

## **HIV and AIDS knowledge and attitudes among different marital statuses in Botswana: Results of the fourth *Botswana Aids Impact Survey* of 2013**

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### **Abstract**

*Marital status has been identified as a contributing factor in the spread of HIV and AIDS. Most studies have found high prevalence rates of HIV and AIDS among couples in stable relationships such as marriage and cohabitation. The objective of this paper is to analyse knowledge and attitudes about HIV and AIDS among the married, never married, cohabiting, separated, divorced and the widowed. The data were derived from the fourth instalment of the Botswana AIDS Impact Survey (BAIS IV). A descriptive analysis using crosstab was applied to the data. The study found that 92% of individuals across the different BAIS surveys had knowledge about HIV and AIDS prevention. However, some culturally embedded attitudes inhibit negotiation for safe sex and refusal to have sex, especially among those in marriage and cohabiting relationships. Such cultural attitudes include the belief that only males can decide on whether or not to have sex, and the terms of such an interaction, as well as the idea that women should not hold their husbands accountable, even in instances where they suspect that infidelity is taking place. The study recommends that the government continue with disseminating information about HIV and AIDS transmission and prevention. However, there is need to put more effort in infusing HIV and AIDS education with life skills such as negotiation and refusal skills especially for those in stable relationships. The BAIS IV results also indicate a slight decline in the prevalence rate of HIV among married women. This is inconsistent with studies that found marriage to be a risk factor in the spread of HIV and AIDS.*

**Key words:** (BAIS), HIV and AIDS marital status, negotiation and refusal skills, safe sex

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## **Introduction**

Most sexually transmitted illnesses, including HIV and AIDS, are preventable. However, they still remain a major social, economic, political, and health issue (Kposowa, 2013). In Botswana, there are approximately 319,750 people living with HIV (Global Aids Response Report, 2013). The latest HIV survey puts the national HIV prevalence rate at 18.5%, and an HIV incidence rate at 2.47% for the population aged six weeks and over (Statistics Botswana, 2013, p.4). The HIV incidence figure is the most concerning as it “measures the degree of new infections” (Statistics Botswana, 2013:3). This means that more people continue to be infected by HIV. The Government of Botswana has used the *Botswana AIDS Impact Survey* (BAIS) to get nationally representative information about HIV and AIDS. Following the first case of HIV in 1985 (Central Statistics Botswana, 2001) the government has implemented programmes to improve knowledge about HIV and AIDS transmission and prevention. The first BAIS was meant to evaluate the efficiency of these programmes (BAIS 2001). The second BAIS estimated the national prevalence rate to be 17.1% (Central Statistics Botswana, 2005) the third 17.6% (Central Statistics Botswana, 2008) and fourth survey at 18.5%, (Statistics Botswana, 2013). This upward trend in prevalence rates is a source of concern as it implies that there are always new infections. However, the rate of new infections has decreased with each BAIS as reflected by the crude incidence rates of 2.7% in BAIS III (Central Statistics Botswana, 2008) and 2.61% in BAIS IV (Statistics Botswana, 2013).

The results from BAIS II and III show that the highest HIV prevalence rate is among those who are widowed and married. However, the results of BAIS IV indicate a slight change in this regard as married women have a lower HIV/AIDS prevalence rate than men, 18.7% and 26.3% respectively compared to single, separated, divorced, widowed and cohabiting women. Most studies have found high HIV prevalence rates among women in stable relationships such as marriage (Smith, 2007; Clark, 2004; Lucy et al 1999) and cohabitation (Omanje, Bosire & Mwenda 2015; Omanje, Bosire & Mwenda 2015). For instance, Clark (2004), in her study of HIV risk in Sub-Saharan Africa found that marriage inherently increases the risk of HIV infection. This is so because it increases the frequency of sexual intercourse, and virtually eliminates the ability to abstain from sex. In addition, husbands are usually older than their wives and have higher HIV prevalence rates than their younger wives (p.158), which means that they are likely to pass on the virus to the wives. Therefore BAIS IV findings which indicate a drop in prevalence rates among the married women are not consistent with most literature from the African region. Therefore this needs further investigation to understand these inconsistencies.

