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Chapter 1

General Introduction

1. Introduction

HIV infection and AIDS epidemic seem to be a universal problem throughout the world. The HIV infections are reported to be increasing in Southern Africa. AIDS in Africa has orphaned more children than anywhere else (UNICEF, 1999: 8). According to the Joint United Programme on HIV/AIDS, at the end of 2000, the following trends of the worldwide epidemic of HIV/AIDS are evident. Currently, 36.1 million people are estimated to be living with HIV/AIDS. Of these, 34.7 million are adults; 16.4 million are women and 1.4 million are children under 15 years. During 2000, AIDS caused the deaths of an estimated 3 million people, including 1.3 million women and 500 000 children under 15. The overwhelming majority of people with HIV/AIDS, approximately 95 % of the global totals now live in the developing world (Center for Disease Control & Prevention, 2001:1). Twenty-one countries with the highest HIV/AIDS prevalence are in Africa.

HIV is spread by sexual contact with an infected person, by sharing needles and/ or syringes (primarily for drug injection) with someone who is infected, or, less commonly, through transfusions of infected blood or blood clotting factors. Babies born to HIV infected women may become infected before or during birth or through breast-feeding after birth (Centre for Disease Control & Prevention, 2001:1).

According to McDonald (1996: 1327) the socio-economic and cultural factors influence the transmission of HIV/AIDS in Botswana. He also mentioned that the rapid transmission of HIV in Botswana has been due to three main factors: the position of women in society, particularly their lack of power in negotiating sexual relationships, cultural attitudes towards fertility and social migration patterns.

The reason for conducting this study is to establish the current cultural practices of the Botswana and find out if they contribute in the spreading HIV infection in Botswana. This study will be very useful in assisting the Government, NGO's, Health institutions and the community

to understand the cultural practices of the Batswana when they develop strategies to combat the spread of HIV infection.

2. Rationale for the study

The researcher was also employed at an organization called BOTUSA (Collaboration of the BOTSWANA & USA governments) which plays a very important role in the prevention of the spread of HIV infection in Botswana. The BOTUSA project had employed an Information Education Communication Coordinator whose role was to develop behaviour change communication strategies for HIV prevention and was also in the process of developing a culturally acceptable radio serial drama to encourage HIV prevention. The researcher's question is: Are the behaviour change programmes for HIV prevention taking into consideration the cultural practices of the Batswana? This study will help answer the above question. The research project will also provide data for the design of a culturally acceptable radio serial drama. The research results will be used to provide current data about the cultural practices of the Batswana, which will help to design culturally acceptable behaviour change communication strategies in an attempt to prevent HIV infection for all NGO'S and Government departments.

The Botswana Sentinel Surveillance Report (1999: 10) estimated that the prevalence of HIV among the general population is 17%, while that of the sexually active adult population aged 15- 49 years is 28%. The report also showed that out of 2586 pregnant women attending Ante Natal Clinic that were tested, 35.88% were found to be HIV positive. The highest prevalence was found in Chobe district (50.83%), Francistown (43%) and Serowe/Palapye (41.79%). The results showed that HIV prevalence rate among young mothers (15-49) is stabilizing and coming down. At the same time in elderly age groups, HIV prevalence is going up, which is expected since age group transition happens before full-blown AIDS and subsequent death occur. The Botswana HIV and STD Sentinel Survey (2000: 16) reports that as of the year 2000 over 277 000 persons among ages 15-49 years are infected with the HIV virus. The Botswana 2002 HIV and STD Sentinel survey revealed that out of 6407 pregnant women between 15 and 49 of age who participated in the study, 2467 of them were found to be HIV positive which is 35.4% (Botswana HIV and STD Sentinel Survey, 2002: 18).

The Second Medium Term Plan (1997-2002: 8) reports that the United States Census Bureau predicted that there will be more adults in their 60s and 70s in Botswana in 20yrs time than

there will be adults in their 40s and 50s. The above statistics is shocking and this is one reason for the motivation of this study. If adults who are economically active and productive are going to die, the country's economic circumstances will be negatively affected. The remaining adults who will be aged are going to suffer as there will be no one to look after them and they have to look after orphaned children. The number of the people in the population will also drop, as the sexually productive people will be infected by the epidemic and therefore die. There will be more orphans who will not be well cared for.

The Botswana HIV and STD Sentinel Survey (2000:12) reported that the National HIV prevalence in Botswana in the year 2000 was 38.5% as compared to 35.88% in 1999. There is a definite increase of HIV infections in the country.

There is an urgent need to establish the causes of HIV infection so that appropriate strategies to combat the infection can be put in place. There is also a need to understand if the cultural practices of the Batswana have an influence in the spread of HIV/AIDS. There is need to conduct further investigations to find out what causes the HIV infection in especially high prevalent areas. This research study will help to identify the causes for the high prevalence.

The death rate in the country and the increase in the number of HIV infection are of concern to the Botswana government. Government Organizations and NGO'S are joining hands in the fight to reduce the rate of HIV infection.

It seems that there is no scientific empirical evidence of the current cultural practices of the Batswana and also no verified information to show that cultural factors may play a role in the spread of HIV infection. Therefore, the researcher thought that this research project would be able to answer questions relating to whether cultural practices of the Batswana have an influence on the spread of HIV infection.

As a professional social worker, the researcher's interest is also on exploring causes of problems experienced by the society. The researcher believes that the society must be viewed in a holistic way and cultural practices seem to be overlooked at times. The researcher's professional interest therefore also motivated her to conduct this research.

The researcher's observations in Botswana about the number of people dying of HIV and AIDS made the researcher interested in the research topic. Batswana are also people who respect their culture very much. The researcher's own experience as a Motswana and knowledge about the Batswana culture which include that it is acceptable that men can have more than one partner, as men are like bulls or they are like an axe and can chop many trees, made the researcher wonder if this kind of cultural practice might be playing a role in the spread of HIV infection. The researcher's concern about these cultural issues made her interested in this study. Many people still believe and practice this behaviour. It is said that to prevent the spread of HIV infection, people should stick to one partner. The Batswana culture encourages men to have more than one partner. It is necessary to find out if this behaviour is still practiced so that it can be known if it contributes to the spread of HIV infection. This information will help in formulating strategies to combat the spread of HIV infection.

3. Problem formulation

The Report on the Global HIV/AIDS Epidemic, UNAIDS (2000:45) indicates that in Botswana, 35% of adults are now infected with HIV. It was estimated that there will be 65 000 AIDS orphans under the age of 15 years by the year 2000. It was also mentioned that the number of people infected with HIV will increase from 180 000 in 1996 to 332000 by the year 2000. This projection is based on the assumption that patterns of new infection will not change greatly over the next decade. The projections made above came to realization in 2001.

According to the UNAIDS/WHO (2002:1) epidemiological fact sheet on Botswana, the population of Botswana as at end of 2001 was 1.554 000 and there were 69 000 AIDS orphans under the age of 15 years. The estimated number of people living with HIV/AIDS at the end of 2001 was 330 000 which was 38% of the adults between the age of 15-49 and 170 000 were women. HIV/AIDS claimed the deaths of 26 000 in 2001. Although the statistics reflected above are only for the year 2001 and not for the year 2000, the projections that were made for 2000 by UNAIDS (2000:45) are almost the same as the estimates for 2001.

However as changes in future infection rates will principally affect men and women under 40 in 2020, the demographic chimney pattern for older adults is hardly affected by this assumption. The missing adults (men and women) who should have reached their 40s and 50s – are now in their 20s and 30s, although some have already died. Many more are already infected with HIV,

which will kill them before they reach their 50s. It is predicted that a small number of young adults, the group that has traditionally provided care for both children and elderly will have to support large numbers of young and old people. Many of these young adults will themselves be debilitated by Aids and may even require care from their children or elderly parents rather than providing it (UNAIDS, 2000: 50).

The Second Medium Plan on HIV/AIDS in Botswana (1997-2002:5) also reports that poverty is a major problem in Botswana. Female-headed households form the majority of households living in poverty. The Second Medium Plan on HIV/AIDS in Botswana (1997-2002: 5) also highlighted that the 1991 census data showed that 47% of the households in Botswana are female headed and 52% of these are in rural areas. The level of poverty is likely to make most people, especially women and those in the rural areas, vulnerable to HIV infection and less able to respond effectively to its consequence issues of literacy, unemployment and gender, which are predisposing factors to HIV infection in Botswana.

The Second Medium Term Plan on HIV/AIDS in Botswana (1997-2002:22) points out that the epidemic is expected to drive the poorer households into deeper poverty. This is expected to result from loss of income support as young sexually and economically active people die. Households are expected to face financial burdens from health bills as they continue to seek treatment for prolonged HIV opportunistic infection. Few surveys of the impact of having a family member with AIDS also showed that households suffer a dramatic decrease in income inevitably, meaning fewer purchases and diminishing savings (UNAIDS, 2000:9). This result in severe stress in the communities.

The literacy rate is also worse among the farming communities where less than 4% of farm household members above the age of 5 years have ever been to school. This makes it difficult for them to read any Information Education Communication material on HIV/AIDS. Lack of women's empowerment against prejudicial cultural and traditional practices in sexual and reproductive matters and relationships have been identified as factors that make women vulnerable to HIV infection. According to the 1994/95 agricultural surveys, women most of whom are widows, divorcees or have never been married head 35% of the traditional farm households in Botswana. Access and control of the most important resource among the agricultural community is by men thus leaving women at their mercy (Adupa, 1999:25).

Consequently the women are left in very subordinate positions in economic terms. This may seriously predispose them to HIV infection, as sex offers are an easy alternative.

It is also evident from the two national referral hospitals of Nyagabongwe in Francistown and Princess Marina in Gaborone that patients with HIV occupy over 50% of hospital beds in the medical and pediatric wards.

It is therefore clear that the health and socio-economic impact of HIV/AIDS is tremendous.

A study conducted by BOTUSA (1999:5) to identify risk factors for HIV infection revealed that 27% of the 93 HIV positive patients who participated in the research believed that a man is like a bull and should not be confined to one pasture and 27% said that a woman should not refuse a man sex. Twenty one percent of the 42 HIV negative patients also believed that a man is like a bull and 26% of the 42 respondents said that a woman should not refuse a man sex; 44% of the HIV patients believed that a man is more likely to marry a woman who has shown she is fertile and only 57% of the HIV – patients had the same belief.

In Botswana it is accepted by society at large that men's sexual networks can be quite extensive. There is a feeling that men may legitimately have multiple relationships irrespective of their marital status but women may not.

It is evident from the above discussion that HIV/AIDS issues are real problems in Botswana and it seems that cultural issues are playing a possible role in the spread of HIV infection. This research study will therefore focus on whether cultural practices of the Batswana have an influence on the transmission of HIV/AIDS in Botswana.

4. Goal and objectives of the study

Goal

To establish the influence of cultural practices of the Batswana on the transmission of HIV/AIDS in Botswana.

Objectives

- To conduct the investigation within a theoretical based framework by undertaking a literature review on HIV/AIDS as a social phenomenon, culture, and cultural practices in general and the culture of Batswana specifically.
- To explore through an empirical study, the nature and prevalence of cultural practices of Batswana in relation to the transmission of HIV/AIDS in Botswana.
- To provide conclusions regarding the cultural practices of the Batswana in relation to the transmission of HIV/AIDS in Botswana.
- To make recommendations for culturally appropriate behaviour - change strategies for Batswana in Botswana in an attempt to decrease the spread of HIV/AIDS.

5. Research questions

The following research questions were formulated for this study:

- **What are the current nature and prevalence of cultural practices of the Batswana in relation to the transmission of HIV/AIDS in Botswana?**
- **To what extent do these cultural practices contribute to the spread of HIV/AIDS?**
- **What can be done to prevent the problem of HIV/AIDS in relation with cultural practices of Batswana people in Botswana?**

6. Research approach

A combined quantitative and qualitative research approach was used in this study namely one of Cresswell's three models of combination which is the dominant- less- dominant model (De Vos, 2002:366). In this design, the researcher presented the study within a single, dominant paradigm with one small component of the overall study drawn from the alternative paradigm. According to De Vos (2002:366) one might engage for instance in qualitative observations with a limited number of informants, followed by a quantitative survey with a sample from a population. In this study, the researcher engaged in quantitative survey using a structured interview schedule with a random sample of individuals and qualitative semi structured group interviews using focus groups. The quantitative approach represented the dominant paradigm

and the qualitative focus group interviews represented the less dominant paradigm. The qualitative focus group discussions supplemented the quantitative structured interviews.

7. Type of research

Applied research was used in this study. According to Grinnell, Rothery and Thomlison (1993) as quoted by De Vos, Schurink and Strydom (1998:8) the goal of applied research is to develop solutions for problems and applications in practice. The research project, which the researcher undertook, will add to the knowledge base of the social work profession, and will help to develop solutions to the problems related to HIV/AIDS. The exploration and understanding of cultural practices of the Batswana on the transmission of HIV/AIDS in Botswana will assist the Government and NGOs to design and develop cultural appropriate behavior change strategies, which can help to prevent HIV/AIDS in practice.

8. Research design

According to Thyer (1993) as quoted by Fouché and De Vos (1998:123) a research design is a blueprint or detailed plan for how a research study is to be conducted.

Bloom and Fischer (1982:10) further mentions that a research design can be understood as the planning of any scientific research from the first to the last step. It is a programme to guide the researcher in collecting, analyzing and interpreting observed facts.

The design used in this study is the exploratory design. According to Bless and Higson-Smith (1995: 42) the purpose of exploratory research is to gain insight into a situation, phenomenon, community or person. The need for such a study could arise out of a lack of basic information on a new area of interest. This research project focuses on the influence of cultural practices on HIV/AIDS. The new area of interest in this study is whether cultural practices play a role in the spread of HIV infection in Botswana.

This design is selected because the purpose of this research was to explore the cultural practices of the Batswana and to find out if there is any relationship between HIV/AIDS and the cultural practices of the Batswana.

9. Research procedure and strategy

Data collection

Data was collected by conducting a survey through structured interviews with a random sample of individuals as well as focus groups with selected adults.

Bless and Higson-Smith (1995:107) say that a structured interview schedule is based on an established questionnaire which is a set of questions with fixed wording and sequence of presentation as well as more or less precise indications of how to answer each question.

According to Greeff (2002:306) a focus group interview is a purposive discussion of a specific topic taking place between eight to ten individuals with a similar background and common interest .

(Compare Schurink, Schurink & Poggenpoel, 1998:314).

Kingry, et al. (1990) as quoted by Greeff (2002:306) defines a focus group as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment.

Before collecting data, the researcher wrote letters to the chiefs of the selected communities to introduce the study and herself and later made protocol visits to the study sites (See Appendix 2: example of letters to the chiefs). During the protocol visits, the researcher met with relevant local leaders in villages where there is high and low prevalence of HIV/AIDS and obtained permission from the community leaders such as chiefs to conduct the research. The researcher worked with village leaders to conduct enumeration and sampling for the key participant interviews and focus groups as well as to introduce the researcher and the research project to them.

The survey interview schedule included questions with open and closed-ended questions (Babbie, 1995:142). According to Bless and Higson-Smith (1995:107) the structured interview schedule is based on an established questionnaire, which is a set of questions with fixed wording and sequence of presentation as well as more or less precise indications of how to answer each question.

The researcher used research assistants who were Setswana speaking people and who had experience in conducting HIV/AIDS related interviews to assist in the conducting of the structured interviews. The researcher trained the research assistants on how to conduct the interviews. The matching of the interviewers and the interviewees was achieved as the interviewers and the interviewees both spoke Setswana.

Bailey (1994:175) talks about interviewer bias in which the interviewer may misunderstand the respondent's answer or the respondent's answers can be affected by his or her reaction to the interviewer's sex, race, social class, age, dress or accent. In this research project language was a very important element to avoid bias. As the researcher also speaks Setswana, the focus groups were also conducted in the Setswana. The researcher conducted the focus groups herself.

The focus groups interviews were taped recorded and notes were taken during the sessions.

Data analysis

Data analysis should be an on-going process of examining information as it comes. Analysis should seek to identify individual or group similarities and differences, by noting major themes that emerge from discussion and observations. The analysis technique for the focus groups will be primarily text analysis. Data was first be analyzed in the language in which the interviews were conducted namely Setswana. The researcher went through all the transcripts to get a sense of the whole. The researcher continued to jot down ideas as they came to mind while writing thoughts in the margin and identifying the major themes. The themes were put into major categories while at the same time identifying subcategories within major categories. During the process of analyses relationships between major and subcategories were also identified.

An independent coder who had experience in qualitative research was asked to do open coding. According to Grinnell (1993: 271) open coding is part of analysis that pertains specifically to the naming and categorizing of phenomena through close examination of data. Thereafter, consensus discussions were held on the themes and categories reached independently by the researcher and the independent coder. The results were translated into English after the consensus.

Quantitative data can be analyzed either manually or by computer (De Vos & Fouché, 1998: 203). In this study, the data collected by using a structured interview schedule was analyzed through a computer based program namely the EXCEL Program.

10. Pilot study

A pilot study involves testing the actual research project on a small sample taken from the community for whom the research project is planned. This allows the researcher to identify any difficulty with the method or materials and to investigate the accuracy and appropriateness of any instrument (Bless & Higson-Smith, 1995: 50).

10.1. Feasibility of the study

The researcher received cooperation from the government of Botswana and NGO's, as permission to conduct the study was forwarded to the Ministry of Health and Office of the President. Permission to conduct the study was granted by the above-mentioned offices in Botswana (See Appendix 1).

Botswana has high rates of HIV/AIDS and prevention of HIV infection is high priority. There is however a need to understand the causes of HIV/AIDS so that appropriate strategies can be developed to control the spread of HIV infection. This research project will draw conclusions regarding cultural factors that influence the spread of HIV/AIDS to the government of Botswana.

The researcher worked in Botswana as a research coordinator and is familiar with the administrative districts and traditional leaders in the country. During the researcher's work in Botswana, she established good relationships with the local NGO's, government departments and the University of Botswana. The respondents were easily available during the day because of the high unemployment rate in Botswana especially in rural areas.

The researcher was allocated funding by the National Research Foundation in South Africa to the value of R21 000.00 and R7 000.00 from the University of Pretoria.

10.2. Pilot test of interview schedules

According to Bless and Higson - Smith (1995: 50) a pilot study allows the researcher to identify any difficulty with the method or materials and to investigate the accuracy and appropriateness of any instrument that have been developed. It also allows the researcher to determine the community's likely response to the actual programme when it is implemented. If the pilot survey uncovers many difficulties in the design of a programme, it will be revised and a further pilot testing of the new design will be implemented. The pilot study was conducted to test reliability, which is concerned with, if the questionnaire is applied repeatedly to the same object, would it yield the same results each time. The more reliable the instrument the less the random error (Babbie, 1992: 162). Validity is the extent to which an empirical measure adequately, reflects the real meaning of the concept under consideration. According to Strydom (1998:183) the pilot study is conducted to test the suitability of the interview schedule, expected non-response rate and testing and adapting measuring instruments.

After the approval of the structured interview schedule by the ethical committee and the government of Botswana, a pilot study was conducted with 5 respondents who were not part of the main study. Three respondents were interviewed from Gaborone (urban area) and 2 from Gabane (rural area). The respondents had no problems answering the questions. The interviews were conducted in Setswana, although the interview schedule was constructed in English (See Appendix 3 – structured interview schedule).

The following questions were however adjusted before the formal empirical study commenced:

- Not Applicable was added as a variable to Question 6.
- Question 74 had to be rephrased as it had two questions in one. The question was changed to: Do you believe that HIV/AIDS is punishment from God? Instead of: Do you believe that HIV/AIDS is sexually transmitted or is it punishment from God?

For the focus group, one male adult group with six people who were randomly selected were gathered to pilot the focus group schedule in Gabane (rural area). Permission to conduct the focus group was requested from the chief and the focus group members. The focus group discussion lasted for an hour. A rural area was chosen because it is where you have people still practicing, respecting and understanding culture. The focus group discussion was held in Setswana although the questions were in English. The focus group members and the

researcher had no problems with the questions asked and the responses given. The pilot study showed that the questions asked in Setswana reflected the questions written in English. The way the researcher asked the questions and the respondents responded, reflected that the focus group guide was reliable and valid and that no changes were necessary. (See Appendix 4- Focus Group Guide).

11. Description of the research population, sample and sampling method

11.1. Research population

According to Bless and Higson-Smith (1995) a population is the entire set of objects and events or group of people which is the object of research and about which the researcher wants to determine some characteristics. It is also a set of elements that the research focuses upon and to which the results obtained by testing the sample should be generalized.

The study population consisted of all the people in the major urban areas of Botswana, which include Francistown, Gaborone and Selibe Phikwe. The total population in Botswana is 1 680 863, Selibe Phikwe is 49 849, Francistown is 83 023, Gaborone is 186 007, Gabane is 10 399, Sebina is 2 878 and Sefophe is 3 821 (Department of Central Statistics, Botswana 2001: 127). These areas also have high prevalence rates of HIV/AIDS. Selibe Phikwe is reported to have 48.1%, Gaborone 38%, and Francistown, 40% prevalence rates. It is reported that the prevalence rate in the surrounding rural areas is higher than in the urban areas. For example Gabane, which is in the Kweneng district, has a prevalence rate of 55% (Botswana Second Generation HIV/AIDS Surveillance, 2002).

The rural areas in this study included: Sebina which is close to Francistown, Gabane which is close to Gaborone and Sefophe which is close to Selibe Phikwe. These areas were selected as villages surrounding the major urban areas in the study (See Appendix 5- Botswana Map with the sampled areas).

11.2. Sample

One of the major issues is to determine samples that best represent a population so as to allow for an accurate generalization of results and such a group is called a representative sample. Sixty-six (66) respondents were randomly selected for the structured interviews. Forty-two of

the respondents were from the urban areas and 24 from the rural areas. (Detail biographical information regarding the sample is given in Part II of the empirical results in chapter 5).

Six focus groups, consisted of 3 adult male groups and 3 adult female groups, were conducted. Each group had a minimum of 6 respondents. The number of group members ranged between 6 and 10. The total number of respondents who were selected and who participated in the focus group discussions was 48. (Detailed biographical information regarding the sample is given in Part 1 of the empirical results in chapter 5).

11.3. Sampling strategy

Reid and Smith (1981) as quoted by Strydom and De Vos (1998:193) mentions that representativeness is always important when to generalize from the sample to the larger population. It means that the sample should have approximately the characteristics of the population relevant to the research in question. The larger the sample, the smaller the sample error (Arkava, 1983: 162). Random sampling is the only technique available that will ensure an optimal chance of drawing a sample that is representative of the population from which it was drawn. Probability sampling is based on randomization and was used in the selection of a sample of respondents involved in structured interviewing. A combination of probability and non- probability sampling were used in the selection of respondents for focus group interviewing.

To conduct structured interviewing the sampling technique used in this study was the multi-stage cluster random sampling scheme. If necessary, sampling should continue until the specified number of interviews is completed. Arkava (1983:161) describes the multistage cluster sampling method as a process of successive random samples from units. The first sample is drawn from the large unit or cluster. Next, selection from within would take place, from the largest (most inclusive) unit, too less inclusive units and finally to the most basic unit of the population to be studied.

The sampling strategy in this study differ somewhat for rural and urban areas. There are six study sites, which include both rural and urban areas. The sampling process to select respondents for the structured interviews, was the following:

11.3.1. Structured interviews

Rural areas

For the selection of respondents in the rural study sites (Sebina near Francistown, Gabane near Gaborone and Sefophe near Selibe Phikwe), the researcher enumerated all the villages in the surrounding areas separately and drew a random sample of two villages from each study site. In order to select the two villages, list of the names of the villages was compiled and the names were separately cut and drawn from a hat. The first two names that were picked up were the ones sampled. All data collection took place in these two villages per study site. The villages in Sebina were Nyaya and Ndzinda, in Gabane were Gasiko and Ntlhagodimo and in Sefophe were Sefophe and Mafoko.

The same procedure was used for the wards in each village. A list of the wards in the selected villages was compiled and two wards were then randomly sampled from each village. The first two names that were picked up were included in the sample. The numbers of the households in each ward were then compiled and the first two house numbers that were picked up, were the households included in the sample. The two households were therefore randomly selected from each ward.

One respondent was then randomly sampled from all adults (aged 18 and above) in each household.

This sampling scheme resulted in the selection of 8 individuals per study site. - In total 24 respondents in rural areas.

Urban areas

In the urban areas, the sampling scheme was modified as they have different composition. Gaborone was divided into four areas: Central, West, North, and South. Francistown was divided into two areas: East and West. These areas were the equivalent sampling unit to villages in the rural study sites. In Selebi-Phikwe, the wards were enumerated and a random sample of three wards in this study site was selected.

- **Gaborone**

All four areas in Gaborone were selected because of the diversity of the population in Gaborone namely Central, West, North, and South. The same sampling procedures used in the rural areas were used in Gaborone:

- Three wards were randomly sampled from each area.
- Two households were then randomly selected from each ward.
- One respondent was randomly sampled from all adults (aged 18 and above) in each household.

This resulted in a selection of 24 individuals.

- **Francistown**

Francistown is divided into two areas namely: East and West. Both areas were included. The same sampling procedures used in the rural areas were used.

- Three wards were randomly sampled from each area.
- Two households were randomly sampled from each ward.
- One respondent were randomly sampled from all adults (aged 18 and above) in the household.

This resulted in a selection of 12 individuals.

- **Selibe-Phikwe**

The same sampling procedures used in the rural areas was used.

Three wards were randomly sampled and then two households were randomly sampled from each ward. One respondent was randomly sampled from all adults (aged 18 and above) in the household. This resulted in a selection of 6 individuals.

The total number of the sample for the structured interviews was thus 66 individuals.

The parameters for each type of interview were intended to include a broad spectrum of the Botswana population by age, residence (rural v/s urban), marital status, sex and ability to provide useful information about the research topic.

11.3.2. Focus groups

Focus groups should be comprised of persons who are similar to each other. The focus groups in this study consisted of adults (people aged 18 and above). Focus groups were conducted separately with men and women. For cost effectiveness and time factor, the researcher conducted a focus group in the same 6 study sites as identified for structured interviewing. The sample of the focus groups was representative as these sites also represent the population of Botswana. The study sites included rural and urban areas. Therefore the researcher had a total of 6 focus groups, (3 men and 3 women) across the country. The study sites where the structured interviews were conducted were compiled and randomly selected in a hat. Then the researcher also compiled a list of the focus groups categories and picked up the first one and matches it with the first study site that was picked up. The same procedure was done for the second focus group. Each site had one category of focus group namely either a female adult or a male adult group. Each group had a minimum of six people. The number of group members ranged between 6 and 10 members. (Detail biographical information regarding the sample is given in Part 1 of the empirical results in this chapter 6). The total number of respondents who participated in the focus group discussions was 48. The sampling procedure used to select the areas where the focus groups were conducted and the categories of the focus groups (males and females) was a random sampling procedure. The researcher compiled a list of the major urban and rural areas for the study and also compiled a list of three male and three female groups. The list was cut down so that the researcher had six pieces of papers with the following words: 3 had female groups and three had male groups. The researcher had two separate hats. One hat had names of areas and one had the categories of the groups. The researcher picked up the first piece of paper in one hat and again in the other hat and matched the category of the group with the rural or urban area, which was also picked up. The procedure was done six times and the researcher ended up with six areas matched with the categories of the six focus groups. The sampling procedure to select the members of the focus groups was a combination of purposive sampling and availability sampling.

Purposive sampling according to Singleton, et al. (1988) as quoted by Strydom and De Vos (1998:198) and Strydom and Venter (2002:207) is based entirely on the judgment of the researcher in that the sample is composed of elements, which contain the most characteristics representative or typical attributes of the population. In this study, the focus group participants should be over 18 years and definitely males and females.

According to Bailey (1994), Collins (1990), Gabor (1993) and Nachmias and Nachmias (1981:430) as quoted by Strydom and De Vos (1998: 198) and Strydom and Venter (2002:207)

respondents in availability sampling are usually those who are nearest and most easily available. Judd, Smith and Kidder (1991) as quoted by Strydom and De Vos (1998: 198) add that the researchers simply reach out and take the cases that are at hand continuing the process until the sample reaches a designated size. The members were selected through community leaders. The community leaders assisted the researcher in organizing the focus group venues. The researcher asked people in the households and those who were met on the streets if they would like to participate in the focus group discussions. The researcher approached the members before the group to ask for their permission to be included in the group.

Two research assistants from Botswana who had experience in conducting research interviews including focus group interviews were trained by the researcher assisted the researcher to take notes and operate the tape recorder.

The researcher did not use the research assistants to conduct the focus group. Their role was more on assisting with the recording of the focus group process which permission was asked from the members to do so. The researcher conducted the focus group interviews in Setswana although the questions were written in English.

12. Ethical issues

12.1. Informed consent

According to Loewenberg and Dolgoff (1988) as quoted by Strydom (1998: 27) deception of subjects means deliberately misrepresenting facts in order to make another person believe what is not true. Corey, et al. (1993) as quoted by Strydom (1998: 27) continues to say that it is withholding information offering incorrect information in order to ensure participation of subjects when they would otherwise possibly have refused it. In this study, the key participants were asked to be part of the research project by asking them to give consent to be interviewed. The interviewer asked the respondents to give written consent for those who can write. They were asked to write their names or sign on the informed consent letter. If they could not write, they were asked to give a verbal consent and then put a cross in the place of a signature. The consent was given after the purpose of the research has been explained according to letters of informed consent. (See Appendix 6 for the consent form).

12.2. Confidentiality and anonymity

Giving the interviewees identity numbers (ID) ensured confidentiality. According to Strydom (2002:67) privacy implies the element of personal privacy and confidentiality indicates the handling of information in a confidential manner. The respondents were informed about how the information will be used and with whom it will be shared. Anonymity on the questionnaires was ensured. Subjects in this study remained anonymous and were not exposed to risks therefore it was acceptable to use tape recorders during the focus groups. Permission to use these was requested from the focus group participants.

Strydom (1998:28) further mentions that the ethical issue becomes relevant when subjects are assured of anonymity while the researcher knows it is not true. Information about subjects, which is available on computer, is not always confidential, since unauthorised persons could possibly have access to data. In this project, the ethical issue discussed above was dealt with by allocating independent ID numbers with no meaning attached to. The ID numbers only served the purpose of knowing how many people have been interviewed. No names were used. The information on the computer may not have been confidential however anonymity was ensured that no one would know whom the responses belonged to. The individual responses were seen as a key to generalising the results.

12.3. Action and competence of researcher and research assistants

The researcher introduced herself to the respondents and focus group members. Her national, ethnic and professional identity was revealed when the respondents enquire about them.

There was no bias and insensitivity regarding culture. Although the researcher is a South African, she speaks Setswana and is of Setswana origin. The researcher was able to identify with Batswana culture.

The research assistants were also Batswana's and originate from Botswana. They all speak Setswana and are familiar with the sites and culture in Botswana. They are university

graduates this year as they were final year students last year and therefore are familiar with the research process although they received training.

Protocol visits were paid to the villages to introduce the research to the chiefs. The researcher conducted protocol visits with a male Motswana person to avoid gender and citizenship biases from both the researcher and the communities involved.

13. Limitations of the study

- Although the respondents were randomly selected a limitation of the study is that the findings are inconclusive and cannot be generalized to the larger population, given the fact that only a sample of 66 respondents and only six study sites were employed. A bigger sample would have been better.
- Recent literature of the cultural practices of the Batswana was limited.
- The exploratory research design was used to gather the quantitative and qualitative data to realise the aim of the study. Ethnography as a research design which is characterized by observation (participant observation) and description of the behaviour of a small number of cases or ethnomethodology which aims at understanding and interpreting the meaning that subjects give to their everyday lives where the researcher enters the subject's life world could have been ideal (De Vos and Fouché, 1998:80; Fouché, 2002:274).

Cresswell (1998) as quoted by Fouché (2002:274) defines ethnography as the study of an intact cultural or social group (or an individual or individuals within that group) based primarily on observations over a prolonged period of time spent by the researcher in the field. The ethnographer examines the group's observable and learned patterns of behaviour, customs and way of life, and listens to and records the voices of informants. The final product of this kind of study is a descriptive and interpretive holistic cultural portrait of the group.

In this research study, the researcher could not use ethnography due to time and financial constraints. The researcher would have needed more time and finances to support herself in Botswana whilst conducting the research as she is not a resident in Botswana. It has already been mentioned before that time and finances were already a constraint even in the methodology used for the research study.

14. Definition of key concepts

14.1. Culture

According to Seymour-Smith (1986:65), culture is that complex whole which includes knowledge, belief, art, morals, law, custom and other capabilities and habits acquired by man as a member of society.

Giddens (1989:31) says culture consists of the values the members of a given group hold, the norms they follow and the material goods they create. Norms represent the “dos” and “don’ts” of social life and values represent issues such as being faithful to a single marriage partner.

Therefore it means that one has to belong to a particular group of society to belong to that society. For one to be accepted in that society, one needs to learn what is acceptable and unacceptable in that society. One needs to adapt his/her values and norms to belong to that society. By so doing one would have adopted the culture of that society.

14.2. Cultural practices

According to Goodnow, Miller, Peggy and Kessel (1995:45) practices are actions. It is what people do. They are not neutral they come packaged with values about what is natural, mature, morally right. The actions may become part of the group’s identity.

Bordieu (1977:49) as quoted by Goodnow, et al. (1995:44) say that cultural practice are social behavior that is habitual and automatic. As these practices are repeated repeatedly, they come to be seen as part of a natural order with the original reasons for their occurrence difficult to resurrect.

Cultural practices are behaviours and actions that are common to a particular group of people. Cultural practices identify groups of people or communities. Cultural practices are everyday actions and behaviours, which people display. These actions become part of the individuals in the society as they adapt to their environment.

14.3. HIV

According to Van Dyk (2001:4) HIV means the Human Immune Deficiency Virus. It is the virus that causes AIDS. The Public Health- Seattle & King County (2001: 1) defines HIV as the virus that attacks the human immune system. HIV destroys the body's defences against diseases, leaving it vulnerable to many infections and cancers that would normally develop in healthy people.

HIV is an infection in the body that kills the body's immune system. HIV is found in human beings and causes AIDS.

14.4. AIDS

According to the Branford (1987: 16) AIDS means Auto Immune Deficiency Syndrome. The human body's immune system deteriorates and this makes the person vulnerable to dreadful infectious diseases.

The Public Health- Seattle & King County (2001:1) stated that by the time a diagnosis of AIDS is made, HIV will already have seriously damaged the body's immune system. It often takes a person with AIDS diagnosis two to four years before death.

AIDS often presents itself with life threatening diseases. It is a collection of infections or different diseases due to the compromised immune system in the body. This means that the immune system in the body fails to fight infections and therefore the body becomes prone to all types of different infections.

14.5. Batswana

According to Bolaane and Mgadla (1997:2) Batswana live in countries of Botswana and South Africa. They speak a language called Setswana.

Branford (1987:833) adds that the Batswana is a group of African people living in Botswana, Bophuthatswana, Transvaal, Free State and Namibia. Their language is called Setswana.

Batswana is therefore an ethnic group of people who are residents in Botswana with citizenship of the country (Botswana).

15. Contents of research report

Chapter one will introduce the general focus of the study and identification of the research problem. The research problem will be formally stated. The motivation and significance of the study will also be discussed as well as the goal and objectives of the study, the research questions, -approach, -design, -procedure and strategy, pilot study, sampling procedures, ethical issues and relevant concepts.

Chapter two will focus on all the relevant issues regarding HIV/AIDS.

Chapter three will discuss culture and cultural practices in general.

Chapter four will describe the culture of the Batswana.

Chapter five will present the empirical findings.

Chapter six will present conclusions and recommendations.

Chapter 2

HIV/AIDS as social phenomena

1. Introduction

AIDS is a relatively new and unique disease (Evian, 2000:3). It is a disease that kills millions of people globally. According to UNAIDS (2002:8) in 2001, 3 million people died around the world. AIDS frightens everyone around the globe and questions are posed everyday about where HIV/AIDS comes from, what it is, why does it kill people. The effects of HIV/AIDS are felt all over the world. The economy is affected due to number of deaths. Children are left without parents. TV's and radios are promoting funeral covers every moment due to the increased death rate since the discovery of HIV/AIDS. Condoms are distributed everywhere and even advertised. This is a very serious pandemic, which needs a full understanding of this disease. Piot, UNAIDS Director (in Cohen, 2000:4) says that whether you do sophisticated molecular biology or research with the latest antiretrovirals, it is important to get a sense of what the epidemic is all about.

This chapter will focus on defining what HIV/AIDS is; its origins; how it is acquired and how can we deal with it so that we save so many people living with it or even dying from it.

2. Definition of HIV/AIDS

According to Berer and Ray (1993: 6) HIV stands for human immunodeficiency virus and it is a sexually transmitted disease. Like some other sexually transmitted diseases, it can also be

transmitted through blood and during pregnancy. Like herpes, and syphilis, HIV is a virus that affects the whole body. It can take few or many years before it causes serious damage, and be fatal. HIV cannot live on its own, or in the air or water.

Berer and Ray (1993: 8) say AIDS stands for acquired immune deficiency syndrom. Immune deficiency means that the immune system is being prevented from functioning. A syndrome is a group of symptoms or illness originating from one cause, in this case HIV.

Berer and Ray (1993:6), Whiteside and Sunter (2000: 1), Van Dyk (2001:4), and Barrett-Grant, Fine, Heywood and Strode (2001: 10) agree that AIDS is an acronym which 'A' stands for Acquired. This means that the virus is not spread through casual or inadvertent contact like flu or chickenpox. In order to be infected, a person has to do something (or have something done to them), which exposes them to the virus. They say that 'I' and 'D' stand for Immunodeficiency. The virus attacks a person's immune system and makes it less capable of fighting infections. Thus, the immune system becomes deficient. 'S' stands for Syndrome. AIDS is not just one disease but it presents itself as a number of diseases that come about as the immune system fails. Hence, it is regarded as a syndrome.

The current Center for Disease Control (CDC) surveillance definition of AIDS requires the presence of a disease at least moderately indicative of defective cell-mediated immunity in an individual, who has no known underlying cause for such a defect or any other reason for diminished resistance to that disease (Cahill, 1984:10).

If HIV reduces immune function to a certain level, and/or when one or more serious illnesses related to HIV occur, a person is said to have AIDS. Immune function can be measured by testing for the number of T4 cells (also called CD4+ lymphocytes) in the blood. Immune function is considered to be at an advanced stage of impairment when this count goes below 200 per cubic millimeters of blood that is when the CD4 count is below 200 (Berer & Ray, 1993:6; Van Dyk, 2001:13; Crewe & Orkin, 1992:4).

Barrett-Grant, et al. (2001:10) agree with the above authors and add that HIV is a virus that is only found in human beings, and it attacks and slowly damages the body's Immune system. When this happens, you get a group of particular medical conditions called AIDS-defining conditions or illnesses' and we say that you have developed Acquired Deficiency Syndrome

(AIDS). Therefore HIV causes AIDS. This explanation of what HIV/AIDS is, is also supported by the World Health Organisation (WHO) - Fact sheet (2000a: 1) as well as Soul City - Know the Facts (2002).

According to Soul City - Know the Facts (2002) extensive studies around the world, in developed and developing countries, have led most scientists, doctors and nurses to conclude that HIV is the cause of AIDS.

Their conclusion is based on a set of four globally recognized criteria that are used to determine the cause of a disease. They are called the Bradford Hill criteria and they state:

- The cause must always come before the disease.
- There must be strong statistical evidence showing the links between the cause and the disease.
- There must be a biologically sound explanation of how the cause results in the disease.
- Higher levels of the cause lead to more disease.

HIV as the cause of AIDS meets all of these criteria and can be explained as follows:

- **The cause must come before the disease**

There have been no cases of HIV infection occurring after a person has already become ill with AIDS.

- **There must be strong statistical evidence showing the links between the cause and the disease**

Numerous follow-up studies conducted around the world have shown that HIV negative people do not get AIDS. For example, a study in the US of 8 000 participants, found that people with HIV were 1 1000 times more likely to develop a disease associated with AIDS than someone without HIV (Soul City - Know the Facts, 2002).

- **There must be a biologically sound explanation of how the cause results in the disease**

When the HIV enters the human body it infects cells known as CD4 cells. These cells are part of the immune system and the cells that the body uses to defend itself. The HIV reproduces in these cells and in so doing destroys CD4 cells. Once enough of the CD4 cells are destroyed, an infected person is likely to fall ill with diseases that are less serious or very rare in people with healthy immune systems. At that stage, the person is said to have AIDS.

- **Higher levels of the cause lead to more disease**

Several studies of HIV infected people show that AIDS starts when there are a certain number of HI viruses in the blood (Soul City - Know the Facts, 2002). Those with 50-200 copies of the virus per cubic milliliter of blood have long survival times while those with over 100 000 copies show rapid deterioration and faster progression towards sickness and death.

Crewe and Orkin (1992: 4) also give an account about HIV affecting the T4 cells, which are a vital part of the body's immune system.

As stated previously HIV is the cause of AIDS. The link between HIV and AIDS is backed up by strong scientific proof (Crewe & Orkin, 1992: 4). They say that people from different backgrounds and lifestyles all over the world have developed AIDS – the thing that they had in common was that they were infected with HIV.

Van Dyk (2001:4) also supports the above authors about what AIDS is all about. According to her, AIDS is the acronym for Acquired Immune Deficiency Syndrome. It is said that this disease is acquired because it is not a disease that is inherited. It is caused by a virus (the human immunodeficiency virus or HIV), which enters the body from outside. Immunity refers to the body's natural inherent ability to defend itself against infection and disease. Deficiency refers to the fact that the body's immune system has been weakened so that it can no longer defend itself against passing infections. A syndrome is a medical term, which refers to a set or collection of specific signs and symptoms that occur together and that are characteristic of a particular pathological condition.

AIDS, whether the transmission is sexual or non-sexual it remains an epidemic disease whose natural history is still partly obscure and whose cure is unknown. It is a delicate, labile virus that does not survive for long outside the human body (Lachman, 1989: 23).

Authors mentioned above all agree on the definition of HIV and AIDS. These acronyms are known globally. However there are always questions about the origins of HIV/AIDS. The next section will give us perspective about the origin of HIV/AIDS in order to understand the phenomena better.

3. History of HIV/AIDS

HIV is a new complex virus. There are debates on how it evolved into its present form. Before anyone knew it existed, it was being passed from one person and country to another and had spread worldwide (Berer & Ray, 1993: 6). Controversial statements are often made regarding the cause of AIDS and where it originates because of its fatal nature and its sudden discovery. For example, during 2000, the South African president Thabo Mbeki's public statements casting doubt on whether HIV causes AIDS resulted in a lot of uncertainty. People were wrongly let into believing that poverty may be a major cause of AIDS, rather than poverty leading to conditions where HIV spreads faster (Barrett-Grant, et al., 2001:12).

Barrett-Grant, et al. (2001: 11) and Adler (1998) as quoted by Van Dyk (2001:5) mention that in 1981, doctors first started to see signs of a new illness amongst gay men in the United States of America. These men had developed unusual conditions, like a rare chest infection and skin disorders, and special test showed that their immune systems were damaged. Evian (2002:3) says that the men developed a rare pneumonia caused by a parasite called pneumocytis carini. He says that these men were previously healthy between 20 and 45 years of age and homosexually orientated. They also had developed severe immune deficiency, which led to the development of this rare pneumonia.

The early cases of AIDS were observed in gay men. After that, major epidemics were seen in another marginalized group namely injecting drug users in Western Europe, South East Asia, China and India. However, HIV and AIDS is not a disease of gay men or injecting drug users. HIV is mainly transmitted by different kinds of sexual behaviour or through accidental exposure to blood or other body fluids that are infected with HIV (Barrett-Grant, et al., 2001: 11).

Soon after 1981, HIV was discovered in Central Africa, was carried to Haiti and from there reached the USA through gay men. This theory was written into documents as a fact although it was later found that it is based on unreliable evidence. On top of this, the earlier numbers of people reported with HIV in Africa were found to be exaggerated because early tests gave many false positives. Westerners explained the high incidence of HIV in Africa as being the result of "promiscuity" and "traumatic sexual practices". This biased reporting resulted in further discrimination against Africans and angered many African governments and those

involved in AIDS programs (Gordan & Klonda, 1988:13; Adler, 1998 in Van Dyk, 2001:5; Evian, 2000:3).

The following section will focus on the extent of HIV/AIDS globally as well as in Africa, South Africa and Botswana.

4. Extend of HIV/AIDS

According to the reports by UNAIDS, the World Health Organisation and USAID in the year 2003 there were 40 million people living with HIV/AIDS globally of which 37 million were adults and 2.5 million were children. In the same year, the global number of people newly infected with HIV was 5 million of which 4.2 million were adults and 700 000 were children. The AIDS deaths globally in 2003 were 3 million people of which 2.5 million were adults and 500 000 were children (AIDS InSite, 2004:1).

According to the UNAIDS nowhere has the impact of HIV/AIDS been more severe than in Sub-Saharan Africa (AIDS & Africa, 2004). The UNAIDS further state that in the year 2002 there was an estimated 3.5 million adults and children who were infected with HIV in Sub-Saharan Africa. During the year 2002, 2.4 million people died of AIDS –related illness in Africa (AIDS & Africa, 2004). In the year 2003, approximately 3.2 million new HIV infections occurred in Sub-Saharan Africa (HIV & AIDS Statistics for Africa, 2004).

There are currently 13 million children orphaned by AIDS worldwide and 11 million of them are in Sub-Saharan Africa (AIDS InSite, 2004:1). In South Africa, there were 5.3 million South Africans living with HIV in the year 2002. In the same year 2.3 million men and 2.95 million women were infected with HIV. There were 91 271 children who were infected by HIV by their mothers (AIDS InSite, 2004:2).

In 2001, it was estimated that there were 330 000 people living with HIV/AIDS in Botswana. This figure is 38.8% of the total population. One in four adults carry the HI virus (HIV&AIDS statistics for Africa: 1). In Botswana, among 25-29-year-old women attending antenatal care in urban areas, 55.6% were living with HIV/AIDS in 2001 (UNAIDS: 2001).

The number of people living and dying with HIV/AIDS is shocking. This calls for concern that we need to be aware of the causes of HIV/AIDS so that we can prevent the spread of HIV/AIDS.

5. Key characteristics of HIV/AIDS

HIV/AIDS seems to be a very complicated disease. From the discussions above it is evident that HIV/AIDS is a fairly new phenomena and it took time for it to be noticed. It is therefore very important that we are able to identify with ease that it is HIV/AIDS that the person is suffering from so that urgent steps can be taken to treat and support people. This section identifies the key characteristics of the disease and how it differs from other diseases.

Whiteside (1998: 14) identifies important features of HIV/AIDS, which he thinks call for mobilization of a broad response to the epidemic, namely:

- AIDS is a new epidemic. It was first recognized as a specific condition only in 1981 and it was not until 1984 that the cause (and a test to detect it) was identified. According to Evian (2000:3) and Van Dyk (2001:5) it was first described in America after a number of men had developed a rare pneumonia caused by a parasite called *Pneumocystis carinii*. These men were all previously healthy, between 20 and 45 years of age and homosexually- orientated.
- It has a long incubation period. Persons who are infected by the virus may have many years of normal productive life, although they can infect others during this period. According to Wilson, Naidoo, Bekker, Cotton and Maartens (2002: 48) and Van Dyk (2001:16) the response to HIV infection varies widely between individuals ranging from severe seroconversion illness with rapid progression to immune failure and death, to asymptomatic infection with essentially normal function. The median time to AIDS in developed countries from the point of infection is 8-10 years. Evian (2000:8) and Wilson, et al. (2002:48) talks about slow progressors and long term non –progressors respectively. These people generally remain well and active without any disease. The asymptomatic phase is usually associated with a CD4 cell count between 500 and 800 cells/mm³.
- The prognosis for people infected with HIV is currently bleak. Wilson, et al. (2002:53) adds that in the absence of successful prevention efforts, AIDS related deaths

are expected to rise from around 225 000 in the year 2001 to a plateau of around 630 000 per annum in 2012. By 2010 it is expected that two out of every three deaths could be AIDS related. The individual prognosis is best determined by integrating a clinical evaluation of the patient's immune status with information provided by the viral load and CD4 count.

- The disease is found mainly in two specific age groups, infants and adults aged between 20-40 years (Evian, 2000:3 &157; Wilson, et al., 2002:5). In the developing world, slightly more females than males are infected, and women are infected and develop the disease at a younger age than men. In this regard UNAIDS (2002:8) for example stated that in the year 2001, it was reported that there were 40 million people who live with HIV/AIDS. Of the 40 million who live with HIV/AIDS, 37.1 million are adults and 3 million are children under the age of 15. Out of the total number of adults who live with HIV/AIDS, 18.5 million are women. It is estimated that there were 6.5 million people in South Africa living with HIV/AIDS on 1 July 2002. Of these, over 6.1 million (95.1%) were in the age group 18-64 years. This is also the age group, which is most likely to form part of the labour force. An estimated 3.2 million women of childbearing age (15-49 years), were living with HIV/AIDS. This group accounted for around half (49.5%) of all infections. In all adult age groups, there were more women than men living with HIV/AIDS (Dorrington, Bradshaw & Budlender, 2002:4).
- HIV interacts with other diseases, both in terms of causing HIV/AIDS to spread (e.g., sexually –transmitted diseases increase the rate of HIV transmission ten-fold) and arising from HIV infection, e.g. significant increase in tuberculosis cases are directly related to HIV (Wilson, et al., 2002:9; Evian, 2000:233-234; Talbot, Kenyon, Halabi, Moeti, More & Binkini, 1999:1). This implies that HIV will not only be a public health burden in itself, but it is directly linked to the burden of other significant public health problems. In general the epidemic is still spreading. In some Southern African countries it may have peaked in urban centers, but it continues to spread in the rural areas. According to Evian (2000:21) AIDS and other sexually transmitted diseases are often more common in lower socio-economic countries. For example, high unemployment rates, overcrowding, poor education, crime, too much alcohol consumption promote the spread of sexually transmitted diseases.
- HIV can only reproduce itself inside a living cell which it parasites for purposes of reproduction. It can therefore only live and multiply in human cells and cannot survive outside the human body (Van Dyk, 2001:7; Evian, 2000:180).

6. HIV/AIDS transmission

In the World Health Organisation (WHO) - Fact Sheet 1(2000a: 2) it is mentioned that HIV can be transmitted by:

- Sexual intercourse (vaginal, anal oral) or through contact with infected blood, semen, or cervical and vaginal fluids. This is the most frequent mode of transmission of HIV world wide, and can be transmitted from any infected person to his or her sexual partner (man to women, women to man, man to man and but less likely, women to women). The presence of other sexually transmitted diseases (hence forth call STDs) (especially those causing genital ulcers) increases the risk of HIV transmission because more mucous membrane is exposed to the virus.
- Blood transfusion or transfusion of blood products (e.g. obtained from donor blood infected by HIV).
- Injecting equipment such as needles or syringes, or skin-piercing equipment, contaminated with HIV.
- Mother to infant transmission of HIV/AIDS can occur during pregnancy, labour, and delivery or because of breast-feeding.

The HIV transmission modes listed above are widely supported by several researchers such as Crewe and Orkin (1992:4); Berer and Ray (1993:6); Ward (1999); Murphy, Brook and Brichal (2000: 2) as well as Gordan and Klonda (1998). Whiteside (1998: 14) further asserts that one of the key reasons for the rapid spread of HIV/AIDS in the world has been its transmission mode, a view shared by Whiteside and Sunter (2000: 10).

Aggleton, Homans, Mojsa, Watson and Watney (1989: 40-41) have the same views as the above authors about HIV transmission. They however further elaborate on how the actual transmission takes place. They say that the virus can be transmitted from man to man and from woman to man through penetrative sex without a condom. Sperm donors can also transmit it via artificial insemination although HIV antibody tests are now carried out on sperm donors to

ensure that the risks associated with this procedure are minimal. There is also some evidence that sexual transmission from woman to woman can take place.

Murphy, et al. (2000: 2) maintains that unprotected receptive anal intercourse is the highest-risk sexual behavior for the acquisition of HIV. Among gay men, anal sex without a condom is the activity, which carries the greatest risk particularly to the receptive partner, and anal sex between a woman and man may carry a similar risk.

Most people infected with HIV do not know that they have become infected. HIV infected persons develop antibodies to HIV antigens usually six (6) weeks to 3 months after being infected. In some individuals, the test for the presence of these antigens may not be positive until 6 months or longer (although this would be considered unusual). This time during which people can be highly infectious and yet unaware of their conditions is known as the window period (Murphy, et al., 2000: 2).

In adults, there is often a long, silent period of HIV infection before the disease progresses to "full blown" AIDS. A person infected with HIV may have no symptoms for up to 10 years or more (WHO- Fact Sheet 1, 2000a: 3). The vast majority of HIV-infected children are infected in the peri-natal period, that is, during pregnancy and childbirth. The period without symptoms is shorter in children, with only a few infants becoming ill in the first few weeks of life. Most children start to become sick at 2 years of age, however a few remain well for several years (WHO- Fact Sheet 1, 2000a: 3).

Sero-conversion is when a person recently infected with HIV tests sero-positive for HIV antibodies. Some people have a "glandular fever" like illness (fever, rash, joint pains and enlarged lymph nodes) at the time of sero-conversion. Occasionally acute infections of the nervous system (e.g. aseptic meningitis, peripheral neuropathies, encephalitis and myelitis) may occur (World Health Organisation (WHO) - Fact Sheet1, 2000a: 2).

Wilson, et al. (2002:50) further explains that severe sero -conversion illness, with symptoms persisting for more than two weeks, is associated with high set point viral load and poor prognosis. At the time of initial illness there is a "window period" when the HIV Elisa test will be negative although viral antigens or RNA can be detected in the blood. Individuals with acute

HIV infection represent a challenge to blood transfusion services as they are HIV antibody negative but contain high levels of infectious virus. Sero-conversion follows the window period.

From the bloodstream, HIV has been isolated in cells in the gastro-intestinal tract, kidney, lungs, bone marrow, certain brain cells, adrenal glands, eyes heart, joints, liver, skin and thymus. HIV is a slow-acting virus. Low levels of HIV may remain quietly in the body for years and appear to cause few or no problems. Overtime, other organisms that can cause illness will get into the bloodstream, and the immune system is activated. T4 cells are also activated, and those containing HIV produce more HIV. New HIV virus can then enter more T4 Cells. This is why maintaining health and getting early treatment for any illness is important for people with HIV. The more the immune system is activated to fight infections or disease, the more HIV replicates. HIV also slowly seems to prevent the blood from producing new T4 cells. It is not clear whether HIV directly destroys the immune system or provokes the immune system into self-destruction. As fewer healthy T4 cells remain to fight infection, a cycle of HIV – related illness begins. Certain potentially fatal organisms, which would normally be controlled by the immune system, are able to cause illness. These infections are called opportunistic because the failing immune system gives them the opportunity to take over (Berer & Ray, 1993: 8).

Perinatal transmission may occur through a number of different pathways; it can happen before birth, during delivery or during breast-feeding (Ward, 1999: 45).

HIV can be transmitted from mother to child before and around birth in a number of ways. Before birth, HIV may be transmitted across the placenta to the blood or perhaps via vaginal and cervical secretions, and after birth there is some, albeit controversial, evidence for transmission via breast milk. It is difficult to distinguish between infection before birth and infection during birth itself since, even if the child is unaffected, it may carry maternal antibodies for time after being born. These make it difficult to determine the child's own antibody status (Aggleton, et al., 1989:41).

Babies born to HIV-positive mothers are usually born with HIV antibodies, irrespective of whether or not they are infected with the virus. These antibodies come from the mother. If the child does not actually have HIV, these antibodies clear out of the body over a period of time. This means that an HIV antibody test is not considered accurate to the first 18 months after birth. However, the more expensive tests, which check directly for the virus, are accurate and

can be used a few weeks after birth (World Health Organisation (WHO) - Fact Sheet 1, 2000a: 2).

The transmission of HIV from an infected patient to an uninfected health-care worker is possible if the health-care worker accidentally cuts himself or herself during surgery or sticks himself or herself with a needle that contains infected blood from the patient. This kind of on the job exposure to HIV is known as occupational exposure (Ward, 1999: 46).

Gordan and Klonda (1988: 15) argue that it is not easy to become infected with HIV. HIV cannot enter the body through the air in the same way as measles. Whiteside and Sunter (2000: 10) also maintain that HIV is hard to transmit. They say in order for a person to be infected, the virus has to enter the body in sufficient quantities. Gordan and Klonda (1988) continue to say that although HIV has been found in many body fluids, it is only infectious in blood, semen and vaginal secretions. HIV from an infected person must enter the white cells of another person in order to survive. HIV can only enter another person when the blood, semen or vaginal secretions of an infected person come into contact with the blood or mucous membranes of another person. The outside of the human body is covered with a thick skin, which keeps out HIV as long as there are no cuts or sores in it.

Evian (2000:18) says that there is no good evidence that HIV is spread through normal, everyday, casual contact between individuals. HIV is not stable and does not survive for long periods outside the human body. Evian (2000:18) continues to say that the virus cannot penetrate normal intact skin and does not readily enter through a healthy mouth or eye. The virus is also not present in high enough quantities in the saliva and urine to cause infection (Van Dyk, 2001:33; Fact Sheet-HIV/AIDS CDC-NCHSTP, 2001: 2-4). A person with a healthy genital tract is less likely to acquire HIV than a person with genital disease such as sexually transmitted diseases (STI).

According to Aggleton, et al. (1989: 42), transmission studies strongly suggest that HIV cannot be transmitted via the following routes: touch, bodily contact, coughing and sneezing, cups, cutlery and food, swimming pools, drinking from same glass, towels, toilet seats, pets, mosquitoes and other insects, sharing baths and showers. Lachman (1989: 23) adds that AIDS is not transmitted through the upper gastrointestinal tract or through the respiratory tract.

Wilson, et al. (2002:61) mentions that HIV is not transmitted through normal household contact including kissing and HIV cannot survive in the environment.

The modes of transmission are well documented above. It is however very important to know what factors can predispose or put people at risk of HIV transmission.

6.1. Risk factors regarding HIV transmission

Van Dyk (2001:16) mentions that different people (for reasons as yet not fully understood) respond differently to HIV infection. Some people remain healthy and active for as long as 10 to 20 years with little or no signs of immune depression, while other people deteriorate rapidly and develop full-blown AIDS within five years, or even sooner. There are many known reasons why HIV infection may progress more rapidly in some individuals than in others. Some of the reasons why people respond differently are: there are different strains of HIV (some are more virulent or active); when people are infected, they receive different dosages of the virus (larger or smaller dosages); different human bodies respond differently to the virus, and the general health status of the person concerned affects the course of the disease.

6.1.1. Biological and sexual risk factors

Ward (1999: 38) identifies factors that may alter an individual's susceptibility and HIV's infectiousness. He further mentions that the presence of either acute HIV infection or advanced HIV disease (AIDS) in the infected partner increases the risk of sexual transmission. Although individuals with asymptomatic disease are also infectious to others, people recently infected temporarily have very high levels of virus in their blood and body fluid and secretions, as do people with advanced disease, which makes them relatively more infectious to their partners. Ward (1999: 38-40) also says that the presence of genital tract infections in either partner also increases risk. The risk of transmission markedly increases if yeast infection or genital sores or ulcers are present.

According to Ward (1999:39) STDs that do not produce ulcers, such as gonorrhoea, chlamydia, and trichomoniasis, increase the risk of acquiring HIV. This is thought to occur because these diseases cause inflammation of the mucous membranes of the genital tract. In the HIV-infected partner this increases the amount of free virus and the number of virus infected cells in genital secretions. In the HIV negative partner the risk of acquiring HIV infection is increased because

the inflammation of the genital tract concentrates cells susceptible to HIV infection in the genital tissues.

As mentioned previously, anal intercourse and, probably, intercourse during menstruation also increase the risk of sexual transmission. Anal intercourse easily causes tear in the rectal lining that result in direct contact between infected semen and the blood of the receptive partner. Number of instances of intercourse is also related to risk. The greater the number of exposures to infected semen or vaginal secretions, the higher the risk of HIV transmission (Ward, 1999:40).

Genetic characteristics of the particular HIV strain to which a person is exposed, as well as genetic characteristics of the exposed person, affect the risk of HIV transmission. Very small percentages of individuals have remained uninfected despite repeated exposure to HIV. It is now believed that certain individuals have genetically determined natural resistance to HIV. Some strains to HIV appear to be more infectious than others. It has been speculated that some HIV subtypes might be more infectious than others through vaginal intercourse (Ward, 1999: 38-40).

Ward (1999: 19 -24) points to some studies, which have suggested that, the use of oral contraceptives, diaphragms, cervical caps, or intrauterine devices (IUDs) increases the risk of HIV transmission. This is difficult to determine because people who use these modes of contraception may be less likely to also use condoms during intercourse. A risk of HIV transmission exists even during safer sex, minimizing this risk requires that condoms be used consistently and correctly.

Berer and Ray (1993: 44-45) demonstrate what it means by the risk of HIV infection. They maintain that the transmission of HIV through sexual intercourse, blood and pregnancy are inter-connected events. They say talking about HIV transmission means talking about risk. No definitive statements can be made that are true for everyone. People may or may not realize or admit to themselves that they are at risk of HIV infection. People with HIV may not know they have it or that they are putting others at risk. The overwhelming majorities of people with HIV never intend or want to infect other people, just as no one wants to become infected.

Being exposed to HIV does not necessarily mean being infected. However, the vast majority of people are at risk through the main routes of transmission. With all forms of exposure, although the relative risk differs, one exposure can lead to infection and each repeated exposure carries the same risk. In general, the more viruses per exposure and the more times a person is exposed, the likely it is that infection will occur. Multiple exposures increase the risk; re-infection through continuing exposure after infection also occurs and may contribute to disease progression (Berer & Ray 1993: 44-45).

Infection of a woman by a man is biologically more likely than infection of a man by a woman, that is, per exposure and if other risk factors are equal. If men generally have more sexual partners than women, then infected men will expose more women, to HIV than vice versa.

Women are getting HIV infection at a younger age than men all over the world, in line with socio-sexual norms. This fact is easily overlooked if gender and social factors are not taken into account. Women also tend to have sexual relationships with men a few years older than themselves, whether inside or outside of marriage. In some cultures, men marry women up to ten years younger than themselves for childbearing and other patriarchal reasons. This notion is supported by Poku (2001:197).

Poku (2001:197) further says this is not a surprise in Africa if one keeps track of teenage pregnancies. She continues to say that older men also select young girls for sex because the girls were perceived to be clean. They are unlikely infected with HIV or STDs.

Poku (2001:197) asserts that, this is confirmed by ongoing studies in Botswana and Zambia. Married men often have extra-marital relations with younger women. In polygamous marriages, second and third wives are often much younger than the husband (Berer & Ray, 1993: 44-45).

In such relationship, the men have had more chance to be exposed to HIV, both because they are older and because they likely to have had more sexual relationships. Their women partners are then more likely to be exposed at an earlier age. A particular area of concern in this respect is that some men have begun to look for younger partners in the hope that they will un-infected. They feel that they will avoid infection themselves if they only sleep with virgins, who will inevitable be much younger than them (Berer & Ray, 1993: 44-45).

