HIV and AIDS Related Stigma and Discrimination in Botswana

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JAPAN

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KIT (Royal Tropical Institute)
Development Policy & Practice/
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HIV and AIDS Related Stigma and Discrimination

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Master of Public Health

By

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Abstract

HIV/AIDS has been the most serious problem in Botswana since the epidemic emerged in 1985. Since then, the Government and its donors have implemented various interventions to combat the epidemic. However, the national HIV prevalence rate was still very high, 17.6% in 2008 (CSO, 2009). Stigma & discrimination is regarded one of the determinants which tends to drive to the spread of the epidemic in Botswana because they militate against prevention and care efforts of the epidemic.

The main objective of this thesis is to identify manifestations, determinants and impacts of HIV/AIDS related stigma & discrimination in Botswana, and to review the interventions domestically and internationally in order to explore the relevant and effective interventions in reducing stigma & discrimination in Botswana. In this descriptive exploratory study, literature review is used.

Stigma & discrimination on HIV/AIDS is a complicated and multifaceted phenomenon, so that they can occur everywhere such as in the family, the community, the school, the workplace and health care settings in Botswana.

HIV/AIDS related stigma & discrimination are rooted in the fear of contagion resulting from lack of in-depth knowledge on HIV/AIDS, negative attitudes towards PLHIV resulting from the linkage between HIV/AIDS and social taboos such as men who have sex with men (MSM) and sex workers, and lack of anti-discriminatory law which can protect PLHIV and the marginalized groups.

The impact of HIV/AIDS related stigma & discrimination is not only a barrier in responding to the HIV/AIDS epidemic, but also it is a tremendous blow to economy in Botswana. Because of fear for stigma & discrimination, people are reluctant to take HIV testing, disclose their HIV status to others, and seek treatment for HIV/AIDS. Furthermore HIV/AIDS related stigma & discrimination affect household finances in Botswana society.

In Botswana, scaling up of treatment and care has already been implemented in Botswana and made a big achievement. The coverage of ART and PMTCT is very high, which can reduce stigma & discrimination. Also the introduction of routine HIV testing (RHT) has made a positive effect for the reduction of stigma & discrimination.

Recommendations have been made for effective interventions including the provision of Promoting HIV/AIDS knowledge and awareness, empowerment of PLHIV and the marginalized groups, greater involvement of PLHIV, legal reform, scaling up of treatment and care, and the improvement of future research.

Key words used: HIV, AIDS, Stigma, Discrimination and Botswana

List of abbreviations

ACER	Antiretroviral community education and referral
ACHAP	The African Comprehensive HIV/AIDS Partnerships
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
BAIS	Botswana AIDS Impact Survey
BCC	Behaviour Change Communication
BCI	Behavioural Change Intervention
BFTU	Botswana Federation of Trade Unions
BNPHA	Botswana National Policy on HIV/AIDS
BONELA	Botswana Network on Ethics, Laws and HIV/AIDS
BONEPWA	Botswana Network of People Living with HIV/AIDS
CBO	Community Based Organization
CEYOHO	The Centre for Youth of Hope
CHBC	Community Home-Based Care
CSO	Central Statistic Office
DFID	Department for International Development
DMSAC	District Multi-Sectoral AIDS Committee
FBO	Faith Based Organization
FHI	Family Health International
FSW	Female Sex Worker
GDP	Gross Domestic Product
GIPA	Greater Involvement of people living with or affected by HIV/AIDS
HIV	Human Immunodeficiency Virus
ICRW	International Centre for Research on Women
IEC	Information, Education and Communication
IGA	Income Generating Activity
ILO	International Labour Organization
LRR	Labour Relations Regulations
MLG	Ministry of Local Government
MLH	Ministry of Labour & Home Affairs Policy
MOH	Ministry of Health
MSM	Men Who Have Sex with Men
MSW	Male Sex Workers
NACA	National AIDS Coordinating Agency
NDF	Namibia Defense Force
NGO	Non Governmental Organization
NSF	National Strategic Framework
OSI	Open Society Institute
PHR	Physicians for Human Rights
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RHT	Routine HIV Test
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWEAT	Sex Worker Education and Advocacy Taskforce
TCB	Teacher capacity Building Programme
UNAIDS	United Nations Joint Programme on AIDS
UNDP	United Nations Development Programme

UNFPA	United Nations Populations Fund
UNGASS	United Nations General Assembly Special Session on AIDS
UNICEF	United Nations International Children's Emergency Fund
UNV	United Nations Volunteer
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Introduction

Stigma is defined as "a process of devaluation of people either living with or associated with HIV/AIDS". Discrimination follows stigma and is the unfair and unjust treatment of those based on their perceived HIV status.

In Botswana, HIV/AIDS has been a major public health challenge since the first case of HIV infection was reported in 1985. The Government of Botswana has estimated that the number of PLHIV is 350,000 in 2008 (NACA, 2008). The national prevalence rate of HIV/AIDS was 17.6% (CSO, 2009), which is the second highest in the world followed by Swaziland (UNAIDS, 2007). Stigma & discrimination is one of factors causing the spread of the epidemic in Botswana because they militate against prevention and care efforts of the epidemic in Botswana. The Government has implemented many interventions to combat the HIV/AIDS epidemic, which of them are targeting the reduction of stigma through policy reforms, media campaign, HIV/AIDS care, support and treatment, and empowerment of PLHIV and the marginalized groups. However, HIV/AIDS related stigma & discrimination are still there in Botswana.

This thesis tries to identify the effective interventions for the reduction of HIV/AIDS related stigma & discrimination in Botswana. In this thesis, Chapter 1 provides general background information on Botswana. Chapter 2 gives the problem statement, objectives and methodology of this thesis. Chapter 3 explores the manifestations and determinants of HIV/AIDS related stigma & discriminations in Botswana. Chapter 4 identifies the impacts of HIV/AIDS related stigma & discrimination in Botswana. Chapter 5 reviews interventions implemented domestically and internationally for the reduction of HIV/AIDS related stigma & discrimination. Chapter 6 discusses how these interventions relate to the determinants as well as which interventions might be useful for Botswana, and provides conclusion and recommendations for the interventions to reduce HIV/AIDS related stigma & discrimination.

It is absolutely essential to continue to tackle HIV/AIDS related stigma & discrimination and also to pay more attention to them, because stigma & discrimination hamper the response to the HIV/AIDS epidemic. The author used to work for Ministry of Local Government (MLG) in Botswana and was engaged in the project focused on capacity development of NGOs, CBOs and support groups in the communities. During this work, he could feel stigma & discrimination in community and self-stigmatized among PLHIV and wanted to explore and identify this issue. He hopes that it will make some contribution to improve interventions of HIV/AIDS and stigma & discrimination in Botswana.

Chapter 1 Background Information on Botswana

1.1-General Background

1.1.1-Geography

Botswana is a landlocked country situated in Southern Africa. It shares border with Zimbabwe in the north-east, South Africa in the east and south, and Namibia in the west and north, Zambia in the north. The country's total land area is 600,370 km^2 (World Bank, 2009). The climate ranges from semi-arid to sub-tropical.

1.1.2- Demographic

The total population of Botswana was estimated at 1,773,240 in 2007. The annual population growth rate for 2000-2005 is 0.85%, with the projected population for the year 2015 at 1,926,872 (CSO, 2007). Age distribution shows that 35.4% of the population is below the age of 15 years, 59.5% is aged between 15-64 years and 5.3% above 64 years. The majority (59.6%) of Botswana population are living in cities/towns and urban villages. The share of rural population is 40.4%. The crude birth rate per 1,000 population is 29.7, and the crude death rate per 1,000 is 11.2 (NACA, 2008).

1.1.3- Political situation

Botswana has been a multiparty parliamentary democracy since independence in 1966. The Botswana Democratic Party (BDP) has been in power since 1966 and elections are held in every 5 years (Government of Botswana, 2009).

1.1.4- Economic situation

Table 1 Basic economic facts

Indicators	Rate/Figure	Sources	Year
Gross domestic products (GDP)	US$13.2 billion	World Bank	2007
GDP per capita	US$7,183	World bank	2007
GDP growth	6.9%	Botswana	2007
Inflation	7.1%	Botswana	2007
Inequality in income or expenditure	6.05	UNDP	2007

Botswana Economy has been sustained by diamonds, which account for 30% of GDP, beef exports, and tourism. Botswana has had one of the fastest growing economies in the world over last 30 years. Diamonds, however, are a finite resource, and the need for economic diversification is one of the economic challenges the country faces (Government of Botswana, 2009).

1.1.5- Gender

In Botswana history, women have been regarded as subordinates of men within Tswana customary law. According to this law, women are subject to the guardianship throughout their life. Inequality between men and women manifests in unequal employment opportunities, unequal access to wealth, unfair division of labour in the household and unequal power relations. Economically, women are dependent on marriage and relationships with men to

gain economic resources. Women have knowledge on HIV/AIDS. However this knowledge is not used because of their powerless status in sexual making-decisions (Ntseane, 2005). Also, access to quality health services and drugs for women is relatively limited, because of their economical capacity (Phaladze & Tlou, 2006). Also, because of the advent of HIV/AIDS, women are likely to quit their employment to care for sick family members or relatives. This causes reducing their income generating capacity (Phaladze & Tlou, 2006).

1.2- Health

1.2.1- Health system

Botswana had three national referral hospitals and one private referral hospitals, 14 district hospitals, 17 primary hospitals, 257 clinics and 810 mobile stops in 2006 (MOH, 2003).The Government devoted 6.4% of its gross domestic product (GDP)[1] to health care services in 2007 (UNDP, 2008). Eighty-four percent of population lives within 5 km radius from the nearest health facilities at national level, 11% of population between 5 to 8 km radiuses. It means totally 95% of the population lives within 8 km radius of any health facilities (CSO, 2007). Under MLG, there are District Multi-Sectoral AIDS Committees (DMSACs), which are the forces of planning, coordination, and monitoring to fight against HIV/AIDS at the district level. DMSACs have been established all over the country and number 27 in all.

1.2.2- Health status

In the last three decades, Botswana has gradually improved on its health status except for HIV/AIDS situation. The crude birth rate per 1,000 declined from 39.3 in 1991 to 25 in 2007. However, due to the advent of the HIV/AIDS epidemic, many of these good accomplishments have been reversed. The crude death rate per 1,000 increased from 11.5 in 1991 to 15 in 2007. Life expectancy also decreased from 65 years in 1991 to 50 years in 2007 (CSO, 2007). The prevalence and incidence of non-communicable diseases also are on the increase. There has been a significant upward trend in cardiovascular diseases over the last two decades. Also, diabetes and cancers have increased.

1.2.3- Health care services

The Government of Botswana provides approximately 90% of health services and the private clinics run by mines companies or private practitioners making up the rest of providers. The ministry of Health and Local Government administrate health services in Botswana. The ministry of Local Government (MLG) delivers primary care services, while the ministry of Health (MOH) provides secondary and tertiary care (CSO, 2007).

The Government has initiatives in collaboration with many partnerships such as the African Comprehensive HIV/AIDS partnerships (ACHAP), having built clinics, scaled up laboratories and trained health workers (WHO, 2004). Also, there are some networking bodies organized to serve as an umbrella for NGOs, CBOs, FBOs and support groups. The Botswana Network of People Living with HIV/AIDS (BONEPWA) is a network of PLHIV, supporting PLHIV and providing care for PLHIV to make them live positively (BONEPWA, 2006). The Botswana Network on Ethics, Law and AIDS (BONELA) is mainly working for the protection of rights of PLHIV (BONELA, 2007).

1.3- HIV epidemic in Botswana

Botswana has developed the second highest prevalence of HIV/AIDS infection, followed by Swaziland since the first case of HIV infection was detected in Gaborone in 1985 (WHO,

[1] Sum of gross value added, at purchaser prices converted at market exchange rates to current U.S. dollars, by all resident producers in the economy plus any product taxes not included in the valuation of output (World Bank).

2004; UNAIDS, 2008a). In 2008, the Botswana AIDS impact survey 3 (BAIS 3) was conducted; the national prevalence rate of HIV/AIDS was 17.6% and the new HIV infection rates was estimated at 2.9%. The HIV/AIDS prevalence rate in urban areas (17.9%) is slightly higher than that in rural area (17.1%) (CSO, 2009). The government's most current sentinel surveillance report shows that 32.4% of pregnant women (the age 15-49 years) making their first antenatal clinic visit were HIV positive (NACA, 2008).

