

Masculinities, gender-based violence, HIV and AIDS in Botswana

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Abstract

Gender-based violence (GBV) is a significant public health problem with a demonstrated link with gender ideologies, power relations, intimate partner violence (IPV) perpetration, and risky sexual behaviours. This paper uses the Botswana AIDS Impact Survey (BAIS IV) (2013) to assess the association between masculinities, intimate partner violence (IPV) and sexual risk. It studies factors that influencing violence, HIV-associated sexual risk-taking behaviours and the bidirectional relationship between violence and HIV status. BAIS IV results indicate that 24.8 % of females with early sexual debut had also reported non-consensual sex at the time of intercourse. The results have significant implications for designing public health/social work interventions that promote population health.

Keywords: *Gender-based violence, intimate partner violence, masculinities, sexual debut, sexually risky behaviours, HIV status, Botswana*

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Introduction

Gender-based violence is widespread, persistent, devastating, and it is intertwined with other forms of power, privilege, and social exclusion. A study by the World Health Organisation (WHO) found that 30 % of ever-partnered females aged 15 years and above have experienced Intimate Partner Violence (IPV) in their lifetime, with regional rates ranging from 16.3 % in East Asia to 66 percent in Central and sub-Saharan Africa (WHO, 2005). The HIV epidemic is one of the greatest public health challenges facing the world today (UNAIDS, 2013; WHO, 2005) and Botswana is experiencing a generalized epidemic, with an estimated prevalence rate of 18.5% (BAIS IV, 2013). The majority of HIV infections in Botswana are acquired through heterosexual transmission, complicated by concurrent sexual partnerships, inconsistent condom use, inter-generational sex, GBV, alcohol abuse, inadequate self-efficacy skills, poor healthcare seeking behaviours for early STI treatment, and low levels of male circumcision (MacDonald, 1996; Phaladze & Tlou, 2006).

Previous research suggests that gender is associated with an increased risk of HIV infection. Men tend to report a higher incidences of forcing sex on women, higher rates of incarceration which the expose them to non-consensual predatory sex (especially anal sex), more sexual partners over a lifetime, and lower rates of condom use (Amaro, 1995; Wingood & DiClemente, 1998; 2000). Though GBV has received notable scientific attention related to rates, risk factors, patterns, and treatment around the world, limited research has explored the relationships between GBV, masculinity, and HIV. Literature has largely neglected the relationships among gendered power relations, sociocultural beliefs and risky sexual behaviour. This article explores HIV prevalence and incidence rates in Botswana and their link to gender-based violence and masculinity, based on the results of BAIS IV of 2013 in order to develop an understanding of the relationship between GBV, masculinity, and HIV. Notions of masculinity and power are used to explore this relationship.

Intimate partner violence and the risk of HIV infection in heterosexual relationships in Botswana

There is great variation in data on the prevalence of violence because studies often use different measurement processes. Inconsistencies in definitions of violence, ideas about what constitutes sexual consent, technical inefficiencies in recording data, and difficulties in establishing standardized definitions of violence have led to unreliable data on violence. Reporting of incidents of violence is low. Data on the violent victimization of females (rape, assault, robbery, and homicide), have remained relatively unchanged, reflecting the following trends: Men are over-represented as perpetrators of all forms of violence, and intimate partner homicide victims are most likely to be women; most GBV survivors know their attackers; women are disinclined to associate their friends, boyfriends, lovers, or male relatives with the perpetration of violent crime; sexual violence against girls is more likely to be perpetrated by teachers, relatives, mother's boyfriends, and neighbours; and many women are sexually victimized in childhood and adolescence, and are more likely to be murdered by an intimate partner than by a stranger.

The GBV Indicators Study Botswana (2009) found that over two-thirds (67%) of women in the country had experienced some form of partner and non-partner violence in their lifetime, with 29% reporting having experienced partner violence in the 12 months before the survey. A study by Modie-Moroka (2009) reported a lifetime prevalence rate of intimate partner violence to be 34% in Botswana with a mean age at first sexual intercourse being 14 years. The youngest age

at first sexual intercourse was ten years with a median of 17 years. Ten percent of the respondents had experienced forced sex before the age of 12. Women were more likely to report having been in a violent relationship than men. In the same study, 49.7 % of women had experienced IPV in the 12 months leading to the study. In a clinical sample, Zungu, Salawu & Ogunbanjo (2010) found that 49.7 % of the respondents reported having experienced IPV at some point in their lifetime. In a tertiary institution in Botswana, Jankey, Próspero and Fawson (2011) explored the prevalence of mutual violence, violent attitudes, and mental health symptoms among students at that institution. Males reported higher violent attitudes than females but were just as likely as females to report controlling behaviours and perpetration of physical violence against their partners.

