

BOTSWANA FEDERATION OF TRADE UNIONS (BFTU)



**POLICY POSITION PAPER ON SOCIAL SECURITY
& SOCIAL PROTECTION IN BOTSWANA – 2007**

Published by

The Botswana Federation of Trade Unions (BFTU)

February, 2007

Publication supported by



Copies of this publication be obtained from

Botswana Federation of Trade Union (BFTU)

Tel/Fax: 3952534/39520013

BOTSWANA FEDERATION OF TRADE UNIONS
(BFTU)

POSITION PAPER ON SOCIAL SECURITY AND SOCIAL
PROTECTION IN BOTSWANA
2007

TABLE OF CONTENTS

Foreword3

Acknowledgments4

Introduction.....5

Definition & Scope of Social Security.....5

Social Security as a National Priority in Botswana.....6

Social Security Program in Botswana.....7

Health, HIV/AIDS and Social Security24

BFTU Policy Position on Social Security & Social Protection44

References.....47

FOREWORD

Social security has become more and more relevant with the advent of globalization and its attendant consequences for the workers. The extended family which used to cushion workers in the event of unemployment, sickness and occupational injury is gradually disintegrating. The BFTU's objective is to collaborate with stakeholders, evaluate the current status of social security and develop strategies in order to improve social security in Botswana.

The Social Charter to which Botswana is signatory provides for the right of every worker to social security. There is a Draft Protocol on Social Security which provides the same right to any worker or indeed any individual in times of need. The Protocol calls for a comprehensive and inclusive social security system, in which the tripartite organizations in the form of labour movement, employers and government will develop a sustainable and inclusive system in keeping with the protocols aspirations.

The Ministry of Labour provides social protection programmes to the needy and disadvantaged members of our society as well as some form of social security to senior citizens. These programmes are intended to avert human suffering that would occur as a result of poverty, ill health, old age, and the effects of HIV/Aids.

This position paper is one of the initiatives that provide policy guidance on the position of the labour movement regarding social security and social protection. It is hoped that one day many of the nine ILO branches of social security will find their way into our statute books.

In solidarity!

Henry Tebogo Makhale
SECRETARY GENERAL
January, 2007

ACKNOWLEDGEMENTS

The Botswana Federation of Trade Unions (BFTU) would like to thank all individuals and organizations that contributed to the success of this document.

Special thanks to Mr. Trywell Kalusopa and Dr. Kholisani Solo, Labour Researchers for the preparation, compilation and presentation of this policy position paper. Thanks also go to the Steering Committee which comprised the following labour organizations: Association of Botswana Tertiary Lecturers (ABOTEL), Botswana Diamond Sorters Union (BDSU), Botswana Telecommunication Union (BOTEU), Botswana Teachers Union (BTU), Central Bank Union (CBU), Botswana Secondary School Teachers Union (BOSETU) for the valuable insights and suggestions raised during the discussions and consultative meetings that enriched the document.

The BFTU also extends gratitude to the following affiliates and associations that participated in the consultative workshop to shape the document: (ABOTEL), BCSA, BDVSU, BHCSU, BOBEU, BOPRITA, BOTEU, BMIWU, BMWU, BPSWU, BPCWU, BULGSA, BSBU, BTU, BRAWU, MSU, and NASU.

The BFTU wishes to thank the Friedrich Ebert Foundation for the generous support that enabled the consultation, preparation and publication of this policy paper.

1.0 INTRODUCTION

This policy position paper arises out of the BFTU's thorough engagement of its affiliates with a view to developing a unified position regarding the social security and security protection in Botswana. The policy paper involves detailed research work and consultations with affiliates and puts forward consolidated policy guides for dealing with the challenges of social security and security in Botswana.

2.0 DEFINITION AND SCOPE OF SOCIAL SECURITY

The International Labour Office defines social security as:

"The protection which the society provides through a series of public resources against economic and social distress that otherwise would be caused by the stoppage or substantial reduction of earnings resulting from sickness, maternity, employment injury, invalidity and death; the provision of medical care; and the provision of subsidies for families with children"(ILO, 1984:2-3).

Social Security has also been defined as:

"A system of assistance guaranteed by the state, granted to people in need when their normal source of income has been interrupted or ended (for example through sickness, unemployment or retirement). It could entail assistance to certain disadvantaged groups (for instance the handicapped, the families of deceased workers or people suffering from industrial injuries), or supplementing the incomes of pensioners. It could also include social insurance schemes but in a more strict sense of the word it refers to assistance schemes financed from taxation" (Barker & Holtzhausen, 1996:138)

The SADC CODE defines social security as

"public and private, or mixed public and private measures, designed to protect individuals and families against income insecurity caused by contingencies such as unemployment, employment injury, maternity, sickness, invalidity, old age and death".(SADC, 2004)

According to the SADC Code, there are three types of social security namely; social allowance, social assistance and social security. The main objectives of these measures are to (a) maintain income, (b) to provide health care and (c) to provide benefits to families.

3.0 SOCIAL SECURITY AS A NATIONAL PRIORITY IN BOTSWANA

Government strategy for social development is founded on four national principles of Democracy, Self Reliance, Development, and Unity. These principles are expected to lead to the attainment of planning objectives of Sustained Development, Rapid Economic Growth, Economic Independence, and Social Justice (NDP 8, 1997-2002: 85). Poverty reduction as well as sustainable employment is the critical issues addressed in this strategy.

Further, in 1997, Botswana published a document now commonly known as “Vision 2016”: A long Term Vision for Botswana. With respect to poverty, the document pronounces that Botswana will be “a compassionate and caring society, offering support and opportunity to those who are poor, including all people in the benefits of growth” (Presidential Task Group, 1997:8). The Vision document projects that by the year 2016, efforts will have been made to eradicate absolute poverty so that no part of the country will have people living with incomes below the poverty datum line.

With specific reference to social security, Vision 2016 states:

“All people will have access to productive resources regardless of ethnic origin, gender, disability, or misfortune. Botswana will have succeeded in helping people to escape from the poverty trap.... There will be a social safety net for those who find themselves in poverty for any reason. This will go hand in hand with the provision of good quality social security, in partnership with the private sector and NGO’s, aimed at vulnerable groups such as the elderly, disabled, orphans and terminally ill” (Presidential Task Force, 1997:9)

The Revised Policy on Rural Development seeks ways to improve the coverage, targeting, adequacy, efficiency, and effectiveness of social security programs. The policy proposes mechanisms to increase economic

empowerment and self-reliance in the provision of social protection schemes (Ministry of Finance and Development, 2002:7)

4.0 SOCIAL SECURITY PROGRAMS IN BOTSWANA

Government provides a wide range of services for families and children. These services are aimed at reducing poverty as well as providing a social safety net for individuals, groups and families. This chapter specifically reviews the following programs:

- Program for Destitute persons
- Orphan Care Program
- Supplementary Feeding for Vulnerable Groups
- Universal Old Age Pension
- World War II Veterans
- Labour Based Drought Relief Program
- Program for Remote Area Dwellers

4.1 PROGRAM FOR DESTITUTE PERSONS

The National Policy on Destitute persons was first introduced in 1980. The objective of this policy was to ensure that government provides minimum assistance to the needy persons to improve their health and welfare conditions and to alleviate poverty. The formulation of this policy was a direct response to the withering of the extended family system and the social support that was part and parcel of pre-independent Botswana society. With the advent of urbanisation, migration and changing family forms, a significant number of people were left without any means of support.

In March 2002, the old National Policy on Destitute Persons was revised to take into consideration the changing economic challenges that the poor and needy face. Interestingly the objectives of this scheme remained unaltered “to ensure that government provides minimum assistance to the genuine destitute persons to ensure their good health and welfare.”¹

¹ Republic of Botswana, 2002. Revised National Policy on Destitute Persons paragraph 2.2

The revised policy defines a destitute person as:

- a) An individual who, due to disabilities or chronic health condition is unable to engage in sustainable economic activities and has insufficient assets and income sources. Insufficient assets and income sources refer to a person possessing not more than four livestock units or earning or receiving an income of less than P120.00 per month without dependents or less than P150.00 per month with dependent.
- b) An individual who is incapable of engaging in sustainable economic activity and has unreliable and limited sources of income due to old age, mental or physical disability, emotional or psychological disability or is a terminally ill patient with no means of support.
- c) A child under the age of 18 who is in need of care and may not be catered for under the orphan care program or has parent (s) who are terminally ill and are incapable of caring for the child or has been abandoned and is in need of care.

Eligibility and Coverage of the Scheme

The definition of the destitute person stated above describes clearly who is covered and who is excluded. Eligibility for destitute benefits is therefore targeted and conditional. For one to register as a destitute they either have to come forward as individuals or they can be referred or nominated by family members, individuals or community leaders. The scheme does not discriminate on the basis of age, gender or ethnicity. Once the individual has been nominated, professional Social Workers then conduct rigorous assessment to determine whether the individual qualifies.

Destitute persons are classified into Permanent or Temporary categories. Permanent destitute persons are individuals whose age and physical or mental conditions render them completely dependent. Permanent destitute persons are eligible for benefits for life, with no conditions apart from an annual assessment by social workers. Temporary destitute persons on the other hand are those who are temporarily incapacitated by ill health or natural disasters until they can support themselves. Recent figures show that there are 38,074

registered destitute persons in Botswana. This number has been growing steadily since the program was implemented. Table 1 shows the number of registered destitute persons since 2002.

