

Gender and HIV/AIDS in Botswana: Thirty years later

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Abstract

The first case of HIV in Botswana was recorded in 1985. For over three decades Botswana experienced one of the highest rates of HIV in the world, with women being the most affected by the virus. This paper discusses the patterns of HIV prevalence in Botswana. It uses the results of the Botswana AIDS Impact Survey of 2013 (BAIS IV) to understand the spread of HIV and AIDS. It also discusses the role of the dominant and pervasive ideologies with regard to gender and sexuality in Botswana in order to account for the differential patterns in the prevalence rates of HIV. The paper adopts a descriptive approach to interpret the findings of the survey by situating them within the literature on HIV. It argues that the differential patterns of HIV prevalence rates in Botswana can be explained by considering socio-economic factors, gendered ideologies and cultural practices. I argue that while the interventions adopted to date have contributed significantly to improved quality of life for people living with HIV, programmes that target women and exclude men (and vice versa) are not helpful, and may reverse the progress made so far. I recommend that while the BAIS IV results are informative, there is need to follow up the statistical findings with more qualitative studies that can elicit the narratives behind the statistics. These narratives would provide first hand information about the real life experiences of research participants and help us understand better the behaviours associated with HIV risk.

Keywords: Gender, HIV and AIDS, prevalence rates, sexuality, culture, ideologies.

Introduction

The first case of AIDS in Botswana was recorded in 1985. By 2003, the HIV prevalence rate among adults was estimated at 37.2 % (UNAIDS 2004). For a long time, Botswana was the epicentre of the epidemic with the highest prevalence rates in the world. Recently it was overtaken by Swaziland (UNICEF 2015). In the last two to three years the prevalence rate of HIV was estimated at 24.8 % (UNAIDS 2014), but other studies put it at 18.5 (BAIS IV, 2013). It is apparent that HIV prevalence rates vary by geographical location, as well as by other factors such as gender, race, sexual orientation, and socio-economic status. In Botswana, HIV prevalence rates were initially higher in cities/towns and large villages, but migration and return migration from rural to urban centres meant that the virus spread to rural areas. This is consistent with global prevalence patterns. For example geographical differentiation of HIV prevalence was the primary subject of interest in the early years of the disease when researchers were interested in the origins of HIV, and when Africa was identified as the possible incubator of the virus, with countries such as France, America, and Portugal were identified as diffusion nodes for the spread of HIV to rest of the world (Cliff and Smallman-Raynor 1992). The geographical model in the study of the spread and prevalence of HIV across the world shows that developing countries, especially those in Sub-

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Saharan Africa and South East Asia, are the worst hit. Botswana's HIV prevalence patterns are thus similar to the global patterns in terms of geographical patterns in that some districts are more affected than others. However, as mentioned above, other factors such as age, sex (being male or female), race, socio-economic class, and sexual orientation are also important factors in the spread of HIV. Patterns of HIV infection in Botswana (and indeed elsewhere in the world) suggest that sections of populations that are socially disadvantaged (because of sexual, racial, economic, cultural or gender related factors) are the ones most at risk of contracting HIV (Jewkes, Levin & Penn-Kekana 2003; Jewkes & Morrell 2009; Ministry of Health, Botswana 2012; Onessimmo 2016).

This paper discusses the patterns of HIV prevalence in Botswana using the results of the Botswana AIDS Impact Survey of 2013 (BAIS IV) to make sense of the differential patterns of HIV prevalence in Botswana. It focuses on gender as a variable, and interprets the results of the fourth *Botswana AIDS Impact Survey* of 2013 (BAIS IV) in terms of how gender correlates with HIV prevalence rates. The benefit of this exercise is two-fold: it facilitates easy access to, and comprehension of the survey results by ordinary people who are critical stakeholder in the fight against HIV and AIDS; secondly, by situating the study within the literature on HIV in Africa and the rest of the world, and by considering dominant cultural gender ideologies, the paper also helps us understand the gender differences in the HIV prevalence rates in Botswana.

HIV/AIDS in Botswana: Prevalence rates and risk factors

The gender variable in HIV prevalence in Botswana is comparable to HIV-related demographics in other low to middle-income countries, and contrasts with those in high income countries. In low to middle-income countries, women constitute between 40-60% of all people living with HIV. For example, in Sub-Saharan Africa, 58% of people living with AIDS are women (United Nations Women's Program 2015). The statistics are similar outside of Africa. For example, in Papua New Guinea 57% of all individuals living with HIV are women and girls (ibid), and young women aged 12-19 are especially vulnerable. In Botswana, most studies that have been conducted on HIV link gender with HIV and AIDS prevalence, HIV related mortality rates, health seeking practices and adherence to treatment (Chilisa 1992; Preece 2001; Dunkle et al 2004; Andersson, Cockcroft and Shea 2008; Botswana Ministry of Health 2012; Onessimo 2016; UNAIDS 2016). Although the national prevalence rate has somewhat decreased over the years, women continue to be disproportionately affected by HIV and AIDS.