Tsai, Leiter, Heisler, et al., (2011) studied the correlates of forced sex perpetration among men and victimization of women in Botswana and Swaziland. Lifetime prevalence rates of forced sex and victimization of women were 10.3 % in Botswana. Among the women, they found a 12-month prevalence rate of 4.6 %. A history of forced sex, engaging in transactional sex, and having multiple sexual partners were strongly correlated with perpetration of various forms of forced sex by men. Shannon et al. (2012) studied adherence to gender inequity norms among men and women in Botswana and found that higher adherence to gender inequity norms scores were associated with increased male-controlled sexual decision-making power, perpetration of rape, unprotected sex with a non-primary partner, intergenerational sex, and multiple concurrent sex partnerships. Similar results of gender inequity norms were found in the USA and Europe (Maman et al., 2002). In this article, we assess, using BAIS IV (2013) results, the association among masculinities, intimate partner violence (IPV) perpetration and risky sexual behaviours in heterosexual relationships.

Methodology

Data were collected through national BAIS IV surveys and secondary data analysis. Document analysis was employed as a method to gather data. Records were obtained from full-text online search engines. Quantitative data from BAIS IV were entered into the Statistical Package for the Social Sciences (SPSS) version 23.0. Descriptive statistical analysis was conducted to characterize the sample's demographics. Alpha level was set at .05 level of significance, and a correlation matrix was generated. We present a description of the study sample and explore relationships among the variables as stated above.

Findings from BAIS IV

The BAIS IV survey covered 92.9 % of targeted sample households with a response rate of 83.9 % of persons aged 10-64 years. The study estimated a national prevalence rate of 18.5% among the population aged 18 months and above. Forty-five percent of respondents were males whereas 54.9 % were females. The survey found an HIV incidence rate (adjusted) of 1.35 %. Females had a prevalence rate of 20.8 % compared to 15.6 % for males. Women's prevalence peaks at an earlier age of 35-39 compared to males whose prevalence rate peaks at 40-44 years old.

HIV prevalence amongst the married is higher among men, estimated at 26.3 %, compared to females at 18.7%. This could suggest that men are not being protected by marriage. Marriage entitles both partners sexual access to each other and implies trust, fidelity, and a promise of children. Extramarital sex, the need to bear children, and polygamy may place partners at risk of HIV infection. Never married females have an HIV prevalence rate of 22 % compared to their male counterparts who are 12.6 %. People in cohabiting/living together relationships had prevalence rates of 34 % for both men and women. Females on separation had the highest HIV

prevalence of 51.2% compared to men who are separated from their spouses at 14.9 %. Divorced females had a prevalence rate of 34.5 % compared to their male counterparts at 27.8 %.

Sexual behaviours of respondents

Results from BAIS IV found that 24% of respondents admitted to having had sexual intercourse in the 12 months leading to the survey. Twenty-six percent reported that they had never had sexual intercourse. The respondents' age at first sexual encounter ranges from 10 to 24 years. Forty-five percent of men compared to 55% of females reported ever having had sex. Eighty-six percent of respondents indicated that they gave their consent at the time of the sexual intercourse whereas 14% said they did not give their consent. Ninety percent of respondents reported using a condom during intercourse while 8.7% responded that they did not use protection during sex. Three percent reportedly had sex without their consent, and 97.5% reported to have had consensual sex in the 24 months leading to the survey. Eighty-one percent of respondents reported having had sex in the 12 months leading to the survey and 18.8% did not engage in sex during that period.

