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The girl child and HIV: Insights from Botswana

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Abstract
Research from Botswana as well as that from other countries indicate that the girl child is at a greater risk of HIV infection than the boy child. For example, in the context of Botswana, for every HIV-positive boy under the age of 14, there are two HIV-positive girls in the same age. This chapter discusses dynamics that account for the high vulnerability of the girl-child to HIV and AIDS in Botswana. It also highlights challenges and the way forward to combat HIV and AIDS infection among girls in Botswana.

Keywords: Botswana, Girl-child, HIV and AIDS, Interventions

Introduction

The AIDS pandemic is a major problem that Botswana is facing in the 21st century. However, little has been documented about HIV and children in the country. AIDS robs children of their healthy childhood, therefore it is vital to find ways of reducing the spread of the disease among them as well as to support and intervene effectively for those living with HIV and AIDS. This paper focuses on HIV and AIDS and the girl child, and as such it is first necessary to define 'the girl child' so that we start on common ground. For the purpose of this chapter, the Authors adopted the Botswana Children's ACT, 2009 section 2 which defines a child as "any person who is below the age of 18 years. This definition is in consonance with that in the Convention on the Rights of the Child (CRC) which provide in article 1 that a child is every human being under the age of 18 years.

The concept of health has been a priority of Batswana from time in memorial. Post-independence, special emphasis has been on women whose health is known to indirectly or directly influence that of the family and in particular, the child. Culturally, children are highly valued because they are regarded as the future of the society. This has led to structured system of care from infancy to adolescent by modern health care providers. At independence, modern health care system was one of the poorest in the world managed by the "Protectorate Masters". Botswana invested heavily on healthcare immediately after independence. Some of the initiation employed include; routine child immunizations, access to healthcare services, and access to clean water.

The discovery of HIV and AIDS in 1985 in Botswana reversed the efforts by the Botswana government on the healthcare system. By the year 3013, the prevalence rate for children aged 15 to 19years stood at 3.6 for male and 6.2 for females, (BIAS IV, 2013) [18].

Existing literature indicates that within the youth population aged fifteen to nineteen years, females have a relatively higher prevalence rate of HIV at 20.4 percent as compared to the male of 14.1 percent, (BIAS IV 2013) [18]. (UNICEF 2015), further noted that when Batswana girls reach adolescence, they face specific and particular challenges that lead to disadvantages in their development in comparison to boys of the similar age. Of particular concern is the hyper-vulnerability of young females to HIV infection. Parker (2011) notated that young women acquire HIV rapidly at rates far greater than the probability of 0.0001found in studies of transmission among people in relatively stable partnerships. Girls face a higher risk of HIV infection, with teenage pregnancy, a related significant concern.

The cause for these challenges have been cited by UNFPA, 2012) as being the process of child development. UNFPA (2012) noted that child development is a process of change in which a child learns to handle ever more complex levels of moving, thinking, feeling, and relating to others. Youth and adolescents are in a time of transition where they reach a full physical, psychological, emotional and somehow economic challenges as they leave childhood and enter into adulthood. Therefore their issues deserve to be handled separately from those of women and male counterparts.

The purpose of this article is to discuss dynamics that put the girl-child at a higher risk of HIV infection.

The remaining parts of this article are divided into three major sections. The section following this one focuses on the theoretical framework. It is followed by one that focuses on dynamics that account for the high vulnerability of the girl child to HIV.

The last section highlights challenges and the way forward. It is hoped that the chapter will make a contribution to the literature on HIV and AIDS in the country. Despite being an upper middle income country, Botswana continues to face challenges such as high HIV prevalence rates, high mortality rates among both children and women; persistent poverty and inequity, high unemployment especially among the youth, (UNICEF, 2016).

Theoretical framework

The theoretical framework for this chapter is informed by a combination of two perspectives.