Recent government data from BAIS 3 revealed that nearly 50% of women ages 30 to 34 were HIV positive and approximately 42% of men between the age of 40 to 44 were HIV positive (CSO, 2009). It has been estimated that 19.600 adults and children died of AIDS in 2007. As a consequence of AIDS, around 90,000 children under the age of 17 have been orphaned (NACA, 2008).

Generally, the main transmission route for HIV/AIDS is heterosexual transmission (Macdonald, 1996). Homosexual transmission is not common (Baral et al, 2009). The number of new child infections has dramatically declined in the last 10 years (4,600 in 1999 and 890 in 2007) since the introduction of mother to child transmission therapy (NACA, 2008).

1.4 - National Policy on HIV/AIDS in Botswana

Various strategies have been implemented by the Government to fight against the epidemic. Four different response phases has been adopted by the Government.

1.4.1- History of HIV/AIDS Policy in Botswana

The early phase (1986-1988) focused on screening blood to avoid the risk of transmission of HIV. At this stage, the Government developed a short-term plan to create awareness about HIV/AIDS and to train health workers in the health facilities. In this plan, HIV/AIDS related stigma & discrimination were not stated (MOH, 1993; UNDP, 2000). In the second phase (1989-1997), the Government had engaged in the introduction of Information, Education and Communication (IEC) programmes. The Botswana National Policy on HIV/AIDS (BNPHA), aimed for a multi-sectoral response (all public sectors, ministries and the private sector) to combat the HIV/AIDS epidemic was drafted in 1993. In this policy, the impact of HIV/AIDS stigma and discrimination was stipulated, referring to its psychological impact in communities. It was stated that PLHIV should be protected them from stigma & discrimination (MOH, 1993). BNPHA was revised in 1998 to add to community and home based care (HBC) as a main factor in the operation of the HIV/AIDS epidemic (MOH, 1998). The third plan (1997-2002) focused on a more comprehensive approach. The objectives were to reduce infection, transmission of HIV and impact of HIV/AIDS at all levels of society. The Government clarified that political commitment was necessary because it set the stage for open discussions on HIV/AIDS, helping to reduce its stigma & discrimination (UNDP, 2000).

1.4.2- Current HIV/AIDS Policy in Botswana

In 2002, the Government of Botswana developed the National Strategic Framework (NSF) for 2003-2009. It was developed to express and declare priorities and strategies to the public to tackle the HIV/AIDS epidemic. It was stated that the collaboration would be the key factors to eliminate the incidence of HIV and to overcome the HIV/AIDS epidemic. In NSF, HIV/AIDS related stigma & discrimination were regarded as one of the most important key thematic issues on the epidemic in the country. It was prioritized that tackling HIV/AIDS related stigma & discrimination through the creation of an enabling environment by developing and adopting protective legislation (NACA. 2003).

Chapter 2 Problem Statement, Objectives and Methodology

2.1- Problem statement

In Botswana, HIV/AIDS has become the leading cause of morbidity and mortality (Phaladze & Tlou, 2006). The national prevalence rate of HIV/AIDS was 17.6% in 2008 (CSO, 2009). The estimated number of adults and children who died of AIDS was around 11,000 in 2007 (UNAIDS, 2008b).

HIV/AIDS related stigma & discrimination are defined as "a process of devaluation of people either living with or associated with HIV/AIDS. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status." (UNAIDS, 2007a). There are different dimensions of stigma on HIV/AIDS. Perceived (Felt) stigma is the shame felt by the person with the attribute and the fear of discrimination (Waterman et al, 2007). This can become internalized so that PLHIV accept their lower status, which is called internalized stigma. Internalized stigma produces internalization of shame, blame, guilt and fear of discrimination related to HIV status (USAID, 2006b). This is to make individuals more sensitive to anticipated rejection and stigmatization by others (Chesney & Smith, 1999). Enacted stigma is a process, moving from perceptions and attitudes into actions by those without HIV. (USAID, 2006c).

There are some determinants causing HIV/AIDS related stigma & discrimination in Botswana. Because of fear of contagion of HIV/AIDS, people stigmatize and discriminate PLHIV. This results from lack of in-depth knowledge on HIV/AIDS such as the transmission routes of HIV infection (CSO, 2005; UNAIDS, 2001). Also, HIV/AIDS is strongly related to the marginalized groups and social taboos such as sex workers, MSM and the poor because HIV infection is linked to a sexual behaviour as well as illegal and immoral behaviors. Finally, there are no legislations which protect the human rights of PLHIV and the marginalized groups (OSI, 2008). There are no legislations which prohibit "pre-employment HIV test" for recruitment in the workplace (BFTU, 2007). Thus, many companies carry out this test and refuse to hire an applicant with HIV. Also, there are no legislations which protect human rights of the marginalized groups such as sex workers and MSM. These groups are thought to be associated with HIV/AIDS and discriminated.

HIV/AIDS related stigma & discrimination are a deep-seated problem and produce calamitous consequences all over the world (USAID, 2006a). They can cause abandonment by spouse and/or family, (Esplen, 2007), job and property loss (UNAIDS, 2007a), refusal of health care services and lack of care and support (Li et al, 2007). Also they hinder human rights of PLHIV to live positively and openly (NACA, 2003). In Botswana, because of fear for stigma & discrimination, individuals are reluctant to visit health facilities to receive the services and they tend to go to health facilities after the stage of disease is progressed since they do not want to disclose their HIV status. In this case, treatment becomes less effective to patients (Wolfe et al, 2006). Stigma & discrimination hamper prevention, care and treatment efforts and the ability to fight against the epidemic in Botswana (Morrison & Hurlburt, 2004).

Stigma and discrimination causes not only a public health problem but also psychological and socio-economic complications at individual and family level in Botswana. Many PLHIV suffer feelings of anxiety, hopelessness and guilty when diagnosed as HIV positive. This could lead to losing family relationships and friendships and suffering in isolation, which creates emotional distress such as depression (USAID, 2006b). Moreover, individuals working for private sectors mentioned that they were denied promotion or salary increase on the basis of HIV positive status (ILO, 2008). Thus, PLHIV are more likely to face psychological burden as well as socio-economic burden because of discrimination.

The Government of Botswana has regarded to tackle stigma & discrimination as a key theme in the strategy of the HIV/AIDS epidemic (NACA, 2003). The Government has established several network bodies to empower PLHIV and the marginalized groups, enacted laws and regulations to protect PLHIV and the marginalized groups (PHR, 2007). However, stigma and discrimination are still there in Botswana. Thus, it is certainly essential to explore and identify the manifestations, determinants and impacts of stigma & discrimination on HIV/AIDS in Botswana, review interventions domestically and internationally and make recommendations for the reduction of stigma & discrimination.

2.2- Thesis objectives

2.2.1- General objective

To explore and identify manifestations, determinants and impacts of HIV/AIDS related stigma & discrimination in Botswana and to review the interventions implemented in Botswana and in other countries in order to make recommendations for the reduction of HIV/AIDS related stigma & discrimination in Botswana.

2.2.2- Specific objectives

- To describe HIV/AIDS related stigma & discrimination and its manifestations and determinants in Botswana.
- To analyze impacts of HIV/AIDS related stigma & discrimination in terms of economic, and public health aspects in Botswana
- To identify and describe the best practices/interventions domestically and internationally to tackle HIV/AIDS related stigma & discrimination.
- To make recommendations for the interventions to reduce HIV/AIDS related stigma & discrimination in Botswana.

2.3- Methodology

2.3.1- Study design

This thesis uses descriptive study as the major study design.

2.3.2- Study method

The thesis is based on a literature review – Internet and KIT library are used to search the published literatures on the topic.

Pubmed, Google scholar: The key words used in the search included: ARV treatment, behavioral change, Botswana, consequences, community based care, community involvement, determinants, discrimination, good practices, health education, health policy, HIV/AIDS, human rights, intervention, multiple sexual partners, prejudice, routine HIV tasting, stigma, sexually transmitted infections (STIs), universal access, voluntary counseling and testing.

Websites: ACHAP, Family Health International, BONELA, BONEPWA, ILO, International Centre for Research on Women (ICRW), Ministry of Health (MOH) in Botswana, Ministry of Local Government in Botswana (MLG), Open Society Institute (OSI), Population Council, UNAIDS, UNFPA, UNICEF, USAID and WHO are used to search literatures.

These search engines and websites are used in order to collect data and information related to HIV/AIDS and stigma & discrimination on HIV/AIDS.

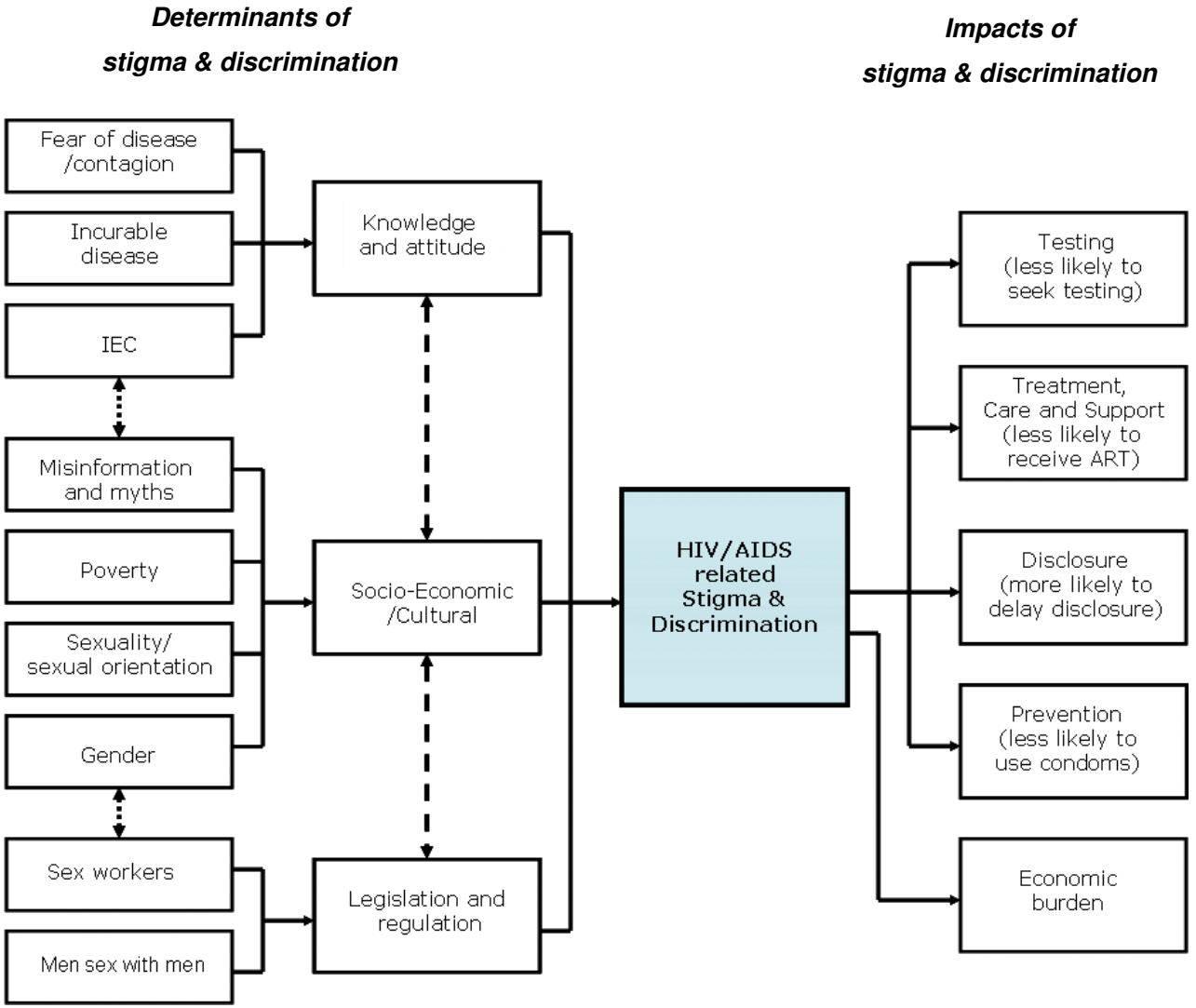
2.3.3- Conceptual framework on HIV/AIDS related stigma and discrimination

The conceptual framework for this study is used to make it easy to explore and identify the determinants and impacts of HIV/AIDS related stigma & discrimination.

