

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 Batswana 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 lead 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.

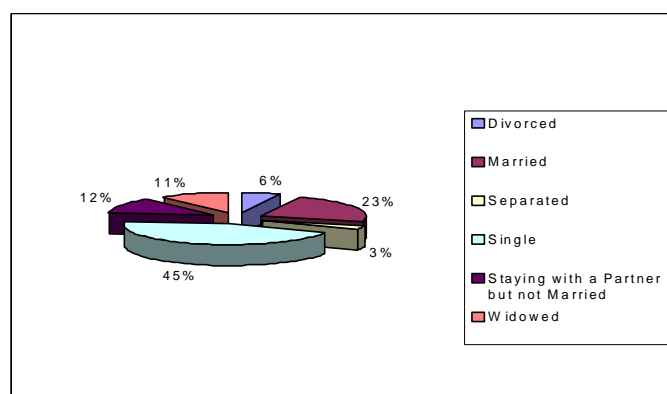


Figure 1: Marital status of the respondents

- **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).

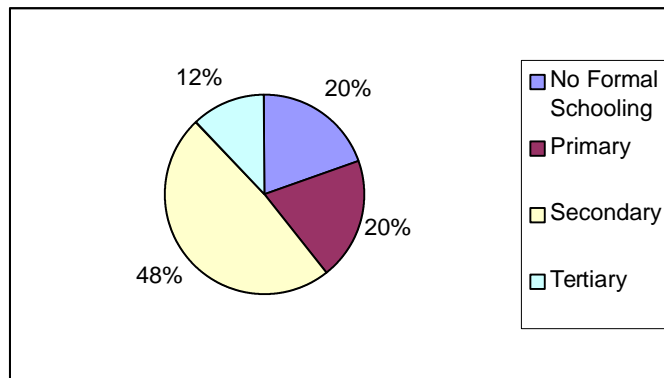


Figure 2: Level of education of the respondents

- **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.

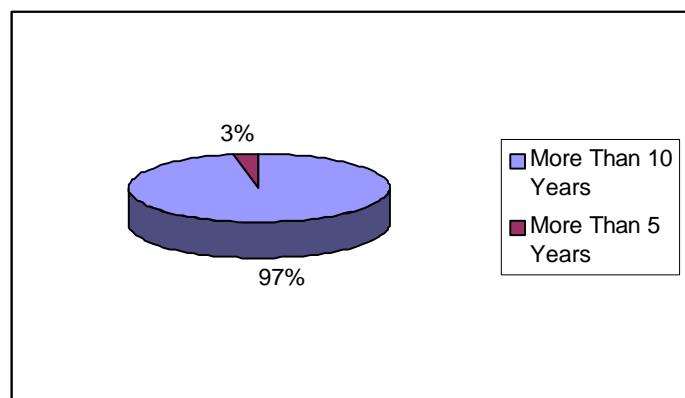


Figure 3: Number of years in Botswana

- **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.

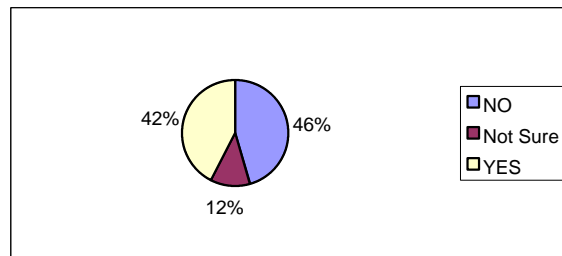


Figure 4: Predisposition of cultural practices to

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).

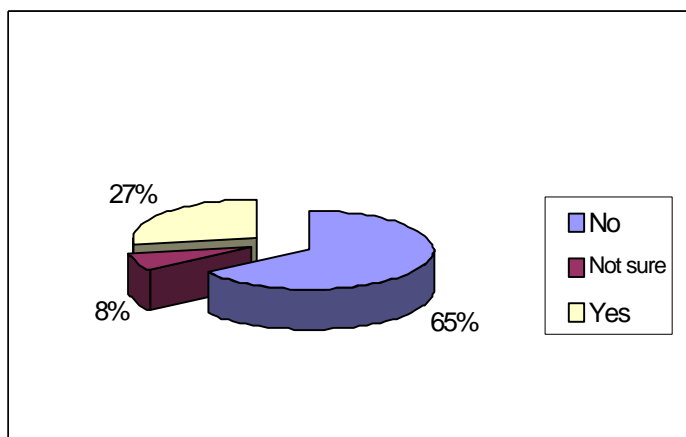


Figure 5: Cultural practices protect people from HIV infection

- ***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.

