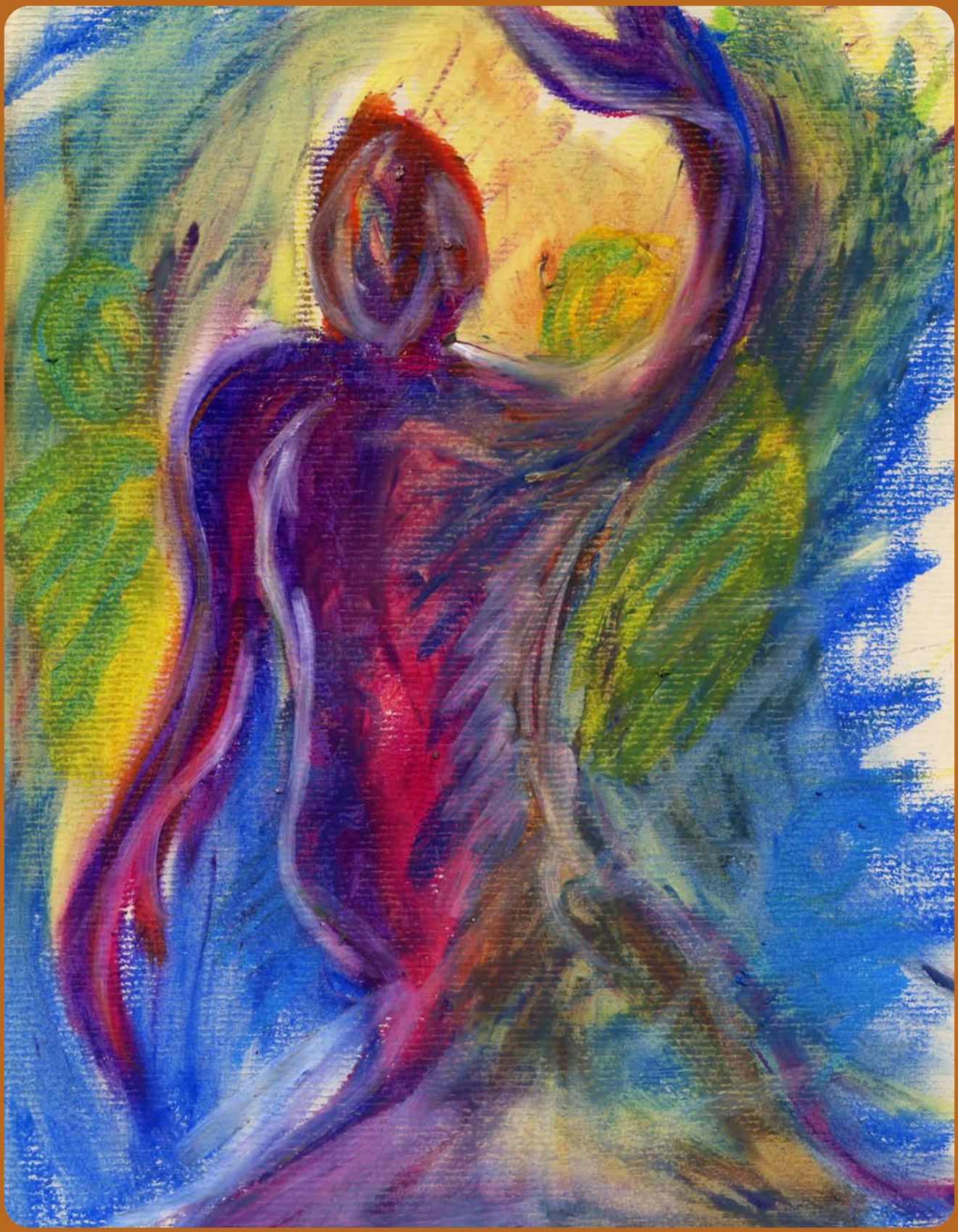


"Anita"

Anushka Virahsawmy

CHAPTER 7
HIV and AIDS

Article 27

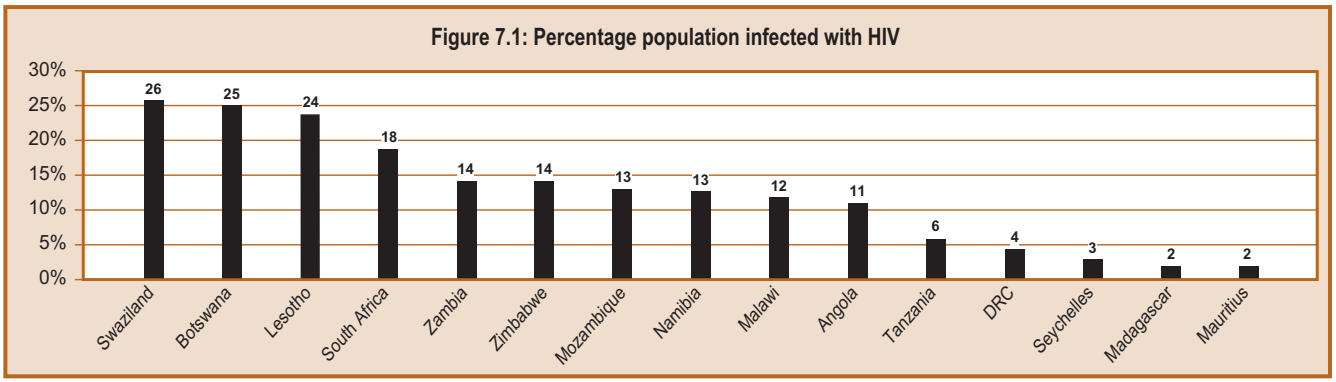
Francistown calls for HIV eradication. *Photo: Mboy Maswabi*

KEY POINTS

- Botswana citizens rated the efforts of their governments at 72% in this sector, while the SGDI score is 70%.
- HIV prevalence has decreased consistently over the past decade: new infections among adults have decreased by more than 50%.
- Provision of antiretroviral therapy has expanded, contributing to the rapid reduction of AIDS-related mortality.
- Tuberculosis remains the leading cause of death among people living with HIV and AIDS.
- Gender disparities continue to be the primary driver of the epidemic.
- Women account for 55% of those living with HIV in Botswana.
- Women continue to bear the greatest burden of care.
- AIDS-related mortality leads to the increased number of orphans and vulnerable children in Botswana. By 2013, 52.9% of children aged 0-17 years had lost at least one parent.

Table 7.1: SGDI and CSC scores for the HIV and AIDS sector		
	SGDI	*CSC*
Scores	70%	72%
Ranks	3	3

Table 7.1 shows that according to the SGDI and CSC scores, Botswana ranks at 70% and 72% respectively. Botswana is amongst the top scoring countries in this sector.



Source: 2013 SADC Gender Protocol Barometer.

Figure 7.1 shows that HIV and AIDS prevalence varies greatly in SADC. Botswana, at 25%, is among four of the 15 countries that have an HIV prevalence rate of more than 15%. Meanwhile, Madagascar and Mauritius have an HIV prevalence rate of just 2%.

The HIV epidemic has shaped the development agenda in Botswana for more than three decades. The country has felt its impact in the exponential increase in the number of orphans as well as child- and elderly-headed households. The continued high prevalence of HIV in the country has placed a significant burden on the nation's health and social services systems. However, large amounts of money and a high level of commitment from governments, communities, donors and civil society is slowly beginning to reduce the impact of the epidemic.

Table 7.2: Botswana AIDS Impact Survey (BAIS) IV prevalence and incidence rate	
Status	**Population 18 month+**
Estimated HIV-negative	943 500
Estimated HIV-positive	213 518
Estimated new HIV infections in the last 12 months (weighted)	10 329
Estimated Prevalence (%)	18.5
Estimated Adjusted incidence (%)	1.35

Source: BAIS IV, 2013.

