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Inadequate services and information

Although the majority of the research participants indicated that clinics were serving them adequately and giving them information, about a third of the research participants indicated gaps in service and information in the area. They indicated that many AIDS service organisations were generally avoiding the Tsabong area because it was dry and poverty stricken. In Ghakibana village, for instance, the geography of the area and its aridity made information access a big challenge, especially for the people in the settlements. In Bokspit, for instance, the second-line ARVs were not available and participants had to go to Tsabong. Given the poverty in the area, finding transport funds to go to Tsabong posed a big challenge. Information lacuna, therefore, could be a factor derailing the prevention process for the people of Tsabong. The following comments by participants support this view:

> *The people of Gakhibane village are in information blackout. The geographical terrain and its aridity has made information availability and access a huge challenge.*
>
> *People who need second-line treatment cannot access them here in Bokspit. One has to go to Tsabong. Transport from here to Tsabong is a big challenge.*

Unhealthy conflict between biomedical practitioners and traditional healers challenge prevention

Virtually all the participants indicated there was no collaboration between the two treatment systems. Participants indicated that many community members had confidence in the traditional healers because of their historical record of assisting the sick. Some indicated that despite the biomedical practitioners' discouragement of the use of the traditional healers' medication, many were still good customers. However, the case of one person who died in the hands of a traditional healer in Werda village and yet he was not HIV positive made many people hesitant to access the services of the traditional healers. They also indicated that people's prevention efforts could be jeopardised by combining the services of the biomedical practitioners and the traditional healers in tandem. The two systems gave advice that was diametrically opposed. The following sentiments were expressed in this regard:

> *The case of a healer who killed a community member in Werda has made people to relent their faith in traditional healers.*
>
> *People in this area have deep faith in traditional healers.*
>
> *We understand that the use of the two systems can compromise the body immunity. But sticking to one system has been a big challenge to most of us here in Tsabong.*
>
> *Members of health fraternity have been discouraging community members against accessing the services of the healers. But people have found it difficult to leave the therapists they have known and accessed their services since time immemorial.*

Discussion of the findings

Many research undertakings in Botswana have found people living with HIV/AIDS in dire need of nutritional support (MOH/JHPIEGO, 2009. In their research in Kweneng District, Mojapelo, Ditirafalo, Tau and Dohlie (2001) found most people living with HIV/AIDS and their caregivers seriously requiring nutritional support. Studies by Jacques and Stegling (2001), still in Kweneng, also found caregivers and their clients in abject poverty, which could compromise the success of the ARVs among the PLWHAs. It is recommended that the government, NGOs, donors and any care-friendly organisations come together and help people

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start income-generating projects to alleviate poverty. The prevention efforts could be failing because of inadequate nutritional support.

The preponderance of women who come out to support the campaign is a feature that cuts across many research findings in Botswana. In his research in 2004 and 2006 in Kanye, Kang'ethe found that care programmes had over 95% women (Kang'ethe, 2004, 2006a). Current literature in Botswana indicates inadequate male involvement in the health campaigns, HIV/AIDS campaigns notwithstanding (Kang'ethe, 2009a). This jeopardises the campaign as it fails to benefit from men's better socio-economic, cultural and leadership social capital qualities. The role of the men's sector to mobilise and win men over to respond to issues of health especially HIV/AIDS campaign is critical (Kang'ethe, 2009a).

While data on conventional prostitution exists in Botswana, there may not be much data on the latent prostitution that was revealed among the Tsabong PLWHA clients, whereby a woman would have several sexual partners providing different kinds of assistance in exchange for sexual favours, instead of the conventional transactional sex (BONEPWA, 2008; BOTUSA, 2007). This kind of prostitution did not require urban facilities. It could thrive even in the rural settings. However, it satisfies the definition of prostitution (BONEPWA, 2008). Though sex work and therefore prostitution is illegal in Botswana, a range of literature provides glaring evidence of its existence. Studies by Motlhabane and Chipfakacha (1995) record evidence of sexual behaviours, such as unprotected sex by male sex workers with their male clients; male and female non-commercial partners; anal sex in female sex workers; genital cleansing for STI/HIV prevention and seeking care for STI from about 66% of the sex workers in Francis Town. The 2007 BOTUSA female sex work study indicated that people living with HIV/AIDS and on ARVs were also engaged in prostitution; while 30% of the female sex work participants voluntarily revealed their HIV-positive status (BOTUSA, 2007). One PLWHA participant had this to say: "Sick or no sick, you have to go to work. I started ARVs a week back. I have headaches, I feel dizzy. Still I am on the job" (BOTUSA, 2007:31). This proves how prostitution possibly put them into a state of vulnerability and compromised prevention.

