CHAPTER 7
HIV and AIDS

Article 27

Sharing knowledge during the GBV Pitso organised by Women's Affairs Department - Maun, November 2011.
Courtesy Women's Affairs Department

KEY POINTS

- At 59%, the SGDI on HIV and AIDS is lower than CSC at 78%.
- Botswana has one of the world's highest HIV and AIDS prevalence rates with 24.8% of the population HIV positive.
- Gender disparities continue to drive the pandemic in Botswana.
- In 2011, more than 80% of HIV-positive mothers had received anti-retroviral drugs for PMTCT.

Table 7.1: HIV and AIDS SGDI and CSC scores		
	SGDI	*CSC*
Scores	59%	76%
Ranks	5	3

The SGDI score for 2013 is 59% compared to 69% in 2012. This is a 10 percentage point decrease which indicates inconsistent government efforts in dealing with HIV and AIDS. On the other hand, citizens scored their government 76%, a two percentage point increase from the 2012 score of 74%.

The SGDI measures comprehensive knowledge on HIV and AIDS; the proportion of women living with HIV as a proportion of the total who are living with HIV and HIV-positive women on the Prevention-of-Mother-to Child- Transmission PMTCT (programme). The SGDI does not measure qualitative nuances such as the physical and psychological welfare of caregivers, of who most are women.

Despite the government's huge investment in the HIV and AIDS response, the SGDI is lowered by the continued high HIV prevalence rates among pregnant women.

The higher citizen score is a vote of confidence. Citizens can see the increased access to treatment and the quality of support and care for people living with HIV and AIDS. They appreciate that Botswana has a comprehensive HIV and AIDS programme which includes providing a stipend and support to home-based caregivers, orphan care, free testing and counselling as well as free ARV treatment.

Moreover, the HIV and AIDS response in Botswana has been at the highest political level (UN 2007). The MDG's progress reports and the National Development Plan (NDP) highlights the positive support and high level of investment in HIV-related programmes during NDP 9, which will continue in NDP 10.

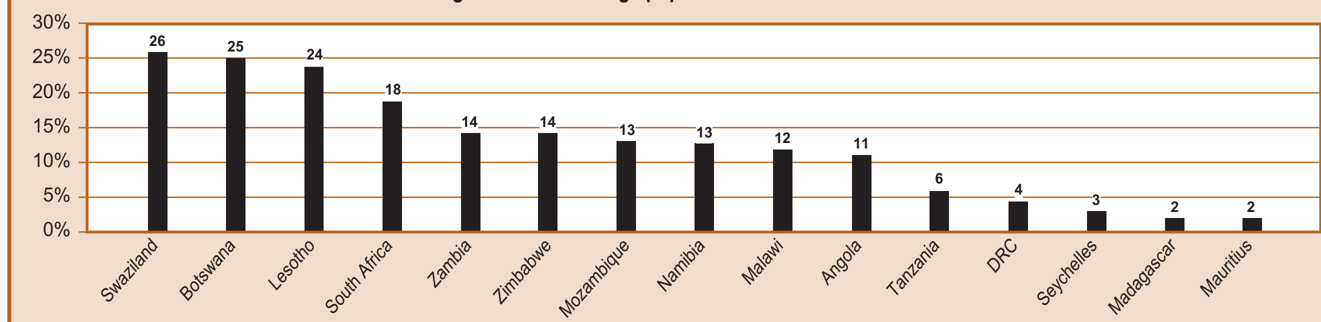
The investments are paying off. Over 90% of pregnant women have access to testing, counselling services and ARV treatment through the PMTCT programme. Also, knowledge and information on HIV and male involvement has increased over the years (UN - MDG's Report 2010).

HIV prevalence among the 15-19 age group decreased from over 30% in 1995 to 17.5%; the HIV prevalence rate for pregnant women decreased from 37.4% in 2003 to 32.4% in 2006.

Also, the HIV prevalence rate for the 20-24 age group decreased slightly from 30.6% in 2003 to 29.4% in 2006 (UN 2010).

The extensive IEC programme has contributed to behavioural change, especially, amongst the youth. The availability of ARVs has increased the life span for people living with the virus compared to 20 ago.

Nevertheless, the impact of HIV has dramatically reversed gains in other health and economic indicators. It has increased the infant and child mortality rates and maternal mortality rates, as well as poverty and unemployment rates (UN 2010).



Source: 2013 SADC Gender Protocol Barometer.

Figure 7.1 shows that Botswana has the second highest HIV and AIDS prevalence rate in the region at 25%.