A study in America found results that are similar to the BAIS IV findings. For example, Kposowa (2013) analysed the third release of US National Longitudinal Mortality study. He found that marital status is associated with death from HIV and AIDS and that “the strongest association were found between single/never married and the divorced/separated” (p.873). The author concluded that this might be the case because those outside marriage may be having a wider sexual network (ibid). Kposowa further reveals that those in marriage have a lower AIDS mortality rate because “marriage confers buffering and may have other advantages that other statuses do not [have]; one major advantage provided by marriage is a stable sexual network” (2013: 873). Do BAIS IV results then mean that married couples are becoming less, or use condoms consistently? More research needs to be carried out to explore these possibilities. One way of accounting for the differences in HIV and AIDS prevalence is to assess knowledge and attitudes of individuals in relation to HIV and AIDS.

Knowledge and attitudes that individuals hold in relation to HIV and AIDS determine how they protect themselves from it. The results from all BAIS surveys indicate that Botswana are

generally knowledgeable about HIV and AIDS. For example, the first survey found “that 94% of people aged between 10-64 years have heard about HIV and AIDS and 79% know at least one way of reducing the rate of infection, specifically the use of a condom” (Central Statistics Botswana, 2001:7). Similar results were found in the second survey which showed that 92% had heard about HIV and AIDS and 83% cited consistent use of a condom as the main method of prevention (Central Statistics Botswana, 2005). Therefore, it is a reasonable assumption that Botswana know how to protect themselves from HIV and AIDS. The question is why the country still reports new cases of infection in each impact survey. There is a possibility that there still exists a gap between knowledge and attitudes. That is, if individuals know that the correct and consistent use of a condom can reduce their chances of getting infected, there must be other reasons why they still engage in unprotected sex. This paper analyses the knowledge of and attitudes towards HIV and AIDS of individuals with the different marital statuses, and how they make decisions about sex and condom use. This is done by analysing the following items from BAIS IV data: 1. Can one persuade their partner not to have sex if they are not interested. 2. Can one persuade their partner to use a condom? Answering these questions is important as it helps us understand whether or not individuals across different marital statuses are able to turn their knowledge into positive/negative action or behaviour.

Being able to persuade one’s sexual partner not to have sex or use a condom depends on one’s communication skills (Widman, Noar, Choukas-Bradley & Francis 2014; Exavery et al 2012). Therefore, knowledge alone is not enough to effect any change in behaviour. Knowledge needs to be accompanied by possession of certain life skills. Life skills facilitate negotiation for safe sex and help individuals avoid vulnerability by enhancing communication, right attitudes and positive thinking about sex related issues (Yankah & Aggleton, 2008; Schinke, 1984; Botvin, Baker, Botvin, E.M, Fillazzola & Miller). Life skills bridge the gap between knowledge and behaviours. Examples of life skills include effective communication, interpersonal relationship skills, self-awareness, (WHO 1997:1) communication and listening; negotiation and refusal skills (Yankah & Aggleton, 2008, p. 466). The result of having effective communication and interpersonal skills is clear thinking, having the right attitudes and staying safe, (Yankah & Aggleton, 2008, p.466). Therefore these life skills are very important as they can ensure that people protect themselves, non-sexually (through communication, self-efficacy) and sexually (through the consistent use of condoms).

## **Literature review**

### **Culture, HIV and AIDS prevalence**

Studies of HIV prevalence worldwide (Kposowa, 2013), in Southern Africa (Adebayo, Idogho, Anyanti, & Ankomah, 2013; Omanje, Bosire, & Mwenda (2015) and in Botswana (Berman 2015; Gumbo 2010) have linked HIV and AIDS with marital relationships. Most of these studies are quantitative. For example, national surveys like Botswana AIDS Impact Surveys I, II, III, and IV, Kenya AIDS Impact Survey, and National longitudinal studies are quantitative while a few are qualitative. The analysis of qualitative data yields themes like cultural beliefs and attitudes related to infidelity. As shall be discussed below, some of these attitudes expose spouses/partners to high risks of infection.