2.4 - Study limitation

There are some limitations to this study. As mentioned above in this chapter, this study is based on the literature review. Few literatures about Stigma & discrimination in Botswana, especially internalized stigma among PLHIV, have been published.

Figure 1 Conceptual framework of determinants and impacts of HIV/AIDS related stigma & discrimination in Botswana



Chapter 3 Stigma & Discrimination and HIV/AIDS

In this chapter, literature study is used to explain stigma & discrimination. Also, the association between pre-existing stigma and HIV/AIDS related stigma is explained. Moreover, the manifestations and determinants of HIV/AIDS related stigma & discrimination in Botswana are explored and identified.

3.1- Stigma and discrimination

3.1.1- Stigma

Stigma is as old as history. The origin from the word "stigma" stems from ancient Greece. In ancient Greece, "stigma" meant the branding of slaves, with using a tattoo mark. Slaves were marked to distinguish them from other people. Greek word for prick is "stig", and the resulting mark, "a stigma". Stigma is a "label" which sets a person differentiated from others and links the labelled person to undesirable characteristics (Sartorius, 2002).

Ervin Goffman who was a US sociologist defied as "a negative sense of social difference from other. It is deeply discrediting and devalues the individual" (Cited in Slade et al, 2007). He mentioned that "the stigmatized individual is seen to be a person who possesses an undesirable difference". "Stigma is conceptualized by society on the basis of what constitutes difference or deviance and that it is applied by society through rules and sanctions resulting in what he described as a kind of spoiled identity for the person concerned" (Cited in Parker & Aggleton, 2003). Goffman emphasized that stigma was "an attribute that is significantly discrediting and which, in the eyes of society, serves to reduce the person who possesses it" (Cited in Aggleton et al, 2003). Stigma can stems from a peculiar characteristic such as a physical deformity or it can result from negative attitudes to the behaviour such as MSM or sex workers (Brown et al, 2001).

We can recognize different dimensions for stigma, perceived (felt) stigma, enacted stigma, and internalized stigma (Jacoby, A. 1994; Brown et al, 2003).

Perceived stigma means real or imagined fear of societal attitudes and potential discrimination arising from a particular undesirable attribute, disease (such as HIV), or association with a particular group (Brown et al, 2003). For instance, people think that they are stigmatized even when they are treated like others.

Enacted stigma refers to the real experiences of stigmatization because they are, or are thought to be HIV positive (Letamo, 2003). Enacted stigma is mentioned when an individual stigmatizes against PLHIV (whether in thought or in action) and sees as very different from him/herself (Herek, 2002). Therefore, enacted stigma is defined as ways or actions in which public reacts towards individuals in certain groups, with the basis of negative attitudes towards to groups characteristics (Brown et al, 2003). Enacted stigma is also called discrimination (USAID, 2006b).

Internalized stigma is manifested in self-blame and self-deprecation (Bond et al., 2002). For instance, the fear of HIV/AIDS-related stigma might cause individuals to isolate themselves to the extent that they do not feel part of the society and can not receive services and supports they need. As a result, internalized stigma can cause anxiety, depression, withdrawal, self-abandonment and feelings of worthlessness (UNAIDS, 2002), reinforcing shame, and social exclusion (Lorentzen & Morris, 2003).

3.1.2- Discrimination

As mentioned above, enacted stigma is also called discrimination. Discrimination consists of actions and omissions that are came from stigma and directed towards those who are

stigmatized (UNAIDS, 2005a). For instance, discrimination include unlawful acts of exclusion, or abuse that occurs in formal institutional setting as well as gossip, social/physical isolation, loss of business clientele because of one's HIV positive status (USAID, 2006c).

HIV/AIDS related discrimination can occur at various levels. Examples of discrimination against PLHIV in the family/community settings are shunning, avoiding everyday contact, verbal harassment, and physical violence, blaming and gossip. In institutional settings, PLHIV face discrimination such as denial of access to care and treatment and breaches of confidentiality at health care services. In workplace settings, they can face denial of employment due to HIV positive status, compulsory testing, and exclusion of PLHIV from pension or medical benefits. Discrimination can occur at a national level. The compulsory screening and testing of groups and individuals and the prohibition of PLHIV from certain occupations and types of employment can be occurred (UNAIDS, 2005a).

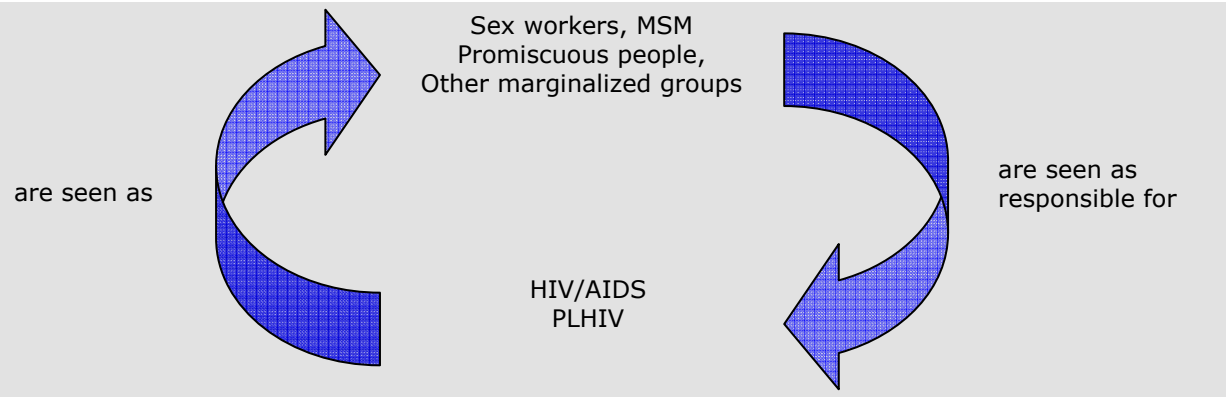
3.1.3- HIV/AIDS related stigma & discrimination

The separation "us" and "them" are converging components that concur in a power context to produce stigma (Link and Phelan, 2002). "Us" is the morally right, normal and uninfected. On the other hand, "Them" is immoral, deviant and infected. HIV is associated with "them" groups, and thus self identity of "us" is protected, which drive and cause stigma (Bond et al, 2003).

HIV/AIDS related stigma & discrimination are the consequence of interaction between diverse pre-existing sources of stigma & discrimination and fear for contagion and disease. Pre-existing stigma such as gender, sexual behaviours, taboos and social status usually overlap and reinforce each other. This interrelation can cause the deep-rooted nature of HIV/AIDS related stigma & discrimination (see figure 2) (USAID, 2002).

Because HIV/AIDS is associated to the marginalized behaviours and groups, all individuals with HIV are thought to be from the marginalized groups. For instance, men might fear to disclose their HIV status since it will be presupposed that they are MSM in some parts of the world. Also, women might fear to disclose their HIV status since they might be regarded as promiscuous or sex workers. Secondly, HIV/AIDS provokes the stigmatization of individuals and groups who are already marginalized. As a result, the stigmatization of individuals and the marginalized groups increases their vulnerability to HIV/AIDS and causes them to be more stigmatized and discriminated (Parker & Aggleton, 2003). This interaction is a vicious circle, making them worse each other.

Figure 2 The vicious circle of HIV/AIDS related stigma & discrimination



(Source: Parker & Aggleton, 2002)

3.2- Manifestations and determinants of HIV/AIDS related to stigma & discrimination in Botswana

3.2.1- Manifestations of HIV/AIDS related stigma & discrimination in Botswana

Stigma is a complicated and multifaceted phenomenon. Stigma & discrimination can occur everywhere, such as in the family, the community, the education sector, the workplace settings, health care settings and the media as well as individuals (UNAIDS, 2001).

3.2.1.1- Family

The family has an important role in providing care and support for PLHIV. However, not all families' response is positive. In fact, negative family responses to PLHIV are common in Botswana (CSO, 2005). When a family learns that one of its family members is HIV positive, he/she can be isolated by other family members. HIV/AIDS brings shame or embarrassment on the family and the family avoids family members with HIV/AIDS (Health and Development Networks, 2006). When PLHIV bring shame on their family, the family members might stigmatize them and treat them as less valuable persons (USAID, 2002).

In Botswana, a family member with HIV/AIDS is often forced to eat his/her meal alone (PHR, 2007). One young lady, who got HIV, said how she tried to keep her HIV-positive status concealed from her family to avoid poor support and care from her family members.

"There was a big problem with the family. They do not want to share meals with me or utensils with me. They think I am dying. They discovered my status because I was given a blanket by president Mogoe. He was giving blankets to people who were HIV-positive and I was one of them. My family discovered it then and started treating me badly then" (PHR, 2007).

3.2.1.2- Community

In the community, people may shun, mock and gossip about PLHIV and stigma might manifest itself in form of blame, scapegoating and punishment (USAID, 2002).

A male from rural area in Botswana said *"If you are known to be HIV positive, a lot of people start to say this person has HIV/AIDS and it ends up affecting the whole family because you have kids who are told every now and then about your status. Stigma like that, you would not like to pass that label onto your kids"* (Rajaraman & Surender, 2006).

A female said "I think nowadays everything is being done to stop discrimination against people living with HIV, but it is still there in society. They haven't properly accepted people with HIV because those who have it say that that people are disgusted with them after they reveal that they are positive…I worry about losing friends and even relatives" (Rajaraman & Surender, 2006).

A male taking ART said "Lot of people come to the treatment centre, take ARVs and hide them. When it is time to take them, they go into the toilet. They hide from their families and communities". (PHR, 2007).

3.2.1.3- Education sector

Children with or associated with HIV/AIDS can be stigmatized and discriminated in schools in many countries. Stigma can cause teasing by classmates of HIV-positive children (USAID, 2002).

In Botswana, children have been regarded as vulnerable to HIV/AIDS related discrimination due to stigma in educational settings (Lorentzen, & Morris, 2003). Orphans whose parents

died of HIV/AIDS are exposed to stigma & discrimination at schools, so that some parents or some school going orphans resist the enrolment of school (NACA, 2007).

3.2.1.4- Workplace

In the workplace, there are negative interactions, manifesting HIV/AIDS related stigma & discrimination. Negative interactions are unjust hiring and firing, unfair payment, limited employment security and health insurance, and unfair promotion (Lorentzen & Morris, 2003).

It is stated in the BONELA report (2006) that more than 5 cases per month were reported involving issues of discrimination because of perceived HIV status in the workplace. One of the cases was that a cleaner working for a bakery was dismissed by the employer because the employer learned that the employee was HIV positive and on treatment.

A male from the city in Botswana said *"Stigma in the workplace is still a big issue. People think that they will lose their job, if it is found out that they are HIV-positive. You have any issues to handle and numerous visits to the clinic are necessary. This needs to be Okay with the employ"* (PHR, 2007).

3.2.1.5- Health care settings

The places where people expect to receive care and support can be the first sites where people experience stigma & discrimination in sub Sahara African countries (UNAIDS, 2001). In health care settings, stigma & discrimination can be expressed in less standard care and support, refusal of patients with HIV, or denial of drugs and treatment. Also, health workers may give confidential information to other people such as their family or even unrelated individuals without patient's consent (Letamo, 2005).

A woman, receiving ART said "*In 1994 there was discrimination from health workers. They said things like, 'Don't come near me. Don't touch me. You are HIV-positive.' Some people would go to a nurse at the clinic worrying about HIV. The nurse would say, 'Ah, who told you this is HIV/AIDS. Just go home.' Comparing previous days, discrimination from health workers has been mitigated. Stigma and discrimination is less now. It's gone down*." (PHR, 2007).