Evian (2000:17) says that a person is most likely to pass on the HIV virus during the following phases:

- Soon after becoming infected with the HIV virus (in the first 4 – 8 weeks)
- When there is a high HIV viral load
- During the later phase of the infection, when symptoms of HIV infection/AIDS appear.

Wilson, et al. (2002:63) concluded that unprotected anal intercourse and unprotected vaginal intercourse put people at high risk of HIV transmission. They also argue that the disruption of the genital tract epithelium by intravaginal spermicides, herbal agents used for 'dry sex', and violent sex especially rape and gang rape, facilitate the increased transmission of HIV from men to women. It is also said that when a man is not circumcised, the foreskin contains large numbers of dendritic cells that are exposed to genital fluids during sexual intercourse and therefore he becomes easily exposed to HIV and transmission can easily happen. It is also believed that when a couple has sex during menstruation, the transmission of HIV from women to men is facilitated.

According to Wilson, et al. (2002:61), the majority of individuals infected with HIV in sub-Saharan Africa get infected with HIV heterosexually. Although homosexual transmission of HIV remains an important cause of infection among gay and bisexual men and intravenous drug use is also likely to cause HIV infection in the next decade.

Women seem to be the group highest at risk of HIV infection because of their biological makeup and their traditional status in the society. They become sexually active also at a young age.

6.1.2. Socio-economic risk factors

According to Popenoe (1986:252) poverty is a condition of scarcity or deprivation of material desirables. It is a condition characterized by a lack of adequate consumption of the necessities of life. It is also viewed as a stigmatized position of social inferiority. The physical appearance of poor people often makes their stigma highly visible e.g. their deteriorated housing, ragged clothing and emaciated faces. According to Popenoe (1986:252) historically the poor have been people without homes. They wander from community to community in search of work and sustenance.

Wilson, et al. (2002:10) postulated that there is clear evidence of a link between poverty and almost any epidemic. Poverty contributes to the spread of HIV because of social and economic factors.

Webster (1991:18-20) and Van Niekerk (2001:146) argue that poverty with its accompanying side effects such as prostitution (the need to sell sex for survival), poor living conditions, poor education, poor health care are major contributing factors to the current spread of HIV/AIDS.

Poku (2001:195-196) adds that poverty is associated with weak endowments of human and financial resources, such as low levels of education, low levels of literacy and few marketable skills. She says that generally poor health status and low labour productivity are also associated with poverty. The poor health status of Africans coexist with undiagnosed and untreated sexually transmitted diseases (STD'S) which are now recognized as a significant co-factor in the transmission of HIV.

She further mentions two examples of this state of affairs, which will perhaps indicate how poverty leads to outcomes, which expose the poor to HIV. First, poverty especially in rural areas and the absence of access to sustainable livelihoods are factors in labour mobility. Mobile populations which often consist of large numbers of young men and women are isolated from traditional cultural and social networks and in the new conditions will often engage in risky sexual behaviours, with obvious consequences in terms of HIV infection.

The case of South Africa is a good example of the relationship between poverty and HIV. Throughout the past century, men from around the Southern African region were drawn or conscripted to work in South African gold and diamond mines. They left their families behind in rural villages, lived in squalid all-male labour camps and returned home maybe once a year. Lack of education and recreation, forced them to rely on home brewed alcohol and sex for leisure. Men who made his living deep inside a South African gold mine had a one in 40 chance of being crushed by falling rock. So the delayed risks of HIV seem comparatively remote (Poku, 2001:195-196).

According to Evian (2000:21) AIDS like other sexually transmitted diseases are often more common in lower socio economic countries. He gives the following as reasons why low socio economic conditions promote the spread of sexually transmitted diseases:

- In many communities women have very little control over their sexual lives, and the ways to prevent STDs. Women are often exploited and have more inferior status than men. Poverty often makes this sexual exploitation worse, and this further contributes to the spread of sexually transmitted diseases.
- High unemployment promotes migrant work and family disruption. People leave their homes and therefore their loved ones, friends, familiar surroundings and local community life. In the far-away places, migrants often find themselves in lonely, unfavourable, hostile or alienating environments. There is a natural need for sex and intimacy resulting in multiple-partner sexual relationships.
- Women are often forced to sell sex to earn precious money for food and basic needs, and to help raise their children. Young girls may sell sex to older men.
- People in poor living conditions often do not have easy access to health care services. Sexually transmitted diseases often go untreated and spread more easily.
- Poor education and low literacy levels help to keep people ignorant of the ways and means to avoid diseases like AIDS.
- Crime and violence is also common in cities and town, and these further stress family and community life.
- Many of the problems described above are also result in the breakdown of the usual traditions, customs, beliefs and cultural practices in a community. These practices usually determine the accepted sexual behaviour and constraints in a society. When these are broken down, it often results in multiple sexual partners and indiscriminate sexual behaviour.

The links between poverty and health are increasingly recognized and understood. It is not clear that AIDS is simply a disease of poverty, although poverty undoubtedly helps drive the epidemic. In early stages AIDS appears to infect the relatively well off. They have the disposable incomes that allow them to travel and, in the case of men, purchase sex. Of course more poor people are infected. It is likely that as the epidemic evolves, they may be proportionately worse affected. It is predicted that AIDS will increase poverty and inequality, but nobody has measured this (Whiteside and Sunter, 2000: 91-92).

It seems therefore as if HIV spreads fastest in conditions of poverty.

6.1.3. Mother to child transmission (MTCT) and breastfeeding as

risk factors

According to Wilson, et al. (2002:358) mother to child transmission of HIV (MTCT) is the major cause of HIV infection in children. There are more than 2 million pregnancies in HIV positive women each year, and more than 1800 infected children are born daily worldwide. The overwhelming majority of these births are in the developing world, especially in Sub-Saharan Africa. In several African countries, more than 30% of women attending antenatal clinics are HIV Positive. In South Africa, upwards of 250 000 HIV –positive women will become pregnant each year and, in the absence of prevention interventions, more than 70 000 of their children will be infected.

According to Evian (2000:213) there are numerous ways to prevent the transmission of HIV from mother to child during pregnancy and childbirth. These ways can be implemented during antenatal and labour phases and post delivery.

Evian (2000: 215) continues to say that any new HIV infection during pregnancy and breast-feeding is likely to result in an increase in the HIV viraemia. This is considered to increase the likelihood of MTCT. For this reason pregnant mothers must be informed of this risk and educated on safer sexual practices. It is especially important for them to use condoms if their partner is HIV infected, or if his HIV status is unknown.

Programmes to prevent mother-to-child-transmission (PMTCT) of HIV have been conducted in many countries including Ivory Coast, South Africa, Thailand and Botswana. These programmes have succeeded in reducing the number of HIV infections in babies born of HIV-positive women. MTCT programmes include counseling, testing and the provision of antiretroviral during birth as well as formula feeding or a 6-month period of exclusive breastfeeding to reduce the transmission of HIV through breast milk. (Mixing breast milk with other feeds may increase the risk of transmission). Counseling on feeding options should be provided to allow women to make informed choices (Soul City- Know the Facts, 2002; Evian, 2000:220-221).

Nevirapine has been shown to be both safe and effective. Thousands of women and children have gone through MTCT prevention programmes using Nevirapine. Studies have been conducted into this in South Africa and other countries and no serious side- effects have been reported (Soul City- Know the Facts, 2002; Evian, 2000:217). A study in Uganda, known as

HIVNET 012, showed that the risk of transmission of HIV from mother to child could be reduced about 47% by using Nevirapine (Soul City- Know the Facts, 2002).

A seminal clinical trial that was conducted in 1994 (Soul City- Know the Facts, 2002) revealed that azidothymidine (AZT) given orally to pregnant women for several weeks prior to delivery, intravenously during delivery, and orally to the newborns for six weeks could reduce perinatal transmission by two-thirds. A strong correlation was later found between levels of free virus in the mother's blood (mother's viral load) and perinatal transmission. The research suggested that AZT help prevent transmission by reducing the amount of free virus in the mother's blood prior to delivery. The research also pointed out that there is a possibility that mothers with a low viral load can transmit HIV to their infants. Wilson, et al. (2002:364) supported the use of AZT.

The mother's immune status (a low CD4 count) was associated with an increased risk of perinatal transmission. The exposure of the infant's mucosal membranes to maternal blood during delivery was also seen as contributing to the transmission of HIV (World Health Organisation [WHO] - Fact Sheet 1,2000a: 2; Evian, 2000:213).

Prolonged period between the time the mother's water breaks and the time of delivery and presence of uncerations in the mother caused by sexually transmitted infections were reported to transmit HIV (Soul City- Know the Facts, 2002, Wilson, et al. 2002:364; Evian, 2000:218).

Vitamin A deficiency in pregnant women in Africa appears to increase the risk of perinatal transmission. However, it is not known yet whether supplements of vitamin A reduce this risk (Soul City- Know the Facts, 2002; Evian, 2000:215).

Some studies also suggest that vaginal deliveries especially with episiotomy increases the risk of transmission, but this has not been conclusively shown, and cesarean section are not recommended as means of reducing the risk of HIV transmission (Ward, 1999: 46; Wilson, et al., 2002:364; Evian, 2000:219).

It is evident from the above discussion that the risks of mother to child transmission are very high therefore the efforts to prevent mother to child transmission should be taken seriously. The following section will focus specifically on the relationship between HIV transmission and feeding choices.

In 1985 transmission of HIV through breastfeeding was first described in women newly infected via blood transfusion or heterosexual exposure after delivery. It has been estimated that breastfeeding by women with established infection increases the rate of transmission by 14%. The risk of transmission may increase to 29% for the mother who acquires the infection during the breastfeeding period (Wilson, 2002:296).

All pregnant women need to decide how they are going to feed their babies, prepare for feeding, and feed safely, within an hour of delivery. Deciding how to feed a baby is especially important for an HIV-positive mother, as this can influence HIV transmission to her baby. It is really important that the mother makes the right decision for herself, and also for her baby (Wilson, 2002:295).

According to Evian (2000:221) MTCT is more likely during the acute HIV infection period. For example, within the first few weeks after a new HIV infection and if there are symptoms of AIDS.

He also says MTCT is more likely if there is a high HIV viral load in the mother and if there is immune-deficiency (signs of opportunistic diseases or a low CD4 cell count.)

Evian (2002:299) lists the advantage of breast milk substitutes, as there is no risk of HIV transmission and no other infections maybe transmitted. He also says that the benefits of breastfeeding are that breast milk provides perfectly for the infant's nutritional needs, this is particularly important in HIV – infection. Breast milk is easily digested and used by the body. There are debates regarding whether babies who are breast fed by HIV positive mothers are more at risk than babies who are formula fed or bottle-fed by HIV positive mothers. It is evident that breast milk contains substances, which protect the baby from many infections and so provides him with extra immunity while he/she builds up his/her own immune system. This additional immunity is particularly important for the baby of an HIV infected mother. The good nutrition provided by breast milk also builds up the immune system (Gordan & Klonda, 1988: 28-29; Wilson, et al., 2002:298-299; Van Dyk, 2001:29).

Wilson (2002:298) says that the viral load in the mother, mastitis and cracked nipples, oral thrush in the infant, and HIV infection of the mother during breastfeeding increase the risk of

breastfeeding transmission. Small amounts of HIV are sometimes found in breast milk (Gordan & Klonda, 1988: 29).

Gordan and Klonda (1988: 28-29), Evian (2000: 223), Van Dyk (2001:30) and Wilson, et al. (2002:299) believe that bottle-feeding/formula feeding on the other hand can introduce many germs into the baby and this often leads to infection. This is particularly serious for an HIV infected baby, as its immune system is so weak that infections are hard to fight. Many bottle-fed babies also become malnourished when mothers cannot afford to make the mixes to the correct strength (and waste valuable money on purchasing the milk in the first place) and this weakens the immune system still further.

Wilson, et al. (2002:296) said that there are feeding choices that mothers can choose from. For example, breast milk or breast milk substitutes such as commercial formulas, modified cow's milk and dried milk powder.

Evian (2000:222) says that the risks of the different methods need to be balanced. He says that if infants of HIV positive mothers can be safely and adequately fed with a breast milk substitute, then the risk of MTCT will be reduced. This is clearly the most ideal and favoured method for feeding infants of HIV positive mothers. In communities where there is a high local infant mortality rate, substituting breast milk feeding may place the infant at risk from disease, eg. malnutrition, gastro-enteritis and other infective conditions. .

The extent to which the HIV antibodies found in breast milk protect the baby from HIV infection, but other antibodies in breast milk certainly protect against the many other infections to which any baby (including one infected with HIV) is exposed.

Gordan and Klonda (1988: 29), Evian (2001:224), Van Dyk (2001:29-30) and Wilson, et al. (2002:300) therefore, suggest that mothers should continue to breast-feed their babies if the mother does not want to formula feed or she is not in a social or economically supportive environment to allow her to safely and adequately formula feed whether they have HIV infection or not.

On the other hand breast milk can also transmit HIV, which is found in both the cells present and the liquid portion of the milk. The risk of transmissions is believed to be highest during periods of high viral load in the mother, that is, during acute HIV infection and during advanced HIV disease, or AIDS (Gordan and Klonda, 1988: 29; Evian, 2000:221 and Wilson, et al. 2002:296-298).

There seems to be lack of understanding that breast milk has HIV and therefore HIV can transmit through breast-feeding. Many people are also unaware of the range of different times when HIV could be transmitted although they seem to understand that a pregnant mother could infect her baby (Tlou, Nyblade, Kidd, Field, Rantona & Sentumo, 2000).

It is therefore critically important for health care workers to assess every mother and her social and economic situation now and in the short-term future. This should be done before advising her on the most appropriate and suitable method for feeding her infant (Evian, 2000:222).

Wilson (2002:295) says that in the developing countries, breastfeeding should remain the standard recommendation for all women, as the advantages outweigh the increase risk of HIV transmission and women known to be HIV- positive should be advised not to breastfeed. Child care practitioners consider breastfeeding of such critical importance to the general health of the infant as well as the mother-infant relationship that special efforts should be made to retain this practice, even during the HIV pandemic (Wilson, 2002:295).

Traditional African mothers face serious challenges with the concepts of exclusive breastfeeding and formula feeding. A traditional African woman is expected by society to breast feed the baby and in African communities it is very common that women are instructed by the elderly to feed the baby because the breast milk is not enough to satisfy the baby's hunger. If the mother opts for breast- feeding, she will be pressurized to feed the baby or other caregivers in the family will feed the baby. Traditionally a family member who is an elderly person in the family after delivery must assist a woman. If the mother insists to breast feed only, she will have to give explanations why she is not feeding the child. Formula feeding is also a challenge given the poverty situation in most communities where there is no running water and electricity. Prevention of mother to child transmission after birth is a very difficult situation to control. The communities need to be educated about these risks in order to prevent the mother to child transmission.

6.1.4. Mental illness as a risk factor

Severe mental illness is a risk factor in the context of HIV/AIDS. According to Shaw and Mahoney (2003:179) severe mental illness typically refers to persons with serious, persistent, and intermittent psychotic disorders, including schizophrenia, bipolar disorder, major

depression, and schizo-affective disabilities in daily living skills, social interactions, family relations, and jobs or education. Little was known about HIV/AIDS in people with severe mental illness until the early 1990s when a series of prevalence studies reported alarming rates of HIV infection, especially in people dually diagnosed with mental illness and substance abuse disorders (Shaw & Mahoney, 2003:179).

Shaw and Mahoney (2003: 180) continue to say that severe mental disorders produce disabling cognitive, emotional, and behavioral symptoms that greatly increase the potential for HIV infection. For example, schizophrenia has a devastating impact on cognitive functioning that results in limited insight. Persons with schizophrenia frequently lack insight into their psychiatric symptoms and comprehension of their own risk for HIV/AIDS. This lack of insight also makes them much less likely to use precautions with sex or needles. Mania phases of bipolar disease, on the other hand, are characterized by impulsivity, lack of judgment, reckless behavior, and increased sexual activity. Hopelessness associated with major depression results in lack of self-care, non-compliance with treatment, and a high risk for substance abuse. Because apathy is a characteristic that accompanies severe mental illness, persons frequently lack the motivation to make the necessary behavioral changes that reduce HIV risk.

Shaw and Mahoney (2003:181) argue that the HIV virus is neurotropic; it crosses the blood brain barrier and enters the central nervous system shortly after infection. CNS manifestations resulting from HIV infection include HIV related dementia, psychotic disorders, CNS opportunistic infections and tumors, mood disorders and delirium. Persons without a previous history of mental illness may develop psychiatric symptoms as result of these HIV related disorders.

7. Stages of HIV infection and signs and symptoms of HIV/AIDS

Wilson, et al. (2002:48) says that the response to HIV infection varies widely between individuals, ranging from a severe sero-conversion illness with rapid progression to immune failure and death to asymptomatic infection with essentially normal immune function (the long-term non-progressor).

Wilson, et al. (2002:51) illustrates the central role of HIV viral load in disease progression and transmission. They say that there are rapid progressors, intermediate progressors and slow progressors or long-term non-progressors.

According to them rapid progressors are a small proportion of individuals who develop AIDS within one to two years following HIV infection. This phase is associated with high levels of viral replication and a precipitous decline in CD4 numbers. Most of these individuals are unable to mount an effective immune response because of the depletion of CD4 cell and are not able to control viral replication. The intermediate progressors are the majority of HIV – infected individuals who are able to regulate viral replication for many years because of an effective immune response. However, over time there is a steady decline of CD4 T-Cell numbers and a slow erosion and eventual destruction of the immune system.

Slow progressors or long-term non-progressors are a small proportion of individuals who are able to control HIV viral load very effectively without the assistance of anti retroviral therapy (ART). Long-term non-progressors have low, and in many cases undetectable, plasma viral loads, with high CD4 counts and robust immune systems. Many such individuals have been infected for more than 20 years. The reasons for slow disease progression appear to be multiple.

Crewe and Orkin (1992:4) say that the asymptomatic phase is a phase when the infected person might not know that they are infected, they are nevertheless infectious to other people. This is one of the most terrifying features of the disease, which makes it so difficult to control. One can be infected, shown no symptoms and yet be infectious at the same time. HIV has a dormancy period of up to ten years before it manifests itself.

Evian (2000:25) says that a person who becomes infected with HIV will usually go through various clinical stages that occur over a long period of time, usually 5-12 years.

There are however conflicting opinions as to the different stages in the progression of the disease. The first symptoms of AIDS usually start manifesting themselves after 28 months, however this can vary between 6 months and 6 years. Stages of HIV infection according Crewe and Orkin (1992: 5); Wilson, et al. (2002:57); Evian (2000:25) & WHO - World Health Organisation Staging System in Evian (2000:116) can be displayed as shown in Table1.

Table 1: Stages of HIV infection

Appropriate Time	Symptom	Phase
12 weeks	Development of anti-bodies	-Sera-conversion -Symptomatic Infection
12 weeks- 7 years	Less than 10% weight loss	HIV well-mild disease episodes
7-10 years	Chronic fatigue, fever and night sweats, serious forms of herpes, thrush, more than 10% weight loss, swelling of lymph glands, diarrhoea, deterioration of central nervous system (in some cases)	HIV disease. Severe illness (Symptomatic)
10-15 years	Opportunistic infection For example: Extra pulmonary TB	AIDS Patient is dying

According to Barrett-Grant, et al. (2001:22-23) there are 5 stages of the HIV/AIDS disease.

They are the following:

- Primary HIV infection
- The asymptomatic or 'silent' disease
- Early HIV symptomatic disease
- Medium-stage HIV Symptomatic disease.
- Late-stage HIV symptomatic disease (AIDS)

7.1. Stage1: Primary HIV infection

This happens within a few weeks after HIV infection and is the time when people sero-convert on their blood test for HIV – in other words, change from being HIV negative to HIV positive. About half of people infected will develop a flu-like illness with fever, sore throat, swollen glands, headache, muscle aches and sometimes a rash. This stage of HIV infection lasts only a week or two – after this, the person will return to feeling and looking completely well.

Evian (2000:28) says that during the sero-conversion illness usually the signs and symptoms are non-specific. It often passes unnoticed by the patient. The HIV antibody test usually becomes positive 4 – 6 weeks after infection. This phase is often called the clinically latent or 'silent' phase of HIV infection.

7. 2. Stage 2: The asymptomatic or silent stage

After recovery from the primary HIV illness, people infected with HIV continue to be completely well for long periods, often for many years. During this time, the only indication that you are infected with HIV is that you will test positive on standard HIV tests and you may have swollen lymph glands. This means that you look and feel healthy and can easily infect other people through unprotected sex – especially if you do not know that you are infected. But HIV is still very active and is continuing to destroy the immune system during this stage.

Evian (2000:29) says that the asymptomatic phase is usually associated with a CD4 cell count between 5000 and 800 cells/mm³ or even less. The phase may last between 3 and 7 years (even up to 10 years) however though the infection is clinically 'silent', the virus is active in the body, usually causing progressive damage to the immune system. The person is able to spread the virus during this phase.

7.3. Stage 3: Early HIV symptomatic stage

According to Evian (2000:30) this stage is between 3 and 7 years after infection and some individuals may develop minor symptoms and signs secondary to the HIV infection. The minor symptomatic phase is usually associated with a CD4 cell count between 350 and 500 cells/mm³ with the following symptoms:

- Shingles
- Mouth ulcers
- Chest infections
- Weight loss
- Herpes zoster
- Occasional fevers
- Skin rashes, such as folliculitis, dermatitis and chronic itchy skin
- Fungal nail infections

7.4. Stage 4: Medium –stage HIV symptomatic

Evian (2000:30 – 31) stated that this stage takes place between 5 – 8 years following HIV infection. The viral load tends to increase progressively, and the immune system continues to deteriorate and become immune-deficient. Signs of more severe HIV-related disease begin to appear.

These signs and symptoms are usually due to overgrowth of some of the body's natural flora with fungal infection and reactivation of old infection (such as TB and herpes). They are also due to uncontrolled multiplication of HIV itself. Later as the immune-deficiency progresses, more frequent and severe opportunistic infections occur. This stage of HIV disease was previously called 'AIDS-related complex' (ARC).

The symptomatic phase is usually associated with a CD4 cell count between 150 and 350 cells/mm³

The most common signs and symptoms of this stage of the HIV-related disease are as follows:

- Oral vaginal candida infection (thrush) – this usually persistent and recurrent
- Hairy leukoplakia on the tongue
- Recurrent herpes simplex infection – cold sores or genital herpes infection
- Herpes zoster (shingles)
- Acne – like bacterial skin infections
- Persistent and unexplained fevers and night sweats
- Skin rashes
- Generalised lymphadenopathy or shrinking or previously enlarged lymph nodes

- Persistent diarrhoea
- Weight loss (more than 10% of usual body weight)
- Reactivation of tuberculosis may also be associated with this stage of infection, especially in people from low socio-economic communities, where tuberculosis is common (endemic)

7.5. Stage 5: Late-stage HIV disease (AIDS)

Without effective treatment, the long-term damage caused to the immune system by HIV results in severe opportunistic infections, cancers and HIV related damage to other organs (e.g. the brain). This stage is usually called AIDS.

According to Evian (2000:31) AIDS is almost always associated with a high HIV viral load and severe immune-deficiency. This usually corresponds to CD4 cell counts below 200 cell / mm³ and to a low lymphocyte count. This allows the development of severe opportunistic infections.

People with severe HIV disease can experience many illnesses at the same time. Many of these infections can be prevented with antibiotic treatment if a person will be tested and become aware of his/her HIV status at an earlier stage. These AIDS-defining illnesses include:

- Severe pneumonia
- Confusion and memory loss
- Pain and difficulty in swallowing
- Severe diarrhoea
- Brain infections
- Severe skin rashes
- Severe weight loss

Evian (2000:32) identified the following signs and symptoms of AIDS defining illness:

- Herpes, seborrhoeic dermatitis, skin sepsis may present with a variety of skin rashes and skin conditions
- Respiratory infection usually presents with persistent cough, chest pain and fever.
- Candidiasis presents with oral and / or genital thrush

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- Infection of the bowel will present with ongoing diarrhea
- Infection of the brain will present with headache, fits and other neurological conditions
- Cancers, such as Kaposi's sarcoma, appear as redish, purple spots on the skin and mucous membranes that increase in size and number. Lymphoma may present with enlarged lymph nodes liver or spleen
- People with AIDS usually experience tiredness, fatigue and weakness.
- Occasionally there may be some memory and concentration loss, and some people may eventually develop severe mental deterioration and confusion.

Adding to the above signs and symptoms Berer and Ray (1993: 17-18) list the following signs and symptoms of HIV/AIDS, which are likely to manifest in women specifically.

- Unexplained enlarged or swollen lymph glands in the neck, armpit or groin for than three months, felt as painless lumps (generalized lymphadenopathy)
- Chronic or severe tiredness, lack of energy, and general weakness.
- Unexplained weight loss of more than 10 per cent of body weight. Women have generally more body fat than men, so weight loss may be ignored or misinterpreted as something desirable in women in some cultures.
- Unexplained fever lasting more than one month, chills and night sweats.
- Itchy skin or skin rash
- Infections of the skin - fungal, bacterial or parasitic
- Muscle and joint pains
- A viral infection on the tongue, which appears as whit marks (oral hairy leukoplakia). This may come and go and is not thought to be infectious. It is very rare i.e. except with HIV.
- Loss of appetite, nausea and vomiting
- Shingles (herpes zoster virus). Shingles is a recurrence of childhood chicken pox and is very infectious. It used to be seen mainly on elderly people and sometimes in those with other illnesses that cause immune deficiency.

Many women with HIV have reported changes in menstrual patterns, most commonly irregularity of periods. A controlled study in Uganda found loss of periods and possible lower fertility (Berer & Ray, 1993: 18).

It is evident from the above discussion that one can remain without HIV/AIDS symptoms while infected for a very long time. During this time the person is infectious (can infect others). The symptoms are also common symptoms of other diseases that are not related to HIV/AIDS. It is therefore very important for people to be tested in order to know their status so that they are able to protect themselves and access treatment if they need it.

The following section will therefore focus on how one goes about to know his/ her status.

8. Counselling and testing of HIV/AIDS (VCT)

According to SAFAIDS (2002:1) the World Health Organization (WHO) defines voluntary counselling and testing (henceforth named VCT) as a confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions related to HIV. People affected by HIV want counselling and testing services for future planning (including planning for marriage and children), emotional support, medical services, and other referral services.

Wilson, et al. (2002:70) argue that a person who has tested HIV positive may never have the same quality of life again. HIV positive individuals who have had positive and helpful experiences at the time of testing deal with their situations more satisfactorily and are better able to talk about their fears and feelings and to plan for their future. Therefore HIV counselling before testing is very important.

8.1. Voluntary counselling and Testing (VCT)

For many patients the only evidence of HIV infection is a positive HIV test. For other patients signs and symptoms of AIDS or immune – deficiency make the chances of HIV infection more probable (Evian, 2000:39).

Evian (2000:39) is of the opinion that testing is normally done if there are clinical signs suggestive of HIV infection or when there are other clinical indications, such as tuberculosis (TB) or sexually transmitted diseases (STDs). There are also other reasons for HIV testing, e.g. life insurance policies, as part of the blood donating screening process, post-needle stick injuries, etc.

Although there are many benefits to knowing one's HIV status, testing may have negative consequences in communities where HIV-infected people are stigmatized. No one should be coerced into being tested. The decision to undergo HIV testing should be entirely voluntary. Given the possibility of discrimination, ostracism and personal recrimination that an individual diagnosed with HIV may face, it is important that confidentiality be guaranteed. As such VCT services require continued comprehensive evaluation to help adapt the services in response to evolving knowledge, client needs and technology.

In the World Health Organisation (WHO) – Fact Sheet 1 (2000a: 5) it is stated that all people taking an HIV test must give informed consent before being tested. The result of the test must be kept absolutely confidential. However, shared confidentiality is encouraged. Shared confidentiality refers to confidentiality that is shared with others. These others might include family members, loved ones, care givers, and trusted friends. This shared confidentiality is at the discretion of the person who will be tested. Although the result of the HIV test should be kept confidential, other professionals such as counselors and health and social service workers, might also need to be aware of the person's HIV status in order to provide appropriate care.

Evian (2000:39) postulates that HIV testing should be done in a proper and ethical manner. He says that before HIV testing is done, pre-and post-test counseling must always be offered to the patient. It is important for the patient to understand the reason for the HIV test, the nature of the test, the meaning of an HIV test, the meaning of HIV positive and negative results, the possible psychosocial implication of the results and a follow-up plan.

Evian (2000:50), Van Dyk (2001:238) and Wilson, et al. (2002:9) agree that there are reasons why counseling may be important e.g. many relationships have broken up due to one partner being HIV positive, people have lost their jobs and have even been rejected by their friends and family, feelings of depression, anger and guilt may result. Some people have even committed suicide after receiving their HIV test results. This means that everyone who has an HIV test must be properly counselled before the test is done (a pre-test counsel or interview) as well as after the test (post-test counsel or interview).

The SAFAIDS (2002:3) emphasizes that VCT-knowledge is power. Communities affected by HIV/AIDS, benefit from VCT as it contributes in the following ways:

- It changes the image of HIV/AIDS from the illness, suffering and death to living positively with HIV.
- It generates optimism as large number of persons tests HIV negative.
- It reduces stigma and enhances the development of care and support services
- It reduces transmission
- It enables access to preventive prophylaxis and antiretroviral therapy where available, and access to needed clinical services (antenatal clinics, STI and TB clinics, primary care clinics).

VCT also helps couples and families benefit in the following ways:

- It enables planning for the future (marriage, pregnancy, relationships, orphan care, financial and property arrangements).
- It enhances faithfulness
- It encourages family planning.

Individuals benefit from VCT as it:

- Empowers the uninfected persons to protect themselves from HIV
- VCT assists infected persons to protect others and live positively

According to SAFAIDS (2002:1) and Wilson, et al. (2002:70) counselling has two main functions namely, prevention of HIV infection, as well as social and psychological support of those affected by HIV. In addition counselling reduces stigma in communities by talking about HIV/AIDS. Prevention counselling involves assessing risks, creating insight into risks among those at risk, and encouraging appropriate behaviour change and sustenance. Prevention takes the two forms of primary and secondary prevention. With the former, counseling works towards preventing infection among those who are not infected, whilst the latter is concerned with preventing onward transmission of HIV. Support for people diagnosed with HIV infection and HIV-related illness and those close to them involves both emotional and practical support. The uncertainty regarding onset of illness and other problems increase the stress experienced by the individual and the family and friends. (Compare also Barrett- Grant, et al., 2001:19; Van Dyk, 2001:238; Evian, 2002:53.)

A successful VCT programme according to SAFAIDS (2002: 1) must have the following components and characteristics:

- Information
- Risk assessment
- Development of a risk reduction plan
- Explanation of the meaning of HIV test
- Informed consent of HIV test
- Psychological support
- Emotional support
- Appropriate referral
- Confidentiality
- Personalized
- Empowering
- Enabling (facilitates the exercise of power, i.e. a women may be empowered to negotiate condom use, but condoms must be available if she is to exercise this new skill)
- How much does the testing protocol cost?
- Is the testing protocol the most appropriate according to given local conditions? If not, how can it be improved?

Wilson, et al. (2002:71) emphasized that the best counseling approach during pre-test counseling should be client centered, where the focus is on what the client is feeling and experiencing. Again in busy clinics this may be very difficult, but reasonable efforts should be made to ensure a private session free of interruptions, where confidentiality can be assured. The practitioner should be able to set aside adequate time.

Wilson, et al. (2002:73) add that post-test counseling helps clients to work through the crisis and other issues that may arise as a result of learning their HIV status.

In this context it is therefore also important to know more about HIV testing and the different types of HIV tests

8.2. HIV testing

Van Dyk (2001:240-241) postulates that it is important to explain the following points to the client before they take an HIV test:

- There is a difference between being ser-positive and having AIDS. The HIV antibody test is not a 'test for AIDS'. It indicates that a person has HIV antibodies in the blood and that the person is infected with HIV. It does not say when or how the infection occurred, or in what phase of infection the person is.
- The presence of HIV antibodies in the blood does not mean that the person is now immune to HIV. On the contrary, it means that he or she has been infected with HIV and that he or she can pass the virus on to others.
- The meaning of a positive and negative test result.
- The meaning of the concept 'window period' stresses the need for further testing if the person practices high-risk sexual behaviour and tests negative.
- The reliability of the testing procedures. A positive HIV antibody test result is always confirmed with a second test and reliability of test results is usually high. False-positive or false-negative results may however occasionally occur despite the general reliability of HIV tests
- The testing procedure. Explain how blood is drawn for the test, where it is sent, when the results will be available and how the person will be informed of the outcome.

8.3. Types of HIV tests

Different authors categorized the types of HIV tests differently. According to Evian (2000:40) the different types of HIV tests can be categorized as follows:

- **HIV antibody tests** are usually done on blood (serum). However it is possible to detect antibodies in other body fluids such as saliva and urine. It must be remembered that this is an HIV antibody test, and it does not detect the actual HIV virus. Antibody tests detect the presence of antibodies, which is the body's response to the HIV infection.
- **HIV antigen and HIV PCR tests** detect the actual HIV virus by picking up actual components of the HIV virus. Antigen tests are commonly known as HIV P24 antigen

tests. The p24 antigen test is often useful in certain clinical situations, but it lacks sensitivity. The antigen test become positive within the first 10-14 days after infection, and are most valuable for diagnosing infection early and for detection of newborn infection. A negative test in the first 2 weeks after infection may be false negative and should be repeated. In infants the tests are more reliable from approximately 1 month after birth (Evian, 2000: 40).

- **An HIV PCR RNA (polymerase chain reaction) test** can also be done. This can be a qualitative test (i.e. negative or positive result), or a quantitative test (i.e. number of viral RNA particles /ml of blood). This is also called the HIV viral load test.

These tests are not widely available and usually need sophisticated laboratories and are expensive (Barret-Grant, et al, 2001:20).

In a nutshell it seems as if the different types of HIV tests can be categorized in two broad categories namely screening tests and confirmatory tests for HIV.

8.3.1. Screening tests for HIV

According to Ward (1999: 19 -20) and Wilson, et al. (2002:38) the screening tests are used for detecting certain medical conditions in populations of people or in large collections of samples. The most popular test in this regard is the enzyme- linked immuno sorbent of the assay (ELISA test). The HIV ELISA tests reveal only the presence of antibodies. They do not directly detect HIV. But because antibodies are produced only in response to infection – not to mere exposure – a positive result on an ELISA test for HIV is a strong indication of HIV infection. It also requires verification with a confirmatory test. A person who is tested and found not to have antibodies to HIV is said to be seronegative for HIV (the prefix "sero" indicates "serum"). A person who tests positive is said to be seropositive for HIV.

Ward (1999: 19 -24) and Evian (2000:40) mention that there are other types of screening tests like the Oral Fluid test, the Home Urine test and the Home Specimen- Collection kits.

The **Oral Fluid test** sometimes called the saliva test, detects the antibodies found in oral mucosal transudate. This fluid is collected using an approved test pad that is placed between the cheek and gum. When done correctly, it is as accurate as the serum antibody test.

Home Urine tests: Low levels of HIV antibodies are also present in urine and therefore a urine test has been developed. An ELISA-type test is used for their detection. As with other HIV ELISA test, positive results must be verified by a Western blot or other confirmatory tests.

The Home Specimen-Collection kits were developed and approved by the food and drug administration (FDA) in 1996. Two kits were designed to allow the self-collection of blood samples, in the privacy of one's own home, to be mailed in for HIV testing under conditions that protect the user anonymity (Ward, 1999:24).

8.3.2. Confirmatory tests for HIV

A large number of serum samples from people in the general population that are reactive on first ELISA tests are not reactive when the test is repeated. If a sample does test positive a second time however the result must be verified by a confirmatory test. A confirmatory test is designed to distinguish a false-positive ELISA result from a true positive result. The following confirmatory tests are the most popular (Evian, 2000:42&49; Ward, 1999: 19-24).

Western Blot: The most common confirmatory test is the Western blot.

Like an ELISA, a Western blot uses HIV proteins to capture anti-HIV antibodies in blood serum. A Western blot has a much lower false-positive rate, because it uses HIV proteins that are separated into distinct groups, or bands. The ELISA tests with, if appropriate, a confirmatory test constitutes what is called the blood test for HIV. It is sometimes loosely – and wrongly – referred to as the AIDS test. This is incorrect because the blood test determines only whether a sample of blood serum contains antibodies to HIV. The presence of such antibodies indicate that the person who has been tested is infected by HIV, is capable of infecting others, and is likely to develop HIV disease.

Viral Genome Test: Another form of a confirmatory test is the Viral Genome Test for HIV, which measures the viral load in the blood. According to Ward (1999: 19 –27) several clinical trials in 1996 concluded that measuring “viral load” (the amount of free virus in the blood) is an earlier and more reliable predictor of future clinical course than measuring a change in the number of CD4 cells. Measuring changes in viral load now also helps physicians and patients determine when antiretroviral drug treatment should begin or to determine when there is viral resistance to anti-HIV treatment and also to decide whether to change treatment or not.

Methods that can detect virus in blood or lymphocytes include the polymerase chain reaction (PCR), quantitative competitive PCR (QC-PCR), and branched-chain DNA amplification (DNA). The last two methods also measure viral load (Ward, 1999: 19 –27; Evian, 2000:74).

The Polymerase Chain Reaction (PCR), which is also another form of a confirmatory test reveals the presence of specific segments of DNA in cells and other kinds of samples. The method is so sensitive that it can detect the presence of a single HIV pro-virus in 100.000 cells (the pro-virus is the DNA that HIV produces and inserts into the chromosomes of infected cells). PCR is the basis for extremely sensitive tests. This is also its drawback: PCR-based test must be done by scientists or experienced technicians using adequate controls and sterile technique, otherwise, contamination with target DNA can easily produce false – positive results (Ward, 1999: 27-29; Evian, 2000:40,46).

The PCR tests for HIV rather than HIV antibodies, and can be used to find HIV even when the sample of body fluid is very small. The PCR test is also useful for emergency situations like a sexual assault because you can test even a tin sample of semen or blood to see if the assaulter is living with HIV.

PCRs are however expensive (Barrett- Grant, et al., 2001:20).

8.4. Accuracy of HIV testing

Ward (1999: 32-33) pinpoints that HIV clinical tests, including those for detecting HIV infection, sometimes produce false-negative and false-positive results. The number of false results a given test is likely to produce depends on the test's sensitivity and specificity.

The sensitivity is a measure of the number of false –negative results a test can be expected to produce and the specificity is a measure of the number of false-positive results a test will likely produce.

Screening tests are designed to have high sensitivity because they are intended to detect all cases of infection, even though this may produce a number of false-positive results.

Today, new ELISA tests provide a sensitivity of essentially 100% and a specificity of 99.9%.

9. Antiretroviral treatment for HIV/AIDS

Evian (2000:79) and Wilson, et al. (2002:329) say that the purpose of ART is to achieve HIV viral suppression and reduce the level of HIV RNA to as low a level as possible, for as long as possible. This in turn will result in less immune damage and will reduce any continued decline in the health status of the patient. It is therefore effective in delaying the onset of AIDS. ART must maintain very low or ideally undetectable HIV viral levels (viral load).

Evian (2000: 80) and Soul City- Know the Facts (2002) stated that most animals, plants and viruses are made up of genetic material called DNA. However, a retrovirus, such as HIV, is constructed from genetic material called RNA. Retroviruses are rare.

Medicines that stop a retrovirus from damaging the human body are called antiretroviral (ART). They interfere with the life cycle of the retrovirus and help the immune system to recover.

Evian (2000: 79) says the role of ART in asymptomatic patients who are not immune-deficient is to inhibit and suppress HIV activity and replication, which will help to prevent immune damage and maintain adequate immune-function that will prevent disease progression and promote ongoing wellness and health. He also says the role of ART in a symptomatic patient with immune-deficiency is to prevent further decline and damage to the immune status and to promote some recovery of immune-status and improve immune-function and capacity.

It is stated in the Soul City- Know the Facts (2002) that there are three main purposes of using ARTs and they are the following:

- To reduce the risk of a woman passing HIV to her newborn child. This involves a short course of medicine.
- To reduce the risks of people getting HIV so that they stay healthier and live longer. Antiretroviral therapy used to treat HIV/AIDS involves taking three or more different antiretroviral medicines on a daily basis. This is called triple-drug therapy, combination therapy or, most commonly, HAART (High Active Antiretroviral Therapy). The different drugs work together to tackle HIV in different ways. These medicines must be taken for life.

Wilson, et al. (2002:330) say patients who are not ready for the commitment to therapy required by ART should not start on therapy. Before beginning therapy they need to be educated about the number of tablets needed and the possible side-effects of the medication. They need to be aware that therapy is potentially life-long; and understand that non-compliance

may result in the failure of current, and possibly future, ART. It is not recommended that someone commence ART too soon after the diagnosis of HIV infection.

Although HIV cannot be cured, through HAART it is becoming a manageable chronic disease similar to diabetes or high blood pressure. It is also stated that people who take HAART need careful monitoring and must take their medicines every day without fail. If the medicines are not taken properly, the virus can become resistant to the medicines. ARVs are an important part of a comprehensive response to the AIDS epidemic. Health services need to be strengthened to ensure treatment programmes are effective. HAART is currently unaffordable to most developing countries. These two issues need to be addressed in the rollout of a country's treatment plan (Soul City- Know the Facts, 2002).

Evian (2000: 81) and Wilson (2002:333) say there are currently three main categories of Antiretrovirals. The three drug categories are nucleoside reverse transcriptase inhibitors (NRTIs), Non-nucleoside reverse transcriptase inhibitors (NNRTI's) and Protease inhibitors (PIs). The NRTIs include Retrovir (AZT), Videx (ddi), Hivid (ddc), Efavir (3TC) and Zerit (d4T). The NNRTIs also disturb the life cycle of HIV by interfering with the reverse transcriptase enzyme in replication process of the virus. They include nevirapine (Virimune). The PIs on the other hand interfere with the life cycle replication of the virus. They include Crixivan, Invirase, Viracept and Norvir.

(See appendix 10 for example of antiretrovirals).

The above drugs are considered able to block the replication of HIV. It is however uncertain whether replication is ever totally suppressed. Research suggests that once ARVT is discontinued, viral replication is usually resumed and viral loads usually rise again (Evian, 2000: 81; Wilson, 2002:333).

According to Barrett- Grant, et al. (2001: 25) since 1996, doctors have treated people with HIV with combinations of anti-retroviral drugs, namely HAART. HAART stops HIV from multiplying and reduces the volume of HIV in the blood, so that patients who take HAART no longer get sick from HIV disease or developing AIDS. Many of these people have now recovered their health and are going back to work. If a person takes HAART, he or she needs regular tests to check on the effect of the treatment on your CD4 cell count (the measure of how strong your immune system is), and your viral loads (the amount of HIV in your blood).

It has been argued that the use of HAART has led to a massive drop in a number of deaths in the USA, Europe and Brazil (Barrett- Grant, et al., 2001: 25). At the moment, people living with HIV or AIDS in South Africa find it hard to get access to counselling and basic treatments for opportunistic infections at government hospitals. HAART is very expensive, and is not available to most people living with HIV.

There is no vaccine against HIV or drugs that specifically target HIV, though many are being investigated. Zidovudine, commonly called AZT, was originally developed for treating cancer. It kills but does not specifically target HIV. In 1986 AZT was shown to make the T4 cell count rise for up to six months, improve wellbeing, lead to weight gain, decrease the frequency and severity of opportunistic infections and increase survival time in those with advanced immune deficiency. In developed countries, zidovudine began to be widely prescribed in high doses for people with advanced disease. With more advanced disease, the advantages of AZT usually outweigh the disadvantages (Berer & Ray, 1993: 30).

AZT in high doses could have serious adverse effects such as nausea, vomiting, diarrhoea, insomnia and headaches. Damage to vital organs and anemia can occur, which if severe, regular blood transfusion may be required. Regular attendance at a specialist clinic for monitoring is very important (Berer & Ray, 1993: 30).

HIV develops resistance to zidovudine in most people with symptomatic disease who have taken it for six months or more. The resistance also occurs in asymptomatic people, but very slowly. If people who are well take zidovudine for several years, it may be of no use to them once they begin to get ill and experience side effects. In people who feel healthy it is not desirable. However, zidovudine has been found to delay progression to AIDS and delay a fall in T4 cell counts in people who are asymptomatic or have early signs of infection (Berer & Ray, 1993: 30).

Wilson, et al. (2002:331) stated that there are factors influencing adherence. They say that the following are factors that promote adherence: motivated patient, good understanding of HIV disease and therapy, education given in a patient's home language prior to and during therapy, participation in a support group and during late or symptomatic HIV disease. Factors that reduce adherence include alcoholism, depression, poor understanding of the disease or

therapy, non-disclosure of HIV status to close family and friends and early symptomatic disease.

9.1. Antiretroviral treatment for children

Wilson, et al. (2002:345) stated that the goals of ART for children are similar to those for adults. In addition to stopping or reversing the progression of the disease, the aim is to restore normal growth and development. By maintaining the immunological status of the infant or child, clinical progression will be prevented. A long - term strategy for the use of anti-retrovirals to prolong art and, hence, extend the child's lifespan should also be developed. Like Wilson, et al. (2002:345) and Evian (2000:180) also say ART for children promotes and restores normal growth and developments, prevents complicating infections and malignancies, mproves the quality of life and prolongs survival.

Wilson, et al. (2002: 345) argued that there is a difference between anti-retrovirals therapy for children and for adults. They say that infants and children depend on the compliance of their caregivers. Occasionally infants may exhibit resistance behaviour that adversely affects compliance, or alternatively, the bad taste of some medications (such as ritonavir) leads to medication refusal. The principles of therapy are the same as for adults – ideally a minimum of three drugs should be used.

9.2. Problems with antiretrovirals

Evian (2000:180), Van Dyk (2001:71) and Wilson, et al. (2002:391-341) said the following are problems associated with antiretroviral treatment:

- The cost of the drugs.
- The need to maintain treatment on an ongoing basis and adherence to therapy may be a problem.
- These are new drugs with unknown long-term side effects and uncertain drug dosage regimens.

- There is the potential for HIV to develop resistance to the drugs
- Side effects may occur.
- Interaction may occur with other drugs.
- Some drug regimens are complex.

Another big problem is that antiretrovirals are unaffordable due to the fact that there are at present few generics (Poku, 2001:201).

10. Psycho- social effects of HIV/AIDS

10.1. Psychological effects of HIV/AIDS

CatalÛn (1999: 22-24) mentions that mental health problems are more likely to occur when the person is given a diagnosis of HIV infection and HIV/AIDS related physical symptoms develop or worsen. The distress associated with notification of a positive HIV test result is usually self-limited, but the way the news is given, the individual's expectation of the result, disclosure to others, and the degree of support available will influence the course and duration of psychological problems. He discussed many studies, which revealed that the development of symptomatic diseases or the worsening of HIV-related symptoms is associated with depression and psychological distress.

CatalÛn (1999: 22-24) emphasizes that individuals with personality difficulties or personality disorders are less likely to cope well with adversity. Therefore they are at greater risk of developing mood disorders and other mental problems. It is also true in the case of HIV infection, where studies have described this association both in cross-sectional and longitudinal designs. There is also some evidence to suggest that people with personality disorder, in particular those with a borderline or antisocial personality disorders, are at greater risk of acquiring HIV infection.

Individuals who, prior to acquiring HIV infection, have received in or outpatient psychiatric care, are at greater risk developing mental health problems following infection. Similarly, events with a negative impact appear to be associated with the development of psychological morbidity in

people with HIV infection, and it has been argued that severe life stress might have a possible adverse role in HIV disease progression (CatalUn, 1999: 24).

While there is no compelling evidence that age is a predictive factor for emotional distress in people with HIV, it has been suggested that older individuals are at greater risk for psychiatric disorders, in particular those related to cognitive impairment and dementia. A number of studies also have suggested that women suffer more HIV-related emotional distress, and that women in developed countries seem to have worse access to medical services than men, which may have adverse affects also on their general physical health (CatalUn, 1999:24).

People who know that they have HIV or AIDS feel many different emotions. Some feel shocked and some feel angry. The feelings of people with HIV or AIDS change often. One day they may feel rejected and lonely. The next day they may feel hopeful. Normally they feel very confused and they do not know what to do. At first some people cannot believe that they have HIV or AIDS and they believe that the doctor must be wrong to say they are HIV positive. Therefore they deny the news they receive. Sometimes they blame themselves or the person they think gave them HIV. Some may even blame God. Some people try to bargain. For example, they think God will cure them if they stop having sex.

According to Uys (2000:163) people with HIV or AIDS often feel lonely and fear many things ranging from pain, losing their jobs, other people knowing that they are infected or their children who will be orphaned. Some people with HIV or AIDS think everyone is looking at them or talking about them. This makes them want to hide. Sometimes they feel rejected by other people, or they reject themselves. Sometimes they feel guilty.

It has been argued that lack of disclosure also allows for the continued denial of the spread of the disease in South African communities (Uys, 2000:163). It is this denial that is the breeding ground for stigma, suspicion and violence.

Some people with HIV or AIDS feel there is no good reason for living. They feel useless. Evian (2000: 275-278), Uys (2000:161-162) and Van Dyk (2001:256-259) describe the psychological impact of HIV/AIDS. They say that HIV-infected people have many fears. They are also particularly fearful about being isolated, stigmatised and rejected. They fear the uncertainty of the future. HIV-infected people often feel that they have lost everything that is most important and beautiful to them. People with HIV infection often have profound feelings of grief about the

losses they have experienced or are anticipating. They grieve for their friends who die from AIDS, and they grieve with and for their loved ones – those who must stay behind and try to cope with life without them.

HIV- infected individuals frequently express guilt and self-reproach for having contracted HIV and for having also possibly infected others. The chronic uncertainty associated with the progress of HIV infection often aggravates feelings of anxiety.

Most HIV positive people go through a phase of denial. Denial is an important and protective defence mechanism because it temporarily reduces emotional stress.

HIV infected people are often very angry with themselves and others and this anger is sometimes directed at the people who are closest to them.

The self-esteem of HIV-infected people is often severely threatened. Rejection by colleagues, friends and loved ones can cause one to lose confidence and a sense of one's social identity – and thus to experience reduced feelings of self-worth. HIV-infected individuals often experience depression because they feel that they have lost so much in life – and that they themselves are to blame for it. Inwardly directed anger may manifest as self-blame, self-destructive behaviour or (in its most intense form) suicidal impulses or intention. Suicide may be construed as a way of avoiding pain and discomfort, of lessening the shame and grief of loved ones, and of trying to obtain a measure of control over one's illness. Some HIV-infected people who are confronted with death, loneliness, and loss of control often ask questions about spiritual matters in their search for religious support (Evian, 2000: 275-278; Uys, 2000:161-162; Van Dyk, 2001:256-259).

After some time most people with HIV or AIDS accept their situation. They often feel more serene (peaceful in mind) and start thinking about the best way to live. They develop hopeful feelings. They hope that they will live a long time, that scientists will find a cure, the doctor will be able to treat each sickness as it comes, because they are loved and accepted for who they are and hope because of their belief in a life after death. It is important to have hope. Hope lifts a person's spirits and gives them strength to face each situation. Hope can help a person to fight HIV and AIDS and live longer needed (Evian, 2000: 275-278); Uys; 2000:161-162 & Van Dyk, 2001:256-259).

The AIDS Control Programme, Ministry of Health, The AIDS Support Organisation, WHO and United Nations Children's Fund (1992: 30) believe that hope and acceptance can help a person to live positively with HIV and AIDS i.e. making choices in his/her life that are good for

his/her health, living as normally as possible, making the best of your life as a person with HIV or AIDS and looking after his/her spiritual and mental health.

10.2. Socio-economic effects of HIV/AIDS

Socio-economical and environmental problems, such as loss of an occupation and income, discrimination, social stigma (if the client's diagnosis becomes commonly know), relationship changes, and changing requirements for sexual expression, may contribute to socio -economic problems after the diagnosis of HIV infection. Many HIV-infected people also have to cope with financial problems; they often cannot afford to buy the anti-retroviral therapy that might give them a longer lease on life. The client's perception of their lives and adequacy of social support is also a very important factor because it may become a source of pressure of frustration when it is not needed (Evian, 2000: 275-278; Uys; 2000:161-162 & Van Dyk, 2001:256-259).

According to Wilson, et al. (2002: 189), Van Dyk (2001: 279) there is a high risk of suicide in HIV- positive people. The high -risk periods during the course of HIV positive people are following losses e.g. financial losses or rejection by family or friends. Van Dyk (2001 296) says that fear of stigmatization and ostracism is very real factors when one has been diagnosed with HIV/AIDS. It is the fear of rejection and isolation that causes AIDS patients the greatest pain. This kind of pain can lead to suicide.

Stigmatized people may therefore be denied the ordinary privileges of social life. If infected people are perceived as guilty, members of the community may be hostile to them and these hostile acts may include acts such as termination of employment.

The AIDS epidemic has also created more than 13 million orphans under the age of 15 years. Extended families are greatly overextended therefore it is no longer practical to take care of AIDS orphans. The stigma associated with AIDS deaths in many communities also make families not willing to take care of AIDS orphans. The consequences of this, is that these children are often isolated and deprived of basic social services such as education and food. The lack of access to education and lack of work skills and family support of any kind contribute to these children living on the streets. Since they have no money to survive, they end up committing crime (Van Dyk, 2001:334-335).

The impact of HIV/AIDS on households can be severe. The household dissolves as parents die and children are sent to relatives for care and upbringing. Before this dissolution occurs, the family assets and income earners further impoverish those already poor. The disposal income falls. The loss of income, additional cares related expenses, the reduced ability of caregivers to work, mounting medical fees and funeral expenses collectively push affected households deeper into poverty (UNAIDS, 2002:47-51; Poku, 2001:196).

Furthermore health budgets and systems are strained by extending prevention and care for sexually transmitted infections, counseling and testing, prevention of mother –to- child transmission services and HIV- treatment Health budgets and systems are strained by extending prevention and care for sexually transmitted infections, counseling and testing, prevention of mother –to- child transmission services and HIV treatment (UNAIDS, 2002:50). Van Niekerk (2001:144) says that up to 70% of hospital AIDS patients occupied beds in Africa.

The UNAIDS (2002:52) further mention that the impact of HIV/AIDS on the education sector is seen in the decline in the number of school enrolments. The contributing factors include the removal of children to take care for parents and relatives dying of HIV/AIDS; an inability to afford school fees and AIDS related infertility. Teachers are also infected and affected by HIV/AIDS and therefore there is also shortage of school- teachers.

AIDS also affect large enterprises by weakening economic activity by squeezing productivity, adding costs, diverting productivity resources and depleting skills. The epidemic hits productivity mainly through increased absenteeism, organizational disruption and loss of skills and organizational memory. Rising absenteeism tends to push visible costs up while forcing productivity down, putting profits at risk. There is high risk that the enterprise will collapse (UNAIDS, 2002: 54; Poku, 2001:193).

Through its impact on the labour force, households and enterprises, HIV/AIDS can act as a significant brake on economic growth and development.

11. Myths about HIV/AIDS

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According to Van Dyk (2001:33) there are some truly horrifying myths that are circulating in some communities about how to avoid HIV infection and AIDS these myths are extremely dangerous and should be counteracted in our society by means of intensive public education.

Aggleton, et al. (1989: 57- 63) postulate that there are several different kinds of lay beliefs about HIV infection and AIDS namely:

- Lay beliefs about AIDS itself, what it is and how it can be diagnosed.
- Lay beliefs, which explain the origins of AIDS.
- Lay beliefs, which explain why some people develop AIDS and others do not.
- Lay beliefs, which identify the people, the situations and the activities that are perceived as particularly risky.
- Lay beliefs, which distinguish between supposedly innocent and guilty victims of infection.

They argue that lay beliefs can also encourage people to misperceive the risk associated with particular kinds of behavior. They also report on evidence from research into tobacco and alcohol use which suggests that lay beliefs about health are very important in determining whether or not a person responds to conventional health education. Lay beliefs about health may weaken the effects of health education campaigns, which emphasize medical information.

Whiteside and Sunter (2000:1) identified and explored myths regarding HIV/AIDS following debates and beliefs regarding the origin of HIV/AIDS. There are a number of myths that will be discussed and also the realities regarding those myths as identified by Whiteside and Sunter (2000:1):

- There is a myth about the existence of HIV as a virus. People believe that there is no evidence that HIV exists as a virus. Therefore it is not responsible for causing AIDS. AIDS has been around a long time and is due to factors such as poor living conditions, malnutrition, trauma and stress. Despite this myth, Whiteside and Sunter (2000:1) argue that while science can never be as certain as mathematics, the majority of the world's leading virologists believe that the HIV hypothesis is correct.

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- Crewe and Orkin (1992: 8) also add that the most lurid myths regarding the origin of AIDS claims that the virus came from the Central African green monkey. The monkey has a related strain of HIV in its blood. This blood is used for circumcision rites in Central Africa. In this way the virus was transmitted from monkey to man, mutated and developed into HIV and spread to the rest of the world from there via prostitutes, airline stewards and missionaries. Recent research has argued that the virus in the green monkey is genetically too distant from that in humans for the idea to be plausible (Crème & Orkin 1992: 9).
- Another myth cited by Crewe and Orkin (1992: 8-9) is that a group of American scientists was requested by the CIA or the FBI to develop a virus capable of destroying the body's immune system for the use of germ warfare. The virus then escaped and soon developed into the AIDS pandemic. It was alleged from a soviet weekly published in October 1985, that the AIDS virus had been engineered by the US Government and was being spread by those US service men who had been used as guinea – pigs
- It is also believed that HIV is a unique virus inflicted on mankind as a punishment for the wicked (Crewe & Orkin, 1992: 9).
- Another common myth is that AIDS is the result of people having sex with monkeys. The disease is likely to have originated from monkeys in Africa, most probably from contact between human blood and the contaminated blood of a monkey. It is not the first, nor will it be the last, disease to cross the species barrier (Crewe & Orkin, 1992: 8-9).
- There is another belief that AIDS can be transmitted through touching and kissing, being close to an infected person and sharing facilities. Blood, semen, vaginal secretions or breast milk have to be involved for transmission to occur. The chances of infection from blood spilt in the absence of contact with another person's open wound are minimal. The virus can only survive for a short period outside the human body. However, common sense dictates that contact with blood should be avoided, and

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people giving first aid should use protective gloves because other blood borne diseases are easily transmitted (Crewe & Orkin, 1992:8-9).

- There is also a very strong feeling that a child born to an infected mother will be HIV positive. However, it has been discovered that the chance of MTCT is about 30 per cent and can be greatly reduced with appropriate interventions. There have been a number of studies into the use of antiretroviral drugs to combat MTCT in South Africa. These have been done at the Chris Hani Baragwanath Hospital in Gauteng and at King Edward Hospital in Durban. Notably, however, the studies show that the chance of MTCT transmission can be greatly reduced at a relatively low cost and using fairly simple treatment regimes (Crewe & Orkin, 1992:8-9).
- There is fear that Antiretroviral drugs are too toxic to be given to mothers and babies. Obviously, if they do not believe HIV exists, you can argue that no antiretroviral drugs should be given to patients because they are unnecessary as well as being toxic, however, if you do believe the virus exists, then antiretroviral drugs should be viewed in the same light as cancer drugs where their toxicity is weighed against the downside of not using them (Crewe & Orkin, 1992:8-9).
- The majority of people feel that babies should not be saved from catching the virus because it adds to the subsequent orphan problem. Every life should be saved where possible. Bringing down the cost of treatment to stop MTCT is therefore a major priority (Crewe & Orkin, 1992:8-9).
- Condoms are not used by a number of people, as they believe that they don't work as the virus can pass through the latex, and anyway they fail. However, the virus cannot pass through the latex. If condoms are used properly, consistently, and are SABS (South African Bureau of Standards) approved, they provide close to 100 per cent protection (Crewe & Orkin, 1992:8-9).
- People lose hope, as AIDS is untreatable. Therapies are available which reduce viral load (and therefore infectiousness). They definitely improve the quality of life of people living with AIDS, but challenge is to make them affordable to everyone.

- Recent medical advances to people mean that AIDS can be cured. Although the medical advances have been spectacular, there is still no cure or vaccine for AIDS. What we know is that taking various combinations of drugs can reduce the virus to undetectable levels (Crewe & Orkin, 1992:8). However, this does not work for all patients. There are side effects, compliance is not easy, and the virus develops resistance to some drugs in some parties and is probable that once people stop taking the drugs, the virus particulars will rebound. The drugs are also very expensive at present; although there is a good chance that price will come down (Crewe & Orkin, 1992:9).
- Another myth about the HIV prevalence is that when HIV prevalence peaks, we can all relax because the main fury of the epidemic will be spent. However, HIV incidence may still be high when HIV prevalence peaks, but it is being offset by AIDS deaths. More over, the curve of AIDS cases can still be rising strongly and it is this one that really affects the economy (Crewe & Orkin, 1992:9).
- There is excitement that AIDS will solve the unemployment problem. The reality is that, by killing the economically active age group, AIDS will provide employment opportunities for those at present unemployed. Equally AIDS will reduce the ranks of the unemployed as they fall sick and die. This impact has not been seen anywhere. Models suggest that economic growth could slow as a result of AIDS, but this hypothesis still has to be proven (Crewe and Orkin, 1992:8-9).

Aggleton, et al. (1989: 57- 63) also listed lay beliefs about HIV infection and AIDS. The following are the myths as identified by the authors:

- When AIDS claimed its first homosexual victims, ordinary people nodded their heads and saw it as God's vengeance on those who led unnatural and promiscuous lives. Other lay beliefs about origins suggest that AIDS might have been manufactured in the research laboratory, perhaps in connection with experiments in genetic engineering or biological warfare. Depending on the person's broader political beliefs, either the CIA or the KGB may to be blame. The first of these suggest that AIDS is the result of

something within people; the second that AIDS is caused by something outside or around them.

- Endogenous beliefs suggest that AIDS be caused not by a virus but by some quality of the individual or person himself or herself. According to this point of view, some people may be predisposed to develop AIDS by virtue of their sexuality or their lifestyle. There is growing evidence from research carried out in the United States and in Britain that some people believe that by generally keeping fit or by being speedy or by being aggressively heterosexual or by being streetwise or by leading a good Christian life, it is possible to avoid HIV infection.
- Another set of lay belief of this kind suggests that AIDS can be found endogenously within us all. Being overstressed or having too much sex were frequently identified by some of those interviewed as critical ways in which this could come about. Some people believe that AIDS is all around us and that everyone, regardless of their own behavior, is currently at risk of infection. Ideas like these link closely to the view that being near an infected person is sufficient for transmission to take place.
- Some people emphasize the role that chance and “bad luck” may play in determining whether or not they become infected. Lay beliefs like these are likely to influence the extent to which people feel able to take effective steps to safeguard themselves and others from infection. Other people suggest that some people may feel they may be able to minimize the risks by being selective in their choice of prospective sexual partners.
- A final set of lay beliefs about HIV infection and AIDS differentiates between supposedly innocent and guilty victims of infection. Hemophiliacs, blood transfusion recipients, children and the married partners of those who engage in extra-marital relationships are usually termed innocent, while gay men, injecting drug users; prostitutes, the promiscuous and bisexuals are usually guilty. These kinds of beliefs often arise not from rational thought but from moral judgments about different kinds of behavior. They can be dangerous and divisive since they imply that some people may have chosen to acquire HIV infection.