Research in 2002 indicated that sex workers had the challenge of care seeking for STI, low condom use and high alcohol intake, especially in Mamuno village, Gaborone city and Kasane town. This necessitated policies and programmes for harm reduction in this population (Wilson & Project Support Group, 2002). The 2003 contextualisation of sex work for women in Tlokweng among the orphans and the street children in Gaborone and its environs revealed the following factors: high alcohol intake among the sex workers; no fixed premise for prostitution increasing their vulnerability to violence and rape; non-payment for the services; prevalence of STI/HIV and inconsistent condom use by different partners (Ministry of Health (MOH)/Family Health Division (FHD), 2003; Ntseane, 2003). Suggestions from the sex workers in the above research included asking for skills training for income generation, improved working conditions (established apartments or brothels to store/sterilise sex toys, keep condoms, inspect clients, ensure payment); legalisation of their profession to reduce and limit police brutality, rape, sabotage and increased incarceration; skills training on condom use and rapid diagnosis and treatment of STI (Ministry of Health (MOH)/Family Health Division (FHD), 2003; Ntseane, 2003). Luke and Kurz (2002) indicate that trans-generational and transactional sex are very common in Sub-Saharan Africa, where adolescent girls engage multiple partners simultaneously in order to maximise the benefits of these relationships. They extract money and gifts from older men for sexual services. This agrees with the Tsabong BONEPWA study that issues of prevention have taken second place, with ways of economic survival assuming

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the primary position or priority (BONEPWA, 2008). Policy-wise, the country's 2003-2009 Botswana National Strategic Framework II also recognises sex workers as a vulnerable population that requires specific targeted intervention (NSF, 2003). Policy makers need to chart out ways and means of diagnosing the environments making the sex trade thrive and make targeted interventions to change the situation. This would do much to strengthen prevention.

The literature on increased sexual motivation due to high sexual libido from taking the antiretroviral drugs (ARV) is scanty in Botswana. However, while sexual libido is both a scientific and social reality attracting people to sexuality, the research indicators vary. One female client in the 2007 BOTUSA female sex workers study indicated that, because of multiple sexual encounters with different men, she learnt more about the sexual preferences of men. She indicated that sex work allowed her a sexual life and excitement that she did not know before she started the trade. In the same study, other women sex workers suggested that they could even give some clients free sex for exciting and treating them well. Nyanzi, Pool and Kinsman (2000) indicate that in many sexual relationship contexts, condom use is viewed as the responsibility of men, but men believe that condoms reduce sexual pleasure. This has led to many unprotected sexual encounters. In other research by the same researchers, younger women's sexual involvements with older partners were found to be mainly financially driven, with some girls reporting that they enjoy the pleasure of sexual activity with more experienced older partners (Nyanzi *et al.,* 2000). This author thinks that this is due to men's raising and provoking women's sexual arousal and libido.

Contrastingly, other women indicated that they do not enjoy sex with clients and they were only motivated by money and not sexual desire (sexual libido) (BOTUSA, 2007). A study in Tanzania concluded that "material benefits are one of the incentives for the relationship, while sheer love or the expectation of marriage is often of secondary importance or none at all" (Komba-Malekela & Liljestrom, 1994:140). Another study by Caldwell, Caldwell, Ankrah, Anarfi, Agyeman, Awusabo-Asare and Orubuloye (1993) indicated that in most relationships sexual encounters are mostly controlled by men with little concern for women's sexual desires. According to the author of this article, all the experiences above could partly explain why HIV prevalence in Botswana is not declining, despite all the government's investments, especially in ARVs (BOTUSA, 2007; CSO, 2008). The government needs to establish other ways of allowing the benefits of the ARVs to effectively produce optimal dividends.

Alcohol abuse in Botswana is a common practice (Kang'ethe, 2007c). People living with HIV/AIDS and on ARVs are also caught in the trap. In some other research undertakings, people living with HIV/AIDS state they are taking alcohol excessively as a result of their hopelessness emanating from poverty, joblessness, stigma and discrimination (BONEPWA, 2008; BOTUSA, 2007; Kang'ethe, 2007a,c). The finding that alcohol intake lures people into encounters of a sexual nature concurs with research findings by this author in Botswana that indicated that alcohol inclines people to sexual behaviour. This could be the same scenario in Tsabong with those on ARVs being suspected of drinking a lot and becoming involved in unprotected sexual activity. Cases of ARVs been left or lost in the bars are a pointer to what excessive intake of alcohol is doing to the prevention efforts in the country (BONEPWA, 2008; Kang'ethe, 2007c). The Tsabong study indicated that people on ARVs were no longer strong or worried about the prevention strategies. This could pose a challenge to drug resistance and therefore decreased response (BONEPWA, 2008). Serious strategies to empower those drinking carelessly as a result of unemployment need to be devised. Strategies for income-generating projects could be way of addressing these challenges.

