Availability of HAART and Risky Sexual Behaviour: Insights from Botswana

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Botswana is one of the countries in the world that has been most affected by HIV and AIDS. Estimates from the 2008 Botswana National AIDS Impact Survey (BAIS)—the most recent nationally representative survey on HIV and AIDS—showed that 17.6 percent of people aged between 18 months and above were infected with HIV; the corresponding figure for 2004 was 17.1%.

The social impact of the epidemic has been devastating as reflected in, among other things, a rise in the number of orphans and breakdown of family structures. A considerable macroeconomic impact has also been felt as the epidemic affected the size of the labour force and the availability of skills and productivity. Outside of its socio-economic effects, HIV and AIDS has caused resources that would otherwise be used to finance other national investments to be diverted (Econsult, 2006).

It is against this background that the Government of Botswana declared the epidemic a national emergency, and mobilised all sectors and stakeholders to respond through various structures, policies and programmes. One venue of the response has been the provision of free HAART to all eligible citizens through the National ARV Therapy Programme. Indeed, the country was the first in Africa to provide the treatment to its citizens on a national scale. When the programme started in 2002, it was available in only four sites throughout the country. These have since increased to 32 sites (comprising of government referral and primary hospitals, and clinics) countrywide and, at the end of September 2011 over 90% of eligible citizens (those with advanced HIV infection) were enrolled in the programme. This roll-out of HAART has enabled the disease to move into a more chronic state, and the wide application of the treatment has been shown to have decreased AIDS-related mortality among individuals (World Health Organisation, 2006).

This success has, however, been accompanied by many anecdotal accounts of an increase in the prevalence of unprotected sex and other risky sexual behaviour. While these accounts are
largely unsubstantiated, they are consistent with concerns that have been raised in the literature that, despite its positive aspects, the availability of HAART may increase opportunities for continued, or relapse of, risky sexual behaviours among HIV infected people and those at risk of infection (Bouhnik et al, 2002). It has been argued, for example, that the improvement in physical health and quality of life due to HAART may enable or encourage individuals to resume sexual activities including unsafe sex (Kennedy et al, 2007). The more dominant thesis, however, relates to perceptions of threat and disease susceptibility, where it is argued that changes in the perceived threat of HIV may lead to reduced caution in sexual practices, reduced concerns about HIV, as well as increases in unsafe sex and incidences of sexually transmitted infections (Bouhnik et al, 2002; Stephenson et al, 2003; Stolte et al, 2006).

Although another body of evidence is showing no association between HAART use and risky sexual behaviour (see for example, Elford et al, 2002; Crepaz et al, 2004), much of the evidence comes largely from studies conducted in developed countries and among HIV-positive people, and those at a particularly higher risk of infection such as men who have sex with men, sex workers and those in unstable unions. Little is, therefore, known about the behaviours and perceptions of general populations in the context of HAART availability. The aim of this paper is, therefore, to contribute to filling this research gap by using nationally representative data to assess the extent to which the wide and free availability of HAART in Botswana, a developing country, has influenced the general population’s HIV risk perception and engagement in risky sexual behaviour.

**Data sources**

The paper uses a combination of qualitative and quantitative data. The latter comes from the 2008 Botswana AIDS Impact Survey’s individual questionnaire which captured information on, among other things, sexual history and behaviour, and knowledge about AIDS and level of exposure to interventions including HAART. The qualitative data, on the other hand, was from an exploratory qualitative survey carried out in January 2007 in a small rural community in the Okavango district of Botswana. Data was collected using semi-structured interviews and focus group discussions with community members aged 15-49 years, as well as interviews with key informants.

**Results**

The overall results show high awareness of and functional knowledge about HAART in Botswana. A general agreement that the introduction of the treatment has brought about a significant and positive change in terms of increased quality of life and willingness to undertake voluntary HIV testing was also evident. However, contrary to anecdotal reports that partly motivated the undertaking of the study, the overall finding was that the wide availability of HAART in the country has not increased risky sexual behaviour among the
general population. Many people still fear contracting HIV and knew that HAART is not a cure. Consequently many continued, or even adopted safer sexual behaviour, particularly consistent condom use and engagement in monogamous relationships. The results also suggest that the wide availability of the treatment has encouraged health seeking behaviours such as uptake of voluntary HIV testing. These findings are consistent with those of studies undertaken among HIV-positive people in other African countries and may suggest that increased contact with health systems to receive HAART may actually encourage positive changes in risky sexual behaviours.

References