Table 1: Number of Registered Destitute Persons²

YEAR	2002/03	2003/04	2004/05	2005/ March
NUMBER	23,873	30,873	35,673	38,074

Levels and Types of Assistance

Under this scheme, deserving individuals are provided with food rations, cash entitlement, access to social services including rehabilitation, provision for funeral expenses and shelter. Temporary destitute persons residing in rural areas are entitled to P181.90 worth of food rations per month whereas those in urban areas receive P181.40. Included in this amount is P61.00 cash for personal needs. Permanent destitute persons on the other hand are entitled to P256.90 per month in rural areas and P256.40 worth of food items for urban areas. They also receive P61.00 cash for personal items. These amounts may go up to P400.00 depending on the rising costs of commodities particularly in the rural areas. Further, adjustments for inflation are made on a yearly base. Table 2 below gives an illustration of a food basket for an adult destitute person:

² Records obtained from the Department of Social Services. Ministry of Local Government

Table 2 Food basket for an adult destitute person³

Table : Destitute Persons Food Ration		
Food Type	Quantity Per Month	Food Rich In
Maize-meal	2 x 12.5 kg	Carbohydrates, iron, thiamine, niacin
Sorghum	1 x 12.5 kg	
meal	1 x 2.5 kg	
Bread flour		
Vegetables	3. 5 kg	Vitamins
Greens	2 x 1.5 kg cabbage	Minerals
Pulses	1 x 1.0 kg beans	Protein, iron
Meat	1 x 2.4 kg	Calcium, Vitamin A, D, E,
Milk	8 x 500 ml (1 x 500g Nespray)	K
Sugar	1 x 1.0 kg	Calories (energy)
Oil	1 x 750 ml	
Salt	1 x 500 g	Iodine
Tea	1 x 250 mg	Vitamin K, B2, magnesium,
Source: Social Welfare Division- Ministry of Local Government, 2002.		

Children under the age of 18 also benefit from the destitute program. According to the provisions of this policy; these are children who are in need of care and may not be catered under the orphan care program. In addition to food rations these children get assistance in the form of school uniforms, toiletries, transport, protective clothing, boarding requisites, tuition in private and vocational schools, street clothes, payment of additional fees required by the schools such as touring fees, sports fees, development fees and other incidental expenses.

All categories of destitute persons are exempted from payment of publicly provided services such as medical fees, school fees, water charges, service levy and electricity charges. Further, when a destitute person dies, the burial expenses are fully covered by the Local Authorities. Finally, social workers are expected to rehabilitation and psycho-social support to enhance quality of life and sustain dignity of the individual clients.

³ Republic of Botswana. 2002 Revised Policy on Destitute Persons page 12

Challenges and Constraints

Lack of shelter for eligible destitute persons

The Revised National Policy on Destitute Persons clearly states that basic shelter will be made available if the destitute person is found lacking this basic need. However, District and Town Council are constrained by financial resources to provide this service. Some NGOs, Civil Society Organizations, Political parties and interested individuals have played a major role in providing shelter for these people. An important point to note is that there is no record of a homeless destitute person in Botswana.

Exit from Destitution

Within the spirit of the Revised Policy, destitute persons are expected to exit the program once they have been provided with relevant skills, knowledge and the right attitude to engage in sustainable economic and social activities. Recently, the Ministry of Local Government drafted guidelines on rehabilitation exit strategy and mechanism. Initial funding has been provided to kick start implementation of the various rehabilitation activities in 2006. The major challenge is that majority of beneficiaries enrolled in the scheme are old, sometimes frail elderly, who have low educational levels and no skills. However, there have been some successes in places like Francistown where registered destitute persons and potential orphans are engaged in horticultural activities and are making a living out of selling fresh vegetables.

Lack of professional personnel

There is acute shortage of professional social workers to conduct thorough assessment and registration of destitute persons and needy students. On average, one social worker covers at least five villages. Further, social workers employed in the field use a large percentage of their time doing clerical duties such as preparing tenders for food rations and clothing, ensuring that suppliers provide the necessary commodities, and supervising food rations. Consequently, social workers fail to concentrate on the core business of the profession. The introduction of the food coupon system may be a step in the right direction as this would also give beneficiaries the choice they need in purchasing the food they want. In addition, the whole system of tendering for food rations and uniforms should be given taken away from the

department of social and community development and given to a department in council that deals with similar administrative activity.

4.2 THE ORPHAN CARE PROGRAM

An orphan is defined as “a child below 18 years who has lost one (single parent) or two (married couples) biological or adoptive parents” This definition also incorporates children who are abandoned or dumped by their parents who can no longer be traced⁴.

The problem of orphans is not a new phenomenon in Botswana. However, in the past, this problem was not pronounced as relatives and the community at large provided a safety net for these children. With the advent of social change coupled with the escalating rates of HIV/AIDS, the number of orphans continues to increase. For example, in 2002 there were 39,571 registered orphans. In 2004, this number increased to 47,964. To date, there are 51,600 registered throughout the country.⁵ This figure is said to be a serious underestimation as some relatives are reported to be refusing to register orphans because of the stigma association with the HIV/AIDS epidemic.

In response to this crisis, the government adopted a Short Term Plan of Action on Care Orphans (STPA) as early as 1999. The main objective of this strategy was to (i) respond to the immediate needs of orphans (food, clothing, education, shelter, protection and care), (ii) identify the various stakeholders and define their roles and responsibilities in responding to the orphan crisis, (iii) identify mechanisms for supporting community based responses to the orphan problem, and (iv) develop a framework for guiding the long term programme development for orphans. Of key significance, STPA addresses the importance of a participatory and multi-sectoral approach in the delivery of services to orphans. Hence, government expects that there will be a collective effort from the private sector as well as community groups in the identification and support of orphans. The ultimate goal of this scheme is to

⁴ Ministry of Local Government and Housing 1999 Short Term Plan of Action for Orphans. See also Republic of Botswana (2003)

⁵ Official statistics obtained from Department of Social Services, Ministry of Local Government, 2006.

give opportunity to these children to become productive citizens thereby removing them from the poverty trap.

Eligibility and Coverage of the Scheme

Unlike the destitute program, the orphan care program is a social allowance program, therefore it is not means tested. Eligibility is therefore open to all Batswana children under the age of 18 who do not have parents and therefore lacking access to basic human needs such as food, clothing, toiletry and shelter. Children over the age of 18 are covered by the destitute program. Identification of orphans is the responsibility of teachers, social workers, relatives, community leaders as well as members of the community. Registration is finally done by social workers who conduct a thorough assessment of the situation. Once the status of the child has been determined and eligibility requirements met, children are then automatically registered. Currently, 92% of registered orphans are receiving assistance and only 8% are supported by relatives.

Levels and Types of Assistance

An orphan receives a food basket of P216.00 per month irrespective of the geographic location. This amount is regularly adjusted for inflation at the beginning of each financial year. The Ministry of Local Government and Lands in partnership with the Ministry of Health has developed this food basket as a measure to ensure that beneficiaries receive a well-balanced nutritional basket. Orphans also receive additional support ranging from clothing, toiletry, assistance with educational needs, and counselling and even protection from abuse. There are other public and private elements that include, free medical fees in government health facilities, transport allowance and assistance with bills for utilities such water and electricity. Ways are also being explored to provide quality and specialised care for orphans who are disabled and mentally handicapped. These are indeed critical areas of need which must be urgently addressed. Social workers, Non Governmental Organisations as well as the health care providers must find new ways of providing care in these areas.

Acute staff shortages

Data collected from the Department of Social Services shows that there are only 82 posts at the D3-C4 level to manage the case load of 51,600 registered orphans. This works out to a case load of 629 orphans for each post on an annualized basis⁶. Given this case load ratio, it is practically impossible for social workers to assess and register all orphans. Measures have to be taken to increase the number of social workers to a level where one social worker takes care of 200 orphans. The problem of staffing constraints was identified as a major set back in the implementation of this program by social workers and beneficiaries in a recent study commissioned by the Ministry of Finance⁷. Social workers acknowledged that they find it impossible to conduct on-going monitoring on those who are registered because of the multiple roles they have to play in the delivery of social safety nets.

Provision of psychosocial support

Research indicates that orphans in Botswana like in other countries experience enormous hardships such as psychological distress, economic hardship, lack of parental nurturing, anxiety about safety, withdrawal from school, increased abuse and risk of HIV infection, malnutrition and illness, lack of love, attention and affection, loss of inheritance, and stigma, discrimination and isolation to name a few (Ministry of Local Government 1999; 2003; Republic of Botswana, 2003; BIDPA, 2006). Traditionally, most of these problems were taken care of by the extended family. However, due to growing poverty and other economic hardships, coupled with the changing family structure and value systems, the burden of care and support has shifted to the state. Despite these challenging situations, provision of holistic and comprehensive psychosocial support is lacking. It is only recently that government commissioned a study to address psychosocial needs of children. The outcome of this study is the development of a training manual that will be used by social workers, educators, health workers, community development workers and other professionals to provide skills and competencies on psychosocial provision.

⁶ Official statistics obtained from Department of Social Services, Ministry of Local Government

⁷ See BIPDA Consultancy on Review of Social Safety Nets 2006

4.3 VULNERABLE GROUP FEEDING PROGRAMME

The vulnerable group feeding program is one of the oldest social safety nets for children and vulnerable groups. Established since independence in 1966, the program aims at distributing meals and nutritional supplements to people who are vulnerable to malnutrition and women of child bearing age from poor or low income households. The program is implemented by the Ministry of Health and the Local Authorities.