Campbell and Kelly (1995) as quoted by Van Dyk (2001:115) add that attributing HIV infection to witchcraft may also help the bereaved family to avoid feeling stigmatized by their community. Ironically, Boahene (1996) as quoted by Van Dyk (2001:115) found that people who believe that AIDS is caused by witches are more likely to be supportive of HIV/AIDS patients because their understanding is that the patients have become infected with the virus through the agency of sources that are beyond their control.

Witchcraft beliefs nevertheless also have very negative implications for AIDS counseling and education in Africa. The belief that everything that happens to a person can be attributed to external, supernatural being or powers (an external locus of control) implies that individuals cannot be held responsible or accountable for their own behavior. This outlook tends to prevent people from exercising their personal initiative in searching for solutions (Viljoen, 1997 in Van Dyk, 2001:115). Boahene (1996) as quoted by Van Dyk (2001:115) found that many people in Africa do not consider their own behavior to be a possible reason for HIV infection, because of this misconception; they cannot appreciate the need for using HIV-preventative methods.

Experience has taught AIDS educators working in Africa that to ignore and ridicule traditional witchcraft beliefs has adverse effects on their HIV/AIDS prevention programmes. These beliefs should rather be taken into account and integrated into HIV/AIDS prevention programmes. Programmes should, for example, recognize the belief that the personal or ultimate cause of an illness may be witchcraft, but the fact should be stressed that the immediate cause is a germ, which is sexually transmitted (Van Dyk, 2001:116).

12. HIV/AIDS prevention and care strategies

Van Dyk (2001:80) states that because there is no cure or vaccine for HIV and AIDS, the only defence against the HIV epidemic is prevention. Prevention however entails much more than a set of rules of what to do and what to avoid. Effective prevention requires an accurate knowledge of how human beings behave in different contexts.

Wilson, et al. (2002:7) also adds that in the absence of successful prevention efforts, AIDS related deaths are expected to rise. According to Wilson, et al. (2002:11) the benefits of prevention at a population level in terms of illness and mortality derive in the long term while

the benefits of treatment derive more rapidly. Whiteside and Sunter (2000: 21) postulate that the developments of prevention and treatment strategies in developed countries have shown a decline in the mortality rates.

According to Barrett- Gordan, et al. (2001: 19) and Wilson, et al. (2002:62) there are a number of ways of preventing HIV transmission namely:

- You can abstain from (not have) sex.
- You can have safer sex
- You can get treatment for sexually transmissible diseases (STDs)
- You can take universal precautions when you touch blood or body fluids.
- You can take post-exposure prophylaxis (treatment) immediately after an exposure to HIV
- Mothers can take anti-retroviral therapy to cut down the risk of passing HIV on to their unborn babies.
- Medical researchers hope that one-day we may have an HIV vaccine to prevent people from getting infected with HIV
- Researchers also hope that we may develop a vaginal microbicide that can be used to prevent HIV from getting passed on during sexual intercourse.

The onset of sexual activity, mutual masturbation, thigh sex and long-term mutual monogamy with an uninfected partner using effective contraceptives should be promoted to prevent HIV infection (Wilson, et al., 2002: 64)

According to Gordan and Klonda (1988: 74) people living with HIV/AIDS can help themselves to stay as healthy and well as possible in the following ways:

- They can avoid getting more HIV into the body because it is likely to hasten the progress of the disease. They can adopt safer sexual practices. This will also prevent infection with other sexually transmitted diseases, which also appear to increase the risk of developing AIDS.
- They can look after their immune systems by avoiding stress as much as possible. They should eat as well as they can, avoid too much alcohol and tobacco, and get enough rest.

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- They need to get treatment for infections to save their immune systems from unnecessary work, for example, tuberculosis and sexually transmitted diseases.
- When they are over the first shock, it helps to develop a positive attitude, perhaps by using their knowledge to help others to avoid HIV infection.

They can also protect others from HIV by not having penetrative sex or always using a condom and not donating blood or sperm.

According to Van Dyk (2001: 326) the magnitude of the HIV/AIDS crisis has inevitably meant that both the family and the community had to become involved in most care programmes. HIV/AIDS make tremendous new demands on health services that cannot be met by hospitals alone, because HIV infection (and all its accompanying complications) can last for months or years, as a person with HIV infection or AIDS may move from the home to the hospital and back again several times. Because hospital care is very expensive, families can often not afford multiple admissions to hospitals.

Hospitals themselves do not have the personnel and resources to cope with the huge demands that AIDS asks of them. The only practical and humane solutions are:

- That patients be cared for in their own homes and communities for as long as possible
- That we utilize clinics and other health care support systems in the community for advice and support.
- That we use hospitals as a last resort when a patient's condition has deteriorated and when professional help is needed. The demands on families and the community do not end with the death of the patient. The AIDS epidemic has left behind millions of orphans in Africa and the conditions in which these children live are appalling. If communities do not reach out to help these children, AIDS will also kill our future (Van Dyk, 2001: 327).

Wilson, et al. (2002: 399) say caring programmes in Sub-Saharan Africa are usually NGO or church led. These organizations care for anything from 10 to 100 patients. Care could include the medical, nursing, social educational, and spiritual aspects. Examples include ongoing counselling, help with cooking and/or cleaning; food parcels; material support; wound care; basic hygiene; supervision of drug taking and treatment of tuberculosis (TB) using directly-observed therapy (DOTS).

Various infrastructures that are able to provide different models of care include:

- Drop-in centres or support groups;
- Outreach and home visiting programmes; and
- Comprehensive Home Based Care (HBC).

Community home-based care is the care given to individuals in their own homes when their families, their extended families or those of their choice, support them. A multidisciplinary team and complementary caregivers who are able to meet the specific needs of the individual and family support these home-based caregivers. The team consists of all people who are involved in care and support may include a medical practitioner, nursing supervisor, social worker, health educator, physiotherapist, occupational therapist, AIDS health promotion workers, volunteers, traditional healers, religious healers and religious leaders (Frohlich, 1999, in Van Dyk, 2001: 327).

According to Wilson, et al. (2002: 154) treatments in the form of drugs are an essential tool in the response to the morbidity and mortality caused by HIV/AIDS. However, it is not the only one. To be able to cope successfully with HIV/AIDS, people living with the virus must have access to a wide range of treatment, care and support options provided across a continuum.

Evian (2000: 299) says if possible involve other terminal care agencies such as hospice associations, cancer associations and AIDS organizations, to assist in managing a dying patient. Social workers, clinical psychologists, bereavement counselors etc. are often experienced in dealing with these issues and can be very helpful. A team approach in caring for dying person and his/her family is best. Usually one person should take the responsibility/leadership and ensure that there is adequate coordination of the team. The primary care doctor or nurse is often in the best position to assume this role.

Communication plays a vital role in promoting all STD/HIV/AIDS prevention, care, support services, which include STD, voluntary counseling and testing (VCT), support groups, people living with HIV/AIDS (PLHA) networks, orphans and vulnerable children (OVC), mother-to-child transmission (MTCT), clinical care for opportunistic infections and social and economic support.

Communication can also play a role in influencing the discourse on HIV/AIDS by attempting to stimulate dialogue and prompt action for reduction of risk, vulnerability and stigma.

According to the WHO- Fact Sheet 6 (2000a: 4) nurses and caregivers must examine their own beliefs, values, assumptions and attitudes toward HIV/AIDS. There is recent documentation suggesting that health care workers are some of the worst offenders in discriminating against and refusing to care for people living with HIV/AIDS. Such behaviors are unacceptable. However, change will only come about through examining long-standing negative thoughts, feelings and behaviors.

Education can also be directly addressed through educational programmes based on sound medical, social and psychological knowledge. Knowledge about HIV/AIDS is constantly expanding. Nurses and caregivers must be continually updated through continuing education programmes. Prevention strategies will continue to be compromised if fear, ignorance, intolerance and discrimination against HIV infected persons persists. Nurses and midwives have a responsibility to help normalize HIV so that the modes of transmission and prevention can be addressed without the emotional and attitudinal overlay that limits open dialogue about AIDS.

Effective and dignified care can only be given where respect and compassion for other people is the norm. Looking inward to examine and challenge long-held beliefs, values, assumptions and attitudes will go a long way to providing compassionate and respectful care.

13. Summary

This chapter gave us background information about HIV/AIDS. HIV/AIDS seems to be a very complicated phenomena with regard to where it originates and how it develops. A person can remain without symptoms for a very long time before they reach the AIDS stage. During the first week of infection, the person is very infectious and during that time, the tests are unable to detect the HIV antibodies through HIV antibodies tests. It is however clear about how it is been transmitted and how it can be prevented from the infected people infecting the uninfected. There are other issues such as cultural factors related to breastfeeding and condom use that affect the prevention of transmitting HIV from the infected people to the uninfected people. There are debates about whether people should breast feed or formula feed, as there are risks involved with both methods. There are also a lot of barriers related to the myths about HIV/AIDS as these are issues that people believe in and unfortunately they are not true. There

is no cure for AIDS. However there is treatment to stop the HIV virus from multiplying called Antiretrovirals. They are however not affordable to everyone who needs them.

HIV/AIDS is referred to as a social disease. Its main mode of transmission is through sexual intercourse. Sex, is however a subject that is not easily discussed. There is a lot of stigma attached to HIV/AIDS because of this mode of transmission. There are cultural issues attached to this stigma and transmission. It is important to discuss cultural issues in general to understand why there seems to be a relationship between HIV/AIDS and culture. The next chapter will therefore focus on culture and cultural practices in general.

Chapter 3

Culture and cultural practices

1. Introduction

In order to obtain the goal of the study namely to establish the influence of cultural practices of the Batswana on the transmission of HIV/AIDS in Botswana it is important to make first of all an in-depth study of culture and cultural practices in general.

This chapter will focus on understanding what culture is all about. It will also help us understand the difference between cultural practices and culture. The different aspects of culture and the importance of culture will also be explored.

Hobbes (in Cuff and Payne, 1981:26) suggests that men coming together and agreeing or making a contract to live side-by-side in peace rather than continuing fighting one another formed societies.

Durkheim (in Cuff and Payne, 1981: 26) argues that for men to come together, at all to make a contract, they must already have some common agreement on the value of such a contract and some agreement to be bound by the unwritten rules of a contractual situation. This prior agreement for Durkheim represents a framework of order, which is the essence of society. If men could make a contract with each other, that means they were already members of a society because they held certain values in common. Consequently, it is their common roles, practices, expectations and beliefs that bind them together. Men are bound together by common values, based on shared and common experiences.

Hoogeveldt (1980:24-25) believes that societal identity is always grounded in common cultural orientations shared by the members. The community defines who are we and who are they and the cultural system says why this is so. He further stated that cultural systems are basically sets of interrelated answers to fundamental questions about the human condition. Who am I? Where was I before I was born? Where am I going after death? What is real, what is unreal? What is true, what is false? (Hoogeveldt, 1980:30-31)

2. Conceptualization of the concept culture

Culture is that complex phenomena which includes knowledge, belief, art, morals, law, customs and any other capabilities and habits acquired by a man as a member of society (Compare Seymour-Smith, 1990:65; Nxumalo, 1998; Giddens, 1990: 31; Pai, 1990 in Goodnow, et al., 1995; Kavanagh & Kennedy, 1992:11.)

Culture is a historically created system of meaning and significance or, what comes to the same thing, a system of beliefs and practices in terms of which group of human beings understand, regulate and structure their individual and collective lives. It is a way of both understanding and organizing human life (Parekh, 2002:143).

Belief systems are conceptual frameworks and explanations that groups and societies create to empower them to deal with their experiences. Such framework includes religions, ideologies, science etc. An understanding of what is right and wrong is based on cultural beliefs, attitudes and knowledge's (Pai, 1990 in Goodnow, et al., 1995; Nxumalo, 1998).

Kwashi (2002:19) perceives culture as a complex whole, the way of life of people. He says that culture is the powerful influence behind the beliefs and practices that govern the daily behaviour and conduct of people. He further argues that culture is dynamic and differs from place to place and from people to people.

Culture is a way of thinking, feeling, believing. It is the group's knowledge stored up (in memories of men, in books and objects) for future use (McNall, 1973:49).

However, cultural differences involve patterned life ways, values, beliefs, ideals, and practices. Cultural and sub cultural differences are not limited to extreme contrasts in, for example, language, national origin, or political orientation, but often involve more subtle differences such as those between religious, class, age, or gender groups (Kavanagh & Kennedy, 1992:11).

According to Kwashi (2002:19) culture may be defined as custom and civilization of particular people or group; or the way of life of people; the beliefs, customs, institutions, arts and all the products of human work and thought created by people or group at a particular time.

Kroeber (1952) as quoted by Moore (1997:73) believed that customs and beliefs existed independently of the individuals who held such beliefs. He continues to say that culture is transmitted by human interactions, 'not by the genetic mechanism of heredity.

Pai (1990) as quoted by Goodnow, et al. (1995) and Williams (1986) argue that culture also includes behavioural norms; dress, food and eating related matters as well as appropriate and inappropriate behaviour.

Giddens (1989:31) supports Pai's views of culture and adds that culture includes how to dress, marriage customs and family life, their patterns of work, religious ceremonies and leisure pursuits. It covers also the goods people create and which become meaningful for them – bows and arrows, factories and machines, books etc. Culture refers to habits, customs and

materials people produce. Society refers to the system of interrelationship, which connect together the individuals who share a common culture.

Mcgurk (1990) also perceives culture as a process that is goal oriented and in its final analysis is morally driven. His view is that culture also determines what foods a person will like, whether he will think something is beautiful or ugly, what gods he will worship, and what he sees in the world.

Every culture develops over time and, since it has no coordinating authority, it remains a complex and unsystematized whole (Parketh, 2002:144).

Kluckhohn (in McNall 1973:45), Nxumalo (1998), Giddens (1990:31) and Pai (1990) as quoted by Goodnow, et al. (1995) argue that the societal legacy the individual acquires from his/her group or culture can be regarded as that part of the environment that is the creation of man.

To the anthropologist, however, to be human is to be cultured. The past experience of other men in the form of culture enters into almost every event. Each specific culture constitutes a kind of blueprint for all of life's activities (McNall, 1973:46). He elaborates on this by saying that any cultural practice must be functional or it will disappear before long. That is, it must somehow contribute to the survival of the society or to the adjustment of the individual. Every culture is precipitate of history. Each culture embraces those aspects of the past, which, usually in altered form and with altered meanings, live on in the present.

Culture is the total behaviour pattern of the group, conditioned in part by the physical environment, both natural and manmade, but primarily by the ideas, attitudes, values and habits that have been developed by the group to meet its needs (Brown, 1957:80; McNall, 1973:45).

It widely agreed that any culture is a set of techniques for adjusting both to the external environment and to other men. However, culture creates problems as well as solves them (McNall, 1973:49).

Seymour-Smith (1990:65), Kavanagh and Kennedy (1992: 11) and Pai (1990) as quoted by Goodnow, et al. (1995) add that culture include material artifacts produced by a human society and transmitted from one generation to another.

Nxumalo (1998), Gillin and Gillin (1965:127) and Giddens (1990: 31) on the other hand explain that material culture relates to physical objects used within a culture. For example, artwork, tools and technology.

Williams (1986) and Pai (1990) as quoted by Goodnow, et al. (1995) further mention that the important elements of culture include verbal and nonverbal communication and linguistic styles.

Like Nxumalo (1998), Pai (1990) as quoted by Goodnow, et al. (1995) postulates that belief systems and knowledge include language, which is seen as an organizing framework for ideas and communication. They say that language can determine or limit understandings. Culture is articulated at several levels. At the most basic level it is reflected in the language shared with some cultural features in common. Culture of a society is also embodied in its proverbs, maxims, myths, rituals, symbols, collective memories, jokes, body language, and modes of non-linguistic communication, customs, traditions, institutions and manners of greeting. A slightly different level it is embodied in its arts, music, oral and written literature, moral life, ideals of excellence, exemplary individuals and the vision of the good life. Being concerned to structure and order human life, culture is also articulated in the rules and norms that govern such basic activities and social relations as how, where, when and whom one eats, associates and makes love, how one mourns and disposes of the dead, and treats one's parents, children, wife, neighbours and strangers (Parketh, 2002:143-144; Pai (1990) in Goodnow, et al., 1995; Nxumalo, 1998).

Pai (1990) as quoted by Goodnow, et al. (1995), Seymour-Smith (1990:65), and Kavanagh and Kennedy (1992: 11) like Kluckhohn (in McNall, 1973:45), Moore (1997: 73), Nxumalo (1998), Williams (1986), McGurk (1990), Billington, Strawbridge, Greenside and Fitzsimon (1994:1-9) and Giddens (1990:31) believe that culture is a learned system of symbols with shared values, meanings, and behavioural norms.

Culture is learned behaviour, a set of techniques allowing the individual to adapt to the world around him. This learning takes place in a group that defines the appropriate way of responding to the patterns of nature (Kluckhohn in McNall, 1973:45; Williams, 1986; McGurk, 1990).

Culture extends to learning styles, family and kinship patterns, gender roles, how an individual is viewed and historical awareness of cultural community (Kavanagh & Kennedy, 1992:11).

By learning styles, Williams (1986) and Pai (1990) as quoted by Goodnow; et al. (1995) refers to the value of education cooperative and competitive approaches to learning. Family kinship patterns refer to who is related to whom, close and distant relations, familial expectations and obligations. Gender roles according to Pai (1990) as quoted by Goodnow, et al. (1995) refers to the roles the society expects males and females to perform. He also says that the historical awareness of a cultural community refers to the religious and spiritual beliefs and practices or differences in communication styles, which can indicate cultural identity.

According to McGurk (1990) culture is a single universe of discourse uniting all people within the single context determined by geographical proximity, social interaction and economic relations.

When a community's culture changes or is abandoned in favour of another it remains the same community, now united in terms of another shared culture. Its cultural identity is different, but since its membership, historical continuity and so on are unaltered, and its communal or ethnic identity remains the same (Parekh, 2002:155).

Parekh further postulates that our culture is the one we live, which has members of our cultural community who share its beliefs and participate in its practices. Like all communities cultural communities are not and cannot be, just imagined communities, for imagination needs content, an experiential basis, constant reinforcement and social relevance (Parekh, 2002: 155).

Culture is important in the relationship between individuals and society. Every society has a set of individuals who share common ways of thinking and behaving and this is what is called common culture. Social structures are created to attain cultural goals. Therefore, individuals learn culture as the result of belonging to some particular group; and it constitutes that part of learned behaviour, which is shared with others. It is one of the important factors, which permits us to live together in an organised society, giving us ready-made solutions to our problems, helping us to predict the behaviour of others, and permitting others to know what to expect of us. Culture regulates our lives at every turn. From the moment we are born until we die, there is, whether we are conscious of it or not, constant pressure upon us to follow certain types of behaviour that other men have created for us (McNall, 1973:51).

Nxumalo (1998) adds that group identity is identified through collective experience and shared culture including common language, dress, beliefs, behaviour patterns and regulations as well as shared music and dances. Group identity is developed through the following mechanisms – language, including use of slang to distinguish members of a group from outsiders or newcomers.

Giddens (1990:32) argues that no culture could exist without a society. But equally no society could exist without culture. He further states that society refers to the system of interrelationships, which connects together the individuals who share a common culture. He argues that without culture, we would not be human at all in the sense in which we usually understand that term. We would have no language in which to express ourselves, no sense of self-consciousness, and our ability to think or reason would be severely limited (Giddens, 1989:31 - 32).

Just as a body of people sharing a common language, religion and structure of civil authority constitute respectively a linguistic, religious and political community; a body of people united in terms of a shared culture constitutes a cultural community. Cultural communities are of several kinds. Some also share a religion, especially when their culture is religiously derived. Some share common ethnicity. Indeed, since every culture is bearer, all cultures tend to have an ethnic basis. However, the two can part company. An ethnic community might lose its traditional culture, as when it migrates or abandons that culture in favour of another. And a culture might lose its ethnic rootedness, as when it is freely adopted by or imposed on outsiders (Parekh, 2002:154).

Parekh (2002:154) also points out that a cultural community has two dimensions, cultural and communal. It has content in the form of a particular culture, and a communal basis in the form of a group of men and women who share that culture. Although the two are closely related, they are distinct enough to be separated in thought and practice. One might retain one's culture but lose or sever ties with one's cultural community; for example, immigrants or those who cherish their culture but leave their community because they find it oppressive or otherwise uncongenial.

The beliefs and practices of a culture are closely related; they are also autonomous and subject to their own distinct logics. The two differ in at least four important respects. Beliefs are

necessarily general, even vague and amendable to different interpretations, whereas practices, which are means to regulate human conduct and social relations, are fairly determinate and concrete. Secondly, while beliefs are not easy to discover and enforce, conformity to practices is easily ascertainable and enforceable. Thirdly, beliefs primarily pertain to the realm of thought and practices to that of conduct. Beliefs are therefore more likely to be influenced by new ideas and knowledge, practices by new social situations and experiences. Fourthly, coherence among beliefs is a matter of intellectual consistency and is different in nature from that among practices where it is basically a matter of practical compatibility. Based on these and other differences, beliefs and practices, although internally related and subject to mutual influences, are also subject to their own characteristic constraints and patterns of change. A society's beliefs might change but its practices might not keep pace and visa versa because either can change at an unusually rapid pace. It might become unduly conservative about the other to retain its sense of continuity or stability (Parketh, 2002:145).

From the above discussion, we learned that culture is learned and transmitted from one generation to the other. It refers to the way of living and the way people adapt to their living environment. Culture also brings people or individuals in a society or community together. Through norms and values, it regulates our lives. The discussion above makes it evident that culture is dynamic. The following section will therefore focus on the functions of culture.

3. Characteristics of culture

3.1. Cultural universals

Cuff and Payne (1981:26) argued that all human association gives rise to expectations of patterns of conduct. As a person associates or develops relationships with others, he/she tends to develop common ways of perceiving, evaluating, feeling and acting. These new patterns of values, perceptions and action then give rise to expectations and constraints on how person should behave. Thus persons associate with each other, so there emerges a collective consciousness, which in turn constrains them and obliges them to behave in particular ways. It is also quite common for people to talk of moral pressures coming from society. People speak of activities which society does not allow and also about the society having to protect itself against those who break its rules, and of wrong doers having to pay their debt to society.

Contained in these observations and ideas is the notion that society somehow exist over and above us. It was this notion, which Durkheim a social theorist appeared to be drawing on when he suggested that a society was a moral reality and moral entity. Durkheim's view is that this moral reality included the collective values, the order of priorities on which the members of the society are agreed. He made the assumption that for any group of people to live together co-operatively, they might have some basic common agreements on what their priorities are as a group and on how they ought to behave to each other and arrange their relationships (Cuff & Payne, 1981:26).

There are common features in the diversity of human cultural behaviour. When these features are found in all or virtually all societies, they are called cultural universals (Oswalt, 1972; Friedl, 1981 in Giddens, 1990:39). For example, there is no known culture without a grammatically complex language. All cultures have some recognizable form of family system, in which there are values and norms associated with the care of children. The institution of marriage is a cultural universal, as are religious rituals and property rights. All cultures also have some form of incest prohibition. For example, the banning of sexual relations between close relatives, such as father and daughter or mother and son, or brother and sister.

According to Brown (1957: 61-62), Popenoe, Cunningham & Boulton (1998:36) and Giddens (1990:39) divergent cultures reveal many elements common, which are, called cultural universals and they include:

- A means of communication commonly understood by all, including verbal expression, facial and other gestures, and art forms. More advance cultures have added written symbols.
- Well-defined and often vigorously enforced familial relationships, including that between the sexes both prior to and after marriage.
- A form of organizational structure, which governs interpersonal relationships both as to behaviour and in relation to property.
- Some form of religious expression that acknowledges the individual's relationship to a power beyond himself and recently prescribes the means of communication with such being or beings.
- Division of labour to maintain a productive economy sufficient for self-preservation.

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- A folkmore of historical tradition relating to origin that includes songs and sagas of its heroes and is reflected in the judgements and values of the group.
- A degree of consciousness of and pride in belonging to the group. This feeling of belonging, which is one aspect of ethnocentrism, is perhaps the most important element of all cultures for it is the basis for continuity of the cultural pattern, and it resists the inroads of other cultures. Identical processes of social interaction are found in every society although the social climate in which they operate may be quite different.
- Cultural universals may include cooking, feasting, folklore, funeral rites, music and laws. Marriage and family are also important cultural universals (Popenoe, et al., 1998:36; Giddens, 1990:39; Popenoe, 1987:64).
- Culture similarities exists in terms of basic values and social processes, however there are distinct culture contrasts in the forms of their expression in the behaviour, in the institutions, and in the cultural artifacts of each group (Brown, 1957: 61-62;Popenoe, et al., 1998:36; Giddens, 1990:39; Popenoe, 1986:64).

A cultural homogeneous society has its own strengths. It facilitates a sense of community and solidarity, makes interpersonal communication easier, sustains a thick culture, is held together with relative ease, is psychologically and politically economical, and can count on and easily mobilize its members loyalties. It also, however, has a tendency to become closed, intolerant, averse to change, claustrophobic and oppressive, and to discourage differences, dissent and what Parekh (2002:170 called experiments living. Since it has limited resources for internal resistance, it can be as easily mobilized for evil as for good purposes (Parekh, 2002:170).

Like any other society, a multicultural society needs a broadly shared culture to sustain it. Since it involves several cultures, the shared culture can only grow out of their interaction and should both respect and nurture their diversity and unite them around a common way of life (Parekh, 2002:219).

McNall (1973:47- 48) and Popenoe, et al. (1998:36) say that the very fact that certain of the same institutions are found in all known societies indicates that at the bottom all human beings and cultural concepts are very much alike.

3.2. Cultural diversity

There are factors that help shape a culture, which include climate, geography, plant and animal life. Physical conditions are not as important as social factors. For example the society's level of technology, its language, its prevailing beliefs and the extent of its contact with other cultures. However, both physical and social factors shape culture and give rise to different values and norms of behaviour that vary from culture to culture (Giddens, 1990:37; Popenoe, et al., 1998:35-36).

According to Giddens (1990:37-39) the diversity of human culture is remarkable. Values and norms of behaviour vary widely from culture to culture. For example, in the modern West the deliberate killing of infants or young children is regarded as one of the worst of all crimes. Yet in traditional Chinese culture, female children were frequently strangled at birth, because they were regarded as a liability rather than an asset to the family. Westerners regard kissing as a normal part of sexual behaviour but in many other cultures the practice is either unknown or regarded as disgusting. All these different traits of behaviour are aspects of broad cultural differences, which distinguish societies from one another. Industrialized societies are themselves culturally diverse involving numerous different sub-cultures. In modern cities, for example, there are many sub-cultural communities living side by side (Giddens, 1990:37-39; Popenoe, et al. 1998:35; Popenoe, 1986:63).

Cordeiro, et al. (1994) and Popenoe, et al. (1998:210) postulate that the mere presence of cultural diversity in a society inevitably means that there will be pressures for both cultural maintenance and cultural assimilation.

Culture and cultural difference can play a critical role in social cohesion. Verbal and non-verbal communication depends upon words, signs and meanings specific to each cultural or linguistic group or sub group. A failure to recognize differences within these meanings, notable when dealing with persons from diverse cultures, can result in failure of understanding and break down in communication.

Some writers argue that since human beings are culturally embedded, they have a right to their culture. Cultural diversity is inescapable and a legitimate outcome of the exercise of that right. Cultural diversity is also an important constituent and condition of human freedom. Unless

human beings are able to step out of their culture, they remain imprisoned within it and tend to absolutize it, imagining it to be the only natural or self-evident way to understand and organize human life. They cannot step out of their culture unless they have access to others (Parekh, 2002:166-167).

Parekh (2002:166-167) further stated that the diversity of culture also alerts us to that within our own. Being used to seeing differences between cultures, makes people tend to look for the differences within our own and learn to do them justice. We appreciate that our culture is a product of different influences. It contains different strands of thought, and is open to different interpretations.

Parekh (2002:166-167) adds that cultural diversity creates a climate in which different cultures can engage in a mutually beneficial dialogue. Different artistic, literary, musical, moral and other traditions interrogate, challenge and probe each other, borrow and experiment with each others' ideas, and often throw up wholly new ideas and sensibilities that none of them could have generated on their own (Parekh, 2002:168).

Although Nxumalo (1998) says that every cultural group defines certain appropriate patterns of behaviour for interaction between people. Differences in cultural traditions and styles can cause confusion and hostile behaviour amongst individuals and groups. Both the form and the content of communication reflect and reinforce power relationships between people and groups. Every culture contains its own unique patterns of behaviour, which seem alien to people from other cultural backgrounds. We cannot understand these practices and beliefs separately from the wider terms of its own meanings and values. Sociologists endeavour as far as possible to avoid ethnocentrism, which is judging other cultures by comparison with one's own. Since human cultures vary so widely it is not surprising that people coming from one culture frequently find it difficult to sympathise with the ideas or behaviour of those from a different culture (Giddens, 1989:394)

4. Functions of culture

There are various functions of culture. Some functions are general and some are specific to the individual and some to groups.

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According to Gillin and Gillin (1965:135 -138), Hobbel and Frost (1976:30) and Giddens (1990:38) it is the possessions of a common culture, which gives the members of a society a feeling of unity with the group and enables them to live and work together without too much confusion and mutual interference. Human society without these common modes of life is unknown.

The following are functions of culture for groups of people or group life according to Gillin and Gillin (1965:138), Hoebel and Frost (1976:29) and Popenoe (1986:54-55):

- It provides a series of patterns whereby the biological demands (primary drives) of the group members can be met for sustenance, shelter and reproduction and the group itself is thereby maintained.
- It provides a set of rules to insure cooperation of the individual members of a group in adjusting to the environmental situation. The group is thus able to act in certain situations as a unit.
- The culture provides channels of interaction for the individuals within the group, thus preserving certain minimum of unity and preventing the group from being torn apart by conflicts.
- It creates acquired drives or needs and provides for aesthetic, moral, and religious interests. The culture thus provides methods of adjustments of the group to its external and internal needs.

For example, in multicultural societies dress often becomes a site of the most heated and intransigent struggles. As a condensed and visible symbol of cultural identity it matters much to the individuals involved, but also for that very reason it arouses all manner of conscious and unconscious fears and resentments within wider society. It would not be too rash to suggest that acceptance of the diversity of dress in a multicultural society is a good indicator of whether or not the latter is at ease with itself (Parekh, 2002:243).

Elliot (1962: 35) as quoted by Billington, et al. (1994:10) and Hoebel and Frost (1976:29) continue to argue that in a healthy society this maintenance of a particular level of culture is to the benefit, not merely of the class, which maintains it, but of the society as a whole.

From an individual point of view, culture provides a large number of ready-made adjustments, which the individual only has to learn. The individual is provided with a whole series of problems already solved. For example, what kind of food to seek; how to protect himself from the weather; and how to get along with other people. The person is thus spared the time and energy, which would be required for analysis and solution of many problems vitally concerned with his very survival.

Culture also provides a series of familiar stimuli to the individual to which he has only to respond in a familiar way. The majority of expectable life situations are already analysed and interpreted in the culture, and through constant reinforcement, the individual respond to them automatically. In addition to supplying patterns of response and artificial stimuli, the culture also provided traditional and therefore familiar interpretations for many situations on the basis of which the individual may determine the precise form of his own behaviour (Gillin & Gillin, 1965: 136-137; Hoebel & Frost, 1976:33 & Giddens, 1990:31).

According to Tepperman and Curtis (1993: 25-26) culture helps to explain how individuals and groups fit together. Culture takes in all the shared ways of thinking, feeling, and behaving that characterize a group of society and distinguish it from another. Culture is uniquely human, learned, not genetically programmed and transmitted by 'socialisation' about which we say more in the next section.

Tepperman and Curtis (1993:27) argue that shared ways of thinking and acting arise naturally out of daily experience. They are not the result of efforts by a ruling class to protect its own interests. Cultural patterns arise and persist because they actually help people make sense of their everyday lives. Culture does not only reflect economic relations, it also shapes them. According to Nxumalo (1998), behaviour patterns usually enable individuals within a community to deal with each other effectively. These forms of behaviour soon translate into the following categories:

- (i). Norms of behaviour, which are, accepted forms of behaviour of any given group. Norms may change dramatically depending on changing circumstances or specific situations and may vary widely between cultures.
- (ii). Customs and traditions -These are learned responses to specific situations developed by neither group nor society. These responses vary from ways of greeting people to

dances and dress. Customs also refer primarily to practices that have been often repeated by a multitude of generations, practices that tend to be followed simply because they have been followed in the past (Davis, 1960:59; Hoebel & Frost, 1976: 24; Webster, 1991:49-52 and Popenoe, et al., 1998:112).

(iii). Laws and regulations –These are mechanisms for determining behaviour within a group. They include both codified and non-codified laws. The effectiveness of a regulation depends on its interaction with existing aspects of culture (i.e. the material culture, beliefs and knowledge, behaviour and customs). According to the Popenoe (1986:59) and Giddens (1990: 121) laws are norms usually mores that have been enacted by the state to regulate human conduct. It is possible for an action to be illegal but at the same time acceptable when judged by certain informal social norms.

There seems to be a lot of benefits from adhering to culture of a group that an individual belongs to. The above sections focussed on functions and definitions of culture. It seems that every single group of people or society or community are guided by their own culture. It is also mentioned that there is no society without culture or culture without society. A lot has also been said about culture being learned. In the next section, we will discuss socialization as a phenomenon in culture.

5. Socialization as a phenomenon in culture

Parsons (in Cuff and Payne, 1981:39-40) emphasizes the acquisition of values and the plasticity and sensitivity of the newborn member of society, whose dependency involves deep emotional attachments. The child is seen as an empty vessel, which has to be filled with a culture, with orientations to values and with expectations about roles. In this way, culture of the society is passed on to new members. The society is therefore internalized in the new generation and it shapes and gives identities to the young. Parsons assumes that individuals are natural seekers after gratification and approval. They are eager to learn and to conform to the values, norms and expectations of society.

However, the transmission of group understanding from generation to generation is interpretative as well as a selective process (Mannheim, 1979: 83). Each act of transmission interprets, and selects certain elements from past experience. One cannot properly visualise this interpretative process without the concurrent social selection, which takes place when a

new generation accepts or modifies the accumulation of the old. The transmission of thoughts is basically a phase in the succession of generations. It is the analysis of this succession, which illuminates the continuity, or discontinuity of thought (Mannheim, 1979: 83).

Giddens (1990: 76) refers to groups or social contexts within which significant processes of socialization occur as agencies of socialization. He says that in all cultures, the family is the main socializing agency of the child during infancy. At later stages of an individual's life, many other socializing agencies come into play. Since family systems vary widely, the range of contacts which the infant experiences is by no means standard across cultures.

In modern societies, most early socialisation occurs within a small-scale of a family context. Varying patterns of child rearing and discipline, together with contrasting values and expectations, are found in different sectors of large-scale societies. It is easy to understand the influence of different types of family background if we think of what life is like, say, for a child growing up in a poor black family living in a run-down city neighbourhood, compared to one born into an affluent white family in a white suburb. Many sociological studies have been carried out allowing us to detail these differences more precisely (Giddens, 1989:77).

According to Glaser and Niringiye (2002:23) a family can be a family put together by culture or family put together by religion.

Giddens (1990:384-385) states that a family is a group of persons directly linked by kin connections, the adult members of which assume responsibility for caring for children. He says that in virtually all societies we can identify what sociologists and anthropologies have come to call the nuclear family which consists of two adults living together in a household with their own or adopted children.

Kwashi (2002:19) adds that a family comes into being when a man and a woman agree to live together and have children. A family is also a group of people living for one another and living together with one another. For example, a child who comes to live with you comes to be a member of the family. Dictionary definitions according to Kwashi, explain that a family include any group of people related by blood or marriage; and parents and their children, a person's children, a set of relatives. All the descendants of a common ancestor, their line of descendants.

Elliot's (1994:4-8), Popenoe's (1986:361), and Giddens' (1990:385-386) views of the family in modern societies is that a family denotes a unit consisting of a husband and wife, and their children. This unit is widely thought of as a group based on marriage and biological parenthood, as sharing a common residence and as united by ties of affection, obligations of care and support and sense of a common identity. The term 'nuclear family' is used to refer to a unit consisting of spouses and their dependent children. The conjugal family may be compared with the 'extended family', a term used to denote any grouping, related by descent, marriage or adoption that is broader than the nuclear family. Functionalism emphasizes the importance of the nuclear family to the stability and continuity of society and so meshes with traditional family values (Bell & Vogel, 1968:3 in Elliot, 1994:8; Popenoe, 1986:302; Popenoe, et al., 1998:274-275).

Institution on the other hand refers to a group of human individuals serving a common purpose on a semi-permanent basis. It means that subdivision of society, which consists in human being in groups, established together with their customs, laws, and material tools, and organised around a central aim or purpose (Fiebleman, 1965:20-21). According to Popenoe (1986:82) an institution is as table cluster of social structures that is organised to meet the basic needs of societies. One basic need, for example, o is for socially approved ways of replacing members and training the very young. The institution known as the family does this. Popenoe (1986:82) further states that this institution consists of such specific social structures as family groups and family roles and statuses. Sexual behaviour is channeled to take place between husbands and wife, and off spring is cared for y by this pair. Husband and wife are expected to teach their children to behave in acceptable ways.

Leeds (1976) as quoted by Seymour-Smith (1990:153) points out that an institution is a form of standardized action or behaviour linked to a set of complex and interdependent norms and roles and applying to a large proportion of persons within a society or territory. More briefly an institution is an established social group working in customary ways with material tools on a common task. The institution is the social function in a steady state. It organizes folkways and usually laws into a unit, which serves a number of social functions. The family is an institution. We must look more closely to the two properties which we have said characterize institutions i.e. societies and culture. A society is that social organization within a culture whose

boundaries are recognized. A feeling of community holds the society together. Culture is the work of man and their effects.

We may characterize the main social function of the family then as falling in for closely related divisions. For example, reproduction, maintenance, placement and socialization of the young (Davis, 1960:395; Hoebel & Frost, 1976:7 & 413-418; Popenoe, 1986:356).

When identity with a certain family gives one membership in a wider group, the process is called descent. All kin groups acquire their membership primarily in this way, one of the most prominent being the clan. Theoretically the clan is an organized body of kinsmen descended from the same ancestor, though actually many clans become so large that their common ancestor is either mythical or forgotten. The clan represents the expansion of the immediate family (Davis, 1960:407; Giddens, 1990:384).

Popenoe (1986:85) also states that the family is the most important unit in the society. Kinship is the basis of all organization. There maybe kinship groups larger than the family such as clans or tribes. The status of old people is directly connected to the place of tradition and kinship in a society. In societies in which the family is strong and religious beliefs are central, the status of the old is usually high. They are storehouses of family traditions and religious beliefs. Furthermore the needs of old people in such societies can be met within the family and community.

As the family has given up some of its former functions to outside specialized agencies, so it has become more specialized in its functions of socializing children and of providing a social environment in which adults can develop and maintain stable, well-balanced personalities (Cuff & Payne, 1981; 41).

According to Popenoe (1986: 134), Popenoe, et al. (1998:92-95) and Giddens (1990:76-78) children now spend almost as much time watching television as they do with their parents. Working families also leave their children in their day care centers. Agents of socialization such as schools, peer groups and the mass media overshadow families these days.

Another socializing agency is the peer group. Peer groups are friendship groups of children of a similar age. In some cultures, particularly small traditional societies, peer groups are formalized as age-grades. Each generation has certain rights and responsibilities, which alter

as its members grow older (Giddens, 1990:77). Through the peer group culture is learned. Culture is passed from one generation to the other through the process of socialization.

Schools and the media are other examples of institutions or vehicles which culture can be passed from one generation to the other.

Schooling is a formal process of socialization. There is a definite curriculum of subjects studied. Yet schools are agencies of socialization in more subtle respects too. Along side the formal curriculum there is what some sociologists have called a hidden curriculum conditioning children's learning (Giddens, 1990:78). Children learn from their homes how to behave in the society. The learned behavior is shared with other children at school. Teachers also expect school children to behave in a certain way when they are in the classroom or at break times. How the children are expected to behave is influenced by how the teachers perceive as acceptable behaviour in the community or culture. In that way, the behaviours learned at school are reinforced at school or what the society expects from their members is maintained at school.

Mass media, for example, television, newspapers, periodicals and journals flourished in the West from the end of the eighteenth century onwards, but were confined to a fairly small leadership. The spread of mass media involving printed documents was soon accompanied by electronic communication (Giddens, 1990:79). Through television for example, children watch movies and news where people enact behaviours that are socially acceptable and behaviours that are unacceptable, are being criticised or people enacting the negative behaviours are seen being punished.

In some conditions, adult individuals may experience resocialization, marked by the disruption of previously accepted values and patterns of behaviour, followed by the adoption of radically different ones. One type of circumstance in which this may happen is when an individual enters a circular organisation – a mental hospital, prison, barracks, or other setting in which he or she is separated from the outside world and subjected to rigorous new disciplines and demands. In situations of extreme stress, the changes in outlook and personality involved may be quite dramatic (Giddens, 1989:80).

Other socializing agencies besides those mentioned, are groups or social contexts, in which individuals spend large parts of their lives. Work is in all cultures an important setting within which socialization processes operate although it is only in industrial societies that large number of people go out to work – that is, go each day to places of work quite separate from the home. In traditional communities many people till the land close to where they live, or have workshops in their dwellings (Giddens, 1990:79).

Kagan and Lamb (1990:152-153) suggest that learning standards is more often a consequence of identification with others, especially emotionally significant authority figures and friends, than it is the result of scaffolding or reward and punishment. Although this view is sympathetic to the role of culture, it holds that observers cannot literally “see” moral development in concrete social interactions because the child's identifications are abstract representations and internal constructs. Morality is self-constructed through culture but not through casual public encounters.

The discussion above confirms that culture is indeed learned. It is through socialization that culture is learned and different institutions throughout life facilitate the process of socialization.

6. Elements of culture

According to Giddens (1990: 31) culture consists of the values the members of a given group hold and the norms they follow. Popenoe (1986: 52) and Williams (1988:27) add that culture is a system of values and meanings shared by a group. Culture, values and norms seem to be inseparable. The previous sections focussed on the conceptualisation of culture to give us a better understanding of the concept. Therefore the following sections will present and discuss norms and values, folkways and mores, language, religion, religion in Africa, traditions and marriage as elements of culture to get a broader picture of the concepts.

6.1. Norms and values

Williams (1986: 27) and Popenoe, et al. (1998: 31) state that the guidelines, used to direct our behaviour within our particular culture, are called norms. He points out that norms are concrete and specific and values are more general. Values are about what is right and wrong, good and

bad. Norms are part of the human society and highly internalised. For the individual growing up in a society, each norm is not necessarily an external rule, which they obey or try to evade, but simply part of himself automatically expressed in behaviour. Such internalized norms guide and determine his intuitive judgments of himself. They lead to the phenomena of conscience, guilt feelings, striving, elation and depression. They are more personal than habit, deeper than consciousness.

A norm is the average or modal behaviour of a given type that is manifested by a social group (Hoebel & Frost, 1976:25).

According to Popenoe, et al. (1998: 30-31) and Popenoe (1986: 57) norms are expectations of how people are supposed to act, think, or feel in specific situations. Norms can either be formal or informal. Formal norms have been written down or codified often in the form of laws and carry specific punishment for violators. Informal norms are not written down but are widely understood by the members of a society.

Most norms however are concerned with the behaviours expected of people occupying specific social positions and playing specific roles such as mother, man or employee (Davis, 1960:55; and Popenoe, et al., 1998: 137).

Values are usually emotionally charged and provide the basis of justification for a person's behaviour. For example an important value in African society would be respecting the elderly. Like symbols, values do not exist in isolation. They relate to one another to form a unified pattern. For example, the values of honesty and integrity reflect society's disapproval of crime. The values of a culture typically come in pairs, so that for every positive value there is a negative value. For every admired quality, there is a quality that is disapproved of. For example, someone who comes from a poor background and achieves financial success through hard work is admired. The person who wastes it all or avoids work is disapproved of (Popenoe, et al., 1998: 30-31; Popenoe, 1986: 57).

Davis (1960:55) and Popenoe, et al. (1998: 137) states that defining a sense of obligation implies the conception of norm. The individual in a given situation should follow certain behaviour. Unless he/she makes an effort to carry the required pattern, the condition that the norm requires will not come about. One can argue that all culturally transmitted behaviour

patterns carry a sense of obligation and are therefore normative. If an individual learns to speak a language there is an obligation to speak it correctly. If he lives among people who possess that language there is an obligation to use it rather than some other language. Most cultural transmissions impart to the learner a sense of obligation. The relations between social norms, the individual's selection from them, his conduct, and his feelings about his conduct are far from self-evident. Acting counter to one's own norms always leads to neurosis. Neurosis develops even more easily in persons who never violate the moral code they recognise as valid but repress and frustrate some strong instinctual motive. A person, who succumbs to temptation, feels guilt, and then purges himself/herself of his guilt in some reliable way. For example by confession he/she may achieve in this way a better balance, and be less neurotic, than the person who never violates his norms and never feels conscious guilt (Davis 1960:55; and Popenoe, et al., 1998: 137).

Culture consists of the values the members of the given group hold, the norms they follow, and the material goods they create. Values are abstract ideas, while norms are definite principles or rules which people are expected to observe. Norms represents the dos and don'ts of social life. Thus monogamy, being faithful to a single marriage partner is a prominent value in most western societies. In many other cultures a person is permitted to have several wives or husband simultaneously. Norms of behaviour in marriage include for example, how husbands and wives are supposed to behave towards their in-laws. In some societies a husband or wife is expected to develop a close relationship with parent's in-law in others they are expected to keep a clear distance from one another (Giddens, 1989:31).

Davis (1960: 55) further states that the norm is observed not simply because it is traditional, not simply because others around one observe it, but because it conforms to an abstract principle of justice, purity, fairness and truth. It is more self-conscious, abstract, and consistent than sheer custom. It is therefore closer to the mores although it stresses the sentiment, rationalisation, and consistency behind the mores.

Internalization is the acceptance of the norms of a group or society as part of one's identity. Once a social norm has been internalised successfully, a person generally continues to obey it even when no one is watching. Everyone sometimes deviate from what the group or society expects of them. The process of internalisation is however never perfect. Internalisation is also one of the most effective means of socially controlling deviant behaviour. Although everyone at

times feel some deviant impulses, the internalisation of social norms tends to keep these impulses in check. For example, people may lie to their parents, teachers or friends but in most cases the internalized social norms lead to remorse and guilt. As a result, the deviant behaviour is likely to be abandoned (Popenoe, et al., 1998:138).

Parsons in Cuff and Payne (1981:39) sees a society in a state of equilibrium, as one in which there is no conflict. One in which everyone knows what is expected of him in any role and one in which these expectations are constantly being met. This is a condition of perfect equilibrium and as such in practice is never realised but is assumed to be a condition society is always striving to attain. The key process of attaining this theoretical state of equilibrium is socialisation and social control. Role players learn or are socialized into the expectations attached to the role and this process is backed up by positive sanctioning (reward) and negative sanctioning (punishment) of role performances, which do or do not meet these expectations.

In this regard Parsons (in Cuff and Payne, 1981: 39), Williams (1986:31) and Popenoe, et al. (1998:134) state that deviants are seen as those who have been inadequately socialised. Those who are insufficiently committed to the values and norms of their society.

Deviance therefore is defined in terms of the dominant value system and is seen as a pathological state. At societal level, it can also be interpreted as a disturbance of the equilibrium of the social system, which requires the intervention of agencies of social control such as the police force, mental institution and the prison service (Cuff & Payne, 1981:40).

Patterns of culture pose an interesting conflict between the individual and culture. On the one hand culture is an expression of core values, which most people learn and absorb and on the other hand, there are individual personalities that lie outside the particular segment of the arc of possibilities that defines that culture. Therefore not only are cultural values relative, but the very definition of deviance as well (Moore, 1997:84).

Giddens (1990:117-121) also argues that our activities would collapse into chaos if we did not stick to rules which define some kinds of behaviour as appropriate in given contexts, and others as inappropriate. The norms we follow in our action give the social world its orderly and predictable character. People quite often deviate from the rules they are expected to follow. Since norms vary between different cultures and different sub-cultures within the same society,

what is normal in one cultural setting is deviant in another. Therefore Giddens (1990) defines deviance as a non-conformity to a given norm or a set of norms that are accepted by a significant number of people in a community or society.

Giddens (1990:120) mentions that all social norms are accompanied by sanctions, which protect against non-conformity. A sanction is any reaction from others to the behaviour of an individual or group, which has the aim of ensuring that a given norm is complied with. He distinguishes between positive and negative sanctions. He says that sanctions may be positive (the offering of rewards for conformity) or negative (punishment for behaviour which does not conform). They can also be formal or informal. A formal sanction exists where there is a definite body of people or an agency whose task it is to ensure that a particular set of norms is followed. Informal sanctions are less organized, and more spontaneous, reactions to non-conformity. The main types of formal sanction in modern societies are those involved in the system of punishment represented by the courts and involved in the system of punishment represented by the courts and prisons. Fines, imprisonment or execution are all types of formal negative sanctions. Formal positive sanctions are found in many other areas of social life. However the presentation of medals for bravery in combat, degrees or diplomas to mark academic success, or awards for performances of sports events. Informal sanctions positive and negative are commonplace features of all context of social activity. Those of a positive type include: saying well done to someone or giving a person an appreciative smile or a pat on the back. Examples of negative informal sanctions are speaking insultingly to, scolding, or physically shunning a given individual.

It seems apparent from the above discussions that positive reinforcement alone cannot maintain a complex social system. Taboo and negative sanctions oppose the desire for immediate gratification of the members of any society and seem to be, therefore a requirement for social living. It also seems that simple punishment for wrongdoing does not create enduring enough inhibitions for the maintenance of social order. Another method that might be used by a society to prevent the extinction of inhibition is that of continuous negative reinforcement (Chasdi, 1994:175).

For example in the case of adultery, Cohen (1992:133) points out that although the law provided that the husband, or the appropriate magistrates, could put to death the adulterer taken in the act, some aggrieved spouses were perceived as responding with silence, extortion,

or complicity. Social norms of honour and shame linked the women's sexual modesty to the honour of her husband and other male relatives, some women were thought to buy the favours of young men, and some men to acquiesce in the financial advantage they might gain from their wives' infidelity.

Cohen (1992:133) further states that such rules represent but one facet of social control in face-to-face societies. They influence, but do not determine, the social practices through which they may reflect the norms of ethical and legal ideals; they may vary widely from other normative expectations, which play a central role in patterns of social conduct. In the case of adultery, then, one must investigate the dynamic interrelation of these normative structures and social practices within the larger social context. At the level of sexual role behaviour, the man who adopts a submissive, passive role is unmanly, women-like, and he therefore dishonours and shames himself. He will experience no pleasure in the act, and hence must be providing services with his body for gain, an act, which dishonours and shames him. Placing him in a submissive role, which is against nature (Cohen, 1992: 189-190).

A somewhat different mechanism of social control found in many societies consists of the belief that dogs, ghosts, and spirits are concerned with moral behaviour of the living and will punish them for wrongdoing. Beliefs in supernatural sanctions of this kind are so familiar to us in the Western World that there is no need not illustrate them. The sin of transgression against the rules of the gods and the belief that retribution will follow either here or in the afterlife is widespread throughout the world and clearly operates to maintain conformity to social rules in many societies (Chasdi, 1994:181).

Another mechanism of social control to be considered is the superego or conscience. It has been a subject of considerable interest in recent years, particularly as it relates to the process of identification. Most research in this field rests on the assumption that internalised moral values are a consequence of identification with the parents, and that guilt, remorse, or the readiness to accept blame is a measurable consequence of the degree of parental identification (Chasdi, 1994:187).

However, according to Fraser (1986:88-89) the problem of moral behaviour is a complex one. It is possible to make a distinction between the contents of moral judgments and the process of arriving at such judgements, which has a strong cognitive component. While there can be no

argument about cultural diversity of content, certain basic principles may well have a biological as well as social basis, being essential to the survival of any human group. For instance, no culture is known where there is freedom to kill, maim, or steal from anybody one dislikes.

A person can seem entirely normal while secretly engaging in acts of extreme deviance. Deviance does not just refer to individual behaviour, but concerns the activities of groups as well (Giddens, 1989:118-119).

The following section will focus on the behaviour patterns in communities and therefore discuss folkways and mores as elements of culture.

6.2. Folkways and mores

Seymour-Smith (1990:121) states that folkways is a term used to describe the customs and habits, or typical behaviour patterns, characteristic of a given community.

Brown (1957: 66), Sumner (in Gillin and Gillin, 1965: 134), Popenoe (1986:59) and Popenoe, et al. (1998:31) add that folkways are behaviour patterns of everyday life, which generally arise unconsciously in a group without planned or rational thought such as tipping the hat, calling on strangers, and shaking hands. The folkways are usually without moral significance. The meanings and values attached to them do not usually carry the idea that the folkways are of great or vital importance to the existence of the group. Folkways are one means by which the ethnocentrism or we-feeling of a group is maintained. They exercise significant influence in determining the behaviour of its individual members.

Folkways are sometimes referred to as folk or popular culture. The two terms refer to the beliefs and practices of ordinary men and women or to culture as it is actually lived, and high culture to the great creative achievements of the talented minds of society (Parekh, 2002:143).

Mores on the other hand are those customs and group routines, which are thought by the members of the society to be necessary to the group's continued existence. Institutions such as the church, state and family are organized patterns of folkways and mores and are often associated (Sumner in Gillin & Gillin, 1965:134; Popenoe, 1986: 59; Popenoe, et al., 1998:31).

Seymour-Smith (1990:199-200) considers mores as the moral norms of human group or society. He says that the domain of norms which relate to the behaviour of persons and which are characterized in that they are justified not in terms of their practical consequences but rather in terms of their intrinsic goodness or badness. Moral values or attitudes are thus those connected with the control which is exercised by social groups over the behaviour of their members, a control internalized by the individual and a part of his or her own set of values, to which emotional importance is attached.

The mores thus prescribe organisational structure and relationships, which a given society regards as essential to its stability at a given time and place. These mores – and accompanying folkways – are so inclusive that an adult member of society finds himself equipped to handle most problems involving social relationships in their terms rather than through reference to more objective procedures. Mores are both positive and negative; that is, they both prescribe certain types of behaviour and prohibit others. The latter are termed taboo that is a prohibition whose infringement results in an automatic penalty, frequently resting on some magical or religious sanction (Brown, 1957:68; Popenoe, 1986:59; and Popenoe, et al., 1998:32).

Krober (in Moore, 1997:73) argued that culture 'embodies values, which may be formulated (overtly as mores) or felt (implicitly, as in folkways) by the society carrying the culture, and it is part of the business.

Whereas each folkway is not considered tremendously important and is not supported by an extremely strong sanction, mores on the other hand are believed to be essential for social welfare and is consequently more strongly sanctioned. There is a greater feeling of horror about violating mores and a greater unwillingness to see it violated. Presumably, therefore the mores relate to the fundamental needs of society more directly than do the folkways (Davis, 1960:59; Popenoe, 1986:59; and Popenoe, et al., 1998:32).

Folkways and mores are basic patterns of behaviour that form a vital part of the cultural heritage of each individual. They are a conservative influence but are subject to change. They are past on informally and in the early stages of the child development, are accepted without even an awareness of their existence in modern heterogeneous. The individuals are

continually forced to choose among the different folkways and mores of the groups with which he identifies himself (Brown, 1957:68-69; Popenoe, 1986:59; and Popenoe, et al., 1998:32).

6.3. Language

Language is one of the most important set of symbols and elements of culture. Through language, the ideas, values and norms of a society find their complete expression. Language is flexible and precise to get across all complex subtleties that humans can understand (Popenoe, 1986:56).

According to Popenoe, et al. (1998:28) language also reflects the culture and environment of its speakers.

Giddens (1990:40) points out that no one disputes that possession of language is one of the most distinctive of all human cultural attributes, shared by all cultures although many thousands of different languages are spoken in the world. Every competent adult human language speaker has a vocabulary of thousands of words and is able to combine them according to rules so complex that linguists spend their entire careers trying to find out what they are.

Language is also a term often used to refer to the unique verbal communication system employed by humans, and which is characterized, amongst other features by its highly specialized and independent development, its complexity of symbolic use and its arbitrary nature (Seymour-Smith, 1990:162).

Verbal communication is not the only aspect of language, non-verbal interactions are also present in language. Non-verbal communication involves numerous forms such as the exchange of information, meaning through facial expressions and gestures or movements of the body. Non-verbal communication is sometimes referred to as body language (Giddens, 1989:91-92).

Cordeiro, et al. (1994) added that language often plays a central role in ethnic and cultural identification. Even after an ethnic community has been largely assimilated into the dominant culture, certain terms and phrases are commonly retained as markers of ethnic identity.

Hoebel and Frost (1976: 368) say that language is a completed system of symbols and abstractions. Every language represents a finished product, a perfect system in the sense that each language is wholly adequate to all human situations. The ideas that a language can express are in some measure dependent on the interest and preoccupations of the society, which develops it.

Hoebel and Frost (1976: 377) continue to say that every language is in itself a cultural phenomenon. Language has nothing to do with biological inheritance. A language is spoken by a group of people solely because they were isolated from other populations and developed their own mode of speech.

In conclusion, language plays a very important role in socialisation. Socialization is the process through which people acquire personality and learn the ways of a society (Popenoe, 1986: 120). Language is a mode of transmitting culture through socialization.

6.4. Religion

Religion can be applied to many kinds of behaviour. According to Popenoe (1986:414) religion is a system of beliefs and practices by which a group of people interprets and responds to what they feel is supernatural and sacred. Religion always involves a focus on some supernatural being, world or force.

Tylor (in Seymour-Smith, 1990:242) defines religion as the belief in spiritual beings. According to Kwashi (2002:19 & 21) religion is the belief in the existence of a super human controlling power, especially of God or Gods and usually expressed in worship. It is a controlling influence in a person's life.

Hoogeveld (1980:33-34) points out that the link between the world of ultimate reality and that of human empirical reality is completely severed with the appearance of the great historic religions of Islam, Buddhism, Hinduism and Judaism. Common to these religions is the conception of a supernatural world that altogether transcends the human world. It is the domain of the sole creator of the universe, the one God who has neither court nor relatives nor whose virtues and attributes are infinitely beyond what is distinctive in the human realm. For the point of view of these religions, it no longer matters who a person is, elevated position in the social order he/she may have. For, in the eyes of the transcendent God, all men are equal and all men are in principle capable of salvation.

Giddens (1990:451) further writes that in the West, most people identify religion with Christianity. This is a belief in a supreme being who commands us to behave in moral fashion on this earth and promises an after-life to come. Certainly, religion cannot be defined as a whole in these terms. These beliefs, and many other aspects of Christianity, are absent from most of the world's other religions.

In order to overcome the pitfalls of culturally biased thinking about religion it is probably best to begin by saying what religion is not, considered in general terms.

According to Wilson, et al.(1972) as quoted by Giddens (1990:451) religion should not be identified with monotheism, which is a belief in one God. For example, Nietzsche's thesis of the death of God was strongly ethnocentric, relating only to Western religious ideas. Secondly, religion should not be identified with moral prescriptions controlling the behaviour of believers like the Commandments Moses was supposed to have received from God. The idea that the Gods are very interested in how we behave on this earth is alien to many religions. Thirdly, religion is not necessarily concerned with explaining how the world came to be as it is. Fourthly, religion cannot be identified with the supernatural, as intrinsically involving belief in a universe beyond the realm of the senses.

Giddens (1990:452) believes that all religions do seem to share the same characteristics. For Giddens, religions involve a set of symbols, invoking feelings of reverence and are linked to ritual or ceremonials such as church services practised by a community of believers. Whether or not the beliefs in a religion involve Gods. There are virtually always beings or objects inspiring attitudes of awe or wonder. The rituals associated with religion are very diverse. Ritual acts may include praying, chanting, singing, eating certain kinds of food or refraining from doing so which can be fasting on certain days.

Durkheim (in Seymour-Smith, 1990:243) however viewed religion as a social creation, which expresses and reinforces social solidarity, so that religious beliefs are in sense metaphors for society itself, the sacred nature of social obligations and social cohesion.

Every major religion stands in intimate relation to the morality of the people who profess the religion. Certain of the moral tenets are explained as having a supernatural origin. The powers

of the other world are conceived as supporting and cherishing these principles being ready to punish their violation and to reward their observance. The salvation and blessedness are interpreted in terms of the individual's relation to other moral ideals. Religion therefore adds something to morality and strengthens it by connecting it with the world lying beyond the senses. It often happens that not all the moral rules are embodied in religion (Davis, 1960: 73-74; Popenoe, 1986:416-417; Popenoe, et al., 1998: 324).

According to Popenoe, et al. (1998: 324) religion strengthens the society's basic norms and values. Social norms are foundations of all social organizations. By giving norms and values enhanced moral meaning, by making some of them sacred, religion consoles people for sacrifices they must make when their personal wishes conflict with social requirements as in times of war. The role of religion in promoting social stability is especially evident within the institution of the family. The impact of religion on the family begins with the concept of marriage. By enforcing the norm of chastity and condemning sexual activity outside a lawful union, many religions promote the sanctity of marriage. People who attend religious services are usually more opposed to premarital sexual relations than those who do not attend services. Religion at times encourages the subordination of women to men and the ideal norm for women is submissive behaviour (Popenoe, et al. 1998: 324).

6.4.1. Religion as a cultural element in Africa

In the context of this study it is important to focus specifically on the role of religion as a cultural element in the African world.

The African world is primarily a religious one in which every object has religious significance and meaning. In this regard the following aspects, according to Onunwa (1994:250) are important. Firstly, man maintains the stability and harmony of the universe through the observance of rules that are codified and ratified, although in unwritten form. Religion offered satisfying and encouraging explanations to the mysteries of life. Whenever an unusual event took place, a religious explanation offered reassurance to curious but bewildered man. Secondly, man uses religion to predict when misfortune would befall him/her or fortune favors him/her. Thirdly, religion becomes a powerful instrument of control in society. Rebellious man is held in check by religious sanctions, ritual laws, and commandments. Apodictic principles establish norms by enshrining religious codes of behavior in the minds of members of primitive

societies. Religious rite is used to control not only man but also God and the spirit beings. When a man wants to curry favor and manipulate a deity to achieve his desire, he performs sacrificial rite

Kwashi (2002: 21) further postulates that religion in Africa shapes our understanding of the family and other social and cultural issues in various ways including the following:

- **Religious roles:** In a few cases men, women and children is seen as equal before God, but most religious traditions give the complete leadership in all matter of faith and worship to men. Religious roles are strictly for men; they are more exposed to the secrets of their religion. Only they can commune with the deity. The man therefore leads in prayer, scripture reading and any ritual performance. Sometimes when he is absent, the women and children are forced simply to wait for his return. The women and children are assigned only minor, supporting roles, such as providing the food and drink
- **Bread winning:** The man is expected to meet all the needs of the family including the provision of food, clothing, health and education expenses. If he fails in this, his leadership is threatened. If laziness is the cause, he stands to loose his respect from other family members. Some religious practices are very strict in reserving this role for the man, whereas others allow the women to participate in providing for the needs of the family.
- **Freedom of association:** Some religions allow freedom of association between men and women, whether married or unmarried but others do not allow close contact even between husband and wife except in the bedroom. In public and even in religious gatherings, husband and wife sit apart from each other. They do not eat together nor are they free to discuss matters of mutual interest. It is common to hear men comment that when the men are talking, women like other children, should keep quiet.
- **Jobs/courses:** Some religions are liberal and open-minded but others are very restrictive. In the latter case, women are not allowed to read engineering courses nor join the armed or police forces nor any paramilitary organization, or to play football nor

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other vigorous sports. Men may be prohibited from following domestic courses such as catering or nursing.