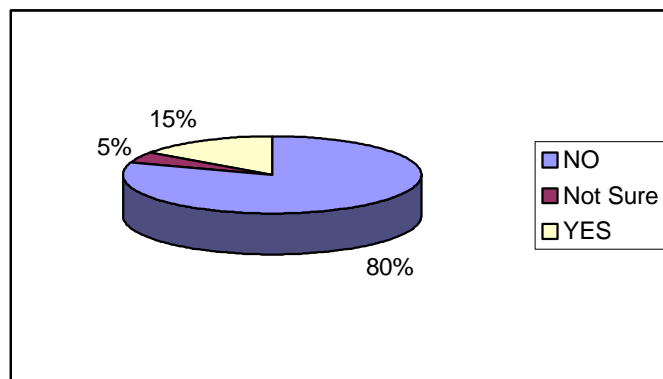


Figure 6: Beliefs in women circumcision

- **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.

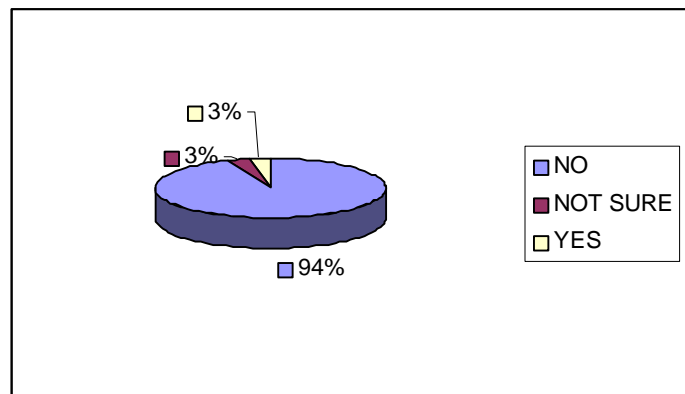


Figure 7: Responses regarding the statement:older men have sexual relationships with young girls who are virgins to prevent HIV transmission

- ***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.

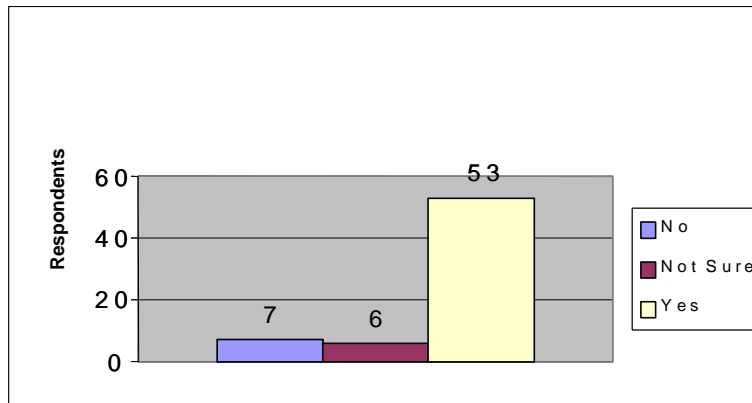


Figure 8: Beliefs in principles of stay with one partner to prevent HIV transmission

- ***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.

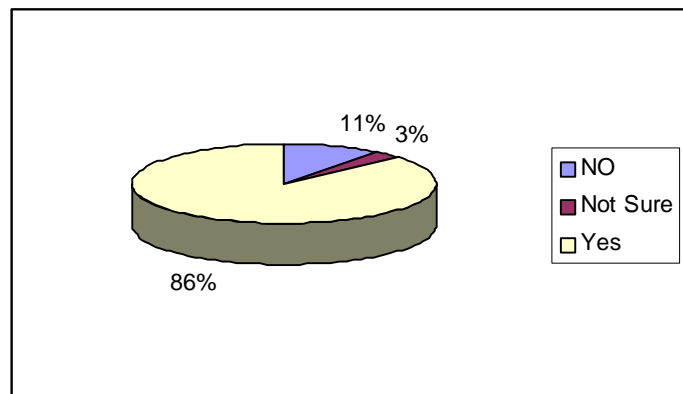


Figure 9: Opinions regarding the helpfulness of antiretroviral to help prolong the lives of HIV

positive people

- ***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.