Table 7.2 shows that the BAIS IV survey estimated a national prevalence rate of 18.5%, compared to 17.6% in BAIS III among the population aged 18 months and older. The HIV incidence (the number of new infections) of the general population dropped from 1.45% in 2008 (BAIS III) to 1.35% in 2013 (BAIS IV).

HIV prevalence in Botswana is highest among the age group 30-45 years (7.3%), among people aged 40-44 years (40.6%) and lowest among 1.5- to 4-year-olds (2.2%). There is an indirect correlation between HIV prevalence and education, such that the higher the education, the lower the HIV prevalence. Females have a relatively higher prevalence rate of 20.8% compared to 15.6% for males.[1]

HIV prevalence is higher among those with no education or non-formal education (28.4% and 28.6% respectively. This compares to those with education higher than secondary school, whose prevalence research estimates to be 16.7%. Within marital status categories, widows have a high HIV prevalence at (39.6%), compared to those who have never married (16.1%).

[1] NACA (2010) Modes of Transmission Study pg. 40 (4.3.4).

AIDS-related mortality leads to the increased number of orphans and vulnerable children in Botswana. By 2013, 52.9% of children aged 0-17 years had lost at least one parent. According to the BAIS IV survey, 13.9% of households with orphans receive primary support from the government.

Rural areas had approximately the same prevalence rate over the years, 17.1% in 2008 and 17.4% in 2013. Towns have a much higher prevalence rate of 21.6%, a slight decrease from 22.1% from BAIS III. Cities have a prevalence of 19.5% that is almost the same as BAIS III prevalence of 19.1%.

Households impacted by HIV and AIDS often experience decreased or complete loss of income, disintegration of the family, increased school dropout (especially amongst girls) and disproportionate increases in household workload on girls and elderly women, which increases vulnerability to further HIV infection.

Intensified global efforts to eliminate HIV and AIDS

In July 2011, the UN General Assembly adopted a political declaration on HIV and AIDS: *Intensifying Our Efforts to Eliminate HIV and AIDS*. Drawing from the Declaration, UNAIDS articulated 10 specific targets for 2015 to guide collective action:

1. Reduce sexual transmission by 50%.
2. Reduce HIV transmission among people who inject drugs by 50%.
3. Eliminate new infections among children and substantially reduce the number of mothers dying from AIDS-related causes.
4. Provide antiretroviral therapy to 15 million people.
5. Reduce the number of people living with HIV who die from tuberculosis by 50%.
6. Close the global AIDS resource gap and reach annual global investment of US$22-24 billion in low- and middle-income countries.
7. Eliminate gender inequalities, gender-based abuse and violence, and increase the capacity of women and girls to protect themselves from HIV.
8. Eliminate the stigma and discrimination against people living with, and affected by, HIV by promoting laws and policies that ensure the full realisation of all human rights and fundamental freedoms.
9. Eliminate restrictions for people living with HIV on entry, stay and residence.
10. Eliminate parallel systems for HIV-related services to strengthen the integration of the AIDS response in global health and development efforts.

Intensified global and national efforts to expand care and prevention, through treatment and support, have helped begin to turn the course of the HIV epidemic. As noted throughout this chapter, this is resulting in fewer new infections, exponential increases in a number of people on treatment and marked declines in AIDS-related death rates.

Despite massive gains in reducing new HIV infections, Botswana remains deeply affected by the HIV epidemic, which is widespread and generalised.

Women remain more vulnerable to HIV infection: Women account for 55% of those living with HIV in the Botswana and women bear the greatest burden of care. The prevalence for females (10.9%) at 60 years and older has slightly gone up from 8.8% in BAIS III (BAIS IV, 2013). Women -young women in particular - remain disproportionately more vulnerable to HIV infection than their male counterparts do.

Women between 15-24 years-old, are twice as likely to be living with HIV as men of the same age. If young women and adolescent girls had the power and means to protect themselves, the picture of the epidemic would look different. This is beginning to happen. The rate of new HIV infections among young women in 26 countries is declining. However, these gains remain fragile.

Some of the factors that exacerbate women's risk to HIV include:

- High incidence of age-disparate sexual relationships (young women in sexual relationships with older men means a heightened risk of contracting HIV);
- Limited female-controlled HIV prevention devices and methods;
- High levels of stigma and discrimination, impacting on women's ability to access HIV counselling and testing and to adhere to treatment;
- Intimate partner violence or fear of violence, leading to women's lowered ability to initiate discussions about safer sex, even when the partner is known to have other sexual partners;

[2] http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf accessed 18 July, 2014

- High rates of multiple concurrent partnerships;
- High rates of alcohol and drug abuse and inconsistent condom use;
- High incidence of rape and sexual violence perpetrated against women;
- Harmful cultural practices, supported by patriarchy - such as polygamy, widow cleansing, widow inheritance, marrying girl-children to older men - limit women's ability to make choices that can protect them from HIV; and
- Gender inequality renders women less able to negotiate and define sexual relations.

Gender norms also increase men's vulnerability to HIV infection: Men can sometimes be encouraged to engage in high-risk behaviour and discouraged from seeking health services. As a result, fewer men than women get tested for HIV. Men also have lower levels of access to treatment than women, which means they have lower CD4 cell count levels by the time they seek treatment and have poorer adherence to treatment. This results in higher mortality rates for men.[3]

A rise in new infections in committed partnerships has grave implications for women's increased vulnerability: Evidence suggests that many new HIV infections in Botswana occur in low-risk heterosexual couples, many of whom remain unaware of their status due to low use of HIV counselling and testing services. In Botswana, studies indicate that women cohabiting with men had the highest prevalence rates at 40%.[4] These statistics underscore the need for a scaling-up of behaviour change programmes dealing with multiple concurrent partnerships with low HIV testing and condom use, which make women more susceptible to contracting HIV.

Botswana documents sex workers' experiences

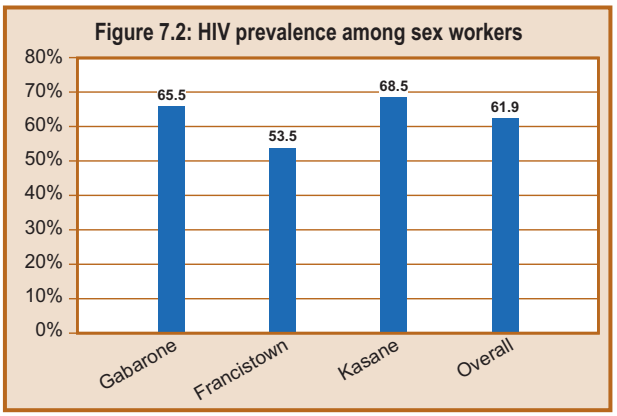
Botswana's Ministry of Labour and Home Affairs said it has launched a booklet and DVD "Documenting the Voices of Female Sex Workers in Botswana." The project combines print and video to capture the experiences of sex workers in areas such as motivation for entry into sex work and access to health and HIV prevention material. The Labour and Home Affairs Ministry Permanent Secretary, Ikwatlhaeng Bagopi, said in a statement that due to the sensitive nature of the industry, the documentary used blurred images to protect the identity of sex workers involved. The DVD comes at a time when former President Festus Mogae has called for the decriminalisation of sex work as another way of fighting the HIV scourge. Botswana is among the countries with a high level of HIV and AIDS infection on the continent.

