

## **CHAPTER 4**

### **HIV/AIDS and cultural practices of Batswana in Botswana**

#### **1. Introduction**

The previous chapters focused on HIV/AIDS as a phenomena and culture and its components in general. The purpose of this study is to find out if the cultural practices of the Batswana people in Botswana have any influence on the transmission of HIV. This chapter will therefore focus on the situation of HIV/AIDS in Botswana in relation to the impact it has on the Batswana people and the influence of cultural practices on HIV/AIDS. Different aspects regarding the social, economic and health impact of HIV/AIDS and the present cultural practices of the Batswana will be discussed. In order to understand these aspects it is first of all very important to get background information of the Batswana people (e.g. where they originate and who are they) and the HIV/AIDS situation in Botswana.

#### **2. History of the Batswana**

According to Bolaane and Mgadla (1997) Batswana live in countries of Botswana and South Africa. They speak a language called Setswana. Batswana from different regions can understand each other because the dialects are closely related. Anything that is regarded as an essential part of the culture is called Setswana. Batswana customs can be referred to as Setswana customs.

About 3 million Batswana live in South Africa, and in 1997 it was estimated that the population in Botswana was 1. 533 million. According to the 2001 census data, the total population of people in Botswana was 1 680 863 (Botswana Central Statistics, 2002).

Bolaane and Mgadla (1997) further state that, the white settlers who established colonial borders separated the Batswana in Botswana and in South Africa in the 1800's. Experts also believe that African people who live in South West Sahara desert spread out across the continent over many years. Many of those who migrated into Southern Africa consisted of related Sotho – Tswana people, of which the Batswana today forms a part. Other major sections of this group include the South Sotho or the Basotho and the North Sotho or Bapedi (Bolaane & Mgadla, 1997).

They continue to state that the Batswana group consists of several subgroups called Merafe (singular-morafe). A Morafe or Chiefdom consists of people descended from the same ancestor. Over many generations, the Merafe split into several branches. This often occurred because of disputes between chiefs, sons or leading men broke away from the Morafe with their followers and established their own independent Morafe. It is through this process that the senior Bahurutshe Morafe gave rise to other Morafe: the Bakwena, Bangwato, Bangwaketse, Batawana, Bakgatlha, Batlharo, Barolong and Batlhaping. The Bangwato are the largest in Botswana and occupy the most land. The totems that they honour identify the Merafe.

According to Cuff and Payne (1981:32) and Bolaane and Mgadla (1997) totems are usually animals that serve as emblems for groups of people with the same origin or ancestry. People never kill, eat or use the skins of their totems. This totem is a tangible means of expressing men's feelings that the society of which they are members is bigger and better than each individual. It serves to remind individuals of their tasks and connections with the whole tribe and

how much they value those links. The individual then feels acted upon by outside and valued forces and he feels solidarity with his fellows (Cuff & Payne, 1981:32).

Most of Botswana people (Batswana) are members of Setswana- speaking ethnic groups. Shibutani, et al. (1976) as quoted by Alexander (1984) state that an ethnic group consists of people who see themselves as being of a kind. They are united by emotional bonds and concerned with the preservation of their type. They speak the same language and they share a common cultural heritage. They believe that they are common descent.

Giddens (1989:243-244) adds that ethnicity refers to cultural practices and outlooks that distinguish a given community of people. Members of ethnic groups see themselves as culturally distinct from other groupings in society and are also seen by those others to be so. Many different characteristics may serve to distinguish ethnic groups from one another, but the most usual are language, history or ancestry, religion and styles of dress or adornment. Other groups in Botswana include for example, Bakalanga in the North East and Baherero in the west. There are also a small number of citizens of Asian and European origin. Therefore in Botswana there are also subcultures (Bolaane and Mgadla, 1997).

According to McNall (1973:45) usually cultures of ethnic groups within a larger society are called 'subcultures'. Although there are subcultures, they are however dominated by the general cultural practices which Setswana language is one example.

According to Goodnow, et al. (1995) cultural practices are actions. It is what people do. Cultural practices are not neutral. They come packaged with values about what is natural, mature, morally right or aesthetically pleasing. The actions become part of a group's identity. The practice may be sustained changed or challenged by a variety of people. Cultural practices are actions that are repeated, shared with others in a social group and invested with normative expectations and with meanings or significance that go beyond the immediate goals of the action. According to Bolaane and Mgadla (1997) the common language of Setswana in Botswana unites all Batswana merafe. The other common cultural practices of the Batswana will be discussed in the next sections.

### **3. HIV/AIDS in Botswana**

According to Poku (2001:191) there are 35 million people infected worldwide and in the Sub Saharan Africa, there are 23.5 million people infected with HIV. She says that at the continental level, 23 million people are now living with HIV/AIDS that is two-thirds of all cases presently on earth. Most will die in the next 5-10 years joining the 13.7 million Africans already claimed by the epidemic and leaving behind shattered families and crippled prospects for development.

Poku (2001:191) says that Botswana is one of the six countries in Southern Africa that now form the global epicenter of the epidemic. One in six adults is HIV positive and AIDS is expected to claim the lives of between 8% and 25% of today's practicing doctors by the year 2005. In Botswana she says, a shocking 35.8% of adults are now infected with HIV.

The (UNAIDS, 2002) states that in the year 2001, 38.8% of the total adult population aged between 15 and 49 in Botswana were affected with HIV and among 25 –29 year old women attending antenatal care in urban areas, 55.6% were living with HIV/AIDS in 2001. The HIV prevalence among pregnant women in urban areas already stood at 38.5% in 1997 and in 2001 it had risen to 44.9% (UNAIDS, 2002: 23).

The implications of change in population structure are shocking. According to the United States Census Bureau, there will be more adults in their 60s and 70s in Botswana in 20 yrs' time than there will be adults in their 40s and 50s (UNAIDS, 2000).

The life expectancy in Botswana at birth has dropped to a level not seen in Botswana since before 1950. In less than ten years time the life expectancies fall to near 30 years. The average life expectancy in Botswana before the AIDS epidemic was 74.4 years. It is expected to decline to only 26.7 years in 2010 if the virus is not slowed down or reversed (The impact of HIV/AIDS on Africa: 2004).

According to the Botswana – Population (2003) the life expectancy before AIDS in Botswana was 63 years and in 1991 it declined to 44 years.

The population projection is based on the assumption that patterns of new infection will not change greatly over the next decade. However as changes in future infection rates will principally affect men and women under 40 in 2020, the demographic chimney pattern for older adults is hardly affected by this assumption. The missing adults (men and women) who should have reached there 40s and 50s in 2020- are now in there 20s and 30s, although some have already died. Many more are already infected with HIV, which will kill them before they reach

their 50s. It is predicted that a small number of young adults, the group that has traditionally provided care for both children and the elderly will have to support large numbers of young and old people. Many of these young adults will themselves be debilitated by AIDS and may even require care from their children or elderly parents rather than providing it (UNAIDS, 2000).

HIV transmission may be facilitated by social migration patterns, cultural attitudes towards fertility, and women's lack of empowerment (BOTUSA, 1999).

#### **4. Social aspects regarding HIV/AIDS in Botswana**

It has already been mentioned in chapter 1 that the socio-economic and cultural factors influence the transmission of HIV/AIDS in Botswana and that factors such as social migration and sexual relationships are to a certain extent influence the transmission of HIV/AIDS (McDonald, 1996:1327). It has also been pointed out that HIV/AIDS is a social disease.

According to University of the Witwatersrand (2002:3) while a considerable body of biomedical research conducted in HIV/AIDS has determined the causes and course of the disease and yielded medical strategies for its control, there is not an equivalent level of understanding of the social and behavioral factors which fuel the epidemic. The discussion of social factors has often not progressed beyond invoking a crude and undifferentiated role of poverty and migrancy. The specific interaction of the historical, social, political and cultural factors, which have shaped the nature of the epidemic needs to be the focus of more extensive research. A more nuance understanding of these areas is essential in order to devise more meaningful and effective intervention and treatment plans.

The researcher has selected the most relevant and applicable aspects in the context of this study.

It is important to discuss the social aspects regarding HIV/AIDS in Botswana with special reference to education, alcohol use, migration, attitudes and beliefs regarding HIV/AIDS, condom use, stigma, religion, polygamy and sexuality. These aspects play a very important role in the lives of the Batswana's. The interaction between these factors and HIV/AIDS need to be explored. The following sections will focus on the social aspects mentioned above in relation to HIV/AIDS.

#### **4.1. The relationship between HIV/AIDS and level of education in Botswana.**

UNAIDS (2000) suggests that generally people with more education lead healthier, more productive lives. Better-educated people generally have greater access to information than those who are illiterate or uneducated and they are more likely to make well-informed decisions and act on that information. In addition, educated people generally have better jobs and greater access to money and other resources, which can help them, support healthier lives. These same resources can however be used to buy alcohol, drugs and sex.

The 1993 Botswana National Literacy Survey shows a national literacy rate of 69.9% (66.9% for males and 70.3% for women). The illiteracy rate is also very low among the farming communities where less than 4% of farm household members above the age of 5 years have ever been to school. This makes it difficult for them to read any Information Education and Communication (IEC) material on HIV/AIDS (Adupa, 1999).

The government of Botswana has however, made impressive achievements recently on education. There is provision of almost universal free education, pupil/teacher ratio of 28:1 and an increase in literacy rates from 34% in 1981 to the current estimated 74% (Botswana Population, 2003). The increase in the literacy rates will assist in reducing the rate of HIV infection, as people will be literate enough to understand prevention and consequences of HIV/AIDS. According to the AIDS/STD Unit (NACP19, 1999) women are the ones who take care of the sick patients and when AIDS patients are taken home, it is the same women with little knowledge about how the virus spreads whom also take care of the patients with AIDS. Their lack of education contributes to them being very ignorant about HIV/AIDS knowledge especially how the virus is spread and therefore do not take precautions in protecting them selves from the infection. Consequently they remain vulnerable to infection from handling body fluids wastes, soiled bedding and linens without adequate protection of gloves.