The first perspective that shaped the content of this chapter is feminist theories. Western literature on gender is embedded in a range of feminist positions that have become

increasingly blurred during the 1990s and influenced by a number of black writers' (Preece, 2001:225) [44]. As such, although there are various types of feminist perspectives, for example, radical, socialist, liberal and post-modern feminist perspectives, they are all concerned about finding equality between males and females in all areas of society, without females being seen as the weaker sex. Feminists question and challenge the origins of oppressive gender relations (Mannathoko, 1992) [26] and they also 'share a commitment to improving the status of women's (*females' – my emphasis)* lives by working to eliminate sexism, patriarchy, and sexual or gender inequality' (Peach: 1998: 5) [42].

Scholars such as Thorne (1992) [49] assert that gender plays a significant role in the organization of both family and the state. Feminists among other things, place heavy emphasis on the role that the oppression of women and children play in creating problems that affect children's well-being.

The family is the primary arena for the socialization of each generation toward their gender-specific roles and behaviours by treating boys and girls differently, holding different expectations, and employing different social pressures toward them (Goodrich *et al.*, 1988) [16]. For instance, families in general socialise males to be heads of households and females to be caretakers. Masculinity is associated with traits implying autonomy and authority, and femininity is associated with those suggesting dependency and passivity.

Feminists have critiqued these stereotypes from as far back as the 1960s (cf. Friedan, 1963; Ellmann, 1968) [11, 9]. They assert that such stereotypes pathologize female's attempts to question the roles assigned to them.

They therefore argue that gender relations are based on power. 'Not only do males as a group exert power over females as a group, but the socially derived definitions of masculinity and femininity reproduce those power relations' (Kimmel, 1987, 12-13) [22]. Thus, the power differential between women and men is institutionalized by the culture and finds expression in their everyday relations. Consequently, it is in the discourse on family and family relations that an understanding of power differential must be included. Power differentials create situations whereby women and children are not equal partners in decision making. Consequently, this leads to among other things problems that expose children to HIV infection such as child sexual abuse.

The second perspective that guided the analysis is the literature that addresses internalized gender oppression (Stockard and Johnson, 1992; Benokraitis and Feagin, 1995) [47, 3]. Gender oppression is internalized through the socialization process.

Under a system of patriarchy, for example, the girl child learns from an early age that she is less valued than the boy child. She learns, too, that she is treated differently from the boy child, through, for example, the use of language that portrays her as: a caregiver; someone who is supposed to behave passively; someone who has to serve other people; inferior. As such, 'She learns that to be a woman (*female – our emphasis)* means to live with, to accept, and to internalize an inferior status' (Monson, 1997: 138) [35]. This in turn has serious consequences as it will be shown later in the chapter.

Dynamics that account for the high vulnerability of the girl-child to HIV and AIDS in Botswana.

In this section, the authors discuss factors that account for the spread of HIV among girl children in Botswana. The authors make no claims for exhaustiveness. There may be other factors besides the ones discussed here. The authors' intention is to shed light on certain key issues in order to stimulate thinking, provoke discussion and generate debates. Before discussing such factors, it is important to list those factors that contribute to the spread of the HIV and AIDS among children and young people (irrespective of gender). These are: sexual activity, pregnancy, (lack of comprehensive sexuality education (Socioeconomic Working Group Botswana, 2005). ACHP (2011), further noted that acts such as transactional sex, having older partners, partner turnover and being linked to sexual networks through concurrent sexual partnership are key factors related to HIV incidence. Individuals who have conservative sexual practices may be exposed to HIV as a consequence of risky practices of their partners.

Parker (2011) reported that early sexual debut results in longer life time exposure to the virus and other related sexually transmitted problems. The timing of first sex directly influences potential immediate and subsequent exposures to HIV. Parker (2011) attributed early sexual debut among young women with mental distress, poor economic status, low education, alcohol abuse, having no close friends and poor parental connectedness**.** Adolescents also have a belief that engaging in sexual activities at an earlier age equips them with skills of managing relationships and staying for a long time without having sex can expose them to diseases and cause inability to have children (Ntshwarang, 2012) [39]. Consistent to Parker (2011) report is the study by UNICEF (2014) which found out that 47.9% of youth in Botswana can correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about transmission.