Star Africa: 21 August 2014

Key populations and HIV

Researchers view key populations as those with an elevated risk or vulnerability to HIV and AIDS due to some form of sexually-risky behavior, occupation or sexual orientation. The list includes sex workers; Lesbian, Gay, Bisexual and Transgender (LGBT) people; prisoners; Injection Drug Usuers (IDUs); truck drivers; military staff; long-distance mobile workers; miners; fishermen; Internally Displaced People (IDPs); and refugees.

In 2012, Botswana conducted a mapping, size estimation and behavioural and biological surveillance of HIV/STI among sex workers and men who sleep with men (MSM) in Gaborone, Francistown and Kasane and found a 62% HIV positive rate among female sex workers from the three sites. The incidence rate stood at 12.5%. This is, by far, the highest rate documented in the SADC region. Thus, stakeholders target sex workers as a high-risk group in prevention programmes, as they remain especially susceptible to HIV and AIDS due to their patterns of sexual behaviour.



Source: 2012 Mapping, Size Estimation & Behavioural, and Biological Surveillance Survey (BBSS) of HIV/STI among Select High Risk Sub-populations in Botswana.

[3] UNAIDS Global Report, 2012.
[4] Botswana Country Report, 2010.

Figure 7.2 shows the highest HIV prevalence rate amongst sex workers is in Kasane (68.5%), followed by Gaborone at 65.6% and Francistown at 53.5%.

Due to prevailing socio-economic conditions, the number of women who have entered sex work has increased rapidly in Botswana. Female sex workers remain especially likely to live in extreme poverty, to face exceptional barriers to safe housing, employment, and access to quality health care. In addition, if HIV-positive, they remain less likely than other populations to receive antiretroviral therapy and more likely to experience negative interactions with health care providers. These women are also disproportionately likely to face violence in a high prevalence of co-occurring poverty, lack of vocational training, unemployment, alcohol abuse, multiple life traumas, poor mental health, and STI/HIV infection.

A 2012 review of available data from 50 countries, which estimated the global HIV prevalence among female sex workers at 12%, found that female sex workers are 13.5 times more likely than other women to be living with HIV.[5] Sub-Saharan Africa is home to 17 of the 18 countries where the HIV prevalence among sex workers is higher than 20%. The median HIV prevalence among sex workers in sub-Saharan Africa is 20.5% compared to a global median of 3.9%. No African countries report an HIV prevalence of less than 6% among sex workers.

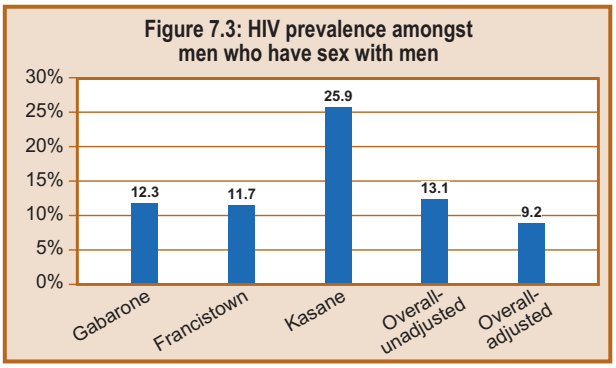
Mobility and proximity to transport routes increases risk of contracting HIV: Southern Africa has long exhibited a trend of higher HIV prevalence along transportation routes and in border towns, partly due to the high incidence of transactional sex. Sexual abuse of women and girls also remains common in border towns. Botswana exhibits localised epidemics, with HIV prevalence more concentrated in some areas than in others, such as Selibe Phikwe, Francistown, North East and Kasane. Cross-border traders, oftentimes women, remain more likely to be HIV-positive.

HIV in the military

A poster showing HIV prevention activities at the Botswana Defence Force. *Photo: Courtesy of Africom*

The military is the largest formal employment sector after the civil service. The military has an age and gender profile that is relatively young, sexually active and predominantly male. In particular, the Botswana Defence Force (BDF) falls mostly in the age group of 18-49 years. The nature of the duty of the members of the military often separates men and women from their families and partners for prolonged periods, and in the process exposes them to sexually risky behaviour.

Behavioural and Biological Surveillance Survey (BBSS) of HIV/STI among Select High Risk Sub-populations in Botswana



Source: 2012 Mapping, Size Estimation & Behavioural, and Biological Surveillance Survey (BBSS) of HIV/STI among Select High Risk Sub-populations in Botswana.

Figure 7.3 illustrates that HIV prevalence is especially high among men who have sex with men. Although same-sex relationships remain illegal in Botswana, available data suggests that HIV prevalence is much higher among men who have sex with men (MSM). Globally, MSM are 19 times more likely to be living with HIV than the general population of men. In Botswana the prevalence is 13.1% (overall unadjusted; adjusted: 9.2%) among MSM compared to 18.5% in the general population. One international review concluded that only one in 10 men who have sex with men receives a basic package of HIV prevention interventions.

There is a shortage of targeted prevention and mitigation interventions for women who have sex with women: Women who have sex with women can also be vulnerable to contracting HIV infection, yet stakeholders in the sector rarely target this group with HIV interventions. This is mostly due to a lack of understanding of the specific sexual practices of women who have sex with women, as well as lack of knowledge of their sexual and reproductive health needs.

Male prisoners remain vulnerable to HIV infection: Data on the prevalence of HIV in prison populations - where condoms remain contraband - remains scarce. It is a common perception that HIV spreads within prisons due to predatory, as well as consensual, sex. While

[5] Baral S et al. Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. Lancet Infectious Diseases, 2012, 12:538-549.

clearly documented cases of HIV transmission in prison do exist, other data points to the possibility of the larger proportion having acquired the virus while free. Botswana does not test inmates upon entry. There is an urgent need for further data in this area.

HIV screening at a government hospital.
Photo: Zotonantenaina Razanadratefa

Reports from the Health Unit Annual Report (2008/2009) in Botswana showed a prevalence of 14% among inmates held under The Prisons and Rehabilitation Department in Botswana. According to report, of the 2586 people that received counselling, 1909 agreed to undergo testing for HIV. Only 14% or 272) tested positive, paving the way for provision of antiretroviral therapy.

The prison population is of great concern to those watching the spread of HIV in the broader society. Men comprise a majority of the prison population in Botswana. Imprisonment effects extend beyond the individual to their relationships and community. Prison sentences disrupt or end intimate partnerships that have been otherwise stable and protective. Upon release, a vast majority of prisoners may face an even greater risk of HIV transmission when reconnecting with a partner who had sex with other partners during the incarceration. So far, in Botswana, researchers know little about the behaviour of HIV-positive men and women after prison release.

While an SADC Declaration on HIV and AIDS already exists, the SADC Gender and Development Protocol seeks to move beyond declarations and conventions previously signed by SADC countries. It does this by specifying the gender dimensions of the problem and coming up with specific time frames and targets which can be translated into real benefits for women living with HIV.

The Protocol states that, by 2015, SADC governments must:

- Develop gender-sensitive strategies to prevent new infections;
- Ensure universal access to HIV and AIDS treatment for infected women, men, boys and girls;
- 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 caregivers as well as promote the involvement of men in the care and support of people living with HIV and AIDS; and
- Have laws on gender-based violence that provide for the testing, treatment, and care of survivors. These should include emergency contraception, access to post-exposure prophylaxis at all health facilities, and the prevention of sexually transmitted infections.

Policies

State parties shall take every step to adopt and implement gender-sensitive policies and programmes, and enact legislation that will address prevention, treatment, care and support in accordance, but not limited to, the Maseru Declaration on HIV and AIDS.

There is no time-bound target for this provision, but it is at the heart of informing HIV interventions. Policies provide a framework for addressing the epidemic with an emphasis on prevention.

