

# Botswana's HIV/ AIDS Programme

A MODEL FOR SADC?

**S**ince 2000 the Botswana government has been a model of political commitment in addressing the HIV and AIDS epidemic. Today its public sector ARV treatment programme is the largest in Africa. In this article, **Christine Stegling** describes the background to the Botswana AIDS programme, explains how Botswana has integrated the response to HIV with its development goals, looks at the issue of 'routine' HIV testing and human rights, and highlights some of the challenges that lie ahead.

## Introduction

Botswana has been internationally celebrated as an example of excellent leadership – both politically and economically – in its response to the devastating consequences of the HIV epidemic. This article will outline the policy and programme response that Botswana has implemented since the late 1980s, making particular reference to the public treatment programme, in both a socio-economic and political context. In critically analysing the national response to HIV, and the achievements and gaps of the programme, the questions to be answered will be ‘what have we done right and where did we go wrong?’ It will be argued that many aspects of the Botswana programme may be seen as a model for other SADC countries. However, there are currently many unresolved challenges that impede the successful implementation of the programme. Any HIV programme needs to be understood and evaluated in the specific socio-cultural environment in which it is placed. Furthermore, while Botswana has attracted much attention from international donor agencies and research institutions, surprisingly little analytical research has been published locally and much of the available research and documentation is descriptive in nature. This lack of critical and analytical research indicates that critical debate about the Botswana programme has yet to take place.

## An overview of Botswana

Botswana gained independence in 1966 and was at the time among the 25 poorest and least developed countries in the world. At independence, Botswana’s physical and social infrastructure had hardly been developed, resulting in high levels of poverty and illiteracy (Vision 2016:14). This situation has changed dramatically in the past three decades and today Botswana has been classified by international financial institutions, such as the World Bank, as a middle income country. Botswana has been a consistent net contributor to the World Bank over the last decade; in 1999, for example, US\$14 million in net transfers was made (Taylor, 2001:6).

As indicated in the 2003 UN Human Development Report, in 2001 Botswana had an adult literacy rate of 78.1 per cent as compared to 40 per cent in 1970. In economic terms, GDP per capita in 2001 was US\$3 066 and US\$7 820 when adjusted for purchasing power parity (PPP), as compared to the GDP per capita of US\$300 in 1966. Similar improvements have been made in the health sector, with a per capita expenditure on health of US\$358 (again adjusted for purchasing power parity) (Human Development Report, 2003). This translates into a better health infrastructure resulting in 80 per cent of the rural population living within a 15 kilometre radius of a health

facility (Taylor, 2001:7). An ongoing challenge for the development of Botswana has been its very small population of about 1.7 million people in a vast country of 581 730 km<sup>2</sup>, which makes the provision of basic services to all parts of the country extremely difficult.

Its achievements are in part due to the economic and fiscal policies that have been followed by government, including the utilisation of revenues from diamond and beef trade for the development of infrastructure in health and educational services; Botswana successfully negotiated a 50-50 ownership of the diamond mines with the De Beers Diamond Company in 1975. Hailed for its political stability, Botswana has been ruled by the Botswana Democratic Party (BDP) since independence. However, grassroots democratic structures, including the political opposition, have undeniably been weak. It could be argued that much of this political stability is rooted in the alliance of different elites, including cattle owners and traditional leaders; and this alliance, combined with a strong commitment by political leaders to develop the country, is partly the explanation for Botswana's success. As Taylor remarks: 'What has occurred in Botswana is a typical developmental state situation where the bureaucracy and the ruling party mesh. ... It can be argued that the embedded autonomy of the bureaucracy and diverse ministries have thus served Botswana well, cushioning policy from special-interest lobbying, though perhaps at a cost of the democratic accountability of the bureaucracy' (Taylor, 2001:15). Taylor and others would argue that two factors have played a central role in Botswana's economic success – the strong position of the state in developing the country and a civil service that has almost become indistinguishable from the ruling party. However, this success has been at the expense of an equitable distribution of wealth and the development of more egalitarian political structures. Creating a more egalitarian society in which wealth is distributed more equitably may be achieved through meaningfully implementing the national vision for the year 2016; a Botswana society that is educated, informed, open, democratic and accountable. Recognising current weaknesses, the vision calls for '... a system of decentralized democracy and political tolerance. Civil society will play a full part in the development of the country, alongside Government. The nation's leaders will be open and accountable to the people. The role of traditional healers will have been enhanced' (Vision 2016:72).