Seventy-one percent reported having had sex with one partner in the 12 months leading to the survey. Seventy-one percent believed that they could persuade a partner to use a condom. Seventeen percent thought that they could sometimes convince their partners to use a condom, and eleven percent believe that they cannot persuade their partners to use a condom. Sixty percent of respondents stated that they had always used a condom with their partner in the past 12 months; 18% had never used a condom with their partner and 22 % use a condom sometimes.

Early sexual debut, gender-bassed violence and HIV

Early sexual debut was 4.4 % for men and 24.8 % for women. Results showed that 24.8 % of females with early sexual debut reported not giving consent at the time of intercourse. For both sexes, respondents aged 15-49 who had multiple concurrent sexual partners. About 81.9 % reported having used a condom during the last sexual intercourse. Higher quality empirical studies consistently find significant bivariate associations between early sexual debut and HIV.

Gender inequity norms and intimate partner violence

In the population of women aged 15 to 49, an estimated 3.1% reported non-consensual sex in the twelve months leading to the survey. Women who report IPV are twice more likely to report sex with multiple partners, unprotected sex, transactional sex, and STIs compared to women who do not report IPV (Campbell et al... 2008; Campbell et al. 2013; Coker, 2007; El-Bassel et al.,1998; Kouyoumdjian et al. 2013; Swain, et al., 2011; WHO, 2013).

Seven percent of the respondents indicated that it was acceptable for a woman to have more than one sexual partner and 93 % thought that it is not acceptable. Ninety percent of respondents reported that they believe it is acceptable for a man to have more than one sexual partner. Only 11 % thought that it is not acceptable for a man to have more than one sexual partner. Fifty-five percent of the respondents could persuade their partner at all times not to have sex if they were not interested. Twenty-four percent could sometimes convince them, and 19 % could not persuade their sex partners not to have sex if they were not interested. Two percent of respondents confessed to having been paid or received gifts for sex in the 12 months leading to the survey while 89.8% of respondents did not get paid or receive gifts for sex.

Masculinities are linked to IPV perpetration and sexual risk behaviours

The first step in understanding the relationship between masculinities, IPVperpetration, and risky sexual behaviours involves theory of masculinity (Connell, 1995; 2003a) and the social structural theory of gender and power (Connell, 1987; Wingood & DiClemente, 2000). Connell's theory of masculinity provides a critical feminist analysis of historically-specific masculinities within a context and is influential in the field of men and masculinities. The theory suggests that masculinity is not fixed, homogenous, or innate, but fluid, relational, contextual, and is in a constant state of flux (Connell, 1995; Connell & Messerschmidt, 2005). Masculinities occupy various levels, including traditional and contemporary; as well as subordinate, complicit, cathartic and symbolic masculinities, all of which interact with race, class, age, religious affiliation, and geographic location (Connell, 1995). Different groups construct their ideal notions of masculinity based on the ideal "man". Hegemonic masculinity refers to the pattern of gender practice based on a social agreement which validates patriarchy and ensures the dominance of men and the subordination of women (Connell, 1995). Collective cultural models and institutional control, power, authority, competition, and aggression sustain hegemony. This includes the formation of social groups and processes that protect the interests of men at the expense of women. It also involves marginalizing and annihilating groups that are perceived to be contrary to hegemonic masculinity.

African traditional masculinities change historically, in accordance with shifting perceptions of gender roles, expectations, and prescriptions. These masculinities may embody a broad range of behaviours such as age-graded systems, winning and holding on to power, cultural benchmarks of normative masculinity like the use of initiation ceremonies and scarification for identity, the belief that men are providers and the payment of bride-price. Other practices include alcohol consumption, the use of physical, sexual, and emotional violence, coercion of women and children and "lesser men," the practice of polygamy, weapon-carrying behaviour, initiation of war and conflict (or being warriors). Fear of failure drives men to adhere to the patriarchal code. The denial of weakness and virility that drives men to seek multiple partners, "having strength as a man," engagement in high-risk situations without restraint or caution, and the desire to father many children who bear one's name are all markers of dominant patriarchal values (Abdool-Karim, et al. 1992; Courtenay, 2000). Hardiness, dominance, and violence in interpersonal conflict resolution are central constructs of masculine identity. Such behaviours increase the risk of acquiring and transmitting HIV (Campbell, 2002; 2012; Thompson, 1997). Also, traditional masculinity incorporates the permissiveness of having girlfriends and non-marital sexual partners.