Midtbo (2012), noted that rapid transmission of HIV and AIDS in Botswana has been due to three main factors, being; lack of power to negotiate sexual relationships, cultural attitudes to fertility, especially the cultural belief that single women have to have children in order to prove that they are fertile and to clean out their womb so that they are not deemed unclean, and social migration patterns that spread HIV into isolated rural areas. The strategy in Botswana has been to distribute condoms through conventional mechanisms. While this strategy is enforced and all efforts are in place to drive it, there are legal and human barriers that affect access to interventions such as stigma and discrimination of Female Sex Worker.

It is also important to note that most of the children born to HIV positive parents before the introduction and up scaling of Anti-retroviral drugs in Botswana were born HIV positive. At that time HIV testing was not compulsory for pregnant women. Studies have shown that children who live with HIV experience issues of disclosure, stigma, adherence and prevention (UNICEF, 2010/11) [54]. Ngwenya *et al.* (2011) [38] assert that adolescents living with HIV in Botswana had problems with disclosing their HIV status because of fear to be stigmatized and discriminated against by relatives, friends and at school. Parents and guardians of these children did not want them to disclose their status to other family members, relatives and friends.

For the sake of clarity, factors that put the girl-child at a higher risk of HIV infection that are discussed in this paper are grouped into two major headings: those that are related to culture and those that are not related to culture. Although

the factors are grouped into the above two main headings, there are some overlaps that the authors will highlight elsewhere in the chapter. Cultural factors discussed in this chapter are: Setswana language, early marriages as well as the girl child's role as caregiver. Factors not related to culture that are discussed include: biological factors, and intergenerational sex between older men and girls.

Cultural factors

Language and related practices

Before discussing how language plays a role in the spread of HIV and AIDS among girl children in Botswana, it is important to highlight some information about language that will help the reader contextualise the discussion on HIV and language. The national language in Botswana is Setswana. It is spoken as a mother tongue by approximately 80% of the total population. Most Batswana who have another language as their mother tongue also speak Setswana (Anderson and Janson, 1997) several scholars have argued that subtle linguistic differences can frame our approaches to different problems and even affect our views on space and time, Moxley (2014). Language therefore can influence people's thinking, beliefs, practices, behaviour as well as actions (Katz and Michael 2013; Maundeni, 2001b). Setswana language is a major route of transmitting culture from one generation to another. Unfortunately it contains expressions that may influence males and females sexual behaviours and therefore putting them (especially girls) at a greater risk of HIV infection. Girls who are named after the parents' relatives are often addressed as wives of the husbands to those they are named after. The girl child is therefore expected to behave like a wife to him, for example, When this man comes you are called to care for him, by giving him water to drink and wash his hands and preparing and/or giving him food, whilst other siblings would be laughing at you. The girl will be addressed as the wife to this man and will be called by their first borns and his wife refers to you as "Mogadikane" (co-wife). As she grows up, the girl child lives with having her body touched and commented upon by male adults. These kind of actions can make the girl to despair and submit coated harassment. These experiences can have damaging consequences, including feeling belittled, oppressed, and may have traumatic stress disorders and sexual dysfunction in later life (Odirile, 2002). It is culturally accepted for the male cross-cousins to call the girl their wife, and to jokingly touch the girl's breasts and buttocks, asking a girl to give him what he deserves, which is a form of sexual harassment, in a way sexually socializing them in the environment where there are other people including adults. This act is condoned as a norm (Seboni, 1997). Also children are bathed by older people even on the genitalia until their grown up. There is a game where the elders touch the children's external genitalia stating that they are snuffing tobacco. This makes the child to be comfortable being touched, as this is perceived as a normal practice. The girl child subjected to these sexual practices may perceive sexual harassment as a normal thing.