Table 7.2: HIV prevalence rate by sex			
AGE	**MALES**	**FEMALES**	**TOTAL**
1.5 - 4	2.3	2.1	2.2
5 - 9	4.6	4.8	4.7
10 - 14	3.5	3.5	3.5
15 - 19	2.4	5.0	3.7
20 - 24	7.4	16.0	12.3
25 -29	16.0	33.9	25.9
30 34	28.6	48.9	39.7
35 - 39	37.3	42.8	40.5
40 - 44	43.6	38.4	40.6
45 - 49	27.7	31.2	29.8
50 - 54	28.8	22.2	24.8
55 - 59	19.5	25.1	22.8
60 - 64	16.7	14.4	15.4
65 +	12.6	8.8	10.4
Total	**14.2**	**20.4**	**17.6**

Source: BIAS 111 (2008).

Education and marital status also influence HIV infection. More educated people have a lower HIV prevalence rate. People with no formal education have a prevalence rate of 28.4% and those with higher than secondary education have a prevalence rate of 16.3%. Regarding marital status, the prevalence rate is higher amongst those who are widowed than those who never married, 39.6% compared to 16.1% (BIAS 111 2008).

Furthermore, urban areas have a higher HIV prevalence rates than rural areas and females have a higher prevalence rates than males in both rural and urban areas.

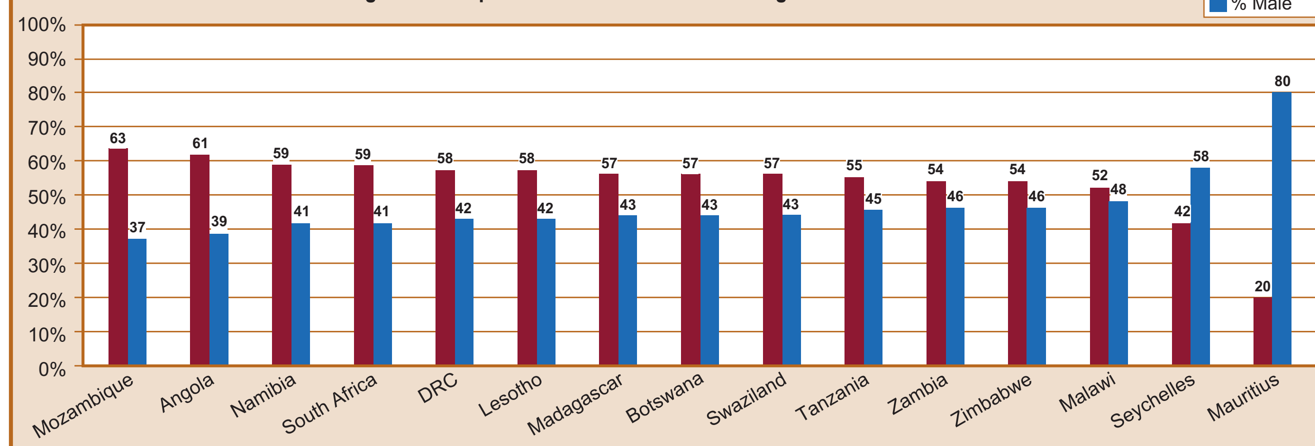
Young women and girls are more vulnerable to HIV infection than men and boys due to biological and social/cultural factors. These include multiple and concurrent relationships, inter-generational relationships, unequal gender and power relations, early marriage and teenage pregnancy amongst girls.

Table 7.3: Estimated prevalence rate by residence and gender			
Residence	**Prevalence rate by gender - Male**	**Prevalence rate by gender - Female**	**All**
Cities	15.2	22.8	19.1
Towns	19.0	24.9	22.1
Urban villages	12.1	20.0	16.6
Rural	14.6	19.3	17.1
Total	**14.2**	**20.4**	**17.6**

Source: BIAS 111 (2008).

Table 7.3 shows that women have high HIV prevalence rates in both urban and rural areas.

The National Prevention Strategy recognises and mainstreams gender in its activities. Although the policy does not cover specific services for orphans and vulnerable children affected by HIV and AIDS the government has an orphan support programme.



Source: UNAIDS 2012

Figure 7.2 shows that women are more vulnerable to HIV infection than men in all SADC countries except the island countries Seychelles and Mauritius. Women make up 57% of those living with HIV in Botswana compared to 43% men.

Table 7.4: Key Gender, HIV and AIDS Indicators

	% women	% men	Total
Extent of comprehensive knowledge on HIV and AIDS (15-24)	40	33	-
HIV infection	57	43	300000
Voluntary Counselling and Testing	-	-	273676
On ARV treatment	-	-	93000
HIV positive pregnant women receiving PMTCT	95	-	10450

Source: WHO, 2008.

ARV's are increasingly being found on shelves in hospitals.
Photo: Trevor Davies

Table 7.4 shows that women make up 57% of the people living with HIV. Huge progress has been made in PMTCT, with 95% of women going through the programme. The SADC Gender Protocol Barometer 2013 notes that 90% of those infected with HIV are on treatment.

