

Exploring the Niche and Contribution of Men in HIV/AIDS Palliative Health Care in Botswana: A Literature Review

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ABSTRACT The paper's aim and objective is to explore the niche and contribution of men in HIV/AIDS arena including palliative issues in Botswana and other social contexts. The paper has used analysis of the literature review from an array of eclectic data sources. The following are salient factors influencing the contribution of men in HIV/AIDS campaign: Inadequate male involvement; Botswana's nature of gender position; Poor policy conceptualization on gender; Poor health campaign conceptualization and operationalization; cultural underpinnings driving men to inadequate involvement in palliative health issues; immense patriarchal forces besetting the HIV/AIDS campaign; and biological factors. The following factors have been suggested to redress the phenomenon: Effecting a paradigm shift of the HIV/AIDS campaign conceptualization and operationalization; and strengthening the campaign for male involvement through men's sector department.

INTRODUCTION

Botswana remains one of the countries hardest hit by the epidemic in the world. The country's HIV/AIDS prevalence rate computed from women attending the ante-natal care clinics (ANC) and men attending clinics due to sex related complications has been very high, oscillating between 30 percent to 40 percent in the last decade (2001-2010) (National AIDS Coordinating Agency (NACA) 2006). The population based prevalence rate computed through Botswana AIDS Impact Survey (BAIS) II and III have continued to paint a gloomy picture of the epidemic with BAIS II in 2004 indicating a prevalence of 17.1 percent and BAIS III conducted in 2008 showing a 0.5 percent increase to 17.6 percent (CSO 2008). These figures have not been impressive considering the immense government goodwill and the heavy capital outlay that has characterized the HIV/AIDS campaign in Botswana (CSO 2008). Though the country has won international awards in recognition of the governmental goodwill to fight the epidemic bravely and determinedly, the environment has severely dented the country; with the leadership sterlingly employing all possible interventions to ensure the epidemic is subdued (Kang'ethe 2006). Nevertheless, Botswana remains one of the best well managed country in Africa and developed countries have not hidden their satisfaction to that end. This, they have shown by continued support to most of the country's pro-

grammes such as through United Nation's Policy Support Document (PSD) (UNDP 2004).

Despite these achievements, the campaign terrain has not been smooth sailing. It has been seriously hit by gender skewedness, to the effect that men's involvement in health issues especially in palliative care and the HIV/AIDS campaign generally has not been impressive. This translates and points to the fact that men's capacities have not adequately been applied to face the epidemic head-on. This has had serious bearing on the success of the programmes that the government has heavily invested in (NACA 2005). Due to the society of Botswana being patriarchal in that it is men who wield immense powers in many facets of life, their low involvement in health issues could have serious negative multiplier effects in derailing the efforts of women and the youth in their endeavor to fight the epidemic (NACA 2005). The preponderance of women in palliative care tasks has been worrying as the country advances to take stock of gender equality and equity in the 2015 Millennium Development Goals assessments (UNDP 2004). This is one of the glaring gaps that the government, policy makers, HIV/AIDS campaign managers and individuals need to work to fill. Perhaps the role of the NGOs could be enlisted to fill any apparent gap that the government has not been able to contain (Kang'ethe 2010a).

However, the pattern and scope is fast changing as campaign for gender gathers momentum.

