

Gender and HIV/AIDS in Botswana: a focus on inequalities and discrimination

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This article discusses the response of Botswana to the HIV/AIDS epidemic. In recognition of the fact that HIV/AIDS is more than just a health issue, Botswana has instigated a multi-sectoral response to the epidemic, which sets Botswana apart as an example of a country following 'best practice' in HIV/AIDS prevention and control. Yet the battle is not over. AIDS is the leading cause of death in Botswana for young adult women aged between 15 and 19 years old. This article makes suggestions for future improvement, to respond to the challenges facing Botswana women living with, and affected by, HIV/AIDS.

In sub-Saharan Africa, of which Botswana is a part, HIV/AIDS has become the leading cause of morbidity and mortality. Botswana has a population of 1.7 million, and its estimated total HIV prevalence is 17.1 per cent (Botswana AIDS Impact Survey II 2004), rising to 37.4 per cent among pregnant women aged 15–49 years (NACA 2003). This remains one of the highest in the world. The Botswana AIDS Impact Survey II (2004) shows that HIV prevalence rates by age for both sexes are highest among the 30–34 age group at 40.2 per cent. These are followed by the rates by age of the 35–39 age group, at 35.9 per cent, the 25–29 age group, at 33 per cent, and the 40–44 age group, at 30.3 per cent. HIV prevalence is estimated to be relatively low among the 15–19 age group, at 6.6 per cent.

Botswana's approach to the pandemic: a brief overview

As suggested at the start, Botswana is known as a country that has responded well to the crisis. It is widely recognised that Botswana's response to the epidemic needs to be comprehensive, and address both the prevention and impact of HIV/AIDS on young men and women.

The multi-sectoral approach of the country is co-ordinated by the National AIDS Council, whose chairperson is the president. This approach involves the Secretariat of the Council and the National AIDS Coordinating Agency (NACA), which was formed in 1999 by a Presidential Directive.

The first national HIV/AIDS policy, in 1993, did not include gender concerns. In the follow-up to the Fourth World Conference on Women (1995) and the International Conference on Population and Development (1994), Botswana started to implement the recommendations related to gender, health and HIV/AIDS, and endorsed them in its health policies. The national policy was reviewed and revised, in 1998 and 2001 respectively.

In January 2002, the Botswana government started to provide antiretroviral (ARV) therapy to all eligible persons. To be eligible for enrolment in the national ARV therapy, one has to have an AIDS-defining illness and a CD4 count less than 200. Data from MASA indicate that about 50,000 people have been enrolled in the national ARV programme, but only 43,000 are currently on treatment, while the remaining 7,000 are awaiting treatment initiation (paper presented at the Nurses Association annual general meeting by the National ARV Co-ordinator, 28 September 2005). All people living with HIV/AIDS should have access to antiretroviral therapy and treatment for opportunistic infections as a matter of urgency. This should be coupled with proper education about lab tests used to decide if one needs the drugs, the side effects of the drugs, and the need for adherence to the schedules for taking the medication correctly.

The overall aim of Botswana's national approach is now to empower men and women in all aspects of HIV/AIDS prevention and care. However, there are still some constraints, relating to holistic and multi-sectoral approaches to health care provision. Women have been the main beneficiaries of the Primary Health Care (PHC) strategy, but despite this there are deficiencies in the services in some critical areas, such as, lack of and/or inadequate screening and treatment of reproductive tract infection. Women are the major consumers of health care compared to their male counterparts, whose use of health services is low. Yet, women's subordinate status also frustrates health promotion and disease prevention strategies, and this has adverse implications for HIV/AIDS spread and transmission.

In the next section, we focus on the reasons why women are particularly likely to contract HIV, and less likely than men to access treatment.

Factors influencing women being infected with HIV

Biological factors

Most Botswana women become infected with HIV through unprotected vaginal intercourse. Women are more vulnerable than men to contracting HIV in this way. Research indicates that the risk of HIV infection is two to four times higher for women than men, because of the larger mucosal surface areas exposed to contact with infected fluids (Mutangadura 2000; UNAIDS 2002), and the greater viral concentration present in semen, as compared with vaginal secretions.