Protocol @ work

Rights of women infected and affected by HIV and AIDS must be recognised

Bomme Isago was registered as a membership organisation in 2006 to address the sexual and reproductive health and rights challenges faced by women infected and affected by HIV. These challenges included the limited access to sexual and reproductive health (SRH) services; stigma and discrimination; the women's limited knowledge of or access to information about their sexual and reproductive health and rights and/or lack of capacity or confidence to demand them; and socio-cultural barriers to women's capacity to exercise their sexual and reproductive health and rights.

Bomme Isago seeks to contribute primarily through advocacy and community outreach. It sees these strategies as essential to bringing about a meaningful, effective and long term impact by facilitating changes in legislation, policy and programming and building community support. In these interventions, Bomme Isago sees as critical the active involvement of its membership to give human faces, and voices, to the issues. Bomme Isago Association is a network of women who are infected or affected by HIV and AIDS, therefore infected and affected women will be directly involved in the design and implementation of the programmes that will help improve the quality of their lives.

Speaking at the SADC Protocol@Work summit in Botswana, Boingotlo Gupta, the Executive Director of Bomme Isago Association said that women continue to struggle to access and enjoy their sexual and reproductive health and rights, irrespective of their HIV status. However, women infected with HIV are dealt additional blows. Anecdotal reports by women themselves have shown that in spite of strides taken in HIV service provision, the state has failed considerably to provide comprehensive SRH services that would address the particular sexual and reproductive health and rights needs of women infected and affected by HIV. The state has also failed to provide legislative and policy frameworks with which to safe guard sexual and reproductive health and rights.

The project thus aims to inform, empower and support women who are infected and affected by HIV to demand and practice their sexual and reproductive health and rights. It also seeks to strengthen and mobilise community support for the improvement of sexual and reproductive health and rights of women infected and affected by HIV.

Women and girls are the target group. In an attempt to demonstrate that HIV positive women's issues have still not been attended to, BIA took an approach of putting a face and a voice to the problems by compiling cases that will attest to the fact that SRH issues are still a problem in Botswana. The cases were grouped into such categories as teenage pregnancy, gender-based violence, stigma and discrimination among other issues.

BIA has raised the awareness of parliamentarians on women's health issues and built the capacity of many of its members with information on their sexual and reproductive health and rights and advocacy skills. This has been done in partnership with civil society groups including The Botswana Network on Ethics, and HIV (BONELA), Parliamentarians for Women's Health Project (PWH) and the International Community of Women Living with HIV (ICW).

Due to its interventions, BIA was nominated the winner of Botswana Awards for 2012 in the category of HIV and AIDS and care work. BIA has also managed to expand its membership through 20 support groups affiliated to it. There has been an increase of individual membership of over 200 members. BIA has also expanded the coverage to where the furthest group is 1000km from the office.

There has been a significant impact on the ground where BIA members are now actively advocating for their SRH rights. This has been evident from the increase in number of cases profiled and solved (25 cases); ranging from infringement of health rights, gender-based violence, socio economic and stigma and discrimination. BIA members are now recognised at community level, which increases on sustainability beyond BIA.

BIA has formed strong local networks with the following: Bonela for legal assistance, Bocongo for mentoring and training, Gender Links to assist with support on gender-based violence and NACA working together towards the elimination of stigma and discrimination. Bonepwa and BIA assist each other on issues of HIV and AIDS, the Ministry of Health assists with a facilitator on SRHR issues and HIV and AIDS, Nkaikela (sex workers) who are also our members, Mothers Union (HIV and teenagers) and Batlang Jehova (orphans).

From talking to HIV positive women it is very clear that there is lack of programmes that addresses their needs. For instance, more often than not HIV positive women are not allowed to make their own family planning choices. There is a lot of stigma and discrimination among service providers, more especially when HIV positive women use or want to use the prevention of mother to child transmission programme.

A plan is needed on how to reach 256 000 PLWHIV and to address the links between GBV and HIV with an emphasis on women and girls.

While some progress has been made in developing legislation to protect women and girls from gender-based violence, there is a need to develop adequate legal responses. Even where laws do exist, implementation is inadequate and services are not available to support the women and girls infected and affected by HIV.