#### **4.2. Orphaned children in Botswana**

One of the most tragic social consequences of HIV/AIDS is the increase of orphaned children worldwide. It is already stated in the previous chapters that there are approximately 14 million children worldwide who have lost one or both parents due to AIDS. Approximately 80% of

these children, about 11 million live in Sub-Saharan Africa (UNAIDS, 2002: 133). Already these figures can show us how HIV/AIDS is a serious problem in sub-Saharan including Botswana as part of the Sub Saharan.

In Botswana, according to Muchuru (1998) a rapid assessment on the situation of orphans in Botswana was initiated as a result of public and political concern on the socio-economic conditions the orphans lived in. The assessment was conducted in 9 districts and 10 villages and towns. About 4496 orphans were identified and registered. Majorities of orphans were living with old grand parents who had no resources to provide essential needs on a regular basis. School going orphans didn't have anything to eat in the morning. On several occasions, the girl's orphans were sexually abused and often fell pregnant and eventually dropped out of school. Orphans related to HIV/AIDS parents have also dropped out of school as a result of stigmatisation, rejection and isolation by other students and occasionally by teachers. Caregivers also identified counselling as an urgent need especially for orphans who were living with AIDS patients.

Orphans are also reported as having inadequate access to basic human needs such as food, clothing, shelter and toiletry. As their parents die, orphans go through serious emotional stress. They are further impoverished, stigmatised, isolated and sometimes rejected. Child Welfare multisectoral committees form parts of the management structure that provides technical and advisory services to the programme that aim at assisting children orphaned by AIDS. The composition of these committees comprises strategic stakeholders who add value to the programme implementation. Stakeholders are individual persons and institutions that are affected directly or indirectly by way of interest or the impact orphanhood has on them. They include non-governmental organizations and community based organizations, religious groups, traditional leaders and private sector, media, politicians, communities and international development organization and donors (Ministry of Local Government, 1999-2003; Van Dyk, 2001:335).

In Sub-Saharan African countries men are dying first followed by the infected wives and partners. Death of the mother is more critical for children below the age of 5, while death of the father has a greater effect on the development opportunities of older children. A child missing both parents is generally the most vulnerable of all types of orphans (UNICEF, 1998). The deep-rooted kinship systems that exist in Africa for example, extended family networks of aunts

and uncles, cousins and grandparents are an age-old social safety net for such children. The systems have long proved that it is resilient even to major social change. However capacity and resources are stretched to breaking point and those providing the necessary care in many cases are already impoverished. Often the elderly people, who have to take care of these orphans, have been financially and physically dependent on the support of the very son or daughter who has died (UNICEF, 1999). For example, it was found that in the high HIV prevalence district of Kweneng, in Botswana, an orphan registration exercise conducted in mid 2000 revealed that only 22.1% of the people registered as caregivers for orphans, were employed. The others lacked productive employment and fully 40% of them were grand parents or elderly relatives (UNAIDS, 2002:137).

The Botswana government encourages communities to provide care for orphans and to rely on institutional care only as last resort. Orphans are therefore still usually absorbed by the extended family. Their caretakers are predominantly women. Female household makes up the majority of all households living in poverty (UNICEF, 1999).

Although the idea of using orphanages as a last resort is supported by researchers such as Van Dyk (2001:338), UNAIDS (2002: 137) argue that the extended family can only serve as part of the solution to mass orphan-hood if adequately supported by the State, the private sector and the surrounding community.

#### **4.3. Alcohol use in Botswana**

The researcher's own experience in Botswana has shown that bars are almost everywhere and generally people in Botswana including those who are visiting feel that alcohol consumption is a serious problem.

According to the AIDS/STD Unit (1998) people in Botswana often drink too much alcohol. The abuse of alcohol seems to assist people escape from the everyday hardships. The use of alcohol however can impair people's judgment and therefore can also encourage people to become loose, and to have sex with different people without the use of condoms (Evian, 2000:21).

In a study conducted in Botswana in 1998, some men used alcohol as an excuse for having casual sex and not using condoms to protect themselves (AIDS/STD Unit, 1998).

Fidzani, Ntseane and Seloilwe (2000) say that the majority of community leaders in Botswana cite that the high number of drinking spots in Botswana is contributory factors in the spread of HIV/AIDS. Practically in each village, there is liquor stores and restaurants selling liquor and a lot of chibuku and khadi. Chibuku and khadi are the kind of African beer sold in Botswana. The liquor shops are open till late and they also sell food items and snacks, which makes it a convenient excuse for people especially the youth to frequently visit these bars (AIDS/STD Unit- NACP 22,1994).

Lauer (1992: 115) asserts that at least half of all alcoholics may have difficulty with problem-solving, abstract thinking, memory tasks and psychomotor performance. He says that alcohol releases inhibitions so that the person who drinks loosens up and may for example be more motivated toward sexual activity. Heavy drinking also inhibits sexual performance and alcoholics report a deficient sex life or even impotence. Many people who are drunk get increasingly aggressive as they become intoxicated. This can lead to ill will and conflict with others. There is also higher rate of both verbal and physical abuse in homes where one or both spouses are alcoholics.

High intake of alcohol can put the Batswanas at risk with HIV transmission as people may be forced into sex without condoms due to aggressive behaviour and loss of control as a result of excessive drinking (AIDS/STD Unit, 1998).

#### **4.4. Migration in Botswana**

Wilson, et al. (2002:8-9) asserts that migrant labour has been practiced extensively in Southern Africa. Migrant labour is characterized by a surplus of men at the destination of the labour and by a deficit of men at the source of labour. These imbalances as well as the disruption to the way of life of the individual contribute greatly to the HIV epidemic. The social disruptions and gender imbalances provide a context in which HIV is easily able to spread. Most of the time, the only sexual contact available is that provided by sex workers or by other migrant workers.

Herd (in Moore, 1997:169) adds that it is only since the onset of the HIV-AIDS epidemic that the relationship between mobility and sexual behaviour has become an object of more systematic research. Such behaviour is not necessarily extra marital sexual behaviour. Marriage is the most important and forceful institution in shaping and regulating sexuality, but its relationship to mobility is not unidirectional. At a glance, marriage appears to be an institution that, in bringing together husband and wife, can account for some degree of mobility, but it also implies settlement, the opposite of mobility.

Migration and mobility play important roles in the HIV/AIDS epidemic. The relationship between HIV/AIDS and migration is complex as not all migrants or people on the move face special risks of infection. The links are evident in Botswana (UNAIDS 2002:114). For example, a study commissioned by the Community Health Services Division determined the linkages that exist between population mobility and the spread of HIV/AIDS (Hope & Gaborone, 1999c).

The following findings were registered: The majority of mobile workers are single and almost one half of them have a live-in partner at their location of employment some of those who are married have set up parallel families in the areas where they work. Mobile workers also went home either every weekend, or every other weekend or at the end of each month and some once every two months. These frequent visits back home intensify the transmission of the HIV in the home areas of these mobile workers. Sexual intercourse was quite frequent – twice or more per week. There was a high rate of unprotected sex.

The separation of family members through transfer in the ministry of agriculture was reported to be a contributing factor to promiscuity. Young staff members said that they have decided to remain single for the time being because they fear that when they are separated from their spouses, some people may “poach” on their wives. In Botswana, owning cattle and taking care of parents is part of the Botswana culture therefore, there is need for staff in the ministry to travel home over long weekends and holidays to their home villages to meet their parents and relatives and also visit the cattle post to see their animals (Hope & Gaborone, 1999b).

However even within the rural areas there is a tremendous amount of internal movement of the population because of the 3 homes that typical Motswana has namely, village, land areas and the cattle post. Consequently men have to move between the three locations which may be many kilometres apart and the turn round time to an abode can also be several months which may even be spread across seasons (Adupa, 1999). Adupa (1999) says that the agricultural

community is by men thus leaving women at their mercy. Consequently the women are left in very subordinate positions in economic terms. This may seriously predispose them to HIV infection, as sex offers are an easy alternative.

Lobatse is close to the South African Border making it a major transit point for border crossings. Residents from surrounding areas also frequently travel through Lobatse in search of employment and other income earning opportunities. In addition, the town is situated nearby a number of camps, which are used as houses for road construction workers. These workers frequently visit Lobatse for recreational and other activities including sexual networking (Hope & Gaborone, 1999a).

Both the migrant labourer and the spouse at home are thus at risk for HIV infection. It is also a misconception that the migrants generally bring AIDS with them. Comparison of forced migration in Africa (Ethopia) revealed that in some cases, the prevalence among the migrants is less than that of the host population (UNAIDS, 2002:116). HIV/AIDS prevention programmes and treatment need thus to be available to all members of the communities.

#### **4.5. Knowledge, attitudes, behaviour and practices about HIV/AIDS in Botswana**

BOTUSA (1999) conducted a study about knowledge, attitudes, and beliefs regarding Tuberculosis Preventative Therapy (TBPT) for HIV-infected persons living in Botswana during 1999. The objectives of the study were to measure knowledge, attitudes and beliefs about Tuberculosis Preventative Therapy (TBPT) and HIV Testing and to identify patient characteristics and program features that would maximize acceptance of TBPT. TB accounts for 44% of deaths in adults who die of AIDS. Tuberculosis (TB) prevention in persons living with HIV could improve quality and duration of life. In Botswana, HIV prevalence and TB rates are among the highest in the world, but less than 1% of the population has sought Voluntary Counseling and Testing (VCT).

The results showed that the majority of the respondents from this study seemed to recognize the relationship between TB and HIV/AIDS and STDs and HIV/AIDS, as they believed that TB caused HIV/AIDS. There was however a misconception about the causal relationship. Some respondents said that AIDS caused TB and some said that sex and STDs caused TB. There

were respondents who were not sure of the causes of TB and HIV/AIDS. The majority of the respondents also knew that TB and HIV/AIDS could be asymptomatic. However not many respondents have taken an HIV test although the majority said that they were planning to take the test and would like to get the HIV test results the same day or at least wait for two weeks. It was also believed that the HIV tests were accurate (BOTUSA, 1999).

