



# THE BOTSWANA REVIEW OF ETHICS, LAW AND HIV/AIDS

**BONELA**



**The Botswana  
Network on  
Ethics, Law  
and HIV/AIDS**

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## Editorial

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Botswana Review on Law, Ethics and HIV and AIDS (BRELA) is a peer-reviewed journal for critical and analytical discussion of a broad range of multi-sectoral issues and debates surrounding ethics, HIV and AIDS. In this respect, BRELA provides an opportunity to contribute to Goal 5 of Botswana's National Strategic Framework on HIV/AIDS 2003-2009, towards a 'Strengthened Legal and Ethical Environment'. Research is necessary to achieve evidence-based advocacy. In this special issue of BRELA we dedicate our efforts to making sexual reproductive health a reality for our youth in the third decade of HIV/AIDS pandemic. The edition has been made possible through a partnership among the University of Botswana Isaac Schapera Project; the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) and the Southern Africa Trust (SAT), and Save The Children International (SCI).

BONELA's mission is "to create an enabling and just environment for those infected with and affected by HIV and AIDS". Through a strategic partnership with the Southern Africa Trust (SAT) for training on Sexual and Reproductive health and Rights (SRH) and advocacy around access to SRH and HIV services, with women living with HIV/AIDS as some of the primary beneficiaries. SAT views the ending of poverty as crucial to overcoming chronic livelihoods insecurity in the context of an HIV/AIDS pandemic. Poverty eradication is thus seen as essential for "improved institutional capacity, participatory and accountable systems of governance, and appropriate public policies across the region" (Southern Africa Trust Vision and Mission).

The vision of the University of Botswana is to be a "leading academic centre of excellence in Africa and the world", by advancing "knowledge and understanding through excellence in research and its application" (University of Botswana Vision). In October 2008, the Department of Sociology of the University of Botswana, through the Isaac Schapera Project, hosted a conference on "Continuity and change in an era of HIV/AIDS". Perspectives from Anthropology from and a variety of other disciplines were presented to consider social change in an era of HIV/AIDS, how such change may be managed, at socio-cultural, institutional, legislative and policy levels (h-africa Discussion Logs, 2008). One major theme emerging from the papers presented at this conference was the changing face of the family (Jacques, 2008). Contributions in the edition include both research papers and focus pieces from practitioners in the field.

This edition starts off with a Sexual Reproductive Health Needs Assessment for Botswana done through the auspices of the Botswana Network on Ethics, Law, HIV and AIDS (BONELA). The needs assessment reveals that although women ought to enjoy reproductive rights that are rooted in ethics, the law, legal procedures, and voluntary conduct on the part of government and civil society, the actual experiences for women living with HIV and AIDS is that of stigmatizing attitudes. They are often abused by health care providers in the public health system when they fall pregnant, either planned or unplanned.

The paper by L. Martindale, A. Tingwane, A. Albers and O. Maruping, provides insights

from the Community Health Program of the Letloa Trust in the Kuru Family of Organisations. It explores the challenges for the Naro San women living on the Ghanzi farms in accessing Sexual Reproductive Health (SRH) Services. Using data based on structured, scientific research on perceptions and experiences of the Ghanzi farm San communities, Martindale, Albers and Maruping, underscore the necessity of programs that acknowledge and incorporate the diverse conceptualization of relationships, risk and health as experienced by different ethnicities because “individual and community HIV prevention efforts require specific cultural integration that is only effective through indigenization”.

The next paper titled ‘Family under Siege in Sub-Saharan Africa: The Challenges of The HIV/AIDS Pandemic’, by Gwen N. Lesetedi, addresses the disturbing impact of the HIV/AIDS pandemic on the structure and functions the family, especially women and children. “For instance, children typically occupy weak positions within the households, with little bargaining power but there is evidence of growth in the number of child-headed households and the law or society does not take cognizance of this fact”.

In Botswana, Multiple Sexual Partners, casual and transactional relationships remain on the increase despite high knowledge levels about transmission and prevention of HIV and AIDS. The empirical review by Robert M. Molebatsi and Brothers W. Malema of the University of Botswana provide supporting statistics to the known fact that the link between knowledge and behaviour is not simple or straight forward. Their findings reiterate fact that it is not always easy to adopt the right sexual practices even when armed with the knowledge. The incidence of casual relationships remains on the increase both males and females, although men were twice more likely to be involved in casual relationships. Transactional relationships were also on the increase. Even respondents with higher formal education engaged in risky sexual behaviour. There is need for more research on the gap between having information and safer sex.

Kopano Kalanke, uses her experience as a teacher at Shashe River School in Botswana to share some of challenges that adolescents face as they transition from junior secondary schools to senior or high schools. Through a refined true story of a 17 year old senior secondary student, Matshwenyego (not her true name), in one of the schools in Botswana, Kalanke brings to the fore the poignant problem; that pastoral care for learners is crucial to SRH. A healthy learning and teaching environment in schools, with teacher’s grievances addressed and more training on pastoral care for learners, can go a long way to making health and productive lives a reality, especially for female students.

Ultimately, the question of empowerment always come up, that until and unless women themselves fight for their reproductive health rights, there is very little chance that attitudes and legal processes will change on their own. The paper by Annig Barrett on argues that only by addressing power inequalities in gender relations can we achieve sustainable reduction in the prevalence of HIV/AIDS.

Finally, we review a book whose relevance has not been reduced since it was written over ten years ago. No safe place: Incest and defilement in Botswana, by the Botswana chapter of Women and Law in Southern Africa Research Trust (WLSA), places the family at the centre of the study, as both a fundamental and basic unit of society but also “an arena within which various forms of child abuse and other forms of gender violence occur” (WLSA, 2002:7).

## Bibliography

Botswana's Parliament strengthens the implementation of the Children's Act  
h-africa Discussion Logs. (2008, June). <http://h-net.msu.edu>. Retrieved November 25, 2013, from Humanities & Social Sciences Online (Hnet): <http://h-net.msu.edu/cgi-bin/logbrowse.pl?trx=vx&list=h-africa&month=0806&week=d&msg=siuiRSlalGnjQsjKYwt2Sw&user=&pw=>

Jacques, G. ( 2008, October 30-31). The Changing Face of Family: HIV and AIDS and Statutory Foster Care in Botswana. Paper Presented at Schapera Project Conference, University of Botswana.

Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States. (1948). Retrieved November 25, 2013, from World Health Organization: <http://www.who.int/about/definition/en/print.html>

Southern Africa Trust Vision and Mission. (n.d.). Retrieved November 25, 2013, from Southern Africa Trust: <http://www.southernafricatrust.org/vision&mission.html>

University of Botswana Vision. (n.d.). Retrieved November 25, 2013, from <http://www.ub.bw>: <http://www.ub.bw/content/id/1372/>

## A Sexual Reproductive Health needs assessment for Botswana

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Botswana Network on Ethics, Law, HIV and AIDS (BONELA).

### *Project Background*

The need to explore the situation of the sexual and reproductive health rights of HIV-positive women in Botswana emerged as a result of unsettling discourse that was publicized in the media. Women living with HIV were being blamed for the spread of HIV. Comments were made by political leaders and leaders in the public health system in particular, suggesting that by having children, women living with HIV were knowingly and irresponsibly putting the lives of their partners as well as their children at risk of infection. The initiative by BONELA to engage and dialogue with women living with HIV, sought to ultimately uncover the context in which women living with HIV exercise their sexual and reproductive rights. These efforts were aimed at ultimately helping to defend the sexual and reproductive health rights of women living with HIV against the criticism being perpetuated in the media.

There has been an increase in stigmatization attitudes towards women and men living with HIV who either exercise or plan to exercise their reproductive rights. In recent years we have witnessed a rise in the incidence of abuse by health care providers in the public health system towards women living with HIV who fall pregnant planned or unplanned. In 2006 the then-Minister of Health, Prof. Sheila Tlou, and certain members of parliament were quoted in the media as blaming women who are HIV positive for spreading the transmission of the virus when they fall pregnant. The then MP for Palapye, Lephimotswe Sebetela, was quoted as saying he is concerned about HIV positive women who continue to fall pregnant, saying they were contributing to the spread of the virus in the country. He further went on to express that there is still no cure for AIDS and people enrolled in ARV programmes are bound to transmit the disease to their partners if they engage in unprotected sex<sup>1</sup>.

Evidence revealed in this assessment is that women living with HIV are not maliciously and selfishly infecting their children and spouses with HIV. To the contrary, women are up against a multitude of social, cultural, legal and public health challenges that have made it difficult for them to make independent and informed choices regarding their reproductive health rights. It is about time that public health specialists and human rights practitioners, women and men living with HIV, and other concerned civil society and state actors come together to draw up a new approach to reconciling public health and human rights interests. Public health interests cannot be won without consideration of the impact on rights.

### *Methodology*

This Sexual Reproductive Health needs assessment for Botswana was made possible by women living with HIV who shared with us their stories, feelings and desires during the community dialogues in Gaborone, Francistown and Kasane. It is their willingness and eagerness to talk about issues that are not talked about openly, not even disclosed to closest relatives, that make this assessment so powerful and informative.

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<sup>1</sup> 31 January, 2006, the daily news

Between 2006 and 2007, BONELA led an advocacy and research project that explored the sexual and reproductive health rights of women living with HIV across Botswana. In 2006, BONELA conducted three community dialogues each one-day long with respondents in Gaborone, Francistown and Kasane. The respondents were women living with HIV who were invited through informal community networks, with the help of local community groups or individuals working with BONELA. At each meeting, a health care provider was invited from a local hospital to give a presentation on the medical considerations of HIV and pregnancy.

In 2007 a series of community dialogues was conducted with women living with HIV from 15 communities. A total of 228 women took part in these informal dialogues, their ages ranging from 21 to 45 years. The dialogues with women were followed by a consultative meeting with health care providers from in and around Gaborone, representatives from the Public Health Department of the Ministry of Health, and representatives of women's groups and private or NGO sexual reproductive health (SRH) service providers such as the Botswana Family Welfare Association (BOFWA). The Health sector had a representation of 19 respondents including nurses from the Infectious Disease Care Clinic (IDCC), Maternal Child Health Department, Ministry of Health Department The Sexual Reproductive Health Unit from Gaborone, Molepolole, Jwaneng and Ramotswa. While the purpose of these community dialogues was to understand the context in which decision making regarding pregnancy was made by women living with HIV, it was deemed pertinent to involve health care workers in the process in order to explore their views regarding HIV and pregnancy.

Graeme Hamilton and his colleagues from Toronto, Canada gathered and organised a great deal of literature on the related socio-cultural, legal and medical evidence. The input from this team of short-term volunteers in 2006 enabled the Botswana Network on Ethics, Law, HIV and AIDS (BONELA) to produce a significantly richer report.

The International Community of Women living with HIV/AIDS (ICW) provided support to the project by making it possible for activist Grace Sedio to co-facilitate the community dialogues with BONELA. Bomme Isago, Francistown Network of People Living with HIV and Pakalemasa Support Groups also took time to help bring together women living with HIV.

### *Sexual and Reproductive Health Rights and HIV*

There is growing recognition of the importance of linking sexual and reproductive health rights (SRHR) to HIV and AIDS in order to increase the effectiveness of the global response to the HIV epidemic<sup>2</sup>. Heterosexual transmission is the most common mode of HIV transmission for women worldwide<sup>3</sup>. The majority of HIV infections around the globe are transmitted sexually, through pregnancy, childbirth and breastfeeding, hence the importance of linking sexual and reproductive health to HIV in the bid to increase the effectiveness of the response to HIV/AIDS. For most people, an HIV-positive diagnosis usually means a different perspective regarding sexual relationships, with most people often feeling confused about

2 Good Practice update: Linkages and integration of sexual and reproductive health, rights and HIV- Seizing opportunities for universal access; February 2009; page1

3 [http://cme.medscape.com/viewarticle/408827\\_2](http://cme.medscape.com/viewarticle/408827_2)

whether to continue engaging in sexual relationships or even having children. In most communities, structural, social and cultural conditions have tended to create barriers that affect how people living with HIV exercise their sexual and reproductive rights. These barriers often leading to the violation of sexual and reproductive rights of people living with HIV, have meant that women living with HIV do not receive comprehensive information and services related to their sexual and reproductive health needs. It means that people are unable to practice safe sex because they are fearful of talking openly with health care providers and, to a greater extent, their sexual partners, about sexual health and HIV.

### *Sexual and Reproductive Health and Rights around the Globe*

The frequency at which women's reproductive rights are violated is of great concern. HIV-positive women from around the world have spoken out about the many sexual and reproductive health right violations they continually face. These include forced and coerced sterilization, refusal to provide services, hostile attitudes towards HIV-positive women who seek to have children, stigmatization at hospitals by hospital staff, breaches of confidentiality and testing for HIV without informed consent<sup>4</sup>. The health care setting has become a breeding ground for violations of sexual and reproductive health rights of women living with HIV; this may be seen in the following examples depicting a dire situation regarding violations of SRHR of women living with HIV.

- In Namibia, there were reported cases of HIV-positive women who were coerced into sterilization. The women claimed they had been sterilized without their consent, while others said they were coerced into being sterilized. Those that did not consent said they only knew about the procedure after returning to the hospitals to access other services such as family planning<sup>5</sup>.

There are no binding international and regional declarations on HIV and sexual and reproductive health rights that are specific to HIV-positive women and men. A few drafts, however, have been developed by activists in order to provide a framework for these demands.<sup>6</sup>

- A) HIV Positive Young Women's Sexual and Reproductive Rights Charter was drawn up in 2004 as part of a young, positive women's dialogue, organized by the International Community of Women living with HIV/AIDS (ICW) in Swaziland. The charter declares that HIV-positive women have the same rights as other women but also need access to HIV-specific information and services. Reproductive rights that are called for in the charter include the rights to: decide whether and when to conceive without being judged; decide on the number of and spacing between children; abortion or sterilisation on demand (without requiring the consent of another person); education on labour, delivery and breastfeeding; quality antenatal care (with or without being accompanied by a partner); equal access to reproductive health care, regardless of social, economic or political status; family planning information and decision-making

4 The forced and coerced sterilization of HIV positive women in Namibia: The international community of women living with HIV (ICW); (March 2009) pg 4

5 <http://www.nshr.org.na/modules.php?op=modload&name=News&file=article&sid=1054&mode=thread&order=0&thold=0&POSTNUKESID=4a90a21fcfc17b5e4af67ec26460b2d8>

6 Bell E, Mthembu P, O'Sullivan S, Moody k/ Reproductive Health Matters 2007;15(29 Supplement):113-135

over the type and use of contraception; access methods to prevent HIV and sexually transmitted infection (STI) such as microbicides when they become available; safe childbirth delivery and in a location preferred by the woman; assisted conception and artificial insemination; feed their babies in the way preferred by the women and have accurate information about feeding options to be able to make an informed decision to prevent mother-to-child transmission of HIV (PMTCT).<sup>7</sup>

- B) Women and HIV: The Barcelona Bill of Rights was initiated at the International AIDS Conference in 2002. This Bill of Rights links inequality to women's vulnerability to HIV. It highlights elements of rights of particular relevance to HIV-positive women, including the rights: to live with dignity and equality; to bodily integrity; to health and health care, including treatment; to safety, security and freedom from fear of physical and sexual violence; to be free from stigma, discrimination, blame and denial; to human rights regardless of sexual orientation; to sexual autonomy and sexual pleasure; to equity in families; to education, information and to economic independence.<sup>8</sup>

HIV-positive people have a right to have families. But the current state of affairs, especially regarding the stigma associated with HIV, bars women and men living with HIV from fully exercising their sexual and reproductive health rights. Although there is a great number of people living with HIV who are able to fully exercise their sexual and reproductive health rights, there is still inadequate information which prevent them from making informed decisions about their sexual and reproductive lives.

The *International Conference on Population Development (ICPD)* 1994, recognizes "the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents."<sup>9</sup> Therefore women and men, HIV-positive or negative, should have full autonomy, free of coercion, in making decisions regarding their reproductive choices.

7 Bell E, Mthembu P, O'Sullivan S, Moody k/ Reproductive Health Matters 2007;15(29 Supplement):113-135

8 Bell E, Mthembu P, O'Sullivan S, Moody k/ Reproductive Health Matters 2007;15(29 Supplement):113-135

9 <http://www.un.org/popin/icpd/conference/offeng/poa.html>

## San Community Health Worker Experiences Indigenizing HIV/AIDS and Sexual Reproductive Health Promotion in Ghanzi, Botswana

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### Abstract:

*This paper provides insight into the challenges for the Naro San women living in the Ghanzi farms in accessing Sexual Reproductive Health (SRH) Services. This topic has arisen as priority in the continuous evaluation of the Kuru Community Health Program. Data based on structured, scientific research on perceptions and experiences of the Ghanzi farm San communities are not available, therefore in this paper we present the qualitative data collected from monthly monitoring visits (including narrative reports and quotes, collected by the San Community Health Workers with Kuru Health), informal conversations, short papers written by the San staff of Kuru Health, as well as unpublished programme documentations such as a baseline study conducted in 2006 (to inform the directions of the health programme) and an external evaluation of the programme conducted in 2009 (Galvin & Dillon, 2009). The findings underscore the importance of context and cultural sensitivity in HIV and AIDS policies and programmes. HIV and AIDS programs must acknowledge and incorporate the diverse conceptualization of relationships, risk and health as experienced by different ethnicities. Also understanding that gender, culture and health are socialized, learned, and dynamic; it is imperative to involve remote area community members in addressing the various socio-cultural factors contributing to the perpetuation of HIV. Ultimately, individual and community HIV prevention efforts require specific cultural integration that is only effective through indigenization.*

## Introduction

Ghanzi District in Western Botswana is characterized as a desert environment, sparsely populated with low frequencies of transport and limited access to centralized government services. Almost one fifth of the Ghanzi District population <sup>1</sup> is formed by San communities, living on remote privately owned farms. Within the context of poverty, historical and political marginalization and discrimination is exacerbated by cultural and language barriers. The health and well being of San communities is challenged by lack of access to culturally appropriate health services and health education. Kuru Family of Organizations (KFO) Letloa Trust Community Health Programme is a local Non-Governmental Organization working to increase access to health care in remote areas. Kuru Health works in partnership to design and implement indigenous public health interventions with San language groups including Naro, Khwe, ||Anikhwe, Ju/'hoansi, Dcui, Dxana and Xoo.