The language and practices that are adopted to socialize the girls into womanhood and as sexual objects are tantamount to violation of their sexual rights. The rights and protections awarded the girl child are different from those given to women. The society has to be aware of the fact that the child has the evolving capacity to exercise her rights in all matters relating her sexuality (IPPF, 2008) [19]

The situation is compounded by the fact that in many African societies, adolescents under the age of eighteen years are not recognized under the law as competent enough to consent to treatment on their own, (WHO 2015). This practice therefore prevents the youth from accessing vital information from the health facilities where they can be empowered on issues relating to HIV and AIDS.

The expressions and actions (highlighted in the previous paragraph) that are frequently used by males, can have serious implications for the sexual well-being of the female later in life as well as her chances of getting infected with HIV. and AIDS. For example, these acts of romance may stimulate her sexual feelings at a point where she is not skilled to deal with them in a health manner. Also, she may internalize the sayings and believe that indeed she is a wife to many men and this may influence her to engage in promiscuous behaviour. As Monson (1997:148) [35] rightly pointed out '….when one lives in a society where women *(females – our emphasis)* are treated daily as secondary citizens and sexual objects, one comes to accept that image as a given'. On the other hand, a girl child who had lived with sexual harassment and who had been the subject of demeaning sexual remarks for years may grow up confused by the affection of others. This girl child had been told by many men that they are going to marry her, when she is an adolescent or young lady, she may find it difficult to know when a man who proposes to fall in love with her or even to marry her is really genuine. She may no longer trust men and may have serious problems in sustaining relationships with them.

Early Engagement and marriage

WHO (2012) [57] purports that 30% of the girls aged 18 years and below in developing countries are married, whilst 14% of girls are married before the age of 15. Forcing girls to be engaged and marry young is a form of sexual abuse. In Botswana girls are sometimes engaged and married at the age of 8 years among the tribes in the northern part of Botswana. The Botswana Network on Ethics, Law and HIV and AIDS (BONELA 2015) embarked on a study aimed at strengthening the provision of the Botswana Children's Act of 2009, which was aligned to the United Nations Convention on the Rights of the Children. Some disturbing incidences of child marriages at an early age as twelve years were noted in the study. Early engagement and marriages of girl children are exacerbated by among other things the low socio-economic position of many families in Botswana (World Bank. 2013, Rivers, 2000). A related issue is that males generally own more resources than females. As such some men have a tendency of enticing young girls to have sexual intercourse with them in exchange for money and gifts. Men's use of money to get sexual favours from young girls is not peculiar to Botswana only, it is a phenomena, which also exists in other countries (Fanning, 2001) [12].

Child marriage has many repercussions. It robs girls to enjoy healthy childhood, the girls education is curtailed, they are often victims of gender based violence by their older husbands which exposes them to HIV infection, it violates their sexual rights and it makes them vulnerable to complications of " too early pregnancy, child bearing and motherhood before they are physically and psychologically ready" (WHO, 2012: 2) [57].

Most of the traditional practices as some outlined above are embraced by the society. They somehow benefit the society

because they bring cohesion among the individuals by way of interacting positively as the practice them. However, some maybe harmful to the youth in several ways and also infringe on their human rights. This has been unearthed by Ras-Work (2006:7) as he argues that the World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) recognize harmful traditional practices by different societies as having adverse effects on the citizens.