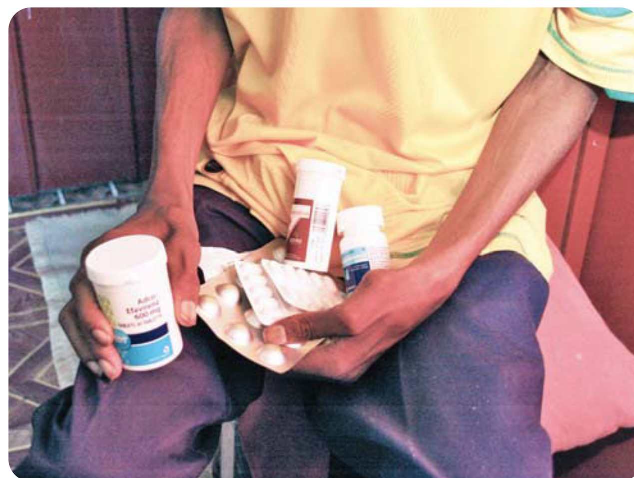
Bomme Isago Association, BONEPWA and BOFWA will come up with a combined effort to work together to reach the wider community. It is important to link SRH and HIV and AIDS with other factors such as economic empowerment using the available resources from the government.

Prevention

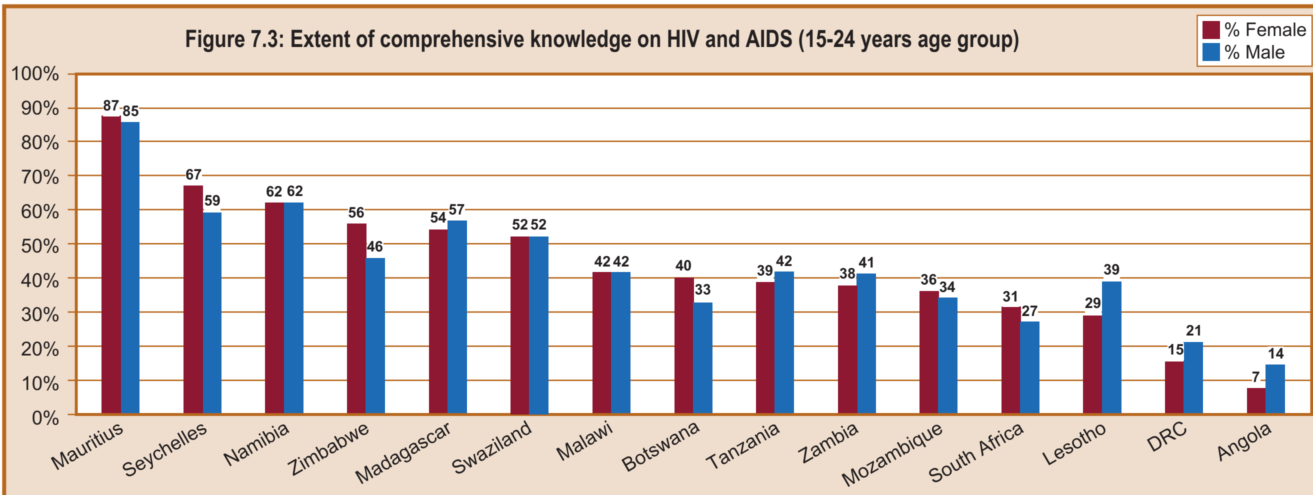
The Protocol requires that by 2015, state parties shall develop gender-sensitive strategies to prevent new infections, taking account of the unequal status of women, and in particular the vulnerability of the girl child as well as harmful practices and biological factors that result in women constituting the majority of those infected and affected by HIV and AIDS.

Botswana's HIV and AIDS policy recognises the need for the promotion of gender equality to enhance women's social and economic status, and to empower them for more effective participation in decision-making about safer sex (Ministry of Health 1998).

In 2007, a mid-term review of the National Strategic Framework for HIV/AIDS emphasised the need to increase prevention efforts in Botswana. The National AIDS Coordination Agency (NACA) developed the 'National operational plan for scaling up HIV prevention in Botswana 2008-2010 (NACA 2009). As a result, a national campaign addressing 'multiple concurrent partnerships', focussed on behaviour change, specifically targetting young people. It also provided information on male circumcision as an important prevention method used in combination with other methods, such as condoms.



