Social and Economic Stress Related to the HIV/AIDS Epidemic in Botswana

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Abstract: The paper describes the consequences of HIV/AIDS in Botswana; the country with the highest HIV prevalence rate in Africa. In addition to frequently experienced trauma due to sickness and death, many households experience rising health expenditures and a sharp deterioration of incomes. High levels of morbidity and mortality among workers result in depressed returns on investment, reduced productivity and increased expenditure on training and replacement of workers. As the health care system finds it increasingly difficult to cope, home-based care provides an inadequate solution since the home infrastructure of many households is inadequate for proper care of seriously ill patients. The stigma associated with AIDS often isolates fragile households and provides an environment in which abuse of infected individuals and of orphans whose parents have died of AIDS is not uncommon. The quality of education also suffers, resulting in an ill prepared skilled manpower, with adverse consequences for social, economic, and political development as well as for good future governance of the country.

Key Words: Botswana, AIDS, stress

Introduction

HIV has spread very quickly throughout Botswana since the first reported AIDS case in 1985, resulting in the country having the highest prevalence rate in Africa. The epidemic has been attributed to multiple causes, including an economic structure that has promoted long-term separation of husbands and wives, insufficient attention to AIDS prevention education in the late 1980s, and a good network of highways that facilitates travel and internal migration and rapid spread of HIV (United Nations Development Program 2000). The national median HIV prevalence among 15-49 year olds increased from 18 percent in 1992 to 36 percent in 2000 (Khan, 2001). The results of the year 2000 sero-prevalence regional survey indicate an HIV prevalence rate ranging from 30.4 percent in Molepoloe (Kweneng East District) to 50.3 percent in the town of Selebi

Phikwe, with a median prevalence of 38.5 percent (National AIDS Coordinating Agency, 2000). This means a large proportion of households will lose at least one member due to AIDS. Current HIV prevalence rates imply increasingly difficult conditions for households with rising expenditures when household incomes are falling. High prevalence rates also imply frequently experienced trauma due to the sickness and death of family members.

As a result of the HIV/AIDS epidemic in Botswana, more than three decades of successful human and economic development are being reduced and reversed. Life expectancy has been estimated to drop from its peak of 67 years to 29 years by the year 2010 and a third of the adult population is expected to be dead by 2010 (UNDP, 2000). Although the population is estimated to continue to grow, the average annual rate of growth will be 0.9 percent, with AIDS, as opposed to 2.8 percent, without AIDS, and the population will be 29 percent less than what it would have been by 2021 (Botswana Institute for Development Policy Analysis, 2001).

Table I: The Percentage of the Population 15—49 years who are HIV positive in Selected African Countries

Botswana	36
Swaziland	25
Zimbabwe	25
Lesotho	24
South Africa	22
Zambia	20
Namibia	20
Malawi	16
Kenya	14
Central Africa Republic	14
Mozambique	13

This article attempts to articulate the psychological, social and economic consequences of the HIV and AIDS epidemic in Botswana. The authors combine knowledge gained from interviews, committee meetings, seminars, conferences, and research literature to contribute to an understanding of the implications of HIV and AIDS for individuals, households and national development.

Economic Implications of HIV and AIDS

An increase in morbidity due to HIV and AIDS will weaken and kill able-bodied working persons who support countless dependent children, elderly parents, and grandparents. It will result in early retirement of infected persons due to ill health and stigmatisation and early retirement of uninfected family members who devote time to looking after their infected relatives. It will result in increased household expenditures on health, increased debt to finance rising health costs, and to finance the cost of funerals of relatives who die of HIV and AIDS. It will also result in reduced household labour and reduced educational and employment opportunities for children from affected households. Productivity in all areas of the economy, especially agriculture, will be depressed (United Nations Development Programme, 2000).

The illness and death of a household breadwinner will result in a sharp deterioration of household income, savings, and assets, which will then reduce the quantity and quality of household food supplies, leading to poor nutrition and ill health. Estimates indicate a drop of 13 percent in per-capita household income for the poorest quarter of households as well as significantly higher income dependency ratios, with every income earner in the poorest category supporting an extra four or more dependents as a result of HIV and AIDS (United Nations Development Programme, 2000). The high HIV prevalence rate is associated with a high rate of poverty, whereby about 47 percent of the population live below the poverty datum line (United Nations Development Programme, 2000). It is also associated with a highly skewed income and cattle ownership (a major source of family wealth) distributions, with the wealthiest one percent of the population owning roughly 25 percent of the herd, while 71 percent of farming households own only eight percent of the herd (United Nations Development Programme, 2000). Without effective intervention, the epidemic will increase the extent of poverty and human suffering and weaken the government's capacity to deliver essential services and sustain human development. This may result in disturbances to the hitherto tranquil and peaceful political landscape.