These remote communities continue to be challenged with lack of basic medical supplies including rapid HIV test kits. Although the majority of people in Botswana have access to a health facility within 15 km radius, in Ghanzi District, this is only the case for 60% of the population (MLG, 2003). Given the current challenges of vast distances to health facilities, it is important to explore how to enable improved access of primary HIV prevention on the farms.

The farm communities are remote, usually only accessible with 4x4 vehicles. Often when one of the family members works for the farmer <sup>2</sup> the entire family stays on the farm. Over the years, informal settlements have thus come into existence on those farms. Residents on the private farms are only able to access government health services by mobile clinic outreaches. The mobile clinic visits are not yet comprehensive or reliable. Some farm communities go for many months without a single visit by the nurse and often are not provided with sexual reproductive health services when the mobile clinic does visit.

This paper provides insight into the challenges for the Naro San women living in the Ghanzi farms in accessing Sexual Reproductive Health (SRH) Services. This topic has arisen as priority in the continuous evaluation of the Kuru Community Health Program. Data based on structured, scientific research on perceptions and experiences of the Ghanzi farm San communities are not available, therefore in this paper we present the qualitative data collected from monthly monitoring visits (including narrative reports and quotes, collected by the San Community Health Workers with Kuru Health), informal conversations, short papers written by the San staff of Kuru Health, as well as unpublished programme documentations such as a baseline study conducted in 2006 (to inform the directions of the health programme) and an external evaluation of the programme conducted in 2009 (Galvin & Dillon, 2009).

1 The total population of Ghanzi District is 33,502, with 9,954 people living in Ghanzi Township, an estimate of 5,377 residing on private farms, mostly Naro speaking San, and 689 people in the Central Kalahari Game Reserve area. The remaining population is scattered throughout the district in about 20 settlements far apart with populations between 400-2000 people (District Health Management Team, 2012).

2 The men on the farms usually work as herders for the cattle in the cattle posts that are scattered on the farm or they provide manual labour. The women sometimes work in the household of the farm owner, but would typically also reside on the farm with the family if they are not employed. This also the case for elderly family members and children.

Reflection on perceptions of Naro San women from the Ghanzi farms provides the basis for Kuru Health's methodology: in order to empower San women to acquire SRH skills and knowledge (including STIs, HIV/AIDS, access to prevention and care, family planning services, ante-natal and post-natal care), SRH issues need to be presented in a contextually relevant approach. Localized health seeking behaviours and sexuality issues amongst the San farm communities must be taken into account when implementing public health initiatives in order to make sexual reproductive health a reality. This paper underwrites the importance of the concepts of indigenous health care and indigenization of health care as used in the public health arena. Analysing the qualitative data collected by the Community Health Workers to get insight in the self-perception of San women of their own autonomy, control over sexuality and their views and beliefs on their own vulnerability to HIV/AIDS, is a starting point for making sexual reproductive health a reality in the remote areas.

For purposes of this paper, the following concepts are defined according to Julia and Kondrat's work done on health care in the social development context. Indigenous health care entails "approaches to wellness, health, primary care, rehabilitative or palliative care that involve or include knowledge, practices, or resources (including personnel) that are locally derived" (2005:542). Whereas indigenized health care "adapts non-local health practices for local and cultural relevance and context sensitivity" (*ibid.*). It is essential to understand the perceptions of these San women to be able to understand their actions and possible opportunities to strengthen resilience, as well as to understand how structural socio-economic factors influence their vulnerability.

## Background

### *Socio-Economic Status in Ghanzi District Farms*

The vastness of the area and unique demographics of isolated San communities have since sparked the classification of 'hard to reach' by national health officials. The majority of RAD (Remote Area Dwellers) in Ghanzi are indigenous populations of San, otherwise known in Botswana as 'Basarwa'. RAD are defined by the Ministry of Local Government (2003:np) as:

...people living in unrecognized villages that do not have basic social services, are remote and socio-economically marginalized...[have] little or no contact with modern life enjoyed by an average citizen; fall outside the scope of and coverage of other national development programmes; lack individual land ownership; [and have] little or no access to formal education. They are comprised of Basarwa...

It is critical to note that Ghanzi has one of the weakest economy bases in the country with an estimated 71% of the population living below the poverty line (UNDP, 2010), 43% illiteracy and school enrolment figures the lowest in the country (*ibid.*). Botswana AIDS Impact Survey III (BAIS III) correlated the relationship that HIV prevalence decreases steadily as education level increases. Those with limited education have the highest HIV prevalence whilst those with education higher than secondary education have lower rates of HIV prevalence respectively (CSO, 2009). Further, HIV knowledge is low in Ghanzi; of those surveyed, only 45.7% were aware of the available voluntary and/or routine counselling and HIV testing services; 47.6% were aware of the ARV program and 48.6% were aware of

the Prevention of Mother to Child Transmission (PMTCT) program available in the district (CSO, 2009). Although efforts can be taken to improve health, without improving overall socio-economic and education status, disease prevention remains additionally challenging.

Health care in Ghanzi District requires service provision to numerous minority language groups. Besides the geographical distance that needs to be covered to reach the minority groups living in these remote areas, the government health service providers face “a challenge relating to language barrier during the implementation of their outreach programs” (BOPA, 2010:np). The language barrier directly affects patient-provider relations and threatens the efficacy of health service delivery. The majority of health care workers come from different places, do not speak the same language as the communities they are serving and often get transferred to a new location before they have a chance to understand their clients’ culture and health seeking behaviors. Although there are different ethnic groups living in the district <sup>3</sup>, most of the farm workers and their families in Ghanzi are San.

### *HIV/AIDS and SRH Issues in Ghanzi District*

The global portrait of HIV/AIDS houses unique epidemics each with distinct history, characteristics and dynamics. The common demographic features of HIV and AIDS are often represented collectively in national statistics and responses, and rarely depict the reality of remote area factors that are faced by many on the outskirts of the general population in Botswana. In addition, it has been observed that national strategies and policies to address behaviour change that should result in decreasing new HIV infections, do not take into account local realities and sexuality experiences <sup>4</sup>. Even though the Botswana Mid-term Review and the National Operational Plan recognize the missing involvement of communities and the lack of cultural specific and tailored HIV prevention messages as gaps in the country’s approach, not much seems to have been done on the ground since. Yet, to be able to address the spread of HIV and the improvement of sexual reproductive health of diverse populations, it is extremely important to direct attention to this cultural diversity. Taking into account international, national and local epidemiological trends, the picture of Ghanzi District has distinct elements that highlight the importance of a locally adapted and indigenous response to HIV/AIDS.

BAIS III reported the overall Ghanzi District HIV prevalence to be 13.5%, with higher rates among females at 16% prevalence compared to 10.6% among males (CSO, 2009). The Botswana Second Generation HIV/AIDS Antenatal Sentinel Surveillance Technical Report (MOH, 2011) shows Ghanzi District’s adjusted HIV prevalence among pregnant women to be 17.3%. With a national prevalence of 30.4% among pregnant women, numerous geographic variations have been observed; Ghanzi District has one of the lowest HIV prevalence rates in Botswana (MOH, 2011).

3 The people of Botswana are known as “Batswana”. The Government of Botswana has adopted a ‘non-racial’ policy at independence in 1966, and ‘holds that all citizens of the country are indigenous’ (Hitchcock, Biesele & Lee, 2003). In reality however, the population of the country is made up of various ethnic groups. Some of them related to each other and come from similar Bantu speaking tribes, such as the Bangwato, Bakgatla and Batawana tribes. Others, such as the San, the Baherero and the Bayeyi, from various different cultural, language and historical backgrounds. While Setswana is the national language, English is the official business language. Over seventy percent of the population speaks Setswana (CSO, 2007).

4 See, amongst others, Ntseane 2004; Ntseane & Preece 2005; Ntshebe, Pitso & Segobye 2006; and Parker 2011.

Although Ghanzi has an overall lower HIV prevalence, there is a higher incidence rate among infants born to HIV positive mothers at 4.9% compared to the national 3.8% (MLG, 2010; NACA, 2010). Figures from the Botswana Maternal Mortality Ratio (MMR) 2006-2010 (CSO, 2011) report indicate Ghanzi District has the highest numbers of recorded non-institutional live births in the country, 365 out of the national 475. The majority of women residing on isolated farms do not have access to clinical antenatal care and therefore give birth at home with traditional San birth attendants rather than at the hospital.

In most studies with San groups in Botswana and Namibia it is said that due to livelihood changes women have lost their relative autonomy and influence, which puts them at higher risk for infection with HIV and other STIs (Lee & Susser, 2004; Susser, 2003; Hitchcock, Biesele & Lee, 2003). These authors sum up factors that historically gave San a strong protection to HIV infection: the relatively isolated status of the communities, as well as a historically rooted “gender egalitarianism. The relatively autonomous and high status of women in these societies formed a protective environment for San in Southern Africa. However Oppression, discrimination, marginalization, gender-related stigmatization and abuse are said to have had particularly harmful effects on the sexual and reproductive health of San women (Pettitt, 2011). This is also supported by findings amongst Ju/’hoansi in the Okavango: “The historical autonomy of women seemed to offer the opportunity for forthright sexual negotiations and mobilization to prevent the spread of HIV/AIDS” (Susser, 2003:126).

Recent influences from neighbouring patriarchal societies have changed San subsistence lifestyles from hunting and gathering to more sedentary means; gender relations are also changing. A better understanding of these dynamics is needed to address their risk to HIV infection in the context of contemporary power and gender relations. Negotiation and decision-making in sexuality issues and opportunities for the use of possible strengths within the group’s social and cultural basis could protect both men and women from infection.

## Perceptions from San communities<sup>5</sup>

### *Sexual Reproductive Health: Perceptions and Experiences on Ghanzi Farms*

Reflections from San Community Health Workers (CHW) working with Kuru reveal that current cultural beliefs of health and illness are repeatedly influenced through a variety of storytelling methods often in relation to the environment, through spiritual and animistic metaphors. These beliefs and health seeking behaviours they provoke sometimes coincide with ideas based on modern medicine as learned from government or NGO health service providers. Effective health promotion requires cultural and contextual adaptation to align with the specific way San experience and identify health. Healers and traditional birth attendants from similar language groups as their patients comprehend the dynamic cultural health context in relation to their environment.

Women on the farms believe and trust their culture and they have more faith in their practices than in the hospitals and clinics (Camm, 2012). CHW have observed similar

5 Unless indicated otherwise, the perceptions on SRH, sexuality and gender as experienced by the Naro San women in the Ghanzi farms, come from interpretations by San staff of Kuru Health.

patterns; women access health services late or not at all due to challenging relationships with providers and a perceived mistrust of the facility based health workers. Some farm community members know of STI prevention and contraception, but due to lack of access to services, are not able to use them. Knowledge about HIV and AIDS in the farms is still foreign; the elderly see it as the disease of the 'black' Tswana speaking groups and therefore if you have HIV it's a result of sleeping with someone from Tswana speaking groups (Maruping, 2012).

According to Camm, for San women there is nothing wrong with delivering on the farms or not registering pregnancies at the clinic because they believe that their mothers and grandmothers have been doing so for years and there is nothing wrong with it (2012). Even where governmental health services are available, many community members still resist utilizing the services. Children on the farms are not taken to the hospitals; women themselves do not go to the hospitals. A mother of 10 children on one of Ghanzi farms described her feelings during a health talk: "When I think of those stitches, injections and non-stop medication I was given at that hospital, I hate it. Not one of my children will ever go to that hospital to give birth and when I am pregnant I will not be taken to the hospital to give birth, I will deliver on the farm" (KFO, 2012). Traditional birth attendants play a very crucial role advising during pregnancy, facilitating delivery and post natal stages. Men are also made aware of their role as the parent during this time. Some men are encouraged not to sleep around, traditionally this is said to bring bad luck to the unborn child and potential STIs that will make both the pregnant women and the child sick (Maruping, 2012).

After delivery, birth attendants assist the mother to bath with some herbs and very hot water mixed with salt so the scars heal fast (Mothibi, 2012). Further research is required to determine how best to engage traditional birth attendants in primary HIV prevention efforts; identification of an effective model to enable indigenized PMTCT and sexual reproductive health in the familiar setting on the farms entails collaborative exploration and design.

### *Gender relations in Ghanzi farms today*

Domestic conflict associated with alcohol use and gender based violence occurs regularly in the remote areas of Ghanzi. There is a lot of pressure put on women when their male partners get drunk and force them into having unprotected sex. A woman cannot refuse when her man wants to have sex, she just does it even if she does not want to, otherwise she will end up being beaten if she tries to speak for herself (Ditsheko, 2012). Even if a woman knows something about contraceptives and condoms for prevention she cannot practice it because the man will not allow it. She will just agree to everything he says, he is the one with power and makes decisions (Camm, 2012).

There is no communication between man and women concerning sexual issues among San communities, especially those dwellers in the farms that have rarely interacted with other communities and do not have much information on sexual rights. He owns and controls everything in the household including the woman. He sees a woman as his property and thinks that he can do whatever he wants to her (Ditsheko, 2012).

It is interesting to note that in the study conducted by Becker, the Naro San interviewed on the Ghanzi farms did not necessarily make the connection between violence and

gendered identity. Rather, they saw the 'fighting' between men and women as a result of heavy drinking, by both men and women it was associated with sexual jealousy or misunderstandings.

Indications are that domestic violence in Ghanzi district is not strongly gendered, i.e. based on distinct, hierarchically organized perceptions of women and men. The general picture suggests that the victims as well as the perpetrators can be either male or female to not dissimilar degrees. It appears that the changes that have challenged the earlier relative gender equality among western Botswana San, particularly the shift to a sedentary lifestyle and the influence of neighboring, dominant agro-pastoralist societies have not resulted in forms of violence that would be rooted in a wide gender gap (Becker, 2003: 11).

Recent insights by a San CHW reinforce the lack of gender perception to violence, "*I don't know if we have those words in our culture. We just know if a woman has done something wrong, maybe her husband will hit her. So it is not about becoming equal. It is just about talking, and not hitting. Also, hitting is not a culture, it is something individual.*" Concepts of gender and violence might not have the same meaning to many of the San women in the farms in Ghanzi District, therefore many of the educational approaches of mainstream health workers who base themselves on 'universal' human rights might not be effective unless adapted to prevalent values and understanding. Chances are interventions may even be harmful and potentially worsen gender relations if not culturally relevant.

San CHW have observed that women do not have negotiation power to prevent HIV and/or pregnancy. The concern is heightened when reviewing the high numbers of children born to HIV positive pregnant mothers, and high rates of unwanted pregnancies. Taking into consideration the shifts in gender relations and lack of control over sexual relations, San women on the farms are vulnerable to HIV and AIDS. Many of the women on the farms do not understand the explanations of how HIV is transmitted or how to prevent HIV; the lack of understanding about HIV puts them at increased risk of infection.

Ghanzi District Health Team continuously reports extremely high rates of STIs which contribute to increased risk of HIV transmission. For the last three years, more than 60% of the female population and more than 30% of the male population between the ages of 15-49 has been diagnosed with an STI (MLG, 2010). Men on the farms have a very strong belief that STI's are not caused by unprotected sex. They believe you can only get sick if you sleep with a woman who is menstruating or has had a miscarriage; they often blame women. The only treatment they know is herbal treatment from traditional doctors, and they do not believe in other solutions (Mothibi, 2012).

Nationally the focus of HIV prevention strategies has been on, amongst others, behavioural change and reducing multiple concurrent partnerships. It is interesting to note that according to San women in the farms, the typical couple in their community is actually faithful to one partner. One woman said, "*With us you know when he is your man, he is your man. Even if he sleeps around, he will always come back to you*". This perception of faithfulness might create a 'false' sense of safety in the context of STIs and sexual health. Women may perceive themselves less at risk of infection, when in their experience their partners are faithful; whereas they are actually having sexual relations with multiple partners.

*Sharing of partners when HIV comes it can spread rapidly. In the olden days Basarwa never shared their men; nowadays they still do not with Basarwa but they do with other tribes. In the olden days Basarwa never shared men, now if you go around you will find one man with three different ladies.*

### **Access to Health Services for the Naro San**

An additional challenge posed to the sexual reproductive health of the San women is the perception of the government health services that are available. It has been observed in numerous community conversations that there is widespread fear amongst some San on the farms about the clinics, which prevents many of them from seeking reproductive health care from the facilities.