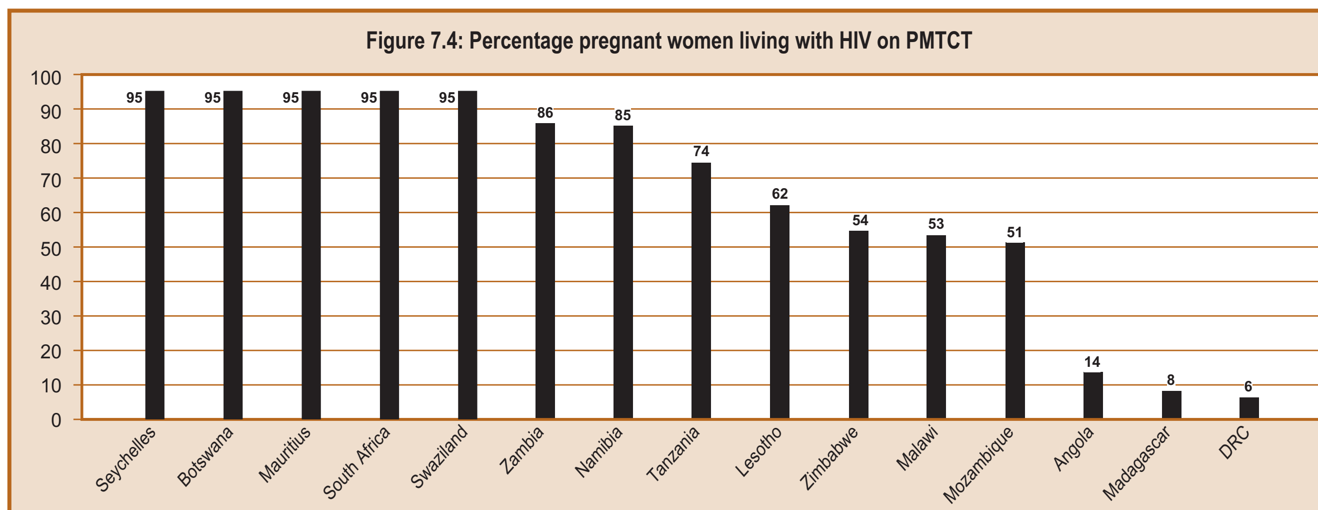
Botswana is making good progress in providing universal access to treatment and care for men and women. *Photo: Trevor Davies*



Source: World Health Organisation [16].

Information, Education and Communication NACA's National Campaign Plan identifies young women as one of the main target groups because they often engage in multiple concurrent partnerships with older men, for personal or material gain, or for advancement in education or employment (NACA 2009). The plan notes the increasing trend of older men taking advantage of their higher income status to have sexual relations with young girls. It recognises that these relationships are further disempowering women to negotiate safe sex, and is a major barrier in HIV prevention.

Prevention of Mother to Child Transmission Programme
The Prevention of Mother to Child Transmission (PMTCT) programme has been in place since 2001. Today PMTCT is in all public health facilities. There has been an increase in testing amongst pregnant women from 83% in 2004 to over 95% in 2010, which will contribute to the implementation of routine and rapid HIV testing in all antenatal settings (MOH 2008, NDP 10).



Source: UNAIDS 2012.

PMTCT uptake is improving dramatically but still remains uneven in the region: On average, 59% of HIV-positive pregnant women in the SADC region receive PMTCT. Figure 7.4 illustrates that five countries including Botswana have PMTCT coverage of 95%, while Zambia has 86% coverage and Namibia has 85%. These countries have already reached the World Health Organisation target of 80% coverage and may soon reach 100% coverage. Meanwhile, four countries have a PMTCT coverage between 50%- 62% and may be able to meet the WHO target by 2015. Only Angola, DRC and Madagascar fall well below 50% coverage.

[16] WHO 2012 Statistics and UNGASS progress country Reports 2012.

Treatment

The Protocol requires state parties to ensure universal access to HIV and AIDS treatment for infected women, men, boys and girls.

Botswana has made good progress in providing universal access to treatment and care for men and women living with HIV and AIDS. UNAIDS/WHO reports that in 2007, between 100,000 and 130,000 people needed ART, and between 86,000- 99,000 people received ART; coverage is between 69%-91%. Botswana is also performing well in PMTCT; 95% of pregnant women received ART to prevent them from passing on the HIV virus to their babies. ARV treatment is provided free to citizens (WHO 2008, MOH 2008).

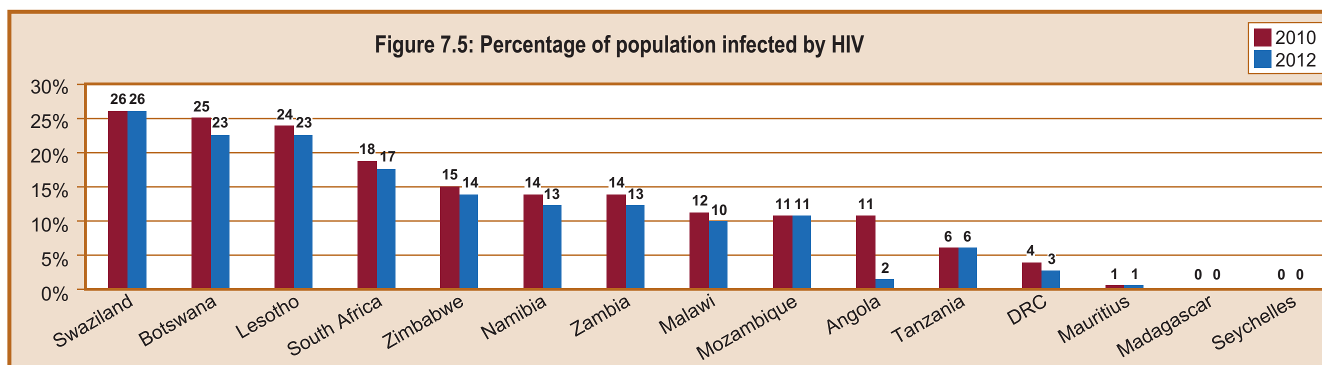


Figure 7.5: Percentage of population infected by HIV

Source: UNAIDS 2010 and UNAIDS 2012.