3.2.1.6- Media

Generally speaking, the media is regarded as useful methods for Information, Education and Communication (IEC) on HIV/AIDS and stigma & discrimination. A study, however, shows that HIV/AIDS related campaigns can arouse fear, anxiety and confusion, rather than changing behaviour or social norms (Gonzalez, 2000). In many African countries, the media has played a role in associating HIV/AIDS with sexual promiscuity, death and the marginalized groups such as sex workers and MSM. However, the media does not always have the appropriate knowledge or information on HIV/AIDS and PLHIV. This can contribute to negative journalism, including inappropriate massages and the usage of negative terms (Lorentzen & Morris, 2003).

3.2.2- Determinants of HIV/AIDS related stigma & discrimination in Botswana

3.2.2.1- Knowledge and Attitude

Information plays an important role in understanding HIV/AIDS. However, too little information, or the wrong information may cause negative responses towards PLHIV (Hivan, 2005). Also, while people are aware of the facts about HIV/AIDS such as the recognition of HIV transmission routes, this does not always affect everyday action. This gap can cause HIV/AIDS related stigma & discrimination in the family, the community and the workplace

(UNAIDS, 2001).

The Botswana population has received education on HIV/AIDS since the epidemic emerged (PHR, 2007). Therefore, people are more likely to have basic knowledge on HIV/AIDS. Botswana AIDS Impact Survey 2 (BAIS 2), conducted in 2004, showed that majority of people have heard about HIV/AIDS (92% men, N=458,757, 93% women, N=545,523). Moreover, 81% of men and 83% of women knew at least one way of preventing HIV transmission. However, they lack in-depth knowledge of HIV/AIDS. For instance, it was revealed that almost 50% of men and women believed HIV/AIDS could be transmitted by mosquito bites. Furthermore, approximately 30% of men and women answered that HIV/AIDS could be transmitted by supernatural means. These misunderstandings and lack of knowledge can help to build fear of contagion and casual contact with PLHIV and negative attitudes towards PLHIV, which can fuel stigma & discrimination.

Individuals may be stigmatized by the health workers because of less experienced and trained health workers in health care settings. Lack of experiences and training on HIV/AIDS may contribute to making health workers become the less awareness of the importance of confidentiality or consent in HIV testing, counselling and treatment. In Botswana, because of the HIV/AIDS epidemic, 17% of health care workforce has been lost from 1999 to 2005 (PHR, 2007). Only 78% of doctor posts and 81 % of nursing posts are able to be filled (Schneider et al, 2004). This can result in the difficulty to sustain the number of skilled and trained health staffs. Consequently, these environments may keep people away from seeking testing, care and treatment.

3.2.2.2- Socio-economic status

The socio-economic status is an important factor of HIV/AIDS related stigma & discrimination. HIV/AIDS related stigma is associated to power and domination in the communities and it plays into and reinforces current social inequalities and stigma of the poor, jobless and homeless (Bond et al. 2002). These marginalized groups in societies often have to bear the burden of HIV/AIDS stigma (Malcolm et al, 1998).

In Botswana, economic status is regarded as one of main factors, causing HIV/AIDS related stigma & discrimination. Botswana's economy has greatly developed since the independence in 1966. However, this development has contributed to expanding economic diversity (Clover, 2003). Forty-seven percent of the population lives in poverty (Lindsey, E et al 2003). Poverty plays a role in driving (especially women) to engage in behaviours such as sex workers, making them more vulnerable to HIV/AIDS infection (ICRW, 2005). Consequently, this groups can be stigmatized and discriminated (Mawar et al, 2005).

3.2.2.3- Gender and Socio-cultural status

HIV/AIDS related stigma & discrimination are closely associated with gender issues (USAID, 2002). HIV/AIDS reinforces pre-existing cultural and social drawbacks and unequal access to information and services related to women living with HIV (Warwick, 1998). Then, the connection of HIV/AIDS related stigma to historical racism and gender has developed a certain form of discrimination. The connection of stigma around HIV to historical racism and gender has developed a particular form of discrimination (Skinner & Mfecane, 2004). Moreover, HIVAIDS related stigma & discrimination are strongly associated with sexual behaviours because HIV/AIDS is mainly transmitted through sex and blood transfusion, and the epidemic initially affected populations whose sexual practices or identities are different from the social norm (USAID, 2002). HIV/AIDS related stigma & discrimination reinforce pre-existing stigma such as MSM and sex workers (Mawar et al, 2005).

In Botswana, HIV is mainly sexually transmitted (Macdonald, 1996). Thus, when people are assumed to be infected with HIV, the question in people's minds may be "where did he/she get it?" Most people may be suspected to have gotten HIV through sexual activities, assumed to have been infected through disorderly sex, and may be shamed for their immoral behaviour.

Also, women living with HIV experience stigma & discrimination more often than men living with HIV (PHR, 2007). Botswana is a patriarchal society. Thus, women are a priori subordinate to men and have endured discriminations as well as disempowerment just because of being women (Stegling, 2004). This discrimination to women can be pre-existing stigma which associated with HIV/AIDS related stigma & discrimination.

Generally, female sex workers (FSWs) are regarded as defying acceptable social norms. Women, selling for compensation break traditional norms (UNFPA, 2005). FSWs are strongly linked to HIV/AIDS in Botswana because people believe that FSWs spread the HIV infection. This contributes to blaming women for the HIV/AIDS spread and the spread of other sexual transmitted diseases (STDs) (Phaladze & Tlou, 2006). MSM is also regarded as a "social deviance" and high risk group for HIV infection (Baral et al, 2009). These immoral behaviours can be pre-existing stigma which results in turning HIV/AIDS related stigma & discrimination.

A female infected with HIV said *"There are more stigmas for women who are HIV positive. Some women are sex workers; people think if you have HIV, you are a prostitute. Yet less than five percent of women are prostitutes or are having sex to get money"*. (PHR, 2007)

Another female said *"I think there are more stigmas against women than men. Men stigmatize women. When men find out that their partner is HIV-positive they say, 'No, I'm going to look for the people who are not HIV [positive].' That's why women stay quiet when they come back home HIV-positive*". (PHR, 2007)

3.2.2.4- Legislations & Policies

Legislations

There are no legislations to protect the human rights of marginalized groups such sex workers and MSM. In fact, both sex work and MSM are illegal in Botswana (OSI, 2008). As discussed in previous section, these marginalized groups are strongly associated with pre-existing stigma and this stigma can cause and reinforce HIV/AIDS related discrimination. These groups are reluctant to seek HIV testing, receive health care services, and participate in community activities, which reinforce stigma & discrimination to PLHIV (USAID, 2002).

There are no legislations which prohibits pre-employment HIV test in Botswana, although there are legislations protecting PLHIV (BFTU, 2007). Thus, many companies can carry out pre-employment HIV testing and they refuse to recruit those tested HIV positive. This is one kind of discrimination occurred in workplace settings.

Policies

Policy dialogue requires reform with reporting and enforcement mechanism for redress which will surely help PLHIV and vulnerable people (UNAIDS, 2007b).

Since HIV/AIDS epidemic appeared in Botswana in 1985, the Government has created policies on HIV/AIDS at various levels. One example of this is that BNPHA stated information about HIV status of individuals (patients, clients and employees) should be treated confidentially, and not be disclosed to others without the consent of the patients at health care settings. Moreover, workers infected with HIV will be treated the same as any

other worker with an illness. They should be retained in employment as long as they are medically fit to work at workplace settings (MOH Botswana, 1998). However, BNPHA is a policy which does not have the force of law, so that people may not follow the policy.

Chapter 4 Impacts of HIV/AIDS related Stigma & Discrimination

This chapter discusses impacts of HIV/AIDS related stigma & discrimination in Botswana and illustrates how HIV/AIDS related stigma & discrimination make negative impacts in terms of public health on HIV/AIDS as well as economic context in Botswana.

Introduction

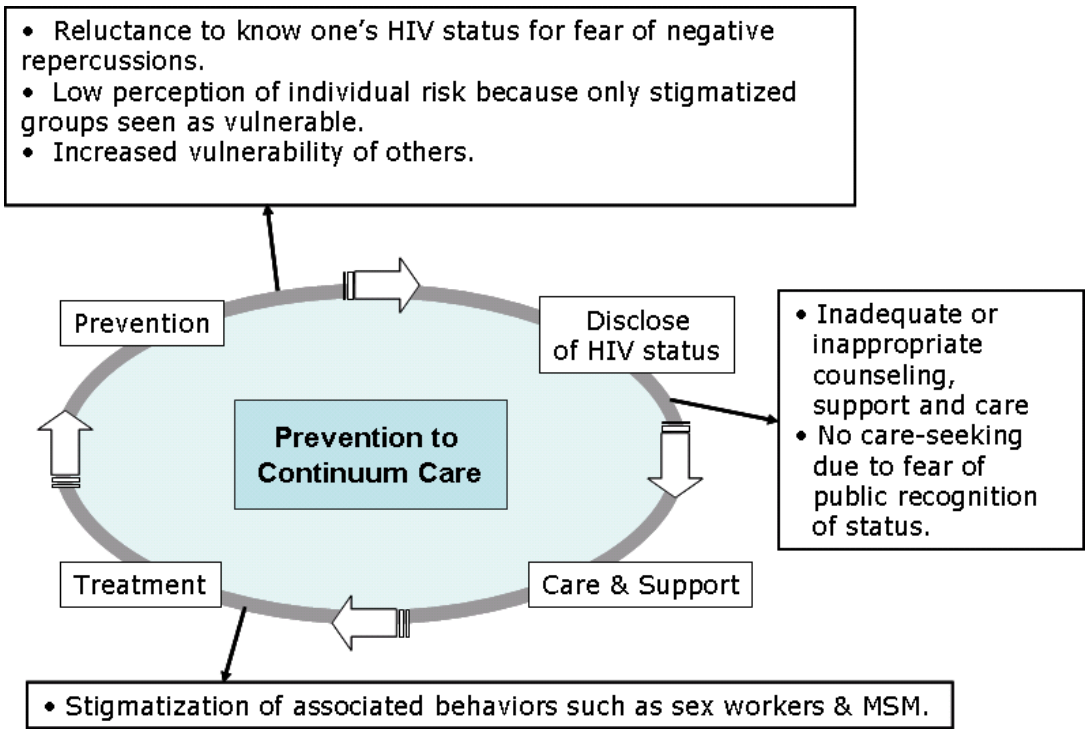
It is certainly essential to address HIV/AIDS related stigma & discrimination in order to achieve public health goals and overcome the HIV/AIDS epidemic. Ideally, people should be able to seek and receive testing and counseling to identify their HIV status without stigma & discrimination. Individuals who are tested HIV negative should receive prevention information so that they can stay negative. On the other hand, individuals who are tested HIV positive should receive appropriate treatment and care, and prevention counseling to protect others from HIV/AIDS infection. PLHIV have a right to live openly and positively. However, people can not receive these services properly because of HIV/AIDS related stigma & discrimination (Parker & Aggleton, 2003).

4.1- Impacts on the prevention to care continuum

HIV/AIDS related stigma & discrimination are linked to lower uptake of HIV preventive services, with under-participation in HIV information meetings and counseling (Campbell et al, 2005). Stigmatizing attitudes are related to denial of risk and less likely to adopt preventive behaviors (Kalichman et al, 2003). HIV/AIDS related stigma & discrimination undermine the prevention activities by preventing people from seeking HIV testing (Wolfe et al, 2006) and from seeking and accessing health care services to protect them from infection. Also, stigma & discrimination prevent people from using condoms for fear of being known with the HIV status (Nyblade et al, 2008). Moreover, fear of stigma & discrimination make PLHIV less adhere to treatment, and disclose their HIV status to others such as family members or sexual partners (UNAIDS, 2005a; Mills, 2006).

Effective responses to HIV/AIDS are composed of a model of “A prevention-to-care continuum (Busze, 1999). Through testing and counseling, people identify their HIV status. Those who are tested HIV positive have to receive the appropriate care, support and treatment. Care and support activity can make people raise awareness of the disease and its transmission routes. Care can also contribute to promoting prevention within the community. Prevention plays a role in changing people’s attitude and behavior and encouraging people to seek information. This cycle needs a supportive and understanding environment, which is easy to receive support and care, because HIV/AIDS related stigma & discrimination pose barriers at all stages of the cycle (See figure 3).