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Repeated pregnancies constitute one of the challenges that the government of Botswana is worried about as it is poses a serious problem for the successful implementation and success of the ARV roll-out in the country. The ARV national roll-out continues to take up a lion's share of the government's national budget (Kang'ethe, 2006a; NACA, 2003, 2005). Many of the clients on ARV who continue to be victims of repeated pregnancies are at risk of reduced immunity that could seriously compromise their health, and sometimes necessitates their moving from one line of treatment to another (Kang'ethe, 2007a). The occurrence of repeated pregnancies is to some extent a sign of failed drug adherence and therefore a deterrent to the prevention of the national campaign. This is why the issue has led to some senior government officials and workers blaming the PLWHAs for repeated pregnancies and spreading the virus to their partners (Moseki, 2007). According to Moseki (2007), this is unfair because the comments do not take into account the critical circumstances on the ground. While women are important players in the national response in Botswana, they have been weighed down by a denial of their human rights in that they have been sexually controlled by men because of the huge gender power differentials in society. This has made it difficult for some women to negotiate for contraceptive use such as condoms. In fact the Tsabong study revealed that very few women on ARVs would like to face the health challenge of repeated pregnancies. They indicated it was embarrassing to their communities and the government at large (BONEPWA, 2008). Many are victims of failed negotiations about condom use, because of men's control over their reproductive health rights, and the fact that many are too poor to be able to afford turning down the demands of their sexual partners. Patriarchy has also had a huge impact in suppressing the women's rights to control their sexual reproductive health (Kang'ethe, 2009a; Lekoko, 2009; Moseki, 2007). Therefore, it is the author's contention that unless the social, economic and cultural forces are adapted to the advantage of women, their capacity to respond to the epidemic may remain low.

On the whole, ARV access and administration is a success story in Botswana. This is internationally recorded in the country meeting the WHO "3x5" targets well in time. Under these targets most countries of the developing world were given a quota of people to access ARVs by the year 2005. The target's rationale was that if all the countries involved would achieve their targeted quotas, 3 million people living with HIV/AIDS would be able to access the ARVs by the year 2005. The country of Botswana was the first among all the countries to achieve its quota target. It had given ARVs to more than 55,000 persons living with HIV/AIDS by the year 2005 (Kang'ethe, 2007b; UNAIDS/WHO, 2005). While accessing ARVs is a good thing, it is important that other structural support systems be explored to extend and influence the results of ARV access. One such important structural challenge is inadequate nutritional support among the people living with HIV/AIDS. The researcher and his team reckoned that most people interviewed looked very needy as far as nutritional support was concerned. The team worried that the ARV success may be compromised by the nutritional challenge. Perhaps the words of South African Development Cooperation (SADC) Executive Secretary, Dr Salomao, quoted in the Botswana *Agrinews Magazine* of October 2006 need to be taken seriously. He contends that ARV roll-out in SADC countries may not achieve desired results if food security is not adequately addressed. He commented that "There is no point in giving people ARVs on an empty stomach" (Otlhabanye, 2006). As lack of adequate food could negatively influence the efect of the ARVs, the government and the NGOs in the care field need to work out strategies to ensure food security in the region.

Kang'ethe's study in 2004 in Kanye indicated that HIV/AIDS is a poverty-friendly disease (Kang'ethe, 2004). Left with no good economic option, some people living with the virus may

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desperately look for economic survival strategies by any means, sex work being such one attractive venture. Among the girls, 14 years and older, in Swaziland, 20 percent reported being sexually active for financial reasons to fill the poverty gaps in their families, while in another study in rural Tanzania, 52 percent of the female primary school students and ten percent of female secondary school students reported being sexually active for money and presents (MacLean, 1995; Matasha, Ntembelea, Payaud, Todd, Mujaya & Tendo-Wambua, 1998). According to the 2007 BOTUSA female sex work study, findings indicated women giving an array of reasons for involving themselves in prostitution. Reasons included the inability to meet basic materials needs, and poor family backgrounds making it difficult to acquire the basics. Other reasons that were advanced include: men's failure to provide adequate financial and emotional support; desire to purchase luxury goods; poor educational backgrounds; lack of or poor prospects of work opportunities; and among those who were working, very little pay to make a living. In sex work, the women participants indicated getting enough to cater for their family needs (BOTUSA, 2007).