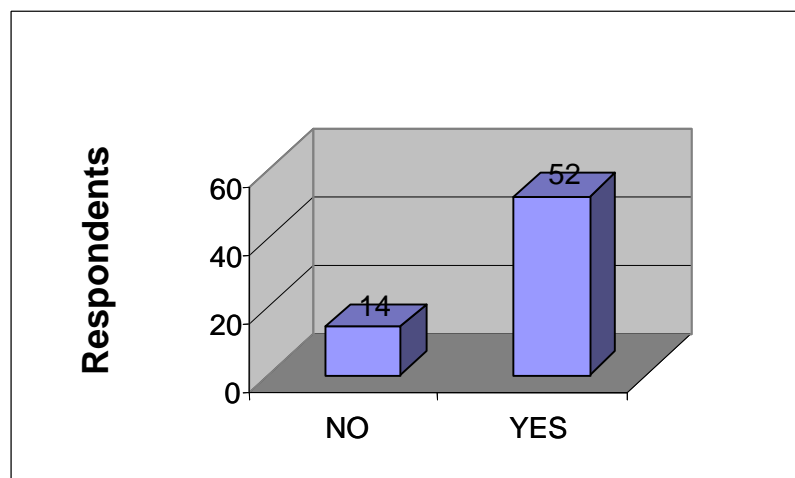


Figure 10:Responsibility of the family to educate children about HIV/AIDS

- ***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.

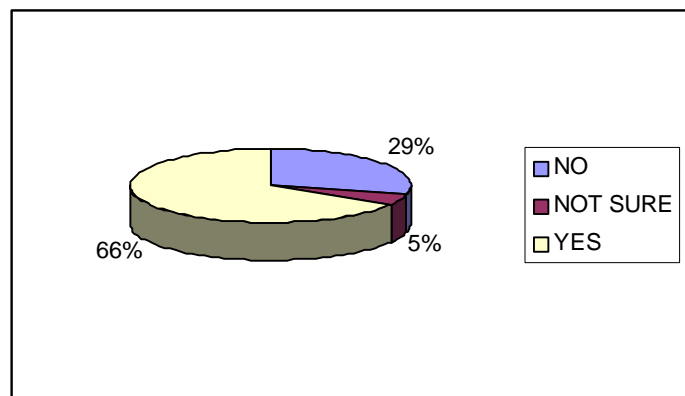


Figure 11: Breast -feeding of HIV positive mothers

- ***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.

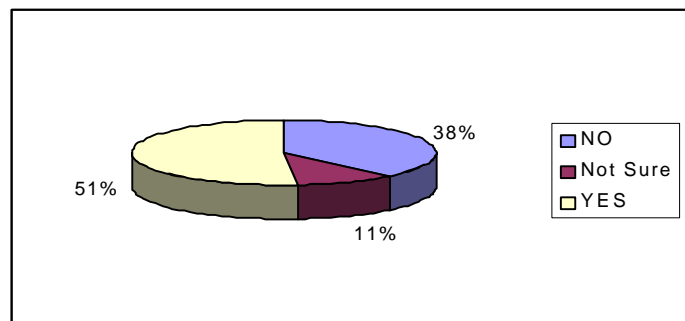


Figure 12: Responses regarding whether HIV positive mothers must feed their babies with other foods whilst they are breastfeeding

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).

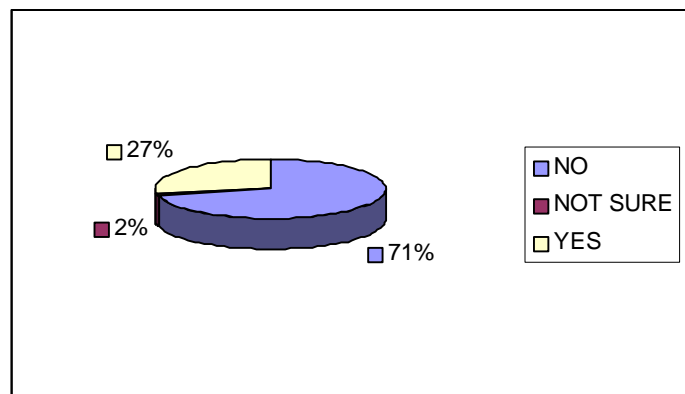


Figure 13: Beliefs regarding men with multiple relationships

- ***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).

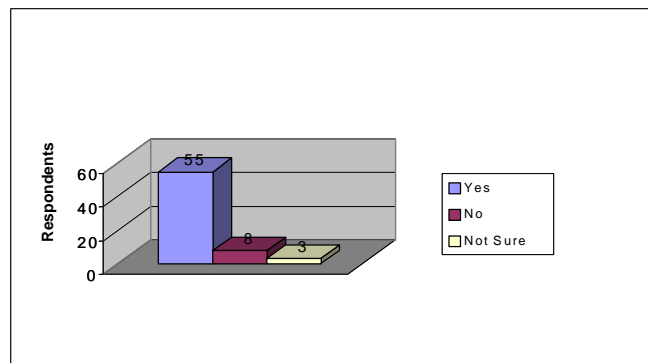


Figure 14: Responses regarding the behavior of men in multiple relationships contributing to the spread of HIV

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.