By contrast, in the United States of America (USA) - a developed country - only 23% of people living with HIV/AIDS are women (Onessimo 2016). However, the consensus theory is that those who exist on the fringes of society, or are in some way marginalised, bear the brunt of HIV infection. In the USA for instance, gay/bisexual men and men who have sex with other men (MSM) are the most affected, especially African American men who have sex with men (MSM) (US Center for Disease Control and Prevention n.d). In general, black/African Americans comprise the largest demographic affected by HIV compared to other ethnicities. For example, while black people make up 12% of the American population, they accounted for 41% of new HIV infections in 2010. Hispanics are the second most affected as they represented 16% of the population and accounted for 21% of new infections in 2010 (ibid.). MSM represent 4% of the male population and 78% of new infections (ibid.).

In Botswana in 2012, the Ministry of Health conducted a biological and behavioural surveillance survey for the most at risk members of the society; namely, female sex workers (FSW), men who have sex with men (MSM) and people who inject drugs (PWID), in order to determine the prevalence of sexually transmitted infections, including HIV, among these populations. This was conducted despite limited studies on these groups of people. The objective was to understand the prevalence and incidence rates of STIs, and accompanying risk factors, in order to put in place targeted interventions. This was one of very few studies on sexual minorities to be conducted in Botswana. The results show that for FSW HIV prevalence rates vary by district from 53.5% in Francistown to 68.5 % in Kasane. Gaborone, the third surveyed city, had a prevalence rate of 65.5%. Thirty-four percent of the HIV positive FSWs were Zimbabwean. Among the Zimbabwean FSW the prevalence rate was 69.5 compared to 57.7% among Botswana FSWs. According to this study, HIV was high among all age groups and ranged from 44.2% for the under 20s, to 79.8% for the 30-39 year olds to 74.9% for the 40-49 year olds.

HIV prevalence rates among MSM have a nationwide average of 9.2% and ranged from 11.7% in Francistown to 25.9% in Kasane. In Gaborone it was 12.3 (Ministry of Health 2012). According to the survey, this could be due to the fact that the sample consists of mainly young men, so it may not reflect accurately the burden of disease among MSM. For instance, in the general population an increase in age is associated with higher HIV prevalence, so it is likely that if the sampling was done among older men the prevalence rate would likely be higher. Additionally, the samples that were used were small in total due to the secrecy of some sex relationships in Botswana. The studies reviewed above show that the socially disadvantaged are more at risk of contracting HIV. For the purpose of this paper, gender is the primary variable, but other variables are considered because gender is intertwined with many socio-cultural and economic variables in the determination of the risk of HIV infection. These are used to account for the current patterns of HIV prevalence rates in the country.

Methodology

This paper uses results of the Botswana AIDS Impact Survey (BAIS IV) (2013) to understand the prevalence of HIV among men and women in Botswana. It adopts a descriptive interpretation of the results by situating them within existing scholarly discourse on HIV/AIDS. The Botswana AIDS Impact Survey IV of 2013 was conducted in 18 districts of Botswana in order to provide up-to-date information on the prevalence and incidence of HIV in Botswana for those aged 18 months and older; to provide indicative trends in sexual and preventative behaviour among those aged 10 to 64 years; to provide comparisons between HIV prevalence rates, behaviour, attitude, poverty and cultural factors associated with the epidemic with estimates from previous surveys; to increase the number of those who know their HIV status, and to link those who were found to be infected with healthcare providers; and to provide information for use by the government and non-governmental stakeholders within and outside Botswana (BAIS IV, 2013:5). The survey used quantitative methods with data collected using interviews and loaded into smart phones. It measured both the prevalence rate (the combined number of old and new infections) and the incidence rate (new infections). The purpose of analysing these results is to facilitate access to the research results for ordinary people by simplifying them for their benefit. First I reproduce the results of the study and then provide a descriptive interpretation of the patterns of HIV prevalence by district, age and gender. The second part of the analysis provides an explanation of the

differentials in HIV prevalence rates by situating the patterns of HIV prevalence within the dominant cultural and gender ideologies in Botswana.

Results

The next two sections present the results of BAIS IV which inform the subsequent discussion.