The girl-child's role as caregiver

Another cultural practice that fuels the spread of HIV among girls is their role as caregivers. As proponents of feminism argue, the socialization of boys and girls in most societies is different. Girls are taught to behave in feminine manner while boys are taught to behave in masculine way. It is not surprising therefore, that studies on home based care in Botswana indicate that elderly women and the girl children are the major caregivers to people living with AIDS and yet they have few resources such as good nutrition, transport and professional support (Kangethe, 2010 Tlou, 1999; Mathebula, 2000) [50, 27]. Dahlgren L. (2012) concurs and further asserts that in Botswana, women are taught from an early stage that caring is their role in the society and failure to fulfill that role is a disgrace both to the family and the society at large. The health care system is unable to cope with the demand of caring for infected people, and as such it has pushed responsibility for care into families and communities where it is mostly performed by women and girl children. Although home-based care relieves the health system from costs and over-crowding in hospitals, it can have serious physical, emotional, social and economic consequences for women and girl children. Young girls are sometimes withdrawn from school to care for sick family members or younger siblings (Tabengwa, *et al.*, 2001) [48]. This infringes on their right to education and to have positive childhood experiences.

The girl child sometimes assumes the caretaking role for AIDS patients without adequate information about how to protect herself from being infected. Generally speaking, more information and education programmes about home based care are targeted at older people especially women as it is assumed that they are the major caretakers. Efforts to educate the girl children about home-based care have so far been very minimal if not non-existent. This situation sometimes results in the girl child being infected due to caring for AIDS patients without adequate protection. It should be pointed out, however, that generally caregivers in Botswana (irrespective of age) are reluctant to wear gloves when providing care to sick people including those suffering from AIDS because they believe that gloves create some social distance between them and the patients (Keboi, 2002) [20].

The girl-child's role as caregiver may result in high failure rates for girls – a phenomenon that exposes them to poverty and a low level of living. Poor girls may condone early sexual relationship in order to have luxurious enjoyed by rich girls such as cell phones, fashionable clothing and others. Poverty and a low level of living are highly associated with a higher risk of HIV infection.

The girl child's role as caregiver does not end with the death of a parent or relative, because following such death, the girl-child is often burdened by caring for her own siblings. Sometimes the affected girl child is highly prone to sexual abuse and can easily resort to sex work to raise most needed funds (Dube, 2001) [8]. For example, *The Rapid Assessment on the Situation of Orphans in Botswana of 1998,* identified twenty-one girls between the ages of 15-18, who had been sexually abused and eleven of them had fallen pregnant and dropped out of school. An uncle was reported to have raped a niece the night her mother was buried. The above circumstances that face the girl child no doubt expose her to a greater risk of HIV infection.

Factors that are not related to culture

In this section, the authors discuss factors that are not related to culture that contribute to the spread of HIV and AIDS among girl children. These are biological factors and intergenerational sex.

Biological factors

One of the non-cultural factors that pre-dispose the girl child to HIV infection than the boy child is related to her biological make-up. Girls grow faster than their male counterparts and reach puberty very early around the age of 10 to 12 years and this exposes them to be sexually attracted to older men, who may initiate sexual intercourse at their tender age. ACHP (2011), noted that some biological factors which include physiological vulnerability as a product of young age at sexual debut and during pregnancy, and transmission risk related to disruption to vaginal flora, being infected with sexually transmitted infections (for example HSV2 bacterial vaginitis, trichomonas vaginitis) and immune activation brought about by other illnesses are some factors that predispose young women to HIV more than their male counterparts. UNAIDS (1997) [52] estimated that the former transmission may be up to four times more efficient. This is due to the larger mucosal surface area exposed to the virus in females and the greater viral concentration present in semen compared with vaginal secretions.

Intergenerational sex between older men and young people

Intergenerational sex between older men and young females contributes to the spread of HIV and AIDS among girl children (Raditloaneng and Molosi (2014). Such sexual relations are characterised by a high level of inequality in terms of both gender and age. Gender inequality is the main cause of higher infection amongst females in Botswana because women and children are traditionally subject to male decision making in the home and this is perpetuated throughout all private or consensual relationships. The gender and age inequality of girls adversely affects their ability to: successfully resist sexual abuse; resist early marriages; as well as to defend their position on safe sex. On the other hand, unequal power relations put men at an advantage to decide on what type of sex, how and when to use protection as well as to have more than one sexual partner. These dynamics show how the 'power differential' between older men and young females make girls highly vulnerable to HIV infection. The girl child's experience of intergenerational sex could take one or more of the following forms: incest, rape, defilement, sexual harassment, sexual abuse and early marriage.