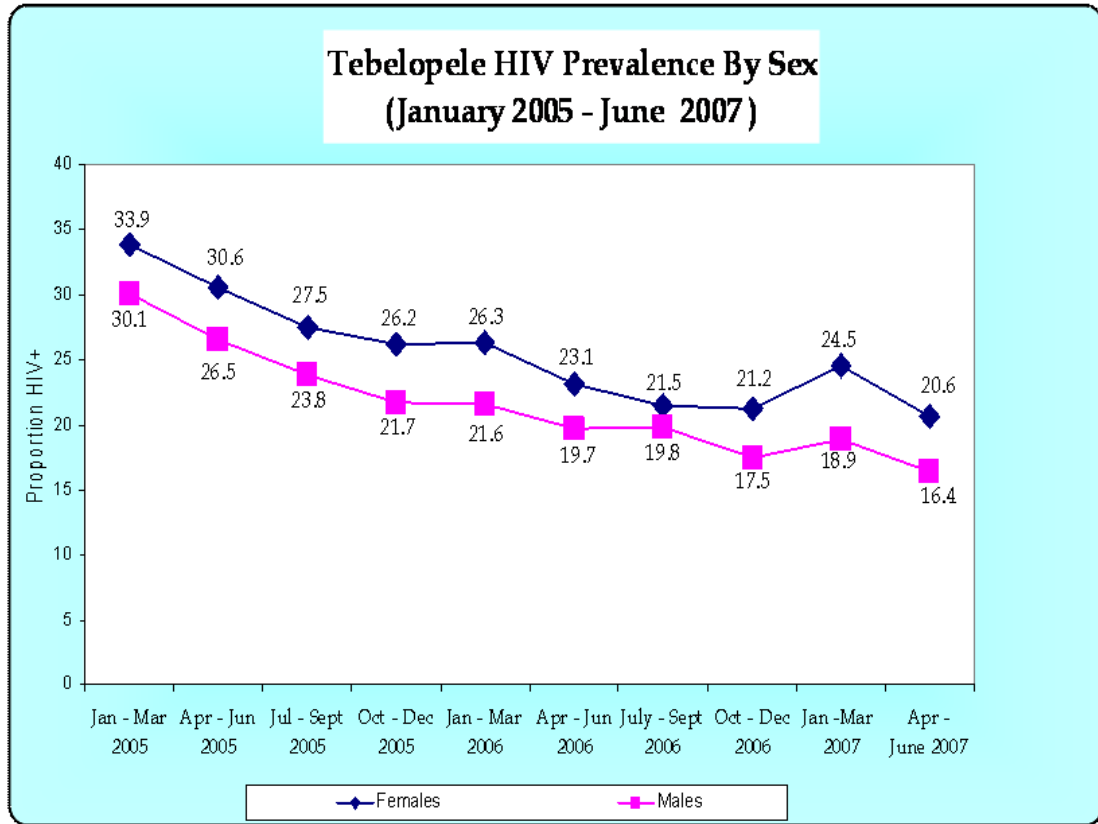


Fig.1. Tebelepele HIV prevalence by sex

This is after the government acknowledged and owned the lacunae and therefore putting in place robust interventions. Such interventions include strengthening women movement through instituting Women Affairs Department (WAD), and starting gender mainstreaming courses at the University of Botswana. Observably, men have not been adequately involved as women in health programmes, such as prevention of mother to child transmission (PMTCT) and HIV testing, use of contraceptives, or in supporting their female counterparts in tackling issues such as palliative care giving (Kang'ethe 2009). This is a glaring gap that an article such as this targets to highlight and possibly catch the attention of policy makers.

Statement of the Problem

The daily burgeoning cases of HIV/AIDS in Botswana and many other African countries calls

for a paradigm shift of attitudes, norms, beliefs, thinking and avoiding the "business as usual" mentality to deal with the epidemic (Kang'ethe 2009). With the epidemic increasing both arithmetically and geometrically especially in some districts in Botswana such as Chobe, Tutume, Fransistown, Selibe phikwe; with some districts experiencing HIV/AIDS prevalence of almost 50 per cent as computed from ante-natal mothers and men who visit the clinics suggesting of sexual related challenges, the country's governing authorities, policy makers and HIV/AIDS campaign managers cannot be complacent if statistics of male involvement in issues of health matters are immensely skewed (Central Statistics Office (CSO) 2008). Adequate involvement of men in health issues such as palliative care is critical as men are endowed with leadership qualities, advocacy as well as lobbying skills, and better financial muscle than

their female counterparts. It is a big concern how especially palliative caregiving appears to be a task of women alone. It is therefore central that the environment and factors influencing this state be explored with the hope of redressing this gender gap (Kang'ethe 2009).

SALIENT FACTORS INDICATIVE OF MEN'S NICHE AND CONTRIBUTION IN HEALTH AND PALLIATIVE ISSUES

Botswana's Gender Position and its Influence on Men's Involvement in Health Issues

The concept gender has not been well understood in many social contexts making it difficult to understand its effects, impacts and other underpinning derivatives; as well differentiating it from sex (Kang'ethe 2009). Gender has to do with the roles, duties, and tasks that societies have assigned men and women, and the way they have been socialized to act, behave, believe, think, and perceive. It is also the thinking, perceptions, beliefs and norms that are associated with a particular society in differentiating between men and women; while sex is the biological differences between men and (Kang'ethe 2009). However, the cases of individuals who display the dual characteristics of either male and female sexual qualities, or hermaphrodites, are few and can be ignored in this context (<http://www.mahalo.com/hermaphrodite-images> 2011).

Contrastingly and poignantly, gender should be understood from various angles or dimensions.