Another study by Tlou, et al. (2000) was conducted to obtain information and data that could be used to improve the effectiveness and acceptability of messages and services regarding Prevention of Mother To Child Transmission (PMTCT) on the community level. Focus group discussions and in-depth interviews were held with women and diverse residents of one community where the MTCT program was launched in 1999 (Tlou, et al., 2000).

The majority of the respondents claimed that they had never seen someone sick from HIV/AIDS, as it is always a secret. AIDS is only mentioned when someone is already dead. There were misconceptions about the transmission of HIV/AIDS. They believed that HIV could be spread through faeces or urine on the open ground by flies or wind and sharing utensils and dishes. Some believed that neglect of traditional culture and the adoption of modern culture are contributory factors to the spread of HIV (Tlou, et al., 2000).

Foreigners were also blamed for the spread of HIV. They also believed that pregnant women who sleep around during pregnancy spread the virus on to the child. The majority of the participants did not know about the Voluntary Counselling and Testing Centres (VCTs). The participants also thought that potential negative reaction to a positive HIV test could range from depression to suicide. Positive results were associated with death is coming up soon as there is no cure for AIDS. They also feared the negative reaction from partners after being tested. Abandonment of a woman by the male partner was assumed to be a potentially common response and that is why HIV positive tests result is not disclosed. Women who are HIV positive are said to be unfaithful (Tlou, et al., 2000).

The media reports and public concern confirm the high prevalence of rape and sexual violation in Botswana. These social ills present serious risks for HIV infection especially for women. There is anecdotal evidence that teenage girls have sexual relations with older men (The Second Medium Plan, 1997-2002).

This sexual relationship formation pattern may in part explain the disproportionate rate of HIV infection between teenage boys and girls. However since most girls who have sexual relationships with older men are likely to have peer boyfriends, who may be infected through this route. There is also concern about the possibility of sodomy among incarcerated prison populations. A study conducted in the Botswana prisons report that the practice of “thigh” sex is common among male inmates. This practice may be a risk factor in cases of cuts and open sores among those practising this behaviour (The Second Medium Plan, 1997-2002).

A baseline research study was undertaken on the knowledge, attitudes, behaviour and practices of young people in Gaborone in 1992 (AIDS/STD Unit - NACP 19, 1992). The study involved a random sample of 627 young people attending secondary school in Gaborone. Focus groups discussions were held with young people, their parents and community leaders. Key informant interviews were conducted with head teachers, teacher-counsellor and YWCA staff. The survey examined the socio-economic profile of young people in Gaborone, their sources of information on AIDS, their knowledge and attitudes about AIDS and STDs. It also focussed on views and behaviour regarding relationships, sexual behaviour, condom use and access. The results of the study confirmed that a considerable proportion of young people still lacked the necessary information on AIDS prevention. It was evident that condoms were not used as a measure to practice safer sex.

In a pilot study addressing male sexuality it was clear that men had misconception about HIV/AIDS. They believed that the condom lubricant has HIV in it. HIV/AIDS was seen as disease among homosexuals and one can also get it when you sleep with whites. HIV is only found in the semen and only fully blown case of AIDS infects people (AIDS/STD Unit, 1998). The study also made it clear that young women feel considerable (unwanted) pressure to have sex before they feel ready and many felt that they did not have the skills to resist this pressure. The young people also clearly stated that they wanted and needed information and guidance on sexuality issues (including AIDS) from their parents (AIDS/STD Unit, 1998).

A study was conducted by BOTUSA in 1999 to identify risk factors for HIV infection. There were 93 HIV positive and 42 HIV negative patients who participated in the study. It was evident from the research results that the respondents who were HIV positive and some HIV negative, believed that a man is like a bull and should not be confined to one pasture and some said that a woman should not refuse a man sex. The HIV positive and HIV negative respondents also

held a believe that a man is more likely to marry a woman who has shown she is fertile meaning that the woman should have a child before she gets married. Alcohol use was also common among all the respondents including men and women. There was an average of three drinks per day. The majority of the HIV positive patients said that they were less than 25 years old at first sexual encounter and they had more than 2 casual sex partners. The HIV negative patients also mentioned that they also had more than 2 casual sex partners. There was also history of sexually transmitted diseases among the HIV positive patients. Men and women hold traditional beliefs about sex that may limit a woman's empowerment. Less than a third received sex education prior to initiating sexual activity (BOTUSA, 1999).

In a study conducted to obtain information and data that could be used to improve the effectiveness and acceptability of messages and services of MTCT prevention on the community level, a number of sources of education were listed during focus group discussions. These were radio, clinic, kgotla, newspapers and schools etc. AIDS was described as the radio disease. There was concern about the negative messages that there is no cure. These were messages specifically from the radio (Tlou, et al., 2000).

There was a support for positive AIDS education through the radio. AIDS education should not scare people. They felt that a negative frightening approach results in resistance to testing (Tlou, et al., 2000). Stigma and discrimination by the community came across as a major deterrent to Voluntary Counselling and Testing (VCT) and of disclosure of either intent to seek an HIV test. The AZT was known to be available but they were not sure if it was available in Botswana (Tlou, et al., 2000).

UNAIDS (2000) reports that the following factors and forces exist that restrict people's autonomy and leave them particularly expose to HIV infection or vulnerable to needless suffering once they are infected: Intolerance of racial, religious or sexual minorities; discrimination against people with known or suspected HIV infection; lower status of women; abuse of power by older or wealthier individuals; scarcity of HIV counselling, testing facilities and of condoms; lack of care and support for those infected or affected; poverty that leads to prostitution; domestic violence and rape; military conflict and labour migration which split up families; lack of respect for the rights of women and children; freedom from inhuman or degrading treatment and the right to privacy and confidentiality.

#### **4.6. Use of condoms in Botswana**

Condoms are key to preventing the spread of HIV/AIDS and sexually transmitted infections, together with sexual abstinence, postponement of sexual debut and mutual fidelity (UNAIDS, 2002:86).

However, condoms are not very popular in Africa. Caldwell and Quiggin (1989) as quoted by Van Dyk (2001: 122) postulate that many Western authors erroneously ascribe the lack of condom use in Africa to promiscuity, permissiveness and to a lack of moral and religious values. This clearly illustrates a lack of understanding of the African philosophy behind sexuality and disrespect for African cultural beliefs. Apart from social and political problems, there are deep-rooted cultural beliefs against the use of condoms in some parts of Africa. The challenge is not to condemn Africa, but to make the hidden cultural logic behind the resistance to condoms known and thereafter to find ways to work with or around it (Scott & Mercer, 1994 in Van Dyk, 2001: 122).

For example, population control remains a sensitive issue in Africa because it negatively impacts on the growth of a tribe, it deprives parents of needed labour and it undermines traditional beliefs and values (Hickson & Mokhobo, 1992 in Van Dyk, 2001:121). Instead of telling people in Africa to use condoms (and thereby inevitably to prevent pregnancy) it is necessary to tell them how to protect themselves from STDs and HIV while sometimes allowing 'unprotected' sex to make children. They should be advised not to use condoms until the wife conceives, and to start using condoms again while she is pregnant and nursing the baby.

Van Dyk (2001: 123) adds that one of the objections often raised by Africans is that condoms are not natural, not only because they inhibit pleasure, but also because they interfere in the process of natural fetal development. It is also believed that semen's contains important vitamins, which are necessary for the continued physical and mental health, beauty and future fertility of women.

In Botswana, condoms are widely available, both free of charge and for sale; their availability does not necessarily imply that condoms are easily accessible to adolescents. Frequently obtaining condoms may an unpleasant experience for adolescents. The embarrassment of going to family planning clinics to obtain condoms and the negative attitudes of some providers

toward adolescents who are obtaining condoms limit adolescents' access to condoms because it discourages them from using these sources. Both boys and girls tend to feel embarrassed at clinics and are concerned that their visits may not be kept confidential (Meekers, Ahmed & Molatlhegi, 1997).

If adults do not condone adolescent sexual relationships, adolescents may not be at liberty to go to clinics and pharmacists to procure condoms, because doing so discloses that they are sexually active. In addition, adolescents may feel uncomfortable interacting with service providers; both of these factors may discourage adolescents from procuring condoms, even when availability is not a problem (Meekers, et al., 1997).

Meekers, et al. (1997) gave an example of a situation in South Africa where adolescents were embarrassed when required to inform security guards at family planning clinics of their reason for visiting the clinics. They were also uncomfortable with the lack of privacy inside the facilities as well as the negative attitudes of clinic staff. Condom providers often assumed that when a person requested condoms, it was for contraceptive purposes rather than for STD/AIDS prevention, and discouraged condom use in favour of other contraceptive methods. Access to free condoms may also be constrained due to the belief that condoms that are distributed for free are of lesser quality than condoms that are sold.

Some research mentioned by Meekers, et al. (1997) has shown that price is associated with perception as of higher quality and that this may discourage persons from obtaining and using products distributed free of charge. Other research studies have shown that people have less faith in the quality of free products than in the quality of products they pay for. (Lewis 1986 & 1997; Ross & Frenkenberg, 1993 in Meekers, et al., 1997).

Focus group discussions with adolescents in two urban areas in Botswana – Francistown and Lobatse were conducted by Meekers, et al. (1997) to illustrate why adolescents who want to use condoms may not always be willing or able to obtain condoms and to explore to what extent adolescents' perceptions of the relative ease of access differs for public and private sector providers. The results showed that condom use was common in both areas. Condom use with casual partners is even higher. The results also showed a low percentage of adolescents use public sector distributors. The most popular source for obtaining condoms is retail outlets including stores, bars, nightclubs and hair salons. The data suggested that many

adolescents overcome their shyness to obtain condoms and that they prefer to obtain condoms from retail outlets rather than from health facilities.

Several adolescents in the study also noted that they feel uncomfortable procuring condoms from clinics, pharmacies or stores because they are shy, worried about disclosing that they are sexually active and because they believe that they may be stigmatized. One adolescent mentioned that it is funny for a 16-year-old to buy a condom (Meekers, et al., 1997).