### **Cultural beliefs, HIV and AIDS in marital relationships**

There are certain social and cultural beliefs that encourage high risk behaviour in marital relationships (Shoko, 2012, p.91). Shoko opines that ‘Macho’ attitudes encourage multiple concurrent partnerships that expose couples to HIV and AIDS. Such risky behaviours often exclude the consistent and/or correct use of condoms, and the decision to use condoms lies with the men by default. Men are “ordained as the decision makers -even in matters regarding sexual intercourse [and they] want to be respected [...]” (Shoko, 2012, p.71; see also Masengwe, 2012). Ewusha (2012) is of the view that the understanding of an ‘ideal man’ includes the idea that “his decisions are never challenged” and that the “wife and his children are his property” (ibid p.73). These cultural attitudes impact on the ability of women to negotiate safe sex as the power to decide on whether or not to use of a condom and when to have sex (if at all) lie with the men in the relationship.

Shaibu and Dube (2002) discuss some male discourses that counter government efforts to fight HIV and AIDS. These include modern myths such as ‘condoms have worms’ and ‘*ga o kake wa ja nekere e phuthetswe*’ (one cannot eat a wrapped candy), (ibid. p.7). Kang’ethe (2014) also observes similar cultural attitudes that impede the fight against HIV and AIDS in Botswana and South Africa. Such attitudes discourage the use of a condom and encourage multiple concurrent partnerships (ibid. p.504), and expose couples to the risk of contracting HIV.

*Bogadi* (or *lobola*) is another cultural practice that links HIV and AIDS with marital status. Mookodi (2004) asserts that once a man has given *bogadi* he seems to believe that he owns the woman (see also Bourdillion, 1976, Schapera, 1939). More importantly, the payment of *bogadi* (or *lobola*) makes it imperative for a woman to bear children for her husband as “the cattle beget the children” (Gluckman 1950, p.184, cited in Ellece 2007). This then compels women to engage in unprotected sex and expose themselves to HIV infection (see also Ellece’s idea of compulsory motherhood, this volume)

### **Infidelity, HIV and AIDS in marital relationships**

Infidelity has also been linked to the high HIV and AIDS prevalence among couples (Smith, 2007; Webb, 1997), especially those in stable relationships such as marriage and cohabitation. Smith observes that in Nigeria, for instance, “being married can contribute to the risk of contracting HIV” (p.997). He further says that “the social organisation of infidelity is shaped by economic inequalities” (ibid, p.997). Webb observes that though infidelity is common “within marriage or semi-permanent relationships, initiating the use of a condom may be extremely difficult [...]; the fear is that such would implicitly be accusing the man of infidelity or admitting it [...]” (1997, p.76). Infidelity is therefore embedded in some cultural beliefs and practices. For example, in Botswana cultural beliefs propagated through linguistic artefacts such as proverbs: ‘*monna poo ga a agelwe lesaka*’ (‘a husband is like a bull which cannot be contained in a kraal’) and *monna selepe oa adimanwa* (‘a husband is like an axe that should exchange hands’) give both men and women the message that men are free to engage in extramarital sex” (Berman, 2012, p.130; Gumbo, 2010; Rapoo 2013). BAIS IV results indicate a drop in the prevalence among married women as compared to those in other marital statuses. This requires a critique of literature that proposes that the propensity towards infidelity stems from cultural ideologies. However, despite the knowledge that the correct and consistent use of a condom can reduce the chances of infection some individuals do not negotiate for safe sex; neither do they refuse sex.

### **Conceptual framework**

## **The AIDS Risk Reduction Model (ARRM)**

This article uses the AIDS Risk Reduction Model (ARRM) to establish the extent to which people perceive themselves as “actually at a risk of being infected with HIV and AIDS and what they know of HIV and AIDS related issues” (Fisher & Fisher 2000). This model was introduced in the 1990s in order to provide a framework for explaining and predicting the behaviour change efforts of individuals in relation to the sexual transmission of HIV (Fisher & Fisher, 2000). Fisher & Fisher explain that the ARRM views “change [a]s a process that individuals must go through, and that different factors affect movement through the different stages of the process” (2000:9). This theory has three stages that are described below.