HIV prevalence by district and gender

The results of the BAIS IV indicate that the prevalence rate is higher in urban centres (19.2) compared to rural areas (17.4%) (p. 10). Table 1 below indicates HIV prevalence rate by gender in each of the 26 districts in Botswana.

Table 1 HIV prevalence rate by district and gender

| District | Male | Female | Total Population |
|-------------------------|-------------|-------------|------------------|
| Gaborone | 13.4 | 19.8 | 17 |
| Francistown | 20.7 | 27.5 | 24.3 |
| Lobatse | 13.4 | 20 | 17.2 |
| Selibe-Phikwe | 25.4 | 29.3 | 27.5 |
| Orapa | 9.9 | 20.2 | 15.6 |
| Jwaneng | 8.5 | 16.7 | 12.8 |
| Sowa | 13.3 | 26.5 | 19.8 |
| Southern | 10.6 | 12.8 | 11.8 |
| Barolong | 8.9 | 25.7 | 20.3 |
| Ngwaketse West | 10.9 | 24.5 | 18.8 |
| Southeast | 19 | 14.6 | 16.6 |
| Kweneng East | 20.2 | 22.1 | 21.5 |
| Kweneng West | 7 | 16.1 | 11.8 |
| Kgatleng | 15.5 | 23.8 | 19.9 |
| Central - Serowe | 16.4 | 17.8 | 17.1 |
| Central -Mahalapye | 20.1 | 25.9 | 23.1 |
| Central- Bobonong | 15.3 | 22 | 19.3 |
| Central- Boteti | 15.3 | 25.5 | 20.3 |
| Central- Tutume | 14.1 | 21.5 | 18.2 |
| Northeast | 13 | 20.4 | 17.7 |
| Ngamiland South | 13.3 | 17.2 | 15.2 |
| Ngamiland North | 10.6 | 15.4 | 13.5 |
| Chobe | 16.5 | 18.9 | 17.7 |
| Ghanzi | 14.6 | 19.9 | 17.1 |
| Kgalagadi South | 7.1 | 15 | 11.1 |
| Kgalagadi North | 18.2 | 18.1 | 18.1 |
| Total Population | 15.6 | 20.8 | 18.5 |

Source: *Botswana AIDS Impact Survey* (Summary report) of 2013 p. 12

The table indicates that there is a strong link between HIV prevalence, geographical location and gender, and shows that women are consistently the most affected. For example, in some cases the prevalence rate among women is two to three times higher than that of their male counterparts (for example, in Orapa, Sowa, Borolong and Ngwaketse West). Certain areas in the country are more affected than others. For instance, in Mahalapye, Ghanzi and Ngwaketse women aged 30-34 are up to five times more likely to be living with HIV than men, whereas in Chobe more men than women are living with HIV; this is a departure from the normal patterns, but the disparity is small. These results show that there is a strong relationship between geographical location, gender and HIV.

Table 2 illustrates the prevalence rate by district, age and gender, showing 9 of the 26 districts of Botswana that took part in BAIS IV of 2013. They were chosen here because they represent the highest and lowest disparities in prevalence rates for men and women.

Table 2 HIV prevalence rate by district, age and gender

| District | 15-19 | | | 20-24 | | | 25-29 | | | 30-34 | | |
|--------------------------|-------|------|-------|-------|------|-------|-------|------|-------|-------|------|-------|
| | M | F | Total | M | F | Total | M | F | Total | M | F | Total |
| Gaborone | 0.0 | 0.0 | 0.0 | 0.0 | 11.8 | 7.2 | 4.2 | 17.0 | 10.9 | 25.0 | 55.5 | 42.2 |
| Francistown | 0.0 | 10.2 | 6.5 | 2.9 | 23.3 | 13.4 | 11.9 | 26.2 | 20.0 | 25.0 | 56.0 | 46.8 |
| Central Mahalapye | 7.4 | 00 | 2.5 | 4.6 | 11.4 | 7.6 | 39.5 | 50.7 | 44.5 | 20.7 | 74.3 | 43.6 |
| Kweneng West | 0.0 | 20.6 | 3.7 | 5.3 | 12.9 | 9.1 | 24.3 | 24.3 | 24.3 | 23.9 | 0.0 | 14.9 |
| Kgatleng | 0.0 | 9.4 | 4.7 | 0.0 | 26.4 | 13.7 | 7.7 | 40.7 | 25.3 | 23.2 | 45.6 | 33.8 |
| Chobe | 0.0 | 23.6 | 15.7 | 14.6 | 13.8 | 14.2 | 10.7 | 20.8 | 16.2 | 28.9 | 20.0 | 25.3 |
| Ngwaketse West | 8.1 | 12.2 | 9.6 | 11.2 | 7.6 | 8.9 | 0.0 | 22.3 | 15.9 | 21.3 | 61.8 | 43.1 |
| Ghanzi | 0.0 | 19.7 | 10.8 | 9.4 | 4.7 | 7.0 | 13.4 | 34.4 | 22.5 | 14.3 | 65.9 | 32.9 |
| Kgalagadi North | 0.0 | 12.9 | 6.1 | 0.0 | 5.3 | 2.9 | 0.0 | 12.9 | 7.7 | 15.4 | 19.1 | 17.5 |

