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ABSTAIN OR DIE: THE DEVELOPMENT OF HIV/AIDS POLICY IN BOTSWANA

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Summary. This paper traces the development of policies dealing with HIV/AIDS in Botswana from their beginning in the late 1980s to the current programme to provide population-wide anti-retroviral therapy (ARV). Using a variety of source material, including long-term ethnographic research, it seeks to account for the failure of Western-inspired approaches in dealing with the pandemic. It does this by looking at the cultural and institutional features that have created resistance to the message and inhibited effective implementation. The negative response to the first educational campaign stressing condom use is described and contextualized in terms of Tswana ideas of morality and illness. Nor, as was initially expected, did the introduction of free ARV therapy operate to break the silence and stigma that had developed around the disease. Take-up was very slow, and did not operate to encourage widespread testing. In 2003, key policymakers in Botswana began to argue for a break with the AIDS ‘exceptionalism’ position, with its emphasis on voluntarism, confidentiality and the human rights of patients. This resulted in routine testing being introduced in 2004. This links to a major argument running through the paper which is that the failure of policy cannot be attributed solely to the nature of local populations. Western cultural assumptions about ‘good practice’ also require critical examination.

Introduction

The 21st century begins as the newest plague in world history affects millions in Africa and threatens equal devastation across many of the poorest regions of other continents. This is occurring in a situation where medical knowledge of the disease is extremely sophisticated and where even if there is no vaccine or cure, there are palliative measures both to prevent infection and to prolong life. Supporting this, there is a panoply of international, indeed global agencies, whose mandate is public health. There is much talk, much money pledged and indeed spent in the ‘war against AIDS’. UNAIDS was formed to co-ordinate policy in 1995 and the Global Fund to

combat HIV/AIDS, TB and malaria was launched in 2002. New initiatives seem to be announced almost monthly, usually with considerable fanfare. In quick succession, since then, there have been the World Bank's Multicountry AIDS Program (MAP), President Bush's Emergency Plan for AIDS Relief, and the Clinton initiative. There remains, however, a searing gap between intention and result, for those measures that have been advocated in Africa have, in the main, been signally ineffective. And, it is only now, 20 years into the pandemic, that the reasons for such failure can be sought, not in the particular difficulties of Africa or in the apparent resistance of its population to take on board the safe-sex message. At long last, a few voices are beginning to question the nature of Western intervention and its ideological underpinnings.

Alex de Waal in 2003 writes 'the AIDS industry is a prisoner of political circumstance, and as a result, may be trapped in a cycle of ineffectiveness' (de Waal, 2003, p. 255). He argues that there is an un-theorized consensus on what an HIV/AIDS programme should look like. This consensus emerged from the contests between different interest groups in the USA in the 1980s. These, as Epstein (1996) has documented, drew their legitimacy from many sources, most particularly medicine, public health and AIDS activism on the part of gay men. Confidentiality was to be at the fore to protect the infected from the dangers of stigma and discrimination. This created a policy where the stress was to be on voluntary behaviour change and condom use advocated as a general population directive. Reinforcing this was growing international NGO concern with issues of human rights, taking a particular focus here with regard to HIV, with the rights of victims of the disease held paramount.

In retrospect, and with particular reference to Africa, this all seems very strange. Little money, for example, was pledged to the development of medical infrastructures in the 1980s or 1990s, despite the fact that in many African countries these had deteriorated under the impact of the structural adjustment policies. Instead, a dangerously infectious disease was combated only by programmes that urged individuals to try and avoid it as best they could in a situation where there was no means of knowing who was infected and who was not and, in the main, no way of finding out.