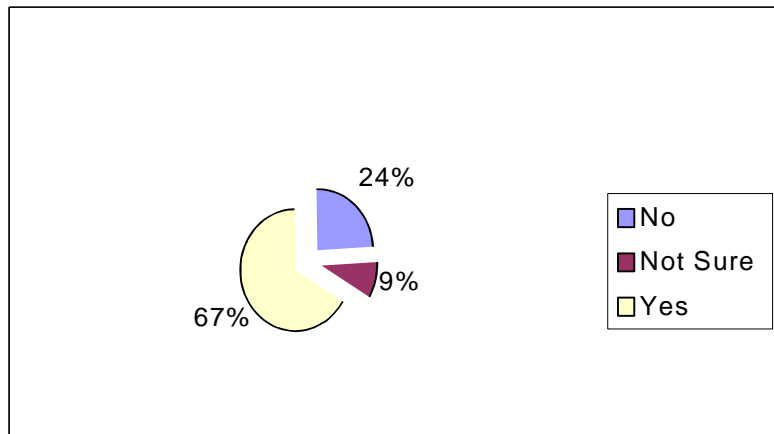


Figure 15: Response regarding the statement a man is like a bull is one of the Batswana cultural practices

- ***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.

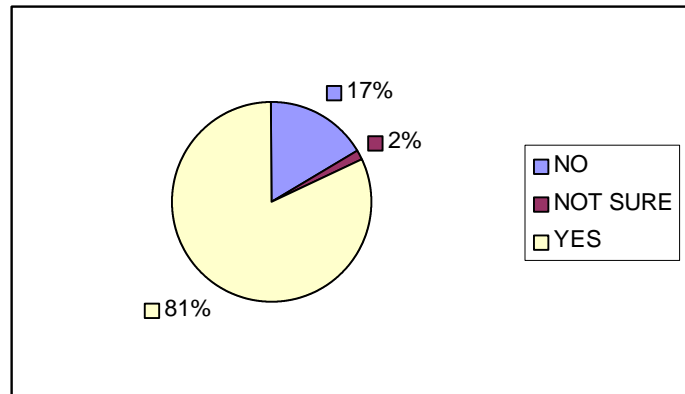


Figure 16: Responses regarding the statement of a man is like a bull spreads HIV

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.

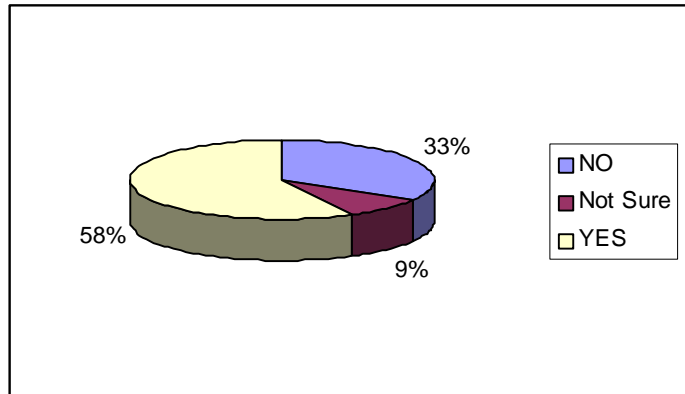


Figure 17: Opinions regarding the statement that women cannot refuse men sex

- ***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.

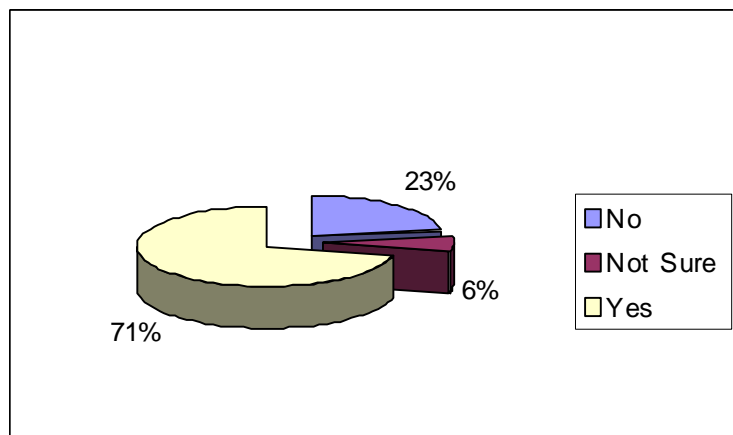


Figure 18: Beliefs regarding older men infect younger women as they become sexually active earlier

- ***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.

