The HIV/AIDS epidemic in Botswana has been increasing at an alarming rate: The country now ranks as one of the four hardest hit in the world.

- More than 25 percent of adults (15 to 49 years old) are HIV-positive.
- An estimated 190,000 adults and 26,000 children under age 5 are living with HIV/AIDS.
- The highest HIV prevalence rate is among 20- to 39-year olds.

**AIDS Deaths** The number of deaths due to HIV/AIDS-related illnesses will rise by 208 percent between 1995 and 2015. By the year 2000, life expectancy will be 47 years, compared with 67 without AIDS, a difference of 43 percent. By 2005, average life expectancy will be 41 years.

**Women and HIV/AIDS** A 1998 NACP survey of pregnant women in antenatal clinics reported seroprevalence ranging from 22 percent in Ghanzi to 43 percent in Francistown. The median seroprevalence rate in STD clinics (male and female) in urban sites was 50 percent in 1997, with rural sites reporting a median of 36 percent.

**Children, Youth and HIV/AIDS** By 2010 the infant mortality rate will be nearly double what the rate would be in the absence of AIDS. There are approximately 75,000 orphans in Botswana. Behavioral studies conducted among youth since 1992 show a 90 percent awareness level of HIV/AIDS and means of transmission. However, sexual behavior change and increased condom use have not accompanied the knowledge.

**Socioeconomic Effects** The mean age of death due to AIDS in Botswana is 25 in females and 35 in males—the reproductive and economically-productive years. It is estimated that 20 to 33 percent of children will be orphaned over the next decade as the adult death toll climbs. A study by the Botswana task force on AIDS indicates that the costs associated with the HIV/AIDS problem will increase sevenfold by 2004.

**National Response** Botswana has dealt successfully with national crises in the past; however, the government has yet to treat the AIDS epidemic as a crisis. Plans and programs require budget allocations and human resources. Major challenges include a shortage of program managers and trained health workers, high levels of poverty and unemployment, and the social stigma of AIDS which interferes with prevention and control efforts. NGOs need financial support as key players in community participation.

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BOTSWANA AND HIV/AIDS

Country Profile

Botswana's economy has historically been based on raising cattle and crops, even though only about 5 percent of its land is arable and at least two-thirds of the country is comprised of the Kalahari Desert. Agriculture provides a livelihood for more than 80 percent of the population but supplies only about 50 percent of food needs and, with erratic rainfall and poor soils, accounted for only 3.4 percent of the 1997 gross domestic product (GDP). The mining industry (mostly diamonds) has been the driving force behind the country's rapid economic growth. With a population of 1.5 million, Botswana's 1997 gross national product (GNP) per capita was $3200. This figure, however, masks highly inequitable income distribution, and the unemployment rate is 24 percent. Sixty-five percent of the population lives in urban areas.

With a 1997 GDP of 7 percent, Botswana is the first African country to achieve a sustainable level of development. However, the country is still challenged by widespread poverty, periodic droughts, and the effects of the HIV/AIDS epidemic.

Botswana has one of the most mobile populations in the world, with people shuttling between cattle posts, land areas, large villages, towns and South African mines and farms. This pattern of migration is a factor in the dynamics of the evolving co-epidemics of tuberculosis (TB), HIV/AIDS, and sexually transmitted diseases (STDs). TB accounts for 44 percent of deaths in HIV/AIDS cases.

Twenty-seven percent of children under age 5 suffer from malnutrition. Nearly 100 percent of Batswana have access to safe water, but while over 90 percent of urban dwellers have adequate sanitation, this is true for only 41 percent of the rural population. The government of Botswana spent 1.9 percent of the GDP on health in 1996.

HIV/AIDS in Botswana

The first AIDS cases were reported in Botswana in 1985. Since then, the HIV/AIDS epidemic has been increasing at an alarming rate and Botswana now ranks as one of the four hardest-hit countries in the world. The epidemic is being driven by high-risk heterosexual sexual behavior with high levels of STDs.

• More than 25 percent of adults (15 to 49 years old) are HIV-positive.
• An estimated 190,000 adults and 26,000 children under age 5 are living with HIV/AIDS.
• The highest HIV prevalence rate is among 20- to 39-year-olds.

A cumulative total of almost 15,000 individuals with HIV-related symptoms and nearly 6,000 AIDS cases were reported by the end of 1997. However, because the government does not require notification of HIV/AIDS infections, the number of AIDS cases should be considered an underestimate.