In Botswana, males are expected to be the heads of households and providers; they are also expected to be strong, tough and in control of their family and intimate partners. Getting married is directly tied to having income and property. Men are expected to initiate married family life before the age of 40. However, contributing to their parents' households delays the formation of their own families. Other extended roles include taking care of the livestock of their fathers, grandfathers, brothers and uncles (Bennett, 1998). Because of the sexual division of labour, females may use sex to get material rewards such as money from their male counterparts, or they may deny them sex if they are not given money. Apart from controlling socioeconomic resources and financial assets, men exercise power, control, authority, and coercion. Being sexually passive, not acquiring knowledge about sex, suggesting condoms or contraceptive use, or accessing sexual and reproductive health services is seen as the acceptable norm for women.

Violence tends to support hegemonic power, and authority. Through socialization, modeling, reinforcement, overt threats, and coercion, beliefs, and values related to masculinity boys and men are socialised to adopt risky sexual behaviours, which include having sex with

someone younger (including underaged girls), alcohol use, and concurrent and/or serial sexual relationships.

The second step in understanding the link between GBV and HIV risk is Wingood and DiClemente's public health model. Gender-based power inequity in society and heterosexual dyadic relationships, including male-perpetrated IPV against female partners, reduce women's control over their sexual relationships, especially the use of condoms. According to Wingood & DiClemente (2000), the public health theory explores the division of labour, the distribution of power and authority within male-female relationships, gender-based definitions of sexually appropriate conduct, affective aspects of relationships, cathexis, and biological properties. According to Wingood & DiClemente (2000), gender-based inequities and disparities generate "exposures or acquired risks."

The risk factors then adversely influence one's health. Wingood & DiClemente (2000) propose that Connell's work on gender and power could be used to develop a public health model that examines exposure through the structures of risk and biological factors in the era of HIV. The exposure or risk factors are associated with gendered HIV-risk sexual behaviour (Wingood & DiClemente, 2000). Acquired risks or exposure are associated with an increased probability that a disease will later develop. The argument is that some populations are more likely to be exposed to a certain risk than others (Wingood & DiClemente, 2000). Risk factors (socioeconomic, behavioural or personal) are associated with one's engagement in certain behaviours that later increase the likelihood of contracting a disease. Each structure corresponds to a level of causation that specifies different risk factors that may increase the potential for disease.

Sexual division of labour leads to exposure to socio-economic risk factors

The HIV epidemic is shaped by social, structural and cultural factors, such as poverty, unemployment, alcohol abuse, violence and ill-treatment. The gendered of the work people do, what they will do, what work is paid and what goes unpaid; the level of demand of the job, the value accorded to the occupation, the amount of work done, and how the work is performed influence one's exposure to the risk of disease. Gender roles determine occupational and economic opportunities. Men's economic power leads to access and control of powerful institutions, persons, economic relations, and policies. Lower economic status and lack of financial independence are positive correlates with HIV risk (Harvey, etal, 2003). Inequities resulting from sexual division of labour are manifested as economic exposure and, in the psychosocial domain, as socioeconomic risk factors (Wingood & DiClemente, 2000). Women tend to experience more adverse economic exposure and socio-economic risk factors. Socioeconomic power is skewed in favour of men; as a result, women are more likely to experience adverse health outcomes, such as higher rates of HIV infection.

Gender inequities exist in employment, income, and education. Women often have minimal work experience and lack access to good paying jobs this renders them economically dependent on their male partners. Men have greater access to employment opportunities and are often gatekeepers to jobs. Due to economic pressure, the poor may remain in poverty over a protracted period, and the poverty they experience may be transmitted from one generation to another, such that poor parents have poor children, who are more likely to become poor adults themselves. Having a secondary school education or less, no permanent home, multiple dependent children with no support, high unemployment or underemployment rates, poor nutrition, inadequate health care, few assets or a lack of opportunities are found in such families. Having more high demand/ low control work environments, such as working in the textile industry,

domestic work, or selling in the marketplace characterize such families. Together, these problems are compounded by the high cost of housing in urban areas, a lack of child support from fathers of their children, a relationship with a violent intimate partner, expensive lifestyle (fashion, alcohol abuse, and smoking) and peer pressure. These experiences leave women dependent on men for material support.