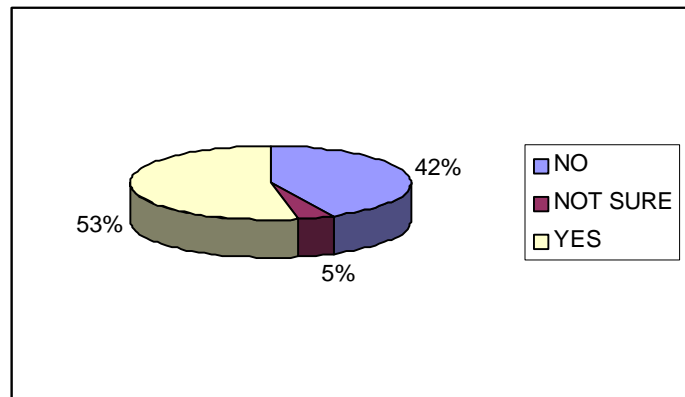


Figure 19: Opinions regarding infertile women can end up having sex with multiple partners in an effort to become pregnant

- ***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.

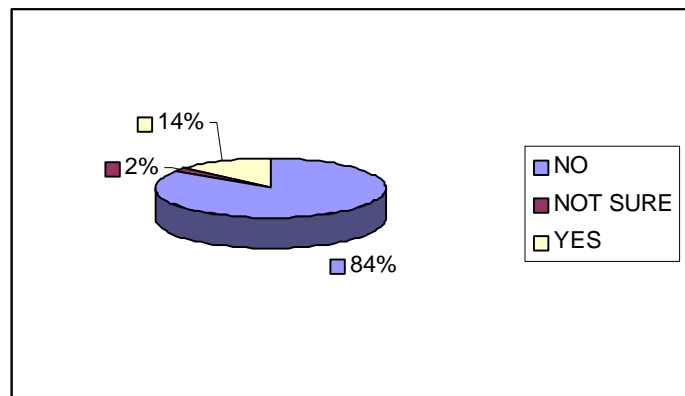


Figure 20: Men are privileged to have sex

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.

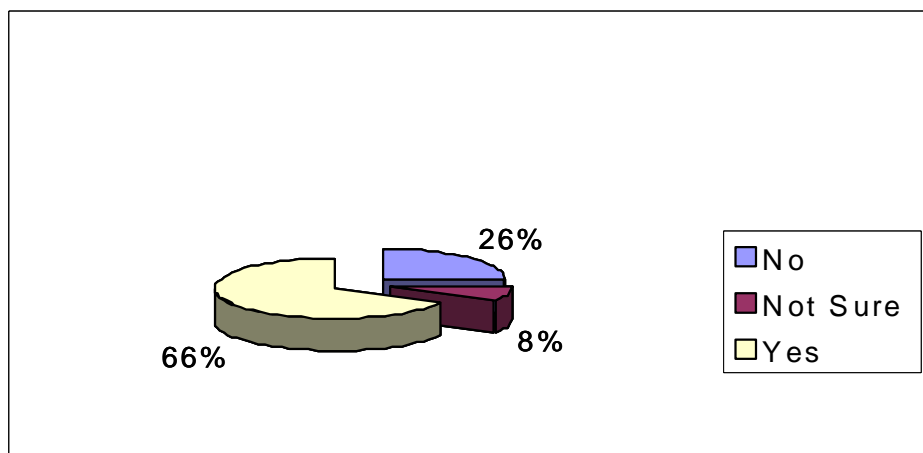


Figure 21: Men are the only persons who can go to the cattle post are one of the Batswana cultural practices and this puts women in subordinate positions

- **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.

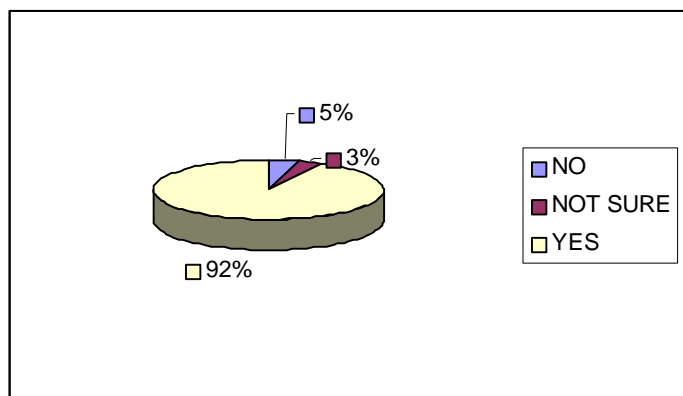


Figure 22: Involvement of women in traditional farming

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.