Source: *Botswana AIDS Impact Survey* (Summary report) of 2013 p. 19

The results of BAIS IV (2013) indicate staggering disparities in HIV prevalence rates between young men and young women. For example, in the Kweneng West District, the prevalence rate for males in the age group 15-19 is 0.0% for males and 20.6% for females. Similarly, in the Chobe District, it is 0.0% for males and 23.6% for females. In ages 20-24 in Sowa, the rates are 0.0% for males and 22.6%, while in the Kgatleng District the rate is 0.0% for males and 26.4% for females. Kgalagadi North figures show that from ages 15-29 the prevalence rate for males is 0.0% and 12.9 for females. There are possible reasons for these differences, and one of them could be that the young women who took part in the survey may be having sexual relations outside their age groups; alternatively, they may have relationships outside the geographical locations in which they reside, but this does not satisfactorily explain such large disparities. For example, in Kweneng West the prevalence rate for women aged 30-34 is 0.0% while for the males it is 23.9%. The most likely explanation for this anomaly is that both the men and women in this district may be having sexual contact with people outside their age group or their geographical location. Or perhaps this is a mistake, since women in this age group are at the peak of sexual activity and are of child bearing

age. It is therefore implausible that their HIV prevalence rate is 0.0% when their male counterparts have a prevalence rate of 23.9%.

Between ages 20-34, women are most sexually active, and are at the optimum age for reproduction. It is unsurprising that women at this age have the highest HIV prevalence in any district. In Mahalapye, for instance, the prevalence rate for men and women in the ages 30-34 is 20.7% and 74.3% respectively (BAIS IV, 2013). This means that in this district, three-quarters of women in this age group are living with HIV, which is more than three times the percentage of men living with HIV in the same age group. Other districts such as Gaborone and Ghanzi also show that while younger women have significantly higher prevalence rates than their male counterparts, the differences in the 30-34 age group is unprecedented. Since women in this age group are relatively mature, the situation can be explained in terms of risky sexual behaviour (such as multiple concurrent partnerships, incorrect use or non-use of condoms by both males and females, deliberate choices to procreate, gender based violence, which leads to 'disability of choice' (Andersson et al 2008), or all of these.

While females clearly bear the brunt of the HIV epidemic, men are not immune either; high numbers of men are HIV positive, especially men in their forties. For example, 26.5%, 30.8% and 24.0% of circumcised men in the ages 30-34, 35-39 and 40-44 respectively tested HIV positive after circumcision (BAIS IV, p.14). This is nearly one and a half times the national average. This is significant because the circumcision programme targets men who are HIV negative. The high HIV prevalence rate among circumcised men is especially worrying as it suggests that men may not be taking seriously the pre-test counselling provided at the health centres, or they misunderstand the purpose of circumcision to mean that they are now immune to the virus. In the next sections, I discuss the results of BAIS IV by situating them within the context of other literature on HIV, as well as critically commenting on gendered ideologies and cultural practices as the main factors that contribute to gender differences in HIV prevalence in Botswana.

Discussion

This section analyses the results of BAIS IV presented above by situating them in the context of dominant gender ideologies and practices that may explain the disparities in HIV prevalence rates. It attempts to explain why women seem to be more vulnerable to HIV infection, and why some geographical areas more affected than others. There are a number of schools of thought concerning culpability: intergenerational sex; women's sexuality is policed and controlled by men; women are biologically predisposed to contracting HIV; women suffer many social and economic disadvantages, such as having to sell sex, and gender based violence and poverty, and these put them at risk of infection. Residing in certain administrative districts increases the likelihood of one becoming HIV positive (BAIS IV).