Figure 3 Impacts of HIV/AIDS related stigma & discrimination on the prevention to care continuum



4.1.1- Impact of stigma and discrimination on testing

People do not want to know their HIV status for fear of being stigmatized and discriminated (PHR, 2007). HIV/AIDS related stigma & discrimination are factors that possibly influence seeking counseling and testing of HIV/AIDS. Stigmatizing beliefs about HIV/AIDS and their associated fears of discrimination can influence decisions to seek testing (Kalichman & Simbayi, 2003).

PLHIV fear HIV/AIDS related stigma & discrimination. This fear intensely impacts the effective HIV prevention, treatment, and care programmes because infected people might be hesitant to use these services. Fewer people would seek testing for fear of their HIV positive result. A positive test result is linked to stigma & discrimination and social repercussions that they will face with if they are HIV positive. People tested may not come back for their result because they fear to be seen at a testing site such as a clinic and a hospital, which could be suspected about their health (ICRW, 2006).

4.1.2-Impact of stigma and discrimination on treatment

HIV/AIDS related stigma & discrimination may be manifest, posing barriers to providing adequate treatment (UNAIDS, 2005a). Stigma is one of main factors preventing people from receiving ART (Posse, 2008).

In 2002, Botswana became the first country in Africa to launch a national antiretroviral therapy (ART) programme known as MASA (WHO, 2006a). ART is provided free to all citizens, being eligible for treatment. The programme is available in 32 sites (government referral, primary hospitals and clinics) in the country (NACA, 2007). 91,780 persons (82.3% of those who need treatment[2]) were on treatment (UNAIDS, 2008c). However, while the

[2] Those who have an AIDS-defining illness and a CD4 count less than 200 (Phaladze & Tlou, 2006).

number of those who receive ART has increased in Botswana, there is a challenge which is lack of adherence to ART (Weiser et al, 2003). This can cause treatment failure and accelerate the emergence of drug resistant of HIV (WHO, 2006a). A study found that one of the factors affecting adherence to ART can be HIV/AIDS related stigma & discrimination (WHO, 2006b; Kip et al, 2009). Because of internalized stigma, PLHIV could not develop a positive and accepting relationship with their status or antiretroviral (Nam et al, 2008). Thus, PLHIV experience adherence difficulties.

33 year old female working in public sector in Botswana said *"How could I take my dedications, I was self-stigmatizing myself – I was always thinking, what about my friends? Are they going to ask why I take medication? I remember thinking, what about boy friends? Are they going to say, what is this kind of medication? They told me that when you take this kind of medication, you can not take alcohol. You just have to change your behavior. I was not ready to change my behavior, so those are the obstacles that made me not to take my medication in the right way."*

Also, 36 year old single male working in public sector in Botswana said *"The break in taking drugs was caused by not accepting me. I want to move on and accept myself. I listened to HIV programmes on the TV and saw all the people who have HIV and I said to myself "why can't I accept like so many people who have that disease? Why shouldn't I tell myself that I am going to live on this medication for the rest of my life?" I was just like, curious on myself, asking to myself, why did it happen to me? Is it true that it is there? Could not accept the fact that it is there?*

Moreover, 29 year old single male working in public sector in Botswana said *"I was on 5 days leave when I came to test for HIV and I stayed another week. They were looking for me at work. I was staying away because I was sort of embarrassed by my own things. I was embarrassed by my own fate."*(Source: Nam et al, 2008).

4.1.3- Impact of stigma and discrimination on disclosure

Stigma & discrimination introduce a desire not to know one's own HIV status so that it is possible to delay testing and accessing treatment. Also, the possibility of disclosure to others, who can become important sources of support such as families and relatives, is limited by stigma & discrimination (Skinner & Mfecane, 2004). Disclosure of HIV status is an important key related to consequences of preventive behaviors such as condom use and health care seeking. A study has proved stigma & discrimination affect disclosure to others (Wolfe et al, 2006).

In Botswana, a study found that 69% of those receiving treatment kept their HIV status a secret from their family members, and 94% kept their status a secret from people from their community (Weiser et al, 2003). It was common to hear of people who were rejected by their partners because they had disclosed their HIV status (PHR, 2007). Also, Individuals often seek services only when they can not hide their symptoms any more. At this time, they are extremely ill. It can be late to receive drug treatment (DFID, 2007).

Some ART users in Botswana said, *"Those on treatment at times do not tell their partners".*

"Some women hide their status fearing to be dumped by their partners after disclosing their HIV status".

"A man will leave you if you tell him (your status)".

"For us, you will find that even when you know your status, it is not easy to disclose because you do not know your partner's status. You end up hiding medications because when you tell them, they disappear after a short period. We usually weigh the situation because we would

not want our name to be defiled" (Source: WHO, 2006a).

4.1.4- Impact of stigma and discrimination on prevention

HIV/AIDS related stigma & discrimination are likely to hamper the opportunity of individuals to discuss condom use with their sexual partners and use condoms properly and regularly. Condoms themselves have a strong linkage to stigma, because health promotion campaigns or the media emphasize the close linkage between HIV/AIDS and condoms. Therefore, if they suggest using condoms, their partners may interpret as equivalent to admitting his/hers own faithlessness (Skinner & Mfecane, 2004).

4.2- Impacts of stigma & discrimination on economical context

Stigma & discrimination cause actions, both unfair and unjust and increase socio-economic difficulties for individuals infected with HIV and their families because stigma & discrimination towards PLHIV often creates the form to separation from communities and families as well as loss of employment (Weiser et al, 2003). These forms of stigma & discrimination often limit their sources of economic support.

PLHIV face loss of employment in Botswana because of their HIV status (BFTU, 2003). According to National Policy on HIV/AIDS, PLHIV are protected to have human rights in workplace settings. Employers can not dismiss their employees because of HIV status of employees. However, many have been dismissed. Once PLHIV lose their job, it is relatively difficult to find new job. Its reason is that pre-employment HIV testing is carried out. Thus, PLHIV are more likely to lose the source of income.

Moreover, according to Botswana AIDS Impact Survey 2 (NACA, 2005), only 50% of people would buy food from a shopkeeper who was HIV positive because of stigma. This means that the shop owners infected with HIV may lose business opportunities.

These burdens negatively influence family finances, which can make economic impacts at community level and nation level.

Chapter 5 Interventions for the reduction of HIV/AIDS related stigma & discrimination

This chapter reviews interventions implemented domestically and internationally for the reduction of HIV/AIDS related stigma & discrimination

5.1- Review of interventions

Stigma is a complex social phenomenon, which involves interaction between social and economic factors in the environmental and psychosocial issues of PLHIV (ICRW, 2005). Therefore, Interventions for the reduction of stigma & discrimination must be multifaceted and multilevel. Multifaceted approaches are accounted for the range of stigmatizing conditions that track with HIV/AIDS related stigma & discrimination, and multilevel approaches are accounted for individuals and structural levels of stigma & discrimination (Mahajan et al, 2008).

The harmful effects of HIV/AIDS related stigma & discrimination have become more clearly understood, and many organizations and institutions have engaged in attentions on these effects. Several successful approaches and strategies have been developed and discussed. These approaches include 1. Promoting HIV knowledge and awareness, tolerance, and compassion, 2. Increasing involvement and visibility of PLHIV, 3. Empowering the community among populations most at risk, 4. Preventing HIV-based discrimination, 5. Prohibiting discrimination against populations most at risk, and 6. Scaling up treatment, care and support (UNAIDS, 2008d).

5.2- HIV/AIDS interventions related to the reduction of stigma & discrimination in Botswana

The Government of Botswana has provided a wide range of services to combat the HIV/AID epidemic since the epidemic appeared. In addition, non-governmental organizations (NGOs), community-based organizations (CBOs) and faith-based organizations (FBOs) have been cooperated with the Government. Moreover, network bodies such as BONEPWA and BONELA have provided programmes and coordinated NGOs, CBOs and support groups to develop implementations of HIV/AIDS programmes. There are services provided by these organizations and network bodies, including antiretroviral therapy (ART), voluntary counseling and testing (VCT), routine HIV testing (RHT), community home-based care (CHBC), prevention of mother to child transmission (PMTCT) and condom distribution & education. Some have affected the reduction of stigma & discrimination.

5.2.1- Promoting HIV/AIDS knowledge and awareness, tolerance and compassion

One of the factors causing stigma & discrimination is lack of in-depth knowledge on HIV/AIDS in Botswana, so that promoting HIV/AIDS knowledge and awareness is essential. Programmes which promote HIV/AIDS knowledge and awareness must be a part of national strategic plans and must be supported by stakeholders such as NGOs, CBOs and FBOs. These programmes also need to be operated at various levels (family, community and institutions), because stigma & discrimination are a complex phenomenon and multifaceted (UNAIDS, 2008d).

Training, education and awareness-raising

Teacher Capacity Building Program (TCB): This programme was designed to enhance the capacity of school system to ease HIV/AIDS related stigma & discrimination by facilitating free and informative discussion about HIV prevention, living with HIV, and caring for adults and children living with HIV/AIDS. This is an interactive educational programme, targeting

Botswana's teachers with information about HIV/AIDS in order to build their capacity to cope with HIV/AIDS issues in the educational institutions. As part of the programme, 54% (527 out of 979) of primary and secondary schools have been provided with a television, videocassette recorder, satellite dish and decoder. A weekly television programme has been developed (Clark & O'Brien, 2003).The direct benefit of this programme was 21,782 teachers to be engaged in. Teachers increased their knowledge on HIV/AIDS and used that knowledge to share with students (ACHAP, 2003). The advantage of this programme is to focus on not only the capacity building of teachers but also that of the whole school to increase knowledge and awareness on HIV/AIDS. Through this programme, children as well as teachers could build their capacity to think about issues on HIV/AIDS.

Education and Awareness-Raising Workshops: BONELA has conducted workshops with a variety of private and public sector organizations in an endeavor to raise awareness about the human rights around the HIV/AIDS epidemic. Its aim is to encourage consideration of human rights perspectives in HIV/AIDS programmes as well as policy development and implementation (BONELA, 2005). BONELA has initiated to organize workshops with health workers and a variety of community services providers and community members. Eight workshops were conducted, reaching 190 people in 2005. However, the effect of the workshops was not measured

Media campaign

Television programme: The television drama called "The bold and the beautiful" was broadcasted in 2002-2003 in Botswana. The story line involved a man, who tested HIV positive, was accepted by his HlV negative prospective spouse, and adopted an AIDS orphan in Africa. A study found that there was a linkage between viewership of this television drama and HIV/AIDS related stigma. Viewers of the drama indicated lower levels of HIV/AIDS related stigma than non-viewers. Stigma was reduced among viewers after watching this TV programme drama (O'Leary et al, 2007). However, there can be the bias in this study because there was no data of pre-HIV/AIDS stigma which was a baseline data. Thus, it could be difficult to conclude that viewers indicated lower levels of HIV/AIDS stigma because of watching this drama. Viewers of this drama could have already had lower HIV/AIDS stigma before this study implemented

Radio programme: BONELA, network on ethics, laws and HIV/AIDS (NGO), has aired to advocate for the rights of those who are affected by HIV/AIDS since 2006. The series of radio jingles primarily portray people who have suffered from HIV/AIDS related stigma & discrimination such as a woman being dismissed from work and a student facing stigma in the classroom. Also, they provide messages about realizing human rights for those affected and infected by HIV/AIDS (BONELA, 2006).

Newsletter: BONELA published the newsletter four times a year. This is called "The BONELA Guardian", written about the area of HIV/AIDS in relation to human rights, ethics and laws. These topics are not often told in mainstream media. Thus this newsletter plays an important role in discussing these issues. During 2006, the BONELA Guardian featured topics such as HIV-positive women speaking up for their reproductive and sexual health rights (BONELA, 2006).

5.2.2- Greater involvement and visibility of PLHIV

The principal of the greater involvement of people living with or affected by HIV/AIDS (GIPA) is effective social programme responses to HIV/AIDS related stigma (Mahajan et al, 2008). The engagement of PLHIV is certainly indispensable to reduce stigma & discrimination. GIPA is not a programme or project, but a principal aiming to realize the

rights of PLHIV. It also includes the rights to self-determinants and participation in decision-making processes. Moreover, GIPA aims at improving the quality and effectiveness of the HIV/AIDS response (UNAIDS, 2007b). Public participation of PLHIV at community levels could promote individual level responses to self-stigmatization (UNAIDS, 2007b).