Only now, 20 years into the pandemic, are some looking outside the tunnel vision that this policy consensus has induced. Working from Nairobi, De Cock *et al.*, in 2002 (p. 67), argue that 'human rights approaches to the HIV/AIDS prevention might have reduced the role of public health and social justice'. They put forward a cogent argument for the acceptance of measures used for other infectious diseases – including sexually transmitted ones – such as widespread testing, partner notification, and the tracing of contacts. The significance of this move can be illustrated by the fact that even now in Africa only 6% of the population who want voluntary testing have access to it, and only 14% of people in need of STD services can obtain them (Global HIV Prevention Group, 2003). Testing facilities simply do not exist over much of Africa.

The response to SARS has in many respects given impetus to this new mood. The SARS epidemic in 2003 demonstrated the ability of global organizations to act rapidly to eradicate the threat of this new disease. There, the danger to public health was the only issue: there was no talk of the danger of quarantining to human liberty.

Of course, there are huge differences in the nature of the diseases in question, in their manner of transmission and in their duration. The one brought evident signs of infection soon after contact; the other operates with a delayed fuse, manifesting symptoms often years after infection and infecting the next generation in the process. Yet, the argument of this paper is that it is not the epidemiology of the disease that is at issue but the specific model of prevention that has been exported by the West and which has dominated programmes in Africa. In this model, normal public health measures have not been to the fore: routine testing and quarantining have (with a few notable exceptions) not been the instruments of choice.

A return will be made to this topic. First, in the time-honoured anthropological way, the argument is pursued through a case study. Through the examination of policies in Botswana, the intention is to illustrate the hold of the consensus and the way it has dictated particularly policy programmes and initiatives. The current paper is based upon research over a two-year period (1997–1999) while lecturing at the University of Botswana. This was followed by a short return fieldtrip with Alinah Segobye and Tim Allen in July 2003, under the auspices of ACHAP (African Comprehensive HIV/AIDS Partnership). Policymakers in the capital and those involved in running the anti-retroviral therapy (ARV) programme were interviewed as well as village leaders in the countryside. The study of the ARV programme was further facilitated by the robust evaluations of the main policymakers and managers, and the wide reporting of these in newspapers and web sources. Finally, the work was facilitated by the researcher's long-term involvement in Africa, with ethnographic field research stretching back over 30 years.

HIV/AIDS and anthropological research

Anthropologists, it should be said, have not been enlisted into the effort to combat HIV/AIDS in Botswana, nor have they achieved an established position elsewhere. Indeed, it would be true to say that anthropology stands outside the coalition of interests represented by those involved in HIV prevention and treatment, the local knowledge of its practitioners and their potential insights having been neglected (Heald, 2003). Thus, even when the calls of the international community emphasize the importance of adapting policy to local cultural understandings and conditions, this has not involved the use of anthropological forms of understanding. On the sidelines, then, anthropology's contribution to the research on HIV/AIDS may be said to be largely a critical one, pointing to the gaps in the policy, its lack of local responsiveness, and its neglect of important social and political contexts that create populations vulnerable to the disease. The work of Farmer (1992, 1999), Manderson & Whiteford (2000), Seidel (2003) and Waterston (1997), as well as many others, point to the dearth of social and political analysis that has been associated with individualistic intervention strategies.

The reasons for the neglect of anthropology are complex but some can be sought in the rise of consultancy social research, with its emphasis on short-term methodologies, such as KAP (knowledge, attitudes, practices) surveys, which are seen to yield immediate results. These snap-shot pictures rarely yield clues as to why – as so often – there is disparity between apparent 'knowledge' and 'practice'. They provide

a picture without the context needed to interpret it. Focus groups may then be utilized to gain some insight but, again, such methods depend on setting up an artificial situation, divorced from the real-life settings in which attitudes and practices emerge. Anthropological research, by contrast, is all about context. It is also long-term; the researcher gaining a deep understanding of the society in question through participant observation in natural settings, supplemented by in-depth interviewing of key informants and by documentary, archival and other bibliographic searches. Its findings relate not just to the statements of individuals surveyed but to the cultural setting in which they have meaning and to the political and economic contexts in which lives are lived.