Fergus and Kebafetotse (1999) [13], contend that incest is the second most common offence that Women against Rape handles. The above authors argue that incest cases are complicated by the fact that mothers of survivors more often

side with perpetrators, especially if he is the husband, boyfriend (breadwinner). Defilement on the other hand is complicated by several factors. One of them is that girls themselves are not empowered to report the abuse because the perpetrators lure them with presents and or threaten to kill them, their siblings and mothers. This trend prevails in both rural and urban areas of the country. One other factor that complicates defilement is that of beliefs and attitudes towards it that some men hold. It is reported that seropositive men believe that when one engages in sexual intercourse with a young girl will not develop AIDS and that will also be cured of AIDS (Canadian International Development Agency, 2005), contend that many HIV positive elderly men in rural Ngamiland think it is therapeutic for them to have sex with young girls who are HIV negative. Men's attempts to minimise risk of infection for themselves results in a concomitant increase in children's risk of infection.

At times a girl child will be sent to live with her newly wed sister or aunt to assist with care of her children. It has been reported that at times the husband to the sister or aunt would sexually abuse this girl. Sometimes girl children are also sexually abused by their step fathers, and their mothers' boyfriends. The survivors of sexual abuse who have endured the trauma and have not overcome the impact of the abuse often disbelieve their children's reports about sexual abuse by the close relative, and resort to blaming the child for the abuse which exposes the child to STIs and HIV infection (Canadian International Development Agency, 2005).

Although intergenerational sex is discussed under non-cultural factors, it should be pointed out that the early marriage of the girl child (which may be a form of intergenerational sex) is a cultural factor. However, the degree to which various cultures tolerate early marriages is different. The Herero, Mbukushi and Zezuru cultures, for instance, are some of the cultures that allow children as young as 8 to 15 years to be engaged and get married. Since girls mature faster than boys, therefore it is okay for them to get married at a very tender age.

Early marriage subjects girls to hazards of early pregnancy and child birth because they are not yet physically, psychologically, socially and emotionally prepared to withstand the processes of pregnancy, labour and delivery. These young pregnant girls have increased the prevalence of maternal morbidity and mortality in Botswana, which has disabled the Botswana Government to achieve the MDGs 4 and 5 (that is, reduction of child mortality and improvement of maternal health). The customary law [1] of Botswana is silent about the marriage age of both girls and boys (acknowledge the source, but what is the significance of this sentence). Rape is another form of intergenerational sex that puts the girl child at a higher risk of HIV infection.

One of the disturbing findings of previous research is that although sexual relations between young females and older men are so common, condom usage is rare among youngsters (Rivers, 2000; Campbell and Rakgoasi, 2002) [6]. Rivers, for example, contends that 50% of the sexually active girls who participated in his study admitted to never using a condom. There are various reasons that lead to the un-popularity of condoms in Botswana (cf. Macdonald, 1996; Fidzani, *et al.*, 1999; Botswana National Council for UNESCO, 1999; and Keboi, 2002) [20, 24, 14, 4, 20]. The finding that half of all sexually active children in Rivers' study admitted to never having used a condom should serve as a wakeup call to those working with children and young people on AIDS education.

Challenges faced by stakeholders and the way forward

It is worth highlighting that stakeholders interested in children's issues are embarking on various programs to address the problem of HIV among children. These programs include: the Prevention of HIV from Mother to Child Program (PMTCT), treatment of those living with HIV and AIDS with ARVs and to promote adherence, provision of education on living positively; prevention of the spread of HIV and reinfection with other strains of HIV; support to develop skills to handle stigmatization and discrimination, skills to disclose, negotiate safe sex and to abstain from sex (Ngwenya *et al* ; 2011, Nthomang et. al; 2011) [38, 38]. There is need for comprehensive sexuality education programs to empower girls to have knowledge and skills to enhance their sexual health and protect their sexual rights (IPPF, 2008) [19].

