

GOAL 6



COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

“ We have often spoken of the HIV/AIDS pandemic as a war that needs to be won. Yet in this war, we remain our worst enemies. The continued generosity of international friends, such as the Bill and Melinda Gates Foundation, may assist us. But, it is we, and we alone, who through behaviour change, must achieve our victory. The stigma surrounding the disease remains one of the greatest barriers to the implementation of various care and prevention strategies. This is why, even with our ability to now offer such interventions as Anti-Retroviral (ARV) therapy to preserve the living and protect the unborn, the majority of our sexually active people still do not know their HIV status.”

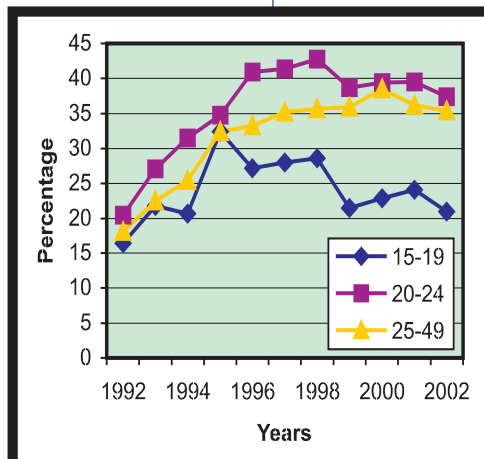
H.E. MR. FESTUS G. MOGAE,
10TH NOVEMBER 2003

Targets	Will target be reached?	Conducive Environment?
14. To halt and reverse the incidence of HIV particularly amongst the youth by 2016	Likely	Strong
15. To reduce the number of infants born to HIV infected mothers who are by HIV positive by their 18th month by half by 2006 and to zero by 2009	Potentially	Good
16. To reduce the morbidity and mortality caused by TB	Likely	Strong
17. To reduce the incidence of confirmed malaria to below 20 cases per 1000 people	Potentially	Strong

Despite Botswana's expansive HIV/AIDS programme, behavioural change still lags behind knowledge about HIV/AIDS, but there are indications that progress is being made. There has been an upsurge in HIV testing since the introduction of routine testing. There have also been reports of stabilisation or even reduction in prevalence rates in some age groups, for instance the 15-19 year group.

1. WHAT IS THE SITUATION LIKE?

Trends in HIV Prevalence in ANC Mothers



Since Botswana's first case of HIV/AIDS was reported in December 1985, the epidemic has progressed rapidly, affecting all levels in society. Annual sentinel sero-surveillance data show an adult HIV prevalence rate of above 30 percent since 1995. The 2002 HIV sentinel survey, conducted in all health districts, shows that HIV prevalence rates among women aged 15-19 dropped from 24.7 percent in 2001 to 21.0 percent in 2002. For women aged 15-49 years, the rate fell from 36.2 in 2001 to 35.4 in 2002.

HIV/AIDS prevalence rates stabilised statistically since 1999, particularly in the urban areas. Rural prevalence rates on the other hand continued to rise. Women with rural residence have slightly higher prevalence, compared to their urban counterparts.

Botswana has mobilised the political will to fight the epidemic and has put substantial resources, into the fight but the results in terms of behavioural change have been poor. A major weakness in the fight is the slow pace of voluntary testing.

Botswana has now adopted an opt in-opt out policy on routine HIV/AIDS testing in health facilities to increase the uptake of HIV-testing and care and support services and, in consequence thereof, promote positive behavioural change.

MOTHER TO CHILD TRANSMISSION

In 2001, it was estimated that 40 percent of infants born to HIV/AIDS infected mothers were likely to be infected with HIV. Prevention of Mother to Child Transmission (PMTCT) is thus one of the key strategies for halting the spread of HIV. A national PMTCT programme is in place and is functioning well. Its objective is to reduce mother to child transmission of HIV to 20 percent by 2006 and to 10 percent by 2009.

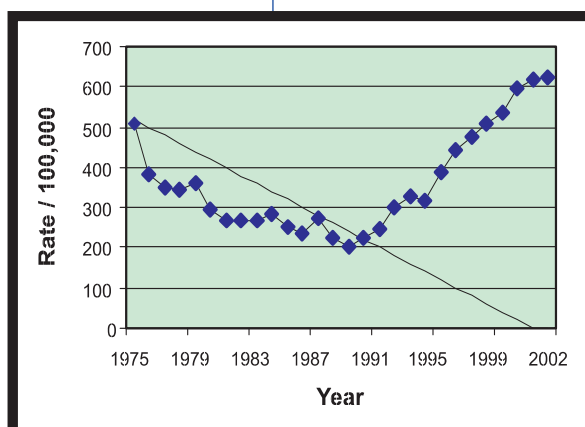
The uptake of the programme was estimated at 36% in 2003. The low uptake of PMTCT could be attributed to HIV/AIDS related stigma and the attendant low

rates of HIV testing. However, recent reports suggest a significant increase in voluntary counselling and testing, in part because of growth in the network of testing centres but also because of a rising propensity to test.