There is much focus on the HIV/AIDS statistics that prove the enormous epidemiological problem the country is facing. There has been disagreement about the accuracy of figures and undoubtedly it has not been easy to provide comprehensive data. For the most part, Botswana gathered information about the epidemic through its sentinel

surveillance of ante-natal clinics and of men presenting with certain sexually transmitted infections at public health facilities. While this is common World Health Organization practice, the process does introduce some bias into the data since both population groups under scrutiny will have engaged in risky sexual activity. In Botswana, sentinel surveillance was made even more difficult by many sites being unable to reach adequate sample size for the male population, which meant that most data was obtained only from pregnant women (Stegling, 2000:3).

In response to the challenges that sentinel surveillance has posed in Botswana, the National AIDS Coordinating Agency started linking surveillance data with data from voluntary testing and counselling centres, AIDS case reporting from hospitals and clinics and data for tuberculosis. While during the 1990s only clinics and hospitals in selected districts participated in the surveillance exercises (with the exception of Gaborone and Francistown which participated every year), from 2001 onwards all districts participated in the gathering of information. For 2001 it was reported that 'with the current prevalence of 35.4 per cent, HIV/AIDS is still a major public health problem in Botswana. It is estimated that in 2002, about 258 000 persons aged 15-49 years are infected with HIV' (National AIDS Coordinating Agency 2002:44). The same report utilises data gathered during the first Botswana AIDS Impact Survey undertaken in 2001 to get a better understanding of the behavioural patterns and changes in the country. A second survey was recently completed (August 2004) and this survey included a biomarker which will provide a better picture of HIV prevalence in the general population. The biomarker entails the collection of an oral specimen of antibodies from the blood vessels in the mucous membranes in the mouth. The survey was administered to a sample of the general population and all participants were invited to submit a sample for the biomarker, with the expectation that this method may provide a better understanding of actual HIV prevalence rates. The first survey indicated that although knowledge levels, such as knowledge that AIDS can be avoided, were high, only a third of the respondents had correct answers to all five knowledge questions they were asked (National AIDS Coordinating Agency 2002:34-35). Such findings seem to indicate that people have a general understanding that the epidemic poses a problem in their communities but there is not necessarily a deeper and more detailed understanding of HIV and AIDS. With regard to mortality rates, the report points out that the crude mortality rate has increased by 73.2 per cent in Botswana. During the early stages of the epidemic it was estimated that about 10 per cent of the proportional mortality rate could be attributed to AIDS. Presently, however, it is now believed that between 1998 and 1999 almost one in five deaths was due to AIDS (National AIDS Coordinating Agency 2002:33).

In 2003 government continued to produce second generation data, linking sentinel surveillance with other data sources. The HIV prevalence rate increased slightly to 37.4 per cent, translating into an estimation that currently one in every three persons aged between 15 and 49 years is HIV-infected. However, the 2003 report also points out that an increase in HIV prevalence in individuals older than 35 years may be an indication that AIDS-related mortality decreases and younger HIV-infected people move into the older age groups. With the introduction of the ARV programme, there is bound to be a lower AIDS proportionate mortality ratio and the number of people living with HIV/AIDS will increase even if there is a reduction in incidence. This scenario in itself is a challenge because there will be a large demand for counselling, as well as for therapy (National AIDS Coordinating Agency 2003:51). The report also notes that the continuous high infection rates in young persons, and particularly in young women, points to the fact that greater efforts are needed to reach young people, with behavioural change messages encouraging them to delay sexual activity and promoting safer sex. Such programmes need to be specifically designed for young women who seem to be targeted by older men of better economic standing, making them vulnerable to engaging in unprotected sex. Unfortunately, the report omits to suggest that programmes should be designed to address those same men who are engaging in such relationships.

Several authors have attempted to explain why Botswana has reached such high HIV infection rates (see, for example, Stegling, 2000). It has become evident that any answer to this question needs to be multi-dimensional, taking into account the demographic, social, economic and political situation of Botswana. One explanation for the high infection rates is the small, but highly mobile, population of Botswana. Many people, even today, have several homes: one in the urban or rural village or town, one on the lands where arable agriculture is pursued, and one on the cattle post where cattle are raised. With the increasing development of physical infrastructure, travelling has become easy and has taken the virus into rural areas (Zaffiro, 1994:84). Another important contextual aspect of the epidemic is the high rate of poverty and income inequality in Botswana. Despite the fact that Botswana is a middle income country, many of the economic indicators paint a picture of serious inequality. In 1993, it was estimated that 47 per cent of the population lived below the poverty line, with 30 per cent of the population living in extreme poverty. While the percentage of people living in poverty has reduced since then, with an estimation of 36.7 per cent below the poverty line in 2002, this still translates into more than a third of Botswana's population being poor (Government of Botswana & UNDP, 2004:21). Furthermore, Botswana has often been cited as an example of extreme income disparity; for example, in 1996 the

income inequality index suggested that the top 20 per cent income category in Botswana earned 47 times more than the lowest 20 per cent income category (Hope, 1996:62). It may, therefore, be argued that the specific context of poverty had a great impact on the rapid spread of the epidemic in Botswana. In addition to the small, highly mobile population and the high degree of poverty and income disparity, one needs to consider gender inequality and high rates of violence against women when considering the extent of the epidemic:

Botswana is a patriarchal society. Therefore, women are *a priori* subordinate to men and have historically endured various forms of discrimination and disempowerment on account of their being women, e.g. in access to and control of resources such as land, cattle, power, education and business opportunities (Ministry of Finance and Development Planning & UN Botswana 2004:39).

Unfortunately, no nationally co-ordinated reports are available covering violence against women but accounts from individual police stations and civil society indicate that rape cases and common assault cases against women are on the increase. All of these contextual explanations, however, only partly provide answers to questions concerning the high incidence and rapid spread of HIV and this may well be an area requiring further analysis.

## The response

Initially the epidemic was understood as a health problem and the first short-term plan to respond to this problem was drawn up in 1987 with the help of the World Health Organization. This first plan of action was soon followed by two medium term plans (MTP I 1989 to 1993 and MTP II 1997 to 2002). The second medium term plan, in particular, established a new thinking with regard to the epidemic. It was now acknowledged that the response to HIV in Botswana required a multi-sectoral approach, involving all major government departments, the business sector and civil society. The plan established new administrative structures and called for the development of a National AIDS Coordinating Agency (NACA) to oversee the implementation of all AIDS programmes, co-ordinate efforts and establish the secretariat for the National AIDS Council, chaired by the Head of State and co-chaired by the Minister of Health. Again, the National AIDS Council was envisaged as multi-sectoral, bringing together permanent secretaries of all major ministries and heads of agencies of civil society and the private sector. While the representation at the level of the National AIDS Council has developed

over time, the multi-sectoral nature of the council remains. Changes include, for example, the establishment of an Ethics, Law and Human Rights sector in 2002 which advises the council on how to apply a human rights approach to the epidemic.

The second medium term plan also outlines how the multi-sectoral idea would be translated at district and at village level. District multi-sectoral AIDS committees, chaired by the District Commissioners, were set up and many villages created AIDS committees at community level (Ministry of Health: AIDS/STD Unit, 1997:66-67). The committees at district level have been strengthened over the years and all districts now have District AIDS Co-ordinators to oversee activities. At the time of implementing the MTP II, the two goals were to reduce the infection rates in Botswana, on the one hand, and on the other hand to mitigate the impact that HIV and AIDS has at all levels of society. These objectives have not changed with the new National Strategic Plan that provides a national guide to the response for 2003 to 2009. This framework is based on extensive national consultation with many communities, district officials, civil society organisations and development partners. The development of the framework started with the evaluation of the second Medium Term Plan which identified many weaknesses in the response. For example, while the medium term plan had indicated responsibilities and activities, it was not entirely clear how the necessary human and administrative capacity would be built. There was also growing evidence that many of the communication strategies were too general and not targeting specific social or ethnic groups. This resulted in a lack of understanding of the epidemic and of the programmes that have been created to assist communities (National AIDS Coordinating Agency, Ministry of State President, 2003:21).

While the recently finalised National Strategic Framework outlined above is an attempt to position the response to HIV within the wider social and political context of Botswana, there is also the Vision 2016 programme. Based on the principles of democracy, development, self-reliance and unity, it states that by the year 2016 the negative impact of the HIV epidemic in Botswana will have been reversed (Vision 2016:71). Unlike all the other plans for the national response to HIV, the National Strategic Framework is linked to the National Development Plan which guides parliament in governing and developing the country, and acknowledges that there has been a shift in how Botswana society, and government in particular, will respond to HIV:

This shift is derived from the fact that time is running out and that what is needed to avert a national catastrophe is concerted, deliberate, and well-targeted action. The National HIV/AIDS Strategic Framework 2003-

2009 begins to deal with the HIV/AIDS epidemic as the national disaster and emergency that it truly is and outlines a direction for action that may appear to be radically ambitious (National AIDS Coordinating Agency, Ministry of State President, 2003:22).