- **Participation in politics:** There is a diversity of opinion as to who may or may not take part in politics.
- **Divorce, remarriage and polygamy:** Some religions frown at divorce, remarriage and polygamy, but other freely permit these practices.
- **Movement:** Some religious traditions take the position that women should not leave their homes in the daytime but may visit relations and friends at night with their head covered.
- **Headship of the family:** As with most cultures, most religious practices see man as the head of the family.
- **Gender issues:** Most religions tend to view women as being the weaker sex, physically mentally and spiritually. Women should therefore be treated with caution and care.
- **Discipline:** Discipline, especially in Africa, is seen as a common responsibility of all within the family.
- **Social life:** Especially in Africa, social events concern all members of the family and community, whether it is a matter for rejoicing such as birth, marriage, and promotion or of sorrow such as sickness, s death or disaster.

The important role of religion in cultural practices is therefore clear and must always be considered.

Onunwa (1994:249- 251) says that society was so afraid of being destroyed by rebellion-prone man that it devised a strategy of self-defense and survival by sacralizing itself. Consequently, when one worships a deity, one is invariably worshipping the society in which one dwells. No

individual put himself above the society as represented in the deity, and no one saw himself or his security outside the confines of that society.

In some monarchical societies kings were regarded as sacred representative figures standing for the people. Such sacred kings were believed to be immortal. Their death would mean death for the whole community that they represented. When they die, people euphemistically describe them as having joined the ancestors.

In different cultures religion plays different roles. No culture can be wholly derived from religion. However a religion can never cover all areas of human life and anticipate all situations. Hardly any religion tells its adherents how to eat, dress, talk, sit, sleep, brush their teeth or make love. Although it might issue such general norms as that they should respect their parents, it does not tell them whether that involves refraining from smoking in their presence or remaining seated when they are standing. These and other areas are largely dealt with by culture. Culture and religion influence each other at various levels. Religion shapes a culture's system of beliefs and practices, which is why when individuals or communities convert to another religion; their ways of thought and life undergo important changes. For its parts culture influences how a religion is interpreted, its rituals conducted, the place assigned to it in the life of society, and so forth, which is why converts carry their culture into their new religion as seen (Parekh, 2002:147).

According to Van Dyk (2001:112) if something bad happens to a traditional African, he or she will not attribute such an event to bad luck, chance or fate. They believe instead that every illness has been directed by an intention and a specific cause, and in order to fight the illness, it is necessary to identify, uproot, punish, eliminate and neutralize the cause, the intention behind the cause, and the agent of the cause and intention.

Van Dyk (2001:112) further mentions that in traditional religious systems in Africa, God is seen as a Supreme Being or creator who has withdrawn himself from human beings, and who is thus perceived as distant and remote from the people. Ancestors can, however, punish their people by sending illness and misfortune if people do not listen to their wise counsel, if certain social norms and taboos are violated, and if culturally prescribed practices and rites are neglected or incorrectly performed. In some cases, it is believed that ancestors do not actually send illness themselves but that they merely allow it to happen by withdrawing their protection. The

illnesses caused by the ancestors are seldom serious or fatal, and traditional Africans are usually quick to restore their relationship with their ancestors through offerings and sacrifices.

She further mentions that the day-to day fate of traditional Africans is regulated and controlled by the complex relations between human and the invisible but powerful beings and creatures who inhabit an intermediate otherworldly zone of existence that is the territory of evil spirits, witches and scorers. Nearly all forms of illness, suffering, misfortunes, conflict, as well as accidents and death, are ascribed to beings that operate from this zone.

Many African people consult both traditional healers as well as Western health care professionals for the same condition (Van Dyk, 2001:113; Tabane, 1995:3). The traditional healers are consulted to diagnose the personal cause of the condition (e.g. bewitchment) or to prevent a recurrence of the illness (e.g. performing a ritual), while a Western doctor is consulted for medication to treat the condition symptomatically.

According to Felhaber (1997) as quoted by Van Dyk (2001:113) witches or sorcerers are usually blamed for illness and misfortune in traditional African societies because people in Africa often use the services of witches and sorcerers to send illness, misfortune, bad luck and suffering to their enemies. They also believe that whatever bad luck or illness befalls them it is sent by witches or sorcerers.

Accusations of witchcraft and sorcery are usually leveled against others when the harmony of a group is threatened or disturbed because conflict, jealousy, tension and unhealthy competition have become too prominent and are threatening to overwhelm the stability of relationship in African community life (Beuster, 1997; Hammond-Tooke, 1989 in Van Dyk, 2001:113). (Compare also Monnig, 1978:71-72; Kuper, 1986:68-69.)

According to Lewis (1990: 71) sorcerers are people who employ magical spells, rites and medicines to achieve their fell ends. Their malevolent apparatus is tangible and external to themselves. He says that witches on the other hand do not need any of these aids. Their power consists in their own innate psychic capacity to cause harm. Their weapon is malicious thought it, not techniques which in principle can be detected and observed.

Witchcraft and sorcery are believed to bring about conceivable misfortunes and illness. If your children are stricken with serious disease or if you or your wife fall ill, then again you suspect witchcraft (Lewis: 1990:72).

6.5. Traditions

Another important element of culture is traditions. Seymour-Smith (1990:279) defines tradition as a set of interrelated cultural elements or traits, which persist over a relatively long time span. In anthropology, the word is used instead for patterns of beliefs, customs, values, behaviour and knowledge or expertise which are passed on from generation to generation by the socialization process within a given population.

According to Kwashi (2002: 20) the following is a list of traditions that would apply to many but not necessarily to all African cultures:

- **Leadership of the family.** The man automatically assumes the leadership of the family. Women may even be seen as property, which can therefore have acquired, changed or given to someone else.
- **Domestic chores and child rearing:** Cooking and other household chores are the women's responsibility. The raising of children, particularly in the early months, is also primarily the woman's responsibility. For example if the father has carried the child for a short while, the child then cries or gives trouble. It is not uncommon to hear him say his wife must come and carry your child
- **Education:** women should not be highly educated because their place is in the kitchen
- **Slavery:** the women are meant to serve the man, to toil and labour without being adequately appreciated.
- **Economic control:** the woman has no rights at all with regard to the family income. The man controls the finances and he alone decides what, when and how family resources should be used.
- **Right to inheritance:** inheritance or rights to property is the prerogative of the man. At the death of the father and mother, the male child or children may inherit what belonged to both parents at the expense of the female children.

- **Divorce:** men may marry and divorce at will like a worn out dress, a woman may be thrown aside and a new marriage contracted.
- **Ownership of children:** the children belong to the man, rather than to both the man and the woman.
- **Communication:** the wife and children are not free to speak to the husband and father at will. The man is viewed almost as a semi-god, and therefore he may not be approached at random
- **Childbearing:** it is often thought to be an essential that a married couple must have children and especially boys. A childless marriage encourages the man to marry again. It is generally assumed that the failed lies with woman and that she is responsible for the lack of children or for the lack of male children.

6.5.1. Marriage

In the context of this study traditions and cultural practices regarding marriage are very important.

Whatever its form, marriage involves at least two individuals who wish to live together, hopefully but not necessarily forever. Their relation with each other are not and need not be closer or morally more important than those with their parents, brothers and friends. Marriage partners share their deepest feelings, make common plans for themselves and their children, and relate to others as a single unit. All this remains true whether their marriage is arranged or self-chosen or romantic or non-romantic, it occurs within a nuclear or a joint family (Parekh, 2002:287).

Lewis (1990:234) sees marriage directly establishing affinal relationships between the kin of the bride and groom. Ideally it also produces offspring and hence provides the ideological principle of descent that is socially recognized common parentage or blood relationship. Marriage thus gives rise to the fundamental social unit of two siblings, one of whom is married, the spouse and their child.

Given the nature of their relationship, married partners need to build up at least some degree of mutual trust, commitment, affection, and an instinctive understanding of each other's desires,

needs and moods. Even if they have known each other before marriage, their relationship acquired a different character after marriage, and they now need to get to know each other at a different level. In the case of some forms of arranged marriages, this task begins after the marriage and is even more demanding. Getting to know another person well enough to live with him or her is a difficult and prolonged process, and required time, energy, leisure, a relative absence of outside interference, and an emotionally relaxed environment. The monogamous relationship provides these conditions better than the polygamous (Parekh, 2002:287).

In some African communities the tradition exists however that marriage is not an individual affair legalizing the relationship between a man and a woman, but a group concern, legalizing a relationship between two groups of relatives. Primarily marriage is a legal act in which the relatives of the groom publicly transfer certain marriage goods to the relatives of the bride. In return for this presentation her relatives publicly transfer the bride to the bogadi (the in-law's place), or literally the place where the 'magadi' (lobola) comes from (Monnig, 1978:129).

Another important tradition or cultural practice regarding marriage which differ between different cultures, is the so-called polygamy or monogamy marriages.

A monogamous marriage according to Popenoe (1986:369) and Hoebel and Frost (1976:198) is marriage between one man and one woman.

Polygamy describes any type of marriage, which allows a husband or wife to have more than one spouse. There are two types of polygamy: polygamy, in which a man may be married to more than one woman at the same time, and polyandry (which is much less common), in which a woman may have two or more husbands simultaneously (Giddens, 1989:386).

Polygamy, including both polygyny (more than one wife) and polyandry (more than more husband), is banned in all western societies. Since polygyny is practiced by some Muslim communities they feel unjustly treated and have campaigned for the ban to be lifted on two grounds, one positive the other negative, the former offering a reasoned defense of it, the latter attacking the ban as incoherent, hypocritical even racist (Cligent, 1970, Gbadegesin, 1993 in Parekh, 2002:282).

Parekh (2002:282-283) found out that Muslim defense of polygamy is fivefold. Their argument invokes the cultural authority of the practice, the rest appeal to its importance to their way of life and the worthwhile values it allegedly realizes:

- Firstly, polygyny is both cultural and a religious practice sanctioned respectively by tradition and the Koran.
- Secondly, in most societies it is common to divorce a woman if she is infertile or sexually incapacitated or if the married partners are emotionally or sexually incompatible. Since divorce causes considerable suffering to all involved, it is more humane to allow the husband to take a second wife without having to divorce the first.
- Thirdly, all males are tempted to stray from the path of matrimonial fidelity and sometimes strike up extramarital liaisons with all the concerned and aisle more honest if the man were allowed to marry women involved rather than break up the existing marriage or lead a life of deceit.
- Fourthly, extramarital relations sometimes result in children who carry the stigma of illegitimacy all their lives, and the males involved have no social or even financial obligations to them or to their mother. In such cases it is more sensible not only to allow but also to require the man concerned to marry the women and accept full responsibility for their children.
- Fifth, in some societies the gender ration is skewed and women out-number men. This results in compulsory spinsterhood for many of them, undesirable pressure on monogamous marriages, and even prostitution. In such situations polygyny has much to be said for it. After the Nigerian civil war when the town of Calabar was swarming with unmarried women and widows, even the Christian tribal elders preferred to allow polygyny to their members rather than risk the obvious dangers.

In a polyandrous culture, husbands seem uninterested in establishing biological paternity. Who is deemed the father of a child is established by means of a ceremony in which one of the husbands presents the pregnant wife with a toy bow and arrow. If other husbands subsequently wish to become fathers, the ritual is re-enacted during further pregnancies. Polyandry seems to exist only in societies living in extreme poverty, in which female infanticide is practised.

In polygynous families, co-wives sometimes live in the same dwelling as one another, but often have different households. The husband usually has one home as his primary dwelling, but may spend a certain number of nights per week or month with each wife in rotation. Co-wives are frequently co-operative and friendly; but their situation is an obviously one that can lead to rivalry and tension, since they may see themselves as competitors for the husband's favours (Gidden, 1990:387).

According to Lewis (1990:260-262) a conspicuous display and the desire for as many heirs as possible encourage men to take more than one wife. They say in Nuristan, a wife is like a field. You plant seed in more than one field. The older and more important men are, the more wives they tend to have. These privileges and prizes are not without cost. They increase familial tensions, not only between co-wives but also between husband and his sons. Conflict centres on competition over women and over the use of family property or how to acquire wives. The family heads latest marital adventures may seriously inconvenience his unmarried sons when they are desperately seeking brides but cannot find the necessary bride-wealth. Co-wives are usually ranked in the order of their marriage to their common spouse. Typically the first wife keeps the keys of the family chest or moneybox. Her authority as first lady over her younger co-wives is to some extent counterbalanced by the family's heads disproportionate interest in his later and younger partners. The legal superiority of the first wife is reflected in the privileged position, which her children assume on their father's death.

Monnig (1978:130) refers to the Pedi ethnic group who many of their marriages are polygamous. Their marriage ceremonies for a first wife differ from the marriage celebrations for subsequent wives. The difference however does not lie in the marriage principles but in the time taken when marriage negotiations are held. The negotiations may for example involve the lobola to be paid to the bride's family. In some cases the initial arrangements take place even before the birth of the bride or groom. The negotiations may take up to two decades.

Herd (in Moore, 1997:216) states that the nature and structure of the traditional family system are also important determinants of patterns of sexual relations within and outside marriage. Polygyny on this scale still found in Nigeria has been sustained only by the very substantial delay of male first marriage. It has inevitably produced a situation where half of adult males are single and sexually active. On the other hand, polygyny has taught men to believe that relations with only one woman are not part of man's nature, while postpartum abstinence makes women unavailable for sex for a considerable part of their reproductive life span. During the long period

of postpartum abstinence men look for partners elsewhere. Commercial sex workers, divorced women and widows meet a significant proportion of their sex needs.

Since polygamy involves sexual discipline which some find trying, they seek from time to time to escape its constraints. However, such lapses are associated with a sense of guilt or at least unease, and incur at least some measure of social disapproval. This why such lapses occur secretly, provoke charges of deception and betrayal, and require an explanation. None of these would happen if monogamy were not a deeply valued liberal practice (Parekh, 2002:288).

The polygamous marriage is likely to be marked by jealousy, unhealthy competition for affection, insecurity, intrigue and mutual manipulation. It is also unlikely to create an environment conducive to the balanced growth of children. It is true that the child in polygamous family has more role models and is not intensely identified with one of them. However such a family at best includes a couple more adults than its monogamous counterpart, and hardly amounts to the kind of community the Muslim critic has in mind. Although the plurality of role models has its advantages, it also has its disadvantages. The opportunity to play off adults against each other, the rivalry among them for the child's affection, the relative lack of a clear structure of authority and so on, mean that children lack a moral and emotional focus, are subjected to conflicting moral and emotional demands, and are less likely to develop their powers of self-direction and self-discipline (Parekh, 2002:290-291).

7. Summary

This chapter focused on culture in general. Many examples of cultural issues of African communities were discussed in this section. It is true that culture exists in all societies especially African societies. In the following chapter one will also learn about the relationship between African societies. How these societies emerged from each other. It is also clear that a society cannot exist without culture and culture also cannot exist without a society.

The following chapter will focus on the cultural practices of the Batswana people in relation to HIV/AIDS.

CHAPTER 4

HIV/AIDS and cultural practices of Batswana in Botswana

1. Introduction

The previous chapters focused on HIV/AIDS as a phenomena and culture and its components in general. The purpose of this study is to find out if the cultural practices of the Batswana people in Botswana have any influence on the transmission of HIV. This chapter will therefore focus on the situation of HIV/AIDS in Botswana in relation to the impact it has on the Batswana people and the influence of cultural practices on HIV/AIDS. Different aspects regarding the social, economic and health impact of HIV/AIDS and the present cultural practices of the Batswana will be discussed. In order to understand these aspects it is first of all very important to get background information of the Batswana people (e.g. where they originate and who are they) and the HIV/AIDS situation in Botswana.

2. History of the Batswana

According to Bolaane and Mgadla (1997) Batswana live in countries of Botswana and South Africa. They speak a language called Setswana. Batswana from different regions can understand each other because the dialects are closely related. Anything that is regarded as an essential part of the culture is called Setswana. Batswana customs can be referred to as Setswana customs.

About 3 million Batswana live in South Africa, and in 1997 it was estimated that the population in Botswana was 1. 533 million. According to the 2001 census data, the total population of people in Botswana was 1 680 863 (Botswana Central Statistics, 2002).

Bolaane and Mgadla (1997) further state that, the white settlers who established colonial borders separated the Batswana in Botswana and in South Africa in the 1800's. Experts also believe that African people who live in South West Sahara desert spread out across the continent over many years. Many of those who migrated into Southern Africa consisted of related Sotho – Tswana people, of which the Batswana today forms a part. Other major sections of this group include the South Sotho or the Basotho and the North Sotho or Bapedi (Bolaane & Mgadla, 1997).

They continue to state that the Batswana group consists of several subgroups called Merafe (singular-morafe). A Morafe or Chiefdom consists of people descended from the same ancestor. Over many generations, the Merafe split into several branches. This often occurred because of disputes between chiefs, sons or leading men broke away from the Morafe with their followers and established their own independent Morafe. It is through this process that the senior Bahurutshe Morafe gave rise to other Morafe: the Bakwena, Bangwato, Bangwaketse, Batawana, Bakgatlha, Batlharo, Barolong and Batlhaping. The Bangwato are the largest in Botswana and occupy the most land. The totems that they honour identify the Merafe.

According to Cuff and Payne (1981:32) and Bolaane and Mgadla (1997) totems are usually animals that serve as emblems for groups of people with the same origin or ancestry. People never kill, eat or use the skins of their totems. This totem is a tangible means of expressing men's feelings that the society of which they are members is bigger and better than each individual. It serves to remind individuals of their tasks and connections with the whole tribe and

how much they value those links. The individual then feels acted upon by outside and valued forces and he feels solidarity with his fellows (Cuff & Payne, 1981:32).

Most of Botswana people (Batswana) are members of Setswana- speaking ethnic groups. Shibutani, et al. (1976) as quoted by Alexander (1984) state that an ethnic group consists of people who see themselves as being of a kind. They are united by emotional bonds and concerned with the preservation of their type. They speak the same language and they share a common cultural heritage. They believe that they are common descent.

Giddens (1989:243-244) adds that ethnicity refers to cultural practices and outlooks that distinguish a given community of people. Members of ethnic groups see themselves as culturally distinct from other groupings in society and are also seen by those others to be so. Many different characteristics may serve to distinguish ethnic groups from one another, but the most usual are language, history or ancestry, religion and styles of dress or adornment. Other groups in Botswana include for example, Bakalanga in the North East and Baherero in the west. There are also a small number of citizens of Asian and European origin. Therefore in Botswana there are also subcultures (Bolaane and Mgadla, 1997).

According to McNall (1973:45) usually cultures of ethnic groups within a larger society are called 'subcultures'. Although there are subcultures, they are however dominated by the general cultural practices which Setswana language is one example.

According to Goodnow, et al. (1995) cultural practices are actions. It is what people do. Cultural practices are not neutral. They come packaged with values about what is natural, mature, morally right or aesthetically pleasing. The actions become part of a group's identity. The practice may be sustained changed or challenged by a variety of people. Cultural practices are actions that are repeated, shared with others in a social group and invested with normative expectations and with meanings or significance that go beyond the immediate goals of the action. According to Bolaane and Mgadla (1997) the common language of Setswana in Botswana unites all Batswana merafe. The other common cultural practices of the Batswana will be discussed in the next sections.

3. HIV/AIDS in Botswana

According to Poku (2001:191) there are 35 million people infected worldwide and in the Sub Saharan Africa, there are 23.5 million people infected with HIV. She says that at the continental level, 23 million people are now living with HIV/AIDS that is two-thirds of all cases presently on earth. Most will die in the next 5-10 years joining the 13.7 million Africans already claimed by the epidemic and leaving behind shattered families and crippled prospects for development.

Poku (2001:191) says that Botswana is one of the six countries in Southern Africa that now form the global epicenter of the epidemic. One in six adults is HIV positive and AIDS is expected to claim the lives of between 8% and 25% of today's practicing doctors by the year 2005. In Botswana she says, a shocking 35.8% of adults are now infected with HIV.

The (UNAIDS, 2002) states that in the year 2001, 38.8% of the total adult population aged between 15 and 49 in Botswana were affected with HIV and among 25 –29 year old women attending antenatal care in urban areas, 55.6% were living with HIV/AIDS in 2001. The HIV prevalence among pregnant women in urban areas already stood at 38.5% in 1997 and in 2001 it had risen to 44.9% (UNAIDS, 2002: 23).

The implications of change in population structure are shocking. According to the United States Census Bureau, there will be more adults in their 60s and 70s in Botswana in 20 yrs' time than there will be adults in their 40s and 50s (UNAIDS, 2000).

The life expectancy in Botswana at birth has dropped to a level not seen in Botswana since before 1950. In less than ten years time the life expectancies fall to near 30 years. The average life expectancy in Botswana before the AIDS epidemic was 74.4 years. It is expected to decline to only 26.7 years in 2010 if the virus is not slowed down or reversed (The impact of HIV/AIDS on Africa: 2004).

According to the Botswana – Population (2003) the life expectancy before AIDS in Botswana was 63 years and in 1991 it declined to 44 years.

The population projection is based on the assumption that patterns of new infection will not change greatly over the next decade. However as changes in future infection rates will principally affect men and women under 40 in 2020, the demographic chimney pattern for older adults is hardly affected by this assumption. The missing adults (men and women) who should have reached there 40s and 50s in 2020- are now in there 20s and 30s, although some have already died. Many more are already infected with HIV, which will kill them before they reach

their 50s. It is predicted that a small number of young adults, the group that has traditionally provided care for both children and the elderly will have to support large numbers of young and old people. Many of these young adults will themselves be debilitated by AIDS and may even require care from their children or elderly parents rather than providing it (UNAIDS, 2000).

HIV transmission may be facilitated by social migration patterns, cultural attitudes towards fertility, and women's lack of empowerment (BOTUSA, 1999).

4. Social aspects regarding HIV/AIDS in Botswana

It has already been mentioned in chapter 1 that the socio-economic and cultural factors influence the transmission of HIV/AIDS in Botswana and that factors such as social migration and sexual relationships are to a certain extent influence the transmission of HIV/AIDS (McDonald, 1996:1327). It has also been pointed out that HIV/AIDS is a social disease.

According to University of the Witwatersrand (2002:3) while a considerable body of biomedical research conducted in HIV/AIDS has determined the causes and course of the disease and yielded medical strategies for its control, there is not an equivalent level of understanding of the social and behavioral factors which fuel the epidemic. The discussion of social factors has often not progressed beyond invoking a crude and undifferentiated role of poverty and migrancy. The specific interaction of the historical, social, political and cultural factors, which have shaped the nature of the epidemic needs to be the focus of more extensive research. A more nuance understanding of these areas is essential in order to devise more meaningful and effective intervention and treatment plans.

The researcher has selected the most relevant and applicable aspects in the context of this study.

It is important to discuss the social aspects regarding HIV/AIDS in Botswana with special reference to education, alcohol use, migration, attitudes and beliefs regarding HIV/AIDS, condom use, stigma, religion, polygamy and sexuality. These aspects play a very important role in the lives of the Batswana's. The interaction between these factors and HIV/AIDS need to be explored. The following sections will focus on the social aspects mentioned above in relation to HIV/AIDS.

4.1. The relationship between HIV/AIDS and level of education in Botswana.

UNAIDS (2000) suggests that generally people with more education lead healthier, more productive lives. Better-educated people generally have greater access to information than those who are illiterate or uneducated and they are more likely to make well-informed decisions and act on that information. In addition, educated people generally have better jobs and greater access to money and other resources, which can help them, support healthier lives. These same resources can however be used to buy alcohol, drugs and sex.

The 1993 Botswana National Literacy Survey shows a national literacy rate of 69.9% (66.9% for males and 70.3% for women). The illiteracy rate is also very low among the farming communities where less than 4% of farm household members above the age of 5 years have ever been to school. This makes it difficult for them to read any Information Education and Communication (IEC) material on HIV/AIDS (Adupa, 1999).

The government of Botswana has however, made impressive achievements recently on education. There is provision of almost universal free education, pupil/teacher ratio of 28:1 and an increase in literacy rates from 34% in 1981 to the current estimated 74% (Botswana Population, 2003). The increase in the literacy rates will assist in reducing the rate of HIV infection, as people will be literate enough to understand prevention and consequences of HIV/AIDS. According to the AIDS/STD Unit (NACP19, 1999) women are the ones who take care of the sick patients and when AIDS patients are taken home, it is the same women with little knowledge about how the virus spreads whom also take care of the patients with AIDS. Their lack of education contributes to them being very ignorant about HIV/AIDS knowledge especially how the virus is spread and therefore do not take precautions in protecting them selves from the infection. Consequently they remain vulnerable to infection from handling body fluids wastes, soiled bedding and linens without adequate protection of gloves.

4.2. Orphaned children in Botswana

One of the most tragic social consequences of HIV/AIDS is the increase of orphaned children worldwide. It is already stated in the previous chapters that there are approximately 14 million children worldwide who have lost one or both parents due to AIDS. Approximately 80% of

these children, about 11 million live in Sub-Saharan Africa (UNAIDS, 2002: 133). Already these figures can show us how HIV/AIDS is a serious problem in sub-Saharan including Botswana as part of the Sub Saharan.

In Botswana, according to Muchuru (1998) a rapid assessment on the situation of orphans in Botswana was initiated as a result of public and political concern on the socio-economic conditions the orphans lived in. The assessment was conducted in 9 districts and 10 villages and towns. About 4496 orphans were identified and registered. Majorities of orphans were living with old grand parents who had no resources to provide essential needs on a regular basis. School going orphans didn't have anything to eat in the morning. On several occasions, the girl's orphans were sexually abused and often fell pregnant and eventually dropped out of school. Orphans related to HIV/AIDS parents have also dropped out of school as a result of stigmatisation, rejection and isolation by other students and occasionally by teachers. Caregivers also identified counselling as an urgent need especially for orphans who were living with AIDS patients.

Orphans are also reported as having inadequate access to basic human needs such as food, clothing, shelter and toiletry. As their parents die, orphans go through serious emotional stress. They are further impoverished, stigmatised, isolated and sometimes rejected. Child Welfare multisectoral committees form parts of the management structure that provides technical and advisory services to the programme that aim at assisting children orphaned by AIDS. The composition of these committees comprises strategic stakeholders who add value to the programme implementation. Stakeholders are individual persons and institutions that are affected directly or indirectly by way of interest or the impact orphanhood has on them. They include non-governmental organizations and community based organizations, religious groups, traditional leaders and private sector, media, politicians, communities and international development organization and donors (Ministry of Local Government, 1999-2003; Van Dyk, 2001:335).

In Sub-Saharan African countries men are dying first followed by the infected wives and partners. Death of the mother is more critical for children below the age of 5, while death of the father has a greater effect on the development opportunities of older children. A child missing both parents is generally the most vulnerable of all types of orphans (UNICEF, 1998). The deep-rooted kinship systems that exist in Africa for example, extended family networks of aunts

and uncles, cousins and grandparents are an age-old social safety net for such children. The systems have long proved that it is resilient even to major social change. However capacity and resources are stretched to breaking point and those providing the necessary care in many cases are already impoverished. Often the elderly people, who have to take care of these orphans, have been financially and physically dependent on the support of the very son or daughter who has died (UNICEF, 1999). For example, it was found that in the high HIV prevalence district of Kweneng, in Botswana, an orphan registration exercise conducted in mid 2000 revealed that only 22.1% of the people registered as caregivers for orphans, were employed. The others lacked productive employment and fully 40% of them were grand parents or elderly relatives (UNAIDS, 2002:137).

The Botswana government encourages communities to provide care for orphans and to rely on institutional care only as last resort. Orphans are therefore still usually absorbed by the extended family. Their caretakers are predominantly women. Female household makes up the majority of all households living in poverty (UNICEF, 1999).

Although the idea of using orphanages as a last resort is supported by researchers such as Van Dyk (2001:338), UNAIDS (2002: 137) argue that the extended family can only serve as part of the solution to mass orphan-hood if adequately supported by the State, the private sector and the surrounding community.

4.3. Alcohol use in Botswana

The researcher's own experience in Botswana has shown that bars are almost everywhere and generally people in Botswana including those who are visiting feel that alcohol consumption is a serious problem.

According to the AIDS/STD Unit (1998) people in Botswana often drink too much alcohol. The abuse of alcohol seems to assist people escape from the everyday hardships. The use of alcohol however can impair people's judgment and therefore can also encourage people to become loose, and to have sex with different people without the use of condoms (Evian, 2000:21).

In a study conducted in Botswana in 1998, some men used alcohol as an excuse for having casual sex and not using condoms to protect themselves (AIDS/STD Unit, 1998).

Fidzani, Ntseane and Seloilwe (2000) say that the majority of community leaders in Botswana cite that the high number of drinking spots in Botswana is contributory factors in the spread of HIV/AIDS. Practically in each village, there is liquor stores and restaurants selling liquor and a lot of chibuku and khadi. Chibuku and khadi are the kind of African beer sold in Botswana. The liquor shops are open till late and they also sell food items and snacks, which makes it a convenient excuse for people especially the youth to frequently visit these bars (AIDS/STD Unit- NACP 22,1994).

Lauer (1992: 115) asserts that at least half of all alcoholics may have difficulty with problem-solving, abstract thinking, memory tasks and psychomotor performance. He says that alcohol releases inhibitions so that the person who drinks loosens up and may for example be more motivated toward sexual activity. Heavy drinking also inhibits sexual performance and alcoholics report a deficient sex life or even impotence. Many people who are drunk get increasingly aggressive as they become intoxicated. This can lead to ill will and conflict with others. There is also higher rate of both verbal and physical abuse in homes where one or both spouses are alcoholics.

High intake of alcohol can put the Batswanas at risk with HIV transmission as people may be forced into sex without condoms due to aggressive behaviour and loss of control as a result of excessive drinking (AIDS/STD Unit, 1998).

4.4. Migration in Botswana

Wilson, et al. (2002:8-9) asserts that migrant labour has been practiced extensively in Southern Africa. Migrant labour is characterized by a surplus of men at the destination of the labour and by a deficit of men at the source of labour. These imbalances as well as the disruption to the way of life of the individual contribute greatly to the HIV epidemic. The social disruptions and gender imbalances provide a context in which HIV is easily able to spread. Most of the time, the only sexual contact available is that provided by sex workers or by other migrant workers.

Herd (in Moore, 1997:169) adds that it is only since the onset of the HIV-AIDS epidemic that the relationship between mobility and sexual behaviour has become an object of more systematic research. Such behaviour is not necessarily extra marital sexual behaviour. Marriage is the most important and forceful institution in shaping and regulating sexuality, but its relationship to mobility is not unidirectional. At a glance, marriage appears to be an institution that, in bringing together husband and wife, can account for some degree of mobility, but it also implies settlement, the opposite of mobility.

Migration and mobility play important roles in the HIV/AIDS epidemic. The relationship between HIV/AIDS and migration is complex as not all migrants or people on the move face special risks of infection. The links are evident in Botswana (UNAIDS 2002:114). For example, a study commissioned by the Community Health Services Division determined the linkages that exist between population mobility and the spread of HIV/AIDS (Hope & Gaborone, 1999c).

The following findings were registered: The majority of mobile workers are single and almost one half of them have a live-in partner at their location of employment some of those who are married have set up parallel families in the areas where they work. Mobile workers also went home either every weekend, or every other weekend or at the end of each month and some once every two months. These frequent visits back home intensify the transmission of the HIV in the home areas of these mobile workers. Sexual intercourse was quite frequent – twice or more per week. There was a high rate of unprotected sex.

The separation of family members through transfer in the ministry of agriculture was reported to be a contributing factor to promiscuity. Young staff members said that they have decided to remain single for the time being because they fear that when they are separated from their spouses, some people may “poach” on their wives. In Botswana, owning cattle and taking care of parents is part of the Botswana culture therefore, there is need for staff in the ministry to travel home over long weekends and holidays to their home villages to meet their parents and relatives and also visit the cattle post to see their animals (Hope & Gaborone, 1999b).

However even within the rural areas there is a tremendous amount of internal movement of the population because of the 3 homes that typical Motswana has namely, village, land areas and the cattle post. Consequently men have to move between the three locations which may be many kilometres apart and the turn round time to an abode can also be several months which may even be spread across seasons (Adupa, 1999). Adupa (1999) says that the agricultural

community is by men thus leaving women at their mercy. Consequently the women are left in very subordinate positions in economic terms. This may seriously predispose them to HIV infection, as sex offers are an easy alternative.

Lobatse is close to the South African Border making it a major transit point for border crossings. Residents from surrounding areas also frequently travel through Lobatse in search of employment and other income earning opportunities. In addition, the town is situated nearby a number of camps, which are used as houses for road construction workers. These workers frequently visit Lobatse for recreational and other activities including sexual networking (Hope & Gaborone, 1999a).

Both the migrant labourer and the spouse at home are thus at risk for HIV infection. It is also a misconception that the migrants generally bring AIDS with them. Comparison of forced migration in Africa (Ethopia) revealed that in some cases, the prevalence among the migrants is less than that of the host population (UNAIDS, 2002:116). HIV/AIDS prevention programmes and treatment need thus to be available to all members of the communities.

4.5. Knowledge, attitudes, behaviour and practices about HIV/AIDS in Botswana

BOTUSA (1999) conducted a study about knowledge, attitudes, and beliefs regarding Tuberculosis Preventative Therapy (TBPT) for HIV-infected persons living in Botswana during 1999. The objectives of the study were to measure knowledge, attitudes and beliefs about Tuberculosis Preventative Therapy (TBPT) and HIV Testing and to identify patient characteristics and program features that would maximize acceptance of TBPT. TB accounts for 44% of deaths in adults who die of AIDS. Tuberculosis (TB) prevention in persons living with HIV could improve quality and duration of life. In Botswana, HIV prevalence and TB rates are among the highest in the world, but less than 1% of the population has sought Voluntary Counseling and Testing (VCT).

The results showed that the majority of the respondents from this study seemed to recognize the relationship between TB and HIV/AIDS and STDs and HIV/AIDS, as they believed that TB caused HIV/AIDS. There was however a misconception about the causal relationship. Some respondents said that AIDS caused TB and some said that sex and STDs caused TB. There

were respondents who were not sure of the causes of TB and HIV/AIDS. The majority of the respondents also knew that TB and HIV/AIDS could be asymptomatic. However not many respondents have taken an HIV test although the majority said that they were planning to take the test and would like to get the HIV test results the same day or at least wait for two weeks. It was also believed that the HIV tests were accurate (BOTUSA, 1999).

Another study by Tlou, et al. (2000) was conducted to obtain information and data that could be used to improve the effectiveness and acceptability of messages and services regarding Prevention of Mother To Child Transmission (PMTCT) on the community level. Focus group discussions and in-depth interviews were held with women and diverse residents of one community where the MTCT program was launched in 1999 (Tlou, et al., 2000).

The majority of the respondents claimed that they had never seen someone sick from HIV/AIDS, as it is always a secret. AIDS is only mentioned when someone is already dead. There were misconceptions about the transmission of HIV/AIDS. They believed that HIV could be spread through faeces or urine on the open ground by flies or wind and sharing utensils and dishes. Some believed that neglect of traditional culture and the adoption of modern culture are contributory factors to the spread of HIV (Tlou, et al., 2000).

Foreigners were also blamed for the spread of HIV. They also believed that pregnant women who sleep around during pregnancy spread the virus on to the child. The majority of the participants did not know about the Voluntary Counselling and Testing Centres (VCTs). The participants also thought that potential negative reaction to a positive HIV test could range from depression to suicide. Positive results were associated with death is coming up soon as there is no cure for AIDS. They also feared the negative reaction from partners after being tested. Abandonment of a woman by the male partner was assumed to be a potentially common response and that is why HIV positive tests result is not disclosed. Women who are HIV positive are said to be unfaithful (Tlou, et al., 2000).

The media reports and public concern confirm the high prevalence of rape and sexual violation in Botswana. These social ills present serious risks for HIV infection especially for women. There is anecdotal evidence that teenage girls have sexual relations with older men (The Second Medium Plan, 1997-2002).

This sexual relationship formation pattern may in part explain the disproportionate rate of HIV infection between teenage boys and girls. However since most girls who have sexual relationships with older men are likely to have peer boyfriends, who may be infected through this route. There is also concern about the possibility of sodomy among incarcerated prison populations. A study conducted in the Botswana prisons report that the practice of “thigh” sex is common among male inmates. This practice may be a risk factor in cases of cuts and open sores among those practising this behaviour (The Second Medium Plan, 1997-2002).

A baseline research study was undertaken on the knowledge, attitudes, behaviour and practices of young people in Gaborone in 1992 (AIDS/STD Unit - NACP 19, 1992). The study involved a random sample of 627 young people attending secondary school in Gaborone. Focus groups discussions were held with young people, their parents and community leaders. Key informant interviews were conducted with head teachers, teacher-counsellor and YWCA staff. The survey examined the socio-economic profile of young people in Gaborone, their sources of information on AIDS, their knowledge and attitudes about AIDS and STDs. It also focussed on views and behaviour regarding relationships, sexual behaviour, condom use and access. The results of the study confirmed that a considerable proportion of young people still lacked the necessary information on AIDS prevention. It was evident that condoms were not used as a measure to practice safer sex.

In a pilot study addressing male sexuality it was clear that men had misconception about HIV/AIDS. They believed that the condom lubricant has HIV in it. HIV/AIDS was seen as disease among homosexuals and one can also get it when you sleep with whites. HIV is only found in the semen and only fully blown case of AIDS infects people (AIDS/STD Unit, 1998). The study also made it clear that young women feel considerable (unwanted) pressure to have sex before they feel ready and many felt that they did not have the skills to resist this pressure. The young people also clearly stated that they wanted and needed information and guidance on sexuality issues (including AIDS) from their parents (AIDS/STD Unit, 1998).

A study was conducted by BOTUSA in 1999 to identify risk factors for HIV infection. There were 93 HIV positive and 42 HIV negative patients who participated in the study. It was evident from the research results that the respondents who were HIV positive and some HIV negative, believed that a man is like a bull and should not be confined to one pasture and some said that a woman should not refuse a man sex. The HIV positive and HIV negative respondents also

held a believe that a man is more likely to marry a woman who has shown she is fertile meaning that the woman should have a child before she gets married. Alcohol use was also common among all the respondents including men and women. There was an average of three drinks per day. The majority of the HIV positive patients said that they were less than 25 years old at first sexual encounter and they had more than 2 casual sex partners. The HIV negative patients also mentioned that they also had more than 2 casual sex partners. There was also history of sexually transmitted diseases among the HIV positive patients. Men and women hold traditional beliefs about sex that may limit a woman's empowerment. Less than a third received sex education prior to initiating sexual activity (BOTUSA, 1999).

In a study conducted to obtain information and data that could be used to improve the effectiveness and acceptability of messages and services of MTCT prevention on the community level, a number of sources of education were listed during focus group discussions. These were radio, clinic, kgotla, newspapers and schools etc. AIDS was described as the radio disease. There was concern about the negative messages that there is no cure. These were messages specifically from the radio (Tlou, et al., 2000).

There was a support for positive AIDS education through the radio. AIDS education should not scare people. They felt that a negative frightening approach results in resistance to testing (Tlou, et al., 2000). Stigma and discrimination by the community came across as a major deterrent to Voluntary Counselling and Testing (VCT) and of disclosure of either intent to seek an HIV test. The AZT was known to be available but they were not sure if it was available in Botswana (Tlou, et al., 2000).

UNAIDS (2000) reports that the following factors and forces exist that restrict people's autonomy and leave them particularly expose to HIV infection or vulnerable to needless suffering once they are infected: Intolerance of racial, religious or sexual minorities; discrimination against people with known or suspected HIV infection; lower status of women; abuse of power by older or wealthier individuals; scarcity of HIV counselling, testing facilities and of condoms; lack of care and support for those infected or affected; poverty that leads to prostitution; domestic violence and rape; military conflict and labour migration which split up families; lack of respect for the rights of women and children; freedom from inhuman or degrading treatment and the right to privacy and confidentiality.

4.6. Use of condoms in Botswana

Condoms are key to preventing the spread of HIV/AIDS and sexually transmitted infections, together with sexual abstinence, postponement of sexual debut and mutual fidelity (UNAIDS, 2002:86).

However, condoms are not very popular in Africa. Caldwell and Quiggin (1989) as quoted by Van Dyk (2001: 122) postulate that many Western authors erroneously ascribe the lack of condom use in Africa to promiscuity, permissiveness and to a lack of moral and religious values. This clearly illustrates a lack of understanding of the African philosophy behind sexuality and disrespect for African cultural beliefs. Apart from social and political problems, there are deep-rooted cultural beliefs against the use of condoms in some parts of Africa. The challenge is not to condemn Africa, but to make the hidden cultural logic behind the resistance to condoms known and thereafter to find ways to work with or around it (Scott & Mercer, 1994 in Van Dyk, 2001: 122).

For example, population control remains a sensitive issue in Africa because it negatively impacts on the growth of a tribe, it deprives parents of needed labour and it undermines traditional beliefs and values (Hickson & Mokhobo, 1992 in Van Dyk, 2001:121). Instead of telling people in Africa to use condoms (and thereby inevitably to prevent pregnancy) it is necessary to tell them how to protect themselves from STDs and HIV while sometimes allowing 'unprotected' sex to make children. They should be advised not to use condoms until the wife conceives, and to start using condoms again while she is pregnant and nursing the baby.

Van Dyk (2001: 123) adds that one of the objections often raised by Africans is that condoms are not natural, not only because they inhibit pleasure, but also because they interfere in the process of natural fetal development. It is also believed that semen's contains important vitamins, which are necessary for the continued physical and mental health, beauty and future fertility of women.

In Botswana, condoms are widely available, both free of charge and for sale; their availability does not necessarily imply that condoms are easily accessible to adolescents. Frequently obtaining condoms may an unpleasant experience for adolescents. The embarrassment of going to family planning clinics to obtain condoms and the negative attitudes of some providers

toward adolescents who are obtaining condoms limit adolescents' access to condoms because it discourages them from using these sources. Both boys and girls tend to feel embarrassed at clinics and are concerned that their visits may not be kept confidential (Meekers, Ahmed & Molatlhegi, 1997).

If adults do not condone adolescent sexual relationships, adolescents may not be at liberty to go to clinics and pharmacists to procure condoms, because doing so discloses that they are sexually active. In addition, adolescents may feel uncomfortable interacting with service providers; both of these factors may discourage adolescents from procuring condoms, even when availability is not a problem (Meekers, et al., 1997).

Meekers, et al. (1997) gave an example of a situation in South Africa where adolescents were embarrassed when required to inform security guards at family planning clinics of their reason for visiting the clinics. They were also uncomfortable with the lack of privacy inside the facilities as well as the negative attitudes of clinic staff. Condom providers often assumed that when a person requested condoms, it was for contraceptive purposes rather than for STD/AIDS prevention, and discouraged condom use in favour of other contraceptive methods. Access to free condoms may also be constrained due to the belief that condoms that are distributed for free are of lesser quality than condoms that are sold.

Some research mentioned by Meekers, et al. (1997) has shown that price is associated with perception as of higher quality and that this may discourage persons from obtaining and using products distributed free of charge. Other research studies have shown that people have less faith in the quality of free products than in the quality of products they pay for. (Lewis 1986 & 1997; Ross & Frenkenberg, 1993 in Meekers, et al., 1997).

Focus group discussions with adolescents in two urban areas in Botswana – Francistown and Lobatse were conducted by Meekers, et al. (1997) to illustrate why adolescents who want to use condoms may not always be willing or able to obtain condoms and to explore to what extent adolescents' perceptions of the relative ease of access differs for public and private sector providers. The results showed that condom use was common in both areas. Condom use with casual partners is even higher. The results also showed a low percentage of adolescents use public sector distributors. The most popular source for obtaining condoms is retail outlets including stores, bars, nightclubs and hair salons. The data suggested that many

adolescents overcome their shyness to obtain condoms and that they prefer to obtain condoms from retail outlets rather than from health facilities.

Several adolescents in the study also noted that they feel uncomfortable procuring condoms from clinics, pharmacies or stores because they are shy, worried about disclosing that they are sexually active and because they believe that they may be stigmatized. One adolescent mentioned that it is funny for a 16-year-old to buy a condom (Meekers, et al., 1997).

Some adolescents in the same study felt that the nurse or shop assistants will think that they are prostitutes. One adolescent schoolboy in Francistown explained that no teenager would like his parent to know that he/she is sexually active because condoms are associated with sex. Some girls mentioned that most boys are not shy about many things. They are able to collect condoms. There was also a belief that since condoms are inserted on boys, it is not necessary for girls to collect condoms. Boys are generally free in life; girls are scared that people will think they are prostitutes.

In the focus groups discussions several adolescents also reported that service providers sometimes intimidate adolescents by questioning them about their reasons for trying to procure condoms and by remarking that persons of their age should not be using condoms.

One adolescent reported that a service provider at a hospital said that he was too young to use a condom. This generally makes adolescents not to go to clinic to get condoms. One adolescent mentioned that place like Bofwa (a Youth Association) is much better than clinics to get condoms because you find people of their age and they do not get scared to ask as many condoms as they want. The condoms are in great demand there. There was a feeling that condoms from the clinic cause illness like rashes and therefore they prefer condoms from the chemists because in most countries condoms are sold and given out for free. They copy cultures of other countries. They believe that those that are given out for free are not useful. That is they depend on those that are sold.

Several boys also stated that obtaining condoms from friends is better than obtaining them from clinics. They also stated that there are not a lot of people who actually use condoms because of the embarrassment they will have to have when they want them. So the best way to get condoms is to ask friends to give them. However girls reported that they are shy to ask

for condoms from friends. The Botswana male and family planning survey conducted between 1990 and 1991 revealed that there were myths that still existed with regard to condoms. About 60% of the males in the survey agreed with the statement that condoms could remain inside a woman's body (Meekers, et al., 1997).

Another study conducted by YWCA/ WHO in 1992 revealed that young people were too embarrassed to talk about condoms with their partner. The males also agreed with the statement that a girl or woman who carries a condom is usually a prostitute. Focus groups discussions also revealed that young women who carried condoms were often viewed, as cheap and available and such behaviour was associated with prostitution. All members of society do not accept condom use. For example, more conservative adults in the community and some religious groups. Condoms are said to promote promiscuity (AIDS/STD Unit - NACP 21,1994). This is however not only happening in Botswana.

In Uganda, there are also signs that young people are avoiding the patterns of behaviour, which led their parents and older siblings to such high levels of HIV infection. Condoms use for example is increasing among young people and there are indications that, among the better educated, sex with casual partners may start later and are less frequent. But these changes are taking place against a background of very high infection rates, especially in young African women (UNAIDS, 2000).

Green (1994) as quoted by Van Dyk (2001: 121) found that although AIDS awareness was reasonably high in Uganda in 1993, and although millions of condoms had been distributed, the percentage of Ugandan men regularly using condoms was about 3% at that time. Taylor (1990) as quoted by Van Dyk (2001: 121) similarly found that although the people for Rwanda were well informed about AIDS and had modified their sexual behaviour on the basis of their perceptions, none of the respondents in his study reported the use of condoms during intercourse. There is another belief and myth about the condom. It is believed that condoms have worms. The disintegration of cultural norms and values is perceived as one of the major determinants for the spread of HIV/AIDS (Fidzani, et al., 2000).

According to Herdt (in Moore, 1997:222) condoms, if properly stored and used, could give adequate protection against STDs and HIV and, in addition, prevent unwanted pregnancies. Until recently, condoms have not proved popular as a means of contraception in Nigeria

primarily because of their association with prostitution and extra marital relationships and because of the fear that a condom can disappear into the womb and thereby cause sterility. Husbands do not like to suggest the use of condoms to their wives because it will imply that they themselves have been using them in extra marital affairs.

It is evident from the above discussion that there are negative attitudes and stigma attached to the use of condoms. In Botswana, it seems to be difficult to talk about condoms and this affects the younger generation who are already at risk as they are sexually active. A recent analysis of study samples from eight countries in sub-Saharan Africa found that attitudes towards condom use are also depended on the nature of relationships (UNAIDS, 2002:88). This suggests that condom promotion messages need to be tailored to the context (UNAIDS, 2002:88).

These messages will work best as part of a comprehensive package of interventions that include HIV/AIDS education, sexual health and human sexuality and gender sensitivity training. The following section will focus on stigma issues in relation to HIV/AIDS in general.

4.7. Stigma issues related to HIV/AIDS in Botswana

According to Van Dyk (2001:296) fear of stigmatisation are very real factors when one has been diagnosed with HIV/AIDS. The infected people may experience social rejection and discrimination.

In low prevalence countries or places where HIV is seen as a problem of marginalized groups, rejection by families or communities may be a common reaction. Fear of rejection or stigma is common reason for declining testing. Linking testing with ongoing care and support services, as well as HIV education and awareness in the community can reduce stigma and may contribute to wider acceptance of Voluntary Counselling and Testing. Voluntary Counselling and Testing may also be seen as an important way of overcoming stigma. Many people become aware of their HIV serostatus and normalize the disease (SAFAIDS, 2002:2).

A household survey was conducted in the Ngami and Tutume sub-district of Botswana in late 1993 and early 1994. About 50 people living with HIV/AIDS and 20 caretakers were interviewed (AIDS/STD Unit - NACP22, 1994). The survey confirmed that AIDS is a lonely disease. Ninety five percent of the persons interviewed had told no one outside the family of their HIV/AIDS diagnosis and about less than half of them, had visited a traditional healer and on average paid 190 pula. People living with HIV/AIDS and the caretakers want to talk to others in the same

situation. At the same time they also agreed that it is important to them that nobody outside the household knows about the diagnosis. The stigma attached to AIDS was given as the main reason for this (AIDS/STD Unit - NACP22, 1994).

The cultural, sexual, religious and legal issues are often associated with sexual practices, preferences, sexual desires, the number and type of sexual partners and the use of birth control difficulties. In addition there is often a "cloak of silence" related to sexual practices and to illicit drug use. Such subjects are often taboo and associated with embarrassment, shame, guilt, and rejection. Nurses and other caregivers may also experience these same feelings of embarrassment, shame, and guilt as they practice certain risk behaviors on their own personal lives. The additional fear of HIV/AIDS as fatal illness compounds the problem of discussing this difficult subject.

HIV/AIDS is also found to be a condition that continues to generate fear, misunderstanding, misinformation and discrimination. For example, there are few nurses and caregivers in the world who have not been affected in some way by the disease and it is easy for the nurses to discriminate (PLWHA) people living with HIV/AIDS. In addition some nurses and caregivers are also living with HIV which can cause them to live in fear and thus make it difficult to understand or care for people living with HIV/AIDS and the affected households (Report of the ICN Conference on HIV/AIDS, 1994:17).

Among the consequences of this stigmatization is early withdrawal from the labour force by those infected. The stigmatization is often in an overt manner. There is fear that contact or helping the PLWHA will infect them (The Second Medium Term Plan, 1997-2002).

Several developing countries have recently set up pilot projects to help HIV-infected women give birth to healthy children and are actively tackling some of the challenges involved. Some of the challenges are the women's reluctance to be tested for HIV infection (UNAIDS, 2000). This reluctance may be driven in part by their fear of stigma and in part by fear that they will not get the social or medical support they need if they are found to be infected. When testing is offered, women who are tested show their reluctance in two ways: either they refuse to be tested or they agree to be tested but do not come back for the test results (UNAIDS, 2000). Care and support need to be given to people living with HIV/AIDS to destigmatize HIV/AIDS.

We also all need to be advocates for acceptance and care and look inward and examine our own beliefs, values, assumptions and attitudes towards HIV/AIDS (Van Dyk, 2001:273).

4.8. Cultural beliefs with regard to HIV/AIDS in Botswana

According to Giddens (1989: 331-332) culture concerns the way of life of a given society. It is their habits and customs together with the material goods they produce. He says that culture is one of the most distinctive properties of human social association. Van Dyk (2001: 128) asserts that culture unite the individual with the rest of his or her community, others should respect both the living and the dead and them. This section will focus on religion and polygamy as they relate to HIV/AIDS in Botswana. There are other aspects of culture that can be included in this section. The researcher however chose the two aspects to be discussed as Botswana is a very religious society and polygamy is a big issue also. Some communities in Botswana are still practising this. Therefore it cannot be ignored.

4.9. HIV/AIDS and religion in Botswana

A large number of Africans even those who are urbanized, still adhere to traditional African beliefs. It is common for Africans to combine traditional beliefs with other religious systems such as Christianity. In traditional Africa, disease is either attributed to natural agents, witchcraft or displeasure of the ancestors. In Botswana, religious leaders attribute the high prevalence of HIV/AIDS situation as punishment from God (UNICEF, 1998). According to these leaders the principles of abstinence and faithfulness have been disregarded by the society. The majority of traditional and religious leaders on the other hand acknowledge their inadequacies to handle patients who are too sick. They normally refer these patients to the health care providers in the clinics. A few traditional healers claimed that they have been successful in curing the disease particularly when patients come during the early stages of the illness (UNICEF, 1998).

In Botswana, according to Fidzani, et al. (2000) consultation of traditional healers has been reported to be more frequent before diagnosis of HIV than afterwards. Health workers' experiences suggest that patients usually come to the hospital and clinics once their condition has deteriorated markedly. The traditional healers are often consulted early in their illness.

The fact that HIV (and other STDs) can infect newborn infants is of great concern to traditional healers in Africa because they realize that AIDS may jeopardize future generations, and indirectly also the immortality of their tribe (Schoepf, 1992 in Van Dyk, 2001:121). Churches, traditional religious leaders and traditional healers will have to engage in prevention and education programmes and also pay attention to the spiritual and physical needs of people who are suffering from illnesses or who experience desperate poverty because of the loss of breadwinners and parents to AIDS (Van Dyk, 2001:321).

4.10. Polygamy in Botswana

According to Giddens (1990:386) polygamy describes any type of marriage, which allows a husband or a wife to have more than one spouse. There are two types of polygamy, which include polygyny and polyandry. Polygyny is when a man marries more than one woman at the same time and polyandry, which is very uncommon, is when a woman marries more than one man simultaneously.

Van Dyk (2001:120) mentions that Western health care professionals mostly frown upon polygamy in African societies, but polygamy often helps to prevent and reduce unfaithfulness, prostitution, STDs and HIV. According to Mbiti (1969) as quoted by Van Dyk (2001:120) polygamy is particularly valuable in modern times when African men are often forced to seek work in the cities and towns. If a husband has several wives he can afford to take one at a time to live with him in the town, while the other wife or wives remain behind to care for the children and family property. As a result polygamy often provides a healthy alternative or solution to problems inherent in certain cultural customs.

Van Dyk (2001:120) further states that in some African societies, for example, sexual intercourse between husband and his wife is prohibited while she is pregnant and this abstinence is observed until after childbirth or in some cases even until after the child is weaned. In such situations, polygamy prevents husbands from turning to casual sex. In societies where polygamy is practiced, AIDS educators are wasting their time when they try to advocate monogamy. Much more will be achieved by emphasizing loyalty and fidelity between a husband and all his wives and by discouraging sex outside that group. Polygamy is, of course, only safe if all the partners in the relationship are HIV negative.

There is also polygamy practised in the subdistrict of Botswana called Ngamiland. There is tacit recognition of multiple partners among other groups in Ngamiland. Girls are introduced to sex at a much earlier age. If these young girls are not with their male counterparts this can only mean that they do so with men who are much older than them. Allegations made in the district-included cases of primary school pupils who leave school to get married as second wives. This kind of practice may expose the girl child to infection by HIV/AIDS infection (Ngamiland Comprehensive District Plan, 1999).

Fidzani, et al. (2000) pointed out that historically for both the Kalanga and Setswana speaking groups, the practice of "Gala thaka" or "Seatlung" was very common. This practice enabled a brother to marry or inherit his brother's wife. There was also the Nkadzana concept where it was accepted for a man to relate to his wife's younger sister or close relative. Polygamy was also practised by all cultures although it is now only amongst the Zezuru community. There are however, new forms of polygamy – for example the concept of a small house. This practice allows a man to have a concubine (Guumba) that is well known to the family. A maguumba, very often would be an unmarried or divorced women.

According to Giddens (1990: 387) polyandry creates a situation, which is not present in polygamy. The biological father of the child is usually not known. This is a risky situation in the transmission of HIV since condoms are not used as the woman conceived and the HIV status of the other partners may not be known. In polygamy, it is however possible to know, who the biological father of the child as it is obvious that the man who impregnated the woman is the one involved with the women. It is however not known whether all the partners are faithful or not. Both polygamy and polyandry are very risky in the transmission of HIV/AIDS.

4.11. Sexuality and gender issues in Botswana

According to Wilson, et al. (2002: 65) sexuality refers to those attributes, desires, roles and identities that are concerned with sexual activity and behaviour. It can also refer to an orientation towards, or preference for, particular forms of sexual activity.

Wilson, et.al. (2002: 65) further stated that while biology determines sex, society, religion, and culture shape sexuality. Wilson, et al. (2002:65) also mentioned that biological sex refers to whether people are genetically male or female and gender identity is socially and culturally constructed. Sexual identity is an important concept in sexuality and gender. They say that sexual identity, describes how people think of themselves, who they are sexually and romantically attracted to, and how others think of them. It also refers specifically to whether a person is attracted to members of the same biological sex or the opposite sex (Wilson, et al., 2002:65).

The next sections will focus on the impact of adolescent, female and male sexuality on HIV/AIDS in Botswana.

4.11.1. The impact of adolescent sexuality on HIV/AIDS in Botswana

According to Meekers and Ahmed (1997) in Botswana, premarital sexual activity is common and most adolescents tend to become sexually active at a relatively early age.

Recent research by Meekers and Ahmed (1997) on adolescents in Lobatse and Francistown, two urban areas in Botswana, revealed that 4% of males and 15% of females aged 15-16 were sexually experienced and among adolescents aged 17-18, roughly 2 out of every 3 male and female adolescents were sexually experienced. Further more the study revealed that multiple-partners and casual sexual relationships are common among Tswana adolescents. For example, among adolescents aged 17-18, 39% of females and 47% of males reported having at least one casual partner in the last twelve month, 16% of females and 21% of males reported having at least two casual partners.

These types of adolescent sexual relationships lead to high level of premarital childbearing, related school dropouts, abortions, and HIV transmission.

It has also been found that the infection rates in young African women are far higher than the infection rates in young men. Among young people in their early twenty's, the rates were three times higher in women. In large measure, this enormous discrepancy is due to age mixing between young women and older men, who have had much more sexual experience and are much more likely to be exposing the girls to HIV. It is the interplay of biological, cultural and economic factors that makes young girls particularly vulnerable to the sexual transmission of HIV. While both girls and boys engage in consensual sex, girls are more likely than boys to be uninformed about HIV, including their own biological vulnerability to infection if they start having

sex at a very young age. Girls are also far more likely than boys to be coerced or raped or to be enticed into sex by someone older, stronger or richer. Sometimes it is social pressure to acquiesce to elders (UNAIDS, 2000).

Sometimes it is a combination of factors, as may be the case with older “sugar daddies” that offer schoolgirls gifts or money for school fees in return for sex. In the era of AIDS, the consequences for young girls can be disastrous (UNAIDS, 2000).

The incidence of “sugar daddy” and sugar mummy” is also highly prevalent in the Gaborone district (UNAIDS, 2000). Youth no longer have fears to engage in sexual relations with older adults. For the young girls, the motive behind this practice is material and financial gain. The youth also succumb to peer pressure and engage in sexual relations for fear of being laughed at by their peers.

Schoolgirl pregnancy is considered a social problem in Botswana (UNAIDS, 2000).

The Norwegian Board of Health and the AIDS/STD Unit of the Ministry of Health (Isa) conducted a study in Molepolole (Kweneng district, Botswana) to determine the prevalence of teenage pregnancy and HIV/AIDS threat among the youth and to explore the factors contributing to teenage pregnancy. Both primary and secondary schoolteachers identified a range of factors as contributing to teenage pregnancy. Top on the list of the identified problems was lack of parental care and abuse of freedom in situations where pupils either live on their own, guardians or relatives when their parents are either at the cattle post or lands or elsewhere trying to earn a living. Two hundred and twenty five primary school pupils and 119 secondary school students were said to be living alone respectively.

Other factors, which were thought to be associated with teenage pregnancies, included:

- Attitude of health workers toward young girls seeking contraception
- Peer pressure
- Lack of communication between parents and their children.
- Disintegration of the extended family, where relatives do not see themselves as equally responsible for children as their biological parents (Ramatswi, 1993 in Meekers & Ahmed, 1997).

The same problem exists for senior secondary graduates. This implies that females stay in school at later ages and that sexuality and reproduction interfere with women's education. Schoolgirl pregnancies are one of the main obstacles to further improvements in women's education. Primary and secondary schoolgirls who become pregnant are required to drop out of school until their child is one year of age (Ramatswi, 1993 in Meekers & Ahmed, 1997)

Despite the fact that particularly, secondary school teachers viewed pregnancy as a serious problem, there was no accessibility of condoms within the school premises. The reasons that were put forward for not making condoms available included: the school teachers felt that the pupils are still young and have not yet shown any indications of being sexually active. The key informants also said that the health workers have never sensitised them about the need to provide condoms at schools. This clearly shows that health workers are solely seen as being responsible for providing health related services. The school teachers felt that if condoms are to be issued at school, this might instil sexual activity ideas into children who are still innocent and would not have engaged in sexual activities (Meekers & Ahmed, 1997).

Teenage pregnancy is said to be a serious problem in secondary schools in Botswana. This means that the teenagers are sexually active and are not using condoms. Pregnancy is a sign of contraceptives including condoms not being used. This means that the teenagers in Botswana are at risk of being infected with HIV/AIDS, as condoms are not easily accessible to teenagers in schools and clinics to prevent HIV transmission.

The study of Teenage pregnancy and risk of HIV infection in Molepolole, also revealed that accessibility of condoms within the school premises is against some of the religious and cultural beliefs (UNAIDS, 2000). Some of the headmasters stated that a school is not a sex training institution but a day school.

Fidzani, et al. (2000) state that historically all parents were charged with the responsibility of disciplining children regardless of whether they were their children or not. There is no longer respect between the youth and adults. In general most parents acknowledge with bitterness that they have given up in their attempt to mould their children into responsible adults as children disrespect parents and all adults. The children think that they can control or guide themselves.

In order to monitor the progress and impact of prevention activities that have been undertaken, a study on knowledge of AIDS reported the occurrence of STDs and sexual behavior amongst

youth aged 18-25 (Ministry of Health, 1992). The youth were misinformed about how the AIDS virus was transmitted. There was a belief that AIDS is transmitted by mosquitoes or other insects and by sharing food/cups or holding hands. The prevalence of STDs was extremely high in Francistown suggesting that those with STDs may be a major factor in the spread of HIV. Health facilities and Radio Botswana were seen as the most important and reliable sources of AIDS information (Ministry of Health, 1992).

Some parents are said to be totally against sex education and would therefore disapprove of their children being exposed to condoms (Norwegian Board of Health and Ministry of Health, [sa]). School authorities have been reluctant to provide family life education because they feared parental opposition. Parents have been reluctant to take responsibility because they were not allowed to do so traditionally and because they lack the necessary knowledge. Communication between parents and their children is poor and because of traditional rules prohibiting children from talking about sexual issues with their parents. This is unlikely to improve in the near future. Girls are not allowed to reapply for admission to school until their child is one year old and they are not allowed to return to their former school.