Measures to end early marriages should be put in place, such as increasing the minimum age of 18 for girls; and sanctioning cultural practices that discriminate girls. It is also crucial that access to youth friendly services, family planning and sexual and reproductive health and rights information, education and counseling including HIV prevention is improved (WHO, 2012) [57]. The root causes of early marriage such as poverty and gender discrimination need to be eradicated.

A majority of HIV positive girls are orphans, and the government of Botswana and civil society organisations have developed orphan care programs. However, a lot still needs to be done in relation to implementation, policy and research on HIV infection among children. Laws which address sexual abuse lack consensus on terms used in sub-Saharan countries, and this may create gaps in the application of sanctions imposed on the perpetrators of sexual assault (Kilonzo, *et al*. 2009) [21]. Botswana Government should develop progressive laws and policies on girls protection against any form of sexual abuse and violence.

By and large, efforts of the various sectors to help children affected by HIV have focused on children as a group, rather than according to gender. In other words, gender has not been mainstreamed into HIV programs for children. In addition, programs for children living with HIV and AIDS in Botswana are provided by IDCCs and have focused on equipping them with knowledge and skills pertaining to disclosure, adherence, stigmatization, prevention of spread of HIV transmission and prevention of re-infection. Children are counseled to enhance their sexual health. The girl child has not benefitted adequately from services offered by youth friendly health services due to inadequate resources. Moreover, health and educational services for the general youth population are relatively at an infancy stage

[1] Two legal systems operate in Botswana. Customary law and statutory/common law. Customary law refers to 'traditional law that obtained before the Tswana tribes came into contact with European missionaries, traders, colonialists and other foreigners' (Molokomme, 1987:129). General laws on the other hand are laws received in Botswana during the period when the country was under British protection. Unlike customary law, general and common laws have written sources. The marriage act is one type of law that falls under the common law. The marriage age of the girl child under the marriage act has up to 2001 being 14, while that of the boy child was 16. In 2001, the marriage age of both boy and girl children was increased to 18.

and they have concentrated largely on orphans. Due to space limitations, the challenges highlighted in this section will be confined to issues discussed in this chapter.

The biggest challenge that stakeholders face is to address factors that put the girl child at risk of HIV infection. One of the ways to do so is to provide comprehensive sexuality education which is age specific and culture sensitive to both in-school and out of school girls and boys. Parents and guardians need to be equipped with knowledge and skills on parent-child communication, Girls need to be sensitized about their sexual rights and how to protect themselves from any form of abuse. This is indeed a challenge because stakeholders' efforts may be met with resistance from some people who believe that issues related to sexuality must not be discussed with children because talking to children about sex can influence them to start sexual activity at an early age. People's reluctance to talk about issues of sex is evidenced in several structures of society, i.e. family, schools and the health sector. This trend has also been noted by Moatlhaping and Osei-Hwedie (1999) [18] who asserted that culture is taken as an excuse to refuse young people the right to education on health risks of sexual and other behaviour as well as important tools for protection. Evidence of research in some parts of Botswana indicate that some professionals such as nurses and family welfare educators who are supposed to play a key role in educating youngsters about sexuality issues are failing to do so. In their studies on HIV and AIDS in Botswana, Fidzani *et al* (1999) [14] found that young people encounter problems in their attempt to get condoms because the hospital staff is unfriendly, and humiliate them by telling them that they are still young to indulge in sex.

In conclusion, different Authors agree that different factors subject a girl child to factor predispose her to HIV. Johnson *et al* (2005) [47] content that unlike boys who have individual rights, girls do not have individual rights but communal rights. They are stereotyped to respect males. They therefore grow up not enjoying the right to express their views freely as they are always thinking of not violating their counterparts' rights. This behavior may not only be limited to domestic decision making but may extend even to marital rights where deciding on when to have sex and how may be solemnly the decision of the man. BONELA (2015) discovered that child marriages are deeply rooted in the religious and cultural norms and practices that do not recognize children's rights. BONELA (2015) also noted that teenage pregnancies are common and affect girls under the age of twelve years.