### ***Recognition and labelling of one’s behaviour as high risk***

The first stage is about how the individual assesses his/her own behaviour in relation to him/her getting infected. Fisher and Fisher (2000) explain that in order for an individual to be able to change his/her behaviour he/she must be able to “label his or her behaviour as risky for contracting HIV” (2000: 9). They further explain that the individual must be able to see his/her current behaviour as problematic. However, for one to be able to label his/her behaviour as problematic one must know which actions or behaviours are problematic where HIV transmission is concerned. The individual needs to be able to ask and answer these questions: what sexual behaviours are associated with HIV/AIDS? To what extent am I personally susceptible to contracting HIV? Is knowledge of HIV necessary? Can I do something to avoid it? What is it that I do that can expose me to HIV infection? If I have sex without a condom, am I exposing myself to HIV and AIDS?

### ***Making a commitment to reduce the HIV risk sexual contacts and to increase low risk activities***

In order for any change in one’s behaviour to take place, the individual must make a commitment to want to change a behaviour that is labelled as risky. This is a process that involves a number of decisions such as whether the behaviour in question can be changed and whether the benefits of doing so outweigh the costs (Fisher & Fisher, 2000, p.10). Are individuals across marital unions able to weigh the advantages and disadvantages of using a condom? The individual needs to understand the costs and benefits of making such commitments. They need to be able to evaluate how the changes in the process of commitment might affect them; for example, will a change to the use of a condom affect my enjoyment of sex? If so, what are the benefits? They also need response efficacy; that is, will the changes successfully reduce my risk of HIV infection? Are the individuals in the different marital status relationships convinced that the use of a condom can reduce their chances of getting infected? Given the results from all the Botswana AIDS Impact Surveys, people in Botswana have factual knowledge about HIV and AIDS. For instance, they know that the correct and consistent use of a condom can reduce the chances of infection. An individual needs self-efficacy; that is, he/she needs to have confidence in his/her ability to effect change.

### ***Finding and enacting strategies to attain HIV risk behavioural change***

Change in behaviour is possible only if there is an action taken to cause change to happen; the individual must make a conscious decision to act; for example, to use a condom or refuse sex. This allows the taking of action which involves information seeking, obtaining remedies and enacting a solution. The individual needs to be able to take action and to know what social networks and what problem solving choices they have, whether they have the ability to communicate verbally with their sexual partner, and what the sexual beliefs and behaviour of their partners are.

This theory is used to assess whether or not the population that responded to the items selected are able to persuade their partners to adopt safe sexual practices like using a condom or not having sex if they do not want to.

## **Methodology**

The paper uses data from BAIS IV (Statistics Botswana, 2014) and other secondary sources on marital status and HIV and AIDS. BAIS IV data were collected through a two stage national sample survey design. Data collection started on the 21<sup>st</sup> January and was completed on 24<sup>th</sup> April 2013. Data collection was done using smart phone tablets instead of the conventional paper based method. The survey estimated the population Botswana to be 2,045,752 compared to the 2013 adjusted population projection estimates of 2,101,715. This provides a difference of 2.67% (less than 5%), rendering the BAIS IV data a good estimate, credible and representative of Botswana population. The data also showed that 73.4% of the population aged 6 weeks and above participated in HIV testing, hence the information provided in the BAIS VI survey is reliable given these good response rates (Statistics Botswana, 2014, p.1). Such data are critical as they allow meaningful estimates of HIV indicators that reflect the magnitude of the HIV and AIDS realities of the country.

## **Variables of interest**

The variables we focus on are knowledge and attitudes of individuals who are married, never married, separated, divorced widowed and cohabiting. The knowledge variable is defined as whether “people [can] reduce their chances of contracting HIV by using a condom correctly every time they have sex’. The attitudes variable is defined by the questions: ‘do you believe you can persuade a partner to use a condom?’ and ‘could you persuade a sex partner not to have sex if you were not interested?’