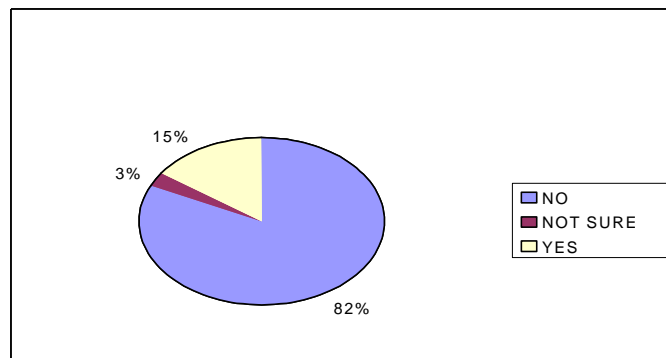


Figure 23: Opinions regarding the statement that HIV positive women can have children

- ***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.

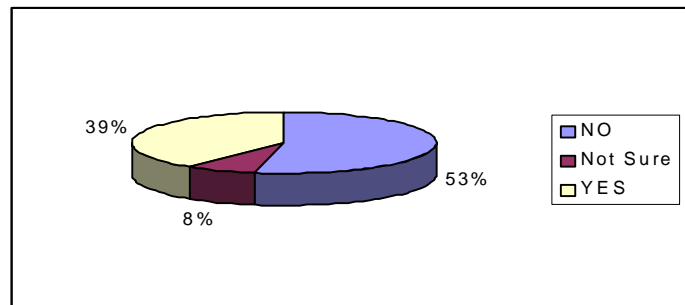


Figure 24: Opinions regarding the fact that man can marry older women

- ***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.

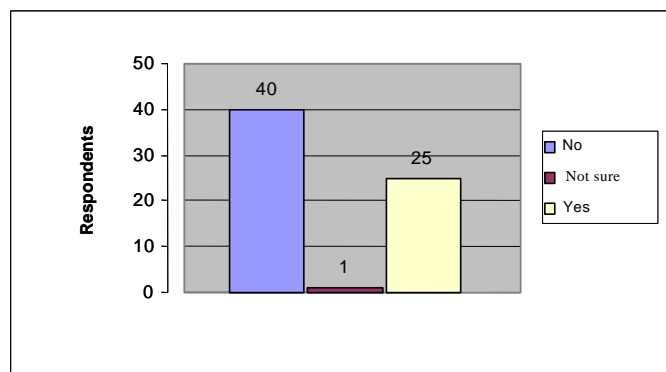


Figure 25: Responses regarding widows remarrying their brother-in-laws

- **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.

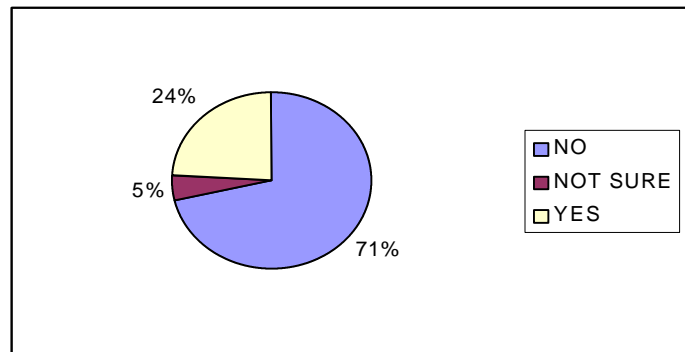


Figure 26: Responses regarding women bear children before marriage

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.

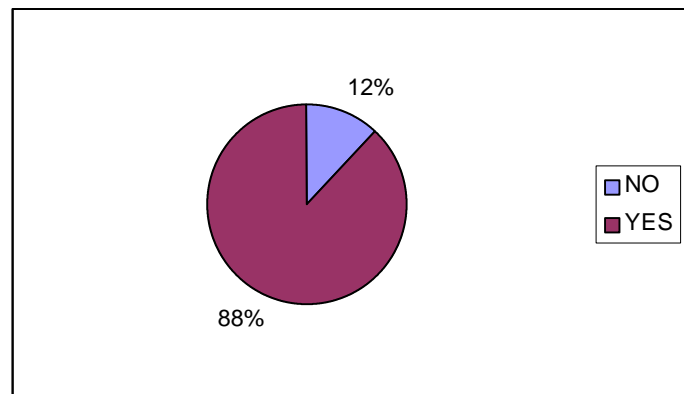


Figure 27: Contribution of alcohol to the spread of HIV

- ***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.