Figure 7.5 illustrates that HIV prevalence rates continue to drop throughout the SADC region. Those countries with the highest prevalence in the region, South Africa, Zambia and Zimbabwe have managed to reduce these rates, as have countries like Angola and DRC, which have historically not had high HIV rates compared to the other countries in the region. The percentage of population infected by HIV in Botswana dropped from 25% in 2010 to 23% in 2012.

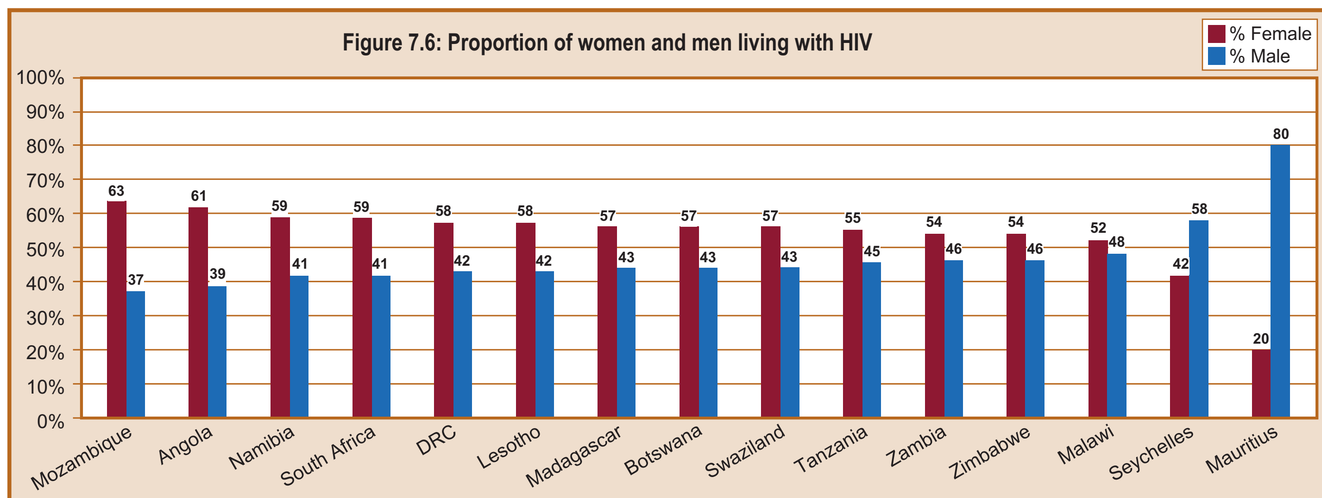
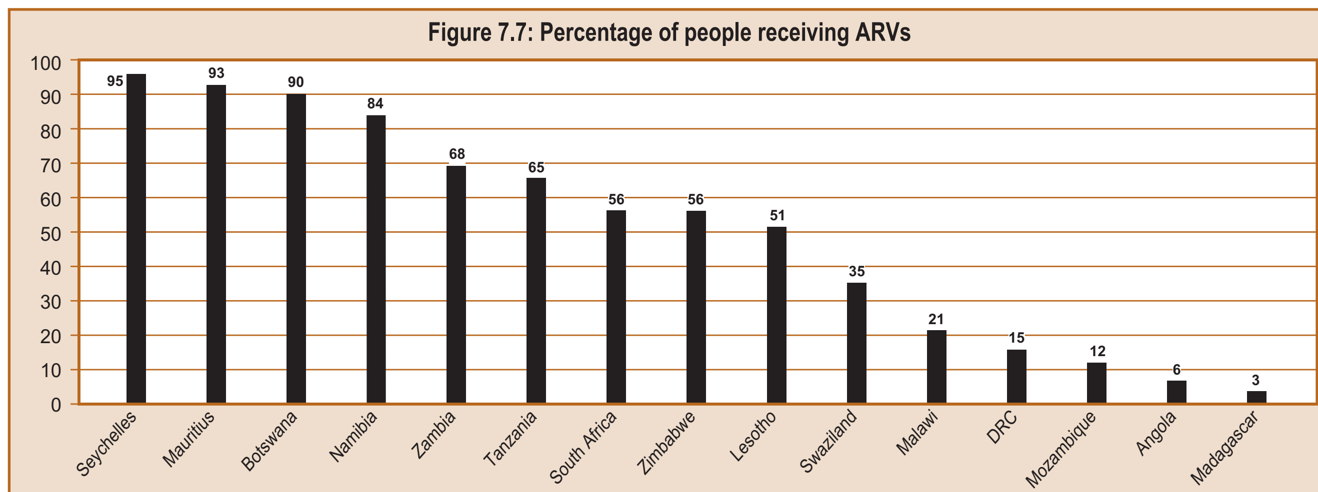


