERCEPTION ON TOURISM IN RELATION TO THE SPREAD OF HIV/AIDS, AND THE IMPACT OF HIV/AIDS ON TOURISM BUSINESSES BASED ON COMPANY SIZE

		N	Mean	Std. Deviation	Std. Error
The possible impact of HIV/AIDS on the Botswana tourism sector in general:	Small	32	2.31	0.518	0.092
	Medium	20	1.90	0.434	0.097
	Large	61	2.31	0.515	0.066
	Total	113	2.24	0.522	0.049
Perceptions of tourism managers on how host communities perceive tourism development in relation to the spread of HIV/AIDS:	Small	31	2.56	0.530	0.095
	Medium	20	2.59	0.516	0.115
	Large	61	2.49	0.517	0.066
	Total	112	2.53	0.517	0.049
The possible impact of HIV/AIDS on the individual tourism businesses in Botswana:	Small	31	3.27	0.719	0.129
	Medium	20	2.74	1.016	0.227
	Large	61	3.03	0.842	0.108
	Total	112	3.05	0.855	0.081

The perceptions of tourism managers who participated in this research vary according the size of the companies in which the respondents come from. On average, tourism managers who participated in the research from both small and large companies agree but not strongly agree with statement indicating that HIV/AIDS have negative impact on Botswana tourism in general. Tourism managers who participated on the research from medium size companies strongly agree

that HIV/AIDS has negative impact on the Botswana tourism in general. The perceptions of tourism managers on how host communities perceive tourism development in relation to its influence on the spread of HIV/AIDS do not differ according to company size. On average, tourism managers who participated in the research agree that host communities are under the impression that tourism influences the spread of HIV/AIDS. Tourism managers who participated in the research from both small and large tourism companies are neutral about the impact of HIV/AIDS on the individual tourism businesses in Botswana. Contrary to small and large size tourism companies, tourism managers who participated in the research from medium size tourism companies agree with the statement indicating that HIV/AIDS has negative impact on individual businesses in Botswana. The possible explanation to these variations is that small size companies are often new in business and they may not have experienced the HIV/AIDS like the medium size company. Unlike the medium size company, the large tourism companies have more resources and can manage the impact of HIV/AIDS. Small medium size tourism companies are at the development stage and getting resources such as human resources is difficult and it is a challenge to deal with HIV/AIDS.

The results of ANOVA test are as follows:

- *The possible impact of HIV/AIDS on the Botswana tourism sector in general:*

$F(2,110) = 5.433, P = 0.006$

This result shows that the respondents' perceptions on the impact of HIV/AIDS do vary according to the size of the companies in which the respondents come from.

- *Perceptions of tourism managers on how host communities perceive tourism development in relation to the spread of HIV/AIDS:*

$F(2, 109) = 0.317, P = .0.729$

This also shows that the respondents' do not vary according to the size of the companies in which the respondents come from.

- *The possible impact of HIV/AIDS on the individual tourism businesses in Botswana:*

$F(2,109) = 2.399, P = 0.096$

Here there are significant differences on perceptions of tourism managers who participated in the research according to the size of tourism companies they come from. To further explore these differences, T-tests were conducted and the table 5.18 presents t-test results.

TABLE 5.18: DIFFERENCE IN PERCEPTION IN THE POSSIBLE IMPACT ON HIV/AIDS ON INDIVIDUAL TOURISM BUSINESS BETWEEN SMALL AND MEDIUM SIZE COMPANIES

	Small	Medium	
Perception	Mean (SD)	Mean (SD)	Sig
The possible impact of HIV/AIDS on individual businesses in Botswana.	3.27 (0.72)	2.74 (1.016)	0.093

Tables 5.18, 5.19 and 5.20 present the differences in perception of the tourism managers who participated on the research regarding the possible impact of HIV/AIDS on individual tourism businesses in Botswana according to the sizes of the tourism companies from which the respondents come from. The results indicate that the impact of HIV/AIDS on the individual tourism businesses vary significantly according to the sizes of the tourism companies. On average, tourism managers from both small size companies are neutral with most statements indicating that their organisations are affected by HIV/AIDS, whereas tourism managers from medium size companies agree though not strongly with the statement indicating that HIV/AIDS has negative impacts on individual tourism businesses.

TABLE 5.19: DIFFERENCE IN PERCEPTION IN THE POSSIBLE IMPACT ON HIV/AIDS ON INDIVIDUAL TOURISM BUSINESS BETWEEN MEDIUM AND LARGE COMPANIES

Perception	Company size		Sig
	Medium	Large	
	Mean (SD)	Mean (SD)	
The possible impact of HIV/AIDS on individual businesses in Botswana.	2.74 (1.016)	3.03 (0.842)	0.529

TABLE 5.20: DIFFERENCE IN PERCEPTION IN THE POSSIBLE IMPACT ON HIV/AIDS ON INDIVIDUAL TOURISM BUSINESS BETWEEN SMALL AND LARGE COMPANIES

Perception	Company size		Sig
	Small	Large	
	Mean (SD)	Mean (SD)	
The possible impact of HIV/AIDS on individual businesses in Botswana.	3.27 (0.72)	3.03 (0.842)	0.641

Unlike respondents from small and large size tourism companies, on average, respondents from medium size companies agreed that HIV/AIDS has negative impacts on their tourism business. This shows that HIV/AIDS affects medium tourism companies more than small and large tourism companies. This could be attributed to the fact that medium size companies are often in development stage and they need more resources such as larger number of employees based on their product life cycle.

More T-tests statistical analyses were also conducted to establish whether the perceptions of tourism managers varied according to the length of business operation.

Table 5.21 presents the difference in perception of HIV/AIDS by length of business operation. The purpose of this analysis was to investigate whether the tourism companies that have been in business operation for a lengthy period, experience the impact of HIV/AIDS more than tourism companies that have been in business operation for a shorter period of time. For the purpose of

this research, companies that have been in business operations for 18 years and below are categorised as new companies, whereas those that have been in business operations for a period longer than 18 years are categorised as old companies. Based on the results presented in the below table, the impact of HIV/AIDS does not significantly vary according to whether the companies have been in business operations for a lengthy period or not. This shows that both old and new companies face similar challenges of HIV/AIDS.

TABLE 5.21: DIFFERENCES IN PERCEPTION OF HIV/AIDS BY LENGTH OF BUSINESS OPERATION

Perception	New Businesses Mean (SD)	Old Business Mean (SD)	t	Sig
The possible impact of HIV/AIDS on the Botswana tourism sector in general	2.20 (0.51)	2.28 (0.49)	-0.949	0.344
Host communities' perception on tourism development in relation to the spread of HIV/AIDS	2.48 (0.54)	2.52 (0.47)	-0.405	0.686
The possible impact of HIV/AIDS on individual tourism businesses in Botswana	3.13 (0.83)	2.85 (0.80)	1.905	0.059

More analyses were also conducted on differences in perception of HIV/AIDS by type of the tourism organisation. The types of tourism organisation from which the tourism managers who participated in the research come from are stipulated on Table 5.1. The statistical analysis which was applied here is ANOVA. The following results were found:

- *The possible impact of HIV/AIDS on the Botswana tourism sector in general:*

F (2, 146) = 1.266, P = 0.285

- *Tourism managers' perceptions on how host communities' perceive tourism development, its contribution, and its possible influence on the spread of HIV/AIDS:*

F (2,145) = 0.362, P = 0.697

- *The possible impact of HIV/AIDS on the individual tourism businesses in Botswana:*

F (2,145) = 0.2.583, P = 0.079

These results indicate that the difference in perceptions by tourism managers is significant. This shows that the impact of HIV/AIDS vary according to types of the organisation.

Another statistical analysis was also conducted to determine the perception of the tourism managers on whether the tourism companies that have HIV/AIDS policies vary according to the organisational ownership. Here the statistical analysis used is chi-square because this is a categorical data in which the respondents were required to say yes or no as to whether their respective companies have an HIV/AIDS policy or not. The table below presents the chi-square results based on the respondents' perceptions on company ownership and HIV/AIDS policy.

Table 5.22 presents the comparison of the companies that have HIV/AIDS policies between the tourism companies owned by Botswana citizens, non-Botswana citizens, and a partnership between non-citizens and citizens of Botswana. The results present insignificant differences in terms of companies that have HIV/AIDS policy and ownership. This shows that the tourism companies that have HIV/AIDS policy do not vary according to ownership.

TABLE 5:22 DIFFERENCE IN PERCEPTION OF HIV/AIDS BY COMPANY OWNER

Owner of the organisation						
HIV/AIDS Policy				Total	Chi-Square	Sig
	A Botswana citizen	A non-Botswana citizen	A partnership between non-citizen and citizen of Botswana			
Yes	22 (32%)	19 (28%)	27 (40%)	68 (100%)	2.37	.31
No	25 (45%)	11 (20%)	19 (35%)	55 (100%)		
Total	47 (38%)	30 (24%)	46 (37%)	123 (100%)		

The analysis of the research explores the possibility that the respondents' perception would differ according to the location of the tourism organizations in which the respondents come from. The table below presents the results of the T-test.

Table 5.23 presents the difference in perception of HIV/AIDS by company location in which the respondents come from. The two locations as indicated in the table are Kasane and Maun. On average, tourism managers who participated in the research from both Kasane and Maun agreed with statements indicating that HIV/AIDS has negative impacts on the Botswana tourism sector in general. With regard to the host communities' perceptions on tourism development in relation to the spread of HIV/AIDS, the perceptions of the tourism managers who participated in the research from both locations differ significantly. On average, tourism managers who participated in the research from Kasane agreed that host communities in Kasane believe that tourism influences the spread of HIV/AIDS in their communities. In contrast, tourism managers from Maun disagreed that host communities in Maun do not perceive tourism as having an influence on the spread of HIV/AIDS in their area.

TABLE 5.23: DIFFERENCE IN PERCEPTION OF HIV/AIDS BY COMPANY LOCATION

Perception	Company Location		t	Sig
	Kasane Mean (SD)	Maun Mean (SD)		
The possible impact of HIV/AIDS on the Botswana tourism sector in general	2.22 (.51)	2.31(.51)	-1.04	.30
Host communities' perception on tourism development in relation to the spread of HIV/AIDS	2.39 (.53)	2.59 (.46)	-2.51	.01
The possible impact of HIV/AIDS on individual tourism businesses in Botswana	2.85 (.81)	3.20 (.77)	-2.70	.01

The perceptions of tourism managers who participated in the research also significantly varied on the possible impact of HIV/AIDS on their individual tourism businesses. On average, tourism managers who participated in the research from Kasane agreed that HIV/AIDS has negative

impact on their organisations, whereas the tourism managers who participated on the research from Maun disagree with the statements indicating that HIV/AIDS affects the running of their businesses.

5.8 SUMMARY

This chapter presented the research findings based on the perception of the tourism managers who participated on this research. The results are presented using various statistical presentations using tables according to the key objectives of the research. Factors covered in this research include contribution to research methods, research limitations, empirical survey and analysis of results, sampling methods, reliability test and analysis, and key findings. In the following chapter, the results of this research are discussed.

CHAPTER 6

RESULTS DISCUSSION

6.1 INTRODUCTION

In this chapter, the key results of the research are discussed. The results are presented and its implications are also explained in detail. Factors covered include possible implication of the results on the Botswana tourism sector, and concluding remarks are made at the end of the chapter.

6.2 POSSIBLE IMPLICATIONS

The purpose of this research is to investigate the impact of HIV/AIDS on the socioeconomic environment in Botswana with special reference to the tourism sector. Tourism managers who participated in the research include both citizens and expatriates. Most (85%) of the tourism managers who participated in this research are the citizens of Botswana (see Table 5.3). These results vary from the research conducted by Mbaiwa (2005) indicating that tourism in the Okavango Delta in Botswana is dominated by expatriates. However, the possible explanation that can be linked to these variations is that many Botswana citizens now venture into tourism businesses.

The majority (53%) of the tourism managers who participated in the research have either certificate or diploma qualifications (see Table 5.3). Specifically, only 12% of the tourism managers who participated in the research indicate that they have undergraduate degree, and only 6% of the tourism managers who participated in the research indicate that they have post graduate degree. The fact that only few tourism managers are educated suggests that a majority of the tourism employees, particularly at lower levels of organisational structure, do not have tertiary qualifications. This shows that the tourism sector in Botswana is facing the challenges of shortage of skilled labour.

Most (59%) of the tourism managers who participated in the research are females (see table 5.4). This shows that women play an important role in the management of tourism businesses in Botswana. Anecdotal records show that in Botswana women are more vulnerable to HIV/AIDS

than men. Therefore, it seems reasonable to think that the Botswana tourism sector is at risk because more women occupy management positions. Most (82%) of the tourism managers who participated in the research are between the ages of 20 and 39 (see table 5.4). This age range is within the population group most vulnerable to HIV/AIDS in Botswana (Nagelkerk, Jha, De Vlas, Korenromp, Moses, Blanchard & Plummer, 2002, Botswana's Ministry of Health, 2005, Botswana's Ministry of State President National AIDS Coordinating Agency, 2005, UNICEF, 2005, WHO, 2005, UNDP, 2006, UNAIDS, 2007 & UNAIDS, 2009). Again this puts the tourism sector at risk. The research conducted by Forsythe in 1999 also stipulates that the tourism sector is general at particular risk from HIV/AIDS because of the mobility of tourism workers, sex tourism, and due to the fact that many developing countries rely on tourism for revenues.

52% of the tourism managers who participated in this research are from Maun, and 48% are from Kasane (see table 5.5). This is because Maun has more tourism companies than Kasane. 50% of the tourism managers who participated in this research indicate that their organisations have an HIV/AIDS policy, whereas 42% indicated that their organisations do not have such a policy (see table 5.5). These results suggest that many tourism companies in Botswana have put measures to combat HIV/AIDS because it has impact on their businesses. However, these results show that not all tourism companies in Botswana take proactive action to fight the impact and prevalence of HIV/AIDS. A significant number of tourism managers who participated in this research indicate that their organisations do not have HIV/AIDS policy.

Most managers who participated in the research come from hotels, lodges/camp, guesthouses and mobile safaris. Most (75%) of the managers came from lodges/camp. This is because ecotourism (nature-based tourism) dominates tourism in remote areas in Botswana and tourists use lodges/camp for accommodation. Majority (75%) of the tourism companies in which respondents come from are owned by either a Botswana citizen or by a partnership between Botswana citizen and a non-Botswana citizen. This shows that Botswana citizens take active role in the development of tourism in the country. However, these results vary with various researches indicating that tourism businesses in Botswana are dominated by expatriates. The possible explanation to this variation could be that many Botswana citizens started venturing into tourism businesses few years ago after such researches were conducted.

All tourism managers who participated in this research indicate that tourism is one of the Botswana's important economic activities. Tourism creates employment, attracts foreign investors in the country, and creates business for local people. Tourism also creates development opportunities for host communities in which tourism activities are taking place.

As already indicated, tourism in Botswana is still at development stage and it is growing at a high rate. Most of the tourism managers who participated in this research strongly agreed that Botswana is one of the countries in the world with a high rate of HIV/AIDS infections.

Besides its impacts on the tourism sector, HIV/AIDS also results in increased levels of poverty particularly in many rural areas of Botswana. The problem is that poverty results in further spread of HIV/AIDS. The continued spread of HIV/AIDS threatens the future of the Botswana tourism sector which is still at development stage.

There are various factors influencing the spread of HIV/AIDS in Botswana such as gender inequality and alcohol abuse. This shows that combating HIV/AIDS in Botswana needs involvement of various sectors including communities. The point of departure in the fight against HIV/AIDS should be poverty alleviation, addressing gender related problems, and discouraging people particularly young people who are vulnerable to HIV/AIDS from alcohol abuse. This also means that the fight against HIV/AIDS cannot be the sole responsibility of the state government but should be a collective responsibility involving all the stakeholders such as tourism businesses in the private sector and host communities.

The fact that HIV/AIDS is the main cause of death and that it results in increased poverty levels in rural areas means that the demand for domestic tourism in Botswana could be threatened. Prospective tourists are likely to spend more money on medical expenses than on tourism activities. Many people living in poverty cannot afford to pay for tourism activities. Tourism is a disposable activity that needs disposable time and income (Ashly, Boyd & Goodwin, 2000, & Reid, Mair & George, 2002). The HIV/AIDS problem therefore, means that in this regard, people are expected to spend more time and money in taking care of their family members and attending funerals instead of participating in tourism activities.