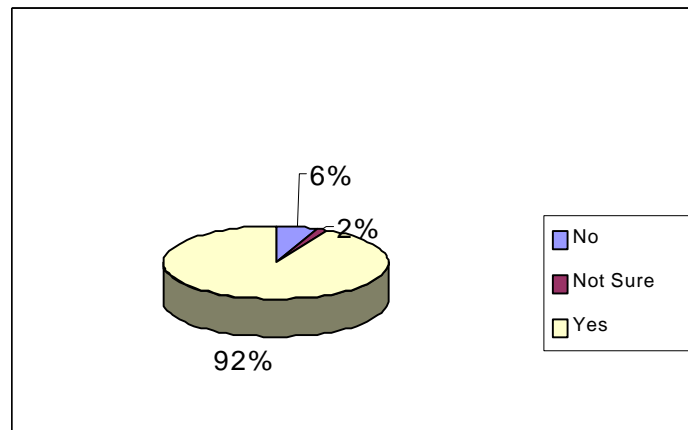


Figure 28: Opinions regarding the request of alcohol reduction to prevent HIV transmission

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

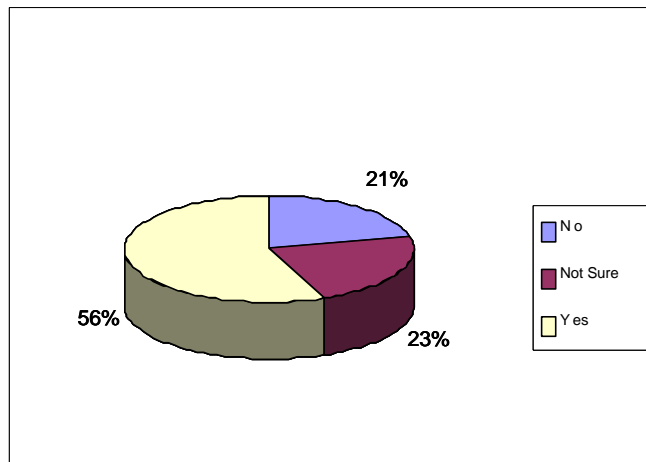


Figure 29: Opinions regarding HIV as a punishment from God

- ***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.

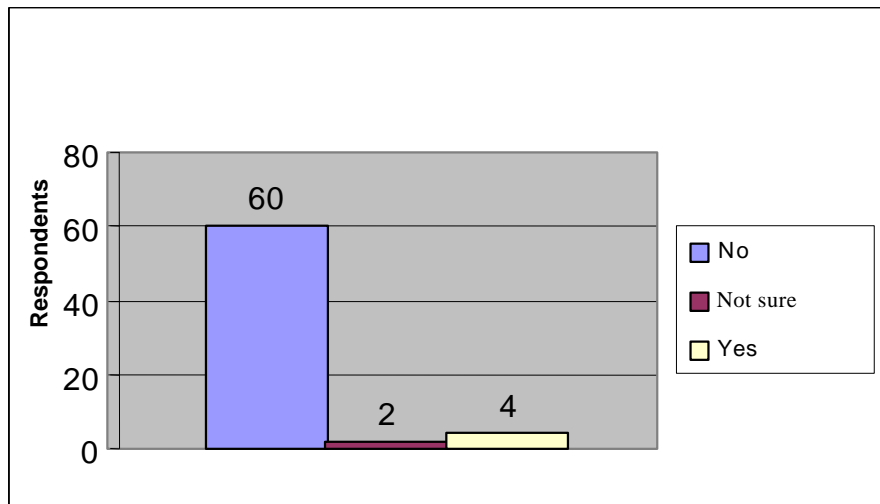


Figure 30: Opinions regarding HIV as witchcraft

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.

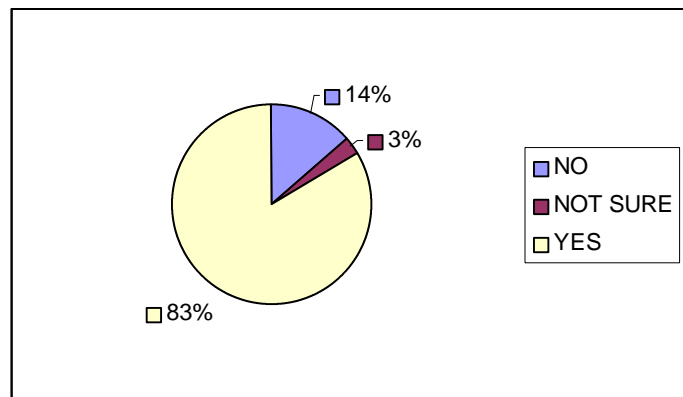


Figure 31: Opinions regarding men with multiple relationships should use condoms

- ***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.