In conclusion, it is evident that children engage in sexual relations without adequate knowledge about HIV and AIDS condition. Some cultures take advantage of the situation of the girl child and use them for their own personal interest. Children therefore need to be empowered on sexuality matters, including HIV and their rights, especially that sexual rights are human rights regarding sexuality. The benefits of offering sex education are enormous. For example, an evaluations of sex education programs in various countries has revealed that they may improve knowledge about sexuality, delay intercourse and increase contraceptive use (Waszak, 1993) [56]. This would be in congruence with recommendations by Hardee, K., Croce-Galis M., and Afari-Dwamena N.A. (2000000) who suggested intervention for adolescent girls across three critical areas being,1) an enabling environment that encompass keeping girls in the school, promoting gender equality, strengthening protective legal norms, and reducing gender-based violence; 2) information and service needs, including provision of age appropriate comprehensive sex education, increasing knowledge about and access to information and services, and expanding harm reduction programs for adolescent girl; and 3) social support, including promoting care relationships with adults and providing support for adolescent female orphans and vulnerable children.

Furthermore, school based sex education should put much emphasis on skills and social norms rather than knowledge. For example, they must focus on communication skills, social pressures for having sex, decision making, assertiveness, how to identify risky situations and behaviours, how to negotiate safer sex or no to sex, (it's part of risky situations) and how to find and use existing services. In equipping youngsters with the above skills, it is crucial that approaches that make children active participants are used. These include giving youngsters a chance to write plays, tape music, distribute education materials and sometimes condoms. The emphasis on skills is crucial and it is an area that has been severely neglected in sex education in Botswana (cf. France, 1988). It has been recognized that some teachers may not have enough time or skills to equip children with knowledge and skills on sexual issues, it is recommended that school social workers be hired as a matter of urgency to handle issues related to personal skills including HIV/AIDS.

The Government of Botswana and Non-Governmental Organisations (NGOs) have taken strides in working with women and children in the country. However, such efforts are hindered by lack of resources which limits their ability to reach out to rural and remote areas of the country. Lack of funds therefore, makes it difficult for service provision to the hard to reach settlements. The lack of support and counseling services to child survivors of HIV and AIDS has serious implications for their wellbeing.

Another rather startling issue highlighted in this chapter is intergenerational sex. This phenomenon has become common in the country. It is recommended that schools and all community levels should join force to ensure zero tolerance of sexual harassment and abuse amongst children and youth; and stakeholders should engage in a national level public education campaign to change adults' attitudes that quietly condone adult-children relationships (Rivers, 2000).

One of the strategies that could go a long way in ensuring that the issue of the girl child and HIV is addressed more efficiently could be the establishment of robust child advocacy organizations. It is also recommended that government should increase financial support to non-governmental organizations that help children affected by HIV so that they could embark on programs that have a greater impact on communities; Government, NGOs, the private sector and communities must work together to reduce the burden of care on the girl child. One such way is to shift the socialization process so both boys and girls are exposed to similar duties and responsibilities.

Although the chapter has highlighted that the girl child is more vulnerable to HIV than the boy child, we must not lose sight of the boy child. This is particularly so because while research has shown that the 'first sexual experience for females, and therefore exposure to sexually transmitted

infections including HIV, is with an older and more experienced man' (Phaladze and Tlou, 2001; 197) [43], it has also shown that young girls who are HIV positive, in turn infect boys of their own age.

In conclusion, girl children are human beings in their own right therefore, their social status as minors should not result in the neglect of issues that affect their lives such as HIV. They should be catered for, like all other members of society, so as to eventually achieve a society that is free from HIV.

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