One lady who has a small baby that is very sick ... She refuses to enroll into any program. Her husband and family are also against being admitted, they say people at the clinics are the ones who inject the patients with poison so they die (KFO, 2007).

Recurrent challenges of access to government health care are a daily reality for many in Ghanzi. Refusal to enroll and slow uptake of available clinical services by remote area community members has been observed for many years by Kuru CHW. Many San do not feel comfortable with clinical based medical procedures due to unconsidered explanation from the health service providers. It is difficult for San community members to understand the benefits of the available treatment and prevention programs with the inferior feeling they get from the majority of health workers that come from dominant ethnic groups. The language barriers between patients and providers proves challenging for both parties and has resulted in reluctance of government service uptake. Such examples illustrate how a lack of understanding of available health services deters community members from clinical facilities and participation in HIV prevention efforts. It also indicates the need for developing an effective model to enable indigenized gender, health and HIV interventions in the familiar setting on the farm.

As Julia & Kondrad (2005) state, it often seems to be self-evident that people participate in their own health and development, but Kuru Health's experience is that this is not always clear to many health professionals. Combined with general prevailing prejudices and negative attitude towards San in Botswana, this leads to distorted power-relations when clients access services. Health workers in general are not well-equipped with skills for intercultural communication and counselling; in turn many San do not feel comfortable, lack self-confidence and hold prejudices against the way they are treated by government providers. Such are the dynamics for the Naro San in Ghanzi farms who do not access services readily, even when available.

### **Kuru Health: Indigenizing Community Health**

With the current campaign 'Rebatlabotshelo' (we want life) the Kuru Health team maintains a strong social movement to encourage positive health motivation and improve access to health care in the remote areas. Through advocacy, communication and social mobilization, Kuru actively integrates San into the health care system with Community TB Care (CTBC) and Voluntary HIV Testing (VCT), sexual reproductive health (SRH) and other services.

One of Kuru Health's most effective methods to provide indigenous public health support is through capacity building of local San CHW. Recruitment and training of native San speakers to implement localized community health programs is one of the most critical aspects of indigenization. A San CHW is able to translate health issues into their specific cultural context. They are trained to facilitate community conversations to engage the 'hard to reach' populations in Ghanzi farms in dialog.

San CHW indicated SRH information is highly needed after talking to women on the farms. When facilitated in Naro language, messages are effectively shared about SRH issues. One group of women that participated in a discussion learned about cervical cancer for the first time: "We introduced the topic of cervical cancer to them, explained diagnosis and some of the factors involved. We also informed the women about STIs and clarified common symptoms. The women enjoyed discussing with us" (Mothibi, 2012).

Ghanzi District Health Management Team reports that VCT services provided by NGOs are more widely accessed than provider initiated routine testing (MLG, 2010). Community members recognize and prefer to access services from a home language speaker and from someone whom is of a similar cultural background. As San language speakers, Kuru lay counsellors are able to provide HIV testing on the farms and in a language that is understood and culturally relevant to the communities. VCT is an integral component of SRH and HIV prevention; San lay counsellors provide an element of indigenization that is vital for improved health. Facility based health workers have also realized the benefits of San CHW, especially with support of San language translation.

The latest perspectives on global health communication theories support the work of Kuru Health's indigenization. It is becoming more apparent that culture, language and contextual meaning are central to public health and development. By building the capacity of community members to "participate in defining the scope of health problems that are relevant to them and determining corresponding and equally relevant solutions...[they] serve as active agents in the determination of their health choices, and on individual and collective rights to healthcare, health policies and specific communication" (Airhinenbuwa & Dutta, 2012:np). The validity of Kuru Health's community conversations with the San is determined by the community members themselves through positive feedback during outreaches and on other occasions when in contact with the formal health system. An external evaluation of the pilot phase of the program covering 2005-2009 was done to determine the effectiveness of program approach. The report revealed that Kuru's indigenized health communications are provided in a way which is accessible across all literacy levels and any language, through images and dialog. Community members acknowledge the cultural sensitivity and take into account San belief, values and customs (Galvin & Dillon, 2009).

Possible strengths within the San communities as recognized by the Kuru CHW form the basis of localized programmatic engagement:

#### *Social cohesion and family support*

One Naro San woman, Bau, that we met during a health talk in D'Kar told us stories of how she uses her friends and social networks to support her when her husband comes home drunk to beat her. She understands that her female friends provide her with refuge and reduce her encounters with gender based violence. With the understanding that well-

functioning community networks and the social resources that flow between them carry protective effects (Kim et al., 2008), Bau is able to maintain her emotional stability with support of her peers despite challenges of domestic abuse. Social cohesion and support is reciprocal among women in the rural areas and extremely important to reduce individual risk factors and vulnerability to HIV infection. Bau explained to us that as women they encourage each other to access health services, communally care for their children and share resources amongst their extended peer groups.

### *Openness to learning new things*

One of the San CHW observes that, “*Any health aspects among these communities are influenced by how the herbalists, traditional birth attendants and traditional healers perceive them. Even though things are like this, these communities are very open to new ideas and information*”. This open attitude of Ghanzi farm San communities is also confirmed by the group of traditional midwives attending a Kuru Health workshop. When asked about PMTCT and ante natal care, they expressed their interest and said they would very much like to be trained on these issues. Traditional healers from different communities in Ghanzi District who participated in a forum meeting with government health service providers also showed willingness to be trained by government on issues such as HIV and TB (KFO, 2011).

### *Opportunities for training Traditional Birth Attendants*

In addressing the higher rates of home deliveries at the remote Ghanzi farms, it would be an opportunity to train the traditional birth attendants in: antenatal-care; danger signs in pregnancy; hygienic and safe delivery; infection control; post-natal care and PMTCT. One of the Kuru CHW notes that, “*The common practice for delivering babies on the farms is home delivery. The women there feel if they are on labour, family members are the ones who should be helping them deliver that baby and should be the ones surrounding her that day of her life*”. Instead of focusing on trying to encourage the San women to deliver their babies in the hospital, where they do not feel comfortable (even if they manage to arrive in time for the delivery), the approach could be to encourage women to give birth at home as long as the process is monitored by a trained birth assistant.

## **Conclusion**

HIV and AIDS programs must acknowledge and incorporate the diverse conceptualization of relationships, risk and health as experienced by different ethnicities (Martindale, 2011).

We, the San, come from healing societies. Disease, conflicts among people, droughts and all the things that would damage relationships need healing. Today family members are separated from each other and people generally deal with life in an aggressive manner. The healer is very vulnerable and many times gets hurt in the process of healing others because he is fighting off evil powers on behalf of other people. [our] symbol for the healing is the eland (Letloa, 2012).

Individual and community HIV prevention efforts require specific cultural integration that is only effective through indigenization. Encouraging words from a young San man in Ghanzi express the importance of cultural identity and the positive change that is possible through constructive social cohesion.

We need empowerment, self-reliance, development, and above all, we need to work together as one people to address this issues. Our ancestors did it, they worked together, they shared, and they gave without demand. They respected the old and cared for the young. They gave good life education to the young and growing ones and they expose them to the world of manhood and womanhood (Morris, 2011).

Understanding that gender, culture and health are socialized, learned, and dynamic; it is imperative to involve remote area community members in addressing the various socio-cultural factors contributing to the perpetuation of HIV. Kuru Health is looking forward to collaborating with the San in future advocacy initiatives to improve implementation with a rights based approach to sexual reproductive health through indigenization.

## References

- Airhihenbuwa, Collins & Mohan Dutta. 2012. New Perspectives on Global Health Communication Affirming Spaces for Rights, Equity and Voices. In *Handbook of Global Health Communication* 1st edition, Rafael Obregon & Silvio Waisbord, 34-51. John Wiley & Sons, UK.
- Becker, H. 2003. The least Sexist Society? Perspectives on Gender, Change and Violence among southern African San. *Journal of Southern African Studies* Vol 29, No 1.
- Camm, K. 2012. Health Issues and Women Living in Farms. Working documentation as UB internship with Letloa Community Health Program. D'Kar, Botswana.
- Ditsheko, G.N. 2012. Women on Ghanzi Farms. Working documentation of experiences as Letloa Trust lay counsellor. D'Kar, Botswana.
- Galvin, T. & R. Dillon. 2009. Facilitating Access to Healthcare for Ethnic Minority Groups in Botswana. An Evaluation of the KFO Community Health Program.
- Hitchcock, M., Biesele & R. Lee. 2003. The San of Southern Africa: A status report
- Julia, M. & M. Kondrat. 2005. Health care in the social development context: Indigenous, participatory and empowering approaches. *International Social Work*, 48(5): 537-552.
- Kim, J., P. Pronyk, T. Barnett & C. Watts. 2008. Exploring the role of economic empowerment in HIV prevention. *AIDS*, 22: Suppl 4, S57-S71.
- Kuru Family of Organisations (KFO) Letloa Trust Community Health Program. 2006-2012. Unpublished Program Reports. D'Kar, Botswana.
- Kuru Family of Organisations (KFO) Letloa Trust Community Health Program. 2011. Ghanzi Healers Coalition Meeting Report.
- Kuru Family of Organisations (KFO) Letloa Trust Community Health Program. 2012. Kuru Health Website. [www.kuruhealth.org.bw](http://www.kuruhealth.org.bw)
- Lee & Susser. 2004. Confounding conventional wisdom: the Ju'hoansi and HIV/AIDS. Paper originally presented at the annual meetings of the American Anthropological association, November 2003.
- Letloa Trust. 2012. Naro San Values. Kuru Family of Organisations (KFO) Custodian Unit. D'Kar, Botswana. ISBN 978-99912-950-0-8.
- Letloa Trust. 2010-2011. Kuru Family of Organisations Annual Report. D'Kar, Botswana. [www.kuru.co.bw](http://www.kuru.co.bw)
- Martindale, L. 2011. The Role of Culture in the HIV/AIDS Epidemic. Unpublished Class Paper PDM.4. Stellenbosch University, Africa Center.

Maruping, O.B. 2012. Women in the Farms. Working documentation of experiences as a management intern with Letloa Trust Community Health Program. D'Kar, Botswana.

Morris, Job. 2011. Help the San. [Electronic version] Retrieved March 17, 2011 from [http://helpthesan.blogspot.com/job\\_morris](http://helpthesan.blogspot.com/job_morris)

Mothibi, S. 2012. Women Perceptions at Farms about Sexual Reproductive Health. Working documentation of experiences with program implementation as Letloa Community Health Program Health Officer. D'Kar Botswana.

Ntseane, P. 2004. Cultural dimensions of sexuality: empowerment challenge for HIV/AIDS prevention in Botswana. Paper presented at the International Seminar/Workshop on "Learning and Empowerment: Key Issues in strategies for HIV/AIDS prevention", March 1-5 2004, Chiangmai, Thailand.

Ntseane, P. &Preece, J. 2005. Why HIV/AIDS prevention strategies fail in Botswana: considering discourses of sexuality. *Development Southern Africa*, 22 (3): 347-363

Ntshebe, O., Pitso, J.M., &Segobye, A.K. 2006. The use of culturally themed HIV messages and their implications for future behaviour change communication campaigns: the case of Botswana. *Journal of Social Aspects of HIV/AIDS*.Vol. 3, No. 2, 2006.

Parker, W. 2011. HIV Prevention in Southern Africa for young people with a focus on young women and girls in Botswana. Literature review and implications for programme planning. Report for African Comprehensive HIV/AIDS Partnership (ACHAP).

Pettitt, E. 2011. Sexual and reproductive health challenges among Botswana's San women. *Exchange Magazine*, 1, 2011.

## Republic of Botswana

Botswana Press Agency (BOPA). 2010, May 17. Ghanzi ahead in TB prevalence. *Botswana Daily News*, Gaborone.

Central Statistics Office (CSO). 2007. Botswana Family Health Survey IV Report. CSO in collaboration with UNICEF

Central Statistics Office (CSO). 2009. Botswana AIDS Impact Survey III, 2008.

Central Statistics Office (CSO). 2011. Botswana Maternal Mortality Ratio (MMR) 2006-2010. Gaborone, Botswana.

Ministry of Health. 2011. Botswana Second Generation HIV/AIDS Antenatal Sentinel Surveillance Technical Report. Department of HIV/AIDS Prevention and Care. Gaborone, Botswana.

Ministry of Local Government (MLG). 2003. Ghanzi District Development Plan 6 (DDP 6), 2003-2009. Ghanzi District Council Development Committee.

Ministry of Local Government (MLG). 2009-2010. Ghanzi District Multi-Sectoral AIDS Committee (DMAC) Profile.

National AIDS Coordinating Agency (NACA). 2010. Progress Report of the National Response to the 2001 Declaration of Commitment on HIV and AIDS. Botswana Country Report.

Susser, I. 2003. Ju'/hoansi Survival in the Face of HIV, questions of poverty and gender. *Anthropologica*, 45: 121-128.

UNAIDS. 2010. Report on the Global AIDS Epidemic.

United Nations Development Program (UNDP). 2010. Botswana Country Profile. The Program of Action for Sustainable Development in Botswana with specific reference to the Cross-Cutting Issues. [Electronic Version] Retrieved on February 20, 2011 from [www.un.org/jsummit/html/prep\\_process/national\\_reports/botswana\\_natl\\_assess.doc](http://www.un.org/jsummit/html/prep_process/national_reports/botswana_natl_assess.doc)

United Nations (UN) Statistics Division. 2011. Country Profile: Botswana. [Electronic version] Retrieved on March 5, 2011 from <http://www.data.un.org/CountryProfile.aspx?cname=Botswana>

## The Family Under Siege in Sub-Saharan Africa: The Challenges of The HIV/AIDS Pandemic

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### Abstract

*The HIV/AIDS pandemic is a medical and social catastrophe that has caused widespread pain and concern. It has affected the entire world but particularly developing countries. The family has not escaped the wrath of this pandemic to which it has brought more challenges in addition to the already existing ones as a result of social, economic and, in some cases, political changes. The advent of the pandemic has had a devastating effect on the family, especially on women and children. The HIV/AIDS pandemic has also had a disturbing impact on its structure and functions. These challenges have not rendered the family completely incapable of discharging its functions, rather they have necessitated the family to transform and reorganise the way it discharges functions without necessarily abandoning them completely. The paper discusses some of the challenges that are facing the family as a result of the pandemic. It extends the argument by proposing that it is necessary to equip the family with coping strategies to deal with the pandemic.*

## Introduction

The family is a universal social institution with many different forms and like other institutions it has not been left unscathed by the tremendous economic and social restructuring taking place globally over recent years. The traditional extended family system is experiencing a lot of challenges due to the changes that society is undergoing. The HIV/AIDS pandemic, a global pandemic that has affected the entire world particularly the developing countries, is one of the major challenges that the family is facing. It has caused more widespread pain and concern than any other medical catastrophe in the 20th century and has become a major challenge to development. It has had a devastating effect on the whole world, destroying national economies and widening the gap between rich and poor nations. The pandemic has brought challenges to the family in addition to the already existing ones like poverty, health risks and economic challenges.

The family is a significant social institution in every society. Despite its significance there exists no universal consensus on the definition of the family. The term denotes different meaning to different persons depending on the context and purpose for which it is being used. The definition of the family is also culture and time specific and in some cases linked to modes of social organisation. One of the widely accepted definitions is that given by Murdock (WLSA, 1997:np) who proposes that a family is a “social group characterised by common residence, economic cooperation and reproduction. It included adults of both sexes, at least two of whom maintain a socially approved sexual relationship and one or more children of their own or adopted by the sexually cohabiting adults”. The family has also been defined as “a set of people related by blood, marriage (or some other agreed-upon relationship) or adoption that share the primary responsibility of reproduction, caring for members of society” (Schaefer and Lamm, 1995:361). The family as defined by Kerven (1980) seems to capture the essence of the family taking into consideration the culture aspect as well as the social organisation. The author describes the family as a “socially recognised group of people related by ties of blood or marriage who recognise mutual and explicit rights and duties towards each other; who contribute their labour, income, and capital to each other and/or to the group; and who may participate in decisions on familial, social, or economic matters pertaining to the group” (Kerven, 1980:235).

As a social institution, the family performs several functions for society that include reproduction, protection and socialization; regulation of sexual behavior; companionship; provision of social status; emotional, social and economic support; and social security for all its members (Adepoju, 1997; Adepoju and Mbugua, 1997; Schaefer and Lamm, 1995). The traditional family also served a legal function. It formulated and enforced laws, settled disputes within the family and represented the family’s interests within the community (Armstrong, 1997). The tremendous transformations in the modern family due to economic and social restructuring taking place globally, however, act to undermine its capacity to perform these functions effectively. Even though the family has experienced certain fundamental socio-cultural and economic changes, nothing has changed the nature and role of the family like HIV/AIDS. The traditional African extended families have always provided material needs and social security for elderly people, disabled persons, widowed women and orphans. The advent of the HIV/AIDS pandemic is making it difficult for family system to continue providing for its needy family members because it has become emotionally, and financially overstretched (Ntozi, 1997).

This paper acknowledges the fact that the family is under siege as a result of the epidemic and discusses some of the challenges that are facing the family as a result of the pandemic. It extends the argument by proposing that it is necessary to equip the family with coping strategies to deal with the pandemic. There is a need for effective social policies and programs that will provide necessary assistance to the family in order to deal with the pandemic more effectively. There is no denying that most governments and other development agencies have come up with policies and programmes that deal with the pandemic but they do not necessarily target the family.