Since researchers discovered the first case of HIV in 1985, Botswana has gone through several stages in its response to the epidemic. Four national initiatives guide the national response system:

- *Vision 2016:* Botswana's response to HIV and AIDS falls under the pillars of Vision 2016, which is the guiding light on Botswana's targets and multi-sectoral strategies for achieving indicators in all sectors. The national goal is to have an "AIDS Free Generation" by 2016. The implementation of national instruments geared towards the fight against HIV and AIDS has included the Community Home-Based Care (CHBC) and palliative care; National Gender Framework;

Botswana's HIV and AIDS Policy; Sexual Harassment Policies; and Civil Service General Orders. This is under the Vision 2016 pillar of "building a compassionate, just and caring nation."

- *The Mid-Term Review of the Eighth National Development Plan 8:* NPD 8 underscores HIV and AIDS as a critical policy issue.
- *The Revised National Policy on HIV and AIDS (2003):* The policy renewed the call to civil society, donor agencies and community organiaations to participate in, and mount, a collective, concerted multi-sectoral response.
- *The Botswana National Strategic Framework for HIV AND AIDS (2003-2009):* The National Strategic Framework identified the prevention of HIV infection as one of the country's primary goals. NSF I emphasised five priority areas: prevention of HIV infection, provision of care and support, strengthened management of the national response, psychosocial and economic impact mitigation and the provision of a strengthened legal and ethical environment.

The Ministry of Health is responsible for the provision of technical leadership, development of policies and standards, and the provision of professional guidance and technical support on health care, including counselling issues (Ministry of Local Government, 2005). The following are the services provided:

- Behavioural Change Information and Communication (BCIC)
- Social and Behaviour Change (SBC)
- Prevention of Mother-to-Child Transmission (PMTCT)
- Community Home-Based Care (CHBC)
- HIV Counselling and Testing (HCT)
- Anti-Retroviral Therapy (ART)
- Post Exposure Prophylaxis (PEP)
- Prevention and control of Sexually Transmitted Infections (STIs)
- Blood safety
- Universal precautions
- Financial and material support to Orphans and Vulnerable Children (OVC)
- Management and control of STIs
- Monitoring and Evaluation (M&E)
- HIV and AIDS workplace and wellness programmes

Most of the programmes remain available from health services. Other programmes, including SBC, HCT and condoms, exist at both the community and health services. A number of policies and legal instruments in Botswana affect HIV prevalence among women and girls.

Botswana's legal and policy frameworks on HIV and AIDS also include the National Operational Plan (NOP) for HIV and AIDS, 2011-2016; the National Gender Strategy; and the National Policy on HIV/AIDS (1998). Stakeholders have also developed guidelines and service standards such as the Sexual and Reproductive Health Policy Guidelines and Service Standards and the Policy Guidance to Male involvement in SRH, HIV/AIDS and GBV prevention and management (2008).

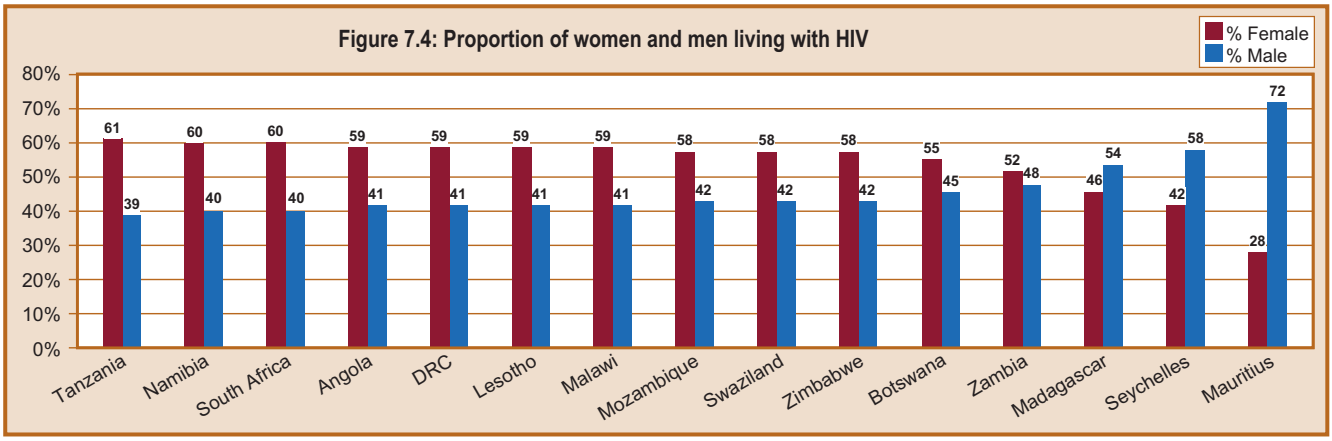
National forums exist such as the National AIDS Council (NAC), the Country Coordinating Mechanism (CCM) and at district level through the District Multi-Sectoral AIDS Committees (DMSAC). The Gender Affairs Department (MLHA) in collaboration with the National AIDS Coordinating Agency (NACA) has the overall mandate for gender and development coordination. Civil society organisations and programmes have continued to target key populations but they remain the most under-funded.

Development partners

In 2013, the US Center for Disease Control (CDC) launched a four-year study called the Botswana Combination Prevention Project (BCPP) in partnership with the Botswana Ministry of Health and the Harvard School of Public Health. The overall goal of the study is to evaluate whether coordinated and strengthened community-based HIV prevention methods prevent the spread of HIV better than the current standard methods.

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.



Source: http://kff.org/global-indicator/women-living-with-hivaids/ - accessed 18 June 2014.

Figure 7.4 shows that women remain more affected by HIV in SADC, with the exception of Madagascar, Mauritius and Seychelles. Thus, it is important to focus prevention campaigns with this in mind.

Comprehensive, accurate knowledge of HIV and AIDS is fundamental to ensuring citizens use HIV services and engage in safe sexual behaviours. BAIS IV found that 4.4% of men and women aged 15-24 had sexual intercourse before the age of 15, compared to 4% in BAIS III. Meanwhile, 15.8% of men and women aged 15-49 had multiple concurrent sexual partners in the 12 months prior to the study.

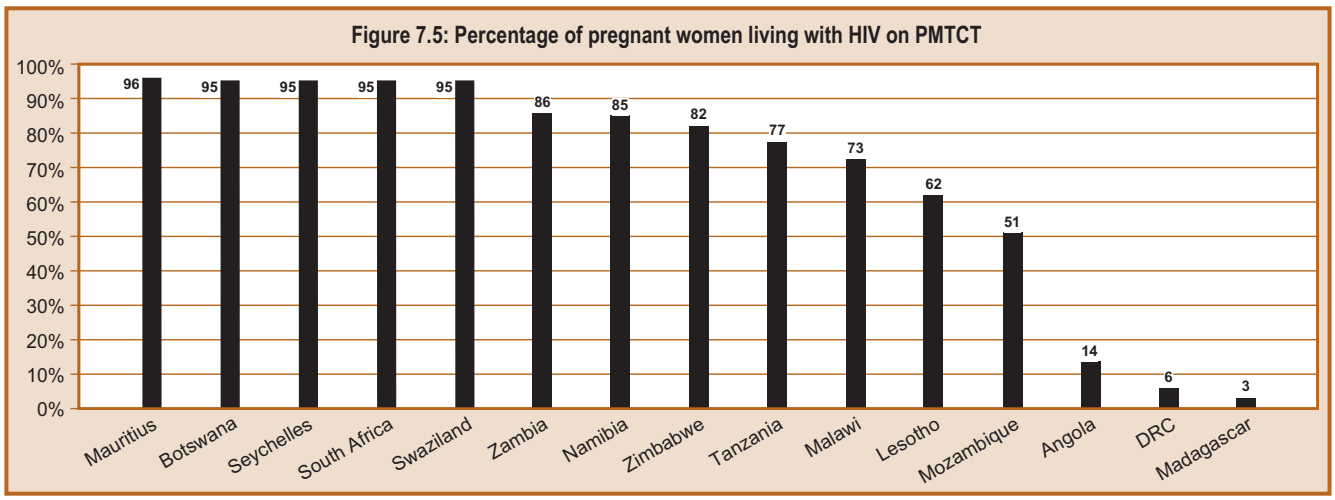
Women are more likely to be aware of their HIV status: HIV testing, counselling and prevention services in antenatal settings offer an excellent opportunity not only to prevent new-borns from becoming infected, but also to protect and enhance the health of HIV-infected women. In numerous countries, women remain significantly more likely to know their HIV serostatus, mainly due to the availability of such testing. Opportunities for programmes that encourage joint testing of an HIV positive woman and her husband as part of a PMTCT programme also exist, so that both can access treatment and care services.