It is an incontrovertible fact that gender roles assigned to men and women change through various social, psychological and cognitive stages of life, civilization, modernization as well as globalization (Wilkinson and Campbell 1997). In Botswana, gender position has placed women in a subordinate position, following the directions and whims of men. This is qualitatively attested by the Setswana proverb that indicates that, "*Ga dinke di etelelwe ke dinama gadi pele*" (A herd of cattle is usually not led by a female but a male one). This means that Botswana societies usually respect and recognize the leadership that is offered by men and not females. In many social contexts in Botswana, the success of a particular phenomenon, it is believed, can only be achieved if led and patron-

ized by men. This means that women's resourcefulness, potent and capabilities may not be adequately realized in many facets of development, health issues serving as examples (UNDP 2008). On the other hand, the gender position in Botswana has also assigned women hospitality tasks and duties leaving men free and out of the fray. Men have therefore distanced themselves from most of the health related involvement such as HIV/AIDS testing and palliative care of the sick. The prevalent gender role demarcation and differentiation has formed the scapegoat (Kang'ethe 2009).

Poor Campaign Conceptualization Informs Inadequate Male Involvement in Botswana

It is an undeniable fact to contend that the HIV/AIDS campaign in Botswana has been gender biased in the sense that male involvement has not been adequate compared to that of women. The ever burgeoning cases of the HIV/AIDS epidemic make it urgent that women are offloaded palliative caregiving tasks by men (Kang'ethe 2010bc). Apparently, there has been programmatic oversight and mistake in the HIV/AIDS campaign conceptualization, operationalization and implementation. In Botswana, the nascent stages of the campaign concentrated on women in an endeavor to save the unborn children through PMTCT. Umpteenth data on HIV/AIDS has been computed from largely women on the antenatal clinics (ANC) and only a few men who visit the clinics with sexually transmitted diseases making HIV/AIDS to be perceived largely as a disease of women more than men. This left men at a distance, only to recall their involvement later. This could partly explain why men have not taken the message and challenge of their inadequate involvement seriously. This is despite the passionate appeal made by the former President Festus Mogae and other HIV/AIDS proponents in the year 2000 during the AIDS Day that they need to change their stand and be more conspicuous especially in matters pertaining to their health and co participating in palliative caregiving tasks alongside women (UNAIDS 2000). Although the situation is greatly improving, men's involvement and impact has not been satisfactory in many HIV/AIDS programmes across the width and breadth of the country (DMSAC Report 2005). In the Southern District of Botswana, for instance, many community based structures

in Botswana, such as village health committees (VHCs) and Village Multi-sectoral AIDS Committees (VMSACs) are virtually run and managed by women. The male factor and experience in running households and other important institutions in the communities is critically lacking in these structures (DMSAC Report 2005).

Cultural Underpinnings Driving Men's Inadequate Involvement in Palliative Health Issues

Culture in many societies has played the role of a mirror in which all what is sanctioned by a society is reflected in it. It is culture that informs people's thinking, beliefs, norms, stereotypes and most of the time, the direction of the future (Kang'ethe 2009). It is usually the culture of most societies especially the traditional ones that demarcates between the do's and don'ts (Kang'ethe 2009). In Botswana, cultural forces have militated against equal participation between men and women in many aspects of the society, severely affecting and informing skewed gender participation in health issues especially palliative ones (Kang'ethe 2010 b, c) Although the situations are fast changing, as gender empowerment and emancipation campaign gathers momentum, Botswana cultural thinking is gravitated towards viewing women as sexual objects as well as relegating women's status to servitude. This has been a fertile ground for women vulnerability. In Botswana, as in many other societies of the world, the thinking that "a real man is not satisfied by one woman" encourages male promiscuity and male dominance. This glaringly finds evidence in Setswana proverbs such as the following that further informs the prevalence of multiple and concurrent partnerships "*monna poo ga a agelwe lesaka*" that loosely translates that a man should not be tied to one woman;

"*Monna ke selepe, o a hapaanelwa*" that translates that a man is an axe that can be shared;

"*Monna ke selepe, o a tsamaya o a rema*" that, loosely translates that a man has liberty to associate with multiple and concurrent partners;

"*Monna ga a botswe kwa otswang teng*" that loosely translates that a man should not be asked where he spent the night;

"*Monna ga a ganelwe dikobo*" that translates that a man should not be denied sex by a woman (Kang'ethe 2009; Lekoko 2009).