The results show that many tourism managers who participated in this research chose 'neutral' on the statement indicating that HIV/AIDS threatens new investments in the tourism private sector. HIV/AIDS threatens in new investments in the Botswana tourism sector because potential investors spend money on medical expenses attributed to HIV/AIDS. New investments depend on demand from the local market which is threatened by HIV/AIDS. As a result, the new investors may also hesitate to invest money where there is no return on investment. The increased individual expenses on medical expenditure results in reduced individual's savings (Bernett, Whiteside & Desmond, 2001). Strengthening the domestic tourism market is imperative particularly in the face of global economic down turn in which the international market is unpredictable.

The results show that tourism managers are neutral on the statement indicating that HIV/AIDS increases the growth rate of average incomes. This shows that the impact of HIV/AIDS on the growth rate of average incomes for tourism workers in Botswana is not significant. HIV/AIDS results in lower population growth in Botswana. The reduced population growth directly or indirectly affects the Botswana's tourism sector because it reduces the availability and quality of labour. It is important to note that tourism is labour intensive (Botswana's Department of Tourism, 2009). HIV/AIDS affects the quality of service rendered to tourists by many tourism companies in Botswana by killing the skilled tourism labour. HIV/AIDS increases the cost of running tourism businesses in Botswana and it also results in low labour productivity. The increased cost of running tourism businesses results from the fact that tourism organisations that face high rate of workers' absenteeism often use temporary workers who are less experienced. This in return affects both service quality and productivity.

On average (2.53), tourism managers who participated in this research indicate that tourism companies in Botswana in general often discuss HIV/AIDS problem among themselves (see table 5.15). This shows that the impact of HIV/AIDS on tourism businesses in Botswana worries a number of individual tourism businesses. . Many tourism businesses particularly in the private sector do not seem to take active role to combat HIV/AIDS because a significant number of the tourism managers who participated in this research indicate that their organisations do not have HIV/AIDS policy. In fighting HIV/AIDS, tourism businesses including those in the private sector should work closely with the host communities and share ideas about HIV/AIDS alleviation strategies.

The second objective of this research is to investigate the perception of tourism managers on how host communities, in areas in which tourism activities are taking place, perceive tourism development in relation to the spread of HIV/AIDS. Tourism managers strongly agreed with the statement indicating that tourism creates employment in their location. This suggests that tourism is an important economic activity within the communities in which tourism activities are taking place. The economic benefits of tourism also motivate communities to improve the appearance of the area by minimising littering. Besides improving the appearance of the area in which tourism activities are taking place, tourism contributes to the conservation of the natural environment and it also brings facilities that improve the quality of life for host communities. Such facilities include hotels, lodges, guesthouses and many others that create employment for host community members (Andereck, Valentine, Knopf & Vogt, 2005, & Blackstock, 2005).

Most of the tourism managers who participated in this research disagreed with the statement indicating that the economic benefits of tourism to the host communities are overrated. These results vary with a number of researches indicating that the economic benefits of tourism in Botswana accrue to minority groups within the host communities (Mbaiwa, 2005). The possible explanation to this variation could be the fact that tourism in Botswana is still at development stage and many tourism companies are small and they cannot employ larger number of people as the host communities may expect. Therefore, few individuals who get the opportunity to own tourism businesses or get employed are often identified by the majority who do not get opportunities to participate on tourism activities. To curb such discrepancies, tourism business community including those in the private sector should work with host communities and also strive to solve socioeconomic challenges that face the host communities such as poverty and HIV/AIDS.

Although on average (3.35) tourism managers disagree that tourism contributes to the spread of HIV/AIDS, few of the tourism managers agree with the statement indicating that tourism contributes to the spread of HIV/AIDS in their locations. Tourism influences the spread of HIV/AIDS in communities in which tourism activities are taking place. This is because tourism involves movement of people from various places. The movement of people often results in social interaction among tourist and host communities including the interaction between tourists and tourism employees. The other indirect influence of tourism on the spread of HIV/AIDS is

due to the fact that tourism activities in Botswana are taking place in remote areas in which tourism employees are required to spend at least three months away from their families and spouse. This is particularly the case with tourism employees who are working for tourism organisations in the Okavango Delta in which they spend three months in the delta and get one month off to spend with their families and spouse. The situation in the Okavango Delta is exacerbated by the fact that the Delta is difficult to access by communities and the common mode of travel to the delta is by charter aircrafts.

Many tourism managers who participated in this research also disagree with the statement indicating that tourism damages the natural environment. This shows that the damage to the environment in areas in which the research was conducted is insignificant. However, the construction of lodges and campsites often damages the ecosystems and natural vegetation particularly in cases whereby tourism activities are not properly planned. Noise pollution is caused by boats used on boat cruise such as in Chobe River in Chobe national Park and vehicles used for game drive activities in the Okavango Delta and Chobe National Park.

Most of the tourism managers who participated in this research agree with the statement indicating that tourism increases the cost of living in host communities. The increased cost of living may result in increased poverty levels for poorer host communities. However, according to many tourism managers, further tourism development is not expected to have more disadvantages on host communities. This suggests that the economic benefits of tourism in Botswana are significant and outweigh its costs. This also indicates that host communities welcome and encourage tourism as an important economic activity.

However, for host communities to support the development of tourism in their area, the tourism developers should involve communities on planning any tourism activity in their area (Keogh, 1990). On average, tourism managers who participated on this research strongly agreed that host communities should be involved and work closely with business community in tourism development. The collaboration between host communities and tourism business community in planning and developing tourism is imperative because it enhances host communities' support for tourism development and it also enhances host communities benefits from tourism. Involving host communities in tourism development is also an important initiative because it also makes the host communities to take the responsibility and ownership of tourism development in their areas.

However, host communities and tourism business communities should not work together only on developing tourism but should also work together in addressing the socioeconomic problems that are facing host communities such as poverty and HIV/AIDS.

This research also focuses on the perception of tourism managers on the possible impact of HIV/AIDS on individual tourism businesses. On average, many tourism managers agreed that HIV/AIDS has negative impact on their businesses. HIV/AIDS affects the direct running of tourism businesses because it results in workers' absenteeism. Workers absenteeism results in many tourism organisations operating with casual workers, and this in return affects the concerned companies' productivity because casual workers often lack the required experience. Operating tourism business with casual workers also compromises service quality and it also result in increased employee costs for tourism companies. The business is obliged to pay both the casual employee and the employee off duty due HIV/AIDS (Forsythe, Hasbun & De Lister, 1998, & Forsythe, 1999).

Many tourism managers who participated in the research also agree that tourism workers' loyalty and commitment to their job is negatively affected by the HIV/AIDS problem. This is because HIV/AIDS causes tremendous stress for people living with the virus and stressed employees are most likely to be demoralised. Tourism employees could also be stressed by the fact that one of the family members is infected with HIV/AIDS particularly in cases the family members is a close relative such as brother sister or parent. The HIV/AIDS problem is a cause for concern for many tourism businesses and many tourism managers who participated in this research agree that they often discuss HIV/AIDS problem during their general staff meetings.

However, majority of the tourism managers disagree that their organisations experience high labour turnover rates as a result of HIV/AIDS. This indicates that despite the fact HIV/AIDS affects the daily running of many tourism businesses, its impact on labour turnover is not significant. It also shows that the impact of HIV/AIDS on tourism businesses in Botswana is manageable. This also shows that the HIV/AIDS treatment such as ARV is cost effective. Most of the tourism managers also disagreed that their workers often go on sick leave for a lengthy period attributed to HIV/AIDS. This can also be linked to HIV/AIDS treatment that prolongs the lives and boosts the immune systems of infected employees who are on treatment.

Despite the fact that HIV/AIDS results in many tourism companies operating their business with casual workers, most of the tourism managers disagree that their organisations incur employment (recruitment and training) costs resulting from the loss of employees to HIV/AIDS. This shows that although HIV/AIDS has negative impact on the Botswana tourism sector, its impact is not as severe as it could be expected.

On average (3.32), many tourism managers who participated in this research also disagree with the statement that HIV/AIDS creates discrimination against tourism employees living with the disease (see table 2.15). This suggests that the educational campaign by the Botswana government and the HIV/AIDS policy discouraging any form of discrimination against people living with HIV/AIDS is cost effective, and accepted by the people (Botswana's Ministry Health, 2008).

Many tourism managers disagree with the statement that tourism results in increased commercial sex work in their location. This indicates that commercial sex work reported in Kasane, Maun and in major cities in Botswana cannot be directly linked to tourism. Many tourism managers also denied that sex tourism is a common practice in their area.

Most of the tourism managers also expressed concern on the impact of HIV/AIDS, and agree that HIV/AIDS is a serious problem for their businesses. HIV/AIDS reduces employees' efficiency on their job. In attempt to curb the impact of HIV/AIDS on their businesses, many tourism managers indicate that their organisations work closely with the local community members to fight the spread of HIV/AIDS. However, most of the tourism managers disagree with the statement indicating that a number of their employees go on an early retirement on medical grounds. This shows that the impact of HIV/AIDS on tourism employees with regard to early retirement on the Botswana tourism sector is not that severe.

In fighting the HIV/AIDS problem in their respective organisations, tourism managers vary according to the company HIV/AIDS policy, company size, length of business operation, and company location (see tables 5.12, 5.13, 5.14, and 5.16 respectively). In this regard, few of the tourism managers also indicate that their companies have an HIV/AIDS policy. In contrast, most of the tourism managers also indicated that their companies do not have an HIV/AIDS policy. This means that many tourism companies in Botswana are not proactive in the fight against

HIV/AIDS. They are reactive because they only take action upon experiencing the HIV/AIDS problem. Tourism companies therefore should be proactive in the fight against HIV/AIDS because waiting until the problem occurs may result in the damage that may be difficult to repair.

Tourism managers from large companies indicated that they face the impact of HIV/AIDS in their businesses, but those from small and medium tourism companies indicated that they do not experience the impacts of HIV/AIDS on their businesses. This shows that large tourism companies are more vulnerable to HIV/AIDS than small and medium tourism companies. Small and medium tourism companies employ smaller number of employees than large tourism companies. The fact that small and medium tourism companies employ lesser employees than large companies means that the impact of HIV/AIDS on small and medium tourism companies such as on staff absenteeism is less significant than its impacts on large companies.

There is significant difference between tourism managers who participated in the research from new and old tourism in terms of the impact of HIV/AIDS on individual businesses (see table 5.21). Tourism managers from new tourism companies indicated that they do not experience the impact of HIV/AIDS on their businesses, but those from older tourism companies indicate that they experience the impact of HIV/AIDS on their businesses. The possible explanation to this variation is that tourism companies that have been in business for a longer period have had time to observe the impact of HIV/AIDS on their business and they have the experience than new companies. Tourism companies that have been in business for longer period also constitutes the large tourism companies, whereas the category of the tourism companies that have been in business for a shorter period constitutes small and medium tourism companies. This does not mean that new tourism companies are not affected by HIV/AIDS but it is because the impact of HIV/AIDS on new tourism companies is less significant than on older companies.

However, tourism managers who participated in this research from both new and old tourism companies agree that HIV/AIDS has negative impact on the Botswana tourism in general and that host communities perceive tourism to be influencing the spread of HIV/AIDS. This is because tourism results in population migration of both tourism workers and clients. Population migration often results in human interaction and the concern factors include activities such as commercial sex.

The perception of tourism managers who participated on this research regarding HIV/AIDS also vary according to location in which the respondents' business in operating. For example, most tourism managers from Kasane indicated that a number of host community members in Kasane believe that tourism contributes to the spread of HIV/AIDS in their locations. Many tourism managers from Kasane also indicated that HIV/AIDS negatively impacts on their individual tourism businesses. In contrast, tourism managers from Maun indicate that most host community members in Maun do not perceive tourism as influencing the spread of HIV/AIDS in their location. Most tourism managers from Maun also deny that HIV/AIDS has significant negative impacts on their individual businesses.

What is amazing with the above variations is that both Kasane and Maun are the two key tourist destinations in Botswana and HIV/AIDS is also reported to be high in these two destinations. However, the interaction between visitors and host community members in Kasane is more significant than in Maun. There are more truck drivers in Kasane than there are in Maun. The high prevalence of HIV/AIDS is often attributed to high movement of people across the borders of Botswana, Namibia, Zambia and Zimbabwe particularly truck drivers who often spend weeks trying to cross the Chobe river to and from Botswana. Kasane is located in the area in which four nations (Botswana, Namibia, Zambia, and Zimbabwe) meet. These countries are separated by Chobe River, and the point where they meet is also a crossing point for truck drivers driving through Botswana into these other countries. According to tourism managers who participated on this research from Kasane, many host community members in Kasane perceives tourism to be influencing the spread of HIV/AIDS probably because they see many truck drivers crossing to and from neighbouring countries. These perceptions are also influenced by the fact that truck drivers who spend time at the borders before they can cross are often seen as opportunities by commercial sex workers. Commercial sex work in the area is exacerbated by the fact that many people living in Kasane are also living in poverty resulting from lack of employment opportunities.

Although observation was not part of the methodology used in this study, during the period of conducting empirical studies in Kazungula/Kasane, the researcher made an observation in the area in which many truck drivers often park at night waiting to cross the borders of Botswana to Zambia. Although it cannot be concluded that sexual activities are indeed taking place, the

researcher can confirm that the movement of girls in and out of trucks is significant in the area particularly at 9:00 pm onwards.

In Maun, tourists are not as visible as those who go to Kasane because they are often in transit to the Okavango Delta and their interaction with host communities is limited. The fact that many tourism managers from Maun deny that HIV/AIDS has negative impact on their individual business is surprising bearing in mind that Maun is one of the areas in Botswana with the highest HIV/AIDS prevalence rate. It is also reported that HIV/AIDS is high in the Okavango Delta, the key tourist attraction in the Ngamiland District where Maun is located. Most of the tourism organisations in Maun have lodges/camps in the Okavango Delta. The Okavango Delta is in a remote area and tourism employees working for the tourism organisations in the delta spend three months without their families and spouse. The worst challenge facing tourism employees working in tourism establishments in the Okavango Delta is the fact that there is no access for their family members or spouse to visit them and that there is no communication because there is no network coverage for cellular communication.

HIV/AIDS is reported to be high among the tourism establishments in the Okavango Delta. For example, Okavango Wilderness Safaris (OWS), a safari company located in Maun has expressed concern on how HIV/AIDS and related illnesses impact negatively on their businesses particularly on its lodges/camps in the Okavango Delta. The OWS is the largest tour operating company in Botswana and it operates 28 lodges/camps in the Okavango Delta. OWS management has taken an initiative in the fight against the impact of HIV/AIDS on their businesses and is one of the tourism companies that have an HIV/AIDS policy in Botswana. OWS management has employed a doctor, three nurses and two counsellors to assist their employees living with HIV/AIDS to cope with challenges of the disease. According to OWS management, doctors and nurses are employed by the company so that employees who are on HIV/AIDS treatment cannot often leave the camp to access to visit doctors for medical check up since there are in Maun and other areas in the country where HIV/AIDS can be accessible. OWS is indeed a shining example of a tourism company in the private sector that addresses the impact of HIV/AIDS in Botswana. The fact that most of the tourism managers who participated in this research from Maun deny that HIV/AIDS has negative impact on their businesses is amazing and it needs further investigations.

6.3 SUMMARY

This chapter covered results discussion, and the key results and their possible implications on the Botswana tourism are discussed. The following chapter covers the construction of a normative model aiming at minimising the spread of HIV/AIDS in the Botswana tourism sector.

CHAPTER 7

CONSTRUCTION OF A NORMATIVE MODEL

Various countries including Botswana use different models in the fight against the spread of HIV/AIDS but HIV/AIDS continue to spread. This shows that there is a need to come up with various initiatives. Before the proposed model is presented, models used in Botswana and other countries in the fight against HIV/AIDS are evaluated and the gaps within such models are identified.