Some of the other factors that have been found to increase women's biological vulnerability to HIV infection as compared to men include general poorer health, and the greater likelihood that women will have other sexually transmitted infections (STIs). The most important and preventable biological risk factors associated with HIV infection are sexually transmitted infections, especially the ulcerative STDs such as chancroid, syphilis and herpes. However, even the non-ulcerative diseases, such as gonorrhoea, chlamydia and trichomoniasis, have now been implicated in the risk of HIV acquisition. With the high incidence of STIs in sub-Saharan Africa, it is evident that these play an important role in HIV transmission. For men, it is easier to have early diagnosis and treatment of STIs, but for women most STIs are asymptomatic and women may be unaware that they need to seek health care. They may also have less control over financial resources, and this is important in limiting their access to private health care. This impedes early detection and timely treatment, thus increasing their chances of HIV infection.

Social factors

The biological differences in susceptibility to HIV of men and women are important, but these are overshadowed by the importance of the social and economic inequality between women and men. Inequality between men and women manifests itself, among other things, in unequal employment opportunities, unequal access to wealth, unfair division of labour in the household and generally unequal power relations. It also manifests itself in violence against women, including battery and rape (Botswana Human Development Report 2000). The following factors will now be discussed: age, economic dependency on men, cultural factors preventing women from negotiating safer sex, and health.

1. Age

In Botswana, as suggested above, data on HIV and AIDS suggest that girls are more susceptible to HIV infection than boys. For every HIV-positive boy under the age of 14, there are two HIV-positive girls of the same age. The ratio then rises to 1:3 in the group aged 15–29, before equalising in older groups (ibid.).

Studies on sexual behaviour in Botswana indicate that first sex for young women is at an average age of 16 (ibid.). The first sexual experience for females tends to be with an older and more experienced man. These gender disparities are manifest, among other things, in unequal employment opportunities and unequal access to wealth. Poverty often forces women, especially young girls, into exploitative sexual relationships now commonly referred to as 'inter-generational sex' – the 'sugar daddy syndrome'. In these asymmetric relationships, women and girls are unlikely to be able to negotiate safer sex, predisposing them to unwanted pregnancies, STDs and HIV infection.

Furthermore, early marriage makes young girls vulnerable to the deadly virus because they are likely to marry experienced older partners. Marrying at an early age disadvantages women in that they are more likely to be economically dependent on their husbands, thus making it even more difficult to refuse sex, or to negotiate for the use of safe sexual practices. The inequality in such relations militates against efforts to prevent HIV.

2. Economic dependency on men

Socially, women in Botswana are dependent on marriage and relationships with other men to gain access to decent levels of income. Most women in Botswana are employed in traditionally female jobs in the informal sector. Large numbers of women work as domestics. Most of the formal sector posts open to the minority of women who have access to them are relatively low-paying in contrast to men's jobs: typists, clerks, secretaries, school teachers and nurses.

With the advent of HIV/AIDS, women are more likely than men to quit their employment to care for sick relatives, thus reducing their income-earning capacity. Similarly, the increased participation of women into the labour market has also forced them to take on additional income-generating activities while continuing with their domestic chores of which family caregiving is a part. The tension brought about by these social and economic changes impact on all household members, but particularly on women. As a result, women are more likely to experience stress, role conflict, depression, fatigue, anger and other frustrations. Since women are typically the providers of care rather than its recipients, when resources are scarce, they defer treatment for their own disorders in order to get care for their families. All these factors militate against HIV prevention strategies for women.

Studies on poverty in Botswana suggest that women are poorer economically than men, and that poverty is likely to be higher among female-headed households, as compared with male-headed households (Botswana Institute for Development Policy Analysis 1997; UNDP 2000). The poverty that women find themselves in due to income inequalities between males and females further encourages them to engage in risky sexual behaviours in an attempt to augment their meagre incomes. The economic disadvantages that women encounter are part of the broader economic development constraints that face Botswana.

3. Cultural factors preventing women from negotiating safer sex

Cultural factors also affect women's likelihood of contracting HIV. Women do not often have the right to sexual and reproductive autonomy. The subordination of women to men creates a highly unfavourable environment for preventing HIV infection. Major

prevention strategies are abstinence, mutual fidelity and the use of the male condom, none of which are under women's control.

In Botswana, women have been historically regarded as inferior to men within Tswana customary law. Under customary law, women are subject to the guardianship throughout their entire life, initially under their fathers' guardianship until they marry, and subsequently under their husbands' – in marriage, a wife is treated as her husband's child (MacDonald 1996; Schapera 1970). The legacy of this cultural norm is important for understanding the contemporary position of women in Tswana society and its connection to the transmission and rapid spread of HIV/AIDS in sub-Saharan Africa, and, in particular, Botswana (Phaladze 1999).