In other instances and cultures, men are discouraged from seeking health related assistance but are instead encouraged to endure pain as a sign of manhood. Many cultures attach and associate the ideal qualities of a strong man to strength, courage, dominance, insatiable and uncontrollable sex (Lekoko 2009). Men in Botswana as in many other social cultural settings are culturally believed to be strong and able to endure social forces like diseases until they are well. The same thinking, norms, beliefs, and stereotypes have become well-grounded and internalized in many men's and women's minds from childhood, continuing to linger and influence men's responses to diseases of various types (Jackson 2002). However, the advent of HIV/AIDS demands a departure from this kind of practice, calling for gender swaps, gender realignment and dismantling of gender stereotypes that relegate a particular task to a particular gender (Kutloano 2001). Co-participation and involvement especially in issues of palliative care between the two genders is critical (Kang'ethe 2010c).

Patriarchal Forces Informs the Niche and Male Involvement in Health Issues

Patriarchy refers to culturally and customarily attained power by men over time and generations. Patriarchy has been pinned down as one of the contributory factors to men's inadequate involvement in health issues in Botswana (Lekoko 2009). This is because women have not been well placed to adequately persuade men to co-participate with them in satisfactory proportions in health matters because societies have bestowed immense powers to men giving them more decision making power over women as dictated by patriarchal power dynamics (Lekoko 2009). Men have used this power to oppress women in many ways, socially and economically (UNDP 2008). Patriarchy is also strengthened by various religious principles and practices such as Christianity and Jewish ones (MacArthur 1997). According to biblical based patriarchy, for example, women are supposed to be controlled and follow the whims and wishes of men. It is believed that the power of men is God's ordained and cannot change. "*Wives, submit to your husbands as to the Lord. For a husband*

has authority over his wife, just as Christ has authority over the Church..." (MacArthur 1997). These patriarchal beliefs are responsible for a wider pace of gender inequality and inequity. This has influenced men to shun sharing and responding to responsibilities of, for instance, palliative care giving and therefore leaving women to toil all alone (UNDP 1995).

Biological Factors Informs the Niche and Nature of Men's Involvement in Health Issues

Inarguably, biological factors play a central role in men's inadequate involvement in health issues. Naturally, biological factors have favoured men in bestowing them with the physique that enables them to take on manually harder tasks while women take lighter and menial tasks (Kimball 1995). This candidly explains the heavy preponderance of women in hospitality based careers such as nursing, house help and palliative caregiving (Kang'ethe 2010 b, c). It is these biological factors that have largely influenced the conspicuous role, tasks and duty differentiation and demarcation between men and women in most societies today, with developing countries leading the pack (Kang'ethe 2010 b, c). Skewed gender involvement in health issues in Botswana can be traced in the same vein and magnitude. However, with increased modernization and technological prowess, the effects of biology in role allocation are becoming weaker and weaker especially in countries whose gender development indices (GDI) are higher (UNDP 1995, 2008)). However, biological influences are still stronger in developing countries where life is still more rural than urban and where women are experiencing low levels of gender development indices (GDI) as well as human development indices (HDI) (UNDP 2008).

Men's Niche and Involvement in Health Care Programmes

To appreciate the niche and position of men's involvement in health care programmes, it is important to examine the care platforms for evidence and assessment of men's place and niche in terms of contribution in the health based campaigns such as the HIV/AIDS campaign. There are several health programs which succinctly indicate men's involvement in HIV activities in Botswana, some of which are outlined below:

Inadequate Male Involvement in Botswana's Community Home-Based -Care (CHBC) Programme

Community home-based care is a valued and a well-grounded institution in Botswana, deeply embedded and inherent in the societal values like in most communities in Africa. It has been a common practice for generations utilizing the culturally grounded social capital as a panacea of addressing health related challenges. Researchers in the field, like Pierre Brouard have commented that in Africa, there's a strong sense of community and a rich tradition of doing good work- reaching out to one's neighbour or sick friend especially in times of sorrow and distress (Armstrong 2000). The care given in CHBC programme may include palliative or rehabilitative, physical, psychosocial, spiritual, and material support. Palliative care, especially for persons living with HIV/AIDS is an overwhelming exercise, as most care givers have no hope of their patients recovering. Therefore, most caregivers are forced to take death as part of life and dying as simply 'living the end of life' (Sims and Moss 1991). To support patients with AIDS 'living to the end of their life' requires caregivers with strength and an awareness of the unique needs of individuals nearing that end.