7.1 INTRODUCTION

This chapter focuses on construction of a normative model. Before the normative model can be constructed, it is imperative to observe other models used in the fight against HIV/AIDS in Botswana and in other African countries. Factors covered in this chapter include

7.2 EXISTING MODELS IN THE FIGHT AGAINST HIV/AIDS

TABLE 7.1: SOUTH AFRICA'S HIV/AIDS MODEL

Expenditure	R30 million (1994)	R3 billion (2006)
Condom distribution	270 million (2003)	346 million(2004)
Female condom distribution	1.3 million (2003)	2.6 million (2004)
Access to condoms	97%	
Public HIV/AIDS service points	123	
Public ARV distribution points	199	
People on public ARV treatment	130 000	
People on private ARV treatment	80 000	
People accessing nutritional support	329 000	
Public VCT sites	1 500 (2002/03)	3 700 (2004/05)

Number of people counselled	691 000 (2003/04) 1.3 m (2004/05)
Prevention of mother-to-child facilities	2 500
Health professionals recruited	1 060
Health professionals trained on HIV	7 600
Community caregivers trained on HIV	61 000
Awareness about HIV/AIDS	92% - 98%

Source: Actuarial Society of South Africa (2004)

It is also stipulated in the table 7.2 that there are 130 000 AIDS patients on public sector ARV treatment, and 80 000 AIDS patients are on private sector ARV treatment. A total of 329 people in Botswana have access to the nutritional support services. During the period between 2002 and 2003, 1 500 public voluntary counselling and testing (VCT) sites were established in the country, and during the period 2004/2005, the government of South Africa established a total of 3 700 voluntary counselling and testing sites. The other indication in the table is that between the period 2003 and 2004, 691 000 people in South Africa used the voluntary counselling and testing services, and in 2004/2005, 1.3 million people in the country were voluntarily counselled and tested for HIV/AIDS.

It is further indicated in table 3.39 that 2 500 prevention of mother-to-child transmission facilities have been established in the country, and there are 1 060 health professionals recruited. There are 7 600 health professionals trained specifically on HIV/AIDS programmes, and 61 000 people have been trained on HIV/AIDS community care-giving programmes. It is also stipulated in table 3.12 that 92% to 98% of people in South Africa are aware of the HIV/AIDS pandemic and the way in which HIV virus is being transmitted. All the above initiatives indicate that HIV/AIDS has significant economic impact. The South Africa's model for HIV/AIDS focuses more on education and treatment campaign than on issues that lead to continued spread of HIV/AIDS such as poverty.

7.3 BOTSWANA'S HIV/AIDS MODEL

As already indicated in this research, the Botswana's National HIV/AIDS Strategic Framework

2003 – 2009 is an the key initiative by the Botswana government in combating HIV/AIDS in the country (NACA) (2002: 6). The Botswana National Strategic Framework (NSF) focuses on distributing educational programmes concerning HIV/AIDS in line with Botswana's Vision 2016. The Botswana's vision 2016 stipulates that Botswana should be free from new HIV/AIDS infection by the year 2016, but the worrying factor is that HIV/AIDS continues to spread in the country. The continuous spread of HIV/AIDS in the country as already indicated in this research makes the achievement of the vision 2016 to be questionable. NSF also provides guidance to various ministries, NGOs and the private sectors and it encourages synergistic approach in curbing HIV/AIDS in Botswana. Despite the fact that the Botswana's vision 2016 states that the country strives to be free from new HIV/AIDS infection in 2016, the spread of the virus in the country continues to increase particularly among young people including those living in areas where tourism activities are taking place.

NACA (2002: 10) indicates that the government of Botswana has declared HIV/AIDS a national emergency and that it is essential to fight the adverse impacts of HIV/AIDS collaboratively. HIV/AIDS is not the only health challenge facing Botswana but is the most serious threat to both current and future socio-economic progress of the country. HIV/AIDS is a complex disease that needs sound leadership and strategic national response involving stakeholders. The lessons learnt by the Botswana Government about HIV/AIDS show that it is imperative to engage in a collaborative approach to fight the disease. It is essential to be flexible in fighting HIV/AIDS so that both micro and macro changes within the society regarding HIV/AIDS can be identified and accommodated. However, one key aspect to the Botswana HIV/AIDS Strategic Framework (NFS) that needs adequate attention, is its implementation (NACA, 2002: 11). Strategic implementation and monitoring are the key considerations that determine the success or failure of the National Strategic Framework. Monitoring and information system facilitating management decision making is also the key component for successful NSF implementation.

Figure 7.1 depicts a comprehensive HIV/AIDS National Strategic Framework for Botswana and the implementation and monitoring process. The implementation of NSF by the Botswana government is a comprehensive and integrated approach. Botswana NSF formulation and implementation is based on various policies and assessments. The community response is imperative and is evaluated based on the feasibility of the plan, and all decisions made are based on strategic information management. An informed decision forms the basis for the government

to establish and implement NSF.

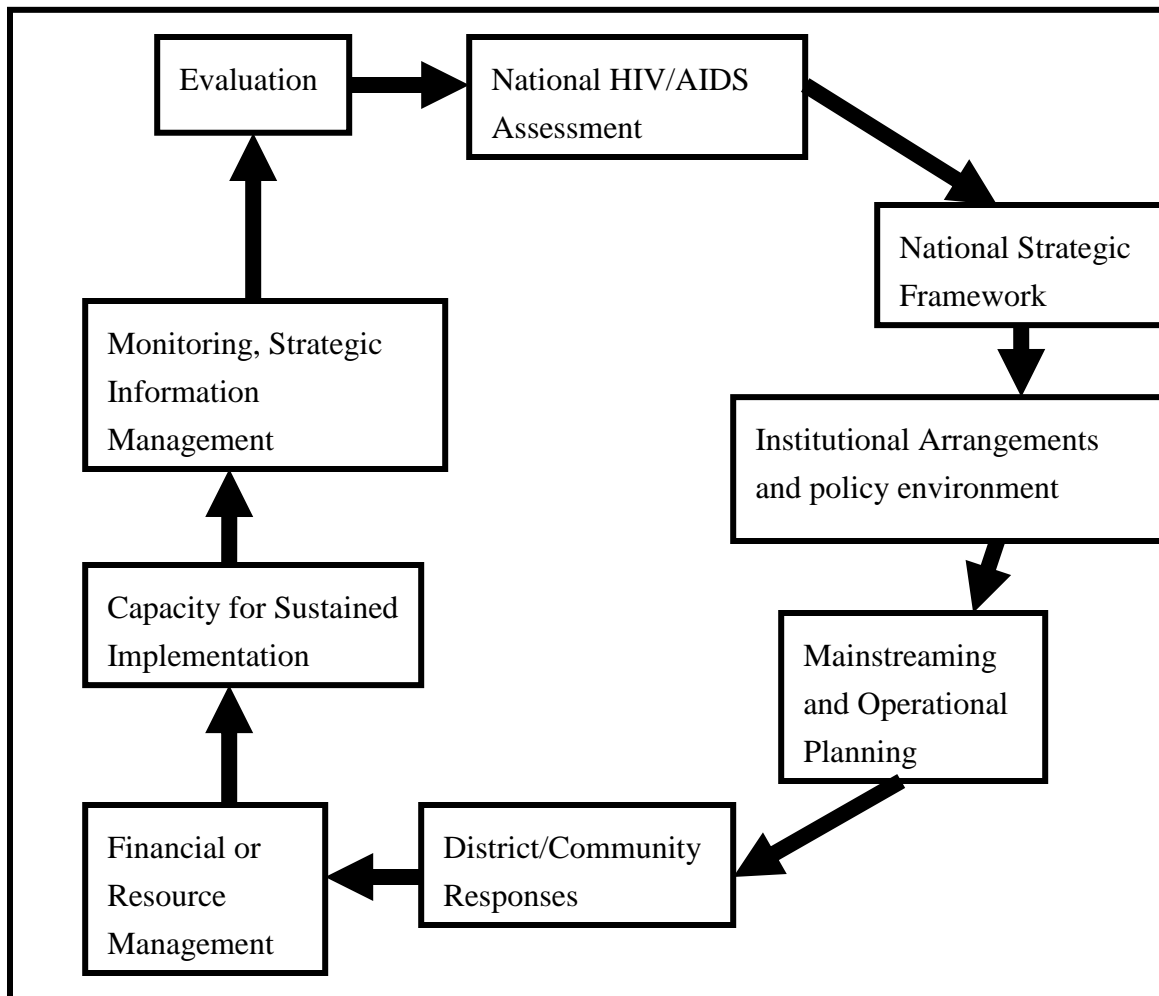


FIGURE 7.1: INTEGRATED BOTSWANA HIV/AIDS NATIONAL STRATEGIC FRAMEWORK

Source: (NACA, 2002)

The Botswana's HIV/AIDS National Strategic Framework (NSF), as indicated in the table 7.1, focuses mainly at national levels. Institutional arrangements and public policy focus at the national and regional levels, but not much is said or done to engage ordinary people particularly your people who live in poverty such as those in areas where tourism activities are taking place. As already indicated in this study, ordinary people should be consulted and be given the opportunity to participate in HIV/AIDS public policy formulation, mainstreaming and operational planning, and strategic evaluation. The Botswana's District/Community response on the

Country's NSF is limited to local authorities such as multi-sectoral representatives and community leaders, but not much is done to engage ordinary people such as youth living in poverty. The financial resources for the Botswana's NSF is also allocated and monitored by the government, and there is often a problem of insufficient funds to implement the strategy in a sustainable manner. Monitoring, Strategic Information Management, evaluation, and national HIV/AIDS assessment is done by the government. It is imperative to engage ordinary people particularly the young, unemployed people living in poverty.

Interventions to control HIV/AIDS are essential in Botswana, particularly among female sex workers. They should be encouraged to use preventive measures such as condoms and other safer sex practices. Commercial female sex workers constitute a population group reported to be most vulnerable to HIV/AIDS. However, data with regards to commercial sex working in Botswana is limited, but research conducted in most African countries indicate that unsafe commercial sex work contributes to the spread of HIV/AIDS.

The continued spread of HIV/AIDS shows that the general use of preventive measures is low in Botswana. Therefore, there is need for a focused intervention to minimise HIV/AIDS transmission (Nagelkerk *et al.*, 2002: 3).

The models used in the fight against HIV/AIDS in Botswana include encouraging people to practice safer sex and providing highly active retroviral therapy (HAART) to people living with HIV/AIDS, but not much is done to address the cause of the spread of HIV/AIDS. Although its long-term impact cannot be predicted, HAART reaps positive results on the mortality of people infected with HIV/AIDS in Botswana, but it does not minimise the spread of HIV/AIDS. HAART does not cure HIV/AIDS but may prolong the life expectancy of a person living with HIV/AIDS. The worrying factor as already stated in this research, is that HAART is expensive. To fight HIV/AIDS, it is imperative to combine various types of interventions. For example, the HIV/AIDS education campaign can be used concurrently with focused female commercial sex workers programme, sexually transmitted infection (STIs) treatment, and prevention of mother-to-child transmission programme. Failure to explore possible strategies that can minimise the spread and impact of HIV/AIDS can threaten the future of Botswana, particularly in the face of global economic recession.

Due to continuous spread and impact of HIV/AIDS, the government of Botswana has established home-based care programme in various parts of the country as an initiative to encourage share of responsibilities in caring for HIV/AIDS patients between government and communities. However, the challenge facing many communities, particularly in rural areas of the country, is the fact that many home-based care givers live in poverty, and poverty forces many care-givers to look for formal employment. This also emphasises that HIV/AIDS is not only a health problem, but it is also a socio-economic, cultural and human rights issue. This suggests that strategies to fight HIV/AIDS should be the collaborative efforts between various sectors of developing societies, including living in poverty.

Studies show that the health care systems in Botswana cannot effectively deal with continuous growing number of HIV/AIDS patients who suffer from the illness for a long time (Ngwenya & Kgathi, 2006: 671). This shows that addressing the HIV/AIDS problem from the medical point of view alone may not effectively help the country to win the battle against the spread the disease. Besides medical treatment, CHBC patients need sufficient nutritional food on a continuous basis, which also put pressure on the economy.

As already indicated in this study, the government of Botswana aims to prevent HIV/AIDS and to provide financial support to foster implementation, monitoring and evaluation by establishing management strategies of HIV/AIDS (UNDP, 2000: 21). However, it is important for communities to cup up with their strategies in addressing the HIV/AIDS problem. It is indicated that the Botswana's response to HIV/AIDS has gone through three various stages (Noble, 2007:1). The first stage was established between 1987 and 1989 and focused primarily on screening blood to reduce the risks of HIV transmission through blood transfusion. The second state established between 1989 and 1997 includes the first Botswana's Medium Term Pan (MTP), which involves the introduction of HIV/AIDS information, communication and education programmes from a narrow perspective. The third stage established in 1997 includes education, prevention, comprehensive care, and provision of antiretroviral (ARV) treatment. In this regard, the researcher recommends that the government should move to the fourth stage, which includes communities identifying ways in which they can prevent the spread of HIV/AIDS, such as addressing their socioeconomic problems like poverty, unemployment, and restoring morality and values.

The Botswana's Ministry of Health (2003: 8) states that the Botswana HIV/AIDS policy is structured on Vision 2016, which stipulates that by 2016 there will be an AIDS free generation in Botswana. The stakeholders in different sectors in Botswana show strong commitment in combating HIV/AIDS, but ordinary people do not make any significant contribution in the fight against HIV/AIDS. The Office of the President of Botswana is taking the lead in fighting the pandemic by providing adequate financial resources and the support of the development partners to contain the HIV/AIDS pandemic.

Noble (2007: 1) indicates that the government of Botswana uses the following strategies to combat HIV/AIDS:

- Public education and awareness
- Education for young people
- Condom distribution and education
- Targeting of highly mobile populations
- Improvement of blood safety
- Prevention of mother-to-child HIV transmission (MTCT)

Noble (2007:2) points out that the Botswana's HIV/AIDS public education and awareness has previously encouraged people to either abstain, be faithful or to use condoms whenever having sex. Botswana has taken a further step countrywide by introducing billboards and posters with the messages encouraging people to practice safe sex, but it is uncertain how effective the educational messages are when looking at the new HIV infection rate in the country.

7.4 IDENTIFIED GAPS WITHIN THE EXISTING MODELS

The challenges facing the Botswana's HIV/AIDS treatment campaign means that the antiretroviral treatment alone is not good enough to help the country to win the battle against the devastating HIV/AIDS infection rate in the country. The Botswana's Vision 2016 is to have HIV/AIDS free nation by the year 2016, when the country will be celebrating 50 years of democracy. This may be difficult to achieve given the fact that HIV/AIDS continues to spread in the country. There is a need to have a comprehensive HIV prevention framework that involves the government, private sectors such as those in tourism, stakeholders including individuals such

as people living in poverty, youth and communities at large. It is imperative to build infrastructure like testing centres in rural areas so that the rest of the country can be covered by the treatment campaign, but also to emphasise on addressing socioeconomic problems facing various communities.

Although this study is focused on Botswana, it is imperative to evaluate the HIV/AIDS response strategies in the countries that share borders with Botswana. The reason for this is that population migration has an influence on the spread of HIV/AIDS, and Botswana and the neighbouring states experience high population migration across their borders. HIV/AIDS is also reported to be high in Southern Africa, with Botswana and the neighbouring states being among the countries with the highest HIV/AIDS infection rates in the world. The Botswana strategies on the fight against HIV/AIDS involve selected government ministries and departments but the private sector such as tourism does not make significant contributions in the fight against HIV/AIDS.

Also what is lacking in the Botswana's model for HIV/AIDS is fact that people from the grass root level are not consulted when formulating and implementing HIV/AIDS policies. The Botswana HIV/AIDS model is similar to that of South Africa, because it focuses on education and treatment campaign, and not much is done on the main course of continuous spread of the disease from grassroots levels. The planning and implementation of the Botswana's model for HIV/AIDS does include ordinary people. In addressing the HIV/AIDS problem, it is imperative for the public policy makers to consult and involve people on the grassroots level including people living in poverty. HIV/AIDS policy planning, formulation and implementation should not be a top-down strategy but it should also be a bottom-up approach. In addition to medical and educational campaigns, modelling HIV/AIDS should also strive to address socioeconomic problems within the communities such as unemployment and poverty. The Botswana's model for HIV/AIDS lacks this initiative, and this research strives to address the gap through the proposed model. The Botswana model for HIV/AIDS is based on top-down instead of bottom-up or integrative approach. HIV/AIDS is a community problem not government problem, therefore any strategies fighting HIV/AIDS should put communities in forefront. The strategic formulation, implementation, and evaluation of the Botswana's NSF on HIV/AIDS are from the government to people, and the researcher recommends that it should be from people to government.