The built-in assumption in most AIDS awareness campaigns that 'knowledge' will dispel 'ignorance' ignores the fact that knowledge exists at many different levels, and is contextualized differently. What one 'knows' in one place or time – in a school classroom or an NGO-run seminar – may have little relevance outside of this context, where other 'knowledges' and incentives come into their own and are more compelling.

Botswana is an interesting case to focus on here because its programmes to combat HIV/AIDS have from the beginning, in the late 1980s, taken their lead from international 'expert' advice. Initially, they were orientated to behaviour change with the condom a key element in the message. Then, in 2001, there was a major shift in policy, with Botswana becoming the first African country to introduce free ARV treatment to its population. In both initiatives, one could say that it was and is ahead of the game, with an effective state willing to recognize the problem of HIV and use its resources in attempts to tackle it. The problems that it has faced are thus instructive and speak to the limitations of Western-based assumptions and ideas of 'good practice'.

Botswana phase one: behaviour change and the condom

Botswana is an unusual African state and, in the era of AIDS, one largely immune from the problems that have perplexed so many other countries of sub-Saharan Africa. Firstly, it is politically stable; there have been no major wars, and the country is justly proud of its constitutional democracy. Further, its wealth has protected it from the effects of economic liberalization and the structural adjustment policies imposed by the World Bank and IMF elsewhere. In African terms, with an estimated GNP *per capita* of almost US\$4000 in 1999, it is rich. This wealth is largely due to diamond mining and, with income exceeding expenditure, the government built up substantial reserves throughout the 1980s and 1990s. This was not at the expense of public investment and welfare programmes. Political leadership in the country was committed to the rapid modernization and development of its admittedly small population, estimated in 2004 as 1.7 million. Educational provision was extended, with universal primary and secondary education and the development of a tertiary sector. Importantly, too, hospitals and clinics were developed and there was approximately one health facility per 2500 persons in 1995 (USAID, 1996).

Botswana also realized the problem of AIDS early in southern African terms, a good ten years before its neighbour, South Africa. At that time, it brought in the international agencies for advice and in 1987 set up a one-year emergency plan that

has been followed by a series of other five-year strategic plans. Programmes were developed aimed both at surveillance and intervention. These were all phrased in terms of the accepted formulations of the international organizations as multi-sectoral, integrated and so on. Reading the plans one cannot but be impressed. The reality has been different.

Initially, one might have supposed that if Western AIDS policies were capable of working anywhere in Africa they should have worked here; that is, in a country with an effective government, small population and modern sector health provision. However, the numbers infected doubled in the five years after 1992, when the first sentinel survey was conducted. In 1997 Botswana became known as the AIDS capital of the world. Nor do more recent figures give grounds for much optimism. The nationwide medians of women tested anonymously at antenatal clinics express the situation well. They show an escalating rate in the early 1990s, then a possible levelling off of prevalence, with percentages rising only from 32.4% to 38.5% in the six years from 1995 to 2000 for 15–45-year-old women (Clarion, 2002, p. 4). However, since such a levelling might be due to the toll of death and infertility among women of that age group due to HIV infection, it gives little cause for optimism. The median prevalence among 15–19-year-olds tends to a more pessimistic interpretation, with 26.7% infected in the 2000 survey. Though estimates vary, life expectancy is projected to fall from 67 years to as low as 33 years before bottoming out.

The first phase of HIV/AIDS policy was to provide surveillance and education. A mass education campaign was launched in 1988 with the condom the central plank in this message. What this encountered initially was widespread disbelief (Ingstad, 1990; Ubomba-Jaswa, 1993). For the population at large, at this point, there was simply no evidence in the form of morbidity or mortality to support the information on the impending epidemic. Botswana expressed this by calling AIDS the 'radio disease' as the radio had been the prime and, for many, the only knowledge they had of this new threat (Ingstad, 1990). By 1995/6, the situation had changed in that many now had direct experience of it in the deaths of family and friends. People continued to call it the radio disease. Indeed, though 'knowledge' of the disease was probably good in the major urban areas, in the sense that people had heard of it, this did not necessarily hold in the rural villages.