Some adolescents in the same study felt that the nurse or shop assistants will think that they are prostitutes. One adolescent schoolboy in Francistown explained that no teenager would like his parent to know that he/she is sexually active because condoms are associated with sex.

Some girls mentioned that most boys are not shy about many things. They are able to collect condoms. There was also a belief that since condoms are inserted on boys, it is not necessary for girls to collect condoms. Boys are generally free in life; girls are scared that people will think they are prostitutes.

In the focus groups discussions several adolescents also reported that service providers sometimes intimidate adolescents by questioning them about their reasons for trying to procure condoms and by remarking that persons of their age should not be using condoms.

One adolescent reported that a service provider at a hospital said that he was too young to use a condom. This generally makes adolescents not to go to clinic to get condoms. One adolescent mentioned that place like Bofwa (a Youth Association) is much better than clinics to get condoms because you find people of their age and they do not get scared to ask as many condoms as they want. The condoms are in great demand there. There was a feeling that condoms from the clinic cause illness like rashes and therefore they prefer condoms from the chemists because in most countries condoms are sold and given out for free. They copy cultures of other countries. They believe that those that are given out for free are not useful. That is they depend on those that are sold.

Several boys also stated that obtaining condoms from friends is better than obtaining them from clinics. They also stated that there are not a lot of people who actually use condoms because of the embarrassment they will have to have when they want them. So the best way to get condoms is to ask friends to give them. However girls reported that they are shy to ask

for condoms from friends. The Botswana male and family planning survey conducted between 1990 and 1991 revealed that there were myths that still existed with regard to condoms. About 60% of the males in the survey agreed with the statement that condoms could remain inside a woman's body (Meekers, et al., 1997).

Another study conducted by YWCA/ WHO in 1992 revealed that young people were too embarrassed to talk about condoms with their partner. The males also agreed with the statement that a girl or woman who carries a condom is usually a prostitute. Focus groups discussions also revealed that young women who carried condoms were often viewed, as cheap and available and such behaviour was associated with prostitution. All members of society do not accept condom use. For example, more conservative adults in the community and some religious groups. Condoms are said to promote promiscuity (AIDS/STD Unit - NACP 21,1994). This is however not only happening in Botswana.

In Uganda, there are also signs that young people are avoiding the patterns of behaviour, which led their parents and older siblings to such high levels of HIV infection. Condoms use for example is increasing among young people and there are indications that, among the better educated, sex with casual partners may start later and are less frequent. But these changes are taking place against a background of very high infection rates, especially in young African women (UNAIDS, 2000).

Green (1994) as quoted by Van Dyk (2001: 121) found that although AIDS awareness was reasonably high in Uganda in 1993, and although millions of condoms had been distributed, the percentage of Ugandan men regularly using condoms was about 3% at that time. Taylor (1990) as quoted by Van Dyk (2001: 121) similarly found that although the people for Rwanda were well informed about AIDS and had modified their sexual behaviour on the basis of their perceptions, none of the respondents in his study reported the use of condoms during intercourse. There is another belief and myth about the condom. It is believed that condoms have worms. The disintegration of cultural norms and values is perceived as one of the major determinants for the spread of HIV/AIDS (Fidzani, et al., 2000).

According to Herdt (in Moore, 1997:222) condoms, if properly stored and used, could give adequate protection against STDs and HIV and, in addition, prevent unwanted pregnancies. Until recently, condoms have not proved popular as a means of contraception in Nigeria

primarily because of their association with prostitution and extra marital relationships and because of the fear that a condom can disappear into the womb and thereby cause sterility. Husbands do not like to suggest the use of condoms to their wives because it will imply that they themselves have been using them in extra marital affairs.

It is evident from the above discussion that there are negative attitudes and stigma attached to the use of condoms. In Botswana, it seems to be difficult to talk about condoms and this affects the younger generation who are already at risk as they are sexually active. A recent analysis of study samples from eight countries in sub-Saharan Africa found that attitudes towards condom use are also depended on the nature of relationships (UNAIDS, 2002:88). This suggests that condom promotion messages need to be tailored to the context (UNAIDS, 2002:88).

These messages will work best as part of a comprehensive package of interventions that include HIV/AIDS education, sexual health and human sexuality and gender sensitivity training. The following section will focus on stigma issues in relation to HIV/AIDS in general.

#### **4.7. Stigma issues related to HIV/AIDS in Botswana**

According to Van Dyk (2001:296) fear of stigmatisation are very real factors when one has been diagnosed with HIV/AIDS. The infected people may experience social rejection and discrimination.

In low prevalence countries or places where HIV is seen as a problem of marginalized groups, rejection by families or communities may be a common reaction. Fear of rejection or stigma is common reason for declining testing. Linking testing with ongoing care and support services, as well as HIV education and awareness in the community can reduce stigma and may contribute to wider acceptance of Voluntary Counselling and Testing. Voluntary Counselling and Testing may also be seen as an important way of overcoming stigma. Many people become aware of their HIV serostatus and normalize the disease (SAFAIDS, 2002:2).

A household survey was conducted in the Ngami and Tutume sub-district of Botswana in late 1993 and early 1994. About 50 people living with HIV/AIDS and 20 caretakers were interviewed (AIDS/STD Unit - NACP22, 1994). The survey confirmed that AIDS is a lonely disease. Ninety five percent of the persons interviewed had told no one outside the family of their HIV/AIDS diagnosis and about less than half of them, had visited a traditional healer and on average paid 190 pula. People living with HIV/AIDS and the caretakers want to talk to others in the same

situation. At the same time they also agreed that it is important to them that nobody outside the household knows about the diagnosis. The stigma attached to AIDS was given as the main reason for this (AIDS/STD Unit - NACP22, 1994).

The cultural, sexual, religious and legal issues are often associated with sexual practices, preferences, sexual desires, the number and type of sexual partners and the use of birth control difficulties. In addition there is often a "cloak of silence" related to sexual practices and to illicit drug use. Such subjects are often taboo and associated with embarrassment, shame, guilt, and rejection. Nurses and other caregivers may also experience these same feelings of embarrassment, shame, and guilt as they practice certain risk behaviors on their own personal lives. The additional fear of HIV/AIDS as fatal illness compounds the problem of discussing this difficult subject.

HIV/AIDS is also found to be a condition that continues to generate fear, misunderstanding, misinformation and discrimination. For example, there are few nurses and caregivers in the world who have not been affected in some way by the disease and it is easy for the nurses to discriminate (PLWHA) people living with HIV/AIDS. In addition some nurses and caregivers are also living with HIV which can cause them to live in fear and thus make it difficult to understand or care for people living with HIV/AIDS and the affected households (Report of the ICN Conference on HIV/AIDS, 1994:17).

Among the consequences of this stigmatization is early withdrawal from the labour force by those infected. The stigmatization is often in an overt manner. There is fear that contact or helping the PLWHA will infect them (The Second Medium Term Plan, 1997-2002).

Several developing countries have recently set up pilot projects to help HIV-infected women give birth to healthy children and are actively tackling some of the challenges involved. Some of the challenges are the women's reluctance to be tested for HIV infection (UNAIDS, 2000). This reluctance may be driven in part by their fear of stigma and in part by fear that they will not get the social or medical support they need if they are found to be infected. When testing is offered, women who are tested show their reluctance in two ways: either they refuse to be tested or they agree to be tested but do not come back for the test results (UNAIDS, 2000). Care and support need to be given to people living with HIV/AIDS to destigmatize HIV/AIDS.

We also all need to be advocates for acceptance and care and look inward and examine our own beliefs, values, assumptions and attitudes towards HIV/AIDS (Van Dyk, 2001:273).

#### **4.8. Cultural beliefs with regard to HIV/AIDS in Botswana**

According to Giddens (1989: 331-332) culture concerns the way of life of a given society. It is their habits and customs together with the material goods they produce. He says that culture is one of the most distinctive properties of human social association. Van Dyk (2001: 128) asserts that culture unite the individual with the rest of his or her community, others should respect both the living and the dead and them. This section will focus on religion and polygamy as they relate to HIV/AIDS in Botswana. There are other aspects of culture that can be included in this section. The researcher however chose the two aspects to be discussed as Botswana is a very religious society and polygamy is a big issue also. Some communities in Botswana are still practising this. Therefore it cannot be ignored.

#### **4.9. HIV/AIDS and religion in Botswana**

A large number of Africans even those who are urbanized, still adhere to traditional African beliefs. It is common for Africans to combine traditional beliefs with other religious systems such as Christianity. In traditional Africa, disease is either attributed to natural agents, witchcraft or displeasure of the ancestors. In Botswana, religious leaders attribute the high prevalence of HIV/AIDS situation as punishment from God (UNICEF, 1998). According to these leaders the principles of abstinence and faithfulness have been disregarded by the society. The majority of traditional and religious leaders on the other hand acknowledge their inadequacies to handle patients who are too sick. They normally refer these patients to the health care providers in the clinics. A few traditional healers claimed that they have been successful in curing the disease particularly when patients come during the early stages of the illness (UNICEF, 1998).

In Botswana, according to Fidzani, et al. (2000) consultation of traditional healers has been reported to be more frequent before diagnosis of HIV than afterwards. Health workers' experiences suggest that patients usually come to the hospital and clinics once their condition has deteriorated markedly. The traditional healers are often consulted early in their illness.

The fact that HIV (and other STDs) can infect newborn infants is of great concern to traditional healers in Africa because they realize that AIDS may jeopardize future generations, and indirectly also the immortality of their tribe (Schoepf, 1992 in Van Dyk, 2001:121). Churches, traditional religious leaders and traditional healers will have to engage in prevention and education programmes and also pay attention to the spiritual and physical needs of people who are suffering from illnesses or who experience desperate poverty because of the loss of breadwinners and parents to AIDS (Van Dyk, 2001:321).