## **An Overview Of The HIV/AIDS Situation In Sub-Saharan Africa**

The HIV/AIDS has affected nearly all countries of the world but the prevalence or scale of infection varies widely both between and within countries. It is now one of the leading causes of death in Africa and the fourth most common cause of death world wide. By the end of 2005, over 38 million people were living with HIV/AIDS and since 1981 over 20 million first cases of AIDS had been identified (UNAIDS, 2004). Developing countries are most affected by the pandemic: in 2004 it was estimated that 90 percent of people living with the virus that causes AIDS were found in developing countries. Out of the 5 million newly infected cases in 2003, more than 95 percent occurred in developing countries (UNAIDS, 2004). The number of those infected continued to grow even further as infection rates continued to rise in countries where poverty, poor health care systems and limited resources for prevention and care fueled the spread of the virus (UNAIDS, 2004). Most HIV infections are acquired through heterosexual sex, but the infections can also be linked to other modes of transmission such as intravenous drug use, transfusion of contaminated blood and through mother to child transmission during pregnancy.

Variations in infection levels have been observed between the different regions of the world; between urban and rural areas within countries and between men and women. It is the leading cause of death in Sub-Saharan Africa and a threat to the region's development. In 2004, the Sub-Saharan Africa region was home to over 10 percent of the world's population, yet it constituted two-thirds of all people living with HIV which was estimated to be 25 million people (UNAIDS, 2004). The region is characterized by variations in HIV prevalence, with some countries displaying disparities between urban and rural areas whilst others are showing stable HIV prevalence. A great majority of HIV infected people are women and hence the 'feminization' of the epidemic which is most apparent in Sub-Saharan Africa where 57 percent of adults infected are women, and 75 percent of young people infected are girls (UNAIDS, 2004). Although Sub-Saharan Africa has the highest number of infected people in the world, some parts of East and Central Africa show a decline in HIV infections. Prevalence in West Africa has remained relatively low with the Sahel region experiencing a HIV prevalence rate of 1 percent (UNAIDS, 2004). Southern Africa was the hardest hit region with an estimated 4.1 million people infected with HIV at the end of 2005 and with those aged between 15 and 24 years old accounting for half of all new HIV infections worldwide (UNAIDS, 2006).

Recent global estimates show that the rate of infection is now stabilizing due to effective prevention, treatment and care programmes, but the scale of the epidemic means that its impact is still being felt and will continue for many generations (UNAIDS, 2008). The rate of new infections has fallen in several countries but these favourable trends are outweighed

by increases in other countries. Sub-Saharan Africa accounts for 67 percent of all people living with HIV and for 75 percent of AIDS death in 2007 (UNAIDS, 2008). Within the Sub-Saharan Africa, Southern African is the most affected region, accounting for 35 percent of HIV infections and 38 percent of AIDS cases in 2007. HIV/AIDS continues to pose a greater risk to women than men. Women account for half of the population living with HIV worldwide and nearly 60 percent of the HIV infections are found in Sub-Saharan Africa. This high incidence of HIV/AIDS in Sub-Saharan Africa has also resulted in an increase in the number of vulnerable children. The majority of the AIDS orphaned children worldwide are in Sub-Saharan Africa.

## **Challenges Facing The Family In The Era Of HIV /AIDS**

The family today is confronted with unprecedented challenges that undermine its function. These include the rise of single-headed households, poverty, alcohol abuse, the abuse of women and children, unemployment and disease, particularly HIV/AIDS. HIV not only infects the individual but also affects the various institutions to which they belong. The family is one such institution and probably the worst affected by the HIV/AIDS pandemic. In Sub-Saharan Africa AIDS is considered to be a family disease (LeBeau and Mufune, 2003; Jacques, 1999). The pandemic has had far reaching consequences on the African family system, which is characterized by extended networks and a far-reaching family support structure. The AIDS pandemic has altered the structure of the extended family significantly. In severely affected areas the composition of families and thus communities is changing at an alarming rate as growing numbers of adults fall ill and die, leaving the young and elderly to cope alone. The HIV/AIDS pandemic is mainly concentrated in the most economically productive segment of the population: 15-49 years old. Deaths in this group lead to the death of a productive household member, which results in loss of income and productive capacity as well as increased costs and changing expenditure patterns. In turn it affects the structure of the family as evidenced by the rising number of child headed households.

Women are also greatly affected by the HIV/AIDS pandemic: young women have higher levels of HIV infection than young men (Lesetedi, 2005). Of particular concern are issues of rising levels of violence against women and higher levels of poverty amongst women than men. Female-headed households have more dependants, fewer income earners and take on more of the care for the sick than male-headed ones. Women's vulnerability to violence and their dependency on men can be attributed to social, economic, cultural and political factors and the situation is further compounded by HIV/AIDS (Wodi, 2005). The social, psychological and economic repercussions of the disease are very pronounced on the individual as well as the whole family. The impact of the virus is felt right from its transmission and through its progression, and the stigma attached to HIV/AIDS can seriously affect the entire family.

### ***Vulnerability to Poverty***

A concept closely related to family is the household, and at times it is difficult to make a distinction between the two. While family refers to a biosocial unit, the household on the other hand is primarily a socio-economic unit (WLSA, 1997). The family is responsible for activities mainly related to reproduction and socialisation, whereas activities to do with production, distribution and consumption take place in the household. In terms of relationships, the family would consist of one or more members who are related to each other, while a household may be comprised of one or more separate families (WLSA, 1997). Most research is conducted on the household and therefore requires re-interpretation to

conduct further analysis on the data to understand the dynamics within a family. In recent years households have also had to cope with the growing burden of HIV/AIDS.

This has put intolerable strain on families who are already struggling to cope (LeBeau and Mufune, 2003). Family members caring for the sick at home lose time at work or looking for work. Poor families end up using whatever savings they have and are unable to put continue saving for the future. In addition the family has to bear the cost of medical expenses to treat opportunistic infections, and in the eventuality of death there is an added expense of funerals. This is more than many poor households can manage. The decreased income and increased costs affect the ability of the household to cope.

The economic impact of an AIDS death is larger on poorer households. Studies reveal that households experiencing an adult death draw on assets to cushion the shock of such an event. It follows that households with lower levels of assets will have more difficulty in coping with an adult death (Cohen, 1992). Although studies (Ntozi, 1997; Ankrah, 1993; Cohen, 1992) indicate that households do employ coping mechanisms to overcome prime age adult deaths, they also show that households are generally worse off after the loss of a productive member. The impact of an adult death on poorer households is most starkly illustrated by changes in food expenditure and food consumption. However, this is not to say that HIV infection is only confined to the poorest even though the poor account absolutely for most of those infected in Africa (Cohen, 1992). The capacity of individuals and households to cope with HIV and AIDS largely depends on both their human and financial status. Poor families have less capacity to deal with the effects of morbidity and mortality than do richer ones. They do not have savings and other assets that can lessen the burden of the impact of illness and death. The poor are already incapacitated by poverty and therefore unable to deal with the ensuing health and other costs as a result of illness and death. These include the costs of drugs to treat opportunistic infections, transport costs to health centres, reduced household productivity through illness and diversion of labour to caring roles, losses of employment through illness and funeral and related costs, and so on. In the longer term poor households find it difficult to get back on their feet as their situation is further worsened through the dying of productive family members and through the sales of any productive assets in order to alleviate the crisis.

### *The Status of Women*

The low economic status of women in many developing nations renders them more vulnerable to HIV infection. Although poverty affects everyone in these countries, women tend to be more disadvantaged (Tembo, 2001). On average, relative to men, women have fewer economic options, own much less than half the world's property, and earn much less than half of global income. They also dominate the categories of the unemployed and low-income earners. Furthermore, there are fewer women than men in higher paid jobs and there are more women than men in lower paid jobs (Tembo, 2001). According to Tembo (2001) low education standards among women results in them occupying low paying jobs. Despite positive action by the government, fewer girls receive a full education than do boys. The low economic status of women undermines their capacity to control their sexual encounters and relationships. Whether or not they are aware of it, poverty, unemployment, and poor pay often lure or force women into high-risk short-term or long-term sexual relationships that place them and their partners at risk of HIV transmission. For instance, these conditions may expose them to unsafe sexual practices such as forced

and unprotected sex, wife inheritance and commercial sex work which would make them more vulnerable to getting infected with the virus. When infected, women are slow to go to medical facilities seek medical treatment as they often consider the needs of their family members first before their own (Bury, 1994).

HIV/AIDS was initially perceived as a health problem requiring a medical solution; over the years HIV/AIDS has emerged to become a multifaceted problem with social, economic, political and legal dimensions. While the disease itself is a health issue, the epidemic has been elevated to a gender issue pertaining to women and inequity in society. The debate surrounding the spread of HIV/AIDS has depicted women not only as one of the most vulnerable groups in our society but also as being mainly responsible for its spread. This has resulted in the stigmatisation, discrimination against and (negative) stereotyping of women within the context of the epidemic which is tantamount to blaming the victim (Mukamaambo et al., 2001). At the heart of the stigma of AIDS lies shame - the perception that those with the virus have done something wrong. On the other hand, discrimination exists when those infected, or suspected to be infected, with HIV are singled out and handled differently or treated in an unequal manner relative to those who are not (Mukamaambo et al., 2001). Although both males and females may be victims of stigmatisation and discrimination, the consequences are more severe for women. Women risk being assaulted and even removed from the house once their status become public knowledge. This occurs even in cases where the women have been infected by their spouses (WHO/UNAIDS Joint Programme on HIV/AIDS, 1998). The rate of abandonment by spouses is also likely to be higher among women. Assaults and other forms of maltreatment or abuse of women who are infected with HIV/AIDS constitute a violation of some of their basic human rights.

Another major manifestation of HIV/AIDS on women is the caring responsibilities that they must shoulder in most societies. Overall, studies have clearly shown that women bear the brunt of the HIV/STD burden because of the multiple roles they play in the family as well as in society as a whole (Tembo, 2001; Lesetedi, 1999). The epidemic affects every aspect of women's lives whether they are infected themselves or other members of their family are infected. As mothers, women are the main formal and informal carers of the sick in society. Most societies rely on women to be voluntary caregivers for their families. Should any close member of the family fall sick, the responsibility for care rests with women. It should be noted that women's caring duties are in addition to other responsibilities that they have in the household; at times they combine the role of family care with that of breadwinners. The girl child also feels the impact of caring for the sick as more often than not, girls are the first to drop out of school to help with household duties and income generation in order to cope with the tasks of caring for siblings and ill parents (Lesetedi, 1999).

It is not uncommon for women to sacrifice their careers and for girl children to forgo their right to education to care for terminally ill patients (UNICEF, 2005). Even where care is institutionalised, the burden still falls on women as women usually assume greater responsibility than men for caring for the sick, at home or in hospital. In recognition of the fact that the health sector cannot cope with the rising numbers of the sick, governments in some countries have formally adopted the home-based care concept for AIDS patients. This is a well-intentioned programme that aims to alleviate the increasing congestion in hospitals caused by patients suffering from AIDS and other HIV related illnesses. The programme has shifted the burden of care to women who provide home based care; in almost all the cases

home care means woman care. The expectation of women to provide most of the care for people with HIV/AIDS, in addition to their usual tasks, results in high stress. Such stress is compounded when the women become ill themselves often with no one to care for them. Even though marriage could protect spouses from sexually transmitted diseases, this can only be true if both spouses enjoy equal power in their marital relationship. Compared to western countries, women in traditional African societies lack the power to deny sex to their spouses even when they can prove instances of marital infidelity in their relationship. In a study in Zimbabwe, it was noted that the majority of HIV-positive women were actually infected by their spouses (UNAIDS, 2003). Even more revealing is that in a survey of a group of rural women in Sierra Leone; one half actually believed that their spouses had a right to beat them. They also admitted that it is the woman's obligation to have sex with her spouse on demand even if she was not interested (UNAIDS, 2003). Females head most of the impoverished households in Sub-Saharan Africa (Cohen, 1992). In the face of increasing needs, these women would likely engage in transactional sexual activities either occasionally or as professional commercial sex workers, thereby promoting a vicious cycle in the spread of HIV/AIDS.

### **Orphans**

The increasing number of orphans is one of the major challenges that the family is facing as a result of the HIV/AIDS pandemic (Jacques, 1999). As AIDS mortality rises, the disease orphans growing numbers of children which exacerbates poverty and inequality. AIDS orphans face a unique set of severe problems. Very young orphans, whose mothers die of AIDS, have higher mortality rates than other orphans because approximately one third to one half of babies born to infected mothers are themselves infected with HIV through mother-to-child transmission.

Orphans are often stigmatized by society. The distress and social isolation experienced by them is made worse by the shame, fear and rejection that normally surrounds people affected by HIV/AIDS. Because of this, orphaned children may be denied access to schooling and health care (Jacques, 1999; Seeley et al., 1993). The death of a parent or adult may lower the nutritional status of surviving children by reducing household income and food expenditure, and by reducing adult attention to child rearing. The vulnerability of HIV/AIDS orphans in most cases starts well before the death of a parent or primary care giver (Jacques, 1999). Emotional suffering of the children usually begins with their parent's distress and progressive illness. Finally the impact of the loss causes a child's life to fall apart; he or she in most cases becomes destitute.

Children are often robbed of their childhoods in many ways by HIV/AIDS. It limits choices and opportunities for successful survival throughout their lives (Ankrah, 1993). Traditionally, children's rights have not featured very prominently within the family, the government or civil society at large. Children have little bargaining power as they occupy weak positions within the households. They face problems both during the illness of a prime age adult within the households, and after the death of the adult. Orphaned children are in many instances removed to the house of a relative, but there is evidence of growth in the number of child-headed households (Jacques, 1999 Ankrah, 1993; Seeley et al., 1993). The traditional system of extended family has helped to look after orphans but the affected households are now increasingly finding it difficult to cope with the unprecedented burden of the

disease (Ngwenya and Phaladze, 2007). Most of these children end up being cared for by grandmothers, who absorb much of the childrearing responsibilities.

While studies show that extended families and communities are currently willing to absorb orphaned children, it remains unknown whether families and communities will be able to provide assistance to the sheer numbers of orphans in the near future. Families are far more willing to care for orphans if some form of support, such as free education, free health care and food supplements, is offered. However, extended family structures are being eroded by urbanization and HIV/AIDS, and thus the efficiency of extended families as social support networks is also being undermined. The weakening of the extended family has resulted in child-headed households and these are more likely to be among the poorest, with older siblings having to leave school in order to take care of the household. Child-headed households tend to be the poorest for the simple reason that a child may not be ready (both physically and constitutionally) to work in order to earn a living. There is a gradual realisation that children have a role to play in their families, their schools and their communities. It is now recognised that young people, are as acutely affected by the pandemic as the adults.

### *Violence in the Family*

The family as a social institution is expected to offer protection and social security for all its family members. This is in addition to providing them with emotional, social and economic support (Adepoju and Mbugua, 1997; Schaefer and Lamm, 1995). However, family violence, which is rife in all communities and countries around the world, undermines this (United Nation, 1995). Domestic violence is committed against family members, or members of a shared household, or a person with whom there is an intimate relationship, such as a dating relationship. Although men may also be victims of this type of abuse it is almost exclusively something that happens to women and children. According to Watts et al. (1997), the few studies that have been conducted in Sub-Saharan Africa indicate that women experience alarming levels of violence primarily at the hands of their partners but also other family members. In Southern Africa, data shows that violence is a great problem and that woman, regardless of their race; class and geographical areas continue to suffer violence at the hands of spouses and partners (SADC, 1999). A national study conducted in Botswana showed that women in over half of the households surveyed reported having been subjected to gender-based violence at the hands of their husbands or intimate partners (Women's Affairs Department, 1999). Very few cases of women battering involved total strangers.

Violence is a key factor in intensifying women's risk in contracting HIV/AIDS. It increases their vulnerability to HIV infection and makes them less able to protect their health if they are positive. Certain forms of family violence are sexual in orientation and predispose women to HIV infection. Studies have shown that there is a link between gender-based violence or fear of violence and the spread of HIV. It limits women's control over their bodies and makes them more vulnerable to getting infected than men. The violence or the fear of violence prevents women from using safe sex practices and also accessing testing and counselling services. A cross-sectional study of 1366 women attending antenatal care conducted in South Africa, found that women who are beaten or dominated by their partners are 48 to 52 percent more likely to become infected with HIV, than those who do not face threats or violence in the home (Dunkle et al., 2004).

Studies have also found that cultural values support sexual violence in South Africa, while laws against rape often are not enforced. A study conducted by Community Information Empowerment and Transparency (CIET) Africa (cited in GENDER-AIDS, 2002) found for instance, the underlying cause of all rape is deeply rooted in cultural values that legitimise men's ready sexual access to and control over women, by women's accession to those values, and by a failure of law enforcement. In some countries such as Botswana, South Africa and Swaziland, where HIV/AIDS is prevalent, the sexual abuse of young girls, including babies, by older men is thought to be partly a consequence of what has come to be referred to as the 'virgin myth' or 'virgin cleansing'. This refers to the belief among men that raping a virgin will cure AIDS (Gender-AIDS, 2002).