Information from both the survey data and the focus group interviews indicate that parental support is a crucial factor in enabling girls to return to school (Meekers, et. al., 1997).

Schoepf (1992) as quoted by Van Dyk (2000: 121) also found out that although many women in the Democratic Republic of Congo were not in a position to negotiate the conditions of their sexual practices or condom use for their own safety, they had taken steps to change their children's behavior. Many of the mothers had in fact broken the taboo against discussing sex with unmarried children in order to help them understand the need for condom protection. Although it may now be too late for many mothers, hope for the children of Africa may still exist (Schoepf, 1992 in Van Dyk, 2001:121).

4.11.2. The impact of women sexuality on HIV/AIDS in Botswana

In many countries, women worry that they would suffer shame and discrimination if they were known to be HIV infected (SAFAIDS, 2002:2). Many women, who are HIV positive, become vulnerable and risk violence, abandonment, rejection or even loss of their homes and children if they disclose their sero-positive status. The need for protection and support of vulnerable women who test sero-positive must be considered when developing Voluntary Counselling Testing services (SAFAIDS, 2002: 2).

The pattern of the HIV epidemic in Botswana, particularly in the sexually active age group, has a clear gender bias. Data on reported HIV cases since the beginning of the epidemic up to the 1st quarter of 1996 show that 56% of infections in the age group 15 to 49 were women (The Second Medium Plan, 1997-2002).

According to Poku (2001:197) the age disparity in HIV infection rates indicates that young women must be having sex with men much older than themselves. This point is confirmed by ongoing studies in Botswana (Poku 2001:197).

The gender gap widens in the youth group 15 to 29 years, where 68% of infections were women. A Civil Registration Pilot Survey between 1990 and 1994 in selected areas in Botswana found that 80% of births were to single mothers, the majority of whom were youth.

Lack of women's empowerment against prejudicial cultural and traditional practices in sexual and reproductive matters and relationships have been identified as factors that make women vulnerable to HIV infection.

According to the 1994/95 agricultural surveys (Adupa, 1999) women, most of who are widows, divorcees or have never been married head 35% of the traditional farm households in Botswana. Access and control of the most important resources among the agricultural community is by men thus leaving women at their mercy.

Fidzani, et al. (2000) added that many women say that they have very little say when it comes to issues of sexual relationships. Females believe that men were largely unwilling and uninterested in AIDS education. Women said that they always initiated the discussion with partners and often were discouraged by their partners who think that women always want to police them.

According to (Van Dyk, 2001:410) all people have the right to insist that they or their sexual partners take appropriate precautionary measures to prevent the transmission of HIV. The especially vulnerable position of women in this regard should be recognized and addressed, as should the position of youth and children.

Van Dyk (2001:119) says that procreation is therefore one way of ensuring that a person's personal immortality is not destroyed. Mbiti (1969) as quoted by Van Dyk (2001:119) postulates that the failure to bear children is for an African woman worse than committing genocide. She

has not only become a dead end for the family's genealogical line but she has also failed to perpetuate her own self through her children. When she dies, nobody of her own immediate blood will be there to remember her and keep her in the state of personal immortality. She will simply be forgotten. The Shona ethnic group in rural Zimbabwe on the other hand believe that those who die childless cannot be accepted into the spirit world of the ancestors and they are doomed to wander the earth as evil, aggrieved or haunted spirits (Scott & Mercer, 1994 in Van Dyk, 2001:120).

According to Giddens (1990:181) many women face domestic violence directly or indirectly. Domestic violence has to do with the way males use their superior social or physical power against women. He says that the home is often idealized as a heaven of security and happiness, but domestic violence is part of the experience of many women. Rossetti and Davies (1999) state that domestic or spousal violence is another factor that puts women in vulnerable positions. They say that domestic or spousal violence is believed to be the most frequent form of violence suffered by women in Botswana.

In the recent women's Affairs Survey 37% of interviewees had suffered a severe beating 1-5 times in 1998 at the hands of their male partners. The survey points out that traditional culture is often cited as the cause and excuse for battering and some men feel they have the right to "chastise" their wives if the latter break with tradition. This can include questioning the man's movements or his relationship with other women, neglecting housework or talking back. Monica Tabengwa, director of Metlhaetsile Women's Information Center says that most women expect to be battered and most men consider it their duty to batter their spouses (Rossetti & Davies, 1999). Women have come to believe violence is a natural part of a relationship between men and women, an indication of passion (Rossetti & Davies, 1999).

According to Rossetti and Davies (1999) the Batawana paramount chief, Kgosi Tawana 11, also said that "when does chastisement turn to abuse". A little slap here and a little slap there to put the wife in line is seen as acceptable as she is like your own child. There is acceptance that this happens in a marriage in Maun. Violence against women is attributed to the break up of the traditional extended family, a rapidly changing society and the loss culture and traditional values. The belief that it is okay for men to beat their wives as they are like children who need

to be put in the right direction, was confirmed by a study conducted to assist Rape Crisis Centre to meet the needs of survivors of abuse (Rossetti & Davies, 1999).

It is evident from this discussion that women are at risk for HIV infection because of their status in society. According to Van Dyk (2001:150) women need to be empowered with life skills to be more assertive and self efficient in sexual matters. Women should believe in their ability and right to make their own choices to insist on condom use and to say no sex.

4.11.3. The impact of men sexuality on HIV/AIDS in Botswana

Adupa (1999) states that men in sexual matters usually dominate women in Botswana. Thus regardless of the sero status of a husband, which the wife may not know anyway, failure to provide sex to the spouse, may earn the wife a divorce. Besides, having multiple sexual partners seems to be universally and culturally accepted/tolerated for men.

The issue of smaller wives/houses is an open secret and the joy of most men who claim that sex with girls or relatively younger women help cleanse and purify their blood. Although this is not tolerated for women the latter are also now insidiously developing these sex networks.

In Botswana it is accepted by the society at large that men's sexual networks can be quiet extensive. There is a feeling that men may legitimately have multiple relationships irrespective of their marital status but women may not (Adupa, 1999). This attitude is justified on the basis of culture. It is believed that men are biologically different from women in their need for sex and as such should have unlimited sexual freedom while a woman is expected to have only one partner. This situation is mirrored in the Kweneng West Sub-district. Women are also treated as minors and socially inferior (UNDP, 1999).

Although most of these practices are no longer predominant, they have gradually taken milder forms, which nonetheless epitomise tolerance of men's extra marital relations. The Setswana saying of "mapako a monna ga a balwe" still holds this means. For example polygamy has taken the milder form of those who migrate to towns cohabiting with other women who may or

may not be known to the family and "Nkadzana" concept has degenerated into child abuse. In essence the belief and understanding that it is culturally correct to have multiple partners may provide some explanations regarding why there is a high incidence of HIV infection in the district. Such beliefs have been transmitted to the youth through the process of socialisation.

Even though men talk about sex, they only talk about it in ways that make them out to be macho individuals with no display of emotions. They do not openly discuss their deepest sexual thoughts, fantasies and secrets. When they do talk about sex, it is often in a joking superficial manner (AIDS/STD Unit, 1998).

5. Economic impact of HIV/AIDS in Botswana

Through the impact on the labour force, households and enterprises, HIV/AIDS can act as a significant brake on economic growth and development (UNAIDS, 2002:56). They also say that more recent calculations have suggested that the rate of economic growth has fallen by 2-4 % in sub-Saharan Africa as a result of AIDS. The nationally focused studies had forecast that by 2015, the economies of Botswana would grow by 2.5% points less than they would have in the absence of the epidemic.

As is the case with many diseases, poverty makes AIDS worse but it does not cause AIDS. HIV must be present for AIDS to occur. Poverty places people at greater risk of acquiring HIV. Poverty and unemployment may lead women to engage in sex work and increase relationships of dependency, making women vulnerable to coercive sex. Single sex hostels, migrant labour, limited health and recreational facilities and lack of access to information all contribute to the spread of AIDS. People who are HIV positive and poor may not be able to eat well. This may make the person weak and can contribute to the person becoming sick with AIDS. Poor people with HIV usually do not have access to the adequate health-care resources necessary for staying healthy longer. The observation that there is no direct causal relationship between poverty and AIDS is also documented in Soul City (Soul City-Know the Facts, 2002).

Contrary to a popular belief, poverty is one of the major problems in Botswana (The Second Medium Plan, 1997-2002). Female-headed households form the majority of households living in poverty. The 1991 census data shows that 47% of the households in Botswana are female headed and 52% of these are in rural area (The Second Medium Plan, 1997-2002). The level

of poverty is likely to make most people especially women and those in the rural area vulnerable to HIV infection and less able to respond effectively to the consequences related to illiteracy; unemployment and gender inequalities, which are predisposing factors to HIV infection in Botswana.

The income gap between the poorest and richest members of society in Botswana is also high. The poorest 40% of the population get only 11.6% whilst the richest 20% get 59% of the income (The Second Medium Plan, 1997-2002). The unemployment rate in Botswana was estimated at 21% in 1993. Data also showed that unemployment is concentrated among the secondary school leavers' youth. The data also suggested that the current level of unemployment is likely to intensify the poverty profile in Botswana (Adupa, 1999).

Poor families, according to Poku (2001:196) have reduced capacity to deal with the effects of morbidity and mortality than do richer ones for very obvious reasons that include the following:

- Absence of savings and other assets that can cushion the impact of illness and death.
- Cost of drugs to treat opportunistic infections
- Transport costs to health centers
- Losses of employment through illness and job discrimination
- Funeral costs

As a result, a true process of immiseration is now observable in many parts of Africa, particularly Southern Africa.

Mr. Alpheus Matlhaku, the Deputy Permanent Secretary, in the office of the President, during the official opening of the workshop called Consultative meeting on HIV/AIDS and Disciplined forces for policy makers held in June 1997, said that with a far reaching epidemic illness such as AIDS, the collective effect of many individuals falling ill is likely to have a major impact in any sector specifically the disciplined forces will be affected by staffs who are ill due to AIDS related problems and who will be less productive on the job and have greater absence due to illness. Healthy staff is also likely to increase absence due to attendance at funerals and the need to care for those who are ill (UNDP & Ministry of Health, 1997).

As those dying are usually in their most productive years, many schools, hospitals, private industries and civil services are short staffed. In the private sector, AIDS related costs including those connected to absenteeism from work, insurance, and the recruitment and retaining of replacement workers are estimated to consume as much as one fifth of all profits (UNICEF, 1999).

The Second Medium Term Plan (1997-2002) points out that the epidemic is expected to drive poorer households into deeper poverty. This is expected to result from loss of income support as the young sexually and economically active die. Households are expected to face financial burdens from health bills as they continue to seek treatment for prolonged HIV opportunistic infections. Few surveys of the impact of having a family member with AIDS show that households suffer a dramatic decrease in income (UNAIDS, 2000). Decreased income inevitably means fewer purchases and diminishing savings (UNAIDS, 2000).

The surveys also indicated that the household might be affected by HIV/AIDS in the following ways:

1. Loss of income, if a breadwinner stops work due o sickness or death (this is a permanent impact).
2. Loss of income, if a breadwinner has to stop working to look after a sick family member (this is a temporary or transient impact.
3. Additional expenditure, on health care and eventually funeral costs (again a transient Impact).

Supporting HIV/AIDS prevention programmes, therefore makes good economic sense. Health care provision is also a good investment since it limits or prevents sickness and absenteeism (UNAIDS, 2002:55).

6. HIV/AIDS and health issues in Botswana

As HIV infection progresses to AIDS, there is an increase in total hospitalisation related to HIV/AIDS (UNAIDS, 2002:55).

Statistics from the two national referral hospitals of Nyagabongwe in Francistown and Princess Marina in Gaborone show that patients with HIV occupy over 50% of hospital beds in the medical and pediatric wards related illnesses. In Princess Marina, statistics from the adult

medical ward (male, female and private) show that, there was 640 patients with HIV related illness between January 1995 to May 1996. The records show that 33% of these patients died during this period. Paediatric wards are also experiencing increasing caseload of HIV related illness. Paediatric AIDS is expected to rise as adult HIV infection increases (The Second Medium Plan, 1997-2002).

The emergence of community rooted home based care initiatives often organized by people living with HIV/AIDS have become one of the outstanding features of the epidemic and a key coping mechanism for mitigating impact (UNAIDS, 2002:51). The community home based care will be discussed later in this chapter. The following section will focus on the relationship between HIV/AIDS and Tuberculosis and Sexually Transmitted Diseases.

6.1. Relationship between HIV/AIDS and tuberculosis (TB) in Botswana

There are important links between AIDS and tuberculosis (TB) according to Evian (2000: 233). He says that HIV infection increases the risk of developing active TB. He further mentions that TB is the most common, serious and life threatening opportunistic infection in people with HIV/AIDS in Africa and other developing countries. Since the beginning of HIV/AIDS epidemic there has been a steady increase in the number of new TB cases. The TB epidemic has shown a parallel rise. In some countries the TB epidemic has doubled and even trebled in size and the fears are the situation will get worse. Coker and Miller (1997), UNAIDS (2000) as quoted by Van Dyk (2002: 43) agree with Evian (2000:233) that approximately 50% and 60% of people with HIV infection will develop active TB disease at some stage of their disease.

In Botswana, it is estimated that HIV and TB co-infection is high. Data on 40 sputum patients in Francistown showed an HIV co-infection rate of 67% (The Second Medium Plan, 1997-2002). A similar study was conducted in Hlabisa, in Kwazulu-Natal. The study shown that together with a steep rise in HIV infections, the number of people admitted to hospital with TB rose by 36% between 1992 and 1998 (The Second Medium Plan, 1997-2002). Similar studies with similar results on the link between HIV and AIDS have been conducted in Tanzania, Malawi, Rwanda, Ivory Coast and DRC (Soul City- Know the Facts, 2002).

6.2. Relationship between HIV/AIDS and sexually transmitted infections (STIs) in Botswana

According to Van Dyk (2001:48) sexually transmitted infections (STIs), constitute a major public health problem in Southern Africa. It has been estimated that more than 1 million patients seek treatment for STDs every year at municipal clinics and in private practice alone.

There is a close relationship and association between common sexually transmitted diseases (STDs) and HIV/AIDS. According to Evian (2000:251) and Van Dyk (2001:48) STDs enhance the transmission and spread of HIV. Evian and Van Dyk say that STDs cause inflammation and HIV is naturally attracted to the immune cells of the body. Many of these cells have specific receptors on their surface and HIV is able to attach to these surfaces to gain entry into the cells. STDs also cause genital inflammation, with a migration of many millions of inflammatory cells to the site of infection. HIV can find these receptors easily. STDs especially genital ulcers/sores make it easier for HIV to enter the body through the above process. STDs also disrupt the natural surfaces and linings of the genital tract. This also increase the likelihood of HIV successfully entering and leaving the body during sexual contact. HIV is spread in the genital discharges and secretions and therefore if a person has HIV infection and an STD, then he/she will shed many HIV viruses in the discharge and infect others more easily.

In 1994, the HIV sentinel surveillance investigated the HIV sero prevalence rate among pregnant women and male patients with sexually transmitted diseases in Botswana (AIDS/STD Unit - NACP 25,1994). The survey was conducted in six selected areas of the country from February to April 1994. The main conclusion from she study was: Younger women < 30 yrs are both more often pregnant and has a higher HIV infection rate than women above the age of 30. Three out of four pregnancies and 85% of HIV infected cases in this survey were found among women below the age of 30. In this survey between 15% and 30% of pregnant women tested at six different sites and between 25% and more than 50% of men with STD's tested at four different sites were found to be HIV positive.

Sexually transmitted diseases (STDs) are both risk and co-factors in HIV infection. STDs are biological evidence of unprotected sex. Biologically, the transmission of most STDs is more efficient from men to women than the converse. The consequences of STDs are more serious for women because most of them may remain asymptomatic for sometime, making them more

vulnerable to HIV infection. STDs are a major public health problem especially amongst the youth in Botswana (The Second Medium Plan, 1997-2002).

The 1994 KAPB study shows that 32.5% of sexually active male respondents in Francistown reported having had sores or discharge in the last 12 months, followed by Maun with 31%, Tutume with 30.7% and Mahalapye with 20%. Control of STDs will therefore be a key activity in the prevention of HIV transmission (The Second Medium Plan of HIV/AIDS, 1997-2002).

Evian (2000: 251) says that numerous research studies have shown that effective community care for STD diseases can effectively reduce the incidence of HIV in the community. Keeping people free of STDs will also help reduce their vulnerability to getting HIV.

7. Care, prevention and treatment programmes in Botswana

The common commodity among health-related disciplines is care. Care that is acceptable to members of specific groups requires understanding of and respect for life – style, community, and socio-cultural orientations as the context for health promotion, maintenance, and restoration (Bauwens, 1978; Brownlee, 1978; Dougherty, 1985; Leininger 1988b as quoted by Kavanagh & Kennedy, 1992:121). Care and caring involve meanings, patterns, processes, and methods that affect health behavior and that occur in patterns that are specific to cultural and sub cultural groups (Kavanagh & Kennedy, 1992:121).

Van Dyk (2001: 126) argues that no AIDS prevention programmes can success in Africa without the help of traditional healers. Traditional healers are effective agent of change because they have authority in their communities. They function as psychologist, marriage and family counselors, physicians, priests, tribal historians and legal and political advisors. About 80% of people in Africa rely on traditional medicines for many of their health care needs. Traditional healers are well known in the communities where they work for their expertise in treating sexually transmitted diseases, and the World Health Organizations has since the early 90s consequently advocated the inclusion of traditional healers in national AIDS programmes (Van Dyk, 2001: 126).

Van Dyk (2001: 126) further states that positive cultural beliefs and behaviors are values and behaviors, which are known to be beneficial, and they should therefore be encouraged and reinforced.

She also states that the exotic behaviors are traditional Africans customs and behaviors that are unfamiliar and strange to Westerners, but are not harmful to health. These exotic behaviors such as polygamous marriages where all partners are uninfected and faithful to each other, cultural rituals, and ceremonies and herbal remedies, need not be changed and should be respected. Although AIDS educators should take care not to interfere in cultural beliefs and behavior, some traditional behaviors are indeed harmful to people's health and attempts should be made to change these.

Van Dyk (2001:125) says that AIDS educators should be creative and imaginative in incorporating traditional beliefs and healing methods into AIDS education programmes. The African tradition social sharing, rituals, story telling, drama, singing, drumming and dancing should be used to relate the thread of HIV infection to traditional Africans. Community involvement in the planning, implementation and evaluation of AIDS education programmes are also important for the success of such programmes. The essential norms and values, cultural images and language of a community can only be appropriately understood and incorporated with the help of the target community (Compare Airhihenbuwa, 1989; Boahene, 1996; Campell & Kelly, 1995; Scott & Mercer; 1994; Walters, Canady & Stein, 1994 in Van Dyk, 2001:125.)

A number of NGOs and CBOs have taken the lead to support these extended and faster families including Childline Botswana, Botswana Christian AIDS intervention program and Tirisanyo Catholic Mission. These organisations provide services in communities throughout the country, ranging from family counselling and day care for orphans to providing for basic needs such as food clothing and education (UNICEF, 1999).

The Botswana Defence Force: Brigadier Thutwe, Commander of the 2nd Brigade said that in 1996 a comprehensive HIV/AIDS program was finally approved by the high command and put in place. The objective of the program was to achieve 90% awareness level in the BD7 personnel by the year 2002, which will help to make informed decisions. The program is consistent with the National AIDS policy. The program aims at education leading to reduced behavioural risk, adequate treatment for STD and health seeking behaviour, condom use, including access, availability and procurement, continued treatment and care of those living with AIDS, appropriate community home-based care and voluntary testing accompanied by pre and post counselling.

Botswana Police Service also formed an advisory committee on HIV/AIDS co-ordinated by the commandant of the Police College, assisted by a trained focal person members of this committee are from all branches of the police service to ensure maximum participation and information dissemination. The committee works towards sensitising members of the Botswana Police Service about the status of HIV/AIDS in Botswana, minimising the spread of the disease, motivating and promoting co-workers participation in the fight against HIV/AIDS, educating them about the prevailing perceptions and myths in order to reduce the stigma attached to the disease and promoting awareness on the disease within the service using peer educators and co-operating with other organisations working against the spread of HIV/AIDS.

Botswana prisons and rehabilitation department: Mr. Orebotse, the Deputy Commissioner said that immediately on governments announcement of the national policy on HIV/AIDS, the prisons department embarked on HIV/AIDS sensitising exercise for inmates. Prisoners were advised on how to safeguard themselves against HIV/AIDS. Inmates are encouraged and actually supplied with condoms on release to the society. An HIV/AIDS policy for prisons has been formulated (UNDP & Ministry of Health, 1997).

STPA is a national strategy to guide a national response on mitigating problems associated with orphanhood. The problem is now viewed as a national crisis that demands an emergency response in the short term and strategic planning for the long term care of orphans. It helps to identify immediate needs of orphans and articulates a strategy on how stakeholders should respond both individually and collectively. The strategy emphasis a participatory, Decentralised process and a multi-sectoral approach in its implementation (Ministry of Local Government, 1999-2003).

The AIDS/STD unit is one component of the Department of Primary Health care (PHC) services in the Ministry of Health (AIDS/STD Unit, 1994). The AIDS/STD unit's strategy of operations is divided into 5 major areas:

1. Program Management
2. Prevention of sexual transmission, including:
 - I.E.C
 - Condom promotion
 - Control of sexually Transmitted Diseases.
3. Prevention of transmission through blood including:

- Safe blood transfusion services
 - Laboratory support
4. Care of persons with HIV/AIDS including:
- Clinical management of HIV/AIDS
 - Home based care and support
 - Counselling for support of persons living with HIV/AIDS and their families
5. Epidemiological surveillance and different types of research, which provide important background information to facilitate further planning, advocacy for AIDS prevention and to monitor the impact of the epidemic. The AIDS/STD UNIT is made up of the following sub-units:
- Information, education and communication (IEC)
 - Counselling
 - Sexually Transmitted Diseases

The institutional framework for the HIV/AIDS response in the Town of Lobatse is spear headed on the governmental side by the Lobatse District Multi-Sectoral AIDS Committee (LDMAC) NGO's like population services International has been the most active and CBO's like Botswana Family Welfare Association (BOFWA) are the most active. Religious organisations are Lobatse Christian AIDS Committee (LOCAC), Lobatse Methodist Church and the Seventh Day Adventist Church (Hope, et al., 1999 b).

In Kweneng West, a Sub-district Multi-sectoral AIDS Committee (SDMAC) was established in February 1998.

There is Ministry of local government AIDS advisory Committee (MOLGAAC) at district level, there is a District Multi-sectoral Child Welfare Advisory Committee (United Nations Development Programme, 1999).

At village level, there are village AIDS Committees. The members are local councilor, Kgosi, Health, Education and VDC Botswana Christian Aids Intervention Program is implementing the girl child project (BOCAIP). The project is being implemented in Northwest Botswana Maun and Sehitwa and Gaborone. The Maun counseling Center is implementing the program in Maun and Nazarene Church in Gaborone. The project equips at least 50 girls with life skills and understanding that will empower young people to make responsible choices and develop

into responsible adults (Botswana Christian AIDS Intervention Programme. Mid-term Report, No.23,[Sa]).

The department of Women's Affairs is divided into North and South Regional Offices. It is planning two stations in Ghanzi and Francistown. The department is the implementing agency for the National Gender Program through which it directly funds women's groups working in HIV/AIDS (Ministry of Labour and Home Affairs, 2000).

The Ministry of Health launched the peer education HIV/AIDS prevention program at the workplace in Botswana in 1991. It was implemented within the Botswana Business Community and has now expanded extensively to the parastatal and government sectors. The program has been quiet successful in the key area of improving knowledge, attitudes, and practices related to risky behaviour. For example the peers said that the program had made them more sensitive to the plight of those with HIV/AIDS. They were becoming aware of fellow workers contracting or dying from HIV/AIDS. The experience made them even more determined to protect them from infection. The program also had led them to reduce the number of their partners (Hope, et al., 1999 c).

Health care service is provided by both the central government (Ministry of Health) and Ngamiland District Health Department Nyangagbwe and is used as a referral hospital. There is a primary hospital called Gumare Primary hospital and district hospital called Maun General hospital. Active NGOs in Ngamiland addressing the HIV/AIDS epidemic are BOFWA, PACT, BOCAIP and WAR (Ngamiland & Comprehensive District Plan, 1999).

According to UNAIDS (2002: 132) in 1999 Botswana became the first country in Africa to start an integrated VCT/MTCT programme using zidovudine for pregnant women testing positive in antenatal clinics. The programme was only introduced first in Gaborone and Francistown. By 2001; the programme had been implemented in all 24 of Botswana's health districts.

7.1. Community home- based care in Botswana

According to Wilson, et al. (2002:45) and Van Dyk (2001:327) the aims of the community home- based care is to provide a framework for care by drawing in, and strengthening, existing community based care initiatives, incorporating the formal and private health sector with non-

governmental organizations (NGOs), and linking palliative community home-based care to prevention and treatment.

In Botswana, like in other countries in sub-Saharan Africa, projects are usually NGO or church led, caring for anything from 10 to 100 patients. Care could include the medical, nursing, social, educational and spiritual aspects (Wilson, et. al., 2002:399).

Frohlich (1999) as quoted by Van Dyk (2001: 327) postulates that community home-based care is the care given to individuals in their own homes where their families, their extended families or those of their choice, support them. A multidisciplinary team and complementary caregivers who are able to meet the specific needs of the individual and family support these home-based caregivers. The team consists of all the people who are involved in care and support and may include a medical practitioner, nursing supervisor, social worker, health educator, physiotherapist, occupational therapist, AIDS health promotion workers, volunteers, traditional healers, religious healers and religious leaders.

A study commissioned by the AIDS/STD Unit, (NACP31) was conducted to monitor and evaluate a Home Based Care Programme for HIV/AIDS and other terminally ill patients. A pretest-posttest experimental design was used.

The objectives of the study were:

- 1.To determine health seeking behavior patterns and their determinants for the chronically ill.
- 2.To determine household capacity to care for the persons with HIV/AIDS in their homes
- 3.To determine the social welfare systems capacity to care for persons with HIV/AIDS in their homes.
- 4.To determine factors influencing the quality of care at the household level.
- 5.To assess referral patterns at various levels.
- 6.To make appropriate recommendations to Government concerning the home based care package for the terminally ill.

The study revealed that unemployment rates are high amongst the heads of households with most households being female headed. Low levels of education and dependency rates further accentuate the high economic vulnerability. The low levels of education imply limited access to

information on AIDS by this category. The quality of inputs used by HBC is inadequate and they attribute this to the households' inability to afford these inputs. The study also established that basic inputs such as draw sheets, and gloves are currently not readily available to households with AIDS patients.

The health personnel feel that the quality of care at home is inadequate. They attribute this to the inadequacy of direct inputs, lack of education, and too much confidentiality about the disease, which limits the caretaker's ability to care for their patients.

The study also revealed that clinics and hospitals are by far the most important source of health care in Botswana. Data from household's health seeking patterns indicate that the clinics are more utilised than hospitals while AIDS patients seem to use hospitals more than clinics. Traditional doctors and spiritual healers feature more in the health seeking patterns of AIDS patients than non-HIV members of households. This source of health care is used relatively less at the post-diagnosis stage than at the pre-diagnosis stage. AIDS patients try different health systems in an effort to understand the nature of their illness. The fact that most patients prefer to be cared for at home in spite of poor economic conditions and inadequate inputs signifies the importance of the emotional effects HBC programmes. The study established that the emotional and counselling needs of the patients have been completely left to pre-and post counselling. There is very little follow-up counselling done by health centres.

A similar study was conducted in Tutume and Molepolole to evaluate the Home Based Care Pilot project in 1998. At both Molepolole and Tutume, the participants (clients, are givers, family welfare educators, nurses and senior administrative staff) expressed enthusiasm to continue with HBC despite the reported hardships they were going through. A large number of participants indicated that they should recommend HBC to a friend or for themselves. In Molepolole transportation was reported to be a problem. However they did indicate that they received adequate emotional support before discharge to HBC (AIDS/STD Unit- NACP 41,1998).

The Declaration of Commitment is a historic landmark in the fight against HIV/AIDS. All the world's governments specifically recognized treatment and care including access to antiretroviral drugs as an essential element of the response to the global HIV/AIDS pandemic.

It is evident from the above discussion that Botswana has put programmes in place to fight this pandemic (UNAIDS, 2002:143).

8. Summary

HIV/AIDS in Botswana seems to be serious problem. The HIV infection rates are very high especially amongst women. The impact of HIV/AIDS seems to be mostly felt by the children who are left as orphans. The attitudes and behaviour of the Batswana's also seem to be contributing to the spread of HIV/AIDS. The use of condoms, which seems to be one way of reducing the transmission of HIV/AIDS in Botswana, seems to be a problem especially regarding accessibility to the teenagers who seem to be at high risk.

Given the uniquely devastating impact of HIV/AIDS on the entire Botswana households, communities and entire societies, national policies and poverty reduction strategies need to be adjusted and expanded accordingly. The strategies to combat the spread are already in place in Botswana and need to be strengthened and expanded. Unless this happens, AIDS will continue to erode human development achievements, deepen poverty and further hinder access to education, health and viable livelihoods (UNAIDS, 2002:59).

In order to assist the country to fight this pandemic, we need to identify all factors that have not been confirmed scientifically that could influence the spread of HIV. Therefore the purpose of this study is to find out if the cultural practices of the Batswana do have an influence in the spread of HIV infection. The next chapter will present the empirical findings of the investigation. The chapter will reveal whether the cultural practices of the Batswana do have an influence in the spread of HIV infection.

Chapter 5

Empirical Research Findings

1. Introduction

In Botswana, at least one in four adults are infected with HIV. Estimates in Botswana also show that between 20% and 26% of people aged 15- 49 years are living with HIV/AIDS (Botswana HIV Sero – prevalence & STD Syndrome Sentinel Survey, 2000: 3). As already mentioned in chapter one the Botswana HIV and STD Sentinel Survey (2000:12) reports that the National HIV prevalence in Botswana in the year 2000 was 38.5% as compared to 35.88% in 1999. There was a definite increase of HIV infections in the country.

The death rate in the country and the increase in the number of HIV infection are of concern to the Botswana government. Government Organizations and NGO'S are joining hands in the fight to reduce the rate of HIV infection and they expressed a need to conduct further investigations to find out what causes the HIV infection in especially high prevalent areas so that appropriate strategies to combat the infection can be put in place.

The goal of this research study was therefore:

To establish the influence of cultural practices of the Batswana on the transmission of HIV/AIDS in Botswana.

In order to achieve the goal the following objectives were formulated:

- To conduct the investigation within a theoretical based framework by conducting literature review on HIV/AIDS as a social phenomenon, culture, and cultural practices in general and the culture of Batswana specifically.
- To explore through an empirical study, the nature and prevalence of cultural practices of Batswana in relation to the transmission of HIV/AIDS in Botswana.
- To provide conclusions regarding the cultural practices of the Batswana in relation to the transmission of HIV/AIDS in Botswana.
- To make recommendations for culturally appropriate behaviour - change strategies for Batswana in Botswana in an attempt to decrease the spread of HIV/AIDS.

According to these goals and objectives, the following research questions guided the study:

- What are the current nature and prevalence of cultural practices of the Batswana in relation to the transmission of HIV/AIDS in Botswana?
- To what extents do these cultural practices contribute to the spread of HIV/AIDS?
- What can be done to prevent the problem of HIV/AIDS in relation with cultural practices of Batswana people in Botswana?

In order to address these research questions, the researcher has conducted an exploratory research study with the purpose of exploring a new area of interest namely the cultural practices of the Batswana and to find out if there is any relationship between HIV/AIDS and the cultural practices of the Batswana.

By conducting this study the researcher tried to develop solutions regarding a specific social problem and therefore applied research was appropriate (De Vos, Schurink & Strydom, 1998:8). The understanding of cultural practices of the Batswana in relation to the transmission of HIV/AIDS in Botswana will assist the Government and NGOs to design and develop cultural appropriate behavior change strategies, which can help to prevent HIV/AIDS in practice.

This research study utilized the combined quantitative and qualitative research approach according to one of Cresswell's three models of combination, which is the dominant- less-dominant model (De Vos, 2002:366). In this study, the researcher engaged in quantitative survey using a structured interview schedule with a random sample of individuals as well as qualitative focus groups. The quantitative approach represented the dominant paradigm and the qualitative focus group interviews represented the less dominant paradigm. The qualitative focus group discussions supplemented the quantitative structured interviews. The structured interview schedule included open and closed-ended questions regarding the respondent's knowledge about HIV/AIDS, cultural practices and their influence on HIV/AIDS.

In the previous chapters the phenomenon of HIV/AIDS was explored. Chapter 1 introduced the general focus of the study and identification of the research problem. The research problem was formally stated. The chapter also explained the research methodological framework on which this study was structured and dedicated a section on the method of data collection. Chapter 2 as part of the literature study focused on all the relevant issues regarding HIV/AIDS and Chapter 3 looked at culture and cultural practices in general. Chapter 4 concluded the literature study by focusing on the cultural practices of the Batswana in relation to HIV/AIDS. The researcher has utilised all these information gathered in these first four chapters to develop a structured interview schedule and focus group guide.

In this chapter, the results of the empirical study will be presented according to both the qualitative and quantitative data collected through focus group interviewing and structured face-to-face interviewing with a schedule. The chapter will first describe the appropriate research methodology and then present the qualitative results and then the quantitative data.

2. Research methods

This section will describe the study population and sample used in both the qualitative and quantitative methods of collecting data. The data collection procedures, including the pilot study results, will also be presented.

2.1. The study population

The study population consisted of all the people in the major urban areas of Botswana, which included Francistown, Gaborone and Selibe Phikwe as well as the rural areas Sebina, Gabane and Sefophe. There were thus six study sites, which include both these rural and urban areas.

2.2. The sample and sampling technique

The researcher selected from the study population two sample groups namely one group of respondents for face- to- face structured interviewing and another group of respondents for focus group interviewing.

2.2.1. Respondents – structured Interviews

Sixty -six (66) respondents were randomly selected for the structured interviews. Forty- two of the respondents were from the urban areas and 24 from the rural areas. They were all residents of Botswana and came from different ethnic groups. They all spoke Setswana. The parameters for interviewing were intended to include a broad spectrum of the Botswana population by age, residence (rural v/s urban), marital status, gender and ability to provide useful information. (Detail biographical information regarding the sample is given in Part 2 of the empirical results in this chapter.)

The sampling technique used in this study was the multi-stage cluster random sampling scheme. Arkava (1983:161) describes the multistage cluster sampling method as a process of successive random samples from units.

Before collecting data, the researcher wrote letters to the chiefs of the identified study sites to introduce the study and herself and also inform them about the dates of the protocol visits (Appendix 2). During the protocol visits, the researcher met with relevant local leaders in villages where the research was conducted to obtain permission from the community leaders such as chiefs to conduct the research. The researcher worked with village leaders to conduct enumeration and sampling for the key participant interviews and focus groups as well as to

introduce the researcher and the research project to them. The chiefs assisted in the listing of villages and wards.

In the rural areas two villages were randomly sampled from each of the three rural study sites namely Sebina, Gabane and Sefophe. The names of all the villages in a study site were written down and were put in a hat. The first two to be picked up were included in the sample.

The same procedure was used for the wards. A list of the wards in the selected villages was compiled and two wards were then randomly sampled from each village. The first two names that were picked up were included in the sample. The numbers of the households in the selected wards were also compiled and the first two house numbers that were picked up, were the households included in the sample. Thus two households were randomly selected from each ward. One respondent was then randomly sampled from all adults (aged 18 and above) in each household. This sampling scheme resulted in the selection of 8 individuals per study site.

In total 24 respondents were randomly selected in the rural areas.

In the urban areas the sampling procedure was as follows:

In Gaborone, all four major sections areas were involved because of the diversity of the population in Gaborone namely Central, West, North, and South. The same sampling procedures used in the rural areas was used in Gaborone. Three wards were randomly sampled from each section. Two households were then randomly selected from each ward. One respondent was randomly sampled from all adults (aged 18 and above) in each household. This resulted in a selection of 24 individuals.

Francistown was divided into two sections (East and West). Both areas were included. The same sampling procedures used in the rural areas was used. Three wards were randomly sampled from each section. Two households were randomly sampled from each ward. One respondent was randomly sampled from all adults (aged 18 and above) in the household. This resulted in a selection of 12 individuals.

In Selibe-Phikwe, the same sampling procedures used in the rural areas was also used. Three wards were randomly sampled and then two households were randomly sampled from each ward. One respondent was randomly sampled from all adults (aged 18 and above) in the household. This resulted in a selection of 6 individuals. **In total 42 respondents were randomly selected in the urban areas.**

2.2.2. Respondents- focus groups

Focus groups should be comprised of persons who are similar to each other. The focus groups consisted of adults (people aged 18 and above). Focus groups were conducted separately with men and women. For cost effectiveness and time factor, the researcher conducted a focus group in each of the same 6 study sites as identified for structured interviewing. The sample of the focus groups was representative as these sites also represent the population of Botswana. The study sites included rural and urban areas. Therefore the researcher had a total of 6 focus groups across the country. The names of the study sites where the structured interviews were conducted were compiled and put in a hat. Then the researcher also compiled a list of the two focus groups categories (men and women) and picked up the first one and matches it with the first study site that was picked up. The same procedure was done for the second focus group. Each site had thus one category of focus group namely either a female adult or a male adult group. Each group had a minimum of six people. The number of group members per focus group ranged between 6 and 10 members. (Detail biographical information regarding the sample is given in Part 1 of the empirical results in this chapter.) **The total number of respondents who participated in the focus group discussions was 48.**

The sampling procedure used to select the areas where the focus groups were conducted and the categories of the focus groups (males and females) was a random sampling procedure. The researcher compiled a list of the major urban and rural areas for the study and also compiled a list of three male and three female groups. The list was cut down so that the researcher had six pieces of papers namely three female groups and three male groups. The researcher had two separate hats. One hat had names of areas and one had the categories of the groups. The researcher picked up the first piece of paper in one hat and again in the other hat and matched the category of the group with the rural or urban area, which was also picked up. The procedure was done six times and the researcher ended up with six areas matched with the six focus groups.

The sampling procedure to select the members of the focus groups was a combination of purposive sampling and availability sampling.

Purposive sampling according to Singleton, et al. (1988) as quoted by Strydom and De Vos (1998:198) and Strydom and Venter (2002:207) is based entirely on the judgment of the researcher in that the sample is composed of elements, which contain the most characteristics

representative or typical attributes of the population. In this study, the focus group participants should be over 18 years and definitely males and females.

According to Bailey (1994), Collins (1990), Gabor (1993) and Nachmias and Nachmias (1981:430) as quoted by Strydom and De Vos (1998: 198) and Strydom and Venter (2002:207) the respondents in availability sampling are usually those who are nearest and most easily available. Judd, Smith and Kidder (1991) as quoted by Strydom and De Vos (1998: 198) add that the researchers simply reach out and take the cases that are at hand continuing the process until the sample reaches a designated size. The members were selected through community leaders. The community leaders assisted the researcher in organizing the focus group venues. The researcher asked people in the households and those who were met on the streets if they would like to participate in the focus group discussions. The researcher approached the members before the group to ask for their permission to be included in the group.

Two research assistants from Botswana who had experience in conducting research interviews including focus group interviews were trained by the researcher assisted the researcher to operate the tape recorder.

The researcher did not use the research assistants to conduct the focus group. Their role was more on assisting with the recording of the focus group process which permission was asked from the members to do so. The researcher conducted the focus group interviews in Setswana although the questions were written in English.

2.3. Data collection methods

The data collection methods included focus group interviews and structured interviews with a schedule. The following two sections will describe the two methods of data collection.

2.3. 1. Structured interview with a schedule

The structured interview schedule included open and closed-ended questions. According to Bless and Higson-Smith (1995:107) the structured interview schedule is based on an established questionnaire which is a set of questions with fixed wording and sequence of

presentation as well as more or less precise indications of how to answer each question. (The structured interview schedule is included as Appendix 3). The responses were recorded by a coding scheme that had been established by the researcher with the assistance of the Medical Research Council in Cape Town and Centre for Disease Control in Botswana and Aid for AIDS, Medscheme- Cape Town.

The researcher developed the structured interview schedule utilising all the information gathered in the first four chapters of this report and it was comprised of fourteen sections that include: the demographic information of the participants, knowledge about HIV/AIDS, cultural practices, HIV/AIDS prevention strategies, polygamy, sexual practices, agricultural practices, stigma issues, cultural taboos, marriage, alcohol use, religious beliefs, condom use and voluntary counselling and testing. In total 87 questions were involved. The final approval of the Ethical Committee of the Faculty of Humanities at the University of Pretoria and the Research Unit of The Ministry of Health, Botswana and the Office of the President, Botswana (Appendix 1) was received before the study could commence.

The researcher used research assistants who were Setswana speaking people and who had experience in conducting HIV/AIDS related interviews to assist in the conducting of the interviews using the interview schedule. The researcher trained the research assistants on how to conduct the interviews and introduced them to the study. Therefore the matching of the interviewers and interviewees was achieved as the interviewers and the interviewees both spoke Setswana.

2.3.2. Focus group interview

According to Schurink, Schurink and Poggenpoel (1998:314) a focus group interview is a purposive discussion of a specific topic or related topics taking place between eight to ten individuals with a similar background and common interest. The researcher was guided by all the information gathered in the first four chapters of this report, the purpose of the study and the interview schedule in the development of the focus group guide. Critical questions that captured the intent of the study were identified. The concepts discussed were broad and were limited to five topics.

The focus group guide therefore consisted of 5 sections, which included knowledge about HIV/AIDS, cultural practices, sexual practices, HIV/AIDS prevention and care strategies and voluntary counselling and testing. (See Appendix 4).

The focus group guide consisted of open-ended questions. The questions were ordered from the more general to the more specific and the questions with the greatest significance were placed in the beginning and those with lesser significance were placed at the end (Stewart & Shamdasani in Schurink, et al., 2000:318).

Bailey (1994:175) talks about interviewer bias in which the interviewer may misunderstand the respondent's answer or the respondent's answers can be affected by his or her reaction to the interviewer's sex, race, social class, age, dress or accent. In this research project language was a very important element to avoid bias. As the researcher also speaks Setswana, the focus group interviews were conducted in Setswana. The researcher conducted the focus groups herself. The focus group interviews were tape-recorded and notes were taken during the discussions.

The focus group guide was approved by the Ethical Committee of the Faculty of Humanities at the University of Pretoria and the Research Unit of The Ministry of Health, Botswana and the Office of the President, Botswana (Appendix 1).

2.4. Pilot testing of structured interview schedule and focus group questions

2.4.1. Structured interview schedule

After the approval of the structured interview schedule by the ethical committee and the government of Botswana, a pilot study was conducted with 5 respondents who were not part of the main study. Three respondents were interviewed from Gaborone (urban area) and 2 from Gabane (rural area). The respondents had no problems answering the questions. The interviews were conducted in Setswana.

The following questions were however adjusted before the formal empirical study commenced:

- Not Applicable was added as a variable to Question 6.
- Question 74 had to be rephrased as it had two questions in one. The question was changed to: Do you believe that HIV/AIDS is punishment from God? Instead of: Do you believe that HIV/AIDS is sexually transmitted or is it punishment from God?

See Appendix 3 (Structured interview schedule)

2.4.2. Pilot study for the focus groups

For the focus group, one male adult group with six people was gathered to pilot the focus group schedule in Gabane (rural area). Permission to conduct the focus group was requested from the chief and the focus group members. The focus group discussion lasted for an hour. A rural area was chosen because it is where you have people still practicing, respecting and understanding culture. The focus group discussion was held in Setswana although the questions were in English. The focus group members and the researcher had no problems with the questions asked and the responses given. The pilot study showed that the questions asked in Setswana reflected the questions written in English. The way the researcher asked the questions and the respondents responded, reflected that the focus group guide was reliable and valid.

2.5. Ethical procedures

In this study, the key participants were asked to be part of the research project by asking them to give consent to be interviewed (See Appendix 6). The interviewer asked the respondent to give a written consent for those who can write. They were asked to sign or put a cross and most of them could sign. Verbal consents were given first and then the cross in the place of the signature. The consent was only given after the purpose and procedures of the research had been explained according to the letters of informed consent.

The respondents were informed about how the information will be used and with whom it will be shared. Anonymity on the questionnaires was ensured. Respondent's names were not used at all. Independent ID numbers were allocated to the respondents with no meaning attached to.

The ID numbers were used only to serve the purpose of knowing how many people have been interviewed. The individual responses were used only as a key to generalizing the results. The respondents were also asked if tape recorders could be used during the focus groups. Only when the focus group participants granted permission, the tapes were used.

The researcher introduced herself to the respondents and focus group members. Her national, ethnic and professional identity was revealed at all times when there was a need.

There was no bias and insensitivity regarding culture. Although the researcher is a South African, she speaks Setswana and is of Setswana origin. The researcher was able to identify with the Batswana culture.

The research assistants are also Batswana's and originate from Botswana. They all speak Setswana and are familiar with the sites and culture in Botswana.

2.6. Data analysis and interpretation

2.6.1. Quantitative data

Quantitative data was analyzed by computer (De Vos and Fouché, 1998:203). In this study, the data collected by using structured interview schedule was analyzed through a computer-based program namely the Excel.

2.6.2. Qualitative data

The analysis technique for the focus groups was primarily text analysis. The data was first analyzed in the language in which the interviews were conducted namely Setswana. Transcripts were written first in Setswana and then translated into English.

The researcher went through the transcripts to get a sense of the whole. The researcher continued to jot down ideas as they came to mind while writing thoughts in the margin and identifying the major categories. The themes were put into major categories while at the same time identifying subcategories within major categories. The researcher also identified relationships between major and subcategories.

An independent coder who had experience in qualitative research from the Medical Research Council in Cape Town was asked to do open coding. According to Grinnell (1993: 271) open coding is part of analysis that pertains specifically to the naming and categorizing of phenomena through close examination of data. Thereafter, consensus discussions were held on the themes and categories by the researcher and the independent coder. The results were translated into English after the consensus (Poggenpoel, 1998: 345).

In the following sections, the quantitative data will be graphically displayed and the qualitative data will be described and discussed according to the open questions answered by the respondents as well as the focus group discussions. The researcher will present the qualitative data first as Part 1 and then the quantitative results as Part 2 as the qualitative data will be used to support the quantitative results.

3. Empirical results

3.1. Part 1: Qualitative data through focus group discussions

3.1.1. Introduction

The focus group guide consisted of 5 sections namely:(See appendix 4)

- Knowledge about HIV/AIDS
- Cultural practices
- Sexual practices
- HIV/AIDS prevention and care strategies
- Voluntary counseling and testing.

Each section will be discussed according to the different questions asked. The biographical information of the respondents will also be presented in this section. The results of the focus group discussions will not be presented with direct quotations as the responses were in Setswana and in the context of this study the quotations will not be understood. Where responses were given in English, the quotes will be presented in English. It must be noted that although the respondents were Setswana speaking and the focus groups were conducted in Setswana, some words and sentences were in Setswana because of the concepts being generally said in English especially HIV/AIDS concepts. The Setswana responses will be translated and summarized in English.

An example of the Setswana transcript is attached as Appendix 9. The other Setswana transcripts are however available on request. The researcher attached examples of focus groups transcripts that have been translated into English and one is in Setswana. (See Appendix 7 and 8).

3.1.2. Biographical information of the respondents

Biographical information regarding the 48 respondents such as the respondent's age, gender, race, home language and number of years the respondents lived in Botswana are discussed below.

3.1.2.1. The respondents' age group

The respondents were all over 18 years. During recruitment, the respondents were only asked if they were over 18 years as the focus group members had to be over 18 years. Purposive sampling procedure was used. The recruitment of the participants depended on the age of the participants. The respondents had to be over 18 years. During the focus group discussions, the researcher made observations that all the developmental stages were represented. The respondents' age groups included adults in the early, middle and late adulthood. There were also people who could have been classified to be in their old age.

Usually people in these age groups have had reasonable experience and exposure of what is happening in their communities and have already developed a sense of identity.

Therefore the age groups were appropriate to engage in discussions related to the topic under investigation namely cultural practices.

3.1.2.2. The respondents' race/ethnicity

It was very important to observe the ethnicity/race during the focus group discussions as in Botswana, there are also people of Asian and European origin who are Batswana as citizens and speak Setswana. The ethnic/race groups could have presented with a limitation, as they would not be aware of other cultural practices of the Batswana people as they also have experience in the origins of their cultures. All 100% (n=48) the respondents in the focus group discussions were black (African), spoke Setswana and were Batswana as citizens and as a cultural group.

3.1.2.3. The respondents' gender

The focus group discussions consisted of males and females even though the groups were conducted separately. There were 22 females and 26 males. It was easier to recruit men through availability sampling than women as the focus groups were conducted in the morning before noon and at the chiefs' kraal. Usually men are the ones who get very involved in community issues and therefore are available in the streets and also many community matters are dealt with at the chief's kraal. Women during this time of the day are involved with household duties.

3.1.2.4. The respondents' home language

It was important to establish the language that the participants spoke to ensure that the focus groups were conducted in a language that the respondents understood. This was also important as in Botswana, there are various other languages spoken for example, Seherero, Sekalaka and Sesarwa. All the respondents could communicate in Setswana although in Francistown, there were 2 women and 3 men who were of Bakalaka origin.

Although we had 5 people who were Bakalaka, the focus group discussions were held in Setswana as they all spoke Setswana. In Botswana almost every citizen of African origin speak Setswana.

3.1.2.5. The respondents' number of years in Botswana

All the respondents in the focus group discussions have lived in Botswana for more than 5 years. The researcher asked this question as part of her recruitment of the members as purposive sampling was used in conjunction with the availability sampling. The number of years in Botswana has an influence on the person's knowledge of the Batswana culture. It has been mentioned in the literature that the Batswana in Botswana are very proud of their culture and culture is practiced at all times. Everything that is done culturally is called Setswana.

Summary: Biographical information

All the developmental stages were included in the sample of focus group members. The respondents were all over 18 years of age and they ranged from young adults to old people in their old age stage of development. Although the researcher did not ask members individually what their ages were, it was easy to observe and judge their ages through the questions asked during recruitment. Purposive sampling was used in conjunction with the availability sampling and therefore the researcher made sure that before the person was invited to the group, he or she matched all the criteria for the focus group. For example, the respondents had to be over 18 years and either female or male. Purposive sampling according to Shingleton, et al. (1988) as quoted by Strydom and De Vos (1998:198) purposive sampling is based entirely on the judgment of the researcher in that the sample is composed of elements which contain the most characteristics representative or typical attributes of the population. The researcher asked the respondents before they joined the focus group if they were over 18 years of age.

During the focus group discussions the researcher also asked if the respondents have lived in Botswana for more than 5 years. All the respondents lived in Botswana for more than 5 years. The respondents also were able to speak and communicate in Setswana although

we had respondents from other ethnic groups, for example, Bakalaka. The focus groups had more males than females. This however did not affect the way culture was perceived. Shibutani, et al. (1976) as quoted by Alexander (1984) said that most of Botswana people (Batswana) are members of Setswana –speaking ethnic groups. Ethnic groups consist of people who see themselves as being of a kind. They are united by emotional bonds and concerned with preservation of their type. They speak the same language and share a common cultural heritage and they believe that they are common descent.

The respondents' number of years they have lived in Botswana qualified them to be knowledgeable about the culture of the Batswana. McNall (1973:45) says that although ethnic groups have subcultures, they are however dominated by the general cultural practices, which is Setswana. Anything that is regarded as an essential part of the culture is called Setswana (Bolaane & Mgadla, 1997). McNall (1973:51) continues to say that from the moment people are born until they die there is constant pressure upon them to follow certain types of behaviour that other men have created for them. Giddens (1990: 38) mentioned that culture gives the members of a society a feeling of unity within the group and enables them to live and work together without too much confusion and mutual interference. Assimilation of culture takes place through the process of socialization, which can take place in a family, peer groups, schools and mass media. The respondents in the focus group were evidently exposed to the Batswana culture as described by the authors above and therefore were knowledgeable about the cultural practices and may have experienced the practices themselves.

3.1.3. Content of focus group guide

As mentioned the focus group guide consisted of 5 sections namely: knowledge about HIV/AIDS, cultural practices, sexual practices, HIV/AIDS prevention and care strategies and voluntary counseling and testing (See Appendix 4). Each section will be discussed according to the different questions asked.

3.1.3.1. Section A: Knowledge about HIV/AIDS

In this section, the researcher wanted to explore the respondent's knowledge about the difference between HIV and AIDS and modes of transmitting HIV. The researcher also

wanted to find out if there were any myths regarding HIV in the Batswana culture. Information will be given according to the different questions asked.

- ***The difference between HIV and AIDS***

Regarding the difference between HIV and AIDS, the respondents said the following:

- ❖ HIV is a virus and AIDS is a disease caused by the HIV virus.
- ❖ The other group members said that there is no cure for AIDS.
- ❖ AIDS is a combination of diseases in the body.
- ❖ AIDS also has opportunistic diseases.
- ❖ It was also said that when someone has AIDS, then the person is like really sick.
- ❖ With HIV, people loose weight and have swollen glands behind their ears.
- ❖ They loose their hair, have sores on their body like small pox and have diarrhea.
- ❖ Some have open sores.
- ❖ HIV was also understood as a stage when a person is not sick yet.
- ❖ AIDS is also "Boswagadi" which means that a widow or widower had sexual intercourse during the period of mourning

- ***HIV/AIDS transmission***

The respondents gave the following responses:

- ❖ Through semen and vaginal fluids during sexual intercourse
- ❖ Through mother to child transmission
- ❖ Blood transfusion
- ❖ During breast feeding
- ❖ Razor blades used by infected people and not sterilized
- ❖ Blood passing through open cuts
- ❖ Not using gloves when you have open cuts and you are assisting an HIV positive person during an accident.
- ❖ Unsterile instruments like injections/needles
- ❖ Not using condoms

- ***Myths about HIV/AIDS in the Batswana culture***

- ❖ The participants mentioned that people believe that the use of condoms cause AIDS.
- ❖ It was also mentioned that AIDS is " Boswagadi" which means that a widow or widower had sexual intercourse during the period of mourning.
- ❖ People with TB are definitely said to have AIDS.
- ❖ Any illness that takes long to heal is AIDS.
- ❖ AIDS is also punishment from God.
- ❖ AIDS comes from the white people and people from other countries.
- ❖ Government had a means of infecting people so that they can reduce the population.
- ❖ White people slept with the gorillas and got infected and they infected the black people.
- ❖ People who get miscarriages get AIDS if they have sexual intercourse thereafter.
- ❖ Widows, widowers and women who get miscarriages need to be treated with traditional medicines if not so they get AIDS.
- ❖ When women are menstruating, they are not supposed to have sexual intercourse as they can infect men with HIV. The blood from the menstruation has HIV.
- ❖ Women are also not supposed to engage in sexual relationships after birth, as they will get infected with HIV.

Summary: Knowledge about HIV/AIDS

The respondents' knowledge about HIV/AIDS was extensive. They were knowledgeable about the general concepts in HIV/AIDS. HIV was said to be a virus and AIDS a disease caused by the HIV (HI virus). There was a general understanding that HIV is a virus that causes AIDS. The respondents were also informed about the modes of transmission which the majority agreed that HIV was transmitted through sexual intercourse with HIV infected people and

condoms are not used. All the modes of transmission were mentioned during the focus group discussions. Authors like Berer and Ray (1993:6) and Whiteside and Sunter (2000:10) also stated that HIV infection is transmitted through sexual intercourse through contact with infected blood, semen or cervical and vaginal fluids. Barrett- Grant, et al. (2001:10) also said that HIV is a virus and HIV causes AIDS.

Various responses were given regarding the myths. One common myth was Boswagadi, which was mentioned in all the groups. Boswagadi is a cultural concept that has been there for years even before HIV/AIDS. Any illness that a widow or a widower gets during the period of mourning after having sexual relationship with another partner during the period is called Boswagadi. During the mourning period the widow and widower are expected to use traditional medicines and these complicate with the functioning of the body if you can get involved sexually. Now Boswagadi is also associated with HIV/AIDS.

Since there are a lot of debates and misconception about the origin of HIV/AIDS and that there is no cure for the disease, Boswagadi, which is also an unexplained concept, is associated with HIV/AIDS. When one suffers from Boswagadi, the person gets very sick and it is usually difficult to know what is troubling the person and how to treat the person. The respondents also associated HIV/AIDS with a combination of unexplained diseases during the focus group discussions. Another common myth was that AIDS is punishment from God. Aggleton, et al. (1989:57-63) stated that ordinary people saw HIV/AIDS as God's vengeance on those who led unnatural and promiscuous lives e.g. the homosexuals.

The respondents knew the difference between HIV/AIDS although at times the two concepts were used interchangeably. The respondents were also knowledgeable about the modes of transmission. There are a lot of myths mentioned by the respondents, which were related to how HIV/AIDS is diagnosed, and its origin and which identified the people, the situations and the activities that are perceived as risky (Aggleton, et al., 1989:57-63).

3.1.3.2. Section B: Cultural practices

In this section, the researcher explored the cultural practices of the Batswana in relation to marriage and the influence of these cultural practices in relation to the spread of HIV/AIDS.

- ***The cultural practices of the Batswana in relation to marriage***

- ❖ Most participants emphasized that polygamy is culture in Botswana although there were those who believed that marrying one partner was part of the Batswana culture.
- ❖ Lobola is paid to the bride's parents or family in cattle.
- ❖ Only married people discuss marriage arrangements.
- ❖ Children mean a lot. The woman must be able to bear children.
- ❖ The extended family gets involved with almost all issues the couple has.
- ❖ During the wedding celebration, traditional beer or alcohol is very important. With all cultural celebrations especially marriage celebrations, there must be alcohol to show respect to the ancestors. This is a way of communicating with the ancestors.
- ❖ The bride is told by the in-laws that a man can have multiple relations whether in marriage or as a single person and the woman cannot complain about that. The say goes "Monna ke selepe o a adimiwa" meaning a man is like an axe, people borrow the axe everytime or the wife must lend people this axe to use. Men are free and independent and therefore they can do what they like. A man is like a bull and should not be confined to one pasture.
- ❖ In polygamy, the first wife chooses the second wife.
- ❖ Arranged marriage is also one common practice. A woman with a son can arrange with a pregnant woman carrying a girl that once the girl is born, the girl will grow as the son's wife and the son irrespective of age will marry the girl at the right age.
- ❖ There were participants who were not in favour of polygamy and said that this was a thing of the past.
- ❖ If a woman is married with a illegitimate child, the bride must pay lobola also to traditionally adopt the child. This is called "O e gapa le namane".
- ❖ A married woman cannot befriend males and unmarried females, as they will teach her all wrong things that are not acceptable in marriage like disrespect for the husband.
- ❖ A married woman, who does not live with her husband maybe because of migrant labour, must not have any sexual relationship with any men other than her husband on the 31st of December. Should she engage in sexual activity, the behavior will cause her husband wherever he is to die.

- ***The influence of the cultural practices of the Batswana regarding marriage in relation to the transmission of HIV/AIDS***

- ❖ The participants felt that culture protected people from the spread of HIV/AIDS. In the past a woman will know which other women was her husband involved with. The woman in polygamy whether married or not, will know that she can only have sexual relationship with her partner in a polygamous relationship. People knew that it was safe. These days' men unofficially go around with other women who no one knows who they go around with. Today the multiple partners are unknown.
- ❖ Culture was also said to be reducing the spread of HIV/AIDS since culture says that married partners should stick to one partner.
- ❖ The other participants on the other hand believed that polygamy can contribute to the spread of HIV since people in multiple relationships, do not use condoms, as it is culture for married people to have children.
- ❖ They say that "Monna ke selepe o a adimiwa", meaning a man is like an axe; people borrow the axe every time or the wife must lend people this axe to use. This behavior contributes to the spread of HIV/AIDS since men do not use condoms as they sleep around with other women.
- ❖ Some participants believed that the arranged marriages predispose people HIV, as the man will definitely be older than the woman. The man would definitely have had sexual relationships before and therefore could have been exposed to HIV and can transmit it to the woman who is younger than him.
- ❖ The issue of not having sex with other men on the last day of the year, was said not to be a guarantee for not getting HIV/AIDS as the woman could have had sexual relationships with other men on other days without a condom. Therefore cultural practices do not protect people from HIV transmission.

- ❖ Alcohol consumption is now a serious problem, as people do not use alcohol as a sign of respecting ancestors. It is used for leisure in large quantities. It puts people at risk for HIV transmission, as people cannot think properly when they are drunk.
- ❖ However befriending males and unmarried females when you are a married woman can contribute to the spread of HIV, as there is likelihood that the woman can engage in other sexual relationships.

Summary: Cultural practices

During the focus group discussions, it was evident that knowledge about cultural practices in Botswana was very extensive amongst the respondents. Polygamy was mentioned at all times by all the groups. It was not supported in today's practices, however it was thought that it was a better arrangement as partners were known and were chosen within the family. In polygamous marriages, culture is respected therefore the likelihood of all the partners involved to go around with other partners outside polygamy is very limited. It is not easy to get infected outside marriage as marriage partners in polygamous marriages only have sexual relationships with partners in that marriage relationship only. If partners are not infected with HIV at the beginning of their relationship, they can remain safe in terms of HIV infection even if condoms are not used, as they are faithful to each other. According to Parekh (2002:288) polygamy involves sexual discipline and Moore (1997:216) states that the nature and structure of the traditional polygamous family are also determinants of patterns of sexual relationships within and outside marriage. Van Dyk (2001:120) says that polygamy often helps to prevent and reduce unfaithfulness, prostitution, STDs and HIV infection.

The cultural practice of believing that "a man is like a bull or axe", was a confirmed Batswana cultural practice. However the behaviour was said to be predisposing people to HIV/AIDS infection as men engage in multiple unknown sexual relationships without the use of condoms. Children are said to be very important and therefore it is possible for women to get desperate to proof that they can bear children. This practice is supported by the fact that it is not a taboo for a woman to have a child before marriage, as it is acceptable that when she gets married, the groom also pays lobola to "adopt the illegitimate child." O e gapa le namane" meaning when you marry a woman with a child, " You take the cow and the calf".

The above responses from the focus group discussions were supported by a study conducted by BOTUSA in 1999 to identify the risk factors for HIV infection. It was evident from the

research results that the majority of the respondents believed that a man is like a bull and should not be confined to one pasture. This behaviour was also believed to be one of the Batswana culture. The study also confirmed that in Botswana a man is more likely to marry a woman who has shown that she is fertile meaning that a woman should have a child before she gets married (BOTUSA, 1999).

Some of the cultural practices mentioned seem to be there to prevent people from engaging in sexual relationships when their spouses are not there. For example the issue of the 31st of December when women are not expected to engage in sexual relationships when they are far from their partners as the partner will die.

There is also a belief of arranged marriages which can put women at risk as the man will in the meantime get involved with other women of his age whilst waiting for the real wife to grow. According to the UNAIDS (2000) a crucial factor that pushes up HIV/AIDS rates in young women is age mixing, where girls have sexual intercourse with older men who have been sexually active for many years and who therefore tend to be more heavily infected than younger males. If the girls' sole sex partners were boys their age, they would run little risk of becoming infected.