Figure 7.6: Proportion of women and men living with HIV

Source: UNAIDS 2012.

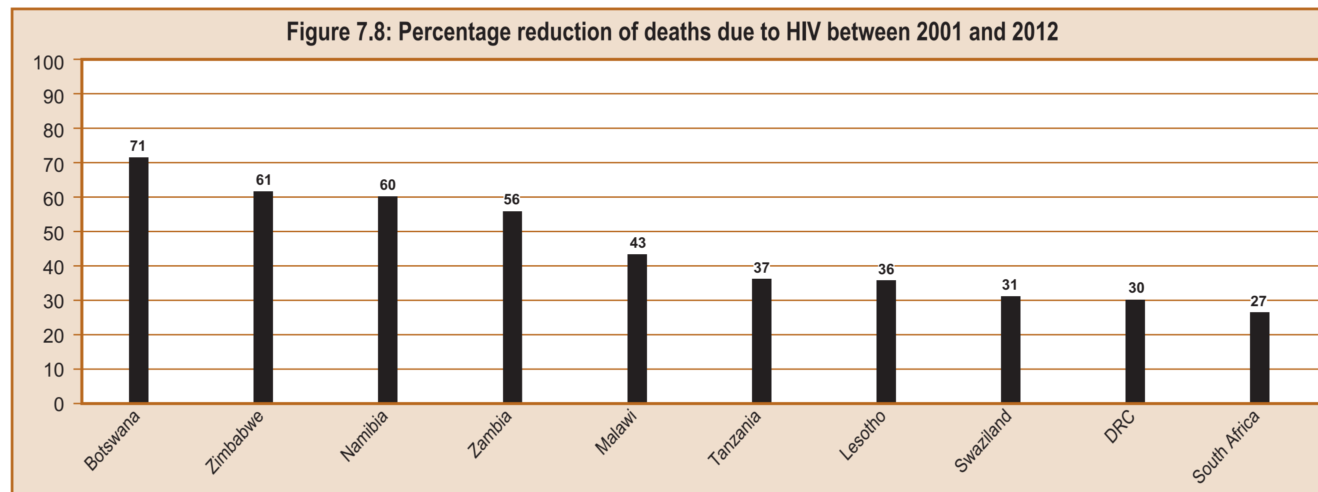
As illustrated in Figure 7.6, more women continue to live with HIV than men. As in 2011, 13 SADC countries including Botswana have a greater proportion of females than males living with HIV. Only Mauritius and the Seychelles have a higher male prevalence, likely because HIV and AIDS infection is concentrated among

injecting drug users. The most pronounced sex difference is in Mozambique (63% women, 37% men) and Angola (61% women, 39% men).



Source: UNAIDS 2012.

There are still major differences between countries: Figure 7.7 illustrates that while there have been vast improvements in access to ARTs, there remains a long way to go. This is especially true in Angola and Madagascar, which respectively only provide ARVs to 6% and 3% of HIV positive citizens. Meanwhile, Seychelles and Mauritius have done much better at 95% and 93% respectively. In Botswana, 90% of those infected are on ART. There is little sex disaggregated data on the uptake of ART but it is clear that gaps and challenges remain across the SADC region:



Graph compiled from UNAIDS 2013 World Aids Day Result Report.

The region has seen a reduction in deaths from HIV and AIDS: The rapid expansion of treatment has resulted in a marked reduction in the number of deaths in the region. The UNAIDS 2013 Results report notes that sub-Saharan Africa has cut the number of deaths from AIDS-related causes by 32% between 2005 and 2011, with the largest drop in AIDS-related deaths recorded in some of those countries where HIV has the strongest grip. For example, Figure 7.8 illustrates that South Africa reduced the number of deaths in this time period by 27%, which amounts to approximately 100 000 deaths.[17] Botswana, meanwhile, saw the largest per capita reduction at 71%.

[17] UNAIDS 2012 World AIDS Day Report: Results.