The major stumbling block to women's equality in Botswana is the customary law, which entrenches women's subordination to men. The traditional perceptions of women as minors held within the legal and judicial system have perpetuated male dominance over women, making it difficult for women to access productive resources. Certain provisions in both the customary and common law do not treat men and women equally. A number of statutes have provisions that discriminate against women to the extent of limiting their opportunities (Women's Affairs Department 1998). These include: the Married Persons Property Act; the Penal Code; the Companies Act; the Deeds Registry Act; and the Adoption Act. These statutes together have the effect of restricting married women in acquiring rights to land, immovable property and advancing their career opportunities in the commercial sector.

Men's role as the 'senior partner' in marriage means that they are the ones who control sexual decision-making, and social norms tolerate them having multiple sexual partners. A study by Palai *et al.* (1998) confirmed that the majority of Botswana men aged 15–19 are sexually active, and most of them have had or have more than one sexual partner. Men tend to think that it is acceptable to have extra-marital affairs, but they are not necessarily keen on using condoms and will use them only when they do not trust the other party, for example for casual sex. These behaviours are among the root causes of the growing AIDS epidemic and need urgent attention. What is also apparent is that even though men generally assume knowledgeable, aggressive and directive roles in sexual encounters with women, they lack the necessary information to make healthy and sensible choices. Palai *et al.* (*ibid.*) found that a significant number of Botswana men are still not aware that having another STD enhances the likelihood of HIV transmission. They prefer to consult traditional doctors or get treatment over the counter, and thus some of them may not be getting adequate treatment for STDs.

Prevention programmes have traditionally neglected the role that heterosexual men have in the transmission of HIV. Even though men are the key stakeholders in policy decisions, they knowingly or unknowingly have excluded men as a target group from prevention programmes. (This is true more widely, also, for the whole health care delivery system.) This perpetuates men's ignorance of HIV/AIDS, and other health information. Studies on the use of health services have repeatedly shown that women use

health services, thus gaining access to health information, while men remain uninformed on these matters. The exclusion of males has serious disadvantages for women, because they cannot initiate HIV/AIDS prevention strategies without their spouses' or partners' approval. The knowledge gained by women can only be useful if they are empowered enough to prevent and avoid risky sexual behaviours to prevent HIV/AIDS.

Another important cultural factor that limits women's ability to prevent themselves from contracting HIV is that fertility and social status are intertwined and underpinned by strong gender biases. A woman's status is closely tied to her reproductive role as a mother and wife, thus a married woman's refusal to have a child may have major social consequences. She can be divorced, ostracised and scorned by family and relatives, and in most cases would suffer physical abuse and assault from the husband. She might even be forced to accept her husband having children with other women (Botswana Human Development Report 2000). Although Tswana culture does not encourage pre-marital sex, as a woman gets older she usually comes under pressure from parents and peers to have a child, even if she is not married. In a situation such as this, women's reproductive choices are limited, and the chances of condoms being used for safer sex are remote.

Another cultural factor is that STDs are popularly associated in Botswana with 'bad women'. In many sub-Saharan countries, STIs are usually referred to as 'women's diseases'. HIV infection is associated with sexual 'wrongdoing', and women are commonly blamed for transmission of HIV and other STIs (Horizons-Population Council *et al.* 2002). In Botswana, HIV/AIDS is associated with sex workers and promiscuity, and this has contributed to blaming young women for its spread and the spread of other STDs (referred to as '*malwetse a basadi*', meaning 'women's diseases'). The fear of being stigmatised as 'loose' has led many young women to avoid openly seeking information on sexual and reproductive health matters. This ignorance and fear predisposes them to HIV infection.

A very worrying sexual practice – which is actually not traditional in Botswana, but is now practised by some women – is the use of vaginal desiccating agents to dry the vagina. This is believed to enhance male pleasure, to show that the woman is a 'good woman' and not promiscuous, and strengthen sexual bonds. Herbs, aluminium hydroxide powder, stones and other agents are inserted into the vagina. Many of these agents are reported to cause inflammation and irritation of the vagina, which can increase the risk of HIV infection. Some Botswana women and girls buy products for this purpose from Zimbabwean hawkers (Botswana Human Development Report 2000; McFarland 1999).