Medical male circumcision

Botswana has taken steps to scale-up Voluntary Medical Male Circumcision (VMMC) for HIV prevention. Results of BAIS IV show that male circumcision increased with age, except at the age of 40-44, where there is a relative drop. The overall circumcision among the male population aged 10-64 years doubled from 11% in 2008 to 24.3% in the 2013 BAIS IV. The uptake of circumcision is high amongst those aged 30-34 (26.5%), 35-39 (30.8%) and 40-44 (24.1%). It peaks at the 55-59 age group at 39.2%.

Botswana's VMMC program recorded 42 679 circumcisions, about 85% of its annual target and 10 000 more than the previous year. Researchers attribute these significant improvements to improved operational efficiencies, increased outreach, and increased demand for PrePex, a new male circumcision device researchers have piloted in Botswana.

There is a need for more awareness creation around other benefits of circumcision, including a reduction of other sexually transmitted infections (STIs), penile cancer, and protection for women and girls from cervical cancer. There is also need for explicit messaging to dispel the notion of VMMC as a once-off solution or prevention measure. Men still need to use condoms and abstain from risky sexual behaviour.



Sources: 2014 SADC Gender Protocol Barometer.

Figure 7.5 illustrates that Botswana has 95% PMTCT coverage. Results of BAIS IV (2013) suggest that a very high percentage (93.5%) of mothers who tested HIV positive had enrolled into PMTCT (27 441 women enrolled out of 29 346 who tested HIV positive).

Social and structural impediments impede scaling up of PMTCT. Programmes for mentoring of mothers, disclosure support, greater involvement of males and families and reduction of stigma might help address this. Further, there is a need for greater efforts to reach marginalised groups such as women prisoners, sex workers, drug users, migrants and people with disabilities. The rate of mother to child transmission in such groups is much higher than in the general population.

Botswana has achieved the target of reducing transmission by more than 50% and transmission rates between mothers and babies have fallen to less than 5%. According to a recent study conducted by the Institute for Health Metrics and Evaluation at the University of Washington, the number of children who died due to AIDS has decreased tenfold over the past 10 years.[6]

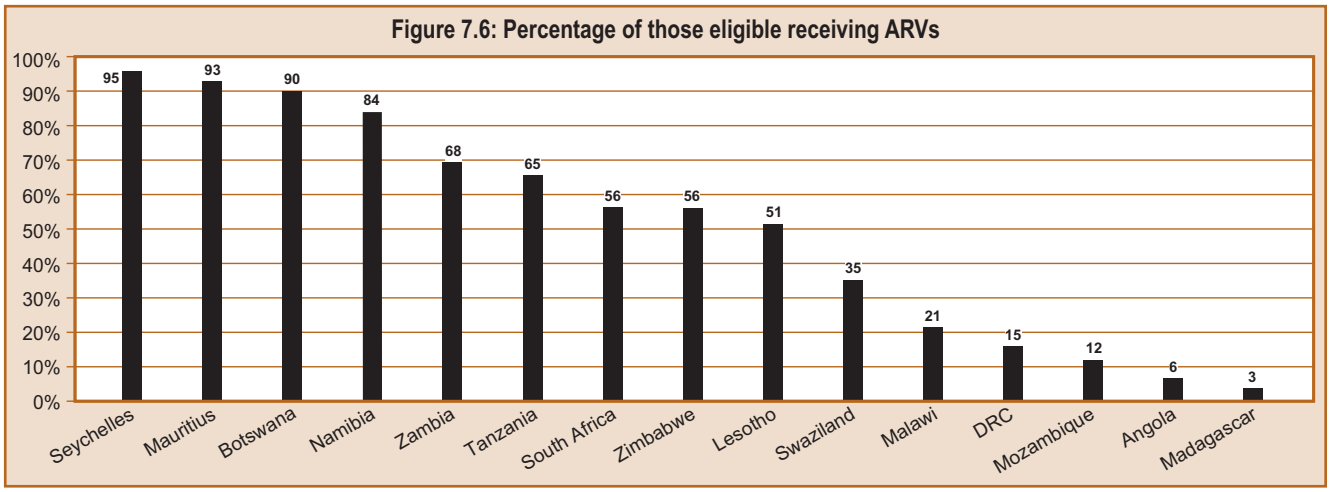
Between 2001 and 2011, the rate of new HIV infections dropped by 71% in Botswana. Studies have linked this decline with population-level changes in sexual behaviour, particularly reductions in the number of sexual partners and increased uptake and use of condoms. Botswana has stepped up efforts and programmes, including an extensive ART programme to address the HIV epidemic. Botswana continues to make enormous strides toward reaching the UNAIDS 2015 target of zero new infections.

HIV treatment

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

Adult access to ARVs currently stands at 90 % .However, according to the 2013 ART guidelines, the number of people living with HIV on treatment still falls significantly short of the 25.9 million people eligible for treatment worldwide.[7] In 2002, Botswana became the first country in the region to offer free antiretroviral drugs to citizens who needed them.

6 Institute for Health Metrics and Evaluation (IHME), 2014. http://mg.co.za/article/2014-07-21-hiv-infections-in-children-under-five-down-by-over-three-quarters.
7 WHO, 2013, WHO 2013 ART Guidelines.



Source: UNAIDS 2012.

Figure 7.6 illustrates that there have been vast improvements in access to ARVs. This is especially true in Botswana, which respectively provides ARVs to 90% of HIV-positive citizens.

Until recently, both refugees and immigrants did not have access to free ART. However, the Red Cross now provides communities in refugee camps with ART.

High Court orders Botswana to provide foreign inmates with ARVs
By Godfrey Ganetsang

Botswana is one of the only three countries in the region with ART coverage above 90 percent. *Photo: Ruben Covane*

High Court Judge Bengbame Sechele on Friday ordered the government of Botswana to provide non-citizen inmates with Highly Active Anti-Retroviral Treatment (HAART). Delivering judgment in a case in which two Zimbabwean inmates, Dickson Tapela and Mbuso Piye, together with Botswana Network on Ethics Law and HIV-AIDS (BONELA) had brought a constitutional challenge against a decision by the government of Botswana not to provide them with ARV treatment, Justice Sechele said:

- Such a decision was a violation of the applicants' constitutional right to life as guaranteed by sections 3, 4, 7 and 15 of the constitution of Botswana.
- Government's decision as invalid and set it aside, saying the state has a duty to provide inmates with basic health services.
- AIDS on its own is not an ailment but a conglomeration of opportunistic infections that descend on an HIV-infected person, whose immunity has been compromised, adding that the savingram only excludes foreign inmates whose condition has deteriorated to the clinical stages known as AIDS and not necessarily those who are HIV positive.
- The state's savingram of 26 March 2004, which sought to exclude non-citizen inmates from HAART, was irrational and invalid.
- Withholding HAART from non-citizen inmates would enable their HIV to replicate and thereby relegate them to the terminal stage known as AIDS.
- HAART is not only a medical necessity, but a lifesaving therapy, the withholding of which will take away a constitutionally guaranteed right to life.
- Constitutional challenges are matters of high importance, and the court will be less inclined in matters such as this to lay emphasis on technical inelegance. A party who seeks shelter under the sanctuary of the constitution should not lightly be turned away.