#### **4.10. Polygamy in Botswana**

According to Giddens (1990:386) polygamy describes any type of marriage, which allows a husband or a wife to have more than one spouse. There are two types of polygamy, which include polygyny and polyandry. Polygyny is when a man marries more than one woman at the same time and polygyny, which is very uncommon, is when a woman marries more than one man simultaneously.

Van Dyk (2001:120) mentions that Western health care professionals mostly frown upon polygamy in African societies, but polygamy often helps to prevent and reduce unfaithfulness, prostitution, STDs and HIV. According to Mbiti (1969) as quoted by Van Dyk (2001:120) polygamy is particularly valuable in modern times when African men are often forced to seek work in the cities and towns. If a husband has several wives he can afford to take one at a time to live with him in the town, while the other wife or wives remain behind to care for the children and family property. As a result polygamy often provides a healthy alternative or solution to problems inherent in certain cultural customs.

Van Dyk (2001:120) further states that in some African societies, for example, sexual intercourse between husband and his wife is prohibited while she is pregnant and this abstinence is observed until after childbirth or in some cases even until after the child is weaned. In such situations, polygamy prevents husbands from turning to casual sex. In societies where polygamy is practiced, AIDS educators are wasting their time when they try to advocate monogamy. Much more will be achieved by emphasizing loyalty and fidelity between a husband and all his wives and by discouraging sex outside that group. Polygamy is, of course, only safe if all the partners in the relationship are HIV negative.

There is also polygamy practised in the subdistrict of Botswana called Ngamiland. There is tacit recognition of multiple partners among other groups in Ngamiland. Girls are introduced to sex at a much earlier age. If these young girls are not with their male counterparts this can only mean that they do so with men who are much older than them. Allegations made in the district-included cases of primary school pupils who leave school to get married as second wives. This kind of practice may expose the girl child to infection by HIV/AIDS infection (Ngamiland Comprehensive District Plan, 1999).

Fidzani, et al. (2000) pointed out that historically for both the Kalanga and Setswana speaking groups, the practice of "Gala thaka" or "Seatlung" was very common. This practice enabled a brother to marry or inherit his brother's wife. There was also the Nkadzana concept where it was accepted for a man to relate to his wife's younger sister or close relative. Polygamy was also practised by all cultures although it is now only amongst the Zezuru community. There are however, new forms of polygamy – for example the concept of a small house. This practice allows a man to have a concubine (Guumba) that is well known to the family. A maguumba, very often would be an unmarried or divorced women.

According to Giddens (1990: 387) polyandry creates a situation, which is not present in polygamy. The biological father of the child is usually not known. This is a risky situation in the transmission of HIV since condoms are not used as the woman conceived and the HIV status of the other partners may not be known. In polygamy, it is however possible to know, who the biological father of the child as it is obvious that the man who impregnated the woman is the one involved with the women. It is however not known whether all the partners are faithful or not. Both polygamy and polyandry are very risky in the transmission of HIV/AIDS.

#### **4.11. Sexuality and gender issues in Botswana**

According to Wilson, et al. (2002: 65) sexuality refers to those attributes, desires, roles and identities that are concerned with sexual activity and behaviour. It can also refer to an orientation towards, or preference for, particular forms of sexual activity.

Wilson, et.al. (2002: 65) further stated that while biology determines sex, society, religion, and culture shape sexuality. Wilson, et al. (2002:65) also mentioned that biological sex refers to whether people are genetically male or female and gender identity is socially and culturally constructed. Sexual identity is an important concept in sexuality and gender. They say that sexual identity, describes how people think of themselves, who they are sexually and romantically attracted to, and how others think of them. It also refers specifically to whether a person is attracted to members of the same biological sex or the opposite sex (Wilson, et al., 2002:65).

The next sections will focus on the impact of adolescent, female and male sexuality on HIV/AIDS in Botswana.

#### **4.11.1. The impact of adolescent sexuality on HIV/AIDS in Botswana**

According to Meekers and Ahmed (1997) in Botswana, premarital sexual activity is common and most adolescents tend to become sexually active at a relatively early age.

Recent research by Meekers and Ahmed (1997) on adolescents in Lobatse and Francistown, two urban areas in Botswana, revealed that 4% of males and 15% of females aged 15-16 were sexually experienced and among adolescents aged 17-18, roughly 2 out of every 3 male and female adolescents were sexually experienced. Further more the study revealed that multiple-partners and casual sexual relationships are common among Tswana adolescents. For example, among adolescents aged 17-18, 39% of females and 47% of males reported having at least one casual partner in the last twelve month, 16% of females and 21% of males reported having at least two casual partners.

These types of adolescent sexual relationships lead to high level of premarital childbearing, related school dropouts, abortions, and HIV transmission.

It has also been found that the infection rates in young African women are far higher than the infection rates in young men. Among young people in their early twenty's, the rates were three times higher in women. In large measure, this enormous discrepancy is due to age mixing between young women and older men, who have had much more sexual experience and are much more likely to be exposing the girls to HIV. It is the interplay of biological, cultural and economic factors that makes young girls particularly vulnerable to the sexual transmission of HIV. While both girls and boys engage in consensual sex, girls are more likely than boys to be uninformed about HIV, including their own biological vulnerability to infection if they start having

sex at a very young age. Girls are also far more likely than boys to be coerced or raped or to be enticed into sex by someone older, stronger or richer. Sometimes it is social pressure to acquiesce to elders (UNAIDS, 2000).

Sometimes it is a combination of factors, as may be the case with older “sugar daddies” that offer schoolgirls gifts or money for school fees in return for sex. In the era of AIDS, the consequences for young girls can be disastrous (UNAIDS, 2000).

The incidence of “sugar daddy” and sugar mummy” is also highly prevalent in the Gaborone district (UNAIDS, 2000). Youth no longer have fears to engage in sexual relations with older adults. For the young girls, the motive behind this practice is material and financial gain. The youth also succumb to peer pressure and engage in sexual relations for fear of being laughed at by their peers.

Schoolgirl pregnancy is considered a social problem in Botswana (UNAIDS, 2000).

The Norwegian Board of Health and the AIDS/STD Unit of the Ministry of Health (Isa) conducted a study in Molepolole (Kweneng district, Botswana) to determine the prevalence of teenage pregnancy and HIV/AIDS threat among the youth and to explore the factors contributing to teenage pregnancy. Both primary and secondary schoolteachers identified a range of factors as contributing to teenage pregnancy. Top on the list of the identified problems was lack of parental care and abuse of freedom in situations where pupils either live on their own, guardians or relatives when their parents are either at the cattle post or lands or elsewhere trying to earn a living. Two hundred and twenty five primary school pupils and 119 secondary school students were said to be living alone respectively.

Other factors, which were thought to be associated with teenage pregnancies, included:

- Attitude of health workers toward young girls seeking contraception
- Peer pressure
- Lack of communication between parents and their children.
- Disintegration of the extended family, where relatives do not see themselves as equally responsible for children as their biological parents (Ramatswi, 1993 in Meekers & Ahmed, 1997).

The same problem exists for senior secondary graduates. This implies that females stay in school at later ages and that sexuality and reproduction interfere with women's education. Schoolgirl pregnancies are one of the main obstacles to further improvements in women's education. Primary and secondary schoolgirls who become pregnant are required to drop out of school until their child is one year of age (Ramatswi, 1993 in Meekers & Ahmed, 1997)

Despite the fact that particularly, secondary school teachers viewed pregnancy as a serious problem, there was no accessibility of condoms within the school premises. The reasons that were put forward for not making condoms available included: the school teachers felt that the pupils are still young and have not yet shown any indications of being sexually active. The key informants also said that the health workers have never sensitised them about the need to provide condoms at schools. This clearly shows that health workers are solely seen as being responsible for providing health related services. The school teachers felt that if condoms are to be issued at school, this might instil sexual activity ideas into children who are still innocent and would not have engaged in sexual activities (Meekers & Ahmed, 1997).

Teenage pregnancy is said to be a serious problem in secondary schools in Botswana. This means that the teenagers are sexually active and are not using condoms. Pregnancy is a sign of contraceptives including condoms not being used. This means that the teenagers in Botswana are at risk of being infected with HIV/AIDS, as condoms are not easily accessible to teenagers in schools and clinics to prevent HIV transmission.

The study of Teenage pregnancy and risk of HIV infection in Molepolole, also revealed that accessibility of condoms within the school premises is against some of the religious and cultural beliefs (UNAIDS, 2000). Some of the headmasters stated that a school is not a sex training institution but a day school.

Fidzani, et al. (2000) state that historically all parents were charged with the responsibility of disciplining children regardless of whether they were their children or not. There is no longer respect between the youth and adults. In general most parents acknowledge with bitterness that they have given up in their attempt to mould their children into responsible adults as children disrespect parents and all adults. The children think that they can control or guide themselves.

In order to monitor the progress and impact of prevention activities that have been undertaken, a study on knowledge of AIDS reported the occurrence of STDs and sexual behavior amongst

youth aged 18-25 (Ministry of Health, 1992). The youth were misinformed about how the AIDS virus was transmitted. There was a belief that AIDS is transmitted by mosquitoes or other insects and by sharing food/cups or holding hands. The prevalence of STDs was extremely high in Francistown suggesting that those with STDs may be a major factor in the spread of HIV. Health facilities and Radio Botswana were seen as the most important and reliable sources of AIDS information (Ministry of Health, 1992).

Some parents are said to be totally against sex education and would therefore disapprove of their children being exposed to condoms (Norwegian Board of Health and Ministry of Health, [sa]). School authorities have been reluctant to provide family life education because they feared parental opposition. Parents have been reluctant to take responsibility because they were not allowed to do so traditionally and because they lack the necessary knowledge. Communication between parents and their children is poor and because of traditional rules prohibiting children from talking about sexual issues with their parents. This is unlikely to improve in the near future. Girls are not allowed to reapply for admission to school until their child is one year old and they are not allowed to return to their former school.

Information from both the survey data and the focus group interviews indicate that parental support is a crucial factor in enabling girls to return to school (Meekers, et. al., 1997).