Further, to initial disbelief was added an element of outrage. The promotion of barrier methods to prevent infection set up the cry of immorality, of encouraging promiscuity. As such, it met the resistance of churches, parents and population. This disbelief of the facts and the opposition in terms of morality fed in and fuelled an alternative discourse of AIDS, which grew out of Tswana beliefs and understanding (Heald, 2002). In this discourse AIDS is not seen as a new disease but as an old one, a manifestation of old 'Tswana' ailments, grown more virulent in response to the disregard for the mores of traditional culture. At the level of experience, this is all too comprehensible. AIDS manifests itself not as a new disease but as a mass of old ones. The association of AIDS here is not with disease *per se* but with pollution, consequent upon the breaking of prohibitions which ideally control reproductive life. These proscribe sexual contact at various times, most particularly during menstruation, following birth or miscarriage and after death. This is based on an elaborate and coherent bio-moral theory. In this, sexual intercourse has an especial value, not just

because of its procreative power, but because it creates connection, a flow of bloods, between legitimate sexual partners. This is deemed health-giving in itself. A corollary of this is that the condom could be seen as designed not to prevent infection but as an agent in its origin and spread. In stopping such flows, it was interpreted by traditional doctors and the leaders of spirit churches as a vector of ill-health and disease (Heald, 2002).

Further, it is worth remembering that this population, like most in Africa, value procreation. The condom message was initially developed for a population that practised recreational and not procreational sex. Few of those involved in the educational effort seem to have stepped back to ask whether the universal condom-use message was equally appropriate in these other very different circumstances. It is relevant to note that around half of female students at the University of Botswana had children and that this was not an aberration. Over the years of male labour migration to South Africa, the age of marriage had been delayed, and having children was seen as a step on the road to marriage: a proof of fertility rather than something that should only happen afterwards.

The educational campaign ran into problems partly because it was culturally inappropriate. More than that, it operated to highlight the fact that this population was far from homogenous. The very rapidity of modernization in the twenty years since the development of mining had led to huge disparities in wealth, education and opportunity. There were many effectively disenfranchised by Botswana's economic miracle with 50% of households estimated to live at or below the poverty line (Botswana, 1996). Many of these households were those headed by the old, who had had no access to modern education, and who found their values and assumptions over-ridden and ignored by the new arbiters of truth. The old truths survived, possibly becoming even more firmly articulated in opposition (Heald, 2002). It is important to note that, in contrast to surrounding countries, traditional doctors, churchmen and local communities were not incorporated in the educational effort. It was exclusively in the hands of official channels and thus to a large extent seen as 'external' and 'white' (*sekgoa* as opposed to *setswana*). In effect, one had two parallel discourses operating in the 1990s: discourses that were not allowed to meet. There simply were no forums in which they could be debated, contested or even discussed. One was government endorsed and public, making the second appear as unofficial and *sub rosa*, though for many it was these truths that appeared self-evident. This polarization took and takes many forms, but of greatest relevance here is that modernity, and indeed the modern state, was increasingly associated with sexual laxity and disease, an affront to Tswana morality and ideas of causation.

If this was one major problem, there were also others. It was apparent that the government-sponsored campaign was not pursued with any great vigour in the 1990s. After the initial campaigns, the issue seemed to sink into a silence that was to dog later efforts to mobilize the population. There were throughout problems with disseminating the information, of staff shortages and the lack of good leaflets for distribution through the health posts (USAID, 1996). When all the major donors pulled out after 1995, on the grounds that the relative wealth of Botswana allowed it to underwrite its own programmes, the dearth of information became increasingly

evident. One conclusion to be drawn is that there was a lack of political will. This invites speculation as to the perverse economic incentives operating in Botswana, where the demographic implications of the epidemic were not matched by equally dismal economic forecasts (see Allen & Heald, 2004). Unlike agricultural-based economies, which dominate throughout most of sub-Saharan Africa, the wealth of Botswana relies largely on a diamond industry employing a small number of workers. Population collapse would not necessarily spell economic collapse. In any event, while dire forecasts were being produced of the demographic time bomb, on how the death rate would produce growing dependency ratios, there was, in the absence of procedures for recording deaths, little direct evidence of rising mortality until the mid-to-late nineties.