Psychological Impact on the Infected and Affected Persons

When they first hear of their diagnosis, people with HIV are frightened by the prospect of sickness and death. Denial is often the first line of response after confirmation of HIV positive status. The person usually does not believe he or she could be infected. For some time he or she may pretend that nothing has happened and continue to live a lifestyle that includes unprotected sex, which puts others at risk of infection. After some time, however, people eventually accept their predicament and may begin to blame themselves for their HIV status. At times there is transference of blame to the person they believe may have passed on the virus to them (Badisang, 1996).

While going through the stage of blaming others, the person may adopt an attitude that he/she does not want to die alone and may deliberately spread the virus to unsuspecting others. This often manifests itself in reckless sexual behaviour. Some infected persons resort to alcohol and drug abuse and in some instances ultimately commit suicide. Some people find comfort in religious commitment and faith in the God who loves them unconditionally and non-judgementally. Other coping strategies include accepting one's condition and attempting to live positively. This includes positive thinking, good nutrition, and practicing relaxation techniques (Fako & Linn, 2003).

Knowledge that one is HIV positive or is faced with an incurable illness such as AIDS brings about a feeling of being unlucky or careless. It also brings about anger, guilt, anxiety, confusion, despair and hopelessness in the absence of a cure. Those infected worry about the idea of facing their own mortality and about the implications of their condition for family and friends. They lose self-esteem, sense of worth and dignity, and suffer perceived and actual social isolation. The infected may also experience both rational and irrational fears, mostly because of what they do not know or understand. This includes fears of stigma associated with HIV, fear of abandonment, and loss of health, income, friendships, sexuality, home life, and work (Fako, 2005).

When people learn they are infected with a deadly virus they are likely to go through some degree of psychological shock and experience feelings of anger, fatigue, anxiety, guilt, and depression. These feelings do not occur in predictable stages or intensity. Some people are overwhelmed by several or all these feelings at once. Depression in persons diagnosed HIV positive may be mild or severe. Mild depression basically runs its course within a few days and often resolves itself without intervention. When depression lasts too long it tends to overwhelm the individual, who may show signs of alienation, deep apathy, profound hopelessness and chronic lethargy as they begin to think of their privacy, intimacy, and independence. The trauma experienced by the patient is often shared by, or in some way affects, relatives and significant others. The main source of trauma is the fact that there is still no cure for AIDS. This trauma is reinforced when traditional medicines fail to eliminate the virus. There are numerous instances where persons with HIV have relied solely on traditional cures. This has resulted in depletion of already limited family resources, more rapid progression of illness than if available drugs had been used, and further sexual exposure of family members to HIV because the infected persons, at least for a while, believed they were cured (Jack, 1999).

HIV/AIDS remains a stigmatised condition in Botswana. Persons with HIV disability are viewed differently than individuals with other disabilities because they are presumed to be responsible for their condition. Stigmatisation leads to victimisation, blame and discrimination. It reinforces and reproduces social divisions, increases misery and supports the spread of disease as resources essential to preventing infection are displaced (United Nations Programme for HIV/AIDS, 2000). Infected persons carry a stigma, a mark or token of social disapproval, shame, infamy, disgrace and condemnation, which leads to exclusion, ostracism and isolation. Stigma is a condition that interferes with normal social interaction and social relationships; causes people to react with dislike or disgust; is blamed on the individual affected; is not alterable; and is perceived as likely to contaminate others physically, socially, or morally (United Nations Programme for HIV/AIDS, 2000). Although HIV transmission is largely heterosexual in Botswana, homosexuals and sex workers, who are generally rejected and their existence sometimes denied, continue to be blamed for HIV transmission through what is perceived as their “deviant” or reckless sexual behaviour. In general, people infected with HIV are stigmatised because:

1. HIV and AIDS are life threatening.
2. People are afraid of contracting HIV.
3. AIDS is associated with behaviours already stigmatised in many societies.
4. HIV infection is often, although not always, blamed on irresponsible behaviours and lifestyle.
5. Religious and moral beliefs associate HIV/AIDS with sin, immoral behaviour, promiscuity, “deviant sex,” homosexuality, drug use, and prostitution; all of which are said to deserve punishment from God (Scrambler and Jacoby, 1994; United Nations Programme For HIV/AIDS, 2000).