In Botswana, it is not culturally acceptable to have same-sex sex. Denial of the existence of male same-sex sex leads to infection. There is still a denial of the rights of lesbians and gay people in Botswana; in fact, sodomy (anal sex) is a criminal offence. There is a lack of data on same-sex sex in the country. Raising the topic of men who have sex with men (Palai *et al.* 1998) elicited mixed responses from young men. Some

were appalled at the idea of a man having sex with another man, but others admitted that it does happen in Botswana society, hence the label '*matanyola*' (anal sex). Because of these sanctions, men who have sex with men are 'in hiding' but it does not mean that they are sexually inactive. Sex between men is a common reality in Botswana's prisons.

This legal and social discrimination against gay people, and the denial that men have sex with men in Botswana, militate against HIV prevention strategies. Neglecting the need of males for help will put many others with whom they have sexual interaction at risk of HIV infection. Worse still, since society expects them to be heterosexual, some have relationships with girls, and even marry under pressure, but continue with their homosexual relationships. Many of the men who engage in same-sex sex lead a double life, which is an unnecessary psychological trauma for them and their families, and it predisposes their partners to HIV infection. Ignoring the pertinence of this issue has adverse implications for HIV spread and transmission.

Male homosexuality in Botswana needs to be addressed openly in relation to HIV/AIDS. Men who have sex with men have a right to be guided and informed about safer sex in the same manner as heterosexual men. Indeed, men who have sex with men have the same rights to education, counselling, treatment and care in relation to HIV and AIDS as heterosexual men.

4. Health factors

The first of the health factors that influence women's likelihood of contracting HIV is access to contraception, as this also prevents HIV transmission. Most contraceptives in Botswana are free in public health facilities. However, as discussed earlier, decisions pertaining to reproductive health lie with men. For instance, the condom that is currently being promoted is the male condom, over the use of which women have very little, if any, control. On the other hand, the female condom is not yet available and accessible without cost in the public facilities.

This further limits women's choices and control over their reproductive health, because the majority of women are economically dependent on their husbands and/or partners. The need to distribute the female condom widely and freely is long overdue, both as a contraceptive and as an intervention to prevent the spread of STIs and HIV infection.

A participant in a study expressed the frustration of many women who want to use condoms but are not allowed to by their husbands or partners:

'When I showed my husband a condom and told him the doctor said we should use them, he was very upset and accused me of having sex with the doctor. I still have itching down there, but he has refused to use condoms with a woman he paid bogadi (bride wealth) for.'

Botswana Human Development Report (2000, 28)

Young people have limited access to sexual health information, and this also affects transmission. It is evident that Botswana boys and girls get most of their information about sex from friends, romance novels, movies and magazines. Historically, adolescents in Botswana were taught about sex by designated relatives. However, urban migration and changing family relationships have contributed to the demise of traditional instruction, while sex education in the schools is limited to the biological facts about reproduction.

Parents are conspicuously absent in the sexual education of their children. Interviews (Tlou 1996) with mothers indicated that mothers feel that their culture forbids them to talk with their daughters about sex. While a few mothers do give their daughters instructions on menstruation and personal hygiene, most of them feel unable to broach any topic related to sex, other than the admonition to stay away from boys. Girls, in turn, feel embarrassed to discuss these matters with their mothers and rely on friends or older sisters. Boys receive even less instruction on how to make responsible sexual decisions. In fact, they reported being pressured by peers, and older brothers and cousins, to become sexually active, since having sex is an achievement and even a mark of male maturity.

Another health factor is women's relatively limited access to quality health services and drugs. In Botswana, women use health care services more often than men, but they do not have access to quality health services available privately. In private clinics, the average nurse-patient ratio is 1:2, and there is prompt access to quality care and a wider range of drugs and treatments. Men are more likely than women to find the money for fees at private clinics. Women and children usually seek attention at government clinics where treatment is free, and hospitals where there are staff shortages and clients have to wait many hours in long queues for services.

The same pattern regarding gender applies when one looks at access to ARV therapy. A survey of the practices of two private doctors revealed that most clients who are on ARV therapy are men, mainly because they can afford the prices charged for the drugs. Some of them are married but are not taking the drugs with their wives, making one wonder whether the wives or partners are even aware of their condition.