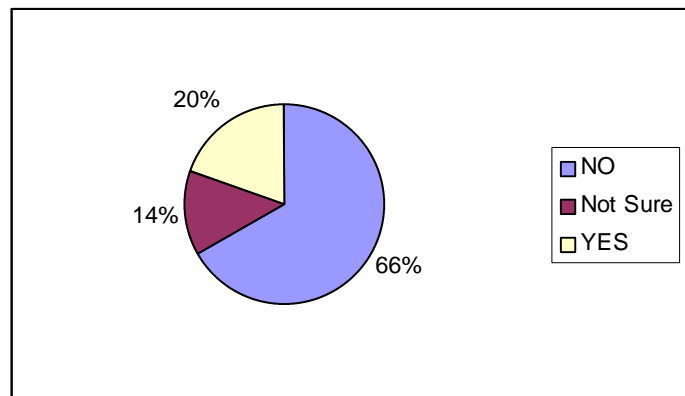


Figure 32: Acceptability of condom use in Botswana

- **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.

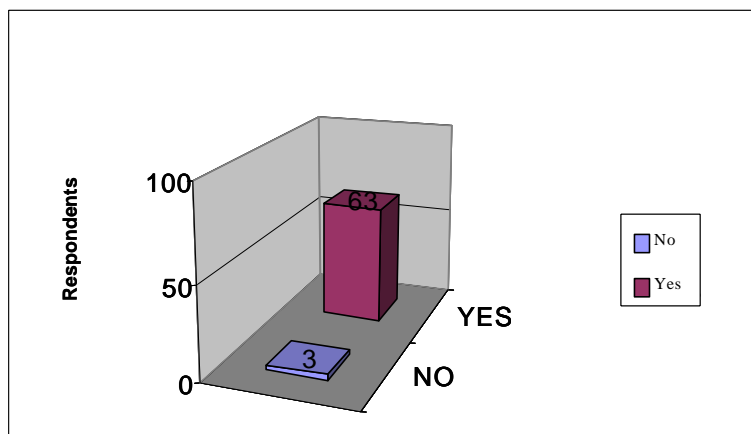


Figure 33: Opinions regarding the statement that condoms should be used to prevent HIV transmission

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.

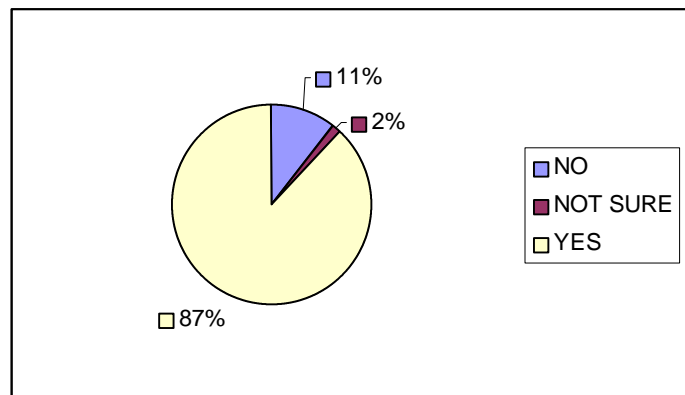


Figure 34: Beliefs in HIV testing

- ***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.

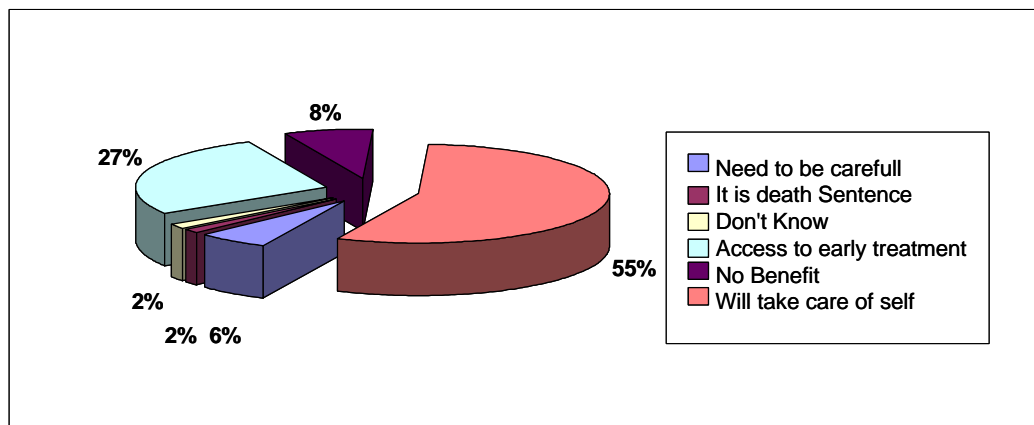


Figure 35: Benefits of knowing one's HIV status

- ***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.