Schoepf (1992) as quoted by Van Dyk (2000: 121) also found out that although many women in the Democratic Republic of Congo were not in a position to negotiate the conditions of their sexual practices or condom use for their own safety, they had taken steps to change their children's behavior. Many of the mothers had in fact broken the taboo against discussing sex with unmarried children in order to help them understand the need for condom protection. Although it may now be too late for many mothers, hope for the children of Africa may still exist (Schoepf, 1992 in Van Dyk, 2001:121).

#### **4.11.2. The impact of women sexuality on HIV/AIDS in Botswana**

In many countries, women worry that they would suffer shame and discrimination if they were known to be HIV infected (SAFAIDS, 2002:2). Many women, who are HIV positive, become vulnerable and risk violence, abandonment, rejection or even loss of their homes and children if they disclose their sero-positive status. The need for protection and support of vulnerable women who test sero-positive must be considered when developing Voluntary Counselling Testing services (SAFAIDS, 2002: 2).

The pattern of the HIV epidemic in Botswana, particularly in the sexually active age group, has a clear gender bias. Data on reported HIV cases since the beginning of the epidemic up to the 1<sup>st</sup> quarter of 1996 show that 56% of infections in the age group 15 to 49 were women (The Second Medium Plan, 1997-2002).

According to Poku (2001:197) the age disparity in HIV infection rates indicates that young women must be having sex with men much older than themselves. This point is confirmed by ongoing studies in Botswana (Poku 2001:197).

The gender gap widens in the youth group 15 to 29 years, where 68% of infections were women. A Civil Registration Pilot Survey between 1990 and 1994 in selected areas in Botswana found that 80% of births were to single mothers, the majority of whom were youth.

Lack of women's empowerment against prejudicial cultural and traditional practices in sexual and reproductive matters and relationships have been identified as factors that make women vulnerable to HIV infection.

According to the 1994/95 agricultural surveys (Adupa, 1999) women, most of who are widows, divorcees or have never been married head 35% of the traditional farm households in Botswana. Access and control of the most important resources among the agricultural community is by men thus leaving women at their mercy.

Fidzani, et al. (2000) added that many women say that they have very little say when it comes to issues of sexual relationships. Females believe that men were largely unwilling and uninterested in AIDS education. Women said that they always initiated the discussion with partners and often were discouraged by their partners who think that women always want to police them.

According to (Van Dyk, 2001:410) all people have the right to insist that they or their sexual partners take appropriate precautionary measures to prevent the transmission of HIV. The especially vulnerable position of women in this regard should be recognized and addressed, as should the position of youth and children.

Van Dyk (2001:119) says that procreation is therefore one way of ensuring that a person's personal immortality is not destroyed. Mbiti (1969) as quoted by Van Dyk (2001:119) postulates that the failure to bear children is for an African woman worse than committing genocide. She

has not only become a dead end for the family's genealogical line but she has also failed to perpetuate her own self through her children. When she dies, nobody of her own immediate blood will be there to remember her and keep her in the state of personal immortality. She will simply be forgotten. The Shona ethnic group in rural Zimbabwe on the other hand believe that those who die childless cannot be accepted into the spirit world of the ancestors and they are doomed to wander the earth as evil, aggrieved or haunted spirits (Scott & Mercer, 1994 in Van Dyk, 2001:120).

According to Giddens (1990:181) many women face domestic violence directly or indirectly. Domestic violence has to do with the way males use their superior social or physical power against women. He says that the home is often idealized as a heaven of security and happiness, but domestic violence is part of the experience of many women. Rossetti and Davies (1999) state that domestic or spousal violence is another factor that puts women in vulnerable positions. They say that domestic or spousal violence is believed to be the most frequent form of violence suffered by women in Botswana.

In the recent women's Affairs Survey 37% of interviewees had suffered a severe beating 1-5 times in 1998 at the hands of their male partners. The survey points out that traditional culture is often cited as the cause and excuse for battering and some men feel they have the right to "chastise" their wives if the latter break with tradition. This can include questioning the man's movements or his relationship with other women, neglecting housework or talking back. Monica Tabengwa, director of Metlhaetsile Women's Information Center says that most women expect to be battered and most men consider it their duty to batter their spouses (Rossetti & Davies, 1999). Women have come to believe violence is a natural part of a relationship between men and women, an indication of passion (Rossetti & Davies, 1999).

According to Rossetti and Davies (1999) the Batawana paramount chief, Kgosi Tawana 11, also said that "when does chastisement turn to abuse". A little slap here and a little slap there to put the wife in line is seen as acceptable as she is like your own child. There is acceptance that this happens in a marriage in Maun. Violence against women is attributed to the break up of the traditional extended family, a rapidly changing society and the loss culture and traditional values. The belief that it is okay for men to beat their wives as they are like children who need

to be put in the right direction, was confirmed by a study conducted to assist Rape Crisis Centre to meet the needs of survivors of abuse (Rossetti & Davies, 1999).

It is evident from this discussion that women are at risk for HIV infection because of their status in society. According to Van Dyk (2001:150) women need to be empowered with life skills to be more assertive and self efficient in sexual matters. Women should believe in their ability and right to make their own choices to insist on condom use and to say no sex.

#### **4.11.3. The impact of men sexuality on HIV/AIDS in Botswana**

Adupa (1999) states that men in sexual matters usually dominate women in Botswana. Thus regardless of the sero status of a husband, which the wife may not know anyway, failure to provide sex to the spouse, may earn the wife a divorce. Besides, having multiple sexual partners seems to be universally and culturally accepted/tolerated for men.

The issue of smaller wives/houses is an open secret and the joy of most men who claim that sex with girls or relatively younger women help cleanse and purify their blood. Although this is not tolerated for women the latter are also now insidiously developing these sex networks.

In Botswana it is accepted by the society at large that men's sexual networks can be quiet extensive. There is a feeling that men may legitimately have multiple relationships irrespective of their marital status but women may not (Adupa, 1999). This attitude is justified on the basis of culture. It is believed that men are biologically different from women in their need for sex and as such should have unlimited sexual freedom while a woman is expected to have only one partner. This situation is mirrored in the Kweneng West Sub-district. Women are also treated as minors and socially inferior (UNDP, 1999).

Although most of these practices are no longer predominant, they have gradually taken milder forms, which nonetheless epitomise tolerance of men's extra marital relations. The Setswana saying of "mapako a monna ga a balwe" still holds this means. For example polygamy has taken the milder form of those who migrate to towns cohabiting with other women who may or

may not be known to the family and "Nkadzana" concept has degenerated into child abuse. In essence the belief and understanding that it is culturally correct to have multiple partners may provide some explanations regarding why there is a high incidence of HIV infection in the district. Such beliefs have been transmitted to the youth through the process of socialisation.

Even though men talk about sex, they only talk about it in ways that make them out to be macho individuals with no display of emotions. They do not openly discuss their deepest sexual thoughts, fantasies and secrets. When they do talk about sex, it is often in a joking superficial manner (AIDS/STD Unit, 1998).

### **5. Economic impact of HIV/AIDS in Botswana**

Through the impact on the labour force, households and enterprises, HIV/AIDS can act as a significant brake on economic growth and development (UNAIDS, 2002:56). They also say that more recent calculations have suggested that the rate of economic growth has fallen by 2-4 % in sub-Saharan Africa as a result of AIDS. The nationally focused studies had forecast that by 2015, the economies of Botswana would grow by 2.5% points less than they would have in the absence of the epidemic.

As is the case with many diseases, poverty makes AIDS worse but it does not cause AIDS. HIV must be present for AIDS to occur. Poverty places people at greater risk of acquiring HIV. Poverty and unemployment may lead women to engage in sex work and increase relationships of dependency, making women vulnerable to coercive sex. Single sex hostels, migrant labour, limited health and recreational facilities and lack of access to information all contribute to the spread of AIDS. People who are HIV positive and poor may not be able to eat well. This may make the person weak and can contribute to the person becoming sick with AIDS. Poor people with HIV usually do not have access to the adequate health-care resources necessary for staying healthy longer. The observation that there is no direct causal relationship between poverty and AIDS is also documented in Soul City (Soul City-Know the Facts, 2002).

Contrary to a popular belief, poverty is one of the major problems in Botswana (The Second Medium Plan, 1997-2002). Female-headed households form the majority of households living in poverty. The 1991 census data shows that 47% of the households in Botswana are female headed and 52% of these are in rural area (The Second Medium Plan, 1997-2002). The level

of poverty is likely to make most people especially women and those in the rural area vulnerable to HIV infection and less able to respond effectively to the consequences related to illiteracy; unemployment and gender inequalities, which are predisposing factors to HIV infection in Botswana.

The income gap between the poorest and richest members of society in Botswana is also high. The poorest 40% of the population get only 11.6% whilst the richest 20% get 59% of the income (The Second Medium Plan, 1997-2002). The unemployment rate in Botswana was estimated at 21% in 1993. Data also showed that unemployment is concentrated among the secondary school leavers' youth. The data also suggested that the current level of unemployment is likely to intensify the poverty profile in Botswana (Adupa, 1999).

Poor families, according to Poku (2001:196) have reduced capacity to deal with the effects of morbidity and mortality than do richer ones for very obvious reasons that include the following:

- Absence of savings and other assets that can cushion the impact of illness and death.
- Cost of drugs to treat opportunistic infections
- Transport costs to health centers
- Losses of employment through illness and job discrimination
- Funeral costs

As a result, a true process of immiseration is now observable in many parts of Africa, particularly Southern Africa.

Mr. Alpheus Matlhaku, the Deputy Permanent Secretary, in the office of the President, during the official opening of the workshop called Consultative meeting on HIV/AIDS and Disciplined forces for policy makers held in June 1997, said that with a far reaching epidemic illness such as AIDS, the collective effect of many individuals falling ill is likely to have a major impact in any sector specifically the disciplined forces will be affected by staffs who are ill due to AIDS related problems and who will be less productive on the job and have greater absence due to illness. Healthy staff is also likely to increase absence due to attendance at funerals and the need to care for those who are ill (UNDP & Ministry of Health, 1997).