## **Data analysis**

Descriptive analysis was used to illustrate the knowledge and attitudes among the different marital statuses. Crosstabs for knowledge and attitudes about HIV and marital statuses were calculated and the results of the frequencies are shown in Tables 1, 2 and 3 below.

**Results**

Table 1 below shows that a total of 1 063 359 individuals who were married, never married, separated, divorced, widowed and cohabiting responded to the item that a correct and consistent use of a condom can reduce the chances of HIV and AIDS infection . Of those who responded, 92% (978236) said ‘Yes’, meaning that they know that a correct and consistent use of a condom can reduce the chances of HIV and AIDS infection.

**Table1: Responses of individuals’ knowledge that a correct and consistent use of a condom can reduce the chances of HIV and AIDS infection.**

		Can people reduce their chances of getting HIV/AIDS by using a condom correctly every time they have sex?			Total
		YES	NO	DON’T KNOW	
What is your current marital status	MARRIED	15.3% (149939)	15.5% (6622)	15.6% (6597)	163158
	NEVER MARRIED	60% (585502)	6.1% (26160)	70.6% (29868)	641530
	COHABITATION	21.5% (210116)	19.8% (8485)	10.4% (4401)	223002
	SEPARATED	0.4% (3630)	0.4% (156)	0.9% (400)	4186
	DIVORCED	1.0% (9885)	0.5% (225)	0% (0)	10110
	WIDOWED	2.0% (19164)	2.7% (1147)	2.5% (1062)	21373
<b>Total</b>		<b>92% (978236)</b>	<b>4% (42795)</b>	<b>4% (42328)</b>	<b>1063359</b>

This means that a large number of the study population know that consistent and correct use of a condom can reduce the chances of getting infected by HIV. Splitting the total of those who said ‘YES’ by marital status yields the following: married 15.3% (149 939); never married, 59.9% (585 502); cohabiting 21.4% (210 116); separated 0.4% (3 630); divorced 1.0% (9 885); widowed 2.0% (19 164).

Those who said they don’t know that consistent and correct use of a condom can reduce the spread of HIV and AIDS, and those who answered ‘NO’ constitute 8% of the population. Therefore, it can be inferred that the majority of Batswana have knowledge about HIV transmission and how it can be prevented.

**Table 2: Responses of individuals on persuading a sex partner not to have sex**

		Could you persuade a sex partner not to have sex if you weren't interested?				Total
		YES, ALL THE TIME	YES, SOMETIMES	NO	Don't Know	
What is your current marital status?	MARRIED	17.5% (78745)	44421	35587	2465	161218
	NEVER MARRIED	45% (229546)	83164	67008	9061	388779
	COHABITATION	26.6% (120474)	58768	45251	2270	226763
	SEPARATED	0.6% (2727)	510	718	232	4187
	DIVORCED	1.3% (5875)	2164	1340	74	9453
	WIDOWED	2.6% (11881)	3818	4358	355	20412
<b>Total</b>		<b>55.4% (449248)</b>	<b>23.8% (192845)</b>	<b>19% (154262)</b>	<b>1.9% (14457)</b>	<b>810812</b>

Table 2 shows that 810 812 individuals responded to the item on whether they believed that they could persuade a sex partner not to have sex if they were not interested. Of those who responded, 55% (449 248) said they believed that they could persuade a sex partner not to have sex if they were not interested all the time; 23.8% (192 845) said they could sometimes and 19% (154 262) said they are never able to persuade a partner not to have sex if they were not interested. By marital status the table shows that those who are able to persuade their partners, all the time, not to have sex when they are not interested are: married 17.5 % (78 745); never married 51.1% (229 546); cohabiting 26.8% (120 474); widowed 2.6% (11 881) while those who are separated and divorced are at 1.6% or less. Those who are in stable relationships such as marriage and cohabitation are less likely to negotiate the terms of sexual intercourse than those who have never been married. The figures suggest that those who are cohabiting are more able to refuse to engage in sex unwillingly than those who are married.