The silence around the topic is often put down to the strength of stigma. This was certainly real enough, with only seven people – as it was said – having ‘come out’ as HIV-positive by 1999. University students who were aware of the figures took a fatalistic if, in some ways, rational view. Believing their chances of being positive were very high, they had little incentive to go for testing and risk the stigmatization of living with the disease. Nor did they have any incentive to change their sexual behaviour: ‘What was the point?’ they said in conversation. They talked of all dying together, of not wanting to live without their friends, and so on.

Botswana phase two: the ARV programme

If the first phase of Botswana’s ‘war against AIDS’ was marked as much by inaction as action, things were to change dramatically in the second phase with the programme to roll out anti-retroviral therapy (ARV). Treatment was fore-grounded by activist groups and endorsed by the WHO’s ‘3 by 5’ initiative aiming to provide ARV therapy to 3 million people in the developing world by the end of 2005. In 2001, Botswana became the first country in Africa to pioneer this on a nationwide basis. Anti-retroviral therapy treatment, it was proposed, would operate not only as a humanitarian intervention but advance behaviour change by breaking the cycle of denial, infection and death, as it was put. The government put its whole weight and considerable resources behind the initiative.

A key date for this change in HIV/AIDS policy was mid-term transfer of power from President Masire to President Mogae in April 1997, though it was not until August 1999 that Mogae launched a new campaign against HIV. He went on to enlist a number of overseas partners and, in 2001, established a public/private partnership with Merck Pharmaceuticals and the Bill and Melinda Gates Foundation, known as the African Comprehensive HIV/AIDS Partnership (ACHAP). The aim, as had been said, was not simply humanitarian: that is to provide relief to the afflicted and prolong life. More significantly, its overall aim was to provide therapy in order to encourage *testing*, and a new openness towards the disease.

The title *Masa* (New Dawn) expressed the initial optimism for the programme, with its aim that by the end of 2002, a little under one-fifth of the 110,000 people whom it was believed could benefit (those with a CD4 count of 200 or less) would be on treatment. However, in the event, the roll-out was much slower. Firstly, although Botswana’s health care sector was well developed in African terms, it did

not have the testing facilities, nor the staff to supply ARVs on this scale. The decision was made to deliver the therapy through special dedicated sites, in order to monitor compliance, toxicity and resistance in this experimental programme. Thirty-two operating sites were planned, but only two centres were operational by end of 2002 and four by April of 2003. At that time, two years after the inception of the programme, only 4643 people were on ARV. The initial target of 19,000 was not to be reached for another year, until April 2004 (Darkoh, 2004).

The problem of infrastructure was real enough but so too was the reluctance to test. The programme initially seems to have little effect on the silence and stigma. The number of those who had 'come out' and gone public with the fact that they were infected had gone up only to twelve, it was said by ACHAP personnel, in 2003 when the ARV programme was in full swing. Further, those who did come forward for treatment were mostly those in the latter stage of the disease, with CD4 counts so low that therapy was difficult and mortality high. The inrush of such patients, in turn, created bottlenecks, slowing the admission into the programme of those who could more easily be treated (Darkoh, 2004).