Economic and material hardship influence sexual risk-taking and material hardship among females may lead to relinquishing reproductive health choices to males, through failure to negotiate safer sex (see Ellece, this volume). Women often have limited access to and control of economic assets in the home, and this could escalate their inability to negotiate safe sexual practices, escalate their use of sex for money (survival sex) and staying in an abusive relationship. HIV feeds into socio-cultural contexts that weaken individuals' power, especially females, for choice and autonomy in sexual activity.

Sexual division of power leads to physical exposure and behavioural risk factors

Sexual division of power concerns male partner control within relationships and the imbalance of power. Sexual division of power results in physical exposure and behavioural risk factors. Power is manifest through violence, alcohol abuse, and coercion of women by controlling their sexuality and by devaluing and silencing them (Barker, 2005). Men's personal power may be expressed by silencing, violence and/or threats of violence, internalized oppression, and a culture of silence among violence survivors, leading to unsafe sexual behaviours.

Women's power may come from the ability to influence the decisions in a family, from being married, having lobola paid for them, and coming from a wealthy family. Women may also feel powerful when they are taken care of and being assured of fidelity by their partners. Men feel powerful in a relationship when they feel that the woman is faithful to them, and women feel powerful when they are loved and cared for. In Tswana marriage, a man pays the bride price, which implies power imbalance in decision-making, including in decisions about sexual matters.

Sexual coercion and control within relationships manifest in IPV as one way by which the risk for STIs is increased. Abusive male partners may also be at a greater risk of contracting STI through risky sexual behaviours. Women in violent and abusive relationships are less likely to use condoms, are more likely to have multiple male sexual partners, are more likely to have sex, and to have more sexual contacts involving blood, and greater rates of STIs (Garcia-Moreno, et al., 2005). Gender power imbalances increases women's risk of sexual assault and STIs/HIV. Male IPV perpetrators are significantly more likely to be infected with STIs/HIV and to be engaging in the sex trade as clients (Silverman, et al., 2007). Violence prevents partners, especially women, from accessing HIV and AIDS information freely, from negotiating condom use, and from refusing to engage in unprotected sex with an HIV-positive partner. Evidence of increased rates of risky sexual behaviour among male perpetrators indicates the need to examine the relationship between men's abusive and risky sexual behaviours (El-Bassel et al. 2001; Raj et al. 2005). A concentration of adverse social and economic influences (poverty, alcohol, and drugs, violence, and mental ill-health) diminishes opportunities for economic advancement for women and limits selection of partners from the same neighbourhood. Referred to as the "feminization of concentrated epidemics," an increase in HIV risk posed by male IPV perpetrators may extend to their female spouses, children and female relatives.

Notable in Botswana is the conflict between international human rights and cultural and ethical relativism in gender power relations. Relativism forbids value judgments directed at other populations, such that harmful practices may be left unchecked in the name of respecting or

preserving the cultures of groups of people. For example, arranged marriages, child betrothal, rituals in rites of passage, polygamy, a man's inheritance of a relative's widow, bride price, preference of male children, violence against women and children, denial of customary land rights to women and other cultural practices, and the general subordination of women and minority groups are generally approved or condoned in Botswana. Polygamy, extramarital affairs, and early child marriages may increase the risk of HIV infection. Studies in Africa have found that women are most likely to become HIV infected by having unprotected sex with their husbands. In most cases, extra-marital sex is the conduit (Stephenson, 2010).

Masculine thinking also supports the idea that males should be viewed as strong, invincible and hypersexual. Male sexuality is, therefore generally considered "uncontrollable" (Ellece 2007) and "spontaneous" and that condoms reduce sexual pleasure. Inadequate and incorrect information on HIV, lower self-care and health-seeking behaviour, low male condom use, low-risk perception, and dislike of condoms are associated with masculinity. Condoning harmful traditional practices leads to internalized traditional female gender practices such as female silencing. In most relationships where gender power relations are pronounced, women tend to engage in conflict avoidance to maintain relationship harmony and avoid abuse and social isolation/rejection, relational loss, and conflicts (Ellece 2011). Male privilege tends to translate into a male-centered justification for verbal, physical, and sexual abuse. Marital intimacy intersects with male privilege, entitlement and power, such that men have the authority to define the process of sexual intercourse. Therefore, forced sex among married couples is not considered sexual abuse. While there has been much work interrogating the connection between male privilege, and sexual abuse, the discussions of male privilege in the current study shed light on the complex dynamics of male privilege and its support in the extended family.