## Discussions and Conclusion

Although the family has faced a lot of challenges, nothing can be compared to what it is undergoing as a result of the HIV/AIDS pandemic. The advent of the pandemic has had a devastating effect on the family and as a result is undergoing transformation in order to meet these challenges. Policies and programs have been introduced to provide necessary assistance to those living with HIV/AIDS in order to deal with the pandemic. These programmes are focused on raising the level of awareness, reducing the infection rates and providing treatment and care to those already affected and infected (Wodi, 2005). International organisations like International Monetary Fund, World Bank and World Health Organisation have designed several programs targeted at Sub-Saharan Africa. For instance the World Health Organization launched a programme aimed at providing anti-retroviral treatment to 3 million people living with HIV/AIDS in sub Saharan Africa by 2005 (Kanabus and Fredriksson-Bass, 2009).

At national level in some countries there have been early and sustained HIV prevention efforts bringing about a lot of changes. For example, the Senegalese government carried out effective HIV prevention campaigns. This has contributed to the country maintaining a relatively low adult HIV prevalence rate of 0.9%. It also through intensive HIV prevention campaigns that in Uganda, the widespread AIDS epidemic is under control (Kanabus and Fredriksson-Bass, 2009). The Botswana Government having recognised the gravity of the HIV/AIDS pandemic, formulated the National Policy on HIV/AIDS to deal with it. Under this policy, programmes such as testing service, counselling service, anti retroviral (ARV) drugs, the prevention of mother to child transmission (PMTCT) programme, food basket service, and the Home Based Care (HBC) programme have been implemented (Ministry of Health, 1996).

Despite all these interventions both at international and national level, the war against the pandemic is yet to be won. Most implemented interventions have not had the necessary impact, as they do not take into consideration the fact that the family is undergoing transformation. As stated previously, HIV/AIDS is a family disease and as such the family should to play a critical role, not only in the formulation but also in the implementation of these interventions. HBC was initiated as an essential response to the HIV/AIDS epidemic with a view to providing care to chronically ill persons within the home environment. Although the HBC programme is a good idea, it is faced with certain challenges that undermine its success. For instance, the programme is based on the idea that in Africa the extended family is traditionally the care-giving unit, without taking into account the impact

of the disease on the same family structure. However, the multiple challenges facing the family including: the breakdown of family values, declining extended family, divorce and poverty, are eroding its capacity to provide care and support. Also, there is a tendency for the health sector to delegate the full responsibility of caring for patients to the family and community. Traditionally, the family maybe the caring unit for ill people but this requires unlimited resources within the family to deal with an increasing number of ill people. Thus, for HBC to operate effectively it needs to be planned as a strategy in which all players acknowledge their responsibility. On the one hand, the quality of HBC is below the care given at hospitals but on the other hand, it is far superior from the point of view of emotional support and closer attention to the patient (Ministry of Health, Botswana, 1996).

Targeting the family rather than the nation or other broader units of intervention, is likely to result in greater effectiveness of programmes. Most of these interventions will have to be drawn from other institutions in society in order to assist the family in continuing to perform its functions and at the same time reducing the rate of HIV infections. However, the success of such interventions can be elevated to new heights through the adoption of a more micro-level unit of intervention, i.e. at the family level. In all this the family is supposed to take a leading role as it is recognized as a basic social unit with responsibility for providing for its members. During the formulation stage, programmes should take into consideration that the family is experiencing a lot of changes not only due to the HIV/AIDS pandemic but also as a result of the transformation that society is undergoing. The family is transforming itself and not dying in the wake of the HIV/AIDS pandemic and therefore it is necessary to empower it to deal with these challenges through effective policies and programmes. The family taking a central role in the formulation and implementation of these programmes will encourage a sense of ownership in the community. The members will participate fully and as a result the envisaged project will certainly have an impact and succeed. To ensure full involvement in the both the formulation and implementation of HIV/AIDS programmes there is need for continued research from both a medical and social perspective on the family as well as HIV/AIDS. It is also important that these studies focus on the legal and socio-cultural implications of the changing family forms as well as the changing face of the infected and affected. For instance, children typically occupy weak positions within the households, with little bargaining power but there is evidence of growth in the number of child-headed households and the law or society does not take cognizance of this fact. It is also necessary to identify the types of intervention required in consultation with the infected and affected and also review the needs of those in vulnerable positions.

To conclude, the family remains the most fundamental and basic social unit in society. Despite the many social and economic changes that it has undergone, the family still plays a significant role in the lives of its members, as it remains the dominant source of shelter and social support. Family life continues and the family as a social unit is certainly alive despite the apparent changes in the structure, organisation and some functions of the family. The pandemic has contributed significantly to the re-definition and reconstitution of the family from a traditional sense as well as in terms of its function. Due to the challenges imposed by the pandemic several aspects of family structure and functions are fundamentally affected. However, it should be acknowledged that the family is under siege from the HIV/AIDS pandemic and it is therefore necessary to research how to empower the family in order to deal with these challenges.

## References

- Adepoju, A. 1997. "Introduction." In A. Adepoju (ed.), *Family, Population and Development in Africa*, London: Zed Books.
- Adepoju, A. and Mbugua W. 1997. "The African Family: An Overview of Changing Forms." In A. Adepoju (ed.), *Family, Population and Development in Africa*, London: Zed Books.
- Ankrah, E.M. 1993. "The Impact of HIV/AIDS on the Family and Other Significant Relationships: the African Clan Revisited." *AIDS Care*. Vol 5. No.1. Pp 5-22.
- Armstrong, A. 1997. "Law and the Family in Southern Africa". In A. Adepoju (ed.), *Family, Population and Development in Africa*, London: Zed Books.
- Bury, J. 1994. 'A Women and HIV/AIDS: Medical Issues', in Lesley Doyal, Jennie Naidoo and Tamsin Wilton (eds), *AIDS: Setting a Feminist Agenda*. London: Taylor and Francis.
- Cohen, D. 1992. Poverty and HIV/AIDS in Sub-Saharan Africa  
<http://www.undp.org/hiv/publications/issues/english/issue27e.html>. Retrieved August, 2008.
- Dunkle, K.L., Jewkes, R., Brown, H.C., Gray, E.G., McIntyre, J.A. and Harlow, S. D. 2004. Gender Based Violence, Relationship Power, and Risk of HIV Infection in Women Attending Antenatal Clinics in South Africa. *The Lancet*. Volume 36, May 1, 200. [www.the.lancet.com](http://www.the.lancet.com). Retrieved September 2008.
- GENDER-AIDS (gender-aids@healthdev.net) (25 January 2002) Re: Summary of Discussion on Violence and HIV/AIDS. E-mail to G. N. Lesetedi(Lesetedi@mopipi.ub.bw)
- Jacques, G. 1999. "Orphans of the AIDS Pandemic: The Sub-Saharan Africa Experience" in Hope, K. R. (ed.) *AIDS and Development in Africa: A Social Science Perspective*, New York: Haworth Press, Inc.
- Kanabus, A. and Fredriksson-Bass, J. 2009. "HIV and AIDS in Africa". AVERTing – HIV and AIDS.[www.avert.org/aafrica.htm](http://www.avert.org/aafrica.htm). Retrieved February 2009.
- Kerven, C.1980. "Rural-Urban Interdependence and Agricultural Development" in Hitchcock R.R. and Smith M.R. (editors) *Proceedings of the Symposium on Settlement in Botswana: The Historical Development of a Human Landscape*, National Museum, Gaborone: Botswana Society. Pp234-244.
- Lebeau, D and Mufune, P. 2003. "The influence of Poverty on the Epidemiology of HIV/AIDS and its Subsequent Reinforcement of Poverty among Economically Marginalised Families in Northern Namibia".In M. Mulinge and P. Mufune (Eds.), *Debt Relief Initiatives and Poverty Alleviation: lessons from Africa*. Pretoria: The African Institute of South Africa.
- Lesetedi, G.N. 2005. "Rethinking Gender within the Context of the Global HIV/AIDS Epidemic". *A Journal of Transnational Women's and Gender Studies* Vol 2 (1), Summer 2005.

Lesetedi, G. N. 1999. "HIV/AIDS and the Status of Women in Botswana", in Hope, K. R. (ed.) *AIDS and Development in Africa: A Social Science Perspective*, New York: Haworth Press, Inc. Pp. 47-57.

Ministry of Health, Botswana. AIDS/STD Unit. 1996. Community Home-based Care for People Living with AIDS: Operational Guidelines (NACP 30). Gaborone: Government Printers.

Mukamaambo, E.P., Lesetedi, G.N. and Mulinge, M.M. 2001. A Situational Analysis of Stigma Associated with HIV/AIDS: A Pilot Study. Gaborone: AIDS/STD Unit, Ministry of Health.

Ngwenya, B.N. and Phaladze, N.A. 2007. "Access to Support and Human Rights – Challenges for Older Carers of Orphaned Children in Botswana". In G. Jacques, G.N. Lesetedi and KwakuOsei-Hwedie (Eds.). *Human Rights and Social Development in Southern Africa*. Gaborone: Bay Publishing.

Ntozi, J.P.M.1997. "AIDS Morbidity and the Role of the Family in Patient Care in Uganda". *Health Transition Review*, Supplement to Volume 7: 1-22.

SADC. 1999. SADC Gender Monitor: Monitoring Implementation of the Beijing Commitments by the SADC Member States. Gaborone: SADC Gender Unit.

Schaefer, R.T. and Lamm, R. P. 1995. *Sociology*. New York: McGraw-Hill, Inc.

Seeley, J., Kajura, E., Bachengana, C., Okongo, M., Wagner, U., and Mulder, D.1999. "The Extended family and Support for People with AIDS in a Rural Population in South West Uganda: A Safety Net with Holes?" *AIDS Care*. Vol 5. No.1 1993. Pp 117-122.

Tembo, G. 2001."An Overview of the Epidemiology of HIV" *Southern African Political and Economic Monthly*. Volume 14. No.7, Pp7-9.

UNAIDS.2008. Report on the Global AIDS Epidemic. UNAIDS: Geneva [http://www.unaids.org/pub/Global\\_Report/2008](http://www.unaids.org/pub/Global_Report/2008). Retrieved August, 2008.

UNAIDS. 2006. AIDS Epidemic Update. December 2006. UNAIDS: Geneva <http://www.unaids.org/en/HIV-data/epi2006> Retrieved August, 2008.

UNAIDS. 2004. AID Epidemic Update. UNAIDS: Geneva <http://www.unaids.org/bangkok2004>. Retrieved August, 2008.

UNAIDS. 2003. Global Estimates of the HIV/AIDS Epidemic as of End 2003. UNAIDS: Geneva.

United Nations. 1995. 1994 International Year of the Family. New York United Nations.

Watts, C.H., Ndlovu, M., Njovana E., Keogh, E .1997."Women, Violence and HIV/AIDS in Zimbabwe" *SAfAIDS News*, Vol. 5. Pp2-6.

Wodi, B. 2005. Re-evaluating Socioeconomic Conditions and the Continuing Spread of HIV/AIDS in Sub-Saharan Africa. *The Western Journal of Black Studies*, Vol. 29.

Wodi, B.E. 2005 "Gender Issues in HIV/AIDS Epidemiology in Sub-Saharan Africa" in *A Journal of Transnational Women's and Gender Studies* Vol 2 (1), Summer 2005.

Women's Affairs Department (1999) Socio-Economic Implications of Violence Against Women in Botswana. Gaborone: Women's Affairs Department, Ministry of Labour and Home Affairs Women and Law in Southern Africa Research Trust, Botswana. 1997. Botswana Families and Women's Rights in a Changing Environment. WLSA, Gaborone.

Women and Law in Southern Africa Research Trust, Botswana (WLSA). 1997. Botswana Families and Women's Rights in a Changing Environment. WLSA, Gaborone.

World Health Organisation/UNAIDS Joint Programme on HIV/AIDS. 1998. AIDS Epidemic Update. Geneva: World Health Organisation/UNAIDS Joint Programme on HIV/AIDS.

## Transition to Form Four: The Most Critical Time in the Pastoral Care of Learners

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### Abstract

*The transition to form 4 is the most challenging period in the school's pastoral care system. It is at this time that adolescents are under immense pressure to assume their freedom, yet often still too immature to differentiate right from wrong. This paper presents a case study of Matshwenyego, a form four student, who went through turmoil since the time she dropped her pen in her last JC examination in November, until she got admitted to form 4 in February. In the four months while waiting to proceed to form four, Matshwenyego changed boy friends at least twice, is raped twice, infected with HIV/AIDS and ultimately commits suicide in her fourth month in senior school. The paper uses the case of Matshwenyego to analyse problems experienced by orphans and vulnerable children at secondary schools and suggests strategies schools can use to reduce the pains suffered by Matshwenyego and her friends.*

## The Story

This is a refined true story of a 17 year old senior secondary student in one of the schools in Botswana. Matswhwenyego (not her true name) found no ear to listen to her life encounters and decided to write them down on a journal, which she left for us to study and reflect on.

### I will never trust a man

It was during the school vacation after our Junior Certificate Examination, when I met one of the worst calamities a woman can encounter and since then I have totally lost trust in the creature called man.

I had decided to take a break from the usual environment by visiting my uncle at Borolong. I woke up very late on the fateful day as my uncle had gone to Gaborone. I was alone with the tenants and squatters. To while time I decided to walk to my uncle's friend in the neighbourhood to borrow some dvds. The guy was very close to my uncle and so I regarded him as an uncle too. I found him playing music loudly and he could not hear me knocking until I walked in. I told him the reason I was there and he invited me into his bedroom to make my choice. While I was still searching for what to pick, he came in and closed the door behind him, then he started touching me all over, even down to my private parts. He begged me to have sex with him, as he was "stiff and hard". I told him I cannot do such an abomination with a man of his age and a trusted friend of my uncle for that matter. He was not prepared to listen to my protest and reasoning and so he pushed me down on his bed and forced himself onto me. When he was done he told me that I should never say anything to anybody about what happened. I complied and to date I never said a thing to anyone. I was however very bitter and felt like avenging onto any man I meet by sleeping with him without protection so that I could infect them with the HIV I got from that man.

### They Charm with Sweet Words and Presents

Two months later I met yet another calamity of the same nature. While still waiting for the results I was dated by a certain guy I met in town. The man could not stop telling me how beautiful, charming, elegant and jolly I was and that he would like to spent the rest of his life with me. After the date we went to his residence, where he continued to tell me how pleasing it was for him to have me in his life. We shared about our life experiences, kissed and touched each other affectionately. Late in the afternoon I asked to be excused to leave, but he told me that I cannot leave him just like that. I asked him what he wanted and he told me that I knew exactly what he wanted. I told him that if he was serious about me he would wait, because love is not all about sex. He told me that I was not serious. He then stood up and locked the door. I pleaded with him to open and let me go and he put it blatantly to me that he will not allow me to go before I proved that I really loved him. He then grabbed me, pushed me on the bed and began to undress me. I tried to shout for help but there was no one who came to my rescue. When he finished, he told me I should never dare tell anyone about what happened, not even about meeting him and that if he hears anything he would kill me and my whole family. Like in the first incident I kept it to myself.

### *My Pleasant Surprise!*

The results finally came and I was one of the lucky ones to be admitted to a senior secondary school. Just as I entered the school, I cast out my eyes and I had the happiest surprises of my life. Right there in front of me was my long lost boyfriend! I pinched myself to check if I was still awake or dreaming. It all turned out to be true; it was Sello, there in person! For two years we hadn't met nor talked. I said to myself what a pleasant surprise! We hugged and exchanged greetings, all relished with smiles. He asked me how I could have dumped him just like that and I told him that he was never there for me when I needed him most.

Two weeks later he visited and we exchanged numbers and he promised to call me as soon as we closed. On the closing date he called and asked me to meet him somewhere in town. I lied that I did not have bus fare but he insisted and said he will come and pick me up in the morning. Indeed he came and we went together to his place. We had a pleasant, private chat and you know! One thing led to another. He told me where he was throughout and I also told him that while he was away I found someone I fell in love with. He understood and told me that I will finally have to make a decision about who is serious amongst them.

### *Joe, the Joy of my Heart*

The guy I told Sello about was none other than Joe, the joy of my heart. I have always wondered how lucky I was to have met such a cute, cool, humble, kind, respectful and caring person like him. Indeed Joe was a man about town. I always wondered whether I was of the right type for Joe! I mean, when I looked at my attitude, my behaviour and style, I realised that we were very different. Sometimes I felt like breaking with him so as not to hurt him. However I feared that I might break his heart if I left him. So I decided to keep him no matter what people thought of us. In any case we knew each other for a long time before we fell in love.

I started dating Joe at the end of November, during school vacation. We knew each other well then, in fact we were friends and so I was initially reluctant to accept his proposal. He told me that he loved me from the moment he set his eyes on me and that he had loved me all along. I kept our love a secret until my aunt came to know about it and she in turn told my mother. Once my parents came to know about it I felt that there was no way back and since then we have been together. However it was not all roses as we once had a misunderstanding. I was at fault and I apologised and he accepted my apologies. All I can say is that Joe is my future husband and I am his wife no matter what!

### *In the End it was the End*

Matshwenyego started bunking school on the second term. Just before the school could contact the parents as to her whereabouts; they came to report that she had committed suicide. She left no message, but it was after her parent rebuked her for sleeping out (suspected to have been with one of the boyfriends). She locked herself in the room and swallowed her parent's ARV medication, and maybe for lack of quick results, she got a rope and hanged herself on the rafters of the house.