Culture and poverty may intertwine to direct the women's sexual behaviour. Some studies have indicated that parents of especially the younger women may also be influencing their daughters' sexual position when, for instance, they pressure them to form relationships with older established partners with economic stability, especially to support them in case of pregnancy (Gage, 1998). Other similar studies reveal parents warning their daughters not to bear a poor boy's child (Gorgen, Yansane, Marx & Millimounou, 1998). Across many countries of the world cultural beliefs, norms, thinking and stereotypes have been found to be some of the underpinning factors making men and women more vulnerable to HIV/AIDS (Kang'ethe, 2009a). According to Orubuloye, Caldwell and Caldwell (1992) and Lekoko (2009), African men, especially, feel that it is their natural rights to have multiple partners, with a preference for younger women. In Botswana Setswana proverbs indicate that it is acceptable for men to be in multiple relationships. Kang'ethe (2009a) mentions Setwana proverbs that endorse this practice, such as "*monna ga a gelwe lesaka*", which loosely translates as 'a man should not be tied to one woman', "*monna ke selepe, o tsamaya o a hapaanelwa, monna ke selepe, o a tsamaya o a rema*", which translates to the idea that a man has the freedom to associate with multiple and concurrent partners. Such cultural beliefs are doing more harm to the HIV/AIDS campaign that strongly advocates for faithfulness and sticking to one partner. A lot of research on the effects of culture on the success of HIV/AIDS campaigns needs to be carried out and results worked out fast. This is because the author thinks that HIV/AIDS in Botswana is culturally grounded and yet the campaign machinery has not yet given this issue due consideration.

Gender inequalities continue to be glaringly common scenarios in many societies, especially in the developing world (UNAIDS, 2000a, 2001). The situation continues to undermine women's responses in the HIV/AIDS campaign (Kang'ethe, 2009a). In the 2008 Tsabong study, women reported being sexually harassed by their partners and being forced to have sex without condoms. This could explain to some extent the cases of repeated pregnancies among a large number of the country's PLWHAs. Though the burden of repeated pregnancies cannot be removed from women, the fact of the matter is that we need to explore and recognise the existence of cultural dynamics that control sex and male sexuality in communities (SAFAIDS, 2004/3-4). Women may need to be assisted in their response by men owning the process and supporting the cause. In the absence of that, the HIV/AIDS battle may continue to weigh the country down. In a research study carried out among 1,366 women who attended health centres in Soweto, Johannesburg, and who agreed to be tested for AIDS, women who were beaten by

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their husbands or boyfriends were found to be 48% likelier to become infected by HIV than their counterparts (http://www.aegis.com/channel/s/AFO40444.html, 2004). The government and care-based organisations need to look especially at the poverty of women and help them start income-generating activities. This could be one of the strongest strategies of empowering women and give them strong control over their reproductive sexual health

While the Tsabong study indicated cases of inadequate services and information in some places such as Gakhibana village because of the geographical challenges of the area, which could impact negatively on the HIV/AIDS response, this author visited most of the Kanye village's clinics in December 2005 and January 2006 and found only about 50% of most of the important components needed for community home-based care services were available (Kang'ethe, 2006a). Though the government has invested heavily in the HIV/AIDS campaign, monitoring of health services need to be strengthened (NSF, 2003). Many communities in the rural areas still lack adequate information on HIV/AIDS. The availability and monitoring of contraceptives such as condoms need to be strengthened (BONEPWA, 2008). An ad hoc visit by this author to a number of clinics in areas around Mabutsane in 2004 revealed that there were no condoms in most of them. The work ethic and level of supervision among most health-service providers in the country need to be strengthened.

The case of one person who died in the hands of a traditional healer in Werda village in Tsabong District is evidence of the dangers of using the untested concoctions sometimes used by the healers (Pinky, 2001; UNAIDS, 2000b). In the Kanye case study by Kang'ethe (2006a), most participants indicated they did not have enough confidence in the healers and that traditional healers were in the trade to obtain other people's fortunes, with a few participants indicating they had confidence as they had come a long way with them. However, the Tsabong people indicated having much confidence in their healers despite the weaknesses inherent in their therapies (BONEPWA, 2008). The Kanye as well as Tsabong studies indicated the existence of bad blood between the two service providers. However, both the Tsabong study as well as Kanye study recommended to the government to map a strategy which could bring the two service provider together for the sake of the HIV/AIDS campaign. This is because of the awareness of each service provider's unique strengths that could be of utmost use if shared mutually between the two parties (Kang'ethe, 2009b).

CONCLUSION

The government of Botswana needs to be acknowledged for its formidable efforts to place prevention strategies in place. The national roll-out of the antiretroviral drugs has made the formerly desperate nation glimmer with hope for the future. But the success in ARV access and administration has not been commensurate with prevention results. People living with HIV/AIDS have failed to adequately rise to the challenge and take advantage of the ARVs sufficiently. Instead, cases of increased alcohol intake, repeated pregnancies and weaker adherence to the ARV regime have continued to derail and to undermine the prevention efforts. This has left the government machinery desperate and in a dilemma. Perhaps other factors of social, economic and cultural environments need to be revisited to assess the effect they may be having on the intended beneficiaries. Poverty, especially, needs critical address. Factors such as the nutritional challenges need to be addressed to ensure that HIV/AIDS prevalence takes a downward turn instead of the current upward trend (CSO, 2008).

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