The need for women to provide home care for people with HIV/AIDS causes further strain on women's health. In most hospitals in Botswana, bed occupancy has more than doubled over the last decade. The nurse-patient ratios have also increased, putting a lot of strain on the already fragile health care system, and more specifically on its human resources. Health professionals themselves are infected and affected by HIV/AIDS to the extent that, amidst all these problems, the health service has not been able to retain its human resources, especially nurses.

The burden of home care in the HIV/AIDS epidemic falls on women, since they are society's traditional caregivers. Caring for people living with AIDS (PLWAs) has been shown to be physically and psychologically stressful. Studies on home-based care (Mathebula 2000; Tlou 1999) indicate that elderly women and girl children are the

major caregivers to PLWAs yet they have few resources. They do not even have access to resources such as good nutrition, transport and professional support. Many are greatly in need of respite care. Very few Botswana men and boys share domestic responsibilities with their partners; therefore the burden of providing respite care for female adult carers falls on girl children.

The selflessness implied in caregiving sometimes prevents caregivers from acknowledging caring for others as a burden; they are afraid of being labelled selfish and uncaring. It appears as if there is a social disregard in wider society, and on the part of policymakers, for the costs of caregiving. Caregivers sacrifice their financial independence to meet their social obligations to be unpaid caregivers. Such costs are borne disproportionately by women (Phaladze 2003). Caregivers in health facilities and home settings are provided with counselling services, to enable them to deal with their emotional feelings, as well as those of their clients. The neglect of caregivers' psychosocial needs could potentially translate into poor quality care (Phaladze 1999).

It is not only adult women who bear the burden of care. Young girls are expected to help with caregiving and other chores immediately after school, and this has a negative effect on their capacity to do homework and school work in general. School grades are affected, and most girls are not performing as well as boys (Tlou 1999). This results in more and more girls being adversely affected. Poor school performance potentially limits girls' career options, and hence an impact of HIV/AIDS is that girls remain in the informal sector, or in lower-paying formal work such as nursing and teaching. If the situation of the schooling of girls is not improved, it may be impossible for Botswana to ever attain gender equity in the economy and in employment.

The next section of the article makes suggestions for strengthening existing policy responses to HIV/AIDS in Botswana, with the above realities in mind.

Strengthening existing responses to HIV/AIDS in Botswana

In addition to mainstreaming a gender perspective in all policies, programmes and activities for youth, we recommend the following strategies.

1. Promotion of BOTHO and life skills among young people, with parental involvement
Botswana people believe in the proverb '*lore lo owa le sale metsi*' – that is, 'strike the rod when it is still hot'. This needs to be put into practice through empowering young boys and girls by providing sexual and reproductive health information, long before they are sexually active. Young people have suggested that the best age to begin imparting such information is 6–7 years. At this time, the concept of BOTHO (a Setswana ideal of well-rounded, well-mannered, courteous, disciplined, assertive individuals, who realise their full potential as integral parts of the community), should be inculcated in young people. This should include life skills education, embracing the sexual and reproductive health and rights of both boys and girls. This would reinforce already

existing moral and religious attitudes and values, and could be fully integrated into the primary and secondary school curriculum (Mugabe 2000).

To reinforce what is taught in schools, parents also need to be empowered with knowledge and skills to talk to their children about responsible sexual behaviour. Pilot projects have been initiated by UNICEF (*ibid.*) and the Ministry of Health/Norwegian People's Aid – NORAD (Tlou 1998). These aim to equip parents and teachers respectively with skills to communicate with young people on sexual and reproductive health matters. These need to be replicated throughout Botswana, to complement other HIV/AIDS prevention strategies for young women and men.

2. Provision of more voluntary HIV testing centres

For all Botswana, an important element of prevention and care strategies is access to information about one's HIV status. This enables people not only to avoid infecting others, but to gain access to treatment that will prolong their lives.

Men and women, especially couples, should be encouraged to visit the centres that have been set up in cities, towns and villages. More such centres need to be set up throughout the country so that people, as the key stakeholders in the response to HIV/AIDS, are able to access information about their HIV status. It is only through voluntary counselling and testing that vertical transmission of HIV from parent to child will be reduced. Studies confirm that people will opt for voluntary counselling and testing if they know treatment is available. There is also evidence that when both sexual partners go together for voluntary counselling and testing, HIV transmission rates tend to drop (Botswana Human Development Report 2000).