BLOOD TRANSFUSION

The national blood transfusion service in the country has adopted high international standards for blood safety. Donated blood is rigorously screened for HIV. Thus, the blood transfusion service in Botswana is safe.

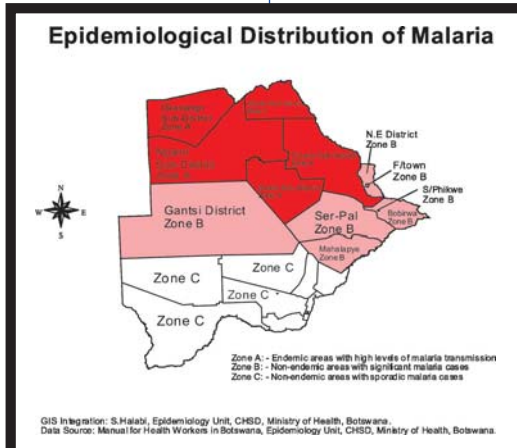
Botswana TB Notification Rate per 100,000 Population 1975-2002



TUBERCULOSIS RELATED MORBIDITY AND MORTALITY

Epidemiological Distribution of Malaria in Botswana

Tuberculosis (TB) cases began to decline in the mid 1970s, reaching an all time low of 202 cases per 100,000 population in 1989. Since then, the notification rate has been on the increase. In 2000, the tuberculosis notification rate in Botswana stood at 591/100,000 persons, rising to 620/100,000 in 2001. The upsurge in the incidence of TB is accounted for by rising HIV/AIDS prevalence. Studies have shown sero-prevalence rates between 50% and 80% among TB patients. An outpatient study in Gaborone showed a sero-prevalence rate of about 73%.



MALARIA

Malaria is the main vector-borne disease in Botswana and is one of Botswana's 14 notifiable diseases. About 40–50 percent of the population is exposed to the risk of infection with Malaria. The incidence of Malaria is closely related to rainfall, which varies considerably from year to year, with major epidemics occurring in years of heavy rainfall. Three epidemiological zones are recognized. These are the northern zone (A), the central zone (B) and the southern zone (C).

The northern zone (A), has a high transmission rate. It is made up of Okavango, Chobe, Ngami, Boteti and Tutume Sub-Districts. It accounts for more than 80 percent of all malaria cases in the country. The central zone (B) has intermediate transmission. The southern zone (C) is largely malaria free, but it can have sporadic cases.

On the whole, the incidence of Malaria in the affected districts declined until 1998 and rose dramatically in 1999 and 2000 before dropping to its lowest in 2002.

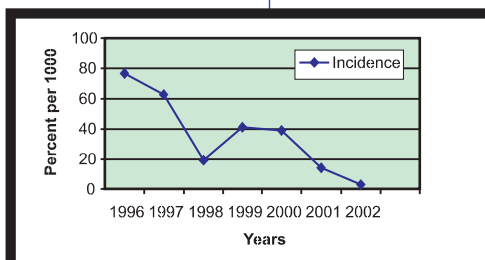
2. MAJOR CHALLENGES

To overcome HIV/AIDS and other life-threatening diseases, Botswana must meet a number of critical challenges.

OVERCOMING STIGMA, FEAR AND REJECTION

The battle against HIV/AIDS related stigma and discrimination is far from being won despite extensive public education. About 90 percent of the population do not know their HIV status even though counselling and testing facilities are available in various parts of the country (16 VCT centres countrywide). By end 2003, only 80,000 people had utilised these centres since they started in 2001. Stigma discourages HIV testing and the uptake of both PMTCT and antiretroviral therapy in general and perpetuates the ignorance on which the epidemic thrives.

Malaria per 1000 population in malaria Epidemic District



COORDINATING AND HARMONIZING ALL THE SYSTEMS AND PROCESSES

In the specific case of HIV/AIDS, there are lots of players who could easily compete with or duplicate each other's efforts. The Government, donors, NGOs, CBOs, private businesses, and the affected communities and individuals are all involved in the fight against HIV/AIDS. This is good but it also presents a major governance, coordination and harmonisation challenge to ensure systemic synergies and maximum impact.