Although concealable early in its course, later stages of HIV infection and AIDS are rarely hidden from others. AIDS physically disables and disfigures. It produces aesthetically unpleasant results that interfere with normal social interaction. Because the course of AIDS is degenerative and not alterable, it poses risks to others, and frequently reinforces dominant ideologies concerning good and bad with respect to sex and illness, and regarding the extent of exclusion and inclusion of those infected (Fako et al, 2003).

Because stigma marginalizes, excludes and reduces a person with an undesired difference to the status of a social outcast who is devalued, tainted, despised, and rejected, it can prevent individuals from engaging in positive actions to access health care or participate in studies designed to find a solution. It can also lead to the continued spread of HIV/AIDS due to infected persons concealing or denying their HIV status, thereby putting their partners at risk. Denial and secrecy are a direct response to panic and fear of discrimination resulting in some HIV infected persons refusing to inform others, avoiding medical advice or treatment, and postponing sharing the devastating news to family and friends (United Nations Programme on HIV/AIDS, 2000).

Rejection by friends, co-workers and family is not uncommon. Rejection may manifest itself by others not wanting to share utensils, equipment, and furniture with the infected. Sometimes it may lead to serious discrimination and/or physical abuse of the infected. There is an example of a child who was physically abused by her father and brother for “bringing shame to the family by revealing her HIV status” (World Health Organisation, 2000).

Children whose parents are infected with HIV, or have died from AIDS, are often discriminated against, shunned, and even abused. Sometimes they are denied the privilege of playing with other children or expelled from school. Some guardians and orphans are reluctant to register with the AIDS orphanage programme from fear of being stigmatised. Infected mothers eligible for retroviral drugs to prevent Mother to Child Transmission (MTCT) in Botswana tend to prefer to keep their status secret for fear of stigmatisation, discrimination and physical violence. Families are reluctant to inform health authorities and trained voluntary caregivers about their patients and attempt to keep the HIV infection a family affair. They attempt to shield infected members by keeping them within the household as a way of managing stigmatisation and reducing its spread within the wider community. This often means early withdrawal of the infected from the labour force. There are cases of patients neglected by their families because the affected family does not want to be part of the label and stigma associated with HIV infection (United Nations AIDS, 1999).

Stress Associated with Caring for Clients with HIV and AIDS

As the HIV/AIDS epidemic spreads, it overwhelms the capacity of health services, health workers, social workers, and non-professional caregivers. The patient becomes progressively more dependent and an increasing burden to those who help to feed, wash and respond to their calls, including at night. Becoming a caregiver changes one’s lifestyle and predisposes one to considerable stress (Fako & Linn, 2003).

In areas badly affected by HIV and AIDS, many who work as counselors, nurses or trained Community Volunteers, are also caring for someone at home who has AIDS (United Nations Programme on HIV/AIDS, 2000). While at work, they are constantly worried about the patient they have left at home, and are under constant stress from fear of being infected both at home and at work. After working throughout the night changing clothes for the patient and answering their calls, caregivers go to work too tired to function effectively and may run the risk of infection due to fatigue-related carelessness. The burden is borne predominantly by women and girls who provide care as part of their nurturing role. The low status of women results in there being little or no discussion within the family about the personal sacrifices that caregiving will demand on women.

The following psychological, behavioural and physical signs and symptoms of stress among AIDS caregivers have been identified (United Nations Programme on HIV/AIDS, 2000):

1. Loss of interest in and commitment to work, as manifested by loss of punctuality and neglect of duties;
2. Feelings of inadequacy;
3. Helplessness and guilt;
4. Loss of confidence and self-esteem;
5. A tendency to withdraw from clients and from colleagues;
6. Loss of sensitivity in dealing with clients;
7. Loss of quality in performance of work;
8. Irritability;
9. Tearfulness;
10. Loss of concentration;
11. Sleeplessness;
12. Excessive fatigue;
13. Depression, and
14. Bowel disturbance.

Much of the stress experienced by carers is due to the fact that AIDS is an incurable disease that causes great suffering. Knowledge that the goal of healing cannot be accomplished for any patient leaves the caregiver as helpless as the patient who is facing certain death. Due to oppressive workloads and over-involvement with patients and their families, there is often no time to mourn the death of one patient since the caregiver has to attend to the immediate needs of the next terminally ill patient. The caregiver soon discovers that HIV/AIDS carries a stigma for both the infected and uninfected caregivers. The caregiver is viewed as having AIDS and is rejected and sometimes isolated. As a result, caregivers experience depression, loss of self-esteem, low job satisfaction, loss of concern for others, a sense of guilt in the midst of helplessness, irritability, excessive fatigue, restlessness, irrational mood swings, negative attitudes towards work and difficulty getting along with others (Ministry of Health, 2003).

