

ONE, TWO, THREE

A pivotal time in Botswana's AIDS crisis sets Kathy Hageman in search of answers

by Kathy Hageman

Teacher, no one has died yet....”

Those words greeted me when I returned to my Peace Corps village of Seronga, Botswana, on the banks of the Okavango Delta. While teaching there in the 1990's, approximately 33% of sexually active adults were living with the HIV virus, as were over 50% of women who had two or more children. By 2002, four years after completing my service, Botswana had attained the highest prevalence of HIV in the world.

Amid the countless, endless nights of grading papers in the stifling heat, legs sticking to the plastic-fiber government-issue furniture, I remember the moment when my mind and heart fully wrapped around the statistic that one in three of my students would die from HIV. The same students who struggled with adjectives and adverbs, spelling and comma use; the same students who frequently counted off “one, two, three, one, two, three...” to form work groups: one in three would die.

Hearing my student update me on the mortality status of his classmates, brought me full circle to that heat drenched night. I felt shattered as he spoke with such pride of the (good) health of his classmates. What was it like to live in an environment where life expectancy came with the caveat that “nothing has happened yet?”

During my years of service in Botswana I witnessed an explosion of HIV knowledge and promotions. Billboards ranged from raising



The author, Kathy Hageman, listens to focus group discussion in Lusaka, Zambia.

awareness of the country's HIV prevalence to the promotion of the ABCs (Abstinence, Be monogamous, Condom use). Newspapers announced the prevalence of HIV infections among civil and government workers, young adults, pregnant women, commercial sex workers, truck drivers, and most any other group that was able to be defined as a specific population. Radio shows talked of HIV. Street drama groups in matching shirts danced and acted to inform about HIV. Students learned how to draw t-cells attacking an immune system. What I *didn't* see among all these aggressive, multi-level efforts to raise awareness and knowledge of HIV was behavioral change at the individual level. Multiple sex partners, unprotected sex and cross-generational relationships continued among students, fellow teachers and friends.

As a teacher, my efforts to raise HIV awareness were largely focused on having students write stories about HIV, teaching grammar using

examples about HIV, and lecturing them to resist peer pressure to have sex—and, for those who were, to use condoms. I did not know if what I was doing was helpful but with limited materials and resources at the national level and virtually nothing in the village, I figured any approach was better than no approach. Meanwhile, the idea of behavior change and what it takes to create it intrigued and inspired me. What would help keep my students HIV negative when knowledge and awareness levels were

already high?

The first trip back to your site is the hardest. Will you be remembered? Does anyone care that you have returned? Did you leave a mark? Whether real or not, you feel tested by your own history. It was a great relief to hear the screams of my former students, now adults with their own children, as they passed the news from one area of the village to another announcing that their teacher had returned. It was a great relief to hear that no one had died yet. Maybe that was my mark, some sense of awareness that translated into needing to tell the teacher the good news when she returned years later. Perhaps it was the heat of those days or the fear that I felt for the lives of my students, but somehow the interest and/or need to prevent people from contracting HIV became a part of me and I realized that my own history was not yet complete.

I do not remember how I was introduced to public health or the concentration of behavioral science

but when I found it, I realized it would allow me to contribute to the health of my students, maybe not directly to them but in understanding and working with the epidemic in southern Africa. Due to the across-the-street proximity to the Centers for Disease Control and Prevention (CDC) and their Global AIDS Program, I selected the Rollins School of Public Health at Emory University to pursue a master's degree.

My introduction to public health was inspiring. Students, professors and the neighboring CDC professionals were passionate about diseases and infections that I had never heard of, in places I did not know existed. I soon discovered that public health was a complex kaleidoscope of illnesses and geographic areas that intersected with all aspects of one's community and life: culture, literacy, human rights, development, capacity-building, policy change, economic status, etc. To understand how diseases and their consequences impact an area or population, public health teams of epidemiologists, statisticians, behavioral scientists, physicians, bench scientists and policy-makers collaborate with local, state, national and international agencies in concert with Ministries of Health to track, prevent and reduce disease. The synchronicity, support and global cooperation were astonishing to me. People were dedicated and making a difference.

By the end of my first year as an MPH student, I realized that as much as I loved programmatic efforts of public health, I was still yearning to know what causes behavior change. *What* could be said or done to keep my students healthy? What level of control of their sexual activities did each one of them really have? Was it personal behavior, cultural factors and/or relationship dynamics that dictated whether condoms were used, how partners were selected, and the number of sexual partners one has? How does one address the need to have sex in exchange for someone to pay their school fees or buy their next school uniform? Such questions,

I discovered, are answerable through behavioral research and I realized that I really liked behavioral research. This realization delayed any immediate trips back to Botswana. Rather, after completing the MPH, I continued on in the field of behavioral science for a doctorate. I wanted to understand behavior and understand how to change it.

From my time in Botswana, I knew that my primary HIV interest involved sexual behavior so I began to pursue collaborations with researchers at Emory and the CDC. Although unable to find ready HIV data from Botswana at the time, I was fortunate to begin collaborations with HIV researchers in Zambia and Rwanda who work with HIV discordant couples (when one partner is HIV negative and the other partner is HIV positive) and young adults in Zimbabwe. Behavioral research is an exciting, on-the-ground field that gives

you access to the populations of risk. It allows you to ask what their needs and concerns are and why they think certain health barriers and risks exist specific to their lifestyle, village or culture. You are given the privilege of understanding their lives and culture, and work with them to find solutions that will increase health and reduce disease.

In many ways, behavioral research is very much like Peace Corps: You contribute technical skills, and they provide everything else. I will never know if my time in the hot and dusty Kalahari Desert increased condom use or reduced the number of sexual partners among my students. I know that I did raise HIV awareness in Seronga. And, as I was told, "No one has died yet."

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