It is a great concern that there are individuals who are still having sex against their will. Though many Batswana (55%) are able to persuade their partners not to have sex if they are not willing to, some are not always able to do so or are never able to do so. From the table for instance, those who responded 'NO' to the item on whether they believe that they could persuade a sex partner not to have sex if they were not interested, implying that they are never able to persuade their partners not to have sex when they are not interested are those who are married 23.1% (35587), never married 43.4% (76008), and cohabiting 29% (45251).

**Table 3: Responses of individuals on persuading a sex partner to use a condom**

		Do you believe you can persuade a sex partner to use a condom?				Total
		YES, ALL THE TIME	YES, SOMETIMES	NO	Don't know	
What is your current marital Status?	MARRIED	16.0 % (91761)	35968	30873	2617	161219
	NEVER MARRIED	52.5% (301704)	53709	25351	8013	388777
	COHABITATING	27.15 (155935)	44254	24289	2285	226763
	SEPARATED	0.5% (3024)	339	371	451	4185
	DIVORCED	1.4 % (7893)	514	973	74	9454
	WIDOWED	2.5% (14431)	1805	3637	539	20412
<b>Total</b>		<b>70.9% (574748)</b>	<b>16.8% (136589)</b>	<b>10.5 % (85494)</b>	<b>1.7% (13979)</b>	<b>810810</b>

Table 3 shows that 81 010 individuals responded to the item on whether they believe they can persuade a sex partner to use a condom. Across all different marital status groups 70.1% (574 748) believe that they can, all the time, negotiate for safe sex; 16.1% (136 589) said they believe they can sometimes, and 10.1% (85 494) responded with a 'NO', which means that they believe that they are unable to persuade a partner to use a condom. The table further shows that in relation to those who are in stable relationships such as marriage and cohabitation, those who are cohabiting are comparatively more able to negotiate for safe sex. It can further be deduced from the table that those who are never able to persuade their partners to use condom are those in marriage 36% (30 873) while those who are never married are at 29.6% (25 351) and those who are cohabitants are at 28.4% (24 289) are able to negotiate for safe sex. Those in other marital statuses constitute less than 4% of the population that responded to this item.

### **Discussion and conclusions**

This paper examined knowledge and attitudes about HIV and AIDS among individuals who are married, never married, cohabiting, separated, divorced and widowed aged 10-64 years using results from the Botswana Aids Impact survey of 2013 (BAIS IV). The BAIS findings, which show that HIV prevalence is high among those in stable relationships such as marriage, are consistent with findings elsewhere in Africa (Clark 2004; Ewusha 2012; Omanje, Bosire & Mwenda 2015). The findings further reveal that a high proportion of individuals in the different marital status relationships have some basic knowledge about HIV and AIDS. However, it is still a concern that despite having access to HIV related information through the many programmes that the government has put in place, there are some individuals in marital relationships who still lack basic knowledge about HIV and how to prevent it.

The findings show that only half of the people across the marital statuses are able to convince their partners to use a condom. Failure to persuade a partner to use a condom is inconsistent with the knowledge that people have about how HIV is transmitted. Married women and those in cohabiting unions are less able to persuade their partners to use condoms when compared to those who were never married. This finding is consistent with literature that suggests marriage is a risk factor in the spread of HIV. This can be attributed to some cultural beliefs that once *bogadi* (bride price) has been paid then the married woman has say on issue relating to her body and can therefore not deny her partner conjugal rights (even if it means having unprotected sex) (Smith 2007). Failure to negotiate the use of a condom shows that there is lack of communication and negotiation skills in negotiating safe sex. Since there is lack of skills, making a commitment to prevent HIV and AIDS is difficult. It has been observed, especially among married women, that women are not able to negotiate for the use of a condom even in instances where they suspect or even know that their husbands are engaged in extra-marital sexual affairs (Smith 2007; Williamson, Liku, McLoughlin, Nyamongo & Nakayima 2006)). In other words, even though individuals may know about the benefits of using a condom, there is fear of initiating its use lest one is either perceived to be accusing the other of infidelity, or admitting to it oneself (Hebling & Guimarães 2004; Chimhiri 2007). There is still a gap between the knowledge that people have and their sexual behaviours, especially where condom use is concerned and practice. Those in stable relationships such as marriage are most likely not to use their knowledge to

negotiate safe sex in such a way that they can maintain peace and stability in the home, conform to cultural expectations and prevent the transmission of HIV at the same time.