- The state for failing to provide evidence of a report from a medical officer from the prisons department detailing his findings on the circumstances connected with treatment of the applicants or any information that could support their argument that provision of HAART to non-citizen inmates will place an undue strain on the state's budget.
- The state had failed to provide information on the number of non-citizen inmates who require HAART enrolment and the costs associated with such enrolment as well as information that could juxtapose the costs of providing HAART to that of treating recurrent opportunistic infections on non-citizen inmates
- Shot down the moral argument raised by the state to the effect that the foreign inmates were convicted criminals who should not benefit from their crimes by enjoying free HAART treatment at the expense of those they have wronged, saying such an argument loses sight of the factor that incarceration and deprivation of liberty is all that was subtracted from the constitutional rights of these people.
- The presidential directive on which the decision to exclude foreign inmates from HAART was based was never put before him. The state attorneys produced a savingram from government confirming approval of the provision of free treatment to non-citizen inmates suffering from ailments other than AIDS.
- Punishment in the form of imprisonment equalizes all inmates regardless of their status and place of origin. It is impermissible for the state to indirectly extend the limits of punishment by withholding certain services to which inmates are lawfully entitled on account of their status as convicted non-citizen inmates.
- The assertion that they should not be granted treatment because they are convicted criminals also casts aspersions on the state's position that treatment was withheld because of lack of resources.
- The deprivation of HAART treatment to non-citizen inmates runs counter to the letter and spirit of section 4 of the constitution and is unlawful. It would be wrong for Botswana's courts to interpret legislation in a manner that conflicts with the international obligations that the country has undertaken.
- The non-treatment of foreign inmates poses a danger to the very citizen inmates that the state is trying so hard to protect because upon contracting opportunistic infections the costs of treatment will be escalated. It can never be in the public interest nor can it ever be reasonably justifiable in a democratic society that provision of life saving medication like HAART is withheld with the ultimate result that the group of people so deprived become more infections to others or die in our hands. The actions of the state in so far as they deny non-citizen inmates access to HAART enrolment is unlawful.

Justice therefore: Ordered that all non-citizen inmates whose CD4 cell counts have reached the threshold for HAART should be enrolled under treatment guidelines on HAART. Ordered to the State to bear the costs of the application.

Source: Sunday Standard: 25 August 2014

Challenges to expanding treatment

Overstretched and understaffed health systems in the region face many challenges as they struggle to expand treatment programmes further. Some of these include:

- Retaining patients in treatment.
- HIV stigma and discrimination still prevent those that need care and treatment from accessing it and adhering to it. This is particularly true for marginalised groups that are the subject to other forms of stigma.
- Poor data availability and management, both crucial to keep growing numbers of patients in the system.
- Reliance on external funding for treatment programmes. Very few countries in the region can fund their programmes. However, there is growing commitment to mobilise domestic resources and much greater emphasis on prudent management of available funds.
- The continuum of care has many gaps between prevention, testing, treatment and on-going adherence.
- Reaching more men earlier and keeping them in care and treatment.
- Improving treatment for children. Botswana and Namibia have met their goal of 80% of eligible children on treatment and South Africa, and Swaziland have been able to get more than 50% of eligible children on treatment. However, few countries provide treatment to more than three out of 10 children who need it.

Post Exposure Prophylaxis (PEP) is provided for in policies but not easily accessible: UNAIDS and UNIFEM reports recognise GBV as one of the leading factors in HIV infection, usually due to lacerations and other trauma. Treatment can help to reduce the likelihood of infection after sexual violence and is an important factor in caring for victims of sexual abuse. Twelve SADC countries (excluding Angola, Lesotho and Zimbabwe) have policies requiring that health facilities administer PEP after a sexual assault and 13 countries have policies aimed at preventing transmitted infection after sexual assault sexually.

In Botswana, the morning-after-pill is one of the currently popular contraceptives. Women prefer to use it to prevent unwanted pregnancies.

The risk of tuberculosis and HIV co-infection remains high: TB case notification rate in Botswana has risen because of HIV. As many as 63% of TB patients

are co-infected with HIV. The threat of drug-resistant TB and multi-drug resistant (MDR) TB is high and tends to complicate treatment. Each year, medical staff report more than 100 new MDR-TB cases across Botswana, and over the past two decades, the rates of MDR-TB in Botswana have increased ten-fold. Since 2007, the country has reported 11 cases of extensively drug-resistant TB, or XDR-TB. In some cases, a more severe form of TB, patients do not respond to treatment with the best medications. Detection and notification of the TB disease remains a challenge. However, the government of Botswana has made tremendous strides in the last decade in responding to both TB and HIV and AIDS.

Botswana grapples with TB

The challenge of dealing with TB continues to undermine Botswana's gains, despite significant strides registered in the national HIV response. Botswana's current estimates of HIV prevalence remained among the highest globally, towering at around 16.9%.

TB remained an important cause of morbidity and mortality globally as well as nationally, and it is the most important opportunistic infection among people living with HIV. People living with HIV have a 10% annual risk of developing TB compared to a 10% lifetime risk among HIV-negative people.

Shenaaz El-Halaabi, Deputy Permanent Secretary for Preventive Health Services at the Botswana Ministry of Health, and TB Survivor Modisamana Koboa, speak at a Press Conference on the 18 March 2014.
Photo: Ruben Covane

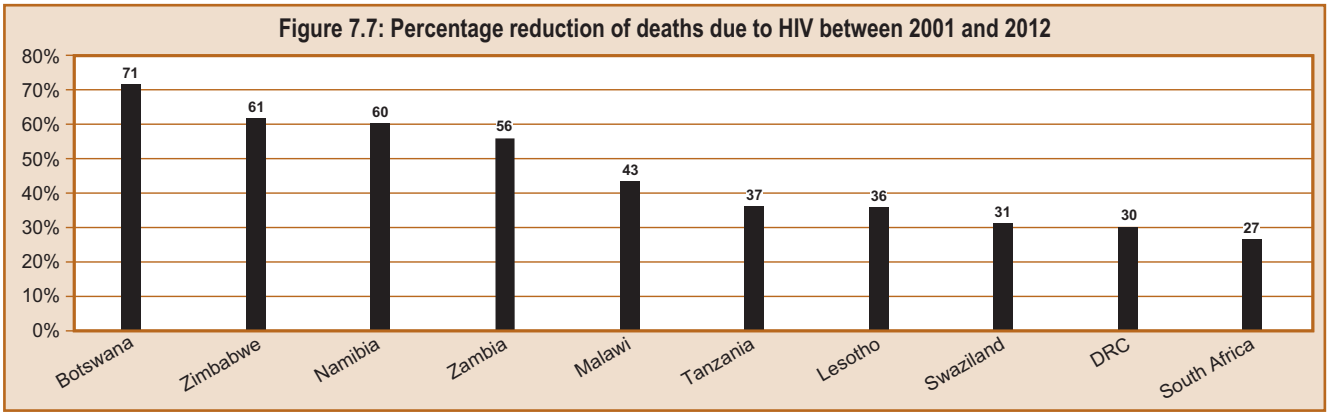
Botswana's notable gains reported in the '70s to contain the TB scourge eroded, resulting in a rapid increase of TB cases. In 2012, health workers reported close to 7 000 cases of TB across the country. The TB burden per capita in Botswana remains among the highest globally with an estimated rate of new episodes of TB as high as 408 cases per 100 000 population in 2012. As much as 63% of these patients also have HIV. Such high co-infection rates justify the urgent call for a comprehensive TB/HIV collaborative response.