When interviewed in July 2003, Donald de Korte, the Director of ACHAP, spoke of a general inertia. High hopes, he said, were running on the scheme as a pioneering model for the whole of southern Africa but, at the moment, all the managers could see were the snags. One source of stagnation was the bureaucracy itself. Donors had flooded in with the ARV programme with the result that Botswana had become a land of acronyms, with a mosaic of programmes and agencies criss-crossing one another. Much of the overarching structure had been established in line with directives from World Bank and UNAIDS, with the establishment of an independent National AIDS Council and a National AIDS Coordinating Agency. This later was mandated to co-ordinate all initiatives but often, in effect, replicated existing structures. As elsewhere, (Putzel, 2004), the immediate effect of this was to create turf wars between different agencies, and different ministries in the government. Further, the many new initiatives were all jumping to meet much the same demands, and all competing for personnel inside their areas of operation. Botswana is a small country with limited trained staff. This, and the stifling effect of bureaucratic regulation, inevitably perhaps had the effect of slowing down the implementation of ambitious programmes.

Then, there was the issue of cost. At the outset, to treat 110,000 people as originally envisaged, Botswana needed a 30% increase in doctors, an almost 200% increase in pharmacists, and so on (Clarion, 2002, p. 11). The cost of ARV therapy per patient per year was put at approximate £750 in 2003. In addition, Botswana experienced what we might call the downside of philanthropy. The mere presence of international organizations immediately raised costs for the government. Salaries in international agencies were 3–10 times higher than in government service. So, the lack of trained personnel was aggravated by transfers out of government health provision. It is important to note that the government remains responsible for most of the health provision in the country. This is true even in the ARV sector, with Botswana funding at least 70% of the bill in the current private–public partnerships. Further, outside resources are pledged only for five years, the idea being that Botswana would then pick up the full cost (AllAfrica, 2003).

Given the expense, it is difficult to estimate how long the country can continue with the programme, let alone export it elsewhere, as originally envisaged. The issue of sustainability is increasingly addressed. A year after his 2003 Washington address, President Mogae had this message for his people: 'abstain from unsafe sex or die' (BBC News, 2004b). With 30,000 people now enrolled in the programme, he had to explain that it could not be continued in the long term unless infection rates were dramatically brought down.

The overall problems with the ARV programme are evident and large enough. Nevertheless, it is important to address the issue of whether it was having any impact on local opinion, or whether the new political determination to increase awareness of the disease and to test was having an effect on attitudes at the village level. In July 2003, interviews were conducted with officials in several villages in a rural area of eastern Botswana. The question was whether there was evidence of the 'community mobilization' advocated in policy directives.

Botswana has a ready-made institution at all levels for the formation and promulgation of policy. During the colonial era, the administration had developed around the kingdoms and their internal hierarchy of chiefs and councils. These continue to exist at all levels from the sub-ward up to the ward, village, tribe and thence to the House of Chiefs. Existing in parallel to the bureaucracy of the modern post-colonial state, however, they have been increasingly marginalized. Thus, though the hereditary chiefs and headmen (*dikgosi*) still sit every day in their councils/courts (*dikgotla*) and are paid a stipend by the government, they have little of the executive power that they had once possessed. Nevertheless, from the point of view of most of rural Botswana, they still represent a significant authority and the one most immediate and easily comprehended (Helle-Valle, 2002). The *kgotla*, usually a circular area, sometimes marked solely by stones, but more usually by elaborately decorated shelters, is still treated almost as sacred space, where the old rules of respect apply. It is also in a sense 'privileged' space as, in principle, it is an arena of free speech, where issues can be discussed openly and where the chief may not only issue directives but be subject to criticism and advice by his subjects. In the past, the arena was a male forum, and this is still largely the case although women may now attend. However, the erosion of the power of the chief means that they deal at lower levels with minor dispute settlement and even here government courts run in parallel.