## A lesson from Matshwenyego's story

The common response we get when sharing such stories with colleagues at junior secondary schools has been, "what has this got to do with us? Didn't we enable her to pass and go to senior school? Did this not happen during the school holidays? Were her parents not aware of her string of boyfriends? And did she not commit suicide in their own home using their own medication and rope?" Those at senior secondary respond that the child was still not in their books at the time and that they could not have done anything since they did not know her background. Our response is: as long as we are educators it has got everything to do with us, because education is supposed to be about empowerment and empowerment brings change.

### *Is there anything the Teachers could have done?*

- Junior secondary school teachers should have relayed any information they learned about Matshwenyego to senior secondary school teachers
- Completing students should be psychologically empowered to face the challenges outside of school
- Senior secondary school teachers should have been able to identify signs of abuse and neglect in Matshwenyego. Such children sometimes divulge pertinent information in their compositions, letters or journals. They also show signs of withdrawal, aggression, concentration difficulty, irregular attendance of school or certain lessons, etc.
- They should have acted immediately to find out where Matshwenyego was from her parents when they started realising that she had not reported for second term
- They could have been able to pick something up had the school required the parent and student to provide information about medical and psychosocial background

### *Is there anything the Parents could have done?*

Children's Act of 2009 stipulates that caring for and supporting a child is the primary responsibility of the child's parents. Although death is beyond human comprehension and power, perhaps Matshwenyego's parents could have averted her death if they could have acted on the following areas:

- Provided the child with parental guidance and direction when they realised that she was engaged in love relations, especially when they realised that it was multiple concurrent partners
- Sought for advice from other family members, teachers, social workers or other community members and followed the advice in the interest of the child
- Been alert to signs of abuse and waywardness in their child's behaviour and made teachers aware of it
- Informed teachers when they realised that she has started bunking school
- Disciplining her with care and dignity by checking on the emotional and psychological impact of their rebuke
- Opening communication channels between the child and themselves to enable her to divulge the pains and hurts in their hearts
- Monitored her movements and actions especially during idle times
- The mother could have disclosed her status to her children and opened good communication about HIV within the family to enable them to accept and cope with it

## *Is there anything the community could have done?*

Neighbours and acquaintances may have noticed Matshwenyego's wayward behaviour.

- Reporting to the parents, school or village authorities when they started seeing her in the village at the opening of school
- Reporting to social workers, teachers, local authorities when they started seeing her in male company at awkward times.

It is important to note Matshwenyego's plight is not isolated. Many orphans and vulnerable children of her calibre face huge challenges in Botswana schools.

## **Problems faced by Orphans and Vulnerable Children in Botswana**

An estimated 130 000 children have lost both or one parent in Botswana due to the HIV/AIDS scourge. However there are countless others who still have at least one parent but are struggling due to poverty, child headed families, sick parents, living with disability or HIV/AIDS, neglect or abuse which leads them to deplorable conditions, injuring their welfare, esteem, and hope for the future (USAID, 2010). Such children are referred to as vulnerable.

Studies by Petso (2005), Muchiru (1998), Ministry of Local Government (2010) show that OVCs face numerous problems in life, some of which are:

- Financial pressure on the family which may ultimately lead to children dropping out of school to fend for themselves
- OVCs are at great risk of abuse and exploitation. The girl child especially is often forced into commercial sex to provide for her and siblings. Such acts usually expose them to sexually transmitted diseases, including HIV
- OVCs also suffer human rights abuses such as arranged marriages or relationships, forced labour, denial of education and denial of government packages
- It is not uncommon for OVCs to be raped by relatives, such as cousins, uncles, and friends who they take as their caregivers
- OVCs are exposed to severe social, psychological, and economic stress. They often live in an environment where sickness and diseases are highly visible. OVCs who are HIV+, suffer great stigma and discrimination. Stigmatisation and discrimination often reduce OVC future opportunities
- To share the burden of raising OVCs, they are often divided among family members. The result is often traumatic for children who have grown together and used to support each other.

Matshwenyego's plight should be seen from this background. Although she had one life parent, that parent was sick and already on ARVs, she was unemployed and not able to provide for the family. The family, being female headed, made children more prone to abuse, even the security of the uncles was not enough to stop exploitation. The traumatic effects of living in a virus infested place and being infected made her see life as a short ride, which must be enjoyed then. Long term endeavours such as going to schools did not matter to her, because she was going to die soon anyway. This attitude was a time bomb, not only to explode on her face, but the faces of those she was connected to. One can imagine the number of men she infected with the virus, the trauma she caused her parents, relatives and friends, the inconveniences caused to the school, etc.

Matshwenyego's predicament became heightened after writing her junior certificate examination. This was due to the lack of preparation in assuming freedom with responsibility. Children tend to consider themselves as 'seniors' ready to enjoy what the adults enjoy without proper preparation for it. Her plight therefore becomes partly the teachers and they need to reflect on what they could have done to avert the situation.

## OVC Care In Schools

Schools in Botswana have come up with a numbers of strategies to address OVC problems, some of which are:

- All schools have a pastoral system headed by Head of Department and Senior Teachers 1 for Guidance and Counselling (G&C) who are exempted from teaching so as to concentrate on pastoral issues. Officers here are supposed to assist students experiencing grief and pain by sharing their feelings with them. One strategy is for teacher counsellors to identify grieving students through constant monitoring of students who show signs of withdrawal from their peers (Petso, 2005). However such teachers are thin on the ground and are not able to reach all students
- All schools have timetabled G&C in the school curriculum, but most lessons are used as free lessons as most teachers are not trained to handle it and many do not have the interest to teach it. The school management is incapacitated to enforce it as it is said to be an optional enrichment subject (Kalanke, 2007)
- A study by Petso (2005) show that all teachers agree that it is their responsibility to mould the whole child educationally, psychologically and socially, however very little is done as teachers are always pressed to finish their own syllabus. Resources to do home visits are usually not available and thus students who bunk school are usually not monitored
- Teachers' capacity to handle issues surrounding HIV/AIDS is enhanced through a 'Talk Back' TV programme, which is aimed at breaking the silence associated with HIV/AIDS (Petso, 2005). However the programme is broadcast during normal school hours when students and teachers are busy in the teaching and learning process. Most schools do not have TV sets or common rooms where they can be watched. Most teachers have shown no interest to watch the programme where it is available
- Some schools have a number of clubs under the Guidance and Counselling Department to try to address OVC issues. Some of the clubs are HIV/AIDS Awareness, Inner Self Confidence, Peer Approach to Counselling by Teenagers, Anti Pregnancy, etc. A peep in some schools shows that these are there by name and no activities to show (Kalanke, 2007). The morale of teachers is so low that they are no longer interested in doing out of the class work
- A few senior secondary schools have an OVC programme which identify students' background as they register. However the register leaves out a lot of details about the students' background information. Some schools have given up on such programmes because the G&C department is overstretched with very little support from management during registration. Some students are also not interested in disclosing important information about themselves
- Though not necessarily specific to OVCs, the government's free feeding scheme, free school and the established policy of schooling has gone a long way in retaining most OVCs in schools

What this therefore means is that students like Matshwenyego see the finishing of their examination as a finishing of a prison sentence. They take completion as victory that must be celebrated yet they are not aware of their lack of capacity to celebrate it. She is also missed at senior secondary because there is no system in place to identify her or where it is available, it is driven by over stretched and discontent teachers.

## Recommendations

For Matshwenyego's kind of calamity to be reduced from schools, a number of initiatives need to be put in place, some of which are:

- All teachers need to have basic training for G&C to be able to teach and counsel students with psychosocial problems. An informed teacher can go a long way in empowering OVCs.
- G&C teachers' positions reflected in the establishment register should be filled as most schools still operate with only senior Teacher 1
- The ministry should speed the formulation of OVC policy in schools, as the current intervention programmes for OVC is fragmented and lacking in comprehensive approach
- Schools should come up with strategies of identifying OVC as they register so that intervention mechanisms could be established to assist them. Such interventions should cover students' medical care, socio-economic support, psychological support, human rights and legal rights
- Intervention should include strengthening families and communities to provide them with skills they can use to handle OVCs. This therefore calls for regular visits to the children's homes for support
- To enable home visits, schools should work with Parents Teachers Associations (PTAs) to establish a trust fund solely devoted to OVCs
- Senior secondary schools should establish contacts with their feeder schools to strike a common ground on assistance of OVCs. Students files from JC should be passed to senior schools and students needing special attention should be made known to the guidance office
- All teachers should show that they care and demonstrate their care by words and action. Volunteering to serve as advisors to the clubs like PACT and actually attending to after school activities can go a long way in showing children that they are important part of the community
- Teachers should take their work as a calling and not just as a means to make a living. Teaching should be considered as a way of establishing and maintaining a caring environment. In other words teachers should want to see their students progressing just as they would their own biological children
- The government should hasten to resolve teachers' grievances such as hours of work, accommodation, progression, transfer, remuneration, among others, as these demoralise teachers and take their attention from their core business

## Conclusion

Transition to form 4 is indeed the most challenging period for our pastoral system in that the students are stranded between two secondary schools. To most students that is freedom,

and to the 'hawks' out there, it is an opportunity to make a picking. Junior and senior secondary schools should therefore collaborate to avert the adverse effects of this transition. Schools have a key role in performing in promoting attitudes and imparting knowledge and skills that can encourage children to behave in such a way that will minimise the risks of HIV and STD infection, rape, multiple concurrent partners, etc. However schools cannot succeed in this role unless teachers are motivated to perform.

## References

Bennell P., Chilisa B., Hyde K., Makgothi A., Molobe E., Mpotokwane L. (2001). The impact of HIV/AIDS on primary and secondary education in Botswana: Developing comprehensive strategic response, Government printers, Gaborone.

Kalanke K. (2001). Influence of stigma and discrimination on coping strategies of people with HIV/AIDS in Botswana: A case of COCEPWA and BONEPWA. A project submitted in partial fulfilment of requirement of degree of Masters of Arts in Development Studies, University of Botswana, Gaborone.

Kalanke K. (2007). The role of leadership in the control of HIV/AIDS in Botswana secondary school. A project submitted in partial fulfilment of requirement of degree of Master of Science in Strategic Management, University of Derby.

Ministry of Local Government, Department of Social Services (2010). User-friendly guide to the care of orphans and vulnerable children.

Muchiru S.M. (1998). The rapid assessment on the situation of orphans in Botswana. Oakwood management and development consultants, Gaborone.

Petso, M.P. (2001). Teachers care of orphans in secondary school: The case of government senior secondary schools in Gaborone, Botswana. A project submitted in partial fulfilment of requirement of degree of masters of Arts in Master of Education, University of Botswana, Gaborone.

Sullivan, A.M. Pursuit of goals in partnership: empowerment in practice. <http://www.empoweringlives.org>.

USAID. (2010). Health policy initiative- assessing implementation of Botswana program for orphans and vulnerable children.

## Addressing Gender Roles and Power Inequalities in Gender Relations: An Essential to Sustainable Reduction in the Prevalence of HIV/AIDS.

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### Abstract

*The HIV and AIDS epidemic is both fuelled by and exacerbates gender inequality. Addressing gender roles and power inequalities in gender relations should therefore be an integral part of HIV prevention programmes in sub-Saharan Africa. It is argued that in this context, interventions involving male participation and adolescent girls will have the highest impact. Adolescent girls are particularly vulnerable due to economic dependency on men for survival strategies (transactional sex), but also due to intergenerational sex work, early marriage and in conflict situations. Much of what constitutes male gender roles in many cultures has given rise to a construct of masculinity that lies at the heart of the problem. It is evident that risky behaviour must be addressed by offering men models of masculinity that are not based on unequal power relations. It is important that interventions do not focus on the irresponsible image of male sexuality and the powerlessness of women but rather encourage constructive roles for men in sexual and reproductive health and redefining gender norms. Programmes such as Stepping Stones offer a participatory and broad based approach to working with communities by focussing on relationship skills.*

## Introduction

The key drivers of the (HIV) pandemic continue to be poverty, gender inequality, injustice and stigma. Women are disproportionately affected by all these factors: they are physically, economically and socially more vulnerable to infection (Concern, 2011). It has become a recognised fact that the HIV and AIDS epidemic is both fuelled by and exacerbates gender inequality. Addressing gender roles and power inequalities in gender relations should therefore be an integral part of HIV prevention programmes.

Although gender considerations are essential to stemming the spread of HIV, the achievement of a sustainable reduction in the prevalence of HIV and AIDS will require the success of all current interventions. Holden points out that in order for a reduction in the prevalence of HIV to take place “the 42 million people now infected would need to live and die without passing HIV onto anyone else ... everyday another 15000 people unknowingly become infected” (2003, p.24). She notes that in sub-Saharan Africa (SSA), it has become endemic, an on going and entrenched problem which is why development agencies must “confront the long-term challenges of containing and coping with HIV infection and the impacts of AIDS, within their broader agenda of working for a more equitable world” (ibid).

If a reduction in the prevalence of HIV is achieved, addressing power inequalities in gender relations is the fundamental criteria. This discourse will focus on exploring why addressing power inequalities and gender roles is crucial to the fight against HIV infection in the context of SSA and conclude; that interventions involving male participation and adolescent girls will have the highest impact.

## Adolescent Girls

The UK Consortium on AIDS and International Development states that in SSA 59% of adults living with HIV are women and that “young women make up 75% of HIV positive 15-25 year old in the region, mostly transmitted through sex with HIV positive men” (2008, p.1). They claim that this is due to economic dependency of women and girls on men for survival strategies but also intergenerational sex work and early marriage, often in conditions of poverty. Holden (2003) highlights further reasons as to why women are more vulnerable to HIV infection, the physical fact that women’s genitals have a greater surface area of mucous membrane through which HIV can enter. Younger women are at greater risk due to a thinner mucous membrane.

## Power Inequalities

Power inequalities in gender relations are heightened for younger women, especially in conflict areas. They are more likely than men to be subject to rape and sexual violence and to “resort to their one portable asset - their bodies - in order that they and their dependants may survive” (Holden, 2003, p.28). Violent sexual practices are also more likely to cause injuries which increase the likelihood of HIV transmission. Because in situations of poverty sex is often connected to some form of exchange, it is probable that a girl’s sexual partner will be older than her, older men more likely to have something that they need. According to Holden “Age gap compounds the gender imbalance of power within the relationship, making it very difficult for the girl to influence sexual decision making” (2003, p.33). An older man is also more likely to be infected with HIV as he will have been sexually active for longer and the power difference will make it harder for the girl to negotiate protection and fidelity if in a relationship.

A 2009 study of how to target adolescent girls in HIV interventions using the PLACE method in the Hwange district of Zimbabwe found that the priorities for HIV control methodology were to identify where the girls in the 15-19 age group socialised and also “to understand whether age disparate relationships were a common occurrence” (Singh et al, 2009, p.200). They found that the girls with the riskiest behaviour were found at venues affiliated with alcohol and that “reporting of partners 5 years older or more was common across the age group and venues” (ibid). They found that in the 15-19 age group who reported that their first partner was 10+ years older had a HIV prevalence of 23% compared to 16% for other women. It was found that sex workers mostly engaged in sex with older partners and that “older partners often became violent with the suggestion of condom use or if sex was refused” (Singh et al, 2009, p.201). Individuals who consumed alcohol had between 57 to 70% greater risk of becoming HIV positive (ibid).

The study found that using the PLACE methodology, targeting places where HIV transmission contacts were initiated, was an effective way to focus prevention resources. It established that 92% of 15-19 year old were found at ‘everyday’ sites and different interventions need to be designed with different aims, ones to target the most adolescents and others to target those with the riskiest behaviour. The PLACE study recommended using information spreading at everyday sites and condom distribution at the riskier venues.

### **Gender Roles**

The gender roles of females as child bearers and care givers are of great significance in interventions aimed at adolescent girls. Lisk notes that the issue of gender roles has not received enough attention in SSA “a region where gender roles are defined and influenced by cultural and social norms and practices” (2010, p.140). Gender roles and expectations of behaviour can prevent girls from accessing HIV and AIDS prevention and treatment services, often due to the inability to discuss sexual matters and taboo surrounding social perceptions of promiscuity. Early marriage is a common tendency and due to the social stigma attached to being childless, young brides are expected to become pregnant. This creates vulnerability as she will not be able to practise safe sex, even if she suspects her husband of having other sexual partners, as is often the case if, for example, he migrates for work. The young women are also exposed to HIV infection through blood transfusion due to anaemia and haemorrhage which are associated with pregnancy and child birth (Holden, 2003). They also face the possibility, if HIV positive, of transmitting the infection to the child they bear and the stigmatization around treatment.

Gender roles are also such that women and adolescent girls are expected, and more likely, to care for a partner or relative when they become infected and sick, it is seen as ‘women’s work’ in many cultures in SSA. This is yet another example of the disproportionate share of the burden of HIV that women bare. Young girls will often be taken out of school to care for infected elders, removing her from an education where she would be exposed to methods of HIV prevention, which perpetuates the cycle of powerlessness. “The care burden is so heavy and profound that it is destroying communities and individual lives” (Concern, 2011, p.1). Often they will be ostracised from society if the person they were caring for dies as many will believe that the carer too is infected.