Intergenerational sex

BAIS IV (2013) results suggest that young women aged 15-19 are not having sexual relationships with men of their age because their age-mates have 0% prevalence rates. Accordingly one can summarise that young women aged 15-19 years are engaging in intergenerational sex with older partners. This conclusion is supported by research in South Africa where it was found that young women are attracted to older wealthier men, which makes them dependent on these men, and renders them unable to negotiate safe sex (Jewkes, Levin and Penn-Kekana 2003). Based on

cultural sanctions, older males have sexual relationships with younger females. In many, if not all cultures of Botswana, it is customary, and even desirable for a man to court and marry a younger woman. The age difference ranges from a couple of years to a couple of decades in some cases. It is believed that men do not age, and they are not constrained by any cultural barriers to engage in sexual relationships with younger women. There are some legal obstacles to intergenerational sex that involves very young girls. For example, Section 147 of the Penal Code (CAP 08:01) proscribes sexual intercourse between adults and minors under the age of 16, yet BAIS IV results show that young women aged 15-19 years are probably engaging in sexual activities with men outside their age group as their age group has a 0.0% prevalence rate in most of the districts. This suggests therefore that young men aged 15-19 are probably virginal and older men (mostly) engage in sex acts with much younger women in the 15-19 age group. Evidence from BAIS IV data indicates that early sexual debut for males is 4.4 % while for women it is 24.8% (see the discussion in Moroka, this volume), and this partly explain higher HIV prevalence rates among females in this age group. Some of the women in the 15-19 year age group are too young (BAIS IV) for the sexual interaction to be considered legally consensual.

The cultural expectation that men will court and marry women who are significantly younger than them ensures the sustenance of intergenerational sexual practices, including statutory rape. Young women, especially those in the ages 15-24 may not have sources of income, especially those who are still in school or have just graduated from school and are unemployed. Such young people are not just easily manipulated by their older, more experienced, partners; they may depend on them for economic support and, therefore, do as the men tell them. However, this argument should not be used to suggest that young women, especially of consenting age, have no agency whatsoever; they may engage in intergenerational sex out of choice.

Intergenerational sex is also linked to transactional sex which entails unequal power relations and the likelihood of unprotected sex (Andersson et al 2008). Women who engage in sex for material gain with older partners are disadvantaged in two ways: they are usually younger and poor, and accordingly are likely to have limited negotiation power, and often do as their richer older partners tell them (Andersson et al 2008; Lindsey, Hirschfeld and Tlou 2003). The very high HIV prevalence rate (68.5%) among female sex workers (FSW) in Botswana (Ministry of Health 2012), suggests that transactional sex is a very high risk activity. It may involve relatively young girls and older partners. In Botswana more young girls, especially from marginalised communities than boys drop out of school due to pregnancy and the fathers of their children are usually older men (Bolaane and Saugestaad 2005). This is because fewer boys are responsible for pregnancy. The BAIS results testify to the fact that while young girls are sexually active boys are mostly inactive. Even country-wide, gender disparities in HIV prevalence rates among the under 25s suggest that more girls than boys engage in unprotected sexual activities with partners outside their age groups. The reasons for this behaviour are varied, but poverty, which leads to transactional sex, may be one of the major drivers of HIV infection among young women. Young women are more likely than men to engage in transactional sex with older partners, hence the higher prevalence rate among females. But the question one can ask is whether poorer younger men are not engaging in transactional sex with rich older women. Perhaps the answer lies in the fact that more young women than men are unemployed (BAIS IV, 2013). Studies of high risk factors indicate that women who engage in 'survival sex' (i.e. those who engage in transactional sex) but don't consider themselves sex workers, may have multiple casual partners in addition to their regular ones (Andersson et al 2008).

In the USA in 2008, young men who have sex with men were more than 2.5 times more likely to be HIV positive than young women in the same age group (Mustanski & Newcomb 2008). Black young men were particularly hard hit. But what was difficult to understand was why young black men who have sex with other men more vulnerable to HIV infection than other racial groups even though they did not engage in higher risk practices than other racial groups, did not have many sexual partners, reported as much as, or more condom use than other racial groups and used drugs less. The explanation they proposed was that young men engage in homophily (same race homosexual relationships) with older men and because older black men had a higher HIV prevalence (28%) young black men who engaged in sexual relationships with older males contracted HIV from them. This was consistent with findings among girls who engaged in sexual relationships with older male partners. But Millet et al (2007) argue that there is no behavioural explanation for why young black men who have sex with other men have a higher prevalence rate (because of their sexual behaviour is not any riskier than other racial groups) and suggest that other factors such as social networks need to be examined to find a satisfactory explanation. Perhaps the case of young men who have sex with men (YMSM) in the USA can help us understand why there are gender disparities in HIV prevalence in Botswana. But more importantly, it helps us realise that intergenerational sex between young women and older men does not provide an exhaustive explanation for gender disparities in HIV prevalence. Perhaps a combination of factors is a play, and the next section focuses on gender based violence and the risk of HIV infection.