The framework is based on five goals that cover prevention; treatment and care; psycho-social and economic impact mitigation; management of the national response; and the strengthening of the legal and ethical environment. In summary, the framework understands HIV and AIDS to be a development issue with structural problems such as poverty and gender inequalities being partly responsible for high infection rates and, at the same time, worsening the impact of HIV and AIDS at community and individual level. In the following paragraphs, a brief discussion of the main programmes will be provided. However, this discussion is by no means exhaustive but rather attempts to give a general overview of the services that are offered on the ground.

## **‘Know your status’: the role of HIV testing in the Botswana response**

A large part of the Botswana response has been public education and behavioural change messages about HIV/AIDS. These public education programmes have undeniably been weak in reaching the diverse populations and social groups of Botswana. Most messages centre around either the theme of ABC (abstain, be faithful and condomise) or encourage people to access services provided to the public such as HIV testing, prevention-of-mother-to-child-transmission (PMTCT) programmes and antiretroviral therapy. Condoms are provided free of charge through government agencies (both male and female condoms, although distribution of the latter is at a lower rate) and through the social marketing of Lovers Plus condoms by Population Services International. The promotion of HIV testing has been a priority for many years and has been mainly promoted through the Tebelopele Voluntary Testing and Counselling Centres, which use the slogan ‘Make a new start today – know your status’. There are currently 16 such centres where clients get to know their status confidentially through the use of rapid test kits, allowing for same-day test results. In addition to the centres, the same services are provided in mobile caravans that reach the remote areas of Botswana. In 2003, voluntary testing services provided through Tebelopele saw a 41 per cent increase with more than 51 795 people tested (Tebelopele, 2004:17). While other factors, such as



better social marketing and easier access to more facilities may be responsible for the greater number of people willing to test, it seems likely that more people come forward for testing due to the increased availability of antiretroviral medication in the public sector. With the higher uptake of testing services, prevalence rates in the centres increased, with 44.7 per cent of women testing positive in 2003 as compared to 29.3 per cent in 2000. Of the men, 36.7 per cent tested positive in 2003 as compared to 20.1 per cent in 2000. This increase in prevalence rate may also be directly linked to clients wanting to establish their status in order to benefit from the public ARV programme (Tebelopele, 2004:29).

In 2003, the Ministry of Health and several of the international key players in Botswana started discussions about the introduction of routine HIV testing. The primary motivation for this was that too many people in Botswana did not know their HIV status and therefore did not access available programmes that provided support and care for people infected with HIV. Doctors on the public ARV programme argued that too many people presented themselves too late to the ARV programme, causing delays in the start of treatment and costing the public health system too much time and too many resources that could otherwise be spent in allowing more patients to enrol in the ARV programme. The heated public debate that ensued about the issue indicated that what seemed to be at stake was not a 'normalising' of HIV tests as one of the essential medical tests to be carried out in any health facility, but rather a call by health providers to coerce patients into testing. Initially, rights activists, lawyers and many health care providers understood the call by the Ministry of Health to be about the routine offer of an HIV test for patients who either presented with signs and symptoms of HIV infection or who narrated risky behaviour to the health professional. It was widely understood that such routine offers for HIV testing were already being made in public and private health facilities and they learned with shock that this was apparently not the case. At a public seminar, organised by civil society in September 2003, it was decided that routine HIV testing should be carried out after the patient has expressly consented to such a test (Botswana Lawyers Task Force on HIV/AIDS, 2003). This recommendation was brought to the National AIDS Council which endorsed it as part of a package that included adequate public education, the use of rapid tests and sensitisation of health care providers. Unfortunately, these recommendations have been implemented reluctantly, with the Ministry of Health referring in their educational materials and policy to 'implied consent'; an 'opt-out approach'; and 'routine HIV testing means making an HIV test an integral part of the clinical services provided at the health facilities. It implies a default (opt-out) policy of HIV testing' (National AIDS

Coordinating Agency, 2004:6). It still appears unclear to many why it is so difficult for health professionals to engage in meaningful conversation with their patients in order to obtain their consent to an HIV test. The attitude displayed during the public debate about routine testing, which in many ways seemed to suggest compulsory testing, implies that doctors in public health facilities do not understand their patients to be rights-bearers and intelligent people who can make informed choices with regard to their own health. Botswana human rights activists, on the other hand, point out that testing a person without their expressed consent is an abrogation of their basic rights (Botswana Lawyers Task Force on HIV/AIDS, 2003:9).