Eligibility and Coverage of the Scheme

Beneficiaries of this program are pregnant and lactating mothers, nutritionally at risk under-fives and TB patients. During drought years, supplementary feeding is provided to all under-fives as well as food rations for lactating mothers. However, in non-drought years, supplementary feeding is based selectively on the weight progression of the child. Seemingly children who are underweight are given are given preference. By July 2005, there were 268,000 beneficiaries under registered under this scheme⁸. Data shows that since the implementation of this program, the prevalence of severe protein energy malnutrition has decreased from 0.5% in 1991 to 0.3% in 1995.⁹

Levels and type of Assistance

The level and type of assistance depends on the nature of vulnerability. Table 3 below provides a summary of what each category receives.

TABLE 3 – FOOD RATIONS FOR THE VULNERABLE GROUP FEEDING PROGRAMME BY BENEFICIARY			
Beneficiary	Food Commodity	Ration	Selection Criteria
Children 4 – 18 months	Tsabana Oil	150g/ day i.e. 2.5kg x 2 every month. 25ml/day i.e. 1 x 750ml bottle / month	All children in this age group
Children 19-	Tsabana	200g/day i.e. 2.5 kg x 3	All children in

⁸ See BIDPA Consultancy on Social Safety Nets 2006

⁹ See Ministry of Finance and Development Planning National Development Plan 8 page 393

36 months	Oil	every month 25ml/day i.e. 1 x 750ml bottle / month	this age group
Children 37 – 60 months	Enriched maize meal Dried Skim Milk Beans Oil	175g/day i.e. 5kg per month 30g/day i.e. 1kg per month 60g/day i.e. 1.8kg per month 25ml/day i.e. 1 x 750ml bottle per month	All children in this age group
Pregnant and lactating mothers, TB and leprosy outpatients	Enriched maize meal Dried Skim Milk Beans Oil	175g/day i.e. 5kg per month 30g/day i.e. 1kg per month 60g/day i.e. 1.8kg per month 25ml/day i.e. 1 x 750ml bottle per month	Medically selected (see above criteria)
Source: Revised National Food Strategy Monitoring Group, 2004			

School- Based Food Program

School feeding program is popular in all public primary and secondary schools in Botswana. The objective of this program is to provide prepared food to children to alleviate short term hunger thereby enhancing classroom learning. In some remote rural areas, school feeding has considerably increased school attendance and retention. Table 4 illustrates a typical weekly meal schedule for secondary school students¹⁰.

TABLE 4 SCHOOL FEEDING MENU		
Day	Food Items	Ration
Monday	Porridge/ Sorghum porridge Stewed steak with gravy Fruit drink	100g/child/day 100g/child/day 340ml
Tuesday	Samp Beans Fruit drink	100g/child/day 100g/child/day 340ml
Wednesday	Porridge Beans	100g/child/day 100g/child/day

¹⁰ See BIDPA Consultancy on Social Safety Nets 2006

	Fruit drink	340ml
Thursday	Bread Milk UHT Jam Peanut butter	3 slices of bread @ 25g 340ml 45g on 3 slices of bread 45g of peanut butter
Friday	Porridge Beans Fruit drink	100g/child/day 100g/child/day 340ml
Source: Revised National Food Strategy Monitoring Group, 2004		

Challenges and Constraints

Records indicate that there has been considerable improvement in the nutritional status of children, particularly the under fives. However, the HIV and AIDS pandemic is reported to be impacting negatively on the health and household food security of the beneficiaries¹¹.

4.4 UNIVERSAL OLD AGE PENSION

The Old Age pension scheme was introduced in Botswana in 1996. This is an entitlement scheme administered by the Commissioner for Social Benefits in the Ministry of Local Government. Implementation is done by social workers in the Local Authorities. Beneficiaries however, receive their allowances from post offices. The major objective of the scheme is to provide financial security to the elderly citizens who otherwise are without means of support due to the disintegration of the extended family support system. Available records show that the number of beneficiaries has steadily increased from 84,577 in 2003 to 86,859 in 2006.¹² The 2002/2003 Household and Income Survey (HIES) indicates that over 95% of the elderly are now registered for this program¹³.

¹¹ See Ministry of Finance and Development Planning National Development Plan 9 page 315.

¹² Source Social Benefits Division, Department of Social Benefits

¹³ See Central Statistics Office Household and Income Survey 2002/03

Eligibility and Coverage of the Scheme

Eligibility for the Old Age Pension is currently defined only by age (65 years and above). Only Botswana citizens qualify. Special efforts are made to ensure that the elderly poor who reside in isolated remote areas have access to this scheme. The allowance is not means tested. Potential beneficiaries are also not expected to contribute anything towards the scheme. Mental patients whether hospitalised or taken care of by families and friends are entitled to the scheme. Citizens who are sentenced to a term of imprisonment whether serving in prison or on extra mural labour are excluded from the scheme until they complete their sentence. Botswana citizens in receipt of other pensions whether in Botswana or residing outside are not excluded. Finally, individuals who are registered under the destitute program are given their benefits as long as they meet the stipulated requirements. Identification to confirm eligibility is through the National Registration Card. Pensioners under the scheme who get paid by cheque or by proxy are required to sign a “Life Certificate” every three months as proof that they are still alive.

Levels and Types of Assistance

Beneficiaries of the scheme currently receive a cash component of P166.00 per month. This amount is adjusted for inflation each financial year.

Challenges and Constraints

- The age limit of 65 is not harmonised with the retirement age of 60 for public servants. Concerns have been expressed that eligibility of pensions should be harmonised with the age of retirement
- The Registration Cards that identify beneficiaries are sometimes lost or misplaced. This poses a big problem in claiming the benefits
- Some pensioners lose out because they do not know their years of birth
- There have been reported cases of physical abuse of beneficiaries by the members of the public and relatives wanting to get money from the elderly
- Some potential beneficiaries in remote areas and cattle posts are excluded from the program due to lack of information and access to services.

4.5 WORLD WAR II VETERANS ALLOWANCE (WW II)

The WW II Veteran allowance is also a universal entitlement program which is not means tested. Government decided at a cabinet of 25th March 1998 that with effect from April 1998, an allowance would be paid to each World War II veteran or his surviving spouse/s or his child or children less than 21 years of age every month. This program is also administered by the Commissioner for Social Benefits, but unlike the Old Age Pension Scheme, it is implemented under the office of the District Commissioner/Officer in various districts. Beneficiaries receive their allowances from post offices.

Eligibility and Coverage of the scheme

The WW II is payable specifically to those veterans or their surviving spouses or their children under 21 years “in recognition of the services they rendered for the security of the country and not other countries. The allowance is also by “extension” payable to World War I veterans or their surviving spouses. Those who have emigrated or have been repatriated do not qualify for such pensions. Where the veteran had more than one spouse or more than one child, the allowance is divided equally among the recipients. Available data from the Department of Social Benefits reflect that the number of WW II beneficiaries has declined from 6,953 in 2003 to 4,033 in 2006.¹⁴ This is to be expected given the fact that most beneficiaries have already died.

Labour Based Drought Relief Program (LBD RP)

The scheme was started in the 1960s as an emergency response to alleviate effects of drought. Invariably, during the drought intervention in the late 1960's and 1970's, payment for participating in drought programs was in the form of “food for work”. The objectives for this program have now shifted to concentrate on¹⁵:

- a) Provision of temporary supplement to rural incomes through wage employment for the most affected by drought

¹⁴ Official statistics obtained from Department of Social Services 2006

¹⁵ See Ministry of Finance and Development Planning National Development 9 2003- 2008

- b) Maximising employment opportunities under the scheme
- c) Creating a socially useful or productive infrastructure
- d) Maximising participation of rural communities in the identification of meaningful projects.

Every year, an Inter-Ministerial team assesses the situation of crop harvest, pastures, water availability and other related contingencies. This team collects information from district extension workers throughout the whole country. With the collected information a special interim committee is tasked to make further recommendations to be submitted to the Rural Development Council. The latter briefs cabinet members who also come up with their recommendations to the President. Around May/June the President may then direct that the scheme be implemented countrywide. Once the draught year is declared by His Excellency the President, implementation commences coordinated by the Ministry of Local Government and implemented by the Local Authorities.

Eligibility and Coverage of the Scheme

Labour Based Drought Relief projects benefit all the able bodied in the rural areas that have lost their livelihoods because of drought. No means testing is used to select participants. However, a rota system is developed to ensure that there is maximum participation to the intended beneficiaries. In the 1980's, 296,000 job opportunities were created under this program, employing 20% of the rural working population, 80% being women. During the 1992/93 drought, over 400,000 people received food aid and about 100,000 people were employed in the reactivated drought relief projects.¹⁶ The 1995/96 drought on the other hand, created a total of 38,558 jobs involving 61,693 workers.¹⁷ The cumulative number of people employed under the 2003/04 was 121,599 workers comprising of 98,968 females and 22,631 males against a total of 1362 projects.¹⁸

¹⁶ See Ministry of Finance and Development Planning 1997 NDP 8

¹⁷ See Ministry of Finance and Dev Planning BIDPA study on poverty 1997

¹⁸ Republic of Botswana Labour Based Drought Relief Program Monthly Report May 2005

Levels and Types of Assistance

A daily rate of P10.00 is given to each participant. Supervisors on the other hand receive P16.00. These amounts are adjustable given the cost of living index in a given period.