Gender-based violence, risky sexual behaviour and HIV

Anderson, Cockcroft and Shea (2008) assert that gender based violence (GBV) is common in the HIV hyper-endemic countries of Southern Africa, among which is Botswana. Studies reviewed by Andersson, Cockcroft and Shea (2008) show that gender-based violence, which affects mainly women, is associated with the risk of HIV infection. A study conducted among women attending an ante-natal clinic in South Africa showed that physical intimate partner violence, on its own, or coupled with sexual intimate partner violence, increased the odds of being HIV positive (Dunkle et al. 2004). Similarly women with controlling partners were more likely to say that they had never used a condom. Intimate partner violence was also associated with transactional sex and the likelihood of having multiple partners. Women who have suffered prolonged physical, sexual, and emotional violence are more likely to have low esteem and engage in multiple sexual relationships as a result (ibid). Andersson, Cockcroft & Shea (2008) assert that gender-based violence impacts women in a number of ways: “choice disability in relation to prevention decisions, reduced self esteem, sexual maladjustment and drug use as a method of coping and psychopathology such as depression” (p.575). Disability of choice and drug use are themselves high risk factors. Drug use inhibits a person’s cognitive faculties leading to poor choices in sex related decisions.

Sexual violence is a common form of GBV in much of sub-Saharan Africa (Onesimo 2016). Feminist theorist Kelly (1988) suggests that sexual access, by which she means “a range of processes through which women are defined as sexual objects available to men” (p.346) leads to the assumption that men have the right of access to women they do not even know, or with whom they have slight acquaintance (ibid.) This assumption leads to men committing sexual assault or rape. According to some research conducted on convicted rapists in the USA, men saw sex as an entitlement (ibid.), a view which is sanctioned by some cultures and sees “women as sexual commodities” (p.347).

A number of other studies conducted on the relationship between gender-based violence and the risk of HIV infection indicate that there is a link between the two (Dunkle et al 2004; Harvard School of Public Health, 2006; Andersson Croft and Shea 2008). In a study conducted among women aged 16 and over attending antenatal clinics in Soweto, South Africa, Dunkle et al (2004) used a cross-sectional survey of 1366 women in order to find out whether past experiences of partner violence, child sexual assault, forced first intercourse, adult sexual assault by non-partners or current involvement with a controlling partner are associated with new HIV infection. They also wanted to find out whether experiences of violence and control are associated with increases in self-reported risk behaviour such as multiple partners, sexual contact with non-primary male partners, transactional sex, non-use of condoms and substance abuse. Their findings show that child sexual assault, forced first intercourse, adult sexual assault by non-partners resulted in increased sexual risk behaviour among the affected women.

Whatever form it takes, gender-based violence is one of the main obstacles to effective prevention of the spread of HIV, especially among women – the largest single affected group. It is thus unsurprising that in Botswana, one of the countries identified as having high rates of GBV, young women of child-bearing age are those most affected by HIV. In fact, compared to their male counterparts, young women of ages 20-34 years are 2-3 times more likely to contract HIV (Andersson, Cockroft & Shea 2008). The consensus in most literature on HIV/AIDS is that gender-based violence increases the vulnerability of women to HIV infection (Khrishnan et. al. 2009; Jewkes & Morrell 2009). Jewkes and Morrell conducted 27 in-depth interviews with 16 young women aged 17-21 in Umthatha, Eastern Cape Province, South Africa. Evidence from the interviews suggested that the young women viewed male control as the natural order and did not challenge them. As a result, these women accepted male dominance, and the accompanying violence, as normal. The fact that male power/violence is viewed as normal suggests that women follow the decisions of men whom they view as leaders by default, and this affects their ability to decide what is right for their sexual health.

Marriage, gender and traditional cultural ideologies

In Botswana gender inequality has been identified as the main cause of higher HIV infections among women (Preece 2001). According to Preece, even though more than half of the households are headed by women, this does not necessarily translate into female power, which women could harness in making important decisions. Following Mookodi (2000), she asserts that the concept of '*tlhogo ya lelwapa*' (head of the household) is often defined narrowly to mean a man who lives in the same physical space as the woman and is the main provider and decision maker. Yet, she says, this does not take into consideration the complex nature of the Tswana extended family structure where a head of a household may be a man who actually resides outside a particular woman's physical space yet still wields a certain amount of (decision-making) power by virtue of being the head of the extended family, or that men in general are primary and women secondary. Preece also charges that the dominant discourses of HIV prevention are male biased in that the insistence on condom use privileges "male forms of sexual relations" (Preece 2001:228), yet women are blamed for spreading HIV. The condom puts men in control and women in a position of the controlled, so that they must accommodate rather than influence sexual relations. Also, cursory observation suggests that female condoms, which could put women in charge of their sexuality, are not readily available in Botswana.