Botswana will experience the largest rise in the crude death rate of those African countries most affected by HIV/AIDS: According to 1999 UNAIDS data, by 2005 AIDS is expected to account for a fourfold increase.

• The number of deaths due to HIV/AIDS-related illnesses will rise by 208 percent between 1995 and 2015.
• The mean age of death due to AIDS in Botswana is 25 in females and 35 in males—the reproductive and economically productive years.

![Crude Death Rate With and Without AIDS in Botswana](source: UNAIDS 1999)
BOTSWANA AND HIV/AIDS

Women and HIV/AIDS

The number of women in Botswana living with HIV/AIDS is growing. Women’s low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound their vulnerability.

- Preliminary findings from the 1998 National AIDS Control Program (NACP) survey of pregnant women in antenatal clinics reported a seroprevalence rate ranging from 22 percent in Ghanzi to 50 percent in Selebi-Phikwe, 39 percent in Gaborone, and 43 percent in Francistown.

- The majority of female AIDS cases reported in 1997 were among 20 to 39 year olds—the reproductive years. This is also the period when women have the most family members under their care.

- The 1998 NACP survey of 65 STD clinics in eight sentinel sites found an HIV prevalence rate in males ranging from 36 to 63 percent.

Children and HIV/AIDS

Forty-three percent of Batswana are under age 15. The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others.

Approximately 25 to 33 percent of infants born to HIV-positive mothers will also become infected with HIV. Among the African countries with the highest HIV-prevalence rates, Botswana has been the most affected in terms of infant mortality.

"Children can't speak for themselves. They are the least of the least in this epidemic, and they are getting hit the hardest."

-- Sandra Thurman, Director of White Office of National AIDS Policy

- The population of Botswana is projected to be 20 percent lower by 2015 with AIDS as a factor than it would have been without AIDS.

- Life expectancy will drop by almost 30 percent during the 1990s as a result of HIV/AIDS. By the year 2000, life expectancy with AIDS as a factor will be 47 years, compared with 67 without AIDS. By 2005, average life expectancy will be 41 years.

- A 1999 UNAIDS report estimates infant mortality in the period 2000 to 2005 to be 59 deaths per 1,000, compared with 39 per 1,000 without AIDS as a factor.

- By 2010 the infant mortality rate will be nearly double what it would be without AIDS.
**BOTSWANA AND HIV/AIDS**

- According to the U.S. Census Bureau, child mortality (under age 5) in 1998 was 121 per 1,000 with AIDS as a factor, compared with 57 per 1,000 without AIDS. By 2010 the rate will be 120 per 1,000 with AIDS as a factor, compared with 38 per 1,000 without AIDS.

It is estimated that 20 to 33 percent of children will be orphaned over the next decade as the adult death toll climbs. Currently there are an estimated 65,000 to 85,000 orphans in Botswana.

The orphan situation was not understood until a 1998 Rapid Assessment revealed the extent of the ravages of AIDS. Botswana now finds itself in a crisis beyond the traditional coping mechanisms of the extended family. According to the assessment, many orphans are living with family members in abject poverty, with inadequate food, clothing, and housing, and many others are fending for themselves on the streets. Abuse of these orphans' basic human rights by society and caregivers is not uncommon, and the number of orphans dropping out of school is rising.

![Child Mortality Under Age 5](source: U.S. Census Bureau 1999)

**Youth and HIV/AIDS**

Behavioral studies conducted among youth since 1992 show a 90 percent awareness level of HIV/AIDS and means of transmission. However, sexual behavior change and condom use have not accompanied the knowledge. According to the NGO Youth Matters, unemployment, poverty, alcohol, and drug abuse create a high-risk environment which facilitates the spread of HIV/AIDS.

As is the case in other countries, the pattern of the HIV epidemic in Botswana is biased toward males for 68 percent of the infected population. Of 545 cases of HIV-related symptoms reported, 79 percent were female.

- According to a civil registration pilot survey conducted between 1990 and 1994, 15- to 29-year-old youth in the country, accounting for 79 percent of HIV-positive pregnant women.