Challenges and Constraints

- Since the scheme is generally extended to all rural areas, it may not be well targeted. The extent to which different rural areas are affected and the required respective response in relative terms is usually not ascertained.
- Decision-making, especially at the community level is usually highly politicized—and suffering sometimes sensationalized. This may also hamper an equitable allocation of funds to the most needy. For example, if implementation coincides with elections, selection of beneficiaries is usually politically influenced.
- Bureaucratic delays at the Ministry of Finance create problems that compromise efficiency. For example, the implementation unit is close to 2 months behind schedule this year.
- Urban poor (especially those in the big villages) are excluded yet many of them also rely on arable crop farming for their livelihoods. It is generally (but sometimes erroneously) assumed that only those in the rural areas need assistance.
- The rate of P10 per day paid to participants (intended beneficiaries) is meant be unattractive, and resorted to when no other normal work is available/ accessible to beneficiaries. However, this seems to challenge the intentions of the scheme to help people meaningfully.
- In the past, intended beneficiaries were involved in deciding which projects they wanted to carry out, at the kgotla/VDC level but Government policy has since changed. Priority is given to already existing planned community development projects. Due to the high quality expected of planned (mostly infrastructure construction) projects, what used to be a labour intensive scheme to help as many local people as possible, now excludes most of the intended beneficiaries as most lack the requisite technical skills.

4.6 PROGRAM FOR REMOTE AREA DWELLERS

The remote area dwellers or Basarwa/Bushmen mainly live in remote and arid parts of western Botswana where there is very little economic activity. By tradition, most were nomadic hunter-gatherers and did not engage in arable agriculture.¹⁹ Previous research has revealed that Basarwa are the most forgotten, undeveloped, and poorest section of the rural society of Botswana.²⁰ Other studies have revealed that there are other thousand of poverty stricken inhabitants besides Basarwa of the extra-rural or remotest areas of Botswana who follow more or less the same way of life and face the same tough conditions as Basarwa.²¹ Over time, there has been encroachment into the traditional hunting and gathering areas of these remote area dwellers by other ethnic groups. Remote area dwellers are in general characterized by severe poverty, lack of incomes and education, low literacy levels and lack of employment opportunities.²² Available data show that children from remote areas who come from areas where basic social services are lacking, or from hunter-gatherer families, non stockholders and non-regular wage earners find themselves in a unique position that requires attention. Their access to and participation in education is inhibited by reason of their distance from educational facilities.²³ These children are often faced with the problem of walking long distances to schools and their inability to speak the languages in school (English or Setswana).

The origin of Remote Area Development Program (RADP) dates back to the 1970s when it was called the Bushmen Training and Settlement Project. After several reviews, the program has evolved to focus specifically on ensuring that beneficiaries achieve sustainable social and economic development and that they benefit equally from rapid economic development of the country.²⁴ According to the Mid Term Review (MTR) of NDP 9, the RADP will be aligned with Vision 2016 and Millennium Development Goals

¹⁹ See Ministry of Finance and Development Planning 1997 page 365

²⁰ Ministry of Local Government and Lands Report on RADP Workshop 1997

²¹ The most affected areas are the western districts of Ghanzi and Kgalegadi, western Kweneng and Southern districts

²² Republic of Botswana Report on the Review of the RADP 2003

²³ See Republic of Botswana 2001

²⁴ See Republic of Botswana Report on Review of the RADP 2003

to fast track developments in remote areas with emphasis on economic empowerment through income generating projects, livestock distribution and capacity building.²⁵ The Ministry of Local Government implements this program in 64 designated settlements through the Department of Social Services.

Eligibility and Coverage of social security schemes under RADP

Remote area dwellers depend largely on the social security schemes provided by the state. Majority if not all receive the destitute rations and allowance. Other social safety nets provided include the old age pension scheme, assistance for orphans and vulnerable children and services for people who are on home based care. Eligibility criteria used in these schemes applies in the RADP program. It is important to note that apart from the social security benefits, government has established the Economic Promotion Fund (EPF) with the aim to create employment opportunities for remote area dwellers. The scheme provides funds for productive and business oriented activities including game ranching, harvesting and utilisation of veldt products and arable agriculture. Other activities under the scheme aim at promoting income generating activities such as tanneries, handicrafts, poultry farming and livestock production.

Challenges and Constraints

A number of challenges have been identified with respect to the delivery of social security provisions in remote settlements.²⁶ These include the following:

- The food basket does not have the flexibility to allow beneficiaries to select items that they are culturally accustomed to.
- Due to remoteness of some of the areas, the amount allocated is often not enough to cover all the food items prescribed in the package.

²⁵ See Mid Term Review of NDP 9 2003/04 – 2008/09

²⁶ See Republic of Botswana Report on the Review of the Remote Area Development Program 2003 page 110-112. and BIDPA Consultancy on the Review of Social Safety Nets 2006

- Many children drop out of school at junior secondary school level and therefore miss out on getting better employment opportunities
- Due to low levels of literacy and skills amongst remote area dwellers, the economic promotion fund has not succeeded in getting people out of the poverty trap.

5.0 HEALTH, HIV/AIDS AND SOCIAL SECURITY

This part discusses the impact of HIV/AIDS in Botswana with reference to three dimensions namely; the social policy, legal and economic and labour markets dimensions. Under the social policy perspective, it discusses the following: status of the HIV/AIDS pandemic; current responses and policy priorities; coverage of social security schemes; poverty implications and gender and vulnerability measures. The legal dimension on the other hand addresses some fundamental questions namely: the legal status of people infected and affected by HIV/AIDS; constitutional protection; equality and discrimination issues; the labour law paradigm and responses; role of international law and minimum standards, and the impact of law reforms. Finally, the economic and labour market dimension discusses; the macro-economic impact of HIV/AIDS, viability of schemes, financial support, and market responses. It concludes by outlining some challenges and making recommendations for a way forward.

Status of the Epidemic in Botswana

HIV/AIDS has become one of the most serious social, health, economic and development problems in most of the countries, particularly in Sub-Saharan Africa. In Botswana, the first case of HIV-related illness was first discovered in 1985. Since then, the virus has spread rapidly throughout the country. For example, data from the 2002 HIV Sentinel Survey carried out among pregnant women reveals that at the national level, the prevalence rate is 35.4%. At the district level, high prevalence rates have been recorded in the northern districts of Boteti, Bobirwa, Chobe, Francistown, Mahalapye, Ngami, North East, Okavango, Selebi/Phikwe, Serowe/Palapye, Southern district and Tutume. In contrast, there is relatively low prevalence rate in the southern districts of Gantsi, Hukuntsi, Goodhope, Kgalagadi, Kgatleng,

Kweneng East and West, and South East.²⁷ Overall, data shows that 258,000 adults and children are now living with HIV and AIDS in Botswana.²⁸ The worst affected group is the 25-29 years age group, with a prevalence rate of 48.4%. Medium prevalence rate among the 15-19 years is 24.1%. It is important to note that HIV prevalence rate for pregnant women aged 15-49 decreased marginally from 36.2% in 2001 to 35.4% in 2002.²⁹

Although the prevalence rate reported show that HIV/AIDS has become an endemic health problem affecting all districts, towns and villages, current data shows that there is a consistent plateau pattern in the HIV prevalence in some age groups and even a decline in others. For example, data indicates that the HIV prevalence rate in the 15-19 age group is lower than in higher age groups and has been stable or even declining over the past recent years. In 1995 for example, the prevalence rate in this age group was the same as for the whole population (32.4%). However, in 2002 the 15-19 year olds prevalence had declined to 22% while that for the entire 15-49 age group had increased to 35.4%.³⁰ This trend seems to indicate that intervention strategies have started to work, giving some ray of hope for the future.

In terms of the impact of the epidemic, the latest figures from the Central Statistics Office (CSO) reveal that about 18% of all deaths were attributed to HIV/AIDS.³¹ Child survival indicators have deteriorated as a result of the epidemic. For example, infant mortality rate has increased from 48 in 1991 to 56 deaths per 1000 live births in 2001. The under-5 mortality rate increased from 62 to 74 deaths per 1000 live births in 2001. Further, death rates among the 25-29 age groups almost doubled from 7.3 to 16 deaths per 1000 people. This rate tripled for the age group 30-34 showing recorded deaths from 8.5 to 23.6 deaths per 1000.³² It was projected that the total population (without AIDS) would rise from 1.327 million in 1991 to 2.648 million in 2021 (an

²⁷ Republic of Botswana *Status of the National Response to the UNGASS Declaration of Commitment on HIV/AIDS* (2003) 14.

²⁸ Republic of Botswana *Botswana National Strategic Framework for HIV/AIDS 2003-2009* (2002) 15.

²⁹ *Ibid* 15.

³⁰ *Op cit* 14.

³¹ CSO National Census Report.

³² Republic of Botswana *Status of the 2002 National Response on HIV/AIDS* 16.

increase of 2.8% per year). With AIDS, the total population is projected to rise to only 1.874 million in 2021, an increase of 0.9% per year.³³

Current Responses and Policy Priorities

HIV/AIDS has been accorded the highest priority at the national and local levels. For example, the national response to HIV/AIDS is coordinated by a multisectoral National AIDS Council (NAC) chaired by President Festus G. Mogae, with the Minister of Health as the Vice Chair. The Secretariat of the NAC is the National AIDS Coordinating Agency (NACA). At the government ministerial level, full-time AIDS coordinators have been appointed to coordinate, plan, implement, and monitor sector responses. In terms of national planning, HIV/AIDS is a cross-cutting issue in all the sectors of National Development Plan 9 (2003/4-2008/9).³⁴

Further, at the National Parliament level, a Parliamentary Select Committee on HIV/AIDS has been formed to enhance the capacity of parliamentarians across party lines and to able them to act as catalysts for information dissemination in their respective constituencies. The district response is coordinated through the District Multisectoral AIDS Committees (DMSAC) chaired by the district commissioners, while civil society efforts are coordinated by various agencies. These include the Network of AIDS service organisations (BONASO), Network of People Living with HIV/AIDS (BONEPWA), Network for ethics and law on HIV/AIDS (BONELA) and Botswana Business Coalition for HIV/AIDS (BBCA).