Here again, one finds the schism between modernity and tradition – between the modern government apparatus, with its democratic constitution and bureaucratic forms, and the older customary one, again designated in terms of the opposition between *Sekgoa* (white) and *Setswana* (Tswana). Today, the *kgotla* continues much of its work of government at village level through a range of elected village committees – for development, health, AIDS – who report to *kgotla* but also to official committees and government offices further up the hierarchy. The chiefs are to an extent sidelined by such a structure and share a common narrative of disempowerment. For example, among those interviewed, none cited AIDS initially as a major village problem. The response to further questioning was to say that it was an external problem, with people coming back from the towns to die. HIV was not, they maintained, in their village. When pressed on questions about controlling sexuality in the village, the standard response was that there was still disbelief; the youth take no

notice – for them it is still the ‘radio disease’. Moreover, the youth were beyond control. With the increasing mobility of the population, many of the old sanctions are difficult to apply. Fining a man for making a girl pregnant can in many cases be enforced when both live in the same or neighbouring villages, but is much more difficult when their home villages are distant or one is from an urban area. Further, they argued that if they tried to intervene, for example by trying to discipline a young man for seduction, they risked having human rights lawyers on their backs. This emphasizes the way the two discourses of HIV and human rights have developed tightly in tandem, with the latter powerful enough to be felt even in fairly remote rural areas of Botswana.

As a counter to this, we did hear of chiefs acting in spheres where they still could. Significantly, this was about the cost of burials for, as the death toll has risen, so too has the cost of death. Twenty-four hour funeral parlours are now a prominent feature of any large township, and the family is expected to provide an elaborate casket and feed mourners at vigils held for the dead in the days before the internment, and after the funeral. Some chiefs, though not in the villages visited, had outlawed vigils to relieve the families of this burden. One village visited, on the initiative of the chief’s wife, had set up a village-wide burial society to club together to build their own mortuary. In other areas, the ability to act on a collective basis, without finance and authorization from above, was clearly very, very limited.

Far from community mobilization at village level, the situation reinforced the message of silence. Up-country, there were a few posters, mainly at bus shelters, and fewer billboards. There were none at all at the village level, either in public places or in the offices visited. Nor was it possible for chiefs to put up their own posters without authorization from the National AIDS Coordinating Agency (NACA). Knowledge could come down – through occasional seminars run by out-reach personnel – but never go up. Paradoxically perhaps, the very legitimacy now given to democratic forms of government created its own blockages. For example, the committees that determined policy only sat when sitting allowances were authorized. This was true all the way up the hierarchy, and applied equally to village, district and national committees. Thus, sittings were infrequent due to the expense, causing delays in the information and decision-making chain. And ultimately, permission for any AIDS-related activity had to be sanctioned by NACA.

The problem of paper policies that, given the political circumstances and dominating understandings, have little real effect is one that has plagued the issue of AIDS from the beginning. Grand policy initiatives developed by AIDS experts and woven, formulaically, into national programmes have proved, even in a country such as Botswana with significant governmental capacity, difficult to implement. Nevertheless, the ARV programme in Botswana was, while conforming in part to this usual dismal story, to eventually challenge consensus thinking. Key agency players in 2003 began to be strongly in favour of breaking with the AIDS ‘exceptionalism’ position, as the view that HIV/AIDS has to be treated differently from other infectious diseases has come to be known.

In June 2003, a seminar was called in Gaborone to discuss the current procedures with regard to testing. Kwame Ampomah, the UNAIDS coordinator, denounced the current testing policy for failing the objectives of public health. In arguing for the

need to 'normalize' HIV/AIDS, he is reported to have posed the question in these terms: 'Has there been a case in history where a major public health catastrophe was effectively managed and brought under control by placing individual rights above collective rights as public interest?' (Botswana Guardian, 20th June 2003). The conference, the reporter filed in his report, 'reacted with palpable ferocity'. In any event, it was unable to reach a decision and had not even produced a draft report by August. There was talk of the need for more workshops.

In the autumn of that year, things were to change through the decisive action of Botswana's President as well as the ability of those in charge of Botswana's ARV programme to critically revise and rethink their approach to the pandemic in the light of their experience.