## Orphans, vulnerable children and home-based care

At the household level, the most noticeable changes over the last few years have been the growing number of orphaned and vulnerable children and the increasing number of patients that are taken care of at home. The government early on made a decision to address both these groups in a similar manner; through the provision of basic welfare services and material support at the family level. There is, however, no agreement about the estimated numbers of orphans in Botswana, since government and UN agencies are working on different statistical assumptions, and estimates vary between 65 000 and 85 000 children having either lost one parent (single parent) or two parents (married parents) to AIDS. The relevant government agency has about 43 000 children registered who are in need of social and material support; this usually comprises a food basket, school uniform and personal clothing. In a recent study of orphans and vulnerable children it was found that most of these children live in large households which in many cases are completely dependent on provisions made by government (Department of Social Services, 2003:xv). Civil society is probably most prominent in the area of service provision for orphans and vulnerable children, with many community-based organisations running day-care centres with after-school activities. Many of these centres run feeding programmes to provide extra nutrition to needy children, in addition to the food that the government provides to all children in public schools, and through food baskets for registered orphans. From the same report it becomes evident that there is, as in so many other areas, a lack of a legal framework to guide the support of vulnerable children (Department of Social Services, 2003:78).

The Convention on the Rights of the Child states that the guiding principle with regard to the health care of children is that the 'best interests of the child must be the primary consideration.' The government, however, has thus far failed to translate its

many good policies into enforceable legislation that would empower service providers to act in the best interests of the child in cases of neglect and abuse. With the increasing number of children on antiretroviral medication, there is a need to review and amend existing legislative provisions to broaden the scope of options available to service providers, particularly in cases where parents prevent the child from receiving life-prolonging medication. It is generally believed that in the majority of cases the best interests of children are served by keeping them in the family environment. Providing parents with the necessary information and counselling with regard to the advantages of ARV therapy should thus be the first approach in discussing appropriate treatment options with parents. Unfortunately, there may be extreme cases in which health care and social service providers may need to remove children from parents who abuse or neglect them. There is presently no provision made by government to remove children from families for their own protection, and there are no shelters for abused and neglected children in the country (Botswana Network on Ethics, Law and HIV/AIDS, 2004 (a)).

As already explained, a policy decision was made in the mid-1990s to divert chronically ill patients from hospitals to a government-supported community home-based care system within the extended family. This system is still in place, connecting community volunteers, district health care workers, families and patients. Government provides for nutritional support, and necessities such as protective materials, bedpans and volunteer allowances. While this system has its merits, it also poses major challenges to poor families and women in particular. As Stegling explains, 'Even though government publications do acknowledge the importance of tackling poverty as part of their home-based care programme, it seems questionable whether this is realistic in a crisis situation when government efforts in the last two decades have not been able to turn the situation around' (2000:13). The increasing availability of antiretroviral drugs will pose new challenges to the home-based care programme. Many patients will be returning to good health but may not be able to find employment that will enable them to take care of their nutritional and material needs, and this situation will present an additional challenge for government and civil society.

## ARV treatment programme

Botswana can rightly claim credit as the first African country to offer antiretrovirals in the public health system (Carroll, 2004), and was the first African government to make the bold decision to provide Highly Active Anti-Retroviral Therapy (HAART) free of charge to all its citizens. At present, it has arguably the greatest number of people

being treated with such medicines on the continent.<sup>1</sup> While there is some speculation as to the reasons for government taking the decision to provide such treatment,<sup>2</sup> the fact is that treatment is being provided, unlike a number of other countries in the region. It must also be noted, of course, that Botswana is in an economic position to undertake such an ambitious project and the population to be treated is comparatively small.<sup>3</sup>

The national treatment programme was preceded by the first national PMTCT programme in Africa, established in 1999. It has been available in all districts of Botswana since 2001, offering a short course of AZT for both mother and infant, and since 2003 a single dose of nevirapine during labour. The programme also provides infant formula for all infants free of charge for 12 months after birth (Creek *et al*, 2004:1). There has been a low up-take by women of about 39 per cent (of women who are eligible, that is to say women who agreed to an HIV test and tested positive, enrolling in the programme in June 2003 (Ntumy, 2003:2)). While there may be many reasons for non-participation in the programme, it seems likely that the stigma attached to HIV is still one of the main barriers. There is, however, growing evidence that more women are willing to participate in the programme where there is the opportunity to be referred to the public ARV programme. In a recent study on the PMTCT programme in the north of Botswana, 76 per cent of the women who agreed to be tested for HIV, possibly to enter the prevention programme, reported that the significant factor influencing their choice to test was the fact that they knew a person on antiretroviral medication (Creek *et al*, 2004:8). While women in this particular study reported that their partners and families were supportive, in many discussions at community level people lament the lack of community participation in such programmes and the specific lack of male involvement.