Men are a Deterrent Factor in Women's Involvement in PMTCT (Prevention of Mother to Child Transmission) Programme

Inarguably, HIV infection in children threatens to reverse the progress the country of Botswana has made through wide-scale implementation of child survival programmes such as immunisation, improved management of childhood illnesses and breastfeeding promotion (Ministry of Health (MOH) 2005). Global research indicates that approximately 50 percent of the HIV positive babies get infected at the time of labour and delivery. This means that children born positive under normal circumstances would not survive their fifth birthday (MOH 2005). It is estimated that without action to interrupt mother to child transmission (MTCT) of HIV, through embracing the PMTCT programme, the under five child mortality rates will more than double in Botswana, Kenya and Zimbabwe by the year 2010. Luckily, the programme is one of those doing well in the country, though with some gender related challenges (National AIDS Coordinating Agency 2009).

For the PMTCT programme to succeed, a mother needs to know her status and then enrol in the programme. However, a proportion of needy mothers have not been able to enrol due to lack of permission or encouragement from their male partners. A score of men and some women have been blackmailed by stronger socio-cultural forces at the detriment of saving the unborn child from being born positive (MOH 2005). As men appear to be affected more than women by stigma, they remain a deterrent to an apparent willing women to go for test and eventually enrol in the programme (Fako and Linn 2003).

Men Testing in Fewer Numbers Than Women in Botswana

Testing, across regions and continents has a cardinal and pivotal role of reinforcing a positive behavioural change process in any campaign process. In Botswana, it would be an important step and hope to cut down the ever burgeoning cases of HIV/AIDS (Ministry of Health/JHPIEGO 2009). This is why Kang'ethe (2007) calls for a campaign dynamic that attracts and encourages couple testing. Anecdotal evidence holds that men are reluctant to go for testing as couples, while women are ready for it. This author contends that couple testing forms is a robust way of approaching the envisaged zero viral transmission or an AIDS free generation at the dawn of Botswana's fifty years of independence (Vision 2016 1997).

Information on testing by Tebelopele Annual Report in Botswana reveals that more women than men go for testing. Another surprising revelation also from Tebelopele testing information was that second time testers for both men and women were decreasing, leaving a big question mark of the repercussions, fate or the detrimental effect of this number who after knowing their status for the first time fail to honour the testing expectations of continued testing (Tebelopele Annual Reports 2007). It is this researcher's suggestion that the country of Botswana interrogate its counselling services that accompany the testing sessions. It could have gaps or not adequately equipping the testers with enough impetus to desire positive living and therefore wish to continue monitoring their viral history. Continued testing, however, is the only sure way of ensuring that one continues to be negative, or if positive, ensure that the monitoring of one's level of viral load in the body is effectuated. This is important as it facilitates

knowledge of the entry point to ARV drug intervention (Kang'ethe 2007). It is also very dangerous, if after knowing one's status, there are no further commitments to behavioural change (Kang'ethe 2007). The government of Botswana has prioritised and diverted a lot of its resources to the direction of fighting the scourge and all people, locals or foreigners, should increase their level of commitment and patriotism to support the efforts and constant passionate call for a strengthened stakeholder partnership and behavioural change made by the former Botswana President, Festus Mogae (Kang'ethe 2007).

Efforts to Redress Inadequate Male Involvement in Health Issues in Botswana

Equal Contribution of Both Men and Women in Botswana Critical in Achieving Different Health Policy Targets

Contribution of both men and women in health related issues such in palliative tasks is critical and instrumental in fulfilling most of the Botswana's visionary developmental goals (UNDP 2008). Internationally, it is central towards making a good score in Millennium Development Goals by year 2015 (UNDP 2004). Incontrovertibly, the HIV/AIDS pandemic has challenged many countries' resources to an extent that equal involvement and participation between men and women as well as concerted efforts by all the national stakeholders, individuals, companies and NGOs is needed to supplement and complement one another for a joint formidable response (Kang'ethe 2010a). In Botswana, for example, Vision 2016 and other important policies such as NDP 9 and NDP 10 apparently face difficult predicament towards their fulfillment especially on an AIDS free generation by the year 2016 if efforts by both men and women is lacking (Government of Botswana 2009; Vision 2016, 1997).