In most cases, TB can be cured by taking a combination of several drugs for six to eight months. However, it is important to avoid inappropriate and incomplete treatment because the TB bacteria can develop resistance to multiple drugs. Treatment of drug resistant TB is currently longer, more toxic, more complicated and less efficient than for drug-susceptible TB. Each year, doctors confirm close to 100 new cases of multi-drug resistant (MDR) TB across the country. Botswana is working in a much more integrated manner to improve patient outcomes. For example, Botswana has developed a national TB/HIV policy guideline to ensure that there is a necessary policy environment for integration.

The policy has three intentions: firstly to create a mechanism for collaboration through coordinating structures at all levels, secondly to define critical interventions aimed at decreasing the burden of TB among people living with HIV such as screening patients for TB among HIV patients, and thirdly the need to scale up interventions that seek to decrease the burden of HIV among TB patients, such as the provision of ARVs and cotrimoxazole.

While there are proven TB/HIV interventions, challenges continue to surface in many national TB programmes. The challenges include delayed detection and treatment, lack of access to treatment, difficulties in completing treatment and weak political support for TB programs. The media can be a catalyst for change and have proven to be a useful tool in promoting awareness among masses.

Adapted from an article by Omphile Ntakhwana - BOPA (20 March 2014)



Source: 2014 SADC Gender Protocol Barometer.

Figure 7.7 illustrates that Botswana has seen a reduction in deaths from HIV and AIDS due to the rapid expansion of treatment. The UNAIDS 2013 results report notes that sub-Saharan Africa 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 7.7 shows that Botswana reduced the number of deaths in this period by 71%.

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 care givers; 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.

Nomcebo Manzini, former head of UN Women Southern Africa Regional Office (UN Women SARO) writes in the foreword to the guidebook, *Why should we care about unpaid care work?*, "Unpaid care work is a major contributing factor to gender inequality and women's poverty. The assumption that unpaid work is elastic and valueless is a primary concern to women. Feminist and gender analysts have consistently called for a thorough analysis of the implications of excluding unpaid work on women's time, opportunities and economic growth and development in general. The amount and intensity of unpaid care work in South Africa have been exacerbated by the HIV and AIDS epidemic."[8]

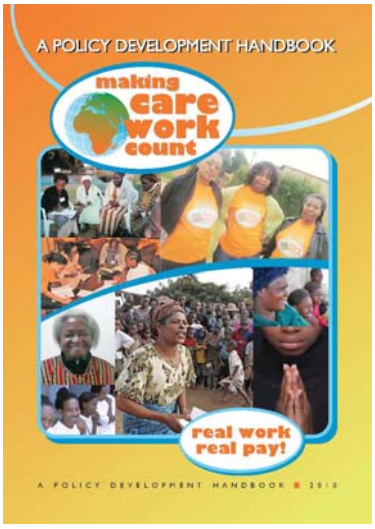
For two decades, HIV led almost inevitably to AIDS, which is a cocktail of many opportunistic infections - diarrhoea, thrush, TB, cervical cancer, pneumonia, shingles, meningitis and others. For many it was a slow "wasting away," with some days and even weeks or months better than others. In many SADC countries, the high morbidity and mortality from HIV and AIDS placed great demands on already under-resourced health care services. Formal health care systems in these countries had not recovered from the health sector reforms and structural adjustment programmes of the mid-1990s.

HIV-positive people occupied a significant proportion of hospital beds in most SADC countries. The long term and progressive nature of HIV and AIDS meant that the health care needs of those infected changed over time from basic clinical treatment of opportunistic infections to day-to-day palliative care and support. HIV-positive people can be healthy for years before succumbing to illness and death. The health infrastructure cannot provide palliative care to so many thousands of very ill people, most with little hope of recovery. In many

8 http://www.sarpn.org/documents/d0000919/P1017-Unpaid_Care_Work.pdf

cases, stakeholders transferred this responsibility to the family and community, work primarily undertaken by women and girls.

The elderly and children provided care as AIDS decimated a generation of able-bodied men and women. Caring for an AIDS patient can increase the workload of a family caretaker by one-third. This is a burden in any family, but particularly onerous for the poor, who already spend much of their day earning a subsistence living. Driven almost entirely by a strong sense of duty and compassion, a "rag-tag" army of community caregivers who provide support to their neighbours and kin, sprang up across the region.



Community and home-based care (C&HBC) programmes remain popular and renowned for their ability to provide a continuum of care for the chronically ill in their homes in a relatively cost effective, sustainable and comprehensive manner that complements institutional care. The C&HBC model, driven by community volunteers, enhances the capacity of families and communities to offer affordable quality care for the sick.

Botswana's efforts to implement these programmes has made great strides. CSOs have a committed pool of volunteers and staff, who have a strong sense of mission, participatory planning, innovation and accessibility, despite an insecure work environment and marginal financial resources. Care providers, however, expect some financial or material compensation for their services, as their patients also expect a lot from them. The WHO has stated "there exists virtually no evidence that volunteerism can be sustained for long periods: as a rule, community health workers are poor and expect and require an income."

Botswana has seen an increase in female-headed households, which tend to have more children (including AIDS-related orphans). In addition, female heads of households had taken on the responsibility for more orphans.[9] As the crisis deepened in Africa, many girls left school to provide home-based care.[10] Older persons providing this care and support lack the resources, energy, skills and knowledge to provide quality care at a time when they should be receiving care themselves.

Protocol @ work

Bomme Isago takes holistic approach to GBV and sexual health

Based in Lobatse, Bomme Isago is an organisation of women who came together to tackle challenges they faced in their community. Established in 2006, Bomme Isago identified that sexual and reproductive health is vital to addressing issues of GBV and HIV and AIDS. Their core objectives herein being, to raise awareness on GBV and sexual reproductive health, support women living with HIV, and understand GBV as well as give a face and voice to GBV issues.

Bomme Isago is using capacity building in the Kalahari and Kumaga regions, to look into policies relating to GBV and HIV, partake in GBV awareness campaigns and contribute to the Gender Links "I" Stories. Apart from this, Bomme Isago has also implemented the Case Profiling Initiative to highlight the types of GBV, how it manifests, the gaps in the laws and teachings that encourage GBV and the need to tackle GBV issues holistically. This approach educates and empowers GBV victims and other affected individuals of issues of GBV, helping them understand how violence affects them and how they can speak out in a language that is best suited them.

In addition to this, Bomme Isago is developing an advocacy toolkit that will include GBV issues. The organisation also plans to establish an STI programme to target adolescents. Bomme Isago works with strong organisations such as Gender Links in order to meet its aims and targets. These organisations help in providing the necessary resources needed in project implementation and expansion.

Lobatse Town Council Drum Majorettes marching to end violence against people with disability. *Photo: Vincent Galatlhwe*

9 UNICEF. 2003. Africa's Orphaned Generations. New York. www.unicef.org
10 http://www.unfpa.org/hiv/women/report/chapter4.html

Care work in the time of ART

As treatment rapidly becomes available, it is necessary to pause and consider the role of community and home-based caregivers in the future. Some areas in which caregivers will continue to be needed is the ongoing engagement in the HIV continuum of care, including provision of psychosocial support; awareness raising for all forms of prevention, including PMTCT; treatment readiness and continuing support for treatment adherence; as well as community mobilisation to decrease stigma. Stakeholders classify services undertaken by care providers in three categories: prevention, treatment and support.