Support groups: Support groups are community based public groups formed by community members. This group consists of five or more people infected with or affected by HIV/AIDS. They are formed to provide care and support for PLHIV. Most of members are women (JICA, 2007). The key functions of support groups is to educate people and create awareness of HIV/AIDS as well as stigma & discrimination in the communities, help PLHIV become more confident and powerful, help to share resources, ideas and information, and lead to change by creating a public or political voice. Support groups are supported by BONEPWA which provides support groups with training workshops on survival skills, community based care and supportive counseling (BONEPWA, 2005). However, these support groups frequently confront technical and financial problems. Also, men with HIV are less likely to involve in support group activities.

Miss stigma free competition: The centre for youth of hope (CEYOHO), an organization committed to mobilizing community support for PLHIV, has implemented "Miss HIV stigma free" competition annually since 2002 (ACHAP, 2006). This activity is supported by the African Comprehensive HIV/AIDS Partnerships (ACHAP), a country-led, public-private development partnerships between Botswana Government and the Bill & Melinda Gates Foundation. This competition is held to select an HIV positive woman to act as a spokes person on behalf of PLHIV community. This idea of a pageant was conceived that HIV positive woman could play a role in challenging misconceptions about HIV/AIDS, and educating people about the need to ease stigma & discrimination surrounding HIV/AIDS. The aim of the competition is to show PLHIV that even if you are HIV positive, you can do things like others.

Mr. HIV positive living pageant: In order to increase the participation of male involvement in HIV/AIDS interventions, BONEPWA implemented Mr. HIV positive living pageant since 2006. This idea is similar to "Miss Stigma free competition". However, this event emphasizes to promote and enhance the greater involvement of men living with HIV/AIDS and empowerment of them. These programmes has not been evaluated in terms of the reduction of stigma & discrimination but currently many people have known these pageants and realized what stigma & discrimination are and how they negatively affect PLHIV. Also, some participants overcame the fears of HIV and internalized stigma.

As discussed in chapter 3, gender is the important determinant of HIV/AIDS related stigma & discrimination in Botswana. Miss Stigma free can play an important role in empowering women living with HIV as well as women without HIV. On the other hand, Mr. HIV positive living pageant programme can play an important role in making men pay attention to the HIV/AIDS activity and participate in it.

5.2.3 - Empowering of the community among populations most at risk

Empowerment is the bases of an effective response to stigma & discrimination. It includes strengthening skills and knowledge, building self-acceptance and social capital and developing the social-political environment for healthy change. Also, Access to social support is crucial to reduce vulnerability of marginalized or disempowered groups such as sex workers and MSM (UNAIDS, 2008d).

Sex workers in Botswana face frequent human rights violations from police, public health and school officials. Although they are harassed by someone, they can not go to the police

because sex work is illegal. There are very few partnerships and supportive groups to protect human rights of sex workers and support them in Botswana. Some sex workers have begun to organize meetings regularly in the communities to talk together and share strategies for problems with customers and police. Also, sex workers care for many fellow sex workers (OSI, 2008).

Lesbians, Gays and Bisexuals of Botswana (LeGaBiBo) is the Lesbians, Gays, Bisexuals, Transgendered and Intersexed organization (LGBTI) in Botswana, established in 1998. Their objectives are to promote a non-discriminatory legal framework for LGBTI community, create a community that is educated and sensitized on LGBTI issues and recognize same-sex relationships. However, projects have not been done much because of lack of resources. Moreover, LeGaBiBo was refused to register the constitution because they were ruled to be contrary to the Botswana penal code (LeGaBiBo, 2009).

5.2.4- Legislations and Policies to prevent HIV-based discrimination and prohibit discrimination against populations most at risk

Legal protection and policy must be strong tools in the response to the HIV/AIDS epidemic (UNAIDS, 2008d). They can support PLHIV and the marginalized groups, and enable these populations to realize their rights. Many areas of law are essential to protect PLHIV and the marginalized groups against stigma & discrimination such as public health law and anti-discrimination laws governing sex work and MSM (UNGASS, 2008).

5.2.4.1- Legislations

There are two national legislations specifically addressing HIV/AIDS and PLHIV, which are The Medical Council (Amendment Regulations 1999) and The Penal Code of 1998 (Amendment Act) in Botswana. It is stated to protect the rights of PLHIV in Section 15 of The Medical Council states. In this section, the protection of fundamental rights and freedoms of the individuals including protection of the right to life, personal liberty, freedom of conscience, expression and movement and a general non-discrimination clause. However, the marginalized groups such as sex workers and MSM are not protected by the legislation. Section 164 of the Penal Code criminalizes MSM. Section 184 of the same code provides that an individual, who does an act that is likely to spread infection of any disease, is guilty of an offence. (Zungu-Dirwayi et al, 2004).

5.2.4.2- Policies

Policy and strategic plan on HIV/AIDS are the basis for the important and continuous response to the epidemic. Policies provide an operating framework for prevention, treatment, care, support and reduce the impact of the HIV/AIDS epidemic. Also, policies include principals on human rights for PLHIV and strategies to reduce vulnerability to HIV/AIDS for the marginalized groups.

One of the key elements of BNPHA is the reduction of the psycho-social impact of HIV/AIDS. For instance, it is stated that PLHIV in the workplace should be protected against stigma & discrimination by colleagues, employers, unions and clients. Organization must consider this protection in the workplace with HIV/AIDS education and information programmes. Also, employees should have access to information and educational programmes on HIV/AIDS at the workplace, as well as counseling and medical care (MOH, 1998).

The National Strategic Framework for HIV/AIDS 2003-2009 (NSF) demonstrates a strong commitment on tackling stigma & discrimination with the creation of an enabling environment by adopting protective regulation and legislation. In NSF, HIV/AIDS related

stigma & discrimination are considered as one of key determinants of the HIV/AIDS epidemic. Moreover, it is emphasized that Behavioral Change Intervention (BCI) should be developed and implemented in order to reduce the levels of stigma & discrimination (NACA, 2003).

According to BAIS 2 (CSO, 2005), 69% of public sectors and large companies had HIV/AIDS workplace policies and programmes, providing HIV/AIDS education, VCT service and access to condoms. However, except for a few large companies, most of private companies do not have HIV/AIDS policies (NACA, 2005).

5.2.5- Scaling up of support, care and treatment

It is certainly necessary to scale up antiretroviral treatment (ART) not only to save lives and reduce suffering but also to mitigate HIV/AIDS related stigma & discrimination (Wolfe et al, 2006) Also, ART reflects the inclusion of HIV positive people in the body politic (UNAIDS, 2008d). Moreover, scaling up treatment can increase incentives for people to be tested and contribute to promoting more open discussion of HIV issues (Weiser et al, 2003).

1. Antiretroviral therapy (ART): Since 2002, the Government of Botswana has started universal access to ART. The rapid expansion of the ART programme has declined the number of AIDS deaths in Botswana. Through 2007, 50,000 adult deaths were averted. Currently, Ministry of Health announced more than 91,780 patients received ART. This figure was 82.3% of those who need treatment in 2007 (NACA, 2008). A study in Botswana found that perceived access to treatment was the protection factor both against holding stigma attitudes towards PLHIV and against stigmatizing yourself which is "Internalized stigma" (Wolfe et al, 2008). Another study in Kenya found that levels of internalized stigma decreased among those who received ART. Moreover, those who received ART are more likely to disclose their status to family members (Population council, 2007). These findings suggested that universal access to ART could play a considerable role in reducing HIV/AIDS related stigma & discrimination.

2. Voluntary counseling and testing (VCT): VCT plays an important role in HIV prevention (UNAIDS. 2000). It is an entry point to care and provides opportunities to know one's HIV status. Individuals who tested HIV positive can benefit from earlier medical care and support to receive, and information preventing others from new infection. A study showed that those who took HIV test were less likely to stigmatize towards PLHIV (Weiser et al, 2006). Furthermore, the increased up-take of testing could lead to a reduction in stigma & discrimination (Castro & Farmer, 2005). In Botswana, some NGOs and all public hospitals have provided VCT services.

3. Routine HIV testing (RHT): RHT is an opt-out testing systems that all patients could be tested as a routine medical visit. However, if you do not want, you do not need to take a test. All patients should receive essential information about HIV testing and be informed of their right to refuse before testing. The objective of routine testing is to increase a number of individuals who are aware of their status, facilitate supportive counseling and reduce "HIV exceptionalism", and mitigate HIV/AIDS related stigma & discrimination (UNAIDS, 2005b). In 2004, Routine HIV testing was introduced in Botswana. A total number of those who took HIV testing were about 270,000 from 2006 to 2007, and 90% of those who were offered or requested HIV test were tested (UNAIDS, 2008b). A study in Botswana found that 81% of participants (n=1,268) were in favor of routine testing, which showed RHT must be accepted in Botswana (Weiser et al, 2006).

4. Community Home-based care (CHBC): As hospital based care can not deal with the increasing numbers of patients, CHBC has been introduced since 1995 in Botswana. CHBC

provides services that are near to patients and are based on the needs of communities (NACA, 2007). A study in Kenya found that CHBC could reduce the stigmatizing behaviors among CHBC staff as well as community members (Waterman et al, 2007). In Botswana, the community response to CHBC is very positive and 300 CBOs participate in the delivery of HBC services through out the country (NACA, 2007). However, CHBC relies on community volunteers and they frequently lack adequate training (NACA, 2007).

5. Preventions mother to child transmission therapy (PMTCT): PMTCT is the service of the Government offering free counseling, testing, ART and free infant formula for babies born to infected mothers (Kebaabetswe, 2007). In Botswana, all public facilities offer PMTCT services and 89.9% of pregnant women received PMTCT in 2006 (NACA, 2007).

5.3- HIV/AIDS interventions related to the reduction of stigma & discrimination in other countries

5.3.1- Promoting HIV knowledge and awareness, tolerance, and compassion

In Zambia, a programme was implemented to involve young people in care and support of PLHIV (UNAIDS, 2005a). 300 youth club members received a basic training to be caregivers to strengthen the capacity of the communities and families to provide care and support for PLHIV and their families. The training included club management, HIV prevention, and care and support for PLHIV. After training, each youth club members visited PLHIV household once or twice a week. This programme led several positive outcomes. Youth caregivers felt satisfied and comfortable to support families in household chores and counseling family members about HIV/AIDS. Trained youth caregivers reported many benefits including achieving satisfaction from serving their communities, gaining the respect of communities and leaders, increasing knowledge and skills on HIV/AIDS and care. Also, family members of PLHIV became more involved in care giving in the family. Furthermore, clients grew friendlier and requested more visits to the youth caregivers and level of trust for the youth caregivers increased (USAID, 2004).

In Tanzania, HIV/AIDS stigma reduction community based project was implemented for 2 years (UNAIDS, 2005a). Programme staffs of Kimara peer educators and health promoters trust (Local NGO), received capacity development training, using a toolkit called "Understanding and Challenging Stigma[3]" to address gaps in staff knowledge and understanding of stigma & discrimination. Ten key community leaders also were trained to clarify and address knowledge gaps on HIV/AIDS related stigma & discrimination, and develop plans to integrate stigma & discrimination into other activities. Moreover, anti-stigma & discrimination messages and participatory activities were integrated into ongoing activities such as dramas, HBC visits, counseling for PLHIV. This project had a positive impact on reducing stigma & discrimination in the community. Stigma & discrimination activities were performed by programme staff in an effective and enduring manner. Also, this project contributed to the improvement of community leader's attitude and behaviors towards PLHIV. Furthermore, community member's awareness of stigma & discrimination increased, and many PLHIV began to attend counseling (USAID, 2008). The way of programme evaluation, however, could have not been conducted properly because the study collected qualitative data at one data point. There is no qualitative data on the state of HIV stigma from baseline. Thus there can be a bias when the level of stigma was measured. Moreover, during this programme implemented, there could have been other activities that

[3] The toolkit was designed for NGOs, community groups and HIV educators to raise awareness and promote actions to challenge HIV stigma and discrimination. Based on research in Ethiopia, Tanzania and Zambia, the toolkit contains more than 125 exercises (ICRW)

affected stigma in the community.