3. Partnerships with civil society

NGO responses to the epidemic have been documented in government reports and studies in Botswana. Many NGOs have been active in awareness building and information dissemination. Much of this has focused on reproductive health and provision of contraceptives, counselling and care to persons living with HIV and AIDS.

An example of the work of the NGOs is to persuade men to protect themselves, so that they can protect their children and families (Tlou *et al.* 2000). To ensure an HIV/AIDS-free generation means strengthening the work of NGOs whose objective is to socialise boys and young men to respect the human rights of girls and women, and to engage in responsible sexuality. One such NGO is the Society for Men and AIDS in Africa (SMAABO). SMAABO men provide role models for young boys, and teach them that it can be 'manly' to care, to be faithful and to use condoms. Situating HIV/AIDS campaigns in places where men frequently gather, for example bars, has also been shown to be effective (*ibid.*).

However, while the NGO response is commendable, Botswana's middle-income status in the early 1990s has prompted many donors to withdraw from the country. Botswana has since acquired the upper-middle income in 2003 and this has further

reduced donor assistance. The President of Botswana also made a plea to the international community in his address to the UN General Assembly in 2005, pointing out that middle-income countries in the developing world still need assistance, given the multitude of problems with which they are faced. Lack of this assistance has left many NGOs without the technical and financial capacity to meet the ever-increasing demand for services. Uncertain funding leads to high staff turnover, causing loss of expertise, and harming institutional memory. Another major stumbling block to stronger partnership between government and NGOs has been a lack of strong NGO policy. To date, an NGO community-based organisation policy was finalised and approved by government in 2004. This promises to boost the partnership between government and NGOs in all spheres of development, including HIV/AIDS response.

4. Greater involvement of people living with HIV/AIDS in communities

Presently, most communities in Botswana seem to tolerate people living with AIDS, but refuse to associate with their families and do not want to acknowledge the existence of HIV/AIDS in the community. This has tended to perpetuate denial, and inhibits communities from coming up with realistic prevention and care strategies. People living with HIV/AIDS must be involved as educators, carers and counsellors in their communities, and also in making and implementing sound and humane public health decisions.

To allow this, a transformation of attitudes in society is needed. This would help in reducing the stigma that normally frustrates prevention efforts. The establishment of community home-based care programmes allows people living with AIDS and their families to see health care providers in the comfort of their own homes. This in turn promotes communication between clients and their care providers, and encourages client participation in their care. In particular, access to ARVs requires people living with AIDS to participate actively in their own care, due to the importance of adherence and the need for commitment to taking the drugs for a long time.

5. Funding and promotion of research on HIV vaccines and female-controlled HIV prevention methods

Ethical guidelines have already been developed relating to HIV vaccine trials (UNAIDS 2002), and Botswana have begun to be mobilised to initiate and participate in such trials. An HIV preventive vaccine would be a prevention strategy available to all, regardless of sex. An HIV vaccine trial began in 2003. The public response to the vaccine trial has been exceptionally good, given that this is the first time Botswana as a country has participated in vaccine trials.

Of major importance is the promotion, as a matter of urgency, of female-controlled HIV prevention methods such as female condoms and microbicides. Microbicides are currently being tested for their effectiveness in other countries, such as Thailand, in the prevention of HIV transmission and other STIs. For young women, who can neither

insist on condom use nor quit relationships that put their health at risk, microbicides are ideal because they are safe, inexpensive, easy to store, and can be used discreetly, without the male partners' knowledge. Women wanting to become mothers could become pregnant by choice by using a microbicide that allows conception yet prevents HIV transmission. For younger women, the ideal microbicides would also have contraceptive properties, to avoid teenage pregnancy.

Conclusion

There are still formidable barriers to success in preventing the further spread of HIV/AIDS in Botswana, and to supporting those already infected and affected. Gender identity, roles and power relations interact with biological, genetic or immunological sex differences to create health conditions and problems that are different for men and women – both as individuals, and as population groups. Gender also cross-cuts with age and other factors. These dynamics have to be understood by health providers and health policymakers in order to plan and intervene effectively.

Botswana can achieve gender equality in HIV/AIDS prevention, treatment and care by combining the recommendations of the Beijing Women's Conference with the legally enforceable provisions of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), when health is considered as a human right, and not merely a social good. More equitable and effective health promotion, disease prevention and control interventions, especially those relating to HIV/AIDS, can be developed on the basis of such understanding.

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