Alcohol seems to be a very important issue in all-social events. This is a way of communicating and show respect to the ancestors. The use of alcohol seems to be extended to other social events, which have nothing to do with ancestor worship. Alcohol consumption is now taken in large quantities in Botswana. Alcohol puts people at risk for HIV transmission, as people cannot make sound judgments when they are drunk especially with sexual behaviour. Lauer (1992:115) asserts that if alcohol is taken in large quantities, it releases inhibitions so that the person who drinks loosens up and may for example be motivated toward sexual activity. In the same study conducted by BOTUSA in 1999, it was found that alcohol use was common amongst all the respondents. There was an average of three drinks per day (BOTUSA, 1999).

There was a general feeling that although the cultural practices are not favoured with the HIV/AIDS epidemic, one has to consider strengthening the practice of culture since culture prescribes a lot of respect and with respect people are able to respect themselves and others and therefore minimize the extent of infecting each other.

3.1.3.3. Section C: Sexual practices

This section explored the cultural practices of the Batswana with regard to sex and the influence of these practices in relation to HIV transmission.

• ***The cultural practices of the Batswana with regard to sex.***

- ❖ One important response to this question was that one common practice was that you only have sex when you are married.
- ❖ Girls and boys are socialized to go for circumcision where they are taught about sex. The girls are taught that you do not engage in sexual activity when you are menstruating. The girls are also taught that women do not initiate any sexual activity only men do.
- ❖ People are socialized that you get married by the age of 18 especially girls and must be married by age 30. Men cannot marry women who are older than them or of the same age. The reason for this is that older women dirty the blood of men during sex. Younger women will also have better respect for their husband.
- ❖ It is also believed that a woman should have sexual intercourse with her husband during pregnancy so that the baby to be born can be able to crawl when the time comes "Go tiisa mokwatla" meaning strengthening the back.
- ❖ If a married woman will engage in sexual relationships with other men after the baby's birth, then the baby will be disabled (segole or mopakwano).
- ❖ The culture also prescribes that children should be born; therefore sex life without a condom in marriage is very important.
- ❖ It was said that in the Batswana culture, condom use was not acceptable, as people should have children.
- ❖ Another common practice is that a widow should get married to her brother-in-law and therefore can only have sex with the brother-in-law. This can also happen between a widower and his sister-in-law (seyantlo).
- ❖ A widow and widower should take traditional medicines during the period of mourning to clean their blood. During this time, they cannot engage in sexual activity.

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- ❖ One respondent said that some people allow a woman to engage in sexual intercourse with her father or father - in - law to prove that the woman is a woman.

- ***The influence of cultural practices of the Batswana regarding sex in relation to HIV/AIDS transmission.***
 - ❖ The participants felt that the cultural practices of the Batswana with regard to sex protected people as in polygamous relationships; you knew which partners were involved. The partners will only stick to each other only. Even if people did not use condoms, they were still safe as it will be the only partners within the same circle.
 - ❖ The culture prescribes that people should stick to one sexual partner and therefore this is not risky for HIV/AIDS transmission.
 - ❖ The other participants strongly felt that polygamous relationships or multiple partner sexual relationships, contribute to HIV/AIDS transmission.
 - ❖ There were participants who believed that the use of condoms contributed to HIV transmission. They said that in the past, there was no HIV/AIDS because condoms were not used.
 - ❖ The participants also mentioned that if widows and widowers do not use traditional medicines during the period of mourning, they would get AIDS. Sex with a person who had taken traditional medicines, does not contribute to the spread of HIV/AIDS “Boswagadi”.

Summary: Sexual practices

It was interesting that circumcision was mentioned as cultural practice in Botswana. It was supported because girls and boys are taught about how to behave in sexual relationships. Girls are taught that you do not negotiate sex with a man. This behaviour however puts the young women in a subordinate position, as they cannot be assertive to refuse men sex as they wish. The women are at risk of HIV transmission as they may not be able to negotiate the use of condoms. They are unable to make decisions about what they want in a sexual relationship. Adupa (1999) stated that in Botswana, men dominate women in sexual matters and the women

are also treated as minors and socially inferior (United Nations Development Programme, 1999).

Men can also not marry women who are older than themselves. This puts young women at risk as the men might have had sexual relationship with other women before they got married. During these sexual contacts, they could have been exposed to HIV infection and therefore infect their marriage partners. The UNAIDS (2000) stated that older men tend to be more heavily infected with HIV than younger males because of their sexual exposure before they get married.

The issue of Boswagadi was again mentioned. Boswagadi is a common cultural belief that is associated with regulating sexual involvement whilst mourning and it is associated with HIV/AIDS, as the researcher has already mentioned that the nature and treatment of the illness are not easily understood.

Women who are widows are also expected to marry the husband's brother. With the belief that condoms are unacceptable and multiple relationships are acceptable, it is possible that the brother-in-law could have been infected and therefore the widow could be at risk for sexual infection.

3.1.3.4. Section D: HIV/AIDS prevention and care strategies

This section focused on prevention and care strategies in Botswana. The researcher explored what the participants thought was already there to prevent HIV/AIDS and what they think can be done to prevent HIV/AIDS in Botswana.

- ***HIV/AIDS prevention in Botswana***

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- ❖ Many respondents felt that the available strategies in Botswana were failing as people are dying in big numbers. They thought that the Botswana people need to go back to their culture, which taught people morals.
- ❖ Circumcision was supported as young boys and girls were taught morals at the traditional schools.
- ❖ The other participants said that the parents should take responsibility in educating children about sex and HIV/ AIDS.
- ❖ Christianity was also seen as a very important vehicle for HIV prevention. Religious organizations should participate in HIV/AIDS care and prevention strategies.
- ❖ Intake of alcohol was seen as being too high in Botswana and therefore people make reckless decisions. This led to prostitution, rape and poverty. It was recommended that increasing the price of alcohol should reduce the alcohol consumption.
- ❖ Health education throughout the country was also seen as necessary to educate people on the following issues: condom use, testing for HIV, abstaining, stick with one partner and antiretrovirals.
- ❖ Families were seen as having primary responsibility in educating children about HIV/AIDS.
- ❖ Many participants supported that prevention and care strategies should take culture into consideration.
- ❖ One respondent mentioned that HIV positive women should not have children.

Summary: HIV/AIDS prevention and care strategies

There was a general agreement amongst the respondents that people are dying in big numbers, as culture is not taken into consideration. The death rate in Botswana in the year 2001 was estimated at 26 000. The total number of people living with HIV/AIDS including children and adults in the 2001 was 330 000 (HIV& AIDS statistics for Africa, 2004:1).

Culture teaches people morals about sexual behaviour especially at circumcision schools. According to Nxumalo (1998), Parketh (2002: 143-144) and Pai (1990) as quoted by Goodnow, et al. (1995) culture is also articulated in the rules and norms that govern such basic activities and social relations as how, where, when and whom one makes love.

Institutions such as the family and the church, should take responsibility in educating people about HIV/AIDS so that prevention can be facilitated. The family is one of the most important institutions facilitating the process of socialization where norms and values of a culture are learned (Popenoe, 1986: 134).

Williams (1986) stated that guidelines used to direct our behaviour within a particular culture are called norms and values are about what is good and right.

In Botswana the religious leaders attribute the high prevalence of HIV/AIDS situation as punishment from God as principles of abstinence and faithfulness have been disregarded by society.

Alcohol seems to be a serious problem in the country. All the focus group respondents mentioned that the intake of alcohol should be regulated in Botswana in order to prevent HIV/AIDS. Fidzani, et al. (2000) mentioned that traditional leaders in Botswana think that the high number of drinking spots in Botswana is contributory factors in the spread of HIV.

It was strongly felt that the prevention programmes need to take culture into consideration. Van Dyk (2001:125-126) states that AIDS educators should be creative and imaginative in incorporating traditional beliefs and healing methods into HIV/AIDS educational programmes. She says that cultural rituals and ceremonies such as polygamy where all partners are uninfected with HIV and are faithful to each other should be respected in HIV/AIDS education.

3.1.3.5. Section E: Voluntary counselling and testing (VCT)

This section explored the opinions of the participants regarding (VCT) voluntary counseling and testing. The researcher wanted to know what the participants thought of VCT.

- ***Opinions About Voluntary Counselling and Testing (VCT)***

Some participants felt that VCT was useless and not good for the following reasons:

- ❖ There is no antiretrovirals available once you know your status.
- ❖ People need to live positively whether they are positive or not.
- ❖ Knowing your status, changes one's life as you get depressed and frightened and therefore can easily commit suicide or want to infect others.
- ❖ VCT's should not show HIV/AIDS videos whilst waiting to be counseled and tested. The videos frighten people and therefore make them not want to be tested.

The other participants were in favour of the VCT programme for the following reasons:

- ❖ Knowing your status results in behavior change that reduces HIV transmission and encourages positive living. Negative people also know how they must take care of themselves.
- ❖ VCT encourages positive living and advise people what to do to live positively.

Some respondents said that there were Antiretrovirals available in the country therefore it was good to get tested and know your status as you will have access to medical care. (See Appendixes 7 and 8 -Focus Group Transcripts).

Summary: Voluntary counselling and testing (VCT)

All the groups were aware of VCT in Botswana. VCT is aggressively advertised in Botswana. (See Appendix 9). There are also mobile VCTs for rural areas and the VCT centers in the urban areas are stand-alone. It was not surprising that everyone knew about the VCT programme. It also seemed that some of the respondents visited the centers as their contributions to the discussions were based on what really happens at the centers. For example the videos, which are shown whilst waiting to be tested.

VCT seems to be supported by the majority of the respondents although some feel that it really demoralizes a person once the positive status is known.

3.2. Part 2: Quantitative data through structured interview schedule

3.2.1. Introduction

The structured interview schedule (See Appendix 3) was divided in 14 sections namely:

- The demographic information of the participants
 - Knowledge about HIV/AIDS
 - Cultural practices
 - HIV/AIDS prevention strategies, polygamy
 - Sexual practices
 - Agricultural practices
 - Stigma issues
 - Cultural taboos
 - Marriage
 - Alcohol use
 - Religious beliefs
 - Condom use

- Voluntary counseling and testing.

These sections will be discussed accordingly.

3.2.2. Section A: Demographic information of the respondents

The following information regarding the demographical information of the 66 respondents, who were interviewed, was gathered. These informations include the gender, age, ethnic group, marital status, types of marriage, level of education, how long the respondent has lived in Botswana and religion.

- ***Gender and Age Distribution of the Respondents***

The sample consisted of 66 respondents of which 66.7% (n= 44) were females and 33.3% (n= 22) were males (Table 2).

The age range was between 18 years and 70 years. About 28.8% (n= 19) of the respondents were between the ages 18 years and 24 years; 16.7% (n= 11) were aged between 25 years and 30 years; 25.7% (n= 17) were aged between 31yrs and 40 yrs; 19.7% (n= 13) were between 41 yrs and 50 yrs; 7.6% (n = 5) were aged between 51years and 60 years and 1.5% (n= 1) were between 61years and 70 years (Table 2).

Table 2: Age and gender distribution of the respondents

Age	18-24	25-30	31-40	41-50	51-60	61-70	Total
Female	13	7	10	10	3	1	44
Male	6	4	7	3	2		22
Total	19	11	17	13	5	1	66
Percentage	28.8%	16.7%	25.7%	19.7%	7.6%	1.5%	100%

- **Ethnic Group**

There were 15 ethnic groups from the sample. The Bakwena formed the majority (27.3%) of the sample; Bangwato 19.7% and the Bakalaka, 15.2%. The Bakgatla and Ba- Mmirwa were both 7.6% and Balete and Baherero were both 4.5%. The Bahurutshe were 3% and the rest of the respondents Bakgalagadi, Barolong, Masarwa, Batawana, Batlharo, Matebele and Bayeyi were all represented by 1.5%.

Table 3: Ethnic group

Ethnic Group	Respondents	Percentage
Ba- Mmirwa	5	7.6%
Maherero	3	4.5%
Bahurutshe	2	3%

Bakalaka	10	15.2%
Bakgalagadi	1	1.5%
Bakgatla	5	7.6%
Bakwena	18	27.3%
Balete	3	4.60%
Bangwato	13	19.7%
Barolong	1	1.5%
Masarwa	1	1.5%
Batawana	1	1.5%
Batlharo	1	1.5%
Matebele	1	1.5%
Bayeyi	1	1.5%
TOTAL	66	100%

- **Marital Status**

The marital status of the respondents is displayed in Figure 1: Of the total sample, the majority of 45% were single, 23% were married, 12% were staying with a partner but not married, 11% were widowed, 6% were divorced and 3% were separated.

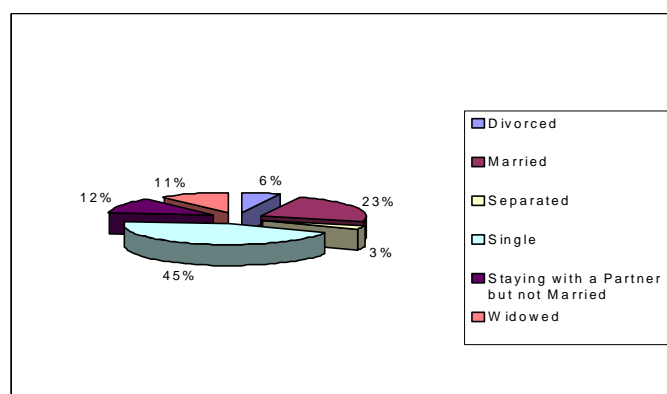


Figure 1: Marital status of the respondents

- **Types of marriages**

Of the 23% (n= 28) who were married, 35.7% (n= 10) were legally married and 64.3% (n= 18) were married traditionally. See Table 4 below:

Table 4: Types of marriages

Legal Marriages	Traditional Marriages	Total Married
10	18	28
35.7%	64.3%	100%

- **Level of education**

Of the total sample, the majority of the respondents, 48% had secondary level education, 20% had primary education, another 20% had no formal schooling and 12% went up to tertiary education (Figure 2).

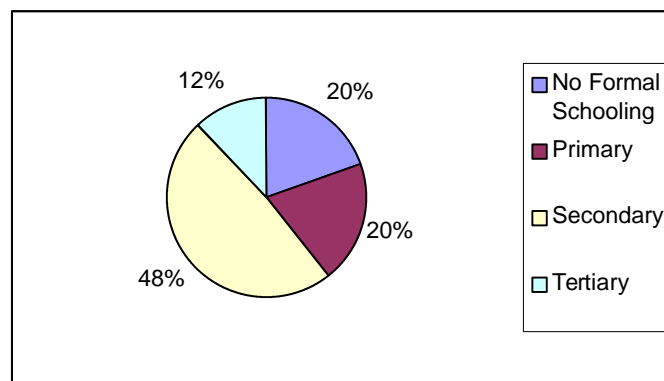


Figure 2: Level of education of the respondents

- **Number of years in Botswana**

The number of years of which the respondents lived in Botswana ranged between 5yrs and 10 yrs. The majority of the respondents, 97% (n= 64) had lived in Botswana for more than 10 yrs and 3% (n= 2) had lived in Botswana more than 5 yrs.

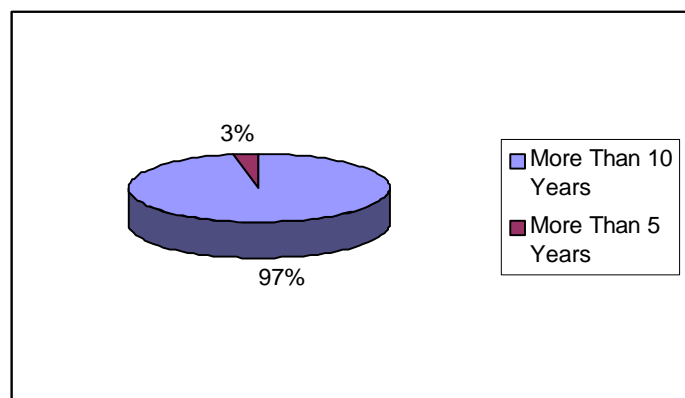


Figure 3: Number of years in Botswana

- **Religion of the respondents**

Of the total sample, 33.3% (n= 22) were members of the African church (Independent church) and another 33.3% (n= 22) also came from the Christian religion (established church). About 27.3% (n= 18) had no affiliation to any religion and 6.1% (n= 4) belonged to other religious denomination like apostolic church.

Summary: Demographical information of the respondents

The majority of the respondents were females (n=44). This could be due to the fact that the interviews were conducted during the day when it is assumed that men are at work. The Second Medium Plan on HIV/AIDS in Botswana (1997-2002:5) reports that female- headed households form the majority of households living in poverty. The range of the respondents was between 18 years and 70 years. Almost all the developmental stages of adulthood were included. The age of the respondents did not influence their knowledge about cultural practices and HIV/AIDS. Giddens (1990:32) argues that no culture could exist without society and no society could exist without culture. If you live in a society you will be aware of the culture. There were 15 ethnic groups identified in the sample. The ethnic groups in the sample were representative of all existing ethnic groups in Botswana.

Bolaane and Mgadla (1997) say that Batswana people or groups consist of several subgroups called "morafe" meaning ethnic groups. It is no surprise that there were a vast number of ethnic groups. The Bakwena formed 27.3% and Bangwato 19.7% of the ethnic groups. These are the common ethnic groups in Botswana.

The marital status of the respondents revealed that the majority of the respondents were single (45%) and this however correlates with the number of people in the age group 18-24 (28.8%) which was the highest. These are young adults who just finished school and are unemployed. The 1994/95 agricultural surveys revealed that 35% of the traditional farm households in Botswana were headed by women who most of them were widows, divorcees or have never been married (Adupa, 1999:25).

Adupa (1999) also says that agricultural surveys in Botswana show that most women who are divorcees or have never been married head 35% of the traditional households. Of those who were married, 64.3% married traditionally meaning that only lobola was paid and there was no legal "magistrate" marriage. This shows that culture still plays a very important part of Botswana culture. According to Monnig (1978:129) "magadi" are paid to the bride's family by the groom's family and therefore the bride is publicly transferred to the groom's family.

The level of education had also no significant effect on the respondents' knowledge of cultural practices and HIV/AIDS. Forty eight percent of the respondents had secondary education, which is also some form of higher education equivalent to high school in South Africa. According to the AIDS/STD Unit (NACP 19) the government of Botswana made impressive achievements recently on education. There is provision of almost free education and a pupil/teacher ratio of 28:1 and an increase in literacy rates from 34% in 1981 to the current estimates of 74% in 2003.

Similarly the number of years the respondents lived in Botswana made them knowledgeable about cultural practices of the Botswana as almost all the respondents 97% lived in Botswana for more than 10 years. Hoogevelt (1980:24-25) believes that societal identity is always grounded in common cultural orientations shared by the members. Hobbel and Frost (1976:30) says that it is the possession of a common culture, which gives the members of a society a feeling of unity with the group and enables them to live and work together without too much confusion and mutual interference.

The practice of religion also seemed to be very important in Botswana as only (n=18) had no affiliation to any religion. The majority of the respondents (n=48) belonged to a religious denomination. According to Kwashi (2002:19) religion is the belief in the existence of a super

human controlling power especially God or Gods usually expressed in worship. Popenoe, et al. (1998: 324) further stated that religion strengthens the society's basic norms and values. Social norms are foundations of all social organizations. Sacred norms and values enhance moral meaning and religion, which therefore consoles people in times of personal conflict. It was of no surprise that the majority of the respondents (n=48) had a church affiliation. Religion is a form of a support system in communities.

3.2.3. Section B: Knowledge about HIV/AIDS

In this section the researcher wanted to explore the knowledge and attitudes of the respondents regarding HIV/AIDS. Data will be given according to each question asked.

- ***The respondents' knowledge about HIV***

Of the total sample 30.3 % (n= 20) mentioned that HIV was a virus and another 30.3% (n=20) also mentioned that HIV is a virus that causes AIDS. Another 7.6% (n= 5) said that HIV is a disease that kills and the same percentage 7.6% (n=5) of the respondents said that they did not know what HIV was. About 6.1% (n= 4) referred to HIV as a virus that weakens the immune system and 4.6% (n= 3) said that HIV was sexually transmitted. The same number of people 4.6% (n= 3) said that HIV was sexually transmitted like STD's.

The rest of the group mentioned the following as HIV:

1.5% (n=1) " Disease of the youth"

1.5% (n=1) " Human Immuno Virus"

1.5% (n=1) " Illness"

1.5% (n=1) " Love"

1.5% (n=1) "Virus in the blood"

1.5% (n=1) " Virus that kills"

- ***The respondents' knowledge about AIDS***

In response to this question which explored knowledge about AIDS, 59.1% (n= 39), said that it is a disease caused by HIV and 15.2% (n=10) thought it was a combination of diseases. About 13.6% (n=9) said that it was sexually transmitted. All the responses are displayed in Table 5.

Table 5: The respondents' knowledge about AIDS

Concept of AIDS	Respondents	Percentage
Acquired Immuno Deficiency Syndrome	2	3%
Combination of diseases	10	15.2%
Diarhoea and fluffy hair	1	1.5%
Disease caused by HIV	39	59.1%
Immune system is affected	1	1.5%
Sexually transmitted diseases	9	13.6%
Virus	2	3%
Infection by women on contraceptives	1	1.5%
Same as HIV	1	1.5%
Total	66	100%

- ***The origin of HIV***

Table 6 gives an indication of the respondents' knowledge about the origin of HIV.

Table 6: The respondents' responses about the origin of HIV

Where Does HIV Come From	Respondents	Percentage
Apes	7	10.6%
Boswagadi	2	3%
Condoms	1	1.5%
Different diseases	1	1.5%
Do not know	9	13.6%
Other countries	2	3%

HIV infected human beings	10	15.2%
Not sure	1	1.5%
Sex	25	38%
White people	7	10.6%
Unfaithful people	1	1.5%
Total	66	100%

The majority of the respondents 38% (n= 25) of the respondents felt that HIV came from "sex". Another 13.6% (n=9) said that they did not know and 15.2% (n=10) mentioned infected human beings. About 10,6% (n=7) believed it came from apes. Of the total sample 3% (n=2) mentioned "Boswagadi".

- **Causes of AIDS**

Of the total sample, the majority of the respondents 43.9% (n=29) mentioned sexual intercourse and 34.8% (n= 23) said HIV/ virus cause AIDS. About 6.1% (n=4) said many diseases and 3% (n= 2) said it is sex out of marriage. About 7.6% (n=5) said they did not know what causes AIDS.

Table 7: Causes of AIDS according to the respondents

Causes Of AIDS	Respondents	Percentage
Sexual intercourse	29	43.9%
Do not know	5	7.6%
Disrespect for culture	1	1.5%
HIV / Virus	23	34.8%
Lubricants from condoms	1	1.5%
Many diseases	4	6.1%
Body fluids of infected persons	1	1.5%
Sex out of marriage	2	3%
Total	66	100%

- **Is HIV/AIDS a problem in Botswan?**

In response to this question, 3% (n=2) of the respondents did not think HIV is a problem in the country and another 3% (n=2) were not sure whether it was a problem or not. However 93.9% (n=62) agreed that HIV/AIDS is a problem in the country. Of the 62 respondents who said HIV/AIDS is a problem mentioned that it is a problem because of the following reasons: (See Table 8 below)

Table 8: Reasons why HIV is a problem in Botswana

Reasons	Respondents	Percent
Kills people	55	88.7%
People do not test	2	3.2%
Not taken seriously	1	1.6%
Waste government money	1	1.6%
Many people affected	2	3.2%
Makes people sick	1	1,6%
Total	62	100%

The majority of the respondents 88.7% (n=55) said that it kills productive people and about 3.2% (n=2) said that people do not go for HIV testing to know their status and the same number of people felt that many people are affected by the epidemic.

- **Recognition of HIV/AIDS**

Table 9 gives an indication of what the respondents' knowledge about the signs and symptoms of HIV/AIDS are.

Table 9: The respondents' knowledge about how HIV/AIDS can be recognized

Signs of HIV/AIDS	Respondents	Percentage
Can't recognize it	4	6.1%
Partners dying	1	1.5%
Weight loss	26	39.4%
Combination of diseases	13	19.7%
Disclosure	1	1.5%
Diarhoea	9	13.6%

Do not know	2	3%
Fluffy hair	9	13.6%
Skin disorders	1	1.5%
Total	66	100%

The data showed that the majority of the respondents 39.4% (n=26) said one common sign is weight loss and only 19.7% (n=13) mentioned a combination of diseases. About 13.6% (n=9) mentioned fluffy hair. A total of 13.6% (n=9) respondents mentioned diarrhoea. However 6.1% said that it is difficult to recognize HIV/AIDS.

- **Modes of HIV transmission**

The majority of the respondents 65.2% (n=43) thought that HIV was spread through sexual intercourse and 24.2% (n=16) mentioned unsterile instruments. About 6.1% (n=4) mentioned blood transfusion.

Table 10 gives an indication of the respondent's knowledge about how HIV is transmitted.

Table 10: The respondents' responses on how HIV is transmitted

Mode of Transmission	Respondents	Percentage
Blood transfusion	4	6.1%
Do not know	1	1.5%
Eating left overs from an infected person	1	1.5%
Sexual intercourse	43	65.2%
Unfaithfulness	1	1.5%
Unsterile instruments	16	24.2%
Total	66	100%

- **Myths about HIV/AIDS**

Of the total sample, 25.8% (n=17) of the respondents said that there were no myths about HIV/AIDS and 28.8% (n= 19) said that they were not sure whether there were any myths or not. Only 45.5% (n=30) said that there were myths about HIV/AIDS.

Of those (n=30) who said that there were myths about HIV/AIDS, 66.6% (n=20) mentioned “Boswagadi” as a myth about HIV/AIDS and 10% (n=3) said that HIV/AIDS was punishment by God. A total of 6.7% (n=2) could not mention the specific myths.

Table11: Myths about HIV/AIDS

Any myths HIV/AIDS	What are myths	Respondent	Percentage
No	-	17	25.8%
Not sure	-	19	28.8%
Yes	Blocked chest is HIV	1	3.3%
	Boswagadi	20	66.6%
	Contraceptives cause AIDS	1	3.3%
	HIV is a traditional disease and having sex after abortion causes AIDS	1	3.3%
	Not sure	2	6.7%
	Prostitutes get AIDS	1	3.3%
	Punishment by God	3	10%
	Witchcraft	1	3.3%
Yes Total		30	45.5%
Grand total		66	100%

Summary: Knowledge about HIV/AIDS

The majority of the respondents were knowledgeable about HIV/AIDS concepts. Only a few (n=5) said that they did not know what HIV/AIDS was all about. A total of (n=61) respondents gave various explanations of what HIV/AIDS is. Many knew that HIV is a virus and a virus that causes AIDS. It was also said that HIV kills people, weakens the immune systems and is sexually transmitted. Barrett-Grant, et al. (2001:10), Berer and Ray (1993:6), Van Dyk (2001:13) and Crewe and Orkin (1992:4) agree that HIV is a virus that is only found in human beings, and it attacks and slowly damages the body's Immune system.

The respondents however used the concepts HIV and AIDS interchangeably. It is evident throughout the literature reviewed that HIV and AIDS are also used as one word- HIV/AIDS.

HIV and AIDS were however thought to be the same thing. This is because of how it is widely used in the society and worldwide. When people talk about AIDS, it is sometimes said that the person has AIDS or HIV/AIDS or HIV. The general feeling was that it is sexually transmitted and that it kills. It also weakens the immune system. The various responses given by the respondents reflected what the literature stated about HIV and AIDS.

Regarding the origin of HIV/AIDS, the majority of respondents (n=25) mentioned that HIV came from sex and (n=10) respondents said that HIV came from HIV infected human beings. However there was a believe that HIV came from apes (n=7), white people (n=7) and "Boswagadi" (n=2), which is a disease that is believed to attack widows and widowers who get involved in sexual relationships with other partners after their spouse's death. There are various explanations about the origin of HIV and misconceptions about the origins. So it is not surprising to get these explanations from the respondents.

Boswagadi was also a word mentioned several times in the focus groups. In Botswana, there is a believe that HIV/AIDS is caused or comes from widows and widowers who sleep around with other sexual partners during the mourning period which is within one year of the death of spouse.

Aggleton, et al. (1989: 57- 63) and Van Dyk (2001:33) state that there are some truly horrifying myths that are circulating in some communities about HIV infection and the origin of AIDS. It was not surprising from the research results of this study that various responses were given about the origin of HIV/AIDS.

The majority of the respondents (n=29) said that sexual intercourse with HIV infected people and the HIV-virus (n=23) were the causes of AIDS. The focus group respondents also mentioned these causes. According to Berer and Ray (1993: 6) HIV stands for human immunodeficiency virus and it is a sexually transmitted disease. As stated previously HIV is the cause of AIDS. The link between HIV and AIDS is backed up by strong scientific proof (Crewe and Orkin, 1992: 4). They say that people from different backgrounds and lifestyles all over the world have developed AIDS – the thing that they had in common was that they were infected with HIV.

Sixty-two, (93.9%) of the respondents definitely felt that HIV/AIDS is a big problem in Botswana. The majority of these respondents said that it is a problem as it kills a lot of productive people and it leaves orphans. Poku (2001:191) confirms by saying that 35.8% of

adults are now infected. UNAIDS (2002:8) say that in the year 2001, 3 million people died around the world.

The signs and symptoms of HIV/AIDS were said to be the following: weight loss, getting very sick, sores, diarrhea, and fluffy hair. The signs and symptoms mentioned correlated with signs and symptoms mentioned in the stages of infection by Crewe and Orkin (1992:5); Wilson, et al. (2002:57); Evian (2000:25). The symptoms mentioned by the respondents were however not reflecting the different stages. They were just mentioned as general symptoms throughout the period when one get infected to when they get full-blown AIDS.

The majority of the respondents (n=43) mentioned that HIV was spread through sexual intercourse and (n=16) respondents mentioned unsterile instruments. The other modes of transmission mentioned by other respondents were blood transfusion, MTCT, open sores and body fluids in contact with an HIV positive person. These responses concur with what Ward (1999:35-36); Berer and Ray (1993:6); Gordon and Klonda (1988) and Whiteside and Sunter (2000:10) said in this regard.

Thirty of the respondents said that there are myths about HIV/AIDS. Of the respondents who said that there are myths about HIV/AIDS, (n=30) of them mentioned Boswagadi as a myth. The focus group discussion also confirmed that the Boswagadi is a common belief or myth in the Batswana culture. Only three (n=3) of the respondents mentioned that HIV/AIDS is punishment by God. There were various responses regarding the HIV/AIDS myths, which are reflected in Table 11. For the purpose of the summary, the researcher focused only on the majority of the responses. Crewe and Orkin (1992:8-9) say that one of the myths is that HIV is a virus inflicted on mankind as punishment for the wicked.

3.2.4. Section C: Cultural practices

- ***The cultural practices of the Batswana in relation to marriage and sexual life***

The majority 24.2% (n=16) of the respondents said that sex before marriage is unacceptable and 12.1% (n=8) of the respondents said that when a man has many women in his life that proves his manhood. About 10.6% (n=7) of the respondents also said that condom use is unacceptable in the Batswana culture and 7.6% (n=5) said that sexual intercourse between older men and younger girls is believed to clean the blood of the men. It was also interesting to note that 6.1% (n=4) respondents believed that women cannot refuse men sex. (See Table 12 below for detail data).

Table12: Identified cultural practices of the Batswana in relation to marriage and sexual life

Marriage and sex life practices	Respondents	Percentage
Children important	4	6.1%
Do not know	6	9.1%
Many wives proof manhood	8	12.1%
Marry one partner	5	7.6%
Condom use unacceptable	7	10.6%
Not sure	5	7.6%
Polygamy	3	4.5%
Sex before marriage unacceptable	16	24.2%
Sexual intercourse with young girls clean blood	5	7.6%
Unprotected sexual intercourse	3	4.5%
Women cannot refuse men sex	4	6.1%
Total	66	100%

- ***The extent, which the above-identified cultural practices in Table 12 possibly contribute to the spread of HIV?***

Table 13 gives an indication of all the responses the respondents mentioned to show how the identified cultural practices in Table 12 could possibly contribute to HIV transmission.

Table 13: The extent to which the cultural practices identified by the respondents could possibly contribute to the spread of HIV

Extent which the cultural practices contribute to the spread of HIV	Respondents	Percentage
Young girls sleep with older men	12	18.2%
Sex language unacceptable	2	3%
Reduces teenage pregnancies	2	3%
Polygamy acceptable	1	1.5%
Not sure	8	12.1%
No contribution	4	6.1%
Ignoring practices can spread HIV	1	1.5%
Faithful relationships	1	1.5%
Do not know	11	16.7%
Condom use unacceptable	24	36.4%
Total	66	100%

Of the total sample, 16.7% (n=11) did not know and 12.1% (n=8) were not sure. About 15.2% (n=10) said that because condoms are not used, thus it is possible that HIV can be easily spread. About 36.4% (n=24) said that condom use is unacceptable in their culture and people are at risk and 18.2% (n=12) thought the involvement of young girls in relationships with older men put them at risk. The responses above are said to contribute to the spread of HIV. If condoms are not used and not acceptable in the culture, definitely people are at risk of contracting HIV easily. Older men have possibly been sexually active before the younger girls and could have been exposed to HIV infection; therefore they can easily infect the younger girls with HIV especially because condoms are not culturally acceptable.

- ***Cultural practices influencing sexual behavior in Botswana***

There were 39.4% (n=26) respondents who said that there were no cultural practices influencing sexual behavior and 15.2% (n=10) were not sure. However 45.5% (n=30) agreed that there were cultural practices influencing sexual behavior.

Of those who said yes, 40% (n=12) said that getting engaged when you are young “Peeletso” was one common cultural practice, which make girls engage in sexual practices without any experience of sexual life.

A total of 16.7% (n= 5) said that sex before marriage is unacceptable therefore sexual behavior is controlled.

Abstinence and not relating to male friends also controls sexual behavior. This was mentioned by 6.6% (n= 2) and 3.3% (n=1) mentioned that the use of alcohol also influences sexual behavior as people do not have control on what they do when they are drunk and therefore they are at risk if not using condoms. In these situations they can easily get infected.

- ***The significance of the cultural practices in shaping sexual behavior***

Of the total respondents 25.7% (n=17) mentioned that sexual behavior is definitely controlled by the belief that people should not have sex before marriage. Sexual activity is thus delayed to a certain extent. About 9% (n=6) added that women tend to respect their husbands in the Batswana culture as they are expected not to refuse them sex. Seven 10.6% respondents mentioned that most sexual behaviour in the Batswana culture is risky. For example some of the cultural practices mentioned in Table 12 namely women being unable to refuse men sex and beliefs that sexual intercourse with young girls clean blood were said to be shaping sexual behavior in a manner that exposes people to HIV infection. Table 14 gives an indication of the respondents’ thoughts of how significant are the cultural practices of the Batswana in shaping sexual behaviour.

Table 14: The significance of cultural practices in shaping sexual behavior

Significance of cultural practices in shaping sexual behavior	Respondents	Percentage
Women respect their husbands	6	9%
Risky sexual behavior	7	10.6%

No significance	1	1.5%
Not applicable	19	28.8%
Do not know	16	24.2%
Controls sexual behavior	17	25.7%
Total	66	100%

- ***The present cultural practices predispose people to HIV infection***

Of the total sample, 46% (n=30) said that the present cultural practices do not predispose people to HIV infection and 12% (n=8) were not sure. The rest of the respondents 42% (n=28) agreed that the present cultural practices predispose people to HIV infection. Figure 4 gives an indication of the respondents' opinions about cultural practices exposing people to HIV infection.

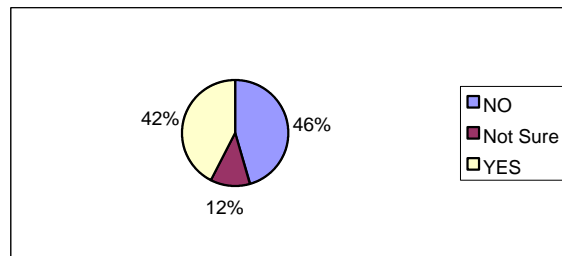


Figure 4: Predisposition of cultural practices to

HIV/AIDS

- ***Cultural practices protect people from HIV infection***

The majority of the respondents 65% (n=43) said that cultural practices do not protect people from HIV infection. About 8% (n= 5) were not sure about this issue. The protection from HIV infection by cultural practices was supported by 27% (n=18).

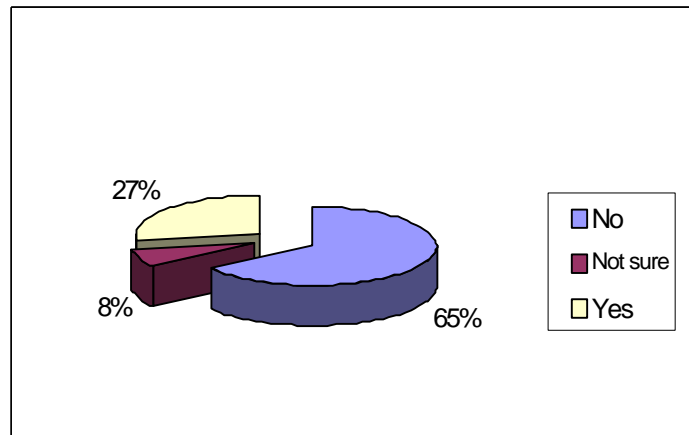


Figure 5: Cultural practices protect people from HIV infection

- ***Cultural circumcision can expose people to HIV transmission***

In response to this issue 32% (n=21) said they do not think that cultural circumcision can expose people to HIV transmission. Only 6.1% (n=4) were not sure about whether cultural circumcision can expose people to HIV transmission and 62.1% (n=41) felt that cultural circumcision could expose people to HIV transmission.

The respondents 62.1% (n=41) who agreed that cultural circumcision could expose people to HIV transmission gave the following reasons as contributory factors to the exposure of HIV transmission:

- ❖ Unsterile instruments are used, 36.5% (n=15)
- ❖ Stop circumcision, 34.1% (n=14)
- ❖ People do not stick to one partner 7.3% (n=3)
- ❖ Condoms are not used, 2.4%
- ❖ Not sure, 19.5% (n=8)

- ***Women should use herbs or other agents to dry out and tighten the vagina for dry sex***

Of the total sample 1.5% (n=1) were not sure of whether women should use herbs or other agents to dry out and tighten the vagina for dry sex. However the majority of the respondents

83.3% (n=55) felt that women should not use herbs or other agents to dry out and tighten the vagina for dry sex.

Only 15.5% (n=10) agreed that women should use herbs or other agents to dry out and tighten the vagina for dry sex.

- **Beliefs in women circumcision**

The research findings revealed that 80% (n=53) did not believe in women circumcision. Only 4.5% (n=3) were not sure of whether there was anything like women circumcision and 15.5% (n= 10) believed in women circumcision.

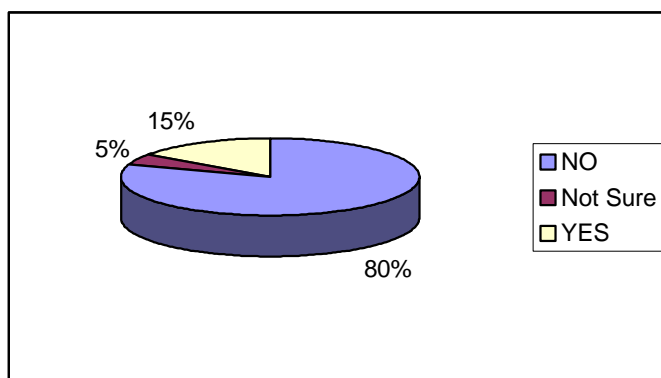


Figure 6: Beliefs in women circumcision

- **Women circumcision predisposes women to HIV transmission**

Table 15 reflects the respondents' opinions about the relationship between women circumcision and HIV transmission.

Table 15: Relationship between women circumcision and HIV transmission

Opinion regarding women circumcision and HIV transmission	Respondents	Percentage
Exposed wounds	16	24.2%
Does not predispose	23	34.8%

Not sure	15	22.7%
Stop circumcision	2	3%
Unsterile instruments	5	7.6%
Predisposes	5	7.6%
Total	66	100%

The majority of the respondents 34.8% (n=23) said that women circumcision does not predispose women to HIV transmission. Only 24.2% (n= 16) said that women usually have exposed wounds when they are at the circumcision schools, which expose them to HIV transmission. Five (7.6%)of the respondents also mentioned that women could be easily exposed to HIV transmission because unsterile instruments are used during women circumcision. Another 7.6% (n=5) said that women circumcision definitely predisposes women to HIV transmission. They however did not give reasons for their answers. Three percent (n=2) of the respondents strongly felt that women circumcision should be stopped. There were 22.7% (n=15) who were not sure whether women circumcision predisposes women to HIV transmission or not.

Summary: Cultural practices

The results showed that there were cultural practices regarding marriage and sexual life in Botswana the respondents could identify in their communities. The majority of the respondents (n=16) strongly felt that it is culturally acceptable to engage in sexual intercourse only after marriage, meaning that one cannot have a child before marriage. It was however mentioned by (n=4) that children are very important. The community can pressurize a person to have children and there is usually stigma attached to women who cannot have children. Another important finding was that the respondents (n=8) mentioned that many women/wives in a man's life proof his manhood. It is therefore common that a man can have many relationships with women. The other respondents (n=5) mentioned that sexual intercourse with young girls clean blood and that women cannot refuse men sex (n=4). About (n=7) respondents mentioned that it is culturally unacceptable to use condoms in the Batswana culture.

The respondents of the focus group discussions confirmed the above beliefs about the cultural practices in relation to sex and marriage.

It seems as if condoms are not very popular in Africa. Caldwell and Quiggin (1989) as quoted by Van Dyk (2001: 122) postulate that many Western authors erroneously ascribe the lack of condom use in Africa to promiscuity, permissiveness and to a lack of moral and religious values. Population control remains a sensitive issue in Africa because it negatively impacts on the growth of a tribe, it deprives parents of needed labour and it undermines traditional beliefs and values (Hickson & Mokhobo, 1992 in Van Dyk, 2001:121).

Kwashi (2002:20) said that childbearing is essential in marriage. Married couples must have children and a childless marriage encourages man to remarry again. Shaw in (Lewis, 1990:237) also mentioned that marriage exist to legitimize sex. Hickson & Mokhob (1992) as quoted by Van Dyk (2001:121) postulate that population control remains a sensitive issue in Africa because it negatively impacts on the growth of the tribe. It is not surprising that research results also revealed that children are very important and therefore people would not use condoms, as they will prevent pregnancy.

Other studies in Botswana also confirmed that in areas such as Ngamiland multiple sexual partners especially by men are recognized. Adupa (1999) states that men in Botswana dominate women in sexual matters. Thus regardless of the sero status of a husband, which the wife may not know anyway, failure to provide sex to the spouse, may earn the wife a divorce. Besides, having multiple sexual partners seems to be universally and culturally accepted and tolerated for men. Girls are also introduced sex matters at a much earlier age .In Ngamiland polygamy is practiced by all cultures although it is now very common amongst the Zezuru community.

Research results of other studies showed that the rates of HIV infection in young African women are far higher than in men. This enormous discrepancy is due to age mixing between young women and older men who have more sexual experience and are much more likely to be exposing the young girls to HIV (UNAIDS, 2000; Berer & Ray, 1993:44-45).

The respondents believes regarding cultural practices, sex and marriage, are reflected in the findings of many studies as mentioned above.

Regarding circumcision, almost all the respondents (n=53) said that they did not believe in women circumcision. However, there were (n=23) respondents who said that women circumcision does not predispose women to HIV transmission. Only (n=28) respondents

thought that women circumcision predisposes women to HIV transmission. Sixteen (n=16) respondents said there was predisposition to HIV infection because there were exposed wounds after the circumcision and (n=5) respondents said that unsterile instruments were used at the circumcision school. The other reasons were reflected in Table 15.

According to the World Health Organisation (WHO) - Fact Sheet 1(2000a: 2), Crewe and Orkin (1992:4), Berer and Ray (1993:6), Ward (1999), Murphy, Brook & Brichal (2000: 2), Gordan and Klonda (1998) and Whiteside and Sunter (1998: 14) HIV can be transmitted by injecting equipment such as needles or syringes, or skin-piercing equipment, contaminated with HIV.

The majority of the respondents (n=55) also felt that women should not use herbs or other agents to dry out and tighten the vagina for dry sex. In this regard Wilson, et al. (2002:63) mentioned that the disruption of the genital tract epithelium by intravagial spermicides, herbal agents used for 'dry sex' facilitate the increased transmission of HIV from men to women. It is evident from the respondents' responses about cultural practices that there are cultural practices of the Batswana in relation to marriage and sexual life that shape sexual behaviour, which facilitates the transmission of HIV/AIDS.

3.2.5. Section D: HIV/AIDS prevention and care strategies

- ***The extent in which strategies to combat the spread of HIV infection in Botswana are taking cultural practices into consideration***

Of the total sample, 25.7% (n=17) were unsure if the strategies to combat the spread of HIV in Botswana are taking cultural practices into consideration.

About 22.7% (n= 15) said that the strategies to combat the spread of HIV infection in Botswana are taking cultural practices into consideration.

The majority of the respondents 51.5% (n=34) strongly felt that the strategies do not take culture into consideration.

The respondents who felt that the strategies do not take culture into consideration gave the following reasons to support their responses:

- AIDS education should be for adults only. Culturally people do not discuss sex issues with children.
- Culture is not recognized, there was no specific reason given.
- HIV is not culture
- Traditional healers are not respected
- ***Older men should have sexual relationships with young girls who are virgins to prevent HIV transmission***

The results showed that 94% (n=62) did not agree that older men should have sexual relationships with young girls who are virgins to prevent HIV transmission and 3% (n=2) were not sure whether this should happen or not Another 3% (n=2) felt that older men should have sexual relationships with young girls who are virgins to prevent HIV transmission.

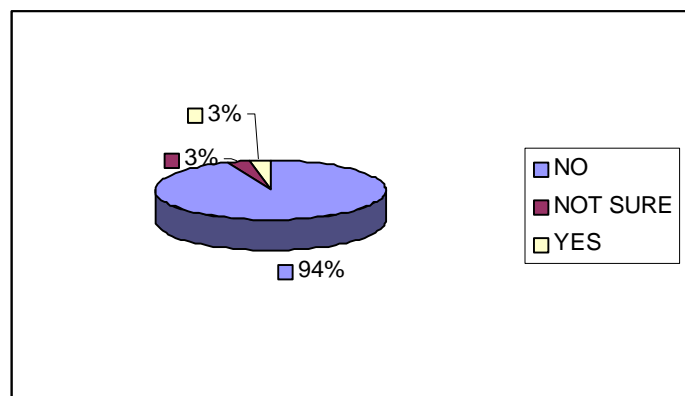


Figure 7: Responses regarding the statement:older men have sexual relationships with young girls who are virgins to prevent HIV transmission

- ***Beliefs in principles of stay with one partner to prevent HIV transmission***

The majority of the respondents 80.3% (n= 53) believed in the principle of stay with one partner to prevent HIV transmission and 10.6% (n=7) did not believe in these principles. Only 9.1%

(n=6) were not sure of whether they should believe in the principle or not. The reasons for their answers were not established.

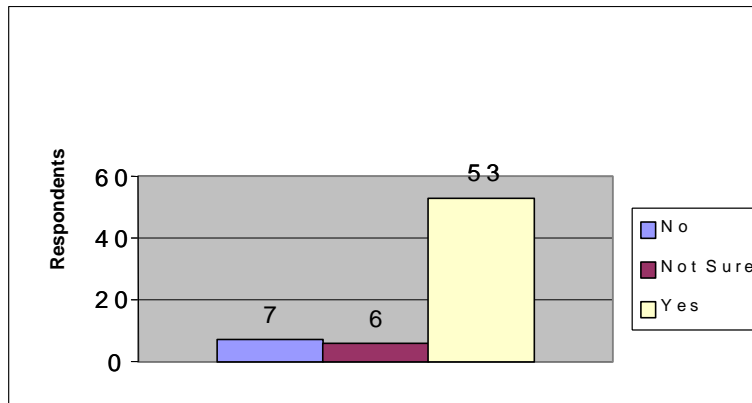


Figure 8: Beliefs in principles of stay with one partner to prevent HIV transmission

- ***Can antiretrovirals help prolong the lives of HIV positive people in your culture?***

The findings revealed that 3% (n=2) were not sure of whether the antiretrovirals can help prolong the lives of HIV positive people in their culture. About 11% (n=7) of the respondents thought that the antiretrovirals could not help prolong the lives of HIV positive people in their culture. However, 86% (n=57) strongly agreed that antiretrovirals could help prolong the lives of HIV positive people in their culture.

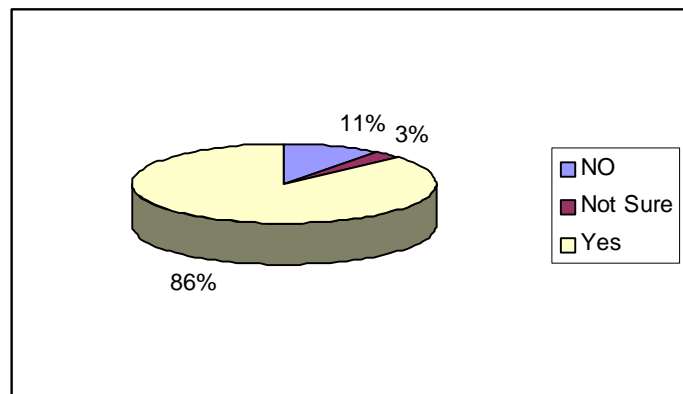


Figure 9: Opinions regarding the helpfulness of antiretroviral to help prolong the lives of HIV positive people in their culture

positive people

- ***Things that can help prolong the lives of HIV positive people in Botswana***

Table 16 below presents the respondents' ideas about how the lives of HIV positive people in Botswana can be prolonged.

Table 16: Responses regarding what can help prolong the lives of HIV positive people in Botswana

Helps Prolong Lives	Respondents	Percentage
Abstain	19	28.8%
Antiretrovirals	17	25.7%
Do not know	3	4.5%
Positive/healthy living	4	6.1%
Nothing	11	16.7%
Stick with one partner	5	7.6%
Traditional medicines	7	10.6%
Total	66	100%

About 16.7% (n=11) said that there was nothing that could help prolong the lives of HIV positive people in their culture and 4.5% (n=3) said that they did not know. Only 25.7% (n=17) mentioned that antiretroviral would help to prolong the lives of HIV positive people. There were 10.6% (n=7) who were in favour of traditional medicines. A total of 28.8% (n=19) said that if people abstain, the behavior can help prolong the lives of HIV positive people in their culture. Only 6.1%(n=4) said healthy living and nutrition can help prolong the lives of HIV positive people in their culture while 7.6% (n=5) said to stick with one partner can help prolong the lives of HIV positive people.

- ***Prevention of HIV transmission***

Of all the respondents in the sample, 30%(n=20) thought if people abstain, HIV transmission could be prevented. About 4.5% (n=3) said that they did not know and 51% (n=34) supported the use of condoms. Some respondents 4.5% (n=3) felt that culture should be respected and another 4.5% (n=3) felt that staying with one partner was the best way of preventing HIV transmission. Only one respondent 1.5% (n=1) thought that getting tested would prevent HIV transmission and another one 1.5% (n=1) said that there was nothing to prevent HIV transmission. The use of antiretrovirals was supported by 1.5% (n=1) respondent.

- ***Should people only consult with traditional healers when they have HIV/AIDS?***

The majority of the sample 89% (n=59) disagreed with the statement that people should only consult with traditional healers when they have HIV/AIDS. One respondent 1.5% (n=1) said people should consult both western doctors and traditional healers as traditional healers only are not helpful. About 3% (n=2) were not sure whether people should only consult with traditional healers when they have HIV/AIDS or not. However, 6% (n=4) said that people should only consult with traditional healers when they have HIV/AIDS, as they are helpful.

- ***The responsibility of the family to educate children about HIV/AIDS***

The data showed that the respondents were in favour of the family taking responsibility-educating children about HIV/AIDS in their culture. The majority 78.8% (n=52) of the respondents answered yes to this question and 21% (n=14) did not think this was a good idea.

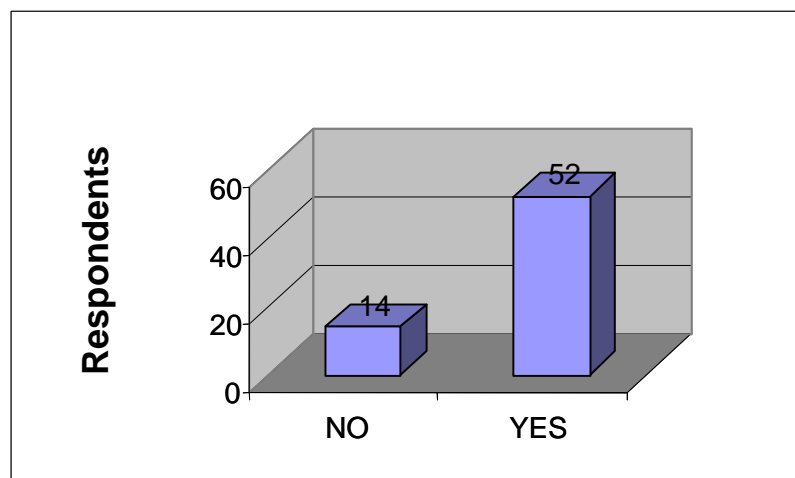


Figure 10:Responsibility of the family to educate children about HIV/AIDS

- ***Should HIV positive mothers not breast-feed their babies?***

Of the total population, 29%(n=19) felt that HIV positive mothers should actually breast-feed their babies and 66% (n=44) felt that HIV positive mothers should not breast-feed their babies. Only 5% (n=3) were not sure of what HIV positive mothers should do in terms of breastfeeding.

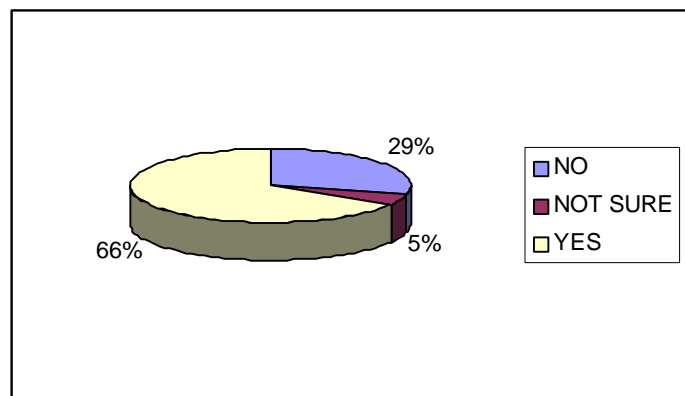


Figure 11: Breast -feeding of HIV positive mothers

- ***Can HIV positive mothers feed their babies with other foods whilst they are breastfeeding?***

There was a strong feeling that HIV positive mothers must feed the babies with other foods whilst they are breastfeeding. This was mentioned by 51% (n=34) of the sample. However 38% (n=25) did not support the idea that HIV positive mothers feed the babies with other foods whilst they are breastfeeding and only 11% (n=7) were not sure about the issue.

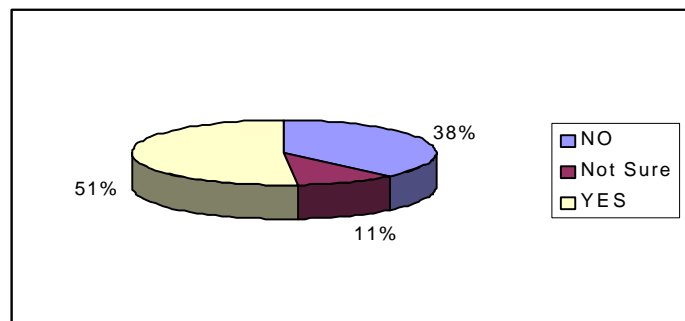


Figure 12: Responses regarding whether HIV positive mothers must feed their babies with other foods whilst they are breastfeeding

Summary: HIV/AIDS prevention and care strategies

The responses regarding whether HIV/AIDS prevention strategies to combat the spread of HIV infection in Botswana are taking cultural practices into consideration were very skewed. Some respondents (n=15) felt that the HIV/AIDS prevention strategies in Botswana do take culture into consideration while (n=17) respondents were not sure about what the strategies were doing in terms of culture. However the majority of the respondents (n=34) strongly felt that the strategies do not take culture into consideration. Van Dyk (2001:125) says that AIDS educators should be creative and imaginative in incorporating traditional beliefs and healing methods into AIDS education programmes.

Almost all the respondents (n=62) did not agree that older men should have sexual relationships with young girls who are virgins to prevent HIV transmission. According to the UNAIDS (2000) it has been found that the infection rates in young African women are far higher than the infection rates in young men. Among young people in their early twenty's, the rates were three times higher in women. In large measure, this enormous discrepancy is due to age mixing between young women and older men, who have had much more sexual experience and are much more likely to be exposing the girls to HIV.

According to Poku (2001:197) the age disparity in HIV infection rates indicates that young women must be having sex with men much older than themselves. This point is confirmed by ongoing studies in Botswana.

It is also evident from the literature reviewed that women are said to be having sex with men much older than themselves. Poku (2001:197) continues to say that older men have sexual intercourse with young women or girls who are virgins, as they believe that the behaviour prevents HIV transmissions.

Principles of staying with one partner to prevent HIV transmission were supported by (n=53) of the respondents. Long-term mutual monogamy with an uninfected partner should be promoted to prevent HIV infection (Wilson, et al., 2002: 64).

The majority of the respondents (n=57) supported the use of antiretrovirals, as they are helpful in prolonging the lives of HIV positive people. Wilson, et al. (2002:330), Evian (2000: 79) and the Soul City- Know the Facts (2002) state that the main purpose of using ARTs is to reduce the risks of people getting HIV so that they stay healthier and live long.

The majority of the respondents (n=59) did not think that people with HIV/AIDS should consult with traditional healers. There were however (n=7) respondents who believed that the use of traditional medicines can help people live long when they have HIV. Van Dyk (2001: 126) argues that no AIDS prevention programmes can succeed in Africa without the help of traditional healers. Traditional healers are effective agents of change because they have authority in their communities. They function as psychologist, marriage and family counselors, physicians, priests, tribal historians and legal and political advisors. About 80% of people in Africa rely on traditional medicines for many of their health care needs.

The majority of the respondents (n=52) strongly felt that the family should take responsibility in educating children about HIV/AIDS. A study conducted in Molepolole (Kweneng) District in Botswana by the AIDS/STD Unit in 1993 to determine the prevalence of teenage pregnancy and HIV/AIDS threat, revealed that lack of communication between parents and their children was a factor in contributing to teenage pregnancies. Therefore it is very important that the family takes responsibility in educating children about sex and HIV/AIDS (Ramatsui, 1993 in Meekers & Ahmed, 1997). Popenoe (1986:85) also states that the family is the most important unit in the society. In modern societies, most early socialisation occurs within a small-scale of a family context. According to Popenoe (1986:120) socialisation is the process through which people acquire personality and learn the ways of a society or a group. Socialisation begins at home where children learn who they are, what they can and should expect in life and how to behave toward others in the society. The family is well suited to take on the task of socialisation as it is a small group in which members have a great deal of face to face contact. The children's progress can be closely watched and adjustments in their behaviour made necessary.

The majority of the respondents (n=44) felt that HIV positive mothers should not breastfeed their babies. However (n=34) respondents felt that babies should be anyway fed with other foods when they are breastfed. Evian (2000: 215) says that any new HIV infection during

pregnancy and breast-feeding is likely to result in an increase in the HIV viraemia. This is considered to increase the likelihood of MTCT.

Programmes to prevent mother-to-child-transmission (PMTCT) of HIV have been conducted in many countries including Botswana. These programmes have succeeded in reducing the number of HIV infections in babies born of HIV-positive women. MTCT programmes include formula feeding or a 6-month period of exclusive breastfeeding to reduce the transmission of HIV through breast milk. Mixing breast milk with other feeds may increase the risk of transmission. There are debates regarding whether babies who are breast fed by HIV positive mothers are more at risk than babies who are formula fed or bottle-fed by HIV positive mothers (Gordan and Klonda, 1988: 28-29; Wilson, et al., 2002:298-299 and Van Dyk, 2001:29). Counseling on feeding options should be provided to allow women to make informed choices (Soul City- Know the Facts, 2002 and Evian, 2000:220-221).

3.2.6. Section E: Polygamy

- ***It is said that men can have multiple relationships irrespective of their marital status but women may not.***

In response to this question, only 2% (n=1) respondent was not sure about the specific statement. The researcher did not explore the reasons for the answer. However 27% (n=18) thought it was a good idea. The majority of the respondents 71% (n=47) said that they disagreed with the statement that men can have multiple relationships irrespective of their marital status but women may not. (See figure 13).

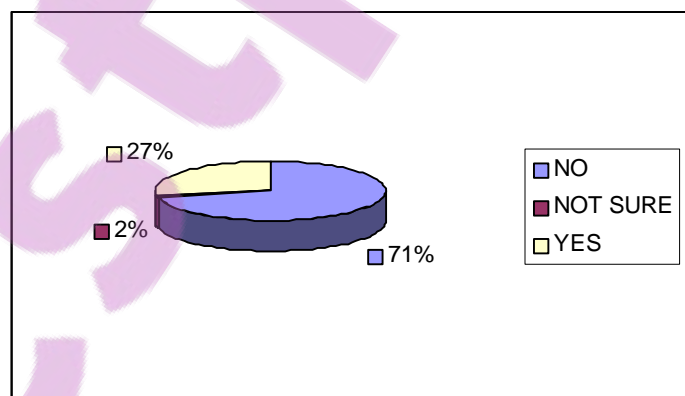


Figure 13: Beliefs regarding men with multiple relationships

- ***The statement that men can have multiple relationships irrespective of their marital status but women may not, is this one of the Batswana culture?***

Of the total sample 27.3% (n=18) felt that the statement that men can have multiple relationships irrespective of their marital status but women may not was not one of the Batswana culture. Another 10.6% (n=7) said that they were not sure whether this was one of the Batswana culture. However, 62.1% (n=41) felt that this was one of the Batswana culture. (See Table 17)

Table 17: Multiple relations and the Batswana culture

Multiple relations Batswana culture	Total	Percentage
No	18	27.3%
Not sure	7	10.6%
Yes	41	62.1%
Grand total	66	100%

- ***It is said that a man can have multiple relationships irrespective of his marital status but women may not. Does the statement contribute to the spread of HIV and if yes what can be done?***

The findings revealed that 12.1% (n=8) said the statement that men can have multiple relationships irrespective of their marital status but women may not, does not contribute to the spread of HIV. However 4.5% (n=3) were not sure whether the behavior of men in multiple relationships irrespective of their marital status could contribute to the spread of HIV. The majority of the respondents 83.3% (n=55) said the statement that men can have multiple

relationships irrespective of their marital status but women may not, does contribute to the spread of HIV. (See figure 14).