SECURING A BREAKTHROUGH BEHAVIOURAL CHANGE

Positive behavioural change remains the key response to reducing the incidence of HIV/AIDS. Hurdles to behavioural change abound – culture, gender inequality, myths, poverty, etc. – but are surmountable. The culture of silence on which the epidemic thrives must be broken through sustained advocacy and education to facilitate the transformation of knowledge about HIV into positive behavioural challenge.

MITIGATING THE IMPACT OF HIV/AIDS ON DELIVERY CAPACITIES

The magnitude of HIV/AIDS induced capacity erosion suggests an urgent need for Botswana and similarly affected countries to re-engineer service delivery. One approach is to mobilise the capacities that reside in the communities, NGOs, CBOs and the private sector and outsource the delivery of some services to them.

Community Home Based Care (CHBC) provides a model in Government/community partnerships for the delivery of health care services. Beyond this, a bold strategy to preserve and strengthen service delivery across sectors in the face of capacity erosion is required. It could involve better use of information and communication technologies (ICTs) i.e., e-services, and rethinking training and recruitment strategies, in particular, shortening the duration of some courses and facilitating increased utilisation of expatriate personnel.



CHALLENGES FOR TB AND MALARIA

Measures have been put in place to ensure success in TB prevention. The default rate on the successful Direct Observation Treatment (DOT), through which Botswana made great progress against TB before the advent of HIV/AIDS, is, at 9 percent, higher than desired and could lead to treatment failure and the development of drug resistance. HIV/AIDS creates an added imperative to ensure strict compliance with TB treatment. However, drug resistance levels are monitored and treatment regimens controlled to secure treatment options should resistance emerge. Tuberculosis treatment could be better integrated into home-based care to reduce treatment interruptions.

With regard to malaria, the two main methods of vector control, residual house spraying and the use of insecticide treated materials are hampered by low coverage and this leads to failure to interrupt malaria transmission. The potential for increasing resistance of parasites to anti-malarials is also a problem at the level of case management.

3. SUPPORT POLICIES AND PROGRAMMES

The table below summarises the range of policies, strategies and programmes that have been developed since 1995 to fight the major diseases – HIV/AIDS, Tuberculosis and Malaria.

Key Policies and Programmes

The Instrument	Year	Objectives
Policies		
HIV/AIDS Policy	Revised 2004	To guide the governance and coordination of HIV/AIDS programmes in Botswana
Strategies		
National Strategic Framework (NSF)	2003	Provides guidance on the national response and encompasses prevention methods, strategies, goals, objectives and targets
Programmes		
Prevention of Mother to Child Transmission (PMTCT)	1999	To improve child survival through the reduction of HIV related morbidity and mortality; reduce the incidence of HIV infections in children through mother to child transmission by 50%
Community Home Based Care (CHBC)	1995	Ensuring quality care at all levels from health facility to home level; To provide food through the food basket strategy
Isoniazid Preventive Therapy (IPT)	2000	To prevent TB among HIV infected persons
ARV/HAART therapy	2002	To reduce the impact of AIDS through treatment
Voluntary counselling and testing (VCT)	2002	To provide opportunities for HIV testing in the whole country
Botswana National TB Control Programme (BNTCP)	1975	To control the spread of Tuberculosis
Information Education and Communication	...	To create awareness through advocacy for prevention of HIV/AIDS; To mobilise participation of different partners and Stakeholders
Routine HIV Testing	2004	To raise the uptake of HIV testing

4. TO TRACK PROGRESS TOWARDS THE TARGETS

Botswana has a credible system of collecting health statistics. The table below suggests that this capacity is fairly robust. Even so, there are areas where significant improvements are needed.



In the specific case of HIV/AIDS, sentinel surveillance data provide an inadequate basis for estimating prevalence. Population based surveys – the maiden survey is being carried out at this time - provide more reliable information on prevalence. Furthermore, there are difficulties in estimating HIV incidence and AIDS related mortality.

The problems of measuring incidence are in part attributable to the nature of HIV/AIDS, especially the long incubation period, and the stigma attached to the disease. The decision by the Government to move from 'voluntary' to 'routine' testing as of January 1st 2004 is likely to improve the situation. Confronting stigma should also make it easier to separate AIDS deaths from other deaths, thus improving the ability to document HIV/AIDS related mortality properly.

Monitoring and Evaluation Capacities

Elements of Monitoring Environment	Assessment		
Data gathering capacities	Strong	Fair	Weak
Quality of recent survey information	Strong	Fair	Weak
Statistical tracking capacities	Strong	Fair	Weak
Statistical analysis capacities	Strong	Fair	Weak
Capacity to incorporate statistical analysis into policy	Strong	Fair	Weak
Monitoring and evaluation mechanisms	Strong	Fair	Weak