7.5 PROPOSED MODEL

Various studies indicate that Botswana is confronted with many risk factors associated with the spread of HIV/AIDS such as the migratory pattern of wage workers in and across the Botswana borders, alcohol abuse, deterioration of traditional family structures that used to reinforce morality, denial, and ignorance (Botswana Ministry of Health, 2000). Other susceptible factors include family and communal disruption (transfers, poverty, low status of women, high proportion of single parents and early parentage. The average age of first sexual encounter in the country is projected to be 17 years. This age group constitutes people who are either studying or those who have recently finished their form three and five (matriculates). The Botswana education system as already indicated in chapter three requires that students should pass form three for them to proceed to form four and five. Students who do not perform well in form three are often left with limited options. In a number of occasions most of these individuals roam the streets with no job or further education opportunities. This indicates that something needs to be done to assist these individuals.

In an attempt to address the continuous spread of HIV/AIDS in Botswana, the researcher identified community collaboration efforts to be one of the most imperative approaches that can be followed. This idea is supported by the studies conducted in Uganda and Thailand, which proved that collaborative efforts in combating HIV/AIDS is a cost effective strategy. For the purpose of this study, the proposed collaborative pilot project that is aiming at fighting the spread of HIV/AIDS through tourism initiative, is conducted in Chobe (Kazungula), and the researcher initiated the project in 2009. Chobe, as already indicated, is one of the key tourist destinations in Botswana and is one of the regions with the highest HIV/AIDS prevalence rate in the country. Kazungula is one of the locations in Chobe projected to be having high proportion of people living in poverty and high number of orphans. This projects aims at poverty alleviation in the area as a pilot project, particularly among young people. The aim here is to educate and equip young people with skills that they can utilise to sustain themselves instead of hoping that the government will provide their basic needs. The ideal objective is to get tourism companies, communities and other stakeholders to work together in fighting poverty and the spread of HIV/AIDS in Kazungula and Chobe in general.

Therefore, in modelling the spread of HIV/AIDS in Kazungula, the researcher proposed a collaborative normative model pilot project involving various stakeholders including those in the public and private sectors, vulnerable community members such as orphans, and communities at large. The purpose of involving various stakeholders is because HIV/AIDS is a complex issue that needs collaborative approach. Involving community members in the fight against HIV/AIDS is imperative because it enhances sense of ownership in strategies formulated. Because HIV/AIDS is a communities' problem, the community members are expected to have a better understanding of their socioeconomic problems that influence the continuous spread of the disease than a government official who is not part of the particular community. Studies conducted in Uganda and Thailand emphasise that fighting HIV/AIDS collaboratively involving communities and stakeholders is cost-effective.

Figure 7.2 presents an approach that can be used to mitigate the spread of HIV/AIDS in Botswana in general. The approach implies that HIV/AIDS should not only be addressed as a health problem, but should be addressed as a socio-economic problem involving the local communities. This is because people infected and affected by HIV/AIDS are community members, and this means that communities should be actively involved in the fight against HIV/AIDS together with other stakeholders. The proposed model is a collaborative approach recognising local communities' involvement in the fight against HIV/AIDS. The sectoral approach in fighting HIV/AIDS by the Botswana government is a good collaborative approach, but it does not incorporate communities from grass-root level and it also does not involve the private companies including those in tourism. A number of sectors playing an active role in the fight against HIV/AIDS in Botswana are those from the public sector. This discrepancy needs adequate attention because individuals working in private sectors such as those in tourism are among people infected and affected by HIV/AIDS. These individuals are also members of their respective communities, hence the need for active community involvement from grass-root level in the fight against HIV/AIDS. Communities should be involved in HIV/AIDS strategic planning, formulation, implementation and evaluation. Communities should also be involved in HIV/AIDS policy formulation. This means that communities should have sense of ownership in HIV/AIDS policy. This is imperative because communities are in a better position to identify risky behaviour leading to the spread of HIV/AIDS.

The following structure presents the proposed normative model that can be used in fighting the spread of HIV/AIDS in Botswana:

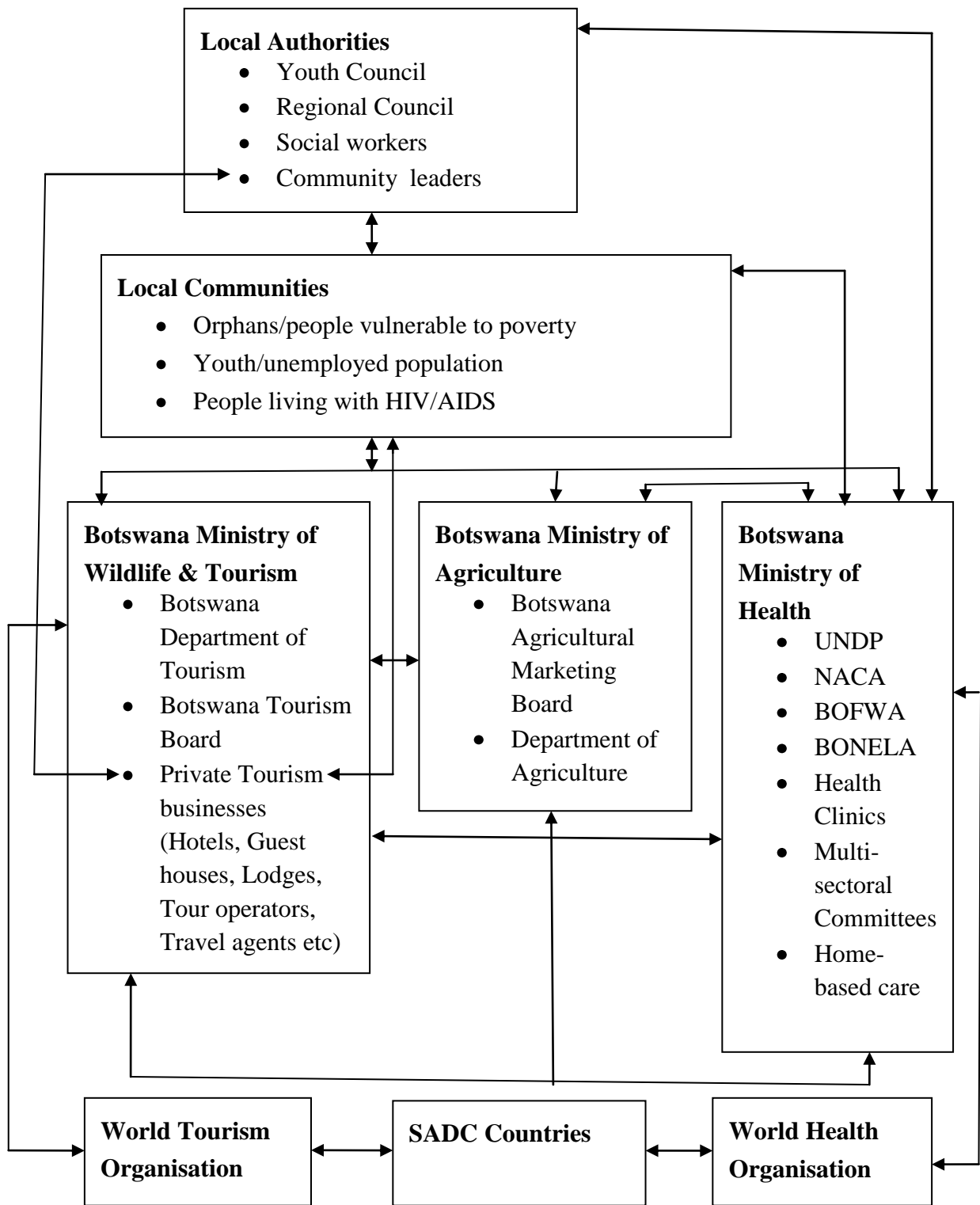


FIGURE 7.2: PROPOSED NORMATIVE MODEL AS A STRATEGIC APPROACH IN FIGHTING THE SPREAD OF HIV/AIDS

Contrary to the Botswana's HIV/AIDS National Strategic Framework (NSF), which involves mainly the government structures (see Figure 7.1), the researcher in the proposed normative model recommends that, in formulating and implementing strategies in the fight against HIV/AIDS, local communities should be consulted and should play an active role. The identified communities include orphans who are often vulnerable to poverty, youth who are often exposed to poverty due to unemployment, and people living with HIV/AIDS. The Botswana's HIV/AIDS NSF's structures are coordinated and financed by the Botswana's Ministry of Health. The researcher, through the proposed normative model, recommends that the Botswana's Ministries of Health, Agriculture, Wildlife and Tourism should work together in the fight against HIV/AIDS. These ministries are recommended to also work closely with the local communities from grass-root levels particularly in rural areas, where most of people in Botswana live. HIV/AIDS is not just a national or regional issue, but is a global problem. The researcher, therefore, recommends that the government of Botswana should work with international organisations such as World Health Organisation and World Tourism Organisation in the fight against HIV/AIDS particularly in the tourism sector.

The proposed approach indicates that local communities should play a pivotal role in fighting the spread of HIV/AIDS. The approach recognises the significant role that general communities can play in spearheading the fight against HIV/AIDS. The proposed normative model recommends that tourism companies in the tourism private sector should work closely with the local communities in which tourism is taking place. However, the proposed model does not divert from the Botswana government sectoral model in fighting the HIV/AIDS pandemic, but it incorporates the local communities and tourism private sectors into the existing government model. As already stated, the government sectoral approach in the fight against HIV/AIDS incorporates more public sectors from various ministries and few community members who facilitate home-based care.

In the proposed approach, community leaders are expected to work closely with the tourism private sectors within the community vicinity in identifying the variables influencing the spread of HIV/AIDS and come up with strategies to address such variables. However, communities and tourism companies in the private sectors are not expected to work in isolation but should work in collaboration with public sectors such as Department of Labour, Ministry of Health, and Ministry of Wildlife and Tourism. Besides identifying variables, this initiative may assist in reporting the socio-economic impact of HIV/AIDS from an informed background. Working with the Department of Labour is imperative because it may give indication to tourism companies and other economic sectors on how severe are the impacts of HIV/AIDS on the labour market. In

fighting poverty, one of the key variables influencing the spread of HIV/AIDS, Botswana Ministry of Agriculture, and Ministry of Health together with local communities should work closely in identifying projects that can generate food for local communities because people who are taking HIV/AIDS drugs such as ARVs need to eat well for the medicine to function properly.

Both the Botswana Ministries of Agriculture, Wildlife and Tourism, and other economic role players should work closely with the Ministry of Health in fighting HIV/AIDS both on local and national levels. However, the fight against HIV/AIDS should not be limited to local or national levels, but it should be approached from an international level. For example, the SADC region is reported to be the region most struck by HIV/AIDS in the world. It is therefore, imperative for Botswana and other SADC countries to work collectively in fighting the pandemic. This could include providing highly subsidised HIV/AIDS drugs such as ARV across the region. Due to economic imbalance, there are few SADC countries that provide ARV free of charge to their citizens. The worrying factor is that the spread of HIV/AIDS is closely linked to population migration both within and across borders. Also linked to population migration is poverty, which is also influences risky behaviour such as commercial sex work. An example of how poverty can influence population migration is that of Zimbabwe in which a number of Zimbabweans flee their countries to foreign countries including Botswana. The vicious cycle of HIV/AIDS presented on figure 7.3 indicates various consequences that influence the spread of HIV/AIDS.

In modelling the spread of HIV/AIDS in Botswana the focus should be on addressing the variables influencing the spread of the disease. Figure 7.3 above depicts the strong relationship between HIV/AIDS and poverty. However, it is indicated that the spread of HIV/AIDS is a consequence of various variables. HIV/AIDS is a complex issue, hence the need for collaborative efforts in combating the disease. From figure 7.3, it is evident that HIV/AIDS and poverty have strong relationship and influence each other significantly. This shows that the fight against HIV/AIDS should be done concurrently with the fight against poverty. Fighting HIV/AIDS in isolation without addressing poverty problem may not benefit the country significantly. The proposed approach encourages collaborative efforts that combat HIV/AIDS through poverty alleviation strategies.

Figure 7.3 indicates that HIV/AIDS results in an increased death rate, which results in deterioration of traditional family structures that used to reinforce morality. High death rate

results in increased poverty level because it increases household expenditure in medication and funeral costs. High death rate also results in high proportion of single parent, which also results in early parentage. Due to poverty, many poorer women are likely to engage in sexual relationship with older men who are believed to have money. This often put the lives of many women engaged in such relationship at risk because younger women may find it difficult to resist unprotected sex with their older male partners. For poorer women, refraining from risky activities such as commercial sex work may be difficult because commercial sex work may be the only means of living for them. This shows that a number of people particularly women are forced by circumstances to engage in commercial sex work. However, this does not mean that men cannot also be forced by poverty engage in commercial sex work, but it means that women are often the victims. The proposed normative model aims to address the variables that influence the spread of HIV/AIDS.

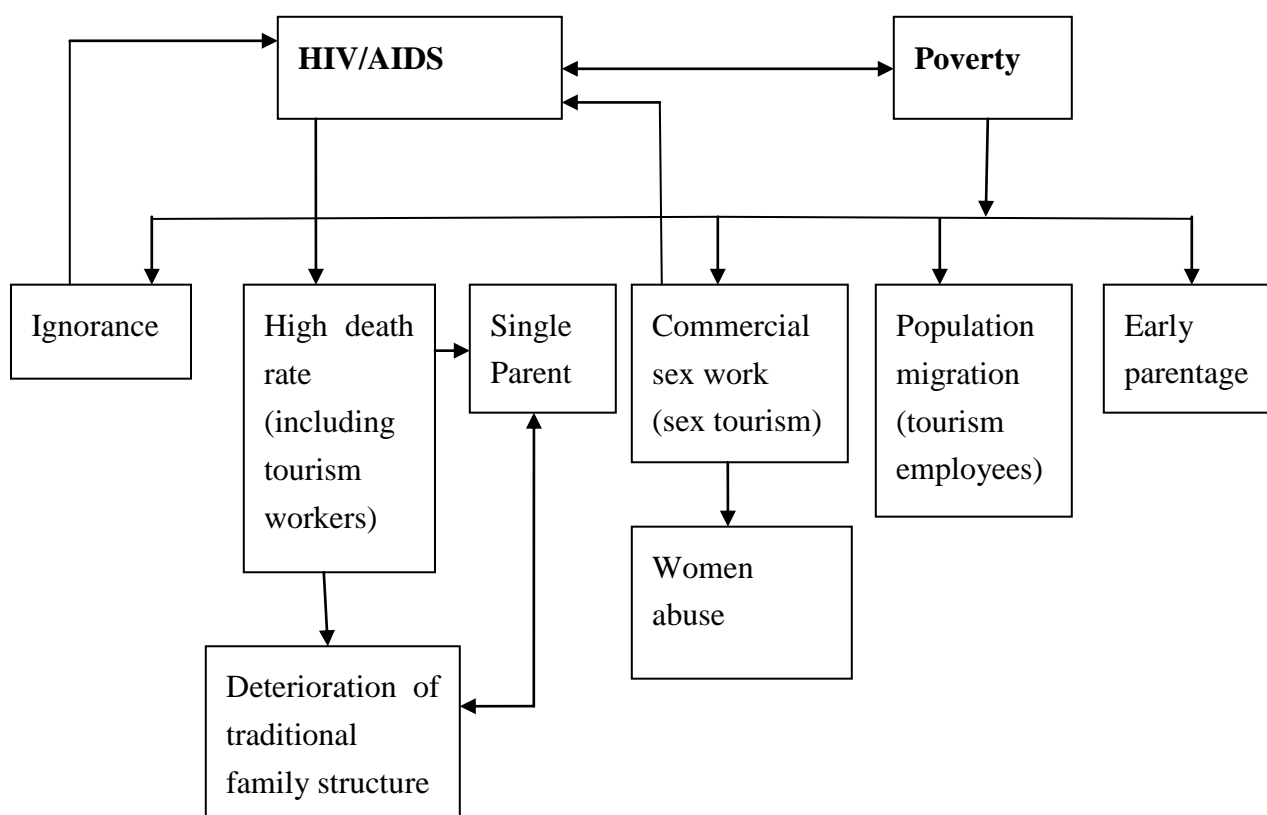


FIGURE 7.3: VICIOUS CYCLE OF HIV/AIDS

In testing the viability and the feasibility of the proposed normative model, the researcher

established a pilot project in Kazungula (Chobe). Prior to establishing the pilot project, the researcher contacted the community leaders and elders in the area to try and examine the reasons why HIV/AIDS is high in the area. This is also imperative to involve the community in such project so that communities can take ownership in fighting the spread of HIV/AIDS. In consultation with the community, the community indicated that lack of employment opportunities and poverty are the susceptible factors influencing young people in the area to engage in risky behaviour such as commercial sex work. The community leaders also indicated that truck drivers are the target for commercial sex work. A number of people who engage in commercial sex work according the community leaders are school leavers, including orphans. The community also indicated that there are incidences of crime such as house breaking and theft at night, which is suspected to be influenced by unemployment. This indicates that in fighting the spread of HIV/AIDS, it is imperative to address both poverty and unemployment problems.