The idea of a public treatment programme took shape in 2001 when the Ministry of Health undertook consultations with international experts and health economists to reach a better understanding of how best to implement such a programme. The McKinsey Report established that, by using an eligibility criteria of a CD4 cell count of less than

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<sup>1</sup> As at June 2004, there were 24 087 people on antiretroviral treatment in Botswana, of whom approximately 6 000 were being treated in the private sector (National AIDS Coordinating Agency, 2004:10).

<sup>2</sup> Mr P. Mazonde, Director of Health Services, explained it thus: 'The Government policy to make antiretroviral drugs available to her citizens, despite their enormous cost, is a clear demonstration that Botswana is a caring and compassionate society'.

<sup>3</sup> Eleven per cent (or BWP 415 million) of the total development budget was allocated to the national HIV/AIDS programme, and a similar amount allocated to the Ministry of Health for the financial year 2004-2005 (Mr B. Gaolathe, Minister of Finance and Development Planning, Budget Speech 2004).

200 or the existence of an AIDS-defining illness, about 110 000 people of the estimated 300 000 people with HIV infection would need treatment. The report outlined a plan to introduce a public treatment programme and preparations commenced to establish the necessary infrastructure. During many consultative meetings with stakeholders it became evident that the physical infrastructure would always be lacking, but that the urgent need required that the programme commence, and that infrastructure and human capacity be developed concurrently.

Named MASA, the Setswana word for 'new dawn', the new programme hoped to influence the perceptions of HIV and AIDS in Botswana. Providing antiretroviral therapy establishes a whole new social and economic context for people living with HIV since it allows for a productive life, averts premature death and prevents opportunistic infections. However, it was evident from the start that strict selection criteria were needed to maximise equitable access in a resource-poor context such as Botswana. Guidelines allowed for those adults with a CD4 cell count of less than 200 or AIDS-defining illnesses (stage IV AIDS as defined by the World Health Organisation) are eligible to commence the programme. Those patients with CD4 cell counts between 200 and 400 are to be monitored at three-monthly intervals in order to establish the point of entry into the treatment programme. All patients with CD4 counts above 400 are to be monitored on a six-monthly basis. In addition to these eligibility criteria, specific criteria were established for the treatment of children. The Ministry of Health considered several issues when deciding about the medication regimens for the national programme. Firstly, considering cost and toxicity, it was determined that first and second line regimen should be non-protease inhibitor-containing. Furthermore, in view of increasing adherence to these drugs, it was decided that regimens needed to be of a low pill load and simple to administer – for example, two pill intakes per day (Ministry of Health, 2002:12). Three regimens were selected for the Botswana programme with all drugs being brand-name drugs and no generic medication being used. Additional policies and structures were put in place to cover post-exposure prophylaxis (PEP). This intervention is mainly aimed at occupational exposure by health professionals and exposure through sexual violence such as rape and child molestation. In all these cases, health facilities should provide a course of Zidovudine (AZT) and Lamivudine (3TC) as soon as possible after the exposure has occurred. These interventions are accompanied by the necessary provisions for HIV testing and counselling to allow for adequate risk assessment and decision-making (Ministry of Health, 2002:36-39). Unfortunately, no comprehensive evaluation of this intervention has taken place to date to establish how accessible these services are to the public.

The national ARV programme started in January 2002 with the introduction of treatment in referral hospitals in Gaborone in the south and Francistown in the north, and at two district hospitals in Maun and Serowe. As of June 2004, 17 sites were operational but the roll-out plan ambitiously envisages 32 operational sites by the end of 2004. Provision of services is modelled on the idea that the programme should be operating as an extension of the general outpatient clinics, ideally as a fully integrated part of the hospital and clinic services. To train health care providers in the administration of ARV treatment, a specialised programme was established – KITSO (Knowledge, Innovation, and Training Shall Overcome AIDS; *kitso* is also the Setswana word for knowledge (Ndwapi, 2004a). Recently, the Bayers Children's Centre of Excellence at Princess Marina Hospital in Gaborone started a specialised programme to train health care workers in paediatric HIV care. Such training will allow doctors and nurses to start treating HIV-infected children at district hospitals, hopefully resulting in an increasing number of children on antiretroviral therapy. It is estimated that about 2 400 children are presently on treatment, most of them either in the private sector or at the Bayers Centre in Gaborone.