Women judge themselves according to external rather than internal standards. They conform to gender stereotypes dictated from outside while feeling angry/rebellious internally (Jack & Dill, 1992). Having voice (communication) within a sexual relationship is a result of the power dynamics of the relationship. Women may adopt and internalize specific cognitive schemas to guide them in many aspects of the relationship. These schemas guide the way that women think and behave within relationships. Silencing the self contributes to low self-esteem, decreased autonomy and intimacy within relationships, depression, and lower levels of income and education, and unemployment for women.

Closely linked to male privilege is violence and alcohol abuse among men, which is seen as a sign of adulthood and masculinity, as well as of modernity. Male power in intimate relationships is associated with infidelity, multiple concurrent and serial sex partners, unprotected sex, forced unprotected sex, and the use of sex workers. Abusive partners pose a greater sexual risk due to their own risky sexual or controlling behaviours associated with low contraceptive or condom use and other adverse sexual and reproductive health outcomes such as pelvic inflammatory diseases, menstrual abnormalities, STIs/HIV, unwanted pregnancy and multiple abortions among women. Women survivors of violence have reported forced pregnancy and prevention of contraception from their abusive male partners (Hathaway, et al 2005; Raj, et al. 2005).

Gender inequality affects women's ability to leave damaging relationships and situations. Silencing may also occur externally, if girls negotiate for condom use and their partners do not listen to them. Violence leads to fear as survivors may live under constant control, and the threat

of violence, restricting a range of actions and reactions to destructive treatment. Women in current physically abusive relationships reported fear of partner reaction in sexual negotiation, lower self-efficacy for sexual negotiation, and increased likelihood of being involved with a risky partner. Internalized oppression is associated with sentiments such as “I am weak,” “I am just a Motswana woman,” “I am not worthy of better treatment,” “I came here to bear children for him” “I have no rights.” According to Aptheker (1989), women’s oppression (and other types of abuse as well) often involve an internal corrosion, a loss of confidence in one’s knowledge, fear of disrupting relationships when alternative partners may not be readily available, an inability to give voice to one’s experience, an inability to give expression to experience, and a loss of self-esteem. The internal corrosion includes alienation from one’s bodily and the sexual self (Martin (1996, p.10).

Forced or coerced sex increases women’s vulnerability to HIV by affecting women’s power and ability to negotiate the conditions of sexual intercourse, and also affects women’s use of health services. Violence during childhood has been associated with early sexual debut, HIV sexual risk behaviours, multiple high-risk sexual partners, unprotected sex, and STIs among women in general populations (Senn, et al., 2008; Jones, et al., 2008). Early sexual debut could expose one to contracting STIs, including HIV, unplanned pregnancy and pelvic inflammatory diseases. Individuals who engage in early initiation of sexual intercourse are less likely to use contraceptives and condoms (Everett et al., 2000; Roye, 1998). Survivors of childhood sexual abuse engage in more high-risk sexual behaviours as adults, are less able to refuse sexually aggressive partners than those who were not abused, and tend to experience difficulty maintaining safer sex practices. Forced sexual acts may include sexually related verbal intimidation, sexual trafficking, and forced sex work, traditionally sanctioned forced marriage, threats of sexual violence rape, forced sexual initiation (either vaginal and anal) experience (García-Moreno et al. 2015; Heise et al. 1995).