However, the community does not work in isolation, but work in conjunction with various stakeholders who were consulted by the researcher. The consulted stakeholders include the Botswana Department of Tourism, the Botswana Tourism Board, NACA, Chobe Youth Council and private tourism companies within the vicinity of Kazungula. The Chobe Youth Council work closely with youth who are the target for this project and the council play a vital role in identifying the beneficiaries. In particular, the private tourism companies that play a vital role in the project are Chobe Safari Lodge, Chobe Marina Lodge, Chobe Mowana Lodge and Chobe Game Lodge. The reason for consulting various stakeholders such as those mentioned above is because the HIV/AIDS problem is complicated and it needs collaborative efforts. To date, 56 young people have been registered and Chobe safari Lodge work with host communities in training such people so that they can be employable or their own small business projects. This project has been running since 2008 to date.

As already indicated above, this is a pilot project that focuses on getting young people who are unemployed out of the street. The key objective is to educate the community, particularly young people, that they can do something positive to sustain their living instead of hoping that the government will provide everything for them or engaging in risky behaviour. In operating this project, the stakeholders together with communities in general engage in fund raising activities such as sponsored work. The raised funds are made available to assist young people who come up with small business ideas as a group not as individuals. In identifying the candidates, Chobe

Safari Lodge together with the other lodge mentioned in the above paragraph, conduct interviews and provides basic training. The basic training prepares the candidates for employment in various sectors. The challenge for this however is that not all trained candidates get employed, hence the need for the proposed project to provide small informal business opportunities.

However, this project does not only aim at people who can be trained for employment or business opportunities, but it also aims to assist younger people who may not be in a position to work such as orphans. For orphans who are still in school, the project provides in their basic needs such as school uniforms, clothes and food so that they can continue with their education like any other children. This is important to assist children not to grow in severe poverty that can lead them to risky behaviour. In identifying children who are legible for the benefits, stakeholders work closely with social workers, in the area and the community leaders. This is to avoid benefits given to people who are not legible instead of vulnerable children. Although the project does not bring measurable results on how it reduces the spread of HIV/AIDS among young people in Kazungula, its contribution to the lives of orphans and people living in poverty and unemployment is expected to be significant in future.

7.6 PROPOSED MODEL'S RECOMMENDATIONS

The researcher recommends that similar projects as the one in Kazungula/Kasane be established in other areas in the country and tourism establishments in the private sector should work with other stakeholders including host communities to establish and sustain such projects.

HIV/AIDS negatively affects the Botswana's economic sectors including the country's tourism industry (Botswana's Ministry of Health, 2008: 24). The researcher recommends that tourism private companies should take active role to conduct research on the impact of HIV/AIDS and make collective effort to combat the disease.

UNAIDS (2006: 17) indicates that reduced labour force and low productivity of Southern African countries has reduced government and private sector revenues including those in the tourism sector. In Botswana in particular, HIV/AIDS is reported to be high in areas in which tourism activities are taking place such as Kasane and Maun. The results of this research show that many

tourism companies do not take active roles in the fight against HIV/AIDS within their organisations. The researcher therefore, recommends that tourism businesses should work collaboratively to investigate and fight the spread and impacts of HIV/AIDS on the tourism businesses.

The Botswana's Ministry of Health (2000:28) states that Botswana is confronted with many risks associated with the spread of HIV/AIDS. These include the migration of wage workers, alcohol abuse, deteriorating traditional family structures, denial and ignorance. Other risks include family and communal disruptions or transfers, poverty, low status of women, high proportion of single parents and early parentage. Poverty and unemployment influence population migration of tourists and/or wage-workers According to the Ministry of Health (2000) HIV/AIDS is also increased by a high rate of alcohol consumption and abuse among the young people in Botswana and in a number of Southern African countries. Alcohol abuse increases the chances of engaging in unprotected sex among the young people in Botswana. To reduce unemployment rate, the tourism companies should work with local communities to establish tourism community-based projects. Besides creating employment, tourism community based projects such as the conservancies may also keep young people busy, which may also reduce both population migration and alcohol abuse.

CHAPTER 8

CONCLUSION

This research investigated the possible impact of HIV/AIDS on the Botswana tourism sector, the perception of tourism managers on host communities' perceptions on the impact of HIV/AIDS on tourism development, and the possible impact of HIV/AIDS on the individual tourism businesses.

Botswana boasts one of the fastest economic growths in Africa, largely depending on natural mineral resources and the booming tourism sector. Mineral mining and tourism are the top two economic contributors to the economy of Botswana. The economy of Botswana is faced with challenges such as poverty and the high prevalence of HIV/AIDS.

Tourism is one of the most important economic activities in Botswana. Tourism creates employment, creates entrepreneurial opportunities for local people, attracts investors in the country and it contributes to the country's GDP. Besides its economic contribution, tourism also creates national pride. Tourism development and facilities improve the appearance of the area in which tourism activities are taking place. Tourism also contributes to the conservation of the natural environment. However, besides positive contribution of tourism to the lives of host communities, tourism also increases the cost of living in host communities. This is because the prices for the basic needs such as food and clothes in most shops located in tourist destinations are relatively higher than in non-tourist destinations. It is advisable that the tourism business community should work closely with the host communities in planning and developing tourism and maximise the host communities' benefits from tourism. They should also fight against HIV/AIDS because it has an impact on tourism.

HIV/AIDS also reduces population growth, which also affects the availability and quality of tourism workforce. It causes shortage of skilled labour because tourism is labour intensive.

Most of the tourism companies in Botswana do not take an initiative to fight the impact of HIV/AIDS but rely on the government policies and strategies. This conclusion is reached based on the fact that many tourism managers who participated on this research indicated that their companies do not have HIV/AIDS policies. Failure to be proactive in the fight against

HIV/AIDS may threaten the future of many tourism businesses in Botswana. The fight against HIV/AIDS should not be the sole responsibility of the state government but it should be a collective responsibility involving all stakeholders such as the tourism organisations in the private sector and host communities in which tourism activities are taking place and in general (Letamo, 2003).

However, the fact that HIV/AIDS has negative impacts on the Botswana tourism sectors does not mean that the country's tourism sector is in a bad situation. The Botswana government's interventions in the fight against HIV/AIDS in the country such as providing free HIV/AIDS treatment like ARV to infected people prolong the lives of people living with HIV/AIDS. The population of people who are on ARV treatment constitutes people who are working in the tourism sector. HIV/AIDS treatments like ARV do not cure HIV/AIDS but it prolongs lives and boosts the immune system of infected persons. The treatment interventions therefore, benefit the tourism sector because it reduces staff turnover death rates that could affect the tourism companies in a no-treatment intervention scenario. However, the Botswana government, tourism business community and host communities need to work together to fight the spread of HIV/AIDS. Further HIV/AIDS infection may threaten the future investments on the Botswana tourism sector particularly with the global economic down turn (recession) because increased demand for people in need of ARV and other HIV/AIDS treatments may put pressure on government budgets. The other worrying factor is that HIV/AIDS treatments like ARV do not cure HIV/AIDS but prolongs lives of the infected people up to a certain period. The increasing number of people in need of ARV means that eventually the death rate may rise in future, which may impact negatively on the country's economic sectors including tourism (Caelers, 2006).

8.1 RECOMMENDATIONS

Based on the research findings, the following recommendations and contributions are made by this research:

This research encourages the tourism business community in Botswana to work closely with the host communities in developing tourism for the benefit of the Botswana tourism sector and communities in general. This research is also of value to academics who wish to increase their knowledge of the socioeconomic impact of HIV/AIDS on the Botswana tourism sector and on individual tourism businesses.

8.2 RESEARCH IMPLICATION AND RECOMMENDATION FOR MANAGEMENT AND GOVERNMENT

The researcher recommends the following for tourism managers and the government:

- The results of this research show that the prevalence rate of HIV/AIDS in remote areas in Botswana including the Okavango Delta is high. In minimising the spread of HIV/AIDS among employees working in remote areas such as the Okavango Delta, the researcher recommends that tourism companies should encourage their employees to work and stay with their spouses where possible. This can be done by employing couples not only in management but among the tourism employees in general. Many tourism companies operating businesses in the Okavango Delta only employ couples in management positions not general staff (Mbaiwa, 2005).
- The empirical results of this research indicate that tourism businesses in Maun and Kasane do not work with communities in the fight against HIV/AIDS. The researcher therefore, recommends that tourism business communities in the private sector should work with the host communities in identifying the possible variables that lead to the spread of HIV/AIDS and devise possible strategies that can be applied in the fight against HIV/AIDS such as projects aimed at poverty alleviation. Most of the tourism companies, particularly in the private sector, do not work with the host communities but only focus on their business.
- This research also concludes that most tourism companies particularly in the areas in which the research was conducted do have HIV/AIDS policy in their businesses. This conclusion is reached based the fact that many tourism managers who participated on this research indicate that their companies do not have HIV/AIDS policy and they do not discuss HIV/AIDS issues on their staff meetings. Tourism companies should incorporate HIV/AIDS policy in their business operations and they should educate and assist their employees to cope with the stresses related to HIV/AIDS and also be able to have open communication on issues regarding HIV/AIDS. Tourism companies in Botswana both in the public and private sector should conduct collaborative researches to investigate the impact of HIV/AIDS on tourism businesses and on the Botswana tourism sector in general. The research can be conducted in collaboration with the academic institutions

such as the University of Botswana. Conducting research is an essential strategy because it will help the tourism role-players to make informed decisions and take appropriate actions in the fight against HIV/AIDS and minimise its impacts on the Botswana tourism sector.

- Both private and public tourism organisations should work closely with the Botswana government, host communities and other economic sectors to draft a code of conduct that prevents significant variables that lead to the spread of HIV/AIDS such as alcohol abuse, gender inequality, domestic violence, and commercial sex work/prostitution. The code of conduct should be made accessible to visitors by placing them in websites, restaurant's menu and brochures.
- The Botswana government should work with other governments from other SADC countries, particularly those sharing borders with Botswana, in the fight against HIV/AIDS. This is because HIV/AIDS is also reported to be high among countries sharing borders with Botswana. Fighting HIV/AIDS as an individual country may not be effective because people travel and interact.
- The Botswana Ministries of Wildlife and Tourism and Agriculture should work together in the fight against poverty. This is because the Ministry of Agriculture is responsible for food production in Botswana and the produced food can be supplied to the tourism sector. In Botswana a number of tourism businesses, particularly in the private sector, import food such as fruits from foreign countries such as South Africa for their businesses. Importing food from foreign countries does not create employment for local people who would be employed on the farms in case more food is locally produced. Buying food from local suppliers is also imperative in minimising repatriation of money be spent in the country.

8.3 FUTURE RESEARCH AND DIRECTIONS

This research focused on the impact of HIV/AIDS on the socioeconomic environment in Botswana with special reference to the country's tourism sector. The specific objectives of this research included the possible impact of HIV/AIDS on the Botswana tourism sector, host community perception on tourism development in relation to the spread of HIV/ADS, and the possible impact of HIV/AIDS on individual tourism businesses in Botswana. Quantitative data

analysis formed the basis upon which self-administered survey was used in conducting this research. It is important for future research to use qualitative methods so that more ideas and opinions of the respondents can be identified. This research responds to the need to investigate the impact of HIV/AIDS on the Botswana tourism sector bearing in mind the fact that tourism is one of the economic pillars of Botswana and that HIV/AIDS is reported to be high in Botswana. The selection of tourism managers as opposed to the general employees within the tourism companies contributed to the quality data collected.

However, the fact that this research focused on tourism managers' perceptions instead of the general tourism employees means that future research on the impact of HIV/AIDS can be focused or include employees working in the tourism sector in general. This can be done by asking questions that can be understood and that are relevant to the general employees' understanding of the HIV/AIDS problem. To make the research understood by the general tourism employees, future researchers can ask questions in local languages such as Setswana because most of the tourism employees at lower levels are local people who can mainly speak and understand Setswana.

This research as it has already been indicated targeted only tourism managers as the participants but not host communities. Future researches can also include host community members as participants because HIV/AIDS does not only affect the tourism businesses but it also affects host communities. The fact that tourists interact with host communities means researches should involve host communities who are not directly involved on tourism activities so that they can express their perceptions on the spread of HIV/AIDS and tourism development on their communities.

Within the tourism businesses, this research focused on obtaining the perceptions of tourism managers on the impact of HIV/AIDS on tourism employees but not comparing the impacts according to skilled and semi-skilled employees. Future research therefore, should categorise the impacts of HIV/AIDS based on skilled and semi-skilled tourism employees to determine whether the effectiveness of the impact of HIV/AIDS on the tourism employees is felt more when it affects the skilled employees or when it affects employees in general.

This research has discovered that not all tourism companies take actions in the fight against

HIV/AIDS, yet HIV/AIDS is reported to be high in areas in which the research was conducted and in Botswana in general. Future research can therefore investigate why many tourism organisations in Botswana, particularly those in the private sector, do not take active role to fight the prevalence of HIV/AIDS and its impacts on their businesses.

This research was conducted in Botswana in the two key tourism destinations. Future research can also be conducted in other areas of the country. Where possible, future research can also be extended to foreign countries, particularly the key tourism destinations within the countries that share borders with Botswana in which the prevalence of HIV/AIDS is reported to be also high.

BIBLIOGRAPHY

ACHAP, NACA & UNAIDS. 2008. *Progress Report of the National Response to the UNGASS Declaration of Commitment on HIV/AIDS*. Gaborone: ACHAP, NACA & UNAIDS.

Actuarial Society of South Africa. 2004. *HIV Positive Women Visiting Antenatal Clinics*. Tshwane: South African Institute of Race Relations.

Actuarial Society of South Africa. 2003. *AIDS and Demographic Model*. Tshwane: Actuarial Society of South Africa.

Agbola, F.W., Damoese, M.Y. & Saini, Y.K. 2004. Impact of HIV/AIDS on Food Demand. *International Journal of Social Economies*, 31 (7): 721 – 731.

Allen, G. & Brennan, F. 2005. *Tourism in the New South Africa*. Cape Town: Department of Economic Development and Tourism.

Andereck, K., Valentine, K., Knopf, R. & Vogt, C.A. 2005. Residents' Perception of Community Tourism Impacts. *Annals of Tourism Research*, 32 (4): 1056 – 1076.

Anon. 2006. HIV/AIDS and Tourism in Botswana. *Botswana Daily News*: 13, Feb 26.

Anon. 2007. AIDS is one of the Factors Inhibiting Foreign Investment in Botswana. *Botswana Gazette*: 7, Aug 21.

Anon. 2003. Botswana Domestic Policy. *Encyclopedia of the Nations*: 1 – 2.

AfroAIDSinfo. Namibia: *Consultation on National HIV/AIDS Policy Begin*.
<http://www.afroaidsinfo.org/public/Home/news145.htm> [30 June 2006].

Appadurai, A. 1988. Cultural Dimensions of Globalisation. 1: 224.

Arndt, C. & Lewis, J.D. 2000. The Macro Implications of HIV/AIDS in South Africa : A

Preliminary Assessment. 1 – 20.

Ashley, C. 2006. *How can Governments Boost the Local Economic Impact of tourism*. London, UK: ODI

Ashley, C. 2006. *Participation by the Poor in Luang Prabang Tourism Economy: Current Earnings and Opportunities for Expansion*. London, UK: ODI & SNV.

Ashley, C. 2006. *Facilitating Pro-Poor Tourism with the Private Sector. Lessons Learned from “Pro-Poor Tourism Pilots in Southern Africa*. London, UK: ODI.