A National AIDS Policy was formulated in 1998 to guide the response of the above actors, including community organisations, parastatal and private sector organisations as well as the members of the community. The policy encourages these sectors to develop and implement their own prevention activities with some technical and financial support from government and development partners. The broad policy interventions include the following:³⁵

- the prevention of HIV/STD transmission;

³³ See Republic of Botswana *Macro-Economic Impact of HIV/AIDS*, 5.

³⁴ See National Development Plan 9 (2003/4- 2008/9).

³⁵ See Botswana National Policy on HIV/AIDS, 4.

- the reduction of the personal and psycho-social impact of HIV/AIDS and STD;
- the mobilisation of all sectors, and communities, for HIV/AIDS prevention and care;
- provision of care for people living with HIV/AIDS;
- the reduction of the socio-economic consequences of HIV/AIDS and STD.;

The policy underscores the need to utilise the social protection system to deal with the consequences of the pandemic. For example, section 4.13 of the policy calls for the revision of the criteria for eligibility for destitute support to enable families caring for people with AIDS and orphaned children to have access to support, in line with the National Policy on Destitute Persons. This section also outlines the need to provide welfare support to ensure that basic needs of children are met, including their health needs, and that sufficient resources are available to implement community home-based programmes.³⁶ Besides provision of basic needs, the policy calls for the protection of the rights of HIV/AIDS-infected workers to enable them to lead normal productive lives.³⁷

The policy further acknowledges that in the long-term, HIV/AIDS will have a devastating effect on the social and economic development and therefore calls for an effective national response to militate against its impact. However, there is no specific mention of the impact of the pandemic on the social protection system, although this is implied in the general principles.

Coverage in terms of the Schemes

A number of social assistance and social insurance schemes have been developed or revised to deal with persons infected and affected by the HIV/AIDS pandemic. These include: the orphan care programme, the national destitute programme, the community home-based programme, the antiretroviral therapy (ARV) and other health insurance packages provided by private companies. These schemes are briefly discussed below:

³⁶ See National Policy on HIV/AIDS, 8.

³⁷ See the ethical and legal aspects, *Ibid* 11.

The Orphan Care Programme

An orphan is defined as a “child below 18 years who has lost one (single) or two (married couples) biological or adoptive parents. This definition also incorporates children who are abandoned or dumped by their parents who can no longer be traced.”³⁸ Although the problem of orphanhood is not new to Botswana, the escalating rate of HIV/AIDS has led to the increase in the number of orphans. To date, 41,700 orphans have been registered throughout the country.³⁹ In 1999, the government adopted a Short Term Plan of Action for the Care of Orphans (STPA). Through this programme, orphans receive a food basket of P216.60 per month. In addition to this, they receive free medical assistance in the government health care system and other basic necessities, such as clothing, toiletry, educational fees, transport and counseling services. Support given to orphans is not means tested and, therefore, eligibility is open to all Batswana children under the age of 18 who are registered by social workers.

Programme for Destitute Persons

The National Destitute Programme was revised in 2002 to accommodate social development challenges, including the consequences of HIV/AIDS. The revised policy now has a focus on assisting terminally ill patients who have no means of support and are incapable of engaging in a sustainable economic activity or has unreliable and limited sources of income.⁴⁰ The number of registered destitute persons has increased from 22,743 in 2002 to 29,672 in 2003. Eligibility for destitute benefits is means tested and available only to Batswana citizens. In the event that non-citizens are desperate for assistance, this is done until they can be repatriated to their place of origin. Social workers make a thorough assessment to determine whether an individual can be classified as a temporary or permanent destitute. Temporary destitute persons residing in rural areas receive P181.90 worth of food items per month whereas those residing in urban areas receive P181.40 worth of food. Permanent destitute persons are given P211.90 per month worth of

³⁸ See Short Term Plan of Action on the Care of Orphans.

³⁹ Ministry of Local Government and Land, Dept of Social Services.

⁴⁰ See *Revised National Policy on Destitute Persons* 3.

food items and P211.40 per month worth of food items in urban areas. In addition, both categories receive P55.00 cash for personal needs.⁴¹

Community Home-Based Care

This programme was established in 1995 in response to increased illnesses due to HIV/AIDS. The aim of the programme is to ensure quality care from health facilities to the home setting. The programme is implemented through joint partnership between the Ministry of Health and Ministry of Local Government. In 2002, 6,380 patients were registered by social workers compared to 1058 in 2001.⁴² Patients enrolled in this programme benefit from the clinical medical assistance as well as a food basket that is aimed at meeting the nutritional needs of the patients. Therefore, the Pula worth of the food basket depends on the nutritional needs of patients. For example, some patients receive as much as P397.00 worth of food, while others get P276.00 or less. Other assistance includes supplies such as gloves, mackintosh bedspreads, bedpans and disinfectants to protect both patients and care givers. Eligibility for assistance under this programme is not means tested.

National Antiretroviral Therapy (ARV) Programme

Government is committed to providing ARV therapy on a national scale to all HIV-infected individuals. By 2002, only four sites were providing this service with an enrolment of 8,000 patients. Out of this number, 554 have died. Plans are underway to increase the number of sites to 13 by the end of 2003. Government has spent P12 million on ARV therapy in partnership with African Comprehensive HIV/AIDS Partnership (ACHAP).

Private Social Assistance Schemes

Private sector organisations have joined hands with government to develop HIV/AIDS workplace policies and strategies. The schemes that have been developed are to complement provisions from government. The private sector initiative is part of a multi-sectoral response to the HIV/AIDS scourge and hence the provisions tend to follow the procedures laid down in the National Policy on HIV/AIDS.

⁴¹ *Ibid*, 6.

⁴² Republic of Botswana *Status of 2002 Response* 25.

The DEBSWANA mining company was the first company to initiate a private sector response to HIV/AIDS. By 2002, it had provided ARV treatment to 186 staff with AIDS. It also implemented care and support programme for the staff and their registered dependents. Barclays Bank also started providing ARV treatment for staff and their dependents in 2002. Other private companies, namely, First National Bank, Botswana Power Corporation, Botswana Confederation of Trade Unions and Bank of Botswana are implementing prevention programmes such as information and awareness campaigns, condom distribution, counselling and on-going counselling and support for employees.⁴³

Informal Social Security

Despite the advent of social change, the informal networks for providing care and support are still part and parcel of Botswana social structure. Members of the family continue to play a critical role in assisting the sick to get medical care, to provide emotional support and to collaborate in raising money to meet funerals costs. In some cases, family members have found the need to create special funding schemes where they periodically contribute to funeral insurance schemes or to a special saving account.

Burial societies, on the other hand, have become a strong informal social security scheme for the majority of people who occupy low paying jobs.⁴⁴ Three main categories of burial societies exist in Botswana namely, work-based societies, ethnic-cum-regional societies and the communal- oriented burial societies.⁴⁵ These societies provide financial as well as logistical support to members during the time of illness and death. Due to the increasing number of deaths, burial societies are not able to cope with the HIV/AIDS pandemic and its consequences. The additional challenge is that Botswana in general prefer to bury the dead after a period of at least a week, to provide food daily for the mourners plus community members before and

⁴³ See Republic of Botswana *Status of National Response*, 19-4.

⁴⁴ Ntseane D & Solo K *Social Protection in the SADC: Developing and Integrated and Inclusive Framework – the case of Botswana* CREDA 2004.

⁴⁵ Ngwenya *Gender and Social Transformation through burial societies* 2000.

after the funeral, and to purchase expensive coffins. Invariably, funerals have become very expensive ventures.

Prevention and Integration

A number of strategies have been put into place by government and other partners to ensure prevention of the spread of the HIV/AIDS pandemic. These include information, education and communication; control of other sexually transmitted infections (STIs); isoniazid preventive therapy (IPT); prevention of the transmission of HIV from mother to child (PMTCT); national condom procurement and distribution; voluntary counselling and testing; and national HIV/AIDS call centres.⁴⁶ Development partners providing assistance include: African Comprehensive HIV/AIDS Partnerships (ACHAP), Botswana –USA Partnership (BOTUSA), Botswana Harvard AIDS Institute Partnership, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and Center for Disease Control (CDC). These interventions are briefly summarised below:

- Through the Information, Education and Communication (IEC) programme, 90% of the population is now aware of HIV/AIDS. Condom usage has increased. In 2002 alone, the government procured 31 million condoms for the public sector. Further, workplace programmes promote the distribution of female and male condoms.
- STI prevention and care is offered free as part of the health care system. It is estimated that HIV prevalence rate among male STD patients is over 50%.
- IPT therapy is given to patients with tuberculosis, the most common opportunistic infection among HIV-infected persons.
- The prevention of mother to child programmes was started in 1998. By the end of 2001 an estimated 2,245 women had received free AZT, 1,653 infants were given AZT and 1,595 infants were given infant formula.
- Thirteen voluntary counseling and testing centers have been established throughout the country. Between April 2000 and

⁴⁶ See the *National Development Plan 9 (2003/4-2008/9)* 323-324 and Republic of Botswana *The status of the 2002 National Response to the UNGASS Declaration* 24.