The Infectious Diseases Care Clinic in Gaborone is arguably the largest HAART clinic in Africa with an enrolment of 8 600 in April 2004. This clinic, situated in the country's main referral hospital, the Princess Marina, and including a good reference laboratory, deals with more patients than any other sites. It reports that the CD4 cell counts of patients increased by about 200 at 48 weeks of treatment, and 85 per cent of patients had undetectable viral loads. Doctors reported an average weight gain of 4,6 kg to an average weight of 60 kg at 48 weeks. Only 10 per cent of patients have been reported lost to follow-up and the mortality rate in the programme stands at about 10 per cent, with chances of long-term survival increasing in line with higher CD4 cell counts at the start of treatment (Ndwapi, 2004a:6). The programme has reported very good adherence of about 85 per cent (Ndwapi, 2004b:4) which may, however, be linked to the fact that many patients enter the treatment programme at an advanced stage of the disease progression, which will naturally have a positive impact on adherence. It needs to be recognised, though, that all the data for the programme is currently produced by the programme itself and no external evaluation has been carried out to objectively assess it. Any discussion about the positive outcomes may therefore be biased in favour of the programme. The programme acknowledges that adherence may become a challenge with time and encourages a 'buddy' system in which every patient has a partner who assists with the regular intake of medicines and attendance of check-up visits. It seems clear that there is a lack of treatment literacy and the involvement of NGOs in the

provision of services is low. Both these areas need to be addressed urgently with government allowing and facilitating civil society, including organisations of People Living with HIV/AIDS, to take on greater responsibilities in rolling out the ARV programme.

Several challenges have been noted with regard to the programme. The most obvious one is the escalating demand for therapy, with many of the people already on therapy encouraging others to be tested and seek assistance if necessary. Due to the pressures on the system, those who are the most ill are given priority which places relatively healthy patients at the end of the queue, eventually resulting in them only being assisted once they are either ill or have a severely depressed immune system. Some health practitioners are therefore suggesting that queues should be split in order to minimise time and resources spent on each patient. It is this late enrolment in the programme that initially led to the calls for routine testing as described above. There are also calls for a 'demystifying' of ARV therapy and making it a regular primary healthcare initiative, using a variety of health care professionals such as nurse practitioners and pharmacy technicians to respond to the severe human resource shortages that Botswana currently experiences (Ndwapi, 2004a:14). The government is currently considering a private-public partnership, utilising private practitioners at a previously negotiated reduced cost to roll out the programme faster. The Ministry of Health commissioned research into such a model earlier this year which is currently being considered by the Ministry of Finance with regard to the financial implications. Furthermore, there has been no transparent discussion as yet with regard to the long-term sustainability of the programme. Any discussion about sustainability needs to make reference to all the programme costs, including prices of medicines, tests (such as viral load and CD4 cell counts) and staff costs. In addition, the many logistical bottlenecks such as the existing often tedious referral system and the enormous demand for treatment need to be urgently addressed in order for the programme to run in a sustainable manner.

## **Are we winning? Could Botswana be a model for SADC?**

Previous sections have highlighted the ways in which Botswana has responded to the HIV epidemic. Much of that response has been led by the government and the author has attempted to explain this heavy government involvement by understanding Botswana as a developmental state. However, it may also be argued that by guiding and implementing the national programme in a top-down approach, activism at the grassroots

was given little room to develop. Molutsi and Badade remark that ‘... the approach has been top-down, bureaucratic, and patronising to the majority of the population, which has been perceived as ignorant, needy, and deserving of urgent assistance. The society, as in the past, has been passive and withdrawn in some respects’ (Molutsi & Badade, 1999:143). This approach by government, in turn, seems to have translated into an artificial dichotomy between the private and the public spheres by desexualising HIV through its public discussion. This is to say that while many programmes are run at government level, within government ministries, public and private workplaces and at public community gatherings such as the *kgotla*, messages about HIV do not seem to have been internalised, resulting in a lack of personal understanding of the epidemic. In fact, there is evidence that HIV is still the disease of ‘the other’. For many communities around the world HIV has been a disease of ‘the other’; the foreigner, the homosexual or the injecting drug-user (Daniel, 1993:34). In Botswana, this ‘other’ is not specified but is understood to be any other person but oneself or any other family but one’s own. There is also a strong notion that this ‘other’ is a promiscuous other. In a recent study on stigma in Botswana, community members believed that HIV/AIDS is a disease that could attack others but not themselves. Furthermore, they still referred to HIV/AIDS as the ‘radio disease’, implying that they hear about HIV on the radio but that they had not seen HIV or AIDS themselves (Muchiru *et al*, 2004:34-37). The same study indicates that strong moral judgments are still attached to HIV, with many respondents noting that promiscuity is the main reason for people becoming infected. It is a concern that so many years into the epidemic the study still identifies that many health care providers are misinformed about HIV. Almost half of the nurses interviewed for the study reported that they were fearful of contracting HIV by handling patients, a fear that may influence the poor way some nurses are treating patients. It is, therefore, not surprising that 68 per cent of the people living with HIV/AIDS who were interviewed for the same study reported that they had been stigmatised by health care workers (Muchiru *et al*, 2004:35).