Ashley, C., Boyd, C. & Goodwin, H. 2000. *Pro-Poor Tourism: Putting Poverty at the Heart of Tourism Agenda*. London, UK: ODI.

Ashley, C. & Mitchell, J. 2005. *Can Tourism Accelerate Pro-Poor Growth in Africa*. London, UK: ODI.

Ashley, C. & Haysom, G. 2005. *From Philanthropy to a Different Way of Doing Business Strategies and Challenges into Tourism Business*. London, UK: ODI.

Auty, R.M. 2001. “The Political State and the Management of Mineral Rents in Capital-surplus Economies: Botswana and Saudi Arabia”. *Resource Policy*, 27: 77-86.

Bagwasi, M. 2005. The role of Language in Adult Education and Poverty Reduction in Botswana.

Balasubramanian, D. 2005. Sustainable Tourism Development. A Compilation and Analysis of Expert Views. *Annals of Tourism Research*.

Baum, T. 1999. Seasonality in Tourism: understanding the Challenges. *Tourism Economics – The Business and Finance of Tourism and recreation*, 5 (1): 4 – 8.

Berman, J.K., Tempest, J. & Morton, L. (eds). 2006. *Evidence Does Not Support Government*

Claims that South Africa's Programmes and Policies in Fighting the AIDS Pandemic are the Best in the World. Pretoria: South African Institute of Race Relations.

BER. 2006. *Assessing HIV/AIDS Risks from Supply Side by Sectors.* Cape Town: BER.

Bernett, T. Whiteside, A. & Desmond, C. 2001. The Social and economic Impact of HIV/AIDS in Poor Countries: Review of Studies and Lessons. *Progress in Development Studies*, 1,2: 151 – 170.

Blackstock, K. 2005. A Critical Look at Community Based Tourism. *Community Development Journal*, 40 (1): 39 – 49.

Blaikie, N. 2003. *Analyzing Quantitative Data.* London, UK: SAGE Publications.

Botswana. Department of Tourism Research and Statistics. 2008. *Tourist Arrivals by Country of Residence and Purpose of Visit.* Gaborone: Department of Tourism Research and Statistics.

Botswana. Department of Tourism. 2009. *Tourism Facts and Figures.* Gaborone: Department of Tourism.

Botswana. Department of Tourism. 2008. *Bajanala: A Tourist Guide to Botswana*, 4: 1 – 24, September.

Botswana. Department of Wildlife and Tourism. 2003. *A Tourist Guide to Botswana.* Gaborone: Department of Wildlife and Tourism.

Botswana Guardian. 2004. HIV/AIDS Cuts Life Expectancy. [13 October 2007].

Botswana Harvard International. 2003. *The HIV/AIDS Sector in Botswana: Communication, Knowledge Management, and Use of Information and Communication Technologies.* Gaborone: Botswana Harvard International.

Botswana Institute of Development Policy Analysis (BIDPA). 1997. *Study of Poverty and*

Poverty Alleviation in Botswana. Gaborone: BIDPA.

Botswana Ministry of Education . 2003. *National Plan of Action for Education for all*. Gaborone: Government Printer.

Botswana. Ministry of Health. 2008. *Macro-Economic Impacts of the HIV/AIDS in Botswana*. Gaborone: Ministry of Health.

Botswana: Ministry of Health. 2005. *The spread of HIV/AIDS in Sub-Saharan Africa*. Gaborone: Government printer.

Botswana. Ministry of Minerals, Energy and Water Resources. 2007. *Industry Prospects in Botswana's Minerals Sector*. Gaborone: Botswana Ministry of Minerals, Energy and Water Resources.

Botswana. Ministry of State President National AIDS Coordinating Agency. 2005. *HIV/AIDS Situation in Botswana*. Gaborone: Botswana Ministry of State President National AIDS Coordinating Agency.

Botswana. Ministry of Wildlife and Tourism. 2008. *Tourism Ripe for Investment*. [Http://www.discover-Botswana.com/articles/invest_tourism.php](http://www.discover-Botswana.com/articles/invest_tourism.php). [24 April 2008].

Botswana National Development Plan. 2003. *Botswana: Support for Education Quality and Technical and Vocational Education and Training*. Gaborone: Botswana National Development Plan.

Botswana. Population Census. 2001. *Geography of the Country*. Gaborone: Botswana Population Census.

Boxill I. 2003. Towards an Alternative Tourism for Belize. *International Journal of Contemporary Hospitality Management*, 15 (3): 147 – 150.

Butler, R. & Hinch, T. (eds). 1996. *Tourism and Indigenous People*. London: International

Thomson Business Press.

Byrd E.T. 2007. *Stakeholders in Sustainable Tourism Development and Roles: Applying Stakeholders Theory to Sustainable Tourism Development*, 62 (2): 6 -13.

Caelers, D.I. 2006. HIV Patients on ARVs Live Years Longer – Study. *Cape Argus*: 3, Jun. 7.

Camerapix Publishers International. 1991. *Spectrum Guides to Zimbabwe*. Nairobi: Camerapix.

Cameroon. Ministry of Public Health. 2002. *National HIV Sentinel Surveillance*. Yaoundé: Ministry of Public Health.

Castro, A. & Farmer, P. Understanding and Addressing AIDS-Related Stigma: From Anthropological Theory to Clinical Practice in Haiti. *American Journal of Public Health*, 95 (1): 53 – 59.

Central Statistics Office. 2005. Botswana AIDS Impact Survey II. In UNICEF (Ed.), *Botswana Child Monitor: A Bulletin of Recent Events, Statistics and Acquisition About Children*. Gaborone: UNICEF.

Chen, Y., Yang, G., Sweeney, S. & Feng, Y. 2010. Household Biogas use in Rural China: A study of Opportunities and constraints. *Renewable & Sustainable Energy Reviews*, 14 (1): 545 – 549.

Choi H.C. & Sirakaya E. 2006. Sustainability Indicators for Managing Community Tourism. *Tourism Management*, 27: 1274 – 1289.

Coate B. & Handmer J. 2006. *Taking Care of people and Communities: Rebuilding livelihoods Through NGOs and the Informal Economy in Southern Thailand*, 15 (1): 135 – 145.

Colclough, C. & McCarthy, S. 2002. The Political Economy of Botswana: A Study of Growth and Distribution. *The Journal of Development Studies*, 18 (2): 400 - 401.

Cooper, D.R. & Schindler, P.S. 2003. *Business Research Methods*. 8th ed. New York: McGraw-Hill/Irwin.

Christopher, H.R. 2001. Economy of Botswana. *International Affaires*, 59 (2): 311 – 312, Spring.

Dabis, F. & Ekpini, E.R. 2002. HIV-1/AIDS and Maternal and Child Health in Africa. *Lancet*, 359: 2097 – 2104, June.

Deininger, K., Garcia, M. & Subbarao, K. 2003. AIDS-induced Orphanhood as a Systemic Shock: Magnitude, Impact and Program Interventions in Africa. *World Development*, 31(7): 1201 – 1220.

Dixon, S. & Macdonald, S. 2002. The impact of HIV and AIDS on Africa's Economic Development. *BMJ*, 324: 232 – 234.

Duffy, R. 2000. *Killing for Conservation. Wildlife Policy in Zimbabwe*. Victoria Falls: Zimbabwean Tourism Authority.

Dwyer L. & Forsyth P. 1997. Measuring the Benefits and Yield from Foreign Tourism. *International Journal of Social Economic*, 1 (2/3): 223 – 236.

Economist Intelligence Unit, 2005. *Country Profile 2005: Botswana*. London, UK: Economist Intelligence Unit.

EcoTravel Africa. n.d. *South Africa Tourist Attractions*. <http://www.Ecotravel.co.za/South-African/travel-guides/tourists-attraction.htm> [10 may 2006].

EcoTravel Africa. n.d. *Zimbabwe Travel Guide*.
<http://www.ecotravel.co.za/Zimbabwean/travel-guide.htm> [10 May 2006].

Ellis, L. & Terwin, J. 2004. *The Impact HIV/AIDS on Selected Business Sectors in South Africa*. Cape Town: Bureau for Economic Research.

- Emory, C.W. & Cooper, D.R. 1991. *Business Research Methods*. 4th ed. New York: Richard, D. Irwin.
- England, J.L. & Albrecht, S.L. 1984. Boomtowns and Social Disruption. *Rural Sociology*, 49 (2): 230 – 246.
- Ezel, P. 2004. *The trouble with tourism without aids*. Cape Town: Ezel.
- FAO. 2001. *The Impact of HIV/AIDS on Traditional Coping Mechanisms in Rural Economies*. Rome: Food and Agriculture Organisation.
- Faulkner B. & Tideswell C. 1997. A Framework for Monitoring Community Impacts of Tourism. *Journal of Sustainable Tourism*, 15 (1): 3 – 28.
- Felicity, Lydia, Sekai, & Hatendi. 2001. *Zimbabwe National HIV/AIDS Policy*. Harare: UNICEF.
- Forsythe, S. 1999. HIV/AIDS and Tourism. *AIDS Anal Afr*, 9 (6): 4 – 6, April – May.
- Forsythe, S., Hasbun, J. & De Lister, M.B. 1998. Protecting Paradise: Tourism and AIDS in the Dominican Republic. *Health Policy and Planning*, 13 (3): 277 – 2286.
- Globastat. 2005. *Percentage of Total Population Living with HIV/AIDS*. <http://www.globastat.com> [16 March 2006].
- Goeldner, C.R. & Ritchie, J.R. 10th ed. 2006. *Tourism Principles, Practices, Philosophies*. New Jersey: John Willey & Sons.
- Gold World, 2006. *Botswana Mining*. <http://www.nationencyclopedia.com/Africa/Botswana-MINING.html> [18 September 2007].
- Goodwin. H. & Robson. S. 2004. *Tourism and Local economic Development. How Can Business in Travel and Tourism Increase the Contribution of the Industry to Local economic development and Pro-Poor Growth*. London, UK: International Tourism Partnership.

Gossling, S. 2000. Sustainable Tourism Development in Developing Countries: Some Aspects of energy Use. *Journal of Sustainable Tourism*, 8 (55): 410 – 425.

Gottlieb, M.S. 2001. “AIDS – Past and Future”. *New England Journal of Medicine*, 344: 91 – 1788, June.

Gunn, C. 1988. *Tourism Planning*. New York: Taylor and Francis.

Hachileka, E. 2003. Sustainability of Wildlife Utilisation in the Chobe District, Botswana. *South African Geographical Journal*, 85 (1): 50 – 57.

Hall C.M. 2000. *Tourism Planning – Policies, Processes and Relationships*. Harlow: Prentice – Hall.

HATAB. 2004. *On Social and Economic Problems Arising in the Wake of the HIV/AIDS Epidemic*. Gaborone: HATAB.

Hill, C. & Knight, J. 1999. “The Diamond Boom, Expectations and Economic Management in Botswana”. *Trade Shocks in Developing Countries*, volume 1: Africa. Oxford University Press.

Hilton P., Mokobi U. & Sprokel C. 2006. *Botswana Small and Medium Enterprise Under – Banked Market Research*: Gaborone: Enterprising Banking Group.

H-Net Reviews. 2001. *Killing for Conservation. Wildlife Policy in Zimbabwe*.
<http://www.h-net.msu.edu/reviews/showrev.cgi?> [18 May 2006].

Holden A. 2003. In Need of New Environmental Ethics for Tourism?. *Annals of Tourism Research*, 30 (1): 94 – 108.

Huang, G.H., Sun, W., Nie, X.H., Qin, X.S. & Zhang, X.D. 2010. Development of a Decision-Support System for Rural Eco-environmental Management in Yongxin County, Jiangxi Province, China. *Environmental Modelling & Software*, 25 (1): 24 – 42.

International Labour Organisation. 2004: Shrinkage of Labour Force Owing to AIDS by 2015. London, UK: ILO.

Jamal, T.B. & Getz, D. 1995. Collaboration Theory and Community Tourism Planning. *Annals of Tourism Research*, 22 (1): 186 – 204.

John, D.F. 1984. *An Evaluation of the Contribution of Eco-tourism to the Economy of Botswana*. Gaborone: Ministry of Finance.

Joppe, M. 1996. Sustainable Community Development revisited. *Tourism Management*, 17 (7): 475 – 479.

Kahn, T. 2006. *AIDS will Hit Economy Less Hard Than Feared*.
<http://www.businessday.co.za/articles/topstories.aspx>? [02 August 2006].

Kaynak, E. & Marandu, E.E. 2006. Tourism Market Potential Analysis in Botswana. *Institutions and Policy*, 45 (2): 227 – 228, November.

Kaynak, E and Marandu, E.E. 2006. Tourism Market Analysis in Botswana: A Delphi Study. *Journal of Travel Research*, 45 (2): 227 – 237.

Keogh, B. 1990. Public Participation in Community Tourism Planning. *Annals of Tourism Research*, 17 (3): 449 – 465.

Ketshabile L. 2007. HIV and AIDS as a Threat to Southern African Tourism.

Khalifah, Z., Hamzah, A. Dahlan, N.A. & Kachik, A.T. 2006. Strategies to Capture Benefits of Tourism for Marginalised Communities in Melaka Historic City.

Ko, T.G. 2005. Development of a Tourism Sustainability Assessment Procedure: A Conceptual Approach. *Tourism Management*, 26 (3): 431 – 445.

- Kothari, C.R. 1990. *Research Methodology*. 2nd ed. Jaipur: Wiley Eastern.
- Kozak, M. 2002. Destination Benchmark. *Annals of Tourism Research*, 29 (2): 497 – 519.
- Lange, G.M., Hassan, R. & Alfieri, A. 2003. “Using Environmental Accounts to Promote Sustainable Development: Experience in Southern Africa”. In: *Natural Resources Forum*, 27 (No issue) 19 – 31.
- Letamo, G. 2003. *Prevalence of, and Factors Associated with, HIV/AIDS-related Stigma and Discriminatory Attitudes in Botswana*, 21(4): 347 – 357, December.
- Lisk, F. 2002. *Labour Market and Employment Implications of HIV/AIDS*. Washington D.C.: US Census Bureau.
- Long, P.T. 1996. Early Impacts of Limited Stakes Casino Gambling on Rural Community Life. *Tourism Management*, 17 (5): 341 – 353.
- Lundberg, C., Gudmundson, A. & Anderson, T.D. 2007. Hertzberg’s Two-Factor Theory of Work Motivation Tested Empirically on Seasonal Workers in Hospitality and Tourism. *Journal of Tourism Management*, 30 (2009): 890 – 899.
- Macfarlan, Maitland, Segherri & Silvia, 2001. The Macroeconomic Impact of HIV/AIDS in Botswana. (42): 1 – 42.
- Maher, D. 2003. The Role of the Community in the Control of Tuberculosis. *Tuberculosis*, 83: 177 – 182.
- Manning T. 1999. Indicators of Tourism Sustainability. *Tourism Management*, 20 (1): 179 – 181.
- Maruatona, T. 2007. *Botswana Non-formal Education – Country Profile Prepared for the Education for all Global Monitoring Report 2008 Education for all by 2015: Will we make it?*. Gaborone: UNESCO.

- Mascarenhas, O.A. Kesavan, R. & Bernacchi, M. 2005. Global Marketing of Lifesaving Drugs: An Analogical Model. *Journal of Consumer Marketing*, 22 (7): 404 – 411.
- Matshediso, I.B. 2005. A Review of Mineral Development and Investment Policies of Botswana. *Resources Policy*, 30 (No issue): 203 – 207.
- Mattes, R. 2002. *AIDS and Democracy: What are the linkages?. Democracy and AIDS in Southern Africa*. Cape Town: DOH.
- Mattes, R., Bratton, M. & Davids, 2002. *Poverty and Survival in Southern Africa*. Cape Town: Afro-barometer.
- Mbaiwa J.E. 2005. The problem and Prospects of Sustainable Tourism Development in the Okavango Delta, Botswana. *Journal of Sustainable Tourism*, 13 (3): 203 – 227.
- Mbendi. 2007. *An Mbendi Industry (Sector) Profile for Botswana: Mining Inclu.* <http://www.mbendi.co.za/indy/ming/af/bo/p005.htm> [18 September 2007].
- McBurney, D.H. 1994. *Research Methods*. California: Brooks/Cole Publishing Company.
- McCool, S.F. & Lime, D.W. 2001. Tourism Carrying capacity: Tempting Fantasy or Useful Reality? *Journal of Sustainable Tourism*, 9 (5): 372 – 388.
- McCrea, B. & Pinchuck, T. 1990. *Zimbabwe and Botswana – The Rough Guide*. London: Harrap Columbus.
- Medupe, F. & Collins, K. 2004. *Treatment for HIV/AIDS in the Workplace: A Case Study of Mine in Botswana*. Cape Town: The Centre for Social Science Research.
- Meyer. D. 2006. *Caribbean Tourism, Local Sourcing and Enterprise Development*. London, UK: ODI.
- Miller, C.M., Gruskin, S., Subramanian, S.V. & Heymann, J. 2007. Emerging Health Disparities

in Botswana: Examining the Situation of Orphans During the AIDS Epidemic. *Social Science & Medicine*, 64: 2476 – 2486, April.