October 2002, a total of 41,744 persons visited these centers. Increasingly, people have come to appreciate the need to be tested for HIV.

- HIV/AIDS call center provides the general public with information and referral services.

Poverty, HIV/AIDS and Implications for Social Security

A major study conducted by the Botswana institute for Development and Policy Analysis (BIDPA) on poverty and poverty alleviation revealed that 47% of the population is below the poverty line. Poverty was found to be higher and more severe in rural area (55%) as compared to urban areas (29%).⁴⁷ A more recent study on the macro-economic impacts of HIV/AIDS in Botswana predicts that poverty levels will rise considerably as a result of the HIV/AIDS pandemic. Specific findings of the study indicate that:⁴⁸

- HIV/AIDS will cause a decrease of between 8% -10% in the household per-capita income over the next 10 years;
- The percentage of people living in poverty in Botswana is likely to increase between 4% and 6% as a result of HIV/AIDS (between 65,000 and 95,000 people);
- The percentage of households in poverty is likely to increase by between 6% - 8% as a result of HIV/AIDS (17,000- 22,500 households);
- The poor will become poorer; and
- There will be an increase of 4000- 7000 destitute persons in the next 10 years. The number of orphans will also increase dramatically.

A few measures have been put in place to link the social security system to poverty alleviation. These include the creation of income-generation projects as part of the home-based care programme, rehabilitation of destitute persons to enable them to engage in productive activities, provision of psycho-social support to orphans to integrate them in the mainstream of society, review of the national policy on destitute persons, provision of ARVs and creation of

⁴⁷ Ministry of Finance and Development, *BIDPA Study on Poverty* 1997.

⁴⁸ See Republic of Botswana *Macro-Economic Impact of the HIV/AIDS Epidemic* 2000, 54- 55.

HIV/AIDS workplace programmes that aim at assisting employees to cope with the devastating effects of HIV/AIDS.

Gender and Vulnerability Dimensions

Gender aggregates show that while the male age specific rate almost doubled, the female age specific death rate almost tripled.⁴⁹ Vulnerability of women to HIV infections can be explained within the context of biological, socio-cultural and economic factors. These are briefly explained below:

- Due to their biological make-up, HIV is more easily transmitted from men to women than from women to men.
- The socially reinforced subordination of women makes them vulnerable to HIV infections. For example most women find it difficult to negotiate for safer sex practices. The high prevalence of violence against women also increases the risks of contracting the virus. Violent acts such as rape, incest and defilement contribute significantly to the transmission of HIV. Due to the “sugar daddy” syndrome, young girls have become victims of sexual abuse and exploitation.
- Women are generally constrained by lower earning capacity, lack of assets, lack of skills, unemployment and a greater burden of dependents. Female-headed households in particular tend to be poorer. Rising poverty among women means that they are unable to meet their daily needs and this forces them to adopt high-risk survival strategies such as unprotected commercial sex work. Findings from studies show that women become pushed into prostitution because of a weak economic base.⁵⁰

The National Strategic Framework for HIV/AIDS 2003-2009 has targeted women as one of the priority groups requiring special responses. Invariably, during the plan period, government plans to provide the following social assistance programmes to women:

⁴⁹ UNDP *Botswana Human Development Report: Towards an AIDS Free Generation* Gaborone 2000.

⁵⁰ See Ntseane & Ncube (2001), Fidzani & Ntseane (1997), Molebatsi & Mogobe (2001), Ntseane (2003).

- ❑ Access to the Prevention of Mother to Child Transmission programme;
- ❑ Access to voluntary testing and counselling;
- ❑ Provision of free female condoms;
- ❑ Provision of Anti-Retroviral Treatment; and
- ❑ Access to the destitute allowance, community home-based care and utilisation of the orphan care programme by the girl child.

The Legal Dimension

HIV/AIDS is not only a health issue; it is also a rights issue.⁵¹ The primary contention of human rights lawyers and organisations is that any HIV/AIDS policy and programme that does not incorporate the human rights dimension is inadequate.⁵² Disregard of human rights may make it difficult to contain the spread of the disease.⁵³

The role of international law and minimum standards

There are several international instruments which have been formulated to protect human rights. These human rights instruments include the Universal Declaration of Human Rights (1948), The International Covenant on Civil and Political Rights⁵⁴ and the International Covenant on Economic, Social and Cultural Rights.⁵⁵ These international instruments, together with other United Nations declarations, resolutions and recommendations laid down the basis of modern human rights law. This human rights law at international level protects human beings, irrespective of whether they are HIV positive or not, and irrespective of whether they have AIDS or not. These afore-stated instruments not only protect both HIV/AIDS infected and affected persons, but also set acceptable minimum standards for the treatment of all human beings. In addition, there are many international declarations, resolutions and recommendations about international human rights which, although not

⁵¹ Industrial Court Judge, Justice De Villiers. Mmegi 31 May – 06 June 2002.

⁵² Oagile KD *HIV/AIDS and the Law*. Printing and Publishing Company 1999, 5.

⁵³ Note 2 above, 5.

⁵⁴ 1966.

⁵⁵ 1966.

legally binding, may have crystallised into binding rules of international customary law.⁵⁶ Civil and political rights include the right to life, liberty, security of the person, freedom of movement, the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment.⁵⁷ Economic, social and cultural rights include the right to the highest attainable standard of health, to work, social security, food, clothing, housing, education, amongst others.⁵⁸ Some of these rights are not only set as minimum standards at the international level but are actually protected and enforced at the municipal level or domestic law level. These instruments on human rights proclaim a catalogue of human rights, which apply to all human beings and therefore, implicitly, to HIV/AIDS infected or affected persons. In the case of Botswana, most of these instruments are reproduced in the constitution in the form of a bill of rights.

Regional standards

Within the region, the Southern African Development Community (SADC) came up with a Code of Conduct on HIV/AIDS and Employment.⁵⁹ This was developed and drawn up by governments, employers' associations and labour movements of the region, taking into account Member States' national codes and also reflecting principles developed by the World Health Organisation and the International Labour Organisation. The Code⁶⁰ does not only balance individual rights and social needs, but also provides a platform on which to build strategies for prevention and management of the epidemic. The Code represents the common standard by which the region deals with the rights and duties relating to HIV/AIDS and employment. According to the Code, it is based;⁶¹

“...on the fundamental principles of human rights and patient rights, WHO/ILO and regional standards and guidelines, medical and occupational health ethical principles, sound epidemiological data, prudent business practice and a humane and compassionate attitude to individuals. The approach aims to achieve a balance in protecting the rights of all parties,

⁵⁶ Note 2 *supra* 7.

⁵⁷ *Ibid.*

⁵⁸ *Ibid.*

⁵⁹ Adopted by the SADC summit, September 1997.

⁶⁰ Code of Conduct on HIV/AIDS and Employment in the Southern African Development Community.

⁶¹ Note 10 *supra*, 4.

including those with and without HIV, employers, employees, state and others. This will include obtaining a balance between individual protection and cooperation between parties”.

The policy components in the SADC Code relating to education, awareness and prevention programmes, job access, workplace testing and confidentiality, HIV testing and training, managing illness and job security, occupational benefits and protection against victimisation are in line with the Botswana National Policy on HIV/AIDS.⁶² This National Policy on HIV/AIDS is the only comprehensive document in Botswana dealing with HIV/AIDS. It is however in the process of revision. It is anticipated that although it does not have the force of law together with the SADC Code, it will greatly impact on those infected and affected by the pandemic. It is expected that should there be litigation relating to HIV/AIDS issues, these would be resolved in the light of not only domestic law and policy, but also in the light of regional and international standards.

Constitutional protection

The Constitution of Botswana⁶³ guarantees to all human beings, regardless of race, place of origin, colour, creed, opinion, political beliefs, including people infected with HIV/AIDS fundamental human rights in its bill of rights subject to respect of freedoms of others and the public interest.

The right to life⁶⁴

The right to life includes the right to live in dignity, freedom and safety. The constitution of Botswana prohibits subjecting any person to inhuman, degrading treatment or punishment. People living with HIV/AIDS have a right to be treated like any other person in the society. They have the right to a full life, respect and dignity regardless of their health status.

⁶² Approved and adopted by Government on 17th November 1993.

⁶³ 1966 Constitution Chapter 01:01.

⁶⁴ Section 4 of the Constitution of Botswana.

The right to security of the person⁶⁵ and protection by law⁶⁶

HIV/AIDS infected persons should not be segregated, condemned or shunned. They should rather be treated with compassion and respect. Their right to security will be breached if they are discriminated against and ridiculed. Like everyone else, they are entitled to full and equal protection of the law.

The right to privacy⁶⁷

People living with HIV/AIDS are entitled to confidentiality in all matters relating to their health and HIV status. Shared confidentiality or openness about their status with family and trusted friends helps people living with HIV/AIDS, but is a matter of individual choice. Health care workers and other professionals such as counsellors may encourage people living with AIDS to be open about their HIV status but they have no right to breach the confidentiality of any person infected or affected by the disease.

Apart from the constitutional rights of infected persons, namely, the right to life, liberty, security of the person, privacy and non discrimination which, amongst others, are guaranteed by the constitution of Botswana, there is no law other than the Public Health Act dealing directly with the HIV/AIDS scourge.