In today's world there is a tendency of sexual objectification of young girls' bodies, submerging other attributes (Sen, 1997). This is reinforced through advertising and porn which co-modify women. According to Sen, this is heightened in a situation of poverty in which poor men, weighed down by oppression, "control, appropriate and objectify in the only sphere possible – the sexual" (1997, p.146). Women submit to this in return for economic resources and protection. "The threat of joblessness and the ever present spectre of hunger work effectively to ensure women's acceptance of molestation" (ibid). There is a need to raise awareness of the concept of the right of young women to the integrity of their own bodies. This objectification culminates in the sex trade industry, which, according to Poudel and Shrestha, "The flesh trade, sex industry and trafficking, are all part of a business that today contributes to most national economies" (1999, p.163).

Holden points out that female gender roles tend to be "being the subordinate partner with less control" (2003, p.34) and male gender roles "adopting a position of relative power" (ibid). There is no doubt that policy to tackle HIV cannot be only medical and behavioural, wider development problems such as poverty and gender inequality need to be addressed. According to Lisk, in SSA "HIV infection rates among young women and girls are as high as four to six times those of young men and boys in the same age group – an unacceptable situation that has been appropriately described as "the misogynistic arithmetic of male promiscuity and female powerlessness"" (2010, p.54). Adolescent girls and young women need to be provided with information about the disease and how to protect themselves from infection. Their rights to equity need to be protected through legal and practical measures and there is a need to "create opportunities to challenge and transform social gender norms, practises, and gaps that are disadvantageous and damaging to women and girls" (Lisk, 2010, p.140).

## Male Participation

There is no doubt that the issue of power inequalities is an important factor in the spread of HIV in the developing world "as recognised by the increasing attention given to the 'feminization' of the epidemic in the global response by UNAIDS and other key stakeholders in recent years" (Lisk, 2010, p.140). However, there is a danger in focussing solely on women when looking for solutions. There is a growing awareness that imbalances in gender relations cannot be corrected without including men in the solution. Adolescent girls may be at greater risk through having sexual relations with older men, but it is the 'sugar daddy's' desire for younger girls that fuels this, often due to their perception of them as 'cleaner', some believing that sex with a virgin can cleanse them of infection.

## Masculinity

According to Drongo "a concern with gender recognises that because men and women occupy different and often unequal positions in society, they have different needs, responsibilities and opportunities. It also means policies, projects and planning need to address both men and women" (2003, p.276). Tackling the 'gender gap' without addressing the underlying causes of discrimination, oppression and patriarchal beliefs will not get to the root of the problem (ibid). Much of what constitutes male gender roles in many cultures has given rise to a construct of masculinity that lies at the heart of the problem. The UNAIDS task team on gender and HIV/AIDS reports that "Attitudes, behaviour and commitment of men as individuals, partners and as religious and political leaders directly impact the spread of HIV" (no date, p.5).

Gender stereotypical roles and gender inequality contribute to men having the power to determine where, when and how sex takes place (Rao Gupta, 2000). Circumstances and behaviour often place men at high risk of contracting HIV such as migration, relationships with sex workers and men in the military where, according to Sen, during times of militancy “oppression in the form of regularised rape of women. punishes militant women in the most direct and brutal manner” (1997, p.147).

Due to power imbalances in gender relations, it is the male head of household that often has control over how the household resources are used. Increased access to resources enables men to undertake risky behaviour such as alcohol, drug consumption and multiple partners. Drug and alcohol use are often associated with increasing the likelihood of unprotected sex and violence. Such behaviour often becomes part of the masculine gender identity, as well as denial of risk. In many cultures it is far more acceptable for a man to have more than one regular partner, regardless of whether or not polygamy is the norm, than it is for women. In order to modify existing social customs, such as ‘inheriting’ a brother’s widow as well as risky behaviour, it is necessary for men to realise that behaviour modification is of mutual benefit. “Definitions of masculinity that equate manhood with dominance over sexual partners, the pursuit of multiple partners and a willingness to take risks while simultaneously depicting health seeking behaviour as a sign of weakness, increase the likelihood that men will contract and pass on the virus” (Men Engage, 2009, no page).

It is evident that risky behaviour must be addressed by offering men models of masculinity that are not based on unequal power relations. “Both women and men must nurture and support positive expressions of masculinity and promote the core concepts of inner strength, respect and care for partners and children” (UNAIDS, no date, p.5). Adolescent boys need male role models that will show them that the capacities to conduct responsible caring relationships are positive attributes in a man.

### **Stepping Stones**

An Action Aid intervention in Mozambique to address HIV and AIDS issues found that AIDS was rarely raised as a concern during community and needs assessment meetings. They were working with women at the Bobole market in the Maputo province which had a truck stop and a thriving trade of sexual services. Staff had to learn about AIDS and its effects on the population they were working with by not mentioning it directly but by raising related issues such as social relations, polygamy and sexual behaviour. The group received AIDS education and access to condoms but this did not have an effect as the men refused to use condoms and the women needed to earn their living. It was then realised that “work to address gender inequality and susceptibility to HIV infection ideally needs to involve both men and women” (Holden, 2003, p.58).

They then began to use the Stepping Stones training package on gender communication and HIV on groups that included men and women. “Stepping Stones is a process of guided discussion and skills building for community members on issues related to HIV, gender and sexual health” (Holden, 2003, p.58). It is a participatory and broad based approach to working with communities by focussing on relationship skills. “It is also sometimes described as a life-skills training package, covering many aspects of our lives, including why we behave in the ways we do, how gender, generation and other issues influence this, and ways in which we can change our behaviour, if we want to” (Stepping Stones, no page).

Action Aid Mozambique found that from using Stepping Stones, the “reported use of condoms increased among participants” (Holden, 2003, p.58). However, there were other outcomes not directly related to HIV. It was found that men were helping their wives more with household work such as cleaning and child rearing; there was a greater sharing of wages and an increase in joint planning of monthly expenditure; there was also reportedly a shift from arguing to discussing (ibid). This integrated way of tackling HIV infection alongside issues related to gender and reproductive health had the effect of shifting gender power relations which is necessary to begin to tackle inequalities.

## Conclusion

Gender defines the ways in which women and men interact with each other in a culture specific context. In SSA, HIV infection is predominantly transmitted through heterosexual sexual activity. Due to differences in roles, access to and control of resources has been relatively difficult for women, creating a position of power for men. “The unequal power balance in gender relations that favours men translates into unequal power balance in heterosexual interactions” (Rao Gupta, 2000, p.2). The power imbalance “curtails women’s sexual autonomy and expands male sexual freedom” (ibid) increasing women and men’s risk and vulnerability to HIV. This is heightened in gender based violence. A study in a testing centre in Dar-es-Salam found that HIV positive women were 2.6 times more likely to have experienced violence in an intimate relationship (Rao Gupta, 2000).

It is important that interventions do not focus on the irresponsible image of male sexuality and the powerlessness of women but rather encourage constructive roles for men in sexual and reproductive health and redefining gender norms. Rao Gupta points out that it is a mistaken belief that empowering women will disempower men “Empowering women will empower households, communities and nations ... Gender roles that disempower women and give men a false sense of power are killing our young and our women and men in their most productive years. This must change” (2000, p.7).

## References

Chachage, C. and Mbilinyi, M. (eds) (2003) *Against Neo Liberalism: Gender, Democracy and Development*, E & D Limited, Dar-es-Salaam.

Concern 'Positive Lives' [Online] Available at: [www.concern.net/positivelives](http://www.concern.net/positivelives). Accessed on: 30/03/11.

Dongo, M. (2003) Ownership of Resources, Decision making and Gender Disparities. In Chachage, C. and Mbilinyi, M. (eds) (2003) *Against Neo Liberalism: Gender, Democracy and Development*, E & D Limited, Dar-es-Salaam.

Garcia Moreno, C. (1997) AIDS: Women are not Just Transmitters. In Visvanathan, N. et al (eds) (1997) *The Women, Gender and Development Reader*, Zed Books, London.

Holden, S. (2003) *AIDS on the Agenda: Adapting Development and Humanitarian Programmes to meet the Challenge of HIV/AIDS*, Oxfam GB, Dorset.

Kabeer, N. (2005) Gender Equality and Women's Empowerment: A critical analysis of the third Millennium Development Goal., *Gender and Development* Vol. 13, No. 1.

Lisk, F. (2010) *Global Institutions and the HIV/AIDS Epidemic: Responding to an international crisis*, Routledge, Oxon.

Men Engage (2009) Global Symposium on Engaging Men and Boys on Achieving Gender Equality. The Rio Declaration.

Poudel, M. and Shrestha, A. (1999) Dealing with hidden issues: Trafficked Women in Nepal. In Rowan-Campbell, D. (ed) *Development with Women*, Oxfam, Oxford.

Panos Dossier (1992) *The Hidden Cost of AIDS: The Challenge of HIV to Development*, The Panos Institute, London.

Rao Gupta, G. (2000) Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How. International Centre for Research on Women, Washington.

Reardon, G. (1995) *Power and Process*, Oxfam, Oxford.

Rao Gupta, G. (2000) Gender, Sexuality and HIV/AIDS: The What, the Why and the How, International Center for Research on Women, Washington.

Sen, G. (1997) Subordination and Sexual Control: A Comparative View of the Control of Women. In Visvanathan, N. et al (eds) (1997) *The Women, Gender and Development Reader*, Zed Books, London.

Singh, K. et al (2009) Targeting HIV Interventions for Adolescent Girls and Young Women in Southern Africa: Use of the PLACE Methodology in Hwange District, Zimbabwe. *AIDS and Behaviour*, Vol. 14, No. 1, 200-208.

Stepping Stones [Online] Available from: <http://www.steppingstonesfeedback.org/> Accessed on 30/3/11.

The Rio Declaration (2009) Global Symposium on Engaging Men and Boys on Achieving Gender Equality [Online] Available from: <http://engagingmen.wordpress.com/2009/04/03the-rio-declaration/> . Accessed on : 31/3/11.

UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS [Online] Available from : <http://www.unfpa.org/hiv/docs/rp/factsheets.pdf>. Accessed on: 30/3/11.

Visvanathan, N. et al. (eds) (1997) *The Women, Gender and Development Reader*, Zed Books, London.

Wallace, T. and March, C. (eds) (1991) *Changing Perceptions: Writings on Gender and Development*, Oxfam, Oxford.

World Bank (2001) *Engendering Development: Through Gender Equality in Rights, Resources and Voice*, Oxford University Press, New York.

## Multiple Sexual Partners, Condom Use, and HIV and AIDS Prevention in Botswana

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### Abstract

*This study reiterated the relationship between multiple sexual partners and higher risk of HIV infection. From the study, it was worrying that increased education tended to be associated with increased number of partners, although with increased condom use. Results point to the necessity for prevention interventions to emphasize that condoms are not enough for prevention of HIV transmission, and that the behavioural aspects of keeping many partners need to be altered. To understand pressures that individuals face, there is need for more in depth qualitative approaches that may unravel choices and constraints faced by individuals in determining the nature of their sexual practices. The results also resonate with the conclusions of the National Operational Plan for Scaling up HIV prevention in Botswana for 2008 – 2010, that HIV prevention strategies need to use targeted campaigns that address risky behaviours such as multiple and concurrent sex partners, intergenerational sex, and gender inequalities (NACA, 2007).*

## Introduction

The spread of HIV infection and AIDS in Botswana is largely reported to be through heterosexual intercourse, fuelled by the practice of multiple sexual partners and unsafe sexual practices. The National Strategic Framework for HIV/AIDS 2003–2009 identifies heterosexual intercourse as the primary mode of transmission in Botswana. Whereas multiple sexual partners and unsafe sexual practices are known risk behavioural practices, and despite the fact that many prevention programmes target them, these practices do not appear to abate.

In Botswana a substantial amount of information and knowledge has been generated to equip people to protect themselves from HIV infections. Various monitoring tools have shown that there is ample knowledge but less behavioural changes in terms of sexual practices (Dinkelman et al., 2006). During the early years of the HIV/AIDS pandemic in Botswana, the Ministry of Health through the AIDS/STD unit commissioned SIAPAC Africa (PTY) to conduct successive studies monitoring youths' (18 to 25 years old) sexual behavioural trends in Botswana (1992, 1993 and 1994). Although these studies showed a positive change in terms of increased condom use, they on the other hand showed an increase in the number of reported sexual partners. It also emerged that males were more likely to report having multiple partners than females. The studies showed that knowledge of effective preventive methods is higher in urban areas for all methods, with condom use being the most known reported HIV and AIDS prevention measure. Studies from other regions of the world report higher knowledge of HIV prevention among males than females (Agrawal et al., 1999; Yelibli et al., 1993). Several other studies across the world have shown high knowledge of risky behaviour among adolescents and students that are not followed by appropriate behavioural practices (Mafa, 1994; Sekirime et al., 2001; Bernardi, 2002). There is massive awareness of AIDS and STI's together with great reluctance in adopting consequential preventive measures (Bernardi, 2002). Another study found high level of knowledge (99.2%) of contraceptive methods and a positive attitude towards contraception (Oindo, 2002). However, the level of actual contraceptive use was relatively lower (57.5%). It has also been observed that whilst it is easy to hold negative views about extramarital sex, this has not been followed by the right behavioural practices (Smith, 1990). The literature cited above shows that people generally know risky sexual practices and that the knowledge does not mean it will be translated in to appropriate behavioural practices.

## Multiple Sexual Partners and Gender

Studies of self reported behaviours across the world generally show that males tend to report multiple partners more than females (Somse et al., 1993; Wiederman, 1997). For both sexes, predictors for multiple partners are: being single, being unemployed, living in an urban area, and drinking alcohol. For men, increased literacy was a risk factor and for women decreased age was. It has also been found that predictors for multiple sex partners for women were: early age at first sexual intercourse, lack of religious affiliation, young age and being unmarried (Seidman et al., 1992).

Having multiple partners and inconsistent condom use was observed to be common among both men and women (Desiderato and Crawford, 1995). Both sexes reported high rate of failure to disclose previous sexual risky behaviour. Another study found consistent condom

use in non-marital relationships significantly higher for males than for females (Adetunji and Meekers, 2001). The study also found that the higher level of consistent condom use exhibited by those who were aware of the efficacy of condoms was due to the fact that men had higher awareness of this, using condoms more consistently than women.

In Botswana, male adolescents were found to use condoms less frequently (Campbell and Rakgoasi, 2002). The study investigated attitudes of adolescents towards condom use and the reduction of sexually transmitted infections and HIV/AIDS. Similar findings were reported in South Africa where men had relatively good awareness of condoms but they were not often used (Maharaj, 2000). The reluctance to use condoms was at times because they were associated with illicit sex. Condoms were also used less consistently among males in non-marital relationships than among females in similar circumstances (Adetunji and Meekers, 2001).

### *Multiple sex partners and age*

A study of adolescents in Botswana found that male adolescents began sexual intercourse at an earlier age (mean age of 16.7 years) and tended to have more sexual partners compared to females (Campbell and Rakgoasi, 2002). The study also found that the level of actual condom use was lower among male adolescents than that of female adolescents. A study of the factors contributing to unsafe sexual behaviour in South African youth (age between 14–35 years) found that between 50% and 60% of sexually active youth reported never using condoms (Eaton et al., 2003).

### **Methods**

The purpose of this paper is (1) to examine the prevalence of multiple sexual partners in Botswana. (2) Examine condom use with both of the sexual partners. The analysis uses multiple sexual partners and condom use as the dependent variables and the independent variables are: gender, age at first sexual experience, education and marital status. The study uses data from the Botswana AIDS Impact Survey II of 2004. We selected those who reported having sex with more than one partner in the last 12 months prior to the data collection period.

### **Results and Discussions**

The analysis revealed that a number of respondents had more than one sexual partner and that a number of them do not regularly use condoms. Earlier studies have reached the same conclusion both in Botswana and abroad (Campbell and Rakgoasi, 2002; Somse et al., 1993; Wiederman, 1997). The use of condoms is associated with the type of partner (regular versus casual partner). Adetunji and Meekers (2001) in Zimbabwe observed similarly that there is a tendency for consistent condom use in non-marital sexual relations. It also reveals that for females sexual activity starts earlier than males. The use of condoms by respondents with different partners was investigated. The analysis further investigated whether condom use with same partners was consistent or varied over time.

## Sexual Debut

The study sought to find out some of the attributes of the respondents at their first ever sexual intercourse. We found that sexual debut was on average delayed longer for males than females, as the average age at first sex was 19.7 years for females and 24.5 years for males. Previously, Campbell and Rakgoasi (2002) reported to the contrary when they found out that boys engage in sexual practices at earlier age than girls. They reported on an independent cross sectional study among adolescents in Botswana.

Even though sexual debut may have been before the respondents acquired their current levels of education, we note that 70.1 % of those with secondary education, 60.3 % with higher, 26.0 % with primary education and 20.2 % with non formal education reported to have used condoms at their sexual debut.

The delayed sexual debut by males relative to females is understandable on a number of fronts, some of which are that culturally a man is expected to be older than his female partner. This means that the risk of HIV infection through sexual exposure was higher for young females than for young males, since sexual debut was almost 7 years earlier on average for females than for males. It could be argued that in the absence of intergenerational sexual relationships, the HIV scourge would be put under control since the sex debut for males at the age of 24.5 years will be with those females aged 19.7 years. However, with the prevalence of intergenerational sex, particularly the sugar daddy type, young females stand a higher risk of infection.