Mitchell, M. & Jolley, J. 1992. *Research Design Explained*. 2nd ed. Orlando: Ted Buchholz.

Mmopelwa, G. & Blignaut, J.N. 2006. The Okavango Delta. *The Value of Tourism*, 9 (1): 113 – 127.

Mogalakwe, M. 2008. *The Making of Foreign “Labour Aristocracy” in Botswana*, 30 (4): 422 – 435.

Moodley, N. 2006. Companies Dig Deep After Ignoring HIV/AIDS Crisis. *Cape Times*: 15, Jun. 19.

Moulin C. 2007. *On Concepts of Community Cultural Tourism*. Ontario.

Msimangira, K.A.B. 2003. Purchasing and Supply Chain Management Practices in Botswana. *Supply Chain Management: An International Journal*, 8 (1): 7 – 11.

Mukumbira, R. 2004. Mining Giant Fights Workplace HIV/AIDS.

Murshed, S.M. 2004. *When Does Natural Resource Abundance Lead to a Resource Curse?*. EEP Discussion Paper 04-01. London, UK: International Institute for Environment and Development.

Muswazi, P. 2000. HIV/AIDS Information Resources and Services: A Swaziland Case Study. *Library Review*, 49 (1): 34 – 39.

Mutula, S.M. & Van Brakel, P. 2007. ICT Skills Readiness for the Emerging Global Digital Economy Among Small Business in Developing Countries: Case Study of Botswana. *Library Hi Tech*, 25 (2): 231 – 245.

Mutula S.M. 2004. Making Botswana an Information Society: Current Developments. *The*

Electronic Library, 22 (2): 144 – 153.

NACA. 2002. *National Strategic Framework for HIV/AIDS 2003 – 2009*. Gaborone: NACA.

NACA. 2008. *HIV/AIDS in Botswana. Estimated Trends and Implications Based on Surveillance and Modelling*. Gaborone: NACA.

Nagelkerk, N.J.D., Jha, P., De Vlas, S.J., Korenromp, E.L., Moses, S., Blanchard, J.F. & Plummer, F.A. 2002. Modelling HIV/AIDS Epidemics in Botswana and India: Impact of Interventions to Prevent Transmission*. *Bull World Health organ*, 80 (2): 1 – 14, Geneva.

Namibia. Colourgem Team. 2006. *Southern Africa Where to Stay – Namibia and Across the Borders*. 10th ed. Windhoek: Colourgem.

Namibia. Namibia Tourism Board. n.d. *Namibia's Community Based Tourism Policy*. http://www.met.gov.na/programmes/cburm/cbtourism_guide.htm [09 June 2006].

Namibia. Ministry of Environment and Tourism. 1994. *Namibia's Environmental Assessment Policy*. Windhoek: Ministry of Environment and Tourism.

Ngwenya, B.N. & Kgathi, D.L. 2006. HIV/AIDS and Access to Water: A Case Study of Home-Based Care in Ngamiland, Botswana. *Physics and Chemistry of the Earth*, 31: 669 – 680.

Ngwenya, B.N. & Mosepele, K. 2007. HIV/AIDS, Artisanal Fishing and Food Security in the Okavango Delta, Botswana. *Physics and Chemistry of Earth*, 32: 1339 – 1349, August.

Noble, R. 2007. *HIV and AIDS in Botswana*. <http://www.avert.org/aidsbotswana.htm> [03 November 2007].

North West District Council. 2005. *Annual Report: Community Home-Based Care in Ngamiland*. Maun: NWDC.

Nyanhi, G. 2003. Prospects of Recovery in Tourism Sector Bleak. *The Financial Gazette*: 12, Apr. 3.

Nyberg L. 2001. *Destination 21 – A Discussion Contribution on a Scheme for Sustainable Tourism development*, 56 (1/2): 54 – 56.

ODINPubAFRICA. 2002. *Economic Without Markets: Policy Inferences From Nature-Based Tourism Studies in Namibia*.

<http://www.iodewebl.vli.be/odin/handle/1834/714> [30 May 2006].

Over, 2001. *Assessing the Potential Economic Impact of HIV/AIDS in the Middle East and North Africa*. London, UK: World Bank.

Pansiri, J. 2006. Harambe: Strategic Alliance Formation and Performance evaluation in the Tourism Sector of Travel.

Park, M. & Stokowski, P.A. 2008. Social Disruption Theory and Crime in Rural Communities: Comparisons Across Three Levels of Tourism Growth. *Journal of Tourism Management*, 30 (2009): 905 – 915.

Parsons, E. & Broadbride, A. 2006. Job Motivation and Satisfaction: Unpacking the key Factors for Charity Shop Managers. *Journal of Retailing and Consumer Services*, 13 (2): 121 – 131.

Piot, P., Bartos, M., Ghys, P.D., Walker, N. & Schwartlander, B. 2001. The Global Impact of HIV/AIDS. *Nature*, 410: 968 – 973.

Poonyth D., Barnes J.I., Suich H. & Monamati M. 2002. *Satellite and Resource Accounting as Tools for Tourism Planning in Southern Africa*. March, 19 (1): 123 – 141.

Preece, J. & Ntseane, G. 2004. Using Adult Education Principles for HIV/AIDS Awareness Intervention Strategies in Botswana. *International Journal of Lifelong Education*, 23 (1) 5 – 22, January – February.

Ramsey, F., Hazoume, F. & Chetty, S. 2002. *HIV/AIDS and Local Governance in Sub-Saharan Africa*. London: The Urban Management Programme Team in the Regional Office for Africa.

Reid D.G., Mair H. & George W. 2004. Community Tourism Planning: A Self-Assessment Instrument. *Annals of Tourism Research*, 31 (3): 623 – 639.

Rephann, T.J., Dalton, M., Stair, A. & Isserman, A. 1997. Casino Gambling as an Economic Strategy. *Tourism Economic*, 3 (2): 161 - 183.

Reuters, 2004. *AIDS Hits SA Mining and Manufacturing Hard-Survey*.

<http://www.engineeringnews.co.za/components/print.asp?id=60283> [15 February 2008].

Rogerson. C.M. & Visser. G. (eds). 2004 *Tourism and development Issues in Contemporary South Africa Tourism*. London, UK: ODI.

Ryan C. 2002. Equity, management, Power Sharing and Sustainability – Issues of the ‘New Tourism’. *Tourism Management*, 23: 17 – 26.

Sarraf, M. & Jiwanji, M. 2001. *Beating the Resource Curse. The Case of Botswana*.

Washington, DC: World Bank Environment department, Environmental Economics Series.

Schell, R. 2002. The Economic, Demographic and Social Implications of the AIDS Pandemic to the Year 2010 in the Southern African Region. *HIV/AIDS: A Threat to the African Renaissance?* Konrad Adenauer Stiftung Occasional Papers. Park Town: Konrad Adenauer Stiftung.

Schilcher, D. 2007. Growth Versus Equity: The Continuum of Pro-poor Tourism and Neoliberal Governance: 4 (4): 166 – 193.

Shoortravel, 2008. *Map of Botswana*. www.shoortravel.com/botswanamap.html [02 April 2008].

Siphambe, H.K. 2004. Botswana’s Economy and Labour Market: Are there any Lessons for SADC Regional Integration?. *Development Southern Africa*, 21 (2): 353 – 364, June.

Sjoberg, E. & Du Guerny, J. 1993. Inter-Relationship Between Gender Relations and the HIV/AIDS Pandemic: Some Possible Considerations for Policies and Programmes. *AIDS*, 7:

1027 – 1034.

Somekh, B. 2006. *Action Research: A Methodology for Change and Development*. New York: Open University.

South Africa. Department of Environmental Affairs and Tourism. 1996. *White Paper, Development and Promotion of Tourism in South Africa*. Pretoria: Department of Environmental Affairs and Tourism.

South Africa. Department of Economic Affairs, Agriculture and Tourism Western Cape. 2001. *Issues in Tourism Destination Development*. Cape Town: Department of Economic Development and Tourism.

South Africa. Department of Economic Development and Tourism. 2004. *The Cost of AIDS: An Imprecise Catastrophe: Economic and Epidemic*. Cape Town: ED & T Knowledge Management.

South Africa. Department of Health. 2005. *HIV/AIDS Infection Rate Remains at the Same Level*. <http://www.info.gov.za/speeches/2006.htm> [02 August 2006].

South Africa. Human Sciences Research Council. 2005. HIV Infection rate in South Africa.

South Africa. Institute of Mining and Metallurgy. 2000. *Managing HIV/AIDS in the Mining and Metallurgical Industries*. Johannesburg: The South African Institute of Mining and Metallurgy.

South Africa. SATOUR. 1991. *Tourism Development in South and Southern Africa – A Strategic Frame Work*.

Sparks, B. 2007. Planning a Wine Tourism Vacation? Factors That Help to Predict Tourist Behavioural Intentions. *Tourism Management*, 28: 1180 – 1192.

Stokowski, P.A. 1966. *Riches and Regrets: Betting on Gambling in two Colorado Mountain Towns*. Niwot: University Press of Colorado.

Strode, A. & Grant, K.B. 2004. *Understanding the Institutional Dynamics of South Africa's Response to the HIV/AIDS Pandemic*. Pretoria: Institute for Democracy in South Africa.

Sun Cape. 2003. *Map Search For Southern Africa*.

<http://www.suncape.com/maps.php?ln=en> [01 March 2007].

Swaney, D. 1992. *Zimbabwe, Botswana and Namibia – A Travel Survival Kit*. Sydney: Lonely Planet Publications.

THETA, 2003. *The Impact of HIV/AIDS on the Hospitality Sector*.

<http://www.theta.org.za> [21 June 2007].

Thur, S.M. 2010. User Fees as Sustainable Financing Mechanisms for Marine Protected Areas: An Application to the Bonaire National Marine Park. *Marine Policy*, 34 (1): 63 – 69.

Tlou, S.D. 2005. *Botswana HIV/AIDS Response Information Management System*. Gaborone: Botswana Ministry of Health.

Topouzis, D. 1998. *The Implications of HIV/AIDS for Rural Development Policy and Programming: Focus on Sub-Saharan Africa*. Rome: UNDP.

Torres R. & Momsen J.H. 2004. *Challenges and Potential for Linking Tourism and Agriculture to Achieve Pro-poor Tourism Objectives*, 4 (4): 294 – 318.

Toteng, E.N. 2004. The Private Sector, Urban Water Conservation and Developing Countries: A stakeholder Theory-Driven Perspective from Botswana. *South African Geographical Journal*, 86 (2) 113 – 121.

Uganda. Ministry of Health. 2002. *STD/HIV/AIDS Surveillance*. Kampala: Ministry of Health Uganda.

Uhegbu, A.N. & Okereke, C.I. 2006. Decades of persistent Ignorance towards sustainable Dissemination of HIV/AIDS Information Among Rural Women in Imo State, Nigeria. *Library*

Review, 55 (1) 35 – 44.

UNAIDS. 2006. *Present Number of HIV Infection in South Africa*. Durban: South African Institute of Race Relations.

UNAIDS. 2006. *Report on the Global AIDS Epidemic*.
www.unaids.org [03 February 2008].

UNAIDS. 2009. *Worldwide HIV & AIDS Statistics*.
<http://www.avert.org/worldstats.htm>. [20 January 2010].

UNAIDS & WHO. 2005. *AIDS Epidemics update*. Appia: UNAIDS & WHO.

UNDP, UNWTO & Botswana Department of Tourism. 2007. *Strengthening Tourism Statistics and Formulation of an Experimental TSA – 2005/2006*. Gaborone: UNDP, UNWTO & Botswana Department of Tourism.

UNDP. 2006. *The Economic Impact of HIV and AIDS in Botswana*. Gaborone: UNDP.

UNDP. 2000. “*Moving Upstream and Engaging Governments in Strategic Policy Advocacy: The Case of UNDP Botswana’s HIV and AIDS Programme*”. New York: United Nations Development Programme.

UNICEF. 2004. *AIDS Orphans Living in South Africa*. London, UK: UNICEF.

UNICEF. 2004. *Children on the Brink 2004: A Joint Report on New Orphan Estimates and a Framework for Action*. New York UNICEF.

UNICEF. 2005. *Botswana Child Monitor: A Bulletin of Recent Events, Statistics and Acquisitions about Children*. New York: UNICEF.

UNICEF. 2005. *Progress of Nations*. Gaborone: UNICEF.

UNAIDS. 2005. *HIV/AIDS Pandemic*. Gaborone: UNAIDS.

United Nations. Department of Economic and Social Affairs. 2004. *Policy Workshop on HIV/AIDS and Family Well-being*. Windhoek: Namibia Government.

United Nations. *Managing Sustainable Tourism Development*. New York: United Nations.

UNWTO & Botswana Department of Tourism. 2008. *Policy for the Growth and Development of Tourism in Botswana*. Gaborone: UNWTO & Botswana Department of Tourism.

USAIDS. 2002. *HIV/AIDS in Zimbabwe*. Harare: USAIDS.

USAIDS. 2005. *AIDS Brief, Mining Sector*.

[Http://www.usaid.gov/regions/afr/hhraa/aids_brief/mining.txt](http://www.usaid.gov/regions/afr/hhraa/aids_brief/mining.txt) [16 February 2008].

Veal A.J. 2006. *Research methods for Leisure and Tourism*. Harlow: Prentice – Hall.

Villarreal, M. 2006. HIV/AIDS: A Threat to the Viability of the Societies it Attacks. *Kybernetes*, 35 (1): 195 – 208.

Welman, J.C. & Kruger, S.J. 2001. *Research Methodology*. 2nd ed. Cape town: Oxford university Press Southern Africa.

Whiteside, A. 2002. Poverty and HIV/AIDS in Africa. *Third World Quarterly*, 23 (2): 313 – 332.

Whiteside, A., Mattes, R., William, S. & Manning, R. 2002. *Examining HIV/AIDS in Southern Africa Through the Eyes of Ordinary Southern Africans*. Cape Town: Centre for Social Science Research.

Whiteside, A. & Wood, G. 1993. *Socio-Economic Impact of HIV/AIDS in Swaziland*. Mbabane: Capricon Africa Economic Associates.

Woods, J. & Sekhwela, M.B.M. 2006. The Vegetation Resources of Botswana's Savannas: An

Overview. *South African Geographical Journal*, 85 (1): 69 – 79.

World Bank. 2004. *World Development Report 2005. A Better Investment Climate for Everyone*. Washington, DC: World Bank.

World Health organisation. 2002. *Community Home-Based Care in Resource Limited Settings: A Framework for Action*. Geneva: WHO.

World Health Organisation. 2004. “*Statistics of Women and HIV/AIDS*”.
www.sunnewsonline.com [01 February 2008].

World Health Organisation. 2005. *HIV/AIDS Epidemiological Surveillance for the African Region*. Harare: WHO.

World Travel & Tourism Council. 2002. *The impact of Travel and Tourism on Jobs and the Economy*. London, UK: World Travel & Tourism Council.

World Travel & Tourism Council. 2007. *The Impact of travel and Tourism on Jobs and the Economy*. Gaborone: World Travel & Tourism Council.

World Tourism Organisation. 1998. *Guide for Local Authorities on Developing Sustainable Tourism*. Madrid: World Tourism Organisation.

Wright, P. 1989. Motivation and job Satisfaction. *Human Resource Management*. Lund, Sweden: Studentlitteratur.

WTTC. 2002. *Corporate Social Leadership in Travel and Tourism*. London, UK: WTTC.