Botswana phase three: from voluntarism to enforcement?

Let me start with the President's story. In June 2003, President Festus Mogae fell ill and feared that he too might have contracted the disease. He took a test and publicly announced this fact. It was negative. Nevertheless, he became the first African President to openly admit such a fear. And, it was clearly a salutary experience for, in a dramatic turnaround in November he backed a full testing programme, recommending that it become routine (with an opt-out clause) in all government facilities. In his view, until testing became universal and accepted, there was little hope of breaking the circle of denial and infection. As he was all too aware, the time is already late, 'our cemeteries are filled with the headstones of people in their 20s and 30s' (speech in Washington, 12th November 2003). Thus, from 1st January 2004, routine testing was to occur in hospitals and conceivably throughout public sector health provision. This was a dramatic change in policy, from a carefully monitored ARV programme, a roll-out in specified sites, to a generalized one of testing. The mother and child clinics in the larger rural villages had no testing facilities of any kind when visited six months earlier.

This raises again the thorny issue of transmission. As mentioned previously, the hopes of preventing transmission rested on encouraging large numbers to come forward for testing, hopefully before they were infected, so they would have an incentive to remain that way. There was no sign of that being the case during our visit to the villages. And, even by April 2004, Ernest Darkoh, Operations Manager of the Programme, admitted that most people still did not know their HIV status. He estimated it as less than 10% and many of these were still presenting at a very late stage of the disease (Darkoh, 2004). This alone threatened to overwhelm the provision in place. But, if 'Know Your Status' has become the new campaigning slogan, it remains unclear what advice is being given to those that test positive. Given that therapy does not commence until an individual's CD4 count falls to 200 or less, there is a long window, approximately eight years, where an individual can transmit the infection. As Darkoh is reported to have said 'therapy is a waste of time if you are not stopping new infections. It's like trying to mop a floor without turning off the tap' (Kaiser Daily HIV/AIDS Report, Tuesday May 11th, 2004).

As has been shown, Western-based knowledge did not dispel indigenous belief nor the possibility of treatment dispel fear. Much of the failure of the programme has

been put down to stigma. Would it not be better now – to escape the universalities implied in such designation – to call this ‘shame’? There is no doubt that it has been a strong feature of the Tswana situation and we need to ask: How far does it relate to the association of HIV with taboo and pollution? But here, we are in a hall of mirrors and it is important to ask how far the ‘special’ status of HIV, imported from the West, with its association with ‘perverted sexuality’ and mandatory emphasis on confidentiality has not coalesced with indigenous ideas to magnify the negative aura surrounding the disease? This, interestingly, is now the line taken by those in charge of the HIV/AIDS programmes in Botswana. For example Dr Banu Khan, the National AIDS co-ordinator, blames international guidelines for creating the problem by the way it created AIDS as a distinct kind of disease, which alone had to be dealt with strict confidentiality (BBC News, 2004a).

Which brings me back to the consensus. What can be said and thought and what cannot rests on the acceptance of often unexamined precepts and normative practices. I have not tried to trace the interlocked interests and institutions that hold the discourse together, making it impermeable, a closed system. What I have been concerned to do is to emphasize its strength, its hold, the way it can continue to promote a particular set of principles and practices, in the name of morality and good practice, in the face of limited or even no success, and of a massive toll on human life. Trying to talk outside or against this consensus is treated as heresy and meets inevitable opposition – even when led by the President. One is left with an impression of a very lonely President Mogae, hitting out in all directions, as his policy for routine testing is castigated by human rights organizations, both in his own country and the West, as smacking of ‘forced testing [which] violates the public’s human rights and rights to privacy’ (Mmegi, 2004). Visibly irritated, the newspaper *Mmegi* reports, Mogae said that because of this they had to prescribe an elaborate rigmarole for offering routine testing, which is dramatically slowing down the programme. Meanwhile his people are not only dying – they are facing extinction.

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