### *Condom use at first sexual intercourse*

The use of condoms at first sexual intercourse was higher for males than for females at 70.6 % and 60.9 % respectively. The relatively lower use of condoms for females at sexual debut further expose them to HIV infection, particularly because they are likely to be HIV negative, given that the predominant mode of HIV infection is by heterosexual intercourse. The lower rate of condom use at sexual debut and the lower average age at the inception of sexual intercourse complement each other in increasing female's vulnerability to HIV infection. Being relatively younger than their male sexual partners, females may feel less empowered to negotiate condom use in such relationships. It has been observed that condom use among male adolescents is more consistent than among female adolescents (Campbell and Rakgoasi, 2002).

The use of condoms at first sexual intercourse was highest for those with secondary education followed by higher education. Those with primary and non-formal education were on the lower end of condom use. This serves to foster the thinking that education is paramount in promoting safe sexual behaviour even though the rates of condom use for those with at least secondary education, at below 70 % on average, is low. Education here refers to the highest level attained at the time of the survey. It should be noted that some of the sexual debuts might have been experienced before the reported education levels were realized.

In the survey, respondents were asked about their most recent partner, next most recent partner and second most recent partner. It is not clear whether these are concurrent and

designated in terms of the seriousness and casualty of the relationship or whether the relationships are not concurrent and yet chronologically ordered. In spite of this limitation we investigated the presence or absence of condom use and the nature of the relationships between respondents and these partners. Whereas girl/boyfriend relationships were dominant for all these types of partners, we observed a decline in the frequency of marriage relationships as we move from the most recent partner to second most recent partners. We equally observe that casual relationships gain prominence as we move from most recent partner to second most recent partner, an observation that tempts one to conclude that the relationships are concurrent. This conclusion is equally driven by the observation that the use of condoms is positively correlated with casual relationships, since condoms are in some cases considered to be meant for casual partners. This is consistent with results obtained in a study in Zimbabwe (Adetunji and Meekers, 2001).

Hospitals and clinics have been the primary source of condom distribution in all cases where condoms have been in use. This scenario we believe is, among other factors, influenced by the free provision of condoms within these facilities.

### **Multiple Partners**

The degree of faithfulness between the sexes is comparable as 92 % of males reported having at most one partner compared to 92.5 % of females. However, for those who were unfaithful, some of them reported having as many as 22 partners concurrently. In particular, the unfaithful tended to have predominantly two partners at a time, as given by 6.1 % of males and 5.7 % of females. The rest of the respondents had at least three partners.

### **Multiple Partners and Education**

The distribution of faithfulness by education indicates that those with non-formal education were more faithful at 95.2 % followed by those with primary education at 93.8 %. Those with secondary and higher education were also faithful at 90.9 %. For those with non-formal education we observe that the unfaithful had only two partners and that they accounted for 4.8 % of all those with this level of education. For those with primary, secondary and higher educational levels, 1.4 %, 2.2 % and 2 % of them had at least three partners.

### **Multiple Partners and Marital Status**

The degree of faithfulness by marital status ranged between a low of 88.5 % for the never married and 98.1 % for the widowed. The married were faithful at 96 %, followed by the divorced, and living together at 94.3 % and separated at 93.6 %.

On the number of sexual partners, we observe a high percentage of faithfulness among both males and females. This is rather strange as studies on self reported sexual behaviour show that respondents are often reluctant to reveal their sexual lives let alone report on their number of sexual partners. Where such behaviours are reported it is often males who report it (Somse et al., 1993; Wiederman, 1997). The majority of those who were unfaithful tended to have two partners even though others had as many as 22 partners reported. The almost equal levels of faithfulness across the sex divide bring into question the often-held view that males are key perpetrators in unfaithfulness.

There are some conflicting results with regard to the impact of education on sexual risk. Education tends to promote condom use but it also increases unfaithfulness. That education tends to be a risk factor for multiple partners is corroborated by other studies that identified other risk factors such as: being single, being unemployed, urban residence and alcohol drinking (Somse et al., 1993). The impact of HIV will then depend on the trade off effect. It can however be argued that unfaithfulness coupled with condom use may not necessarily promote HIV infection if condoms are used efficiently all the time.

There is a relatively higher degree of unfaithfulness amongst the never married compared to all other marital status. The failure of the analysis to make gender comparison denies the opportunity to establish if married men are more unfaithful relative to married women as is often argued. It is also worrying that where there is unfaithfulness; at times a large number of partners are involved.

### **Condom Use and Different Partners**

We went on further to analyse the sexual behaviour of respondents relative to their different partners. In this survey respondents were asked about their most recent partner, next most recent partner and second most recent partner. It is not clear as to whether the partners were concurrent or not. The analysis investigated the nature of relationships between respondents and these classes of partners.

### **Condom Use and Most Recent Partners**

It was found that 24.3 % of males' most recent partners were their wives and 24.9 % of females' most recent partners were their husbands. Live-in partners accounted for 26.6 % of males' partners and the same accounted for 29.3 % of females' partners. The most prevalent class of relationships was girl/boyfriends not living together at 45.8 % and 44.6 % for males and females respectively. Casual acquaintances accounted for 2.9 % of males' partners and 0.6 % of females' partners.

In cases of first sexual intercourse with the most recent partner, we observe that 63.6 % of males use condoms compared to 60.6 % of females. These percentages declined marginally for males to 62.8 % and 58 % for females in the last sexual intercourse. We observe relatively higher percentages of those who reported using condoms always with the most recent partner at 88.6 % and 86 % for males and females respectively.

The most popular sources of condom acquisition were hospitals and clinics at 67 % for males and 67.9 % for females. Shops came second 17.8 % and 17.8 % for males and females respectively. Pharmacies and offices/places of work accounted for 5.6 % and 5.5 % on average respectively.

### **Condom Use and Next Most Recent Partner**

In the case of next most recent partner, the girl/boyfriend relationships were more dominant as reported by 72.53 % and 83.60 % of males and females respectively. The next most popular kind of relationship was casual acquaintances at 16.3 % for males and 6.6 % for females. The live-in partner relationships accounted for 6.4 % of males' relationships and

5.7 % of females' relationships and marriage accounted for 2.83 % and 1.9 % of male and female relationships respectively. The rate of same sex relationships accounted for 1.4 % and 1.3 % of males and females relationships respectively.

The use of condoms at first sexual intercourse stood at 81.7 % for males and 82.6 % for females. There was however, a decline in condom use in last sexual intercourse at 80.9 % and 81.3 % for males and females respectively. A higher percentage of both males and females reported higher rates of always using condoms at 94.3 % for males and 92.2 % for females.

Hospitals and clinics continued to be the popular avenues for the acquisition of condoms at 66.8 % for males and 64.3 % for females followed by shops at 19 % and 21.2 % for males and females respectively. Offices/places of work followed at an average of 4.8 % and 4 % for pharmacies for both sexes.

### *Condom Use and Second most recent partner*

Even though we continue to observe the dominance of the girl/boyfriend not living together relationships for this class of partners at 64.7 % and 73.3 % for males and females respectively, we note that casual relationships have increased significantly to 27.8 % for males and 13.3 % for females. The transactional relationships were also higher for these types of partners than the two previous ones. Of all the relations involving these partners, 0.6 % of them were between men and 3.5 % between women. The rate of condom use was also highest among this class of partner at 85.8 % for males and 89.7 % for females in partners' first sexual intercourse. There was a notable decline in condom use in the last sexual intercourse, particularly amongst women as only 83.2 % and 75 % of males and females respectively used condoms. Quizzed about their frequency of condom use with these partners, a relatively higher percentage indicated that they used condoms always. The percentages were 97.1 for males and 95.5 for females.

The major outlets for condom distribution continue to be hospitals and clinics at 66.2 % for males and 69.6 % for females. Shops come second at 20.4 % and 26.1 % for males and females.

### **Conclusion**

In this study we realize that on the average females have their sexual debits when they are relatively younger than males and that their rate of condom use is relatively less than that of males. Seidman et al. (1992) had similar findings among women with multiple sex partners. It is important that more educational programmes aimed at further promoting the use of condoms at the inception stages of sexual intercourse be promoted, especially for women. Given the relative lower use of condoms for females at first sexual intercourse, preventive efforts need to recognize this early exposure for females. It is clear that people may have the same information on HIV modes of transmission and prevention. It however seems evident that females may not always be able to act independently to deal with their unique situations.

The multiplicity of partners in the face of increased education rightfully deserves substantive investigation to establish the causes and possible remedies to such a scenario. This is as a result of the observation that the effect of education on sexual risk is mixed as it promotes condom use and unfaithfulness. We are aware that education was measured at time of survey and not at first sexual experience. The number of sexual partners in a period of twelve months is one measure that can gauge the risk of incident infection. It is nonetheless noted that condom uses reported with additional sex partners.

Although there is a high level of reported faithfulness to one sexual partner, there are also worrying elements of multiple partners more so among males. Studies have shown that males are more likely to report their incidences of multiple partners than females (Somse et al., 1993; Wiederman, 1997). Even more worrying is that increased education tends to be associated with increased number of partners, though with increased condom use. Prevention interventions need to emphasize that condoms are not enough for prevention of HIV transmission, and that the behavioural aspects of keeping many partners need to be altered.

The HIV prevention strategy needs to use targeted campaigns that address risky behaviours such as multiple and concurrent sex partners, intergenerational sex, and gender inequalities (National AIDS Coordinating Agency, 2007). The interventions may have to focus on identified predictors of multiple sexual partners and condom use. To understand pressures that individuals face, there is need for more in depth qualitative approaches that may unravel choices and constraints faced by individuals in determining the nature of their sexual practices. This needs to take into consideration that it may not be knowledge that is lacking but the adoption of the right sexual practices. As shown by Dinkelman et al. (2006), knowledge about HIV in Botswana has been generated but the right behavioural practices are lagging behind.

## References

- Adetunji, J. and Meekers, D. (2001) Consistency in condom use in the context of HIV/AIDS in Zimbabwe, *Journal of Biosocial Science*, Vol. 33, No. 1, pp. 121-138.
- Agrawal, H. K., Rao, R. S., Chandrashekar, S. and Coulter, J.B. (1999) Knowledge of and Attitudes to HIV/AIDS of Senior Secondary School Pupils and Trainee Teachers in Udupi District, Karnataka, India, *ANN Trop Pediatr*, Vol. 19, pp. 143-149.
- Bernardi, L. (2002) Determinants of Individual AIDS Risk Perception: knowledge, behavioural control and social influence, *African Journal of AIDS Research*, Vol. 1, No. 2, pp. 111-24.
- Campbell, E.U. and Rakgoasi, D. (2002) Condom Use among Youth in Botswana in the era of HIV and AIDS, *Social Development Issues*, Vol. 24, No. 1, pp. 56-67.
- Desiderato, L. L. and Crawford H. J. (1995) Risky Sexual Behaviour in college students: relationships between number of sexual partners, disclosure of previous risky behavior and alcohol use, *Journal of Youth and Adolescence*, Vol. 24, No. 1, pp. 55-68.
- Dinkelman, T., Levinsohn, J. and Majelantle, R. (2006) When Knowledge is Not Enough: HIV/AIDS Information and Risky Behaviour in Botswana. Research Seminar in International Economics. Discussion Paper No. 553. The University of Michigan.
- Eaton, L., Flisher, A. J. and Aaro, L. E. (2003) Unsafe sexual behavior in South African Youth, *Social Science and Medicine*, Vol. 56, No. 1, pp. 149-165.
- Mafa, M. (1994) Knowledge and attitudes of pregnant women on HIV testing. Unpublished Research Paper, University of Botswana.
- Maharaj, P. (2000) Male attitudes to family planning in the era of HIV/AIDS: Evidence from KwaZulu-Natal, South Africa, *Journal of Southern African Studies*, Vol. 27, No. 2, pp. 245-257.
- National AIDS Coordinating Agency (2007) National Operational Plan for Scaling up HIV prevention in Botswana: 2008 – 2010. (Final Draft), Ministry of Presidential Affairs and Public Administration.
- Oindo, M. L. (2002) Contraception and sexuality among youth in Kisumu, Kenya. *African Health Sciences*, Vol. 2, No. 1, pp.33-39.
- Seidman, S. N., Mosher, W. D. and Aral, S. O. (1992) Women with Multiple Sex Partners, 1988. *American Journal of Public Health*, Vol. 82, No. 10.
- Sekirime, W. K., Tamale, J., Lule, J. C., and Wabwire-Mangen, F. (2001) Knowledge, attitude and practice about sexually transmitted diseases among university students in Kampala, *African Health Sciences*, Vol. 1, No. 1, pp.16-22.
- Smith, T. W. (1990) The sexual Revolution, *Public Opinion Quarterly*, No. 54, pp. 415-435.

Somse, P., Chapko, M. K. and Hawkins, R. V. (1993) Multiple Sexual Partners: Results of a national HIV/AIDS survey in the Central African Republic, *AIDS*, Vol. 7, No. 4, pp. 579-584.

Wiederman, M. W. (1997) The truth must be in here somewhere: Examining the gender discrepancy in self-reported lifetime number of sexual partners, *The Journal of Sex Research*, Vol. 34, pp. 375-386.

Yelibi, S., Valenti, P., Volpe, C., Caprara, A., Dedy, S. and Tape, G. (1993) Sociocultural Aspects of AIDS in an urban peripheral area of Abidjan (Cote d'Ivoire) *AIDS Care*, Vol.5, No. 2, pp. 187-97.

## Book Review of 'No safe place: Incest and defilement in Botswana'

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### Abstract

*No safe place: Incest and defilement in Botswana*, by the Botswana chapter of Women and Law in Southern Africa Research Trust (WLSA) places the family at the centre of the study, as both a fundamental and basic unit of society but also "an arena within which various forms of child abuse and other forms of gender violence occur" (WLSA, 2002:7). This 123 page study report was done by a team of researchers including Puseletso Kidd, a gender and human rights activist, WLSA research associate Chikazi Joseph, University of Botswana lecturer Gwen Lesetedi, Botswana Television producer KitsoMosiieman and at the time law lecturer, now High Court Judge Key Dingake.

Although written 11 years ago, *No safe place: Incest and defilement in Botswana*, remains relevant today. Every week in the media, there are harrowing stories of innocent children abused by adults for sexual gratification and of getting killed when the relationship between their mother and boyfriends or husbands turns sour. In Botswana, on Friday 8th November 2013, a local newspaper, *The Voice*, carried headlines such as “Man, 89 indecently assaults 4-year old”; “Rejected lover kills ex’s 3 year old child”; and “Incest shock” – about a 55 year old headman fathering a child with his 12 year old daughter (*Voice*, 2013).

The entry point of the study was concern at the number of teenage pregnancies that indicated high rates of defilement. Related to this was concern about the exposure of young girls to HIV infection. Another area of concern was that, while incest and defilement were above the jurisdiction of customary courts, in fact parents often took the matter through customary courts. New attention was also given to the defilement of boys.

The main finding is that often both the family and the justice system in Botswana treat defilement and incest as private matters to be resolved outside the courts of law. The result is an under reporting of incest and defilement, high rates of withdrawal of cases reported to the police and treatment of incest and defilement as just rape. This is exacerbated by the fact that the police, medical practitioners and other professionals involved in handling of incest and defilement cases often lack sufficient training. The result is that offenders often go unpunished and children unprotected. “The common response from most adult respondents – parents, tribal and community leaders, members of the judiciary, law enforcement officers and social workers – was that both incest and defilement were family matters, offences that were better resolved within and between families, despite the existence of statutory laws addressing such crimes” (WLSA, 2002:vii).

Since the study was done in 2002, a review of the Children’s Act of 1981 has been undertaken to harmonize it with the provisions of the Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC). The new Children’s Act was put in place in 2009. The Children’s Act of 1981 defined a ‘child’ as any person who is under the age of 14 years whereas the 2009 Children’s Act defines a ‘child’ as any person who is below the age of 18 years. There remain inconsistencies in the definition of a child in the various Acts, such as the Employment Act, the Marriage Act, the Electoral Act and the Penal Code on minimum age of criminal responsibility. Many of the provisions of the Act are yet to translate into policy and be implemented. Updating Parliament on progress made on the implementation of the Children’s Act, the late Assistant Minister of Local Government Maxwell Motowane, on 9 April 2012, acknowledged that children with disabilities, those living in remote areas or belonging to certain ethnic groups, and others were still denied some of their fundamental rights. Also, there remains a lack of available children’s courts and lawyers trained to handle children’s issues (Tjezuva, 2012).

## References

The Botswana's Parliament strengthens the implementation of the Children's Act h-africa Discussion Logs. (2008, June). Retrieved November 25, 2013, from Humanities & Social Sciences Online (Hnet): <http://h-net.msu.edu/cgi-bin/logbrowse.pl?trx=vx&list=h-africa&month=0806&week=d&msg=siuiRSIalGnjQsjKYwt2Sw&user=&pw=>

Jacques, G. ( 2008, October 30-31). The Changing Face of Family: HIV and AIDS and Statutory Foster Care in Botswana. Paper Presented at Schapera Project Conference, University of Botswana.

Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States. (1948). Retrieved November 25, 2013, from World Health Organization: <http://www.who.int/about/definition/en/print.html>

Southern Africa Trust Vision and Mission. (n.d.). Retrieved November 25, 2013, from Southern Africa Trust: <http://www.southernafricatrust.org/vision&mission.html>

University of Botswana Vision. (n.d.). Retrieved November 25, 2013, from <http://www.ub.bw>: <http://www.ub.bw/content/id/1372/>

Women and Law in Southern Africa Research Trust (2002). No safe place: Incest and defilement in Botswana. Gaborone, Botswana: Lentswedi la Lesedi, 2002. 123pp.







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