ANNEXURE A: MAP OF BOTSWANA



ANNEXURE B: GLOBAL HIV/AIDS STATISTICS

People living with HIV/AIDS (adults and children)

2005

Rank Table by: Country Name Number

Rank	Country Name ▲	Number
	Global	38,600,000
98	Afghanistan	<1000
101	Albania	NA
59	Algeria	19,000
101	American Samoa	NA
101	Andorra	NA
20	Angola	320,000
101	Anguilla	NA
101	Antigua and Barbuda	NA
32	Argentina	130,000
91	Armenia	2,900
101	Aruba	NA
62	Australia	16,000
66	Austria	12,000
80	Azerbaijan	5,400
77	Bahamas	6,800
98	Bahrain	<1000
67	Bangladesh	11,000
92	Barbados	2,700
58	Belarus	20,000
64	Belgium	14,000

88	Belize	3,700
36	Benin	87,000
101	Bermuda	NA
99	Bhutan	<500
76	Bolivia	7,000
99	Bosnia and Herzegovina	<500
21	Botswana	270,000
101	Bouvet Island	NA
14	Brazil	620,000
101	British Indian Ocean Territory	NA
101	British Virgin Islands	NA
100	Brunei Darussalam	<100
99	Bulgaria	<500
30	Burkina Faso	150,000
30	Burundi	150,000
32	Cambodia	130,000
16	Cameroon	510,000
45	Canada	60,000
101	Cape Verde	NA
101	Cayman Islands	NA
23	Central African Republic	250,000
27	Chad	180,000
54	Chile	28,000
13	China	650,000
101	Christmas Island	NA
101	Cocos (Keeling Islands)	NA
29	Colombia	160,000
99	Comoros	<500
33	Congo	120,000

10	Congo (Dem. Republic of)	1,000,000
101	Cook Islands	NA
74	Costa Rica	7,400
12	Cote d'Ivoire	750,000
99	Croatia	<500
85	Cuba	4,800
99	Cyprus	<500
95	Czech Republic	1,500
78	Denmark	5,600
63	Djibouti	15,000
101	Dominica	NA
42	Dominican Republic	66,000
57	Ecuador	23,000
81	Egypt	5,300
50	El Salvador	36,000
71	Equatorial Guinea	8,900
46	Eritrea	59,000
68	Estonia	10,000
101	Ethiopia	NA
101	Faeroe Islands	NA
101	Falkland Islands (Malvinas)	NA
98	Fiji	<1000
94	Finland	1,900
32	France	130,000
101	French Guiana	NA
101	French Polynesia	NA
101	French Southern Territories and Antarctic Lands	NA
45	Gabon	60,000
58	Gambia	20,000

78	Georgia	5,600
47	Germany	49,000
20	Ghana	320,000
101	Gibraltar	NA
70	Greece	9,300
101	Greenland	NA
101	Grenada	NA
101	Guadeloupe	NA
101	Guam	NA
44	Guatemala	61,000
37	Guinea	85,000
51	Guinea-Bissau	32,000
66	Guyana	12,000
26	Haiti	190,000
101	Heard Island and McDonald Islands	NA
43	Honduras	63,000
90	Hungary	3,200
99	Iceland	<500
1	India	5,700,000
28	Indonesia	170,000
42	Iran (Islamic Republic of)	66,000
101	Iraq	NA
83	Ireland	5,000
87	Israel	4,000
30	Italy	150,000
56	Jamaica	25,000
61	Japan	17,000
101	Johnston Atoll	NA
98	Jordan	<1000

66	Kazakhstan	12,000
7	Kenya	1,300,000
101	Kiribati	NA
101	Korea (Dem. Peo. Rep. of)	NA
65	Korea (Republic of)	13,000
98	Kuwait	<1000
87	Kyrgyzstan	4,000
88	Lao People's Democratic Rep.	3,700
68	Latvia	10,000
91	Lebanon	2,900
21	Lesotho	270,000
101	Liberia	NA
101	Libyan Arab Jamahiriya	NA
101	Liechtenstein	NA
89	Lithuania	3,300
98	Luxembourg	<1000
99	Macedonia (The former Yugoslav Republic of)	<500
47	Madagascar	49,000
11	Malawi	940,000
40	Malaysia	69,000
101	Maldives	NA
32	Mali	130,000
99	Malta	<500
101	Marshall Islands	NA
101	Martinique	NA
66	Mauritania	12,000
86	Mauritius	4,100
101	Mayotte	NA
27	Mexico	180,000

101	Micronesia (Federated States of)	NA
101	Midway	NA
53	Moldova (Republic of)	29,000
101	Monaco	NA
99	Mongolia	<500
101	Montserrat	NA
59	Morocco	19,000
4	Mozambique	1,800,000
18	Myanmar	360,000
24	Namibia	230,000
101	Nauru	NA
39	Nepal	75,000
60	Netherlands	18,000
101	Netherlands Antilles	NA
101	New Caledonia	NA
96	New Zealand	1,400
75	Nicaragua	7,300
38	Niger	79,000
3	Nigeria	2,900,000
101	Niue	NA
101	Norfolk Island	NA
101	Northern Mariana Islands	NA
93	Norway	2,500
101	Oman	NA
37	Pakistan	85,000
101	Palau	NA
61	Panama	17,000
45	Papua New Guinea	60,000
65	Paraguay	13,000

35	Peru	93,000
66	Philippines	12,000
101	Pitcairn Island	NA
56	Poland	25,000
51	Portugal	32,000
101	Puerto Rico	NA
101	Qatar	NA
101	Reunion	NA
76	Romania	7,000
11	Russian Federation	940,000
26	Rwanda	190,000
101	Saint Helena	NA
101	Saint Kitts and Nevis	NA
101	Saint Lucia	NA
101	Saint Vincent and the Grenadines	NA
101	Samoa	NA
101	San Marino	NA
101	Sao Tome and Principe	NA
101	Saudi Arabia	NA
44	Senegal	61,000
68	Serbia and Montenegro	10,000
101	Seychelles	NA
48	Sierra Leone	48,000
79	Singapore	5,500
99	Slovakia	<500
99	Slovenia	<500
101	Solomon Islands	NA
49	Somalia	44,000
2	South Africa	5,500,000

31	Spain	140,000
83	Sri Lanka	5,000
19	Sudan	350,000
82	Suriname	5,200
101	Svalbard and Jan Mayen Islands	NA
25	Swaziland	220,000
73	Sweden	8,000
61	Switzerland	17,000
101	Syrian Arab Republic	NA
84	Tajikistan	4,900
6	Tanzania (United Rep. of)	1,400,000
15	Thailand	580,000
101	Timor Leste	NA
34	Togo	110,000
101	Tokelau	NA
101	Tonga	NA
55	Trinidad and Tobago	27,000
72	Tunisia	8,700
97	Turkey	<2000
99	Turkmenistan	<500
101	Turks and Caicos Island	NA
101	Tuvalu	NA
10	Uganda	1,000,000
17	Ukraine	410,000
101	United Arab Emirates	NA
41	United Kingdom	68,000
8	United States of America	1,200,000
69	Uruguay	9,600
52	Uzbekistan	31,000

101	Vanuatu	NA
34	Venezuela	110,000
22	Viet Nam	260,000
101	Virgin Islands (U.S.)	NA
101	Wake Island	NA
101	Wallis and Futuna Islands	NA
101	West Bank and Gaza	NA
101	Western Sahara	NA
101	Yemen	NA
9	Zambia	1,100,000
5	Zimbabwe	1,700,000

Notes: Data are estimates. UNAIDS indicates that data are still preliminary for Canada, Ethiopia and the United Kingdom.

Definitions: HIV: human immunodeficiency virus, the virus that causes AIDS; AIDS: acquired immunodeficiency syndrome.

Sources: UNAIDS, 2006 Report on the Global AIDS Epidemic, May 2006, available at: http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp.



About this Site	Email Sign-Up	Contact Us
---------------------------------	-------------------------------	----------------------------

© 2006 Kaiser Family Foundation

kff.org / kaisernetwork.org /

ANNEXURE C: RESEARCH QUESTIONNAIRE



TO WHOM IT MAY CONCERN

I am a student from Cape Peninsula University of Technology in Cape Town (South Africa). I am studying D–Tech (PhD) in Tourism and Hospitality Management. I am currently working on a research dissertation to investigate the possible impact of HIV/AIDS on the socio-economic environment in Botswana with special reference to the tourism sector. As part of this research, I am conducting surveys with a number of tourism businesses in Botswana. I trust that your level of expertise and experience in the tourism sector will help me to gather quality data. I would be grateful if you would spare your precious time to answer the questions on the attached questionnaire. The questions are fairly broad and not of a personal nature, and the answers will not in any way reflect the identity of the interviewee nor employees of the organisations that are part of the study.

Your co-operation to provide your views on the various aspects mentioned in the questionnaire will be highly appreciated.

Yours Faithfully

Lisbon Simeon Ketshabile

Doctoral student at the Cape Peninsula University of Technology

University of Botswana

Private Bag UB 00701

Gaborone

31 October 2008

QUESTIONNAIRE

THE IMPACT OF HIV/AIDS ON THE SOCIO-ECONOMIC ENVIRONMENT IN BOTSWANA WITH SPECIAL REFERENCE TO THE TOURISM SECTOR

Date _____

Please answer the following questions by writing your answer on the space provided or by ticking the box or circling the options that apply best to you.

1. How long have you been working for this organisation? _____ years

2. How many people have been working in your organisation in the past 12 months?

2.1 Full time _____

2.2 Part-time _____

3. What type of tourism organisation (the unit you are based) do you working for?

Hotel

Lodge/camp

Guest house

Self-catering

Other (please specify) _____

4. How long has your organisation (the unit you are based) been in business operation?

_____ Years

5. Does your company have an HIV/AIDS policy?

Yes

No

6. What is your position in the organisation?

General Manager

Food and beverage Manager

Financial Manager

Human Resources Manager

Other, please specify: _____

7. To what extent do you agree with the following statements about tourism and HIV/AIDS in Botswana?

Please circle the option that applies to you:

	Strongly agree	Agree	Not agree nor disagree	Disagree	Strongly Disagree
7.1. Tourism is one of Botswana's most important economic activities.	1	2	3	4	5
7.2. Botswana is one of the countries in the world with the highest rate of HIV/AIDS infection.	1	2	3	4	5
7.3. HIV/AIDS increases the levels of poverty in a number of rural areas in Botswana.	1	2	3	4	5
7.4. Botswana tourism sector is losing experienced workers.	1	2	3	4	5
7.5. The Botswana tourism sector is seriously threatened by HIV/AIDS in future.	1	2	3	4	5
7.6. Gender inequality contributes to the spread of HIV/AIDS in Botswana	1	2	3	4	5
7.7. The government should do more to address HIV/AIDS problems.	1	2	3	4	5
7.8. Prospective domestic tourism demand in Botswana is threatened by the HIV/AIDS.	1	2	3	4	5
7.9. HIV/AIDS threatens new investment in the tourism private sector.	1	2	3	4	5
7.10. HIV/AIDS increases health expenditure on individuals, and tourism businesses.	1	2	3	4	5
7.11. The HIV/AIDS problem reduces individual's savings due to medical expenses.	1	2	3	4	5
7.12. HIV/AIDS reduces the government investment in tourism public sector.	1	2	3	4	5
7.13. Tourism organisations often discuss HIV/AIDS problems among themselves.	1	2	3	4	5
7.14. HIV/AIDS increases the growth rate of average incomes.	1	2	3	4	5
7.15. The HIV/AIDS problem results in lower population growth.	1	2	3	4	5
7.16. In general tourism companies are not doing much in fighting the impact of HIV/AIDS in their	1	2	3	4	5
7.17. The HIV/AIDS problem is expected to become much worse in future.	1	2	3	4	5
7.18. The quality of service in general is affected by the HIV/AIDS problem.	1	2	3	4	5
7.19. Alcohol abuse influences the spread of HIV/AIDS in Botswana	1	2	3	4	5

7.20. HIV/AIDS increases the costs of running tourism businesses.	1	2	3	4	5
7.21. Tourism organisations experience low labour productivity resulting from HIV/AIDS.	1	2	3	4	5
7.22. HIV/AIDS is a serious problem for tourism industry.	1	2	3	4	5
7.23. The tourism business community in Botswana often discusses the HIV/AIDS problem with the local	1	2	3	4	5

8. Do you personally agree or disagree with the following statements about tourism and community in Your and work location?

Please circle the most suitable option (number 1-5) from every statement:

	Strongly agree	Agree	Not agree nor disagree	Disagree	Strongly Disagree
8.1. Tourism creates employment in our location.	1	2	3	4	5
8.2. Tourism motivates host communities to be more conscious of the need to maintain and improve the appearance of the area.	1	2	3	4	5
8.3. The development of tourism facilities has generally improved the appearance of the area.	1	2	3	4	5
8.4. Tourism contributes to the conservation of the environment as a national asset.	1	2	3	4	5
8.5. Tourism development brings facilities that improve the quality of life of residents.	1	2	3	4	5
8.6. The economic benefits of tourism to the communities are overrated.	1	2	3	4	5
8.7. Tourism benefits only a small proportion of the community members.	1	2	3	4	5
8.8. Tourism contributes to the spread of HIV/AIDS in your location.	1	2	3	4	5
8.9. Tourism increases social cultural problems such as commercial sex work.	1	2	3	4	5
8.10. Tourists are often an intrusion on communities' lifestyles.	1	2	3	4	5
8.11. Tourism results in damage to the natural environment.	1	2	3	4	5
8.12. Tourism increases the cost of living in host communities.	1	2	3	4	5
8.13. Further tourism development will disadvantage the community.	1	2	3	4	5

8.14. The host community should be involved and work closely with business community in tourism development.	1	2	3	4	5
--	---	---	---	---	---

9. Based on Your Personal experience and opinions, indicate your level of agreement with the following statements with regard to the impact of HIV/AIDS in the organisation you are working for

Please circle the most suitable option (number 1-5) from every statement:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
9.1. The HIV/AIDS problem directly affects the daily running of our business.	1	2	3	4	5
9.2. HIV/AIDS results in increased employee costs for us.	1	2	3	4	5
9.3. The quality of our service is affected by the HIV/AIDS problem.	1	2	3	4	5
9.4. We have experienced high labour turnover rates attributed to HIV/AIDS.	1	2	3	4	5
9.5. Our workers go on sick leave for lengthy periods.	1	2	3	4	5
9.6. Some tourism workers' loyalty and commitment to their job is negatively affected by the HIV/AIDS.	1	2	3	4	5
9.7. The cost of business operations have increased because of the need to replace workers who are absent	1	2	3	4	5
9.8. We have experienced employment (recruiting and training) costs resulting from the loss of employees	1	2	3	4	5
9.9. The HIV/AIDS affects workers relationship to each other by creating discrimination against those living	1	2	3	4	5
9.10. We often discuss HIV/AIDS problems in our meetings.	1	2	3	4	5
9.11. Tourism results in increased commercial sex work in our region.	1	2	3	4	5
9.12. Sex tourism is a common practice in our area.	1	2	3	4	5
9.13. Our organisation work closely with the local community members in fighting the spread of	1	2	3	4	5
9.14. A number of our workers have gone on early retirement on medical grounds.	1	2	3	4	5
9.15. HIV/AIDS reduces infected tourism employees' efficiency on their job.	1	2	3	4	5

9.16. HIV/AIDS is a serious problem for our business.	1	2	3	4	5
---	---	---	---	---	---

Background information:

10. Who owns the organisation (the unit you are based)?

- A Botswana citizen
- A non-Botswana citizen
- A partnership between non-citizen and citizen of Botswana

11. What is your gender? Female Male

12. What is your age?

- under 20 years
- 20–29 years
- 30–39 years
- 40–49 years
- 50–59 years
- 60 years and over

13. What is your nationality? _____

14. What is your highest educational level completed?

- Primary
- Secondary
- Certificate/Diploma
- Undergraduate degree
- Postgraduate degree
- Other, Please specify: _____

15. Do you have any comments or feedback related to the impacts of HIV/AIDS to tourism or this research?

Thank you for your cooperation.

Lisbon Simeon Ketshabile

Cell no: (00267) 72383803

E-mail: Lsketshabile@yahoo.com or Ketshabilel@mopipi.ub.bw

E-mail: FerreiraI@cput.ac.za (Co-supervisor) and manwah@mopipi.ub.bw (Supervisor)