Labour law Paradigm and Responses

There is nothing specified in any of the laws of Botswana, such as the Trade Dispute Act, Employment Act and Public Health Act which specifically addresses HIV/AIDS issues. Section 5 of the Public Health Act⁶⁸ makes notification of notifiable diseases compulsory by a health officer to the Ministry of Health. HIV/AIDS is however not classified as a notifiable disease.

⁶⁵ Section 7 of the Constitution of Botswana.

⁶⁶ Section 10 of the Constitution of Botswana.

⁶⁷ Section 9 of the Constitution of Botswana.

⁶⁸ Chapter 63:01 of the Laws of Botswana.

Section 11 of the Public Health Act provides that it is a criminal offence for any person, who while suffering from a communicable disease, willfully spreads the disease. HIV/AIDS, although not specifically stated, is a communicable disease.

According to the Botswana National Policy on HIV/AIDS, there should be no direct or indirect pre-employment testing for HIV. Employees should be given the normal medical tests for current fitness for work and these tests should not include testing for HIV.

There should be no compulsory workplace testing for HIV.⁶⁹ Voluntary testing for HIV on the request of the employee should be done by a suitably qualified person in a health facility with the informed consent of the employee, in accordance with normal medical ethical rules and with pre-and post-test counselling.⁷⁰

Persons with HIV/AIDS should have the legal right to confidentiality about their HIV status in any aspect of their employment.⁷¹ An employee is under no obligation to inform an employer of his or her HIV/AIDS status. Information regarding the HIV status of an employee should not be disclosed without the employee's consent.⁷² The principle of "shared confidentiality" should be applied, that is, those who need to know in order for appropriate health and social welfare care to be provided should be told.

HIV-infected workers who are healthy should be treated the same as all other workers, with regard to training and promotion. As for workers with HIV-related illnesses and AIDS, they should be treated the same way as any other worker with an illness. HIV-infected employees should have access to and receive standard social security and occupational benefits.

⁶⁹ Note 1 supra 29. See further *Botswana HIV/AIDS Human Right Charter* September, 2002 5.

⁷⁰ Note 1 supra 29. See further *Botswana HIV/AIDS Human Rights Charter* September 2002 5.

⁷¹ Note 1 supra pg 29. See further *Botswana HIV/AIDS Human Rights Charter* September 2002 5.

⁷² *Botswana HIV/AIDS Human Rights Charter* September 2002 5. See further, SADC Code *supra*.

If the employee has HIV/AIDS but is still fit for work and does his work up to the required standard, he cannot be dismissed from work because of his status. Like other workers, he must be given time off from work and sick leave if he is entitled to it. There may be a time however, when the HIV/AIDS-infected person reaches a stage when his health will inevitably have to affect his work performance. It is only then that he can justifiably be classified as a poor or unsatisfactory work performer.⁷³

Social security law paradigm and responses

Apart from the protection in relation to privacy, security, non-discrimination and equality amongst others, there is no law specifically targeting social security and HIV/AIDS. In Botswana, social security is somewhat undeveloped, fragmented and in some cases services are delivered without any underlying policy to guide the implementation.⁷⁴ Social services rendered to the needy population often have social policy as their basis. As yet no law has been passed encompassing social security. Anti-retroviral drugs are being administered to the infected without strict legal regulation in place.

Economic and Labour Market Dimensions Macro- economic Impact of HIV/AIDS

The study on the macro-economic impact of HIV/AIDS in Botswana projects that AIDS will have an impact on GDP and average incomes, household incomes, and direct effects on government revenues and spending. The study predicts that the rate of GDP is expected to fall from the projected 3.9 per cent a year without AIDS to between 2.0 and 3.1 per cent with AIDS, and after 25 years, the economy is predicted to be 24 -38 per cent smaller with AIDS than it would have been without AIDS.⁷⁵ Further, GDP per capita growth will fall to 1 per cent a year, and average incomes will be 13 per cent lower after 25 years as a result of AIDS.

Household incomes will be negatively affected due to the loss of income if the breadwinner stops working as a result of sickness and death. Other factors affecting household income include additional expenditures on health care,

⁷³ Note 1 supra, 29.

⁷⁴ See Mabua GN *Social Protection Programmes in Botswana* 2003.

⁷⁵ Republic of Botswana *Macro-Economic Impacts of HIV/AIDS* (2000) 35.

funeral costs and time spent providing emotional and psycho-social support. Overall, the direct effects of HIV/AIDS will worsen poverty at the household level. Finally, HIV/AIDS will have direct effects on government revenues and spending.⁷⁶ For example, government expenditure on health care is likely to go up and as a result government may be forced to impose taxes to increase revenues. The introduction of VAT in 2002 is one example of the indirect effects of HIV/AIDS. Due to increased expenditure on health care, training and sick pay, investments as well as savings will also be significantly reduced.⁷⁷

Viability of the Schemes

HIV/AIDS is expected to cause enormous burden on the financing of social assistance and social protection programmes. As indicated earlier, AIDS is likely to cause an increase of 4,000 - 7000 destitute households over the next ten years. In addition, there will be an estimated 16,000 additional destitute persons resulting from HIV/AIDS over the next 10 years. The recurrent budget for the destitute allowance is projected to increase to over P15.4 million per annum. It seems reasonable, however, to assume that not all of these people would appear as government liability. It is expected that the extended family and informal support networks will continue to act as safety nets. For the purposes of estimation, it is assumed that at least 50 per cent will require support from the destitute allowance, amounting to 0.1 per cent of the total recurrent budget over the next ten years.⁷⁸

With respect to the orphan care programme, it is estimated that there will be an increase of 30,000 orphans from destitute households resulting from HIV/AIDS in the next 10 years. If each of these orphans were to receive the P216.00 worth of food per month, the total bill would be P77.9 million per annum or about 0.6% of the total recurrent budget.⁷⁹

The impact of HIV/AIDS is not only on the financial sustainability of the schemes, but also on the availability of human resource capacity to implement these services. The challenge is that currently, professionals are

⁷⁶ *Ibid*, 35

⁷⁷ *Ibid*, 7.

⁷⁸ *Ibid* 62.

⁷⁹ *Ibid* 62.

also affected and infected by HIV/AIDS. This results in absenteeism due to sickness, caring for sick family members and death of the employee⁸⁰.

Despite these challenges, there is no indication that these schemes and other related prevention schemes will collapse. HIV/AIDS is a national priority area and there is commitment at the national policy level to ensure that measures are taken to address the impact of the scourge. The vision of the National HIV/AIDS Strategic Planning Framework is that there will be “no new HIV infections in the country by 2009.” Output of the National Response to HIV/AIDS is to eliminate the incidence of HIV and reduce the impact of AIDS in Botswana.⁸¹ Care, prevention, support, treatment and the strengthening of the management of the National Response to HIV/AIDS are critical areas for the National Development Plan 9 (2003/4-2008/9) and the National HIV/AIDS Strategic Framework. Finally, Botswana is fortunate to have forged committed partnerships at regional and international level to support the national response. A brief discussion of the roles of development partners is provided in the discussion on financial support.

Financial Support

Government, civil society organisations, parastatals, private insurance companies and development partners have introduced specific financial measures to provide support to those affected and infected by HIV and AIDS. Estimated direct HIV/AIDS-related expenditure of the government for 2002/2003 is US\$69.8 million. This figure does not reflect all the indirect costs such as infrastructural development, drug procurement, training, hospital recurrent budget and similar costs.⁸² Private health insurance companies such as Botswana Medical AID Society (BOMAID) are providing access to HIV/AIDS drugs at a highly subsidised rate to members who are willing to receive these benefits. Support granted by the development partners is provided below:

⁸⁰ Mabua GN *Social Protection Programmes in Botswana* (2003) 3.

⁸¹ *National HIV/AIDS Strategic Framework and NDP*, 9.

⁸² *Status of the 2002 National Response*, 19.

Current support of Development Partners

Development partners include United Nations agencies and other multi-lateral and bilateral partners, including diplomatic missions. The table below provides a rough estimation of where development partner support is currently focused. It is expected that this support will continue until the end of the 2003-2009 plan period.⁸³

PROGRAMME GOAL	Development Partner Commitment (US \$)
1. Prevention of HIV Infection	48,500,242
2. Provision of Treatment, Care and Support	18,615,000
3. Management of the National Response to HIV and AIDS	22,158,144
4. Psycho-social and Economic Impact Mitigation	3,815,843
5. Providing a Strengthened Legal and Ethical Environment	614,176

Labour Market Impact

The impact of HIV/AIDS on the labour market is expected to be negative. Due to predicted deaths of employees and frequent absenteeism, skilled labour will be relatively in short supply, with a predicted growth of only 1.2% a year. Seemingly, wages of skilled workers are predicted to rise relatively faster. On the other hand, supply of unskilled labour in the informal sector will be reduced, leading to a fall on employment level by 1% a year.⁸⁴

With respect to access to and exit from the labour market by those infected by HIV/AIDS, two scenarios are likely to occur, namely, rising morbidity (greater sickness) and rising mortality (higher death rates). Rising morbidity results in reduced productivity due to workers' time off to attend to personal health problems or looking after a sick relative and lower productivity at work, due to illness or worry. On the other hand, rising mortality means that there will be a smaller population and labour force, skilled labour will be

⁸³ *Op cit* 82.

⁸⁴ See *Study on Macro-Economic Impact of HIV/AIDS* 32

scarce and there may be a change in labour force participation rates.⁸⁵ Overall, predictions show that there will be higher productivity loss due to AIDS, higher HIV prevalence amongst skilled workers, and a slower growth rate of skilled workforce.