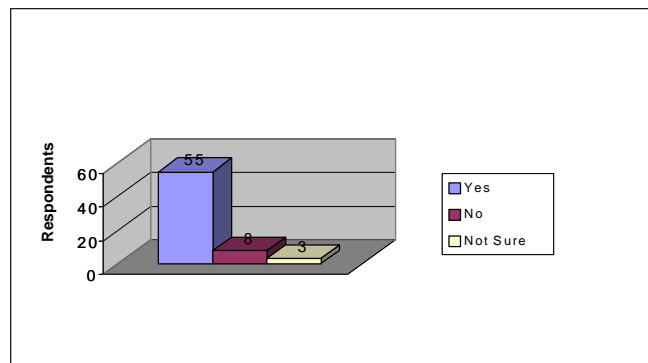


Figure 14: Responses regarding the behavior of men in multiple relationships contributing to the spread of HIV

The following were given as solutions to deal with the problem of multiple relationships by the respondents (n=55) who agreed that the behavior does contribute to the spread of HIV: (See Table 18 below).

Table 18: Solutions to prevent HIV transmission in multiple relationships

Solution in multiple relationships	Respondents	Percentage
Abstain	1	1.8%
Condom use	9	16.4%
Health education	13	23.6%
No solution	1	1.8%
Pray	3	5.5%
Stick with one partner	27	49.1%
Know your status	1	1.8%
Total	55	100%

The majority of the respondents 49.1% (n=27) felt that sticking to one partner was one of the solutions for preventing HIV transmission in multiple relationships. Health education was supported by 23.6% (n=13) of the respondents whilst condom use was supported by 16.4% (n=9). Some respondents 5.5% (n=3) thought prayers could help solve problems related to multiple relationships such as HIV transmission.

- ***It is said that “a man is like a bull and should not be confined to one pasture”, is this one of the Batswana cultural practices?***

It was found that 67% (n=44) agreed that the statement “a man is like a bull and should not be confined to one pasture” is in fact one of the Batswana cultural practices. However 24% (n=16) felt it is not part of Batswana culture at all. Nine percent of the respondents (n=6) were not sure whether people were practicing this out of their own or as part of culture.

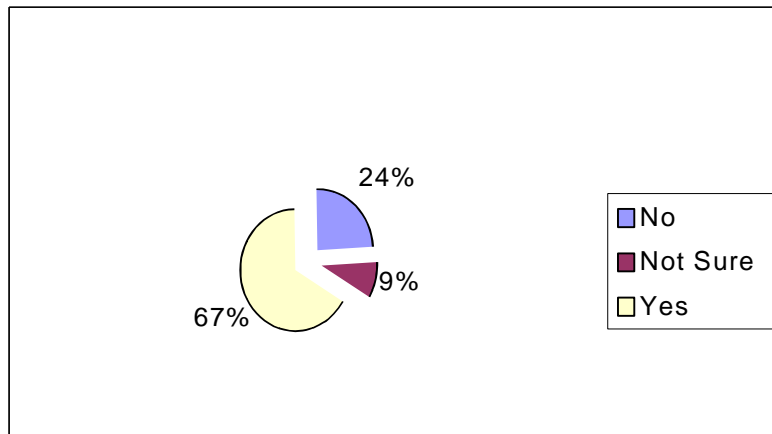


Figure 15: Response regarding the statement a man is like a bull is one of the Batswana cultural practices

- ***It is said that a man is like a bull and should not be confined to one pasture. Does this contribute to the spread of HIV and what can be done?***

Of the total sample 17% did not think that the statement, “a man is like a bull and should not be confined to one pasture” contribute to the spread of HIV. Only one respondent 2% was not sure

of whether this behavior contribute to the spread of HIV. The majority 81% of the sample thought that the statement contributes to the spread of HIV.

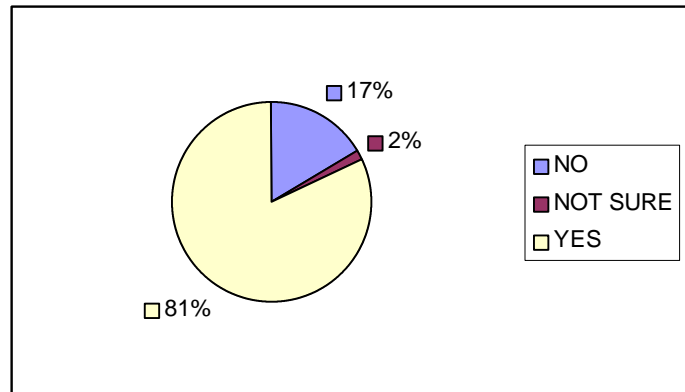


Figure 16: Responses regarding the statement of a man is like a bull spreads HIV

The following were given as solutions to deal with the problem of men behaving like bulls by the respondents (n=54) who agreed that the behavior contribute to the spread of HIV:

Table 19: Solutions regarding “man is like a bull”problem

Solution	Respondents	Percentage
Challenge men	6	11.1%
Condom use	12	22.2%
Health education	9	16.7%
Nothing can be done	2	3.7%
Pray	3	5.6%
Stick with one partner	21	38.9%
Infect them with HIV	1	1.8%
Total	54	100%

Of the total number of respondents (n=54) who agreed that the behavior of “ Man is like a bull ” contributes to the spread of HIV; the majority 38.9% (n=21) mentioned that sticking with one partner was one of the best options to prevent HIV transmission. Condom use was another preferred option by 22.2% (n=12) respondents. Health education was supported by 16.7% (n=9) as an option to prevent HIV transmission in these circumstances and 11.1% (n=6) wanted men to be challenged for this kind of behaviour. Praying was mentioned again by

another 5.6% (n=3) in this behaviour of “ a man is like a bull and should not be confined to one pasture” This behaviour means that men can have multiple relationships whether they are married or not. An interesting response from one respondent (1.8%) was that men had to be infected with the HI virus so that they can stop having multiple relationships.

- ***Ways to ensure that people in polygamous marriages do not infect each other***

The respondents’ responses regarding the methods to be used in ensuring that people in polygamous marriages do not infect each other are reflected in Table 20.

Table 20: Prevention of HIV transmission in polygamous marriages

Prevention in polygamous marriages	Respondents	Percentage
Condom use	38	57.5%
Traditional medicines	1	1.5%
Health education	3	4.5%
Stop polygamy	4	6.1%
Faithfulness	13	19.7%
Nothing	5	7.6%
Abstain	2	3%
Total	66	100%

The majority of the respondents 57.5% (n=38) felt that condom use should be encouraged and 19.7% (n=13) said that people should practice faithfulness. About 6.1% (n=4) supported that polygamy should be stopped and 7.6% (n=5) felt that nothing could be done. Health education was supported by 4.5% (n=3) and 3% n=2) felt that abstinence should be encouraged. It was interesting to note that 1.5% (n=1) thought that people in polygamous marriages should use traditional medicines to prevent transmission of HIV.

Summary: Polygamy

The majority of the respondents (n=47) did not support the notion that men can have multiple relationships irrespective of their marital status but women may not. The majority of the respondents (n=41) however said that the behaviour of men having multiple relationships irrespective of their marital status in Botswana is in fact one of the Botswana cultural practices. The majority of the respondents (n=55) mentioned that the behaviour however contribute to the spread of HIV in Botswana. The respondents (n=27) said that one solution to prevent the spread of HIV in this respect was for people to stick with one partner. About (n=13) respondents said that people should be encouraged to stick with one partner and (n=13) respondents said that people should get health education regarding HIV/AIDS prevention. Nine (n=9) respondents supported condom usage to prevent HIV transmission in multiple relationships. The majority of the respondents 81% said that the behaviour however contribute to the spread of HIV infection. Health education, condom use and sticking with one partner were again mentioned as ways which HIV transmission could be prevented.

The majority of the respondents (n=38) thought that people in polygamous marriages should use condoms to prevent the spread of HIV transmission. The focus group discussions also supported that polygamy is still practiced in parts of Botswana although it is not supported by the younger generation.

Barrett- Grant, et al. (2001: 19) and Wilson, et al. (2002:62-64) mentioned safer sex (emphasizing the use of condoms) and long-term mutual monogamy with an uninfected partner using condoms as ways of preventing HIV infection. Condoms are key to preventing the spread of HIV/AIDS and sexually transmitted infections, together with sexual abstinence, postponement of sexual debut and mutual fidelity (UNAIDS, 2002:86).

According to Giddens (1990:386) polygamy describes any type of marriage, which allows a husband or a wife to have more than one spouse. Van Dyk (2001:120) mentions that Western health care professionals mostly frown upon polygamy in African societies, but polygamy often helps to prevent and reduce unfaithfulness, prostitution, STDs and HIV. According to Mbiti (1969) as quoted by Van Dyk (2001:120) polygamy is particularly valuable in modern times when African men are often forced to seek work in the cities and towns. If a husband has several wives he can afford to take one at a time to live with him in the town, while the other wife or wives remain behind to care for the children and family property. As a result polygamy often provides a healthy alternative or solution to problems inherent in certain cultural customs.

Adupa (1999) mentioned that in Botswana it is accepted by the society at large that men's sexual networks can be quite extensive. There is a feeling that men may legitimately have multiple relationships irrespective of their marital status but women may not.

Previous research results from a study conducted by BOTUSA in 1999 to identify risk factors for HIV revealed and also confirm that the respondents believed that "a man is like a bull and should not be confined to one pasture" (BOTUSA, 1999). The respondents believed that it is acceptable for men to have multiple relationships in Botswana.

3.2.7. Section F: Sexual practices

- ***Opinions regarding women who should at all times be prepared to have sex with their partners***

Of the total sample 30.3% (n= 20) of the respondents felt that women should at all times be prepared to have sex with their partners and 7.6% (n=5) said that they were not sure what should happen. However, 62.1% (n=41) felt that women should not at all times be prepared to have sex with their partners.

- ***Beliefs that women cannot refuse their partners sex***

Of the total sample, 58% (n=38) said that they believe that women cannot refuse their partners sex and 33% (n=22) said that women could refuse their partners sex. Only 9% (n=6) were not sure of whether women cannot refuse their partners sex.

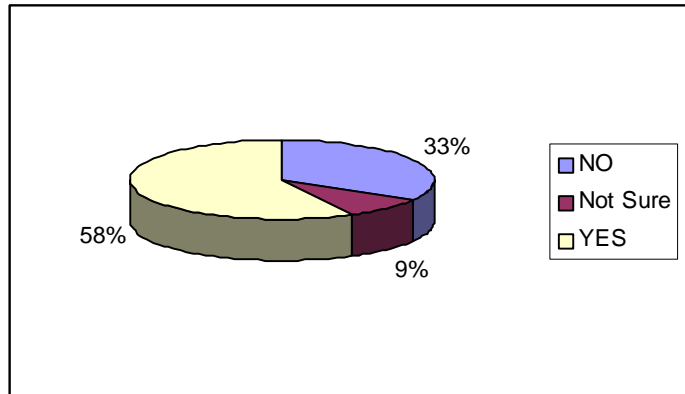


Figure 17: Opinions regarding the statement that women cannot refuse men sex

- ***Beliefs regarding older men have more chances of infecting younger women, as they have been sexually active before the women***

The results showed that 71% (n=47) believed that older men have more chances of infecting younger women, as they have been sexually active before the women and 23% (n=15) did not hold this belief. Only 6% (n=4) of the respondents were not sure whether they believed or not.

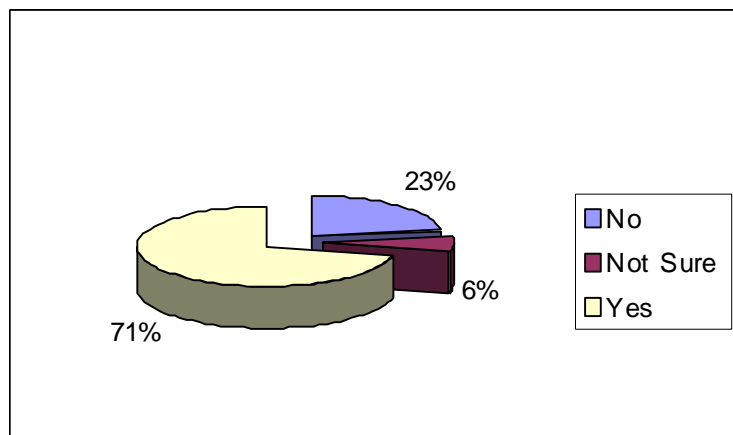


Figure 18: Beliefs regarding older men infect younger women as they become sexually active earlier

- ***Opinions regarding women who should be making decisions regarding sexual practices***

The findings showed that 77.3%(n=51) thought that women should make decisions regarding sexual practices and 19.7% (n=13) thought that women couldn't make decisions regarding sexual practices. About 3% (n=2) were not sure whether they could or not.

Table 21: Women can decide whether they want sex or not

Women should decide sex	Respondents	Percentage
No	13	19.7%
Not sure	2	3%
Yes	51	77.3%
Grand total	66	100%

- ***Opinions regarding infertile women who can end up having sex with multiple partners in an effort to become pregnant***

About 53% (n=35) respondents agreed that infertile women could end up having sex with multiple partners in an effort to become pregnant. However 42% (n=28) did not agree. Only 5% (n=3) said that they were not sure whether infertile women could end up having sex with multiple partners in an effort to become pregnant.

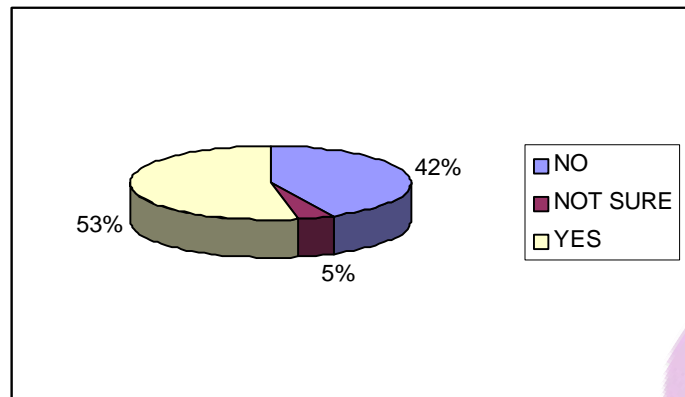


Figure 19: Opinions regarding infertile women can end up having sex with multiple partners in an effort to become pregnant

- ***Opinions with regard to the behaviour of infertile women that would lead them into having sex with multiple partners in effort to become pregnant increases HIV infection.***

The majority of the sample, 91% (n=60) felt that they agree with the statement that the behaviour of infertile women which makes them ending up having sex with multiple partners in an effort to become pregnant increase HIV infection.

Only 3% (n=2) were not sure whether this behaviour increases HIV infection and another 3% (n=2) said that they did not know if this behaviour increased HIV infection. The rest 3% (n=2) of the respondents said that one couldn't get HIV when they are infertile. The respondents who agreed with the statement mentioned that because the women do not use condoms as they try to conceive, they could easily get infected if they do not know the status of the sex partner.

- **Opinions regarding men having multiple sex partners**

The results showed that 71% (n=47) believed that men cannot have multiple sex partners and 27.3% (n=18) believed that men could have multiple sex partners.

Only 1.5% (n=1) respondent was not sure whether men could have multiple sex partners.

- **Opinions regarding the statement that it is only the privilege of men to decide whether they want sex or not**

Of all the respondents, 84% (n=56) strongly felt that it was not only the privilege of men to decide whether they want sex or not. Women could also decide. However, 14% (n=9) said that it was the privilege of men to decide whether they want sex or not. Only 2% (n=1) respondent was not sure.

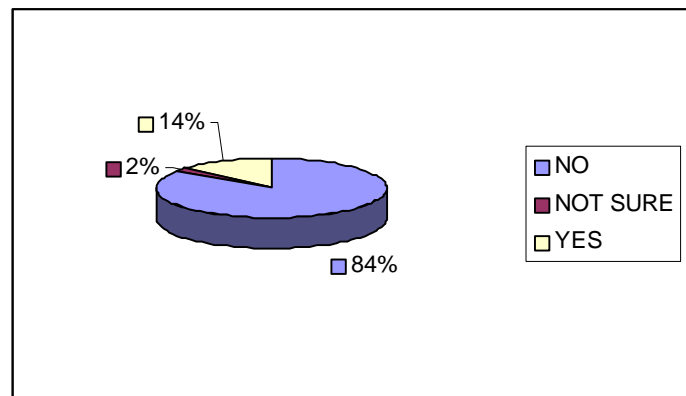


Figure 20: Men are privileged to have sex

Summary: Sexual practices

The majority of the respondents (n=41) felt that women should not at all times be prepared to have sex with their partners. Van Dyk (2001:150) says that women should believe in their ability and right to make their own choice to insist on condom use and to say no to sex. It is though interesting to note that more than 50% of the respondents (n=38) still believe that women cannot refuse their partners sex.

The majority of the respondents (n=47) also believed that older men have more chances of infecting younger women, as they have been sexually active before the women. In a nation study in Zambia, over a quarter of the men who had extramarital encounters had casual sex with women 10years or more their junior. Men who had sex with younger women may also have other high-risk partners (UNAIDS, 2000).

It has also been found that the infection rates in young African women are far higher than the infection rates in young men. Among young people in their early twenty's, the rates were three times higher in women. In large measure, this enormous discrepancy is due to age mixing between young women and older men, who have had much more sexual experience and are much more likely to be exposing the girls to HIV. It is the interplay of biological, cultural and economic factors that makes young girls particularly vulnerable to the sexual transmission of HIV. While both girls and boys engage in consensual sex, girls are more likely than boys to be uninformed about

HIV, including their own biological vulnerability to infection if they start having sex at a very young age. Girls are also far more likely than boys to be coerced or raped or to be enticed into sex by someone older, stronger or richer. Sometimes it is social pressure to acquiesce to elders (UNAIDS, 2000).

The majority of the respondents (n=51) strongly felt that women should make decisions regarding sexual practices. Fidzani, et al. (2000) added that many women say that they have very little say when it comes to issues of sexual relationships. Females believe that men were largely unwilling and uninterested in AIDS education. Women said that they always initiated the discussion with partners and often were discouraged by their partners who think that women always want to police them.

The majority of the respondents (n=35) agreed that infertile women could end up having sex with multiple partners in an effort to become pregnant. Mbiti (in Van Dyk, 2001:11) says that the failure to bear children is for an African woman worse than committing genocide.

Almost the entire respondents in the sample (n=60) felt that the behaviour of infertile women, which makes them end up having sex with multiple partners in an effort to become pregnant, increases HIV infection.

The respondents also strongly believed that men cannot have multiple sex partners although it is said that in Botswana it is accepted by the society at large that men's sexual networks can be quite extensive. There is a feeling that men may legitimately have multiple relationships irrespective of their marital status but women may not (Adupa, 1999). The respondents did not support these statements including the issue that it is the privilege of men to decide whether they want sex or not.

The majority of the respondents (n=56) strongly felt that it was not only the privilege of men to decide on whether they want sex or not. According to Van Dyk (2001:410), all people have the right to insist that they or their sexual partners take appropriate precautionary measures to prevent the transmission of HIV especially women.

3.2.8. Section G: Agricultural practices

- ***It is said that men are the only persons who can go to the cattle post. Is this one of the Batswana cultural practices and if so, does this behaviour put women in subordinates' positions?***

The majority of the respondents (n=44) agreed that the practice of men being the only persons who can go to the cattle post is one of the Batswana cultural practices and this behaviour puts women in subordinate positions. Only 26% (n=17) said that it is not one of Batswana cultural practices. However 8% (n=5) were not sure of whether this was a cultural practice of the Batswana.

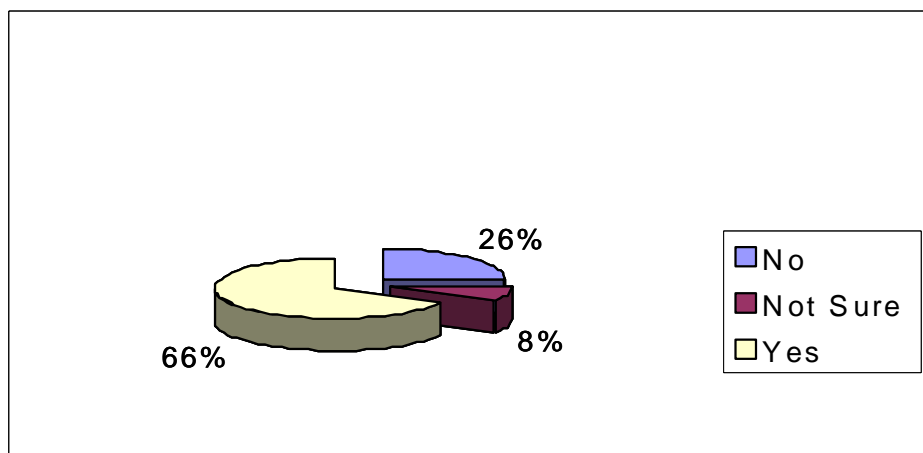


Figure 21: Men are the only persons who can go to the cattle post are one of the Batswana cultural practices and this puts women in subordinate positions

- **Solutions regarding HIV transmission problems related to the statement that men are the only persons who can go to the cattle post and this puts women in subordinate positions.**

Of the total number of the respondents, 19.7% (n=13) said that the statement that men are the only persons who can go to the cattle post and this puts women in subordinate positions, does not contribute to the spread of HIV.

Only 7.6% (n=5) were not sure of whether this behaviour does contribute to the spread of HIV.

However the majority 72.7% (n=48) of the respondents thought that the statement that men are the only persons who can go to the cattle post and this puts women in subordinate positions, does contribute to the spread of HIV.

From the group of the respondents (n=48) who said that the behaviour contribute to HIV transmission, the following were mentioned as solutions to the problem:

The majority 90% (n=43) said that both men and women must go to the cattle post. Counselling was recommended by 1.5% (n=1) respondents and condom use by also 1.5% (n=1).

The other individual responses given were: It is difficult to say what to do with the problem; some were not sure; some believed that trust was needed between the partners; head boys must be hired so that no one goes to the cattle posts and that no one should go to the cattle post at all.

- **Opinions regarding the statement that women should be involved in traditional farming of cattle so that they can go with their husbands to the cattle posts**

There was a strong feeling that women must be involved in traditional farming 92% (n=61). Only 5% (n=3) felt that women should not get involved in traditional farming. About 3% (n=2) were not sure whether women should get involved in traditional farming.

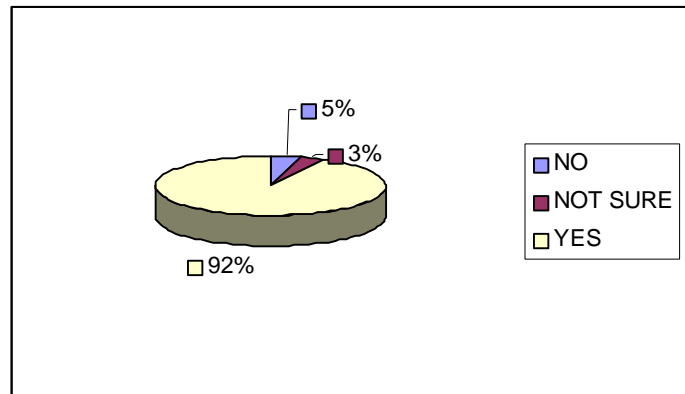


Figure 22: Involvement of women in traditional farming

Summary: Agricultural practices

The majority of the respondents (n=44) confirmed that the practice of men being the only persons who can go to the cattle post is one of the Batswana's cultural practices. Almost all the respondents (n=48) agreed that the behaviour does contribute to the spread of HIV/AIDS. There was a strong feeling from the respondents (n=61) that women should get involved in traditional farming so that they can go with their husbands to the cattle posts.

According to Adupa (1999) in Botswana, access and control of the most important resources among agricultural community is by men thus leaving women at their mercy. This statement is supported by the research results of this study. According to the 1994/95 agricultural surveys, women most of whom are widows, divorcees or have never been married head 35% of the traditional farm households in Botswana. Access and control of the most important resource among the agricultural community is by men thus leaving women at their mercy (Adupa, 1999:25). Consequently the women are left in very subordinate positions in economic terms. This may seriously predispose them to HIV infection, as sex offers are an easy alternative.

Authors like Kwashi (2002:20) mentioned that in almost all African cultures, cooking and other household chores are the women's responsibility. The woman has no rights at all with regard to the family income. The man control and he alone decides what, when and how family resources should be used.

According to Van Dyk (2001:150) women need to be empowered with life skills to be self-efficient.

3.2.9. Section H: Stigma issues

- ***Women who are HIV positive and know their status should have children to expand the family***

It was interesting to note that the majority of the sample 82% (n= 54) thought that women who are HIV positive and know their status, should not have children to expand the family.

Only 15% (n=10) thought that they could have children even if they were HIV positive and 3% (n=2) were not sure.

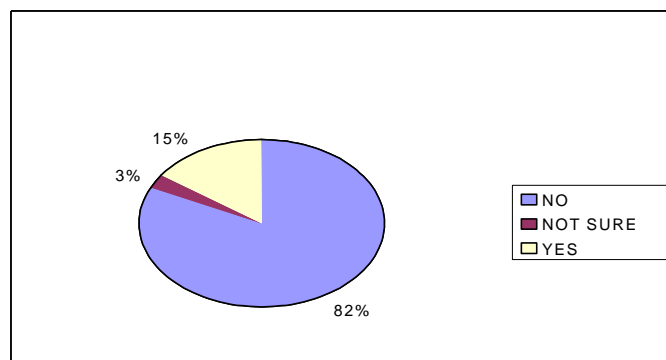


Figure 23: Opinions regarding the statement that HIV positive women can have children

- ***Opinions regarding people who are HIV positive***

The majority of the respondents felt that people who are HIV positive should live positively 22.7% (n=15) and 7.6% (n=5) said that they should not be discriminated. There was a feeling of feeling sorry for people who are HIV positive by 7.6% (n=5) respondents. It was also felt by

the same number of people 7.6% (n=5) that HIV positive people are a danger to the community and should abstain from sex. See detail responses in Table 22.

Table 22: Opinions regarding HIV positive people

Opinions	Respondents	Percentage
Bewitched	1	1.5%
Danger to the community	5	7.6%
Should disclose status	1	1.5%
Do not know	2	3%
Feel sorry for them	5	7.6%
Encourage other people to test	2	3%
Punished by God	1	1.5%
Should abstain	5	7.6%
Should consult traditional healers	1	1.5%
Should be isolated	1	1.5%
Should not be discriminated	5	7.6%
Should live positively	15	22.7%
Should not have children	4	6.1%
Sick people	5	7.6%
Spread HIV	4	6.1%
Prostitutes	2	3%
Unlucky people	5	7.6%
Very ignorant	2	3%
Total	66	100%

Summary: Stigma issues

Although it was mentioned that children are very important in the other findings, the majority of the respondents (n=54) strongly felt that women who are HIV positive and know their status, should not have children to expand the family. The respondents felt that they will infect more people e.g. their sexual partner and unborn babies. According to Wilson, et al. (2002:358) mother to child transmission of HIV (MTCT) is the major cause of HIV infection in children.

There are more than 2 million pregnancies in HIV positive women each year, and more than 1800 infected children are born daily worldwide. The overwhelming majority of these births are in the developing world, especially in Sub-Saharan Africa.

A large number of the respondents (n=15) however felt that HIV positive people should live positively. Van Dyk (2001:273) however emphasizes that care and support should be given to HIV positive people.

A study conducted by Tlou, et al. (2000) in Botswana exploring stigma and discrimination revealed that stigma and discrimination came across as major deterrent to voluntary counselling and testing (VCT) and also of disclosure of either intent to seek an HIV test or reveal one's status. The study looked at obtaining information and data that could be used to improve the effectiveness and acceptability of messages and services of MTCT prevention at community level.

3.2.10. Section I: Cultural taboos

- ***It is a taboo for women to discuss/negotiate sex with men?***

About 56% (n=37) said it is not taboo for women to discuss/negotiate sex with men. Only 44% (n=29) thought it is taboo for women to discuss/negotiate sex with men.

Table 23: Opinions regarding the fact that it is a taboo for women to negotiate sex

Taboo women negotiate sex	Respondents	Percentage
NO	37	56%
YES	29	44%
Total	66	100%

- ***It is taboo to discuss sex with children?***

The findings showed that 63.3% (n=42) thought it is not taboo to discuss sex with children.

However 36.4% (n=24) said it is taboo to discuss sex with children.

- ***It is acceptable for men to beat their wives if they do not want to have sex with them?***

In response to this question, the respondents 88% (n=58) thought that it is not acceptable for men to beat their wives if they do not want to have sex with them.

However, 4.5% (n=3) said it is acceptable for men to beat their wives if they do not want to have sex with them and 7.6% (n= 5) were not sure.

Summary: Cultural taboos

The majority of the respondents (n=37) thought that it was not taboo for women to discuss sex with men and (n=58) respondents also felt that it was not acceptable for men to beat their wives if they do not want to have sex with them.

Giddens (1990:181) mentioned that many women face domestic violence directly or indirectly. Fidzani, et al. (2000) add by saying that many women say that they have very little to say when it comes to issues of sexual relationships. Rossetti and Davies (1999) mentioned that domestic or spousal violence is another factor that puts women in vulnerable positions.

It is good to note that the respondents in this study feel that women have the right to discuss sex with their partners.

The respondents (n=42) also said that it was not taboo to discuss sex with children. However studies of teenage pregnancies and risk of HIV infection in Molepolole, Botswana revealed that parents do not discuss sexual matters with their own children (Fidzani, et-al. 2000). A similar study conducted by the Ministry of Health in Botswana (1992) revealed that parents are said to be totally against sex education (Meekers, et al., 1997). It is interesting to note the shift in thoughts of people in Botswana regarding discussing sex with children.

3.2.11. Section J: Marriage

In this section results will be given regarding different statements in the marital context

- ***Payment of lobola gives men the right to demand sex from their wives***

Of the total sample, 78.8% (n=52) did not agree that payment of lobola gives men the right to demand sex from their wives.

However 19.7% (n=13) said that payment of lobola gives men the right to demand sex from their wives and only one 1.5% (n=1) respondent was not sure whether the men had the right or not.

- ***Men can marry women who are older than themselves***

Only 39% (n=26) agreed that men can marry women who are older than them and 53% (n=35) did not think that men should marry women who are older than them. However there were 8% (n=5) who were not sure whether men could marry women who are older than them.

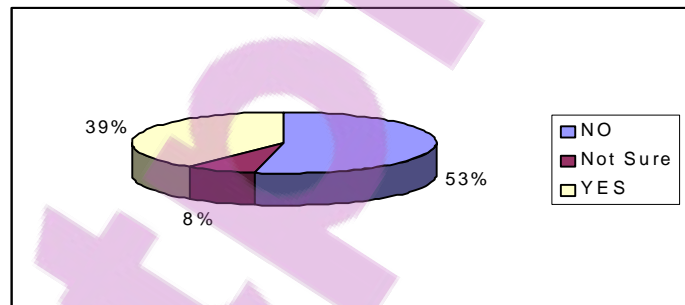


Figure 24: Opinions regarding the fact that man can marry older women

- ***Beliefs regarding men marrying or having sexual relationship with women younger than themselves***

About 70% (n=46) believed that men can marry or may have sexual relationship with women younger than themselves and 24% (n=16) did not hold this belief. Only 6.1% (n=4) were not sure whether men should marry or have sexual relationships with women younger than themselves or not.

- **Beliefs regarding men marrying more than one wife and the behaviour contributing to the transmission of HIV in Botswana**

Only 3% (n=2) of the sample, said that they were not sure if men should marry more than one wife and 15% (n=10) said that men can marry more than one wife as this is part of culture and that it does not contribute to the spread of HIV. The majority 82% (n=54) of the respondents said that men couldn't marry more than one wife.

- **Widows should remarry their husband's relatives or brothers**

Of the total sample, 60.6% (n=40) did not believe that widows should remarry their husband's relatives or brothers. However, 38% (n=25) believe that widows should remarry their husband's relatives or brothers. Only one 1.5% (n=1) respondent was not sure if this should happen or not.

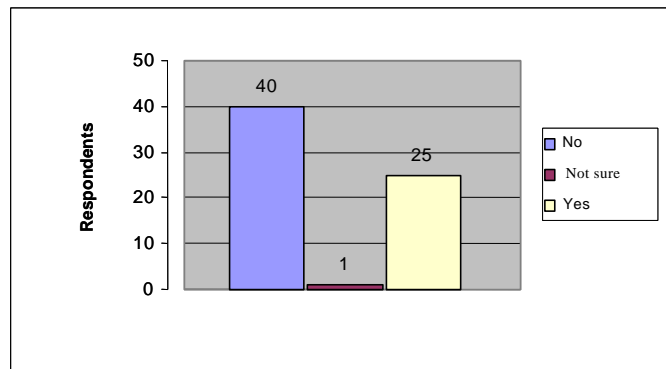


Figure 25: Responses regarding widows remarrying their brother-in-laws

- **Opinions regarding a woman who is in polygamous marriage and insists on using condoms**

The majority of the respondents 80.3% (n=53) said that the woman would be protecting herself and 9% (n=6) felt that she would be disrespectful. Some 3% (n=2) mentioned that the woman would be untrustworthy and 6.1% (n=4) said no condoms must be used in marriage.

Table 24: Opinions regarding women in polygamy using condoms

Opinions	Respondents	Percentage
Protecting Self	53	80.3%
Disrespectful	6	9.1%
Untrustworthy	2	3%
She is HIV positive	1	1.5%
No condom use In marriage	4	6.1%
Total	66	100%

- ***Women should have children before they get married?***

There was a feeling that women should have children before they get married. This was supported by 24% (n=16) respondents.

However most respondents 71% (n=47) felt that women do not have to have children before they get married and 4.5% (n=3) were not sure whether women should have children before they get married or not.

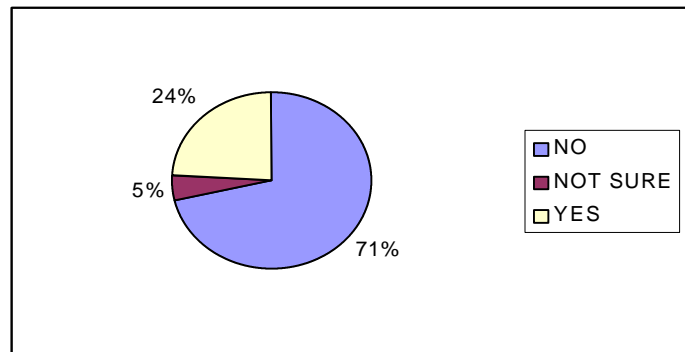


Figure 26: Responses regarding women bear children before marriage

Summary: Marriage

It is stated that men in Botswana usually dominate women in sexual matters. Regardless of the sero status of a husband, which the wife may not know anyway, failure to provide sex to the spouse may earn the wife a divorce. Besides, having multiple sexual partners seems to be universally and culturally accepted and tolerated (Adupa, 1999).

A study conducted by BOTUSA in 1999 in Botswana revealed that a man is more likely to marry a woman who has shown that she is fertile. Van Dyk (2001:120) also mentioned that polygamy in African societies is supported as it is seen as preventing and reducing unfaithfulness.

With regard to the above statements, the results of this research revealed the following:

- Almost all of the respondents in the sample (n=52) did not see payment of lobola giving men the right to demand sex from their wives.
- Only (n=35) did not agree that men could marry women who were older than them. Some of the respondents (n=26) however agreed that men could marry women who are older than them.
- Similarly (n=46) of the respondents believed that men could marry or have sexual relationship with women younger than them.
- There was however a strong feeling from (n=54) respondents that men cannot marry more than one wife as this behaviour contributes to the transmission of HIV.

- The majority of the respondents (n=40) did not believe that widows should remarry their husband's relatives or brothers.
- About (n=53) of the respondents thought that women in polygamous marriages insisting on using condoms knew how to protect themselves from HIV transmission.
- The respondents (n= 47) said that it was not necessary for women to have children before they get married.

3.2.12. Section K: Alcohol Use

- ***Alcohol use can contribute to the spread of HIV?***

Of the total sample, 88%(n=58) strongly felt that alcohol use could contribute to the spread of HIV. Although 12% (n=8) felt that alcohol use did not contribute to the spread of HIV.

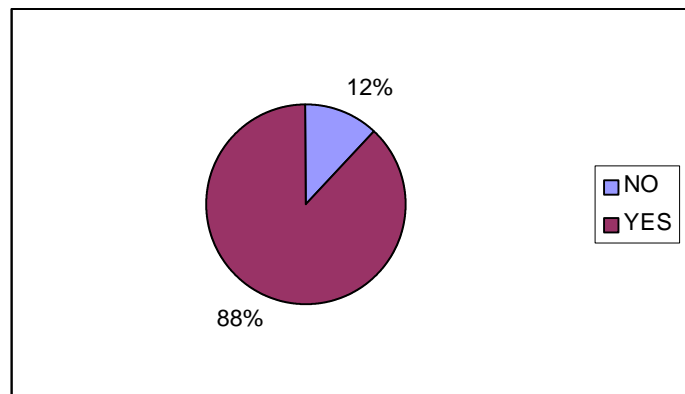


Figure 27: Contribution of alcohol to the spread of HIV

- ***People can be asked to reduce alcohol consumption to prevent HIV transmission?***

The majority of the respondents 92% (n=61) strongly felt that people could be asked to reduce alcohol consumption to prevent HIV transmission.

Only 6%(n=4) did not think it was a good idea.

One respondent 2% (n=1) was not sure of whether people can be asked to reduce alcohol consumption to prevent HIV transmission.

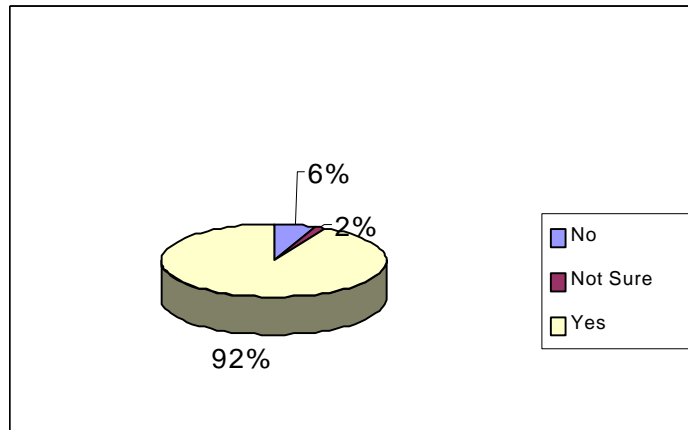


Figure 28: Opinions regarding the request of alcohol reduction to prevent HIV transmission

Summary: Alcohol Use

The majority of the respondents 88% strongly felt that alcohol use could contribute to the spread of HIV. The respondents 92% also felt that asking people to reduce alcohol consumption can prevent HIV transmission.

It was mentioned by Fidzani, et al. (2000) in the literature that in Botswana practically in each village there is a liquor store or spots where traditional African beer is sold. The community leaders in Botswana are also saying that the high prevalence of drinking spots in Botswana is contributory factors in HIV transmission. Evian (2000:21) says that drinking too much alcohol may also encourage people to become loose and have sex with different people.

3.2.13. Section L: Religious beliefs

Opinion regarding the following statements:

- ***HIV/AIDS is punishment from GOD***

The respondents 56% (n=37) believed that HIV/AIDS is punishment from GOD and 21% (n=14) said that HIV/AIDS was not punishment from GOD. However, 23% (n=15) doubted. They were not sure whether HIV/AIDS was punishment from God

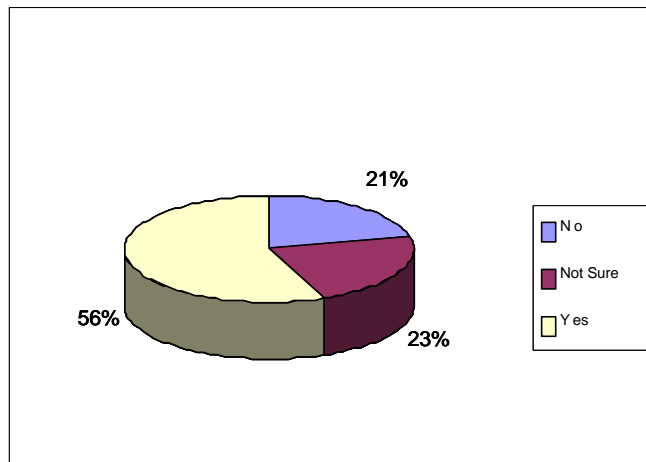


Figure 29: Opinions regarding HIV as a punishment from God

- ***People who are infected with HIV are being bewitched***

It was interesting to note that 91% (n=60) respondents did not believe that people who are infected with HIV are being bewitched. Yet 6% (n=4) believed that people who are infected with HIV are being bewitched. There were 3% (n=2) who were not sure whether witchcraft was involved or not.

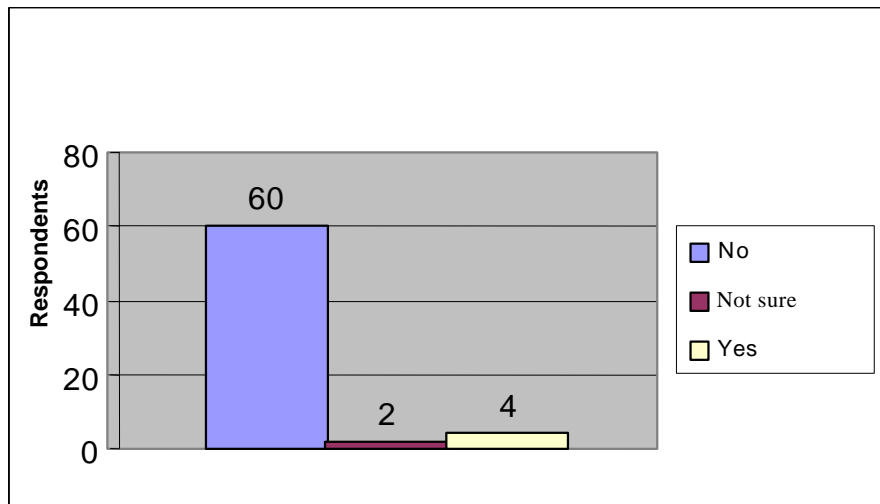


Figure 30: Opinions regarding HIV as witchcraft

Summary: Religious beliefs

More than half of the respondents in the sample 56% believed that HIV/AIDS is punishment from God. However 91% respondents did not believe that people who are infected with HIV are being bewitched.

These responses are supported by Felhaber (1997) as quoted by Van Dyk (2001:113) who argues that witches or sorcerers are usually blamed for illness and misfortune in traditional African societies. Felhaber further states that in Africa people often use the services of witches and sorcerers to send illness, misfortune and suffering to enemies. It is also believe that whatever bad luck or illness befalls them is sent by witches or sorcerers.

Ward (2002:19) on the other hand explains that people believe in the existence of a super human controlling power especially of God, usually expressed in worship. It is a controlling influence in a person's life. In Botswana, religious leaders attribute the high prevalence of HIV/AIDS situation as punishment from God (UNICEF, 1998). According to these leaders the principles of abstinence and faithfulness have been disregarded by the society.

3.2.14. Section M: Condom use

Opinions regarding statements on condom use:

- ***A man with multiple partners (polygamous) relationship should use condoms***

The data showed that 83% (n=55) of the respondents felt that a man with multiple partners (polygamous) relationship should use condoms and 14% (n= 9) did not hold this belief.

About 3% (n=2) of the respondents were not sure of whether a man with multiple partners (polygamous) relationship should use condoms or not.

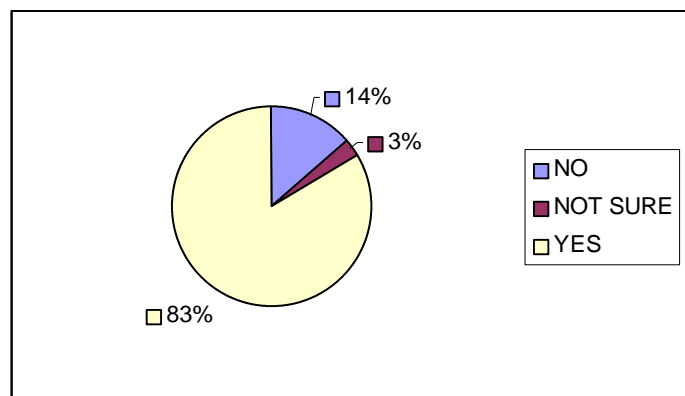


Figure 31: Opinions regarding men with multiple relationships should use condoms

- ***Opinions regarding people who use condoms in Botswana***

The majority of the respondents 70% (n=46) said that people use condoms to protect themselves from HIV transmission. Another group of respondents 15% (n=10) thought that the people who use condoms are untrustworthy. It means that they are involved in multiple relationships or they are prostitutes.

About 3% (n=2) of the respondents said that condoms should not be used as they prevent procreation. If people use condoms, they cannot have children and another 3% (n=2) of the respondents said that condoms cause AIDS. One respondent 1.5% (n=1) said that people who use condoms in their culture invite HIV as condoms cause AIDS.

Table 25: Opinions about condom use in Botswana culture

Condom use	Respondents	Percentage
Cause AIDS	2	3%
Prevent procreation	2	3%
Do not know	1	1.5%

Invite HIV	1	1.5%
Should not use condoms	1	1.5%
Not trustworthy	10	15%
Protecting self	46	70%
Increases prostitution	3	4.5%
Total	66	100%

- **Condoms is culturally acceptable**

The majority of the respondents 66% (n=44) strongly felt that using condoms was culturally unacceptable and 20%(n=13) thought condom use was culturally acceptable.

There were 14% (n= 9) respondents who were not sure about condoms being culturally acceptable or not.

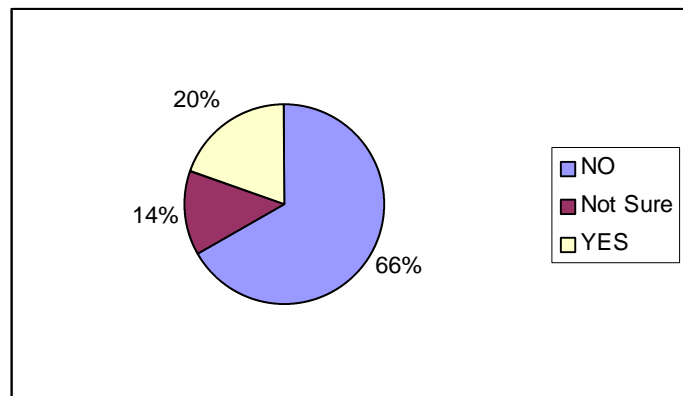


Figure 32: Acceptability of condom use in Botswana

- **Condoms should be used to prevent HIV transmission**

The majority of the respondents 95.5% (n=63) strongly felt that condoms should be used to prevent HIV transmission and 4.5 (n=3) did not think condoms should be used to prevent HIV transmission.

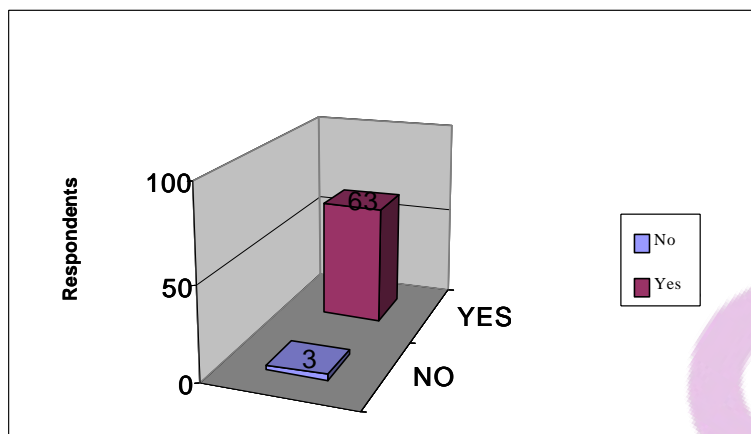


Figure 33: Opinions regarding the statement that condoms should be used to prevent HIV transmission

Summary: Condom use

The use of condoms by men with multiple partners (polygamous relationship) was strongly supported by all the respondents in the sample (83%). The results also showed that (70%) of the respondents thought that people who use condoms in their culture knew how to prevent HIV transmission.

However (66%) of the respondents said that condom use in Botswana is not culturally acceptable. The general feeling from the respondents (95.5%) was that condoms should however be used to prevent HIV transmission in Botswana.

UNAIDS (2002:86) mentioned that condoms are key to preventing the spread of HIV/AIDS. Authors like Caldwell and Quiggin (1989) as quoted by Van Dyk (2001:122) postulate that the lack of condom use in Africa however is ascribed to promiscuity, permissiveness and to a lack of moral and religious values.

Scott and Mercer (1994) as quoted by Van Dyk (2001:122) add that in some parts of Africa including Botswana there are deep-rooted cultural beliefs against the use of condoms.

3.2.15. Section N: Voluntary counselling and testing (VCT)

- ***Beliefs in HIV testing***

Of the total sample the majority of the respondents 87% (n=58) believed in HIV testing and 11% (n=7) did not believe in HIV testing. One respondent 2% (n=1) was not sure of what HIV testing was all about.

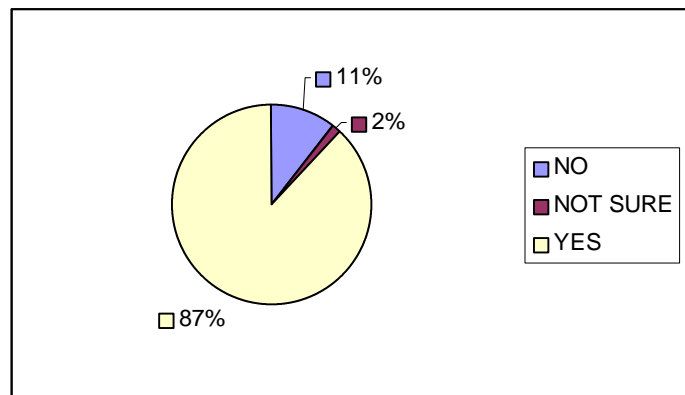


Figure 34: Beliefs in HIV testing

- ***The benefits of knowing one's HIV status***

The majority of the respondents 55% felt that the benefits to knowing one's status was that one would be able to take care of her/himself.

Some respondents 27% felt that people will have access to early treatment and 8% felt that there were no benefits in knowing one's status.

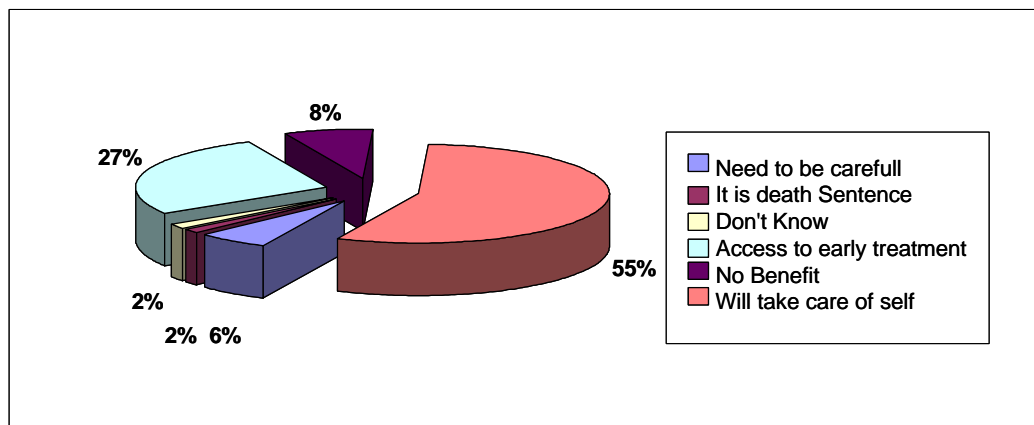


Figure 35: Benefits of knowing one's HIV status

- ***Feelings about disclosing a person's HIV status***

Of the total respondents, the majority 56.1% (n=37) said that it was a good thing to disclose one's HIV status. One reason given was that it would encourage other people to test their HIV status. About 7.6%(n=5) of the respondents were not sure whether it was a good thing to disclose one's HIV status or not. About 10.6% (n=7) thought it was not a good thing to disclose one's HIV status because it is embarrassing; it demoralizes a person, the community disrespects the person who discloses the HIV status, the person becomes discriminated and stigmatized and it also frightens other people.

Table 26: Feelings about disclosing a person's HIV status

Feelings about disclosure	Respondents	Percentage
Demoralising	7	10.6%
Stigma and discrimination	3	4.5%
Disrespectful	2	3%
Doesn't matter	3	4.5%
Embarrassing	1	1.5%
Encouraging others to test	1	1.5%
Very good	37	56.1%
Not good	7	10.6%
Not sure	5	7.6%
Total	66	100%

- **Awareness of voluntary counselling and testing (VCT)**

The majority of the respondents 77.3%(n=51) said that they were aware of voluntary counselling and testing, however 22.7% (n=15) of the respondents were not aware of voluntary counselling and testing.

Table 27: Awareness of voluntary counselling and testing (VCT)

Aware of VCT	Respondents	Percentage
No	15	22.7%
Yes	51	77.3%
Total	66	100%

Summary: VCT

The majority of the respondents (n=58) believed in HIV testing. The participants in the focus groups also supported the VCT programme. They were in favour of the VCT programme because VCT encourages positive living and advise people about what to do to live positively.

Access to medical care including antiretroviral was mentioned as a benefit of knowing one status. Focus group participants and almost all the respondents in the structured interviews supported the antiretroviral as a benefit. It was also believed that VCT reduces transmission. The SAFAIDS (2002:3) emphasised that one of the benefits of VCT is to enable access to antiretroviral and preventive prophylaxis. It also reduces HIV transmission.

The SAFAIDS (2002:3) also mentions that VCT knowledge reduces stigma and enhances the development of care and support. The more people test, the more of those who have not tested, think that there is nothing wrong with HIV/AIDS. The SAFAIDS (2002:3) also states that VCT generates optimism as a large number of persons test HIV negative.

There were respondents who were sceptical about VCT. There were (n=7) respondents who did not believe in HIV testing and about 8% of the respondents said that there were no benefits in knowing one's status.

It is not surprising that there were participants and respondents who were skeptical about VCT as Evian (2000:39) says that testing may have negative consequences in communities where HIV infected people are stigmatised. Fear of stigma could also influence people negatively. Antiretrovirals are also a big problem as they are unaffordable therefore not accessible to all (Poku, 2001). There are few generics in Sub Saharan Africa.

The majority of the respondents 77.3% were aware of Voluntary Counselling and Testing. In Botswana, VCT services are advertised everywhere in the country (See Appendix 9). The Botswana government in collaboration with the United States of America government run stand alone VCT programmes with mobile facilities to rural areas. All the districts in Botswana have stand alone VCTs.

The results from this study about the awareness of VCTs show that there is increasing awareness of VCT compared to a study conducted by Tlou, et al. (2000) to obtain information and data that could be used to improve the effectiveness and acceptability of messages and services regarding PMTCT on the community level. The majority of the respondents in their

study did not know about the voluntary and testing centres in Botswana. Positive results were also associated with no cure for AIDS and association with death. Therefore people feared to know their status. Stigma and discrimination by the community also came across as a major deterrent to voluntary counselling and testing and disclosure (Tlou, et al., 2000).

3.3. Conclusion

In this chapter the researcher presented, analysed and interpreted the dominant quantitative findings through structured interview schedule (Part 2) and the qualitative findings through focus groups (Part 1) which both established the influence of cultural practices of the Batswana on the transmission of HIV/AIDS in Botswana. The following chapter will present a general summary, conclusions and recommendations.

Chapter 6

General summary, conclusions and recommendations

1. Introduction

It has already been mentioned in Chapter 2 that HIV/AIDS is a relatively new, unique and complex disease. It is a disease that kills millions of people globally. In the year 2000, AIDS caused the deaths of an estimated 3 million people worldwide. The overwhelming majority of people with HIV/AIDS, approximately 95% of the global total live in the developing world. Twenty-one countries with the highest HIV/AIDS prevalence are in Africa (Center for Disease Control and Prevention, 2001:1). Botswana is one of the six countries in Southern Africa that forms the global epicentre of the epidemic. One in six adults is HIV positive. About 35.8% of adults are now infected with HIV in Botswana. (Poku, 2001:191).

AIDS frightens everyone around the globe. The impact of HIV/AIDS is devastating whether one is infected or affected.

Controversial statements are often made regarding the cause of AIDS and where it originates because of its fatal nature and its sudden discovery. For example whether HIV is caused by poverty or poverty leads to conditions where HIV spreads faster (Barret-Grant et al, 2001:12). Authors like Webster (1991,18-20), Van Niekerk (2001:146) and Poku (2001:195-196) support Barret-Grant, et al. (2001:12). They say that poverty with its accompanying sides is major contributing factors to the current spread of HIV/AIDS.

According to McDonald (1996:1327), the socio-economic and cultural factors influence the transmission of HIV/AIDS in Botswana.

A considerable body of biomedical research conducted in HIV/AIDS has determined the causes and course of the disease and yielded medical strategies for its control. However there is not an equivalent level of understanding of the social and behavioural factors which fuel the epidemic. The discussion of social factors has often not progressed beyond invoking and crude and undifferentiated role of poverty. The specific interaction of the historical, social, political and cultural factors, which have shaped the nature of the epidemic needs to be the focus of more extensive research. A more nuance understanding of these areas is essential in order to devise more meaningful and effective intervention and treatment plans (University of the Witwatersrand, 2002:3).

The aim of this study was thus to establish the influence of cultural practices of the Batswana on the transmission of HIV/AIDS in Botswana.

The study objectives included:

- To conduct the investigation within a theoretical based framework by undertaking a literature review on HIV/AIDS as a social phenomena, culture and cultural practices in general and the culture of the Batswana specifically.
- To explore through an empirical study, the nature and prevalence of cultural practices of Batswana in relation to the transmission of HIV/AIDS in Botswana
- To provide conclusions regarding the cultural practices of the Batswana in relation to the transmission of HIV/AIDS in Botswana.
- To make recommendations for culturally appropriate behaviour-change strategies for Batswana in Botswana in an attempt to decrease the spread of HIV/AIDS

The following research questions were formulated for this study:

- What are the current nature and prevalence of cultural practices of the Batswana in relation to the transmission of HIV/AIDS in Botswana?
- To what extent do these cultural practices contribute to the spread of HIV/AIDS?
- What can be done to prevent the problem of HIV/AIDS in relation with cultural practices of Batswana people in Botswana?

The investigation inevitably brought certain insights that are now in the form of a general summary, conclusions and recommendation, which will be presented according to the next discussion points:

- Literature Study:
 - General introduction to the study.
 - HIV/AIDS as social phenomena
 - Culture and cultural practices of Batswana in Botswana.
- Empirical research findings
 - Qualitative data through focus group discussions
 - Quantitative data through structured interview schedule.

2. Literature Study

2.1. General introduction to the study.

2.1.1. Summary

Chapter one provides an introduction and general orientation to the study. This chapter is set out in terms of the study's rationale, research methodology collection and analysis of data. The researcher begins with the motive for the choice of HIV/AIDS as subject for the study, followed

by the formulation of the problem. The goal and objectives of the study are also identified and research questions are formulated. Thereafter a description of the research approach, the type of research, research design, research procedure and strategy followed. Aspects concerning the pilot study are also explained and a description of the research population and sampling methods are given. Ethical aspects are briefly outlined and key concepts, problems and limitations of the study are denied. The chapter ends by highlighting the topic of the subsequent chapters in the thesis.

2.1.2. Conclusions

From the literature in this chapter the research concludes that:

- a. HIV infection and AIDS epidemic seem to be a universal problem throughout the world especially in Southern Africa. AIDS in Africa has orphaned more children than anywhere else. HIV/AIDS patients occupy Fifty percent of hospital beds in the medical and paediatric wards in Botswana.
- b. The socio-economic and cultural factors influence the transmission of HIV/AIDS in Botswana.
- c. The death rate in Botswana and the increase in the number of HIV infection are of concern to the Botswana Government.
 - There is an urgent need to establish the causes of HIV infection in Botswana so that appropriate strategies to combat the infection can be put in place. There is also a need to understand if the cultural practices of the Batswana have an influence in the spread of HIV/AIDS.
- d. Government organisations and NGO's are joining hands in the fight to reduce the rate of HIV infection. The concern is whether the current prevention strategies are appropriate to the people of Botswana and are they taking cultural practices into consideration.
- e. There seem to be no scientific empirical evidence of the current cultural practices of the Batswana and also to show that cultural factors may play a role in the spread of HIV infection.

- The combined quantitative and qualitative research approach in this study was effective as it enabled the researcher to draw information on the process and aim of the study from a sample of the population by using structured interviews and thus information was supplemented by the qualitative focus group discussions with a limited number of informants.
- The type of research i.e. applied research selected for this study was suitable as the study was in essence a problem solving process which adds to the knowledge base of the social work profession and will help to develop solutions to the problems related to HIV/AIDS.
- The exploratory research design was used to gain insight into the role played by cultural practices in the spread of HIV infection in Botswana. The study also explores the cultural practices of the Batswana.
- The limitations of the study are that the findings are inconclusive and cannot be generalized to the larger population. Given the fact that only a sample of 66 respondents and only six study sites were employed.
- This study can make a valuable contribution to the social work profession as it represents a groundbreaking investigation regarding HIV/AIDS prevention strategies in Botswana.

2.1.2. Recommendations

- HIV/AIDS prevention research should increase in Botswana. Researchers should however focus on the specific interaction of the historical, social, political and cultural factors, which have shaped the nature of the HIV/AIDS epidemic. These factors need to be the focus for more extensive research.
- Collaboration between government sectors, private and community sectors is highly recommended in developing HIV/AIDS prevention strategies.
- Research in the field of HIV/AIDS prevention strategies in Botswana need to also link with the research capacities and perspectives of other researchers in other African and overseas countries.

2.2. HIV/AIDS as a social phenomena

2.2.1. Summary

The literature study in chapter 2 provides a description of the following basic concept i.e.: HIV/AIDS transmission and prevention. The risk factors and stages of infection are also presented in this chapter. Furthermore the prevention and care strategies, which include voluntary counselling and testing and anti retrovirals are explained. The psychosocial effects of HIV/AIDS are also discussed and finally a summary of the issues touched on in the chapter is presented.

2.2.2. Conclusions

- This chapter confirms that HIV caused AIDS and that the number of people living and dying with HIV/AIDS is shocking. For example in 2001 there were 40 million people living with HIV and there were 3 million AIDS deaths in the same year (Wilson, et al., 2002:8). The effects of HIV/AIDS are felt all over the world.
- The major mode of HIV/AIDS transmission is through sexual intercourse and mother to child transmission. The incubation period of HIV/AIDS is long
- HIV/AIDS is referred to as a social disease. The links between socio-economic and cultural factors and HIV/AIDS are increasingly recognized and understood.
- There is a lot of stigma attached to HIV/AIDS and cultural issues are also attached to this stigma.
- There are several kinds of lay beliefs about HIV infection and AIDS.
- The magnitude of the HIV/AIDS crisis has inevitable meant that both the family and the community had to become involved in most care programmes.
- Communication plays a vital role in promoting all HIV/AIDS prevention, care and support services.

2.2.3. Recommendations

- Health care professionals including social workers and HIV/AIDS community home based carers in the HIV/AIDS field should be knowledgeable about HIV/AIDS concepts and care and prevention strategies that are available. The care strategies should however be viewed in a holistic way which takes the environment into account.

- HIV/AIDS kills millions of people and therefore an individual approach in trying to prevent HIV transmission and control its impact should be a multidisciplinary approach that involves every person from government, health professionals to the community that is affected.
- Social workers should also take a lead in empowering lay people and other professionals who are not in the counselling field with basic counselling skills as counselling is needed by those who are affected and infected.