AIDS Orphans and Changes in the Structure of Families

One of the significant social and economic consequences of the HIV/AIDS epidemic is the soaring numbers of orphaned children faced with the grim reality of not having a mother or father. Some children have absolutely no adult relative who can care for them. The exact number of orphans is difficult to specify due to different age limits used for the classification of young people as orphans. For purposes of government policy and action in Botswana, an orphan is a child below the age of 18 years who has lost one (single parent) or two (married couple) biological or adoptive parents (Ministry of Local Government Lands and Housing, 1999). Although this definition excludes many school-going dependent children above 18 years of age, thereby underestimating the number of children whose lives are severely affected by the loss of parents due to HIV/AIDS, the trends in numbers of orphans are clearly on the increase.

Dingake (2000) noted that by the end of 1997 around 4 percent of children under the age of 15 years in Botswana had been orphaned as a result of HIV/AIDS. It has been estimated that the number of AIDS orphans below the age of 15 years will increase to 65,000 by the year 2000 (Ministry of Local Government Lands and Housing, 1999). The rapid assessment of the situation of orphans in Botswana conducted in Francistown, Kanye, Mahalapye, Maun, Mochudi, Masunga, Molepolole, Serowe, Tutume, and Palapye, identified and registered 4,496 orphans in 52 days (Ministry of Health, 1998). As many as 1,346 had dropped out of school permanently for various reasons including fear of rejection, isolation and stigmatisation, lack of uniforms, ill health, and/or to provide care to their younger sisters and brothers. More girls than boys had dropped out of school to give care to other orphans. Many of the girls were secondary school students about to sit for their examinations in Forms Two and Five (Ministry of Health, 1998).

Table 2: Distribution of Orphans by Sex and Study Sites

DISTRICT	POPULATION	ORPHANS		
		MALE	FEMALE	TOTAL
Francistown	652,000	295	242	537
Kanye	314,000	315	271	*586*
Mahalapye	281,000	356	328	684
Masunga	not available	114	139	286
Maun	268,000	232	194	448
Mochudi	255,000	117	115	232
Molepolole	369,000	161	186	347
Serowe	303,000	293	*343*	636
Tutume	101,000	226	220	446
Palapye	173,000	181	168	349
		2,290	2,206	4,496

Source: Ministry of Health. 1998:13

Although orphans have been a part of society since time immemorial, and were adequately cared for within the extended family system, the traditional means of caring for orphans have become insufficient to cope with the growing numbers of additional orphans and dependents due to HIV/AIDS. The social and economic impact of orphanhood is just beginning to emerge. As able-bodied household income earners die of AIDS, the family safety net has been overstretched and significantly weakened, leaving an unprecedented strain on the family. The death of economically active members of households means that young adults leave the unfinished job of raising, socialising, educating, and setting an example for their own children. They also leave behind a growing number of their aging parents who tend to be very old, unemployed, dependent and often helpless. In many cases, orphans left in these circumstances are forced to become caregivers for their aged grandparents. Further, orphans are less likely to complete their schooling or to secure employment. They are at risk for becoming a permanently marginal social and economic group (Fako et al, 2005).

Conclusion

HIV and AIDS are devastating conditions that have imposed, and will continue to impose in the foreseeable future, a significant and potentially crippling burden on the peoples, economies and health care systems of African countries. It has emerged as an uncontrolled worldwide public health emergency as well as a human and economic disaster exacting a devastating toll on the health, economic and social fabric of many communities worldwide. The social impact of HIV/AIDS is far-reaching and can be felt by individuals, families, and communities. HIV and AIDS will result in frequent trauma and grief associated with caring for a patient who wastes away very slowly and eventually dies. While volunteers and health workers may drop out if HIV-related stress becomes too great, those at home are more likely to be isolated with their problems, without easy access to anyone who can help them find solutions or relief.

Although vaccine candidates have been tested since 1987, vaccine development for HIV has not been and will not be an easy process. The complexities of HIV as a virus and AIDS as a disease have made successful vaccine development a formidable task. Finding an effective and safe vaccine and protecting the population from HIV infection and its long-term consequences remain urgent goals of the global community, which will only be realized with substantial increases in funding from the donor nations.

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