Marriage rituals involve the grooming of brides to obey their husbands at all costs, including advising them against making their husbands account for their absences from the marital bed, and instead to act as fools (Ellece 2011). Women are groomed to ensure harmony in their marriage, and sacrifice their own welfare. Also, the marital relationship in Botswana is often constructed symbolically as that of the ‘child wife’ (women’s infantilisation) and the ‘father husband’ (ibid). As Rapoo (2013) puts it, gendered ideologies in Botswana are couched in proverbs such as “*poo ga ke di tlhakanela lesaka*” [Two bulls can never share a kraal]. Such sayings construct gender relationships that preclude women’s power to negotiate as equals in a ‘sexual’ relationship. The metaphor of two bulls suggest that if a man and a woman were to have equal rights, there would be no peace as bulls are prone to fight. In other words man and woman cannot be equals, even in a relationship that can determine their reproductive health status.

Onesimo (2016) argues that in Botswana poverty cannot be said to fuel the spread of HIV because there are poorer countries with much lower per capita GDP that have much lower HIV prevalence rates. Instead, she asserts that at the heart of the HIV crisis in Botswana are gender ideologies. While she acknowledges that biologically women are more predisposed to HIV infection (see Quinn & Overbaugh 2005), she says that the real drivers of HIV in Botswana are cultural ideologies, including gender ideologies. She cites inequality in the professions and politics as the main drivers of the spread of HIV. However, these arguments are puzzling because Botswana has one of the highest literacy rates in Sub-Saharan Africa and women’s literacy rate is higher than that of men at 89.6 and 87.9 respectively (Statistics Botswana 2014). More women than men are employed in wholesale and retail, hotels and restaurants, finance, public administration local government, education, health and other community projects, while more men than women are employed in agriculture, mining and quarrying, manufacturing, electricity and water, transport and communication and real estate (Statistics Botswana 2014). Botswana’s gender based oppression and inequality is not idiosyncratic. So the gender oppression argument is not convincing.

Similarly, Rakgoasi (2010) argues that traditional gender ideologies are responsible for the marginalisation of men in sexual health services provision in Botswana. He criticises Botswana’s health care system, especially primary health care which offers among other services, reproductive health education. He accuses the health system of being female oriented (Rakgoasi 2010). Rakgoasi argues that even when men are included, it is for the benefit of the women, who are the real target of health care programmes such as the Prevention of Mother to Child Transmission (PMTCT). Men are left out, Rakgoasi claims, and as a result more men have died of HIV related complications than women, even though more women than men live with the virus. He attributed this to the fact that while women learn about reproductive health matters from health care professionals (e.g. the ante-natal care clinic is traditionally attended by women alone, and issues of child birth and care are a culturally exclusive women’s domain); men on the other hand rely on the (mis-) information from their peers. They are not willing to seek medical assistance timely and end up dying from preventable causes because health care programmes are not male friendly. According to Rakgoasi, traditional masculinity dictates that a man should not show weakness by going to the clinic for ‘minor ailments’. This has led to many men concealing illnesses until it is too late, or seeking medical advice from their peers. There is also the element of shame in seeking health care in a health care system that is perceived to be female oriented. If we extrapolate this to HIV/AIDS prevention and care programmes, Rakgoasi’s argument is appealing for two reasons. First, if men are culturally regarded as heads of households, and important decision-making lies

with them, it follows that a health care system that excludes men is not going to be effective in the prevention of HIV. Secondly, men will not develop a culture of seeking healthcare services and may have a phobia for professional medical help, especially if the majority of healthcare workers are female. This can only result in important health information being available to the people who do not have decision-making powers, thus rendering the information of far less value.

Female sexuality and compulsory parenthood

Another cultural ideology is the mandatory motherhood discourse; and it puts women under tremendous pressure to have children, even outside wedlock (Mokomane 2001; Ellece 2012). Cultural values place parenthood, and especially motherhood, on a pedestal, and consider childbirth as a measure of womanhood (Ellece 2012); women (and men) sometimes find themselves under pressure to procreate either to prove that they are capable, or to fulfil a perceived need for children. Such cultural expectations may lead young women (and men) who have no steady partners to engage in unprotected sex to have children, even though there is no promise of long term commitment to the relationship, or to the children issuing from it. Traditional expectations of a woman to give birth soon after wedlock compel women to engage in unprotected sex to fulfil the cultural requirement of bearing the “cattle” children (Ellece 2012). The primacy of reproduction means that HIV infection is especially punishing as it attacks the very basis on which family is founded. Ironically, the expectations that young people will ensure the survival of their family line through procreation may also mean that they will act sacrificially to try to do so.