The study further reveals that some individuals are not able to avoid non-consensual sex as they are not able to convince their partners not to have sex if they are not interested. This implies that they are having sex against their will. The data show that those who are married are less likely to decline sexual advances from their partners. Those who have never been married are more able to do so. The article concludes that marriage is still a risk factor in the spread of HIV and AIDS. This, however, does not explain why the BAIS IV findings show that there is a decline of the infection among those who are married.

Though data from BAIS IV do not analyse the statistics of the responses by gender, for instance, how many men and women responded to the selected items, literature shows that men are usually the decision makers (Ewusha 2012; Masengwe 2012). Therefore one can reasonably infer that those who responded that they are never able to persuade their partner to use a condom or they are not able to refuse sex are women. A further inference can be made that those who responded that they are able to persuade their partners to use a condom and they are able to refuse sex are men. One may infer that marriage, especially the payment of *bogadi*, can explain married women's inability to negotiate safe sex because of the link between the practice of *bogadi* and male dominance in the relationships. This, however, does not explain why those in cohabiting relationships are unable to refuse sex since no '*bogadi*' has been paid for them. The socio-cultural assumptions that women are asexual, and sex is a defining feature of manhood could explain the dominance of men across marital relationships even where the relationship has not been formalised through the payment of *bogadi*.

This paper concludes that though many people in the different marital statuses know the basic facts about HIV and AIDS, there are some who still cannot negotiate safe sex or refuse sex. This suggests a possibility that they might lack effective communication, negotiation and refusal skills. Individuals who are married and those who are cohabiting seem to lack such negotiation skills because of patriarchal beliefs and practices.

## **Recommendations**

The main limitation of the BAIS IV data is that it is 'weighted'; that is, it represented populations. This hinders statistical inference in the form of testing of hypotheses. This study could have been more meaningful if the selected variables (refusal of sex and negotiating for the use of a condom) could be analysed by gender, educational and occupational levels. These would allow for more specific recommendations to be made.

This paper has shown that people in all marital status relationships know basic facts about HIV and AIDS, but seem to lack skills to communicate and negotiate the terms of their sexual encounters. We therefore recommend that the government should continue to educate people on HIV and AIDS, but focus more on life skills. This could be achieved by utilising the already existing structures like clinics, social workers in different departments, and churches that have marriage counsellors as the human resources with relevant skills already exist in these facilities. This way a life skills education can be infused effectively.

The BAIS IV results show that individuals who are cohabiting and those in marriages have more challenges in persuading their partners to use condoms and are unable to refuse sex. This calls for culturally sensitive programmes that would empower these people. Both men and women need to be empowered with communication and life skills. Culturally sensitive programmes would

identify and address gender stereotypes which empower those who are married and cohabiting. Therefore a skills based education, tailor-made for those in stable relationships, is needed. That is, the focus should be directed to behavioural change than dissemination of information since the four BAIS results already indicate that there is adequate knowledge about HIV across the different marital statuses. The government, through the ministries of Health, Education and Skills Development, the Women Affairs Department and Men's Sector need to invest in skills development in order to improve communication and the negotiation for safe sex.

Most literature on cultural beliefs about HIV and AIDS is qualitative, and relies mostly on secondary sources (Ewusha, 2012; Mbonu, Borne & De Vries, 2009). With more knowledge about HIV and AIDs there is need to evaluate the current perceptions towards sexual issues. Therefore research institutions like the University of Botswana need to be sensitised to do cultural studies that are representative of the population to de-mystify traditional beliefs relating to reproductive health, including issues of HIV. For instance, traditional patriarchal values such that those encoded in and transmitted through linguistic artefacts such as the proverbs '*monna poo ga a agelwe lesaka* and *monna selepe oa adimanwa* should be interrogated and debunked.

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