The registration survey also found 80 percent of the 545 cases of HIV and AIDS were from mothers, the majority of them 15 to 29 years old. The high rate of teen pregnancy is attributable to situations where pupils either live on their own, with guardians, or with relatives; attitudes of contraception; peer pressure; lack of communication between parents and children;

![Male/Female Ratio in HIV-Positive Youth Ages 15-29](source: MTP II 1997-2002)

**Socioeconomic Effects of AIDS**

About 90 percent of reported AIDS cases are 20 to 49 years old, the most economically productive segment of the population, an important economic burden is rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of train new employees. The diminished labor pool affects economic prosperity, foreign investment, and cattle raising sectors likewise feel the effects of...
HIV/AIDS with a loss of agricultural labor. In many cases farmers switch from less labor-intensive export crops to food crops—thus affecting production of cash and food crops.

A study by the Botswana task force on AIDS indicates that the costs associated with the HIV/AIDS problem will increase sevenfold by 2004. There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when forced to care for sick family members. AIDS also adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children and 10- to 12-year-olds become heads of households. The 1998 Rapid Assessment on the Situation of Orphans in Botswana revealed a crisis situation that the traditional safety net of extended family could no longer cope with.

(For country-specific information on the socioeconomic impact of HIV/AIDS refer to the analysis presented by the Policy Project.)

**Interventions**

**National Response**

The National AIDS Council (NAC), chaired by the Minister of Health, is the HIV/AIDS policy making body. The NACP, established in 1989, serves as the secretariat of the NAC. The AIDS/STD Unit in the Ministry of Health, established in 1992, takes the lead role in prevention and care activities. The National AIDS Policy was adopted through Presidential Directive in 1993. The National Multisectoral Second Medium Term Plan for HIV/AIDS (MTP2), for the period 1997 to 2002, provides a strategic plan for the involvement of all sectors in society and for support by aid and development agencies.

In addition to epidemiological surveillance, carried out since 1992 in antenatal and STD clinics, and other research, the NACP's three broad strategies include:

- Prevention of sexual transmission of HIV, through information, education, and counseling (IEC) activities, control of STDs, and condom promotion;

- Prevention of transmission through blood;

- Care of people living with HIV/AIDS (PLWHA), including clinical management of HIV/AIDS, home-based care and support, and counseling for support of PLWHA and their families.

The AIDS/STD Unit's IEC activities have targeted in- and out-of-school youth, STD patients, sex workers, truck drivers and mobile workers, and sexually active women and men. Condoms provided by the Ministry of Health are popularized and marketed at the community level. Community mobilization efforts are expected to improve with the training of newly-formed multisectoral AIDS committees.

Although NGOs play a critical role in prevention education, there is no formal funding mechanism to support their activities. An assistance plan from the Ministry of Finance is scheduled for implementation in 1999.

STD control is one of the primary prevention strategies for HIV transmission. Accordingly, the national response to STD control has evolved from the first medium term plan (MTP1) and the syndromic case management approach is now used throughout Botswana.

*It is difficult to care for patients who cannot have their own or their families' basic needs met.*

--Christina Rehlen,
Swedish Ambassador
Despite a healthy economy, Botswana suffers from a chronic shortage of human resources within its health care system and Ministry of Health. This is due in part to the lack of a national medical school and an absence of donor agencies. Until recently, the national response consisted largely of policies, frameworks, and strategies, but little implementation due to lack of an operational plan for MPT2. The Ministry of Health AIDS/STD Unit, UNDP and the Swedish International Development Agency (SIDA) organized a 1998 Consultative Meeting on HIV/AIDS and Development for Members of Parliament, to mobilize steps for short- and long-term interventions.

After a slow start, the government shows signs of recognizing the enormous human development challenge faced by Botswana that bears consequences for economic development and diminishing social welfare in the next century. The government has been funding 80 to 90 percent of the HIV/AIDS program. However, in recent years, the budget allocation has been reduced from US$850,000 to US$213,000 due to a shortage of personnel allocated to implement programs.

The president proclaimed HIV/AIDS one of his top three priorities in his inaugural address, and the new vice president is active in fighting the epidemic, having initiated a weekly HIV/AIDS radio program. Every *Daily News*, the government newspaper, provides information on HIV/AIDS. The NACP's operational Plan of Action, based on MTP2, will be available in June 1999.

**Donors**

Multilateral and bilateral donors are actively engaged in HIV/AIDS activities in Botswana.