2.3. Culture and cultural practices

2.3.1. Summary

Chapter 3 provides a discussion on the importance and functions of culture and the differences between culture and cultural practices. The chapter conceptualises the concept of culture. Socialization and agencies of socialisation are presented. Thereafter the elements of culture are identified. The chapter ends with a short summary.

2.3.2. Conclusions

- The reviewed literature suggests that men are bound together by common values, based on shared and common experiences. Societal identity is always grounded in common cultural orientations shared by the members.
- Culture is important in the relationship between individual and society. Every society has a set of individuals who share common ways of thinking and behaving and this is what is called common culture.
- No culture could exist without a society but equally no society could exist without culture.
- Culture gives the members of a society a feeling of unity with the group and enables them to live and work together without too much confusion and mutual interference.
- The most common agents of socialization are the family, peer group, work, school and mass media. Language, religion and marriage are important elements of culture.
- The transmission of culture from one generation to the other is through the process of socialization.

- Deviants in a society are seen as those who have been inadequately socialized. Those who are insufficiently committed to the values and norms of their society.
- If something bad happens to a traditional African, he or she will not attribute such an event to bad luck, chance or fate but instead it is believed that every illness has been directed by intention and specific cause, and in order to fight the illness, it is necessary to identify, approve, punish, eliminate and neutralize the cause, the intention behind the cause, and the agent of the cause and intention.

2.3.3. **Recommendations**

- Since society cannot exist without culture and culture without society, it is important that HIV/AIDS prevention and care programmes should always take culture into consideration.
- People in the community i.e. traditional leaders should be involved in the development of HIV/AIDS prevention and care programmes.
- The agents of socialization that have been identified in this chapter i.e. family, peer group, school and mass medium not for getting the church should be used to communicate HIV/AIDS prevention and care strategies. An appropriate language should be used during the communication.

2.4. **HIV/AIDS and cultural practices of Batswana in Botswana.**

2.4.1. **Summary**

Chapter 4 covered the following aspects: (a) the situation of HIV/AIDS in Botswana in relation to the impact it has on the Batswana people and (b) the influence on HIV/AIDS.

An overview of the social, economic and health impact of HIV/AIDS and the present cultural practices of the Batswana are provided. The researcher also gives background information of the Batswana people e.g. where they originate and who they are and the situation of HIV/AIDS in Botswana.

2.4.2. Conclusions

- The literature reviewed suggests that Batswana people live in countries of Botswana and South Africa. There are in fact more Batswana in South Africa than the total population of the Batswana people in Botswana. They all speak a language called Setswana and Batswana from different regions can understand each other because the dialects and culture are closely related. The study however focussed on Batswana in Botswana.
- There are several ethnic groups in Botswana speaking Setswana. There are a small number of Asian and European people.
- In Botswana one in six adults is HIV positive and about 35.8% of adults are now infected with HIV.
- The literacy rate is very low among farming communities.
- Majority of HIV/AIDS orphans in Botswana are taken care of by old grand parents who have no resources. Orphans drop out of school as a result of stigmatisation, rejection and isolation by other students and occasionally teachers.
- The intake of alcohol is very high in Botswana and the high numbers of drinking spots are seen as contributory factors in the spread of HIV/AIDS.
- Foreigners are blamed for the spread of HIV infection.
- Condoms are not easily accessible to adolescents.
- The HIV infected people experience social rejection and discrimination.
- The high prevalence of HIV/AIDS is attributed as punishment from God.
- Polygamy is still practised in Botswana.
- Premarital sexual activity is common and most adolescents tend to become sexually active at a relatively early age.
- Many women have very little say when it comes to issues of sexual relationships. Women face domestic violence directly and indirectly.
- In Botswana it is accepted by the society at large that men's sexual networks can be quite extensive. The issue of smaller wives/houses is an open secret and the joy of most men who claim that sex with girls or relatively younger women cleanses and purifies their blood.

- The level of poverty is likely to make most people especially women and those in rural areas vulnerable to HIV infection and less able to respond effectively to the consequences related to illiteracy, unemployment and gender inequalities, which are predisposing factors to HIV infection.
- A number of Non Governmental Organisations and Community Based Organisations and government have taken the lead to support HIV/AIDS programmes in Botswana.

2.4.3. Recommendations

- Similar studies focussing on the influence of cultural factors of the Batswana people on the transmission of HIV/AIDS should be conducted also in South Africa as the Batswana in South Africa are related to the Batswana in Botswana. South Africa is only a few kilometres away from Botswana.
- The knowledge gained through this study can be shared and used by South Africans who are Batswanas and speak Setswana.
- HIV/AIDS prevention and care strategies in Botswana need to be localised (e.g. Restricted to particular region, groups or points in time) as there are different ethnic groups although they share a common language.
- The education system in Botswana needs to be strengthened and education needs to be compulsory as it is anyway free in public schools. The education system also needs to be made accessible to the farming communities.
- Welfare services need to be improved so that they can provide services for the orphans.
- Social workers need to vigorously recruit young foster parents to provide care for the orphans.
- Counselling skills need to be extended to lay people. Social workers and other counselling professionals need to train lay people in counselling skills to counsel the affected especially children and the infected people.
- Alcohol intake needs to be reduced as it puts people at risk. Reducing the number of liquor licences can do this.
- Condoms need to be easily accessible to the teenagers. The attitudes of adults – parents and health professionals need to change in terms of providing health talks to teenagers.

- Sex education needs to be provided in schools and families including parents need to play a very important role in providing sex education to children.
- Collaboration between agencies such as government, Non Governmental Organizations, Community Based Organization, churches community Home based care programmes need to be strengthened. Fragmented services need to be put together so that there is no duplication.
- Women need to be empowered so that they can be assertive and make decisions in their social lives.

3. Empirical Research Findings

3.1. Qualitative data through focus group discussions

3.1.1 Summary

The aim of the study was to establish whether the cultural practices of the Batswana influence the transmission of HIV/AIDS in Botswana, in order to examine and answer the research questions that were formulated:

- a. What are the current nature and prevalence of cultural practices of the Batswana in relation to the transmission of HIV/AIDS in Botswana?
- b. To what extent do these cultural practices contribute to the spread of HIV/AIDS?
- c. What can be done to prevent the problem of HIV/AIDS in relation with cultural practices of Batswana people in Botswana?

The researcher conducted six focus groups separately with men and women in the six study sites of the research study, which included rural and urban area. The total number of respondents who participated in the focus group discussions was 48.

The focus group participants responded to the research questions, which were posed through a focus group guide.

3.1.2 Conclusions

Demographical details

- All respondents were over 18 years.
- The respondents represented the criteria set up for the focus groups. The male focus group had males only and female focus group had females only. However there were 22 female and 26 males.
- All the respondents were African (100%).
- The majority (n=48) 89% of the respondents were Setswana speaking
- All the respondents lived in Botswana for more than 5 years.

Knowledge about HIV/AIDS

- The difference between HIV and AIDS:

There was a general feeling that HIV is a virus and AIDS is a disease caused by the HIV virus. AIDS was however associated with Boswagadi which is a disease that only affect widows and widowers who have sexual relationships with other partners during the mourning period which is usually a year.

- HIV/AIDS transmission

The transmission of HIV/AIDS is through semen and vaginal fluids during sexual intercourse. Other modes are mother to child, blood transfusion, HIV infected blood through open cuts.

- Myths regarding HIV

The most important myths that were identified were: Condoms cause AIDS; AIDS is "Boswagadi"; Government had a means of infecting people to reduce the population.

Cultural Practices

- **Cultural practices of the Batswana in relation to marriage**

It is very important for women to have children. It is acceptable that men can have multiple relationships even after he is married. Women cannot challenge this. Polygamy is still part of the Batswana culture. Arranged marriages are still common and they put young girls at risk of HIV infection as the men who are older may have been sexually active before they met the young girls.

- **The influence of cultural practice of the Batswana regarding marriage in relation to the transmission of HIV/AIDS**

Culture protected people from the spread of HIV. In polygamous marriages, the partners are faithful therefore chances of infecting each other are very slim. Multiple relationships however today contribute to the spread of HIV so since the partners are not well known and maybe unfaithful. Polygamy is culturally acceptable and therefore partners are faithful because culture is respected. Arranged marriages predispose young women to HIV infection since their partners were long sexually active.

SEXUAL PRACTICES

- **Cultural practices of the Batswana with regard to sex**

Sex is only for married people. Girls and boys are socialized to go for circumcision where they are taught about sex and women are taught not to initiate any sexual activity.

Children are very important therefore the use of condoms is unacceptable.

- **The influence of cultural practices of the Batswana regarding sex in relation to HIV transmission**

Polygamous relationships protect people from HIV transmission because of the faithfulness the culture prescribes.

If the partners are unfaithful, therefore the practice influences the transmission of HIV positively.

HIV/AIDS PREVENTION AND CARE STRATEGIES

- **Prevention of HIV in Botswana**

Prevention strategies need to take culture into consideration. Religious organizations need to take a lead. Circumcision should be respected as it teaches children good morals. Alcohol consumption needs to be reduced. Families need to play a role in educating children about sexual issues.

Voluntary Counselling and Testing

- **Opinions about voluntary counselling and testing (VCT)**

Antiretrovirals are not available after one's positive HIV status is known. VCT also encourages positive living whether one's status is positive or negative.

3.1.3. Recommendations

- HIV/AIDS prevention and care strategies need to explore the issue of Boswagadi, which is a concept that is within the Batswana culture for many years. It seems that it also controls sexual activities that could prevent HIV transmission. Health educators need to find a way of supporting the concept of Boswagadi and at the same time emphasize the prevention of HIV transmission.
- Culture is still entrenched among the Batswana and therefore education programmes focussing on HIV/AIDS prevention and care strategies need to make use of the cultural practices in a positive way as long as the practices can minimise HIV transmission. For example polygamy, boswagadi and circumcision.

- The use of condoms should be emphasized and condoms should be made accessible in a culturally acceptable way. Partners should be encouraged to remain faithful and use condoms when they are not planning to have children.
- Religious organizations and families should also be used in HIV/AIDS prevention and care strategies.
- Government and communities need to collaborate and find a way in which alcohol consumption and availability can be reduced.
- Voluntary Counselling and testing centres should be expanded also in public sectors.
- Government should find a way of making antiretroviral cheap and accessible to all.

3.2 Quantitative data through structured interview schedule

3.2.1 Summary

The quantitative findings based on establishing the influence of cultural practices of the Batswana on the transmission of HIV/AIDS in Botswana were described in chapter 5 of this research report. The information was gathered by means of a structured interview schedule. The sample included a total of 66 respondents from the six study sites, which included rural and urban areas.

3.2.2 Conclusions

Demographical details

- All the respondents were between the ages 18 – 70 years.
- There were 15 ethnic groups with the majority being the Bakwena 27.27%, Bakalaka 15.5% and Batalaote 10.6%.
- The majority 45% of the respondents was single and 23% were married.
- Of the married couples, 64.3% were married traditionally and 35.7% were legally married.
- The majority of the respondents 48% had secondary level education equivalent to form 3 to form 5 or Std 8 to Std 10 in South Africa and 20% had primary education and

another (20%) had primary education and another (20%) had no formal education. Only a few (2%) went to tertiary education.

- The respondent's number of years in Botswana ranged from 5 years to 10 years with (97%) who live for more than 10 years in Botswana.
- Only a few respondents (27.3%) had no affiliation to any religion.

Knowledge about HIV/AIDS

- Most respondents 30% mentioned that HIV was a virus and another 30% said that HIV is a virus that causes AIDS.
- AIDS was said to be a disease caused by HIV (59%) and another group 15% said that AIDS was a combination of diseases.
- HIV was said to come from sex (38%), HIV infected human beings 15% and white people (10.6%).
- The causes of AIDS were said to be HIV (34.8%) and sexual intercourses (44%).
- HIV was thought to be a big problem in Botswana (93.3%) because it kills a lot of people (88.7%).
- Most respondents (39%) said weight loss was one of the signs of HIV/AIDS and a combination of diseases (20%).
- HIV is spread through sexual intercourse 65% and unsterile instruments 24%.
- Only 45% said that there were myths about HIV/AIDS. One common myth was Boswagadi. This was said by 67% of the respondents.

Cultural Practices

Cultural practices of the Batswana in relation to marriage and sexual life

- Sex before marriage is unacceptable (24%), men with many women in their lives proof manhood 12% and condoms are unacceptable.

University of Pretoria etd – Tabane, E M (2004)

- If condom use is unacceptable (36.4%) then it is possible to spread HIV and young girls sleeping with older men (18%) are at risk since the men have long being sexually active.
- There are cultural practices influencing sexual behaviour (45.5%). Peeletso (getting engaged when you are young) make girls engage in sexual activities without experience sexual life (40%).
- Sex before marriage being culturally unacceptable controls sexual behaviour (17%).
- The respondents (45.5%) mentioned that the present cultural practices do not predispose people to HIV infection. It was however interesting to note that the majority of the respondents think that cultural practices however protect people from HIV infection. The first question was general and latter explored the respondents' individual opinions. It seems that the respondents were sceptical about the cultural practices of the Batswana. There was a strong feeling to support the cultural practices and at the same time not to support them.
- Cultural circumcision can expose people to HIV transmission (62%) because unsterile instruments are used (36.5%). Circumcision needs to be stopped (34%).
- It was felt (83%) that women should not use herbs or other agents to dry out and tighten the vagina for dry sex.
- The majority of the respondents (80%) did not believe in women circumcision.
- Women circumcision does not predispose people to HIV infection (35%).

HIV/AIDS prevention and care strategies

- The majority of the respondents (52%) felt that strategies do not take culture into consideration.
- Men should not have sexual relationships with young girls who are virgins to prevent HIV transmission (93%).
- The majority of the respondents (80%) believed in principles of stay with one partner to prevent HIV transmission.
- It was felt (86%) that antiretrovirals could help prolong the lives of the HIV positive people.
- Condom use was also supported (51%) as a method of preventing HIV transmission.

University of Pretoria etd – Tabane, E M (2004)

- The majority (89%) did not support the idea of traditional healers being consulted by HIV positive people.
- The majority of the respondents (79%) felt that the family should take responsibility in educating children about HIV/AIDS.
- Breastfeeding was not supported by 67% in HIV positive mother. However if they choose to breastfeed, they can feed their babies simultaneously with solids (52%).

Polygamy

- The majority of the respondents (62%) felt that the issue of men can have multiple relationships irrespective of their marital status but women may not was one of the Batswana culture. However (71%) of the respondents disagreed with the statement as the behaviour contributes to the spread of HIV infection (83%). People should be encouraged to stay with one partner 49.1% and health education is necessary 24%.
- The statement – “A man is like a bull and should not be confined to one pasture” is in fact one of the Batswana culture (67%) and the behaviour does contribute to the spread of HIV infection (81%). The respondents felt that people should be encouraged to stick with one partner (39%), use condoms (22%) and health education needs to be provided (17%).
- People in polygamous marriages should also be encouraged to use condoms to ensure that they do not infect each other (57.5%).

Sexual Practices

- The majority of the respondents (62%) felt that women should not at all times be prepared to have sex with their partners.
- Most of the respondents (57%) believed that women couldn't refuse their partners sex.
- Older men have more chances of infecting younger women as they have been sexually active before the women (71%).
- The respondents (77%) felt that women should make decisions regarding sexual practices.

University of Pretoria etd – Tabane, E M (2004)

- Most of the respondents (53%) thought that those infertile women could end up having sex with multiple partners in an effort to become pregnant. The majority of the sample 91% agreed that the above-mentioned behaviour increases HIV infection.
- The majority of the respondents (71%) believed that men couldn't have multiple sex partners.
- The respondents (85%) felt that it was not only the privilege of men to decide whether they want sex or not. Women could also decide.

Agricultural practices

- The majority of the respondents agreed that the practice of men being the only persons who can go to the cattle post is one of the Batswana culture and puts women in subordinate positions. This behavior however is said (73%) to contribute to the spread of HIV. The solution to the problem was that both men and women must go to the cattle post (90%).
- The majority of the respondents (92%) strongly felt that women should be involved in traditional farming.

Stigma issues

- It was interesting to note that the majority of the respondents (82%) thought that women who are HIV positive and know their status should not have children to expand the family
- The majority of the respondents (22.7%) strongly felt that HIV positive people should live positively.

Cultural taboos

- The respondents (56%) said that it is not taboo for women to discuss/negotiate sex with men and it is also not taboo to discuss sex with children (63%).
- The majority of the respondents (88%) thought that it is not acceptable for men to beat their wives if they do not want to have sex with them.

Marriage

- The majority of the respondents (79%) did not think that the payment of lobola gave men the right to demand sex from their wives.
- The respondents (53%) did not think that men should marry women who are older than them.
- The majority of the respondents (70%) believed that men could marry or have sexual relationship with women younger than them.
- The respondents (82%) said that men could not marry more than one wife and (60%) did not believe that widows should remarry their husband's relatives or brothers.
- The majority of the respondents (80%) said that women who are in polygamous marriages and insists on using condoms would be protecting themselves.
- Women do not have to have children before they get married.

Alcohol use

- The majority of the respondents (88%) felt that alcohol use could contribute to the spread of HIV and that people could be asked to reduce alcohol consumption to prevent HIV transmission.

Religious Beliefs

- The respondents (56%) believed that HIV/AIDS is punishment from God and that people who are infected with HIV are not bewitched (91%).

Condom Use

- The majority of the respondents (83%) felt that a man with multiple partners (Polygamous) relationship should use condoms and that people who use condoms in their culture are protecting themselves (70%).
- However condoms were said to be culturally unacceptable (67%). Condoms should still be used to prevent HIV transmission (96%).

Voluntary Counselling and Testing

- The majority of the respondents (88%) believed in HIV testing and about (77%) was aware of Voluntary Counselling and Testing in Botswana.

3.2.3. Recommendations

- Multiple relationships by men in Botswana is said to be one of the Batswana culture. Therefore condom use should be encouraged in Botswana. However health care professionals, social workers and community carers should be very sensitive to the culture of the Batswana when presenting condoms as a method of preventing HIV transmission. Condom use must not be introduced by coercion but more through mutual agreement with the community.
- Alcohol consumption should also be reduced. The relationship between alcohol and HIV transmission should be emphasized in HIV/AIDS health talks.
- Churches and religious leaders should play an active role in educating and counselling the community about HIV/AIDS and care strategies.
- Women should be involved in life skills programmes focusing on assertiveness and skills development so that they can empower themselves and be independent and be able to take responsibility and make decisions about their lives.
- Women should also get involved in traditional farming.
- HIV/AIDS prevention and care strategies should take cultural practices of the Batswana into consideration so that the community can cooperate in the fight against HIV/AIDS. The cultural practices should be used in a positive way. For example circumcision schools should not be discouraged and people should be educated on how to prevent HIV transmission at the circumcision schools.
- Health professionals and community carers should be knowledgeable about HIV/AIDS to be able to clear misconceptions and myths about HIV/AIDS.

4. Aim and objectives of the study

Aim of the study: To establish the influence of cultural practices of the Batswana on the transmission of HIV/AIDS in Botswana.

Table 28 focuses on how the above aim and resulting objectives of the study were accomplished:

Table 28: Accomplishment of the study objectives

No.	Objective	Objective achievement
1	To conduct the investigation within a theoretical based framework by undertaking a literature review on HIV/AIDS as a social phenomena, culture and cultural practices in general and the culture of the Batswana specifically.	This aim was achieved as reflected in the discussions presented in chapters 2-4.
2	To explore through an empirical study, the nature and prevalence of cultural practices of Batswana in relation to the transmission of HIV/AIDS in Botswana	This aim was achieved through the presentation of a detailed discussion in chapter 5 on the qualitative and quantitative findings of the study, which explored the influence of the current cultural practices of the Batswana in relation to HIV/AIDS in Botswana.
3	To provide conclusions regarding the cultural practices of the Batswana in relation to the transmission of HIV/AIDS in Botswana.	This aim was achieved through a detailed presentation of the conclusions in chapter 6 of this research report.
4	To make recommendations for culturally appropriate behaviour-change strategies for Batswana in Botswana in an Attempt to decrease the spread of HIV/AIDS	This aim was achieved through a detailed presentation of recommendations made in chapter 6 of this research report.

5. Closing statement

HIV/AIDS is a worldwide pandemic, which affects everyone irrespective of race, ethnicity, and gender and economic status. HIV/AIDS is also a complex phenomenon, which needs to be understood in the context society as it affects the society. The transmission of HIV infection and factors contributing to this transmission needs extensive understanding. The HIV/AIDS pandemic is now out of control as millions of people are dying. Multi-sectoral collaboration is needed from government, private sector, community based and non- governmental organizations in order to fight the pandemic. However HIV/AIDS educators and carers must examine their own beliefs, values, assumptions and attitudes toward HIV/AIDS before they get involved with HIV/AIDS prevention and care strategies so that those who are affected and infected can also examine these issues to be able to cope with the pandemic.

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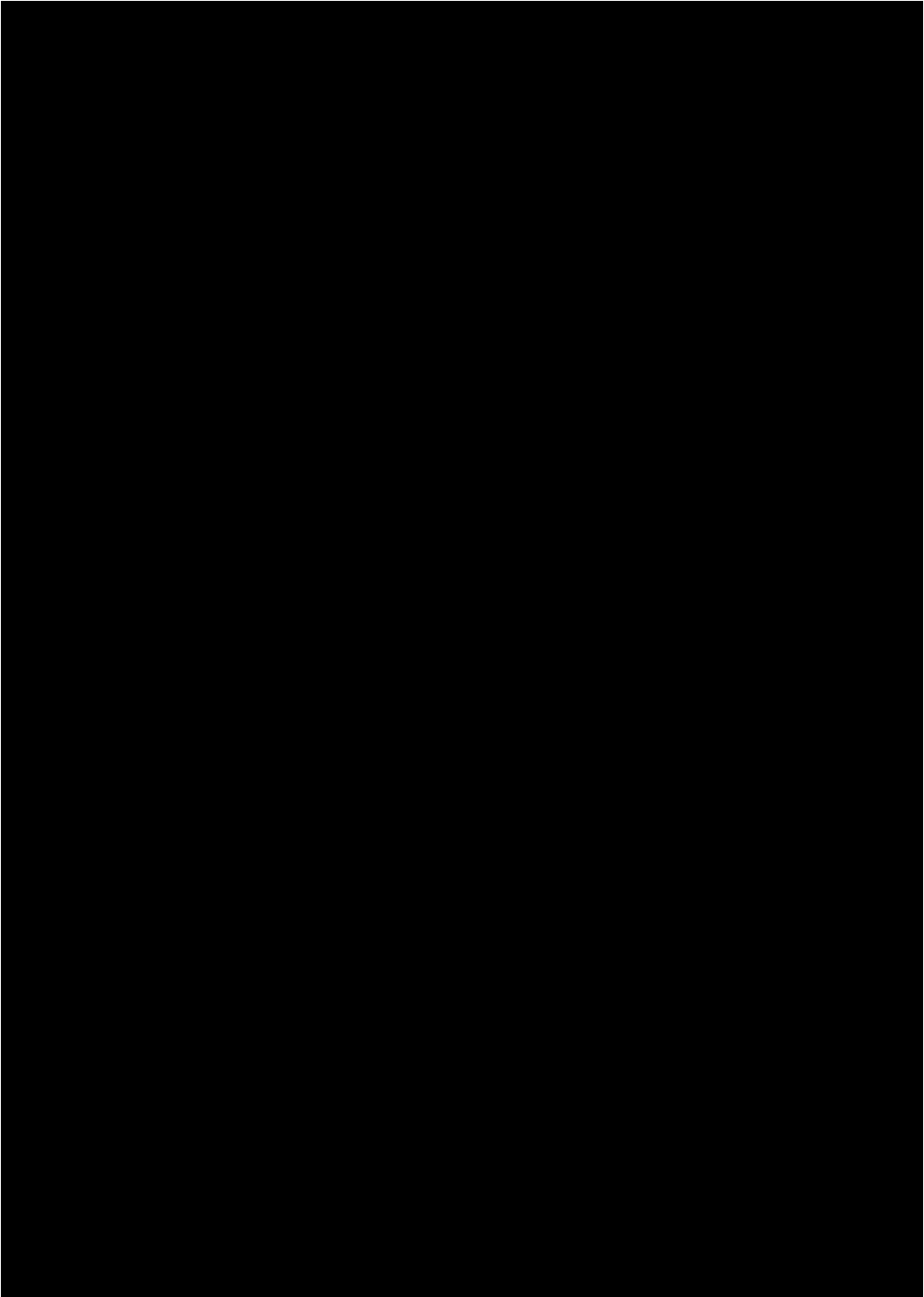
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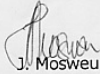
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Appendix 1: Permission letter to conduct study



4. Any changes to the approved proposal should be resubmitted to the Health Research Unit for approval.
5. The permit does not give authority to enter any premises, private establishment or protected area. Permission for such entry should be negotiated with those concerned.
6. Failure to comply with any of the above-stipulated conditions will result in the immediate cancellation of the permit.

Yours faithfully



J. Mosweu

for /PERMANENT SECRETARY TO THE PRESIDENT

cc: Permanent Secretary, Ministry of Health
Clerk of the National Assembly
Head, Health Research Unit
Executive Secretary, National Conservation Strategy Agency
Director, National Archives
Director, National Library Service
Director, Research and Development Office
Librarian, University of Botswana Library
District Commissioner/Town Clerk/Council Secretary

- Gaborone
- Francistown
- Selebi-Phikwe
- Kgatleng District
- Central District
- North-East District

Land Board Secretary

- Kgatleng Land Board
- Ngwato Land Board
- Tati Land Board

TELEGRAMS: PULA
TELEPHONE: 350800
TELEX: 2655 BD



REPUBLIC OF BOTSWANA

OFFICE OF THE P
PRIVATE
G

OP 46/1 CIV (26)

February 24, 2003

Ms. E.M.Tabane
P. O. Box 53374
Kenilworth
Cape Town 7745
South Africa

Dear Madam,

RE: GRANT OF A RESEARCH PERMIT: MS. E.M. TABANE

Your research permit OP 46/1 CIV (24) refers.

The study will be conducted at Gabane, Sebina and Sefophe and not Mochudi, Tutume and Palapye as contained in the permit. Other areas and conditions remain valid and binding.

Thank you



J. Mosweu

for/PERMANENT SECRETARY TO THE PRESIDENT

cc: Permanent Secretary, Ministry of Health
Head, Health Research Unit
District Commissioner/Council Secretary

- Kgatleng District Council
- Central District
- North-East District
- Kweneng District

Land Board Secretary

- Kgatleng Land Board
- Ngwato Land Board
- Tati Land Board
- Kweneng Land Board

Appendix 2: Letter of introduction to the chiefs

P.O.Box 53374
Kenilworth
7745
Cape Town
South Africa

26 June 2003

Attention: Kgosi Botsabelo

The Chief
P.O.Box 60
Selebi Phikwe

Dear Kgosi Botsabelo

Re: Research Study: The Influence of Cultural Practices of the Batswana People in Relation to the Transmission of HIV/AIDS in Botswana

I am a registered doctoral student at the University of Pretoria, South Africa. I am conducting a research study in Botswana on HIV/AIDS. The purpose of the study is to establish the influence of cultural practices of the Batswana on the transmission of HIV in Botswana. The study will provide conclusions regarding the influence of cultural practices of the Batswana in relation to the transmission of HIV/AIDS in Botswana. Recommendations for culturally appropriate behavior- change strategies for Batswana in Botswana in an attempt to decrease the spread of HIV/AIDS.

Permission to conduct the study has been granted by the Office of the President in Botswana, the Ministry of Health in Botswana and the University of Pretoria.

Structured interviews and focus groups will be conducted in Gaborone, Gabane, and Selebi Phikwe. Sefophe, Francistown and Sebina with adults aged 21 and above. The focus groups will be conducted with men and women separately.

I am kindly requesting permission to conduct the study in Selibe Phikwe and Sefophe between the 11th and 18th of July 2003. You are also requested to assist me in organizing a venue to

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conduct a randomly selected focus group. Only about six people are needed in a group meaning six women and six men aged 21 and above. The male group can be conducted on the 14th July 2003 at 8h30 and female group at 10h00. The groups will only be conducted for an hour.

The interviews will be conducted with only 6 individuals in three of your wards, which will be randomly selected in both Selibe Phikwe and Sefophe.

For further information please call me on 00 27 83542 1804 or fax your enquiry to 00 27 21 483 6033.

Find attached copies of letters of permission granted.

I hope my request for your assistance will be favourably considered.

Yours sincerely

E.M.C.Tabane
Principal Investigator

Appendix 3: Structured Interview Schedule

INTERVIEW SCHEDULE

**TOPIC: THE INFLUENCE OF CULTURAL PRACTICES OF THE
BATSWANA PEOPLE IN RELATION TO THE TRANSMISSION OF HIV IN
BOTSWANA**

JUNE 2003

[Instruction to the interviewer is in this type between brackets] *Text in italics is not to be read to the respondent*

[Interviewer: Fill in this top portion before starting the interview]

Date: (DD/MM/YYYY) -----

Interviewer code: (Name or Code)-----

Study Site: (CODES 1- 18)-----

SAMPLING: Village ----- Ward -----

Respondent No-----

A. DEMOGRAPHIC INFORMATION

[Please tick in the appropriate box]

[1: YES 2: NO 3: DON'T KNOW 4: NOT APPLICABLE

5: REFUSED TO ANSWER]

1. Sex of the Respondent Male YES

Female YES

2. What is your age? [Read Choices] Age Group:

18 - 24

25 - 30

31 - 40

41 - 50

51 - 60

61 - 70

Older than 70

3. What is your ethnic group?

4. Which of the following best describes your religion? [Read Choices]

Christian (established church)

African (independent church)

Muslim

Other

None

Not sure

5. What is your marital status? Are you: [Read choices]

Married

Staying with a partner but not married

Single

Divorced

Widowed

Separated

6. Is your marriage legal or traditional?

Legal

Traditional

Not sure

Refused to answer

Other

Not Applicable

7. What is your highest level of education? [Read choices]

No formal schooling

Primary Education

Secondary Education

Tertiary Education

Not sure

8. How long have you lived in Botswana?

Less than 2 years

5 years

More than 5 years

10 years

More than 10 years

KNOWLEDGE ABOUT HIV/AIDS

9. What is HIV?

10. What is AIDS?

11. Where does HIV come from?

12. What causes AIDS?

13. Do you think HIV/AIDS is a problem in this country?

YES

NO

NOT SURE

14. (Please motivate your answer)

15. How does one recognize HIV/AIDS? How do you know that a person has AIDS?

16. How is HIV spread/transmitted?

17. Are there any myths about HIV/AIDS in your culture?

YES

NO

NOT SURE

18. If yes, what are the myths?

CULTURAL PRACTICES

19. What are the common cultural practices of the Batswana in relation to marriage and sexual life?

20. To what extent does each of the above-mentioned cultural practices possibly contribute to the spread of HIV?

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21. Do you think there are cultural practices in your country influencing sexual behaviour?

YES

NO

NOT SURE

22. If yes what are the cultural practices that are influencing sexual behavior?

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23. How significant are they in shaping sexual behaviour?

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.....
.....

24. Do you think the present cultural practices predispose people to HIV infection?

YES

NO

NOT SURE

25. Do you think the present cultural practices protect people from HIV infection?

YES

NO

NOT SURE

26. Do you think that cultural circumcision can expose people to HIV transmission?

YES

NO

NOT SURE

27. If yes, what do you think can be done?

28. Do you believe that women should use herbs or other agents to dry out and tighten the vagina for dry sex?

YES

NO

NOT SURE

29. Do you believe in women circumcision?

YES

NO

NOT SURE

30. It is believed that women circumcision predisposes women to HIV transmission. What do you think?

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HIV/AIDS PREVENTION AND CARE STRATEGIES

31. Do you think strategies to combat the spread of HIV infection in Botswana are taking cultural practices into consideration?

YES

NO

NOT SURE

32. Please motivate your answer.

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.....

33. Do you think older men should have sexual relationships with young girls who are virgins to prevent HIV transmission?

YES

NO

NOT SURE

34. Do you believe in principles of stay with one partner to prevent HIV transmission?

YES

NO

NOT SURE

35. Do you think anti-retrovirals can help prolong the lives of HIV positive people?

YES

NO

NOT SURE

36. What is it that can help prolong the lives of HIV positive people in your culture?

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37. How can HIV transmission be prevented?

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38. Do you think that people should only consult with traditional healers when they have HIV/AIDS?

YES

NO

NOT SURE

39. If yes, why must they only consult traditional healers?

40. Do you think that the family in your culture should take responsibility in educating children about HIV/AIDS?

YES

NO

NOT SURE

41. Do you think HIV positive mothers should not breast-feed their babies?

YES

NO

NOT SURE

42. Should they feed the babies with other foods whilst they are breastfeeding?

YES

NO

NOT SURE

POLYGAMY

43. It is said that men can have multiple relationships irrespective of their marital status but women may not. Do you also hold this belief?

YES

NO

NOT SURE

44. Is this one of the Batswana's cultural practices?

YES

NO

NOT SURE

45. Does this contribute to the spread of HIV?

YES

NO

NOT SURE

46. If yes what can be done to deal with the problem?

47. It is said that a man is like a bull and should not be confined to one pasture.

47.1. Is this one of the Batswana's cultural practices?

YES

NO

NOT SURE

47.2 Does this contribute to the spread of HIV?

YES

NO

NOT SURE

47.3.If yes what can be done to deal with the problem?

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.....
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48. How can we ensure that people in polygamous marriages do not infect each other?

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SEXUAL PRACTICES

49. Do you think that women should at all times be prepared to have sex with their partners?

YES

NO

NOT SURE

50. Do you believe that women cannot refuse their partners sex?

YES

NO

NOT SURE

51. Do you believe older men have more chances of infecting younger women, as they have been sexually active before the women?

YES

NO

NOT SURE

52. Do you think women should make decisions regarding sexual practices?

YES

NO

NOT SURE

53. Do you think infertile women can end up having sex with multiple partners in an effort to become pregnant?

YES

NO

NOT SURE

54. This behaviour is believed to increase HIV infection. What do you think?

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55. Do you believe in men having multiple sexual partners?

YES

NO

NOT SURE

56. Do you think it is only the privilege of men to decide whether they want sex or not?

YES

NO

NOT SURE

AGRICULTURAL PRACTICES

57. It is said that men are the only persons who can go to the cattle post and this puts women in subordinate positions.

57.1. Is this one of the Batswana's cultural practices?

YES

NO

NOT SURE

57.2. Does this cultural practice contribute to the spread of HIV?

YES

NO

NOT SURE

57.3. If yes, what can be done to deal with the problem?

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58. Should women be involved in traditional farming of cattle so that they can go with their husbands to the cattle posts?

YES

NO

NOT SURE

STIGMA ISSUES

59. Do you think women who are HIV positive and know their status, should have children to expand the family?

YES

NO

NOT SURE

60. What do you think of people who are HIV positive?

.....
.....
.....

CULTURAL TABOOS

61. Do you think it is a taboo for women to discuss/negotiate sex with men?

YES

NO

NOT SURE

62. Do you think it is a taboo to discuss sex with children especially unmarried children?

YES

NO

NOT SURE

63. Do you think it is acceptable for men to beat their wives if they do not want to have sex with them?

YES

NO

NOT SURE

MARRIAGE

64. Do you think that the payment of lobola give men the right to demand sex from their wives?

YES

NO

NOT SURE

65. Can men marry women who are older than them?

YES

NO

NOT SURE

66. Do you believe that men should marry or have sexual relationship with women younger than them?

YES

NO

NOT SURE

67. Do you believe that men should marry more than one wife?

YES

NO

NOT SURE

68. If yes, do you think it can contribute to the transmission of HIV.

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.....
.....

69. Do you believe that widows should remarry their husband's relatives or brothers?

YES

NO

NOT SURE

70. What would you think of a woman who is in a polygamous marriage insists on using condoms?

71. Do you believe that women should have children before they get married?

YES

NO

NOT SURE

ALCOHOL USE

72. Do you think alcohol use can contribute to the spread of HIV?

YES

NO

NOT SURE

73. Do you think that people can be asked to reduce alcohol consumption to prevent HIV transmission?

YES

NO

NOT SURE

RELIGIOUS BELIEFS

74. Do you believe that HIV/AIDS is punishment from God?

YES

NO

NOT SURE

75. Do you believe that people who are infected with HIV are being bewitched?

YES

NO

NOT SURE

CONDOM USE

76. Should a man with multiple partners (polygamous) relationship use condoms?

YES

NO

NOT SURE

77. What do you think of people who use condoms in your culture?

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.....

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78. Do you think using condoms is a culturally acceptable?

YES

NO

NOT SURE

79. Do you think condoms should be used to prevent HIV transmission?

YES

NO

NOT SURE

VOLUNTARY COUNSELLING AND TESTING

80. Do you believe in HIV testing?

YES

NO

NOT SURE

81. What are the benefits of knowing your HIV status?

82. What are your feelings about disclosing a person's HIV status?

83. Are you aware of Voluntary Counselling and Testing?

YES

NO

NOT SURE

Appendix 4: Focus Group Guide

DATE: JUNE 2003

**TOPIC: THE INFLUENCE OF CULTURAL PRACTICES OF THE
BATSWANA PEOPLE IN RELATION TO THE TRANSMISSION OF HIV IN
BOTSWANA**

FOCUS GROUPS GUIDE

KNOWLEDGE ABOUT HIV/AIDS

- ❖ What is the difference between HIV and AIDS?
- ❖ How can HIV/AIDS be transmitted?
- ❖ What myths are there in your culture regarding HIV?

CULTURAL PRACTICES

- ❖ What are the common cultural practices of the Batswana in relation to marriage?

- ❖ What is the influence of cultural practices of the Batswana regarding marriage in relation to the transmission of HIV?

SEXUAL PRACTICES

- ❖ What are the cultural practices or beliefs of the Batswana with regard to sex?
- ❖ What is the influence of cultural practices of the Batswana regarding sex in relation to the transmission of HIV?

HIV/AIDS PREVENTION AND CARE STRATEGIES

- ❖ How can HIV transmission be prevented in Botswana?

VOLUNTARY COUNSELLING AND TESTING

- ❖ What do you think about Voluntary Counselling and Testing of HIV?

Appendix 5: Botswana Map



Appendix 6: Consent form

Participants name:Date:.....

Principal investigator: Elizabeth Mamatle Cily Tabane

University Of Pretoria
Hatfield
Pretoria
0001
South Africa

OR

P.O. Box 53374
Kenilworth
7745
South Africa

OR

Research Unit
Ministry of health
Gaborone
Botswana

Informed consent

1. Title of study: **THE INFLUENCE OF CULTURAL PRACTICES OF THE BATSWANA PEOPLE IN RELATION TO THE TRANSMISSION OF HIV/AIDS IN BOTSWANA.**
2. Purpose of study: To establish the influence of cultural practices of the Batswana on the transmission HIV/AIDS in Botswana.
3. Procedures: I will be asked questions regarding cultural practices of the bat swan in relation to the transmission of HIV/AIDS. I will also be asked to give person details such as age, sex, occupation, religion but not my person name and address. The

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questions asked will not take more than 30 minutes. The interview will be scheduled at my own convenience. I will give permission to participate.

4. Risk and discomforts: There are no known medical risks and discomforts associated with the project.
5. Benefits: I understand that there are no known direct medical or financial benefits to me participating in this study. However, the results of the study may help researcher's gain better understanding of the Batswana cultural practices in relation to HIV/aids in Botswana. The government and organization dealing with the prevention of HIV infection will be able to plan and develop culturally appropriate strategies to prevent HIV transmission in Botswana.
6. Participants rights: I may withdraw from participating in the study at any time.
7. Financial compensation: There will be no financial compensation nor will I be reimbursed any travel expenses.
8. Confidentiality: In order to record exactly what I say in the interviews, a tape recorder will be used. The tape will be listened to only by the principal investigator and authorized members of the research team at the university of Pretoria and Botswana. I understand that the results of the interviews will be kept confidential unless I ask that they be released. The results of this study may be published in professional journals or presented at professional conferences, but my records or identity unless required by law.
9. If I have any questions or concerns, I can call Mrs Cily Tabane at 00-27-835421804 or 71850590 or Ms. Halabi at 3914672 or 3956582 at any time during the day (8h00 to 16h00).

I understand my rights as a research subject, and I voluntarily consent to participation in this study. I understand what the study is about and how and why it is being done. I will receive a signed copy of this consent form.

Subject signature

Date:.....

Signature of Investigator

Date:.....

**Appendix 7: Focus group discussion transcripts 10 men-
Gaborone**

Dumelang Borra – Nna ke bidiwa Cily Tabane, ke tswa ke le ko South Africa. Ke Student ko University Of Pretoria, ke ithuta ka ga HIV/AIDS ke dira research ka ga HIV/AIDS mo Botswana – ke setse ke dirile ko Phikwe le Francistown jaanong ke mo Gaborone. Ke kopile permission/tetla ya go dira research kwa go Office of the President, Ministry of Health le mo Dikgosing. Jaanong ke tlo go kopa mo go lona gape le fake buile le lona pele re kopana. Gompiano jaana re tlo bua ka ga HIV/AIDS gore ke eng, e tswa kae, setso sa rona se re eng ka ga HIV/AIDS, lenyalo le thobalano, le gore a re a itse ka ga VCT le gore re akanya eng ka distrategy tsa go preventa HIV/AIDS mo Botswana.

Ke tlo kopa mongwe le mongwe a bue se se leng mo maikutlong le se a se itseng.

Ga go na motho o tla bang le phoso wrong kampo right. Botlhe re bua se re se utlwileng kampo se re se itseng. Ke tla botsa dipotso mme ke tla kopa dikakanyo tsa lona. A le a dumalana go tsaya kgato mo kopanong e jaanong – Ee, Ee Eeng. Ga ke tlo tsaya maina a lona fela ke tlo kopa go dirisa tape ke tle ke kgone go gopola tsothe tse re di boletseng mo kopanong e. A go na le o anang le kगतलhanong le go dirisa tape. E tla re fa re fetsa mo kopanong Borra ra bo re nwa drinki le dibiskiti – rea leboga Mma. Kopano e etla tsaya Ura.

Ke lebogile thata ga le dumetse go tsaya kgato mo kopanong e. Ke tla simolola ka go botsa gore HIV ke eng? ke eng se re se itseng kaga HIV?

HIV ke mogare, ke virus, eng ke mogare, ke mogare o tsalang AIDS. Mogare o ga ona kalafi ke gone fela ka HIV, go na le sengwe ka ga HIV? Nyaaya. HIV ke one mogare o tsalang AIDS. AIDS yona ke eng?

AIDS ke bolwetse bo bo sa foleng. Ga go na kalafi ya AIDS. Ke malwetse a kopakopaneng. O lwala tota. HIV e tsena jaang mo mmeleng? How does one get HIV. O e fitlhela jaang HIV?

Breastfeeding, thobalano, eng ka go anyinsa – masi a ne le HIV a na le mogare – ka go dirisa dinalete le magare a batho ba banang le HIV –

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tshwanetse go diriswe di gloves fa o dirisana ka madi go thibela mogare go tseana mo dinthong - mogare o tsena jaang mo dinthong? Fa ona le dicuts le mongwe a na le mogare wa HIV – Kamano ya madi e tsaya mogare mo mothong o mongwe fa o sa dirisi condom o robala le motho a a na leng mogare (HIV) A go na le sengwe – no,no, nyaa. Re ka tswela pele neng. A gona l di myths ka HIV/AIDS? Di myths ke raya dikgang or tumelo e re nang le yona mme e se nnete. Dipuo tse batho ba di buang ka ga HIV/AIDS mme e se nnete. Ee, di dintsi ke tse dintsi. A re di utlweng.

AIDS ke boswagadi, gape e tlisitswe ke makgome – fa o tlhokafaletswe o tswanetse go alafiwa setswana, fa o sa alafiwa, o tla tshwara ke AIDS – government e fokotsa population ya Batswana ka goba tsenya mogare wa HIV. Makgowa a mo Botswana ke bona ba tsenang batho le go roglala le tbatswana. AIDS ga se bolwetse ba makgowa. Rra e na reng eng ke utlwana le bona – AIDS ke boswagadi. A gona le sengwe se re batlang go se tlaleletsa? Nyaa.

Jaanong ke setswana go na le setso / ditso tsa batswana setso sa reng ka ga lenyalo? Re dira eng mo setsong mo lenyalong?

Setso sa rego ntshiwe bogadi –lobola – bo malome ba ntsha bogadi – saty with one partner – mosadi ke bana – mosadi o tshwanetse go tshola bana mo lenyalong. Setso gape se re go ga ka nna le polygamy – Nyaa ke setso sa Borra rona. Polygamy ga e sa diriwa mo setswanaeng ke setso s makalaka. Mosadi o tshwanetse go tlhompaa monna wa gagwe, mosadi o tlhokomela lapa laga mbo monna. Monna ke selpe se a amoganwa. – laughing – Ee – Mosadi ga botse monna dipotso. Fa mosadi a na le ngwana pele ga lenyalo, ga twe o e gapla le namane. Go na le sengwe gaple. O kare ke topic e re e ratang faana. Di dintsi re ka buathe holeday – buang – Nyaa o kare re build tse di bothokwa.

Bangwe ba reng eng – Ee, se se bothokwa ke go re nuyalo ke bogadi le bana. Monna wa duela mme Mme ena oa tsala. Fa go se jalo ga gona nyalo. A go na le sengwe? Nyaa –

Ditso tse tsa rona ka lenyalo, a dira bothofo gore re trswenewe ke mogare wa HIV kampo setso se a re protecta? Se a re thusa go thibela HIV – Ee. – setso

se a re thusa gothibla fela gape mo go nngwe se dira go re re tsenwe ke mogare botlhofo. Se re thibela jaang?

Setso sere stay with one partner ke jalo re ka se infectiwe kemogare wa HIV – Ee

Fela setso sa polygamy se dira gore go nne botlhofo go bona HIV ka gore ga o tsie go re partner enngwe yona e faithful kampo jaang – Ee – ke nnete – Nyaa gape ge mosadi a tlhompama monna ka setsa sa rona, go raya gore re a tshepana. Mosadi a ka se tsamye le n banna ba bangwe. Ee – setso se siame, kajeno ga go se polygamy, go raya gore banna ba itsamela fela. Gape ka polygamy vasadi ba, ba itsane gape ba tlhompana. Ka moo fa re tlotla setso mogare o wa HIV a ga go botlhofo gre ore tsene. A re dumelana gore polygamy e a e thusa? Ee. Nyaa mo nakong e e fetileng.

Nyaa polygamy e tshwanetse gore e fetsiswe ka gore ga go dirisiwe sekausa gape tlhompama e d ffedile mo nakong tsa kejaeno. Kang ya gore monna ke selepe o a adimiwa yona e re thusa jaang? Nyaa ga e thsuse ka re go go dirisiwe sekausa monakong tsa ka jeno gare is tse gore monna o kapqna la basadi ba ba ntseng jaaang – ka jalo puo e ga e re thuse mo go thibeleng mogare wa HIV gore o spreade. A go na le sengwe, Nyaa Mma.

Re ke tswelapele go bua ka setso mabapi le thobalano? Setso se a e reng kaa thobalano (sexual behaviour)

You only have sex when you are married? Ee – setso sa re o tshwanetse o be o le mo nyalong pelo o ka bua kampo go amana le thobalano. Mosadi ga a tshwanela go kopa monna dikobo. Setso sa re re dirise dicondom ka gore re tshwanetse re tshoole bana – Ee. Condom ga se setso. Monna ga aamane le mosadi a le mo kgwedding – Ee A gona di dingwe? Ee Ka ge re boletse mosadi ga a go na le bojale le bogwera?

Basimane and basetsana ba rutiwa ka ga thobalano mo setsong. O raya circumcision – Eeng Ka setso go dirwa bogwera le bojale – ke yona circumcision Mo bo Gaborone mo toropong –E dirwa mo dikgaolong. Ke a leboga – jaanong setso kamopo ditso tse mabapi le thobalano di re ama jang ka mogare

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wa HIV. A setso se a re protecta kampo go botlhofo go tsena ke mogare wa HIV. Ee – go kanna botlhofo ka gore ko bogwereng le bojanleng, go dirisiwa magare a a sa sterilizwang, ka jalo ga re itse gore ke mang o na leng mogare. Kwa bogwera le bojaleng ba tshwanetse go dirisa magare a sterilizitsweng – Ee Ee

Setso se are thusa gape ka gore monna le modsadi ba kopaa ka diobo ba le mo nyalong, seo se raya gore ba kopana ba se na mogare. Ka jalo, setso se a re thusa – Ee se thibela mogare go tsena mo mmeleng. Ee – gape fa re sa dirise dicondom o fitlhela gore botlhofo go tsena ke mogare kagore ga o mo itse moth o o tla kopaleng dikobo le nena kano tsa ka jeno, motho ga a itsewe e se naga. Batho ga ba tshapagale. Ga go itsewe faan le mogare kamo jaang. A setso se aa re thusa Nna? Ee Mma mo gongwe ga se re thuse. Fa o sa dirise condom, o tla tsenwe k ke mogare ka jalo gase re thuse. Fa o leta gore o nyale kampo o nyalwe, mogare o a thibelwa ka jalo setso se a re thusa. Ba bangwe ba re eng? Ee Mma re a dumalana. A gona le dingwe? Nyaa Mma. Re tla tswelela go bua ka distrategies tsa go thibela ogare wa HIV mo reng ka k distrategy; tsa HIV/AIDS mo Botswana, a dia re kgotsofatsa kampo jang? Botswana. A distrategies tsa mo Botswana di atlegile kampo di na le mathatanyana. A di considara culture setso sa rona, ra

Nna kare culture ga etlotliwe ka gore bana ba bua le bagolo ka thobalano. Ka setso kang ya thobalano, e ya bagolo fela. Setso ga se tselwe kwa tlhogong, setso ga se tlotliwe – gape ba bus hat a ka do dicondom mme gase kang e tlwaelegileng me setsong sa e rona. Setso se tswanetse se tlotliwe fare rutwa ka HIV/AIDS. Gape gatw re se dirise melemo ya Setswana mme melemo yan a thusa. Ga twe stay with one partner, nna ke a dumelana le kgang mme le yona ke ksetso.

Batsadi ba tshwanetse go bua le bana ba bona – Ee Ee ga bo boima ka gore gare a tlwaela go dira jalo – fela re tshwanetse go practisa. Dikgosi le tsona di tswanetse go tsaya kgato mo go ruteng batho ka ga HIV.

A re dumalana gore distrategies tsa rona di tshwanetse go includa culture. Re tshwanetse go tlotla culture – Ee Mma. A gona le sengwe se re batlang go se tlaleletsa – Nyaa Mma.

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VCT yona re a itse – Ee ke yona Tebelopele. Yona ra reng ka yona. A e siame kampo jang. Ee go gabedi – e siame – ga e a siama – Why? E thusa ka gore you know your status, e re ruta le ka go itshola sentle

Galpe e go dira gore o akanye that ka botshelo. Motho o nna le stress fa a itse status sa a gagwe. Ee- le a dumelana- Ee Ee- e siame gaya siama.

Mm botlhokwa go itse status sa gago? Ee – e thusa ka gore o tla amogela di-drugs ARV'S, Ota itse le gore o ye neng ko cliniking, yona e siame re tshwanetse go itse maemo a rona, go botlhokwa .re adumela le kgang e? Ee, Ee. A go na le sengwe se re batlang go se bua? Nyaya.

E kare re fitlhile bokhutlong ba kgang ya rona. Ga go se na kgang enngwe, ke tla rata go le leboga thata thata. Ke itumetse tota. Ka ge ke santse ke boletse gore re tla na le driniki le dibiscit fa re feta re tla ja botlhe. Ke lebogile gape.

Ke kopa le nsignela fa gore le nnile teng mo kopanong e. ge ke battle maina fela disignature. Dankie Re lebogile Mma – le rona re lebogile – ke kgang e e masisi e Ee.

Appendix 8: Focus Group Discussion Transcript (Six Women, Francistown West)

What is HIV

- HIV – Mogare/Virus

AIDS – Bolwetse bobo bakwang ke mogare wa HIV

- What is a virus – Organism in the blood cells found on body fluids
- How does it get into the body?
- A amana anyhow
- Sexual intercourse
- Needles
- Any blood fluids in contact in accidents when you have cuts
- During birth – Mother can pass it to child
- How – Breast feeding during birth
- Baby gets infected from breast milk, injections, blood transfusion infected blood from
- Razor blades – dintho – open cuts – molwetse assisting a patient with HIV without
- Gloves – toilet need to be cleaned every now and then to avoid transmission.

MYTHS

- AIDS ke boswagadi-
- Other partner is dead-
- The surviving partner needs traditional medicines – no treatment – leads
- AIDS – The person is not clean. The dirt of the previous partner needs to be cleaned.

MYTHS

- Miscarriages – no traditional treatment – must be traditionally treated before you have sex with another men.

MYTHS

- Menstruating people having sex with males contributes to HIV infection.

MYTHS

- After birth one should stay away from the partner sexual relationships

CULTURE

- Cultural practices – one man one woman
- NO – disputes – polygamy is culture
- When someone you marry – parents, uncles aunts mallome, rakgadi, rangwane, bogadi
- bo a patelwa ke monna – cows – cattle
- The woman goes to the in-laws when you get there oa laiwa uncle's wives, paternal aunts
- Nyalo – children should be born
- Setswana marriage – in-laws
- Extended family becomes part of family.
- Celebration – Setswana – go a tlhabiwa, bojalwa ba setswana
- Setswana – woman leaves her family for the husbands
- Any complaints to the in-laws

Transmission v/s Culture

- Polygamy
- Go laiwa – monna ke selepe o a adimanwa
- Monna you dont ask where they come from
- Monna ke poo ga a golegwe
- Ga a thatellwe
- Men are free to do whatever they want to do
- Society gives them freedom
- Differs
- Moral and values – men marry when you decide to marry – first wife chooses
- Polygamy protects in our culture

- Today unknown multiple partners
- Culture very significant
- No morals no values – free life
- Culture – was good – oit is misused
- It is to the advantage
- Alcohol use is scapegoat (Jesus also drank)
- Infertility women – polygamy
- Arrange birth for the husband
- Today, they are all over the show
- Culture v/s sexual behaviour
- Only have sexual intercourse when you married – even men
- Polygamy – men are socialised to get married
- Curls are socialised to get married (bojale, bogwera) circumcision talks about marriage
- You dont get involved when you are menstruating
- Monna always must initiate – mosadi ga a tsogelwe
- Men are the only one who propose marriage
- Menstruation also protects
- Today people do not go for circumcision – people must go because you learn about sex.
- In the past you stick to one partner
- Basadi ke khumo (affordability on the side of the husband even when in polygamy it is arranged).

STRATEGIES OF PREVENTION

- E padile
- Self discipline
- Back to culture (morals)
- Bojale le bogwera – we are now reckless
- Parents should also teach children about sex
- Not only at school
- Bojale / bogwera – sterilise
- Cultural schools – puberty we all know about it
- Behaviour is the main theme
- Puberty teachings in secondary schools should feature
- Christianity should be encouraged and taken seriously

- Intake of alc ohol is too high in Botswana
- Alcohol content reduced 5% tp 2%
- Prizes must go up
- People are loose (no pretection)
- Reckless decisions
- Prostitiounss – poverty –rape, idling

VCT

- They are good not good some people are weak (psychological)
- When people find out then they do not live long – stress depression, suicide
- Change lifestyle
- No treatment ARV'S useless
- People need to live positively whether positive or negative

FOCUS GROUP DISCUSSION TRANSCRIPT–

SEVEN MEN – FRANCISTOWN

- **HIV** – mogare o tsala bolwetse ba AIDS
- Mogare o tsala bolwetse
- Bo bo senang kalafi

AIDS

- Malwetsi
- Opportunistic disease
- With no kalafi
- Malwetsi a a kopakopaneng
- Bo tlhodilwe ke different diseases mo mmeleng

TRANSMISSION

- Sexual intercourse with no preventio – socks – condoms
- Go dira le moth o o naleng AIDS
- No protection
- Use gloves
- Wounds-

- Go kopana ga madi
- Pelegi
- During birth –
- During the cutting the umbilical cord
- Blood can cross to the babies body
- Breastfeeding caused HIV transfusion breast milk contains HIV

MYTHS

- HIV e tsana motho with many girlfriends
- Clarified questions
- If you are not sexually active you can still get AIDS
- Miscarriages and widows Moila
- Need traditional treatment in modern terms it is AIDS in our culture
- It is moila

CULTURE v/s MARRIAGE

- Arrangements should be made
- Merero
- Magadi – the man who marries pay for the children born in the family to the girls
- Culture – polygamy – it is the past
- Marriage was arranged
- Today men look for their own wives
- Marry a woman without children
- Relation to HIV
- Polygamy – infects people HIV
- No protection as there must be children
- Causes of HIV is multiple partners
- You dont know the woman whose marriage is being arranged for you

CULTURE v/s SEXUAL PRACTICES

- You marry before sexual intercourses
- Age restriction (20 by 30 you must marry)
- Woman can marry when they are young 18
- It is to get infected

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- Polygamy is the only one making it possible for HIV
- Morals and values – polygamy
- Protected as you only face only those people
- People are not equal
- Men had to be older
- Age difference causes HIV
- Women should not be older than men
- Older women condemn men's blood
- Younger women should respect men and when they are of equal age there is no respect.

VCT

- Good
- You know your status
- Behaviour change resulting in less HIV transmission
- Positive living
- Negative people know how they must live

STRATEGIES

- Maikemisetso to educate people that HIV affects our lives
- Listen and understands all these prevention strategies
- Stick to one partner
- Condom use
- Check yourselves at VCT when you want to have children
- Abstain
- We must educate each other
- Talk to families (from children to adults)
- Young children need to learn in their families
- Educate each other

FOCUS GROUP DISCUSSION TRANSCRIPT- **SELIBE -PHIKWE (10MALES)**

- **HIV** – mogare

- **AIDS** – When you are really sick
- HIV – loose weight
- Swollen glands behind ears, hair loss, sores open, goes to the toilet every now and
- Then diarrhoea.
- HIV – Where it comes – comes from Africa, sexual intercourse
- America
- Use of utensils of someone with HIV
- Taking care of someone with AIDS without HIV
- Blood
- Not using Condom
- Open sores sharing needles

MYTHS

- If you believe in the bible you will not have AIDS
- Do not share women
- Where was it before there is nothing about
- Aids ke boswagadi
- It is self made illness – government reducing population
- White people brought the illness 1985 only came
- No whites have AIDS
- White people slept with gorillas
- Government reducing people

CULTURAL PRACTICES MABAPI LE LENYALO (MARRIAGE)

- Bogadi – Tlhagela / Mokwela – Bogadi ba ngwana born
- Go a laiwa
- Do not go around with men/women unmarried
- Monna selepe se a amoganwa (you do not ask where the man comes)
- When you have problems - (Woman – discuss with in-laws)
- O e gapa le namane

Protects

- One partner

Predispose

- Monna selepe wa patsha

- AIDS – Different wives
- Polygamy – Makalaka, Mazazu (Shona)
- It is not culture, it is religious
- Only a culture

SEXUAL PRACTICE

- Sexual intercourse after marriage
- Tiisa mokwatla – sleep with wife so that child can crawl
- Mopakwano / disabled/segole – if mosadi a nyetswe a robala le monna yo mongwe mo botsetseng ngwana e ba segole

PROTECTS

- After marriage stick to one partner
- **Contribute to HIV transmission** – if you marry many wives (polygamy)
- No culture in strategies fashion
- In the past there was no HIV
- No condoms – no HIV in the past
- Since condoms now HIV
- Traditional medicines can assist in curing HIV

STRATEGIES

- Go back to culture
- ARV'S
- Bible lessons
- Traditional medicines used in the past
- Listen to parents
- No hope and faith – No religious country

TEBELOPELE

- Know your status
- You get ARV'S
- You know your CD counts

- Tebelope create stress when you know your status
- People infect each other when they know status
- You can plan your future
- Live a healthy positive life
- You learn about condoms
- You spread if you do not know status
- Alcohol use is (Traditional/ is culture)
- Reducing alcohol will not reduce AIDS
- People used to drink in the past and there was AIDS
- Children should not drink
- People should be employed to raid bars
- This will create job opportunities
- Needs AIDS education in Botshabelo

FOCUS GROUP DISCUSSION TRANSCRIPTS

6 FEMALES (SELIBE – PHIKWE)

WHAT IS AIDS

- HIV – Mogare o sa lwale mo mmeleng
- AIDS – you are not sick
- AIDS is an illensss
- HIV – Sexual intercourse
- IT comes from boswagadi
- Malwetsi a dikobo (Thosola, STD, Rasiphphi (Syphillis
- Open sores on private parts

E TSWA KAE AIDS

- Sexual intercourse
- No sexual intercourse no Aids
- No condom no aids

TRANSMISSION

- Blood through sexual intercourse
- Open sores /scratches – blood
- Contact on open sores
- Breast milk
- Semen and vaginal fluids
- No condom use

HOW DO YOU RECOGNIZE HIV

- Loss of hair / weight
- Sores on the body
- Mollo wa badim
- Something like small pox

MYTHS

- Ke Boswagadi
- When you have TB you have AIDS
- Headaches are AIDS
- Any illness no healing quick is AIDS
- Diarrhoea (Frequently) means you have AIDS
- AIDS comes from the whites
- AIDS is brought by people outside the country
- AIDS ke bolwetse like leprosy
- It is punishment from God
- God is punishing us as we do not believe

CULTURE v/s MARRIAGE

- Predisposes to HIV
- Pregnant women is hit by a woman with a big boy and then decides if the baby is born and is a girl then it will be a daughter in law
- Arranged marriage
- Older men sexually active

- When you married and husband works in another country should not spend new years' eve (kgaola ngwaga) with another man (1st January)
- Do not sleep with another man The husband will die
- If a man married with a wife, you do not ask your husband where you come from.
- Only married people discuss marriage arrangements (ga o laye ngwetsi ge osa nyalwa)
- In the past it protected people from HIV

- Arranged marriage predispose HIV
- Older men infect younger women
- No guarantee about the 1st of January. It is only one day
- Protection – both can infect each other-
- Not asking man (predisposes)
- If you befriend an unmarried woman, you can be predisposed to HIV

SEXUAL PRACTICES

- Only sexual intercourse when you are married
- Setso se re re tshole bana no protection
- Sexual intercourse with daughter in law by the father-in-law to proof that the woman is woman
- Seyantlo
- When you are married and husband dies and you drink traditional medicine and rould.
- You can't sleep with another man shilst on traditional treatment.
- If you dont drink medicines (you will be infected)
- Dirty and boiling blood
- You have the medicines every year
- Today children are sexually active at an early age
- Parents do not know about it

VCT

- Know about it
- Good because – you know your status
- Not good because it frightens
- Because (health education
- During testing is not good

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- Videos showing people with HIV whilst waiting for results is not good
- People purposefully infect others when they get frightened.

- Good – you know your status.If you dont you do not know your status. It is good to go for VCT Bad
- Will not go for testing as she does not have support system
- Good – ARV'S are available
- Access to medical care
- Advised as to healty positive living

STRATEGIES

- Culture taken into consideration
- Condom all the cultural myths
- Most of the time culture is condemned

PREVENTION

- Culture should be strongly supported
- One partner only
- No sexual intercourse
- Condom use not 100% prevention
- Educate children from primary about sexual practices
- No childbearing

Appendix 9: Voluntary counselling and testing

(VCT) Marketing in Botswana



Appendix 10: Example of antiretrovirals