Caregivers who are in the labour market are also likely to be affected by these market forces. This will be in the form of absence from work to care for the AIDS patients on home-based care, absence attending funerals and also loss of time making phone calls to provide emotional and psycho-social support to family members. Income levels of these employees are also expected to be negatively affected because of medical and funeral expenses provided to a sick or dying family member.

Further, discrimination in the workplace is a likely outcome due to the stigma attached to AIDS. However, as mentioned in the section on the legal dimension, government has put some policy measures in place to address this issue. In addition, structures have been established in each Ministry to address issues of stigma and discrimination. Likewise, workplace HIV/AIDS programmes have been set up in private and parastatal organisations to raise the level of awareness and to offer a much more inclusive framework to ensure that an employee with AIDS can feel secure while he/she is still productive.

Labour market responses

Apart from the provisions specified under the discussion on the legal framework, there are no labour market regulations that deal with the impact of HIV/AIDS on the labour market or special provisions for those affected or infected by HIV/AIDS. The following labour market regulations are critical:

- Protection of people living with HIV/AIDS in the workplace in terms of training, promotion and retention;
- The importation of unskilled and skilled workers; and
- Granting of work permits to foreigners bringing scarce skills.

⁸⁵ Ibid, 7

Challenges

Challenges encountered by government and other actors in providing social protection to affected and infected HIV/AIDS patients include the following:

- Lack of human resource capacity to implement programmes. For example, social workers carry heavy case loads and there is a high attrition of trained health care personnel due to lack of incentives;
- More counsellors are needed to make sure that every woman visiting the health care facilities has access to quality PMTCT counselling;
- There is inadequate infrastructure to implement ARV treatment programme;
- People are not coming forward to receive services as a result of stigma and discrimination attached to HIV/AIDS. Women in particular are not coming forward in large numbers to enroll in the PMTCT programme due to fear of cultural expectations to breastfeed and lack of support from partners;
- Civil society organisations are experiencing difficulties accessing HIV/AIDS funds as a result of bureaucratic bottlenecks and procedures created by development partners;
- Despite numerous behavior change interventions put in place, new infections continue to be recorded.

6.0 BFTU POLICY POSITION ON SOCIAL SECURITY & SOCIAL PROTECTION

The BFTU acknowledges that the role of the State in providing some form of social security in Botswana is comparatively better in the SADC region. However, the current social security system is rather reactive, indirect and unsystematic. It is fragmented and hidden in various indirect social expenditure by the State. What is clear from this analysis is that though the majority of the very poor in Botswana are provided with some basic essential services to sustain their livelihoods, these schemes are not intended to provide skills to enable the poor to get out of the poverty trap. What then remains a challenge is finding innovative strategies that would eradicate poverty in line with Vision 2016. These strategies would have to be preventive and holistic in nature and therefore targeted at eliminating risk and vulnerability.

On social security and social protection, the BFTU, will engage with all relevant stakeholders guided by the following policy statements:

- Need for conducting a comprehensive review of social security system to assess the impact of these programmes on labour.
- Advocate for a comprehensive national social security policy which is integrated, inclusive and participatory. There should be integration and coordination of social security components under one government organ.
- Advocate for the establishment of a National Social Security Commission to implement the proposed National Social Security Policy.
- Advocate for the strengthening and promote social security arrangements for the informal economy.
- Need for the labour movement to work with other strategic partners such as the private sector and civil society to devise strategies that encourage a savings culture in the nation.
- Demand for a social system that must empower, educate and reintegrate beneficiaries.
- Demand for collective agreements that have social security issues infused into them.
- Demand for ratification of all Social Security Conventions of the International Labour Organization including Convention 102 of 1952.
- Demand for the signing of all SADC instruments related to social security including the Social Charter and Code on Social Security (still in draft form).
- Campaign for the strengthening of the family structure, provision of free education (formal and vocational), shelter, health care, access to

land and credit facilities, supportive mentoring and counselling of vulnerable children and creation of employment opportunities.

- Campaign for the creation of adequate incentives to retain qualified professionals particularly nurses, social workers, counsellors and community home- based care volunteers to support social security programmes.
- Campaign for appropriate legislation that should be put in place to address issues of co-ordination of programmes on social security and protection.
- Demand for the development of labour market regulations to deal with the impact of HIV/AIDS.
- Campaign for strengthening the human resource capacity of key personnel. Academic institutions should be requested to increase enrolments in key fields and to offer relevant and appropriate courses to mitigate effects of HIV/AIDS;
- Advocate for the National Strategic Framework on HIV/AIDS that will provide for a comprehensive response to mitigate the impact of the pandemic. This plan must be fully implemented to ensure that resources are mobilised to finance social security programmes.
- Campaign for the increase of access to funding sources by NACA and development partners by simplifying procedures of applying for these funds.
- Create avenues for increasing the involvement of men in HIV/AIDS programmes such as PMTCT, orphan care, home-based care and burial societies.

REFERENCES

BIDPA Study on Poverty and Poverty Alleviation in Botswana Ministry of Finance and Development Planning Gaborone 1997.

BIDPA Consultancy on the Review of Social Safety Nets Gaborone: 2006.

Central Statistics Office Household Income and Expenditure Survey 2002/03 Government Printer 2004.

Dingake K HIV/AIDS and the Law. Gaborone Printing and Publishing 1999
Employment Act Chapter 47:01.

Fidzani H & Ntseane D The Situation and Response Analysis of HIV/AIDS in South East District UNDP Gaborone 1997.

Mabua GN Social Protection Programmes in Botswana Paper Presented at the SADC Social Security Core Group Meeting held in Gaborone 18th Sept 2003..

Mmegi “Industrial Court Judge De Villiers” The Reporter Gaborone 2002.
Ministry of Local Government and Lands Short Term Plan of Action on the Care of orphans Gaborone 1999.

Ministry of Finance & Development Planning BIDPA study on Poverty and Poverty Alleviation in Botswana Vol 2 Gaborone: 1997

Ministry of Finance & Development Planning National Development Plan 8 1997-2003 Government Printer 1997

Ministry of Finance & Development Planning Revised National Policy for Rural Development Government Printer 2002.

Ministry of Finance & Development Planning National Development Plan 9 2003/04 – 2008/09 Government Printer 2003.

Ministry of Finance & Development Planning Mid Term Review of National Development Plan 9 Government Printer 2005.

Ministry of Local Government and Lands Report of the Remote Area Development Workshop 4th – 15th June 1997 Gaborone: 1997

Ministry of Local Government and Housing Short Term Plan of Action on Care and Protection of Orphans in Botswana. Gaborone: 1999

Ministry of Local Government and Lands Revised National Policy on Destitute Persons Gaborone 2002.

Ministry of State President/NACA Botswana 2002 Second Generation HIV/AIDS Surveillance: A technical Report Gaborone 2002.

Ministry of Local Government Situation Analysis of Orphans and Vulnerable Children in Botswana: Gaborone 2003

Molebatsi C & Mogobe Strategic Plan for Ngamiland District UNDP Gaborone 1999. Ngwenya BN Gender and Social Transformation through Burial Societies in a Contemporary Southern African Society: The Case of Botswana. (Unpublished PhD Thesis) University of Michigan 2000.

Ntseane D Socio-Cultural Factors and the Spread of HIV/AIDS: Implications for Indigenous Social Work Curriculum Paper Presented at the Joint University Council (JUC) Conference held at Oasis Motel, Gaborone, September 2001.

Ntseane D & Ncube E The Situation and Response Analysis of HIV/AIDS in Serowe/Palapye. UNDP, Gaborone 2001.

Ntseane D & Solo K Social Protection in the SADC: Developing an Integrated and Inclusive Framework - the case of Botswana CREDA 2004.

Public Health Act Chapter 63: 01.

Republic of Botswana Constitution of the Republic of Botswana, Government Printer Gaborone 1996.

Republic of Botswana The Rapid Assessment of the Situation of Orphans in Botswana Gaborone: 1998

Republic of Botswana Botswana National Policy on HIV/AIDS. Ministry of Health Gaborone 1998.

Republic of Botswana Macro-Economic Impact of the HIV/AIDS Epidemic in Botswana.

BIDPA, Gaborone 2000.

Republic of Botswana Initial Report to the United Nations Committee for the Convention on the Rights of the Child Gaborone: 2001

Republic of Botswana Revised National Policy on Destitute Persons. Gaborone: 2002

Republic of Botswana National Development Plan 9. 2003/4 - 2008/9 Ministry of Finance and Development Planning, Government Printer Gaborone 2003.

Republic of Botswana/UNICEF/UNAIDS Status of the 2002 National Response to the UNGASS Declaration of Commitment on HIV/AIDS NACA Gaborone 2003.

Republic of Botswana Botswana National Strategic Framework for HIV/AIDS 2003-2009 Pyramid Publishing Gaborone 2003

Republic of Botswana Report on the Review of the Remote Area Development Program (RADP) Gaborone: 2003

Republic of Botswana Family Care Model for Home Based Care and Orphan Care: Guidelines and Tools Government Printer 2003

Republic of Botswana Labour Based Drought Relief Program Monthly Report Gaborone: May 2005

SADC Code of Conduct on HIV/AIDS and Employment 1997.

Trade Dispute Act Chapter 47: 01.

UNDP Botswana Human Development Report: Towards an AIDS Free Generation Gaborone 2000.

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....