**The U.S. government** finances HIV/AIDS activities through: the Centers for Disease Control (CDC)-sponsored BOTUSA Project that focuses on TB and HIV operational research; the U.S. Embassy self-help program ($25,000) for orphans, hospice, and education projects; and the Humanitarian Assistance Program that is financing construction of the National TB Reference Laboratory ($300,000) and space for another Hospital HIV and TB Laboratory ($50,000)

**USAID**'s population, health, and nutrition (PHN) funding from FY 1992 to FY 1996, the year Botswana graduated from U.S. development assistance, was $2.8 million, almost all of which went to HIV/AIDS prevention activities. HIV/AIDS activities were programmed in cooperation with the European Union (EU).

The Botswana Population Sector Assistance Project (BOTSPA), which continued after USAID departure, had three components: improving the quality of family planning and STD services; developing a condom social marketing program; and building capacity of NGOs to design and implement reproductive health communication programs with a particular focus on AIDS education. USAID also played a major

The newly-established Multisectoral Task Force is under the direction of the National AIDS Council. Currently, ten of 23 districts have established multisectoral committees to implement the MTP2 action plans. A mother-to-child-transmission (MTCT) pilot project which provides AZT to infected mothers has been funded for one year. The Home-Based Care program remains in its infancy but has national priority status.

The Ministry of Health AIDS/STD Unit commissioned a Rapid Assessment of the orphan situation in Botswana in 1998. This was followed with the Short Term Plan of Action (STPA) on Care of Orphans for the period 1999 to 2001.

The National Gender Program Framework was issued from the Ministry of Labor and Home Affairs in 1998. Areas of focus include: women and poverty; power and decision making; education and training; health; girls; and violence against women, including human rights.

The Red Cross tests all donated blood specimens and runs an active counseling and testing center. HIV testing is mandatory among young male military recruits. However, these data are inaccessible.

The Botswana HIV/AIDS and Human Rights Charter, a non-legal document, was drawn up by a group of PLWHA at a 1995 conference hosted by the Red Cross AIDS Information and Voluntary Testing Center and Ditshwanelo, the Botswana Center for Human Rights.
coordinating role among multilateral and bilateral donors.

UNAIDS has a coordinating Theme Group based in Botswana, chaired by WHO and including representatives from UNDP, WHO, UNFPA, and UNICEF. It also includes the World Bank in its programs. In the period 1996 to 1997, UNAIDS supported HIV/AIDS activities in Botswana with US$338,894, the bulk of which was contributed by the Norwegian government. The UN Theme Group conducted joint program review and planning with the government. UNAIDS contributed US$140,000 in the period 1998 to 1999 for HIV/AIDS activities, including the production of a booklet documenting the mobilization of youth in the promotion of sexual health. The UN Theme Group currently has four major areas of focus: community care and children affected by HIV/AIDS; strengthening institutional capacity; strengthening research capacity; and HIV in the disciplined forces.

UNDP collaborates with the government of Botswana on institution building and HIV/AIDS policy and program development.

UNFPA has supported government HIV/AIDS policy and program development.

UNICEF is collaborating with the Ministry of Health on the MTCT pilot project providing AZT to HIV-positive pregnant women.

WHO assisted in the formulation of MTP1 and has supported evaluations and assessments of STD services.

The World Bank is supporting Community Home-Based Care activities with US$330,000 (1998-1999).

EU is funding a National STD Referral, Research and Training Center. The EU financed the setup of the Women and AIDS Project.

SIDA organized the Consultative Meeting on HIV/AIDS and Development for Members of Parliament.

Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)

The Botswana Network of AIDS Service Organizations (BONASO) gives a voice to grassroots organizations working for home-based care, counseling, HIV/AIDS policy advocacy, NGO-government relations, and NGO participation in national HIV programs. BONASO provides information sharing and advocacy as well as institutional capacity building. NGOs and private and parastatal businesses are members. BONASO produces a quarterly newsletter.

The Botswana Council of Women sponsors the Women and AIDS Project, which focuses on the female vulnerability to HIV/AIDS. The project educates youth in life and reproductive health skills; educates men in gender issues in HIV/AIDS prevention and promotes their role in reproductive health; and helps communities mobilize to deal with challenges such as orphans, funerals, and care and support of PLWHA and those affected by HIV/AIDS. The project is a resource center for gender and HIV/AIDS issues in the country and the region.

A number of PVOs implement activities funded by multilateral and bilateral donors. One of the major PVOs is Population Services International, which currently receives funding from the government of Botswana. See attached preliminary chart for PVO and NGO target areas of HIV/AIDS activities. This list is evolving and changes periodically.