As those dying are usually in their most productive years, many schools, hospitals, private industries and civil services are short staffed. In the private sector, AIDS related costs including those connected to absenteeism from work, insurance, and the recruitment and retaining of replacement workers are estimated to consume as much as one fifth of all profits (UNICEF, 1999).

The Second Medium Term Plan (1997-2002) points out that the epidemic is expected to drive poorer households into deeper poverty. This is expected to result from loss of income support as the young sexually and economically active die. Households are expected to face financial burdens from health bills as they continue to seek treatment for prolonged HIV opportunistic infections. Few surveys of the impact of having a family member with AIDS show that households suffer a dramatic decrease in income (UNAIDS, 2000). Decreased income inevitably means fewer purchases and diminishing savings (UNAIDS, 2000).

The surveys also indicated that the household might be affected by HIV/AIDS in the following ways:

1. Loss of income, if a breadwinner stops work due o sickness or death (this is a permanent impact).
2. Loss of income, if a breadwinner has to stop working to look after a sick family member (this is a temporary or transient impact.
3. Additional expenditure, on health care and eventually funeral costs (again a transient Impact).

Supporting HIV/AIDS prevention programmes, therefore makes good economic sense. Health care provision is also a good investment since it limits or prevents sickness and absenteeism (UNAIDS, 2002:55).

## **6. HIV/AIDS and health issues in Botswana**

As HIV infection progresses to AIDS, there is an increase in total hospitalisation related to HIV/AIDS (UNAIDS, 2002:55).

Statistics from the two national referral hospitals of Nyagabongwe in Francistown and Princess Marina in Gaborone show that patients with HIV occupy over 50% of hospital beds in the medical and pediatric wards related illnesses. In Princess Marina, statistics from the adult

medical ward (male, female and private) show that, there was 640 patients with HIV related illness between January 1995 to May 1996. The records show that 33% of these patients died during this period. Paediatric wards are also experiencing increasing caseload of HIV related illness. Paediatric AIDS is expected to rise as adult HIV infection increases (The Second Medium Plan, 1997-2002).

The emergence of community rooted home based care initiatives often organized by people living with HIV/AIDS have become one of the outstanding features of the epidemic and a key coping mechanism for mitigating impact (UNAIDS, 2002:51). The community home based care will be discussed later in this chapter. The following section will focus on the relationship between HIV/AIDS and Tuberculosis and Sexually Transmitted Diseases.

### **6.1. Relationship between HIV/AIDS and tuberculosis (TB) in Botswana**

There are important links between AIDS and tuberculosis (TB) according to Evian (2000: 233). He says that HIV infection increases the risk of developing active TB. He further mentions that TB is the most common, serious and life threatening opportunistic infection in people with HIV/AIDS in Africa and other developing countries. Since the beginning of HIV/AIDS epidemic there has been a steady increase in the number of new TB cases. The TB epidemic has shown a parallel rise. In some countries the TB epidemic has doubled and even trebled in size and the fears are the situation will get worse. Coker and Miller (1997), UNAIDS (2000) as quoted by Van Dyk (2002: 43) agree with Evian (2000:233) that approximately 50% and 60% of people with HIV infection will develop active TB disease at some stage of their disease.

In Botswana, it is estimated that HIV and TB co-infection is high. Data on 40 sputum patients in Francistown showed an HIV co-infection rate of 67% (The Second Medium Plan, 1997-2002). A similar study was conducted in Hlabisa, in Kwazulu-Natal. The study shown that together with a steep rise in HIV infections, the number of people admitted to hospital with TB rose by 36% between 1992 and 1998 (The Second Medium Plan, 1997-2002). Similar studies with similar results on the link between HIV and AIDS have been conducted in Tanzania, Malawi, Rwanda, Ivory Coast and DRC (Soul City- Know the Facts, 2002).

## **6.2. Relationship between HIV/AIDS and sexually transmitted infections (STIs) in Botswana**

According to Van Dyk (2001:48) sexually transmitted infections (STIs), constitute a major public health problem in Southern Africa. It has been estimated that more than 1 million patients seek treatment for STDs every year at municipal clinics and in private practice alone.

There is a close relationship and association between common sexually transmitted diseases (STDs) and HIV/AIDS. According to Evian (2000:251) and Van Dyk (2001:48) STDs enhance the transmission and spread of HIV. Evian and Van Dyk say that STDs cause inflammation and HIV is naturally attracted to the immune cells of the body. Many of these cells have specific receptors on their surface and HIV is able to attach to these surfaces to gain entry into the cells. STDs also cause genital inflammation, with a migration of many millions of inflammatory cells to the site of infection. HIV can find these receptors easily. STDs especially genital ulcers/sores make it easier for HIV to enter the body through the above process. STDs also disrupt the natural surfaces and linings of the genital tract. This also increase the likelihood of HIV successfully entering and leaving the body during sexual contact. HIV is spread in the genital discharges and secretions and therefore if a person has HIV infection and an STD, then he/she will shed many HIV viruses in the discharge and infect others more easily.

In 1994, the HIV sentinel surveillance investigated the HIV sero prevalence rate among pregnant women and male patients with sexually transmitted diseases in Botswana (AIDS/STD Unit - NACP 25,1994). The survey was conducted in six selected areas of the country from February to April 1994. The main conclusion from she study was: Younger women < 30 yrs are both more often pregnant and has a higher HIV infection rate than women above the age of 30. Three out of four pregnancies and 85% of HIV infected cases in this survey were found among women below the age of 30. In this survey between 15% and 30% of pregnant women tested at six different sites and between 25% and more than 50% of men with STD's tested at four different sites were found to be HIV positive.

Sexually transmitted diseases (STDs) are both risk and co-factors in HIV infection. STDs are biological evidence of unprotected sex. Biologically, the transmission of most STDs is more efficient from men to women than the converse. The consequences of STDs are more serious for women because most of them may remain asymptomatic for sometime, making them more

vulnerable to HIV infection. STDs are a major public health problem especially amongst the youth in Botswana (The Second Medium Plan, 1997-2002).

The 1994 KAPB study shows that 32.5% of sexually active male respondents in Francistown reported having had sores or discharge in the last 12 months, followed by Maun with 31%, Tutume with 30.7% and Mahalapye with 20%. Control of STDs will therefore be a key activity in the prevention of HIV transmission (The Second Medium Plan of HIV/AIDS, 1997-2002).

Evian (2000: 251) says that numerous research studies have shown that effective community care for STD diseases can effectively reduce the incidence of HIV in the community. Keeping people free of STDs will also help reduce their vulnerability to getting HIV.

### **7. Care, prevention and treatment programmes in Botswana**

The common commodity among health-related disciplines is care. Care that is acceptable to members of specific groups requires understanding of and respect for life – style, community, and socio-cultural orientations as the context for health promotion, maintenance, and restoration (Bauwens, 1978; Brownlee, 1978; Dougherty, 1985; Leininger 1988b as quoted by Kavanagh & Kennedy, 1992:121). Care and caring involve meanings, patterns, processes, and methods that affect health behavior and that occur in patterns that are specific to cultural and sub cultural groups (Kavanagh & Kennedy, 1992:121).

Van Dyk (2001: 126) argues that no AIDS prevention programmes can success in Africa without the help of traditional healers. Traditional healers are effective agent of change because they have authority in their communities. They function as psychologist, marriage and family counselors, physicians, priests, tribal historians and legal and political advisors. About 80% of people in Africa rely on traditional medicines for many of their health care needs. Traditional healers are well known in the communities where they work for their expertise in treating sexually transmitted diseases, and the World Health Organizations has since the early 90s consequently advocated the inclusion of traditional healers in national AIDS programmes (Van Dyk, 2001: 126).

Van Dyk (2001: 126) further states that positive cultural beliefs and behaviors are values and behaviors, which are known to be beneficial, and they should therefore be encouraged and reinforced.

She also states that the exotic behaviors are traditional Africans customs and behaviors that are unfamiliar and strange to Westerners, but are not harmful to health. These exotic behaviors such as polygamous marriages where all partners are uninfected and faithful to each other, cultural rituals, and ceremonies and herbal remedies, need not be changed and should be respected. Although AIDS educators should take care not to interfere in cultural beliefs and behavior, some traditional behaviors are indeed harmful to people's health and attempts should be made to change these.

Van Dyk (2001:125) says that AIDS educators should be creative and imaginative in incorporating traditional beliefs and healing methods into AIDS education programmes. The African tradition social sharing, rituals, story telling, drama, singing, drumming and dancing should be used to relate the threat of HIV infection to traditional Africans. Community involvement in the planning, implementation and evaluation of AIDS education programmes are also important for the success of such programmes. The essential norms and values, cultural images and language of a community can only be appropriately understood and incorporated with the help of the target community (Compare Airhihenbuwa, 1989; Boahene, 1996; Campell & Kelly, 1995; Scott & Mercer; 1994; Walters, Canady & Stein, 1994 in Van Dyk, 2001:125.)

A number of NGOs and CBOs have taken the lead to support these extended and foster families including Childline Botswana, Botswana Christian AIDS intervention program and Tirisanyo Catholic Mission. These organisations provide services in communities throughout the country, ranging from family counselling and day care for orphans to providing for basic needs such as food clothing and education (UNICEF, 1999).

The Botswana Defence Force: Brigadier Thutwe, Commander of the 2<sup>nd</sup> Brigade said that in 1996 a comprehensive HIV/AIDS program was finally approved by the high command and put in place. The objective of the program was to achieve 90% awareness level in the BD7 personnel by the year 2002, which will help to make informed decisions. The program is consistent with the National AIDS policy. The program aims at education leading to reduced behavioural risk, adequate treatment for STD and health seeking behaviour, condom use, including access, availability and procurement, continued treatment and care of those living with AIDS, appropriate community home-based care and voluntary testing accompanied by pre and post counselling.