Multiple concurrent partnerships

The differential HIV prevalence rates may also be partly explained by reference to the culture of multiple concurrent partnerships (MCP) in Botswana. Multiple concurrent partnerships are defined as involvement in sexual relationships with more than one sexual partner at any given time (Gourvenec et al. 2007). MCPs contrast with ‘serial monogamy’ because in the case of the latter an individual engages in a new relationship after the previous one has ended. There is a consensual agreement that multiple concurrent relationships (MCP) are responsible for fanning the spread of HIV, especially in Botswana. This is because persons engaged in MCP are connected through a network of sexual relations which link multiple individuals in that network. Potentially it would thus take only one individual in such a network to spread HIV to the others.

According to Ditiro et al. (2009), more men reportedly engage in MCP than women, with 19% of men and 6% of women reporting having concurrent sex partners. This difference may imply that women under-report multiple concurrent partnerships because of the gendered social stigma associated with the phenomenon among women. But their findings are supported by the baseline survey of 2007 in which Gouvernec et al. (2007) sought to understand the nature, drivers of and barriers to multiple concurrent partnerships (MCP) among young men and women aged 15-34. The results of the survey showed that more men than women had reported multiple concurrent relationships at 33% and 17% respectively (see also Laletsang et. al. 2009). We can infer from this that women have a higher prevalence rate of HIV than men because one man who is HIV-positive can infect several women in his sexual network. However, this does not exclude the fact that women, especially those who engage in transactional sex, have several sexual partners and so they put themselves and their many partners at risk. The 2007 baseline study showed that married, unmarried and co-habiting persons all reported having more than one sexual partner in the 12

months leading to the study. The percentages may have changed, but what is clear is that MCPs are practised by all demographic groups, which is why they pose such a high risk.

Summary and recommendations

The results of the Botswana AIDS Impact Survey IV of 2013 show that HIV prevalence rates are highly gendered, with women being the most affected. Also, it shows that some geographical districts are more affected than others. Young women aged between 15 and 34 years bear the brunt of HIV infection, while their male counterparts are not as severely affected. For example, young men aged 15 to 24 years have prevalence rates that are about 0.0% while for their female counterparts, prevalence rates range from single digits to about 23%. The highest disparities in HIV prevalence rates are found in the 30-34 age groups where in some districts such as Mahalapye the rate for women is 74.3% and 20.7% for men. This is a gross disparity which shows that women are three times more likely than men to be living with HIV in this district. Other districts display similar disparities, but none as big as Mahalapye.

While I concur with feminist theorists that women are not a homogeneous group, do not experience oppression in the same way and accordingly cannot be labelled with the same essentialist terms (Kelly 1988), it is clear from the results of BAIS IV that women need help. HIV infection in Botswana does not discriminate in that in some cases the educated are more affected than less educated members of the society (BAIS IV). But young people aged less than 20 years, especially men, have very low prevalence rates. This suggests that older people may have been infected when they were younger, and this could be a case of people ageing with the virus, and a testimony to the effectiveness of anti-retroviral therapy. However, this does not explain why women in their early thirties are so severely affected; in the mid-1990s when HIV was at its peak, they were still too young to be sexually active. Men who are widowed are also more affected than their female counterparts.

Having discussed the different factors above, it is difficult to say with certainty that one factor is responsible for the differential nature of HIV prevalence rates in Botswana. For every argument, there is a possible counter argument and one, two, or all of the factors may be responsible for this phenomenon, which makes intervention challenging. The nature of HIV prevalence in Botswana require that the Government and other stakeholders sustain the original message of ABC (Abstain, Be faithful and Condomise). Also, more aggressive programmes are needed to address inter-generational sex, and such education should not only empower young women, but it should also target men who are having sexual relationships with younger women. Primary health education should aim to breach cultural barriers related to sexual and reproductive health matters and target couples rather than treat males and females as separate. Women must be educated to support their partners and encourage them to seek professional medical assistance in time and vice versa. The testing together campaign should be reinvigorated to help couples make informed choices about sexual matters, including if and when to have children. Culture also needs to be de-mystified so that women (and men) do not feel that they should have children at all costs or that men are the only decision makers in relationships, even if it hurts them. A study is needed to find out why older, presumably wiser men, seem to be resisting the use of condoms. Such a study would help us understand how men understand reproductive health risks and how they respond to them.

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