Care work

The Protocol requires member states to develop and implement policies and programmes to ensure the appropriate recognition of the work carried out by caregivers; the majority of whom are women, to allocate resources and psychological support for care givers as well as promote the involvement of men in the care and support of People Living with AIDS.

The government provides an orphan support programme and a community home based-care programme. Women and girls bear the burden of home-based care, which limits their participation in productive activities.

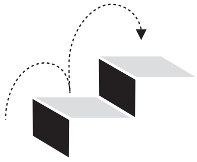
During May 2009, GEMSA conducted a policy audit of care work in Botswana. GEMSA evaluated current and future provisions for care-givers in the country, to identify policy gaps, and to provide recommendations on how stakeholders can strengthen the care work programme. Ultimately, the findings from this report will contribute to a model home-based care policy for the SADC region.

GEMSA held three focus group meetings and conducted interviews. Researchers identified participants through desktop research and discussions with organisations involved in care work. The first meeting brought together 10 community home-based care (CHBC) organisations. The second focus group involved six civil society organisations involved in gender and HIV/AIDS, such as the Botswana Network of AIDS Service Organisations (BONASO), the Botswana Network on Ethics Law and HIV/AIDS (BONELA) and Women in Action (WIA). GEMSA also conducted an interview with a representative from the Joint United Nations Programme on HIV/AIDS (UNAIDS). In addition, GEMSA held several interviews with government employees. The third focus group brought together five health workers and one home-based care coordinator. GEMSA also interviewed the Gaborone district CHBC coordinator.

Botswana has had a community health based care (CHBC) programme since the early 1990s. The guidelines, which the government revised in 1996, continue to be used today. The government provides a monthly transport allowance and clinical supplies. The CHBC programme has succeeded in impacting people infected and affected by HIV and AIDS. However, given the changing AIDS epidemic, the current programme relies too heavily on the out dated guideline.

Home based caregivers and partners attending a Making Care Work Count cyber dialogue during 16 Days of Activism against gender violence campaign in Ramotswa, Botswana in December 2010. *Photo: Roos van Dorp*

Table 7.5: Care workers			
ISSUE	**POLICIES**	**OPPORTUNITIES**	**RECOMMENDATION**
Training/ professional recognition	The government currently has a well-defined training programme for nurses, CHBC volunteers at the clinics covering TB, adherence and care for patients. Many care-givers working for NGOs receive training from the CHBC programme or other civil society organisations.		Consider moving towards a standardised, mandated training programme. Clinics should provide greater clarity on their training sessions. Explore the possibility of accrediting training to help professionalise CHBC and create a career path within the sector.
Logistic and material support	The government provides CHBC volunteers with a transport allowance of P151 per month (about US$22) and clinical supplies.	The government is currently reviewing the CHBC programme. During this evaluation the government could explore new provisions for care-givers and request feedback from stakeholders.	Improve management and evaluation of systems to accurately predict community needs. Promote more efficient communication between departments to minimise backlogs. Provide clear guidelines on transport reimbursement and explore alternative forms of transport such as bicycles. Examine the CHBC budget to make room for new concessions for volunteers. Fund provisions that have the most meaningful impact on the lives and work of CHBC volunteers.
Psychosocial support	The government provides psychosocial support through supervisors at the clinics or through the social welfare officers. As part of Ministry of Health's monitoring of CHBC, government representatives often visit volunteers to discuss their challenges. CHBC organisations often facilitate discussions for volunteers to share their challenges and frustrations.	The government is currently reviewing the CHBC programme, which provides an opportunity to strengthen psychosocial support for caregivers and request ideas and feedback from stakeholders.	Increase the capacity of nurses and social workers. Implement a report back session with volunteers on concerns raised during evaluations. Incorporate stress management and exercises on how to cope with the loss of patients in volunteer training. Encourage peer counselling so volunteers can support one another.
Gender equality	The CHBC guidelines do not address the gender disparity in CHBC.	The review of the programme provides an opportunity to encourage men to be more involved.	Communities should approach and sensitise men on issues of equality from an early age. The Ministry of Health should actively recruit and engage men in volunteering. They should also raise awareness on sharing responsibilities in care work. Improve volunteer incentives. Sign the SADC Protocol on Gender and Development.



Next steps

- HIV prevention needs to find innovative ways to address the gender issues that drive the pandemic. Although HIV awareness is high, traditional leaders need to be engaged to help eliminate negative traditional and cultural beliefs that increase women's vulnerability to HIV and AIDS.
- IEC campaigns should effectively mainstream gender concerns to empower girls and boys on the importance of negotiating and practicing safe sexual relations.
- The Government, NGOs and churches need to increase support support the rising number of orphans.
- The government needs to broaden the focus of CHBC to address the needs and wellbeing of volunteers.
- The government needs to promote men's involvement in in care work, so the burden does not fall on girls and women.

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