5.3.2- Greater involvement and visibility of PLHIV

In Malawi, Greater Involvement of people living with or affected by HIV/AIDS (GIPA) was implemented with 23 PLHIV who were recruited and trained as United Nations Volunteers[4] (UNV) in selected partner organizations. The main role of them was to raise issues about HIV/AIDS prevention and care for the affected in the workplace. Additionally, they provided basic HIV/AIDS information and participated in community mobilization. The objectives of GIPA were to make sure that people infected with and affected by HIV/AIDS contributes to decision-making at all levels and in all relevant institutions and that their needs are reflected in policy, to strengthen the capacity of networks and organizations of PLHIV for planning and programme management. GIPA in Malawi brought acceptable results. UNVs participated in the formulation of the Malawi National Strategic Framework, and they helped to establish new support groups of PLHIV. Also, they mobilized individuals, communities and organizations to understand HIV/AIDS. Furthermore, they helped to contribute to breaking the silence on HIV/AIDS, breaking barriers, and reinforcing HIV/AIDS programmes (MANET, 2009)

5.3.3- Empowering the community among populations most at risk

In Kenya, a peer-mediated FSWs intervention was implemented (Luchters et al, 2008). This aimed to empower FSWs by increasing their HIV/AIDS knowledge and condom negotiation skills, reduce unprotected sex by increasing condom use and reduce factors associated with HIV transmission by providing information, HIV testing and counseling. Sixty-two FSWs were selected and trained as peer educators. They acted as channel between local FSWs community and the project, facilitated local involvement and participation and conducted one-on-one weekly group discussions. The drop-in centre was used as not only training facility but also the distribution of information, education and communication (IEC) materials and condoms. These activities had lasted for 5 years. This intervention brought the positive outcomes for FSWs. FSWs got empowered to start to more frequently use a condom with paying clients; to negotiate condom use with clients and to refuse their clients unwilling to use condoms. Furthermore, those, who had attended four times or more peer education sessions, had less sexual partners and higher levels of protected sex than women who had attended fewer sessions.

A programme was implemented in Kenya, which is to train MSM and male sex workers (MSWs) as peer educators and counselors (Population Council, 2009). International centre for reproductive health trained 40 MSM as peer educators to increase knowledge and skills related to HIV and STI prevention, behavior change, improve self esteem, reduce stigma and provide leadership skills. As a result, more than 1,900 MSM have been reached through peer education. Also, MSWs were trained as outreach workers, who go to out in field teams to offer counseling to MSWs and to meet weekly to discuss their experiences. Level of self esteem among those who participated in the programme increased.

An organization was started, which demonstrates MSM is a reality in Burundi (UNAIDS, 2008d). This organization was set up in order to fight for social integration, to claim understanding of MSM from the society, and to fight against the marginalization and HIV/AIDS. Two local NGOs and UNAIDS financially support them. Also, members of this organization meet twice a month to mobilize MSM fellows and partners with sessions. With setting up this organization, MSM have gained opportunity to help each other and address

[4] The United Nations Volunteers (UNV) programme is the UN organization that contributes to peace and development through volunteerism worldwide (UN Volunteer).

their human rights. It makes them live positively and be proud of themselves.

5.3.4- Preventing HIV-based discrimination

In the workplace setting, potential or current employees should be protected not to take HIV testing by laws and policies. Some laws and policies prohibit mandatory HIV testing for recruiting and employment. For instance, one approach mostly adopted is to proscribe mandatory HIV testing from the beginning of the recruitment process throughout the job tenure at the workplace. Employees can not be forced to test for HIV at any time without their consent. Furthermore, test results can not be used as a reason to deny employment, promotion and any benefits to employees. In Zimbabwe, the Labour Relations Regulations (LRR) has prohibited mandatory HIV testing for recruitment of employees. Employers can not require directly or indirectly anyone to take testing for HIV when they hire employees. Also, in Malawi, National HIV/AIDS policy proscribe that employers require HIV testing to employees for recruiting. However, this does not have the force of law.

In Namibia, the AIDS Law Unit, a non profit public interest law centre promotes human rights based response to HIV/AIDS in Namibia. The unit provides a free legal advice and litigation service for PLHIV to deal with discrimination related to employment and insurance. This unit also conducts research into existing and emerging discrimination issues. For instance, the unit has conducted a research on how PLHIV are treated in the workplace to determinate the effect of the government's guidelines for the implementation of a National Code on HIV/AIDS. Moreover, the unit provides assistance for employers and trade unions in workplace AIDS policies, and runs programmes with PLHIV to develop advocacy skills in NGOs and CBOs (UNAIDS, 2005a). Positive outcomes can be achieved. The unit challenged the Namibia Defense Force's (NDF) policy of pre-employment testing and the exclusion of PLHIV from employment. Based on this challenge, the Namibian Labour court said that NDF was not entitled to exclude applicants from recruitment on the basis of their HIV status (AIDS Analysis Africa, 2000) Also, the unit contributed to developing appropriate AIDS workplace policies in the public and private sectors. Moreover, it has lobbied government for legal reform to address HIV/AIDS related stigma & discrimination (UNAIDS, 2005a).

5.3.5- Prohibiting discrimination against populations most at risk

As discussed in chapter 3, HIV/AIDS related stigma & discrimination are strongly associated with the marginalized groups such as sex workers and MSM. In order to mitigate stigma & discrimination on HIV/AIDS, these marginalized groups should be protected by policies and laws and provided support and care equally by health facilities (UNAIDS, 2008d).

In South Africa, a national network body "Sisonke" was established in 2003 supported by the Sex Workers Education and Advocacy Taskforce (SWEAT). Sisonke is organized by sex workers to protest unlawful arrests, detention of sex workers police extortion and violence from police. A partnership between Sisonke and SWEAT has led to a campaign for the decriminalization of sex workers and the recognition of sex workers' human and labour lights. Moreover, SWEAT has documented abuse against sex workers and worked with Sisonke members to campaign in the media against sexual and physical violence by police. SWEAT continues to negotiate with the Government of South Africa to reform laws to protect sex workers and regularly submits advocacy briefs. These actions will contribute to the improvement of sex workers' position (OSI, 2008).

5.3.6- Scaling up care, support and treatment

In Zambia, a project whose name is antiretroviral community education and referral (ACER) was implemented to improve adherence to ART and prevention for PLHIV in communities

(Population Council, 2008). This project was supported by the International HIV/AIDS Alliance. ACER was based on a community engagement strategy to enhance HIV prevention, treatment, care and support for PLHIV. Community engagement involved bringing together PLHIV, community stakeholders and health providers to develop collaborations, and address gaps and challenges of the service. Firstly, Alliance Zambia conducted a capacity development programme for partners such as the Network for Zambian Living with HIV/AIDS, Traditional Health Practitioners Association of Zambia, CHBC programmes and so on. Topics covered information about ART, how it work and what types of medications are available in Zambia. Once these partners were trained, they carried out four types of activities including to conduct sensitization and educational activities, set up support groups for people on ART, provide home-based care and make referrals to health and community services. The following outcomes were achieved, a significant increase of those on ART who cited peer groups as a source of information and those who took HIV testing, a significant reductions in internalized stigma among people on ART, and community stigma also decreased.

In Uganda, a programme implemented to improve adherence to ART and reduce self stigma among 200 adolescents (JCRC, 2007). An adolescent peer support group was set up in 2006 to encourage the adolescents infected with HIV (the ages between 10 and 19) to adhere to ART. This group met every Saturday. Activities include interactive health talks, group discussions, sharing experiences, role plays, art and crafts, music, dance and drama. Activities were facilitated by adherence officers, doctor, nurses and caretakers. After 15 months, adolescents who had self-stigma, lack of confidence and fear have become confident. Some of them became leaders at their schools persons for information regarding HIV/AIDS. Furthermore, 26% of those who participated in this programme improved adherence to ART. However, this is a pilot programme which was implemented in only one site, so that the sample size is small and limited.

Chapter 6 Discussion, Conclusion and Recommendations

6.1- Discussion- Gaps and challenges in Botswana

Since the epidemic emerged, Botswana has implemented many programmes and interventions to combat the HIV/AIDS epidemic, including stigma & discrimination reduction activities. Some programmes such as ART and RHT have been effective to reduce levels of stigma. However, the Government and its donors have faced gaps and challenges in. In this section, the gaps between interventions implemented in Botswana and in other countries are discussed to improve programmes and interventions for the reduction of stigma & discrimination in Botswana.

6.1.1- Promoting HIV/AIDS knowledge and awareness, tolerance and compassion

In Botswana, there exist youth groups working in the field of HIV/AIDS. However, groups engaged in care and support for PLHIV and their families are rare. Most of their activities include the peer education, the media and advocacy (dance, sing and performance). Thus, the programme implemented in Zambia could be functional for young people as well as communities in Botswana.

6.1.2- Greater involvement and visibility of PLHIV

Support groups have been formed to empower PLHIV and their families through income generating activities (IGA) and general meetings. Some face problems economically and technically. For instance, they need to produce income to sustain their group. However, some groups can not manage and coordinate their activities because of lack of support from BONEPWA as well as the Government. Moreover, they can not apply for funds to the Government or donors because of lack of skills such as proposal writing.

Also, members of support groups are mostly female with HIV (JICA, 2007). Men with HIV are less likely to join and engage in support groups. Thus, they are more likely to be exposed to depression or isolation from society because of no opportunities to talk with other PLHIV and share experiences with them.

6.1.3- Empowerment of the marginalized groups

Sex work is illegal and the predominant attitude to Sex workers is common in Botswana. At present, there are no activities on policy reform related to sex work. They frequently face human right violations from police or health workers (OSI, 2008). MSM is also illegal (BONELA, 2008) and is regarded as a social deviance (Baral et al, 2009). There exist currently groups and networks to protect human rights of PLHIV and to provide them with HIV/AIDS education. However, the number of these groups is very few and they are not very active. Thus, it is difficult for them to live positively and openly and insist their human rights. In order to prevent these marginalized groups from going underground, working as a group, helping each other and empowering them can be very effective.

6.1.4- Legislations and policies

In order to reduce stigma & discrimination, building legal capacity must be essential because it can protect PLHIV and the marginalized groups. In BNPHA and two national legislations, there are the declarations stated to protect human rights of PLHIV in Botswana. These legal protections can play an important role in reducing HIV/AIDS related stigma & discrimination. On the other hand, there are no legislations and policies addressing to protect the marginalized groups such as sex workers and MSM.

Also, there are no legislations prohibiting pre-employment HIV testing in the workplace. On

the other hand, BNPHA states “pre-employment HIV testing is unnecessary and should not be carried out”. This disunity between the legislation and the policy can lead to confusion in society.

While 69% of public sectors and large companies have HIV/AIDS workplace polices and programmes, most of private companies (especially small companies) do not have these policies and programmes. One of reasons can be that although BNPHA states that HIV/AIDS work policies is essential in the workplace, it does not have the force of law. Thus, most of private companies may not attach importance to setting up these policies and programmes.

6.1.5- Scaling up of care, support and treatment

A study found that RHT is more acceptable than voluntary testing in Botswana (Creek et al, 2007). However, there are challenges to scale up in health care settings. Offering RHT to patients is not conducted consistently in health facilities. For instance, individuals with AIDS-related diseases were more likely to be offered RHT than those with general conditions such as diabetes and high blood pressure (Kessler et al, 2008).

ART coverage in Botswana is much higher than neighboring countries with high HIV prevalence such as South Africa and Swaziland (UNAIDS, 2008e; UNAIDS, 2008f). However, adherence to ART is one of the challenges Botswana faces (Weiser et al, 2003; Num et al, 2008). In order to improve adherence to ART, it can be insufficient to implement programmes focused on adherence to ART because there are various factors for patients to miss medications, such as cost (registration, transportation and food), knowledge of ART and HIV/AID and lack of care and support for PLHIV (WHO, 2006a), so that a comprehensive approach is necessary to improve adherence to ART.

Although CHBC has been provided through out the country, there are some challenges,. Poor remuneration and insufficient resources such as transport for workers can lead to staff attrition. Also, CHBC depends on volunteers who lack adequate training and skills (NACA, 2007). Moreover, CHBC guidelines are not standardized by districts, which can result in inconsistent interpretation.