The call by the United Nations based advocacy and campaign on gender holds that the contribution and response of both the male and female genders need to strike a balance (UNDP 2008). The principle of "shared rights and shared responsibilities" espoused in the 1995 World Health Organisation's AIDS Day theme implicitly calls for both the genders to actively participate and reinforce one another to beat down the epidemic (National AIDS Control Programme (NACP) 30 1996). Additionally, if the world is to

fulfill the 2001 United Nations Declarations, espoused in the so called United Nations General Assembly Special Sessions (UNGASS) that also formed the global AIDS Day theme for 2005 and 2006 “keep the promise”, whereby many countries, Botswana included, committed to relentlessly fight against the HIV/AIDS to the fullest to halt the spread of the epidemic, then both genders need to form a formidable front to tackle the epidemic head-on (UNAIDS 2001).

A Paradigm Shift of the Campaign Conceptualization

It is this author’s contention that the national HIV and AIDS campaign in Botswana has been run on a wrong footing as the male gender has not been well catered for by some aspects of the campaign. This could be due to poor vision and poor understanding of the gender dynamics and the challenges they pose to the HIV and AIDS campaign. Again, the methodology and approaches that have traditionally been used, such as testing only pregnant women and a few men suggestive of STD infections at health facilities made AIDS to appear as more of a problem of women than men (NACA 2005). This was also ignorantly reinforced by many cultures seeing women as the ones more responsible in transmitting the virus than the converse. For the most part of the campaign, therefore, policy frameworks and programme interventions directed at sexual reproductive health and HIV and AIDS in Botswana have focused on females, and, therefore, more is known about females and HIV than about males and HIV. The concept feminization of HIV/AIDS has been strongly grounded, whether by design or by default. Adequate inclusion of males in the campaign on the ground and correcting the HIV and AIDS policy and programme interventions gaps to fully embrace men has dragged and taken a snail’s pace (Kang’ethe 2010b). The campaign, therefore, needs to undergo a paradigm shift in which the challenges associated with initial campaign conceptualization could be filled.

Rebirth of Men’s Sector as a Measure to Increase Men’s Involvement in Health Issues

Currently, it is incontrovertible that the gap in involvement in health issues between men

and women is glaring and huge. However, it is only after the government dawned on the realisation of the gap of overly targeting women at the detriment of men that it started laying special emphasis and making formidable fronts on the men’s response to the epidemic (NACA 2005). This saw the birth of the men’s sector targeting the defense force, police service, immigration and prison’s department (National Strategic Framework (NSF) 2003, 2003-2009). In this sector, it is men who are reaching out to other men by emphasizing behavioural change. The goal of the men’s sector is to discuss and brainstorm on factors that would encourage men to have greater contribution and ownership of the HIV/AIDS campaign; and how men can be persuaded to use their political, economical and socio-cultural might and muscle to change the landscape of the epidemic (NACA 2005).

The efforts of the men’s sector is critical and is in line with the World Health Organisation’s year 2000 AIDS day theme “Men can make a difference” (UNAIDS 2000). This has motivated and challenged men to step up their response which has been found to be inadequate compared to that of women. The men’s sector has enjoyed a lot of government goodwill and resources. With patronage revolving among the four initiative departments of Police, Immigrations, Prisons and Army, the men’s sector has been going all over the country to convey and sell its message of more commitment by men in the HIV and AIDS campaign. It has been taking advantage of all the available forums like the District Multisectoral AIDS Committees (DMSAC) to mainstream, mobilise and drum up support. This has culminated in forming men’s sector committees at district and other levels in the society (NACA 2005).

CONCLUSION

It is pivotal and central to position men at the centre of HIV and AIDS campaign if meaningful male involvement is to be realised. The result of inadequate male involvement in health issues including palliative ones is a result of an omission by the campaign architects in Botswana, that has seen a campaign tilted towards women. Policy frameworks need to adjust to allow men to move in tandem with their female counterparts. However, besides inadequate involvement in the campaign, cultures reinforced

by patriarchal forces and beliefs have bestowed man with power of dominance and oppression of the female gender. The behaviour displayed by men-women power balance has been detrimental to the HIV and AIDS campaign as well as women empowerment and dispensation. Advocacy and lobbying for men to undergo a paradigm shift of their thinking, norms, beliefs to change their culturally held stereotypes surrounding the role, task demarcation and differentiation is long overdue. This change will ensure men co participate in tandem with women in many erstwhile female domain occupations such as caregiving and other areas of hospitality.

RECOMMENDATIONS

- ♦ Strategies and interventions to persuade men to use their leadership and economic position in the society to get involved in the HIV/AIDS campaign as good as women is critical.
- ♦ Cultures that impede men's patriarchal thinking giving them scapegoats that HIV/AIDS care and prevention should be done by women need to be diluted.
- ♦ More resources to strengthen the men sector in Botswana needs to be increased.

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