Table 7.3: Services undertaken by care providers

Prevention	Treatment	Support
• Condom distribution • Family planning education • Counselling for HIV testing • Infant feeding guidance • Education on infection prevention and control • Education on anti-retroviral treatment • Community education on sexually transmitted infections • Community education on HIV testing • Home testing • Palliative care	• Adherence support • Refilling prescriptions • Treatment follow-up • Treatment of minor ailments • Training household members in treatment literacy and adherence • Facilitating referrals of clients to health centres/professionals • Palliative care	• Providing psychosocial support to clients and their families • Helping clients to access transport • Physical care • Nursing care • Training household members in care and support • Assisting with household chores • Nutrition support • Referring clients and their families to social services and other agencies • Resource mobilisation

Table 7.3 details the types of activities included in each area of care work.

Care work policy and legislation

In 2010, inspired by Article 27(c) of the SADC Protocol on Gender and Development (SGP) and Gender and Media Southern Africa (GEMSA), Voluntary Service Overseas Regional AIDS Initiative of Southern Africa (VSO-RAISA) developed the Making Care Work Count Policy Handbook. The objectives of the handbook include influencing the development, adoption, implementation and enforcement of policy frameworks that promote the recognition and support of care providers in the context of HIV and AIDS, and to promote public engagement on care work related issues. The handbook proposes six principles that need to inform care work policies:

- ***Remuneration:*** People doing the work of government have the right to be financially rewarded.
- ***Logistic and material support:*** It is imperative that care providers have access to care kits as well as other support, such as uniforms for identification, bicycles, food packs, monthly monetary allowances, soap, free medical treatment, and financial support for income generating projects, raincoats, umbrellas, agricultural inputs, stationery and transport allowances, among others, to provide quality care.
- ***Training and professional recognition:*** Stakeholders should develop protocols of training and accreditation through a governing body within the region to regulate and standardise the training.
- ***Psychosocial support:*** Stakeholders should prioritise care for care providers with psychosocial support programmes developed and provided.
- ***Gender equality:*** The gender dimensions of HIV and care work should be recognised and catered for.
- ***Public, private partnerships:*** There is a need to advocate stronger public, private partnerships in the delivery of primary health care services through C&HBC programmes.

In Botswana, donor organisations continue to provide financial incentives for C&HBC volunteers working through NGOs. The state still defines care work as volunteerism. In terms of logistic and material support, government provides C&HBC volunteers with transportation allowances of P151 (roughly USD$22) per month and clinical supplies. Government has no mandated, minimum level of training. Nurses train volunteers at clinics. Typically, the training lasts about a week. As new issues arise, the clinic offers caregivers refresher courses. Many caregivers working for NGOs receive training from either clinics or other civil society organisations. The government provides psychosocial support through supervisors at the clinic or through the social welfare office. Moreover, as part of the Ministry of Health's monitoring of C&HBC, government representatives often visit volunteers to discuss their challenges.

SGP Post 2015

HIV and AIDS in the SADC region post-2015

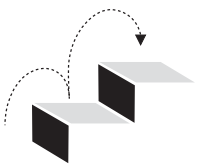
UNAIDS is challenging the world to set targets to stop HIV infections for an AIDS-free generation. UNAIDS is targeting 90% of tested and HIV positive people to be initiated on ART and targeting 90% of those on treatment with viral suppression by 2020. These targets may be ambitious, but the target of zero new infections through maternal to child transmission is certainly attainable.

Table 7.4: HIV and AIDS post-2015 targets and indicators

Thematic area/target	Proposed post-2015 targets	Proposed post-2015 indicators	Priority indicators
HIV and AIDS			
Policies: State parties shall take every step to adopt and implement gender-sensitive policies and programmes, and enact legislation that will address prevention, treatment, care and support in accordance, but not limited to, the Maseru Declaration on HIV and AIDS	1. State parties shall take every step to adopt and implement gender-sensitive policies and programmes, and enact legislation that will address prevention, treatment, care and support in accordance, but not limited to, the Maseru Declaration on HIV and AIDS	1. National policies which address gender issues	1. Countries where HIV is in the school curriculum
		2. National policies that are implemented	2. Comprehensive knowledge on HIV and AIDS[11] (%) disaggregated by sex
Prevention			
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	2. Promote behavioural change through FBOs and NGOs	3. HIV prevalence disaggregated by sex (%)	3. Percentage of pregnant mothers living with HIV initiated on treatment
	3. Ensure HIV and AIDS as part of the school curricula	4. Comprehensive knowledge on HIV and AIDS[12] (%) disaggregated by sex	4. HIV prevalence in: Sex workers, Men who have sex with men, Women who have sex with women, People who inject drugs, Prisoners Migrants (percentage)
	4. Provide health gardens for survivors through local government	5. Countries where HIV is in the school curriculum	5. Number of recognised and accredited caregivers
	5. Focus more attention on adolescents (15 - 24): Reduce adolescent HIV prevalence by 20% by 2020	6. HIV prevalence among young people (%)	
	6. Invest in integrated programmes which include social benefits or cash transfers	7. Upper secondary school gross enrolment ratio;	
		8. Lower secondary school gross enrolment ratio	
		9. Comprehensive knowledge of HIV among adolescents (%)	
		10. Percent of adolescents in need of social protection that receive regular cash transfer and support	

[11] WHO, Health Demographic surveys, UNAIDS.
[12] WHO, Health Demographic surveys, UNAIDS.

Thematic area/target	Proposed post-2015 targets	Proposed post-2015 indicators	Priority indicators
	7. Increase testing to at least 90% of population: by 2020	11. Percent of population which has been tested, disaggregated by sex	
	8. 100% of pregnant mothers tested for HIV; 90% of those that test positive initiated on treatment	12. Percentage of pregnant mothers tested for HIV	
		13. Percentage of pregnant mothers living with HIV initiated on treatment	
	9. Tackle stigma associated with key populations such as sex workers, men who sleep with men and women who sleep with women, people who inject drugs, prisoners, migrants and ensure that they all access comprehensive HIV care, support and treatment services to reduce the prevalence of HIV	14. HIV prevalence in: Sex workers, Men who have sex with men, Women who have sex with women, People who inject drugs, Prisoners, Migrants (percentage)	
Treatment			
Ensure universal access to HIV and AIDS treatment for infected women, men, boys and girls	10. Ensure universal access to HIV and AIDS treatment for infected women, men, girls and boys by 2020	15. Percentage of those living with HIV who access to ARV treatment, disaggregated by gender	
	11. 50% people over 50 have access to integrated health, HIV and social services	16. Percentage of people over 50 who have access to integrated health, HIV and social services	
	12. At least 30% of those that are eligible for social protection are receiving support	17. Percentage of people over 50 who are eligible for social protection that receive it	
Care work			
Develop and implement policies and programmes to ensure the appropriate recognition, of the work carried out by care givers, the majority of whom are women; the allocation of 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	13. Have and enforce policies and programmes for the recognition, of the work carried out by caregivers, the majority of whom are women by 2020	18. Number of recognised and accredited caregivers	
		19. Number of policies on care giving, safety, legal protection	
		20. Number of countries with final policies on care work	
		21. Number of countries which are implementing policies on care work	
		22. Proportion of recognised care workers that are men	



Next steps

- Recognise the marginalised in health policies.
- Invest more government money in HIV and AIDS activities (and include HIV and AIDS activities when budgeting).
- Distribute condoms, and provide sex education, in schools and prisons.
- Include HIV and ARV facilities in the main health facility structure.
- Intensify training of service providers (for example police, social workers, teachers etc.) and policymakers on sexual orientations and gender diversity.
- Advocate for the use of female condoms.
- Lobby for care work campaigns to take root at the local level.
- Advocate for a remuneration scheme for careworkers.
- Encourage men to get involved in care work.