Ninety-five percent of Batswana have access to condoms. The social marketing of condoms program, started in 1992 by Population Services International and currently funded by the government, has been one of the most successful worldwide, with over ten million condoms sold since project inception.
BOTSWANA AND HIV/AIDS

Challenges

Major constraints to HIV/AIDS control in Botswana include the following:

- Lack of experienced managers and trained health workers.
- Shortage of allocation of funding and human resources in the health sector.
- Lack of funding for NGOs that play a critical role in the fight against HIV/AIDS.
- Limitations of social welfare for orphans and caregivers.
- High levels of poverty and unemployment.
- Denial and the social stigma of AIDS interfere with prevention and control efforts.
- Teenagers do not receive needed support and information regarding sexual behavior.
- Lack of voluntary counseling and testing.

Programming gaps which require focus include:

- Few action plans are in place to implement policy and the strategies of MTP2.
- Communities and NGOs are asked to share responsibility for HIV/AIDS education and care and support, but without training or resources.
- Although a national framework is in place for addressing the unequal status of women, grassroots efforts are the most visible.
- With an imminent labor shortage crisis, few programs are in place for accelerated training of replacement labor for the more than 20 percent who are unemployed. More programs are needed for the skills training of youth who most often complete their education at the pre-secondary school level.
- Reproductive health/STD/HIV services would benefit from a more youth-friendly approach.
- There are limited STD services for sex workers.

The Future

It is unfortunate that the impact of AIDS has advanced to such a critical level. Botswana has dealt effectively with national crises in the past (e.g., drought and the cattle lung disease) but the AIDS epidemic has yet to be acknowledged by the country's leaders and policy makers as a crisis. New plans and programs have no value without money and staff. There is no shortage of financial resources, only limited budget allocation to the crisis. Recruitment and allocation of human resources for HIV/AIDS programs in all sectors are needed now. In addition to government efforts, community participation at all levels is essential for effective HIV/AIDS care, prevention, and support activities; NGOs need financial support as key players in communities.

There is a limited understanding in Botswana of the dynamics of AIDS and its impact on society. Aggressive public outreach campaigns and education interventions must continue to target key high-risk populations, such as sex workers, migrant populations and adolescents.

Important Links

1. AIDS/STD Control Unit: Ministry of Health, Rose Mondevu, Manager, Tel: (267) 312-492; Fax: (267) 302-033
2. National Center for HIV, STD and TB, Director Dr. Helene Gayle, 1600 Clifton Road, NE, MS-E07, Atlanta, GA 30333; Tel: (404) 639-8000; Fax: (404) 639-8600; E-mail: hdg1@cdc.gov
3. UNAIDS Focal Point: Innocent Modisaotsile, UNDP, P.O. Box 54, Gaborone, Tel (267) 35 21 21, Fax J(267) 35 60 93 E-mail i.modisaotsile@undp.org
4. National MTCT Working Group: Coordinator Dr. Loeto Maxhani, Nyangabwe Hospital, Francistown. Tel: (267) 211-211; Fax: (267) 216-527
5. CDC BOTUSA TB Research Project: Director Dr. Tom Kenyon, P.O. Box 90, Gaborone. Tel: (267) 301-696; Fax: (267) 303-532; E-mail: tak8@cdc.gov
6. The Botswana Network of AIDS Service Organizations (BONASO): Chairman Ivor Williams, Tel 311-319, Fax 570-582 or c/o PSI; Tel: (267) 357-610; Fax (267) 305-265; E-mail: psibots.lplus@info.bw

7. The Women and AIDS Project: Koketso Rantona, Tel 306 352, Fax 352 109

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June 1999
### Botswana

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**KEY:**
- **Advoc.** Advocacy
- **BCI** Behavior Change Intervention
- **Care/S** Care & Support Activities
- **Training** HIV/AIDS training programs
- **Cond.** Condom Distribution
- **SM** Social Marketing
- **Eval.** Evaluation of several projects
- **HR** Human Rights activities
- **IEC** Information, education, communication activities
- **MTCT** Mother to Child Transmission activities
- **Research** HIV/AIDS research activities
- **Policy** Policy monitoring or development
- **STD** STD services or drug distribution
- **VCT** Voluntary counseling and testing
- **Orphan** AIDS orphan activities
- **TB** TB control
- **Other** (I.e. blood supply, etc.)