PMTCT has made a considerable achievement. However, because of social and cultural perceptions, some women do not want to introduce uptake of formula-feeding. Some mothers feel that a woman without doing breastfeeding may not be accepted in the community (NACA, 2007). PMTCT also rely on volunteers whose skills are insufficient.

6.2- Conclusion

HIV/AIDS has been the most considerable problem since the advent of the epidemic in Botswana. Because of the HIV/AIDS epidemic, PLHIV experience HIV/AIDS related stigma & discrimination, and this phenomenon has enormous negative impacts on prevention, care, and support of HIV/AIDS as well as Botswana economy.

HIV/AIDS related stigma & discrimination are outcomes of interaction between various pre-existing stigma and fear of contagion and disease itself. In Botswana, the determinants of HIV/AIDS related stigma & discrimination are associated with lack of in-depth knowledge of HIV/AIDS and misconceptions such as the modes of transmission of HIV. Other important factors are social norms and taboos. The marginalized populations such as sex workers and MSM are seen as a taboo in Botswana society and they are associated with HIV/AIDS. Moreover, there are no legislations to protect PLHIV and these marginalized groups who are vulnerable to HIV/AIDS.

It is stated in NSF that stigma & discrimination are the key determinant of the HIV/AIDS epidemic in Botswana. They create “an environment maintaining the potential for increased

infection as well as limiting the ability of people to live positively and responsibly with HIV/AIDS" (NACA, 2003). Various programmes have been implemented by the Government and its donors to combat the HIV/AIDS epidemic and to reduce stigma & discrimination. There are strong points and weak points in programmes implemented in Botswana. Since the introduction of health services related HIV/AIDS such as ART, CHBC and PMTCT, coverage rates of them have consistently increased. Especially, coverage rates of ART and PMTCT has reached at 85% and are the highest in the world. The government and it donors have implemented these programmes very well, which can reduce HIV/AIDS related stigma & discrimination. On the other hand, legislations and policies to protect PLHIV and the marginalized groups need to be reformed to protect their human rights, and this can result in reducing the level of stigma and discrimination in Botswana.

6.3- Recommendations

There are some recommendations made to improve the interventions focused on HIV/AIDS related stigma & discrimination. Each of interventions must be important. However, it is not down to earth to implement all interventions described. In author's opinion, developing anti-discrimination law to protect PLHIV and the marginalized groups and empowering PLHIV and the marginalized groups can be a priority to implement because "the force of law" is essential to protect the human rights of PLHIV and the marginalized groups. Also, through empowerment of PLHIV and the marginalized groups, they develop skills and knowledge, build self-acceptance and social capital.

6.3.1- Knowledge, attitude and awareness

Family/Community level

- Train members of youth groups as caregivers to involve in care and support of PLHIV. Youth people can play an important role in working as a bridge between the community and PLHIV and their family.
- Provide HIV/AIDS education programmes for the marginalized groups
- Create supportive and confidential spaces for the discussion of sensitive topics such as social taboos to provide opportunities for people to access information and to discuss their concern. Telephone hotlines and drop-in centres can be the opportunity for people to talk more openly about their experiences and anxieties.
- Train local NGOs, CBOs, FBOs staffs and community leaders as peer educators utilizing a toolkit called "Understanding and Challenging Stigma" to integrate stigma & discrimination into other ongoing activities, and improve community leader's attitude and behaviors towards PLHIV.
- Expand the TCB programme to all primary and secondary schools in Botswana.

Workplace settings

- Mobilize resources of all society. Especially public sectors such as education and health department and, TV/Radio stations, civil societies, must conduct HIV/AIDS education programmes.
- Mainstream HIV/AIDS in the workplace to provide employees with IEC to raise awareness of stigma & discrimination on HIV/AIDS, and improve a safe workplace environment, adopting VCT and ART services for employees.

Health care settings

- Strengthen capacity building of health staffs on HIV/AIDS to improve the health care

service and respect the confidentiality and privacy.

6.3.2- Greater involvement of people living with or affected by HIV/AIDS (GIPA)

- Train and support PLHIV and support groups as public speakers, educators and counselors to encourage greater community acceptance of PLHIV and promote a better understanding of the circumstances of people affected by HIV/AIDS.
- Promote openness and discussion around HIV/AIDS to encourage further disclosures of their HIV status.
- Strengthen the system of the Botswana Network on People Living with HIV/AIDS (BONEPWA) by support from the Government or its donors to provide technical support for support groups and empower them to make their activities sustain.

6.3.3- Empowerment of PLHIV and the marginalized groups

- Develop capacities of support groups by local NGOs and CBOs as well as the Government to empower PLHIV and their families.
- Organize a network body of the marginalized populations such as sex workers, MSM and the poor people to protect their human rights and labour rights.
- Train sex workers and MSM as peer educators or counselors to provide the peer education for others sex workers and MSM to increase their knowledge and skills related to HIV and STIs prevention, change behaviors, improve self esteem and develop leadership skills.
- Promote men living with HIV to participate in support groups to engage men in the prevention and care-giving of HIV/AIDS.

6.3.4- Legislations and policies

- Advocate for all human right based policies to be enforced through legislation.
- Advocate for legislative reform to develop an anti-discrimination law against the marginalized groups such as sex workers and MSM to protect their human rights and labour rights.
- Use the knowledge and expertise of BONELA and support it when it needed.
- Encourage private companies to create and enforce HIV/AIDS workplace policies.

6.3.5- Scaling up of care, support and treatment

- Strengthen capacity building of health staff at each level of health facilities to enhance adherence to ART.
- Plan and implement a comprehensive approach to improve adherence to ART.
- Strengthen capacity building of those supporting HIV/AIDS services such as CHBC, ART and PMTCT. These services rely on volunteers, lay counselors and CBOs staffs, whose skills remain weak, so that it is surely essential to develop their capacity to implement the programmes appropriately and effectively.

6.4- Need future research

Various interventions have been implemented to mitigate HIV/AIDS related stigma & discrimination in Botswana. Also, several studies on interventions have been conducted. However, assessments of progress and impact of interventions of stigma & discrimination reduction have been not conducted much.. It is certainly essential to adopt tools and

indicators to measure stigma & discrimination.

Also, the study about internalized stigma among PLHIV has not been done much in Botswana. In terms of GIPA and empowerment of PLHIV and the marginalized groups, this research should be required.

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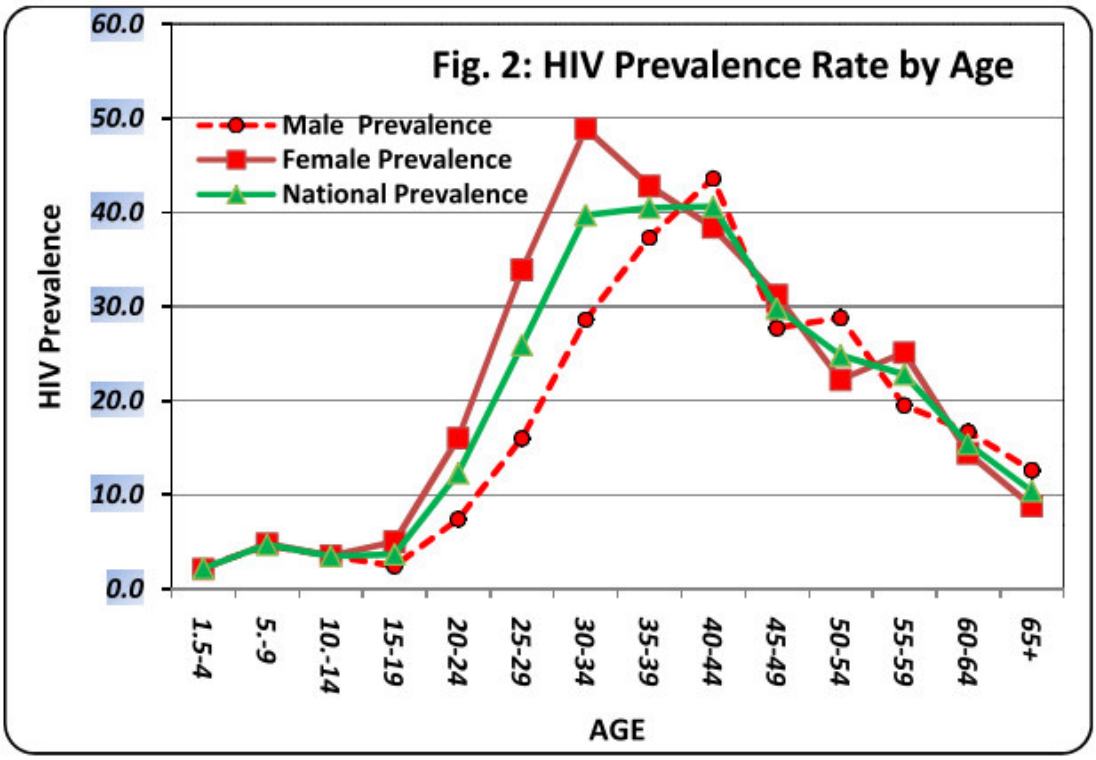
Annexes

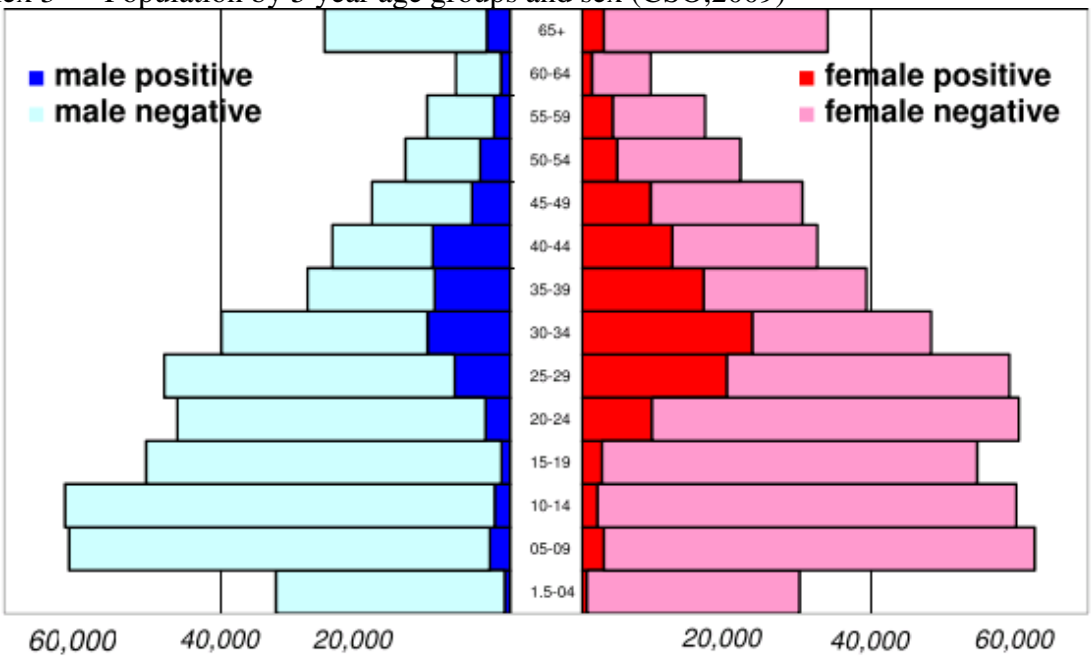
Annex 1 Basic health indicators in Botswana

Indicators	Rate/Figure	Sources	Year
Under 5 child mortality rate (per 1000 live births	40	UNICEF	2007
Infant mortality rate (per 1000 live births)	33	UNICEF	2007
Maternal mortality ratio (per 100,000 live births)	330	MOH	2005
Total fertility rate (%)	2.9	UNICEF	2007
Total adult literacy rate (2000-2007) (%)	83	UNICEF	2008
Literacy rate (the age of 14-25) of male	93%	UNICEF	2008
Literacy rate (the age of 14-25) of female	95%	UNICEF	2008
Life expectancy	50	UNICEF	2007
HIV prevalence rate (%)	17.6	CSO	2008

Annex 2 HIV prevalence rate by age (CSO, 2009)



Annex 3 Population by 5 year age groups and sex (CSO,2009)



Annex 4 Estimated HIV prevalence rate by age and gender (CSO, 2009)

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