Affective attachments and social norms leading to social exposure and personal risk factors
Wingood and DiClemente (2000, p.544) define the structure of cathexis as “societal norms and expectations regarding women’s sexual behaviour characterized by their sexual and emotional attachments to men” (p.544). The structure extends to the gender roles and gendered norms of behaviour, the emotional attachments that explain sexual desire as emotional energy attached to an object, and the motivations for sexual attraction, love, connection and intimacy (Cornell, 1995; Wedgwood, 2009). The structure further deals with the acceptance of conventional, male dominant social norms and beliefs; the expectation of sexual passivity among women, the open-ended tolerance of multiple concurrent partnerships for men. The structure of affective attachments and social norms further explores why commitment in relationships, trust, perseverance, and the duration of a relationship, would result in safer sex being practiced less in those relationships. Studies show that married partners are less likely to use condoms, the longer the duration of the relationship, the less the condom use and the less the communication about condom use (Shearer, Hosterman, & Gillen, 2005; Saul et al. (2000). Fear of intimate relationship loss among women has been associated with less likelihood of using condoms (Cabral et al., 1998). Choices and decisions regarding the practice of safe sex or other self-protective behaviours are inextricably linked to this structure.

Beliefs, expectations, and prescriptions about masculinity tend to define and set the pace for violence perpetration, HIV infection, and progression to AIDS. Adherence to masculine gender role expectations (toughness, aggression, stoicism, hyper-sexuality, patterns of partner power and control, multiple intimate relationships, and violence lead to the adoption of risky sexual practices,

and poor health outcomes as a consequence. For example, men believe that getting a woman pregnant, having multiple sex partners and non-condom use are proof of masculinity. Ultimately, women have little power in intimate relationships as they internalize oppressive gender norms of masculinity and femininity.

Biological properties

Results from BAIS IV show that a significant number of respondents experienced child sexual abuse (CSA). Wyatt, Guthrie, & Notgrass (1992) found CSA to be related to victimization in later life, and this may increase vulnerability to engage in high-risk sexual behaviours and acquiring HIV. The likelihood of having more sexual partners (serial or concurrent) during one's lifetime and engaging in other sexually risky behaviours as life progresses is another effect of CSA (Li et al., 2000). Vaginal trauma and lacerations resulting from violent sex offer the perfect conduit for HIV transmission. Research shows that violence against women may weaken their immune system and put them at greater risk of infection.

Women are more susceptible to HIV because of hormonal changes, vaginal microbial ecology and physiology, and a higher prevalence of sexually transmitted diseases (STDs). In sexual violence, the vagina or anus is traumatized, making it easier for HIV to enter the bloodstream. Semen carries more HIV than vaginal secretions. Forced sex poses a direct biological risk for HIV infection resulting from vaginal trauma and lacerations. Early sexual debut places young girls at greater risk of HIV infection (Campbell 2002; Campbell et al. 2012).

CSA also leads to poor mental health outcomes (Klot et al. 2013). For example, internalizing trauma, condemned isolation, and self-silencing are part of Botswana cultural norms of dealing with shame in the family and to maintain family order and identity, legacy, and harmony. Some of the effects of early sexual debut include the use of drug and alcohol abuse before sex, self-harm, depression and suicidal ideation, running away from home, sex work and having sex with high-risk partners (Thompson, et al. 1997).

Conclusion and future directions

This article set out to discuss the relationship between GBV and the risk factors that shape exposure to HIV. The HIV epidemic is shaped by social, structural and cultural oppressive factors, such as poverty, unemployment, alcohol abuse, violence and ill-treatment. The article also highlighted the multiple, complex and causal psychosocial pathways through which sexual violence, coercion, and fear of abuse may escalate HIV risk through survivors' limited ability to refuse unwanted sex and negotiate safe sex. The paper further noted that violence is problematic for the survivor, but tends to negatively affect the perpetrators as well. For example, perpetrators also tend to engage in higher levels of risky sexual behaviour, such as multiple sex partners, engagement in transactional sex; being customers of sex workers, and inconsistent and incorrect condom use. Perpetrators of (sexual) violence are therefore more likely to be HIV positive.

BAIS IV findings imply the need for theory-based interventions that address cognitive factors following a sexual assault during childhood, to help survivors deal better with trauma and make healthy decisions about their reproductive health in later life. Despite clear evidence of the relationship between violence and HIV risk, sexual violence as a manifestation of GBV remains poorly researched. While several studies have shed light on the relationship, a model that integrates differential psycho-cognitive factors in the causal chain, is still lacking. Future studies should focus on the role of sexual violence and HIV transmission risk, the physiology of sexual violence as a

co-factor in HIV transmission, the modes of acquisition, and pathogenesis (Klot, 2013). The unexplored relationship could shed light on perpetrator characteristics and motivation, different rates of infection among young women; co-factors such as STIs and co-infections. Understanding the salient biological and psychosocial co-factors that may influence variability in HIV vulnerability and susceptibility may help improve knowledge about genital trauma and transmission probability. Understanding this factor could lead to placing sexual violence prevention at the center of HIV prevention.