Botswana Police Service also formed an advisory committee on HIV/AIDS co-ordinated by the commandant of the Police College, assisted by a trained focal person members of this committee are from all branches of the police service to ensure maximum participation and information dissemination. The committee works towards sensitising members of the Botswana Police Service about the status of HIV/AIDS in Botswana, minimising the spread of the disease, motivating and promoting co-workers participation in the fight against HIV/AIDS, educating them about the prevailing perceptions and myths in order to reduce the stigma attached to the disease and promoting awareness on the disease within the service using peer educators and co-operating with other organisations working against the spread of HIV/AIDS.

Botswana prisons and rehabilitation department: Mr. Orebotse, the Deputy Commissioner said that immediately on governments announcement of the national policy on HIV/AIDS, the prisons department embarked on HIV/AIDS sensitising exercise for inmates. Prisoners were advised on how to safeguard themselves against HIV/AIDS. Inmates are encouraged and actually supplied with condoms on release to the society. An HIV/AIDS policy for prisons has been formulated (UNDP & Ministry of Health, 1997).

STPA is a national strategy to guide a national response on mitigating problems associated with orphanhood. The problem is now viewed as a national crisis that demands an emergency response in the short term and strategic planning for the long term care of orphans. It helps to identify immediate needs of orphans and articulates a strategy on how stakeholders should respond both individually and collectively. The strategy emphasis a participatory, Decentralised process and a multi-sectoral approach in its implementation (Ministry of Local Government, 1999-2003).

The AIDS/STD unit is one component of the Department of Primary Health care (PHC) services in the Ministry of Health (AIDS/STD Unit, 1994). The AIDS/STD unit's strategy of operations is divided into 5 major areas:

1. Program Management
2. Prevention of sexual transmission, including:
  - I.E.C
  - Condom promotion
  - Control of sexually Transmitted Diseases.
3. Prevention of transmission through blood including:

- Safe blood transfusion services
  - Laboratory support
4. Care of persons with HIV/AIDS including:
- Clinical management of HIV/AIDS
  - Home based care and support
  - Counselling for support of persons living with HIV/AIDS and their families
5. Epidemiological surveillance and different types of research, which provide important background information to facilitate further planning, advocacy for AIDS prevention and to monitor the impact of the epidemic. The AIDS/STD UNIT is made up of the following sub-units:
- Information, education and communication (IEC)
  - Counselling
  - Sexually Transmitted Diseases

The institutional framework for the HIV/AIDS response in the Town of Lobatse is spear headed on the governmental side by the Lobatse District Multi-Sectoral AIDS Committee (LDMAC) NGO's like population services International has been the most active and CBO's like Botswana Family Welfare Association (BOFWA) are the most active. Religious organisations are Lobatse Christian AIDS Committee (LOCAC), Lobatse Methodist Church and the Seventh Day Adventist Church (Hope, et al., 1999 b).

In Kweneng West, a Sub-district Multi-sectoral AIDS Committee (SDMAC) was established in February 1998.

There is Ministry of local government AIDS advisory Committee (MOLGAAC) at district level, there is a District Multi-sectoral Child Welfare Advisory Committee (United Nations Development Programme, 1999).

At village level, there are village AIDS Committees. The members are local councilor, Kgosi, Health, Education and VDC Botswana Christian Aids Intervention Program is implementing the girl child project (BOCAIP). The project is being implemented in Northwest Botswana Maun and Sehitwa and Gaborone. The Maun counseling Center is implementing the program in Maun and Nazarene Church in Gaborone. The project equips at least 50 girls with life skills and understanding that will empower young people to make responsible choices and develop

into responsible adults (Botswana Christian AIDS Intervention Programme. Mid-term Report, No.23,[Sa]).

The department of Women's Affairs is divided into North and South Regional Offices. It is planning two stations in Ghanzi and Francistown. The department is the implementing agency for the National Gender Program through which it directly funds women's groups working in HIV/AIDS (Ministry of Labour and Home Affairs, 2000).

The Ministry of Health launched the peer education HIV/AIDS prevention program at the workplace in Botswana in 1991. It was implemented within the Botswana Business Community and has now expanded extensively to the parastatal and government sectors. The program has been quiet successful in the key area of improving knowledge, attitudes, and practices related to risky behaviour. For example the peers said that the program had made them more sensitive to the plight of those with HIV/AIDS. They were becoming aware of fellow workers contracting or dying from HIV/AIDS. The experience made them even more determined to protect them from infection. The program also had led them to reduce the number of their partners (Hope, et al., 1999 c).

Health care service is provided by both the central government (Ministry of Health) and Ngamiland District Health Department Nyangagbwe and is used as a referral hospital. There is a primary hospital called Gumare Primary hospital and district hospital called Maun General hospital. Active NGOs in Ngamiland addressing the HIV/AIDS epidemic are BOFWA, PACT, BOCAIP and WAR (Ngamiland & Comprehensive District Plan, 1999).

According to UNAIDS (2002: 132) in 1999 Botswana became the first country in Africa to start an integrated VCT/MTCT programme using zidovudine for pregnant women testing positive in antenatal clinics. The programme was only introduced first in Gaborone and Francistown. By 2001; the programme had been implemented in all 24 of Botswana's health districts.

### **7.1. Community home- based care in Botswana**

According to Wilson, et al. (2002:45) and Van Dyk (2001:327) the aims of the community home- based care is to provide a framework for care by drawing in, and strengthening, existing community based care initiatives, incorporating the formal and private health sector with non-

governmental organizations (NGOs), and linking palliative community home-based care to prevention and treatment.

In Botswana, like in other countries in sub-Saharan Africa, projects are usually NGO or church led, caring for anything from 10 to 100 patients. Care could include the medical, nursing, social, educational and spiritual aspects (Wilson, et. al., 2002:399).

Frohlich (1999) as quoted by Van Dyk (2001: 327) postulates that community home-based care is the care given to individuals in their own homes where their families, their extended families or those of their choice, support them. A multidisciplinary team and complementary caregivers who are able to meet the specific needs of the individual and family support these home-based caregivers. The team consists of all the people who are involved in care and support and may include a medical practitioner, nursing supervisor, social worker, health educator, physiotherapist, occupational therapist, AIDS health promotion workers, volunteers, traditional healers, religious healers and religious leaders.

A study commissioned by the AIDS/STD Unit, (NACP31) was conducted to monitor and evaluate a Home Based Care Programme for HIV/AIDS and other terminally ill patients. A pretest-posttest experimental design was used.

The objectives of the study were:

- 1.To determine health seeking behavior patterns and their determinants for the chronically ill.
- 2.To determine household capacity to care for the persons with HIV/AIDS in their homes
- 3.To determine the social welfare systems capacity to care for persons with HIV/AIDS in their homes.
- 4.To determine factors influencing the quality of care at the household level.
- 5.To assess referral patterns at various levels.
- 6.To make appropriate recommendations to Government concerning the home based care package for the terminally ill.

The study revealed that unemployment rates are high amongst the heads of households with most households being female headed. Low levels of education and dependency rates further accentuate the high economic vulnerability. The low levels of education imply limited access to

information on AIDS by this category. The quality of inputs used by HBC is inadequate and they attribute this to the households' inability to afford these inputs. The study also established that basic inputs such as draw sheets, and gloves are currently not readily available to households with AIDS patients.

The health personnel feel that the quality of care at home is inadequate. They attribute this to the inadequacy of direct inputs, lack of education, and too much confidentiality about the disease, which limits the caretaker's ability to care for their patients.

The study also revealed that clinics and hospitals are by far the most important source of health care in Botswana. Data from household's health seeking patterns indicate that the clinics are more utilised than hospitals while AIDS patients seem to use hospitals more than clinics. Traditional doctors and spiritual healers feature more in the health seeking patterns of AIDS patients than non-HIV members of households. This source of health care is used relatively less at the post-diagnosis stage than at the pre-diagnosis stage. AIDS patients try different health systems in an effort to understand the nature of their illness. The fact that most patients prefer to be cared for at home in spite of poor economic conditions and inadequate inputs signifies the importance of the emotional effects HBC programmes. The study established that the emotional and counselling needs of the patients have been completely left to pre-and post counselling. There is very little follow-up counselling done by health centres.

A similar study was conducted in Tutume and Molepolole to evaluate the Home Based Care Pilot project in 1998. At both Molepolole and Tutume, the participants (clients, are givers, family welfare educators, nurses and senior administrative staff) expressed enthusiasm to continue with HBC despite the reported hardships they were going through. A large number of participants indicated that they should recommend HBC to a friend or for themselves. In Molepolole transportation was reported to be a problem. However they did indicate that they received adequate emotional support before discharge to HBC (AIDS/STD Unit- NACP 41,1998).

The Declaration of Commitment is a historic landmark in the fight against HIV/AIDS. All the world's governments specifically recognized treatment and care including access to antiretroviral drugs as an essential element of the response to the global HIV/AIDS pandemic.

It is evident from the above discussion that Botswana has put programmes in place to fight this pandemic (UNAIDS, 2002:143).

## **8. Summary**

HIV/AIDS in Botswana seems to be serious problem. The HIV infection rates are very high especially amongst women. The impact of HIV/AIDS seems to be mostly felt by the children who are left as orphans. The attitudes and behaviour of the Batswana's also seem to be contributing to the spread of HIV/AIDS. The use of condoms, which seems to be one way of reducing the transmission of HIV/AIDS in Botswana, seems to be a problem especially regarding accessibility to the teenagers who seem to be at high risk.

Given the uniquely devastating impact of HIV/AIDS on the entire Botswana households, communities and entire societies, national policies and poverty reduction strategies need to be adjusted and expanded accordingly. The strategies to combat the spread are already in place in Botswana and need to be strengthened and expanded. Unless this happens, AIDS will continue to erode human development achievements, deepen poverty and further hinder access to education, health and viable livelihoods (UNAIDS, 2002:59).

In order to assist the country to fight this pandemic, we need to identify all factors that have not been confirmed scientifically that could influence the spread of HIV. Therefore the purpose of this study is to find out if the cultural practices of the Batswana do have an influence in the spread of HIV infection. The next chapter will present the empirical findings of the investigation. The chapter will reveal whether the cultural practices of the Batswana do have an influence in the spread of HIV infection.