It is unfortunate that such reports about stigma and the constant public debate about stigma and discrimination have not been translated into a severe sanctioning of discrimination. Late last year the Court of Appeal and the Industrial Court noted the apparent and problematic lack of legislation to protect HIV-infected workers at the workplace. In two cases that were heard in the Industrial Court, one of which was later addressed by the Court of Appeal, judges pointed to the lack of legislation to uphold government policy which discourages pre-employment HIV testing. It is of great concern that employers are allowed to screen prospective employees and deny work opportunities to HIV-positive employees (Botswana Network on Ethics, Law and HIV/AIDS 2004b:3-



4). An added factor is that the number of healthy HIV-positive people able to participate in the employment sector will be steadily increasing as more people are treated with antiretroviral medicines, and it is important to ensure that such HIV-positive workers are protected from discrimination.

Sustained advocacy around the implementation of a human rights-based approach to HIV has had some success, such as provisions in the national framework on HIV/AIDS and the establishment of a particular sector to oversee implementation of such an approach at the level of the National AIDS Council. However, this commitment has not translated into a real understanding of what such an approach may mean in practice, and neither has it led to the creation of an adequate legal framework. As Dingake points out: 'Careful and informed debate can guide the formulation of the appropriate legal regime that can govern issues of HIV/AIDS. It is important that an appropriate legal framework be devised which can be used to protect and support people who are HIV-positive and those who are not' (Dingake, 2000:68). There may be a real opportunity ahead with the Global Fund recently providing funding for a legislative review which will hopefully identify gaps and propose appropriate legislation. Any such legislation must be preceded by a policy formulation process which may be highly politicised, and possibly ill-informed. The policy debate on routine testing indicated a level of ignorance, where the individual right to autonomy and the right to full and informed consent was interpreted as a luxury that had no place in Botswana's public health facilities.

That debates around HIV policies and programmes are highly politicised is undeniable. For example, a policy decision was made that the treatment programme will be available to citizens only; this is problematic, given that a high proportion of people in the public sector are foreigners recruited by government after independence to address the skills shortage. Many of the health professionals themselves are from outside the country, and these 'residents' have access to all the public health services except for the treatment programme. Considering the high rate of interaction between citizens and foreigners and the many cross-national marriages, this policy was definitely not based on public health considerations but on political considerations. In the case of the PMTCT programme, it has led to the fact that only those mothers who will be giving birth to future citizens, either because the mother is married to a citizen or because she is a citizen herself, will be receiving treatment on the programme (Ntumy, 2003:3). While the political nature of many of the policy decisions has been apparent for some time these have never been portrayed as openly as during the ongoing campaign by the ruling Botswana Democratic Party for this year's general elections. The party is currently

advertising itself with a well-known person living with HIV on one of its campaign posters with the slogan 'Free HIV/AIDS drugs. But please protect yourself. Vote BDP.' (Chwaane, 2004:5). Many people have voiced concerns about the ruling party making political mileage out of a catastrophic national situation and utilising the benefits of a programme that is funded from the national coffers and not through a particular party. As a member of the opposition notes: 'This is political naivety and insensitive to the nation's HIV/AIDS plight and it undermines national efforts and divides the nation on a bi-partisan issue' (Saleshando, 2004).

This article has made an attempt to discuss the many valuable national initiatives that have made the Botswana programme as successful as it is today. However, there remain many shortcomings and gaps that need to be addressed. There has been a real reluctance to foster open and critical discussion about the programme, as if the acknowledgement of failures would suggest that all our efforts have been in vain. There is a need for frank discussion of pertinent issues such as how to make the national treatment programme more sustainable. Are there opportunities for Botswana to use generic drugs and could these be produced in the region and for the region? How can we create meaningful and honest partnerships between government and civil society? Who determines the national agenda – government, the public, development partners, or civil society? And, finally, what does it take to implement a human rights approach to HIV – and is Botswana ready to embrace such an approach? Seeking answers to these questions and evaluating the existing programmes will bring us a step closer to finding the right model for the SADC region, while acknowledging that each country will have to respond to HIV within its own socio-economic and political context.

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