The influence of traditional and contemporary masculinities requires attention and interventions should focus on males to enable them to understand their socially-constructed gender roles and expectations and how these impact their health and that of the women in their lives. Another area that requires research is the role of IPV in HIV transmission and progression to AIDS. Early sexual debut, adoption of risky sexual behaviours and HIV infection, disease progression and effects on the immune system are associated with early sexual debut. Early sexual debut, risky sexual behaviours and harmful traditional practices also require an in-depth study.

Multiple epidemics afflict populations in Botswana, and each of them interacts with the others. These epidemics interact to drive HIV risk and infection among Botswana. GBV and other forms of oppression such as racism, ageism, sexism, classism, and disability are some of the many social and health issues that afflict the people of Botswana, and each is linked to others. Progress in the fight against HIV is hampered by the Government's inability to effectively address these other issues which play a role in the spread of HIV. Also, traditional health behaviour models used to understand factors associated with HIV vulnerability are inadequate in helping the nation to comprehend and respond to the intricate factors influencing health.

There needs to be consistency and standardization in the definition of violence in literature and research. For example, there are some gaps in that men as victims are largely absent from research on GBV, HIV and AIDS. Future research should focus on men's experience of violence as victims. Research is needed to understand the mechanisms through which men experience violence and how to measure IPV appropriately among male victims.

In Botswana, HIV prevention efforts still need to address methods of reducing violence perpetration among men in order to develop and test instruments that help us understand power relations, individual autonomy, social and political power, communication within intimate relationships, and internalization of negatively ascribed characteristics based on gender, class, and race/ethnicity. Efforts should be made to mitigate the weaknesses in the current data collection instruments linking GBV in general, and intimate partner violence in particular, to HIV and AIDS. These have concentrated on individual behaviours such as the survivor's inability to negotiate safe sex and overall sexual risk taking and ignored other important factors such as violence and substance abuse. The interaction of unmitigated violence and substance abuse is a significant barrier to behaviour change and HIV prevention in Botswana. Laws and policies should be enforced to protect women's rights. Male survivors of IPV should be studied to develop balanced gender-sensitive prevention strategies. HIV prevention messages for women should debunk traditional understandings of female sexuality that ignore the female experience and desire within patriarchal institutions, which restrict and disempower women. This paper has demonstrated that there is a high prevalence of IPV in Botswana. The findings indicate the potential usefulness of IPV screening and intervention in primary health care settings and the need to integrate partner violence-related interventions with STI/HIV prevention efforts.

We suggest that in future BAIS surveys, gender-based violence and risky sexual behaviour should be clearly defined, because they account for the majority of new HIV infections regardless

of sex, age, lifestyle, geographic location or ethnicity. Multidisciplinary collaboration is urgently needed to develop research and practice protocols for assessing the link between sexual violence and HIV. There is a need to develop screening tools for IPV and alcohol abuse and providing access to health care for male and female survivors of violence. Professionals such as social workers, the police, nurses, and psychiatrists must take into consideration socio-cultural influences when developing HIV prevention strategies for women.

Summary

The field of HIV and AIDS should move towards equality between men and women and the transformation and recreation of all social relations that promote inequality in human relations. Responses to violence should maintain and promote a gender perspective in all policies and program and lead to the formulation of meaningful policies and programs. Violence can be overcome by broad structural innovations that would dismantle the existing myths around tradition, custom, and religion and the interpretation and symbolization of violence. Strategies that inform practice, especially those borrowed from critical forms of practice, such as consciousness raising, empowerment, and training of response systems are needed to disentangle oppression and victimization. Practice models for historically oppressed populations should be derived from the context of political practice and critical reflection. All humans, irrespective of the diversity they (re)present, have the right to equality, safety in relationships, self-development, fulfillment and freedom from victimization.

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